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KENTUCKY CHILDREN'S HOSPITAL

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT ORTHOPEDICS 2022-23

BEST CHILDREN'S HOSPITALS U.S.News & WORLD REPORT CARDIOLOGY & HEART SURGERY 2022-23

# Pediatric Town Hall

## 7/21/22

# Youth Suicide Prevention in a Primary Care Setting

The Joint Congenital Heart Program, a collaboration of Kentucky Children's Hospital and Cincinnati Children's, is jointly ranked by *U.S. News & World Report*.

# Zoom Instructions

- So that we can better facilitate networking and follow up communication, **please enter your name, title, organization and email into the chat box**. If you are dialing in as a group, enter each individual's name and contact information.
- If you are logged in under your initials, username or nickname, please modify your login in to first and last name.
- Please ensure your microphone remains muted and type any questions for the presenters in the chat box. Questions will be answered at the end of the presentation.
- For the optimal viewing experience, please select "speaker view" to highlight the presenter on your screen.
- We will be recording this session and will provide everyone who has entered an email address with a link to the recording and a pdf of the slides.
- This is a community-wide forum, so please do not share patient specific information or quality or safety issues. We have protected venues to discuss those topics.

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# AGENDA

1. **Opening**: Dr. Scottie Day, *Chair, UK Department of Pediatrics and Physician-in-Chief, Kentucky Children's Hospital*
2. Discuss the **prevalence** of youth suicidality and the language to use when **talking about suicide** – Dr. Alissa Briggs, *Licensed Psychologist, Division of Adolescent Medicine*
3. Identify tools for **screening for suicide in youth**, how to use them, and when to use them – Dr. Mandakini Sadhir, *Chief, Division of Adolescent Medicine*
4. Identify how to **assess for suicide risk** level in youth – Dr. Sadhir
5. Discuss how to **develop and communicate care plans** for youth at risk of suicide – Dr. Briggs

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# WHAT ADOLESCENTS NEED



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# YOUTH SUICIDALITY – WHAT PROTECTS THEM?

- **Connectedness** – family, friends, school, community
- Spirituality
- Regular school attendance
- Access to healthcare (physical and behavioral)
- Strong therapeutic relationship
- Coping skills
- Problem-solving skills
- Frustration tolerance
- Feeling in control of their life
- Life satisfaction

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# YOUTH SUICIDALITY – WHAT INCREASES RISK?

- Prior attempt
- Mood disorder
- Substance abuse
- Access to lethal means
- Family history of trauma, suicide, or violence
- Loneliness
- Impulsivity
- Recent losses
- **Irritability/agitation/ aggression**
- Chronic pain or condition
- Insomnia
- Brain injury
- **Perceived burdensomeness**
- Exposure to suicide

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# DEMOGRAPHIC VARIABLES

- Gender
- Transgender identity
- Age
- Sexual orientation
- Race/ethnicity
- Location

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# PREVALENCE

- 2nd leading cause of death in adolescents
- 19% reported seriously considering suicide
- Increased since 2007 by about 60%
- A firearm is used for about half of suicide deaths
- ***Kentucky's rate is 10.80 and ranks #18***
  - 130 children and adolescents between the age of 5 and 25 died by suicide in 2019
  - Previous rank was #32

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# PANDEMIC

- Feeling close to people at school protected youth from depression and suicidality
  - 5.8% of those who felt connected attempted suicide
  - 11.9% of those who did not feel connected attempted suicide

- Depression, self-harm and suicidality increased
  - Nearly half reported feeling depressed at some point
  - Over one-third experienced poor mental health

Jones SE, Ethier KA, Hertz M, et al. Mental Health, Suicidality, and Connectedness Among High School Students During the COVID-19 Pandemic — Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022;71(Suppl-3):16–21. DOI: http://dx.doi.org/10.15585/mmwr.su7103a3external icon

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# YOUTH SUICIDALITY – WHEN DO WE WORRY?

- Threatening to kill oneself
- Seeking means to kill oneself
- Practicing lethal behaviors
- Hopelessness
- Increased substance use
- **Dramatic shifts in mood**
- **Rage**
- Giving away important belongings
- Withdrawing from others
- **Acting reckless or engaging in high risk activities**

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# LANGUAGE

DO NOT LET THE FEAR OF SAYING THE WRONG THING KEEP YOU FROM SAYING ANYTHING


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# Is it safe to ask about suicide?

