

SUICIDE ASSESSMENT DURING PRIMARY CARE VISITS

PCC USERS CONFERENCE 2021

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Goals and Objectives

- **Examine** the prevalence of mental health disorders and why screen for suicide in youth
- **Outline** the common mental/behavioral health issues affecting youth
- **Learn** how the COVID-19 pandemic has exacerbated the problem
- **Explore** how pediatric practitioners during acute visits can look for clues for mental health disorders especially suicide and why it is so important
- **Introduce** a suicide screening tool (ASQ) for use during visits other than well care
- **Determine** what to do with a positive screen
- **Evaluate** how we can improve

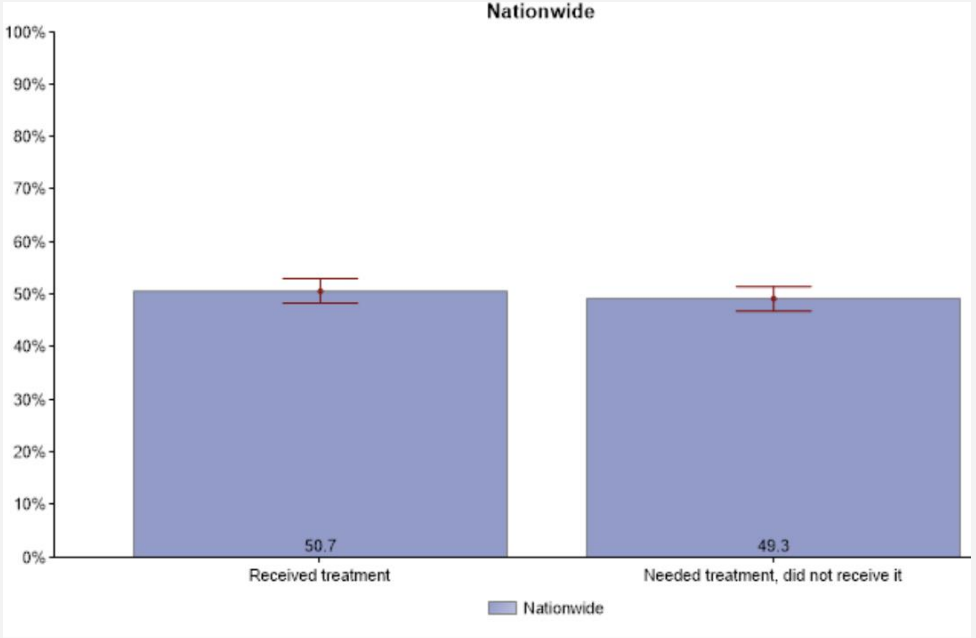
Prevalence of Mental/Behavioral Disorders in US

- 1 in 5 children/adolescents aged 9-17 years have been diagnosed with a mental health issue
- 1 in 6 children aged 2–8 years had a diagnosed mental, behavioral, or developmental disorder
    - 9% of children aged 2-17 years (~6 million) have received an ADHD diagnosis
    - 7% of children aged 3-17 years (~4 million) have a diagnosed behavior problem
    - 7% of children aged 3-17 years (~4 million) have diagnosed anxiety
    - 3% of children aged 3-17 years (~2 million) have diagnosed depression

https://www.cdc.gov/childrensmentalhealth/data.html

How Many Kids Are Going Without Treatment?

Percent of Children with a Mental/Behavioral Condition Who Do Not Receive Treatment or Counseling



Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 8/25/20 from [www.childhealthdata.org].

Wait Times to Access Care

- Adult study; (Boston, Houston, Chicago)

  -The mean ± SD number of days until the first available appointment was 25 ± 22 days (range 0–93 days), and this did not differ significantly across city or payment type.

Malowney, M. “Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three US Cities” Jan 2015

- Pediatric study (NY State)

  -Wait times were varied by season and region

  -Wait times for psychiatry appointments were significantly longer in the spring than in the summer (50 vs.37 days)

  -Wait times for therapy appointments were significantly shorter in community clinics than hospital clinics (19 days vs.35 days).

Olin SC, O'Connor BC, Storfer-Isser A, et al. Access to Care for Youth in a State Mental Health System: A Simulated Patient Approach. *J Am Acad Child Adolesc Psychiatry*. 2016;55(5):392-399. doi:10.1016/j.jaac.2016.02.014

Effects of Non-Treatment

The following can be directly affected by lack of treatment or early intervention:

- Disease worsening
- Suicide
- Worsening Overall Health and Well-Being
- Poorer School Performance
- Increased strain on Child Welfare System
- Expanded Juvenile Justice System
- Increased Burden on Public Education
- Decreased Lifelong Productivity and Success

Challenges for Children to Receive Behavioral Health Services

A fragmented system

- Stigma of mental health disorders
- Lack of medical home and its' ability to identify and treat mild to moderate conditions
- Lack of appropriate payment for this care

- Poor coordination and assistance navigating this care
- Lack of early and effective treatments in children
- Lack of training by pediatricians and lack of recognition of resources as well as the appropriate infrastructure to manage and sustain services needed

What Happens to These Children?

