Responding to a Positive Suicide Screen in Pediatric Primary Care Settings

John Ackerman, Ph.D.
Suicide Prevention Coordinator
Center for Suicide Prevention and Research
Nationwide Children's Hospital Behavioral Health

Jeff Bridge, Ph.D.
Director, Center for Suicide Prevention and Research
The Research Institute at Nationwide Children's Hospital
Professor of Pediatrics and Psychiatry, OSU College of Medicine

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When your child needs a hospital, everything matters.℠

Disclosures

- Drs. Bridge and Ackerman have no financial relationships or Conflicts of Interest (COIs) to disclose

Webinar for Primary Care Part 1

- Provided an overview of youth suicide and national efforts to reduce suicide rate
- Highlighted pediatric primary care as a site for youth suicide prevention & suicide risk screening
- Summarized the ASQ, a brief and effective suicide-screening tool used across in PCP settings

- Link: https://rec.nationwidechildrens.org/userportal/index.html#/player/vod/R3bf99dc5ca684311818e663f207a2ab0

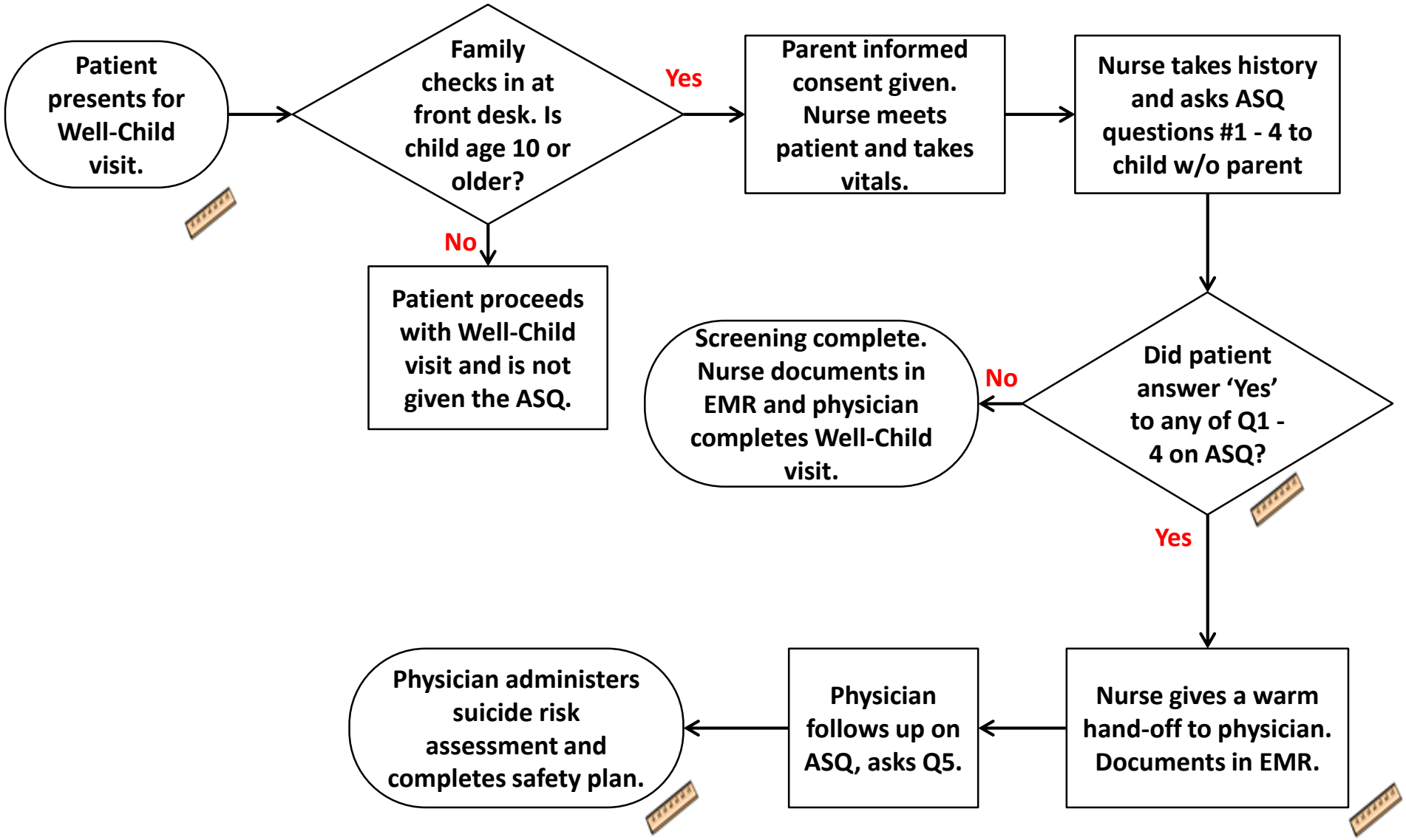
Screening, Risk Assessment, Safety Planning

