Maryland Behavioral Health Integration in Pediatric Primary Care (MD BHIPP) Crisis Training

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Suicide Prevention Part 2: Safety and Crisis Planning

Robert Paine, DO

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Maryland Behavioral Health Integration in Pediatric Primary Care

855-MD-BHIPP (632-4477)

www.mdbhipp.org

Conflict of interest disclosure

- No potential conflicts of interest
- Faculty at the University of Maryland School of Medicine
- Salary funding from the State of Maryland (BHIPP)
- Member of the American Academy of Child & Adolescent Psychiatry (AACAP)

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Learning Objectives

1) Learn evidence-based treatments for nonsuicidal self-injury in children and adolescents
2) Describe the specific components of an evidence-based safety plan intervention
3) Discuss additional elements to consider specifically for kids when engaging in safety planning

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Acknowledgement

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Case

- In the privacy of his bathroom, Alejandro, 15, prepared to cut his wrist. He knew it would hurt and knew people would wonder why. But he didn't care. It hurt the first few moments of cutting, but soon he felt no pain. He felt only relief.
- Then he looked down at his wrist. The amount of blood in the bathroom sink shocked him. He wrapped his wrist in a towel and told his mother. She took him immediately to the hospital, where the doctor stitched up his wound.
- The ER Social Worker was concerned. She asked Alejandro "When you cut your wrist, how much did you want to die?" He responded "I didn't want to die, I just wanted to feel better."
- He explained that his girlfriend had broken up with him that day at school. "I couldn't stop crying. When I cut myself, it calms me down. I swear, I wasn't trying to kill myself."

Freedenthal, 2018

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Case (continued)

- The social worker believed him, but only after completing a suicide risk assessment and talking with Alejandro's mother for corroboration. Alejandro had not previously revealed any signs of suicidal thoughts or behaviors. There was no sign that he had undertaken preparations to end his life.
- For safety planning, the social worker helped Alejandro come up with safer things he could do to relieve emotional pain, as well as places and people he could turn to for distraction and help.
- He was referred to an outpatient psychotherapist and was discharged home with his mother.

Freedenthal, 2018

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NSSI: Treatments that Work

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Therapy helps

- Strongest evidence and largest effect sizes:
  - Dialectical Behavioral Therapy
  - Cognitive-Behavioral Therapy
  - Mentalization Based Therapy

- Key ingredients in treatment:
  - Focus on family interactions
  - Frequent meetings with the adolescent
  - Emphasize self-care: sobriety, sleep, increasing positive experiences

Ougrin, D., Tranah, T., Stahl, D., Moran, P., & Asarnow, J. R. (2015). Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis. Journal of the American Academy of Child & Adolescent Psychiatry, 54(2), 97-107.

Brent, D. A., McMakin, D. L., Kennard, B. D., Goldstein, T. R., Mayes, T. L., & Douaihy, A. B. (2013). Protecting adolescents from self-harm: a critical review of intervention studies. Journal of the American Academy of Child & Adolescent Psychiatry, 52(12), 1260-1271.

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DBT vs CBT

Dialectical Behavioral Therapy

- Strongest evidence base
- Mix of group and individual treatment
- Parent component
- Emphasis on “skills” to replace self-injury
- “On-call” skills coaching
- Hard to find treatment in rural areas

Cognitive Behavioral Therapy

- Weaker evidence base
- Individual and parent treatment
- Emphasis on thoughts and behaviors
- No “skills coaching”
- Much more commonly found treatment
- Treats many comorbid conditions

