National PRQC

Pediatric Readiness Quality Collaborative

Ensuring Emergency Care for All Children

Fireside Chat
Suicide Bundle

June 27, 2023

EMSC Quality Improvement Collaboratives

Acknowledgments

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Thank you for joining!

Session is being recorded and posted online along with slides

Utilize the Q&A feature to ask questions

Place your name in the chat for nursing and social work credit

Discussion will follow presentation

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Objectives

After participating in this session, attendees will be able to:

- Describe the current state of suicidality of children and adolescents
- Understand the patient flow when a child presents to the ED with a non mental health complaint
- Understand the importance of a structured suicide screen/identify strategies to improve adherence
- Identify discharge and safety planning strategies and resources

Speakers

Mohsen Saidinejad, MD, MBA, FAAP, FACEP
Executive Leader, EMS for Children Innovation and Improvement Center
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Pediatric Emergency Medicine Physician
Assistant Professor of Pediatrics and Emergency Medicine
Harvard Medical School
Director of the New England PECC Collaborative
Leader of the New England Behavioral Health Toolkit

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Speakers Cont.

Vera Feuer, MD
AVP, School Mental Health
Director, Emergency Psychiatry and Behavioral Health Urgent Care
Cohen Children's Medical Center, Northwell Health
Associate Professor, Psychiatry, Pediatrics and Emergency Medicine
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Department of Health Social Work
Dell Medical School, The University of Texas at Austin
Assistant Professor of Practice
Steve Hicks School of Social Work

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The Burden of Mental and Behavioral Health in Children and Adolescents

1 in 5 youth ages 13 to 18 live with a **serious mental illness.**

Suicide was the **second-leading cause of death** among those ages 13 to 19 in 2019.

629,000
ATTEMPTED SUICIDE.

12%
OF ADOLESCENTS 12 TO 17 HAD SERIOUS THOUGHTS OF SUICIDE.

There have been **double-digit increases** in mental health emergency visits in 2020.

AGES 5-11
+24%

AGES 12-17
+30%

Black children are nearly **twice as likely** as White children to die by suicide.

In a 2020 survey of **LGBTQ youth** (ages 13 to 17):

73%
REPORTED SYMPTOMS OF ANXIETY.

67%
REPORTED SYMPTOMS OF DEPRESSION.

Sources: AAP, AACAP, CHA, NAMI, Modern Healthcare, CDC, SAMHSA, JAMA Pediatrics, JAMA Psychiatry, HHS, and Kaiser Family Foundation.

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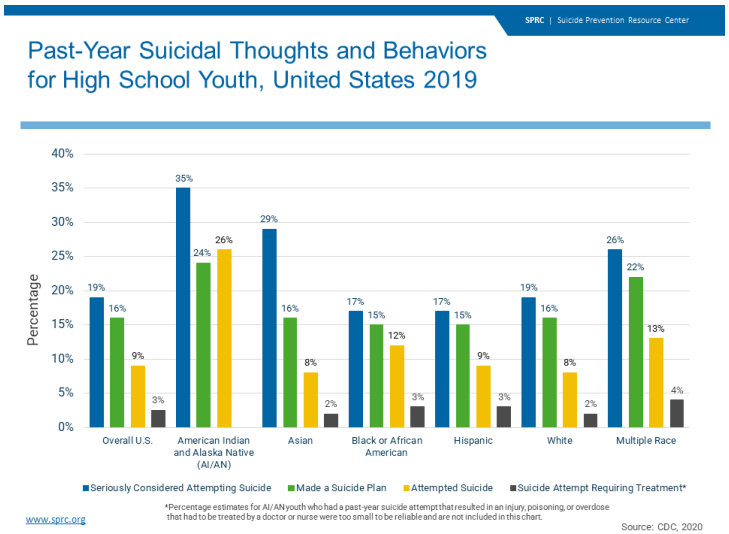
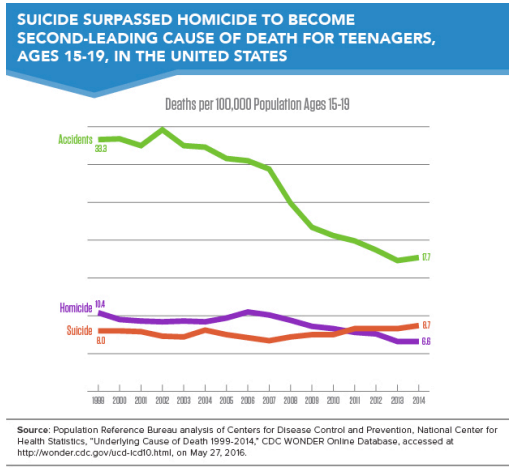
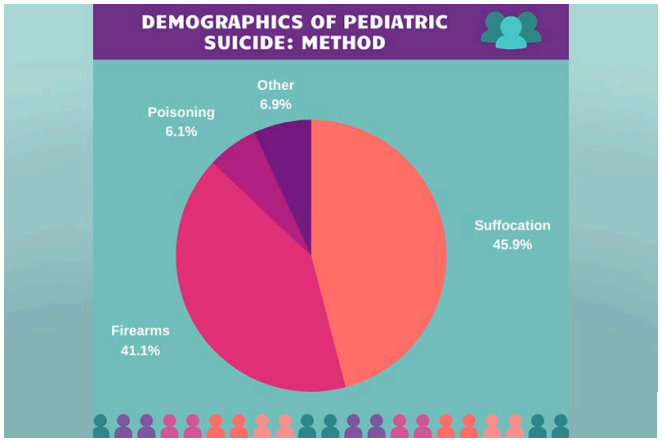
Suicide Risk and Lethality







- Screening: Who is likely to die by suicide
  - Lethality of suicide
  - Lethal means restriction

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Acute suicidality

10 Leading Causes of Death, United States

2020, Both Sexes, All Ages, All Races

	<1	1-4	5-9	10-14	15-24	25-34	35-44
1	Congenital Anomalies 4,043	Unintentional Injury 1,153	Unintentional Injury 685	Unintentional Injury 881	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,057
2	Short Gestation 3,141	Congenital Anomalies 382	Malignant Neoplasms 382	Suicide 581	Homicide 6,466	Suicide 8,454	Heart Disease 12,177
3	Sids 1,389	Homicide 311	Congenital Anomalies 171	Malignant Neoplasms 410	Suicide 6,062	Homicide 7,125	Malignant Neoplasms 10,730
4	Unintentional Injury 1,194	Malignant Neoplasms 307	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	Suicide 7,314

