ACEs LA NoC Clinician Meeting
July 5, 2022
Suicide Screening & Assessment

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Agenda

- Engagement: Suicide screening experiences (15 min)
- Suicide screening and assessment algorithms (15 min)
- Engagement: Putting algorithms into practice (15 min)

ACEs Screening and Response

1. ACEs LA/ CALQIC – Initial workflows
2. SHARK – specialized referrals and management
3. Network of Care – connecting to resources, expanding prior efforts
4. UCAAN pilot projects – novel strategies to respond to ACEs
5. Clinician response to ACE-associated health conditions:
    1. Today **suicide**

Clinical scenario for engagement (15 min)

- 13 yo patient to clinic for WCC
- Intake: PHQ 9 = 14
- “Thoughts that you would be better off dead, or of hurting yourself in someway?”
  - Several days
- SW/Behavioral health not available

Questions for clinicians:

- *Any training to respond?*
- *How comfortable to respond? Why?*
- *What is your/clinic protocol for responding to suicidal ideation?*

Responses

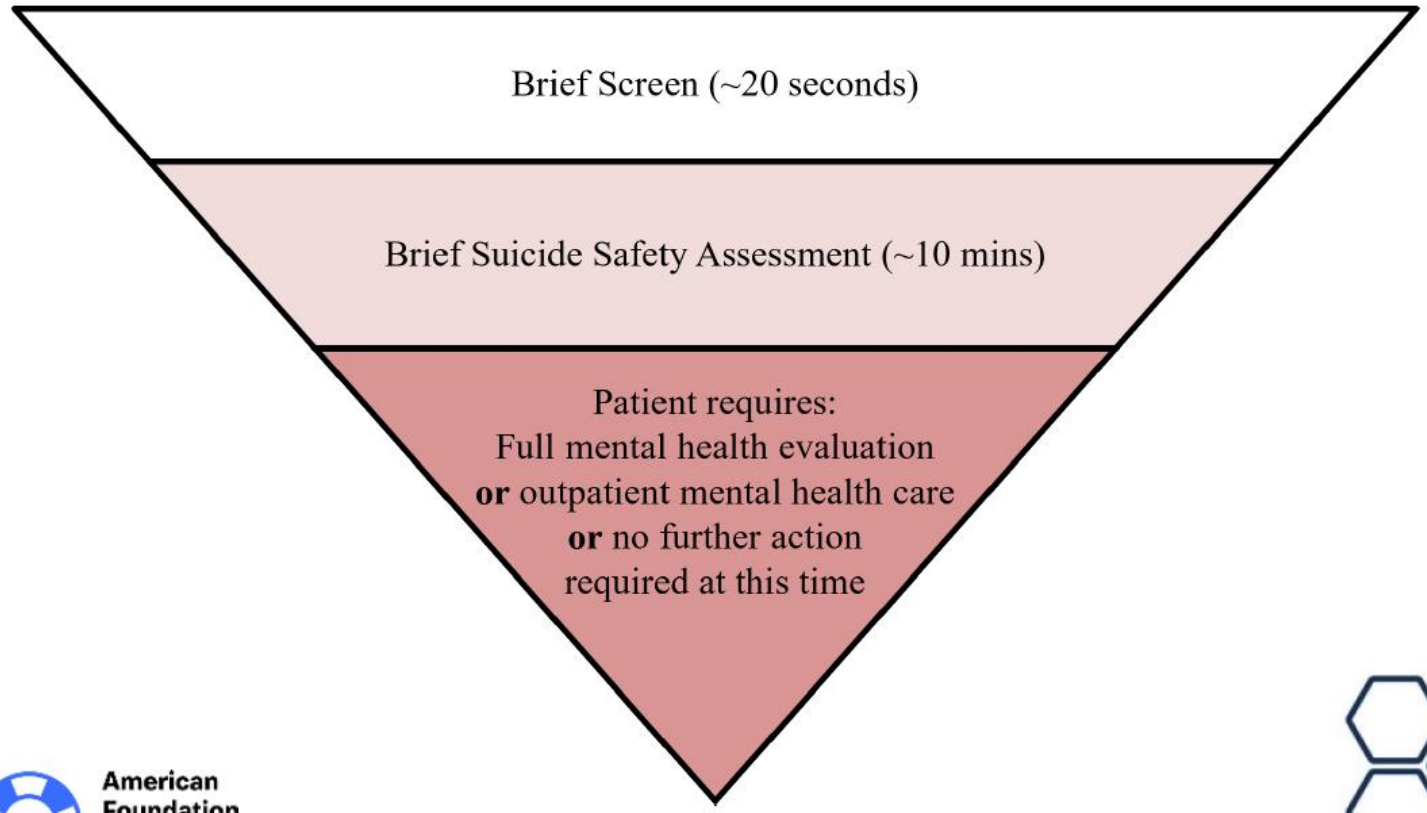
- Training: Not much, perhaps some during residency, on the job
- Level of comfort: Moderate to high, especially with practice and support

