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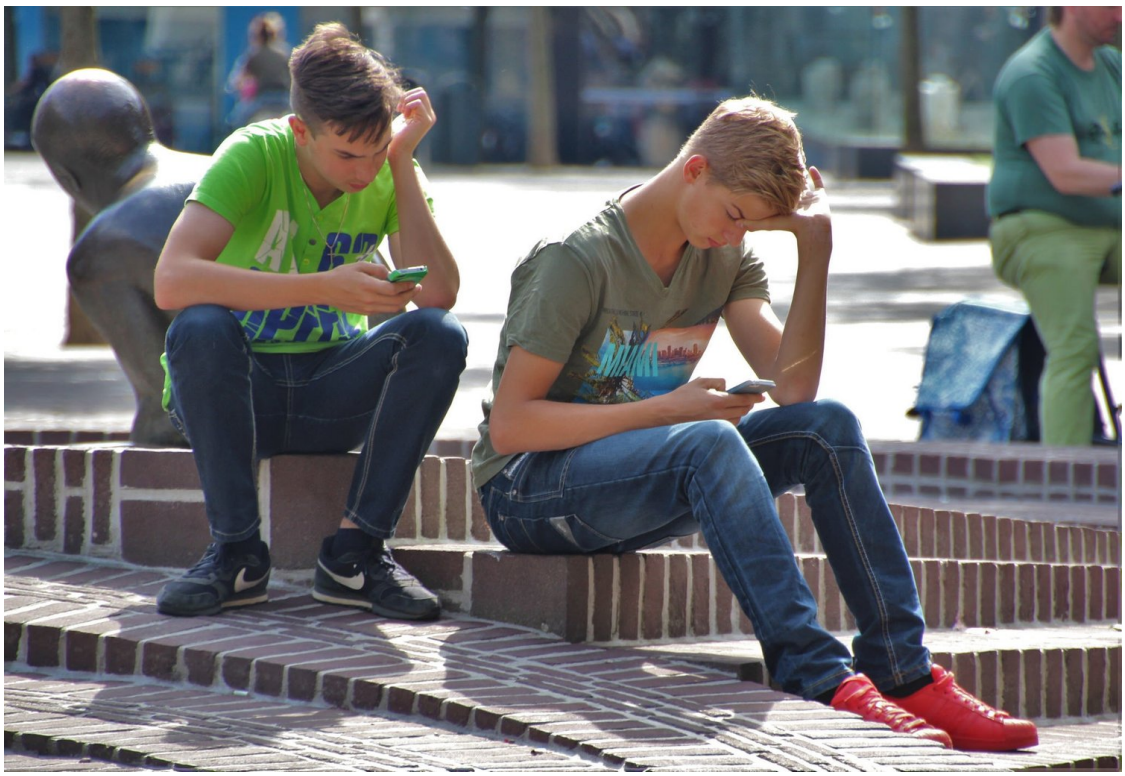
Universal Screening for Depression and Sustained Sadness in Kids to Prevent Youth Suicide



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Synopsis: Screening kids for depression (and sustained sadness) and connecting them with mental health services is an effective step in preventing suicide in youth. This article reviews recent research that supports this intervention and includes other data that shows this approach to be logical, strategic, and a high-yield use of suicide prevention funding.

BY **LEN LANTZ, MD** / 12.18.21; No. 53 / 9 min read

Disclaimer: Yes, I am a physician, but I'm not your doctor and this article does not create a doctor-patient relationship. This article is for educational purposes and should not be seen as medical advice. You should consult with your physician before you rely on this information. This post also contains affiliate links. Please click this LINK for the full disclaimer.

NOBODY, ESPECIALLY A CHILD, NEEDS TO DIE BY SUICIDE

1. Experiencing happiness
2. Having fun

So, when it comes to youth suicide, it's understandable that we wonder, "Why is this happening? When and where did things start going wrong? What is the cause of this?" You might wonder if certain societal factors such as the following have led to the increase in youth suicides:

- Fragmentation of families
- Less free time for daydreaming and imaginative play
- Helicopter parenting that results in restricted freedom for kids to explore and problem-solve on their own
- The rise of technology and exposure to unhealthy content on the internet
- A decline in spiritual practices
- An increase in identity confusion
- An increase in societal acceptance of nicotine (vaping) and cannabis
- Increasing polarization in our communities

While societal factors might be playing a role in the rising tide of childhood suicides, what can we do to change things? I would argue that we must become increasingly strategic in our approach to suicide – that we need to look at approaches that intervene at the right time, provide the most effective help, are the least intrusive, and are the most cost-effective.

