Suicidal Ideation and the Primary Care Physician

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Medical Director of Psychiatric Emergency Services

Assistant Professor at George Washington University in Psychiatry, Pediatrics, and Emergency Medicine

(BACK TO THE) **FUTURE OF PEDIATRICS**

Disclosures

No conflicts to disclose:

- No financial or business interest, arrangement or affiliation that could be perceived as a real or apparent conflict of interest in the subject (content) of their presentation.
- No unapproved or investigational use of any drugs, commercial products or devices.

Speaker Bios

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Meghan Schott, DO, FAPA attended Oberlin College and University of North Texas-Health Science Center for medical school. She completed residency training at Allegheny General Hospital in Pittsburgh and Northwestern University/Lurie Children's Hospital of Chicago for her child psychiatry fellowship. Prior to working at Children's National, she worked at Denver Health and was actively involved in the community buprenorphine program. Now she works at Children's National as the Medical Director of Psychiatric Emergency Services and is an Assistant Professor at the George Washington University Medical School in pediatrics, psychiatry, and emergency medicine. She has become an advocate in the community serving committees on local and national levels and serves as a co-chair on the DC Hospital Association Opioid Task Force, a member of the DC Hospital Associations Behavioral Health Collaborative, a committee member of American Academy of Child and Adolescent Psychiatry (AACAP) Early Career Psychiatry Committee and of AACAP Emergency Child Psychiatry committee, on the executive board for Washington Psychiatric Society, and a regional representative for the ACCAP Assembly. She also serves as a committee member of Academy of Consult Liaison Psychiatrists (ACLP) program subcommittee for Early Career Psychiatrists. Due to these advocacy efforts, she has become a Child Health Advocate Institute (CHAI) affiliate faculty member. She also serves on several hospital committees including: The Disruptive Patient Task Force, the Pharmacy and Therapeutics Committee, the Diversity and Inclusion Education Subcommittee, and the SAFER committee for gun violence and is actively involved in STEM mentorship.

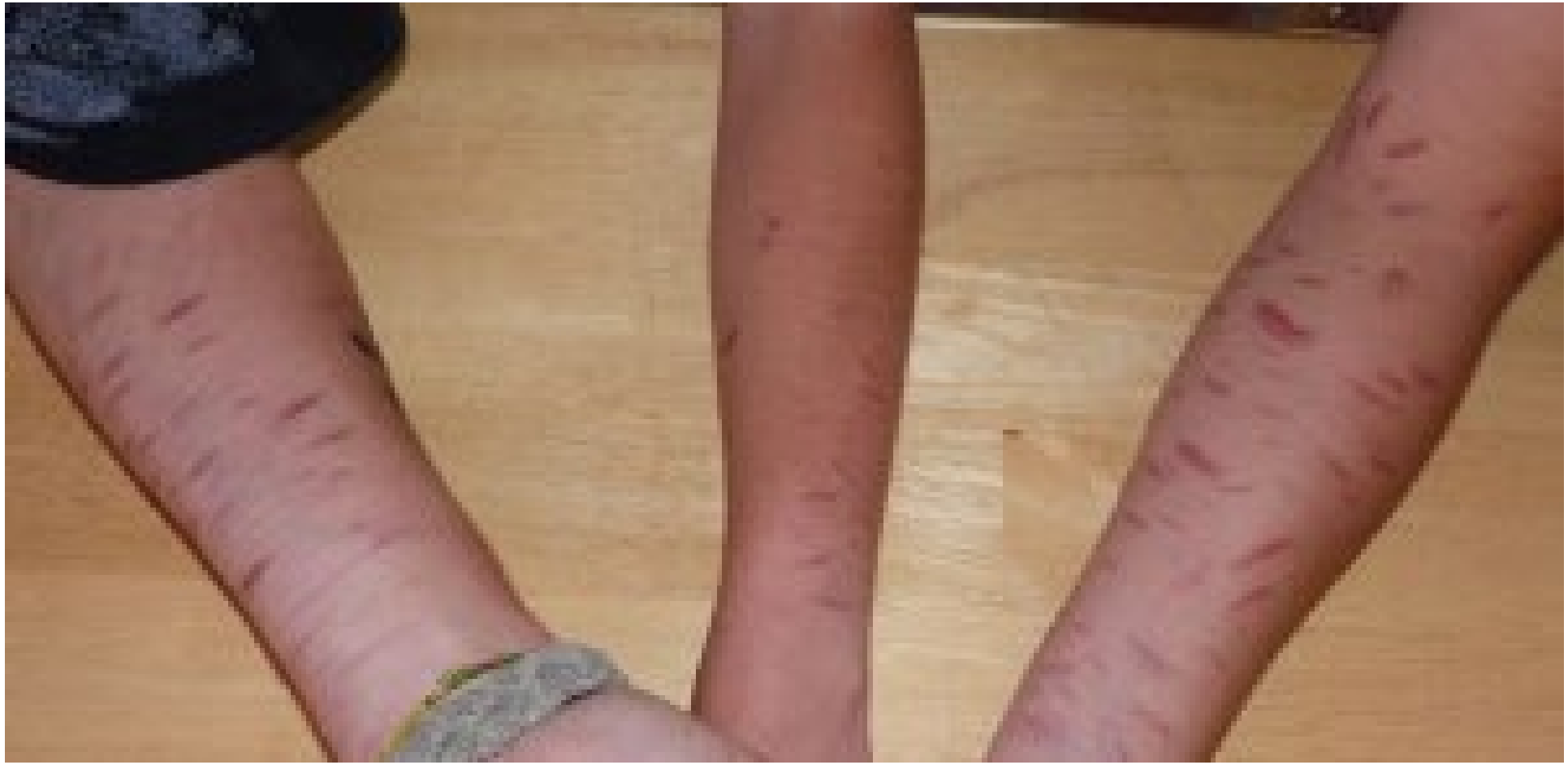
What is Suicide?

Suicide is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.

A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.

Suicidal ideation refers to thinking about, considering, or planning suicide.

Cutting



Is cutting a suicide attempt?

Cutting Facts

One in every 200 girls between 13 and 19 cut themselves regularly

Boys account for 10% of self harm

Suicide is a Leading Cause of Death in the United States

According to the Centers for Disease Control and Prevention (CDC) WISQARS Leading Causes of Death Reports, in 2017:

- Suicide was the tenth leading cause of death overall in the United States, claiming the lives of over 47,000 people.
- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.
- There were more than twice as many suicides (47,173) in the United States as there were homicides (19,510).

Leading Causes of Death in the United States (2016)

Data Courtesy of CDC

	Select Age Groups							
Rank	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	CLRD 131,002	Unintentional Injury 161,374
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	CLRD 17,810	Cerebro-vascular 121,630	CLRD 154,596
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575	Cerebro-vascular 1,851	CLRD 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	**Suicide 44,965**

(BACK TO THE) **FUTURE OF PEDIATRICS**

Trends in the Prevalence of Suicide–Related Behaviors
National YRBS: 1991–2019

The national Youth Risk Behavior Survey (YRBS) monitors health behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States. The national YRBS is conducted every two years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools throughout the United States.

