# Screening for Suicide in Pediatric Primary Care Settings


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# Reminders

We have **muted** all participants.

We will allow participants to unmute using ***6** during the Q&A and discussion portions of the call. During this time:

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- This webinar is being recorded.

# Disclosures

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

# Objectives

- Provide a brief overview of the problem of suicide in children and adolescents and national efforts to reduce suicide rate
- Highlight pediatric primary care as a site for youth suicide prevention
- Discuss depression & suicide risk screening and brief interventions

# Key definitions

- **Suicide**—death caused by injurious behavior to the self with an intent to die
- **Suicide attempt**—a non-fatal, injurious behavior to the self with an intent to die; might not result in injury
- **Suicidal ideation**—Thinking about, considering, or planning suicide
- **Self injury** —Purposeful acts of physical harm to the self with the potential to damage body tissue but performed *without* the intent to die

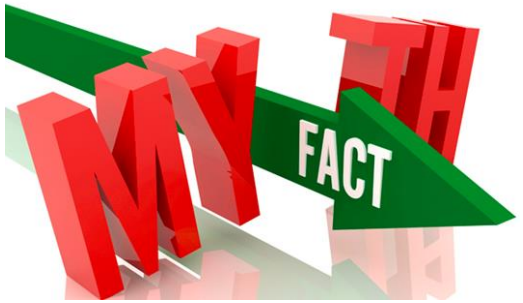
# Continuum of Suicidality

- Continuum of severity also predictive of future attempts and deaths by suicide
  - Passive thoughts about wanting to be dead
  - Pervasive suicidal ideation
  - Preparatory suicidal behaviors with intent to die
  - Suicide attempts with intent to die

- **Significant marker of emotional distress**

Tishler, 2007; Posner, 2007

# Myths or Fact?



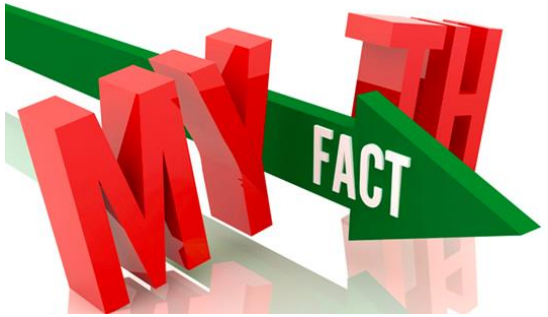

**Talking to someone about suicide is risky because it might put the idea of suicide in their heads.**

## MYTH

- You don't cause a person to consider killing him or herself by talking about suicide
- Bringing up the subject of suicide and discussing it openly is one of the most helpful things you can do

Gould et al., 2005; Crawford et al., 2011; Mathias et al., 2012

# Myths and Facts?




**If a person is determined to take their own life, there isn't much that can be done to prevent it.**

## MYTH

- Ambivalence about death is very common among suicidal individuals
- Most suicidal people do not want death; they want the pain to stop

The New York Times | http://nyti.ms/212FMnr

HEALTH

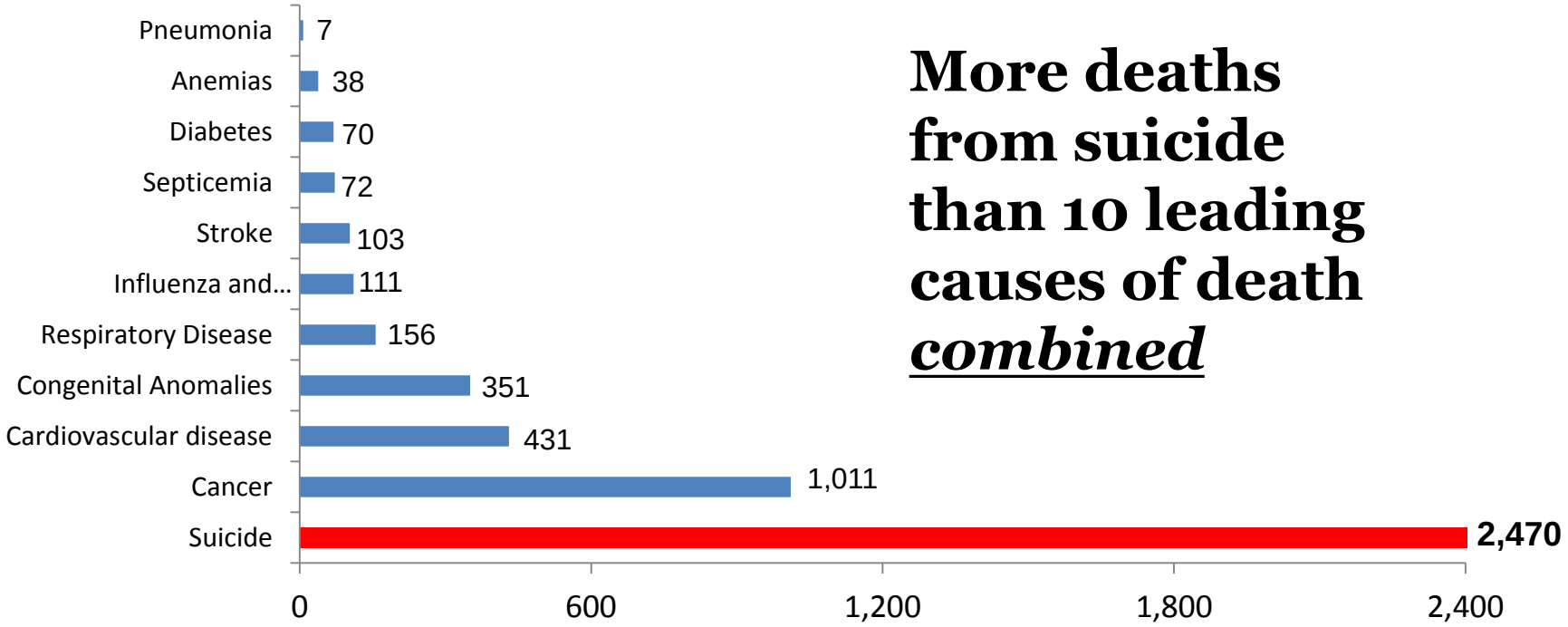
# U.S. Suicide Rate Surges to a 30-Year High

By SABRINA TAVERNISE APRIL 22, 2016

WASHINGTON — Suicide in the United States has surged to the highest levels in nearly 30 years, a federal data analysis has found, with increases in every age group except older adults. The rise was particularly steep for women. It was also substantial among middle-aged Americans, sending a signal of deep anguish from a group whose suicide rates had been stable or falling since the 1950s.

