

BRIEF REPORT

An Investigation of Suicide Screening and Prevention Procedures Used in Pediatric Offices Across the State of Mississippi

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Introduction

Suicide remains a nationwide public health problem in young people, with suicide deaths increasing nationwide since 2007.¹ This problem is even worse among states such as Mississippi, where individuals have higher rates of planning, suicide attempts, and suicide attempts requiring medical treatment than the National average.² In addition to these heightened rates, Mississippi has a dearth of health care providers statewide,³ making it difficult to assess or treat for suicide risk. Therefore, the burden of assessing and treating suicidal thoughts and behaviors may be placed with other health care providers, such as pediatricians.

Of the individuals who die by suicide, 45% reportedly see a primary care physician in the year before their death.⁴ This fact indicates that pediatricians may be uniquely suited to assess and refer individuals with suicidal ideation to treatment. However, we know relatively little about what pediatricians in the state of Mississippi are already doing for assessment and treatment of suicidality. Therefore, our current study explored the practices used by pediatricians for suicide risk screening and procedures following positive suicide screens. Our goal was to learn where aid could best be provided to pediatricians in screening for suicide, determining high suicide risk, and what to incorporate for future training.

Methods

Participants and Procedure: For our study, 30 pediatricians practicing in the state of Mississippi were recruited via emails to the Mississippi Chapter of the American Academy of Pediatrics and social media platforms (i.e., Reddit, X) between October 2023 and March 2024. All participants completed a 5–10-minute survey asking about their experiences with suicide risk screening, procedures, assessment, treatment, previous training they had received, and barriers to implementing universal suicide risk screening. All

participants were entered into a drawing to win one of 10 available \$50 gift cards. Ethical approval was obtained from the American Academy of Pediatrics (IRB#: 23EM03) and all participants provided informed consent.

Results

Suicide Risk Screening Protocols

Most pediatricians stated that their health care practice conducted suicide risk assessments/screens, with 27% listing this as happening always, 70% sometimes, and only 3% reporting never.

Pediatricians were asked to select all the suicide risk screeners that were used in their office. Pediatricians used a variety of suicide risk screeners, which mainly included the Patient Health Questionnaire-9 (PHQ-9; 57%) or Verbal inquiry (24%). One individual each also endorsed using the Mini-International Neuropsychiatric Interview- Structured Clinical Interview for DSM-5, Suicide Behaviors Questionnaire, Edinburgh Postnatal Depression Scale, Generalized Anxiety Disorder-7, CRAFFT (Car; Relax; Alone; Forget; Friends; Trouble), and the Pediatric Symptom Checklist. An additional one individual was unsure which screener he or she used, and another stated that he or she used no screener.

Most of these surveys were conducted during the appointment (60%), with an additional 33% giving the surveys both before and after the appointment (33%), and only 3% conducting the screen before the appointment with no other screening during or after the appointments. These screenings were usually conducted in-person (80%) or both online and in person (13%), with only 3% of pediatricians indicating that the screener was given online only.

Pediatricians were asked to whom these screeners were given. Of our sample, 7% stated that they conducted universal risk assessments for their patients, with only 2% giving them universally to parents of patients to ask about parental suicidal thoughts. Others reported only giving suicide screeners to individuals taking antidepressants (10%), those answering positively to a depression screener (24%), new mothers (14%), those with a history of suicidal thoughts or actions (14%), or all patients within a specific age group (24%). Out of those reporting giving the screener to certain age groups, 5% reported giving the screener to individuals over age 10, 18% over age 11, 27% over age 12, and 50% over age 13.

Practices after suicide risk is determined

Our sample was asked what practices are used when a patient answers positively on a suicide screener, and which of these options were required by their practice. Twenty-six individuals reported that they talked to the parents/caregiver. Of these, 11 (42.3%) were required by their clinic. For those reporting that they talk to the parents or caregiver, we asked how

collaborative the pediatrician was with the child or teen surrounding disclosure. Thirteen pediatricians reported that this behavior depends on the age of the child, with 4 reporting that the child can be present, and 1 reporting the child must be present. Seven pediatricians reported that they would lead the conversation, with 0 reporting that the child would lead the conversation. Additionally, 4 individuals reported that the child can choose not to disclose in some cases, such as if the child was nonverbal or is not suicidal but just at risk for depression.

Twenty-four pediatricians reported that they would talk to the child if he or she answered positively on a suicide screener, with 9 (37.5%) required by their practice. Sixteen would provide resources (N=6 required; 37.5%), 19 would refer the patients (N=5 required; 26.3%), 16 would assess further (N=8 required, 50%), and 14 would partner with psychologists, psychiatrists, or social workers (N=5 required; 35.7%). An additional 10 reported that “it depends/varies”, and 3 reported other.

