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# Suicide assessment and treatment in pediatric primary care settings

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## Abstract

**Topic:** This article will briefly review screening for depression and suicidal ideation in primary care and school-based clinics, with a focus on in-depth screening for imminent suicide risk, developing a safety plan, and incorporating handoffs to urgent and emergency mental health care personnel. The article will cover current definitions of levels of suicidal risk and clinic-based protocols for a team approach to adolescents in crisis.

**Purpose:** To provide primary care and behavioral health nurses with evidence-based suicide risk screening and assessment tools and best practices for using them in patient-centered encounters with adolescents with suicidal thinking or behavior.

**Sources Used:** Journal articles, books, and reports.

**Conclusion:** Past studies have shown that many individuals who died by suicide had seen a primary care provider in 30 days before their deaths. Nurses in primary care settings should develop clinic-based protocols for screening all adolescents for suicide risk, developing safety plans, and providing suicidal youth and families with monitoring, appropriate referrals, follow-up, and support.

**KEYWORDS**
adolescent suicide, behavioral health integration, suicide prevention

## 1 | INTRODUCTION

Suicide is the second leading cause of death in adolescents (Centers for Disease Control, 2017). From 1999 to 2017, rates of pediatric death by suicide in the United States increased 33%, with increases among both males and females from ages 10 to 14 and 15 to 24 (Hedegaard, Curtin, & Warner, 2018). The overall suicide rates for youth ages 15–19 increased, between 2015 and 2017, to the highest rates since 2000 (Miron, Yu, Wilf-Miron, & Kohane, 2019). A review of deaths by suicide in 37 states found that 57% of youths ages 10–24 did not have a previously diagnosed mental health condition (Stone et al., 2018). Although all youth who present with suicidal ideation should ideally have immediate access to a mental health professional, this is not always possible. Over 100 million U.S. residents live in mental health professional shortage areas (Kaiser Family Foundation, 2019), with declining numbers of practicing psychiatrists (Bishop, Seirus, Pincus, & Ross, 2016), and unnecessary practice limitations on psychiatric mental health nurse practitioners (Chapman, Phoenix, Hahn, & Strod, 2018).

Responding to these shortages, the American Academy of Pediatrics (AAP) has recommended that primary care providers (PCPs) screen and assess for suicidal ideation and learn to manage mild to moderate mental health conditions, to make more effective linkages to limited specialized care (Shain & AAP Committee on

Adolescence, 2016; Zuckerbrot, Cheung, Jensen, Stein, & Laraque, 2018). This article will introduce nurses working in primary care settings to the current epidemiology of youth suicide in the United States, and evidence-based approaches to screening, assessment, and treatment planning for youth presenting with suicidal ideation, as well as best practices for documentation. The article will address the need for timely and effective consultation with mental health professionals, to facilitate emergency psychiatric care for youth in greatest need, and timely support and referral for those with less acute presentations. This article is also useful for psychiatric nurses who might be integrated into primary care sites or providing support and consultation to nurses and other PCPs from emergency psychiatric settings.

## 1.1 | Background—Epidemiology

In 2017, 15% of a national sample of college students reported seriously thinking about suicide in the last 12 months, compared with 10% ten years before (American Foundation for Suicide Prevention [AFSP], 2017). The most recent *Youth Risk Behavior Surveillance Survey* (YRBSS; Centers for Disease Control and Prevention, 2017) estimates that 17.2% of high school students "seriously considered" suicide, 13.6% made a suicide plan, 7.4% attempted suicide, and 2.4% made an attempt that required medical attention; all reflecting a steady rise from 2009 (Kann et al., 2018). Identified females considered suicide at almost double the rates of male counterparts (22% vs. 12%), attempted at higher rates (9% vs. 5%) and required more medical attention for attempts (3.1% vs. 1.5%; Kann et al., 2018).

However, males die by suicide at much higher rates than females. Suicide rates in 2017 were 3.3/100,000 for males (compared with 1.7/100,000 for females) in the 10–14-year-old age group; in contrast, rates among 15–24-year-olds were 22.7/100,000 for males and 5.8/100,000 for females (Hedegaard et al., 2018). See Table 1 for a breakdown of deaths by suicide by reported gender and ethnicity. Although rates of death by suicide for males are much higher than for females in adolescence, it is important to also view these estimates in the context of greater trends for the communities we serve. For example, a review of deaths by suicide in African American adolescents from 2001 to 2017 found that rates for females increased by 182%, while rates for males increased 60% (Price & Khubchandani, 2019). These data highlight subpopulation differences within overall suicide prevalence and trends. Unfortunately, many current analyses of specific characteristics associated with individuals who die by suicide aggregate all ages together.

Recently, 37 states participated in the National Violent Death Reporting System (Stone et al., 2018). An analysis of all individuals in this database who died by suicide in 2015, and for whom toxicology tests were performed, found that 78% of those with and 70.9% of those without known mental health conditions tested positive for at least one illicit substance, most commonly alcohol (Stone et al., 2018); adolescents and young adults aged 20–24 comprised 13.7% of the total database. Recent or upcoming crises and physical health

problems were noted for those with and without prior mental health diagnoses. School problems were noted among youth 10–18 (17.18% of those with a mental health condition, and 21.9% of those without; Stone et al., 2018).

In the same study, 75.2% of individuals with a mental health condition had been diagnosed with depression, followed in frequency by anxiety (16.8%), bipolar disorder (15.2%), schizophrenia (5.4%), and posttraumatic stress disorder (4.5%; Stone et al., 2018). Rates of depressive symptoms in U.S. adolescents, which have been tracked most consistently among mental health problems, have been increasing steadily from 2012 to 2018, with 37.5% of girls and 19.8% of boys in 2018 Monitoring the Future sample ranking in the top 75th percentile of scores on questions about depressive symptoms (Keyes, Gary, O'Malley, Hamilton, & Schulenberg, 2019). According to self-report figures from the YRBSS (Centers for Disease Control and Prevention, 2017), as many as 31.5% of high school students reported persistent feelings of sadness or hopelessness in the last year. Yet, approximately half of those with behavioral health problems or psychiatric concerns did *not* see a behavioral health professional (Whitney & Peterson, 2018), which often leaves nurses and other PCPs to cover this gap in care (Zuckerbrot et al., 2018). In fact, individuals of all ages who died by suicide were more likely to have seen their PCP in the 30 days before death by suicide (Ahmedani et al., 2014), reinforcing the need for more experiential training of PCPs and more effective use of nurses at all levels of training (Chapman et al., 2018; Zuckerbrot et al., 2018). Sadly, these estimates rarely take into consideration the sheer number of adolescents and families that do not see a PCP at all.