CDC Centers for Disease Control and Prevention

https://wisqars.cdc.gov/data/lcd/home

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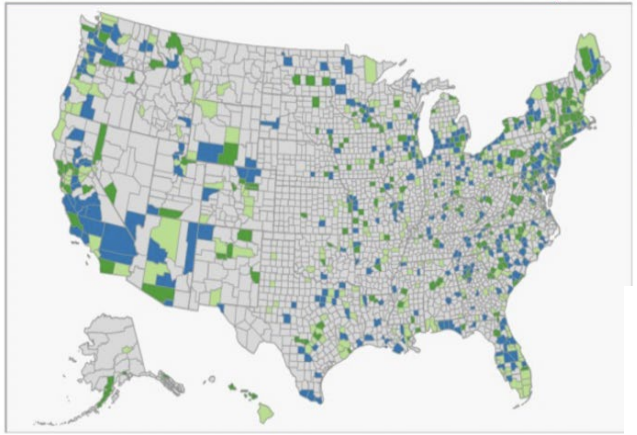
Disparities in Pediatric Mental Health

Figure: *Map of Child & Adolescent Psychiatrists per 100,000 Population Under Age 18 by U.S. County*

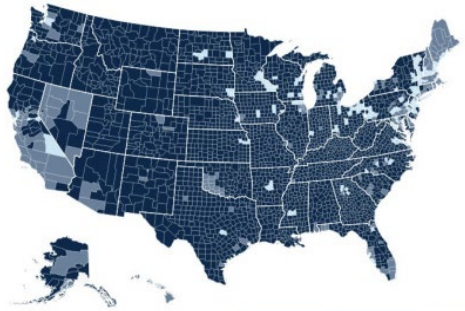


SCHOOL OF PUBLIC HEALTH
BEHAVIORAL HEALTH WORKFORCE RESEARCH CENTER
UNIVERSITY OF MICHIGAN

Child and Adolescent Psychiatrists per
100,000 County Population Aged 17 and Younger

- 0
- 0.1 - 8.7
- 8.8 - 17.7
- 17.8+

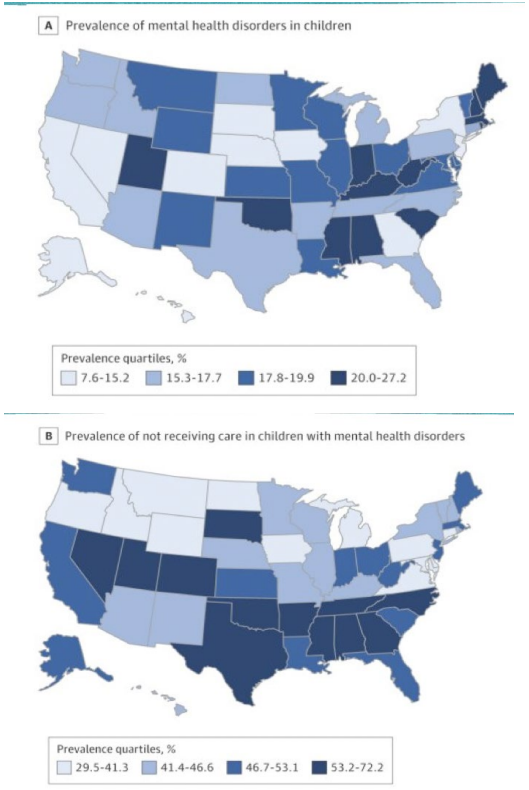
Health Professional Shortage Areas: Mental Health, by County, 2022



None of county is shortage area | Part of county is shortage area | Whole county is shortage area

RHIhub

Source: data.HRSA.gov, January 2022.



Whitney DG, Peterson MD. US National and State-Level Prevalence of Mental Health Disorders and Disparities of Mental Health Care Use in Children. JAMA Pediatr. 2019;173(4):389–391.

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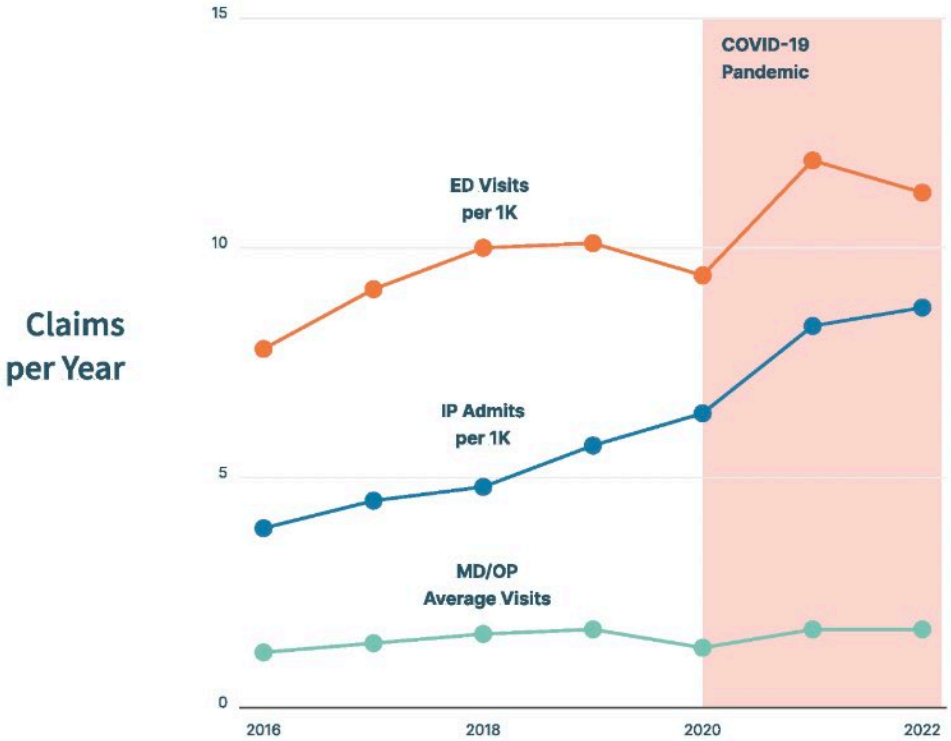
The Role of the Emergency Department (ED)

Increasing demand and decreasing supply of mental and behavioral health specialists have stressed the safety net of the healthcare system (ED)

Clarify Health Institute

Trends in Mental Health-Related Utilization Among Children and Young Adults, 2016–2022



Emergency Department Visits up 45% since 2016
(per 1K Patients)

Inpatient Admissions up 124%
(per 1K Patients)

MD/OP Office Visits up 43%
(avg per Patient)

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https://www.businesswire.com/news/home/20230518005082/en/Latest-Research-from-Clarify-Health-Institute-Uncovers-Key-Trends-and-Diagnoses-in-Mental-Health-Crisis-Among-US-Children-and-Young-Adults

Pediatric Mental Health Crisis – Call to Action

AAP News

AAP, AACAP, CHA declare national emergency in children's mental health

October 19, 2021

The AAP, American Academy of Child and Adolescent Psychiatry (AACAP) and Children's Hospital Association have declared a national emergency in children's mental health, citing the serious toll of the COVID-19 pandemic on top of existing challenges.

