Behavioral Health Webinar Series for Primary Care

Thursday, December 13, 2018
Noon to 1:00 p.m.

Depression and Suicide Screening:
Year-end Summary and Lessons from the Field

John Ackerman, PhD

Nancy Cunningham, PsyD

Join by Phone: Call 614-355-5333, Conference ID: 4099027
Join by Skype: https://meet.nationwidechildrens.org/megan.mashhadian/JDR2Z77P?sl=1

This session is eligible for 1.0 Category 1 CME credit upon completion of the CME Evaluation Survey
A link to the survey will be shared just prior to the presentation

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Depression and Suicide Screening: Year-end summary and lessons from the field

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Disclosures

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

Objectives

At the conclusion of this event, participants will be able to:

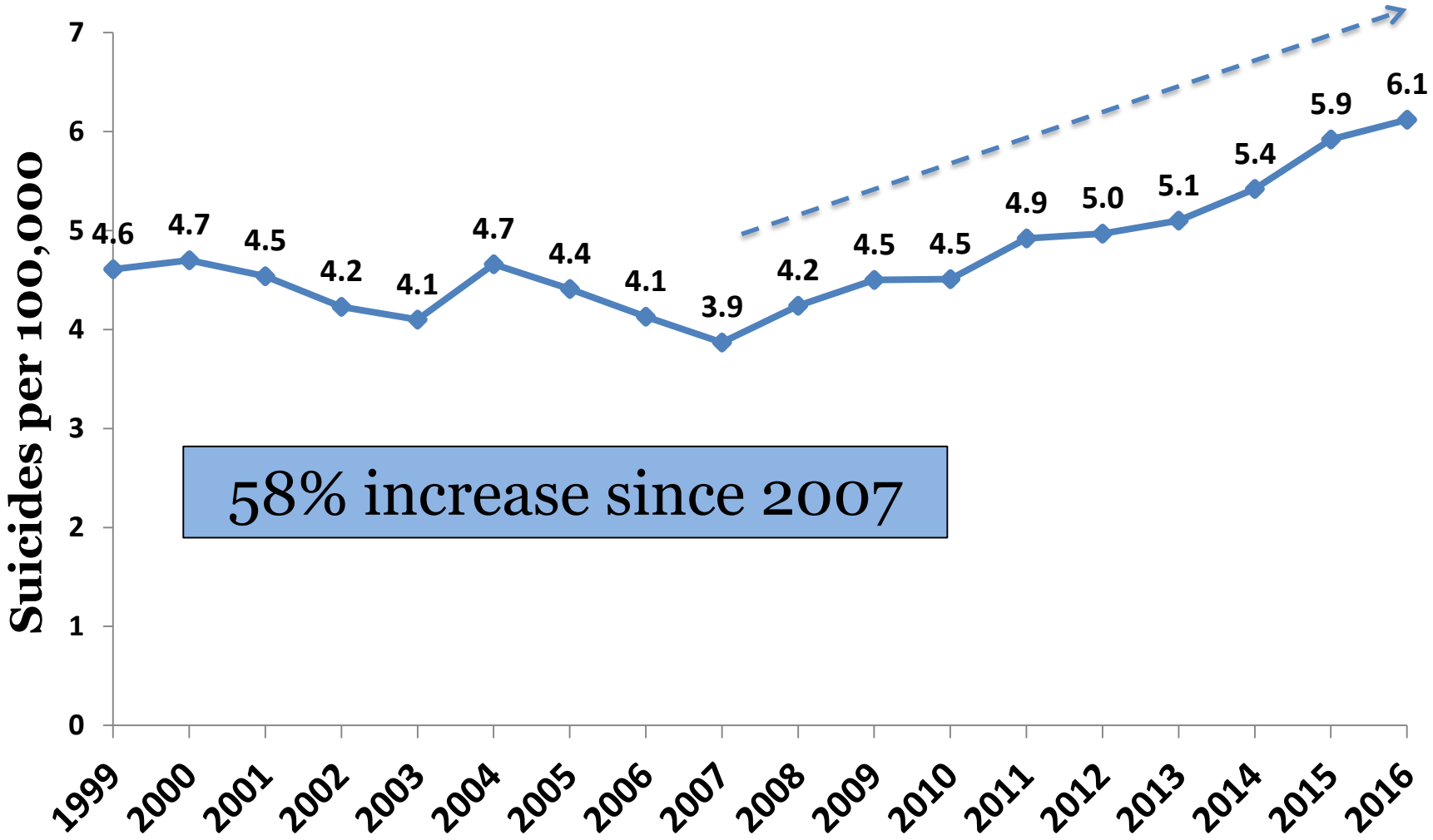
- Use, or consider for their own practice, lessons learned from the primary care field about implementation of depression and suicide risk screening: benefits, obstacles, and opportunities
- Increase their knowledge of new research updates on pediatric depression and suicidality relevant to primary care settings
- Acquire feedback from BH experts to questions from the audience regarding primary care implementation of screening, triage and referral for depression and suicidality

