CSN Children's Safety Network

EDC Education Development Center

July 30, 2019

Screening Youth for Suicide Risk

Funding Sponsor

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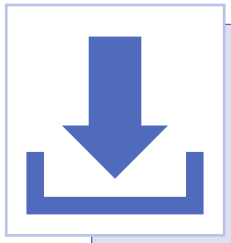
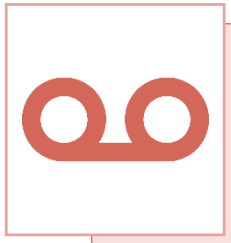
You are muted



Download resources in the File Share pod (above the slides)

Use the Q & A (bottom left) to ask questions at any time



This session is being recorded

Presenters

Bonnie Lipton, MPH

Moderator

Lisa Horowitz, PhD, MPH

Jeff Bridge, PhD

Suicide Prevention in the Medical Setting: Turning Research into Clinical Practice

Lisa M. Horowitz, PhD, MPH
Office of the Clinical Director
Intramural Research Program
National Institute of Mental Health, NIH
Bethesda, Maryland

Children's Safety Network Webinar
July 30, 2019

The views expressed in this presentation do not necessarily represent the views of the NIH, DHHS, or any other government agency or official. I have no financial conflicts to disclose.

Take Home Messages

- Universal suicide risk screening for all patients in medical settings: Ask directly
- Clinicians require population-specific and site-specific validated screening instruments
- Clinical Pathway- 3-tiered system
  - Brief Screen (20 seconds)
  - Brief Suicide Safety Assessment (~10 minutes)
  - Full Psychiatric/Safety Evaluation (30 minutes)
- Discharge all patients with safety plan, resources (National Suicide Lifeline and Crisis Text Line), and means restriction education

Robin Williams
1951 – 2014

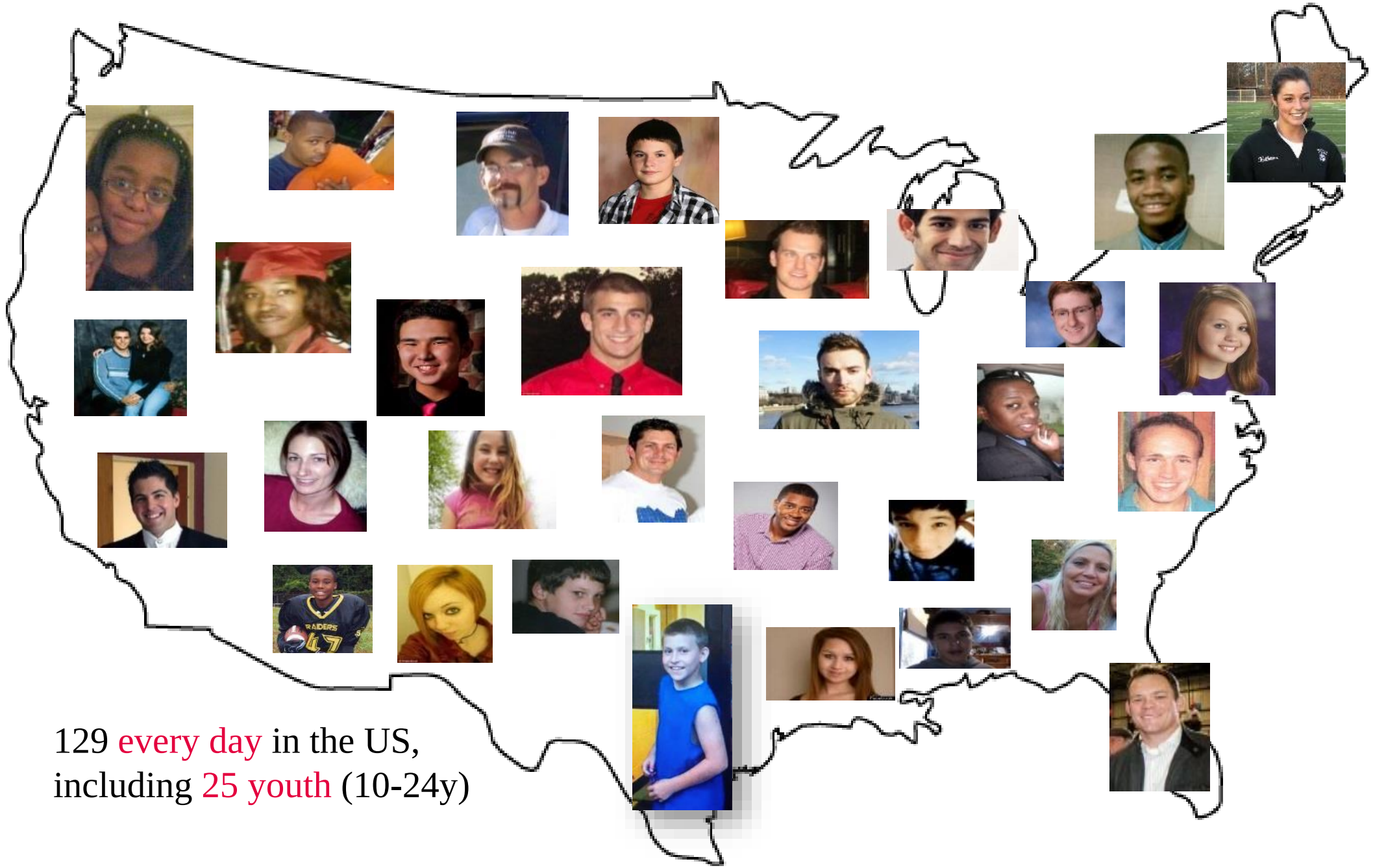
Anthony Bourdain
1956 – 2018

Kelly Catlin
1995 – 2019

Kate Spade
1962 – 2018

Sydney Aiello
1999 – 2019

Calvin Desir
2002 – 2019



129 every day in the US,
including 25 youth (10-24y)

National Institute of Mental Health

CDC, 2017

Defining terms

- Suicidality - Any thoughts or actions related to volitionally ending one's own life
  - The whole continuum
- Manifestations along the continuum are linked
  - e.g., passive thoughts about wanting to be dead; suicide attempts with intent to die
- Significant marker of emotional distress

Tishler, 2007; Posner, 2007

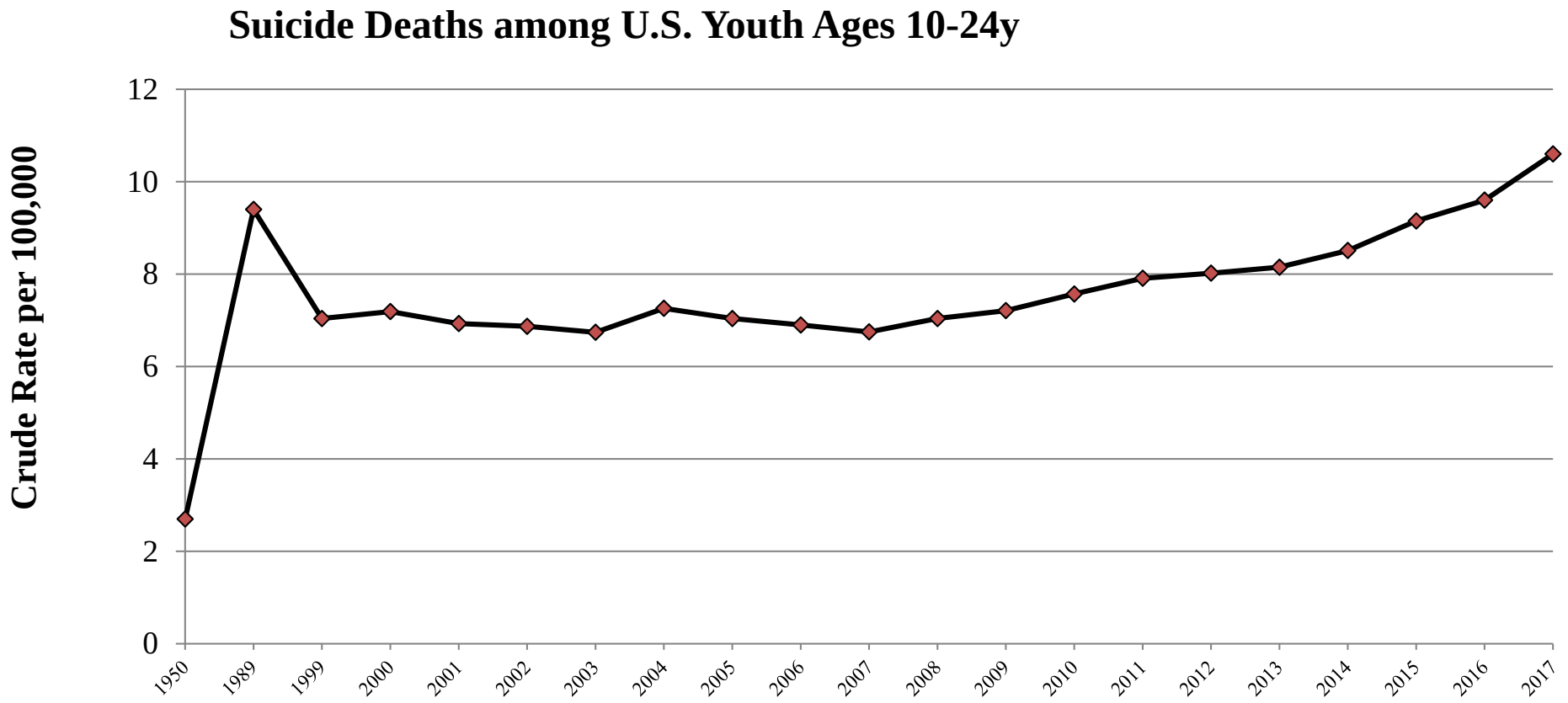
Completed Suicide Worldwide

- 800,000+ deaths from suicide annually, worldwide
- 2nd leading cause of death for young people
- In 2008, global toll from suicide exceeded the number of estimated deaths by homicide (535,000) and war (182,000) combined

WHO, 2014; CDC WISQARS, 2016; Varnik, 2012

Youth Suicide in the U.S.

- **2nd leading cause of death** for youth aged 10-24y
- 26,799 deaths in 2017 - 6,769 (**25%**) deaths by suicide



CDC WISQARS, 2017; Slide courtesy of Jeff Bridge, PhD

Youth Suicide by State

- 2017 crude rates (per 100,000), 10-24y
- Highest rates
  - Alaska: 31.1 deaths
  - Montana: 23.5 deaths
- Lowest rates
  - New Jersey: 6.3 deaths
  - New York: 8.5 deaths

CDC WISQARS, 2017

Youth Suicidal Behavior

- **~ 2 million adolescents** attempt suicide annually
  - 7.4% of high school students in the US attempted suicide one or more times in the past year (Range: 5.4 – 16.8)
    - 3% made an attempt resulting in medical treatment (1.9 – 7.6)

CDC 2016; Youth Risk Behavior Surveillance, 2017

Youth Suicidal Ideation

- **Youth**
  - 17.3% of high school students reported “seriously considered attempting suicide” in the last year
    - Range: 11.9 – 22.31
  - 13.6% of high school students made a suicide plan in the past year
    - Range: 9.7 – 17.1

SAMHSA 2016; Youth Risk Behavior Surveillance, 2017

Younger Children and Suicidality

- Children under 12 yrs plan, attempt and die by suicide
  - 2nd leading cause of death for 10-14-year-olds
  - 10th leading cause of death for children ages 5-11 years
- Suicide Risk in the Emergency Department
  - 29.1% of preteens (10-12) screened positive for suicide risk, 17% of which reported a past suicide attempt (Lanzillo et al., 2019)
  - 43.1 % of SA/SI visits to an ED were for children 5-11 years old (Burstein et al., 2019)
- Bridge et al., 2015:
  - 1993-2012: suicide rate stable for children <12
  - Significant racial disparity

    ↑ rate for black children

    ↓ rate for white children
  - 29% disclosed suicidal thoughts to an adult (Sheftall et al. 2016)

CDC WISQARS, 2017

Characteristics of Suicide Attempters and Ideators

- 69% of attempters ages 13-34 did not tell anyone about attempt
  - *The majority of attempts are unknown to parents*

- 48% of adolescent attempters report **19 or less minutes** between deciding to kill themselves and attempting

Simon 2001; Negron et al. 1997

High Risk Factors

- **Previous attempt**
- **Mental illness**
- Symptoms of depression, anxiety, agitation, impulsivity
- Exposure to suicide of a relative, friend or peer
- Physical/sexual abuse history
- Drug or alcohol abuse
- Lack of mental health treatment
- Suicide ideation
- Over age 60 and male
- Between the ages of 15 and 24
- LGBTQ
- Neurodevelopmental disorders
- Isolation
- Hopelessness
- **Medical illness**

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

Suicide Is Preventable.

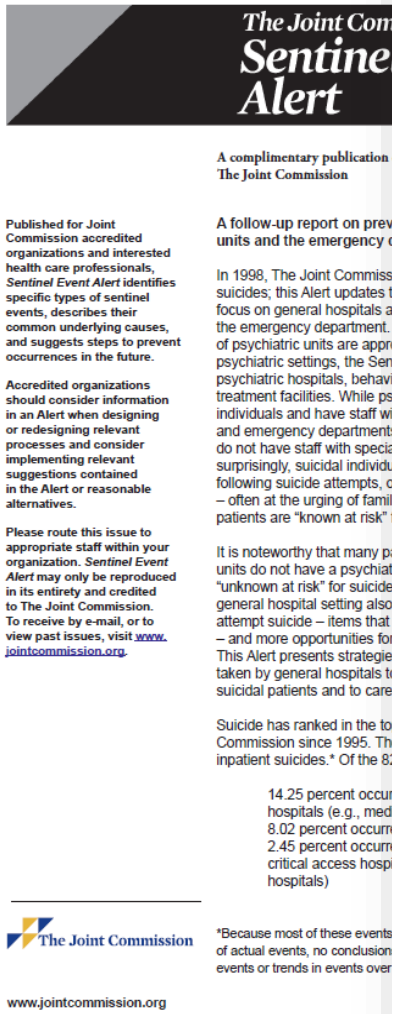
Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope

NIH National Institute of Mental Health

http://suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf

Can we save lives by screening for suicide risk in the medical setting?



The Joint Commission, 2010, 2011, 2016

Underdetection

- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves
  - ~80% of adolescents visited healthcare provider within the year prior to death by suicide
  - 49% of youth had been to an ED within 1 year
  - 38% of adolescents had contact with a health care system within 4 weeks prior
  - Frequently present with somatic complaints

Ahmedani, 2014; Rhodes, 2013; Blum, 1996

What are valid questions that nurses/physicians can use to screen pediatric medical patients for suicide risk in the medical setting?

Screening vs. Assessment: What's the difference?