They are urging policymakers to take action swiftly to address the crisis.

CRITICAL CROSSROADS: PEDIATRIC MENTAL HEALTH CARE IN THE EMERGENCY DEPARTMENT

A Care Pathway Resource Toolkit

Version 1.0

July 2019
U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau

HRSA
Health Resources & Services Administration

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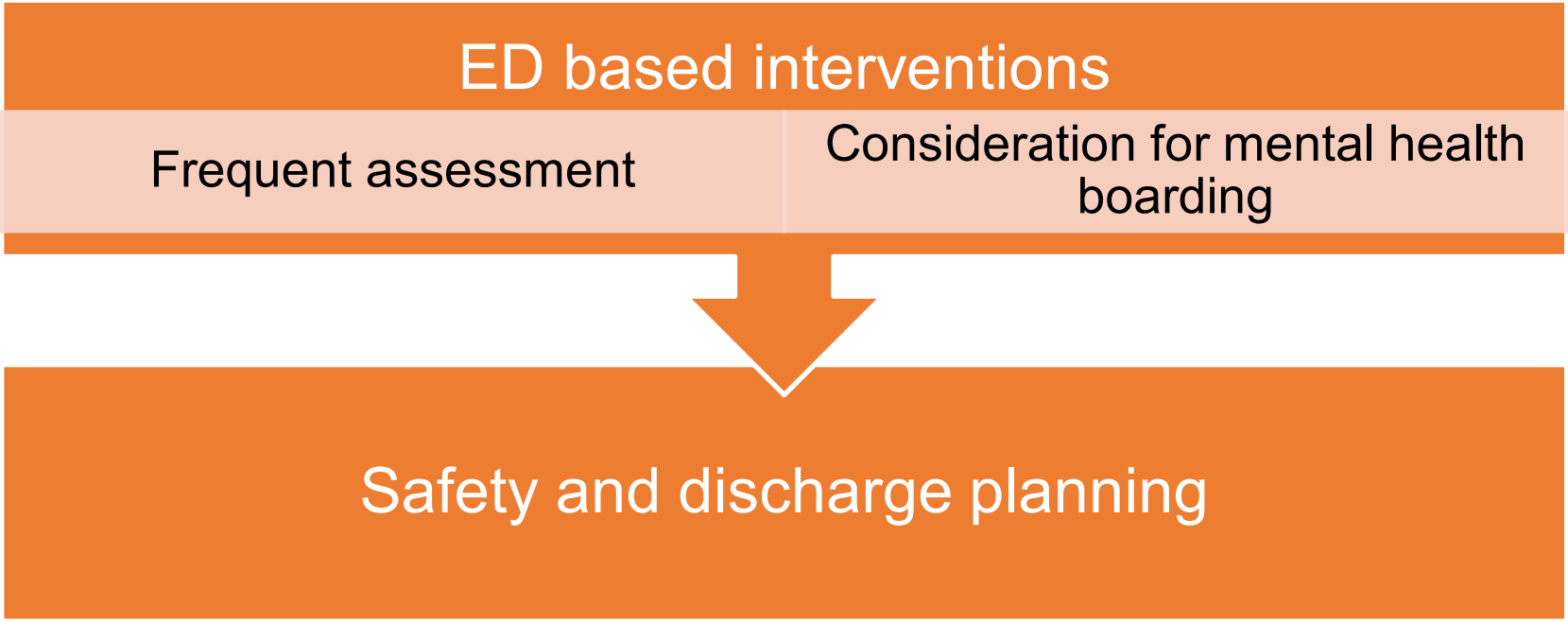
So, what can we do?

- Crisis or event intervention – Can ED be avoided?
- Provide resources (ED-based interventions)
  - Prioritize the most acute patients (screen)
  - Communication and attention to ADL needs
  - Least restrictive means
  - Regionalization of mental and behavioral health care
- Expand space (when possible)
- Expand workforce (if available)
- Advocate and secure funding and support

Systematic Approach

SCREENING ASSESSMENT

Systematic Approach



PEAK Suicide

Pediatric Education and Advocacy Kit (PEAK): Suicide

In the United States, suicide is the second leading cause of death for youths ages 10-18 (CDC NCHS Data Brief, 2019). Increasingly, the emergency care system has become a safety net for treating pediatric mental health issues: from 2007 to 2015, ED visits for suicide attempts and ideation doubled among the nation's youth (JAMA Pediatrics, 2019).

In light of the urgent need to improve pediatric suicide screening and mental health care in emergency settings, we are pleased to share new resources as part of our latest Pediatric Education and Advocacy Kit (PEAK): Suicide.

Through these resources, individuals can learn how to properly screen for pediatric suicide risk and assess acuity, develop safety plans, advocate for improved mental health care; and create care pathways to improve care for children and adolescents in crisis.

Last updated: October 2021

AUDIENCE

- Advocates & Policymakers
- Clinicians 14
- Nurses 14
- Patients & Families 4
- Prehospital Practitioners 4

SORT ORDER

- Pinned
- Most Recent
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16 Results

Document · Pinned
HRSA Critical Crossroads: Pediatric Mental Health Care in the Emergency Department Toolkit
45 minutes · Details

Practice Guideline · Pinned
EIIC-TREKK Bottom Line Recommendation: Suicidal Risk Screening and Assessment Practice Guideline
10 minutes · Details

Podcast
AAP Mental Health Advocacy: A Conversation with AAP President Lee Beers, MD, FAAP, Podcast
50 minutes · Details

Video
AAP Pediatric Mental Health Minute Series: Mental Health of Infants & Small Children with Dr. Mary Margaret Gleasson Video
13 minutes · Details

BOTTOM LINE RECOMMENDATIONS

Suicidal Risk Screening & Assessment

Suicide is the second leading cause of death for North American adolescents.[1,2] Children as young as 10 years old can experience suicidal ideation and engage in suicidal behavior.[3] Suicide risk must be determined for all pediatric patients receiving mental health care in an emergency department. Follow these two steps to determine risk:

- ***Step 1:*** Screen to identify those at risk of suicide and determine acuity.
- ***Step 2:*** Patients who screen positive in Step 1 require in-depth assessment to determine the need for treatment and safety planning.

