Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP)
BHIPP Mental Health Crisis Training

March 21, 2024

Assessment of Self-Injury and Suicidal Thoughts

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855-MD-BHIPP (632-4477)

www.mdbhipp.org

Partners & Funding

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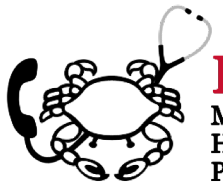
Conflict of interest disclosure

- No potential conflicts of interest
- Faculty at the Johns Hopkins School of Medicine



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Learning Objectives

- Addressing Suicidality
  - Identify risk and protective factors for pediatric suicide
  - Learn pros and cons of suicide screening
  - Learn how to conduct a safety assessment
- Addressing Self-Harm
  - Identify conditions and characteristics associated with self-injury
  - Identify 4 risk factors for when self-injury is most associated with suicide attempts
  - Know how to ask about self-injury to understand its function and assess its dangerousness

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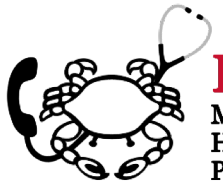
Demographics and Risk Factors

A Changing Landscape



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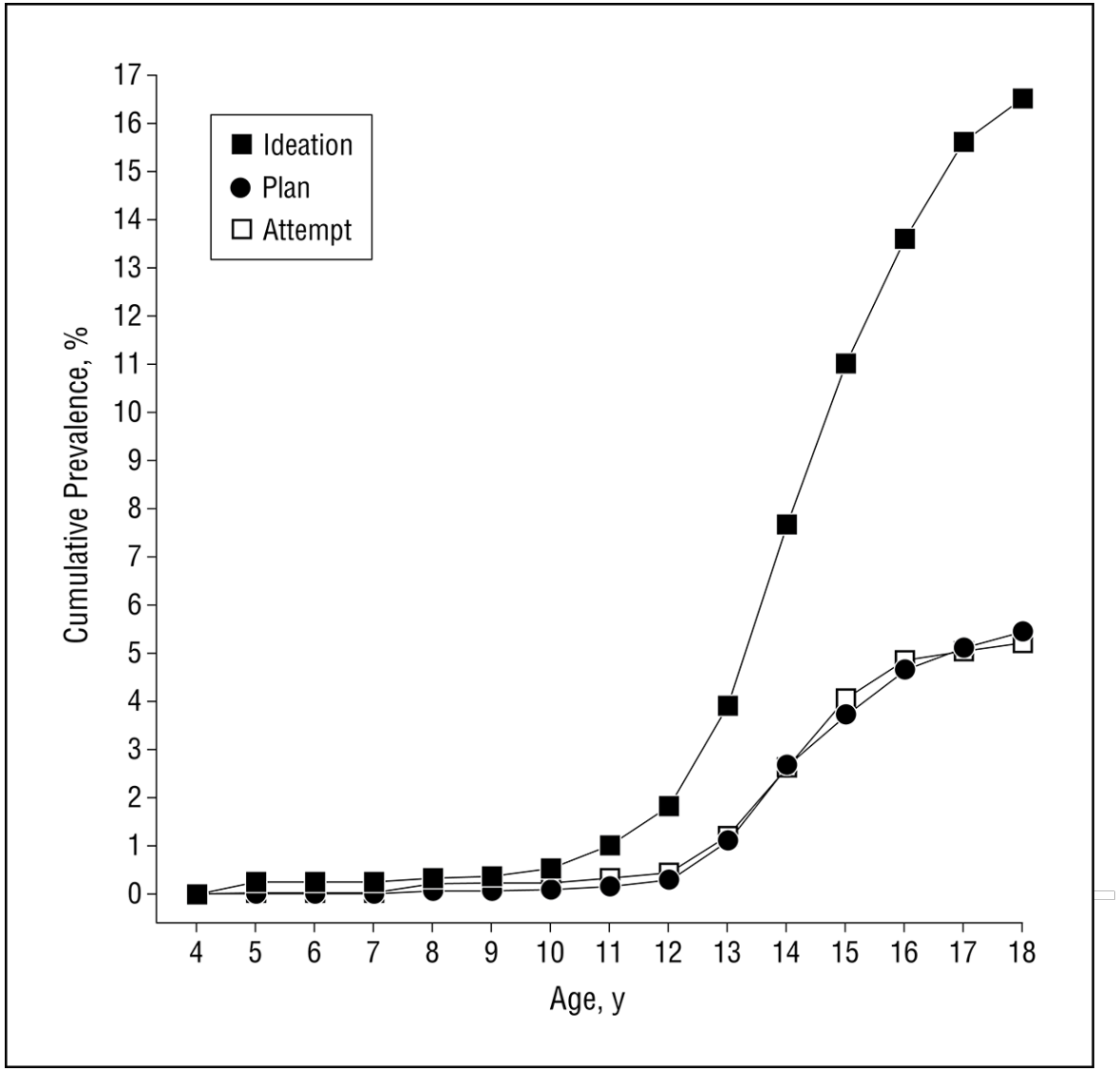
Suicidal Behavior by Age

- From the National Comorbidity Survey Replication Study (2013)
- Incidences of suicidality and depression become much more prevalent around puberty



Nock, M. K., Green, J. G., Hwang, I., McLaughlin, K. A., Sampson, N. A., Zaslavsky, A. M., & Kessler, R. C. (2013). Prevalence, correlates, and treatment of lifetime suicidal behavior among adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement. *JAMA psychiatry*, 70(3), 300-310.