- Myth- “Asking will put idea in their head”

Multiple research studies have established that it is safe to ask about suicide

In fact, asking them may just save their lives!!

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# HOW TO ASK

Questions to uncover suicidal thinking:[39]

*"Sometimes, people in your situation (describe the situation) lose hope; I'm wondering if you may have lost hope, too?"*

*"Have you ever thought things would be better if you were dead?"*

*"With this much stress (or hopelessness) in your life, have you thought of hurting yourself?"*

*"Have you ever thought about killing yourself?"*

National Suicide Prevention Toolkit:
https://sprc.org/sites/default/files/Final%20National%20Suicide%20Prevention%20Toolkit%202.15.18%20FINAL.pdf

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# LANGUAGE

Validate


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# LANGUAGE

| What not to say | What to say instead |
|---|---|
| They committed suicide | The died by suicide |
| Their death was a cry for help<br>They did this for attention | They were in pain, and they took an action |
| It was a(n) successful/ unsuccessful suicide attempt | They died by suicide OR<br>They attempted suicide |
| Lethal means restriction | Lethal means safety |
| Suicide is preventable | Suicide can be prevented |

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Source: Partners for Children's Mental Health https://pcmh.org/

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# Screening

# SCREENING FOR SUICIDALITY

- Adolescents are reluctant to talk about mental health concerns
- Often present with other somatic complaints
- As a result many adolescents at risk for suicide pass through healthcare system and go unnoticed because no one asked them directly about suicidal thoughts and behaviors

# Contact with healthcare provider prior to suicide

- **80%** of adolescents visited a healthcare provider within the year prior to death by suicide
- **49%** of youth had visited an emergency department (ED) within the year before their death
- **38%** of adolescents had contact with a healthcare system within the 4 weeks before their death
- **34%** of people ages 15+ years had contact with a healthcare provider in the week before their death

**Missed opportunities in Healthcare system !!!!!**

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# SCREENING FOR DEPRESSION

## Universal screenings for depression and suicidality 12 and older (AAP) - PHQ 9 Modified for Adolescents

- Annual visits
- When patient/parent or provider concerned for mental health
- Some may consider all new patients

**This approach helps with identifying patients on initial or annual or as needed basis but we can still miss many adolescents at risk for suicide who are not forth coming or presenting with physical complaints**

Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management

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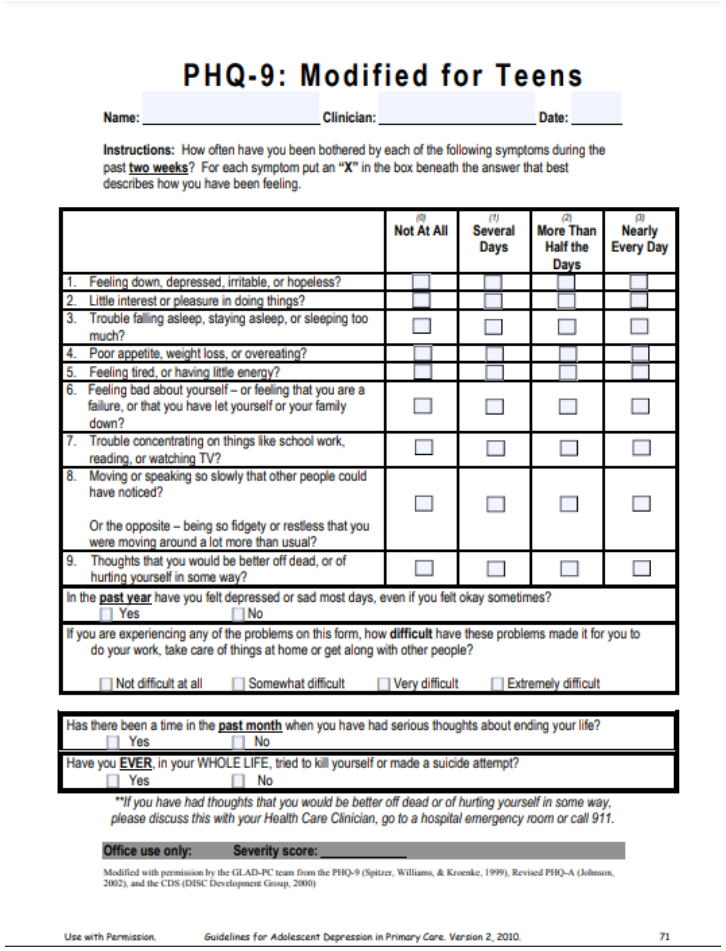
# Screening – is PHQ 9 A best screening tool for suicide?

