



California School-Based Health Conference

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Ashlyn Davis, LCSW Mental Health Team Lead at
McClymond's School-Based Health Clinic

Lauren Haack, PhD Associate Professor, UCSF
Department of Psychiatry and Behavioral Sciences &
UCSF Weill Institute for Neurosciences

Shelly Nakaishi, CPNP Pediatric Primary Care Mental
Health Specialist at Youth Uprising\Castlemont School-
Based Health Clinic

Disclosures and Conflicts of Interest

- No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose.
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DISCLAIMERS

- We recognize that every setting is unique with its own policies and procedures, as well as team roles and resources
- This presentation is intended to share resources and best practices; all recommendations should be considered with supervisors, administrators, and relevant stakeholders in each setting before changes to policies and procedures are made

Suicide can be a sensitive topic to discuss, but talking about suicide is crucial for prevention and we are grateful that you have joined us for this important conversation. If at any point during today's presentation you feel the need to step away, please do so.

As always, if you or someone you know is struggling you can contact the Suicide Prevention Line at 988 or text TALK-TO-4741

Learning Objectives

01

Describe 2 key talking points about suicide education and prevention

02

Describe the updated AAP Suicide Blueprint universal screening guidelines

03

Practice using the ASQ and ASQ-BSSA tool

04

Describe 2 steps that should be identified in a schools postvention procedures

Agenda

3:15 pm to 4:30pm

3:15 to 3:35 (20 minutes)
Introductions & Suicide Prevention
Overview

3:35 to 3:50 (15 minutes)
Demonstration

3:50 to 4:20 (30 minutes)
Interactive role play between
participants

4:20 to 4:30 (10 minutes)
Review and closing



Discuss your own
experience and comfort
in suicide assessment
with person next to you

Common myths about Suicide/Self Harm



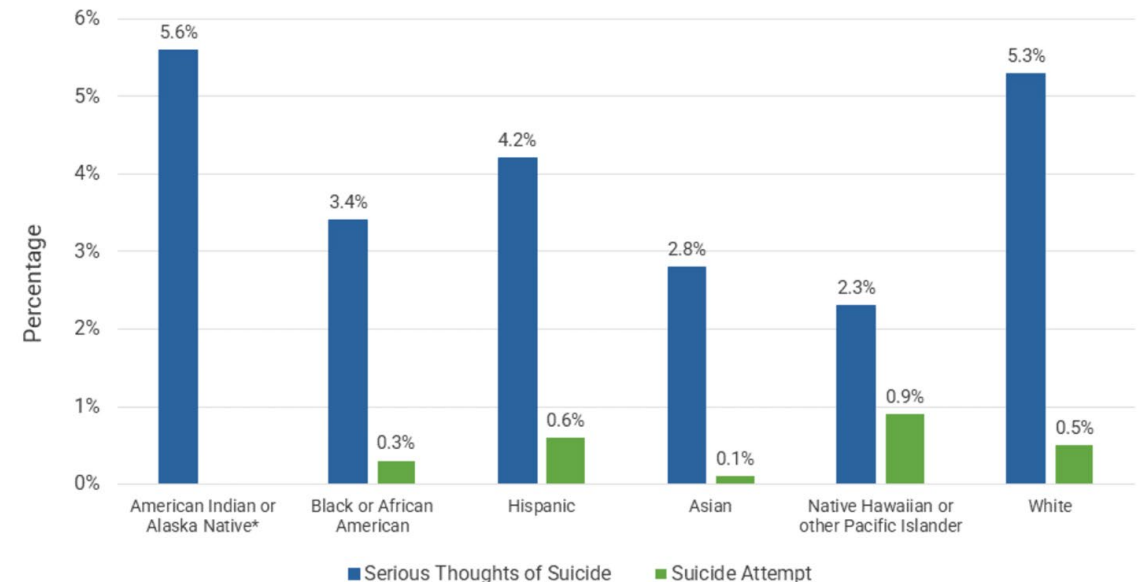
1. If I ask about suicide/self-harm, I'll be putting those ideas into patients' head
2. If I ask about suicide/self-harm, the patient will just lie anyway
3. There's nothing I can do; once a person is suicidal they'll always be that way, and we don't have any treatments that work
4. Most suicides happen without warning, so even if I ask it won't help me reduce risk
5. People who own firearms won't be willing to adjust their storage and safety practices based on facts/my advice

Why is this important?

- Suicide is the second leading cause of death in U.S. individuals aged 10-24
 - Since 2011, suicide death rates increased for all races and ethnicities (though
 - AACAP declared national emergency in 2021 due to increased ER visits (rising 24-51%)
- More young people die by suicide than the top 17 leading medical causes of death combined
- Girls account for an increasingly large share of youth suicides
- Though in smaller numbers and underrepresented in current research, pre-teens and younger children contemplate, plan, and die by suicide

SPRC | Suicide Prevention Resource Center

Past-Year Suicidal Thoughts and Suicide Attempts for Adults, United States 2020



www.sprc.org

*Suicide attempt data not available due to research limitations.

Source: SAMHSA, 2020



School setting

- FERPA
- Reports to school district
- SAMHSA Suicide Prevention Toolkit for Schools 2012
- Mental health staff (school psychologist, school nurse, school counselors, school social worker, wellness provider, restorative justice, culture/climate keeper, community school managers, etc.)

Collaboration



School-based health clinic on school site

- HIPAA
- Can include medical services (FQHC)
 - Medical providers
 - AAP Suicide Blueprint 2022
 - Medical social workers
- Can include county mental health providers – EPSDT funded

SAMHSA Suicide Prevention

A Toolkit for High Schools

*California Law,
Assembly Bill
2246 in 2017-18
must have
procedures for
suicide for 7-12th
graders*

1. Engagement

2. Procedures

1. Prevention

2. Intervention

3. Postvention

3. Training

Continuum of Strategies to Promote School Mental Health

Prevention

- Systems for promoting and preventing mental health problems

Intervention

- Systems for early intervention
- Systems for active evaluation and return to school

Postvention

- Systems for organized response following extremely adverse event (e.g. suicide, homicide, death)
- Facilitate healing & reduce negative impact of exposure



SUICIDE PREVENTION



Suicide Screening in School Setting

- Someone can feel suicidal even if they are not depressed
- Typically screening begins with general mental health screening risks
 - Schools usually have a COST team to identify and work with students who are having academic, emotional and behavioral concerns
 - Create a formalized procedure on screening for suicide if someone is identified
- Find ways for teachers, staff, students, parents to identify/communicate if there is someone at risk for suicide
- Find ways to communicate how any one can reach out for support
- Youth may be screened if they visit the school-based health clinic

Teen Suicide Warning Signs

KNOW THE SIGNS

Pain isn't always obvious, but most suicidal people show some signs that they are thinking about suicide. The signs may appear in conversations, through their actions, or in social media posts. **If you observe one or more of these warning signs**, especially if the behavior is new, has increased, or seems related to a painful event, loss, or change, **step in or speak up**.

