Resources Advancing Mental Health in Pediatrics

RAMP

Mental health care in the pediatric clinic

Suicide Assessment and Safety Planning

Objectives

- Review epidemiology and risk factors for suicide
- Describe the practice and process of screening for suicide
- Practice risk assessment for suicide and safety planning
- Provide case example of suicide screening and risk assessment

Definitions

Suicide: Death caused by injurious behavior to the self with an intent to die
Suicide attempt: non-fatal, injurious behavior to the self with an intent to die; might not result in injury
Suicidal ideation: thinking about, considering, or planning suicide
Non-Suicidal Self injury (NSSI): purposeful acts of physical harm to the self with the potential to damage body tissue but performed *without* the intent to die

Suicide is a multifaceted public health issue with *societal, environmental, interpersonal, biological,* and *psychological* underpinnings.

- Encounters for suicidal ideation and attempts at US children's hospitals have increased steadily from 2008 and accounted for an increasing percentage of all hospital encounters.

- Suicide is the third leading cause of death among youth ages 10 to 24 years.

- Non-fatal suicide attempts are more prevalent during high school years, affecting between 5–9% of children and adolescents annually.

Risk and Protective Factors

Among 6448 adolescents presenting to an emergency department for non-suicide related complaints:

- 51.9% reported lifetime history of suicidal ideation
- 39.4% reported lifetime history of suicidal behaviors
- 4.9% made a suicide attempt within 3 months after the index ED visit (King et al. 2020).

There is no single risk factor for suicide attempt.

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Domains of Risk

- **Demographic**
  - Females and those identifying as LGBTQ more at risk for suicide ideation
  - Males without prior mental health services more at risk for suicide attempts
  - Family history of suicide (2.6 times more likely)
  - "Clusters", point clusters in communities, mass clusters related to media
- **Clinical**
  - Previous history of suicidal ideation and NSSI (intensity is predictive of suicide attempts)
  - History of physical and sexual abuse
  - Depression and hopelessness
  - Agitation, poor impulse control, and substance use are strong predictors of suicide attempts
  - Sleep disturbance
- **Social/Environmental**
  - Low social and school connectedness relate to increased suicidal thoughts and behaviors
  - Interpersonal conflict, financial, legal, and disciplinary problems

Suicide Screening

The majority of youth who die by suicide have had recent contact with a health care provider (Luoma, et al. 2002). Screening is essential to prevention.

- Adolescents rarely spontaneously disclose but will when asked directly by a trusted adult.
- Screening may *double* detection of adolescents at risk (DeVylder et al., 2019).

Limitations of screeners for suicide

- All screening measures are dependent on willingness to disclose.
- Low overall prevalence of suicide attempts
  - Balancing Sensitivity/Specificity – Need for high sensitivity to limit false positives
- Many studies are completed in emergent or high-risk populations, making application to primary care settings difficult.
- Many screeners initially validated with adults.

Screening Instruments:

PHQ-9, Item 9 "Thoughts you would be better off dead or of hurting yourself"

- Designed to measure depression severity, not suicidal risk
- Simon et al. 2013 (n= 84,418) adolescents who responded "nearly every day" to question 9 had a 4% risk of suicide attempt over the following year.
- PHQ-9 missed 1/3 of suicide risk (Kemper et al, 2021).

Columbia - Suicide Screening for Primary Care

- 2- and 5-item version for primary care, with triage points

- No validation studies of the 2-item screener with adolescents
- Columbia Suicide Severity Rating Scale (C-SSRS), a semi-structured interview has been validated for use with adolescents (Cwick et al, 2020).

