

Blueprint for Youth Suicide Prevention



A joint initiative of the American Academy of Pediatrics
and the American Foundation for Suicide Prevention,
in collaboration with experts from the National Institute of Mental Health



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Introduction

[Suicide](#) and [suicidal behavior](#) among youth and young adults is a major public health crisis. Suicide is the 2nd leading cause of death among people 10-24 years of age in the United States (US), and [rates](#) have been rising for decades. Our children should grow, thrive, and live long, healthy lives; yet among youth in the US who die, over a quarter die from suicide.

As today's youth navigate their social and emotional development, various forms of health inequities, systemic discrimination, and recent challenges from the COVID-19 pandemic have added stress and barriers to overall health. Stressors such as social isolation, losses, grief, academic and extracurricular disengagement, and financial hardships for families have exacerbated mental health symptoms and other suicide risk factors. [According to a Centers for Disease Control and Prevention \(CDC\) report](#), the proportion of mental health–related emergency department (ED) visits for suicide attempts in early 2021 among adolescents 12–17 years of age increased 31% compared with the same period in 2019.

Suicide is complex but often preventable. Pediatric health clinicians, adults working with youth in school and community settings, families, and peers can play a critical role in identifying and supporting youth at risk for suicide.

Suicide affects all populations. Youth of any race, ethnicity, gender identity, sexual orientation, socioeconomic status, or community may be at risk for suicide.

Health equity is critical to suicide prevention. [Research shows significant disparities](#) in suicide rates, risk, and care for youth across cultures and communities. Race is a social construct, and a history of systemic racism within the healthcare system and scientific research community has resulted in an evidence base that does not include sufficient information about trends in suicidal thoughts, behaviors, and risk factors among Black youth, Indigenous youth, Latino youth, Asian American youth, and youth from other communities of color. Few studies have fully assessed the impacts of racism, discrimination, and historical or intergenerational trauma on suicidal ideation among affected youth; yet [research](#) has shown that experience with discrimination impacts youths' risk for suicidal thoughts. Furthermore, youth access to developmentally and culturally responsive mental health services is limited in many communities, clinics, and schools.

In order to truly serve all youth, there is a critical need for dedicated research and suicide prevention programs to support [Black youth](#), [Indigenous youth](#), [Latino youth](#), [Asian American youth](#), and [youth who identify as lesbian, gay, bisexual, transgender, queer, or two-spirit \(LGBTQ2S+\)](#). There is also a critical need to understand and address suicide prevention in communities that have been marginalized or underserved, including (but not limited to) youth in rural communities, youth in low-resource urban settings, [youth with special healthcare needs](#), youth in the child welfare system, youth who have experienced family disruption, youth who are homeless, and youth involved in the juvenile justice system. Multi-sectoral [strategies](#) are needed to identify and support youth at risk, as well as to address the upstream factors and social determinants of health (SDOH) that cause and intensify disparities.

These sobering realities are a call to action—**pediatric health clinicians and other adults who work with youth can make a difference**. Now more than ever there is an urgent need for national leadership and partnerships to advance youth suicide prevention.

Purpose of this Blueprint

The American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH), created this *Blueprint for Youth Suicide Prevention* as an educational resource to support pediatric health clinicians in identifying strategies and key partnerships to support youth at risk for suicide.

To develop this Blueprint, AAP, AFSP, and NIMH convened a [Virtual Summit on Youth Suicide Prevention](#), including listening sessions with partners serving youth from under-resourced communities, as well as federal agencies. Key multidisciplinary collaborators who focus on strategies to promote health equity offered insights that inform this resource.

Data and considerations presented in this Blueprint are based on the current landscape and gaps in science, practice, and programs related to youth suicide prevention. This Blueprint is intended to serve as a complementary effort to ongoing, large-scale comprehensive suicide prevention initiatives supported by the [US Centers for Disease Control and Prevention](#), the [National Action Alliance for Suicide Prevention](#), the [Substance Abuse and Mental Health Services Administration](#), the US Surgeon General's Advisory on [Protecting Youth Mental Health](#), the [Suicide Prevention Resource Center](#), and other leaders in the field.

This Blueprint is designed to outline clinical and community strategies and partnership opportunities that pediatric health clinicians can use to better identify and support youth at risk for suicide. To complement these strategies, AAP and AFSP have created an Advocacy resource to help those interested in advocating for policies to prevent suicide among youth. The National Institute of Mental Health (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.

Language note

Throughout this document, we refer to “pediatric health clinicians.” This term is intended to include all health clinicians who provide care to youth and young adults, including (but not limited to) pediatricians, pediatric medical subspecialists, pediatric surgical subspecialists, family physicians, subspecialists, mental and behavioral health professionals, nurses, nurse practitioners, physician assistants, medical assistants, school nurses, and any other clinician who provides health care to youth.

Full content

This PDF includes the “Strategies for Clinical Settings” section of the *Blueprint for Youth Suicide Prevention*. To access the full content, visit www.aap.org/suicideprevention.

Preventing Youth Suicide: Strategies for Clinical Settings

Why is it Important to Implement Youth Suicide Prevention in Clinical Settings?

Suicide is the second leading cause of death in youth and young adults, ages 10-24 years

Medical settings are well-positioned to prevent and treat illness and save lives. Over a quarter of deaths in young people 10-24 years of age are from suicide, a potentially preventable [outcome](#).

Data from the [2019 Youth Risk Behavior Survey](#) indicate that:

- 18.8% of high school students reported “seriously considering” suicide
- 8.9% of high school students attempted suicide within the past year

Moreover, data from the [2019 CDC death reports](#) reveal that in 2019:

- 6,488 children, adolescents, and young adults died by suicide
- Out of the 32,935 youth deaths, 20% were from suicide
- Every day, approximately 18 youth died by suicide

Clinical settings are well-positioned to identify and treat suicide risk

Many young people that die by suicide visit a healthcare provider in the months or weeks, prior to their death:

- [80%](#) of adolescents visited a healthcare provider within the year prior to death by suicide
- [49%](#) of youth had visited an emergency department (ED) within the year before their death
- [38%](#) of adolescents had contact with a healthcare system within the 4 weeks before their death
- [34%](#) of people ages 15+ years had contact with a healthcare provider in the week before their death

Most young people keep suicidal thoughts to themselves and do not bring up the topic on their own:

- Youth at risk for suicide may present to the clinic with somatic complaints; physical symptoms are often easier to talk about than mental health concerns
- Screening can open a potentially life-saving discussion about suicidal thoughts. Unfortunately, most youth who are thinking about suicide pass through the healthcare system with their suicide risk unrecognized because they were not asked directly about suicidal thoughts and behaviors

Protecting Youth Mental Health: The US Surgeon General’s Advisory

The 2021 US Surgeon General’s Advisory, [Protecting Youth Mental Health](#) highlights that mental health is inseparable from overall health. Therefore, suicide prevention is part of overall health promotion.

In clinical practice, efforts to promote health and prevent suicide can include encouraging physical activity, healthy sleeping/eating habits, positive communication, strong peer/family relationships, and developmentally appropriate problem-solving strategies. Importantly, building trusting relationships and providing trauma-informed care to patients and families can help to support healthy mental health development.

The Surgeon General’s Advisory notes that clinical treatment is a critical part of the broader public health approach to protecting mental health, and includes:

- Risk identification, screening, and assessment
- Indicated interventions (eg, safety planning and lethal means counseling for youth with suicidal ideation or behavior)

- Treatment (eg, use of medications, more frequent visits, or referral to cognitive behavioral therapy or other evidence-based suicide risk reducing treatment)
- Recovery (eg, supporting individuals to maintain progress, encouraging post-traumatic growth, facilitating individuals to find meaning and purpose)

Pediatric clinicians are encountering suicidal ideation, behavior, and death in their patient populations

[Data](#) from the 2019 AAP Periodic Survey of Fellows indicate:

- 92% of pediatricians have had a patient disclose suicidal ideation
- 80% of pediatricians have had a patient attempt or die by suicide
- 48% of pediatricians reported that they had a patient attempt or die by suicide in the past year

In 2021, AAP partnered with the American Academy of Child and Adolescent Psychiatry (AACAP) and Children’s Hospital Association (CHA) to declare a [national emergency in child and adolescent mental health](#).

In a response to these concerning trends, this section of the Blueprint presents strategies for identifying youth at risk of suicide and providing appropriate supports in clinical practice settings. All you need to implement these strategies is the vision to save lives, a clinician champion, tools to identify suicide risk, guidelines to manage patients that screen positive, and motivation.

Youth Suicide Prevention is a Health Equity Issue

Efforts are needed to address disparities in youth suicide risk

Many populations have traditionally been underrepresented in suicide prevention and research efforts, yet these populations are experiencing rising rates of suicide and higher rates of suicidal thoughts and behavior.

Clinical suicide prevention efforts need to provide comprehensive, effective, and culturally appropriate care to youth populations, including (but not limited to):

- [American Indian/Alaska Native youth](#)
- [Asian-American youth](#)
- [Black youth](#)
- [Latino youth](#)
- [Youth from other communities of color](#)
- Youth who identify as lesbian, gay, bisexual, transgender, queer, or two-spirit ([LGBTQ2S+](#))
- Youth in [rural](#) and [medically underserved areas](#)
- Youth involved with the [child welfare system or those who have experienced family disruption](#)
- Youth involved with the [juvenile justice system](#)
- Youth with special health care needs, including [youth with developmental disabilities](#)

Note: Suicide rates are not directly tied to race, gender, or any other social construct. Rather, youth may experience discrimination or long-standing health, social, or systemic inequities that may impact their development and risk for suicide.

