Universal Screening for Suicidality: Identifying Kids, Getting them Help

Jennifer Zaspel, MD

Medical College of Wisconsin/Children's Wisconsin

WIAAP Youth Canvas: Painting a Picture of Mental Wellness

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Brief Bio

Jennifer Zaspel, MD is a Child and Adolescent Psychiatrist, the Medical Director of Emergency Mental and Behavioral Health at Children's Wisconsin (CW), and an Assistant Professor of Psychiatry and Behavioral Medicine at the Medical College of Wisconsin (MCW). She earned her medical degree from MCW in 2014. She completed her residency training in Psychiatry at MCW in 2017 and fellowship training in Child and Adolescent Psychiatry at MCW in 2019, after which she joined the faculty. Her primary clinical appointment is at Children's Wisconsin as a consultant in the Emergency Department Trauma Center (EDTC) and she has been a member of the EDTC's Mental and Behavioral Health Crisis Response Team since its inception. She continues to provide emergency psychiatry care to patients of all ages at Milwaukee's Mental Health Emergency Center and Froedtert Hospital's Emergency Department. Dr. Zaspel's academic areas of interest include suicide prevention, LGBTQ+ health needs, and advocacy. She has made significant contributions to collaborative efforts with community mental health partners on behalf of Children's and MCW, including her ongoing work with Milwaukee's Suicide Review Commission and Milwaukee County's Youth Behavioral Health Care Delivery Redesign. She is an affiliate faculty member of MCW's Comprehensive Injury Center and is currently leading CW's efforts on bringing Counseling on Access to Lethal Means training to CW providers across the organization.

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Objectives

Objective 1: Review current data and recommendations on pediatric suicide screening.

Objective 2: Outline the journey towards Universal Suicide Screening at Children's Wisconsin.

Objective 3: Discuss next steps for physicians both in and outside of the Children's Wisconsin system.

Current Data and Recommendations

Question 1

Which of the following is considered patient-centered or person-centered language?

A. Committed suicide
B. Unsuccessful suicide attempt
C. Died by suicide
D. Suicide victim

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Which of the following is considered patient-centered or person-centered language?

A. Committed suicide

B. Unsuccessful suicide attempt

C. Died by suicide

D. Suicide victim

Explanation: One of the ways that we can promote suicide prevention is by reducing the stigma associated with suicide and mental health challenges and care. An easy way to do this is by being conscious of the language that we use when we speak with youth and families about suicide. These language swaps can help reduce the risk of harm while increasing awareness and understanding of the complexities of suicide.

Source: International Association for Suicide Prevention Language Guidelines - https://www.iasp.info/languageguidelines/ ; Hua LL, Lee J, Rahmandar MH, Sigel EJ; COMMITTEE ON ADOLESCENCE; COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION. Suicide and Suicide Risk in Adolescents. *Pediatrics*. 2024;153(1):e2023064800. doi:10.1542/peds.2023-064800

Person-First or Person-Centered Language

- Person-first language refers to choosing or using words that recognize and refer to individuals—first and foremost—as people
- Demonstrates respect for each person's basic humanity
- Emphasizes unique traits, strengths, and worth
- Reduces stigma and shows compassion
- Feeling stigmatized can make people with a substance use disorder less willing to seek treatment
- Negative stereotypes about people with substance use disorders can make others feel pity, fear, and even anger.

LANGUAGE GUIDELINES

International Association for Suicide Prevention

Certain language can be problematic when discussing suicide. The language guide below provides some examples of problematic language and suggested safer alternatives. These language guidelines aim to reduce risk of harm while increasing awareness and understanding of suicide and its complexities.

PROBLEMATIC	PREFFERED
'committed suicide' or 'commit suicide'	'died by suicide' or 'took their own life' or 'suicide death'
'unsuccessful suicide' or 'failed suicide'	'suicide attempt' or 'non-fatal suicide attempt'
'successful suicide attempt'	'A fatal suicide attempt'
'suicide victim'	'Those who die by suicide'

Avoid sharing details of suicide method and location

Research shows that public communication that includes descriptions of suicide method or location has been associated with increased rates of suicide behaviour and imitation of the suicide method/location.

