Depression and Suicide

Screening, Assessment and Referrals

Community of Practice

DEPRESSION AN INTRODUCTION

Depressive disorders prevalence

MAJOR DEPRESSION

- Pre-schoolers: 0.3% (community), 0.9% (clinic)
- School age: 2% Boys>Girls
- Adolescents: 5% (community), 20-40% (patients in psych Hospital)
- depressive sx 14 –62%, Duration: 26 –36 wks Girls>Boys

- The risk of depression increases by a factor of 2 to 4 after puberty, particularly in females
- The cumulative incidence by age 18 is approximately 20% in community samples

DYSTHYMIA-PERSISTENT DEPRESSIVE DISORDER

- 0.6% to 1.7% in children and 1.6% to 8.0% in adolescents

Other Mood Disorders

- Childhood Depression
- Major Depressive Disorder
- Persistent Depressive disorder (Dysthymia)
- Disruptive Mood dysregulation disorder
- Bipolar Affective Disorder
  - Mainly Depressive
  - Mainly Hypomanic
  - Mixed
- Mood Disorders complicating other psychiatric disorders

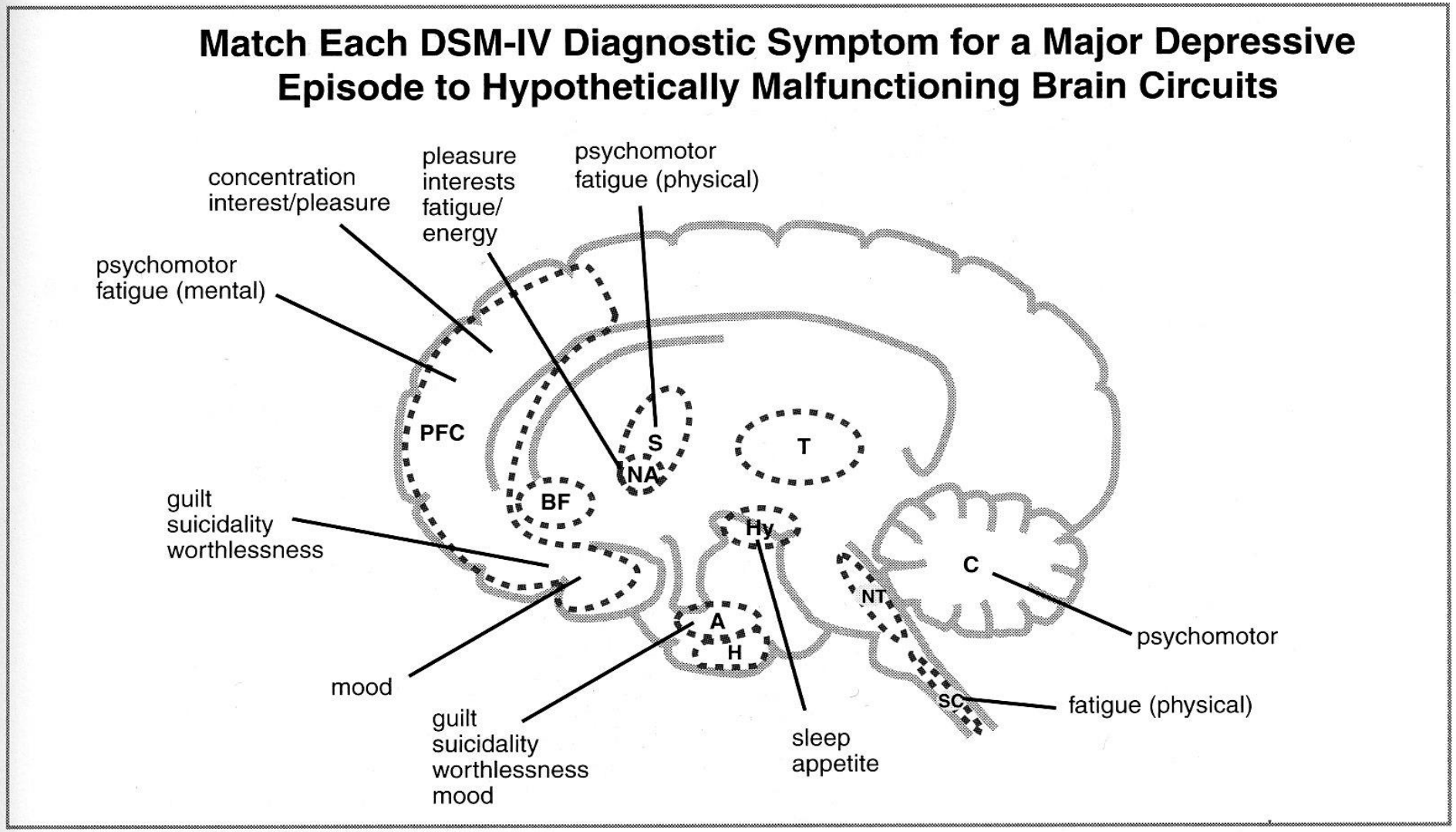
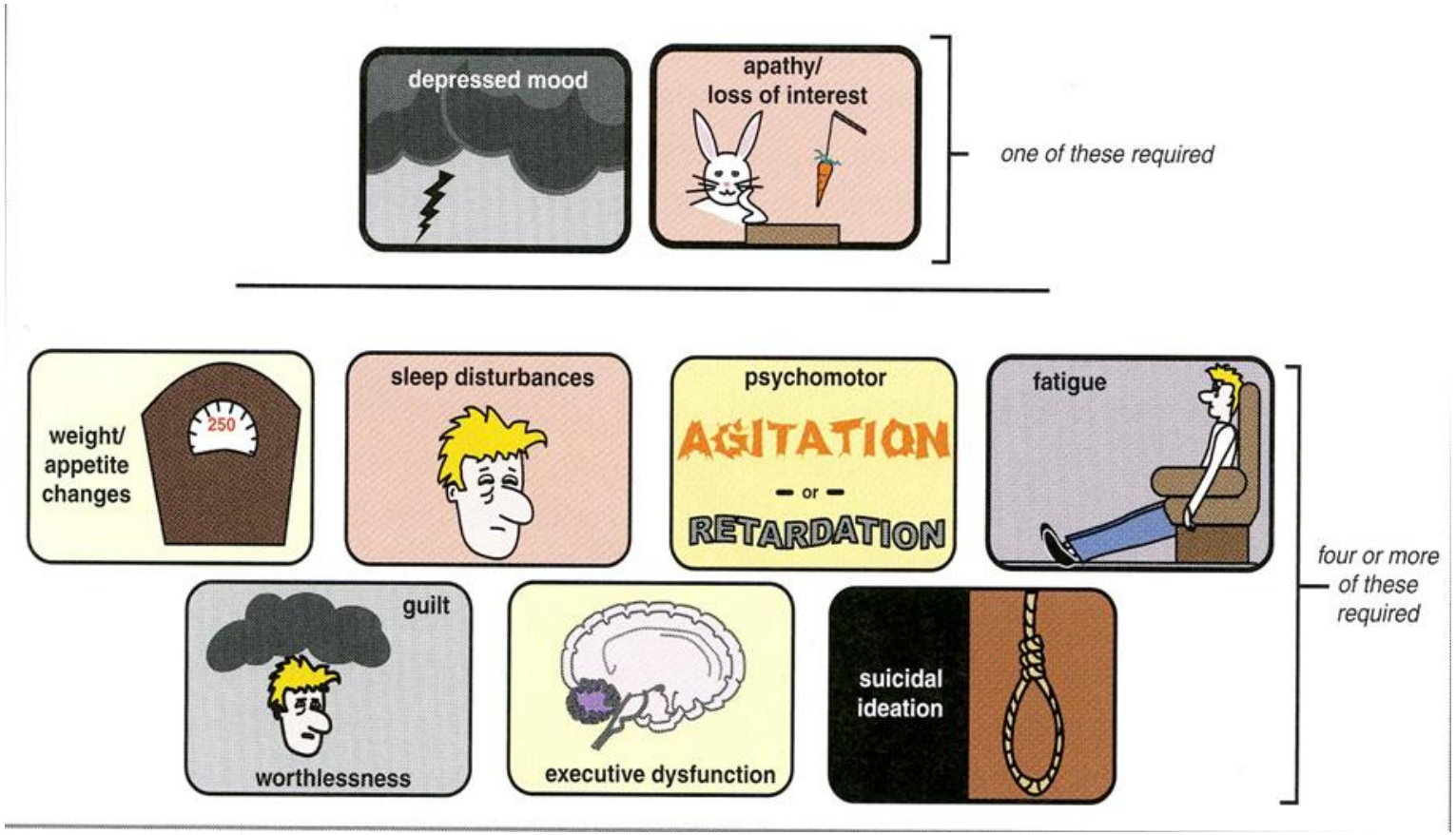


