Ask, Act, Prevent: The Case for Universal Suicide Screening in School-Based Health Centers

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Faculty Disclosure Information

- I have no relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider(s) of commercial services discussed in this CME activity.

- I **do not** intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.

Content Warning

- This presentation includes discussion of **youth suicide**, including risk factors, warning signs, lived experiences, and systems-level challenges. Some content may be emotionally distressing or triggering, particularly for individuals with personal experience of suicide or mental health struggles.
- If at any point you need to take a break, step out, or speak with a support person, please feel free to do so. Your well-being matters.
- Resources and support services will be shared at the end of the session.

Learning Objectives

- At the conclusion of this presentation, participants should be able to:

1. Identify suicide as a national and global public health crisis.
2. Implement effective, evidence-based suicide screening protocols and management procedures to identify and manage youth at risk for suicide.
3. Identify resources that can be utilized when having a positive suicide risk screen.

Practice Changes

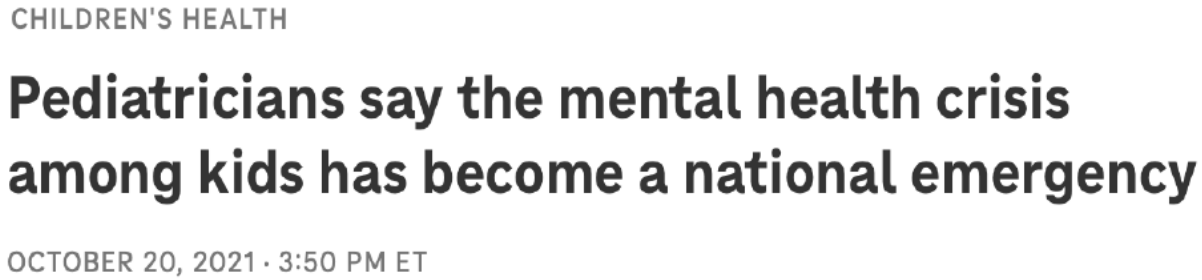
- Changes you may wish to make in practice:

1. Implement universal suicide screening in patients 12 years of age and older.
2. Use evidence-based suicide screening and secondary assessment tools to assess patients at risk of suicide.
3. Adopt safety planning and means safety counseling as part of routine interventions for suicidal patients in your practice.

Identify suicide as a national and global public health crisis.

Declaration of National State of Emergency in Child and Adolescent Mental Health

- Joint declaration in October 2021 by:
  - American Academy of Pediatrics (AAP)
  - American Academy of Child & Adolescent Psychiatry (AACAP)
  - Children's Hospital Association (CHA)



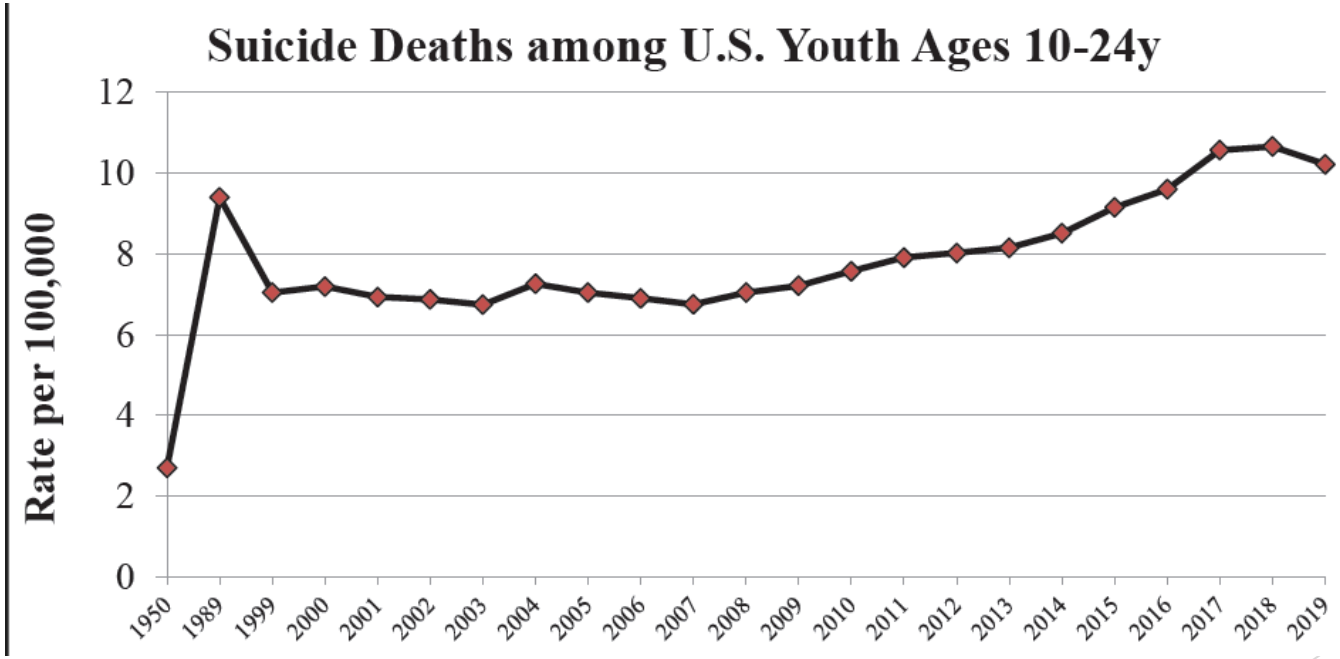
CHILDREN'S HEALTH

Pediatricians say the mental health crisis among kids has become a national emergency

OCTOBER 20, 2021 · 3:50 PM ET

Youth Suicide in the U.S.

- Among children between the ages of 10 and 24, suicide is the **second leading cause of death**, and the **leading cause of death for 14- to 15-year-olds**.
- Youth and young adults ages 10–24 years account for 15% of all suicides.



Younger Children & Suicidality

- Children under 12 yrs plan, attempt and die by suicide

HOSPITAL Pediatrics

BRIEF REPORT

The Importance of Screening Preteens for Suicide Risk in the Emergency Department

- 29.1% of preteens (10-12) screened positive for suicide risk (Lanzillo et al., 2019)

JAMA Pediatrics

RESEARCH LETTER

Suicidal Attempts and Ideation Among Children and Adolescents in US Emergency Departments, 2007-2015

- 43.1 % of SA/SI visits to an ED were for children 5-11 years old (Burstein et al., 2019)

JAMA Pediatrics

Original Investigation

Suicide Trends Among Elementary School–Aged Children in the United States From 1993 to 2012

- Racial disparity for children < 12: ↑ rate for black children ↓ rate for white children (Bridge et al., 2015)

Horowitz et. al

Suicide Risk Screening for Underserved Youth

- Many youth populations at higher risk for suicide are understudied by research.
  - Black, Indigenous, and people of color (BIPOC)
  - LGBTQ+ youth
  - Individuals with ASD or NDD
  - Child Welfare System
  - Rural areas
  - Juvenile Detention Facilities
- Screening can help identify underserved youth at risk for suicide and link them to care.

Horowitz et. al

2025 Era…

11-year-old girl dies by suicide after bullies threatened to call ICE on her family

IMMIGRATION

The suicides of two Latina children in the South further erode immigrant parents' sense of safety

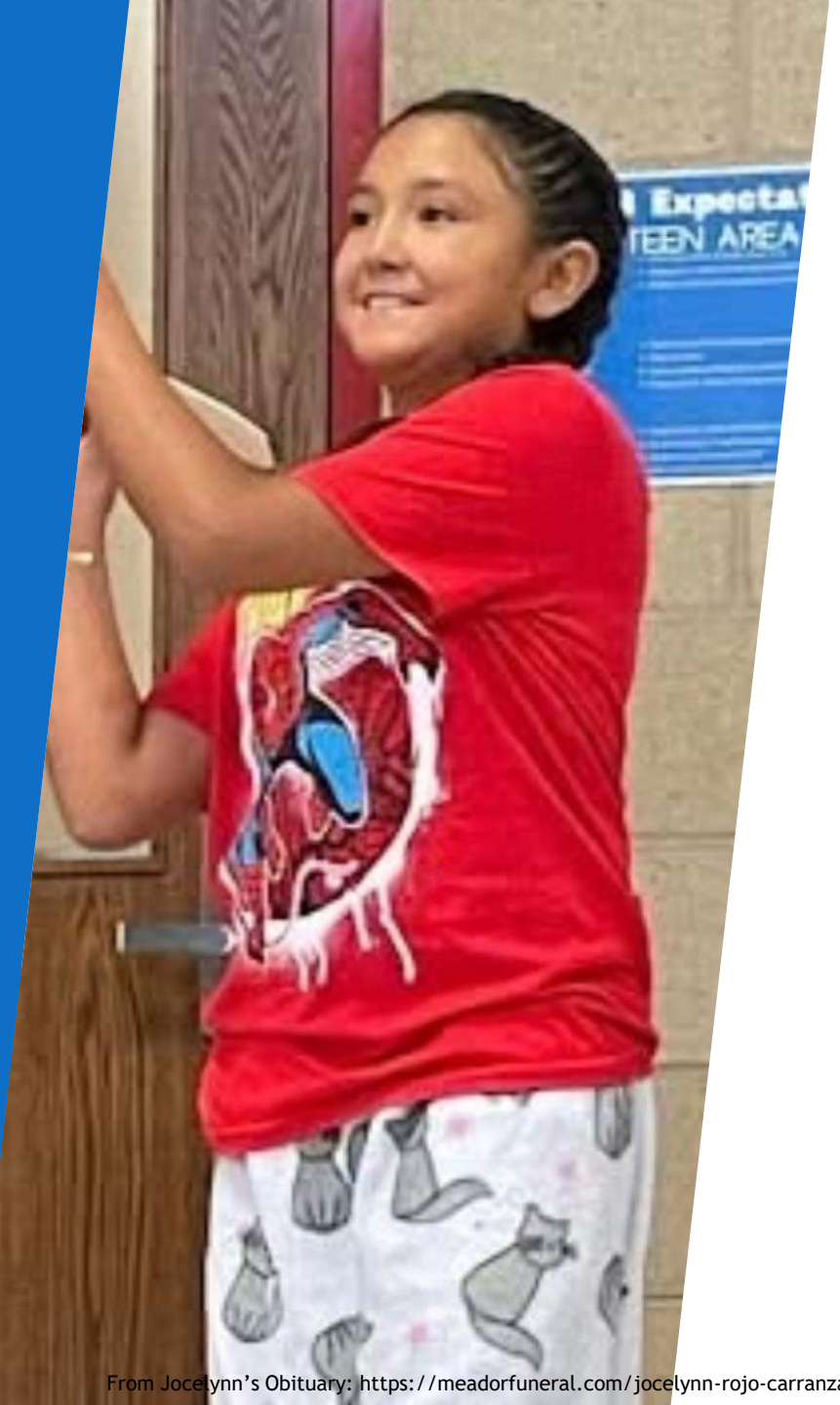
Jocelynn Rojo Carranza, 11, of Texas and Gabriela Aparicio Ortega, 13, of North Carolina died by suicide in February after being bullied about their parents' alleged immigration statuses

Alarming Suicide Rates Impacting Latino Youth – NBC News Featuring CII

January 31, 2024 CII COMMUNICATIONS

Jocelyn's Story, Age 11

- **Jocelyn Rojo Carranza- 11-year-old girl in Texas who died by suicide after she was bullied about her family's immigration status**
- "I never knew anything about that," "My daughter **never showed changes**. I mean, there was never anything that gave me a sign that she was suffering from bullying."



“But surely there were signs…”

- “I remember her fondly because she was a very happy girl, she was a joyful girl,”
- “kind, sweet and a great friend to many.”
- Jocelynn is remembered as “a wonderful daughter, sister, niece and friend to everyone,”
- Her mom said Jocelynn told her every day that she loved her.
- She played the French horn, made TikTok videos, swam, did cartwheels and spent Friday nights watching movies with her family
- “She loved when her grandma took her to get her nails done”

From Jocelynn’s Obituary: https://meadorfuneral.com/jocelynn-rojo-carranza/

Can we actually save lives by screening for suicide risk in the medical setting?

