# Safety Planning with Pre-Teens

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Behavioral Health Therapist II

*Group #1: 12:45PM-2:00PM*


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## Learning Objectives:

1. Identify and use age-appropriate language to assess suicidality and introduce the concept of safety planning
2. Apply safety planning steps to collaboratively create safety plan with pre-adolescents
3. Confidently communicate safety plan components to parents and caregivers of pre-teens for effective implementation

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## Outline

- Assessing suicidality
  - Choosing language
  - Screener and assessment
- Introducing safety planning
  - Rationale to create plan
  - Collaboration in design
- Including parents and caregivers
  - Reviewing and preparing to use plan <u>together</u>

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## Why this is important?

- Suicide is 5th leading cause of death in children 5-12yo (Horowitz et al, 2020)
- Preteens with suicidal ideation/suicide attempts are less likely to be in treatment then teens with suicidal ideation/suicide attempts (Lawrence et al, 2021)
- Youth in sexual minority or family income less than 50k/year appear to be at elevated risk for suicidal ideation and behaviors (2021)

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# Assessing Suicidality



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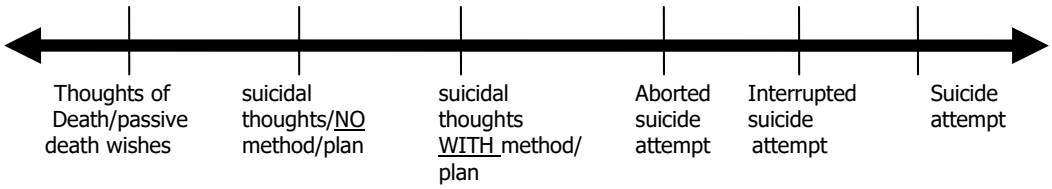
# Suicide Continuum

## Assessment of Suicidality




***COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)***
*Lifetime/Recent Version- Version 1/14/09*
***Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.***

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# Choosing Language

- **Ask Suicide Questions (ASQ)**
  - Screener from NIMH
  - Validated for 8-years-old and older
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- **Columbia-Suicide Severity Rating Scale (C-SSRS)**
  - Assessment tool by Posner et al.
  - Validated for 5-years-old and older
  - *Additional version adapted for 4 to 5-year-old children or those with cognitive impairment
  - https://cssrs.columbia.edu/

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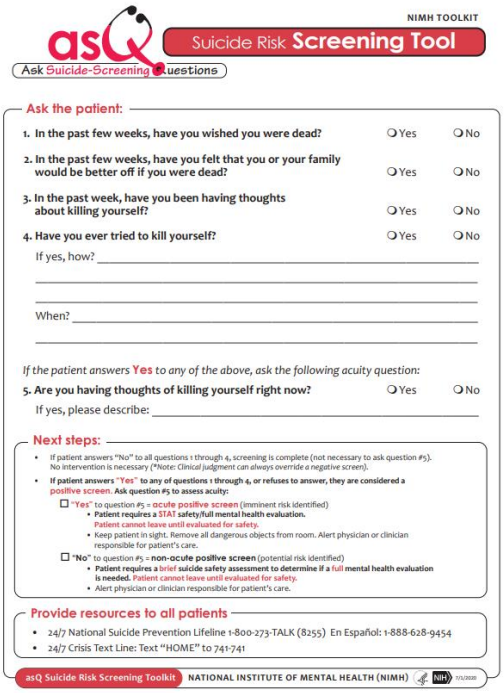

NIMH TOOLKIT

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)

# ASQ Screening Tool from NIMH

(Horowitz et al, 2012)

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**COLUMBIA-SUICIDE SEVERITY RATING SCALE**

**(C-SSRS)**

Lifetime Recent

Version 1/14/09 m9/12/17 m5/3/21

*Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.*

**C-SSRS: Very Young Child/Cognitively Impaired – Lifetime Recent (Same authors as above)**

Alternatives for young children (younger than 5yo)

- Do you ever wish you weren't alive anymore?
- Have you thought about doing something to make yourself not alive anymore?
- Did you ever do anything to try to kill yourself or make yourself not alive anymore? What did you do?

