The Blueprint for Youth Suicide Prevention

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

Objectives

- Discuss the AAP/AFSP Blueprint for Youth Suicide Prevention
- Universal suicide risk screening for patients in all healthcare settings: Ask directly
- Clinical Pathway- 3-tiered system
  - Brief Screen (20 seconds)
  - Brief Suicide Safety Assessment (~10 minutes)
  - Disposition: identify next steps for care
- The *Blueprint* offers clinical, community, school, and policy resources

Public Health Problems

- 2020 deaths among all ages
  - COVID-19: ~350,000 deaths = ~960 per day
    - Among 10-24-year-olds: ~530 deaths a year = 10 per week

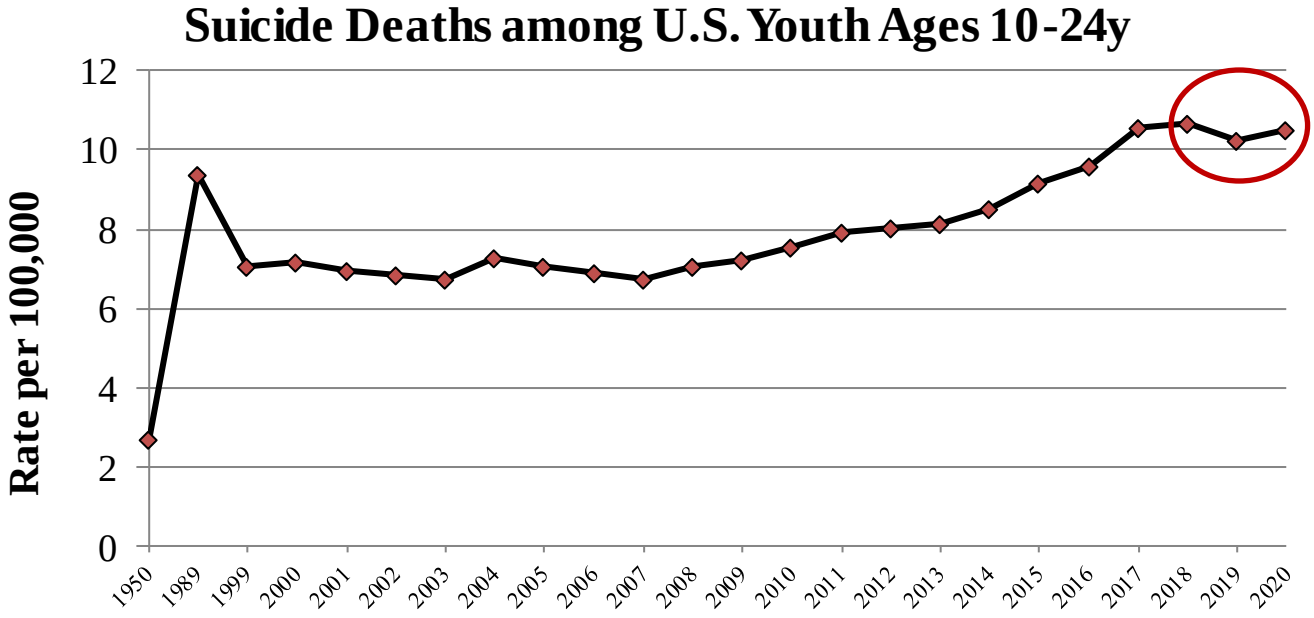
  - MVA: ~43,000 deaths = 118 deaths a day
    - Among 10-24-year-olds: ~7,500 deaths = 20 deaths a day

  - Suicide: ~ 46,000 deaths = 126 deaths a day
    - Among 10-24-year-olds: ~ 6,600 deaths = 18 deaths a day

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK
www.suicidepreventionlifeline.org

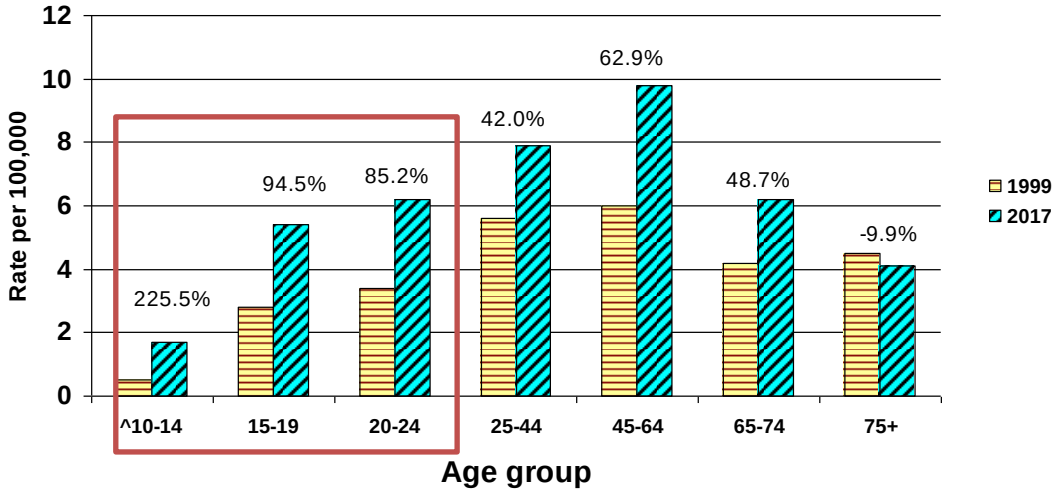
Youth Suicide in the U.S.

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



CDC WISQARS, 2020

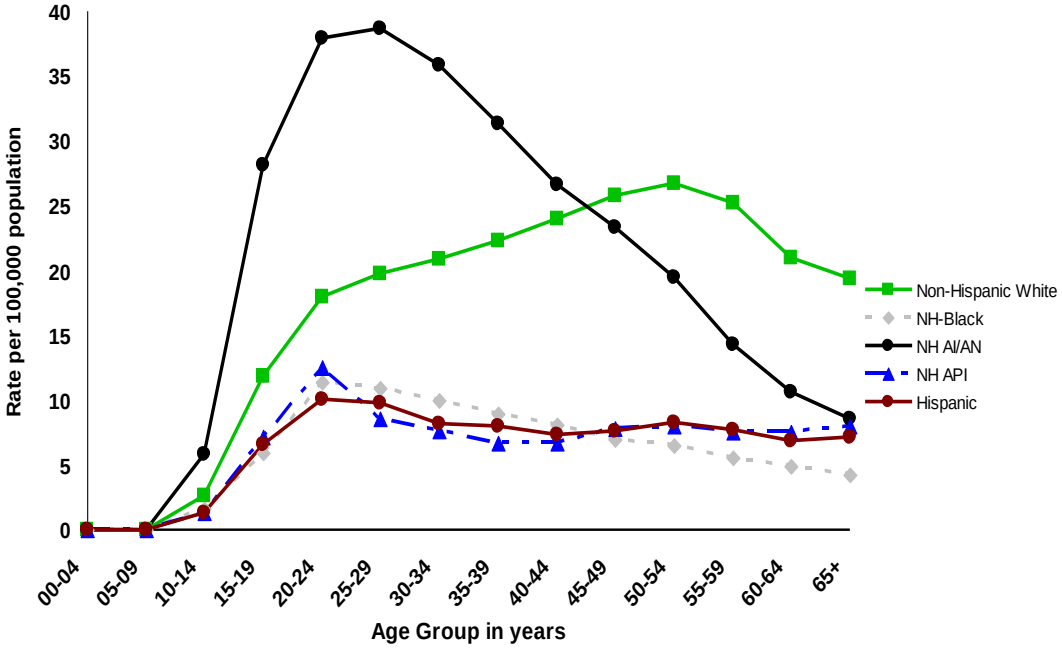
Suicide Rates Among Females by Age Group -- United States, 1999 and 2017



