Trauma Informed Suicide Prevention in Pediatric Practice

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Stellar Pediatrics

Disclosures

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Acknowledgement

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These slides include content that has been adapted from previous presentations given by Heather Forkey, MD, FAAP and Moira Szilagyi, MD, PhD, FAAP.

For more information about trauma-informed care from the American Academy of Pediatrics, visit www.aap.org/tic.

Objectives

- Describe the relationship between childhood trauma, toxic stress, and suicide risk in children and adolescents using a trauma-informed framework.
- Integrate trauma-informed communication strategies that promote emotional safety, trust, and family partnership when addressing suicide risk with youth and caregivers.
- Identify practical opportunities to build suicide-safer pediatric systems of care

National Center for Relational Health & Trauma-Informed Care
FROM THE AMERICAN ACADEMY OF PEDIATRICS

Trauma-Informed Care Defined

SAMHSA defines trauma-informed care as "a care approach that recognizes the widespread impact of trauma and understands potential paths for recovery."

The AAP defines TIC not as a specific intervention, but a **universal relationship-based approach in which all providers recognize, respond to, and prevent the effects of traumatic stress on children, families, and care teams.**

TIC integrates prevention, identification, assessment, response and recovery from trauma across all levels of care. This approach helps providers to consider a more complete picture of a patient and family's life situations – past and present – when providing care.

AAP Policy Guidance

- 2021 Policy Statement: Trauma-Informed Care in Child Health Systems
- 2021 Clinical Report: Trauma-Informed Care

Why this matters

- Suicide remains a leading cause of death among adolescents
- Ongoing mental health concerns in pediatric populations
- Pediatric settings are critical prevention points

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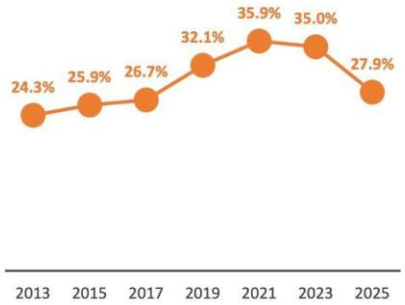
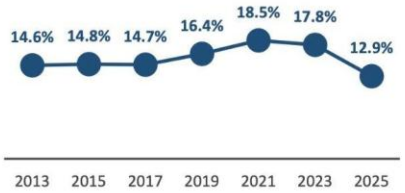
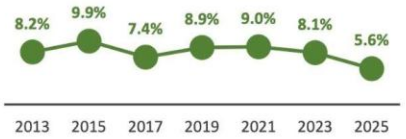
MIYHS HS 2025: Mental Health



27.9% felt sad or hopeless for 2 or more weeks (past 12 months)



12.9% seriously considered suicide in the past 12 months



5.6% attempted suicide at least once in the past 12 months

Slide courtesy of Sheila Nelson, MSW, MPH
Program Manager, Adolescent Health and Injury Prevention Program
Sheila.nelson@maine.gov

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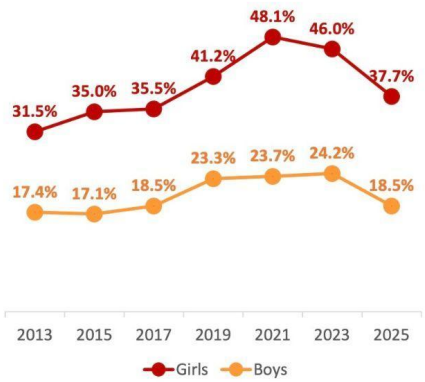
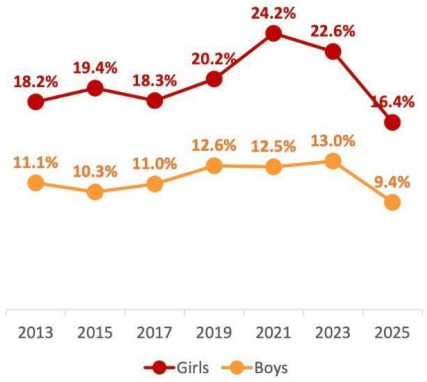
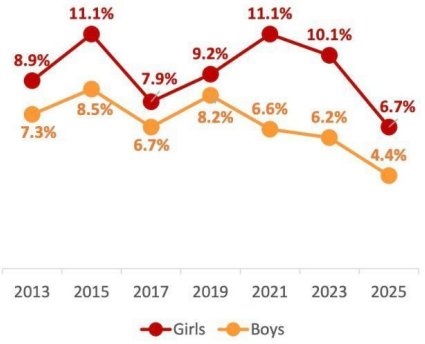
MIYHS HS 2025: Mental Health by Gender



37.7% of girls felt sad or hopeless for 2 or more weeks (past 12 months), as compared to **18.5%** of boys



16.4% of girls seriously considered suicide in the past 12 months, as compared to **9.4%** of boys



6.7% of girls attempted suicide at least once in the past 12 months, as compared to **4.4%** of boys

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Program Manager, Adolescent Health and Injury Prevention Program
Sheila.nelson@maine.gov

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Why is Trauma-Informed Care Important?

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- Many children experience potentially traumatic events.
- Cumulative childhood adversities alter biology and can negatively affect lifelong health, if not buffered by safe, stable, and nurturing relationships.
- **There is something pediatricians can do about it!**
- TIC is evidence-informed - derived from research in related fields
  - Attachment
  - Parenting
  - Resilience
  - Brain development (neuroscience)
  - Epigenetics
  - Mental health care

“Pediatric Care Advantage”

Pediatricians are ***uniquely positioned*** to play a central role in promoting healthy mental development:

- Develop a longitudinal therapeutic relationship
- View health from a developmental perspective
- Can identify immediate MH concerns, intervene early
- Promote supportive parenting behaviors
- Foster safe, stable, nurturing relationships
- Serve as a trusted source of information and support for families

Key Concept

Healthy Mental Development

- Promotion of emotional, psychological, and social wellness across the lifespan
- Determined by complex interactions between biology, relationships, and environment
- Sometimes called “Resilience”
- Mental health is not a series of diagnoses and symptoms: it’s a developmental process that occurs over the lifespan.