Other factors contributing to increased risk in adolescent populations include social media consumption (Sedgwick, Epstein, Dutta, & Ougrin, 2019); increase in bullying and cyberbullying (Shain & AAP Committee on Adolescence, 2016; van Geel, Vedder, & Tanilon, 2014); bullying and family rejection of lesbian, gay, bisexual, and transgender (LGBT) youths (Bouris, Everett, Heath, Elsaesser, & Neilands, 2016; Shain & AAP Committee on Adolescence, 2016); a history of physical or sexual abuse (Shain & AAP Committee on Adolescence, 2016); history of adoption (Keyes, Malone, Sharma, Iacono, & McGue, 2013; Slap, Goodman, & Huang, 2001); the

**TABLE 1** Rates of death by suicide by reported gender and ethnicity

| Rates of death by suicide, ages 15–19 | Male/100,000 population | Female/100,000 population |
|---|---|---|
| Total | 22.7 | 5.8 |
| Native American/Alaska Native | 28.8 | 10.2 |
| White, non-Hispanic | 22.0 | 5.8 |
| Hispanic | 12.5 | 4.6 |
| Black | 11.1 | 4.0 |
| Asian/Pacific Islander | 11.6 | 5.2 |

*Source:* Data from Child Trends (2017).

potential glamorization of suicide in media, such as the 2017 Netflix web-series "13 Reasons Why" (D'Agati, Beaudry, & Swartz, 2019); and, the persistent and bidirectional impact of stigmatization about suicide (Carpiniello & Federica Pinna, 2017). There is no one cause for the spike in suicide rates among this population (Little, Roche, Chow, Schenck, & Byam, 2016); it is an amalgamation of factors that play out differently in each individual. The most important elements for PCP focus are (1) assessment of the adolescent's cognitive and socioemotional capacity *and* current context and (2) how a treatment plan will most safely and effectively serve their unique needs.

## 1.2 | A developmental lens

One of the key explanations for these trends in an adolescent's risk for suicide is that there is a distinct discrepancy in the developmental capacity of adolescents to process stress and to cope effectively, specifically surrounding deficits in abstract thought. Adolescents are cognitively able to recognize life stressors and act on these emotions (e.g., sadness, desperation, etc.), but often without fully developed impulse control or long-term planning ability, putting them at an increased risk of generating suicide as a possible solution and having the ability to create and carry out plans for suicide (Grøholt, Ekeberg, Wichstrøm, & Haldorsen, 1998; Horwitz, Berona, Czyz, Yeguez, & King, 2017). The timing of puberty also plays a significant role, as girls who are found to mature earlier than peers are at increased risk of depression, substance use, and early sexual behavior, and boys with asynchronous (i.e., early or late), pubertal development, may also have more psychopathology (Graber, 2013; Mendle, Ryan, & McKone, 2017). In a large British longitudinal study, early menarche was associated with increased incidence of self-harm, with and without suicidal intent (Roberts, Fraser, Gunnell, Joinson, & Mars, 2019). And for males, late puberty has been associated with poorer mental health outcomes, including depression and anxiety (Zhu & Chan, 2017). Although the developmental context and capacity of an adolescent is not considered a causal risk factor for suicide, the correlations indicate a need to acknowledge and integrate a contextual developmental framework into suicide screening, treatment, and prevention plans

## 1.3 | Definitions

To assess and prevent suicide, it is important to first understand the concepts of suicidal thinking and behavior (STB; Franklin et al., 2017). Per the National Institute of Mental Health (NIMH, 2019), current nomenclature distinguishes STBs as the following:

– *Suicide*: "Death caused by self-directed injurious behavior with an *intent* to die as a result of the behavior" (Crosby, Ortega, & Melanson, 2011). Many terms previously used in the literature that discuss suicide are out-of-date and perhaps even dangerous. These include: committed suicide, suicidality, failed attempt,

completed suicide, nonfatal suicide, parasuicide, and successful suicide (Crosby et al., 2011). The preferred terms are now "death by suicide" or "died by suicide" (Kaslow, 2014).

– *Suicide attempt*: An explicit intention to die as a result of a self-directed injurious behavior. The attempt is nonfatal and does not necessarily result in personal injury, though there is the potential of serious harm (Crosby et al., 2011).

– *Suicidal ideation*: The mentation or planning one's own suicide. It may or may not result in death, but does reflect a desire to die (Crosby et al., 2011). The concept of suicidal ideation has historically been divided into "active" and "passive" processes of suicidal ideation, where active connotes a desire to die accompanied by a plan for suicide, and passive is the desire to die without a specific plan around death and is sometimes simply stated as suicidal ideation with plan and/or intent, or suicidal ideation without plan or intent.

For a glossary of terms relating to suicide, refer to Table 2.

## 2 | SUICIDE SCREENING

Although the current position of the United States Preventive Services Task Force (LeFevre, 2014) reports insufficient evidence for general suicide screening in the pediatric population (i.e., those adolescents without mental health concerns), the AAP guidelines recommend that all pediatric patients be screened for STB (Shain & AAP Committee on Adolescence, 2016). In fact, there is evidence suggesting that these adolescents with suicidal ideation carry a greater lifetime risk for suicide attempts (Fergusson, Horwood, Ridder, & Beautrais, 2005; Kessler, Borges, & Walters, 1999), thus early screening and intervention is a key element in a public mental health approach to suicide.

