Detecting and Managing Suicide Risk for Youth in Medical Settings: Turning Research into Practice

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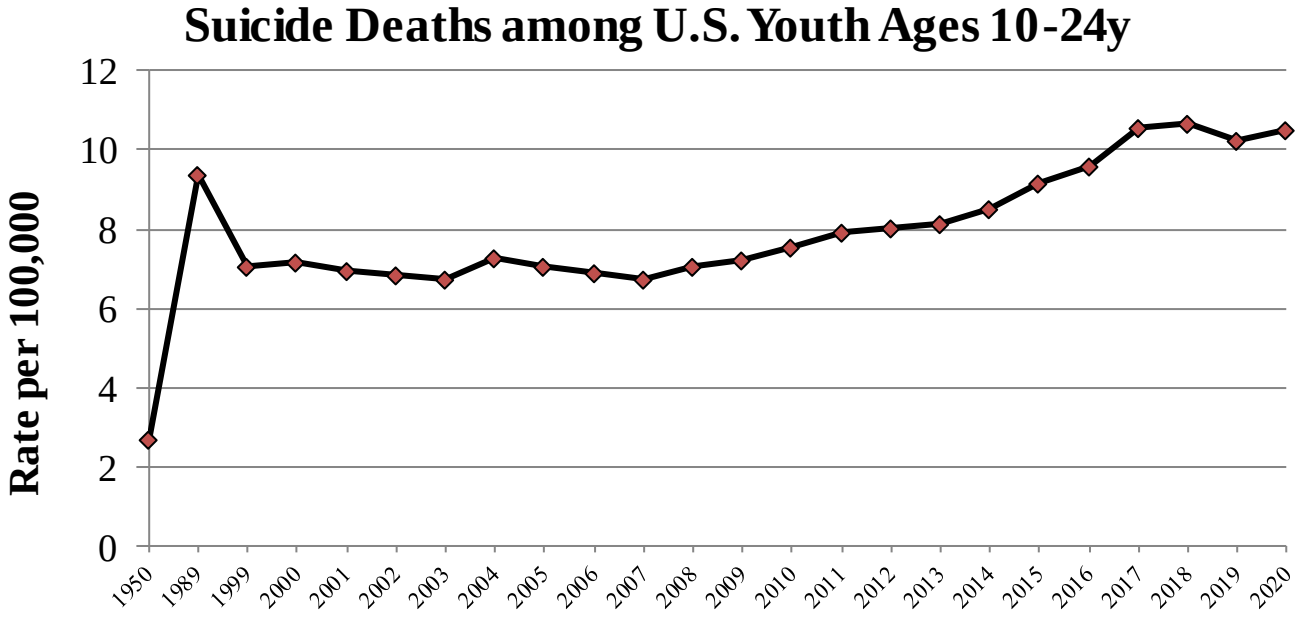
The views expressed in this presentation do not necessarily represent the views of the DHHS, NIH, or any other government agency or official. I have no financial conflicts to disclose.

Take Home Messages

- Youth suicide is a major public health problem; the medical setting can be leveraged for suicide prevention
- Identifying suicide risk early can mitigate long-term consequences
- Research has been translated into practice successfully, making universal suicide risk screening feasible
  - Ask directly
  - Clinical Pathways

