ABSTRACT:
Suicide is a leading cause of death among our young patients. Healthcare providers in acute care settings like the emergency department have an opportunity to identify and intervene with those at risk in order to prevent death from suicide, future psychiatric emergencies, and the considerable morbidity that patients with unmet behavioral health needs experience. This article describes the current state of depression and suicide among young people and the strategies for implementing and improving screening in the emergency department. Finally, the article will articulate how to prepare for the challenges that emergency care providers face, as we work to reduce barriers for all patients to access behavioral health resources and receive needed care.

Keywords:
suicide; depression; screening; emergency department

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Suicide Screening and Behavioral Health Assessment in the Emergency Department

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Suicide is among the leading causes of death for children and adolescents. Identifying and caring for patients with behavioral health issues, particularly those who are suicidal, remains a challenge. Clinicians and institutions committed to addressing this growing public health crisis must recognize the prevalence and impact of mental illness, the challenges of patient management, and work for solutions to improve care.

In the emergency department (ED), the healthcare team is expected to recognize life-threatening illness and injury. Some patients present with a problem that is easily diagnosed, while others require careful questioning, examination, and diagnostic testing. When the ill or unstable patient arrives, we act as a team to provide care according to current evidence and expert consensus. The patient with sepsis, for example, requires a detailed history and exam, lab work-up, monitoring, timely intravenous fluids and antibiotics, and potentially, pressors and intensive care unit admission. Failure to diagnose and intervene quickly may result in patient decompensation and death.

Now consider a 14-year-old female presenting to the ED with 3 days of abdominal pain causing her to miss school. She describes the pain as constant, dull, and diffuse. Her review of systems is negative, and the examination reveals subjective abdominal tenderness, but no peritoneal findings. After normal labs and abdominal ultrasound, she is discharged home. Two days later, she

is brought to the ED after an intentional overdose of acetaminophen. She is admitted to the hospital for monitoring and medical clearance, then transferred to inpatient psychiatric care. During this admission she endorses months of depression and suicidality after being bullied at school. She was never asked about her mental health at the first ED visit, yet the potential lethality of her illness is no less than our sepsis patient.

SUICIDE IN THE UNITED STATES

According to the Centers for Disease Control and Prevention, suicide is the second leading cause of death for youth and young adults 10 to 24 years of age in the United States.[1] When data concerning adolescent deaths due to the 4th to 24th leading causes are combined (including cancer, heart disease, diabetes, and infectious diseases), more teens die due to suicide. Research and innovation have improved outcomes for medical conditions for decades, while advancements and funding for suicide prevention have not kept pace with the needs of young patients. In 2014, death by suicide among children 10 to 14 years of age surpassed the number of deaths by motor vehicle collisions (MVCs) for the first time.[2] Car safety education and legislation helped reduce death from MVCs, evidence of the impact of comprehensive strategies. Efforts aimed at suicide prevention and the promotion of behavioral health should achieve improved outcomes for this deadly disease as well.

The most recent Youth Risk Behavior Survey, given nationally to students in grades 9 through 12, measured high prevalence for both suicidality and depression, the latter a predisposing risk factor for suicide. In 12 months preceding the survey, 41% of girls and 21% of boys reported feeling sad or hopeless almost every day for at least 2 weeks in a row, 17% self-reported seriously considering suicide, 14% made a suicide plan, and 7.4% attempted suicide.[3] These alarming statistics provide the necessary call to action to improve the care we provide to our patients.

CURRENT CHALLENGES AND OPPORTUNITIES

There are several challenges that must be addressed to improve care for patients with behavioral health needs. First, the stigma that surrounds mental illness can result in silence, shame, and failure to seek help.[4] Second, there is limited access to psychiatric care. This complex problem includes financial and insurance barriers, as well as workforce shortages. According to a 2016 Health Affairs report, more than half of all counties in the US have no psychiatrists.[5] This crisis is reflected in ED use, where visits for mental health complaints between 2001 and 2011 increased from 4.4% to 7.2%.[6] Also, more children and adolescents are being hospitalized for suicidal thoughts or attempts. From 2008 to 2015, youth admissions have more than doubled.[7]

With psychiatric provider shortages, increased screening for mental illness may appear to exacerbate the problem by further taxing healthcare resources. But consider these statistics for those who successfully complete suicide: 77% saw a healthcare provider in the preceding year and 38% in the 4 weeks prior, while only 24% carried a mental health diagnosis in the month prior to death..[8] Under-diagnosing or ignoring this life-threatening disease is not the answer. Early recognition and intervention improves the daily functioning in developing youth, while effective ED screening can save lives.

