APPENDIX A:

Introduction to the Clinical Pathway for Suicide Risk Screening

Background

Youth suicide is a leading cause of death worldwide ([1]). In 2016, more than 6,000 young people aged 10 to 24 years died by suicide in the United States ([2]). Further, the suicide death rate for children ages 10 to 14 years surpassed the death rate due to motor vehicle accidents for this age group ([3]). Importantly, of children 0 to19 years olds who had died by suicide, 77.4% had visited a health care provider in the year prior to their death and 37.9% in the four weeks prior to their death ([4]). This includes contact with an inpatient, outpatient, or emergency department (ED) setting ([4]). This positions the medical setting as an ideal venue to identify patients at high risk and connect them with mental health care. Consequently, the Joint Commission issued a Sentinel Event Alert in February of 2016 recommending that hospitals screen all patients, **including pediatric patients**, for suicide risk in all medical settings ([5]).

Development of a Clinical Care Pathway for Suicide Risk Screening

The Suicide Risk Screening clinical pathway material was generated by the American Academy of Child and Adolescent Psychiatry (AACAP) Pathways for Clinical Care (PaCC) workgroup to assist hospitals, emergency departments, and inpatient medical/surgical units with the implementation of suicide risk screening pathways for pediatric patients. These pathways can assist healthcare providers in identifying youth at elevated risk for suicide and connecting individuals to the appropriate level of mental health care.

The suicide risk clinical pathway provides guidance for screening pediatric patients for suicide risk in medical settings using the Ask Suicide-Screening Questions (ASQ) and effectively managing patients who screen positive. The ASQ is a four-item questionnaire that has been validated in pediatric patients in medical settings ([6]). The pathway proposes a three-tiered approach to screening: 1) screening for suicide risk with the ASQ (≈ 20 seconds), 2) a brief suicide safety assessment (BSSA) to conduct a more in depth suicide risk assessment for patients who screen positive on the ASQ (≈ 10 minutes), and, if deemed necessary by the BSSA, 3) a full suicide safety assessment that includes a broader mental health assessment. The BSSA is critical in optimizing mental health resources and ensuring a viable screening program. Examples of guides for conducting the BSSA include the ASQ Brief Suicide Safety Assessment (www.nimh.nih.gov/asq) or the Columbia Suicide Severity Rating Scale ([7]).

Suicide risk screening with this three-tiered approach has successfully been implemented in several pediatric hospitals throughout the United States. Over 90% of patients screened for suicide risk were found to be negative with a positive identification rate of 2-8% (unpublished data shared as personal communication with LH, Feb. 2018). This

highlights both the importance of screening to identify these patients as well as the feasibility of conducting the screening without overwhelming hospital resources. By identifying key personnel who will be responsible for each tier of the screening program, and implementing a clear standardized approach to interventions at each risk level, screening can be seamlessly integrated into standard of care.

References:

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4. Ahmedani BK, Simon GE, Stewart C, Beck A, Waitzfelder BE, Rossom R, et al. Health care contacts in the year before suicide death. J Gen Intern Med. 2014;29(6):870-877.
5. Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings. A complimentary publication of The Joint Commission. 2016(56).
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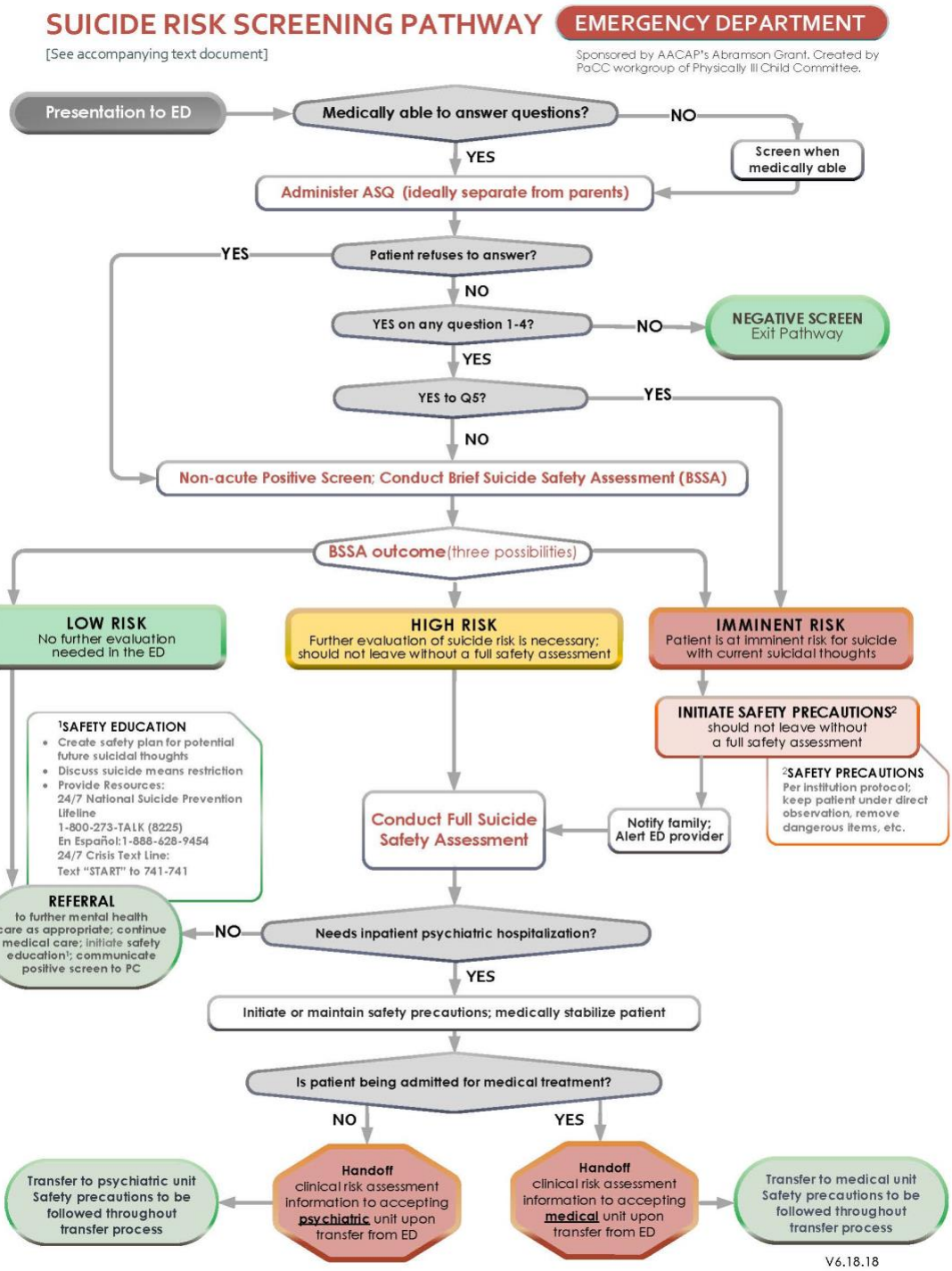
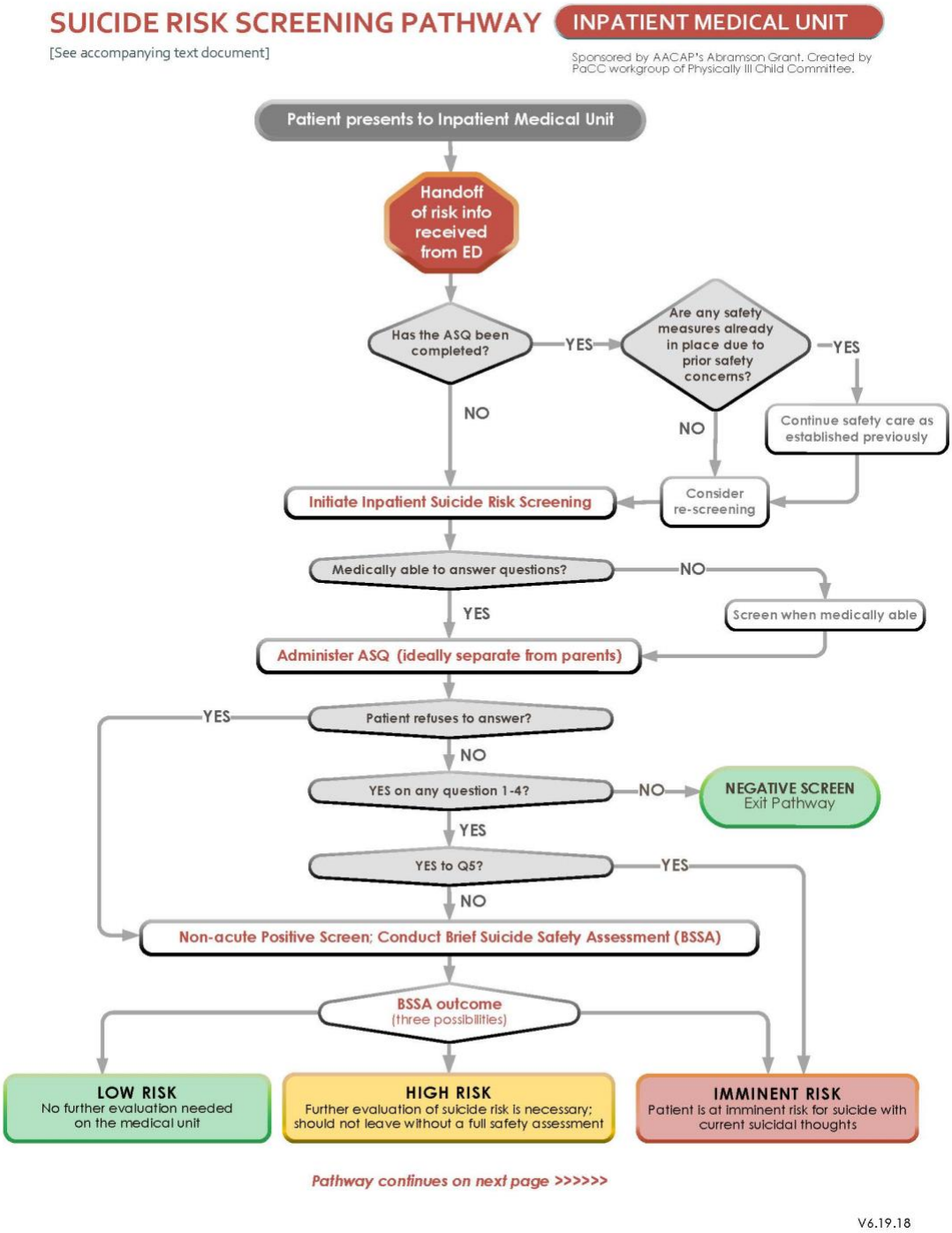
7. Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, et al. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. The American journal of psychiatry. 2011;168(12):1266-77.

APPENDIX B:

B.1 EMERGENCY DEPARTMENT



B.2: INPATIENT UNITS



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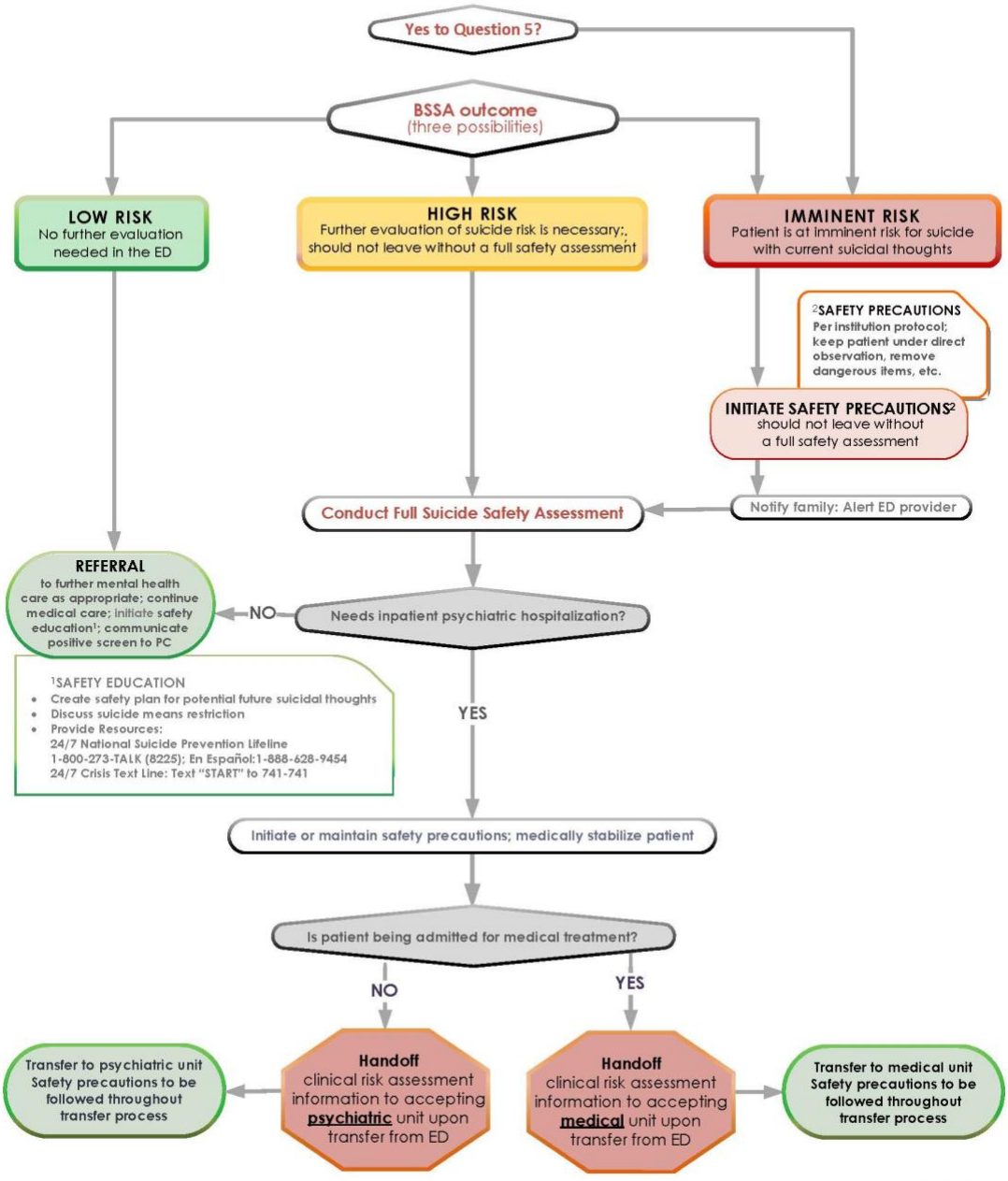
SUICIDE RISK SCREENING PATHWAY

INPATIENT MEDICAL UNIT

Sponsored by AACAP's Abramson Grant. Created by PaCC workgroup of Physically Ill Child Committee.



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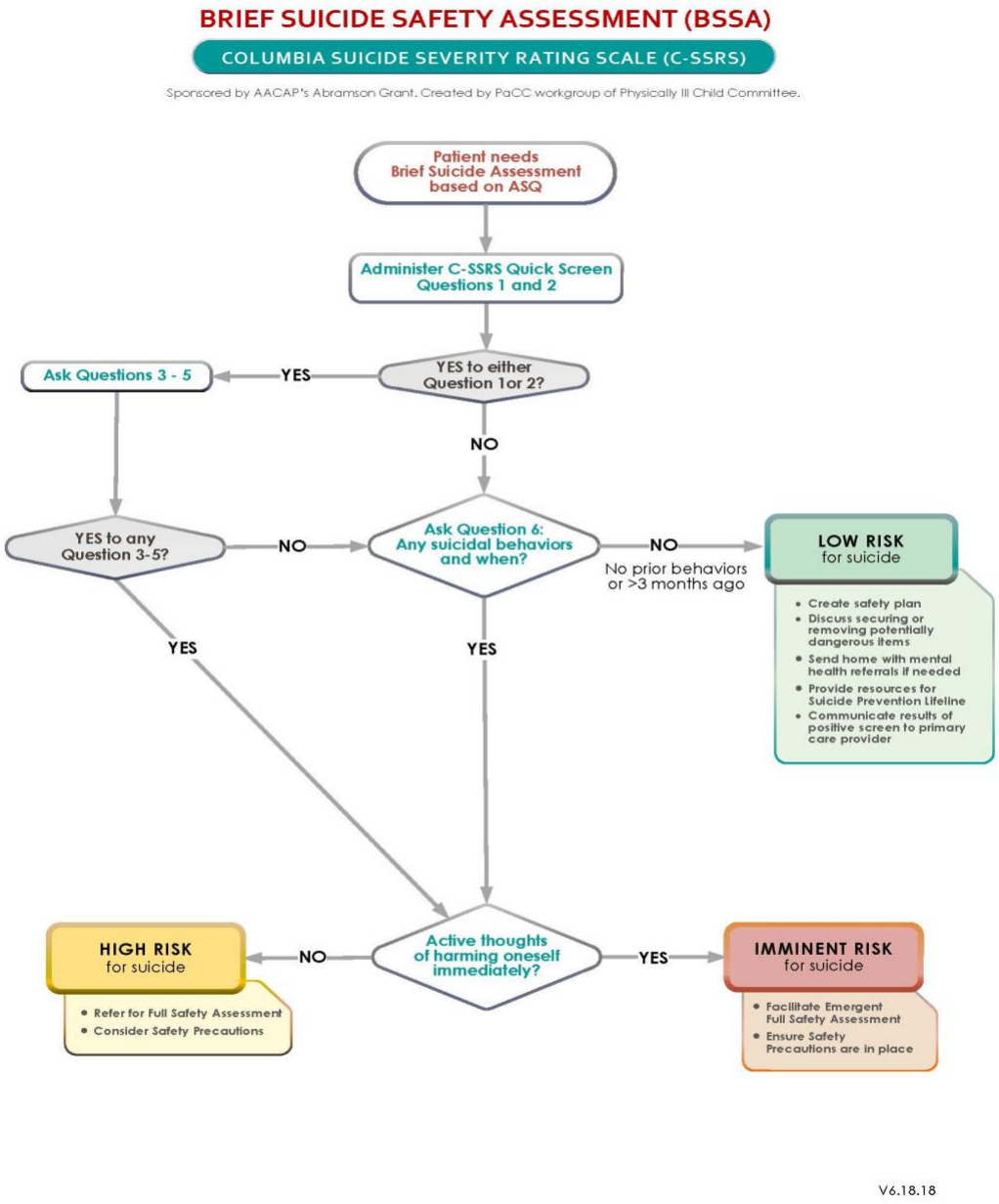
B.3 COLUMBIA SUICIDE SEVERITY SCREENING BREIF SUICIDE SAFETY ASSESSMENT