Relational Health

- Development and maintenance of safe, stable, nurturing relationships
- Important from infancy through young adulthood (and beyond!)
- Mental health of children and caregivers are inherently linked
- Family relationships promote resilience and positive mental outcomes for children and caregivers

Blueprint for Youth Suicide Prevention

Educational resource

- Designed for:
  - Clinicians, public health professionals, educators, advocates
- Strategies to support youth via:
  - Clinical pathways
  - Community partnerships
  - Policy and advocacy
- Co-authored by AAP and AFSP, in collaboration with experts from NIMH
- Endorsed by 18 medical/public health organizations

www.aap.org/suicideprevention

Create a Suicide Safer Practice

- Staff Training
- Workflows
- Reduce Stigma
- Clear Response Pathways

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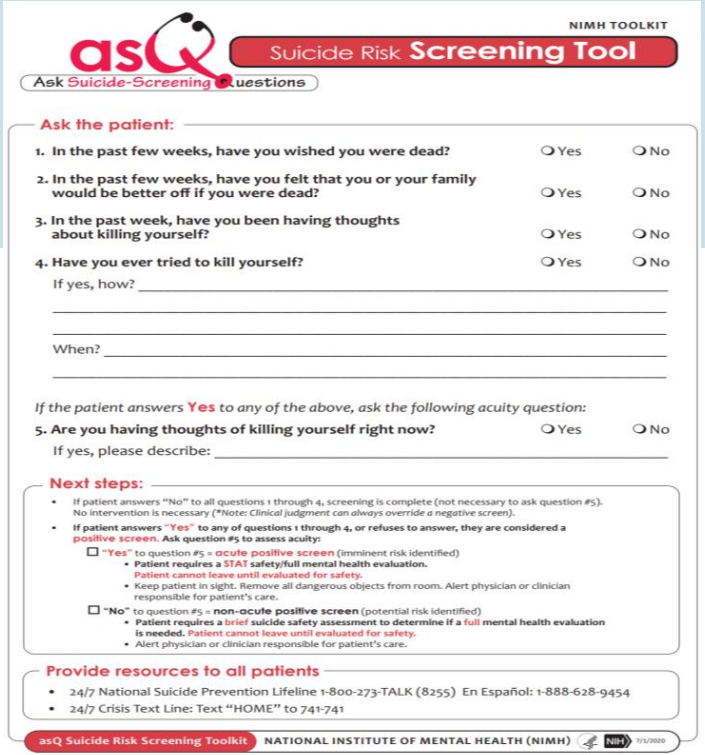
Identify Youth at Risk

- Asking questions about suicidal thoughts does not put the idea into someone's head
- Age recommendations for screening:
  - —Youth ages 12+: universal screening
  - —Youth ages 8-11: screen when clinically indicated
  - —Youth under age 8: screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present
- Anyone who is trained can screen for suicide risk



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. Have you ever tried to kill yourself? ❍ Yes ❍ No

If yes, how? _____

When? _____

If the patient answers Yes to any of the above, ask the following acuity question:

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

If yes, please describe: _____

Next steps:

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

Provide resources to all patients

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

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

Horowitz, Bridge…Pao, et al. (2012*) JAMAPediatrics*

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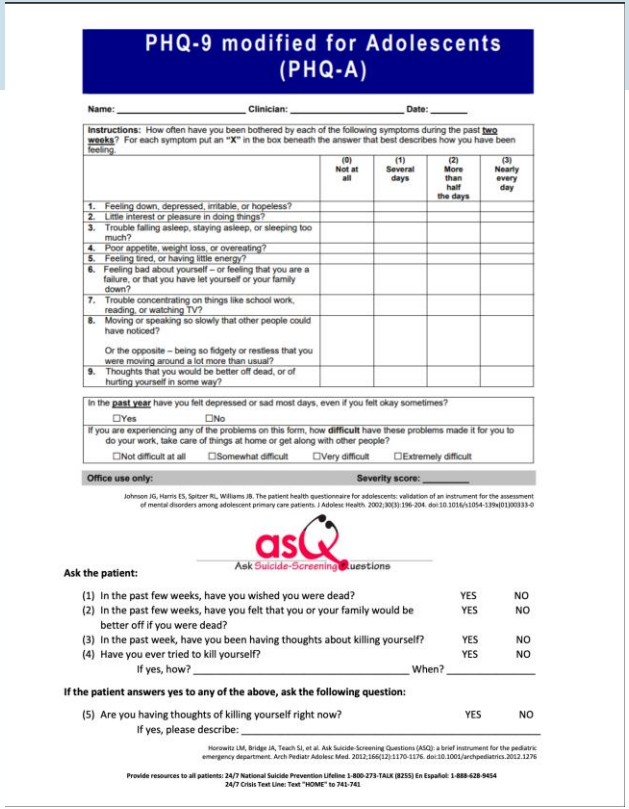
Differences between the PHQ-A and ASQ



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

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

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

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: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