Specific AAP recommendations are to use a formal depression screen yearly, and to also ask about mood disorders, bullying victimization or perpetration, drug and alcohol use, sexual orientation, gender identity, and other factors that might increase risk for STB (Shain & AAP Committee on Adolescence, 2016). The American Psychiatric Association (Jacobs et al., 2010) and The American Academy of Child and Adolescent Psychiatry (2001) recommend that screening begin with a detailed history to evaluate any past psychiatric conditions, family history of suicide, personal history/relationship with suicide, school disturbances, and the patient's risk and protective factors, in addition to a detailed psychosocial history. Most specifically, it is important to screen for active mood disorders, as they are a primary risk factor in adolescence (American Academy of Child and Adolescent Psychiatry, 2001; Nock et al., 2013; Peyre et al., 2017; Ten Have, van Dorsselaer, & de Graaf, 2012). When there is a history of STB, it is important to know that the patient carries a heightened risk for additional STBs for at least 1 year after the acute episode (Nock et al., 2013).

Most outpatient psychosocial screens cover a range of risk factors for suicidal ideation and can be used to help guide assessment.

**TABLE 2** Glossary

| | |
|---|---|
| Suicide | "Death caused by self-directed injurious behavior with an *intent* to die as a result of the behavior" (Crosby et al., 2011). Many terms previously used in the literature that discuss suicide are out-of-date and perhaps even dangerous. These include committed suicide, suicidality, failed attempt, completed suicide, nonfatal suicide, parasuicide, and successful suicide (Crosby et al., 2011). The preferred terms are now "death by suicide" or "died by suicide" (Kaslow, 2014) |
| Suicide attempt | An explicit intention to die as a result of a self-directed injurious behavior. The attempt is nonfatal and does not necessarily result in personal injury, though there is the potential of harm (Crosby et al., 2011) |
| Suicidal ideation | The mentation or planning about a suicide. It may or may not result in death, but does reflect a desire to die (Crosby et al., 2011). The concept of suicidal ideation is often divided into "active" and "passive" processes of suicidal ideation, where active connotates a desire to die accompanied by a plan for suicide, and passive is the desire to die without a specific plan around death |
| Aborted attempt | When an individual takes step to end life, but does not complete the act and does not sustain an injury (Barber, Marzuk, Leon, & Portera, 1998) |
| Interrupted attempt | There are noted step to end life by an individual, but the act is stopped before fatal injury by oneself or by others (Crosby et al., 2011) |
| Means reduction | Reducing a suicidal person's access to highly lethal means (Means Matter, 2020) |
| Nonsuicidal self-injurious behavior (NSSI) | Deliberately injuring oneself without suicidal intent (Crosby et al., 2011) |
| Preparatory behaviors | Any other behavior with suicidal intent (e.g., buying pills buying a gun, writing a suicide note) |
| Suicide attempt | A self-injurious act performed with at least some intent to die as a result of the act; there does not have to be an injury, just the potential (Crosby et al., 2011) |
| Suicide contagion | Process by which suicidal behavior or suicide influences an increase in suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides (CITE) |

*Note:* To assess and prevent suicide, it is important to first understand the concepts of suicidal thinking and behavior (STB; Franklin et al., 2017). Current nomenclature distinguishes suicidal thinking and behaviors as per the National Institute of Mental Health (NIMH, 2019).

One of the highly recommended screens is the SSHADESS (Ginsburg, 2014). Endorsed by the AAP, SSHADESS explores risk and protective factors via eight key domains, including Strengths, School, Home, Activities, Drug/substance use, Emotions/eating/depression, Sexuality, and Safety (Ginsburg, 2014); see Table 3 for a link to the SSHADESS screen. Embedded in these domains, the line of questioning touches on some important variables that are associated with increased risk for suicide, including previous suicide attempts or self-harm history; co-occurring psychiatric conditions (e.g., depression, anxiety, or substance use); sexual and gender minority status; current or historic bullying or sexual abuse; and, insomnia, among others.

## 2.1 | Primary care application

Specific elements of the suicide risk screening, assessment, and safety planning can be used within the primary care setting to help provide overall structure and guidance. These include the need to develop clinic-based protocols for safety plans, the monitoring and referral of suicidal youth to appropriate care, and providing proper follow-up care. It is important to note that screening for suicide risk does not increase the frequency of suicidal thoughts in adolescents (Gould et al., 2005).

The majority of primary care clinics screen for suicide risk through self-report mental health questionnaires. Many clinics use the Patient Health Questionnaire (PHQ), which is commonly embedded in the electronic medical record. The Adolescent version is preferred (PHQ-9-Adol; Johnson, Harris, Spitzer, & Williams, 2002), however, a clinic may use the Adult version (PHQ; Kroenke, Spitzer, & Williams, 2001). In that case, it is critical to pay specific attention to question 9, where questions regarding suicide are addressed. Of note, if an adolescent answers "no" to the screening question in the PHQ-9, the provider or nurse should still screen for suicide risk during the patient interview. The depression screen is a tool to help facilitate conversation. While it is an efficient and cost-effective medium, self-report measures "tend to be oversensitive, underspecific, and lack predictive value" (Shain & AAP Committee on Adolescence, 2016, p. 4). Tools such as the SSHADESS/HEADSS (Ginsburg, 2014), PHQ-9 (Johnson et al., 2002), and ASQ (Horowitz et al., 2012) have built-in components to ask about STBs. If the provider does choose to screen during a clinical interview, the screen is best presented in a neutral, matter-of-fact manner. It is critical that we, as nurses, understand how to work in an over-taxed system, how/when to delegate various pieces of the triage process, how to work within realistic time demands, and how to reach mental health professionals who are available for consultation in person or via phone in emergency situations.