PROBLEMATIC	PREFFERED
Detail about method or location of suicide	No details of method or location. If needed, use general terms instead of specific details.
Images that show method or location of a suicide	No photos, illustrations, diagrams or video that show suicide method or location.

Responsible reporting of suicide during COVID-19: https://youtu.be/gozDLnnuo7A

Reporting on Suicide During the COVID-19 Pandemic, IASP & SAVE

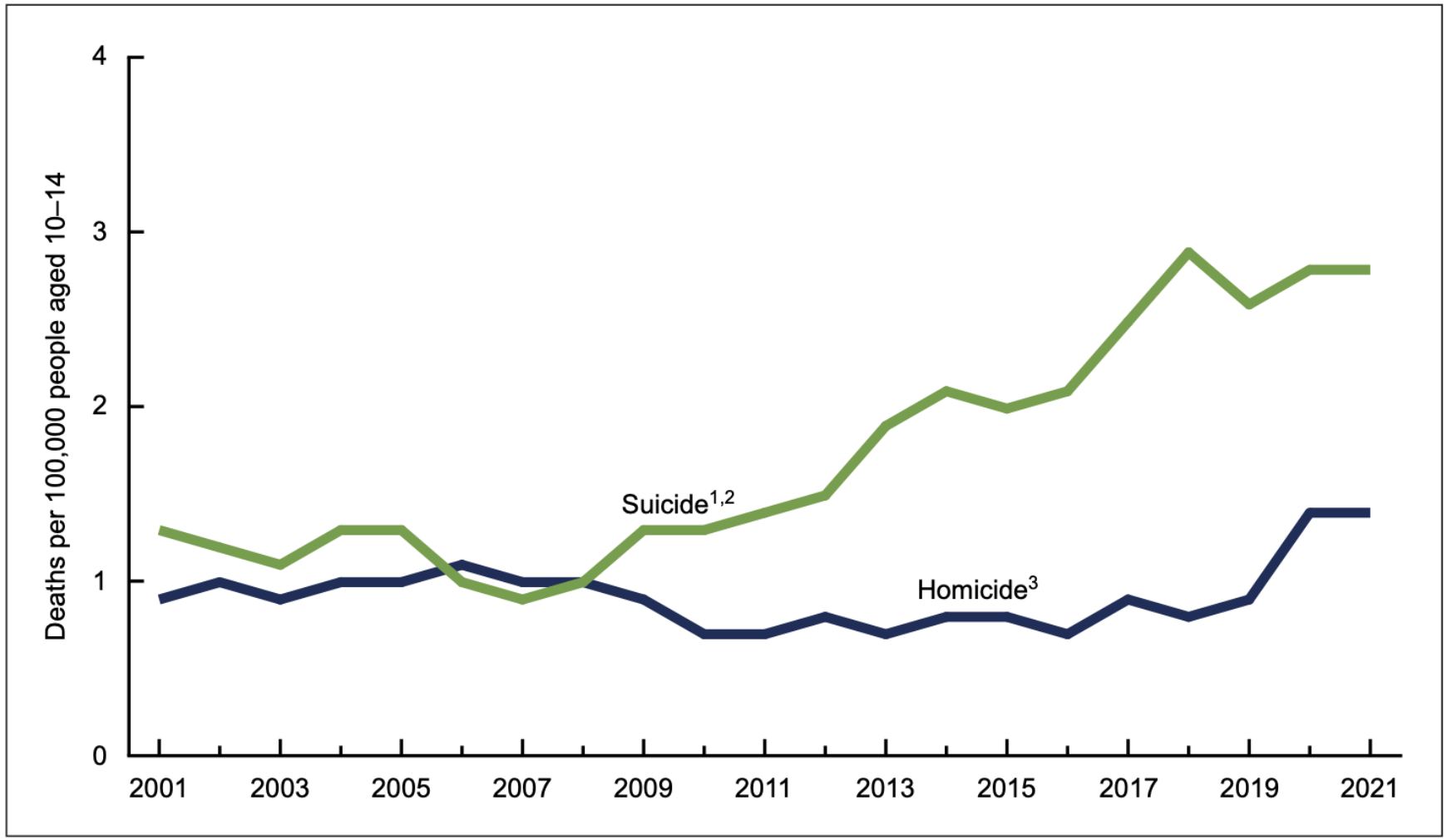
If in need of support, visit the 'Find a Helpline' online tool on the IASP website: https://www.iasp.info/resources/Crisis_Centres/