- **Often come to the surface in a crisis**
- Often end up in emergency rooms - not well trained to identify and manage resources needed
- Often escalate in schools and other environments leading to shame, blame and potential suspension, truancy and criminal activities
- Fragmentally treated and never to a stable baseline
- They grow up and become dysfunctional adults adding to socioeconomic burden to the system as well as not being a productive and contributing member to society
- Should they develop adult disease those disease outcomes are hindered almost 50% by mental health disorders

Why Is This Critical Now ?

- **Mental Health rates in children now exceed trauma, respiratory, and infectious illness**
- **Many states have declared states of emergency for pediatric behavioral health latest are Colorado and Connecticut**
- The cost for this care continues to escalate and requires earlier, more comprehensive and collaborative care
- The unintended consequences of Covid-19 have yet to be identified and we already have an overwhelmed dysfunctional system
- Cost figures for the most common pediatric conditions:
  - 14 Billion Mental Health
  - 8 Billion Trauma
  - 8 Billion Respiratory Illness
  - 2.5 Billion Infectious Disease

Most Common Disorders in Children

ADD

-

Anxiety

Depression

-

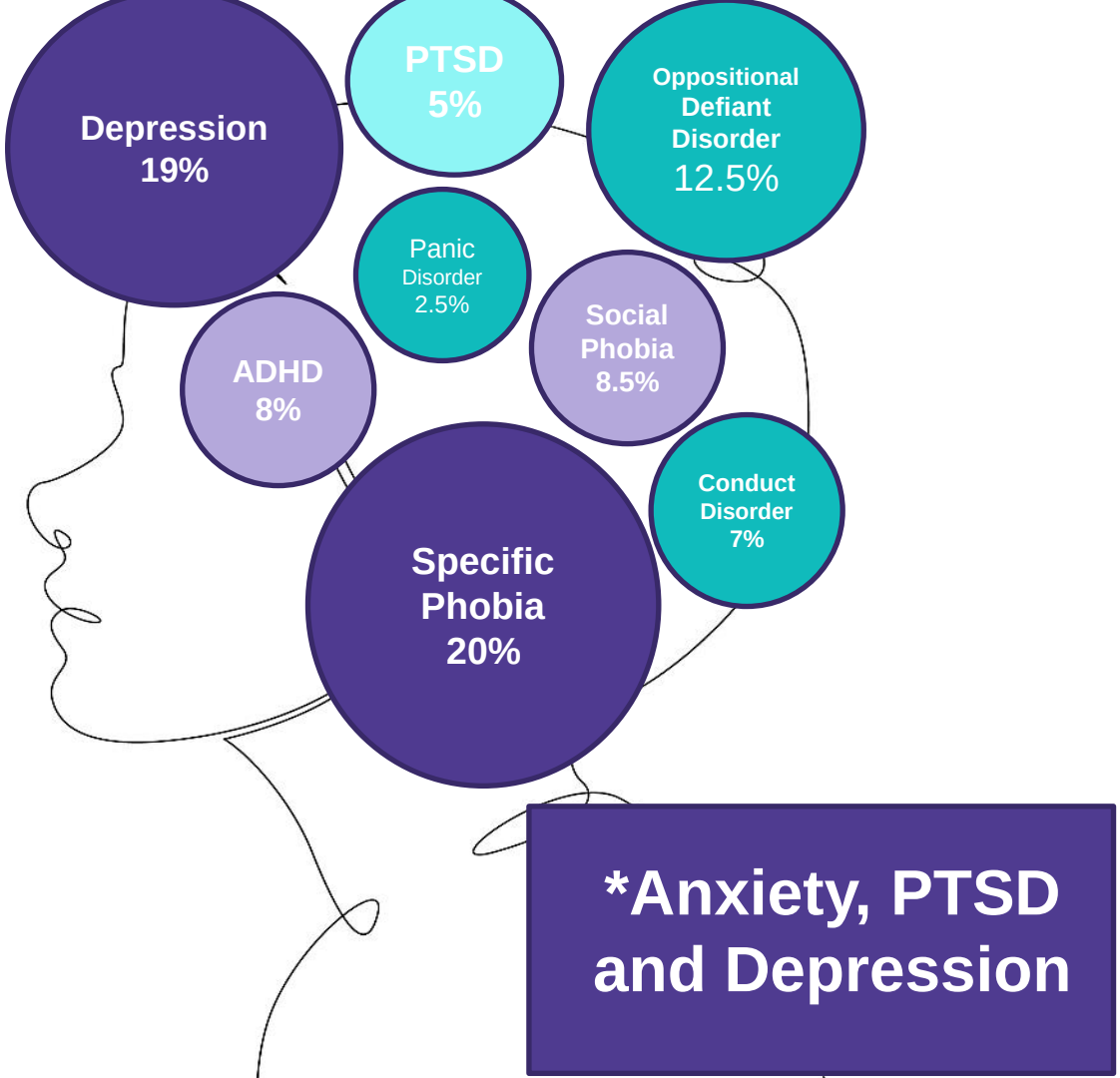
Conduct Disorders

Autism Spectrum Disorders

-

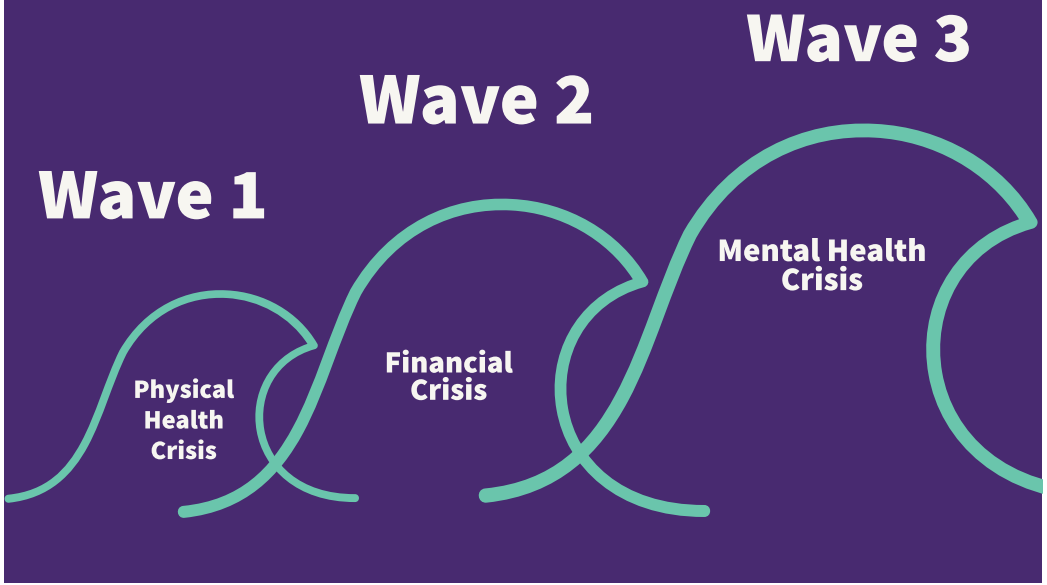
Tourette's Syndrome

How Has COVID-19 Affected Mental Health?



Prevalence of Behavioral and Mental Health Diagnoses up to Age 18

Next Wave of the Pandemic: Mental Health



Next Wave of Pandemic: Predicted Increase in Mental Health Needs Extends to Pediatric Patients

- Behavioral health needs are escalating due to many issues related to COVID-19
  - May continue 3-5 years !
  - Family stress and loss