- Study compared suicide screening using PHQ 9 A vs ASQ (Ask Suicide-Screening Questions) across 12 primary care clinics
- 56.4% of patients had a positive PHQ-9A screen for any type of depression
- 24.7% had a positive PHQ-9A screen for MDD.
- The median PHQ-9A score among those with a positive screen for MDD was 14 (interquartile range: 11–17)
- The overall proportion with a positive ASQ screen result was 21.1%
- **Among those who responded on the PHQ-9A that they did not have suicidal thoughts in the past month, 13.2% (93 of 612) had a positive ASQ result.**



**PHQ-9: Modified for Teens**

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 by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)

Use with Permission. Guidelines for Adolescent Depression in Primary Care. Version 2, 2010. 71

Kemper A et al Depression and Suicide-Risk Screening Results in Pediatric Primary Care Pediatrics July 2021, 148 (1) e2021049999;

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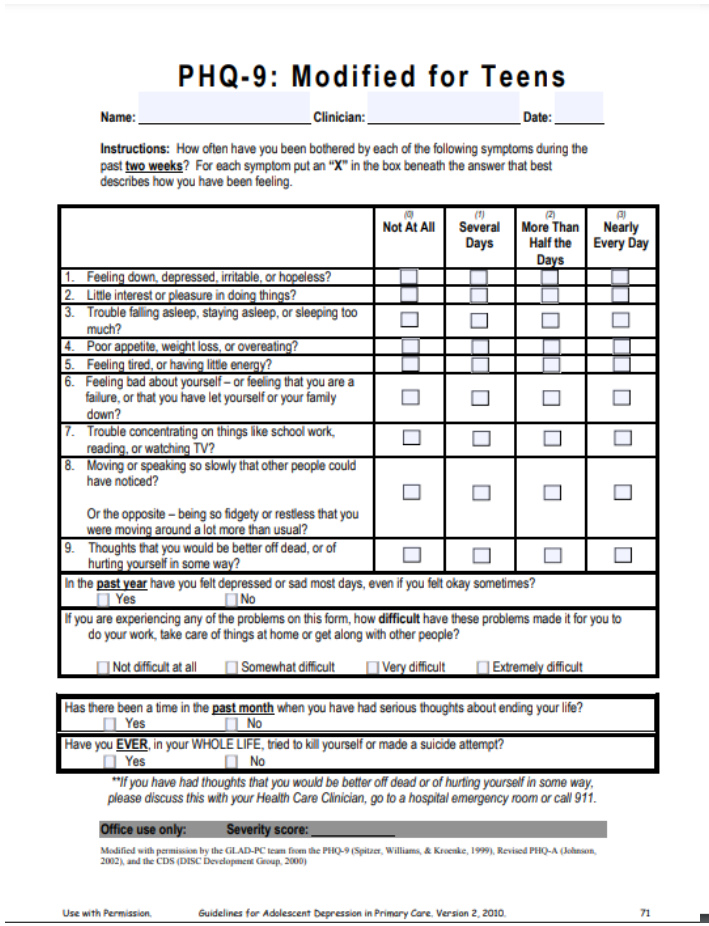
# PHQ 9 and ASQ combined