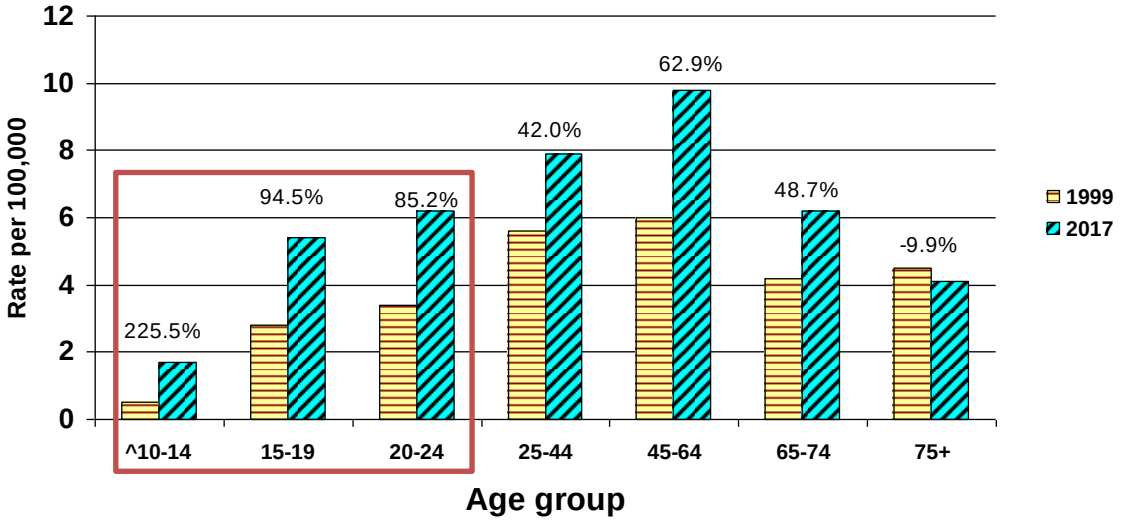
Youth Suicide in the U.S.

- **3rd leading cause of death** for youth aged 10-24y
- 39,229 total youth deaths in 2020, 6,643 **(17%)** deaths by suicide



CDC WISQARS, 2020

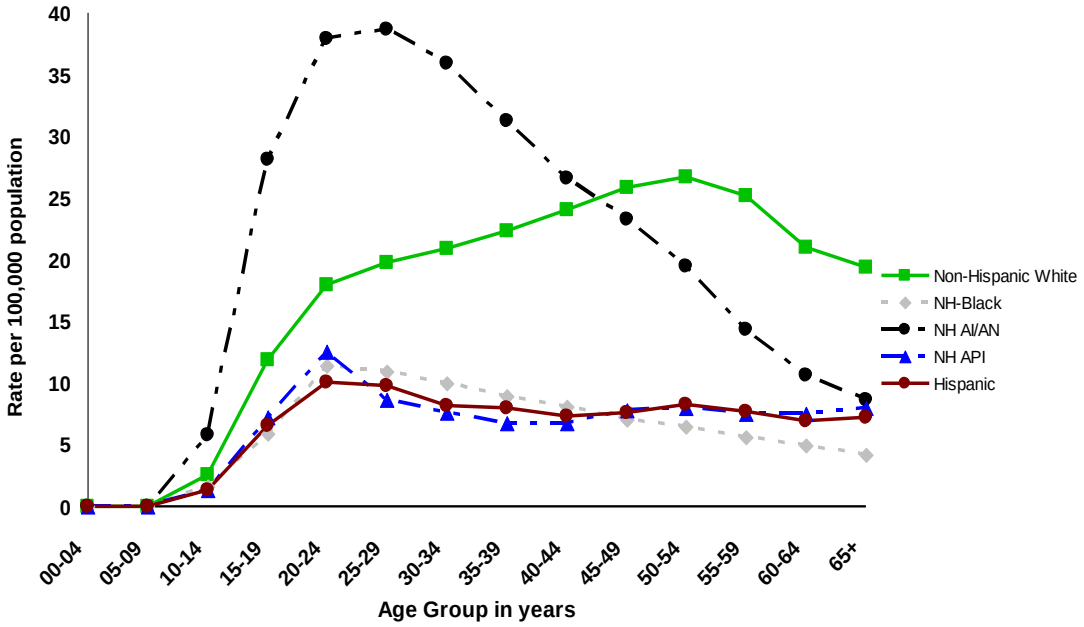
Suicide Rates Among Females by Age Group – United States, 1999 and 2017



Source: CDC WISQARS Fatal Injury Reports, https://www.cdc.gov/injury/wisqars/fatal.html

Slide courtesy of Dr. Deborah Stone, CDC

Suicide Rates by Ethnicity and Age Group – United States, 2013-2017



Source: CDC WISQARS Fatal Injury Reports, https://www.cdc.gov/injury/wisqars/fatal.html

Slide courtesy of Dr. Deborah Stone, CDC

"…lack of research on both risk and protective factors associated with suicidal thoughts and attempts in this population."

