Curbside Consult with a CAP: Suicide Risk Assessment in the Pediatric Care Setting

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There Are No Disclosures
Learning Objectives

• Describe the process for assessing for a suicide intent and plan through the use of screening and assessment tools
• Utilize 3 elements of communication when identifying suicide ideation in pediatric patients
• Identify examples of para-verbal & non-verbal communication to use with pediatric patients
• Discuss identification and examples of non-suicidal self-injury and suicide risk
• Describe the process for assessing for a suicide intent and plan through the use of screening and assessment tools
• Understand the 3-tiered process for assessing and triaging a suicidal patient
Primary Screening in Pediatric Primary Care

Dr. Melissa Wallach
Pediatric Symptom Checklist (PSC)

- **PSC-35**
  - Completed by parent of children 6-18 yrs.

- **PSC-Y-37**
  - Completed by youth 11 yrs. and up
  - Two questions to screen for suicidal ideation (#36 & #37)

- **3 Subscales** – internalizing, externalizing, attention
PSC Subscale Scoring

- **Attention Subscale:**
  - Sum responses to items 4, 7, 8, 9, 14
  - 7 or higher is considered significant

- **Internalization Subscale (Mood/Anxiety Symptoms):**
  - Sum responses to items 11, 13, 19, 22, and 27
  - 5 or higher is considered significant

- **Externalization (ODD / Conduct Disorder):**
  - Sum responses to items 16, 29, 31, 32, 33, 34, and 35
  - 7 or higher is considered significant
Secondary Screening Flow Chart

- **PSC-35 is Positive**
  - PSC-35 $\geq 28$
  - Y-PSC $\geq 30$

  - **Internalization Subscale is Positive** $\geq 5$
    - Secondary Screeners:
      - PHQ-9 / PHQ-A
      - SCARED (Parent and Child)

  - **Externalization Subscale is Positive** $\geq 7$
    - Vanderbilt or Refer to Behavior Assessment with BCBA.

- **Attention Subscale is Positive** $\geq 7$
  - Secondary Screeners:
    - SNAP-IV (Parent and Youth)
    - Vanderbilt (Parent)

- **Depression Symptoms**
  - Secondary Screeners:
    - PHQ-9 / PHQ-A

- **Anxiety Symptoms**
  - Secondary Screeners:
    - SCARED (Parent and Child)

- **Depression and Anxiety Symptoms**
  - Secondary Screeners:
    - PHQ-SADS

- **Concerns of OCD**
  - Secondary Screeners: SCARED (Parent and Child) / CY-BOC

- **Family history of bipolar and child presents with similar symptoms**
  - Secondary Screeners: MDQ
Screening for Depression

- AAP recommendation for depression screening - PHQ-9 (modified for teens)
- However, **PSC-Y-37** is a required NJPPC primary screening tool – captures more than just depression
  - If PSC-Y-37 internalizing subscale is positive, PHQ-9 can be used as a secondary tool for depression
What to do if PSC-Y-37 or other primary screening results are positive for suicidal thinking or behavior (STB)

• Administer the **ASQ, Columbia** or other secondary screening tool for suicide
  • Important to do in real time when the PSC/PHQ-9 checks positive

• As a NJPPC member, access to consultation at the Hubs is available:
  • On Screening tools and/or disposition and treatment plan for the patient
  • With Clinical Navigators at the PPC Hubs as they are trained in assessing suicide and self-harm and are available to assist with any concerns while you are climbing the learning curve.
  • With Child and Adolescent Psychiatrists (CAPs) if needed and once scheduled with the Hubs
Secondary Screening Tools: Suicide Risk Assessment

ASQ: Ask Suicide-Screening Questions

C-SSRS: Columbia Suicide Severity Rating Scale
Communicating with your Patients:
Dialogue that can help address Suicidal Thoughts and Behavior (STB) or guide clinicians through Screening Tools/Assessment

Dr. Danielle Forshee
Open-Ended VS. Closed-Ended Questions

**Open ended:**
why, what, how describe, tell me more about

**Closed ended:**
yields a yes/no response

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Open-Ended Question Examples (PSC-Y)

#26: Patient endorsed:

“Want to be with parent more than before”

• You wrote that you “often” want to be with your parent more than before. Can you tell me more about when you find yourself wanting to be with your parent?

#25: Patient endorsed:

“Taking unnecessary risks”

• You wrote you have “often” been taking unnecessary risks. Can you give me an example of an unnecessary risk you recently took so I can understand better what you mean?
Open-Ended Question Examples (PSC-Y)

#36: Patient endorsed “yes” to:

“During the past 3-months, have you thought of killing yourself”?

• You wrote “yes”, that you have had thoughts about killing yourself during past 3 months. If I could be in your head and hear what these thoughts are, what would I hear you saying/telling yourself?

• What does it mean to you, to have thoughts of killing yourself?