    - Lost jobs, financial difficulties, food insecurity
  - Social isolation
  - Uncertainty about the future

Next Wave of Pandemic: Predicted Increase in Mental Health Needs Extends to Pediatric Patients

Wuhan survey of 1784 students, grades 2-6

- **Depression and anxiety increased significantly**
- 23% of students reported depressive symptoms (compared to a similar study pre-pandemic rate 17%)
- 19% of students reports anxiety-related symptoms (compared to similar study pre-pandemic rate of 9%)
- Similar studies from SARS 2003 epidemic showed severe psychological symptoms in students in months following the epidemic

Xie X, Xue Q, Zhou Y, et al. Mental Health Status Among Children in Home Confinement During the Coronavirus Disease 2019 Outbreak in Hubei Province, China. *JAMA Pediatr*. Published online April 24, 2020. doi:10.1001/jamapediatrics.2020.1619

Mental Health Related ED Visits Increased Post-Pandemic

- Study examined children <18 y from the CDC's National Syndromic Surveillance Program
  - **Mid-March through mid-October of 2020, proportion of ED visits for mental health ↑↑ 44%.**
  - About 1,673/100,000 visits were for mental health during that period in 2020 compared to 1,161/100,000 visits in 2019
- Adolescents ages 12-17 made up the largest proportion of ED visits for mental health.
  - Their proportion of ED visits for mental health was 31% higher in 2020 compared to 2019
- For children ages 5-11 years, the proportion of mental health visits was up 24%

What Can Be Done at an Acute Care Visit?

Seize Opportunity

Check in and ask how youth are doing

Engage Your Patients

Assess for stressors

Assess for co-morbidities with chronic illnesses

Assess for challenges they might be having that may not be related to their chief complaint

Create

Create your own brief review of systems for how they are doing

What Can Be Done at an Acute Care Visit?

