Clinical Guideline for Primary Care Medical Homes on the Screening and Care for Children and Adolescents at Risk for Suicide

Submitted to Clinical Excellence Guideline Committee

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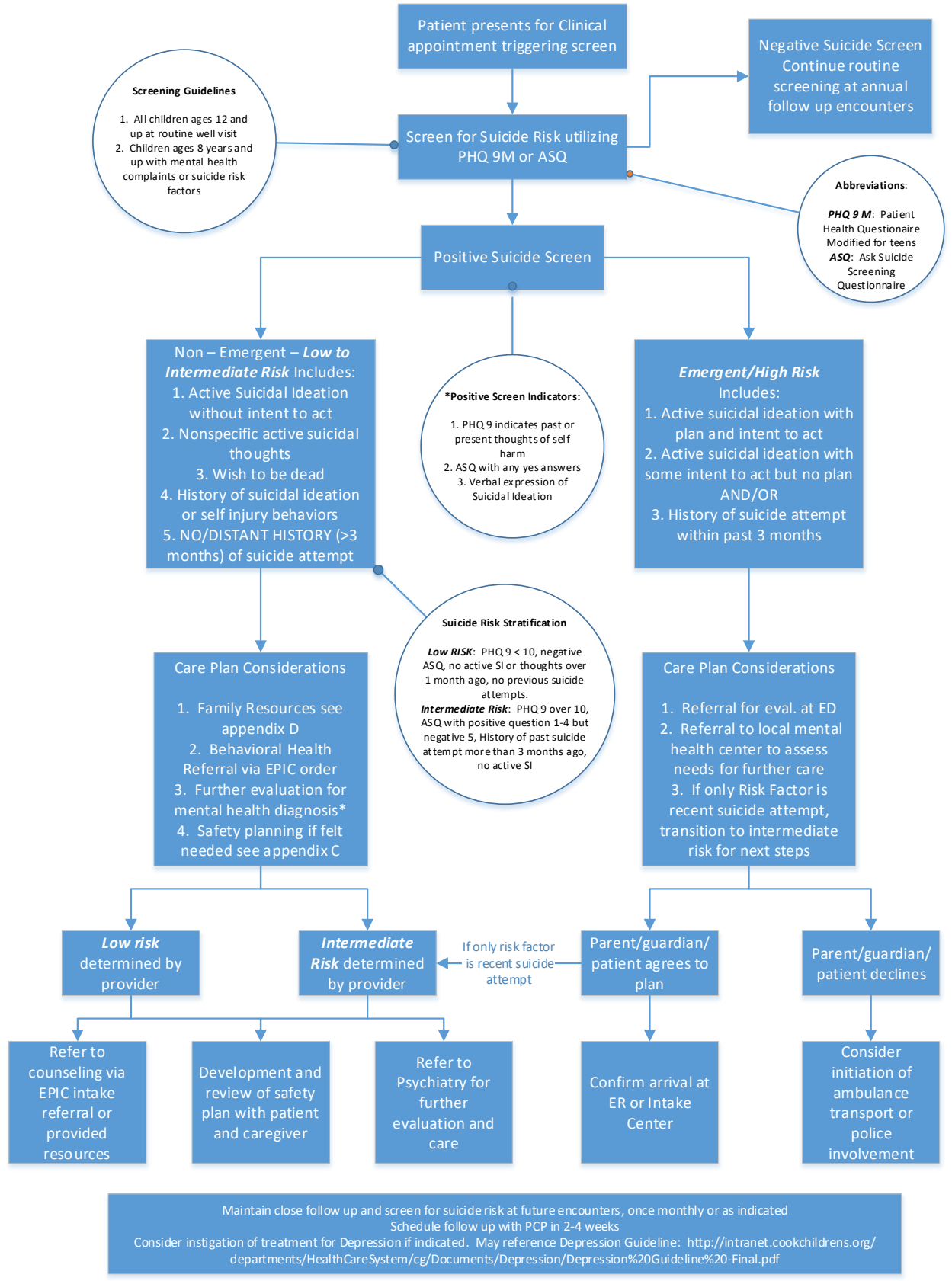

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I. Inclusion Criteria

1. All Children ages 12 and up to be screened at annual well visit
2. All Children ages 8 years and older with presenting complaints concerning for mental health and/or suicide risk

II. Goals

1. Create standardized work flows for screening all children for depression and suicide within primary care medical homes
2. Early recognition of teens at risk for suicide
3. Establishment of referral patterns to improve care and long term outcomes for patients identified to be at risk for suicide

III. Metrics

1. Number of patients screened at annual well visit for ages 12 and up utilizing PHQ 9 modified for teens.
2. Number of patients who screen positive for depression utilizing data collected from current best practice advisory in production which notifies providers if PHQ 9 over 5.
3. Number of patients who screen positive for suicide risk based on data collected from best practice advisory currently in production which notifies providers if PHQ 9 screens positive for suicide assessment questions.