Underdetection is an issue!

- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves:
  - 80% of youth visited healthcare provider
  - 38% of adolescents had contact with a health care system within 4 weeks
  - 50% of youth had been to ED within 1 year
  - Frequently present with somatic complaints

Ahmedani, 2017; Pan, 2009; Rhodes, 2013; Blum, 1996

Leveraging SBHCs

- 42% of students report persistent sadness/hopelessness
- SBHCs = trusted, confidential, frontline access
- Can bridge the gap for those at higher risk of suicide, e.g. underserved youth.
- BH integration
- Immigration concerns → reluctance to seek care elsewhere.

Horowitz et. al

Role of Pediatric Clinicians

- De-facto principal mental healthcare provider for children and adolescents
- Able to develop relationships and gain trust with youth
- Youth report more comfort discussing risk-taking activities with PCPs than with specialists
- Suicide risk screening is in-line with other screening efforts: STIs, obesity, substance use, vaccinations

Horowitz et. al

National Recommendations

- American Academy of Pediatrics (AAP) - Bright Futures Recommendations for Preventative Pediatric Care (2022):

Screening for **suicide risk** for **all youth ages 12 and above**

Age Recommendations:

- **Youth ages 12+: Universal screening**
- Youth ages 8-11: Screen when clinically indicated*
- Youth age < 8: Screening not indicated.

**Assess for suicidal thoughts/behaviors if warning signs present*

Depression Screening vs. Suicide Risk Screening

SUICIDE VS. DEPRESSION SCREENING

Depression Screening (PHQ-2, PHQ-9, PHQ-A) ≠ **Suicide Screening**

Depression Screening

- Focus: depressive symptoms
- Evaluates: suicidality in the context of depression
- Goal: detect and treat depressive disorders

Suicide Risk Screening

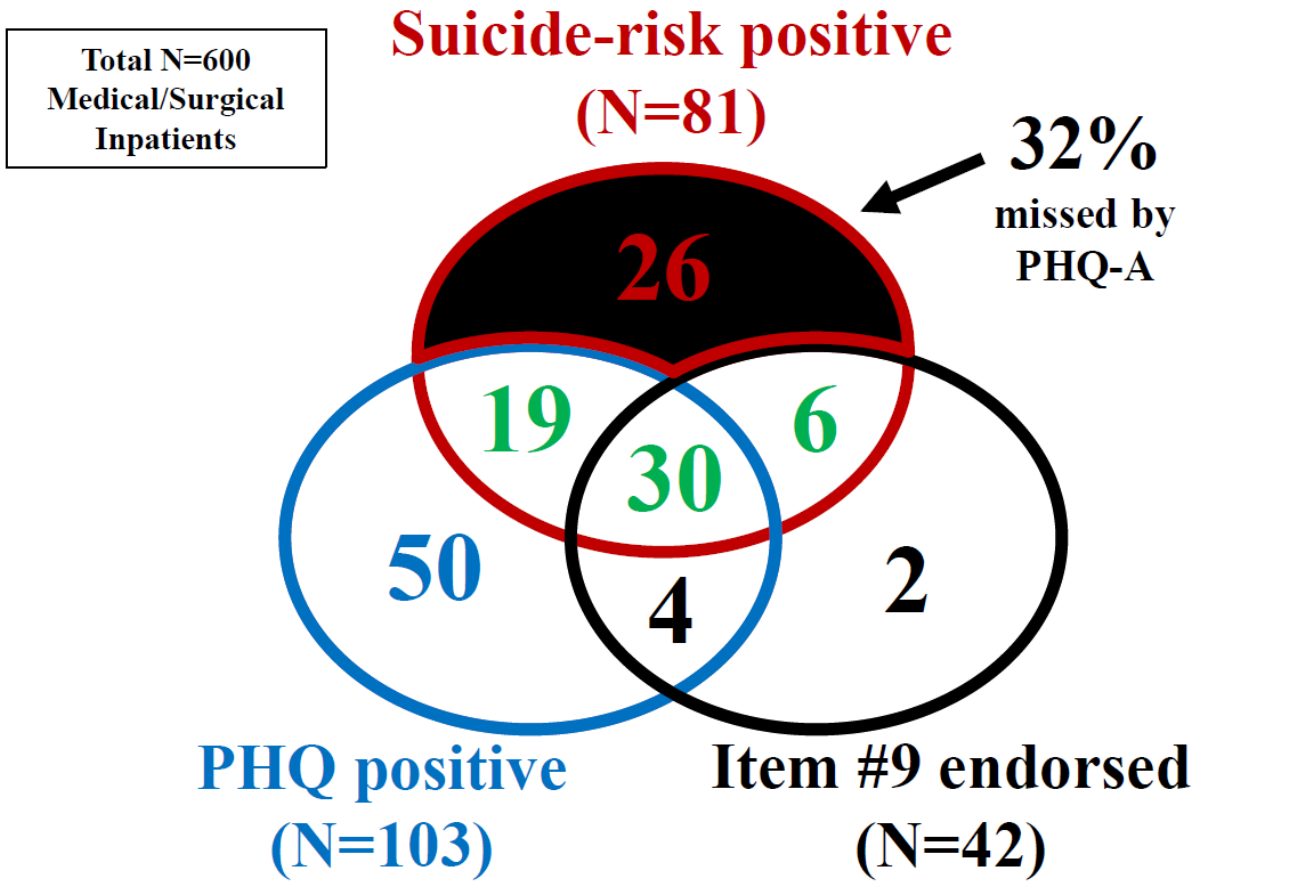
- Focus: suicide risk
- Evaluates: suicidal thoughts and behaviors
- Goal: detect persons at risk for suicide to decrease potential morbidity/mortality

Pitts, B., and Carubia, B. 2025

Patient Health Questionnaire for Adolescents (PHQ-A)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain
- Commonly used in medical settings
- One suicide-risk question, Item #9: *"Thoughts that you would be better off dead **or** of **hurting** yourself in some way"*

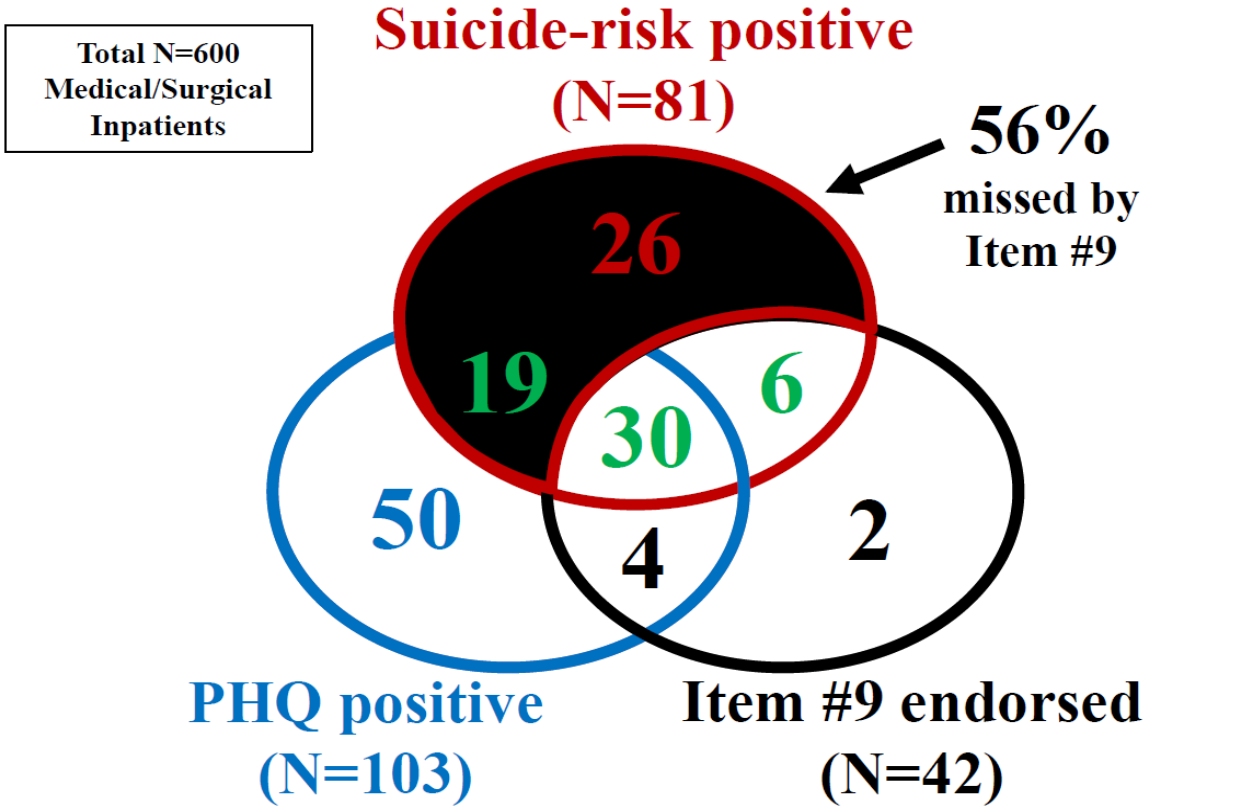
Are depression screenings enough?



Horowitz et al. (2021) *Journal of Adolescent Health*

Horowitz et. al (2021)Screening pediatric medical patients for suicide risk: Is depression screening enough?

Are depression screenings enough?

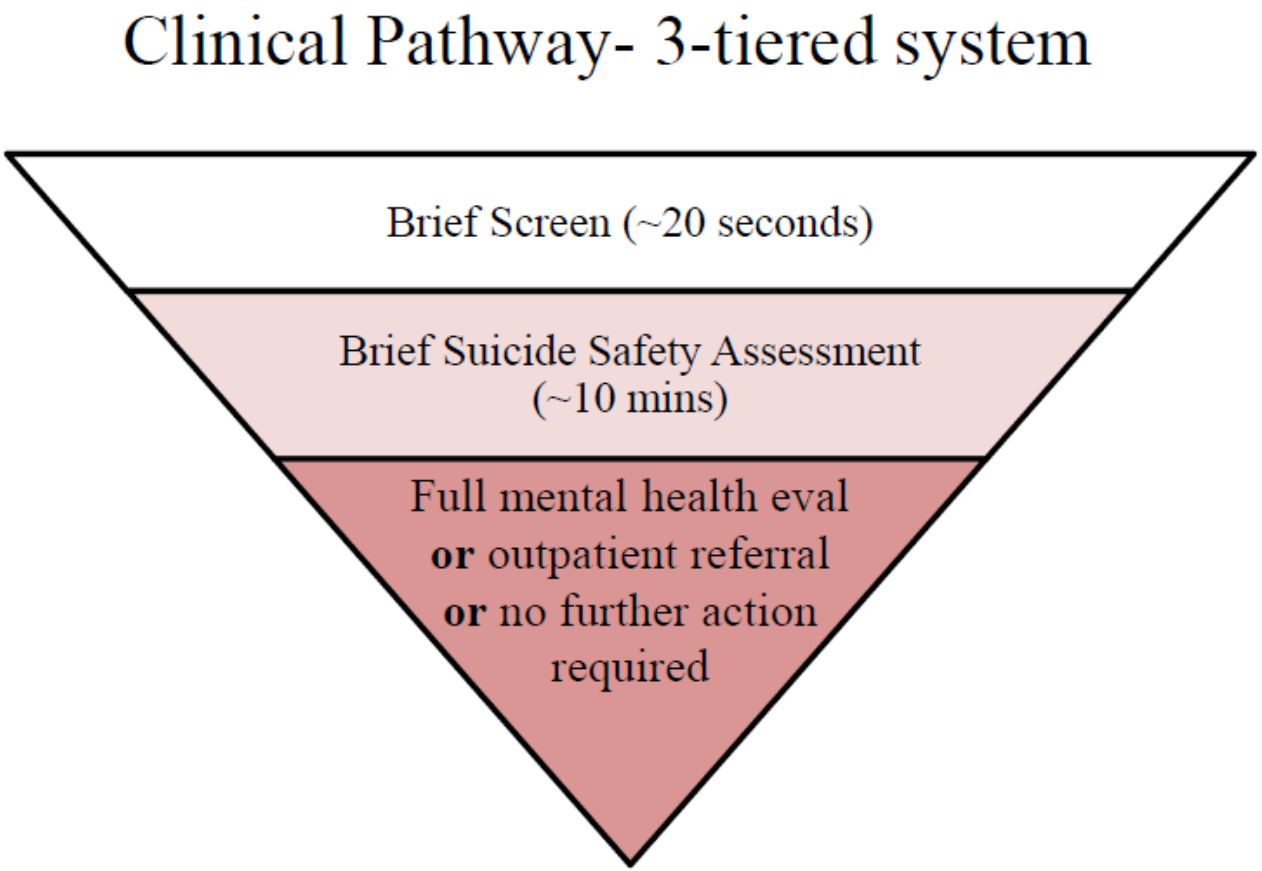


Horowitz et al. (2021) *Journal of Adolescent Health*

Horowitz et. al (2021)Screening pediatric medical patients for suicide risk: Is depression screening enough?