Pediatricians were also asked which out of a list of practices they used, and whether they were used always, sometimes, or never. Most commonly used practices included assessing if the patient has a plan (N=27 Always; N=2 Sometimes; N=0 Never), involving a third party such as a parent (N=25 Always; N=3 Sometimes; N=1 Never), instructing the family on removal of lethal means (N=23 Always; N=5 Sometimes; N=1 Never), and referring the patient for mental health services (N=20 Always; N=9 Sometimes; N=0 Never). Pediatricians also often asked the family about additional risk factors (N=17 Always; N=11 Sometimes; N=1 Never), provided emergency numbers (N=16 always, N=11 Sometimes; N=2 Never), developed a management plan for the patient (N=16 Always; N=9 Sometimes, N=2 Never), established follow-up with their office (N=16 Always, N=8 Sometimes; N=1 Never), and provided coping resources (N=15 Always; N=12 sometimes; N=1 Never). Lastly, a few pediatricians made safety contracts (N=10 Always; N=9 Sometimes; N=8 Never) and sent the patient to the emergency room (N=5 Always; N=20 Sometimes; N=2 Never).

Confidence in implementing suicide screening

Our sample was asked, “What is your current confidence in implementing suicide screening in your current practice?” Participants rated their confidence from 0-100 on a slider scale. Our sample was on average 57.9% confident (Median= 60.5; SD: 26.7), with 27% of our sample reporting below 50% confidence, and 73% of our sample reporting below 75% confidence.

Barriers to implementing universal screening

Pediatricians were asked an open-ended question of “What barriers do you foresee in conducting widespread suicide risk assessments for all clients?” Fourteen of the pediatricians responded. The main concerns fell under the category of Time and Effort (n= 8; e.g., “The patient volume would be

overwhelming and too demanding”, “time constraints, paperwork, scanning, documentation”, “timeframe during clinic visit”). Pediatricians also listed a lack of resources as a concern (n= 2; e.g., “Limited resources for referrals”). Other pediatricians listed barriers such as the age of the patient (n=2; e.g., “Age of patients leading to some not understanding questions”), parents being concerned (n=1; e.g., “parental concern that the questions introduce an ‘idea’ to a child who previously didn’t know that was even an ‘option.’”), and other patient characteristics (n=1; Patients being nonverbal due to global delay”).

Training

Seventy percent of pediatricians received no training on suicide prevention in the past year, and 48% received no lifetime training on suicide prevention. On average, those who did indicate receipt of training received 2.6 (SD: 1.8) hours of training in the past year, and 4.4 (SD: 5.4) hours of training in previous years. When asked how interested those in our sample were for additional training, 67% were at least moderately interested, with 97% at least somewhat interested in additional training. Specifically, pediatricians wanted additional training on risk assessments, which resources to provide, how to approach the topic of suicide, decision-making when someone is suicidal, and safety planning. They also asked for additional handouts or resources to provide to patients and parents and places to refer patients if they are suicidal.

Discussion

Pediatricians in Mississippi report a variety of suicide risk screening and management techniques. Important organizations such as the American Academy of Pediatrics and American Foundation for Suicide Prevention have developed the *Blueprint for Youth Suicide Prevention*^{5,6} which contains a list of recommendations for youth suicide assessment and management. In the state of Mississippi, however, it seems that pediatricians may be unfamiliar with these guidelines or other best practices for suicide risk and could use training that best improves their knowledge of these practices.

For instance, our study found that many pediatricians used depression screeners or non-standard risk assessment measures such as verbal inquiry. Certain depression screeners, such as the Patient Health Questionnaire (PHQ-9), were highly endorsed by our study participants. However, these questionnaires rely on a single item assessing suicide risk, which has been found to miss many individuals still at risk for suicide.⁷ The *Blueprint for Youth Suicide Prevention* recommends that pediatricians add suicide-specific questions such as those on the Ask Suicide-Screening Questions (ASQ)⁸ to the PHQ-9 when assessing for suicide risk.⁵ These questions are brief and therefore may not add significant doctor or patient burden, as was a main concern for the individuals in our sample.