Step 1: Screening for Suicide Risk

- While universal screening would be ideal, targeted screening of those presenting with mental health complaints is appropriate.
- Screening should be done at triage, be brief and employ validated tools.
- Asking about suicide or assessing suicidality does not increase a patient's risk of suicide.[4]
- Use a screening tool to *detect* risk (e.g., "The Ask Suicide-Screening Questions (ASQ)[5] which takes 20 seconds to administer, 98% sensitive for detecting suicide risk").[6]

Ask Suicide-Screening Questions (ASQ)[6]

Questions	Responses	Outcomes
1.In the past few weeks, have you wished you were dead?	Yes/No	***Acute positive (imminent risk identified):*** Patient answers 'yes' to any of questions 1-4, or refuses to answer, AND answers 'yes' to question 5. » The patient's clinical needs are emergent and they should not leave the hospital until evaluated for safety. » The patient should remain under constant observation, ideally in a private room, without access to potentially dangerous objects until a suicide risk assessment has been completed.
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 few weeks, have you been having thoughts about killing yourself?	Yes/No	***Non-acute positive (potential risk identified):*** Patient answers 'yes' to any of questions 1-4, or refuses to answer, AND answers 'no' to question 5. » The patient should not leave the hospital until a suicide risk assessment has been completed.
4.Have you ever tried to kill yourself?	Yes/No	
If a patient answers 'yes' to any of these questions, a 5th question is asked to determine risk acuity:		***Negative:*** A patient who answers 'no' to questions 1-4. » The patient does not require a further suicide risk assessment in the emergency department.
5.Are you having thoughts of killing yourself right now?	Yes/No	

Step 2: Comprehensive Suicide Risk Assessment

- Perform a suicide risk assessment for patients who screen positive in Step 1.
- The assessment should obtain detailed information from the patient and parents/caregivers to inform safety planning and identify specific risk factors that can be addressed with targeted interventions.
- Part of the interview should be conducted privately with the patient.
- Inform the patient of the limits of confidentiality, including your obligation to inform appropriate people about immediate safety concerns.
- Establish rapport by making eye contact, using the patient's name, and explaining the purpose of the assessment.
- Demonstrate empathy by actively listening.
- There are no currently available assessment tools that can reliably predict future suicidal behaviour.[4,7]
- Validated interview tools for ages 6 and up (e.g., HEADS-ED available at www.HEADS-ED.com) can be used to structure the assessment.[8]

Suicidal Risk Screening & Assessment

The HEADS-ED has 7 domains for organizing the detailed information collected:

1. Home (*e.g., How does your family get along with each other? Can probe for child protection issues, family violence*)
2. Education and Employment (*e.g., How is your school attendance? Are you working?*)
3. Activities and peers (*e.g., What are your relationships like with your friends? Can probe for bullying*)
4. Drugs and alcohol (*e.g., How often are you using drugs or alcohol? Cigarettes and/or vaping?*)
5. Suicidality (*e.g., Do you have thoughts of wanting to kill yourself? When do you have these thoughts? How and when would you do it?*)
6. Emotions, behaviours, thought disturbance (*e.g., How have you been feeling lately? Can assess for agitation*)
7. Discharge or current resources (*e.g., Do you have a mental health care provider or are you waiting to receive help?*)

Step 3: Safety Planning/Management

- Identify *potentially modifiable* and *non-modifiable* risk factors to understand the patient's background and current life circumstances to inform safety planning and recommended resources.[9]
- Identify *immediate* risk factors associated with suicide.

Potentially modifiable risk factors

- Mental illness, including depression, substance use disorders, bipolar disorder, psychotic disorders
- Impulsivity
- Family conflict
- Living outside of home (e.g., homeless, group home, correctional facility)
- Social isolation

Non-modifiable risk factors

- Previous deliberate non-suicidal self-injury or suicide attempt
- Family history of suicide
- History of adoption
- History of bullying
- History of abuse and/or trauma
- Identification as transgender

Immediate Risk Factors

- Intoxication*
- Agitation*
- Recent stressful life event

*If present, suicide risk assessment should be repeated once the patient's intoxication and/or agitation has resolved.

The purpose of this document is to provide healthcare professionals with key facts and recommendations for the screening and assessment of suicidal risk in children in the emergency department. This summary was co-produced by the suicidal risk screening and assessment content advisors for TREKK, Dr. Matthew Morrissette of the University of Alberta, Dr. Amanda Newton of the University of Alberta, Dr. Stephen Freedman of the Cumming School of Medicine, University of Calgary, and Dr. Laurence Katz of the Winnipeg Health Sciences Centre (HSC), and content advisors for EIIC, Dr. Susan Duffy of the Alpert Medical School, Brown University, and Dr. Vera Feuer of the Cohen Children's Medical Center, and uses the best available knowledge at the time of publication. However, healthcare professionals should continue to use their own judgment and take into consideration context, resources and other relevant factors. The TREKK Network and EIIC are not liable for any damages, claims, liabilities, costs or obligations arising from the use of this document including loss or damages arising from any claims made by a third party. The TREKK Network and EIIC also assumes no responsibility or liability for changes made to this document without its consent. This summary is based on:

1. Statistics Canada. Table 13-10-0394-01 Leading causes of death, total population, by age group. Ottawa: Statistics Canada; 2021. [cited 2021 April 6]. Available from: https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310039401.
2. National Center for Health Statistics. Adolescent Health. USA: National Center for Health Statistics. [cited June 29, 2021]. Available from: https://www.cdc.gov/nchs/fastats/adolescent-health.htm
3. Lanzillo EC, Horowitz LM, Wharff EA, et al. The importance of screening preteens for suicide risk in the emergency department. *Hosp Pediatr.* 2019;9(4):305-307.
4. DeCou CR, Schumann ME. On the iatrogenic risk of assessing suicidality: A meta-analysis. Suicide and Life-Threatening Behavior. 2018;48(5):531-543.
5. Newton AS, Soleimani A, Kirkland SW, & Gokiert RJ. A systematic review of instruments to identify mental health and substance use problems among children in the emergency department. *Acad Emerg Med.* 2017;24(5):552-568.
6. Cwik MF, O'Keefe VM & Haroz EE. Suicide in the pediatric population: screening, risk assessment, and treatment. *Int Rev Psychiatry.* 2020;32(3):254-264.
7. Cartier G, Milner A, McGill K, et al. Predicting suicidal behaviours using clinical instruments: systematic review and meta-analysis of positive predictive values for risk scales. *Br J Psychiatry.* 2017;210(6):387-395.
8. Cappelli M, Gray C, Zemek R, et al. The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department. *Pediatrics.* 2012;130(2): e321–7.
9. Shain B & American Academy of Pediatrics Committee on Adolescence. Suicide and suicide attempts in adolescents. *Pediatrics.* 2016;138(1): e20161420.

