3.2 Suicidality

VMAP

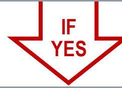
SURVEILLANCE FOR **SUICIDE RISK**:

Clinician should use **EVERY teen visit to obtain:**

- Routine PHQ-A and specifically look at Q9. Current or history of + answer.
- Concerning behavior (incl. suspected attempt), statement (suicidal/homicidal ideation?) or symptoms (NSSI?).
- Within 3 months of discharge from a psychiatric facility.
- New patient data with symptoms of any mental/emotional disorder.

Age recommendations for screening:

- **Ages 12+:** universal screening
- **Ages 8-11:** when clinically indicated
- **Under 8:** screening not indicated; assess for suicidal thoughts/behaviors if warning signs present



Screen for suicide risk using **ASQ suicide risk screening tool** (valid for ages 8-24)

SEVERITY

NEGATIVE SCREEN
Patient answers "NO" to all questions AND clinical presentation is unremarkable

- Screening is negative
- Consider follow-up in 2-4 weeks
- Psychoeducation
- Address any underlying mental health concerns identified in surveillance

Patient answers "NO" to all questions BUT **clinical presentation is concerning**

POSITIVE SCREEN
Patient answers "YES" to any screening question **OR** clinical presentation is obviously critical

In office, keep patient under direct observation; remove dangerous items

Complete **ASQ Brief Suicide Safety Assessment**

- Complete ASQ Brief Suicide Safety Assessment

OR

- Send immediately to ED for extensive mental health evaluation

Assess **DEGREE** of possible suicide risk. **ENGAGE CAREGIVERS**/adult supports in safety planning (especially in restricting access to dangerous items and behaviors that increase risk).

Low Risk	Possible Risk	Imminent Risk
No further evaluation needed at this time.	Further evaluation of risk is necessary.	Patient is at imminent risk for suicide (current suicidal plan and/or intent).
Recommend non-urgent mental health provider appointment.	Mental health referral needed as soon as possible.	Emergency mental health evaluation required.
Review safety plan and send home with a mental health referral. Continue medical care.	Consider VMAP consultation. Create a safety plan, review with caregivers, send home with referral list of mental health crisis services to access immediately, follow up with family in 24-48 hours.	Keep patient under direct observation, remove dangerous items, follow practice policies regarding alerting staff. Send to ED for thorough mental health evaluation to determine level of mental health care needed. Safe transport to ED; if not agreeing, call Emergency Services (911).

Note that high/imminent suicide risk negates privacy for all patients, even adults.

The 2019 Youth Risk Behavior Survey reported that **18.8% of high school students in the United States had seriously considered suicide**, and **8.9% had made a suicide attempt, in the past year.**

SCREENING FOR SUICIDE RISK

Suicide and suicidal behavior among youth and young adults is a major public health crisis. Suicide is the 2nd leading cause of death among young people age 10-24 in the United States, and rates have been rising for decades.

In 2022 the American Academy of Pediatrics and the American Foundation for Suicide Prevention released the *Blueprint for Youth Suicide Prevention*.

Age Recommendations for Suicide Risk Screening	
Youth ages 12+	Universal screening
Youth ages 8-11	Screen when clinically indicated: • When presenting with behavioral health chief complaint • If the patient or caregiver raises a concern • If reported history of suicidal ideation or behavior • If the patient displays warning signs of suicide
Youth under age 8	Screening not indicated. Assess for suicidal thoughts and behaviors if warning signs or caregiver report of suicidal behaviors are present. Examples include, but aren't 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

Asking kids about suicide is:

- Safe
- Very important for suicide prevention
- Not harmful
- Does not put thoughts or ideas into their heads

The ASQ Brief Suicide Safety Assessment offers sample statements!