Slide courtesy of Dr. Tami Benton

Suicide Risk Screening for Underserved Populations

- Many underserved populations at higher risk for suicide are understudied by research
  - Black, Indigenous, and people of color (BIPOC)
  - LGBTQ+ individuals
  - Individuals with ASD or NDD
  - Child Welfare System
  - Juvenile detention centers
  - Rural areas

- Screening can help identify underserved individuals at risk for suicide and link them to care

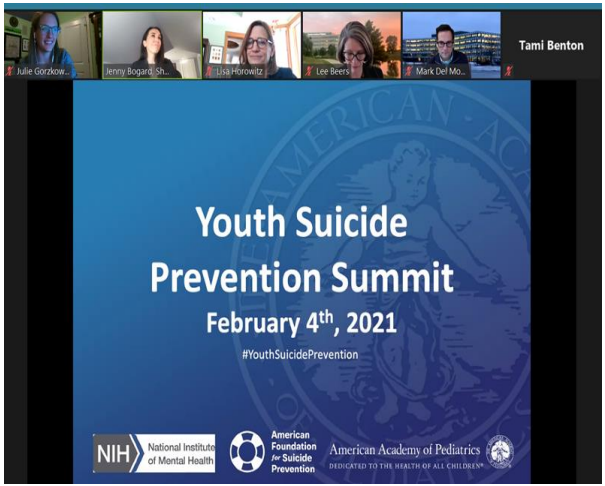
COVID-19 Pandemic Seems to Have Exacerbated This Crisis

- Increase in youth suicidal ideation and attempts
- Increase in Emergency Department visits for pediatric mental health emergencies
  - During February-March 2021, when compared to the same time period in 2019, there was a 39% increase in ED visits for suspected suicide attempts among youth aged 12-17 years
  - The increase for females aged 12-17 years was 51%
  - The increase for males aged 12-17 years was 4%

Hill et al., 2021; Leeb et al., 2020; Siliman-Cohen et al., 2020

Process for Developing the Blueprint for Youth Suicide Prevention

- Youth Suicide Prevention Summit
  Feb – June, 2021
  www.aap.org/suicideprevention
- Convened key partners:
  - Clinicians, Public Health Officials
  - Schools, Community Organizations
  - Academia
- Blueprint focuses on:
  - Clinical settings
  - Community/school settings
  - Policy arena
- Focus on health equity, lived experience



NIMH experts collaborated with AAP and AFSP on both the Summit and the Blueprint. This does not necessarily imply NIMH endorsement of the Blueprint and the Blueprint does not necessarily reflect the views of NIMH, the National Institutes of Health, the Department of Health and Human Services, or the US government broadly.

Key Take-Aways from the Summits

- Suicide is often preventable
  - Identification and support to youth at immediate risk
  - Population-health efforts to address upstream risk and protective factors
- Health equity is critical
- Strategies to improve suicide prevention fall into 2 domains:
  - Resources for medical settings, communities, schools
  - Education for all adults that work with youth
- Partnerships are essential

Blueprint for Youth Suicide Prevention

- Roadmap for future action and partnerships

- Strategies to identify and support youth via:
  - Clinical care pathways
  - Community and school partnerships
  - Advocacy and policy approaches

aap.org/suicideprevention

NIMH experts collaborated with AAP and AFSP on the Blueprint. This does not necessarily imply NIMH endorsement of the Blueprint.
NIMH did not contribute to the Advocacy section of this Blueprint and any information described in this section does not necessarily reflect the views of NIMH, the National Institutes of Health, the Department of Health and Human Services, or the US government broadly.

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.

Suicide Is Preventable.