Familiarize Yourself

What are some local resources which you can provide to your patient?

Recognize Timing

Most children we are speaking of see their PCP once a year for screenings and often are seen not by others for visits in-between

Yes…

this can be done quickly!

Clues During Visits for Mental Health Signs and Symptoms

- **Observe**
  - Communication, eye contact and voice
  - Psychomotor function

- **Classic emotions** that are recognized and expressed* by most cultures
  - Fear
  - Disgust
  - Anger
  - Happiness
  - Sadness

**Masks limit these observations*

Pell, M.D., Monetta, L., Paulmann, S. *et al.* Recognizing Emotions in a Foreign Language. *J Nonverbal Behav* **33,** 107–120 (2009). https://doi.org/10.1007/s10919-008-0065-7

Somatic Complaints

- Studies have investigated prevalence of psychiatric conditions and unexplained medical symptoms
- Emiroglu et al looked at 31 patients with neurologic symptoms (vertigo, headache, syncope) referred to pediatric neurology with testing showing no identifiable source
  - **93.5% were found to have a diagnosable mental health disorder**
- Tunaoglu et al looked at pediatric patients in a cardiology clinic for chest pain with normal medical workups
  - **Prevalence of psychiatric disorders in 74% of patients**
  - Primarily anxiety, depression and somatic symptom related disorder

How Can We Get The Most Out Of Our Time?

DO

Be as attentive and undistracted as possible

Display interest with nodding and eye contact

Maintain an open body position (avoid crossing arms)

DO

Sit down, even if the patient is standing

Be sensitive; ask direct questions

DON’T

Use defensive body language

Hesitate to ask more questions

Youth Suicide in the US

Youth Suicide in the US

Second leading cause of death 10-24 years

Tenth leading cause of death 5-10 years and has increased by 55% this year

ER’s are overburdened with mental health this year - biggest increase in 6-11 years

Suicide Statistics

- Prior to COVID, the national suicide rate among persons aged 10-24 increased 57.4%*
- 2019 Youth Risk Behavior Survey (YRBS) results indicate that in the 12 months prior**
  - **18.8% of students reported seriously considered attempting suicide**
  - **15.7% of students had made a plan about how they would attempt suicide**
  - **8.9% had attempted suicide ≥1 time**

*ClickCurtin, Sally. State Suicide Rates Among Adolescents and Young Adults Aged 10-24: United States 2000-2018. National Vital Statistics Reports; Volume 69, Number 11

** Ivey-Stephenson et al. (2020). Suicidal ideation and behaviors among high school students – Youth risk behavior survey, United States, 2019. MMWR Supplements, 69(1), 47-55. doi: 10.15585/mmwr.su6901a6

Suicidality

- Even prior to COVID, the national suicide rate among persons aged 10-24 increased 57.4%
- A huge increase this year in the 5-11 age group

- **40% of kids who commit suicide have never had a mental health complaint**

- **90% of parents had no idea their child was suffering to this extent**

- **80 % of kids who commit suicide have visited health care providers and more than half saw someone in the week or two prior**

Curtin, Sally. State Suicide Rates Among Adolescents and Young Adults Aged 10-24: United States 2000-2018. National Vital Statistics Reports; Volume 69, Number 11

Health Visits May Provide Opportunity for Suicide Prevention

- NIMH funded study looked at 22,387 individuals who attempted suicide between 2009 and 2011
  - **38% of patients had a healthcare visit within a week before attempting suicide**
  - **64 % of patients had a healthcare visit within a month before attempting suicide**
  - **95% of patients had a healthcare visit within a year before attempting suicide**

- 2013 retrospective study looked at 724 patients in Ontario who committed suicide between 2003 and 2007
  - Found 80% had presented to a healthcare setting in the month prior

J Psychiatry2013 May;58(5):274-82.doi: 10.1177/070674371305800504

Brian K. Ahmedani, et alRacial/Ethnic Differences in Health Care Visits Made Before Suicide Attempt Across the United States. *Medical Care*, 2015; 53 (5)

‘Their Tank Is Empty’: Children’s Hospital Colorado Declares A State Of Emergency Over Kids’ Mental Health

Children’s Hospital Colorado declares mental health state of emergency as suicide attempts rise

