Columbia-Suicide Severity Rating Scale (C-SSRs):

A Common Language for the Community

Valerie Martin LISW-S
valerie.martin@cchmc.org

Laura Deitzel LPCC-S
laura.deitzel@cchmc.org

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CEU Information

- The State of Ohio Counselor, Social Worker and Marriage and Family Therapist Board has approved this seminar for 2.75 CEU credits. Cincinnati Children's Hospital Medical Center is an approved provider by the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board (provider number RCX111201).
- No partial credit will be given.
- Be sure your sign in and your email is correct.
- Complete the survey at the end of the training through Survey Monkey.
- Failure to complete sign in, full attendance and survey may result in CEU not given.

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Objectives

- Describe how and when to use the Columbia-Suicide Severity Rating Scale (C-SSRS).
- Utilize assessment findings of the C-SSRS as a common language when discussing suicide with PIRC.

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Helpful Hints

- Stay logged in, even if you step away
- There will be two breaks, but keep your zoom logged in
- You patience and support is appreciated
- Ask questions
- Self Care: the topic is a hard one, take care of you

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Statistics on Suicide

- One million people die by suicide per year. Or one person every 40 seconds.
- Suicide is the #1 kill of adolescent girls around the world
- Since 1999 suicide rates have increased 33% in the United States. Up 5% since 2016

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CDC Statistics on youth

- Nearly 1 in 10 high school student attempt suicide each year.
- 16% of high school students have seriously considered suicide.
- Suicide attempts rose 73% between 1991 and 2017 among Black high school students.
- Survey in June 2020 found the a quarter of 18 to 24 year olds had seriously considered suicide in the past month

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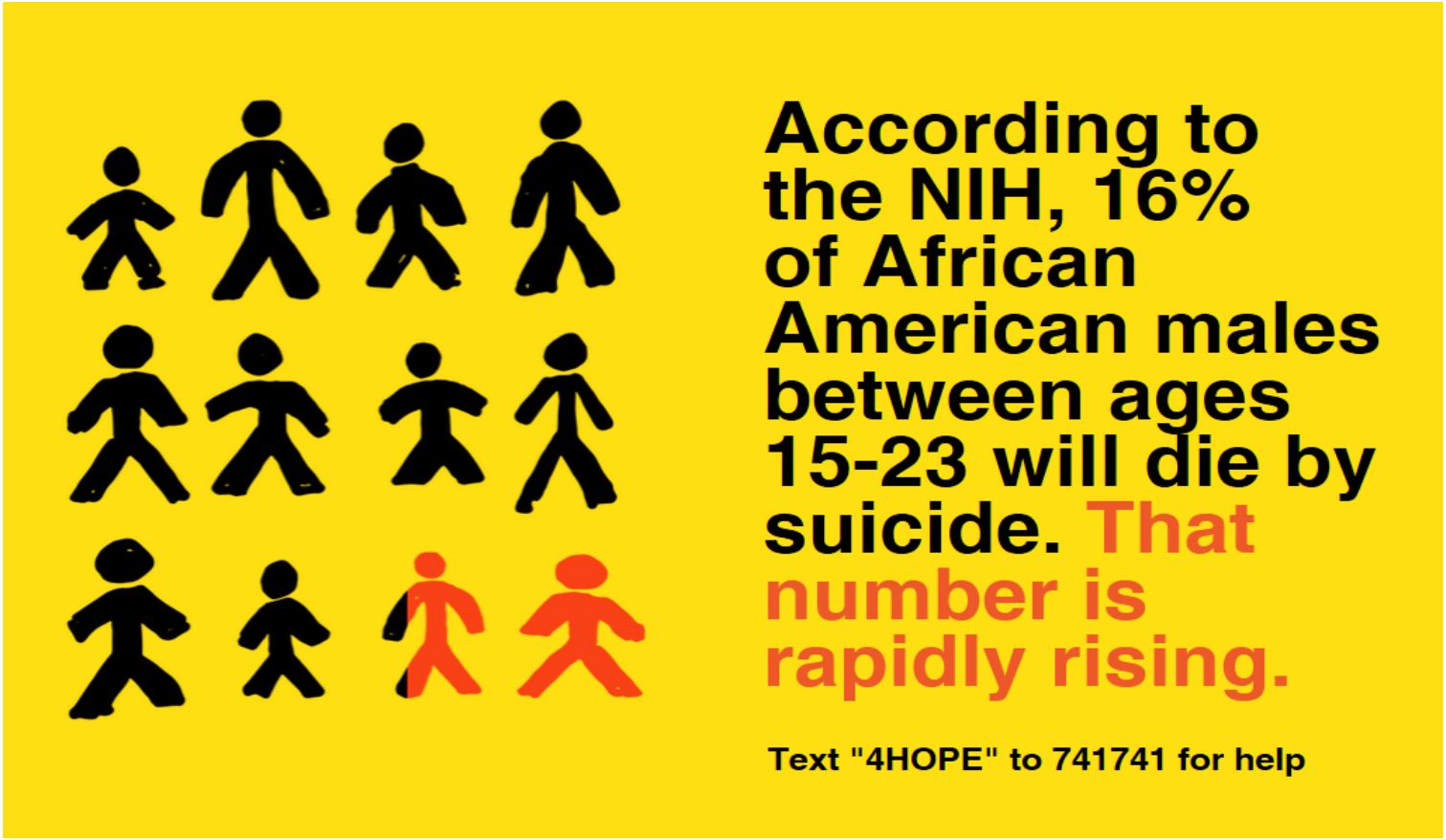
NIH Statistic



Visual from https://www.withyouhere.org/

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2020 CDC statistics on Emergency Department visits

- During mid-March–October 2020 average weekly reported numbers of total ED visits by children were 43% lower compared with those during 2019
- During the same time period children's mental health–related ED visits was approximately 44% higher in 2020 than that in 2019.

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In Ohio

"Suicide is the leading cause of death among Ohioans ages 10-14 and the second leading cause of death among Ohioans age 15-34."

Dr. Amy Action November 2019

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Ohio Statistics

- From 2007 to 2018 the number of suicide deaths increased nearly 45% in Ohio.
- From 2007 to 2018 the number of suicides among youth ages 10-24 increased by 56%. In 2018, 271 of Ohio's suicide deaths were in this age group.
- From 2014 to 2018 the suicide rate among black non-Hispanic males increased nearly 54%.

