Emergency Medical Services for Children Innovation and Improvement Center

ED STOP Suicide QI Collaborative

February 2, 2023 – November 2, 2023

Suicide Screening
INTERVENTION BUNDLE #1

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Introduction

DISCLOSURE

This intervention bundle was designed exclusively for sites participating in the ED STOP Suicide QI Collaborative and has not been validated. The clinical care team should use independent judgment in the management of any specific patient and is responsible, in consultation with the patient and/or the patient's family, to make the ultimate decisions regarding care. This material may conflict with "existing" local quality improvement efforts. Participants are encouraged to seek support from their ED and hospital leadership regarding the adoption of the proposed change strategies as standard practice for the ED site in which the improvement processes are to be implemented.

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SUBJECT MATTER EXPERTS

We would like to recognize the following experts for presenting information on this intervention bundle guide during the collaborative.

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BACKGROUND

This Intervention Bundle Guide was developed by the Emergency Medical Services for Children Innovation and Improvement Center (EIIC) for sites participating in the Emergency Department (ED) Screening and Treatment Options for Pediatric (STOP) Suicide Quality Improvement (QI) Collaborative convened in 2023. The material is evidence-based, includes references as well as resources and is 1 of 4 bundle guides that offer background information to support professionals to optimize the clinical care processes for children and adolescents (children) presenting to the ED with acute suicidality. The Intervention Bundle Guide #1: Suicide Screening focuses on supporting ED professionals to create or enhance processes and clinical pathways to standardize suicide screening for pediatric patients. This bundle focuses on supporting ED clinicians and staff in suicide risk screening using validated tools and processes that ensure reliable and evidence-based methodology. The goal of screening is to identify which child, who may have expressed ideation of committing suicide, or made a written or verbal statement about committing suicide or wishing to be dead, is more likely to be "actively" suicidal, or at risk for harming themself. The child may have a plan or simply have thoughts of suicide with or without intent.

Suicide is the second leading cause of death in children and adolescents 10-19 years of age. Globally, it is also the fourth leading cause of death in the 15-29 year age group.[1] Suicide risk identification, screening, and prevention have been top priority areas for the World Health Organization, and in the United States, several organizations including the American Academy of Pediatrics, Joint Commission, and the National Institute of Mental Health (NIMH) have recommended screening for suicide for children beginning at age 10, while some studies even recommend lowering suicide screening to children who are 8 or 9 years of age.[2] This approach is consistent with new alarming findings that suicide is becoming a top 10 cause of death in children as young as 5 through 9 years.[3] For this reason, and continued increasing prevalence and mortality risk of suicidality in the pediatric age group, suicide screening is an important focus for quality improvement efforts, and allows identification of those who are at greater risk for dying by suicide.

For the purposes of this bundle guide, screening is based on using standardized validated tools that have been field-tested and are included in peer-reviewed literature. Clinical care processes and strategies in this guide are intended for acute care (ED) settings, although they can be used in any setting specific to youth suicide prevention.[4,5,6,7] These approaches include considerations for trauma-informed care.[8] This bundle will cover the process and procedures for screening a patient in an ED for patients who are stable and not in immediate physical danger.

The screening bundle seeks to align its content with Critical Crossroads: Pediatric Mental Health Care in the ED, published by HRSA. To this end, several validated suicide screening tools that are mentioned in Critical Crossroads are being provided as options, without necessarily emphasizing one as the most preferred. Each screening tool has a specific methodology and approach, and therefore, which screening tool to choose, is based on what is most useful or feasible in each ED.

Each ED site team can review existing screening processes and decide whether to change to an alternate validated screening tool, train staff on the appropriate use of the tool, or evaluate compliance with one or more selected screening tool(s). The goal of the suicide screening process is to assess the level of suicide risk for an individual child to ensure access to appropriate resources and placement in a safe ED environment. Screening and/or mental health assessments sometimes need to be repeated to determine whether a patient's level of risk has changed while they are awaiting higher level care or inpatient placement. Screening for suicide allows for early identification and assessment of patients at risk for suicide, and therefore plays a key role in suicide prevention. Select validated screening tools are included in the resources section of this intervention bundle guide, and some are adapted from information in Critical Crossroads.