FIGURE 1-45 Matching depression symptoms to circuits. Alterations in neuronal activity and in the efficiency of information processing within each of the eleven brain regions shown here can lead to symptoms of a major depressive episode. Functionality in each brain region is hypothetically associated with a different constellation of symptoms. PFC, prefrontal cortex; BF, basal forebrain; S, striatum; NA, nucleus accumbens; T, thalamus; HY, hypothalamus; A, amygdala; H, hippocampus; NT, brainstem neurotransmitter centers; SC, spinal cord; C, cerebellum.

Dsm 5 Major Depressive Disorder-mild/moderate/severe/with psychosis; in partial remission/full remission/unspecified



Specifiers

- With anxious distress
- Mixed features
- Melancholic features
- Atypical features
- Mood congruent psychotic features
- Mood incongruent psychotic features
- Catatonia
- Postpartum onset
- Seasonal pattern

Clinical presentation variation compared to adult symptom onset for major depressive disorder

Age, y	Clinical Presentation Variation
3-5	Trouble verbalizing feelings, marked decreased interest in play, self-destructive themes in play, thoughts of worthlessness or suicide, symptoms do not need to be present for 2 wk
6-8	Trouble verbalizing feelings, increased somatic complaints, crying or shouting outbursts, unexplained irritability, observed anhedonia
9-12	Low self-esteem, guilt, hopelessness, increased boredom, feelings of wanting to run away, and fear of death. **Idea that life is temporary and death is permanent starts to form at 9 or 10 years**
13-18	Increased irritability, impulsivity, and behavior changes; decreased grades and poor school performance; increased disturbances in sleep and appetite; suicidality similar to adults; increased likelihood of chronic course of depression; stronger genetic association
≥19	Symptoms similar to adult presentation

Clinical Signs and Symptoms of Child vs Adolescent Depression

Signs and Symptoms	Child	Adolescent
Anhedonia	**+ +**	**+ + +**
Hopelessness	**+**	**+ + + +**
Sleep	**+**	**+ + +**
Weight	**+**	**+ + /- -**
Appearance	**+ + + +**	**+ +**
Somatic Complaints	**+ + + +**	**+ +**
Fears and Worries	**+ + + +**	**+**
Suicide	**+**	**+ + + +**

Ryan et al. (1987) and Rosenberg et al (1992, 1994)

Disruptive Mood Dysregulation Disorder

- Severe verbal and physical aggression
- Inconsistent with developmental level
- 3 or more/week
- Mood between outbursts obviously irritable
- Present for 12 or more months, not absent for =/< 3 months
- Two settings (home, school, peers)
- 6-18 years
- No mania/hypomania/MDE/ASD/PTSD/Other mood disorder/separation anxiety
- Not due to substances/neurological condition
- Prev:2-5%, males>females, children>adolescents

Persistent depressive disorder

- Depressed mood for 1 year (2 years in adults)
- 2 or more of: symptoms similar to Major depression
- SX continuously for 2 years, never sx free for >2 months

Same specifiers as MDD plus Partial remission\full remission, onset before or after 21 years

Pure dysthymia/Persistent MDE\Intermittent MDE with or without current episode

Premenstrual dysphoric disorder

5 sx week before, improve within days of onset of menstrual cycle and become minimal or stop in the week post

One or more of:

- Affective lability
- Irritability and anger
- Depressed mood, hopelessness
- Anxiety, tension, on edge
- Decreased interest
- Decreased concentration
- Lethargy

Premenstrual dysphoric disorder

- Appetite changes
- Hypersomnia\insomnia
- Sense of being overwhelmed
- Physical sx-breast tenderness, bloating, muscle or joint pain
- Prevalence: 1.8-5.8%

Vulnerabilities to depression

- Genetic factors:
- Genetic effect = 60% of variance MZ: 50% concordance and DZ: 20%
- Family studies
  - Familial aggregation
  - Heritability =30-40%
- Physiological factors
- Developmental factors
  - Temperament
  - Cognitive style
- Family factors
- Life events

Age, gender and family risk factors

- Up to age 10: Females = Males

  After age 10: Females > Males
- More 1st and 2nd degree relatives have depression
- Risk of depression before 18:
  - 1 Depressed Parent = 2x risk.
  - 2 Depressed Parents = 4x risk
- Males whose fathers die, before the age of 13, are more likely to develop depression

Depression and Temperament

- Characteristic ways of interacting with the world which is moulded by both genetically transmitted traits and interactions with the environment that begin at birth or before and may influence the development of depression in the following ways
- Direct
- Indirect
  - Mediate the role of factors such as stress
  - Moderate the role of temperament (related to coping styles)

Depression and puberty

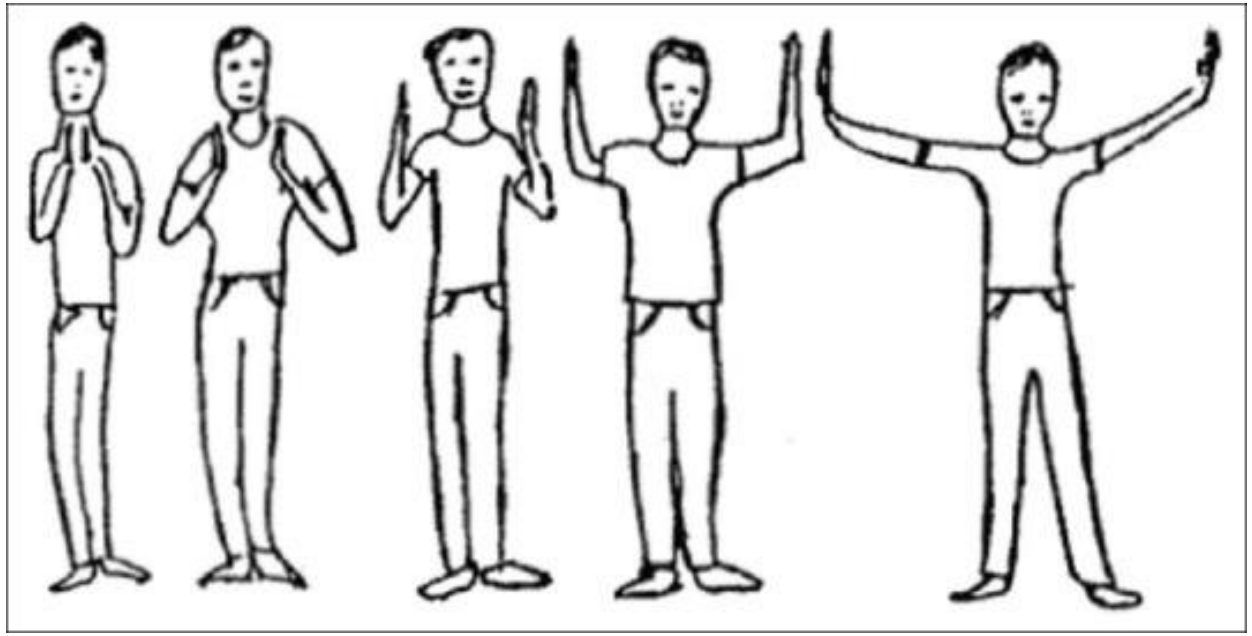
- High Hormonal levels Cortisol, Dehydroepiandosterone
- Increase in rates of depression after puberty
- Rate increases more rapidly mid puberty
- Higher rates in females than males

