Suicide Prevention Resource Center

Adolescent Suicide Prevention and Medical Settings

June 30, 2021

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Funding and Disclaimer

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Disclosures

No financial relationships or conflicts of interest to report.

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.

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body.

CME Credit

This activity is being accredited and implemented by the American Psychiatric Association (APA) as part of a subaward from the Suicide Prevention Resource Center (SPRC).

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The Suicide Prevention Resource Center is the sole owner of the activity content, including views expressed in written materials and by the speakers.

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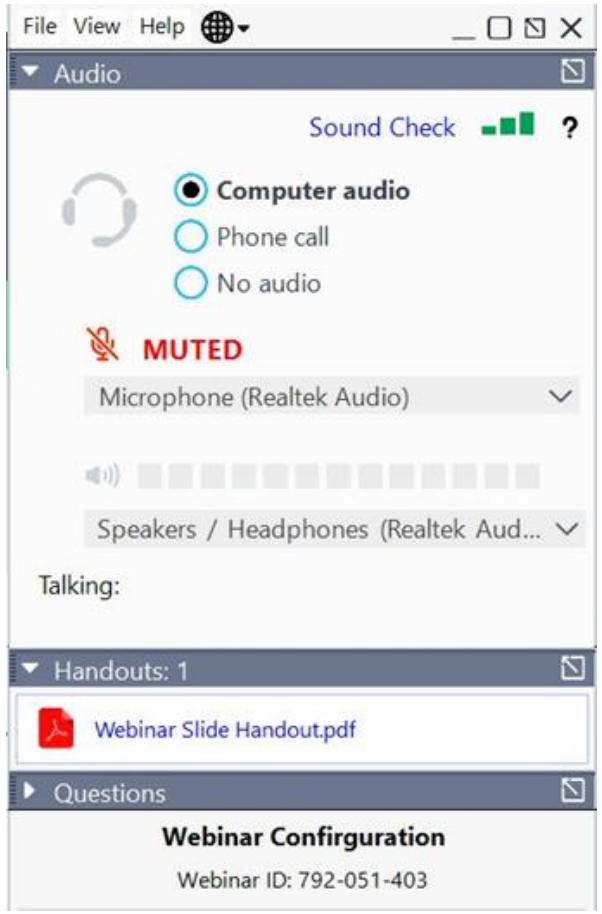

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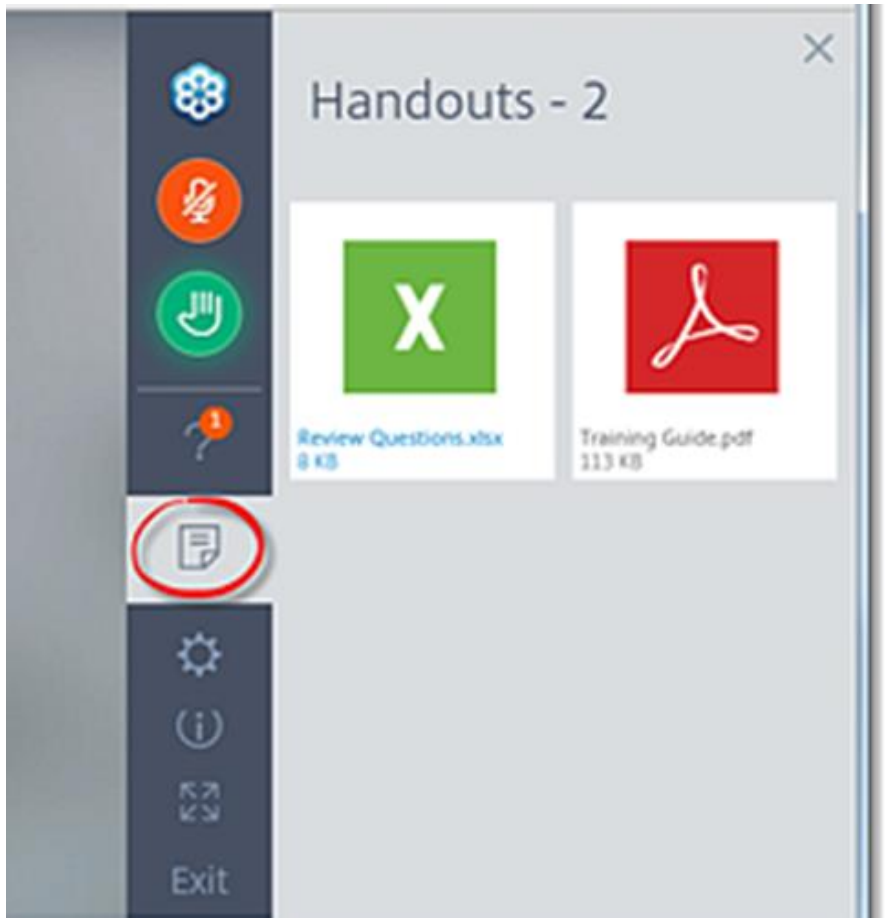

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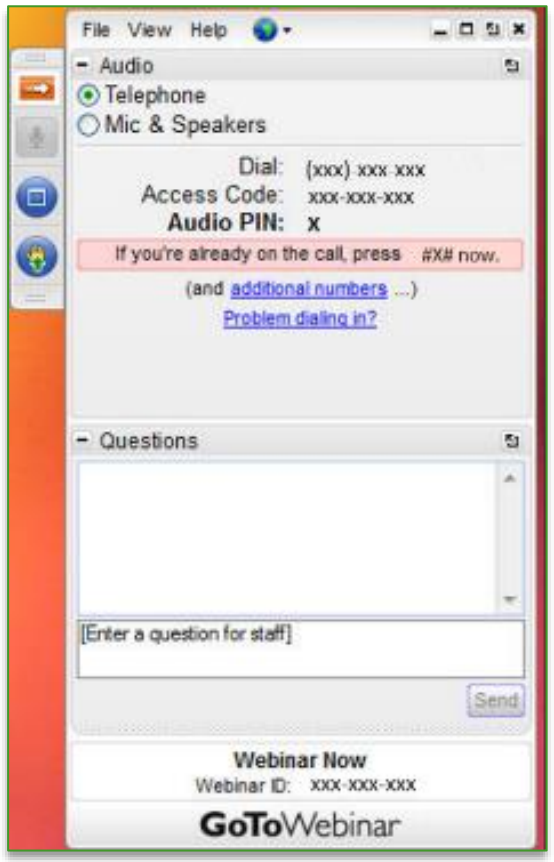

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Click the “?” symbol to display the “Questions” area.

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 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.

Zero Suicide Framework

CORE COMPONENTS OF SAFE SUICIDE CARE

- These seven elements are critical to safe care.
- Represent a holistic approach to suicide prevention.
- Can and should be considered on a simultaneous continuum.

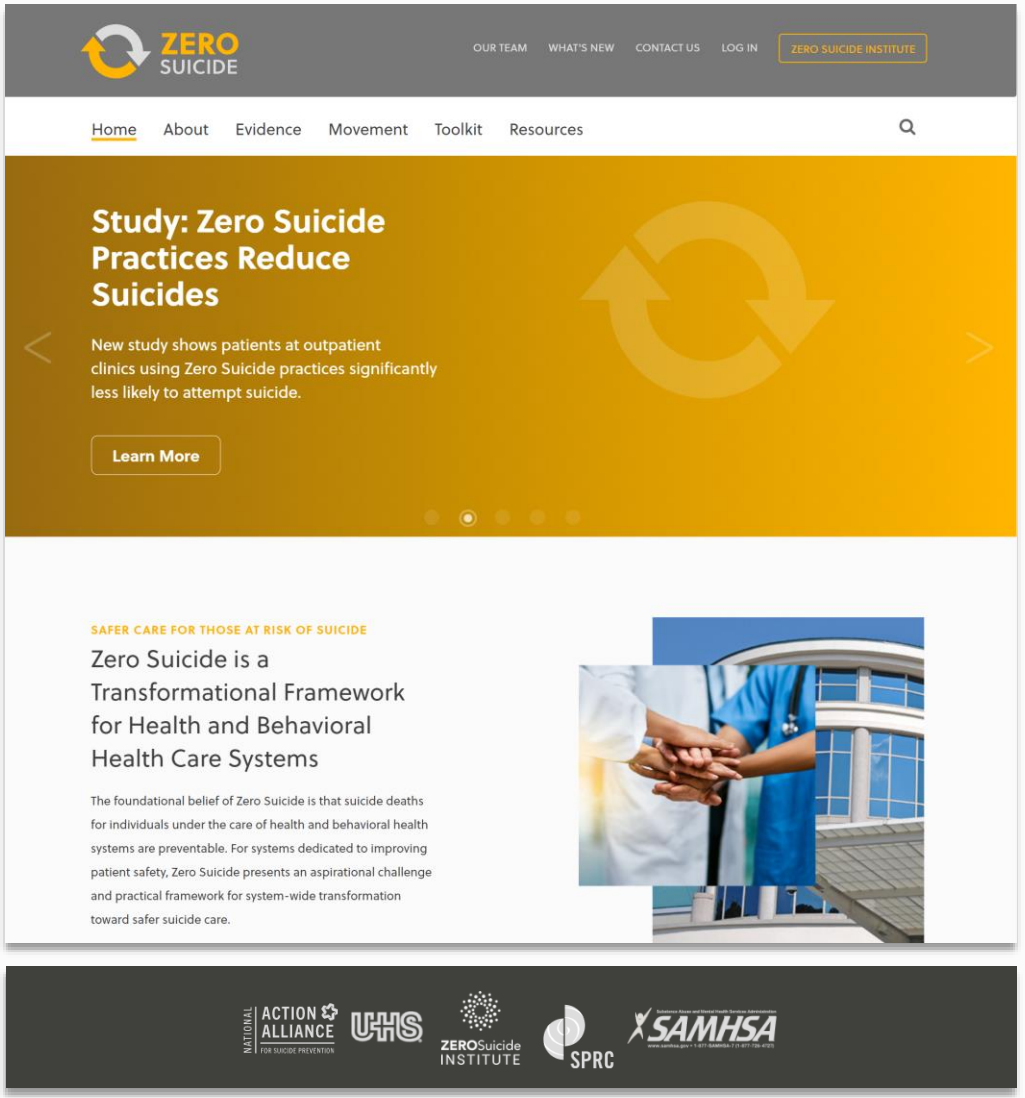
Zero Suicide Toolkit

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

National Institute of Mental Health, NIH

Bethesda, Maryland

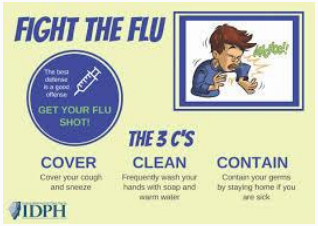
The views expressed in this presentation do not necessarily represent the views of the NIH, DHHS, or any other government agency or official. I have no financial conflicts to disclose.

Take-Home Messages

- 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

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK
www.suicidepreventionlifeline.org

CDC, 2018

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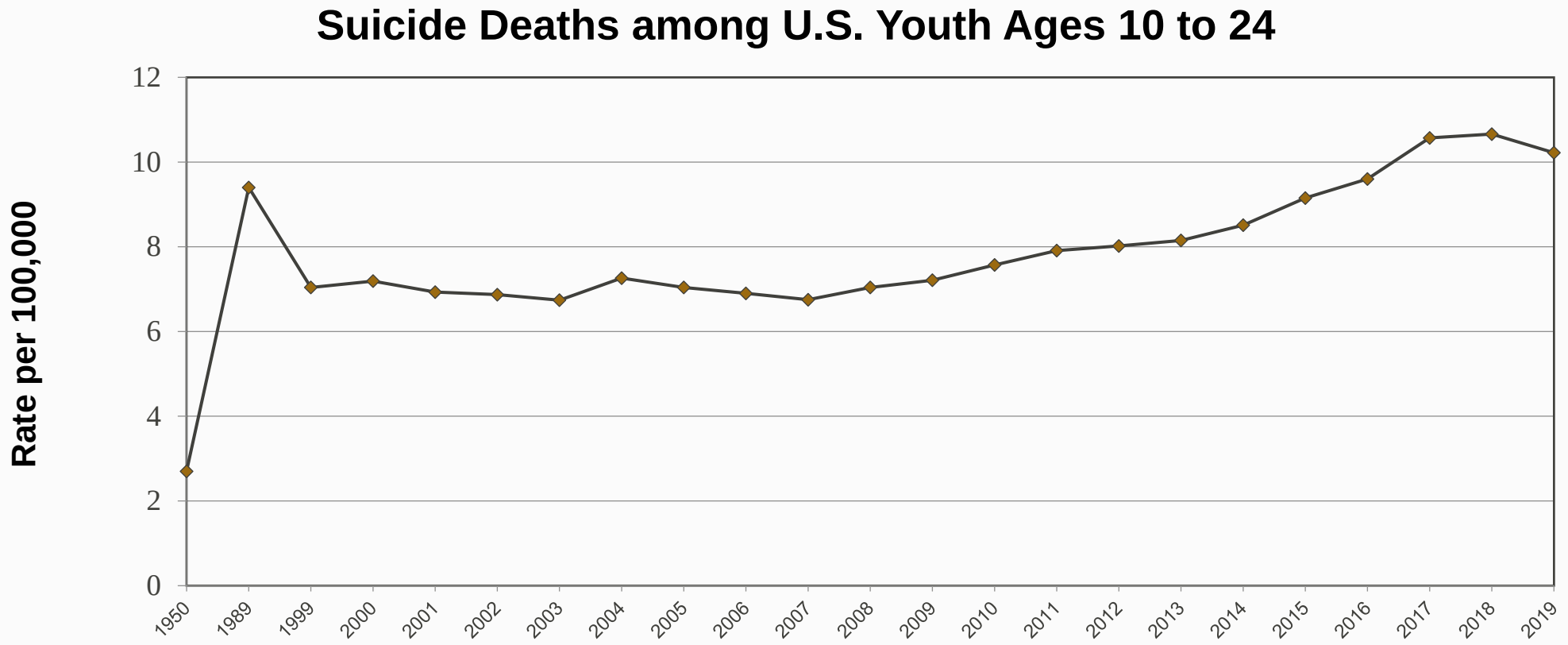
Youth Suicide in the U.S.

