Evidence-Based Practices for Suicide Screening and Prevention: Supporting Youth Experiencing a Mental Health Crisis

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No Disclosures

I have no financial relationships with ineligible companies.

Learning Objectives

1. Describe prevalence of youth mental health concerns, including suicide

2. Outline effective methods for suicide screening

3. Discuss triage of patients based on suicide risk

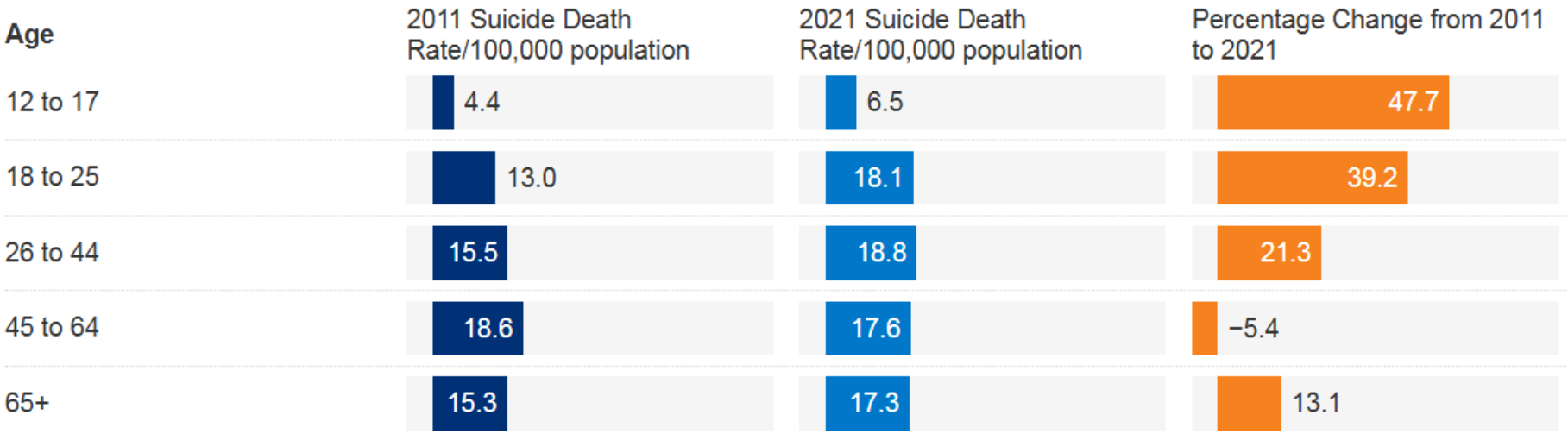
Colorado Department of Public Health and Environment. (2021). https://cdphe.colorado.gov/center-for-health-and-environmental-data/registries-and-vital-statistics/colorado-violent-death-reporting-system

Youth Mental Health Crisis

- 1 in 5 youth are living with a mental health disorder

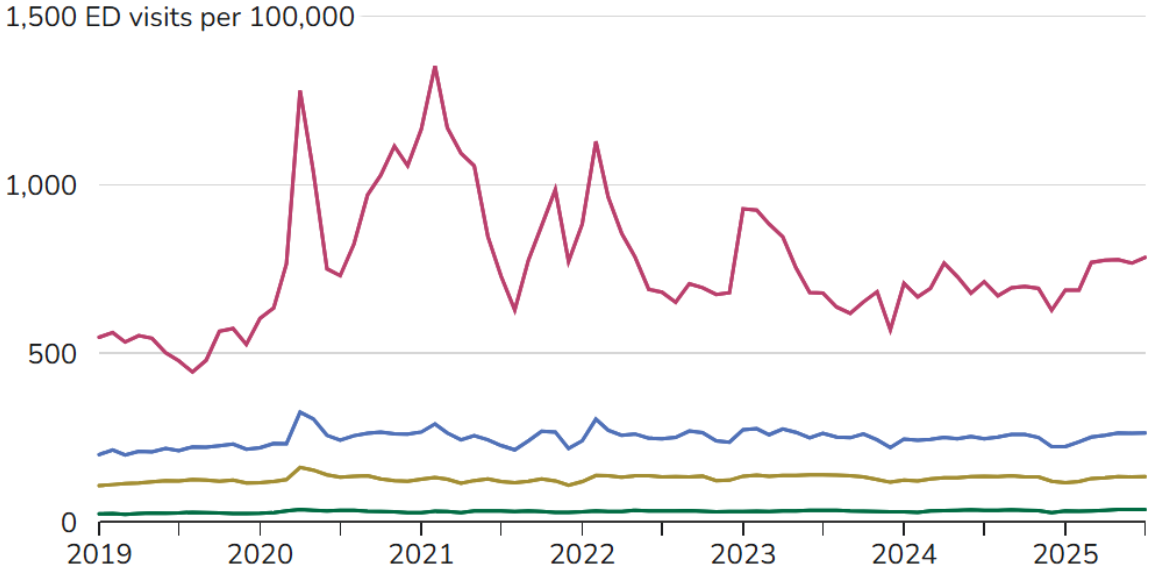
- **<u>*Less than 50%*</u>** will ever receive the appropriate treatment

