Adolescent Suicide Prevention and Medical Settings

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About SPRC

The Suicide Prevention Resource Center (SPRC) is the only federally funded resource center devoted to advancing the implementation of the *National Strategy for Suicide Prevention*. SPRC is supported through a grant from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

SPRC builds capacity and infrastructure for effective suicide prevention through consultation, training, and resources for state, tribal, health/behavioral health, and community systems; professionals and professional education programs; and national public and private partners and stakeholders.
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How to Participate in Q&A

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Use the “Questions” area of the attendee control panel.

Instant Join Viewer

Click the “?” symbol to display the “Questions” area.
Moderator

Julie Goldstein Grumet, PhD
Zero Suicide in Health Care Systems

Zero Suicide is useful for any system interested in providing the most effective and data-informed suicide care practices available.

Systems that adopt the Zero Suicide mission are:

» Challenging themselves to be high-reliability organizations.
» Embedding evidence-based interventions into care practice.
» Collecting data to measure both outcomes and fidelity.
» Improving continuously through training and protocols.
» Normalizing suicide prevention for clients, staff, and families.
These seven elements are critical to safe care.

Represent a holistic approach to suicide prevention.

Can and should be considered on a simultaneous continuum.
Zero Suicide Toolkit
Your practical guide to systemic change.

The online Zero Suicide Toolkit offers free and publicly available tools, strategies, and resources.

RESOURCES
» Information
» Materials
» Outcomes
» Innovations
» Research
» Tools
» Readings
» Videos
» Webinars
» Podcasts

zerosuicide.edc.org
Overview

- Identifying suicide risk among youth
- Clinical pathways for youth in medical settings
- Suicide prevention in pediatric primary care
- Leveraging Collaborative Care for suicide prevention
Presenter

Lisa Horowitz, PhD, MPH
UTILIZING TOOLS TO IDENTIFY AND MANAGE YOUTH AT RISK FOR SUICIDE IN THE MEDICAL SETTING

Lisa Horowitz, PhD, MPH
Intramural Research Program
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Bethesda, Maryland
The views expressed in this presentation do not necessarily represent the views of the NIH, DHHS, or any other government agency or official. I have no financial conflicts to disclose.
Feasible suicide risk screening for all patients in all medical settings: **Ask directly**

Clinicians require population-specific and site-specific validated screening instruments

Clinical Pathway is a three-tiered system
  - Brief screen (20 seconds)
  - Brief suicide safety assessment (BSSA) (~10 minutes)
  - Full mental health/safety evaluation (30 minutes)

Discharge all patients with safety plan, resources (National Suicide Prevention Lifeline and Crisis Text Line), and lethal means safety counseling
Public Health Problems

- 2018 deaths among all ages
  - Influenza and pneumonia: ~55,000 deaths a year = 150 per day
    - Among 10 to 24-year-olds: ~241 deaths a year = 4 per week
  - Motor vehicle accidents: ~39,000 deaths = 108 deaths a day
    - Among 10 to 24-year-olds: ~7,000 deaths = 19 deaths a day
  - Suicide: ~ 48,000 deaths = 132 deaths a day
    - Among 10 to 24-year-olds: ~ 6,800 deaths = 18 deaths a day

Zero Suicide | zerosuicide.edc.org

CDC, 2018
Youth Suicide in the U.S.

- 2nd leading cause of death for youth ages 10 to 24
- 24,587 total deaths in 2019: 6,488 (26%) deaths by suicide

Suicide Deaths among U.S. Youth Ages 10 to 24

CDC WISQARS, 2019; Slide courtesy of Jeff Bridge, PhD
Younger Children and Suicidality

- Children under 12 plan, attempt, and die by suicide

- 29.1% of preteens (10-12) screened positive for suicide risk (Lanzillo et al., 2019)

- 43.1% of SA/SI visits to an emergency department were for children ages 5-11 (Burstein et al., 2019)

- Racial disparity for children <12: ↑ rate for black children ↓ rate for white children (Bridge et al., 2015)

CDC WISQARS, 2018
Age-Related Racial Disparity in Suicide Rates Among U.S. Youth from 2001 through 2015

Figure. Comparison of Suicide Incidence Rates Between Black and White Youths in the United States From 2001 to 2015 by Age

Squares indicate the estimated natural logarithm of the age-specific incidence rate ratio (IRR); vertical lines, 95% CI. The reference group is white youth. The 95% CIs that do not include zero are considered to be statistically significant.