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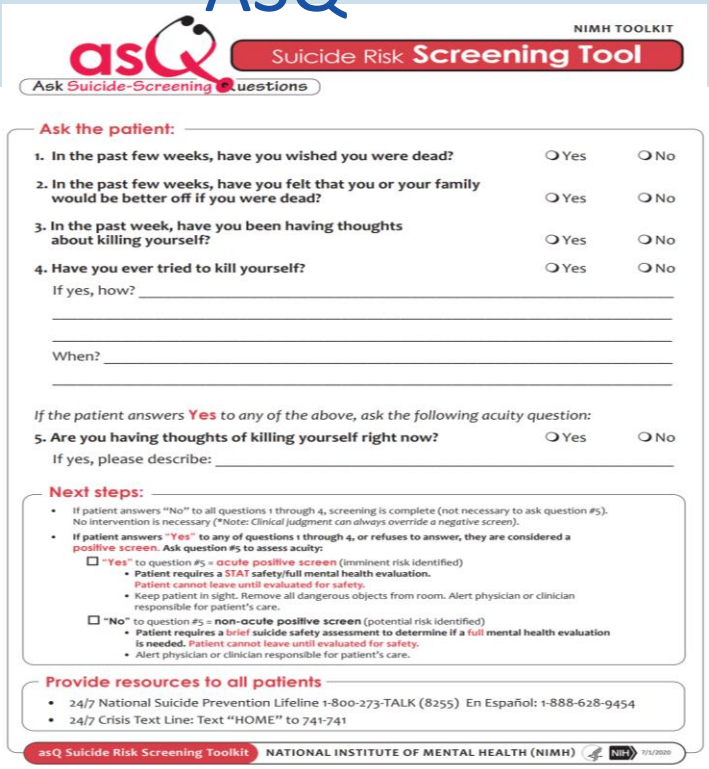

NIMH TOOLKIT

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Ask the patient:

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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:*

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   If yes, please describe: _____

Next steps:

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

To facilitate screening for both depression and suicidality we combine the PHQ-9 and ASQ into one form (PHQ-A).

Screening for depression is not screening for suicidality. Not all youth suicidal ideation is related to depression.

PHQ-A

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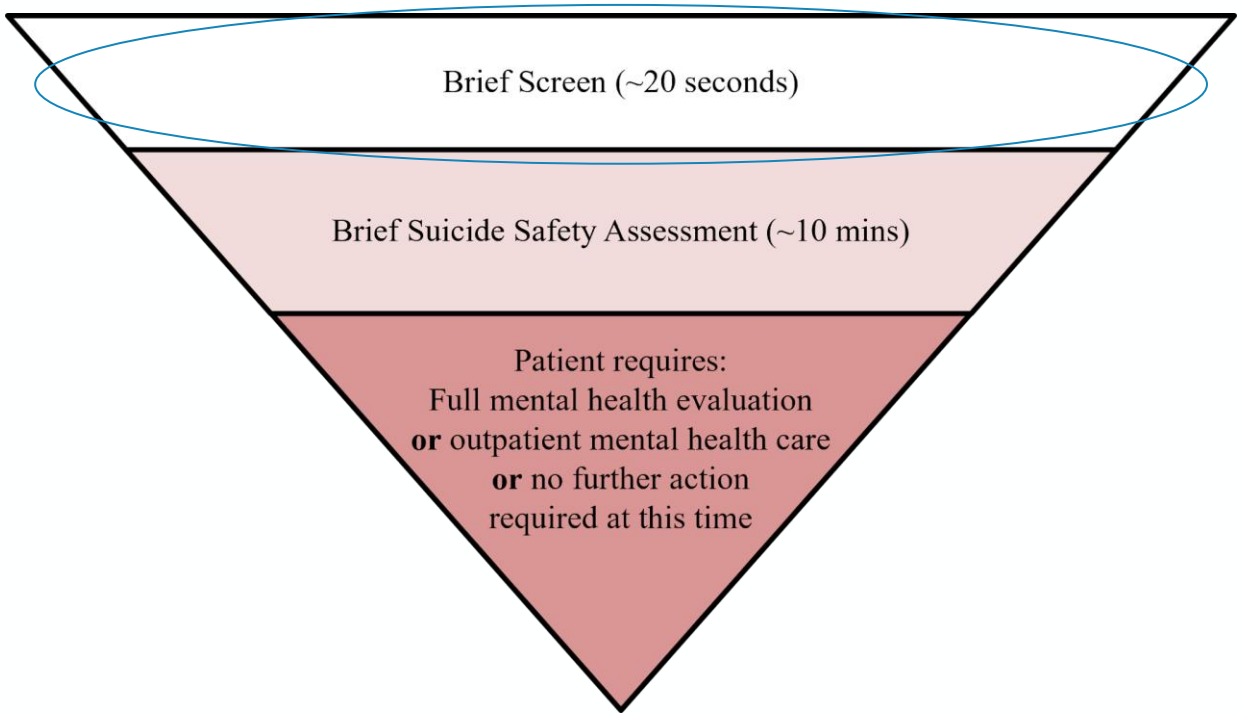
Let's Meet Jack

- 16 year old male who presents for a well visit with a history of anxiety, ADHD, insomnia, and OCD.
- He has been struggling at school and has not been attending.
- Further discussion reveals a history of bullying, social isolation, and recent depressive symptoms.

The Blueprint is Based on a 3-Tiered Universal Suicide Risk Clinical Pathway



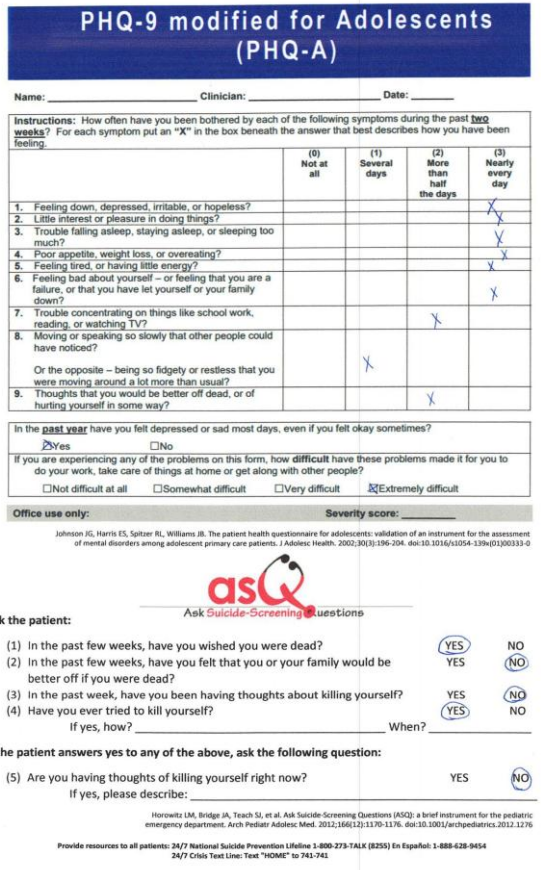
Let's Review our Patient's ASQ

What would your next steps be?