Youth Suicide Death Rate is Rising



Kaiser Family Foundation, 2023

Rate of ED visits related to suspected suicide attempts

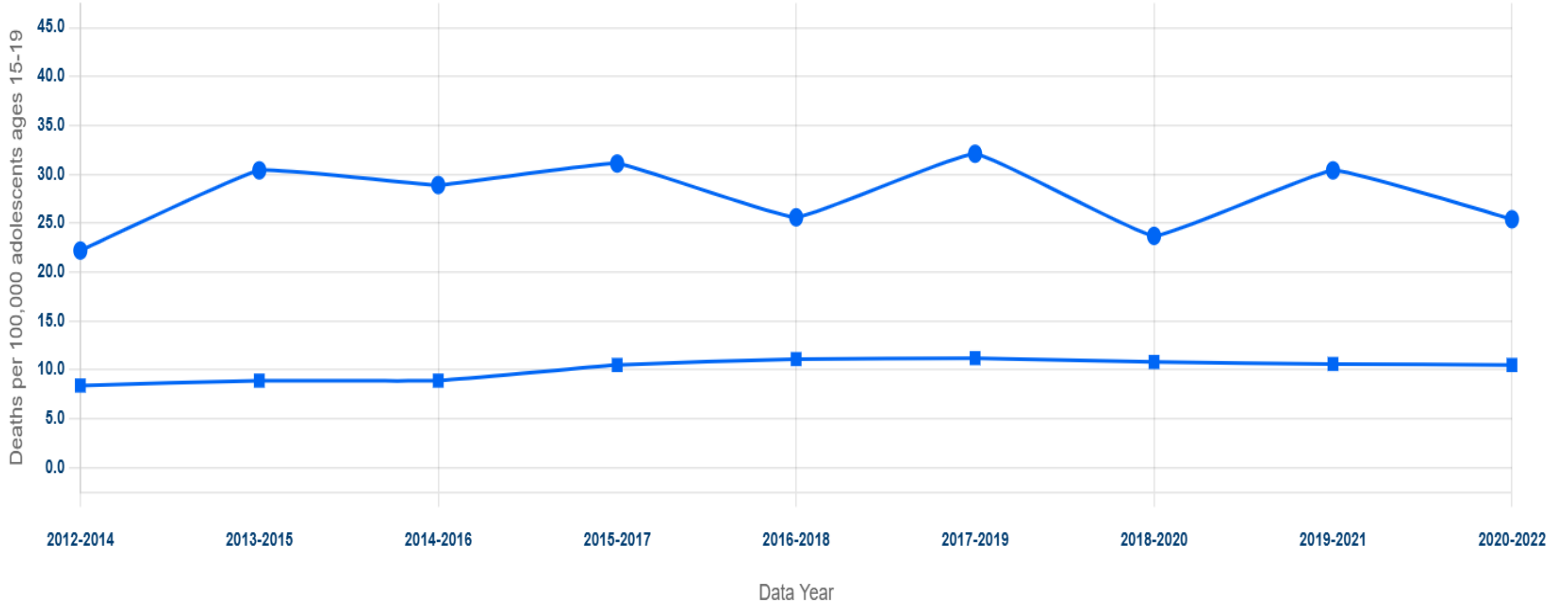


Tap on or mouse over the chart to open additional data details. Select a group to isolate on the chart. **Maximum rate of ED visits may vary by chart.**

12-17 years 18-34 years 35-64 years 65+ years

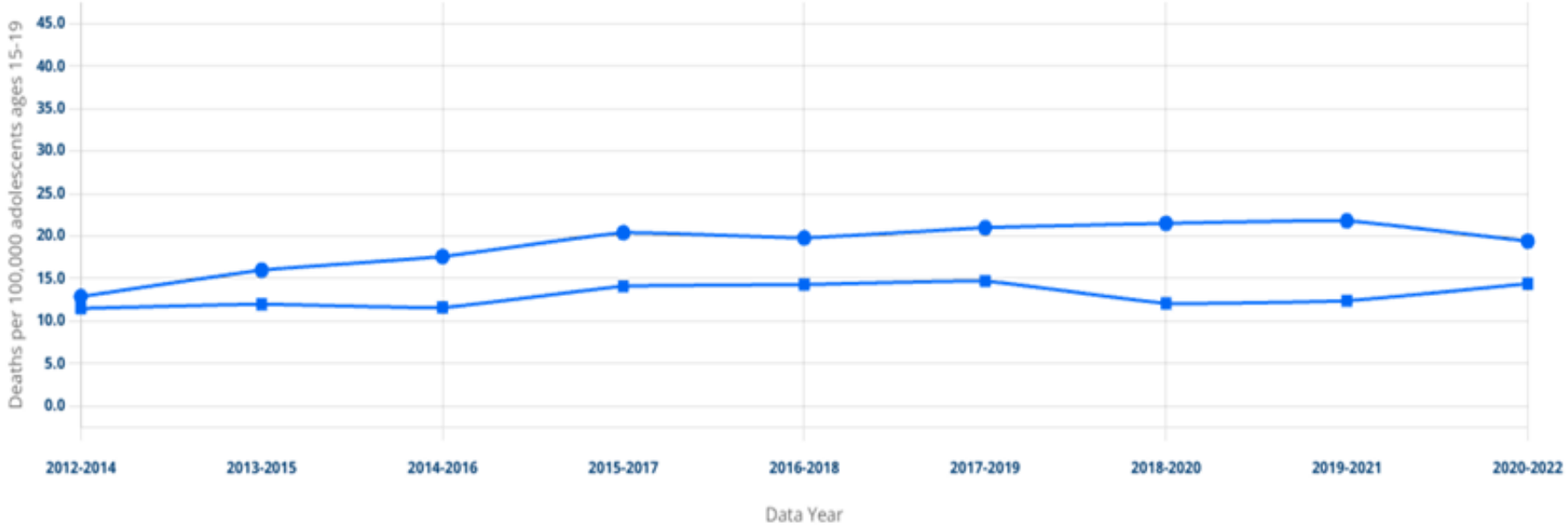
Source: National Syndromic Surveillance Program (NSSP). View this dataset on data.cdc.gov.

