Collaborative Care: Adolescent Depression Management and Bullying Mitigation - Tackling Tough Topics in Your Office

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Celia Neavel, MD, FSAHM, FAAFP

Director, Center for Adolescent Health and GOALS Program, People's Community Clinic, Austin, Texas

Dr. Neavel earned her medical degree from Baylor College of Medicine, Houston, Texas, and completed residency and a fellowship at the University of Cincinnati, Ohio. She is board certified in family medicine and has a Certificate of Added Qualifications (CAQ) in Adolescent Medicine, as well as fellowship training in both adolescent medicine and developmental disorders. Dr. Neavel supervises and teaches a variety of health care professionals within her own team, as well as trainees rotating through the clinic. She founded—and continues to direct—the Center for Adolescent Health and the GOALS Program at People's Community Clinic, a nonprofit federally qualified health center (FQHC). The Center for Adolescent Health provides primary, behavioral, and reproductive care at a main clinic site, with additional sites embedded in youth-serving community agencies. The GOALS Program is a developmental, behavioral, and primary care program for individuals ages 4 to 19.

Dr. Neavel works with diverse community organizations. She is on the Texas Health Steps Advisory Council, as well as serving as a Travis County Medical Society delegate to the Texas Medical Association and a medical advisor for the Texas Youth-Friendly Initiative. The recipient of numerous awards, she frequently is named Austin's top adolescent medicine physician in Austin Monthly magazine. Dr. Neavel has given national, state, and local presentations on integrated behavioral health, adolescent wellness care, reproductive health, and minor consent and confidentiality. She currently collaborates with University of Texas faculty on research on integrated behavioral health.

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Geordi Cortez-Neavel

Intern/Volunteer, People's Community Clinic, Austin, Texas

Cortez-Neavel earned his bachelor's degree in global health from Washington University in St. Louis, Missouri. He is currently pursuing a master's degree in clinical research management from University of North Texas Health Science Center and applying to medical schools for the 2019-2020 cycle. Previously, he has participated in projects focused on access to quality care; youth assessment and treatment; emergency medicine; and primary care. He has received training as an emergency medical technician-basic (EMT-B), a National Academy of Sports Medicine (NASM) trainer, and—most recently—a youth peer wellness specialist. As a volunteer at People's Community Clinic, he serves as an ambassador and a member of the Youth Advisory Council.

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Sasha D. Jaquez, PhD

Pediatric Psychologist, Dell Children's Medical Center, Austin, Texas; Clinical Assistant Professor, Department of Psychiatry, Dell Medical School, Austin, Texas; Clinical Assistant Professor, Department of Educational Psychology, University of Texas at Austin

Jaquez received her doctorate degree in Clinical Psychology, with an emphasis on pediatric/child clinical psychology, from Oklahoma State University, Stillwater. She completed her predoctoral psychology internship at University of Alabama at Birmingham/Children's of Alabama, followed by a postdoctoral fellowship at University of Texas at Austin, where she worked both at Dell Children's Medical Center and Texas Child Study Center. Following postdoctoral fellowship, she moved to Akron, Ohio, where she received training in pediatric behavioral sleep medicine, established the Sleep Psychology Clinic at Akron Children's Hospital, and worked on the inpatient consultation/liaison team. Upon returning to Austin, Jaquez became the director of the Medical Coping Specialty Clinic at Texas Child Study Center and saw patients within the Texas Center for the Prevention and Treatment of Childhood Obesity (TCPTCO). She sees patients in the Dermatology, Allergy, and Comprehensive Care Clinics at Dell Children's Medical Group. In these clinics, she specializes in cognitive behavioral therapy with youth who present with comorbid psychological and medical concerns, as well as sleep disorders. In addition to medical residents and fellows, she trains psychology graduate students, interns, and postdoctoral fellows. Her current research focuses on weight bias among pediatric providers and trainees and use of behavioral interventions during dermatology procedures.

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Learning Objectives

1. Utilize appropriate diagnostic criteria to screen adolescent patients for depression, bullying, mood disorders, and suicide risk.
2. Counsel caregivers and adolescent patients regarding bullying prevention and intervention.
3. Devise collaborative treatment plans, including appropriate psychotherapy and pharmacotherapy, that take into account the risks and benefits of various interventions.
4. Coordinate care for adolescent patients who require referral to sub-specialists or admission to hospitals for suicide prevention.