Systemic inequities that impact youth mental health

- [Racism](#)
- [Homophobia or transphobia](#)
- [Economic inequities](#)
- [Under-resourced schools](#)
- [Medically underserved communities](#)

Pediatric health clinicians can promote health equity in clinical suicide prevention efforts

Pediatric health clinicians should be trained to understand and address the impact of systemic discrimination on health, and address these topics in practice:

- Youth and family experiences with systemic discrimination should be incorporated into clinical history taking and counseling discussions
- Pediatric health clinicians should discuss topics such as sexual orientation and gender identity in a way that is not stigmatizing or discriminatory, but [promotes inclusion and non-judgmental listening](#)

Universal suicide risk screening can help support equity in suicide prevention efforts:

- Universal screening helps ensure that specific questions to measure suicide risk are asked of all patients, not just those deemed by the pediatric health clinician to be high-risk (See “*Screening for Suicide Risk in Clinical Practice*,” below)
- Validated, evidence-based screening tools should be used to identify suicide risk
 - Importantly, more research is needed to establish whether existing suicide risk screening tools are effective in identifying risk in understudied populations
 - As the research progresses and because suicide is a pressing public health threat, the available evidence-based instruments can be utilized (See “*Conducting a Brief Suicide Safety Assessment*,” below)

Pediatric health clinicians can help address disparities by connecting youth and families to accessible and culturally appropriate behavioral health supports (See “*Two Critical Steps Before You Begin*,” below)

Pediatric clinicians can build a welcoming practice to serve **all** patients

- Encourage clinicians and staff to recognize and reflect on their own biases and work to prevent these biases from impacting care delivery
- Use inclusive language and imagery in signage, materials, and office art
- Ask patients about their names and pronouns and use them consistently during clinical visits
- Use respectful language and [trauma-informed care principles](#) when interacting with patients and families
- Utilize translation services, interpreters, and assistive technology to support accessible written, electronic, and verbal communication
- Engage families and community members in program development/evaluation and solicit feedback on the practice environment and care received
- For more information, see “*How to Prepare your Clinic or Health System for a Suicide Prevention Program*,” below

Implementing Suicide Prevention in Clinical Settings is Feasible

Integrating suicide prevention strategies into clinical settings is feasible. [Health care settings across the country](#) have successfully integrated suicide prevention initiatives into their clinical care without overtaxing or disrupting workflow in their health systems.

Addressing suicide and other mental health concerns early on can reduce strain on healthcare systems, by reducing the severity of symptoms for individual patients. Severe symptoms can take an emotional and financial toll on patients, families, providers, and health systems.

Consider the “asthma analogy”

Most pediatric primary care providers (PCPs) are not pulmonologists; however, PCPs regularly treat youth with asthma and support them in managing symptoms. If a PCP encounters a patient with a complicated case of asthma, they refer that patient to a pulmonologist.

Suicide prevention protocols can be straightforward and uncomplicated, just like asthma treatment:

- Screen for risk factors
- Provide standard resources and supports in practice
- Refer out for specialized care when needed

Which Clinical Settings Can Implement Suicide Prevention Protocols?

Any clinical setting can be a partner in suicide prevention. Common settings include community practice settings, outpatient clinics, specialty clinics, emergency departments (ED), federally qualified health centers, community health centers, urgent care settings, inpatient medical/surgical units, behavioral health settings, school nurse offices, school-based health centers, Indian Health Service settings, tribal contract clinics, urban Indian health centers, juvenile detention centers, child abuse clinics, college campus health centers, and clinics serving youth in foster care.

Two Critical Steps Before You Begin

1. Connect with mental and behavioral health resources in your community

Prior to implementing a suicide prevention protocol in your clinic, it is critical to establish a list of mental and behavioral health providers that you can refer patients and families to.

Ensure that the providers on your list are:

- Accessible to your patient community
- Affordable (eg, accepts public/private insurance or has a sliding-scale fee system)
- Multidisciplinary, diverse, and culturally and linguistically representative of your patient population
- Experience working with children and adolescents
- Able to assess for suicide risk and plan for safety

If possible, establish a connection with these providers prior to implementing the suicide prevention protocol in your clinic. Tell them you are going to start screening for suicide risk and ask if they can accommodate any of your patients that need further evaluation. Building these connections will allow you to make a warm hand-off for patients in the future.

What to do when facing a lack of community resources

Many areas lack sufficient access to mental and behavioral health supports. This is a systemic challenge that requires long-term, appropriately resourced solutions.

When mental health care is unavailable, clinicians and office staff can help families consider alternative options such as telehealth services, school-based behavioral health services, or follow-up appointments with the pediatrician until mental health services can be arranged.

Alternative strategies include:

- Safety planning and lethal means safety counseling can be conducted in your practice during the visit to help ensure safety during long wait times for mental health intervention
- [Telehealth](#) can be used to increase youth access to mental and behavioral health care
 - Promote telehealth access to all families by using a modality that is mobile-friendly and using multiple languages, interpreters, and assistive technology to facilitate visits
 - Note: Accessibility of telehealth is dependent on the availability of reliable broadband and network access and state laws, which may vary by geographic region. For an overview of state telehealth laws, click [here](#)
- School, community, or tribal-based behavioral health services may be available
- Pediatric health clinicians can consider working with [Pediatric Mental Health Care Access Programs \(PMHCA\)](#), also called Child Psychiatry Access Programs (CPAP). These are collaborative programs that provide training and support to primary care providers related to addressing mental health conditions in practice. Please see the [National Network of Child Psychiatry Access Programs](#) to identify child psychiatry consultation programs across the country.

For more information, see “*How to Prepare your Clinic or Health System for a Suicide Prevention Program*,” below.

2. Understand the difference between screening versus assessment – you need both!

Identifying youth at risk of suicide requires both screening and assessment. These are two distinct parts of the suicide prevention process. Both are necessary.

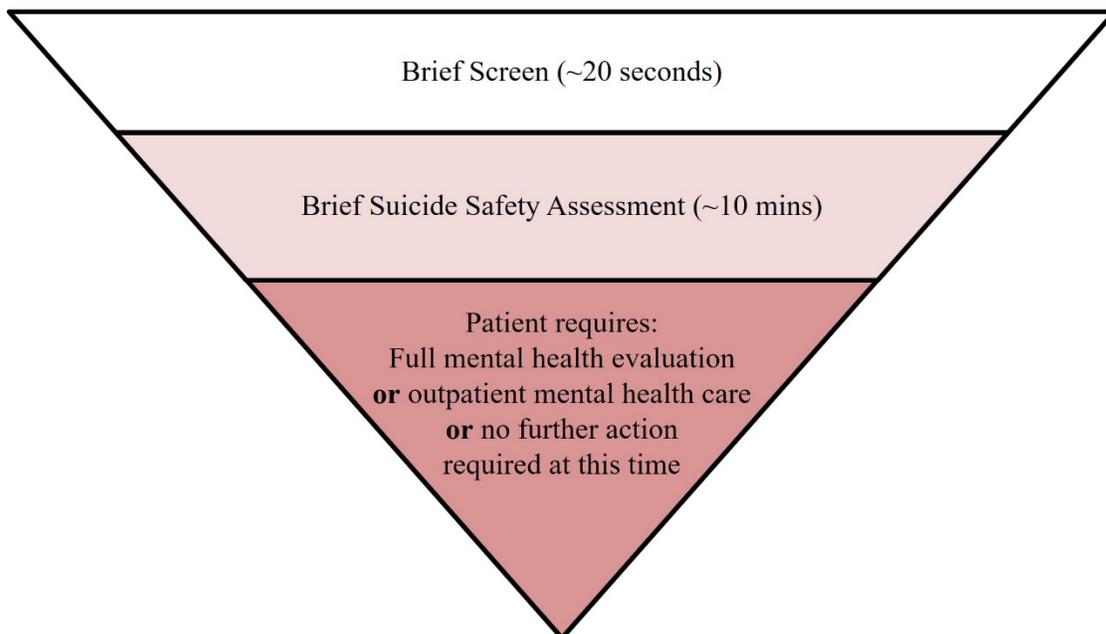
Suicide risk screening is a very rapid way to identify someone who needs *further assessment* for suicide risk. It can be completed through a variety of methods, including verbal asking, self-report paper/pencil forms, or computer questionnaires. Because we do not have tools that can predict who will die by suicide, anyone who is detected “at risk” by a suicide risk screening tool will require a brief suicide risk assessment to follow up on the tool.

Suicide risk assessment is a comprehensive evaluation to confirm suicide risk, assess risk and protective factors, and guide next steps. It may also assess other mental health symptoms and warning signs such as excessive alcohol or other substance use. Parents, families, and caregivers can be important corroborators when assessing a young person’s suicide risk and should be included, when appropriate and available.

Utilize Clinical Pathways for Suicide Prevention

Use an evidence-based clinical pathway to guide screening and management of suicide risk

[Evidence-based clinical pathways](#) give guidance on how to manage patients who screen positive for suicide risk. Having a detailed process in place will save time and resources when responding to a positive screen. The pathway below provides an *overview* of a suicide prevention strategy. Please see the text that follows for more detailed descriptions of each step.