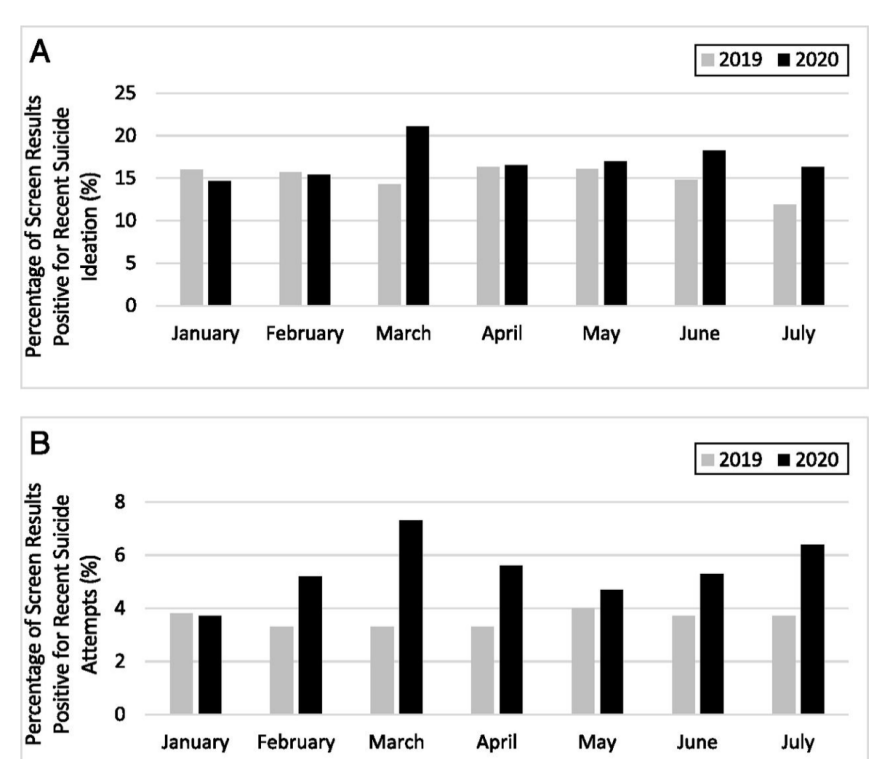
Suicide attempts are rising and emergency room visits for mental health crises were up 90% last month. Mental health experts are asking for help.

COVID Impact on Suicidality

- Study: Frequency of suicide-related behaviors during the 2020 COVID-19 pandemic compared to 2019
- Rates of positive suicide-risk screen results from January to July 2020 compared to corresponding rates January to July 2019
- Results
  - ↑↑ **rate of suicide ideation** March & July 2020
  - ↑↑ **rates of suicide attempts** in February, March, April, and July 2020 as compared with the same months in 2019

Ryan M. Hill et al Pediatrics March 2021, 147 (3) e2020029280; DOI: https://doi.org/10.1542/peds.2020-029280

COVID Impact on Suicidality



Ryan M. Hill et al Pediatrics March 2021, 147 (3) e2020029280; DOI: https://doi.org/10.1542/peds.2020-029280

Risk Factors for Suicide

- Prior Suicide Attempt
- Family History
- Sexual Orientation
- History of Depression
- Impulsivity, Aggression
- History of Abuse
- Substance Abuse
- Medical Illness
- Bullying, Cyberbullying
- Other psychiatric illnesses

healthychildren.org (aap)

