Adolescent suicide prevention in primary care

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Abstract

Introduction: One method of identifying adolescents at risk for suicide is screening for suicidal thoughts in primary care.

Objective: to describe the management of suicide in the primary care setting within the 12-month period following first identification.

Methods: A retrospective descriptive study of 200 adolescent patients who tested positive for suicide risk was conducted.

Results: Of the 200 patients who endorsed the suicidal risk element at their initial visit, 70.5% (n = 141) had a follow-up visit in primary care within 12 months.

Conclusions: it is important to follow up with adolescents after a primary care visit when suicidal ideation is confirmed.

Keywords: suicide, adolescence, prevention, primary care source: DeCS

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Resumen

Introducción: Un método para identificar a los adolescentes en riesgo de suicidio es la detección de pensamientos suicidas en atención primaria.

Objetivo: describir el manejo del suicidio en el entorno de atención primaria, dentro del período de 12 meses posterior a la primera identificación

Método: Se realizó un estudio descriptivo retrospectivo de 200 pacientes adolescentes que dieron positivo en riesgo de suicidio

Resultados: De los 200 pacientes que respaldaron el elemento de riesgo suicida en su visita inicial, el 70,5 % (n = 141) tuvo una visita de seguimiento en atención primaria dentro de los siguientes 12 meses

Conclusiones: es importante el seguimiento de los adolescentes después de una visita de atención primaria cuando se confirmaron ideas suicidas.

Palabras clave: suicidio, adolescencia, prevención, atención primaria

fuente: DeCS

Introduction

Suicidal ideation is relatively common among adolescents, with 19% of adolescents aged 13-18 years experiencing suicidal ideation (having seriously thought about suicide). Suicidal ideation increases the likelihood that adolescents will subsequently plan and therefore attempt suicide, although more than 80% of adolescents who have attempted suicide have already received some form of mental health treatment[1].

One method of identifying adolescents at risk for suicide is preventive screening for suicidal

thoughts and behaviors in the primary care setting. This is important since 50% or more of adolescents attend a primary visit yearly for any health-related reason. In addition, it is common for those who die by suicide to use primary care facilities within a year prior to suicide. For example, in a study of adults who died by suicide, 50% had attended a medical visit within four weeks prior to death[2].

Standards for suicide risk management are unclear in the existing research literature. The Guidelines for Adolescent Depression in Primary Care (GLAD-PC) toolkit recommends initial management and safety planning, including restricting access to lethal means, preparing the family to monitor suicide risk, establishing emergency contacts and crisis resources, engaging in mental health treatment, and arranging follow-up care[3]. If necessary, providers are encouraged to refer suicidal youth to crisis or emergency services and inpatient care.[4]

Other safety guidelines differ depending on the severity of suicide risk and the needs of the adolescent. Interventions for adolescents at moderate or high risk include an immediate assessment by a mental health professional, while low-risk individuals need appropriate follow-up and referral for evaluation. However, ongoing primary care management of youth with suicidal attempts and behaviors is unclear.

Self-harm was defined as any act of self-poisoning or self-injury, regardless of motivation, including non-suicidal self-harm and suicide attempts[5]. Among the young people in the study with a history of self-harm, a diagnosis of depression was very common (recorded in more than one-third of young women and more than one-quarter of young men).

Although primary care providers are not tasked with treating youth with suicidal behaviors, the reality is that they are increasingly administering psychiatric treatment to their patients. Recent estimates indicate that their primary care provider treated approximately one-third of patients for mental health problems[6]. In addition, while visits to psychiatrists have remained fairly stable, psychiatric medication visits to primary care have increased substantially. In summary, primary care providers are managing a growing population of youth with mental health problems that are complex and include psychiatric medication management, referrals for treatment, and ongoing symptom and medication evaluation. In addition, youth are presenting to primary care with suicidal behavior, a complex biopsychosocial phenomenon[7].