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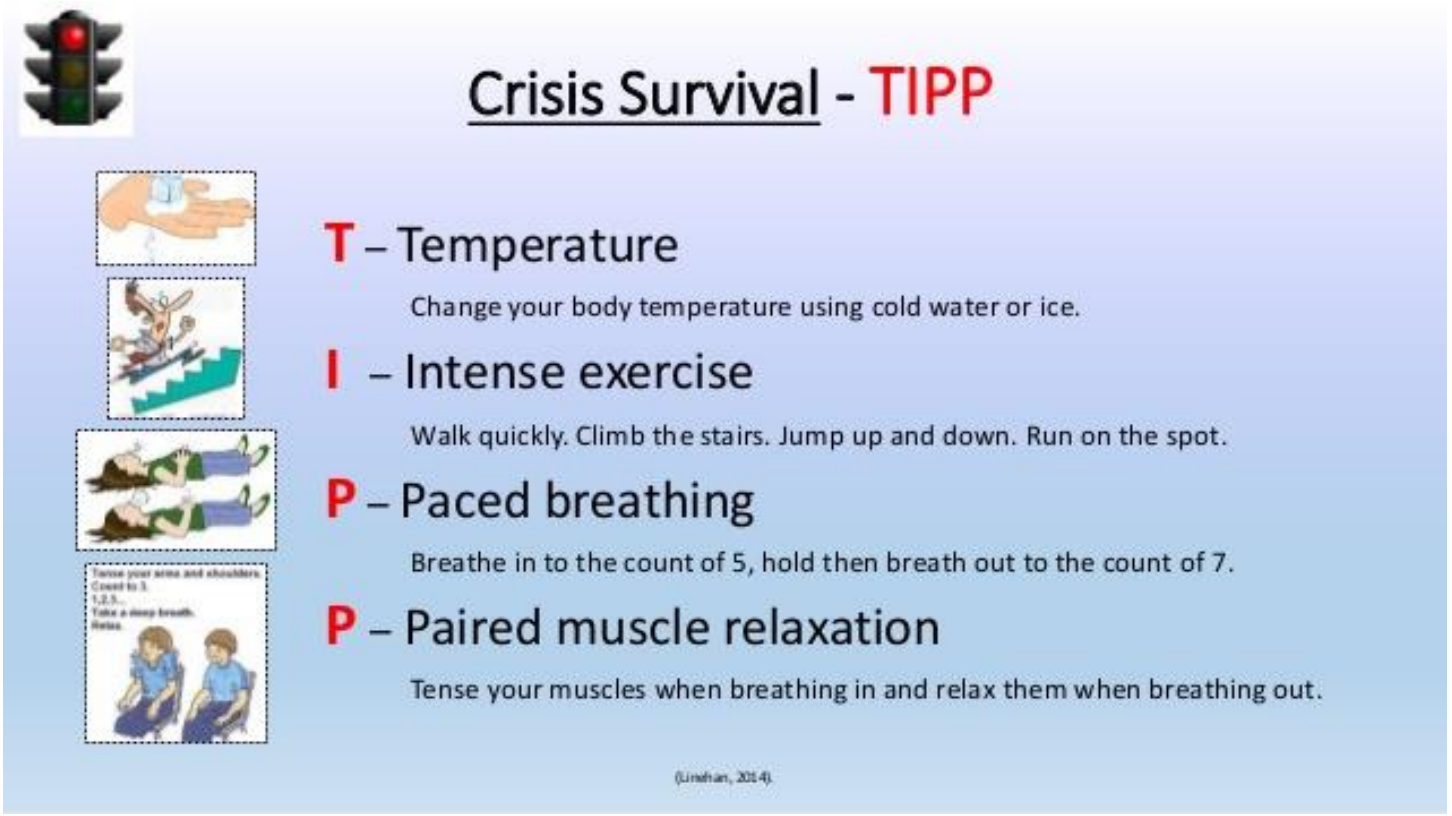
DBT Skill Example



https://dialecticalbehavioraltherapy.wordpress.com/distress-tolerance-tipp-skills/

