Youth Suicide: Review and Assessment Considerations for Pediatric Advanced Practice

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MEDICINE *of* THE HIGHEST ORDER

Objectives

1. Identify the prevalence of youth suicide and risk factors.
2. Discuss potential APP roles in suicide prevention, as well as identification and screening of at-risk youth.
3. Evaluate tools and resources for mood and suicide screening and assessment.
4. Reflect on potential personal and professional biases regarding suicide and screening for mental health conditions.

Caution advised…..

- Suicide is a serious topic
- All suicide talk is to be taken seriously and explored
- Practice within your scope and experience, this is not a “how to”
- Get continuing education
- Know and use your resources



Overview:

Facts, Statistics, Definitions, Myths

Youth suicide: a serious and growing problem

- **2016 data**: adolescents and young adults aged 15 to 24 had a suicide rate of 13.2/100,000.
- Adolescents and young adults have lower rates than middle age, older and elder adults.

www.afsp.org

- However, it is the **second leading cause of death** in 10-24 year olds.
- And, some "**accidental"** deaths may actually represent deaths where intent was not known, so suicide rates may be actually be higher than reported
- Suicide affects young people from all races and SES

www.aacap.org

The majority of youth suicides occur in the context of mental health disorders

- Most youth who attempt suicide have a significant mental health disorder, **usually depression**
- Other MH conditions that increase the risk of youth suicide include: **eating disorders, anxiety, substance use, and disruptive behavior disorders**
- Most youth with MH conditions, suicidal thoughts, or a h/o suicide attempts are **not** receiving specialized mental health treatment
- **Physical health problems,** chronic illness, and chronic pain increase the risk of suicide

Early identification and treatment in youth settings!!



"Pediatric nurse practitioners (PNPs) and their fellow pediatric-focused advanced practice registered nurses (APRNs) play a key role in early detection for mental and behavioral health issues in children and teens." https://www.napnap.org/mental-health-facts

Understanding youth suicide: it's complicated….

Multiple, complex, and interrelated individual, family, school, and community factors are at play. Suicide may appear to be "a solution" to problems and distress for some youth.

- **Younger children-**
  - suicide attempts are often impulsive
  - may be associated with feelings of *sadness, confusion and anger*.

- **Teens**
  - suicide attempts may be associated with feelings of *stress, self-doubt, pressure to succeed, resource uncertainty, disappointment, and loss*.

10 Leading Causes of Death by Age Group, United States – 2014

	Age Groups										
Rank	**<1**	**1-4**	**5-9**	**10-14**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**	**Total**
1	Congenital Anomalies 4,746	Unintentional Injury 1,216	Unintentional Injury 730	Unintentional Injury 750	Unintentional Injury 11,836	Unintentional Injury 17,357	Unintentional Injury 16,048	Malignant Neoplasms 44,834	Malignant Neoplasms 115,282	Heart Disease 489,722	Heart Disease 614,348
2	Short Gestation 4,173	Congenital Anomalies 399	Malignant Neoplasms 436	Suicide 425	Suicide 5,079	Suicide 6,569	Malignant Neoplasms 11,267	Heart Disease 34,791	Heart Disease 74,473	Malignant Neoplasms 413,885	Malignant Neoplasms 591,699
3	Maternal Pregnancy Comp. 1,574	Homicide 364	Congenital Anomalies 192	Malignant Neoplasms 416	Homicide 4,144	Homicide 4,159	Heart Disease 10,368	Unintentional Injury 20,610	Unintentional Injury 18,030	Chronic Low. Respiratory Disease 124,693	Chronic Low. Respiratory Disease 147,101
4	SIDS 1,545	Malignant Neoplasms 321	Homicide 123	Congenital Anomalies 156	Malignant Neoplasms 1,569	Malignant Neoplasms 3,624	Suicide 6,706	Suicide 8,767	Chronic Low. Respiratory Disease 16,492	Cerebro-vascular 113,308	Unintentional Injury 136,053
5	Unintentional Injury 1,161	Heart Disease 149	Heart Disease 69	Homicide 156	Heart Disease 953	Heart Disease 3,341	Homicide 2,588	Liver Disease 8,627	Diabetes Mellitus 13,342	Alzheimer's Disease 92,604	Cerebro-vascular 133,103
6	Placenta Cord. Membranes 965	Influenza & Pneumonia 109	Chronic Low. Respiratory Disease 68	Heart Disease 122	Congenital Anomalies 377	Liver Disease 725	Liver Disease 2,582	Diabetes Mellitus 6,062	Liver Disease 12,792	Diabetes Mellitus 54,161	Alzheimer's Disease 93,541
7	Bacterial Sepsis 544	Chronic Low Respiratory Disease 53	Influenza & Pneumonia 57	Chronic Low Respiratory Disease 71	Influenza & Pneumonia 199	Diabetes Mellitus 709	Diabetes Mellitus 1,999	Cerebro-vascular 5,349	Cerebro-vascular 11,727	Unintentional Injury 48,295	Diabetes Mellitus 76,488
8	Respiratory Distress 460	Septicemia 53	Cerebro-vascular 45	Cerebro-vascular 43	Diabetes Mellitus 181	HIV 583	Cerebro-vascular 1,745	Chronic Low. Respiratory Disease 4,402	Suicide 7,527	Influenza & Pneumonia 44,836	Influenza & Pneumonia 55,227
9	Circulatory System Disease 444	Benign Neoplasms 38	Benign Neoplasms 36	Influenza & Pneumonia 41	Chronic Low Respiratory Disease 178	Cerebro-vascular 579	HIV 1,174	Influenza & Pneumonia 2,731	Septicemia 5,709	Nephritis 39,957	Nephritis 48,146
10	Neonatal Hemorrhage 441	Perinatal Period 38	Septicemia 33	Benign Neoplasms 38	Cerebro-vascular 177	Influenza & Pneumonia 549	Influenza & Pneumonia 1,125	Septicemia 2,514	Influenza & Pneumonia 5,390	Septicemia 29,124	Suicide 42,773

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

Suicide risk and adolescent developmental tasks—
"identity vs role confusion" (remember Erik Erikson)

- Adolescence: huge transition between childhood and adulthood
- Remarkable individual, cognitive, emotional, mental, neurologic and social changes
- Significant opportunities for mental health issues and challenges to arise



risk for suicide

2013 CDC data US Youth Risk Behavior Survey, grades 9-12

Previous 12 months:	% Boys	% Girls
• Sad/hopeless every day x 2 weeks in a row	20.8	39.1
• Planned a suicide attempt	10.3	16.9
• Made a suicide attempt	5.4	10.6
• Made a suicide attempt, required medical attention	1.8	3.6

CDC data: suicide methods—15-19 yrs

Suffocation-- *recent increase in rate, esp for girls, harder to prevent in home, more likely than poisoning to be fatal*	**43%**
Firearms*-- **Firearms in the home are associated with higher risk of completed adolescent suicide*	**42%**
Poisoning	6%
Falling	3%

2013 CDC US Youth Risk Behavior Survey





Suicide: female vs male differences, 15-19 yrs

Girls

Attempt suicide

2x more than boys

With less lethal means



Boys

Complete suicide

3x more than girls

2013 CDC US Youth Risk Behavior Survey

Understanding the spectrum of self harm behaviors:
Definitions from Center for Disease Control (CDC) and Self Directed Violence

✓**Non-suicidal self-directed violence:** self-directed, deliberately results in injury or the potential for injury to oneself. There is *no evidence of suicidal intent*.

✓**Suicidal self-directed violence:** self-directed and deliberately results in injury or the potential for injury to oneself, *with evidence of suicidal intent*.

