Preventing suicide through universal SBHC screening safety plans and lethal means reduction

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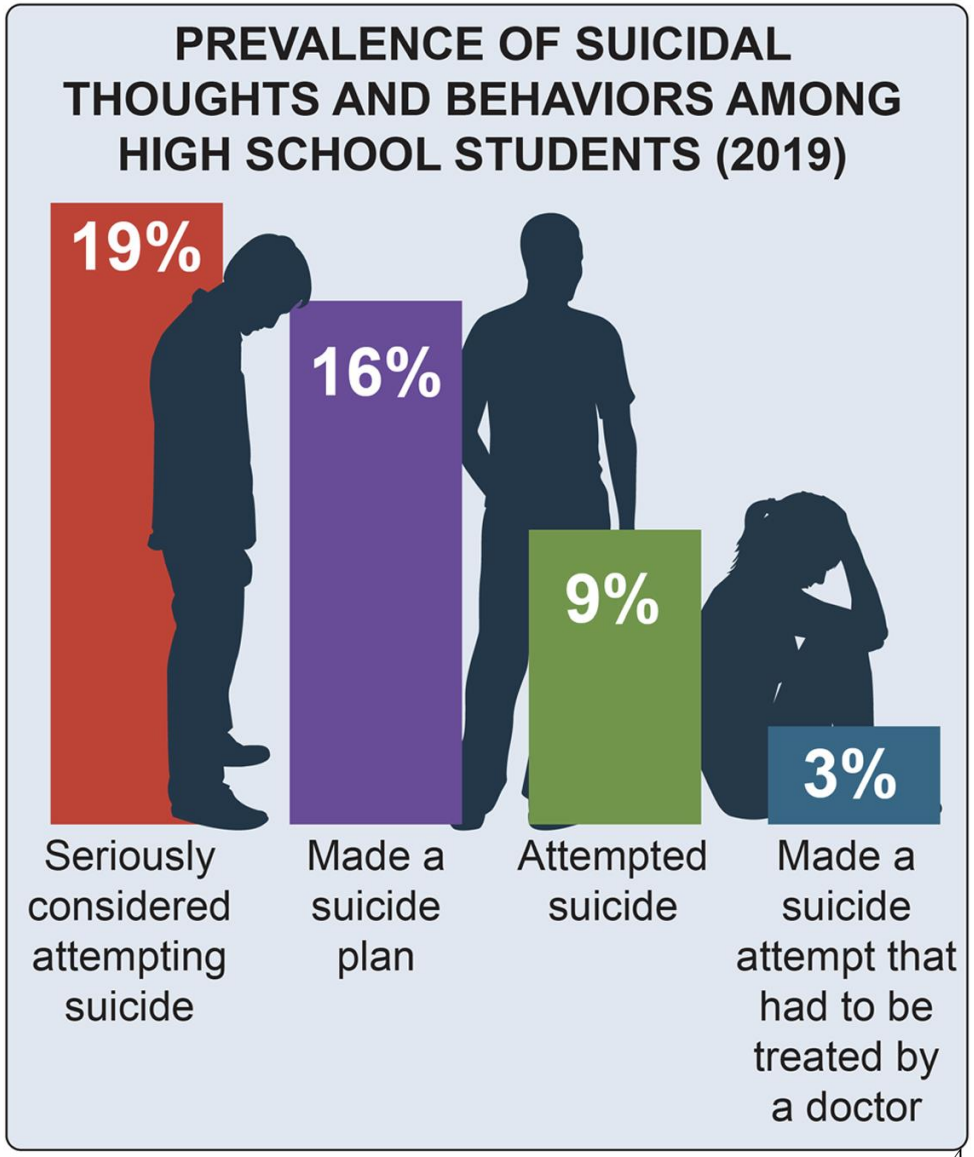
Disclosures

- There are no relevant (direct or indirect) financial relationship or conflicts of interest between the authors and any for-profit company.
- We are obligated to disclose any products which are off-label, unlabeled, experimental, and/or under investigation (not FDA approved) and any limitations on the information that we present, such as data that are preliminary or that represent ongoing research, interim analyses, and/or unsupported opinion.

Objectives

1. Discuss rationale for screening every youth ages 10 and up for suicidality.
2. Evaluate their site's protocol for assessment of suicidality, safety planning and emergency care.
3. Name three elements of lethal means reduction counseling.

Rationale for Direct, Universal Screening of all Youth for Suicidal Thoughts and Behaviors

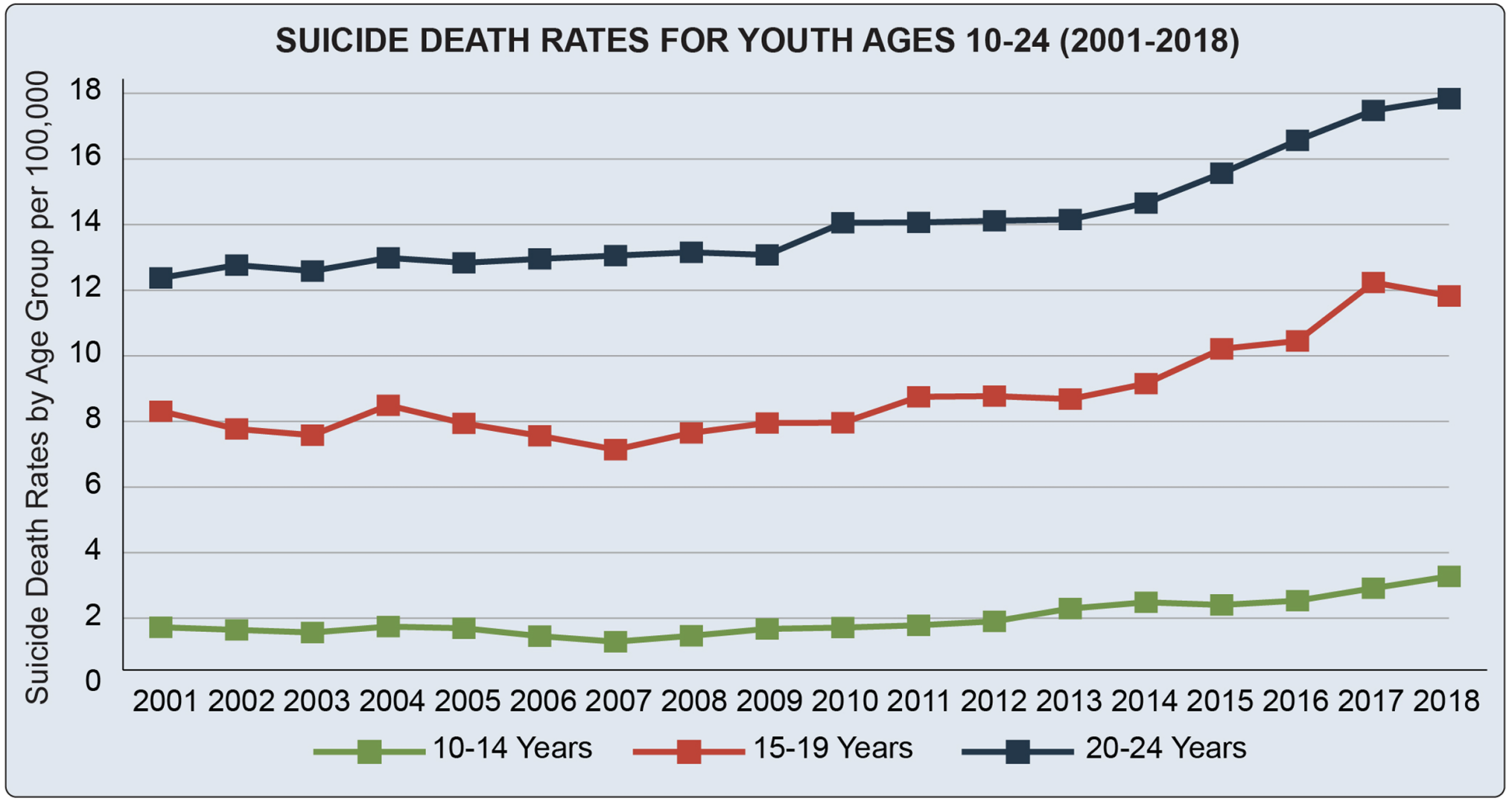


Source: 2019 United States Youth Risk Behavior Survey

Youth Suicide: An Overview

- 2nd leading cause of death in 10-to-24-year-olds
- 5th leading cause of death in 5-to-12-year-olds
  - More young people die by suicide than the top 17 leading medical causes of death combined.
  - Prevalence is higher in some subgroups – LGBTQ+ youth, racial and minoritized youth (e.g.., American Indian & Alaska Native youth, mixed)
- Suicidal Ideation, Non-Suicidal Self Injury, and Suicide Attempts are higher among youth than adults (SAMHSA, 2020)
  - 17% of HS students report SI in the past year
  - 7.4% of HS students reported SA

(CDC, 2020)



Source: CDC Web-based Injury Statistics Query and Reporting System (WISQARS)[1].