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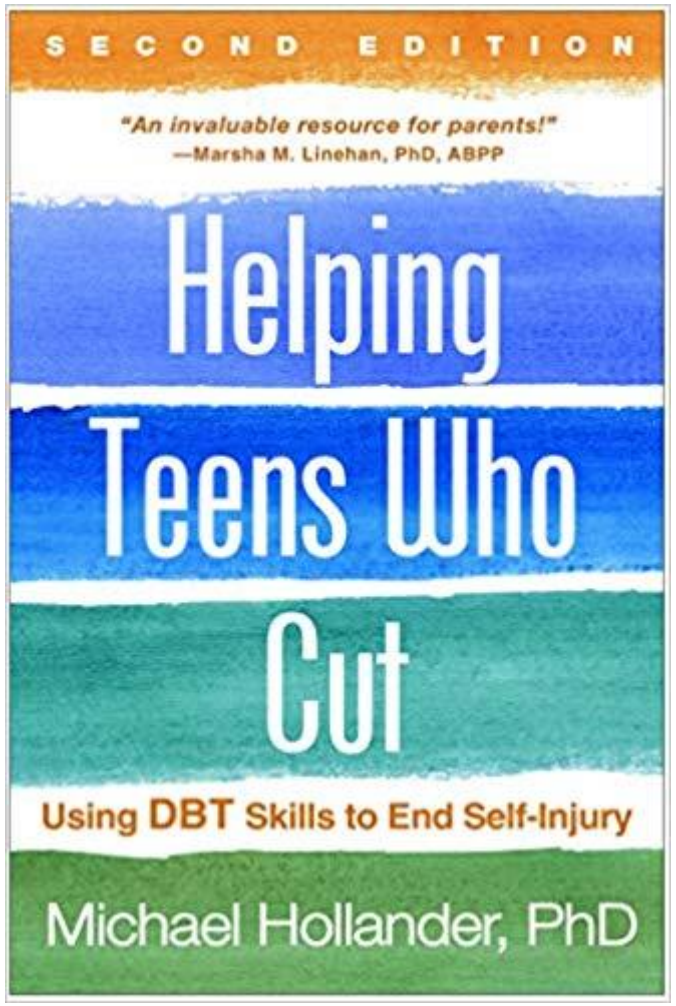
Educating Parents



- Book intended for lay audiences by a major DBT authority
- Explains the concepts and skills of DBT
- May help parents respond to emotional distress more effectively

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Educating Parents

Table. Credible Health-Information Websites That Can be Recommended to Patients Who Self-Injure[a]

Organization Name	URL	Description	Stakeholders
Self-Injury Outreach and Support	www.sioutreach.org	International nonprofit outreach initiative providing information, family and professional resources, and coping guides for NSSI	Individuals who self-injure, families, friends (other youth), romantic partners, physicians, mental health professionals, school professionals
Self-Abuse Finally Ends	www.selfinjury.com	Offers a recognized treatment approach for NSSI; also serves as a professional network and resource website	Individuals who self-injure, families, mental health professionals, school professionals
Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults	~~www.crpsib.com~~ www.selfinjury.bctr.cornell.edu	Summarizes research and provides resources related to understanding, identifying, treating, and preventing self-injury	Individuals who self-injure, families, mental health professionals, school professionals

Abbreviations: NSSI, nonsuicidal self-injury; URL, uniform resource locator.

[a] Although not accessible on the first page of Google search results, these websites meet most (if not all) of the Health on the Internet quality of health information criteria, are current and up to date, do not propagate NSSI-related myths, and are sponsored by credible academic institutions.

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Your patient is suicidal. Now what?

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The Big Question

- Does the patient feel that they can keep from seriously harming themselves with appropriate supervision and do the parents/caregivers feel that they can provide adequate supervision to keep their child safe?
  - If yes – proceed to safety planning
    - After safety planning, reconsider the above question to ensure that all parties feel the safety plan can be realistically followed
  - If no – further evaluation is needed immediately
    - Consider ED (or alternate setting) referral

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Safety Planning

- Few robust studies in safety planning alone in pediatric populations
- Safety Planning Intervention + single phone check-in reduced 6-month suicide behaviors by 45% among adults with ED visits for suicide-related concerns (Stanley et al 2018)
  - Intervention took 15-45 minutes to conduct
- Safety plans are often combined into a comprehensive treatment approach (such as in CBT or DBT)

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Safety Contract vs Safety Plan

- With a no-suicide contract aka safety contract, the patient promises (either orally or in writing) not to act on their suicidal thoughts within a specified period of time.
- Safety *planning* offers a concrete way to collaborate with the suicidal person about ways to resist acting on suicidal urges.

