Screening 2: Suicidality Screening Program Description

**Literature for screenings reviewed and updated as needed, on July 1, 2026.*

Suicide screening has evolved substantially over time from informal clinical judgment to structured, evidence-based practice and is now recognized as a critical component of suicide prevention. Historically, early approaches to identifying suicide risk relied heavily on clinician observation and subjective assessment, with limited standardization or empirical support. Over the latter half of the twentieth century, advances in psychiatry led to the identification of key risk factors such as depression, prior suicide attempts, and substance use, prompting the development of standardized tools designed to assess suicidal ideation more systematically. By the early 2000s, suicide was increasingly framed as a preventable public health issue, leading to broader integration of screening practices into healthcare systems, including primary care, emergency departments, and school-based settings. Contemporary approaches emphasize universal or routine screening, particularly in high-risk populations, as well as integration with comprehensive care models to improve detection and prevention outcomes (Hughes et al., 2023; Thangada & Kasoju, 2024).

The importance of suicide screening is grounded in both epidemiological trends and clinical necessity. Suicide remains one of the leading causes of death worldwide, particularly among adolescents and young adults, underscoring the urgency of early identification strategies (Hughes et al., 2023). A key rationale for screening is that many individuals at risk do not disclose suicidal thoughts unless directly asked, and a substantial proportion of individuals who die by suicide have recent contact with healthcare providers without their risk being recognized (National Institute of Mental Health [NIMH], 2024). Screening tools provide a structured method to identify otherwise hidden risk, including suicidal ideation and associated mental health conditions. Evidence indicates that commonly used screening instruments demonstrate good diagnostic accuracy, with sensitivity and specificity rates around 85%, supporting their reliability in clinical practice (O'Connor et al., 2023). Moreover, screening has been shown to increase identification of at-risk individuals and improve engagement in mental health treatment, particularly when implemented as part of a broader system of care (Sekhar et al., 2022).

Beyond identification, suicide screening plays a foundational role in prevention. Because there are no biological markers or laboratory tests available to reliably detect suicide risk, structured screening and assessment remain essential clinical tools (Ryan & Oquendo, 2020). When combined with appropriate follow-up interventions—such as safety planning, counseling, and referral to mental health services—screening can contribute to meaningful reductions in suicide attempts and improved patient outcomes (NIMH, 2024).

Guidelines and research suggest that suicide screening should be conducted at multiple points across the continuum of care, using both universal and targeted approaches. Routine or universal screening is increasingly recommended in primary care settings, where many individuals receive regular healthcare and where opportunities for early detection are frequent. This is particularly important given that a significant proportion of individuals who die by suicide have had recent primary care visits (NIMH, 2024). Similarly, screening is recommended in emergency departments, especially for patients presenting with mental health concerns, substance use, or other indicators of distress. In pediatric and school-based settings, universal screening has been shown to improve

identification of at-risk youth and increase treatment initiation, supporting its use as a preventative strategy (Baldini et al., 2025).

In addition to universal approaches, targeted screening should be conducted for individuals with known risk factors, including mental health disorders, prior suicide attempts, substance use, and major life stressors. Screening is also warranted whenever clinical concern arises, such as when patients exhibit warning signs like withdrawal, agitation, or expressions of hopelessness. Importantly, suicide screening should not be viewed as a one-time event; rather, it should be conducted periodically, as risk can fluctuate over time. Repeated assessment allows clinicians to identify changes in risk status and intervene appropriately, reinforcing the role of screening as a dynamic and ongoing component of patient care.

Access Behavioral Health's Suicidality Screening Program has been designed to make the ASQ and the PHQ-9/PHQ-9-A readily available to practitioners in order to screen for suicide risk. The recommended assessments are straightforward and allow for both practitioner use and recipient self-screening to maximize identification of suicidality.

Eligible Members

ABH utilizes a systematic approach when identifying members eligible for the program. Data sources include member claims data and provider record monitoring data. Any member who is receiving behavioral health services is eligible for the program.

Frequency

ABH also providers the SAFE-T Suicide Assessment, a comprehensive guide to assessing suicide risk.

Suicide assessments should be conducted at the following occurrences:

1. At first contact;
2. With any subsequent suicidal behavior, increased ideation, or pertinent clinical change;
3. Prior to changes in behavioral health treatment;
4. and at inpatient discharge.

Age recommendations for screening also include:

- Youth ages 12+: Universal screening
- Youth ages 8-11: Screen when clinically indicated
- Youth under age 8: Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present

Conditions

The suicide screening tools are indicated whenever suicidal behaviors or ideations are displayed by a member, or as a matter of routine screening to determine diagnosis, treatment planning, and/or changing level of care.

Provider & Practitioner Input

Practitioner input on ABH's Suicidality Screening Program is acquired through the Quality Improvement and Utilization Management (QIUM) Subcommittee and consultation with network psychiatrists. Provider and practitioner input includes program design and implementation. The QIUM subcommittee met on June 17, 2026, and selected Suicidality as the second behavioral health screening for ABH members.

Promotion

ABH's Suicidality Screening Program is promoted to practitioners via the ABH website, where the tables may be accessed freely by both members and providers. More information is readily available at https://abhfl.org. ABH also provides bi-annual training to all network providers and practitioners and the behavioral health screening programs are promoted during at least one of the sessions.

References:

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