# The Problem of Youth Suicide*

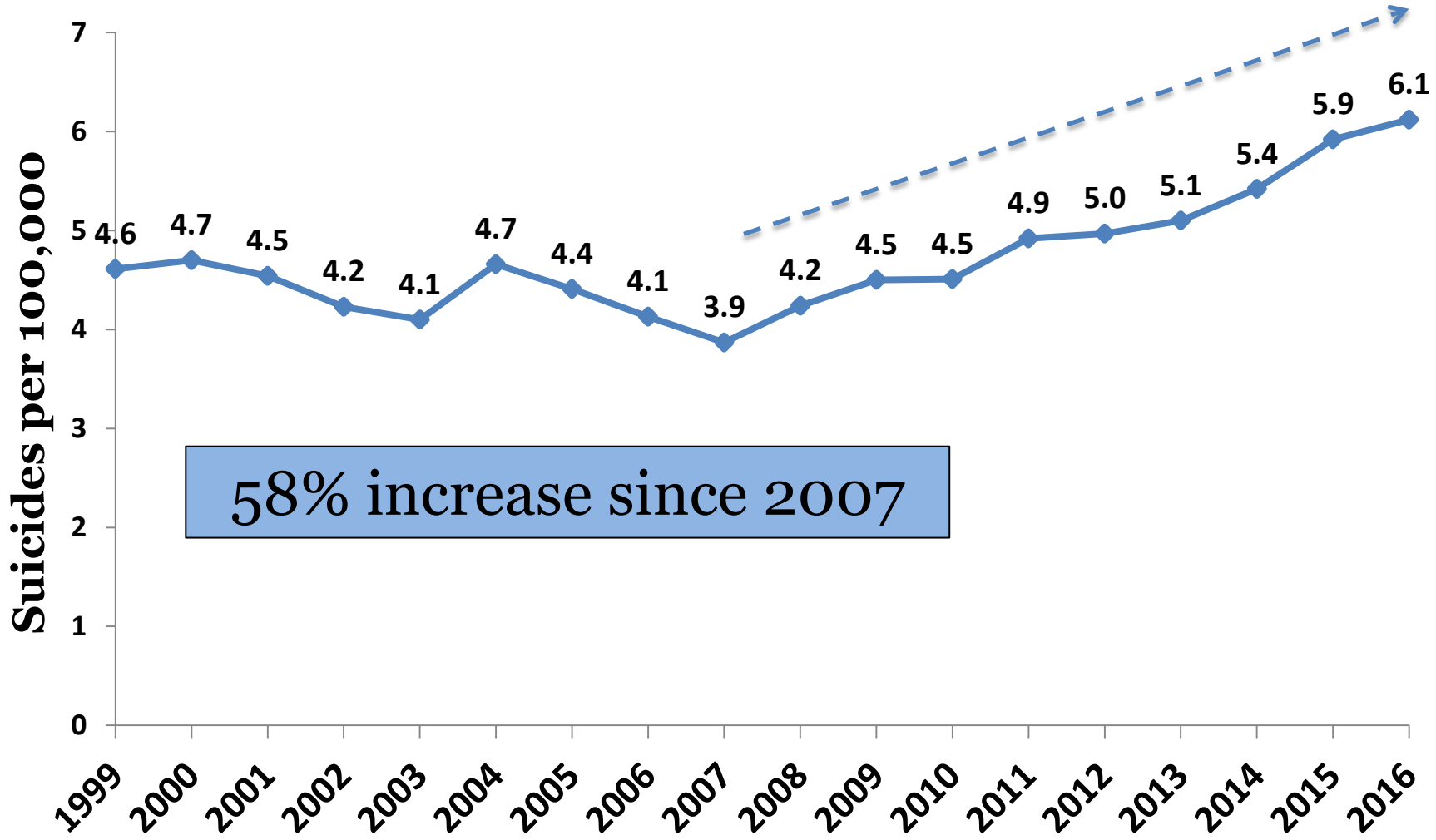
- In 2015, suicide was the 10th leading cause of death for all ages but the **2nd leading cause of death** for youth aged 10-19 years in the United States




**More deaths from suicide than 10 leading causes of death *combined***

Source: CDC WISQARS, 2017, www.cdc.gov/injury/wisqars/index.html

# U.S. Youth Suicide Rate: Ages 10-19

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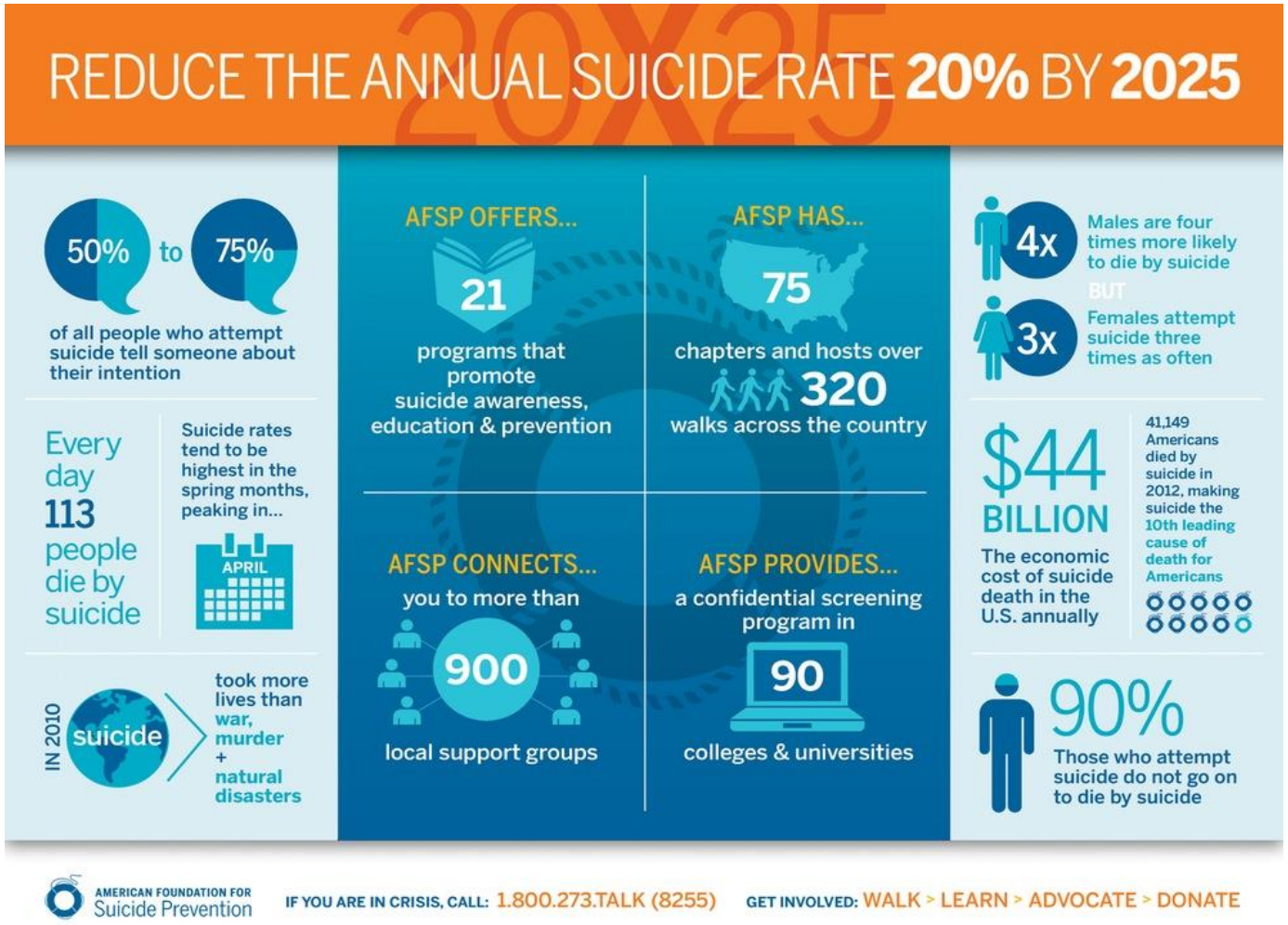
# The American Foundation for Suicide Prevention Launches Project 2025

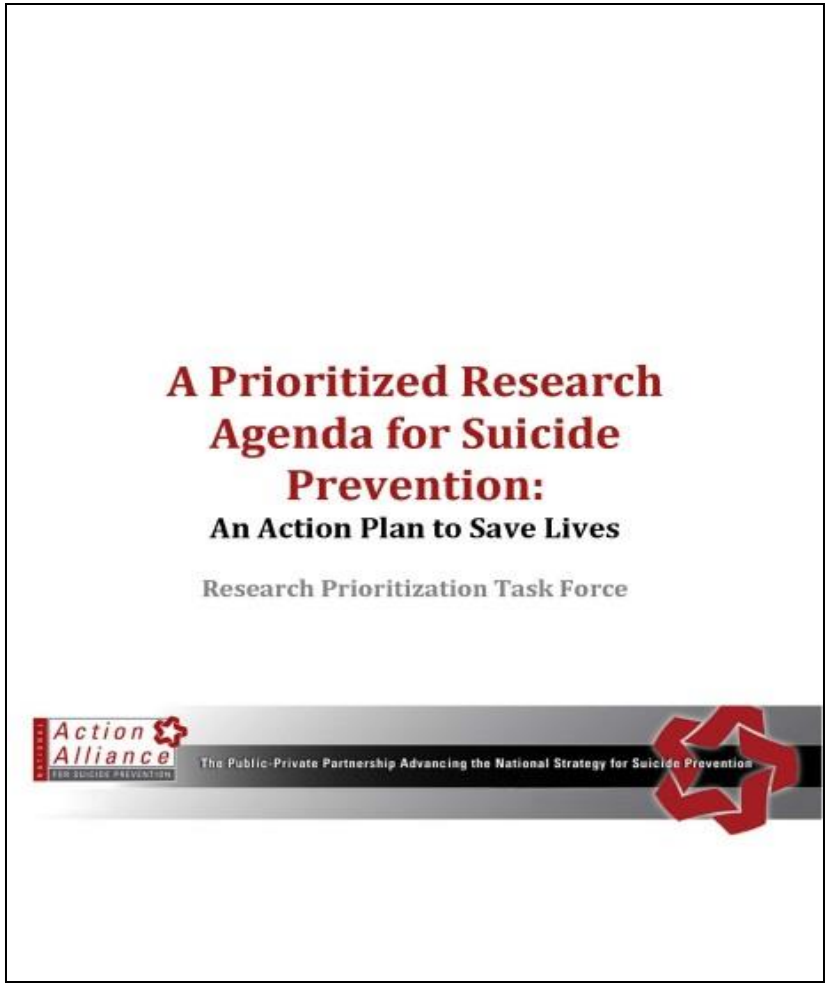



Source: http://afsp.org/american-foundation-suicide-prevention-launches-project-2025/