As ED providers, we have a unique vantage point and understanding of the impact of mental health crises on youth and their families. Our institutions and communities must find solutions to meet the needs of youth through ED screening tools, effective care models, and advocacy for preventions strategies, professional recruitment, and legislation that increases funding for research and access.

RISK FACTORS FOR SUICIDE

Understanding risk factors for suicide helps identify vulnerable patients and informs disposition decisions. Take care when evaluating risk factors, which are much more common in the adolescent patient population that completed suicide. Also, remember that the lack of most risk factors does not mean a child is "safe" from suicide. A summary of these risk factors is provided in Table 1.[9-11] "Fixed" risk factors, or those that a young person is unable to change, include a previous suicide attempt, family history of suicide or suicide attempts, parental mental health problems, male gender, a history of adoption, history of physical or sexual abuse, lesbian, gay, bisexual, or questioning orientation, and transgender identification. Remember that LGBQT youth are five times more likely to die by suicide than their peers.[11]

Risk factors that can predispose a young person to suicide include mental health conditions (including depression, bipolar disorder, psychosis, post-traumatic stress disorder, and anxiety), a history of aggression or impulsivity, sleep disturbances, substance abuse and chemical dependence, access to firearms, chronic medical illness, social isolation, prolonged periods of stress, a recent tragedy or loss, and bullying.[12-15] In recent decades, pathologic Internet use must be considered a risk factor for suicide, as it provides the means for adolescents to search for and find suicide-

TABLE 1. Suicide risk factors. [9,10,12-15]

Immediate risk factors
Agitation
Acute intoxication
Recent stressful life event
Fixed risk factors for suicide
Previous suicide attempt
Parent/guardian with mental health problems
Male gender
History of adoption
History of physical or sexual abuse
Lesbian, gay, bisexual, questioning, transgender identification
Factors that predispose to suicide *
Behavioral health disorders, including depression, bipolar disorder, anxiety disorder, psychosis
History of aggression, severe anger, impulsivity
Chemical dependence, substance abuse
Posttraumatic stress disorder
Pathologic internet use
Sleep disturbances
Chronic medical conditions
Prolonged periods of stress
Recent tragedy or loss
Social isolation
Access to firearms

* Non-suicidal self-injury (NSSI) = (+) risk factor for suicide attempt, but low risk of death.

related topics and groups. Internet use has been shown to correlate with suicidal ideation, and can be another outlet for bullying.[16-18]

MENTAL HEALTH SCREENING OPTIONS

When implementing ED mental health screening, key steps should be undertaken. First is the decision about whom to screen, whether it is applied universally to all patients, regardless of risk factor assessment or presenting complaint, or targeted to a particular "high risk" group. As with our 14-year-old case example, it is impossible to predict suicidality by chief complaint or visual inspection, making universal screening the best practice for detecting and preventing suicide. However, simply asking one question about suicide at a triage entry point is insufficient, especially if it is abrupt, out of context, and in front of parents or adult caregivers.

The next decision is the selection of a particular tool or method of screening. Face-to-face interviews with the patient allow for optimal connection between the patient and provider, who may be a nurse, nurse practitioner, physician assistant, social worker, other mental health professional, or emergency physician. It is important to attempt to speak to the patient alone, as conversations in front of caregivers may result in the withholding of important information and failure to detect those at risk. Some providers and trainees struggle with these sensitive conversations; however, it becomes easier with practice and may be the most important part of the patient's visit.

One step-wise approach is to initiate the conversation by sitting down at the level of the patient and making a general statement, such as "I know it may not be easy to talk to someone you don't know." Explain your role, why the conversation is happening, and what confidentiality means. It is important for clinicians to communicate to the patient that safety takes precedent over confidentiality. It may be helpful to focus first on positive aspects of a patient's life through an open-ended question. For example, "What do you like best about your life?" Specific suicide screening questions are then introduced including, "Have you ever thought about killing yourself or wished you were dead?" Regardless or a yes or no answer, this question should be followed with, "Have you ever done anything on purpose to hurt or kill yourself?" For the teen, thoughts may be disconnected from behavior, so it is important to ask both questions. If either question elicits a positive response, follow-up questions should address specific plans, behaviors, timing, intent, and risk factors.[9] A comprehensive mental health evaluation is not the goal yet, but these questions are essential to assess suicide risk.