- **Suicide Risk Screening**
  - Identify individuals at risk for suicide
  - Oral, paper/pencil, computer
- **Suicide Risk Assessment**
  - Comprehensive evaluation
  - Confirms risk
  - Estimates imminent risk of danger to patient
  - Guides next steps

Ask Suicide-Screening Questions (ASQ)

- 3 pediatric EDs
  - Boston Children's Hospital, Boston, MA
  - Children's National Medical Center, Washington, D.C.
  - Nationwide Children's Hospital, Columbus, OH

- September 2008 to January 2011

- 524 pediatric ED patients
  - 344 medical/surgical, 180 psychiatric
  - 57% female, 50% white, 53% privately insured
  - 10 to 21 years (mean=15.2 years; SD = 2.6y)

Horowitz et al. (2012) *Arch Pediatr Adolsc Med*

NIMH TOOLKIT

asQ

Ask Suicide-Screening Questions

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

Next steps:

- If patient answers "No" to all questions
  No intervention is necessary (*Note: Cli
- If patient answers "Yes" to any of que
  positive screen. Ask question #5 to as
  - ☐ "Yes" to question #5 = acute po
    - Patient requires a STAT saf
      Patient cannot leave until
    - Keep patient in sight. Remo
      responsible for patient's ca
  - ☐ "No" to question #5 = non-acut
    - Patient requires a brief sui
      is needed. Patient cannot
    - Alert physician or clinician

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) NIH 6/13/2017

CI, 91.3-99.4)

CI, 84.0-90.5)

es:

atients: 99.7%

)

s: 96.9% (95%

NIH National Institute of Mental Health

Horowitz, Bridge, Teach, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

Results

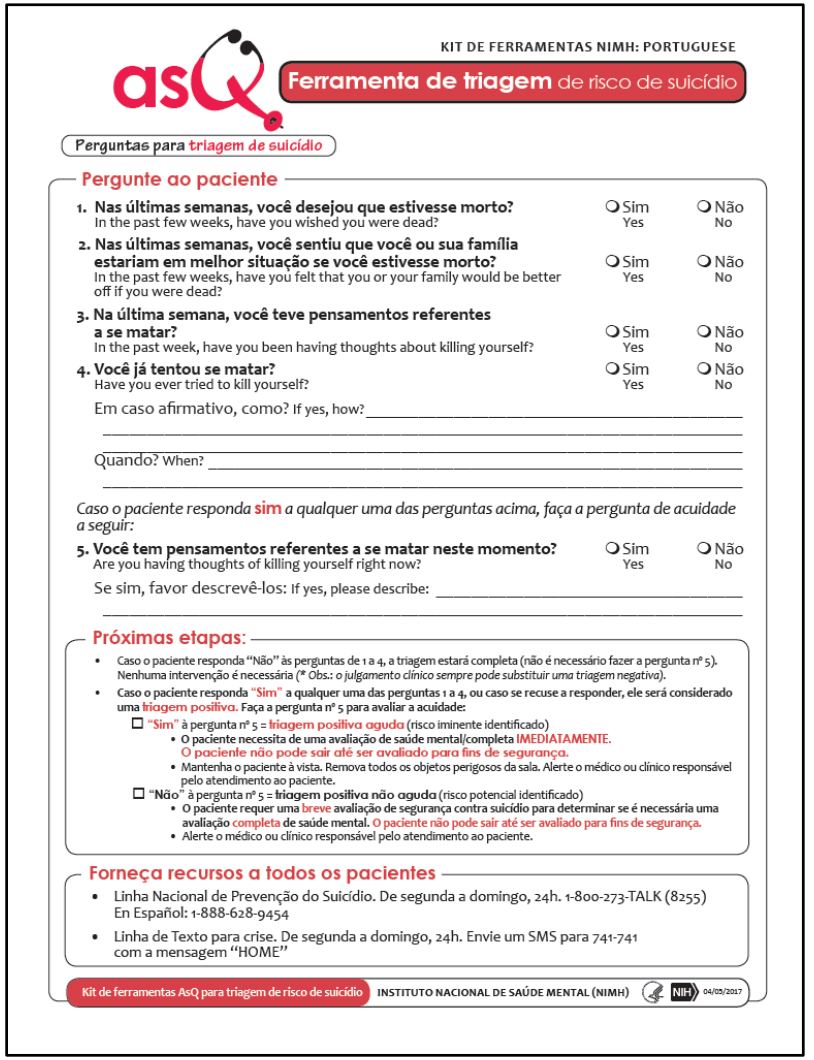
- 98/524 (18.7%) screened positive for suicide risk
  - 14/344 (4%) medical/surgical chief complaints
  - 84/180 (47%) psychiatric chief complaints
- Feasible
  - Less than 1 minute to administer
  - Non-disruptive to workflow
- Acceptable
  - Parents/guardians gave permission for screening
  - Over 95% of patients were in favor of screening
- ASQ is now available in the public domain

Validation and Implementations in Other Settings: Ongoing Research

- Inpatient medical/surgical unit
- Outpatient primary care/specialty clinics
- Schools
- Child abuse clinics
- Detention Facilities
- Indian Health Service (IHS)
- ASD/NDD/ID Population

Foreign languages

- Spanish
- Italian
- French
- Portuguese
- Dutch
- Arabic
- Somali
- Hindi
- Hebrew
- Vietnamese
- Mandarin
- Korean
- Japanese
- Russian
- Tagalog
- Urdu



KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ Ferramenta de triagem de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

1. **Nas últimas semanas, você desejou que estivesse morto?** Sim Não
   In the past few weeks, have you wished you were dead? Yes No
2. **Nas últimas semanas, você sentiu que você ou sua família estariam em melhor situação se você estivesse morto?** Sim Não
   In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. **Na última semana, você teve pensamentos referentes a se matar?** Sim Não
   In the past week, have you been having thoughts about killing yourself? Yes No
4. **Você já tentou se matar?** Sim Não
   Have you ever tried to kill yourself? Yes No

   Em caso afirmativo, como? If yes, how? _____

   Quando? When? _____

Caso o paciente responda sim a qualquer uma das perguntas acima, faça a pergunta de acuidade a seguir:

5. **Você tem pensamentos referentes a se matar neste momento?** Sim Não
   Are you having thoughts of killing yourself right now? Yes No

   Se sim, favor descrevê-los: If yes, please describe: _____

Próximas etapas:

- Caso o paciente responda "Não" às perguntas de 1 a 4, a triagem estará completa (não é necessário fazer a pergunta nº 5). Nenhuma intervenção é necessária *(* Obs.: o julgamento clínico sempre pode substituir uma triagem negativa).*
- **Caso o paciente responda "Sim" a qualquer uma das perguntas 1 a 4, ou caso se recuse a responder, ele será considerado uma triagem positiva. Faça a pergunta nº 5 para avaliar a acuidade:**
  - ☐ "Sim" à pergunta nº 5 = **triagem positiva aguda** (risco iminente identificado)
    - O paciente necessita de uma avaliação de saúde mental/completa IMEDIATAMENTE. O paciente não pode sair até ser avaliado para fins de segurança.
    - Mantenha o paciente à vista. Remova todos os objetos perigosos da sala. Alerte o médico ou clínico responsável pelo atendimento ao paciente.
  - ☐ "Não" à pergunta nº 5 = **triagem positiva não aguda** (risco potencial identificado)
    - O paciente requer uma breve avaliação de segurança contra suicídio para determinar se é necessária uma avaliação completa de saúde mental. O paciente não pode sair até ser avaliado para fins de segurança.
    - Alerte o médico ou clínico responsável pelo atendimento ao paciente.

Forneça recursos a todos os pacientes

- Linha Nacional de Prevenção do Suicídio. De segunda a domingo, 24h. 1-800-273-TALK (8255) En Español: 1-888-628-9454
- Linha de Texto para crise. De segunda a domingo, 24h. Envie um SMS para 741-741 com a mensagem "HOME"

Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH) | NIH | 04/05/2017

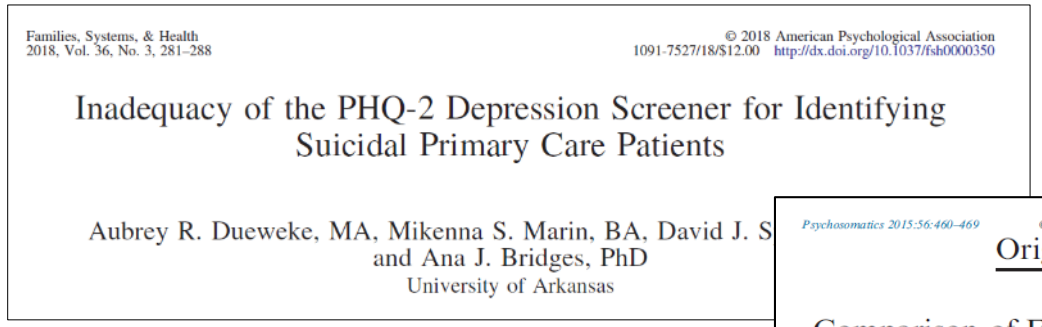
ASQ Toolkit: www.nimh.nih.gov/ASQ

NIH National Institute of Mental Health

Can depression screening be used to effectively screen for suicide risk?

Patient Health Questionnaire for Adolescents (PHQ-A)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain
- Commonly used in medical settings
- One suicide-risk question, Item #9: *"Thoughts that you would be better off dead* ***or*** *of* ***hurting*** *yourself in some way"*

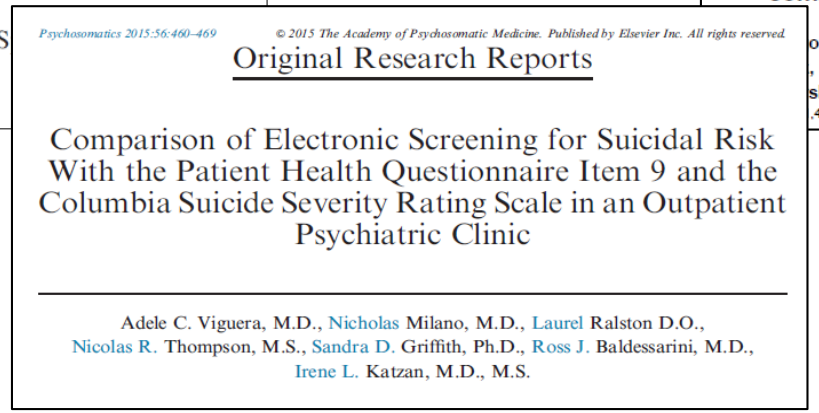


Families, Systems, & Health
2018, Vol. 36, No. 3, 281–288

© 2018 American Psychological Association
1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000350

Inadequacy of the PHQ-2 Depression Screener for Identifying Suicidal Primary Care Patients

Aubrey R. Dueweke, MA, Mikenna S. Marin, BA, David J. S
and Ana J. Bridges, PhD
University of Arkansas

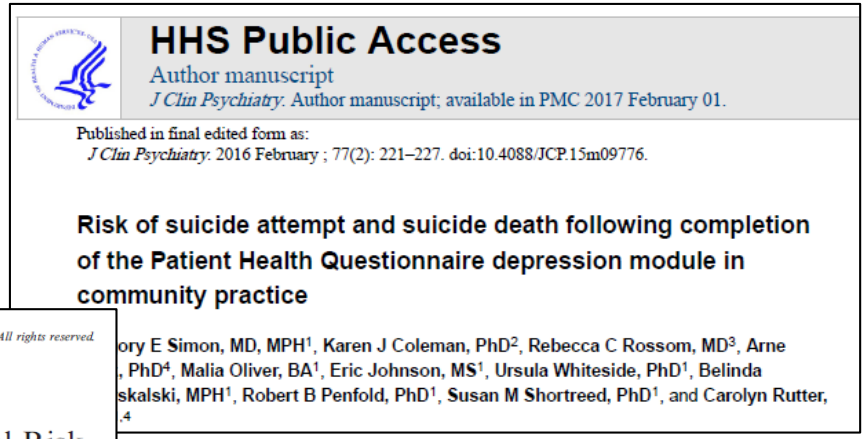


Psychosomatics 2015:56:460–469 © 2015 The Academy of Psychosomatic Medicine. Published by Elsevier Inc. All rights reserved.

Original Research Reports

Comparison of Electronic Screening for Suicidal Risk With the Patient Health Questionnaire Item 9 and the Columbia Suicide Severity Rating Scale in an Outpatient Psychiatric Clinic

Adele C. Viguera, M.D., Nicholas Milano, M.D., Laurel Ralston D.O., Nicolas R. Thompson, M.S., Sandra D. Griffith, Ph.D., Ross J. Baldessarini, M.D., Irene L. Katzan, M.D., M.S.



HHS Public Access
Author manuscript
J Clin Psychiatry: Author manuscript; available in PMC 2017 February 01.

Published in final edited form as:
J Clin Psychiatry. 2016 February ; 77(2): 221–227. doi:10.4088/JCP.15m09776.

Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice

ory E Simon, MD, MPH[1], Karen J Coleman, PhD[2], Rebecca C Rossom, MD[3], Arne , PhD[4], Malia Oliver, BA[1], Eric Johnson, MS[1], Ursula Whiteside, PhD[1], Belinda skalski, MPH[1], Robert B Penfold, PhD[1], Susan M Shortreed, PhD[1], and Carolyn Rutter, [4]

Dueweke, 2018; Simon, 2016; Viguera 2015

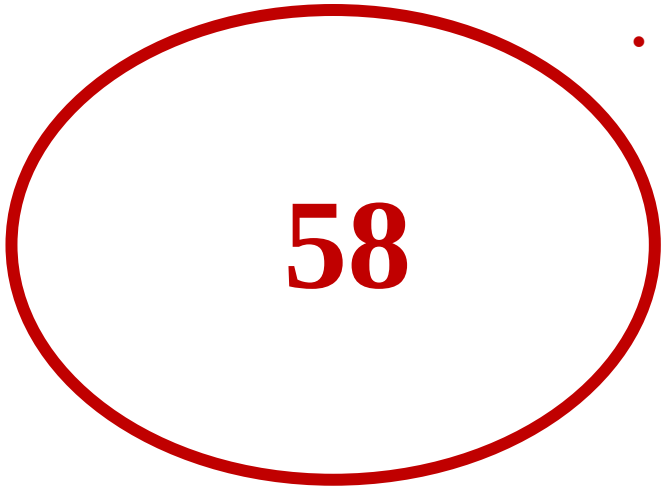
Depression Screening vs. Suicide Risk Screening

PHQ-9 vs. ASQ

NIH National Institute of Mental Health

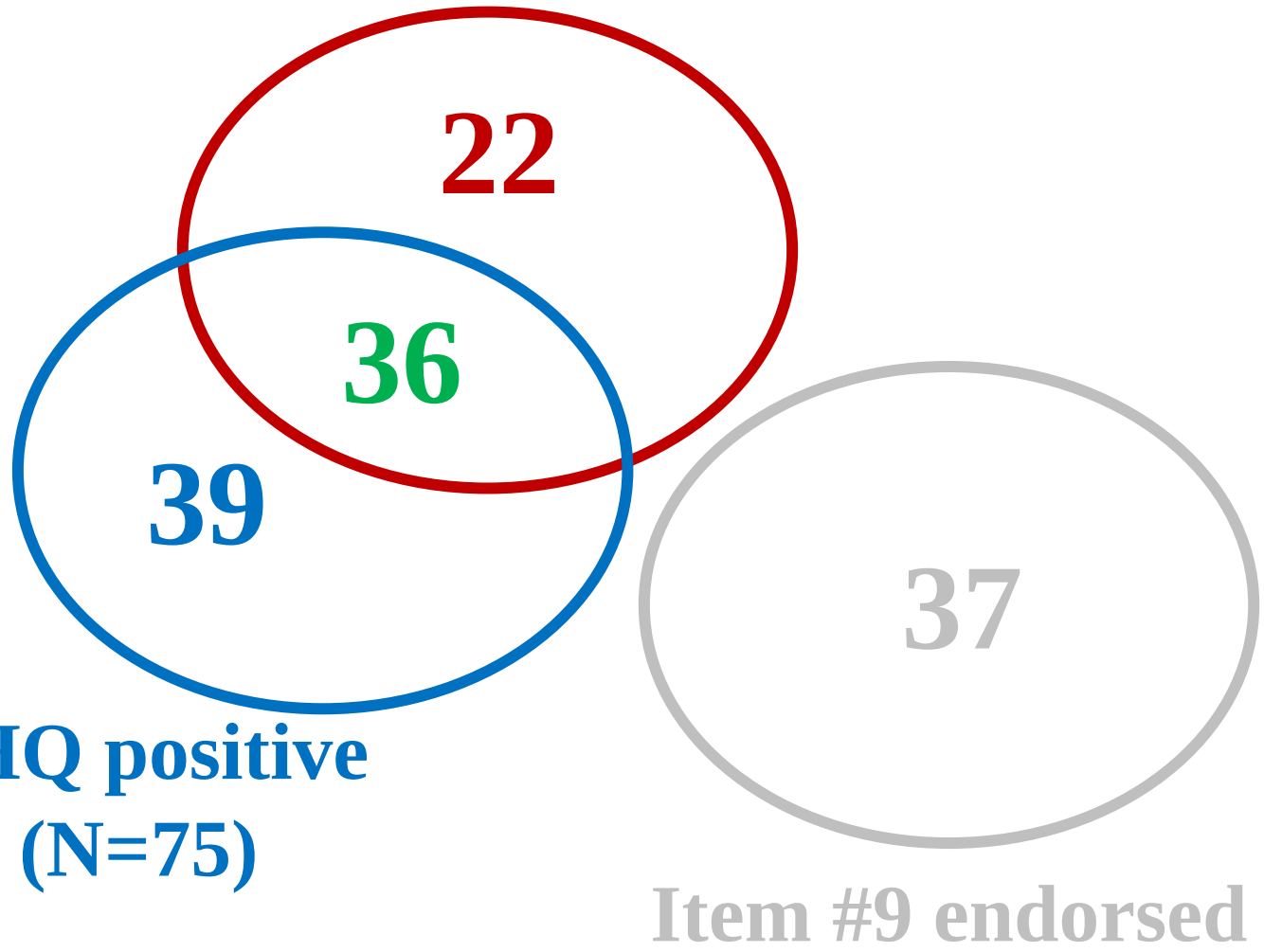
Suicide-risk positive (15%)