✓**Undetermined self-directed violence:** self-directed and deliberately results in injury or the potential for injury to oneself. *Suicidal intent is unclear.*

https://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf

Understanding the spectrum of self harm behaviors: :
Definitions from Center for Disease Control (CDC) and Self Directed Violence

- ✓**Suicide attempt:** non-fatal, self-directed, potentially injurious behavior, intent to die as a result of the behavior; *may or may not result in injury*.
- ✓**Interrupted self-directed violence** - person takes steps to injure self but is stopped by another person or self prior to fatal injury.
- ✓**Other suicidal behavior/preparatory acts:** acts towards making a suicide attempt, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away).
- ✓**Suicide:** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior

https://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf

Fact or myth?

Asking about depression or suicidal thoughts will give someone the idea to commit suicide.

?

Youth with suicidal talk or actions are just getting doing it for attention.

?



If someone really wants to commit suicide there is nothing that can prevent it.

?

Fact or myth?

Myth:

Asking about depression or suicidal thoughts will give someone the idea to commit suicide.

Fact:

Asking children and teens about feelings, thoughts, and specifically about thoughts of ending life are important roles for nurses and those caring for or working with children

Myth:

Youth with suicidal talk or actions are just getting attention.

Fact:

Open and supportive discussions are often the avenue for getting help and reducing pain, sadness, stress and isolation for at-risk teens



Myth:

If someone really wants to commit suicide there is nothing that can prevent it.

Fact:

Most individuals with suicide attempt or thoughts do not want to die, but want their pain to stop. Most people who have attempted or died by suicide gave warning signs.

Prevention-

Access to Care, Stigma, Risk Factors, Models

Suicide prevention goals:

- Reduce risk factors that are *modifiable*
- Identify vulnerable youth
- Increase MH/suicide screening
- Improve skills for talking to youth
- Know warning signs and resources
- Increase protective factors
- Identify targeted individual, family, school, community, medical and MH interventions

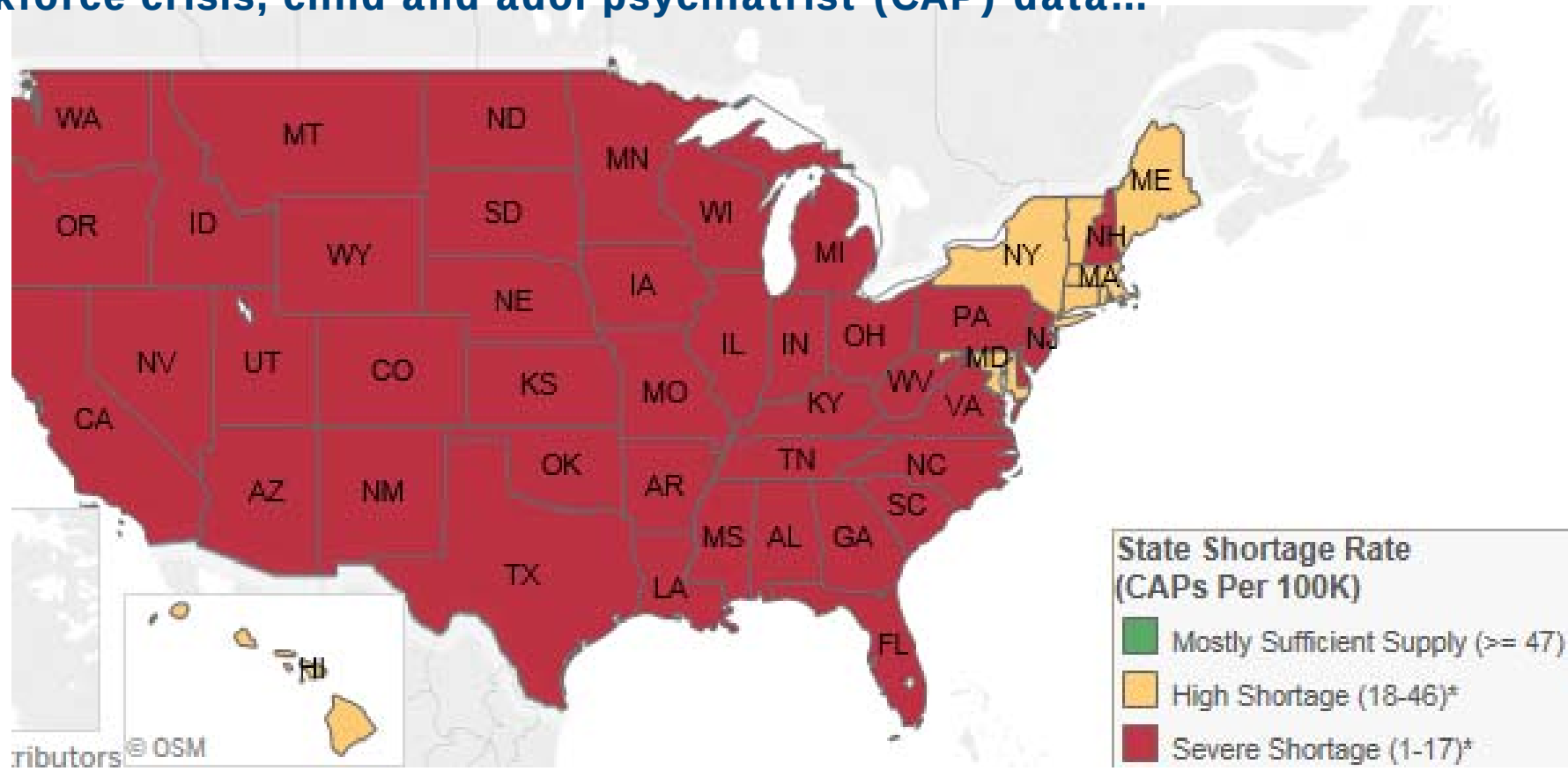
Who can help?



- Youth, peers
- Family members, friends
- Nurses, NPs, all health care
- Teachers, school administrators, counselors
- Coaches, extracurricular leaders
- Mentors, service providers
- Faith communities
- First responders
- Others…

Mental health (MH) system realities

MH workforce crisis, child and adol psychiatrist (CAP) data…



Note that child and adolescent psychiatrists are in "good supply" in the green states…… *(basically, none, only Washington DC, too small on map)*

Mental health (MH) system realities

Most referrals to MH services are never kept……

Factors:

- Stigma
- Insurance coverage and costs
- Transportation and location
- Wait lists and schedules
- Fears, shame and denial
- Motivation, readiness to change are not assessed
- Language and cultural barriers
- Other basic needs are more pressing (think Maslow…)

Stigma: the real public health crisis…

Stigma: ***when person is viewed by others in a negative way because of a disability or MH condition***

- It may be a feeling of shame or judgement by others
- It can come from an internal place, confusing *feeling* bad with *being* bad.
- People with MH conditions and or disabilities face rejection, bullying and discrimination
- Mental health conditions are the leading cause of disability across the US
- Delays in care are the norm, adults report typically an 8-10 ***year*** delay between identification of a symptom and finally getting treatment
- Basically, many who need treatment do not get it

Fighting stigma—but what can I do?

Talk openly about mental health, normalize stress and challenges

- Every contact with youth, families, peers, colleagues

Educate yourself and others

- Continuing education, training, interdisciplinary work to grow skills

Be conscious of language

- Use "*people first language*", don't label youth by a diagnosis or prejorative terms; (reduce use of stigmatizing words like *crazy, cuckoo, nuts, retarded;* speak up*)*

Encourage equality between physical and mental illness

- We get dental and medical check ups "*feelings need check ups too*" *(AAP)*
- We don't blame the pt with asthma and a cold because symptoms flared up
- And..youth and families with behavioral disorders will surely demonstrate the behavioral signs of their diagnosis.

Fighting stigma—what can I do? (cont'd)

Show compassion for youth with mental health conditions

- you may be the only one who has ever provided that acceptance, you can be a role model for others

Choose empowerment over shame

- encourage youth to reject negative stereotypes, believe that they can achieve their life goals, take control, be active and help them be optimistic

Be honest about treatment

- encourage and facilitate self disclosure for pt/families/self *as appropriate*; can you be a role model, or provide hope? What have you overcome?

