

Addressing Youth Suicide Risk in Primary Care

Jennifer L. Hughes, PhD, MPH

*Psychologist and Principal Investigator,
Center for Suicide Prevention and Research*

*Abigail Wexner Research Institute
Nationwide Children's Hospital*

*Associate Professor,
Department of Psychiatry & Behavioral Health, College of Medicine
Division of Health Behavior & Health Promotion, College of Public Health
The Ohio State University*



NATIONWIDE CHILDREN'S®

My Disclosures



- Employer: Nationwide Children's Hospital and The Ohio State University
- Grants: AFSP (SAFETY-P), NIMH, NINR, NCCIH, PCORI, NCH private donors and foundations
- Consulting: Mental Health in Mind, International AB (YAM Developer)
- Royalties: Guilford Press
- Speaker's Fees/Honoraria for trainings in suicide prevention intervention throughout the US

Learning Objectives



- Identify the common elements of a clinical pathway for screening, assessment, and management for suicidal youth in primary care.
- Describe safety planning and care linkage strategies to use with suicidal youth and families.
- Describe lethal means restriction strategies to use with suicidal youth and families.

Youth Suicide: The Numbers

Suicide is a serious public health problem world-wide and in the United States (CDC)

- 2nd-3rd leading cause of death for 10-to-24-year-olds
- 4th leading cause of death for 5-to-14-year-olds

Annual percentage of encounters identified as suicidality or self-harm more than doubled, from 0.67 percent in 2008 to 1.79 percent in 2015 (Plemmons et al., 2018)

2025 Youth Risk Behavior Survey: in their lifetime,

- 14.5% of US adolescents reported seriously considering suicide
- 12.5% had made a plan
- 6.4% had made an attempt



NATIONWIDE CHILDREN'S®

Number of suicide deaths per 100,000 population, by county, Ohio, 2017-2022*



Source: HPIO Data Snapshot “Suicide in Ohio.” Data from Ohio Department of Health, Public Health Data Warehouse



NATIONWIDE CHILDREN'S®

Some groups have higher suicide rates than others. . .

- Race/ethnicity
 - Highest rates are among American Indian/Alaska Native and non-Hispanic White populations
 - The suicide death rate among Black youth is increasing faster than that of any other racial/ethnic group
- People who live in rural areas
- Sexual and gender minority youth



NATIONWIDE CHILDREN'S®

Elements of a Zero Suicide Approach



- Is an aspirational goal
- Systems approach that began in Behavioral Health
- Prioritizes lived experience input and quality improvement at all phases
- Focuses on error reduction and safety in health care



**Why is suicide prevention
necessary in primary care
pediatrics?**

**What might screening,
assessment, and management
look like in this setting?**

Pediatric Primary Care as a Site for Suicide Prevention

- PCPs are often the de-facto principal mental healthcare provider for children and adolescents.
- Screening for suicide risk has been advocated because of high frequency of visits to PCP compared to other health settings.
 - >80% of youths visit their PCP each year.
 - ~80% of youth who die by suicide have a health service contact with an outpatient physician in the year before death .

Source: www.actionalliance.org; Horowitz et al., 2014; Rhodes et al., 2013

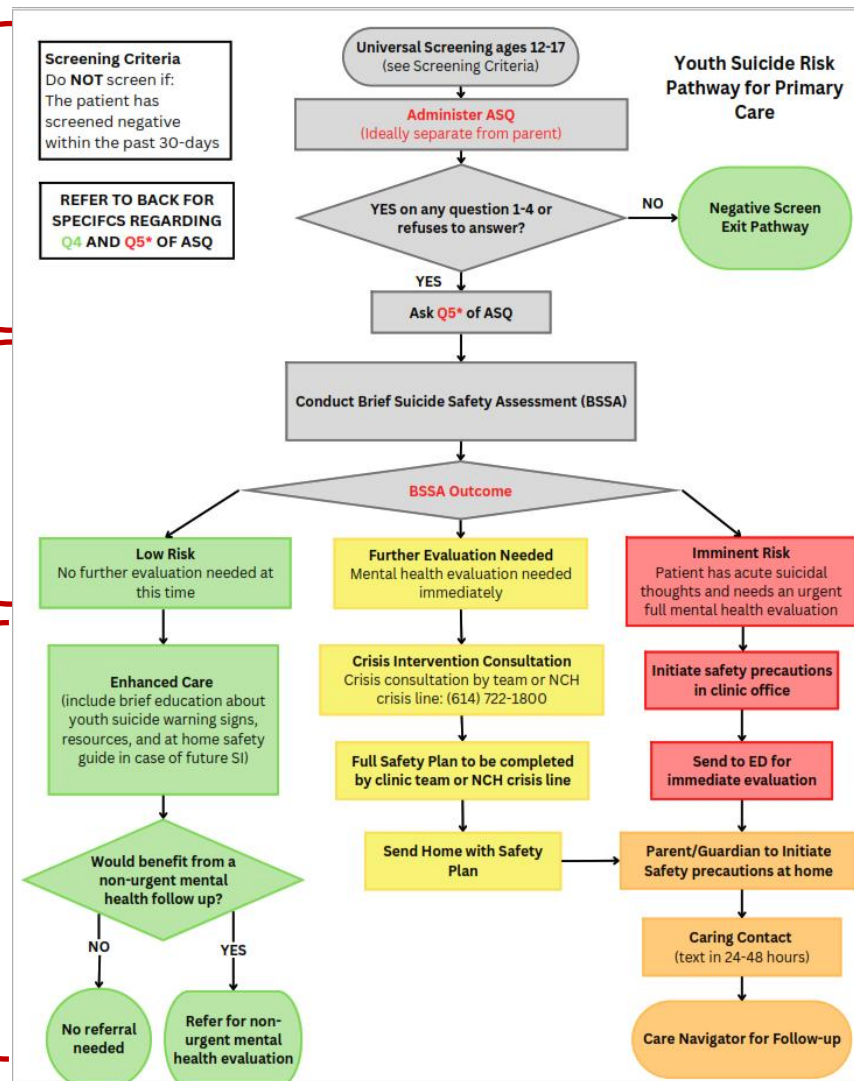


NATIONWIDE CHILDREN'S®

Universal Suicide Screening Steps

Suicide Safety Assessment
How at risk is the individual for suicide?