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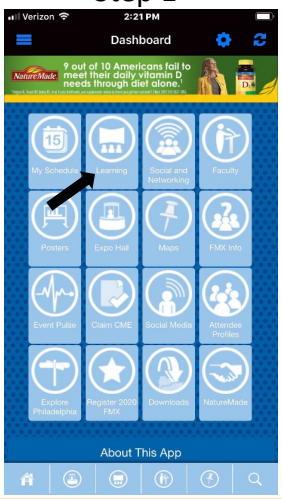
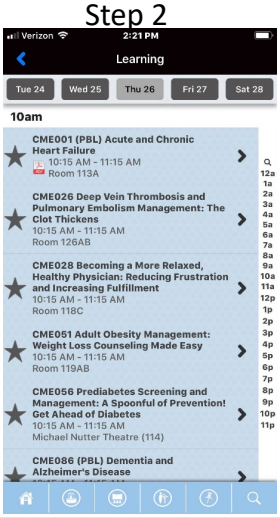
Audience Engagement System

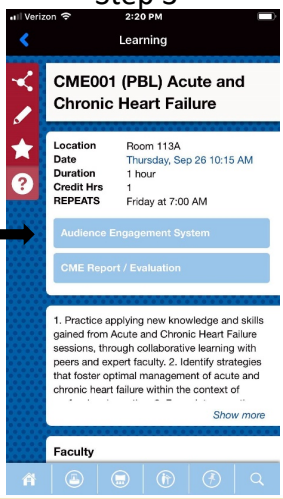
Step 1



Step 2



Step 3



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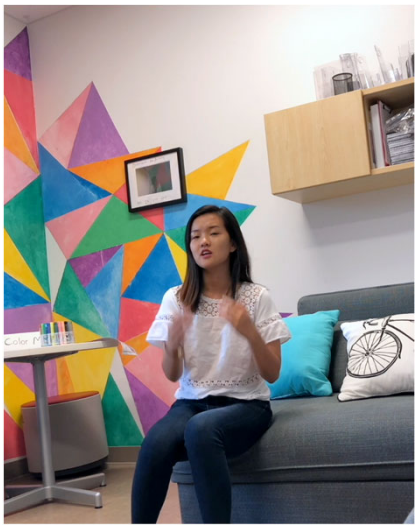
AES POLL QUESTION #1

What % of your practice is between the ages of 10-24?

1) 0-10%
2) 10-30%
3) 30-50%
4) >50%

Youth Account of Experiences



YOUTH RISK BEHAVIOR SURVEY 2017

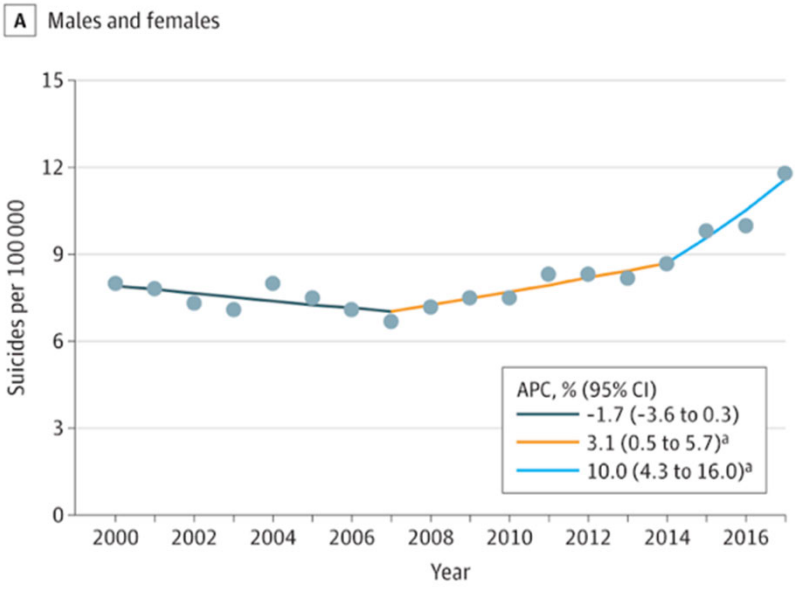
During the 12 months before the survey, 31.5% of students nationwide had felt so sad or hopeless almost every day for 2 or more weeks in a row that they stopped doing some usual activities

