Suicide-Related Behaviors Among Abused and Maltreated Youth: A Call to Action and Recommendations for Providers

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Suicide is the second leading cause of death among U.S. adolescents (Centers for Disease Control and Prevention, 2018). Given associations between child abuse and maltreatment and suicide-related behaviors (e.g., Norman et al., 2012), service providers who work with abused and maltreated youth have a unique opportunity to reach those adolescents at high risk for suicide-related behaviors, provide support, and ensure that they receive appropriate services. With increased awareness of risk markers for suicide-related behaviors, knowledge of the types of services available to at-risk youth, and training in identifying and assessing suicide risk, service providers working with abused and maltreated youth can and will save more lives. In support of this mission, we provide a brief overview of suicide-related behaviors, indicators of suicide risk among adolescents, the association between child abuse/maltreatment and suicide, and preventive interventions for reducing suicide risk. Finally, for service providers that wish to actively support suicide prevention among abused and maltreated youth, we provide several suggested action steps for advancing suicide prevention across a variety of disciplines.

Adolescent Suicide Is a Serious Public Health Concern

From 2007-2016, suicide accounted for more than 11,000 deaths among children aged 12-17 years (Centers for Disease Control and Prevention, 2018). While suicide is rare prior to the onset of adolescence, the suicide rate increases from 0.29 per 100,000 to 17.32 per 100,000 between 10-21 years of age, a nearly 60-fold increase, and remains elevated throughout adulthood (Centers for Disease Control and Prevention, 2018). Suicide ideation and attempts are also frequent during adolescence: Data from a nationally-representative survey of U.S. high school students indicate that 17.7% of students reported seriously considering suicide in the past 12 months and 8.6% reported a suicide attempt (Kann et al., 2016a). Suicidal thoughts and attempts are frequent among middle school students as well (Centers for Disease Control and Prevention, 2017). One recent estimate places the economic impact of suicide and suicide attempts among 15-24 year olds at over $15.5 billion in 2013 alone (Shepherd, Gurewich, Lwin, Reed, & Silverman, 2016). The elevated rate of suicide-related behaviors during adolescence indicates the enormity of the unaddressed mental health burden among this population. Further, child and adolescent suicide ideation is associated with negative mental health outcomes and lower socioeconomic status in adulthood (Reinherz,

Tanner, Berger, Beardslee, & Fitzmaurice, 2006). Taken together, these data point toward adolescence as a key period for addressing suicide risk and demonstrate a need for awareness, screening, and intervention to effectively prevent suicide-related behaviors.

Risk Markers for Adolescent Suicide-Related Behaviors

In the empirical literature, research has identified a wide array of risk markers and warning signs of adolescent suicide-related behaviors (King, Ewell Foster, & Rogalski, 2013; Gould, Greenberg, Velting, & Shaffer, 2003). A risk marker can be thought of as *indicative of risk* for suicide, but not necessarily *predictive of risk* for suicide. In contrast, warning signs are factors indicative of *immediate* concern and should prompt assessment by a healthcare professional and, potentially, life-saving action. Psychiatric risk markers include a range of psychiatric symptoms and disorders associated with increased suicide ideation, suicide attempts, or suicide, including anxiety (Hill, Castellanos, & Pettit, 2011), depression, behavior problems, substance abuse (Brent et al., 1993; Nock et al., 2013), and post-traumatic stress (Waldrop et al., 2007). Interpersonal and social risk markers include bullying, peer rejection, perceived parental support, parent-child conflict, social isolation (Kim & Leventhal, 2008; King & Merchant, 2008), perceived burdensomeness, and thwarted belongingness (Hill & Pettit, 2014; Van Orden et al., 2010). Cognitive risk markers include hopelessness and low self-esteem (Beautrais, Joyce, & Mulder, 1999), avoidant coping strategies (Kaplow, Gipson, Horwitz, Burch, & King, 2014), and problem-solving difficulties (Speckens & Hawton, 2005). Experiential risk markers include adverse childhood experiences (ACE), such as childhood instability, physical abuse, neglect, sexual abuse, family violence (Thompson et al., 2012), stressful life events (Kaplow et al., 2014), discrimination (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009) and contact with the juvenile justice system (Abram et al., 2008). Demographic indicators of risk include gender, age, race/ethnicity, and sexual orientation (Gould et al., 2003). The presence of risk markers can identify individuals or groups at elevated risk for suicide-related behaviors and, if supported by longitudinal findings, may indicate possible targets for interventions to prevent suicide among youth.