Percentages															Trend from 1991–2019[1]	Change from 2017–2019[2]
1991	1993	1995	1997	1999	2001	2003	2005	2007	2009	2011	2013	2015	2017	2019		
Seriously considered attempting suicide (during the 12 months before the survey)																
29.0	24.1	24.1	20.5	19.3	19.0	16.9	16.9	14.5	13.8	15.8	17.0	17.7	17.2	18.8	Decreased 1991–2019 Decreased 1991–2007 Increased 2007–2019	No change
Made a suicide plan (during the 12 months before the survey)																
18.6	19.0	17.7	15.7	14.5	14.8	16.5	13.0	11.3	10.9	12.8	13.6	14.6	13.6	15.7	Decreased 1991–2019 Decreased 1991–2009 Increased 2009–2019	Increased
Attempted suicide (one or more times during the 12 months before the survey)																
7.3	8.6	8.7	7.7	8.3	8.8	8.5	8.4	6.9	6.3	7.8	8.0	8.6	7.4	8.9	Decreased 1991–2019	Increased
Made a suicide attempt that had to be treated by a doctor or nurse (during the 12 months before the survey)																
1.7	2.7	2.8	2.6	2.6	2.6	2.9	2.3	2.0	1.9	2.4	2.7	2.8	2.4	2.5	No change 1991–2019	No change

[1] Based on linear and quadratic trend analyses using logistic regression models controlling for sex, race/ethnicity, and grade, $p < 0.05$. Significant linear trends (if present) across all available years are described first followed by linear changes in each segment of significant quadratic trends (if present).
[2] Based on t-test analysis, $p < 0.05$.

2019 District of Columbia

Felt sad or hopeless (almost every day for 2 or more weeks in a row so that they stopped doing some usual activities, during the 12 months before the survey)	33.1 (32.2–34.1) 10,083	36.7 (35.1–38.3) 13,421	0.00		●	
Seriously considered attempting suicide (during the 12 months before the survey)	19.2 (18.4–20.0) 10,050	18.8 (17.6–20.0) 13,437	0.60			●
Made a plan about how they would attempt suicide (during the 12 months before the survey)	17.9 (17.2–18.7) 10,092	15.7 (14.6–16.9) 13,422	0.00	●		
Actually attempted suicide (one or more times during the 12 months before the survey)	14.9 (14.1–15.7) 8,419	8.9 (7.9–10.0) 10,520	0.00	●		
Suicide attempt resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	5.6 (5.1–6.2) 8,239	2.5 (2.1–3.0) 8,749	0.00	●		

Adolescent Behaviors and Experience Survey (ABES)

- CDC developed to assess the impact of COVID-19 on behaviors and experiences of high school students

ABES was administered during the **spring 2021** academic semester, from **January – June, 2021**. A total of **7,998 students** participated in ABES, representing **128 schools**. After processing, valid data were gathered from **7,705 questionnaires**.

ABES

Mental Health

	Total	
Mental Health	**Percentage**	**Confidence Interval***
Who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	44.2	41.6 - 46.8
Seriously considered attempting suicide (during the 12 months before the survey)	19.9	18.0 - 22.0
Made a plan about how they would attempt suicide (during the 12 months before the survey)	15.3	13.6 - 17.2
Actually attempted suicide (one or more times during the 12 months before the survey)	9.0	7.7 - 10.5
Had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	1.9	1.4 - 2.5
Reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)	31.1	28.5 - 33.7

ABES based on gender

Mental Health

	Female		Male	
Mental Health	Percentage	Confidence Interval*	Percentage	Confidence Interval*
Who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	56.5	53.4 - 59.5	31.4	29.1 - 33.7
Seriously considered attempting suicide (during the 12 months before the survey)	26.0	23.4 - 28.6	13.6	12.0 - 15.4
Made a plan about how they would attempt suicide (during the 12 months before the survey)	20.5	18.0 - 23.2	10.0	8.6 - 11.5
Actually attempted suicide (one or more times during the 12 months before the survey)	12.4	10.5 - 14.5	5.3	4.2 - 6.6
Had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	2.6	1.8 - 3.6	1.2	0.8 - 1.8
Reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)	41.6	38.4 - 44.9	19.6	17.6 - 21.8

ABES based on race

Adolescent Behaviors and Experiences Survey														
	American Indian or Alaska Native*		Asian*		Black or African American*		Hispanic or Latino*		Native Hawaiian or Other Pacific Islander*		White*		Multiple Race*	
Mental Health	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval
Who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	49.5	42.2 - 56.9	40.2	34.4 - 46.3	39.7	35.9 - 43.6	46.4	42.1 - 50.8	45.8	19.2 - 75.0	43.8	40.3 - 47.2	51.0	44.5 - 57.4
Seriously considered attempting suicide (during the 12 months before the survey)	23.3	15.6 - 33.5	15.9	12.6 - 19.9	16.2	13.0 - 20.0	19.7	16.9 - 22.7	12.4	3.3 - 36.5	21.0	18.6 - 23.6	25.6	18.1 - 34.8
Made a plan about how they would attempt suicide (during the 12 months before the survey)	14.4	5.8 - 31.6	14.1	6.5 - 28.1	12.1	8.8 - 16.3	15.8	13.8 - 18.0	13.3	3.6 - 39.0	15.7	13.4 - 18.3	20.2	14.4 - 27.6
Actually attempted suicide (one or more times during the 12 months before the survey)	20.1	12.4 - 30.9	7.4	4.9 - 11.0	10.0	7.7 - 12.9	8.4	6.5 - 10.7	N/A	N/A	8.9	7.1 - 11.0	12.3	8.0 - 18.5
Had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	8.9	3.3 - 22.0	0.9	0.3 - 2.4	2.2	1.3 - 3.7	1.6	0.9 - 2.9	N/A	N/A	2.0	1.4 - 2.9	1.3	0.6 - 3.0
Reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)	20.5	9.0 - 40.2	29.1	23.7 - 35.1	25.6	22.0 - 29.5	31.1	27.9 - 34.6	N/A	N/A	32.8	29.6 - 36.2	32.5	27.0 - 38.5