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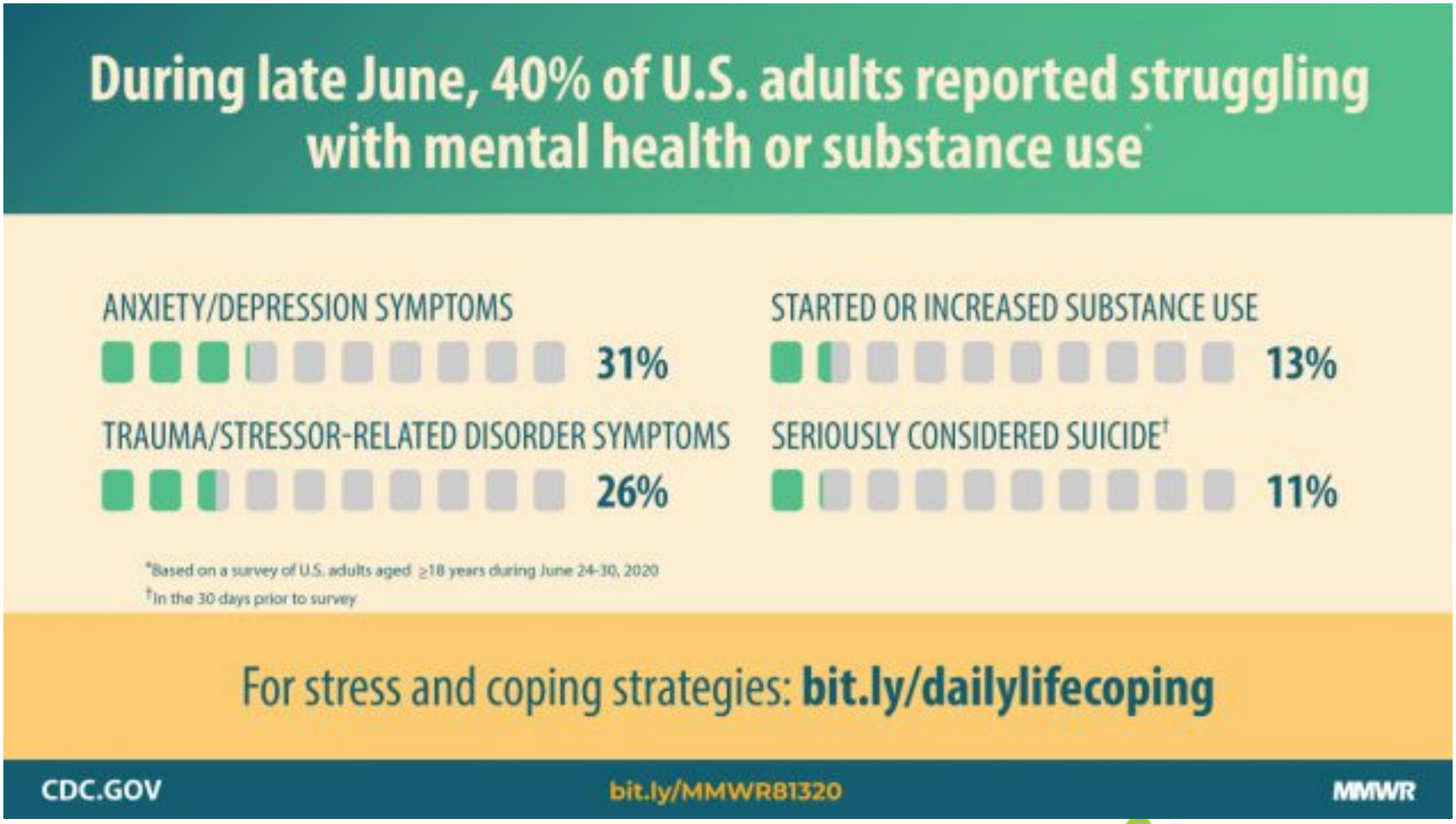
It's not just for the kids



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CCHMC and C-SSRs

PIRC adopted the C-SSRs in January 2017 and it is now being used by PIRC, Social Work, and Inpatient psychiatry at CCHMC and throughout community mental health.

Why the C-SSRS?

- Need for inter-rater reliability
- Documentation of medical necessity
- Common language
- Simple
- Efficient
- Evidence Supported
- Free

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History of the C-SSRS

- Created in 2007 by Columbia University, the University of Pennsylvania, and the University of Pittsburgh as a screening decrease suicide risk among adolescents with depression.
- In 2011, the Centers for Disease Control and Prevention adopted the scale's definitions for suicidal behavior and recommended the use of the C-SSRS for data collection.
- In 2012, the Food and Drug Administration declared the C-SSRS the standard for measuring suicidal ideation and behavior in clinical trials.
- Today, the C-SSRS is used in clinical trials, public settings, and everyday situations, such as in schools, faith communities, hospitals, and the military, to identify who needs help — saving lives in 45 nations on six continents.

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Questions and Misconceptions

- Is suicide really preventable?
- Does asking people about suicide put the idea into their heads?
- If someone intended to attempt suicide, why would that person tell you?
- How can asking the Columbia Protocol questions help me allocate my available resources?

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What is the C-SSRs

- A series of evidenced based question about **suicidal thoughts** and **suicidal behaviors**

- Provides information to laymen and clinical staff to identify next steps for an individual in crisis

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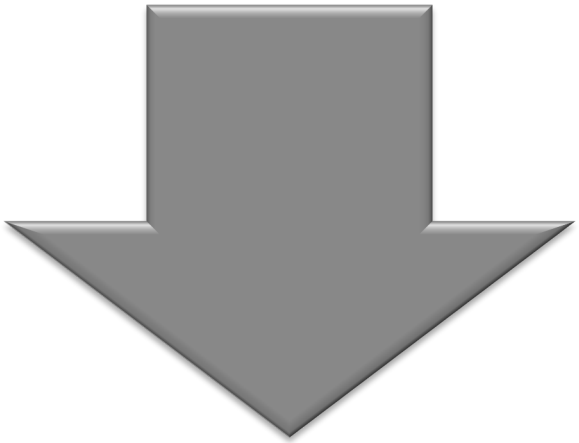
Change in Language…Culture

ACCEPTABLE

- Attempted suicide
- Died by suicide



UNACCEPTABLE

- Completed or Committed suicide
- Successful or Failed attempt
- Non-fatal suicide
- Suicidal gesture or threat
- Manipulative suicide

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Type of C-SSRs

- There are many various versions and formats to the C-SSRs include screener, triage and full scale versions.
- C-SSRs can be modified for different agency needs. Throughout this presentation we will discuss modifications used by PIRC.

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Two Types of C-SSRs

Full Scale

- Up to 26 questions
- Asks about Suicidal Ideation, Intensity of Ideation and Suicidal Behaviors
- More suited of those with Mental Health knowledge

Screener

- Up to 6 questions
- Asks about Suicidal Ideation and Suicidal Behaviors
- Any and Everyone can use

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Using the Scale

- Who can use the Columbia Protocol?
- Do I need training to use it?
- Which version of the protocol should I use?

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Who should use which tool?

Full Scale

- Clinical Counselor
- Licensed Social Worker
- School Psychologist
- Guidance Counselors
- Nurses
- Those with some mental health training

Screener

- School Administrator
- Juvenile Justice Professional
- Teacher/Aide
- Police/Firefighter
- Front Office staff
- Parent/Coach
- Everyone

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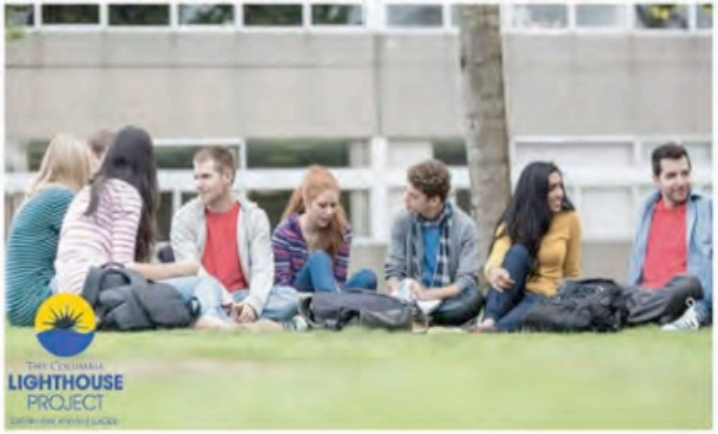
COMMUNITY CARD



ASK YOUR FRIENDS

CARE FOR YOUR FRIENDS

EMBRACE YOUR FRIENDS

See Reverse for Questions that Can Save a Life

	Past 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 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? Do you intend to carry out this plan?	**High Risk**
Always Ask Question 6	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**

Any YES must be taken seriously. Seek help from friends, family
If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for care or call 1-800-273-8255 or text 741741 or call 911