Validated screening tools may be chosen instead, and are summarized in Table 2. Some screens focus solely on suicide while others incorporate other mental health concerns and risk factors. Suicide screening tools include the Ask Suicide-Screening Questions (ASQ) and Columbia-Suicide Severity Rating Scale (C-SSRS).[19,20] The ASQ was designed specifically for the ED, but can be used in a variety of clinical settings. It is available in multiple languages and includes four screening questions. The ASQ tool carries a 97% sensitivity rate for suicide detection, and high negative predictive value.[19] The C-SSRS is best done by face-to-face interview, is available in over 100 languages, and has a pediatric version that can be downloaded. The C-SSRS necessitates some training as it includes more detailed questioning on risk assessment, past suicide attempts, and suicidal intent. The level of suicidal intent and a past history of self-injury elicited through the C-SSRS has been shown to predict return visits.[21]

There are a variety of tools that integrate questions about suicidality with other behavioral health concerns. One major advantage is that they meet a broader need: identification of patients with

TABLE 2. Mental health screening tools.[19,20,22-24,26] *

Screening Tool	What	How	Comments
Ask Suicide-Screening Questions (ASQ)	Suicide screening	Interview	Brief, four-question screen
Columbia Suicide-Severity Rating Scale (C-SSRS)	Suicide screening	Interview	Incorporates risk assessment
HEADS-ED	Depression screening Suicide screening	Interview	Broad, psychosocial screen
Patient Health Questionnaire-9 (PHQ-9)	Depression screening	Self-report	Last question validated for suicide risk Can be combined with other suicide screens
Behavioral Health Screen (BHS-ED)	Depression screening Suicide screening	Self-report	Also screens for violence, trauma, substance use, and access to guns

* All screening tools can be integrated into the electronic health record.

unrecognized mental health needs, not just the suicidal teen. While these patients may not require an emergency psychiatric evaluation, the ED provider can still provide behavioral health referrals and connect the family to outpatient resources, potentially preventing future mental health crises.

The HEADS-ED is a screening tool designed for pediatric mental health screening.[22,23] It can be completed online or on paper, and provides sample questions for providers. The Patient Health Questionnaire (PHQ-9) is often used in outpatient primary care settings, but can be used in the ED as well.[24] The PHQ-9 consists of nine questions that screen for depression, but the final question has been validated for the identification of suicide risk in patients.[25] The PHQ-9 can be used alone or combined with a more in-depth suicide screening tool such as the ASQ. The Behavioral Health Screen (BHS-ED) is an electronic screening tool that includes questions about suicidality, depression, violence, traumatic stress, and substance use.[26] Its feasibility and validity have been demonstrated in a children's hospital ED with both high volume and acuity. Patients complete the screen on a computer or tablet, and audio options are available.[27,28]

Finally, implementation of a screening tool necessitates the decision about timing, or when to screen during the ED encounter. In general, screening should take place early in the patient's visit. Standardizing the screening process during triage or shortly thereafter is ideal, but screening can be performed at any time, including during a wait for provider arrival or test results. Some screens involve a clinician directly asking questions, including the ASQ, C-SSRS, and HEADS-ED. The PHQ-9 and BHS-ED are completed by the patient independently, and results are reviewed by a clinician. All screening tools have the potential to be integrated into the electronic health record (EHR).

ADDRESSING POSITIVE SCREENS

Prior to implementing behavioral health and suicide screening, the response to the positive screen must be considered. This planning is best achieved with the assembly of a multidisciplinary team, including emergency providers, nurses, social workers, and other institutional and local mental health professionals. Review current care processes in the context of your hospital's resources as well as individual patient and family needs. One care plan does not work for all, as geographic location, local mental health resources, health insurance coverage, and regulations vary among communities.

When a positive suicide screen is elicited either through face-to-face interaction or a self-reporting tool, proceed with detailed follow-up questions to assess risk. This interview may be conducted by any number of trained clinicians, according to your team's care plan and local hospital resources. Again, attempt to talk with the patient privately, separate from any discussion with a parent or guardian. While performing this evaluation, open-ended questions should be asked to obtain the specifics of suicidal plan(s), timing, intent, behaviors, and exploration of all risk factors, especially prior suicide attempts, recent loss, and past psychiatric history and care.[9] Plans that include high lethality or access to guns place a patient at a higher risk. Patients who are disoriented or whose thought patterns are disordered, or those who express narrow views, limited options, or hopelessness are also at increased risk. This detailed interview also serves to assess the patient's coping skills and resources, support systems, and the attitudes of both the patient

and family toward seeking treatment and follow-up.[29] A lack of family support and stability is critical to the final disposition decision. Additionally, the interview should identify any protective factors in the patient's life, including school engagement, future plans, family support, coping skills, and specific reasons for living.

