UCSF Benioff Children's Hospitals

Suicidal Ideation in Pediatric Primary Care

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UCSF Child and Adolescent Psychiatry Portal

American Academy of Pediatrics, California- Chapter 4 |

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Disclosure

No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose

Learning Objectives

By the end of this lecture, participants will be able to:

- Use suicide risk screening tools for youth in the primary care setting.
- Recognize protective factors and risks for youth suicide attempts and death by suicide.
- Describe important next steps when safety concerns arise during an in office and telehealth visit.

Suicide Ideation (SI) and Attempts

- Suicide rates among youth have been rising for decades[1]
- Worse during the pandemic?[2-4]
  - Behavioral/mental health issues
  - Youth SI and attempts during the COVID-19 pandemic

Sources:

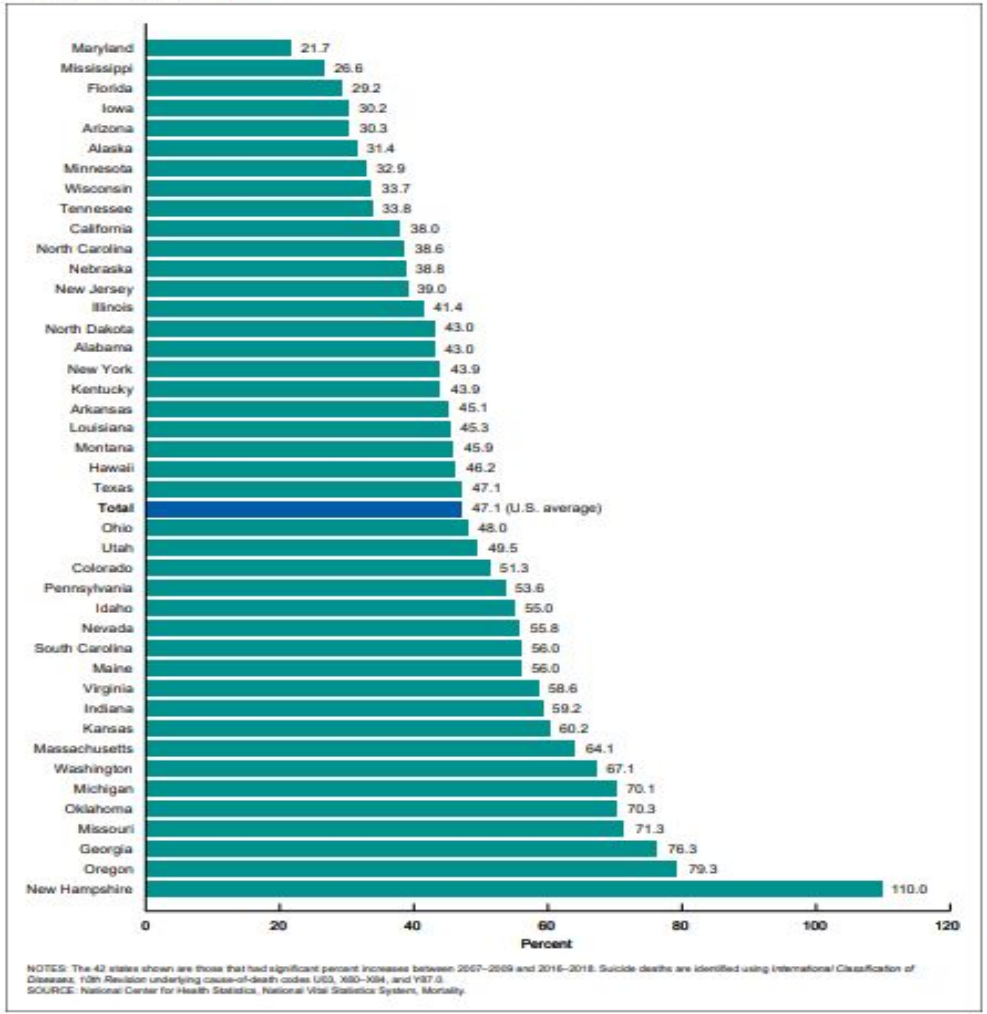
1. National Vital Statistics Reports 2020. https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf
2. Hill RM, Rufino K, Kurian S, et al. Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19. *Pediatrics*. 2021;147(3): e2020029280
3. Leeb RT et al. Mental Health Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic—US January 1 – October 17 2020. *MMWR.* November 2020.
4. Silliman-Cohen RI et al. Vulnerable Youth and the COVID-19 Pandemic. *Pediatrics.* July 2020.

