Adolescent suicide prevention:

Risk screening, assessment, and safety planning

Melissa Weddle, MD, MPH

Pediatric Review and Update

October 18, 2018

DOERNBECHER CHILDREN'S *Hospital*

Objectives

- Recognize adolescent suicide risk
- Identify strategies for screening of suicide risk
- Describe assessment and management of those at increased risk

OHSU

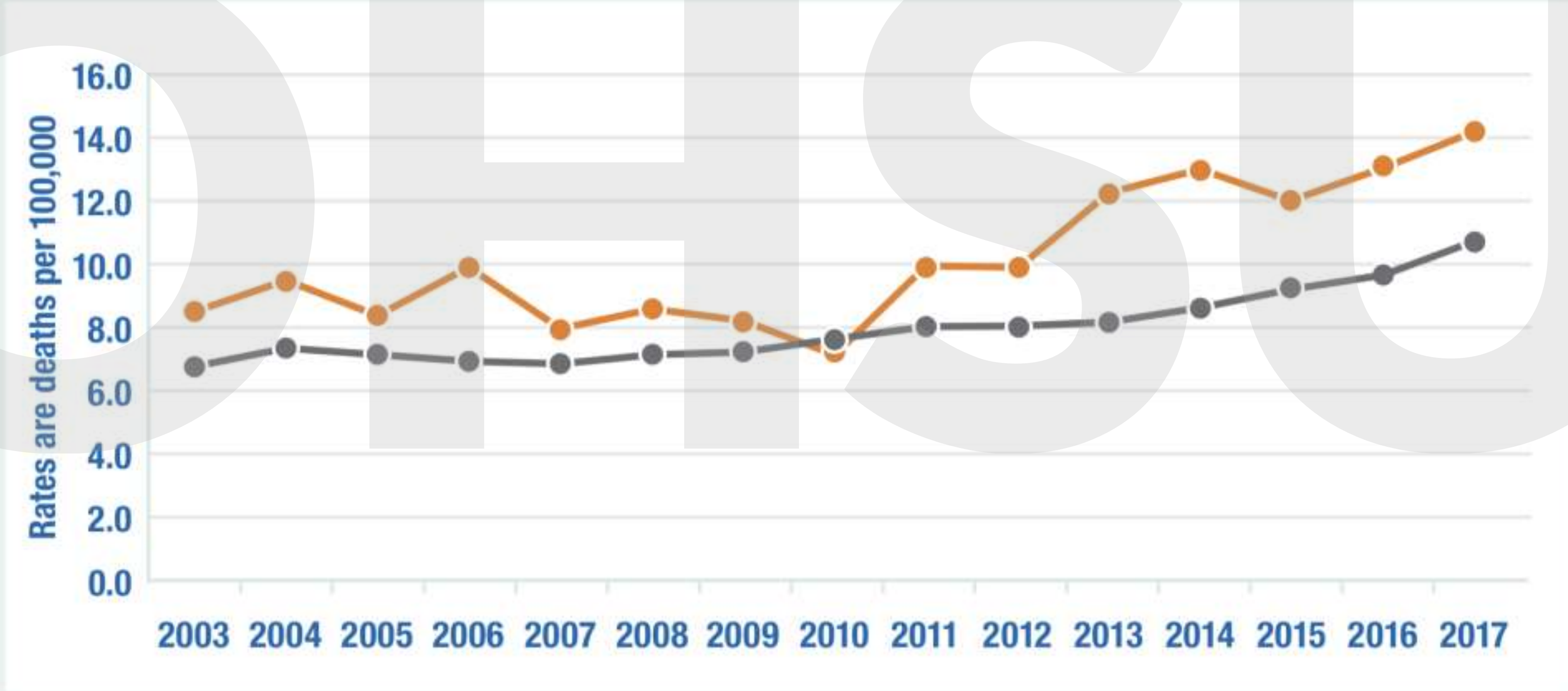
PART 1

The Evidence

FOR SUICIDE RISK SCREENING

OHSU

Youth Suicide in Oregon



Source: CDC WISQARS and OPHAT

Youth Suicide in Oregon

Contemplated Suicide in Last 12 Months