# AFSP's Project 2025

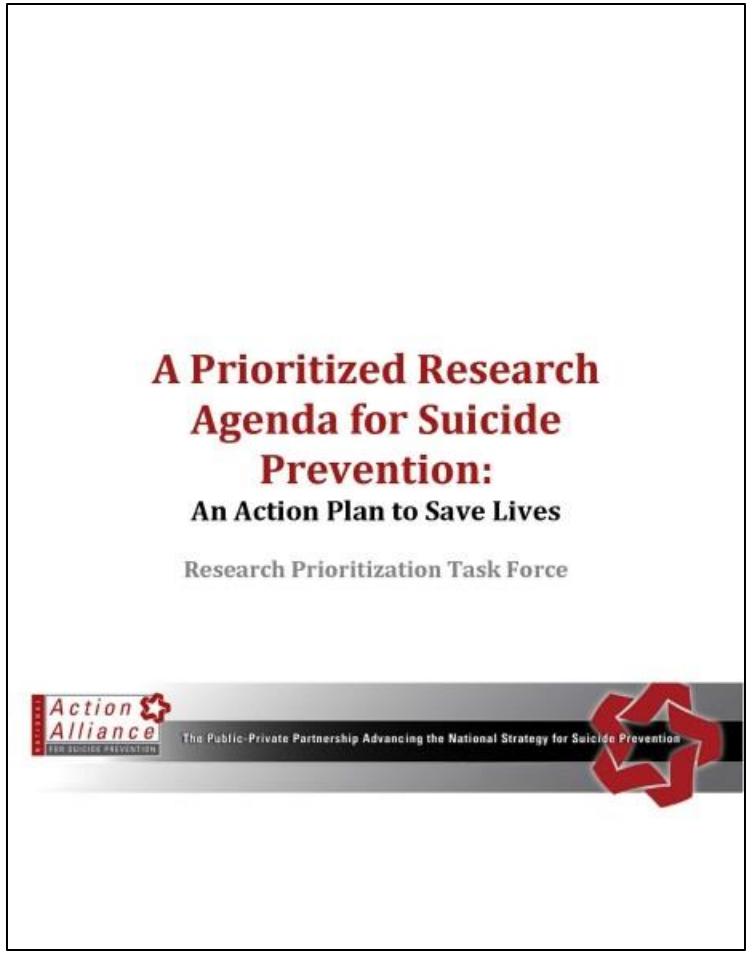
- **Create** a predictability model to determine which prevention measures have greatest impact
- **Establish** benchmarks to measure against for the next 10 years
- Based on these findings, AFSP will **develop strategies** for reducing the rate of suicide, and collaborate with partners to focus prevention efforts on policies, programs and interventions that will save the most lives in the shortest amount of time

# National Action Alliance for Suicide Prevention (i.e. Action Alliance)




Source: http://actionallianceforsuicideprevention.org/about-us

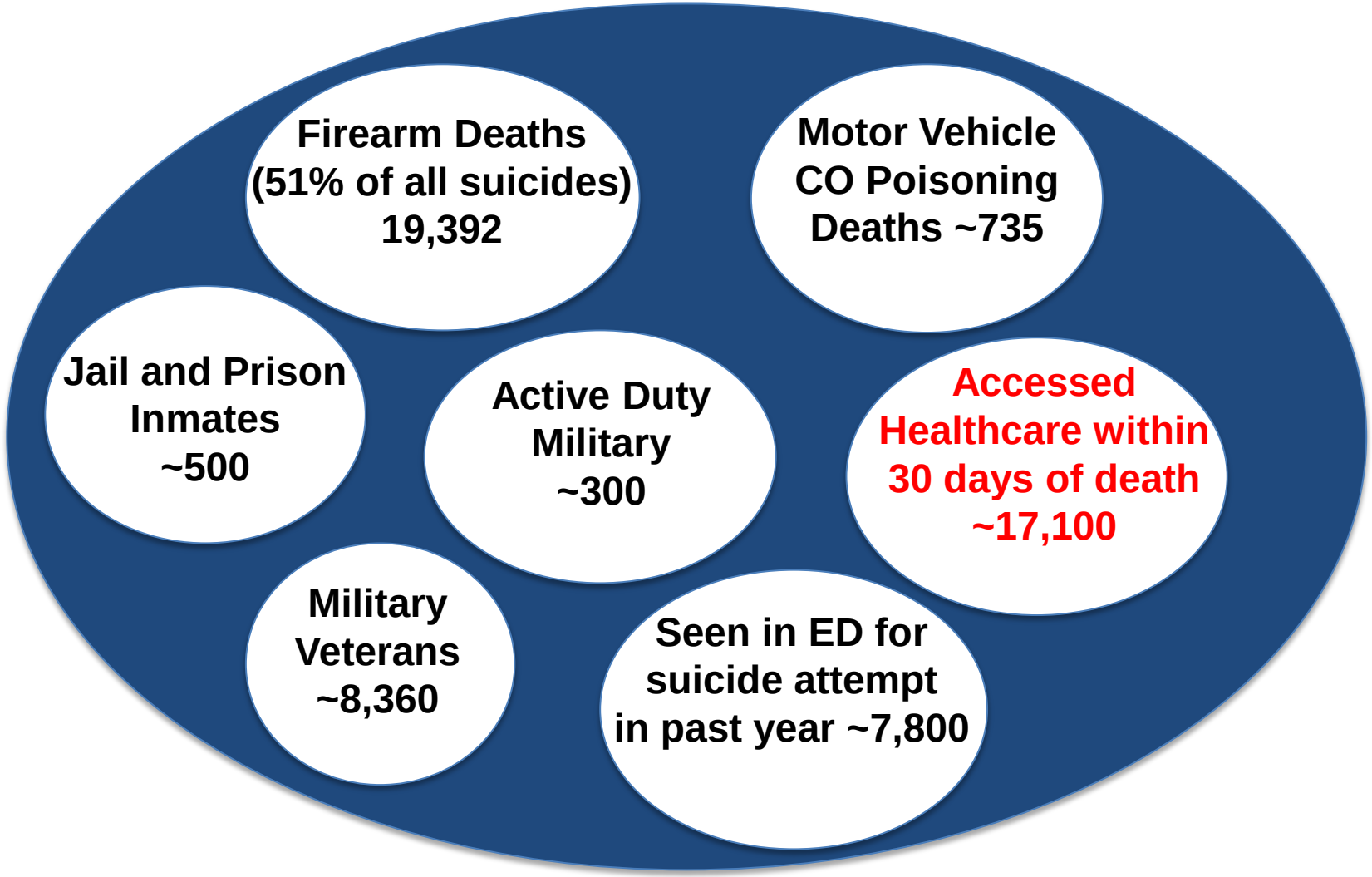
# Public Health Approach to Suicide Prevention




1. Identify large subgroups with concentrated risk in boundaried settings (e.g., EDs, primary care)
2. Identify effective practices and match them to subgroups
3. Estimate the results of implementation
4. Assess timeline for implementation and research

Source: Pringle et al., *Psychiatr Serv*, 64:71-5, 2013; Action Alliance Research Prioritization Report, 2014