Childhood is the best time to start helping people. Most mental illness is a condition of youth that follows us into adulthood. **50% of lifetime mental illness begins by age 14 and 75% of lifetime mental illness begins by age 24** (Kessler, et al. *Arch Gen Psychiatry*. 2005). It is also important to note that the faster you treat depression, the better the outcomes and the less likely the condition is to become chronic (Kraus, et al. *Translational Psychiatry*. 2019). We must consider the enormous power of intervening early and how this can improve the trajectory of people's lives by helping them with their mental health and protecting them from suicide.

The problem of depression and suicidality in youth is moving from crisis to emergency. We have already run out of time. On December 7, 2021, the US Surgeon General Dr. Vivek Murthy issued a 53-page advisory on the current youth mental health crisis and called for urgent, coordinated action

of individuals, families, community organizations, governments, and others

DEPRESSION IS THE NUMBER ONE CAUSE OF SUICIDES

Depression has been identified as the cause of up to 70% of suicides (Takahashi. *JMAJ*. 2001). Experts cite data showing anxiety and substance abuse are also substantial contributors to suicide, however, depression is by far the leading cause of suicide. Therefore, **identifying suicide risk itself and treating depression is the most strategic approach to preventing suicide**.

Adolescent depression rates have increased during the Covid pandemic (Racine, et al. *JAMA Pediatrics*. 2021), however, depression rates were rising for kids even before the pandemic, with evidence of a growing number whose depression went untreated (Lu. *Am J Health Behav*. 2019). In addition to reports of an increase in youth suicide attempts during the pandemic, suicide completions by youth aged 10-24 have increased every year since 2007, making suicide the second leading cause of death for these young people (Curtin. *NVSR*. 2020). According to the 2020 *National Vital Statistics Report*, "Between 2007 and 2018, the national suicide rate among persons aged 10–24 increased 57.4%."

SUSTAINED SADNESS IN KIDS MUST NOT BE DISMISSED

You might think that it's normal for kids to feel down every once in a while, and you are correct, however, sustained sadness or the condition of major depressive disorder places a child at greater risk of a suicide attempt. In a recent study (Trimble, et al. *Frontiers in Pediatrics*. 2021), it was suggested that sustained sadness in youth be monitored for intervention as it too is a substantial risk factor for a suicide attempt. The authors of the article provided this disturbing statistic: "There was an 8–11-fold increased odds of all suicidal behaviors among those who reported sad feelings among both

females and males." So, as we are screening kids for depression, we also

attempted suicide in the last 12 months. According to the 2021 Montana Youth Risk Behavior Survey, "A **30-year high of 41% of high school students** reported feelings of sadness or hopelessness (depression) over the last year." We have a job to do. We are failing our children.

The sad fact is that some kids do attempt suicide and many of them die. If the numbers I just provided seem unbelievable, I understand. I felt that way the first time I started looking into the data and trying to do something in Montana to prevent suicide, however, the disturbing reality is that those numbers are accurate or might even be underreporting the true numbers because of the stigma of suicide.

HOW DO WE REACH CHILDREN BEFORE THEY ATTEMPT SUICIDE?

Some research suggests that if a suicidal adult shows up in the emergency room (ER), then helping the person develop a safety plan followed by a telephone call after discharge can save lives (Stanley, et al. *JAMA Psychiatry*. 2018). There is also an ER intervention for families of suicidal youth called the Family Intervention for Suicide Prevention which may reduce suicide risk (Asarnow, et al. *Professional Psychology: Research and Practice*. 2009). While ER interventions are important and save lives, solely relying on these would miss too many at-risk kids. According to data from the Youth Risk Behavior Survey, only about 1/3 of kids who survive a suicide attempt end up receiving any sort of medical attention after the event.

The pediatrician's office is one place to screen kids for depression and suicidal ideation. Pediatricians do a lot of great work in screening kids for many medical conditions. Some also work with pediatric psychiatrists in integrated behavioral health (IBH) or Collaborative Care approaches in depression care, however, most of these treatment models have limited availability/adoption and rely on an already established diagnosis of depression. Also, not all kids go to the doctor. It is estimated that over 60% of children do not receive routine preventive medical care (Rand, et al. *Academic Pediatrics*. 2018; Irwin, et al. *Pediatrics*. 2009), so a 2-item depression screening questionnaire at the doctor's office is not sufficient to save our children.

Given that the vast majority of kids are enrolled in school, schools are the best location for universal screening for depression.

UNIVERSAL DEPRESSION SCREENING OF KIDS IS POSSIBLE

The most recent research (Sekhar, et al. *JAMA Network Open*. 2021) on

depression than did the usual process of targeted student referral. With universal screening three times as many kids were referred to mental health treatment and were far more likely to follow up with mental health treatment and receive care. Fortunately, it is possible to provide universal depression screening for kids.