The patient's disclosures during screening for suicide and depressive symptoms is only one part of the assessment. Information from the parent or guardian should also be obtained for patients expressing suicidality, or for those whose behavior has raised a safety concern. The child may have little insight into his or her actions, and a parent, guardian, household member, or peer may provide vital information. Understanding the parent's concept of mental health, their insight into their child's distress, and their level of support for their child is essential to forming a care plan. Use of texts and social media posts to communicate hopelessness or demonstrate preparatory activity, for example saying goodbye to friends online, may provide critical information to assessing safety and risk of suicide.

If the child is actively suicidal by screening, or the emergency provider has significant safety concerns, proceed with a plan of care in discussion with behavioral health team members for inpatient psychiatric care and/or further comprehensive mental health assessment. This may require transfer to another facility and will necessitate medical clearance and adherence to safety precautions, including continuous observation of the child and removal of dangerous items on the person or in the room. Employ support staff and hospital security staff as needed to maintain the rules of safety for patients, families, and staff. If the patient is confined to a room under in-person or video observation, consider safe activities that engage and distract the patient, including nonclinical conversation with trained hospital volunteers or personnel, movie viewing, pet therapy, or coloring with crayons.

Patients determined to be at lower risk for suicide after screening and assessment should receive the behavioral health resources and close follow-up. Other treatment plans may include a partial hospitalization program (PHP) or intensive outpatient care. "Safety contracts" are also used by some mental health providers. These contracts have not demonstrated utility in effective prevention of suicidal behavior, but they may help in assessment of risk.[30] For example, if an adolescent refuses to contract for safety, i.e. will not agree to not harming themselves or telling someone in their support system about their intent to harm themselves, the teen is at higher risk and may require inpatient placement. Safety contracts also offer the benefit of family involvement and instructions on a stepwise response to rising concerns or immediate action in times of crisis. In all cases, safety must be maximized within the child's environment(s), including removal of firearms, weapons, prescription and over-the-counter medications, and other toxins. Complete removal of firearms is preferable to "safe storage," which includes unloading and locking the gun, with a separate location for ammunition.

With the use of a broader screening tool (e.g., the PHQ-9, HEADS-ED, or BHS-ED), a patient may screen negative for suicide, but positive for depressive symptoms, and should be referred to outpatient services for prompt initiation of care and prevention of future crises. Some patients may be in counseling/mental health treatment already and in some cases continuing the current care is sufficient. However, additional resources or referrals may be required.

Communication with the child's primary care provider (PCP) is essential. Information for the PCP may include the current and past behavioral health concerns, referrals and plan for care, and the family's response and needs. A teen's pediatrician or family physician provides the necessary continuity of care, may assist the family with access to psychiatric care, support ongoing counseling, and provide vital "check-ins" with patients and families after ED discharge.

SCREENING IN ACTION

At the Children's Hospital of Philadelphia (CHOP), the BHS-ED has been used in the ED since 2009. In addition to brief behavioral health screening questions during triage, the BHS-ED is universally given to patients ages 12 to 19 years. The nurse initiates this electronic, self-reporting screen early in the visit, unless the patient is too ill or has a known developmental delay. Other emergency clinicians on the team can request the screen for the patient at any time during the ED visit. This may occur when the provider is out of the room, or while awaiting lab or imaging results. Once completed, the BHS-ED is viewed by the care team in the electronic health record (EHR) through an electronic alert. The screening tool summarizes the scores for depression, suicidality, trauma, and substance abuse on the first page, and answers to each question can be viewed on subsequent pages.

For positive depression and suicide screens, the electronic alert outlines steps to be taken by the clinician, including talking to the patient alone about the screen or further consultation with social work if concerns persist. Patients with positive depression screening without suicidal concerns are given mental health resources. For suicidal patients, psychiatry is consulted to further assess the patient and help with disposition planning. If a patient is

discharged, the emergency provider communicates with the PCP via electronic messaging in the EHR, or by telephone, to ensure assistance for the family with necessary follow-up. It may be weeks before a child has an appointment for the initial mental health visit, making PCP contact imperative.[31] Screening results, actions taken, and follow-up recommendations are documented in the EHR.

Use of the BHS-ED at CHOP has revealed that each month, approximately 33% of screens are positive for severe depression, and 5 to 10% are positive for active suicidality. We learned that the majority of patients with positive depression screens present with non-psychiatric chief complaints, including headache, abdominal pain, and chest pain. Chart review revealed that many of these screen-positive cases had presented to the ED previously with similar complaints, prior to the screening protocol, and mental health issues were never addressed. This information allowed us to better understand our patient population and identify those in need, as well as advocate for additional resources and plan future intervention strategies. Identifying suicidal patients was paramount, but using a screening tool that includes depression, trauma, and substance abuse helped expand our focus to preventive strategies and early referral to mental health resources.

