



**Addressing the Youth Mental Health Crisis:
Evidence-Based Practices for Suicide
Screening and Prevention**

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No Disclosures

I have no financial relationships with ineligible companies.


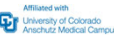
 

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Learning Objectives

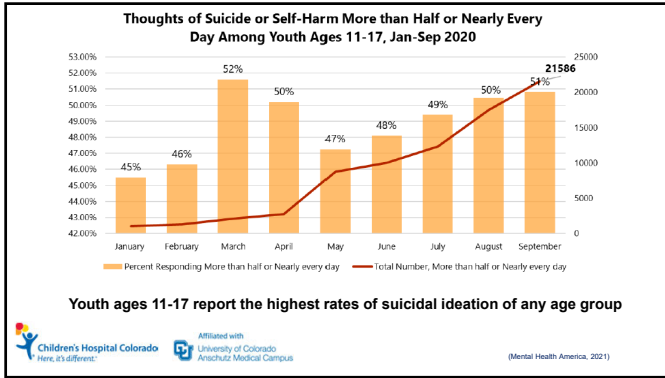
1. Describe prevalence of youth mental health concerns, including suicide
2. Outline effective methods for suicide screening
3. Discuss triage of patients based on suicide risk

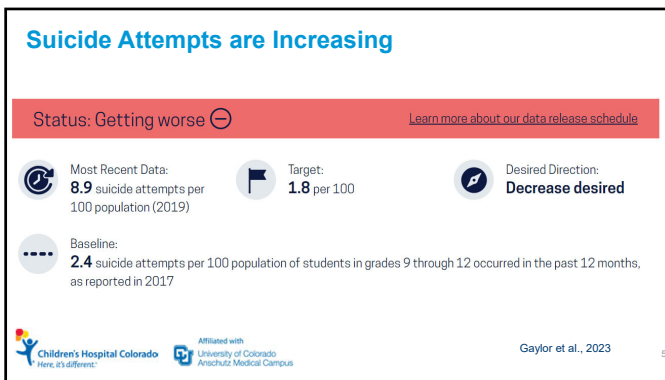
Colorado Department of Public Health and Environment (2021) <https://www.colorado.gov/health>

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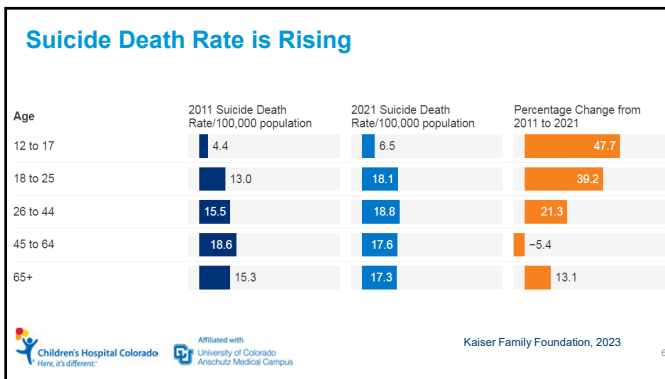
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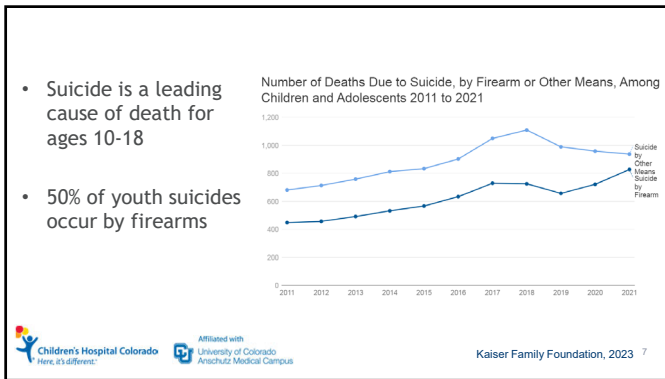
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Why are we seeing this increase?