Steps for care are based on risk level



**NIMH ASQ
Clinical
Pathway**

Tool for Universal Screening for Suicide Risk

- The **Ask Suicide-Screening Questions (ASQ)** is a **valid suicide-specific screening tool**.
- Helps healthcare professionals to better understand if **further assessment is required**.
- For the ASQ, positive “yes” responses should accurately detect youth who need a more thorough assessment of suicide risk.

Source:

https://www.nimh.nih.gov/sites/default/files/documents/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit.pdf

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No
If yes, how? _____
When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No
If yes, please describe: _____

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary. (Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - ☐ “Yes” to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **3A1** safety/mental health evaluation.
 - Patient cannot leave until evaluated for safety.
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
 - ☐ “No” to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

asQ Suicide Risk Screening Toolkit NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) NIMH 7/1/2008



NATIONWIDE CHILDREN'S®

Brief Suicide Safety Assessment Page 1



NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

What to do when a pediatric patient screens positive for suicide risk:

- Use after a patient (8 - 24 years) screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

(If possible, assess patient alone depending on developmental considerations and parent willingness.)

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" If yes, ask "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

"Are you having thoughts of killing yourself right now?" (If "yes," patient requires an urgent/STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" If yes, ask "What is your plan?" If no plan, ask "If you were going to kill yourself, how would you do it?"

Notes: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) Ask "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms *Ask the patient about:*

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchy than usual?"

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

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

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

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" If yes, ask "When?"

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

Brief Suicide Safety Assessment

Page 2



NIMH TOOLKIT: YOUTH OUTPATIENT

Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

3 Interview patient & parent/guardian together

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join.

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said... (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behavior that you're aware of?" If yes, say: "Please explain."
- "Does your child seem:
 - Sad or depressed?"
 - Anxious?"
 - Impulsive? Reckless?"
 - Hopeless?"
 - Irritable?"
 - Unable to enjoy the things that usually bring him/her pleasure?"
 - Withdrawn from friends or to be keeping to him/herself?"

- "Have you noticed changes in your child's:
 - Sleeping pattern?"
 - Appetite?"
- "Does your child use drugs or alcohol?"
- "Has anyone in your family/close friend network ever tried to kill themselves?"
- "How are potentially dangerous items stored in your home?" (e.g. guns, medications, poisons, etc.)
- "Does your child have a trusted adult they can talk to?" (Normalize that youth are often more comfortable talking to adults who are not their parents)
- "Are you comfortable keeping your child safe at home?"

At the end of the interview, ask the parent/guardian:
"Is there anything you would like to tell me in private?"

4 Make a safety plan with the patient Include the parent/guardian, if possible.

Create a safety plan for managing potential future suicidal thoughts. A safety plan is different than making a "safety contract"; asking the patient to contract for safety is NOT effective and may be dangerous or give a false sense of security.

Say to patient: "Our first priority is keeping you safe. Let's work together to develop a safety plan for when you are having thoughts of suicide."

Examples: "I will tell my mom/coach/teacher."
"I will call the hotline." "I will call _____."

Discuss coping strategies to manage stress (such as journal writing, distraction, exercise, self-soothing techniques).

Discuss means restriction (securing or removing lethal means): "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"

Ask safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe; but a "yes" is a reason to act immediately to ensure safety.)

5 Determine disposition

After completing the assessment, choose the appropriate disposition plan. If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.

- ☐ **Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts). Send to emergency department for extensive mental health evaluation (unless contact with a patient's current mental health provider is possible and alternative safety plan for imminent risk is established).
- ☐ **Further evaluation of risk is necessary:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
- ☐ **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.
- ☐ **No further intervention is necessary at this time.**

For all positive screens, follow up with patient at next appointment.

6 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

Need more research into effective interventions

- Only a few interventions are evidence-based* at this time. . .
 - CBT-SP (Cognitive Therapy for Suicide Prevention)
 - **DBT (Dialectical Behavior Therapy)**
 - CAMS (Collaborative Assessment and Management of Suicidality)
 - SPI (Safety Planning Intervention)
 - **Care Linkage (SAFETY-A/FISP)**
 - Caring Contacts
 - Reducing Access to Lethal Means
- *outcomes vary in these studies – include reducing suicidal ideation, reducing repeat suicidal behavior, linking to care*



Common Elements of Effective Treatment Programs – Youth

- Comprehensive assessment to inform treatment
- Safety planning
- Family involvement in separate or joint sessions
- Coping skills training to match the needs identified in the assessment
- Promotion of continuity of care



Brief Intervention for Suicidal Adolescents

Safety Planning



Safety Planning

- Found in:
 - Emergency department
 - Primary care (often used in response to a positive screen in a suicide prevention clinical pathway, though data is limited)
 - As part of suicide-specific outpatient intervention
- Safety Planning often is a term used for a suite of brief interventions, including safety planning, lethal means safety counseling, motivation-enhancement and problem-solving to support mental health care linkage, and plans for follow-up and monitoring



Safety Planning

- Brief intervention
- An evidence-based and effective technique to reduce suicide risk
- Safety planning supports individuals during a suicidal crisis to develop steps to reduce the likelihood of engaging in suicidal behavior

Safety Planning: Evidence-Base

Safety planning is an element of cognitive-behavioral therapy for suicide prevention and can be used as a brief standalone intervention paired with referral for mental health treatment (Ferguson et al., 2022; Stanley et al., 2009; Brown et al., 2005)

Safety planning is effective at reducing suicidal ideation and behavior in adults, yet there are limited studies with youth (Abbott-Smith et al., 2023; Asarnow et al., 2009; Czyz et al., 2018; Hughes & Asarnow, 2013; Adrian et al., 2023)

One meta-analysis looking at effectiveness of safety planning on suicidal ideation and behavior only found studies from high-income country settings (US, Switzerland, Taiwan; Nuij et al., 2021)

Most hospital staff have positive views of safety planning, but more studies are needed to understand decision-making (Moscardini et al., 2020; Chesin et al., 2017; Reyes-Portillo et al., 2019)