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

DON'T LEAVE THE PERSON ALONE
STAY ENGAGED UNTIL YOU MAKE A WARM HAND OFF TO SOMEONE WHO CAN HELP

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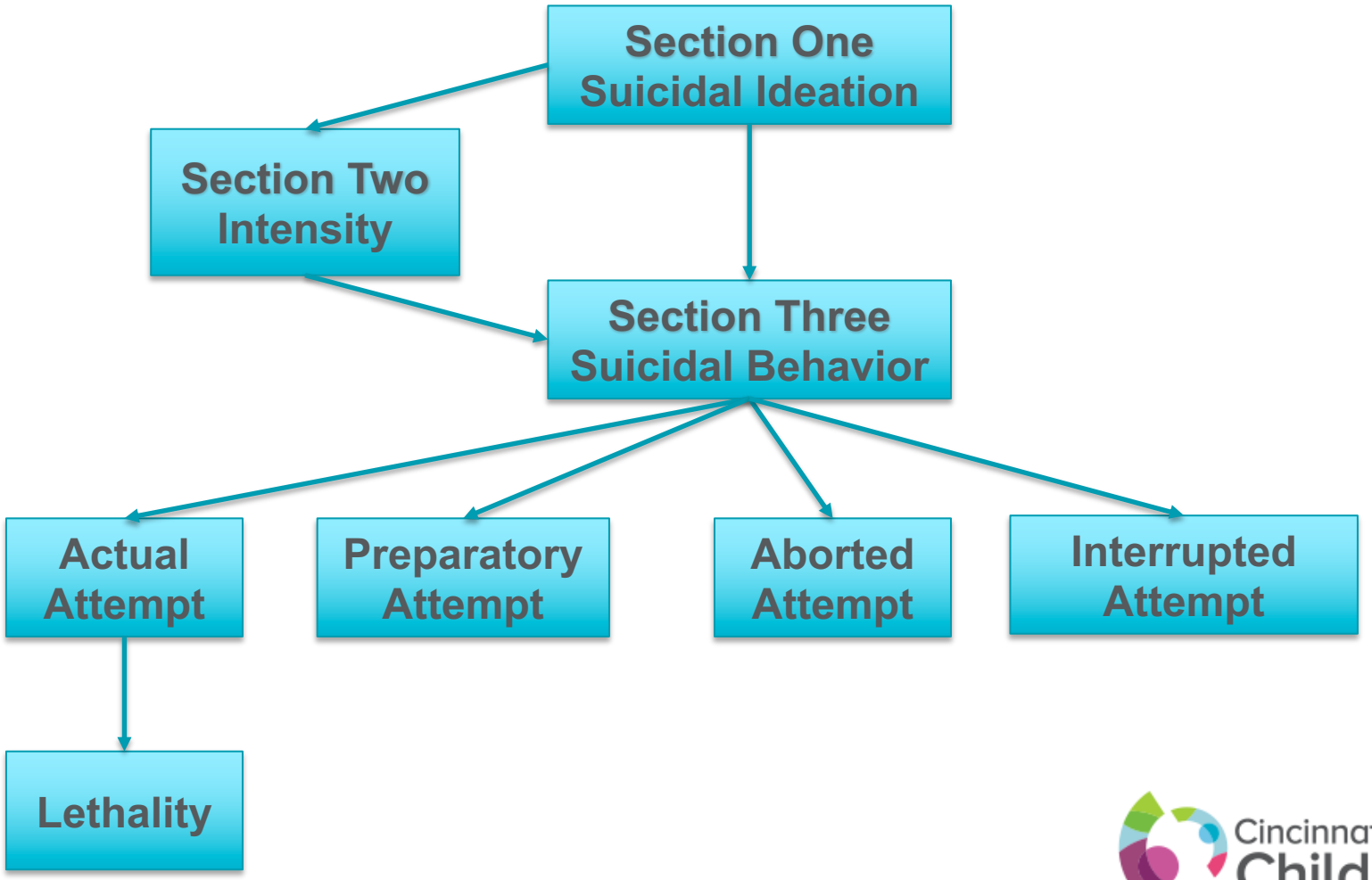
Lifetime/Recent Structure



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Section 1: Suicide Ideation

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 ☐**

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Section 1: Suicide Ideation

- Ask questions 1 & 2. If the answer is **NO** to both, **STOP** - do not ask questions 3-5, **GO** to Section 3: Suicide Behavior.
- If the answer to both or only question 2 is **yes**, **continue** to ask questions 3-5. Then **continue** to Section 2: Suicidal Intensity
- **Auditory hallucination saying "Kill yourself" = Ideation**
- For young Children (under 12), instead of "dead" can use "not alive." See the young child form for different options of how to phrase questions.

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Section 1: Suicide Ideation

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 <u>some intent to act on such thoughts</u>, 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? Do you intend to carry out this plan?** **If yes, describe:**	**Yes No** □ □	**Yes No** □ □

Section 1: Suicide Ideation

- Definition: **Means**
  - "Have you been thinking about how you might do this?"
  - Has the client thought about different ways
    - Hanging, overdosing, jumping off at tall building
- Definition: **Plan**
  - "Have you started to work out the details of how to kill yourself?"
  - Client has answered the questions of how, when, where in their response.
    - After school I would take the pills that I have been hiding in my room before anyone else is home.

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Suicidal Ideation Exceptions

- For young children
  - Use “not alive” instead of “dead”
  - Need to have a concept of death which is different than sleep.
- Hearing a voice telling them to kill themselves counts as a Yes – Auditory Hallucinations

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Polling Questions

- For each questions
  - Select the correct way to complete question 1 and 2 on the C-SSRs
  - Select which questions on the C-SSRs should be asked next

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Polling Question 1

Andy, a ten year old male, presents with anxiety. He says that he is afraid to go asleep after his grandfather died in his sleep. Pt denies wanting to die or thoughts about killing himself ever.

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Polling Question 1

Andy, a ten year old male, presents with anxiety. He says that he is afraid to go asleep after his grandfather died in his sleep. Pt denies wanting to die or thoughts about killing himself ever.

	Lifetime	Past month
Question 1:	No	No
Question 2:	No	No

Next CSSRs questions to ask: Suicidal Behaviors

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Polling Question 2

Violet, 17 year old female, reports that three months ago she wished she could die in her sleep, but denies these thoughts in the last month. She also denies ever thinking about killing herself.

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Polling Question 2

Violet, 17 year old female, reports that three months ago she wished she could die in her sleep, but denies these thoughts in the last month. She also denies ever thinking about killing herself.

	Lifetime	Past month
Question 1:	Yes	No
Question 2:	No	No

Next CSSRs questions to ask: Intensity of Ideation Section

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Polling Questions 3

Olaf, 13 year old male, reports that every day for the past 3 months he wishes he was dead and in the past week has started to have thoughts about killing himself.

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Polling Questions 3

Olaf, 13 year old male, reports that every day for the past 3 months he wishes he was dead and in the past week has started to have thoughts about killing himself.

	Lifetime	Past month
Question 1:	Yes	Yes
Question 2:	Yes	Yes

Next CSSRs questions to ask: Question 3-5 followed Intensity of Ideation and Suicidal Behaviors

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Section 2: Suicide Intensity

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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Section 2: Suicide Intensity

- Once it has been determined patient has suicide ideation, follow-up questions are necessary to help inform your clinical judgement.
- Top part of this section is just bringing down the data from suicidal ideation or what was the last question the child said yes to for each time period.
- **For very young children**
  - Only ask “How many times have you had these thoughts?”
  - Options are, “Only one time,” “A few times,” “A lot,” “All the time” and “Don’t know/Not Applicable.”

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Section 2: Suicide Intensity

- **Intensity Questions:**
  - **Frequency**: How many times have you had these thoughts? (Only one question for the very young child version)
  - **Duration**: When you have these thoughts how long do they last? (studies have shown that teenagers with higher duration of the suicidal ideation are at higher risk compared to other questions in this section.)