Number of deaths due to intentional self-harm per 100,000 adolescents ages 15-19



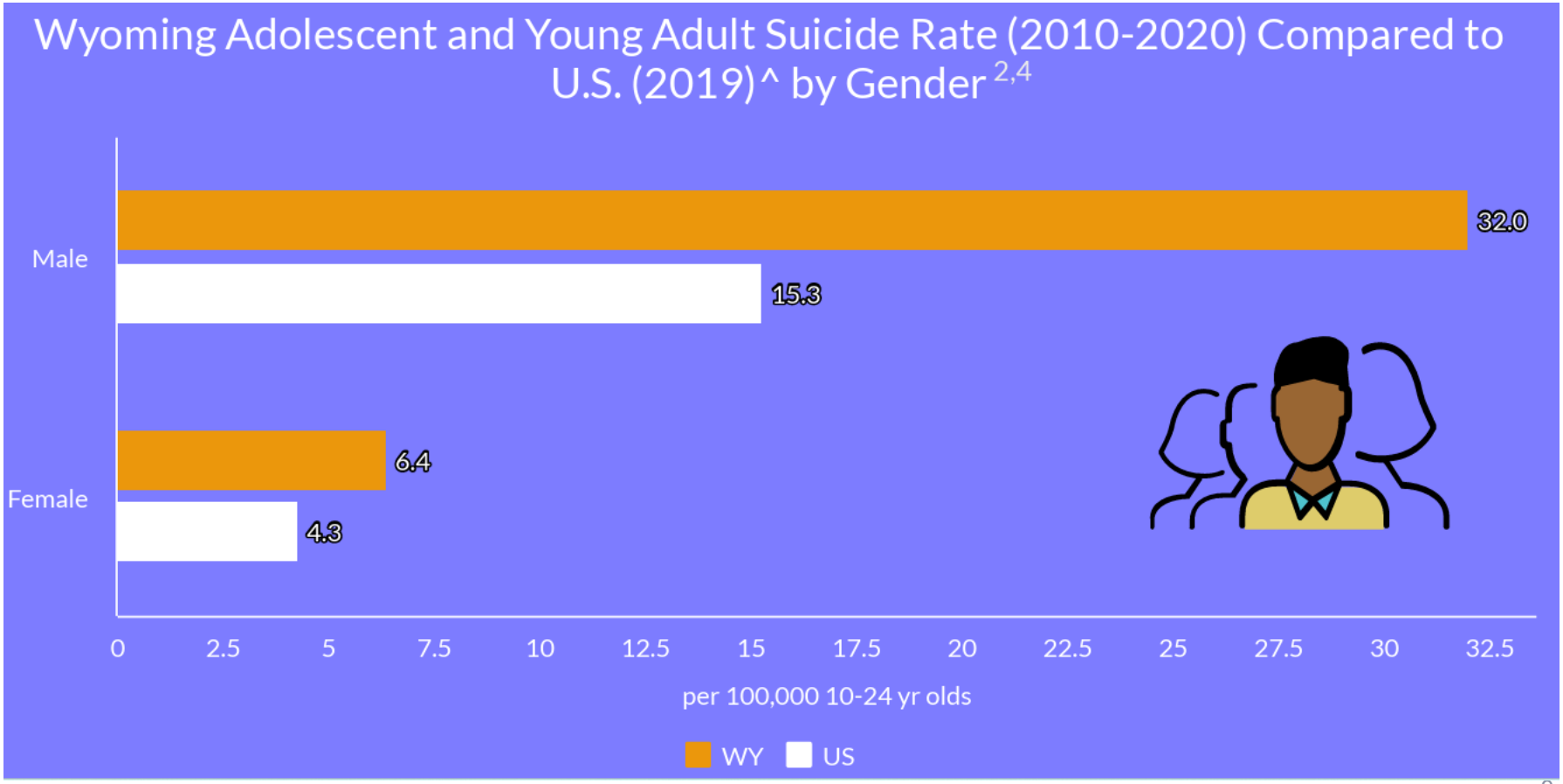
Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death by Single Race Files via CDC WONDER Online Database

Number of deaths due to intentional self-harm per 100,000 adolescents ages 15-19

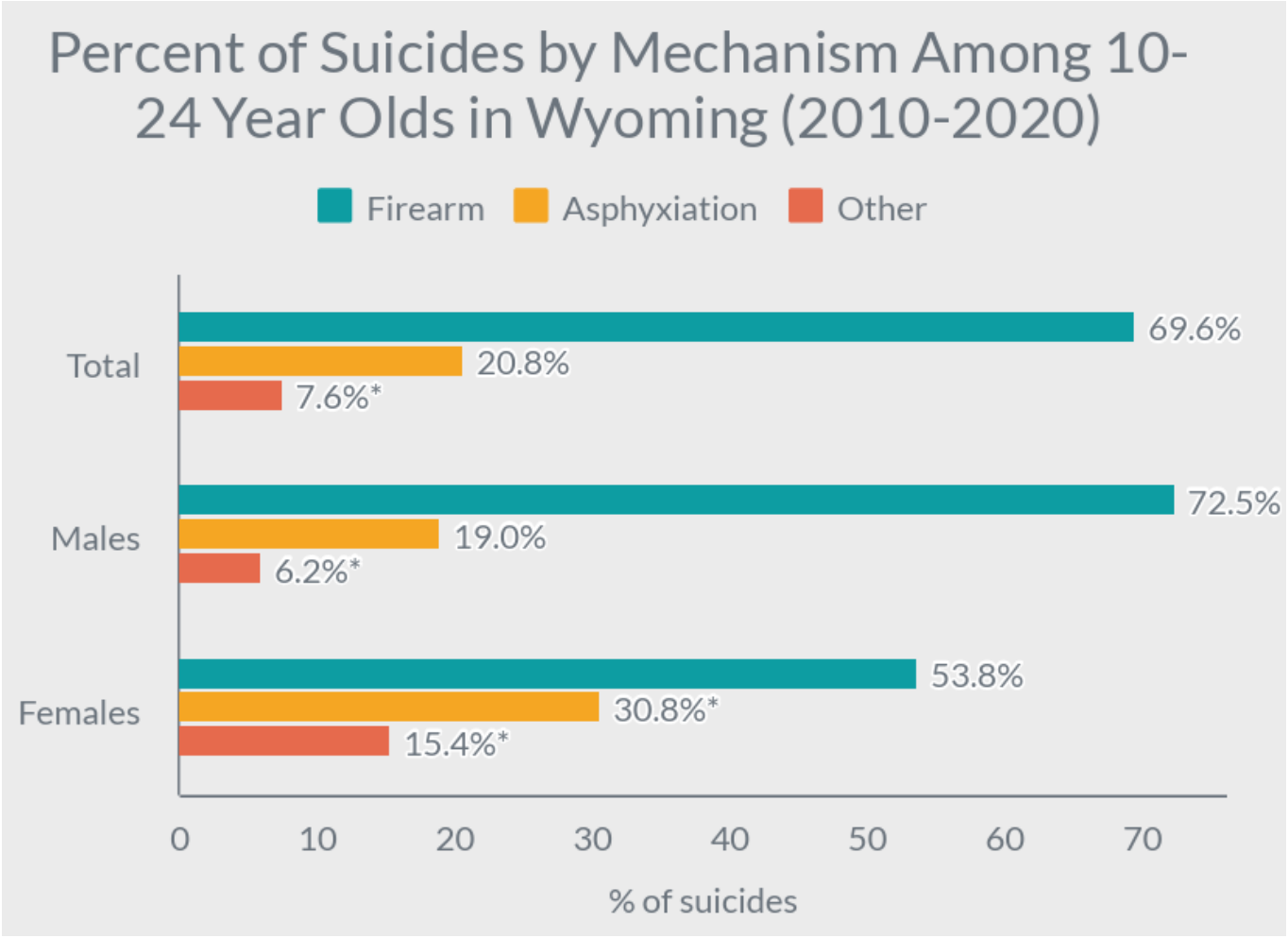


Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death by Single Race Files via CDC WONDER Online Database