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

Slide courtesy of Dr. Deborah Stone, CDC

Suicide rates by ethnicity and age group -- United States, 2013-2017

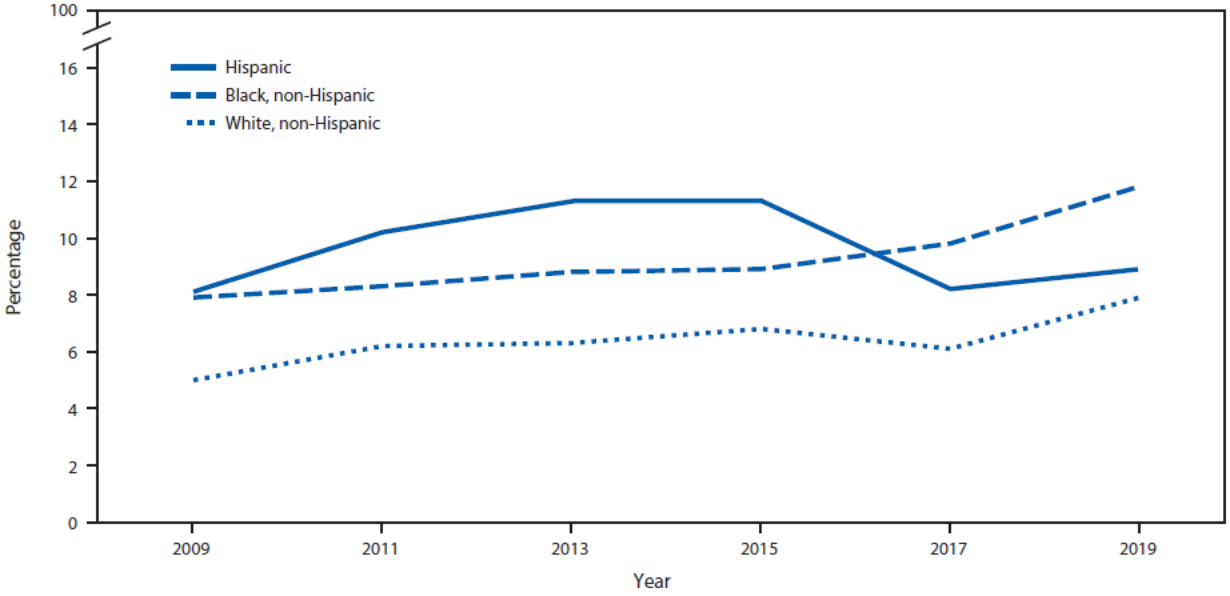


Source: CDC WISQARS Fatal Injury Reports, https://www.cdc.gov/injury/wisqars/fatal.html

Slide courtesy of Dr. Deborah Stone, CDC

Racial Disparities Among High School Students

FIGURE 2. Percentage of high school students who attempted suicide during the 12 months before the survey, by race/ethnicity — Youth Risk Behavior Survey, United States, 2009–2019



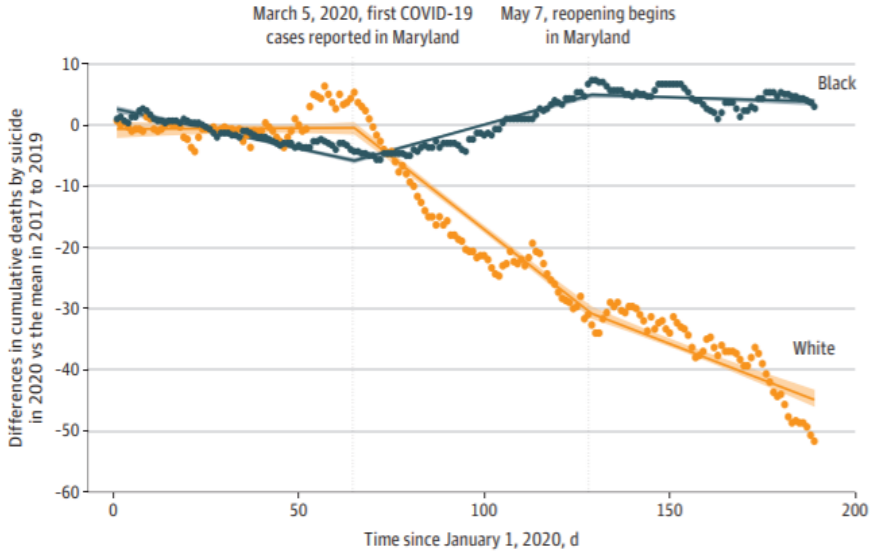
Ivey-Stephenson et al., 2020

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

Slide courtesy of Dr. Tami Benton

Racial Disparities in Suicide Rates During COVID-19

- **Comparing pre-pandemic to post-pandemic rates**
  - Overall, suicide rates decreased during the pandemic.
  - Among Black residents, suicide mortality appeared to double from March 2020 to May 2020.
  - Among White residents, suicide mortality nearly halved in the same period.



Bray et al., 2021

Suicide Risk Screening for Underserved Populations

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

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

Youth Suicide Attempts Pre and Post COVID-19 Pandemic

- During February-March 2021, when compared to the same time period in 2019, there was a **39% increase** in ED visits for suspected suicide attempts among youth aged 12-17 years.
  - The increase for females aged 12-17 years was 51%
  - The increase for males aged 12-17 years was 4%
- Young people (aged 18-24 years) did not see a similar increase as adolescents

CDC Morbidity and Mortality Weekly Report, 2021

Top 10 Leading Causes of Death Among Youth 5-11 Years Old, United States

	2014	2016	2018	2020
1	Unintentional Injury	Unintentional Injury	Unintentional Injury	Unintentional Injury
2	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms	Malignant Neoplasms
3	Congenital Anomalies	Congenital Anomalies	Congenital Anomalies	Homicide
4	Homicide	Homicide	Homicide	Congenital Anomalies
5	Heart Disease	Heart Disease	Heart Disease	Chronic Low Respiratory Disease
6	Chronic Low Respiratory Disease	Chronic Low Respiratory Disease	Chronic Low Respiratory Disease	**Suicide (87 deaths)**
7	Influenza & Pneumonia	Influenza & pneumonia	Influenza & pneumonia	Heart Disease
8	Cerebrovascular	Cerebrovascular	**Suicide (84 deaths)**	Influenza & pneumonia
9	Benign Neoplasm	**Suicide (53 deaths)**	Cerebrovascular	Cerebrovascular
10	**Suicide (49 deaths)**	Septicemia	Septicemia	Benign neoplasms

CDC, 2020

Youth Suicidal Behavior & Ideation

- **2019 YRBS**
  - 8.9% of high school students attempted suicide one or more times in the past year
  - 18.8% of high school students reported “seriously considering attempting suicide” in the last year

Youth Risk Behavior Surveillance, 2019

High Risk Factors

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

Suicide Warning Signs

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

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

Suicide Is Preventable.

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

With Help Comes Hope

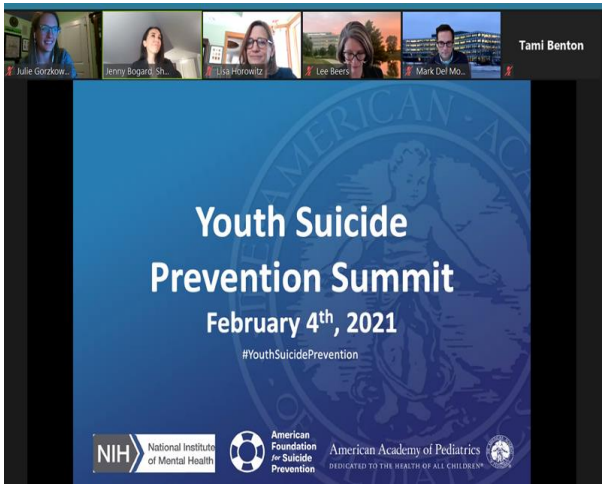
NIH National Institute of Mental Health

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

Merlin

Process for Developing the Blueprint for Youth Suicide Prevention

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



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

Key Take-Aways from the Summits

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

Blueprint for Youth Suicide Prevention

- Roadmap for future action and partnerships

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

aap.org/suicideprevention

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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.

