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# Teen Suicide Prevention and Response

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# Section 1: Introduction

**References:** 1, 10, 11, 12, 13, 14, 15, 16, 17, 18, 24, 29, 31

Adolescence is defined as the “transitional phase of growth and development between childhood and adulthood” (Csikszentmihalyi, 2026, para. 1). It occurs between the ages of 10 and 19 (World Health Organization [WHO], n.d.). Adolescence is noted to be “a unique stage of human development and an important time for laying the foundations of good health (WHO, n.d., para. 1). As stated by the World Health Organization (WHO) (n.d.), during adolescence, people establish behavioral patterns that can either protect their health and the health of those around them or put them at risk now and in the future. While adolescence is overall considered a healthy stage of life, there can be a significant amount of death, illness, and injury during this time, which is mostly preventable or treatable (para. 3).

The teenage years, generally defined as ages 13 to 19, are marked by many exciting and difficult changes in physical, intellectual, psychological, social, and moral development. Physically, puberty is underway, which means hormones are changing the body; growth spurts occur, acne and body hair develop, and sexual organs mature. Females also begin to develop breasts and experience their first period. Intellectually, the brain is developing rapidly. Rather than thinking only concretely, teenagers begin to display abstract thinking, reasoning, impulse control, creativity, problem-solving, and decision-making skills. Emotionally, teenagers become more aware of their own feelings and those of others. They also start to manage emotions and build their self-confidence. Socially, they begin searching for their identity, become more independent, develop an interest in sexuality and romantic relationships, and invest in friendships. Morally, they begin developing their values, gain a deeper understanding of the world, share opinions

about what is right and wrong, and explore religion and spirituality (Cleveland Clinic, 2023).

All these aspects of development are considered significant in a person's life. While teenagers may welcome some changes, others may be unsettling, especially when they are accompanied by life stressors, such as changes in family (e.g., divorce), changes in friendships, issues arising from social media, in-person or cyberbullying, problems at school, and other losses. In addition to these changes, teenagers may experience strong feelings of stress, confusion, fear, and doubt, which may impact their ability to problem-solve and make decisions. There may also be pressure to succeed placed on them by various people in their lives. For some teenagers, developmental changes, life stressors, and strong feelings may feel like problems too difficult to overcome. Teenagers also lack the life experience to recognize that certain difficulties are temporary. For some people, suicide may seem like a solution instead of feeling any ongoing pain (Chambers, 2025; Johns Hopkins Medicine, n.d.). The current trends in mental health and suicidal thoughts and behaviors among adolescents are reviewed next.

## Current Trends in Mental Health and Suicidal Thoughts and Behaviors

According to the Centers for Disease Control and Prevention (CDC) (2024a), suicide was the second leading cause of death for people ages 10 to 14 and 15 to 24. People ages 10 to 24 account for 13% of all suicides in the U.S. The suicide rate for this age group has been overall increasing over time, with Black youth having the largest increase (Ajluni & Amarasignhe, 2024). From 2007 to 2021, suicide deaths increased by 62% in this age group. For Black youth ages 10 to 17, the suicide rate increased 144% from 2007 to 2020 (Cornman, 2024).

### *2024 Youth Risk Behavior Survey*

In 2024, the CDC published the "Youth Risk Behavior Survey Data Summary and Trends Report: 2013 to 2023," which examined the health behaviors and experiences of high school students in the U.S. during this time frame. This report specifically looked at trends in mental health and suicidal thoughts and behaviors, among other topics such as sexual behavior, substance use, and violence.

Data from 2013 to 2023 overall showed a large and growing number of adolescents who experienced indicators of poor mental health and suicidal thoughts and behaviors. There were increases in the number of students who:

- Had persistent feelings of sadness or hopelessness.
    - Of note, the number of students who experienced these feelings decreased only from 2021 to 2023.
- Seriously considered a suicide attempt.
- Made a suicide plan.
- Attempted suicide.

In addition, the percentage of students who were injured in a suicide attempt that had to be treated by a doctor or nurse remained the same (about 3%) from 2013 to 2023. Furthermore, the percentage of students with poor mental health was the same at 29% from 2021 (the first year the CDC included these measures) to 2023.

While overall there are increasing numbers of students who are struggling with mental health concerns and suicidal thoughts and behaviors, the following progress has been made from 2021 to 2023:

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- As stated above, the number of students who experienced persistent feelings of sadness or hopelessness decreased. However, the overall data show that all other experiences and behaviors remained unchanged during these two years.
- Hispanic students had decreases in measures that report poor mental health and suicidal thoughts and behaviors.
- The percentage of female students who experienced persistent feelings of sadness or hopelessness decreased.
- The percentage of Black students who attempted suicide and were injured during an attempt decreased.