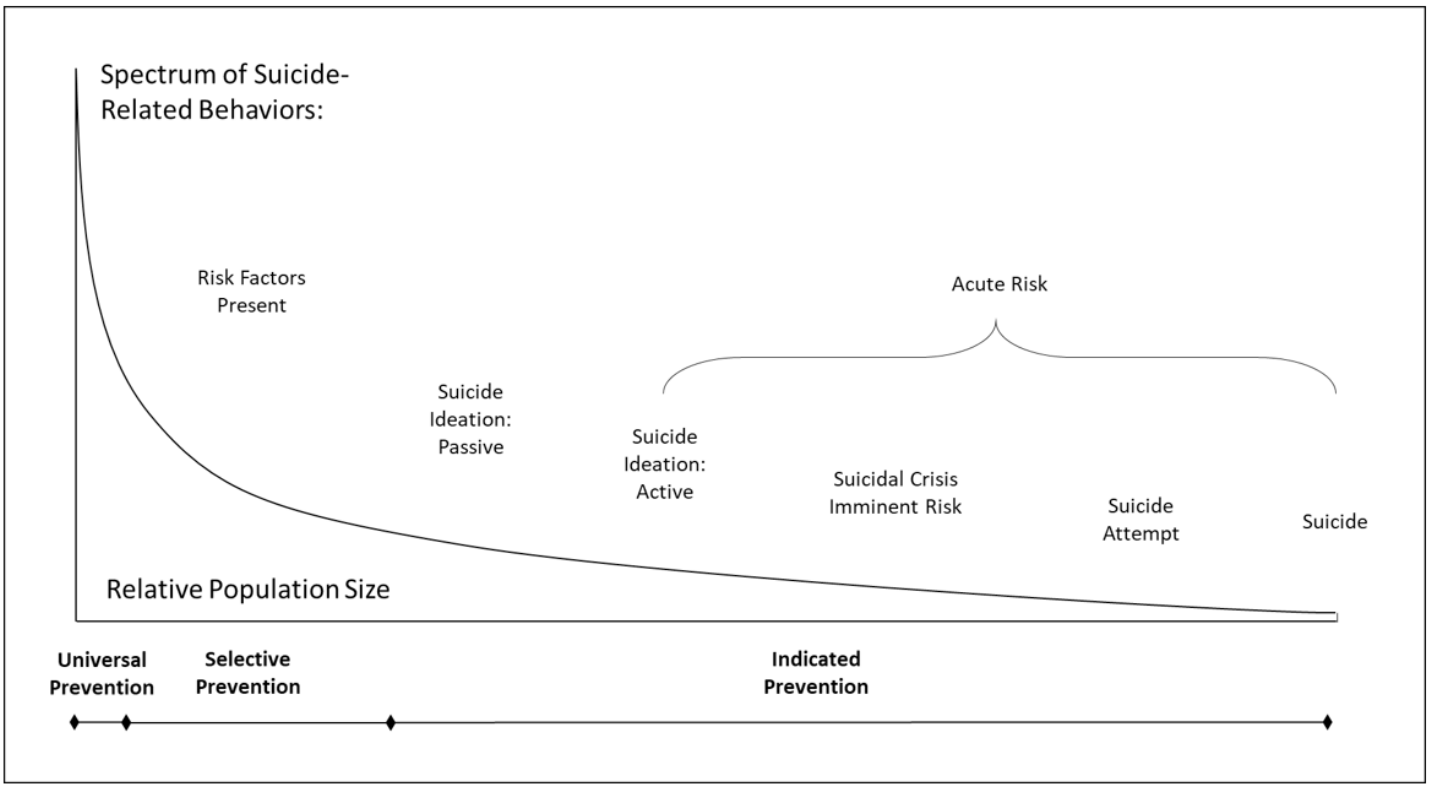
As described above, warning signs are proximally-situated factors that indicate *immediate* or *imminent* risk and the need for prompt risk assessment by a professional, as life-saving action may be necessary. Warning signs may be conceptualized as a subset of risk markers that are indicative of the possibility of acute escalation of suicide risk in the present or very near future (Freedenthal, 2018). As identified by Rudd (2014), warning signs may include frequent, intense suicidal thoughts, suicidal intent, preparations for suicide (such as gathering necessary materials, writing a will, or preparing a note), agitation, hopelessness, recklessness, feeling trapped, and having no reasons for living, among others. It is particularly important that service providers be vigilant for the presence of warning signs.