Implement effective, evidence-based suicide screening protocols and management procedures to identify and manage youth at risk for suicide.

Universal Suicide Risk Screening Clinical Pathway



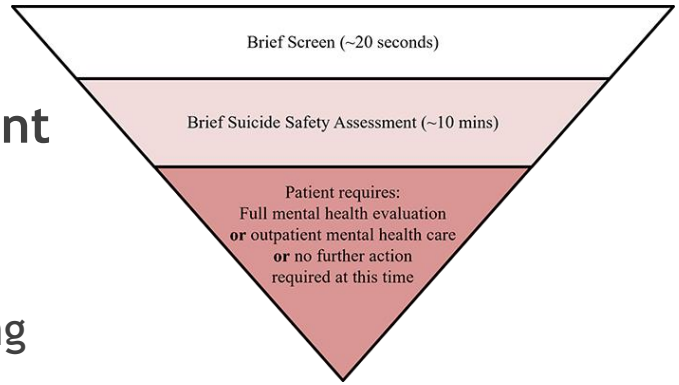
https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-forclinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/

Clinical Pathway - NIMH/AAP Blueprint

1. **Step One: Brief Screening (~1min)**
   A. Ask Suicide-Screening Questions (ASQ)
   B. Columbia Suicide Severity Rating Scale (C-SSRS)- Triage Version
   C. Suicide Behavior Questionnaire-Revised (SBQ-R)

2. **Step Two: Secondary Assessment (~10-15 min)**
   A. Brief Suicide Safety Assessment (BSSA)
   B. Columbia Suicide Severity Rating Scale (C-SSRS)- Full Version
   C. Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)

3. **Step Three: Full Psychiatric/BH/Crisis Assessment (~1-2 hr)**



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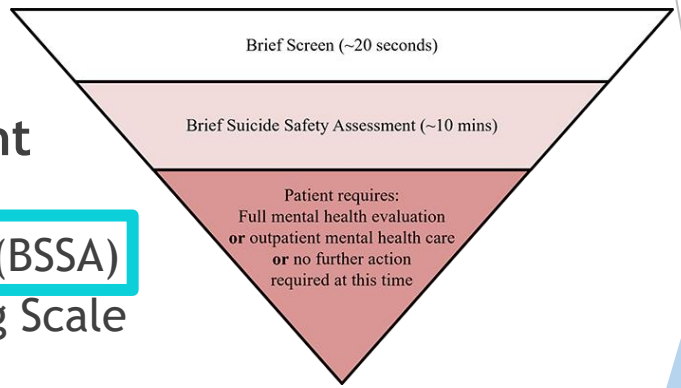

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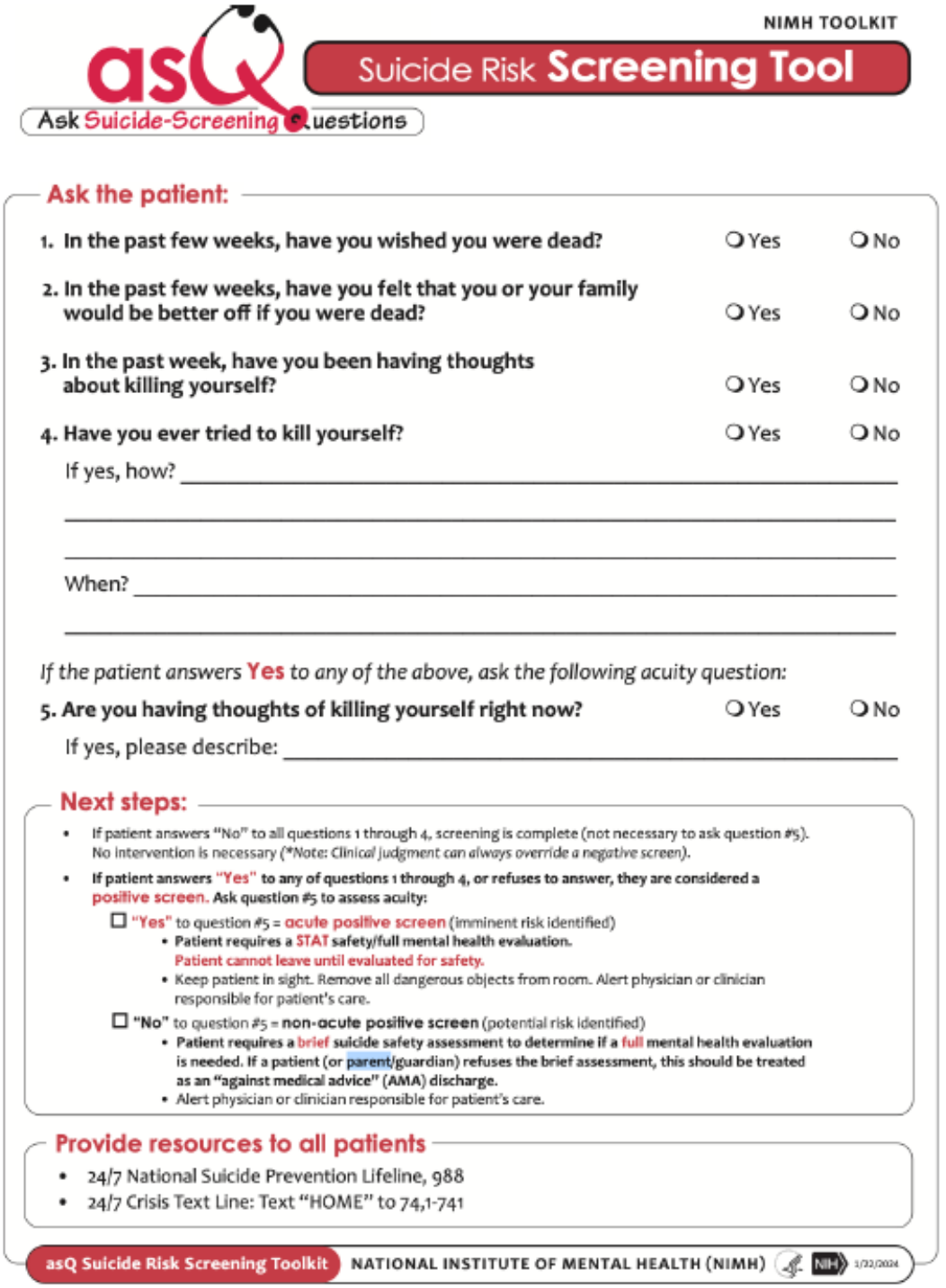
Brief Screening Tools

Ask Suicide-Screening Questions (ASQ)

- Patient report questionnaire
- For use by non-psychiatry clinicians
- Takes less than 2 minutes
- 4 yes/no screening questions + 1 follow-up if positive
- Free, translated, EMR-adaptable
- Validated for ages 8-24 yo
  - Yes on Questions #1-4: Non - Acute Positive
    - Requires secondary assessment
  - Yes on Question #5: Acute Positive
    - Requires Full BH/Risk/Crisis Assessment
    - Consider ED Referral



NIMH TOOLKIT

asQ Ask Suicide-Screening Questions

Suicide Risk Screening Tool

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. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 74,1-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 1/32/2024

ASQ- Ask Suicide Questions

- Available in public domain for free.
- ASQ Toolkit: www.nimh.nih.gov/ASQ includes questionnaires, follow up, youth screening clinical pathways, other resources.
- Available in multiple foreign languages including Spanish, Hebrew, Italian, Vietnamese, French, Mandarin, Portuguese, Korean, Dutch, Japanese, Arabic, Russian, Somali, Tagalog, Hindi, Urdu
- Sensitivity: 96.9% (95% CI, 91.3-99.4)
- Specificity: 87.6% (95% CI, 84.0-90.5)

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials

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? _____

   _____

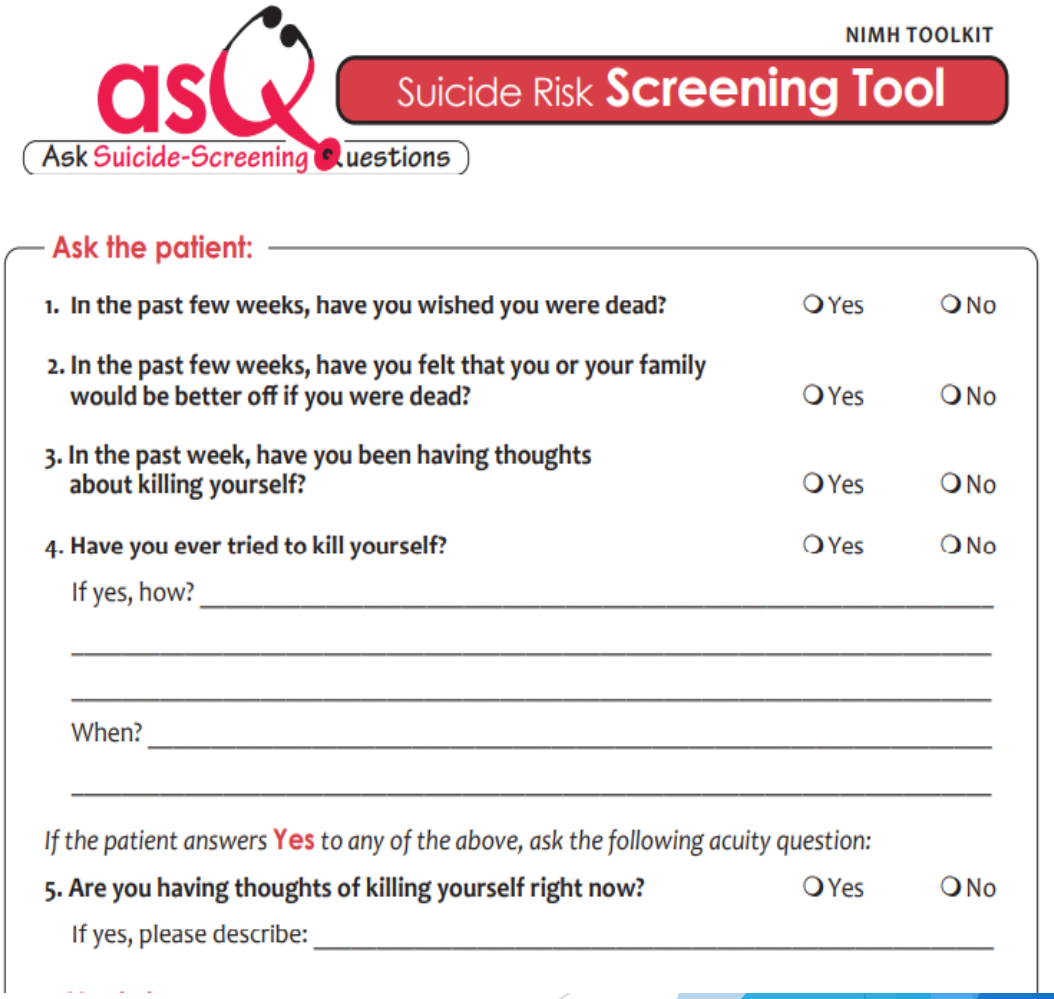
If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Brief Screening Tools

- Yes (or refuse) on Questions #1-4:
  Non - Acute Positive
  - Requires secondary assessment (BSSA) by licensed clinician (NP/PA/MD/DO/MSW)
- Yes on Question #5:
  Acute Positive
  - Requires Full BH/Risk/Crisis Assessment
  - Consider ED Referral



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

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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: _____

Example of "Yes" only to past behavior 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? _____

Non-Acute Positive

If the only "yes" answer is to Q4 (past suicidal behavior), factors to consider:

- ☐ Was the attempt more than a year ago?
- ☐ Has the patient received or is currently in mental health care?
- ☐ Is parent aware of past suicidal behavior?
- ☐ Is the suicidal behavior not a current, active concern?