Increase in state suicide death rates among youth ages 10-24

Figure 1. **Percent Increase in suicide death rates among persons aged 10-24 years**: United States and selected states, 2007-2008 to 2016-2018

Source: CDC, 2020
https://www.cdc.gov/nchs/data/nvsr/nvsr69/NVSR-69-11-508.pdf

Figure 1. Percent increase in suicide death rates among persons aged 10–24 years: United States and selected states, 2007–2009 to 2016–2018



NOTES: The 42 states shown are those that had significant percent increases between 2007–2009 and 2016–2018. Suicide deaths are identified using International Classification of Diseases, 10th Revision underlying cause-of-death codes U03, X60–X84, and Y87.0.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

From: **Suicide Ideation and Attempts in a Pediatric Emergency Department Before and During COVID-19**

Pediatrics. 2021;147(3). doi:10.1542/peds.2020-029280

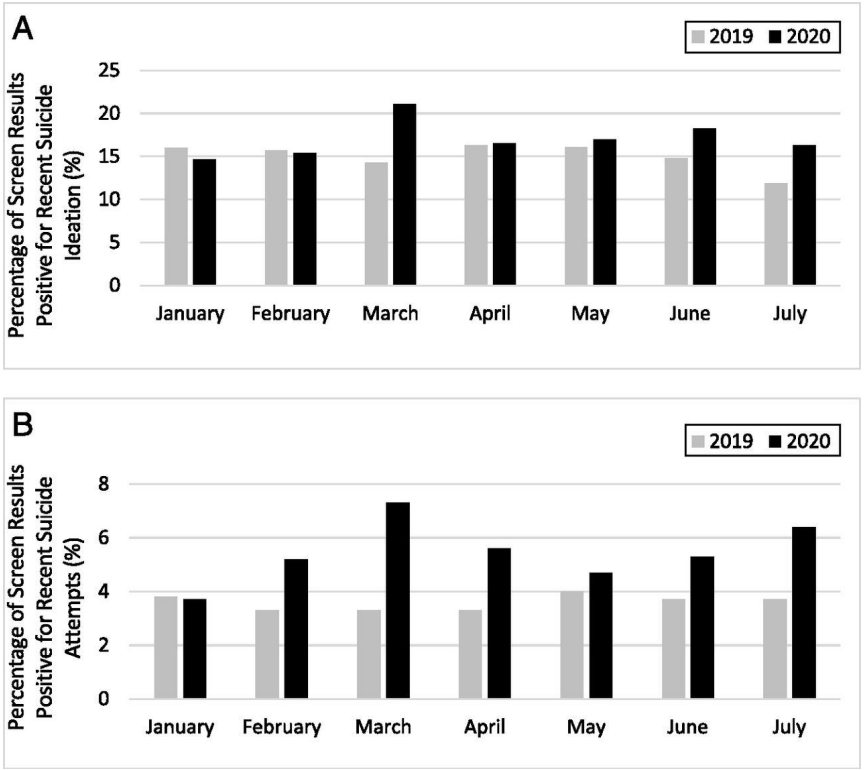


Figure Legend:

A and B, Rates of screen results positive for suicide ideation (A) and attempt (B), January to July.