IMPORTANT RESOURCE:

The AAP **Blueprint for Youth Suicide Prevention** (2022) includes Strategies for Clinical Settings for Youth Suicide Prevention

NIMH TOOLKIT

Suicide Risk **Screening Tool**

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? ______________________________

   ____

   ____

   When? ______________________________

   ____

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

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

   If yes, please describe: ______________________________

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen).*
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

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

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

WORKSHEET

Patient name:________________________________ **DOB:** ____________

Interviewer name: ________________________________ **Assessment date:**____________

1 Praise patient *for discussing their thoughts*

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

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

❑ Frequency of suicidal thoughts

(If possible, assess patient alone depending on developmental considerations and parent willingness.)
Determine if and how often the patient is having suicidal thoughts.
Ask the patient: "In the past few weeks, have you been thinking about killing yourself?"
If yes, ask: "How often?"_______(once or twice a day, several times a day, a couple times a week, etc.)
"When was the last time you had these thoughts?" ________________________

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

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❑ Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means). **Ask the patient:** "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

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

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❑ Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).
Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"
If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?"
"Did you want to die?" (for youth, intent is as important as lethality of method)
Ask: "Did you receive medical/psychiatric treatment?"

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

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NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety **Assessment**

WORKSHEET

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

❑ Symptoms Ask the patient about:

- ❑ **Depression:** "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"
- ❑ **Anxiety:** "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"
- ❑ **Impulsivity/Recklessness:** "Do you often act without thinking?"
- ❑ **Hopelessness:** "In the past few weeks, have you felt hopeless, like things would never get better?"
- ❑ **Anhedonia:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
- ❑ **Isolation:** "Have you been keeping to yourself more than usual?"
- ❑ **Irritability:** "In the past few weeks, have you been feeling more irritable or grouchier than usual?"
- ❑ **Substance and alcohol use:** "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"
- ❑ **Sleep pattern:** "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"
- ❑ **Appetite:** "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"
- ❑ **Other concerns:** "Recently, have there been any concerning changes in how you are thinking or feeling?"

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❑ Social Support & Stressors *(For all questions below, if patient answers yes, ask them to describe.)*

- ❑ **Support network:** "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"
- ❑ **Family situation:** "Are there any conflicts at home that are hard to handle?"
- ❑ **School functioning:** "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"
- ❑ **Bullying:** "Are you being bullied or picked on?"
- ❑ **Suicide contagion:** "Do you know anyone who has killed themselves or tried to kill themselves?"
- ❑ **Reasons for living:** "What are some of the reasons you would NOT kill yourself?"

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asQ Suicide Risk Screening Toolkit

7/1/2020

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

WORKSHEET page 3 of 4

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join. Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

"Your child said… (reference positive responses on the asQ). Is this something he/she shared with you?"

"Does your child have a history of suicidal thoughts or behavior that you're aware of?" **If yes, say:** "Please explain."

"Does your child seem:

- ❑ Sad or depressed?" ❑ Anxious?" ❑ Impulsive? ❑ Reckless?" ❑ Hopeless?" ❑ Irritable?"
- ❑ Unable to enjoy the things that usually bring him/her pleasure?"
- ❑ Withdrawn from friends or to be keeping to him/herself?"

"Have you noticed changes in your child's: ❑ Sleeping pattern?" ❑ Appetite?"

"Does your child use drugs or alcohol?" ❑ Yes ❑ No

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

"How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)

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"Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents) ❑ Yes ❑ No

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

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

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4 Make a safety plan with the patient

Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security. **Say to patient:** "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide." Examples: "I will tell my mom/coach/teacher." "I will call the hotline." "I will call____."