Total N=400



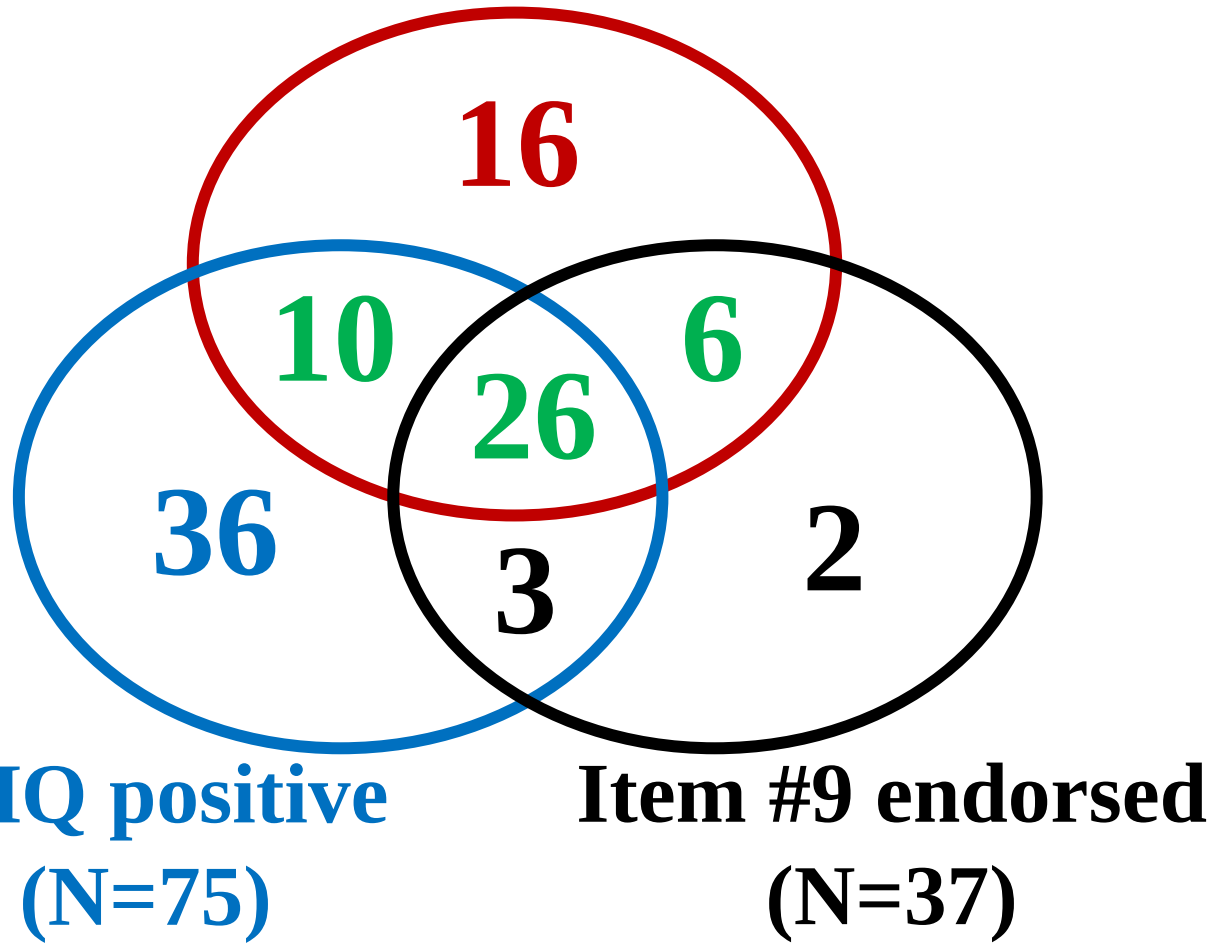
- SIQ ≥ 41
- SIQ-JR ≥ 31
- "Yes" to any ASQ item

N=400

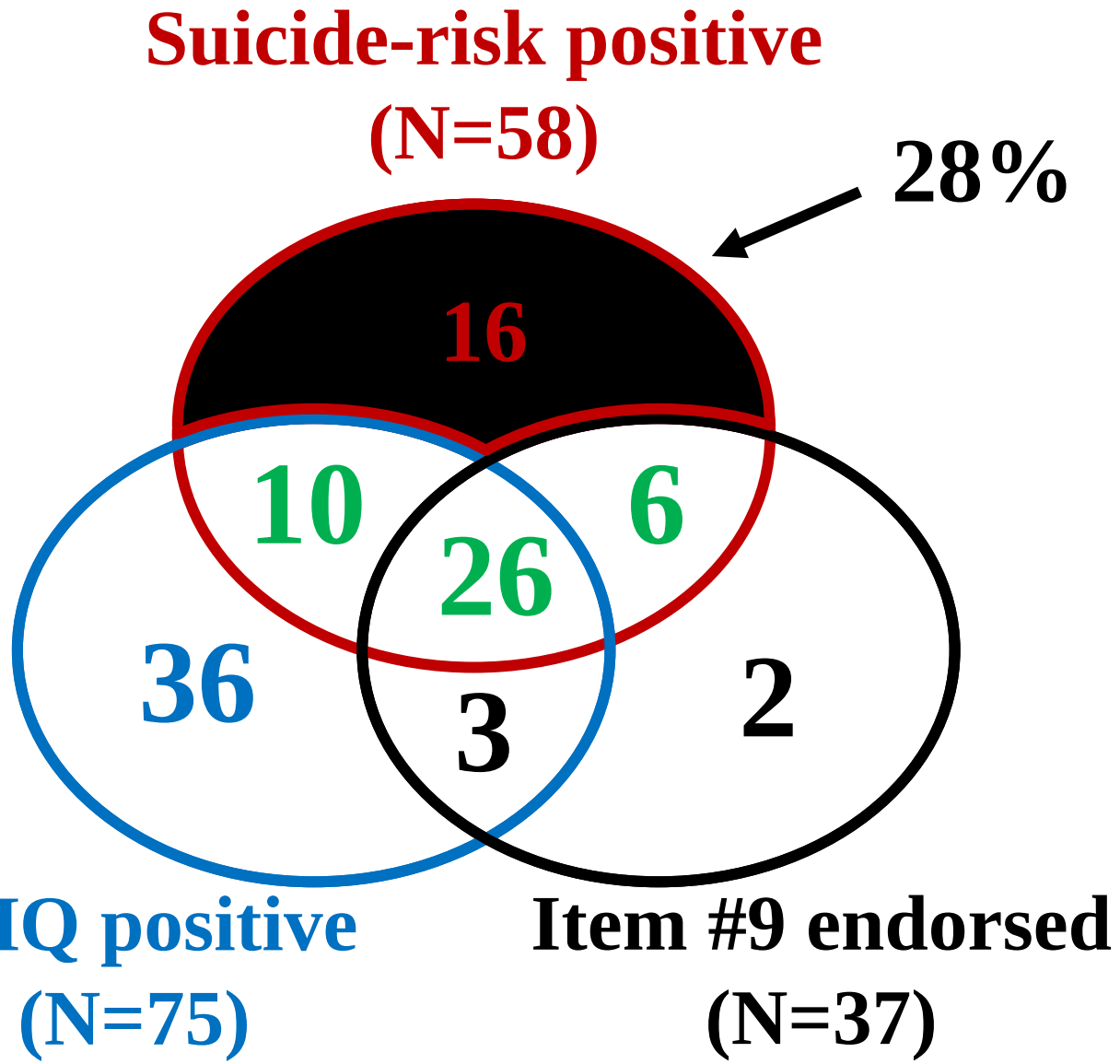


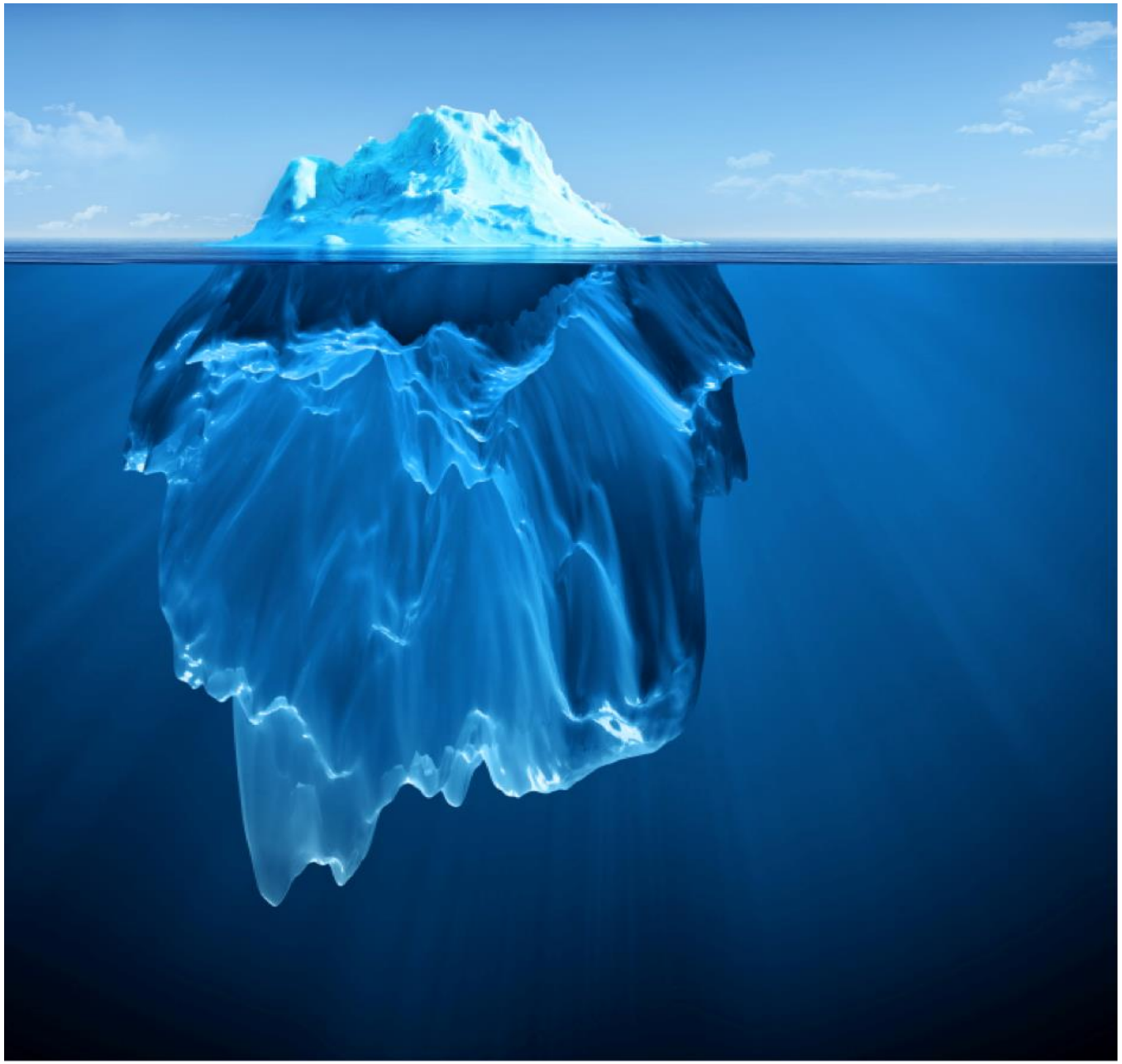
Lanzillo et al., 2017, Poster presented at The American Academy of Child & Adolescent Psychiatry 64th Annual Meeting

N=400


Suicide-risk positive
(N=58)
16
10
6
26
36
3
2
PHQ positive
(N=75)
Item #9 endorsed
(N=37)

N=400


Suicide-risk positive
(N=58)
28%
16
10
26
6
36
3
2
PHQ positive
(N=75)
Item #9 endorsed
(N=37)



Primary Care Providers Role & Barriers

- De-facto principal mental healthcare provider
  - Over 70% of youth have contact with a primary care pediatrician once per year

- Barriers for detecting risk in medical settings:
  - Time & resources
  - Difficulty of interpretation of suicidal ideation or behavior
  - Stigma
  - Asking ineffectively
  - Discomfort

Williams et al., 2009

Screening in pediatric outpatient primary care & specialty clinics

Elizabeth Wharff, PhD
Laika Aguinaldo, PhD, LICSW

Boston Children's Hospital
Until every child is well™

Children's Mercy HOSPITAL KANSAS

Shayla Sullivant, MD, Site PI
Andrea Bradley-Ewing, MA, MPA
David Williams, MPH
Sabra Boyd MSW, LCSW, LSCSW
Sharee Smallwood, MSW
Kristen Williams, BSN, CPN, CCRC,
Kathy Goggin, PhD, BSN, CPN, CCRC

NIH National Institute of Mental Health

Turning research into practice

“How can we implement suicide screening in our pediatric practice?”

-Dr. A

PEDIATRIC & ADOLESCENT HEALTH PARTNERS

NIH National Institute of Mental Health

Common concern:

Can asking kids questions about suicidal thoughts put ‘ideas’ into their heads?

Gould et al., 2005; Crawford et al., 2011; Mathias et al., 2012

Iatrogenic Risk?

On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis

2017

Christopher R. DeCou, MS, and Matthew E. Schumann, MA

Previous studies have failed to detect an iatrogenic effect of assessing suicidality. However, the perception that asking about suicide may induce suicidality persists. This meta-analysis quantitatively synthesized research concerning the iatrogenic risks of assessing suicidality. T explicitly evaluated the iatrogenic effects of as research methods. Thirteen articles were iden Evaluation of the pooled effect of assessing s outcomes did not demonstrate significant iatr port the appropriateness of universal screenin fears that assessing suicidality is harmful.

What's the Harm in Asking About Suicidal Ideation?

Charles W. Mathias, PhD, R. Michael Furr, PhD, Arielle H. Sheftall, PhD, Nathalie Hill-Kapturczak, PhD, Paige Crum, BA, and Donald M. Dougherty, PhD

2012

Both researchers and oversight committees share concerns about patient safety in the study-related assessment of suicidality. However, concern about assessing suicidal thoughts can be a barrier to the development of empirical evidence that informs research on how to safely conduct these assessments. A question has been raised if asking about suicidal thoughts can result in iatrogenic increases of such thoughts, especially among at-risk samples. The current study repeatedly tested suicidal ideation at 6-month intervals for up to 2-years. Suicidal ideation was measured with the Suicidal Ideation Questionnaire Junior, and administered to adolescents who had previously received inpatient psychiatric care. Change in suicidal ideation was tested using several analytic techniques, each of which pointed to a significant decline in suicidal ideation in the context

Evaluating Iatrogenic Risk of Screening Programs

A Randomized Controlled Trial

Madelyn S. Gould, PhD, MPH
Frank A. Marrocco, PhD
Marjorie Kleinman, MS

Context Universal screening for m
front of the national agenda for yo
addressed the potential harm of su

ective To examine whether a
ening program creates distress or increases suicidal ideation among high school
ents generally or among high-risk students reporting depressive symptoms, sub-
ce use problems, or suicide attempts.

ign, Setting, and Participants A randomized controlled study conducted within
context of a 2-day screening strategy. Participants were 2342 students in 6 high
ols in New York State in 2002-2004. Classes were randomized to an experimen-
roup (n=1172), which received the first survey with suicide questions, or to a con-
roup (n=1170), which did not receive suicide questions.

Impact of screening for risk of suicide: randomised controlled trial

2011

Mike J. Crawford, Lavanya Thana, Caroline Methuen, Pradip Ghosh, Sian V. Stanley, Juliette Ross, Fabiana Gordon, Grant Blair and Priya Bajaj

Background
Concerns have been expressed about the impact that screening for risk of suicide may have on a person's mental health.

