

SCREENING FOR DEPRESSION AND THOUGHTS OF SUICIDE: A TOOL FOR USE IN ALASKA'S VILLAGE CLINICS

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Abstract: Depression occurs at a significant rate in the U.S. population. Untreated depressive symptoms are a primary risk factor for suicide. Studies show that a significant percentage of individuals who commit suicide had visited their health care providers in the months before their deaths. Alaska ranks number one in the nation for suicide. Routine screening for depression and risk of suicide in Alaska village clinics could lead to reduced depressive illness and death statewide.

Introduction

On average, almost 10% of American adults suffer from depressive symptoms annually (National Institute of Mental Health, 2000). Research shows that 90% of individuals who commit suicide were found to suffer from some type of untreated mental disorder prior to their deaths (Moscicki, 2001; Alaska Suicide Prevention Plan, 2001; Conwell & Brent, 1995; Goldsmith, Pellmar, Kleinman, & Bunney, 2002). These studies and statistics point to the need for early, accurate identification and referral of individuals who may have an undisclosed mental illness and subsequently are at increased risk for self-harm. The *National Strategy for Suicide Prevention* (U.S. Department of Health and Human Services, 2001) and the *Alaska Suicide Prevention Plan* (Statewide Suicide Prevention Council, 2001) outline viable goals aimed at reducing suffering from mental illness and loss of life by suicide. Goal 7 of the *National Strategy* is to "Develop and promote effective clinical and professional practices" and one of the objectives within this goal is "Incorporating suicide-risk screening in primary care." Goal 7 of the *Alaska Suicide Prevention Plan* recommends that "People who work in institutions and groups that

serve or work with high risk populations are able to identify warning signs and respond appropriately." Research shows that more than 80% of people who commit suicide have seen their health care provider within 12 months of their death and more than 65% have visited a health clinic within the last 30 days (Luoma, Martin, & Pearson, 2002). Routine screening to assess for the presence of depressive symptomology and suicide risk, coupled with immediate referral to mental health staff when such symptoms and evidence of risk are present, has the potential to alleviate unnecessary suffering of those in psychological pain and prevent untimely and unnecessary loss of life.

The High Rate and Cost of Suicide

It is estimated that in the United States, there is a completed suicide every 18 minutes and a suicide attempt every minute. According to the most recent data, more than 31,000 people died as the result of suicide in 2003 (American Foundation for Suicide Prevention, 2006). Nationwide, suicide is the 11th leading cause of death while Alaska ranks number one for suicide in the U.S. (National Association of Suicidology, 2004). On average, 125 Alaskans die by suicide annually. Statewide, suicide is the number one cause of death for those under 50 years of age, and Alaska Natives are 4 times as likely to die by suicide as non-Natives (Statewide Suicide Prevention Council, 2006). Alaska Native children as young as 10 have been seen in the emergency rooms of village clinics because of suicide attempts, and Alaska Native children as young as 7 have been reported to experience suicidal ideation (personal experience and observation). Financially, the economic burden of suicide within Alaska is enormous: The average medical cost per hospitalization for attempted suicide is \$15,209 (Education Development Center, Inc., 2003-2005) and the total annual hospital costs are estimated to be in excess of \$5.5 million dollars (Statewide Suicide Prevention Council, 2006).

Information written for layperson and professional alike stresses the importance of inquiring directly about suicidal ideation when such thoughts are suspected. Prevention training programs emphasize that asking about suicidal thoughts does not make suicide more likely, but instead opens the door to exploration of thoughts that an individual might otherwise be reluctant to voice on his or her own (The QPR Institute, 1999; Clark, Thompson & Welzant, 2003). Studies show that screening for suicide in primary care settings can increase identification of people experiencing depressive disorders and suicidal ideation (Pfaff, Acres, & McKelvey, 2001), reduce suicidal ideation in those identified

(Bruce et al., 2004), and decrease suicide attempts overall (Asarnow et al., 2005). Screening in primary care has the potential to ease suffering and save lives in all age groups (Mann et al., 2005).

The Health Care Provider's Unique Opportunity to Intervene

Despite the fact that almost one-tenth of Americans suffer with a depressive illness annually, many delay seeking treatment—or decide not to seek treatment at all—for their symptoms (National Institute of Mental Health, 2000). Only a small percentage of patients experiencing suicidal ideation verbalize their thoughts to their health care providers, despite the fact that a high percentage of individuals who commit suicide have visited their health clinic in the months prior to their deaths. Instead, most individuals choose to share their symptoms with a spouse, friend, or even coworker—who is often at a loss as to how to deal with such information (Fawcett, 2006). Recognizing that patients are rarely forthcoming about their depressive symptoms, health care workers have the unique opportunity and, indeed, the responsibility to take a proactive stance in asking directly about matters that patients are otherwise reluctant to bring up. Straightforward questions aimed at screening for depressive symptoms and suicide risk are perhaps the simplest and most effective way to uncover these serious problems.