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Section 2: Suicide Intensity

Controllability **Could/can you stop thinking about killing yourself or wanting to die if you want to?** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	___	___
Deterrents **Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?** (1) Deterrents definitely stopped you (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	___	___
Reasons for Ideation What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both? (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on and to end/stop the pain living with the pain or how you were feeling) (0) Does not apply	___	___

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Section 2: Suicide Intensity

- **Intensity Questions**
  - **Controllability**: Can you stop thinking about killing yourself or wanting to die if you want to?
  - **Deterrents**: Are there thigs – anyone or anything that stopped you from wanting to die or acting on thoughts of committing suicide?
  - **Reasons for ideation**: What reasons did you have for thinking about wanting to die or killing yourself? To end the pain or stop the way you were feeling? To get attention, revenge or a reaction from others?

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Practice in Breakout Rooms

- Group will create scenario in which either or both questions 1 and 2 are yes
- 4 to 5 people in a room and each has a role
  - Child, Counselor, and other are observers
- Complete the C-SSRs through the 1st two sections (suicidal ideation and intensity of ideation)

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Section 3: Suicidal Behavior

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)	Lifetime	Past 3 months
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as meth-od to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be any injury or harm, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a highly floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. Have you made a suicide attempt? Have you done anything to harm yourself? Have you done anything dangerous where you could have died? What did you do? Did you_____ as a way to end your life? Did you want to die (even a little) when you_____? Were you trying to end your life when you _____? Or Did you think it was possible you could have died from_____?	Yes No ☐ ☐ Total # of Attempts _____	Yes No ☐ ☐ Total # of Attempts _____
Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)? (Self-Injurious Behavior without suicidal intent) If yes, describe: Has subject engaged in Non-Suicidal Self-Injurious Behavior?	Yes No ☐ ☐	Yes No ☐ ☐

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Section 3: Suicidal Behavior

- Definition: **Suicide attempt**
  - "potentially self-injurious act with at least some intent to die"
  - Actual harm is not needed, just **potential** for injury
  - A suicide attempt begins with the first pill swallowed or scratch with a knife

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Intent is of primary importance

- Definition: **Intent**
  - **"Wish to die"** Client does not have to endorse 100% wanting to die, if any part of them wanted to die then the act would be considered an attempt
  - Helps determine if act was a suicide attempt or self harm

- Definition: **Inferred Intent**
  - A client does not respond or denies intent/plan to die, but the behavior and potential for being lethal is evident.
  - A client denies intent to die, but they thought that what they did could be lethal.
  - "**Clinically impressive**" circumstances – highly lethal act where no other intent but suicide can be inferred

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How to ask the questions

- Have you made a suicide attempt?
- Have you done anything to harm yourself?
- Have you done anything dangerous where you could have died?
- What did you do?
- Did you_____ as a way to end your life?
- Did you want to die (even a little) when you_____?
- Were you trying to end your life when you _____?
- Or Did you think it was possible you could have died from_____?

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Section 3: Suicidal Behavior

- Definition: **Self injurious behavior**
  - Self harming for other reasons than to kill oneself
  - No intention of death
  - Purpose of action was to relieve stress, feel better get sympathy or *get sympathy, attention, make someone angry*

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Section 3: Suicidal Behavior

Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:	Yes ☐ No ☐ Total # of interrupted _____	Yes ☐ No ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:	Yes ☐ No ☐ Total # of aborted or self-interrupted _____	Yes ☐ No ☐ Total # of aborted or self-interrupted _____

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Section 3: Suicidal Behavior

- Definition: **Interrupted Attempt**
  - When person starts to take steps to end their life, but someone or something stops them. Bottle of pills or gun in hand but someone grabs it. On ledge poised to jump, but police stop them.
  - "*Has there been a time when you started to do something to end our life, but someone or something stopped you before you actually did anything?*"

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Section 3: Suicidal Behavior

- Definition: **Aborted or Self Interrupted Attempt**
  - When a person begins to take steps towards making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior.
  - "*Has there been a time when you started to do something to end your life, but you stopped yourself before you actually did anything?*"

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Section 3: Suicidal Behavior

Preparatory Acts or Behavior: **Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).** **Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?** **If yes, describe:**	**Yes No** □ □ **Total # of preparatory acts** _____	**Yes No** □ □ **Total # of preparatory acts** _____

- Definition: **Preparatory Acts or Behavior**
  - Any other behavior – beyond saying something with suicide intent. Not impulsive, but planned. Collecting or buying pills; Purchasing a gun; Writing a will or suicide note
  - *"Have you taken any steps towards making a suicide attempt or preparing to kill yourself such as, collecting pills, getting a gun, giving valuables away, writing a suicide note?"*

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Section 3: Suicidal Behavior

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/ First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	Enter Code _____	Enter Code _____	Enter Code _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	Enter Code _____	Enter Code _____	Enter Code _____

Actual Lethality/ Medical Damage

0. No physical damage or very minor physical damage (i.e., surface scratches)
1. Minor physical damage (i.e., lethargic speech; 1st degree burns; mild bleeding; sprain)
2. Moderate physical damage/medical attention needed (i.e., conscious, but sleepy; somewhat responsive; 2nd degree burns; bleeding of major vessel)
3. Moderately severe physical damage/medical hospitalization and likely intensive care required (i.e., comatose with reflexes intact; 3rd degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage/medical hospitalization with intensive care required (i.e., comatose without reflexes; 3rd degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

Potential Lethality:

Only answer if actual lethality is 0

1. Behavior not likely to result in injury
2. Behavior likely to result in injury but not likely to cause death
3. Behavior likely to result in death despite available medical care

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Polling Question 4

Rapunzel wanted to escape from her mother's home. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother's home. She was taken to the emergency department where her stomach was pumped and she was admitted to a psychiatric unit.

Was this a suicide attempt?

◯ Yes ◯ No ◯ Not enough information

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Polling Question 4

Rapunzel wanted to escape from her mother's home. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only to escape from her mother's home. She was taken to the emergency department where her stomach was pumped and she was admitted to a psychiatric unit.

Was this a suicide attempt?

No – She never wanted to die. No intent

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Polling Question 5

Anna, age 15, following a fight with her boyfriend, felt like she wanted to die, impulsively took a kitchen knife and made a superficial scratch to her wrist. Before she actually punctured the skin or bled, she changed her mind and stopped.

Was this a suicide attempt?

◯ Yes ◯ No ◯ Not enough information

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Polling Question 5

Anna, age 15, following a fight with her boyfriend, felt like she wanted to die, impulsively took a kitchen knife and made a superficial scratch to her wrist. Before she actually punctured the skin or bled, she changed her mind and stopped.

Was this a suicide attempt?

Yes – She wanted to die. There was intent.

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Polling Question 6

Ralph was feeling ignored. He went into the kitchen where mother and sister were talking. He took a knife out of the drawer and made a cut on his arm. He denied that he wanted to die, but just wanted them to pay attention.

Was this a suicide attempt?

◯ Yes ◯ No ◯ Not enough information

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Polling Question 6

Ralph was feeling ignored. He went into the family kitchen where mother and sister were talking. He took a knife out of the drawer and made a cut on his arm. He denied that he wanted to die, but just wanted them to pay attention.

Was this a suicide attempt?

No – He didn't want to die. There was no intent

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Polling Question 7

Sally cut her wrist after an argument with her boyfriend.

Was this a suicide attempt?

◯ Yes ◯ No ◯ Not enough information

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Polling Question 7

Sally cut her wrist after an argument with her boyfriend.

Was this a suicide attempt?

Not enough information

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Polling Question 8

Wendy stated that she experienced heartbreak over the "loss of her boyfriend" a week ago. She stated that she took 4 clonazepam, called a girlfriend, and talked/cried it out while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose.

Was this a:

- ◯ Suicide attempt
- ◯ Interrupted attempt
- ◯ Aborted attempt

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Polling Question 8

Wendy stated that she experienced heartbreak over the "loss of her boyfriend" a week ago. She stated that she took 4 clonazepam, called a girlfriend, and talked/cried it out while on the phone. She was dismissive of the seriousness of the attempt, but indicated that she wanted to die at the time she took the overdose.