# Identifying 38,000 Suicide Decedents in the United States



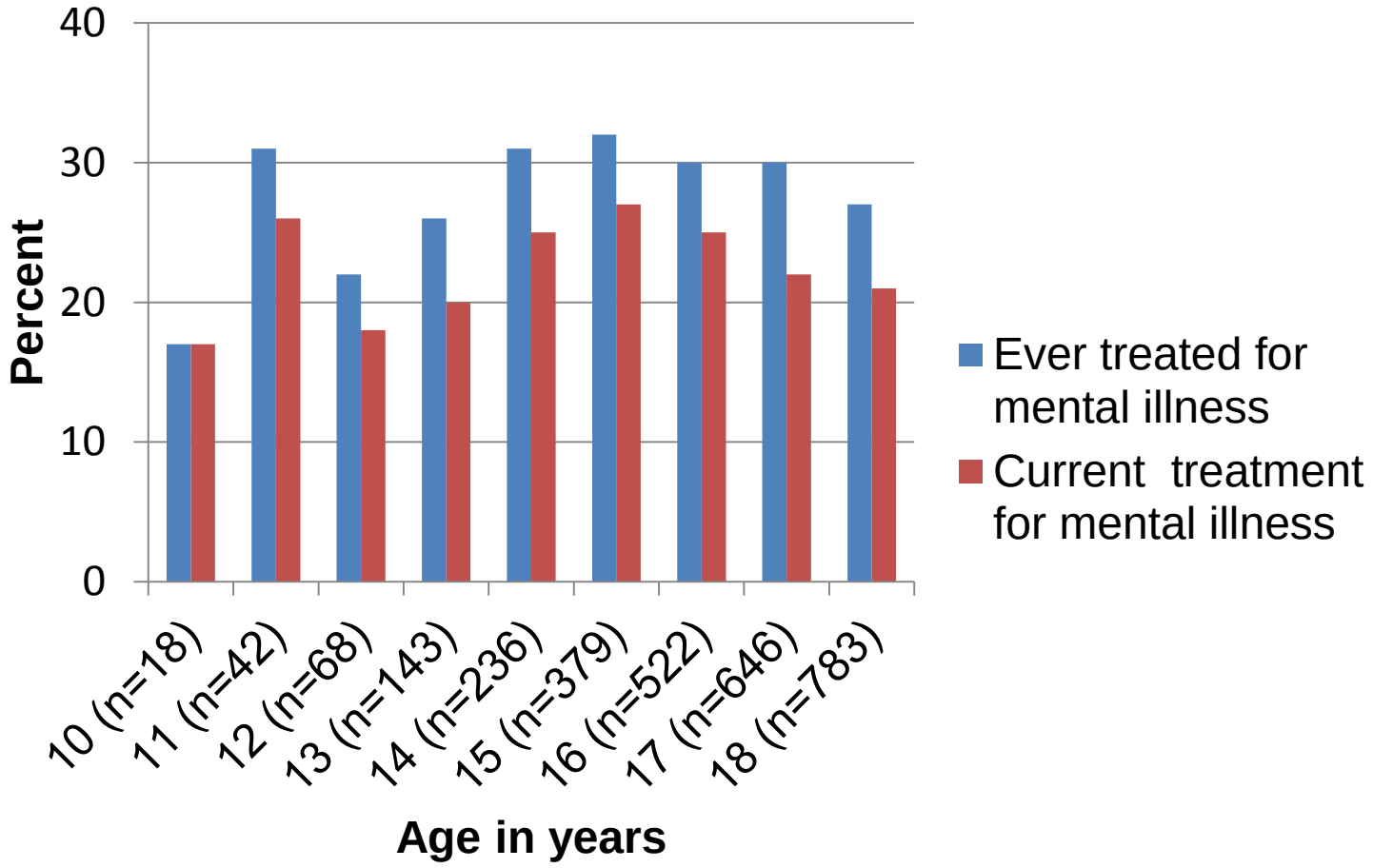

Data source: Action Alliance Research Prioritization Report, page 80, 2014; data sources for estimates provided on page 81

# Pediatric Primary Care (PC) as a Site for Suicide Prevention

- **Screening for suicide risk** has been advocated by many in the suicide prevention community because of the relatively high frequency of visits to PC compared to other health settings
- **More than 80%** of youths visit their PC doctor each year, making the PC clinic well situated to identify youth at risk
- **About 80%** of youth who die by suicide have a health service contact with an outpatient physician in the year before death

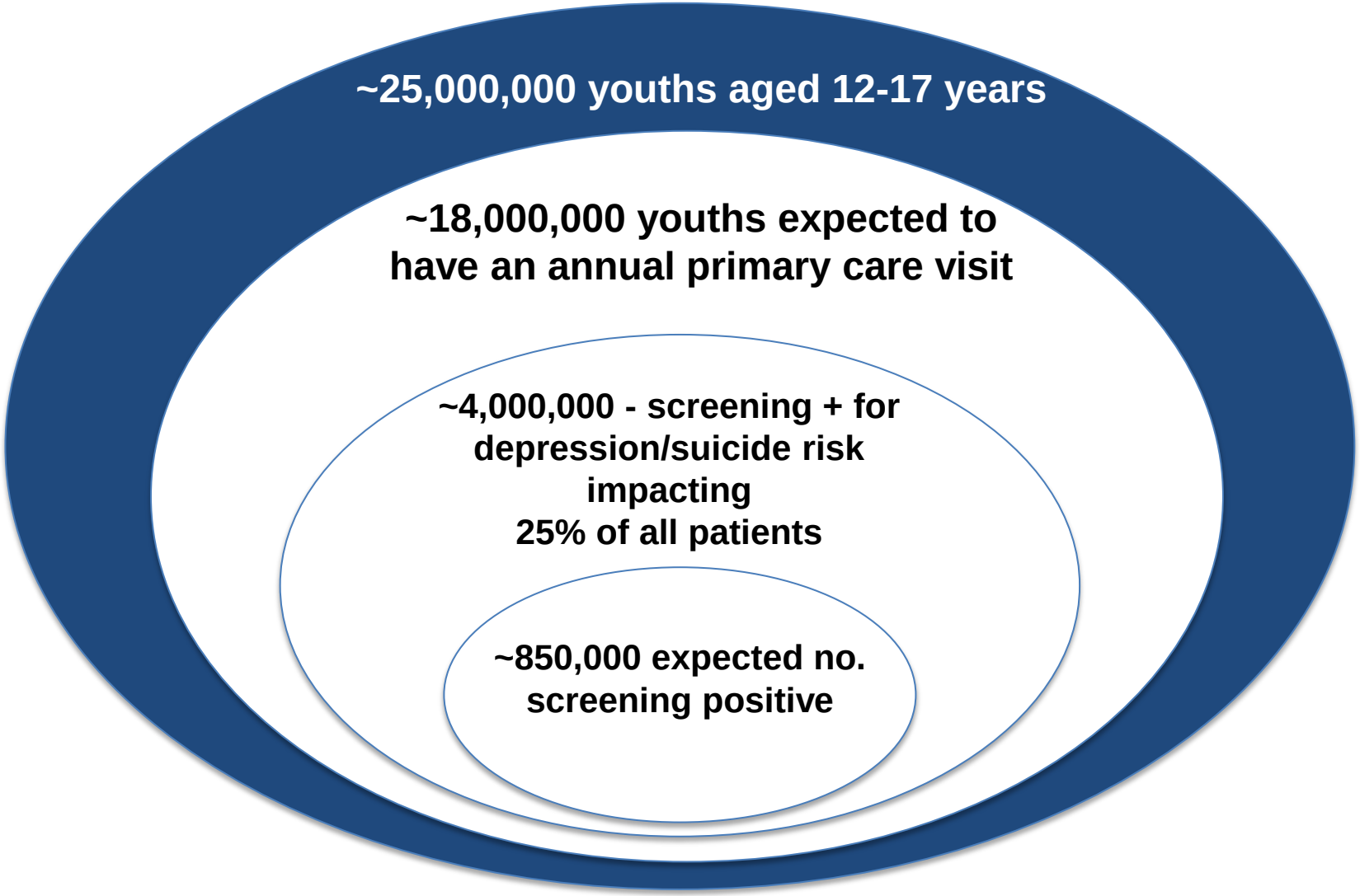
Source: www.actionalliance.org; Horowitz et al., 2014; Rhodes et al., 2013

# Rates of Mental Health Treatment in Young Suicide Completers, by Age, 2003-2010




Source: National Violent Death Reporting System, participating states, multiple years

# Step 1: Identify Large Subgroups at Elevated Risk in Boundaried Service Settings: Primary Care As Intervention Setting




Data source: WISQARS Non-fatal Injury Report , 2014, http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html

# Youth Partners in Care (YPIC) Asarnow et al., 2005

- RCT evaluated the effectiveness of a QI intervention aimed at improving access to evidence-based treatments for depression, among adolescents in primary care practices
- Intervention involved: 1) expert leader teams 2) care managers (CMs) who supported PCCs 3) CBT training for CMs 4) patient and clinician choice of treatment modality (CBT, medication, combination, CM follow up, or referral)