International Association for Suicide Prevention

Epidemiology

- An estimated 5.0 million adolescents aged 12-17 experienced at least one major depressive episode in 2021 (NIMH, SAMSHA)
  - 3.7 million adolescents experienced major depressive episodes with severe impairment, representing 14.7% of the total population of individuals aged 12-17.
- Comorbidities are common: of children aged 3-17 who have been diagnosed with depression, 73.8% have also been diagnosed with anxiety and 47.2% have also been diagnosed with behavior problems (DSM5-TR)
- Diagnoses of depression and anxiety are more common with increasing age
- Depression prevalence rates differ significantly by sex, race, socioeconomic status, LGBTQ+ status, and more
- Rates of adolescent depression have increased over time: 8.1% in 2009, 15.8% in 2019

Figure 2. Suicide and homicide death rates among people aged 10–14: United States, 2001–2021



[1]Significant decreasing trend from 2001–2007, then significant increasing trend from 2007–2021 ($p < 0.05$). The rate in 2021 was not significantly different from the rate in 2020 ($p < 0.05$).
[2]Rate significantly higher than the rate for homicide from 2001–2005 and from 2009–2021 ($p < 0.05$).
[3]Significant decreasing trend from 2001–2016, then significant increasing trend from 2016–2021 ($p < 0.05$). The rate in 2021 was not significantly different from the rate in 2020 ($p < 0.05$).
NOTES: Suicides are identified with *International Classification of Diseases, 10th Revision* codes U03, X60–X84, and Y87.0, and homicides with codes U01–U02, X85–Y09, and Y87.1. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db471-tables.pdf#2.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality data file.

10 Leading Causes of Death, United States

2023, All Deaths with drilldown to ICD codes, All Sexes, All Races, All Ethnicities