Wyoming Adolescent and Young Adult Suicide Rate (2010-2020) Compared to U.S. (2019)^ by Gender [2,4]

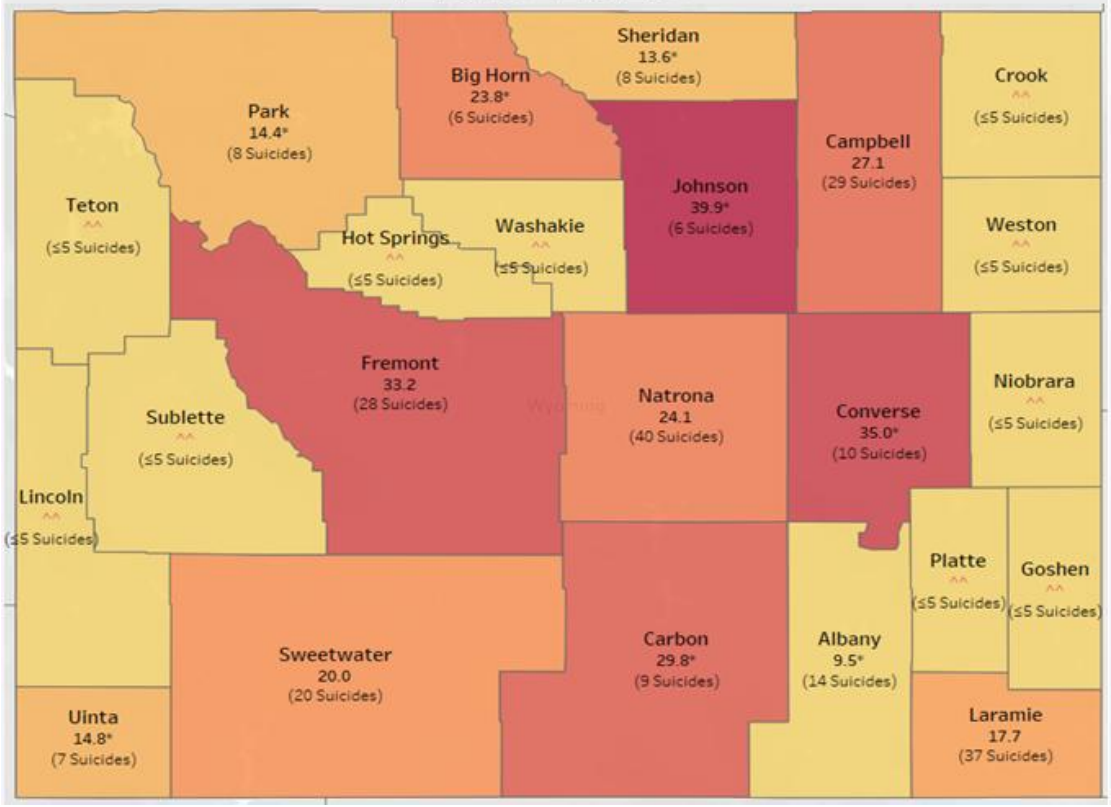


https://www.americashealthrankings.org/explore/measures/teen_suicide/WY



https://www.americashealthrankings.org/explore/measures/teen_suicide/WY

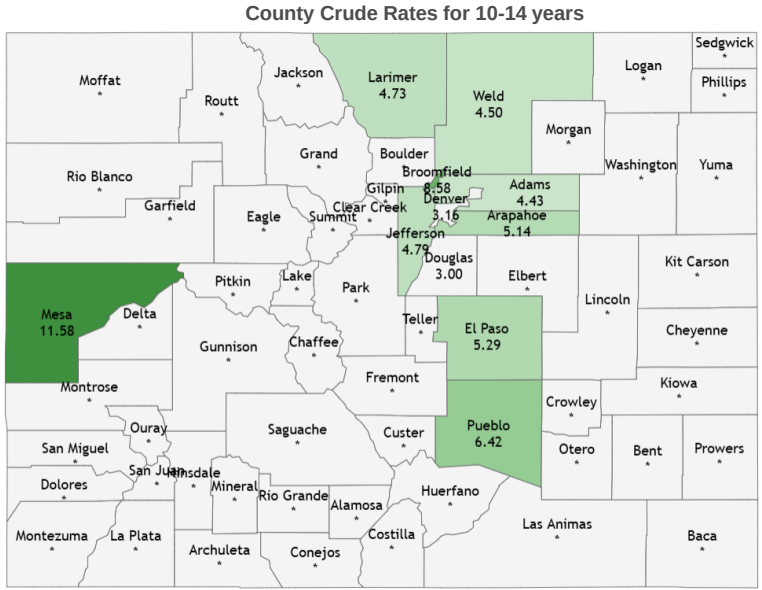
Wyoming Adolescent and Young Adult Suicide Rate (per 100,000 10-24 yr olds) by County 2010-2020 [2]