Suicide is Preventable

- 83% of suicides (all ages) had contact with a primary care clinician in the preceding year
- 66% had contact in the preceding month
- Over 90% have a psychiatric disorder
- Over 80% of these are untreated at time of death

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159:909-916.

Health Equity

- Research shows significant disparities in suicide rates, risk, and care for youth across cultures and communities.
- Suicide rates are not directly tied to race, gender, or any other social construct. Rather, youth may experience discrimination or long-standing health, social, or systemic inequities that may impact their development and risk for suicide.
- **Systemic inequities that impact youth mental health**
  - Racism
  - Homophobia or transphobia
  - Economic inequities
  - Under-resourced schools
  - Medically underserved communities

American Academy of Pediatrics

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American Foundation for Suicide Prevention

AAP Blueprint for Youth Suicide Prevention

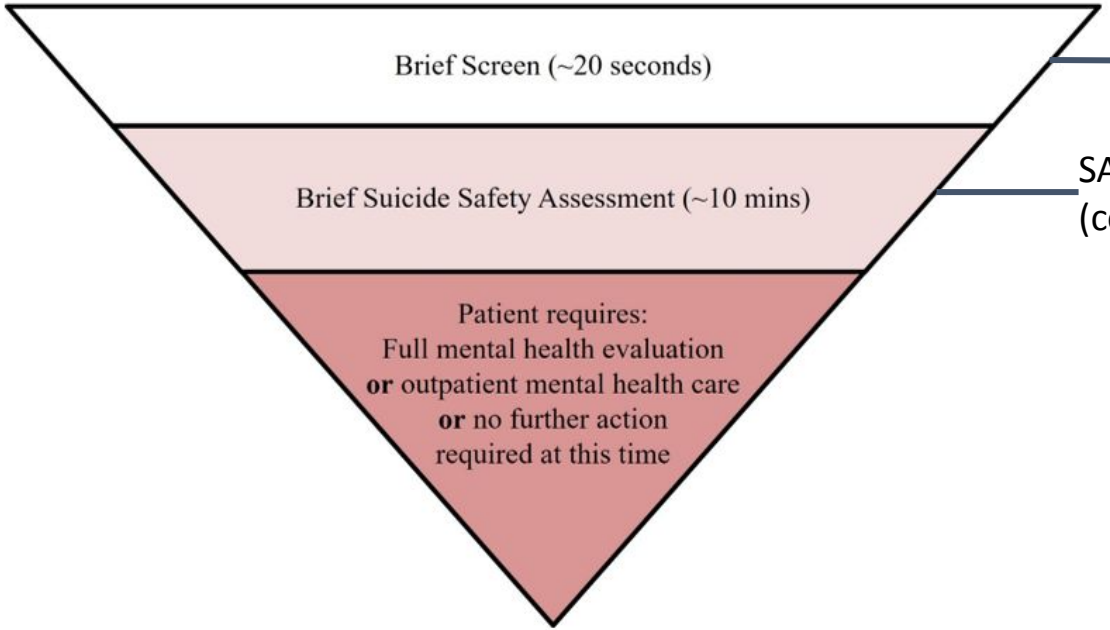
https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

The American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH), created this Blueprint for Youth Suicide Prevention as an educational resource to support pediatric health clinicians and other health professionals in identifying strategies and key partnerships to support youth at risk for suicide.

Universal Screening helps support equity in suicide prevention efforts –AAP Blueprint Recommendations

1. Universal screen all patients ages 12+ years
   - *No hx of suicide risk recommend no more than 1x/month & no less than 1x/year*
2. May screen 8-11 y/o presenting with behavioral health symptom with targeted strategies – screen when clinically indicated
3. <8 years should not be screened for suicide risk, BUT we can still assess for suicide risk when a parent reports suicidal behavior, or when patient presents with depressed mood, severe irritability, or suicidal ideation or history of suicidal behaviors

Suicide Screening and Suicide Assessment



Universal screen: ASQ, SBQ-R

SAFE-T, ASQ-BSSA, C-SSRS
(collateral input may be necessary)

ASQ Suicide Screen Questionnaire

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 1-4, done

If “YES” to 1-4 or no answer, = Positive Screen

- If ”YES” to 5 = acute positive screen (imminent risk, full safety evaluation & maintain safety
- If “NO” to 5 = non-acute positive screen. Complete brief suicide safety assessment. Patient cannot leave until evaluated for safety.