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

With Help Comes Hope

NIH National Institute of Mental Health

http://suicidepreventionlifeline.org/App_Files/Media/PDF/NSPL_WalletCard.pdf

Strategies for Implementing Suicide Prevention in Clinical Settings

Underdetection

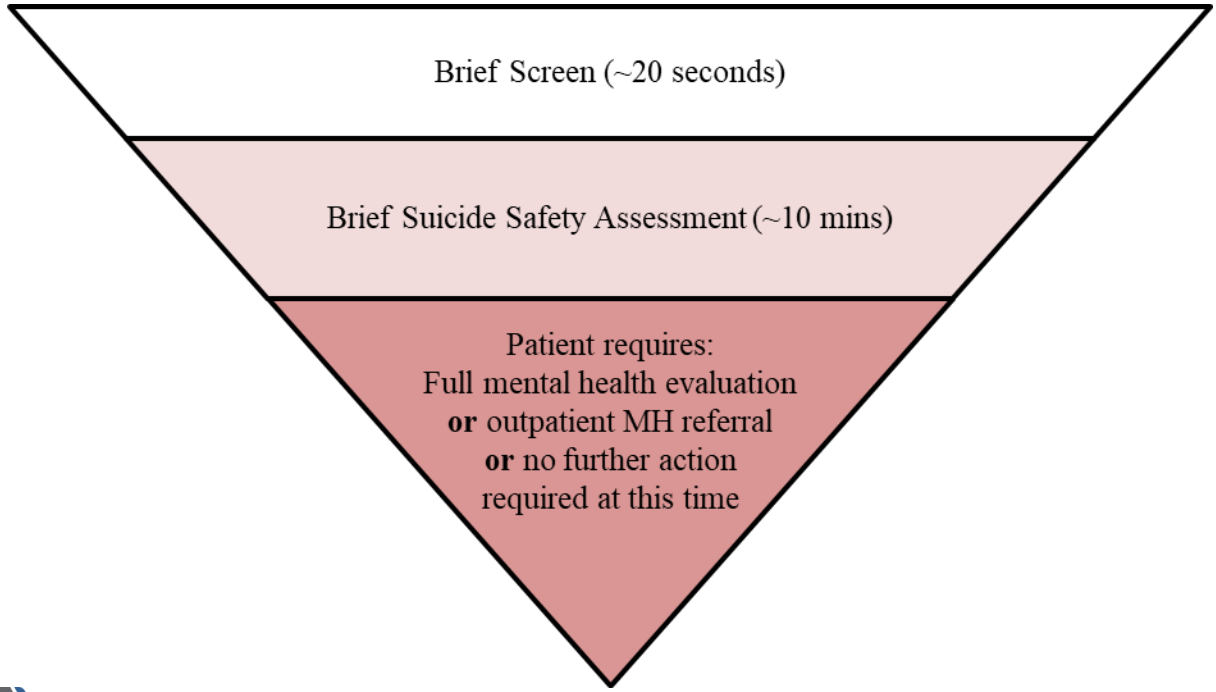
- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves
  - ~80% of adolescents visited healthcare provider within the year prior to death by suicide
  - 49% of youth had been to an ED within 1 year
  - 38% of adolescents had contact with a health care system within 4 weeks prior
  - Frequently present with somatic complaints

Ahmedani, 2014; Rhodes, 2013; Blum, 1996

Can We Save Lives by Screening for Suicide Risk in the Medical Setting?

Universal Suicide Risk Screening Clinical Pathway

Clinical Pathway- 3-tiered system



National Institute of Mental Health

Brahmbhatt, Kurtz, Afzal…Pao, Horowitz, et al. (2018) *Psychosomatics*

Screening vs. Assessment: What's the difference?

- **Suicide Risk Screening**
  - Identify individuals at risk for suicide
  - Oral, paper/pencil, computer

- **Suicide Risk Assessment**
  - Comprehensive evaluation
  - Confirms risk
  - Estimates imminent risk of danger to patient
  - Guides next steps

Common Concern:

Can asking kids questions about suicidal thoughts put ‘ideas’ into their heads?

Iatrogenic Risk?