- ❑ **Discuss coping strategies** to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).
- ❑ **Discuss means restriction** (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
- ❑ **Ask safety question:** "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

Comments ____

asQ Suicide Risk Screening Toolkit

7/1/2020

NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety **Assessment**

WORKSHEET page 4 of 4

5 Determine disposition

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

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

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

Comments ____

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6 Provide resources to all patients

- **24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454**
- **24/7 Crisis Text Line: Text "HOME" to 741-741**

National Institute of Mental Health

asQ Suicide Risk Screening Toolkit

7/1/2020

EVIDENCE-BASED BEHAVIORAL INTERVENTIONS FOR SUICIDALITY

1. Currently there are no interventions that have been deemed evidence-based. It is difficult to design ethical research for individuals experiencing suicidal ideation. Despite limitations in the literature, there is research to support the use of some techniques over others.
2. There is good evidence supporting use of Safety Planning and Lethal Means Restriction to reduce both suicide attempts and deaths from suicide.

SAFETY PLANS
LETHAL MEANS RESTRICTION
DIRECT OBSERVATION (line of sight, no locked doors, buddy)
MENTAL HEALTH THERAPY

3. Selective serotonin reuptake inhibitors (SSRIs) may help reduce suicidal ideation; however, in some individuals they may cause suicidal ideation.

Box Warning: Monitor carefully for suicidal thoughts, especially in early treatment phase.

- 2004 FDA review of 24 clinical trials (4,400 children and teens prescribed antidepressants for MDD, anxiety, OCD). **No completed suicides in any trials.**
- See Module 1.4 on Psychopharmocology Basics

4. Cognitive behavioral therapy (CBT) and dialectical behavior therapy (DBT) have both shown promise in reducing suicidal ideation in some youth when paired with appropriate medication therapy.
5. Address sleep.
6. When lethal means are made less available or less deadly, suicide rates decline.
   - Keeping firearms locked and eliminating unsupervised exposure to firearms may decrease the likelihood of youth suicide involving firearms.
   - During routine evaluations and where consistent with state law, ask whether firearms are kept in the home and discuss with caregivers the increased risk of adolescent suicide with the presence of firearms.
   - Specifically for adolescents at risk for suicide, advise caregivers to remove guns and ammunition from the house, keep razors and other sharp objects locked away, and secure supplies of prescription and over-the-counter medications.

PROVIDER TIPS & CLINICAL PEARLS

- Suicide is the second leading cause of death for youth ages 10-24.
- Adolescents and young adults: leading method of **completed** suicide is the use of firearms; over 80% of US youth under 18 who died by suicide used a gun.
- Children ages 10-14: most likely to **complete** suicide by strangulation or hanging.
  - Discuss with caregivers the need for direct (REMAIN IN LINE-OF-SIGHT) observation and uncompromising intervention if this method has been considered or prior attempts included these methods.
- The most common method of attempted suicide is overdose/poisoning with medications, street drugs or alcohol, or chemical ingestions. However, the LETHALITY of suicide attempts is much greater with firearms (90%) versus other means (10%).
- **Short-term risk:** same day to 2 weeks
  - Recent breakup
  - Recent exposure to suicide
  - Stressful life event
  - Sleep disturbance
- **Psychiatric hospitalization is almost always indicated** for children and adolescents with suicidal attempt, plan/intent, or immediate high risk of suicide.
- **Protective factors:**
  - Access to effective physical and behavioral health care
  - Strong connection to family, friends, and/or community
  - Optimism for the future (e.g., looking forward to college)
  - Constructive use of leisure time
  - Fear of death and dying

FAMILY HANDOUT

Your child's health and safety is our #1 priority. We use a screening tool created by the National Institute of Mental Health specifically for youth and children. You can find more information about this screening at www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials.

Suicide is the 2nd leading cause of death for youth. Please note that asking youth questions about suicide is safe and is very important for suicide prevention. Research has shown that asking youth about thoughts of suicide is not harmful and does not put thoughts or ideas into their heads.

Although attempting and completing suicide is more common in youth with depression and other mood disorders, impulsive suicide attempts can occur in those with no known history of mental illness. Families can make homes safer, helping to protect children and teens. Although it is not possible to make a home perfectly safe, following these suggestions can help reduce the risks and chance for a suicide attempt.