Depression and Suicidal Ideation in Youth

- **> 1 million** teens (~8 % of youths aged 12-17) have a MDE each year, but <40% receive treatment
- According to youth self-report in the prior 12 months on the 2017 Youth Risk Behavior Survey
  - 17.2% HS students reported “seriously considered suicide”
  - 13.6% HS students made a plan
  - 7.4% HS students reported making a suicide attempt

CDC, 2014; SAMHSA, 2012; YRBS, 2017

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



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What Can Pediatricians Do to Help Prevent Suicide?

- Majority of individuals who die by suicide have contact with a medical professional prior to death
- Majority of attempters (83%) go unrecognized by their PCP as being at risk
- Majority of settings do not screen for socio-behavioral health risks including suicide
- PCPs are often de-facto mental healthcare provider
- PCPs are able to develop trusting relationships
- Youth report more comfort discussing risk-taking activities with PCPs

Sources: Pan, 2009; Rhodes 2013; Gairin, 2003; Larkin & Beautrais, 2010; McDowell, 2011

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

- Consistent with many other screening initiatives
- 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

Barriers to Detecting Risk in Primary Care

- Time & resources
- Patient distortion of suicidal ideation or behavior
  - Shame/embarrassment
  - Fear of repercussions
- Asking ineffectively
  - Leading questions; patient tells what they think you want to hear
- Physician discomfort
  - Less than half of physicians (46%) feel they are able to adequately identify depression in adolescents
  - Suicide not often discussed with depressed patients
  - Only 36% of simulated patients requesting antidepressants were asked about suicide

CDC, 2005; Shea, 2012

Summary Take-Home Messages from Prior Webinars

- **ASK directly about depression and suicide**
- Know risk factors for suicide & suicidal behavior in youth
- Develop working relationships with EDs and colleagues in the mental health professions
- Discuss with parents risks associated with all lethal means in the home, especially if the child is suicidal

Shain and the Committee on Adolescence, 2007; GLAD-PC, 2018

Summary Take-Home Messages from Prior Webinars

- Primary care setting is an important place to identify youth at risk
- Clinicians require validated, pediatric-specific screening instruments (e.g., PHQ-9, ASQ)
- Screening can take <2 minutes
- Important to have a workflow and plan in place for managing positive screens