Aims
To examine whether screening for suicidal ideation among people who attend primary care services and have signs of depression increases the short-term incidence of feeling that life is not worth living.

Method
In a multicentre, single-blind, randomised controlled trial, 443 patients in four general practices were randomised to screening for suicidal ideation or control questions on health and lifestyle (trial registration: ISRCTN84692657). The primary outcome was thinking that life is not worth living measured 10–14 days after randomisation. Secondary outcome measures comprised other aspects of suicidal ideation and behaviour.

Results
A total of 443 participants were randomised to early ($n=230$) or delayed screening ($n=213$). Their mean age was 48.5 years (s.d. = 18.4, range 16–92) and 137 (30.9%) were male. The adjusted odds of experiencing thoughts that life was not worth living at follow-up among those randomised to early compared with delayed screening was 0.88 (95% CI 0.66–1.18). Differences in secondary outcomes between the two groups were not seen. Among those randomised to early screening, 37 people (22.3%) reported thinking about taking their life at baseline and 24 (14.6%) that they had this thought 2 weeks later.

Conclusions
Screening for suicidal ideation in primary care among people who have signs of depression does not appear to induce feelings that life is not worth living.

Declaration of interest
None.

DeCou & Schumann, 2017; Mathias et al., 2012; Crawford et al., 2011; Gould et al., 2005

ASQ Toolkit

www.nimh.nih.gov/asq

asQ
Ask Suicide-Screening Questions

ASQ Toolkit Summary

The ASQ toolkit is organized by the medical setting in which it will be used: **emergency department, inpatient medical/surgical unit, and outpatient primary care and specialty clinics.** All toolkit materials are available on the NIMH website at **www.nimh.nih.gov/asq.** Questions about the materials or how to implement suicide risk screening can be directed to Lisa Horowitz, PhD, MPH at horowitzl@mail.nih.gov or Debbie Snyder, MSW at DeborahSnyder@mail.nih.gov.

Emergency Department (ED/ER):
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

Inpatient Medical/Surgical Unit:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

Outpatient Primary Care/Specialty Clinics:
-ASQ Information Sheet*
-ASQ Tool*
-Brief Suicide Safety Assessment Guide
-Nursing Script
-Parent/Guardian Flyer
-Patient Resource List*
-Educational Videos*

***Note: The following materials remain the same across all medical settings. These materials can be used in other settings with youth (e.g. school nursing office, juvenile detention centers).**
-ASQ Information Sheet
-ASQ Tool
-ASQ in other languages
-Patient Resource List
-Educational Videos

Alert the parents

NIMH TOOLKIT:

Parent/guardian flyer

asQ: Ask Suicide-Screening Questions

Your child's health and safety is our #1 priority. New national safety guidelines recommend that we screen children and adolescents for suicide risk.

During today's visit, we will ask you to step out of the room for a few minutes so a nurse can ask your child some additional questions about suicide risk and other safety issues in private.

If we have any concerns about your child's safety, we will let you know.

Suicide is the 2nd leading cause of death for youth. Please note that **asking kids questions about suicide is safe**, and is very important for suicide prevention. Research has shown that asking kids about thoughts of suicide is not harmful and **does not put thoughts or ideas into their heads**.

Please feel free to ask your child's doctor if you have any questions about our patient safety efforts.

Thank you in advance for your cooperation.

Script for Nurses - Youth

NIMH TOOLKIT: OUTPATIENT

Script for nursing staff

Say to parent/guardian:
"National safety guidelines recommend that we screen all kids for suicide risk. We ask these questions in private, so I am going to ask you to step out of the room for a few minutes. If we have any concerns about your child's safety, we will let you know."

Once parent steps out, say to patient:
"Now I'm going to ask you a few more questions."
Administer the ASQ and any other questions you want to ask in private (e.g. domestic violence).

If patient screens positive, say to patient:
"These are hard things to talk about. Thank you for telling me. I'm going to share your answers with [insert name of MD, PA, NP, or mental health clinician] and he/she will come speak with you."

If patient screens positive, and parent/guardian is awaiting results, say:
"We have some concerns about your child's safety that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to [insert name of MD, PA, NP, or mental health clinician], and he/she will further evaluate your child for safety."

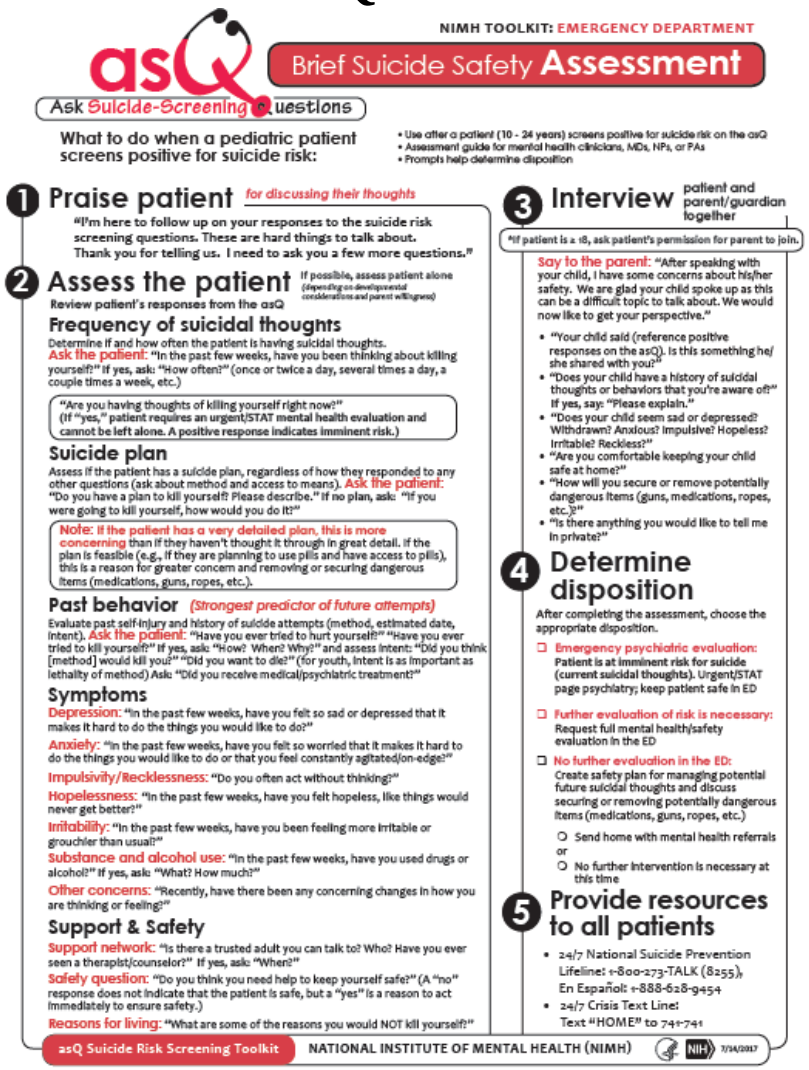
What happens when a patient screens positive?

What is Considered a Positive Screen?

- Two ways to screen positive:
  - **Non-Acute:** answers "yes" to any of questions #1-4 or refuses to answer
    - Provider conducts a brief suicide safety assessment (BSSA) to determine if more extensive psychiatric evaluation is necessary
    - Patient may not leave until BSSA is completed
  - **Acute:** answers "yes" to #5: "Are you having thoughts of killing yourself right now?"
    - Very rare for non-behavioral health patients
    - Patient should not be left alone
    - Place on safety precautions

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

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

- Use after a patient (10 - 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.)

"Are you having thoughts of killing yourself right now?" (If "yes," patient requires an urgent/STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). Ask the patient: "Do you have a plan to kill yourself? Please describe." If no plan, ask: "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior *(Strongest predictor of future attempts)*

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?"

Symptoms

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?"

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?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Support & Safety

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask: "When?"

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.)

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

3 Interview patient and parent/guardian together

*If patient is ≥ 18, ask patient's permission for parent 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 behaviors that you're aware of?" If yes, say: "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

- ❑ Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry; keep patient safe in ED
- ❑ Further evaluation of risk is necessary: Request full mental health/safety evaluation in the ED
- ❑ No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)
  - ○ Send home with mental health referrals or
  - ○ No further intervention is necessary at this time

5 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

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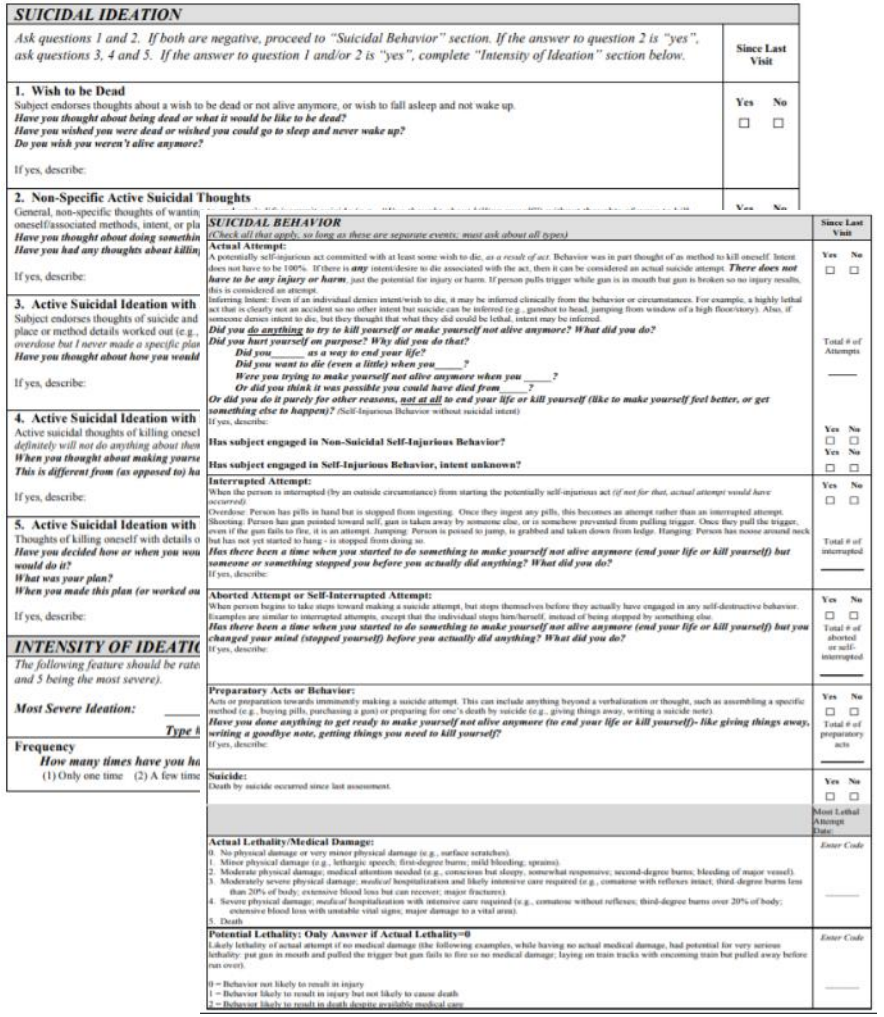
C-SSRS



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 — Yes / No

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:

2. Non-Specific Active Suicidal Thoughts

General, non-specific thoughts of wantin… oneself/associated methods, intent, or pla…
Have you thought about doing somethin…
Have you had any thoughts about killin…

If yes, describe:

3. Active Suicidal Ideation with

Subject endorses thoughts of suicide and place or method details worked out (e.g., *overdose but I never made a specific plan*)
Have you thought about how you would…

If yes, describe:

4. Active Suicidal Ideation with

Active suicidal thoughts of killing oneself *definitely will not do anything about them*
When you thought about making yourse…
This is different from (as opposed to) ha…

If yes, describe:

5. Active Suicidal Ideation with

Thoughts of killing oneself with details o…
Have you decided how or when you wou…
would do it?
What was your plan?
When you made this plan (or worked ou…

If yes, describe:

INTENSITY OF IDEATI…

The following feature should be rate… and 5 being the most severe).

Most Severe Ideation: ____ *Type h…*

Frequency

How many times have you ha…
(1) Only one time (2) A few time…

SUICIDAL BEHAVIOR

(Check all that apply; so long as these are separate events; must ask about all types)

Since Last Visit

Actual Attempt: — Yes / No

A potentially self-injurious act committed with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is *any* intent/desire to die associated with the act, then it can be considered an actual suicide attempt. *There does not have to be any injury or harm*, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?
Did you hurt yourself on purpose? Why did you do that?
Did you_____ as a way to end your life?
Did you want to die (even a little) when you_____?
Were you trying to make yourself not alive anymore when you_____?
Or did you think it was possible you could have died from_____?
Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

Total # of Attempts: ____

If yes, describe:

Yes / No — **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**

Yes / No — **Has subject engaged in Self-Injurious Behavior, intent unknown?**

Interrupted Attempt: — Yes / No

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*.

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.
Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

Total # of interrupted: ____

If yes, describe:

Aborted Attempt or Self-Interrupted Attempt: — Yes / No

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

Total # of aborted or self-interrupted: ____

If yes, describe:

Preparatory Acts or Behavior: — Yes / No

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

Total # of preparatory acts: ____

If yes, describe:

Suicide: — Yes / No

Death by suicide occurred since last assessment.

Most Lethal Attempt Date: ____

Actual Lethality/Medical Damage: — Enter Code

0. No physical damage or very minor physical damage (e.g., surface scratches).
1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).
2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

Potential Lethality: Only Answer if Actual Lethality=0 — Enter Code

Likely lethality of actual attempt *if no* medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

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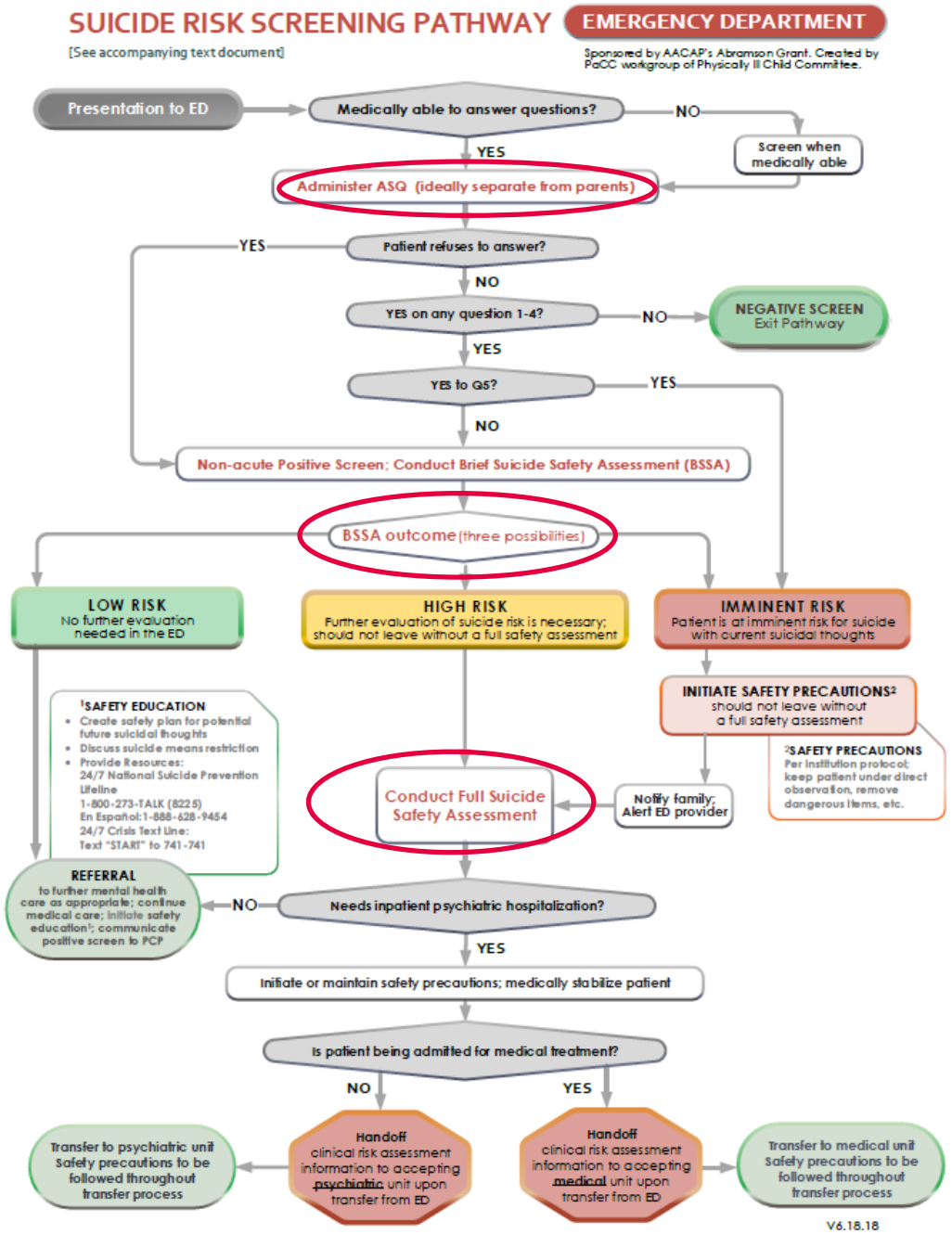
What is the purpose of the BSSA?