Aim Statement

The global aim for this bundle is that 100% of sites participating in (or selecting to focus on) this bundle will have a process or guideline that relates to universal suicide screening of children over 10 years of age using a validated screening tool.

Quality Measures

It is anticipated that an individual ED site team will choose one or more measures to work on. The following measures have been suggested by the ED STOP Suicide QI Collaborative Advisory Committee.

(Structural) Measure 1 - Presence of a mental health clinical care process or guideline that utilizes a validated screening tool for suicide and recommends *universal* screening for all children over 10 years of age.

(Outcome) Measure 2 - Percentage of physicians and nurse staff who demonstrate high-level knowledge in using a validated screening tool to assess for suicide risk in the pediatric population.

(Process) Measure 3 – Stretch Goal - Percentage of pediatric patients over 10 years of age with documentation of suicide screening.

Data Collection

Assessment of Knowledge: Assessment of knowledge and use of the validated screening tool by physicians, nurses, and/or other designated staff might include the following elements:

1. Type of screening tool adopted by site
2. Ability to access and complete the tool components
3. Appropriate use of the tool including location for administration and privacy considerations
4. Minimum age for separating parents/caregivers from the child during the screening process
5. Self-assessment of knowledge with using the tool
6. Self-assessment of proficiency in completing a pediatric suicide screening for children over 10 years of age. Five-point Likert scales (1-5) have been well-adopted for use in knowledge assessment tools. Studies have demonstrated loss of knowledge and skills in as little as six months. Ongoing training, practice, or re-assessment are recommended to ensure maintenance of this skill set

Evaluation of compliance with pediatric suicide screening may be conducted in real time or retrospectively. Depending on pediatric patient volume, charts may be selected for surveillance using a relevant sampling technique: random sample, systematic approach (e.g., every 5th patient over 10 years of age), or all pediatric patients evaluated over a given time period. If adherence to suicide screening remains below the team's goal, team members are encouraged to determine why failure to appropriately screen children occurred. The challenge in following agreed upon screening protocols may be related to staff training, particular times or days, process, availability of resources, and/or the environment.

Intervention Strategies

KEY DRIVER 1: PROCESS OR GUIDELINE THAT USES A VALIDATED SCREENING TOOL

Identification of one or more validated screening tools to be used in all children over 10 years of age and a related process for multidisciplinary care teams to ensure consistent identification of children at risk for suicide.

Change Strategies

- Develop a process or guideline to use an identified validated screening tool to guide the screening of all children over the age of 10 to be assessed for risk (and level of risk) for suicide.