**TABLE 3** Website references

| | |
|---|---|
| Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2010) | https://cssrs.columbia.edu/wp-content/uploads/C-SSRS_Pediatric-SLC_11.14.16.pdf |
| SSHADESS Screener (Ginsburg, 2014) | https://www.aap.org/en-us/professional-resources/Reaching-Teens/Documents/Private/SSHADESS_handout.pdfs |
| Suicide Assessment Five-step Evaluation and Triage (SAFE-T; Jacobs, 2009) | – Card: https://store.samhsa.gov/product/suicide-safe<br>– App: https://store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432<br>– SAFE-T + C-SSRS: https://cssrs.columbia.edu/documents/safe-t-c-ssrs/ |
| SLAP mnemonic (Morris, 1998) | https://ncyi.org/wp-content/uploads/2018/01/DITSF_p149.pdf |
| Safety plan template | – My3 app (Mental Health Organization of New York): https://my3app.org/<br>– Print-out: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf |
| Suicide Prevention Resource Center (SPRC) overview of suicide resources for adolescents | Overview: https://www.sprc.org/populations/adolescents<br><br>Safety plan (linked) |
| SPRC's "Suicide Prevention Toolkit for Primary Care Practices" | https://www.sprc.org/resources-programs/suicide-prevention-toolkit-rural-primary-care |
| Mental Illness Policy Org.—list of state statutes regarding involuntary commitment | https://mentalillnesspolicy.org/national-studies/state-standards-involuntary-treatment.html |
| Means Matter | https://www.hsph.harvard.edu/means-matter/ |
| Local Community Resources for Suicide Preventions | Organizations below can connect providers and patients to local resources:<br><br>– American Foundation for Suicide Prevention (AFSP), https://afsp.org/find-support/resources/<br>– Suicide Prevention Resource Center (SPRC), http://www.sprc.org/<br>– The Society for the Prevention of Teen Suicide (SPTS) http://www.sptsusa.org/<br>– Action Alliance for Suicide Prevention http://actionallianceforsuicideprevention.org/resources<br>– Crisis Text Line, https://www.risistextline.org/<br>– The Trevor Project, http://www.thetrevorproject.org/<br>– SAVE, https://save.org/ |
| National Crisis Lines | – National Suicide Prevention Lifeline: 800-273-TALK (8255)<br>– 24/7 Crisis Text Line: 741741 |

# 3 | SUICIDE ASSESSMENT

If a youth screens positive for suicidal thinking or behaviors on self-report questionnaires or in the psychosocial interview, it is critical to follow up about the screen during the visit with the adolescent, *alone*, to gain more context regarding the severity, frequency, and actual intent in 'any suicidal behaviors and thinking. Given the sensitive nature of the material and need for transparency, family influence may filter or challenge the patient's story, as well as threaten the therapeutic partnership. Therefore, completing a one-on-one assessment will facilitate building trust and rapport with the youth and elicit more accurate information (Morrison & Flegel, 2016).

The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2010) is commonly recommended in child and adolescent psychiatry and is strategically designed for administration by a range of professionals and paraprofessionals, including PCPs, teachers, clinic staff, and law enforcement. C-SSRS can be accessed online (see

Table 3) and is an open-access, "all-in-one" screener that aims to standardize how suicidal behaviors are classified (Interian et al., 2017). The C-SSRS uses simple questions and a clinical algorithm to blend collateral input with clinical presentation to gauge the ideation type/intensity and the important suicidal behaviors involved (e.g., actual, interrupted, aborted, preparatory), as well as the associated level of support or services needed for the youth (Posner et al., 2010). The severity and intensity of suicidal ideation, lifetime suicide attempt, and nonsuicidal self-injury (NSSI) behavior, as measured by the C-SSRS, were found to predict future suicide attempts among adolescent and young adult psychiatric emergency department (ED) patients (Horwitz, Czyz, & King, 2014). There is a specific C-SSRS Screen with Triage Points for Primary Care which provides a response protocol to "yes" answers for each question. Other tools with similar goals that are commonly used in primary care and school settings are *Suicide Assessment Five-step Evaluation and Triage* (SAFE-T; Jacobs, 2009) and the *SLAP mnemonic* (Morris, 1998; see Table 3 for screen links).

## 3.1 | Approach

In engaging a youth with suicidal thinking or behavior, providers must meet the patient where they are: be clear and direct; and genuinely and empathically ask questions, with an emphasis on validating the adolescent's feelings; and, show appropriate concern (Western Interstate Commission for Higher Education Mental Health Program [WICHE MHP] & Suicide Prevention Resource Center [SPRC], 2017). While the patient–provider relationship remains essential, the top priority within the encounter is always patient safety, followed by the patient's emotional well-being. It can be helpful to call out the critical need for a joint safety strategy involving the patient's support systems during the assessment to help patients and their families understand what is required in this unique situation. Additionally, it can help to explicitly identify where the patient is currently exhibiting strengths, highlighting any healthy coping skills and practices that the patient and family can draw upon in times of crisis (e.g., grounding, mindfulness). In this way, the clinician draws attention to the adolescent's ability to self-generate hope, thus subtly reinforcing reasons for living.

Assessing and triaging care related to suicide may very stressful not only for patients and their family units, but also for providers (Wiche Mhp & Sprc, 2017). Self-awareness and self-care should remain a top priority, even if the nurse is seasoned in suicide prevention and triage. During the encounter, remaining mindful of one's own emotions and body language is crucial (Wiche Mhp & Sprc, 2017). Pausing to identify and manage one's own difficult feelings, even if just to take a few deep breaths, may help to reduce the stress of suicide assessment, and may help to clarify conceptualization and subsequent decision-making. When asking specifically about suicide, it is best to approach the behavior or thinking directly, invoking a neutral perspective (i.e., using the appropriate terminology for suicide without editorial bias) to strip away any stigmas or feelings about the situation (Gould et al., 2005). While empathy is important, it is critical to avoid loading the situation with additional feelings, fear, or opinions about suicide. It is also important for clinicians to consider their own views on suicide, as they approach care for these patients (Wiche Mhp & Sprc, 2017). Keeping a critical eye on one's own well-being (e.g., physical, emotional, behavioral, and cognitive reactions) as a nurse or as a provider can help mitigate any secondary traumatic stress when working with families in crisis.

## 3.2 | Physical examination and mental status exam

In addition to an in-depth interview, the physical exam, including evaluation of mental status, warrants special consideration, as well as evaluation of possible medical causes for the psychiatric symptoms, and any evidence of injury or ingestion. It is known that youth who engage in NSSI are at significantly increased risk of attempting suicide, so it is important to look for evidence of self-injury on physical exam (Grandcler, De Labrouhe, Spondenkiewicz, Lachal, & Moro, 2016). It is also important to assess for any signs of medical disorders that may be contributing to, or coexisting with, depression (Grandcler et al., 2016). The crucial elements of the mental status exam will include the patient's relatedness, or level of engagement, as well as their subjective, stated mood, and objective, observable affect, and assessment of cognitive ability, impulse control, and any concerns for perceptual disturbance or thought disorder (Cepeda & Gotanco, 2016).