Asking Suicide-Screening Questions (ASQ) (part of the Zero Suicide initiative)

- Preferred measure for adolescents
- Age 10 and up in Behavioral Health (targeted use age 8 and up)
- Sensitivity 96.9%; Specificity 87.6% for suicidal ideation
- Any "yes" response requires further questions
- *ASQ can be delivered in EPIC MyChart*

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? _____

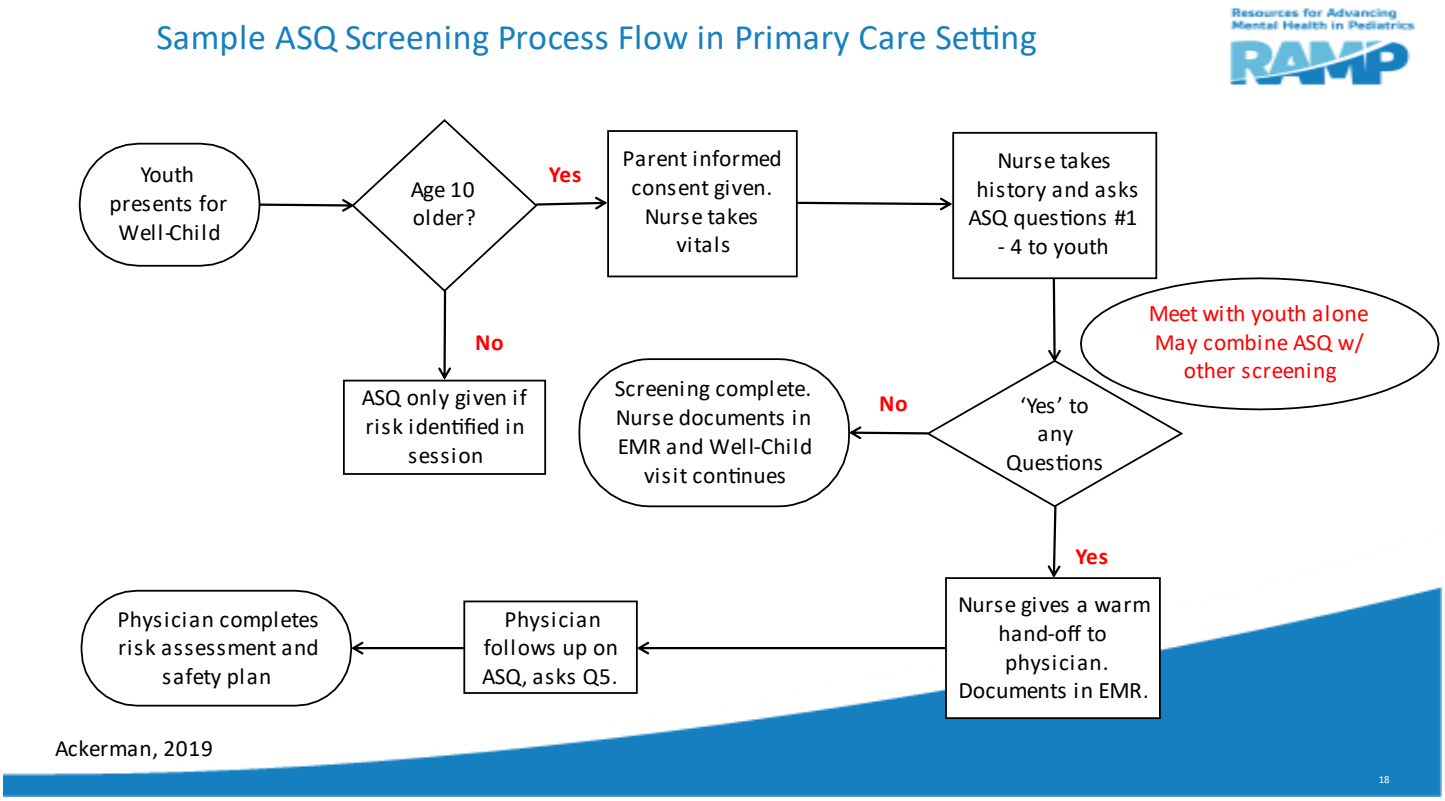
   _____

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

Responding to a patient after a positive screen

"I want to follow-up on your responses to the suicide risk screening questions. These can be hard things to talk about. I need to ask you a few more questions."