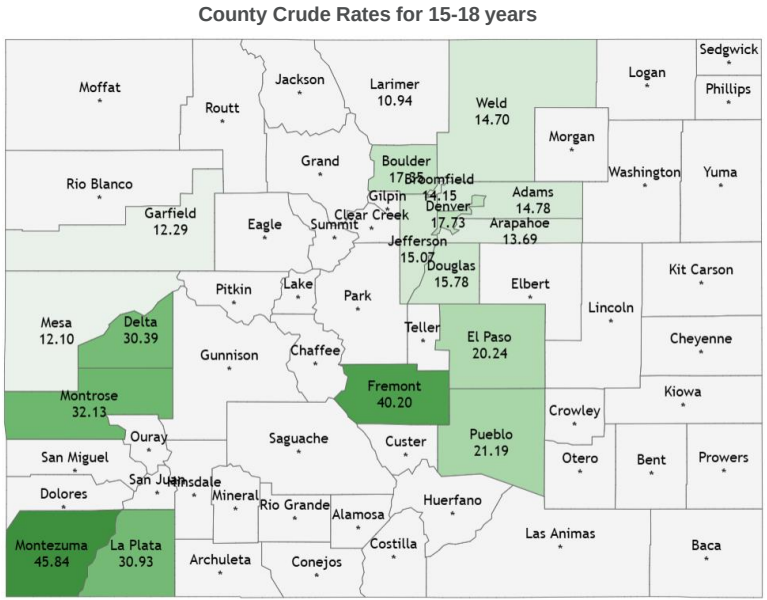


https://www.americashealthrankings.org/explore/measures/teen_suicide/WY

Colorado Youth Suicide Statistics

CDPHE Violent Death Reporting System Data, 2004-2023, 10-18 years old





From 2018-2024

- **466** Colorado youth died by suicide
- **255** Colorado youth died by motor vehicle accidents

Crude Rates per 100,000

https://cdphe.colorado.gov/colorado-suicide-statistics

Why are we seeing this increase?

- Increased visibility to mental health[1]
- Limited and delayed access to mental health care[2]
  - Suicide rates have increased faster in rural areas
- Social media and social isolation[3]
- Increased pressure to achieve[4]
- Societal stressors[5]
  - Finances, racism, gun violence, climate change

1. Armstrong, 2020; 2. Twenge et al., 2018; 3. Riehm et al., 2019; 4. Eckersley & Dear, 2002; 5. Hedegard et al., 2020

Risk Factors of Suicidality

- Gender
  - Females more likely to attempt suicide; Males more likely to die by suicide
- Race
  - In WY (and Rocky Mountain region), America Indian/Alaska Native are highest risk
- LGBTQ+
  - Four times more likely to consider and attempt suicide
- Socioeconomic Status (SES)
  - Poverty increases risk
- Substance Use

Western Interstate Commission for Higher Education Mental Health Program & Suicide Prevention Resource Center, (2017).

Risk Factors of Suicide Attempt

- Prior Suicide Attempt
- Recent Hospitalization
- Hopelessness
- Access to Lethal Means
- Substance Abuse
- Stressors (e.g., recent break-up)

Western Interstate Commission for Higher Education Mental Health Program & Suicide Prevention Resource Center, (2017).

Importance of Healthcare Providers

- 80% of youth who died by suicide saw a healthcare provider in the previous year[1]

- Youth who die by suicide are more likely to have seen a PCP in the month prior to their death than any other health care provider[2]

1. Rhodes et al., 2013; 2. Ahmedani et al., 2014

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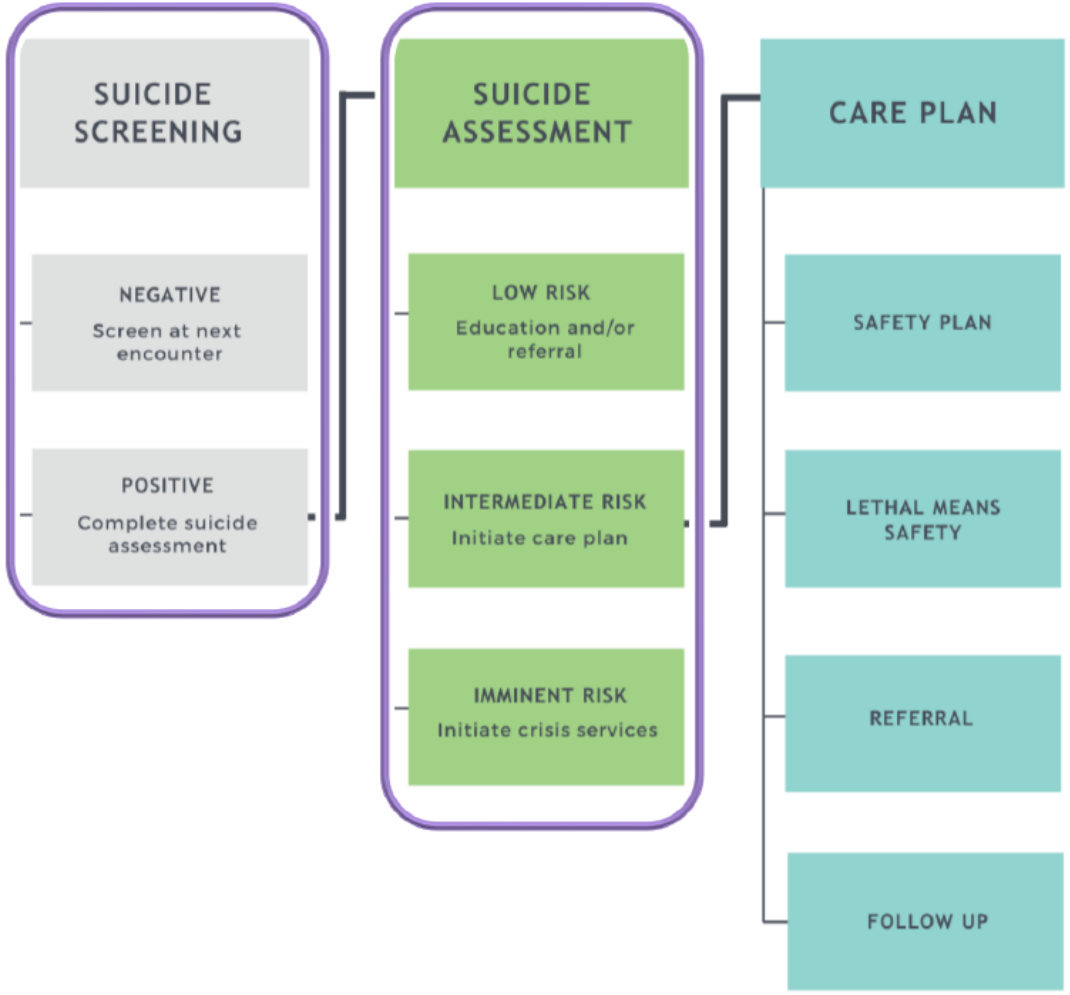
Youth Suicide Care Pathway