*Non-Hispanic
N/A: Less than 30 respondents for the subgroup

ABES for LBGTQ population

Adolescent Behaviors and Experiences Survey						
	Heterosexual		Gay, Lesbian, or Bisexual		Other/Questioning	
Mental Health	Percentage	Confidence Interval	Percentage	Confidence Interval	Percentage	Confidence Interval
Who felt sad or hopeless (almost every day for two or more weeks in a row so that they stopped doing some usual activities, ever during the 12 months before the survey)	36.7	34.1 - 39.4	75.7	70.9 - 79.9	68.7	63.6 - 73.4
Seriously considered attempting suicide (during the 12 months before the survey)	13.6	11.7 - 15.8	46.8	41.5 - 52.2	39.5	34.6 - 44.7
Made a plan about how they would attempt suicide (during the 12 months before the survey)	9.9	8.3 - 11.8	37.9	34.3 - 41.8	32.3	27.4 - 37.5
Actually attempted suicide (one or more times during the 12 months before the survey)	5.2	4.2 - 6.5	26.3	21.8 - 31.4	16.5	11.8 - 22.7
Had a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse (during the 12 months before the survey)	0.9	0.7 - 1.3	5.9	3.7 - 9.4	3.6	2.1 - 6.0
Reported that their mental health was most of the time or always not good (including stress, anxiety, and depression, during the 30 days before the survey)	25.5	22.5 - 28.8	54.9	49.5 - 60.2	45.7	40.5 - 50.9

Signs and Symptoms

Talking about wanting to die or wanting to kill themselves

Talking about feeling empty, hopeless, or having no reason to live

Making a plan or looking for a way to kill themselves, such as searching online, stockpiling pills, or buying a gun

Talking about great guilt or shame

Talking about feeling trapped or feeling that there are no solutions

Feeling unbearable pain (emotional pain or physical pain)

Talking about being a burden to others

Using alcohol or drugs more often

Acting anxious or agitated

Withdrawing from family and friends

Changing eating and/or sleeping habits

Showing rage or talking about seeking revenge

Taking great risks that could lead to death, such as driving extremely fast

Talking or thinking about death often

Displaying extreme mood swings, suddenly changing from very sad to very calm or happy

Giving away important possessions

Saying goodbye to friends and family

Putting affairs in order, making a will

The Joint Commission (July 2019)

- Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool

- In July 2020 changed to 12 and above

- Use an evidence-based process to conduct a suicide risk assessment of individuals served who have screen positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors

Joint Commission Recommendations for Evidence Based Screeners

- ED Safe Secondary Screener
- Patient Health Questionnaire (PHQ-9)
- Patient Safety Screener (PSS-3)
- Tool for Assessment of Suicidal Risk (TASR) Adolescent Screener
- Suicide Behavior Questionnaire Revised (SBQ-R)
- Ask Suicide Screening Questions (ASQ) Suicide Risk Screening Tool
- Columbia-Suicide Severity Rating Scale (C-SSRS)

  With SAFE-T can also be used as assessment

Choosing a Suicide Screen

Single item measures of construct, including suicidality should be avoided as only in rare situations when single item perform as well as validated multiple item measures.

Some psychometricians have determined the ideal number of item response choices to be 4-7

The ACEP (American College of Emergency Physicians) reports that screening suicide screening is positive for 42%, but only 1.5% cases are true positive. Hence important to have a test with high specificity to help reduce healthcare burdens

ED Safe Secondary Screener

Assess the following six indicators using all data available to you, including patient self-report, collateral information, medical record review, and current observations. Each "Yes" gets a score of 1.

1. Positive on both safety screener (PSS-3) items – active ideation with a past attempt
Source: Safety screening (PSS-3), documented on chart.
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

2. Recent or current suicide plan*
Suggested wording: Have you been thinking about how you might kill yourself?
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

3. Recent or current intent to act on ideation*
Suggested wording: Have you had some intention of acting on your thoughts?
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

4. Lifetime psychiatric hospitalization
Suggested wording: Have you ever been hospitalized for a mental health or substance use problem?
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

5. Pattern of excessive substance use
Suggested wording: Has drinking or drug abuse ever been a problem for you? Or positive on CAGE or other standardized substance use screener.
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

6. Current irritability, agitation, or aggression
Source: Clinical observation, collateral report
☐Yes[1] ☐No[0] ☐Unable to complete Notes:_____

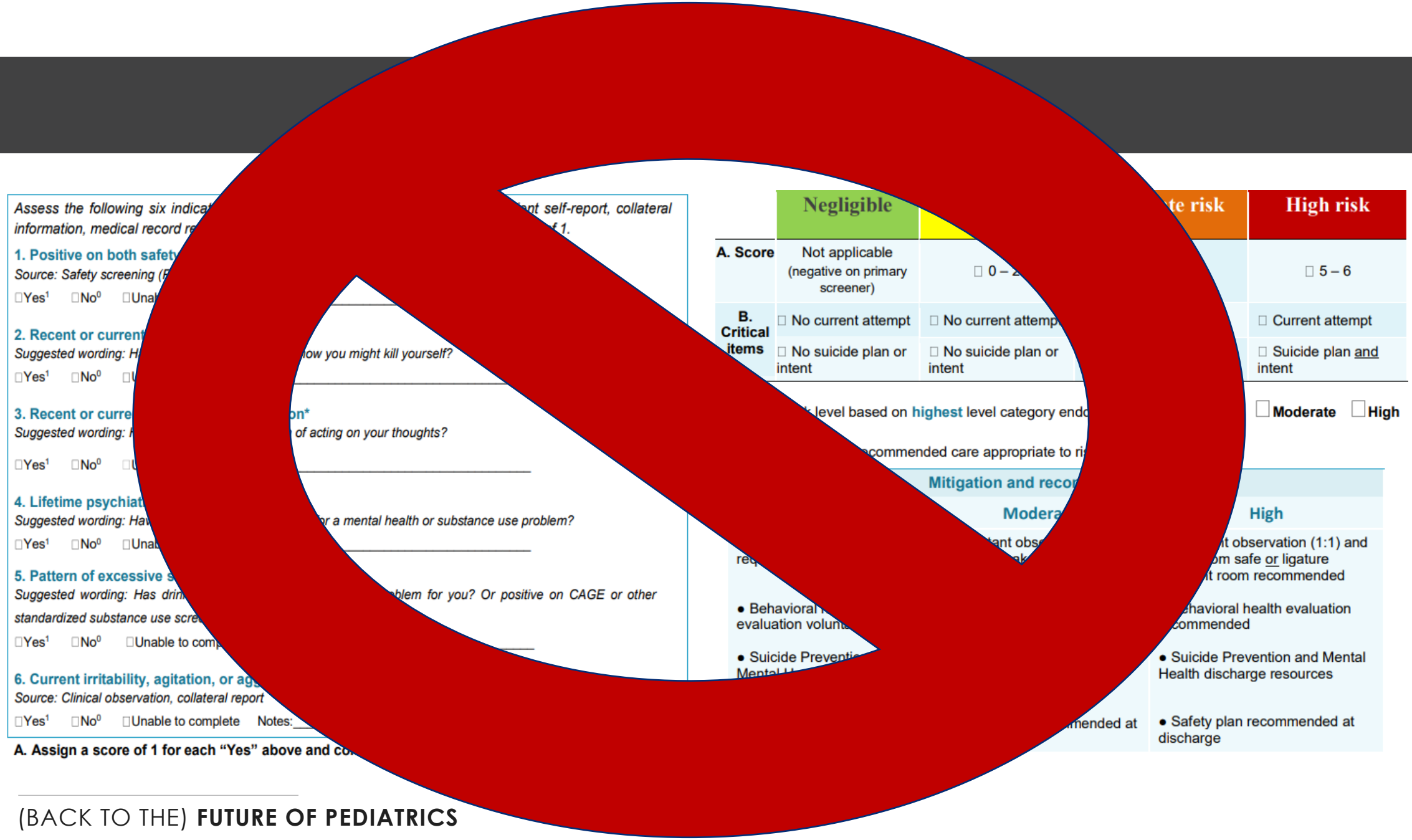
A. Assign a score of 1 for each "Yes" above and combine to obtain a total score. Score: _____/ 6