There are 2 ways to screen positive on the ASQ:

- **Acute:** "Yes" to #5: "Are you having thoughts of killing yourself right now?"
  - Emergent assessment is needed.
  - Patient shouldn't be left alone.
- **Non-Acute:** answers "yes" on #1-4 or refuses to answer
  - Refusal to answer is consider a positive
  - Risk assessment to determine if more extensive psychiatric evaluation is needed.
  - "Thank you for speaking up. It's important that we have a plan with your parents and medical team to keep you safe"

Suicide Risk Assessment

- Occurs if screen is positive
- Involves clinical evaluation
- Identifies risk and protective factors
- Estimates imminent risk of danger to patient

To increase the likelihood of getting a truthful response when inquiring about suicidal thoughts, behaviors, and plans, be:

Non-Judgmental

- Appreciate your patient's openness and honesty
- Validate that this may feel uncomfortable to talk about with a caregiver, while also stressing importance of caregiver involvement
- Discussion of confidentiality is to be integrated throughout

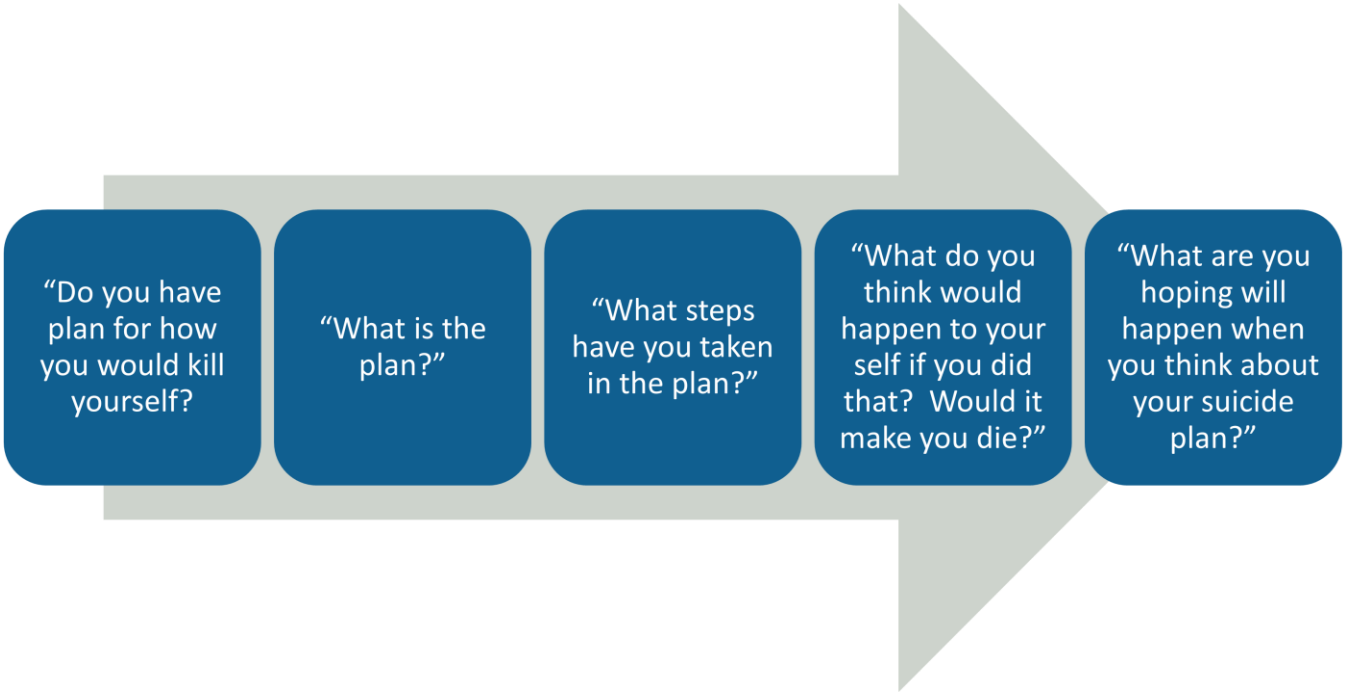
Matter of fact language

- Being upfront and not tip toeing around words like "suicide." Direct discussion leads to a better intervention in the office

Self-awareness and body language

- Remaining present in that moment

Ask about suicidality as you would any other symptom: frequency, duration, intensity, circumstances, what makes it better, what makes it worse.