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



CDC WISQARS, 2019; Slide courtesy of Jeff Bridge, PhD

Younger Children and Suicidality

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

HOSPITAL Pediatrics

BRIEF REPORT

The Importance of Screening Preteens for Suicide Risk in the Emergency Department

Elizabeth C. Lanzillo, BA,[a] Lisa M. Horowitz, PhD, MPH,[a] Elizabeth A. Wharff, PhD,[b] Arielle H. Sheftall, PhD,[c,e] Maryland Pao, MD,[a] Jeffrey A. Bridge, PhD[c,d,e]

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

JAMA Pediatrics

RESEARCH LETTER

Suicidal Attempts and Ideation Among Children and Adolescents in US Emergency Departments, 2007-2015

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

JAMA Pediatrics

Original Investigation

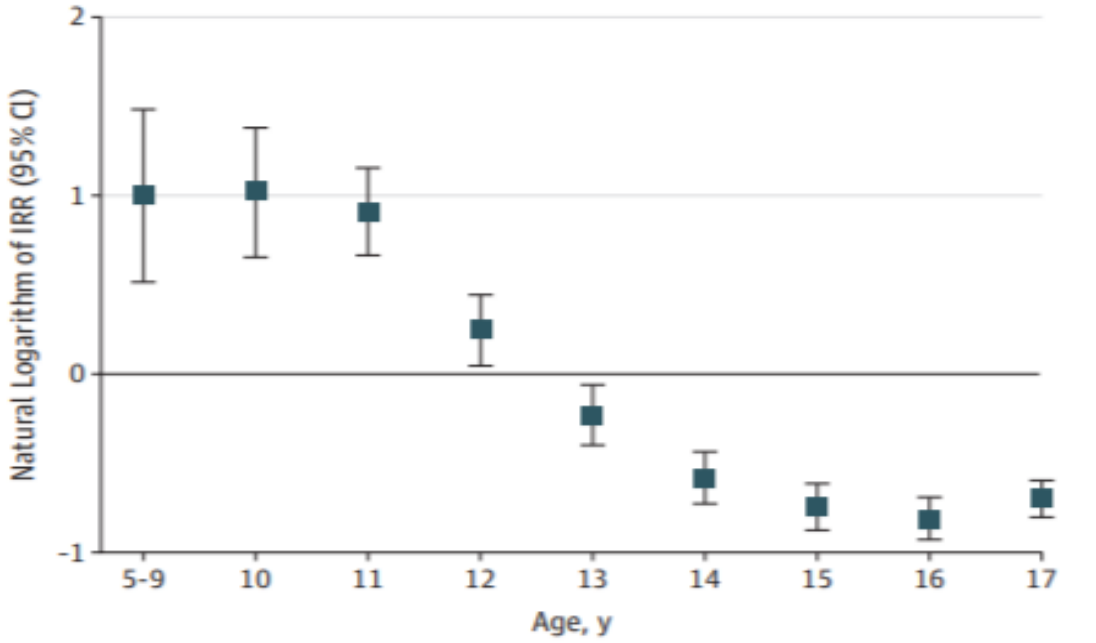
Suicide Trends Among Elementary School–Aged Children in the United States From 1993 to 2012

- 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

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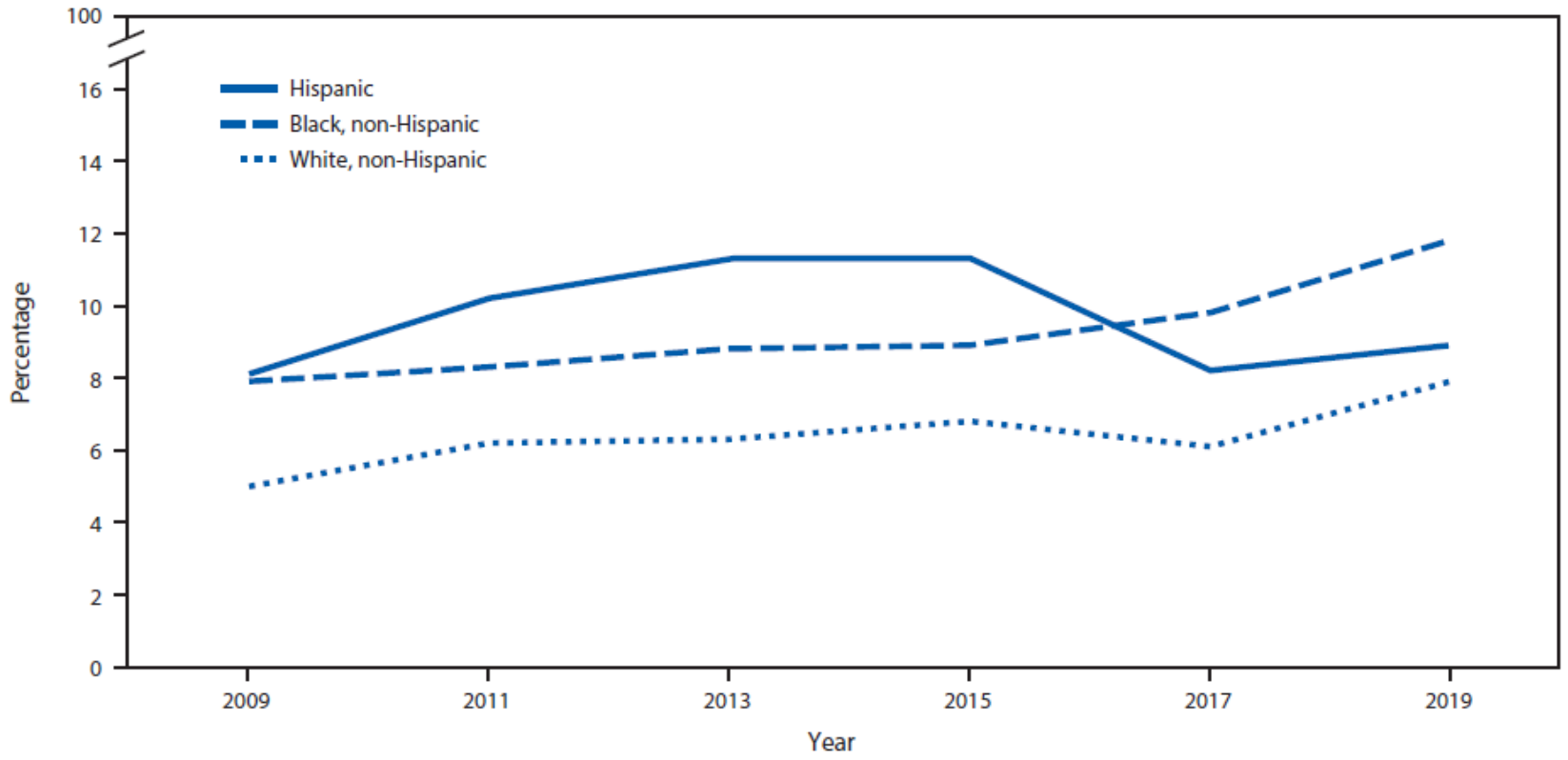
Racial Disparities Among High School Students

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

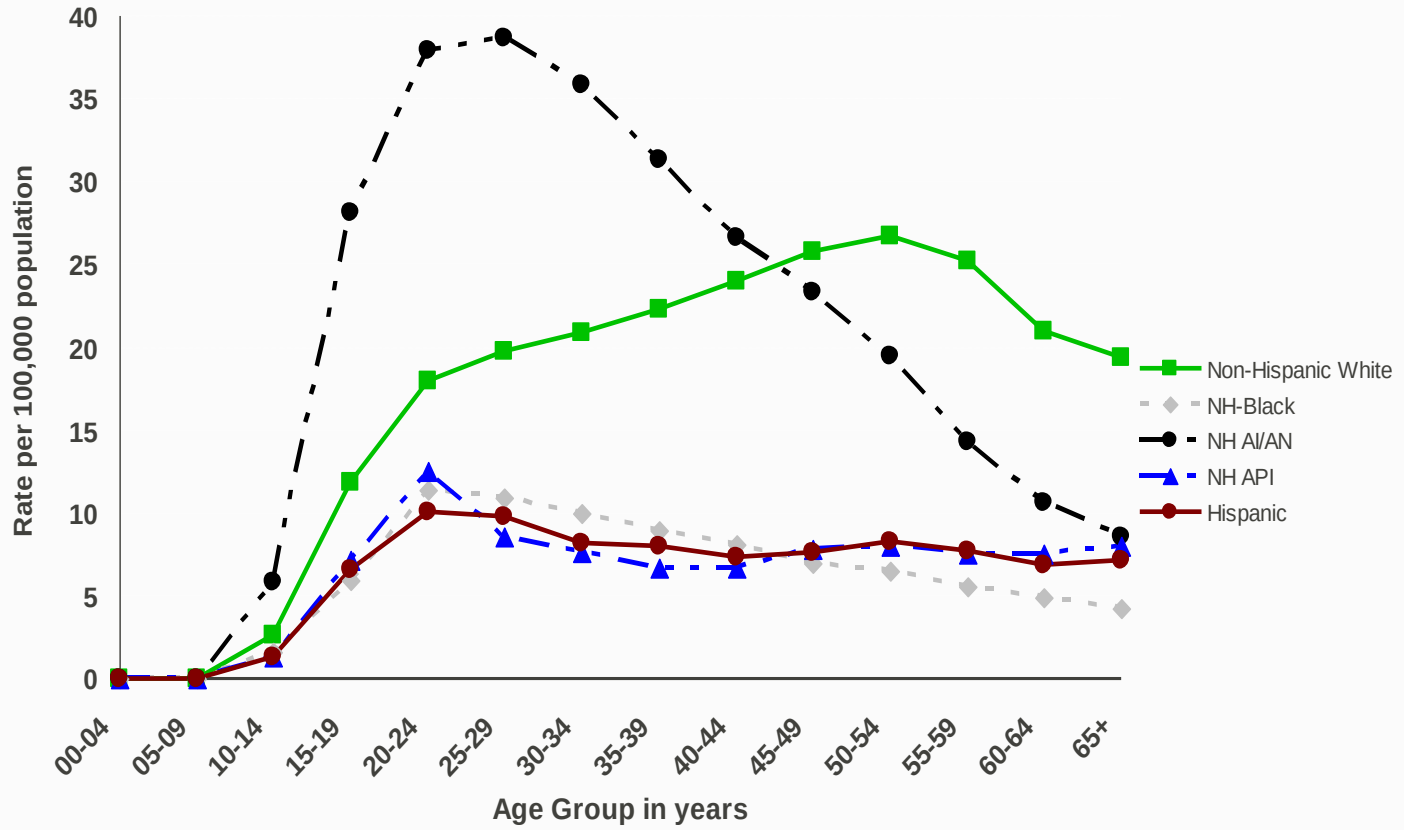


Ivey-Stephenson et al., 2020

"…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
- 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

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Can we save lives by screening for suicide risk in medical settings?

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Trade groups support youth suicide prevention

AAP News

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

Alyson Sulaski Wyckoff, Associate Editor
March 03, 2021

PRESS RELEASES

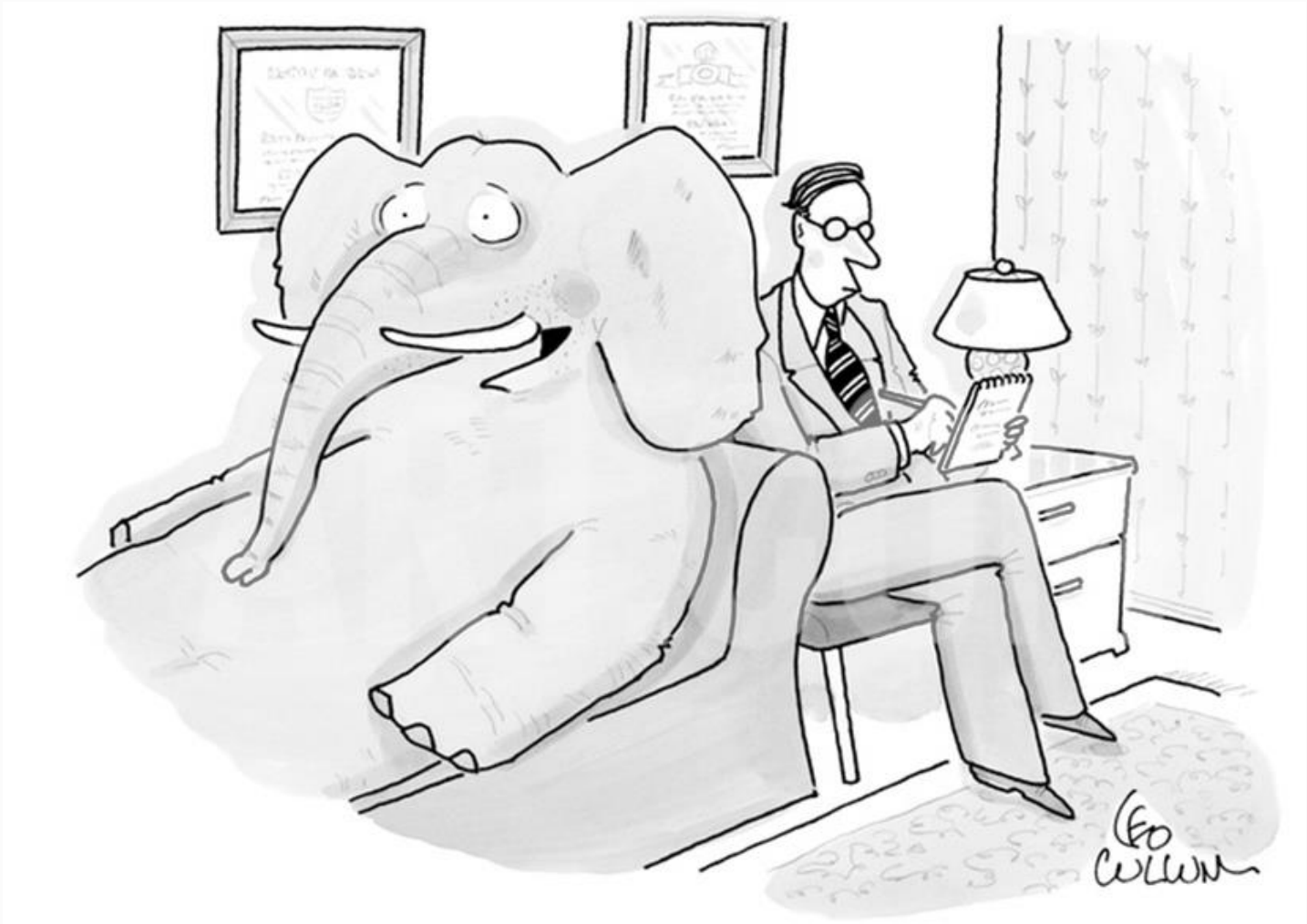
AMA adopts policy to address increases in youth suicide and save lives