Risk Factors

Table 5. Estimated Odds of the Association Among Health Care Visits, Clinical Characteristics, and Suicide

Variable	OR (95% CI)	*P* Value
Count of mental health visits, 5-U increase per 30 d	0.78 (0.65-0.92)	.005
Type of mental disorder		
ADHD	1.13 (0.88-1.44)	.35
Conduct[a]	1.18 (0.88-1.59)	.28
Depression	3.19 (2.49-4.09)	<.001
Bipolar and other mood disorders	2.09 (1.58-2.76)	<.001
Anxiety	1.20 (0.87-1.66)	.26
Schizophrenia or psychosis	3.18 (2.00-5.06)	<.001
Adjustment	1.43 (1.01-2.03)	.05
Other mental health conditions[b]	1.41 (0.996-1.99)	.05
Any substance use disorder	2.65 (1.67-4.20)	<.001
Dual diagnosis (substance use and mental health)	1.02 (0.57-1.83)	.95
Type of medical condition		
Asthma	1.28 (0.91-1.78)	.16
Cancer	0.80 (0.41-1.57)	.52
Congenital anomaly	0.59 (0.26-1.34)	.21
Seizure disorder	4.89 (2.81-8.48)	<.001
Diabetes	0.94 (0.43-2.06)	.88
Cerebral palsy	0.23 (0.07-0.81)	.02

Abbreviations: ADHD, attention-deficit/hyperactivity disorder; OR, odds ratio.

[a] Includes oppositional defiant disorder.

[b] Includes all mental health disorders coded as *International Classification of Diseases, Ninth Revision, Clinical Modification*, diagnosis codes 290 to 319 not otherwise categorized above.

Case-control study of Medicaid data of youth 10-18

- More mental health visits w/in 30 days of a crisis decreased odds of suicide
- Suicide most highly associated with MDD, psychotic illness, substance use disorder, bipolar disorder, and seizure disorder

Fontanella CA, Warner LA, Steelesmith D, Bridge JA, Sweeney HA, Campo JV. Clinical Profiles and Health Services Patterns of Medicaid-Enrolled Youths Who Died by Suicide. *JAMA Pediatr.* 2020;174(5):470–477. doi:10.1001/jamapediatrics.2020.0002

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Risk Factors for Completed Suicide

Risk Factor	Description
Past suicide attempts	About 30% of youth who died by suicide have had a prior attempt (Keeshin et al. 2017)
Access to lethal means	Firearms are used in about 20% of youth suicides (Ruch et al. 2021), higher in rural areas
Gender	Males represent nearly ¾ of all youth who die by suicide (Trigylidas et al. 2016)
Being bullied	**Highest risk for suicidal thoughts among those who experienced both in-person and cyber bullying > cyber bullying > in-person bullying (Messias et al. 2014)**
Life stressor	**Adolescents with suicidal thoughts are 5x more likely to report a recent life stressor, most often interpersonal in nature, school-related, health-related, or bullying (Stanley et al. 2013)**

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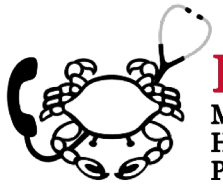
Suicide Screening



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To Screen or Not to Screen

Summary of Recommendations

Population	Recommendation	Grade
Adolescents aged 12 to 18 years	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years.	B
Children 11 years or younger	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for MDD in children 11 years or younger.	I
Children and adolescents	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in children and adolescents.	I

See the Practice Considerations section for additional information regarding the I statement. USPSTF indicates US Preventive Services Task Force.

Mangione, C. M., Barry, M. J., Nicholson, W. K., Cabana, M., Chelmow, D., Coker, T. R., ... & US Preventive Services Task Force. (2022). Screening for depression and suicide risk in children and adolescents: US Preventive Services Task Force Recommendation Statement. *JAMA*, *328*(15), 1534-1542.

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To Screen or Not To Screen

- In Spring of 2022, *AAP* and other released the "Blueprint for Youth Suicide Prevention"
  - Recommended screening "all patients ages 12+ years for suicide risk during preventive service visits, using a validated suicide risk screening tool"
  - For youth 8-11, screen when presenting with behavioral health symptoms
  - Do not screen under age 8
  - https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

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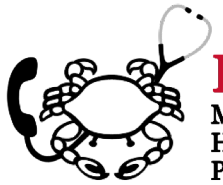
Screening Tools

Pros and Cons



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PHQ-9A

- The PHQ-9A (recommended by the GLAD-PC guidelines) also has suicide screening questions (below)
  - In a large study in pediatric primary care use, 8.6% of kids were positive on the suicide screen and **half** of those kids did not meet the threshold to screen positive for depression (Farley et al 2020)
  - Reminder: PHQ-9A is designed for kids 12 and older
- Screening younger children can be challenging as they may not understand the concepts

Has there been a time in the **past month** when you have had serious thoughts about ending your life? ☐Yes ☐No
Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? ☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

