MAINE AAP | ADVANCING YOUTH WELL-BEING THROUGH PARTNERSHIP

Recognize Risk. Build Connection.

A pediatric-psychiatric approach to identifying and supporting youth at risk for suicide

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The promise of this hour

1

A screen is a beginning

A positive screen is an opening, not a disposition.

2

Conversation over scores

A risk score cannot replace a conversation.

3

Context reveals risk

A young person’s context reveals what checklists miss.

4

Small primary actions

Concrete primary care actions improve safety and connection.

By the end, you will be able to…

01 Use a screening → brief assessment → action pathway for youth suicide risk.

02 Distinguish a positive screen from imminent danger and choose a proportionate next step.

03 Ask about belonging, identity stress, relationships, and protective connections.

04 Collaboratively initiate safety planning, lethal-means counseling, and timely follow-up.

05 Identify when and how to partner with families, schools, and behavioral health.

RECOGNIZE

Start with healthy mental development

FOUNDATION 01

Not only illness

Mental health is a developmental process—not simply a list of diagnoses or symptoms.

FOUNDATION 02

Relationships matter

Safe, stable, nurturing relationships support emotional, psychological, and social wellness.

FOUNDATION 03

Context matters

Biology, relationships, environment, culture, and community interact across development.

RECOGNIZE

Meet Jordan

CLINICAL PRESENTATION

15-year-old in clinic

Presenting for frequent headaches, sleep difficulty, and recurring missed school.

Screening signal: PHQ-9 suggests moderate depressive symptoms; Jordan says, “I’m fine.”

Relational fracture: A friend group has fractured; Jordan feels misunderstood at school and at home.

Patient voice: They describe being “too much for some people, not enough for others.”

Caregiver observation: A parent says, “They’re just being dramatic.”

RECOGNIZE | CLINICAL OBSERVATION

Suicide risk may enter the room sideways

- **Somatic clues:** New or worsening sleep disturbance, pain, fatigue, irritability, or school avoidance.
- **Behavioral changes:** Withdrawal, conflict, bullying, online distress, acute loss, or abrupt behavioral shifts.
- **Internal state:** Hopelessness, shame, feeling trapped, or perceived burdensomeness.
- **Relational stress:** Recent transition, rejection, identity disclosure, or loss of a trusted connection.
- **Collateral worry:** Concerning caregiver, school, or clinician observations—even when youth denies distress.

SCREEN

Screening is not assessment

SCREEN

STEP 01

Brief, validated tool to identify who needs a closer look. Universal screening recommended for ages 12+.

ASSESS

STEP 02

Follow positive screens with a Brief Suicide Safety Assessment (BSSA)—not automatic emergency transfer.

ACT

STEP 03

Use the assessment to determine immediate safety needs, proportionate evaluation, and follow-up.

SCREEN | VALIDATED TOOLS & RELIABLE WORKFLOW

Who should be screened—and with what?

Target Populations

Ages 12 and older: Universal suicide risk screening is recommended in the AAP Blueprint pathway.

Ages 8–11: Screen when clinically indicated; assess younger children whenever warning signs appear.

Tool & Team Process

Validated screen: ASQ is a brief, validated tool. A depression screen alone is not a suicide screen.

Team workflow: Any trained team member can administer; define who receives and acts on results.

ASSESS

A positive screen is not automatically an emergency

The next step is a Brief Suicide Safety Assessment (BSSA)—avoiding both overreaction and underreaction.

DO

Pause and thank the youth for answering honestly. Clarify what the response means. Assess current safety and determine proportionate next steps.

DON'T

Assume every positive screen requires emergency department transfer—or assume a flat denial means there is zero underlying risk.

The BSSA: a focused conversation

Current suicidal thoughts: frequency, intensity, timing, and whether present now

Plan, intent, access to means, preparatory behavior, and past attempts

Recent self-harm, substance use, agitation, impulsivity, sleep, and acute stressors

Protective factors, reasons for living, trusted adults, and ability to use support

Caregiver perspective and supervision; obtain collateral when appropriate

ASSESS | CLINICAL TRIAGE

Three broad pathways—not a score

IMMINENT / ACUTE

Active suicidal ideation with immediate danger, intent, or inability to maintain safety.

Urgent emergency mental health evaluation + constant supervision.

FURTHER EVALUATION

No immediate crisis identified, but positive screen or concerning past history present.

Timely mental health evaluation, safety plan, and close follow-up.

LOWER ACUITY

No current indication for urgent evaluation; underlying distress or past stressors.

Reinforce strengths, provide resources, address distress, reassess as needed.

What a screen cannot tell you

“I don’t fit anywhere.”

The underlying relational injury that symptom checklists easily overlook.

Context Over Checklist

A checklist can identify suicidal thoughts—not the relational meaning underneath them.

Crossing Boundaries

Standard diagnostic categories miss youth whose experiences bridge distinct identities or systems.

The Essential Inquiry

The clinical question shifts from only “Who are they?” to also “Where do they feel they belong?”

A useful formulation: the belonging triad

TRIAD ELEMENT 01

Unstable Belonging

Sometimes included, sometimes excluded; connection feels conditional or unpredictable.

TRIAD ELEMENT 02

Identity Invalidation

The young person's experience is dismissed, questioned, stereotyped, or made invisible.

TRIAD ELEMENT 03

Absent Community

Few people or places where the youth feels authentically known, safe, and accepted.