APPENDIX C:

Suicide Risk Screening Clinical Pathway

I. General Principles of Suicide Risk Screening

A. The Joint Commission has issued a sentinel event alert in 2016 that recommends all patients in medical hospitals, including children, be screened for suicide risk.[1]. While a specific age is not mentioned in the alert, the Pathways for Clinical Care (PaCC) AACAP workgroup recommends screening for ages 10 and above as there are validated scales that can be used for children in this age group. However, for patients who present primarily with psychiatric or behavioral chief complaints, it may be advisable to screen younger children. Patients are eligible to be screened using the Ask Suicide-Screening Questions (ASQ), if they are verbal and medically stable to answer questions. For those who are not medically stable, screening should be considered once the patient is stabilized. For non-verbal patients, alternate methodologies such as the use of picture-assisted communication, caregiver interview, and behavioral observations, can be considered for suicide risk assessment. Depression screening tools, such as the patient health questionnaires (PHQ), are found to be inaccurate in screening for suicide risk. Screening for suicide risk in youth requires the use of pediatric specific validated tools.

B. The ASQ is one of several suicide risk screening tools. It has been validated in patients 10-24 years of age who are being assessed in a medical setting. The ASQ is used to identify patients who may require further evaluation [2]

C. When conducting the screening in patients 18 years of age or older, consent is required to include the parents/guardians in the screening/evaluation and planning process.

D. Hospitals can create appropriate workflows, taking into account their local resources and realities. Where and when in the process screening should occur may vary based on individualized workflows at each site. Generally, PaCC recommends that patients presenting with psychiatric or behavioral health chief complaints be screened as early as possible during the visit, to prevent potential self-harm in the emergency department (ED).

E. It is a myth that asking about suicide will put this idea into a child's heads. Research has shown asking questions about suicide DOES NOT lead to an increase in suicidality, and is actually very helpful and essential in providing the appropriate

level of care to a patient experiencing these thoughts.[3,4,5,6]. It also helps to facilitate more open communication and decrease mental health stigma.

II. Conducting the ASQ Screening:

A. **When to screen:** It is important to share educational material with parents/guardians about screening, such as a parent/guardian informational flyer to be distributed at the beginning of the visit. Generally, PaCC recommends that patients presenting with psychiatric or behavioral health chief complaints be screened for suicide risk at the triage phase of the ED visit. For patients presenting with physical health chief complaints, it is acceptable to screen once they are in an exam room during the initial nursing assessment. For inpatient medical units, it is recommended that screening occur during the initial nursing assessment during patient admission to the unit.

B. **Privacy:** Screening is most often conducted by nursing staff, but this may vary by institution or depend on workflow. The nurse (or other trained screener) asks the parent/guardian to briefly "step out" of the exam room or "step away" (from triage) while the screening is conducted. This is important because the patient may be less likely to give frank responses if the parent/guardian is present during screening. Scripts for how nurses may approach parents/guardians with this request are available in the Appendix. . The screener should not "ask" if it is okay for a parent/guardian to leave the room, but instead make it standard practice to ask parents to step out. However, if the parent/guardian refuses to leave the room or the patient makes a special request that the parent/guardian stay, then screening should proceed with the parent/guardian present. During this "private" interaction, the screener can also inquire about other sensitive questions meant to be asked in private, such as abuse/neglect/substance abuse/sexuality, etc. If the parent/guardian disagrees with performing the evaluation, the medically responsible provider should be alerted and the refusal managed in the same manner as any other medical procedure that is refused.

C. **How to initiate screening:** After the parent/guardian leaves the room, (or with the parent/guardian present if necessary), the screener should begin with, "*Now I'm going to ask you a few questions.*" Tell the patient they may respond with "yes" or "no" and then, while making good eye contact, ask the **first four** ASQ questions <u>verbatim, exactly as they are written.</u> It should take approximately 20 seconds to administer all four questions. If the patient refuses to answer the questions, this should be noted as "refused to answer," which will require further evaluation. The ASQ screen has been validated by means of a live person administering the questions; however, some centers have used tablets and self-report as ways of administering the scale.