Turning Research Into Practice

“How can we implement suicide screening in our pediatric practice?”
-Dr. A

https://www.youtube.com/watch?v=OTjxEZkp4-Y&feature=youtu.be

PEDIATRIC & ADOLESCENT
HEALTH PARTNERS

Screening, Risk Assessment, Safety Planning and Referral

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

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? _____

   _____

   _____

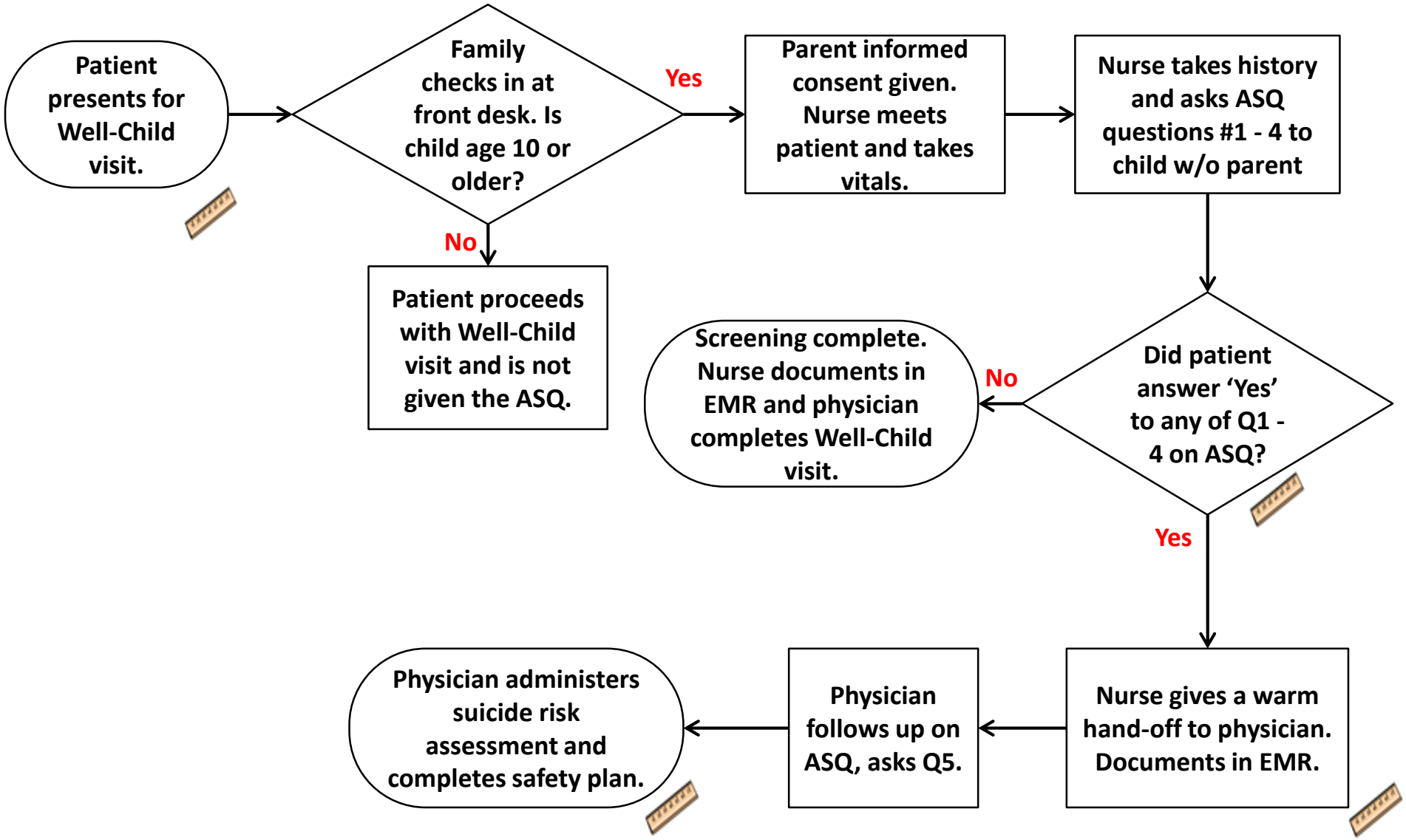
   When? _____

   _____

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



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

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)

When to Complete a Risk Assessment and Safety Plan

- Any positive response on the ASQ (#1-5)
  - Indicates suicidal thoughts in the past few weeks or lifetime suicide attempt
  - If patient refuses to respond or suspected safety concerns arise, conduct a risk assessment

- Presence of suicide warning signs (e.g., burden, hopelessness, talking/posting about death/suicide)
- ***Safety to be evaluated before patient leaves***