IV. Background

Data shows the prevalence of adolescent depression to be 12.8% with 28.5 % of high school students dealing with significant depressive symptoms. Alarming data also shows that 24 % of adolescents with moderate to severe depression and 60 % in the mild range receive no follow up.

Suicide currently represents the second leading cause of death for ages 10 – 24.

In 2021, 22% of high school students seriously considered attempting suicide during the past year.

In 2021, 18% of high school students made a suicide plan during the past year.

In 2021, 10% of high school students attempted suicide one or more times during the past year.

Screening for suicide within a pediatric clinic creates one of the most potentially stressful clinical situations for providers. This can result in reluctance of providers to engage in these conversations due to lack of training and fear of triggering suicidal thoughts. Data clearly shows that asking about suicide does not increase thoughts of suicide. Key to meaningful discussions in this area include:

1. Normalizing asking questions about the experience of suicidal ideation

2. Nonjudgmental and matter-of-fact tone to lower defenses.
3. Asking permission to engage in the questions
4. Empathetic dialogue
5. Open ended questions

V. Definitions as taken from the Columbia Suicide Severity Rating Scale

Suicidal Ideation from highest to lowest risk:

1. Active Suicidal Ideation with Specific Plan and Intent – patient has thoughts of killing themselves with details of plan fully or partially worked out and intent to carry out.
2. Active Suicidal Ideation with Some Intent to Act but no Specific Plan – active suicide thoughts with some intent to act
3. Active Suicidal Ideation without Intent to Act – patient endorses thoughts of suicide but includes a statement such as. “I have thought about taking an overdose but I have no plan and I would never do it.”
4. Non-Specific Active Suicidal Thoughts – General, nonspecific thoughts of wanting to end one’s life but no thoughts on methods, intent or plan.
5. Wish to be Dead – Patient has a wish to be dead or fall asleep and not wake up.

Non-suicidal self-injury represents behavior that has the potential for injury but without conscious suicidal intent.

VI. Suicide Risk Stratification

1. Low Risk
   a. Patient Health Questionnaire Modified for Teens (PHQ 9M) score less than 10
   b. Ask Suicide Screening Questionnaire (ASQ) with no “yes” answers
   c. No active Suicidal Ideation (SI)
   d. No previous suicide attempts
   e. Thoughts of suicidal ideation over 1 month ago
   f. Self-harm behaviors over 3 months ago
2. Intermediate Risk
   a. PHQ 9 M of 10 or more
   b. ASQ with positive question 1-4 but negative 5
   c. History of past suicide attempt more than 3 months ago
   d. No active SI
3. High Risk
   a. Active suicidal ideation with specific plan and intent to act
   b. Active suicidal ideation with some intent to act but no plan
   c. History of suicide attempt less than 3 months ago

NOTE: Stratification meant as a guide and any concerns surrounding aggressive behavior, substance abuse, disclosed abuse or other factors should be taken into consideration.

VII. Risk Factors

1. Prior suicide attempt is the single largest predictor of suicide, especially in boys

   a. 30 fold increase risk for boys
   b. 3 fold increase for girls
   c. Highest risk window is first year after suicide attempt
2. Sad Persons
      a. S – Sex – females attempt more but males complete more
      b. A – Age – over 16
      c. D – Depression or other psychiatric diagnosis
      d. P - Previous Attempts
      e. E - Ethanol or other substance abuse
      f. R - Rational thinking lost or psychosis
      g. S - Social supports lacking
      h. O - Organized plan
      i. N – No significant other
      j. S – Sickness or life stressors
3. ***FIRST- DEGREE RELATIVE OF A SUICIDE COMPLETER***
4. Access to firearms or unsecured medications
5. Rates are highest among non-Hispanic American Indian and Alaska Native people with rising rates for non-Hispanic Black
6. Youth who identify as LGBTQ youth at increased risk for SI and face rejection/isolation