Our study also found large differences in which patients received suicide screeners. The Blueprint recommends universal screening for individuals 12+, and screening only when risk factors are present for ages 8-11.⁵ These risk factors may include a history of suicidal thoughts or actions, as well as having patients who come in with mental health problems as their chief complaint.⁵ Therefore, pediatricians who screened for suicide in their patients currently taking antidepressants or currently depressed may be fulfilling best practices. However, it is important to note that, while depression is a risk factor for suicide, not all youth who die by suicide are diagnosed with depression, or have any pre-existing mental health disorder.⁹ The use of depression-related screeners and indicators for suicide risk illustrates that pediatricians in Mississippi may benefit from training on how non-depressed individuals die by suicide. Some pediatricians also opted to screen new mothers, which is beneficial due to heightened risk for postpartum suicidal ideation and death by suicide in this population.¹⁰

Interestingly, once a patient has been identified to have some level of suicide risk, pediatricians differed on whether they would talk to the child, with more of our pediatricians listing that they would talk to the parents/caregiver than to the child themselves. This factor is notable, as the *Blueprint for Youth Suicide Prevention* suggests talking to youth to let them know the next steps in the process if suicidal thoughts or behaviors are disclosed.⁵ Therefore, even if youth are not asked further questions, they should be informed about the process before proceeding to notify the parents. Most pediatricians reported that they would gather more information about their patient's suicide risk before acting. This gathering included assessing if their patient has a plan for suicide and asking the patient's family about additional risk factors. These are important steps to take that can signify to pediatricians their patients' level of risk.⁵ The majority of pediatricians also indicated that they would speak to the family about removal of lethal means. There is evidence that lethal means counseling with parents works to improve safe storage procedures and to limit access to lethal means in the home.¹¹ As suicidal crises are often time-limited and lethality of method often determines the likelihood of death when making a suicide attempt, lethal means counseling is crucial to decreasing youth suicides.^{5,11} Pediatricians also opted to provide emergency numbers, develop management plans, and provide coping tools for their patients. These strategies have all been recommended as individual interventions, or even combined into safety plans¹² and have shown effectiveness in decreasing suicidal ideation and attempts, and hospitalizations.^{13,14} Many pediatricians, however, reported that they engage in use of safety contracts, with 19 pediatricians reporting that they use them at least sometimes. However, safety contracts, also referred to as "no-harm contracts", have been shown to be an ineffective suicide intervention, unlikely to protect against suicide-related legal action, and are generally not recommended.¹⁵

A few pediatricians reported that they would send their clients to the emergency room always, and a few reported that they would never use this as a risk management strategy. However, sending clients to the emergency room should only be done in cases involving imminent risk⁵ (i.e., those who are at risk of harming themselves immediately or within hours/day), which means that it should neither be the standard practice, nor avoided altogether. Overuse of hospitalization can remove patients' autonomy, erode their trust in health providers, and over-fill hospital beds that may be needed for other more severe cases.¹⁶⁻¹⁸

Pediatricians in Mississippi consistently indicated having low levels of training in suicide risk management and prevention, and many reported being interested in increasing their training on this subject. Specifically, our sample was looking for extra training that focuses on how to empathetically assess patients for risk, conduct safety planning, and make decisions about care for individuals at risk for suicide. Additional information about special populations, such as nonverbal patients or those with intellectual disabilities should be provided. In addition, pediatricians need access to standardized resources to provide their clients, should they be in a suicidal crisis.

Limitations: The current study only included 30 pediatricians. In addition, demographic characteristics of these pediatricians, the location within Mississippi of their offices, office size, partnership with mental health professionals, and other characteristics of their offices were unknown. It is possible that those who volunteered to take our study were more knowledgeable about suicide practices or more willing to learn about suicide practices than other pediatricians in the state.

Conclusions: This study allowed us to identify gaps in Mississippi pediatricians' knowledge of suicide risk screening, assessment, and management. Training on the *Blueprint*, and steps to take to ensure the safety of patients would be beneficial in Mississippi pediatric offices. In addition, as many pediatricians were worried about the time and effort required to implement more screening. Individuals creating these resources should consider how to maximize benefits while minimizing financial-, time-, and effort-related costs.