20%
15%
10%
5%
0%

16% 14%
16% 16%
17% 18%

2013
2015
2017

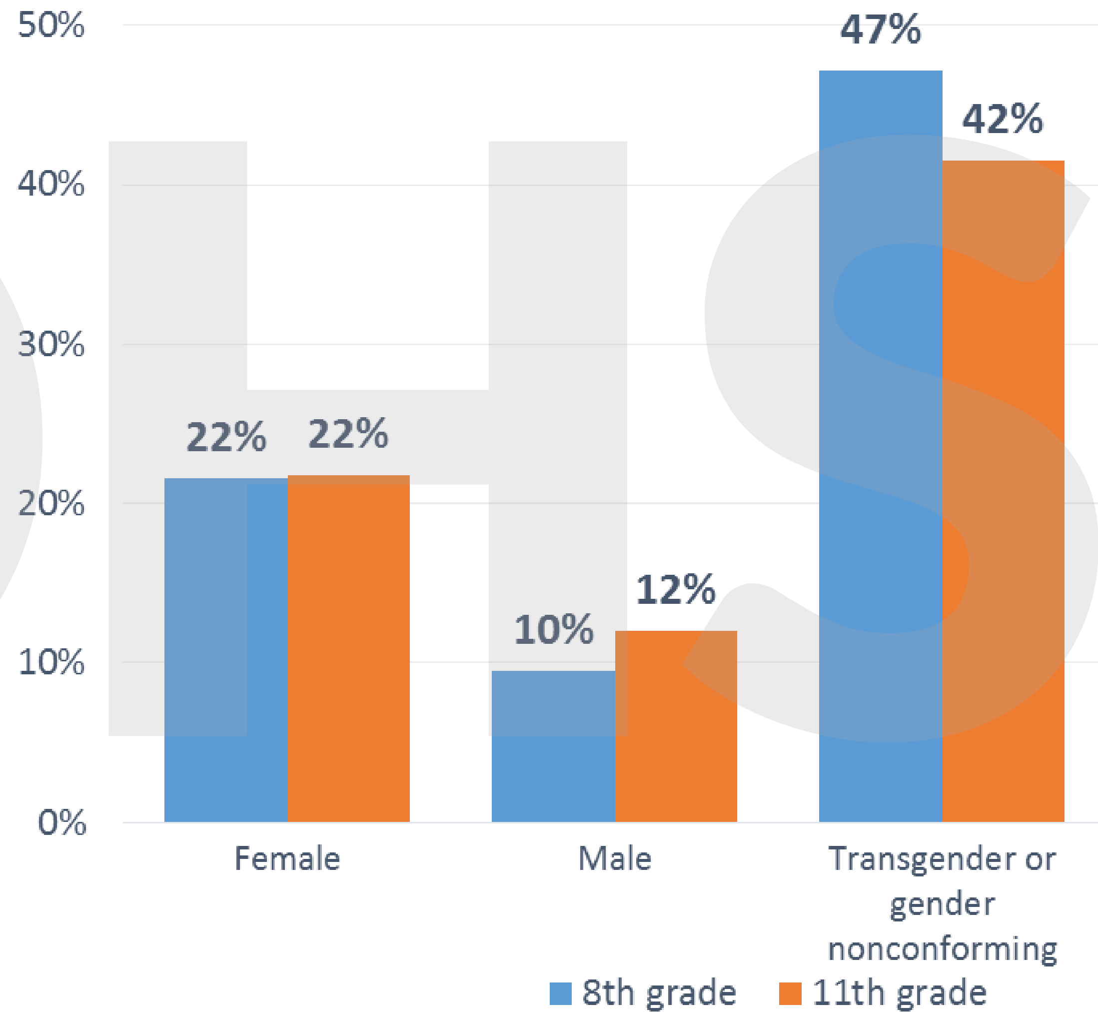
8th Grade 11th Grade

OHSU

PUBLIC HEALTH DIVISION
Adolescent and School Health

Source: 2013, 2015, 2017
Oregon Healthy Teens Survey

Youth Suicide in Oregon

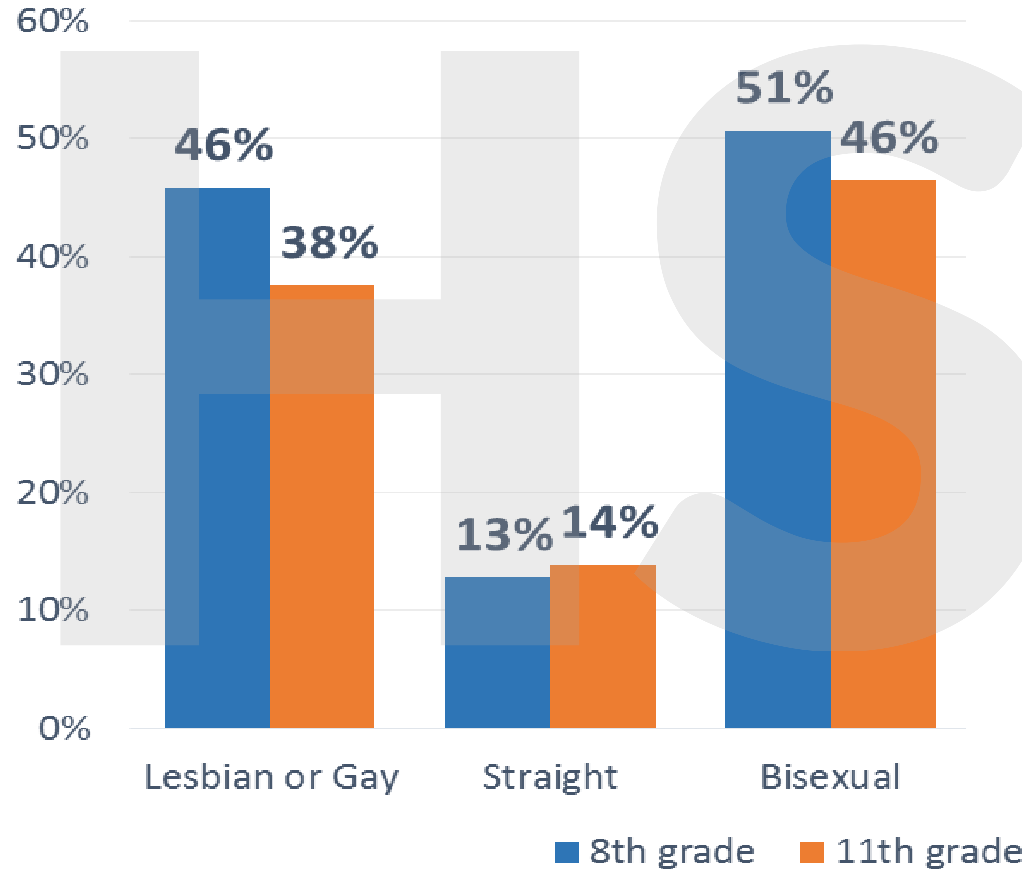


PUBLIC HEALTH DIVISION
Adolescent and School Health

Note: "Transgender or gender.." includes those who identified as transgender, gender fluid, genderqueer, gender nonconforming, intersex/intergender, multiple responses, and "not sure of gender"