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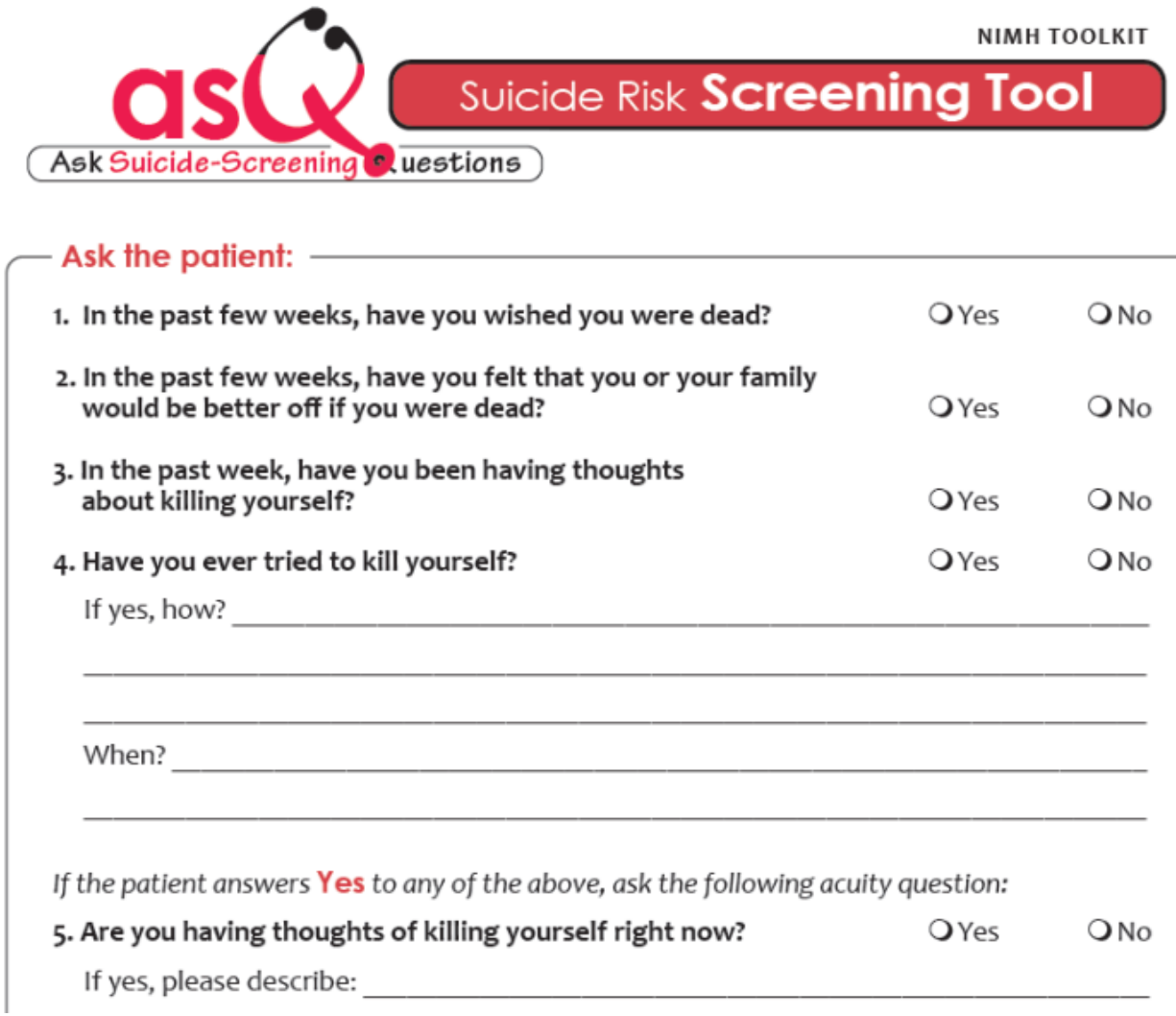
ASQ (Ask Suicide Screening Questions)



