Assessing and Managing Adolescent Suicide Risk In Primary Care

ProjectTEACH
FAMILIES THRIVE WITH GOOD MENTAL HEALTH

NEW YORK STATE | Office of Mental Health

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NEW YORK STATE | Office of Mental Health

Disclosure

I have no relevant financial relationships with ineligible companies

The way through it is by talking about it……..

Suicide risk grows in shame and silence

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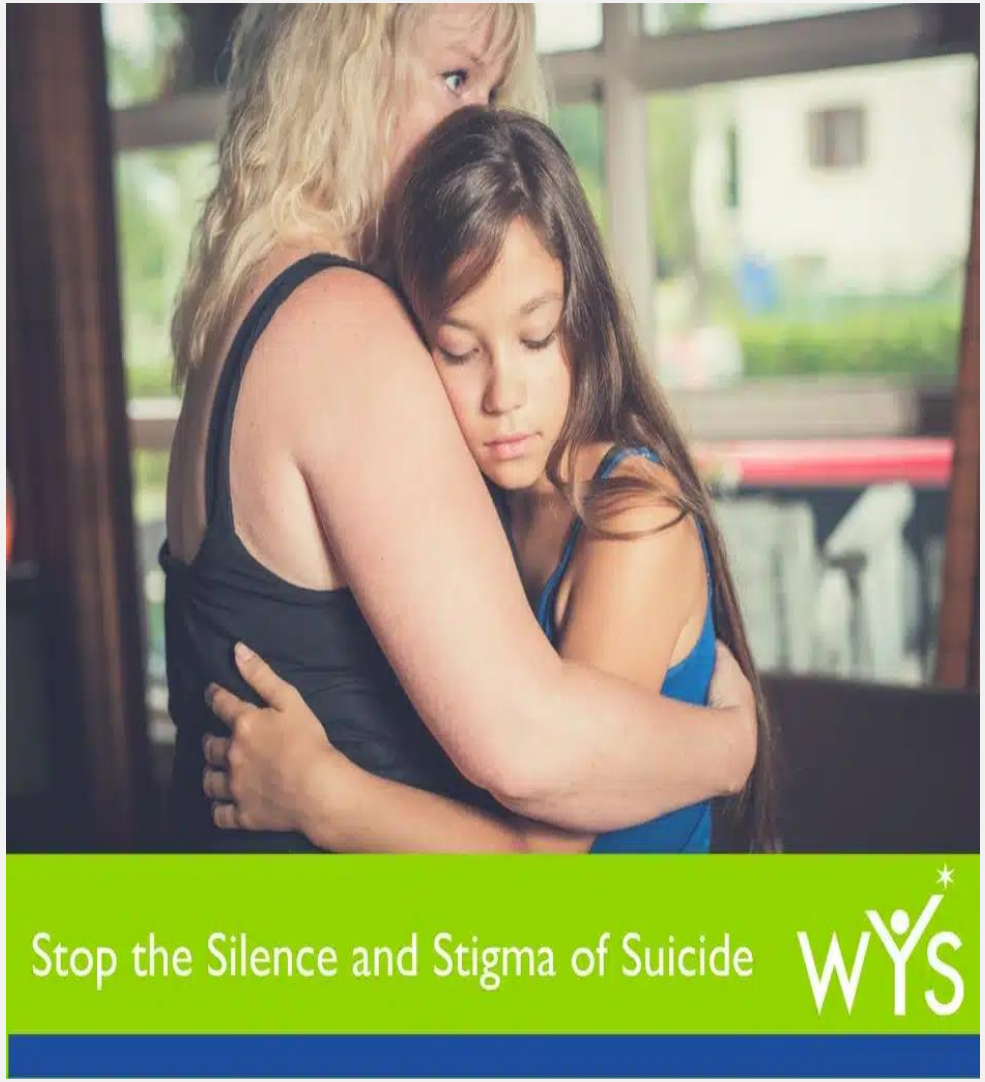
“When you live with something that you thought was maybe your own private despair, and you finally are brave enough to come out with it, only to find that, guess what, a large percentage of the people around you relate to it – that’s a powerful experience”