Suicide-Related Behaviors and Child Maltreatment

A substantial body of empirical evidence demonstrates associations between childhood abuse and maltreatment and suicide-related behaviors in adolescence and adulthood (Devries et al., 2014; Liu et al., 2017; Norman et al., 2012; Zatti et al., 2017). A meta-analysis of 124 studies found significantly increased odds of a suicide attempt among adults who were victims of childhood physical abuse, emotional abuse, and neglect (Norman et al., 2012). Other recent meta-analyses found similar results, with childhood sexual abuse, physical abuse, emotional abuse, and physical neglect each associated with suicide attempts up to 30 years later (Devries et al., 2014; Liu et al., 2017; Zatti et al., 2017).

Numerous individual studies concur with the findings of these meta-analyses, indicating that child abuse and maltreatment are associated with suicide-related behaviors across the lifespan: Sexual and physical abuse prior to age 16 years were significantly associated with suicide ideation and suicide attempts among adolescents, older adolescents, and young adults (Fergusson, Boden, & Horwood, 2008). Having a greater number of ACEs was significantly associated with younger first attempts as well as repeat attempts over a lifetime (Choi, DiNitto, Marti, & Segal, 2017). Data from a nationally-representative study of U.S. adults identified significant associations between childhood physical and sexual abuse and suicide ideation and

Figure 1. Universal, Selective, and Indicated Suicide Prevention



attempts in adult women (Afifi et al., 2008). The study found a similar pattern of results for adult men, with childhood physical and sexual abuse associated with suicide attempts (Afifi et al., 2008). Childhood experience of physical abuse, psychological abuse, and neglect have even been associated with new onset of suicide ideation and suicide attempts in adulthood, after controlling for sociodemographic characteristic and comorbid mental health disorders (Enns et al., 2006). This body of literature provides clear evidence that childhood abuse and maltreatment are associated with a sustained increased risk of suicide ideation and attempts across adolescence and into adulthood. Very few studies to date have examined the mediating mechanisms that may help to explain the relation between child abuse/maltreatment and future suicide risk. Some preliminary evidence suggests that maladaptive coping strategies (e.g., Kaplow et al., 2014) and/or severe interpersonal difficulties (Johnson et al., 2002) may increase the likelihood of suicide risk following trauma in general. Future studies that help to clarify these and other potential mechanisms are needed.

A Brief Review of Suicide Prevention

Given links between childhood abuse/maltreatment and suicide-related behaviors and associated psychological, societal, and economic costs, suicide prevention efforts for victims of abuse and maltreatment are an important public health issue. The complex nature of suicide risk screening and detection, the variable nature of suicide risk, and the fact that psychiatric and psychosocial treatments for suicidal youth are not universally effective, means that no single screening or treatment program is sufficient to reduce suicide risk across all at-risk populations. Optimal suicide prevention requires a multi-layered network of screening and preventive interventions that occur at several points in time and across a variety of settings so that all youth have multiple opportunities to be identified and referred for appropriate services. Understanding the complex landscape of suicide prevention can help service providers better understand the available resources and services, identify ways to contribute to suicide prevention, and more effectively advocate for children in need.