Let the media know when they're being stigmatizing

- for example, when the description of an individual is the symptom or diagnosis ("autistic" "schizophrenic" "suicidal") or, if a TV show is stereotyping negative attributes, speak up!

Don't Harbor Self-Stigma

- reflect on ways your own life or family experiences might affect your practice or beliefs, self -acceptance

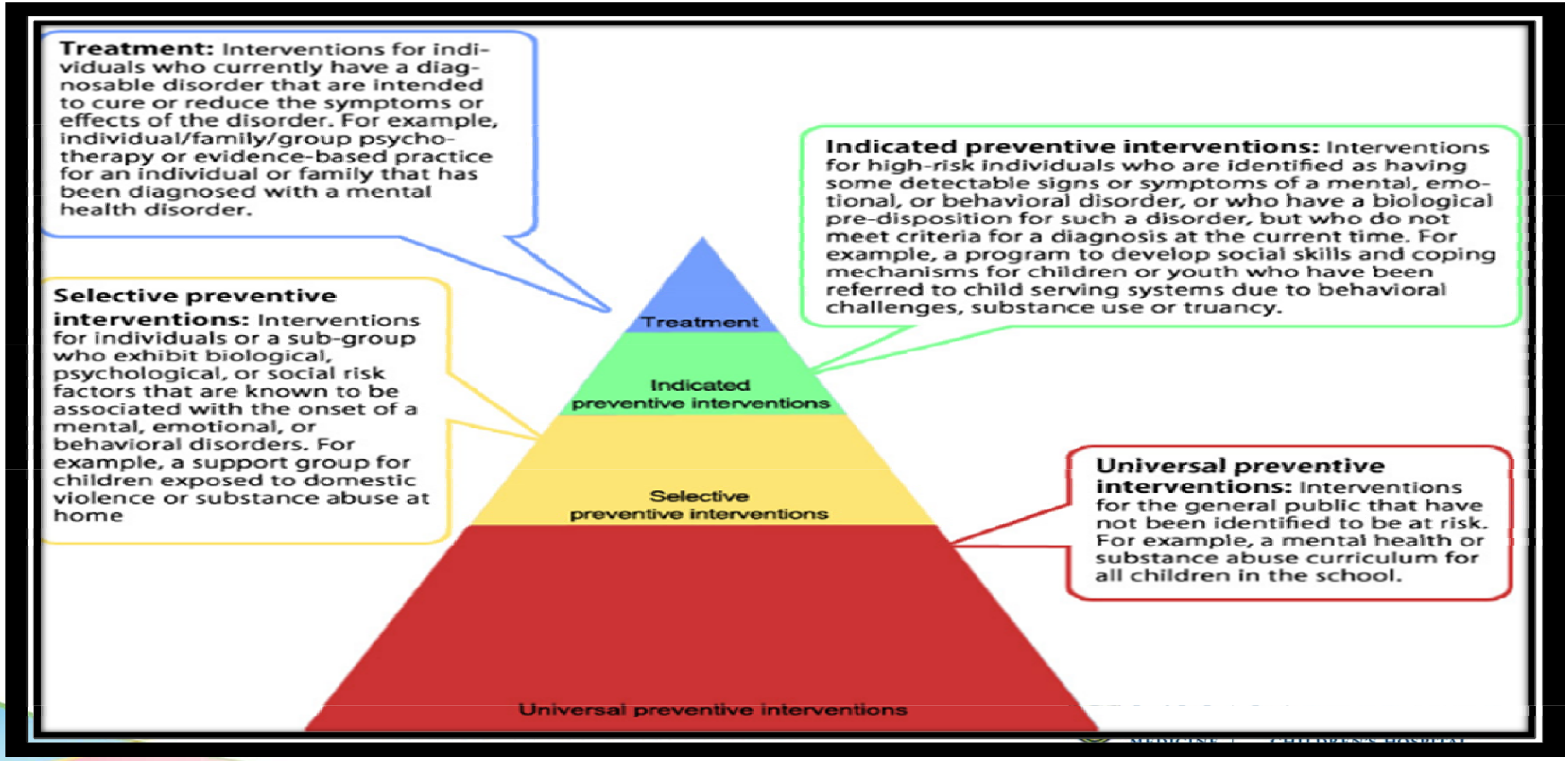
National Alliance on Mental Illness (NAMI) **is an amazing advocacy organization promoting:**

- ✓ **Education**
- ✓ **Communication**
- ✓ **Person centered care**
- ✓ **Advocacy and support**
- ✓ **Treatment**

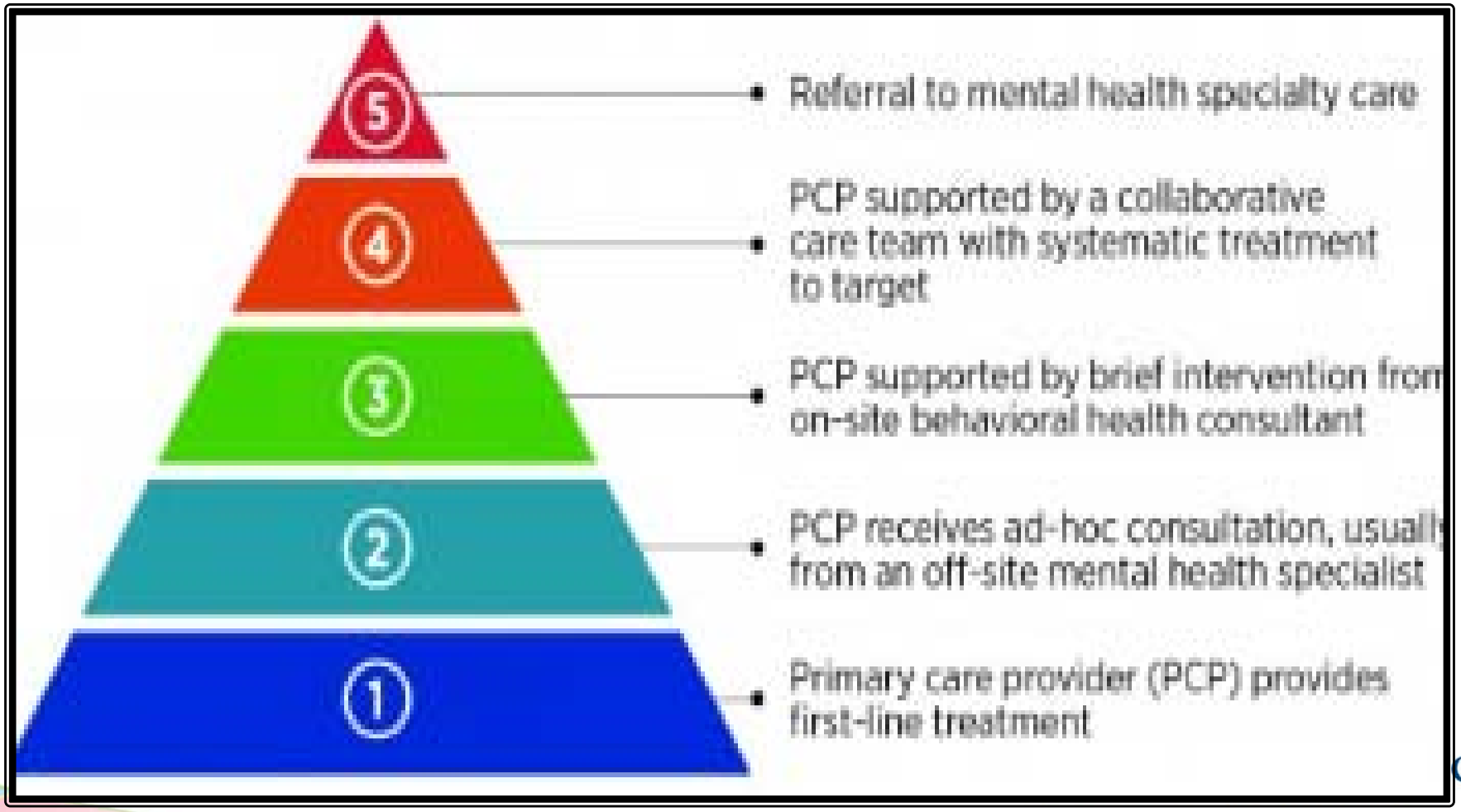
www.nami.org



How can we improve access to care: mental health screening, early intervention in youth settings