# YPIC Study Results

- Six months after baseline assessments, YPIC patients reported:
- Significantly fewer depressive symptoms
- Higher mental health-related quality of life
- Greater satisfaction with mental health care
- Exploratory outcome: Suicide attempts
  - Odds ratio = 0.55 (95% CI: 0.23 – 1.34, p=0.19), indicating a trend toward greater decline of suicide attempts associated with the quality improvement intervention

# Public Health Approach

1. Identify large subgroups with concentrated risk and a feasible service setting (e.g., emergency departments, child welfare)

2. Identify effective practices and match them to subgroups

3. Estimate the results of implementation

4. Assess timeline for implementation and research

Source: Pringle et al., *Psychiatr Serv*, 64:71-5, 2013

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## Estimated Number of Suicide Deaths in Youths Aged 12-17 Years Averted with Primary Care-Based SBIRT or QI Intervention for Depression and/or Suicide Risk

| | |
|---|---|
| **U.S. Census Data (2010)** | |
| Number of Youths aged 12-17 years in U.S. | 25,344,492 |
| Expected number of youths having an annual primary care visit (0.70) (Chevarley et al., 2006) | 17,741,144 |
| SBIRT or QI intervention implemented in primary care practices impacting 25% of all patients aged 12-17 years | 4,435,286 |
| Expected number of youths screening positive for depression and/or suicide risk (0.2) (Gardner et al., 2010; Stevens et al., 2008; Asarnow et al., 2005; Richardson et al., 2010a, 2010b) | 887,057 |
| **Expected estimates of suicide attempt (Fergusson et al., 2003; Bridge, unpublished data)** | |
| Group A: Suicide attempts expected within 12 months of primary care visit after usual follow-up care (0.08 x 887,057) | 70,965 |
| Group B: Suicide attempts expected within 12 months of primary care visit after SBIRT/QI intervention (0.04 x 887,057) | 35,482 |
| **Expected estimates of suicide deaths (based on roughly 200-300 suicide attempts for every completed suicide)** | |
| Group A: Deaths expected within 12 months of ED discharge after usual follow-up care (.003 x 70,965) (.005 x 70,965) | 213 – 355 |
| Group B: Deaths expected within 12 months of ED discharge after EB intervention (.003 x 35,482) (.005 x 35,482) | 106 – 177 |
| **Range of potential # of suicide deaths averted through application of SBIRT/QI interventions in primary care**<br>(213 – 106 = 107)<br>(355 – 177 = 178) | **107 – 178** |

Average annual number of suicide deaths in young persons aged 12-17 years, 2006-2010, United States: 936.

**107 - 178 averted suicide deaths would represent an approximate 11-19% annual reduction**

# Risk Factors for Suicide

- Mental illness
  - Over 90% of people who die by suicide have a least one major mental illness (Gould et al., 2003)
  - Poses a 9-fold increased risk for suicide (Brent et al., 1988, 1993; Marttunen et al., 1991; Shaffer et al., 1996; Shafii et al., 1988)

- The strongest risk factors for suicide in yout
  - depression
  - alcohol and drug use
  - previous attempts (NAMI, 2003)

# Previous Suicidal Behavior

- Prior suicide attempt is the single most potent risk factor for youth suicide (Brent et al., 1999; Marttunen et al., 1992; Shaffer et al., 1996)

- According to Goldston et al. (1999) and Lewinsohn et al. (1996), risk for repetition
  - Risk highest in first 3 – 6 months after a suicide attempt; youth remain vulnerable immediately after an inpatient discharge
  - remains substantially elevated from the general population for at least 2 years

# Suicidal Ideation

- The more severe and pervasive the suicidal ideation, the more likely it will eventually lead to a suicide attempt (Lewinsohn et al., 2006)
- Attempters with persistent suicidal ideation, particularly with a plan and/or high intent to engage in suicidal behavior are at increased risk to reattempt (Goldston et al., 1999; Lewinsohn et al., 1996)

# Lethality of Suicide Attempt

- Adolescents who make attempts of high medical lethality (e.g. hanging, shooting, or jumping) are at extremely high risk for dying by suicide
  (Brent et al., 1988; Garfinkel et al., 1982)

- Attempts of low lethality do not necessarily indicate low suicidal intent
  - Younger children
  - Impulsive individuals (Brent et al., 1993; Gunnell et al., 1997)

# Suicidal Intent

- Items that discriminate between completers and attempters
  - evidence of planning,
  - timing the attempt to avoid detection,
  - confiding suicidal plans ahead of time and
  - expressing a wish to die

Sources: Brent et al., 1988

# Other Risk Factors for Suicide

- Being male
- Access to lethal means (e.g., firearms)
- Aggressive/impulsive/risky behavior
- History of sexual or physical abuse
- Family psychiatric history
- History of bullying
- LGBTQ - Sexual orientation and gender identity
- Medical conditions, chronic pain, brain injury


# Risk Factors for Suicide

- Many health conditions are linked to increased risk of suicidal ideation & attempts
- Presence of multiple health conditions increases risk
- Conditions with elevated rates of suicidal behavior:
  - TBI, Sleep disorders, Epilepsy, Cancer, HIV/AIDS
  - Asthma, Diabetes, Chronic pain, Skin disorders
  - Disorders of Sexual Development, Eating disorders, Substance use disorders

Ahmedani et al., 2017; Rodway et al., 2016; Shah et al., 2015; Thibault et al., 2016

# Risk Factors for Children

- Impulsive and thoughts change rapidly
- Brains are still developing
- Solving problems/regulating intense emotions hard
- May not fully understand permanence of death
- ALWAYS take a child seriously when they make a statement about suicide - no matter what their age.

# Younger Children and Suicidality

- Even children 12 years old and younger plan, attempt and die by suicide
  - 3rd leading cause of death for 12 year olds
  - 13th leading cause of death for children 12 and under
  - 12% of children age 6-12 have suicidal thoughts

- 117 deaths in children 5-12 years old (likely an underestimate)

CDC, 2015; Tishler, Reiss, & Rhodes, 2007; Natl Vital Stat Rep, 2006

# Triggering Events

No single event causes suicidality

Examples:

- breakup
- bullying
- school problems
- rejection or perceived failure
- sudden death of a loved one
- suicide of a friend or relative
- family stressors like divorce, jail, deployment


# Warning Signs

- Most people who attempt suicide give warning signs of suicide
  - Wanting to be alone all of the time
  - ↓ interest in usual activities
  - Giving away important belongings
  - Risky or reckless behavior
  - Self-injury
  - Increase in energy following a period of depression

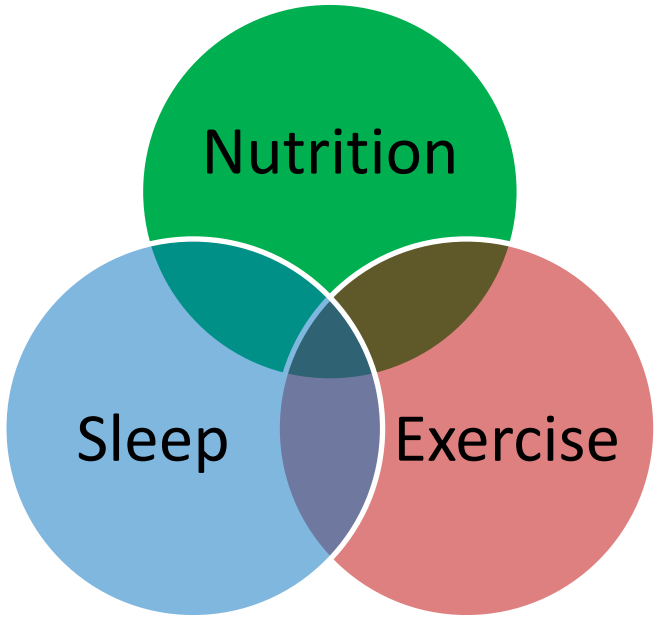
# Warning Signs

- **Seek Immediate Help**
  - Threatening to attempt suicide
  - Obtaining a weapon or seeking means to kill oneself
  - Talking or writing about wanting to end one's life in school or social media

