



# Teenage Suicidality

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Advances in Pediatrics Symposium

AAP California Chapter 2

February 27, 2021

Los Angeles, CA (via Zoom)

# LEARNING OBJECTIVES

1. Describe trends in the rates of teenage suicidality and changes during the COVID-19 pandemic.
2. Examine how certain factors including Adverse Childhood Experiences (ACES) and minority stress may place certain youth at increased risk for suicidality.
3. Formulate strategies to prevent, recognize, and appropriately respond to youth experiencing suicidal ideation.

# Definitions & Model of Youth Suicidality

# Definitions

**Suicidal Ideation (SI)**: Thinking about, considering, or planning to die by suicide

**Passive SI**: Thoughts of dying or “better off if not around” (more abstract)

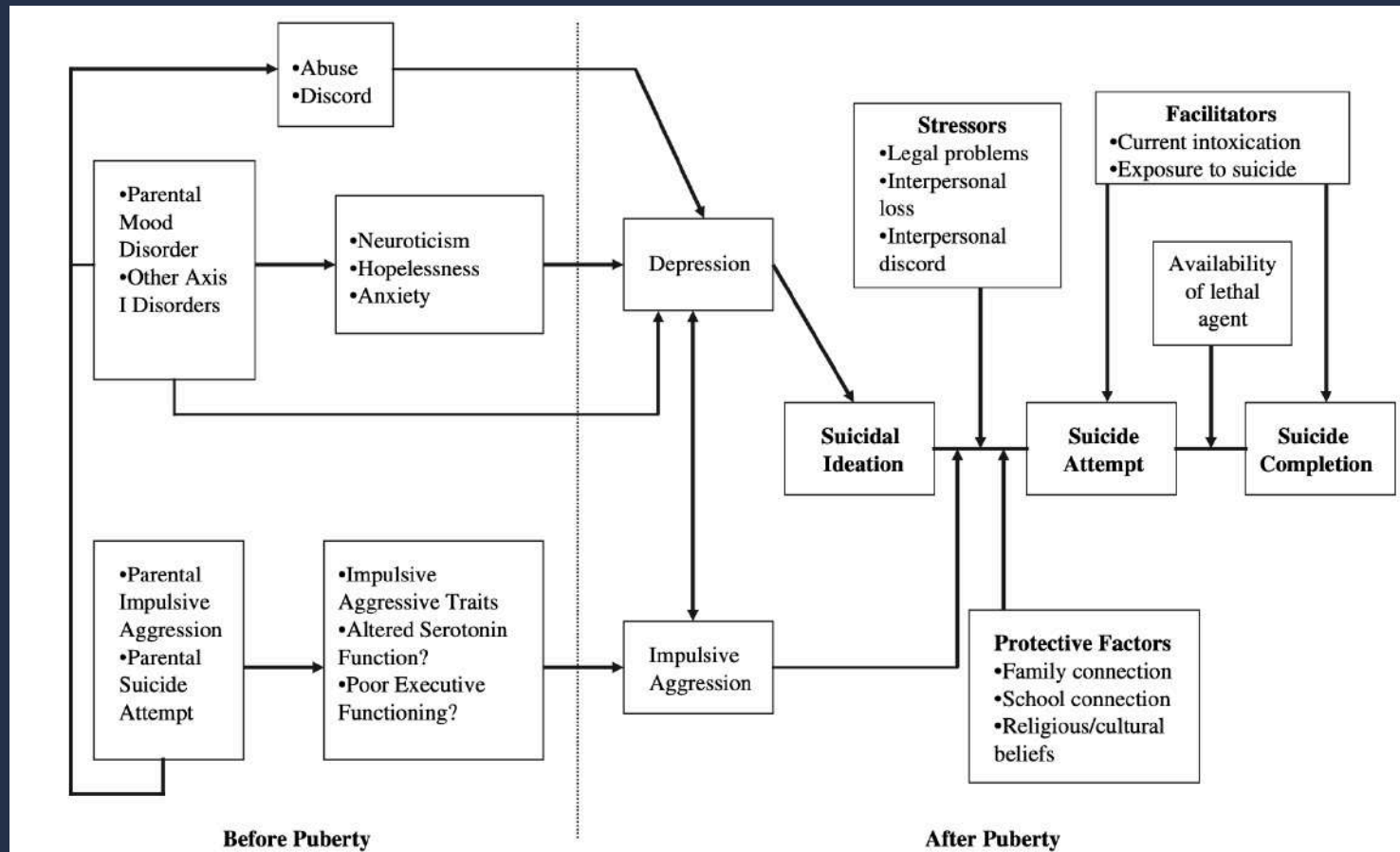
**Active SI**: Specific plan to die by suicide (more concrete)

**Attempted Suicide**: A non-fatal, self-inflicted destructive act with explicit or inferred intent to die

**Suicide**: A fatal, self-inflicted destructive act with explicit or inferred intent to die

**Suicidality**: Refers to all suicide-related behaviors and thoughts including completing or attempting suicide, suicidal ideation or communications

