Acute Suicidal Behavior in Children and Adolescents

Risk Assessment, Screening, Resources and Guidance

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LEARNING OBJECTIVES

1. Gain an understanding of the importance of screening for suicide in teens and adolescents.
2. Working knowledge of the screening tools available.
3. How and where to find resources for providers as well as youth and families.
4. How to talk to youth, adolescents and families about suicide.

Disclosure Statement

- I do have a relevant financial relationship with commercial interest whose products and services relate to the content of the educational presentation.
  - Company: EOCCO/Moda
  - To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review for best evidence.

Suicide is a problem of Humanity but Preventable

- Everday there are approximately 12 youth death by suicide
- Everday (<25 y/o) dies by suicide every 2 hours 1 minute
- The number of children and adolescents dying by suicide is increasing over time. Patterns for who is at risk are also changing, leading to a need to review clinical suicide prevention progress and identify limitations with existing practices and research that can help us further address this growing problem.
- 14-18 y/o 2021: 9/100,000, 3rd leading cause of death, 1,952 suicides occurred
- From 2019-2021 Females seriously considered plan 24% to 30%, attempts % to 13.3 % Males had been stable 13% to 14.3% indication increasing
- Male and Female Black, Hispanic, LGBTQ+ had increase in self injury that required medical treatment
- The suicide Analyses revealed that the suicide rate among those younger than 13 years is approximately 2 times higher for black children compared with white children

More Statistics

- Researchers found that between 2008 and 2018, the suicide rate among 13- and 14-year-olds nationwide more than doubled — from roughly two deaths per 100,000 teens in 2008, to five per 100,000 a decade later.
- For youth (10–24 year olds), suicide was the second leading cause of death in 2017, accounting for 6,758 deaths. Suicide patterns are also changing with groups historically at lower risk now at increased risk—the suicide rate for females 10–14 years old tripled from 1999 (0.5/100,000) to 2014 (1.5/100,000), narrowing the gap between male and female rates of suicide (Ruch et al., 2019).
- The suicide rate among black boys and girls younger than 13 years was approximately 2 times higher than white children from 2001–2015 (Bridge et al., 2018).
- The proportion of Emergency Department (ED) and inpatient visits for suicidal ideation and attempts nationally nearly doubling between 2008 (0.66%) and 2015 (1.82%) among youth 5–17 years old (Dueweke, Marin, Sparkman, & Bridges, 2018).

Statistic Resources

- April 2023 www.cdc.gov/mmwr/volumes/72/su/su7201a6.htm
- https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7190447/
- https://jamanetwork.com/journals/jamapediatrics/article-abstract/2680952?redirect=true
- US NEWS May 2023:
- Sarah Wood, MD, professor, pediatrics, interim chair, department of women's and children's health, Schmidt College of Medicine, Florida Atlantic University, Boca Raton; Joseph Feinglass, PhD, research professor, medicine, Northwestern University Feinberg School of Medicine, Chicago; *Annals of Pediatrics and Child Health*, March 19, 2023, online

ACCESS

The Bowman Family Foundation

For children and teens under 18 (defined here as “adolescents”), the “care not received” figure was 69% for mental health or substance use compared to 17% for physical health. This indicates that adolescents had worse access than adults to mental health and substance use care, but better access than adults to physical health care.

https://www.mhtari.org/Survey_Conducted_by_NORC.pdf

American Academy of Pediatrics

- Universal Screening ages 12+
- 8-11 y/o Screen when clinically indicated
- < 8 y/o warning signs

Why Universal Screening

- Youth and adults respond to direct questioning and youth do not typically bring it up on their own
- More comprehensive to screen everyone which promotes equity and better community care
- Unmask other mental health issues
- Helps all patients feel less alone