Source: NIMH ASQ Toolkit. Used with Permission.

Consider this 3-tiered youth suicide risk clinical pathway developed by an American Academy of Child and Adolescent Psychiatry (AACAP) Pathways to Clinical Care suicide risk workgroup for the inpatient and ED setting ([available here](#)), and NIMH adapted the pathway for the outpatient and specialty care settings ([available here](#)). It has 3 main steps (as mentioned in the above diagram):

1. Brief Screen (less than a minute)

Screening is a way to identify someone who needs further mental health evaluation. There are no suicide risk screening tools that can predict who will die by suicide; therefore, anyone who screens positive on a screener needs further evaluation.

- Screen all patients ages 12+ years for suicide risk during preventive service visits, using a validated suicide risk screening tool
 - Screening can be included with other adolescent intake screeners. If the patient screens positive, a portion of the well visit may need to be postponed. This would be akin to finding a physical ailment on routine exam that then takes precedent over the well visit
- For youth aged 8-11 years, targeted screening strategies may be implemented for patients presenting with behavioral health symptoms
- Youth below the age of 8 years should not be screened for suicide risk, as it is unclear if children at this age can comprehend the screening questions on existing tools

- Clinicians can assess for suicide risk in young children when a parent reports suicidal behavior, or when patient presents with depressed mood, severe irritability, or suicidal ideation or history of suicidal behaviors
- For detailed information, see “*Screening for Suicide Risk in Clinical Practice*,” below)

2. Brief Suicide Safety Assessment (10-15 minutes)

This step is different from the screen, which simply identifies risk. The assessment is a conversation with the patient that assists in further triage by evaluating the frequency of suicidal thoughts, plans, mental health symptoms, suicide history, supports, and other factors. This is the most critical step of the pathway because it identifies appropriate safety needs and guides next steps for the patient.

- This should not be a full mental health evaluation but rather a brief way for clinicians to decide what the patient needs next
- A brief suicide safety assessment can be conducted by a physician, social worker, nurse practitioner, physician assistant, or other mental health professional. These individuals should have advanced training and be trained to administer a brief suicide safety assessment
- There are tools that can be used to guide a clinician in conducting a brief suicide safety assessment
- For detailed information, see “*Conducting a Brief Suicide Safety Assessment*,” below

3. Disposition: Identify next steps for care, based on the brief suicide safety assessment

Imminent Risk: Patient requires an emergency mental health evaluation

- The patient has acute suicidal thoughts and needs an emergent full mental health evaluation
- If there is not an onsite mental health professional embedded in the practice, send the patient to the emergency department (ED) or engage a mobile crisis team or acute mental health evaluation center for extensive mental health evaluation (unless contact with a patient’s current mental health provider is possible and an alternative safety plan for imminent risk has previously been established)
- For detailed information, see “*Caring for Patients at Imminent Risk of Suicide*,” below

Note: It is rare for patients presenting to a medical setting with medical chief complaints to be at *imminent* risk for suicide. However, your clinic should have a plan in place for how to manage patients who require urgent evaluation (see section on caring for patients at imminent risk of suicide).

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.

- The patient is non-acute positive and is not at imminent risk for suicide but remains a moderate risk and needs a full mental health evaluation from a mental health professional or a primary care provider with sufficient training in the assessment and management of mental health conditions
- If mental health evaluation is not available within your practice, refer the patient to an outpatient mental health clinician for the full evaluation
- Take steps to protect the patient’s safety for when they go home
- For full details, see “*Caring for Patients Who Need Further Mental Health Evaluation*,” below

Low Risk: No further evaluation is needed at this time.

- Determine if the patient might benefit from non-urgent mental health follow-up
- Send patient home with a mental health referral if indicated
- For full details, see “*Caring for Patients at Low Risk of Suicide*,” below

Screening for Suicide Risk in Clinical Practice

Age Recommendations for Screening:

Youth ages 12+: Universal screening

Youth ages 8-11: Screen when clinically indicated

Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present

Screening is a quick way to identify someone that needs further evaluation. Anyone who screens positive on a suicide risk screening tool should be followed up with a brief suicide safety assessment (see above). The 2022 American Academy of Pediatrics/Bright Futures Recommendations for Preventive Pediatric Care (Periodicity Schedule) recommends screening for suicide risk for all youth ages 12 and above.

Youth ages 12 and older: Universal screening

All patients ages 12 and older who are medically and developmentally able to answer questions should be screened for suicide risk. This practice is called “universal screening,” and is used in a developmentally and medically appropriate manner with pediatric patients.

Why universal screening?

- Most young people keep suicidal thoughts to themselves and may not bring up the topic on their own if they aren’t asked a direct question
- Universal screening is a more comprehensive strategy than “targeted screening,” wherein a setting chooses to screen only behavioral health patients for suicide risk
- While patients who present with a behavioral health concern are at a significantly higher risk for suicide, patients presenting with other health concerns or even those simply engaging with the medical system for preventive care can have pressing mental health concerns that they are not talking about with anyone
- Universal screening is an important way to help all patients feel less alone with suicidal thoughts. Otherwise, they may pass through healthcare settings undetected
 - [Research shows](#) that most people who die by suicide have visited a healthcare provider in the weeks or months before to their death. Asking about suicide risk can be a way to recognize someone at risk and get them help
- Universal screening helps to promote equity and address bias in care delivery, by ensuring that all youth are screened for suicide risk across demographic groups, communities, and care settings

Youth ages 8-11: Screen when clinically indicated

Patients ages 8-11 should be screened for suicide risk when they are presenting with behavioral health chief complaints, if the patient or parent raises a concern, if there is a reported history of suicidal ideation or behavior, or if the patient displays warning signs of [suicide](#).

Note: there are also [medical settings](#) that have had success with universal screening for youth as young as 10 years old, as some screening tools have been validated down to age 10.

Youth under age 8: Screening not indicated. Assess for suicidal thoughts and behaviors if warning signs or parent report of suicidal behaviors are present

Warning signs of suicide risk that requires further evaluation in children under age 8 include (but not limited to):

- Talking about wanting to die or wanting to kill oneself
- Actions such as grabbing their throat in a “choking” motion, or placing their hands in the shape of a gun pointed toward their head
- Engaging in self-harming behaviors
- Acting with impulsive aggression
- Giving away treasured toys or possessions

Death by suicide is rare for children under 8 years old. However, upstream factors such as depression, anxiety, or suicidal ideation are sometimes present even in young children. Importantly, [research has shown](#) racial disparities in suicide rates among children under 12, with young Black children being twice as likely to die by suicide than young white children.

For children under 8 years old that present suicide risk, the clinician should privately meet with the parent to discuss these concerns and conduct lethal means safety counseling.

Screening Tools

Evidence-based, publicly available, validated tools for suicide risk screening in medical settings that can be used to detect suicidal ideation or behaviors:

- [Ask Suicide-Screening Questions \(ASQ\)](#)
- [Suicide Behavior Questionnaire-Revised \(SBO-R\)](#)

Other publicly available tools that are commonly used in primary care settings:

- [Columbia Suicide Severity Rating Scale \(C-SSRS\) – Triage Version](#)
- [Patient Health Questionnaire – 9 Adolescent Version \(PHQ-9A\)](#)
- [Patient Safety Screener – 3 \(PSS-3\)](#)

When selecting the tools that are right for your clinical practice, be sure to choose ones that have been validated via scientific research. Unvalidated tools may over- or under-detect suicide risk. The tools listed above are commonly used for youth ages 10 and older.

Note: Please be aware that these validated tools may not have been developed or tested with diverse communities of youth. Future research is needed to ensure that screening tools serve youth from diverse backgrounds, identities, and cultures. Tools that are culturally and linguistically appropriate should be validated/checked with native speakers. Because suicide is a pressing public health threat, existing validated tools can be utilized and interpreted sensitively, while the research is underway.

Integrating screening into clinical practice

- Screening tools can be integrated into the clinical workflow or electronic health record (EHR) systems to ease implementation
- Any member of the clinical team who is trained in administering a screening tool can screen a patient. In many cases, a nurse or medical assistant will administer the screening early in the visit, when taking the health history
- Screening tools can be administered verbally, via paper-and-pencil, or on an electronic tablet
- Screening tools can be administered along with other preventive service screeners and questionnaires
- When utilizing screening tools with patients or parents/caregivers with limited English proficiency, it is critical to use a properly trained interpreter. Failure to do so can result in misdiagnosis or development of inappropriate treatment strategies. Some of the tools are available in languages other than English
- It is best to screen patients without a parent/caregiver in the room, to encourage open and honest discussion
 - If the parent refuses to leave the room, it is still okay to proceed with screening. While the patient may be less open with their responses, this conversation will model for the parent how to ask young people about suicide risk

Frequency of Screening

Young people need to be screened more frequently than adults because adolescence and young adulthood are times of rapid developmental change. As such, circumstances can shift frequently.