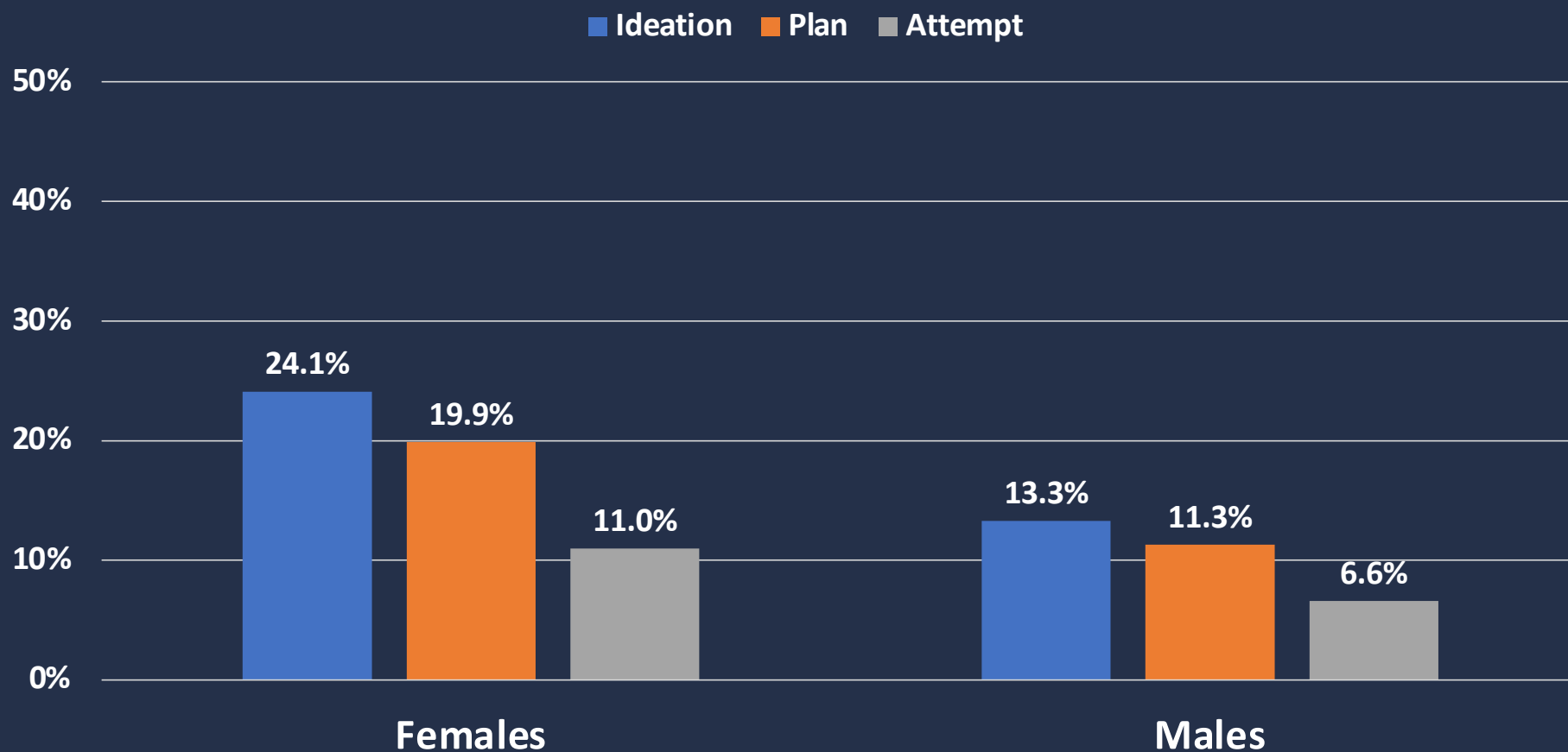
# A Model of Youth Suicidal Behavior



**Figure 1** Developmental-transactional model of youth suicidal behavior

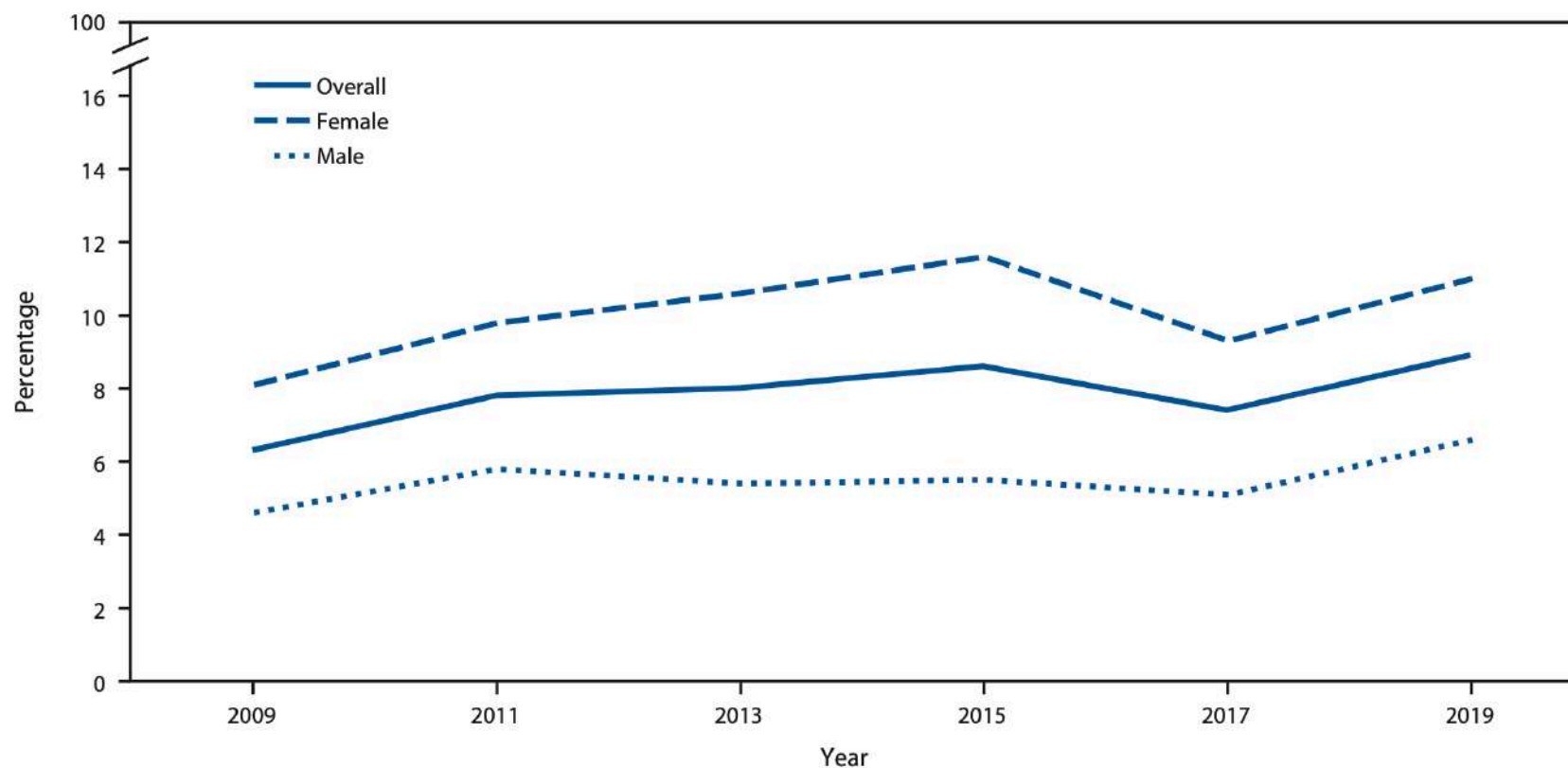
# Trends in Youth Suicidality

# Past Year Suicidality in 2019 (YRBS)



# Suicide Attempts by Sex (YRBS)

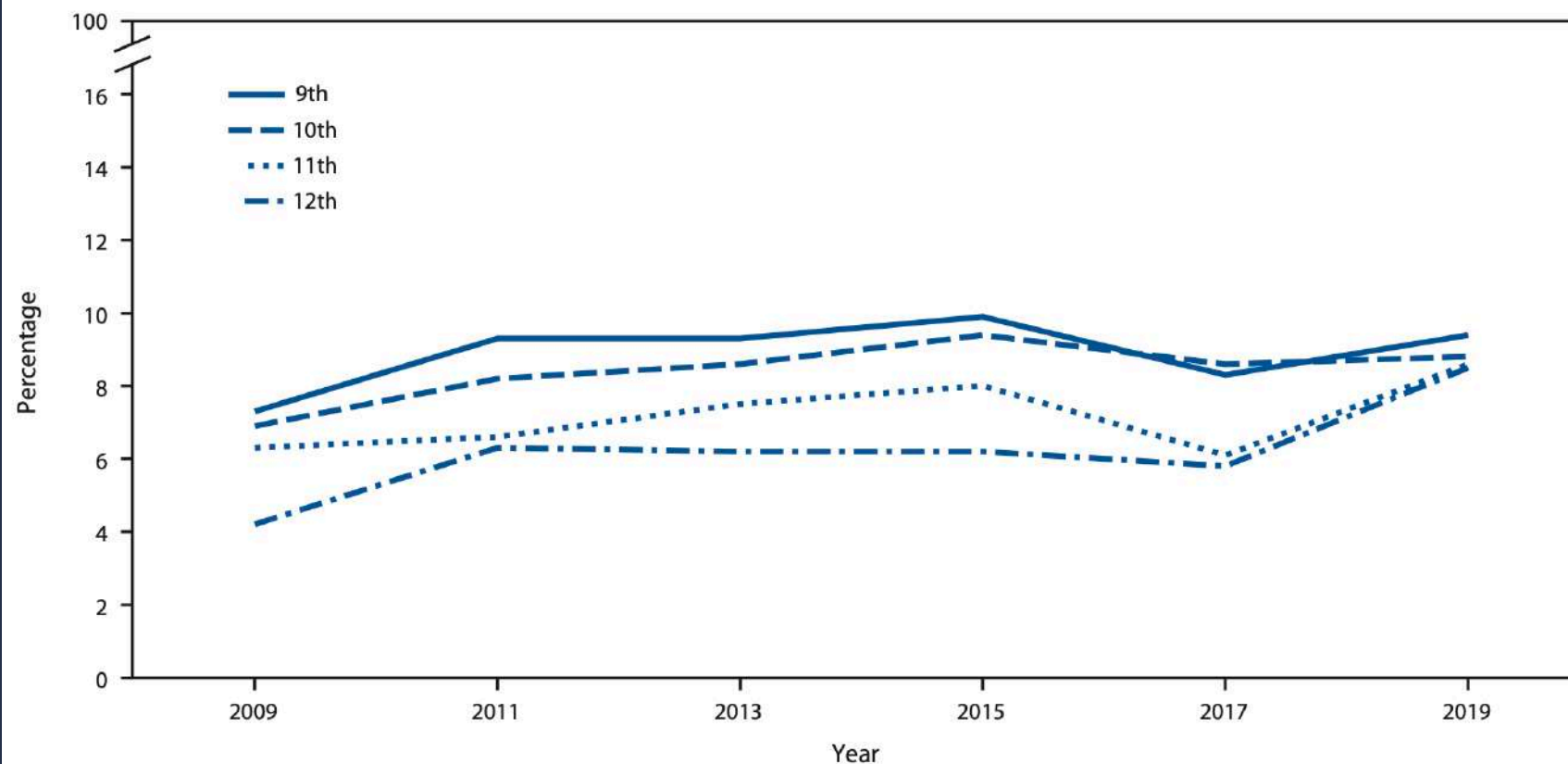
FIGURE 1. Percentage of high school students who attempted suicide during the 12 months before the survey, overall and by sex — Youth Risk Behavior Survey, United States, 2009–2019





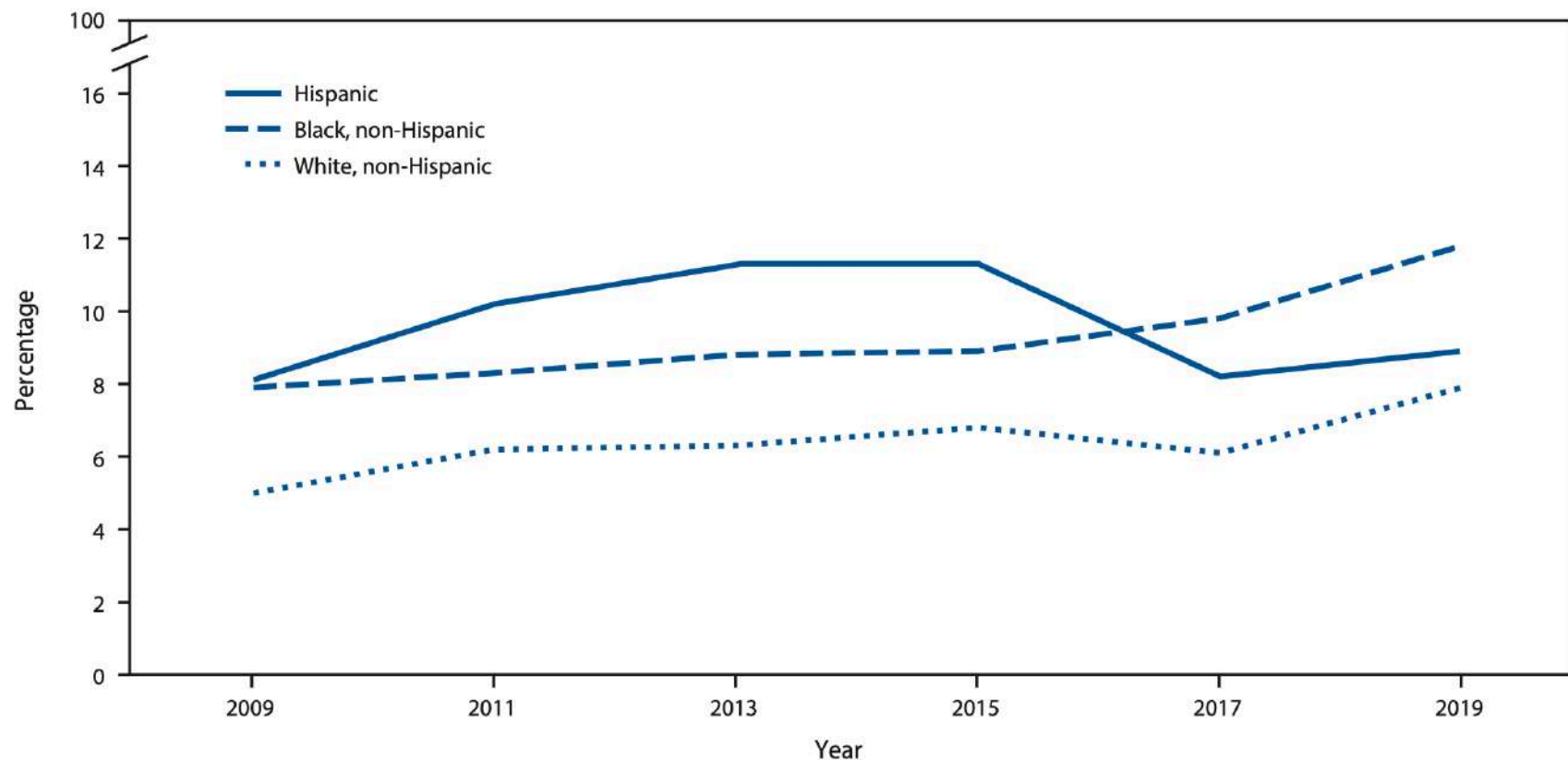
# Suicide Attempts by Grade (YRBS)