Depression screening in the medical office

- Mood and Feelings Questionnaire: Child and parent versions

https://devepi.duhs.duke.edu/measures/the-mood-and-feelings-questionnaire-mfq/

Visual analogue scales for the non verbal kids

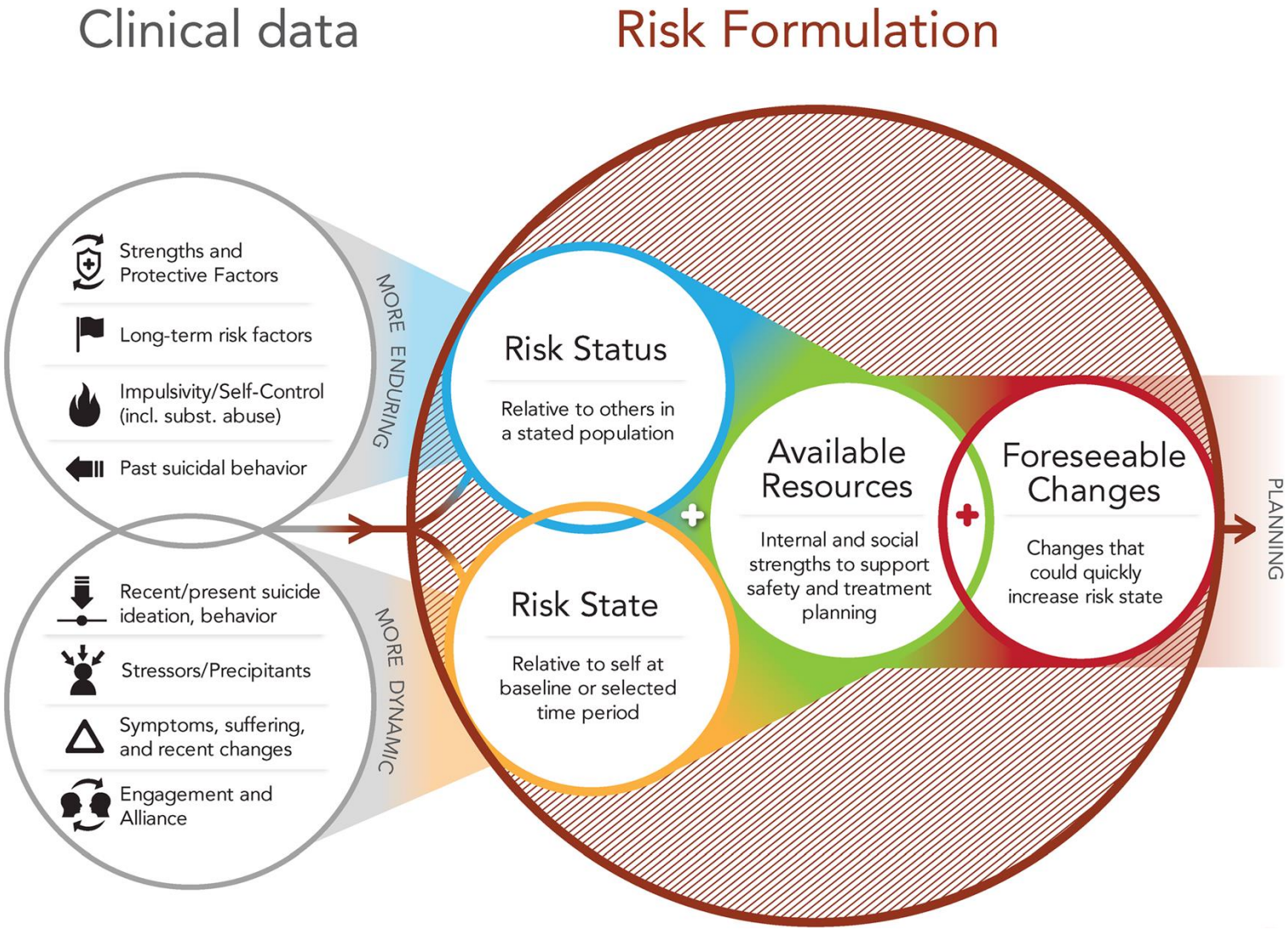


Pictorial Instrument for children and adolescents for depression: (show first picture) Do you get like him sometimes? (show the second picture) How much? Do you feel sad the way he does? Do people tell you that you look sad? (show the second picture) How much? What about crying? (show the second picture) How much does it happen to you?

Formulation and its importance

- The first step post assessment is to create a formulation.
- Formulation helps guide the focus of treatment especially the psychological therapy in depression.
- It helps choose the type of therapy that is most likely to be useful for the consumer
- Ratings of suicide risk based on a Likert type low, moderate and high prediction focused scale is not evidence based
- A more useful approach is the creation of a risk formulation that is based in the aim of prevention rather than prediction.

RISK FORMULATION TO PREVENT RISK OF SUICIDE



Phases of treatment of depression

- **Acute phase**
- Acute phase treatment aims at achieving response defined as at least 50% reduction in symptoms. This period may range from 2 weeks to 2 months.
- **Maintenance phase**
- It is aimed at consolidation of gains achieved in acute phase and prevention of relapse.
- **Continuation phase**
- It is defined as recovery phase where the aim is to prevent any recurrence of depressive symptoms.