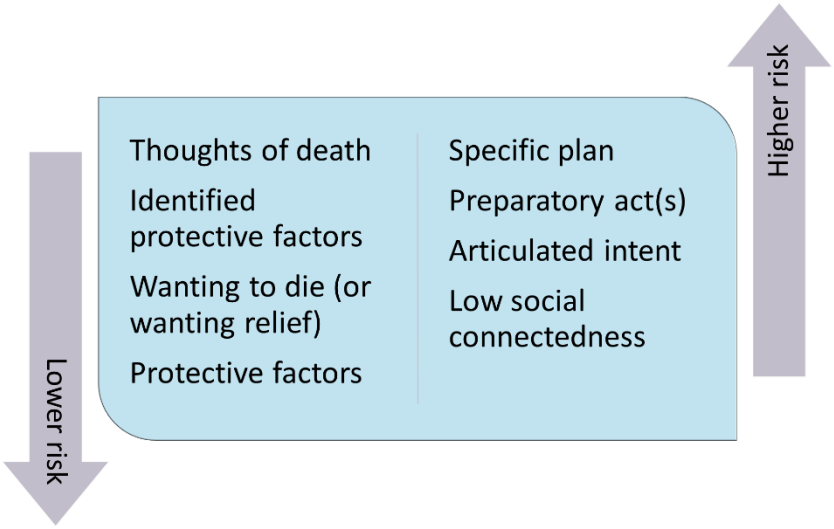
The questions listed here help you to evaluate the thoughts and behaviors around a suicidal plan. You want to know explicitly what steps a patient has taken in a plan, such as looking up videos on suicidal methods, or hoarding medications. You want to know what the child predicts will be the outcome of the plan, both to the child themselves or to others around them.

One caveat here: some children, especially younger children, may have intense suicidal thoughts and intent to harm themselves but describe a non-lethal method, such as holding their breath, because of their limited understanding of physiology. These high-intent, low lethality suicidal plans should be taken seriously, because a child with high intention may stumble on a more lethal method.

A useful question: “Do you want to die, or do you want this painful stuff to go away?”

Often, kids want the painful things in their lives to go away, or just to rest and be left alone for a while. When this seems impossible, death becomes an option.

On the other end of the spectrum are kids who express specific plans which they have researched and practiced. They clearly state their intention and can override any suggestion of mitigating circumstances. These young people are clearly at very high risk for suicide.



Risk Assessment

A methodical, targeted assessment is the key to decision-making around suicidal risk.

This includes:

1. An assessment of risk and protective factors
2. A suicidal risk inquiry into thoughts, plans, intent and access to means
3. The application of clinical judgement
4. Documentation of the assessment