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

Suicide in the Hospital Setting

- Hospital-based suicides are rare and devastating
  - Ranked as a top-five Sentinel Event reported to TJC
  - 25% of hospital suicides occur in non-behavioral health settings

Sentinel Event Alert

Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6,7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[9,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

The Joint Commission, 2016

Underdetection

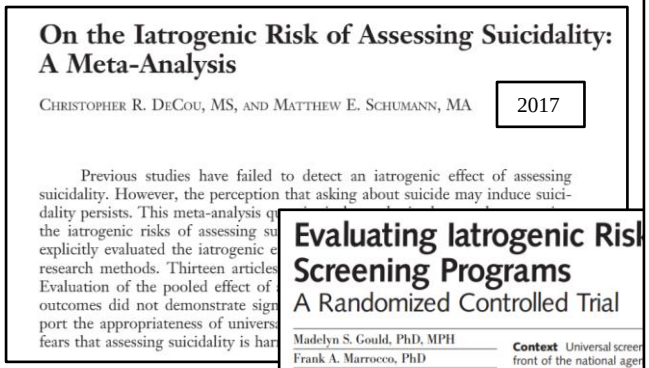
- Majority of those who die by suicide have contact with a medical professional within 3 months of killing themselves
  - 80% of youth visited healthcare provider
  - 38% of adolescents had contact with a health care system within 4 weeks
  - 50% of youth had been to ED within 1 year
  - Frequently present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

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

Common Concern:

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

Iatrogenic Risk?



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

Christopher R. DeCou, MS, and Matthew E. Schumann, MA

2017

Previous studies have failed to detect an iatrogenic effect of assessing suicidality. However, the perception that asking about suicide may induce suici-
dality persists. This meta-analysis q
the iatrogenic risks of assessing su
explicitly evaluated the iatrogenic e
research methods. Thirteen articles
Evaluation of the pooled effect of
outcomes did not demonstrate sign
port the appropriateness of univers
fears that assessing suicidality is har

Evaluating Iatrogenic Risk
Screening Programs
A Randomized Controlled Trial

Madelyn S. Gould, PhD, MPH
Frank A. Marrocco, PhD
Marjorie Kleinman, MS

Context Universal screen
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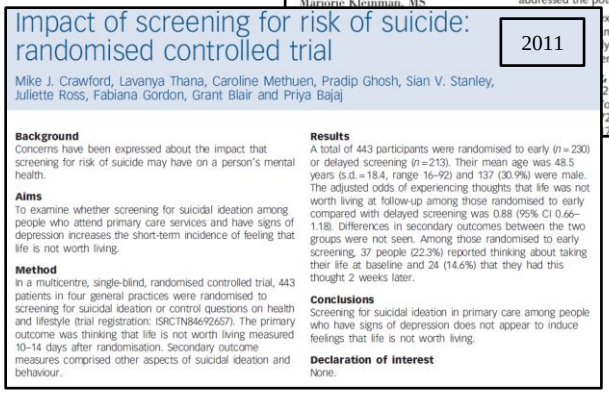


Impact of screening for risk of suicide: randomised controlled trial

2011

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

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

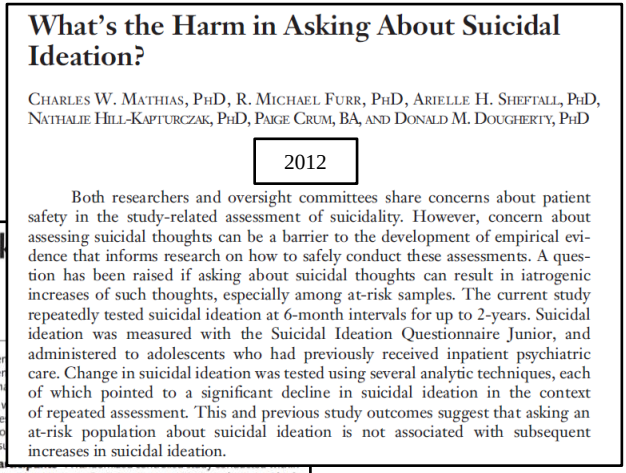
Aims
To examine whether screening for suicidal ideation among people who attend primary care services and have signs of depression increases the short-term incidence of feeling that life is not worth living.

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

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

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

Declaration of interest
None.



What's the Harm in Asking About Suicidal Ideation?

Charles W. Mathias, PhD, R. Michael Furr, PhD, Arielle H. Sheftall, PhD, Nathalie Hill-Kapturczak, PhD, Paige Crum, BA, and Donald M. Dougherty, PhD

2012

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

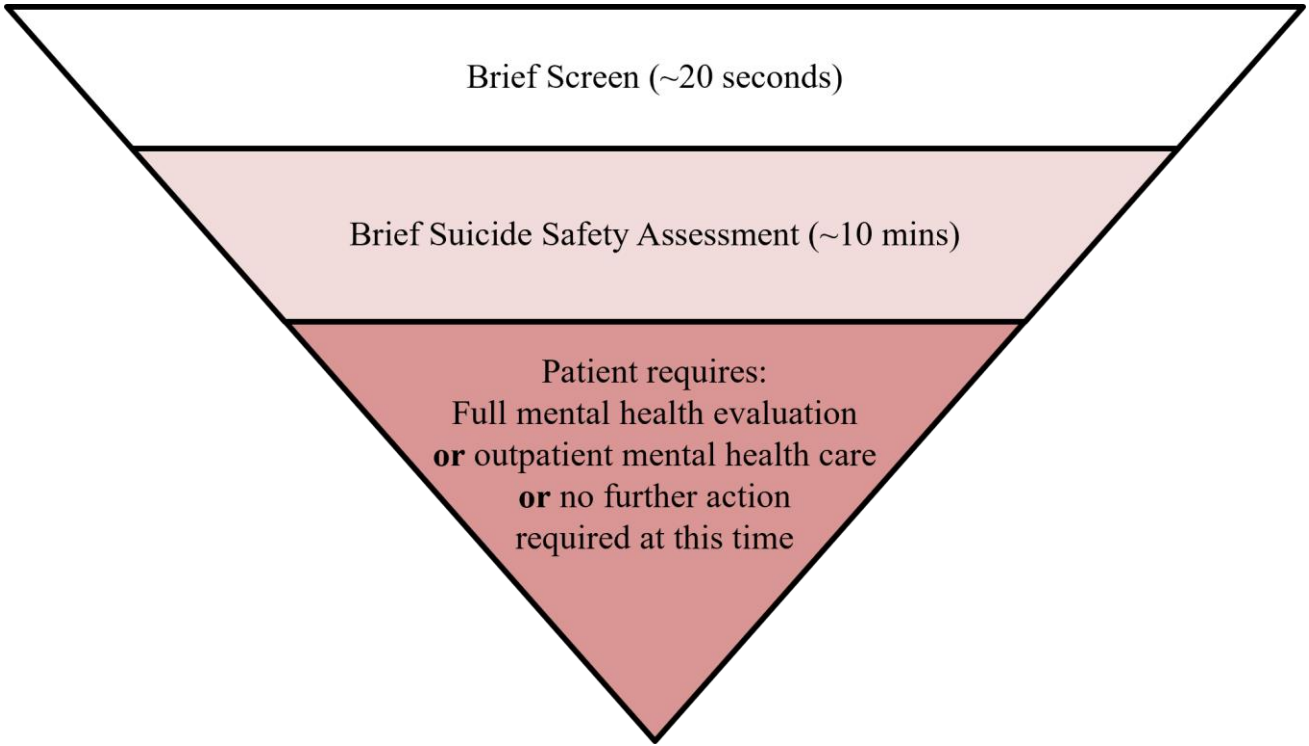
DeCou & Schumann, 2017; Mathias et al., 2012; Crawford et al., 2011; Gould et al., 2005

Screening vs. Assessment: What's the difference?