D. **Assessment:** Assessing answers to the ASQ should happen immediately, while in the patient's room. Importantly, if the child answers in a way that, in the clinical judgment of the screener, suggests there is reason for concern, the screener can override a negative screen and request the positive screen protocol be followed. Screening results should be interpreted as follows:

1. **Negative Screen:** If the patient answers "**no**" to questions 1 through 4, screening is complete (NEGATIVE SCREEN), and it is not necessary to ask question number 5. No intervention is necessary.
2. **Positive Screen:** If the patient answers "**yes**" to **any** of questions #1-4, or refuses to answer any one of the questions, they are considered a POSTIVE SCREEN for suicide risk. At this point, the nurse should ask question #5, "Are you having thoughts of killing yourself right now?" This is done in order to assess clinical acuity in the ED. There are two ways to screen positive for suicide risk: acute and non-acute.
    a. **Acute Positive Screening**: If the patient answers "yes" to question #5, they are considered an acute positive screen, and possibly at **imminent** risk for suicide. The screener should explain the results and next steps as per the script in the Appendix. The patient should then be treated per standard of care for suicidal patients in the ED. The patient requires an emergent full-safety evaluation (see below for more details). The Patient cannot leave the ED until evaluated thoroughly for safety. If a parent denies or declines further evaluation of safety after screening positive, the attending physician should be alerted. This matter should be treated according to the same rules of the institution as when a parent/guardian declines what is considered urgent medical care for other life threatening conditions. Safety precautions, such as direct observation of the patient, and environmental precautions (e.g., removal of all dangerous objects from the room and patient's belongings) should be followed. The medically responsible provider should be alerted.
    b. Non-acute Positive Screen: If the patient answers "yes" to any of the questions #1-4, but answers "no" to question #5, they are considered a non-acute positive screen, meaning that *potentia*l suicide risk has been identified and requires further evaluation. The nurse should use the scripts found in the Appendix to describe the next steps to the patient and parents. The patient requires a brief suicide safety assessment (BSSA) to determine whether or not a full safety assessment is needed (see below for more details). The patient cannot leave the ED until evaluated for safety. If a parent denies or declines further evaluation of safety after screening positive, the attending physician should be alerted. This matter should be treated according to the same rules of

the institution as when a parent/guardian declines what is considered urgent medical care for other life threatening conditions. The medically responsible provider should be alerted

III. Brief Suicide Safety Assessment (BSSA):

Essential to the success of suicide screening implementation is a three-tiered approach that includes a BSSA. When screening with the ASQ yields a non-acute positive screen, a brief safety assessment should be conducted in order to determine whether or not a full suicide safety assessment and safety measures are required in the ED. This BSSA should typically be conducted by a trained mental health or medical provider, and usually takes less than 10 minutes. Not every patient who screens positive on the ASQ initial screen will require intensive safety precautions or a full safety evaluation. Using the BSSA optimizes mental health resources and ensures a viable screening program.

A. General principles of a BSSA

1. The BSSA is utilized when the initial screening with ASQ is a **NON-ACUTE POSITIVE SCREEN.**
2. The purpose of this assessment is to determine whether a more thorough, full, mental health/safety assessment is needed.
3. The BSSA should typically be a 10-minute or less evaluation conducted by a **trained mental health provider** (for example an MD/DO, NP, PA, LCSW or other mental health provider).
4. The PaCC recommends using standardized questionnaires as a guide for assessing risk and the need for further intervention, i.e., the ASQ BSSA or the Columbia Suicide Severity Rating Scale (C-SSRS) BSSA.
5. After the BSSA is completed, the trained mental health provider must determine level of risk (imminent, high, low) to decide next steps.

B. ASQ Brief Suicide Safety Assessment (see Toolkit at www.nimh.nih.gov/asq. for more details)

1. Explain your role and praise patient for discussing their thoughts. Explain to the patient that the details of the information they share is confidential, though you will share any concerns about their safety with parent/guardian. Inform them that you will be speaking with the parents separately. Scripts for introducing the BSSA can be found in the Appendix.

2. Assess the patient (separated from parent/guardian if possible) by reviewing responses from the ASQ. This assessment involves determining the presence and frequency of suicidal thoughts, the presence of a suicide plan, the presence of self-injury and history of suicide attempts, assessment of

psychiatric symptoms that are associated with increased risk of suicide, and support network; and using sources of collateral information to supplement the information provided by the patient. These elements are described in more detail below.

a. Determine if and how often the patient is having suicidal thoughts by asking, "*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.) In general, more frequent thoughts are concerning for higher risk of suicide, though other factors have to be considered.
b. Assess if the patient has a suicide plan. You can ask "*Do you have a plan to kill yourself*?" **If they respond YES, ask,** "*Please describe*." **If no plan, ask**: "*If you were going to kill yourself, how would you do it*?" Patients who have a detailed plan or have made efforts to execute on a possible plan (e.g., collect pills, do research on what to do, etc.) are considered to be at higher risk for suicide.
c. Evaluate past self-injury and history of suicide attempts. Ask "*Have you ever tried to hurt/harm yourself in any way*?" **If yes, ask**: "*How? When? Why*?". "*Have you ever tried to kill yourself*?" **If yes, ask:** "*How? When? Why*?" **AND** assess intent: "*Did you believe [method] would kill you*?" "*Did you want to die*? "*Did you receive medical/psychiatric treatmen*t?" Past attempts at suicide significantly increase the risk for of future suicide attempts.
d. Assess for symptoms of depression, anxiety, impulsivity/recklessness, hopelessness, substance and alcohol use, and other concerns as these are often the underlying diagnosis or concerns that are known to increase the risk of suicide in a patient who experiences them.
    i. **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?*"
    ii. **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*?"
    iii. **Impulsivity/Recklessness:** "*Do you often act without thinking*?"
    iv. **Hopelessness:** "*In the past few weeks, have you felt hopeless, like things would never get better*?"
    v. **Irritability:** "*In the past few weeks, have you been feeling more irritable or grouchier than usual*?"