Suicide rates among America's young people continue to soar, study shows

By Jacqueline Howard, CNN

Updated 12:09 PM ET, Tue June 18, 2019

> "our new information shows that suicide [among] adolescents has reached its highest recorded level, and it shows that there's especially an increase in recent years in adolescent males," he said. "The data shows that it is a very real threat."
> First author Oren Miron, research associate Harvard Medical school



Research Letter
June 18, 2019

Suicide Rates Among Adolescents and Young Adults in the United States, 2000-2017

Oren Miron, MA[1]; Kun-Hsing Yu, MD, PhD[1]; Rachel Wilf-Miron, MD, MPH[2]; et al
Isaac S. Kohane, MD, PhD[1]
Author Affiliations Article Information
JAMA. 2019;321(23):2362-2364.
doi:10.1001/jama.2019.5054

AES POLL QUESTION #2

Which organization(s) recommend depression screening starting at age 12? (Select all that apply)

1) United States Preventive Services Task Force
2) American Academy of Family Practice
3) American Academy of Pediatrics
4) Bright Futures
5) Institute Of Medicine

A Look at Each Agency's Guidelines

1) USPSTF: screening for major depressive disorder (MDD) in adolescents (12 to 18 years).
   - should be implemented with adequate systems in place (ensures accurate diagnosis, effective treatment, and appropriate follow-up). Grade B
2) AAFP: supports the USPSTF recommendation
3) AAP: supports that adolescent patients ages 12 years and older be screened annually for depression (MDD or depressive disorders) with a formal self-report screening tool either on paper or electronically (universal screening) (grade of evidence: 2; strength of recommendation: very strong)
4) Bright Futures: screen teens for depression, if indicated. (Share results of screening with teen and parents).
5) In light of the benefits associated with early intervention and the existence of effective treatment options, the IOM recommended that physicians in primary care settings screen adolescents for MDD

VALIDATED TOOLS

- PSC, PSC-17, PSCY **Pediatric Symptom Checklist**
- CRAFFT **Car, Relax, Alone, Friends, Forget, Trouble**
- PHQ 2, 9, & A
- SCARED **Screen for Child Anxiety Related Disorders**
- CES-DC **Center for Epidemiological Studies Depression Scale for Children**
- CDI **Beck Child Depression Inventory for Primary Care (not free)**
- CBCL **Child Behavior Checklist (not free), TRF, YSR Achenbach System of Empirically Based Assessment** (ASEBA)
- RAAPS **Rapid Assessment for Adolescent Preventive Services**

EXAMPLE HEEADSSSS INTERVIEW

- Home
- Education
- Eating
- Activities
- Drugs
- Sexuality
- Suicide/Depression
- Safety
- Strengths

PRACTICE RECOMMENDATIONS

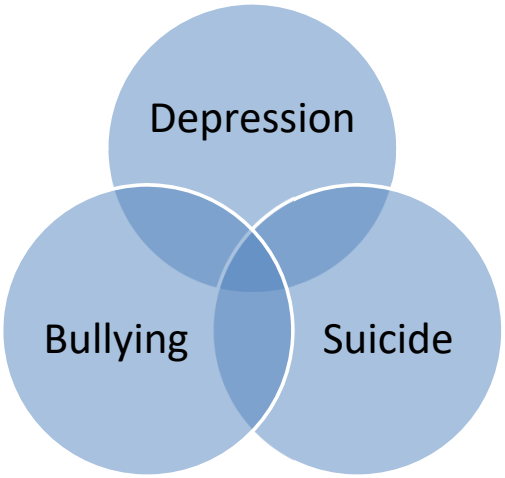
– Universal screen for depression WCC 12 & up