- Protocols:
  - Determine “active vs passive”
  - Contact DMH/local BH support
  - Arrange for close f/u

Why we need suicide screen/assess protocol

- Suicidal ideation associated w/ACEs & trauma
- Epidemiology
  - 2nd leading cause of death teens (CDC, 2016)
  - ~2 million annual attempts in US (YBRFSS, 2017)
  - 92% of clinicians reported patient disclosed SI in past year (Sisk, PAS, 2020)
- Validated response protocols exist
- Bright Futures 2022 Recommends
- We already screen everyone with PHQ 9!

AAP Suicide Screening Blueprint: 3 Tiers

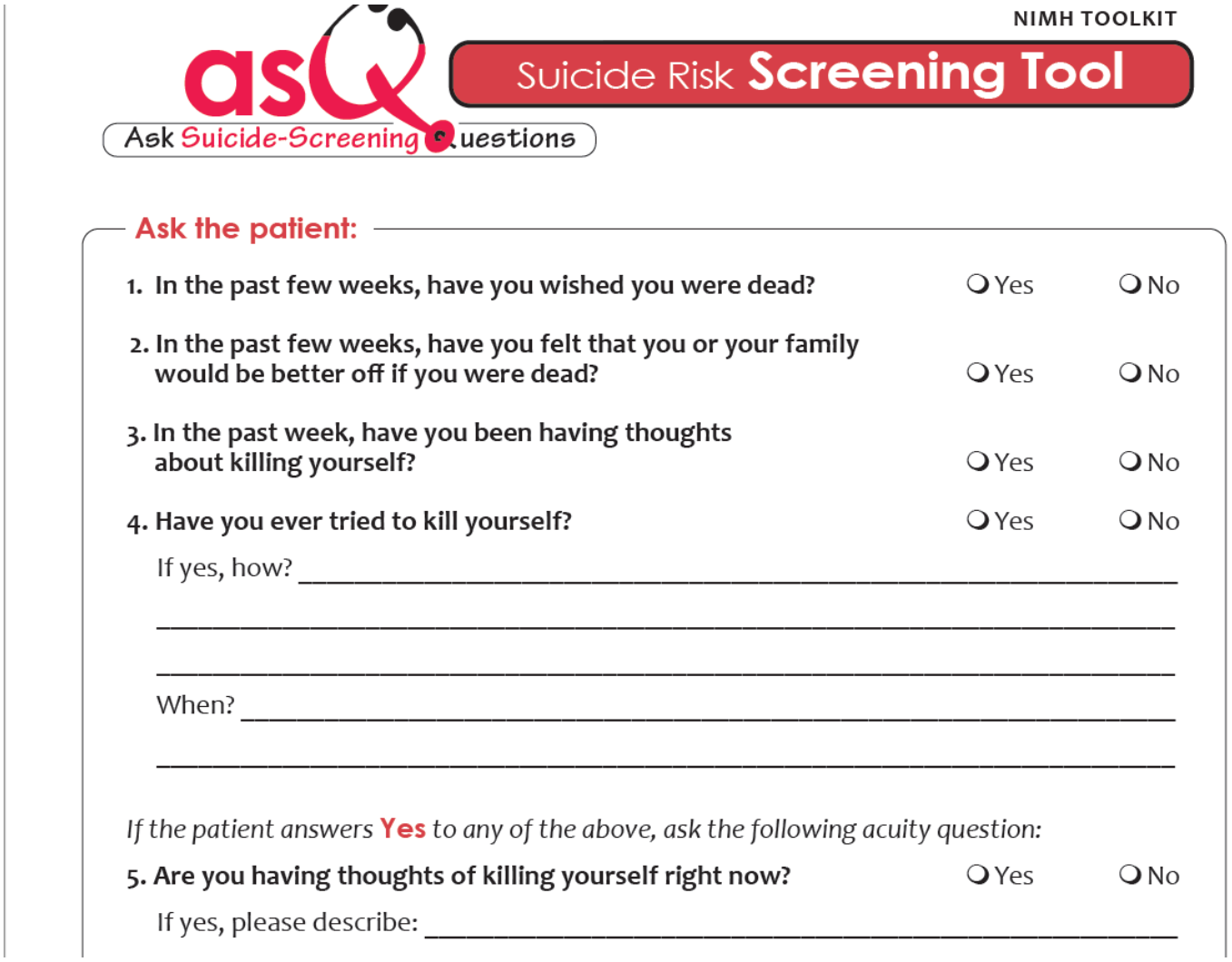


American Academy of Pediatrics

American Foundation for Suicide Prevention

PAS Pediatric Academic Societies

Brief Screen: Review Privately, Do Not Promise Confidentiality



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 "**no**" to Q1-4, no further assess needed (low risk), +/- non-urgent referral

If "**yes**" to any 1-4, go to Q5

If "**yes**" to Q5:

- Imminent risk. Initiate safety precautions until emergency full psych eval obtained

If **"no"** to Q5 AND**"yes"** to any of others, proceed to brief safety assessment

Disposition

- Imminent risk — Safety precautions until full psych eval obtained
- High risk — Safety plan, F/u within ~72 hrs
- Low risk — +/- non-urgent MH referral, f/u as clinically indicated

Validated Brief Suicide Safety Assessments

- Columbia (in ORCHID as Ad Hoc)
- Suicide Behavior Questionnaire, Revised (SBQ-R)
- PHQ-9A, Patient Safety Screener-3 (PSS-3)
- **NIMH Brief Suicide Safey Assessment (BSSA)**
  - Valid. in ED, inpatient, outpatient