Overview: Estimates of Suicidal Thoughts & Behaviors

YOUTH RISK BEHAVIOR SURVEY DATA SUMMARY & TRENDS REPORT: 2009–2019

THE PERCENTAGE OF HIGH SCHOOL STUDENTS WHO:	2009 Total	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	Trend
Experienced persistent feelings of sadness or hopelessness	26.1	28.5	29.9	29.9	31.5	36.7	
Seriously considered attempting suicide	13.8	15.8	17.0	17.7	17.2	18.8	
Made a suicide plan	10.9	12.8	13.6	14.6	13.6	15.7	
Attempted suicide	6.3	7.8	8.0	8.6	7.4	8.9	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	1.9	2.4	2.7	2.8	2.4	2.5	

LEGEND  In wrong direction  No change  In right direction

Inequities in Youth Suicide

Youth with higher rates of suicidal ideation and behavior

- American Indian and Alaska Natives
- Black youth, especially < 10
- Lesbian, gay, bisexual, transgender, and queer or questioning youth
- Individuals with neurodevelopmental diversity
- Children in the foster care system
- Children with substance misuse

Table. Comparison of Suicide Rates Between US Black and White Youths by Age and Sex, 2001-2015

Age, y	Youth Suicides, No. (Rate per 1 Million Persons)		
	Black	White	IRR (95% CI)[a]
All			
5-9	26 (0.53)	45 (0.19)	2.73 (1.69-4.43)
10	47 (4.68)	79 (1.68)	2.79 (1.95-4.00)
11	101 (9.93)	190 (4.00)	2.48 (1.95-3.16)
12	129 (12.57)	471 (9.86)	1.28 (1.05-1.55)
13	167 (16.16)	979 (20.37)	0.79 (0.67-0.93)
14	194 (18.69)	1625 (33.65)	0.56 (0.48-0.64)
15	252 (24.25)	2496 (51.48)	0.47 (0.41-0.54)
16	317 (30.49)	3372 (69.20)	0.44 (0.39-0.49)
17	428 (41.13)	4084 (83.39)	0.49 (0.45-0.54)

Suicide rates for black youth ages 5-15 are greater than for white non-Latinx youth (Bridge et al., 2018)

Why were these inequities missed?

Norms for assessment based in white youth

- Traditionally higher rates
- Focus on Adolescents/Young Adults
- Black and brown children are less likely to be assessed for mental health problems than white children

Presentation of suicidality is different in young black youth

- Generally, did not have a pre-existing diagnosis, except ADHD
- Did not express suicidality before act in 71% of cases
- Family/peer relationship issues
- Died by suffocation or hanging

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Suicide rates for black youth ages 5-12 are greater than for white non-Latinx youth (Bridge et al., 2018)

Implicit Bias in Suicide Prevention

- Implicit biases & racialized ideologies are pervasive -
- People are often unaware of their implicit bias
- People rely upon racialized ideologies due to a number of factors (family, media, etc.)
- People differ in levels of implicit bias & use of relying on racialized ideologies.
- Implicit biases predict behavior

Slide from Terence Fitzgerald, PhD, EdM, MSW & Naomi Schapiro, PhD, CPNP-PC

Applying a JEDI lens to suicide prevention programs

JEDI = Justice, Equity, Diversity, Inclusion

- Disproportionate access to BH resources
- Disproportionate involvement in child protective, juvenile incarceration systems
- Provider bias – less likely to ask about depression, anxiety, trauma reactions, interpret externalizing behaviors as discipline/parenting issue vs. sign of mental health problem
- School-based prevention programs set within schools that apply harsher discipline to black and brown students
- Dialectical BT considered evidence-based prevention, but tested primarily in white children

Slide from Terence Fitzgerald, PhD, EdM, MSW & Naomi Schapiro, PhD, CPNP-PC

Blueprint for Youth Suicide Prevention

2021, AAP & AFSP & NIMH declare national emergency to advance youth suicide prevention, partnerships included

NIH National Institute of Mental Health

American Foundation for Suicide Prevention

American Academy of Child & Adolescent Psychiatry
WWW.AACAP.ORG

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

Blueprint for Youth Suicide Prevention
March 2022

- **Age Recommendations for Screening:**
- Youth ages 12+: Universal screening
- Youth ages 8-11: Screen when clinically indicated
- Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present

- **Universal Screening**
- Direct screen for suicidal thoughts and behaviors, whether or not
  - Signs or positive screens for depression or anxiety
  - On a regular schedule – at least yearly, some settings screen at every visit
- Youth with positive screens, should be assessed in your setting

NIH National Institute of Mental Health

American Foundation for Suicide Prevention

American Academy of Child & Adolescent Psychiatry
www.aacap.org

https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

Questions to ask before starting to screen

- Does your SBHC use a standardized tool to screen and assess for suicidal thoughts, behaviors, risk and protective factors?
- Do you have a written protocol in your setting that delineates roles of all staff in assessing and protecting a youth at risk for suicide?
- Does your protocol include names/numbers of school personnel and emergency mental health consults?
- Do you have a written protocol for interacting with emergency transport and sites where youth would be evaluated for admission?

Suicide Screening vs. Assessment

Screening

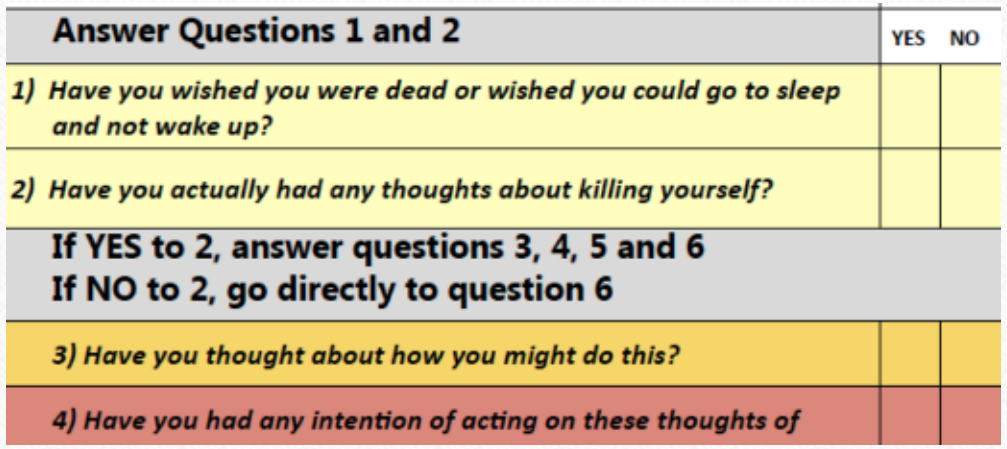
- Rapid
- Identifies if further assessment needed

Assessment

- Comprehensive evaluation
- Determines suicide risk
- Identifies risk & protective factors
- Includes collateral input

Youth Suicide Screening & Assessment Tools

DEPRESSION SCREEN	SUICIDE SCREENS	SUICIDE ASSESSMENTS
• <u>NOT</u> validated or sufficient for suicide • Can miss ~35% of suicidal ideation! • Example: PHQ-9 Adolescent	• ASQ Suicide Screening Questions (ASQ) for emergency room – *free* • Columbia Suicide Severity Rating Scale Primary Care (C-SSRS) – *free* ✓	**Anyone:** Columbia Suicide Severity Rating Scale & SAFE-T **Crisis Team Evaluation:** • Collaborative Assessment and Management of Suicidality (CAMS) • Linehan L-RAMP *Dialectical Behavior Therapy (DBT)* ✓

Screening	• Rapid • Identifies if further assessment needed	
Assessment	• Comprehensive evaluation • Determines suicide risk • Identifies risk & protective features • Includes collateral input	

Case study: Gary – 15-year-old cis-male

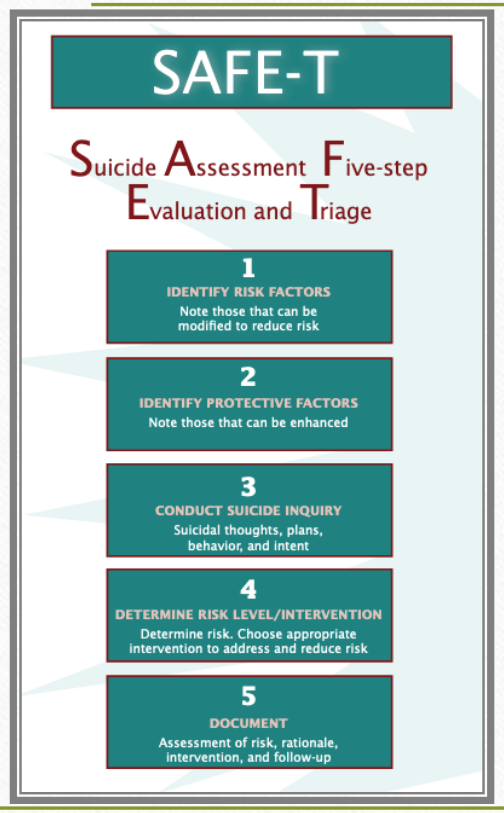
- Chief Complaint: Trouble sleeping.
- Over last 2 months, he has not been sleeping well, gaining weight, not attending school regularly, he spends most of his time playing video games and smoking marijuana.
- Gary has not been skateboarding with his friends in 1 month, used to skateboard almost daily with them.
- Gary's friend was shot and killed 6 months ago in drive by shooting.
- Gary's mom yelled at him this morning for skipping school
- Social history: lives with Mom and Dad and younger brother. Attends church occasionally.
- Family history: maternal history of depression
- Substance use: hx of binge drinking ETOH (last episode >1 yr ago), smokes marijuana daily
- Strengths: skateboards, was honor roll student

