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CENTER FOR DISEASE PREVENTION & EPIDEMIOLOGY • OREGON HEALTH DIVISION

IDENTIFYING AND PREVENTING YOUTH'S SUICIDAL BEHAVIOR

ALTHOUGH Oregonians of every age group die by suicide, the upward trend in rates over the past few decades has been driven principally by suicide among adolescents and young adults. Approximately 75 Oregon youth aged 10–24 die each year by suicide, and it is the second leading cause of death.

Even larger numbers of youth attempt suicide and report suicidal ideation. Some 750 youth are treated annually in Oregon's emergency departments for attempts, and according to self reports in Oregon's *1999 Youth Risk Behavior Survey* (*YRBS*)[1], 16% of youth aged 15–19 reported seriously considering suicide in the preceding 12 months.

The purpose of this article is to provide physicians with data to assist in the recognition of suicide risk among Oregon youth and encourage physicians to play a key role in suicide prevention. This *CD Summary* issue presents findings from the *1999 YRBS* which document the numerous risk factors that are associated with self reports of suicidal behavior among youth taking the survey. In addition, this article introduces strategies of interest from *The Oregon Plan to Prevent Youth Suicide: A Call to Action*[2], and provides guidelines for suicide prevention in primary care.[3]

YRBS RESULTS

The survey included four questions regarding sadness, suicidal ideation, and behavior:

1. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
2. During the past 12 months, did you ever seriously consider attempting suicide?
3. During the past 12 months, how many times did you actually attempt suicide?
4. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?

Simple frequency extrapolation of the data on self-reported suicidal behavior among Oregon youth can assist us in developing a sense of how many Oregon youth may be at risk for suicidal behavior. The table illustrates the percentages and population estimates of Oregon youth reporting suicidal behavior in the *1999 YRBS*.

These numbers may seem high, but they are what the students reported, and are consistent with the national *YRBS* results. Nationally, in 1999, 28% of surveyed youth reported sadness, 19% reported considering suicide, 8% reported suicide attempts, and 3% reported being treated for attempts.

Prevalence and population estimates of suicidal behavior

Behavior reported in YRBS	% of youth surveyed who reported risk	Oregon youth population esimates
Sad	24	39,000
Seriously considered suicide	16	26,000
Attempted suicide	6.4	10,000
Treated for attempts	1.7	2,800

Source: *1999 Oregon Youth Risk Behavior Survey*

YRBS data show that suicidal behavior is strongly linked to other environmental and behavioral risk factors. When compared to their peers who do not report a suicide attempt, these youth have increased risk for other problems. These behaviors or environmental factors include:

- poly-substance abuse;
- depression, anxiety or eating disorder;
- history of being forced to have sexual relations;
- history of injected drug use;
- history of physical abuse;
- physical, learning or emotional condition that limits ability to go to school or do school work;
- lack of caring adults;
- harassment: sexual, racial, and due to perceived sexual orientation.

While not all youth who exhibit these problems are suicidal, the majority of youth who die by suicide have been discovered retrospectively to have a variety of these and other risks.[4] Existence of these risk factors in a youth's history point to the need for further investigation to find out if a youth has plans, means and firm intentions to carry out an act of self-harm. For a copy of the full *Oregon Health Trends YRBS Report*, see *http://www.ohd.hr.state.or.us /chs/oht.htm.*

OREGON'S SUICIDE PREVENTION PLAN

The Oregon Plan to Prevent Youth Suicide: A Call to Action (*www.ohd.hr.state.or.us/ipe/suicide.htm*) has just been released by the Health Division as a tool for communities to use in assessing the need for preventive measures and planning to improve suicide prevention. Some are surprised to learn that the plan includes activities for journalists, teachers, juvenile justice workers, pastors of faith communities, coaches, parents of those who have lost youth to suicide, as well as physicians and behavioral health practitioners. The plan includes three prevention approaches: community education, integration of systems serving high risk youth, and access to a full range of health care that includes mental health and alcohol and drug abuse treatment services.

The primary care physician is on the front line and can play a key role in community suicide prevention. Retro-

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spective research indicates that at least for adults, many individuals consult a physician in the months preceding a suicide.[5] Identification of suicidal thought and intentions can be as simple as asking a series of questions to assess psychological well being. Unfortunately, many physicians receive little or no training in the assessment of suicidal behavior or risk. Like most people in our culture, physicians may find themselves uncomfortable with the topic of suicide. Many may believe that asking about suicidal behavior or thoughts may encourage suicide, or that a suicide is not preventable.

Professional education is necessary to raise awareness of the problem and assist practitioners with assessment and intervention skills. Medical literature in assessment and treatment of suicide among patients in the primary care setting can offer physicians information needed to begin incorporating new assessment techniques into practice. The state youth suicide prevention plan calls for champions from different professional disciplines to take up the cause to prevent suicide and assist in educating peers. Information in the following section is from an article entitled: *Suicide prevention in primary care: careful questioning, prompt treatment can save lives.*[3]

ASSESSMENT IN PRIMARY CARE

Certain individuals are at higher risk for suicide than others. Interviews with all new patients should include questions about history of psychiatric disorders, substance abuse, and suicide attempts. Careful assessment which includes the following questions and areas of inquiry can provide physicians with the information necessary to intervene and save the life of a patient.

RECOMMENDED QUESTIONS AND AREAS OF INQUIRY

1. Asking "how is your mood" is a good way to start a conversation about the patient's state of mind.
2. Patients who indicate a depressed or anxious mood should be asked about symptoms of depression, anxiety, and other psychiatric disorders.

   Explore problems: the onset of symptoms, recurrence of symptoms, previous treatments, recent stresses, social and economic factors, concomitant illnesses, hormonal changes, and medications that can cause or exacerbate psychiatric disturbance.

   Explore strengths: sources of hope, strength, self esteem, family and social support.
3. Patients with a history of psychotic symptoms should be asked whether they have experienced hallucinations that feature commands to commit suicide.
4. If psychological distress is noted, ask, "Have things gotten so bad you have considered taking your own life?" (Most patients will discuss suicidal feelings).
5. A question that must follow an affirmative response to suicidal ideation is, "Do you have a plan to harm yourself?"

   Follow-up questions to an affirmative response include exploring: patient's access to firearms, harmful medications, and other means of suicide.

Action is necessary in the event that a patient has reported suicidal ideation. All patients with suicidal ideation should receive an immediate thorough evaluation and treatment. For further discussion on treatment of suicidal individuals see the entire article at *http://www.postgradmed.com/issues/2000/11_00/hamilton.htm*. The information above was included in an article that is part of a four-part series on psychiatric crises in primary care.

CONCLUSION

Increasingly over the past three decades adolescent angst has given way to suicidal behavior among youth with a frequency unheard of in the 1950's. The burden of assessment and treatment of suicidal youth falls to primary care physicians in each community. Physicians are encouraged to assess their skills and confidence in assessment and treatment of suicidal youth. Medical literature and educational resources are available and the Health Division can assist in accessing them.

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