- Christine Yu Moutier

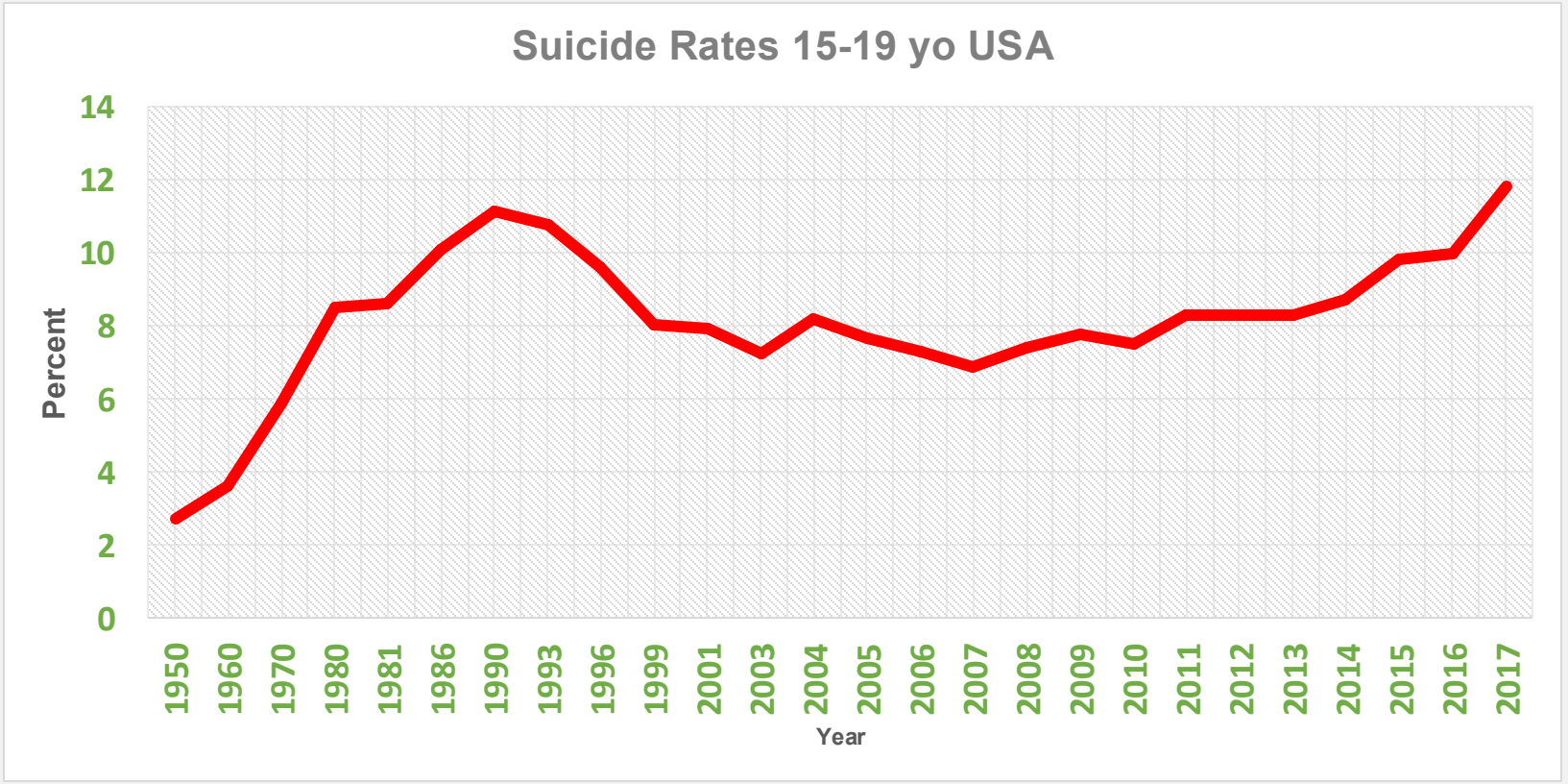


Why Screen?

CDC: Teen suicide rates increase dramatically in last decade

POSTED 10:29 PM, MARCH 26, 2018, BY Q13 FOX NEWS STAFF

FACEBOOK TWITTER REDDIT LINKEDIN TUMBLR PINTEREST EMAIL PRINT



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10 Leading Causes of Death, United States

2022, All Deaths with drilldown to ICD codes, Both Sexes, All Races, All Ethnicities

Unintentional Injury Homic

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 3,970	Unintentional Injury 1,288	Unintentional Injury 726	Unintentional Injury 926	Unintentional Injury 14,669	Unintentional Injury 33,058	Unintentional Injury 36,972	Malignant Neoplasms 33,363	Malignant Neoplasms 105,133	Heart Disease 567,365	Heart Disease 702,880
2	Short Gestation 2,884	Congenital Anomalies 441	Malignant Neoplasms 393	Suicide 493	Homicide 6,262	Suicide 8,663	Heart Disease 12,258	Heart Disease 32,298	Heart Disease 85,733	Malignant Neoplasms 452,490	Malignant Neoplasms 608,371
3	Sids 1,529	Homicide 343	Congenital Anomalies 241	Malignant Neoplasms 442	Suicide 6,040	Homicide 6,712	Malignant Neoplasms 11,177	Unintentional Injury 31,394	Unintentional Injury 34,017	Covid-19 146,320	Unintentional Injury 227,039
4	Unintentional Injury 1,354	Malignant Neoplasms 266	Homicide 180	Homicide 366	Malignant Neoplasms 1,421	Heart Disease 3,789	Suicide 8,185	Covid-19 9,678	Covid-19 24,252	Cerebrovascular 142,513	Covid-19 186,552

Center for Disease Control and Prevention – WISQARS Leading Causes of Death Visualization.

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Why Screen in Primary Care?

40% of youth who died by suicide visited a primary care medical setting *within the month prior*

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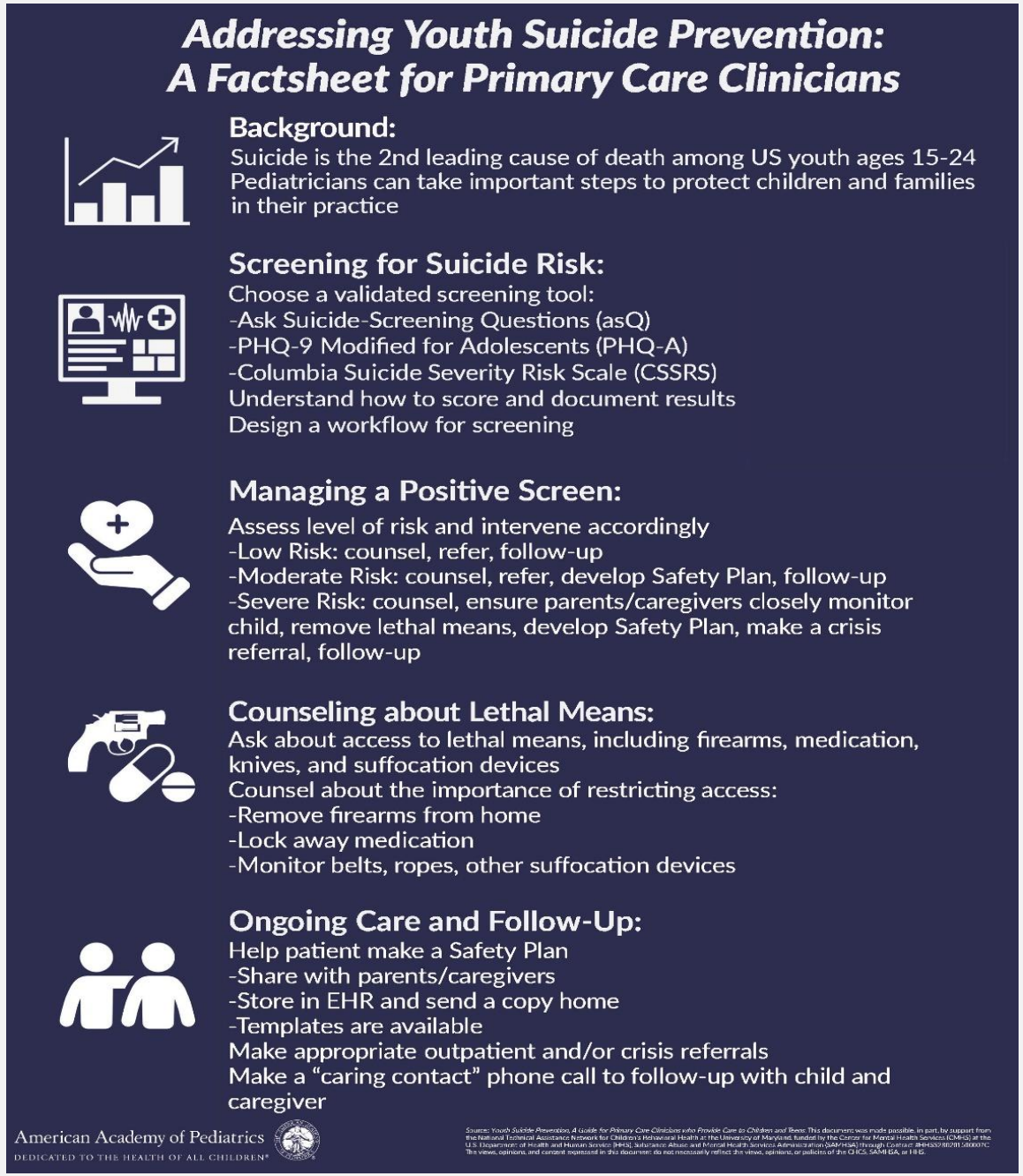
Why Screen Universally?