Select a
category



CRITICAL
TEENS
THE SIGNS

Personality
change

Loss of
interest

Withdrawal

Neglect of
personal
appearance

Changes
in sleep

Sudden mood
changes

Reckless
behavior

Physical
pain

Substance
abuse

Giving away
belongings

If any of these signs are present, call or text [988](tel:988) or chat [988lifeline.org](https://www.988lifeline.org) to reach the Suicide & Crisis Lifeline.

- Talking about death or suicide
- Seeking methods for self harm, such as searching online or obtaining a gun
- Talking about feeling hopeless or having no reason to live

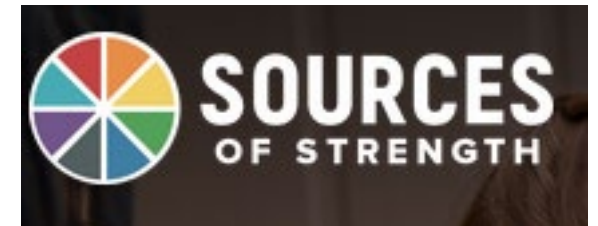
<https://www.suicideispreventable.org/>

Key talking points about suicide education

- Education about suicide
- Address blaming and scapegoating
- Do not talk about the method
- Address feelings of anger & responsibility
- Encourage help seeking
- Include resources
 - 9-8-8
 - Local mental health resources
- Teach everyone about warning signs and it is okay to ask, “are you okay?”
- **Suicide education can be included in general education when talking about mental health**

Some Peer Led Intervention Programs

HOPE
S Q U A D





Interventions

School Suicide Assessment

Training should include all STAFF to recognize warning signs for students at risk (*aka “gatekeeper” training programs*)

ONLY a professionals with some background in mental health assessments should be trained to assess suicide risk.

- School psychologist, social worker, nurse, counselor
- If none, check with school district or community mental health partners
- Note: not all mental health professionals have been trained to assess suicide risk

Suicide Protocols (School & Clinic)

From school site identified

- Principal notified
- Student not left alone
- Mental health identified crisis person completes suicide screen/assessment
- Caregiver involvement for safety planning
- Referrals and follow-up plan

From school-based health clinic on school site (known patient)

- Health provider screens for suicide
- Health provider follows clinic suicide crisis procedures
- If imminent danger, then school notified
- Caregiver involvement for safety planning
- Referrals and follow-up plan

School- Based Health Clinic Suicide Protocol

Support plan

- Who can help with other clients, who can monitor

Consultation plan – Moderate to Severe

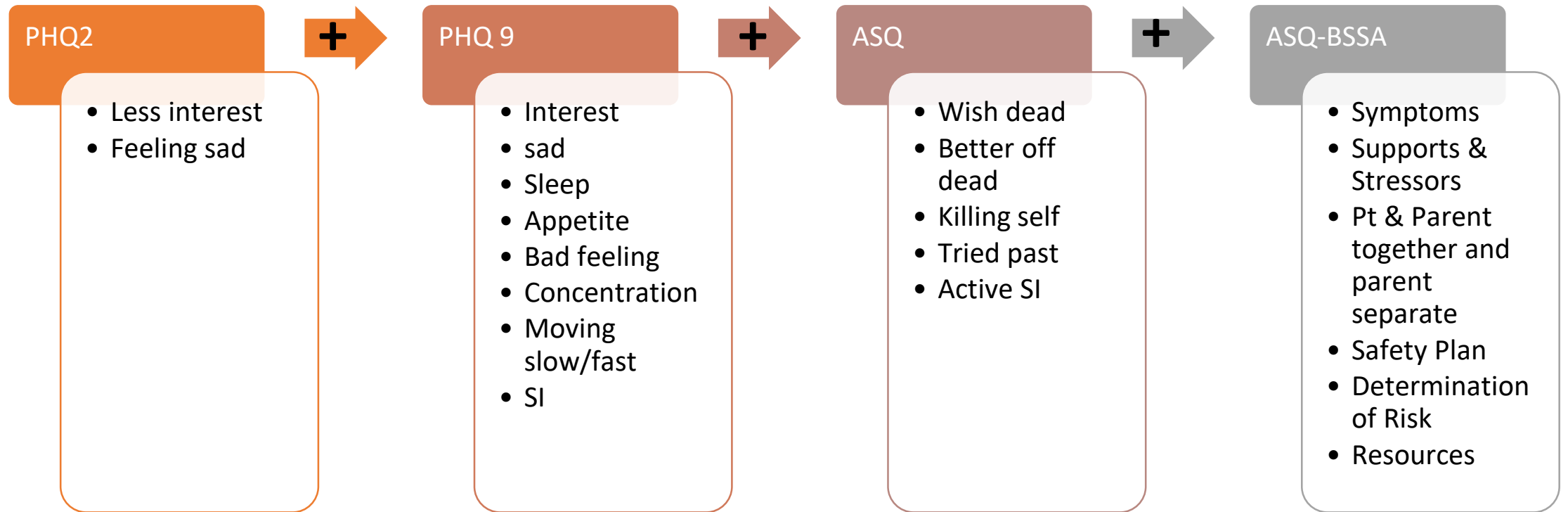
- Reduces anxiety
- Helps with risk level

Communication plan

- When/who to tell at school/school district
- When/how to call if police/ambulance/mobile crisis needed

Trauma Informed Approach

Sample 1- Current Well Child Visit (before AAP Blueprint)



This set up would only do a validated suicide ASQ screen if the PHQ2 was positive and PHQ9 was positive for SI

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®



**American
Foundation
for Suicide
Prevention**

AAP Blueprint for Youth Suicide

The American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH), created this Blueprint for Youth Suicide Prevention as an educational resource to support pediatric health clinicians and other health professionals in identifying strategies and key partnerships to support youth at risk for suicide.