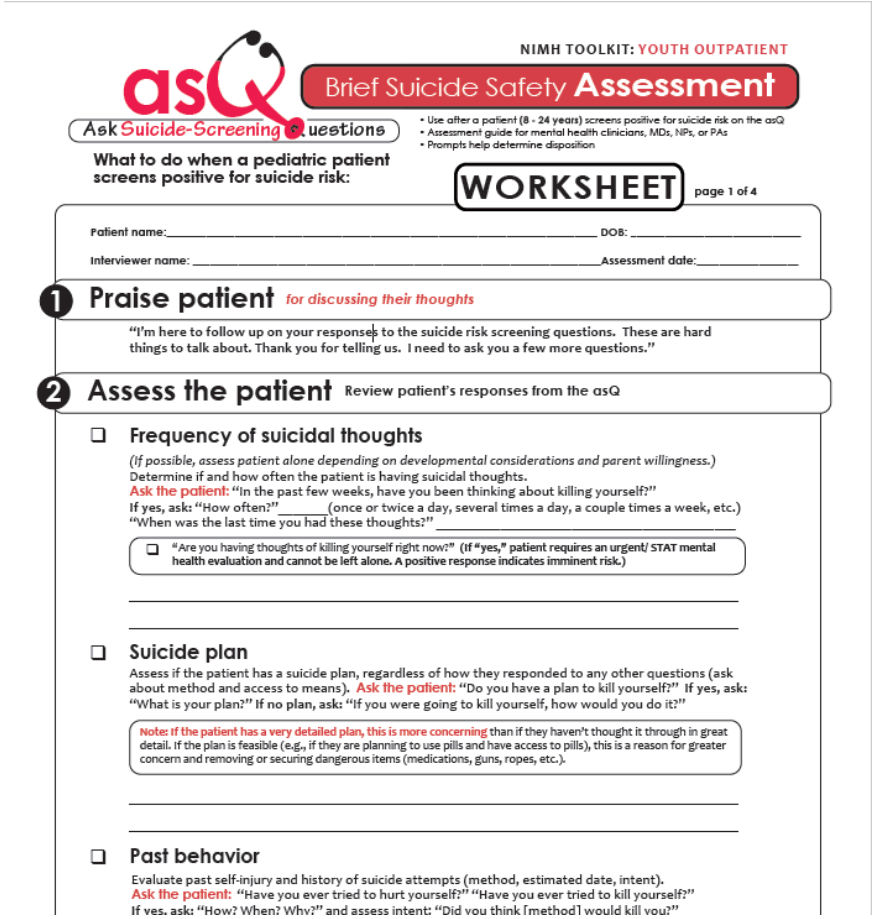
- Goal of BSSA
  - Decide on level of risk **(10-15 min)**
    - Imminent, high, low
- Use as a step-by-step guide (not rigidly following the script)

NIMH Brief Suicide Safety Assessment

Use 4-page worksheet, guided prompts

If at any time you are concerned about imminent risk:

Stop and initiate safety precautions until full eval