FIGURE 3. Percentage of high school students who attempted suicide during the 12 months before the survey, by grade — Youth Risk Behavior Survey, United States, 2009–2019



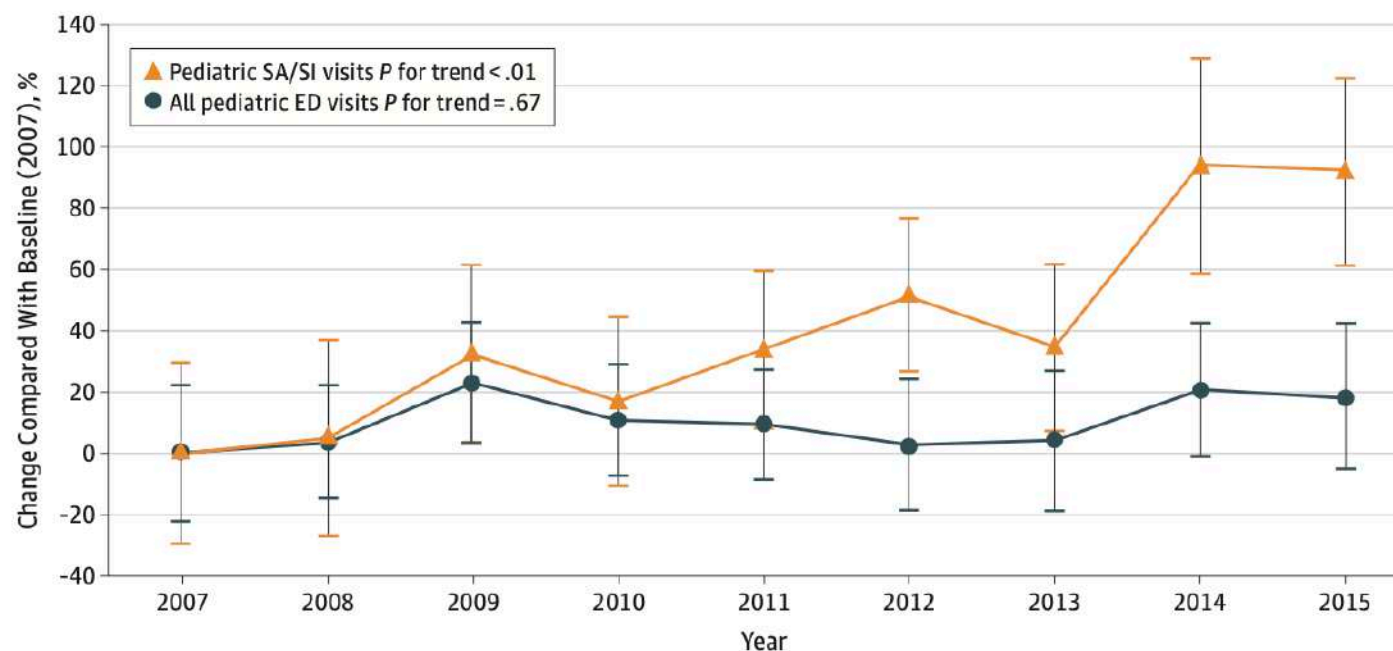
# Suicide Attempts by Race/Ethnicity (YRBS)

FIGURE 2. Percentage of high school students who attempted suicide during the 12 months before the survey, by race/ethnicity — Youth Risk Behavior Survey, United States, 2009–2019



# US Ped Visits to ED for SI/SA (5 to <18 yo)

Figure. Associated Changes in Pediatric Emergency Department (ED) Visits for Suicide Attempts (SA) and Suicidal Ideation (SI)



Total Ped Visits to ED for SI/SA increased **1.93x** between 2007-2015

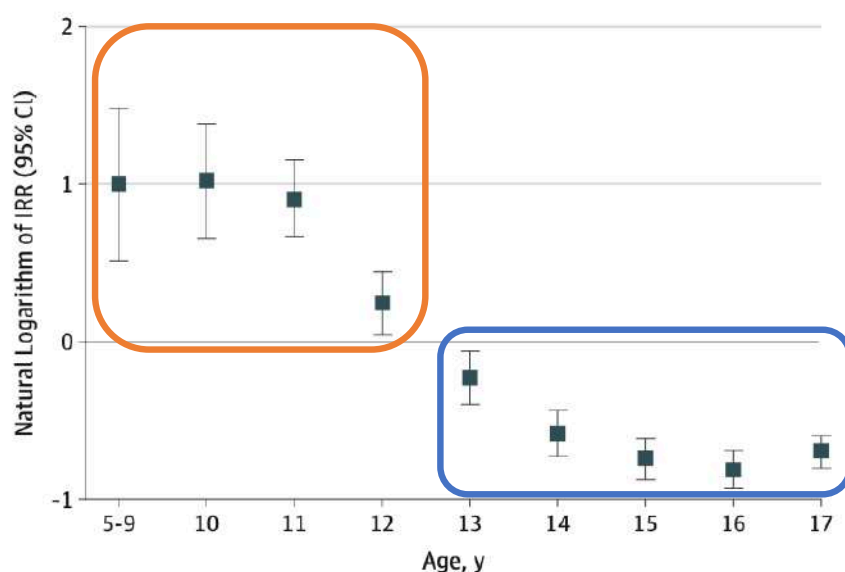
**43.1%** Peds ED visits for SI/SA were in children 5 to <11 years old

**Limitations:** Lumped together SI/SA and may have included some NSSI

For children age 5 to younger than 18 years and overall pediatric emergency department visits for all children age younger than 18 years over time. Error bars indicate 95% CI.

# Suicide Incidence Rates – Black & White Youth

Figure. Comparison of Suicide Incidence Rates Between Black and White Youths in the United States From 2001 to 2015 by Age



Squares indicate the estimated natural logarithm of the age-specific incidence rate ratio (IRR); vertical lines, 95% CI. The reference group is white youth. The 95% CIs that do not include zero are considered to be statistically significant.

Black	Boys: 1,225	Girls: 436	Rate: 1.26 per 100,000
White	Boys: 9,916	Girls: 3,425	Rate: 2.16 per 100,000

**5-12 yo:** Black youth had significantly higher incidence of suicide (**IRR 1.82**)

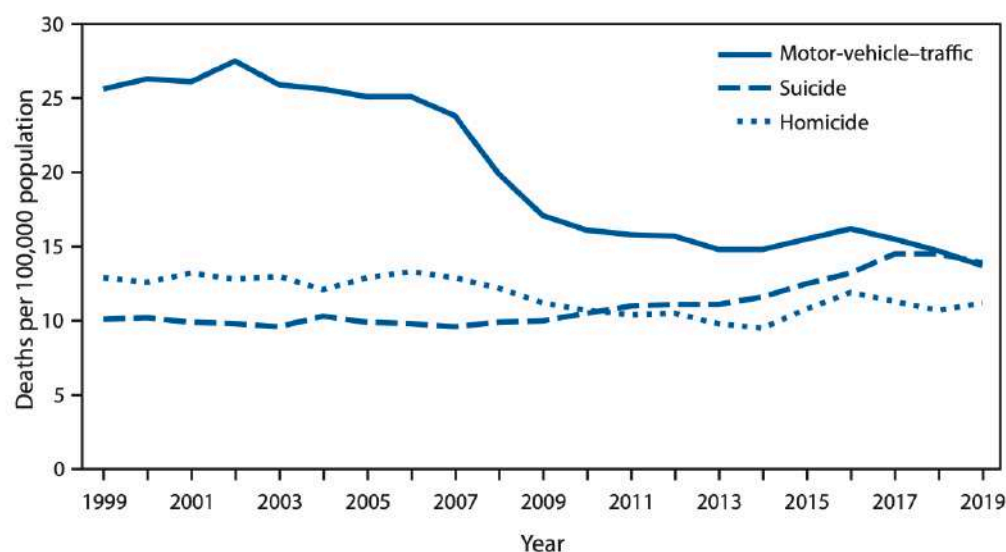
**13-17 yo:** Black youth had significantly lower incidence of suicide (**IRR 0.51**)

This pattern of results was similar in analyses stratified by sex and did not change during the study period