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: _____

- Very brief suicide screening tool developed by NIMH for kids 12 and up
- Meant specifically for use in pediatric primary care
- Validated in ED and outpatient settings in large-scale studies
- https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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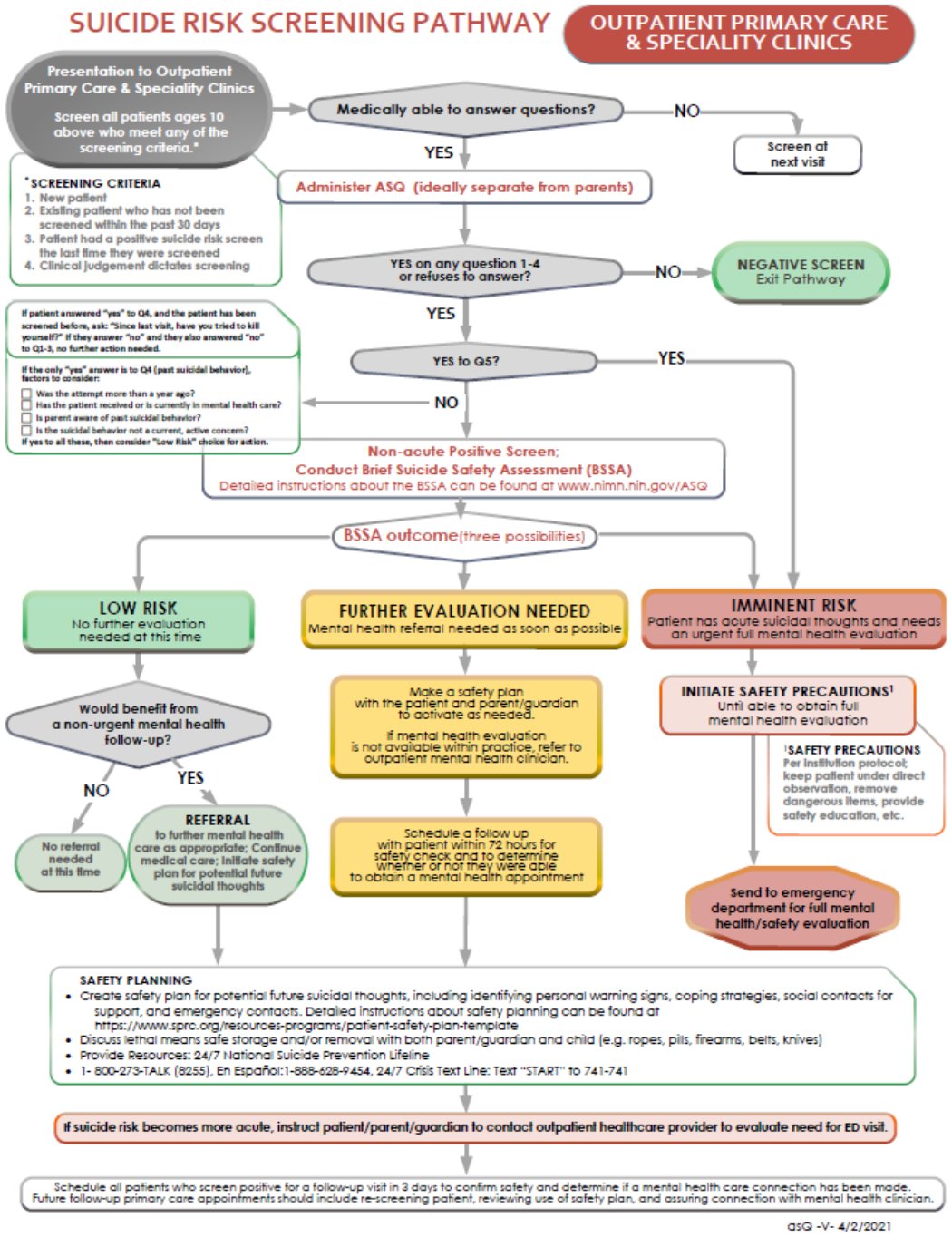

ASQ (Ask Suicide Screening Questions)

- ASQ is screening portion of a broader suicide assessment
- Positive screens are meant to have a more comprehensive evaluation, including the Brief Suicide Safety Assessment
- Meant to help divide patients into three risk groups requiring differing intensity of interventions

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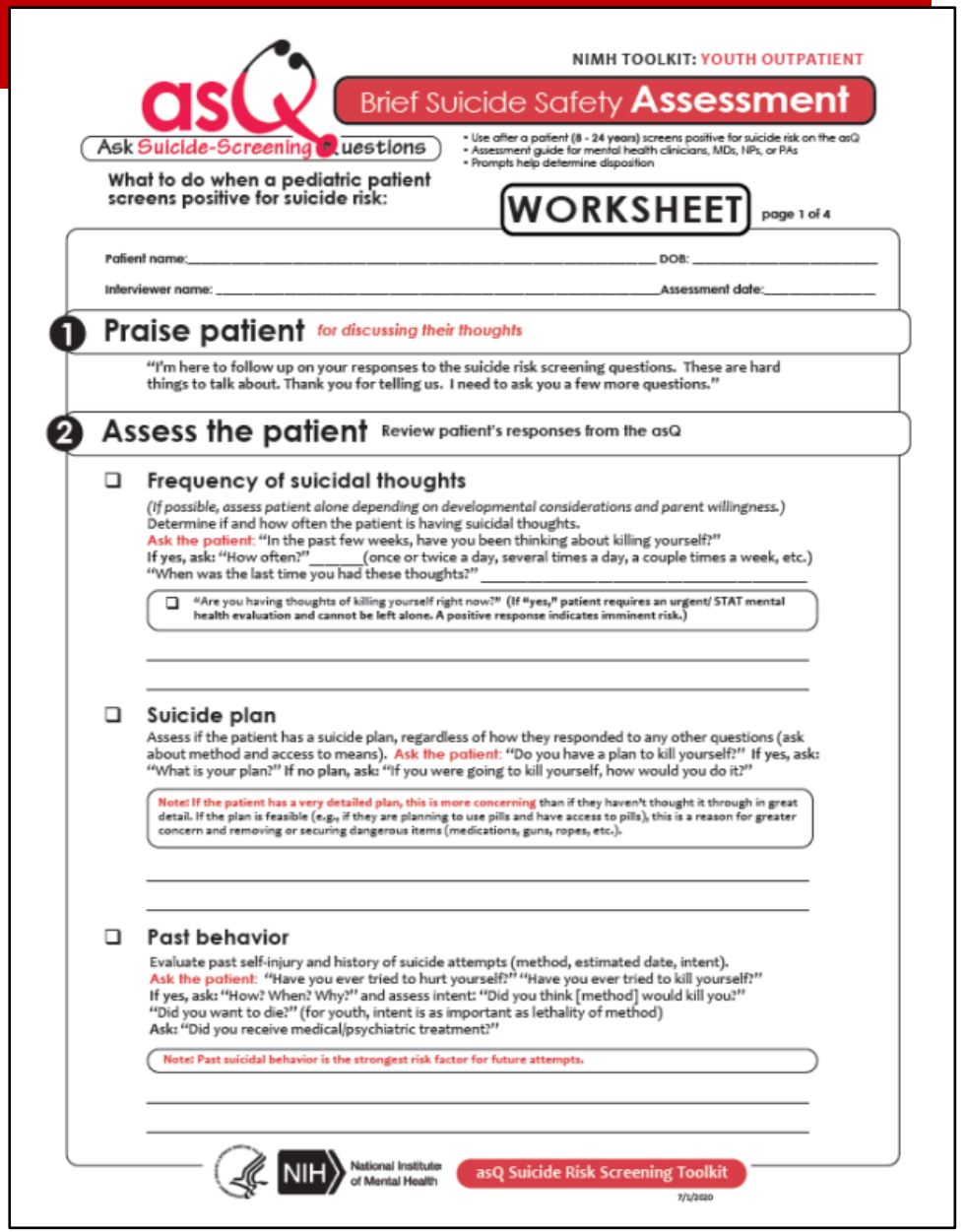
ASQ (Ask Suicide Screening Questions)