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

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

The Blueprint is Based on a 3-Tiered Universal Suicide Risk Clinical Pathway

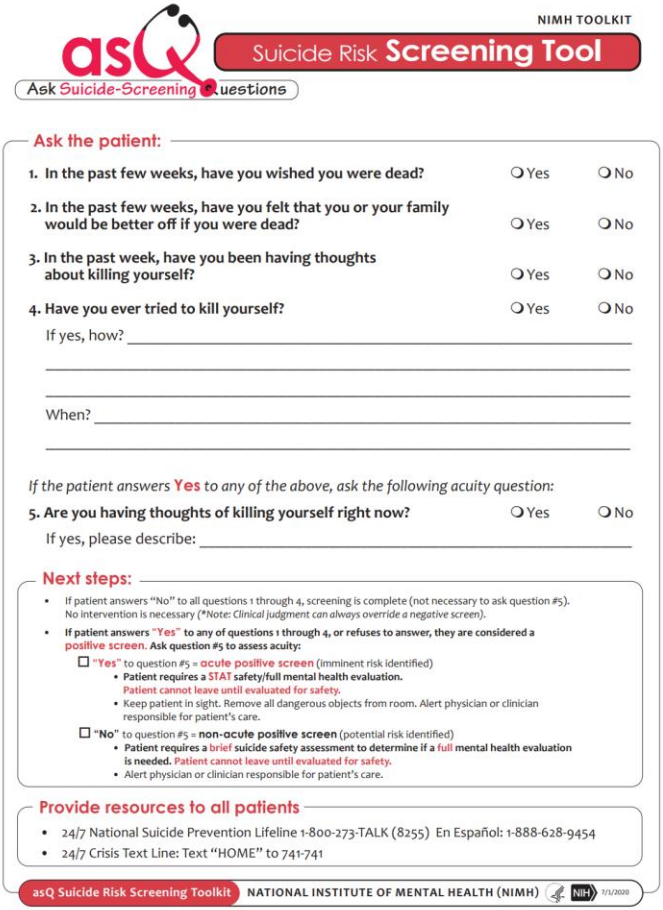


Brahmbhatt, Kurtz, Afzal…Pao, Horowitz, et al. (2018) *Psychosomatics*

Tier 1: Brief Screen (Less than 1 minute)

- 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
- Anyone who is trained can screen for suicide risk

Example Screening Tool: ASQ



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

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

   If yes, how? _____

   _____

   _____

   When? _____

   _____

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

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

   If yes, please describe: _____

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No

2. In the past few w
would be better o

3. In the past week,
about killing your

4. Have you ever tri

If yes, how? _____

_____

_____

When? _____

_____

If the patient answer

5. Are you having th

If yes, please desc

Next steps:

- If patient answers "N
No intervention is ne
- If patient answers "Y
positive screen. Ask
☐ "Yes" to quest
• Patient r
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• Alert phy

Provide resourc

- 24/7 National Suic
- 24/7 Crisis Text Li

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIH 6/13/2017

Sensitivity: 96.9% (95% CI, 91.3-99.4)

84.0-90.5)

ents:
99.9)
96.9%

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? _____

_____

ACUTE POSITIVE

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

NIH National Institute of Mental Health

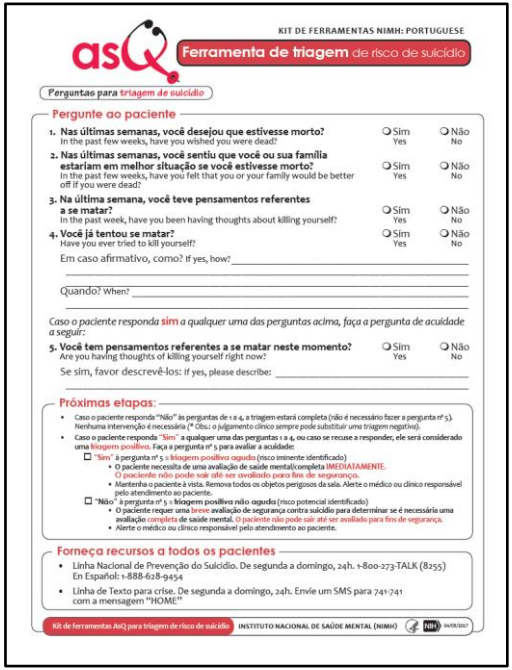
Horowitz, Bridge, Wharff, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

Validation and Implementations in Other Settings: Ongoing Research

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

Foreign languages

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



KIT DE FERRAMENTAS NIMH: PORTUGUESE

asQ Ferramenta de triagem de risco de suicídio

Perguntas para triagem de suicídio

Pergunte ao paciente

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

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

Quando? When? _____

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

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

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

Próximas etapas:

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

Forneça recursos a todos os pacientes

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

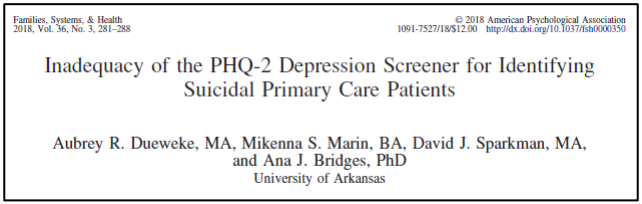
Kit de ferramentas AsQ para triagem de risco de suicídio | INSTITUTO NACIONAL DE SAÚDE MENTAL (NIMH) | NIH | 04/09/2017

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

Patient Health Questionnaire -9 (PHQ-9)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain and commonly used in medical settings

- One "suicide-risk" question: Item #9
  - How often have you been bothered by the following symptoms during the past two weeks? *"Thoughts that you would be better off dead* ***or*** *of* ***hurting*** *yourself in some way"*


Families, Systems, & Health
2018, Vol. 36, No. 3, 281–288

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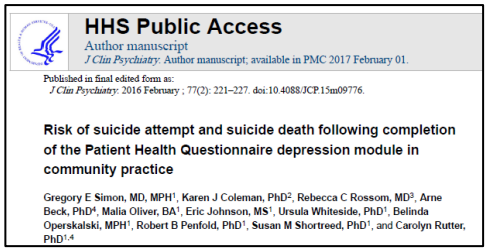
1091-7527/18/$12.00 http://dx.doi.org/10.1037/fsh0000350

Inadequacy of the PHQ-2 Depression Screener for Identifying Suicidal Primary Care Patients

Aubrey R. Dueweke, MA, Mikenna S. Marin, BA, David J. Sparkman, MA, and Ana J. Bridges, PhD
University of Arkansas


HHS Public Access
Author manuscript
J Clin Psychiatry. Author manuscript; available in PMC 2017 February 01.

Published in final edited form as:
J Clin Psychiatry. 2016 February ; 77(2): 221–227. doi:10.4088/JCP.15m09776.

Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice

Gregory E Simon, MD, MPH[1], Karen J Coleman, PhD[2], Rebecca C Rossom, MD[3], Arne Beck, PhD[4], Malia Oliver, BA[1], Eric Johnson, MS[1], Ursula Whiteside, PhD[1], Belinda Operskalski, MPH[1], Robert B Penfold, PhD[1], Susan M Shortreed, PhD[1], and Carolyn Rutter, PhD[1,4]


Psychosomatics 2015;56:490–469 © 2015 The Academy of Psychosomatic Medicine. Published by Elsevier Inc. All rights reserved.

