Behavioral Health Integration Collaborative

"Practical Strategies for Managing Suicidal Ideation and Reducing Risk"

September 23, 2021

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About the BHI Collaborative

*The BHI Collaborative was established by several of the nation's leading physician organizations** to catalyze effective and sustainable integration of behavioral and mental health care into physician practices.*

With an initial focus on primary care, the Collaborative is committed to ensuring a professionally satisfying, sustainable physician practice experience and will act as a trusted partner to help them overcome the obstacles that stand in the way of meeting their patients' mental and behavioral health needs.

***American Academy of Child & Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Medical Association, American Osteopathic Association, and the American Psychiatric Association.*

TODAY'S SPEAKERS

Christine Yu Moutier, MD

Chief Medical Officer

American Foundation for Suicide Prevention

Cori Green, MD MS, FAAP

Director of Behavioral Health Education and Integration

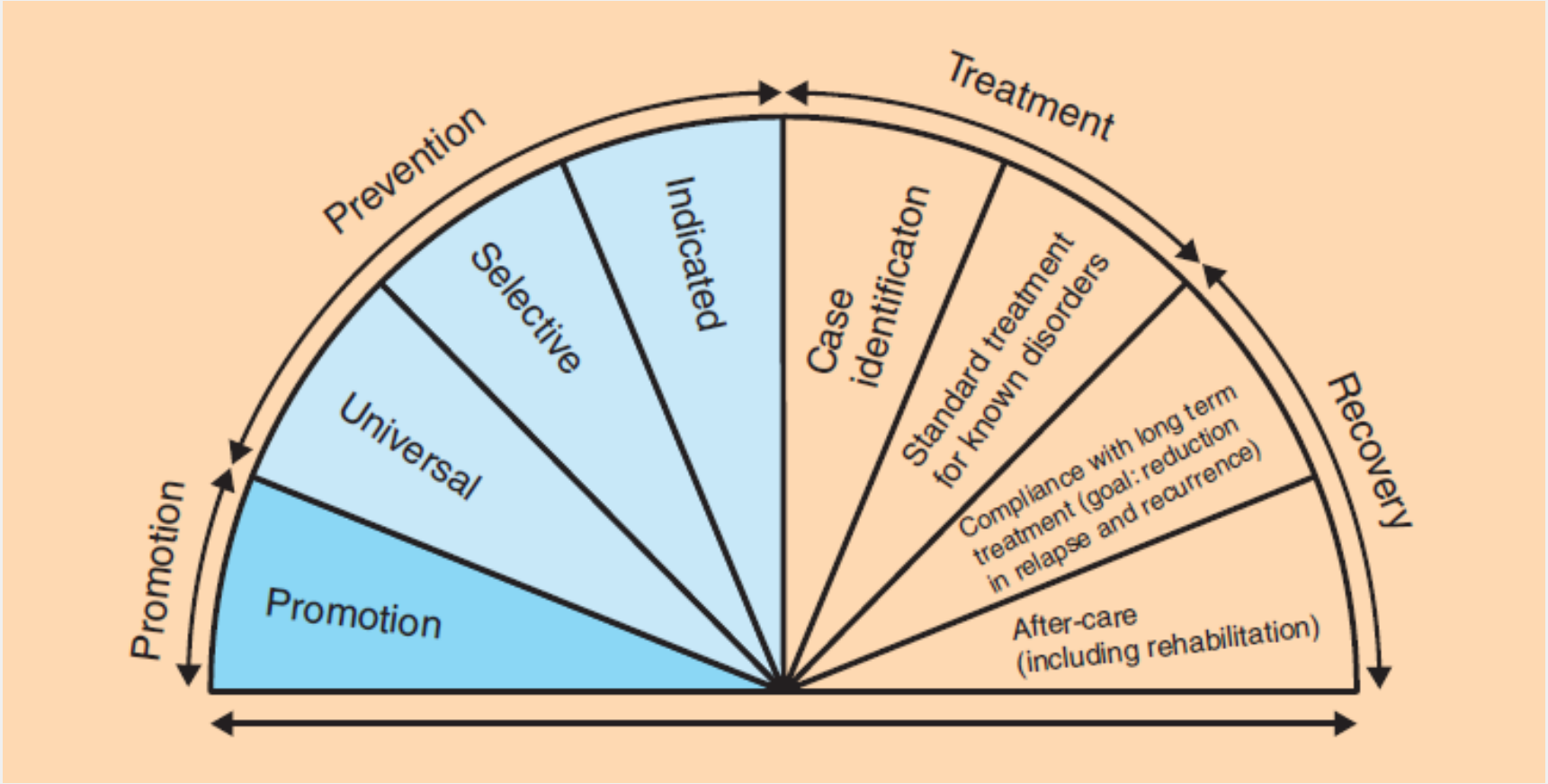
Weill Cornell Medicine

Strategies for Preventing Suicide

Christine Moutier, MD
AFSP Chief Medical Officer
@cmoutierMD

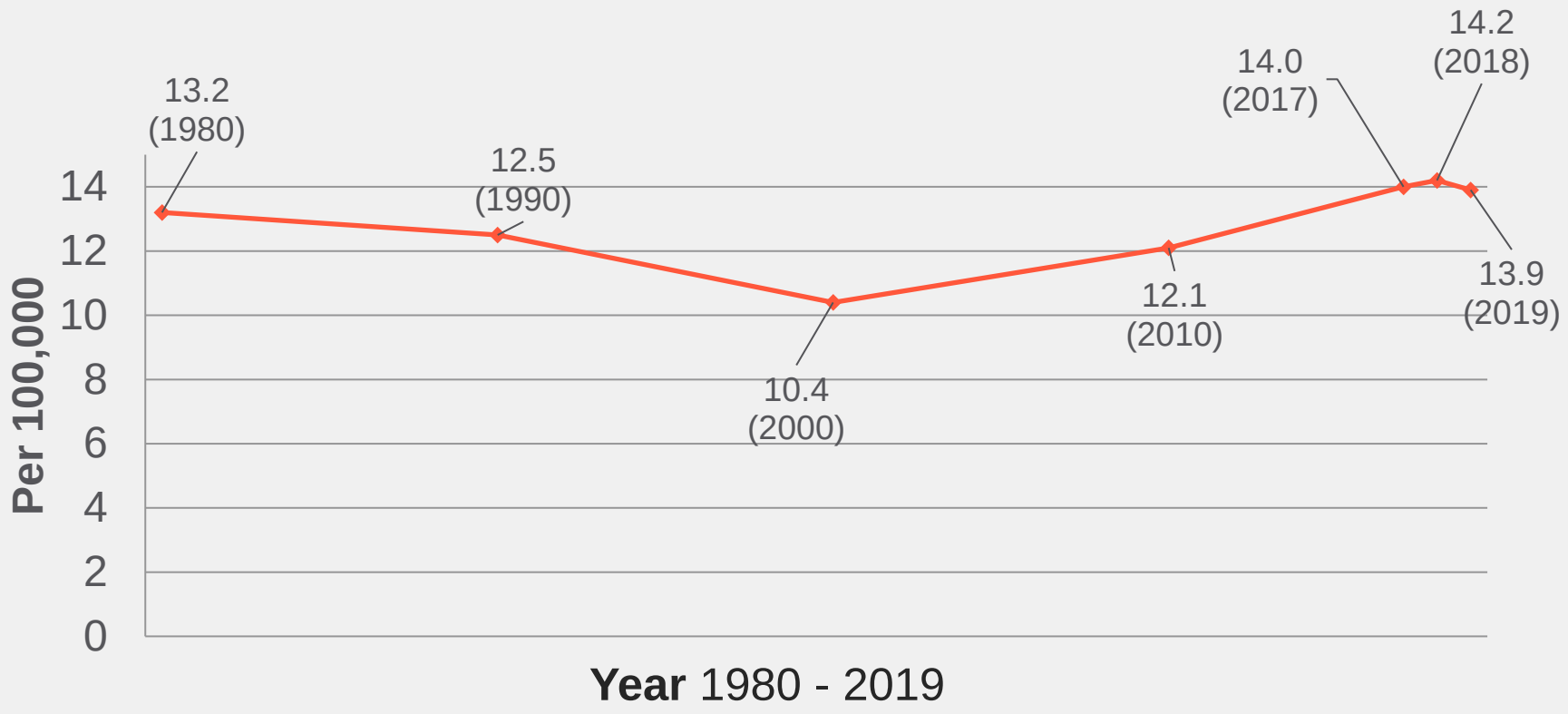
American Foundation for Suicide Prevention