KEY DRIVER 2: EDUCATION

Change Strategies

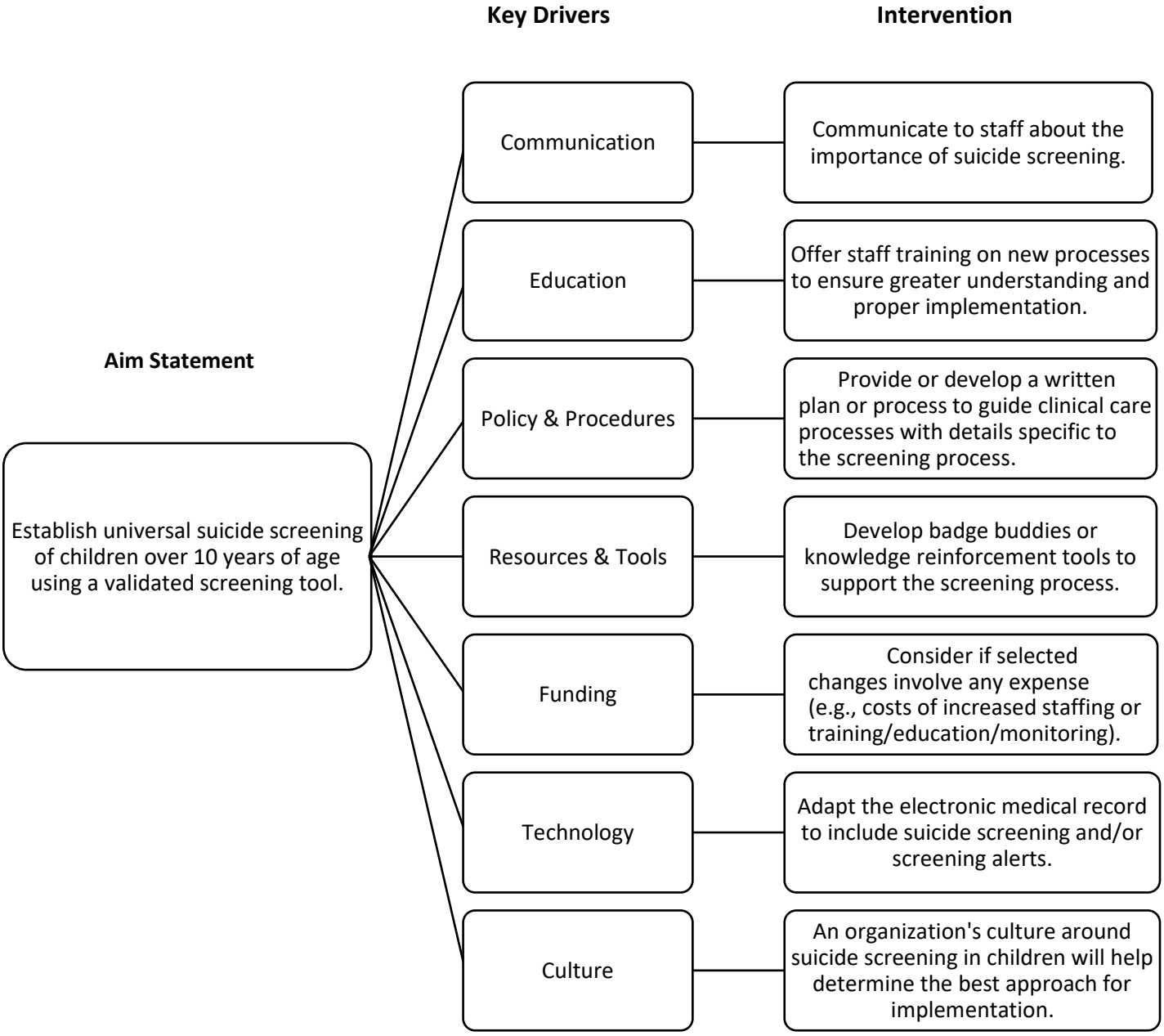
- Develop a training or education program that includes:
  - Learning Objectives: Components and importance of universal screening of pediatric patients for risk of suicide and instructions for use of identified/validated suicide screening tool.
  - Identification of training modality (i.e., presentation with PowerPoint slides during a staff meeting, just-in-time education, observation of a screening being conducted, peer to peer discussions).
- Determine a method of how to measure “high level knowledge” through self-reports or use of a test with a percentage of knowledge score.

KEY DRIVER 3: ELECTRONIC MEDICAL RECORD (EMR) OPTIMIZATION

Change Strategies

- Integrate suicide screening into the EMR.
- Implement standing physician orders.
- Develop an automated alert to remind the care team to use the identified screening tool(s) with links to the tool(s).

SAMPLE KEY DRIVER AND CHANGE STRATEGIES DIAGRAM



Resources

Ask Suicide Risk Screening Tool (ASQ)
ASQ Questionnaire https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit.pdf
Toolkit https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

One of the EIIC Pediatric Education and Advocacy Kits (PEAK: Suicide) includes an audio podcast which is an interview with Dr. Lisa Horowitz from the NIMH and is one of the developers of the ASQ tool.

- The ASQ is a brief validated screening tool for use in both children and adults.
- The ASQ tool is recommended for ED clinicians to rule out suicide risk among pediatric patients who present to the ED for any reason[13]
- The ASQ tool includes four suicide screening questions that take about 20 seconds to administer.
- A "yes" response to any of the following questions means that the patient is at high risk for attempting suicide.
    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?*

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)
https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

- The SAFE-T offers 3 sets of questions about risk and protective factors and suicide inquiry.
- This tool is an evaluation tool that supports professionals through a 5-step comprehensive suicide screening assessment and triage process (identify risk factors, identify protective factors, conduct suicide inquiry, determine risk level/intervention, and document).