How would you approach the conversation?

What protective factors would you explore?

[PHQ modified for adolescents]



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Name: _____ Clinician: _____ Date: _____

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

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

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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: _____

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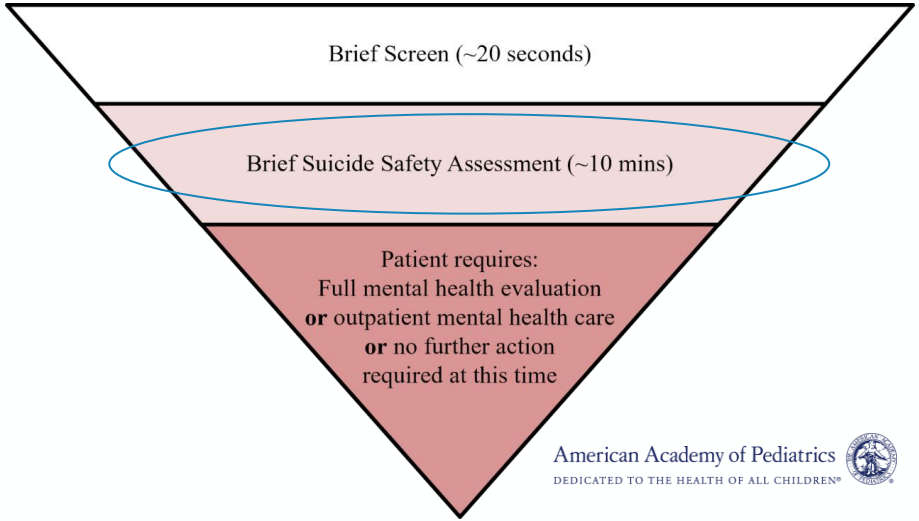
Responding to a positive screen

Here is what should NOT happen:

- Do not treat every young person who has a thought about suicide as an emergency
- The Blueprint is a guide to avoid unnecessary interventions

Here is what should happen:

Tier 2: Follow up Positive Screens with a Brief Suicide Safety Assessment (BSSA)



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The Purpose of the Brief Suicide Safety Assessment

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**

Connect Youth to Care

Refer to mental health provider when indicated by the BSSA:

- When possible, make a warm hand-off by connecting the while still in in your office.
- Follow up by phone to see if they were able to see the mental health provider.
- If there no available mental health appointments, schedule a follow-up visit with the patient (either in person or via telehealth) in a few days to “check in”.

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Return to Trauma Informed Principles

- Safety
- Trustworthiness
- Peer and family support
- Collaboration
- Empowerment
- Cultural responsiveness

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The HOW (promote safety)– Start Here!

RESET (Regulate self)
- Ground yourself and create safety
- Assume patients/ families doing the best they can
- Universal precaution re: trauma

RAISE (Raise the Concern)
- Introduce the topic with sensitivity and consent
- Neuroception
- Verbal and non-verbal

REFLECT (Hold Space Together)
- Listen, Validate
- Engagement
- Share power
- Stance of not knowing

RESPOND (with support and resources)
- Psychoeducation
- Affect management
- 3R's
- Discuss next steps – referrals, meds

Language matters

Trauma-informed communication emphasizes curiosity rather than judgment.

Examples include:

- "Thank you for sharing that with me."
- "Can you tell me more about what has been happening?"
- "It sounds like you've been carrying a lot."

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Family Partnership

Key strategies include:

- Providing education.
- Using non-stigmatizing language.
- Involving families in safety planning.
- Highlighting strengths and protective factors.
- Family partnership increases the likelihood that safety plans will be implemented successfully.

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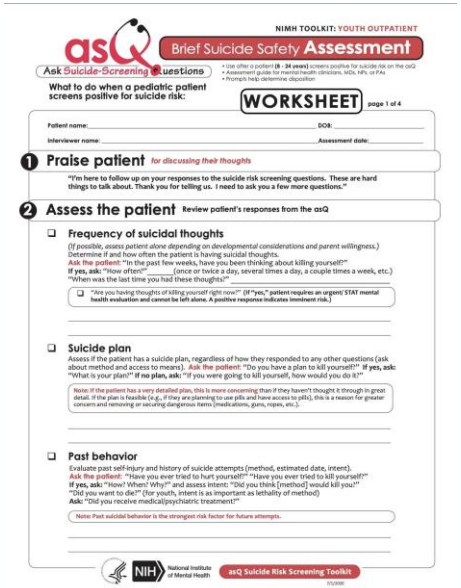
Completing the BSSA: Paper Form or EMR Integration