	Negligible	Mild risk	Moderate risk	High risk
A. Score	Not applicable (negative on primary screener)	☐ 0 – 2	☐ 3 – 4	☐ 5 – 6
B. Critical items	☐ No current attempt	☐ No current attempt	☐ No current attempt	☐ Current attempt
	☐ No suicide plan or intent	☐ No suicide plan or intent	☐ Suicide plan or intent (not both)	☐ Suicide plan and intent

Conclude risk level based on **highest** level category endorsed on any row: ☐ **Mild** ☐ **Moderate** ☐ **High**

Enact mitigation and recommended care appropriate to risk level:

Mitigation and recommended care		
Mild	**Moderate**	**High**
• Constant observation not required	• Constant observation (1: several), make room safe recommended	• Constant observation (1:1) and make room safe or ligature resistant room recommended
• Behavioral health evaluation voluntary	• Behavioral health evaluation recommended	• Behavioral health evaluation recommended
• Suicide Prevention and Mental Health discharge resources	• Suicide Prevention and Mental Health discharge resources	• Suicide Prevention and Mental Health discharge resources
• Safety plan recommended at discharge	• Safety plan recommended at discharge	• Safety plan recommended at discharge


Assess the following six indicat
nt self-report, collateral
information, medical record re
f 1.
1. Positive on both safety
Source: Safety screening (P
Yes1 No0 Unab
2. Recent or current
Suggested wording: H
ow you might kill yourself?
Yes1 No0
3. Recent or curre
on*
Suggested wording: H
of acting on your thoughts?
Yes1 No0
4. Lifetime psychiat
Suggested wording: Hav
or a mental health or substance use problem?
Yes1 No0 Unab
5. Pattern of excessive s
Suggested wording: Has drin
blem for you? Or positive on CAGE or other
standardized substance use scre
Yes1 No0 Unable to comp
6. Current irritability, agitation, or ag
Source: Clinical observation, collateral report
Yes1 No0 Unable to complete Notes:
A. Assign a score of 1 for each "Yes" above and co
Negligible
te risk
High risk
A. Score
Not applicable (negative on primary screener)
0 – 2
5 – 6
B. Critical items
No current attempt
No current attemp
Current attempt
No suicide plan or intent
No suicide plan or intent
Suicide plan and intent
level based on highest level category endo
Moderate
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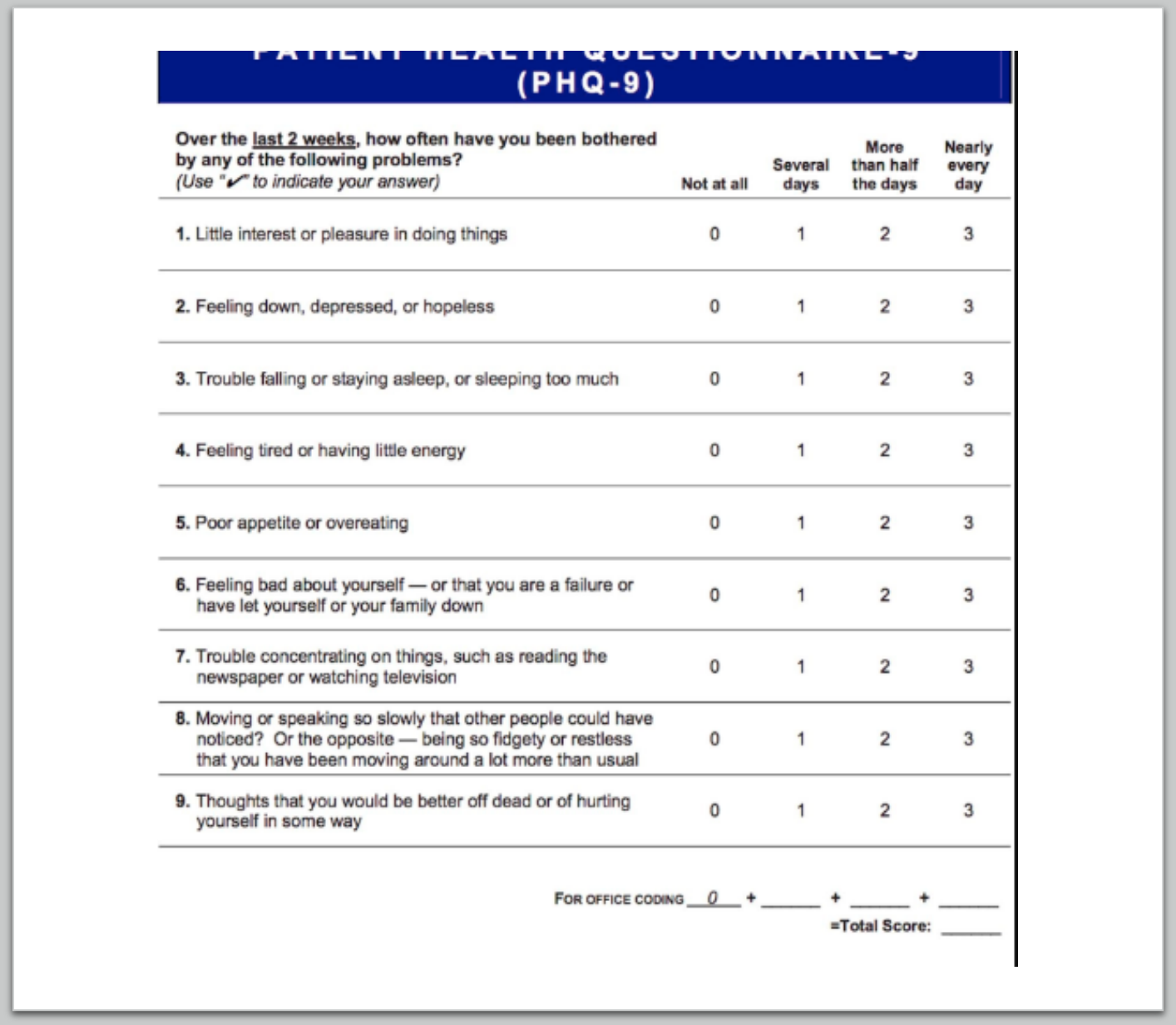
• Suicide Preventi
Mental H
• Suicide Prevention and Mental Health discharge resources
mended at
• Safety plan recommended at discharge