As depicted in Figure 1, prevention occurs in three

general phases: universal, selective, and indicated, with each corresponding to a different level of risk (Munoz, Mrazek, & Haggerty, 1996). Universal prevention includes broad approaches delivered to an entire target population, regardless of individual level of risk. Examples of universal prevention include using seatbelts to prevent injury during traffic collisions and adding fluoride to drinking water to prevent tooth decay. Selective prevention includes interventions delivered to a subset of the general population at increased risk of some negative outcome, as determined by the presence of a predefined risk marker. For example, doctors may identify patients with high blood pressure (a predefined risk marker) and prescribe medication to reduce the likelihood of a heart attack. Finally, indicated prevention includes interventions that are directed toward individuals with detectable levels of a disorder in order to prevent progress of the disease or to reduce the duration of illness. For example, providing antiretroviral medication to individuals living with human immunodeficiency virus (HIV) can prevent progression from HIV to acquired immunodeficiency syndrome and reduce disease mortality.

As prevention shifts from the universal phase to the selective and indicated phases, the intensity of interventions typically increases. Universal prevention may involve brief advertisements or interventions delivered to very large groups, where individual attention is highly limited and the cost per person (in terms of financial cost, time spent, and resources required) is low. In contrast, indicated prevention is often one-to-one, with highly trained service providers or expensive procedures (e.g., hospitalization). Fortunately, as the intensity of prevention efforts increases, the size of the population in need of such intensive services typically decreases. Knowing what services exist at each level of prevention can aid in determining which services may be most appropriate for a given child – and avoid either under- or over-application of resources.

Universal Prevention

In terms of suicide prevention, universal approaches often include training gatekeepers or peer leaders to notice warning signs of suicide and increase participants' knowledge of appropriate action when encountering a suicidal individual (Isaac et al., 2009; Wyman et al., 2010). For example, the Question, Persuade, Refer (QPR) program teaches individuals to recognize warning signs for suicide and encourage treatment-seeking (Quinnett, 1995). QPR has been shown to increase knowledge of suicide warning signs among teachers, counselors, and hospital employees (Cross, Matthieu, Cerel, & Knox, 2007; Reis & Cornell, 2008). A similar program, ASK About Suicide to Save a Life, also provides training so that anyone can learn to recognize warning signs of suicide (Mental Health America of Texas, 2013). The Sources of Strength program (Wyman et al., 2010), seeks to increase awareness of suicide risk factors and encourage help-seeking in high schools through training peer leaders to recognize suicide risk. A similar program for use by the military is called ACE, Ask, Care, Escort. ACE is a friend/bystander support program, which increases active duty service members' awareness of the potential for suicidality in fellow service members and provides instruction to calm the upset person and escort them to a professional for care (United States Air Force, 2018). A substantial body of research supports the efficacy of these programs for increasing knowledge related to suicide risk factors and warning signs and increasing help-seeking (Isaac et al., 2009). However, evidence demonstrating whether these prevention-through-awareness programs result in significant reductions in suicide-related behaviors is less well documented (Isaac et al., 2009). Other universal prevention efforts include programs to increase awareness of suicide as a public health issue and efforts to support increased gun safety.

Selective Prevention

With regard to selective prevention, programs vary widely depending on the targeted risk marker. For example, gay, lesbian, and bisexual adolescents report highly elevated rates of suicide-related behaviors (Kann et al., 2016b). As a result, efforts have been made to support gay, lesbian, and bisexual youth, including introducing gay-straight alliances and safe spaces in schools or promoting supportive messaging for sexual and gender minority youth (e.g., the It Gets Better campaign; www.itgetsbetter.org). Interventions to address mental health, such as depression, anxiety, bereavement, and post-traumatic stress responses also act as selective prevention approaches (e.g., Lejuez,

Hopko, & Hopko, 2001; Saltzman et al., 2017). Programs to help abused and maltreated youth, either by removing them from the abusive setting or helping them to cope with the mental health consequences of those experiences, would also constitute selective prevention. Though empirical studies of such interventions seldom consider suicide risk as a targeted outcome, given that they address known risk markers for suicide-related behaviors, these programs serve as selective prevention approaches.