Original Research Reports

Comparison of Electronic Screening for Suicidal Risk With the Patient Health Questionnaire Item 9 and the Columbia Suicide Severity Rating Scale in an Outpatient Psychiatric Clinic

Adele C. Viguera, M.D., Nicholas Milano, M.D., Laurel Ralston D.O., Nicolas R. Thompson, M.S., Sandra D. Griffith, Ph.D., Ross J. Baldessarini, M.D., Irene L. Katzan, M.D., M.S.

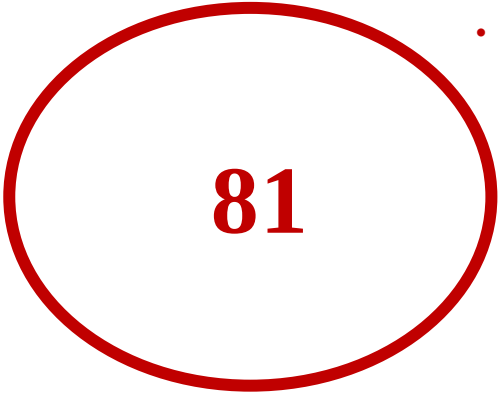
Dueweke, 2018; Simon, 2016; Viguera 2015

Depression Screening vs. Suicide Risk Screening

ASQ vs. PHQ-A

Suicide-risk positive (13.5%)

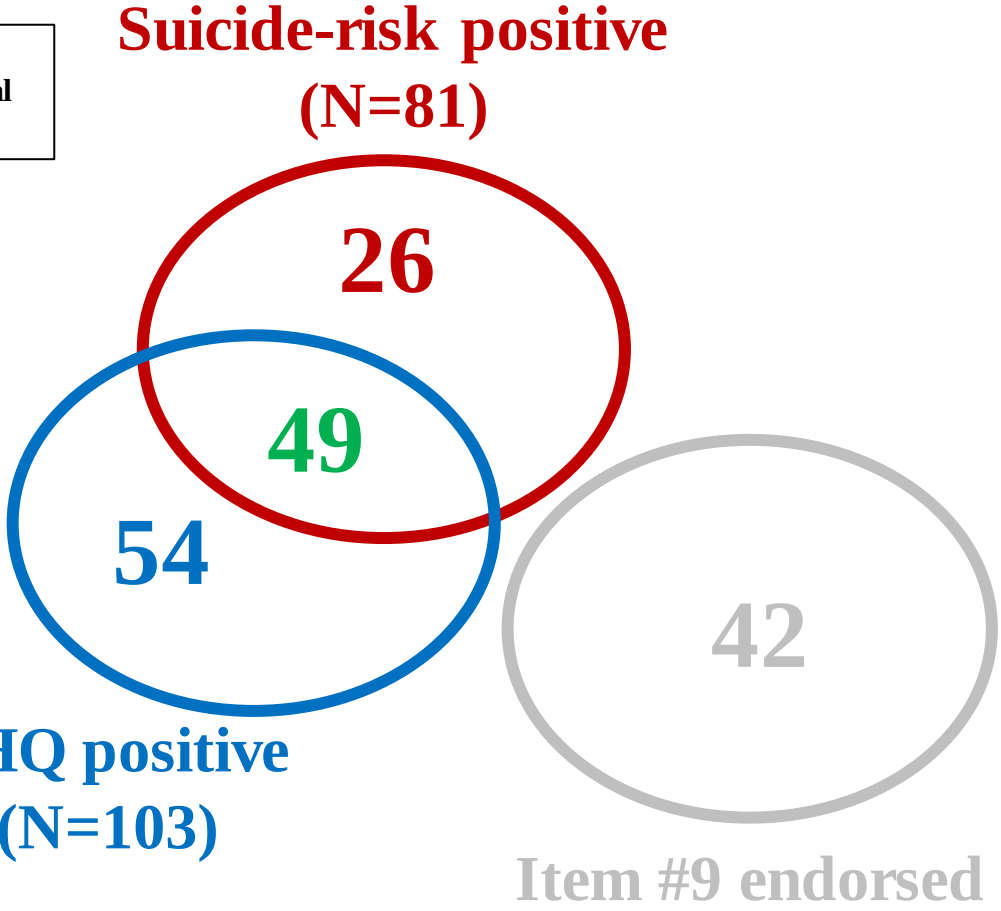
Total N=600
Medical/Surgical Inpatients



- SIQ ≥ 41
- SIQ-JR ≥ 31
- "Yes" to any ASQ item

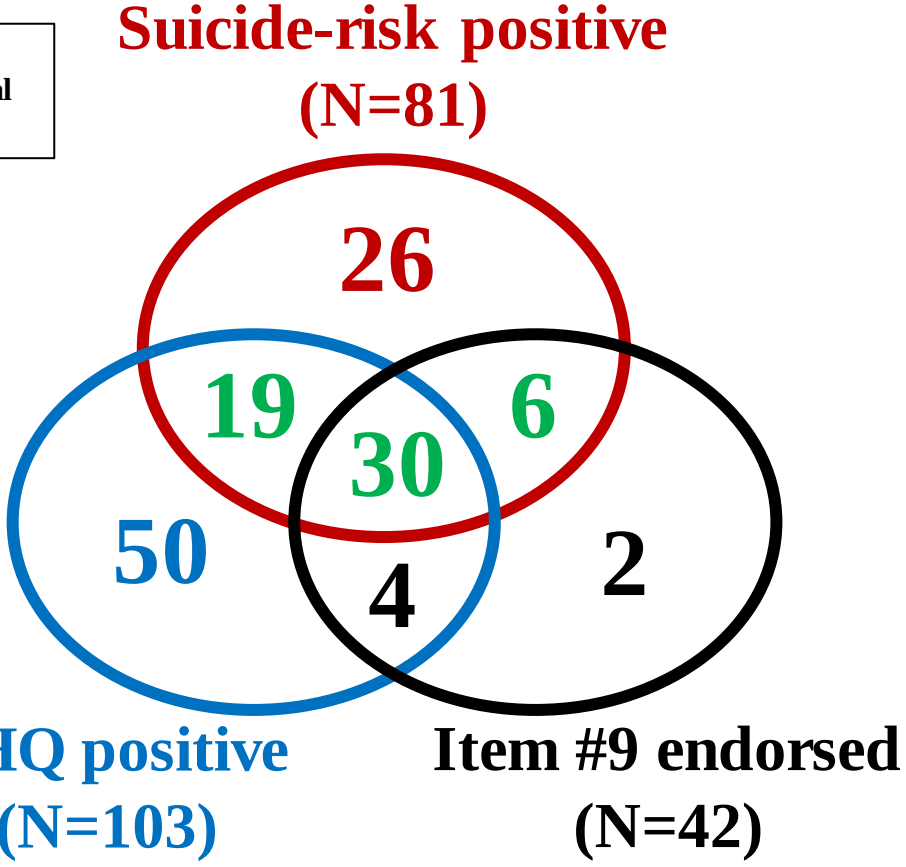
Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