On the Iatrogenic Risk of Assessing Suicidality: A Meta-Analysis

CHRISTOPHER R. DECOU, MS, AND MATTHEW E. SCHUMANN, MA

2017

Previous studies have failed to detect an iatrogenic effect of assessing suicidality. However, the perception that asking about suicide may induce suicidality persists. This meta-analysis quantitatively synthesized research concerning the iatrogenic risks of assessing suicidality. This review included studies that explicitly evaluated the iatrogenic effects of assessing suicidality via prospective research methods. Thirteen articles were identified that met inclusion criteria. Evaluation of the pooled effect of assessing suicidality with regard to negative outcomes did not demonstrate significant iatrogenic effects. Our findings support the appropriateness of universal screening for suicidality, and should allay fears that assessing suicidality is harmful.

Impact of screening for risk of suicide: randomised controlled trial

2011

Mike J. Crawford, Lavanya Thana, Caroline Methuen, Pradip Ghosh, Sian V. Stanley, Juliette Ross, Fabiana Gordon, Grant Blair and Priya Bajaj

Background
Concerns have been expressed about the impact that screening for risk of suicide may have on a person's mental health.

Aims
To examine whether screening for suicidal ideation among people who attend primary care services and have signs of depression increases the short-term incidence of feeling that life is not worth living.

Method
In a multicentre, single-blind, randomised controlled trial, 443 patients in four general practices were randomised to screening for suicidal ideation or control questions on health and lifestyle (trial registration: ISRCTN84692657). The primary outcome was thinking that life is not worth living measured 10–14 days after randomisation. Secondary outcome measures comprised other aspects of suicidal ideation and behaviour.

Results
A total of 443 participants were randomised to early ($n = 230$) or delayed screening ($n = 213$). Their mean age was 48.5 years (s.d. = 18.4, range 16–92) and 137 (30.9%) were male. The adjusted odds of experiencing thoughts that life was not worth living at follow-up among those randomised to early compared with delayed screening was 0.88 (95% CI 0.66–1.18). Differences in secondary outcomes between the two groups were not seen. Among those randomised to early screening, 37 people (22.3%) reported thinking about taking their life at baseline and 24 (14.6%) that they had this thought 2 weeks later.

Conclusions
Screening for suicidal ideation in primary care among people who have signs of depression does not appear to induce feelings that life is not worth living.

Declaration of interest
None.

What's the Harm in Asking About Suicidal Ideation?

CHARLES W. MATHIAS, PHD, R. MICHAEL FURR, PHD, ARIELLE H. SHEFTALL, PHD, NATHALIE HILL-KAPTURCZAK, PHD, PAIGE CRUM, BA, AND DONALD M. DOUGHERTY, PHD

2012

Both researchers and oversight committees share concerns about patient safety in the study-related assessment of suicidality. However, concern about assessing suicidal thoughts can be a barrier to the development of empirical evidence that informs research on how to safely conduct these assessments. A question has been raised if asking about suicidal thoughts can result in iatrogenic increases of such thoughts, especially among at-risk samples. The current study repeatedly tested suicidal ideation at 6-month intervals for up to 2-years. Suicidal ideation was measured with the Suicidal Ideation Questionnaire Junior, and administered to adolescents who had previously received inpatient psychiatric care. Change in suicidal ideation was tested using several analytic techniques, each of which pointed to a significant decline in suicidal ideation in the context of repeated assessment. This and previous study outcomes suggest that asking an at-risk population about suicidal ideation is not associated with subsequent increases in suicidal ideation.

Evaluating Iatrogenic Risk of Youth Suicide Screening Programs

A Randomized Controlled Trial

Madelyn S. Gould, PhD, MPH
Frank A. Marrocco, PhD
Marjorie Kleinman, MS
John Graham Thomas, BS
Katherine Mostkoff, CSW
Jean Cote, CSW
Mark Davies, MPH

THE PRESIDENT'S NEW FREEdom Commission[1] and the Children's Mental Health

Context Universal screening for mental health problems and suicide risk is at the forefront of the national agenda for youth suicide prevention, yet no study has directly addressed the potential harm of suicide screening.

Objective To examine whether asking about suicidal ideation or behavior during a screening program creates distress or increases suicidal ideation among high school students generally or among high-risk students reporting depressive symptoms, substance use problems, or suicide attempts.