– Screen as indicated by clinical situation

– Use validated tools

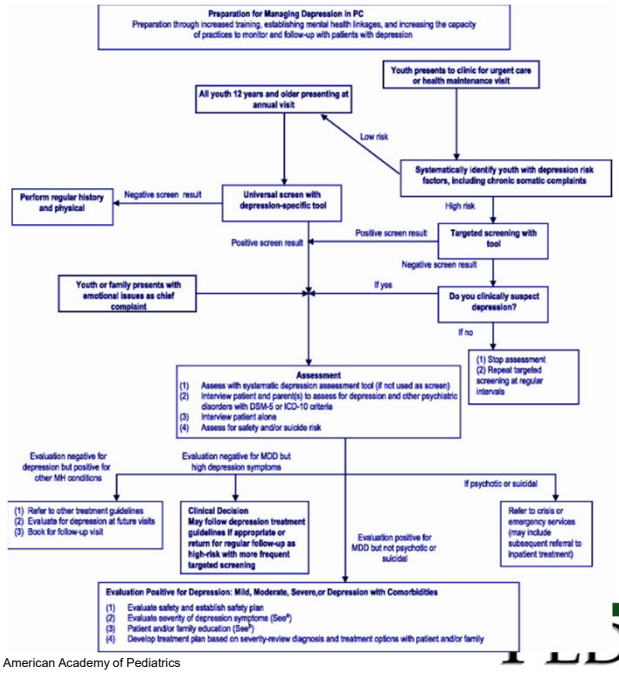
– Office champion

LISTENING/WATCHING FOR FLAGS



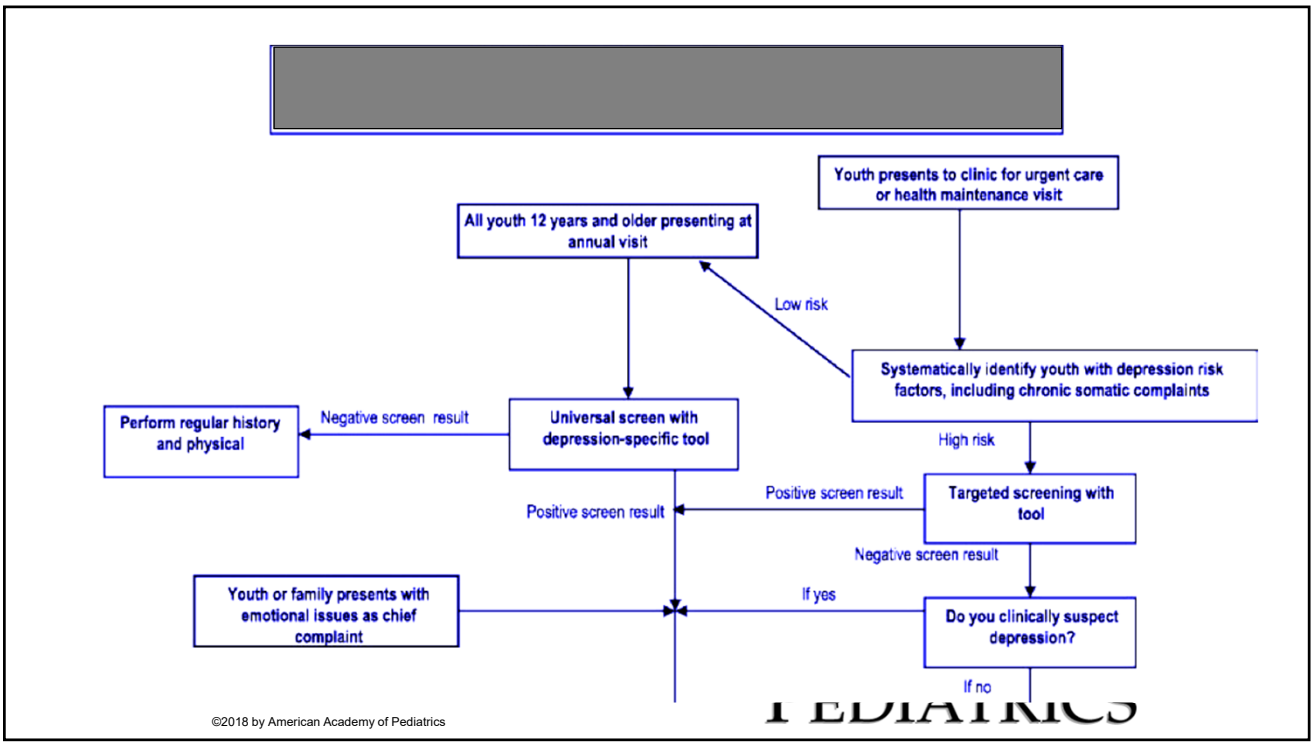
- Somatization
- Declining medical adherence
- Behavior change
- Affect in office
- LGBTQ youth at risk for all 3
- Depressed AND being bullied: higher risk for suicide
- History of trauma or ACES