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REFERENCES

1. Curtin SC, Garnett MF. Suicide and homicide death rates among youth and young adults aged 10–24: United States, 2001–2021. doi:[10.15620/cdc.128423](https://doi.org/10.15620/cdc.128423)
2. Centers for Disease Control and Prevention. Youth Online: High School YRBS - T-Test Mississippi 2021 and United States 2021 Results | DASH | CDC. Accessed November 20, 2024. <https://nccd.cdc.gov/Youthonline/App/Results.aspx?TT=G&OUT=0&SID=HS&QID=QQ&LID=MS&YID=2021&LID2=XX&YID2=2021&COL=T&ROW1=N&ROW2=N&HT=QQ&LCT=LL&FS=S1&FR=R1&FG=G1&FA=A1&FI=I1&FP=P1&FSL=S1&FRL=R1&FGL=G1&FAL=A1&FIL=I1&FPL=P1&PV=&TST=True&C1=MS2021&C2=XX2021&QP=G&DP=1&VA=CI&CS=Y&SYID=&EYID=&SC=DEFAULT&SO=ASC&PF=1>
3. Shahbazi M, Azevedo MJ. Chapter 3. Primary Health Care in Mississippi: Past, Present, and Future. In: *The State of Health and Health Care in Mississippi*. University Press of Mississippi; 2015:69-88. Accessed November 25, 2024. https://muse.jhu.edu/pub/201/edited_volume/chapter/1659696
4. Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry*. 2002;159(6):909-916. doi:[10.1176/appi.ajp.159.6.909](https://doi.org/10.1176/appi.ajp.159.6.909). PMID:12042175
5. American Academy of Pediatrics. Suicide: Blueprint for Youth Suicide Prevention. Accessed November 20, 2024. <https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention>
6. Gorzkowski Hamilton J, Horowitz LM, Standley CJ, et al. Developing the Blueprint for Youth Suicide Prevention. *J Public Health Manag Pract*. 2023;29(5):E214. doi:[10.1097/PHH.0000000000001764](https://doi.org/10.1097/PHH.0000000000001764). PMID:37131276
7. Gratch I, Tezanos KM, Fernades SN, Bell KA, Pollak OH, Cha CB. Single- vs. Multi-Item Assessment of Suicidal Ideation Among Adolescents. *R I Med J* 2013. 2022;105(4):16-21.
8. Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. *Arch Pediatr Adolesc Med*. 2012;166(12):1170-1176. doi:[10.1001/archpediatrics.2012.1276](https://doi.org/10.1001/archpediatrics.2012.1276). PMID:23027429
9. Chaudhary S, Hoffmann JA, Pulcini CD, et al. Youth Suicide and Preceding Mental Health Diagnosis. *JAMA Netw Open*. 2024;7(7):e2423996. doi:[10.1001/jamanetworkopen.2024.23996](https://doi.org/10.1001/jamanetworkopen.2024.23996). PMID:39078631
10. Lindahl V, Pearson JL, Colpe L. Prevalence of suicidality during pregnancy and the postpartum. *Arch Women's Ment Health*. 2005;8(2):77-87. doi:[10.1007/s00737-005-0080-1](https://doi.org/10.1007/s00737-005-0080-1)
11. Sisler SM, Hart S, Hamilton J, Schapiro NA. Preventing Suicide Through Lethal Means Restriction in Pediatric Care. *J Pediatr Health Care*. Published online January 10, 2025. doi:[10.1016/j.pedhc.2024.09.004](https://doi.org/10.1016/j.pedhc.2024.09.004)
12. Moscardini EH, Hill RM, Dodd CG, Do C, Kaplow JB, Tucker RP. Suicide Safety Planning: Clinician Training, Comfort, and Safety Plan Utilization. *Int J Environ Res Public Health*. 2020;17(18):6444. doi:[10.3390/ijerph17186444](https://doi.org/10.3390/ijerph17186444). PMID:32899637
13. Ferguson M, Rhodes K, Loughhead M, McIntyre H, Procter N. The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review. *Arch Suicide Res*. 2022;26(3):1022-1045. doi:[10.1080/13811118.2021.1915217](https://doi.org/10.1080/13811118.2021.1915217)
14. Rudd DM, Bryan CJ, Jobes DA, Feuerstein S, Conley D. A Standard Protocol for the Clinical Management of Suicidal Thoughts and Behavior: Implications for the Suicide Prevention Narrative. *Front Psychiatry*. 2022;13. doi:[10.3389/fpsyt.2022.929305](https://doi.org/10.3389/fpsyt.2022.929305)

15. Lewis LM. No-Harm Contracts: A Review of What We Know. *Suicide Life Threat Behav.* 2007;37(1):50-57. doi:[10.1521/suli.2007.37.1.50](https://doi.org/10.1521/suli.2007.37.1.50)
16. Ward-Ciesielski EF, Rizvi SL. The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: A critical review and recommendations for research. *Clin Psychol Sci Pract.* 2021;28(1):60-71. doi:[10.1111/cpsp.12332](https://doi.org/10.1111/cpsp.12332)
17. Nadler A, Avner D, Khine H, Avner JR, Fein DM. Rising Clinical Burden of Psychiatric Visits on the Pediatric Emergency Department. *Pediatr Emerg Care.* 2021;37(1):1. doi:[10.1097/PEC.0000000000001473](https://doi.org/10.1097/PEC.0000000000001473)
18. Jones N, Gius BK, Shields M, Collings S, Rosen C, Munson M. Investigating the impact of involuntary psychiatric hospitalization on youth and young adult trust and help-seeking in pathways to care. *Soc Psychiatry Psychiatr Epidemiol.* 2021;56(11):2017-2027. doi:[10.1007/s00127-021-02048-2](https://doi.org/10.1007/s00127-021-02048-2). PMID:33751175