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

NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

WORKSHEET page 2 of 4

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

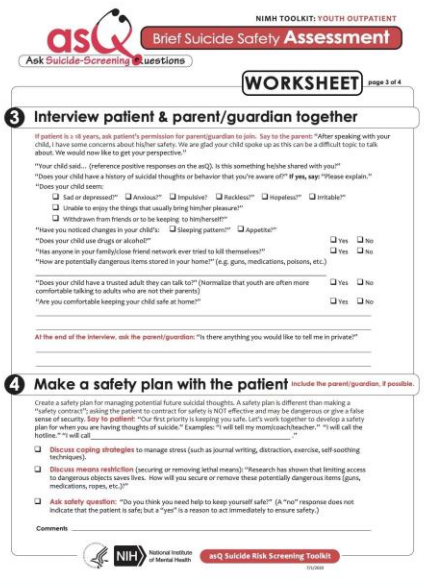
❑ **Symptoms** Ask the patient about:

- **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 grouchier than usual?"
- **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

❑ **Social Support & Stressors** *(For all questions below, if patient answers yes, ask them to describe.)*

- **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/ counselor?" **If yes, ask:** "When?"
- **Family situation:** "Are there any conflicts at home that are hard to handle?"
- **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- **Bullying:** "Are you being bullied or picked on?"
- **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

WORKSHEET page 3 of 4

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?" ❑ Yes ❑ No
"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No
"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ❑ Yes ❑ No
"Are you comfortable keeping your child safe at home?" ❑ Yes ❑ No

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient Include the parent/guardian, if possible.

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 the hotline." "I will call _____."

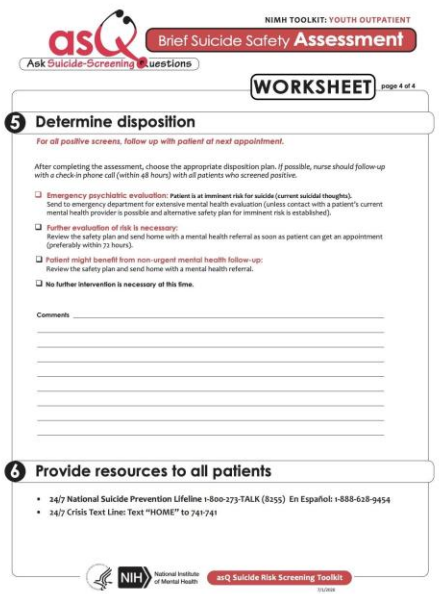
❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

❑ **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 (guns, 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.)

Comments _____

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit



NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

WORKSHEET page 4 of 4

5 Determine disposition

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

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should 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 (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).

❑ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (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.**

Comments _____

6 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

NIH National Institute of Mental Health — asQ Suicide Risk Screening Toolkit

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https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#outpatient

Practical Strategies

At the clinician level:

- Normalize screening.
- Build relational health into every encounter.

At the practice level:

- Establish workflows.
- Train staff.
- Develop referral networks.

At the systems level:

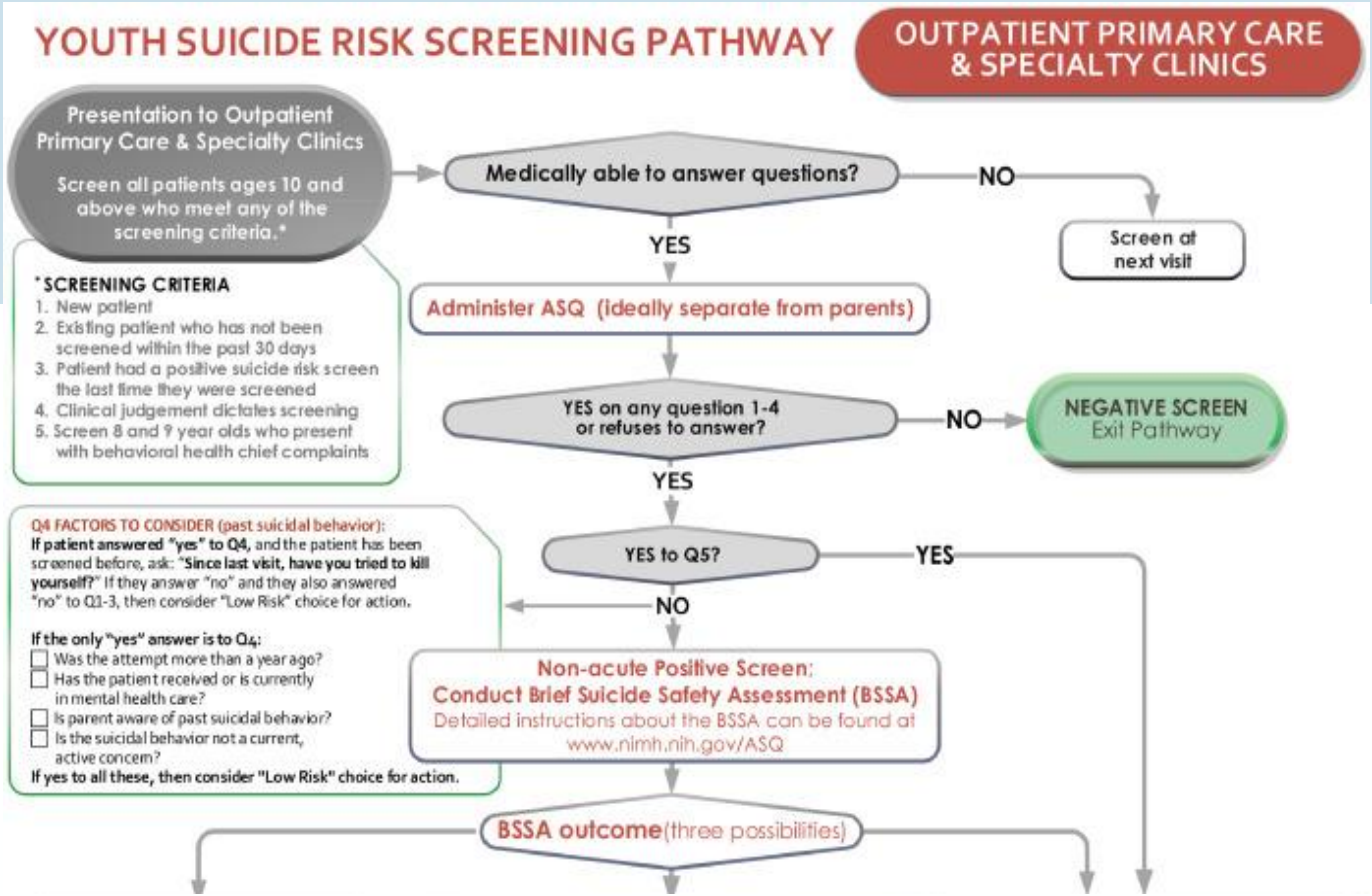
- Strengthen integrated behavioral health.
- Monitor outcomes and follow-up.
- Promote equitable access to care.