Safety Planning: Evidence-Base

- Although safety planning reduces suicidal behavior in adults (e.g., ~43% reduction; number needed to treat to benefit = 16), evidence in youth is more limited and mixed (Albaum et al., 2025; Nuij et al., 2021)
- Recent meta-analytic findings in youth samples show no significant effects on suicidal ideation or behavior, though safety planning may improve coping and self-efficacy (Czyz et al., 2019; Micol et al., 2022).
- Studies on adult safety planning have found that it is not always completed with a high level of quality and that more provider training is needed (Gamarra et al., 2015; Moscardini et al., 2020)
- More research is needed to identify which components of safety planning are most effective for youth, as well as strategies to improve implementation fidelity

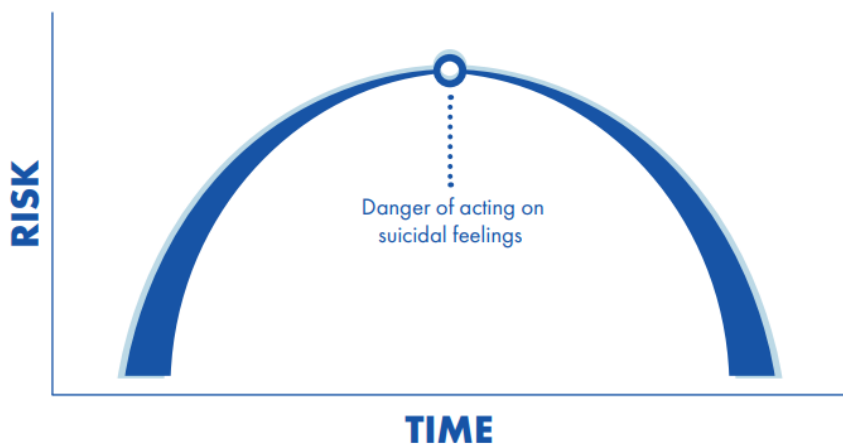
The Safety Plan

- NOT a “no harm contract” or “no suicide contract” (i.e., practice of having patient sign document stating they will not attempt suicide or engage in self-harm)
 - No suicide contracts may help to lower clinician anxiety regarding potential suicide risk, there is no empirical evidence to support the effectiveness of no suicide contracts for preventing suicidal behavior (Kelly & Knudson, 2000; Reid, 1998; Shaffer & Pfeffer, 2001; Gould et al., 1998)

Safety Plan: An agreement and commitment to use skills, safety plan, or seek support before trying to hurt self.

Purpose of Safety Plan

SUICIDE RISK CURVE



- Help get through period of high emotion/distress safely
- Have to get through the peak of wave of emotion

<https://suicidesafetyplan.com/forms/>



NATIONWIDE CHILDREN'S

Safety Planning with Youth

- Working collaboratively with the youth and the family, providers can guide patients to identify effective coping techniques to use during crisis events
- Safety planning helps the youth think about what they will do when they have suicidal thoughts after they leave the provider's office and includes identifying:
 - Youth's own warning signs or triggers for suicidal thoughts
 - Coping strategies (e.g., distress tolerance skills, helpful cognitions/thoughts)
 - Social contacts/supports
 - Emergency contacts
 - Action steps for youth and parents to reducing access to potentially lethal means (e.g., parents lock up medications)

Safety Planning Approaches used with Youth

Safety
Planning
Intervention
(SPI)

SAFETY-Acute
(SAFETY-A)



NATIONWIDE CHILDREN'S®

SPI

(also known as Stanley-Brown Safety Plan)



Description

- Brief, collaborative intervention between the provider and the individual with suicidal thoughts or urges that aims to reduce immediate risk
- Intervention completed in 60-90 minutes over 1-2 sessions (virtual or in-person)
- Follow-up phone calls (at least 2) to monitor suicide risk, review safety plan and adapt as needed, and address engagement with ongoing care



Components

- Interventions:
 - Suicide Risk Curve: narrative assessment of recent suicidal crisis
 - Safety Plan: warning signs, internal coping, people and social settings, people to ask for help, professional contacts, making the environment safe
- Tools:
 - Suicide Risk Curve handout
 - Safety Plan worksheet (template-based safety plan with 6 steps)



Evidence-Base

- 2 randomized controlled trials in adults showing reduction in repeat suicidal behavior
- Was originally part of Cognitive Behavioral Therapy-Suicide Prevention (CBT-SP) for adolescents (in Treatment of Adolescent Suicide Attempters Study)
- Ongoing United States randomized controlled trial in adolescents (Nationwide Children's Hospital/Seattle Children's; Adrian et al., 2023)



SAFETY-Acute (formerly Family Intervention for Suicide Prevention, FISP)



Description

- Developmentally-informed approach to safety planning; cognitive-behavioral youth and family centered
- Originally developed for the emergency department, and has been used in pediatric primary care and schools
- Intervention completed in 20-45 minute session (virtual or in-person) with youth alone, parent alone, and youth and parent together
- Follow-up phone calls (at least 2) address engagement with ongoing care



Components

- Interventions:
 - Youth & Family Strengths Identification
 - Feelings Thermometer: Danger Zone
 - Safety Action Plan
 - Lethal Means Safety & Counseling
 - Increasing Hope & Reasons for Living: Hope Kit
 - Increasing Protective Support
 - Increase Safe Settings
- Tools:
 - Feelings Thermometer
 - Safety Action Plan (template-based safety plan)
 - Safe Settings Checklist (for parent/caregiver)



Evidence-Base

- 2 randomized controlled trials in youth showing improved rates of linking to follow-up treatment (Rotheram-Borus et al., 2000; Asarnow et al., 2011)
- When combined with cognitive-behavioral family intervention, reduced repeat suicidal behavior and suicide ideation severity (Asarnow et al., 2017; Asarnow et al., 2015)

When to Safety Plan?