PHQ-9

- The Patient Health Questionnaire-9 (PHQ-9) Depression Scale is a validated widely used nine-item tool used to diagnose and monitor the severity of depression.
- Question 9 screens for the presence and duration of suicide ideation.
- It is available in Spanish and other languages and has also been modified for the adolescent population.
- All screening tools and instruction manuals are available at no cost.
- Ages 12+
- Can be used in primary care and behavioral Health Centers
- Item 9 (suicide Sensitivity 80%, Specificity 70%



(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Patient Safety Screener (PSS-3)

3 question screener

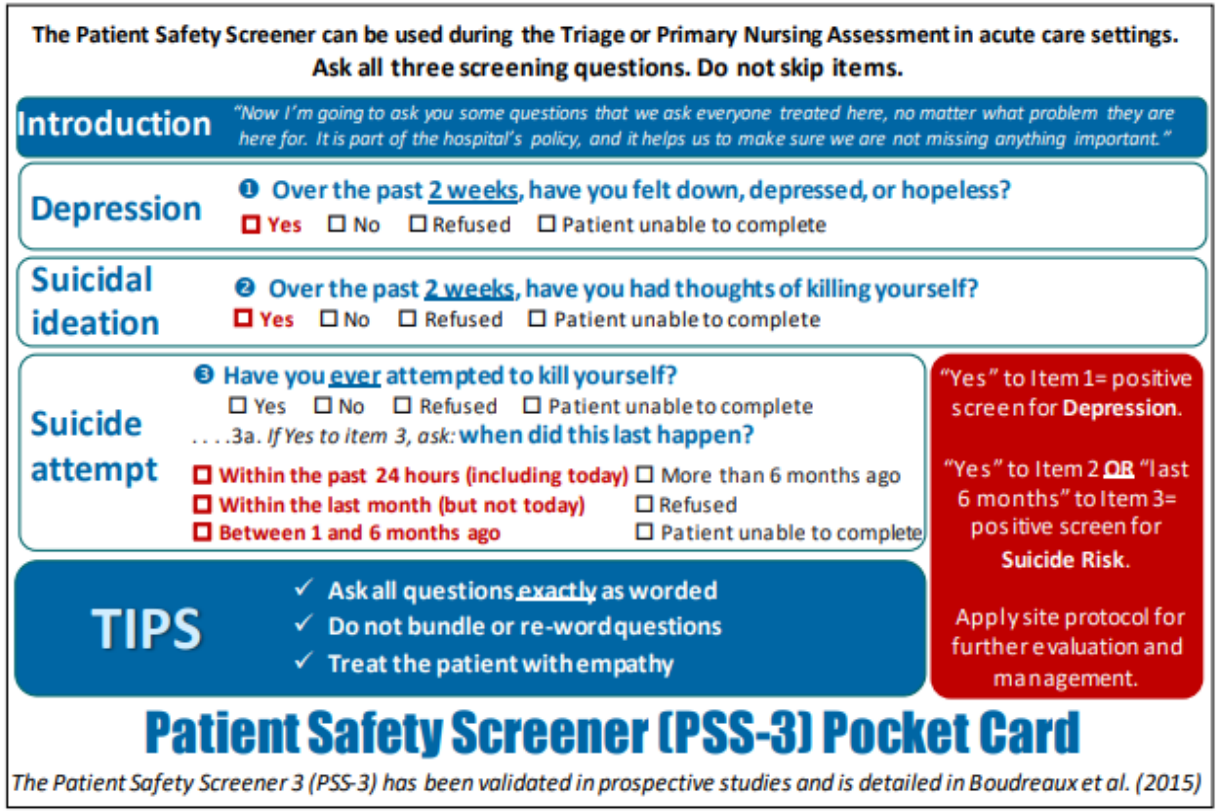
Meant for universal screening

Ages 12 and up

Sensitivity 95%

Specificity 35%

Use this pocket card as a job aid or training tool when implementing universal suicide screening in acute care settings.



The Patient Safety Screener can be used during the Triage or Primary Nursing Assessment in acute care settings.
Ask all three screening questions. Do not skip items.

Introduction *"Now I'm going to ask you some questions that we ask everyone treated here, no matter what problem they are here for. It is part of the hospital's policy, and it helps us to make sure we are not missing anything important."*

Depression
❶ Over the past 2 weeks, have you felt down, depressed, or hopeless?
☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

Suicidal ideation
❷ Over the past 2 weeks, have you had thoughts of killing yourself?
☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete

Suicide attempt
❸ Have you ever attempted to kill yourself?
☐ Yes ☐ No ☐ Refused ☐ Patient unable to complete
. . . .3a. *If Yes to item 3, ask:* when did this last happen?
☐ Within the past 24 hours (including today) ☐ More than 6 months ago
☐ Within the last month (but not today) ☐ Refused
☐ Between 1 and 6 months ago ☐ Patient unable to complete

TIPS
✓ Ask all questions exactly as worded
✓ Do not bundle or re-word questions
✓ Treat the patient with empathy

"Yes" to Item 1= positive screen for **Depression**.

"Yes" to Item 2 **OR** "last 6 months" to Item 3= positive screen for **Suicide Risk**.

Apply site protocol for further evaluation and management.

Patient Safety Screener (PSS-3) Pocket Card

The Patient Safety Screener 3 (PSS-3) has been validated in prospective studies and is detailed in Boudreaux et al. (2015)

Tool for Assessment of Suicidal Risk (TASR-A)

Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A)

Name: _____ **Chart #:** _____

Individual Risk Profile	Yes	No
Male		
Family History of Suicide		
Psychiatric Illness		
Substance Abuse		
Poor Social Supports/Problematic Environment		

Symptom Risk Profile	Yes	No
Depressive Symptoms		
Psychotic Symptoms		
Hoplessness/Worthlessness		
Anhedonia		
Anger/Impulsivity		

Interview Risk Profile	Yes	No
Suicidal Ideation		
Suicidal Intent		
Suicide Plan		
Access to Lethal Means		
Past Suicidal Behavior		
Current Problems Seem Unsolvable		
Command Hallucinations (Suicidal/ Homicidal)		
Recent Substance Use		

6 item KADS Score: _____

Level of Immediate Suicide Risk

High _____
Moderate _____
Low _____

Disposition: _____

Assessment Completed by: _____ Date: _____

Ages 13-18

Adds a section with 6 question K-SADS (a depression inventory)

TASR-A is a semi-structured instrument that the clinician can follow to ensure that the most common risk factors known to be associated with suicide in young people have been assessed.