Source: 2017 Oregon Healthy Teens Survey

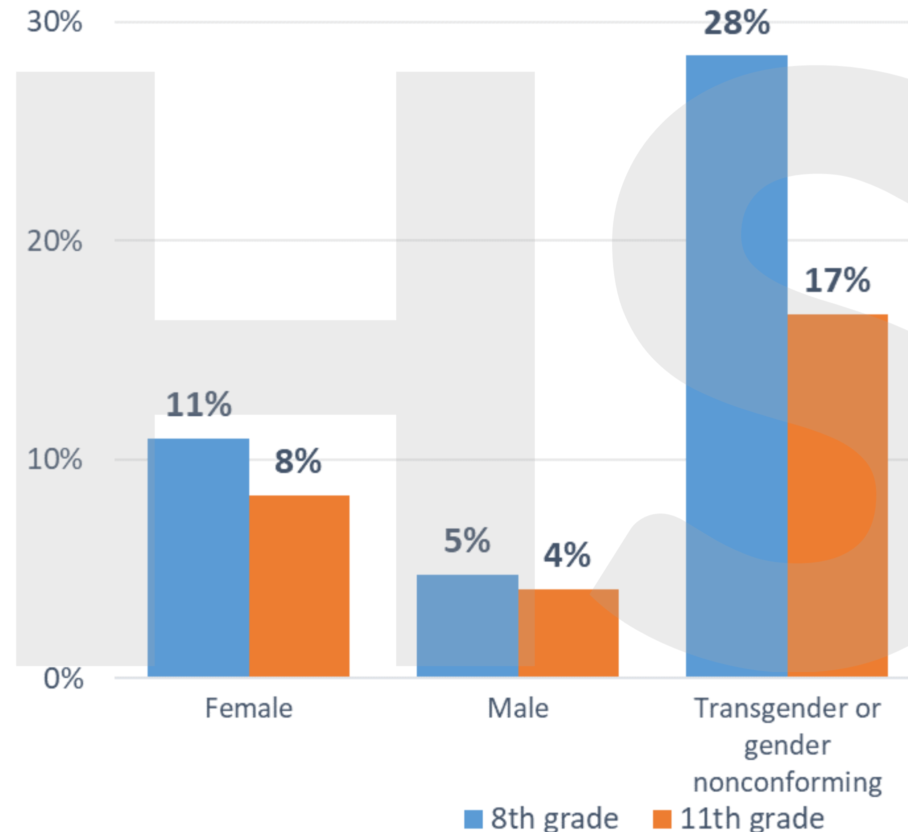
Youth Suicide in Oregon



PUBLIC HEALTH DIVISION
Adolescent and School Health

Source: 2017 Oregon Healthy Teens Survey

Youth Suicide in Oregon

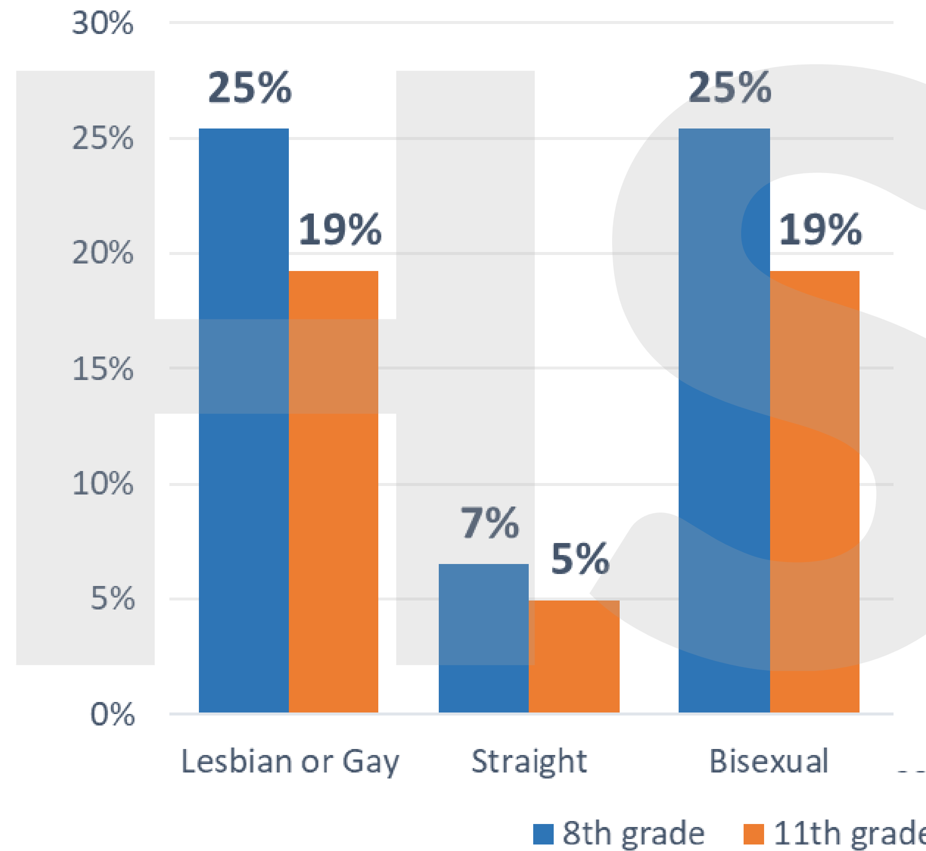


Note: "Transgender or gender.." includes those who identified as transgender, gender fluid, genderqueer, gender nonconforming, intersex/intergender, multiple responses, and "not sure of gender"