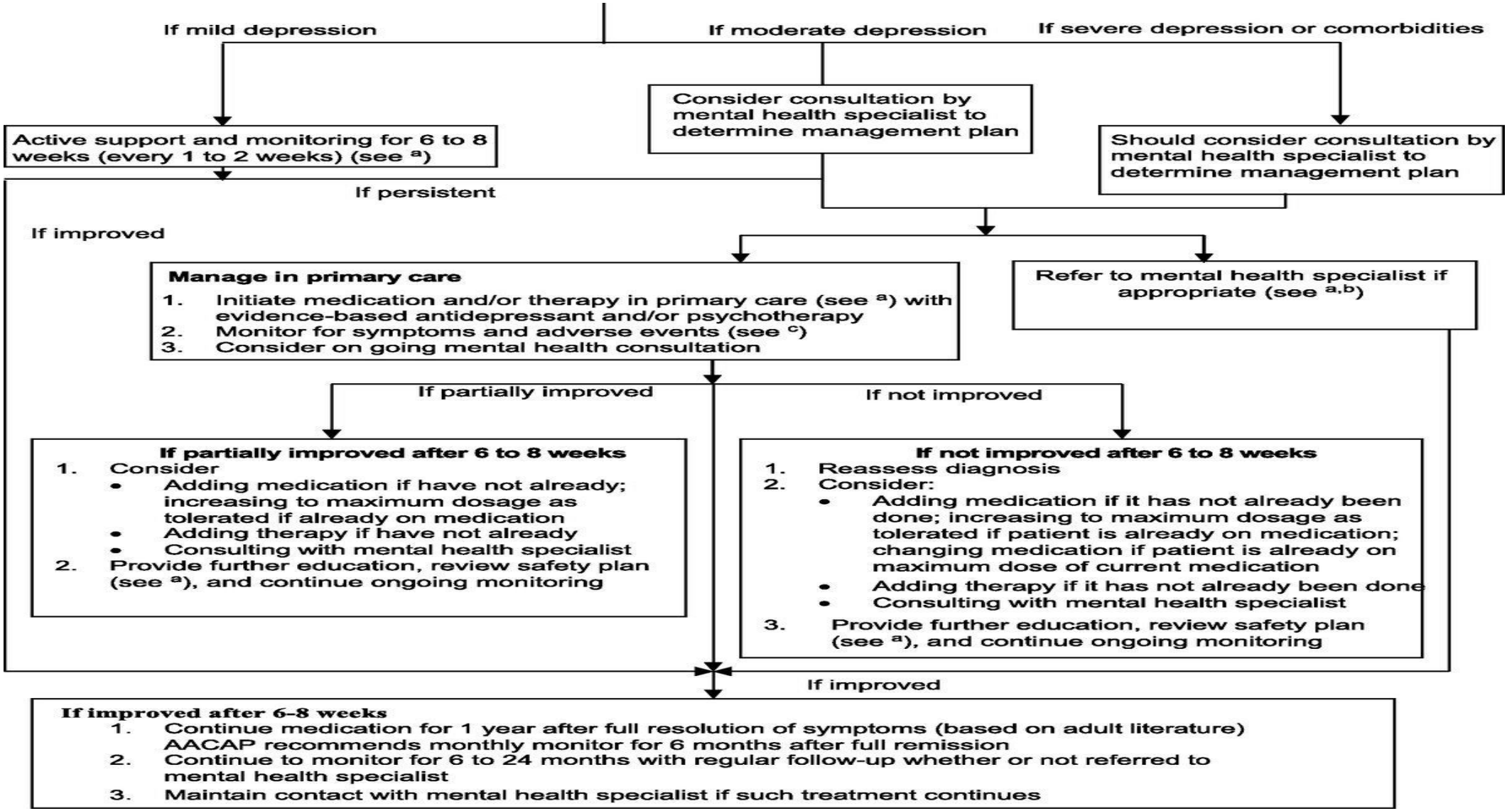
Improving insomnia and reducing suicidality

- Insomnia is significantly associated with increased suicide risk
- Studies show that sleep disturbances may be a marker of distress that leads to the suicide risk
- Multiple different types of sleep problems that are concurrent may confer greater risk for suicide than single sleep problems.
- Recommend focus on 1. Sleep disturbance screening 2. Suicide assessment and safety planning 3. Sleep treatment options in the suicidal patient
- CBT-Insomnia (CBT-I) has good evidence base but requires high levels of motivation and engagement from the consumer
- Melatonin effective in YPs with ASD and sleep problems.
- Use of Clonidine 50-200 mcgs, Zopiclone 7.5-15 mgs max.
- Use of Prazosin 1-3 mgs max in those with PTSD or trauma related nightmares

Cardiovascular exercise and depression treatment

- Physical activity is associated with decreased concurrent depressive symptoms; the association with future depressive symptoms is weak.
- This association found was stronger in cross-sectional studies than for longitudinal studies, in which the mean effect size was significant, but weak.
- PA of increased frequency and intensity was more strongly associated with decreased depressive symptoms compared with PA that was intense but not frequent

Clinical management flowchart



Psychological therapies

The full list of tried and tested Psychological therapies for Depression

- Child, Parent Psycho education
- Cognitive/Coping
- Problem Solving
- Activity Scheduling
- Skill-building/Behavioral Rehearsal
- Social Skills Training
- Communication Skills
- Interpersonal therapy
- Acceptance and Commitment Therapy
- Attachment Based Family Therapy

What works in depression treatment

- Promoting engagement in therapy through: Motivational Interviewing
- Therapeutic Assessment
- Psychoeducation is an essential part of promoting engagement in therapy
- Psychoeducation has been shown to be effective also as a stand alone intervention

What works in depression treatment

- Routine specialist care that includes non specific individual, family and group work too has been found to be helpful.

CBT

- Numerous meta-analyses and reviews have been conducted on CBT in the treatment of adolescent depression and showed improved outcomes for subjects treated with CBT.
- Computerised (CCBT) may be a valid treatment option for young people with mild depression.

Individual Treatments

- CBT-Suicide Prevention (CBT-SP):
- risk reduction, relapse prevention
- CBT, DBT and targeted therapies for suicidal, depressed youth.
- Consists of acute and continuation phases, each about 12 sessions,
- includes a chain analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

Individual treatments

- Dialectical Behaviour Therapy (DBT): teaches YPs to learn to accept life as a balance between the pleasant and unpleasant and teaches them to learn distress tolerance, mindfulness and interpersonal effectiveness skills
- Mentalization Based Therapy (MBT): Teaches young people to be aware of their own and others' mental states and learn to modulate their thoughts and actions through an improved understanding of the dissonance between their own assumptions of others and the reality. This therapy teaches patients to think about things before reacting to them. This therapy method teaches patients how to process their feelings more effectively.

Individual treatments

Acceptance and Commitment Therapy teaches Yps to:

- accept automatic thoughts, sensations and urges
- defuse from thinking (ie. observe thoughts without believing them or following their directions)
- experience self as an observer of psychological experiences
- attend to the present moment with self awareness
- clearly articulate values (ie. self chosen, desirable ways of behaving)
- engage in committed action (ie. participating in values-consistent activities, even when psychologically challenging).

Individual treatments

Interpersonal Therapy-Adolescents (IPT-A)

- IPT is a time-limited (acutely, 12-16 weeks) treatment with three phases: a beginning (1-3 sessions), middle, and end (3 sessions). The initial phase requires the therapist to identify and link the depression to the interpersonal context in which it presents. The therapist uses specific strategies to deal with the interpersonal areas of focus and then prepares for ending the therapy by assisting the YP to gain confidence in themselves to manage their interpersonal relation ships more adaptively.
- IPT-A was found to have significantly higher effects on reducing severity of depression, suicidal ideation, and hopelessness compared with treatment as usual.
- Adolescents who were depressed who reported higher baseline levels of interpersonal difficulties showed a greater and more rapid reduction in depressive symptoms if treated with IPT-A compared with treatment as usual.

Individual therapies

Cognitive Analytic Therapy

- CAT is a relational therapy, and focuses on the interaction between the client and therapist.
- It explores familiar roles and patterns, naming patterns in the way the person has been related to since childhood, postulating that these are replicated in current relationships and in the person's internal conversations.
- It is a helpful model for understanding social processes as well as for conducting a therapeutic relationship
- It is done over 16 or 24 weeks and uses letters and diagrams as the focus of a collaborative journey with the patient to work out how they experience themselves in relation to key people in their lives and to draw out the "states" they get into.