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Pediatric Mental Health in the ED

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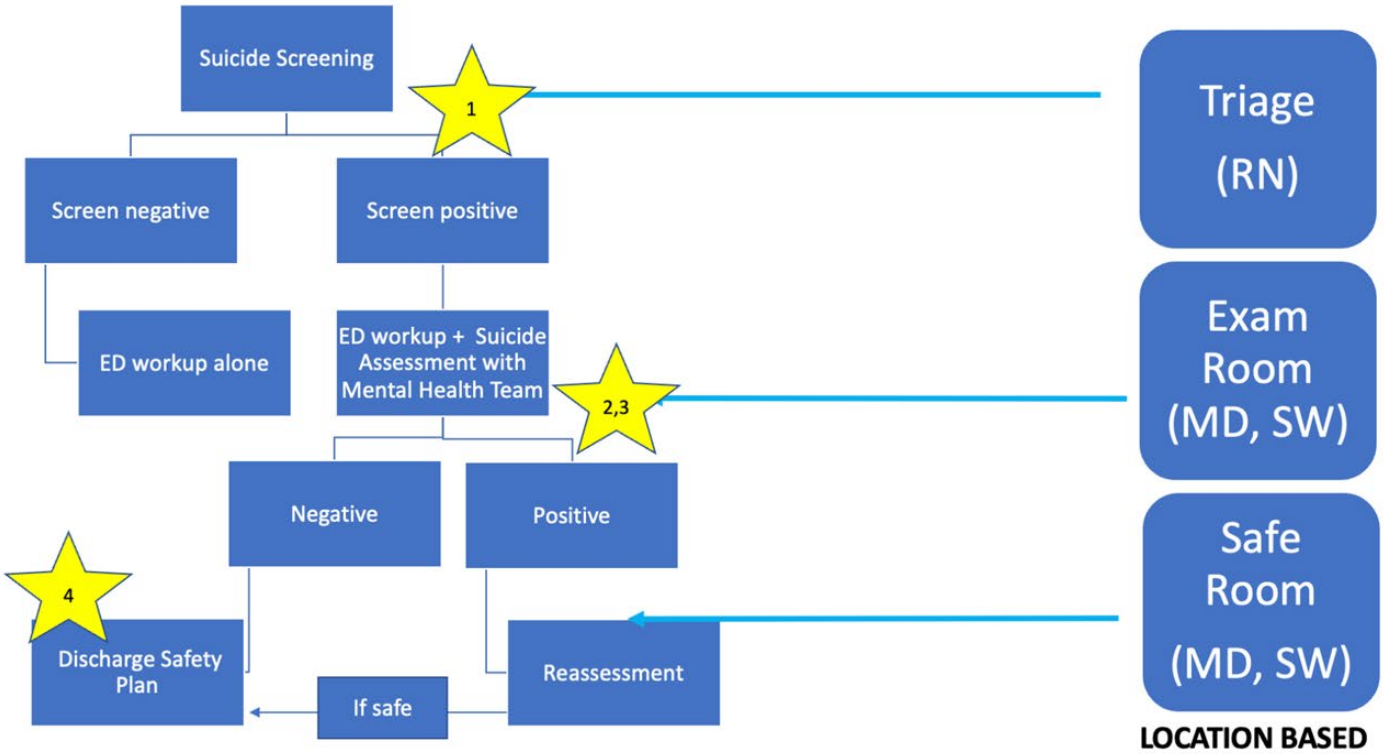
Patient Flow Diagram

14yo F with abdominal pain, Vitals are stable, Pain is adequately controlled



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Suicide Screening and Assessment

- Understand the importance of a structured suicide screen
- Learn strategies to improve adherence

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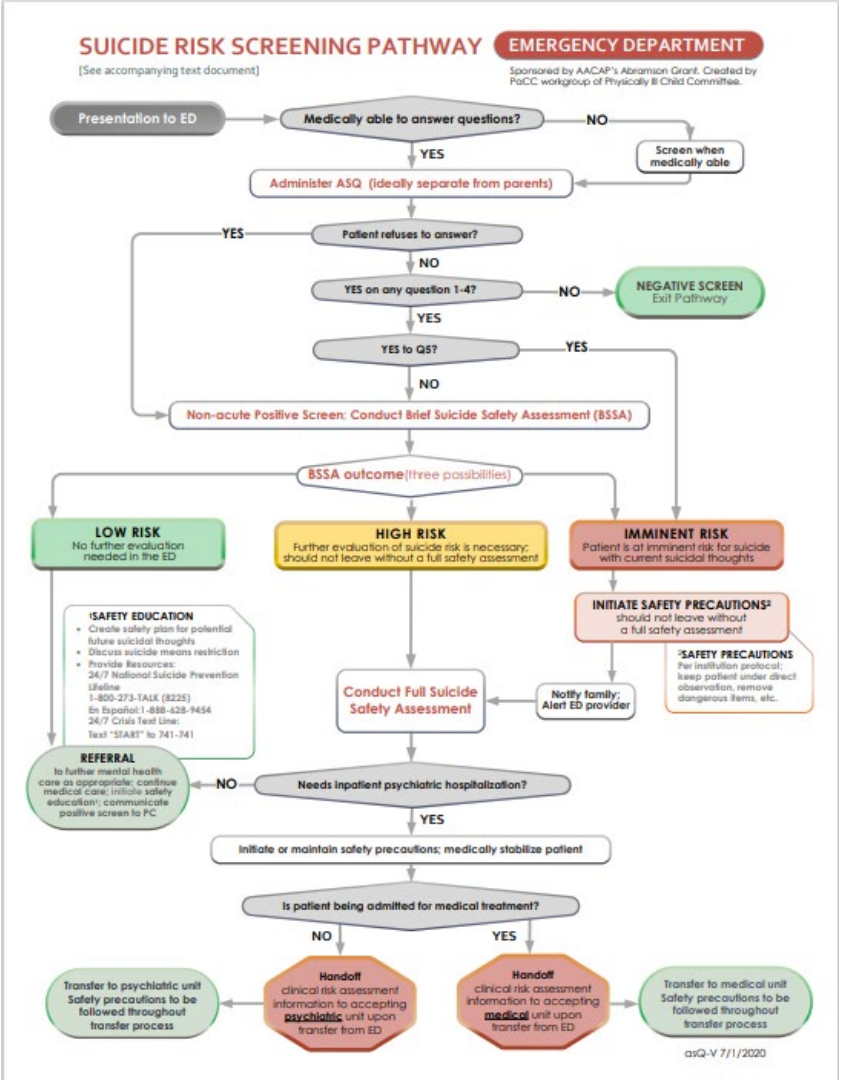
Screening vs Assessment