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

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

e. Ask about support network, reasons for living, and if patient believes they need help to keep themselves safe.

i. **Support network:** "*Is there a trusted adult you can talk to*?" *Who*? *Have you ever seen a therapist/counselor*?" **If yes, ask:** "*When*?" Having a supportive adult in their life and/or being engaged in therapy/counseling can be a protective factor in those at risk for suicide.

ii. **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.)

iii. **Reasons for living:** "*What are some of the reasons you would NOT kill yourself*?" OR "*How have you been able to resist killing yourself in the past*? "

3. Thank the patient for answering the question.

4. Interview the parent/guardian alone. Introduce your role and the purpose of the brief assessment as described in the scripts located in the Appendix.

a. Gather parent/guardian perspective regarding patient's response to ASQ questions. "*Your child said (reference positive responses on the ASQ). Is this something he/she has shared with you?" "What do you make of their response?*"

b. Ask about past suicidal thoughts or behaviors. You can say "*Does your child have a history of suicidal thoughts or behaviors that you're aware of*?" **If yes, say:** "*Please share what you know*."

c. Assess parent/guardian perspective on symptoms of depression, anxiety, impulsivity, hopelessness, irritability or recklessness. "*Does your child seem sad or depressed or irritable all the time? Withdrawn? Anxious? Impulsive? Hopeless? Reckless?*"

d. Ask if parent/guardian is comfortable keeping patient safe at home. "*Given what I have shared with you so far, how comfortable are you keeping your child safe at home*?" Ask specifics if needed.

e. Assess follow up options/access to care including if actively engaged in mental health treatment. You can say, "*When they go home I believe they would benefit from mental health care to help address (suicidality and underlying factors)". "Has your child ever seen a mental health provider before?" "How did it go?" "Are you open to taking your*

child to a mental health care provider when the child comes home?"
"How easy or possible do you think this will be for you?"

f. Ask parent/guardian if there is anything else that they would like to discuss "*Is there anything you would like to tell me*?" and ask "*is there anything you would like to tell me in private*?" in case they have some information that they did not want to share in front of the child.

5. Based on the interview, determine if patient is at imminent, high, or low risk and the next steps you think should be taken (see section D - Risk levels below)

C. Columbia Suicide Severity Rating Scale Brief Suicide Safety Assessment (C-SSRS BSSA) (see C-SSRS BSSA Visio for more details)

1. Explain your role and praise patient for discussing their thoughts. Explain to the patient that the details of the information they share is confidential, though you will share any concerns about their safety with parent/guardian. Inform them that you will be speaking with the parents separately. Scripts for introducing the BSSA can be found in the Appendix.
2. Assess the patient (separated from parent/guardian if possible) by asking questions from the C-SSRS BSSA.
   a. Confirm presence of suicidal ideation by clarifying ASQ responses and asking questions #1 and #2. These questions can be adapted to the age of the child and could include any of the following phrases:
      i. Question #1 assesses for a wish to be dead: "*In the past month have you wished you were dead or wished you could go to sleep and not wake up*?" or "*In the past month have you thought about being dead or what it would be like to be dead*?" or "*In the past month, do you ever wish you weren't alive anymore*?"
      ii. Question 2 assesses for non-specific active suicidal thoughts: "*In the past month have you had any thoughts of killing yourself*?" Or "*In the past month have you thought about doing something to make yourself not be alive anymore*?"
      iii. **If patient respond yes to either question 1 or 2:** Ask questions #3-#5 (see below).
      iv. If no to both questions: Ask question #6
   b. Assess for suicidal methods, intent, and plan by asking questions #3-#5.
      i. Question #3 assesses for active suicidal ideation with any methods: "*In the past month have you been thinking about how you might kill yourself*?" or "*In the past month, have you thought about how you would make yourself not be alive anymore*?"

ii. Question #4 assesses for active suicidal ideation with some intent to act: "*In the past month, have you had these thoughts and wanted to act on or carry out the thoughts*?" or "*In the past month, when you thought about making yourself not alive, did you think this was something you might actually do*? *This is different from having thoughts but knowing you wouldn't do anything about them*."
iii. Question #5 assesses for active suicidal ideation with a specific plan: "*In the past month, have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan*?" Or "*In the past month, have you ever decided how or when you would make yourself not alive anymore (or kill yourself)? Have you ever planned out how you would do it? What was your plan? When you made this (or worked out these details), was any part of you thinking about doing it*?"
iv. **If response is YES to any of these questions:** Patient is considered high risk and will require a full suicide safety evaluation (see below). If patient is having active thoughts of killing themselves now they are considered at **imminent risk** and need safety precautions in place in addition to an emergent full suicide safety evaluation (see below).
v. **If they respond NO to all questions:** Ask question #6

c. Assess for past suicidal behavior by asking question #6: "*Have you ever done anything, started to do anything, or prepared to do anything to end your life*?" or "*Did you ever do anything to try to make yourself not alive anymore (or kill yourself)? Did you every hurt yourself on purpose*?" Suicidal behavior includes **actual attempts** (a potentially self-injurious act committed with at least some wish to die), **aborted or self-interrupted attempts** (when a person takes steps towards making a suicide attempt, but stops him or herself before actually engaging in any self-destructive behaviors), **interrupted attempts** (when a person is interrupted by an outside circumstance from starting the potentially self-injurious act), and **preparatory acts** or behaviors (acts or preparation toward imminently making a suicide attempt).
i. **If they respond YES to behaviors within the past 3** month**:** Patient is considered high risk and will require a full suicide safety evaluation (see below). If patient is having active thoughts of killing themselves now they are considered at **imminent risk** and need safety precautions in place in addition to an emergent full suicide safety evaluation (see below)
ii. **If they respond NO or if behaviors have been longer than 3 months:** Patient is considered low risk and is safe to discharge

home from the ED with appropriate safety planning and referrals (see below for more details).

3. Thank the patient for answering the question.

4. Interview the parent/guardian alone. Introduce your role and the purpose of the brief assessment as described in the scripts located in the Appendix.

    a. Gather parent/guardian perspective regarding patient's response to the C-SSRS BSSA questions. "*Your child said (reference positive responses on the C-SSRS). Is this something he/she has shared with you*?" "*What do you make of their response*?"
    b. Ask parent/guardian if there is anything else that they would like to discuss "*Is there anything you would like to tell me*?" and ask "*is there anything you would like to tell me in private*?" in case they have some information that they did not want to share in front of the child.