Physical Exam
PE: Skin: 3 new superficial cuts on inner wrist, otherwise unremarkable physical exam.
Mental Status Exam
affect & mood: restricted, "sad"
speech: slow, monotone
thought process: linear
thought content: feels like he wants to die, feels hopeless
no perceptual disturbances

SAFE-T Protocol with C-SSRS, Safety Planning and Telephone Follow-up - Gary

Step 1: Identify Risk Factors			
C-SSCS Suicidal Ideation Severity	**48 hr**	**Month**	**Lifetime (Worst)**
1) Wish to be dead *Have you wished you were dead or wished you could go to sleep and not wake up?*	yes	yes	
2) Current suicidal thoughts *Have you actually had any thoughts of killing yourself?*	yes	*yes*	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) *Have you been thinking about how you might kill yourself?*	yes	*yes*	
4) Suicidal Intent without Specific Plan *Have you had these thoughts and had some intention of acting on them?*	No	**NO**	
5) Intent with Plan *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*	No	*NO*	
C-SSRS Suicidal Behavior	**48 hr**	**3 Months**	**Lifetime**
6) Suicidal Behavior *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Yes**	**No**	**No**

BEYOND THE C-SSRS



1

Risk Factors

- Current and past psychiatric disorders
- Key symptoms
- Family history of suicide
- Precipitants, stressors, interpersonal
- Change in treatment
- Access to firearms

2

Protective Factors

- Internal
- External

3

Suicide Inquiry

- Ideation
- Plan
- Behavior
- Intent

4

Determine risk

- Low
- Moderate
- High
- Imminent

5

Document

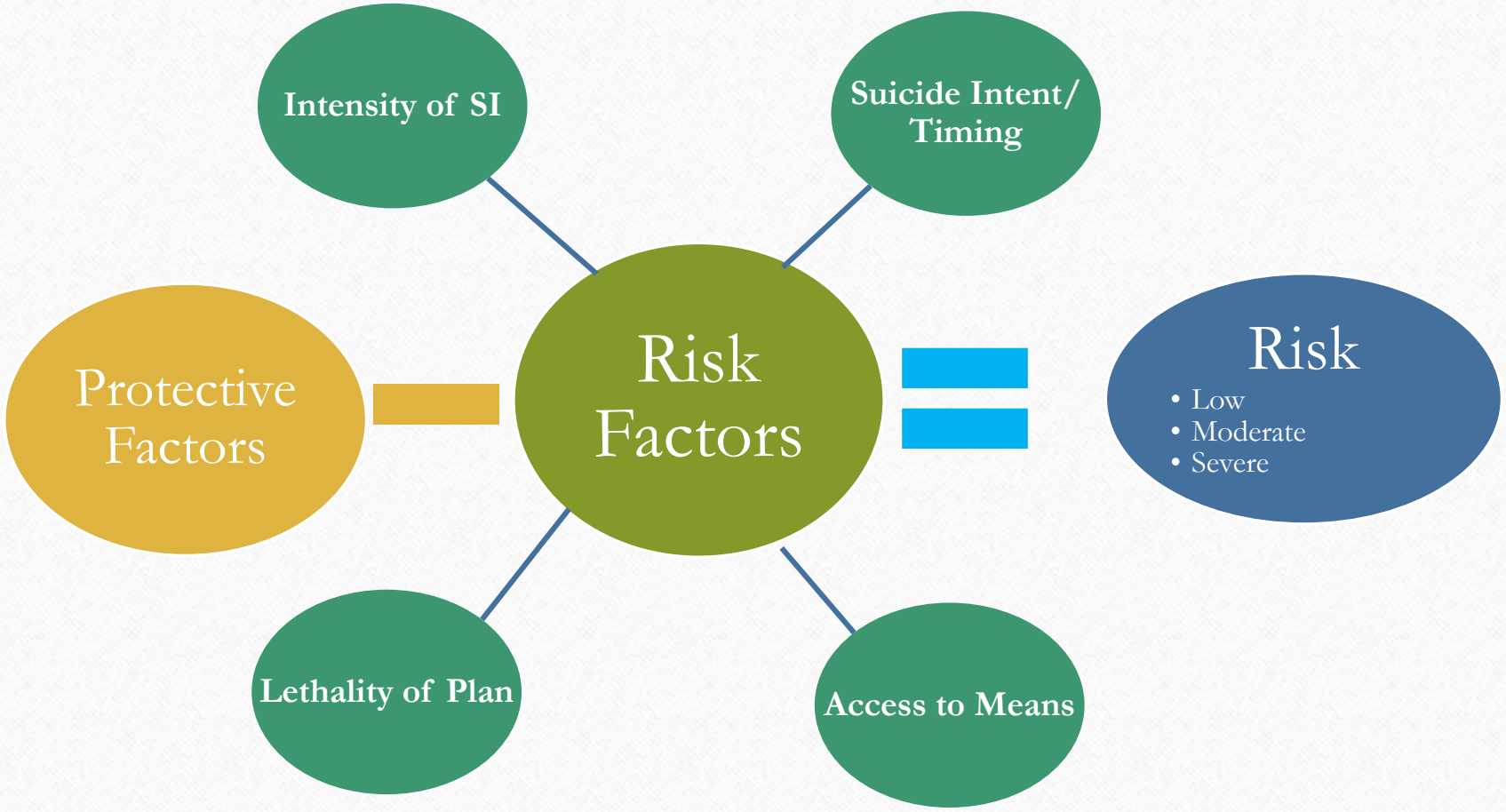
- Risk level and rational
- Treatment plan to address risk/problem
- Safety plan
- F/U
- Communication

Risk	Risk/Protective	Suicidality	Possible interventions
High	Psych dx –severe symptoms, acute stressor, protective factors not relevant	Potential lethal suicide attempt w/ strong intent or rehearsal	Psychiatric crisis procedure
Moderate	Multiple risk factors, few protective	Ideation w/ plan but no intent or behavior	Consider psych crisis, psych consult, safety plan
Low	Modifiable risk factors, strong protective	Thoughts of death, no plan, no intent /behavior	Safety plan, Outpatient referral, symptom reduction

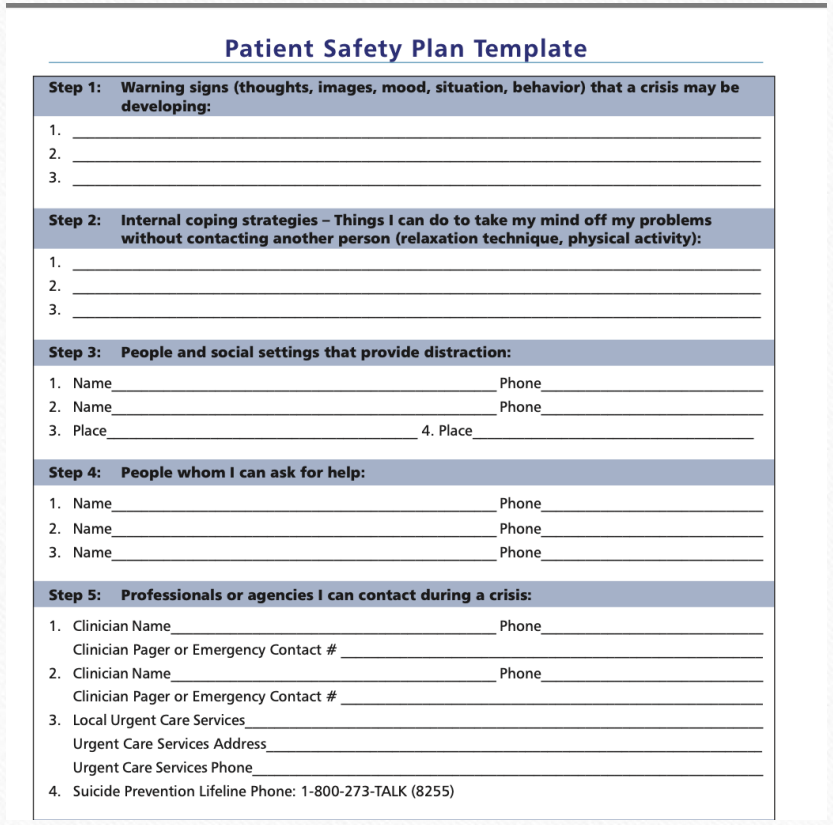
Revisiting Gary

What is your initial clinical risk assessment ?