Bridge et al., 2018
Racial Disparities Among High School Students

**FIGURE 2.** Percentage of high school students who attempted suicide during the 12 months before the survey, by race/ethnicity — Youth Risk Behavior Survey, United States, 2009–2019

Ivey-Stephenson et al., 2020
“...lack of research on both risk and protective factors associated with suicidal thoughts and attempts in this population.”

Slide courtesy of Dr. Tami Benton
Suicide rates by ethnicity and age group -- United States, 2013-2017

CDC WISQARS; Slide courtesy of Dr. Deborah Stone
Suicide Risk Screening for Minoritized Youth

- Many youth populations at higher risk for suicide are understudied by research
  - American Indians/Alaskan Natives
  - Black, Indigenous, and people of color (BIPOC)
  - LGBTQ youth
  - Individuals with ASD or NDD
  - Child Welfare System
  - Rural areas

- Screening can help identify minoritized youth at risk for suicide and link them to care
Youth Suicidal Behavior and Ideation

- **2019 Youth Risk Behavior Survey (YRBS)**
  - 8.9% of high school students attempted suicide one or more times in the past year
  - 18.8% of high school students reported “seriously considering attempting suicide” in the past year

CDC, 2019
Risk Factors

- Previous attempt
- Mental illness
  - Symptoms of depression, anxiety, agitation, impulsivity
  - Exposure to suicide of a relative, friend, or peer
  - Physical/sexual abuse history
  - Drug or alcohol abuse
  - Lack of mental health treatment
- Drug or alcohol abuse
- Lack of mental health treatment
- Suicidal ideation
- Over age 60 and male
- Between the ages of 15 and 24
- LGBTQ
- Neurodevelopmental disorders
- Isolation
- Hopelessness
- Medical illness
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
Can we save lives by screening for suicide risk in medical settings?
Trade groups support youth suicide prevention

‘It’s everybody’s problem’: Goal to end youth suicide unites experts, organizations

Alyson Sulaski Wyckoff. Associate Editor
March 03, 2021

AMA adopts policy to address increases in youth suicide and save lives

JUN 16, 2021
Underdetection

- Majority of those who die by suicide have had contact with a medical professional within previous three months
  - ~80% of adolescents visited health care provider within the year prior to death by suicide
  - 49% of youth had been to an emergency department within one year
  - 38% of adolescents had contact with a health care system within four weeks prior
  - Frequently present with somatic complaints

Ahmedani, 2019; Ahmedani, 2014; Rhodes, 2013
“I’m right there in the room and no one even acknowledges me.”
Screening Questions for Medical Patients

What are valid questions that nurses and physicians can use to screen medical patients for suicide risk in the medical setting?
Screening vs. Assessment: What’s the Difference?

- **Suicide Risk 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
Common Suicide Risk Screeners for Youth in Clinical Settings

- Columbia Suicide Severity Rating Scale (C-SSRS)
- Patient Health Questionnaire – Adolescent version (PHQ-A)
- Ask Suicide-Screening Questions (ASQ)

Horowitz et al., 2012; Johnson et al. 2002; Posner et al. 2011
Ask Suicide-Screening Questions (ASQ)

- Three pediatric emergency departments
  - Boston Children’s Hospital, Boston, MA
  - Children’s National Medical Center, Washington, D.C.
  - Nationwide Children’s Hospital, Columbus, OH
- September 2008 to January 2011
- 524 pediatric emergency department patients
  - 344 medical/surgical, 180 psychiatric
  - 57% female, 50% white, 53% privately insured
  - Ages 10 to 21 (mean=15.2 years; SD = 2.6y)

Horowitz et al., 2012
Sensitivity: 96.9% (95% CI, 91.3-99.4)
Specificity: 87.6% (95% CI, 84.0-90.5)

Neg: 99.7% (95% CI, 98.2-99.9)
Pos: 96.9%
Results

- 98/524 (18.7%) screened positive for suicide risk
  - 14/344 (4%) medical/surgical chief complaints
  - 84/180 (47%) psychiatric chief complaints
- Feasible
  - Less than one minute to administer
  - Non-disruptive to workflow
- Acceptable
  - Parents/guardians gave permission for screening
  - Over 95% of patients were in favor of screening
- ASQ is now available in the public domain