The tool also provides the clinician with a convenient overview of the entire risk factor assessment, thus allowing the clinician to make a best judgment call as to the level of risk for imminent suicide. Furthermore, the TASR-A provides an excellent documentation of the comprehensiveness of the suicide risk assessment conducted by the clinician and thus may be useful for both clinical record keeping and in medico-legal cases

Developers provided no psychometric properties of the instrument, nor any indication of its validity in assessing suicidal risk

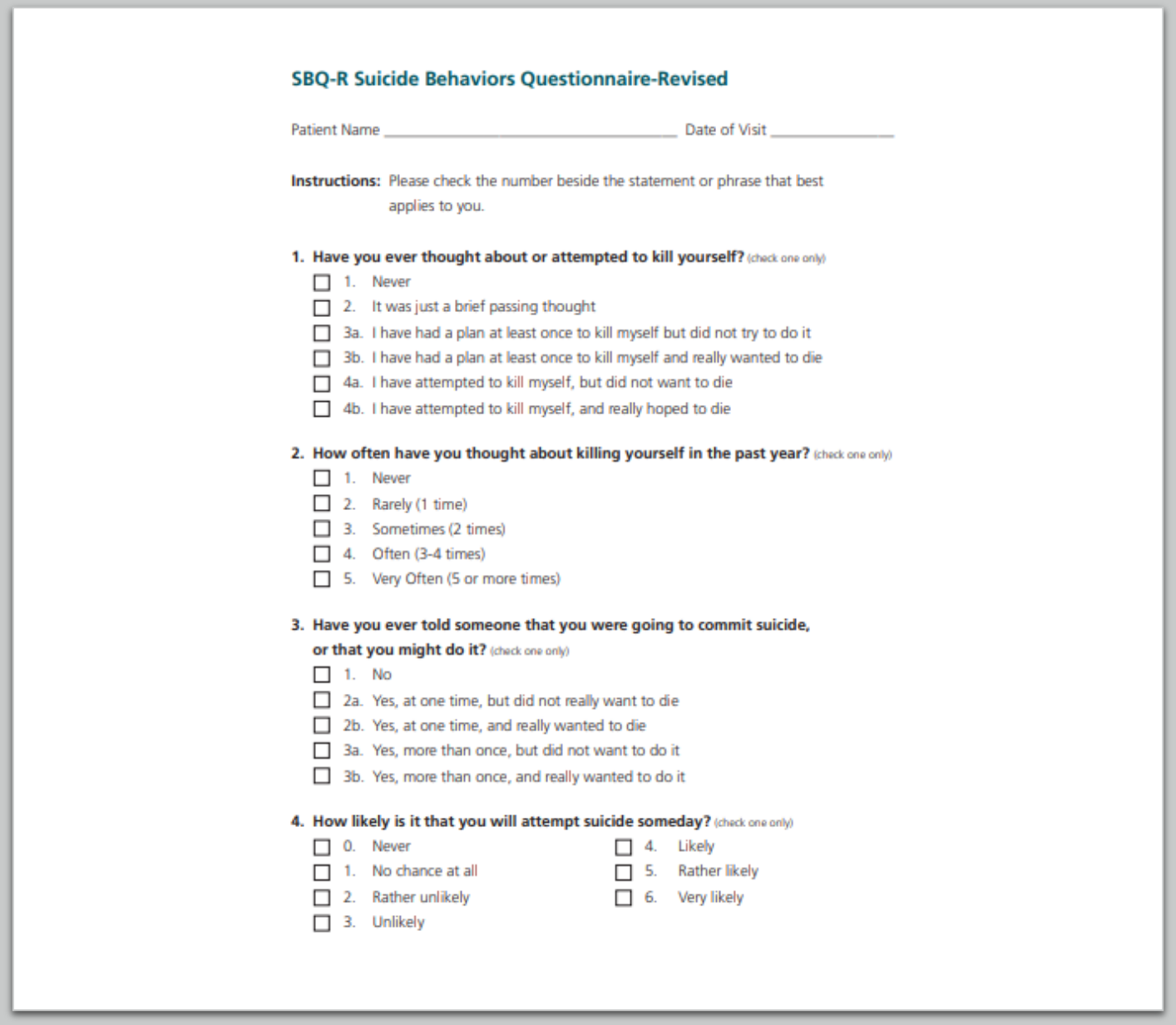
Suicide Behavior Questionnaire Revised (SBQ-R)

- 4 item self-report questionnaire that asks about future anticipation of suicidal thoughts or behaviors as well as past and present ones, and includes a question about lifetime suicidal ideation, plans to commit suicide, and actual attempts

- Ages 13-18

- Sensitivity 93%

- Specificity 95%



SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

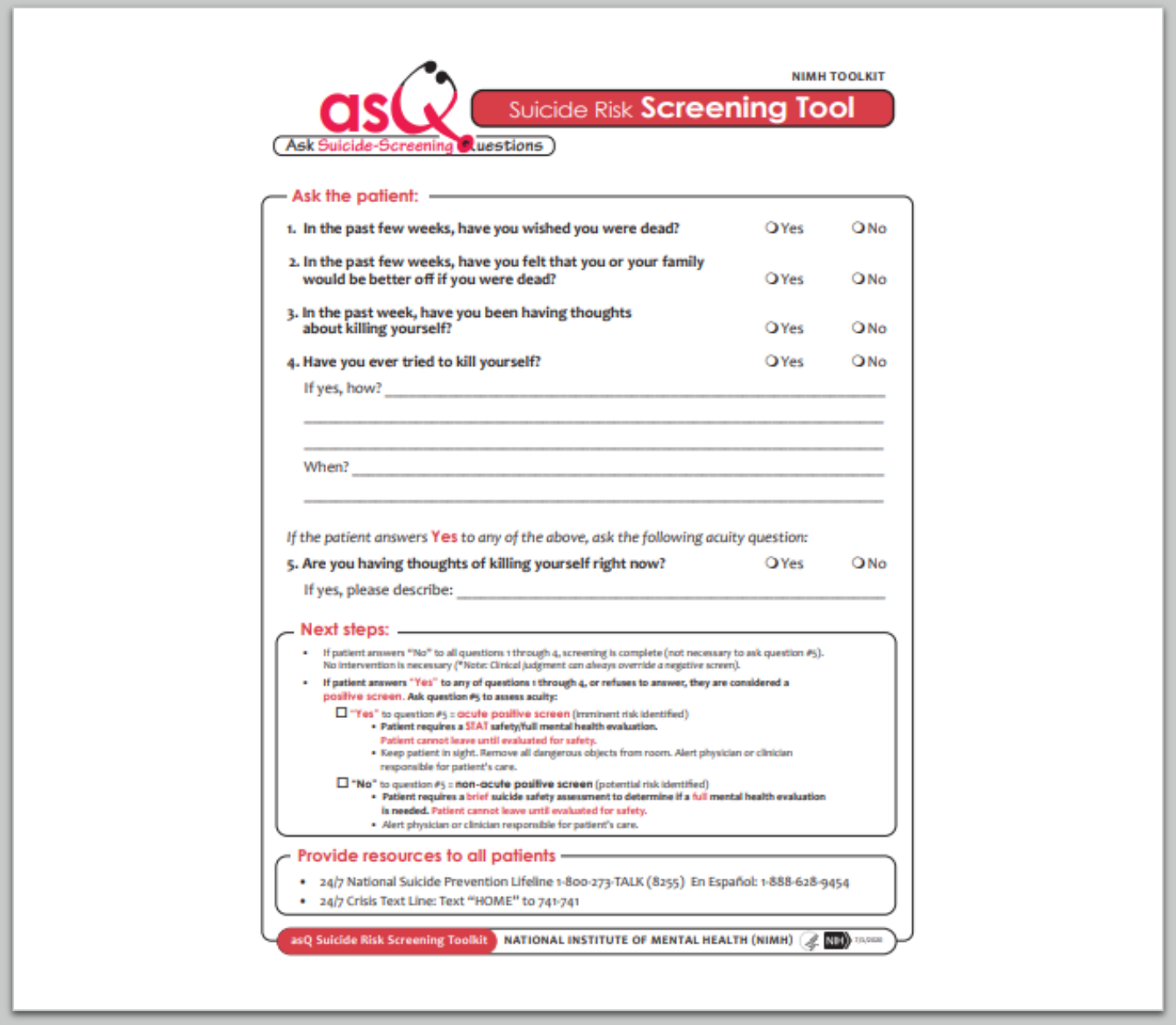
4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Ask Suicide Screening Questions (ASQ)

