Depression Screening and Suicide Prevention in Healthcare Settings for AI/AN Youth
Goals and Objectives

• Interpret epidemiology on depression and suicide risk prevalence among American Indian and Alaska Native youth

• Identify risk and protective factors for depression and suicide

• Apply best practices for screening and assessment of depression and suicidal behavior
Depression Prevalence

• 11% of 13-18 year olds in the US have ever had an episode of major depression

• 7.5% have experienced major depression within the past year

• 28% of depressed teens report having suicidal thoughts in the prior year
Prevalence of Depression/Suicidal Thoughts

Percent Reporting Behavior

- **AI/AN**
- **Hispanic**
- **Black**
- **Asian**
- **White**

- Depression
- Suicidal Ideation
- Suicide Attempt
Impact of Depression

- Poor relationships and social isolation
- School failure and low long-term educational attainment
- Substance use: drugs, alcohol, and tobacco
- Poor overall health
- Depression recurrence (~70% within 5 years)
- Other mental health disorders
Suicide Rates by Race/Ethnicity

Suicide Rate per 100,000 Population

- AI/AN
- Hispanic
- Black
- Asian/PI
- White

Females
Males
Risk Factors for Depression and Suicide

- Family: Family conflict, family history of depression/substance abuse/suicide, and low socioeconomic status

- Negative life events: Parental divorce or separation, loss of a friend or parent, poor peer relationships, poor school performance, bullying, abuse or neglect

- Characteristics of youth: anxiety, low self-esteem, high self-criticism, impulsivity, sexual orientation
Additional Factors Affecting Depression and Suicide Among AI/AN Youth

- **Individual**
  - Identity
  - Perceived discrimination
  - Alienation
- **Family**
  - Connectedness
  - Spirituality
- **Community**
  - Adaptation
  - Acculturation
  - Clustering
Parents and Elders Perspectives on Youth Suicide Rates

• Qualitative Analysis of AI parents and elders
  • n=49, 9 elders

• Identified 4 external factors:
  • Effect of the “modern world”
  • Historical trauma
  • School difficulties
  • Problems finding a job
Accessing Care for Treatment

- In a national survey, 60% of depressed adolescents reported that they had received some type of care for their depression.

- <40% of US adolescents with depression receive treatment by mental health specialists.

- AI/AN youth may experience additional barriers to accessing mental health care.
Seeking Help When Suicidal

• When suicidal, most (76%) AI/AN youth seek help
  • 63% family and/or friends
  • 41% mental health professional
  • 13% school counselor or teacher
  • 3% medicine man
Reasons for Not Seeking Help when Suicidal

- cost/lack of services
- fear of consequences
- self-reliance
- felt nobody could help
- felt had enough help
- stigma/embarrassed
- not aware
Most Commonly Cited Barriers to Treatment

- awareness
- disorganization
- acceptance
- motivation
- belief
- ambivalence
- stigma
- competing demands
- resources
Strategies to Address Patient Barriers to Care

Screening
- Lack of awareness

Education/Engagement
- Lack of acceptance/belief in diagnosis
- Stigma of seeking or receiving treatment
- Lack of motivation
- Ambivalence

Ongoing Support (Care Management)
- Lack of resources
- Disorganization
- Competing demands
- Lack of motivation
- Ambivalence
Screening for Depression in Adolescents

- Recommended beginning at age 12 by:
  - Preventive Health Guidelines (Bright Futures, GAPS)
  - US Preventive Services Task Force

- US Preventive Services Task Force stipulates that screening should only be done….when systems are in place to ensure accurate diagnosis, treatment, and follow-up
Key steps for implementing screening

- Develop a Plan for Screening
- Making a Plan for Further Evaluation
- Engaging Patients in Treatment
Factors to Consider When Choosing a Screen

- What are you interested in screening for?
  - Depression-specific vs. more general behavioral screen