Screening vs. Risk Assessment: What's the difference?

- **Suicide Screening**
  - Identify individuals at risk for suicide
  - Oral, paper/pencil, computer

- **Suicide Risk Assessment**
  - Comprehensive evaluation
  - Confirms risk
  - Estimates imminent risk of danger to patient
  - Guides next steps

Sample ASQ Screening Process Flow in Primary Care Setting



ASQ Toolkit

www.nimh.nih.gov/asq

Alert the parents

asQ Ask Suicide-Screening Questions

Parent/guardian flyer

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

Script for Initial Nursing Assessment

asQ Ask Suicide-Screening Questions

Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [insert name of MD, PA, NP, or mental health clinician] and he/she will come speak with you."

If patient screens positive, and parent/guardian is awaiting results, say:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to [insert name of MD, PA, NP, or mental health clinician], and he/she will further evaluate your child for safety."

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? _____

   _____

   _____

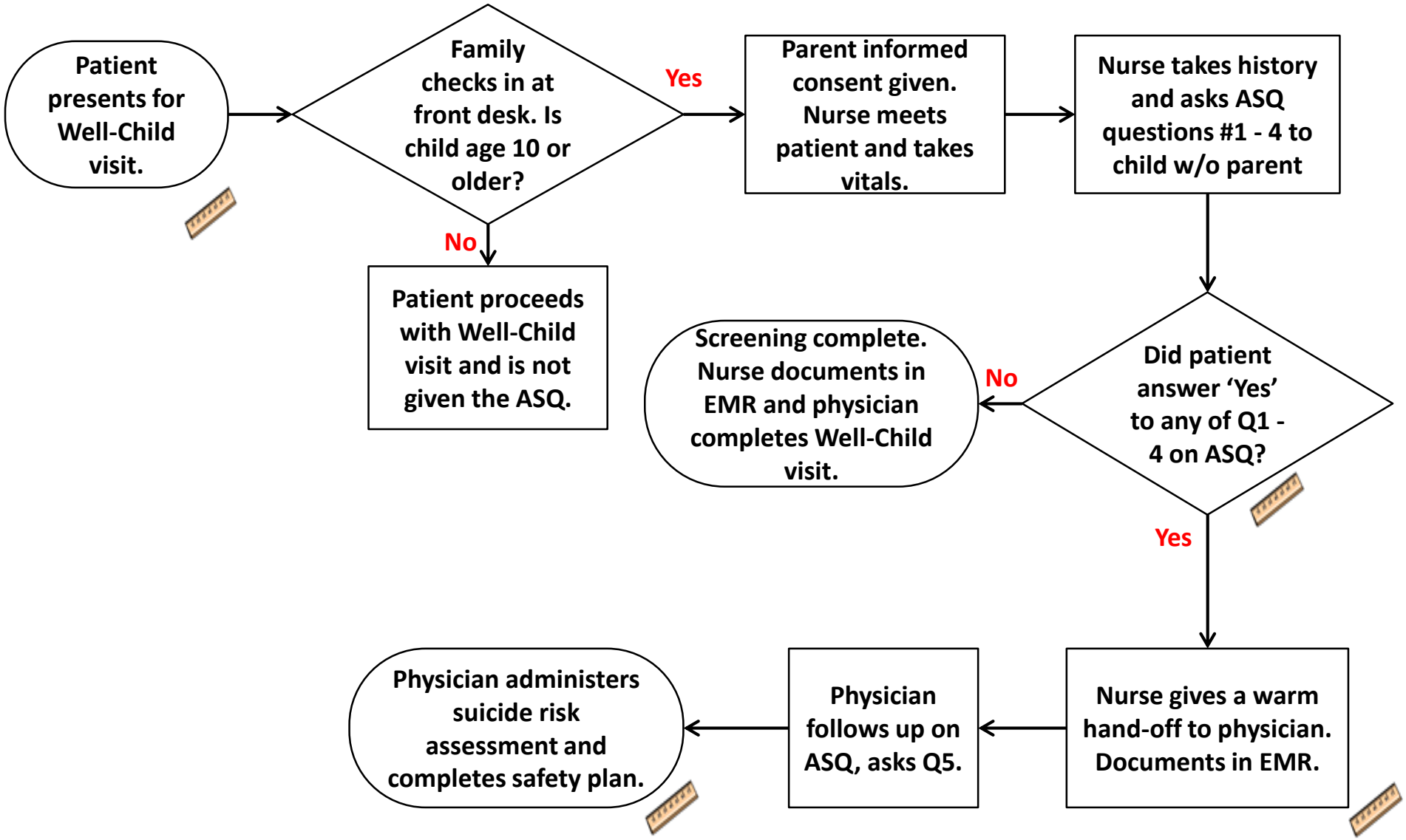
   When? _____

   _____

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

Sample ASQ Screening Process Flow in Primary Care Setting



asQ
Ask Suicide-Screening Questions

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Managing Positive Screens

- If patient answers “yes” on #1-4 or refuses to answer:
  - Inform patient that results will be discussed with parent and medical team
  - Warm hand-off to physician or mental health clinician conducting the risk assessment who will then ask Q5: “Are you having thoughts of killing yourself right now?”
  - Conduct risk assessment to determine if more extensive psychiatric evaluation is necessary
  - Develop a collaborative safety plan
  - Patient may not be discharged until risk assessment and safety plan are completed

Positive screen –Documentation

- Document the following:
  1. Suicidal statements or behaviors
     - What the patient said (verbatim) or did
     - Try not to over or under report – just state what happened
  2. Document who was notified
  3. Document the plan
     - Nursing interventions (if any)

Screening, **Risk Assessment**, Safety Planning

When to Complete a Risk Assessment

Any positive response on the ASQ (#1-5)

- Indicates suicidal thoughts in the past few weeks or lifetime suicide attempt
- If suicidal thoughts in past 3 months are reported, also consider risk assessment
- If patient refuses to respond or suspected safety concerns arise, conduct a risk assessment
- ***Patient cannot leave until evaluated for safety.***

Responding to a patient after a positive screen

"I want to follow-up on your responses to the suicide risk screening questions. These can be hard things to talk about. I need to ask you a few more questions."