- To help clinician make “next step” decision
- 4 Disposition Choices on ASQ BSSA
  - **Imminent Risk**
    - **Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts “right now”). Initiate suicide safety precautions and request emergency mental health evaluation
  - **High Risk**
    - **Further evaluation of risk is necessary**
    - Patient will require a further mental health evaluation from a mental health clinician before discharge
  - **Low Risk**
    - **Not the “business of the day”**
    - **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.

    OR
  - **No further intervention is necessary at this time.**

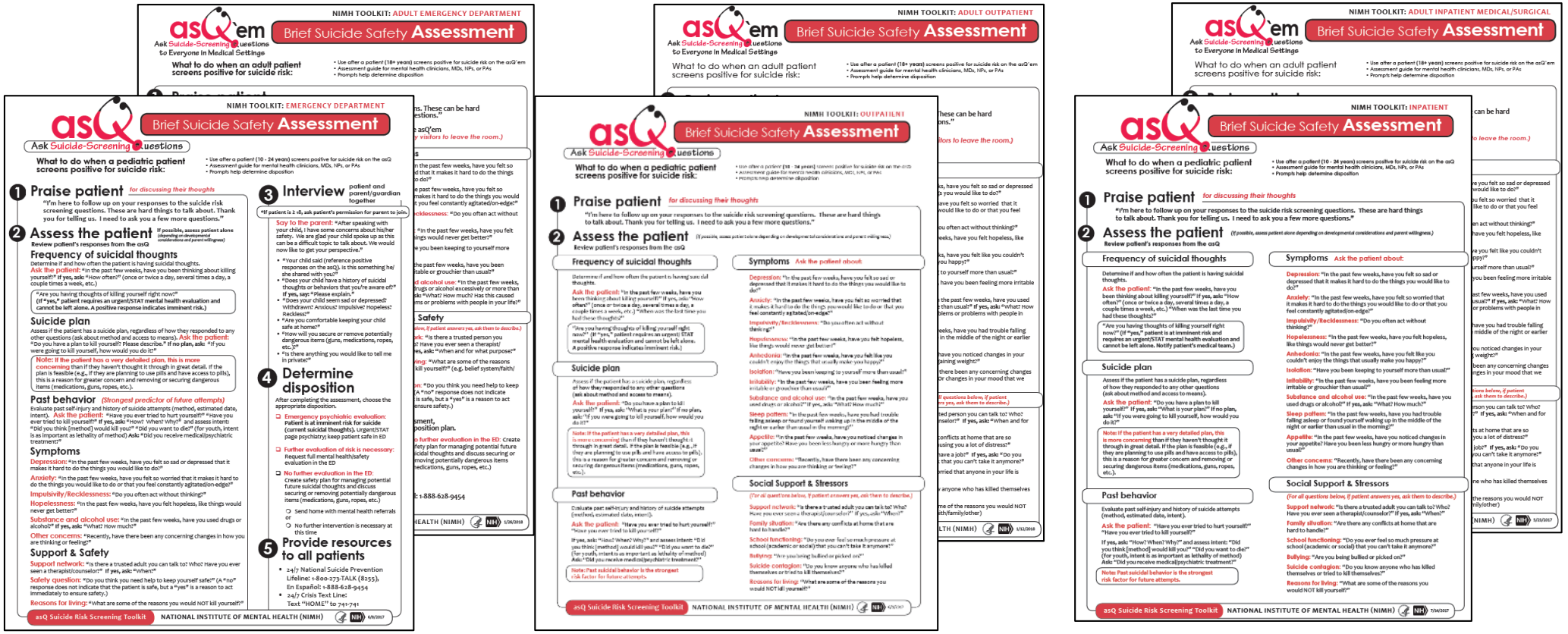


National Institute of Mental Health

Brahmbhatt, Kurtz, Afzal…Horowitz, et al. (2018) *Psychosomatics*

Brief Suicide Safety Assessments

- BSSA and Worksheets available for Youth and Adults
  - Emergency Departments
  - Inpatient Medical/Surgical Unit setting
  - Outpatient settings



Resources for Patients at Risk

NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Mental Health Resources

National Suicide Prevention Lifeline
1-800-273-TALK (8255)
Spanish/Español: 1-888-628-9454

Crisis Text Line
Text HOME to 741-741

Suicide Prevention Resource Center
www.sprc.org

National Institutes of Health
www.nimh.nih.gov

Substance Abuse and Mental Health Services Administration
www.samhsa.gov

NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Links to Videos

Nurses: The Importance of Screening
-Video produced by Children's Mercy Kansas City Hospital
http://bcove.video/2pWyvcN

Physicians: The Importance of Screening
-Video featuring doctors Ted Abernathy and Scott Keel
Long version: https://youtu.be/OTjxEZkp4-Y
Short version: https://youtu.be/QaPeu6s__YM

Mayo Clinic: Youth Suicide Prevention - What to Say & Not to Say
https://www.youtube.com/watch?v=3BByqa7bhto&feature=youtu.be

Implementation Example

- Parkland Health and Hospital Systems
  - Implemented house-wide (ED, inpatient medical/surgical, outpatient); screened over 2 million patients
  - 2 years of data collected by Dr. Kim Roaten

Parkland

NIH National Institute of Mental Health

*Preliminary unpublished data, please do not disseminate

Lessons Learned

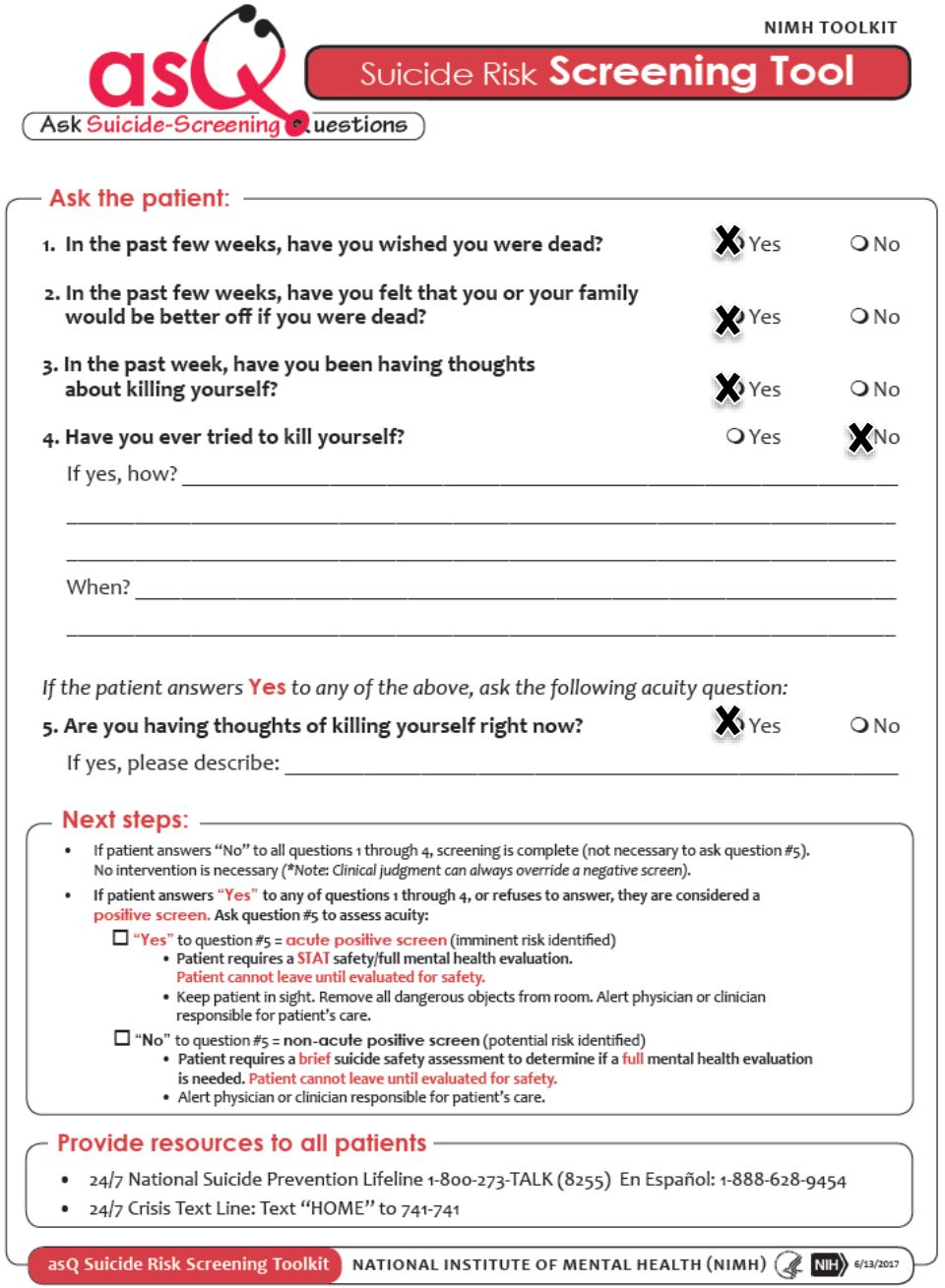
- Involve physician and nursing leadership from the start
- Requires clinician champions
- Train the nurses/medical assistants
  - Screening must be systematic
  - Ask the questions verbatim
  - Politely **tell** the parents to leave the room for 2 minutes
  - Make the screener forced questions in the EHR if possible
- Train the social workers, MDs, NPs, PAs or any other staff conducting the BSSA
- Positive screen rates are manageable
- Majority of parents/guardians ok with leaving the room
- Non-disruptive to workflow
- 1 extra patient to refer to mental health resources per week

Summary

- Medical setting is important venue to identify individuals at risk for suicide
- Clinicians require population-specific and site-specific validated screening instruments
- Screening can take 20 seconds
- Requires practice guidelines for managing positive screens
  - Clinical Pathway- 3-tiered system
    - Brief screen (20 seconds)
    - BSSA (~10 minutes)
    - Full mental health/safety evaluation (30 minutes)
- Safety planning and safe storage/means restriction for all patients

A patient example

- 18 y.o. male presenting with fatigue
- Nurse intuition – something not right
- Administered ASQ



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

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

If yes, how? _____

When? _____

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

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

If yes, please describe: _____

Next steps:

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

Provide resources to all patients

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

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 6/13/2017

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NIH National Institute of Mental Health

Any Questions?

Just asQ !

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Suicide Prevention Programs in the School Setting: Lessons Learned from Signs of Suicide (SOS)

Jeff Bridge, Ph.D.
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NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Disclosures

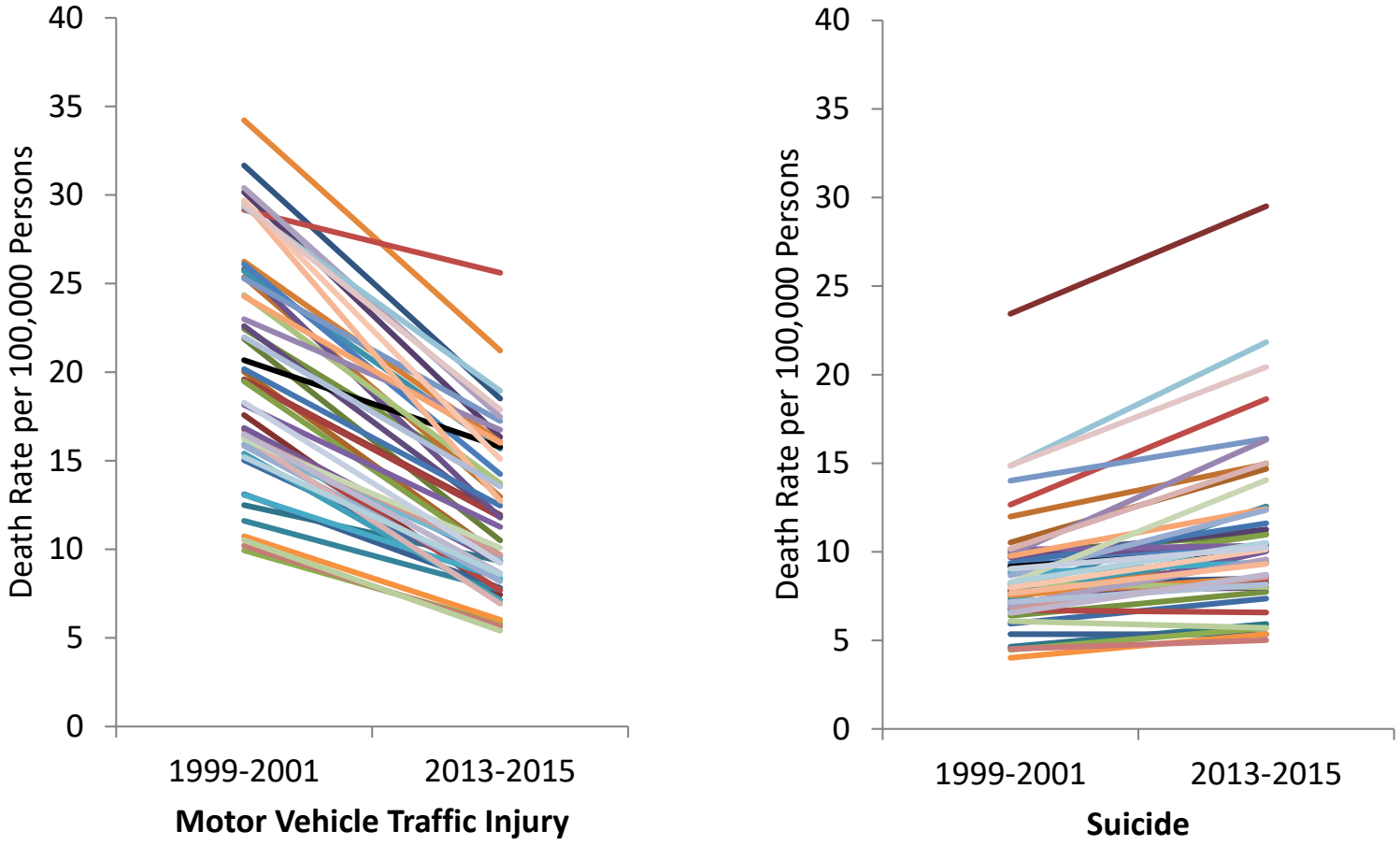
- I receive funding from the National Institute of Mental Health (NIMH) and the Patient-Centered Outcomes Research Institute (PCORI)

- Scientific Advisory Board of Clarigent Health

Objectives

- Highlight the school setting as a site for youth suicide prevention
- Discuss the Signs of Suicide Program as implemented in central Ohio

State-Level Mortality Rates for MVT Injury and Suicide in U.S. Youth Aged 10-24 Years



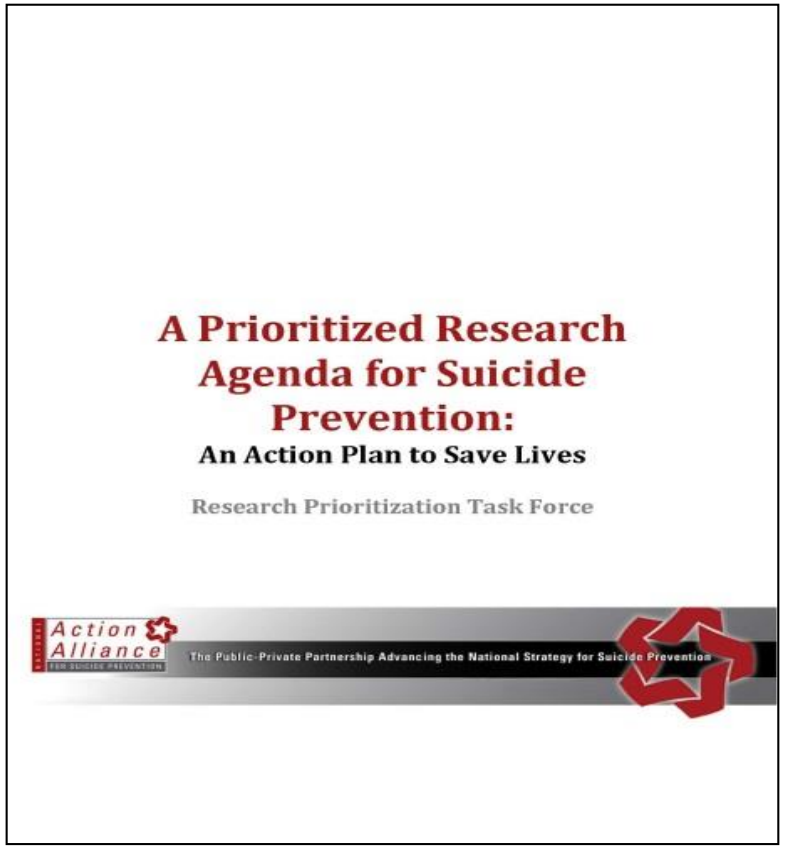
*Each line represents one state. Between 1999-2001 and 2013-2015, motor vehicle traffic injury death rates decreased significantly in 49 states (all *P*s <.05) and were unchanged in 1 state. Suicide rates increased significantly in 27 states and were unchanged in 23 states.