Screening frequency will depend upon practice preference:

- Screening patients who have no history of suicide risk is recommended no more than once a month and no less than once a year
- It is important to remember that screening is used to detect suicide risk. Therefore, if you know a patient is at risk for suicide, you do not have to screen them repeatedly; you need to assess safety at subsequent visits. Consider phrases like, *“Last time you were here, you told me you had some thoughts about suicide. I wanted to check in with you about that”*

Screening for depression is not enough

Some practices only screen patients for suicide if they have screened positive for depression. While it is an important practice to screen for depression, not all young people at risk for suicide have depression symptoms.

Research has shown that screening for depression is important but may not be sufficient for identifying suicide risk.

- For example, the PHQ-9A, while being a good depression screen, [missed 36%](#) (item #9 alone missed 56%) of pediatric patients who screened positive for suicide risk.
- [Recent work](#) supports adding suicide risk screening to depression screening so that youth at risk will not pass through the healthcare system with their suicide risk undetected.
- Depression screening is best utilized alongside suicide risk screening. Both are important.

The following tools have combined a depression screen with a suicide risk screen:

- Patient Health Questionnaire-9 Adolescent version + Ask Suicide-Screening Questions ([PHQ-9A+ASQ](#))
Patient Health Questionnaire-9 Adolescent version that includes the GLAD-PC suicide risk [questions](#) (created through consensus and not research)

Is it safe to ask youth if they are having thoughts of suicide?

Yes! It is safe to ask youth if they are having thoughts of suicide. One of the most common myths about asking youth about suicide is that it will “put the idea into their heads.”

Multiple research studies have established that it is safe to ask young people about suicide:

- Among a sample of people ages 13+, asking about suicide did not significantly impact distress levels immediately or [two days later](#)
- Other studies have found no longitudinal changes in suicidal ideation that are associated with assessing for [suicide risk](#)

The best way to identify suicide risk in clinical settings is to ask the patient directly and listen to their answer.

- When asking about suicide, use a validated screening tool
- Ask your patient direct questions such as, “Have you been having thoughts about killing yourself?”
 - Ensure this question is asked in a non-judgmental way and follow it with questions that help build a personal connection (See “*Further Considerations for Caring for all Patients at Risk for Suicide*,” below)
 - Of note, this question alone should not be used as a screening tool, as research has found that using one question to screen for suicide risk under-detects
- Allowing a young person to discuss their thoughts of suicide makes it safe to talk and may bring them relief

Conducting a Brief Suicide Safety Assessment

Evidence-based tools for a brief suicide safety assessment (also referred to as a suicide risk assessment)

There are several publicly available, evidence-based [assessment](#) tools that can be used to assess risk of suicidal ideation or behaviors in individual patients. Each tool will have different methods of scoring for suicide risk. The purpose of the assessment is to determine next steps.

Commonly used tools include:

- [Columbia Suicide Severity Rating Scale \(C-SSRS\)](#)—Full Version
- [Ask Suicide-Screening Questions Brief Suicide Safety Assessment \(ASQ-BSSA\)](#)
- [Suicide Assessment Five-Step Evaluation and Triage \(SAFE-T\)](#)

Integrating brief suicide safety assessments into clinical practice

- The brief suicide safety assessment (BSSA) is the middle step of the 3-tiered clinical pathway
- The BSSA helps the pediatric health clinician decide whether it is safe to send the patient home, or whether there is a need for immediate intervention
 - The BSSA is different from the screening tool, which simply identifies risk
 - The BSSA is a brief conversation with the patient that assists in further triage by evaluating their personal risk and protective factors (eg, frequency of suicidal thoughts, plans, psychiatric symptoms, suicide attempt history, reasons to live, social support)
- Brief suicide safety assessment/risk assessment tools can be integrated into the clinical workflow or electronic health record (EHR) systems to ease implementation
- The brief suicide safety assessment can be performed by anyone with advanced training (e.g., physician, nurse practitioner, physician assistant, or mental health professional) and has been trained in how to administer the specific assessment tool
- Some tools have trainings available online (eg, see [ASQ-BSSA](#) and [C-SSRS](#))

- The brief suicide safety assessment should be conducted during one-on-one time between the youth and the pediatric health clinician. When a child screens positive for suicide risk, parents should be carefully and thoughtfully notified:
 - Explain to the patient that you will need to talk with their parents/caregivers and talk with the patient about how they would like to be involved in that conversation (See “*Further Considerations for Caring for all Patients at Risk for Suicide*,” below)
 - Ask the parent/caregiver if they know about the child’s suicidal ideation/behavior in a way that does not come across as blaming or judgmental. For example, you can say, “Your child spoke about suicidal ideation. Is this something they have shared with you?”
 - Be aware that youth are often private about their suicidal thoughts, and it is common for parents/caregivers to be unaware of suicidal ideation or behaviors
- The ASQ Toolkit provides language to use with parents/caregivers [here](#)
 - Ask the parent/caregiver if there is anything they want to tell you in private
 - Parents/caregivers may have information about family history that they do not want to speak about in front of the child
 - A private conversation with the parent/caregiver provides an opportunity to speak privately to gather relevant health information
- See [NIMH ASQ toolkit](#) for more details on administering the brief suicide safety assessment

Note: If the patient is found to be an “acute” positive (Imminent Risk) on the screener, meaning they are at imminent risk for suicide, they do not need a brief suicide safety assessment because we already know they need an emergent full mental health and safety evaluation. **The brief suicide safety assessment is a way to triage patients who screen positive (non-acute/not imminent) to determine next steps.**

It is not always an emergency if a patient discloses thoughts of suicide

- While many young people think about suicide, and detection is necessary to ensure safety and assess risk, suicidal behavior is a relatively rare event. Most youth who have suicidal thoughts will not require emergency care. However, youth who have thoughts of suicide need compassion, attention, and further evaluation
- Only the patients who are assessed to be at imminent or acute risk of suicide need full safety precautions (eg, a 1:1 observer and searched belongings)
- Patients who are not at imminent risk of suicide but require further evaluation, do not require safety precautions
- The majority of young people who screen positive for suicide risk are [non-acute cases](#)
- Regardless of level of risk, all patients and their parents/caregivers should be given the [National Suicide Prevention Lifeline](#) and [Crisis Text Line](#)

Why is it important to determine level of risk?

- Pediatric health care settings should work to provide a level of care that appropriately matches the level of risk for each patient
- Sometimes, pediatric health clinicians over-respond to reports of thoughts of suicide:
 - For example, sometimes when a patient reveals suicidal ideation, they are treated in what may be perceived as a punitive way. They are sent to the ED where their clothes are taken and they are put in a paper gown, their belongings and cell phone are taken, and they are given a 1:1 observer or automatically sent to a psychiatric unit

- These extreme measures are considered full safety precautions. They are only meant to keep people safe who are at imminent risk of harming themselves
- Utilizing full safety precautions for patients who are not at imminent risk comes with several disadvantages:
 - Youth value informed treatment options, with involvement in decision-making processes. Forced safety precautions or hospitalizations without patient input removes patient agency and can decrease the perception that care is a collaborative process between a patient and their clinician
 - Over-response to previous suicidal behavior can be traumatizing for patients, or can be such a negative experience that they may feel reluctant to return for care or disclose suicidal ideation in the future
 - Taking unnecessary safety precautions, like finding a hospital bed or using a 1:1 observer, can disrupt workflow systems and overtax already-strapped mental health resources within the health system
- However, while rare, there are some patients who will require immediate intervention and comprehensive safety precautions. Importantly, hospitalization is only recommended when the patient presents an immediate plan to attempt suicide, which cannot wait for non-urgent assessment

Since suicide risk is stratified, pediatric health clinicians can provide care that is appropriate for the level of risk.

After the brief suicide safety assessment, determine next steps

- 1) Patient is at imminent risk and needs emergent mental health evaluation
- 2) Patient requires further evaluation but is not at imminent risk
- 3) Patient is deemed low risk, and receives resources and possible mental health referral for the future

(See corresponding sections below for full details on caring for a patient in each category.)

A Note on Previous Suicide Attempts:
 A past suicide attempt is the most potent risk factor for a future suicide attempt.

However, if a patient has a previous suicide attempt, they may not want to discuss it every time they are screened. While screening tools remain the same, responses to positive screens can be adjusted.

For example, with the [ASQ](#) and the [C-SSRS](#) screen, the tools allow for amended language to account for past reported behavior, such as, *since your last visit, have you tried to kill yourself?* “Since last visit” is added to avoid unnecessary delving into something that may no longer be a pressing issue or a danger for the youth.

In addition, if the patient reports a previous suicide attempt as their only positive response, with no recent suicidal ideation, the pediatric provider should consider the following:

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

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

Caring for Patients at Imminent Risk of Suicide

Praise the patient for sharing their feelings

When patients are found to be at imminent risk for suicide, they need compassionate care and to be kept safe. Patients should be praised for talking about thoughts they usually keep to themselves. They should be listened to openly and patiently, without judgement. No one can be “convinced” out of suicidal thoughts, attending to the patient in a caring and compassionate way may help them feel less alone with their thoughts and struggles.

Example phrases include:

- *Thank you for telling me how you're feeling. It was very brave to share those thoughts*
- *I am here to help you; you don't have to go through this alone*

Note: If the patient disclosed their suicide risk to you confidentially, explain that you'll need to talk with their parents/caregivers. (See “*Further Considerations for Caring for all Patients at Risk for Suicide*” for more information on navigating confidentiality concerns.)