# Protective Factors for Suicide

- Access to effective clinical care for mental, physical, and substance abuse disorders
- Restricted access to highly lethal means of suicide
- Strong connections to family & community support
- Use of a variety of coping skills and a flexible problem solving approach
- Cultural and religious beliefs that discourage suicide and support self-preservation
- Reasons for living; future orientation

# Healthy Habits – "Free Medicine"




- Nutrition, Sleep and Exercise work together to keep our mind and body working at its best
- They are behaviors that can prevent and treat depression

Credit to MF-PEP, Mary Fristad

# What Can Pediatricians Do to Help Prevent Suicide?

# If Your Practice has the Resources and Capacity

- Consider implementing a version of the Youth Partners in Care Study in your practice
- Independent external reviewers gave the intervention its highest marks for Readiness for Dissemination
- There are costs (~$3,000-$5,000) for start-up, training, and technical assistance
- Materials are available online: http://www.nrepp.samhsa.gov

# And for Everyone Else?

# Depression and Suicidal Ideation in Youth

- **> 1 million** adolescents (~8 % of youths aged 12 to 17) are estimated to experience a MDE each year, with less than 40% receiving treatment
- **2.8 million** (17.0%) high school students reported “seriously considered suicide” in 2011
- **2.3 million** (13.6%) high school students made a plan

CDC, 2013, 2014; SAMHSA, 2012

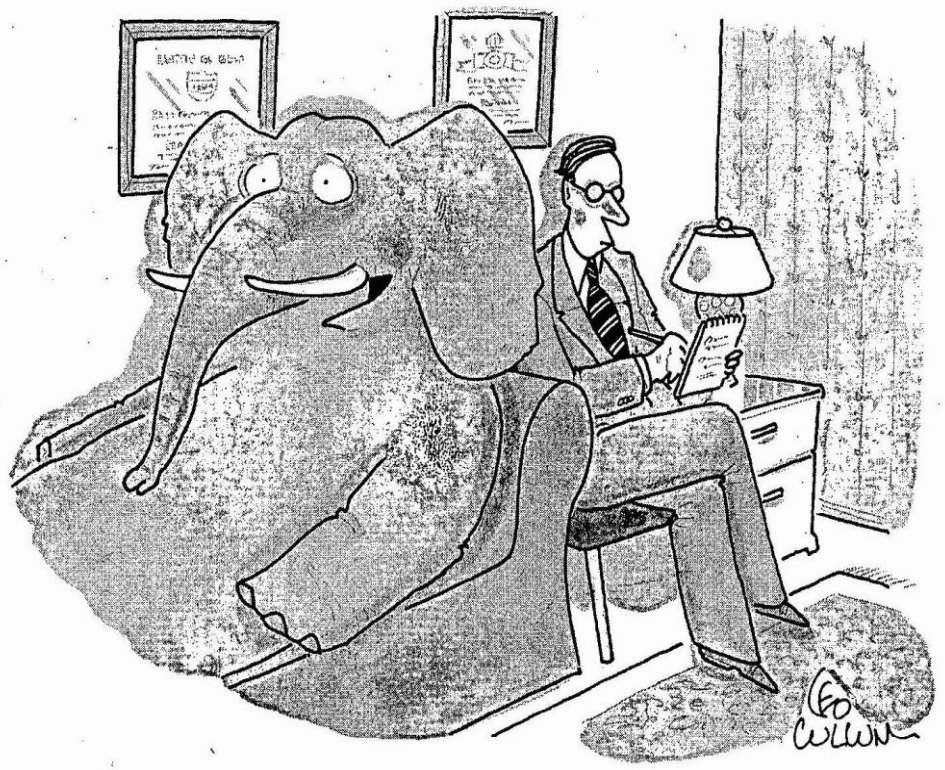
# Underdetection

- Majority of those who die by suicide have contact with a medical professional prior to death

- Majority of attempters unrecognized by medical professionals
  - 83% of attempters not recognized by PCP as suicidal
  - 47% of PCP reported having at least one adolescent patient attempt suicide in the previous year

- Majority of practice settings do not screen for socio-behavioral health risks
  - Only 23% of PCPs surveyed reported routinely screening for suicidal behaviors

Sources: Pan, 2009; Rhodes 2013; Gairin, 2003; Frankenfield, 2000; Clark, 1993; Blum, 1996; McDowell, 2011



*"I'm right there in the room, and no one even acknowledges me."*

"I'm right there in the room and no one even acknowledges me"

# Should All Patients be Screened for Suicide Risk?



# Who Should be Screened?

- Everyone?
  - Some may argue that the evidence base for universal screening of a relatively low base rate event is lacking
  - Potentially high burden of managing false positives
- Those presenting with specific risk factors?
  - e.g., depression
  - But, potentially miss youth at risk of suicide

# Role of the Primary Care Provider

- PCPs are often the de-facto principal mental healthcare provider for children and adolescents

- PCPs are able to develop relationships with patients and gain trust
  - Many adolescents report more comfort discussing risk-taking activities with PCPs than with specialists

- In line with other important screening efforts (e.g., obesity)

Larkin & Beautrais (2010) *Crisis*; American Academy of Pediatrics (2009) *Pediatrics;* Wilson & Klein (2000) *Arch Pediatr Adolesc Med*

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# Opportunity in Primary Care

Screening is acceptable to many parents and adolescents in a primary care setting and does not disrupt the flow of patient care

- Many adolescents will disclose suicidal ideation when asked in a primary care setting
  - Sample of 1503 youths (ages 11-20): 209 (14%) reported suicidal ideation in the previous month

Source: Luoma, 2002; Gardner, 2010; McDowell, 2011; Wintersteen, 2010

# Screening in Primary Care

- In one study, there was a 4-fold increase in detection of suicidal ideation by pediatricians when screening tools were used in outpatient clinics

  - base rate: 0.8%, screening rate: 3.6%

- **Minimal increased burden**: Screening resulted in one additional youth per week requiring further mental health follow-up, which did not overwhelm the pediatric care clinics

Source: Wintersteen, 2010

# Barriers to Detecting Risk in Primary Care

- Time & resources
  - Existing measures are impractical in primary care setting
  - Average face-to-face time between pediatrician and patient was 16.3 minutes
- Patient distortion of suicidal ideation or behavior
  - Shame/embarrassment
  - Fear of repercussions
  - Cultural norms
- Asking ineffectively
  - Leading questions; patient tells what they think you want to hear
- Physician discomfort

CDC, 2005; Shea, 2012

# Physician Discomfort when Screening for Suicide Risk

- Less than half of physicians (46%) feel they are able to adequately identify depression in adolescents

- Only 51% say they know how to manage mental health information from adolescents
  - Many triage patients with suicidal ideation to EDs
    - Overburdening ED

- Suicide not often discussed with depressed patients
  - Only 36% of simulated patients requesting antidepressants were asked about suicide

Wintersteen, 2013; Kalucy, 2006; McDowell, 2011; Feldman, 2007

# Use Validated Measures for Screening

- Depression:

  **Patient Health Questionnaire for Adolescents (PHQ-A)**

  - Good psychometric properties
    - 73% Sensitivity, 94% Specificity, 56% PPV
  - Prevalence of MDD among adolescent primary care patients: 12.4%

Source: Johnson et al., 2002

# Ask Suicide-Screening Questions (ASQ)

- 3 pediatric EDs – September 2008 to January 2011
  - Children's National Medical Center, Washington, DC
  - Children's Hospital Boston, Boston, MA
  - Nationwide Children's Hospital, Columbus, OH

- 524 pediatric ED patients
  - 344 medical/surgical, 180 psychiatric
  - 57% female, 50% white, 53% privately insured
  - 10 to 21 years (mean=15.2 years; SD = 2.6y)

Horowitz et al. (2012) *Arch Pediatr Adolsc Med*

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**•Ask Suicide-Screening Questions (ASQ) Study***

- Develop a new screening instrument to identify patients with **medical/surgical chief complaints at risk for suicide** in the pediatric ED
  - Gold Standard was the Suicidal Ideation Questionnaire (SIQ)
- **ASQ features:** Excellent psychometric properties
- **Results:**
  - 98/524 (18.7%) screened positive for suicide risk
  - 84/180 (46.7%) of psychiatric patients
  - **14/344 (4.1%) of medical patients screened positive for suicide risk**
- **Feasible and Acceptable to Families**
  - Less than 2 minutes to administer
  - Non-disruptive to ED workflow
  - Over 95% of patients were in favor of screening
- **ASQ is available in the public domain**

asQ
Ask Suicide Screening Questions

Suicide Screening Questions

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

If yes, how?