Suicide Assessment



Safety Planning



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_____

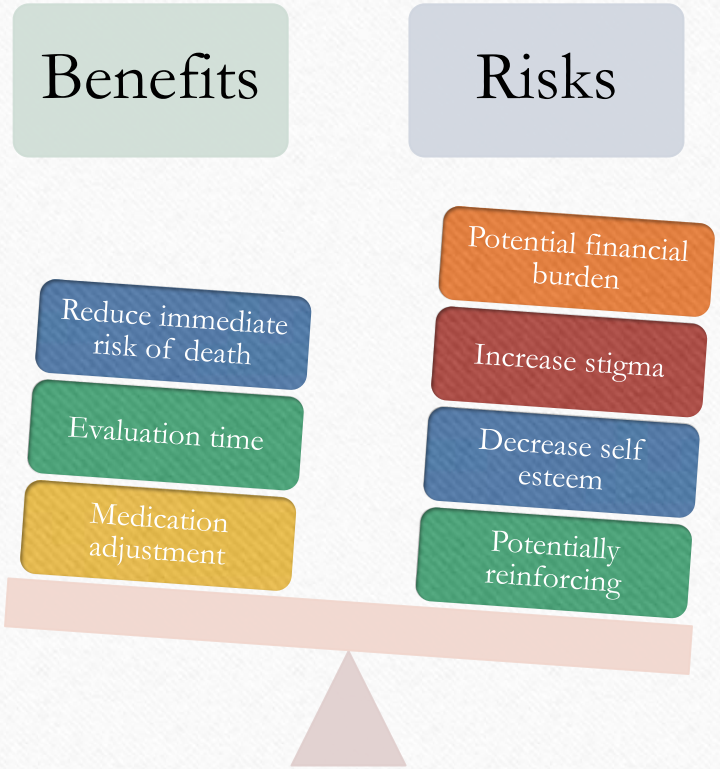
Step 5: Professionals or agencies I can contact during a crisis:

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)

- Warning signs/triggers
- Coping strategies
- Social supports
- Professional supports
- Means restriction –
  - Always ask about meds, weapons (guns).
  - Restriction focus on SI plan and past attempts.
- Follow-up plan
- Communication plan
- Ask for specific commitment (e.g. next visit)

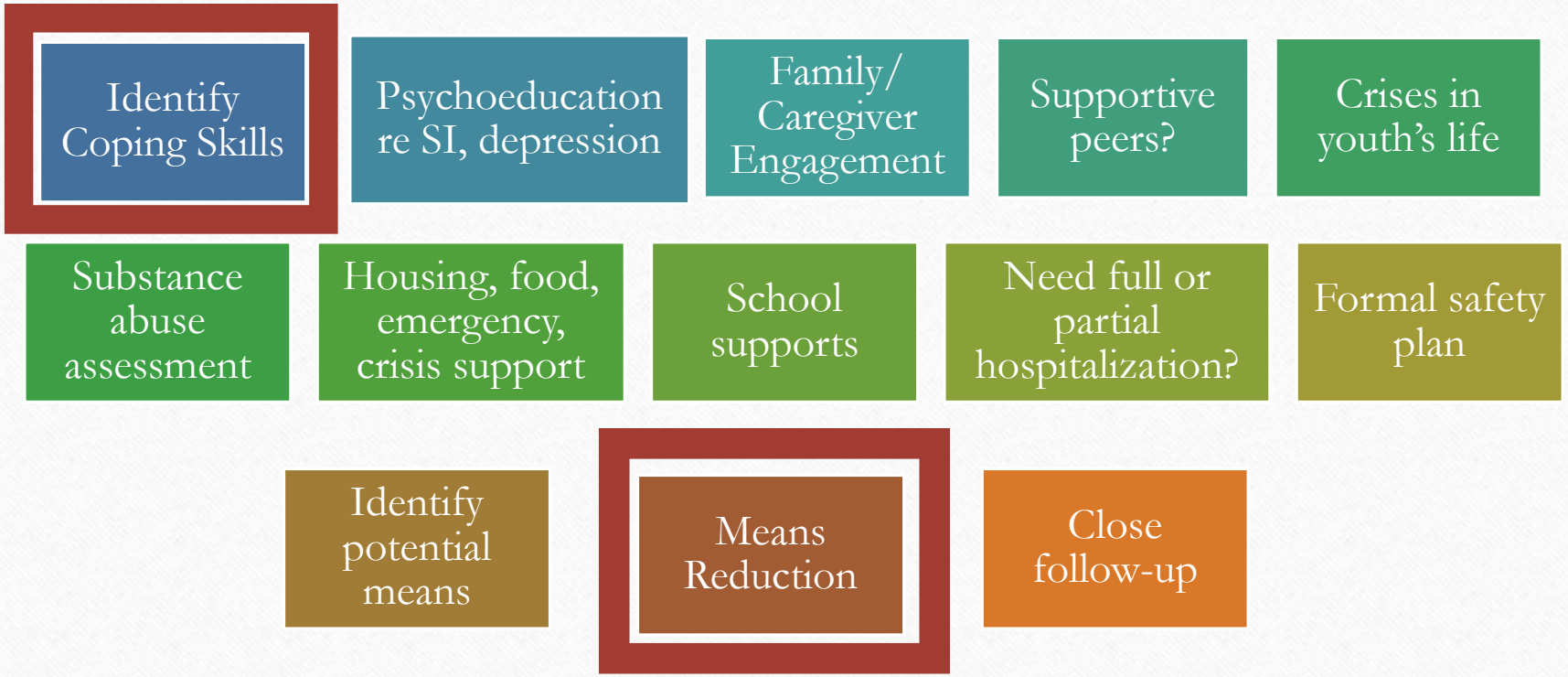
https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

Psychiatric Hospitalization: Benefits vs. Risks



- High lethality attempt or attempt with clear expectation of death
- Suicide risk outweighs risk of inappropriate hospitalization
- Limited capacity to follow through on crisis plan
- Insufficient available support system
- Inability to restrict access to lethal means
- Most likely to be beneficial in situations of high *acute* risk (less if high chronic risk)
- Hospital time can allow for thorough evaluation, medication adjustments, decrease future suicidal behaviors, especially if hospitalization aversive

Treatment Planning



Clinical Procedures for Psychiatric Crisis

Have a team approach reduces anxiety & ensures safety for all.

- Consultation support
- Patient monitoring
- Mobile crisis\police liaison
- Ambulance liaison
- Ongoing outpatient treatment – multiple approaches can work

Suicide Treatment: Outpatient Therapy

Suicidal behavior is often a maladaptive solution to a problem.

- Dialectical Behavior Therapy (DBT)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Family Intervention for Suicide Prevention/Safe Alternatives for Teens and Youths (SAFETY)
- Multi Systemic Therapy (MST)
- Cognitive Behavior Therapy for Suicide Prevention (CBT-SP)

Schools *can be a big part of…*

The Solution

- Accessible mental health services
- Trusted teachers/counselors
- Support for mental health issues
- Protection

OR

The Problem

- Site of racial/ethnic/gender/ sexuality discrimination
- Punishment for mental health issues
- Increased bullying

Schools and SBHCs should develop a crisis protocol for suicidal youth, train staff in response, assign roles

Connecting Schools & Clinics

Connect with mental health providers in your community & any county crisis providers to ensure/develop linkages & referral sources

In areas of mental health shortage:

- Primary care follow up visits
- School services
- Pediatric Mental Health Care Access Programs can support PCPs, including SBHC providers

Considerations with Students & Families

Confidentiality doesn't extend to youth with active suicidal ideation

- May need to have separate conversations with parents, youth to elicit feelings, information
- Frank, separate conversations about means reduction, increased supervision
  - Assess whether parents can keep youth safe, youth will tell parents if suicidal feelings increase
  - Safe Incorporation of other family members, peers into safety plans
- Provide parent support
  - Reinforce they are the experts in their children's lives
  - Through health systems
  - Organizations like NAMI
  - Help parents to be supportive

Considerations with Younger Children

Warning sides of suicide with younger children may include:

- Talking about wanting to die or wanting to kill oneself
- Actions such as grabbing their throat in a "choking" motion, or placing their hands in the shape of a gun pointed toward their head
- Engaging in self-harming behaviors
- Acting with impulsive aggression
- Giving away treasured toys or possessions

KNOW YOUR ABCs

- **Antecedent:**
  Identify where/when & triggers
- **Behavior:**
  What is behavior
- **Consequence:**
  Assess for any reinforcers

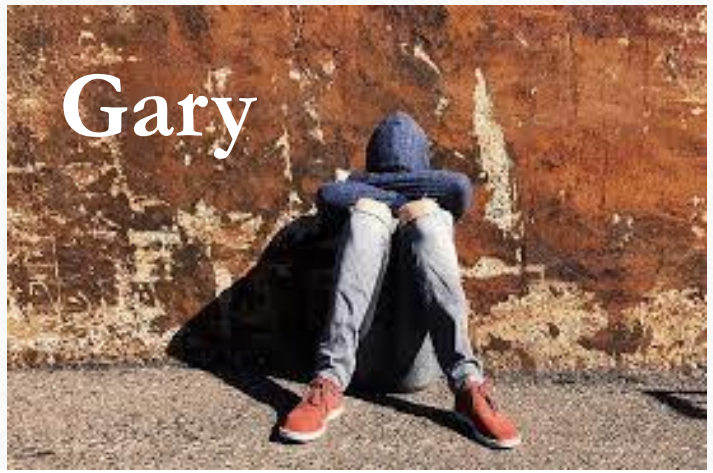
Lethal Means Reduction

Suicide attempts take place during a *short-term crisis*, so it is important to consider a person's access to lethal means during these periods of increased risk.