Implement immediate safety precautions

Explain to the patient that their safety is your number one priority and that you are going to keep them safe while you figure out how to get them the help they need. Explain safety precautions, and ensure the patient understands that these measures are being taken to protect them, not to punish them.

Utilize [trauma-informed care principles](#) when talking with youth and families about suicide. Be careful not to rush the conversation and choose words carefully to avoid making the family feel blame or guilty about their child's suicidal ideation or behaviors.

Example phrases include:

- *I care about you, and I am going to take some steps to help keep you safe while you're feeling this way*
- *I'm going to have your dad stay in the room with you, while I step out to make arrangements to get you some more support today*

Remove all potentially dangerous objects from the room, including belts, shoelaces, pills, knives, firearms, ropes, etc.

Do not leave the patient alone in the room, and ensure someone escorts them to the restroom, if needed.

Connect patient and family to urgent mental health care

Find out if the patient has a mental health clinician they are in treatment with. If they do, ask permission to reach out because they may already have a safety plan in place, which could help avoid an unnecessary visit to the ED.

If there is not an onsite mental health professional embedded in your practice, transfer the patient with an escort to the ED, community mobile crisis team, or acute mental health evaluation center for emergency evaluation.

Follow up

Conduct a follow-up phone call check in with the patient and their family after stabilization in an ED. The provider can phone the patient within the next 72 hours to inquire about mental health treatment linkage.

Caring for Patients Who Need Further Mental Health Evaluation

Praise the patient for sharing their feelings

When patients are found to be at risk for suicide, they need further evaluation and compassionate care. Patients should be praised for talking about thoughts they usually keep to themselves. They should be listened to openly and patiently, without judgement. No one can be “convinced” out of suicidal thoughts, attending to the patient in a caring and compassionate way may help them feel less alone with their thoughts and struggles.

Example phrases include:

- *Thank you for telling me how you're feeling. It was very brave to share those thoughts*
- *I am here to help you; you don't have to go through this alone*

Note: If the patient disclosed their suicide risk to you confidentially, explain that you'll need to talk with their parents/caregivers. (See “Further Considerations for Caring for all Patients at Risk for Suicide” for more information on navigating confidentiality concerns.)

Utilize [trauma-informed care principles](#) when talking with youth and families about suicide. Be careful not to rush the conversation and choose words carefully to avoid making the patient or parents/caregivers feel blame or guilty about the suicidal ideation or behaviors.

Example phrases [include](#):

- *It was very brave of you to share these thoughts: thank you for telling me*
- *I want to connect you to a colleague of mine who is trained in mental health and can work with you. I'll help you and your parent/caregiver make an appointment at their clinic*
- *I also want to talk to you about some steps we can take now that'll help keep you safe in case you have thoughts of suicide in the future*

Talk with parents/caregivers about warning signs to watch for in their child, including significant changes in behavior, decreases in social engagement or activities, giving away possessions, or talking about wanting to die or feeling like a burden. (See the “Risk Factors, Protective Factors, and Warning Signs” section of this Blueprint for more information.)

Provide brief intervention and support patient safety

- Refer the patient to an outpatient mental health provider when clinically indicated by the brief suicide safety assessment
- Conduct safety planning with the family, and counsel about reducing access to lethal means
 - Make a safety plan with the patient and parent/caregiver that can be activated as needed
 - Talk with patient and their family about access to lethal means
- If the brief suicide safety assessment confirms suicide risk, ask the parent/caregiver if they feel that they can keep their child safe at home. If they say no, this may influence your decision about the next steps for the child's care, meaning you may not be able to send them home with parent. In these rare situations, you may need to send family to the ED
- For full details, see “Brief Interventions that Can Make a Difference,” below

Connect family to outside resources

- Give patient and their parent/caregiver the [National Suicide Prevention Lifeline](#) and [Crisis Text Line](#) resources upon discharge or leaving the clinic
- Provide parents, caregivers, and families with resources to support them:
 - [AFSP: Teens and Suicide- What Parents Should Know](#)
 - [Seize the Awkward](#)
 - [National Alliance on Mental Illness: Family Members and Caregivers](#)
- Share resources with the family to help them speak openly with each other about mental health and suicide, such as [AFSP's #RealConvo](#) guide or the National Suicide Prevention Lifeline's [#BeTheTo](#) campaign.
- For full details, see “*Brief Interventions that Can Make a Difference*,” below

Follow up

- Schedule a follow up with patient within 72 hours, or as soon as possible, for a safety check and to determine whether they were able to obtain a mental health appointment
- If a mental health appointment is not possible, consider telehealth or having the patient come back to your office to check in with you until they are evaluated by a mental health clinician

Caring for Patients at Low Risk of Suicide

Patients found to be at low risk of suicide may need nothing more at this time, or they may benefit from further mental health care, but the level of risk does not require focal attention during the visit.

Sometimes suicide risk screening tools pick up other mental health concerns such as anxiety, distress, PTSD, or angst that may not be related to current suicide risk. A patient may screen positive for suicide risk on a screening tool, and the clinician, after performing a risk assessment, determines that they are not at current risk.

Examples of low-risk scenarios include:

- A 17-year-old patient may answer that they “wished they were dead” on the screener. Upon further inquiry, the pediatric health clinician learns that they had no intention of killing themselves and had several strong protective factors. In this situation, the patient may still benefit from mental health care to support managing their stress, but they do not require an urgent mental health care evaluation. This patient can be given a referral to mental health resources for non-urgent therapy
- A 16-year-old patient may disclose a suicide attempt from 4 years ago. Upon further discussion, the pediatric health clinician may learn that the patient has received mental health treatment and did not have any recent ideation. This knowledge of a past suicide attempt would be important for the clinician in informing future care, but the patient would be deemed low risk at the current time

Provide appropriate care

- Determine if the patient might benefit from non-urgent mental health follow-up
- Send patient home with a mental health referral if indicated
- Provide parents, caregivers, and families with resources to support them:
 - i. [National Suicide Lifeline](#) and [Crisis Text Line](#) resources
 - ii. [AFSP: Teens and Suicide- What Parents Should Know](#)
 - iii. [Seize the Awkward](#)
 - iv. [National Alliance on Mental Illness: Family Members and Caregivers](#)

Brief Interventions that Can Make a Difference

Safety planning

[Safety planning](#) is an evidence-based and effective technique to reduce suicide risk. Working with the patient and the family, clinicians can guide patients to identify effective coping techniques to use during crisis events.

Safety planning helps your patient think about what they will do when they have suicidal thoughts after they leave your office and includes identifying:

- Patient's own warning signs or triggers for suicidal thoughts
- Coping strategies
- Social contacts/supports
- Emergency contacts
- Reducing access to lethal means

For example, the clinician can ask: "What will you do if it is 2:00am and you are thinking of killing yourself?" and then help the patient plan out coping strategies and write them down. Sample solutions may include: "I will call my aunt, or listen to music, or write in my journal, or exercise, or watch a TV series."

Safety plans should:

- Be personalized to each patient
- Be developed collaboratively with each patient and family
- Be developmentally, culturally, and linguistically appropriate to the patient and family
- Include specific activities and people to call in the event of intense suicidal feelings
- Include strategies that can be used at all times of day or night
- Include a back-up plan, such as calling the [National Suicide Prevention Lifeline](#) or texting the Crisis Text Line

Thinking about safety plans in advance can help patients prepare to get through intense suicidal feelings.

When introducing safety planning to a patient at risk and their family, consider the "fire drill" analogy:

"A safety plan is a bit like a fire drill. Schools plan for emergencies by holding fire drills. These drills ensure that everyone knows what to do and where to go if they smell smoke. Having that plan of action in place helps people act quickly in an emergency. In the same way, a safety plan can help you plan for a future time that you're having suicidal thoughts. We'll come up with a plan now, and you can keep it with you. That way, if you start having thoughts of suicide, you'll know what to do to help get you through the situation safely."

Developing a safety plan with a patient and their parent/caregiver can be time-consuming. This process can be led by anyone in the office who has been trained in safety planning, including the pediatric health clinician, nursing staff, physician assistants, or social workers.

Safety plans can be developed via a smartphone app or on a paper template. If you use a paper template, consider encouraging the patient to take a picture of the plan on their phone, so that they don't lose it.

Commonly used safety planning tools include:

- [Stanley Brown safety planning tool](#) (Access tool template [here](#) and mobile app [here](#))
- [Virtual Hope Box](#)

Lethal means safety counseling

Pediatric health clinicians can speak with parents/caregivers about keeping dangerous items away from their children during a suicidal crisis.

It is important that families know that suicidal crises can escalate quickly, and that suicide among youth is often impulsive and hard to predict. It is not always possible to stop someone from *attempting* suicide. However, reducing access to lethal means can help prevent youth from dying from a suicide attempt.

The goal is to protect the child in a "moment of crisis" which requires actively making the child's environment safe before the crisis ensues. Because of this, families should work to reduce their child's access to dangerous items to help protect their safety.

Most people are not familiar with the term "lethal means." Because of this, pediatric health clinicians can talk plainly with parents/caregivers about dangerous items in their home, which may include pills, poisons, chemicals, firearms, ropes, belts, knives, and other objects.

An example phrase is:

- *"I want to help you keep your home as safe as possible for Andre while he's feeling this way. Because a moment of crisis can escalate very quickly, it's important that we make sure that he doesn't have access to guns, medications, or other household items that he could use to harm himself in a crisis"*

Firearms

Half of youth suicides occur with [firearms](#). Suicide attempts using a firearm are almost always [fatal](#).