**Disparities**

Some disparities shown in the Youth Risk Behavior Survey in the areas of mental health and suicidal thoughts are as follows:

- Female students, American Indian or Alaska Native students, and students who identify as lesbian, gay, bisexual, questioning, or another non-heterosexual identity (LGBTQ+) experienced persistent feelings of sadness or hopelessness, poor mental health, serious consideration of attempting suicide, made a suicide plan, and were injured in a suicide attempt.
- In the area of suicide attempts, female students and LGBTQ+ students had the highest rates.
- When looking at racial and ethnic groups, though American Indian or Alaska Native students most often experienced the majority of issues noted above, Native Hawaiian or Pacific Islander students had the highest rates of attempted suicides of any racial and ethnic group (CDC, 2024b).

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### *2024 National Survey on Drug Use and Health (NSDUH)*

The 2024 National Survey on Drug Use and Health (NSDUH), conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), published data in 2025 outlining the current state of mental health among adolescents, including substance use disorders, and the frequency of suicidal thoughts and behaviors.

**Anxiety**

In 2024, SAMHSA added the seven-item generalized anxiety disorder (GAD-7) scale to the survey. The GAD-7 screens for and assesses symptoms of anxiety in the last 2 weeks. In 2024:

- About 1 in 5 (18.8% or 4.9 million) adolescents aged 12 to 17 reported moderate or severe symptoms of generalized anxiety disorder (GAD).
- About 1 in 4 (23.1% or 6 million) had mild symptoms of GAD.
- In total, close to 42% (about 11 million) adolescents were living with anxiety symptoms.

**Major Depressive Episode**

The NSDUH also assessed adolescents for having a major depressive episode (MDE) in the past 12 months. The questions were based on the depression criteria in the Diagnostic and Statistical Manual-5, which requires a person to have 5 or more symptoms of depression during the same 2-week period. The survey also included questions on whether MDE in the past 12 months caused impairment in four major life activities (doing chores at home, doing well at school and/or work, getting along with family, and having a social life) or role domains.

- About 15% (3.8 million) adolescents aged 12 to 17 had an MDE in the last 12 months.

- Close to 11% (2.8 million) had MDE with severe impairment in the last 12 months.
- Of note, these numbers show about a 4-5% decrease when compared to the NSDUH conducted in 2021.

**Substance Use Disorders**

Additionally, the NSDUH screened for substance use disorders (SUD). In 2024, for adolescents aged 12 to 17:

- About 3% (775,000 people) had an alcohol use disorder in the last year (the same number as in 2021).
- About 6% (1.7 million people) had a drug use disorder in the last year (the same number as in 2021).

**Co-Occurring Anxiety Symptoms and Substance Use**

Regarding co-occurring moderate to severe anxiety symptoms and substance use, in 2024, among adolescents aged 12 to 17 were:

- More likely than adolescents with no or mild symptoms to have used illicit drugs, marijuana, tobacco products, or vaped nicotine, misused opioids, and binged on alcohol.

Co-Occurring Major Depressive Episode and Substance Use Disorders

Regarding a co-occurring major depressive episode (MDE) and substance use disorder (SUD), in 2024, among adolescents aged 12 to 17:

- About 20% (5.1 million people) had an MDE or an SUD in the last 12 months.

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- Of the about 3.8 million people with MDE, about 3 million of them did not have an SUD.
- However, about 40% of adolescents with an SUD also had an MDE (792,000 people).

**Suicidal Thoughts and Behaviors**

According to the 2024 NSDUH report, the trends in suicidal thoughts and behaviors have been increasing among adolescents, leading them to be a significant public health concern in the U.S.

The 2024 NSDUH included questions to better understand suicidal thoughts and behaviors in adolescents aged 12 to 17, including if they seriously thought about trying to kill themselves, if they made a plan to kill themselves, and if they tried to kill themselves in the last 12 months. The survey showed:

- About 10% (2.6 million people) had serious thoughts of suicide in the past year. This number is down from about 13% (3.4 million people) in 2021.
    - Of note, about 7% (1.7 million people) reported they were unsure or did not know whether they had serious thoughts of suicide, and another close to 7% (1.8 million people) did not want to report whether they had these thoughts. Therefore, the NSDUH has concluded that the estimate of 2.6 million people having serious thoughts of suicide is conservative.
- About 5% (1.2 million people) made a suicide plan in the past year. This number is down from about 6% (1.6 million people) in 2021.
    - Of note, about 3% (668,000 people) reported they were unsure or did not know whether they had made a suicide plan, and close to 6% (1.5 million people) did not want to report whether they had made a plan.