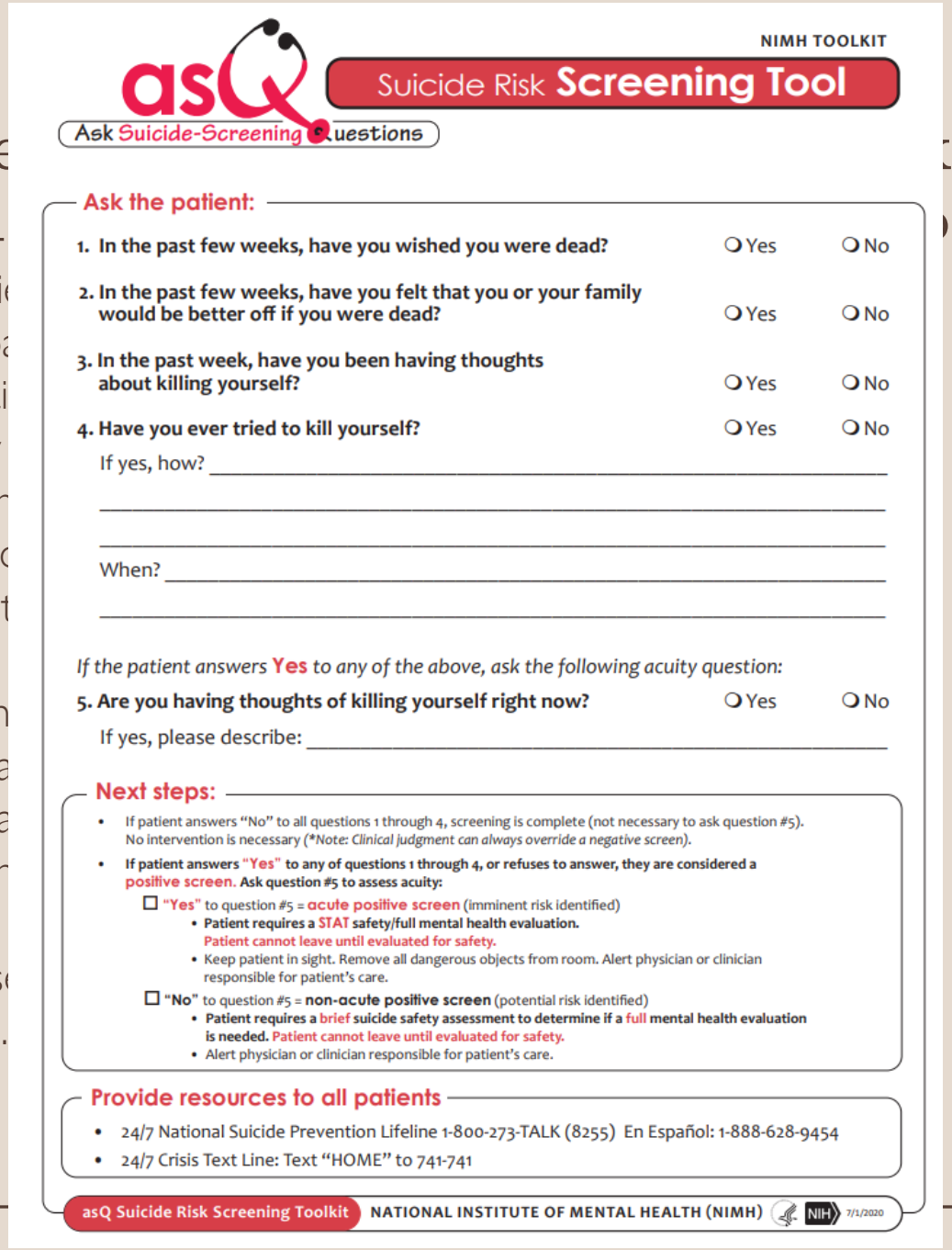
<12 Suicide Screening

- 8-11 y/o
- Parents or patient raise concerns
- Reported history of suicidal behaviors
- >8 Warning signs
- Talking about wanting to die
- Engaging in self harm behaviors
- Gesture finger gun to head or choking self
- Acting with impulsive aggression
- Giving aways treasured toys or possessions

The Ask Suicide … kit is designed to screen medical … or risk of suicide.

- After the patient intervi… should meet with the pa… safety plan with the pati… plan (e.g. an emergency … evaluation, non-urgent m… intervention), and provi… patients—a resource list…

- Strengths of the ASQ in… specifically for children a… paediatric populations, a… facilitate implementation… specificity (Horowitz et … implementation and res… ED setting (Ballard et al.…



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

TOOL KIT Pearls

- Thank you so much for letting us know you're having these thoughts, and these can be hard things to talk about. I need to ask you a few more questions
- Child or Adolescent who said, yes, that they're having thoughts of killing themselves right now. That they have a plan. That you just are concerned about their safety imminently. They need a emergency psychiatric evaluation
- Imminent risk patient is going to have to be sent to the emergency department or call Crisis
- Screened positive or no, or this was a part of a false positive
- Further evaluation of risk is necessary.
- Evaluate intent and access
- "What are some of the reasons you would not kill yourself?"
- If you are looking at sending them home, with a mental health referral. And someone will need to evaluate them, preferably within 72 hours, you review a safety plan or you make a safety plan.