Improving access to care: integrated care settings are one solution



Youth suicide risk factors*:

"Fixed" risk factors, these are non- modifiable

- FH suicide, or suicide attempts
- FH parent MH problem, substance abuse
- Male gender
- LGBTQ
- Previous suicide attempt
- H/O physical or sexual abuse
- H/O exposure to violence
- Acute losses, rejection

**remember risk factors are common, suicide is still uncommon*

Youth suicide risk factors*:

*risk factors are common, suicide is still uncommon

Mental illness diagnoses/other symptoms (may be modifiable or amenable to treatments):

- Sleep disturbances
- Depression, Bipolar d/o
- Substance use d/o
- Panic d/o, PTSD, complex trauma
- Aggression, anger, impulsivity
- Psychosis* (markedly increased risk)
- Non suicidal self injury or suicidal ideation
- Preoccupation with death
- Disordered internet use (ie:looking at pro-suicide sites)
- Chronic pain, chronic illness

Youth suicide risk factors*:

**risk factors are common, suicide is still uncommon*

Risk is also increased for youth who:

- Are exposed to the suicide of another: esp if school mate; esp if online or with media exposure******
- Are involved in child welfare and/or juvenile justice systems
- Are a sexual minority-LGBTQ (2x rate of suicidal ideation)
- Are American Indian or Native Alaskan males
- Are military service members and their children
- Are involved in bullying (all types)
- Are perpetrators **and** victims of bullying

********NIMH has best practices for media and reporting deaths by suicide to prevent clustering of suicides*

Moving from a suicide prediction model to a prevention model…

Prediction based models

- Clinicians integrate risk factor information
- Try to estimate the likelihood of a relatively rare event
- Rate risks as low vs medium vs high
- No algorithms, no data on effectiveness
- Subjective, with likely biases

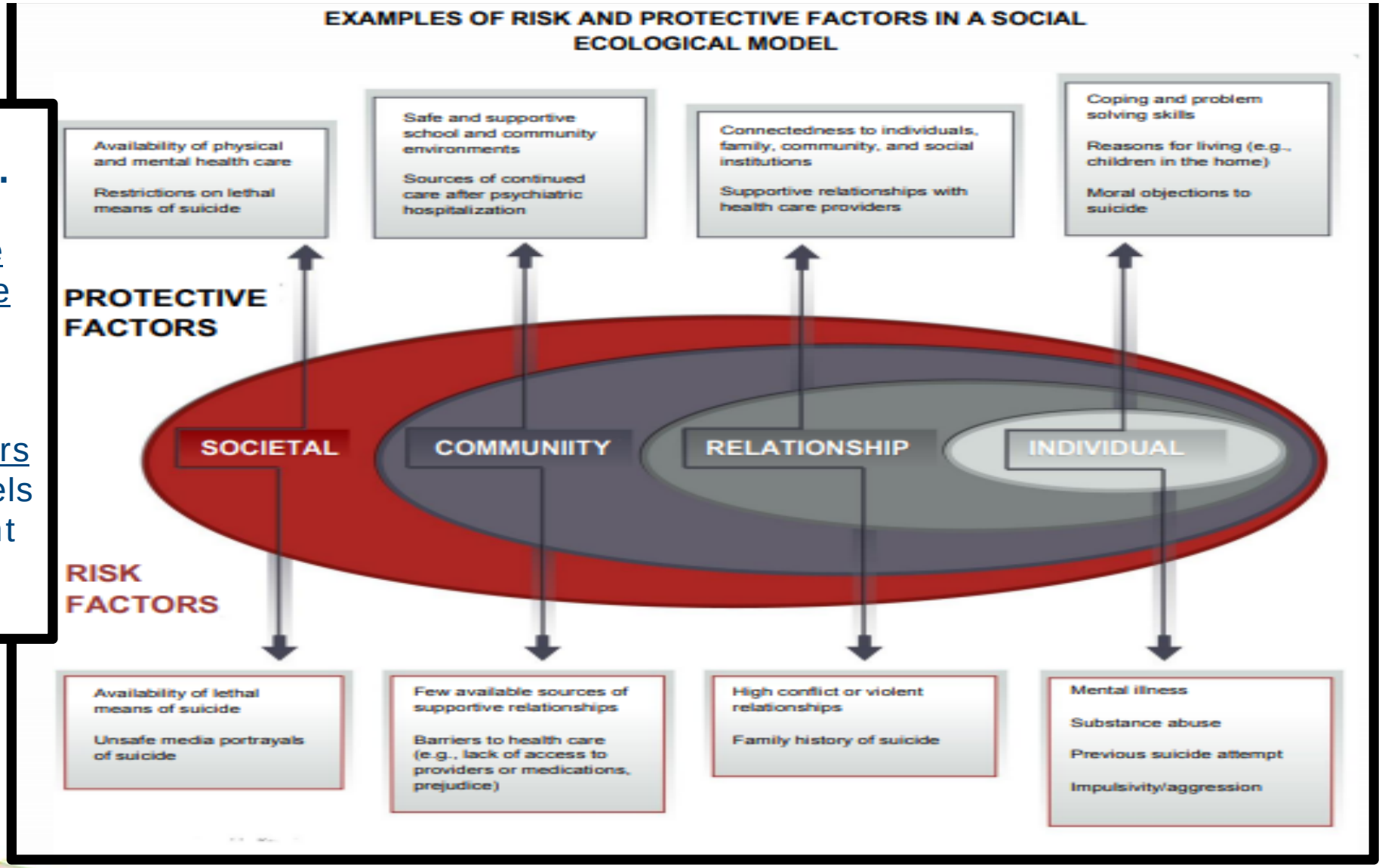
Prevention based models

- Assess *risk status* compared to similar population (ie: youth in outpatient settings; youth in ED; youth inpatient)
- Assess *risk state* (compared to other points in time)
- Identify *available resources* to address current crisis
- Identify *foreseeable changes* that could increase risk

2016, Pisani et al, Academic Psychiatry

The big picture…

maximize protective factors and minimize risk factors at all levels to prevent youth suicide



Clinical roles and responsibilities for nurses, NPs, APPs--

- Emphasize building rapport, which increases willingness to talk about suicide
- Take all threats or suicide attempts seriously and convey concern
- Look for warning signs and discuss them with the youth/family
- Collaborate with colleagues, patient for safety planning
- Support youth in learning to cope with negative thoughts
- Involve parents, supportive family members/friends, get youth permission when non urgent
- Have access to referral resources such as emergency phone contacts; call 911 if a patient in the community is agitated or seems in imminent danger of self-harm.
- Document assessment of risk, with rationale for interventions.

- ***If you are unsure whether a referral is necessary, err on the side of caution.***

https://www.americannursetoday.com/saving-lives-preventing-suicide/

Developing Skills

Communication, Screening, Warning signs

Developing skills-- communicate effectively with children and teens....

- Work on getting comfortable with difficult topics, and stay calm
- Normalize talking about MH concerns with youth and families
- Ask, ask, ask—ask regularly about feelings, mood, stress, “dark thoughts”
- Normalize talking about these topics, including thoughts of death or suicide
- Reassure that thoughts of death or suicide are not uncommon, talking about them is often a relief
- Actively listen, explore, reflect; don’t preach, lecture or shame
- Discuss limits of confidentiality with youth and parents
- Interview youth alone, and reassure parents you will communicate about high risk situations

Developing skills-
suicide specific questions, (adjust to appropriate level)..