This was a:

Suicide attempt – There was intent and she actually took pills. It does not matter that it was not a lethal dose.

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What's next?

- Complete a crisis management plan.
- Connect the student to their mental health provider or primary care physician.
- Call PIRC **513-636-4124** if further assessment is needed either through Bridge Clinic or the Emergency Department.

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C-SSRs in a Co-Vid19 World

- You need the location of the student.
- Ask if there are adults in the home or at their location.
- Try to ensure child has privacy when answering questions.
- If you can use a visual platform to do the assessment. (non-verbal communication)
- Then follow up with parent.

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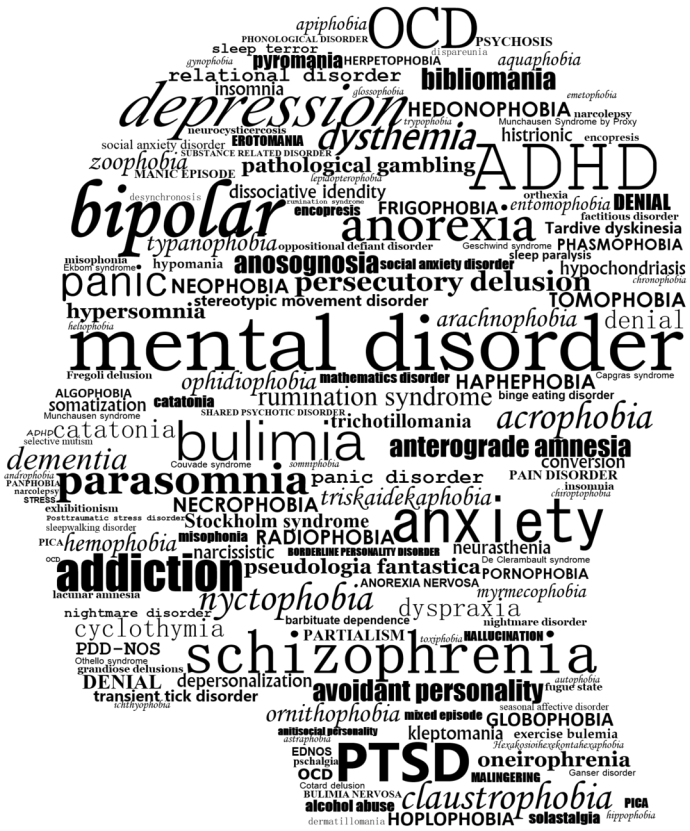
PIRC

Psychiatric
Intake
Response
Center

513-636-4124



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What does PIRC do

A. Psychiatric Consult Team to the ED at Base and Liberty Campuses
Coordinate psychiatric admissions based on medical necessity

- Licensed independent Social Workers and Clinical Counselors
- Psychiatric assessments to determine level of care
- Evidence Based Suicidal Screen and/or Assessments
- Evidence Based interventions
- 24/7

B. Intake Coordinators available assist with connecting to mental health service
Triage calls from community and families, Information and referral
Schedule and/or refer patients to the appropriate service based on clinical need

- Emergency Department
- PHP
- Outpatient
- Bridge

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What does PIRC NOT do

- Threat Assessment
- Letters to schools indicating the patient is NOT a threat and is safe to return to school
- Medication assessment and/or management
- Alcohol/Drug Assessment
- Residential Assessment
- Psychological Testing
- Psychiatric Hold on a patient ≤ 17 year old

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Endorsed, Recommended and adopted by

- The Joint Commission
- Center for Disease Control and Prevention
- Federal Drug Administration
- National Institute of Health
- World Health Organization
- SAMHSA

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Questions?

For more information:
http://www.cssrs.Columbia.edu

For further trainings:
http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/cssrs_web/course.htm

https://www.youtube.com/watch?v=Xfddz_Yfnc4

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Crisis Management Planning: A Critical Mental Health Intervention to Mitigate Suicide Risk

Monica vonAhlefeld, LISW
Emergency Department Social Worker/ Bridge Clinician
Psychiatric Intake Response Center (PIRC)

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Objectives

1

Understand the necessary elements to create an effective mental health crisis plan.

2

Understand that Crisis Management planning is a critical intervention with individuals at risk for suicide.

3

Understand that a Crisis Management plan and a suicide risk assessment, such as the C-SSRS, work cooperatively to decrease risk.

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Polling Question One

Does your employment setting have a Mental Health Crisis Management Plan template in place for your use?

- ❑ Yes
- ❑ No

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Crisis Management Plan Defined (Mental Health Crisis Plan)

According to the (National Alliance of Mental Illness, NAMI (2018)

"A crisis plan is a written plan developed by the person with the mental health condition and their support team, typically family and close friends. It's designed to address symptoms and behaviors and help prepare for a crisis."

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Crisis Management Planning

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WHY Initiate a Crisis Management Plan

- Increase safety/ Decrease risk
- Propose safe options when unable to reason in a crisis.
- Crisis Management Plans may be used both for self-harming behavior as well as suicidal thoughts without acute intent or plan. Other non-acute issues may be addressed on a Crisis Management Plan.
- Help an individual feel more in control of their problems and treatment.
- Assist with future treatment goals.
- Provide reassurance for the individual and guardian/family.
- Enhance Communication with individual and guardian/family.

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WHY it works?

According to the Centre for suicide prevention,

"A safety plan is an assets-based approach designed to focus on a person's strengths. Their unique abilities are identified and emphasized so they can draw on them when their suicidal thoughts become intense."

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Polling Question Two

The best time to complete a mental health crisis plan is when:

a. Youth is in crisis.
b. Youth is stabilized and calm.
c. Youth is alone.
d. Youth and guardian are present.

(Choose all that apply)

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WHEN it is appropriate to initiate

A Crisis Management Plan is formulated *AFTER* risk is assessed and *WHEN* it is determined appropriate and safe to proceed. When assessing risk, the provider must ask specific questions about suicidality.

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Some Examples of WHEN Crisis Management Planning May be Appropriate

- Youth is cooperative and able to participate in a safety/risk assessment. Youth denies current plan, intent, means.
- A qualified support provider has assessed safety.
- There is no known immediate risk and the outpatient provider is available to assess.
- Guardian is not requesting an Emergency Department Assessment.
- No medical concerns.
- The symptoms are being managed appropriately by an outpatient provider.
- Behavioral Issues are not emergent or acute.
- Guardian feels safe with child at home.
- Guardian is able and willing to implement home safety.
- Guardian is involved in the crisis planning process.

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WHO is involved

Youth ~ Guardian ~ Support Provider

- A Guardian *MUST* be involved and in agreement with this plan of care.
- Youth must be engaged and willing to participate.
- Support provider who can assist in a risk assessment and if appropriate, the crisis management plan.

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Examples not limited to:

- Individuals with increased risk factors, but *without* acute risk of suicide.
- Individuals struggling with mental health concerns that are not life-threatening. Examples include anxiety, depression, school refusal, behavior issues, etc. (not imminent)
- Individuals capable, willing, and able to be assessed and to discuss the intervention.
- Guardians who are involved, willing and capable of safety planning for their child.
- Individuals with Protective Factors

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Protective Factors

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Protective Factors

- **Social Connectedness**
  - Connectedness to parents/ non-parental adults/ friends/ neighbors
  - Connectedness to community organizations (schools, faith groups).
- **Self-esteem/Sense of Purpose**
- **Life Skills**
  - Problem solving/ Coping skills
  - Adaptability to change
  - Overall resilience – positive self-concept and optimism
  - Academic Achievement
- **Cultural, religious, personal beliefs that discourage suicide**.
- **Access to Effective Behavioral Health Care**

(Suicide Prevention Resource Center, https://www.sprc.org/about-suicide/risk-protective-factors)

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WHERE Crisis Management Planning Occurs

Crisis Management Planning may occur in schools, outpatient clinics, agencies, Physician's offices, etc.