Safety Planning

- Safety contracts with patients where the patient promises not to harm themselves is no longer a valid practice.
- Lethal Means : It's important to reduce the access to lethal means which may include the removal of guns from the house or make sure they are locked in a safe.
- Children who are vulnerable and at risk for suicide, you have to discuss locking up RX medication and OTC and sharp objects like knives
- You should talk with the patient about the warning signs and the triggers for the patient
- They need to write down what are the warning signs/ red flags.
- What are their coping strategies? How are they going to cope?
- Who are their contacts for support and who are their emergency contacts?

Talking to parents

- "After speaking with your child, I have some concerns about his or her safety. We are glad your child spoke up about this as it can be a difficult topic to talk about and we now want to get your perspective."
- There's no confidentiality when it comes to the topic of suicide and it's important, after the child screens positive to tell them that this is something you have to share with their parents. And actually for kids under 18, by law you are in Mandatory reporting
- Kids and Parents need to understand this is not to get them in trouble. This is not to be blaming. This is all about getting them help. And sometimes some groundwork has to be done with parents around this too. The child should not be punished for talking about this. This is a good thing that they're speaking up about it.
- "So your child said they were having thoughts about killing themselves. Is this something that they have shared with you?"
- Validate parents so that they will not feel foolish if they didn't know. We want them to know that kids talking about suicide is very secretive. Kids can be very secretive about this topic so it's not their fault if they don't know.
- It's important to know if it's something they know about. And then, "Does your child have a history of suicidal thoughts or behaviors that you're aware of?"
- "Are you comfortable keeping your child safe at home?" Now if they say yes, again, that doesn't mean that the child is safe at home. But if they say no, then that's important to pay attention to.
- "Is there anything you would like to tell me in private?" Because sometimes the parent has information that they don't want to share in front of the patient and it's important to give them that opportunity.
- A relative that killed themselves.

Suicide Behaviors Questionnaire - Revised

STABLE RESOURCE TOOLKIT

The Suicide Behaviors Questionnaire-Revised (SBQ-R) - Overview

The SBQ-R has 4 items, each tapping a different dimension of suicidality:[1]

- Item 1 taps into lifetime suicide ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past twelve months.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Responses can be used to identify at-risk individuals and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]

	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	93%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

https://youthsuicideprevention.nebraska.edu/wp-content/uploads/2019/09/SBQ-R.pdf

1. Osman A, Bagge CL, Guitierrez PM, Konick LC, Kooper BA, Barrios FX., The Suicidal Behaviors Questionnair Revised (SBQ-R): Validation with clinical and nonclinical samples, Assessment, 2001, (5), 443-454.

STABLE RESOURCE TOOLKIT

SBQ-R - Scoring

Item 1: taps into *lifetime* suicide ideation and/or suicide attempts			
Selected response 1	Non-Suicidal subgroup	1 point	
Selected response 2	Suicide Risk Ideation subgroup	2 points	
Selected response 3a or 3b	Suicide Plan subgroup	3 points	_____
Selected response 4a or 4b	Suicide Attempt subgroup	4 points	**Total Points**

Item 2: assesses the *frequency* of suicidal *ideation* over the past 12 months			
Selected Response:	Never	1 point	
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3-4 times)	4 points	_____
	Very Often (5 or more times)	5 points	**Total Points**

Item 3: taps into the *threat of* suicide *attempt*		
Selected response 1	1 point	
Selected response 2a or 2b	2 points	
Selected response 3a or 3b	3 points	_____ **Total Points**

Item 4: evaluates *self-reported likelihood* of suicidal behavior in the future			
Selected Response:	Never	0 points	
	No chance at all	1 point	
	Rather unlikely	2 points	
	Unlikely	3 points	
	Likely	4 points	
	Rather Likely	5 points	_____
	Very Likely	6 points	**Total Points**

Sum all the scores circled/checked by the respondents.
The total score should range from 3-18. _____ **Total Score**

AUC = Area Under the Receiver Operating Characteristic Curve; the area measures discrimination, that is, the ability of the test to correctly classify those with and without the risk. [.90-1.0 = Excellent; .80-.90 = Good; .70-.80 = Fair; .60-.70 = Poor]

	Sensitivity	Specificity	PPV	AUC
Item 1: a cutoff score of ≥ 2				
• Validation Reference: Adult Inpatient	0.80	0.97	.95	0.92
• Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R : a cutoff score of ≥7				
• Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: a cutoff score of ≥ 8				
• Validation Reference: Adult Inpatient	0.80	0.91	0.87	0.89