Horowitz et al., 2012
Validation and Implementations in Other Settings: Ongoing Research

- Inpatient medical/surgical unit
- Outpatient primary care/specialty clinics
- ASQ in adult medical patients
- Schools
- Child abuse clinics
- Detention facilities
- Indian Health Service (IHS)
- ASD/NDD population
- Global initiatives
- Translated in to 16 languages

ASQ Toolkit: www.nimh.nih.gov/ASQ
The ASQ Toolkit

- Organized by medical setting:
  - ASQ Tool
  - Brief Suicide Safety Assessments
  - Information Sheets
  - Scripts for staff
  - Flyers for guardians
  - Patient resources list
  - Educational videos

ASQ Toolkit: [www.nimh.nih.gov/ASQ](http://www.nimh.nih.gov/ASQ)
Can depression screening be used to effectively screen for suicide risk?
Patient Health Questionnaire -9 (PHQ-9)

- Nine-item depression screen assessing symptoms during the past two weeks
- Available in the public domain and commonly used in medical settings
- One “suicide-risk” question: Item #9
  - How often have you been bothered by the following symptoms during the past two weeks?
  
  "Thoughts that you would be better off dead or of hurting yourself in some way"
Depression Screening vs. Suicide Risk Screening
Suicide-risk positive (13.5%)

Total N=600 Medical/Surgical Inpatients

- SIQ ≥ 41
- SIQ-JR ≥ 31
- “Yes” to any ASQ item

Horowitz et al., 2021
Suicide-risk positive (N=81)

PHQ positive (N=103)

Item #9 endorsed

Total N=600
Medical/Surgical Inpatients

Horowitz et al., 2021
Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients

PHQ positive (N=103)

Item #9 endorsed (N=42)

Horowitz et al., 2021
Suicide-risk positive (N=81)

Total N=600 Medical/Surgical Inpatients

PHQ positive (N=103)

32% missed by PHQ-A

Item #9 endorsed (N=42)

Horowitz et al., 2021
Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients

PHQ positive (N=103)

56% missed by Item #9

Item #9 endorsed (N=42)

Horowitz et al., 2021
PHQ-9 modified for Adolescents (PHQ-A)

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.

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

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 others?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Office use only: Severity score: _______

Ask the patient:

1. In the past few weeks, have you wished you were dead? YES NO
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO
3. In the past week, have you been having thoughts about killing yourself? YES NO
4. Have you ever tried to kill yourself? YES NO
   If yes, how? _______________ When? _______________

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

5. Are you having thoughts of killing yourself right now? YES NO
   If yes, please describe: _______________
Common concern:

Can asking kids questions about suicidal thoughts put “ideas” into their heads?
Iatrogenic Risk?

On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis

Christopher R. DeCou, MS, and Matthew E. Schumann, MA

Previous studies have failed to detect an association between suicidality and suicide risk. However, the perception that assessment of suicidality persists. This meta-analysis quantitatively assessed the pooled effect of assessing suicidality. Thirteen articles were identified for inclusion. Evaluation of the pooled effect of assessing suicidality showed a significant correlation between assessment and suicide risk. Results suggest that assessing suicidality may be harmful.

Impact of screening for risk of suicide: randomised controlled trial

Mike J. Crawford, Lavinia Thanu, Caroline Methuen, Pradip Ghosh, San V. Stanley, Juliette Ross, Fabiano Gordon, Grant Brier and Priya Bajaj

Background

Concerns have been expressed about the impact that screening for risk of suicide may have on a person’s mental health.

Aims

To examine whether screening for suicidal ideation among people who attend primary care services and have signs of depression increases the short-term incidence of suicide attempts among patients.
Additional Considerations

• Who can screen?

• What if patient refuses to answer the questions?

• Do I “contract for safety?”

• Can asking questions about suicide make the patient suicidal?

• What if the patient does not “seem” like they are suicidal, do I still need to ask?

• What if patient starts talking to the nurse about suicidal thoughts in detail?

• What if parent refuses to leave the room?