- Decreases bias
- Systematic
- Destigmatizes so opens up discussion, decreases isolation
- Even kids who are not at risk that day know for sure you are safe person to discuss this with

AAP Blueprint for Youth Suicide Prevention

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/



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2022 AAAP/Bright Futures Recommendations for Preventive Pediatric Care

- Youth ages 12+: Universal screening
- Youth ages 8-11: Screen when clinically indicated
- Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present

3-Step Approach

Brief Screen (universal)

<1 minute

Ages 12 +

8-11 if at risk

Brief Suicide Safety Assessment

If identified to be at risk

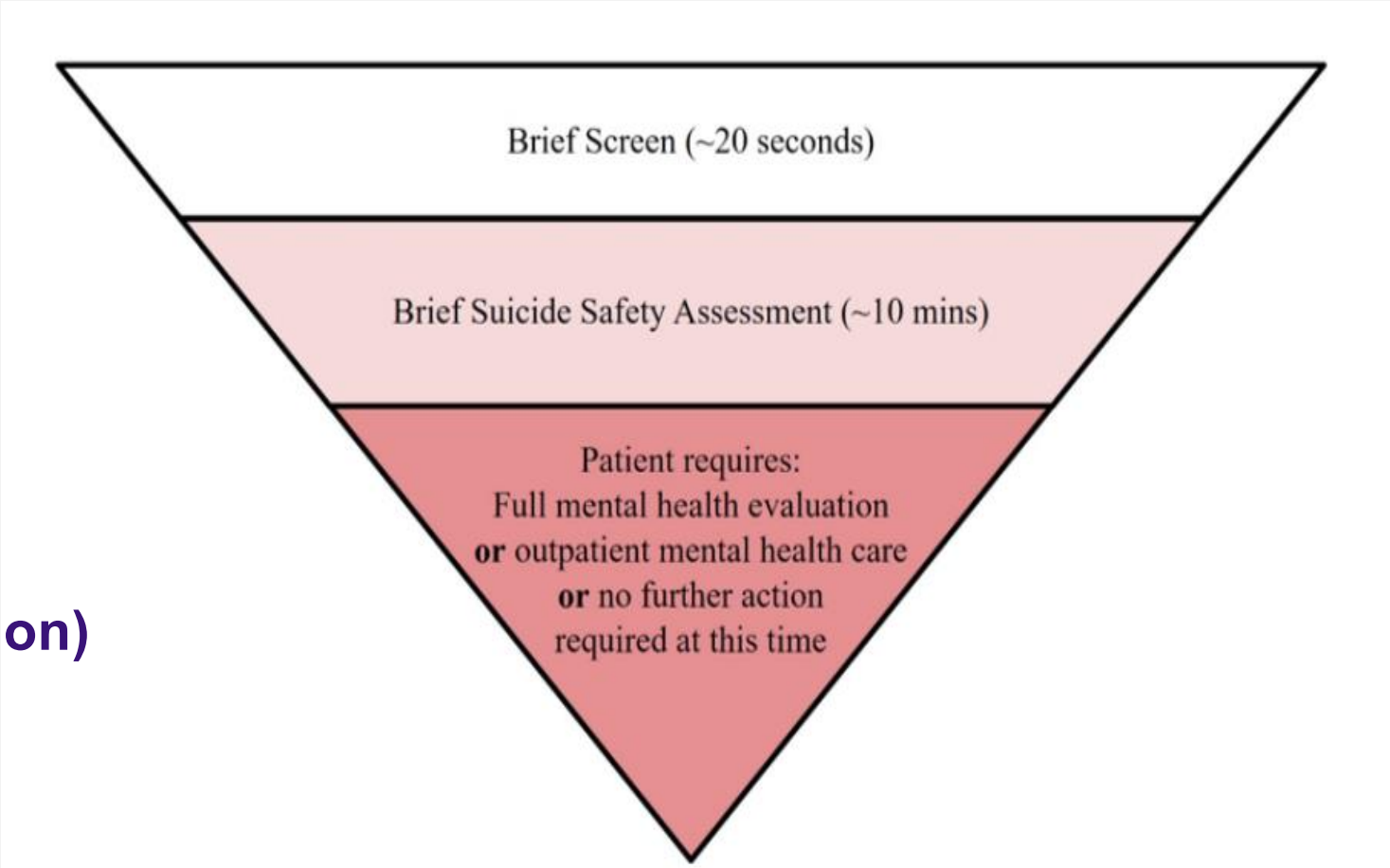
10-15 minutes

Stratify Risk (to determine disposition)

Imminent

Further evaluation needed

Low Risk



https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/clinical-pathways-for-suicide-prevention/

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Identifying Suicide Risk:

Suicide Brief Screen

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: *Was this within the past 3 months?*	**Past 3 Months**	