To make universal depression screening work, we will need a respectful opt-out option. When it comes to large-scale interventions that help people to make healthy choices, interventions that rely on opt-in are a recipe for failure. Opt-in strategies are often ineffective, and more kids will die if a "universal" opt-in screening approach is used as we will only be able to screen a fraction of kids. Why is this the case? The same parents who fail to opt-in their child for depression screening might also be failing to notice the signs of depression in their child. We must set up our screening programs as opt-out to include everyone and allow the minority to skip the process if they want to.

According to Karl Rosston, Suicide Prevention Coordinator for the state of Montana, "**86% of parents who lost a child to suicide didn't even know their child was depressed**. This is because as parents we lose our objectivity when it comes to our own kids. It's hard for us to accept that our child may want to die. This is one of the most important reasons for universal screening for depression and anxiety. Give parents the information they need about their child to make the best decision for them."

WHAT MONTANA IS DOING TO SCREEN CHILDREN FOR DEPRESSION

Currently, there is a pilot program led by the Rural Behavioral Health Institute (RBHI), a Livingston-based nonprofit, which is taking depression screening of Montana youth to the next level. RBHI is performing digital mental health screenings of students. The mental health screenings are done privately, with each student using a tablet or smartphone, and take less than 10 minutes. The screening uses the best-known measure for identifying suicide risk, the electronic Columbia-Suicidality Severity Rating Scale (eC-SSRS) (Posner, et al. *Am J Psychiatry*. 2011) plus the PHQ-9 for depression and a measure for anxiety. RBHI's goal is to identify kids at risk of suicide and connect them to mental health professionals **the same day.** The program is called **Screening Linked to Care** (SLTC). Linking care to screening is necessary because schools are not advised to screen for depression and suicide risk if they do not have an effective intervention plan when they find it.

You cannot screen for depression and suicidality if you don't know what you

2017. The Montana CAST-S is a free, 156-page toolkit created for Montana districts and communities to develop evidence-based crisis protocols for preventing and addressing youth suicides. In 2018, Shodair Children's Hospital purchased and shipped a physical copy of the CAST-S to every school principal (public and private) in Montana. Having a response plan when screening for depression and suicidality is critical.

Working directly with RBHI, Shodair Children's Hospital provides the essential care for children who screen positive for suicide risk or depression. Students at the highest risk are seen on the day of screening and those with lower risk are seen soon after. This method provides the dual benefits of truly standardized digital screening and greater disclosure of suicidal ideation and behaviors than clinicians obtain when seeing children face-to-face. The report is available within a minute of completion and linked with timely Shodair further evaluation that ultimately guides children to appropriate ongoing care.

WHAT ELSE WORKS TO PREVENT SUICIDES IN KIDS?

There are other strategies to prevent youth suicide. For example, there are several systems classified as "gatekeeper" programs that promise to train adults on what to do if they think a child is suicidal. While these programs might save a few lives, they also might give adults a false sense of security that they are making a difference when often they are not. These training programs are the most helpful for teachers and other adults to have an appropriate response when other interventions uncover a problem of depression or suicidality.

Newer research (Lindow, et al. *Journal of Adolescent Health*. 2020) has shown that programs such as Youth Aware of Mental Health (YAM) are demonstrating promise as universal, school-based mental health promotion/suicide prevention interventions for adolescents. Programs like YAM directly teach kids how to deal with their emotions and prevent suicide by providing a safe space for reflection, role-play, and discussion of everyday mental health challenges. Also, a classroom-based intervention strategy for younger kids called the Good Behavior Game addresses aggressive and disruptive behavior in early elementary school and has been associated with lower suicide risk later in life (Wilcox, et al. *Drug and Alcohol Dependence*. 2008).

Another area of suicide prevention, which I will address in a future article, involves reducing access to lethal means, or "means restriction." This strategy is heavily focused on safely storing and otherwise reducing access to

(Grossman, et al. JAMA. 2005).

UNIVERSAL DEPRESSION SCREENING FOR YOUTH WILL SAVE LIVES

Universally screening kids for depression and sustained sadness in our schools must be a foundational approach to suicide prevention. This approach will be the most effective if it is implemented as an opt-out intervention that also connects vulnerable kids to mental health services. Imagine no longer reading newspaper obituaries of children who died by suicide or hearing about children attending the funerals of other children. We can start to turn the tide of increasing youth suicides. America is in desperate need of more funding for suicide prevention research and further research on depression screening in kids, which appears to be one of the most promising interventions that will reach the most kids. Our federal and state governments and our communities must fund the implementation of these necessary interventions. We can save the lives of our youth. Universal depression screening of kids is an essential step for accomplishing this.

FOR FURTHER READING, CHECK OUT:

- Len's article, "Your Safety Plan for Suicide Prevention"
- Len's article, "Helping Depressed Friends and Family"
- Len's article, "The Most Important New Findings in Depression"
- Len's article, "Finding a Good Psychiatrist"
- Len's article, "Finding Quality Psychotherapy – Moving Beyond Talk Therapy"

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