Public Health Approach to Suicide Prevention



National Collaborating Centre for Mental Health (UK). Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance: Updated edition. Leicester (UK): British Psychological Society; 2014 (NICE Clinical Guidelines, No. 192.)
www.ncbi.nlm.nih.gov/books/NBK338542/figure/app9.f1

US Suicide Rate (1980–2019)



Centers for Disease Control and Prevention. Data and Statistics Fatal Injury Reports through 2020. Age-adjusted rates.

10 Leading Causes of Death, United States

2019, Both Sexes, All Ages, All Races

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 4,301	Unintentional Injury 1,149	Unintentional Injury 714	Unintentional Injury 778	Unintentional Injury 11,755	Unintentional Injury 24,516	Unintentional Injury 24,070	Malignant Neoplasms 35,587	Malignant Neoplasms 111,765	Heart Disease 531,583	Heart Disease 659,041
2	Short Gestation 3,445	Congenital Anomalies 416	Malignant Neoplasms 371	Suicide 534	Suicide 5,954	Suicide 8,059	Malignant Neoplasms 10,695	Heart Disease 31,138	Heart Disease 80,837	Malignant Neoplasms 435,462	Malignant Neoplasms 599,601
3	Unintentional Injury 1,266	Malignant Neoplasms 285	Congenital Anomalies 192	Malignant Neoplasms 404	Homicide 4,774	Homicide 5,341	Heart Disease 10,499	Unintentional Injury 23,359	Unintentional Injury 24,892	Chronic Low. Respiratory Disease 133,246	Unintentional Injury 173,040
4	Sids 1,248	Homicide 284	Homicide 155	Homicide 191	Malignant Neoplasms 1,388	Malignant Neoplasms 3,577	Suicide 7,525	Liver Disease 8,098	Chronic Low. Respiratory Disease 18,743	Cerebrovascular 129,193	Chronic Low. Respiratory Disease 156,979
5	Maternal Pregnancy Comp. 1,245	Heart Disease 133	Heart Disease 91	Congenital Anomalies 189	Heart Disease 872	Heart Disease 3,495	Homicide 3,446	Suicide 8,012	Diabetes Mellitus 15,508	Alzheimer's Disease 120,090	Cerebrovascular 150,005
6	Placenta Cord Membranes 742	Influenza & Pneumonia 122	Chronic Low. Respiratory Disease 69	Heart Disease 87	Congenital Anomalies 390	Liver Disease 1,112	Liver Disease 3,417	Diabetes Mellitus 6,348	Liver Disease 14,385	Diabetes Mellitus 62,397	Alzheimer's Disease 121,499
7	Bacterial Sepsis 603	Perinatal Period 57	Influenza & Pneumonia 52	Chronic Low. Respiratory Disease 81	Diabetes Mellitus 248	Diabetes Mellitus 887	Diabetes Mellitus 2,228	Cerebrovascular 5,153	Cerebrovascular 12,931	Unintentional Injury 60,527	Diabetes Mellitus 87,647
8	Respiratory Distress 424	Septicemia 53	Cerebrovascular 37	Influenza & Pneumonia 71	Influenza & Pneumonia 175	Cerebrovascular 585	Cerebrovascular 1,741	Chronic Low. Respiratory Disease 3,592	Suicide 8,238	Nephritis 42,230	Nephritis 51,565
9	Circulatory System Disease 406	Cerebrovascular 52	Septicemia 36	Cerebrovascular 48	Chronic Low. Respiratory Disease 168	Complicated Pregnancy 532	Influenza & Pneumonia 951	Nephritis 2,269	Nephritis 5,857	Influenza & Pneumonia 40,399	Influenza & Pneumonia 49,783
10	Necrotizing Enterocolitis 354	Benign Neoplasms 49	Benign Neoplasms 31	Benign Neoplasms 35	Cerebrovascular 158	Hiv 486	Septicemia 812	Septicemia 2,176	Septicemia 5,672	Parkinson's Disease 34,435	Suicide 47,511