Freedenthal, 2018

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Safety Planning Principles

- Provide kids and families with a prioritized and specific set of coping strategies and contacts should suicidal thoughts emerge
- Sees suicidal crises as intense but temporary challenges
- Crafted in close collaboration with the individual who will use it
- A good safety plan is concrete, detailed, and within the patient's ability to achieve

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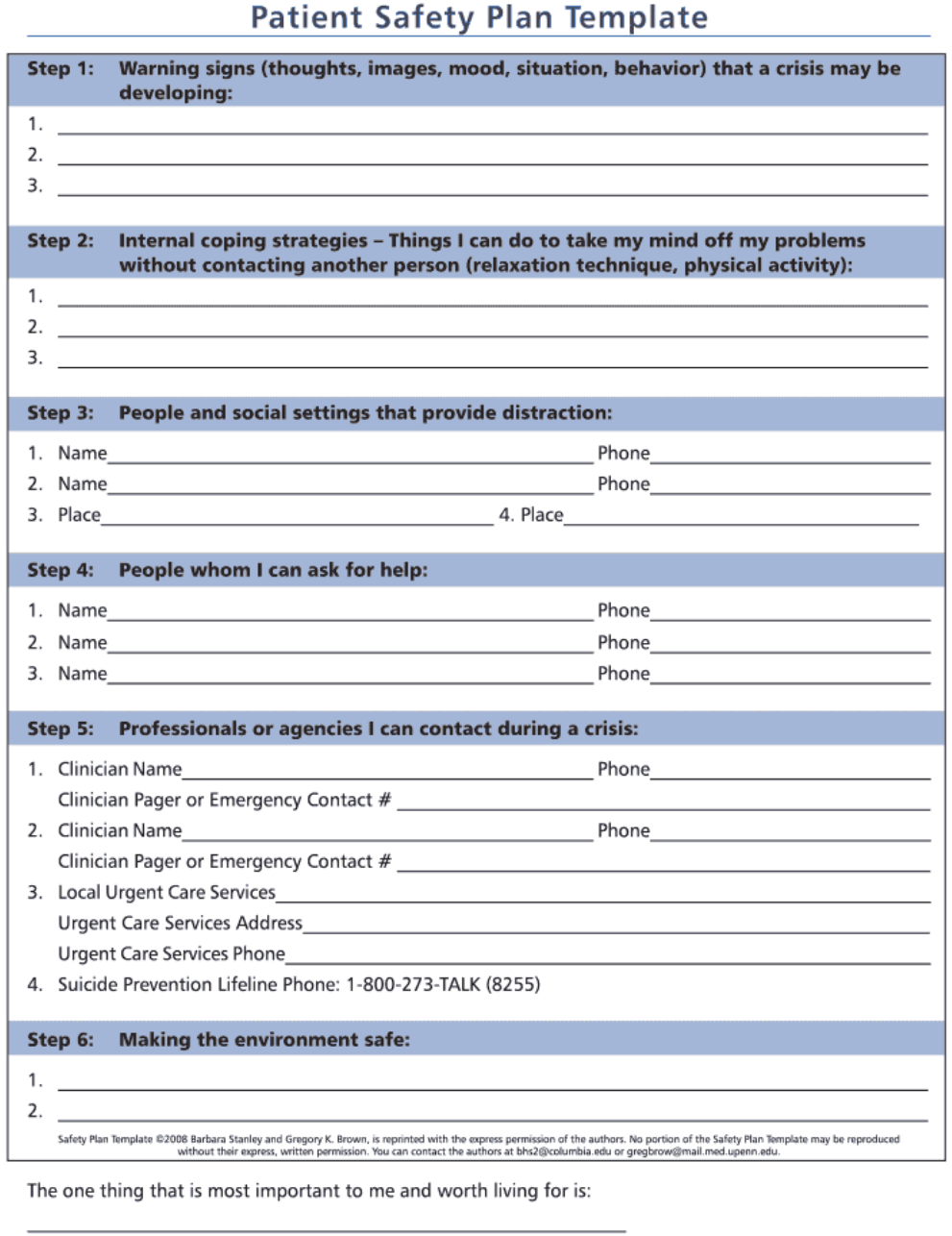

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

- Safety Plan adapted from Safety Planning Intervention
  - https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
  - Moves from internal coping to external coping to reaching out for help
- Additional considerations for kids:
  - Plan for increased supervision
  - Establishing a check-in system

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Step 1: Warning Signs

Step 1:	Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1.	_____
2.	_____
3.	_____

- Emphasize thoughts, feelings, and behaviors that the adolescent can identify on their own
- Include observable behaviors as well that parents, caregivers, or other informed adults might be able to recognize without the adolescent saying that they are present

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Step 2: Internal Coping Strategies