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| 4. Poor appetite, weight loss, or overeating? | ☐ | ☐ | ☐ | ☐ |
| 5. Feeling tired, or having little energy? | ☐ | ☐ | ☐ | ☐ |
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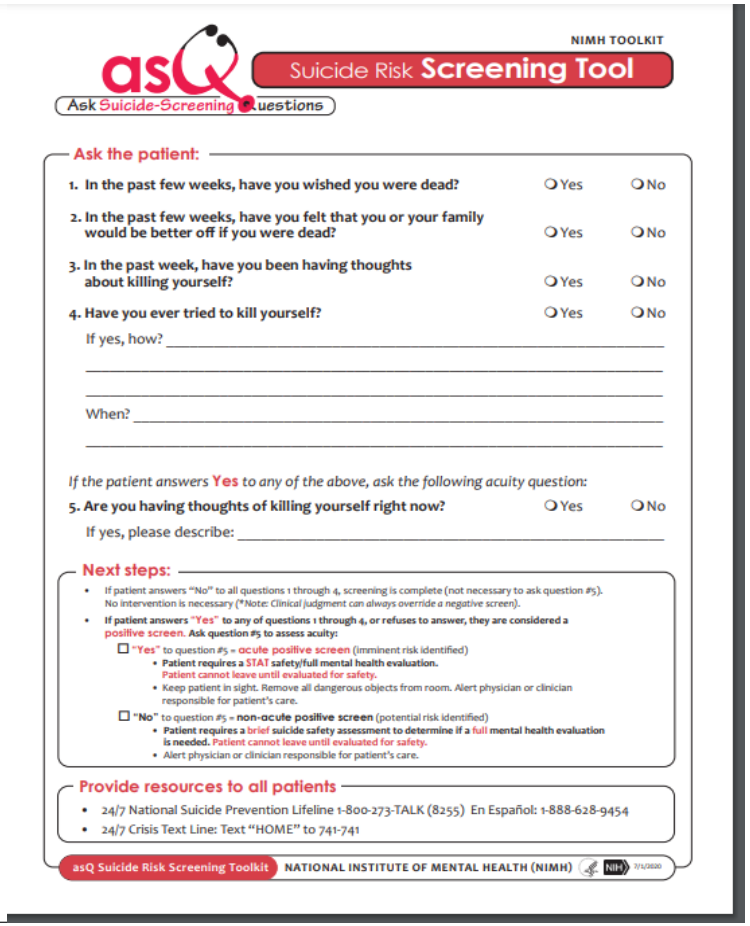

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

**Ask the patient:**

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

If yes, how? _____

When? _____

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

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

If yes, please describe: _____

**Next steps:**

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

**Provide resources to all patients**

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) 7/1/2020

- ASQ: Brief validated tool for youth 10-24; 20 seconds to administer
- Can be used in inpatient, ER, ambulatory settings
- Available in many languages

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# OTHER SCREENING TOOLS

- Columbia Suicide Severity Rating Scale ( C-SSRS)
- Patient Safety Screener

# WHEN TO SCREEN ?

- Adolescent need to be screened more frequently
- Patient who have no history of suicide risk, screening no more than once a month and no less than once a year
- Screen all patients 10 and older who meet screening criteria
  - New patient
  - Existing patients who have not been screened in past 30 days
  - Patient who has positive suicide screen during last visit
  - Clinically indicated
- Administer screening without parents so that patients can be more honest

ASQ- Ask Suicide screening questions – Toolkit
https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#outpatient

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# AFTER POSITIVE SCREEN

- Do not treat every young person who has a thought about suicide as an emergency!!!!
- Do not panic, be present and mindful
- Assess for risk and protective factors
- Provide hope, focus on strengths and supports
- Important to include caregiver in the safety planning

