

Medical Home Phone Conference
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"Risk Factors for Utah Youth Suicide"
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Dr Samson-Fang: We are here today to talk about youth suicide in Utah, what is the risk, what are the things as primary care physicians, health care providers and health care coordinators we should know about suicide risks and our roles in preventing them.

Dr Grey: I would like to give a broad overview, which may spur some questions. We know that 90% of the suicide completers who are adolescents have a psychiatric diagnosis. We know that from a technique called "psychological autopsy" where after the death we go and interview the parents, schoolteachers or siblings and go through specific psychiatric symptoms. The same has been found with adult suicides and even with geriatric suicides, which we sometimes suppose is due to cancer or other medical problems, but actually depression is the most common cause. The most common diagnosis is major depression or something in the mood disorder category. The most high-risk diagnosis are bi-polar and schizophrenia. But depression is so much more common and is the most common diagnosis for suicide. Another diagnosis is substance abuse. A deadly combination is a teenager, especially a boy since 90% of completed suicides are male; girls tend to use less violent methods. If you have a teenage boy who struggles with bi-polar disorder and who then gets into substance abuse you get into a higher risk category kid. If you add in the availability of firearms and add to that some type psychotropic stress like breaking up with a girlfriend, then you have a scenario of the highest risk for suicide. Teenagers, unlike older adults, are more prone to cluster-type suicide. We have to be very cautious of what we say in the media because you can have one suicide and then if that person gains a lot of attention and notoriety and is put up on a pedestal, someone else who is also vulnerable, who's mentally ill, may attempt suicide because of that incident. The CDC website has guidelines for the media. If you ever get a call from the media asking if they should report a suicide, have them go to the CDC website and pull off the information because it is important to follow, especially because of the aspect of cluster suicide. Statistically, suicides increased for several decades but most teenagers who complete suicide have never made an attempt, so you get into a dichotomy where making attempts puts you at risk for decades for suicide increase risk. But often with teenagers completion is initial. One of the most frequent questions I'm asked why is 90% of suicide completer's are male and suicide attempters are female. As a career some people study suicide genders and I've had an opportunity to talk to them at length. Interestingly, if you take high school students and have them read vignettes about a girl who attempts suicide, a girl who completes suicide, a boy who attempts suicide and a boy who competes suicide, the teenagers seems to have empathy for all of them except when a male is reading about a male who attempts because it seems more feminine. There is a push in our culture for boys, that if you are going to commit suicide you better complete it because that is more masculine.

I am also frequently asked why the suicide rate is so high in Utah. It is high compared to the national average. However, its a misnomer because in terms of the Rocky Mountain states, and sometimes Alaska, that's been broken down by age and gender so no matter how you look at it the rates in the Rocky Mountain states are higher than the rest of the United States. Firearms availability is one factor that plays a role in that but it turns out that in some parts of the country like the southeast where there is higher firearm availability, there are lower suicide rates. Culture seems to be a big factor. I don't know what it is about the culture in the Rockies, whether the people who moved here are fiercely independent, or what that gene is, but the answer is: we don't know from a scientific standpoint. The CDC has looked into it and they don't know. I think it's better to say that the Rocky Mountains have a

higher suicide rate, which includes our neighbors like Nevada and Colorado, rather than pinning it on Utah. So Las Vegas and Salt Lake are the same - they both have high suicide rates. In the suicide study in Utah we found that when we went into the homes of parents who lost kids to suicide, many of the parents said that their child was on medications. However, in working with the Medical Examiner and seeing the toxicology reports on these children we found that not one of those children had any psychotropic drugs in their systems. Sometimes parents have a perception that their kids have stayed on their psychotropic meds but they really are not taking it. One thought is that the stopping of the medications and then the use of opium's or any type of self-medicating is what pushed them towards suicide. Another interesting thing I found is that all the prevention programs are at schools. I questioned whether these children were actually in school. We found through a study that approximately a third of the children were just in school and a third were just in the juvenile court system and a third were both in the school and the juvenile court system. I also found that each school district is like it's own sanctum and when a parent moves and registers their child if they don't show up the parent is in trouble. When a parent moves and doesn't register a child they are off the radar screen, no one knows they exist. Those children can still be picked up for smoking or drugs and end up in the juvenile court. So probably one of the biggest findings is that prevention needs to be not only in the schools but also in the juvenile court. Recently our research group received a grant and because of this we are now able to take mental health services to some of the kids in the courts who have mental health problems. We did a pilot study in the juvenile courts where we picked out two mentally ill 15 year olds. With one of the kids they did a really rapid access to psychiatric treatment, in home services and case management. The other one could just go out in the city and find anything they wanted, they could even come and see me. But, as you know, it's hard to access services normally because the mental health system is broken into pieces so, not surprisingly, the mental health of the kids in the treatment group did much better. But what was really interesting is that the kids we treated stopped offending and the kids who were not in the treatment group, even though they had access to community services, that group didn't get care, they ended up in emergency rooms, they were in lock downs, there were suicide attempts and other things that cost a lot of money and obviously was not good for the child and family. Those kids got what everybody gets now. We are hoping to bring with this grant health and treatment to a much larger group of kids. It won't really be research but it will evaluate the kids and make sure services are working. It is not a true research design. We will apply for another grant to do that piece that breaks down the services into bits and see which of the services are most effective.