Other EDs have been successful in implementing and managing mental health screens. In busy EDs, screening has been accepted by clinicians and feasible for ED staff without significant impact on patient length of stay.[28,32,33] Studies also reveal successful efforts to intervene with positive suicide or depression screens, including ways promote access to mental health services for patients discharged from the ED.[34-36]

ADDRESSING MYTHS AND BARRIERS

The challenges for creating and implementing ED suicide screening tools are always present, requiring preparation for questions, concerns, and barriers. The following Q&A section identifies barriers and the strategies for success.

Could suicide screening be dangerous?

Some parents and healthcare providers express concern that asking about suicidality provokes suicidal ideation, increasing the teen's risk for planning and completing suicide. There is no data suggesting that inquiring about suicide leads to an increase in suicidal thoughts or dangerous behaviors.[37,38]

What if a parent or guardian will not leave the room during suicide screening?

By normalizing screening and integrating this brief assessment into routine medical care, most parents or guardians will step out of the room to allow for a private interview of their child. Reassure the adult caretaker that if during the interview any concerns about the patient's safety arises, they will be notified. If a parent refuses to leave, proceed with the screen in the presence of the caretaker.

The ED is busy. What if I don't have the time?

Studies have demonstrated the feasibility of routine suicide and/or depression screens in busy ED settings.[28,33] While ED implementation requires time and teamwork, it is important to remember that this clinical setting may be the teen's only contact with a medical provider over the course of a year. We must seize this limited opportunity to identify all at risk. An adolescent patient may present with a nondisplaced fracture, easily splinted and discharged. If that teen screens positive for active suicidal thinking, the ED intervention may have saved his or her life.

What if our ED doesn't have enough staff?

Even the most resource-rich medical settings struggle with creating a perfect process. Initial screening does not require extra staff, however positive screens necessitate involvement of mental health professionals, requiring advanced planning. Some hospitals integrate a mental health professional (nurse, social worker, psychologist, psychiatrist) into the ED process, while others rely on partnerships with community providers or telemedicine-access for comprehensive assessment. For those teens discharged from the ED with further outpatient care recommended, mental health provider shortages in the community should not discourage ED screening.

Social workers and other mental health professionals who provide an ED assessment function may be trained to begin a teen's education in the ED as well, providing strategies for dealing with stressors, panic and anxiety, and friend/family conflict. Also, preprinted information with common strategies that promote mental health and local resources for evaluation and counseling can be available for all patients.

In creating a care model and response plan for positive screens, emergency providers will be better equipped to manage these patients and understand their needs. Quality improvement practices assess the current plan and inform advocacy for future resources. Publication and broad communication of

a successful program, with discussion of the challenges faced and overcome, allow sharing of effective solutions to a daunting problem.

What if staff members aren't comfortable with discussing or managing mental health patients?

Emergency providers and all ED staff must be trained and confident in their skills addressing mental health concerns. Open discussion in the appropriate venue (e.g., team conference or meeting) allows staff members to express discomfort and concern. Consider personal mental health struggles among staff and reach out to offer support. Behavioral health professionals, e.g. local psychologists or psychiatrists, may be recruited to provide essential training and feedback, including in-person conferences, simulated cases, or online learning modules.

What about the ED burden of patients "boarding" while awaiting inpatient psychiatric placement?

If patients are identified as needing inpatient psychiatric care and no beds are available, patients may have to board in the ED to continue safe observation. The burden and stress of this boarding is felt by ED staff, a patient's caretaker or family, and the patient, often trapped in a windowless room. Initiating a hospital- and community-wide discussion about this issue is essential for effective problem solving. Workforce issues in the field of child and adolescent psychiatry clearly challenge the provision of timely care for all, but mobilization of alternative resources, engagement with other inpatient teams, collaboration with community mental health partners, and creative solutions like "telepsychiatry" access, may provide alternate solutions. The suicidal patient's safety is paramount, so access to mental health services in a timely fashion must be the goal not only for the ED team, but hospital administration, local public health departments, and all community partners invested in mental health among youth.

SUMMARY

The ED has functioned as a safety net for patients for decades. Every day, emergency providers identify suicidal teens, as well as many with unmet behavioral health needs. Despite barriers, emergency providers and hospital-based mental health professionals evaluate and provide access to care for these patients. This requires effective screening tools, planned care models, staff recruitment and education, advocacy for resources, and a proactive approach toward achieving mental health for our young patients. Integrating screening in ED settings has promoted research and advocacy, informing policymakers on the true burden of mental illness within society. With the emergency department on the frontline of adolescent mental health, our patients need us more than ever.

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