SUICIDE SCREENING
NEGATIVE
Screen at next encounter
POSITIVE
Complete suicide assessment
SUICIDE ASSESSMENT
LOW RISK
Education and/or referral
INTERMEDIATE RISK
Initiate care plan
IMMINENT RISK
Initiate crisis services
CARE PLAN
SAFETY PLAN
LETHAL MEANS SAFETY
REFERRAL
FOLLOW UP

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Suicide Screening

Suicide Screening

- Evidence-based suicide screening tool developed for pediatric medical settings for youth ages 8-24[1]
- ASQ[2] is free and available in multiple languages
- Four yes/no questions and takes 20 seconds to administer
- A “yes” response to 1 or more questions identified 97% of youth at risk of suicide[2]

1. Horowitz et al., 2012; 2. National Institute of Mental Health (NIMH), 2020

ASQ 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: _____

ASQ: Next Steps

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 741741

SUICIDE SCREENING

NEGATIVE

Screen at next encounter

POSITIVE

Complete suicide assessment

asQ
Ask Suicide-Screening Questions

Please circle Yes or No for the below questions.

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 to question #4, how and when?

If you answered YES to any of the above questions, please also answer the below question:

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

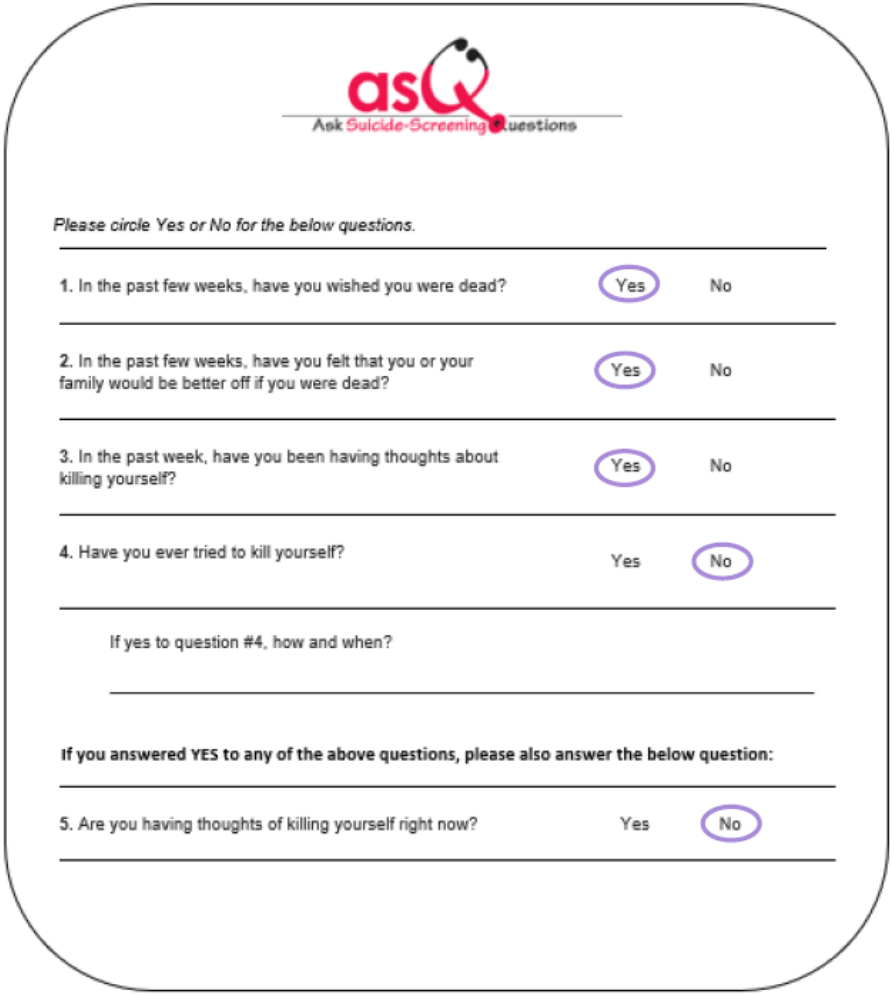
NIMH, 2020

Example #1

A 17-year-old Hispanic female presents to PCP for her annual well child check with a history of depression, visible self-harm cuts on her arms. Her ASQ is as follows:

1. Is this a positive or negative screen?
   - Positive

2. What is the next step for this patient?
   - Complete a suicide assessment



asQ
Ask Suicide-Screening Questions

Please circle Yes or No for the below questions.

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 to question #4, how and when?

If you answered YES to any of the above questions, please also answer the below question:

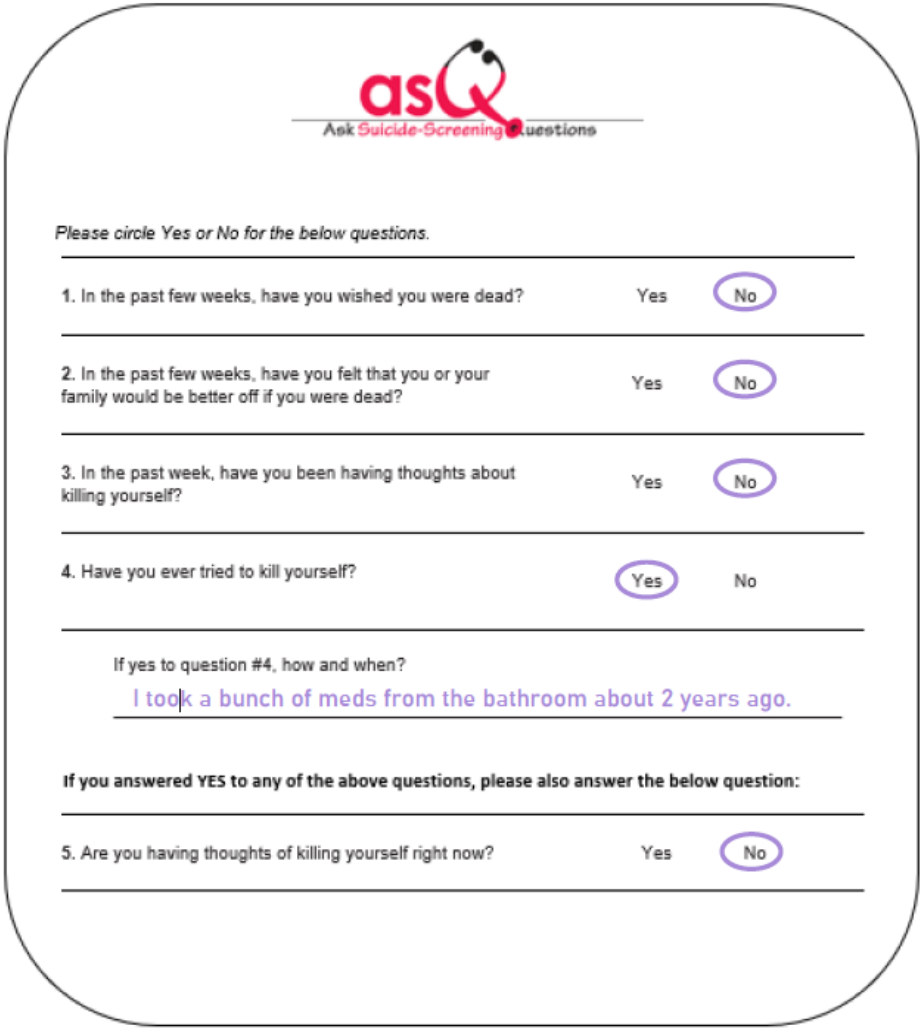
5. Are you having thoughts of killing yourself right now? Yes (No)