VIII. Screening Tools

1. **PHQ 9 Modified for teens** – recommended depression/suicide screening tool for ALL COOK PCPs/NHC (see Appendix A)
   a. Completed by patients, themselves, validated for ages 11+
   b. Along with clinical judgment and patient/family discussion this tool divides major depressive disorder into the following categories based on scoring:
      i. Score 0-4 – no or minimal depression
      ii. Score 5-9 – mild depression
      iii. Score 10-14 – moderate depression
      iv. Score 15-19 – moderately severe depression
      v. Score 20-27 – severe depression
   c. With a cut off score of 11 PHQ-9 has a sensitivity of 89.5% and a specificity of 77.5%
   d. In contrast the shorter PHQ-2 with a cut score of 3 had a sensitivity of 73.7% and a specificity of 75.2%
   e. ***19% of teenagers who did endorse suicidality did not screen positive on the PHQ-2***
   f. IHC MHI Depression Fact Sheet: Children and Adolescents (aacap.org)
   g. PHQ-A Spanish_II .pdf (aidsetc.org)

2. **ASQ - Ask Suicide Screening Questionnaire** (See Appendix B)
   a. Validated Screening tool for ages 8 and older
   b. Secondary screening tool if depression screen or discussion creates need to further investigate suicidal ideation
   c. Five questions about suicidal thinking, planning, and prior attempts
   d. Includes a worksheet to guide the clinician
   e. Available at: screening_tool_asq_nimh_toolkit.pdf (nih.gov)

IX. Screening recommendations

The following recommendations for screening are made in accordance with the American Academy of Pediatrics and Guideline for Adolescent Depression in Primary Care (GLAD PC) Toolkit.

a. Universal Screening of all Youth ages 12 and older preferably at annual routine well visit
b. Screening of children ages 8 – 11 when clinically indicated to include a behavioral health chief complaint, history of suicidal ideation or warning signs of suicide.
c. Recommended frequency of screening is no more than once a month and no less than once a year
d. All patients evaluated for a new behavioral health concern should be fully screened for suicide.
e. Mental health follow up patients should be screened for suicide risk at every subsequent encounter.
f. Routine screening of children less than 8 years of age is not recommended. Death by suicide in this age range is rare. If warning signs for suicide as listed below are present then further evaluation would be indicated:
    i. Talking about wanting to die
    ii. Actions which mimic an aggressive motion such as choking or pointing a gun to the head
    iii. Self-harming behaviors
    iv. Impulsive aggression
    v. Giving away toys or possessions
g. Patient can complete the screening tool independently or with assistance if needed due to physical disabilities, language barriers, or literacy delays

X. Safety Plan – See Appendix C

A Safety Plan represents a list of triggers, coping skills and supports available to help teens experiencing suicide crisis. It includes a set of steps the teen can utilize to reduce the likelihood of engaging in suicide. Consider a safety plan on any youth felt to be in the intermediate or high-risk zones.

Studies show the efficacy of such planning. In the ED setting, it was found that patients who received safety-planning instructions with follow up phone counseling were half as likely to make a suicide attempt in the 6 months following hospitalization. The components of a Safety Plan include:

a. Recognizing warning signs and triggers. What are the things that trigger overwhelming feelings of sadness or thoughts of suicide? Be able to recognize these.

b. Using known coping strategies. Write down a list of things to do to help deal with the problem. Examples:
    i. Listen to music
    ii. Read
    iii. Watch TV
    iv. Journal
    v. Go for a walk
    vi. Start an art project
c. Having list of support adults and social contacts to reach out to in crisis. Stress to the youth that an adult is critical, as it must be someone who will be responsible to making sure the individual gets emergent help if needed.
d. Contact list of mental health agencies and professionals if needed
e. Restricting access to lethal means
    i. Locking up all firearms
    ii. Separate firearms from ammunition
    iii. Securing medications

XI. Physician/APP Resources

There are a number of ways to contact behavioral health intake. They are ranked here from fastest to slowest:

1. Call directly at 682-885-7439 (backline) or 682-885-3917 option 1 (our physician line). Both lines ring the same phone, so there is no need to call both. Attempts are made to answer this phone 24/7 – though on occasion - all intake staff are out of the office seeing patients in the ER.
2. Send a text message via Vocera to the "On-Call Psych Intake Group." If you don't have access to Vocera, you can have the PBX operator send the message for you by calling 682-885-4000. These messages go out to all intake staff who are currently on the clock. It is helpful if you set the priority of the message from "Normal" to "High," but that is not strictly necessary.
3. Send an email to PsychiatryIntake@CookChildrens.org. This email inbox is monitored by all intake staff, but it might be up to four hours before the email is read, depending on how busy intake staff are.
4. Route a message/chart to the "Behavioral Health Intake" pool in Epic. This inbox is monitored by all staff, but it might be a day or so before the email is read.
5. Submit a referral for outpatient behavioral health services in Epic. This work queue is also monitored by all staff with a turnaround time of about one day on average

Emergent Referral Options:

Location	***Address***	***Phone***	***Ages treated***	***Website***	***Notes***
Cook Children's	801 Seventh Avenue Fort Worth 76104	Main: 682-885-4000 Intake: 682-885-3917	Inpatient: ages 2 – 12 PHP: Ages 6 – 17	Community Support Resources | Cook Children's (cookchildrens.org)	Emergency access through ED 24/7 Intake available 24/7
JPS Health Network	1500 South Main Fort Worth 76104	Main: 817-927-3636	Inpatient ages 13 – 16	Behavioral Health | JPS Health Network	ED 24 hours Outpatient behavioral clinics

Millwood Hospital	1011 North Cooper Street Arlington 76011	Main: 817-261-3121	Inpatient ages ???	www.millwoodhospital.com	Call 24/7
Mesa Springs	5560 Mesa Springs Drive Fort Worth 76123	817-398-08382	Inpatient ages 12 and up PHP ages 5 and up	Inpatient Mental Health & Addiction Treatment Facility in Fort Worth, TX (mesasprings.com)	Walk Ins accepted 24/7
Springwood	2717 Tibbets Drive Bedford 76022	682-549-7916	Inpatient ages 18 and older	Texas Health Springwood Behavioral Health HEB	Walk Ins accepted 8 AM to 8 PM
Perimeter	7000 US Highway 287 Arlington 76001	817-662-6342	Inpatient ages 5 – 17	Perimeter Behavioral Hospital of Arlington, Texas (perimeterhealthcare.com)	Phone 24/7 for intake assessment
Mind Above Matter	Keller: 4232 Heritage Trace PKY 76244 Burleson: 2915 South Burleson Blvd. 76028 Arlington: 1215 West Randol Mill Road 76112	817-662-6169	Emergent mental health assessments PHP Program Partnerships with regional ISDs including FWISD, Grapevine-Colleyville, Keller, Aledo, HEB, Birdville, and Decatur	Home - Mind Above Matter	Monday – Friday 8:30 AM to 5:30 PM
Texas Health Resources Emergency Departments	Multiple Regional Locations	Varies	Emergency referral source for ages 18 and older		Access 24/7
Child Psychiatry Access Network	Not Applicable	888-901-CPAN (2726)	Texas legislative funded access point. Providers can call to connect with a child psychiatrist or mental health provider		Access 24/7
Connections Wellness Group	Multiple Regional Locations	940-394-8507	Partial Hospitalization Program for ages 7 – 18	Partial Hospitalization Program Dallas/Fort Worth | PHP Treatment (connectionswellnessgroup.com)	
Changes	Frisco: 6870 Lebanon Road 75034 McKinney: 1820 North Lake Forest Drive 75071	940-360-8803	Partial Hospitalization Program	Behavioral Health for Children & Teens in Dallas, TX | Carrollton Springs	Phone availability 24/7

SEE APPENDIX D FOR DETAILED LISTING OF PSYCHIATRIC DAY PROGRAMS

Appendix A: PHQ 9 Modified for Teens

PHQ-9: Modified for Teens

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?	☐	☐	☐	☐
2. Little interest or pleasure in doing things?	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Poor appetite, weight loss, or overeating?	☐	☐	☐	☐
5. Feeling tired, or having little energy?	☐	☐	☐	☐
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things like school work, reading, or watching TV?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	☐	☐	☐	☐

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐ Yes ☐ No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐ Yes ☐ No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Appendix A continued: PHQ 9 Modified for Teens

Scoring the PHQ-9 modified for Teens

Scoring the PHQ-9 modified for teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a "2" or "3"
- Need five or more positive symptoms (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9).
- The functional impairment question (How difficult....) needs to be rated at least as "somewhat difficult."