To date, selective preventive interventions specifically designed to reduce suicide risk have received less empirical attention. Links to Enhancing Teens' Connectedness is a selective preventive intervention for bully victims, bully perpetrators, and socially isolated adolescents (Gipson, King, Opperman, & Ewell-Foster, 2014). Links to Enhancing Teens' Connectedness utilizes both adolescent-nominated mentors and trained community mentors to help adolescents build supportive relationships (Gipson et al., 2014). Another selective preventive intervention is the Learn, Explore, Assess Your Options, Do (LEAD) intervention, a web-based brief intervention for adolescents who perceive that they are a burden on others (Hill & Pettit, 2016).

Indicated Prevention

In the case of suicide prevention, indicated prevention involves programs designed to treat suicide ideation in order to prevent suicide attempts and deaths. Indicated outpatient therapy focuses on managing and reducing suicide risk. Dialectical Behavior Therapy is an outpatient therapy modality frequently used with chronically suicidal patients. Dialectical Behavior Therapy includes both individual and group therapy components, in-the-moment skills coaching for managing crises, and case management (Melhum et al., 2014; Miller, Rathus, & Linehan, 2017; Rathus & Miller, 2014). The Collaborative Assessment and Management of Suicidality is an outpatient therapy approach for assessing, monitoring, and managing suicide risk; research supports the efficacy of this approach for reducing suicide risk (Jobes, 2006, 2012). In addition to outpatient programs, many clinicians utilize safety planning as an additional prevention step. Safety planning involves developing a written plan for patients to manage their suicidal thoughts and urges via distraction, social support seeking, and maintaining a safe environment (Stanley & Brown, 2012).

Other indicated suicide prevention programs focus on the management of imminent suicide risk. These include crisis lines, such as the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org), The Trevor Project Lifeline (www.trevorproject.org), and the Crisis Text Line (crisistextline.org), as well as inpatient hospitalization, which provides a space for youth to receive psychiatric care and remain safe during a suicidal crisis. It should be noted, however, that these imminent risk responses are safety-oriented and time-limited and should not be used as stand-alone therapies. Crisis management and imminent risk hospitalizations should be followed by acute risk management approaches, such as the aforementioned outpatient therapy approaches, once the suicidal crisis has passed.

Summary

A variety of programs, ranging from brief universal programs to intensive outpatient treatment and inpatient hospitalizations, are available to help reduce the risk of suicide among youth (for a detailed review, see Calear et al., 2016). While there is need for further development of suicide prevention approaches, and some programs are not yet widely available, the science of suicide prevention is constantly evolving, with the goal of making suicide prevention available to everyone. Efforts are needed to expand those services supported by the empirical literature, and to evaluate those services that have not yet been studied empirically. For those working with potentially suicidal youth, awareness of existing services can aid in referring youth to appropriate interventions.

The Role of Abuse/ Maltreatment Service Providers in Suicide Prevention

Those who provide services to youth who have dealt with child abuse and/or maltreatment play a role in suicide prevention. It is vital for those working with these youth to be aware of their increased vulnerability to suicide-related behaviors and to be knowledgeable

about appropriate action steps, referrals for additional care, and emergency resources. Given the elevated risk of suicide-related behaviors among abused and maltreated children, any efforts providers can make to identify suicide risk and provide appropriate referrals have life-saving potential.

Recognize Risk

Since child abuse and maltreatment have been consistently associated with suicide risk, anyone working with abused and maltreated youth is, by default, working with an at-risk population. This makes the process of identifying youth with acute or imminent suicide risk both more critical and more challenging. While abuse and maltreatment may be the most prominent indicators of increased suicide risk in this population, their critical nature may overshadow the presence of co-occurring risk markers. Thus, it is important that service providers take the time to actively consider additional indicators of suicide risk and pay particular attention to youth with multiple sources of risk, as reviewed above. Critically, service providers should pay particular attention to the presence of warning signs as indicators that immediate action is needed.