Overview of the Rural Alaska Health Care System

Alaska's health care system is unique compared to any other in the United States. The Community Health Aide Program (CHAP) is the foundation for the majority of rural health care in Alaska. The CHAP originated in the 1950s as a result of the nationwide tuberculosis epidemic, and continues today as the primary health care system in the rural areas of the state. Alaska is a vast, predominantly roadless state where harsh weather and isolated conditions are the rule rather than the exception. Transportation between villages and regional hubs is costly and occurs primarily by all-terrain vehicle, snowmobile, small plane, and boat. The CHAP trains local people from each village to work in their respective village clinics managing acute and chronic illnesses, as well as providing preventive care. Usually these Community Health Aides/Practitioners (CHA/Ps) work without a physician assistant, nurse practitioner, or physician on site. In the Norton Sound region of western Alaska, for example, there are no physicians stationed in any of the 15 village clinics served by the hub hospital in Nome. In a couple of the larger

villages of 700 people or more, there is a resident physician assistant (PA). In the remaining villages, a PA rotates through on a monthly basis to provide training and work alongside the CHA/Ps. CHA/Ps staff the village clinics during regular business hours and maintain an on-call schedule around the clock to cover emergencies, with supervision provided via phone or telemedicine by a licensed physician at the regional hub hospital. What falls beyond the CHA/Ps' direct scope of practice is attended to in regional hub hospitals. What falls beyond the hub hospitals' scope is attended to in the closest metropolitan area—which can be more than 500 miles away.

The Community Health Aide/Practitioner Manual and Community Health Aide/Practitioner Manual Patient Encounter Form

The Alaska Community Health Aide/Practitioner Manual (CHAM) is the guidebook used in all village clinics throughout rural Alaska (Alaska Native Health Board and Alaska Native Tribal Health Consortium, 2006a). CHA/Ps of all certification levels refer to the manual for protocol on how to treat every medical problem within their scope of practice. The standard form on which all patient visits are recorded is the Community Health Aide/Practitioner Manual Patient Encounter Form (CHAM PEF; Alaska Native Health Board and Alaska Native Tribal Health Consortium, 2006b). The CHAM PEF was designed to closely follow the “New Problem or Complaint” outline designed as the standard guide for all patient visits. However, as is common with most standardized forms, the CHAM PEF has been customized throughout Alaska's various regions to better fit the particular needs of each region. For example, the CHAM PEF and modified CHAM PEF used in the Norton Sound region of western Alaska include screening questions regarding patients' alcohol use (alcohol is known to be used as a means of self-medication by those with depressive symptoms); however, neither form includes questions aimed at detecting depressive symptoms or risk of suicide. The rationale for not including such questions is that screening for these problems is not part of the standard interview for new problems or complaints.

Suicide Prevention Efforts Already Occurring in Alaska

Suicide prevention is a work in progress in Alaska. As of 2006, the overarching goal of the Statewide Suicide Prevention Council is to reduce the current 3-year average of 21 deaths by suicide per 100,000 to

15 deaths per 100,000 within a 7-year period ending in 2013. Following are a few of the specific ways Alaska is currently working to prevent suicide.

State Efforts

Over the last few years, the State of Alaska Department of Health and Social Services, Division of Behavioral Health (2007) joined with other key stakeholders to develop the Alaska Screening Tool (AST) and the Client Status Review (CSR). Both the AST and CSR are mandated for use by all Alaska mental health and substance abuse programs receiving grant monies from DBH, and are intended to enhance earlier intervention and accurate diagnosis of mental health problems (State of Alaska Department of Health and Social Services, 2006). Both forms assess the presence of depressive symptomology by asking directly about sadness, suicidal ideation, and disruptions in daily activities due to mental or emotional problems. Other statewide suicide prevention activities include monthly State Suicide Prevention Council reports to the legislature; a 24-hour, 7-day-a-week staffed suicide hotline (Suicide Prevention Careline); and print, radio, and television announcements aimed at reducing the stigma surrounding mental illness as well as providing information about services available in various regions. The Alaska Mental Health Consumer Web site is a recovery-oriented resource for consumers as well as friends and family of consumers.

Regional Efforts

Regional prevention efforts occur during annual wellness conferences, health fairs, and dance festivals which take place at regional hubs and in individual villages. A portion of programming time at these events is devoted to mental health issues, including segments aimed at preventive mental health care. Almost every community mental health center within Alaska accepts collect calls or offers a 24-hour toll-free crisis helpline. Telemedicine is also beginning to take hold in many remote villages, offering more immediate help to those who might otherwise have to wait days or weeks to see a mental health provider.