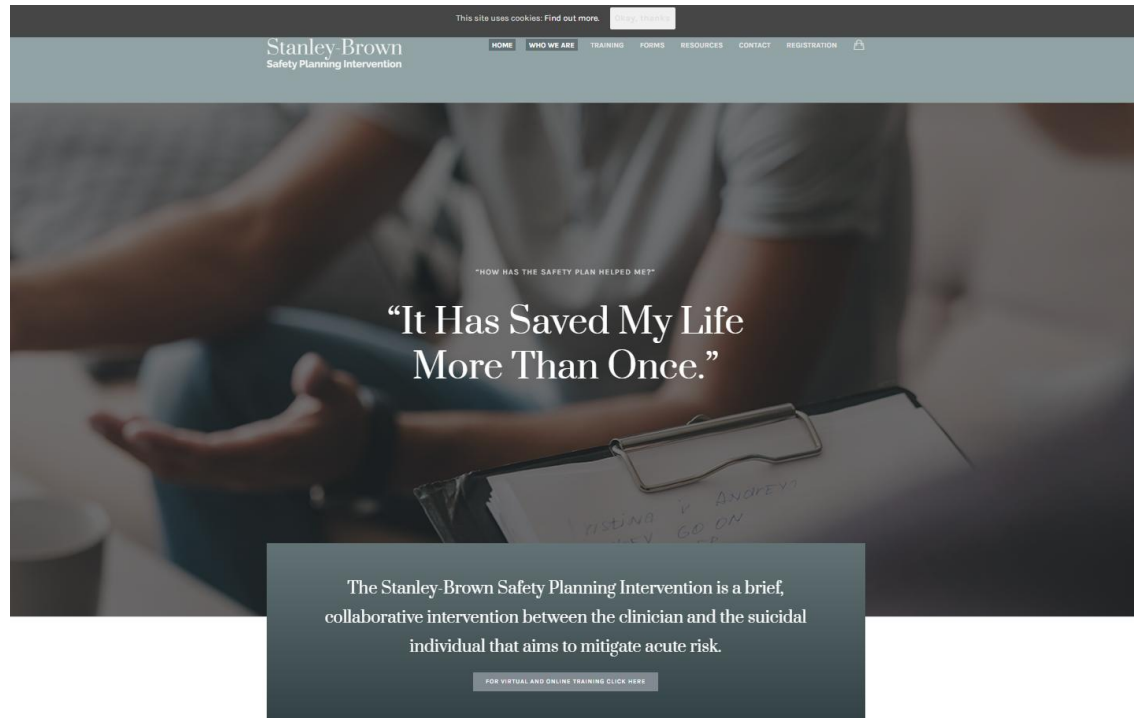
- Whenever a participant or patient presents with suicide risk
- In settings where youth have a history of depression and a history of suicidal ideation and/or behavior – will **OFTEN** need to discuss safety
 - Particularly with depressed youth who present with SI, past suicide attempts, or NSSI (with NSSI, at even GREATER risk for suicidal behavior than even those with past attempt; Asarnow et al., 2011; Wilkinson et al., 2011)
 - If someone presents with SI (of ANY kind), important to acknowledge it, ask if they have talked to their clinical provider (*if not you), and recommend they continue to work with their clinical provider to address
 - Consider directly engaging the clinical provider if you are working with patient for research or consultation



Safety Planning Intervention (SPI)

- Stanley & Brown, 2012; Stanley et al., 2009; Stanley et al., 2018; Adrian et al., 2023

SPI: <https://suicidesafetyplan.com/>

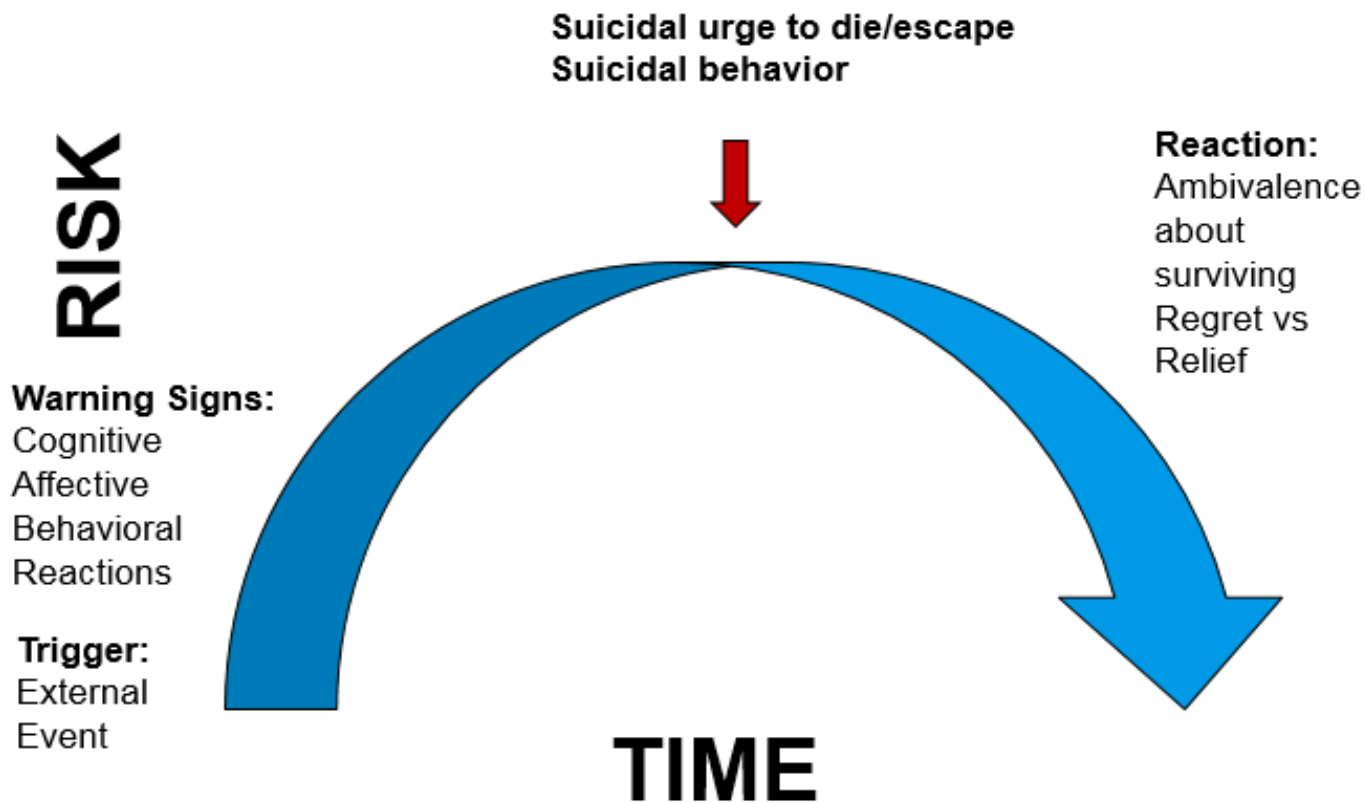


ASSIST Study (NIMH MH123442)