To use the PHQ-9 to screen for all types of depression or other mental illness:

- All positive answers (positive is defined by a "2" or "3" in questions 1-8 and by a "1", "2", or "3" in question 9) should be followed up by interview.
- A total PHQ-9 score $\geq$ 10 (see below for instructions on how to obtain a total score) has a good sensitivity and specificity for MDD.

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year...) should be endorsed as "yes."

To use the PHQ-9 to screen for suicide risk:

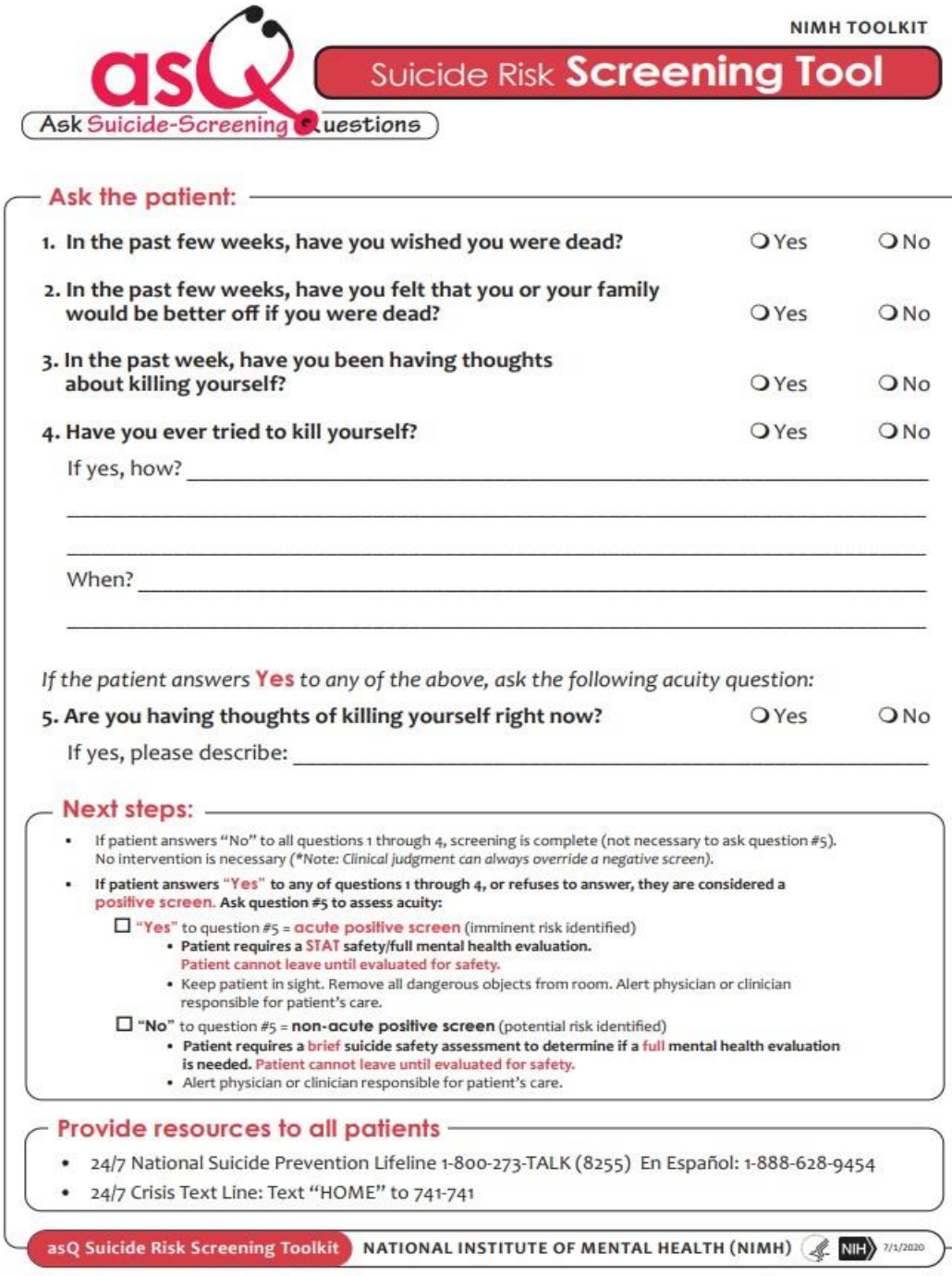
- All positive answers to question 9 as well as the two additional suicide items MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	Depression Severity
0-4	No or Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Appendix B: Ask Suicide Screening Questions