- Step 1: Screen to identify those at risk of suicide and determine acuity
- Step 2: Assess those who screen positive to determine need for treatment and safety planning



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Screening

- Identifies individuals at risk
- Universal screening is ideal, targeted screening is appropriate
- Screening should be done at triage, be brief and employ validated tools
- Standardize response to positive screens
- Provide education and support to staff
- Asking about suicide or assessing suicidality does not increase a patient's risk of suicide

The Tools

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)

C-SSRS

Always ask questions 1 and 2.	Past Month
1) Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Have you actually had any thoughts about killing yourself?	
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3) Have you been thinking about how you might do this?	
4) Have you had these thoughts and had some intention of acting on them?	High Risk
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk

Always Ask Question 6	Life-time	Past 3 Months
6) Have you 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, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		High Risk

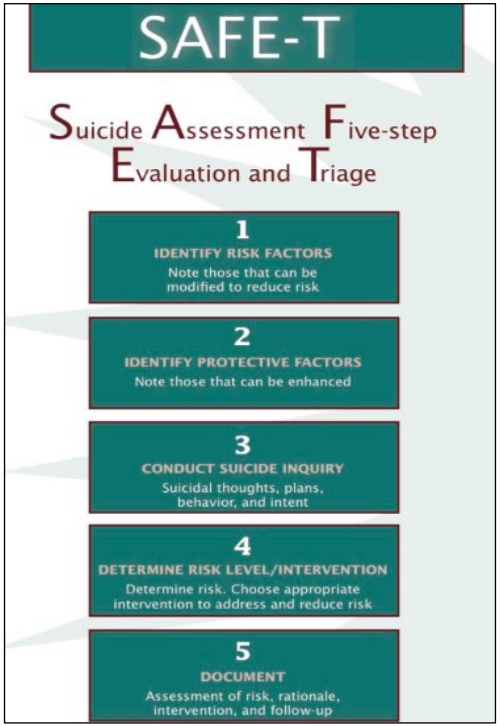
988 SUICIDE & CRISIS LIFELINE

Any **YES** indicates that someone should **seek behavioral healthcare.**

However, if the answer to **4, 5** or **6** is **YES**, get **immediate help: Call or text 988, call 911 or go to the emergency room. STAY WITH THEM until they can be evaluated.**

Download Columbia Protocol app

SAFE-T



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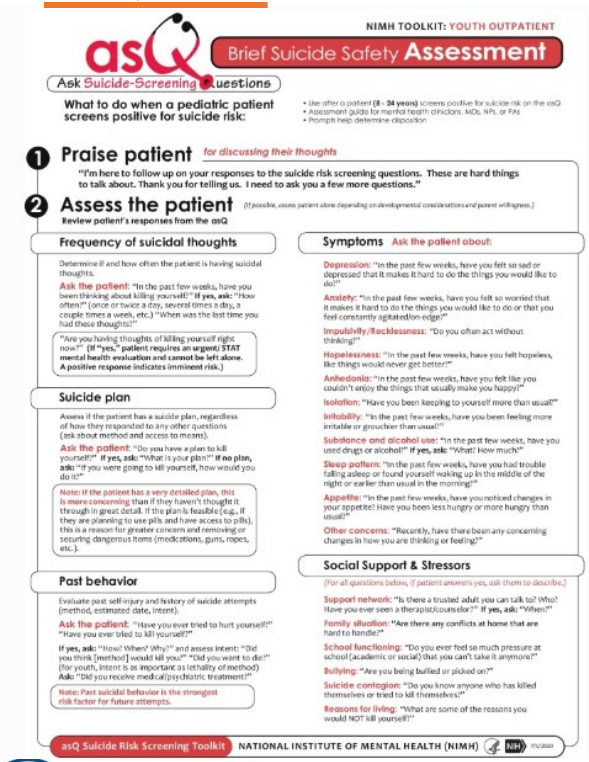
Assessment

- Suicide assessment usually refers to a more comprehensive evaluation done by a mental health clinician
- Goals are:
  - Evaluate severity of suicide risk
  - Estimate the immediate danger to the patient
  - Decide on a course of treatment
  - Track progress
- Can involve structured questionnaires, BUT typically also open-ended conversation with a patient and/or friends and family

The Tools

ASQ-BSSA



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- Use after a patient (8 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

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.) "When was the last time you had these thoughts?"

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

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

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

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms *Ask the patient about:*

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

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

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

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

Family situation: **"Are there any conflicts at home that are hard to handle?"**

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

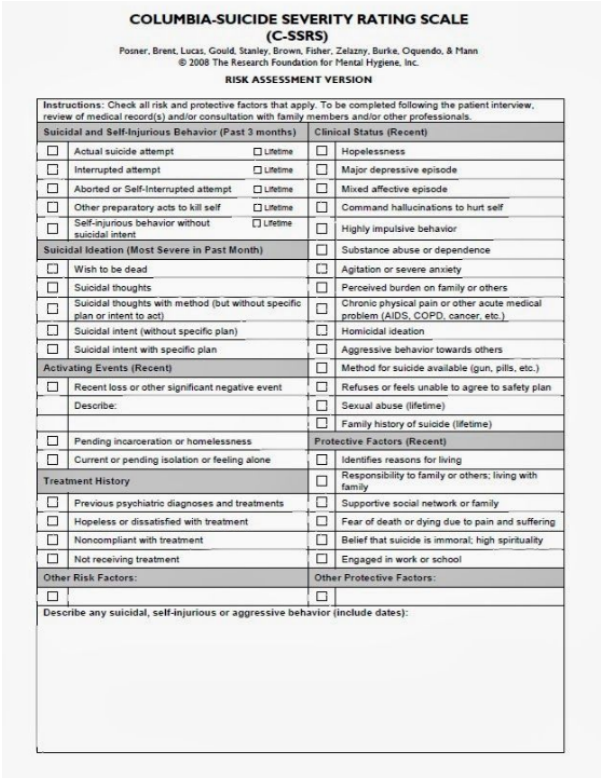
Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)