The purpose of this study is to describe the management of suicide in the primary care setting, including follow-up assessments and referral practices, within the 12 months following the first identification of suicide risk. This study focuses on the long-term follow-up of youth whom the physician determined to be of concern for suicidality, which was recorded as no suicidal concern or suicidal concern on the electronic screening tool.[21]

Method

A retrospective descriptive study was conducted of 200 adolescent patients (aged 12-20 years) who screened positive for suicide risk in 10 primary care practices in a city in the Sierra-Central zone of Ecuador. All charts with a positive indication of suicide risk (i.e., youth checked yes to the electronic suicide risk screening question) were reviewed regardless of provider designation of need for follow-up care by the primary care provider. This designation of need for follow-up care was based on the physician indicating whether there was a “concern” versus “no concern” for the youth that supported the suicide risk item. This study was approved by the Universidad Regional Autónoma de Los Andes (UNIANDES).

The Child Health Improvement through Informatics Automation (CHICA) system[8] was implemented by the research team in 10 primary care clinics. One component of the CHICA system is a pre-screening form (PSF), administered to patients via a tablet when registering for their primary care visit. The PSF consisted of a 20-item questionnaire for adolescents, which included screening items for depression, substance use, diet, and sexual behaviors. The PSF was administered to adolescents between 12 and 20 years of age.

Retrospective chart reviews were conducted for all patients who screened positive for suicide risk at their initial primary care visit between 2017 and 2020 (n = 200 patients). The first set included patient characteristics, and the second set of variables focused on suicidal and self-

injurious behavior. Given the importance of behavioral health care for people with suicidality, the last two groups of variables assessed behavioral health care and psychiatric medications.

Univariate differences in patient records between levels of suicide risk were compared using Student's t-test or the Wilcoxon test for continuous variables and the chi-square test for categorical variables. Database and statistical processing of the data were performed and analyzed in the SPSS 26 statistical program (SPSS Inc., Chicago, IL, USA). Descriptive statistics were used for the results collection, presentation and interpretation.

Results

Among the 200 patients who endorsed the suicidal risk item, the primary care physician considered 19.5% (n = 39) to represent a suicidal concern after further evaluation. The mean age of the 200 patients at the first positive endorsement of suicide was 14.7 years (SD ± 2.0). Seventy-two percent (n = 144) were female. Between those deemed by the physician to have a suicidal concern (n = 39) and the no concern group (n = 161), there was a significant difference in reported active suicidal ideation, higher in the suicide concern group.

The records indicated that 87% (n = 173) of patients had a history and mental health status documented in their visit notes. Thirteen percent (n = 25) of patients who endorsed the suicide item were asked whether or not there were weapons in their homes. Primary care providers asked 7% (n = 13) of patients whether they had a safety plan and referred 51% (n = 102) to behavioral health treatment. The percentage of patients who had been referred to behavioral health counseling was higher in the suicidal concern group versus the no concern group [suicidal concern = 28 (72%); no concern = 74 (46%); p-value < 0.003].

At the index visit when suicide screening was performed in primary care, 56 % (n = 112) of patients had a diagnosis of depression, and the group with suicidal concern had a slightly higher percentage compared with the no concern group [suicidal concern = 28 (72%); no concern = 84 (52%); p-value < 0.02]. Differences in diagnoses of anxiety, autism spectrum disorder, and other mental health complaints were insignificant between the suicidal worry and no worry groups. In addition, the type of psychotropic medication (antidepressant, anxiolytic, etc.) was not statistically significantly different between the suicide preoccupation and no preoccupation groups.

Of the 200 patients who endorsed the suicidal risk element at their initial visit, 70.5% (n = 141) had a follow-up visit in primary care within the next 12 months. At follow-up, the rates of youth with active suicidal ideation, past reported suicidal ideation, and past reported suicide attempts were not statistically significantly different.