Staff Efforts

Behavioral Health Service (BHS) workers are trained to use the AST and CSR to screen clients at risk for self-harm. Services for those found to be at risk are delivered at the regional hub or, in the case of a traveling itinerant clinician, within the client's village. Throughout the state, Village-Based Counselors (VBCs) and Behavioral Health Aides (BHAs) work in concert with supervising mental health and/or substance abuse staff. VBCs and BHAs are most often local Alaska Native residents who are trained to provide basic mental health and substance abuse treatment, and who parallel the CHA/Ps in that they act as first responders for mental health or substance abuse problems that arise in their villages. VBCs, BHAs, traveling itinerant clinicians, and counselors make suicide prevention presentations within village communities and schools by invitation. They also debrief the residents of a village after a suicide has occurred. Mental health and substance abuse staff are provided ongoing instruction in suicide prevention and intervention through in-house trainings as well as annual statewide trainings. These trainings coincide with Goal 6 of the *National Strategy for Suicide Prevention*: "Implement training for recognition of at-risk Behavior and delivery of effective treatment" and Goal 7 of the *Alaska Suicide Prevention Plan*: "People who work in institutions and groups that serve or work with high risk populations are able to identify warning signs and respond appropriately."

Grants

Alaska has access to state and Federal government grant opportunities targeting suicide prevention. One such grant (now lapsed) funded Community-Based Suicide Prevention Coordinators, who were charged with initiating healthful activities at the village level to promote mental wellness especially in youth. In the Norton Sound region, a multiagency, multidisciplinary Suicide Prevention Council was formed in 2006 to seek a Substance Abuse and Mental Health Services Administration grant. These monies would ultimately reestablish lapsed suicide prevention programs as well as create new ones throughout the region.

The “Screening for Depression and Thoughts of Suicide” Form

In the Norton Sound region of Alaska (the region with the highest rate of suicide overall) a social worker who had a great deal of experience working with suicidal clients and the aftermath of completed suicide spearheaded the creation of the “Screening for Depression and Thoughts of Suicide” form. This one-page paper-and-pencil form was intended to become a permanent part of each patient’s chart that would (1) provide rich research data, (2) help prevent premature death from untreated mental illness, (3) work to destigmatize mental illness by directly asking about symptomatology, and (4) complement the AST and CSR currently in use in the mental health and substance abuse fields. To the author’s knowledge, no such form had ever been used in the Norton Sound Regional clinics. The form also would be an adjunct to the standard CHAM PEF. Brevity, simplicity, and ease of use were primary concerns as the author drew from the *Beck Depression Inventory BDI-II* (Beck, 1996), the *Diagnostic and Statistical Manual IV-TR* (American Psychiatric Association, 2000), the CHAM, and her personal experience working in the Alaska bush in creating it. In January 2007, the first draft of the form (along with a paper outlining research in support of screening in primary care settings) was presented to Norton Sound Health Corporation’s department heads and staff for feedback and assurance of cultural sensitivity. (Alaska Natives make up 90 to 95% of the Norton Sound region villages’ population.) A few small changes were made prior to March 2007, when the first teleconference was held with CHA/Ps, mid-levels, departmental supervisors, quality assurance staff, and the hospital’s medical director. During the meeting, it was decided that the form would be faxed to all clinics to be used in a two-week trial, after which a second teleconference would be held to review the results. The form has been minimally revised twice since then as feedback has been solicited from the various clinics and staff members during follow-up teleconferences. (Illustration)

Factors that May Facilitate or Hinder Change

The widely recognized need to fight the serious public health problem of suicide is facilitating use of the “Screening for Depression and Thoughts of Suicide” form in the Norton Sound region. There is no question among health care staff, corporation board members, and community members alike that suicide is an enormous problem in the region and statewide. Although the form increases overall paperwork,

Illustration



Norton Sound Health Corporation
P.O. Box 966
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Screening for Depression and Thoughts of Suicide

Fax all positive screens to NSHC Behavioral Health Services: 443-5915.
Put original in patient's chart.

Name of Patient: _____

DOB: _____

Home Phone: _____

[] Patient Refused Screen

Please ask all patients over the age of 7, the following questions...

1. Over the last couple of weeks, have you felt sad none of the time, some of the time, much of the time, all of the time?

(If some of the time, provide "Patient Education: Depression" from CHAM (pages 706-707) verbally and/or in writing. If much of the time or all of the time, Go NOW to CHAM (page 705) to gather more information. Report NOW to BHS (443-3344) and fax this form to BHS (443-5915).

2. Over the last couple of weeks, have you had any thoughts or plans of wanting to hurt yourself?

(If YES, Go NOW to "Information for CHA/P: Suicide Risk and Prevention" in CHAM (page 697) to gather more information. Report NOW to BHS (443-3344) and fax this form to BHS (443-5915). Keep patient in the clinic if possible until BHS staff talks to him or her.