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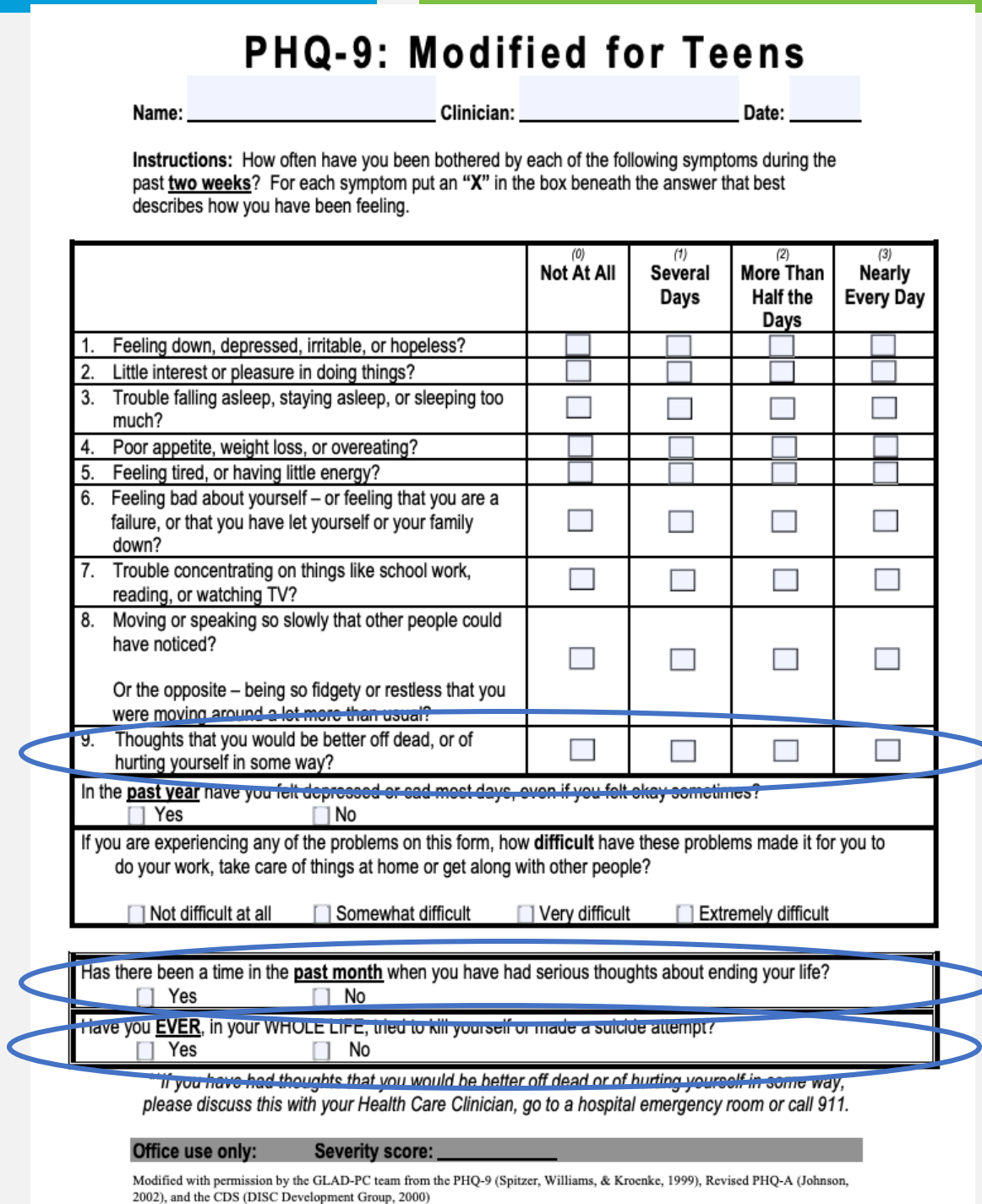
Identifying Suicide Risk:

Depression *Screening Tools*



PHQ-9: Modified for Teens

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐ Yes ☐ No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
☐ Yes ☐ No

If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.

Office use only: **Severity score:** _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

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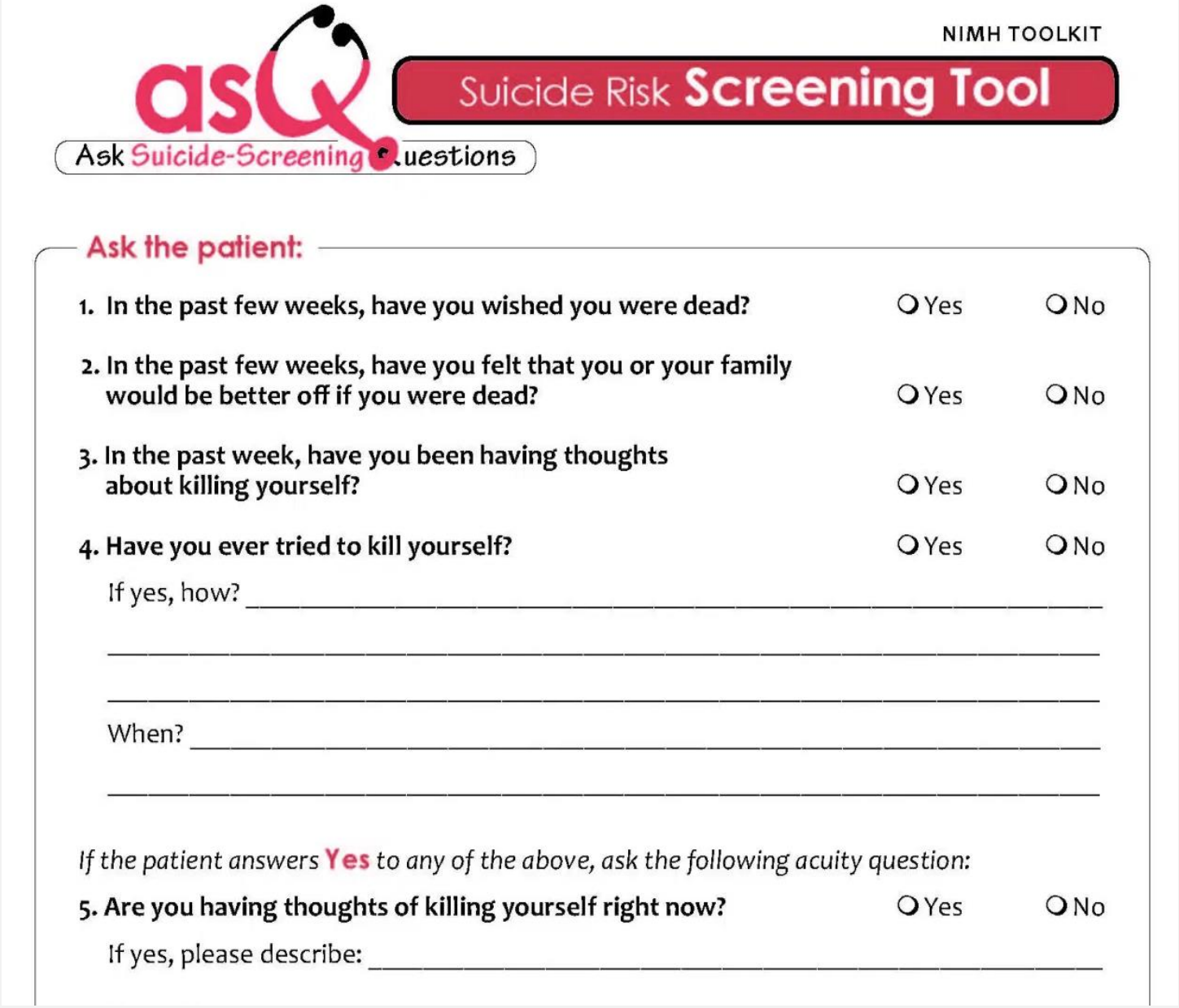
Identifying Suicide Risk:

Suicide Brief Screen

Integrated with PHQ9

https://www.nimh.nih.gov/sites/default/files/documents/PHQ-A_with_depression_questions_and_ASQ_PDF.pdf



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

If yes, how? _____

_____

_____

When? _____

_____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

If yes, please describe: _____

https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/suicide_risk_screening_pathway_outpatient_youth.pdf

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PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

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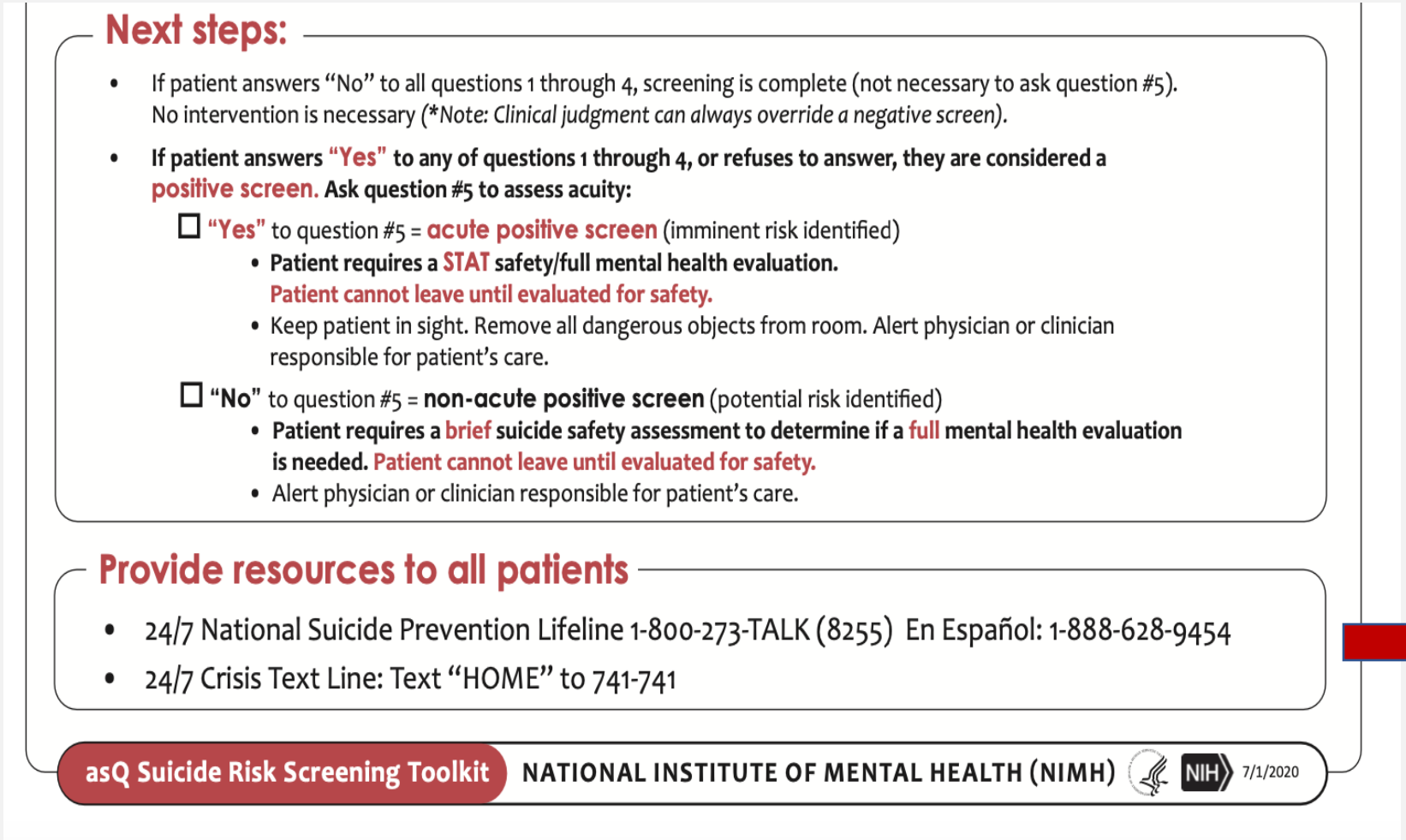
If Q1-4 "Yes"
then it is a positive screen……



Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: *Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

988

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If the AsQ Positive, then…
Brief Suicide Safety Assessment

1. Recognize, convey respect for the patient (feel valued)
2. Assess the patient – frequency; plan; past behavior; symptoms , social support& stressors
3. Interview patient and parent together, *alone*
4. Determine a disposition
5. Make a safety plan (including means restriction)
6. Provide resources

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ASQ BSSA

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient *(If possible, assess patient alone depending on developmental considerations and parent willingness.)*

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts

Symptoms Ask the patient about:

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

Support network: "Is there a trusted adult you can talk to? Who?

NIMH TOOLKIT: YOUTH INPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join.