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

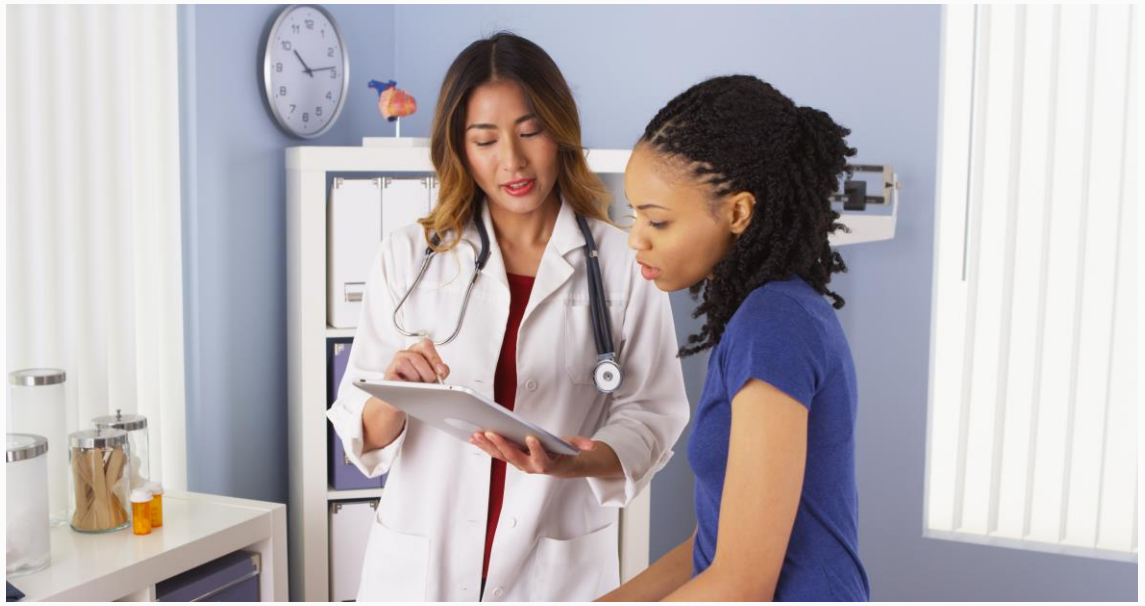
Ahmedani, 2019; Ahmedani, 2014; Rhodes, 2013



"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

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: No intervention is necessary (*Note:
- If patient answers "Yes" to any of the above: positive screen. Ask question #5 t
  - ☐ "Yes" to question #5 = acute
    - Patient requires a STAT
    - Patient cannot leave u
    - Keep patient in sight. R
    - responsible for patient
  - ☐ "No" to question #5 = non-a
    - Patient requires a brie
    - is needed. Patient can
    - Alert physician or clinic

Provide resources to all

- 24/7 National Suicide Prevent
- 24/7 Crisis Text Line: Text "HOME" to 741741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 6/13/2017

CI, 91.3-99.4)

CI, 84.0-90.5)

s:

tients: 99.7%

s: 96.9%

NON-ACUTE POSITIVE

ACUTE POSITIVE

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Results

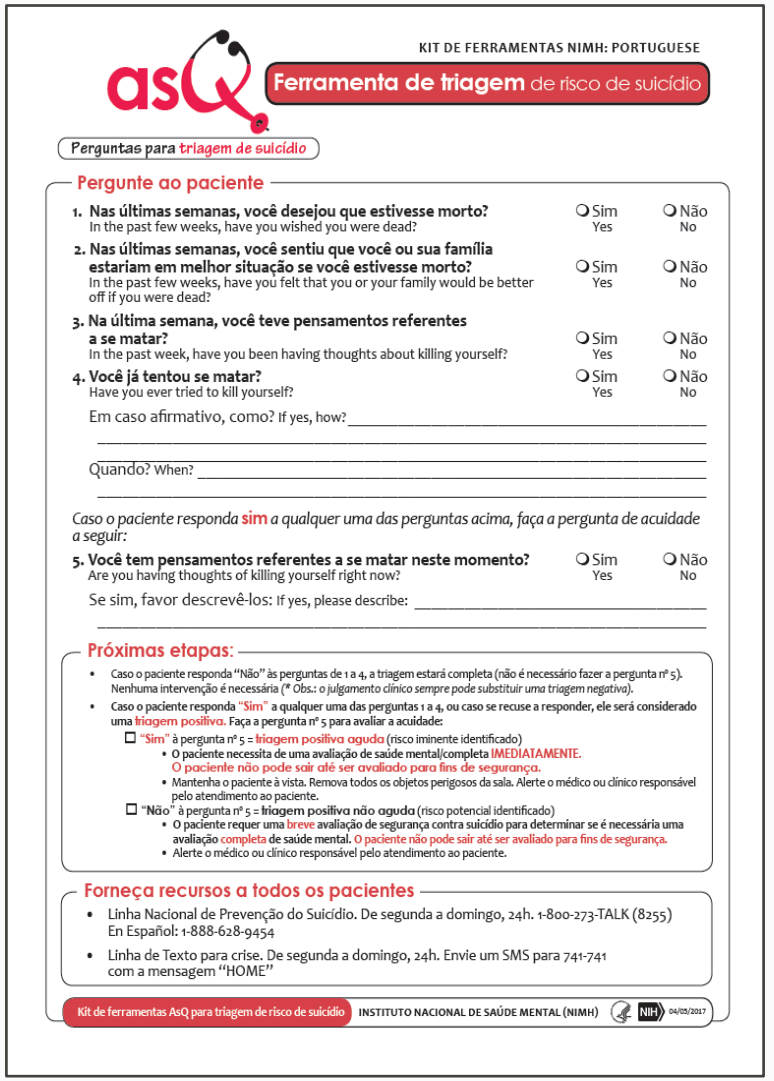
- 98/524 (18.7%) screened positive for suicide risk
  - 14/344 (4%) medical/surgical chief complaints
  - 84/180 (47%) psychiatric chief complaints
- Feasible
  - Less than one minute to administer
  - Non-disruptive to workflow
- Acceptable
  - Parents/guardians gave permission for screening
  - Over 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



KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ **Ferramenta de triagem** de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

1. **Nas últimas semanas, você desejou que estivesse morto?** In the past few weeks, have you wished you were dead? ❍ Sim Yes ❍ Não No
2. **Nas últimas semanas, você sentiu que você ou sua família estariam em melhor situação se você estivesse morto?** In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Sim Yes ❍ Não No
3. **Na última semana, você teve pensamentos referentes a se matar?** In the past week, have you been having thoughts about killing yourself? ❍ Sim Yes ❍ Não No
4. **Você já tentou se matar?** Have you ever tried to kill yourself? ❍ Sim Yes ❍ Não No

Em caso afirmativo, como? If yes, how? _____

Quando? When? _____

*Caso o paciente responda **sim** a qualquer uma das perguntas acima, faça a pergunta de acuidade a seguir:*

5. **Você tem pensamentos referentes a se matar neste momento?** Are you having thoughts of killing yourself right now? ❍ Sim Yes ❍ Não No

Se sim, favor descrevê-los: If yes, please describe: _____

Próximas etapas:

- Caso o paciente responda "Não" às perguntas de 1 a 4, a triagem estará completa (não é necessário fazer a pergunta nº 5). Nenhuma intervenção é necessária (* *Obs.: o julgamento clínico sempre pode substituir uma triagem negativa).*
- **Caso o paciente responda "Sim" a qualquer uma das perguntas 1 a 4, ou caso se recuse a responder, ele será considerado uma triagem positiva.** Faça a pergunta nº 5 para avaliar a acuidade:
  - ☐ "Sim" à pergunta nº 5 = **triagem positiva aguda** (risco iminente identificado)
    - O paciente necessita de uma avaliação de saúde mental/completa IMEDIATAMENTE. O paciente não pode sair até ser avaliado para fins de segurança.
    - Mantenha o paciente à vista. Remova todos os objetos perigosos da sala. Alerte o médico ou clínico responsável pelo atendimento ao paciente.
  - ☐ "Não" à pergunta nº 5 = **triagem positiva não aguda** (risco potencial identificado)
    - O paciente requer uma breve avaliação de segurança contra suicídio para determinar se é necessária uma avaliação completa de saúde mental. O paciente não pode sair até ser avaliado para fins de segurança.
    - Alerte o médico ou clínico responsável pelo atendimento ao paciente.

Forneça recursos a todos os pacientes

- Linha Nacional de Prevenção do Suicídio. De segunda a domingo, 24h. 1-800-273-TALK (8255) En Español: 1-888-628-9454
- Linha de Texto para crise. De segunda a domingo, 24h. Envie um SMS para 741-741 com a mensagem "HOME"

Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH) | 04/05/2017

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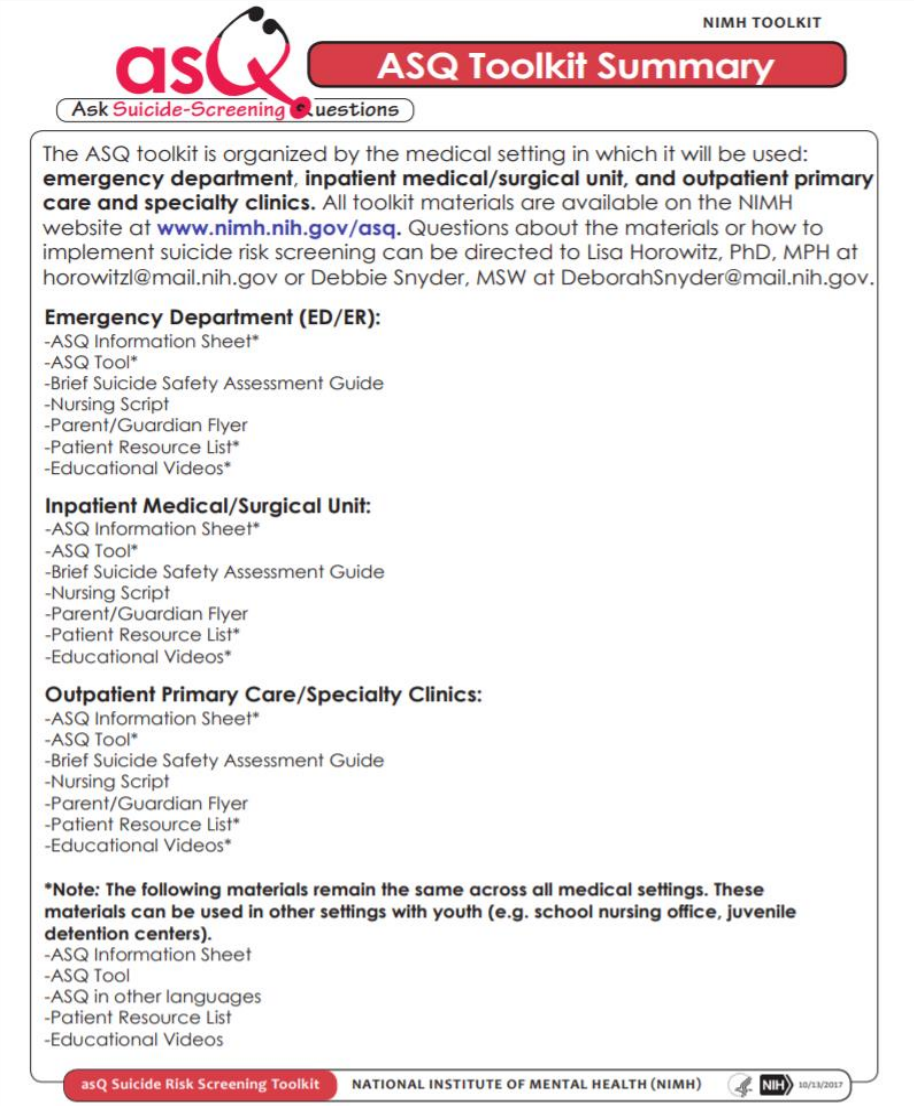
The ASQ Toolkit