Reduction in Youth MVT Deaths: Contributing Factors

- General contributors
  - Speed limits, Drinking/Texting & Driving Laws
- Graduated Driver Licensing (GDL)
  - 3 Stages
    - Learners Permit
    - Intermediate (“Provisional”) License
      - Limits on nighttime driving, driving with teen passengers
    - Unrestricted
- All 50 states and D.C. have implemented all or some of the GDL components

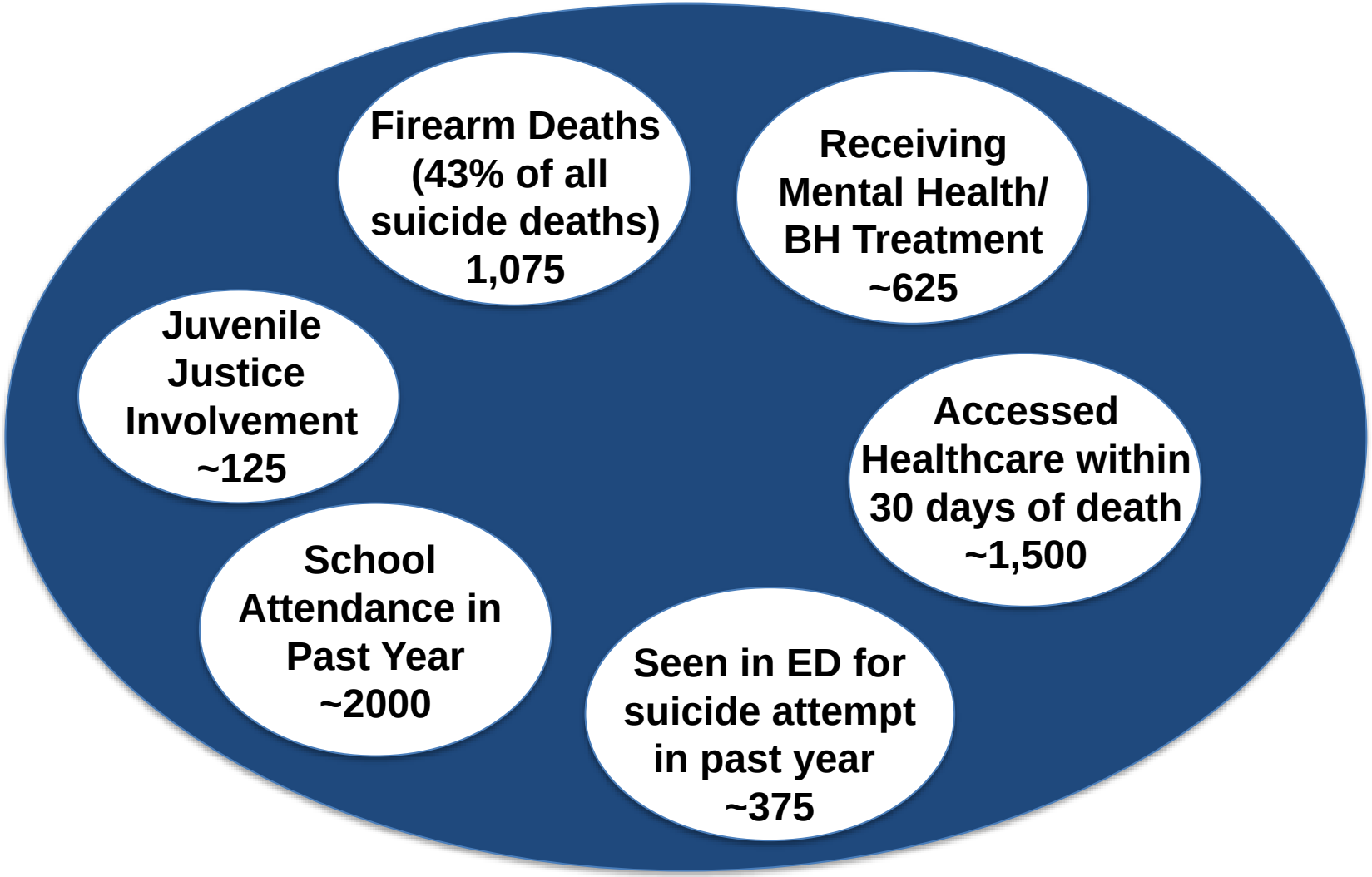
The American Foundation for Suicide Prevention Launches Project 2025

The National Action Alliance for Suicide Prevention Adopts the Same Timeline



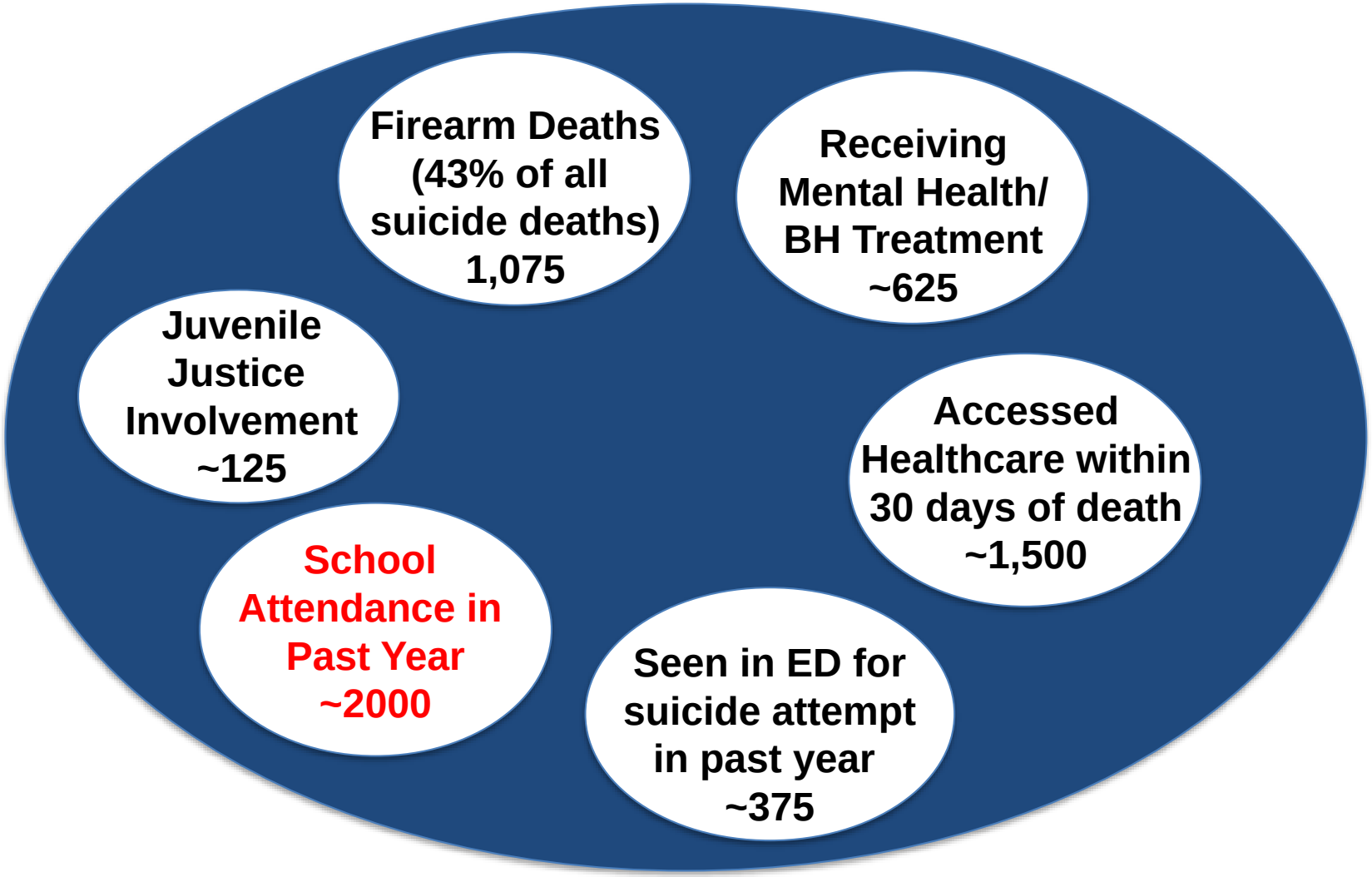
Source: http://afsp.org/american-foundation-suicide-prevention-launches-project-2025/; http://actionallianceforsuicideprevention.org/about-us

Identifying 2,500 Youth Suicide Decedents in the United States



Data source: Action Alliance Research Prioritization Report, page 80, 2014; data sources for estimates provided on page 81

Identifying 2,500 Youth Suicide Decedents in the United States



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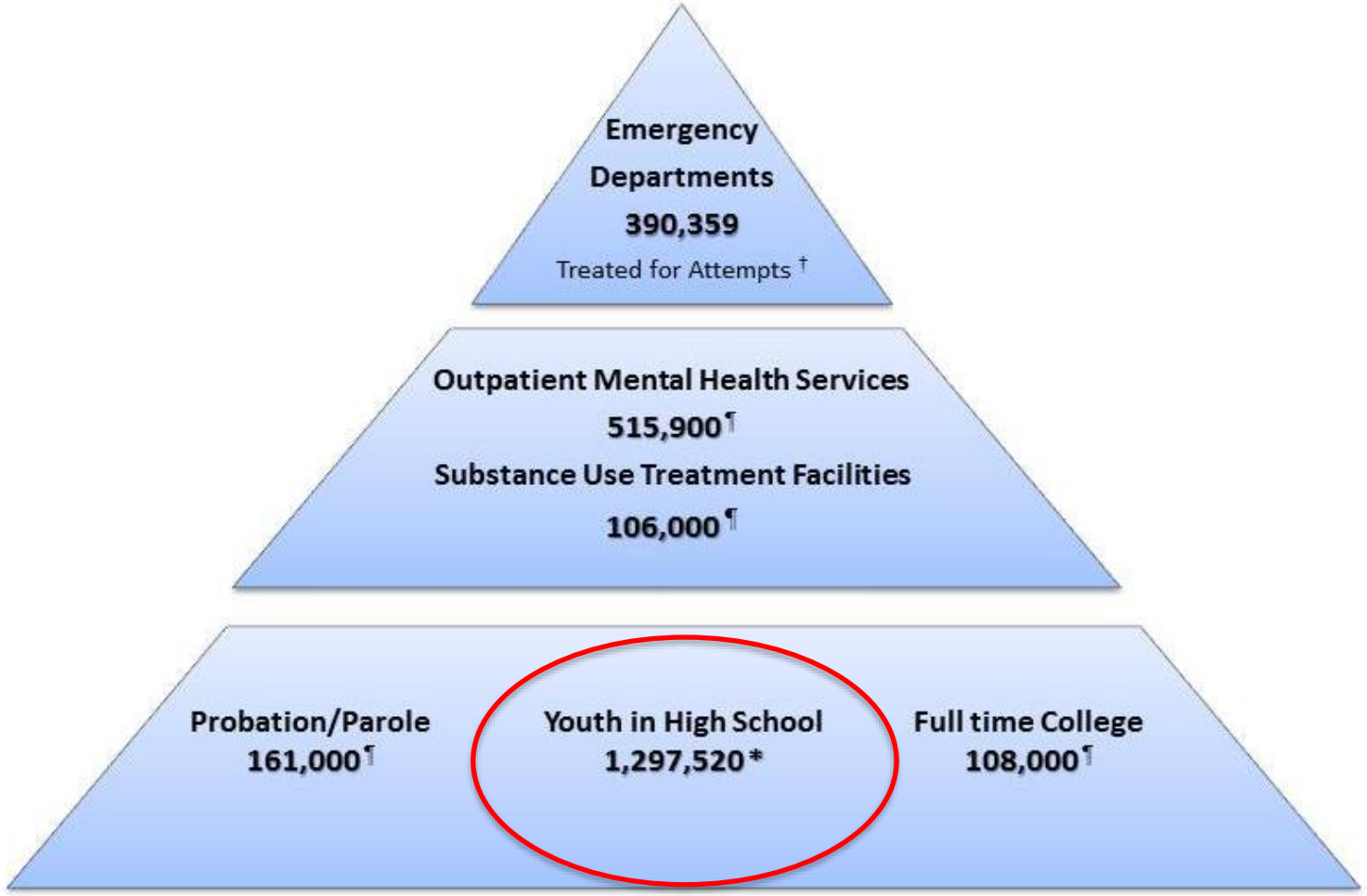
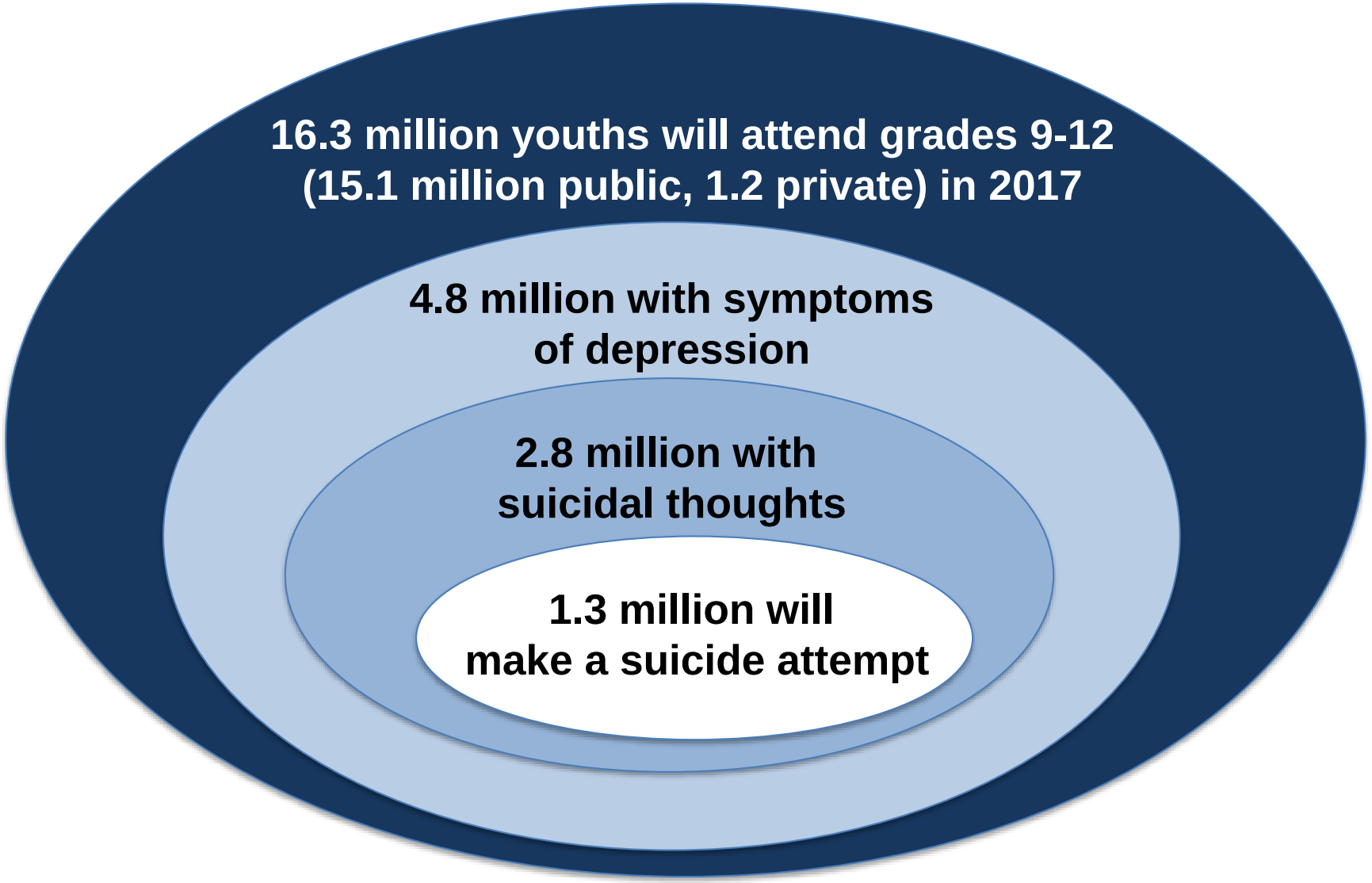
Opportunities to Reduce Suicide and Suicide Attempts in Young People and Adults