The records indicated that 80% (n = 113) of the 141 patients who had follow-up had a documented mental health history and status at their follow-up visit. No significant differences were observed between levels of suicide risk [suicidal preoccupation = 21 (75%); no preoccupation = 92 (81%); p-value = 0.44]. Twelve patients who attended a primary care visit during the follow-up period were asked about weapons in the home, with no significant difference between levels of suicide risk (p-value = 0.77). Primary care providers also asked patients if they had a safety plan, with no significant difference between suicide risk levels [p value = 0.59].

Between the suicide concern and no concern groups, there was no difference in the frequency with which patients were referred for behavioral health counseling [suicide concern = 14 (50%); no concern = 54 (48%); p-value = 0.83], and 26% (n = 37) of patients were compliant with their behavioral health visits. During the 1-year follow-up period, 15% (n = 21) of patients were hospitalized for unspecified reasons. There was no significant difference in hospitalization between groups. The type of psychotropic medication was also not significantly different between the suicide preoccupation and no preoccupation groups (p-values ranged from 0.06 to 0.98).

Discussion

Following identifying youth risk for suicidal behaviors or thoughts at the first primary care visit, we found that follow-up actions taken by physicians included a low rate of safety planning discussions. However, rates of discussing the patient's mental health history/status and

referrals to behavioral health counseling were high. This was true, however, only for the suicidal concern group. Follow-up actions by physicians when the youth came to primary care in the next 12 months were similar to those found at the initial visit, but there was no difference between the suicide concern groups in the rate of referrals to behavioral health counseling. It found a low participation rate in behavioral health counseling visits[22].

At initial primary care visits, few youth were asked whether or not guns were present in the home or discussed with their physician about safety plans, 13% and 7%, respectively. Similar rates were found at follow-up care visits. Only 12 patients out of 141 were asked about guns in the home, with no significant difference between levels of suicide risk. In addition, only eight patients were asked if they had a safety plan. Mental health symptoms, such as depression, may influence whether or not people attempt suicide[9, 10,11]. In addition, a recent study of adults in a primary care setting found that physicians rarely asked about access to firearms[12]. In summary, the low reported rates of physicians asking about guns in the home and safety plans are concerning, and to determine whether adolescents are safe after leaving primary care, these topics should be discussed more frequently[13].

In comparison, referral rates to behavioral health counseling were higher in both initial and follow-up care compared with rates of safety planning and discussion of gun access. It has been speculated that physicians may more readily refer their suicide-risk patients to outside mental health care providers because primary care physicians may view the care of suicidal patients as a greater vulnerability to malpractice complaints if an adverse event occurs after meeting with the patient[14,15]. Unfortunately, only 26% of patients are referred to behavioral health care for referral[16].

The continuity rate of prescribed medications was also reported to be low during follow-up visits (32 %, n = 45). The continuity of psychiatric medication is an important issue for adolescents. There is a wide range of reasons for the lack of continuity. Qualitative interviews about the experiences of children, adolescents, and their parents recorded reasons for not continuing a medication, including unintentional continuity, forgetting to take medication, not filling prescriptions, and forgetting medications when traveling[17]. Medication continuity can be improved by individualized medication management plans with patients and their families before they leave the primary care setting so that families know the challenges they will face in adhering to medication regimens and are better prepared to deal with potential problems.

Guidelines are helpful in initially evaluating youth for suicide in primary care. However, guidelines for follow-up management of youth with suicidal concerns are lacking. A recent review of suicide screening interventions in primary care emphasizes the importance of education, screening, depression management, and further assessment of suicide risk[18,19]. In addition, primary care models for suicide intervention have been evaluated. For example, Wintersteen trained primary care staff to implement direct. However, brief interventions with youth presenting a suicide risk and training clinicians to refer patients to behavioral health counseling in an outpatient setting rather than directly to the emergency department in cases of acute risk[20].

Conclusions

Given the results of our study, we believe that identification and management of at-risk adolescents are important within the primary care setting and that continued follow-up of adolescents after a primary care visit when suicidal ideation was confirmed is also important.

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