If yes to all these, then consider "Low Risk" choice for action.

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: _____

Example of "Yes" only to past behavior NIMH TOOLKIT

asQ
Ask Suicide-Screening Questions

Suicide Risk Screening Tool

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**
   woul ✕ No

3. **In th**
   abou ✕ No

4. **Have** ○ No

   If yes

STILL REQUIRES A BRIEF SUICIDE SAFETY ASSESSMENT (BSSA)

Non-Acute Positive

- ☐ Was the attempt more than a year ago?
- ☐ Has the patient received or is currently in mental health care?
- ☐ Is parent aware of past suicidal behavior?
- ☐ Is the suicidal behavior not a current, active concern?

If yes to all these, then consider "Low Risk" choice for action.

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: _____

Combined PHQ-A/ASQ Tool

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
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 question:

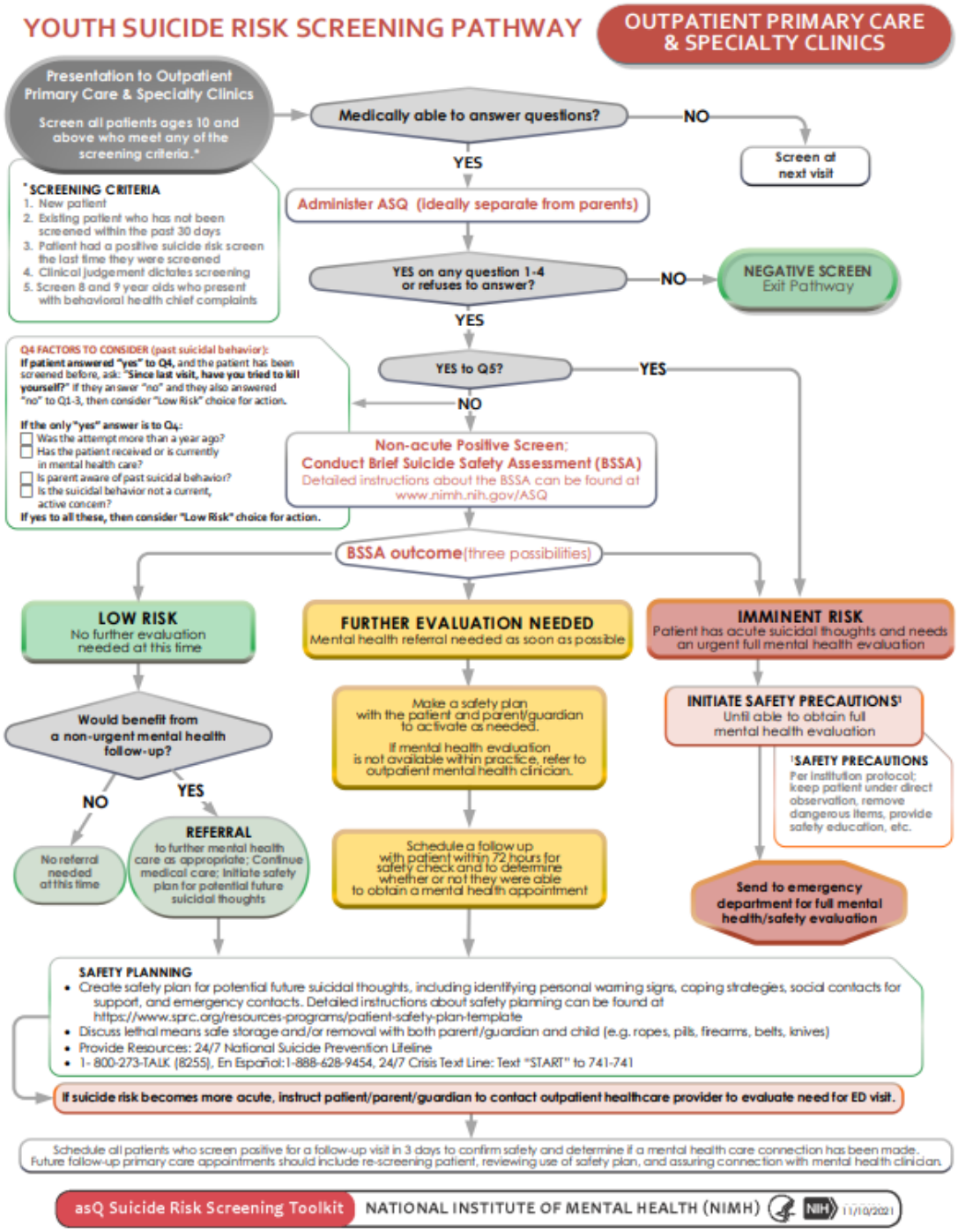
(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

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

Available from: https://www.nimh.nih.gov/sites/default/files/documents/PHQ-A_with_depression_questions_and_ASQ_PDF.pdf



www.nimh.nih.gov/asq

What Happens When a Patient Screens Positive?

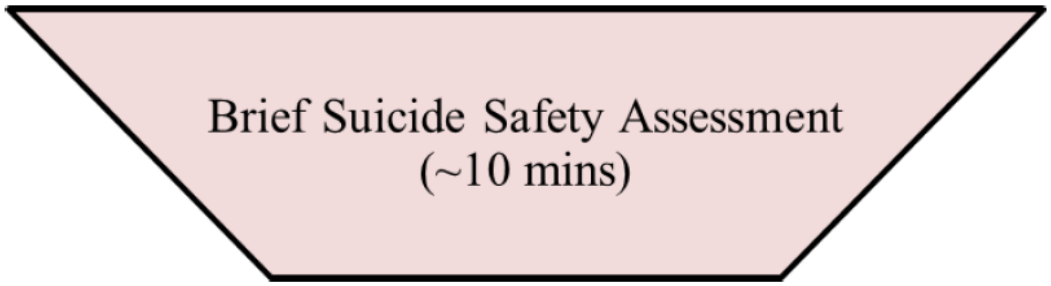
Here's What Should NOT Happen

- Do not treat every young person who has a thought about suicide as an emergency.

1:1 sitter

Identify resources that can be utilized when having a positive suicide risk screen

The Role of the Clinician



Conducted by an MD, DO, NP, PA, Social Worker, Mental Health Clinician **or other trained clinical professional**

Brief Suicide Safety Assessment (BSSA)

- Complete the asQ BSSA for all patients who screen positive or have numerous warning signs and risk factors of suicide.
- The asQ BSSA is a brief risk assessment tool that assesses risk factors, protective factors, and warning signs.
- It focuses on determining current suicidal thoughts, past suicidal behavior, comorbid symptoms, and the presence of social supports and stressors.

Risk Factors vs. Protective Factors vs. Warning Signs

	Suicide	Asthma
RISK FACTORS (Population Level) Indicate that someone is at higher risk of suicide or asthma	✓ Prior suicide attempt ✓ Mood disorder ✓ Substance abuse ✓ Access to lethal means	✓ Family history ✓ Maternal or family history of smoking ✓ Early childhood respiratory infections
PROTECTIVE FACTORS (Population Level) Indicate that someone is at lower risk of suicide or asthma	✓ Connectedness ✓ Availability of physical and ✓ mental health care ✓ Coping ability	✓ Regular use of asthma medications ✓ Seasonal vaccinations ✓ Regular preventative measures against ✓ triggers and allergens
WARNING SIGNS (Individual Level) Indicate that someone is seriously considering suicide or having an asthma attack	✓ Threatening to hurt or kill oneself ✓ Seeking a means to kill oneself ✓ Hopelessness ✓ Increased alcohol or drug use ✓ Dramatic mood changes	✓ Severe wheezing when breathing in and out ✓ Coughing that won't stop ✓ Very rapid breathing ✓ Chest pressure or tightness ✓ Worsening symptoms even with medication use

Pitts, B., and Carubia, B. 2025

High Risk Factors

- **Previous attempt**
- **Mental illness**
- **Symptoms of depression, anxiety, agitation, impulsivity**
- **Exposure to suicide of a relative, friend or peer**
- Physical/sexual abuse history
- Drug or alcohol abuse
- Lack of mental health treatment
- **Suicide ideation**
- Over age 60 and male
- **Between the ages of 15 and 24**
- **LGBTQ**
- Neurodevelopmental disorders
- Isolation
- Hopelessness
- Medical illness

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

SUDDEN IMPROVEMENT IN DEPRESSION SYMPTOMS

Suicide Is Preventable.

Call the Lifeline at 1-800-273-TALK (8255).

With Help Comes Hope

Secondary Assessment Tools

Brief Suicide Safety Assessment (BSSA)

NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a pediatric patient screens positive for suicide risk:

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

(If possible, assess patient alone depending on developmental considerations and parent willingness.)

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" **(If "yes," patient requires an urgent/ STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)**

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms *Ask the patient about:*

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

NIMH TOOLKIT: YOUTH OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join.

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."
- "Does your child seem:
  - Sad or depressed?"
  - Anxious?"
  - Impulsive? Reckless?"
  - Hopeless?"
  - Irritable?"
  - Unable to enjoy the things that usually bring him/her pleasure?"
  - Withdrawn from friends or to be keeping to him/herself?"
- "Have you noticed changes in your child's:
  - Sleeping pattern?"
  - Appetite?"
- "Does your child use drugs or alcohol?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
- "Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents)
- "Are you comfortable keeping your child safe at home?"