However, in certain circumstances it is most appropriate to refer to the Emergency Department.

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Factors to consider when establishing WHERE to safety plan

Immediate Safety Concern  Emergency Department

Helpful Factors when able to safety plan:

- Least Restrictive
- Least Traumatic
- Does not stress families - Logistics/Financial Stressors
- Avoids transmission risk/ ED exposure

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Some Examples of Appropriate Referrals to the Emergency Department

- Guardian has an acute safety concern and/or requests an ED evaluation.
- Recent/immediate suicide attempt.
- Youth has Plan/Intent/Means.
- Youth is unwilling to discuss suicidality or to state that they will be safe.
- Medical concern (possible ingestion, etc.)
- Provider does not feel capable to assess for safety or to complete crisis plan.
- Your instincts tell you the youth is at risk for suicide and other social or environmental dynamics are or concern for safety.

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Polling Question Three

Sarah notifies her school guidance counselor that she has had past thoughts about wanting to die. She reports that she last had the thoughts one week ago. At that time, she did not attempt to end her life and she did not have a plan. Sarah's guidance counselor completes the C-SSRs with Sarah and determines that she has no intent or plan presently to end her life. She has been recently cutting, however she denies that this was with intent to die.

Based on initial information, should the guidance counselor refer Sarah directly to the Emergency Department?

- ❑ Yes
- ❑ No

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Trust Your Instincts

Every situation is unique. Sometimes Crisis Management Planning is an appropriate deterrent from the ED.

Trust your instincts about safety and call PIRC

(513-636-4124)

for guidance when considering the Emergency Department.

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WHAT are some components to include in a Crisis Management Plan ?

Crisis Management Plans may be individualized for your setting, however key components to include are:

- Warning Signs/Triggers
- Home Safety Planning
- Coping skills & Problem Solving
- Family/Friends/Community Supports
- Interventions
- Steps to Use when in Crisis
- Crisis Resources

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Cincinnati Public Schools Crisis Management Plan

	CRISIS MANAGEMENT PLAN SAFETY PLAN TRANSITION PLAN	Page 1 of 2

This plan is designed to help maintain my wellbeing and prepare me for times of high stress and/or anxiety. It includes plans to make my day safer, identifies when I need help, helps me figure out what to do cope, and what to do in crisis situations.

PREVENTATIVE STRATEGIES How can the day be safer?	
☐	Check-in and out with an adult at certain times → Describe:
☐	Increase supervision – Describe:
☐	Practice coping skills with an adult
☐	Review daily routine with staff member
☐	Staff member will search child's bookbag/locker to ensure unsafe items are removed
☐	Supervise at all times (Not allowed alone to restroom or in the hallway)
☐	Other:
☐	Other:

TRIGGERS What words, events, or actions ignite negative feelings and risky behavior? What makes me upset?	
Locations/Events	***Triggers***
At home	
During class	
During specials/ electives (i.e. Art, Music, PE)	
Cafeteria/Playground (breakfast/lunch)	
During school arrival/dismissal	
Other locations/events:	

KNOWING WHEN I NEED HELP (WARNING SIGNS OF ANXIETY) *I know I am beginning to feel stressed and unsafe when:*	
Physical (Body)	**Thoughts & Feelings**

MY COPING SKILLS What can I do when I am faced with my triggers?		
*What can I do when I **start to feel anxious and/or getting upset**?*		
☐ Ask to get a drink of water	☐ Draw/Color/Write in journal	☐ Think of a peaceful place
☐ Ask to go to the "Calming corner"	☐ Forgive, let go, and move on	☐ Tell the teacher and ask to be moved
☐ Ask who is bothering me to "Please stop."	☐ Stretch	☐ Use a stress ball/fidget
☐ Count to 10	☐ Take slow mindful breaths	☐ Use kind caring positive self-talk
☐	☐	☐
*What can **my teachers do to help** when they notice me getting anxious?*		
☐ Allow me to see a trusted adult	☐ Give space, but check in	☐ Spend 1:1 time
☐ Give me a task to do	☐ Listen	☐
☐	☐	☐

CRISIS PLAN *When it becomes dangerous for me or others around me*	
List dangerous behaviors:	What steps should be taken: (list at least 3) 1. 3.

Name: _____ DOB: _____ Grade: _____ School: _____ Date: _____ Transitioning From: _____ To _____	CRISIS MANAGEMENT PLAN SAFETY PLAN TRANSITION PLAN	Page 2 of 2

RE-ENTRY	
How am I going to tell my friends when I get back to school about where I have been?	Who is going to tell my teachers about my plan?
I will: ☐ Refer to this plan when I am in a crisis ☐ Review this my family ☐ Review with someone I trust at my school ☐ Review with my mental health provider	

MY SCHOOL SUPPORTS When my coping skills aren't working, who can I talk to for additional support?		
Name (Role)	**Phone number/Extension**	**How can I get access to them? (Ask, signal)**

MY UPCOMING APPOINTMENTS		
Name of Organization	**Reason**	**Date/Time**

MY ADDITIONAL COMMUNITY RESOURCES When my coping skills aren't working outside of school, who can I talk to for additional help?			
Place/Name	**Phone number/Ext.**	**Place/Name**	**Phone number/Ext.**
CCHMC Psychiatric Intake Response	(513) 636 – 4124	National Suicide Prevention Lifeline	1 (800) 273-TALK [8255]
Children's Home (main line)	(513) 272-2800	St. Joseph's Orphanage (Central Access)	(513) 741-5690 ext. 2214
Crisis Text Hotline	Text 4hope to 741741	Suicide Prevention My3 App	http://my3app.org/
Emergency Services	911	Talbert House Care Crisis Hotline	(513) 281-CARE [2273] OR Text Talbert to 839863
Hamilton County Mobile Crisis	(513) 584-5098	Trevor Project (LGBTQ Youth)	1 (866) 488-7386

SIGNATURES: Use an asterisk (*) to indicate the central contact person

Name	Title	Best method of contact (i.e. phone, email)	Signature
	Student		
	Parent/Guardian		
	Administrator		
	General Ed. Teacher		
	Intervention Specialist		
	School Psychologist		
	School Resource Officer		
	Other:		
	Other:		

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Crisis Management Plan

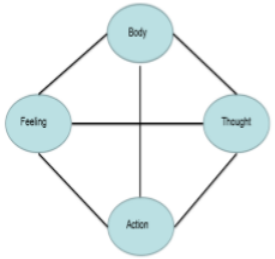
Name: _____
DOB: _____
MRN: _____

Date: _____

This plan is designed to help maintain my well-being and prepare me for times of high stress and/or crisis. It includes making my environment safe, identifies when I need help, and my coping strategies.

MAKING MY HOME SAFE
☐ Lock up all sharp objects, weapons, medications, choking items, and poisons
☐ Increase supervision
☐ Guardian will search child's room to ensure unsafe items are removed
☐ Follow daily routine
☐ Bedroom door remains open and bathroom door remains open/unlocked
☐

Cognitive Behavioral Therapy Model: Helps me better understand the connections between my thoughts, feelings, body, and actions



COPING SKILLS & PROBLEM SOLVING	
What can I do on my own to make the situation better?	
☐ Draw/color	☐ Write in journal
☐ Listen to music	☐ Deep belly breaths
☐	☐
When my parents/caregivers notice my warning signs, what can they do to help?	
☐ Listen	☐ Spend one-on-one time
☐ Give space, but check in	☐
☐	☐

FAMILY/FRIEND/COMMUNITY SUPPORTS

When my parents/caregivers and I struggle to resolve my crisis, who can we call for additional help?