Health Visits Provide Opportunity for Suicide Prevention

- NIMH study: 22,387 individuals who attempted suicide between 2009 and 2011
  - 38% had healthcare visit <1 week before attempting suicide
  - 64% had healthcare visit <1 month before attempting suicide
  - 95% had healthcare visit <1 year before attempting suicide
- 2013 retrospective study: 724 patients in Ontario who committed suicide between 2003 and 2007
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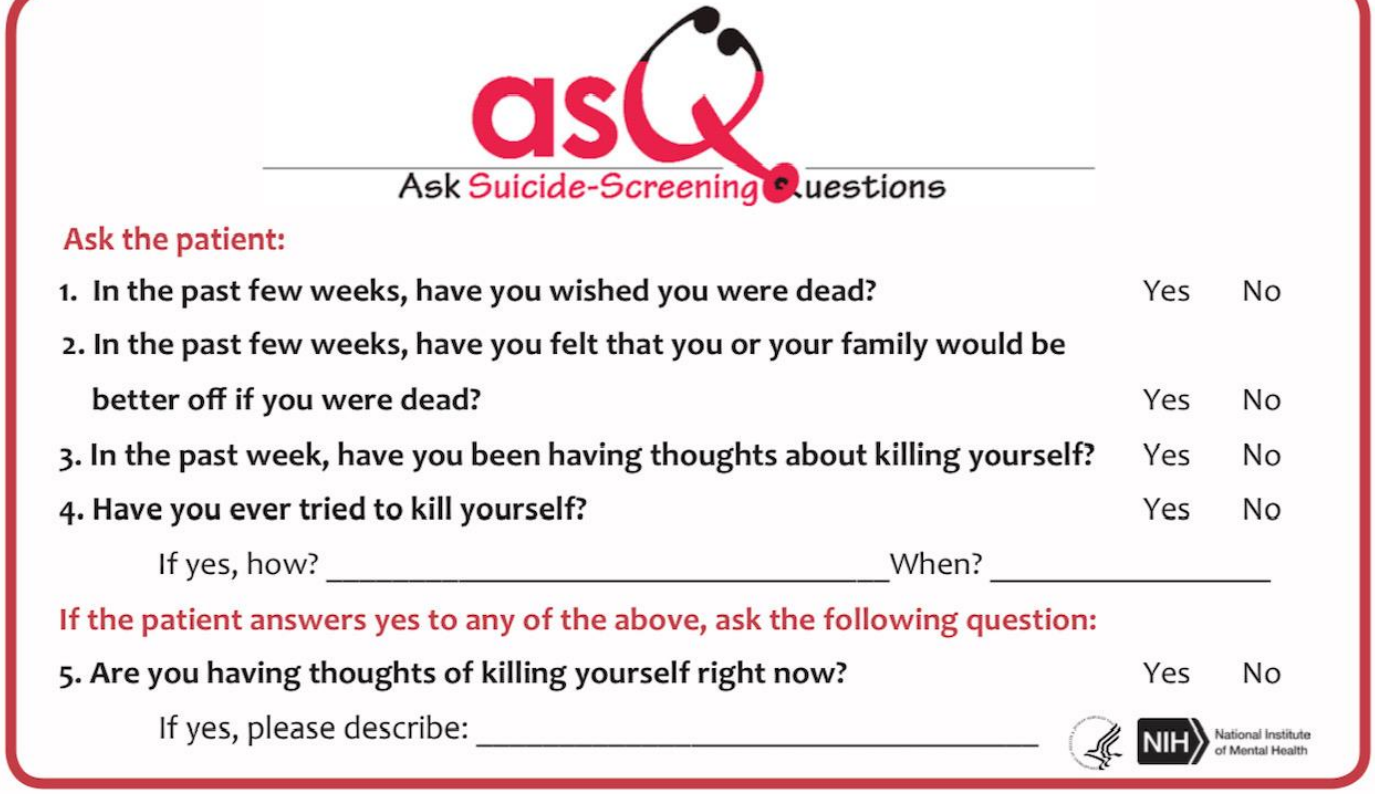
Emergency Department/Pediatric Urgent Care Screenings

- 4,786 patients screened, **95 (2%) positive screen**
  - Of these, 75 (79%) also had a positive C-SSRS
- Of positives, only 7 (7%) had chief complaints related to mental health
- **Did not significantly affect flow ,** able to detect patients at risk of suicide, especially those with chief complaints unrelated to mental health
  - ASQ **< 20 seconds to administer**

Patel, A., Watts, C., Shiddell, S., Couch, K., Smith, A. M., Moran, M. J., & Conners, G. P. (2018). Universal adolescent suicide screening in a pediatric urgent care center. Archive of Suicide Research, 22, 118-127. doi: 10.1080/13811118.2017.1304303

Screening

Initial ASQ Screen:	Brief Suicide Safety Assessment:	Full Mental Health Evaluation:
20 seconds	**10 min**	**30 min**



For description of study:
*Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P, Pao M. Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176.

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

Interpreting Results of Screen

Questions 1-4 All No	Questions 1-4 Any Yes	Question 5 Acuity of Risk
Negative Screen	**Positive Screen**	**Yes: Acute Positive Screen** **No: Non-Acute Positive Screen**