Language Matters

Avoid

- Commit suicide
- Successful/failed attempt

Say

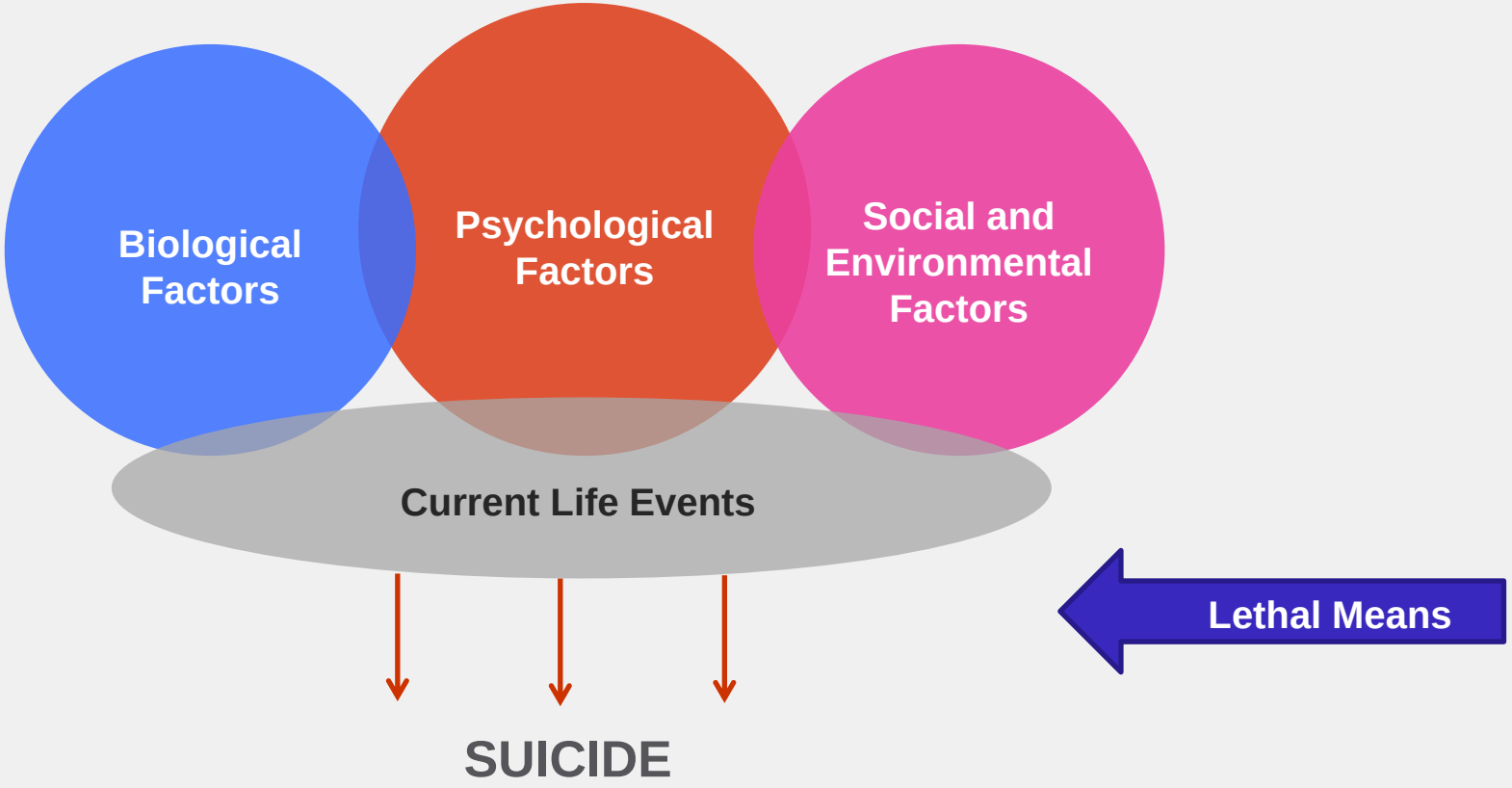
- Died by suicide
- Attempted suicide

Health System Opportunities

- Suicide hasn’t always been a clinical focus
- Stigma has limited self-care and patient care
- 90% suicide decedents seen in prior year
    - 50% within prior month/30% past week
        - 40% saw PC within month of suicide
        - 20% saw MHP within month of suicide

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: review of the evidence. *Am J Psychiatry* 2002

Interacting Risk and Protective Factors



AFSP 2014

Top Scientific Findings

- Multi-factorial risk, mental health key
- Genetics play a role but don't determine destiny
- Epigenetics
- Suicidal mindset
- Cognitive constriction
- Timing of acute risk
- Cultural factors (self-sufficiency)
- Shame/humiliation/despair

- Access to lethal means matters
- Effective MH treatment matters
- Contagion is real
- …but often conflated with asking
- Storytelling can also improve outcome
- Connection, processing are protective

Science dispels myths…

Science is providing interventions that reduce suicide risk.

Steps Health Systems Can Take

- Provide education to staff; Lethal Means Counseling
- Routine consent to involve fam at the start of Tx
- Routine screening/assessment
- Put ‘Caring Contacts’ in place systematically
- EHR for suicide preventive steps
  - Referral to BH, communication w family
  - Safety Plan completed, provided Lifeline
  - Counseled on lethal means removal

Practical Take-Aways

- Just because someone is thinking about suicide does not mean they are at risk of death. **Ask and listen.**
- To prevent suicide, we need to address the individual's drivers of risk (go beyond the presence of suicidal ideation or past attempts).
- Health systems, clinicians, loved ones have a role to play.
- Limiting access to lethal means saves lives.
- There are interventions that are effective in reducing suicidal behavior.

THANK YOU!

Save lives and bring hope
to those affected by suicide

@cmoutierMD

@afspNational

afsp.org

American Foundation for Suicide Prevention

Clinical Resources

Recommended Clinical Standards of Care for Suicide Prevention
https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

ASQ NIMH Suicide Risk Screening Pathway (NIMH site)

C-SSRS (Columbia Lighthouse Project)

SafeSide Suicide Prevention Training (AFSP will sponsor PC)

Collaborative Assessment and Management of Suicidality – CAMS (Jobes, Comtois) https://cams-care.com/

Safety Planning Intervention – SPI (Stanley, Brown) http://suicidesafetyplan.com/

Counseling on Access Lethal Means "CALM" (SPRC)

National Crisis Resources

National Suicide Prevention Lifeline, 800-273-8255
Crisis Text Line Text TALK to 741741

Clinician Support

Physician Support Line 888-409-0141 physiciansupportline.com
Emotional PPE Project www.emotionalppe.org/

AFSP Resources

https://afsp.org/physician
COVID resources www.AFSP.org/covid19
Find Local AFSP Chapter: www.afsp.org/find-a-local-chapter

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Practical Strategies for Managing Suicidal Ideation and Reducing Risk: The Role of a Pediatrician

Cori Green, MD, MS
Associate Professor of Clinical Pediatrics
Director, Behavioral Health Education and Integration in Pediatrics

Integrating Mental Health into Pediatric Care: *Continuum of Care*

- Prevention/Promotion
  - Anticipatory guidance to support healthy emotional development
  - Screen for risk factors to healthy emotional development
- Screening and Early identification
- Diagnostic Assessment
- Making a diagnosis
- Treatment
- Refer/Co-manage

Foy, Green, Earls: Mental Health Competencies for Pediatric Practice, *Pediatrics,* 2019

Identify and manage suicide risk

Pediatricians Experiences and Attitudes

Summary of national survey distributed to post-trainee respondents that provide primary care to patients over age 9:

- **8 in 10** had a patient attempt suicide in their career
- Only over half feel prepared on suicide prevention

Summary of resident survey at one program

- **100%** agree it is the pediatricians' responsibility to identify suicide risk
- **96%** agree it is the pediatrician's responsibility to perform a safety plan when risk identified

Role of the Pediatrician

Photo Credit: Youth In Health: Inclusive Stock Photography Collection. Adolescent Health Initiative. Heather Nash Photography. 2021