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

- 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 4

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.)
"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**

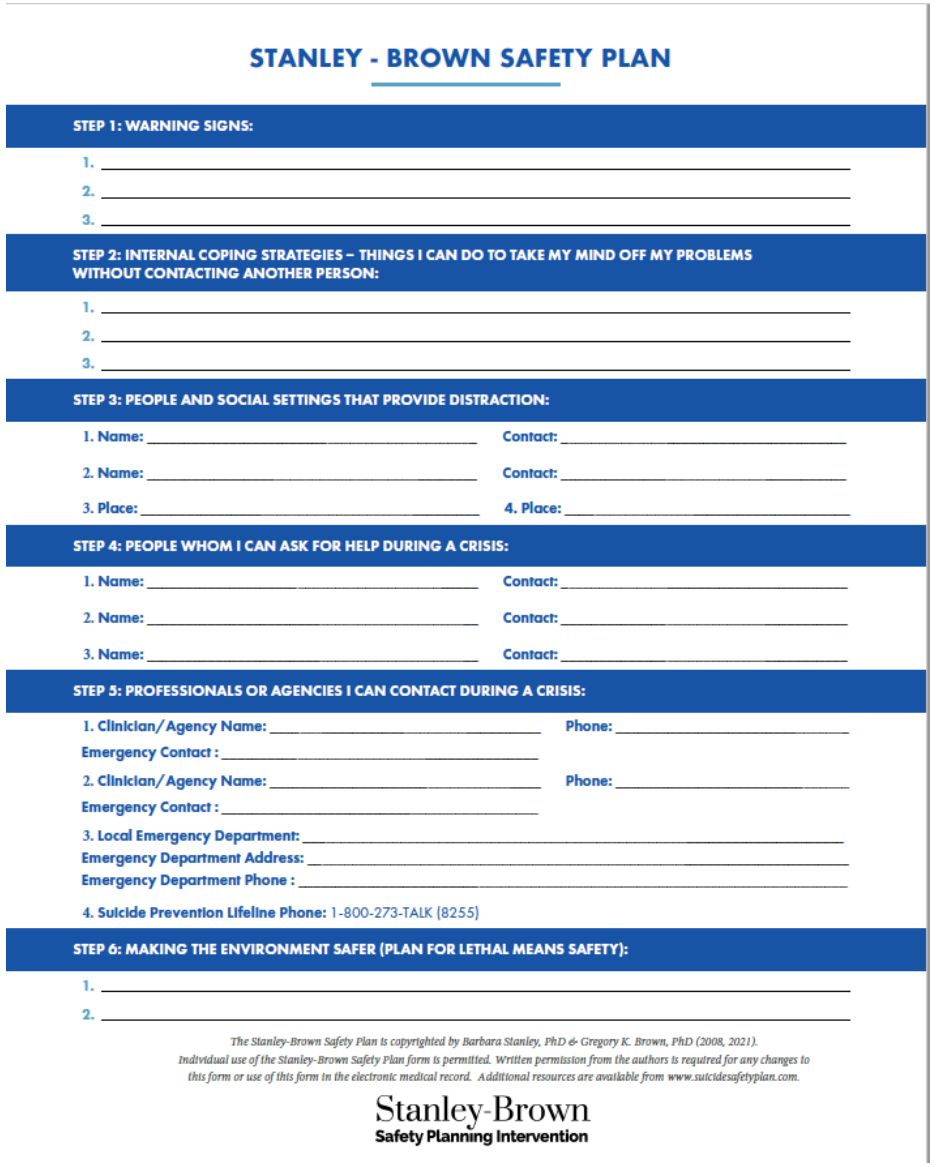
Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"