9 (Posner et al, 2008)

| ***SUICIDAL IDEATION*** *Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.* | **Lifetime: Time He/She Felt Most Suicidal** | **Past 1 month** |
|---|---|---|
| **1. Wish to be Dead** Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **2. Non-Specific Active Suicidal Thoughts** General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act** Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan** Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them"* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| **5. Active Suicidal Ideation with Specific Plan and Intent** Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** If yes, describe: | Yes ☐ No ☐ | Yes ☐ No ☐ |
| ***INTENSITY OF IDEATION*** *The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.* Lifetime - ***Most Severe Ideation:*** ____ Type # (1-5) ____ Description of Ideation Recent - ***Most Severe Ideation:*** ____ Type # (1-5) ____ Description of Ideation | Most Severe | Most Severe |
| **Frequency** ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day | ____ | ____ |
| **Duration** ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous | ____ | ____ |

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# C-SSRS

## Risk Identification with the Columbia Protocol

(Pocket Card – available on website)

| | Past 1 Month | |
|---|---|---|
| **1) Have you wished you were dead or wished you could go to sleep and not wake up?** | | |
| **2) Have you actually had any thoughts about killing yourself?** | | |
| If **YES** to 2, answer questions 3, 4, 5 and 6<br>If **NO** to 2, go directly to question 6 | | |
| **3) Have you thought about how you might do this?** | | |
| **4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?** | **High Risk** | |
| **5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?** | **High Risk** | |
| **Always Ask Question 6** | **Life-time** | **Past 3 Months** |
| **6) Have you done anything, started to do anything, or prepared to do anything to end your life?** *Examples*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc. | | **High Risk** |

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10 (Posner et al, 2008)

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# After suicide risk assessment, then what?



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# Introduce Safety Planning

- First, thank the child for their willingness to talk about suicidal thoughts and behaviors. Explain that you would like to help them come up with a plan in case they experience these thoughts again.
- Remind the child that suicidal thoughts usually pass with time.
- "We want to help you feel better, which can take some time. If you have thoughts to hurt yourself while we are still working on helping you feel better, you will be in charge of using your safety plan to stay safe and alive."
- "We will write it down together so you can take a copy home with you today."

(Samra & Bilsker, 2007)

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# Safety Plan: individualized plan created collaboratively with child and caregivers for coping with suicidal thoughts and urges

1. Safety plan can be updated over time based on further exploration of precipitants, vulnerabilities, cognitions, and emotions that lead to past behavior

2. Child commits to family and clinician not to engage in suicidal behavior

3. Child will implement safety plan if noticing warning signs or experiencing suicidal thoughts/urges

(Stanley & Brown, 2008)

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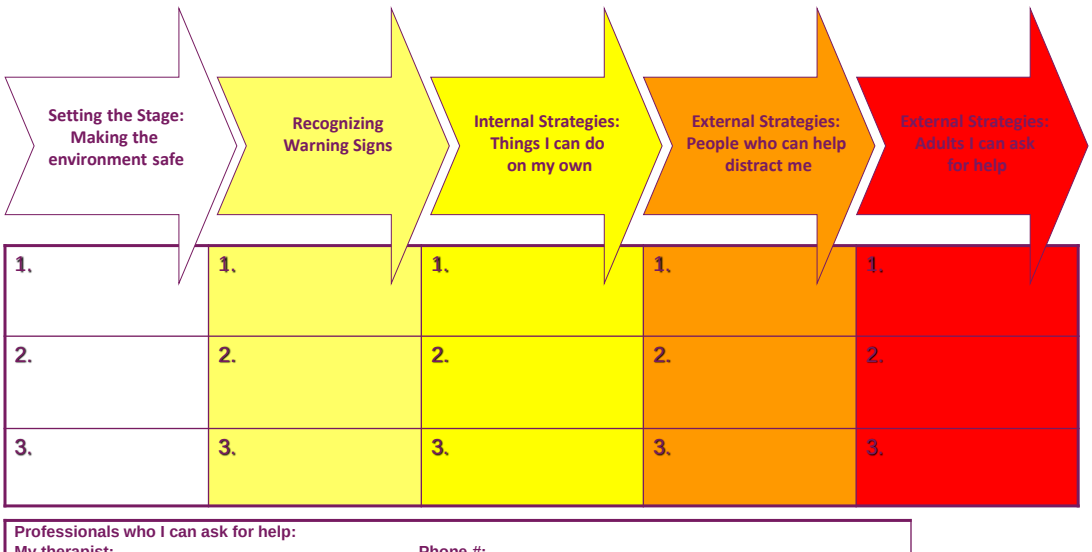