• Out of the 7 days a week, how many days do you find yourself having thoughts of {insert here the words/thoughts they told you}

• Tell me about the most recent time you had one of these thoughts and what was going on/what happened?
Three Elements of Communication

1. Ask targeted, non-leading, open-ended questions;
2. Summarize often using their words;
3. Salt & peppering of empathy/validation
Leading VS. Non-Leading Questions

Leading:

A question that suggests the answer or contains information you are looking to have confirmed ("You don’t have suicidal thoughts anymore, right?")

Non-leading:

A question that allows the individual to offer a range of thoughts, opinions, beliefs and feelings ("Tell me about your thoughts of suicide since the last time we saw each other")

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Assessing for Intent & Plan: Question Examples

- Can you tell me if you have ever tried to kill yourself {or insert the word they used here} before?
- When is the last time this happened?
- Can you tell me the story of what happened?
- How did you come up with the idea to {insert their word here}?
- How far did you get?
- What happened that you stopped?
- Can you tell me some reasons for not wanting to live at the time?
- Are you have the same or different thoughts now?
- What are your thoughts about the fact that you are alive right now?
- Can you tell me some reasons for wanting to live?
Asking Questions: General Tips

- Use your patients’ words as much as possible. If they use the word “suicide”, this is the word you should continue to use with them;
- Use often: “Tell me more about what you mean when you say” {insert their word/phrase here};
- Use often: “Has anything like this happened before?” “Tell me about the most recent time”;
- Use often: “What do you think you need right now”?
- Use often: “What do you think your {whoever is with them at the appointment}, or I could do to help you with this?”

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Function of Summarizing

- Ensures your patient feels heard and understood
- Builds rapport quickly = trust
- One aspect of active listening
- Acts as a natural screening measure to ensure you are both talking about the same thing

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Para-Verbal & Non-Verbal Communication

Para-verbal: How you say it (38%)
• Speed, pitch, energy level, tone

Non-verbal: Behavioral (55%)
• Posture, eye gaze, expression, gestures
Examples: Expressing Empathy & Understanding (Para-Verbal & Non-Verbal)

• If your patient is sitting, sit; if their volume is low, transition yours to match;
• Generally, mirror your patient as much as possible para-verbally & behaviorally;
• Nonverbal communication is rooted in the brain: humans have mirror neurons that respond equally when we perform an action;
• Keep an open body position;
• Maintain eye contact & focus only on the patient;
• Ensure your facial expressions are consistent with your words
Examples: Expressing Empathy & Understanding (Verbal)

- "It sounds like you’ve been feeling really alone with these feelings/thoughts for quite some time”;
- “It really sounds like you feel trapped and out of options”;
- “Now that you’ve explained more, I have a better understanding of why you’re struggling so much/what you’re struggling with”;
- “Most would probably have trouble with that too”;
- “I see what you’re saying”;
- “I know it’s really scary and uncomfortable to talk about these things…”

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Non-Suicidal Self-Injury (NSSI)  
Dr. Forshee

The intentional direct injuring of body tissue without suicidal intent
NSSI: Prevalence & Forms

- NSSI is highly prevalent:
  - 13-45% of adolescents; 15% of college students;

- Typically appears
  - Between 14-24 years of age;

- Most common forms:
  - Skin cutting (70-90%);
  - Banging or hitting (21-44%);
  - Burning (15-35%)
NSSI & Suicide Risk

- Research suggests that those who engage in NSSI are at a higher risk of committing suicide, and were/are to have likely experienced suicidal thoughts.
- Therefore, when you notice or have been informed that your patient has cuts/burns, etc., it is imperative to assess these as you would suicide.

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Potential Functions of NSSI

• Affect Regulation
• Anti Dissociation
• Anti Suicide
• Interpersonal Influence
• Interpersonal Boundaries
• Self-Punishment
Open-Ended Question Examples (NSSI)

Scenario: You notice cut/burn marks (scabbing, new or scarring) on the patient’s body.

What to do:

1) Point out your observation: “I can see here (show the patient) you have these marks”;

2) Inquire: What can you tell me about this/these? How did it happen? Can you tell me what was going on right before this happened? How were you feeling when this happened? How did you feel after it happened? Has this happened before? When is the first time this happened? Last? What did you use? How did you know when to stop? Does anyone else know?
Generally, What Not to Do When Asking Questions about Suicide/NSSI

- Assume what the individual is thinking or feeling;
- Assume your idea of a “suicidal thought” or “killing yourself” is the same as your patients;
- Assume NSSI is the patients attempt at suicide;
- Self-disclose;
- Appear overly concerned about what you are hearing;
- Have concerns about/avoid inquiring. Talking openly about suicide/NSSI will not increase emotional distress/evoke increased suicidal thoughts/intent. Openly addressing these topics provides a sense of relief to the individual;
- Become a victim of emotional contagion;
- Try to convince them they should not feel the way they are feeling;
- Get sucked into irrelevant details