Pros

- Takes very little time to administer
- Part of a larger "toolkit" that includes a clinical pathway flowchart and more comprehensive suicide assessment (see right)
- High sensitivity (100%) and high specificity (90%)

Cons

- Fairly low positive predictive value (30% of positive screens were actually "true positives")
- Asking if kids have "ever" tried to kill themselves can be overly broad
- Language used on the screener can be a little jarring to patients.
- Likely not appropriate or useful for younger children



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

- 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

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

WORKSHEET page 1 of 4

Patient name:_____ DOB: _____

Interviewer name: _____ Assessment date:_____

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

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

❑ **Frequency of suicidal thoughts**

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_____(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" _____

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

❑ **Suicide plan**

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

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

❑ **Past behavior**

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

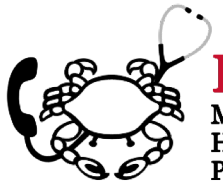
Note: Past suicidal behavior is the strongest risk factor for future attempts.

NIH National Institute of Mental Health

asQ Suicide Risk Screening Toolkit

7/1/2020

Assessing Suicide as Part of the Clinical Interview



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Assessing Suicide Directly

- Start broad and open-ended: “Over the last month, how have you been feeling about being alive?”
- Follow-up questions gently move up to a higher level of acuity and specificity: “Have you had moments when you wished you were dead?” and “Did you ever reach a point where you thought about trying to end your life?”
- If there is a specific thought to commit suicide, follow-up again with questions about the plan’s details, including lethality, feasibility, and desire to act on it
- Ask about frequency, intensity, and “how do you manage those thoughts when they come?”
- As about who else knows
- Ask what’s kept them from acting on their plan thus far
- Don’t forget to ask about home: to what extent can parents/caregivers supervise if needed?

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Assessing Suicide Directly

- At the end of your suicide assessment, you should know:
  - Has your patient had thoughts of wanting to be dead?
  - Has your patient had thoughts of committing suicide?
    - How frequent and how intense?
  - Does your patient have a plan for suicide?
    - Specifically, what would your patient do?
    - Does your patient have available the tools/objects to act on that plan?
    - What has kept your patient from acting on that plan?
  - Do parents/caregivers have the ability to provide additional supervision if needed?

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The Big Question

- Does the patient feel that they can keep from seriously harming themselves with appropriate supervision and do the parents/caregivers feel that they can provide adequate supervision to keep their child safe?
  - If yes – proceed to safety planning
    - After safety planning, reconsider the above question to ensure that all parties feel the safety plan can be realistically followed
  - If no – further evaluation is needed immediately
    - Consider emergent psychiatric evaluation (in the ED or other setting)

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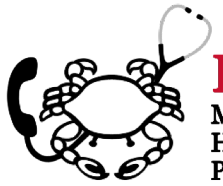
Non-Suicidal Self-Injury



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Definitions

- Self-harm/self-injury (also known as “NSSI” or non-suicidal self-injury)
  - Deliberate inducement of pain or tissue damage without suicidal intent
  - Often refers to “cutting” or “scratching”

Self-harm as a behavior

- Why see it that way?
  - Self-harm is not necessarily a treatable disorder itself but can signal the presence of other disorders
  - Something reinforces self-harm to enable the behavior to persist
  - To stop self-harm, you must address the antecedents and consequences

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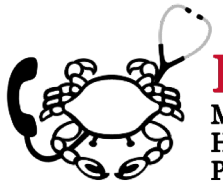
Prevalence, Risk Factors, and Characteristics of Self-Harm



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By the Numbers: Rates of NSSI

- Lifetime prevalence: 23%
- Females 1.72x more likely than males to self-harm
- Mean age at the first instance is 13 years
- 47% of kids self-harm once or twice
- 5% of kids self-harm more than ten times
- Rates have been increasing since 1990

Gillies, D., Christou, M. A., Dixon, A. C., Featherston, O. J., Rapti, I., Garcia-Anguita, A., ... & Christou, P. A. (2018). Prevalence and characteristics of self-harm in adolescents: meta-analyses of community-based studies 1990–2015. Journal of the American Academy of Child & Adolescent Psychiatry, 57(10), 733-741.