Stellar Pediatrics

Key Takeaways

- Trauma and suicide risk are connected.
- Relationships are powerful protective factors.
- The AAP Blueprint provides a practical roadmap for pediatric practices.
- Trauma-informed communication improves engagement and trust.
- Every pediatric professional has a role in promoting safety, connection, and resilience.

Stellar Pediatrics



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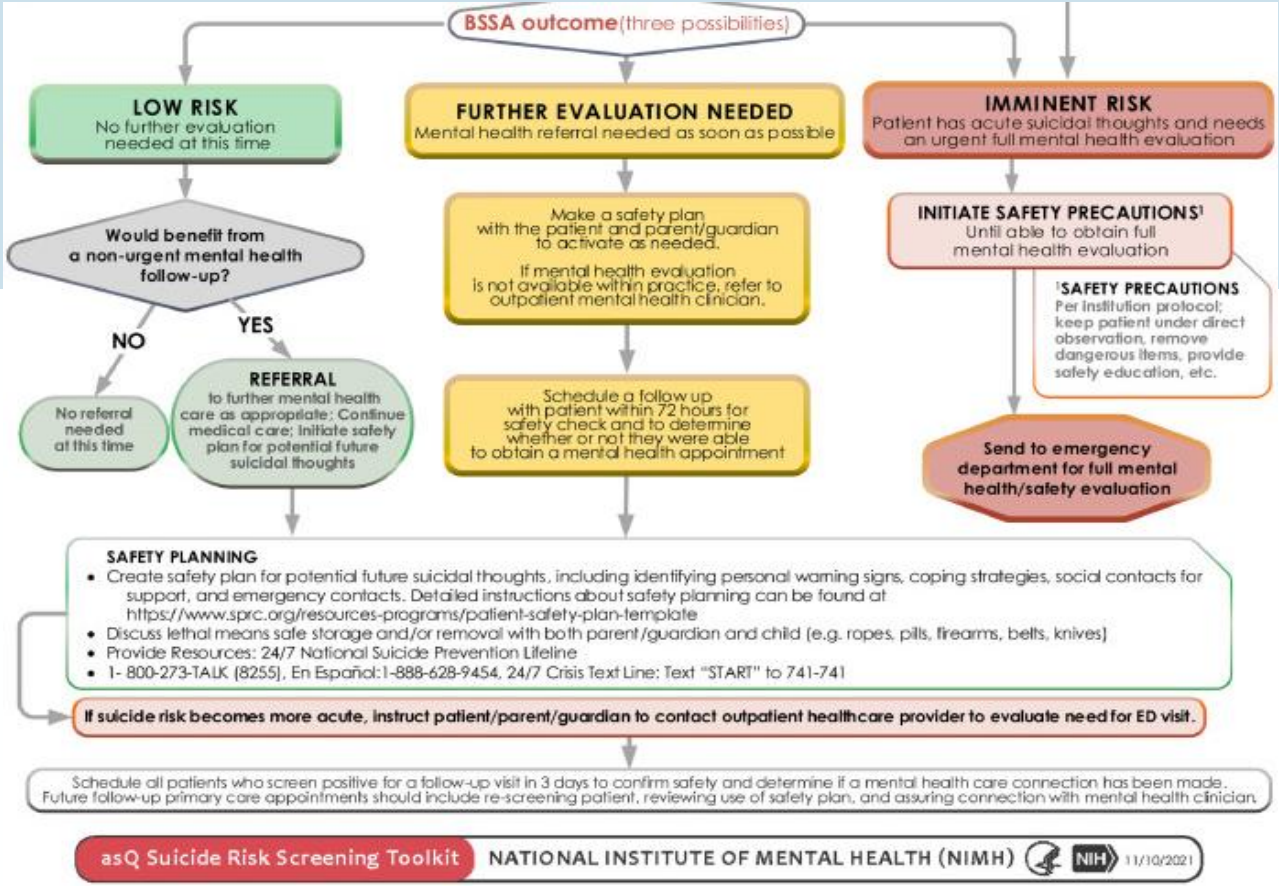

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Questions?

Thank you!

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Additional resources

- 988 Suicide and Crisis Lifeline – Dial “988”, text HOME to 741741 to reach the Crisis Text Line
  - “2” to reach Nacional de Prevencion del Suicidio (Spanish)
  - Lifeline option for Deaf + Hard of Hearing for TTY users – 711 then 988, text 988, or use the chat function available at 988Lifeline.org
- Blueprint for Youth Suicide Prevention - Organizations with community and school-based suicide prevention programs and resources
- https://www.maine.gov/miyhs/

Additional resources

- NAMI Warmline Directory
- Therapy for Latinx – Resources and Therapist directory for Latinx populations
- Trans Lifeline – Call (877) 565-8860, services in Spanish available
- Trevor Project – Call (866) 488-7386, text START to 678-678, or chat, Programs and resources for LGBTQ youth
- Safe Storage of Firearms (AAP) – video series to support health professionals
- CALM: Counseling on Access to Lethal Means (AAP) – FREE Pedialink course
- AAP Pediatric Mental Health Care Access (PMHCA) Technical Assistance Program