- Who are you screening?
  - Age & developmental level
  - Cultural context

- How feasible is it to administer?
  - Can you afford it?
  - How easily/quickly can you score and interpret it?
Depression-Specific Tool: the Patient Health Questionnaire 9-item Screen (PHQ-9)

• Brief tool validated for screening for adult or adolescent depression in medical settings

• Includes 9 questions that represent key symptoms of depression over the prior 2 weeks each with a 0-3 response option (27 possible)

• The 9th item is a broad-based suicide screening item

• A score of $\geq 11$ has a 89.5% sensitivity and 77.5% specificity for detecting major depression in teens
# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use “✓” to indicate your answer)*

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

*add columns + + + + *

**TOTAL:**

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)*

**10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
Very Brief Depression Tool: the Patient Health Questionnaire 2-item Screen (PHQ-2)

- In the past two weeks how often have you been bothered by (scaled 0-3):
  - Feeling down or depressed or hopeless?
  - Little interest or pleasure in doing things?

- A score of 3 or higher has a sensitivity 74% & Specificity 75% for detecting major depression

- However, 20% of youth with suicidal ideation would be missed by screening with the PHQ-2 alone
Screening for Suicide in Non-Depressed Teens

• Although suicidality is more common in depressed teens, not all suicidal teens are depressed

• It is important to screen all teens specifically for suicidal thoughts, not just depressed teens

• Suicide Item from Bright Futures:
  – Have you had thoughts in the past year about wanting to hurt or kill yourself?
Developing a Plan for Screening for Your Practice

• Create a plan regarding which visits will include screening (e.g. well child, other)
• Assign who in the practice will be responsible for administering the screen and for reviewing the results
• Develop protocols and resources for patients who need further evaluation
• Make sure confidentiality policy is in place
Screening and Confidentiality

• Teens are LESS likely to endorse suicidal ideation in the presence of their parent and should be interviewed independently

• Policies regarding confidentiality should be clear and shared with teens before screening

• Confidentiality should be broken if there is any concern that the teen is at risk of hurting him/herself
Key questions for implementing screening

- Choosing a screening test
- Making a Plan for Further Evaluation
- Engaging Patients in Treatment
Making a Plan to Follow-up on Positive Depressive Screens

• All teens with a positive screen should have an interview with a clinician to assess for depression

• The higher the number of symptoms the less likely that the symptoms will spontaneously remit
  • 93% of teens with a PHQ-9≥20 continue to be depressed 6-weeks later compared to 35% of those with PHQ-9=11-14

• Teens with mild symptoms might be appropriate for a period of “watchful waiting” but should have clear follow-up plans
Making a Plan to Follow-up on a Positive Suicide Screen

• Any teen who endorses suicidal ideation on a screening question should be evaluated before leaving the appointment
• Assessment should include the “4 P’s”: past suicide attempts, suicide plan, probability of completing suicide, and preventive factors
• Subsequent plans should be based on level of risk
  • High risk – mental health evaluation emergent (within 24 hours)
  • Moderate risk - evaluation by ~72 hours
  • Low risk – might not require external evaluation
Safety Plan for Suicidal Teens

1. Warning signs
2. Coping strategies
3. People who can help
4. Professionals and resources to contact during a crisis
5. Making the environment safe
When to break confidentiality?

- Teen endorses suicidal ideation assessed to be more than mild musings about death
- Teen reports having a plan and/or intention around what they would do and access to lethal means
- Teen is unwilling to do safety planning
- Teen is actively engaging in self-injurious behavior, of which parent is not aware
- When in doubt or uncomfortable
Key questions for implementing screening

- Choosing a screening test
- Making a Plan for Further Evaluation
- Engaging Patients in Treatment
Education and Engagement Following Screening

- **Listening:**
  - Context and meaning of the depression for the teen
  - Main strengths and motivators for the teen
  - Key challenges for the teen
- **Discussing:**
  - Depression in a way that reflects what the teen has shared about context
  - Treatment options in a balanced, non-judgmental way
- Treatment choice and plan next steps
- Develop safety plan
Tips about Engagement