Design, Setting, and Participants A randomized controlled study conducted within the context of a 2-day screening strategy. Participants were 2342 students in 6 high schools in New York State in 2002-2004. Classes were randomized to an experimental group (n=1172), which received the first survey with suicide questions, or to a control group (n=1170), which did not receive suicide questions.

DeCou & Schumann, 2017; Mathias et al., 2012; Crawford et al., 2011; Gould et al., 2005

Tier 1: Brief Screen (Less than 1 Minute)

- Age recommendations for screening:
  - Youth age 12+: Universal screening
  - Youth ages 8-11: screen when clinically indicated
  - Youth under 8: screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present
- Anyone who is trained can screen for suicide risk

Example Screening Tool: ASQ

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

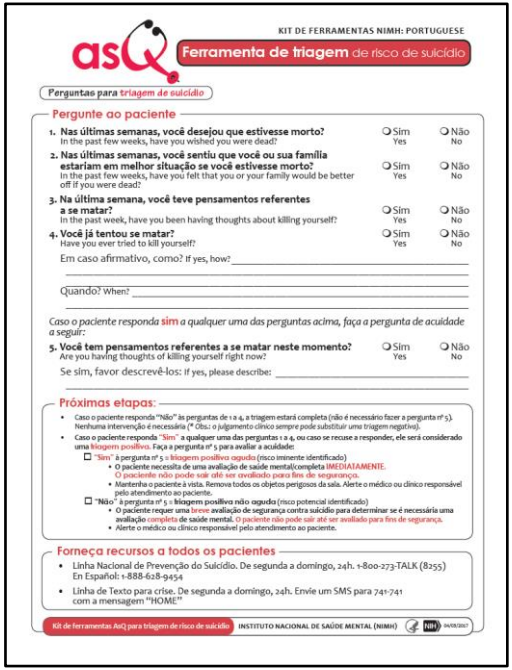
Horowitz, Bridge, Wharff, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

Validation and Implementations in Other Settings: Ongoing Research

- Inpatient medical/surgical unit
- Outpatient primary care/specialty clinics
- ASQ in adult medical patients
- Schools
- Child abuse clinics
- Detention Facilities
- Indian Health Service (IHS)
- ASD/NDD Population

Foreign languages

- Spanish
- Italian
- French
- Portuguese
- Dutch
- Arabic
- Somali
- Hindi
- Hebrew
- Vietnamese
- Mandarin
- Korean
- Japanese
- Russian
- Tagalog
- Urdu



KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ Ferramenta de triagem de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

1. **Nas últimas semanas, você desejou que estivesse morto?** In the past few weeks, have you wished you were dead? ○ Sim Yes ○ Não No
2. **Nas últimas semanas, você sentiu que você ou sua família estariam em melhor situação se você estivesse morto?** In the past few weeks, have you felt that you or your family would be better off if you were dead? ○ Sim Yes ○ Não No
3. **Na última semana, você teve pensamentos referentes a se matar?** In the past week, have you been having thoughts about killing yourself? ○ Sim Yes ○ Não No
4. **Você já tentou se matar?** Have you ever tried to kill yourself? ○ Sim Yes ○ Não No

Em caso afirmativo, como? If yes, how? _____

Quando? When? _____

Caso o paciente responda sim a qualquer uma das perguntas acima, faça a pergunta de acuidade a seguir:

5. **Você tem pensamentos referentes a se matar neste momento?** Are you having thoughts of killing yourself right now? ○ Sim Yes ○ Não No

Se sim, favor descrevê-los: If yes, please describe: _____

Próximas etapas:

- Caso o paciente responda "Não" às perguntas de 1 a 4, a triagem estará completa (não é necessário fazer a pergunta nº 5). Nenhuma intervenção é necessária (* Obs.: o julgamento clínico sempre pode substituir uma triagem negativa).
- Caso o paciente responda "Sim" a qualquer uma das perguntas 1 a 4, ou caso se recuse a responder, ele será considerado uma triagem positiva. Faça a pergunta nº 5 para avaliar a acuidade:
  - ☐ "Sim" à pergunta nº 5 = triagem positiva aguda (risco iminente identificado)
    - O paciente necessita de uma avaliação de saúde mental/completa IMEDIATAMENTE. O paciente não pode sair até ser avaliado para fins de segurança.
    - Mantenha o paciente à vista. Remova todos os objetos perigosos da sala. Alerte o médico ou clínico responsável pelo atendimento ao paciente.
  - ☐ "Não" à pergunta nº 5 = triagem positiva não aguda (risco potencial identificado)
    - O paciente requer uma breve avaliação de segurança contra suicídio para determinar se é necessária uma avaliação completa de saúde mental. O paciente não pode sair até ser avaliado para fins de segurança.
    - Alerte o médico ou clínico responsável pelo atendimento ao paciente.