- ASQ is a four-item suicide-screening tool designed to be used for people of all ages in emergency departments, inpatient units, and primary care facilities.
- A Brief Suicide Safety Assessment is available to be used when patients screen positive for suicide risk on the ASQ.
- Emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.
- Sensitivity 96%
- Specificity 87%
- Return to ED specificity 43%

(BACK TO THE) **FUTURE OF PEDIATRICS**



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 SEAT 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)

Columbia-Suicide Severity Rating Scale (C-SSRS)

SUICIDAL IDEATION	
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Since Last Visit**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you wish you weren't alive anymore?*** If yes, describe:	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	**Yes** ☐ **No** ☐

There are brief versions of the C-SSRS often used as a screening tool (first two questions) that, based on patient response, can lead to the administration of the additional questions to triage patients.

All settings including community settings like schools, police

Ages 6 and up

Sensitivity 95%

Sensitivity 95%

When used with SAFE-T can also account for the assessment

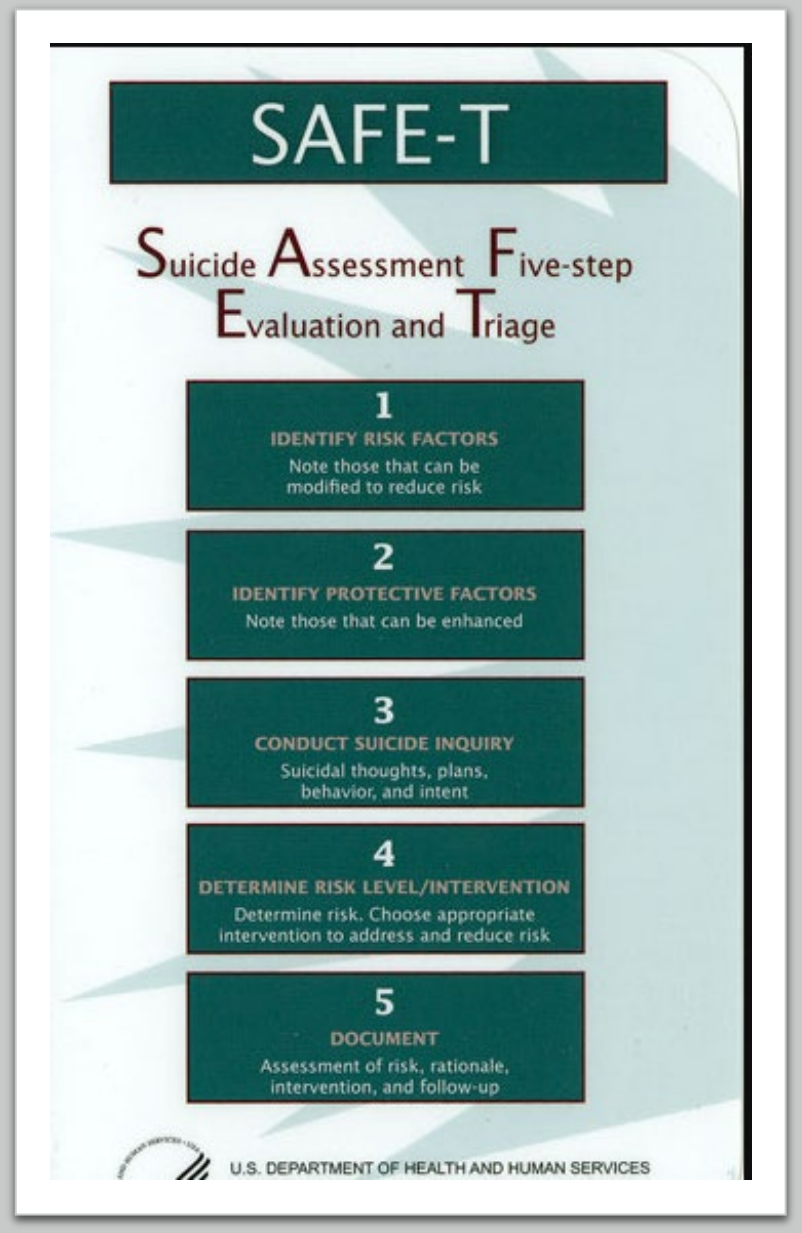
What to do with a positive screen?

Need to do an assessment

Use an evidence-based process to conduct a suicide risk assessment of patients who have screened positive for suicidal ideation.

The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

C-SSRS with SAFE-T



SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors

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

Activating Events:	Clinical Status:
□ Recent losses or other significant negative event(s) (legal, financial, relationship, etc.) □ Pending incarceration or homelessness □ Current or pending isolation or feeling alone **Treatment History:** □ Previous psychiatric diagnosis and treatments □ Hopeless or dissatisfied with treatment □ Non-compliant with treatment □ Not receiving treatment □ Insomnia **Other:** □ _____ □ _____ □ _____	□ Hopelessness □ Major depressive episode □ Mixed affect episode (e.g. Bipolar) □ Command Hallucinations to hurt self □ Chronic physical pain or other acute medical problem (e.g. CNS disorders) □ Highly impulsive behavior □ Substance abuse or dependence □ Agitation or severe anxiety □ Perceived burden on family or others □ Homicidal ideation □ Aggressive behavior towards others □ Refuses or feels unable to agree to safety plan □ Sexual abuse (lifetime) □ Family history of suicide

□ **Access to lethal methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:	External:
□ Fear of death or dying due to pain and suffering □ Identifies reasons for living □ _____ □ _____	□ Belief that suicide is immoral; high spirituality □ Responsibility to family or others; living with family □ Supportive social network of family or friends □ Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-3 times a week (4) Daily or almost daily (5) Many times each day	
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting – few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time	
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (6) Does not attempt to control thoughts	
Deterrents ***Are there things – anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (3) Deterrents most likely did not stop you (2) Deterrents probably stopped you (4) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (5) Does not apply	
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (3) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (4) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (5) Does not apply	
Total Score	

Scale for Suicidal Ideation – Worst (SSI/SSI-W)

Interviewer-administered rating scale that measures the intensity of patients' specific attitudes, behaviors, and plans to commit suicide during the time period that they were the most suicidal.