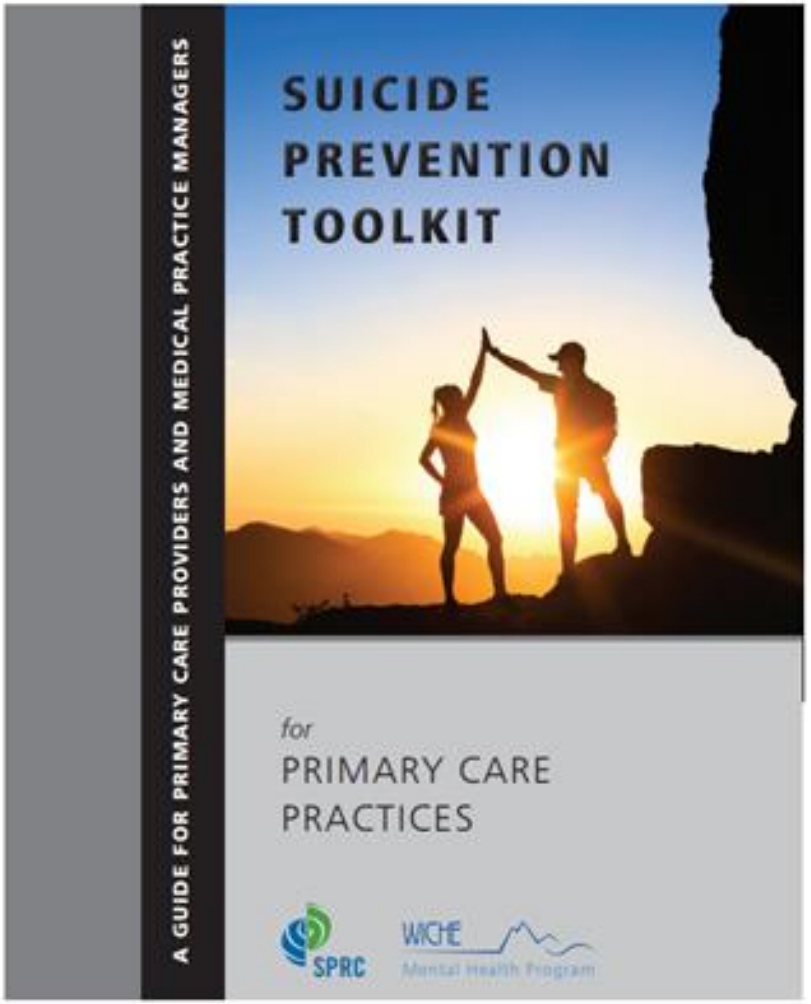
Risk Assessment overview

- Assess risk/protective factors and warning signs
- Suicide Inquiry: thoughts/plan/intent/access to means using screening data as a starting point
- Clinical judgment
- Evaluate ability to collaboratively safety plan
- Columbia Suicide Severity Rating Scale
  - Strong evidence-base supporting use
  - Structured, but flexible tool that helps identify suicide risk severity and need for intervention

Safety Planning

- Set of co-created strategies to decrease risk of suicidal behavior during a crisis
- Not a “no-suicide contract”
- Seeking a patient-centered commitment to safety
- Safety planning is part of risk assessment as well as a clinical intervention
- Patient’s inability to safety plan is an indicator that hospitalization may be necessary

Suicide Prevention Toolkit for Primary Care Practices



Complementing the ASQ

http://www.sprc.org/settings/primary-care/toolkit

- Getting Started
- Educating Clinicians and Office Staff
- Developing Mental Health Partnerships
- Practice Management Tools
- State Resources, Policy and Reimbursement
- Health Care Provider Self Care
- Patient Education Tools

Glad-PC Toolkit (2018 update)

- 2018 updated guidelines integrate research and evidence since 2007 to improve identification and management of depression of adolescents 10-21 years old
- Discusses use of valid screening tools, practice readiness for implementation, and training of staff
- Highlights standards for management of depression with a focus on treatment, consultation, and referral
- Integrated MH care options or strong networks are key
- Annual screening of patients 12+ and more frequent for those with elevated risk

Glad-PC Toolkit (2018 update)

- Family involvement in depression care is recommended
- Referral to evidence-based treatments for depression with specific attention to suicide risk
- Strong emphasis on collaborative safety planning
- Identify multiple support persons for youth to navigate a crisis (at least one needs to be an adult)
- Means safety especially during a crisis is critical but given youth impulsivity there are best practices around medication and firearm safety to reduce risk

Implementation Checklist

- **Discuss suicide prevention initiative with all office staff, determine lead coordinator for the office**
- **Educate clinicians/ all office staff on tools and resources**
- **Develop processes and write procedures**
  - Determine which screen to use; patients to target; when and where; who reviews screens, documents, and flags positive screens; who conducts risk assessment; what are the local crisis contacts; who manages referral and tracking; data monitoring

Implementation Checklist

- **Develop a referral network to facilitate collaborative care**
  - Enhance internal capacity, integrated behavioral health care, linkage with established providers.
- **Follow-up/Outreach:**
  - Identify who will follow-up with patients and how follow-up will occur (e.g. office visit, phone call)
- **In case of the need for hospitalization:**
  - Last resort when efforts at illness management, safety planning, and referral fail to mitigate risk
  - Know local resources and procedures

Current Trends & Research

- Number of youth hospitalized for suicidal thoughts or attempts **doubled** from 2008-2015
- 2/3 of those encounters were girls
- Increases were highest among teens ages 15-17, followed by youth ages 12-14
- 50% of encounters were children ages 15-17; 37% were ages 12-14; **12.8% were ages 5-11**
- Seasonal variation: 2x # of encounters in Oct than July
- 9.8% increase in suicides among 15-24 year olds and 18% increase among 5-14 year-olds from 2016 to 2017