5. Based on interview, determine if patient is at imminent, high, or low risk and the next steps you think should be taken (see section D- Risk levels below)

D. **Risk Levels** Based on answers to ASQ or CRSS BSSA, the patients can be identified as being at imminent, high, or low risk for suicide. Once the risk level is identified, discuss the results with patient and parents as described in sample scripts (see Appendix), and take the necessary steps to maintain the safety of the patient while addressing any need for interventions. Risk stratification and proposed intervention are applicable in the ED and inpatient settings.

1. **Imminent risk** for suicide (current, active suicidal thoughts)→ needs emergency psychiatry evaluation
    a. Ensure safety precautions are in place. (Follow your institution's protocol. Examples include: keeping patient under direct observation, removing dangerous items, etc.)
    b. Emergency full mental health/safety evaluation
2. **High risk** for suicide →needs full mental health safety evaluation
    a. Request routine full safety evaluation
    b. If appropriate or needed, consider safety precautions (follow your institution's protocol. Examples include: keeping patient under direct observation, removing dangerous items.

3. **Low risk** for suicide→ no further evaluation needed at this time
    a. Create safety plan for managing potential future suicidal thoughts:
        i. Ensure that they have a safe plan. Further ask "*What are your plans for making sure other potentially dangerous items are also*

out of your child's reach (medications, sharps etc.?" Ensure that they have a safe plan; help them make a plan if they are unclear what to do.

b. Discuss securing or removing potentially dangerous items:
    i. Discuss means restriction (securing or removing dangerous objects such as guns, medications or ropes). You can say "*We strongly recommend that when the child comes home you either remove dangerous items from the home or make sure your child doesn't have access to them*." Common examples include guns, all medications, ropes, knives etc. Ask, "*Do you have a gun or other weapon at home*?" If YES ask, "*What can you do to make sure your child cannot use this to harm themselves*?"
c. Send patient home with mental health referrals if needed.
d. Provide resources for Suicide Prevention Lifeline and 24/7 Crisis Text Line.
e. Communicate results of positive screen to primary care provider.

IV. Full Suicide Safety Assessment

A. General Principles of a Full Suicide Safety Assessment

1. The full suicide safety assessment is completed when there is an acute positive screen from the ASQ or high or imminent risk from the BSSA (ASQ or CRRS). If BSSA occurred previously, it should be reviewed.

2. The purpose of a full suicide safety assessment is to:

    a. Further assess suicide safety risk and determine interventions needed to keep patient safe such as:

        i. Need for the patient to be under direct observation.
        ii. Level of safety precautions (such as restrictions on access to sharps, electronics, specific articles of clothing, cords etc) that need to be in place.
        iii. Need for hospitalization in an inpatient psychiatric setting for ongoing suicide safety monitoring and treatment of underlying cause.

    b. Develop an initial differential diagnosis.

    c. Formulate the case according to the biopsychosocial model.

d .Develop a treatment plan in collaboration with the youth and the parent/guardian.

3. The full suicide safety assessment is typically completed by a licensed mental health provider such as a psychiatrist, psychologist, psychiatric nurse practitioner, physician assistant, MSW/LCSW, or other trained mental health professional.

4. During the full suicide safety assessment, at least a portion of the time should be spent interviewing the patient and caregivers separately

5. It is important to obtain collateral information when possible since many children and adolescents may not to share all pertinent information..

6. While this document highlights the important components of a full suicide safety assessment it is not intended to be a comprehensive review for conducting a full suicide safety assessment. Please refer to appropriate materials and ensure providers are clinically trained to conduct suicide safety assessments.

B. Components of a full suicide safety assessment:

1. Interview process:

    a. Speak to medical team to clarify consultation question and review the medical record
    b. Introduction and explanation of the purpose of the interview should be provided to the parents/guardians and the youth together
    c. Ideally, at least part of the interview with the youth should be conducted without the presence of family members/visitors
    d. At least part of the interview with parents/guardians should be conducted withoutthe presence of the patient

2. If possible, collect collateral information to facilitate a comprehensive assessment. Collateral information can include: outpatient mental health providers, school staff, child protective services, department of children and family services, correction officers, and pharmacies

3. Complete assessment based on bio-psycho-social model including clear identification of risk as well as protective factors

i. Assess for more details regarding suicidal ideation and intent
ii. Collect information regarding past suicide attempts and non-suicidal self-injury
iii. Evaluate for additional risk and protective factors that may influence the desire to attempt suicide:
    1. Common risk factors may include feelings of hopelessness, evidence of major depressive disorder or severe anxiety, ongoing acute stressors, substance use, history of non-suicidal self-injury.
    2. Common protective factors may include strong support network, strong belief system, and active engagement in treatment.
iv. Obtain information about past psychiatric and medical histories, family history and social history.
v. Evaluate for potential contributing psychiatric conditions such as major depressive disorder, bipolar affective disorder, substance use disorders, and anxiety disorders.
vi. Evaluate current mental status.

b. Recommendations
    i. Should be communicated to both parent/guardian and the youth together and clearly communicated to the medical team
    ii. If psychiatric hospitalization is recommended, the following should be completed:
        1. The patient remains in as secure an environment as possible. A secure environment includes but is not limited to: close supervision, removing dangerous objects from the room, decreasing attachment points potentially used for strangulation, removal of personal items including communication devices, and careful consideration of visitor list.
        2. Information about the hospitalization and process should be communicated to the youth and family.
        3. Safety precautions should continue until transfer takes place and ensured during transfer.
    iii. If the patient is felt to be safe to discharge home (upon medical clearance), a safety plan should be completed with the patient and their family. The safety plan typically includes restriction of means such as removing firearms from home and securing all medicines in home including over-the-counter medicines. The safety plan can also include coping strategies, provide crisis resources, and an outline of a follow-up plan for mental health care.
        1. Creating a safety plan if patient will be discharged:

a. Warning signs of a crisis that may be developing: e.g., increasing isolation, increasing irritability, suspicious behavior, increased feelings of loneliness or sadness, etc.
b. Restriction of Means: e.g., locking up medications including over the counter medications
c. Secure weapons including guns in the home are removed or locked away and not accessible
d. Identify internal coping strategies and distractions such as listening to music, physical activity, relaxation techniques or distress tolerance skills, calling a friend
e. Identify who to contact if a crisis arises: parent, friend, clinician, urgent care/ED, 24/7 National Suicide Prevention Lifeline 1.800.273.TALK (8225), En Espanol: 1.888.628.9454, 24/7 Crisis Text Line: Text "START" to 741-741
f. Example of a safety plan template: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