- Increased visibility to mental health¹
- Limited and delayed access to mental health care²
- Social media and social isolation³
- Increased pressure to achieve⁴
- Societal stressors⁵
 - Finances, racism, gun violence, climate change

Children's Hospital Colorado Here, it's different. Affiliated with University of Colorado Anschutz Medical Campus 1. Armstrong, 2020; 2. Twenge et al., 2018; 3. Riehm et al., 2019; 4. Eckersley & Dear, 2002; 5. Hedegard et al., 2020 8

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Importance of PCPs



- 80% of youth who died by suicide saw their PCP in the previous year¹
- People who die by suicide are more likely to have seen a PCP in the previous month before their death than any other health care provider²

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Risk Factors of Suicidality



- Gender
 - Females more likely to attempt suicide; Males more likely to die by suicide
- Race
 - Black youth twice as likely to die by suicide compared to White youth
- LGBTQ+
 - Four times more likely to consider and attempt suicide
- Socioeconomic Status (SES)
 - Poverty increases risk
- Substance Use

  Affiliated with University of Colorado Anschutz Medical Campus Western Interstate Commission for Higher Education Mental Health Program & Suicide Prevention Resource Center, (2017). 10



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Risk Factors of Suicide Attempt


- Prior Suicide Attempt
- Recent Hospitalization
- Hopelessness
- Access to Lethal Means
- Substance Abuse
- Stressors (e.g., recent break-up)

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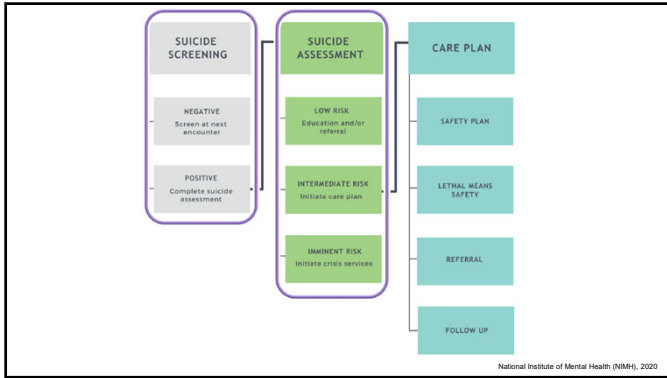
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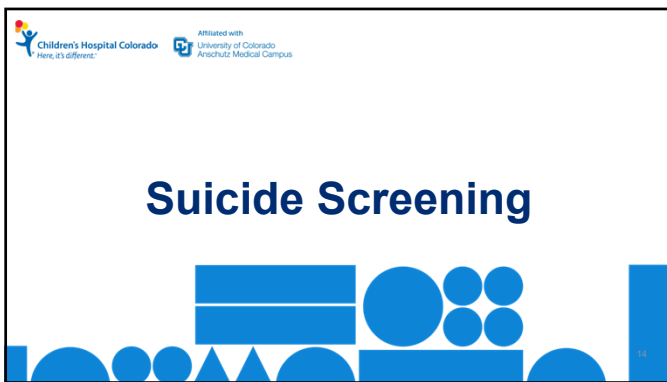
Youth Suicide Care Pathway



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Suicide Screening

- Evidence-based suicide screening tool developed for pediatric medical settings for youth ages 8-24¹
- ASQ² is free and available in multiple languages
- Four yes/no questions and takes 20 seconds to administer
- A "yes" response to 1 or more questions identified 97% of youth at risk of suicide²



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1. Horowitz et al., 2012; 2. National Institute of Mental Health (NIMH), 2020 15

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ASQ Suicide Risk Screening Tool

Ask the patient:

- In the past few weeks, have you wished you were dead? Yes No
- In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
- In the past week, have you been having thoughts about killing yourself? Yes No
- 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:

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

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ASQ: Next Steps

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 (provider 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 = **immediate positive screen** (imminent risk identified)
 - Patient requires a STAT safety/full 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 +800-273-TALK (8255) En Español: +888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

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SUICIDE SCREENING

NEGATIVE
Screen at next encounter

POSITIVE
Complete suicide assessment

Please circle Yes or No for the below questions

- In the past few weeks, have you wished you were dead? Yes No
- In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
- In the past week, have you been having thoughts about killing yourself? Yes No
- Have you ever tried to kill yourself? Yes No

If you to question #4, how and when? _____

If you answered **YES** to any of the above questions, please also answer the below question:

- Are you having thoughts of killing yourself right now? Yes No


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Example #1

A 17-year-old Hispanic female presents to PCP for her annual well child check with a history of depression, visible self-harm cuts on her arms. Her ASQ is as follows:

1. Is this a positive or negative screen?
 - Positive
2. What is the next step for this patient?
 - Complete a suicide assessment



The ASQ form for Example #1 shows the following responses: Question 1: Yes (circled); Question 2: Yes (circled); Question 3: Yes (circled); Question 4: No (circled). The patient answered 'Yes' to any of the above questions, so the follow-up question 5 was answered: 'Are you having thoughts of killing yourself right now?' with 'No' (circled).