• Engagement may take several visits
• Teens are likely to be more engaged when the treatment plan honors their preferences
• Parents play a critical role in providing resources for teens to receive treatment and their perspectives should be considered when making the treatment plan
Care Management

- All teens who screen positive should have a follow-up appointment and repeat symptom assessment.
- Practices should have a system to track patients and a plan to reach out to those who don’t return.
- All patients in active treatment should have frequent follow-up to:
  - Assess medication treatment engagement/side effects.
  - Assess receipt of psychotherapy/assist with connecting with provider.
  - Re-assess symptoms – repeating a tool like the PHQ-9 can help providers determine if treatment intensity needs to be increased (“stepped care”).
Case 1: Tiva

- 15 year old girl who is in for a well check
- PHQ-9 = 13
- Symptoms make daily life “somewhat difficult”
- No suicide ideation
Tiva: Clinical Evaluation

- First episode for her or her family
- Very anxious teen
- Strengths:
  - Insightful
  - Supportive friends & parents
- Stressors:
  - Heavy school load
  - Recently asked to take on increased family responsibilities
Depression

1. Thoughts and Feelings (Worries, Sadness)
2. Behavior (putting off schoolwork, seeing friends less)
3. Physical Health (sleep problems)
4. Stressors (caring for siblings, school work)

The cycle shows how depression can be perpetuated through these linked factors.
Tiva: Treatment Plan

- Symptom tracking
- Cognitive behavioral therapy:
  - Behavioral activation
  - Discussion with parents
  - Time management
- Work on sleep hygiene and relaxation (tapes)
Tiva: PHQ-9 Score

Baseline  Wk 2  Wk 4  Wk 6  Wk 8  Wk 12  Wk 16  Wk 20
Tiva’s Relapse Prevention Plan

- Warning signs: feeling overwhelmed, poor sleep, withdrawal
- Early strategies: spending time with friends, stress relief (relaxation tapes, music)
- If not getting better: talk with parents or doctor
- What worked: talk therapy
Case 2: Dakota

• 16 year old boy
• On probation at school due to fighting and poor grades
• Has become withdrawn recently
• PHQ-9 score is 10
• Indicates frequent thoughts of hurting himself on 9th item
Dakota: Clinical Evaluation

- No prior depression but alcoholism in family
- Strengths:
  - Good athlete
  - Wants to feel better
- Stressors:
  - Fighting/Anger issues
  - Mom drinks frequently
  - Bullying
Suicide Risk Assessment with Dakota (4Ps)

- **Past** suicide attempts: None
- Suicide **plan**: Does not have a specific plan; thoughts are triggered by bullying, occur frequently
- **Probability** of completing suicide: Indicators of high risk include impulsivity and possible substance use
- **Preventive** factors: Suicide unacceptable; discusses how difficult it would be for his family if he were not alive; long-term athletic goals
Bringing Dakota’s parents into the conversation

• Notify Dakota of your obligation to tell an adult

• Explain the reasons you need to break confidentiality, emphasizing the importance of keeping him safe

• Offer Dakota the opportunity to communicate these concerns himself, but he declines. He does decide to be present during the conversation
Dakota’s Next Steps in Treatment

• Create a safety plan
• Initiate treatment for depression
• Problem-solve around bullying
• Further assess substance use
• Maintain close follow-up
Conclusions

- Screening for depression and suicidal behavior in adolescents is important for AI/AN youth
- All youth who screen positive for depression should have further evaluation to determine if depression is present
- All youth who screen positive for suicide should have further evaluation to determine level of risk and next steps in care
- Screening alone is not enough, to be successful, practices must also consider education and engagement and ongoing care management to help keep youth in care
Thank you!

Cari McCarty, PhD
Laura Richardson, MD
Linda Smith, RN, BSN, MN
Michaela Voss, MD