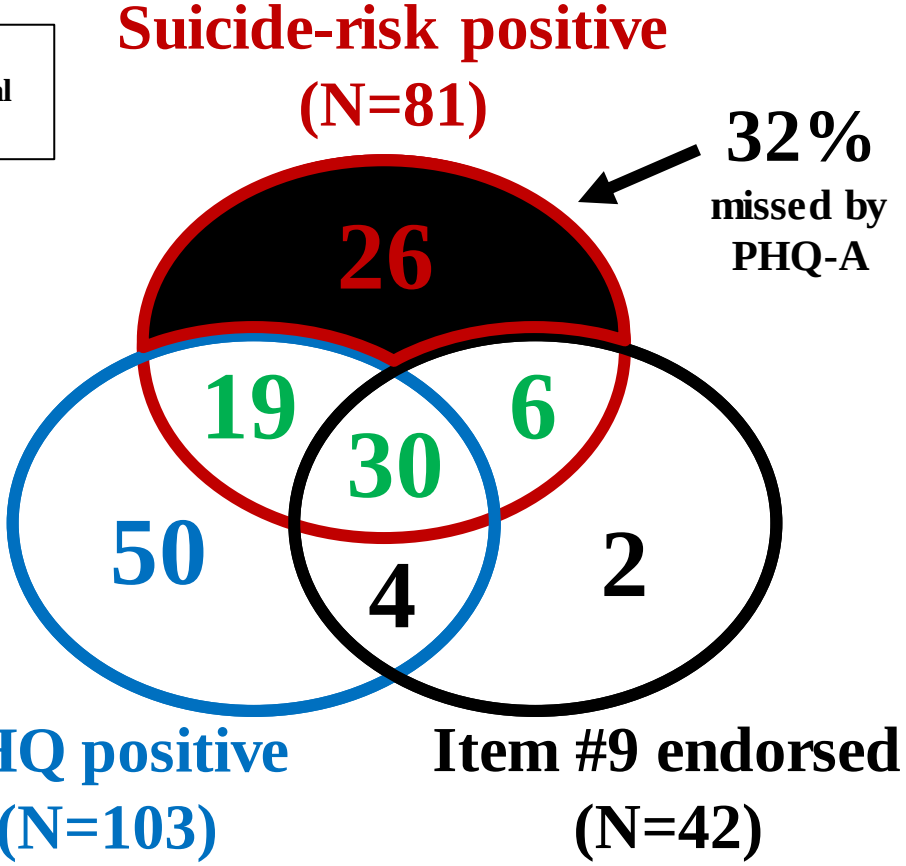
Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



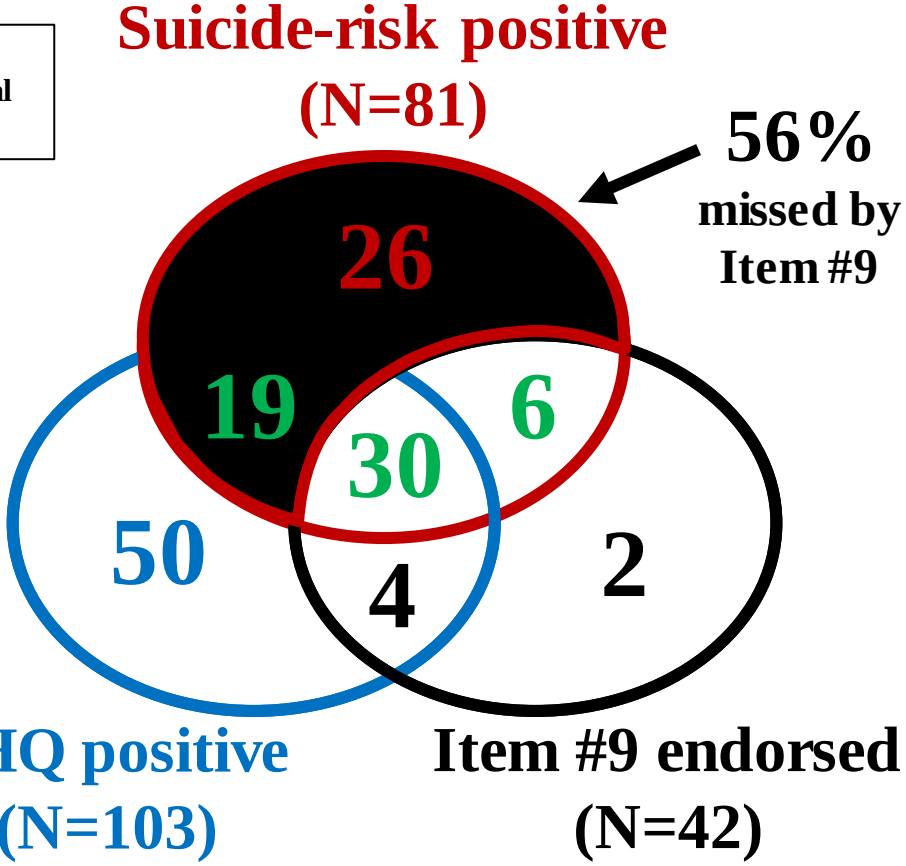
Horowitz et al. (2021) *Journal of Adolescent Health*

Total N=600
Medical/Surgical
Inpatients



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

Total N=600
Medical/Surgical
Inpatients



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

PHQ-2

PHQ-9

Suicide Risk Screen

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

PHQ-9 modified for Adolescents (PHQ-A)

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

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

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

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

☐Yes ☐No

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

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

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

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO
(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO
(3) In the past week, have you been having thoughts about killing yourself? YES NO
(4) Have you ever tried to kill yourself? YES NO
If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO
If yes, please describe: _____

What happens when a patient screens positive?

Here's What Should NOT Happen

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

1:1 sitter

The Blueprint is a guide to avoid unnecessary interventions

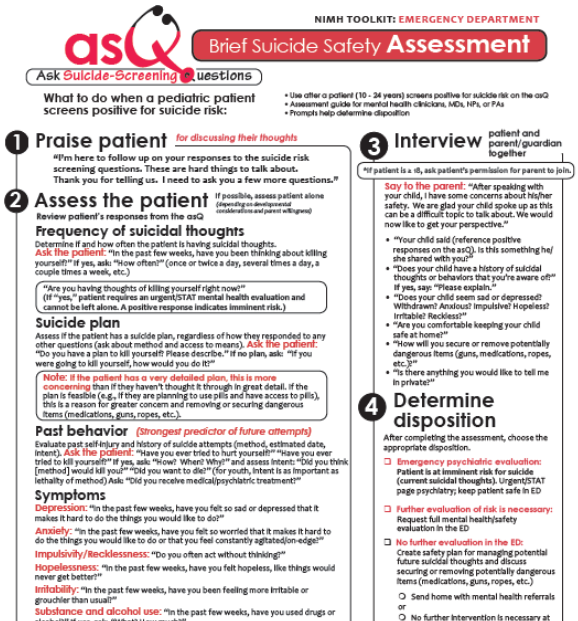
Tier 2: Follow-up Positive Screens with a Brief Suicide Safety Assessment

Brief Suicide Safety Assessment
(~10 mins)

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

Brief Suicide Safety Assessment

ASQ BSSA



NIMH TOOLKIT: EMERGENCY DEPARTMENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- Use after a patient (10 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

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

2 Assess the patient If possible, assess patient alone (depending on developmental considerations and parent willingness)

Review patient's responses from the asQ

Frequency of suicidal thoughts

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

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

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

Suicide plan

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

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

Past behavior *(Strongest predictor of future attempts)*

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

Symptoms

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

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

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

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

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

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

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

Support & Safety

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

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

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

3 Interview patient and parent/guardian together

*If patient is ≥ 18, ask patient's permission for parent to join.

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

- "Your child said (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behaviors that you're aware of?" If yes, say: "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

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

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

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

❍ Send home with mental health referrals or

❍ No further intervention is necessary at this time

5 Provide resources to all patients

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | 7/14/2017

C-SSRS

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.

Since Last Visit

1. Wish to be Dead — Yes ☐ No ☐

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

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

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

Do you wish you weren't alive anymore?

If yes, describe:

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

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

Have you thought about doing

Have you had any thoughts ab

If yes, describe:

3. Active Suicidal Ideati

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

Have you thought about how y

If yes, describe:

4. Active Suicidal Ideati

Active suicidal thoughts of kill
definitely will not do anything a

When you thought about maki

This is different from (as appr

If yes, describe:

5. Active Suicidal Ideati

Thoughts of killing oneself wit

Have you decided how or when would do it?