To assist with identifying at-risk youth, service providers working with abused and/or maltreated youth may wish to acquire formal training in recognizing the warning signs of suicide. Several training programs exist to provide instruction in recognizing warning signs, asking about suicide, and encouraging appropriate help-seeking behavior. The QPR program provides brief training modules, both in person and online, to promote active recognition of suicide risk (Quinnett, 1995). QPR uses a three-step approach of recognizing and asking about suicide risk, encouraging others to seek professional assistance, and referral to appropriate resources. The American Association of Suicidology also provides accredited training programs for clinicians, physicians, and others for recognizing and responding to suicide risk (www.suicidology.org). The American Foundation for Suicide Prevention provides similar programs for early risk detection, designed for educators and others (www.afsp.org).

Screen for Suicide Risk

Service providers may also wish to include suicide risk screening as a regular part of working with abused and maltreated youth. Numerous suicide screening measures exist, some of which include formal training programs and are available at no cost. The Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) is a brief but well-validated suicide risk screening and risk assessment tool that has been adapted for use in a multitude of settings (e.g., Hill, Hatkevich, Kazimi, & Sharp, 2017; Horwitz, Czyz, & King, 2015). In addition, the C-SSRS website provides risk assessment triage tools to help service providers determine the appropriate course of action depending upon the youth's answers to the C-SSRS screening items. Besides the C-SSRS, there are many other screening tools available, such as the Suicidal Ideation Questionnaire and Suicidal Ideation Questionnaire-JR (Reynolds, 1988), Suicide Risk Screen (Thompson & Eggert, 1999), and the Suicide Behavior Questionnaire – Revised (Osman et al., 2001). Each of these questionnaires includes a screen for and/or assessment of suicidal thoughts and behaviors. Additionally, the Patient Health Questionnaire-9 (Manea, Gilbody, & McMillan, 2015) and the Home, Education, Activities, Drug use and abuse, Sexual behavior, Suicidality and depression (HEADSS; Cohen, Mackenzie, & Yates, 1991) are commonly used screeners in primary care and other medical settings. Both include a brief suicide risk components and may be used as a first step, followed by a more in-depth assessment if suicide ideation is reported.

A persistent concern of both providers and laypersons is whether broaching the subject of suicidality and self-harm, specifically asking about it, could trigger a child or adolescent to become suicidal or act on ideation. A growing body of research shows that asking about suicide does not lead to negative consequences and may decrease distress among suicidal youth (Gould et al., 2005; Pena & Caine, 2006). Asking about suicide also helps destigmatize the topic and creates a safe space for the youth in the future if they begin struggling with suicidality. Consequently, providers can feel confident that they are not inducing suicidal thoughts through screening efforts.

Take Appropriate Action

Service providers who take steps to recognize warning signs or screen for suicide risk must also be prepared to take appropriate action steps when suicide risk is identified. In the event of mild to moderate suicide risk (as determined by a suicide risk screening tool), referral to a mental health professional for further evaluation and intervention is the most likely action step. To aid in making referrals, service providers should know what local resources are available, including the names and contact information for outpatient mental health services providers or agencies. As many outpatient psychology clinics have waitlists, it is helpful to be aware of any providers or agencies that are available to see families on short notice. It can also be helpful to know which providers accept Medicaid/CHIP insurance or provide free or low-cost services to low-income families. Service providers should also have emergency suicide prevention resources on hand, such as the number for the National Suicide Prevention Lifeline (phone: 1-800-273-TALK/8255; Substance Abuse and Mental Health Services Administration, 2017) and the Crisis Text Line (text: 741-741; Crisis Text Line, 2018), and provide this information to youth and families with any level of suicide risk. Even if youths may be unlikely to need crisis services, reviewing the resources available to them requires little effort and having these available likely does no harm. In addition to offering a list of local resources for youth mental health care, a provider may consider small actions they can take themselves that can have a big impact. For instance, the Safety Planning Intervention (Stanley & Brown, 2012), described above, can help youth to make better choices during a suicidal crisis.