Family based treatment

Attachment based family therapy

- Can be used concurrently with medication and individual therapy
- Reframes depression as occurring due to attachment rupture
- Teaches the YP and the parents over 5 tasks how to repair the attachment and enable the YP to go to their parents for comnfirt or assistance when feeling distressed and suicidal

Medications

Published double-blind, placebo-controlled studies: SSRI efficacy for MDD

- <u>Studies in children & adolescents:</u>
- Emslie et al (1997): modest fluoxetine efficacy: fluoxetine 58%, placebo 32%
- Keller et al (2001): paroxetine efficacy: paroxetine 63%, imipramine 50%, placebo 46%, 1 of 2 primary outcome measures was significant; 2 other studies were negative
- Emslie et al (2002): fluoxetine efficacy: effects modest (fluoxetine 41%, placebo 20%) & not all outcome measures were significantly different than placebo
- Wagner et al (2003): sertraline efficacy: sertraline 69%, placebo 59%

Other relevant studies

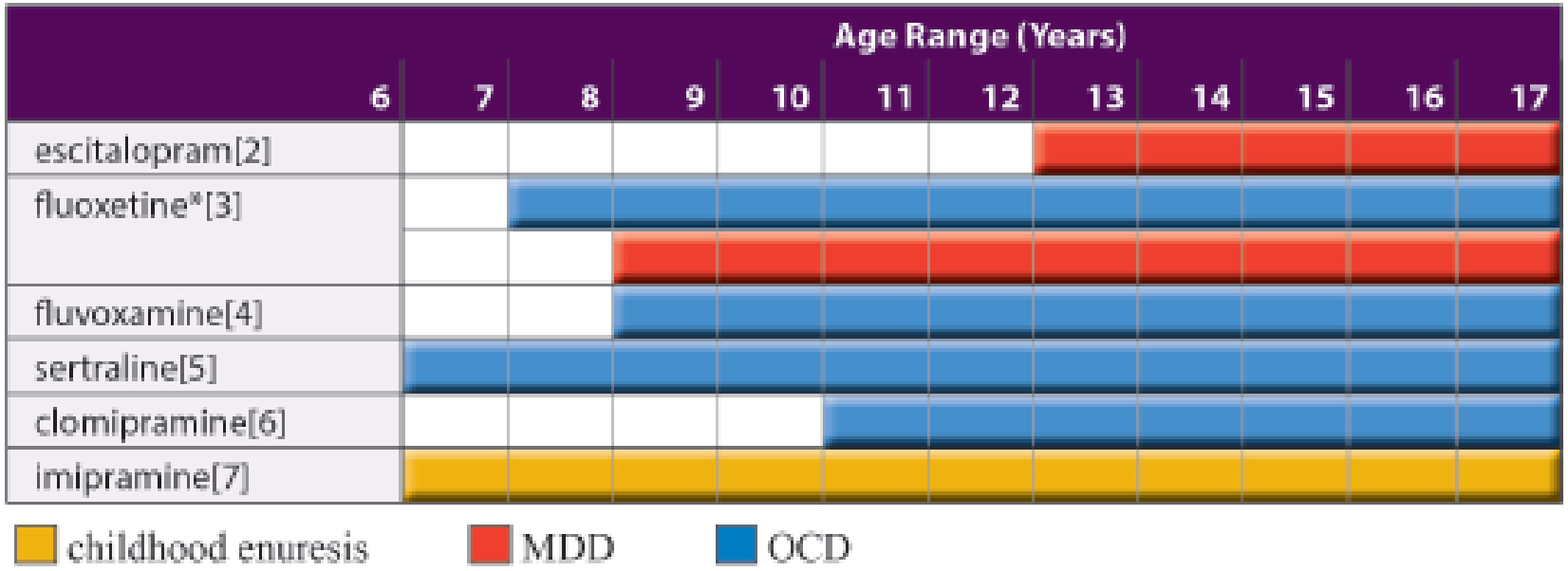
- Showed that adolescents can benefit from Fluoxetine even in mild to moderate depression (Gibbons 2012).
- Same review shows that all SSRIs are now equal in suicide risk. SSRIs reduce factors behind suicide risk such as NSSI, depressed mood and does not directly increase risk of completed suicide.

FDA Review of Studies for Antidepressant Drugs

- 20 placebo-controlled studies of 4100 pediatric patients for 8 antidepressant drugs (citalopram, fluoxetine, fluvoxamine, mirtazapine, nefazodone, paroxetine, sertraline, venlafaxine)
- Excess of suicidal ideation & suicide attempts when receiving certain antidepressant drugs; no suicides
- FDA could not rule out an increased risk of suicidality for any of these medications
- Data was adequate to establish effectiveness in MDD only for fluoxetine based on 2 studies (by Emslie et al)

FDA approval

Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Antidepressant Medications



*Fluoxetine is FDA approved for the treatment of MDD in pediatric patients up to 18 years old.

Depression-TADS-Kennard 2009

- 459 Depressed adolescents
- 12-17 years, 54.4 % girls 73.8 white, 12.5% African-American, 8.9% Hispanic
- Co morbid: GAD, ADHD, ODD, Social Phobia, Dysthymia
- Fluoxetine, CBT, Combo & Placebo
- Acute phase: 0-12 weeks, Continuation: 12-18, Maintainence 18-36.
- At 36 weeks combo was better than either alone, CBT slightly better than FLX
- Majority of patients remitted by 9 months

Depression-TORDIA study updates June 2011-Vitiello et al

- 334 initial SSRI treatment resistant depressed teenagers (12-18 years) randomized to another SSRI (fluoxetine, citalopram, paroxetine), Venlafaxine with or without CBT.
- Most patients (2/3) remitted at 24 weeks but ¼ remitters relapsed
- Best response to SSRI+CBT
- NSSI & CSA worsened chance of suicide attempts
- Those with a h/o physical response responded poorly to SSRI + CBT treatment

Newer antidepressants

Duloxetine (Cymbalta)-SNRI

- Half life is 12 hours so requires twice daily dosing
- Dose: 30 -120 mg a day
- Deemed safe for use in children and teenagers (7-17 years). Possibly efficacious (Burkhart 2012)
- Useful in treating ADHD in teenagers (Mahmoudi Gharei et al 2011). Improvements noted in 5 weeks

Other antidepressants

Desvenlafaxine- Prestig SNRI

- 50-200 mg once daily dose
- Gradual withdrawal may be required to prevent discontinuation syndrome
- Main side effect is nausea
- Double blind placebo controlled studies underway

Vortioxetine (Brintellix)

- 5–20 mg/day is generally safe and well tolerated and is associated with continued effectiveness in children (aged 7–11 years) and adolescents (aged 12–17 years) with a depressive and/or anxiety disorder.

Other Antidepressants

- Agomelatine (25-50 mgs) MT1/MT2 receptor agonist, 5 HT2C antagonist was studied in >200 patients vs Fluoxetine
- Agomelatine superior to Fluoxetine Hale et al 2010 Oct
- Agomelatine was found to improve depressive symptoms & improving sleep
- Rates of liver injury found to be higher. (agomelatine 4.6%, 1.4% for escitalopram, 0.6% for paroxetine, 0.4% for fluoxetine, and 0% for sertraline).