Clinical Assessment Flowchart



Rachel A. Zuckerbrot et al.
Pediatrics 2018;141:e20174081

PEDIATRICS®



Asses if Bullying Victim

- *"Any unwanted aggressive behavior by another youth or group of youths who are not sibling or current dating partners that involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated."* CDC, 2014
- Can be physical, verbal or relational
- Direct – blatant attacks on a targeted young person
- Indirect – communication with others about targeted individual
- Makes it more difficult for others to recognize what is happening

Prevalence Rates (US)

- 20% of 12-28 yo students
- 19% in grades 9-12 at school
- 49% in grades 4-12 in last month
- 30% youth admit bullying others
- Mostly in school, school grounds, school bus
- Only 20 to 30% bullied students notify adults

Stopbullying.gov

Screening: Best Practice

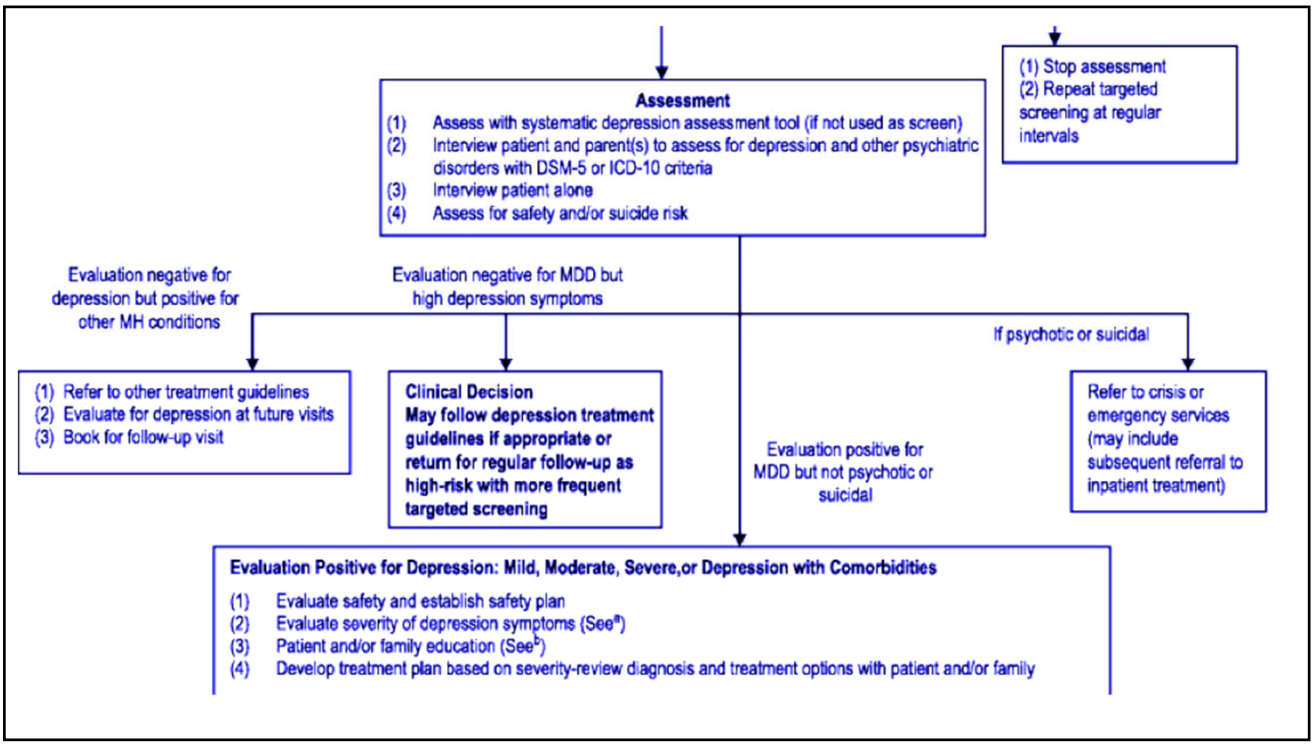
- Start when enter elementary school
- Screen high risk groups
  - Special needs (including chronic illness)
  - Under- or overweight
  - Identify as LGBTQ+
- Watch for indicators and ask about behaviors
  - Mood changes, psychosomatic sxs, behavioral concern, substance use
  - SIB, SI or attempt, decline academic functioning, school truancy
- Screen if engaging in bullying behavior
- Screen if bystander to bullying