Therefore, the NSDUH has concluded that the estimate of 1.2 million people having made a suicide plan is conservative.

- About 3% (700,000 people) attempted suicide in the past year. This number decreased from 940,000 people in 2021.
    - Of note, about 2% (431,000 people) reported they were unsure or did not know whether they had attempted suicide, and close 5% (1.2 million people) did not want to report whether they attempted suicide. Therefore, the NSDUH has concluded that the estimate of 700,000 people attempting suicide is conservative.
- About 2% (537,000 people) had serious thoughts, made a plan, and attempted suicide in the past year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2025).

## Teen Suicide Myths

While teen suicide is a significant public health concern in the U.S., several myths on the topic remain.

One of the most common myths about suicide is that talking about it will cause a person to attempt it. However, research has shown that talking openly about suicide can reduce suicidal ideation and does not increase the risk of an attempt (Camber Mental Health, 2021; Cartlidge, 2017). It is helpful for a teen who is depressed or suicidal to be able to talk about their thoughts and feelings openly, though talking about these topics should be carefully managed. Social workers need to create a safe, non-judgmental space to talk with teens about suicide in an empathetic, age-appropriate manner. Asking direct questions and allowing a person to express themself may provide a sense of comfort and reassurance that others care about them. It can also help to be aware of the warning signs of

suicide in case they are mentioned in a conversation with a person who is struggling with depression or suicidal ideation (Camber Mental Health, 2021).

Another common myth is that a person who threatens suicide is not serious about killing themself. Still, a suicide threat or attempt is more often than not a call for help, not a normal stress response, and must be taken very seriously.

An additional common myth is that depression and suicidal thoughts and behaviors are rare in adolescents (Cartlidge, 2017). However, as the data above shows, there are millions of adolescents dealing with depression, and suicide is the second leading cause of death for people ages 10 to 24 (CDC, 2024a; SAMHSA, 2025).

Another myth related to depression and suicide is that only teens who are depressed will make a suicide attempt. However, a report from the CDC in 2019 showed that about 54% of people who died by suicide in 2019 did not have a known mental health condition. While there can be a link between depression and suicidal thoughts and behaviors, not every person diagnosed with depression is suicidal. Furthermore, suicidal thoughts and behaviors can happen to anyone regardless of their age, gender, race, ethnicity, or other socioeconomic factors.

Lastly, the myth that suicide is not preventable exists. People may think that if someone wants to end their life, there is nothing that will prevent them from doing so. Research has shown that professional counseling, medications, and other treatment approaches have been helping in supporting people who are struggling with suicidal thoughts and behaviors (Camber Mental Health, 2021).

## Course Summary

As noted in the data presented above, adolescent mental health, substance use, and suicide remain significant and growing concerns in the U.S., with many

contributing factors, such as exposure to self-harm and suicide contagion through social media, in-person and cyberbullying, self-esteem and body image issues, stress, and peer pressure, among others. Social workers across many settings, including clinical, school, community, and healthcare settings, are increasingly likely to encounter adolescents at risk for suicide and are expected to respond appropriately.

This course provides information on warning signs of teen suicide as well as risk and protective factors, conducting suicide screening and risk assessments, implementing evidence-based safety planning interventions, and documenting risk and interventions. Trauma-informed, developmentally appropriate approaches to supporting youth following a suicide attempt, as well as responding to the impact of suicide deaths within families, schools, and communities, are also reviewed.

## Section 1 Key Terms

Suicide is "death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death" (U.S. Department of Health and Human Services [HHS], 2001, p. 7).

A suicide attempt is a "potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries" (HHS, 2001, p. 6).

Suicidal behavior is a "spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide" (HHS, 2001, p. 6).

Suicidal ideation is "self-reported thoughts of engaging in suicide-related behavior" (HHS, 2001, p. 6).

# Section 2: Warning Signs, Risk Factors, and Protective Factors

**References:** 9, 11, 14, 18, 19, 22, 29

## Warning Signs of Teen Suicide

The American Foundation for Suicide Prevention (AFSP) (n.d.b) states, “most people who take their lives exhibit one or more warning signs, either through what they say or what they do” (para. 7). The more warning signs, the greater the risk of suicide (Chambers, 2025, p. 20).