Source: Plemmons et al., 2018, CDC, 2018

Current Trends & Research

- Suicide in very young children (<12) seems to be characterized by different risk factors
  - Decedents were more likely to be male and black
  - Suicide more likely to occur at home and method to be hanging/strangulation/suffocation
  - Often involved relationship problems with family or friends and unlikely to leave a suicide note (7.7%)
  - Compared to teens, twice as likely to be diagnosed with ADHD (59.3% vs 29.0%) and half as likely to be diagnosed with depression/dysthymia (33% vs 66%)

Source: Bridge et al., 2018; Sheftall et al., 2016

Current Trends & Research

- Practice implications
  - Need to account for increased impulsivity, diminished reward sensitivity and risk-taking of ADHD youth
  - Increase screening/monitoring of mood changes and warning signs of suicide for children with ADHD
  - Tiered screening in which suicide is only assessed if youth is positive for depression will underdetect
  - Safety planning likely means increased direct supervision especially during periods of crisis
  - Increase education to parents

Source: Bridge et al., 2018; Sheftall et al., 2016

Current Trends & Research

- Technology and Social Media
  - Frequency, quality, and type of use matters
  - Personality characteristics, social factors contribute
  - Smart phone use and screen time are positively correlated with increased depression and anxiety
  - Hypotheses for negative outcomes include: sleep disruption, social comparison, reduced distress tolerance, decreased activity, cyber-bullying
  - Face-to-face contact is important
  - Academic pressure not likely to blame

Source: Baker & Algorta, 2016; Lin et al., 2016; Twenge et al., 2018

Current Trends & Research

- Practice implications
  - Ask about screen time and, just as importantly, what that screen time is displacing ("SEE" behaviors)
    - Sleeping
    - Eating
    - Exercise
  - Discuss how screen time is being used (passive vs. active) and how it impacts mood
  - What kinds of exposures are reported?
  - Youth developmental readiness to self-manage use?

Source: Fristad et al., 2011

Feedback from the Field: Mary Rutan Hospital Pediatrics

Staffing: 4 Docs, 4 NP's, 1 MH NP and 5 LPN's

Practice Size: Average of approximately 7,000 patients

What prompted decision for current screening strategy?

- Prevalence of BH concerns in pediatric population, challenges with access, opportunity to embed services, and role and responsibility of primary care providers in identifying and supporting youth in need
- Deaths by suicide in community, some in MR practice
- Research support/available screening tools: Use PHQ-9 and ASQ

Preparation/Training

Training

- From local provider (Consolidated Care) and their own psychiatric APN
- Webinars ☺
- Support from PFK on office processes

Process

- PHQ9 completed at every well child visit, patients 11/up, or when trigger for concern about risk at other visits.
- Positive screen on PHQ9 prompts ASQ. ASQ given to youth by nurse, reviewed by provider with youth.
- Nurse gives pt. paper/pencil screen at initial work up while Doc talking with caregiver. May assist younger pts.
- Moving to new EMR next year, nurse will add responses to EMR, may use laptop to enter responses directly
- Doc/NP scores and reviews screen with youth
- If concern about time may reschedule well visit and attend to concern. May do both.

Response to positive screen(s)

- Develop safety plan with youth and caregiver
  -SP format align with local provider safety plan
- Refer for counseling, considers medication management, may refer to psychiatric APN
- Directly refer to ED, who completes full assessment and refers to appropriate level of care as needed. (Makes decision about transport, caregiver or EMS.) Follows up afterwards.
- Enters intervention plan in medical record

Screening Adherence and Billing

- Currently billing 96127, considering billing Z13.31 (depression screen) for better tracking
- 99% of youth screening at well child visit
- Not currently formally tracking positive screens but intuitively about 3 to 5 patients per month are scoring (+) on PHQ9, intuitive hunch about 10% positive on ASQ, concerning recent perceived increase in positive suicide screens.

Benefits and Opportunities

Benefits

- Identifying youth at risk who might otherwise have gone undetected (reducing suffering and may be saving lives)
- Addressing unmet need, addressing gaps in care
- Builds on trust present in PCP/patient relationship

Opportunities

- Better follow-up and tracking for youth referred for counseling or other specialty care

Feedback from the Field: Olentangy Pediatrics

Staffing: 7 pediatricians, (9 MA's and 5 Nurses)

Practice Size: App. 18,000 prior to recently adding new doc

What prompted decision for current screening strategy?