STABLE RESOURCE TOOLKIT

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

Columbia Suicide Severity Rating Scale

ASK YOUR CLIENTS

CARE FOR YOUR CLIENTS

ESCORT YOUR CLIENTS

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

See Reverse for Questions that Can Save a Life

Always ask questions 1 and 2.	Past Month
1) Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Have you actually had any thoughts about killing yourself?	
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.	
3) Have you been thinking about how you might do this?	
4) Have you had these thoughts and had some intention of acting on them?	**High Risk**
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	**High Risk**

Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		**High Risk**

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

https://cssrs.columbia.edu/wp-content/uploads/Community-Card-Clients-3.pdf

Columbia Suicide Severity Rating Scale CRS

Strengths of the CSSR-S is that it is focussed directly on the spectrum of suicidal behaviours, from ideation to an actual attempt, and is part of a package of suicide assessment tools for a variety of age groups and settings. Limits include that there is no published validation data specific to the CSSRS-Screener Version for its use with children and adolescents.

https://www.ohsu.edu/sites/default/files/2022-08/%28CSSRS%29%20Columbia%20Suicide%20Severity%20Rating%20Scale.pdf

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** • Over a year ago? • Between three months and a year ago? • Within the last three months?		

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Visit	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
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Oregon Psychiatric Access Line (OPAL)

- What is OPAL? OPAL-K about Kids OPAL-A about Adults
- OPAL provides free, same-day, Monday through Friday, child and adult psychiatric phone consultation to primary care providers in Oregon.
- OPAL is a collaboration between OHSU's Division of Child and Adolescent Psychiatry, Adult Psychiatry, the Oregon Pediatric Society (OPS) and the Oregon Council of Child and Adolescent Psychiatry (OCCAP).
- The program expands the availability of high-quality mental health treatment to Oregon youth and adults via timely psychiatric consultation, medical practitioner education, and connections with mental health professionals throughout the state.
- Hours and Contact 9 a.m. – 5 p.m.
  Monday through Friday, excluding major holidays
- Toll-Free: 1-855-966-7255
  Portland Metro: 503-346-1000

988

https://988lifeline.org/help-yourself/youth/

https://www.youthsuicidewarningsigns.org/youth

https://zerosuicide.edc.org/

GOBHI EASTERN OREGON

- https://www.gobhi.org/crisis-lines

County	Community Mental Health Program	After-Hours Crisis Number	Non-Emergency Law Enforcement
Baker	New Directions Northwest (541) 523-7400	(541) 519-7126	(541) 523-3644
Gilliam	Community Counseling Solutions (541) 384-2666	After-Hours: 911	(541) 384-2080
Grant	Community Counseling Solutions (541) 575-1466	After-Hours: 911	(541) 575-0195
Harney	Symmetry Care (541) 573-8376	(541) 573-8376	(541) 573-6156
Hood River	Mid-Columbia Center for Living (541) 386-2620	(888) 877-9147	(541) 386-2711
Lake	Lake District Wellness Center (541) 947-6021	(877) 456-2293 (541) 947-6021	(541) 947-2345
Malheur	Lifeways, Inc. (541) 889-9167	(541) 889-9167	(541) 473-5125
Morrow	Community Counseling Solutions Boardman Office: (541) 481-2911 Heppner Office: (541) 676-9161	After-Hours: 911	(541) 676-5317
Sherman	Mid-Columbia Center for Living (541) 296-5452	(888) 877-9147	M-F 8am - 4:30pm: (541) 565-3622 After hours: (541) 384-2080
Umatilla	Community Counseling Solutions Pendleton Office: (541) 276-6207 Hermiston Office: (541) 567-2536	(541)240-8030	(541) 966-3651
Union	Center for Human Development (541) 962-8800	(541) 962-8800	(541) 963-1017
Wallowa	Wallowa Valley Center for Wellness (541) 426-4524	(541) 398-1175	(541) 426-3131
Wasco	Mid-Columbia Center for Living (541) 296-5452	(888) 877-9147	(541) 296-5454
Wheeler	Community Counseling Solutions (541) 763-2746	After-Hours: 911	(541) 384-2080

Integrating Screening into clinical practice

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

Frequency of screening

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

Screening frequency will depend upon practice preference:

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

Screening for Depression is not enough

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

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

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

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

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

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

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

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

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

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

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

Thank You

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