Some warning signs of teen suicide look similar to depression symptoms. They are as follows:

- Changes in normal eating habits, such as eating more or less
- Changes in sleep habits, such as sleeping more or less
- Neglecting personal hygiene or appearance
- Increasing physical issues, such as headaches, stomachaches, and extreme fatigue
- Loss of interest in normal activities
- Loss of interest in school or homework
- Lack response to positive feedback or praise
- Withdrawing from family members and friends
- Acting out or running away
- Risk-taking behaviors, or in contrast, boredom

- Trouble concentrating
- Substance use, including alcohol and/or drugs, or an increase in use
- Obsession with death and dying
- Feeling a desire to die

The AFSP (n.d.b) also states, “something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of sharpest concern if the new or changed behavior is related to a painful event, loss, or change” (para. 7). Some of the behaviors may indicate depression, anxiety, irritability, humiliation, shame, agitation, and anger.

Additional warning signs include:

- Talking about wanting to die. A person may make direct statements like “I want to kill myself” or “I am going to kill myself.”
- Indicating that they are a burden to other people. A person may say something like “I will not be a problem for much longer” or “If something happens to me, you must know…”
- Talking about killing oneself, looking for ways to kill oneself, expressing feelings of hopelessness, having no purpose, feeling trapped, or being in unbearable pain.
- Giving way or throwing away belongings, including favorite or important things.
- Sudden happiness after showing signs of depression.
- Visiting or calling people to say goodbye.
- Writing one or more suicide notes.

## Risk Factors

A teen's suicide risk varies with their age, gender, culture, and social influences, which can change over time. The chances of suicide are greatly increased when several risk factors are experienced at the same time. The following factors increase the risk of suicide:

- Having one or more mental health conditions, such as depression, anxiety, or substance use problems
- Prior or current trauma
- Experiencing stressful life events, such as the death of a loved one or bullying, and having prolonged exposure to stressful situations
- Discrimination
- Social isolation
- Dealing with relationship issues, such as a break-up with a partner or other losses
- Identifying as LGBTQ+
- Engaging in violent or impulsive behaviors
- Having a past suicide attempt
- Being exposed to violence and/or the suicidal behaviors of other people
- Easy access to lethal means, such as a gun or prescription medicines
- Having a family history of:
    - Suicide
    - Mental health conditions or substance abuse problems

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    - Violence, including physical, mental, emotional, sexual, or verbal
    - Generational trauma (American Foundation for Suicide Prevention [AFSP], n.d.b; Cartlidge, 2017; Chambers, 2025; Johns Hopkins Medicine, n.d.; National Alliance on Mental Illness, n.d.)

### *High-Risk Groups*

According to the National Alliance on Mental Illness (n.d.), some groups of people are at a higher risk than others, most often groups that are historically disadvantaged and have experienced discrimination. In addition, groups with social and environmental stressors and limited access to care and support have higher rates of suicide.

- Black American youth have rates of suicide that have been increasing in recent years due to racism, discrimination, and inequity.
- Indigenous Communities, including Alaska Natives, have higher rates of suicide when compared to the general population because of generational trauma, poverty, stigma, and other factors.
- Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Intersex (LGBTQI) youth are at a higher risk of suicide due to facing many issues that negatively impact them, including discrimination, prejudice, harassment, and rejection.

## Protective Factors

- The following are protective factors that contrast risk factors:
- Positive coping skills, the ability to solve problems, and deal with stressful or frustrating situations

- Religious and/or cultural beliefs that encourage connection and seeking help, discourage suicidal thoughts and behaviors, and/or create a strong sense of purpose and self-esteem
- Interests and involvement in activities
- Responsibility to a loved one, including pets
- Healthy positive relationships and social supports, including family, community, and/or an important person that a teenager relates to or looks up to
- Access to mental health care and taking a proactive approach to it
- Limited or no access to lethal means (Chambers, 2025; Nevada Division of Public and Behavioral Health, Office of Suicide Prevention, n.d.)

### Section 2 Key Terms

Risk factors are "those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological, or social factors in the individual, family, and environment" (HHS, 2001, p. 5).

Protective factors are "factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological, or social factors in the individual, family, and environment" (HHS, 2001, p. 5).

## Section 3: Suicide Screening and Risk Assessments

**References:** 2, 4, 5, 6, 7, 14, 20, 21, 23, 26, 27, 28, 29

### Brief Suicide Risk Screening

The American Academy of Pediatrics (AAP) (2023d) states, "screening is a quick way to identify someone who needs further evaluation. Anyone who screens

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positive on a suicide risk screening tool should be followed up with a brief suicide safety assessment" (para. 1). Screening only identifies risk (AAP, 2023b).