APPENDIX D:

Suicide Risk Screening

Sample Scripts

1) Conducting the ASQ Screen:

    a. If parent/guardian is present, say to patient and parent/guardian together: *National safety guidelines recommend that we screen all patients for suicide risk and/or safety concerns. We ask these questions in private so I'm going to ask you (parent/guardian) to step out of the room for a few minutes. If we have any concerns about your child's safety we will let you know.* (If the parent/guardian insists on staying, continue the screening with parent/guardian present).
    After the caregiver leaves the room, say: *Now I am going to ask you a few questions. . .*

    b. If patient is alone: *National safety guidelines recommend that we screen all patients for suicide risk. Now I am going to ask you a few questions. . .*

2) Assessed ASQ Initial Screen as NEGATIVE SCREEN:

    a. Patient and Parent/Guardian: *I appreciate you taking the time to speak with us/fill out the form to help assess your risk for suicide. Based on your responses, we think that you are currently feeling safe.*

3) Assessed ASQ Initial Screen as ACUTE POSITIVE SCREEN:

    a. Patient: *I'm so glad you spoke up about this. I'm going to talk to your parent/guardian and your medical team. Someone who is trained to talk with children/teens about suicide is going to come speak with you. In order to keep you safe, we will be implementing safety precautions* (describe safety precautions).

    b. Parent/Guardian: *We have concerns about your child's risk for suicide that we would like to further evaluate. It's really important that he/she/they spoke up about this. I'm going to talk to your medical team, and someone who is trained to talk with children/teens about suicide is going to come speak with you and your child. In order to keep your child safe, we will be implementing safety precautions* (describe safety precautions).

4) Assessed ASQ Initial Screen as NON ACUTE POSITIVE SCREEN:

   a. Patient: *I'm so glad you spoke up about this. We are going to need to get more information in order to make sure we can provide the best care for you. I'm going to talk to your parent/guardian and your medical team. Someone who is trained to talk with children/teens about suicide is going to come speak with you further.*

   b. Parent/Guardian: *We have some concerns about your child's risk for suicide that we would like to further evaluate. It's really important that he/she spoke up about this. I'm going to talk to your child's medical team, and someone who is trained to talk with children/teens about suicide is going to come speak with you and your child.*

5) Brief Suicide Safety Assessment Introduction:

   a. Patient: *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. I have spoken with your parents/guardians separately.* (Or, if you have not spoken with parent/guardian first say: *after I speak with you I will talk with your parents/guardians separately*). *I am required to share any safety concerns I may have with your parent/guardian though everything else will be confidential*.

   b. Parent/Guardian: *I'm here to follow-up on your child's responses to the suicide risk screening questions. These are hard things to talk about. I am really glad he/she/they was/were able to share this with us. I need to ask him/her/them a few more questions. We ask these questions in private so I'm going to ask you to step out of the room for a few minutes. I am required to share any safety concerns I may have with you, though everything else is confidential. If after the evaluation we have any concerns about your child's risk for suicide, we will let you know. After (Before* – if speaking with parent/guardian first) *speaking with him/her/them I would like to get your perspective on any concerns you might have about his/her/their risk for suicide.*

6) After the Brief Suicide Safety Assessment:

   a. Patient: *I appreciate you sharing this information with me. Based on what you have shared and what I learned from your parent/guardian I think you are …*

i. **For low risk patients say:** … *dealing with some challenges (mood/anxiety, etc.), but not currently at risk for suicide. However, it is very important that you get the help you need to deal with these feelings and reduce your chances of developing thoughts of suicide. I will share some resources with your parent/guardian to help you with getting the help you need.*

ii. **For high risk patients say:** *... experiencing thoughts of suicide, even though you do not have a specific plan at this time. I am concerned that you are at risk for suicide and will need a full suicide safety assessment to better understand how we can best help you. While you are waiting, we will keep you safe by implementing safety precautions* (describe the safety precautions).

iii. **For imminent risk patients say**: … *experiencing thoughts of suicide and have an active thought or plan to carry it out at this time. I am very concerned about your risk for suicide and you will need an evaluation with a full suicide safety assessment to better understand what might be contributing to this risk and how we can help. While you are waiting, we will keep you safe by implementing safety precautions* (describe the safety precautions).

b. Parent/Guardian: *We are glad your child spoke to us about this as mental health concerns can be a difficult topic to talk about. Based on my discussion your child as well as my discussion with you, , I think your child is …*

i. **For low risk patients say:** *... dealing with challenges (mood/anxiety, etc.) but not currently at risk for suicide. However, it is very important that he/she/they get the help he/she/ needs to deal with these emotions and reduce his/her/their chances of developing thoughts of suicide. I will share some resources with you to help you with getting him/her the help they need.*

ii. **For high risk patients say:** *... experiencing thoughts of suicide even though he/she/they does/do not have a plan at this time. I am concerned that he/she/they is/are at risk for suicide and will need a full suicide safety assessment to better understand what might be contributing to this risk. While you are waiting, we will keep you safe by implementing safety precautions* (describe the safety precautions).

iii. **For imminent risk patients say:** *... experiencing thoughts of suicide and currently have an active thought or plan to carry this out. I am very concerned about his/her/their risk for suicide and he/she/they will need a full suicide safety assessment to better understand what*

might be contributing to this risk and how we can help. While you are waiting, we will keep him/her safe by implementing safety precautions (describe the safety precautions).