†Source: CDC's National Electronic Surveillance System, 2010
¶Source: SAMHSA's National Survey on Drug Use and Health, 2008–2009
*Source: CDCs Youth Risk Behavior Surveillance System, 2011 (Attempters treated by Doctor or Nurse)

Action Alliance, 2014

Step 1: Identify Large Subgroups at Elevated Risk in “Boundaried” Systems: High Schools



Data source: WISQARS Non-fatal Injury Report , 2014, http://webappa.cdc.gov/sasweb/ncipc/nfirates2001.html

Why Suicide Prevention in Schools?

- Universal prevention
  - Almost all children go to school
  - All students benefit and play a role
  - Depression/suicidal thinking impacts academics
- Staff can identify what “typical behavior”
  - Can use that to identify **major changes**
- Trusted adults make talking about depression or suicide less scary
- Modify culture and enhance “connectedness”

Suicide Prevention Programs should:

- **Decrease** student risk by increasing knowledge about depression and suicide warning signs
- **Reduce** stigma: mental illness, like physical illness, requires timely treatment
- **Encourage** help-seeking for oneself or to obtain support for a friend
- **Engage** parents and school staff as partners in prevention through education

School Concerns about Adopting Suicide Prevention

Concern	But…
Talking about suicide increases risk	Suicide prevention actually decreases risk
I am here to teach	Depression impacts learning and memory
It takes too much time	Weeks of learning time can be lost post-suicide
We don’t have those problems	No school or family is immune
We don’t have MH services available	Suicide not going away Creative problem-solving

Signs of Suicide (SOS)

- Train all adults to identify depression symptoms and warning signs for suicide
- Teach action steps to students and adults when encountering suicidal behavior
- Increase student awareness and help-seeking

Acronym (**ACT**)

- **A**cknowledge
- **C**are - show that you care
- **T**ell a trusted adult

Warning Signs

- Most people who attempt suicide give warning signs of suicide
  - Wanting to be alone all of the time
  - ↓ interest in usual activities
  - Giving away important belongings
  - Risky or reckless behavior
  - Self-injury
  - Increase in energy following a period of depression

Warning signs

- **Seek immediate help when a student:**
- Threatens to attempt suicide or injures him or herself intentionally
- Obtains a weapon or seeks the means to kill him or herself
- Talks or writes about wanting to end his or her life in school or social media

Triggering Events

•No single event causes suicidal thought or attempts

Examples:

- breakup
- bullying
- school problems or perceived failure
- sudden death of a loved one
- suicide of a friend or relative
- family stressors like divorce, jail, instability

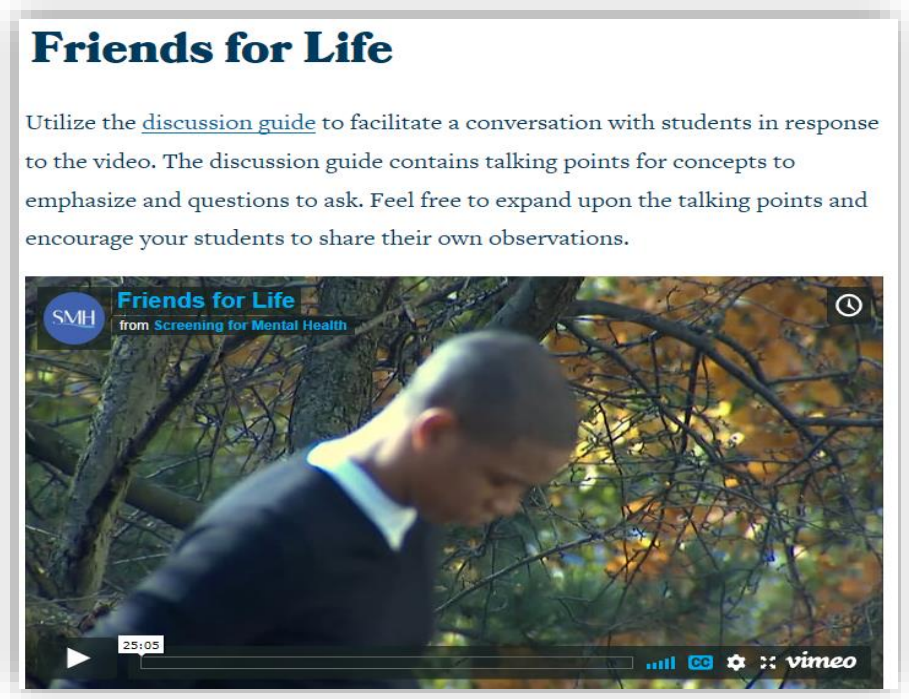
Evaluation of the SOS Program

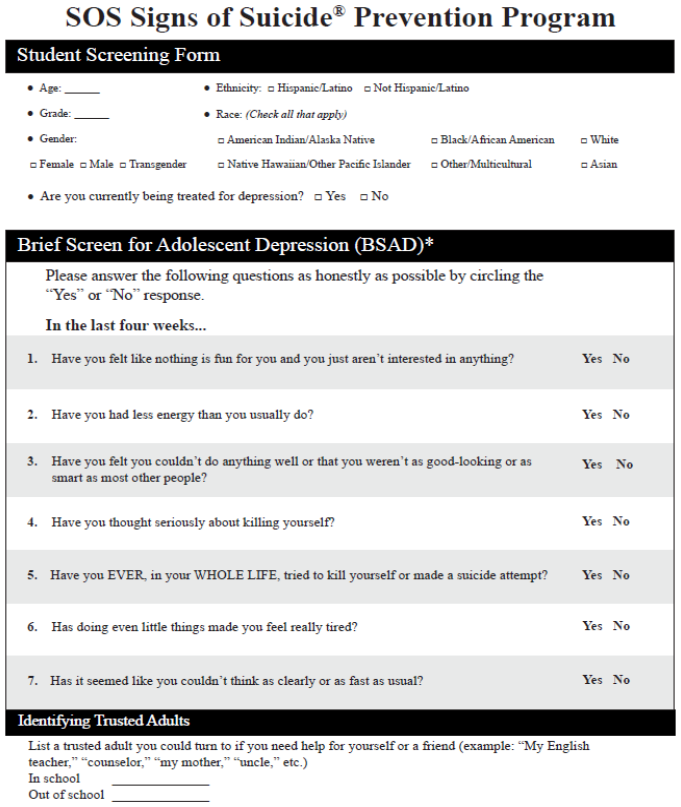
- Only universal school-based suicide prevention program for which a reduction in self-reported suicide attempts has been documented
- In 3 separate randomized controlled studies, SOS Program has shown a reduction in self-reported suicide attempts by 40%-64%.
- A recent replication study published in the Prevention Science Journal (2016) found SOS to be associated with:
  - greater knowledge and more adaptive attitudes about depression and suicide
  - 64% fewer suicide attempts among intervention youths relative to untreated controls
  - decrease in suicide planning for “high risk participants” (those who reported a lifetime history of suicide attempt) (Schilling et al., 2016)

SOS Program Components

Universal education:

- video & guided discussion





SOS Signs of Suicide® Prevention Program

Student Screening Form

- Age: _____
- Grade: _____
- Gender: ☐ Female ☐ Male ☐ Transgender
- Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
- Race: *(Check all that apply)* ☐ American Indian/Alaska Native ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ Other/Multicultural ☐ White ☐ Asian
- Are you currently being treated for depression? ☐ Yes ☐ No

Brief Screen for Adolescent Depression (BSAD)*

Please answer the following questions as honestly as possible by circling the "Yes" or "No" response.

In the last four weeks...

1.	Have you felt like nothing is fun for you and you just aren't interested in anything?	Yes No
2.	Have you had less energy than you usually do?	Yes No
3.	Have you felt you couldn't do anything well or that you weren't as good-looking or as smart as most other people?	Yes No
4.	Have you thought seriously about killing yourself?	Yes No
5.	Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?	Yes No
6.	Has doing even little things made you feel really tired?	Yes No
7.	Has it seemed like you couldn't think as clearly or as fast as usual?	Yes No

Identifying Trusted Adults

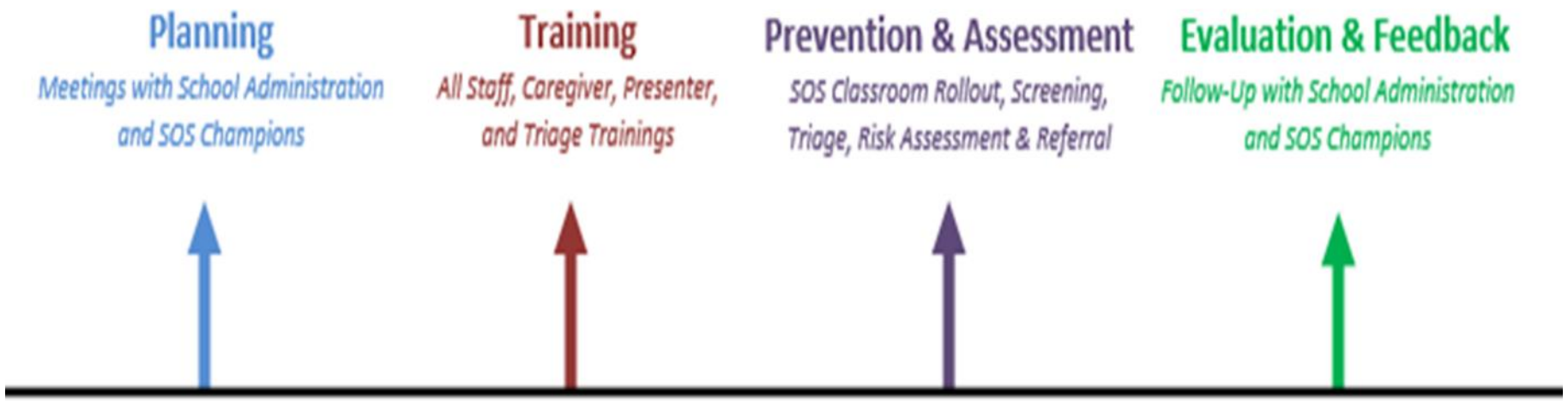
List a trusted adult you could turn to if you need help for yourself or a friend (example: "My English teacher," "counselor," "my mother," "uncle," etc.)

In school _____

Out of school _____

Screening: depression & warning signs of suicide

SOS implementation / evaluation timeline



Triage Assessment

- **5-7 minute assessment by school staff**
  - Need for triage indicated by BSAD Screener or Student Response Card

- **Questions probe:**
  - Concern for a friend
  - Current or past suicidal thoughts
  - Past suicide attempt
  - Current counselor for presenting issues
  - Level of distress

Risk Assessment

If triage assessment reveals current or recent suicidal ideation and/or attempt in past year:

- Administer a validated suicide risk assessment tool
  - Columbia Suicide Severity Rating Scale (C-SSRS)
- Safety Plan
  - Whether a student can readily complete this provides valuable assessment information and reduces risk
- Determine disposition
  - Outpatient counseling
  - Outpatient crisis or emergency department

Advantages of SOS

- Implemented by school staff
- Engages existing supports including school staff, parents, peers, community
- Incorporates many best practice elements
- Increases dialogue around mental health
  - Reduces stigma
- Sustainable

Center for Suicide Prevention and Research (CSPR)

- Joint prevention and research focus combining efforts of NCH Behavioral Health and the Research Institute
- Implementation of SOS Signs of Suicide prevention program in central/southeastern Ohio schools at no cost:
  - Train youth, caregivers, and school staff to increase depression and suicide awareness
  - Teach adults and youth how to identify, support, and respond to individuals at risk for suicide

Expansion of Hospital-School Partnerships

- CSPR version of SOS disseminated across Ohio
  - Over **3000 school staff** trained across 10 counties
  - School-based therapists, nurses, athletic trainers
  - Over 200 Columbus City School Counselors & SWs
  - Dozens of community partners who serve youth

- Training elements and clinical support processes
  - Increase clarity of SOS
  - "Sustainable fidelity”