Example #2

A 13-year-old White male presents to PCP for a sick visit. Recent romantic breakup, sporadic school attendance, and parent reported increased irritability. Started seeing a therapist 2 months ago. His ASQ is as follows:

1. Is this a positive or negative screen?
   - Positive

2. What is the next step for this patient?
   - Complete a suicide assessment



asQ
Ask Suicide-Screening Questions

Please circle Yes or No for the below questions.

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 to question #4, how and when?

I took a bunch of meds from the bathroom about 2 years ago.

If you answered YES to any of the above questions, please also answer the below question:

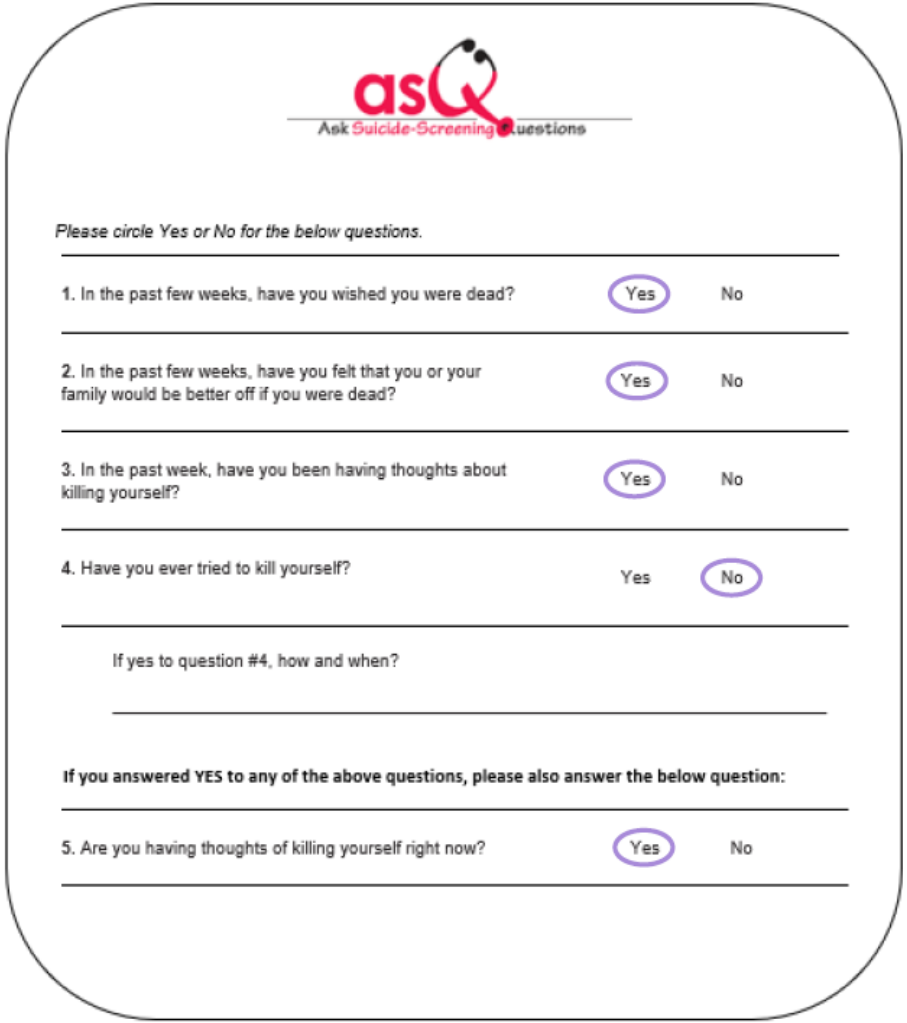
5. Are you having thoughts of killing yourself right now? Yes **No**

Example #3

A 16-year-old American Indian female presents to PCP for a mental health visit. Parent reported patient has been tearful, isolated, and low motivation. Her ASQ is as follows:

1. Is this a positive or negative screen?
   - Acute Positive

2. What is the next step for this patient?
   - Complete a suicide assessment or initiate transfer to ED/Crisis Clinic



asQ
Ask Suicide-Screening Questions

Please circle Yes or No for the below questions.

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 to question #4, how and when?

If you answered YES to any of the above questions, please also answer the below question:

5. Are you having thoughts of killing yourself right now? (Yes) No

NIMH, 2020

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Suicide Assessment

Brief Suicide Safety Assessment

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 Review patient's responses from the asQ

❑ Frequency of suicidal thoughts

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

NIMH, 2020

2 Assess the patient Review patient's responses from the asQ

❑ 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?"