For imminent risk (i.e., when there is substantial concern that the youth may act on suicidal thoughts or urges in the near future) or when youth perceive their suicidal urges as being uncontrollable, it may be necessary to contact emergency services. Emergency services for imminent suicide risk include hospital emergency department visits and inpatient psychiatric hospitalizations. While the need for emergency services should be relatively infrequent, anyone assessing suicide risk should be aware of where these services may be obtained in the event they are indicated. In the event of an emergency, professionals can also call upon security personnel or law enforcement to provide an escort to a local emergency department or psychiatric inpatient hospital. Additionally, strong evidence supports the importance of reducing access to lethal means of suicide, such as locking up or removing household medications and removal of firearms from the homes of those at risk for suicide (e.g., Barber & Miller, 2014; Miller & Hemenway, 2008). A discussion with youth and caregivers may be essential to removing youth access to lethal means and ensuring safety during a suicidal crisis.

Support Families in the Transition to Mental Health Care

After the initial interaction with the suicidal youth, research shows that follow-up care is effective and essential to youths' recovery and mental health (e.g., Luxton et al., 2014; Richardson, Mark, & McKeon, 2014). Most critically, youth experiencing suicidal thoughts need to be linked to local mental health services in a timely manner. While providing referral information is a first step, referral information alone may not be sufficient to ensure linkage to mental health care (Krulee & Hales, 1988). Periodic phone calls, text messages, letters or postcards to the youth letting them know you care and are available to provide support can help ensure that youth feel valued. Simple follow-up messages also provide an opportunity to continue to encourage contact with mental health services and to provide additional resources as needed. A little persistence can have an enormous impact.

Ensure a Trained and Engaged Workforce

While every additional service provider engaging in suicide prevention efforts can save lives, developing an engaged and unified workforce that emphasizes suicide prevention can provide support for service providers and help reduce individual provider burnout. When suicide prevention exists as an organizational goal, many share the challenge of supporting vulnerable youth. A unified workforce can also support its members in maintaining self-care strategies and work-life balance. For providers interested in developing organizational commitment to suicide prevention, it may

be helpful to provide large-scale training in suicide risk assessment and prevention. "Train the trainer" programs make it possible to train groups of providers. For example, the QPR program (Quinnett, 1995) described above uses a "train the trainer" model, in which a representative of the organization can receive training to become an instructor in the QPR program. In this way, an organization can provide ongoing training to its personnel, while limiting training expenses.

Know Your Legal and Ethical Responsibility

Professional legal and ethical responsibilities vary between professions and across states. As a result, before engaging in suicide risk screening, providers may wish to review the legal and ethical requirements of their profession and the state in which they practice, to ensure that they take all appropriate steps in the event that they identify a suicidal youth. This is particularly important when working with abused and/or maltreated youth, since one of the most common actions when working with at-risk youth is to inform caregivers, who can be responsible for ensuring that youth stay safe and receive mental health care. In the case of abused and/or maltreated youth, complex legal situations concerning guardianship and parental rights may be common. Knowing exactly who to inform regarding a youth's suicide risk may not always be immediately clear, and there may be consequences for failing to report suicide risk. Furthermore, when substantial, immediate safety concerns exist, it may be necessary to suggest hospitalization. In our experience, if clearly and calmly explained, parents typically understand the need for, and consent to, hospitalization for the sake of safety. However, should parents refuse and the provider deem the child to be at imminent, acute risk for self-harm, involuntary hospitalization may be necessary. Service providers assessing suicide risk should be aware of available avenues for involuntary hospitalization in their jurisdiction. Finally, the adoption of "red flag" gun laws or "extreme risk protection orders" in some areas may provide another option for ensuring safety for a child. These laws allow a judge to order law enforcement to confiscate firearms in the event of severe risk of harm. As these laws are still emerging, their role in suicide prevention efforts is also emerging, though initial evidence seems to support modest impacts on suicide (Swanson et al., 2017). Taken together, careful review of reporting requirements and legal options to ensure patient safety specific to your discipline and jurisdiction is an important step. Those with access to legal consultation may wish to seek assistance in interpreting the applicable laws and statutes.