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



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

ASQ Toolkit Summary

The ASQ toolkit is organized by the medical setting in which it will be used: **emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.** All toolkit materials are available on the NIMH website at **www.nimh.nih.gov/asq.** Questions about the materials or how to implement suicide risk screening can be directed to Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

Emergency Department (ED/ER):
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

Inpatient Medical/Surgical Unit:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

Outpatient Primary Care/Specialty Clinics:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

***Note: The following materials remain the same across all medical settings. These materials can be used in other settings with youth (e.g. school nursing office, juvenile detention centers).**
-ASQ Information Sheet
-ASQ Tool
-ASQ in other languages
-Patient Resource List
-Educational Videos

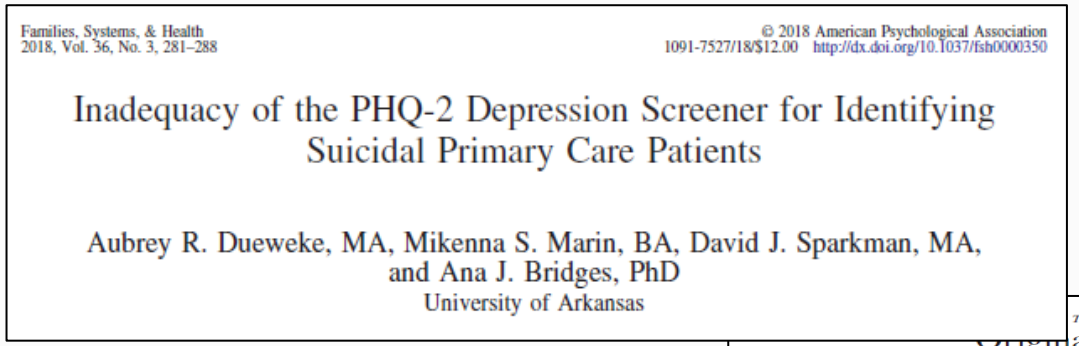
asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 10/13/2017

ASQ Toolkit: 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”*


Families, Systems, & Health
2018, Vol. 36, No. 3, 281–288

1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000350

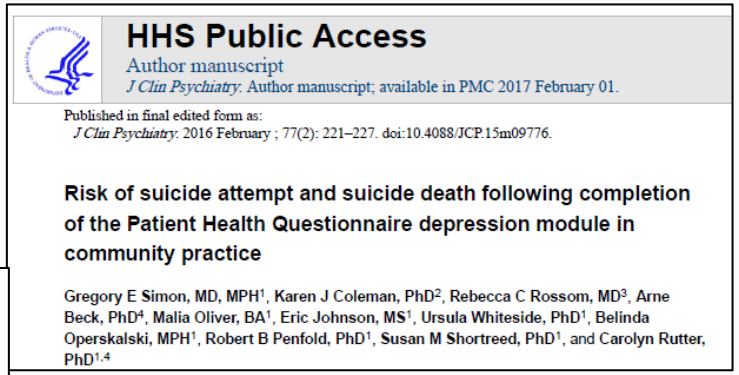
Inadequacy of the PHQ-2 Depression Screener for Identifying Suicidal Primary Care Patients

Aubrey R. Dueweke, MA, Mikenna S. Marin, BA, David J. Sparkman, MA, and Ana J. Bridges, PhD
University of Arkansas

Original Research Reports

Comparison of Electronic Screening for Suicidal Risk With the Patient Health Questionnaire Item 9 and the Columbia Suicide Severity Rating Scale in an Outpatient Psychiatric Clinic

Adele C. Viguera, M.D., Nicholas Milano, M.D., Laurel Ralston D.O., Nicolas R. Thompson, M.S., Sandra D. Griffith, Ph.D., Ross J. Baldessarini, M.D., Irene L. Katzan, M.D., M.S.



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J Clin Psychiatry. 2016 February ; 77(2): 221–227. doi:10.4088/JCP.15m09776.

Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice

Gregory E Simon, MD, MPH[1], Karen J Coleman, PhD[2], Rebecca C Rossom, MD[3], Arne Beck, PhD[4], Malia Oliver, BA[1], Eric Johnson, MS[1], Ursula Whiteside, PhD[1], Belinda Operskalski, MPH[1], Robert B Penfold, PhD[1], Susan M Shortreed, PhD[1], and Carolyn Rutter, PhD[1,4]

Depression Screening vs. Suicide Risk Screening

Suicide-risk positive (13.5%)

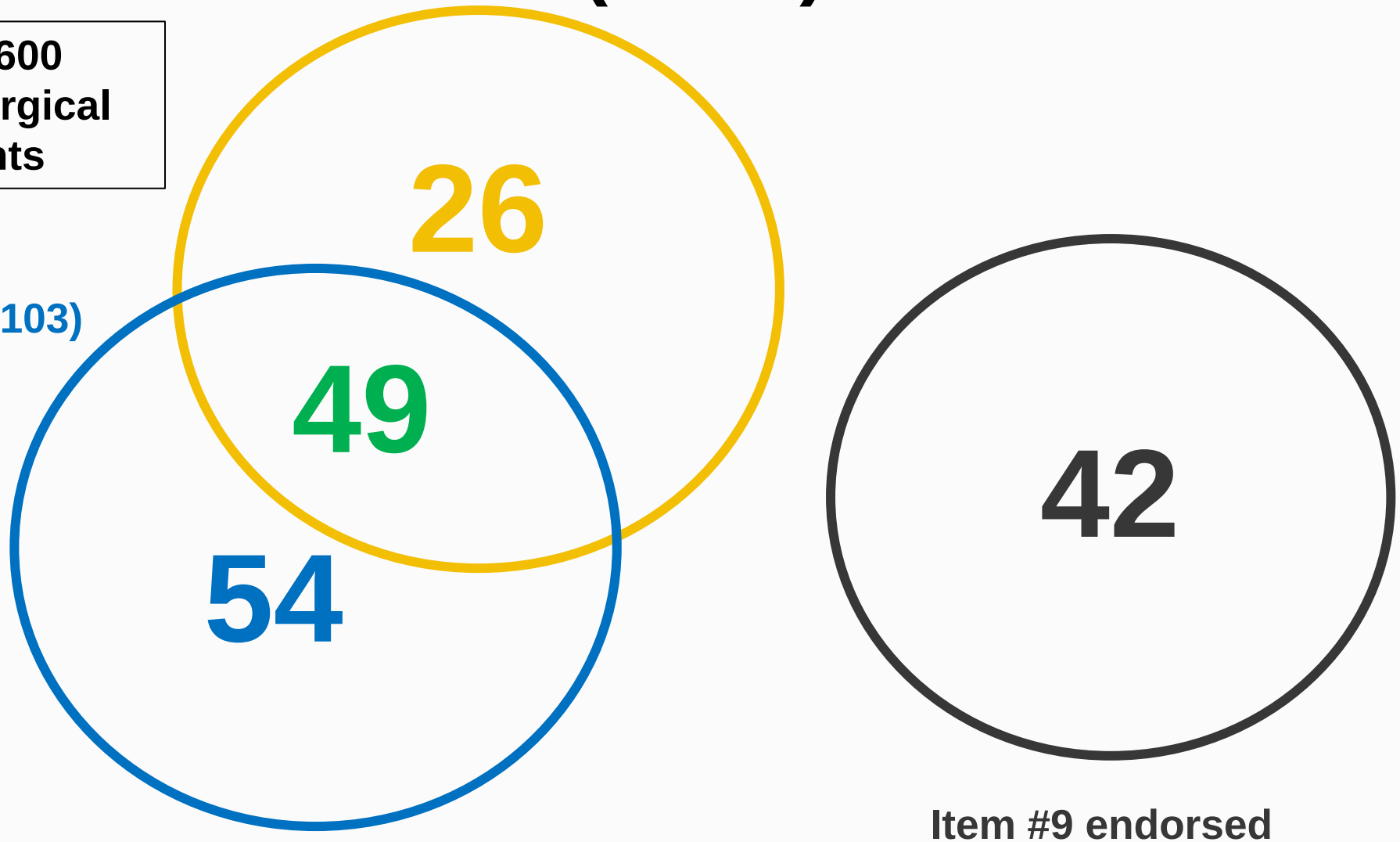
Total N=600
Medical/Surgical Inpatients

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

Horowitz et al., 2021

Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients



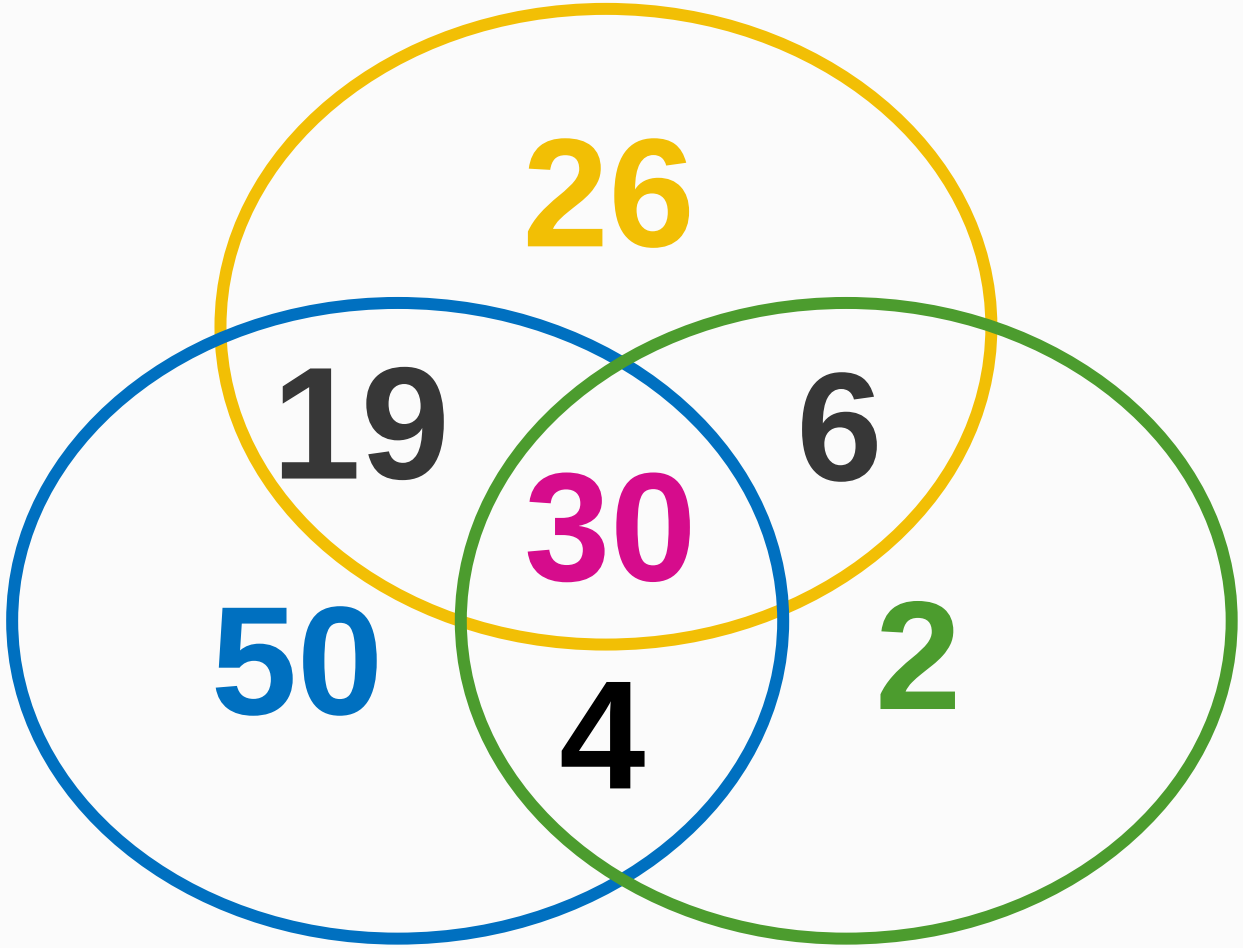
Horowitz et al., 2021

Item #9 endorsed

Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients

PHQ positive (N=103)