CYBERBULLYING

- May not admit
- Don't want access restricted
- Less common, but correlated trad'l bullying
- School environment impt, but can take place away from school
- Cyberbullies can be anonymous
- Can happen 24 hrs/day
- No amt parent monitoring can catch all
- Higher rates suicidality

INTERVENING BULLYING

- **Information**:
  - For families https://www.stopbullying.gov/ https://www.helpguide.org/articles/abuse/bullying-and-cyberbullying.htm & others
  - Most effective interventions school-based
  - Legislation: https://www.stopbullying.gov/laws/index.html
- **Recs for Parents**:
  - support the teen with empathy, take it seriously, **don't confront other parents**, advocate at school
- **In the office**:
  - Express support – kids right to feel safe
  - *Engage in problem solving* – create a plan for school, create family media plan
    - https://www.healthychildren.org/English/media/Pages/default.aspx
- **Advocate** with the teen's school and inquire about resources



MAJOR DEPRESSIVE DISORDER

F32 (recurrent F33)

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (*Note: In children and adolescents, can be irritable mood.*)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation.) I
3. Significant weight loss when not dieting or wt gain more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.) A
4. Insomnia or hypersomnia nearly every day. S
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down). P
6. Fatigue or loss of energy nearly every day. E
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick). G
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others). C
9. Recurrent thoughts of death,recurrent suicidal ideation without specific plan, or suicide attempt or a specific plan for committing suicide. S

ASSESSING RISK

RISKS:

- Interpersonal loss & stressors
- Psychiatric disorders
- Prior attempts
- Substance use / risky behaviors
- LGBTQ with little support
- Access to means
- Isolation
- Chronic disease or disability

PROTECTIVE:

- Access to interventions
- Social support/**connectedness**
- Life skills
- Restricted access to means
- Self-esteem & sense of purpose
- Cultural/religious/personal beliefs against suicide

FURTHER SAFETY ASSESSMENT

Sex

Age

Depression or affective disorder

Previous attempt

ETOH or drug abuse

Rational thinking loss

Social supports lacking

Organized plan

Negligent parenting or family stress or suicidal modeling

School Problems

*Self harm not always equal suicidality

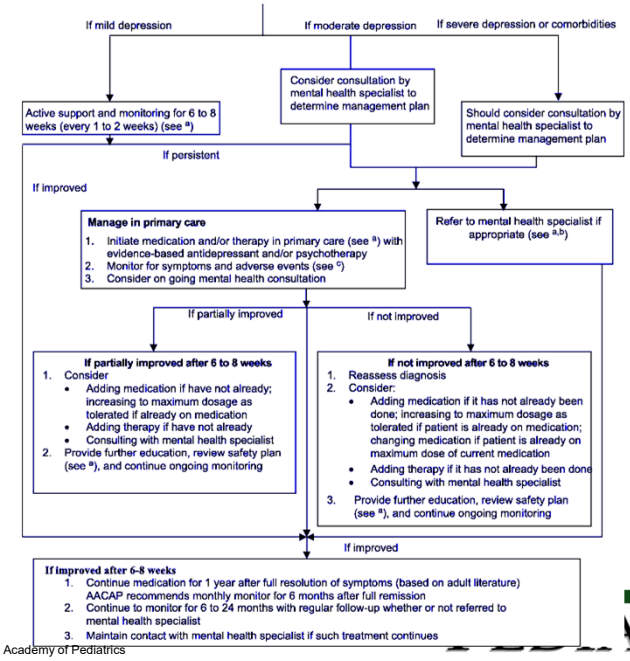
*Clarify passive vs active thoughts

*Who knows? Trusted adult relationship?

*Try stay neutral. Keep pt focused on questions and history. Bring structure.

*Your presence invaluable

Clinical Management Flowchart



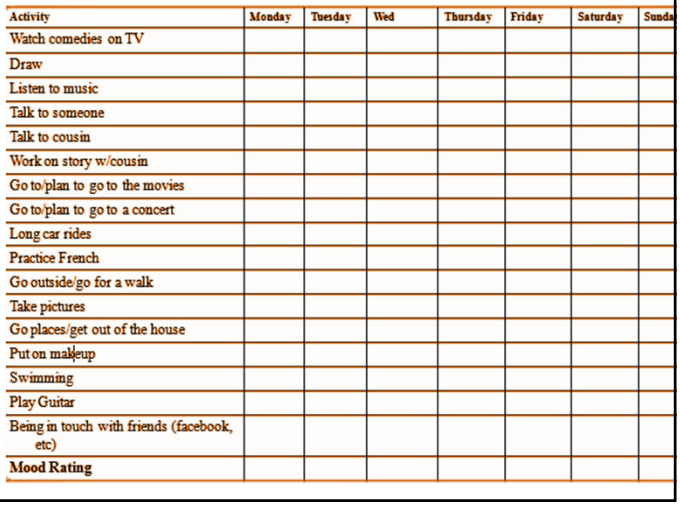
Amy H. Cheung et al.
Pediatrics
doi:10.1542/peds.2017-4082