We learned that kids that commit suicide either don't take medicine or stop taking medicine and this has been replicated in other states. Kids who turn to illicit drugs and combine that with access to firearms really increases suicide risks. Any questions?

Dr. Samson-Fang: When you work with an adolescent and his parents, what do you tell the parents about who should be giving the meds and who should be responsible for giving the meds?

Dr. Grey: That is variable. It depends on a lot of factors. I have some teenagers who come to see me who have depression and feel miserable. Some of those teenagers are very organized kind of kids and they are almost self-referred; they've asked their parents to bring them in. Those are kids who often take their own medications, although I like to see them use a pillbox and I like to have the parents check to make sure the medications are being taken. On the other hand, if I have younger kids or kids who are disorganized or kids with ADHD or teenagers who are real ambivalent about the medication, then I am more likely to ask the parents to give the medications every day. Sometimes we get into stalemates where kids will say they aren't going to take the meds unless they can do it themselves and the parent will say that they want to watch them take it. Then they will come to some compromise where for the first month the parents are responsible for administering the medication then after that

they load the pillbox. If the kids can get a full month of treatment with good compliance then they can see that the medication is working and if they stop taking it they can see and feel the difference.

Dr. Samson-Fang: Other Questions?

Can you tell me if statistics are higher for single parent families and secondly, is it the first born child or in which birth order has the greatest risk of depression?

Dr. Grey: I don't think anyone has looked at birth order that I know of. I haven't seen anybody who has done a study on that yet. In terms of family make up, one thing we've found in our study is that there are quite a few kids who had their parent divorce within six months of the suicide. We were taken aback at how many kids had their parent split up in proximity of six months to the suicide. So that may turn out to be a risk factor. Dr. Gould, who is one of the top young suicide analysts in Columbia, New York, has done some of the biggest psychological autopsies studies. Initially, they found that there was a lot of family conflict playing a role in suicide but when they did other studies they used a control group where there was a kid who was alive but had the same diagnosis as the teenager who died by suicide and when you give the kid the same diagnosis in the control group a lot of the conflict disappears statistically. In other words, it may be that the kids' diagnosis causes the conflict rather than the kids responding to family conflict. It looks like most of it has to do with how stressful it is dealing with a child with schizophrenia or how stressful it is dealing with a child who is bipolar and the actual diagnosis that is creating the stress.

Dr. Samson-Fang: What do you think Medical Homes could be doing to decrease the suicide risk in the individual that they see as well as in society in general?

Dr. Grey: I think the main thing is for each patient to have a thorough evaluation, whether that is done by a psychologist or psychiatrist, someone who is focused on children and adolescents. There is so much more to it than just standard medical treatment or referring someone to a specific therapy. I saw a college student who was demoralized because she planned to apply to a professional school, she had always been a straight A student but now she was getting Ds and Fs and she was struggling with daily suicidal feelings. She believed she could get better with treatment, but when I told her that I would talk to her dean and get her removed from school and have those grades released, I could see the weight lifting off her shoulders. We were able to do that so she could start with a clean slate. All it showed on her records was that she took a semester off, which is not a big deal. She ended up back in school getting good grades again with a fresh start. So besides getting a diagnosis there are other factors that have to do with understanding who that person is, what's important to them, what the future looks like and where they need help. So besides thinking of the standard treatment, it's the art of what we do in terms of figuring out for that individual what is causing them stress.

There is an increasing tendency for primary care providers to treat psychiatric diagnosis. This trend started with ADHD and now, increasingly, depression is being treated by primary care providers, I've even seen bipolar disorder being treated by them. I've heard you mention psychological or psychiatric evaluation and I tend to do that because I feel more comfortable having the psych team as consultants. Can you comment on that trend and how that might be affecting the outcome of patients with a psychiatric diagnosis?

Dr. Grey: I think each practitioner needs to decide where his or her line in the sand is. So you may decide you feel comfortable treating ADHD, especially if the parents can get the data from teachers or if a school psychologist helps gather data. With depression you may say you are comfortable treating mild or moderate but not someone psychotic and depressed. With anxiety you might say you are

comfortable treating particular disorders but not others. I had a wonderful experience working in New Zealand for a year where all the medical specialties worked together for all the needs of the children we saw. It was an excellent model of what we could do in this country. However, at this point we don't have the funding for a team approach.

Dr. Samson-Fang: You mentioned a lot of these kids are in treatment at the time of their suicide. Had their depression been recognized and they just didn't get treatment or had they not even been recognized?

Dr Grey: When we went into these homes, about two thirds of the parents identified their kids as having psychiatric illness. We did another study where we talked to all the parents who had lost their kids by suicide, the best friends, schoolteachers and we asked them about the barriers to treatment. We had a list of 20 potential areas including other areas we didn't think of. The interesting thing is no matter whom you asked, they came up with same 5 barriers and they all had to do with stigma. The person who died was embarrassed of having a mental problem and they didn't think anything would help them. It's very important that we break down the stigma about mental illness. There are several programs designed to do this: The National Alliance for the Mentally Ill has a program "Hope for Tomorrow" that is in the schools. I am working with the First Lady Mrs. Huntsman's program "The Power in You" designed to help break down the stigmas about mental illness.

Next Conference is August

In attendance:

Dr. Lisa Samson-Fang, Dr. Grey, Al Romeo, Budge Clinic, Bob Terashima, Dinosaurland Vernal, UVP Cherry Tree, UVP Plaza Office, Montezuma Creek, Redwood.