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."
- "Does your child seem:
  - Sad or depressed?"
  - Anxious?"
  - Impulsive? Reckless?"
  - Hopeless?"
  - Irritable?"
  - Unable to enjoy the things that usually bring him/her pleasure?"
  - Withdrawn from friends or to be keeping to him/herself?
- "Have you noticed changes in your child's:
  - Sleeping pattern?"
  - Appetite?"
- "Does your child use drugs or alcohol?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
- "Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents)
- "Are you comfortable keeping your child safe at home?"

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient

Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan.

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Keep patient safe on the unit. Follow the standard of care for a suicidal patient (e.g. remove dangerous objects, 1:1 observer). Request a STAT, emergency psychiatric evaluation.
- ❑ **Further evaluation of risk is necessary:** Request a comprehensive mental health/safety evaluation prior to discharge.
- ❑ **Patient might benefit from non-urgent mental health follow-up post-discharge:** No further mental health evaluation in the hospital is needed at this time. Review safety plan for potential future suicidal thoughts and refer patient for a follow-up mental health evaluation in the community, post-discharge.
- ❑ **No further intervention is necessary at this time.**

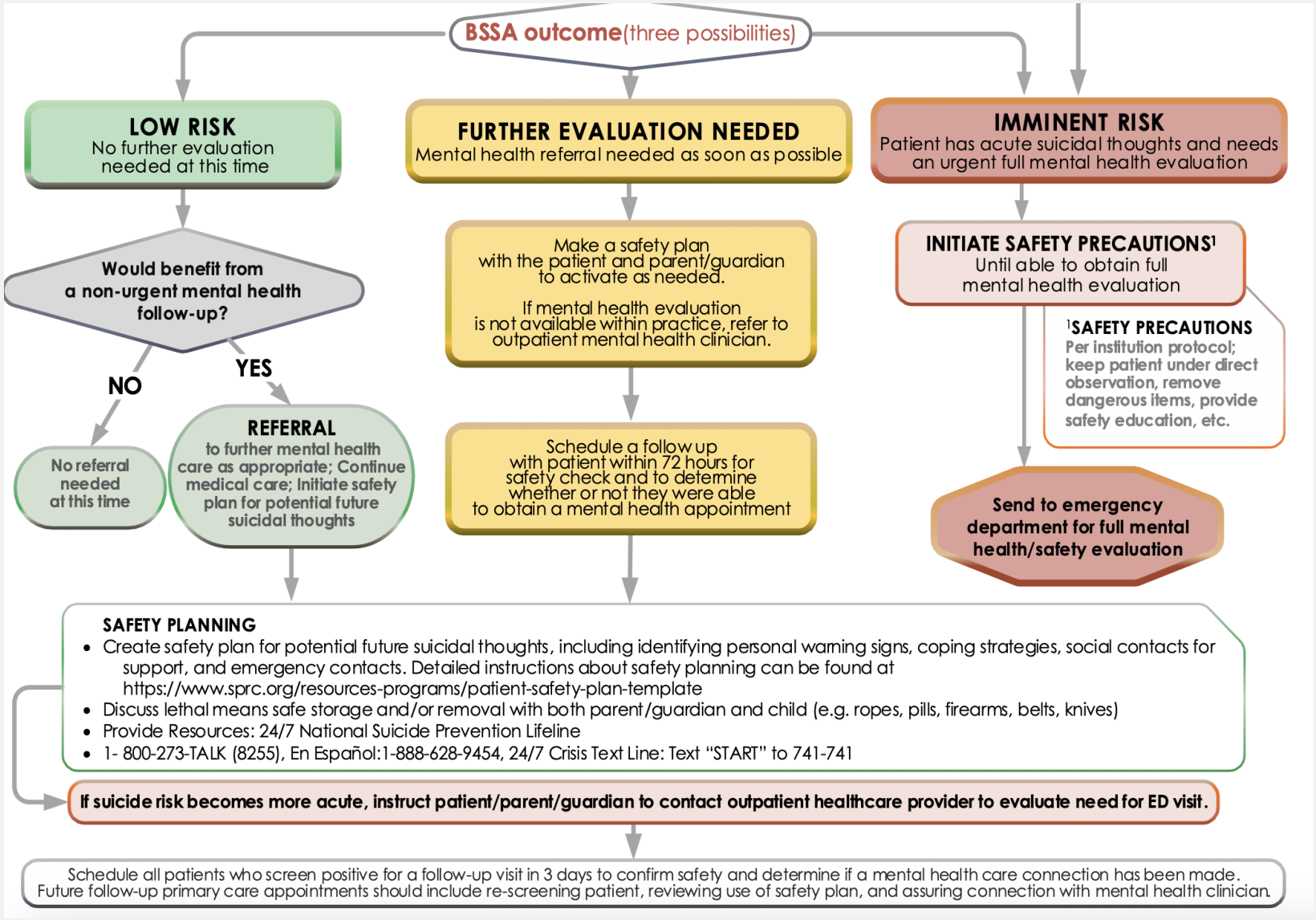
6 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

Further Questions to Assess (ideally alone)

- Have you had thoughts of killing yourself?
- How often do you have thoughts of killing yourself or that you wished you were dead?
- Do you have a plan of how you would kill yourself? What have you thought about?
- When was last time?
- How long do these thoughts stay with you?
- Are they hard to get out of your mind? Does it interfere with functioning?
- At those times Is there anything you do that helps? Makes it better?
- Is there anyone you can talk to when you feel like that?
- On a scale of 0-10 (0=none, 10=actually doing something) how close have you come to actually doing something to hurt or kill yourself?
- What stopped you from doing anything? What keeps you wanting to be alive?

Disposition Based On BSS Assessment



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Safety Plan Intervention

- A brief intervention to mitigate risk for mild-moderate risk.
- NOT A NO SUICIDE CONTRACT
- Intent is to collaboratively help individuals lower their imminent risk by constructing
  - a predetermined set of personal coping strategies and
  - a list of individuals and/or agencies they can contact.
- Results in a one page document to use when suicide risk is emerging.
- Suicide risk fluctuates over time, SPI is for staying safe when these feelings emerge.

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Best Safety Plans:

for staying safe when these feelings emerge.

- Brief, Feasible
- Collaborative: include the
- patient's own words,
- Done Side by side
- Done BEFORE imminent risk
- Involve family members

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Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

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https://projectteachny.org/app/uploads/2023/10/safety-plan-stanley-template.pdf

Means Restriction

MICHIGAN MEDICINE
UNIVERSITY OF MICHIGAN

Funding for this brochure was supported by grant no. 5H79SM082148-02 from the Substance Abuse and Mental Health Services Administration (SAMHSA) to the Michigan Department of Health and Human Services. Original version created by the Oakland County Youth Suicide Prevention Task Force.