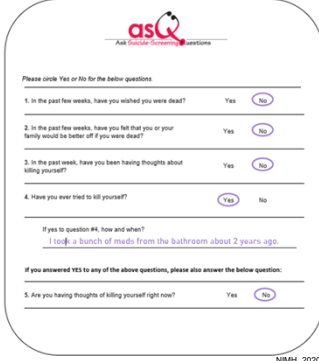
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Example #2

A 13-year-old White male presents to PCP for a sick visit. Recent romantic breakup, sporadic school attendance, and parent reported increased irritability. Started seeing a therapist 2 months ago. His ASQ is as follows:

1. Is this a positive or negative screen?
 - Positive
2. What is the next step for this patient?
 - Complete a suicide assessment



The ASQ form for Example #2 shows the following responses: Question 1: Yes (circled); Question 2: Yes (circled); Question 3: Yes (circled); Question 4: Yes (circled). The patient answered 'Yes' to any of the above questions, so the follow-up question was answered: 'Are you having thoughts of killing yourself right now?' with 'No' (circled).

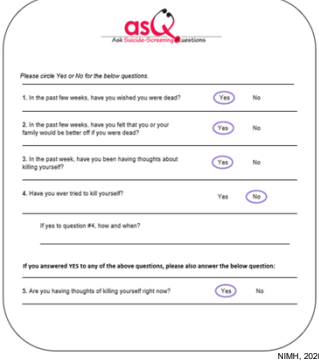
NIMH, 2020

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Example #3

A 16-year-old Black female presents to PCP for a mental health visit. Parent reported patient has been tearful, isolated, and low motivation. Her ASQ is as follows:

1. Is this a positive or negative screen?
 - Acute Positive
2. What is the next step for this patient?
 - Complete a suicide assessment or initiate transfer to ED/Crisis Clinic



The ASQ form for Example #3 shows the following responses: Question 1: Yes (circled); Question 2: Yes (circled); Question 3: Yes (circled); Question 4: No (circled). The patient answered 'Yes' to any of the above questions, so the follow-up question 5 was answered: 'Are you having thoughts of killing yourself right now?' with 'Yes' (circled).

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Suicide Assessment

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Brief Suicide Safety Assessment

1 Praise patient for discussing their thoughts
"We have to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for talking to us. I need to ask you a few more questions."

2 Assess the patient Review patient's responses from the eSQ

- Frequency of suicidal thoughts**
If possible, assess patient clinic (depending on developmental considerations and parent willingness). 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?"
- 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?"
- Past behavior**
Evaluate past self-harm and history of suicide attempts (method, estimated date, intent). Ask the patient: "Have you ever tried to harm yourself?" "Have you ever tried to kill yourself?" "Did you want to die?" (For youth, intent is an important risk indicator of method.) Ask: "Did you receive medical/psychiatric treatment?"

Factor most suicidal behavior is the strongest risk factor for future attempts.

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2 Assess the patient Review patient's responses from the eSQ

- 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/nervous?"
 - Impulsivity/Recklessness:** "Do you often act without thinking?"
 - Insomnia:** "In the past few weeks, have you felt hopeless, like things would never get better?"
 - Alcohol/Drugs:** "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"
 - Irritability:** "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 use/abuse:** "In the past few weeks, have you used drugs or alcohol?"
 - Weight gain/loss:** "If you, ask "What? How much?"
 - Sleep problems:** "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, [patient consent], ask them to describe)
 - Support network:** "Is there a trusted adult you can talk to? What 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/Work/Leisure:** "Do you ever feel so much pressure at school (academic or social) that you can't take a breath?"
 - Bullying:** "Are you being bullied or picked on?"
 - Isolation challenges:** "Do you know anyone who is bullied themselves or that is still themselves?"
 - Reasons for being:** "What are some of the reasons you would NOT kill yourself?"