Unintentional Injury Homicide Suicide

	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies **4,005**	Unintentional Injury **1,275**	Unintentional Injury **684**	Unintentional Injury **914**	Unintentional Injury **14,126**	Unintentional Injury **30,163**	Unintentional Injury **36,159**	Malignant Neoplasms **32,867**	Malignant Neoplasms **101,714**	Heart Disease **554,413**	Heart Disease **680,981**
2	Short Gestation **2,922**	Congenital Anomalies **426**	Malignant Neoplasms **387**	Suicide **481**	Suicide **5,936**	Suicide **8,453**	Heart Disease **11,528**	Unintentional Injury **30,559**	Heart Disease **79,726**	Malignant Neoplasms **461,345**	Malignant Neoplasms **613,352**
3	Sids **1,445**	Homicide **275**	Congenital Anomalies **210**	Malignant Neoplasms **463**	Homicide **5,745**	Homicide **5,828**	Malignant Neoplasms **11,291**	Heart Disease **30,430**	Unintentional Injury **33,710**	Cerebrovascular **140,813**	Unintentional Injury **222,698**
4	Unintentional Injury **1,291**	Malignant Neoplasms **269**	Homicide **187**	Homicide **338**	Malignant Neoplasms **1,463**	Malignant Neoplasms **3,503**	Suicide **8,533**	Liver Disease **8,866**	Diabetes Mellitus **15,958**	Chronic Low. Respiratory Disease **125,603**	Cerebrovascular **162,639**
5	Maternal Pregnancy Comp. **1,141**	Influenza & Pneumonia **142**	Heart Disease **77**	Congenital Anomalies **192**	Heart Disease **835**	Heart Disease **3,474**	Liver Disease **5,013**	Suicide **7,653**	Chronic Low. Respiratory Disease **15,748**	Alzheimer's Disease **112,548**	Chronic Low. Respiratory Disease **145,357**
6	Bacterial Sepsis **621**	Heart Disease **131**	Influenza & Pneumonia **67**	Heart Disease **96**	Congenital Anomalies **443**	Liver Disease **1,626**	Homicide **4,487**	Diabetes Mellitus **6,653**	Liver Disease **14,764**	Unintentional Injury **73,804**	Alzheimer's Disease **114,034**
7	Placenta Cord Membranes **569**	Septicemia **68**	Septicemia **52**	Cerebrovascular **66**	Diabetes Mellitus **259**	Diabetes Mellitus **1,110**	Diabetes Mellitus **2,604**	Cerebrovascular **5,364**	Cerebrovascular **13,425**	Diabetes Mellitus **68,550**	Diabetes Mellitus **95,190**
8	Respiratory Distress **449**	Perinatal Period **54**	Chronic Low. Respiratory Disease **46**	Chronic Low. Respiratory Disease **58**	Chronic Low. Respiratory Disease **219**	Cerebrovascular **579**	Cerebrovascular **2,057**	Chronic Low. Respiratory Disease **2,641**	Suicide **7,816**	Nephritis **45,200**	Nephritis **55,253**
9	Intrauterine Hypoxia **365**	Cerebrovascular **53**	Cerebrovascular **37**	Influenza & Pneumonia **48**	Cerebrovascular **162**	Complicated Pregnancy **522**	Septicemia **987**	Homicide **2,571**	Nephritis **6,196**	Covid-19 **44,097**	Liver Disease **52,222**
10	Circulatory System Disease **356**	Covid-19 **44**	Covid-19 **26**	Diabetes Mellitus **35**	Influenza & Pneumonia **157**	Influenza & Pneumonia **458**	Influenza & Pneumonia **967**	Nephritis **2,442**	Septicemia **5,665**	Parkinson's Disease **39,238**	Covid-19 **49,932**

Applied Filters

Intent of Injury: All Deaths with drilldown to ICD codes
Years: 2023
Age: 1-14 in 5-year groups; 15-65+ in 10-year groups
Race: All Races
Number of Causes: 10
Race Year: 2018 - 2021 by Single Race

Geography: United States
Sex: All Sexes
Ethnicity: All Ethnicities

Notation:
** indicates unstable value (<20 deaths);
-- indicates suppressed value; (between one to nine deaths or nonfatal injury counts based on <20 unweighted count, <1,200 weighted count, or coefficient of variation of the estimate >30%);
--* indicates secondary suppression.

Question 2

How frequently does the American Academy of Pediatrics recommend that youth ages 12 and older be screened for suicide risk?

A. Once per lifetime

B. Once per year

C. Once per month

D. Once per medical encounter

Question 2

How frequently does the American Academy of Pediatrics recommend that youth ages 12 and older be screened for suicide risk?

A. Once per lifetime
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C. Once per month
D. Once per medical encounter

Explanation: Per the most recent recommendations from the AAP, youth ages 12 and older should be screened at least annually for suicide risk as part of their well-child visit. Screening can and should be completed more frequently in individuals who are found to be at higher risk of harm to themselves. This can include youth who are presenting with behavioral or mental health concerns, or those with additional risk factors. Screening for depression alone is not sufficient to identify suicide risk.

Source: Hua LL, Lee J, Rahmandar MH, Sigel EJ; COMMITTEE ON ADOLESCENCE; COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION. Suicide and Suicide Risk in Adolescents. *Pediatrics*. 2024;153(1):e2023064800. doi:10.1542/peds.2023-064800

How Do We Appropriately Screen?

Depression Rating Scale – PHQ-9A

- 9 Items, 5 min to complete
- Adolescent version: Age 13-17
- Scores of 5, 10, 15 & 20 are cutoffs for mild, moderate, moderately severe, and severe depression

- Appropriate screening tool for depression, not necessarily suicidal ideation or suicide risk factors

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

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?