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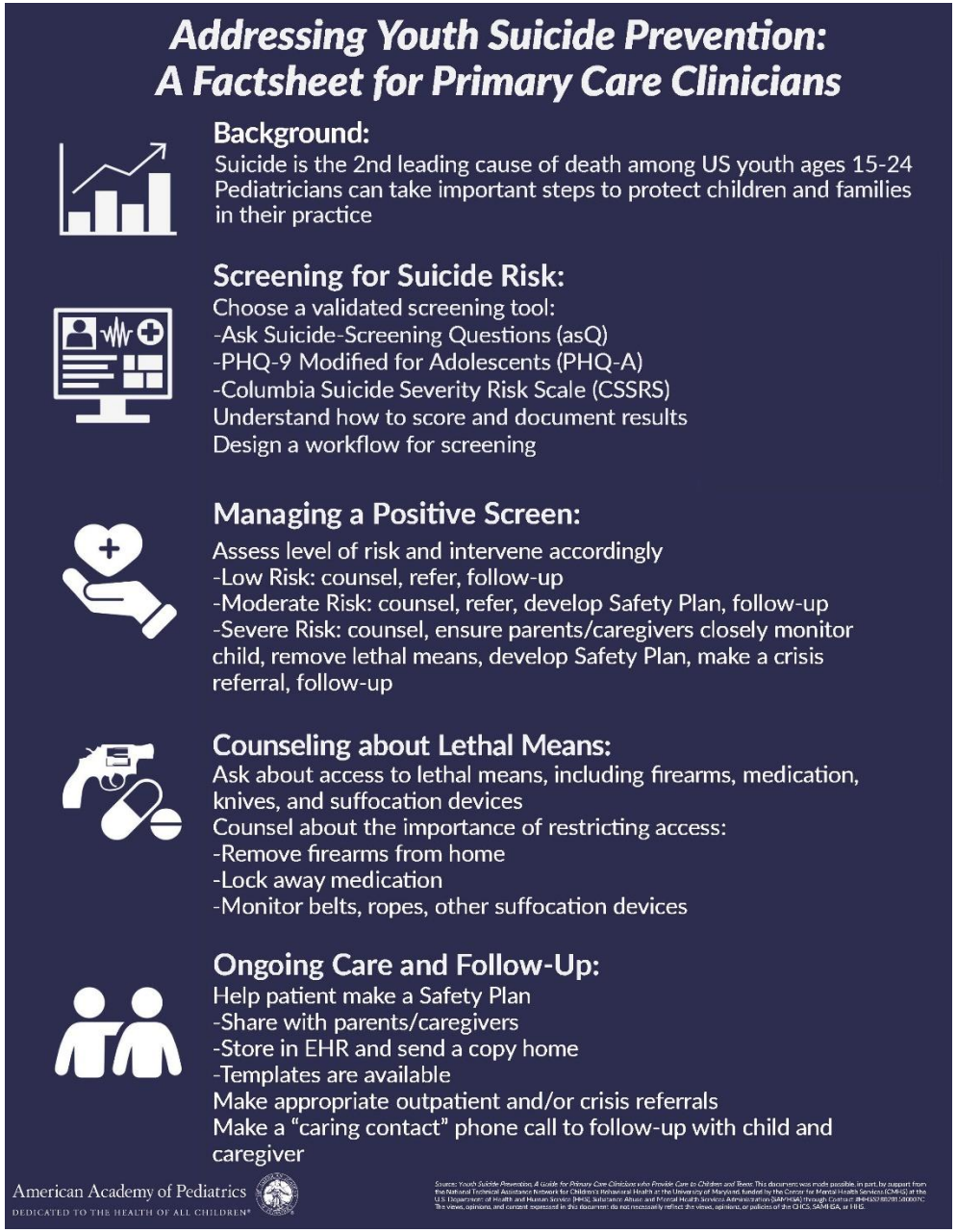

Photo credit: American Academy of Pediatrics Suicide Prevention Campaign Toolkit. Used with permission.

Identification and Screening

HEADS[4]: Home, Education, Activities, Drugs, Sexual Activity, Safety, Suicide, Social Media

Screening Tools:

- PHQ9 Modified for Adolescents (PHQ-A)
- Ask Suicide Questions (ASQ)
- Columbia Suicide Severity Rating Scale (CSSRS)

Identifying Suicide Risk: *Screening Tools*

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)

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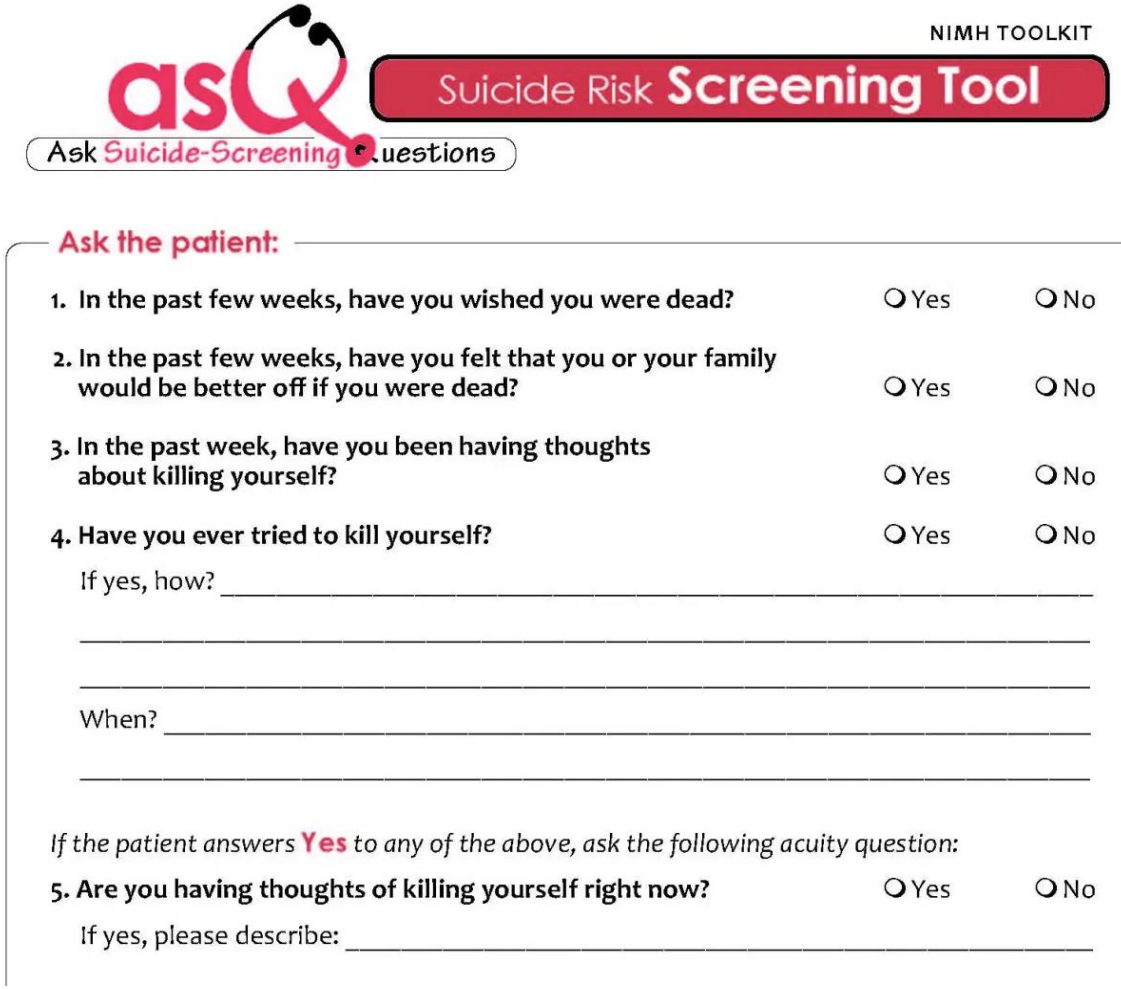
Identifying Suicide Risk:
Screening Tools

COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Primary Care***

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you had any actual thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *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.	**Lifetime**	
If YES, ask: *Was this within the past 3 months?*	**Past 3 Months**	

Identifying Suicide Risk: *Screening Tools*



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: _____

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https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/suicide_risk_screening_pathway_outpatient_youth.pdf

Managing a positive screen:
Engaging patient and parent or guardian using common factors

H	Hope: for improvement, identify strengths
E	Empathy: listen attentively
L2	Language: use family's language, check understanding Loyalty: express support and commitment
P3	Permission: ask permission to explore sensitive subjects, offer advice Partnership: identify and overcome barriers Plan: establish plan or at least a first step

Managing a Positive Screen:
Assess Level of Risk and Intervene Accordingly

Low: counsel, refer, follow up

Medium: counsel, refer, safety plan, follow up

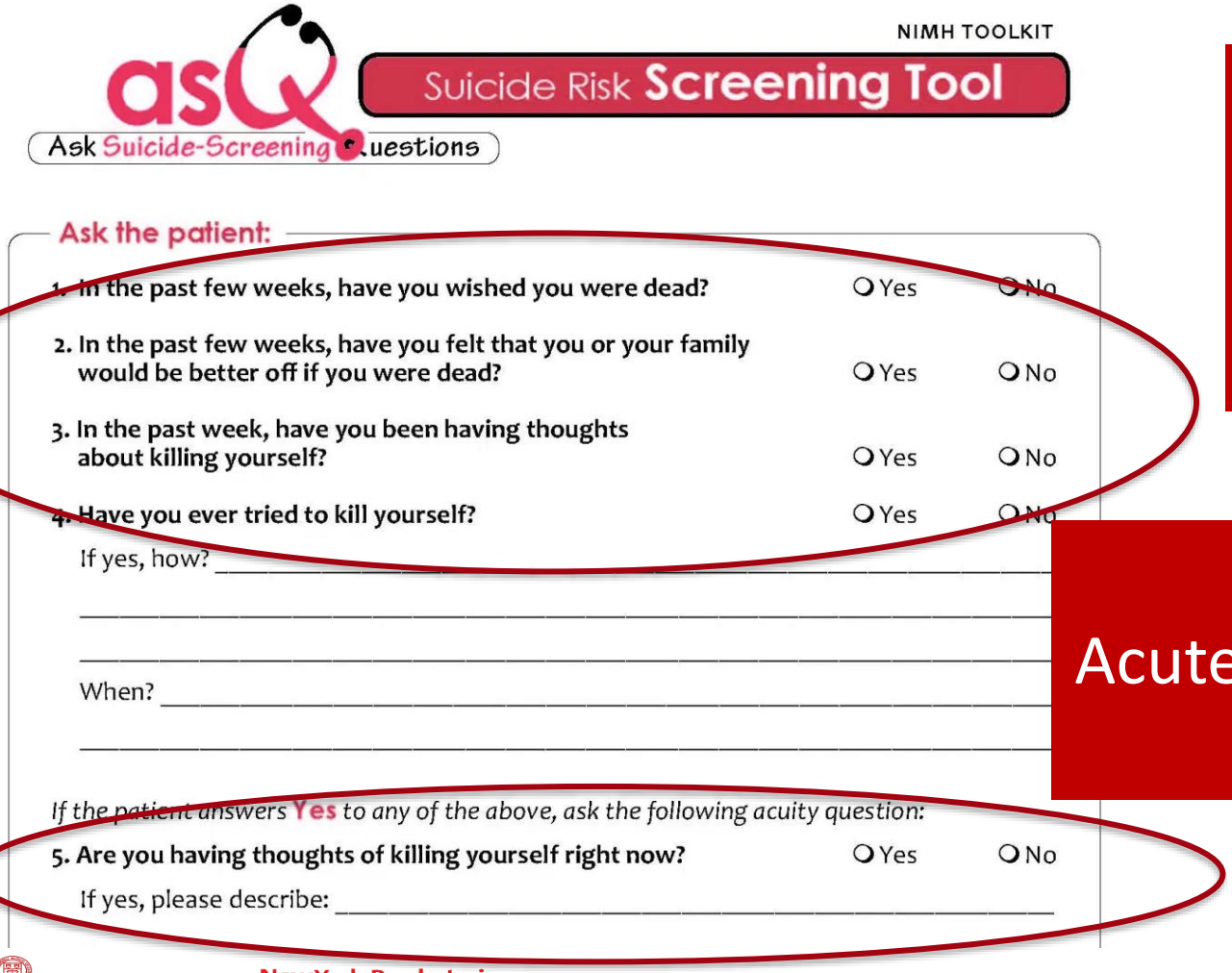
Severe: ensure caregiver closely monitors patient, remove lethal means from home, safety plan, crisis referral

RISK STRATIFICAITON*

LOW RISK	INTERMEDIATE RISK	HIGH RISK
Wish to die and/or suicidal ideation without method, plan, intent, or behavior *or* Modifiable risk/strong protective factors	Suicidal ideation with method, but without a plan or intent *and/or* Suicidal behavior > **3 months ago**	Suicidal ideation with intent +/- plan in the past month *and/or* Suicidal behavior **within past 3 months**
MANAGEMENT • Add **"risk for suicide"** to problem list • Complete Stanley/Brown Safety Plan • Counsel on lethal means restriction • Consider social work • Provide list of mental health resources • Provide family with children's mobile crisis (**1-888-NYC-WELL**) • Schedule 1 week follow up with PCP	**MANAGEMENT** • Add **"risk for suicide"** to problem list • Complete Stanley/Brown Safety Plan • Counsel on lethal means restriction • Involve on-site social work • Provide list of mental resources • Provide family with children's mobile crisis (**1-888-NYC-WELL**) • Schedule 1 week follow up with PCP • Talk to patient's mental health provider (if applicable) before sending home	**MANAGEMENT** • Add **"risk for suicide"** to problem lis • Send patient to ED to determine appropriateness of psychiatric hospitalization to maintain safety • Sign out to *both* the pediatric ED attending and psychiatry attending • Involve on-site social worker • Schedule 1 week follow up with PCP

https://www.aap.org/en/news-room/campaigns-and-toolkits/suicide-prevention/

Identifying Suicide Risk: *Screening Tools*



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: _____

If yes on any of 1-4 and **yes** to Q5: Are you having thoughts of killing yourself right now?