The AAP (2023d) has published the following brief suicide screening recommendations based on age (not including youth under age 8):

- Youth who are aged 12 and up - Universal screening
    - Screening all people aged 12 and up is recommended for the following reasons:
        - Young people may keep suicidal thoughts to themselves and not bring up the topic if they are not asked directly.
        - Universal screening is a more comprehensive strategy when compared to "targeted" screening, which may only screen for suicide in behavioral health settings.
        - Young people who engage in the medical system to receive preventive care can have mental health concerns that they are not talking about with anyone.
        - Universal screening can help people feel less alone with their suicidal thoughts, so that they do not go undetected or unsupported.
        - Equity in care delivery is promoted when each person is screened the same way.
        - Research has shown that most people who die by suicide have visited a healthcare provider in the weeks or months before their death. Screening can help identify people at risk and offer them support.

- Youth who are ages 8 to 11 - Screening administered when clinically indicated
    - Screening when clinically indicated could include the following situations:
        - The patient presents with behavioral health-related complaints
        - The patient or their parent expresses a concern
        - The patient has a reported history of suicidal ideation or behavior
        - The patient is showing the warning signs of suicide

The following suicide screening tools are recommended by the AAP (2023d) as they are clinically validated:

- Ask Suicide-Screening Questions (ASQ) - includes four brief screening questions that take less than 30 seconds to administer (National Institute of Mental Health, n.d.).
- Suicide Behavior Questionnaire-Revised (SBQ-R) - includes four brief screening questions that each ask about a different dimension of suicidality (Nebraska Youth Suicide Prevention, 2019).
- Columbia Suicide Severity Rating Scale (C-SSRS) - Triage Version - an up to six-question screening tool to identify suicide risk (The Columbia Lighthouse Project, n.d.b).
- Patient Health Questionnaire-9 Adolescent Version (PHQ-9A) - a 13-item questionnaire that screens for depression and other mental illnesses as well as suicide risk (American Academy of Child and Adolescent Psychiatry, 2010).

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- Patient Safety Screener-3 (PSS-3) - the first three questions (with one possible follow-up question) of the PSS that assesses depression, active suicidal ideation, and lifetime suicide attempt (Suicide Prevention Resource Center, n.d.b).

In practice, the workflow, including the screening tool and frequency, and interventions will vary based on practice preferences. However, the AAP recommends screening patients who have no history of suicide risk no more than monthly and no less than annually. Furthermore, if a patient has already been identified to be at risk of suicide, they do not have to be rescreened, but safety should be assessed at subsequent visits. Lastly, depression screening alone is not adequate when screening for suicidality, as not all people who are at risk of suicide have symptoms of depression (American Academy of Pediatrics [AAP], 2023d).

## Brief Suicide Risk and Safety Assessment

Determining suicide risk and safety is important so that patients receive the appropriate level of care and support that they need. Some patients may need immediate intervention and safety precautions, while others may need less intervention.

Each of the screening tools mentioned above has its own scoring methods and guidelines to help a clinician learn if a person is at risk of suicide. As noted above, if a person screens positive for risk, a social worker must complete a more in-depth assessment, using clinical judgment to determine the person's level of risk and the appropriate interventions (AAP, 2023c). This type of assessment is called a brief suicide safety assessment, which is a "conversation with the patient that assists in further triage by evaluating the frequency of suicidal thoughts, plans, mental health symptoms, suicide history, supports, and other factors" (AAP, 2023b, para. 7).

The following are commonly used tools to conduct a brief suicide risk and safety assessment:

- SAMHSA's SAFE-T Suicide Assessment 5-Step Evaluation and Triage - provides an overview of completing a suicide assessment using a 5-step

evaluation and triage plan, including identifying risk factors, protective factors, inquiring about suicide, determining risk level and interventions, and treatment plan documentation (SAMHSA, 2024).

- SAFE-T Protocol with C-SSRS Lifetime/Recent - Youth - includes the C-SSRS plus risk and protective factors in SAMHSA's SAFE-T format for youth.
- Columbia Suicide Severity Rating Scale (C-SSRS) - Full Version - assesses full and recent history of suicidal ideation and behavior (The Columbia Lighthouse Project, n.d.a).

The AAP (2023c) recommends that the suicide safety assessment be done between the adolescent patient and the social worker. An AAP policy, "Unique Needs of the Adolescent" and "Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents," highlight the need for a confidential, one-on-one visit between an adolescent patient and a social worker as an opportunity to have an open and honest discussion about the adolescent's psychosocial situation, mental health, and suicidal thoughts and behaviors. State law considerations regarding adolescent confidentiality, consent, and documentation must be taken into account (AAP, 2023c; AAP, 2026).

During these conversations, a social worker needs to be mindful of language about suicide and terms that could insinuate stigma or blame. Having these conversations through a trauma-informed lens can provide a supportive environment. Using a non-judgmental tone, asking open-ended questions, actively listening, making eye contact, and using culturally responsive, family-centered language are all a part of trauma-informed patient-centered care. Furthermore, the social worker can consider sharing that the steps they are taking are standard practice, which can normalize the experience for the patient and their family (AAP, 2026).