SUICIDE-SAFE TIPS

Firearms: Remove as needed. Always lock.

- Ask a trusted friend or family member to keep it temporarily.
- If you can't remove them from the home, securely lock firearm and ammunition separately.

Medications: Follow the M.E.D.S. method

Monitor: Keep track of how many pills are in each prescription bottle or pack and don't keep lethal doses at home.

Educate: Educate yourself and family members on the dangers of abusing prescription drugs.

Dispose: Dispose of medicines safely to prevent medication abuse and environmental pollution.

Secure: Keep medications, both prescription and over-the-counter, in a safe and secure location, such as a locked cabinet or private bathroom.

Alcohol and drugs:

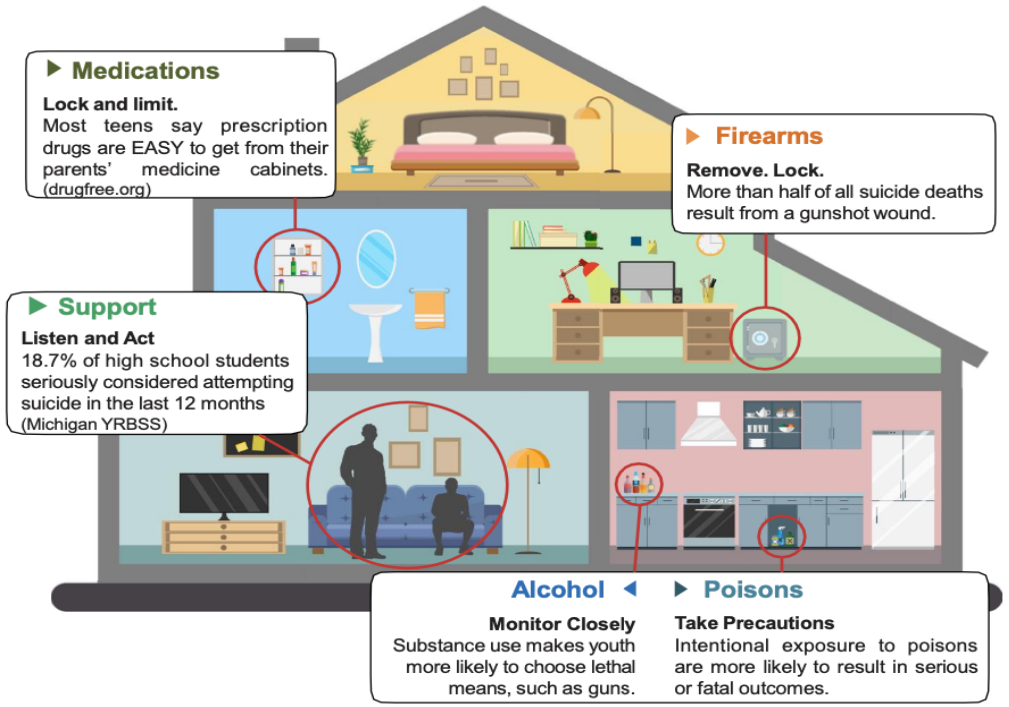
- Talk to your kids about substance use as a major risk factor for suicide.
- Lock up potentially harmful common household products / poisons.

Provide Support:

- Know the suicide warning signs.
- Create a safe, judgment-free environment when talking about tough issues.
- If you notice significant changes, ask them directly if they're thinking about suicide.
- Don't be afraid to seek help when needed.

IS YOUR HOME SUICIDE-SAFE?

Take these actions to reduce access to lethal means of suicide.



No method of means restriction is foolproof. If you are concerned about a loved one, seek help.

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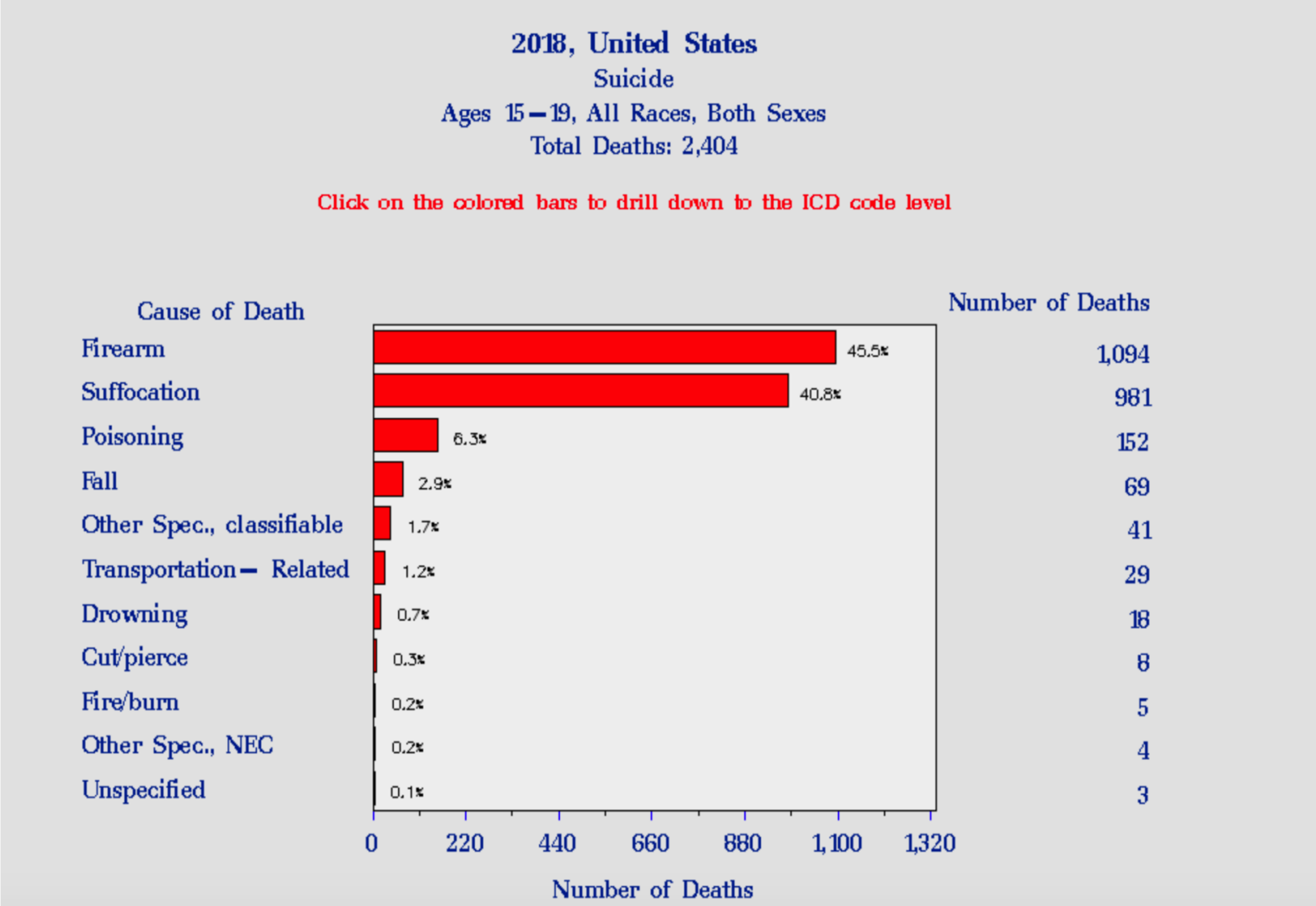
Sidebar: Firearms #1 Cause, 15-19 yo