**Professionals who I can ask for help:**
**My therapist:** _____ **Phone #:** _____
**Hospital ER:** _____ **Phone #:** _____
**Crisis hotline/Other:** _____

From: Treating Depressed and Suicidal Adolescents by David A. Brent, Kimberly D. Poling, and Tina R. Goldstein. Copyright 2011 by the Guilford Press

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## Safety Plan Basics

- Make your space safe
- Red flags or warning signs
- Things I can do on my own
- People who can help distract me
- Adults I can ask for help
- Phone Number + Crisis Resources

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## Making the environment safe

- **Always** includes removal of lethal means
  - All medications including OTC, supplements, prescriptions
  - Talk to parent individually about firearm removal
  - Discuss other hazards such as high windows or balcony, ropes, belts, sharps (including bathroom razors), knives, or other weapons
- Make sure coping skills and strategies are accessible
  - If the child is going to call Grandma as a strategy… make sure they have a way to call Grandma!
  - Easy access to review and use safety plan

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16 (Ruch et al, 2021)

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# Red flags / Warning Signs

- Include any information learned from suicide risk assessment
  - What were you feeling physically right before *(last suicidal behavior)*? What were you thinking about? What happened right before you thought about killing yourself?
  - How might *(your friend, mom, teacher, aunt)* know you are feeling sad?
- **Examples**: physical feelings such as tight muscles, crying, heart racing, feeling hot, feeling tired, anger; precipitating events such as receiving bad news (bad grades, punishment), fight with family or friend; other behavioral urges such as self-injury urges, wanting to throw things or yell, wanting to be alone

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# Things I can do on my own

- What could you do on your own to help you not act on the thought to hurt yourself? What helps you feel better when you are *(sad, angry, etc.)*?
- Distractions are common at assessment prior to learning coping skills and tools – be sure to update this part of the safety plan as child progresses through treatment!

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## People who can help distract me

- Who could you talk to that might make you feel better?
- *Explain that this is someone who can help you distract from suicidal thoughts – not necessarily someone who you are telling about your thoughts (which should be an adult)*
- This can include friends, cousins, aunts/uncles, parents
  - Be creative: phone call, text messaging, Facetime/Skype if child has access to these platforms
  - Pets count and can be a great protective factor!

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## Adults I can ask for help

- If what we talked about so far did not help, and you were still having thoughts to hurt or kill yourself, what adult could you ask for help?
- **Always** includes at least one adult that is accessible to the child **and** agrees to be on the child's safety plan

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# Adults I can ask for help

- **What is the child replies, "no one"?**
  - *Explain your rationale for adding an adult to our plan. Give the child encouragement by reviewing the great distractions and skills they already added.*
  - *Compare to fire drill practice at school. If the alarm (warning sign) goes off, you know how to get outside (things I can do on my own). There might be water sprinklers or fire extinguishers for teachers to use (people who can help). But the school still needs other adults (firefighters) to call if the fire is out of control (adults I can ask for help).*
  - Ask the child what would stop them from asking the primary caregiver for help. The child might identify barriers that have workable solutions ("I don't know what to say" "What if they are mad" etc.)