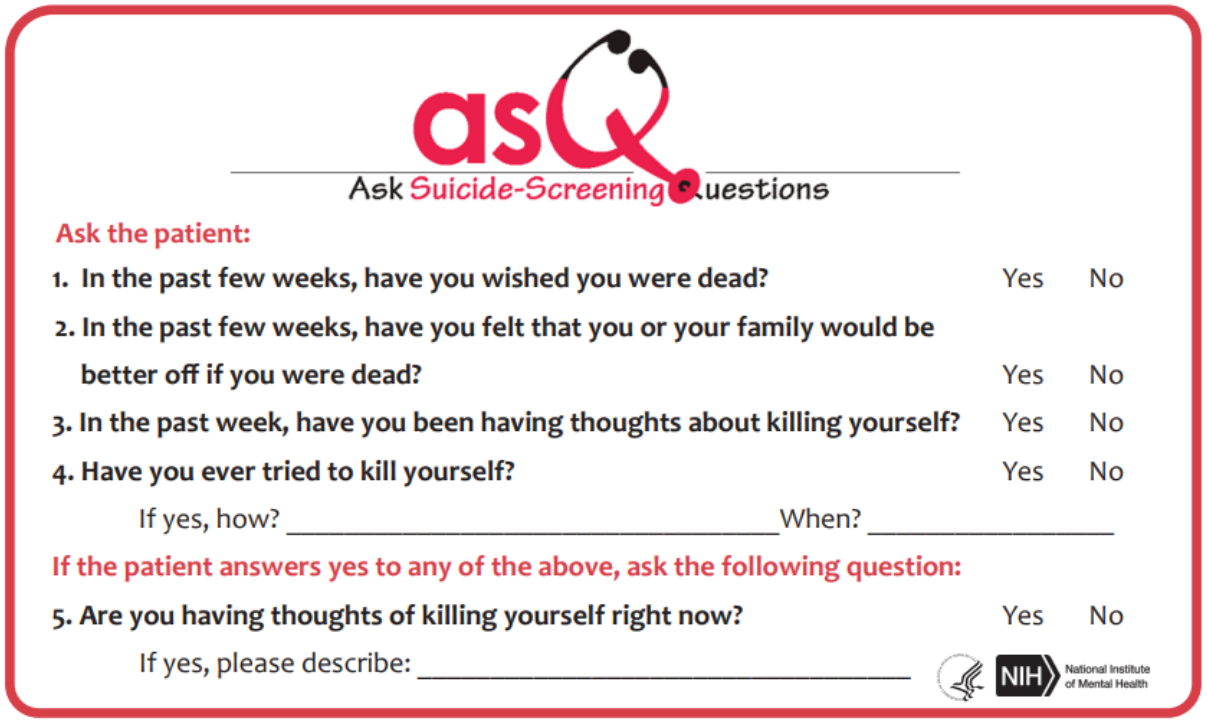
☐Yes ☐No

***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.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Ask Suicide-Screening Questions - ASQ



asQ

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 question:

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

   If yes, please describe: _____

NIH National Institute of Mental Health

Next steps:

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

Provide resources to all patients

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 7/1/2020

Columbia-Suicide Severity Rating Scale – C-SSRS

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

SAFE-T

- Developed by SAMHSA
- Designed to span age spectrum
- More of a documentation tool than a screening or assessment tool

Suicide Assessment Five-step Evaluation and Triage

- Identify risk factors
  - Note if these can be modified to reduce risk
- Identify protective factors
  - Note those that can be enhanced
- Conduct suicide inquiry
  - Suicidal thoughts, plans, behavior, and intent
- Determine risk level/intervention
  - Determine risk, choose appropriate intervention to address and reduce risk
- Document
  - Assessment of risk, rationale, intervention, follow-up