The instrument was developed to obtain a more accurate estimate of suicide risk.

As with the SSI, each SSI-W item consists of three options graded according to the suicidal intensity on a 3-point scale ranging from 0 13 to 2. The ratings are then summed to yield a total score, which ranges from 0 to 38.

Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt.

The SSI-W takes approximately 10 minutes to administer.

Beck Scale for Suicidal Ideation (BSI)

21-item self-report instrument for detecting and measuring the current intensity of the patients' specific attitudes, behaviors, and plans to commit suicide during the past week.

The BSI was developed as a self-report version of the interviewer-administered Scale for Suicide Ideation.

The first 19 items consist of three options graded according to the intensity of the suicidality and rated on a 3-point scale ranging from 0 to 2. These ratings are then summed to yield a total score, which ranges from 0 to 38.

Individual items assess characteristics such as wish to die, desire to make an active or passive suicide attempt, duration and frequency of ideation, sense of control over making an attempt, number of deterrents, and amount of actual preparation for a contemplated attempt. The last two items assess the number of previous suicide attempts and the seriousness of the intent to die associated with the last attempt.

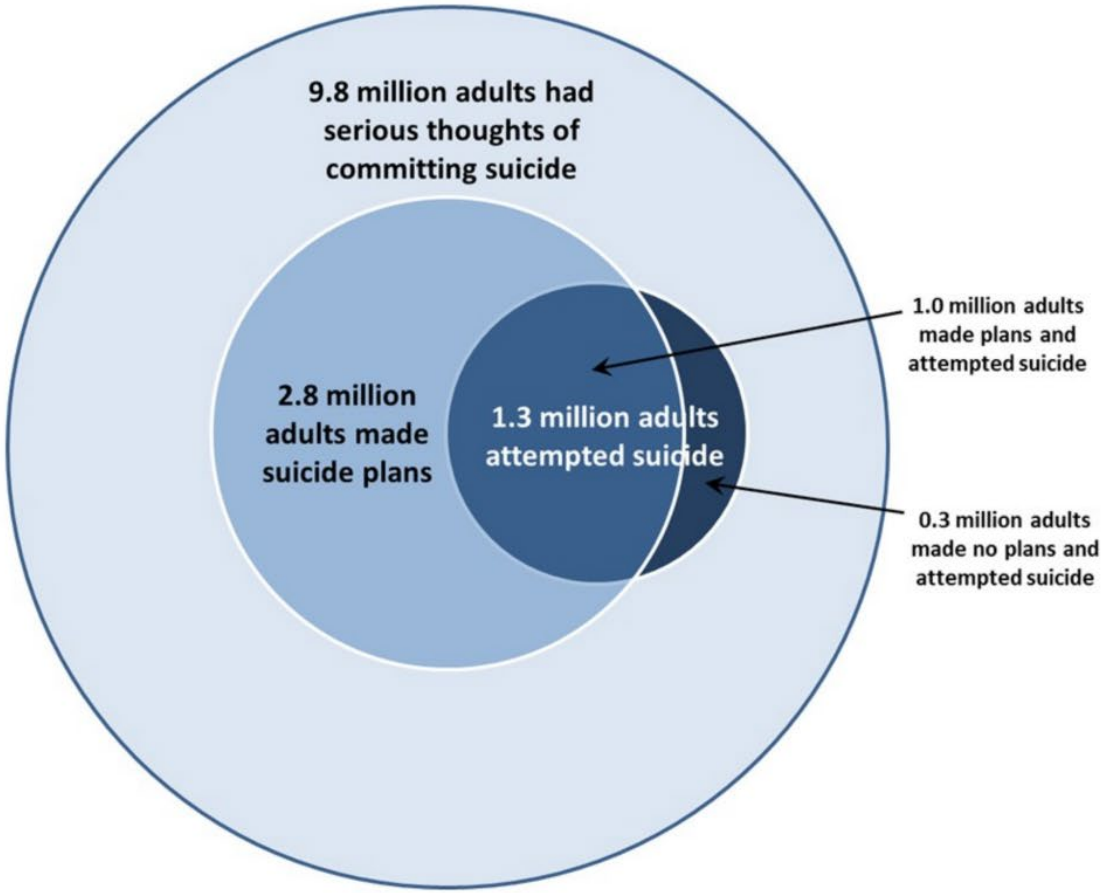
As with the SSI, the BSI consists of five screening items. If the respondent reports any active or passive desire to commit suicide, then an additional 14 items are administered.

The BSI takes approximately 10 minutes to administer.

The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.

Past Year Suicidal Thoughts and Behaviors Among U.S. Adults (2017)

Data Courtesy of SAMHSA



What to do with the information?

- Know when to refer to the emergency department

- Know local resources for referrals
- -DC Medicaid- DC Access
- ----1(888)7WE-HELP or **1-888-793-4357**

- Call DCMAP, VMAP, or B-HIPP

- Be comfortable with treating basic mental health concerns

June 27, 2022

(BACK TO THE) **FUTURE OF PEDIATRICS**


WORKING TOGETHER FOR A SAFE AND HEALING ENVIRONMENT
Speak up if you need help managing your stress.
Ask a Children's National team member for help.
TO KEEP EVERYONE SAFE
#$&$!!
NO Alcohol
NO Drug Use
NO Weapons
NO Yelling
NO Profanity
NO Recording without approval
NO Threats
NO Violence
IF OUR SAFE AND HEALING ENVIRONMENT IS DISRUPTED,
YOU MAY BE ASKED TO LEAVE.


PERSONAL BELONGINGS NOT PERMITTED.
SECURE IN LOCKERS.
LOS EFECTOS PERSONALES NO SON PERMITIDOS.
GUÁRDELOS BAJO LLAVE EN LOS CASILLEROS.

Why address suicidal ideation in Pediatric outpatient clinics?

- The risk of a suicide attempt or death is highest within 30 days of discharge from an ED or inpatient psychiatric unit.
- Up to 70 percent of patients who leave the ED after a suicide attempt never attend their first outpatient appointment.
- Approximately 37% of individuals without a mental health or chemical dependency diagnosis who died by suicide make an ED visit within a year of their death.
- Average wait time to see a psychiatrist is 3 to 9 months

Do’s and Don’t’s

- Remain calm
- Ask the youth directly if he or she is thinking about suicide (e.g., "Are you thinking of suicide?")
- Focus on your concern for their well-being and avoid being accusatory
- Listen
- Reassure them that there is help and they will not feel like this forever
- Do not judge
- Provide constant supervision. Do not leave the youth alone
- Remove means for self-harm
- ***Get Help***

Resources

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Q&A