- Multi-site study: Seattle Children's (PI: Adrian) and Nationwide Children's (PI: Bridge)
- Testing relative effectiveness of two brief interventions (against TAU) in adolescents:
 - Safety Planning Intervention+ (SPI+, Stanley & Brown)
 - Collaborative Assessment and Management of Suicidality (CAMS, Jobes)
- Analyze mechanisms of change in reducing suicidal behavior
- Recruiting now!
 - Adolescents 11-17 admitted to acute care for suicidal thoughts or behaviors



Suicide Risk Curve: Critical Components



NATIONWIDE CHILDREN'S®

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ Address: _____
4. Place: _____ Address: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR PROFESSIONAL SERVICES I CAN CONTACT DURING A CRISIS:

1. Professional/Services Name: _____ Phone: _____
Emergency Contact: _____
2. Professional/Services Name: _____ Phone: _____
Emergency Contact: _____
3. Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone: _____
4. Crisis Line Phone (e.g. 988): _____

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

The Stanley-Brown Safety Plan is copyrighted by Barbara Stanley, PhD & Gregory K. Brown, PhD (2008, 2021).
Individual use of the Stanley-Brown Safety Plan form is permitted. Written permission from the authors is required for any changes to this form or
use of this form in the electronic medical record. Additional resources are available from www.suicidesafetyplan.com.

Stanley-Brown
Safety Planning Intervention



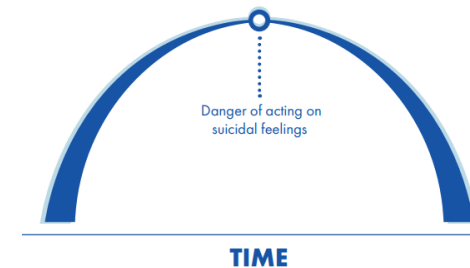
NATIONWIDE CHILDREN'S®

Step 1: Warning Signs

Rationale: Warning signs serve as a reminder to utilize the Safety Plan because a crisis is beginning or the crisis is getting worse.

- Focus on understanding the narrative of the youth's suicide risk
 - Identify **specific and individualized warning signs** that a crisis is
- Typically includes:
 - Recurrent stressors
 - Body signs
 - Thoughts
 - Emotions

SUICIDE RISK CURVE



NATIONWIDE CHILDREN'S®

Step 2: Internal Coping Strategies

Rationale: Distraction helps individuals not think about their problems, or suicidal thoughts, which helps to reduce risk by allowing time for the suicidal thoughts to subside



Identify specific and individualized distracting activities that the youth could do on their own, like journaling, watching TV, or reading.



Distraction helps youth not think about their problems, which helps to reduce risk by allowing time for the suicidal thoughts to pass



Distractions helps youth not focus on the suicidal thoughts and remind them that a thought is a thought, and doesn't have to be an action.



Distracting activities may also increase positive emotion, which can also be protective against suicidal thoughts

Internal Coping Strategies

- Focus on matching the needs identified in the crisis curve assessment
 - E.g., if youth does not have much to put on “Internal Coping Skills” section of Safety Plan. . .can teach some distress tolerance skills
 - Make sure identified coping strategies would be available to youth during times of need



NATIONWIDE CHILDREN'S®

Internal strategies: How can I cope when I am alone?

- Coping and commitment thoughts
- Distress tolerance skills (“skills to help you get through it without making it worse; Linehan, 1994”)
 - Distraction
 - Soothing
 - Physiological
 - Temperature (Jay, Christensen, & White, 2006; Foster et al., 2005)
 - Intense exercise (Tate & Petruzzello, 1995)
 - Paced breathing (Clark & Hirshman, 1990; McCaul, Solomon, & Holmes, 1979; Stark et al., 2000)
 - Progressive muscle relaxation

Internal Strategies

- Promotion of positive affect could be protective against suicidal behavior because “not being able to stand the feeling” is a common reason that individuals give for attempting suicide, across diagnoses
- In recent years, affective science has demonstrated that positive affect is not just about “feeling good” but additionally promotes characteristics that can protect against suicidal urges:
 - Mental flexibility (Isen, 2000)
 - Problem solving ability (Isen, 2000)
 - Decision making (Isen, 2000)
 - Adaptive emotion regulation (Fredrickson et al., 2000)



Internal Strategies: Distress Tolerance Skills

- Increase pause between urge and action
- Reduce impulsive responding
- Alternative coping strategies:
 - TIPP (rapid physiological regulation)
 - Distraction
 - Self-soothing
 - Radical acceptance



Step 3: People and Social Settings That Provide Distraction

Rationale: Distraction helps individuals not think about their problems, or suicidal thoughts, which helps to reduce risk by allowing time for the suicidal thoughts to subside.

- A list of activities youth can request to do with a person to help distract from suicidal urges
 - List specific people and specific activities
 - Example: “Watch YouTube with my best friend, Jess” or “Go to the corner market.”
- *Not* people that are used to share or discuss the suicidal crisis, just to distract from it

External strategies: people who can help distract me

- Meant to be a list of activities patient can request to do with a person to help distract from suicidal urges
 - Want specific people listed
 - Want specific activities listed
 - E.g., “watch favorite YouTube creator with my best friend, Jess”



NATIONWIDE CHILDREN'S®

External Strategies

- Individuals with higher social support may be over 30% less likely to have a lifetime suicide attempt than those with lower social support, even after considering a host of known risk and protective factors for suicidal behaviors (Kleiman & Liu, 2013)



NATIONWIDE CHILDREN'S®

Step 4: People Whom I Can Ask for Help During a Crisis

Rationale: Family or friends are often readily available and can provide support.

- A list of people the youth will really talk to about how they feel
- Preference for adults on this list
 - If another youth is on the list (e.g., best friend, boyfriend), youth agrees to discuss how other youth might get adult help if needed
 - E.g., youth agrees not to get mad if best friend calls Mom when concerned



NATIONWIDE CHILDREN'S®

Step 5: Professionals or Professional Services I Can Contact During a Crisis

Rationale: Professionals or agencies are trained to provide or get help during a crisis.