_____

_____

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?" ❑ Yes ❑ No

"Has anyone in your family/close friend network ever tried to kill themselves?" ❑ Yes ❑ No

"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) ❑ Yes ❑ No

"Are you comfortable keeping your child safe at home?" ❑ Yes ❑ No

_____

_____

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

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

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.**

Comments _____

	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 you 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

Example #1

- 13-year-old biracial male patient presents for well-child check. Reports pressure related to academics and peer conflict
- *“Sometimes I think it’d be easier for everyone if I didn’t exist.”*
- No access to lethal means. Denies a plan or intent.
- Parents very supportive and involved

Low Risk

- Provider referral list and resources
- If indicated, provide educational materials to patient/parents
- Consider follow-up contact within next 4 weeks

Example #2

- 15-year-old Hispanic female patient presents for sick visit
- History of self-harm but not within past 3 months
- Presents with suicidal ideation but no plan or intent
- Good relationships with family but no friends at school

Intermediate Risk

- Initiate safety plan
- Counseling on lethal means restriction
- Referral to mental health services (preferably within 72 hours)

Example #3

- 17-year-old White male patient presents for mental health visit. Reports increased tearfulness, isolation, and substance use
- Access to lethal means (gun in the home)
- Endorsed suicidal thoughts and a plan, unclear on intent
- Texted a friend last night "*No one would even care if I died.*"

Imminent Risk

- Initiate transfer to crisis center or ED for crisis assessment
- Do not leave patient alone and remove dangerous objects from room
- Alert any relevant care team members

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Safety Planning

Safety Planning

- Do not use “suicide contract” language
  - Not evidence-based

- Do use “safety plan”
  - Proactive planning
  - Focuses on what can be done vs what not to do
  - Enhances self-efficacy and sense of control

- Stanley-Brown Safety Plan[1]

Stanley et al., (2009)

Core Steps to Safety Planning

1. Identify reasons for living
2. Recognize warning signs
3. Identify internal coping strategies
4. Identify external healthy distractions
5. List people who can provide support
6. List professionals/resources who can provide support
7. Make environment safe

Stanley et al., (2009)

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/ Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/ Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

Step 1: My warning signs:

Signs that I am having strong feelings or I am not feeling safe:

1	

Signs my supporting adult(s) may notice:

1	

Step 2: Things I can do to help myself

1	

Step 3: Reasons to be safe

1	

Step 4: Things others can do to help me

1	

Step 5: People who can help me

☐ Patient did not identify any contacts

	Name	Contact Information
1		

Step 6: Health care workers and agencies to call

Clinician/Agency Name	Phone	Emergency Contact

Colorado Crisis Services: 1-844-493-TALK (8255) or text TALK to 38255

www.ColoradoCrisisServices.org

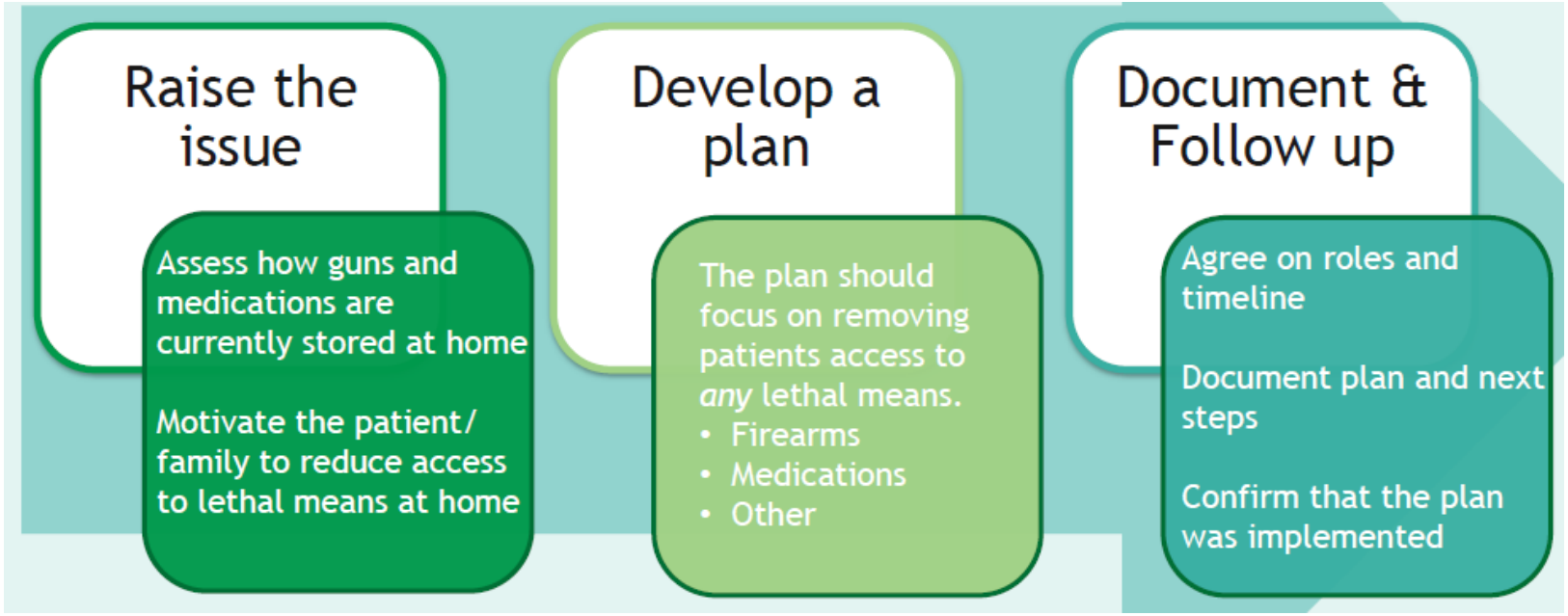
Call 911 or go to the nearest Emergency Department for immediate safety concerns

Adaptation of Stanley-Brown Safety Plan - Children's Hospital Colorado

Step 7: Ways to make your environment safer

1	

Counseling on Lethal Means Restriction



Resources

- Suicide Prevention Toolkit for PCPs
  - https://sprc.org/settings/primary-care/toolkit/
- CALM: Counseling on Access to Lethal Means
  - https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/
- Safety Planning Guide
  - https://sprc.org/online-library/safety-planning-guide-a-quick-guide-for-clinicians/
- NIMH Ask Suicide-Screening Questions (ASQ) Toolkit
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials
- Colorado Crisis Services
  - 1-844-493-8255 or text “TALK” to 38255
    - www.coloradocrisisservices.org
- National Suicide Prevention Line
  - 1-800-273-8255

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Questions?

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