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Resources

- Suicide Prevention (AAP)
- Society for the Prevention of Teen Suicide (SPTSUSA)
- Suicide Resource Center (AACAP)
- What to Do if You’re Worried About Suicide (Child Mind Institute)
- Resources for Suicide Prevention (SAMSHA)
- 10 Things Parents Can Do to Prevent Suicide (Healthy Children)
Suicide Risk Assessment

Dr. Sonali Mahajan
Triaging a Suicidal Patient in a Pediatricians’ Office

- Review the PSC-Y-37 screening tool with the patient once they have completed it;
  - If question #36 or #37 is checked (positive), use the **3 tiered system**:
    1. Administer secondary screening tool for suicide, such as ASQ
    2. Talk with the patient and consider using the Brief Suicide Safety Assessment (BSSA)
    3. Decision, based on these options: full MH evaluation, or outpatient referral, or no further action needed
**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, 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:

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**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: Video and Tool Kit

https://www.youtube.com/watch?v=hlemr7Oq7-E
Brief Suicide Safety Assessment (BSSA)

NIMH recommends using standardized questionnaires as a guide for assessing risk and the need for further intervention, i.e., the ASQ, BSSA or the Columbia Suicide Severity Rating Scale (C-SSRS).

- **BSSA**
  - Use when ASQ is a **NON-ACUTE POSITIVE SCREEN** in a patient 8-24yo
  - An assessment tool for mental health clinicians, MDs, NPs, or PAs
  - Prompts help determine disposition – mainly whether a more thorough, full mental health/safety assessment is needed.
  - After the BSSA is completed, the trained clinician must determine level of risk (imminent, high, low) to decide next steps.

Triaging, continued - after administering the BSSA, options may include:

- **Imminent Risk**: Refer the patient directly to the ED
  - Offer resources from the Society for the Prevention of Teen Suicide to give families on their way - [https://sptsusa.org/parents/](https://sptsusa.org/parents/)

- **High Risk**: Assist the patient’s family with calling Mobile Response for them to make a home visit.
  - Should be done from PCP’s office before the patient leaves the office

- **Low Risk**: Refer the patient to Outpatient Services:
  - NJPPC, psychiatry, therapy, and/or other community and mental health resources

*All Patients: PCP should Follow-up with parent/patient the next day*
Documentation

DO NOT:
Administer screening tools without reviewing them before the family leaves the office

DO:
• Document which screening tools were administered and that they were reviewed
• Document what steps were taken and what recommendations were provided after reviewing the screening tools (sent to ER, call Mobile Response, parents making the home safe, decrease access to guns, etc.).
• Document your reasoning behind your recommendations (for example, if you didn’t send them to the ER or have them call Mobile Response right away then document why)
• Keep a record of the ASQ & BSSA performed
• Documentation indicates that a PCP thought through the risk assessment and took steps to minimize the risk

*All of this takes time, but it protects the patient and helps minimize your liability.
New Jersey Pediatric Psychiatry Collaborative Regional Hubs

- Atlantic Health Hub @ Newton Medical Center
- Atlantic Health Hub @ Goryeb Children’s Hospital
- Hackensack Meridian Hub @ Hackensack University Medical Center
- Hackensack Meridian Hub @ Palisades Medical Center
- Hackensack Meridian Hub @ Middlesex and Mercer
- Hackensack Meridian Hub @ Jersey Shore University Medical Center
- Cooper Hub @ Cooper University Medical Center
- Cooper Hub @ Pennsville

Essex County served by Rutgers University Behavioral Health Care.
More information on the Essex Hub can be found here: https://abhc.rutgers.edu/clinical/community/collaborative-behavioral-health-care-project-essex-hub/collaborative-behavioral-health-care-project-essex-hub
NJPPC Hub Benefits

- A child and adolescent psychiatrist (CAP) available for consultative support
- A psychologist/social worker available to:
  - Assist the pediatrician with diagnostic clarification and medication consultation,
  - Speak with a referred child’s family regarding the child’s mental health concerns and to assist in providing diagnostic clarification.
- One-time evaluation by a CAP at no charge to the patient when appropriate
  - Based on the recommendation of the CAP, the NJPPC Hub staff will work with the family to develop the treatment and care coordination plan.
- Continuous education opportunities in care management and treatment in the primary care office for common child mental health issues: ADHD, depression, anxiety, etc.
NJPPC Hub Telepsychiatry Services

Implementation rolling out as an expansion of the NJPPC

- Three platforms to be utilized
  - Face to face
  - Telepsych from home
  - Telepsych from pediatric offices

- Notify your Regional Hub if interested
References

2. https://www.youtube.com/watch?v=hlemr7Oq7-E
5. https://www.childrenssafetynetwork.org/sites/default/files/19_7_30_ScreeningYouthForSuicideRisk.pdf
8. https://www.youtube.com/watch?v=hlemr7Oq7-E
NJAAP Membership

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Thank you!

For more Information or to Register for the NJPPC

Visit:

https://njaap.org/mental-health/njppc/

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