Know Where to Find Resources

National suicide prevention organizations provide a variety of resources, fact sheets, handouts, and training information for both service providers and community members. The American Foundation for Suicide Prevention (www.afsp.org), Suicide Prevention Resource Center (www.sprc.org), American Association for Suicidology (www.suicidology.org), and The Trevor Project (www.thetrevorproject.org) all offer suicide prevention resources for service providers. National suicide prevention organizations may also be a good place for to find supportive professionals. For example, the American Association for Suicidology has a publicly available listserv where providers can seek advice or referral information. For those interested in more information on suicide statistics, including data specific to a particular state or region, the Centers for Disease Control website (www.cdc.gov) houses both the Wide-ranging Online Data for Epidemiologic Research (WONDER) database and the Youth Risk Behavior Surveillance System data, which provide some of the most up-to-date statistics on suicide deaths as well as suicide attempts and ideation, respectively.

Conclusions

Abused and maltreated children are at elevated risk for suicide-related behaviors. Fortunately, a wide variety of preventive interventions exist to provide support and care for at-risk youth. Service providers working with these youth have a unique opportunity and responsibility to identify youth at risk for suicide and direct them to appropriate preventive interventions. By incorporating suicide prevention efforts into their daily practices, service providers working with abused and maltreated youth can save even more lives.

Table 1. Action Steps for Engaging in Suicide Prevention Efforts

The Role of Abuse/Maltreatment Service Providers in Suicide Prevention	
Recognize Risk	• Recognize the association between abuse/maltreatment and suicide risk. • Be mindful of additional risk markers. • Prioritize warning signs as indicators that immediate action may be needed. • Seek training in how to respond to suicide risk.
Screen for Suicide Risk	• Consider both formal (e.g., using C-SSRS or another screening tool) and informal screens (asking about suicidal thoughts conversationally). • Seek training in the use of formal screening tools. • Know that asking about suicide risk does NOT increase youth suicide risk.
Take Appropriate Action	• Know what to do when youths report suicide risk. • Facilitate access to quality care by having resources readily available and creating a warm hand off. • Be prepared to contact emergency services if necessary. • Consider a discussion of youth access to lethal means and how to reduce/limit access to such items for the protection of at-risk youth.
Support Families in the Transition to Mental Health Care	• Assist youth in linking to local mental health services in a timely manner. • Continually encourage contact with mental health services.
Ensure a Trained and Engaged Workforce	• Develop an engaged and unified workforce that emphasizes suicide prevention to support for service providers and help reduce individual provider burnout. • Ensure workforce members maintain self-care and work-life balance.
Know Your Legal and Ethical Responsibilities	• Review the legal and ethical requirements of your profession and the state in which you practice. • Know how, when, and to whom to report youth suicide risk. • Review any relevant laws in your jurisdiction and seek legal consultation if needed.
Know Where to Find Resources	• Identify sources of additional information or resources, so that you have access to support and can find answers to questions that may arise.

Table 2. Resource List

Resources	
Hotlines/Textlines	
National Suicide Prevention Lifeline	1-800-273- 8255 (TALK) 1-888-628-9454 (in Español)
Crisis Text Line	Text HOME to 741-741
Trevor Lifeline (for LGBTQ+ youth):	1-866-488-7386
Fact Sheets, Handouts, and Training Information	
American Association for Suicidology	www.suicidology.org
The American Foundation for Suicide Prevention	www.afsp.org
The Centers for Disease Control and Prevention	www.cdc.gov
Crisis Text Line	www.crisistextline.org
National Institute of Mental Health	https://www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml
National Suicide Prevention Lifeline	www.suicidepreventionlifeline.org
Suicide Prevention Resource Center	www.sprc.org
The Trevor Project	www.thetrevorproject.org

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