Mitigating Suicide Risk in Young Patients: Urgent Care's Role in Identifying Patients At-Risk And Saving Lives

Jeanne Marconi, MD

Over the past 20 years, and more recently throughout the pandemic, suicide rates in the United States have generally been increasing; this has been especially true among adolescents and young adults.[1] Despite improvements in recognition and appreciation of the impact of mental health issues, suicide rates continue to climb in America. Healthcare centers, whether inpatient or outpatient, have the unique opportunity to identify patients at-risk for self-harm and to intervene. These opportunities can occur wherever patients seek care with the use of appropriate tools. Given the number of urgent care (UC) centers in the United States and continuously increasing patient volumes, we are well situated to serve patients in reducing suicide risk within the larger medical community.

Concerning Trends in Suicide Rates Among Youth in America

The current trends in suicides among younger patients are worrisome. Suicide is now the second leading cause of death in youth aged 10-24 years and the eighth leading cause of death in children 5-10 years of age.[2] The rates of childhood mental health concerns and suicide have been rising steadily for more than a decade.[2]

In 2021, the American Academy of Child and Adolescent Psychiatry declared a national emergency in children's mental health related to the issue of increasing suicide rates in this demographic. In 2022, the American Academy of Pediatrics recommended regular suicide screening for all children 12 years and older and when clinically indicated for children younger than 12.[3] Despite these recommendations, suicide screening among this age group is still not commonplace in non-mental health and/or specialty care settings. The problem is compounded by the nationwide shortage of behavioral health services for children, which means that many at-risk children will have limited or no contact with these specialists.

For the UC industry, which serves as a touch point for episodic care, it is now critical to fill the screening gap we are experiencing and support the care for young patients with acute mental health crises and risk for suicide.

Guidance for Suicide Risk Assessment

In 2016, the Joint Commission released an updated sentinel event alert on suicide prevention, advising all inpatient and outpatient healthcare settings to improve their ability to detect suicidality and assure care for at-risk patients. While the 2023 update to the document does not issue any requirement for suicide screening in non-behavioral health settings, the recommendation to perform suicide risk screening was confirmed.[4] Since these recommendations are advisory and not mandatory, considerable variation exists on how healthcare centers approach the process of suicide risk screening.

Clinicians commonly cite concerns about inadvertently increasing suicide risk as their reason for avoiding questions regarding suicidal thoughts. However, this consideration has been thoroughly studied and is not supported by the available evidence.[5]

The feasibility of screening for suicide has also been well studied in behavioral health centers, emergency departments (ED) and primary care settings. As such,

Jeanne Marconi, MD, Vice President, Clinical Integration, PM Pediatric Care

standardized tools have been developed and validated which are brief, easy to interpret, and have favorable sensitivity and specificity; these tools are ideal for use in an UC practice.

"Clinicians may be reluctant to use the tool due to time constraints, but our experience has shown the tool does not decrease UC efficiency."

We have seen significant changes in suicide screening over the past decade. With the improvements and move toward measurement-based care, new screening tools have been developed and validated for standardization. Two of the most commonly utilized tools for suicide screening in youth are the Ask Suicide Questions (ASQ)[6] and the Columbia-Suicide Severity rating Scale (CSSR).[7] Both tool kits are found online at no cost and are very easy to teach and use. The ASQ only takes about 20 seconds to complete, while the CSSR is a bit more involved and generally will take 5 minutes to complete.[8] The commonly used depression screening tool, Patient Health Questionnaire-9, is not strictly a suicide risk tool and importantly is less reliable in youth than adults.[9]

Early intervention through screening has proven paramount. As many as 60% of youth who commit suicide have visited a provider in the 30 days prior to the event,[10] and 90% of parents of youth who commit suicide were unaware that their child was struggling.[11] Clinicians, therefore, have an opportunity to identify youth at risk for suicide. Screening at annual well visits is important, but many of these tragedies occur between health maintenance visits.

Our Suicide Screening Experience

In our organization, we have invested in mental health screening as a critical initiative in the care of children by implementing universal ASQ screening for suicide in patients 11 years and up. Our organization, PM Pediatric Care, is the largest pediatric-specific UC network in the United States with 79 locations and a virtual telehealth network covering 17 states. Recognizing the growing epidemic of mental health challenges among children, this initiative has allowed our UC centers to transcend the traditional acute care model and offer a public health service in an attempt to curb the alarming growing rate of mental health issues facing America's youth. The screening takes less than 30 seconds to complete and has been shown to have a sensitivity of 96.9% and a specificity of 87.6% for detecting youth at risk for suicide.[8]

Many UC clinicians have expressed concerns about large numbers of positive results and the challenges that may ensue in caring for and/or referring these cases. In reviewing our initial data for quality purposes, however, we've found that our results mirror that of another published study with a similar sample size by Patel et al., finding approximately 4% of patients screening positive. Importantly, less than 1% of those who screened positive in the Patel study had a mental health complaint.[12] After identification, safety, and treatment plans were initiated with these patients, they received information and were referred back to the medical home. About half of those who screened positive required immediate referral to higher level of care, and the others were sent home with close supervision and a safety plan.[12]

Implementation

Suicide-risk-screening training for clinicians and staff is straightforward, as the ASQ screen is validated and easy to interpret. What will likely be unique to each practice are the requisite workflows for educating parents as well as how to administer and score the tool and determine referral options in the community. Based on my experience leading this initiative in our organization, the two most critical steps I've found to getting suicide screening into practice are:

1. Identifying a champion in the practice to ensure a smooth and efficient process rollout and who will maintain accountability for implementation and ongoing oversight.
2. Partnering with community resources and knowing which EDs have services that can support pediatric behavioral health for those who need further evaluation and/or inpatient treatment.