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?"
"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.

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

ASQ-BSSA

❑ 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?"

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- ❑ Sad or depressed?" ❑ Anxious?" ❑ Impulsive? ❑ Reckless?" ❑ Hopeless?" ❑ Irritable?"
- ❑ Unable to enjoy the things that usually bring him/her pleasure?"
- ❑ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ❑ Sleeping pattern?" ❑ Appetite?"

"Does your child use drugs or alcohol?" ❑ Yes ❑ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

4 Make a safety plan with the patient Include the par

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than makir "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or giv sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will hotline." "I will call_____."

- ❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-so techniques).
- ❑ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limitir to dangerous objects saves lives. How will you secure or remove these potentially dangerous items medications, ropes, etc.)?"
- ❑ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response doe indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

ASQ-BSSA

5 Determine disposition

For all positive screens, follow up with patient at next appointi

After completing the assessment, choose the appropriate disposition p *with a check-in phone call (within 48 hours) with all patients who screene*

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suic** Send to emergency department for extensive mental health evaluation (mental health provider is possible and alternative safety plan for immine
- ❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as s (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.**

Youth Suicidality: Some Protective Factors

- Good problem-solving abilities
- Strong social connections
- Restricted access to highly lethal means
- Cultural and religious beliefs that discourage suicide and that support self-preservation
- Ready access to appropriate clinical intervention
- Effective medical and behavioral health

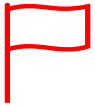
Shain B and AAP COMMITTEE ON ADOLESCENCE. Suicide and Suicide Attempts in Adolescents. Pediatrics. 2016;138(1):e20161420

Youth Suicidality: Some Risk Factors

Previous attempt	Presence of psychiatric disorders	Family history of depression or suicide
Loss of a parent to death or divorce	Social loss	Physical and/or sexual abuse
Lack of a support network	Bullying	Substance use

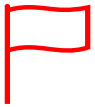
Shain B and AAP COMMITTEE ON ADOLESCENCE. Suicide and Suicide Attempts in Adolescents. Pediatrics. 2016;138(1):e20161420

Look for Red Flags



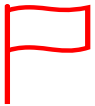
Plan

- “Do you have a plan for how you might try to end your life?”



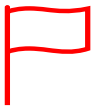
Intent

- “Lately, have you felt that you want to act on your thoughts and do something to end your life?”