- Have you had thoughts about a way or plan to kill yourself?
- Do you have a way to do this? Do you have access to guns?
- Have you shared your thoughts, ideas with anyone?
- Do you have someone with whom you can talk about your thoughts?
- Have you practiced or mentally rehearsed your plan?
- What keeps you from carrying out your plan?

Depression is a primary risk factor for suicide:

- Suicide thoughts/attempts are most often associated with depression
- Screening and referral for depression is an important prevention strategy
- Screening can happen in all settings
- Common and easy to use screening tools for depression are widely available



Be aware of depressive symptoms in adolescents:

AAP, 2016 Clinical Report

TABLE 1 Depressive Symptoms and Examples in Adolescents[54]

Signs and Symptoms of Major Depressive Disorder	Signs of Depression Frequently Seen in Youth
Depressed mood most of the day	Irritable or cranky mood; preoccupation with song lyrics that suggest life is meaningless
Decreased interest/enjoyment in once-favorite activities	Loss of interest in sports, video games, and activities with friends
Significant wt loss/gain	Failure to gain wt as normally expected; anorexia or bulimia; frequent complaints of physical illness (eg, headache, stomach ache)
Insomnia or hypersomnia	Excessive late-night TV; refusal to wake for school in the morning
Psychomotor agitation/retardation	Talk of running away from home or efforts to do so
Fatigue or loss of energy	Persistent boredom
Low self-esteem; feelings of guilt	Oppositional and/or negative behavior
Decreased ability to concentrate; indecisive	Poor performance in school; frequent absences
Recurrent thoughts of death or suicidal ideation or behavior	Recurrent suicidal ideation or behavior (threats of suicide, writing about death; giving away favorite toys or belongings)

Common screening tools for depression

Patient Health Questionnaire–

Depression screener, 3 versions:

- **PHQ-9** has mood AND suicide questions
  - Find it in Erecord, in screener tab, also paper versions
- **PHQ-2** is 2 easy questions;
  - Past 2 weeks “little interest in doing things?” and “feel down, depressed, hopeless?” any yes, do the full screen
- **PHQ-9 A**
  - Adolescent version

http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9_English.pdf

Columbia Depression Screener-

- Teen 11 and up
- Parent
- Spanish version
- Mood monitoring form and tips

http://lphi.org/CMSuploads/Columbia-Depression-Scale-64716.pdf

PHQ 9--
depression screener with suicide questions

3 PHQ Screens

- **PHQ2**
- **PHQ9**
- **PHQ A Adol**

Total Score	Depression Severity
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately Severe
20-27	Severe

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

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 figety 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	0	1	2	3
add columns		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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A2663B 10-04-2005

Common screening tools for suicide
Columbia-Suicide Severity Rating Scale (C-SSRC)

- ✓Questionnaire- suicide assessment
- ✓Available in 114 country-specific languages
- ✓Several versions: lifetime; “since last seen”; pediatric; quick screener; risk assessment; school; some versions with triage
- ✓No specific training--physicians, nurses, psychologists, social workers, peer counselors, coordinators, research assistants, high school students, teachers and clergy
- ✓Online training video available

http://www.cssrs.columbia.edu/

C-SSRS

Example: Primary care version with a triage protocol

COLUMBIA-SUICIDE SEVERITY RATING SCALE

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

Ask questions that are in bold and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
If YES, ask: *Was this within the past 3 months?*	**Past 3 Months**	

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral
Item 2 Behavioral Health Referral
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Behavioral Health Consultation and Patient Safety Precautions
Item 5 Behavioral Health Consultation and Patient Safety Precautions
Item 6 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Behavioral Health Consultation and Patient Safety Precautions

Tips to Remember for Mood Monitoring Form

- Explain form to child and give him/her examples for each column.
- Explain 1–10 mood ratings to child (e.g., 1 is best you have ever felt or can imagine feeling, and 10 is the worst) and have child give examples of different ratings.
- Start small — have child fill out the form for one day of the week and then increase the amount of time if appropriate.
- In the beginning of treatment, have child fill out day/time, situation, and mood rating columns.
- As treatment progresses, have child fill out thoughts column.
- Use form to identify the link between thoughts and feelings and to identify negative thoughts.
- Once negative thoughts have been identified, have child write down more accurate thoughts.
- Discuss with child how these more accurate thoughts lead to changes in his/her mood.

Promoting mood self monitoring- Columbia Depression Toolkit

Mood Monitoring Form

Day and Time	Situation	Thoughts	Mood Rating (Scale of 1–10)

lphi.org/CMSuploads/Columbia-Depression-Scale-64716.pdf

Mnemonics can guide the interview "SADPERSONS.."

S—sex (males complete more, females attempt more)

A—age (over16)

D—depression

P—previous attempts

E—ETOH, substance abuse

R—rational thought loss (psychosis, substance)

S—social supports low

O—organized plan (lethal, with wish to die, hiding it)

N—no trusted friend, significant other, or confidante

S (x 3)—sickness / stressors / school

AND CHECK Family Hx—if first degree relative completed

(From GLAD –PC depression toolkit for primary care , Patterson et al)

Recognizing youth suicide warning signs:

- Talking about wanting to kill oneself/dying, or being a burden to others
- Planning--searching methods online, buying a gun, or stockpiling pills
- Feeling empty, hopeless, or like there is no reason to live
- Feeling trapped or in unbearable pain
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little/too much
- Withdrawing from family, friends; isolating
- Showing rage, or talking about seeking revenge
- Displaying extreme mood swings
- Saying good-bye to loved ones, putting affairs in order

Interventions

Risk Reduction, Safety Plans, Treatments,

Referrals, Resources

Suicide risk reduction:
mobilize protective factors to buffer suicidal thought and action

✓Increase strong connections to family and community support

✓Pets, hobbies, extra-curriculars, safe neighborhood and school environments

✓Promote skills in problem solving, conflict resolution, and non-violent handling of disputes

✓Identify personal, social, cultural and religious beliefs that discourage suicide and support self-preservation

✓Develop a plan for restricted access to means of suicide

✓Identify a plan to get prompt help and access to quality care for mental and physical illnesses.

Prevention –write out a safety/crisis plan

Goal: prevent situations from escalation to crisis events

- Honestly discuss "distress triggers" (peer, HW, chores, sad, angry, limits)
- Identify early warning signs (physical clues, pacing, yelling, clenching, blushing, withdrawing, shutting down)
- Caregiver interventions that youth agrees to (space to calm down, remind of a coping skill, offer to talk, offer a hug
- Youth coping/interventions (music, walking, breathing, time away, draw, write, color, relaxation techniques

- **Write the plan down together, post it, revise it, share it!**

Prevention –write out a safety plan, crisis plan (cont'd)

- Other + supports (peers, relatives, older sibs, coach, teacher, therapist)
- Hotlines: Lifeline crisis, hotline, teen hotline, suicide hotline
- Limit access to items that could be used to harm self or others:
  - Sharps-razors, scissors, knives
  - Strangulation risk-cords, belts, ropes
  - Firearms and ammunition
  - All meds-OTC, supplements, prescription, all family members,
- Maintain routines, structure, predictability and supervision
- Follow house rules but pick your battles

- **Write the plan down together, post it, revise it, share it!**

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

SPRC
Suicide Prevention Resource Center
Promoting a public health approach to suicide prevention

Safety/ crisis plans are more effective than "no-suicide contracts"

There are many forms, can create your own template

https://www.sprc.org/resources-programs/patient-safety-plan-template

Treatments:

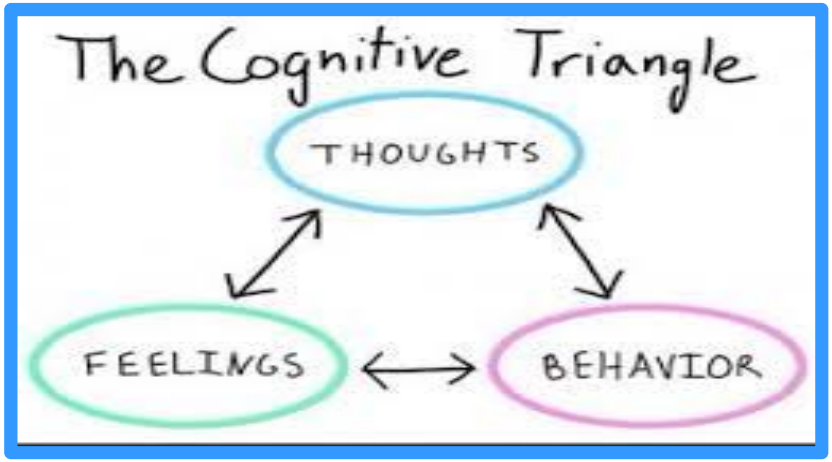
addressing basic patient and family resource needs..