PUBLIC HEALTH DIVISION
Adolescent and School Health

Source: 2017 Oregon Healthy Teens Survey

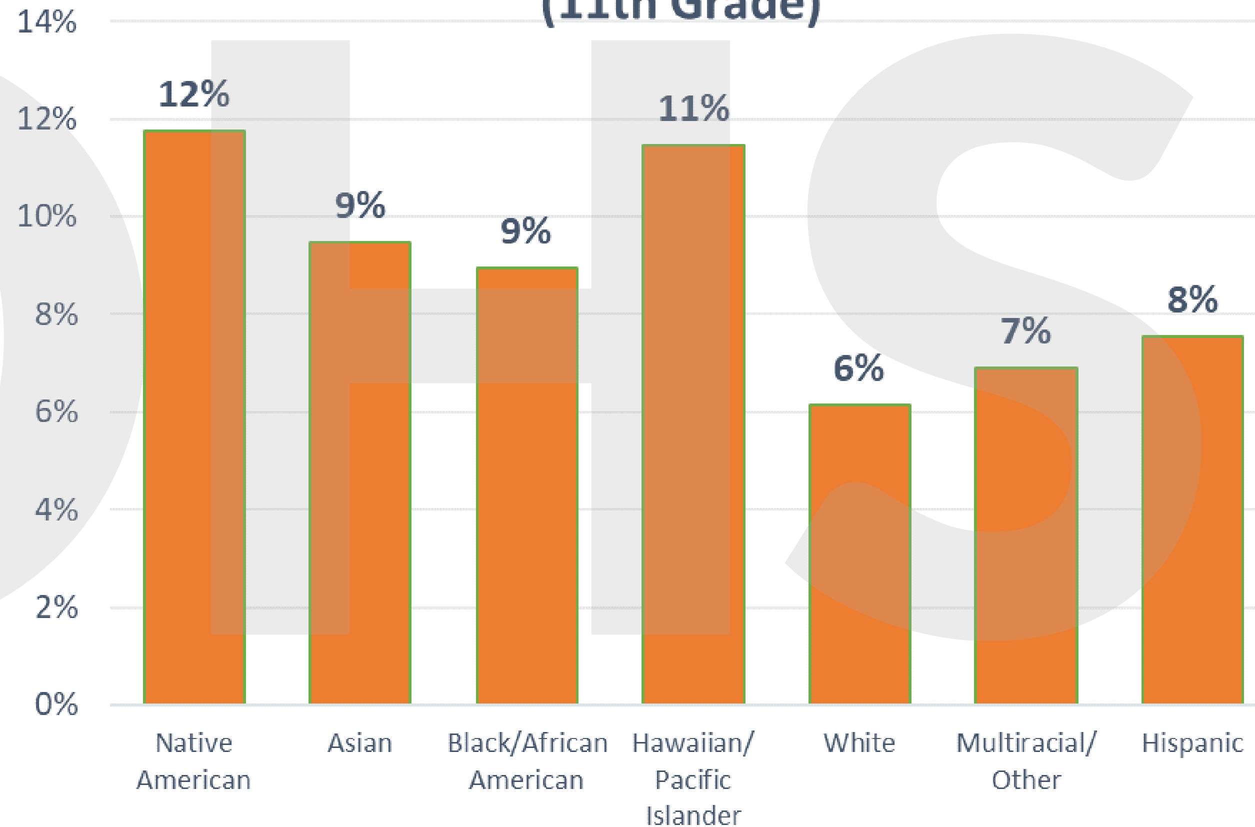
Youth Suicide in Oregon



PUBLIC HEALTH DIVISION
Adolescent and School Health

Source: 2017 Oregon Healthy Teens Survey

Youth Suicide in Oregon

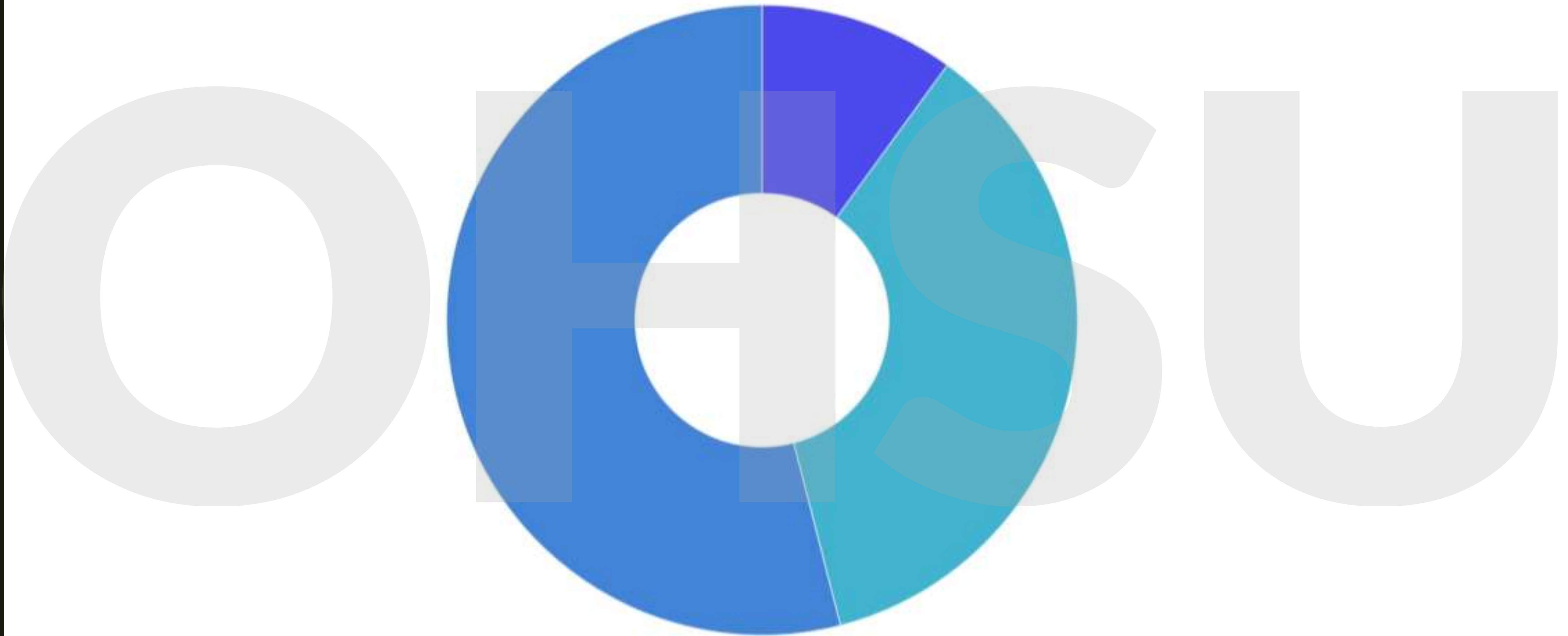


PUBLIC HEALTH DIVISION
Adolescent and School Health

Source: 2017 Oregon Healthy Teens Survey

Youth Suicide in Oregon

Suicide deaths by age, Oregon 2017

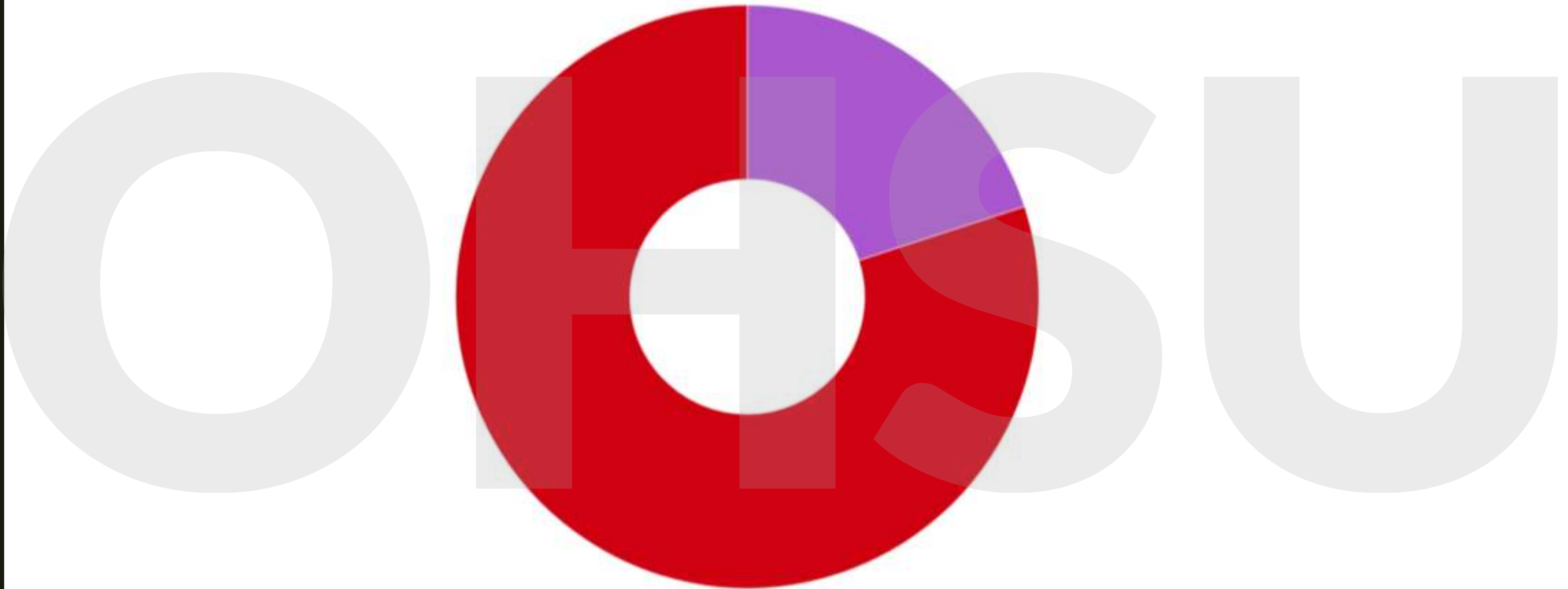


Source: Oregon Violent Death Reporting System

10-14 10% 15-19 36% 20-24 54%

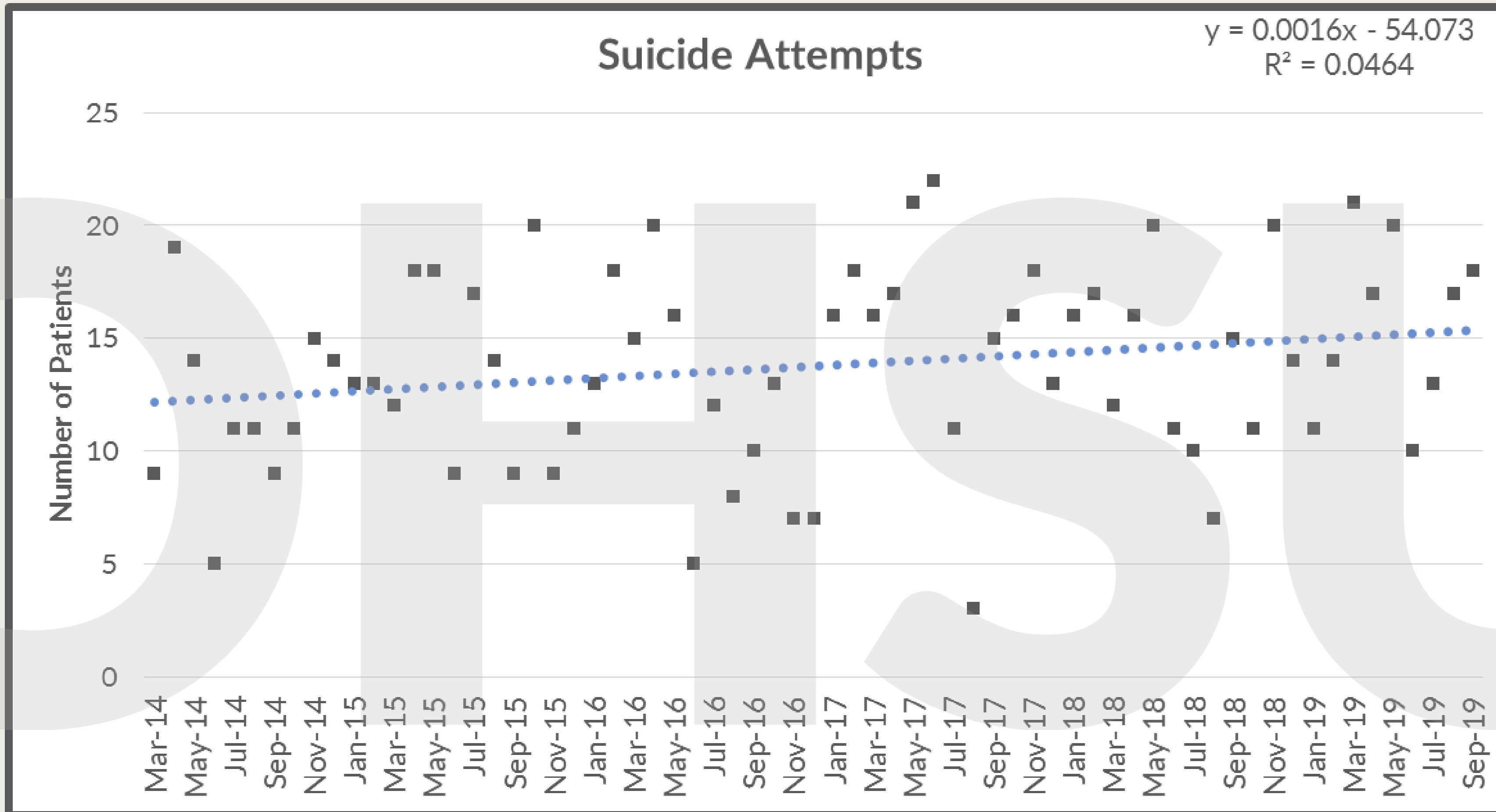
Youth Suicide in Oregon

Suicide deaths by gender, Oregon 2017



September 2019	2019 Year to Date
47 youth served	414 youth served
38% of cases were suicide attempts	34% of cases were suicide attempts
89% of suicide attempts were overdoses	89% of suicide attempts were overdoses
18 lockboxes provided to families	107 lockboxes provided to families
38% of referrals were from the ED	50% of the referrals were from the ED
34% of patients went to inpatient 9% went to subacute 2% went to residential 55% were discharged to outpatient	23% of cases went to inpatient 8% went to subacute 2% went to residential 68% were discharged to outpatient
70% of patients were female 28% of patients were male 0% of patients were trans: feminine 2% of patient were trans: masculine	62% of patients were female 35% of patients were male 0% patients were trans: feminine 3% of patient were trans: masculine