Access to lethal means is a risk factor for suicide.

Reducing access to lethal means saves lives.

Harvard T. H. Chan School of Public Health. (n.d.). Means matter website. Retrieved from http://www.hsph.harvard.edu/means-matter



With Clinical Assessment, what is Gary's Risk Level?

What is an initial Treatment Plan?

RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY/HOMICIDALITY	POSSIBLE INTERVENTIONS
High	Mental health disorder with severe symptoms, or acute precipitating event; protective factors not relevant.	Potentially lethal attempt or persistent ideation with strong intent or rehearsal.	Admission generally indicated unless a significant change reduces risk. Suicide/homicide precautions.
Moderate	Multiple risk factors, few protective factors.	Ideation with plan, but no intent or behavior.	Admission may be necessary depending on risk factors. Develop safety plan. Give emergency/crisis numbers.
Low	Modifiable risk factors, strong protective factors.	Ideation, but with no plan, intent or behavior.	Outpatient referral, symptom reduction. Develop safety plan. Give emergency/crisis numbers.

*** This chart is intended to represent a range of risk levels and interventions, not actual determinations.**

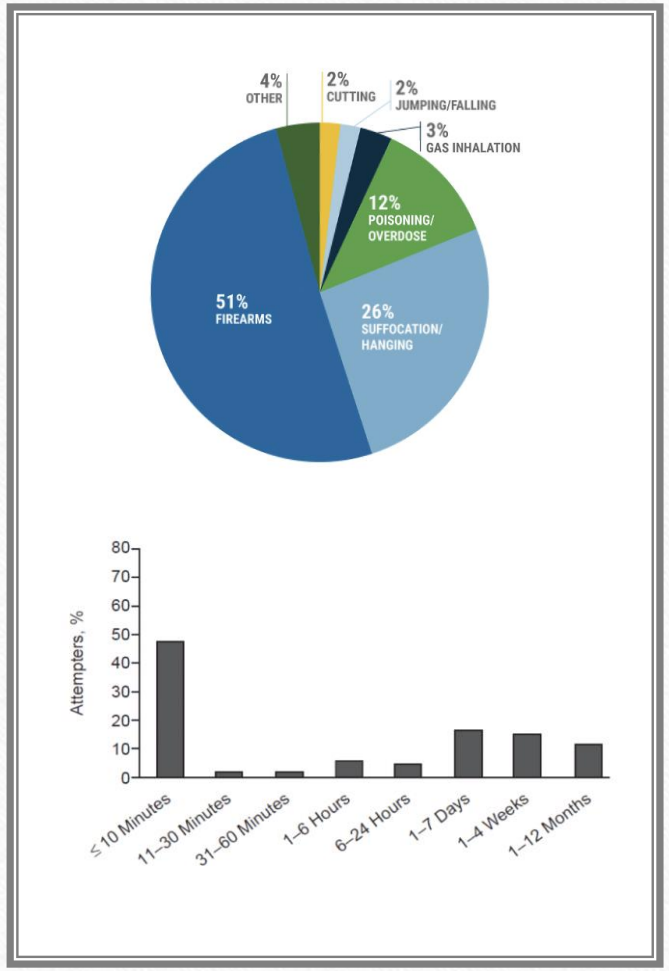
Gary Patient Scenario

XX Moderate Risk ☐ Suicidal ideation **WITHOUT plan, intent or behavior in past month** (C-SSRS screen #2 or #3) **Or** ☐ Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior) **Or** ☐ Multiple risk factors and few protective factors	**Refer to mental health professional to evaluate risk factors and determine appropriate treatment setting**	x Pharmacological treatment x☐ Psychotherapy (CBT, DBT) x☐ Psychoeducation (coping skills, stress management, symptom management, etc.) x☐ Engagement with family-member or significant-other x Safety Plan x Provide National Suicide Prevention Lifeline card and local emergency contacts

Treatment Plan for Reducing Risk Level:

☐

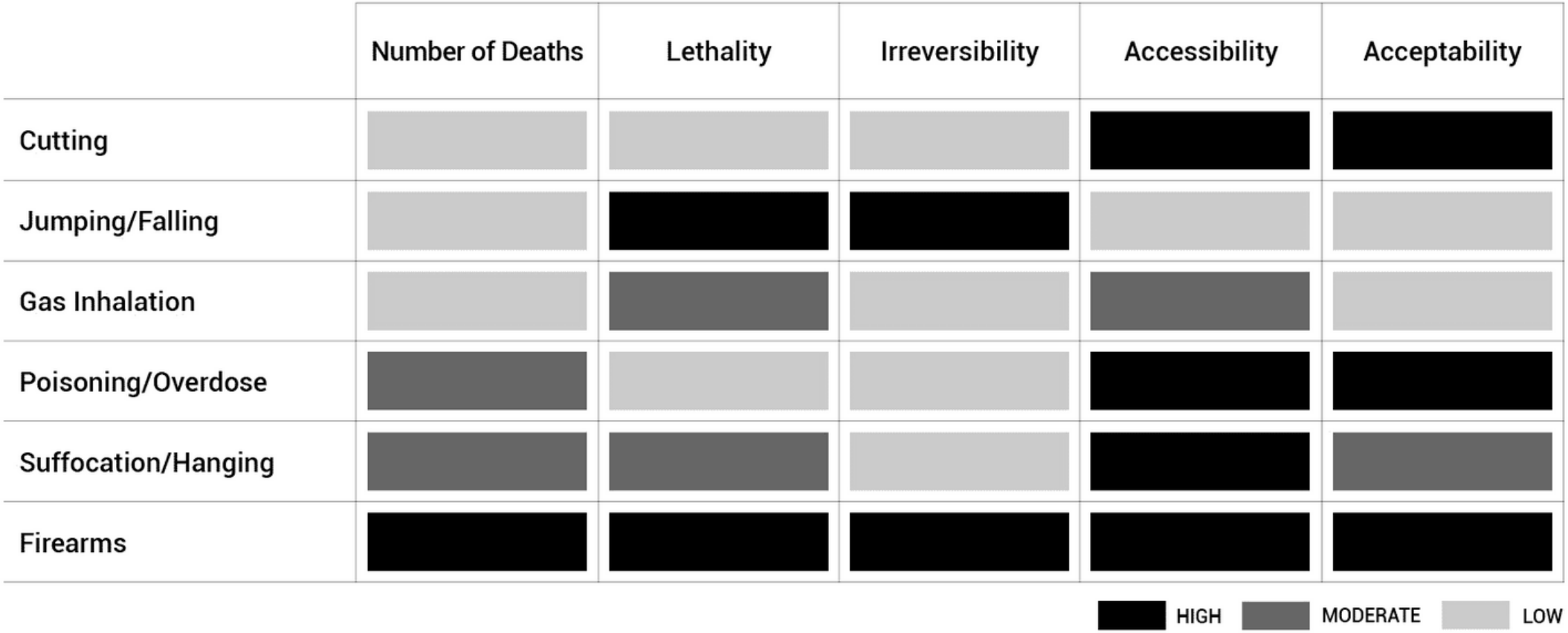
1- Consulted with behavioral health provider – David Jams, LCSW.
2- Completed safety plan with patient and then with family, means restriction discussed (removal of meds, sharps and gun safety-gun will be removed from home to another family members house.
3- Called access together and set up therapy for next week
4- Start Prozac 10 mg in morning for depression and SI. Return to clinic in 2 weeks, telephone check in next week. provided SSRI handout to parents , discussed risks/benefits and alternatives to SSRI medication treatment, obtained parental and patient consent for Prozac medication.
5- Provide family with psycho-education of suicide, depression and suicide prevention resources
6- Provided crisis phone numbers and on-call numbers



Why lethal means reduction?