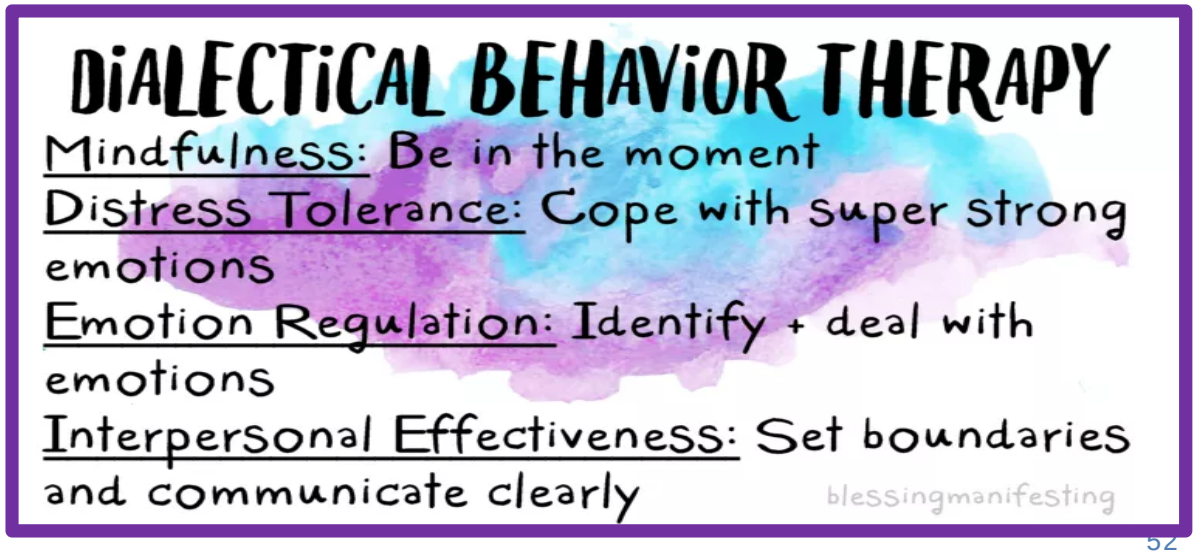


Treatments for depression:

Psychotherapies--

- **Family Therapy**
- **IPT-**Interpersonal therapy
- **CBT-**Cognitive Behavioral Therapy
- **DBT—**Dialectical Behavioral Therapy
- **Behavioral activation—**set positive activity goals ,counter lack of motivation





Treatments for depression: medication -selective serotonin reuptake inhibitors (SSRI)

- **SSRIs:** are first line meds for youth depression
- **FDA approved for youth:**—fluoxetine, sertraline, escitalopram
- **Black box warning**: SSRI requires close monitoring
- Decisional balance is individual for each case, risks vs benefits
- Shared decision making--patient and family are at center
- Maximize all treatments for underlying MH diagnoses
- There is no medication for “suicide”

Treatments: referral sources to consider-

- ✓**Does the patient have a therapist / MH provider / safety plan / prescriber?**
- ✓**Lifeline** locally **--**275-5151
- ✓**211**- emergency resource identification in any most of US, Canada, 24/7
- ✓**Mobile Crisis Team (MCT), URMC:**
- ✓mobile psychiatric emergency team for individuals and families within Monroe County who are experiencing a non-suicidal crisis in mental health.
- ✓**Suicide Hotlines**
  - ✓National Suicide Prevention Lifeline, Call 1-800-273-TALK (1-800-273-8255)
- ✓**Comprehensive Psychiatric Emergency Program (CPEP), URMC**:
- ✓Evaluation and safety determination *if inpatient hospital intervention is needed*; crisis intervention; access to crisis beds

Hotlines are 24/7



National Suicide Prevention Lifeline
50 Broadway, 19th Floor • New York, NY 10004
T 212-614-6357 • F 212-964-7302
www.suicidepreventionlifeline.org

"1-800-273-8255" Song Impact

The release of "1-800-273-8255" was a watershed event for the National Suicide Prevention Lifeline. By using his artistic voice, Logic addressed suicide thoughtfully and creatively to inspire fans to seek help and find hope.

Call Volume Metrics

- On the day of the song release (April 28, 2017), the Lifeline received the second highest daily call volume in its history at the time. We received over 4,573 calls that day, an increase of 27% when compared to the average volume on the same day of the week for the previous 3 weeks.
- On August 28, 2017, the day following Logic's performance of the song on the MTV Video Music Awards, the Lifeline received 5,041 calls, a surge in call volume that exceeded the volume received on the song's release date. Call volume has remained at the higher level initially established on the song's release date.

Additional Statistics

- Google searches for the Lifeline phone number spiked significantly on April 28 by more

Talking with youth after there is a suicide…

- Be calm and straightforward, provide information and support
- Give accurate information about why people suicide
- Avoid blame
- Do not focus on details
- Address feelings such as anger and responsibility, reassure emotions will vary
- Encourage help seeking (parent, teacher, counselor, doctor, nurse)
- Ask about suicidal thoughts
- Stay with anyone you believe is at risk, remove any means in the vicinity and seek support for evaluation

Resources:

Child and adolescent psychiatry (CAP-PC)
a valuable resource, trainings, phone consultations

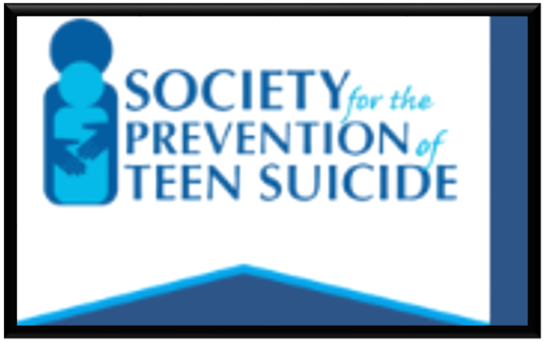
http://www.cappcny.org/home/



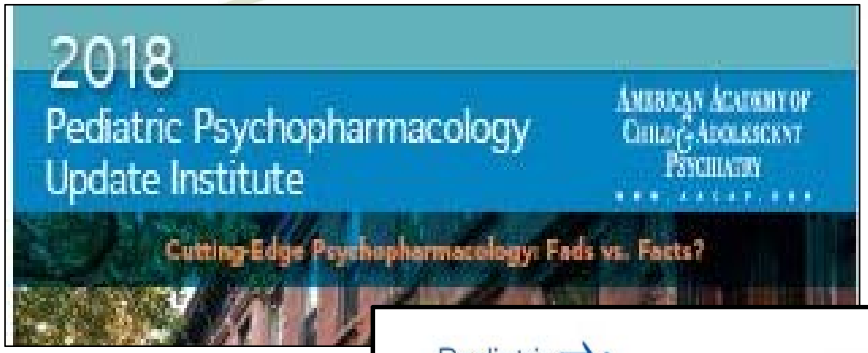
Resources:
parents and school fact sheets