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

APPENDIX C – SAFETY PLAN

SAFETY/SUPPORT PLAN FOR THE FOLLOWING PROBLEM:

☐ SELF-HARM ☐ SUICIDE ☐ AGGRESSION ☐ ALTERED THOUGHT PROCESSES ☐ OTHER _____

PROBLEM TRIGGERS:

1. _____
2. _____
3. _____

COPING SKILLS – THINGS I CAN DO TO DEAL WITH MY PROBLEM OR TAKE MY MIND OFF OF MY PROBLEM (EXAMPLES: LISTEN TO MUSIC, EXERCISE, READ, WATCH TV, JOURNAL, DO ARTWORK):

1. _____
2. _____
3. _____

PEOPLE I CAN TALK TO OR ASK FOR HELP WHEN I FEEL UPSET:

1. _____ **TELEPHONE NUMBER** _____
2. _____ **TELEPHONE NUMBER** _____
3. _____ **TELEPHONE NUMBER** _____

IMPORTANT TELEPHONE NUMBER FOR GETTING HELP

NAME OF AGENCY/PROFESSIONAL	TELEPHONE NUMBER
COOK CHILDREN'S MEDICAL CENTER PSYCHIATRY INTAKE	**682.885.3917** (press the emergency prompt)
TARRANT COUNTY MHMR CRISIS LINE	1.800.866.2465 (available 24 hours a day)
SUICIDE PREVENTION LIFELINE	1.800.273.TALK (8255)
OTHER:	
OTHER:	

_____ **I WILL CLOSELY MONITOR MY CHILD.**

_____ **I WILL REMOVE OR LOCK UP ALL SHARPS, WEAPONS, MEDICATIONS, CHEMICALS OR OTHER ITEMS THAT COULD BE USED TO HARM SELF OR OTHERS.**

_____ **I WILL** _____

_____

PERSON	SIGNATURE	DATE	TIME
PATIENT			
PARENT/LEGAL GUARDIAN			
STAFF WITNESS			

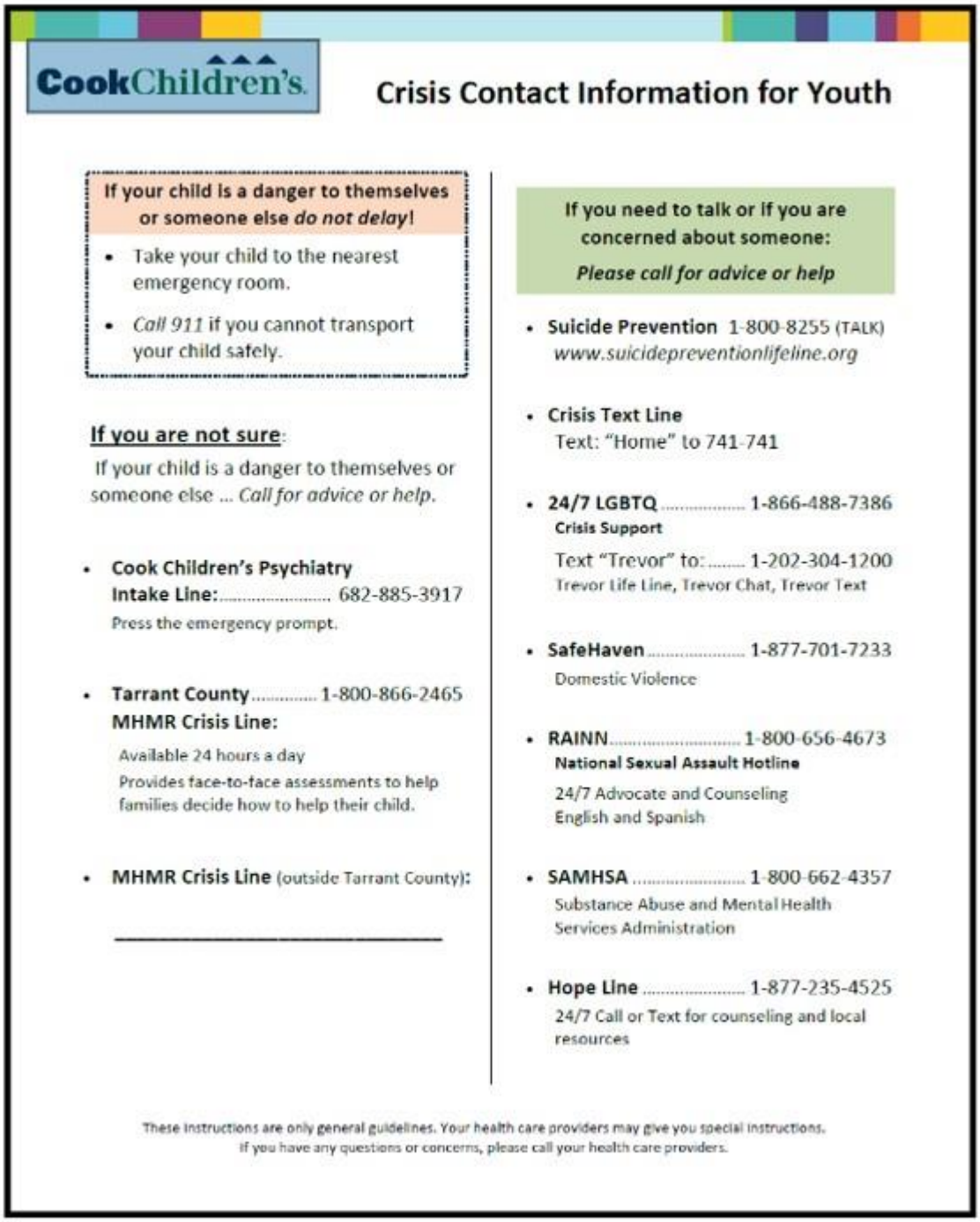
NOTE: Texting options for assistance include 988 or 741741