- Many suicide attempts occur with little planning during a short-term crisis
- A **ten-minute delay** in access to means may be enough to deter a suicide attempt
- 90% of attempters who survive do NOT go on to die by suicide later
- Access to firearms is a risk factor for suicide – 1/3 of households in U.S. have firearms
- Firearms used in youth suicide usually belong to a parent
- Reducing access to lethal means saves lives

Summary


Number of Deaths
Lethality
Irreversibility
Accessibility
Acceptability
Cutting
Jumping/Falling
Gas Inhalation
Poisoning/Overdose
Suffocation/Hanging
Firearms
HIGH
MODERATE
LOW

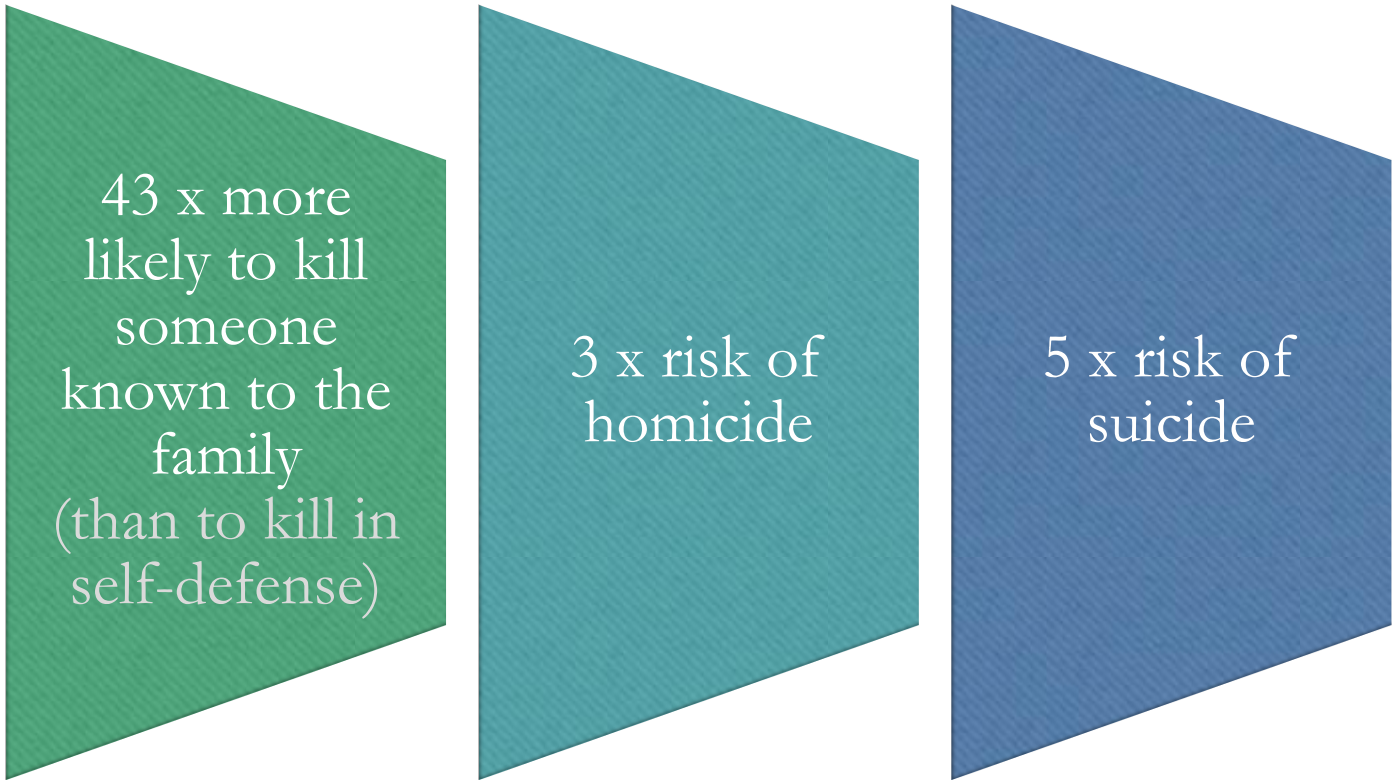
Who Can Benefit From Lethal Means Counseling?

- Anyone who expresses suicidal ideation
- Anyone who has attempted suicide or expressed suicidal ideation in the past
- Anyone with mental health and/or substance abuse issues, especially when struggling with a painful life crisis

Most effective when done BEFORE a crisis occurs.

Zero Suicide Institute - Counseling on Access to Lethal Means Course
AACAP Suicide Safety: Precautions at Home

Fast facts for use in firearm safety counseling



Surest way to prevent injury?

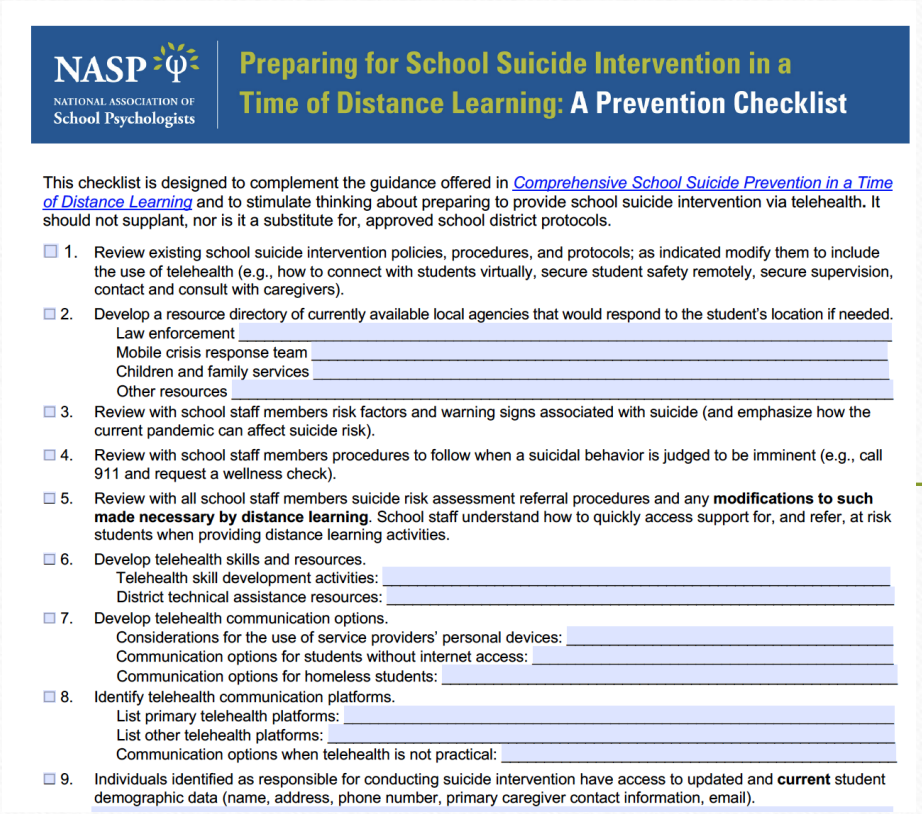
Remove guns from the home.

Counseling About Removing Access to Firearms for Suicidal Youth

- Use a client-centered approach WITH THE STAKEHOLDER (gun owner)
- Focus on safety for the suicidal youth
  - Most adolescents know where guns are stored in home and how to gain access
  - SAFEST way to protect youth = temporary removal from home
    - Options include with a friend/family member, at a local gun store, with law enforcement
  - SAFER to change and improve security of storage, disable gun in addition to storing ammunition separately
- Make a SPECIFIC plan: when, for how long, who will check

Counseling about Removing Access to Medications for Suicidal Youth

- Most common means of attempting suicide
- Important to prevent access to potentially lethal doses of drugs
  - Include opioids, giant-size containers of acetaminophen (Tylenol)
- Remove old medicines from house
- Use lock box teen cannot get into
- Consider storing necessary but potentially lethal medications outside of home



NASP NATIONAL ASSOCIATION OF School Psychologists

Preparing for School Suicide Intervention in a Time of Distance Learning: A Prevention Checklist

This checklist is designed to complement the guidance offered in *Comprehensive School Suicide Prevention in a Time of Distance Learning* and to stimulate thinking about preparing to provide school suicide intervention via telehealth. It should not supplant, nor is it a substitute for, approved school district protocols.

- ☐ 1. Review existing school suicide intervention policies, procedures, and protocols; as indicated modify them to include the use of telehealth (e.g., how to connect with students virtually, secure student safety remotely, secure supervision, contact and consult with caregivers).
- ☐ 2. Develop a resource directory of currently available local agencies that would respond to the student's location if needed.
  - Law enforcement _____
  - Mobile crisis response team _____
  - Children and family services _____
  - Other resources _____
- ☐ 3. Review with school staff members risk factors and warning signs associated with suicide (and emphasize how the current pandemic can affect suicide risk).
- ☐ 4. Review with school staff members procedures to follow when a suicidal behavior is judged to be imminent (e.g., call 911 and request a wellness check).
- ☐ 5. Review with all school staff members suicide risk assessment referral procedures and any **modifications to such made necessary by distance learning**. School staff understand how to quickly access support for, and refer, at risk students when providing distance learning activities.
- ☐ 6. Develop telehealth skills and resources.
  - Telehealth skill development activities: _____
  - District technical assistance resources: _____
- ☐ 7. Develop telehealth communication options.
  - Considerations for the use of service providers' personal devices: _____
  - Communication options for students without internet access: _____
  - Communication options for homeless students: _____
- ☐ 8. Identify telehealth communication platforms.
  - List primary telehealth platforms: _____
  - List other telehealth platforms: _____
  - Communication options when telehealth is not practical: _____
- ☐ 9. Individuals identified as responsible for conducting suicide intervention have access to updated and **current** student demographic data (name, address, phone number, primary caregiver contact information, email).