IMMINENT RISK

Acute suicidal thoughts needs urgent full mental health evaluation

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https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/suicide_risk_screening_pathway_outpatient_youth.pdf

Identifying Suicide Risk: *Screening Tools*

NIMH TOOLKIT

Suicide Risk Screening Tool

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: _____

If yes on any of 1-4 and **NO** to Q5, look at Q4 asking about attempt

Yes

Low risk if

>1 year ago, parent aware, received or in MH services, behavior not an active concern

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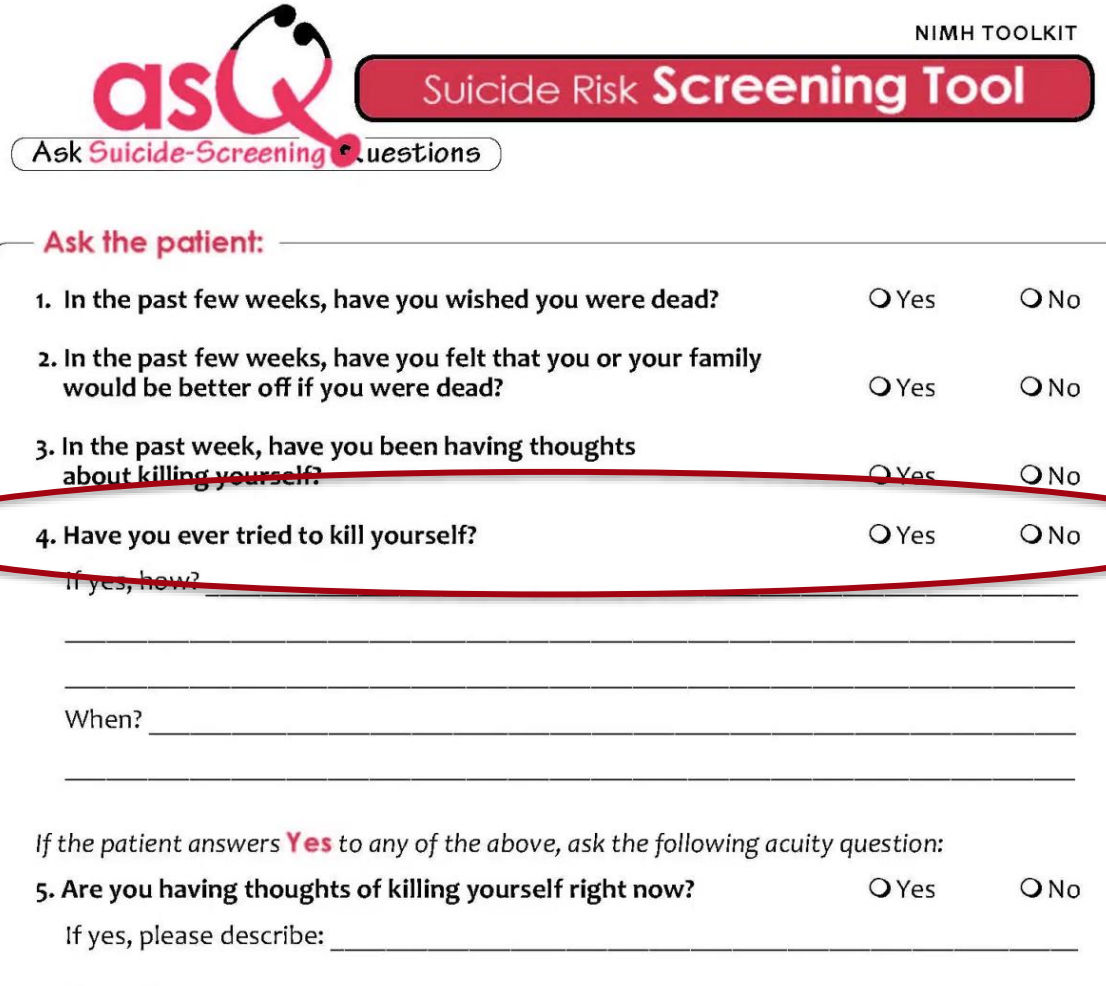
Identifying Suicide Risk: *Screening Tools*



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: _____

If yes on any of 1-4 and **NO** to Q4 and Q5?

Brief Suicide Safety Assessment

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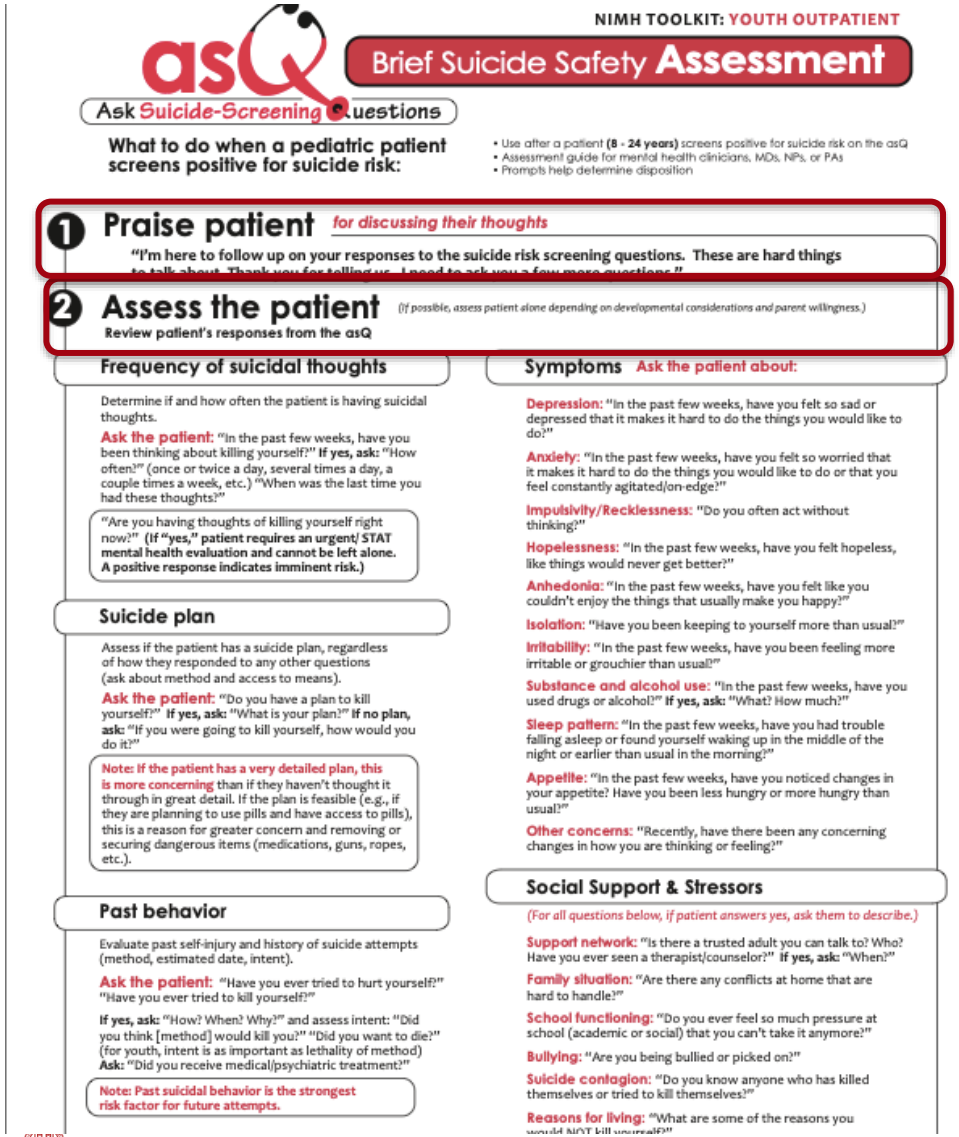
https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/suicide_risk_screening_pathway_outpatient_youth.pdf

Not just little adults: risk and protective factors to consider

- Bullying
- Child abuse, trauma, neglect
- Impulsive/aggressive
- Internet use
- Unsupportive environment for LGBTQ Youth
- Chronic medical conditions

- Engaged in school or activities
- Future Oriented
- Strong social supports/connectedness
- Responsibility to family or pets

Brief Suicide Safety Assessment



NIMH TOOLKIT: YOUTH OUTPATIENT

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 **(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

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?"