Place/Name	Phone Number
1.	
2.	
3.	

UPCOMING APPOINTMENTS

Place/Name	Date/Time
1.	
2.	

If you or your parents/caregivers notice you are struggling or are in crisis, follow these steps:

1. Tell your parent/caregiver (or someone you trust) that you feel unsafe.
2. Parent/caregiver: ask your child how they are feeling.
3. Review the Crisis Management Plan and the intervention(s) you and your child learned (see below).
4. If you are still in need of help, call your child's outpatient mental health provider.
5. If you are in need of additional assistance call the Psychiatric Intake Response Center (PIRC) at 513-636-4124.
6. After you have tried numbers 1-4 above and feel you cannot keep your child safe call 911 or take your child to the nearest emergency room.

INTERVENTIONS (Please check all that apply)

☐ Cognitive Behavioral Therapy (CBT) Model – Diagram on page one.
- Discussed the connection between thoughts, feelings, actions and body.
- Outlined current symptoms and how a change in one area can impact the other areas.

☐ Behavioral Activation Intervention
- Engaging in activities improves mood and combats negative thoughts.
- Identify an activity you enjoy and identify a time to engage in the activity.
- Specifically: _____

☐ Cognitive Intervention
- Self-talk/Self instruction- change the inner dialogue: "just because_____doesn't mean_____."
- Specifically: _____

☐ Praise Intervention
- Praise/attention given to a behavior increases the likelihood the behavior will occur more frequently.
- Remember the behavior(s) you identified to work on and practice the strategies that you learned.
- Always give Specific Praise for Compliance.
- Specifically: _____

☐ Effective Directions
- Avoid unnecessary commands, "information" questions and avoid "tone of voice" questions.
- Specifically: _____

RESOURCES PROVIDED

Agency Name	Phone Number
1.	
2.	

ADDITIONAL COMMUNITY RESOURCES:

☐ National Suicide Prevention Lifeline: **1 (800) 273-TALK [8255]**

☐ Suicide Prevention Apps: **My3** http://my3app.org/ | **A Friend Asks** http://jasonfoundation.com/get-involved/student/a-friend-asks-app/

☐ CCHMC Psychiatric Intake Response: **(513) 636-4124**

☐ Crisis Text Line: **text HOME to 741741**

☐ Trevor Project LGBTQ: **1-866-488-7386** *or* **Text START to 678678**
or online **TrevorChat** at: https://www.thetrevorproject.org/get-help-now/

☐ Emergency Services: **911**

Name of persons completing form:

Patient: _____ Parent/Caregiver: _____

Clinician: _____ Other: _____

Guiding Youth and Families Through Crisis Management

Step One	Risk - Rapport- Communication
Step Two	Introduce the Safety Plan / Family Engagement
Step Three	Establish Home Safety
Step Four	Discuss Coping Skills and Problem Solving
Step Five	Identify Community Supports and Secure Appointments
Step Six	Encourage Use of Resources and Follow-up
Step Seven	Review Steps to Use in a Crisis

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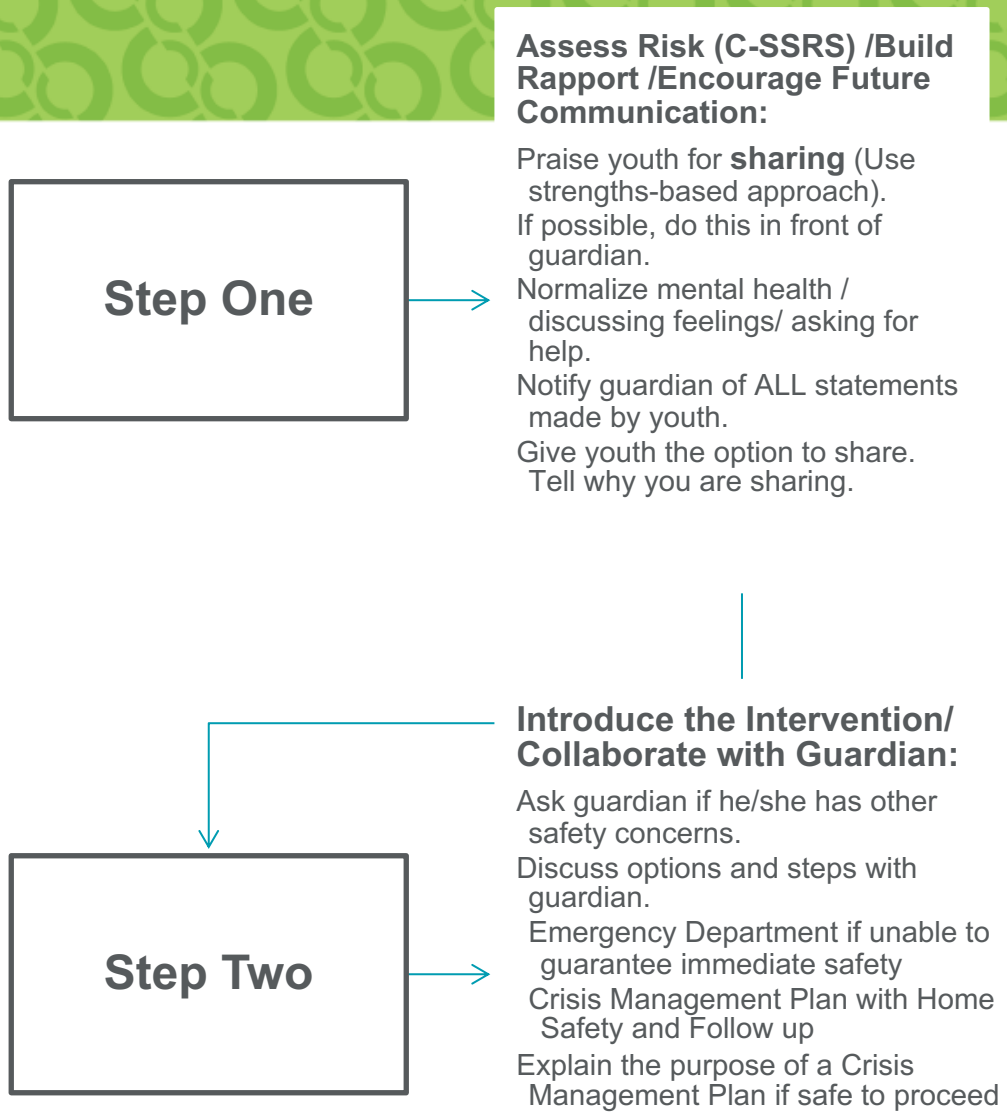
Assess Risk/ Introduce the Intervention



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Home Safety Coping Skills

Step Three

Establish Home Safety :

Provide information on safety planning. (Handouts recommended).

"Keeping My Child Safe at Home"

Stress securing all items, but especially those related to history of plans or methods.

Ask guardian about safety concerns in home. This should be done in private.

Recommend ***strict rules of safety*** until further mental health resources are implemented.

Step Four

Discuss Coping Skills / Problem Solving:

Youth lists current coping skills used.

Encourage coping away from home (at school, youth group, etc.)

Encourage youth to ask guardian for help.

Use tools of communication when needed (1-10 rating scale; code word)

Ask youth what guardian can do if they notice warning signs.

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Home Safety Handout

Keeping Your Child Safe at Home

Research tells us that children are at high risk for suicide or self-harm after discharge and before their first mental health outpatient appointment.

It is now important for you to help your child in these ways.