- Most youth suicides using firearms occur with a firearm stored unsafely in the home
- Locking all guns reduces firearm suicide risk [substantially](#) compared with having any unlocked guns
- Unloading all guns also substantially reduces firearm suicide risk, and that locking the ammunition separately also reduces risk, but only if the youth doesn't know the combination to the lock or where the key is hidden

[AAP policy, "Firearm-Related Injuries Affecting the Pediatric Population."](#) recommends that pediatricians and other pediatric health clinicians counsel parents/caregivers about the dangers of allowing children and youth to have access to guns inside and outside their home:

- Counsel families that the safest option is to temporarily remove guns from the home while their child is experiencing thoughts of suicide could save their life
- Consider an approach like, *"What some families do is store their guns away from home until their child is feeling better: for example, with a relative or at a gun shop. Is this a good option for you?"*
- Safe storage is the second-safest option, if the family is unable to remove the firearm from the home:
 - Firearms should be stored unloaded and locked
 - Ammunition should be locked and stored separately
 - When possible, firearms can be disassembled, and essential pieces can be locked and stored separately
 - Families should ensure that the child does not know the codes to the locks or locations of keys

Medications

- Most families have medicine cabinets in their bathrooms where medications are stored
- Many medications (eg, insulin, prescription medications, over-the-counter pills) can become a hazard during a suicidal crisis
- Talk with parents/caregivers about locking up both prescription and over-the-counter medications, reducing the quantity of medications in the home, and removing unneeded or expired medications from their home
- Suggest that families purchase necessary medications in blister-packs which can help to slow down access to larger quantities of medication in a crisis

Other household items

Common items found in the home can be lethal in a suicide attempt. Counsel families about temporarily removing these products from the home or storing them safely where youth cannot access them. This includes but is not limited to:

- Alcohol
- Illicit drugs
- Medications
- Carbon monoxide/car exhaust
- Household cleaners and other poisonous products
- Canned dusting products
- Inhalants
- Antifreeze
- Knives, razors, or other weapons
- Ropes, belts, or plastic bags

Pediatric health clinicians can counsel parents/caregivers on these important practices. Clinicians should be aware that lethal means safety counseling may involve variations based on culture, family circumstances, or parent/caregivers' profession (for example, families may need medication on hand to care for a relative or may have firearms in the house because a parent serves in the military or law enforcement). Counseling should always be specific to the family.

When addressing lethal means safety with families, utilize trauma-informed care principles. Choose your words carefully and avoid making the family feel judged or shamed if they own guns, or if they cannot remove all lethal means from the home. Emphasize to the family that these safety measures are temporary, and you are not singling them out, but rather this is common practice when someone is found to be at risk for suicide.

Commonly used courses for lethal means counseling include:

- [Counseling on Access to Lethal Means \(CALM\)](#)
- [Means Matter](#)
- [Bullet Points Project](#)

Connect all patients and families with ongoing support and resources

Refer the patient to an outpatient mental health provider when clinically indicated by the brief suicide safety assessment:

- When possible, make a warm hand-off by connecting the family to a mental health provider while they are still in in your office for the appointment

- Follow up by phone over the next few days with families to see if they were able to see the mental health provider
- Families can be frustrated by trying to make appointments and hearing about long waiting lists or appointments too far into the future. If there no available mental health appointments, schedule a follow-up visit with the patient (either in person or via telehealth) in a few days to “check in”

Build community connections to support the patient and family when they leave your office

- [AAP policy, “Guiding Principles for Team-Based Pediatric Care”](#) recommends using a team-based care model to ensure youth are supported at home, at school, and in all settings where they spend time. Team-based care involves building connections between medical providers and community partners (eg, educators, pharmacists, state agencies, and families) and engaging these partners in supporting the youth’s overall health
- With permission, connect with the school nurse, school-based/college health center, and/or behavioral health professionals at the patient’s school to ensure they are aware of the situation and can provide supportive care at school
- Connect parents/caregivers to a [Family Support Group](#) from the National Alliance on Mental Illness (NAMI) or other [additional resources](#) as they support their child’s mental health
- Pediatric health clinicians can also engage other members of the patient’s community, such as community organizations (eg, Boys and Girls Club, 4H), clergy or religious leaders, or community or tribal elders
- To learn more about [how to support a patient who is struggling](#), or about general suicide prevention efforts in the community, providers and families can establish connections with a [local AFSP chapter](#)

Connect all patients with free national resources that are available 24 hours/day, 7 days/week

- [National Suicide Prevention Lifeline](#) 1-800-273-8255 (TALK)
- [Crisis Text Line](#) text “talk” to 741 741

Provide patients and families with educational information

Consider connecting patients, parents/caregivers, and families to information to help them cope with suicide risk, a suicide attempt, or a suicide loss.

- Suicide Prevention: [What to do when someone is at risk](#)
- After a Suicide Attempt:
 - [Information for the person who has made an attempt](#)
 - [Information for the loved ones of a person who has made an attempt](#)
- After a Suicide Loss:
 - [Surviving a Suicide Loss: Resource and Healing Guide](#)
 - [Children, Teens, and Suicide Loss](#)

Follow-up with a “caring contact”

Follow-up care is a critical way to support patients and their families. Schedule a follow-up phone call, virtual visit or brief in-person visit within 24-48 hours to see how the patient is doing. Anyone in the practice or health system can provide these “caring contacts” – find the workflow that works best for your team.

During this follow-up, you can check in on whether lethal means have been removed/stored safely and ensure the family has connected with a mental health provider, if applicable. Most importantly, you can assure youth and families that you care about their mental health and are here to help them as they navigate this challenge.

[Research has shown](#) that even a series of simple communications (eg, 5-10 postcards or phone calls over a 6-12 month period) after the visit can reduce suicide risk.

You can access examples of “caring contact” postcards here, provided by Zero Suicide:

- [We care about you - postcard](#)
- [Chickasaw Nation - card](#)
- [Anything worthwhile takes time – postcard examples](#)

Further Considerations for Caring for all Patients at Risk for Suicide

Have a conversation with your patient about suicide risk

After using an evidence-based tool to conduct the brief suicide safety assessment, pediatric health clinicians can ask subsequent questions that build an understanding of what suicidal thoughts are like for each individual person. For example, if a patient shares that they have had thoughts of suicide, consider these follow up questions:

- *Does that make you feel worried?*
- *Does that scare you?*
- *Have you talked with anyone about this before?*

Pediatric health clinicians can also consider connecting with family members to understand their experiences of their child’s suicidal thoughts. Consider follow-up questions such as:

- *What was it like for you to hear that?*
- *Does it feel overwhelming?*
- *Does that scare you?*

These types of questions can help build an understanding of the patient and family’s experiences, which may make it easier to communicate and work together on a safety plan and any necessary follow-up care.

Provide trauma-informed, patient-centered care

Suicide is complex, with many different factors contributing to individual youths’ risk of suicide. Youth and families may respond differently to screening and risk-assessment questions, and pediatric health clinicians should work to center their efforts around the patient’s needs and experiences.

Pediatric health clinicians can consider the following when screening and assessing risk:

- Establish a trusting relationship and rapport with the patient
- Use a non-judgmental tone when asking questions
- Use active listening when a patient discloses information related to suicidal thoughts and behaviors
- Understand that follow-up questions about mental health may need to be adapted to a patient’s family or culture; language used in screening and assessment forms is often white-centric

Pediatric health clinicians can help youth and families understand and contextualize suicidal ideation:

- Many youth experience suicidal thoughts: however, it is not common to attempt or die by suicide

- Suicidal thoughts are an indicator of other mental health concerns (eg, a mental health condition, excessive stress, or a need for building more effective coping skills). These underlying concerns are treatable, and pediatric health clinicians can support the youth and parent/caregiver in addressing these concerns
- Pediatric health clinicians see the strengths in each patient and can be trusted adults that foster resilience. They can also [help parents foster resilience](#) by helping them shift from being “managers” of their child’s life to becoming “consultants” as their children grow, allowing for more developmentally appropriate independence
- Pediatric health clinicians can emphasize that they are on the youth’s team and can help manage the suicidal thoughts by working together.
 - Example phrase: *You’re not stuck here, and these feelings can change. I’m here to help you get through this*

Pediatric health clinicians can utilize [trauma-informed care principles](#) when addressing mental health and suicide. This includes care that promotes:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration
- Empowerment
- Humility and responsiveness

Language, stigma, and myths

Language matters when speaking with youth and families about suicide. Avoid terms that have a negative connotation or perpetuate stigma or blame:

- Use “die by suicide” instead of “commit suicide”
- Use “death by suicide” instead of “successful suicide”
- Use “suicide attempt” instead of “failed suicide attempt”
- When talking about warning signs or concerning behaviors, name the behaviors explicitly instead of using euphemisms like “suicidal gesture,” or “parasuicidal behavior” and avoid referring to people as “suicidal”

Talk directly with patients and families about how to navigate stigma and myths around mental health. Challenge the myth that people who are talking about suicide are only trying to get attention, or someone who is thinking about suicide is “crazy” or the myth that talking about suicide puts the idea into someone’s head.