• What if the parent/guardian won’t cooperate with the disposition plan?
What happens when a patient screens positive?
Here’s what should NOT happen

• Do not treat every young person who has a thought about suicide as an emergency
Universal Suicide Risk Screening
Clinical Pathway

Clinical Pathway - Three-tiered system

- Brief Screen (~20 seconds)
- Brief Suicide Safety Assessment (~10 mins)
- Full mental health evaluation or outpatient referral or no further action required

Zero Suicide | zerosuicide.edc.org

Adolescent Suicide Prevention and Medical Settings
If patient answered “yes” to Q4, and the patient has been screened before, ask: “Since last visit, have you tried to kill yourself?” If they answer “no” and they also answered “no” to Q1-3, no further action needed.

If the only “yes” answer is to Q4 (past suicidal behavior), factors to consider:

- Was the attempt more than a year ago?
- Has the patient received or is currently in mental health care?
- Is parent aware of past suicidal behavior?
- Is the suicidal behavior not a current, active concern?

If yes to all these, then consider "Low Risk" choice for action.
Brief Suicide Safety Assessment

BSSA

C-SSRS

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**Brief Suicide Safety Assessment**

**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.**

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**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 741741

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**Zero Suicide | zerosuicide.edc.org**
What is the purpose of the Brief Suicide Safety Assessment?

- To help clinician make “next step” decision
- Four choices
  - **Imminent Risk**
    - Emergency psychiatric evaluation.
  - **High Risk**
    - Further evaluation of risk is necessary.
  - **Low Risk**
    - Not the “business of the day.”
    - No further intervention necessary at this time.
COVID-19: YOUTH SUICIDE RISK SCREENING PATHWAY

Medically able to answer questions? NO

Administer ASQ (ideally separate from parent/guardian)?

From which clinician's perspective should the primary care provider re-evaluate need for ED visit:

YES

YES on any question 1-4 or refuses to answer?

YES to Q5?

NEGATIVE SCREEN

Exit Pathway

YES

SCREEN ON next visit

End of process

Low Risk

Further Evaluation Needed

IMMEDIATE RISK

Parent/Guardian to initiate safety precautions:

Safely plan with the patient and parent/guardian to activate an acute mental health appointment

Assess need for ED visit based on parent/guardian's assessment of suicidal behavior or imminent risk to self and safety planning

Advising patient to seek immediate safety planning and direct observation of all items and removal of safety-threatening items

Parent/Guardian to implement immediate safety precautions

End of process

High Risk

Low Risk

Would benefit from a non-urgent mental health follow-up

NO

NO

YES

Referral to ED

Safety Planning

- Create safety plan for suicidal ideation and thoughts, including planning personal safety steps and contact for additional support services, professional resources, and emergency contacts. Contact local mental health crisis services/crisis hotline in immediate need of support or potential emergency contact. If suicidal ideation is confirmed by the healthcare provider, contact the local mental health crisis services/crisis hotline in immediate need of support or potential emergency contact. (Contact local mental health crisis services/crisis hotline in immediate need of support or potential emergency contact.)

- Contact local mental health crisis services/crisis hotline in immediate need of support or potential emergency contact.

- Use crisis services/crisis hotline to initiate treatment and/or contact local mental health crisis services/crisis hotline in immediate need of support or potential emergency contact. (1-800-273-TALK (1-800-273-8255) in US/Canada, 688-680-2654 in the UK, Crisis Text Line: Text "HELLO" to 688-680-2654.)

- Safety planning and non-urgent mental health appointment should be scheduled with patient and parent/guardian.

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Safety Planning

- Warning Signs
- Coping Strategies
- Social Contacts for Support
- Emergency Contacts
- Reduce Access to Lethal Means

---

### Patient Safety Plan Template

<table>
<thead>
<tr>
<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: People and social settings that provide distraction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_________ Phone_________</td>
</tr>
<tr>
<td>2. Name_________ Phone_________</td>
</tr>
<tr>
<td>3. Place_________ 1. Place_________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 4: People whom I can ask for help:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name_________ Phone_________</td>
</tr>
<tr>
<td>2. Name_________ Phone_________</td>
</tr>
<tr>
<td>3. Name_________ Phone_________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clinician Name_________ Phone_________</td>
</tr>
<tr>
<td>2. Clinician Name_________ Phone_________</td>
</tr>
</tbody>
</table>
| 3. Local Urgent Care Services
  Urgent Care Services Address
  Urgent Care Services Phone |
| 4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255) |

<table>
<thead>
<tr>
<th>Step 6: Making the environment safe:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>

Stanley & Brown, 2012

---

Zero Suicide | zerosuicide.edc.org
Lethal Means Safety
Can we adapt suicide risk screeners for youth under age 8?