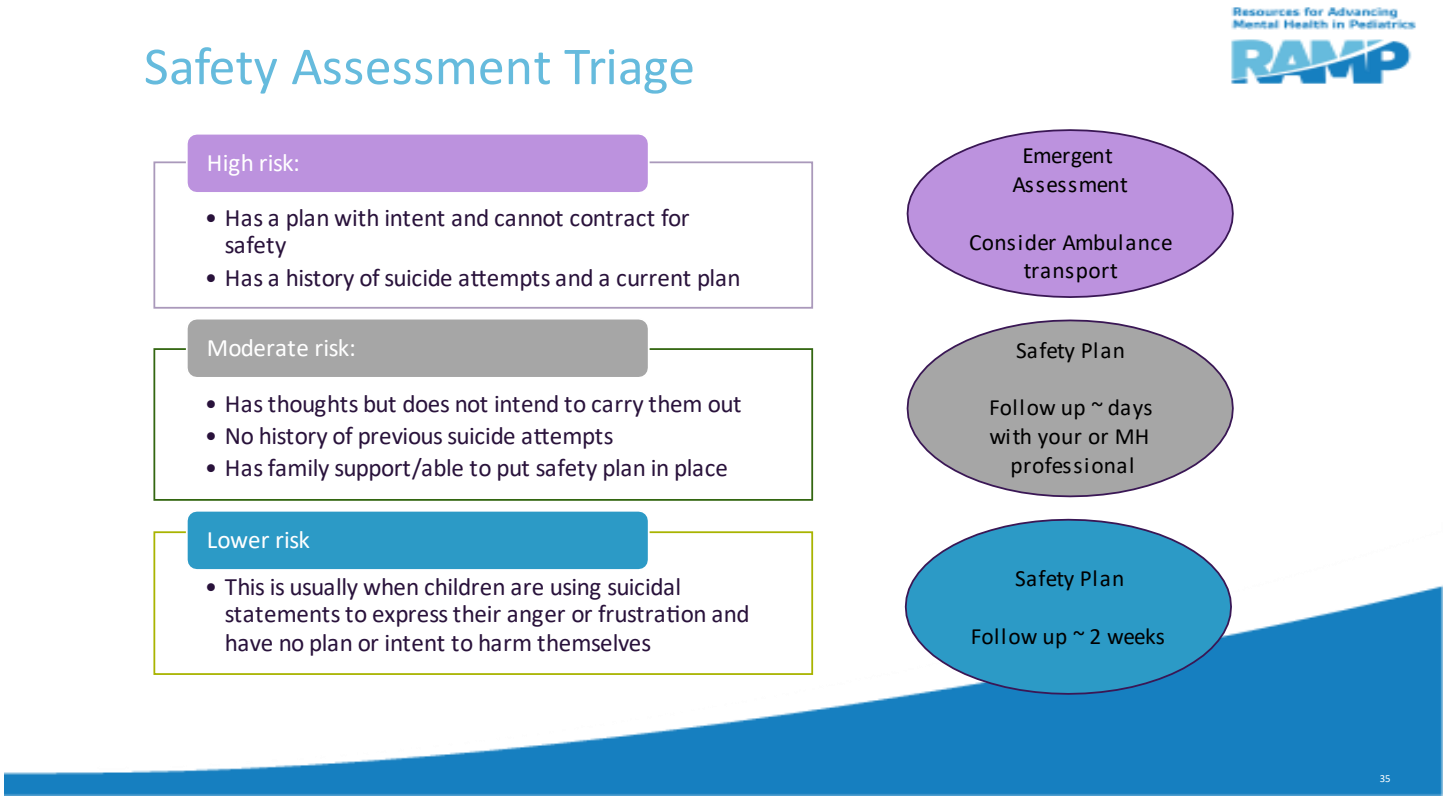
Protective factors can mitigate risk in a person with moderate to low suicide risk. A person who is strongly connected to others and has a hopeful future may be able to draw on those factors in assessing their own suicidal thoughts. A person with higher suicide risk, however, may still attempt or commit suicide despite an apparently "good life”.

Suicidality is a spectrum of risk

Suicidality is a spectrum of risk, and we have been addressing it so far in the context of rational weighing of risks and protective factors. Irrationality or impaired judgement increase risk across the spectrum. This can include intoxication, psychosis, brain injury, and impulsivity**.**

Any of these factors can impair judgment:

- Intoxication
- Psychosis (including command auditory hallucinations)
- Traumatic brain injury
- Impulsivity



Once a level of risk is assigned, you can make a triage plan. High risk patients require emergent further assessment, usually in an emergency department setting.

For moderate and lower risk patients, you can arrange follow-up and make a safety plan.

Safety Planning

A safety plan is a brief, collaborative intervention that engages the patient in identifying protective factors and various supports. If viewed as an intervention versus a strategy to mitigate liability, safety planning can help youth and caregivers tap into internal and external resources and reduce suicide risk.