Brief Interventions That Make a Difference in Suicide Prevention

- Safety planning
- Lethal means safety counseling
- Providing resources
  - —National Suicide Prevention Lifeline
  - —Crisis Text Line

American Foundation for Suicide Prevention

American Academy of Pediatrics
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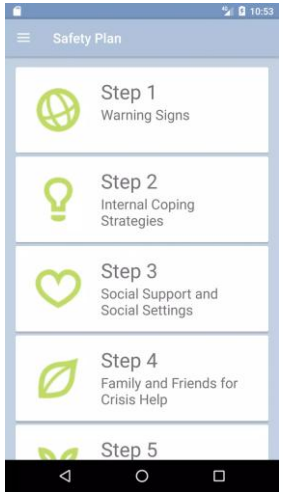
Safety Planning

Safety planning is an evidence-based and effective technique to reduce suicide risk. Working with the patient and the family, clinicians can guide patients to identify effective coping techniques to use during crisis events.

Commonly Used Safety Planning Tools Include:

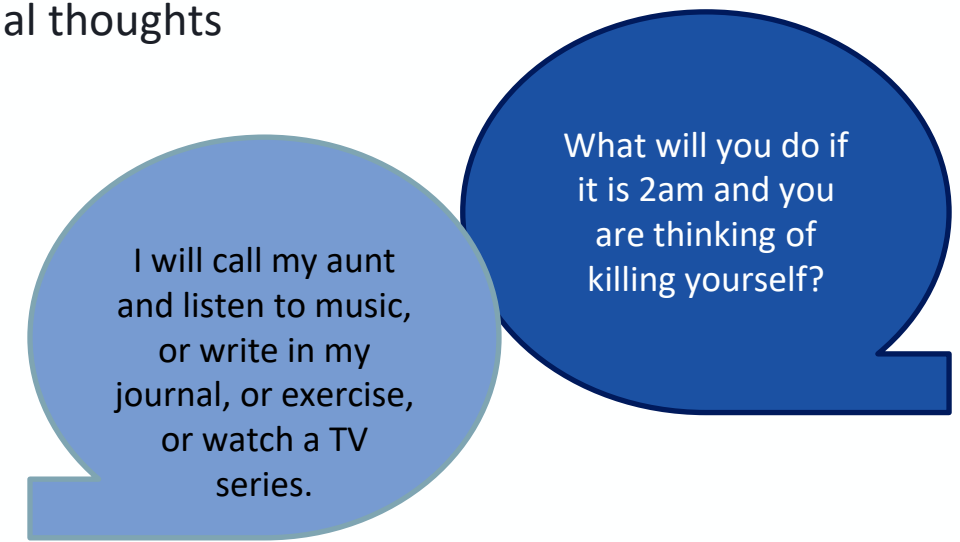
- **Stanley Brown safety planning tool** (Access tool template **here** and mobile app **here**)
- **Safety plan app**
- **Not OK**



Safety Planning

Helps patients think about what to do when they have suicidal thoughts, by identifying:

- Warning signs or triggers for suicidal thoughts
- Coping strategies
- Social contacts/supports
- Emergency contacts
- Reducing access to lethal means

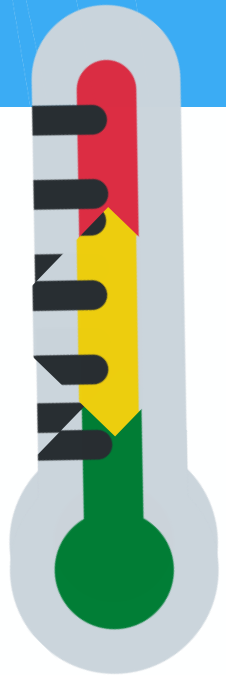


Safety Plans Should:

Thinking about safety plans in advance can help patients prepare to get through intense suicidal feelings

- Be personalized to each patient
- Be developed collaboratively with each patient and family
- Be developmentally, culturally, and linguistically appropriate to the patient and family
- Include specific activities and people to call in the event of intense suicidal feelings
- Include strategies that can be used at all times of day or night
- Include a back-up plan, such as calling the **988 Suicide and Crisis Lifeline** or texting the **Crisis Text Line**

Warning Signs



Emotional Thermometer

Develop SAFETY Plan
Warning signs

Tool to Understand and Describe Emotional States/Reactions

Identify situations likely to trigger suicidal or self-harm urges, and patterns of emotional escalation

Identify different emotional states and associated “body signs,” thoughts, and behaviors

Set foundation for identifying emotion regulation strategies for safety plan

What Can You Think to Stay Safe?

USE FEELINGS THERMOMETER

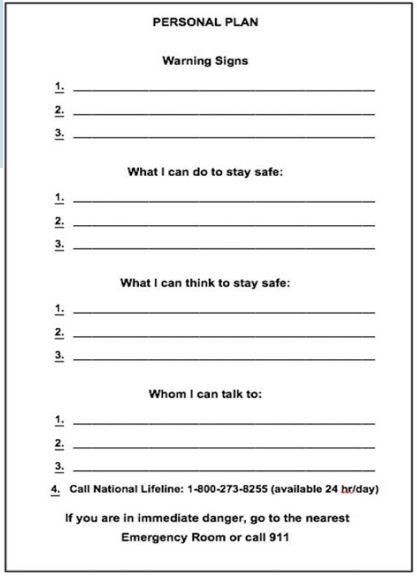
Examples:

–"When I start to think about suicide, it means I am hurting, but I don't have to act on those thoughts"

–"I'll be 18 years in two years and then be able to move out of the house"

–"I feel bad, but it would be hard on my brothers and sisters if I killed myself"

–"I have felt this way before, and I know I have the strength to pull through again"



PERSONAL PLAN

Warning Signs

1. _____
2. _____
3. _____

What I can do to stay safe:

1. _____
2. _____
3. _____

What I can think to stay safe:

1. _____
2. _____
3. _____

Whom I can talk to:

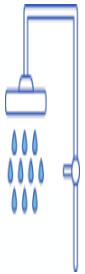
1. _____
2. _____
3. _____
4. Call National Lifeline: 1-800-273-8255 (available 24 hr/day)

If you are in immediate danger, go to the nearest Emergency Room or call 911

What Can You Do to Stay Safe?