Other things to treat: Associated conditions

- Inpatient participants
  - Reported NSSI in the last 12 months
  - Age 12-17
- Comorbidities:
  - High rates of depression
  - High rates of trauma
  - High rates of problems with “self-regulation”
  - High rates of substance use

Table 1
Axis I diagnoses of adolescents engaging in NSSI

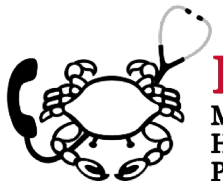
Variable	%
Axis I diagnosis on DISC	
Any internalizing	51.7
Major depressive disorder	41.6
Post-traumatic stress disorder	23.6
Generalized anxiety disorder	15.7
Any externalizing disorder	62.9
Conduct disorder	49.4
Oppositional defiant disorder	44.9
Any substance use disorder	59.6
Alcohol abuse	18.0
Alcohol dependence	16.8
Nicotine dependence	38.6
Marijuana abuse	12.6
Marijuana dependence	29.5
Other substance abuse	3.4
Other substance dependence	5.6

Note: DISC = Diagnostic Interview Schedule for Children.

Nock, M. K., Joiner, T. E., Gordon, K. H., Lloyd-Richardson, E., & Prinstein, M. J. (2006). Non-suicidal self-injury among adolescents: Diagnostic correlates and relation to suicide attempts. *Psychiatry research*, 144(1), 65-72.

Why Do Kids Self-Harm?

Understanding the problem more fully



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Self-Harm's Four Outcomes

Increase in desired feelings	Decrease in undesired feelings	Increase a desired social response	Decrease an undesired social response
• Self-punishment • Self-stimulation • "Endorphin release"	• Stop feeling "overwhelmed" • Decrease anger or sadness • Reduce feelings of "emptiness"	• Gain attention or support	• End bullying • Stop parental fighting

Nock, M. K. (2010). Self-injury. *Annual review of clinical psychology*, *6*, 339-363.

What Kids Report

- 25% to increase a desired feeling
- 65% to decrease an unpleasant feeling
  - 35% to escape anxiety (feeling “overwhelmed”)
  - 24% to escape sadness
  - 20% to escape anger
  - 29% to escape a “bad thought” or “bad memory”
- 4% to create a desired interpersonal outcome
- 15% to decrease a negative interpersonal outcome

Nock, M. K., Prinstein, M. J., & Sterba, S. K. (2009). Revealing the form and function of self-injurious thoughts and behaviors: A real-time ecological assessment study among adolescents and young adults. *Journal of abnormal psychology*, *118*(4), 816.

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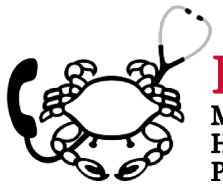
Asking About Self-Harm

No Such Thing as a “Stupid Question”



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Guiding Principles

- Respond with “supportive concern”
- Review confidentiality rules but give yourself some wiggle room (what’s ok, what’s not ok, and what do you and your patient do when there’s something in between)
- Keep the Four Outcomes Model in mind
  - Create a feeling
  - Relieve a feeling
  - Create a social outcome
  - Stop/prevent a social outcome
- Safety first!

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The "What" of Cutting

- When did it start?
- How do you self-harm?
  - Cutting? Burning? Scratching? Purging? Using drugs? How many different ways?
  - How often?
  - Where do you self-harm?
  - With what?
  - Ask to see scars
- Who knows?
  - How do those people feel about it?
  - What do your parents know about your self-harm?

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The “Why” of Cutting

- In general, how are you feeling before you cut?
- What does it do for you?
  - Does it help you feel more or less of a particular emotion?
- How do other people react to your cutting?
  - How do you feel about that reaction?
- How “well” does it work?

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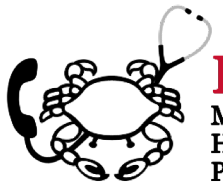
The “What Next” of Cutting

- Assess suicidality (self-harm may not be a suicide attempt, but the person self-harming may still be suicidal)
- Figure out what to treat (remember all those comorbid disorders?)
  - No medication can treat self-harm
  - Many medications **can** treat comorbid disorders
- Be wary of being a “secret keeper”
  - “How are we going to talk to your parents about cutting?”
- Therapy helps!



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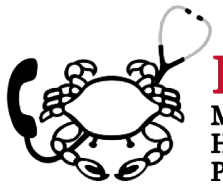
Treatments that Work



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Therapy helps

- Strongest evidence and largest effect sizes:
  - Dialectical Behavioral Therapy
  - Cognitive-Behavioral Therapy
  - Mentalization Based Therapy
- Key ingredients in treatment:
  - Focus on family interactions
  - Frequent meetings with the adolescent
  - Emphasize self-care: sobriety, sleep, increasing positive experiences

Ougrin, D., Tranah, T., Stahl, D., Moran, P., & Asarnow, J. R. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis. Journal of the American Academy of Child & Adolescent Psychiatry, 54(2), 97-107.

Brent, D. A., McMakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. (2013). Protecting adolescents from self-harm: a critical review of intervention studies. Journal of the American Academy of Child & Adolescent Psychiatry, 52(12), 1260-1271.