Safety planning engages the patient and caregiver in five areas:

- Environmental safety (reducing access)
- Identify risk factors/warning signs
- Use of internal coping strategies
- External supports
- Resource phone numbers

Step 1	Warning signs of developing crisis
Step 2	Personal coping mechanisms
Step 3	People that provide support and distraction
Step 4	Contact people and numbers for support
Step 5	Professional/agencies where help can be sought
Step 6	Environmental safety
Step 7	One thing that is important to keep living for

Step 6: Elements of environmental safety

1. *Patient* and parent/guardian will go through the house together to identify and remove all sharps, weapons and medications
2. Any firearms will be secured or removed from the home
3. *Patient* will be supervised at all times
4. Monitor safety while at school. Parent/guardian will inform *School Social Worker* of this plan.
5. Parent/guardian will bring *Patient* to the nearest ER, contact 911 or CARES at 800-345-9049, if *Patient* is experiencing a psychiatric emergency.

Safety planning apps include MY3 and Mood Tools

Involvement of the caregiver

- The safety plan is a "map" of ways to cope when it becomes difficult.

Safety plans work best when they are creative and personalized to the child

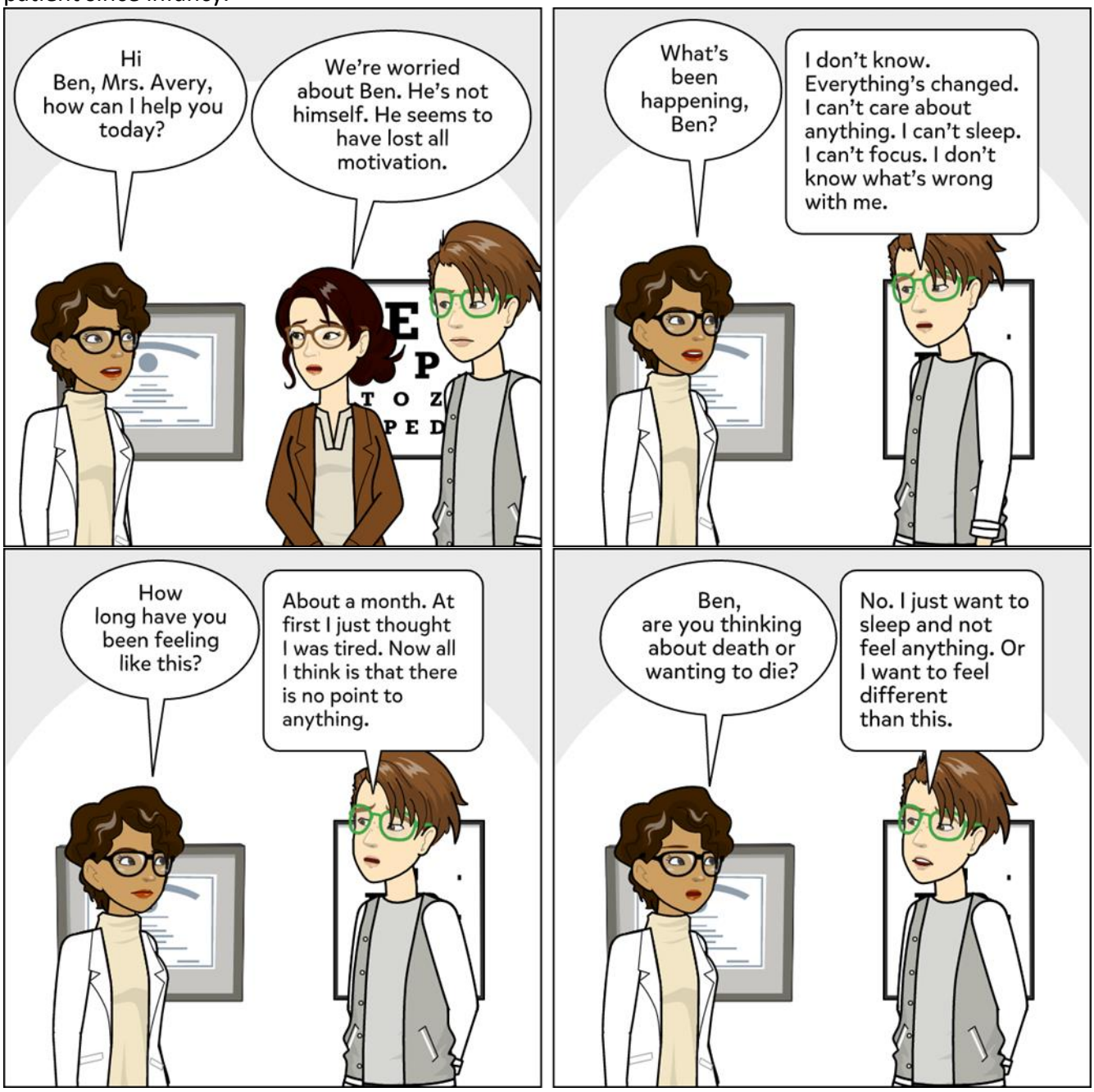
- What are the patient's interests?
- Social media (in moderation and with monitoring); phones (have them enter crisis lines into their phones in the office)
- Resources to meet the patient's specific and unique needs (i.e., LGBTQ)