## 3.3 | How to determine risk severity

To determine suicide risk, nurses should determine whether there is active suicidal ideation. This includes exploring the details of the plan; what method the youth intends to use; the lethality of method; access to the method; and, how imminent the intent is (Jacobs, 2009). In assessing the patient's ability to maintain safety, it is recommended to include the level of family presence and support, the ability and willingness of the family to monitor the patient, any history of prior suicide attempts, and relevant features from the physical or mental status exam that particularly concerns the nurse (Jacobs, 2009; see Table 4 for details regarding severity grading rubric).

When assessing current level of risk, use the phrase "apparent risk" in your documentation, thus accounting for any fluctuations in the adolescent's behavior and feelings or for the fact that the adolescent may not be comfortable fully disclosing feelings at the time of assessment. Additionally, note that part of determining level of risk involves determining protective factors and the patient's and family's willingness and ability to engage in creating and following a specific suicide prevention plan, sometimes called a "safety plan" (Grant & Lusk, 2015). Although the literature on the ability of a safety plan to prevent suicide is scant (Zuckerbrot et al., 2018), it is generally agreed that safety or "no harm" contracts are both ineffective and detrimental to the patient and provider, and are not recommended given the inherent false sense of patient security and its tendency to decrease clinical vigilance (Edwards & Sachmann, 2010; King, Horwitz, Czyz, & Lindsay, 2017).

It is strongly recommended that primary care nurses consult with a behavioral health clinician, in-person, or by phone, before determining risk level, and for behavioral health experts to consult with psychiatric practitioners as needed (Shain & AAP Committee on Adolescence, 2016). In the case where the patient exhibits no symptoms or history of suicidal thinking or behavior, providers and behavioral health nurses can categorize their risk as "minimal." In no circumstances should "none" be listed as the risk; clinicians have a limited picture of the risk and can never extinguish all risk. Risk factors and circumstances of suicide can fluctuate rapidly in adolescents. Thus, it can often help to differentiate between acute risk and chronic risk. Meaning, while it is imperative to document the severity of a patient's acute symptoms at the time of the appointment, there is also value in documenting their chronic state

**TABLE 4** Risk levels and interventions

| Risk level | Risk/protective factors | Suicidal thinking, behavior | Possible interventions |
|---|---|---|---|
| Extreme | Frequent intense and enduring suicidal ideation, specific plans, clear subjective, and objective intent | Severe dysphoria, impaired self-control, many risk factors, no protective factors | Emergency evaluation for Hospitalization |
| High | Frequent intense and enduring suicidal ideation, specific plans, no subjective intent but some objective markers of intent (i.e., method chosen & accessible, some limited preparatory behavior) | Potentially lethal suicide attempt or persistent ideations with strong intent or suicide rehearsal | Emergency evaluation: Hospitalization generally indicated unless a significant change reduces risk. Suicide precautions |
| | Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant | Severe dysphoria, impaired self-control, multiple risk factors, few if any protective factors, particularly a lack of social support | |
| Moderate | Frequent suicidal ideation with limited intensity and duration, some specificity in terms of plans, no intent | Suicidal ideation with plan, but intent or behavior | Emergency evaluation: Hospitalization may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers. Outpatient care plan should include close follow-up, medication management, and therapies as indicated |
| | Multiple risk factors, few protective factors | Limited dysphoria, good self-control, some risk factors and protective factors, including available social support | |
| Low | Suicidal ideation of limited frequency, intensity, duration and specificity | Thought of death; no plan, intent, or behavior. No suicide plans or intent, good self-control, mild dysphoria, few other risk factors & identifiable protective factors including available social support | Outpatient referral, symptom reduction, give emergency/crisis numbers. Outpatient care plan should include close follow-up, medication management, and therapies as indicated |
| | Modifiable risk factors, strong protective factors | | |

*Source:* Data from Jacobs (2009).

regarding STB (e.g., "Acute—severe risk, Chronic—moderate risk"). This severity designation should be reflected in the chosen intervention and can be used to highlight any changes or impact on the follow-up plan.

Once the severity has been determined, justify the designation and document relevant risk assessment accordingly. SAFE-T (Jacobs, 2009) guidelines recommend evaluating for the frequency, intensity, and duration of an ideation event, with a distinct focus on assessing for symptoms in last 48 h, the past month, and "worst ever" situation. The evaluation should address the importance of eliciting types of historic attempts—actual attempts, aborted attempts, rehearsals (e.g., tying noose and loading gun), and NSSI behavior. This information better captures the variability of patient mood or behavior, which will aid in creating a more realistic and potentially impactful treatment plan, as discussed below. Documentation of these details must include timing, location, lethality, availability, and mentioned preparatory acts, as well as extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal versus self-injurious (Jacobs, 2009). If details are not forthcoming, use the strategy of exploring ambivalence (e.g., "reasons to die vs. reasons to live") to open the conversation (Hoy, Natarajan, & Petra, 2016). Finally, when appropriate, posit an open-ended inquiry to the child's parent/guardian to help inform assessment, specifically probing for what prior knowledge they have regarding the child's suicidal thoughts, plans, behaviors, or change in disposition.

## 3.4 | Safety planning

The creation of a safety plan is highly recommended for primary care practices as a collaborative process of involving both the patient and family, a means of assessing whether there are sufficient protective factors, and as a place to aggregate support resources (Grant & Lusk, 2015). A safety plan involves: documenting any warning signs that suicidal ideation is increasing; exploring the coping strategies the patient already uses or is willing to use; identifying people and social settings that might distract the patient; listing the people (and phone numbers) the patient can call to ask for help, as well as the professionals (and phone numbers) that can be called; and, agreeing on steps to make the environment safe (Grant & Lusk, 2015).