At the end of the interview, ask the parent/guardian: "Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient *Include the parent/guardian, if possible.*

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan. *If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.*

- ☐ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ☐ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ☐ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ☐ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

6 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) 7/1/2020

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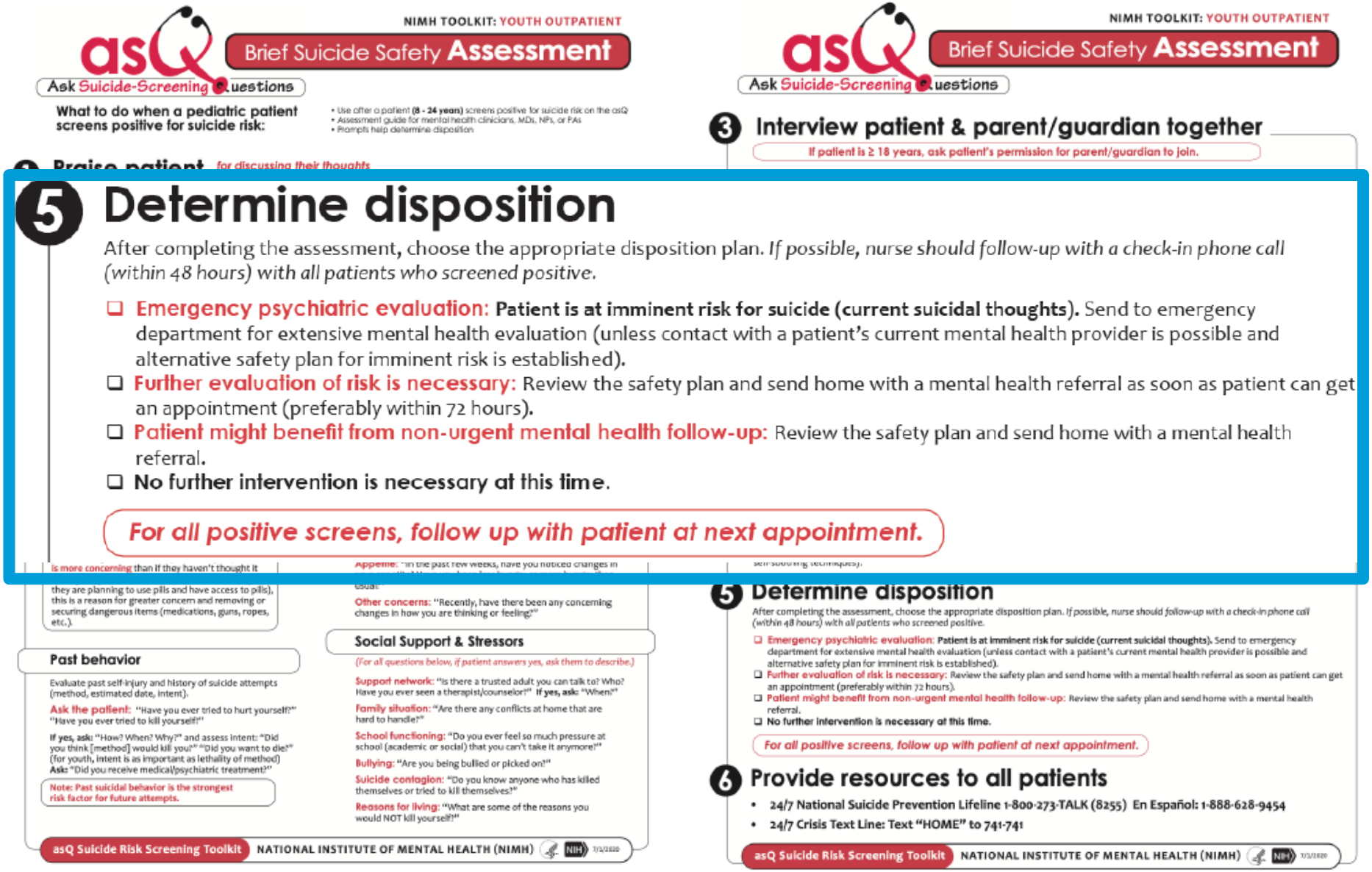

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Note: Past suicidal behavior is the strongest risk factor for future attempts.

Appetite: "In the past few weeks, have you noticed changes in usual?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

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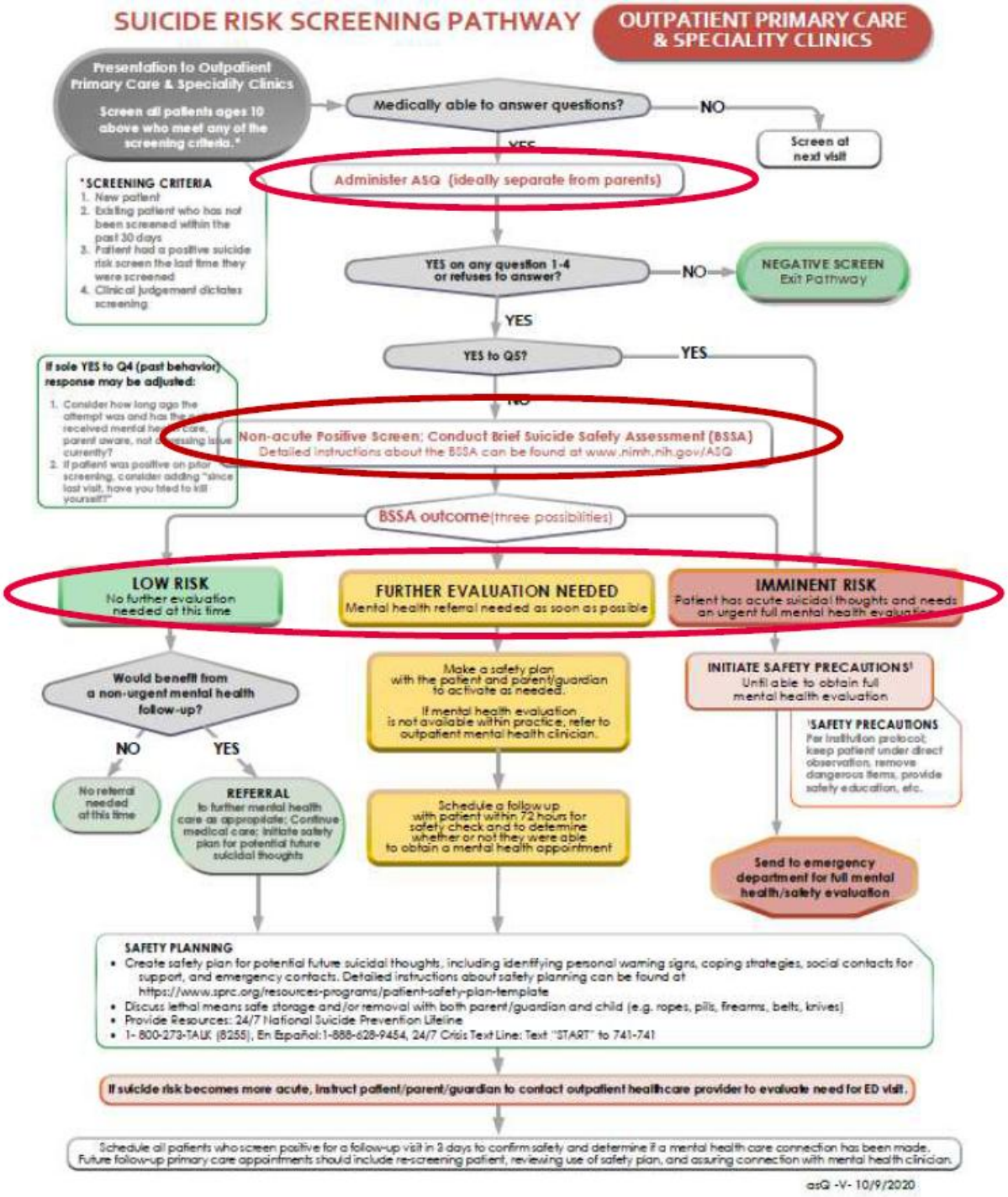
Purpose of the BSSA

- To help you make **"next step"** decision
- Four choices:
  - **Imminent Risk**
    - Emergency psychiatric evaluation
  - **High Risk**
    - Further evaluation of risk is necessary
  - **Low Risk**
    - **Not the "business of the day"**
    - **No further intervention necessary at this time**


SUICIDE RISK SCREENING PATHWAY
OUTPATIENT PRIMARY CARE & SPECIALITY CLINICS
Presentation to Outpatient Primary Care & Speciality Clinics
Screen all patients ages 10 above who meet any of the screening criteria.*
*SCREENING CRITERIA
1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
Medically able to answer questions?
NO
Screen at next visit
YES
Administer ASQ (ideally separate from parents)
YES on any question 1-4 or refuses to answer?
NO
NEGATIVE SCREEN Exit Pathway
YES
YES to Q5?
YES
NO
If sole YES to Q4 (past behavior) response may be adjusted:
1. Consider how long ago the attempt was and has the patient received mental health care, parent aware, not a pressing issue currently?
2. If patient was positive on prior screening, consider adding "since last visit, have you tried to kill yourself?"
Non-acute Positive Screen: Conduct Brief Suicide Safety Assessment (BSSA)
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ
BSSA outcome (three possibilities)
LOW RISK
No further evaluation needed at this time
FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible
IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation
Would benefit from a non-urgent mental health follow-up?
NO
YES
No referral needed at this time
REFERRAL
to further mental health care as appropriate; Continue medical care; initiate safety plan for potential future suicidal thoughts
Make a safety plan with the patient and parent/guardian to activate as needed.
If mental health evaluation is not available within practice, refer to outpatient mental health clinician.
Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment
INITIATE SAFETY PRECAUTIONS‡
Until able to obtain full mental health evaluation
‡SAFETY PRECAUTIONS
Per institution protocol; keep patient under direct observation, remove dangerous items, provide safety education, etc.
Send to emergency department for full mental health/safety evaluation
SAFETY PLANNING
• Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
• Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
• Provide Resources: 24/7 National Suicide Prevention Lifeline
• 1-800-273-TALK (8255), En Español: 1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741
If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.
Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.
asQ -V- 10/9/2020

RISK FORMULATION & DISPOSITION PLANNING

Utilizing all of the information gathered during the asQ assessment, determine level of risk and appropriate disposition plan.

	RISK FORMULATION	DISPOSITION
LOW RISK	• Suicidal thoughts, but no plan • No access to lethal means	• Provide referral list of behavioral health services along with local and national supports • If clinically indicated, provide psychoeducation materials to the patient and parent/legal guardian • Consider follow up contact within next 4 weeks
INTERMEDIATE RISK	• Suicidal thoughts, may have a plan • May have intent to act on plan • Access to lethal means • Multiple risk factors • Some protective factors • Can meaningfully engage in care planning	• Initiate care plan
IMMINENT RISK	• Currently has thoughts of suicide, with a plan • May have intent to act on plan • Access to lethal means • May have engaged in preparatory or rehearsal behaviors • Multiple risk factors • Shows warning signs • Low or no protective factors (or perception of)	• Initiate transfer to crisis center or ER for further evaluation. If necessary, call your local non-emergency dispatch or 911 • Do not leave the patient alone/ remove dangerous objects from the room • Alert physician or clinician responsible for patient's care