# US Death Rates (15-24 Years) – 1999-2019

FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

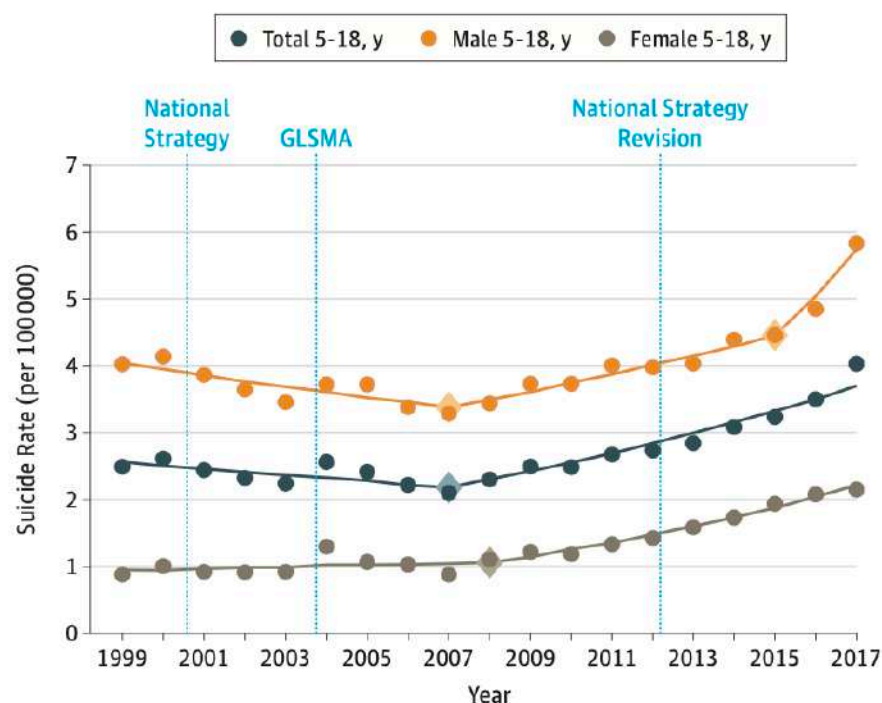
## Death Rates\* for Motor-Vehicle–Traffic Injuries, Suicide, and Homicide Among Adolescents and Young Adults Aged 15–24 Years — United States, 1999–2019



\* Rates are per 100,000 population aged 15–24 years. Deaths from motor-vehicle–traffic injuries are identified with *International Classification of Diseases, Tenth Edition* (ICD-10) codes V02–V04[.1–.9], V09.2, V12–V14[.3–.9], V19[.4–.6], V20–V28[.3–.9], V29–V79[.4–.9], V80[.3–.5], V81.1, V82.1, V83–V86[.0–.3], V87[.0–.8], V89.2. All motor-vehicle–traffic injuries are unintended. Suicides are identified with ICD-10 codes U03, X60–X84, and Y87.0, and homicides with codes U01–U02, X85–Y09, and Y87.1.

# US Suicide Rates (5-18 Years) – 1999-2017

Figure 1. Joinpoint Analysis of Changes in Trends of US Suicide Rates of Children and Adolescents Aged 5 to 18 Years, by Sex, United States, 1999-2017

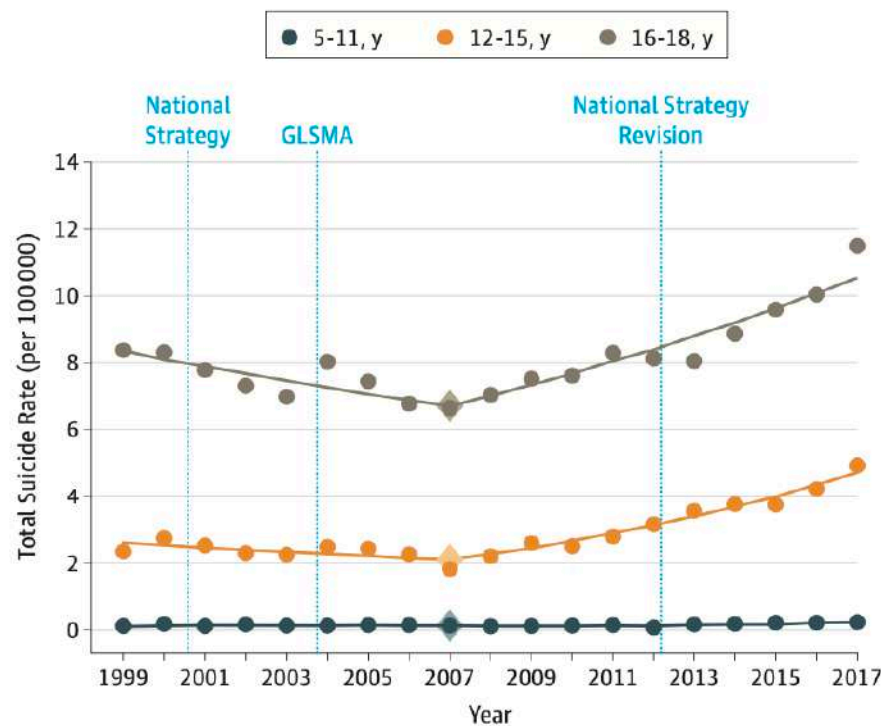


	APC (95% CI)	P Value
<b>Total</b>		
1999-2007	1.98 (-3.5 to -0.4)	.02
2007-2017	5.40 (4.2 to 6.6)	<.001
<b>Male</b>		
1999-2007	2.25 (-3.5 to -1.0)	.003
2007-2015	3.50 (1.9 to 5.2)	.006
2015-2017	13.56 (0.8 to 28.0)	.04
<b>Female</b>		
1999-2008	1.43 (-1.2 to 4.1)	.26
2008-2017	8.45 (5.7 to 11.3)	<.001

Figures were prepared with data from the US Centers for Disease Control and Prevention. GLSMA indicates the Garrett Lee Smith Memorial Act.

# US Suicide Rates (5-18 Years) – 1999-2017

Figure 2. Suicide Rates of Children Ages 5 to 18 Years, Stratified by Age Group, United States, 1999-2017



Age, y	APC (95% CI)	P Value
<b>5-11</b>		
1999-2012	-1.27 (-3.5 to 1.1)	.26
2012-2017	14.69 (3.8 to 26.7)	.01
<b>12-15</b>		
1999-2007	-2.79 (-4.6 to -0.9)	.007
2007-2017	8.47 (7.0 to 9.9)	<.001
<b>16-18</b>		
1999-2007	-2.72 (-4.4 to -1.0)	.004
2007-2017	4.65 (3.4 to 6.0)	<.001

Figures were prepared with data from the US Centers for Disease Control and Prevention. GLSMA indicates the Garrett Lee Smith Memorial Act.



# COVID-19 Pandemic



GETTY IMAGES; Kaiser Health News Illustration

## Kids Already Coping With Mental Disorders Spiral as Pandemic Topples Vital Support Systems

By Christine Herman, [Side Effects Public Media](#) and Cory Turner, [NPR](#) and Ritu Chatterjee, [NPR](#)

JANUARY 29, 2021





## Keep paying attention to your kids' mental health in this pandemic

By Lisa Selin Davis, CNN

Updated 4:37 AM ET, Wed February 10, 2021



## The Coronavirus Seems to Spare Most Kids From Illness, but Its Effect on Their Mental Health Is Deepening

HEALTH • COVID-19

TIME



The New York Times

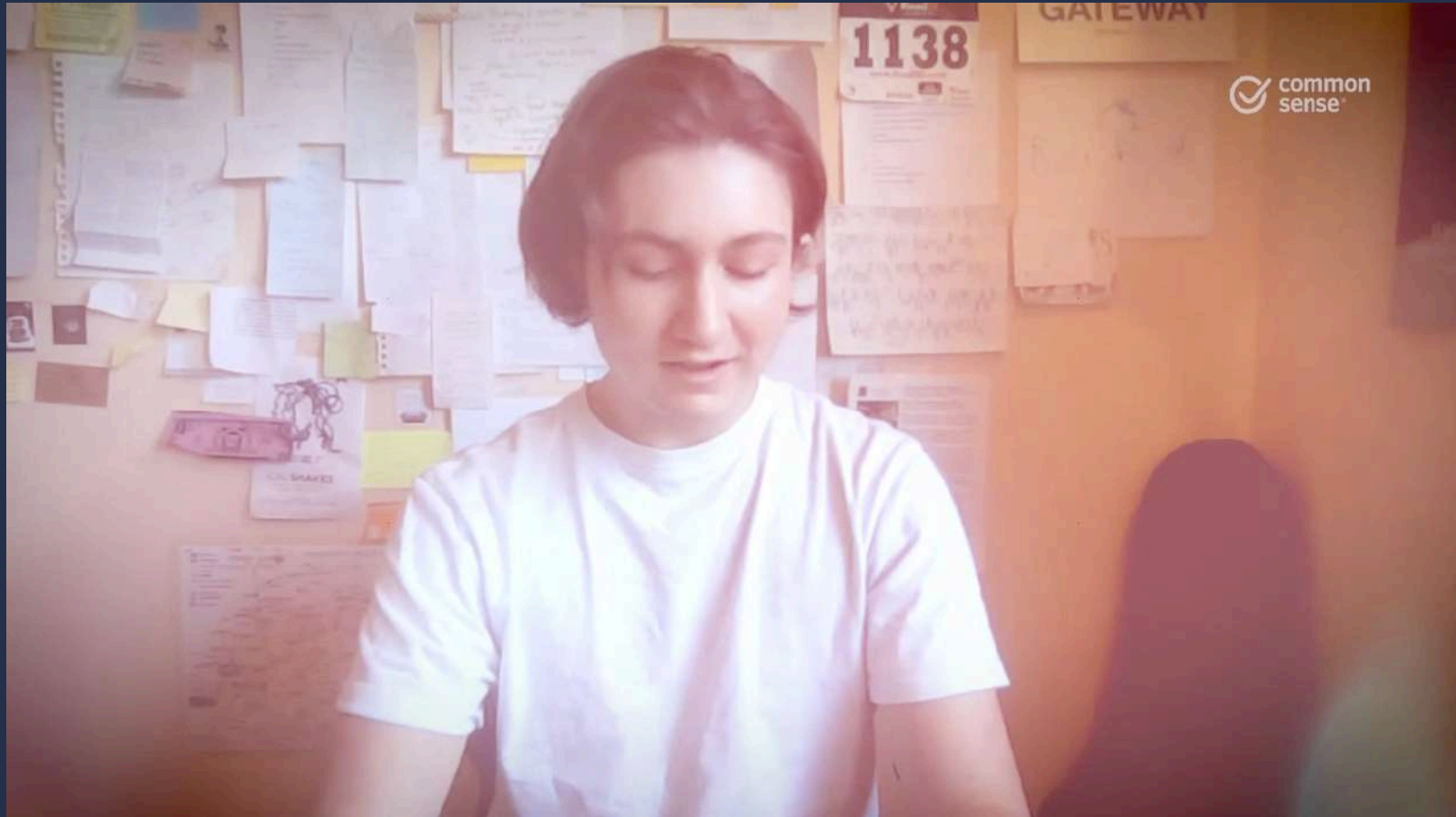
THE CHECKUP

### How to Help When Adolescents Have Suicidal Thoughts

Even when rates of suicidal ideation increase, there are ways to keep kids safe.