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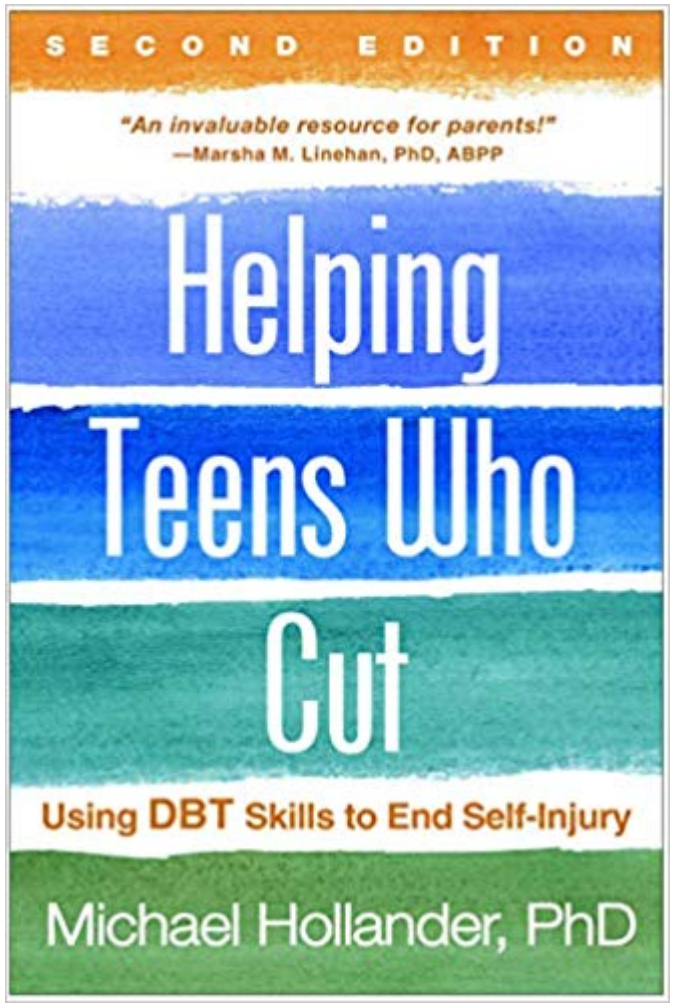
Educating Parents



- Book intended for lay audiences by a major DBT authority
- Explains the concepts and skills of DBT
- May help parents respond to emotional distress more effectively

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Key Take-Home Points

Whats

- Cutting alone doesn't tell us everything about diagnosis
- Kids who cut rarely engage in more than 10 discrete episodes in their lives
- Non-suicidal self injury is strongly associated with future suicide attempts

Whys

- Most kids typically self-harm to make a feeling go away
- Self-harm is rarely “for attention”

What nows

- Assess suicidality
- Determine the function of the self-harm
- Identify comorbidities

What next

- Treatments work!

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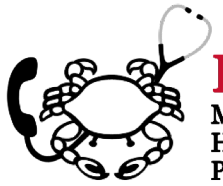
Safety Planning

What We Know and What to Do



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Safety Planning

- Few robust studies in safety planning alone in pediatric populations
- Safety Planning Intervention + single phone check-in reduced 6-month suicide behaviors by 45% among adults with ED visits for suicide-related concerns (Stanley et al 2018)
  - Intervention took 15-45 minutes to conduct
- Safety plans are often combined into a comprehensive treatment approach (such as in CBT or DBT)

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Why Safety Plan?

- There is an inevitable lag between leaving your office and initiating mental health treatment
- Provides kids and families with a set of behaviors to pursue, as opposed to a “no-suicide contract” (aka “contracting for safety”)
- Can be useful for addressing suicidal thoughts **and** self-injurious behaviors

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Safety Planning Principles

- Provide kids and families with a prioritized and specific set of coping strategies and contacts should suicidal thoughts emerge
- Sees suicidal crises as intense but temporary challenges
- Crafted in close collaboration with the individual who will use it
- Shared with parents
- Easily found or displayed in the home