What was your plan?

When you made this plan (or w

If yes, describe:

INTENSITY OF ID

The following feature should and 5 being the most severe.

Most Severe Ideation:

Frequency

How many times hav

(1) Only one time (2) A

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

Actual Attempt: — Yes ☐ No ☐

A potentially self-injurious act committed with at least some wish to die, *as a result of act*. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm,*** just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.

Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.

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

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

Did you _____ as a way to end your life?

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

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

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

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

If yes, describe:

Total # of Attempts: _____

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

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

Interrupted Attempt: — Yes ☐ No ☐

When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred)*.

Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.

Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?

If yes, describe:

Total # of interrupted: _____

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

When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.

Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?

If yes, describe:

Total # of aborted or self-interrupted: _____

Preparatory Acts or Behavior: — Yes ☐ No ☐

Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).

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

If yes, describe:

Total # of preparatory acts: _____

Suicide: — Yes ☐ No ☐

Death by suicide occurred since last assessment.

Most Lethal Attempt Date: _____

Actual Lethality/Medical Damage: — Enter Code

0. No physical damage or very minor physical damage (e.g., surface scratches).
1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding, sprains).
2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).
3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).
4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).
5. Death

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

Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage, laying on train tracks with oncoming train but pulled away before run over).

0 = Behavior not likely to result in injury
1 = Behavior likely to result in injury but not likely to cause death
2 = Behavior likely to result in death despite available medical care

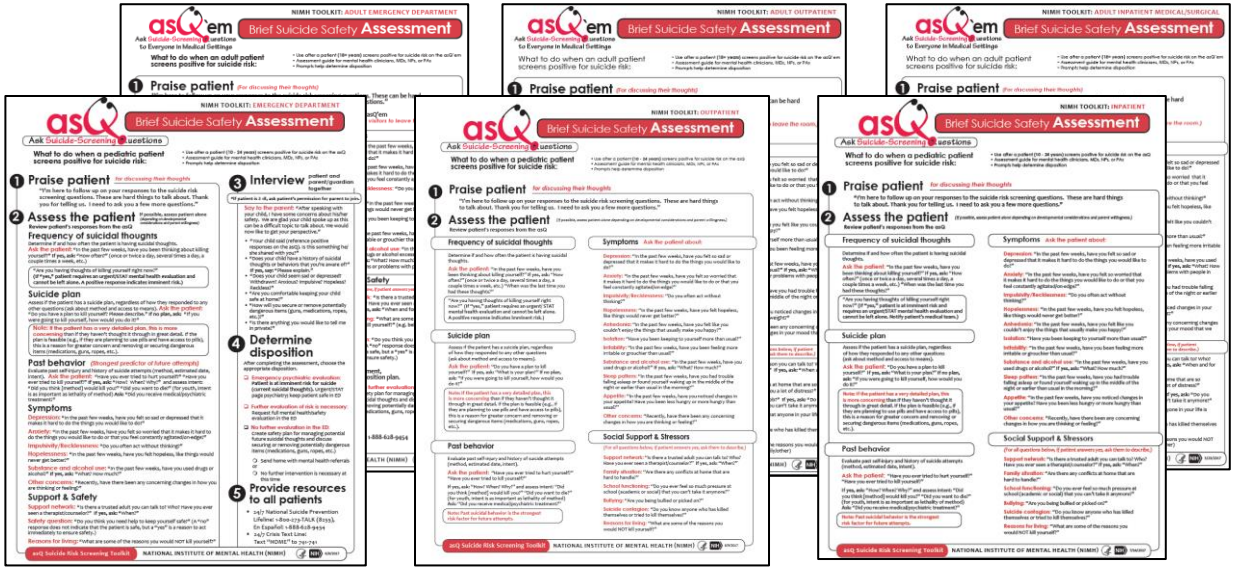
What is the Purpose of the Brief Suicide Safety Assessment?

- To help clinician identify next steps for care

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

Brief Suicide Safety Assessment

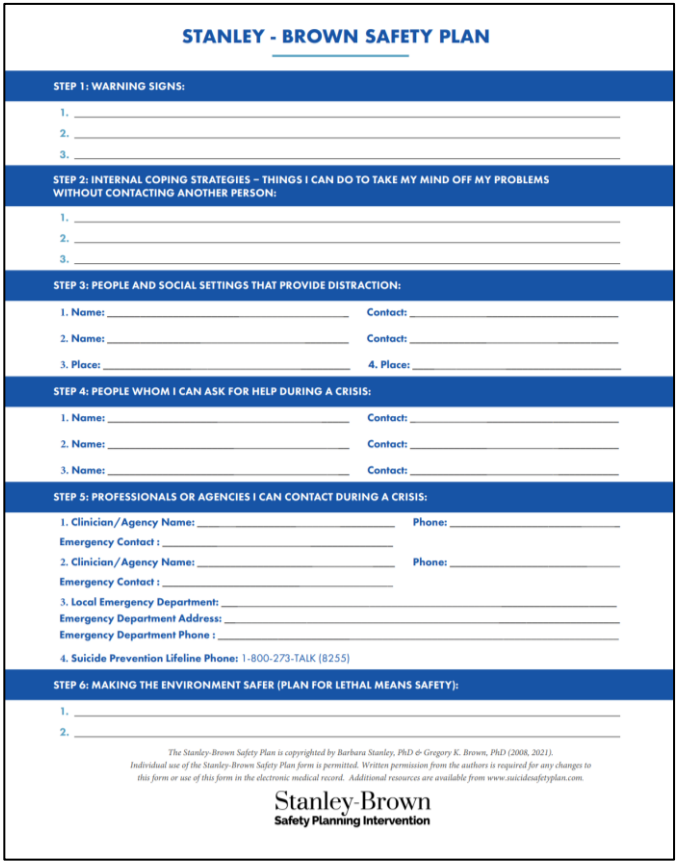
- BSSA and Worksheets available for Youth and Adults
  - Emergency Departments
  - Inpatient Medical/Surgical Unit setting
  - Outpatient settings



The Blueprint Describes A Few Brief Interventions That Can Make a Difference

National Institute of Mental Health

Safety Planning



STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

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

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

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

- Warning Signs
- Coping Strategies
- Social Contacts for Support
- Emergency Contacts
- Reduce Access to Lethal Means

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.

Lethal Means Safety

Provide Resources

Implementation Examples

- Parkland Health and Hospital Systems
  - Implemented house-wide (ED, inpatient medical/surgical, outpatient); screened over 2 million patients
  - Screened over 90,000 young people 12-17yrs with the ASQ
  - 2.9% of screen positive rate across health care settings, with the highest rate in the ED (8.5%)
    - 0.3% acute positive screen rate

Roaten et al. (2020) *Journal of the Academy of Consultation-Liaison Psychiatry*

Implementation Examples

Parkland

OHSU Doernbecher Children's Hospital

Kennedy Krieger Institute

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

Metropolitan Pediatrics, LLC

Boston Children's Hospital
Until every child is well™

Connecticut Children's

Children's Mercy Hospital Kansas

Nationwide Children's

UCSF Benioff Children's Hospitals

NIH National Institutes of Health
Clinical Center

Blueprint is a Guide For Implementing Suicide Prevention

- Identify a multidisciplinary team of champions
- Secure buy-in from senior leadership
- Connect with mental health providers in your community
- Tailor the program to best meet cultural considerations of the patient population you serve
- Train Train Train!!!
- If a patient in your practice dies by suicide

aap.org/suicideprevention

The Blueprint for Youth Suicide Prevention: Community, School, and Policy Resources

www.aap.org/suicideprevention

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American Foundation for Suicide Prevention

Guiding Principle for Blueprint

Suicide is complex and tragic. It can also be **preventable**.