Identify suitable professionals, agencies, or other emergency services

Directly lists their contact information

Can be the youth's provider(s), and a local/national call or text line(s)



NATIONWIDE CHILDREN'S®

Step 6: Making the Environment Safe

Rationale: The longer it takes to obtain a lethal method, the less likely that the individual will act on impulsive feelings and the more likely that suicidal feelings will diminish and become more manageable.

- Think about ways in which the youth might play a role in making their environment safe, such as:
 - Turning in or disposing of any hidden or collected pills, razors, etc
 - Making a plan with parents/caregiver for room checks and/or “no questions asked” turn-in policy
 - Creating “safe space” in room (i.e., removing any upsetting pictures, posters, music, etc.)
 - Avoiding “risky” places where youth might feel increased self-harm urges (e.g., always cut alone in closet, avoid closet)
 - Avoiding places where youth is tempted to use drugs and alcohol

Safety Plan Tips: Family Involvement

- Typically, provider and youth develop safety plan first
- Then, parents/caregivers involved in planning
 - Identify barriers to implementation
 - Parents/caregivers asked to remove or secure potentially lethal means (e.g., pesticides, firearms)
 - Support creating plan for youth access ongoing follow-up care
- Youth and parent/caregiver provided with written copy of the safety plan; family members can take extra copies or picture with cell phone

Safety Plan Tips: Supporting Youth's Return to School/Community

- Remember that the time after a suicide attempt (first 3 months) is often a period of high risk
 - Have system for supporting youth who return to school/youth group from treatment facilities
 - Consider having designated counselor or trusted teacher/youth leader to periodically “check-in”
 - Work with youth and family to develop plan
 - Check-in plan and/or ways to support youth's safety at organization/school
 - Consider if more formalized plan is needed at school (e.g., 504, IEP) and way to make up missed work

Safety Plan Tips: Safety Plan Via TeleHealth

- Discuss how safety plan can be provided to youth
 - Share on screen while developing (if using video platform)
 - Have youth take picture of screen, or email to the youth
- Consider how to engage school-based clinicians, nurses, or crisis team (if applicable)
 - If youth is in school during session, how can safety plan recommendations include distraction and soothing options that can be done in that environment (generally good to do this anyway!)



NATIONWIDE CHILDREN'S®

SPI:

Continuity of Care

- Series of phone calls or brief sessions aiming for rapid referral with scheduling appointment
 - Check-in with youth about suicide risk and use of safety plan
 - Increasing motivation to engage in treatment
 - Address & problem solve treatment barriers with parent



NATIONWIDE CHILDREN'S®

Addressing Home Safety (Lethal Means Restriction Education)

- Reducing access to lethal means is based on the following:
 - Many suicide attempts occur with little planning during a short-term crisis
 - Intent isn't all that determines whether an attempter lives or dies; means also matter
 - 90% of attempters who survive do NOT go on to die by suicide later
 - Access to firearms is a risk factor for suicide
 - Firearms used in youth suicide usually belong to a parent



Availability of Means: Firearms

- Firearms used by 66.4% male suicide victims; 48.3% female suicide victims (McIntosh, 2000)
- Availability of firearms in home differentiates adolescent suicide victims (74.1%) from hospitalized suicidal adolescents (33.9%) (Brent et al., 1998)



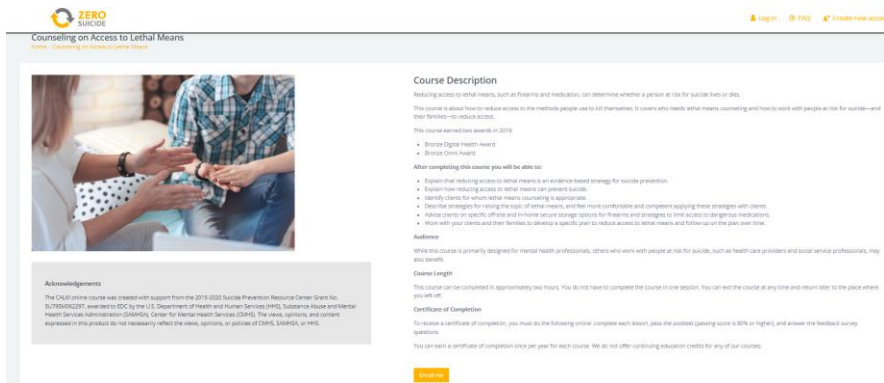
Addressing Access to Lethal Means: Evidence-Base

- Limiting access to methods used in suicide attempts—has been shown to reduce suicide rates (Mann et al., 2021) and is recommended as part of comprehensive youth suicide prevention strategies (Sisler et al., 2025; Wasserman et al., 2021)
- Means safety counseling is also a core component of many evidence-based interventions (Meza et al., 2023)
- In ED settings, counseling increased the likelihood of restricting access to dangerous items fourfold (Kruesi et al., 1999)



Counseling on Access to Lethal Means (CALM)

- <https://zerosuicidetraining.edc.org/enrol/index.php?id=20>
- While this course is primarily designed for mental health professionals, others who work with people at risk for suicide, like social service professionals and health care providers, may also benefit from taking it



ZERO SUICIDE

Counseling on Access to Lethal Means

Course Description

Reducing access to lethal means, such as firearms and medication, can determine whether a person is at risk for suicide (Baker et al., 2018). This course is about how to reduce access to the methods people use to kill themselves. It covers who needs lethal means counseling and how to work with people at risk for suicide—and their families—to reduce access.

This course earned two awards in 2018:

- Bronze Digital Health Award
- Bronze Child Award

After completing this course you will be able to:

- Explain how reducing access to lethal means is an evidence-based strategy for suicide prevention.
- Explain how reducing access to lethal means can prevent suicide.
- Identify clients for whom lethal means counseling is appropriate.
- Describe strategies for using the topic of lethal means, and how to communicate and competently applying these strategies with clients.
- Advise clients on specific off-site and in-home secure storage options for firearms and strategies to limit access to dangerous medications.
- Work with your clients and their families to develop a specific plan to reduce access to lethal means and follow up on the plan over time.

Audience

While this course is primarily designed for mental health professionals, others who work with people at risk for suicide, such as health care providers and social service professionals, may also benefit.

Course length

This course can be completed in approximately two hours. You do not have to complete the course in one session. You can exit the course at any time and return later to the place where you left off.

Certificate of Completion

To receive a certificate of completion, you must do the following: enroll, complete each lesson, pass the posttest (passing score is 80% or higher), and answer the feedback survey questions.