A good example of such a plan, published by B. Stanley & Brown (2008) is entitled the *Patient Safety Template*. The Suicide Prevention Resource Center (SPRC) also has an example online (see Table 3). The safety plan should be physically given to the patient and family as a therapeutic tool. It can also be a way to document the risk assessment and plan for the medical record as an appendix to the clinical note. If such a plan is made, it is important to document the response and agreement, along with family safety measures, for longitudinal follow-up and for future prevention conversations. Providers can use these tools to formulate a more comprehensive plan for safety with their adolescent patients and families. Of note, upon completing the plan, the provider should encourage the patient to keep the plan handy at all times, or take a digital picture of the

plan on their phone for easier accessibility. *Once a patient expresses current suicidal ideation with a suicide plan and any intent to carry out the plan, they should be supervised at all times until a complete determination of risk has been made.*

In cases where there is a dearth of behavioral health providers or nurses, safety plans must still be created. It is crucial for primary care settings to plan, develop, and train nurses, providers, and staff on a written protocol for assessment, safety planning and safe monitoring of a suicidal adolescent in the clinic in advance (Zuckerbrot et al., 2018 and see Table 3, for SPRC's clinic toolkit). It is a reality that PCPs have other patients to see and cannot sit with the patient until, for example, the transportation arrives to bring the youth to the hospital or crisis center. In these cases, it is important to leverage the scope of each staff to assist in the situation. As such, a paraprofessional can sit with youth or help the youth feel "heard"; although they are not making decisions about next steps, they add important protection for the patient. Additionally, if a primary care clinical setting has a structured safety planning form, the plan can continue to be filled out by another member of the staff. Then the suicide assessment (e.g., C-SSRS), and the safety plan should be reviewed with the nurse's or other PCPs clinical supervisor, a behavioral health professional on site or by telephone consult, or at the receiving emergency psychiatric setting, before determining that an emergency evaluation is needed or that the patient is safe to leave the clinic. Seeking expert consult from established psychiatric partners can increases professional support for decision-making, reduces provider anxiety, and results in better outcomes (Brodsky, Spruch-Feiner, & Stanley, 2018; Zuckerbrot et al., 2018).

## 3.5 | Benefits versus risk of psychiatric hospitalization

Nurses and other PCPs play an essential role in the detection and triage of suicidal behavior and thinking in youth. However, it is very important to note that PCPs alone will not make the determination about whether or not to psychiatrically hospitalize the youth. Rather, it is the provider's role, with consultation, to decide whether or enlist designated emergency services, that is, law enforcement or mental health providers who are designated to determine the need for psychiatric care without consent. Specific protocols for evaluation and possible inpatient psychiatric admission vary from state to state, as do guidelines for confidentiality (Chun, Mace, & Katz, 2016). (See Table 3 for a list of state statutes regarding involuntary commitment.)

Unfortunately, there are no validated criteria available to guide a pediatric provider or behavioral health nurse in assessing level of risk for a subsequent suicide attempt and determining level of care needs. However, psychiatric hospitalization can provide necessary safety, assessment, stabilization, and initial treatment (Shain & AAP Committee on Adolescence, 2016; Sharfstein, 2009). Thus, it provokes the important question—when does a provider refer a patient for a psychiatric hospitalization evaluation versus other psychiatric

services, such as intensive outpatient programs (IOP), partial hospitalization programs (PHP)? Within the primary care domain, it is generally agreed that criteria for psychiatric hospitalization include any the following (Wolff, 1999):

1. Reported high lethality attempt (or attempt with clear expectation of death).
2. Professional judgment of suicide risk level, where the suicide risk outweighs risk of inappropriate hospitalization.
3. Patient possesses limited capacity to follow through on safety planning (i.e., continued desire to die, severe hopelessness, ongoing agitation, inability to engage in safety planning).
4. Insufficient available support system to keep the youth safe and to monitor follow-up.
5. Inability to restrict access to lethal means.

There may be cases in which a patient presents with recurrent, apparent high-risk factors and symptoms, in which repeated psychiatric hospitalization is inadvertently reinforcing the suicidal presentation, but this is best assessed in close collaboration with the patient's mental health treatment team. Of note, the risk of a suicide attempt is highest during first 2 weeks after the youth is released from a psychiatric hospitalization (Cyz, Liu, & King, 2012).

To date, there is minimal data to suggest that hospitalization reduces risk or prevents eventual suicide in adults (Qin & Nordentoft, 2005) and minimal studies in pediatric literature exist, to the knowledge of the authors. There is evidence that hospitalization may increase the youth's long-term risk due to: the increased stigmatization and isolation (Moses, 2011; Xu et al., 2018), decreased self-esteem and hope for the future (Choi & Ferro, 2018), negative impact on the therapeutic alliance (Reshetukha et al., 2017), and increased risk of school dropout (Best, Hauser, Gralinski-Bakker, Allen, & Crowell, 2004).

## 4 | TREATMENT CONSIDERATIONS

All cases are dynamically different; it is not a "one size fits all" clinical algorithm. Thus, taking into account context and risk factors is critical to tailoring the suicide prevention and treatment plans. Psychotherapeutic intervention is a cornerstone of treatment for youth presenting with suicidal behavior and thinking. Specific therapies aimed at reducing STB as an area of focus include dialectical behavior therapy (DBT), cognitive behavioral therapy (CBT), and interpersonal therapy (IPT); see Table 5 for a brief description of each and related links. Regardless of the chosen outpatient therapy, it is critical to gain an understanding of the entire ecosystem for each patient that may drive risk or protection for the patients experiencing STBs. With a better understanding of the emotional and behavioral drivers, a therapy modality can matched more effectively to the needs of the youth and family. There is evidence that such therapeutic intervention may prevent self-harm as well (Ougrin, Tranah, Stahl, Moran, & Asarnow, 2015). Other helpful modalities to consider