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Universal Screening

1. Universal screen all patients ages 12+ years
 - *No hx of suicide risk recommend no more than 1x/month & no less than 1x/year*
2. May screen 8-11 y/o presenting with behavioral health symptom with targeted strategies – screen when clinically indicated
3. <8 years should not be screened for suicide risk, BUT we can still assess for suicide risk when a parent reports suicidal behavior, or when patient presents with depressed mood, severe irritability, or suicidal ideation or history of suicidal behaviors

Universal suicide risk screening can help support equity in suicide prevention efforts

Proposed Current Clinical practice for Well Child Visit, Not Screened in last 30 days, + in past visit, or clinical judgement

If pt was not screened yet this year, or was (+) in past visit, or (+) clinical concerns

PHQ 2 + ASQ (Suicide Screen)

- PHQ2
 - Less interest
 - Feeling Sad
- ASQ
 - Wish dead
 - Better off dead
 - Killing self
 - Tried past
 - Active SI

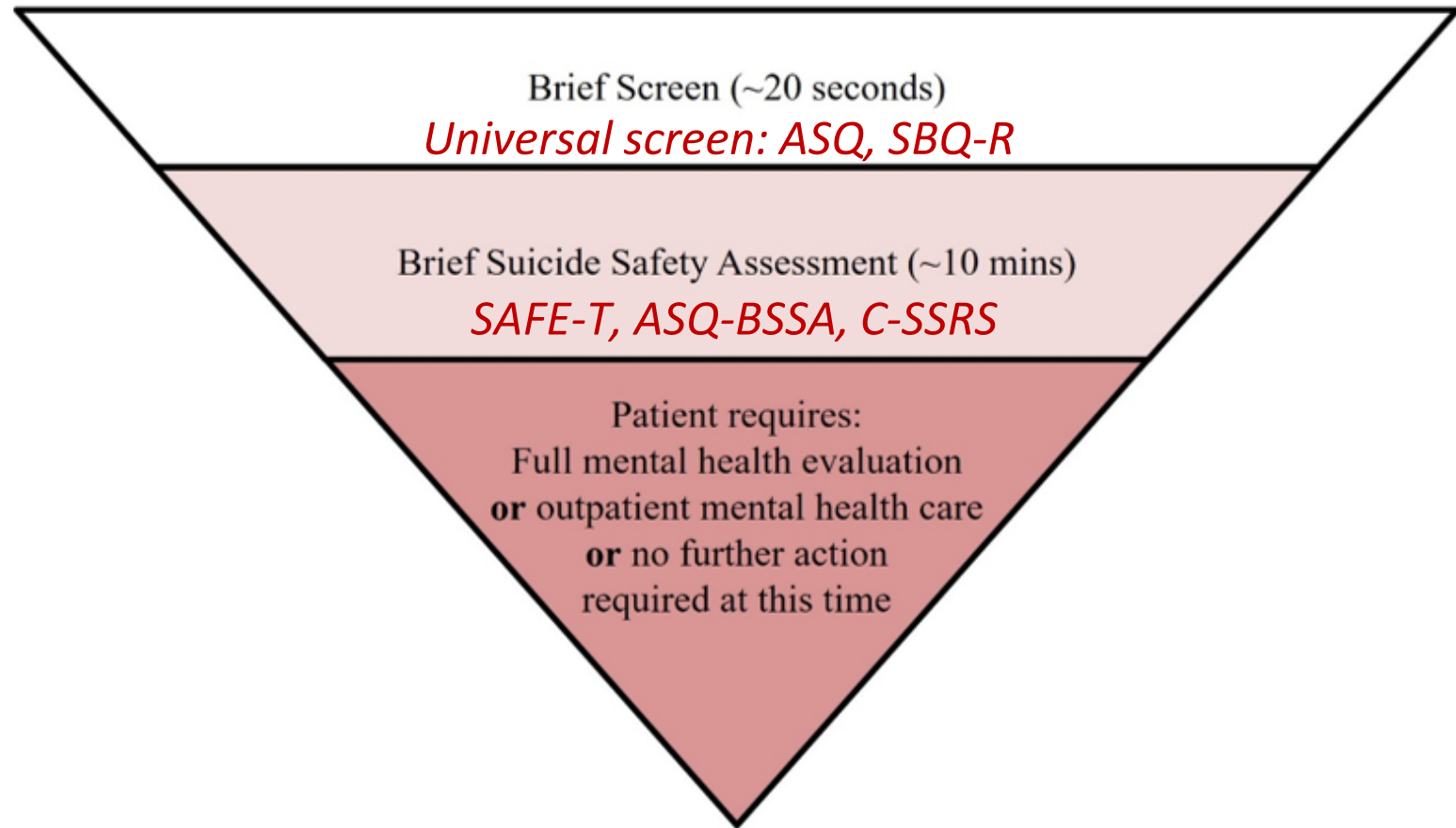
If + ASQ

ASQ-BSSA

- Symptoms
- Supports & Stressors
- Pt & Parent together and parent separate
- Safety Plan
- Determination of Risk
- Resources

Screening vs. Assessment: What's the Difference?

- Suicide risk screening
 - Identify individuals at risk for suicide
 - Oral, paper/pencil, computer
- Suicide risk assessment
 - Comprehensive evaluation
 - Confirms risk & identifies protective factors
 - Estimates imminent risk of danger to patient
 - Guides next steps



Suicide Screen: Approximately 20 Seconds

AAP Suicide Blueprint Suicide Screen Recommendations

ASQ	SBQ-R
Past few weeks, wished you were dead	Have you ever thought or attempted to kill yourself
Past few weeks, felt you would be better off dead	How often have you thought about killing yourself in past year
Past few weeks, thoughts about killing yourself	Have you ever told someone that you were going to commit suicide or you might do it
Have you ever tried to kills self, if yes how.	How likely is it that you will attempt suicide some day?
Are you have thoughts about killing self now.	

What is the Purpose of the Brief Suicide Safety Assessment?