1. Praise the patient

2. Assess the patient

Frequency
Plan
Past Behavior
Symptoms
Social Supports and Stressors

"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?

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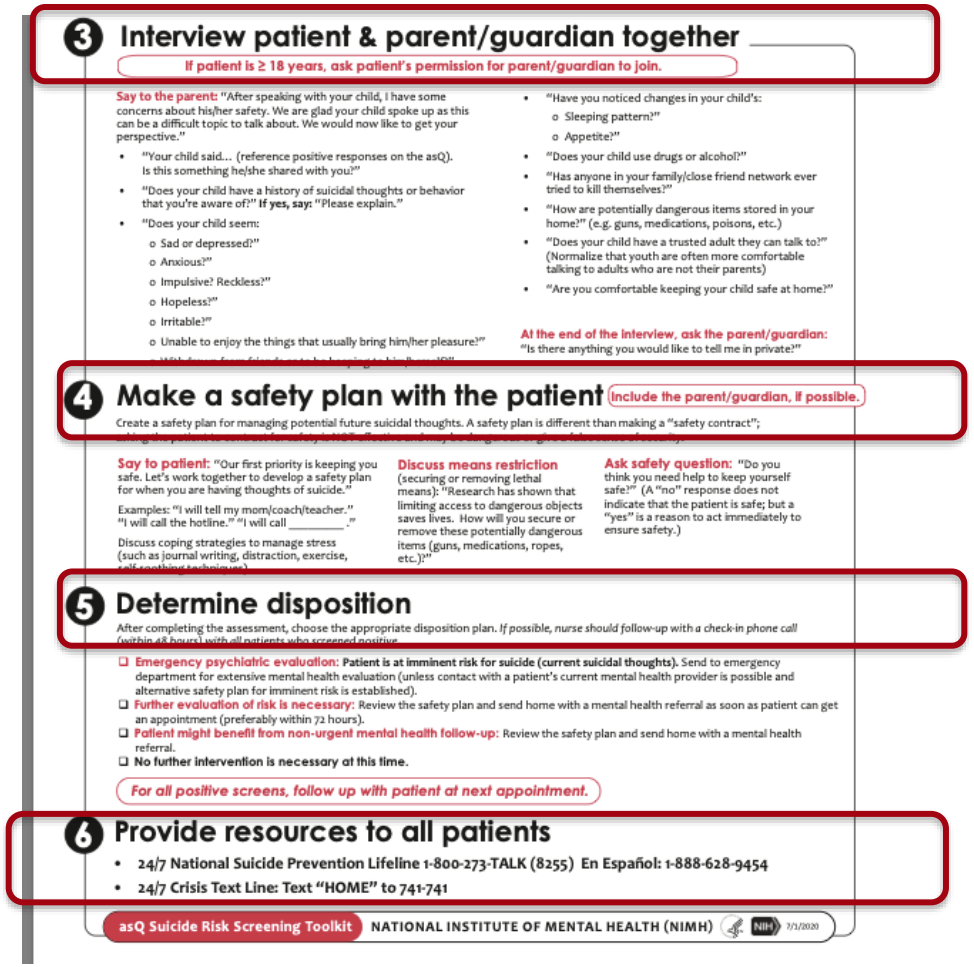
https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/bssa_outpatient_youth_asq_nimh_toolkit.pdf

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?"
- "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";

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,

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

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

3. Interview patient and guardian together

4. Make a safety plan with the patient and guardian

5. Determine disposition

6. Provide resources to all patients

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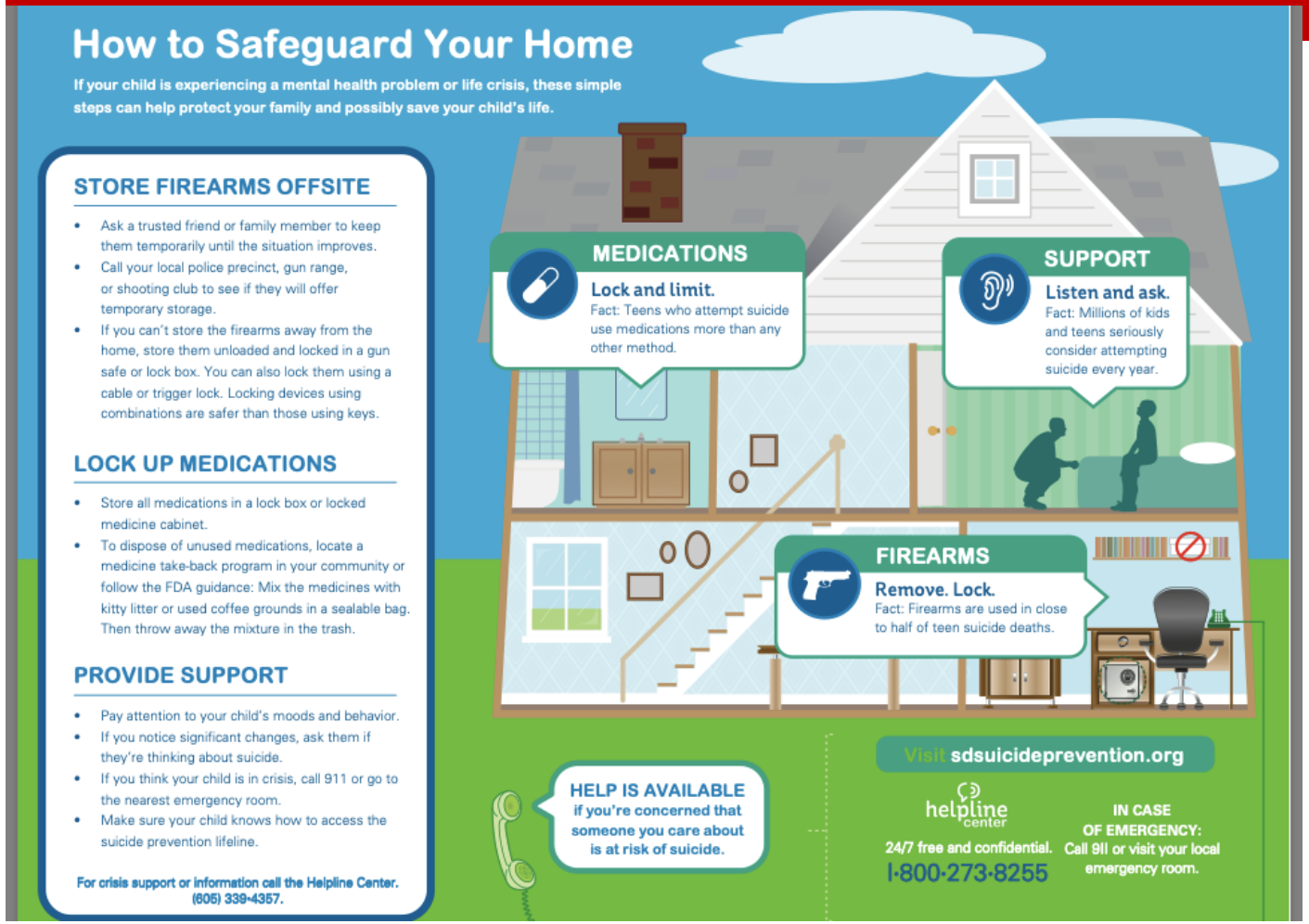
https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/youth-outpatient/bssa_outpatient_youth_asq_nimh_toolkit.pdf