- **ASQ**
  - 3.2 grade reading level

- **C-SSRS**
  - 4.3 grade reading level

- **PHQ-A**
  - 6.5 grade reading level

![PHQ-9 modified for Adolescents (PHQ-A)](image)

---

**Ask the patient:**

1. In the past 2 weeks, how often have you been bothered by feeling...
2. In the past 2 weeks, how often would you describe your interest or pleasure in doing things...
3. In the past 2 weeks, how often have you been thinking about killing yourself...
4. If yes, how often did you think about killing yourself...
5. Are you thinking about hurting yourself?

**Past month**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>t wake up?</td>
<td>☒ No</td>
<td>No</td>
</tr>
<tr>
<td>on 6.</td>
<td>☒ No</td>
<td>No</td>
</tr>
<tr>
<td>to when</td>
<td>☒ No</td>
<td>No</td>
</tr>
<tr>
<td>them?</td>
<td>☒ No</td>
<td>No</td>
</tr>
<tr>
<td>... yourself?</td>
<td>☒ No</td>
<td>No</td>
</tr>
</tbody>
</table>

**In the past week,**

- 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 others?
  - ☐ Not difficult at all
  - ☐ Somewhat difficult
  - ☐ Very difficult
  - ☐ Extremely difficult

- Have you ever, in your whole life, tried to kill yourself or made a suicide attempt?
  - ☐ Yes
  - ☐ No

**Office use only:**

| **Severity score:** |       |

---

modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2000).
Should we be screening kids under 8 for coping strategies instead:

What do you do when you feel really bad/sad/mad?
Summary

- Universal screening – ask directly
  - 10 and older for medical chief complaints
  - 8 and older for psychiatric chief complaints
  - Under 8 years, recognize warning signs and assess for risk
- Screening can take 20 seconds
- Requires practice guidelines for managing positive screens
  - Clinical Pathway is a three-tiered system
    - Brief screen (20 seconds)
    - Brief Suicide Safety Assessment (~10 minutes)
    - Full mental health/safety evaluation (30 minutes)
- Studies to ensure that existing tools are accurately identifying suicide risk in minoritized youth
- Instruct patients/families to safely store or remove lethal means (firearms, pills, knives, ropes)
Thank You!

Study teams and staff at:
National Institute of Mental Health
Maryland Pao, MD
Elizabeth Ballard, PhD
Deborah Snyder, MSW
Michael Schoenbaum, PhD
Jane Pearson, PhD
Ian Stanley, PhD
Dan Powell, BA
Eliza Lanzillo, BA
Mary Tipton, BA
Annabelle Mournet, BA
Nathan Lowry, BA

Nationwide Children’s Hospital
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John Campo, MD
Arielle Sheftall, PhD
Elizabeth Cannon, MA
Sandy McBee-Strayer, PhD
Emory Bergdoll, BS

Parkland Memorial Hospital
Kim Roaten, PhD
Celeste Johnson, DNP, APRN, PMH, CNS
Carol North, MD, MPE

Boston Children’s Hospital
Elizabeth Wharf, PhD
Fran Damian, MS, RN, NEA-BC
Laika Aguinaldo, PhD

Pediatric & Adolescent Health Partners
Ted Abernathy, MD

Children’s Mercy Kansas City
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Andrea Bradley-Ewing, MA, MPA

PaCC Working Group
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Khaled Afzal, MD
Lisa Giles, MD
Kyle Johnson, MD
Elizabeth Kowal, MD

Catholic University
Dave Jobes, PhD

Children’s National Medical Center
Martine Solages, MD
Paramjit Joshi, MD

Harvard Injury Control Research Center
Matthew Miller, MD, MPH, Sc.D.

American Foundation for Suicide Prevention for supporting our ASQ Inpatient Study at CNMC

A special thank you to nursing staff, who are instrumental in suicide risk screening.

We would like to thank the patients and their families for their time and insight.