Older children, who understand the perils of the pandemic, may require more care than toddlers [Lisa Sorgini](#)

# COVID-19 Pandemic: Youth Voices



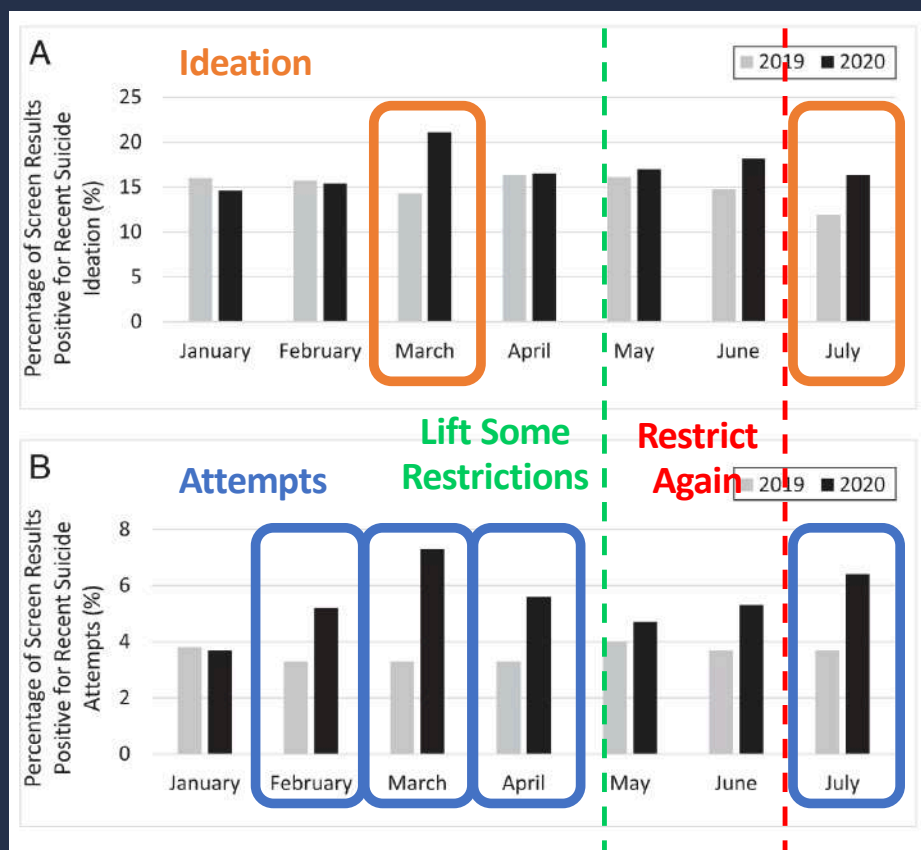
COMMON SENSE MEDIA

# COVID-19 Pandemic: Youth Voices

**RISK FOR SUICIDALITY**

DEPRESSION ALONE FRIENDS SOCIAL MEDIA  
STRESS  
NOT KNOWING SAD TECHNOLOGY  
ISOLATED  
I MISS... ZOOM FUTURE ANXIETY  
WORRY  
SICK CONNECTIONS DYSPHORIA  
FRUSTRATED

# COVID-19 and Reports of SI/SA in Youth



## Routine suicide-risk screening in youth 11-21 yo in Pediatric ED (TX)

Reported suicidal ideation in past 1 month

2019: **15.1%**, 2020: **16.9%**

Reported suicide attempt in past 3 months

2019: **3.6%**, 2020: **5.4%**

# COVID-19 and Suicide in Youth

Dr. Christine Moutier,  
*American Foundation for  
Suicide Prevention*

“We do not yet have national suicide data during most of the COVID-19 pandemic, therefore, claims about increasing suicide rates during COVID-19, in general and as a direct result of remote learning, are not based in current available data and are unfounded.”



“While increased stress can contribute to feelings of depression and anxiety, that mental health distress is linked but also distinct from suicide.”

# **Risk Factors for Suicidality**

# Nonsuicidal Self-Injury (NSSI) and Suicidality

**NSSI:** Deliberate immediate destruction of one's own body tissue (eg. self-cutting, bruising, burning) in the absence of conscious suicidal intent

As many as 1 in 5 youth report engaging in NSSI

Associated with emotional regulation difficulties, inattention, impulsivity, self-hatred, negative cognitive style (eg, pessimism), problematic body image

Why?

- Regulation of distress/anxiety (“feeling too much”, “can’t feel anything”)
- Self-punishment
- Communicate distress to others (less common)



# Nonsuicidal Self-Injury (NSSI) and Suicidality

After nonfatal self-harm, adolescents and young adults were at markedly elevated risk of death by suicide.

Suicide standardized mortality ratio (compared to gen pop):

Adolescents: 46.0

Young adults: 19.2

Those who used violent self-harm methods, particularly firearms, were at especially high risk.

NSSI does not necessarily lead to future suicide attempts but is associated with higher risk for death by suicide.



# Teen Suicidal Ideation in CA High Schools

**Table III.** Student-level logistic model predicting student suicide ideation based on student characteristics

Characteristics	2011-2013 (N = 325 414)			2009-2011 (N = 370 389)		
	OR	Lower limit of 95% CI	Upper limit of 95% CI	OR	Lower limit of 95% CI	Upper limit of 95% CI
<b>Higher SI Rates</b>						
<b>Lower SI Rates</b>						
African American/black <sup>†</sup>	0.86*	0.82	0.90	0.93*	0.89	0.97
Asian <sup>†</sup>	1.13*	1.10	1.16	1.06*	1.03	1.10
Hispanic <sup>†</sup>	1.04*	1.02	1.06	1.03*	1.01	1.05
Other race or ethnicity <sup>†</sup>	1.20*	1.17	1.23	1.21*	1.18	1.24
Male <sup>†</sup>	0.48*	0.47	0.49	0.52*	0.51	0.53
Grade 9 student <sup>†</sup>	1.01	0.99	1.03	1.02	1.00	1.03
School belonging <sup>‡</sup>	0.76*	0.76	0.76	0.77*	0.76	0.78
School adult support <sup>‡</sup>	0.83*	0.82	0.84	0.82*	0.81	0.83
Moderate violence victimization <sup>§</sup>	2.12*	2.10	2.14	1.89*	1.86	1.91
Discrimination victimization <sup>§</sup>	1.42*	1.40	1.44	1.48*	1.46	1.51
Severe violence victimization <sup>§</sup>	1.23*	1.21	1.25	1.24*	1.22	1.26
Weapon involvement <sup>§</sup>	1.03*	1.01	1.05	1.08*	1.06	1.10
Gang member <sup>†</sup>	1.47*	1.43	1.51	1.54*	1.50	1.58
<b>R<sup>2</sup></b>		.20*			.17*	

\*P < .01 significance of the OR.

†1 = yes, 0 = no.

‡From 1 (strongly disagree) to 5 (strongly agree).

§From 1 (0 times during the prior 12 months) to 4 (4 or more times during the prior 12 months).

# Risk Factors for Youth Death by Suicide

Fixed Risk Factors	Personal Mental Health Problems	Social/Environmental Factors
<p>Family history suicide/attempts</p> <p>History of adoption</p> <p>Male gender</p> <p>Parental mental health problems</p> <p>LGBQ sexual orientation</p> <p>Transgender identification</p> <p>History of physical/sexual abuse</p> <p>Previous suicide attempt</p>	<p>Sleep disturbances</p> <p>Depression</p> <p>Bipolar disorder</p> <p>Substance use</p> <p>Psychosis</p> <p>Posttraumatic stress disorder (PTSD)</p> <p>Panic attacks</p> <p>History of aggression/anger</p> <p>Impulsivity</p> <p>Pathologic internet use</p>	<p>Bullying/Cyberbullying</p> <p>Impaired parent-child relationship</p> <p>Living outside home (homeless, group home, corrections facility)</p> <p>Difficulties in school</p> <p>Not working or attending school</p> <p>Social isolation</p> <p>Stressful life events (ACEs)</p> <p>Exposure to suicide (clustering)</p> <p>Firearm in the home</p>
Immediate Risk Factors		
Agitation	Recent stressful life event	Intoxication