Step 2:	**Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):**
1.	_____
2.	_____
3.	_____

- Initial step, meant to enhance self-efficacy
- Often are distraction techniques (going for a walk, taking a shower, etc)
  - DBT skill example: ACCEPTS (https://www.dbtselfhelp.com/html/accepts.html)
- These strategies should be usable at **any time** by the individual

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Step 3: Utilize social contacts as a means of distraction from suicidal thoughts

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

- May identify individuals or places where socializing occurs
- Not meant to be emotional supports, but rather people around whom you can be and feel safe
- Places may be private (a walk in the woods) or public (a trip to the Zoo)
- Aim is still to focus on self-efficacy

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Step 4: Contacting family members or friends who may help with the crisis

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

- Inform trusted contacts of the suicidal crisis
  - These individuals should know that they may be contacted in a crisis
  - Individuals should adults
- At this stage, the actual crisis is meant to be discussed openly
  - Sometimes, validation and support is sufficient to alleviate suicidality, but distress and other psychiatric symptoms may remain

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Step 5: Contact mental health professionals or agencies

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

- At this stage, clinician involvement is necessary
- This should be discussed in advance with outpatient providers to ensure that conditions for being emergently contacted are clear

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Step 6: Reduce the potential use of lethal means

Step 6: Making the environment safe:

1. _____

2. _____

- Some aspects of this should be Step 0 (i.e. firearm safety)
  - Firearms used in pediatric suicides come from the youth's home in approximately 9 of 10 deaths (Monuteaux et al. 2019)
  - The association of firearms ownership and suicide was 2x stronger in adolescents than adults and child access prevention laws ("safe storage laws") may reduce adolescent firearm suicide by 13% (Kivisto et al. 2021)
  - While the AAP recommends all firearms should be securely stored in a locked location, unloaded, and separate from ammunition, only 3 in 10 households with children and firearms do this (Monuteaux et al. 2019)
- Other aspects should be done on an as needed basis
  - Consider locking medications and preferred objects for self-injury

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Additional Considerations for Kids

- Plan for increased level of supervision at home
  - Could be anything from limiting time left alone, increased time spent with family, social media monitoring, etc.
  - Parents should make this explicit
- Devise a “check-in system” for parents and kids
  - There should be limits on both ends
    - Supportive concern =/= nagging
    - The goal is to assess safety and not (primarily) to manage parent anxiety
  - Fine to adopt means of checking in beyond explicit verbal statements as long as it’s predetermined
    - Can use codes (“red zone”) or a chart if needed

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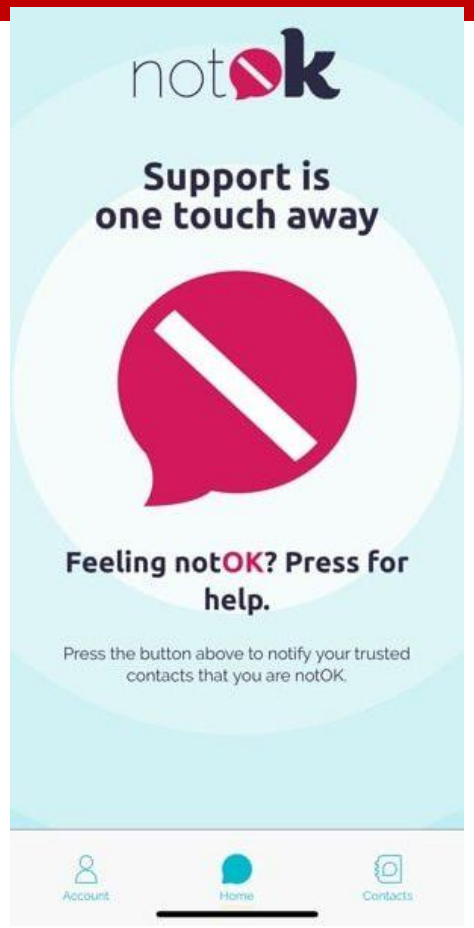
There's An App For That!