Forneça recursos a todos os pacientes

- Linha Nacional de Prevenção do Suicídio. De segunda a domingo, 24h. 1-800-273-TALK (8255) En Español: 1-888-628-9454
- Linha de Texto para crise. De segunda a domingo, 24h. Envie um SMS para 741-741 com a mensagem "HOME"

Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH) | NIH | 04/09/2017

NIH National Institute of Mental Health

ASQ Toolkit: www.nimh.nih.gov/ASQ

Can Depression Screening Be Used to Effectively Screen for Suicide Risk?

POSITIVE ON DEPRESSION SCREEN → **SUICIDE RISK SCREEN**

Blueprint has alternatives to ensure more youth at risk for suicide are detected through screening

What Happens When a Patient Screens Positive?

Here's What Should NOT Happen

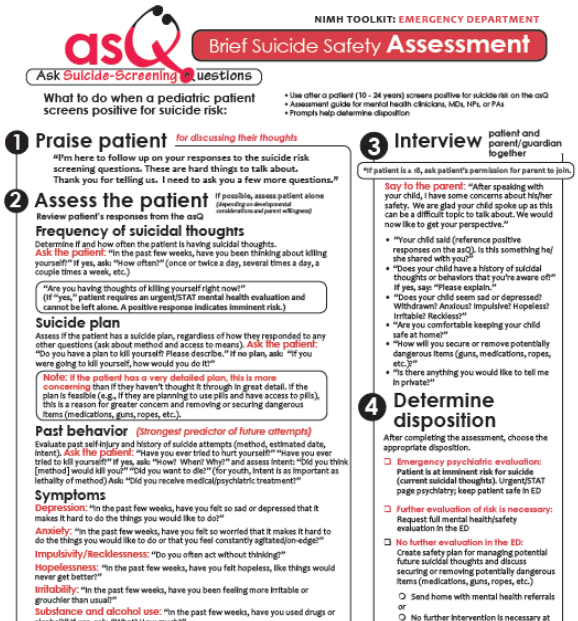
Do not treat every young person who has a thought about suicide as an emergency

1:1 sitter

Tier 2: Follow-up Positive Screen with a Brief Suicide Safety Assessment

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

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 (10 - 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.)

"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? Please describe." 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 *(Strongest predictor of future attempts)*

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?"

Symptoms

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?"

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?"

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

Support & Safety

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

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.)

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

3 Interview patient and parent/guardian together

*If patient is ≥ 18, ask patient's permission for parent 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 behaviors that you're aware of?" If yes, say: "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

❑ Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Urgent/STAT page psychiatry; keep patient safe in ED

❑ Further evaluation of risk is necessary: Request full mental health/safety evaluation in the ED

❑ No further evaluation in the ED: Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)

❍ Send home with mental health referrals or

❍ No further intervention is necessary at this time

5 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) | 7/14/2017

C-SSRS

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.

Since Last Visit

1. Wish to be Dead — Yes ☐ No ☐

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

Have you thought about being dead or what it would be like to be dead?

Have you wished you were dead or wished you could go to sleep and never wake up?

Do you wish you weren't alive anymore?

If yes, describe:

2. Non-Specific Active Suicidal Thoughts — Yes ☐ No ☐

General, non-specific thoughts of wanting to end one's life/commit 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 thought about doing

Have you had any thoughts ab

If yes, describe:

3. Active Suicidal Ideati

Subject endorses thoughts of su
place or method details worked
overdose but I never made a sp

Have you thought about how y

If yes, describe:

4. Active Suicidal Ideati

Active suicidal thoughts of kill
definitely will not do anything a

When you thought about maki

This is different from (as appr

If yes, describe:

5. Active Suicidal Ideati

Thoughts of killing oneself wit

Have you decided how or when would do it?