DEPRESSION INTERVENTION

- *Educate*:
  - AACAP Facts for Families https://www.aacap.org & others
  - Stress mind-body connection
- *For Caregivers*:
  - Importance of treating; clear directions
  - No blame; offer support
- *With Adolescent*
  - Validate, normalize
  - Behavioral activation
  - Consider medication and/or referral
  - Close follow-up

BRIEF INTERVENTION: BEHAVIORAL ACTIVATION

- 5 minutes
- Make or provide list
- Teen tracks completion and rates mood
- Present as a "prescription"



Activity	Monday	Tuesday	Wed	Thursday	Friday	Saturday	Sunda
Watch comedies on TV							
Draw							
Listen to music							
Talk to someone							
Talk to cousin							
Work on story w/cousin							
Go to/plan to go to the movies							
Go to/plan to go to a concert							
Long car rides							
Practice French							
Go outside/go for a walk							
Take pictures							
Go places/get out of the house							
Put on makeup							
Swimming							
Play Guitar							
Being in touch with friends (facebook, etc)							
Mood Rating							

REFERRALS: Behavioral Health

- **Doctoral Level**: Psychologists (PhD, PsyD, EdD), Psychiatrists - **Telehealth available? Develop relationships with consulting psychiatrist & others**
- **Master's Level**: Social Workers (LMSW, LCSW), Licensed Counselors (LPC), Licensed Marriage and Family Therapists (LMFT)
- **Bachelor's Level**: Licensed Chemical Dependency Counselors (LCDC)
- **Mental Health Nurse**

- *Assess patient & family readiness & potential barriers*
- *Ensure insurance will work*
- *Ensure evidence-based treatment*

OTHER RESOURCES

- National Alliance Mentally Ill (NAMI)
- MHMR
- Child Guidance Center
- Schools, especially if on-site therapy
- Insurance Plan
- Specialized Hospital Systems
- Local Non-profits
- Regional Academic Center

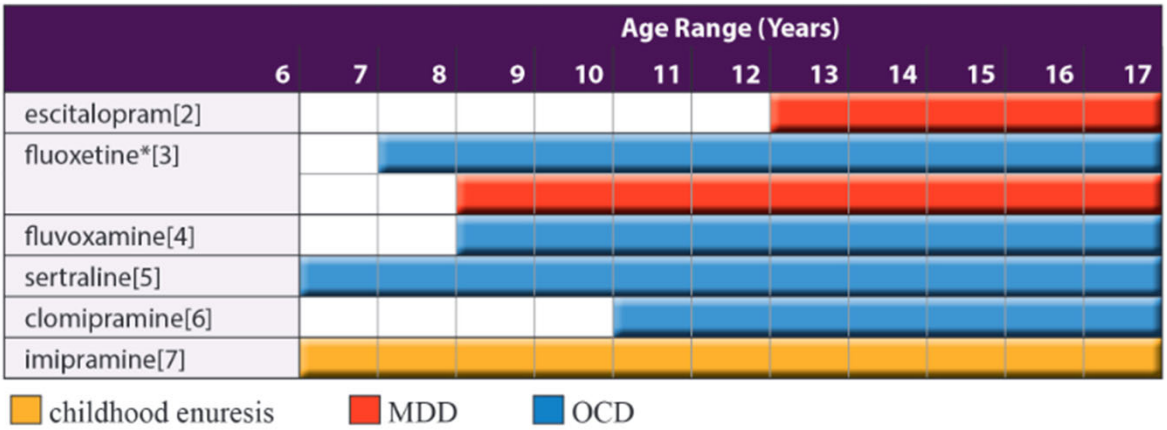
AES POLL QUESTION #3

Which medication is FDA approved for treating depression in a 14 yo?