OHSU Child & Adolescent Psychiatry Consultation-Liaison service


Suicide Attempts
y = 0.0016x - 54.073
R² = 0.0464
Number of Patients
25
20
15
10
5
0
Mar-14
May-14
Jul-14
Sep-14
Nov-14
Jan-15
Mar-15
May-15
Jul-15
Sep-15
Nov-15
Jan-16
Mar-16
May-16
Jul-16
Sep-16
Nov-16
Jan-17
Mar-17
May-17
Jul-17
Sep-17
Nov-17
Jan-18
Mar-18
May-18
Jul-18
Sep-18
Nov-18
Jan-19
Mar-19
May-19
Jul-19
Sep-19

PART 2

Recommended
SCREENING & ASSESSMENT TOOLS

National Recommendations

American Academy of Pediatrics recommends that pediatricians ask questions about mood disorders, sexual orientation, suicidal thoughts, and other risk factors associated with suicide during routine health care visits

American Academy of Child and Adolescent Psychiatry recommends that physicians be aware of patients at high risk for suicide

American Medical Association Guidelines for Adolescent Preventive Services recommends that all adolescents be asked annually about behaviors or emotions that indicate risk for suicide

OHSU

Why should Primary Care Practitioners Screen?

- Suicide is the #2 cause of death of 10 – 24 year olds
- 70% of adolescents seen by PCP annually
- Adolescents more comfortable with PCP
- Patients who died by suicide visited PCPs over 2 times as often as mental health clinicians

OHSU

Barriers to PCP Screening & Assessment

Time **32.8%**

Adequate training **25.5%**

Adequate knowledge **32.9%**

Comfort discussing suicide **64.2%**

OHSU

Why screen in the hospital or ED?

- 30% of adolescents have <u>not</u> been seen by a PCP in the past year
- PCP may not have screened or had adequate training

Minor Consent and Confidentiality

ORS 109.675 - a minor who is 14 years or older may access outpatient mental health, drug, or alcohol treatment without parental consent

ORS 109.860 - for mental health and chemical dependency services, the provider may disclose health information to a minor's parent or guardian if:

- It is clinically appropriate and in the minor's best interests
- The minor must be admitted to a detoxification program
- The **minor is at risk of committing suicide** and requires hospital admission.

Confidentiality Exceptions:

- Risk of harm to self or others
- Abuse

OHSU

Risk Factors for Suicide

- Family history of suicide or child maltreatment
- Previous suicide attempt(s)
- History of trauma and/or personality or mood disorders
- History of alcohol and substance abuse

OHSU

Risk Factors for Suicide

- Feelings of hopelessness
- Isolation
- Barriers to accessing mental health treatment
- Loss (relational, social, work, or financial)

OHSU

Warning Signs

- Talking about wanting to die
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Acting anxious or agitated, behaving recklessly

OHSU

Warning Signs

- Sleeping too little or too much
- Withdrawing from family or friends or feeling isolated
- Displaying extreme mood swings
- Saying good-bye to loved ones, giving belongings away

OHSU

Protective Factors

- Family and community support (connectedness)
- Self-esteem and a sense of purpose and meaning
- Problem solving, conflict resolution, coping, and nonviolent communications skills
- Cultural or religious beliefs
- Effective clinical care

Components of Evaluation

- Screening
- Assessment
- Safety Plan
- Lethal Means Counseling
- Disposition

OHSU

Suicide Risk Screening and Assessment Tools

Screening Tools

- PHQ-A (Patient Health Questionnaire for Adolescents)
- asQ (Ask Suicide-Screening Questions)
- C-SSRS (Columbia-Suicide Screening Rating Scale)

Assessment Tools

- asQ BSSA (Brief Suicide Screening Assessment)
- C-SSRS

OHSU

Depression and Suicide Risk Screening

PHQ-9 modified for Adolescents (PHQ-A)

Name: ______________________ Clinician: ______________________ Date: _______

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

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

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

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

☐Yes ☐No

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

Office use only: **Severity score:** _________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

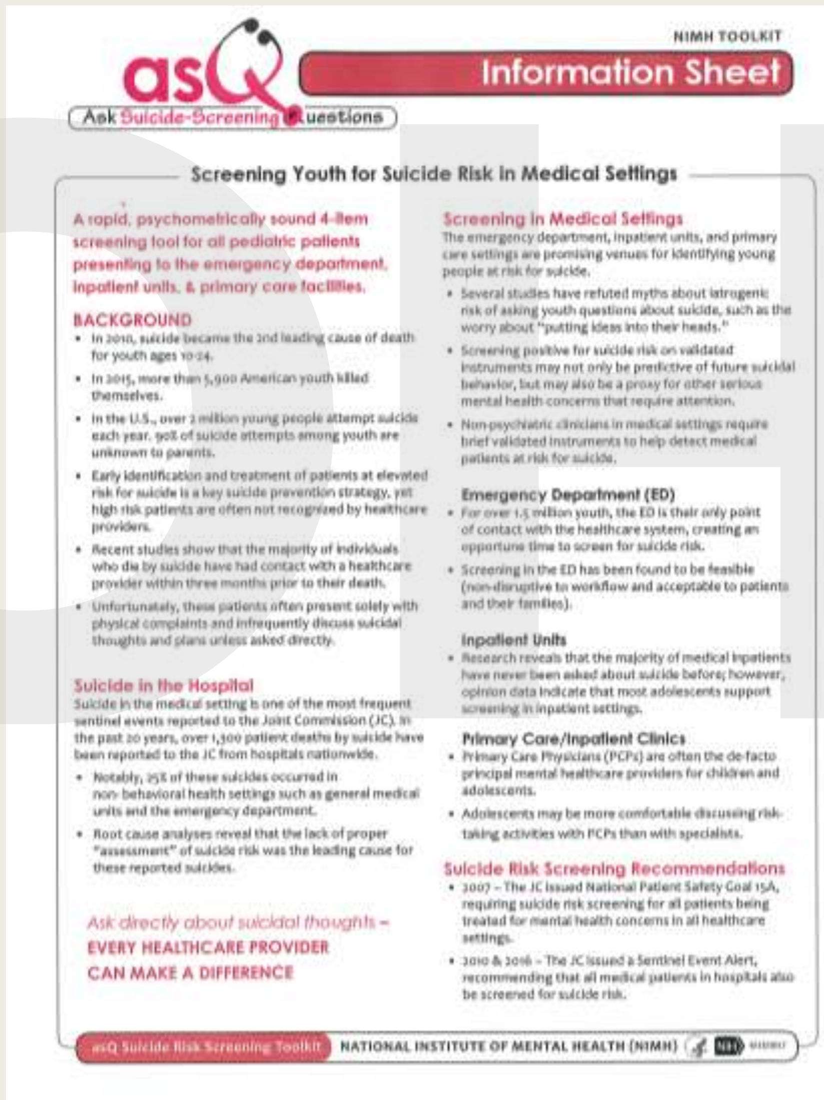
PHQ-9 Modified for Adolescents

PHQ-9 *plus* suicide questions

11-17 years old

The PHQ-A can be considered a suicide risk screening tool **ONLY** if suicide questions are included and everyone answers them (e.g. not only when PHQ-2 is positive)