You can earn a certificate of completion once per year for each course. We do not offer continuing education credits for any of our courses.

Acknowledgements

The CALM online course was created with support from the 2015-2020 Suicide Prevention Resource Center Grant No. 30766042020 awarded to EDC by the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS). The views, opinions, and content expressed in this product do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS.

New American Academy of Pediatrics (AAP) CALM Training

[PediaLink & EQIPP Courses](#) / CALM: Suicide Prevention Through Secure Firearm Access Counseling



PediaLink
AAP EDUCATION – WHERE KNOWLEDGE THRIVES



CALM: Suicide Prevention Through Secure Firearm Access Counseling

MOC

Available: 06/16/2026-06/15/2029

Format

✓ Online Course

Price: **\$0.00**

Member Price: **\$0.00**

[Log in to see pricing](#)



NATIONWIDE CHILDREN'S®

Safe Settings

Means
restriction/Home
safety

Counsel on
disinhibiting effects
of alcohol and
drugs



NATIONWIDE CHILDREN'S®

Means Restriction/Home Safety Education for Parents

Psychoeducation on suicide warning signs

Review importance of taking any suicidal talk or behavior seriously

Lethal means restriction (steps to support home/environment safety)

Protective monitoring

Disinhibiting effects of substance use

Supporting youth in Safety Plan use

Review emergency protocol



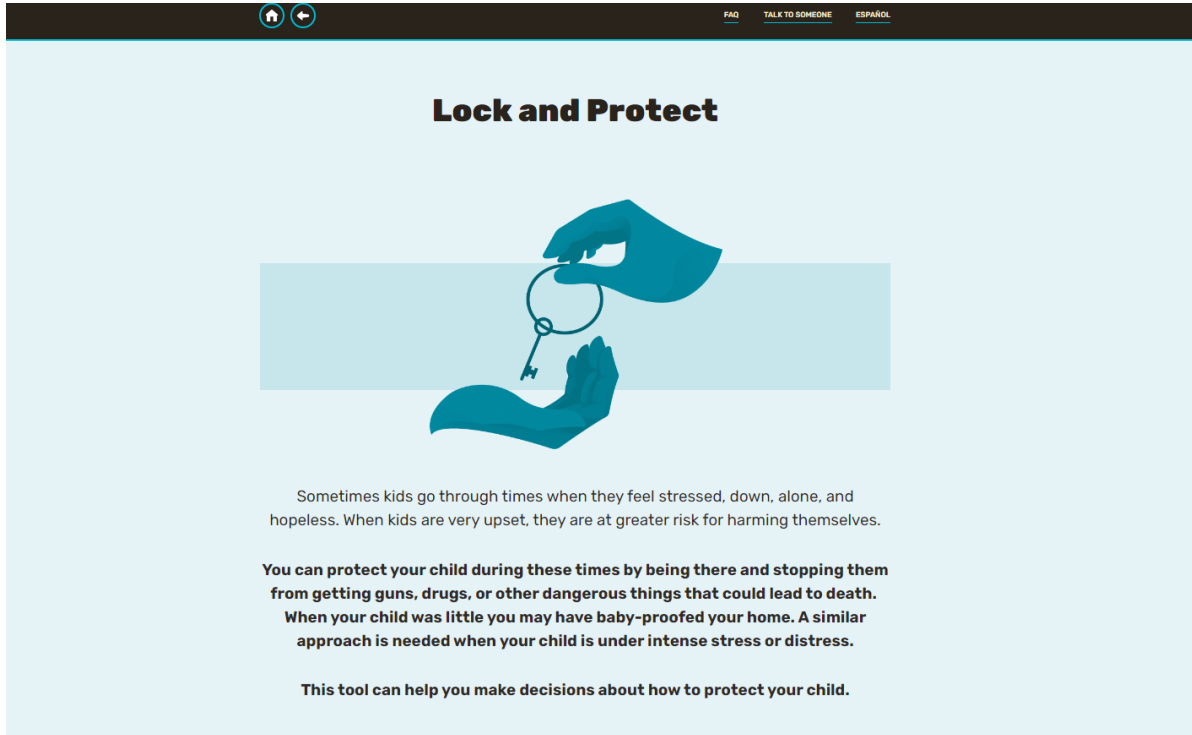
NATIONWIDE CHILDREN'S®

SAFE SETTINGS CHECKLIST

☐ Guns must be absent.		
☐ Potentially lethal medications (e.g., antidepressants, heart medications, ibuprofen) must be stored in a place where person at risk cannot access them.		
Medication	Quantity/Dose	Action Taken
☐ All other potentially dangerous self-harm methods (including items youths has used previously to self-harm and other dangerous methods) must be absent or stored safely to restrict access. List secured items and how secured: 1. 2. 3. 4. 5. 6.		
☐ Presence of safe place for youth to be monitored.		
☐ Adult caregiver(s) understands the severity of the situation.		
☐ Adult caregiver(s) are willing to participate in the treatment plan for a specific amount of time.		
☐ Adult caregiver(s) agree that the safety plan is a viable one.		
☐ Adult caregiver(s) seem to possess cognitive abilities and resources (e.g. access to telephone) to monitor the youth and contact the clinician or police when indicated.		
☐ Copy of safety plan given to caregiver.		



<https://ucla.chsprc.com/>



The screenshot shows the top navigation bar of the UCLA CHSPRC website with links for 'FAQ', 'TALK TO SOMEONE', and 'ESPAÑOL'. The main heading is 'Lock and Protect'. Below it is an illustration of two hands, one holding a key and the other holding a lock. The text below the illustration discusses the risks of children feeling stressed and provides guidance on how to protect them during these times.

Lock and Protect



Sometimes kids go through times when they feel stressed, down, alone, and hopeless. When kids are very upset, they are at greater risk for harming themselves.

You can protect your child during these times by being there and stopping them from getting guns, drugs, or other dangerous things that could lead to death. When your child was little you may have baby-proofed your home. A similar approach is needed when your child is under intense stress or distress.

This tool can help you make decisions about how to protect your child.



FAQTALK TO SOMEONE

Lock and Protect



Sometimes kids go through times when they feel stressed, down, alone, and hopeless.

When kids are very upset, risk for suicide and harming themselves increases.

You can protect your child during these times by being there for them and doing all you can to stop them from getting guns, drugs, or other things that could lead to death.