Youth Suicide Prevention: Call to Action

We all have a role to play in supporting youth at risk for suicide.

- Children and adolescents live, learn, play, and seek care in many different settings.
- Cross-sectoral partnerships are critical to building a safety net for youth.

Schools, Colleges, and Universities	Community, Faith, or Parent Organizations	Sporting, Scouts, or Youth Groups	Medical Professionals or Groups	Juvenile Justice System	Child Welfare System	Lawmakers or Policy Organizations
						

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Evidence-Informed Suicide Prevention Strategies

- Increase access to mental healthcare, substance use programs
- Infuse evidence-based clinical pathways into healthcare
- Increase interpersonal connectedness
- Reduce access to lethal means
- Coping, problem solving skills, resilience
- Identify suicide risk and support youth who are struggling
- Focus on equity and lived experience
- Environmental, social, family, economic supports
- Postvention = Prevention

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Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Promoting Equity in Suicide Prevention

Identity on its own is not thought to lead to higher risk of suicide.

Rather, ***experiences of discrimination and inequities impact youth's development, mental health and risk for suicide****.*

We can promote equity in these ways:

- Educate clinical, school, community leaders about health disparities
- Differences in expression of distress between populations
- Provide examples such as those in Blueprint (school to prison pipeline)
- Promote trauma-informed approaches in schools/orgs/health systems
- Meaningful engagement of community members, lived experience

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Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Overview: Community and School Partnerships

Practical Tips for Clinical-Community Partnerships

- Tools to support clinical- community partnerships to prevent youth suicide
  - —Team-based, collaborative care models
  - —Suicide prevention strategies for schools, universities, community organizations
  - —Supporting youth in the juvenile justice system or child welfare system
  - —Tips for making your voice heard at the community level
  - —Promoting equity in suicide prevention efforts

www.aap.org/suicideprevention

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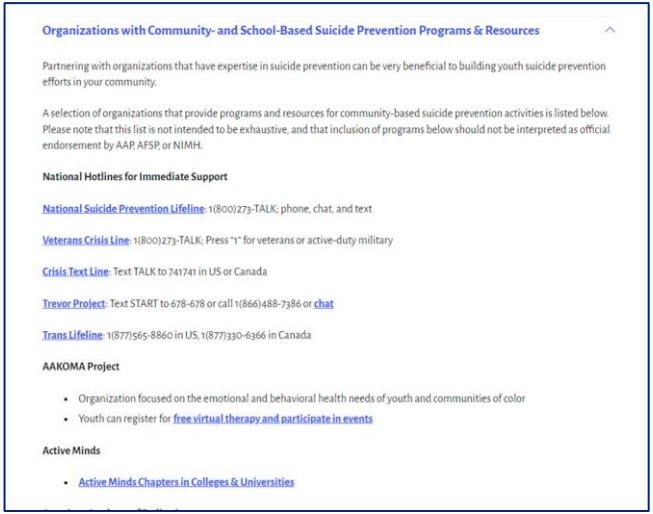
Examples: Community and School Resources

Educational Programs and Community Resources:

- Links to evidence-based suicide prevention education programs
- Links to community-based mental health & suicide prevention resources, tailored for use with diverse populations and identities



Organizations with Community- and School-Based Suicide Prevention Programs & Resources

Partnering with organizations that have expertise in suicide prevention can be very beneficial to building youth suicide prevention efforts in your community.

A selection of organizations that provide programs and resources for community-based suicide prevention activities is listed below. Please note that this list is not intended to be exhaustive, and that inclusion of programs below should not be interpreted as official endorsement by AAP, AFSP, or NIMH.

National Hotlines for Immediate Support

National Suicide Prevention Lifeline: 1(800)273-TALK; phone, chat, and text

Veterans Crisis Line: 1(800)273-TALK; Press "1" for veterans or active-duty military

Crisis Text Line: Text TALK to 741741 in US or Canada

Trevor Project: Text START to 678-678 or call 1(866)488-7386 or chat

Trans Lifeline: 1(877)565-8860 in US, 1(877)330-6366 in Canada

AAKOMA Project

- Organization focused on the emotional and behavioral health needs of youth and communities of color
- Youth can register for free virtual therapy and participate in events

Active Minds

- Active Minds Chapters in Colleges & Universities

www.aap.org/suicideprevention

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Template Outreach Letter

Blueprint for Youth Suicide Prevention: Letters to the Editor

How to Send a Letter to an Editor

- Published letters are usually 150 - 250 words
- Call your local newspaper or look on their website for length limit and submission information; there often is a special email address specifically for submissions (eg, letters@newspaper.com)
- The draft below is about 150 words. You can make it your own by filling in personal information about why you are advocating for suicide prevention; be sure to stay within the length limit
- Be selective. Because letters are so short, choose 1 or 2 key messages. Including a data point can strengthen your position.
- Put the letter in the text of the email; do not send it as an attachment, or it will not be accepted
- Include your name, city or town, and daytime phone number (preferably cell phone) so a paper can verify information
- A newspaper may propose edits or cuts to shorten it; that is ok, as long as the message meaning is not altered

Letter to the Editor Template

Dear Editor,

«Customize your opener to reflect the priorities of your community»

[Open by explaining why the issue is important, eg; *"After years of living with the COVID-19 pandemic, young people in our community are struggling with their mental health," or "The current generation of youth in Smith County are facing unprecedented stressors impacting their day to day lives"*]. Research shows that building resiliency and life skills, promoting connectedness, and encouraging help-seeking behaviors in adolescents and young adults supports overall well-being, helps them thrive, and protects their mental health.

Each of us can help support our young people by reaching out to those around us and checking in, asking "how are you, really?" and being available for a conversation by listening and showing support.

«Personalize your message with your story and action»

One action I'm taking this month is to [provide an example action here, eg: *"speak to my local school board about steps they can take in preventing suicide," or "implement a new training program at my clinical practice to ensure all staff know how to ask the right questions about suicide risk,"*] in partnership with my local [*doctor's office, school or community or faith center*].

«Close with a strong call to action for people in your community»

Together, we can help protect our children and ensure we are all doing our part to prioritize and practice good mental health just as we approach our physical health.

Sincerely,

[NAME]

Overview: Advocacy and Policy Priorities

- Policy and advocacy efforts are needed to:
  - Support youth at immediate risk of suicide
  - Address upstream risk and protective factors
  - Promote equitable access to health and health care
- Key policy priorities at local, state, and federal level

www.aap.org/suicideprevention

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Key Policy Priorities for Youth Suicide Prevention

- Build the evidence base to address disparities in youth suicide
- Increase access to affordable, effective care for all youth
- Promote payment and insurance coverage for mental health services
- Build the mental and behavioral health workforce
- Address lethal means access to reduce suicide risk
- Address disparities in suicide risk via education and policy change
- Foster healthy mental development in children and adolescents
- Support children and adolescents in crisis

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Recap: Blueprint for Youth Suicide Prevention

- Educational resource
- Designed for:
  - Clinicians, public health professionals, educators, advocates
- Strategies to support youth via:
  - Clinical pathways
  - Community partnerships
  - Policy and advocacy
- Co-authored by AAP and AFSP, in collaboration with experts from NIMH
- Endorsed by 18 medical/public health organizations

www.aap.org/suicideprevention

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We Can Do This!

Every adult that works with youth can help save a life

Thank You!

Study teams and staff at

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Harvard Injury Control Research Center
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A special thank you to **nursing staff**, who are instrumental in suicide risk screening.

We would like to thank the **patients** and their **families** for their time and insight.

NIH National Institute of Mental Health

Any questions?

Just asQ !

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Teen Suicide Prevention – Mayo Clinic PSA
(Short Version)

Link to video:
https://www.youtube.com/watch?v=3BByqa7bhto&feature=youtu.be

National Institute of Mental Health