What was your plan?

When you made this plan (or w

If yes, describe:

INTENSITY OF ID

The following feature should and 5 being the most severe.

Most Severe Ideation:

Frequency

How many times hav

(1) Only one time (2) A

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)* — Since Last Visit

Actual Attempt: — Yes ☐ No ☐

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 method 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 high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?

Did you hurt yourself on purpose? Why did you do that?

Did you _____ as a way to end your life?

Did you want to die (even a little) when you _____?

Were you trying to make yourself not alive anymore when you _____?

Or did you think it was possible you could have died from _____?

Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)? (Self-Injurious Behavior without suicidal intent)

If yes, describe:

Total # of Attempts: _____

Has subject engaged in Non-Suicidal Self-Injurious Behavior? — Yes ☐ No ☐

Has subject engaged in Self-Injurious Behavior, intent unknown? — Yes ☐ No ☐

Interrupted Attempt: — Yes ☐ No ☐

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 make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Total # of interrupted: _____

Aborted Attempt or Self-Interrupted Attempt: — Yes ☐ No ☐

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 make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Total # of aborted or self-interrupted: _____

Preparatory Acts or Behavior: — Yes ☐ No ☐

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 done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?

If yes, describe:

Total # of preparatory acts: _____

Suicide: — Yes ☐ No ☐

Death by suicide occurred since last assessment.

Most Lethal Attempt Date: _____

Actual Lethality/Medical Damage: — Enter Code

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

Potential Lethality: Only Answer if Actual Lethality=0 — Enter Code

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

What is the Purpose of the Brief Suicide Safety Assessment?

- To help clinician identify next steps for care

- **Imminent Risk**
  - **Patient requires an emergency mental health evaluation**
- **Further Evaluation is Needed**
  - **This is not an emergency, but patient will require further mental health evaluation from a mental health professional as soon as possible**
- **Low Risk**
  - **No further evaluation is needed at this time**

Brief Interventions That Can Make a Difference

- Safety planning
- Lethal Means Safety Counseling
- Providing resources
  - National Suicide Prevention Lifeline
  - Crisis Text Line

Implementation Examples

Parkland

OHSU Doernbecher Children's Hospital

Metropolitan Pediatrics, LLC

CHEO
Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario

Kennedy Krieger Institute

Boston Children's Hospital
Until every child is well™

UCSF Benioff Children's Hospitals

Children's Mercy HOSPITAL KANSAS

Nationwide Children's

NIH National Institutes of Health
Clinical Center

Implementation Example

- Parkland Health and Hospital Systems
  - Implemented house-wide (ED, inpatient medical/surgical, outpatient);
  - Screened over 2 million patients (adults/youth)
  - Led by Dr. Kim Roaten

What Can We Do to Support Youth and Family?

- Preventive interventions (family-based and school-based) implemented early in children's lives can have long-term and cross-over effects, unanticipated beneficial effects, including reducing suicide risk.
  - Family Check-up
  - Family Intervention for Suicide Prevention (FISP)
  - Family Based Crisis Interventions (FBCI)
  - SOS (Signs of Suicide)

- Further develop, test and implement interventions for youth and families
  - Other intervention examples:
    - Caring contacts
    - Lethal means safety counseling
    - Safety planning

- Disseminate the findings/learnings

Connell et al., (2022) *Prevention Science;* Asarnow et al., (2009) *Professional Psychology*; Wharff et al., (2019) *Pediatr Emerg Care*; Schilling et al., (2016) *Prevention Science*

What Do We Need to Make This Happen?

- Buy in from medical and community leadership
- Resources within hospitals/outpatient settings
- Training for staff in all disciplines
- Access to mental health care follow up for those identified
- Options for acute care for those at imminent risk

We Can Do This!

Every adult that works with youth can help save a life

Thank You!

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NIH National Institute of Mental Health

Any Questions?

Just asQ !

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