We ask that you:

- Watch your child closely until safety planning is progressed through collaboration with outpatient mental health provider.
- Talk with the therapist about how you will keep your child safe.
- Keep all mental health appointments.
- Remove all firearms from the home.
- Keep checking your child's room for unsafe items.
- Secure all razors, knives, scissors, and other sharp objects. If your child needs to use these objects, he/she should do so under adult supervision. If your child has a history of self-harm or there are new concerns of self-harming behavior, conduct skin checks 1 times per week, or more often if needed.
- Search your child's room before discharge in order to remove any potentially unsafe objects. Conduct room checks 1 times per week, or more often if needed.
- Lock medications (prescription, over-the-counter, and vitamins), household chemicals, cleaners, poisons, and all sharp objects in a lock box or locked tool/tackle box.
    - Look for these items in your home, garage, basement, kitchen, bathroom, and storage areas.
    - Give all medication to your child and watch him/her swallow it.
- Secure all car keys (regardless of your child's age) and if applicable, do not permit your child to drive a vehicle for a minimum of 30 days following discharge.
- Use car harness, door/window locks and alarms, cameras, and/or GPS tracker as recommended.
- Ask your child to stay in common areas of the home to avoid isolation (when awake).
- Ask your child to keep doors open (bedroom and bathroom doors can be partly open).
- Do not permit sleep overs or social activities unless you or a trusted adult can supervise your child the entire time.
- Listen to your child. Do not judge or criticize. Be mindful of the way your behavior/reactions and attitudes affect your child.
- If you or your child believes that things are getting worse, follow these steps:
    - Ask your child if he/she is thinking about hurting self or others.
    - Read your child's Safety Plan and calmly help your child remember the coping skills.
    - Call your child's outpatient mental health provider for help.
    - Call the Psychiatric Intake Response Center (PIRC) at 513-636-4124 for help.
    - Call 911 or take your child to the nearest emergency room if you feel you cannot keep your child safe.

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Appointments Resources

Step Five

Identify Community Supports/ Secure Appointments:

Youth and guardian will provide names/ phone numbers of who to contact when in crisis.

Ensure that child has an adult contact and that they utilize an adult's support in crisis.

Assist in securing appointments as able.

Step Six

Encourage Use of Resources:

List area resources on crisis plan.

Discuss apps, crisis hotlines and other links to help when in need.

Normalize help.

Therapists talk to therapist. Doctors go to Doctors.

Decrease apprehension/ fear in community support.

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Step Seven

Review Steps to Use in Crisis:

Go over the following steps with youth and guardian.

Ensure understanding and adherence.

Youth will tell guardian/ a trusted adult when feeling unsafe.

Guardian will ask additional questions about feelings, thoughts, safety.

Review the youth's Crisis Plan (Coping Skills & Problem Solving).

If still in need of help, call mental health provider.

If needing additional assistance of information, call PIRC.

If you have tried the initial steps and guardian feels that youth is unsafe, call 911 or take youth to the nearest Emergency Department.

Steps to Use in Crisis

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Community Resources

Mobile Response & Stabilization Services (MRSS)

https://mobileresponse.org/

Serving Butler, Preble, Warren and Clinton

Access by calling the County's hotline 24/7

- **Butler Co. Mobile Crisis 1 (844) 427-4747**
- **Warren/Clinton Co. Mobile Crisis 1 (877) 695-6333**
- **Preble County: (866) 532-3097**
- **Hamilton Co. Mobile Crisis (513) 584-5098**
- **Clermont Co. Mobile Crisis (513) 528-7283**
- **National Suicide Prevention Lifeline 800-273-8255**

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When in doubt, Call us:

1. Do not leave patient unsupervised

2. **Call PIRC 513-636-4124**

3. Provide your contact information and caregiver contact information

4. Report: triage symptoms and concerns

5. Review Complicating factors
   - aggression/impulsiveness
   - transportation

6. Discuss and determine urgency of evaluation

7. Parent consent

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PIRC BRIDGE

Purpose:

Provide an alternative level of care for patients who have been assessed in the ED, triaged by PIRC via phone, or stepped-down from acute hospitalization

Objectives:

- Minimize unnecessary inpatient stays
- Reduce unnecessary ED visits via the availability of a crisis clinic
- Provide crisis management intervention for safety and stability
- Support transition to ongoing mental health providers

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PIRC BRIDGE

Service Components

1. Care Coordination Calls (CCC):
   Telephonic assistance to families

2. Crisis Intervention appointments:
   Outpatient appointment with PIRC Clinician

3. Psychiatric prescriber appointments:
   Medication management with MD or APRN

4. Telehealth appointments via TEAMS

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Bridge Criteria

- No current Mental Health Providers
- Delay in care: Patient's current provider is not accessible to assist in the current crisis event
- Patient not actively suicidal/homicidal with plan within the last 24 hours
- Patient not actively aggressive causing significant harm to others/objects within the last 24 hours
- Patient has engaged parent/guardian, who has the ability to complete safety plan
- Patient is not developmentally delayed – e.g. patient with Dx of Intellectual Disability

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Pathways to PIRC Bridge

1. ED diversion – family, community providers, schools and PCP's
2. Psychiatric patients discharged from the emergency department
3. CCHMC outpatient providers who have patients who are experiencing a mental health crisis
4. Patients presenting to the ED who have no medical concern (triaged at greeter's desk)

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Telehealth During Crisis Assessment and Crisis Management

Pros

- Access to remote locations
- Access to clients unable or unwilling to leave home.
- Child Welfare Concerns Discovered
- Increased frequency of service delivery
- Health/Wellness of provider and youth
- Increased safety for provider in dangerous settings
- Less shame/stigma than in person

Cons

- Challenges addressing suicidal/homicidal concerns
- Challenges Addressing Child Welfare Concerns
- Decreased Control over the Clinical Interaction
- Impersonal, Issues picking up on non-verbal cues
- Technology Difficulties

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Telehealth: Managing Mental Health and Child Welfare Concerns

Establish a Crisis Protocol for Telehealth Use

Be aware of State Guidelines

Have Crisis Resources Available

Know when to Contact Authorities / Child Welfare Agencies

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Breakout Session One

Gina, age 16, was sent to the office to speak with the school counselor after peers reported a concern to staff. Peers report that Gina sent photos of cuts on her wrist and texted, “I need help.” Peers state that Gina is always sad and a few weeks ago she talked about ending her life.

Gina meets with the counselor and refuses to answer questions on C-SSRs. She discloses that a month ago, she had thoughts of ending her life by hanging. Otherwise, she won’t discuss. When asked about more immediate thoughts, she repeats, “I don’t know.”

Gina’s guardian is called to school and will do whatever steps you recommend.

What are some things you would say or do to try to engage Gina?

What questions would you ask her guardian?

Can you create a Crisis Management Plan?

What would you do next and why?

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You Cannot Establish Safety

- Call PIRC to notify of your referral.
- A Psychiatric Assessment is needed.
- Gina is refusing to participate (specifically to answer questions about suicidality).
- You have a history of risk and concern for her immediate safety.
- It is safest to assume risk when youth will not participate.

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Breakout Session Two

John, age 14, tells his school therapist that sometimes when he has panic attacks, he thinks he should end his life. The last time he had this thought was 3 days ago and he had no intent or plan to end his life at that time. He has history of one suicide attempt by ingestion two years ago. When completing the C-SSRS at school, he denies current intent or plan. He reports that he tells his mom about his thoughts and she stays with him and helps him to feel better. The Therapist refers John to the Emergency Department, however his mother decides to have John seen by his Pediatrician and she makes an appointment that day.

Can you create a Crisis Management Plan? Why or why not? If so, practice the 7 steps you would take if you are able to complete a Crisis Management Plan.

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Initial Information is Encouraging for Safety

- John denies immediate intent or plan
- He has "Protective Factors"
  - John has established mental health services.
  - He is communicative and he requested to speak with therapist.
  - John talks with his mother about risk.
- Guardian collateral is still needed to proceed with Crisis Management Plan
- If appropriate, proceed with Crisis Management Plan.
- Contact PIRC to discuss additional mental health supports (Partial Hospitalization).

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Questions?

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