Zero Suicide | zerosuicide.edc.org
Using the chat: Share one key takeaway from the presentation.
SUICIDE SAFER CARE: SUICIDE PREVENTION IN PEDIATRIC PRIMARY CARE

Virna Little, PsyD, LCSW-r, CCM
Chief Operating Officer, Co-founder
Concert Health
Language Matters
Choosing Compassionate & Accurate Language

Died of/by Suicide vs Committed Suicide
Suicide vs Successful Attempt
Suicide Attempt vs Unsuccessful Attempt
Describe Behavior vs Manipulative/Attention-Seeking
Describe Behavior vs Suicidal Gesture/Cry for Help
Diagnosed with vs they're Borderline/Schizophrenic
Working with vs Dealing with Suicidal Patients

© NowMattersNow.org, All Rights Reserved, 2018
Overview

- Role of the pediatric primary care provider (PCP) in suicide safe care
- Identification of patients at risk for suicide
- Assessment of patients at risk for suicide
- Safety planning
- Office-based interventions for PCPs
- Collaborative Care for pediatric patients
Why Focus on Primary Care Settings?

- 84% of those who die by suicide have a health care visit in the year before their death.

- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt.

- Almost 40% of individuals who died by suicide had an emergency department (ED) visit, but not a mental health diagnosis.

Ahmedani, 2014; Ahmedani, 2015
The suggested actions in this alert cover detection of suicidal ideation, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of individuals at risk. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk of suicide, and documenting their care.
National Patient Safety Goal (NPSG) 15.01.01

- SEA 56 was retired in February 2019.
- NPSG 15.01.01 covers the topics in SEA 56 and includes new and revised performance elements effective July 2019.
- The Joint Commission website includes a Suicide Prevention Portal with resources and guidance.
National Patient Safety Goal 15.01.01

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
What We Hear Sometimes…

“I don’t have the knowledge to assess or intervene.”

“With such a short amount of time, I don’t have time to ask or address suicide risk.”
In the Office:
Three Things that People at Risk of Suicide Want from You

• Do not panic.

• Be present, listen carefully, and reflect.

• Provide some hope, e.g., “You have been through a lot, I see that strength.”

LANGUAGE MATTERS!
Population of Patients at Risk for Suicide

- Do you know how many are on your panel, in your practice, or organization?
- Are you adding ICD-10 codes to your problem list?
- Do you have expectations/standards for BOTH newly identified patients and patients following up for routine primary care?
- What does excellent care for patients at risk of suicide in your organization look like?
**PHQ-9 modified for Adolescents (PHQ-A)**

**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.

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

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)
Collaborative Care as a Resource for Pediatric Patients at Risk

The AIMS Center, 2021
Collaborative Care is…

- …a Medicare benefit
- …Medicaid benefit in 18 states
- …recognized by commercial plans
- …billed in MONTHLY case rate
- …affordable and accessible form of health care
- …reimbursable for telephonic and virtual care as well as in person
Core Principles of Collaborative Care

- **Patient-Centered Care.** Primary care and mental health providers collaborate effectively using shared care plans.

- **Population-Based Care.** A defined group of patients is tracked in a registry so that no one falls through the cracks.

- **Treatment to Target.** Progress is measured regularly and treatments are actively changed until clinical goals are achieved.

- **Evidence-Based Care.** Providers use treatments that have research evidence for effectiveness.

- **Accountable Care.** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just volume of care.
Registry is Required

No patient “falls off the radar”

Can flag for risk

Tracks population

Adolescent Suicide Prevention and Medical Settings
Appropriate Levels of Care

- Not everyone needs an alternate level of care.
- There is no “emergency room magic.”
References


Using the chat: Share one key takeaway from the presentation.
Questions?
FOR MORE INFO

Visit zerosuicide.edc.org to learn more about Zero Suicide.

Join the Zero Suicide listserv at go.edc.org/ZSListserv
How To Claim Credit

Simply follow the instructions below. Email LearningCenter@psych.org with any questions.

1. Attend the virtual event.
2. Submit the evaluation.
3. Select the CLAIM CREDITS tab.
4. Choose the number of credits from the dropdown menu.
5. Click the CLAIM button.

Claimed certificates are accessible in My Courses > My Completed Activities
Thank you!

Julie Goldstein Grumet
jgoldstein@edc.org

Lisa Horowitz
horowitzl@mail.nih.gov

Virna Little
virna@concerthealth.io

Suicide Prevention Resource Center
940 N.E. 13th Street
Nicholson Tower, 4N, 4900
Oklahoma City, OK 73104
sprc.org