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Example #1

- 13-year-old biracial nonbinary patient presents for well-child check. Reports pressure related to academics and peer conflict
- *“Sometimes I think it’d be easier for everyone if I didn’t exist.”*
- No access to lethal means. Denies a plan or intent.
- Parents very supportive and involved

Low Risk

- Provider referral list and resources
- If indicated, provide educational materials to patient/parents
- Consider follow-up contact within next 4 weeks



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Example #2

- 15-year-old Hispanic female patient presents for sick visit
- History of self-harm but not within past 3 months
- Presents with suicidal ideation but no plan or intent
- Good relationships with family but no friends at school

Intermediate Risk

- Initiate safety plan
- Counseling on lethal means restriction
- Referral to mental health services (preferably within 72 hours)



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Example #3

- 17-year-old White male patient presents for mental health visit. Reports increased tearfulness, isolation, and substance use
- Access to lethal means (medications)
- Texted a friend last night *“No one would even care if I died.”*
- Family and friends are supportive but patient reports nobody understands him

Imminent Risk

- Initiate transfer to crisis center or ED for crisis assessment
- Do not leave patient alone and remove dangerous objects from room
- Alert any relevant care team members



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Safety Planning



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Safety Planning

- Do not use “suicide contract” language
 - Not evidence-based
- Do use “safety plan”
 - Proactive planning
 - Focuses on what can be done vs what not to do
 - Enhances self-efficacy and sense of control
- Stanley-Brown Safety Plan¹






Stanley et al., (2009) 32

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Core Steps to Safety Planning

1. Identify reasons for living
2. Recognize warning signs
3. Identify internal coping strategies
4. Identify external healthy distractions
5. List people who can provide support
6. List professionals/resources who can provide support
7. Make environment safe

Stanley et al., (2009) 33

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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: _____ 4. Place: _____

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 AGENCIES I CAN CONTACT DURING A CRISIS:
 1. Clinician/Agency Name: _____ Phone: _____
 Emergency Contact: _____ Phone: _____
 2. Clinician/Agency Name: _____ Phone: _____
 Emergency Contact: _____
 3. Local Emergency Department: _____
 Emergency Department Address: _____
 Emergency Department Phone: _____
 4. Suicide Prevention Helpline (toll-free): 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):
 1. _____
 2. _____
 3. _____

The Stanley-Brown Safety Plan is a registered trademark of Stanley-Brown, PhD at Children's Hospital Colorado, 2010.
 Modification of this Safety Plan is prohibited. The plan is provided as a service to patients and families at no charge.

suicidesafetyplan.com

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Step 1: My warning signs:
 Signs that I am having strong feelings or I am not feeling safe:
 1. _____
 2. _____
 3. _____

Signs my supporting adult(s) may notice:
 1. _____
 2. _____

Step 2: Things I can do to help myself
 1. _____
 2. _____

Step 3: Reasons to be safe
 1. _____
 2. _____

Step 4: Things others can do to help me
 1. _____
 2. _____

Step 5: People who can help me
 Patient did not identify any contacts

Name	Contact Information
_____	_____
_____	_____

Step 6: Health care workers and agencies to call

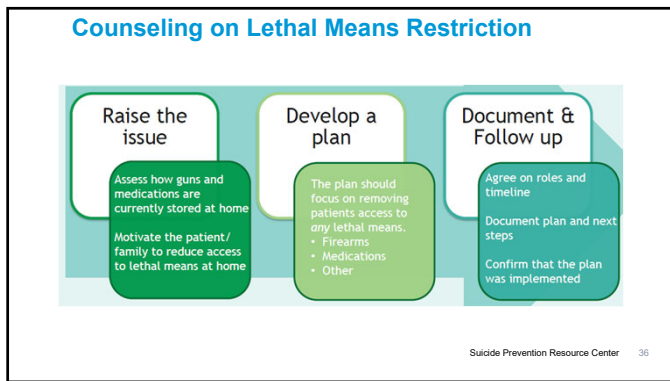
Clinician/Agency Name	Phone	Emergency Contact
_____	_____	_____
_____	_____	_____

Colorado Crisis Services: 1.844.493.TALK (8255) or text TALK to 38255
 www.ColoradoCrisisServices.org
 Call 911 or go to the nearest Emergency Department for immediate safety concerns

Adaptation of Stanley-Brown Safety Plan - Children's Hospital Colorado

Step 7: Ways to make your environment safer
 1. _____
 2. _____
 3. _____

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Resources

- Suicide Prevention Toolkit for PCPs
 - <https://sprc.org/settings/primary-care/toolkit/>
- CALM: Counseling on Access to Lethal Means
 - <https://sprc.org/online-library/calm-counseling-on-access-to-lethal-means/>
- Safety Planning Guide
 - <https://sprc.org/online-library/safety-planning-guide-a-quick-guide-for-clinicians/>
- NIMH Ask Suicide-Screening Questions (ASQ) Toolkit
 - <https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials>
- Colorado Crisis Services
 - 1-844-493-8255 or text "TALK" to 38255
 - www.coloradocrisiservices.org
- National Suicide Prevention Line
 - 1-800-273-8255

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Questions???

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