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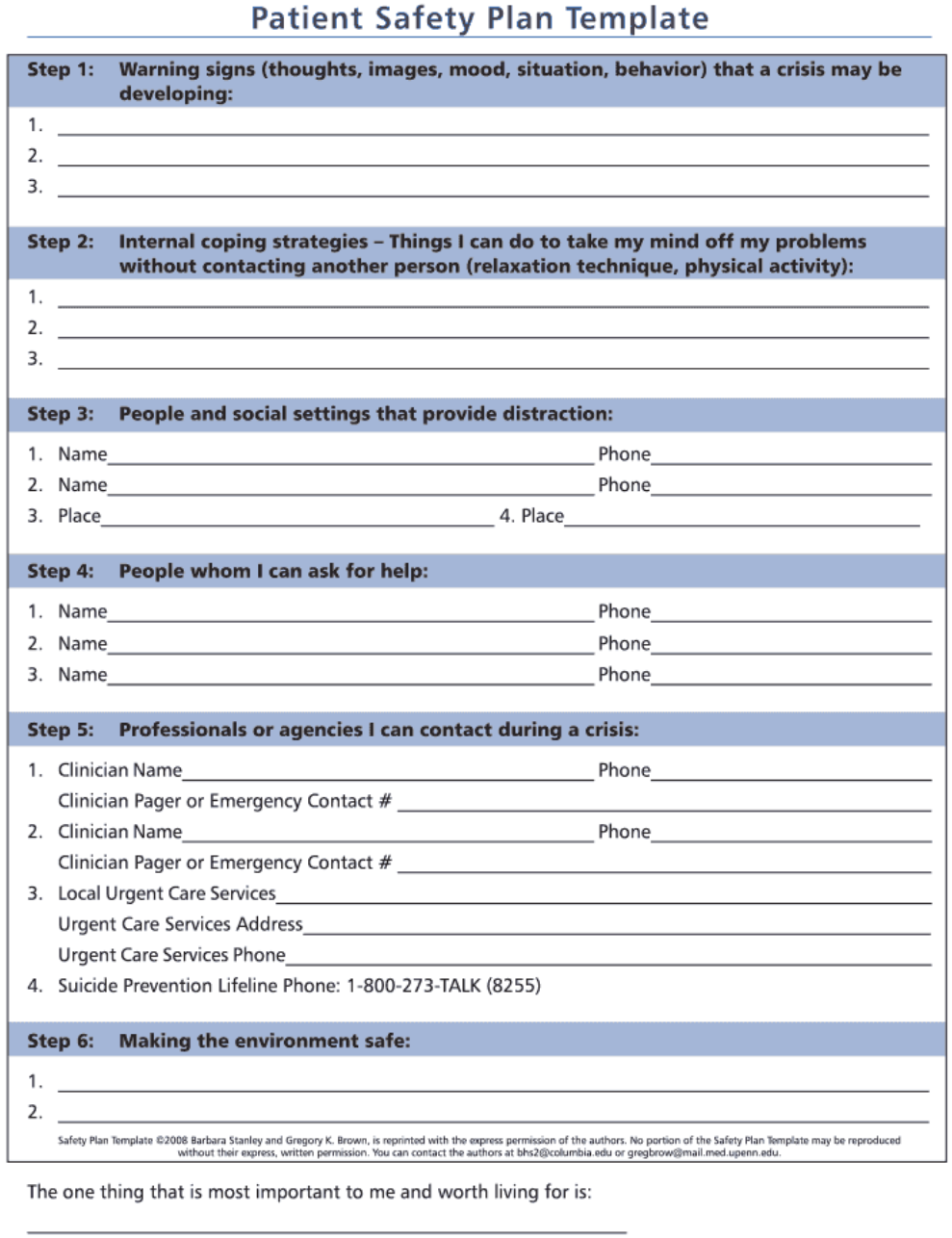

Patient Safety Plan Template

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

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 4: People whom I can ask for help:

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

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

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

Step 6: Making the environment safe:

1. _____
2. _____

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

_____

- Safety Plan adapted from Safety Planning Intervention
  - https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
  - Moves from internal coping to external coping to reaching out for help
- Additional considerations for kids:
  - Plan for increased supervision
  - Establishing a check-in system

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Step 1: Warning Signs

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

- Emphasize thoughts, feelings, and behaviors that the adolescent can identify on their own
- Include observable behaviors as well that parents, caregivers, or other informed adults might be able to recognize without the adolescent saying that they are present

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Step 2: Internal Coping Strategies

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.	_____

- Initial step, meant to enhance self-efficacy
- Often are distraction techniques (going for a walk, taking a shower, etc)
  - DBT skill example: ACCEPTS (https://www.dbtselfhelp.com/html/accepts.html)
- These strategies should be usable at **any time** by the individual

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Step 3: Utilize social contacts as a means of distraction from suicidal thoughts

Step 3: People and social settings that provide distraction:

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

- May identify individuals or places where socializing occurs
- Not meant to be emotional supports, but rather people around whom you can be and feel safe
- Places may be private (a walk in the woods) or public (a trip to the Zoo)
- Aim is still to focus on self-efficacy

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Step 4: Contacting family members or friends who may help with the crisis

Step 4: People whom I can ask for help:

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

- Inform trusted contacts of the suicidal crisis
  - These individuals should know that they may be contacted in a crisis
  - Individuals should adults
- At this stage, the actual crisis is meant to be discussed openly
  - Sometimes, validation and support is sufficient to alleviate suicidality, but distress and other psychiatric symptoms may remain

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Step 5: Contact mental health professionals or agencies

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

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

- At this stage, clinician involvement is necessary
- This should be discussed in advance with outpatient providers to ensure that conditions for being emergently contacted are clear

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Step 6: Reduce the potential use of lethal means

Step 6: Making the environment safe:

1. _____

2. _____

- Some aspects of this should be Step 0 (i.e. firearm safety)
  - Firearms used in pediatric suicides come from the youth's home in approximately 9 of 10 deaths (Monuteaux et al. 2019)
  - The association of firearms ownership and suicide was 2x stronger in adolescents than adults and child access prevention laws ("safe storage laws") may reduce adolescent firearm suicide by 13% (Kivisto et al. 2021)
  - While the AAP recommends all firearms should be securely stored in a locked location, unloaded, and separate from ammunition, only 3 in 10 households with children and firearms do this (Monuteaux et al. 2019)
- Other aspects should be done on an as needed basis
  - Consider locking medications and preferred objects for self-injury

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Additional Considerations for Kids

- Plan for increased level of supervision at home
  - Could be anything from limiting time left alone, increased time spent with family, social media monitoring, etc.
  - Parents should make this explicit
- Devise a “check-in system” for parents and kids
  - There should be limits on both ends
    - Supportive concern =/= nagging
    - The goal is to assess safety and not (primarily) to manage parent anxiety
  - Fine to adopt means of checking in beyond explicit verbal statements as long as it’s predetermined
    - Can use codes (“red zone”) or a chart if needed

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Summary

- There are no firm guidelines for universal suicide screening in youth pediatric visits
- Screening tools can help guide our assessment of suicidality
- A positive screen is no substitute from a thorough assessment
- Safety planning is essential for kids who do not need an immediate higher level of care

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