Confidentiality and parental engagement

Confidential care is a key tenet of adolescent health care. However, confidentiality has limits, and pediatric health clinicians are considered mandated state reporters when they discover that someone is a danger to themselves or others. This means that navigating confidentiality in the context of suicide risk can be challenging.

The [AAP policy, “Unique Needs of the Adolescent,”](#) and [Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents \(4th Edition\)](#) highlight the need for [confidential, one-on-one time](#) between a pediatric health clinician and an adolescent during clinical visits, to discuss preventive services and individual health questions. This one-on-one time allows an opportunity for youth and clinicians to have an open, honest discussion and helps prepare the youth to be an active participant in their own health care. Pediatric health clinicians may choose to address mental health and suicide risk during these one-on-one discussions, when the parent is not in the room.

Pediatric health clinicians should set the expectation for this confidential, one-on-one time early in adolescence, and remind both youth and parents that this is a standard protocol at the beginning of the visit.

- Explain that anything discussed during that one-on-one time will remain confidential unless someone's immediate safety is at risk
- AAP provides [tips and resources](#) about how to implement confidential discussions with adolescents

If suicide risk is detected on the screener or during a confidential discussion, pediatric clinicians will need to notify the parents/caregivers. Prior to doing so, talk with the youth about what will happen next:

- Explain that you need to have a conversation with the patient's parents/caregivers to make sure they know about the risk
- Give the youth options for how they'd like their parent to be informed, to ensure they are an active participant in their care. For example, the patient can choose whether they'd prefer:
 - Clinician to disclose to the parent privately
 - Clinician to disclose to the parent with the adolescent in the room
 - Patient to disclose to their parent privately
 - Patient to disclose to their parent with the clinician in the room
- Some example phrases include:
 - *Your safety is the most important thing, so I am going to tell your parents how you're feeling*
 - *I don't want you to die. I'm going to tell your grandma what's going on so we can all keep you safe*
 - *I'm going to say something like, "Our screener indicated that Jaime is having thoughts of suicide, and that these thoughts scare him. He says they get worse at night, and he has trouble sleeping." Does that sound right to you? Is there anything you want me to add?*
- If the youth expresses fear that they may get in trouble for expressing suicidal thoughts, talk with them about these concerns, and assure them that you will help keep them safe. In this case, have a separate discussion with the parent/caregiver to assess and address their reaction to the disclosure, to further assess safety of the young person, including the parent/caregiver's ability to keep the young person safe

Then, engage parents:

- Ask the parent/caregiver if they know about the child's suicidal ideation/behavior in a way that does not come across as blaming or judgmental. For example, you can say, "Your child spoke about having suicidal thoughts. Is this something they have shared with you?"
 - Youth are often private about their suicidal thoughts
 - It is common for parents/caregivers to be unaware of suicidal ideation or behaviors
- Ask the parent/caregiver if there is anything they want to tell you in private
 - A private conversation with the parent/caregiver provides an opportunity to speak privately to gather relevant health information about family history or dynamics

Be aware there are [variations in state laws](#) related to adolescent confidentiality, minor consent, and documentation. For a listing of state laws related to adolescent confidentiality, visit the [Center for Adolescent Health and the Law](#).

Social media and youth mental health

Pediatric clinicians may encounter questions from parents about the role of social media in mental health and suicide risk. Social media offers a potential platform for the critical developmental tasks of adolescence, including establishing peer relationships, building independence, and exploring identity.

Research on the impact of social media on youth mental health is a growing field, and [studies](#) have identified both harms (eg, cyberbullying, social exclusion, or anxiety around peer-comparisons) and benefits (eg, finding community, connecting with friends, reducing stigma around mental health treatment).

When addressing social media use, [Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents \(4th Edition\)](#) notes that pediatric health clinicians can encourage patients and families to communicate openly about social media, protect online safety and privacy, and set healthy limits on screen time.

Non-suicidal self-injury

Non-suicidal self-injury (NSSI) is defined as deliberately injuring oneself without suicidal intent for purposes not socially or culturally [sanctioned](#). Common behaviors can include cutting, scratching, head-banging, hitting, burning, or intentionally preventing wounds from healing. Although the specific behavior is not linked to suicidal intent, youth who engage in NSSI have been found to have a higher risk of suicide over [time](#).

Medication treatment

Medications can be a useful tool in treating mental health conditions in youth. Research has found that the combination of medication and therapy customized to the patient's condition can be especially helpful. The AAP-endorsed policy statement, [Guidelines for Adolescent Depression in Primary Care \(GLAD-PC\): Treatment and Ongoing Management](#), outlines considerations for use of medications to treat depression in adolescents. To learn more about specific risks and benefits of medication and how to maximize treatment for reducing suicide risk, consider [these resources](#).

Evidence-based behavioral health treatments

There are evidence-based behavioral health treatments and psychotherapies that are approved for use with patients who attempt suicide or live with mental health conditions. These treatments include cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) and are designed to be provided by trained mental and behavioral health providers as part of an ongoing care plan. For more information on behavioral health treatments aimed at reducing suicide risk, visit the [American Foundation for Suicide Prevention](#) or the [American Academy of Child and Adolescent Psychiatry](#) (AACAP).

How to Prepare your Clinic or Health System for a Suicide Prevention Program

Get support from leadership

One of the main steps in building a successful suicide prevention program is to get support from senior leaders of the organization. The following components can help build a foundation of support:

- Identify champions who represent multiple disciplines and diverse backgrounds to move the program forward
- Involve *all* healthcare staff (physicians, nurses, medical assistants/technicians, social workers, behavioral health professionals, front-desk workers, environmental services staff, etc) in the suicide prevention program
- Secure sustained buy-in from senior leadership is crucial for a plan's longevity. Any changes in senior leadership or champions should be accompanied with transition plans so suicide prevention programs do not falter or discontinue because of staff departures
- Involve youth, parents/caregivers, or families early in the process for feedback, particularly those with lived experience of suicide

Assign roles

Staff from different disciplines can take on various roles in suicide prevention initiatives. These roles may vary between settings. Health systems can assign roles based on available staff and resources:

- Nurses and medical assistants/technicians can be trained to administer screening tools during initial nursing assessments or at triage
- Physicians, nurse practitioners, physician assistants, social workers, and other mental health clinicians can be trained to administer brief suicide safety assessments (see “Clinical Pathways,” below)
- Office staff can be trained in support roles, such as handing out screening forms and telling parents/caregivers that they will communicate questions to the clinical staff

Collaborative or integrated care models present a promising method to connect medical patients with mental health resources. These models may:

- Ease referral processes for patients at risk for suicide
- Ensure that participating clinicians are competent in suicide prevention practices (eg, providing evidence-based care, appropriately managing patients at risk for suicide)
- These models have also been demonstrated to reduce suicidal [ideation](#)
- For more information on collaborative or integrated care models, visit:
 - [AIMS Center for Collaborative Care](#)
 - [Primary Care Behavioral Health Model](#)
 - [Integration of Behavioral Health into Pediatric Primary Care Settings](#)
 - [Center of Excellence for Integrated Health Solutions](#)

Connect with mental and behavioral health providers in your community

When planning to integrate a suicide prevention protocol in your clinic, it is critical to first identify mental and behavioral health providers in your community, build connections with those providers, and identify alternate strategies for communities that have a lack of mental health resources. See “*Two Critical Steps Before You Begin*,” above for full details.

Build a suicide prevention program that best serves your community of patients

Individual communities experience and discuss mental health, distress, and suicide in different ways. Terms used to talk about death or suicide may vary by population and culture, and beliefs or stigmas about mental health may impact delivery of patient care.

Partnerships with community members are critical to building effective suicide prevention programs:

- Engage community/tribal leaders, youth, and parents/caregivers from the beginning, to identify needs and desires for suicide prevention and mental health services among your patient population
- Youth and families with lived experience of suicide are especially important collaborators to engage in the design of programs. Learn more about safely engaging people with lived experience [here](#)
- Partner with community/tribal members, faith leaders, and school leaders in the implementation of your suicide prevention program, as care navigators, clinic staff, or peer educators

Health systems can build an inclusive and welcoming care environment for their patient community:

- Use inclusive language in office signage, forms, and clinical interactions
- Ask patients about their names and pronouns and avoid gendered language in clinical discussions
- Display signs or printed materials in the language(s) spoken by the patient population

- Ensure that posters and photographs in the office reflect a diverse range of families and patients
- Display posters or signs conveying that patients and families deserve to feel welcome and respected
- Seek feedback from patients and families about the physical environment of the clinic
- Ensure clinic documents are professionally translated into the languages spoken by your patient population
- Utilize an interpreter during clinical visits with patients who speak a language other than your own. Ensure that family members of the patient are not asked to serve as interpreters
- In telehealth visits, utilize interpreters and assistive technology to promote accessibility for all families

Assess and address barriers

Barriers can be overcome, but they are also real issues that need to be addressed by each institution. Understanding common barriers to suicide prevention protocols can help health systems overcome potential roadblocks. Barriers can be addressed through staff training and by adapting the evidence-based clinical pathway below to meet the individual needs of your practice.