Clinicians may be reluctant to use the tool due to time constraints, but our experience has shown the tool does not decrease UC efficiency when implemented. One patient who came in for a COVID-19 vaccine was screened per our protocol. He screened positive, and further questioning revealed that he had an active suicide plan to hang himself that evening. He had even prepared the noose. Another patient who had been following with a psychiatrist had a positive

screen and noted she had been having suicidal thoughts for some time. She divulged that her psychiatrist had not asked about suicidality for a number of visits. These are examples of inappropriate and common assumptions that minor visits don't have anything serious to consider or that another clinician will screen for suicide risk.

The ASQ tool can be completed by the patient on paper forms, wipe off laminated form, or directly into the electronic medical record (EMR), in some cases. We have used a vendor that can send the screening questionnaire via text message. After completion, the questionnaire is automatically scored and returned to the clinician. The results are then recorded in the EMR as part of the visit note.

"Meanwhile, the benefits of suicide screening far outweigh these hypothetical drawbacks"

As part of monitoring this initiative, we looked closely at how implementing such screening may affect workflow by asking our providers to document the amount of additional time spent when encountering a positive screen. We found that even with a positive screen, it took providers less than 6 minutes to complete an additional mental health evaluation and necessary safety planning or referral to the ED. Parents have not been resistant to this screening, and we experienced less than a 10% refusal rate. When collecting feedback from staff about how long it took to offer the screen and input the results in the chart, they reported that it didn't require much time or interfere with the daily workflow.

From personal experience, we found the biggest hurdle to implementing suicide screening in our centers to be clinical staff buy-in, owing to discomfort and worry about potential parent/caregiver questions. Once our staff realized that most parents were used to these screenings in primary care visits, this resistance seemed to wane. As with any new quality initiative, creating specific workflows and getting staff trained took some time and support from our clinical leaders. However, today this is now accepted as standard practice in our organization.

Conclusion

In UC, we have an opportunity when young patients present to our centers to mitigate the vast unmet behavioral health needs of this demographic. With any change, resistance is to be expected. Yet, the concerns expressed by our staff for how suicide risk screening would decrease flow and add untenable amounts of extra work have not been realized. Meanwhile, the benefits of suicide screening far outweigh these hypothetical drawbacks.

Whether we previously have appreciated it or not, in UC, we find ourselves on the frontlines of the mental health crisis of America's youth. We've shown through implementation of suicide risk screening in our centers, that this is not only achievable in UC, but lives have been saved and tragedies averted. ■

References

1. Garnett MF, Curtin SC. Suicide Mortality in the United States, 2001–2021. NCHS Data Brief. 2023;(464). Hyattsville, MD: National Center for Health Statistics, Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/products/databriefs/db464.htm. Accessed February 20, 2024.
2. Centers for Disease Control and Prevention. Facts about Suicide. Centers for Disease Control and Prevention, 8 May 2023, www.cdc.gov/suicide/facts/index.html. Accessed February 20, 2024.
3. American Academy of Pediatrics. Screening for Suicide Risk in Clinical Practice. American Academy of Pediatrics. https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/screening-for-suicide-risk-in-clinical-practice. Accessed February 20, 2024.
4. The Joint Commission. Ligature And/or Suicide Risk Reduction - Screening Requirements. May 7, 2019. www.jointcommission.org/standards/standard-faqs/critical-access-hospital/national-patient-safety-goals-npsg/000002240/. Accessed February 20, 2024
5. Dazzi, T., Gribble, R. Wessely, S. & fear, N. (2014). Does asking about suicide and related behaviors induce suicidal ideation? What is the evidence? Psychological Medicine, 44(16) 3361-3363. Doi: 10.1017/S00332917 14001299.
6. National Institute of Mental Health. Ask Suicide-Screening Questions (ASQ) Toolkit. National Institute of Mental Health; 2022. https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials. Accessed February 20, 2024.
7. Salvi J. Calculated Decisions: Columbia-Suicide Severity Rating Scale (C-SSRS). *Emerg Med Pract.* 2019 Mar 19;21(5):CD3-4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7974826/. Accessed February 20, 2024.
8. Horowitz LM, et al. Ask Suicide-Screening Questions (ASQ). *Arch Pediatr Adolesc Med*. 2012 Dec 1;166(12):1170. https://jamanetwork.com/journals/jamapediatrics/fullarticle/1363508. doi:10.1001/archpediatrics.2012.1276. Accessed February 20, 2024.
9. Ford J, et al. Use of the Patient Health Questionnaire (PHQ-9) in Practice: Interactions between Patients and Physicians. *Qual Health Res.* 2020 Jun 20;30(13):2146–2159. https://journals.sagepub.com/doi/full/10.1177/1049732320924625. Accessed February 20, 2024.
10. Rhodes AE, Khan S, Boyle MH, et al. Sex Differences in Suicides among Children and Youth: The Potential Impact of Help-Seeking Behaviour. *The Canadian Journal of Psychiatry.* 2013;58(5):274-282. doi:10.1177/07067 4371305800504
11. Curtin SC. State suicide rates among adolescents and young adults aged 10–24: United States, 2000–2018. NCHS Data Brief. 2020;(362):1-8. Accessed February 20, 2024.
12. Patel A, et al. Universal Adolescent Suicide Screening in a Pediatric Urgent Care Center. *Arch Suicide Res.* 2017 Apr 7;22(1):118–127. https://www.tandfonline.com/doi/abs/10.1080/13811118.2017.1304303. Accessed February 20, 2024.