- Opens a caring conversation about suicide prevention and mental health with youth and family
- Facilitates mental referral and f/u
- Avoids sending every youth w some suicidal ideation to the ED or mental health crisis unit
 - Process of transport/evaluation may be traumatic
 - May not lead to timely or appropriate f/u mental health care
- Can increase equitable access to care

To help clinicians identify next steps for care

- **Imminent Risk**
 - Patient requires an emergency mental health evaluation
- **Further Evaluation is Needed**
 - This is not an emergency, but patient will require further mental health evaluation from a mental health professional as soon as possible
- **Low Risk**
 - No further evaluation is needed at this time

C-SSRS Full	ASQ BSSA	SAFE-T
Wish to be dead	Past few weeks, wished you were dead?	Risk Factors: esp note: modifiable
Non-specific active suicidal thoughts	Past few weeks, felt you or your family would be better off you were dead	Protective Factors: esp note: those that can be enhanced
Active suicidal ideation with any methods w/out intent to act	Past week, thoughts about killing yourself?	Suicidal inquiry: thoughts, plan, behaviors, intent
Active suicidal ideation with specific plan & intent	Have you ever tried to kill yourself?	Determine Risk Level & Interventions to address risk
Intensity of ideation	Are you having thoughts of killing yourself right now?	Document risk, rational, interventions, and follow-up
Suicidal behavior, actual attempt (lifetime, past 3 months)	Symptoms (depression, anxiety, impulsivity, hopelessness, anhedonia, isolation, irritability, substance/ETOH, sleep, appetite, other)	<div style="border: 2px solid black; border-radius: 25px; padding: 20px; text-align: center;"> <p>Brief Suicide Assessment : Approximately 15 minutes</p> <p>AAP Suicide Blueprint Brief Suicide Assessment Recommendations</p> </div>
Interrupted attempt	Social support & Stressors (support, family, school, bullying, SI contagion, reason for living)	
Aborted or self-interrupted attempt	Interview patient & parent together. Ask parent alone.	
Preparatory acts/behavior	Make a safety plan, means restriction	
Actual lethality/damage	Determine disposition	
Potential lethality	Provide resources	

Brief Suicide Safety Assessment: Positive Screen

When a child screens positive for suicide risk, notify parents carefully and thoughtfully:

- Explain to the patient your need to talk with their parents/caregivers and talk with the patient about how they would like to be involved in that conversation
- Ask the parent/caregiver if they know about the child's suicidal ideation/behavior in a way that does not come across as blaming or judgmental.
 - For example, you can say, "Your child spoke about suicidal ideation. Is this something they have shared with you?"
 - Be aware that youth are often private about their suicidal thoughts, and it is common for parents/caregivers to be unaware of suicidal ideation or behaviors
 - **Elements of crisis precipitating suicidal ideation may still be confidential**
- Be direct and thorough in your assessment about plans, timing, behaviors, access to lethal means, supports or lack of support

Safety Plan Development: 6 Steps



Assess Suicide Risk (Beginning & End of Session)



Assess the Present-Moment Problem



Address the Present-Moment Problem



Reduce Environmental Risk
(e.g. Means, Social Isolation, Stressors)



Get & Troubleshoot Commitment

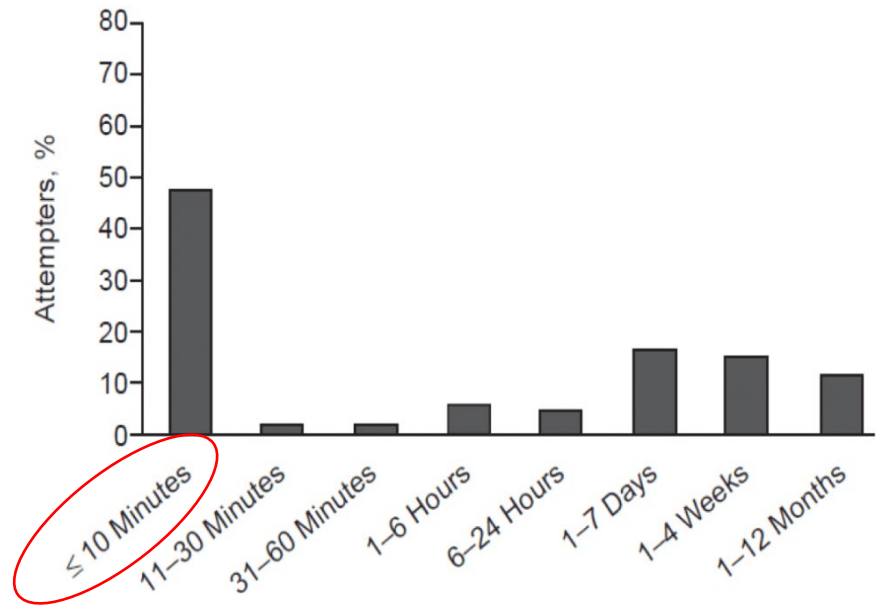


Schedule Follow-Up Contact

Means Reduction=Save Lives

- Many suicide attempts occur with little planning during a short-term crisis.
- Intent isn't all that determines whether an attempter lives or dies; means also matter.
- 90% of attempters who survive do NOT go on to die by suicide later.
- Access to firearms is a risk factor for suicide.
- Firearms used in youth suicide usually belong to a parent.
- Reducing access to lethal means saves lives.

<https://www.hsph.harvard.edu/means-matter/>



You do so much to keep your loved ones safe...

- ✓ Car seats
- ✓ Smoke alarms
- ✓ First Aid kits
- ✓ Bike helmets

LOCK UP AND LIMIT ACCESS RX MEDICATIONS AND FIREARMS

SUICIDE IS PREVENTABLE
Medication overdoses too.