Evaluate your site's protocol for assessment of suicide, safety planning & emergency care

Connect with local mental health & crisis resources to develop linkage plans

https://www.nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center/crisis-and-mental-health-resources/preparing-for-virtual-school-suicide-assessment-checklist

Postvention: After a school suicide

- Incident reporting
- Grief process, Address stigma
- Postvention protocols
  - Contact with family-compassionate family contact reduces liability & facilitates healing
- Supports, Counseling
- Post-Traumatic growth

https://www.sprc.org/sites/default/files/resource-program/AfteraSuicideToolkitforSchools.pdf

School Shootings & Murder-Suicide

- Young people who engage in mass shootings intend to die in the event.
- Shooters often have a history of long-standing, undertreated trauma and psychiatric problems.
- Lack of consistent treatment, clinical guidelines, safety practices for youth with chronic, undertreated trauma and psychiatric problems
- Schools can be a location for treatment –for engagement and caring follow-up

On the horizon: 988 instead of 911

988 as the first nationwide number to offer 24/7 behavioral health crisis call services.

Scheduled to go live for the U.S. on July 16, 2022. Details regarding its implementation and logistics fall to each individual state.

Expected to receive >24 million calls, texts, and chat requests by 2027.

1.Reduce reliance on the police by linking Lifeline/988 centers with mobile crisis teams. Relieves emergency room boarding.

https://www.samhsa.gov/find-help/988

YOU CAN HELP END YOUTH SUICIDE.

Youth suicide is a national and global public health crisis exacerbated by the COVID-19 pandemic and an ongoing lack of access to pediatric behavioral health care. Pediatric clinicians can identify and intervene with youth at risk for suicide who might otherwise pass through the health care system. Pediatric clinicians also need greater knowledge of prevention strategies that limit access to the most common means of youth suicide, foster resilience in children and adolescents, and address health equity and social determinants of health that contribute to youth suicide.

Help end youth suicide today.

Learn more, donate and get involved: napnappartners.org

NAPNAP Partners for Vulnerable Youth (napnappartners.org) has launched a national awareness and education campaign called The Alliance to Prevent Youth Suicide (APYS). Through this campaign, we are educating healthcare providers across the country to identify, support and treat suicidal youth and to prevent these vulnerable youth from dying by suicide. Your support today will help fund our grassroots training efforts.

IF YOU THINK A CHILD OR ADOLESCENT IS SUICIDAL CALL:

1 (800) 273-5255

NATIONAL SUICIDE PREVENTION HOTLINE

PARTNERS FOR VULNERABLE YOUTH

National Association of Pediatric Nurse Practitioners

NAPNAP Partners for Vulnerable Youth

- Alliance to Prevent Youth Suicide
- Designing trainings for clinicians
- Working with other healthcare and policy partners

https://www.napnappartners.org/our-new-initiatives

Treatment Considerations

- Check yourself first – deep breaths!
- Ask suicide questions directly.
- Learn crisis protocols and local resources.
- Suicide is a significant, preventable pediatric health condition.
- Understanding risk factors, including bullying, mood disorders, substance abuse, and psychosis, is important in assessing risk.
- Careful risk documentation is critical.
- Work as a team – get consultation.

Thank you!

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Resources

- AAP BluePrint for Suicide Prevention
- Tips for AAP Chapters: Increasing Access to Behavioral Health Care via Telehealth by Partnering with Pediatric Mental Health Care Access Programs
- Zero Suicide Institute - Counseling on Access to Lethal Means Course
- AACAP Suicide Safety: Precautions at Home
- https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

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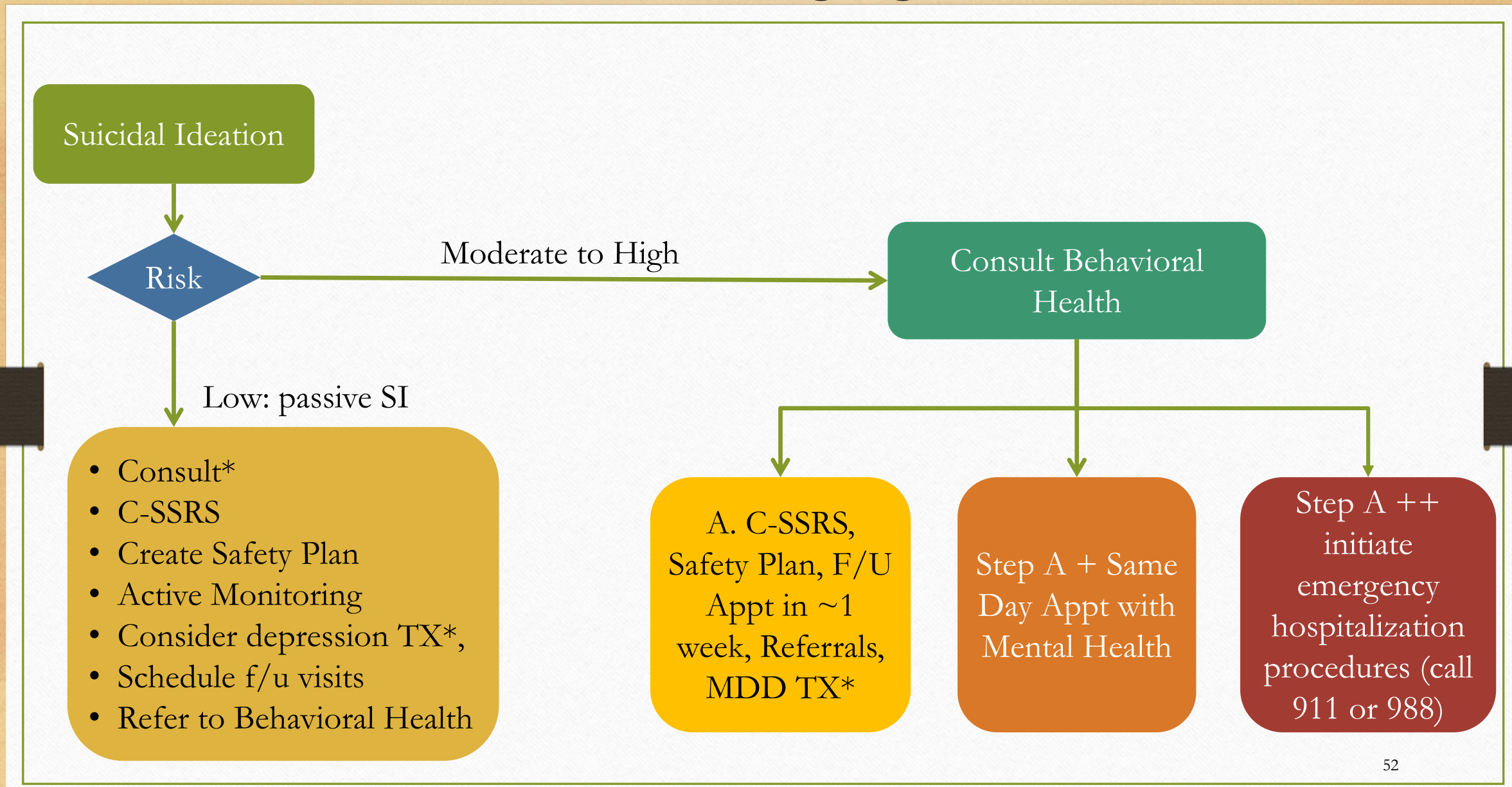
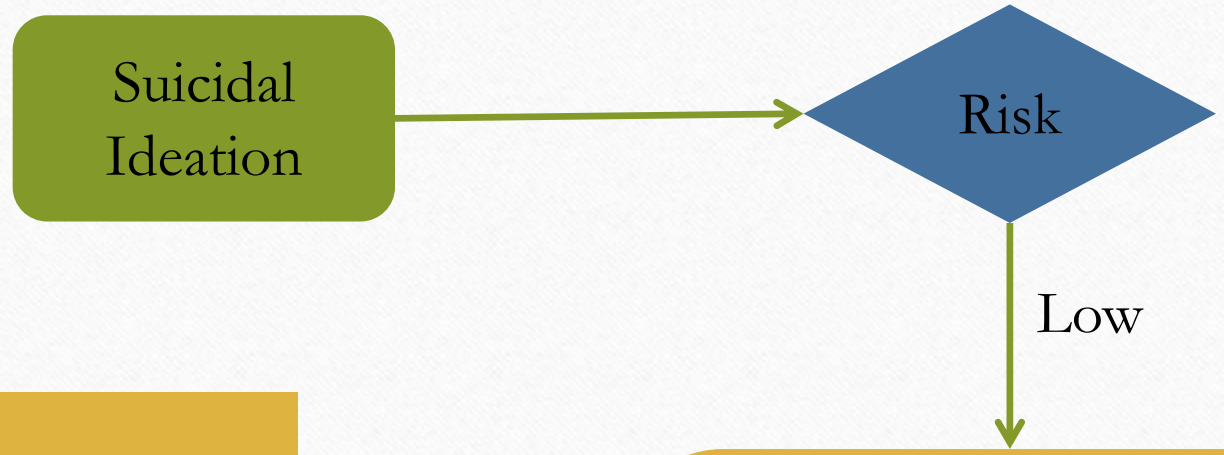
Suicide Screening Algorithm