DRAW FROM STRENGTHS

USE FEELINGS THERMOMETER



Examples:

- Go on a walk or shoot basketball
- Take deep, calming breaths
- Play video games
- Try to be around others
- Draw
- Take a cold shower or splash cold water on your face
- Listen to music

PERSONAL PLAN

Warning Signs

1. _____
2. _____
3. _____

What I can do to stay safe:

1. _____
2. _____
3. _____

What I can think to stay safe:

1. _____
2. _____
3. _____

Whom I can talk to:

1. _____
2. _____
3. _____
4. Call National Lifeline: 1-800-273-8255 (available 24 hr/day)

If you are in immediate danger, go to the nearest Emergency Room or call 911

Who Can You Talk To?

INCLUDE ADULTS ON PLAN

Examples:

- Grandma
- Older, young adult brother
- Church youth minister
- Favorite school teacher
- Coach
- Doctor
- Therapist

CONNECT

PERSONAL PLAN

Warning Signs

1. _____
2. _____
3. _____

What I can do to stay safe:

1. _____
2. _____
3. _____

What I can think to stay safe:

1. _____
2. _____
3. _____

Whom I can talk to:

1. _____
2. _____
3. _____
4. Call National Lifeline: 1-800-273-8255 (available 24 hr/day)

If you are in immediate danger, go to the nearest Emergency Room or call 911

Connect Patients and Families with Ongoing Support

Refer to mental health provider when indicated by the BSSA:

- When possible, make a warm hand-off by connecting the while still in in your office.
- Follow up by phone to see if they were able to see the mental health provider.
- If there no available mental health appointments, schedule a follow-up visit with the patient (either in person or via telehealth) in a few days to “check in”.

Follow-Up with a “Caring Contact”

- Schedule a follow-up call, virtual visit or brief in-person visit within 24-48 hours to:
  - See how the patient is doing
  - Check in on whether lethal means have been removed/stored safely
  - Ensure the family has connected with a mental health provider
  - Assure youth and families that you care about their mental health and are here to help them as they navigate this challenge
- A series of simple communications (eg, 5-10 postcards or phone calls over a 6–12-month period) after the visit can reduce suicide risk
  - **We care about you - postcard**
  - **Chickasaw Nation - card**
  - **Anything worthwhile takes time – postcard examples**

Build Community Connections

- With permission, connect with the school nurse, health center, and/or behavioral health professionals.
- Connect caregivers to a **Family Support Group** from the National Alliance on Mental Illness (NAMI) or other **additional resources** from NAMI/AFSP.
- Engage other members of the patient's community, such as community organizations (eg, Boys and Girls Club, 4H), clergy or religious leaders, or community or tribal elders.
- Learn more about **how to support a patient who is struggling**, or establish connections with a **local AFSP chapter**.

Provide Patients and Families with Educational Information

- Suicide Prevention: **What to do when someone is at risk**
- After a Suicide Attempt:
  - **Information for the person who has made an attempt**
  - **Information for the loved ones of a person who has made an attempt**
- After a Suicide Loss:
  - **Surviving a Suicide Loss: Resource and Healing Guide**
  - **Children, Teens, and Suicide Loss**

Lethal Means Safety Counseling

- Speak with caregivers about keeping dangerous items away during a crisis.
- Goal to protect child/adolescent in a "moment of crisis" by making environment safe.

"I want to help you keep your home as safe as possible for (pt name) while he's feeling this way. Because a moment of crisis can escalate very quickly, it's important that we make sure that he doesn't have access to guns, medications, or other household items that he could use to harm himself in a crisis."

Firearms

Half of youth suicides occur with **firearms**.

Suicide attempts using a firearm are almost always **fatal**.

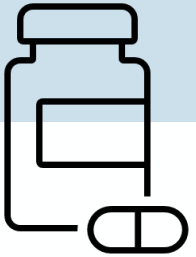
- Safest option is to temporarily remove guns from the home when suicidal thoughts occur.

"What some families do is store their guns away from home until their child is feeling better: for example, with a relative or at a gun shop. Is this a good option for you?"

- Safe storage is the second-safest option

More information is in the AAP policy, "Firearm-Related Injuries Affecting the Pediatric Population"

Medications



- Many medications (eg, insulin, prescription medications, over-the-counter pills) can become a hazard during a suicidal crisis.
- Talk with parents/caregivers about:
  - Locking up both prescription and over-the-counter medications
  - Reducing the quantity of medications in the home
  - Removing unneeded or expired medications from their home
  - Blister-packs, which can help to slow down access to larger quantities

Other Household Items

Discuss temporarily removing these products from the home or storing them safely where youth cannot access them:

- Alcohol
- Illicit drugs
- Medications
- Carbon monoxide/car exhaust
- Household cleaners and other poisonous products
- Canned dusting products
- Inhalants
- Antifreeze
- Knives, razors, or other weapons
- Ropes, belts, or plastic bags

Courses and Resources for Lethal Means Counseling

- **CALM for Pediatric Providers: Counseling on Access to Lethal Means to Prevent Youth Suicide** (AAP Course)
- **Counseling on Access to Lethal Means** (CALM)
- **Means Matter**
- **Bullet Points Project**
- **Store it Safe** (Ohio AAP)