C-SSRS-RISK ASSESMENT VERSION



COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

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RISK ASSESSMENT VERSION

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

Suicidal and Self-Injurious Behavior (Past 3 months)		Clinical Status (Recent)
☐	Actual suicide attempt ☐ Lifetime	☐ Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐ Major depressive episode
☐	Aborted or Self-Interrupted attempt ☐ Lifetime	☐ Mixed affective episode
☐	Other preparatory acts to kill self ☐ Lifetime	☐ Command hallucinations to hurt self
☐	Self-injurious behavior without suicidal intent ☐ Lifetime	☐ Highly impulsive behavior
Suicidal Ideation (Most Severe in Past Month)		☐ Substance abuse or dependence
☐	Wish to be dead	☐ Agitation or severe anxiety
☐	Suicidal thoughts	☐ Perceived burden on family or others
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐ Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
☐	Suicidal intent (without specific plan)	☐ Homicidal ideation
☐	Suicidal intent with specific plan	☐ Aggressive behavior towards others
Activating Events (Recent)		☐ Method for suicide available (gun, pills, etc.)
☐	Recent loss or other significant negative event	☐ Refuses or feels unable to agree to safety plan
	Describe:	☐ Sexual abuse (lifetime)
		☐ Family history of suicide (lifetime)
☐	Pending incarceration or homelessness	**Protective Factors (Recent)**
☐	Current or pending isolation or feeling alone	☐ Identifies reasons for living
Treatment History		☐ Responsibility to family or others; living with family
☐	Previous psychiatric diagnoses and treatments	☐ Supportive social network or family
☐	Hopeless or dissatisfied with treatment	☐ Fear of death or dying due to pain and suffering
☐	Noncompliant with treatment	☐ Belief that suicide is immoral; high spirituality
☐	Not receiving treatment	☐ Engaged in work or school
Other Risk Factors:		**Other Protective Factors:**
☐		☐

Describe any suicidal, self-injurious or aggressive behavior (include dates):

CLINICAL ASSESSMENT

- Thoughts/plan/intent/ access to means using screening data as a starting point
- Insight, risk factors, protective factors
- Medical and mental health history
- Current symptoms and triggers
- Available resources
- Mitigating factors
- Ability to engage in safety planning

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Implementation Pearls

- Identify stakeholders and champions
- Assess culture and barriers
- Structure a pathway
- Embed in medical record
- Have resources available

Culture Shift

- Educate about and highlight data lessons
- Empower all team members in their role
- Highlight stories
- Celebrate the successes

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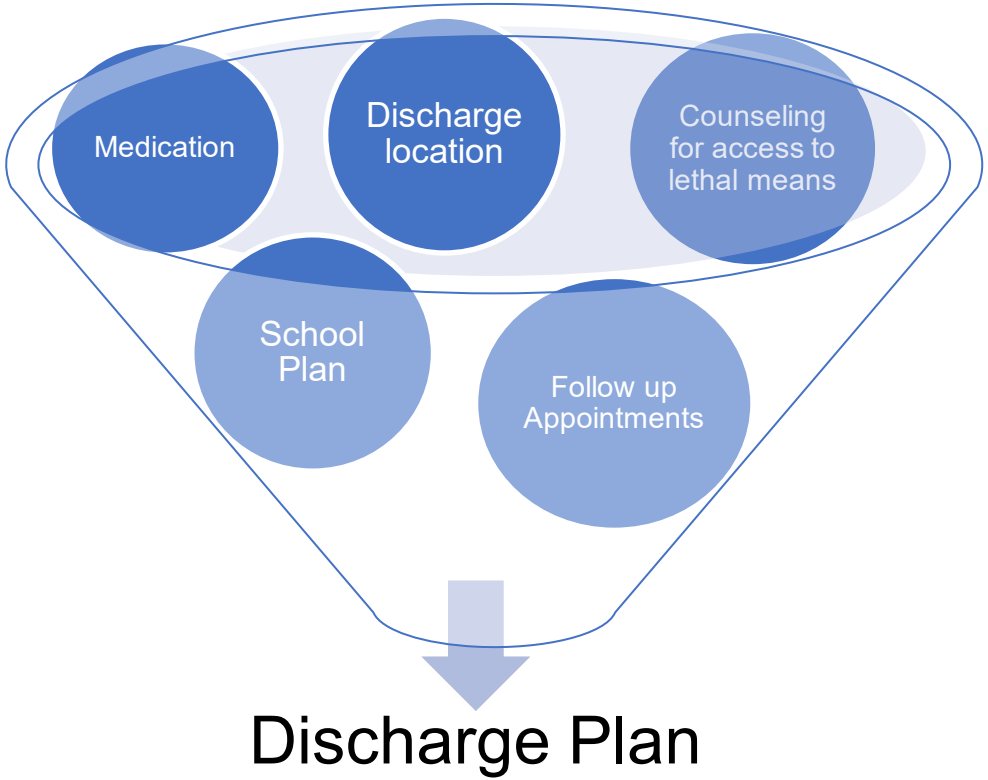
Discharge and Safety Planning



Safety Planning

Safety Planning

Incorporates elements of effective brief interventions and suicide risk reduction:

- Teaching self-monitoring skills
- Teaching brief problem solving and coping skills
- Enhancing social support and identifying emergency contacts
- Motivational enhancement for further treatment
- Enhancing hope and motivation for living
- Reducing access to lethal means

Assumptions Underlying Safety Planning

- Suicide fluctuates over time
- Individuals often fail to recognize their early warning signs
- Problem solving and coping capacity reduces during times of stress
- Working collaboratively helps ensure engagement and feasibility
- Over-practicing can help create rote memory (habit) for times of crisis