PARTNERS FOR Children's Mental Health

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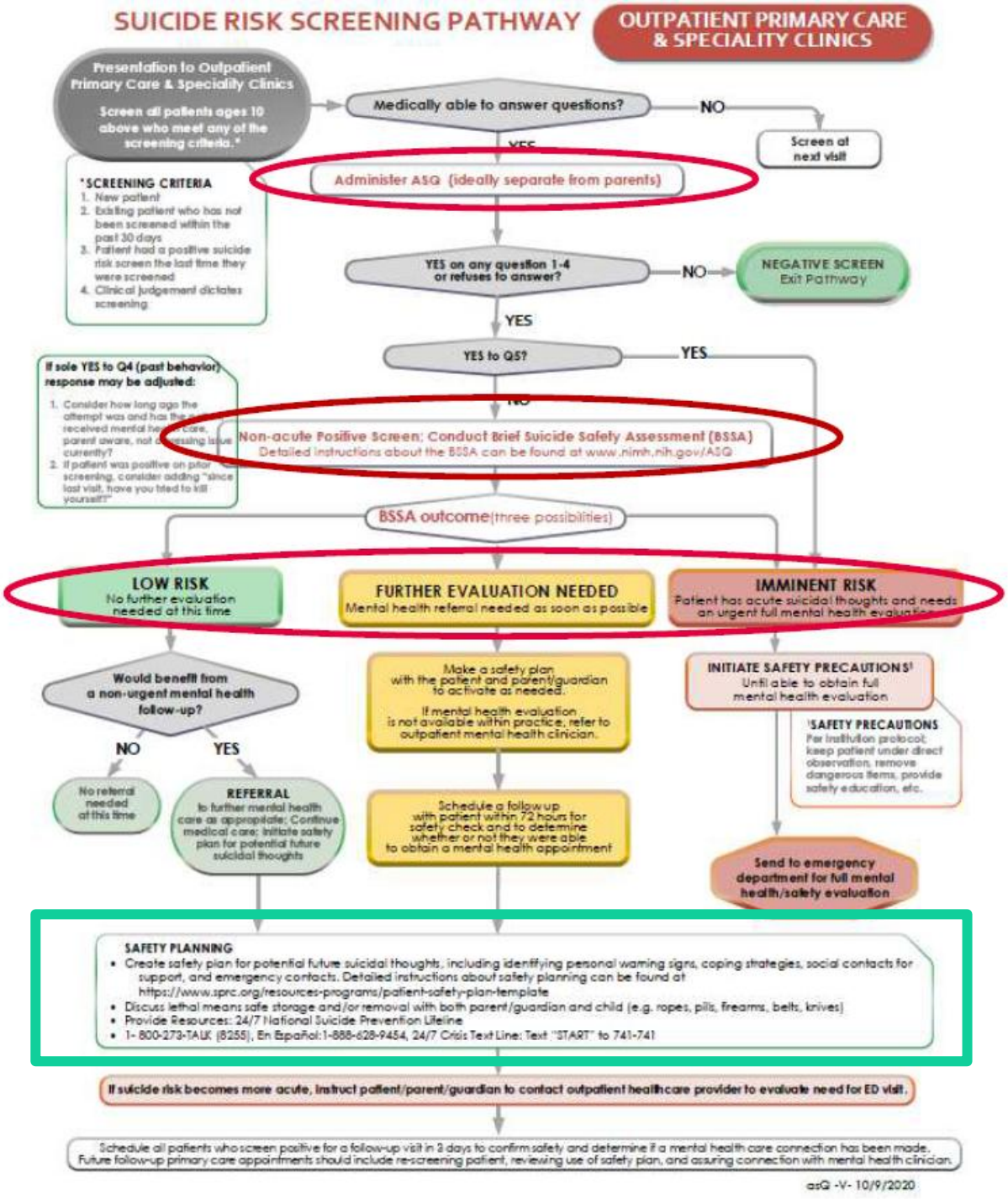
PARTNERS FOR Children's Mental Health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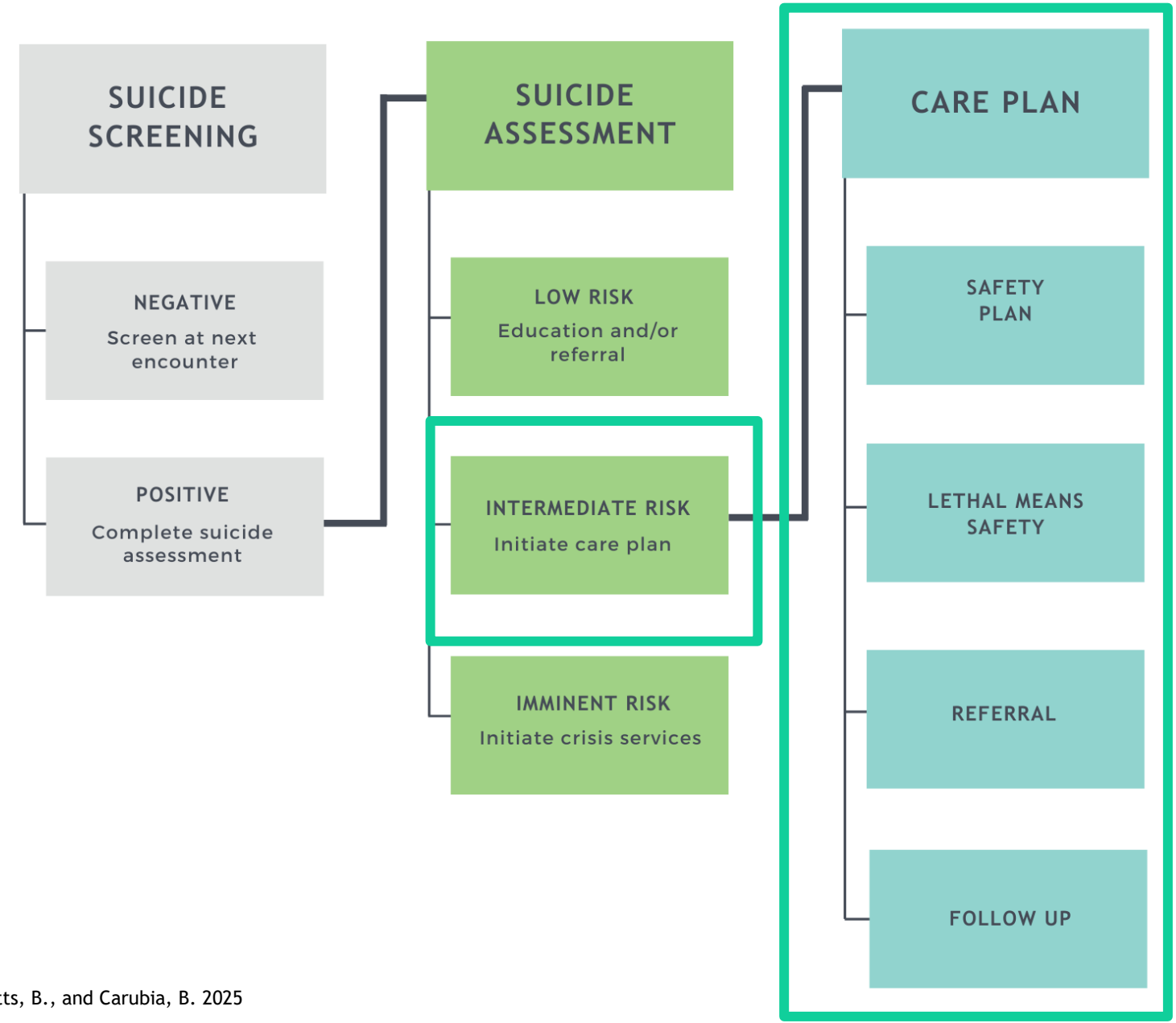
asQ -V- 10/9/2020

Youth Suicide Care Pathway



Pitts, B., and Carubia, B. 2025

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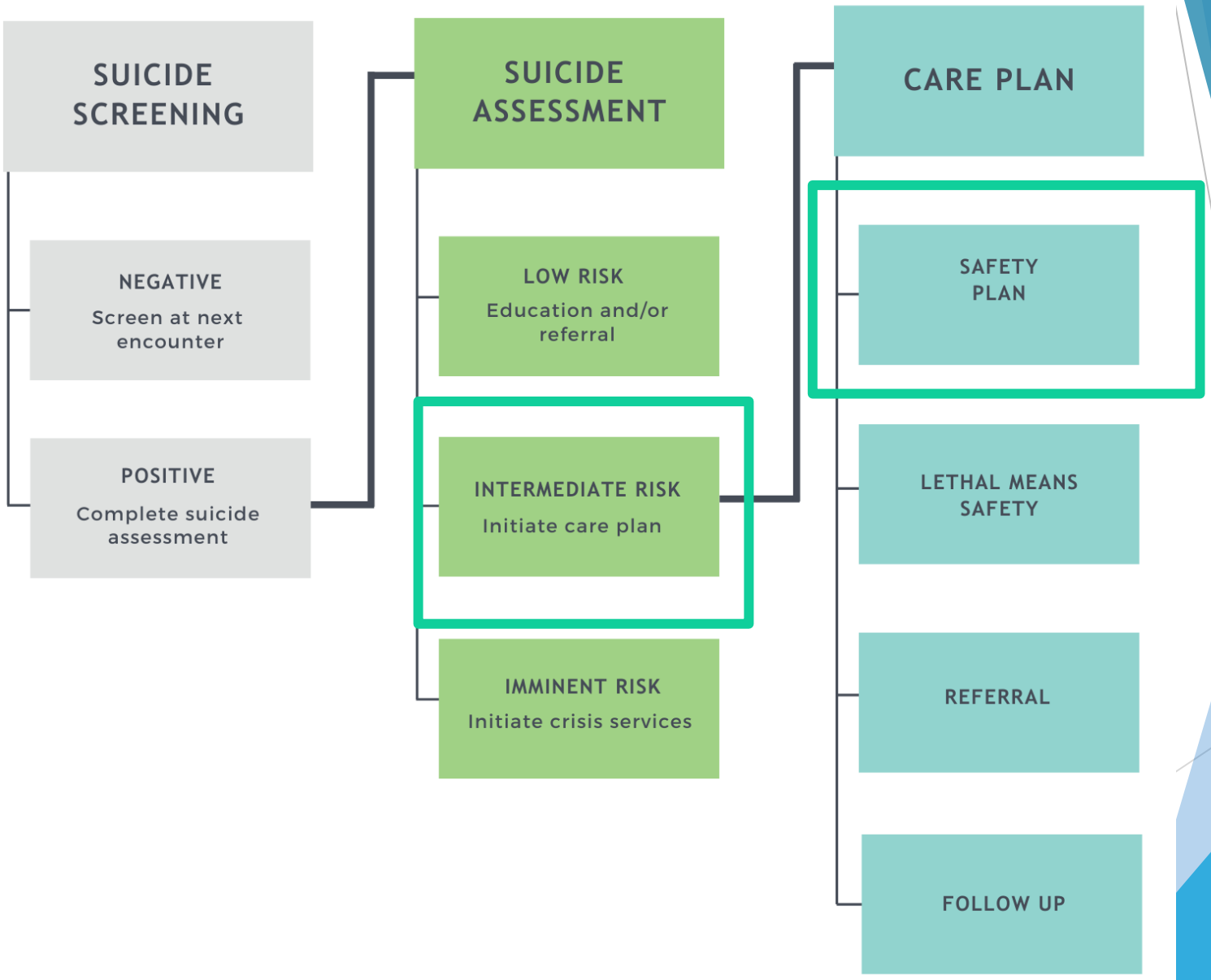


No Suicide Contract vs. Safety Plan

"NO-SUICIDE" CONTRACT

- Patients sign a contract promising not to kill themselves
- Is **not** based on research
- "Contract" language is perceived as confining and restrictive which is disastrous to a patient struggling with suicidal thoughts and behaviors

SAFETY PLAN

- Gives hope by reinforcing that suicidal thoughts come and go
- Focuses on what can be done vs. what not to do
- Enhances self-efficacy and sense of control of their personal safety and environment

Pitts, B., and Carubia, B. 2025

7 Steps to Safety Planning

Reasons for Living

Recognize Warning Signs

Internal Coping Strategies

Healthy Distractions

People for Support and Help

Professionals and Agencies

Making the Environment Safe

Safety Plan

- Recommended tool: Stanley Brown Safety Plan.
- Collaboratively develop a safety plan with the patient and review with parent/legal guardian the same day that suicide risk is identified.
- Provide educational materials to the patient and family regarding symptoms and when to utilize safety plan.
- Safety plans are most powerful when developed collaboratively with a provider or parent.

Safety Plan Example

SAFETY PLAN

A safety plan can help keep you safe if you are feeling overwhelmed and having thoughts of ending your life. Making a plan like this can help you understand yourself better, keeping you safer. It's important to share this plan with your support people so they can help you. If your needs or warning signs change, revise your safety plan with your caregivers or professional support people.

Who are the people or animals I live for?

What are other things I have to live for?

<u>Warning Signs:</u> What are my warning signs that tell me I'm starting to get overwhelmed?

Thoughts	Emotions	Body sensations	Behaviors

If people notice any of my warning signs, they can help by:

Safety Plan Example

Internal Coping Strategies: How can I manage my triggers or things that set me off?

Healthy Distractions: Who are the safe people that I can call/hangout with or where can I go that will take my mind off of the problem?

People for Support and Help: Who are the main people that I can turn to for support if I am overwhelmed? People to whom I can say, "Hey, I'm not feeling good right now, I really need someone to talk to. I don't need advice. I just need you to listen. Can we talk?"