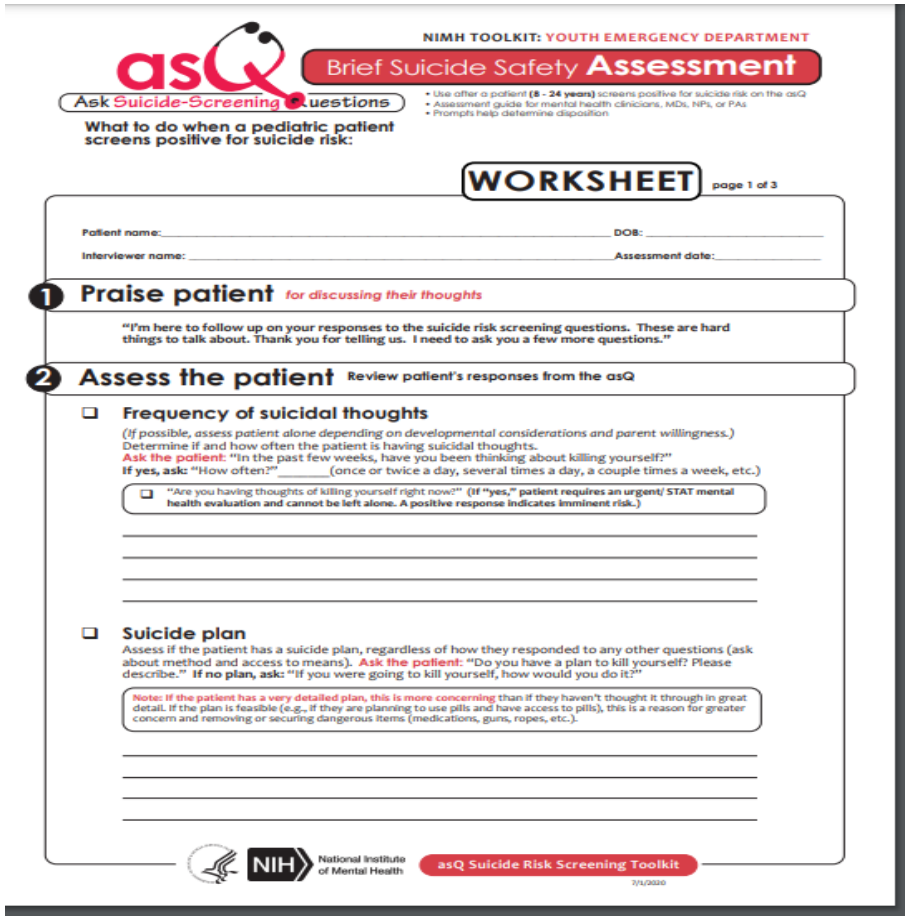
Boergers J, Spirito A, Donaldson D. Reasons for adolescent suicide attempts: associations with psychological functioning. J Am Acad Child Adolesc Psychiatry. 1998 Dec;37(12):1287-93.

# Suicide Risk Assessment

- Suicide risk assessment is similar to Asthma Action plan
  - Recognize clinical presentation
  - Assess for risk and protective factors
  - Care plan based on severity of presenting condition - Green, Yellow and Red zone

# Brief suicide safety assessment

- **Suicidal desire**,
  - including suicidal ideation, frequency of SI, psychological pain, hopelessness, helplessness, perceived burden on others, feeling trapped, feeling extremely alone
- **Suicidal capability**,
  - including history of previous suicide attempts, exposure to close family member or peer's death by suicide, available means of killing self/others, currently intoxicated, substance abuse, acute symptoms of mental illness, and extreme agitation/rage
- **Suicidal intent**,
  - including attempt in progress, plan to kill self/others, preparatory behaviors, and expressed intent to die; and
- **Buffers/connectedness**,
  - including immediate supports, social supports, planning for the future, engagement with adult or peer, ambivalence for living/dying, core values/beliefs, and sense of purpose.



NIMH TOOLKIT: YOUTH EMERGENCY DEPARTMENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

- Use after a patient (8 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

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

WORKSHEET page 1 of 3

Patient name: _____ DOB: _____

Interviewer name: _____ Assessment date: _____

1 **Praise patient** *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 **Assess the patient** Review patient's responses from the asQ

❑ **Frequency of suicidal thoughts**

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

NIH National Institute of Mental Health asQ Suicide Risk Screening Toolkit

7/1/2020

Suicide care in Systems Framework- National Action Alliance: Clinical and Intervention Task force
https://theactionalliance.org/sites/default/files/clinicalcareinterventionreport.pdf

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# ASSESSMENT FOR SUICIDALITY

Low Risk – Green Zone

- Suicidal ideation, no plan, no intent
- No access to lethal means
- Supportive adults
- No other risk factors

Disposition

- Discuss with family and patient about behavioral health supports
- Psychoeducation materials/coping strategies
- Consider follow up contact in 4 weeks