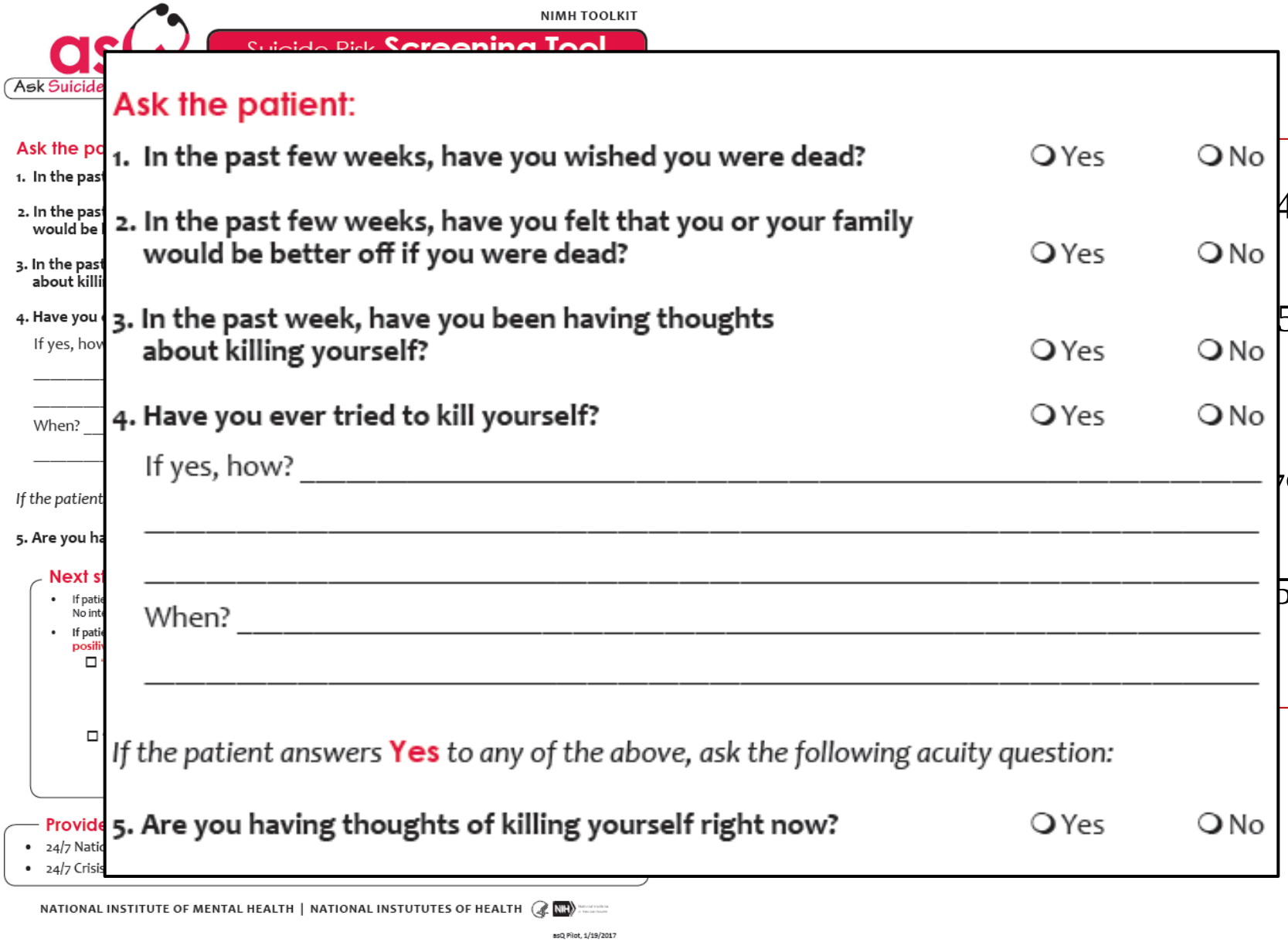
When?

Patient Name: Date:

Medical Record #: (or Patient Label)

NIMH National Institute of Mental Health

*Horowitz et al., 2013




4)

5)

7%

5%

National Institute of Mental Health

Horowitz, Bridge, Teach, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

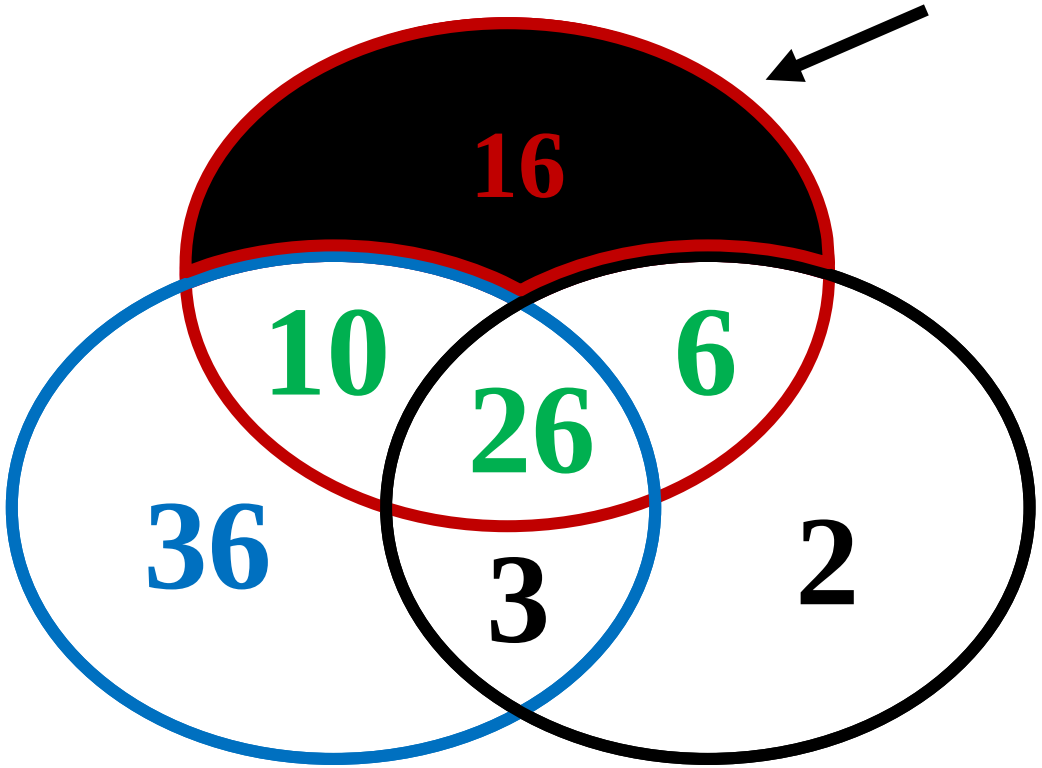
# Other Instruments

- Behavioral Health Screen
- Child Depression Inventory
- Beck Scale for Suicide Ideation
- Columbia-Suicide Severity Rating Scale

# Can depression screening be used to effectively screen for suicide risk?

# Patient Health Questionnaire for Adolescents (PHQ-A)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain
- Commonly used in medical settings
- One suicide-risk question, Item #9:
  - *"Thoughts that you would be better off dead* ***or*** *of hurting yourself in some way"*




N=400

*Preliminary unpublished data, please do not disseminate

NIH National Institute of Mental Health

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# Interpreting the Screening Results

- A positive score on the PHQ-A or ASQ suggests the need to further assess the patient for depression and suicide risk
- **Primary care providers should**:
  - Review the items endorsed on the questionnaire (including no responses)
  - Inquire about suicidal intent, the nature of past and present thoughts and behaviors, time frame, degree of planning, and who knows and how they found out

Source: Shain and the Committee on Adolescence, 2007; TeenScreen Primary Care, 2009

# Interpreting the Screening Results

- A positive score on the PHQ-A or ASQ suggests the need to further assess the patient for depression and suicide risk
- **Primary care providers should also**:
  - Inquire about whether there are firearms in the home
    - If so, counsel about means restriction
  - Interview the patient separately from the parent
  - Obtain information from parents and others as appropriate

Source: Shain and the Committee on Adolescence, 2007; TeenScreen Primary Care, 2009

# Limits of Confidentiality

- For adolescents at risk to themselves or others, safety takes precedence over confidentiality
  - Adolescent patient should clearly understand that at the outset