Suicide Inquiry

Ideation	Plan	Behaviors	Intent	Collateral
• Frequency, intensity, duration (last 48 hours, past month, worst ever)	• Timing, location, lethality, availability, preparatory acts	• Past attempts, aborted attempt, rehearsals, non-suicidal self-injurious behavior	• Extent to which patient expects to carry out their plan, believes the plan to be lethal	• Ask parent/guardian about evidence of suicidal thoughts/plan, changes in mood/behavior

Pearls

- Developmental age and understanding of death must be taken into consideration
- Consider social climate and cultural context when thinking about risk and protective factors
- Suicidal ideation is a spectrum
- Suicidal ideation/positive inquiry > risk factors alone
- Patients should be compared to their own baseline
- Intervention should match risk level
- Documentation does not drive good care, but it should support it

Universal Suicide Screening at Children's Wisconsin

Roadmap

Step 1
Planning

Step 2
Training and building confidence

Step 3
Implementing

Step 1: Planning

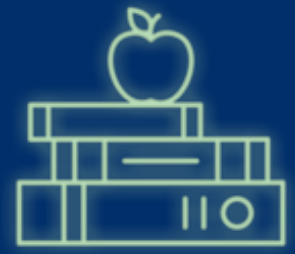
Planning Committee

- Alignment with the system strategy
- 2021 pilot
- Developed new committee in January 2022
- Presented to governing bodies

Criteria and Process

- Ask Suicide Screening Questions (ASQ) used as screening measure
  - If non-acute positive, administer Columbia Suicide Severity Rating Scale screener (C-SSRS)
- Children ages 10 and older, every 30 days
- Laminated screening tool completed upon rooming
- Best Practice Advisories (BPAs) in Epic with next steps
- Medical Social Work available for consults for positive screens

Step 2: Training and building confidence



Training

- Created refreshed education
- Developed a variety of educational materials
  - Process maps
  - Scripting
  - Competency
  - Patient-focused education
- Met with department leadership and frontline staff

Building Confidence

- Began “Life Savers” weekly meetings which served as office hours
- Hosted lunch and learns with Medical Assistants
- Staff role playing with supervisors and Medical Social Work

Step 3: Implementing

Phase 1: Jul. 2023

- Urology
- Asthma Allergy
- Endocrine
- New Berlin*
- Pain & Headache

Phase 2: Oct. 2023

- Delafield*
- Kenosha*
- Mequon*
- Complex Care
- Derm/Plastics
- ENT
- GI
- Genetics
- Herma Heart
- Infectious Disease
- Multi-disciplinary
- Nephrology
- Rheumatology
- Surgery

Phase 3: Nov. – Dec. 2023

- Fox Valley*
- East DePere*

Phase 4: Jan. – Feb. 2024

- Orthopedics
- Forest Home*
- MACC Fund (Oncology)
- Fetal Concerns

*Care closer to home locations with multi-department clinics

Mile Markers

ASQ	22,509
Total Positive	1,248 (5.9%)
Elevated	1,091 (5.2%)
High	42 (0.2%)
C-SSRS Screener	1,122
PHQ-9	3,394
Total Screens	26,995
Social Work Consults	400+

Data 7/3/23 through 1/31/24

Roadblocks

- Change management
- Parent experience
- Technology
- Finances

What's Ahead

- Technology
- Quality improvement initiatives
- Understanding our data
- Updated suicide policy
- Hiring of licensed LCSW as consultant/educator
- Acceptance into Zero Suicide

Practical Guidance for Management in the Community

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

SAMHSA

Risk Level and Intervention

- Key indicators of high-risk patients
  - Felt their attempt would kill them
  - Low chance of being found following their attempt
  - Ongoing suicidal ideation and planning
  - Reluctant to communicate about their feelings or their attempt
  - Unwilling to accept help
- Some patients are chronically at high risk of harm to themselves, so their baseline must be considered

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

But What If It's a Triage Call?

But What If It's a Triage Call?