# Risk Factors for Youth Death by Suicide

<u>Fixed Risk Factors</u>	<u>Personal Mental Health Problems</u>	<u>Social/Environmental Factors</u>
Family history suicide/attempts History of adoption Male gender Parental mental health problems <b>LGBQ sexual orientation</b> <b>Transgender identification</b> History of physical/sexual abuse Previous suicide attempt	Sleep disturbances Depression Bipolar disorder Substance use Psychosis Posttraumatic stress disorder (PTSD) Panic attacks History of aggression/anger Impulsivity Pathologic internet use	<b>Bullying/Cyberbullying</b> <b>Impaired parent-child relationship</b> Living outside home (homeless, group home, corrections facility) Difficulties in school Not working or attending school <b>Social isolation</b> <b>Stressful life events (ACEs)</b> Exposure to suicide (clustering) Firearm in the home
<u>Immediate Risk Factors</u>		
Agitation	Recent stressful life event	Intoxication

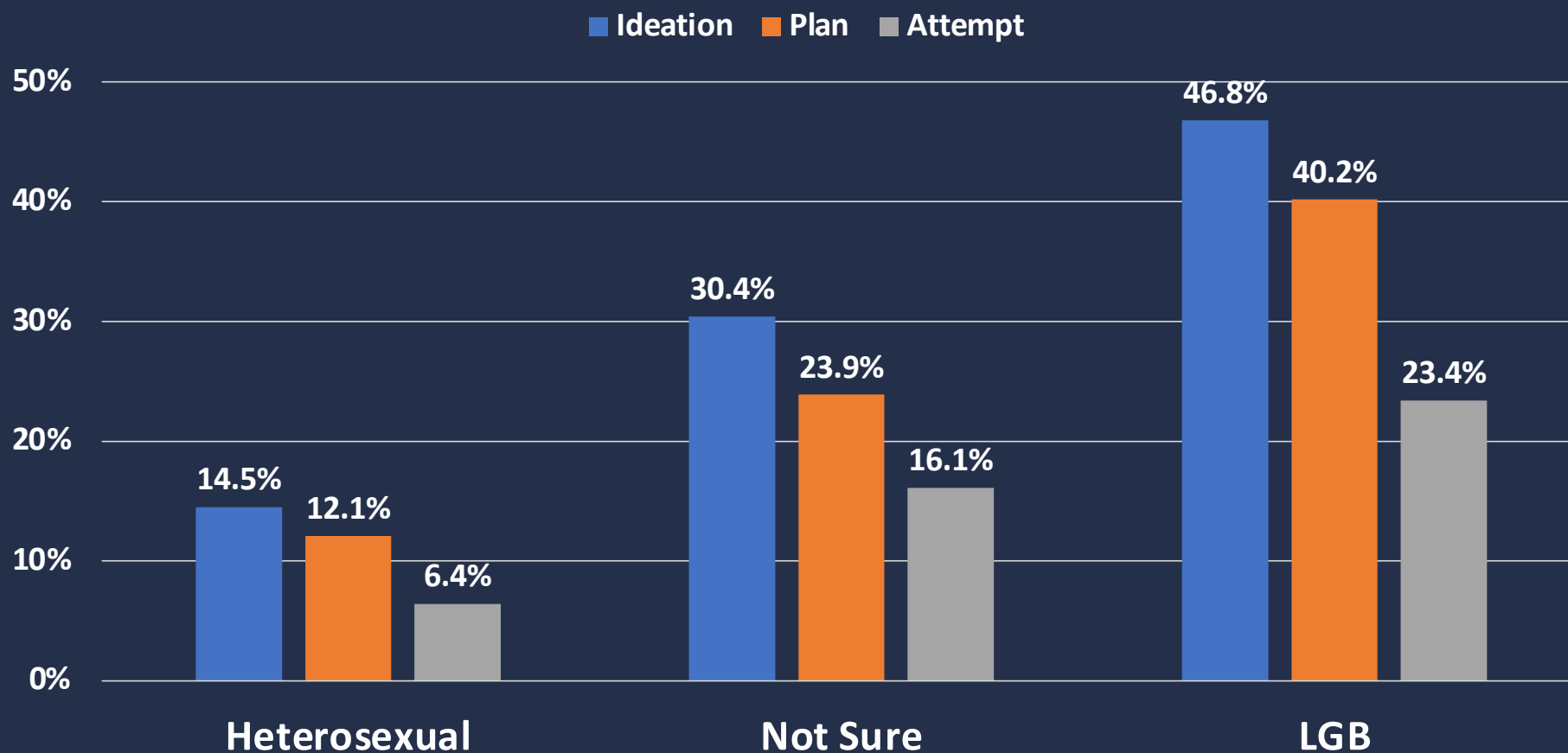
# Suicidality in LGBTQ+ Youth

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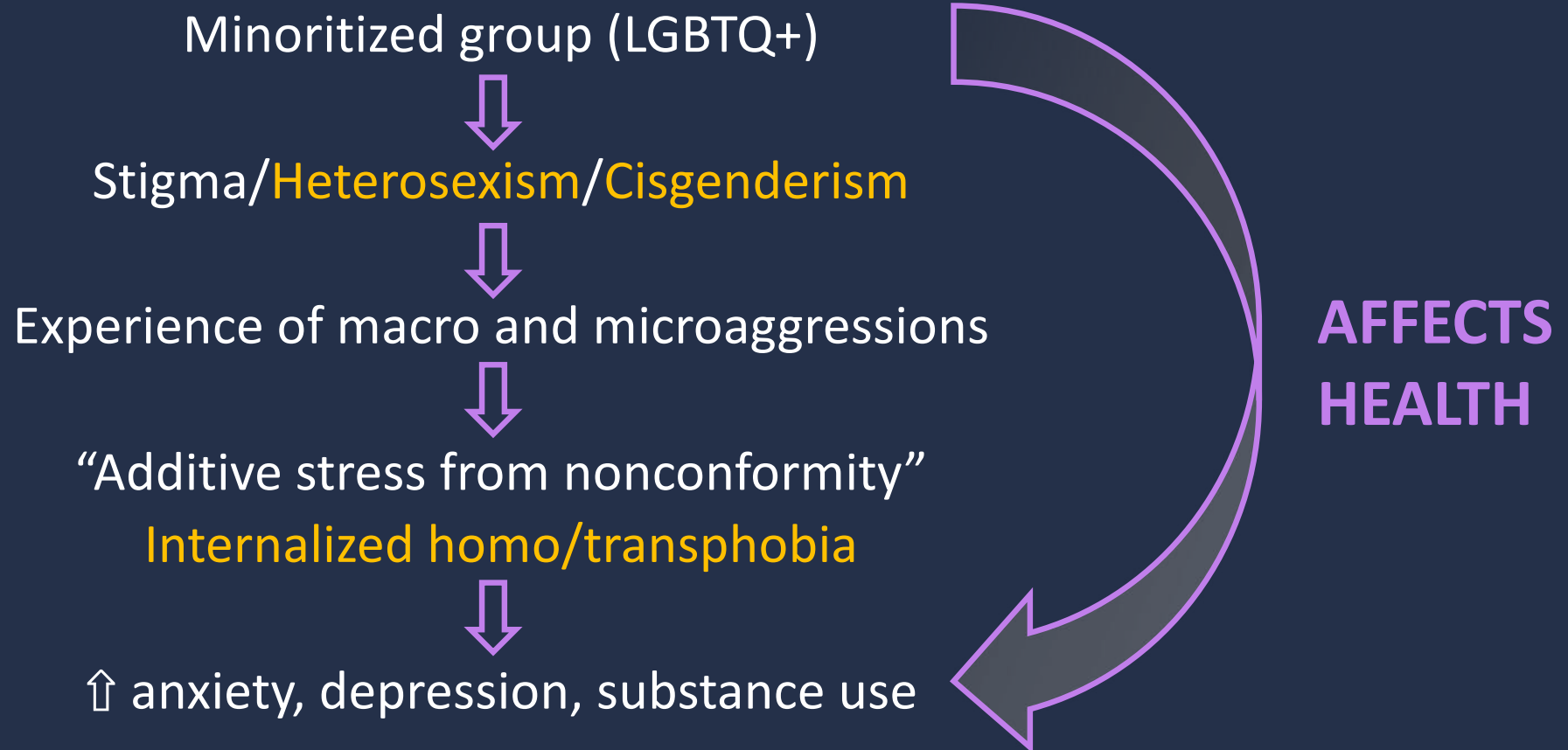
- L – Lesbian
- G – Gay
- B – Bisexual
- T – Transgender
- Q – Queer/Questioning
- I – Intersex
- A – Asexual/Allies



# Past Year Suicidality in 2019 (YRBS)



# Minority Stress Model



# Minority Stress

- “Lesbian and gay [and BTQ] adolescents are the only social minority who must learn to manage a stigmatized identity without active support and modeling from parents and family”





# Minority Stress

- Stressors unique or pronounced for LGBTQ+ individuals:

## FAMILY

- Family Rejection and Non-Recognition
- Family Harassment and Violence
- Risk for Coercion to Change
- Throwaway Phenomenon
- Runaway Phenomenon

- Positive Role Model Deprivation
- Possible Survival Sex

## COMMUNITY & SOCIETY

- Social Stigma
- Risk for Discrimination/Bullying
- Risk for Violence and Abuse

- Possible Limited Police Protection
- Impeded Friendships
- Lack of Appropriate Social Network
- Social Isolation

## INTERNALIZATION

- Poorly Developed Dating Skills
- School Avoidance
- Possible Employment Loss

- Self-Hatred
- Low Self-Esteem
- Shame
- Feelings of Inferiority
- Hypervigilance/Self-Monitoring

- Increased Alcohol/Drug Use
- Increased Sexual Risk
- Increased STI/HIV/Pregnancy Risk
- Increased Depression and Suicide Risk
- Possible Disordered Eating

# Framing ACEs in LGBTQ+ Youth

## Pediatric ACEs and Related Life Events Screener (PEARLS)

TEEN (Self-Report)- To be completed by: **Patient**

FAMILY

COMMUNITY &  
SOCIETY

### PART 1:

1. Have you ever lived with a parent/caregiver who went to jail/prison?
2. Have you ever felt unsupported, unloved and/or unprotected?
3. Have you ever lived with a parent/caregiver who had mental health issues?  
(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)
4. Has a parent/caregiver ever insulted, humiliated, or put you down?
5. Has your biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Have you ever lacked appropriate care by any caregiver?  
(for example, not being protected from unsafe situations, or not being cared for when sick or injured even when the resources were available)
7. Have you ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?  
  