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# ASSESSMENT OF SUICIDALITY

- Intermediate Risk- Yellow Zone
  - Suicidal thoughts, may have a plan
  - May have intent to act
  - Access to lethal means
  - Multiple risk factors
  - Some protective factors
  - Can meaningfully engage in care planning

- Disposition - Initiate care plan

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# ASSESSMENT OF SUICIDALITY

- Imminent  Risk- Red Zone
  - Suicidal thoughts with plan
  - May have intent to act on plan
  - Access to lethal means
  - Multiple risk factors - engaged in preparatory or rehearsal behaviors
  - Low or no (perceived) protective factors

- Disposition
  - ER/Crisis center evaluation
  - Do not leave patient alone/remove dangerous objects from room
  - Alert physician/clinician responsible for patient's care as applicable

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# CARE PLAN DEVELOPMENT

1. Warning signs of a crisis
2. Coping strategies
3. Distraction strategies
    1. Friends and family who can be contacted
    2. Social settings
    3. Activities
4. Friends and family who can be contacted for support
5. Health Professionals and Agencies with crisis support
6. Making the environment safe – reduce access to lethal means

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# LETHAL MEANS SAFETY

- 10 minutes
- 5 minutes

Most survivors regret the attempt

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# CARE PLAN COMMUNICATION

- Patient takes home a copy and has it in an accessible place
- Parent is provided with a copy as well
- Follow up
- Revisit the care plan at each visit

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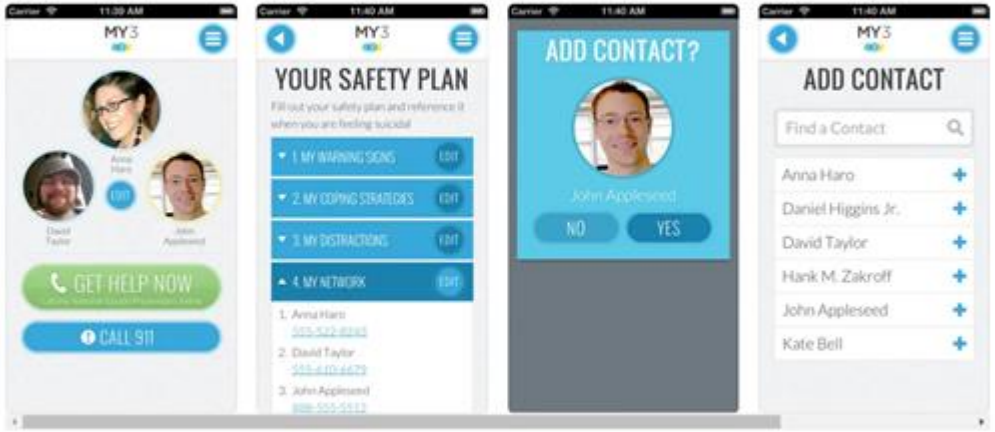
# SAFETY PLAN APPS

App Store Preview

iPhone Screenshots




Stay connected to your network when you are in a time of crisis with MY3. With MY3, you define your network, and your plan to stay safe. With MY3 you can be prepared to help yourself and reach out to others when you are feeling suicidal.

App Store Preview

Open the Mac App Store to buy and download apps.

**Stanley-Brown Safety Plan** 4+

Two Penguins Studios LLC

Designed for iPad

3.7 • 6 Ratings

Free

Screenshots iPad iPhone

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# RESOURCES

- **Partner's for Children's Mental Health** (pcmh.org) offers free training and consultation
- Links to Toolkits for primary care and schools: https://pcmh.org/resources/
- Gun locks free of charge: https://projectchildsafe.org/safety/get-a-safety-kit/
- Course on Counseling on Access to Lethal Means (CALM): https://zerosuicide.edc.org/resources/resource-database/counseling-access-lethal-means-calm

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# RESOURCES

- AAP- Suicide: Blueprint for Youth Suicide Prevention
  - https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/
- Suicide Prevention Toolkit for Primary care Practices

  https://www.sprc.org/settings/primary-care/toolkit
- National Institute of Mental health – ASQ ToolKit
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#outpatient

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