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ZERO SUICIDE

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Counseling on Access to Lethal Means

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Course Description

Reducing access to lethal means, such as firearms and medication, can determine whether a person at risk for suicide lives or dies.

This course is about how to reduce access to the methods people use to kill themselves. It covers who needs lethal means counseling and how to work with people at risk for suicide—and their families—to reduce access.

This course earned two awards in 2019:

- Bronze Digital Health Award
- Bronze Omni Award

Free 2-hour course

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Resources for Parents and Teens

- Phone/chat resources
  - Know your local/regional crisis services
  - 988
  - 1-800 273-Talk
  - Text Got5 (AYUDA for Spanish) to 741-741
- Trevor Project https://www.thetrevorproject.org/get-help-now/ (LGBTQ)
  - 1-866-488-7386
  - Text START to 678-678
- Trans Lifeline https://translifeline.org/hotline/ 1-877-565-8860
- Now Matters Now (peer based DBT skills) https://www.nowmattersnow.org/
- JED Foundation https://www.jedfoundation.org/
- UPMC STAR Center (for adolescents and families) https://www.starcenter.pitt.edu

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CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Suicide and Suicide Risk in Adolescents

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COMMITTEE ON ADOLESCENCE; COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION

Suicide is the second leading cause of death for 10- to 24-year-olds in the United States and is a global public health issue, with a recent declaration of a National State of Emergency in Children's Mental Health by the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, and Children's Hospital Association. This clinical report is an update to the previous American Academy of Pediatrics clinical report, "Suicide and Suicide Attempts in Adolescents." Because pediatricians and pediatric health care providers are at the

abstract

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Resources for Professionals

- AAP Blueprint for Suicide Prevention Strategies for Clinical Settings

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/

- Ask Suicide Screening Toolkit (ASQ) https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

- Counseling on Access to Lethal Means (CALM) Free online course https://zerosuicidetraining.edc.org/enrol/index.php?id=20

- Pediatric Meltdown Podcast Episodes 8, 37, 38, 96

Conclusions: Suicide is Preventable

- Suicide in adolescents is a major public health problem and tragedy when it occurs
- Suicide risk grows in silence—talking saves lives
- Universal screening opens up the conversation
- Suicidal ideation is often linked with depression; depression can be treated.….if it's recognized!
- Suicide is often impulsive
  - promote limiting access to means and
  - Promote bridging relationships:
    Pediatric clinicians CAN BE THAT BRIDGE, Caring Connection

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Demonstration: Assessing and Managing Suicide/Safety Risk

Friday Afternoon: 5:00 PM

Dr. Diane has a patient in the room and her clinic gives her this brief triage information:

Triage Note for Casey

- **Patient Name**: Casey Long (They/Them)
- **Chief complaint:** 15-year-old previously healthy patient who screened positive for minimal depression on the PHQ-9 at their well child visit 2 weeks ago. During this visit, brief interventions including behavioral activation techniques were encouraged. Returns today for follow up mental health video visit.
- **Repeat PHQ-9 modified administered prior to visit:** Score 12 (*completed screen attached*)
  - **PMH:** None
  - **Meds:** None
  - **Allergies:** None

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PHQ-9: Modified for Teens

Name: Casey Long **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	x	☐
2. Little interest or pleasure in doing things?	☐	☐	x	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	x	☐	☐
4. Poor appetite, weight loss, or overeating?	x	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	x
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	x	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	x	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	x	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	x	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
[x] Yes [ ] No

If you are experiencing any of the problems on this form, 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 [x] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
[ ] Yes [x] No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

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Dr. Diane and Casey

- Let's watch Dr. Diane's next steps:

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ☑ Yes ☐ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ☑ Yes ☐ No
3. **In the past week, have you been having thoughts about killing yourself?** ☑ Yes ☐ No
4. **Have you ever tried to kill yourself?** ☐ Yes ☑ No

   If yes, how? _____

   _____

   _____

   When? _____

   _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ☐ Yes ☑ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☑ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 988 ☑
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. Night time
2. Nothing to distract me
3. Feeling alone with my thoughts

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. Walking with fluffy
2. Cuddle with fluffy in bed
3. Write in my journal

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: Cousin Jimmy Contact: 917-555-1212

2. Name: English teacher – Ms. K Contact: 718-867-5309

3. Place: Gaming 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: Dad Contact: _____

2. Name: Ms. K? Contact: 718-867-5309

3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/ Agency Name: Dr. Bloomfield Phone: 718-555-3456
Emergency Contact: 718-555-3000

2. Clinician/ Agency Name: _____ Phone: _____
Emergency Contact: _____

3. Local Emergency Department: Children's Hospital of Montefiore / 9-1-1
Emergency Department Address: _____
Emergency Department Phone: _____

4. Suicide Prevention Lifeline Phone: ~~1-800-273-TALK (8255)~~ 988 Call / **Text** / Chat

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. Will keep door open (a little)
2. Mom will keep all pills

Stanley-Brown
Safety Planning Intervention