Elements of Risk Assessment

- Assess risk and protective factors
- Suicide Inquiry: thoughts/plan/intent/access to means using screening data as a starting point
- Evaluate ability to collaboratively safety plan
- Clinical judgment
- Document

NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a pediatric patient screens positive for suicide risk:

- Use after a patient **(10 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

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 (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future 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? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ❑ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

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

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 7/14/2017

Columbia Suicide Severity Rating Scale (C-SSRS)

- C-SSRS
  - Strong evidence-base supporting use
  - Structured, but flexible tool that helps identify suicide risk and need for intervention
  - Reviews suicidal ideation and behavior
  - Use of this tool allows for a common language
  - Information about severity guides next steps
  - Can repeat administration to at-risk individuals

Columbia Suicide Severity Rating Scale (C-SSRS)

Online training:
http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm

C-SSRS: pediatric option

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric/Cognitively Impaired – Lifetime Recent - Clinical

Version 6/23/10

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M.A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First (Ed.) Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)

For reprints of the C-SSRS contact: Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact: posnerk@nyspi.columbia.edu

Elements of C-SSRS (Ideation)

1. Wish to be Dead
2. Non-Specific Active Suicidal Thoughts
3. Suicidal Ideation with Methods (Not Plan) without Intent to Act
4. Suicidal Ideation with Some Intent to Act, but without Specific Plan
5. Suicidal Ideation with Specific Plan and Intent

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you ever wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)?*** ***What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you ever decided how or when you would make yourself not alive anymore/kill yourself? Have you ever planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

C-SSRS – Intensity of Ideation

INTENSITY OF IDEATION		
The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Lifetime - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** ***Recent - Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	**Most Severe**	**Most Severe**
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____	____

Elements of C-SSRS (Behavior)