- FACTS – Warning Signs of Suicide
- Frequently Asked Questions About Referral to Mental Health Services
- I am Worried About My Child. Where do I start?
- Not My Kid
- Talking to Your Kids About Suicide
- How to Talk to Children About School Violence
- What If My Child Needs Medication?
- After an Attempt
- When a Child's Friend Attempts Suicide
- When a Child's Friend Dies by Suicide

SPTS | TALKING TO YOUR KID ABOUT SUICIDE



Resources:
continuing education, resources for psychopharmacology……

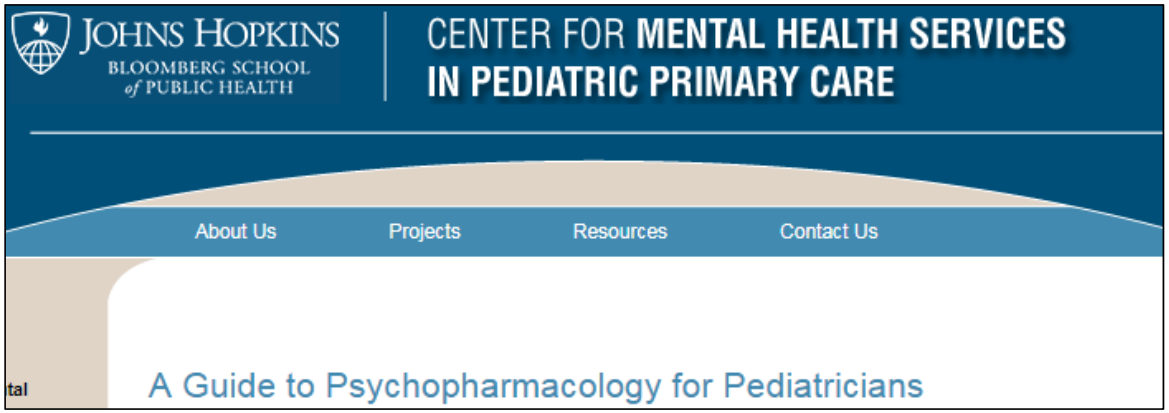


American Psychiatric Nurses Association

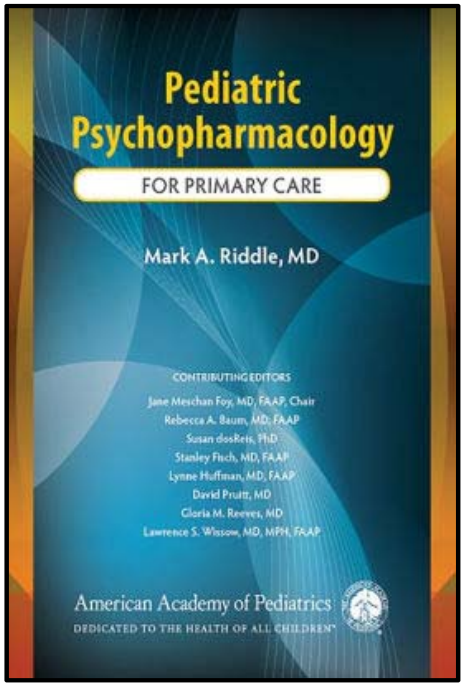
Pediatric Nurse Practitioners
The Leader in Pediatric Education for Nurse Practitioners
pedsCE Powered by NAPNAP

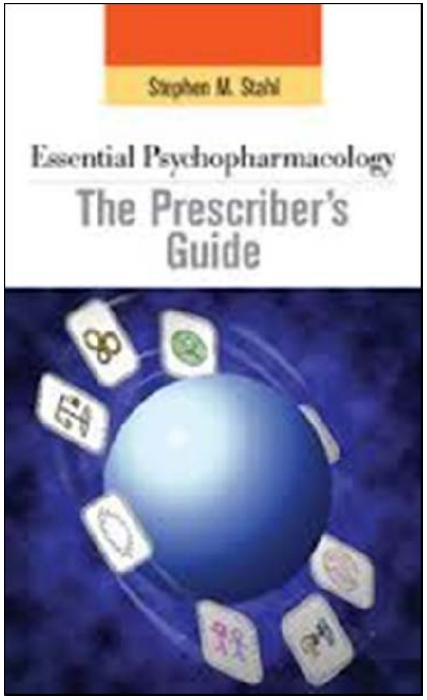
UpToDate®

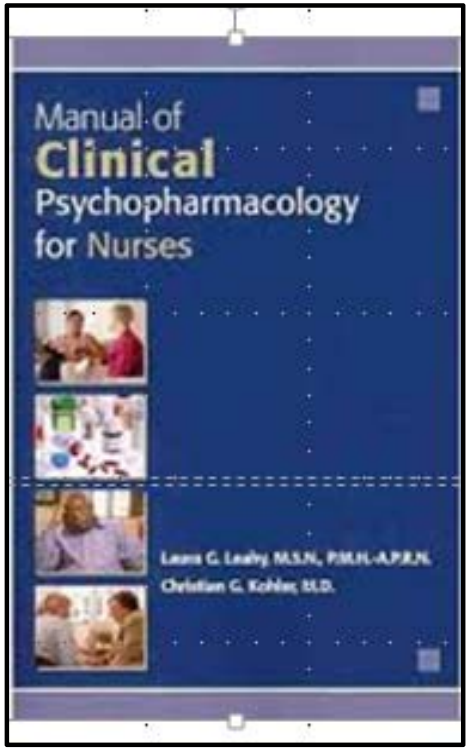
UpToDate®
Lexicomp® Drug Interactions



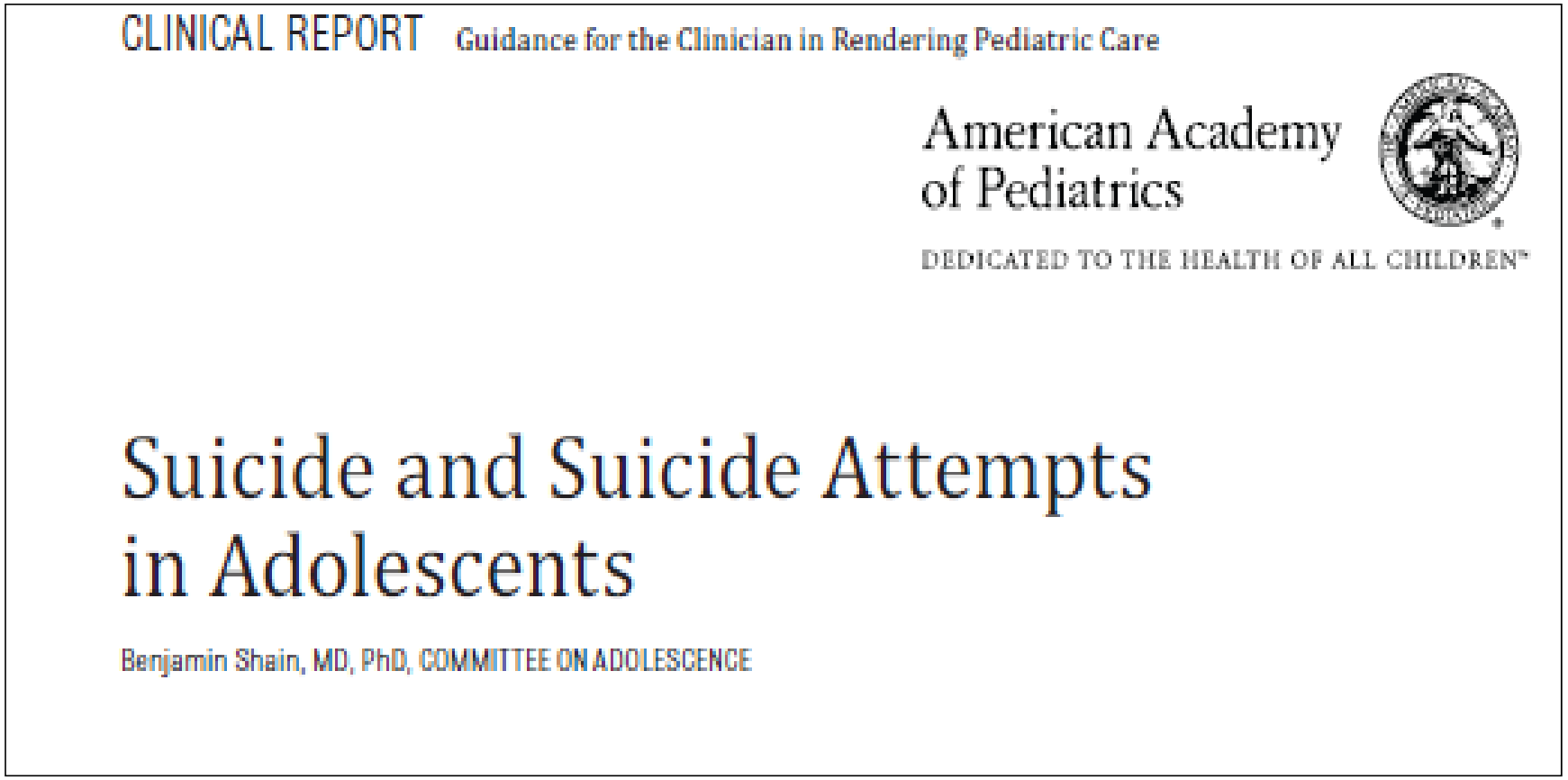
Resources:
pediatric psychopharmacology references….