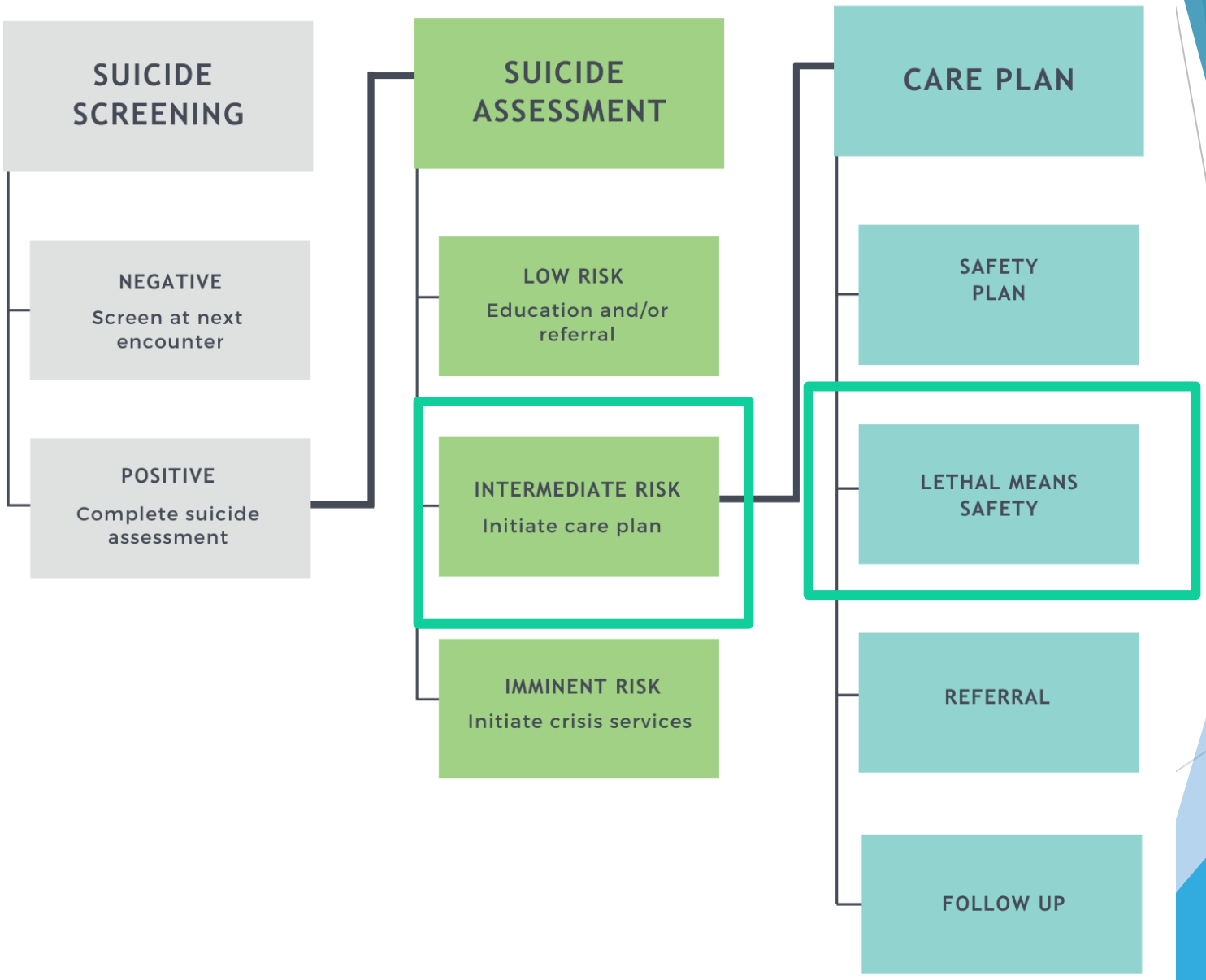
Making the Environment Safe: How can I make my surroundings safe? (remove things, go to a safer space)

Professionals and Agencies: If no one is available, who can I call during a suicidal crisis?

- Suicide and Crisis Lifeline
  - Call or text 988
- Colorado Crisis Services
  - Call 1-844-493-TALK (8255)
  - Text TALK to 38255
- Trevor Project Hotline
  - Call 1-866-488-7386
  - Text Start to 678678
- 911

Follow up phone call
Name:
Phone number:

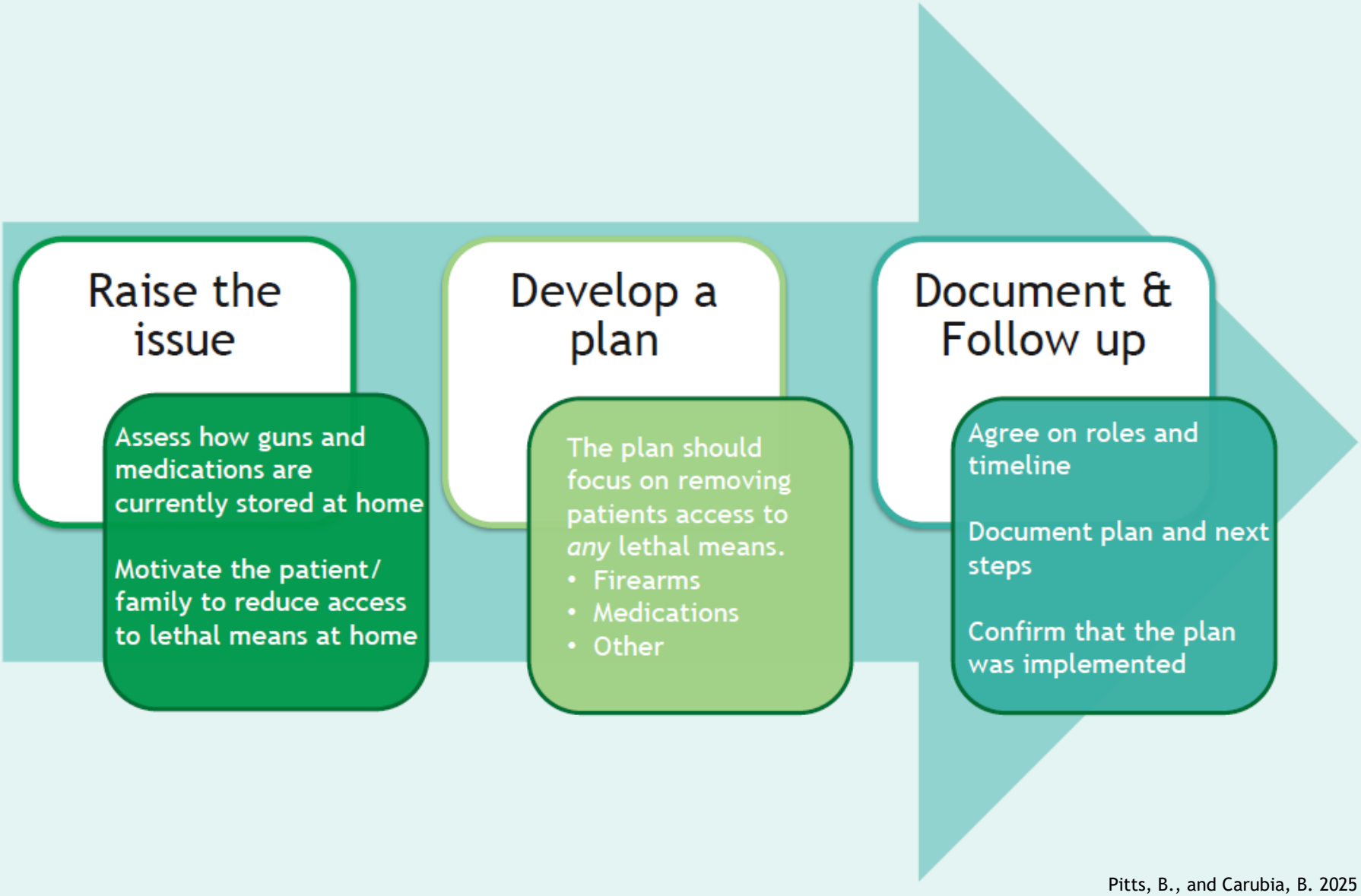
Youth Suicide Care Pathway



Ensuring Means Safety

- This refers to reducing access to objects or items (“means”) by which people die by suicide. Means could include pills, firearms, or sharp objects. This is an important tool for reducing suicide risk.
- Lethal means safety conversations should come from a place of seeking to understand and focusing on safety.
- Voluntary removal or safe storage of firearms, medications, and dangerous sharps **has been shown to save lives**.

Steps to Means Safety



Pitts, B., and Carubia, B. 2025

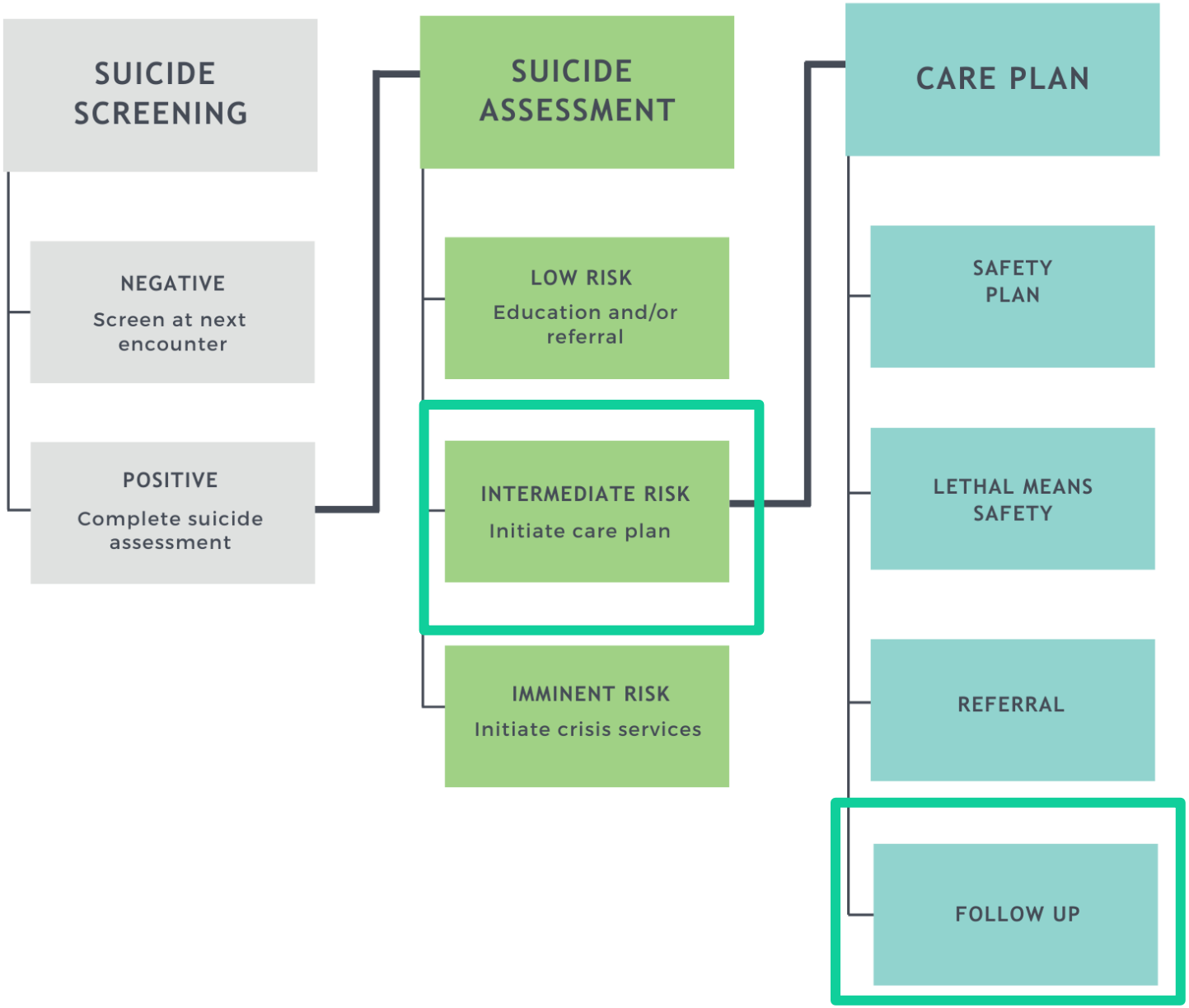
Means Safety Sample Language

- When someone is struggling in the ways your child is, sometimes suicidal intention can emerge and escalate rapidly - there are a few steps we recommend that can make your home safer for your child.
- Because we cannot predict when an adolescent may choose to attempt suicide, we know that it is important that teens do not have any access to guns, or other lethal means.
- If you were thinking about removing your guns from your house temporarily while your child is having suicidal thoughts, where do you think the best place would be?