Before beginning the assessment, the social worker can set expectations for the visit and review confidentiality with the patient and their parent(s)/caregiver(s) together. The social worker needs to share that they will keep anything discussed during the one-on-one visit confidential unless someone's safety is at risk (AAP, 2023c; AAP, 2026).

Then, the social worker can meet with the patient one-on-one to assess their situation, mental health, and suicide risk. During the part of the assessment that is focused on suicidality, the social worker should include specific questions about the following:

- Thoughts (frequency, intensity, and duration) within the last 2 days, past month, and worst ever
- Plans (timing, location, method, availability of lethal means, preparatory acts)
- Behaviors (past suicide attempts, aborted attempts, rehearsals versus injuries or actions that were not suicidal)
- Intent (extent to which the patient will carry out the plan and their belief in the plan being lethal; ambivalence and reasons to live instead of die can be explored) (SAMHSA, 2024)

If suicide risk is detected during screening and/or within the assessment, the social worker must notify the patient's parent(s)/caregiver(s). Prior to doing so, the social worker can gently reinforce confidentiality, explain the need to speak with their family after the assessment, and outline what will happen next. The social worker can also ask the patient how they want to be involved in that conversation, including whether the social worker will disclose to the family privately or with the patient in the room, if the patient will disclose to their family

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privately, or if the patient would like the social worker to be in the room when they talk with their family.

No matter whether the social worker is a part of a conversation or leading it, they need to have the opportunity to speak with the parent(s)/caregiver(s) before the end of the visit. They can offer to meet with the patient and their family together or privately (AAP, 2023c; AAP, 2026).

After completing the suicide risk and safety assessment, the following is a framework developed by SAMHSA to help clinicians determine risk level and appropriate interventions.

| **Risk Level** | **Risk/Protective Factor** | **Suicidality** | **Possible Interventions** |
|---|---|---|---|
| Low | Modifiable risk factors and strong protective factors | Thoughts of death, but no plan, intent, or behavior | Outpatient referral for symptom reduction. Provide a crisis phone number. |
| Moderate | Multiple risk factors and a few protective factors | Suicidal ideation with a plan, but no intent or behavior | May need to be admitted based on risk factors. If not admitted, develop a crisis plan. Provide a crisis phone number. |
| High | Psychiatric diagnosis with severe symptoms or an acute precipitating event. Protective factors are not relevant in this situation. | Potentially lethal suicide attempt or persistent ideation with a strong intent or suicide rehearsal | Admission is generally indicated unless there is a significant change that reduces risk. Implement suicide precautions. |

(Chambers, 2025, p. 184; SAMHSA, 2024)

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### Section 3 Key Terms

Screening is the "administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment" (HHS, 2001, p. 5).

Screening tools are "those instruments and techniques (questionnaires, check lists, self-assessment forms) used to evaluate individuals for increased risk of certain health problems" (HHS, 2001, p. 6).

Suicidality is "a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide" (HHS, 2001, p. 7).

### Section 3 Reflection Questions

What has been your experience conducting suicide screening and suicide risk and safety assessments?

What aspects of these conversations do you find most challenging?

## Section 4: Trauma-Informed Safety Planning

**References:** 3, 7, 8

A safety plan is a personal and unique plan that "includes the individual's identification of the thoughts, feelings, and experiences just prior to a decline in mental health that they can learn may signal an impending suicidal crisis; and helpful and effective actions they have found helpful at earlier times of distress in their life" (AFSP, n.d.a, para. 3). It can be written down in a document or kept in a mobile app.

Safety planning is an evidence-based intervention to reduce suicide risk. It is most effective when a patient creates their own plan with the support and guidance of

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someone knowledgeable about the goals and components, such as a social worker. When a patient creates their own plan, they learn to trust themselves and become an expert in their experience. The AAP (2023a) recommends that safety plans should be:

- Personalized.
- Developed in collaboration with each patient and their family member(s)/ caregiver(s).
- Developmentally, culturally, and linguistically appropriate.

The safety plan should identify the patient's:

- Own warning signs or suicidal thought triggers.
- Coping strategies.
- Social support/contacts.
- Emergency contacts.
- Ways they will reduce access to lethal means (AAP, 2023a).