Reference:
American Academy of Pediatrics 2016 Clinical Report…



Reference:
Moving from prediction to a prevention model.....

Acad Psychiatry (2016) 40:623–629
DOI 10.1007/s40596-015-0434-6

COLUMN: EDUCATIONAL RESOURCE

Reformulating Suicide Risk Formulation: From Prediction to Prevention

Anthony R. Pisani[1] · Daniel C. Murrie[2] · Morton M. Silverman[3]

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Abstract Psychiatrists-in-training typically learn that assessments of suicide risk should culminate in a probability judgment expressed as "low," "moderate," or "high." This way of formulating risk has predominated in psychiatric education and practice, despite little evidence for its validity, reliability, or utility. We present a model for teaching and communicating suicide risk as-

Suicidal symptoms and suicidal behavior are commo among patients in psychiatric service settings, and man individuals who die by suicide have had recent contac with a mental health professional or crisis responder [1] Educating the mental health workforce to assess an respond to suicide risk is essential to the National Strat egy for Suicide Prevention [2, 3], and to efforts such a

Resources and references

National Institute of Mental Health *www.nimh.org*

American Association of Suicidology *www.suicidology.org/*

American Foundation for Suicide Prevention *www.afsp.org*

Society for the Prevention of Teen Suicide: *www.sptsusa.org/*

Youth Suicide Prevention Program *www.yspp.org*

Resources and references

National Alliance Mental Illness https://www.nami.org

NAPNAP https://ce.napnap.org/content/adolescent-suicide-risk-assessment-0

American Academy of Pediatrics

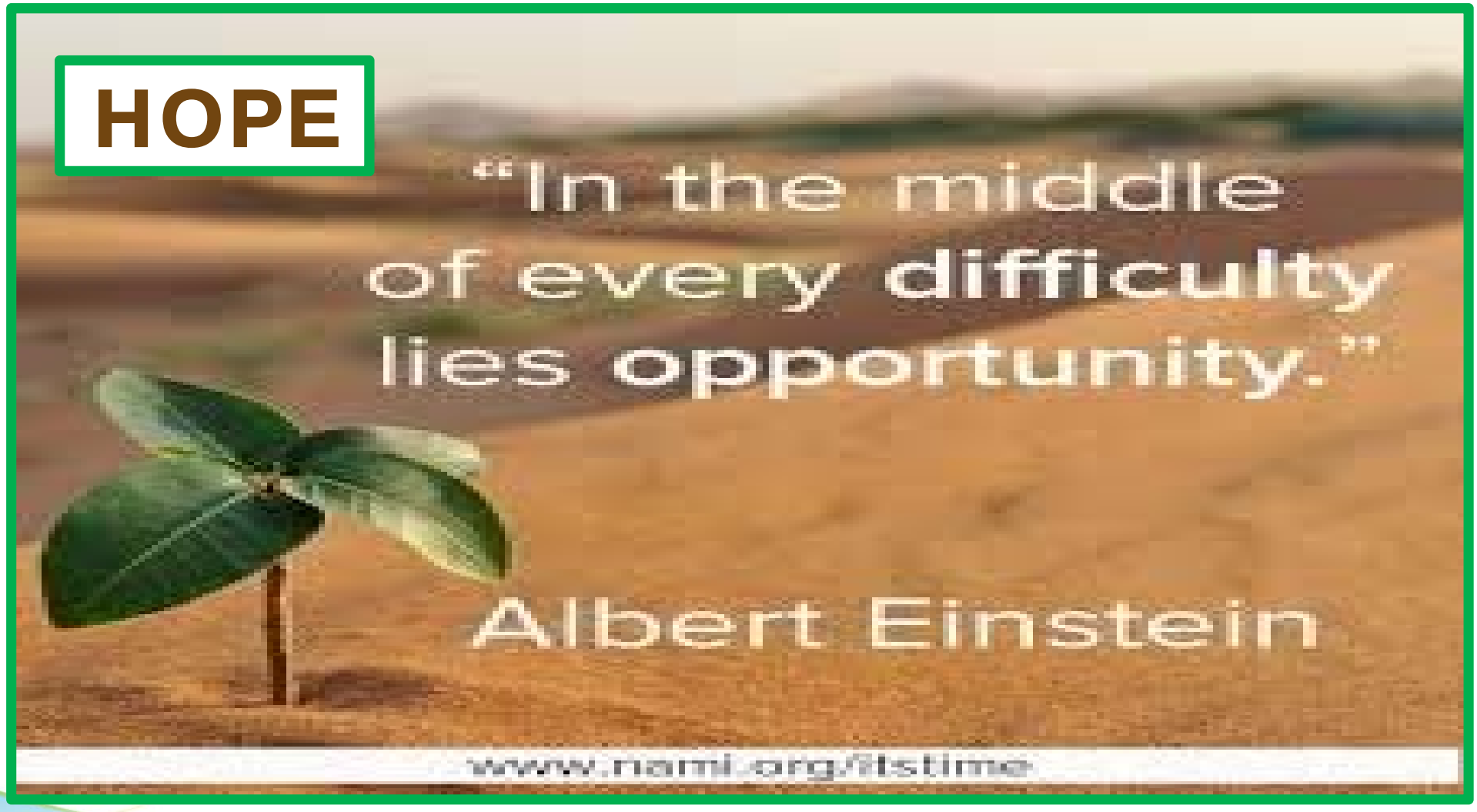
https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Child-Death-Review/Pages/Suicide-Prevention.aspx

American Academy of Child and Adolescent Psychiatry

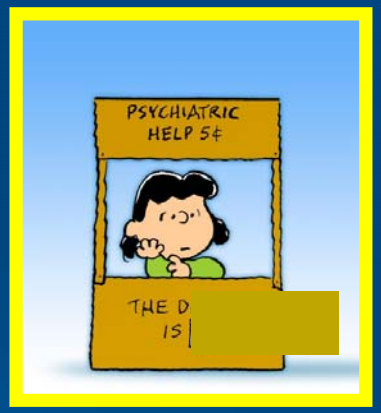
https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Suicide_Resource_Center/Home.aspx

Surgeon General

https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf


HOPE
"In the middle
of every difficulty
lies opportunity."
Albert Einstein
www.nami.org/itstime

Thank you!



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