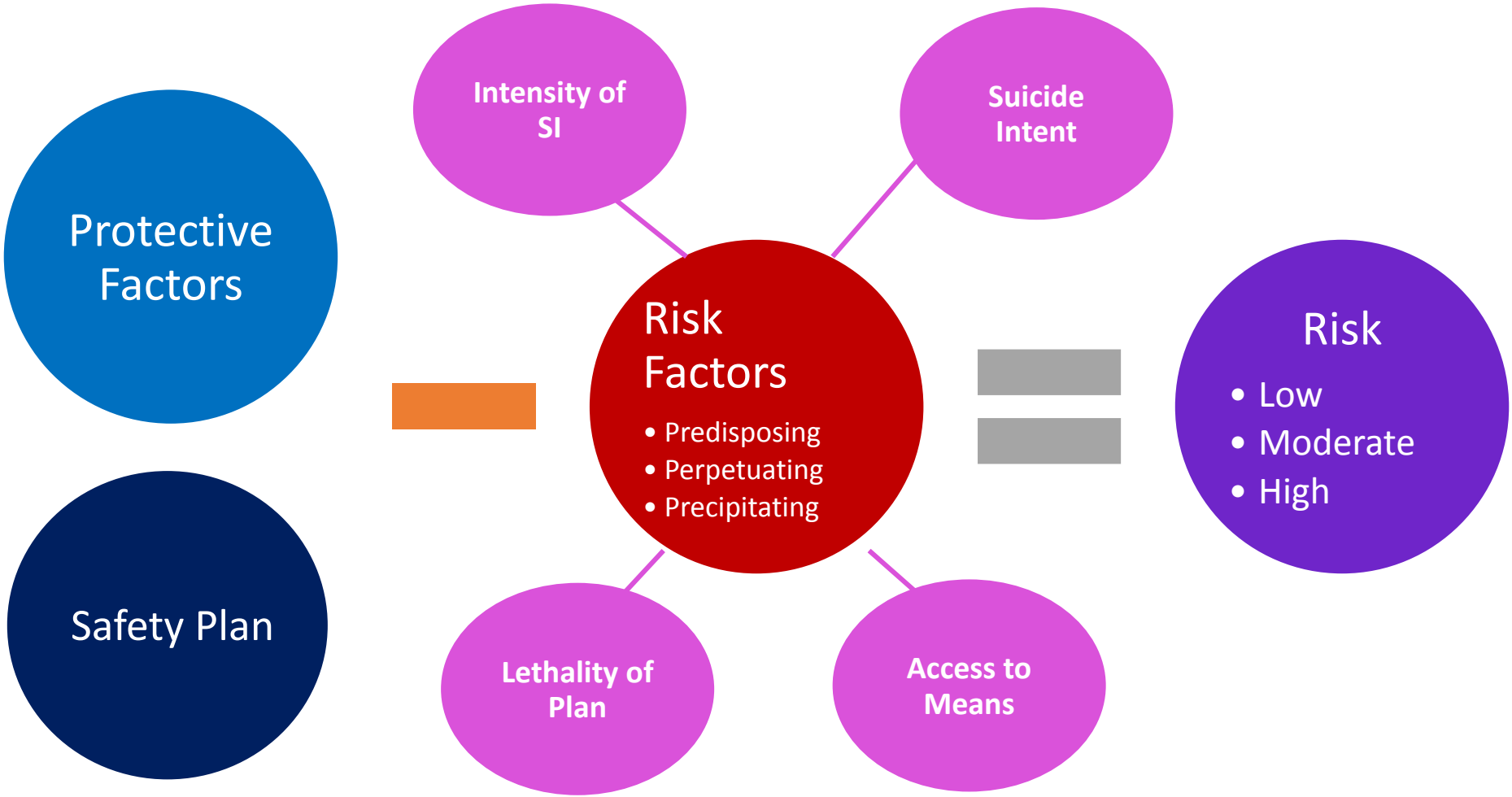


Attempt

- “Have you ever tried to end your life?” *past few days, weeks*



Access to lethal means


Protective Factors
Safety Plan
Intensity of SI
Suicide Intent
Risk Factors
• Predisposing
• Perpetuating
• Precipitating
Lethality of Plan
Access to Means
Risk
• Low
• Moderate
• High

Low Suicide Risk

1. Patient may benefit from non-urgent mental health follow-up
2. Provide parents, caregivers, and families with resources to support them:
   - 988 Lifeline and Crisis Text Line

While many young people think about suicide, and detection is necessary to ensure safety and assess risk, suicidal behavior is a relatively rare event. Most youth who have suicidal thoughts will not require emergency care.