- No known death by suicide of current pt. in recent past, but known prevalence of BH concerns, challenges with access to BH and opportunity to embed response
- Desire to influence health outcomes (BH concerns seen as primary in overall health and wellness for patients)
- Research support, tools, integrated BH provider; currently use PHQ-9 and ASQ

Preparation/Training

Training

- Training from on site psychologist (Dr. Claire Ackerman) to implement the PHQ9 (last year)
- Training by Dr. John Ackerman to implement the ASQ (this spring), including screening, risk assessment and safety planning

Process

- PHQ/ASQ screen completed at every well child visit on patients 12 and up, or when other triggers for concern at other visits or for visit scheduled specifically for concern about depression/suicidality
- Paper & pencil screen given by MA during initial work up.
- MA adds raw score from PHQ to the EMR, and the EMR will total, score and provide AAP recommendations automatically. Also documents the ASQ in the medical record.
- Provider reviews screen with youth, sometimes before the automatic scoring is complete, whether screen is positive or not

Response to positive screen(s)

- Refer to Dr. C. Ackerman for triage, or…
- Develop safety plan with youth and caregiver

  Refer to Dr. Ackerman for follow-up, acts as a bridge for external longer term therapy when needed
- Call the NCH BH crisis line and follow prompt from clinicians
- Considers medication management, may refer to psychiatrist
- Provides psychoeducation to youth and family about relevant supportive interventions (eat, sleep, exercise)

Screening Adherence and Billing

- Currently billing Z13.31, variable reimbursement
- Good adherence to screening at well child visit, approximately 99%
- Not currently formally tracking positive screens but in recent review of providers one pediatrician stated about 1 in 4 youth are screening positive for depression and 1 in 10 are positive on the ASQ

Benefits and Opportunities

Benefits

- Identifying youth at risk who might otherwise have gone undetected (reducing suffering and may be saving lives)
- Surprised by youth screened when parents/provider are unaware
- Increased awareness of broader BH issues (gender identify, etc.)
- Increasing sense of competency/skills to manage patients

Opportunities

- Continue to address time barriers created by follow-up needs
- Increase training to nurses to more independently triage, provide safety planning, at the phone level for those calling in with concerns, or to support follow-up more generally
- Continue to increase pediatricians confidence in safety planning
- Develop a more standardized strategy for response to (+) screens

Case Study

- F, 16 year old, call from family about mood symptoms
- Scheduled for ill visit same day
- Chronic intermittent mood symptoms, S/I, multiple stressors
- Screening completed, PCP reviews
- Seen by practice psychologist, provides risk assessment, safety plan and follow-up psychosocial care
- Pediatrician provides medication management (Zoloft)
- At 6 months and one year continuous improvement, minimal symptoms, no S/I

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

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

Risk Assessment Framework

- Columbia Suicide Severity Rating Scale (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
  - Common language between providers
  - Information about severity guides next steps
  - Can repeat administration to at-risk individuals

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

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

Thank you for participating!

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Thursday, December 20, 2018

https://www.surveymonkey.com/r/6CVLDFY
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CME Posting

Series Name: Behavioral Health Webinar Series for Primary Care

Date: December 13, 2018 / Noon-1PM

Presentation Title: Depression and Suicide Screening: Year-End Summary and Lessons from the Field

Speakers Name(s): John Ackerman, PhD and Nancy Cunningham, PsyD

Planning Committee: Jennifer White, MD; William Long, MD; Nancy Cunningham, PsyD; Jennifer Reese, PsyD; Sue Orme, MSN, RN; Megan Rhodes; Jessica Dudley

- No one in a position to control content has any relationships with commercial interests

Session Objectives:
At the conclusion of this activity, participants should be able to:

1. Use, or consider for their own practice, lessons learned from the primary care field about implementation of depression and suicide risk screening: benefits, obstacles, and opportunities.
2. Increase their knowledge of new research updates on pediatric depression and suicidality relevant to primary care settings.
3. Acquire feedback from BH experts to questions from the audience regarding primary care implementation of screening, triage and referral for depression and suicidality.

Commercial Support: N/A

Join by Phone:
Call 614-355-5333, Conference ID: 4099027

Join by Skype: https://meet.nationwidechildrens.org/megan.mashhadian/JDR2Z77P?sl=1

SAVE THE DATE(S) for the 2019 BH Webinar sessions!

Wednesday, February 13, 2019
Thursday, April 11, 2019
Wednesday, June 12, 2019
Thursday, September 12, 2019
Wednesday, October 16, 2019
Thursday, November 14, 2019

Visit our BH Webinar Website for more information:
https://www.nationwidechildrens.org/specialties/behavioral-health/for-providers/webinar-series%C2%A0

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The Nationwide Children's Hospital designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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