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

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

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

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

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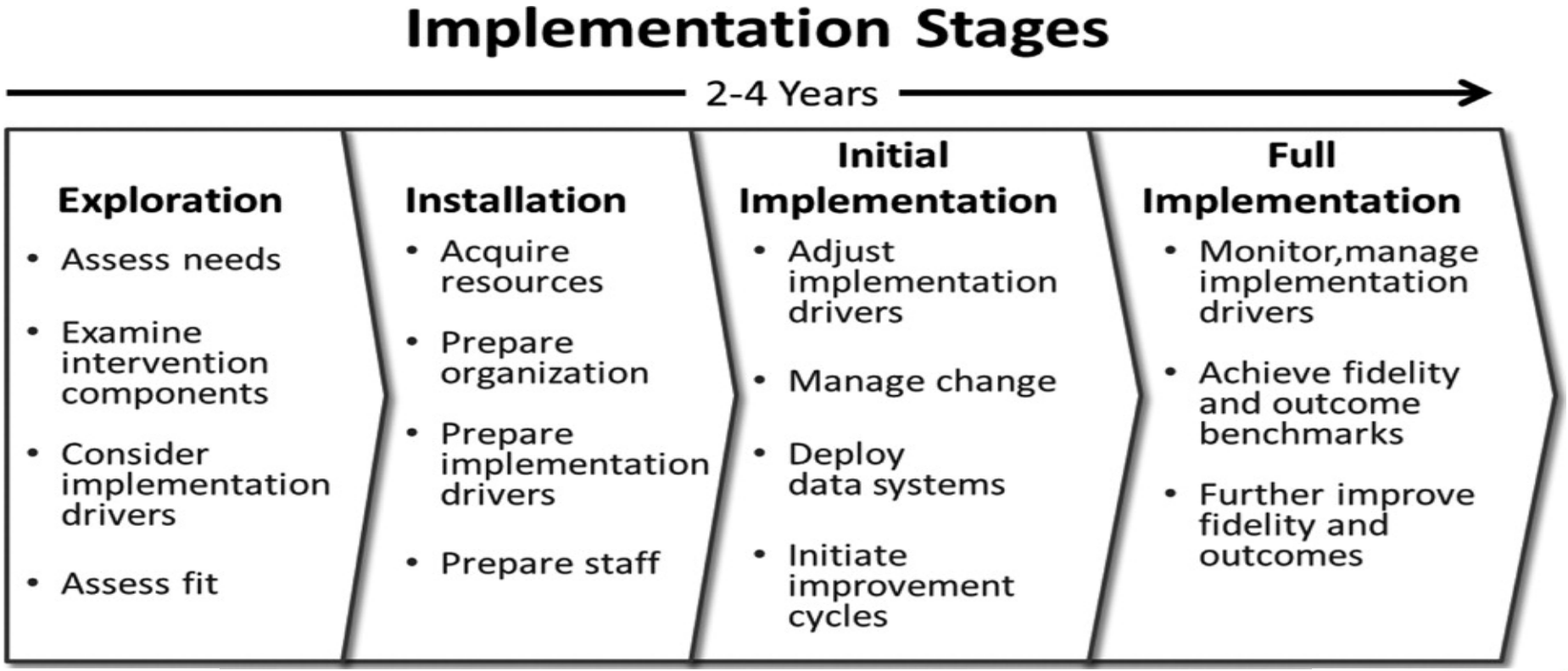
Change Strategies (Fixsen et al, 2005)



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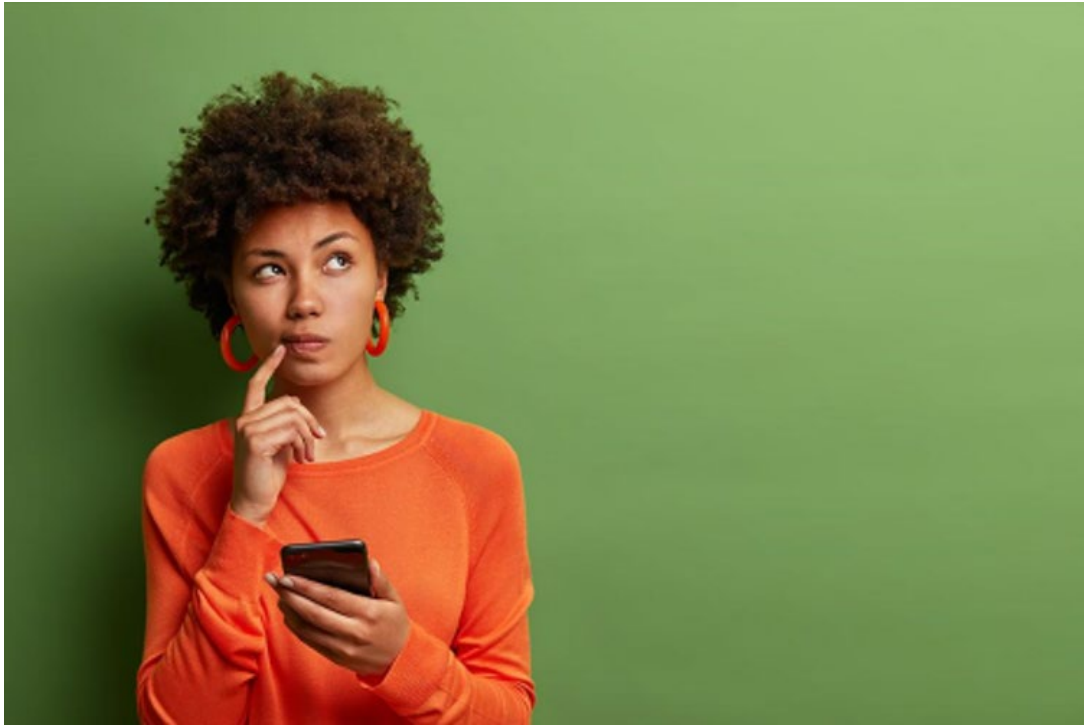
Change Strategies

- Policy/Procedures
- Education
- EMR Optimization
- Reinforcement/Resources

Intervention Bundle	Phase of Care	Quality Measures
Acute Suicidality Encounters	Assessment	Percentage of patients who had a structured suicide screen
		Percentage of patients with a positive suicide screen who had a structured suicide screen
	Intervention	Percentage of patients with a positive sucide screen who had a consultation with a licensed mental health professional
		Percentage of patients with a positive suicide screen that received a discharge safety plan

Q&A Session



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Complete Registration for the Data Platform

- Share demographics
- Provide data platform users
- *Include name, email, phone # of POA signatory*
- *Upload signed POA to data portal registration*

Register for the Next Fireside Chat

- July 11, 2023
- 1-2 pm CT
- Topic: Pain Management

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Pain Management

July 11, 2023

Data Platform Overview

July 25, 2023

Assessment

August 1, 2023

Patient Safety

August 8, 2023

Join Us for Future Fireside Chats

Interactive presentations by multidisciplinary experts
on bundle topics June through September

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Nursing - CE contact hours

Fireside Chat #1 June 27, 2023

1. Enter your first and last name in the **chat** if you have not done so already
2. Scan the QR code/use link to access session evaluation
3. Submit completed evaluation by 1700 (Pacific) on **6/29/2023** to be eligible for CE hours

https://bit.ly/PRQCFireside1

If you have any questions, please contact Robin Goodman at robin.goodmanrn@gmail.com

BRN CE Provider: Pediatric Liaison Nurses Los Angeles County. Provider approved by the California Board of Registered Nursing, Provider # 15456, for 1 Contact Hours

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Social Work Professionals – CEU's
Fireside Chat #1 June 27, 2023

1. Enter your first and last name in the **chat** if you have not done so already
2. Scan the QR code/use link to access session evaluation

https://utexas.qualtrics.com/jfe/form/SV_8eO1s9LrJqGx6cK

EIIC EMSC Innovation and Improvement Center

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Please Complete Session Evaluation

Thank you!

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