NIMH BSSA

1. Praise patient
2. Assess patient
   - Frequency of thoughts
     - High → imminent risk
   - Plan?
     - Detailed → imminent risk
   - Past attempts/behaviors?
     - If yes, and no positive supports → imminent risk
   - Symptoms
     - Anxiety, depression, impulsivity, substance use, sleep…
       - If high/risky symptoms → imminent risk
   - Social support/ACEs/Resilience
     - *PEARLS: ACEs/Resilience/SDOH
     - Social network, school functioning
     - Hopefulness
       - If low → imminent risk
3. Interview parent & patient together

Safety Plan: Complete w/Family

- Triggers/warning signs
- Coping strategies
  - Internal
  - People/settings for distraction
  - Adults to call for help
  - Suicide help lines
- Lethal means restrictions
- Referral (DMH/Health plan)
- F/u ~72 Hours



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

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

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

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

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

AAP/NSF Recommendation: Screen all w/ASQ Co-admin w/ PHQ

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

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

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

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

If yes, please describe: _____

Other Topics

- Does asking trigger SI? **No, it saves lives**
- Will this create extra burden?
  - Most will be low risk
  - With training should not take more than **10-15 min**
  - Don't cover all WCC in one visit
  - May create burden of f/u
  - **Will save lives across health system, help respond to ACE-as'd health conditions**
- Can staff be trained to administer? **Yes**
- More screening questions… Don't we have enough already?
  - **Lots of questions, but well-equipped to know the patient**
  - **Can't cover all in 1 visit**
- Can I use this for younger kids?
  - **Okay to use 8-11 yo**

Proposal - PDSA

- Don’t screen everyone yet
- When SI identified, print forms and try it out
- Copy of safety plan to family
- Report back: PDSA
- If protocol works well, consider:
  - Alter PHQ 9 screening form
  - Material on Sharepoint
  - E-consult section on SI

- <u>Thoughts:</u>
- Consider modifying suicide screening ad hoc to be more algorithmic and guideline-based
- Some clinicians willing to try it out, especially the expanded screener

Resources

- Great 1-Hour Training Video (NIMH, 2019)
- AAP Blueprint for Youth Suicide Prevention (2022)
- AAP Adolescent Depression Guidelines (2018)

- 24/7 National Suicide Prevention Lifeline (800) 273-TALK (8255)
- 24/7 Text « HOME » to 741-741