Referral Made to BHS? By Phone: Yes/No By Fax: Yes/No
Gave out Patient Education? Yes/No
Gave out NSHC toll-free number? Yes/No
Is there a prior history of suicide attempts? Yes/No/Unknown
Number of attempts if yes: ____
Other comments: _____

Health Aide/Mid-level's Name: _____ Date: _____

Village: _____ Clinic Phone Number: _____

***Note to Health Aide and Mid-level: It is not always easy talking to patients about depression and suicide. A preface to the screening questions (for an adult) might be, "as you probably know, we have a lot of depression and suicide in our region. I'd like to ask you a couple of questions about how you've been feeling lately..." When talking with a child, a suggestion might be to say, "Sometimes we feel sad about something and don't really want to tell our mom or dad. But mom and dad love you and want to know if you feel sad..."

its use ultimately aims to decrease staff burnout as mortal wounds and death potentially will be encountered less frequently. Reports coming back from the field indicate that the form is simple to use and takes very little time to administer (“about 30 seconds”), and that the response from patients has been positive overall (“I’m glad we’re talking about this.”). The form is adaptable and the author encourages its use in other regions of Alaska and nationwide, thus eliminating the need to create a similar form from scratch. Lastly, because the wording of the form intermeshes with the CHAM, it is more likely that the form will be used systematically by the village CHA/Ps.

Factors that may hinder the use of the form include human resistance to change, departmental turf wars, staff personalities and idiosyncrasies, reluctance of staff to take on additional work, and staff turnover. Some specific concerns have been voiced regarding the use of the form. For example, field staff have expressed discomfort at asking young children the question about self-harm, and have asked whether parental/guardian consent will be needed when interviewing children, whether enough BHS staff will be available to respond to the referrals generated, and even exactly what is meant by the word “sad.”

To encourage the consistent use of the form, staff questions have been addressed individually by e-mail, by phone, and in the regularly scheduled monthly teleconference meetings. Everyone continues to be given the opportunity to voice concerns and questions, as the form is presented as a work in progress. BHS support staff were initially trained in a face-to-face meeting on how incoming referrals should be triaged. Verbal training of all staff is followed up via group e-mails, and periodic updates and retraining occur as needed. BHS management encourages its staff to support the use of the form in the villages in their frequent conversations with health care coworkers (again, weighing the extra work created by the form with the extra benefit it will provide over the long run).

In addition, CHAP training for new health care providers entering the certification program will need to be modified to include instruction in using the form. The CHAP director’s input on the form has been included since the beginning to increase buy-in and willingness to modify the training program to fully integrate the form’s use.

Quality assurance is ongoing, and revisions have been made to increase the form’s ease of use as well as the comfort of staff using it. Both the corporation compliance officer in charge of performance improvement and the quality assurance staff of the village health services department (which oversees all village staff) have been involved from

the beginning. Discussions are underway about gathering statistics from the more than 200 forms completed as of June 2007; these statistics will provide rich research information to further improve the form and the service behind it.

Implications for Future Work

It is important to recognize that all aspects of health and treatment (e.g., physical health, mental health, substance abuse treatment) are inextricably intertwined and should be treated together to provide the most efficacious outcome. It is essential that BHS regional field workers familiar with Alaska's villages be included in future revisions of the CHAM and CHAM PEF. BHS staff are well-suited to provide ongoing education to medical team members, assist with the destigmatization of language regarding mental health and substance abuse treatment (coinciding with Goal 3 of the *National Strategy for Suicide Prevention*: "Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services"), and show how BHS referrals can more seamlessly fit into the routine clinic visit.

Routine administration of screening and referral for depression and suicide risk can provide invaluable statistics throughout the state that can be used to improve services in each region and to assist with grant applications. Organized and accurate recording of the information gathered coincides with *Alaska Suicide Prevention Plan* Goal 12: "Alaska suicide prevention and intervention research is supported and on-going" and Goal 13: "Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions, and evaluating progress" as well as Goal 10 of the *National Strategy*: "[to] Promote and Support Research on Suicide and Suicide Prevention."

Conclusion

Health care professionals will always spend the bulk of their time being reactive to the needs of their patients and/or clients who come to clinic for services. However, it is time and money well spent when health care staff are proactive in patient care. In the case of depressive illness (and suicide in particular), prevention not only saves time and money, but more importantly invaluable human life. The public health problem of suicide looms ugly in the great state of Alaska. Speaking from my own experience as a health care provider serving Alaska Natives

and their families, there is nothing more important than stemming the suffering and death of those I serve. May we all as health care providers remain open to every potentially life-affirming, lifesaving measure we can employ towards this end.

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