**TABLE 5** Therapy modalities that target adolescents with suicidal thinking and behaviors (STBs) in outpatient settings

| Therapy type | Targets | Key concepts |
|---|---|---|
| Dialectical Behavior Therapy for Adolescents (DBT-A); https://behavioraltech.org/ | treats persons with severe emotional dysregulation, often manifested as recurrent suicidal ideation in the biosocial context of the patient (Linehan, 2015) | Uses core modules and lessons that emphasize mood regulation and healthy decision-making; essentially, it builds a framework toward acknowledging a life worth living (Linehan, 2015) |
| | Also used in the context of bipolar disorder, borderline personality disorder, substance use disorder, posttraumatic stress disorder, among others (Gorg et al., 2019; Ougrin et al., 2015) | Emphasizes the inherent biological vulnerability of the patient, and the social context that can reinforce emotional dysregulation; or it can be leveraged to cultivate a more effective coping style |
| | | Treatment includes individual therapy, group therapy, phone coaching, and team consultation to target suicidal behavior as maladaptive coping mechanism |
| Interpersonal Psychotherapy for Adolescents (IPT-A); https://iptinstitute.com/ | Targets depression symptoms in adolescent, acknowledging the role that genetic, biological, and personality plays in the development of depression and how interpersonal relationships may moderate these symptoms (IPT Institute, 2020) | Utilizes a time-limited (12–16 sessions) treatment. Key concepts include: (1) help adolescents to recognize their feelings and think about how interpersonal events or conflicts might affect their mood; (2) improve communication and problem-solving skills; (3) enhance social functioning and lessen stress experienced in relationships; and (4) decrease depressive symptoms |
| Cognitive behavior psychotherapy for suicide prevention (CBT-SP); www.abct.org | Targets STBs in adolescents, but clearest effects for those individuals who attempt individuals (Stanley et al., 2009) | Utilizes manualized, risk reduction intervention models to focus on relieving symptoms of depression. Rooted in cognitive-behavioral therapy and DBT (Stanley et al., 2009) |

include family therapy, psychodynamic therapies, and psycho-pharmacological interventions, as indicated.

AACAP guidelines (Birmaher & Brent, 2007) suggest that mild symptoms can respond well to therapy, such as CBT, but that moderate or severe symptoms likely require psychotherapies with the additional of an antidepressant. Treatment of all symptoms should continue for 6–12 months after baseline is achieved to avoid relapse (Birmaher & Brent, 2007). Tracking the efficacy of such therapies, however, has been problematic in this population, given the higher rate of treatment refusal and lower rates of retention in longitudinal studies (Rotheram-Borus, Piacentini, Cantwell, Belin, & Song, 2000). Thus, many of these treatments that show clinical promise lack a strong evidence-base. An in-depth discussion of medications is outside the scope of this current article. However, it is critical for pre-scribers to acknowledge the potential for medication lethality (i.e., number of pills dispensed, etc.) before refills are allowed.

Regardless of approach, there are five key pillars for care, which include: wellness planning (exercise, diet, sleep); coping skill development; psychoeducation about suicide ideation and depression; safety planning and means reduction; and, increasing family and caregiving engagement (Zuckerbrot et al., 2018). It is extremely important to learn about and try to contextualize the patients' emotions that triggered the current crisis. Nurses can make sure that they have a thorough understanding of the current acuity, and all of the precipitating factors, and can accurately and collaboratively communicate with the caregivers and other involved medical teams. Within the visit, it is important to give the patient advice and offer

solutions to decrease the suicidal thinking or behavior, always prioritizing safety. Some strategies recommended by the American Psychological Association (2019) include talking to adolescents about STBs by explicitly expressing concerns about their situation and letting the adolescent talk freely about the experience, all the while authentically listening and actively showing compassion. Finally, it is useful to have handouts or websites that the patient can reference. The Suicide Prevention Resource Center (SPRC) offers an overview of suicide resources for adolescents, as do some mobile applications, such as My3app. org (see Table 3).

## 4.1 | Patient and family education

Along with the treatment plan and referrals to a mental health clinician, nurses and other PCPs must include safety instructions, which are also given to patients and caregivers. These instructions should explicitly include: (1) the removal of firearms & lethal medications, including alcohol, at the home; (2) written or digital support plans, specifying names of people (and their contact information) that the youth trusts in crisis; (3) the specific role of each caregiver with anticipatory guidance in crises management; and, (4) immediate access to a suicide prevention hotline number, 911 and emergency services, and the local EDs. Of note, all such instructions should be clearly stated in the safety plan as well. In the event that the adolescent is not currently engaged with mental health services, but not severe enough to warrant psychiatric hold and evaluation for

inpatient psychiatric hospitalization, it is important to establish a clear connection on the day of the assessment.

Suicide attempts in the pediatric population occur with little planning during a short-term crisis. Intent is not all that determines whether an individual lives or dies; therefore, means reduction is also a critical piece of a comprehensive approach to suicide prevention (Substance Abuse and Mental Health Services Administration, 2017). In fact, more than 90% of attempters who survive do NOT go on to die by suicide later (Owens, Horrocks, & House, 2002). This seems to suggest reducing means in real-time provides ample opportunity to save lives.

There are a number of measures clinicians and health systems can encourage to reduce the means for suicide (i.e., a firearm used in youth suicide usually belongs to a parent; Means Matter, 2020). If a clinician helps a family reduce access to lethal means, it can save a child's life (Grossman et al., 2005). All medications, including over-the-counter medications, should be locked up; old prescriptions should be responsibly discarded. Sharp objects, such as knives and razor blades, should be locked in drawers or other secure places. If firearms cannot be removed from the house, new systems for locking the arms and ammunition should be implemented. In regard to a possible hanging attempt, intervention can be more difficult, though ensuring prevention measures, such as introducing safe bedding or removing belts and ropes, and then minimizing ligature points (a place used for tying or binding something tightly) can be important to mitigate the risk (Gunnell, Bennewith, Hawton, Simkin, & Kapur, 2005). However, even when paying close attention to these harbingers, red flags, and clinical algorithms, safety planning is not guaranteed to eliminate the risk.

After an acute presentation of significant suicide risk or recent psychiatric hospitalization, the PCP or nurse should follow up via telephone and/or clinic visit, given the increased risk of re-hospitalization and related safety concerns related to psychiatric discharge (Chung et al., 2017). Treatment approaches may involve psychopharmacologic treatment and psychotherapy. Other referrals from the primary care team could connect the family with services to address unmet social needs as well, such as housing, food, school supports, etc. Levels of support outside of psychiatric hospitalization include PHP, IOP, in-home/crisis stabilization, weekly counseling, and primary care follow-up. Given their often long-term relationship with and knowledge of the patient and family, PCPs may join the mental health team in support of a referral to long-term residential treatment when appropriate (i.e., in cases of long-term and severe psychopathology and complex psychosocial situations).

Shared decision making around options and safety plans can be used to customize treatment planning (Drake, Climpean, & Torrey, 2009). Within the appointment, the provider should also maintain the position that suicide is an ineffective or maladaptive solution to the current problem(s). A parent or guardian should be given anticipatory guidance regarding the pros/cons of disclosing to others, including school, acknowledging that the decision to disclose is ultimately up to the patient and/or parents, depending on context.