Documentation is evidence that serves as a record of your safety evaluation

- Helps provide support and justification for your plans
- Informs other providers of the plan

- Highlights what you did to help increase safety
- Provide details of the questions you asked and information you obtained
- Discuss where the safety plan will live in the home

Let's review suicide assessment and safety planning with Ben, who is 16 years old. Ben has been your patient since infancy.



You administer an ASQ:

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

Ben is having thoughts of death, and that his family would be better off without him, but he denies thoughts of killing himself now or in the past few weeks. He has no history of suicide attempt.

You assess risk and protective factors next.

Risk

- Probable depression, onset 1-2 months ago
- Significant sleep disruption
- Family history of depression (Ben's father)

Protective

- Has reached out for help
- Has supportive family
- Rich social connections, has done well academically, involved in sports

Drilling into Ben's suicidal thoughts and risk factors:

- Ben has had the wish to dead at least weekly for the past month. He has thought he would prefer to not wake up but denies plans to hurt or injure himself.
- He has no previous suicide attempts or acts of self-harm
- No exposure to suicide in family or friend
- No substance abuse, trauma, abuse, or social isolation
- No means or access to firearms

You determine that Ben is at low-moderate risk for suicide or suicidal behavior. You do not feel he needs an emergent further evaluation or inpatient care. The next step is to arrange close follow-up with you and make a safety plan.

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. **Feeling down**
2. **Staying alone in my room**

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. **Drawing anime figures**
2. **Playing guitar**

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. **Cody, my snapchat group buddy**
2. **Shooting hoops with Dad**

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS

1. **Coach Thompson**
2. **Uncle Brian**

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. **Clinician/Agency Name:** Dr. Shah **Phone:** 312-222-2211_____
2. **Local Emergency Department:** Central Hospital
3. **Suicide Prevention Lifeline Phone:** 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

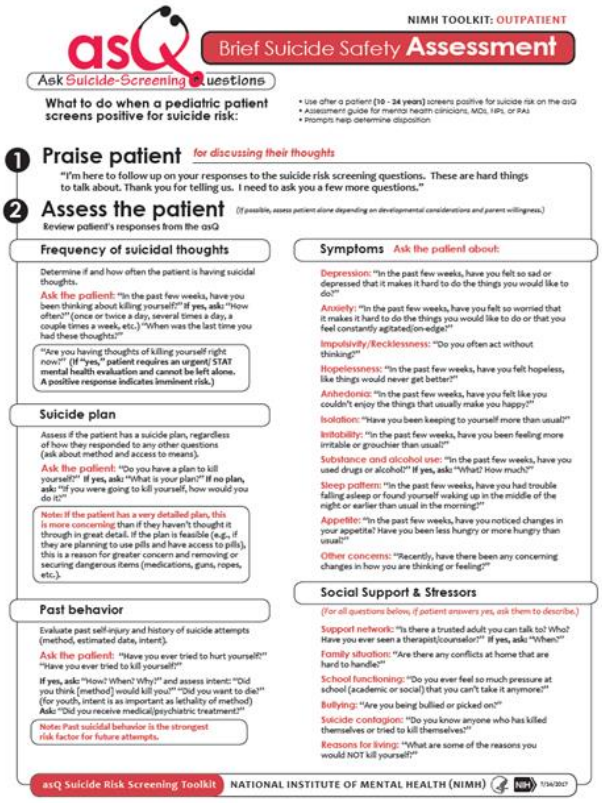
1. **I will let my mom and dad know if I am thinking about hurting myself. The house is pretty safe right now.**