Brief Suicide Safety Assessment

1.Praise Patient

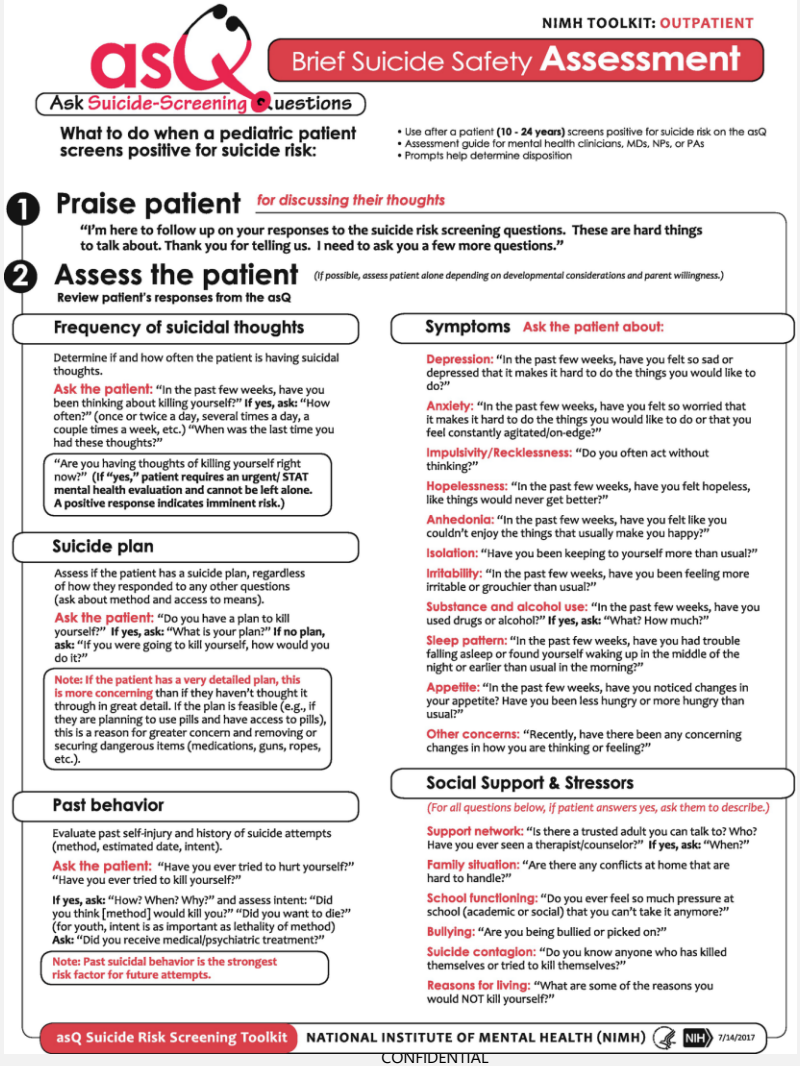
2. Assess Patient

3. Interview Patient and Parent

4. Make a Safety Plan

5. Determine Disposition

6. Provide Resource Lists



NIMH TOOLKIT: OUTPATIENT

asQ Brief Suicide Safety Assessment

Ask Suicide-Screening Questions

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

- Use after a patient **(10 - 24 years)** screens positive for suicide risk on the asQ
- Assessment guide for mental health clinicians, MDs, NPs, or PAs
- Prompts help determine disposition

1 Praise patient *for discussing their thoughts*

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

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

Review patient's responses from the asQ

Frequency of suicidal thoughts

Determine if and how often the patient is having suicidal thoughts.

Ask the patient: "In the past few weeks, have you been thinking about killing yourself?" **If yes, ask:** "How often?" (once or twice a day, several times a day, a couple times a week, etc.) "When was the last time you had these thoughts?"

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

Suicide plan

Assess if the patient has a suicide plan, regardless of how they responded to any other questions (ask about method and access to means).

Ask the patient: "Do you have a plan to kill yourself?" **If yes, ask:** "What is your plan?" **If no plan, ask:** "If you were going to kill yourself, how would you do it?"

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

Past behavior

Evaluate past self-injury and history of suicide attempts (method, estimated date, intent).

Ask the patient: "Have you ever tried to hurt yourself?" "Have you ever tried to kill yourself?"

If yes, ask: "How? When? Why?" and assess intent: "Did you think [method] would kill you?" "Did you want to die?" (for youth, intent is as important as lethality of method) **Ask:** "Did you receive medical/psychiatric treatment?"

Note: Past suicidal behavior is the strongest risk factor for future attempts.

Symptoms Ask the patient about:

Depression: "In the past few weeks, have you felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety: "In the past few weeks, have you felt so worried that it makes it hard to do the things you would like to do or that you feel constantly agitated/on-edge?"

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

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

Anhedonia: "In the past few weeks, have you felt like you couldn't enjoy the things that usually make you happy?"

Isolation: "Have you been keeping to yourself more than usual?"

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

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

Sleep pattern: "In the past few weeks, have you had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the morning?"

Appetite: "In the past few weeks, have you noticed changes in your appetite? Have you been less hungry or more hungry than usual?"

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

Social Support & Stressors

(For all questions below, if patient answers yes, ask them to describe.)

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

Family situation: "Are there any conflicts at home that are hard to handle?"

School functioning: "Do you ever feel so much pressure at school (academic or social) that you can't take it anymore?"

Bullying: "Are you being bullied or picked on?"

Suicide contagion: "Do you know anyone who has killed themselves or tried to kill themselves?"