1. Previous suicide attempts
2. History of non-suicidal self-injury
3. Interrupted or self-aborted attempts
4. Preparatory actions
5. Potential or actual medical lethality

SUICIDAL BEHAVIOR ***(Check all that apply, so long as these are separate events; must ask about all types)***	**Lifetime**	**Past 3 Months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just potential for injury/harm. ***Did you ever <u>do anything</u> to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you ever hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?** **Has subject engaged in Self-Injurious Behavior, intent unknown?**	**Yes No** ☐ ☐ Total # of Attempts _____ **Yes No** ☐ ☐ **Yes No** ☐ ☐	**Yes No** ☐ ☐ Total # of Attempts _____ **Yes No** ☐ ☐ **Yes No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of interrupted ____	**Yes No** ☐ ☐ Total # of interrupted ____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted ____	**Yes No** ☐ ☐ Total # of aborted or self-interrupted ____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____	**Yes No** ☐ ☐ Total # of preparatory acts _____

C-SSRS - Medical Lethality

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Collaborate, Document, Communicate

- Use tools to help document steps taken and recommendations
  - Screener for suicide risk (ASQ)
  - Risk assessment (C-SSRS or BSSA from ASQ toolkit)
  - Safety Plan (Adapted from Brown & Stanley, 2008)
- When making decisions, be sure to consult
- Prompt disclosure of a suicide threat to a parent is nearly always ethically and legally advisable

Screening, Risk Assessment, **Safety Planning**

Safety Planning

- Set of co-created strategies to decrease risk of suicidal behavior during a crisis
- Not a “no-suicide contract”
- Seeking a defined commitment to safety
- Safety planning is part of risk assessment as well as a clinical intervention

Safety Planning

- When asking about commitment and safety planning you are looking at patient's
  - Facial Expressions
  - Affect
  - Body language
  - Tone of Voice
  - Language
  - Confidence vs. Ambivalence
  - Ability to develop realistic ways to maintain safety

Safety Planning

- Patient's inability to safety plan reliably is an indicator that hospitalization may be necessary
- Safety plan is only as good as the value the patient places on it
- Incomplete or overly directive safety plans will not increase patient safety meaningfully

Safety Planning

Know WHEN you are in need of help (Self Monitoring)

Warning signs that I'm not doing well: What you experience when you start to think about death/dying/suicide or feel depressed/down/sad?

1. _____
2. _____
3. _____

*Elicit this by highlighting negative automatic thoughts, physical symptoms, changes in emotions and behaviors from baseline.

Safety Planning

Know HOW to help yourself.

(Internal Coping Skills)

Things I can do on my own to feel better: What can you do if a crisis develops in order to keep yourself safe?

*1.*_____

*2.*_____

*3.*_____

*Shift negative thoughts and support change self-talk. Review possible coping skills for emotional regulation, relaxation, mindfulness, self-soothing, and distress tolerance.

Safety Planning

Know **HOW** to help yourself (part 2).

(External Distractions if Internal Coping Skills are not Working)

People or places that can take my mind off of my problems: Who/what places help you take your mind off your problems at least for a little while?

*1.*_____

*2.*_____

*3.*_____

*Go somewhere, do something, be with someone. Schedule pleasant activities. This isn't just about distraction – it's about keeping safe until can get to a place where their brain is back "online" or reset and plan more effectively. Ways to cool down and ride out the storm.

Safety Planning

Know WHY you are finding help and bringing reasons for living into consciousness

Two things that are very important to me and worth living for:

*1.*_____

*2.*_____

*Use this section to identify common goals (staying safe, avoiding hospitalization, protecting family/friends, dreams) and weighting reasons for living over reasons for ending one's life

Safety Planning

Know **WHO** to ask for help.

Who can you contact who will help you during a crisis? (Must be above the age of 21 years old.)

1. *Name/number:*_____
2. *Name/number:*_____
3. *Name/number:*_____

*Patient may not realistically have 3 adults in their life whom they are willing to call on the phone. Focus instead on quality of the relationship and how they will reach out. What can you do to help them build up their support network?

Safety Planning

Setting the Stage for Success.

Ways to keep myself safe: How can we limit your access to lethal means/keep you safe during a crisis at home, school or in the community?

*1.*_____

*2.*_____

*3.*_____

Collaboratively agreeing to safety precautions . Put systems in place to make this plan effective. Engage support system. Consider code words, texting, regular check-ins. Role-play and rehearse.