Or have you ever seen or heard a parent/caregiver being slapped, kicked, punched beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at you?  
  
Or has any adult in the household ever hit you so hard that you had marks or were injured?  
  
Or has any adult in the household ever threatened you or acted in a way that made you afraid that you might be hurt?
9. Have you ever experienced sexual abuse?  
(for example, has anyone touched you or asked you to touch that person in a way that was unwanted, or made you feel uncomfortable, or anyone ever attempted or actually had oral, anal, or vaginal sex with you)

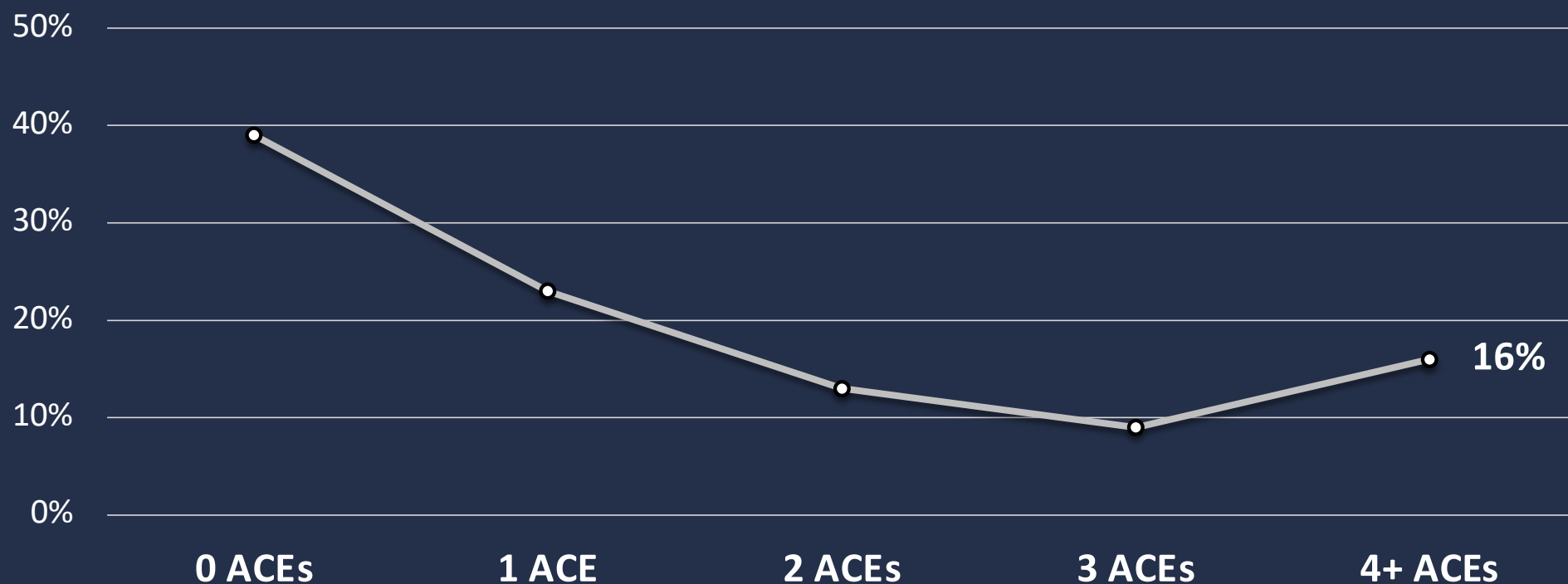
10. Have there ever been significant changes in the relationship status of your caregiver(s)?  
(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)

### PART 2:

1. Have you ever seen, heard, or been a victim of violence in your neighborhood, community or school?  
(for example, targeted bullying, assault or other violent actions, war or terrorism)
2. Have you experienced discrimination?  
(for example, being hassled or made to feel inferior or excluded because of their race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disabilities)
3. Have you ever had problems with housing?  
(for example, being homeless, not having a stable place to live, moved more than two times in a six-month period, faced eviction or foreclosure, or had to live with multiple families or family members)
4. Have you ever worried that you did not have enough food to eat or that food would run out before you or your parent/caregiver could buy more?
5. Have you ever been separated from your parent or caregiver due to foster care, or immigration?
6. Have you ever lived with a parent/caregiver who had a serious physical illness or disability?
7. Have you ever lived with a parent or caregiver who died?
8. Have you ever been detained, arrested or incarcerated?
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners?  
(for example, a boyfriend or girlfriend)

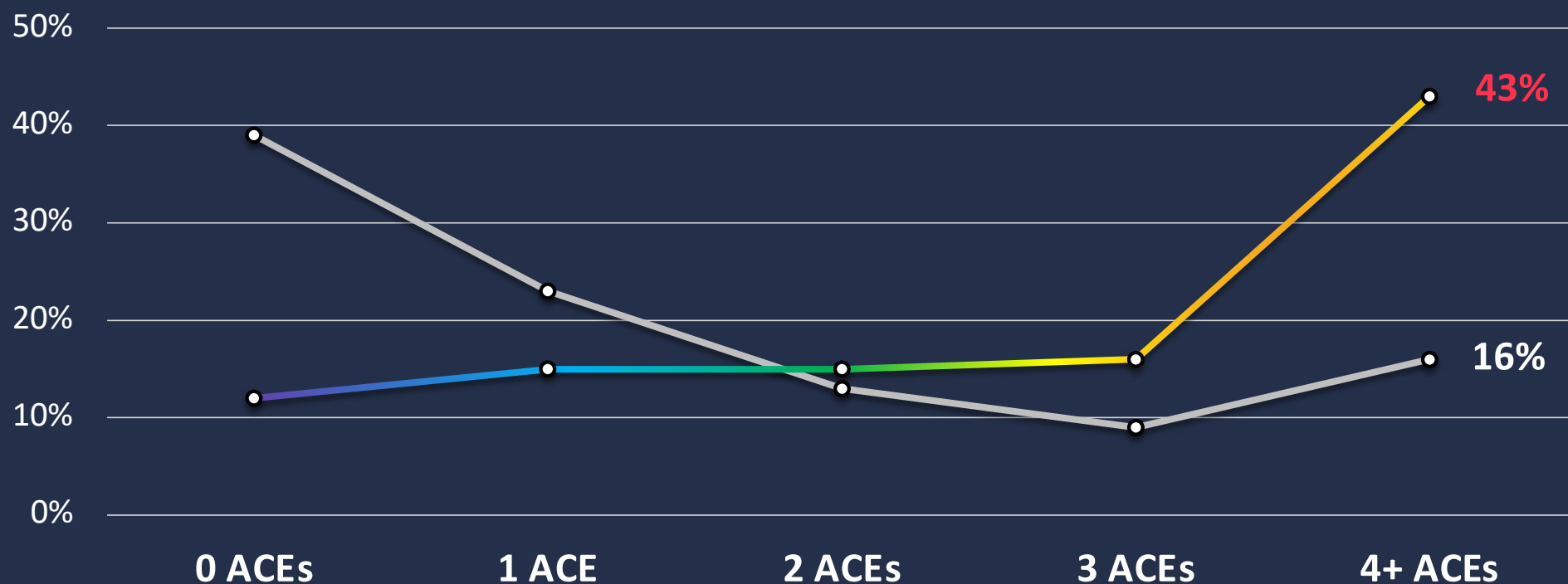
# ACEs in LGBTQ+ Populations

Comparison of ACE Prevalence: Behavioral Risk Factor Surveillance System in 23 States (BRFSS, 2011-14, 18+ yo) and Project Queery (2016, 14-18 yo)



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Comparison of ACE Prevalence: Behavioral Risk Factor Surveillance System in 23 States (BRFSS, 2011-14, 18+ yo) and Project Queery (2016, 14-18 yo)



# Internalizing Prejudice: Suicidality

- Increased rates of:
  - Disordered Eating: Increased rates of bingeing, purging in all bisexual teens and gay males
  - Psychiatric Conditions: 3-4x the rate of having 2+ conditions
  - Suicide: 3x more likely intent, 5x more likely attempt,  
If family rejection: 8.4x more likely attempt than other LGB

# Internalizing Prejudice

- Transgender and gender non-binary individuals are often “lumped together” with LGBTQ+ populations in research

## 2015 U.S. Transgender Survey

- **40%** of transgender adults reported at least one suicide attempt compared to **4.6%** of the general population (nearly **9x more likely**)
- **92%** of these individuals reported a suicide attempt before the age of 25 years old

# Protective Factors in Youth Suicidality

# Protective Factors in Youth Suicidality

Shain et al,  
*Pediatrics* 2016  
Breslin et al,  
*Curr Opin Pediatr* 2020

## Protective Factors

Connection with parents or a caring adult (including doctors!)

Connection with school (extracurricular, antibullying)

Connection with peers

Connection with community (including spirituality or religion)

Decreased access to lethal means

High emotional intelligence (EQ)





# Care As Advocacy and Social Justice

*“A vital role of health professionals in promoting the health and wellbeing of LGBTQ individuals is to challenge and ultimately change homophobic/heterosexist norms, practices, and policies that are sources of stress and stigma for LGBTQ individuals, not just to provide LGBTQ individuals with the necessary resources and opportunities to learn how to positively cope with them on their own.”*

# Suicidality Screening & Response

# Screening in Primary Care: ACEs

Medi-Cal will now reimburse \$29 per annual ACEs screen through 20 yo!