Even if you have made your home safer, if your child is talking about thoughts or plans of suicide, they should be urgently evaluated by a qualified mental health provider.

Sources of Risk in the Home

Weapons

- Research shows that having a gun or weapon in the home increases the risk of dying by suicide.
- Guns should be stored unloaded in a locked safe. Bullets should be also locked, but in a separate place.
- Gun safe keys or combination to the lock should be kept only by the adults in the house.
- Consider purchasing trigger locks for guns.
- When children and teens go to friends' or relatives' homes, ask about gun ownership and storage.
- Lock away knives, razor blades, and other sharp objects from children and teens.

Medications

- Keep all medications, both prescribed and non-prescribed (over-the-counter), in a locked box.
- An adult should hand out and control all prescribed and over-the-counter medications to children and adolescents.
- Keep track of all bottles of medication as well as the number of pills in each container, including those prescribed as over-the-counter medications (such as pain relief, allergy pills, vitamins, and supplements, etc.) for every person and any pets in the home.
- Dispose of all expired and no-longer-used prescribed medications by bringing them to your local pharmacy or fire station.
- Ask the parents of your child's friends how their medications are stored in their home.

Other substances

- If substances that can be abused are kept in the home, they should be monitored and locked.
- Keep track of bottles of alcohol and lock them away. It is not enough to put these items "out of reach."
- If marijuana is kept in the home, lock all forms of it in a lock box that only adults in the house have the key or combination to.
- Talk with the parents of your child's friends about how they store alcohol or marijuana in the home.

Other items can be used for self-harm and suicide

- Keep your vehicle keys with you at all times or consider locking them in a lock box.
- Lock away all toxic household cleaners, pesticides, and industrial chemicals.
- Consider limiting ropes, electrical wire, and long cords within the home or lock them away.
- Secure and lock high-level windows and access to rooftops.

Online activities

- Parents and caregivers should monitor the online activities of their children, watching for:
  - Researching methods of suicide.
  - Purchasing of any materials or items that could be used for self-harm.
  - Spending time in chat rooms or social media sites dedicated to self-harm or suicide.
  - Receiving texts or direct messages from peers about suicide, calls for help or peer bullying.

The risk of dying by suicide can be decreased when families and caregivers reduce access to ways children can harm themselves. Following these steps can help to improve safety in your home.

Additional resources:

- American Foundation for Suicide Prevention, Virginia Chapter: afsp.org/chapter/virginia
- National Suicide Prevention Lifeline: 1-800-273-8255 or **Text *TALK* to 741-741**
- Suicide Prevention Resource Center: 1-800-273-talk or www.sprc.org/

INDIVIDUAL SAFETY PLAN (for youth to complete)

Make the environment safe: remove access ex: lock up medications	1. ____ 2. ____ 3. ____
Warning signs and vulnerabilities ex: not getting my homework done	1. ____ 2. ____ 3. ____
Things I can do on my own to distract me ex: listen to favorite band	1. ____ 2. ____ 3. ____
People who can help distract me ex: my brother	1. ____ 2. ____ 3. ____
Adults I can ask for help ex: my parent, my neighbor	1. ____ 2. ____ 3. ____
Future goals and things I'm looking forward to	1. ____ 2. ____ 3. ____

Professionals I can ask for help:

My therapist: ____ Phone: ____

My provider: ____ Phone: ____

My psychiatrist: ____ Phone: ____

If my health care provider is not available and I find myself preparing for suicide, I'll call

____ (person/agency) at ____ (number) for emergency help.

If I feel that I can't control my suicidal behavior, I'll go to the nearest emergency department or call 911.

24-Hour Crisis Hotlines

- Crisis Text Line **Text:** HOME to 741-741
- National Suicide Prevention Hotline **Phone:** 1-800-273-TALK (8255)
- National Hopeline Network **Phone:** 1-800-SUICIDE (784-2433)

Local Emergency Room or call 911

Adapted from: GMU Center for Psychological Services