*** These elements are prompts for deeper assessment—not a mathematical checklist predicting suicide.**

Four questions that widen the assessment

> **“Where do you feel most like yourself?”**

> **“Where do you feel like a guest—or like you have to edit part of yourself?”**

> **“Who really gets you? Is there anyone you can be fully yourself with?”**

> **“Have you felt rejected, targeted, misunderstood, or pressured to choose between parts of who you are?”**

APPLY

Jordan: what changes when we ask?

JORDAN REFLECTS:

“I can be myself with one friend online, but at school I’m the weird one. At home I don’t talk about it because my parents won’t understand.”

QUESTION 1

What would you want to clarify about suicide risk right now?

QUESTION 2

What does this tell you about belonging and protective connections?

QUESTION 3

What is one small action you could take before Jordan leaves?

Strengths are clinical data

Past resilience: Ask what has helped the young person navigate hard moments before.

Specific traits: Name strengths specifically: persistence, humor, creativity, advocacy, caregiving, problem-solving.

Anchors: Identify people, places, routines, teams, cultural/community ties, and future commitments that matter.

Clinical caveat: Never use protective factors to cancel out active risk or bypass a required safety assessment.

The intervention may be small—and specific

MICRO-INTERVENTION 01

ONE PERSON

Name one trusted adult or peer who can notice, listen, and respond when distress rises.

MICRO-INTERVENTION 02

ONE PLACE

Identify one physical or social setting where the youth feels welcomed, accepted, and unedited.

MICRO-INTERVENTION 03

ONE NEXT STEP

Establish an actionable connection: a warm handoff, club, coach, school counselor, or follow-up call.

ACT | COLLABORATIVE, SPECIFIC, USABLE

A safety plan is a bridge through a crisis

1. Warning signs: What personal cues indicate a crisis is building?

2. Internal coping: What can I do independently to de-escalate?

3. Social distractions: People and settings that provide connection.

4. Trusted adults: Specific individuals I can ask directly for help.

5. Crisis support: Professionals and 24/7 lifelines (including 988).

6. Means safety: Concrete steps to make the environment safer.

Lethal-means safety: make the environment safer

FIREARMS

Temporary off-site storage is the safest approach during a suicidal crisis. Otherwise, store locked and unloaded, with ammunition locked separately and keys/combinations inaccessible to youth.

MEDICATIONS & OTHER MEANS

Lock prescription and over-the-counter medications in a lockbox; limit dispensing quantities and supervise use. Clarify other household access points based on individualized assessment.

Framing phrase: “I want to help make home as safe as possible while things feel this hard.”

PARTNER | PROTECT SAFETY AND PRESERVE TRUST

Bring caregivers in—thoughtfully

Set boundaries: Explain confidentiality and safety exceptions before initiating sensitive questions.

Proportionate sharing: Involve caregivers for safety; share minimum necessary information to maintain trust.

Youth partnership: Ask youth who feels safe to involve; identify another trusted adult if family support is strained.

Parent coaching: Guide caregivers to listen, validate feelings, stay curious, and eliminate lethal means access.

Systemic context: Family mental health and youth mental health are intimately interconnected.

You do not have to do this alone

Delegate screening and BSSA steps to trained team members with clear escalation rules.

Build warm handoffs to behavioral health, crisis services, and community supports.

With permission, coordinate with school nurse/counselor, therapist, coach, or community organization.

If access is delayed, schedule a near-term check-in rather than handing the family a list and hoping.

FOLLOW THROUGH | CLOSE THE LOOP

The visit is not the end of the intervention

TIMELINE 01

24–48 HOURS

Conduct a brief phone call, portal message, or visit to verify immediate safety, means restriction, and connection to care.

TIMELINE 02

NEXT FEW DAYS

Confirm referral connection; troubleshoot roadblocks and reassess safety plan while awaiting specialist appointment.

TIMELINE 03

ONGOING

Caring contacts directly communicate that the young person matters and has not been forgotten by their care team.

PRACTICE | WHAT MIGHT YOU SAY?

Practice the first 90 seconds

> “Sometimes when things feel unbearable, young people think about not being here. Has that happened to you?”

> “Thank you for telling me.”

> “I’m glad you said something. I want to understand what this has been like.”

> “Are you thinking about killing yourself right now?”

> “Let’s work out the next safe step together.”

TAKE HOME | FIVE ACTIONS

A simple playbook to take back to clinic

1. SCREEN	Use a validated tool and a reliable clinic-wide workflow.
2. ASSESS	Follow every positive screen with a BSSA to determine acuity.
3. UNDERSTAND	Ask about context, identity stress, belonging, and protective connections.
4. ACT	Collaborate on safety planning, means safety, warm handoffs, and proportionate triage.
5. FOLLOW UP	Assign a named team member responsible for the next patient contact.

Tools and resources

AAP Blueprint for Youth Suicide Prevention
aap.org/suicideprevention

988 Suicide & Crisis Lifeline
Call or text 988 | 988lifeline.org

NIMH ASQ Toolkit (Screening + BSSA)
nimh.nih.gov/research/.../asq-toolkit-materials

Crisis Text Line
Text TALK to 741741

Stanley–Brown Safety Planning Intervention
safetyplanningapp.com

CALM Training
Counseling on Access to Lethal Means (suicideprevention.org)

“The goal is not to have every answer. It is to make sure no young person leaves feeling unseen, unsafe, or alone.”

Recognize risk. Listen without judgment. Build connection. Follow through.

Questions & Discussion