Common Implementation Barriers and Strategies to Overcome* Them	
Limited time/resources and competing priorities in a busy health system	<ul style="list-style-type: none"> • Consider strategies to efficiently integrate a suicide prevention protocol into your standard workflow: How can your Electronic Health Record (EHR) system facilitate screening? How can other members of the care team support safety planning or referrals? • Utilize a standardized care pathway, as described above. This pathway is designed as a straightforward workflow to ease decision making and care processes
Limited access to mental and behavioral health providers in the community	<ul style="list-style-type: none"> • Make a list of available pediatric mental health providers and connect with them to assess affordability and determine capacity for new patients • In areas with limited mental health support, consider alternative options, such as telehealth or school-based mental health resources • Consider consulting with a Pediatric Mental Health Care Access Program (PHMCA) to obtain timely training and support in addressing mental and behavioral health concerns in primary care settings • Build relationships with local schools, community organizations, juvenile justice centers, and child welfare organizations to support wrap-around care services for youth
Language or cultural barriers	<ul style="list-style-type: none"> • Identify mental and behavioral health supports in the community that are culturally and linguistically appropriate for your patient population; if these resources do not exist in the community, consider telehealth services, community/school-based services, or consulting with a Pediatric Mental Health Care Access Program (PHMCA) • Utilize multiple languages, translation and interpreter services, and assistive technology to increase access to care for all patients and families • Be aware of cultural factors, historical trauma, systemic racism, and other factors that may impact a patient's or family's experience with mental health and the medical system • Utilize trauma-informed care principles when working with patients and families • Understand that existing, validated suicide screening and risk assessment tools may not have been developed and tested with diverse populations—this is a limitation of the field, and research is needed to build culturally appropriate screening/assessment tools. In the meantime, use existing, validated screening tools with patients in your practice

Families facing logistical challenges in making/accessing mental health appointments	<ul style="list-style-type: none"> • Consider employing care-navigators to partner with families to support them in making appointments and facilitating access to those referrals • Consider a multi-disciplinary team-based care approach, when possible, to provide care coordination or social work support to families accessing care
Stigma around mental health symptoms	<ul style="list-style-type: none"> • Talk with clinicians, health system administrators, families, and other community members about the essential role that mental health plays in overall child health and development. Challenge the false dichotomy between mental and physical health • Use careful language when talking about suicide, to avoid inadvertently blaming the patient or family for suicidal ideation or behaviors
Clinician discomfort in talking about mental health	<ul style="list-style-type: none"> • Review this Blueprint and other resources about youth suicide prevention • Utilize a clinical pathway for suicide risk screening, brief suicide safety assessment/risk assessment, and management • Ask patients about their mental health – practice talking about mental health as a standard part of all visits with patients and families • Practice asking directly about suicide risk – use the mirror, and rehearse how you will ask, and what you will do if you hear a positive response • Understand that you do not need to be an expert in mental health to advance suicide prevention: you just need to ask the right questions and refer high-risk patients to a mental health professional for specialized care • Know that you do not have to do this work alone—develop a workflow that engages other members of the clinical team • Take time to check in with your own mental health, especially in times of stress
Concerns around billing/payment for mental health services	<ul style="list-style-type: none"> • Zero Suicide provides resources on financing suicide prevention care in clinical settings • Consult AAP coding resources to support billing for pediatric visits that address: <ul style="list-style-type: none"> ○ Adolescent Health ○ Anxiety ○ Bereavement ○ Bright Futures and Preventive Medicine ○ Depression ○ Posttraumatic Stress Disorder ○ Social Determinants of Health ○ Substance Use ○ Trauma • (For other topic areas, visit AAP's repository of coding fact sheets)

**Many of the barriers listed in this table result from systemic factors that impact disparities in access and delivery of health care across the US. Meaningfully addressing these barriers requires large-scale changes to systems and resources.*

In the meantime, pediatric health clinicians can ensure they are aware of these barriers and use the strategies outlined above to address them as well as possible during the clinical visit. More information on these strategies can be found in the sections above.

Train the staff

All staff should be involved in suicide prevention training. Training can build skills, confidence, and self-efficacy in staff and can help staff communicate compassionately and more effectively with parents, caregivers, and families.

Interactive training strategies, such as role-plays, standardized patients, or peer feedback on skills and techniques may help staff understand and integrate this content into practice.

Training programs should address the following topics:

- Epidemiology of suicide among youth and young adults
- Addressing common myths and stigma related to suicide
- Specific training in how to use the screening and assessment tools that will be used by your health system (see “Screening and Assessment tools,” below)
- Knowing what to say and do (and what not to say or do) when a patient reports suicidal thoughts or behaviors
- Trauma-informed care
- Safety planning
- Lethal Means Safety Counseling
- Understanding the impact of a suicide loss on child/youth mental health
- Understanding the impact of a suicide loss on healthcare professionals
- Billing procedures (including CPT codes and payments)
- Working with interpreters
- Confidentiality practices and limits for adolescent healthcare
- Rare emergencies, such as patients at imminent risk for suicide
- Regulatory procedures (The Joint Commission, insurance, state requirements)
- Maintenance of Certification and quality improvement strategies for implementation
- Health equity and cultural considerations for care provision
- Understanding and addressing personal and systemic biases that impact care delivery

To promote a program’s longevity, training should be repeated regularly for all staff, and updated as new information becomes available. During leadership transitions or when onboarding new employees, suicide education and prevention training should be incorporated into the training process for smooth transitions.

Experts are available to train your health system staff in person, online, or via recorded trainings:

- [National Institute of Mental Health](#)
- [American Foundation for Suicide Prevention](#)
- [Suicide Prevention Resource Center](#)
- [Zero Suicide Institute](#)

Launching your Clinic or Health System’s Suicide Prevention Program

Implement your program

Establish a timeline and pick a realistic date to launch the suicide clinical pathway protocol.

Prepare your staff and patient population:

- Announce plans to staff to incorporate the suicide clinical pathway protocol

- Provide an overview to all staff and initiate training for key staff on the clinical pathway protocol, individual roles, and any related Quality Improvement (QI) processes (see “Train the Staff,” above)
- Consider engaging staff in preparing emails or flyers for patients and families, announcing that you are now screening all patients above age 12 years for suicide risk. In these documents, address some of the common myths about suicide, and reassure families that it’s safe to ask questions about suicide risk
- Consider adding a statement that you are now screening all patients for suicide risk to the paperwork that is provided during office visits: [click here for a customizable template](#)

Promote adherence and fidelity

Quality Improvement (QI) projects are initiatives that utilize an iterative process with continuous feedback to make process improvements in a short amount of time.

QI projects may be instrumental to success for suicide risk screening and management programs. These projects allow healthcare settings to evaluate effectiveness, as well as identify areas for improvement. QI projects can also fulfill Maintenance of Certification (MOC) Part 4 requirements for pediatricians.

Existing frameworks include:

- [Getting to Outcomes® Improving Community-Based Prevention](#)
- [Plan-Do-Study-Act Approach](#)
- [Consolidated Framework for Implementation Research](#)
- [Institute for Healthcare Improvement QI Model](#)
- [Extension for Community Healthcare Outcomes \(ECHO\) with QI](#)

Provide ongoing support to staff

After the program is implemented, unanticipated issues may arise. Maintain open lines of communication between staff and leadership and revise your suicide prevention protocols as needed.

When possible, obtain feedback from staff, patients, and families using brief surveys. Use this feedback to guide future tweaks to the program.

Support your staff:

- Hold a debriefing session after positive screens so all staff involved can discuss what happened and identify opportunities for improvement
- Consider regular, quarterly check-ins to allow staff to talk about the process, provide emotional support, and give frontline staff an opportunity to talk

If a patient in your practice dies by suicide

The death of every person who dies by suicide leaves endless ripple effects of loss and grief in families, friends, and communities. The loss of a patient to suicide can have a profound impact on pediatric clinicians and office staff.

Common experiences after losing a patient to suicide may [include](#):

- Feelings of sadness, anxiety, guilt, shame, or distress
- Shaken confidence in professional abilities
- Impacts on sleep or other aspects of health

- Changes in care delivery: hyper-vigilance or avoiding certain patients

Considerations for clinicians who have lost a patient to suicide include

- Debrief with clinical team, and participate in institutional processes (eg, case review, sentinel event, root-cause analysis)
- Meet with the health system's risk management team
- Promote healthy habits related to sleep, substance use, exercise, and time for reflection
- Offer to meet with the deceased patient's family: to listen and provide empathy, to answer questions without violating patient confidentiality, and to offer condolences
- Seek support in colleagues, and in the resources below

In the event of a suicide loss, resources are available to support families, schools, and healthcare systems. (Please note that this list is not intended to be exhaustive).

Resources for Families

- [AFSP web resources](#) to support families after suicide loss
 - [Practical Information for immediately after a loss](#)
 - [Surviving a Suicide Loss Resource and Healing Guide](#)
 - [Children, Teens, and Suicide Loss](#)
- [AFSP Healing Conversations: Personal Support for Suicide Loss](#)

Resources for Schools and Universities

- [After a Suicide: A Toolkit for Schools](#)
- [Postvention: A Guide for Response to Suicide on College Campuses](#)
- [AFSP Healing Conversations: Personal Support for Suicide Loss](#)

Resources for Healthcare Professionals and Organizations

- [After a Physician Suicide: Responding as an Organization](#)
- [Support After Suicide Loss for Healthcare Professionals and Organizations](#)
- [AFSP Healing Conversations: Personal Support for Suicide Loss](#)