Cardiac toxicity of Citalopram & Escitalopram

- Mohammed et al Dec 2010: OD with Escitalopram (15-20 tabs)with Lithium (15-20 tabs of 300 mgs)
- Fayssoil Et al Jan 2011: Single case report of Lonq QTc with Citalopram taken with Amiodarone
- Liotter Oct 2011: OD with Citalopram caused long QTc
- Howland et al Nov 2011: Not enough clinically significant evidence to justify FDA caution
- Yager et al May 2013:1.1% of patients receiving citalopram *or* sertraline experienced ventricular arrhythmias. Cardiac deaths occurred in 3.3% of citalopram recipients and 4.0% of sertraline recipients

Transcranial Magnetic Stimulation TMS

- TMS is a non-invasive form of brain stimulation that involves using a magnetic coil to stimulate the brain.
- Sessions typically last around 30 minutes.
- A course of at least 20 sessions over consecutive weekdays is typically recommended for therapeutic results.
- TMS has antidepressant effects when applied over the frontal areas of the brain.
- There are now well over 30 studies in adults with depression, showing that TMS is an effective treatment for depression.
- Studies being planned with adolescents at OYH

References

- The Strong Relationship Between Sleep and Suicide

https://www.psychiatrictimes.com/view/strong-relationship-between-sleep-and-suicide

- Psychoeducational interventions in adolescent depression: A systematic review

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5933524/

- A Web-Based Psychoeducational Intervention for Adolescent Depression: Design and Development of MoodHwb

https://pubmed.ncbi.nlm.nih.gov/29449202/

- Randomized study of school-based intensive interpersonal psychotherapy for depressed adolescents with suicidal risk and parasuicide behaviors

https://pubmed.ncbi.nlm.nih.gov/19531111/

- Children's Physical Activity and Depression: A Meta-analysis

https://pediatrics.aappublications.org/content/139/4/e20162266

Resources

- ASQ: **A**sk **S**uicide screening **Q**uestions

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf

- Brief Suicide Safety Assessment

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#emergency

- The Columbia Suicide project (Lighthouse): screening and assessment tools, info cards for parents, teachers, coaches etc

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

- Management of Paediatric depression

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6213890

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6532464/

Resources

- Pittsburg Sleep Quality Index

https://www.opapc.com/uploads/documents/PSQI.pdf

Guidelines for the management of depression

- NICE guidelines
- https://www.nice.org.uk/guidance/ng134/resources/depression-in-children-and-young-people-identification-and-management-pdf-66141719350981
- AACAP guidelines
- https://www.jaacap.org/article/S0890-8567(09)62053-0/fulltext

SUICIDE SCREENING ASSESSMENT

IN A MEDICAL OFFICE

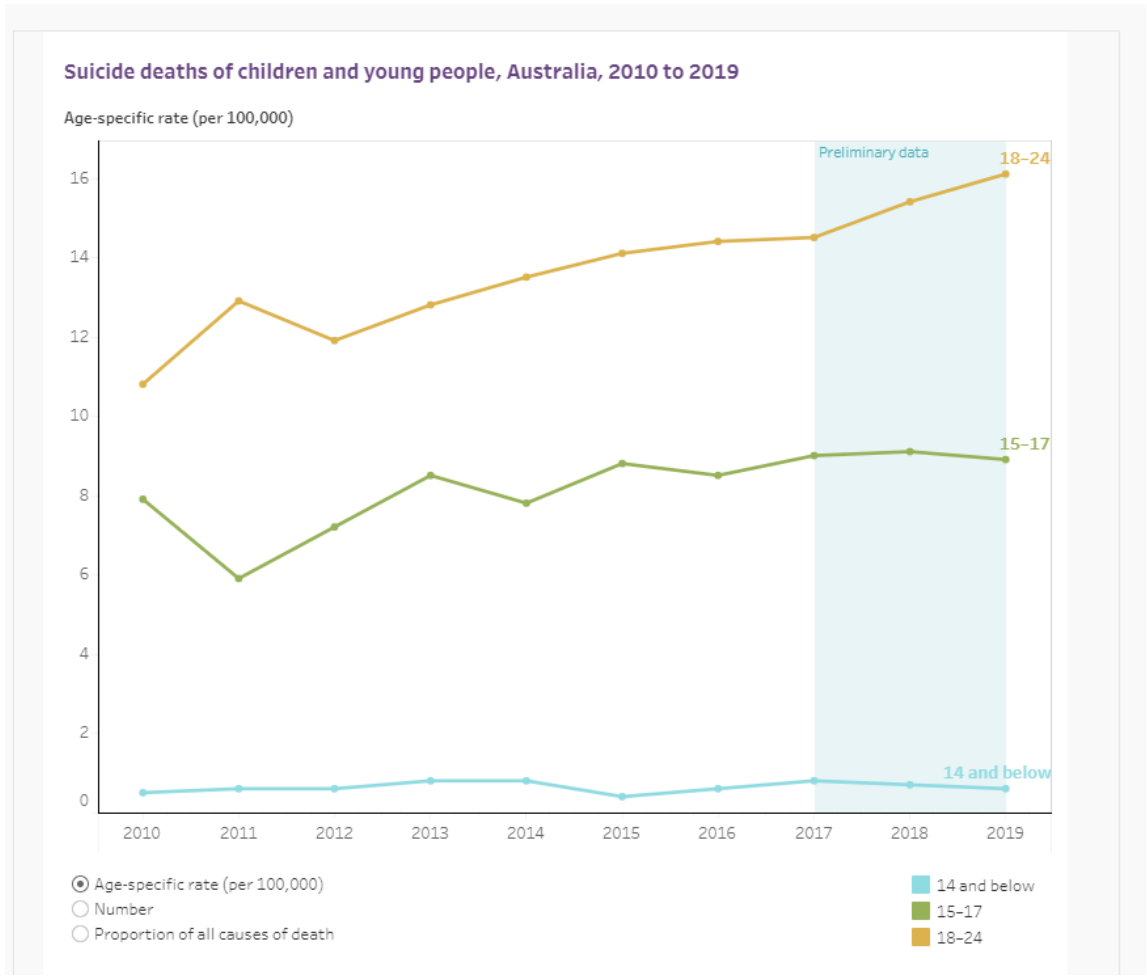
Suicide rates in adolescents in Australia

- In 2019:
- 384 Australian young people (aged 18–24) took their own lives
- 96 deaths by suicide occurred among children and adolescents (aged 5–17) with the majority occurring in those aged 15–17 (80% in 2019)
- deaths by suicide represented
- 40% of all deaths in young people aged 15–17 and
- 36% of all deaths in those aged 18–24
- up from approximately 25% of all deaths in these age groups in 2010.
- In children aged 14 in 2019 deaths by suicide represented 7.4% of all deaths in this age group

Suicide rates 2010-2019

g-young-people

- deaths by suicide represented 40% of all deaths in young people aged 15–17 and 36% of all deaths in those aged 18–24—up from approximately 25% of all deaths in these age groups in 2010. In children aged 14 and below the proportion of deaths by suicide is low by comparison with the 2 older age groups; in 2019 deaths by suicide represented 7.4% of all deaths in this age group.



Proximal Risk Factors

Agitation - Anxiety, agitation, EPS, insomnia

Ideation - Active ideation with a plan

Depression - Depression and decline, hopelessness

Instability - Substance use, Psychosis, affective lability, mixed state or rapid cycling, brain injury

Loss - Of relationship, work, health, or function

Lethal agent- Availability of

Distal Risk Factors

Suicidal history - Personal or in family

Aggression and impulsivity

Difficult course - Poor treatment response, comorbid, severe

Difficult patient - Non-adherent

Abuse and trauma history

Disconnection from support, work, relationships

Substance

Why Target Depression?