- Pediatricians need to inform appropriate people when they believe the adolescent is at risk of suicide

Source: Shain and the Committee on Adolescence, 2007; Taylor & Adelman, 1989

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# Advice for Pediatricians

- **ASK**
- Know the risk factors for suicide and suicidal behavior in youth
- Develop working relationships with EDs and colleagues in the mental health professions to ensure good communication, continuity, and follow-up through the medical home
- During routine evaluations, ask about the presence of firearms in the home. Discuss with parents the risks associated with guns in the home, especially if the child is suicidal

Shain and the Committee on Adolescence, 2007

# Turning Research Into Practice

**“How can we implement suicide screening in our pediatric practice?”**

**-Dr. A**

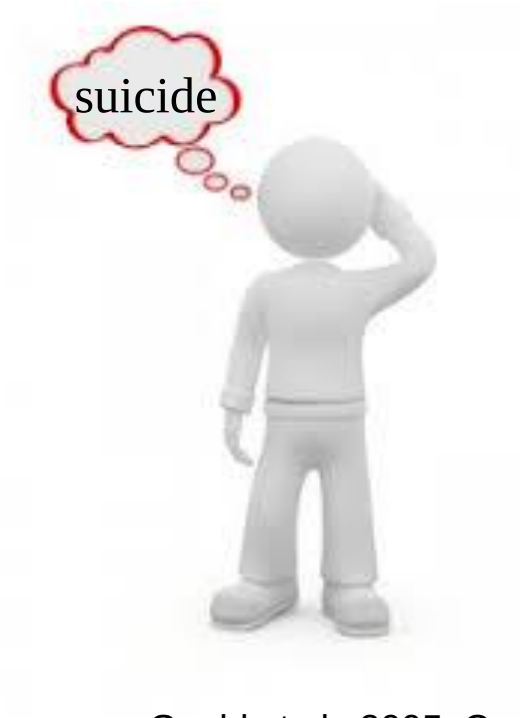
PEDIATRIC & ADOLESCENT
HEALTH PARTNERS

# Pediatric & Adolescent Health Partners (PAHP)

- Implemented routine suicide risk screening for all well patient visits, ages 12+
- Receptionist hands info sheet to parent upon sign-in
  - Notifies parent of the screening effort
- ASQ screen administered by nurses during initial nursing assessment
- Scored in real time, results recorded in chart
- Physician notified if patient screens positive

# Common Concern:

Can asking kids questions about suicidal thoughts put ‘ideas’ into their heads?






Gould et al., 2005; Crawford et al., 2011; Mathias et al., 2012


At P.A.H.P. your child's health and safety is our #1 priority.

During today's visit, a nurse will ask your child some additional questions in private. These additional questions ask about depression and suicide risk, which are major public health problems for youth in the United States.

If we have any concerns after asking the screening questions, we will let you know.

Suicide is the 2nd leading cause of death for youth. **Please note that screening for suicide risk is safe**, and is very important for suicide prevention. Extensive research has shown that asking youth 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 quality improvement efforts.

# Preliminary Screening Results

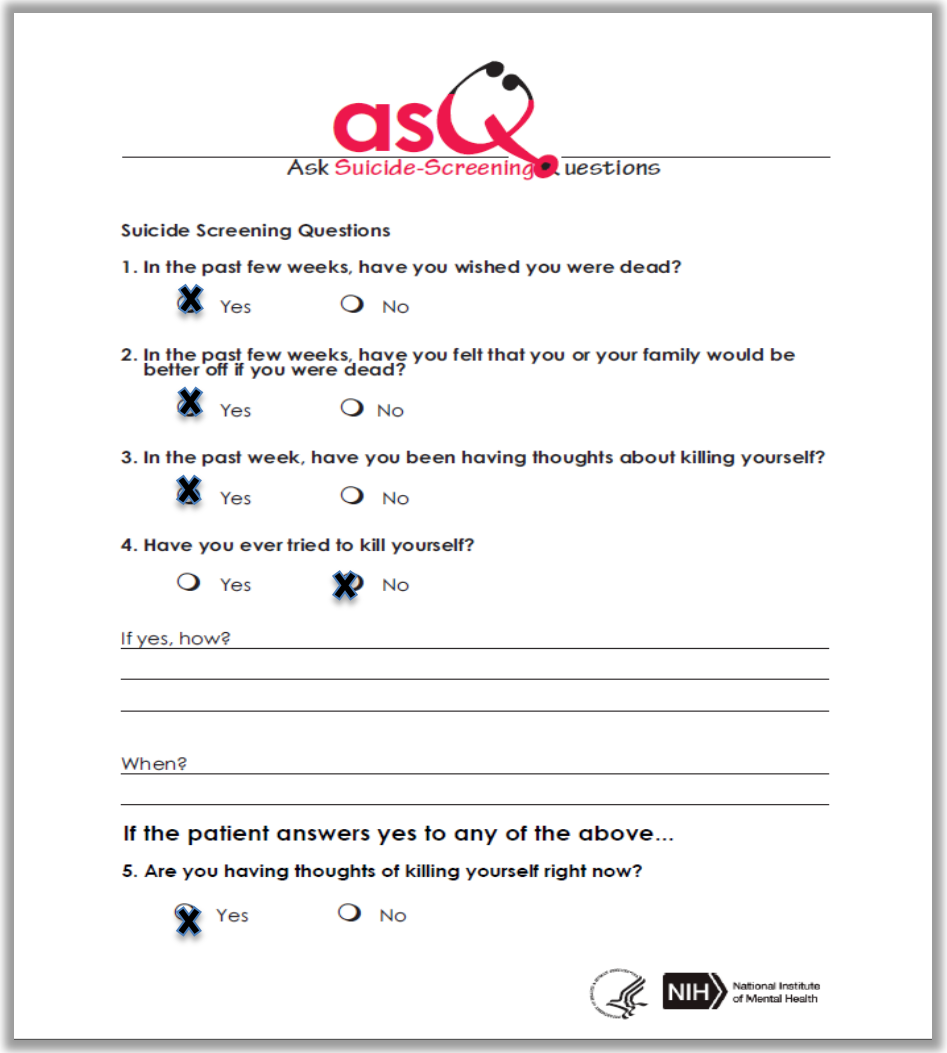
- Screening data analyzed from 231 patients
- 29 patients screened positive (13%)
  - Including 16 with previous attempts
  - 1 patients at imminent risk (thoughts right now)
- Only 35% had previously been asked about suicide
- 55% of positive screens endorsed “past behavior”



(Unpublished pilot data)

# A Patient Example

- 18 y.o. male presenting with fatigue
- Nurse intuition – something not right
- Administered ASQ



asQ
Ask Suicide-Screening Questions

Suicide Screening Questions

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...

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

NIH National Institute of Mental Health

# What Do Kids Think?

- **98%** agreed clinicians should ask kids about suicidal thoughts when they are at the doctor's office
- Why?
  - *[The doctor's office] could be the only time suicide is brought up.*
  - *Some kids probably feel like committing suicide and don't think that they can talk about it. So when someone asks them, then they might come out.*
- Why not?
  - *Not appropriate.*
  - *Kids aren't going to be honest if asked by someone they don't really know like that and may be afraid of parents finding out.*



(Unpublished pilot data)

# What Do Parents Think?

- Collected from voluntary, anonymous parent survey (N=49)
- Should kids be asked about suicide when at the doctor's office?
  - Yes: 36 (73.5%) No: 5 (10.2%) I don't know: 8 (16.3%)
- Why/why not?
  - *Kids feel comfortable at the doctor's office.*
  - *Because my child might share with a medical professional and not with me. I love this initiative.*
  - *Teens may not be comfortable telling mom or dad.*
  - *Will make my son uncomfortable.*
  - *This is going to make my child think about suicide.*
  - *The child is [at the doctor's office] to fix a physical ailment.*

# 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?

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# Thank You!


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**Partners**

- NCH School-based Team
- Columbus City Schools
- Syntero Inc.
- Screening for Mental Health


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

# Thank you for participating!

If you would like receive CME credit for today's presentation, please complete the following survey **by Friday, June 8, 2018:**

**https://redcap.nchri.org/surveys/?s=TKWCDJ443L**
**(copy & paste this link into your web browser)**

**Please note: we are unable to give CME credit past this deadline**

**Save the Date for our next Behavioral Health Webinar:**

## June 28, 2018 from 12-1pm

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