- Only the patients who are assessed to be at imminent or acute risk of suicide need full safety precautions (eg, a 1:1 observer and searched belongings)

- Patients who are not at imminent risk of suicide but require further evaluation, do not require safety precautions

- The majority of young people who screen positive for suicide risk are non-acute cases

- Regardless of level of risk, all patients and their parents/caregivers should be given the National Suicide Prevention Lifeline and Crisis Text Line

Moderate Suicide Risk

1. Refer to outpatient mental health
2. Conduct safety planning with the family, and counsel about reducing access to lethal means
3. F/u with the patient within 72 hours or ASAP for a safety check
4. If mental health f/u is not available then you will check in with them until they are evaluated by a mental health clinician
5. If the family doesn't feel they can keep their child safe at home then you may need to send them to the ED
6. Give patient/family the National Suicide Prevention Lifeline and Crisis Text Line
7. Provide parents, caregivers, and families with resources to support them:
   - AFSP: Teens and Suicide- What Parents Should Know
   - Seize the Awkward
   - National Alliance on Mental Illness: Family Members and Caregivers

Collaborative Safety Planning

1. Warning signs/triggers
2. Coping strategies
3. Social supports
4. Professional supports
5. Lethal means safety counseling
   (guns, sharps, cleaning products, meds/otc)
6. Follow-up plan
7. Communication plan

BE AS SPECIFIC AS POSSIBLE

Completing a Safety Plan helps to determine suicide risk level

Avoid using "safety contract"

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

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

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

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

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

_____

High Suicide Risk

1. Praise the patient for sharing their feelings
2. Implement immediate safety precautions using trauma informed principles
3. Connect with the patient's mental health clinician and see if they have a safety plan
4. If there is not an onsite MH in your practice, transfer the patient to the ED, community mobile crisis team, or acute mental health evaluation center for emergency evaluation
5. Conduct a follow-up phone call check within the next 72 hours to inquire about mental health treatment linkage

Emergencies in the office and telehealth setting

- The clinician will need an adult to stay with the patient.
- Assess safety to be transported to emergency department (ED) by caregivers.
  - If the family is able, encourage them to call for emergency services and stay connected with the family until help arrives.
  - Call the ED to give history and concerns of the patient – this helps to maintain continuity of care.
- What does your community 911 response look like?
  - Police officer only +/- crisis intervention training.
  - Officer partnered with behavioral/mental health professional.
- Are crisis services to home available?

AAP Resources

- AAP Suicide Prevention Resources
- AAP/AFSP: Blueprint for Youth Suicide Prevention
  - American Foundation for Suicide Prevention Project 2025
  - AAP Suicide Prevention Campaign Toolkit
- American Academy of Child and Adolescent Psychiatry (AACAP)
  - Facts for Families – Suicide Safety: Precautions at Home
  - Facts for Families – Suicide in Children and Teens
  - Patient Safety and Emergency Management in Telepsychiatry with Children and Adolescents – Video
  - Suicide Resource Center
- Creating an Emergency Plan – HHS.gov
- Bright Futures National Center
  - *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 4th Edition*
  - Promoting Mental Health - Health Promotion Theme
  - Integrating Adolescent Health Screening into Health Supervision Visits
  - Tips to Link Your Practice to Community Resources
- Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic
- Virtual Office Hours: Considerations for Safety and Suicidality in a Telehealth Environment (Recording of live session on 2/24/2021)
- Suicide: Pediatric Mental Health Minute Series
- National Suicide Line: 1-844-493-TALK; or text “Talk” to 38255

CDC's Suicide Prevention Resource for Action

- *Updated, expanded, and renamed* and includes strategies with the best available evidence to make an impact on saving lives.
- The Suicide Prevention Resource has three components:
  - **Strategies** are the collection of actions to achieve the goal of preventing suicide.
  - **Approaches** are the specific ways to advance each strategy.
  - **Policies**, **programs**, and **practices** show evidence of impact on suicide, suicide attempts, or risk and protective factors.

Other Resources:

- Comprehensive Suicide Prevention
- CDC's Suicide Prevention Infographic
- Comprehensive Suicide Prevention: Program Profiles
- Learn the Five Steps for how to talk to someone who might be suicidal

Resources: UCSF Child & Adolescent Psychiatry Portal