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

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/14/2017

https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml

Safety Plan

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

CONFIDENTIAL

https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

What To Do In A Crisis

What to Do in a Crisis

- Involve the patient's parents and PCP if feasible
- INVOLVE the patient
- Disposition should depend on:
  - Does the patient demonstrate imminent and substantial danger to themselves or others?
  - What is the most appropriate level of care?
  - Parent's ability to provide adequate care of the child after assessment
  - Parent's need to be able to protect the child from the environment her/she is living in as well as follow disposition recommendations
- Advice to parents (usually would be in consultation with a psychiatrist):
  - Preparing the patient for discharge to home
    - Remove weapons, guns, ammunition, ropes from home
    - Secure medications in a locked cabinet
    - 1:1 supervision

American Academy of Pediatrics, Mental Health Toolkit

How to Implement This in Your Practice

- ASQ has a handout for parents explaining why we are doing the screening
- Parents may need to step out just like during well care
- The patient may fill it out or you can ask the simple questions yourself
- The screen takes 20 seconds
- Will a positive screen interrupt flow?
  - Yes, just like an asthma visit might or stitches or any other lengthy visit
- There will be everlasting reward to you if you even avert 1 crisis

Mental Health Crisis Team

For example, nyc.gov

Request team; can perform assessment, crisis intervention, supportive counseling, information/referrals; transport to the ED

National Suicide Prevention Hotline

1-800-273-TALK (8255); 24 hours a day

Crisis Text Line

Text HOME to 741-741

The Trevor Project

Call 1-866-488-7386 or text START to 678-678

24-hour phone hotline, as well as 24-hour webchat and text options, for lesbian, gay, bisexual, transgender and questioning youth

www.thetrevorproject.org/get-help-now

Resources on Hand

- Create a directory of mental health referral providers for your practice

- Understand the crisis response in your community
  - Mobile mental health crisis teams in the community
    - May respond to offices, schools, homes
    - PALS in academic centers for help

- Have emergency hotline resources available, the new 911 for suicide is 988 by 2022

- List of hospitals that have psychiatric floors/consultation

Summary

Summary

Mental health issues are on the rise, and this trend will continue for the foreseeable future

More patients with mental health needs may present to you but may not be apparent

Look for signs and symptoms

Develop a how are you doing approach in your practice specifically aimed at these possibilities

If you do not have behavioral health in your practice align closely with community colleagues

Schools will be burdened once reopened be prepared to assist them

A quick 4 question screen can effectively screen for suicidal ideation in less than 20 seconds

Know the resources available to you to keep your patients safe

Educate parents to be more aware and encourage them to have conversations with their children about how they are doing

Thank You

References

1. https://www.cdc.gov/childrensmentalhealth/data.html
2. Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved 8/25/20 from [www.childhealthdata.org].
3. Malowney, M. "Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three US Cities" Jan 2015
4. Olin SC, O'Connor BC, Storfer-Isser A, et al. Access to Care for Youth in a State Mental Health System: A Simulated Patient Approach. *J Am Acad Child Adolesc Psychiatry*. 2016;55(5):392-399. doi:10.1016/j.jaac.2016.02.014
5. Xie X, Xue Q, Zhou Y, et al. Mental Health Status Among Children in Home Confinement During the Coronavirus Disease 2019 Outbreak in Hubei Province, China. *JAMA Pediatr.* Published online April 24, 2020. doi:10.1001/jamapediatrics.2020.1619
6. Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external icon.
7. *JAMA Pediatr.* 2020;174(9):898-900. doi:10.1001/jamapediatrics.2020.1619

References

8. Pell, M.D., Monetta, L., Paulmann, S. *et al.* Recognizing Emotions in a Foreign Language. *J Nonverbal Behav* **33,** 107–120 (2009). https://doi.org/10.1007/s10919-008-0065-7
9. Foley, G, and J. Gentile. Nonverbal Communication in Psychotherapy. Psychiatry. 2010Jun 7(6): 38-44.
10. Chun, TH et al. AAP Committee on Pediatric Emergency medicine. Evaluation and Management of Children with Acute Mental Health or Behavioral Problems. Part II: Recognition of Clinically Challenging Mental Health Related Conditions Presenting with Medical or Uncertain Symptoms. Pediatrics. 2016; 138
11. Emiroglu, FN et al. Assessment of child neurology outpatients with headache, dizziness and fainting. J child Neurol. 2004; 19 (5): 332-336
12. Tunaoglu FS, et al. Chest pain in children referred to a cardiology clinic. Pediatr Cardiol. 1995: 16(2): 69-72.
13. Curtin, Sally. State Suicide Rates Among Adolescents and Young Adults Aged 10-24: United States 2000-2018. National Vital Statistics Reports; Volume 69, Number 11
14. Ryan M. Hill et al Pediatrics March 2021, 147 (3) e2020029280; DOI: https://doi.org/10.1542/peds.2020-029280
15. Brian K. Ahmedani, et alRacial/Ethnic Differences in Health Care Visits Made Before Suicide Attempt Across the United States. *Medical Care*, 2015; 53 (5)
16. Patel, A., Watts, C., Shiddell, S., Couch, K., Smith, A. M., Moran, M. J., & Conners, G. P. (2018). Universal adolescent suicide screening in a pediatric urgent care center. Archive of Suicide Research, 22, 118-127. doi: 10.1080/13811118.2017.1304303
17. J Psychiatry2013 May;58(5):274-82 doi: 10.1177/0706743713058005