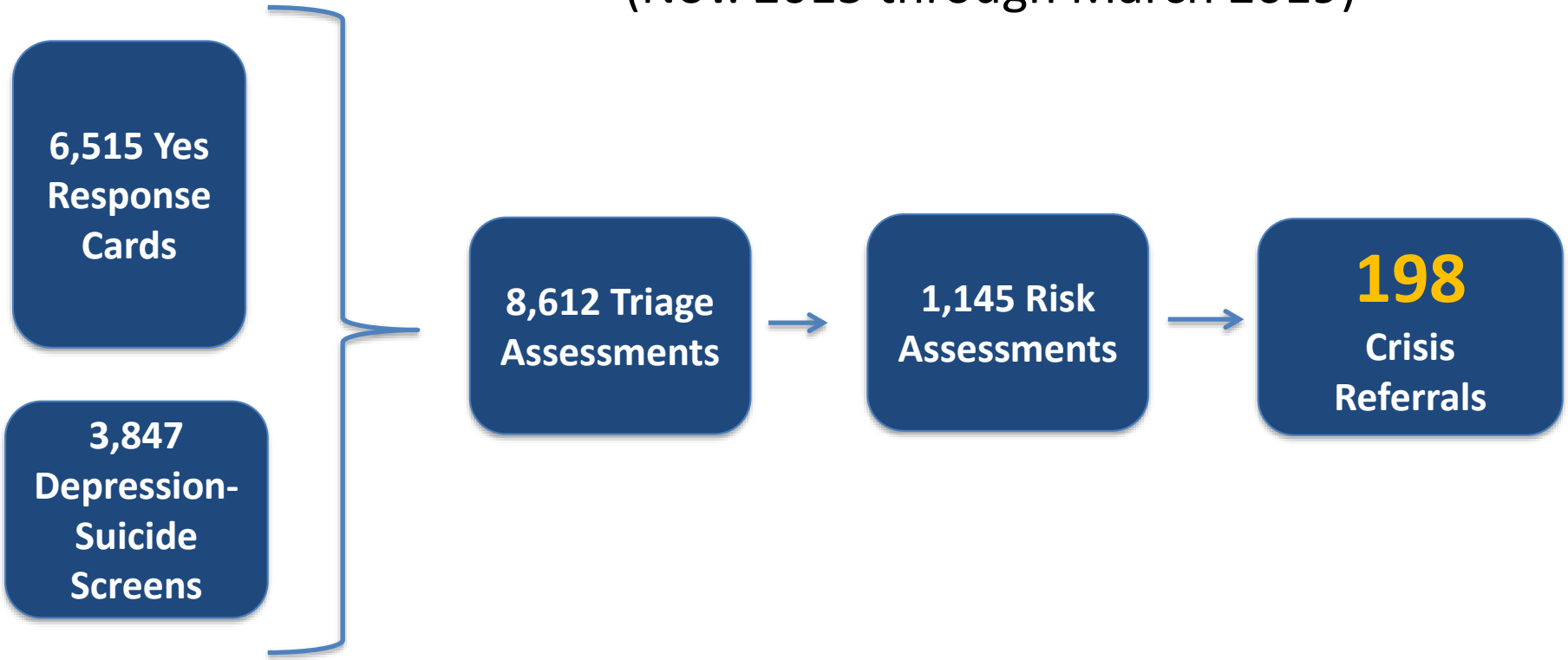
NCH SOS Gatekeeper Training Outcomes

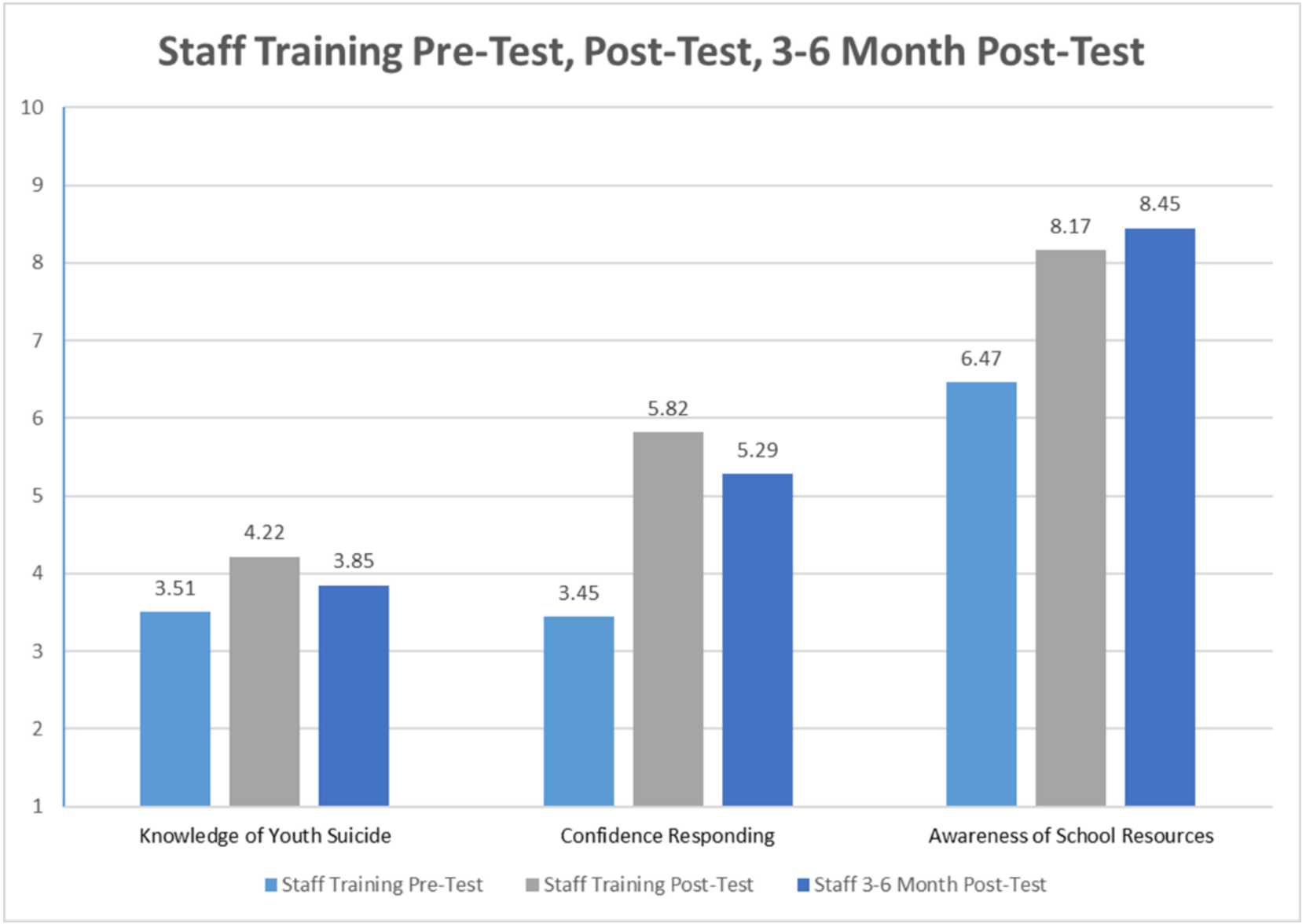
- SOS Gatekeeper staff training pre/post survey assesses changes in:
  - Staff knowledge about suicide
  - Staff awareness of school resources
  - Staff confidence in addressing student needs

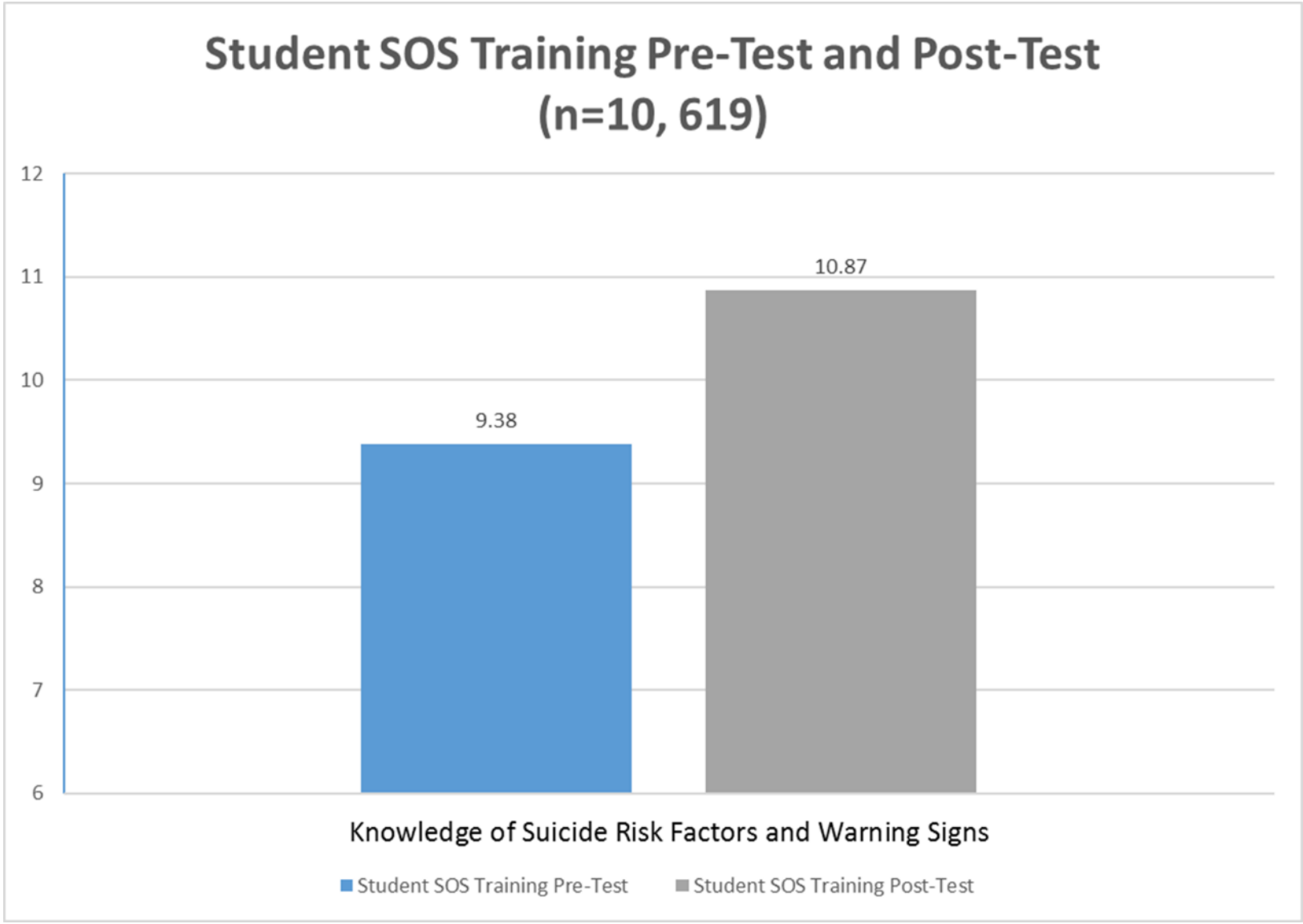
NCH Signs of Suicide Implementation

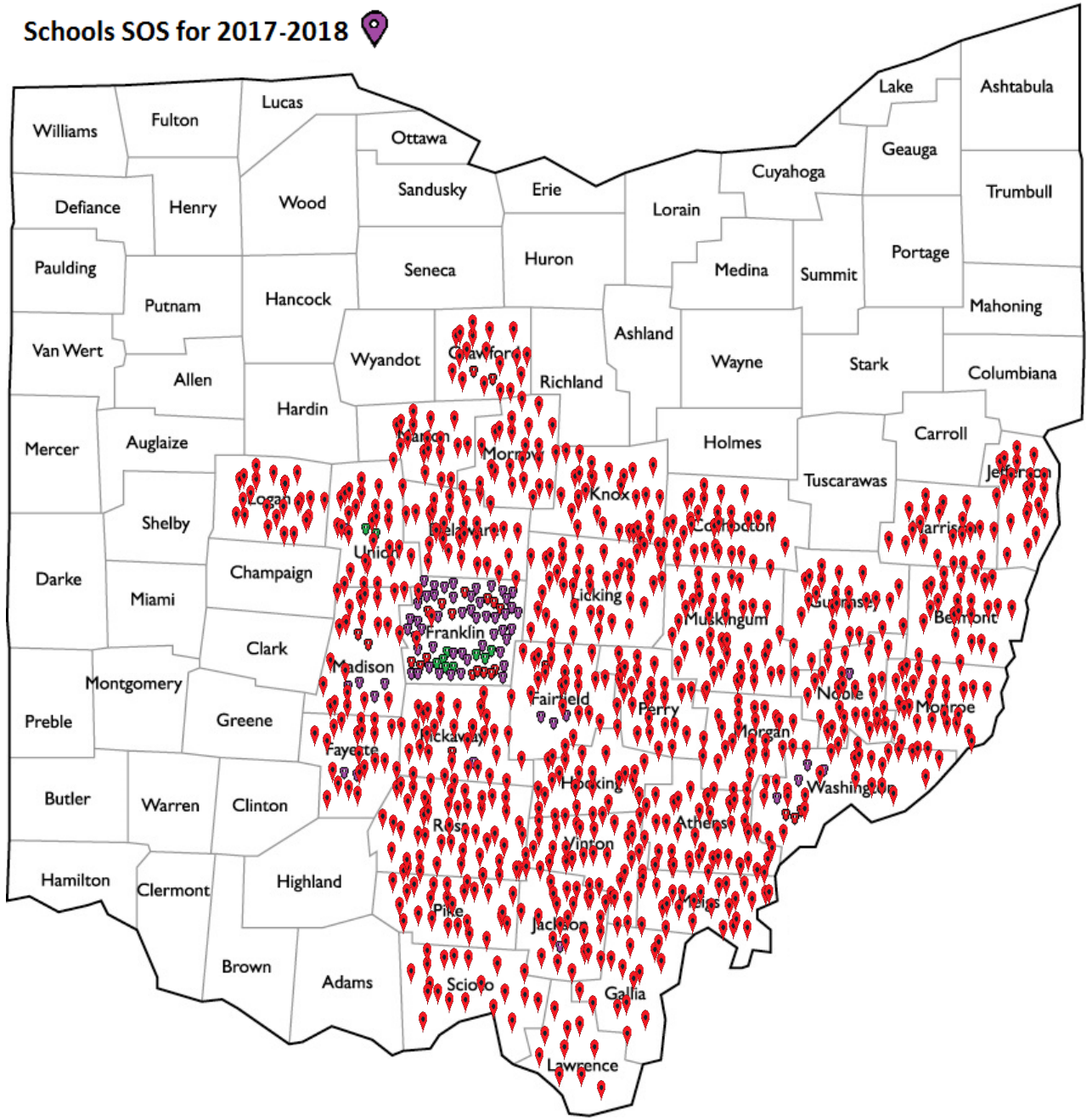
- **34,005 students, 1571 classrooms, 122 schools**

(Nov. 2015 through March 2019)




Staff Training Pre-Test, Post-Test, 3-6 Month Post-Test
10
9
8
7
6
5
4
3
2
1
3.51
4.22
3.85
3.45
5.82
5.29
6.47
8.17
8.45
Knowledge of Youth Suicide
Confidence Responding
Awareness of School Resources
Staff Training Pre-Test
Staff Training Post-Test
Staff 3-6 Month Post-Test


Student SOS Training Pre-Test and Post-Test
(n=10, 619)
12
11
10
9
8
7
6
10.87
9.38
Knowledge of Suicide Risk Factors and Warning Signs
Student SOS Training Pre-Test
Student SOS Training Post-Test


Schools SOS for 2017-2018
Williams
Fulton
Lucas
Ottawa
Lake
Ashtabula
Geauga
Cuyahoga
Trumbull
Defiance
Henry
Wood
Sandusky
Erie
Lorain
Portage
Paulding
Putnam
Hancock
Seneca
Huron
Medina
Summit
Mahoning
Van Wert
Allen
Wyandot
Crawford
Richland
Ashland
Wayne
Stark
Columbiana
Hardin
Mercer
Auglaize
Marion
Morrow
Holmes
Carroll
Tuscarawas
Jefferson
Logan
Knox
Coshocton
Harrison
Shelby
Union
Darke
Champaign
Licking
Muskingum
Guernsey
Belmont
Miami
Franklin
Clark
Madison
Montgomery
Fairfield
Perry
Noble
Monroe
Preble
Greene
Pickaway
Morgan
Fayette
Hocking
Washington
Butler
Warren
Clinton
Ross
Athens
Vinton
Hamilton
Clermont
Highland
Meigs
Pike
Jackson
Brown
Adams
Scioto
Gallia
Lawrence

Lessons Learned

- Staff buy-in is imperative → assess needs first
  - Strong administrator support enables success
- Talking about suicide can be anxiety provoking
  - Increase staff training & exposure to material
- Don't rush implementation
  - Make sure all roles and expectations established
- Start suicide prevention by middle school

Working with Limited Resources

- Creative problem-solving
  - Student follow-up is not limited to counselors
  - Engage local MH agencies, county boards, community & faith-based partners, and hospitals
- Never underestimate the power of caring & passionate school staff
  - Stars rise at every implementation at every school
- Consider the big picture
  - Sustainability conversations from the beginning

Impact of SOS Program on schools

"SOS helped us uncover issues with kids that we never suspected were considering suicide. Students came forward concerned about friends; others felt free to share their feelings and ask for help. Some parents had no idea their kids were entertaining dangerous thoughts and thanked us for having SOS. All in all, it was the most important activity we did all year."

- Middle School Guidance Counselor

Thank you!

CSPR Research Team

- Kendra Heck, MPH
- Arielle Sheftall, PhD
- Sandy McBee-Strayer, PhD
- Jacki Tissue, LPCC
- Donna Ruch, PhD
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- Elena Camacho, LISW

Partners

- NCH School-based Team
- Columbus City Schools
- Syntero
- Screening for Mental Health

NATIONWIDE CHILDREN'S

When your child needs a hospital, everything matters.℠

Questions?

The Center for Suicide Prevention and Research

http://www.nationwidechildrens.org/suicide-prevention

Phone: 614-355-0850

Email: suicideprevention@nationwidechildrens.org

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

Questions?

Please enter your questions in the Q & A pod

Thank you!

Please fill out our evaluation: https://www.surveymonkey.com/r/HPGXXWG

Visit our website:
www.ChildrensSafetyNetwork.org