Collaborative, interdisciplinary management should be considered for all youth with STB. This prevention team should include the PCP, on-site behavioral health teams, psychiatry consults/service, community therapist(s), nurses, and school counselor. Given the limited bandwidth and resources of primary care nurses and providers to maintain a comprehensive behavioral health system, it is also important to educate and reinforce the role that psychiatric-mental health nurse practitioners can play in assessment and treatment at a system-level and policy-level, particularly in regard to public mental health settings (Chapman et al., 2018).

## 4.2 | Getting the school involved

Many adolescents with STB may first present with suicidal ideation to school personnel or a school-based friend, and most return to school after emergency evaluation and/or hospitalization. School-based mental health services are associated with lower rates of depressive episodes and suicidal ideation (Paschall & Bersamin, 2018), and the AAP recommends including school services in co-ordinated, comprehensive planning for maintaining optimal health of children and adolescents (AAP, 2014). However, it is important, when communicating with schools, for nurses working with suicidal youth to recognize that schools operate under different confidentiality rules (California School-Based Health Alliance, 2012).

The Family Educational Rights and Privacy Act (FERPA; 34 C.F.R. § 99, 2011) was established by the United States Department of Education as a safeguard for student privacy in school, explicitly requiring parental consent to disclose personal identifiers from a students' individual education records. FERPA guidelines carve out an exception for this privilege when a child has a health or safety emergency, including suicidal ideation or attempts. Although a thorough discussion of the Health Insurance Portability and Accountability Act (HIPAA) is beyond the scope of this article, it is important for nurses working with suicidal children and adolescents to recognize that mental health information is more protected under HIPAA than FERPA, and there are no explicit adolescent confidentiality rights under FERPA (California School-Based Health Alliance, 2012). In developing plans for returning to school, nurses should discuss the protective benefits of involving school personnel, including school-based mental health clinicians in therapeutic and safety plans (if available), balanced with any concerns the family might have about negative effects of disclosure.

## 5 | DOCUMENTATION AND REPORTING

Documenting the risk level and describing the assessment and treatment rationale is important for the patient's safety, for the clinic's protocols, and for legal reasons (I. H. Stanley, Simpson, Wortzel, & Joiner, 2019). The documentation should include a summary of the biopsychosocial picture of the patient, including any significant protective factors. It is helpful to include direct quotes from the youth and the family, as well as

any direct observations of behavior. From the physical exam, it is prudent to include all pertinent positive and negative findings from skin exam, given the potential for NSSI, trauma, and other important risk factors (Carrigan & Lynch, 2003). The explicit treatment plan should be listed and should specify the measures taken to reduce current risk (e.g., setting, medication, psychotherapy, adjunct therapies, contact with significant others, etc.). For example, if the goal is to reduce availability of lethal means and the family has a gun at home, document the firearm instructions given the patient and family, including their response and chosen plan. The safety plan previously discussed can include all of these measures in one document. Both the C-SSRS and the SAFE-T offer language or templates within their tools for this documentation. It is expected that clinicians will reapproach suicide assessments over time, as the adolescent's situation can rapidly change; suicide prevention is a dynamic, ongoing process and conversation (Borges, Nazem, Matarazzo, Barnes, & Wortzel, 2019; Kleiman et al., 2017).

Should a PCP decide to refer the patient for evaluation for a psychiatric hold, the clinic and provider should take detailed notes on who was called, when, and what was discussed. The details of the call are to be documented in the initial note as an addendum. Finally, consultation notes from other mental health providers or supervisors is expected. Consultation should be sought in all cases with suicidal youth, regardless of provider type or level of expertise (Brodsky et al., 2018; Shain & AAP Committee on Adolescence, 2016). Common questions asked during a clinical consultation include details related to immediacy of suicidal intent, patient's access to firearms or other lethal means; history or presence of NSSI behaviors; impulsivity/recent risky behaviors; present or past use of drugs and/or alcohol; any changes in medical and mental illness; any changes in social factors; patient and family's ability to commit to safety; and, a review of the current safety plan

In summary, suicide assessment and management is a critical skill for nurses and other PCPs, who are at the front lines of clinical care for most children and adolescents. There are a number of strategies used by seasoned providers to feel more at ease in acute situations. Knowledge and implementation of key screening and assessment tools, including crisis protocols, lists of local resources for patients, and clinical role plays, can increase clinical confidence and judgment regarding treatment planning. Many states have mental health consultation programs for pediatric providers (Zuckerbrot et al., 2018) and in other states, there may be local or regional consultation resources. Understanding where and with whom patients can get care helps to distribute the burden of care. Even simple connections, such as visiting the local community suicide prevention organizations (see Table 3 for specific web site links) and introducing yourself, can provide more meaningful, care connections for patients.

## 6 | CONCLUSION

Suicide assessment and management are critical skills for nurses in primary care settings, who are at the front lines of clinical care for most children and adolescents. By practicing and implementing the

tools and strategies outlined in this article, the health care team can assess youth in crisis, calmly and systematically; convey hope and compassion; implement safety plans; and, make appropriate referrals for specialized care as indicated by assessment and risk stratification. Working at the broadest extent of our scopes of practice as nurses, nurse practitioners, and clinical nurse specialists, we have the ability to advocate and provide greater access to behavioral health care. Addressing prevention at the individual and systemic levels, nurses can meaningfully contribute to reversing current suicide trends, saving lives, and improving training around this serious public health issue.

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*If you or someone you know is struggling with suicidal thoughts, call the National Suicide Prevention Lifeline at 800-273-TALK (8255). You can also reach out to the Crisis Text Line, a free, 24/7 confidential text messaging service that provides support to people in crisis when they text 741741.*

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## CONFLICT OF INTERESTS

The authors declare that there are no conflict of interests.

## AUTHOR CONTRIBUTIONS

S. M. S. and N. S. drafted the manuscript and all authors contributed substantially to its revision. S. M. S. and N. S. developed the original curricula and content. P. S. and N. S. provided significant supervision regarding content and organization. S. M. S. takes responsibility for the paper as a whole.

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