It should also include:

- Specific activities, places, and people that can provide a distraction away from suicidal thoughts
- The things that make a person unique, including their hopes for the future and reasons for living
- People to contact when intense suicidal thoughts and feelings arise, including a mental health professional (as appropriate)
- Strategies that can be used at any time, day or night

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- Ways to reduce lethal means in the home or immediate environment
- A back-up plan, such as calling the 988 Suicide and Crisis Lifeline or texting the Crisis Text Line (AAP, 2023a; AFSP, n.d.a)

While engaging in safety planning, a social worker needs to be mindful of any language that could insinuate stigma or blame. They can also have these conversations using trauma-informed, patient-centered care strategies, such as a non-judgmental tone, open-ended questions, active listening, making eye contact, and culturally responsive, family-centered language (AAP, 2026).

### Section 4 Reflection Question

What strategies do you find most helpful when engaging in the safety planning process with a patient or client and their family?

## Section 5: Lethal Means Counseling

**References:** 3, 8

Lethal means counseling is an intervention that can reduce the risk of suicide as it engages the patient and their parent(s)/caregiver(s) in securing any lethal means and reducing access to them, especially in the home environment. The goal of this intervention is to protect a teenager during a crisis by making the environment safe beforehand. Since suicidal crises can escalate quickly and a person may make a quick decision to end their life (even if they have thought about suicide for a long time), it is essential to put distance between the suicidal person and dangerous items. With time and distance, the crisis moment can pass, and the person in crisis can turn to their coping strategies and supportive people in their life.

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Lethal means counseling includes the following steps:

- A social worker expresses concern for the patient's safety.
- The social worker talks to the patient and their family about what they need to do to create a safe environment, including removing or securing any type of lethal means from the home environment, such as firearms, medications (prescription and over-the-counter), toxic chemicals, ropes, belts, and sharp objects. Alcohol and illicit drugs also need to be removed. Since patients and their families may not be familiar with the term "lethal means," it is important to talk directly and practically with them about the meaning and examples.
    - Half of youth suicides happen with firearms that were unsecured at home, and these attempts are almost always fatal.
    - Medications are commonly found in homes, so they need to be locked up, the quantity needs to be reduced, and unneeded medications need to be removed.
- The social worker provides education about lethal means safety by:
    - Explaining that, since times of crisis cannot be predicted and teenagers may make impulsive decisions, access to all lethal means must be reduced at all times.
    - Sharing that thinking is less flexible in moments of crisis, and that a person typically cannot think clearly enough to change their mind about the method they may use to kill themselves.
    - Explaining that since it is not always possible to stop someone from going through with an attempt, if an attempt occurs, it will likely be

less lethal if all lethal means are not available (AAP, 2023a; AFSP, n.d.a).

Of note, the AAP (2023a) states the following about lethal means counseling:

> *"Clinicians should be aware that lethal means safety counseling may involve variations based on culture, family circumstances, or parent/caregivers' profession (for example, families may need medication on hand to care for a relative or may have firearms in the house because a parent serves in the military or law enforcement). Counseling should always be specific to the family" (para. 28).*

The AAP (2023a) also states that trauma-informed communication should be utilized when addressing lethal means. Some strategies include:

- Being thoughtful about the words that are used to avoid the family feeling judged or shamed if they own a gun or guns, or if they cannot remove everything that is lethal from their home.
- Emphasizing that safety measures are often temporary.
- Explaining that they are not alone or being singled out, and that lethal means counseling is a part of normal practice when someone is at risk of suicide.

## Section 6: Navigating Clinical Pathways and Referral Options

**References:** 4, 14

Brief suicide screening and suicide risk and safety assessment are the first two steps of an evidence-based clinical pathway. The American Academy of Child and

Adolescent Psychiatry (AACAP) Pathways to Clinical Care suicide risk workgroup developed pathways for suicide prevention for the inpatient and emergency department settings. The National Institute of Mental Health adapted these pathways for the outpatient and specialty care settings. The main difference between the pathways is the proposed interventions. The purpose of the pathways is to have processes in place to respond to someone who is at risk of suicide and to have the needed resources available to guide the management of suicide risk, which is a prevention strategy.

After the brief suicide screening and suicide risk and safety assessment are complete, a social worker will determine a person's risk of suicide. The above proposed chart from SAMHSA and the following recommendations from the AAP can help determine risk level and appropriate interventions.

- If a person is at high or imminent risk, they require an emergency mental health evaluation. If a mental health professional who can do this evaluation is not available on site, the patient needs to be sent to the emergency department, or a mobile crisis team or acute mental health evaluation center needs to be engaged in the patient's care. The only situation that does not require these interventions is if contact with the patient's current mental health provider is possible and a safety plan for imminent risk has been established previously.
- If a patient is at moderate risk, they may be admitted based on their risk factors. If they are not admitted, they will need a full mental health evaluation from a mental health professional or primary care physician who can manage these types of concerns. If this type of evaluation is not available on-site, the person conducting the brief suicide safety assessment can refer the patient to an outpatient mental health professional for a comprehensive evaluation. Steps, such as a crisis plan, should also be

developed to protect the patient's safety at home (AAP, 2023b; Chambers, 2025).