- Develop definitions for emergent, urgent, and non-urgent situations
  - Emergent: symptoms and conditions with imminent risk of death or permanent harm-–requires immediate mental health evaluation
  - Urgent: concerning changes in behavior and function that require evaluation within 24-72 hours
  - Non-urgent: questions or concerns that can be addressed at the next available appointment or through home care advice
- Work with staff to create supportive scripting
- Incorporate your system and community resources into your workflows, as well as the individual's treatment team

<u>EMERGENT</u>: Symptoms and conditions with imminent risk of death or permanent harm

Requires *<u>immediate</u>* medical and mental health specialty evaluation.

- Threats of imminent harm to self or others (e.g., suicidal ideation with plan and/or intent)
- Aggressive behavior/outbursts that raise imminent safety concerns at home or school
- Acute mental status changes such as psychosis or delirium
- Known or suspected disordered eating behavior with objective changes in physical exam (e.g., abnormal labs, abnormal vitals, syncope)
- Ingestion in the last 72 hours
- Acute intoxication

DISPOSITION: NEAREST ED, MOBILE CRISIS TEAM, 911, OR PSYCHIATRIC HOSPITAL

<u>URGENT:</u> concerning changes in behavior and function that require evaluation within 24-72 hours.

<u>Conditions requiring same-day evaluation:</u>

- Suicidal ideation without intent or plan
- Moderate symptoms of mental health symptoms AND risk factors (e.g., depression worsening in patient with history of suicide attempt)
- Overwhelming caregiver or child distress; not able to wait until next day

DISPOSITION: PCP AND/OR BHC IF SAME DAY APPOINTMENT AVAILABLE; WALK-IN CLINIC IF NO APPOINTMENTS AVAILABLE (Note: Walk-In CANNOT see patients for medication refills or adjustments, notes for school, or conditions requiring physical exam or labs.)

<u>NON-URGENT</u>: questions or concerns that can be addressed at the next available appointment or through home care advice

- **<u>Visit needed:</u>**
  - Stable mental health condition (e.g., non-emergent/non-urgent medication side effect)
  - Able to engage in usual daily activities to some extent (e.g., grades have dropped but child still going to school most days)
  - Mild to moderate symptoms suggestive of new mental health diagnosis
  - School requests evaluation
  - Academic concerns
  - Request for referral to mental health specialist (see PCP and BHC first - may be able to treat in clinic without referral; BHC will place referral if needed and provide care to bridge to therapy appointment)

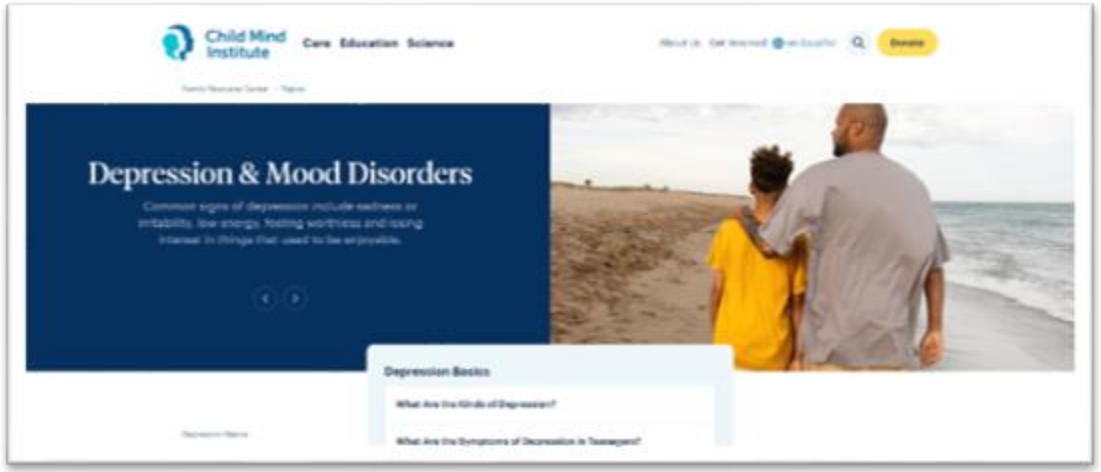
DISPOSITION: SCHEDULE WITHIN 2 WEEKS WITH PROVIDER; BHC CONSULT OFFERED AT VISIT IF INDICATED