Go to [SaferHomesCoalition.org](https://www.SaferHomesCoalition.org)

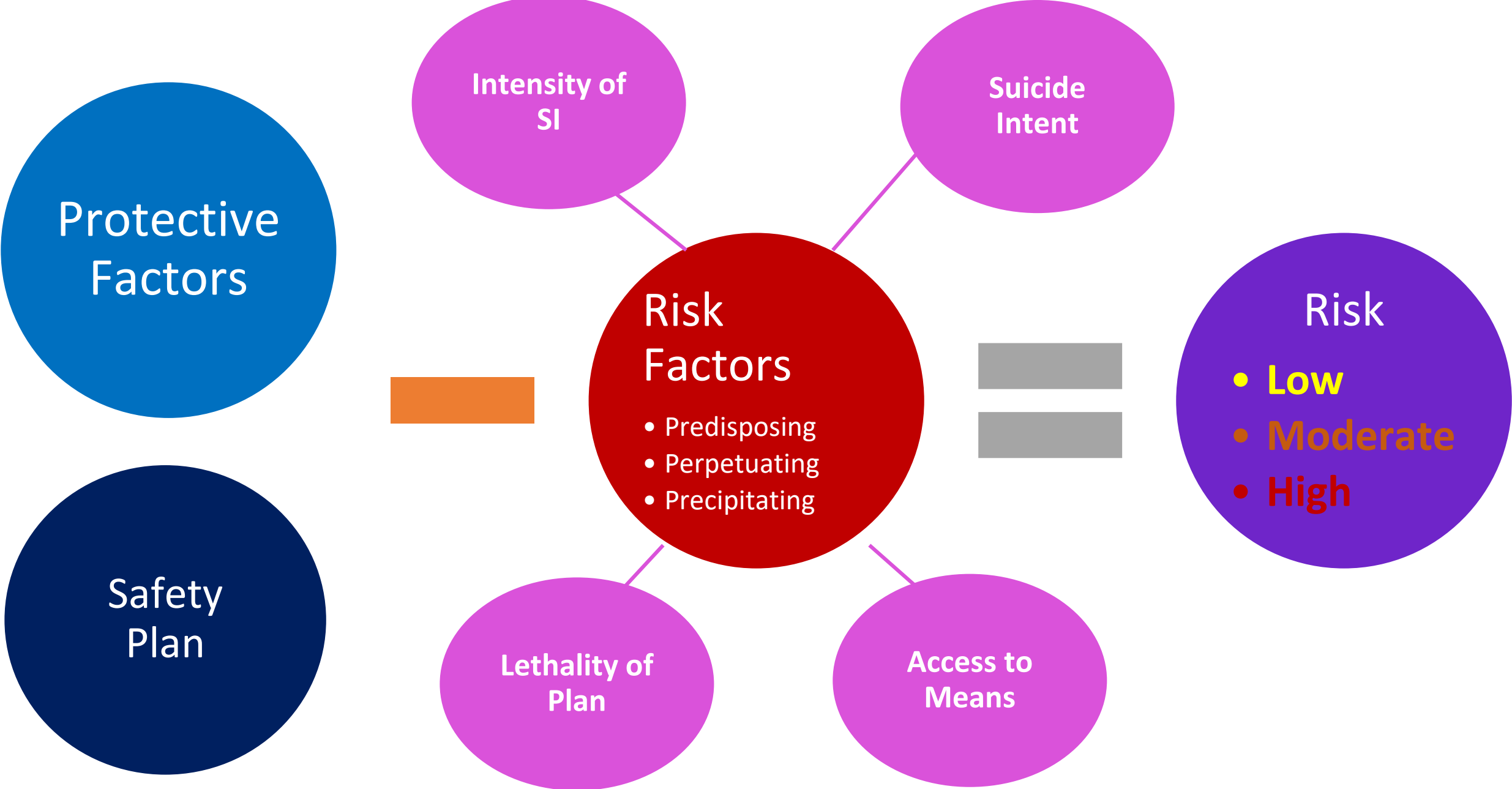
These steps protect against suicide/overdose/poisoning

LOCK UP all medications, Rx & over-the-counter, except 1-week supply	LIMIT ACCESS 1-day dose of meds for those in mental health crisis
TAKE-BACK go to takebackyourmeds.org	DISPOSE of meds with dirt or coffee grounds; place in your trash