Horowitz et al., 2021

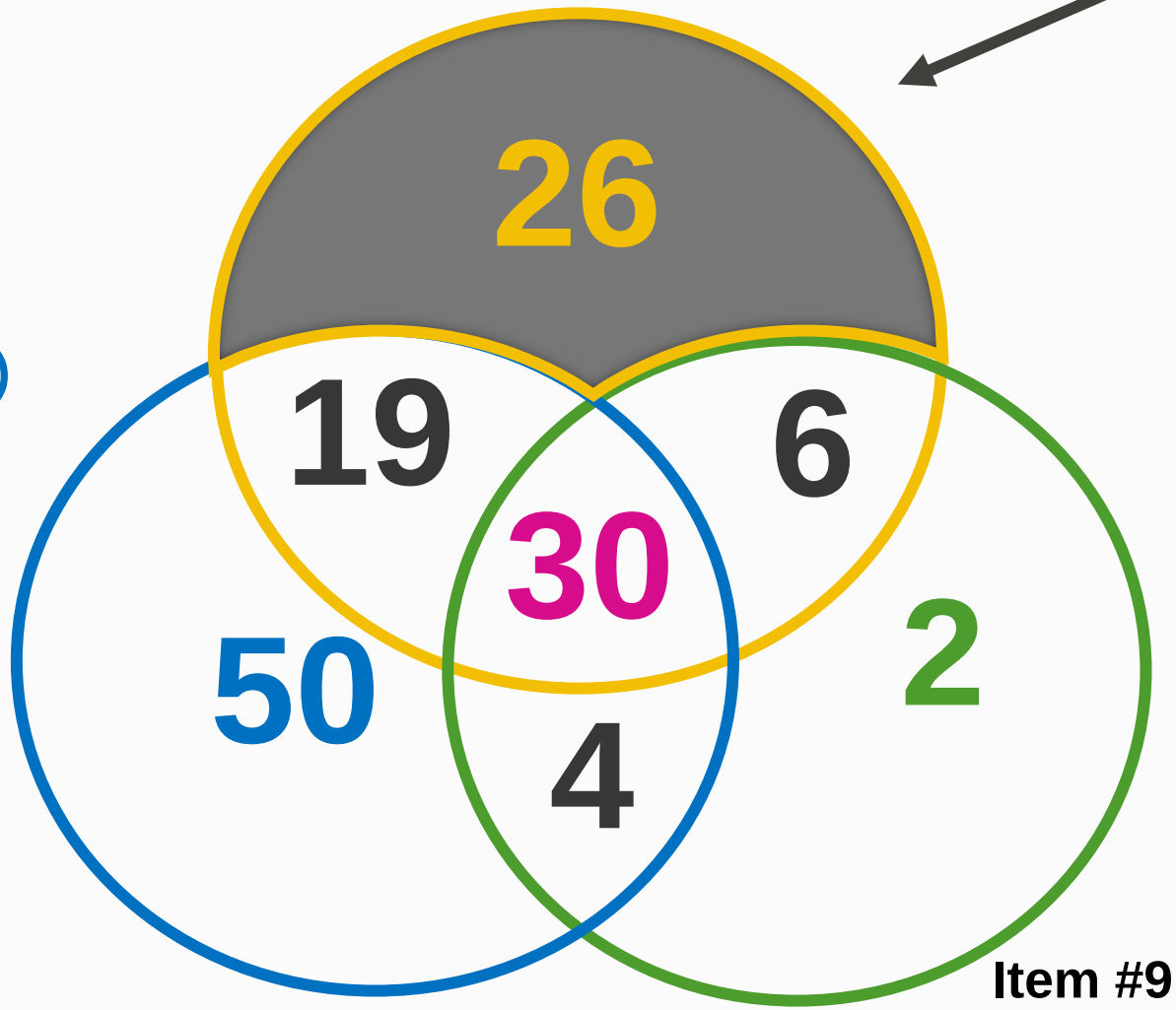
Item #9 endorsed (N=42)

Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients

PHQ positive (N=103)

32% missed by PHQ-A



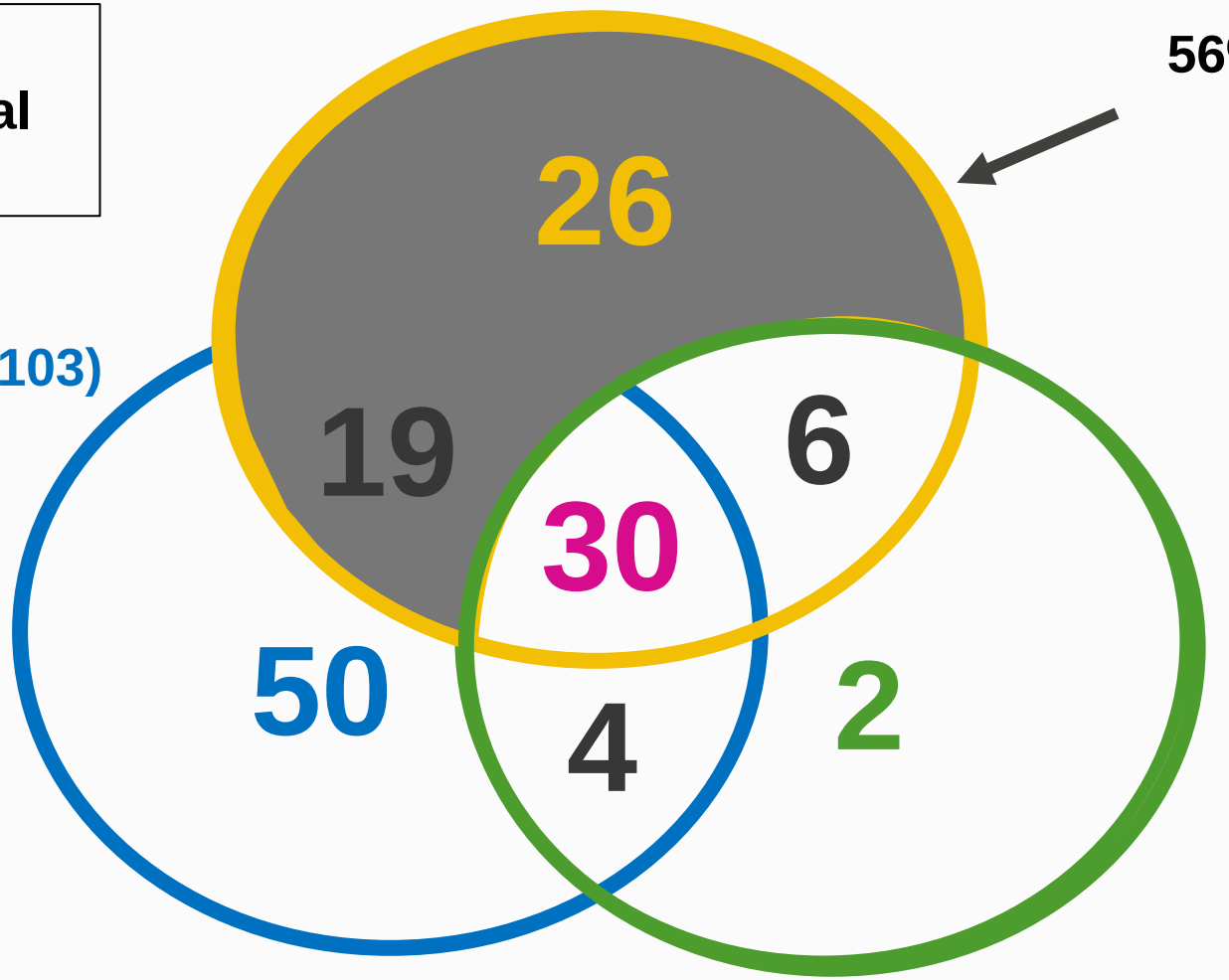
Item #9 endorsed (N=42)

Horowitz et al., 2021

Suicide-risk positive (N=81)

Total N=600
Medical/Surgical Inpatients

56% missed by Item #9



Horowitz et al., 2021

PHQ-2

PHQ-9

Suicide Risk Screen

PHQ-9 modified for Adolescents (PHQ-A)

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

Office use only: **Severity score:** _____

asQ
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 question:

(5) Are you having thoughts of killing yourself right now?	YES	NO

If yes, please describe: _____

SPRC

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

2017

Previous studies have failed to detect an
suicidality. However, the perception that asking a
dality persists. This meta-analysis quantitatively s
the iatrogenic risks of assessing suicidality. Thi
explicitly evaluated the iatrogenic effects of asses
research methods. Thirteen articles were identif
Evaluation of the pooled effect of assessing suic
outcomes did not demonstrate significant iatrog
port the appropriateness of universal screening f
fears that assessing suicidality is harmful.

What's the Harm in Asking About Suicidal Ideation?

CHARLES W. MATHIAS, PHD, R. MICHAEL FURR, PHD, ARIELLE H. SHEFTALL, PHD, NATHALIE HILL-KAPTURCZAK, PHD, PAIGE CRUM, BA, AND DONALD M. DOUGHERTY, PHD

2012

Both researchers and oversight committees share concerns about patient safety in the study-related assessment of suicidality. However, concern about assessing suicidal thoughts can be a barrier to the development of empirical evidence that informs research on how to safely conduct these assessments. A question has been raised if asking about suicidal thoughts can result in iatrogenic increases of such thoughts, especially among at-risk samples. The current study repeatedly tested suicidal ideation at 6-month intervals for up to 2-years. Suicidal ideation was measured with the Suicidal Ideation Questionnaire Junior, and administered to adolescents who had previously received inpatient psychiatric care. Change in suicidal ideation was tested using several analytic techniques, each of which pointed to a significant decline in suicidal ideation in the context of repeated assessment. This and previous study outcomes suggest that asking an at-risk population about suicidal ideation is not associated with subsequent increases in suicidal ideation.

Evaluating Iatrogenic Risk of Screening Programs
A Randomized Controlled Trial

Madelyn S. Gould, PhD, MPH
Frank A. Marrocco, PhD
Marjorie Kleinman, MS
John Graham Thomas, BS
Katherine Mostkoff, CSW

Context Universal screening for me
front of the national agenda for yo
addressed the potential harm of suicide screening.

Objective To examine whether asking about suicidal ideation or behavior during a screening program creates distress or increases suicidal ideation among high school students generally or among high-risk students reporting depressive symptoms, substance use problems, or suicide attempts.

Design, Setting, and Participants A randomized controlled study conducted within the context of a 2-day screening strategy. Participants were 2342 students in 6 high schools in New York State in 2002-2004. Classes were randomized to an experimental group (n=1172), which received the first survey with suicide questions, or to a control group (n=1170), which did not receive suicide questions.

's New Free-
sion[1] and the
lental Health

Impact of screening for risk of suicide: randomised controlled trial

2011

Mike J. Crawford, Lavanya Thana, Caroline Methuen, Pradip Ghosh, Sian V. Stanley, Juliette Ross, Fabiana Gordon, Grant Blair 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 feeling that life is not worth living.

Method
In a multicentre, single-blind, randomised controlled trial, 443 patients in four general practices were randomised to screening for suicidal ideation or control questions on health and lifestyle (trial registration: ISRCTN84692657). The primary outcome was thinking that life is not worth living measured 10–14 days after randomisation. Secondary outcome measures comprised other aspects of suicidal ideation and behaviour.

Results
A total of 443 participants were randomised to early ($n=230$) or delayed screening ($n=213$). Their mean age was 48.5 years (s.d. = 18.4, range 16–92) and 137 (30.9%) were male. The adjusted odds of experiencing thoughts that life was not worth living at follow-up among those randomised to early compared with delayed screening was 0.88 (95% CI 0.66–1.18). Differences in secondary outcomes between the two groups were not seen. Among those randomised to early screening, 37 people (22.3%) reported thinking about taking their life at baseline and 24 (14.6%) that they had this thought 2 weeks later.

Conclusions
Screening for suicidal ideation in primary care among people who have signs of depression does not appear to induce feelings that life is not worth living.

Declaration of interest
None.

DeCou & Schumann, 2017; Mathias et al., 2012; Crawford et al., 2011; Gould et al., 2005

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?

SPRC

What happens when a patient screens positive?