Suicide Risk Screening - **asQ**



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Information Sheet

Screening Youth for Suicide Risk in Medical Settings

A rapid, psychometrically sound 4-item screening tool for all pediatric patients presenting to the emergency department, inpatient units, & primary care facilities.

BACKGROUND

- In 2010, suicide became the 2nd leading cause of death for youth ages 10-24.
- In 2015, more than 5,900 American youth killed themselves.
- In the U.S., over 2 million young people attempt suicide each year. 90% of suicide attempts among youth are unknown to parents.
- Early identification and treatment of patients at elevated risk for suicide is a key suicide prevention strategy, yet high risk patients are often not recognized by healthcare providers.
- Recent studies show that the majority of individuals who die by suicide have had contact with a healthcare provider within three months prior to their death.
- Unfortunately, these patients often present solely with physical complaints and infrequently discuss suicidal thoughts and plans unless asked directly.

Suicide in the Hospital

Suicide in the medical setting is one of the most frequent sentinel events reported to the Joint Commission (JC). In the past 20 years, over 1,300 patient deaths by suicide have been reported to the JC from hospitals nationwide.

- Notably, 25% of these suicides occurred in non-behavioral health settings such as general medical units and the emergency department.
- Root cause analyses reveal that the lack of proper "assessment" of suicide risk was the leading cause for these reported suicides.

Ask directly about suicidal thoughts –
EVERY HEALTHCARE PROVIDER
CAN MAKE A DIFFERENCE

Screening in Medical Settings

The emergency department, inpatient units, and primary care settings are promising venues for identifying young people at risk for suicide.

- Several studies have refuted myths about iatrogenic risk of asking youth questions about suicide, such as the worry about "putting ideas into their heads."
- Screening positive for suicide risk on validated instruments may not only be predictive of future suicidal behavior, but may also be a proxy for other serious mental health concerns that require attention.
- Non-psychiatric clinicians in medical settings require brief validated instruments to help detect medical patients at risk for suicide.

Emergency Department (ED)

- For over 1.5 million youth, the ED is their only point of contact with the healthcare system, creating an opportune time to screen for suicide risk.
- Screening in the ED has been found to be feasible (non-disruptive to workflow and acceptable to patients and their families).

Inpatient Units

- Research reveals that the majority of medical inpatients have never been asked about suicide before; however, opinion data indicate that most adolescents support screening in inpatient settings.

Primary Care/Inpatient Clinics

- Primary Care Physicians (PCPs) are often the de-facto principal mental healthcare providers for children and adolescents.
- Adolescents may be more comfortable discussing risk-taking activities with PCPs than with specialists.

Suicide Risk Screening Recommendations

- 2007 – The JC issued National Patient Safety Goal 15A, requiring suicide risk screening for all patients being treated for mental health concerns in all healthcare settings.
- 2010 & 2016 – The JC issued a Sentinel Event Alert, recommending that all medical patients in hospitals also be screened for suicide risk.

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

asQ Information Sheet

Developed for patients 10-24, for use in pediatric EDs, inpatient, and primary care settings

For use by non-psychiatric clinicians

12.1% of US adolescents experience suicide ideation, 4% develop a suicide plan, and 4.1% attempt suicide

Solely relying on depression screening through PHQ-9 missed up to 28% of participants at risk for suicide

Suicide Risk Screening - **asQ**

NIMH TOOLKIT

asQ Suicide Risk **Screening Tool**

Ask Suicide-Screening Questions

Ask the patient:

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

If yes, how? ______________________

When? ______________________

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

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

If yes, please describe: ______________________

Next steps:

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

Provide resources to all patients

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

asQ Suicide Risk Screening Tool

Available in **multiple languages**

Takes **1-2 minutes** to screen

100% Sensitivity in Primary Care

88% Specificity in Primary Care

Negative Screen: **"No"** on first 4 questions; end of screen

Positive screen: **"Yes"** to any of first 4 questions requires answer to question 5, **patients cannot leave until evaluated for safety**

Acute positive screen: **"Yes"** on question 5, patient requires STAT safety/full mental health evaluation

Non-acute positive screen: **"No"** on question 5, use asQ Brief Suicide Safety Assessment (BSSA) (~10-15 minutes)

OHSU

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.

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.

OHSU

Brief Suicide Safety Assessment

NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

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

Review patient's responses from the asQ

Frequency of suicidal thoughts

Symptoms Ask the patient about:

Suicide plan

Past behavior

Social Support & Stressors

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

asQ BSSA (Outpatient Version)

Developed for primary care

For use by non-psychiatric clinicians

Contains protocol and scripts for talking to pediatric patients and parents

OHSU

Brief Suicide Safety Assessment

asQ BSSA (Outpatient Version)

Cues each step of process:

1. *Praise patient*
2. *Assess the patient*
3. *Interview patient & parent/guardian together*
4. *Make a safety plan with the patient*
5. *Determine disposition*
6. *Provide Resources to all patients*

BSSA Step 1: Praise Patient

NIMH TOOLKIT: OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety **Assessment**

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."

BSSA Step 2: Assess the Patient

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?"

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

asQ BSSA (Outpatient Version)

Step 2: Assess the patient

- *Frequency of suicide thoughts*
- *Suicide plan*
- *Past behaviors*
- *Symptoms*
- *Social supports and stressors*

BSSA Step 2a: Frequency of Suicidal Thoughts

2 Assess the patient

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.)**

OHSU

BSSA Step 2b: Suicide Plan

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.).