APPENDIX D PSYCHIATRIC DAY PROGRAMS

Psychiatric Day Programs:

FACILITY	CITY	PHONE	AGES	COMMENTS
Cook Children's	Fort Worth	682-885-3917	5-17	5yo must be in Kindergarten
Charlie Health	Online only	866-491-5196	11+	All commercial insurance and all Medicaids
Grace IOP	Fort Worth	800-972-0643	12+	Commercial insurance only, no Humana/Champ VA
Pathlight	Fort Worth	877-825-8584	13-18	Commercial insurance only. 12yo may be accepted if mature
Innovations - FW	Fort Worth	817-841-8002	6-18	Sometimes takes Amerigroup
Innovations - Arlington	Arlington	682-320-2800	9-18	Sometimes takes Amerigroup
Innovations - Northwest	Keller	682-593-6001	5-18	Can be in PreK if 5yo. Must be in high school if 18yo
Excel Center	Fort Worth	817-335-6429	6-18	
Excel Center II	Lewisville	972-906-5522	5-18	
Excel Center III	Willow Park	817-678-8808	12+	1/2 day program, no school enrollment
Reflections	The Colony	469-777-4688	11-17	Tricare, Medicaid, transportation
Mind Above Matter	Burleson	817-447-3001	13-18	
Mind Above Matter	Keller	817-484-6523	13-18	
Charis Kinder Club	Southlake	817-997-4525	5-7	Self-pay
THR - Springwood	Bedford	682-236-6023	12-18	M-F 8:30AM-4PM
THR - Huguley	Burlson	682-236-6024	12-18	
THR - Arlington	Arlington	682-236-6023	12-18	Commercial insurance only
THR - Southlake	Southlake	682-236-6023	12-18	Commercial insurance only
THR - Seay Center	Plano	682-236-6023	12-18	Commercial insurance only
THR - Allen	Allen	682-236-6023	12-18	Commercial insurance only
THR - Glen Lakes	Dallas	682-236-6023	12-18	Commercial insurance only
THR - Rockwall	Rockwall	682-236-6023	12-18	Commercial insurance only
MindFULL	Denton	940-222-2399	12-18.	Eating Disorder Treatment Program (PHP/IOP)
Elevate Healthcare	Frisco	469-294-0148	5-17	No Amerigroup
Elevate Healthcare	Garland	469-969-0581	5-17	No Amerigroup
Elevate Healthcare	Mesquite	469-917-9201	5-17	No Amerigroup
Bricolage	Flower Mnd	469-968-5700	7-17	Currently working on getting paneled with insurances
Hickory Trails	DeSoto	972-394-4357	13-18	
Dallas Behavioral	DeSoto	972-982-0900	5-18	
Dallas Children's	Dallas	214-456-8899	3-17	
Dallas Children's - Eating Disorder	Dallas	214-456-8899	5-17	
Center for Discovery	Addison	714-828-0808	9+	Commercial insurance only
Eating Recovery Center	Plano	972-362-0933	7-18+	
Changes at Carrollton Springs	Frisco	469-850-2040	5-18	Commercial insurance only
Northpoint - UBH	Denton	972-394-4357	13-18	
Connections Wellness	Denton	940-222-2399	12+	Commercial insurance only. Also has eating disorder PHP.
Connections Wellness	McKinney	940-222-2399	13-18	Commercial insurance only
Rose Street Outpatient	Wichita Falls	940-723-4488	5-18	Also offers autism and some in-home services