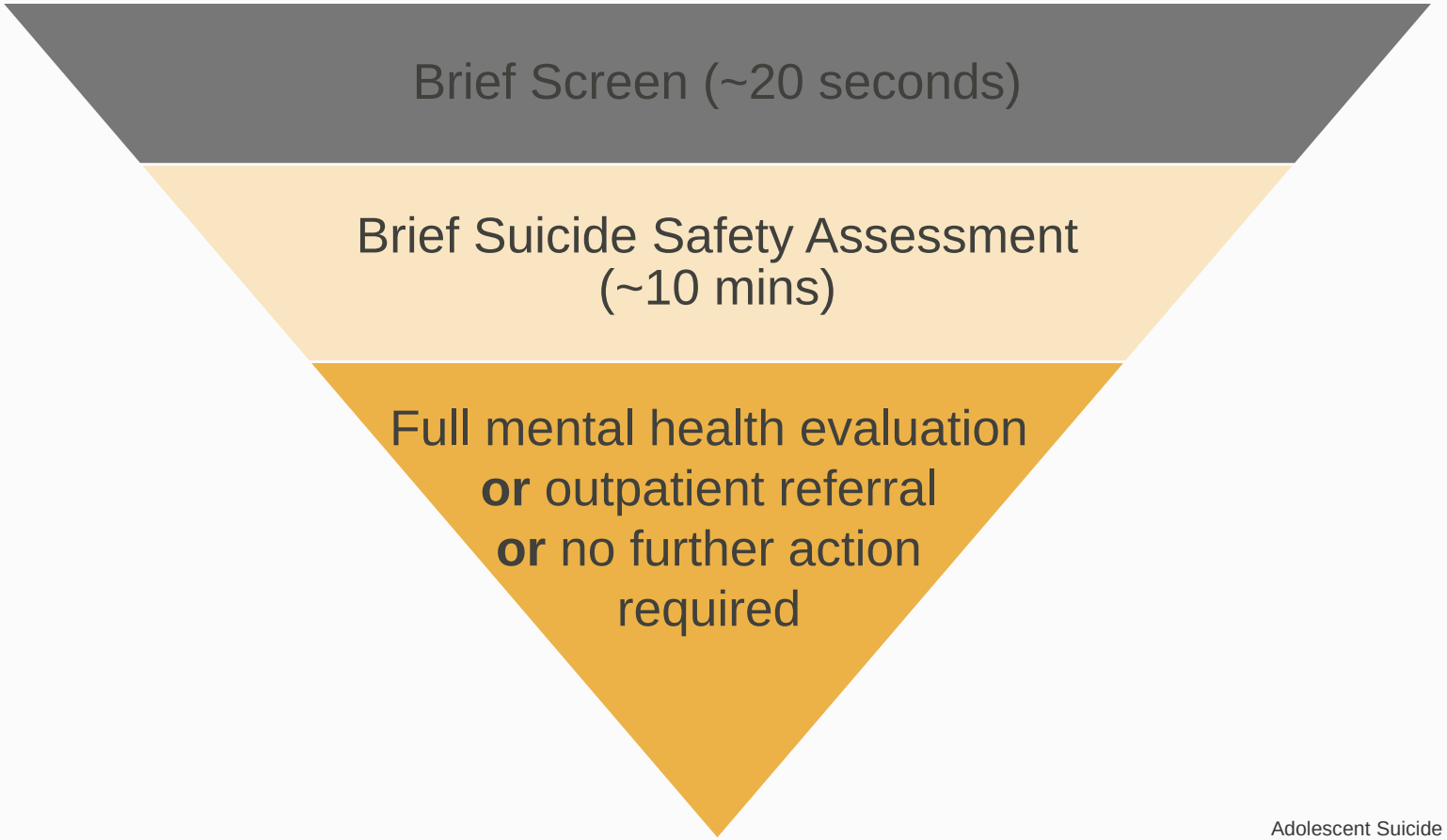
Here’s what should NOT happen

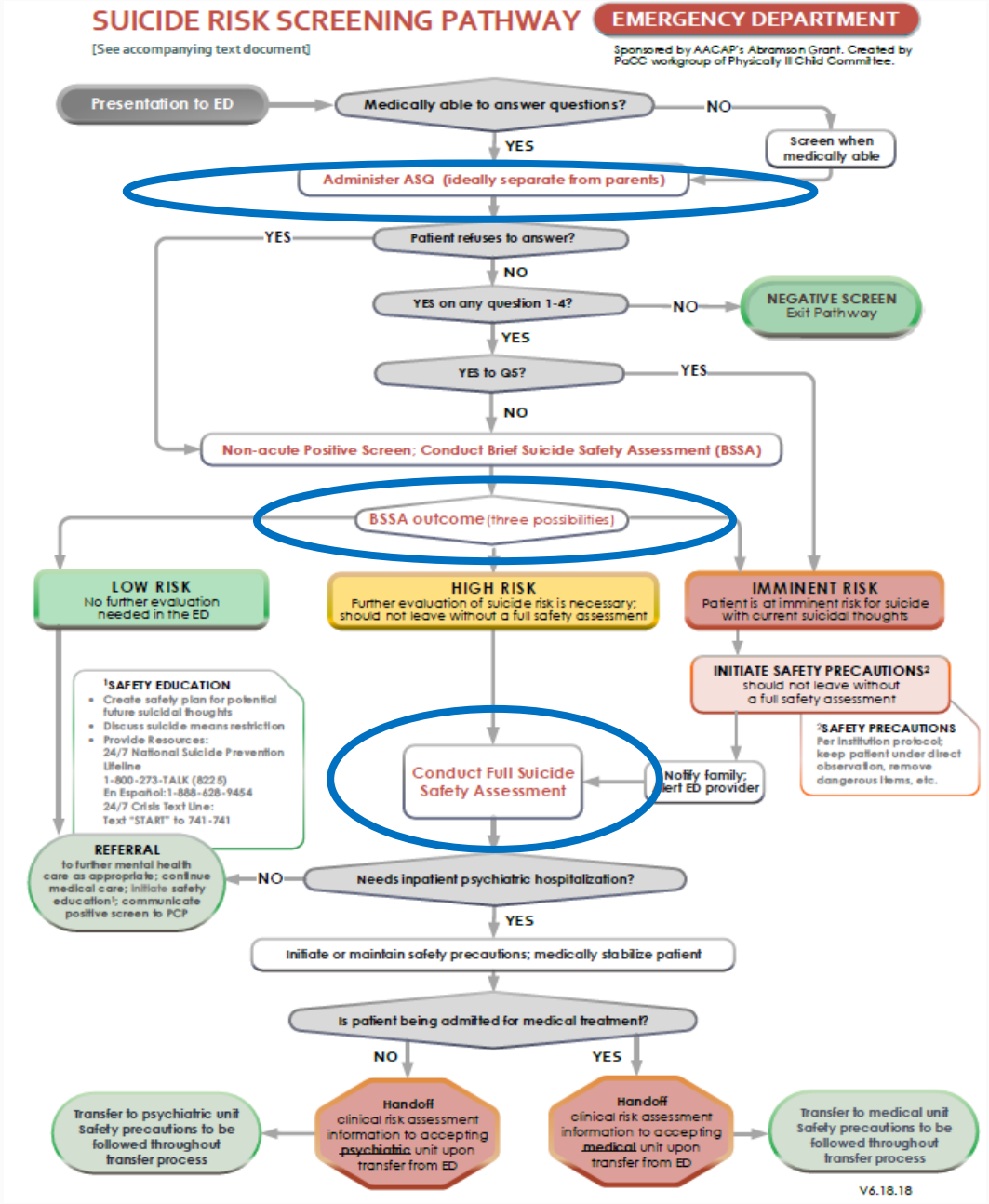
- Do not treat every young person who has a thought about suicide as an emergency

1:1 sitter

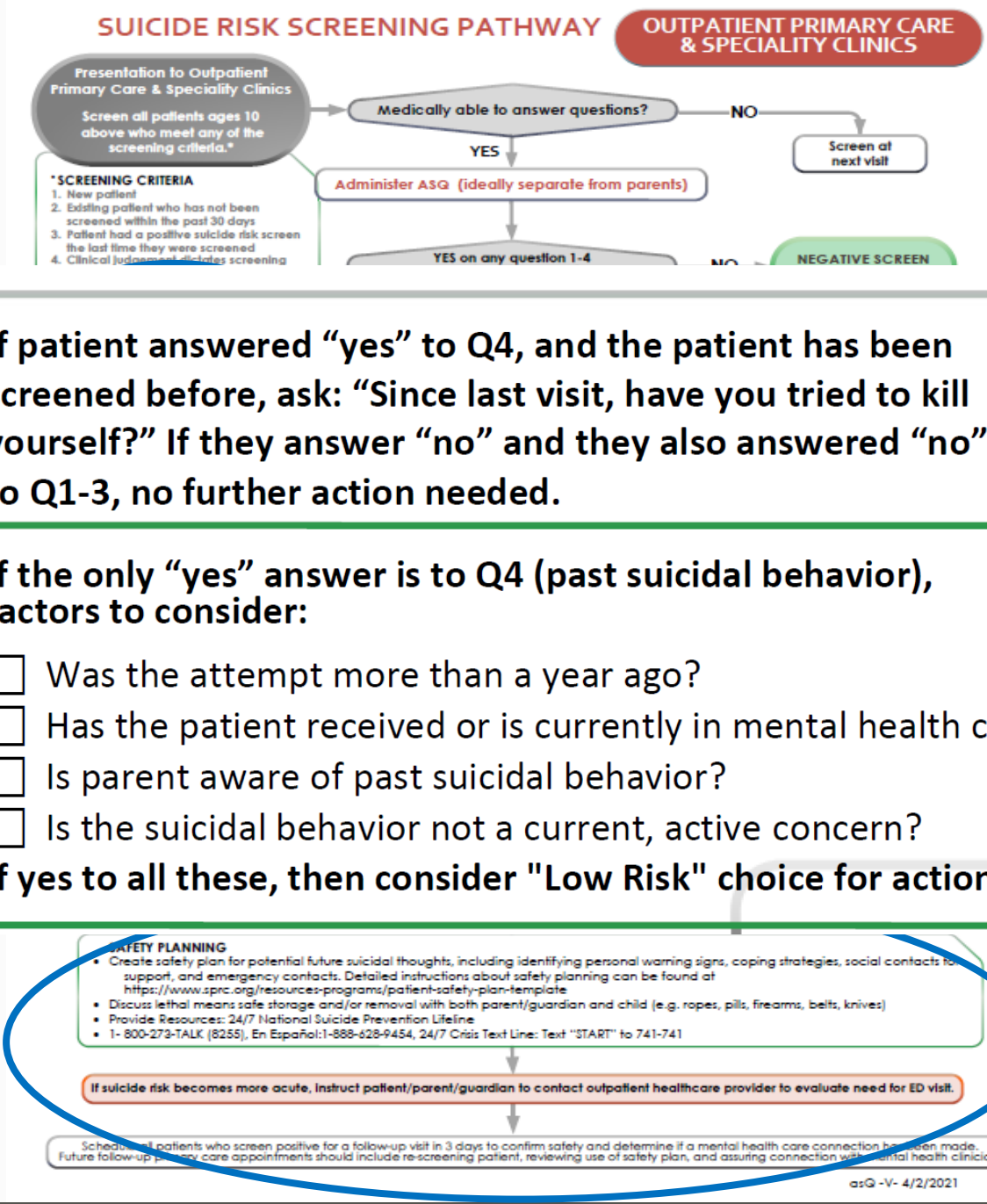
Universal Suicide Risk Screening Clinical Pathway

Clinical Pathway - Three-tiered system



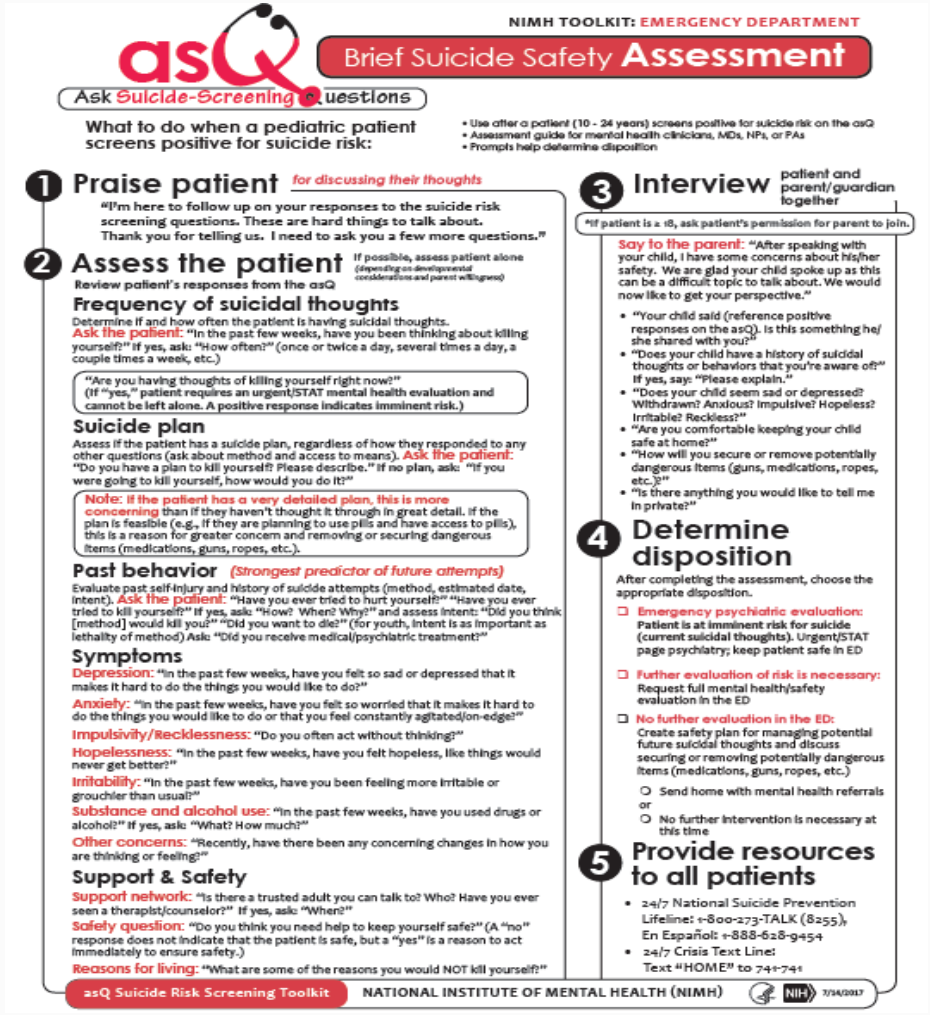


Brahmbhatt et al, 2018


SUICIDE RISK SCREENING PATHWAY
OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS
Presentation to Outpatient Primary Care & Speciality Clinics
Screen all patients ages 10 above who meet any of the screening criteria.*
*SCREENING CRITERIA
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
Medically able to answer questions?
NO
Screen at next visit
YES
Administer ASQ (ideally separate from parents)
YES on any question 1-4
NO
NEGATIVE SCREEN
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.
SAFETY PLANNING
Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
Provide Resources: 24/7 National Suicide Prevention Lifeline
1- 800-273-TALK (8255), En Español:1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made.
Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ -V- 4/2/2021

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

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.)

"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? Please describe." 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 *(Strongest predictor of future attempts)*

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?"

Symptoms

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?"

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?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Support & Safety

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask: "When?"

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.)