SAFER HOMES SUICIDE AWARE

You Can Save A Life

<https://www.atrainceu.com/content/7-lethal-means-0>

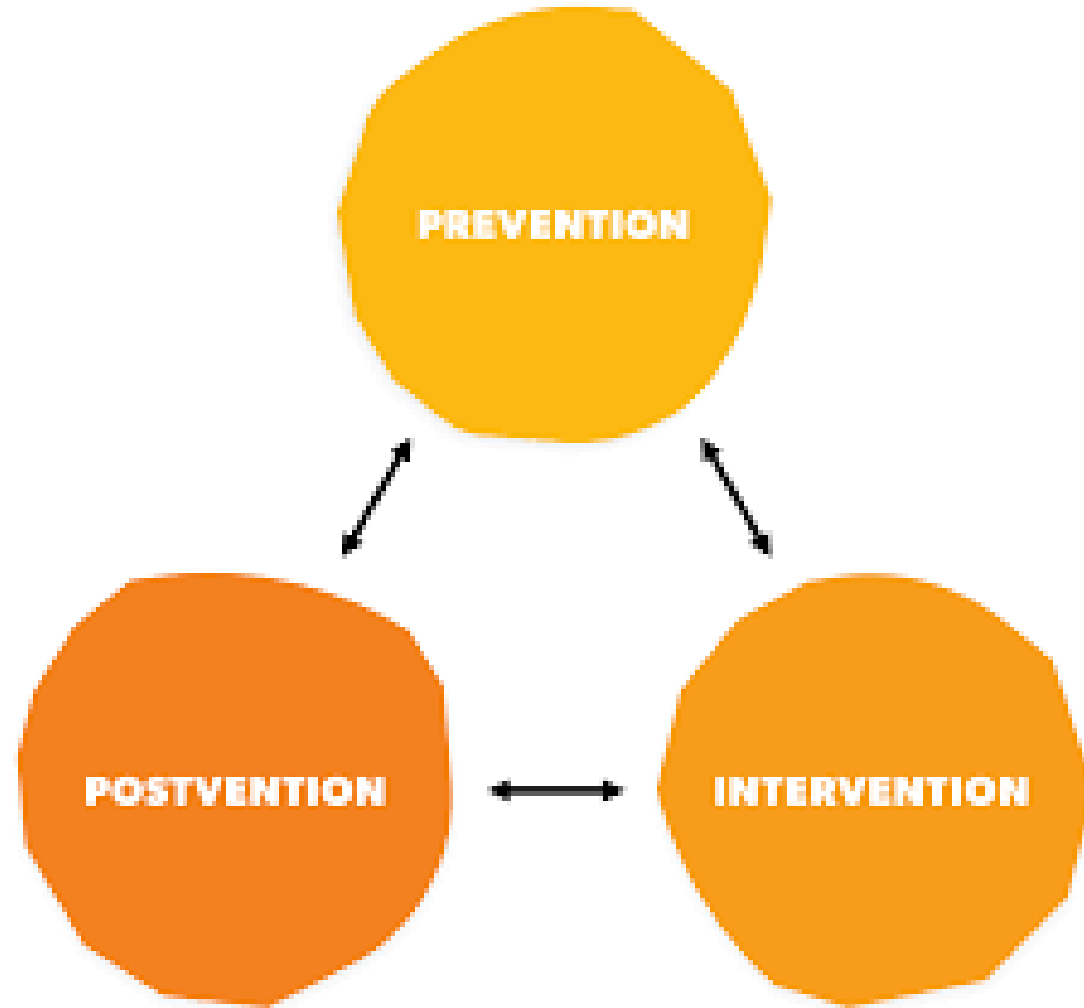


Low Suicide Risk	Moderate Suicide Risk	Severe-Acute Suicide Risk
<ul style="list-style-type: none"> • Modifiable risk factors • Strong protective factors • Ideation - frequency low • No plan • No intent • No behaviors 	<ul style="list-style-type: none"> • Multiple risk factors • Few protective factors • Ideation - frequency – often • Possible or clear plan • No intent • No suicidal behaviors 	<ul style="list-style-type: none"> • Multiple high-risk factors and severe symptoms. No supports/coping skills in safety plan • Acute precipitating event(s) • Ideation – persistent • Potential lethal plan • Strong intent • Suicidal behaviors (rehearsal)
Interventions		
Consider mental health referral	Mental health referral	Immediate safety precautions using trauma informed principles (1 on 1 observer)
Monitor for symptom reduction	Monitor for symptom reduction until seen by mental health	Collaborate with mental health provider for safety planning
Develop safety plan	Safety planning, lethal means counseling	Safety planning, lethal means counseling
	If caregiver or youth does not feel they can keep safe, sent to ED/Crisis Unit(s). Provide key info to receiving service	Transfer youth to ED, mobile crisis or for acute mental health eval. Provide key info to receiving service
	Complete 72-hour f/u (check sx)	Complete 72-hour f/u – confirm linked to services
Provide caregivers and youth with resources and suicide crisis phone #		

Postvention

At School Settings

Prevent Suicide Contagion



After a Suicide: A Toolkit for Schools

Second Edition

Postvention

1. Identify group to create protocols
2. Identify community partners
3. Immediate response protocol
 - Classroom Announcements
4. Long term response to suicide protocol
 - Memorialization guidelines same for all deaths
5. Communication (include media) & training of protocols
6. Updating the protocols

Demonstration Role Play

Lisa – 15-year-old

- Teacher was notified by a student who saw Lisa's social media posting that she felt like she wanted to die and hated school
- Teacher told Principle; Principle brought Lisa to school-based health clinic to be assessed for safety

HPI

- Lisa is a 10th grader who has been having panic attacks at school and has missed several days of school in last month after Lisa was in a fight with a school peer and the fight was posted on social media
- No current mental health services

Physical exam:

- Appears tired, one-word answers
- Notice healed cuts on left arm during your exam
- Otherwise, unremarkable physical exam or ROS

No medical conditions

Not prescribed any medications

ASQ Suicide Screen Questionnaire

[With Lisa](#)

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: _____

If "NO" to 1-4, done

If "YES" to 1-4 or no answer, =
Positive Screen

If "YES" to 5 = acute positive screen (imminent risk, full safety evaluation & maintain safety)

If "NO" to 5 = non-acute positive screen. Complete brief suicide safety assessment. Patient cannot leave until evaluated for safety.



Suicidal thinking:

- Yes, has suicidal ideation
- Yes, thinks about overdosing on Benadryl,
- No intent
- No suicidal behaviors
- No recent cutting (last time was a year ago)
- Willing to go to therapy

HEADSSSS for Lisa, 15 year old female

Home	Recent move-in with GM, Brother Father recently lost job; parents discussing divorce
Emotions/ Thoughts/ Behaviors	Panic attacks, anxiety, anhedonia, worries about family, increase social isolation, irritable, feels lonely no mania, no psychotic symptoms <i>No current therapy</i>
Activities	Working part time, Has friends, Played soccer
Diet	Appetite down
Substance Use	Marijuana 5-7 times a week, no other ATOD
School	10 th grader, Attendance good, grades slipping (now Bs, Cs)
Sex	“I’m not attracted to anybody”
Sleep	Trouble falling asleep, wakes up early, feels tired from decreased sleep, no nightmares
Safety	Uses seatbelts, no guns in home, does not feel socially safe at school. <i>History of cutting,</i>

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions 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 safety.) 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 of times a week, or every day) "When was the last time you had these thoughts?" _____"

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

It varies, a few weeks ago it was every day.

This week, not at all

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to a question about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself? 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 provided detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), consider removing or securing dangerous items (medications, guns, ropes, etc.).

I know we have some Benadryl in the house and if I took that maybe I would just go to sleep and not wake up. I have not had any intentions to do this.

Past behavior

✓ Hx of self harm

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

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

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 grouchy 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?"

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" If yes, say: "Please explain."

"Does your child seem:

- Sad or depressed?" Anxious?" Impulsive? Reckless?" Hopeless?" Irritable?"
- Unable to enjoy the things that usually bring him/her pleasure?"
- Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: Sleeping pattern?" Appetite?"

"Does your child use drugs or alcohol?"

"Has anyone in your family/close friend network ever tried to kill themselves?"

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc

ASQ-BSSA

4 Make a safety plan with the patient Include the parent/guardian

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call my hotline." "I will call _____."

- Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (medications, ropes, etc.)?"
- Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)


5 Determine disposition

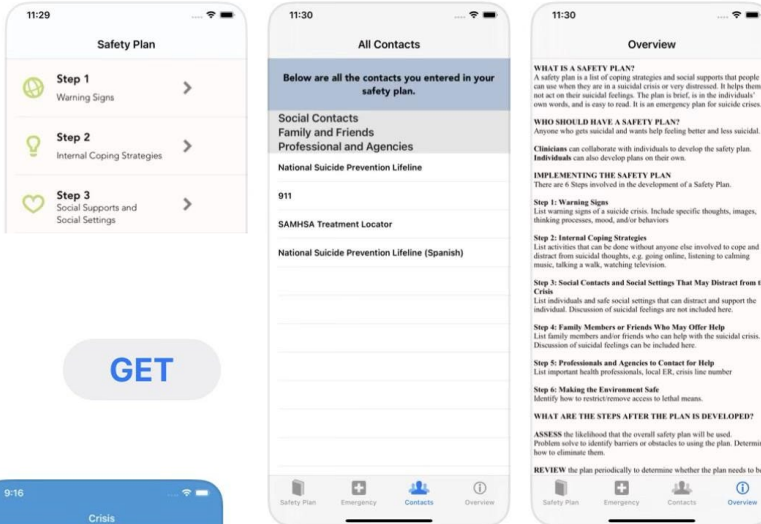
For all positive screens, follow up with patient at next appointment.


After completing the assessment, choose the appropriate disposition plan. Follow up with a check-in phone call (within 48 hours) with all patients who screened positive.

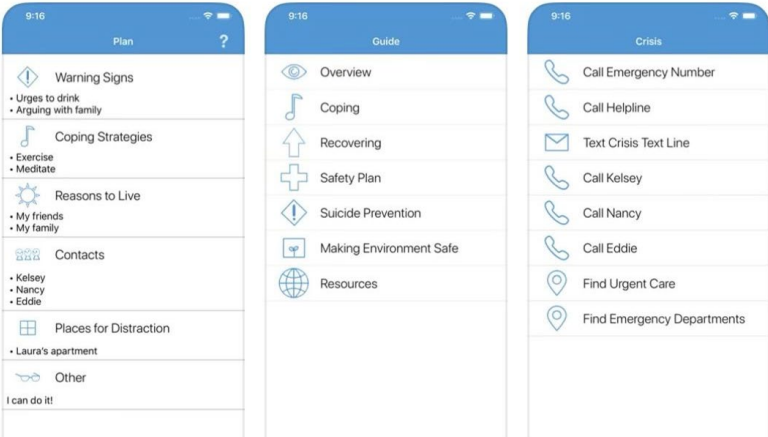
- Emergency psychiatric evaluation:** Patient is at imminent risk for suicide. Send to emergency department for extensive mental health evaluation. If a mental health provider is possible and alternative safety plan for immediate follow-up is available, consider this option.
- Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as possible (preferably within 72 hours).
- Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- No further intervention is necessary at this time.**

Safety Plans


Stanley-Brown Safety P...
Medical
★★★★☆ 6
OPEN




Suicide Safety Plan
Stay safe during a crisis
★★★★★ 30
GET



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. _____

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Sample Documentation

Suicide Assessment

Precipitating event: ***

Suicidal ideation

(onset, location, duration, frequency):

Suicidal plan: ***

Suicidal rehearsal\behaviors: ***

Suicidal intent: ***

Who else knows about suicidal feelings:

Risk factors:

Mental health concerns: ***

Substance use: ***

Psychosis: ***

Past suicide attempts: ***

Past suicide ideation: ***

Current\Past non-suicidal
self-injurious behaviors: ***

Recent psych hospitalization: ***

Sexual orientation: ***

Gender identity: ***

Trauma: ***

Recent stressors: ***

Family history mental illness: ***

Increase insomnia: ***

Assessment

[] Mild - Suicidal ideation of limited frequency, intensity, duration and specificity. No suicide plans or intent, good self-control, mild dysphoria, few other risk factors & identifiable protective factors including available social support.

[] Moderate-Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans, no intent. Limited dysphoria, good self-control, some risk factors and protective factors, including available social support.

[] Severe-Frequent intense and enduring suicidal ideation, specific plans, no subjective intent but some objective markers of intent (i.e. method chosen & accessible, some limited preparatory behavior). Severe dysphoria, impaired self-control, multiple risk factors, few if any protective factors, particularly a lack of social support.

[] Extreme-Frequent intense and enduring suicidal ideation, specific plans, clear subjective and objective intent. Severe dysphoria, impaired self-control, many risk factors, no protective factors.

Protective factors:

Strengths: ***

Available supports: ***

Activities/Hobbies: ***

Friends: ***

Family: ***

Community/Religion: ***

School: ***

Self-control: ***

Use of coping skills: ***

Future oriented: ***

Parent communication: ***

Help seeking behaviors: ***

Adherence to treatment: ***

Intervention

[] Validated current emotions for pt. Identified events that set current crisis response.

[] Formulated and summarized problem situation with pt and caregivers.

[] Discussed interventions/safety plan to reduce suicidality.

[] Provided handout on coping skills from seeking safety handout

[] Informed/educated caregiver re: means restriction and safety planning

Plan

[] Called mobile crisis/Police to evaluate for 5150/5585 transport hold, called ambulance for transport

[] Called psychiatric facility to provide key patient information for incoming psychiatric crisis

[] Referrals made to: ***

[] Completed safety plan with crisis numbers

[] Caregivers to monitor and remove dangerous items/medications

[] Consulted with : ***

Follow-up visit: *** Therapy plan: ***

A person in a grey long-sleeved shirt is demonstrating a hand gesture to a group of people. The person's right hand is held palm up, with fingers slightly spread. The background shows several other people sitting around a table, some looking towards the demonstrator. The scene appears to be a workshop or training session.

Demonstration

Interactive Role Play

A. Please pair up

1. 1 person will be a teen with suicidal thoughts/behaviors
2. 1 person will be the provider

Provider - please use the ASQ-BSSA Worksheet and Ask "Lisa" the questions, including a Stanley-Brown safety plan