Home care advice only/no visit needed:

- Mild-moderate headache, diarrhea, nausea, abdominal pain, or fatigue in first 2 weeks after starting a new med or a dosage change (reassurance and f/u at scheduled med check)
- Parent requests home care advice only and patient does not meet criteria for urgent or emergent response
- Developmentally appropriate behavior with minimal to moderate caregiver distress

DISPOSITION: HOME CARE ADVICE; FOLLOW UP PRN

General Resources



Crisis Resources

- **The National Suicide Prevention Lifeline, available 24/7: 988** *formerly 1-800-273-8255 (TALK)*
- Veterans Crisis Line press 1, or send a text message to 838255
- Deaf or Hard of Hearing use video relay or voice/caption at main number, or for TTY dial 1-800-799-4889
- En Español, Nacional de Prevención del Suicidio: 1-888-628-9454
- The National Suicide Prevention Lifeline can also be contacted through Lifeline Chat.

- **A list of Wisconsin county crisis lines can be found at:** preventsuicidewi.org.

- Crisis Text Line**:** Text **HOPELINE to 741741** to text with a trained crisis counselor, available 24/7.

- The Trevor Project, a crisis intervention and suicide prevention service for LGBTQ young people, available 24/7.
- TrevorLifeline, call **1-866-488-7386**
- TrevorText, text **START to 678678**
- TrevorChat, **instant messaging** (with computer)

Additional Resources

- **Mental Health America**
- mentalhealthamerica.net

- **National Alliance on Mental Illness (NAMI)**
- nami.org

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

- **National Institute of Mental Health**
- nimh.nih.gov

- **American Association of Suicidology**
- suicidology.org

- **Crisis Text Line**
- crisistextline.org

References

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders Text Revision (DSM-5-TR)* (5th ed.).

American Psychiatric Association. (2010). *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* (2nd ed.).

Bitsko RH, Holbrook JR, Ghandour RM, Blumberg SJ, Visser SN, Perou R, Walkup J. (2018). Epidemiology and impact of healthcare provider diagnosed anxiety and depression among US children. *Journal of Developmental and Behavioral Pediatrics*.

Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. (2018). Prevalence and treatment of depression, anxiety, and conduct problems in U.S. children. *The Journal of Pediatrics*.

Hua LL, Lee J, Rahmandar MH, Sigel EJ; COMMITTEE ON ADOLESCENCE; COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION. Suicide and Suicide Risk in Adolescents. *Pediatrics*. 2024;153(1):e2023064800. doi:10.1542/peds.2023-064800

International Association for Suicide Prevention Language Guidelines - https://www.iasp.info/languageguidelines/ ; Hua LL, Lee J, Rahmandar MH, Sigel EJ

Saddock, B.J. (2015). *Kaplan & Saddock's Synopsis of Psychiatry* (11th ed.). Wolters Kluwer.

Sheftall AH, Asti L, Horowitz LM, et al. Suicide in Elementary School-Aged Children and Early Adolescents. *Pediatrics*. 2016;138(4):e20160436

Substance Abuse and Mental Health Services Administration. (2009). *SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians*. Publication ID: SMA09-4432

Shea, S. C. (2002). *The Practical Art of Suicide Assessment* (2nd ed.). Hoboken, NJ: Wiley & Sons.

Shaffer, D., et. Al. (2001). Summary of the Practice Parameters for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. *Journal of the American Academy of Child and Adolescent Psychiatry,* 40(4): 495-499.

Tishler, C.L., et. Al. (2007). Suicidal Behavior in Children Younger Than Twelve: A Diagnostic Challenge for Emergency Department Personnel. *Academic Emergency Medicine,* 14:810-818.

Zun, L. S., Chepnik, L. G., & Mallory, M. N. S. (Eds.). (2013). *Behavioral Emergencies for the Emergency Physician*. Cambridge, UK: Cambridge University Press.

Q&A Discussion