- 80% of attempters and 60% of completers are depressed
- Depression increases the risk for suicidal behavior 10- to 50-fold
- Quality improvement studies also suggest that improved treatment of depression reduces suicidality risk (Asarnow et al., 2005; Wells et al., 2001; Brown et al., 2001)
- Pharmacoepidemiological studies show reduction in suicide with SSRI use

Factors relating to current Suicidal Ideation & Past Behavior

- Intensity, now and worst ever
- Frequency
- Presence of active plan
- Wish to carry out plan
- Past history of attempt particularly within the past 6 months
- Hopelessness, Impulsivity and aggression, Social skills deficits, Homosexuality, bisexuality, Gender identity problems
- Inflexibility

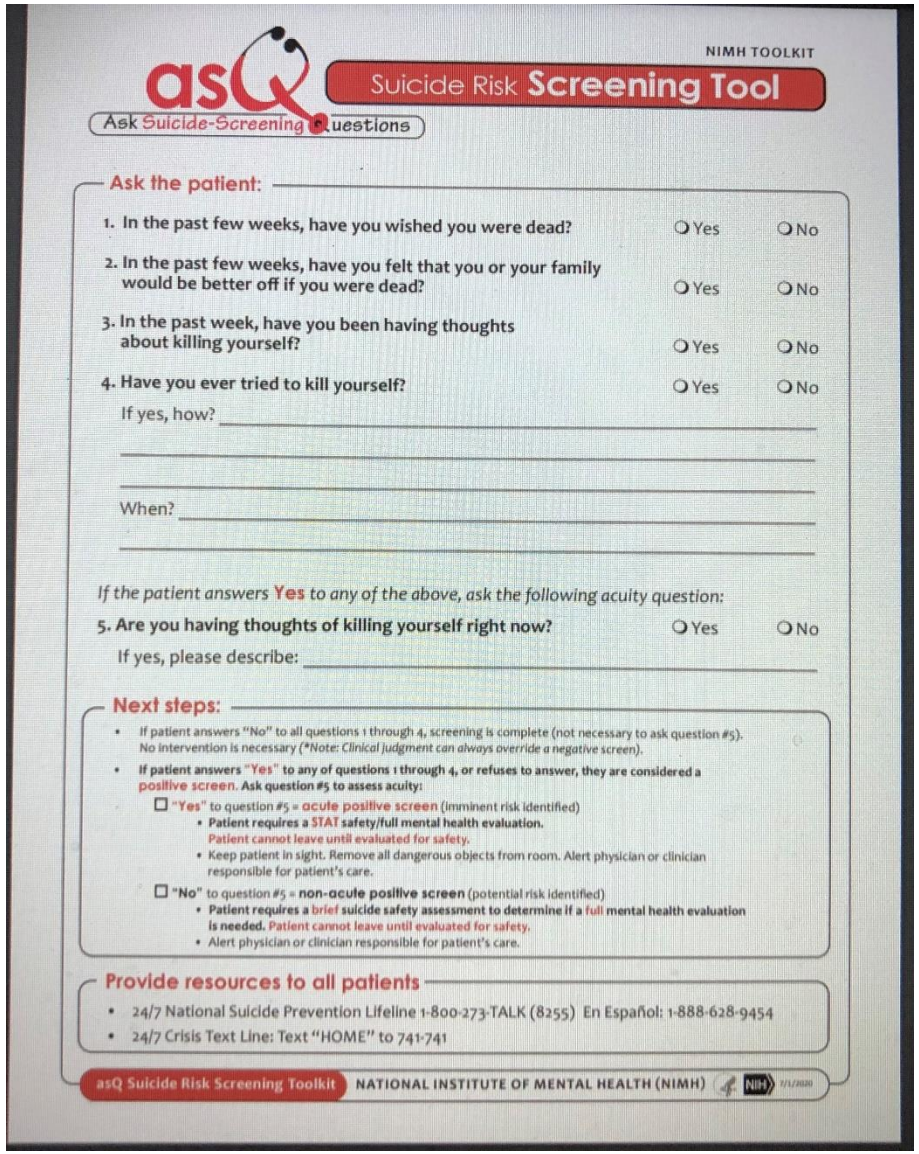
Motivation

- **Wish to die or permanently escape psychological painful situation (1/3 in younger individuals, but increases with age)**
- To influence others
- Get attention
- Express hostility
- Induce guilt

Family and Social Factors

- Parental history of psychiatric illness and suicidal behavior
- Abuse and neglect
- Discord and Disruption of interpersonal relationships
- Grief
- Disconnect

Screening for suicide in the medical office



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? ❍ Yes ❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ❍ Yes ❍ No
3. In the past week, have you been having thoughts about killing yourself? ❍ Yes ❍ No
4. 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:

5. Are you having thoughts of killing yourself right now? ❍ Yes ❍ No

If yes, please describe: _____

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 (**Note: 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 = **acute 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 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