Counseling about Lethal Means Restriction



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https://sdsuicideprevention.org/wp-content/uploads/2016/04/Suicide-Proof-Your-Home-Brochure_Final.pdf

Ongoing Care and Follow Up :
Complete Stanley & Brown Safety Plan

- Seeking a defined commitment to safety
- *Not* meant to be a safety contract
- Set of co-directed **coping strategies to decrease the risk of suicidal behavior** during a crisis
- Recognizes personal warning signs
- Identifies a patient's support network
- Involve the patient's parent/guardian

Always *document* your safety plan in the EMR

Stanley & Brown Safety Plan Template

STEP 1: Warning signs (e.g. thoughts, images, mood, situation, behavior) that a crisis may be developing

STEP 2: Internal coping strategies; Things I can do to take my mind off my problems without contacting another person (e.g. relaxation technique, physical activity)

STEP 3: People (including phone numbers) and social settings that provide distractions

STEP 4: People (including phone numbers) whom I can ask for help

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

- Clinician name and number
- Local urgent care services
- **Suicide Prevention Lifeline Phone: 1-800-273-TALK (85255)**
- **Crisis Text Line: Text HOME to 741741**

STEP 6: Making the environment safe

The one thing that is most important to me and worth living for is: _____

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

Ongoing Care and Follow Up

BHI Collaborative *"On Demand"* Webinars

- The Value of Collaboration and Shared Culture in BHI
- Behavioral Health Billing & Coding 101: How to Get Paid
- Implementation Strategies for Virtual BHI
- Financial Planning: Quantifying the Impact of BHI
- Physicians Leading the Charge: Dismantling Stigma around Behavioral Health Conditions & Treatment
- Privacy & Security: Know the Rules for Communication of Behavioral Health Information
- Effective BHI Strategies for Independent Practices
- Advancing Health Equity through BHI
- Bolstering Chronic Care Management with BHI
- How to Address the Growing Behavioral Health Concerns Among Children, Adolescents, and Families

Watch all these webinars and more on the Overcoming Obstacles YouTube playlist now!

Collaborative Resource – *BHI Compendium*

The BHI Compendium serves as a tool to learn about behavioral health integration and how to make it effective for your practice and patients.

Table of Contents

Download Now
to learn how to make the best decisions for the mental health of your patients.


Thank you for joining!

Additional Resources

Apps and Internet Resources

Safety Planning Apps (Stanley-Brown, notOK app)

ETUDES Brite Path app for clinicians, safety planning

Nowmattersnow.org (DBT, mindfulness techniques for public)

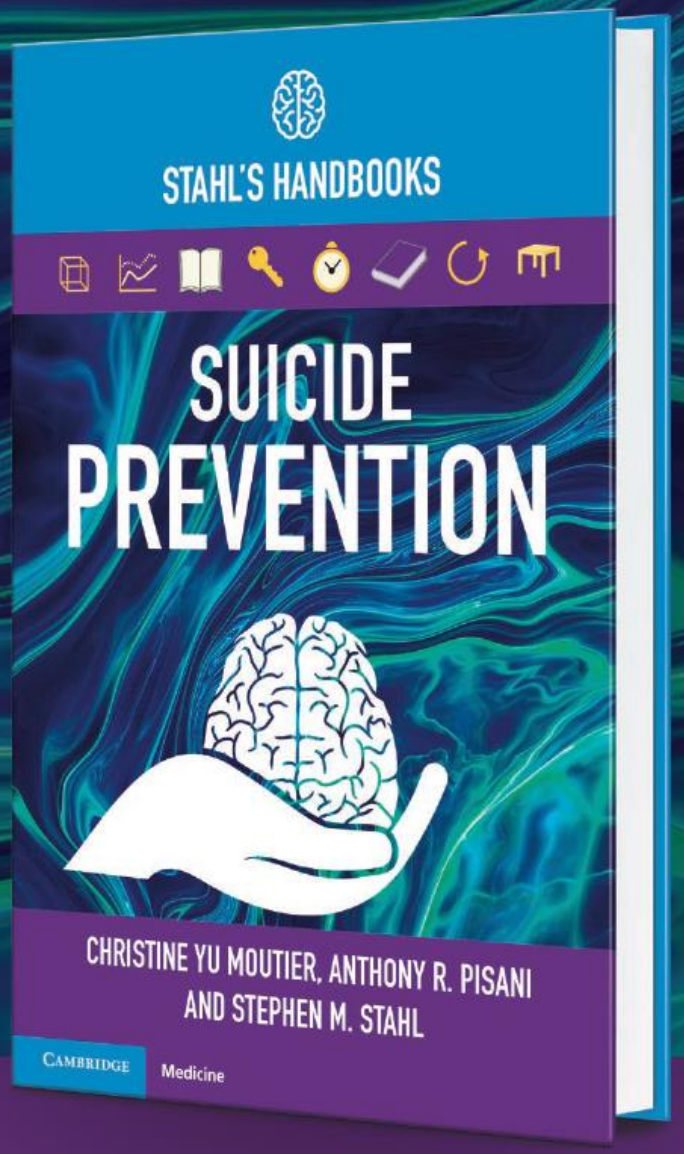
Virtual Hope Box app

AFSP.ORG for patient/family/advocacy resources

STAHL'S HANDBOOKS

SUICIDE PREVENTION

CHRISTINE YU MOUTIER, ANTHONY R. PISANI AND STEPHEN M. STAHL



AMA's Preventing Physician Suicide Resource

- The Preventing Physician Suicide online resource provides information about physician suicide, how to identify and address warning signs and risk factors, and AMA efforts and resources to prioritize mental health and well-being.
- https://www.ama-assn.org/practice-management/physician-health/preventing-physician-suicide