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# Adults I can ask for help

- This section of the safety plan might include specific instructions for the adult to follow
  - Code words, what to say/do, reminders to stay with the child
  - Remember that the adult will probably be panicking, so clear instructions will help them help their child!
- **Always** provide adults on the safety plan with crisis resources, at minimum a local crisis phone number and addresses for their local ER or psychiatric ER

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| Setting the Stage: Making the environment safe | Recognizing Warning Signs | Internal Strategies: Things I can do on my own | External Strategies: People who can help distract me | External Strategies: Adults I can ask for help |
|---|---|---|---|---|
| 1. Remove things I could hurt myself with (pills, sharps, firearms, ropes) | 1. Yelling or throwing things | 1. Color in my coloring book | 1. Play video games with my sister | 1. Grandma |
| 2. Make sure my coping skills and tools are available | 2. Feeling hot or sweaty | 2. Ride my bike or swing on the swing set | 2. Play with my dogs Burton & Ollie | 2. Mrs. Smith (school nurse) |
| 3. Review my safety plan with dad at least 3x/week | 3. Heart beating really fast | 3. Listen to my favorite music | 3. Ask mom to watch our favorite TV show together | 3. Mom and Dad *code word: starfish* |

**Professionals who I can ask for help:**
My therapist: Kelsey Bero - Phone #: (412) 246-5242
Re:solve Crisis Network 333 N Braddock Avenue Pgh PA 15208 - Phone #: 1 (888) 796-8226
UPMC Western Psychiatric Hospital 3811 O'Hara Street, Pgh, PA 15213 - Phone #: (412) 624-2100

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# "Test-driving" a Safety Plan

- "How likely are you to reach out to **(adults)** if you have strong suicidal thoughts?"
  - *Not at all, Maybe, Mostly likely, Definitely*
- "What might make it difficult to ask for help?"
  - *Then problem-solve!!*
- "What would make it easier for you to ask for help?"
  - *Make it happen if possible!!*

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# Talking to Parents/Caregivers



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## Talking to Parents/Caregivers

- Clearly let them know about the child's safety concerns
  - Type of thoughts, methods, frequency, and most severe suicidal behavior(s)
- Clear, specific instructions
- **Always** provide adults on the safety plan with crisis resources, at minimum a local crisis phone number and addresses for their local ER or psychiatric ER



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# Tips for Talking to Parents/Caregivers

- Review what you will say to the child
  - Be transparent. Ask the child if they want to do the talking or if prefer for clinician to talk
- Start with the positives
  - Provide positive reinforcement for child's ability and willingness to talk about thoughts, feelings, and specifically suicidal thoughts and behaviors
- Validate parents' experience while communicating our need for them to help – that is, be a part of the safety plan
- Be willing to answer questions!

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## Johnny's Safety Plan

| Setting the Stage: Making the environment safe | Recognizing Warning Signs | Internal Strategies: Things I can do on my own | External Strategies: People who can help distract me | External Strategies: Adults I can ask for help |
|---|---|---|---|---|
| 1. Remove things I could hurt myself with (pills, sharps, firearms, ropes) | 1. Yelling or throwing things | 1. Color in my coloring book | 1. Play video games with my sister | 1. Grandma |
| 2. Make sure my coping skills and tools are available | 2. Feeling hot or sweaty | 2. Ride my bike or swing on the swing set | 2. Play with my dogs Burton & Ollie | 2. Mrs. Smith (school nurse) |
| 3. Review my safety plan with dad at least 3x/week | 3. Heart beating really fast | 3. Listen to my favorite music | 3. Ask mom to watch our favorite TV show together | 3. Mom and Dad *code word: starfish* |

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**Checklist when we get home:**

- Remove access to lethal means
- Put safety plan on refrigerator, teen's phone, etc.
- Let grandma and school nurse know about safety plan (and what to do – share Re:solve phone number)
- Save therapist, Re:solve, and WPH PES phone number in phone

**If Johnny uses code word *star fish*:**

1. Stay with him, walk with him to the kitchen to get a glass of juice
2. Ask him what he needs (could present options such as "call Re:solve together, talk about how you are feeling, or watch a movie together"
3. After 15 minutes, check-in to see if what you are doing is helping
4. If not, repeat offer to call Re:solve, do something different
5. Repeat every 15 minutes until Johnny reports feeling better

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# Questions?

Thank you!

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