OHSU

BSSA Step 2c: Past Behavior

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.

OHSU

BSSA Step 2d: Symptoms

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?"

BSSA Step 2e: Social Support & Stressors

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?"

OHSU

BSSA Step 3: Interview Parent/Guardian Together

NIMH TOOLKIT: OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

3 Interview patient & parent/guardian together

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

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

- "Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behavior that you're aware of?" If yes, say: "Please explain."
- "Does your child seem:
  - o Sad or depressed?"
  - o Anxious?"
  - o Impulsive? Reckless?"
  - o Hopeless?"
  - o Irritable?"
  - o Unable to enjoy the things that usually bring him/her pleasure?"
  - o Withdrawn from friends or to be keeping to him/herself?"
- "Have you noticed changes in your child's:
  - o Sleeping pattern?"
  - o 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?"

OHSU

BSSA Step 4: Make a Safety Plan with the Patient

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.)

OHSU

BSSA Step 5: Determine Disposition

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.

Outcomes based on assessment:

1. *Immediate referral to mental health provider*
2. *Safety planning with urgent referral to mental health provider within 72 hours*
3. *Safety planning with non-urgent referral to mental health provider*
4. *No further intervention needed at this time*

OHSU

BSSA Step 6: Provide Resources to all Patients

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

OHSU

Oregon Resources:

Lines For Life - National Suicide Prevention Lifeline above re-directs here

YouthLine – a teen to teen crisis and help line; teens available to help daily from 4-10PM, off-hours call re-direct to Lines for Life

Call: 877-968-8491

Text: teen2teen to 839863

Chat: http://www.oregonyouthline.org

PART 3

Management, Referral, and Structured Follow-up

OHSU

Safety Planning Template

Patient Safety Plan Template

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

1. ______
2. ______
3. ______

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

1. ______
2. ______
3. ______

Step 3: People and social settings that provide distraction:

1. Name ______ Phone ______
2. Name ______ Phone ______
3. Place ______ 4. Place ______

Step 4: People whom I can ask for help:

1. Name ______ Phone ______
2. Name ______ Phone ______
3. Name ______ Phone ______

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

1. Clinician Name ______ Phone ______
   Clinician Pager or Emergency Contact # ______
2. Clinician Name ______ Phone ______
   Clinician Pager or Emergency Contact # ______
3. Local Urgent Care Services ______
   Urgent Care Services Address ______
   Urgent Care Services Phone ______
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. ______
2. ______

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.

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

______

Safety Plan Template (Brown and Stanley)

Free to use after registering on website

~20-30 minutes to complete with patient, collaborative process

Identifies

- Internal coping strategies
- Enhancing social support
- Professional Supports
- Emergency contacts

Safety Planning Intervention Example

SAFETY PLAN

Step 1: Warning signs:
1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:
1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:
1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:
1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name ______ Phone ______
   Clinician Pager or Emergency Contact # ______
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:
1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. ______

Steps:

Step 1: Recognize warning signs

Step 2: Identify and employ internal coping strategies

Step 3: Use healthy social contacts as a means of distraction.

Step 4: Contact family and friends for help

Step 5: Contact MH professional or emergency services if needed

Step 6: Reduce access to lethal means

Lethal Means Statistics

What is it about guns?

- 85% lethality
- > 33% of households have guns
- Irreversible damage
- 85% come from the victim’s home

OHSU

Lethal Means: Special Issues Related to Suicidal Youth

Involve parents and guardians whenever possible. Ask questions about means restriction with parents privately.

Gently assume there may be guns in the home.

Example scripts:

"Let's talk about securing your guns so we can keep your child safe"

"Now might be a good time to give your guns to a friend or family member for safe-keeping"

OHSU

Lethal Means: Special Issues Related to Suicidal Youth

It is important to remove and limit access to other lethal means:

- material that could be used for hanging
- medication lockbox

OHSU

Means Safety Resources

Lockmed.com

Referrals

Local Mental Health Resources

Identify community mental health partners

OPAL-K

Can assist with diagnostic questions

Lines For Life

Can assist with identifying local community mental health providers and resources

OHSU

PART 4

Implementation

OHSU

Implementation

“It’s not how are we going to do this, but how are we going to handle it if we lose one of our patients?”

~Ted Abernathy, MD
(Pilot Pediatrican for asQ Implementation)

OHSU

Implementation

1. Education of staff about importance of screening

2. Identify a champion(s)

3. Provide information about confidentiality

OHSU

Office Implementation

4. Establish flow of screening forms

When and where do patients receive screen?

Confidential space for patient to complete screen?

Who will review/score screen?

How is provider notified of results?

How are results documented in the chart?

OHSU

Office Implementation

5. Can forms be embedded in EMR?

6. Establish tracking system to follow-up with patients

OHSU

PART 5

Resources

OHSU

OPAL-K
(Oregon Psychiatric Access Line about Kids)

Psychiatric phone consultation for medical practitioners who treat children and adolescents with mental health difficulties

9 am to 5 pm, Monday through Friday
855-966-7255 (toll-free) or 503-346-1000 (Portland metro)

Register online: www.ohsu.edu/opalk
Fax: 503-346-1389
Email: opalk@ohsu.edu

OHSU

Other Resources/Toolkits

Resources for providers

OCCAP (Oregon Council of Child and Adolescent Psychiatry)

Zero Suicide

Suicide Prevention Resource Center (SPRC)

Suicide Prevention in Primary Care Settings Toolkit (Deschutes County)

Resources for youth

Lines For Life YouthLine

Teens Finding Hope

Trevor Project

Youth ERA

Resources for parents

Child Mind

NAMI (National Alliance on Mental Illness) Toolkit

OFSN (Oregon Families Support Network)

Teens Finding Hope

OHSU

OHSU
?

Thanks to Oregon Pediatric Society and the Adolescent Suicide Prevention Task Force members who generously provided their time and expertise

Barbara Long, MD, MPH
Greg Blaschke, MD, MPH
Kristin Case, FNP
Colbie Caughlan, MPH
Keith Cheng, MD
Kristan Collins, MD
Michael Harris, PhD
Ajit Jetmalani, MD
Kyle Johnson, MD
Rita Lahlou, MD
Stewart Newman, MD
Kristi Nix, MD
Teri Petterson, MD
Liz Stevenson, JD, MPH
Liz Thorne, MPH
Melissa Weddle, MD, MPH

OHSU