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

3 Interview patient and parent/guardian together

*If patient is a 18, ask patient's permission for parent 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 behaviors that you're aware of?" If yes, say: "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

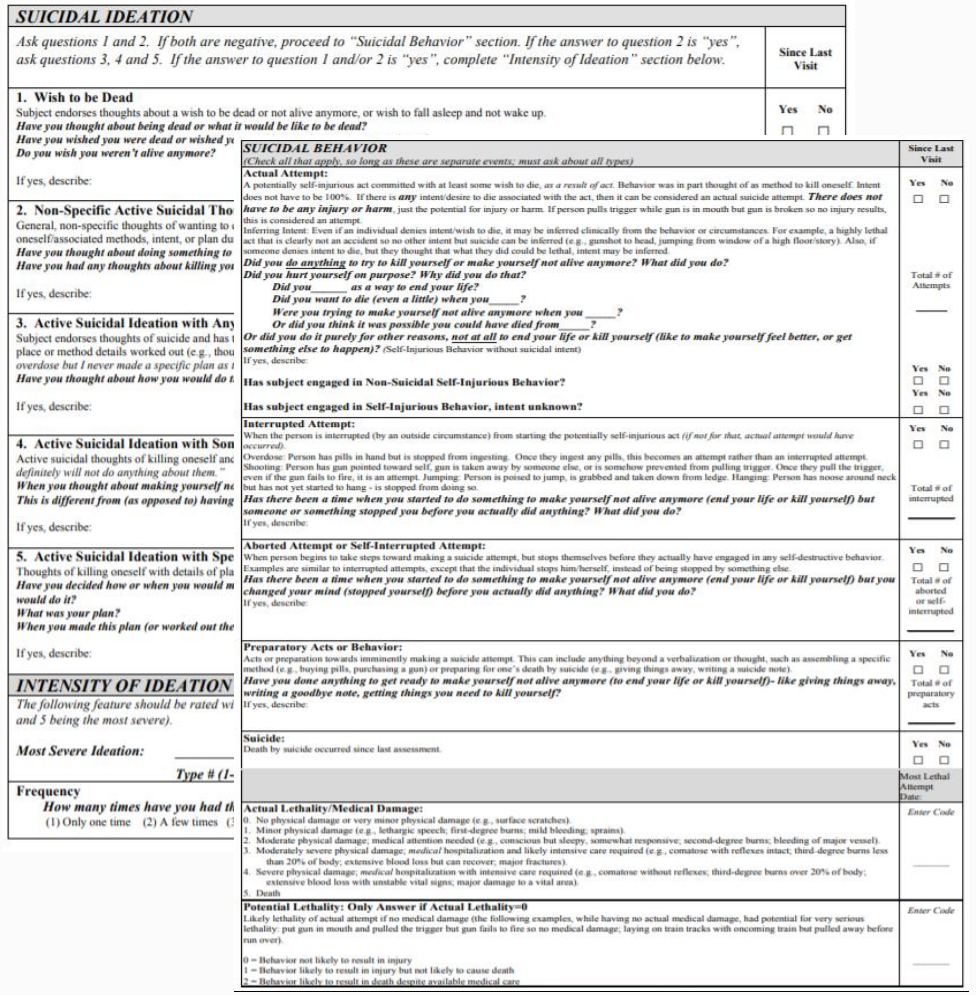
- ☐ Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry; keep patient safe in ED
- ☐ Further evaluation of risk is necessary: Request full mental health/safety evaluation in the ED
- ☐ No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)
  - ○ Send home with mental health referrals or
  - ○ No further intervention is necessary at this time

5 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

C-SSRS



SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead Yes No

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead?

Have you wished you were dead or wished y

Do you wish you weren't alive anymore?

If yes, describe:

2. Non-Specific Active Suicidal Tho

General, non-specific thoughts of wanting to

oneself/associated methods, intent, or plan du

Have you thought about doing something to

Have you had any thoughts about killing you

If yes, describe:

3. Active Suicidal Ideation with Any

Subject endorses thoughts of suicide and has t

place or method details worked out (e.g., thou

overdose but I never made a specific plan as t

Have you thought about how you would do t

If yes, describe:

4. Active Suicidal Ideation with Son

Active suicidal thoughts of killing oneself and

definitely will not do anything about them."

When you thought about making yourself n

This is different from (as opposed to) having

If yes, describe:

5. Active Suicidal Ideation with Spe

Thoughts of killing oneself with details of pla

Have you decided how or when you would m

would do it?

What was your plan?

When you made this plan (or worked out the

If yes, describe:

INTENSITY OF IDEATION

The following feature should be rated wi

and 5 being the most severe).

Most Severe Ideation: _____

Type # (1-

Frequency

How many times have you had th

(1) Only one time (2) A few times (3

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*

Since Last Visit

Actual Attempt: Yes No

A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?

Did you hurt yourself on purpose? Why did you do that?

Did you_____ as a way to end your life?

Did you want to die (even a little) when you_____?

Were you trying to make yourself not alive anymore when you _____?

Or did you think it was possible you could have died from_____?

Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

If yes, describe:

Total # of Attempts _____

Has subject engaged in Non-Suicidal Self-Injurious Behavior? Yes No

Has subject engaged in Self-Injurious Behavior, intent unknown? Yes No

Interrupted Attempt: Yes No

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).*

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Total # of interrupted _____

Aborted Attempt or Self-Interrupted Attempt: Yes No

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Total # of aborted or self-interrupted _____

Preparatory Acts or Behavior: Yes No

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

If yes, describe:

Total # of preparatory acts _____

Suicide: Yes No

Death by suicide occurred since last assessment.

Most Lethal Attempt Date:

Actual Lethality/Medical Damage: Enter Code

0. No physical damage or very minor physical damage (e.g., surface scratches).
1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

Potential Lethality: Only Answer if Actual Lethality=0 Enter Code

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

SPRC

Brief Suicide Safety Assessment

asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: OUTPATIENT

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."

2 Assess the patient *(If possible, assess patient alone depending on developmental considerations and parent willingness.)*

(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.

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 | 6/9/2017

NIMH TOOLKIT: OUTPATIENT

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).
- "Have you noticed changes in your child's:
  - Sleeping pattern?"
  - Appetite?"
- "Does your child use drugs or alcohol?"

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

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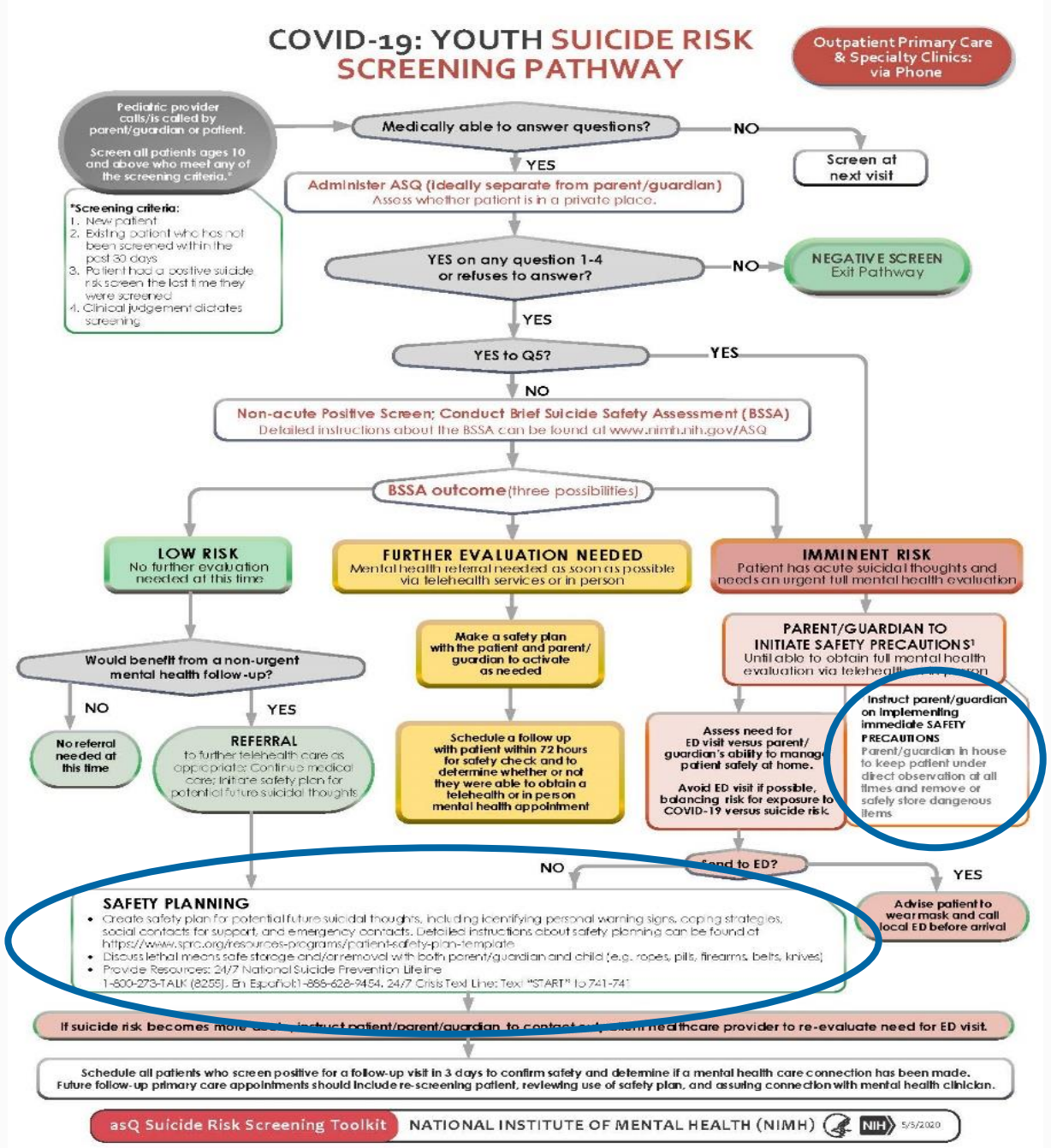
SPRC

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.**

SPRC


COVID-19: YOUTH SUICIDE RISK SCREENING PATHWAY
Outpatient Primary Care & Specialty Clinics: via Phone
Pediatric provider calls/is called by parent/guardian or patient.
Screen all patients ages 10 and above who meet any of the screening criteria.*
*Screening criteria:
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
Medically able to answer questions?
NO
Screen at next visit
YES
Administer ASQ (ideally separate from parent/guardian)
Assess whether patient is in a private place.
YES on any question 1-4 or refuses to answer?
NO
NEGATIVE SCREEN
Exit Pathway
YES
YES to Q5?
YES
NO
Non-acute Positive Screen; Conduct Brief Suicide Safety Assessment (BSSA)
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ
BSSA outcome (three possibilities)
LOW RISK
No further evaluation needed at this time
FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible via telehealth services or in person
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further telehealth care as appropriate; Continue medical care; Initiate safety plan for potential future suicidal thoughts
Make a safety plan with the patient and parent/guardian to activate as needed
Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a telehealth or in person mental health appointment
PARENT/GUARDIAN TO INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation via telehealth
Assess need for ED visit versus parent/guardian's ability to manage patient safety at home.
Avoid ED visit if possible, balancing risk for exposure to COVID-19 versus suicide risk.
Instruct parent/guardian on implementing immediate SAFETY PRECAUTIONS
Parent/guardian in house to keep patient under direct observation at all times and remove or safely store dangerous items
Send to ED?
NO
YES
Advise patient to wear mask and call local ED before arrival
SAFETY PLANNING
Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
Provide Resources: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255). En Español:1-888-628-9454. 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact patient healthcare provider to re-evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made.
Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ Suicide Risk Screening Toolkit
NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
NIH
5/5/2020

NIMH, 2020

Safety Planning

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

Stanley & Brown, 2012

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)

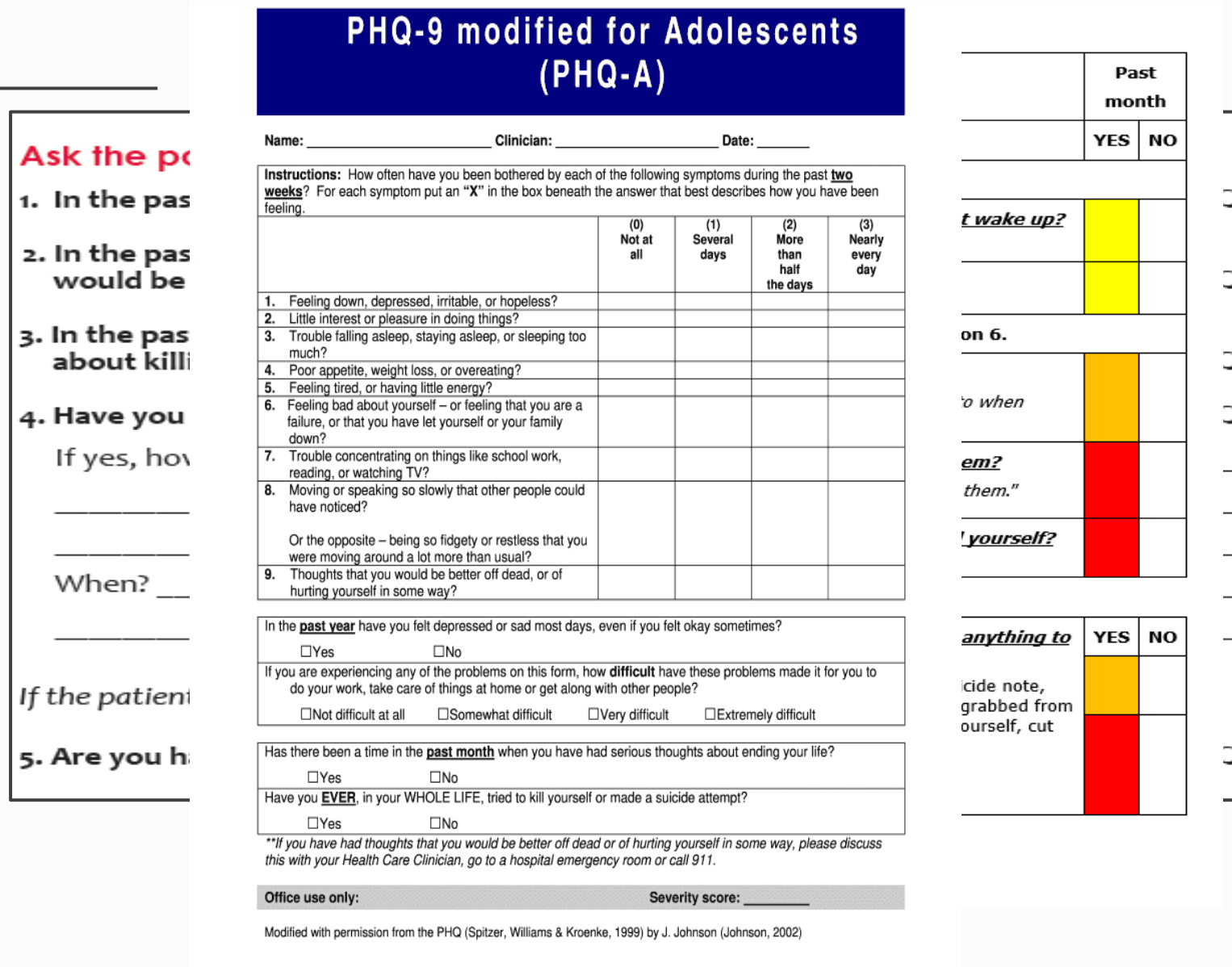
Step 6: Making the environment safe:

1. _____
2. _____

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



Ask the pa

1. In the pas
2. In the pas would be
3. In the pas about killi
4. Have you

If yes, hov

_____

_____

When? ___

_____

If the patient

5. Are you h

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)

	Past month	
	YES	NO
t wake up?		
on 6.		
o when		
em?		
them."		
yourself?		

anything to	YES	NO
icide note, grabbed from ourself, cut		

No

No

No

No

No

SPRC

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!