→ PEARLS

Caregiver:

0-11 yo

12-19 yo

Patient:

12-19 yo

## Pediatric ACEs and Related Life Events Screener (PEARLS)

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### PART 1:

1. Have you ever lived with a parent/caregiver who went to jail/prison?
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(for example, depression, schizophrenia, bipolar disorder, PTSD, or an anxiety disorder)
4. Has a parent/caregiver ever insulted, humiliated, or put you down?
5. Has your biological parent or any caregiver ever had, or currently has a problem with too much alcohol, street drugs or prescription medications use?
6. Have you ever lacked appropriate care by any caregiver?  
(for example, not being protected from unsafe situations, or not being cared for when sick or injured even when the resources were available)
7. Have you ever seen or heard a parent/caregiver being screamed at, sworn at, insulted or humiliated by another adult?  
Or have you ever seen or heard a parent/caregiver being slapped, kicked, punched, beaten up or hurt with a weapon?
8. Has any adult in the household often or very often pushed, grabbed, slapped or thrown something at you?  
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10. Have there ever been significant changes in the relationship status of your caregiver(s)?  
(for example, a parent/caregiver got a divorce or separated, or a romantic partner moved in or out)

### PART 2:

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(for example, targeted bullying, assault or other violent actions, war or terrorism)
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7. Have you ever lived with a parent or caregiver who died?
8. Have you ever been detained, arrested or incarcerated?
9. Have you ever experienced verbal or physical abuse or threats from a romantic partners?  
(for example, a boyfriend or girlfriend)

# Screening in Primary Care: Depression

Horowitz et al,  
*Curr Opin Pediatr* 2009  
Shain et al,  
*Pediatrics* 2016  
Siu (USPSTF),  
*Ann Intern Med* 2016

AAP Bright Futures: All those 11-21 yo should be screened for depression

USPSTF: Screen those 12-18 yo (insufficient evidence for 7-11 yo)

When possible, screening should occur separate from parent(s)

\*Safety takes precedence over confidentiality\*

→ Patient Health Questionnaire (PHQ-2/PHQ-9)

# Screening in Primary Care: Depression

**PHQ-2** includes only the first 2 questions of the PHQ-9

Possible scores are 0-6

3 or greater indicates likely major depressive disorder → PHQ-9

These 2 questions specifically address suicidality

**PHQ-9: Modified for Teens (ages 11-17)**

Name: \_\_\_\_\_ 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. Little interest or pleasure in doing things?	0	1	2	3
2. Feeling down, depressed, irritable, or hopeless?	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3
4. Feeling tired, or having little energy?	0	1	2	3
5. Poor appetite, weight loss, or overeating?	0	1	2	3
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3
7. Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3
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?	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

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

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

☐ Yes   ☐ No

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

**OFFICE USE ONLY:**

SCORE: \_\_\_\_\_ Screener Name: \_\_\_\_\_ Date: \_\_\_\_\_ ☐

## 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

# Assessing Suicidality

“Have you ever thought about killing yourself or wished you were dead?”

“Have you ever done anything on purpose to hurt or kill yourself?”



**Nature** of past/present thoughts and behaviors



**Timeframe**, frequency, pattern, triggers



**Plan** – past/present (avoid hypotheticals)



**Access** to lethal means



**Who knows** and who or what has been helpful

# Responding to Suicidality

No one can accurately predict suicide, even experts can only try to assess risk

Intent is a key issue in determination of risk

**Suicidal Ideation (SI)**: Thinking about, considering, or planning to die by suicide

**Passive SI**: Thoughts of dying or “better off if not around” (more abstract)

**Active SI**: Specific plan to die by suicide (more concrete)

High Risk:

- Those with a plan or recent attempt with high probability of lethality
- Stated current intent to kill themselves
- Recent SI or behavior accompanied by current agitation or severe hopelessness
- Impulsivity and profoundly dysphoric mood a/w BPD, MDD, Psychosis, or SUD



# Responding to Suicidality

The most important aspect to management is **ensuring safety**

## Immediate Intervention:



Same-day appt with a  
mental health professional



Transfer to ED  
or call 911



Hospitalization or  
treatment facility

## Outpatient Care (Safety Planning with Parents/Family):



Secure/remove firearms,  
meds, sharps, ropes



Identify coping skills/resources  
and plan if thoughts occur



Call 911 or to nearest ED  
if any threat to safety



# Antidepressants and Suicidality

## BLACK BOX WARNING

Issued in Oct 2004 based on:

24 clinical trials  
>4,400 children/adolescents  
9 different antidepressants

Suicidality (spontaneous reporting)

Placebo: 2%

Medication: 4%

No completed suicides occurred  
during any studies

### FLUOXETINE CAPSULES, USP FLUOXETINE ORAL SOLUTION, USP FLUOXETINE DELAYED-RELEASE CAPSULES, USP

#### WARNING

**Suicidality and Antidepressant Drugs** — Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents, and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of Prozac or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Prozac is approved for use in pediatric patients with MDD and obsessive compulsive disorder (OCD). (*See WARNINGS, Clinical Worsening and Suicide Risk, PRECAUTIONS, Information for Patients, and PRECAUTIONS, Pediatric Use.*)

# Antidepressants and Suicidality

In young people who died by suicide in a review study, only 1.6% had recent exposure to SSRI medications.

“Suicidal ideation and behavior are common, and suicides are vastly less common, which makes it difficult to relate a change in one to a change in the other.”

Many studies show decreases in antidepressant prescribing in youth after the black-box warning and increases in youth suicide rates.

The warning should be discussed with patients/parents/guardians and appropriately documented.

**TABLE 2** Treatment With Antidepressant Medication: Warning Signs for Family Members To Contact the Physician

New or more frequent thoughts of wanting to die
Self-destructive behavior
Signs of increased anxiety/panic, agitation, aggressiveness, impulsivity, insomnia, or irritability
New or more involuntary restlessness (akathisia), such as pacing or fidgeting
Extreme degree of elation or energy
Fast, driven speech
New onset of unrealistic plans or goals

# Goals for Health Care Providers

Interventions that prevent childhood trauma

- Role of providers in normalizing diversity with patients and families

Support post-traumatic growth and resilience

- Relationships with empathetic and supportive adults

Consider trauma and ACEs, particularly in minority populations

- Universal screening reimbursed by Medi-Cal

Trauma-informed care

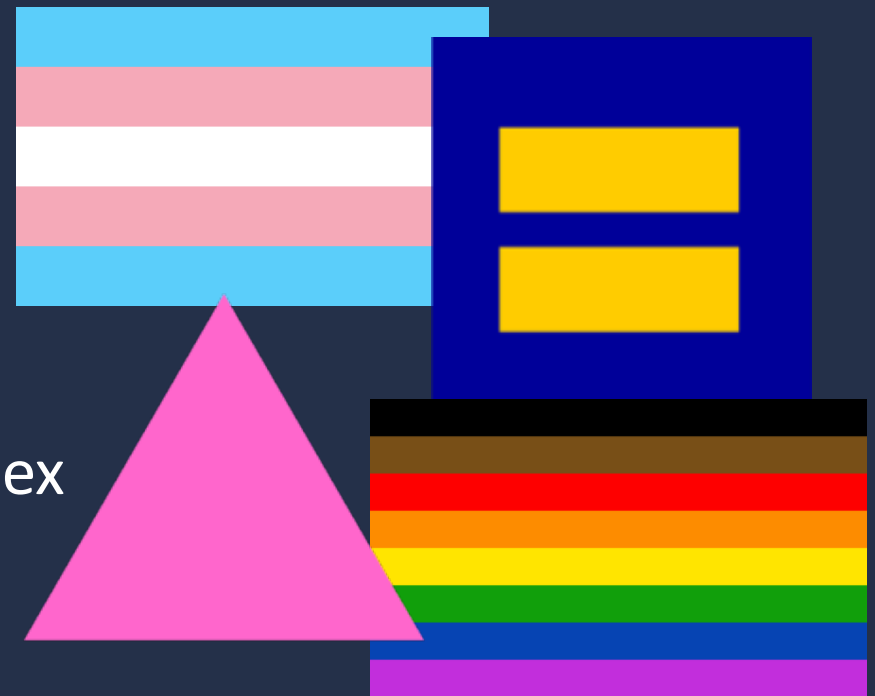
- Safety, trust, collaboration, choices, avoid re-traumatization

Create safe spaces (and brave spaces)

- Advocacy inside and outside of the clinical setting

# LGBTQ+ Friendly Environment

- Welcoming office staff and waiting area
  - Rainbow/HRC Stickers
  - LGBTQ+ friendly materials
  - Gender neutral bathrooms
- Brochures about LGBTQ+ health concerns such as mental health, substance use, STIs, safe sex
- LGBTQ+ friendly intake forms
- Statement of Non-discrimination



# Resources for Patients/Families

- CHLA DAYAM
- LA LGBT Center
- The Trevor Project
  - 1-866-4-U-TREVOR
- Trans Lifeline
- GLSEN
- PFLAG
- LeadWithLoveFilm.org
- FamilyProject.SFSU.edu



# Resources for Providers

- [www.aap.org](http://www.aap.org) (Office-Based Care for LGBTQ Youth)
- [www.apa.org/topics/orientation.html](http://www.apa.org/topics/orientation.html)
- [www.glaad.org](http://www.glaad.org) (Gay and Lesbian Alliance Against Defamation)
- [www.nctsn.org](http://www.nctsn.org) (The National Child Traumatic Stress Network)
- [www.aclu.org](http://www.aclu.org) (American Civil Liberties Union)
- [www.lambdalegal.org](http://www.lambdalegal.org) (Lambda Legal)



THANK YOU!  
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