Your documentation for Ben:

Met with Ben, 16-year-old male, identifying depression and symptoms of *suicidality* over the past month. Ben screened affirmatively on the ASQ, *wishing he would not wake up.* Discussed recent *psychosocial stressors* and engaged Ben in suicidal inquiry. Ben identified multiple *protective factors.* Identified Ben as **moderate risk.**

Completed safety plan document with Ben and informed his mother, who attended the appointment with him. *Safety plan was sent home* with the family in the AVS.

The ASQ is part of the National Institute for Mental Health's [Ask Suicide-Screening Questions (ASQ) Toolkit]



asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: OUTPUTIENT

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.)*

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" (**If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.**)

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms Ask the patient about:

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

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

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

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

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

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

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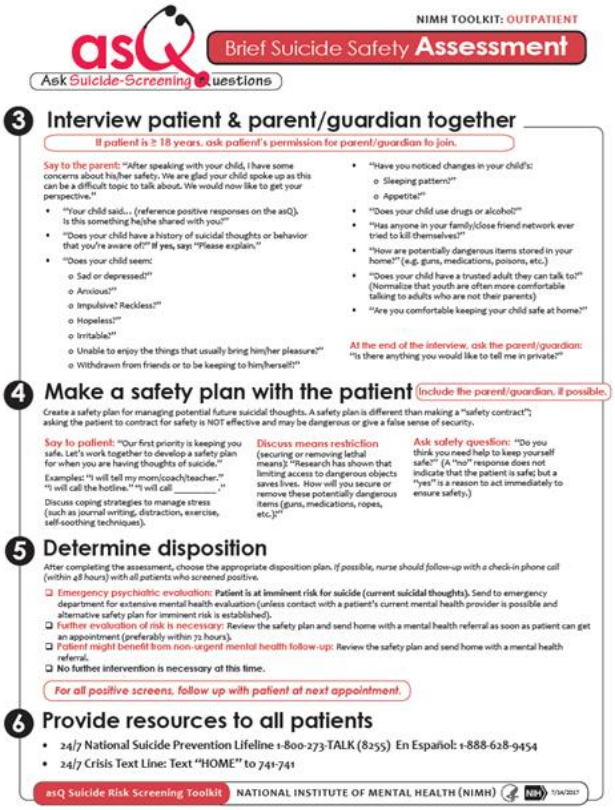

asQ Ask Suicide-Screening Questions

NIMH TOOLKIT: OUTPUTIENT

Brief Suicide Safety Assessment

3 Interview patient & parent/guardian together

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

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

- "Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."
- "Does your child seem:
  - Sad or depressed?"
  - Anxious?"
  - Impulsive? Reckless?"
  - Hopeless?"
  - Irritable?"
  - Unable to enjoy the things that usually bring him/her pleasure?"
  - Withdrawn from friends or to be keeping to him/herself?"
- "Have you noticed changes in your child's:
  - Sleeping pattern?"
  - Appetite?"
- "Does your child use drugs or alcohol?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
- "Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents)
- "Are you comfortable keeping your child safe at home?"

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ❑ Emergency psychiatric evaluation: **Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ❑ Further evaluation of risk is necessary: Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ❑ Patient might benefit from non-urgent mental health follow-up: Review the safety plan and send home with a mental health referral.
- ❑ No further intervention is necessary at this time.

For all positive screens, follow up with patient at next appointment.

6 Provide resources to all patients

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

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