- If the patient is low risk, the AAP (2023b) states that the person conducting the brief suicide safety assessment can determine if the patient might benefit from outpatient mental health follow-up. SAMHSA recommends an outpatient referral for symptom reduction and that a patient receive a crisis phone number (Chambers, 2025).

## Section 7: Documentation

**References:** 14, 23

After the assessment and interventions are complete, documentation follows and should include the following components:

- Risk level (as outlined in the table above) and rationale
- Treatment plan to address and reduce the current risk, including the roles for parent(s)/caregiver(s). A treatment plan can include:
    - Safety planning
    - Medication
    - Psychotherapy
    - Contact with supportive people in the patient's life
    - Consultation
- Details of lethal means counseling
- Follow-up plan

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Patients and their families should receive a copy of the safety plan (Chambers, 2025; SAMHSA, 2024).

## Section 8: Implementing Basic Postvention Practices

**References:** 25, 30

Postvention is defined as:

> *"An organized response in the aftermath of a suicide to accomplish any one or more of the following: to facilitate the healing of individals from the grief and distress of suicide loss, to mitigate other negative effects of exposure to suicide, to prevent suicide among people who are at high risk after exposure to suicide" (Survivors of Suicide Loss Task Force, as cited in Suicide Prevention Resource Center, n.d.a, para. 4).*

Postvention is a part of a comprehensive approach to suicide prevention, as all communities and organizations should be prepared to respond to a suicide death. The key principles and actions of comprehensive postvention are to:

- Plan to address the needs of individuals and communities.
    - Have protocols in place to respond quickly and compassionately after a suicide death, both to the immediate emotional needs of people who were directly impacted by the death, as well as the long-term risks and effects of the exposure.
    - Provide education and build relationships with people who interact with bereaved people, including law enforcement, first responders, mental health providers, and more.

    - Adopt the Active Postvention Model, which provides an opportunity for volunteers to reach out to suicide loss survivors proactively to provide support and resources.
- Respond effectively and provide immediate and long-term support.
    - Work with news media to encourage safe reporting.
    - Work with those impacted by the suicide death to decrease the risk of suicide contagion.
    - Have options for ongoing support and treatment for people who need it.
    - Provide support and guidance to the bereaved and their family members and friends to help them provide ongoing support.
- Tailor responses and services to the unique needs of suicide loss survivors and involve them in planning and implementing postvention efforts.

More information about postvention can be found in the "Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines" developed by the Survivors of Suicide Loss Task Force of the National Action Alliance for Suicide Prevention (Suicide Prevention Resource Center, n.d.a).

## Section 8 Key Terms

Safe reporting is a method for the news media to report on suicide in an accurate way that does not negatively impact people at risk (Suicide Prevention Resource Center, n.d.a).

Suicide contagion is "the exposure to suicide or suicidal behaviors within one's family, one's peer group, or through media reports of suicide and can result in an

increase in suicide and suicidal behaviors. Direct and indirect exposure to suicidal behavior has been shown to precede an increase in suicidal behavior in persons at risk for suicide, especially in adolescents and young adults" (HHS, 2023, para. 1).

# Additional Resources

## Screening and Assessment

- Ask Suicide-Screening Questions (ASQ) Toolkit
    - Brief Suicide Safety Assessment - Youth Outpatient
- Suicide Behavior Questionnaire-Revised (SBQ-R) Toolkit
- The Columbia Protocol for Healthcare and Other Community Settings - includes screeners, full scales, and support documents.
    - Columbia Suicide Severity Rating Scale (C-SSRS) - Triage Version
    - Columbia Suicide Severity Rating Scale (C-SSRS) - Full Version
    - SAFE-T Protocol with C-SSRS Lifetime/Recent - Youth
- Patient Health Questionnaire-9 Adolescent Version (PHQ-9A)
- Patient Safety Screener
- SAMHSA's SAFE-T Suicide Assessment Five Step Evaluation and Triage, including the Suicide Safe Mobile App
- How to Talk about Suicide Risk with Patients and Their Families: Recommendations from the American Academy of Pediatrics.

## Safety Planning

- Stanley Brown Safety Plan
- Mayo Clinic - Teen Safety Plan
- 988 Suicide and Crisis Lifeline (includes calling, texting, chatting, and videophone)
    - 988 Safety Plan
- Crisis Text Line

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