Ensuring Means Safety

Good resource: https://hsph.harvard.edu/research/means-matter/ **but many available!**

Youth Suicide Care Pathway

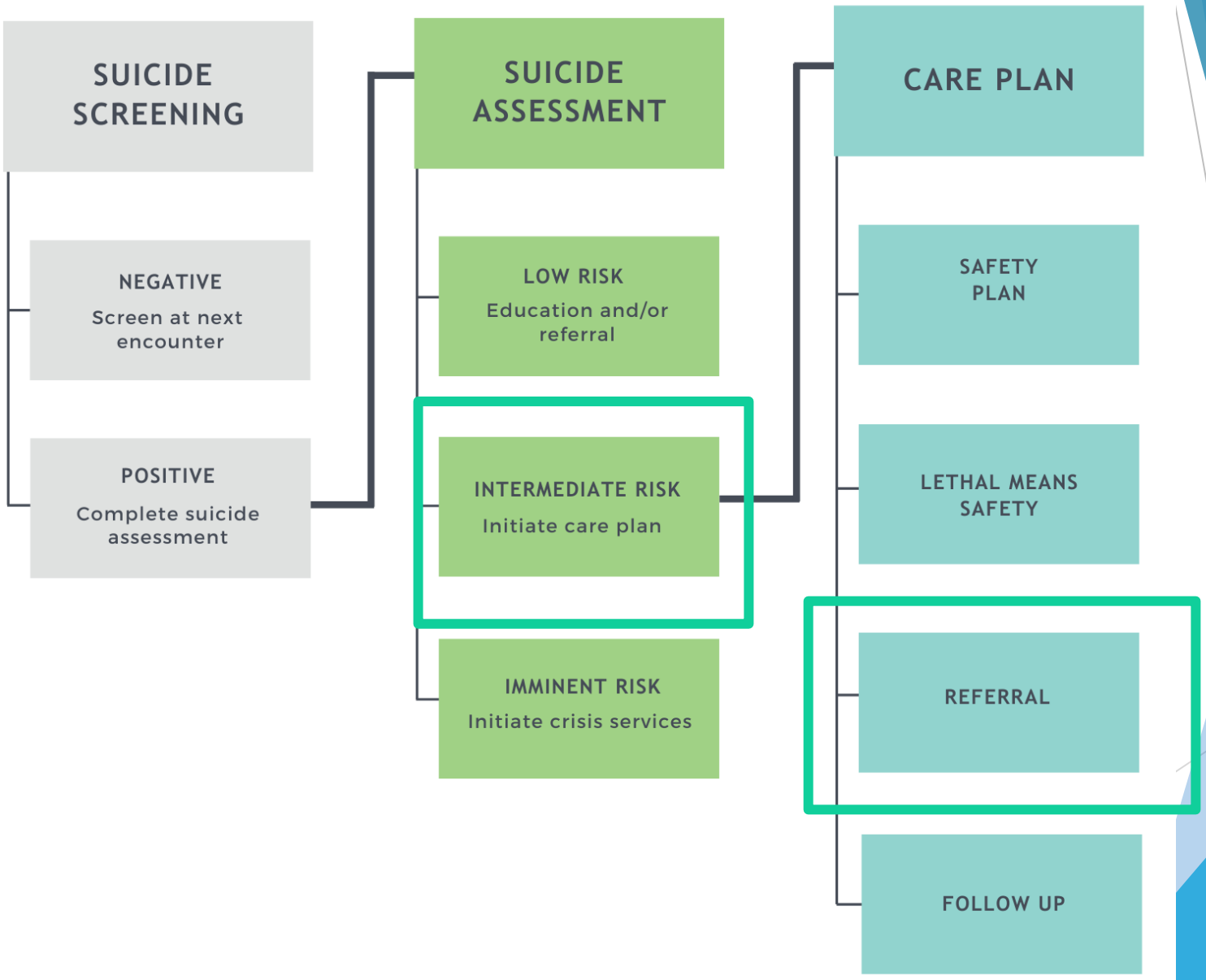


Follow Up

- 48 hours after visit, conduct a telephone outreach to check in regarding:
  - Assessment of current suicide risk
  - Engagement in recommended behavioral health care
  - Utilization of safety plan
  - Means safety follow up
- Follow-up can occur by phone or in person. It does not have to be long but should hit the high points above.

Follow Up

Youth Suicide Care Pathway



Tap into your resources!

Youth Suicide Prevention is a Team Sport!

IBH	If behavioral health provider is integrated, refer the patient and parent/legal guardian within your practice. •Practice warm hand-offs, workflow in your setting •WCC “check ins”
Refer	Otherwise, refer the patient and parent/legal guardian to behavioral health providers or systems that provide evidenced-based care specific to suicide risk.
Resource List	Create and annually update a community specific resource/referral list of behavioral health providers.

Referral & Escalation Pathways

1. Largely depends on each clinical setting and embedded resources
    1. Integrated, co-located, e-consult services available, or nothing?
2. All ambulatory/clinic settings can be expected to initiate brief screens (ASQ)
    A. High risk flag → majority will send to ED or crisis center for full behavioral health/crisis assessment
        i. Know your state laws regarding allowed transport. (Secure vs. not?)
    B. Require plan for secondary/brief assessment for those that flag as moderate risk
3. Consider safety plan, means safety discussions, and mental health referrals with low and moderate risk patients that don't require full crisis assessment after completion of screening and brief assessments (steps 1 & 2)

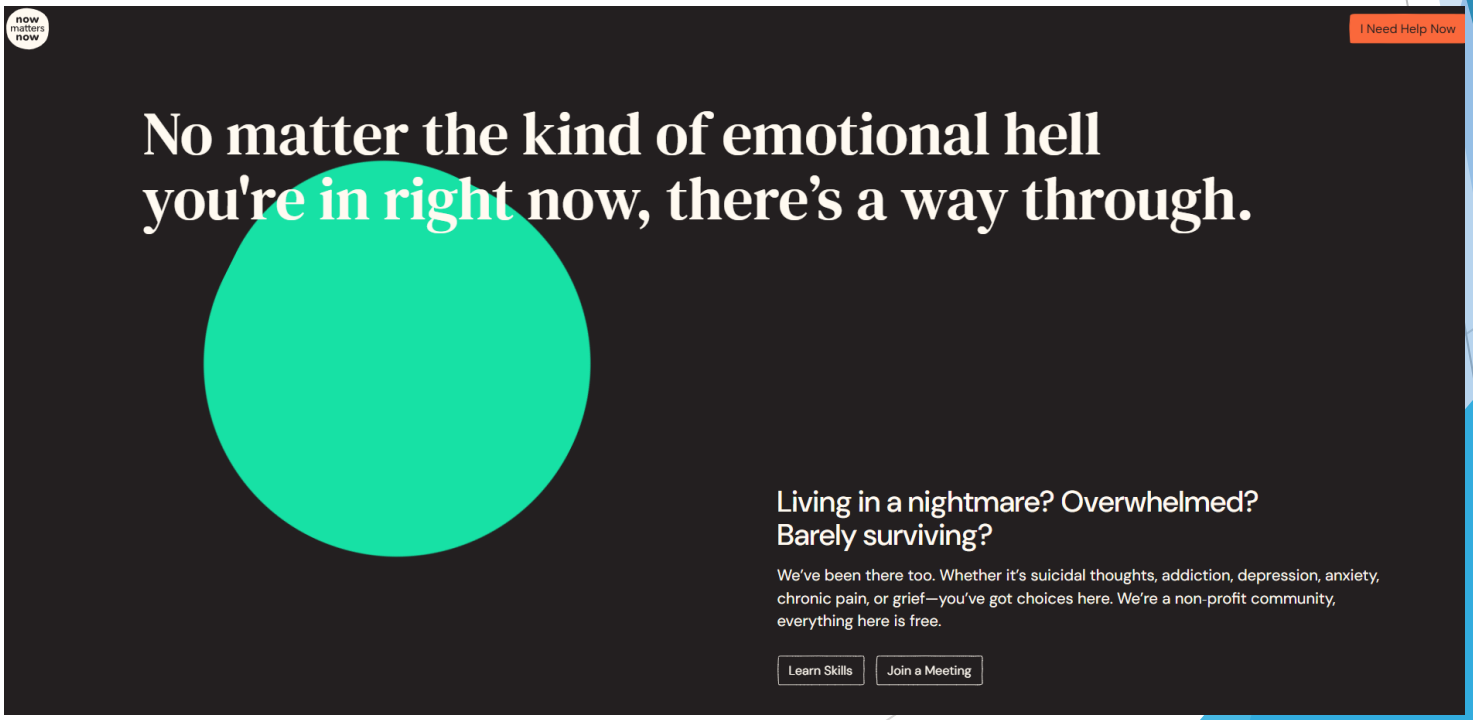
The Minimum WHAT (To Do)

BEFORE THEY LEAVE YOUR OFFICE

- Suicide Prevention Lifeline or Crisis Text Line in their phone
  - 1-800-273-8255 or text the word “Hello” to 741741
- Address guns in the home and preferred method of suicide
- Give them a caring message (NowMattersNow.org → “More”)

NowMattersNow.org WORKS

- **Website visits are associated with decreased intensity of suicidal thoughts and negative emotions.**
- This includes people who rated their thoughts as “completely overwhelming.”



Common Concern from Clinicians

How am I going to manage all the extra people I'm going to identify that are at risk for suicide?

Common Concern from Clinicians

What would you say to other pediatricians about the ASQ suicide screening?

Video courtesy of Anne Moss Rogers – Beacon Tree Foundation President

Take Home Messages

- Universal suicide risk screening for patients in all healthcare settings: ASK DIRECTLY
- Clinical Pathway- 3-tiered system
  - Brief Screen(ASQ)
  - Brief Suicide Safety Assessment (BSSA)
  - Full Psychiatric/Safety Evaluation
- Discharge all patients with safety plan, resources (National Suicide Prevention Lifeline and Crisis Text Line, nowmattersnow.org), and lethal means safety counseling

Resources

- ASQ Toolkit: https://sprc.org/wp-content/uploads/2022/12/asQToolkit_0-1.pdf
- Youth Suicide Care Pathway: https://pcmh.org/youth-suicide-care-pathway/
- Zerosuicide.edc.org
- Nowmattersnow.org
- Safety Plan Template: https://pcmh.org/wp-content/uploads/2024/09/UG24-Safety-Plan-Template.pdf
- Suicideisdifferent.org
- Contact me: florenciakantt@live.com

References

For more information on this subject, see the following publications:

- Please see reference hyperlinks on individual slides.
- Liwei L et al, COMMITTEE ON ADOLESCENCE, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION; Suicide and Suicide Risk in Adolescents. *Pediatrics* January 2024; 153 (1): e2023064800. 10.1542/peds.2023-064800
- Mohsen S et al, AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee; The Management of Children and Youth With Pediatric Mental and Behavioral Health Emergencies. *Pediatrics* September 2023; 152 (3):e2023063256. 10.1542/peds.2023-063256
- Curtin SC, Garnett MF. Suicide and homicide death rates among youth and young adults aged 10–24: United States, 2001–2021. NCHS Data Brief, no 471. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi.org/10.15620/cdc:128423
- Other resources:
  - https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-forclinical-
  - settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice/
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
  - National Suicide Prevention Lifeline Wallet Card
  - https://pcmh.org/wp-content/uploads/2024/09/UG24-Factors-and-Signs.pdf
  - https://www.seattlechildrens.org/clinics/suicide-prevention-program/what-to-expect/
  - https://medicine.yale.edu/news-article/youth-suicide-is-on-the-rise-yale-aims-to-save-lives/
  - https://pmc.ncbi.nlm.nih.gov/articles/PMC8154669/pdf/nihms-1670155.pdf
  - https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12508
  - https://jamanetwork.com/journals/jama/fullarticle/2797145
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/asq-information-sheet
  - https://www.childrenshospital.org/conditions/suicide-and-teens

“One hundred years from now it won't matter what kind of car I drove, what kind of house I lived in, how much money I had in the bank, nor what my clothes looked like… but the world may be a little better because I was important in the life of a child.” **Forest E. Witcraft** teacher, scholar