APPENDIX E Crisis Contact Numbers



Cook Children's

Crisis Contact Information for Youth

If your child is a danger to themselves or someone else *do not delay*!

- Take your child to the nearest emergency room.
- *Call 911* if you cannot transport your child safely.

If you are not sure:

If your child is a danger to themselves or someone else ... *Call for advice or help.*

- **Cook Children's Psychiatry Intake Line:** 682-885-3917
  Press the emergency prompt.
- **Tarrant County** 1-800-866-2465
  MHMR Crisis Line:
  Available 24 hours a day
  Provides face-to-face assessments to help families decide how to help their child.
- **MHMR Crisis Line** (outside Tarrant County):

_____

If you need to talk or if you are concerned about someone:

Please call for advice or help

- **Suicide Prevention** 1-800-8255 (TALK)
  www.suicidepreventionlifeline.org
- **Crisis Text Line**
  Text: "Home" to 741-741
- **24/7 LGBTQ** 1-866-488-7386
  Crisis Support
  Text "Trevor" to: 1-202-304-1200
  Trevor Life Line, Trevor Chat, Trevor Text
- **SafeHaven** 1-877-701-7233
  Domestic Violence
- **RAINN** 1-800-656-4673
  National Sexual Assault Hotline
  24/7 Advocate and Counseling
  English and Spanish
- **SAMHSA** 1-800-662-4357
  Substance Abuse and Mental Health Services Administration
- **Hope Line** 1-877-235-4525
  24/7 Call or Text for counseling and local resources

These instructions are only general guidelines. Your health care providers may give you special instructions.
If you have any questions or concerns, please call your health care providers.

RESOURCES

1. Pettit JW, Buitron V, Green KL. Assessment and Management of Suicide Risk in Children and Adolescents. Cogn Behav Pract. 2018 Nov;25(4):460-472. doi: 10.1016/j.cbpra.2018.04.001. Epub 2018 Jun 5. PMID: 31787833; PMCID: PMC6884133.
2. Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, Currier GW, Melvin GA, Greenhill L, Shen S, Mann JJ. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011 Dec;168(12):1266-77. doi: 10.1176/appi.ajp.2011.10111704. PMID: 22193671; PMCID: PMC3893686.
3. Beck KE, Snyder D, Toth C, Hostutler CA, Tinto J, Letostak TB, Chandawarkar A, Kemper AR. Improving Primary Care Adolescent Depression Screening and Initial Management: A Quality Improvement Study. Pediatr Qual Saf. 2022 Mar 30;7(2):e549. doi: 10.1097/pq9.0000000000000549. PMID: 35369419; PMCID: PMC8970087.
4. Centers for Disease Control. (2022) Youth Risk Behavior Survey. Retrieved from: Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 (cdc.gov)
5. Centers for Disease Control (5/9/23) Disparities in Suicide. Retrieved from: Disparities in Suicide | CDC
6. American Academy of Pediatrics. (2/22/23) Screening for Suicide Risk in Clinical Practice. Retrieved from: Screening for Suicide Risk in Clinical Practice (aap.org)
7. The REACH Institute (2018) Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Retrieved from: Guidelines for Adolescent Depression in Primary Care (thereachinstitute.org)
8. Patterson W.M., et al. (1983). Evaluation of suicidal patients: The SAD PERSONS scale. Psychosomatics, 24 (4), 343-349
9. PHQ – 9 Modified for teens: IHC MHI Depression Fact Sheet: Children and Adolescents (aacap.org)
10. Practice Parameter for the Assessment and Treatment for Children and Adolescents with Suicidal Behavior. AACAP. July 2001
11. Stanley, Barbara, and Gregory K. Brown. "Safety planning intervention: a brief intervention to mitigate suicide risk." *Cognitive and behavioral practice* 19.2 (2012): 256-264.