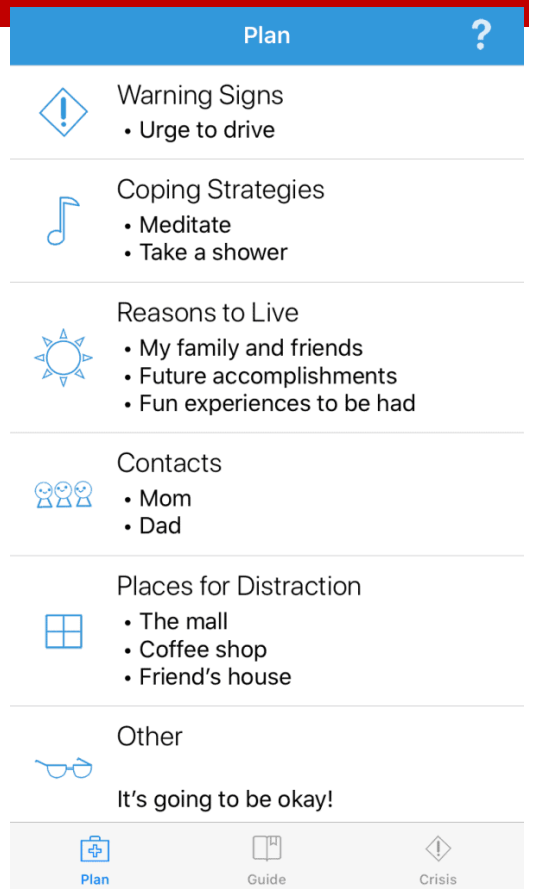
1) notOK: Free app that contains a large red button that, when tapped, alerts close trusted contacts that the user is in urgent need of help.

- The app will send an alert to pre-selected friends, family members, and supporters with a GPS location and a message letting them know that the user needs them to reach out.
- https://www.notokapp.com/

2) Suicide Safety Plan: Free app that allows users to program safety plan and easily contact help if needed.

- https://www.suicidesafetyplan.app/





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Possible Alternatives to ED Referral

- Walk-In Behavioral Health Services
  - Non-ED settings to evaluate mental health crises (not necessarily open 24/7)
    - Frederick – Mental Health Association - https://fcmha.org/how-we-help/behavioral-health
    - Harford County – Harford Crisis Center - https://harfordcrisiscenter.org/
    - Montgomery County – Montgomery County Crisis Center - https://www.montgomerycountymd.gov/HHS-Program/Program.aspx?id=BHCS/BHCS24hrcrisiscenter-p204.html
    - Sheppard Pratt Walk-In Clinics – Towson and Elkridge - https://www.sheppardpratt.org/care-finder/crisis-walk-in-clinic/

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An Emerging Crisis-Based Treatment

- Family-based Crisis Intervention (Wharff et al 2019)
  - 60-90 minute single session for suicidal adolescents and their families
  - Studied and implemented in pediatric emergency rooms
  - Involves elucidating the “crisis-narrative,” psychoeducation, brief CBT intervention, safety planning
  - In ED study, reduced the need for hospitalization of suicidal adolescents by about half (68% vs 38%)
  - Not yet adapted to primary care settings but this is in progress!

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Recommended Readings

- Berk, M: Evidence-Based Treatment Approaches for Suicidal Adolescents: Translating Science Into Practice. Washington DC, American Psychiatric Association Publishing, 2019.
- Chiles, JA, Strosahl, KD, and Roberts, LWR: Clinical Manual for Assessment and Treatment of Suicidal Patients, Second Edition. Washington DC, American Psychiatric Association Publishing, 2019
- Choi-Kain, LW and Sharp, C: Handbook of Good Psychiatric Management for Adolescents with Borderline Personality Disorder. Washington DC, American Psychiatric Association Publishing, 2022.
- Freedenthal S: Helping the Suicidal Person: Tips and Techniques for Professionals. New York, Routledge, 2017
- Miller AL, Rathus JH, Linehan MM: Dialectical Behavior Therapy With Suicidal Adolescents. New York, Guilford, 2007
- Rathus JH, Miller AL: DBT Skills Manual for Adolescents. New York, Guilford, 2015

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Resource for Patients

988

A new crisis hotline number

Patients experiencing mental health crises can call or text 988 and will be directed to the National Suicide Prevention Lifeline.

Coming July 16th nationwide!

Learn more at https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/

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Thank you!

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For resources related to the COVID-19 pandemic, please visit us at [BHIPP Covid-19 Resources](#).

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