Suicide Screening Algorithm: Low Risk

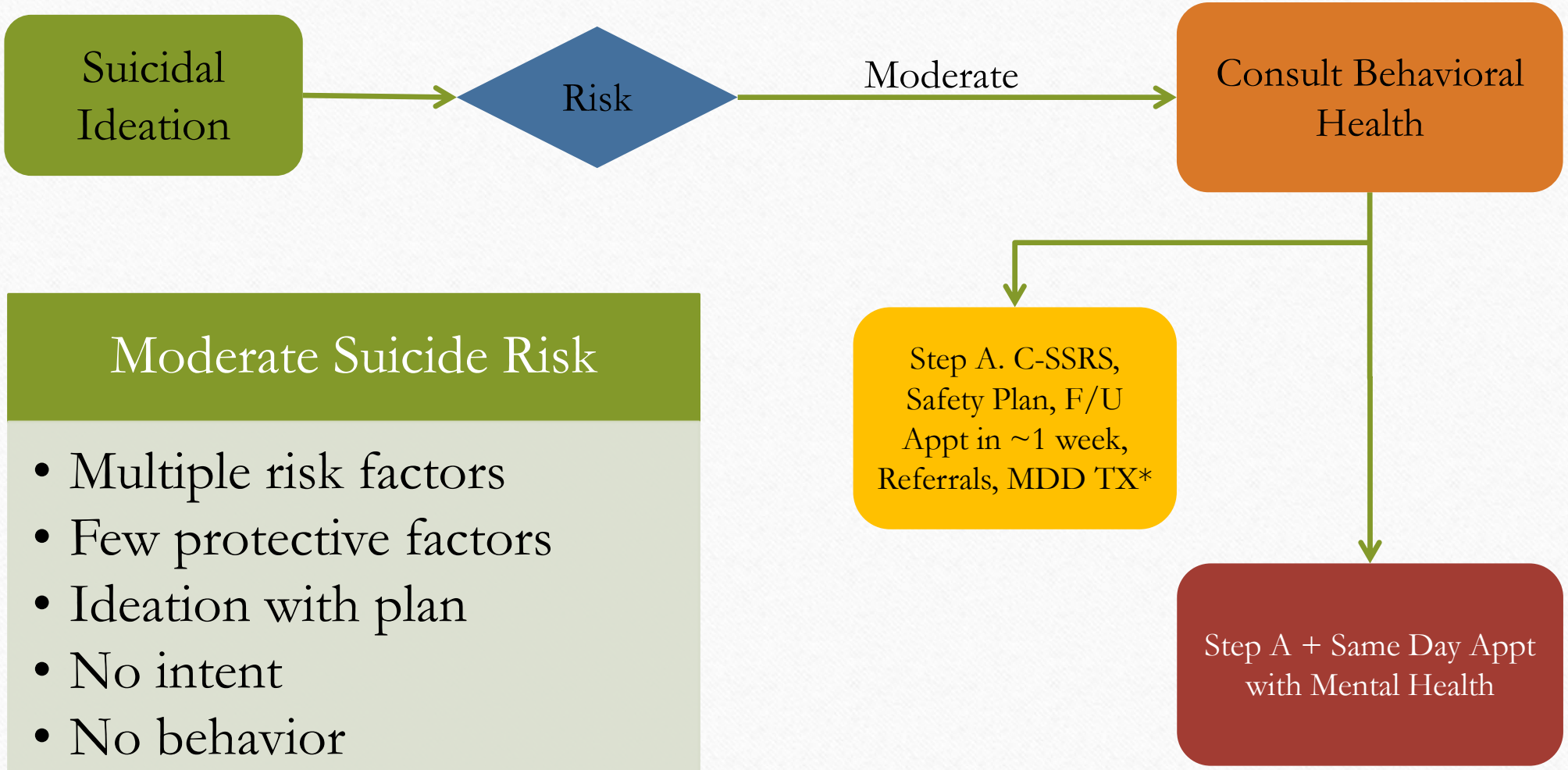


Low Suicide Risk

- Modifiable risk factors
- Strong protective factors
- Ideation but with no plan, no intent, no behavior

- Consult*
- C-SSRS
- Create Safety Plan
- Active Monitoring
- Consider Depression Tx*,
- Schedule f/u visits
- Refer to Behavioral Health

Suicide Screening Algorithm: Moderate Risk



Moderate Suicide Risk

- Multiple risk factors
- Few protective factors
- Ideation with plan
- No intent
- No behavior

Suicide Screening Algorithm: High or Imminent Risk

High Suicide Risk

- Mental Health dx w/ severe sx
- Acute precipitating event
- Protective factors not relevant
- Potentially lethal attempt
- Persistent ideation
- Strong intent
- Rehearsal
- Suicide behaviors

Emergency hospital evaluation Procedures (active safety monitoring) + C-SSRS, Safety Plan, F/U Appt, Referrals, MDD TX*

AAP Suicide Blueprint

1. **Implement universal suicide risk screening with all pediatric patients ages 12 and older**
    a. Use a validated, evidence-based screening tool to identify suicidal ideation or behaviors
    b. It is best to screen youth ages 12+ without their parent/caregiver in the room, to encourage open discussion
    c. Screening tools can be verbal, paper, or electronic and administered by any properly trained staff-person
    d. Be sure to use a screening tool that is specific to suicide risk. Research has shown that depression screeners are insufficient to identify suicide risk
    e. For considerations for screening youth under age 12, see the *Blueprint for Youth Suicide Prevention*

2. **Use a Brief Suicide Safety Assessment (BSSA) to determine next steps for all patients who screen positive**
    a. If a patient screens positive for suicidal ideation, assess immediate risk with a BSSA
    b. Praise the patient for sharing their feelings
    c. Use an evidence-based assessment tool to evaluate frequency of suicidal thoughts, mental health symptoms, history of suicidal ideation/behaviors, means and plans for suicide, and relevant supports or risk factors
    d. It is best to conduct the BSSA without the parent/caregiver in the room, to encourage open discussion
    e. If any level of suicide risk is detected, support the patient in engaging their parents/caregivers in the care plan and next steps. For more about confidentiality and parent/caregiver engagement, see the *Blueprint for Youth Suicide Prevention*

3. **Identify next steps for care, based on patient's level of risk**
    a. Imminent Risk: Patient has acute suicidal thoughts and requires an emergency mental health evaluation
        i. Praise the patient for sharing their feelings
        ii. Take immediate safety precautions and ensure the patient is not left alone
        iii. Connect patient and family with qualified professionals for an extensive mental health evaluation. Options include an on-site mental health professional in the practice, the emergency department (ED), a mobile crisis team, or an acute mental health evaluation center
        iv. Follow-up with a "caring contact" in 24-48 hours
    b. Further Evaluation Needed: This is not an emergency, but patient is at moderate risk and requires further evaluation from a mental health professional as soon as possible
        i. Create a safety plan for the patient and their family/caregivers
        ii. Counsel about the importance of safe storage or removal of lethal means (see below)
        iii. Connect patient and family with an outpatient mental health provider and provide educational information and resources for additional support (National Suicide Lifeline and Crisis Text Line)
        iv. Follow-up with a "caring contact" in 24-48 hours
    c. Low Risk: No further evaluation is needed at this time
        i. Patient may benefit from a non-urgent mental health follow-up
        ii. If indicated, provide patient and family with a mental health referral and provide educational information and resources for additional support (National Suicide Lifeline and Crisis Text Line)

Safety Planning for Youth at Risk for Suicide

Pediatric health clinicians can use safety planning to support youth at risk for suicide.

Safety planning helps the patient think through strategies that they can use to keep themselves safe if they experience suicidal thoughts in the future. Clinicians and patients can develop a personalized written or electronic safety plan that identifies:

- Personal warning signs or triggers for suicidal ideation or behavior
- Coping strategies that can be used at any time of the day or night if a youth is experiencing thoughts of suicide
- Social supports, including a trusted adult, friends, and family to call for help when experiencing thoughts of suicide
- A back-up plan, such as calling the National Suicide Prevention Lifeline or contacting the Crisis Text Line

For more details and tools to support safety planning, see the *Blueprint for Youth Suicide Prevention*

Lethal Means Safety Counseling for Families

Pediatric health clinicians can help families understand that suicidal crises can be hard to predict and can escalate quickly. Reducing access to dangerous items can help prevent youth from dying from a suicide attempt. The goal is to protect youth in a "moment of crisis," by their environment safe before the crisis ensues. Pediatric health clinicians can help families reduce access to dangerous items, including medications, poison, firearms, ropes, belts, knives, or other household items.

Pediatric health clinicians can address lethal means with patients and families by:

- Helping patients and families understand the types of objects in their home that could be used in a suicide attempt
- Identifying ways to restrict their child's access to these items, including:
    - Temporarily removing firearms from the home while the child is experiencing thoughts of suicide
        - If removal is not possible, firearms should be stored unloaded and locked with ammunition locked and stored separately. Children should not have access to the lock codes/keys.
    - Locking up prescription/over-the-counter medications and reducing the quantity of medication in the home
    - Temporarily removing or locking up alcohol, drugs, household cleaners, weapons, or other products