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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.

SPRC

Using the chat: Share one key takeaway from the presentation.

Presenter

Virna Little, PsyD, LCSW-r, CCM

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

now matters now

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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

Joint Commission Sentinel Event Alert 56

Sentinel Event Alert

EMBARGOED UNTIL FEB. 24

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The Joint Commission

www.jointcommission.org

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[8] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

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

R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018
UPDATED Nov. 20, 2019

Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) were applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. Effective July 1, 2020, these requirements also will be applicable to Joint Commission-accredited critical access hospitals. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission held five technical expert panel meetings between June 2017 and March 2018. The results of the first four meetings were published in the November 2017, January 2018, and February 2018 editions of *The Joint Commission Perspectives*.

The revisions for the critical access hospital (CAH) accreditation program only have been posted on the Prepublication Standards page of The Joint Commission website and will be available online until the end of June 2020. The new and revised EPs also will be published online in the spring 2020 E-dition update of the CAH accreditation program, and in print in the 2020 Update 1 to the *Comprehensive Accreditation Manual* for the CAH accreditation program. After July 1, 2020, please access the new requirement in the E-dition or standards manual.

National Patient Safety Goal

NPSG.15.01.01: Reduce the risk for suicide.

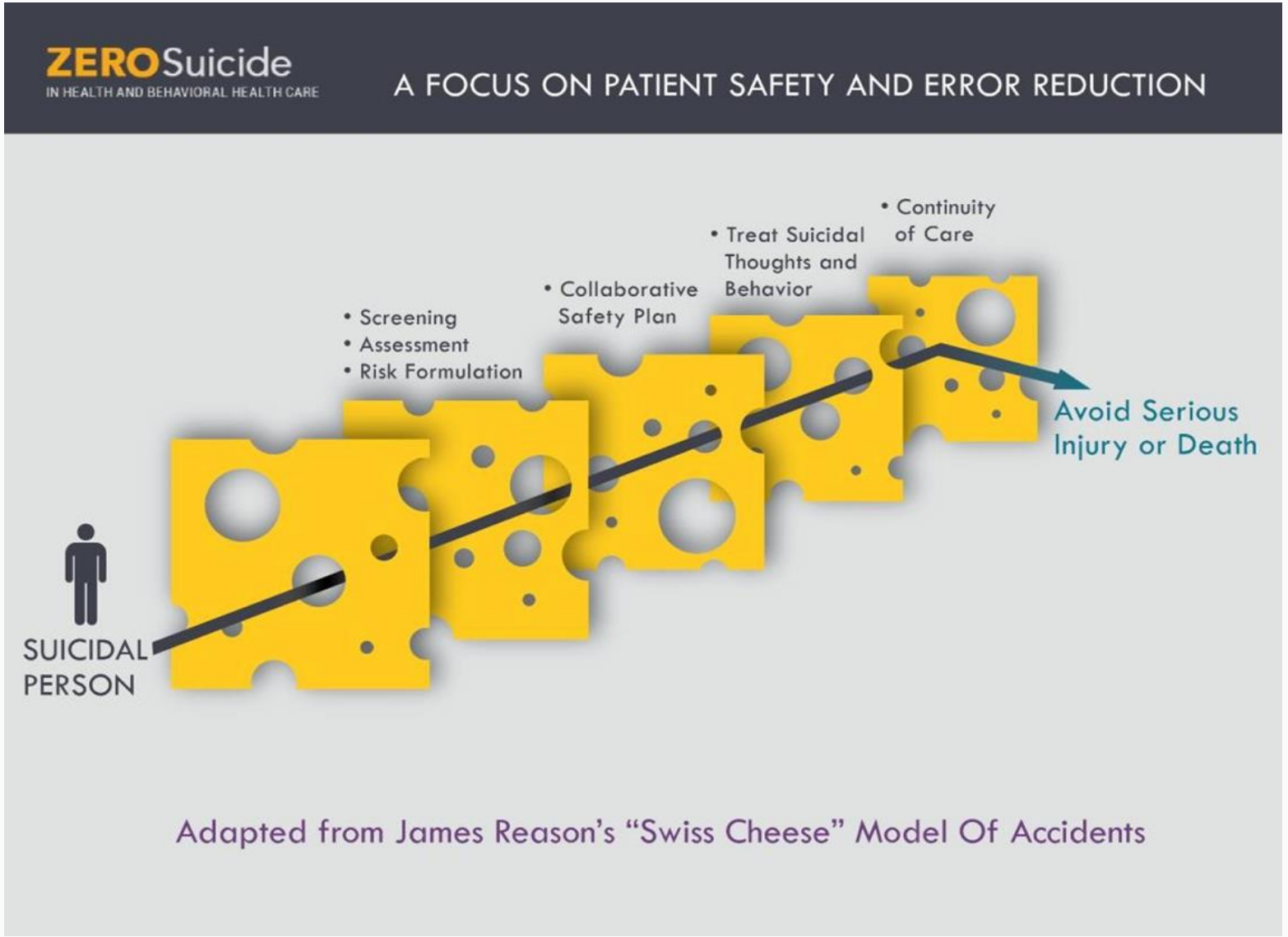
HAP Note: EPs 2-7 apply to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3-7 apply to all patients who express suicidal ideation during the course of care.

CAH Note: EPs 2-7 apply to patients in psychiatric distinct part units in critical access hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care in critical access hospitals. In addition, EPs 3-7 apply to all patients who express suicidal ideation during the course of care.

The Joint Commission

- 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



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)

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?				
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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?

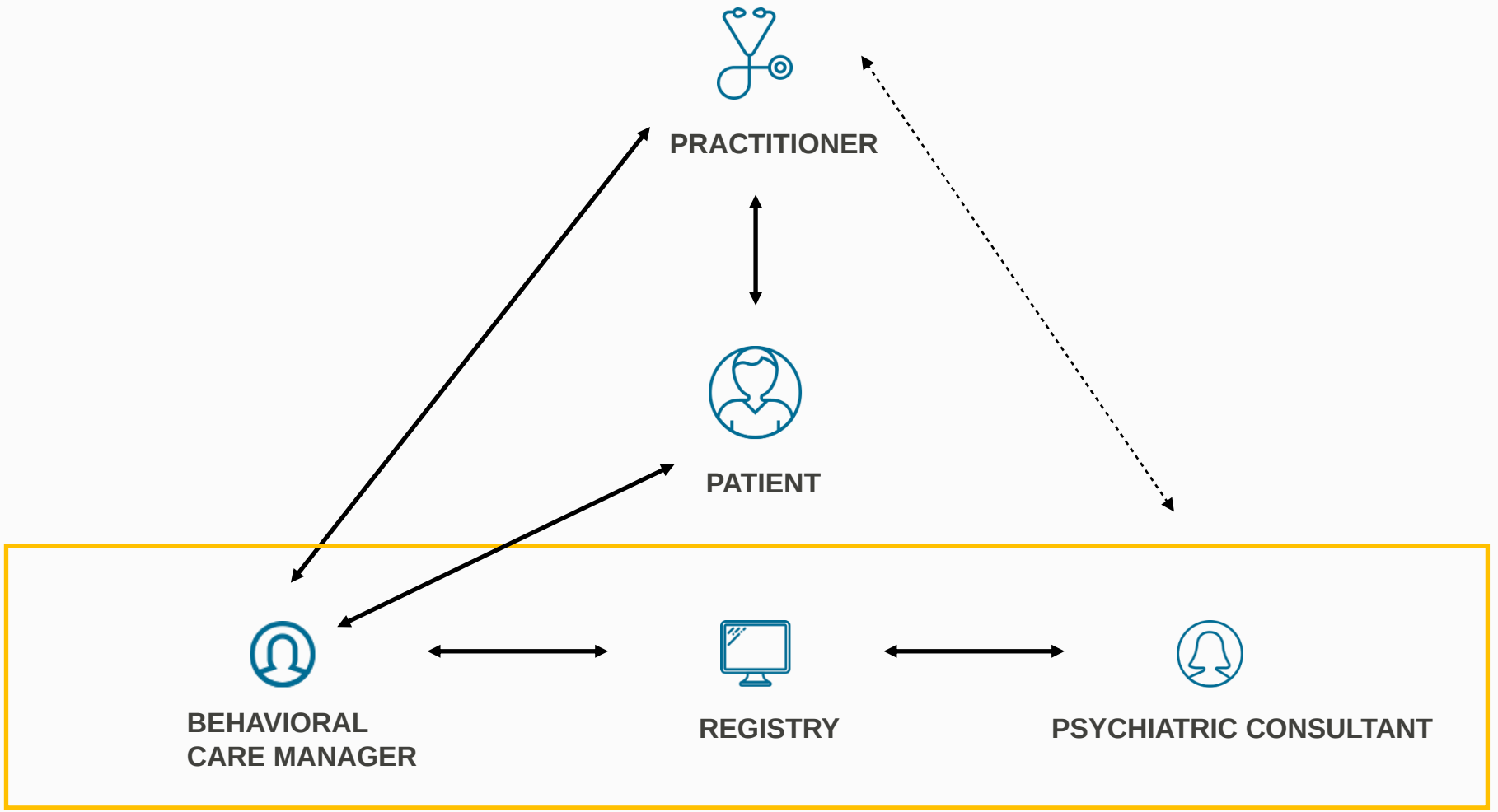
☐Yes ☐No

***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.

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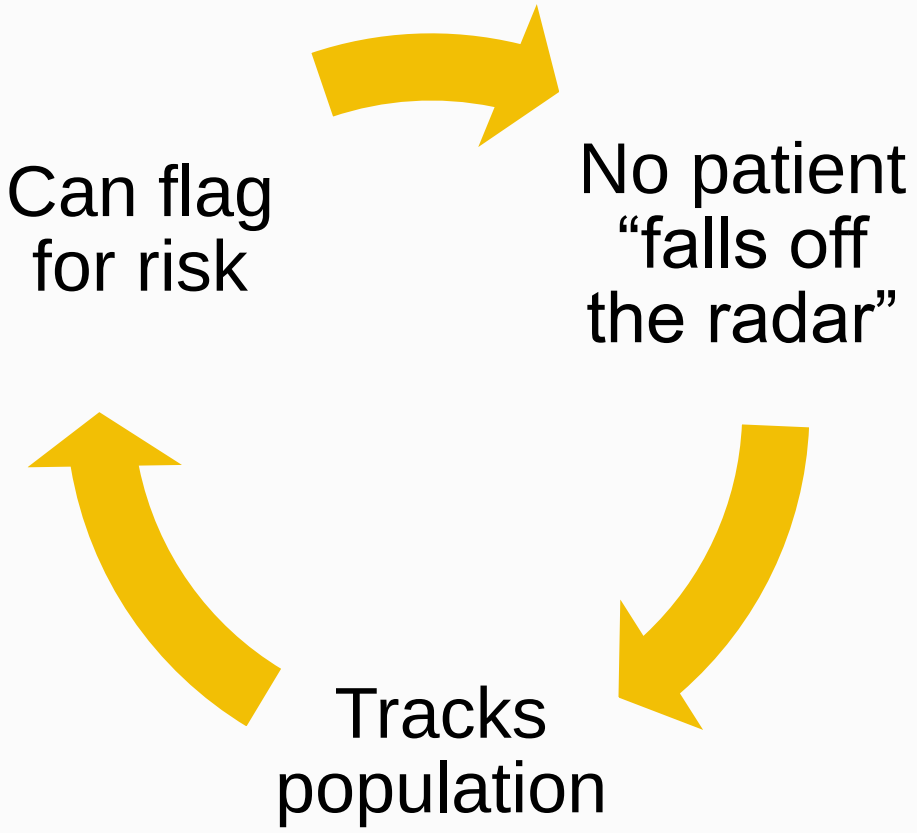
Registry is Required



Appropriate Levels of Care

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

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Using the chat: Share one key takeaway from the presentation.


Questions?

ZERO SUICIDE

FOR MORE INFO

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

Join the Zero Suicide listserv at go.edc.org/ZSListserv

EDC Education Development Center

How To Claim Credit

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

1. Attend the virtual event.
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3. Select the CLAIM CREDITS tab.
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5. Click the CLAIM button.

Claimed certificates are accessible in My Courses > My Completed Activities

Suicide Prevention Resource Center

Thank you!

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