YOUTH SUICIDE RISK SCREENING PATHWAY

OUTPATIENT PRIMARY CARE & SPECIALTY CLINICS

Presentation to Outpatient Primary Care & Specialty Clinics

Screen all patients ages 10 and above who meet any of the screening criteria.*

Medically able to answer questions?

NO → Screen at next visit

YES → Administer ASQ (ideally separate from parents)

YES on any question 1-4 or refuses to answer?

NO → **NEGATIVE SCREEN** Exit Pathway

YES → **YES to Q5?**

YES → IMMINENT RISK

NO → **Non-acute Positive Screen; Conduct Brief Suicide Safety Assessment (BSSA)**
Detailed instructions about the BSSA can be found at www.nimh.nih.gov/ASQ

BSSA outcome (three possibilities)

*SCREENING CRITERIA

1. New patient
2. Existing patient who has not been screened within the past 30 days
3. Patient had a positive suicide risk screen the last time they were screened
4. Clinical judgement dictates screening
5. Screen 8 and 9 year olds who present with behavioral health chief complaints

Q4 FACTORS TO CONSIDER (past suicidal behavior):

If patient answered "yes" to Q4, and the patient has been screened before, ask: "**Since last visit, have you tried to kill yourself?**" If they answer "no" and they also answered "no" to Q1-3, then consider "Low Risk" choice for action.

If the only "yes" answer is to Q4:

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

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

LOW RISK
No further evaluation needed at this time

Would benefit from a non-urgent mental health follow-up?

NO → No referral needed at this time

YES → **REFERRAL** to further mental health care as appropriate; Continue medical care; Initiate safety plan for potential future suicidal thoughts

FURTHER EVALUATION NEEDED
Mental health referral needed as soon as possible

Make a safety plan with the patient and parent/guardian to activate as needed.

If mental health evaluation is not available within practice, refer to outpatient mental health clinician.

Schedule a follow up with patient within 72 hours for safety check and to determine whether or not they were able to obtain a mental health appointment

IMMINENT RISK
Patient has acute suicidal thoughts and needs an urgent full mental health evaluation

INITIATE SAFETY PRECAUTIONS[1]
Until able to obtain full mental health evaluation

[1]**SAFETY PRECAUTIONS**
Per institution protocol; keep patient under direct observation, remove dangerous items, provide safety education, etc.

Send to emergency department for full mental health/safety evaluation

SAFETY PLANNING

- Create safety plan for potential future suicidal thoughts, including identifying personal warning signs, coping strategies, social contacts for support, and emergency contacts. Detailed instructions about safety planning can be found at https://www.sprc.org/resources-programs/patient-safety-plan-template
- Discuss lethal means safe storage and/or removal with both parent/guardian and child (e.g. ropes, pills, firearms, belts, knives)
- Provide Resources: 24/7 National Suicide Prevention Lifeline
- 1- 800-273-TALK (8255), En Español:1-888-628-9454, 24/7 Crisis Text Line: Text "START" to 741-741

If suicide risk becomes more acute, instruct patient/parent/guardian to contact outpatient healthcare provider to evaluate need for ED visit.

Schedule all patients who screen positive for a follow-up visit in 3 days to confirm safety and determine if a mental health care connection has been made. Future follow-up primary care appointments should include re-screening patient, reviewing use of safety plan, and assuring connection with mental health clinician.