Safety Planning

Education and additional resources.

Professional Agencies I can call for help. (call until you reach someone)

1. *NCH County Crisis Line: 614-722-1800*
2. *National Suicide Prevention Lifeline: 1-800-273-8255*
3. *Crisis Text Line: text "4HOPE" to 741-741*
4. ***911***

*Provide psycho-education, normalize asking for help, using crisis resources. Program numbers into phone with them. Assume and problem solve potential barriers.

Other Safety Planning Tips

- Have student take a picture of it so it is always with them or co-develop it on an app
- If there is time, practice calling local or national crisis line and/or texting Crisis Text Line
- Where will they put this at home? Accessible?

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

CRISIS TEXT LINE |

Mobile Safety Plans

Suicide Prevention-
Is there an app for that?

<u>Good apps</u>
MY3
Mood Tools
A Friend Asks
RUOK:OSU

Decision-making: Disposition

- Based on level of risk and presenting concerns, the following referrals could be made:
- Outpatient counseling referral
- Outpatient crisis counseling referral (if available)
  - Local psychiatric crisis hotline, mobile crisis team, etc.
  - Local behavioral health intake
- Inpatient hospitalization
- Proposed disposition should be discussed with family in a timely and complete manner

Triggers for hospitalization

- Suicide/homicide, realistic/lethal plan and intent
- Cannot commit to safety of self/others for 24 hours
- Cannot commit to safety of self/others until next session
- Cannot actively convincingly commit to safety planning
- Ideation or intent to die imminent and significant harm to self/others and cannot contract for safety of self/others
- First break psychosis with command hallucinations related to harm to self or others
- Use of a firearm in threatening harm to self or others

Summary

- Primary care setting is an important place to capture youth at risk
- Clinicians require validated, pediatric-specific screening instruments
- Screening can take less than 2 minutes
- Important to have a plan in place for managing positive screens
- Every clinician can make a difference

uestions?

Jeff.Bridge@Nationwidechildrens.org
John.Ackerman@nationwidechildrens.org

Thank You!

CSPR Research Team

- Kendra Heck, MPH
- Arielle Sheftall, PhD
- Sandy McBee-Strayer, PhD
- Jacki Tissue, LPCC
- Paige Schlagbaum
- Monae James
- Emory Bergdoll
- Connor Bauer
- Nate Meizlish
- Jeff Bridge, PhD

CSPR Prevention Team

- Elizabeth Cannon, LPCC
- Laurel Biever, Med, LPC
- Melanie Fluellen, LPCC
- Amy Coleman, LISW
- Glenn Thomas, PhD
- John Ackerman, PhD

NIMH

- Lisa Horowitz, PhD
- Eliza Lanzillo, BA
- Elizabeth Ballard, PhD

NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.℠

Resources

Local

http://www.nationwidechildrens.org/suicide-research
http://www.ohiospf.org/
http://franklincountyloss.org/
http://www.ncmhs.org/SuicidePrevention.htm
http://suicideprevention.osu.edu/

Franklin County Psychiatric Crisis Line (< age 17)
614-722-1800
Netcare Access (> age 18)
614-276-2273
North Central Mental Health Services Teen Hotline
614-294-3300

National

http://www.sprc.org/
http://afsp.org/
http://jasonfoundation.com/
http://www.thetrevorproject.org/
http://www.crisistextline.org/
http://www.suicidepreventionlifeline.org/

Spanish Suicide Prevention Lifeline 1-888-628-9454
Suicide Prevention Lifeline 1-800-273-TALK (8255)
Crisis Text 741-741; text "4HOPE"
Signs of Suicide (SOS)
https://mentalhealthscreening.org/programs/youth

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide Is Preventable.

Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope

http://suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf

asQ Ask Suicide-Screening Questions

Links to Videos

Nurses: The Importance of Screening

-Video produced by Children's Mercy Kansas City Hospital

http://bcove.video/2pWyvcN

Physicians: The Importance of Screening

-Video featuring doctors Ted Abernathy and Scott Keel

Long version: https://youtu.be/OTjxEZkp4-Y

Short version: https://youtu.be/QaPeu6s__YM

Mayo Clinic: Youth Suicide Prevention - What to Say & Not to Say

https://www.youtube.com/watch?v=3BByqa7bhto&feature=youtu.be