Columbia Suicide Severity Rating Scale (C-SRRS)
https://cssrs.columbia.edu/wp-content/uploads/Columbia_Protocol.pdf

- The C-SRRS offers 2-6 questions.
- This scale is designed to assess the severity of suicidal ideation and is a prelude to a more comprehensive C-SRRS.
- The C-SRRS is validated for use in adolescents in the ED setting.
- Online, in-person, and webinar training options are available https://cssrs.columbia.edu/training/training-options/.

Suicidal Ideation Questionnaire (SIQ) and SIQ Junior
https://cssrs.columbia.edu/training/training-options/

- The SIQ consists of 30 items for students in grades 10 through 12.
- The SIQ-JR includes 15 items for students in grades 7 through 9.
- Online administration and scoring is available via PARIConnect https://www.parinc.com/Products/PARiConnect#Product-413
- There may be costs associated with these tools, kits, and resources

Reasons for Living for Adolescents (RFL-A)
https://www.phenxtoolkit.org/protocols/view/640901

- The RFL-A includes 32 items and is a self-report inventory that measures protective factors that are deterrents to suicidal behavior
- The tool and related resources are available online for free
- Materials are included in the PhenX Toolkit https://www.phenxtoolkit.org/search/results?searchTerm=RFL-a&searchtype=smartsearch

HEADS-ED
https://www.heads-ed.com/en/content?id=4#:~:text=The%20HEADS-ED%20is%20a%20validated%20interview%20tool%20that,of%20the%20HEADS-ED%20tool%3A%20Home%20Education%20%26%20Employment

- The HEADS-ED is a rapid mental health screening tool
- This tool can be used to rule in ED admission among pediatric patients for mental health care[13]
- Videos and print-friendly resources are available https://www.heads-ed.com/en/infoSheets

Suicide: Blueprint for Youth Suicide Prevention
https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/

- A "Call to Action" tool developed by the American Academy of Pediatrics
- 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.

References

1. Mancinelli-Hough K, Lucas Breda K, Karl C, Wentland BA. Don't Ask, Won't Tell: Suicide Screening in the Pediatric Perioperative Setting. Compr Child Adolesc Nurs. 2022 Dec;45(4):395-402. PMID: 36440865
2. Cwik M, Jay S, Ryan TC, DeVylder J, Edwards S, Wilson ME, Virden J, Goldstein M, Wilcox HC. Lowering the Age Limit in Suicide Risk Screening: Clinical Differences and Screening Form Predictive Ability. J Am Acad Child Adolesc Psychiatry. 2021 May;60(5):537-540. PMID: 33667604
3. Ruch DA, Heck KM, Sheftall AH, Fontanella CA, Stevens J, Zhu M, Horowitz LM, Campo JV, Bridge JA. Characteristics and Precipitating Circumstances of Suicide Among Children Aged 5 to 11 Years in the United States, 2013-2017. JAMA Netw Open. 2021 Jul 1;4(7):e2115683. PMID: 34313741; PMCID
4. *Youth mental health - current priorities of the U.S. Surgeon general*. - Current Priorities of the U.S. Surgeon General. (n.d.). Retrieved February 8, 2023, from https://www.hhs.gov/surgeongeneral/priorities/youth-mental-health/index.html
5. U.S. Department of Health and Human Resources, Health Resources and Services Administration, Maternal and Child Health Bureau (2019). Critical Crossroads: Pediatric Mental Health Care in the Emergency Department, A Care Pathway Resource Toolkit, version 1.0. Retrieved February 8, 2023, from https://www.hrsa.gov/sites/default/files/hrsa/critical-crossroads/critical-crossroads-tool.pdf
6. Chun, T. H., Mace, S. E., & Katz, E. R. (2016). Evaluation and management of children and adolescents with acute mental health or behavioral problems. part I: Common clinical challenges of patients with mental health and/or behavioral emergencies. *Pediatrics*, *138*(3). https://doi.org/10.1542/peds.2016-1570
7. Chun, T. H., Mace, S. E., & Katz, E. R. (2016). Evaluation and management of children with acute mental health or behavioral problems. part II: Recognition of clinically challenging mental health related conditions presenting with medical or uncertain symptoms. *Pediatrics*, *138*(3). https://doi.org/10.1542/peds.2016-1573
8. Suicide: Blueprint for youth suicide prevention. (n.d.). Retrieved February 8, 2023, from https://www.aap.org/SuicidePrevention