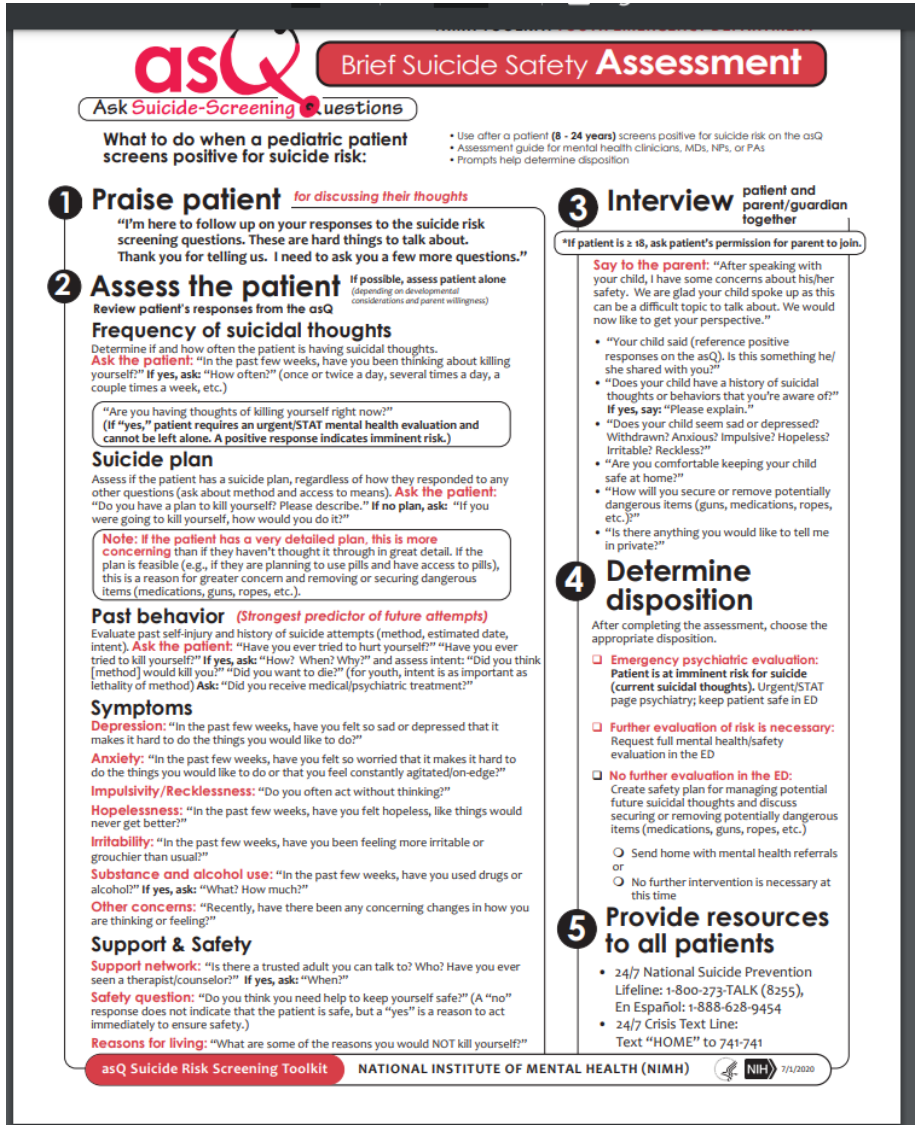
The 5 screening questions

1. In the past few weeks, have you wished you were dead? Yes or No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes or No
3. In the past week, have you been having thoughts about killing yourself? Yes or No
4. Have you ever tried to kill yourself? Yes or No If yes, how? _____ When? _____

- If the patient answers Yes to any of the above, ask the following acuity question: 5. Are you having thoughts of killing yourself right now? mYes mNo If yes, please describe:

  _____

Further assessment in the medical office



asQ Ask Suicide-Screening Questions

Brief Suicide Safety Assessment

What to do when a pediatric patient screens positive for suicide risk:

- Use after a patient **(8 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

"I'm here to follow up on your responses to the suicide risk screening questions. These are hard things to talk about. Thank you for telling us. I need to ask you a few more questions."

2 Assess the patient

If possible, assess patient alone *(depending on developmental considerations and parent willingness)*

Review patient's responses from the asQ

Frequency of suicidal thoughts

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.)

"Are you having thoughts of killing yourself right now?"
(If "yes," patient requires an urgent/STAT mental health evaluation and cannot be left alone. A positive response indicates imminent risk.)

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? Please describe." **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

Note: If the patient has a very detailed plan, this is more concerning than if they haven't thought it through in great detail. If the plan is feasible (e.g., if they are planning to use pills and have access to pills), this is a reason for greater concern and removing or securing dangerous items (medications, guns, ropes, etc.).

Past behavior *(Strongest predictor of future attempts)*

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent). **Ask the patient:** "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?" **If yes, ask:** "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Symptoms

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/on-edge?"

Impulsivity/Recklessness: "Do you often act without thinking?"

Hopelessness: "In the past few weeks, have you felt hopeless, like things would never get better?"

Irritability: "In the past few weeks, have you been feeling more irritable or grouchier than usual?"

Substance and alcohol use: "In the past few weeks, have you used drugs or alcohol?" **If yes, ask:** "What? How much?"

Other concerns: "Recently, have there been any concerning changes in how you are thinking or feeling?"

Support & Safety

Support network: "Is there a trusted adult you can talk to? Who? Have you ever seen a therapist/counselor?" **If yes, ask:** "When?"

Safety question: "Do you think you need help to keep yourself safe?" (A "no" response does not indicate that the patient is safe, but a "yes" is a reason to act immediately to ensure safety.)

Reasons for living: "What are some of the reasons you would NOT kill yourself?"

3 Interview *patient and parent/guardian together*

***If patient is ≥ 18, ask patient's permission for parent to join.**

Say to the parent: "After speaking with your child, I have some concerns about his/her safety. We are glad your child spoke up as this can be a difficult topic to talk about. We would now like to get your perspective."

- "Your child said (reference positive responses on the asQ). Is this something he/she shared with you?"
- "Does your child have a history of suicidal thoughts or behaviors that you're aware of?" **If yes, say:** "Please explain."
- "Does your child seem sad or depressed? Withdrawn? Anxious? Impulsive? Hopeless? Irritable? Reckless?"
- "Are you comfortable keeping your child safe at home?"
- "How will you secure or remove potentially dangerous items (guns, medications, ropes, etc.)?"
- "Is there anything you would like to tell me in private?"

4 Determine disposition

After completing the assessment, choose the appropriate disposition.

- ❑ **Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts).** Urgent/STAT page psychiatry; keep patient safe in ED
- ❑ **Further evaluation of risk is necessary:** Request full mental health/safety evaluation in the ED
- ❑ **No further evaluation in the ED:** Create safety plan for managing potential future suicidal thoughts and discuss securing or removing potentially dangerous items (medications, guns, ropes, etc.)
  - ❍ Send home with mental health referrals
  - or
  - ❍ No further intervention is necessary at this time

5 Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline: 1-800-273-TALK (8255), En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH 7/1/2020

After completing the assessment, choose the appropriate disposition and referral pathway.

- ❑**Emergency psychiatric evaluation**: Patient is at imminent risk for suicide (current well formed suicide plan): **keep patient under watch as you talk to the parents and refer to RCH ED**
- ❑**Urgent psychiatric evaluation**: patient able to keep themselves safe but only whilst you talk to the parents and refer to RCH ED
- ❑**Semi urgent evaluation of risk is necessary**: patient able to keep themselves safe for 24-48 hours Request full mental health/safety evaluation in the next 24 hours: (< 15 YEARS 1800 44 55 11 RCH MH intake M-F 9-5 or email mhs.intake@rch.org.au after 5 PM **OR** >15 years 1800 888 320 OYH YAT triage M-F 9AM-9 PM). Discuss securing or removing potentially dangerous items (medications, sharps, ropes, etc.)

After completing the assessment, choose the appropriate disposition and referral pathway.

❑**Routine psychiatric evaluation needed** but can be safe for 1 week:

- Create safety plan (see below) & discuss securing or removing potentially dangerous items (medications, sharps, ropes, etc.)
- Send home with mental health referrals (< 15 YEARS 1800 44 55 11 RCH MH intake M-F 9-5 or >15 years 1800 888 320 OYH YAT triage M-F 9AM-9 PM)
- Create a safety plan(encourage the parent to do it with the child/teenager)

https://parents.au.reachout.com/common-concerns/mental-health/things-to-try-suicide-prevention/create-a-safety-plan-with-your-teenager

❑**No Psychiatric evaluation needed** but needs routine engagement in therapy and other interventions: Headspace, MH Care Plan and refer to psychologist https://www.psychology.org.au/Find-a-Psychologist

Resources

- ASQ: **A**sk **S**uicide screening **Q**uestions

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/asq-tool/screening_tool_asq_nimh_toolkit_155867.pdf

- Brief Suicide Safety Assessment

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/youth-asq-toolkit#emergency

- The Columbia Suicide project (Lighthouse): screening and assessment tools, info cards for parents, teachers, coaches etc

https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english

- Management of Paediatric depression

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6213890

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6532464/

Free Treatment Resources

- Brief CBT manual: useful for clinicians working with older adolescents

https://depts.washington.edu/dbpeds/therapists_guide_to_brief_cbtmanual.pdf

- Online worksheets and other useful resources for clinicians working with consumers of all ages

https://www.therapistaid.com/therapy-worksheets/cbt/none

- CBT toolbox for working with children and adolescents

https://www.readpbn.com/pdf/CBT-Toolbox-for-Children-and-Adolescents-Over-200-Worksheets-and%20Exercises-Sample-Pages.pdf

https://thinkcbt.com/think-cbt-worksheets