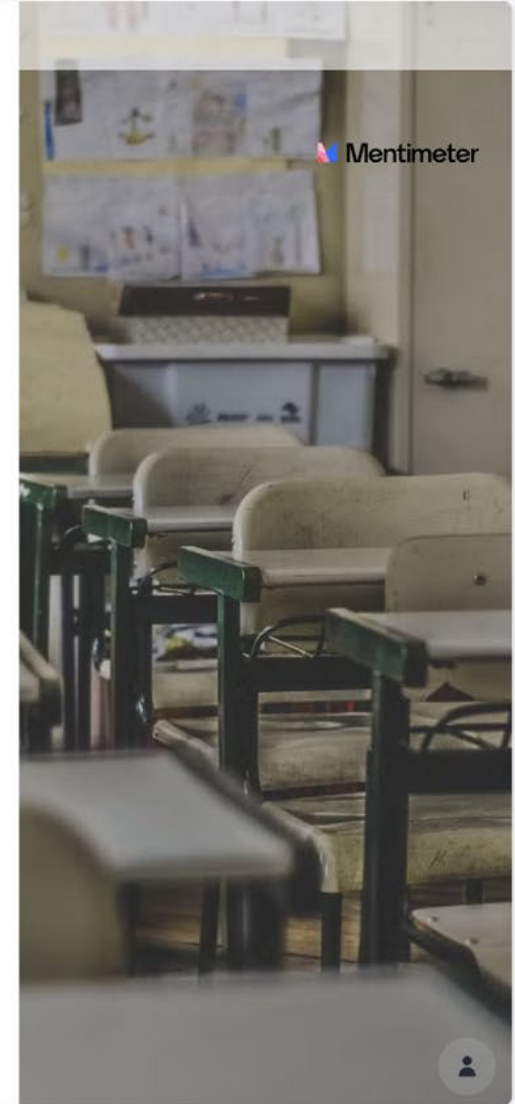
B. Once done, switch roles. Feel free to switch up the answers from Lisa

C. At the end, we will de-brief as a large group

Reflection & Feedback

Go to www.menti.com and use the code 9734 4219

What are your key take-aways from today's workshop?



Reflection & Feedback

Go to www.menti.com and use the code 9734 4219


How effective was today's workshop in impacting your ability to:

Mentimeter


Extremely Ineffective

- Apply 2 key talking points about suicide education and prevention
- Describe the updated AAP Suicide Blueprint universal screening guidelines
- Practice using the ASQ and ASQ-BSSA tool
- Identify 2 steps that should be identified in a schools post-vention procedures
- Overall, feel knowledgeable and confident about suicide prevention, assessment, and post-vention in school settings

Extremely Effective



GO TO
menti.com
ENTER THE CODE
9734 4219
0



Summary

- Suicide is identifiable, preventable and treatable
- Team-based, trauma-informed approach
- Universal screening
- Preparation with procedures and resources before getting started
- Safety planning and lethal means counseling are KEY interventions

CAPP Website Resources

capp.ucsf.edu

University of California San Francisco

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UCSF Benioff Children's Hospital
Child & Adolescent Psychiatry Portal

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Resources ▾

News & Events ▾

Provider Resources

Patient Resources

Suicide and Safety

Safety Assessment Pathway

SAFETY ASSESSMENT PATHWAY

Home > Resources > Provider Resources

Provider Resources

GENERAL
SCREENING TOOLS

ADHD &
BEHAVIORAL
CHALLENGES

ANXIETY

AUTISM

DEPRESSION

SUICIDE AND
SAFETY

SLEEP

OCD

EATING
DISORDERS

Suicide risk assessment and Safety plan

Columbia-Suicide Severity Rating Scale

C-SSRS,
AMBULATORY/OUTPATIENT

C-SSRS, FULL SCALE

NIMH ASQ (Ask Suicide-screening
Questions) Toolkit

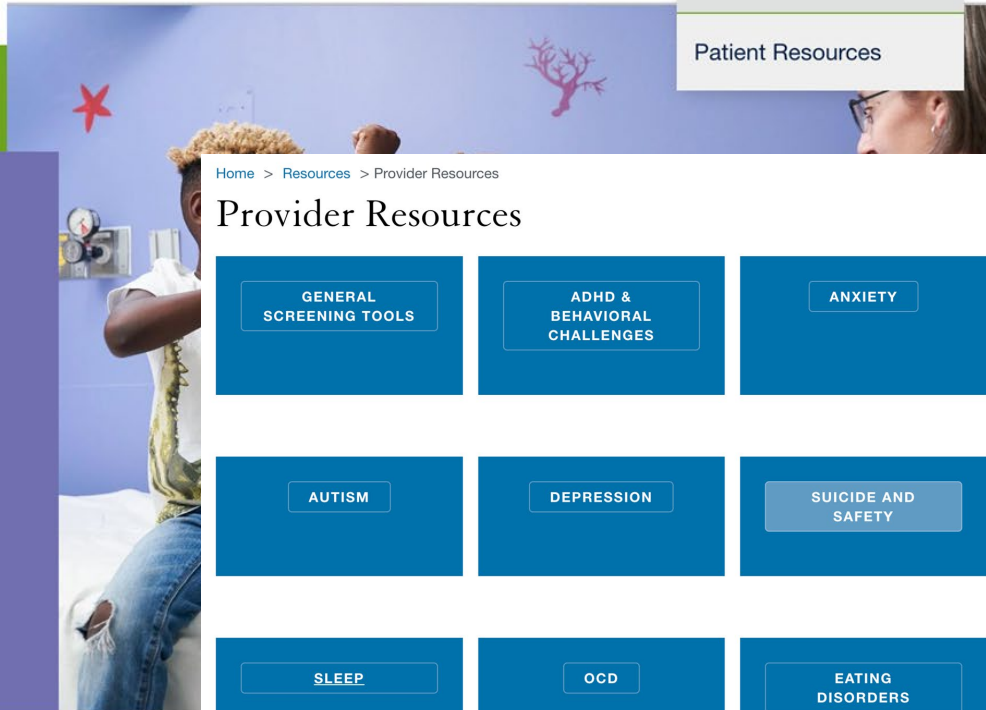
ASQ SUICIDE RISK
SCREENING SELF-REPORT

If above ASQ Screening Positive (+) >

SUICIDE SAFETY PLAN

(Stanley & Brown)

Welcome to the UCSF
Benioff Children's
Hospitals Child &
Adolescent Psychiatry
Portal



Additional Resources

- <https://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>
- <https://www.nasponline.org/resources-and-publications/resources-and-podcasts/school-safety-and-crisis/mental-health-resources/preventing-youth-suicide/model-school-district-suicide-prevention-policy>
- <https://www.heardalliance.org/>
 - <https://www.heardalliance.org/help-toolkit/>
- <https://afsp.org/after-a-suicide-a-toolkit-for-schools>
- <https://www.cde.ca.gov/ls/mh/suicideprevres.asp>
- <https://www.stanfordchildrens.org/content-public/pdf/a-handbook-for-teachers-and-administrators.pdf>
- <https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/>