This tool can help you to make decisions about how to best protect your child.

Get Started

© Joan Asarnow PhD
Trademark

Asarnow JR, Zullo L, Ernestus SM, Venables CW, Goldston DB, Tunno AM and Betz ME (2021) "Lock and Protect": Development of a Digital Decision Aid to Support Lethal Means Counseling in Parents of Suicidal Youth. *Frontiers in Psychiatry* 12:736236. doi: 10.3389/fpsy.2021.736236.

Three Ways to Protect Your Child

- Remove items that could be dangerous
- Lock up items that could be dangerous
- Do not leave the child alone, unprotected without monitoring
- When your child was little you may have baby-proofed your home. A similar approach is needed when your child is under intense stress or distress.



My Storage Plan

You said the following are in the home: **Medicines, Alcohol, Drugs & Poisons.**

YOU MAY REVIEW AND EDIT YOUR STORAGE OPTIONS BELOW.

Your Selected Medication Storage Options

+	Locked Up at Home Read More	(\$)	SELECT ☒
+	Disposal (Look online for safe options) Read More	(FREE)	SELECT ☒
-	Review and Edit All Medication Storage Options		
+	Family, Friend, Neighbor Read More	(FREE)	SELECT ☐
+	Other	(\$) or	SELECT ☐



Participant Ratings: Lock & Protect Final Version

Firearms (n=33)		
	n	%
Found Decision Aid Useful	33	100%
Enough Information to Help Reduce LM Access	27	81.8%

Asarnow JR, Zullo L, Ernestus SM, Venables CW, Goldston DB, Tunno AM and Betz ME (2021) “Lock and Protect”: Development of a Digital Decision Aid to Support Lethal Means Counseling in Parents of Suicidal Youth. *Frontiers in Psychiatry* 12:736236. doi: 10.3389/fpsyt.2021.736236.

Future Directions

- Need to improve training for SPI, and understand when this intervention is most helpful (e.g., to address suicidal behavior/crisis, or also for ideation?)
- Need to consider implementation factors for using safety planning interventions in places like primary care (in response to screening positive) vs. ED (in response to crisis)
- Look for outcomes of Adrian et al. ASSIST study regarding SPI+ and CAMS4Teens



Thank you! Questions?

Jennifer.Hughes@nationwidechildrens.org

The Center for Suicide Prevention and Research

<http://www.nationwidechildrens.org/suicide-prevention>



NATIONWIDE CHILDREN'S®

Additional Resources



Suicide Prevention Resource Center
[About Suicide](#) [Effective Prevention](#) [Resources & Programs](#) [Training](#) [News & Highlights](#) [Organizations](#)



8 2 5 5
1 (800) 273 TALK

[SEARCH](#) [ABOUT SPRC](#) [CONTACT US](#) [LOGIN](#)

Filter By

☐ Display only items by SPRC

Date Range to

Resource and Program Type

Select

☐ Display only Programs with Evidence of Effectiveness ☒

Populations

Select

Settings

Select

About Suicide

Select

Planning and Implementing

Select

Strategies

Select

State

Select

Keyword

Resources and Programs

Use the Resource and Program Type filter on the left to find:

- ☐ **Resources** (e.g., articles, tools, fact sheets, reports) developed by SPRC and other suicide prevention organizations and experts
- ☐ **Programs and Practices** (e.g., education, screening, treatment, environmental change), including [former BPR listings](#)
 - ☐ Programs with evidence of effectiveness are indicated by the icon ☒. To learn more about programs with this designation, see [Evidence-Based Prevention](#).
 - ☐ Check the box on the left to display *only* programs with evidence of effectiveness.
 - ☐ For information about other program registries and lists, visit our [Finding Programs and Practices](#) page.

Displaying 1388 results. Refine results using the filters on the left.

RESOURCE LIST/BIBLIOGRAPHY

SUICIDE PREVENTION MONTH
IDEAS FOR ACTION
2021

Suicide Prevention Month: Ideas for Action
2021
This two-page resource offers information to help anyone, anywhere get involved in Suicide Prevention

FACT SHEET/ISSUE BRIEF

Suicide and Serious Mental Illness: An Overview of Considerations, Assessment, and Safety Planning
2021
Source

WEBINAR/PRESENTATION

Tools to Build a Strong State Foundation: Infrastructure Development (AAS21 Presentation)
2021
This presentation includes an overview of SPRC's Recommendations for State Suicide Prevention Infrastructure (Infrastructure Recommendations) and...
[Download \(3.44 MB\)](#)

Additional Resources

- Zero Suicide Institute
 - Lists options for training, depending on setting, role, and experience.
 - Available at: <https://zerosuicide.edc.org/resources/resource-database/suicide-care-training-options>



NATIONWIDE CHILDREN'S®

Additional Resources

- Counseling on Access to Lethal Means (CALM)
 - This course is primarily designed for mental health professionals, but may be helpful for others who work with people at risk for suicide
 - Available at no cost: <https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>
- Safety Planning
 - <https://practiceinnovations.org/i-want-to-learn-about/Suicide-Prevention/Trainings/Intervene>
 - <https://www.sprc.org/resources-programs/patient-safety-plan-template>
 - <https://zerosuicide.edc.org/resources/resource-database/safety-planning-intervention-suicide-prevention>
- Telehealth Considerations
 - Developed by the SAMHSA-funded UCLA-Duke Act, Support, and Protect (ASAP) Center, which specializes in treating and preventing suicidal behavior, self-harm, depression, and substance abuse with a trauma-informed approach (in partnership with the National Child Traumatic Stress Network, NCTSN). Available at: <https://www.asapnctsn.org/wp-content/uploads/2020/05/Trauma-Informed-Telehealth-Recommendations-for-Suicidal-Patients.pdf>
 - Developed by the Suicide Prevention Resource Center to aid clinicians in adapting the Safety Planning Intervention, developed by Barbara Stanley and Greg Brown, to telehealth. Available at: <http://www.sprc.org/events-trainings/treating-suicidal-patients-during-covid-19-best-practices-telehealth>



Thank you! Questions?

Jennifer.Hughes@nationwidechildrens.org

The Center for Suicide Prevention and Research

<http://www.nationwidechildrens.org/suicide-prevention>



NATIONWIDE CHILDREN'S®