1) Paroxetine
2) Fluoxetine
3) Bupropion
4) Amitriptyline

SSRIs

Figure 1. FDA-Approved Pediatric Age Ranges and Indications for Antidepressant Medications



*Fluoxetine is FDA approved for the treatment of MDD in pediatric patients up to 18 years old.

SSRI TITRATION SCHEDULE

Medication	Starting Dose (qd/od), mg	Increments, mg	Effective Dose, mg	Maximum Dosage, mg
Citalopram	10	10	20	60
Fluoxetine	10	10–20	20	60
Fluvoxamine	50	50	150	300
Sertraline	25	12.5–25	50	200
Escitalopram	10	5	10	20

STARTING MEDICATION

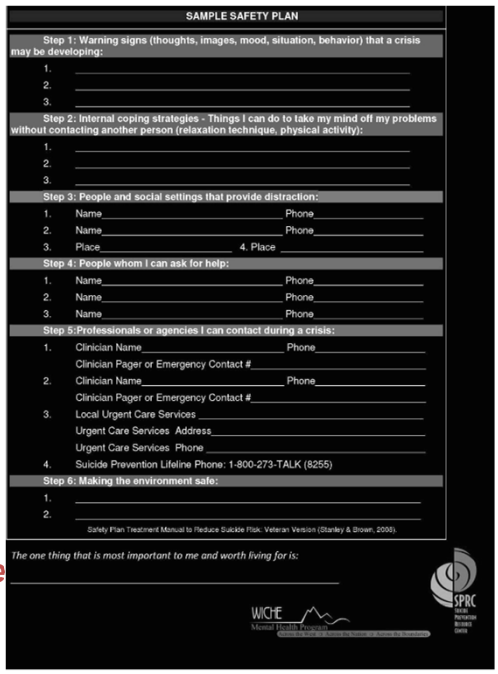
- **Be positive and optimistic**

- Take with breakfast
- Start low
- See or connect q week 1st 4 weeks
- Clinical effects continue improve 3-6 weeks
- Primary care may underdose
- If no response > 4 weeks, consider switch
  - May be 30-40%

SAFETY PLAN

Coping strategies and resources
Do together
Gives control, framework
www.sprc.org/library/SafetyPlanTemplate.pdf
or search:
Developing effective safety plan for suicidal youth
-Star Center

Have handouts, websites, textlines, hotline numbers available



SAMPLE SAFETY PLAN

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)

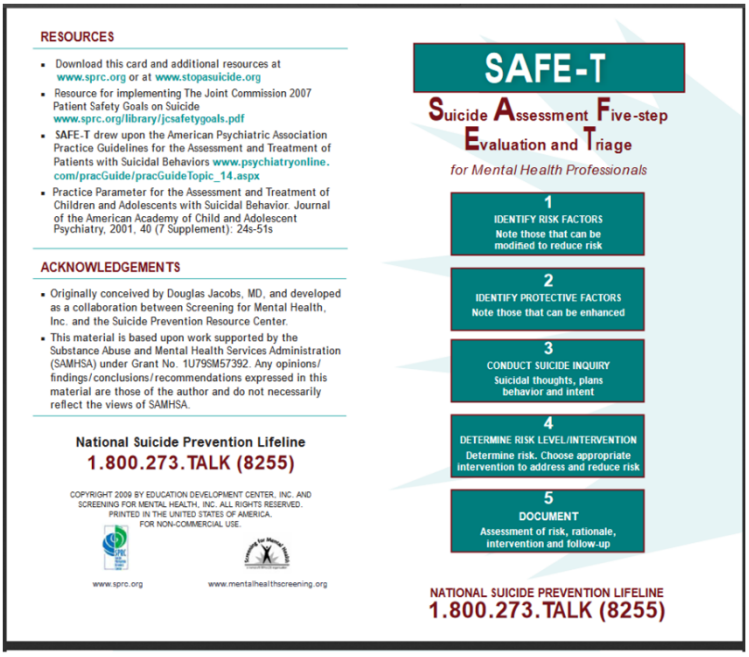
Step 6: Making the environment safe:
1.
2.

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2009).

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

WICHE Mental Health Program

SPRC



RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psychiatryonline.com/pracGuide/pracGuideTopic_14.aspx
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement): 24s-51s

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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

www.sprc.org www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

for Mental Health Professionals

1 IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

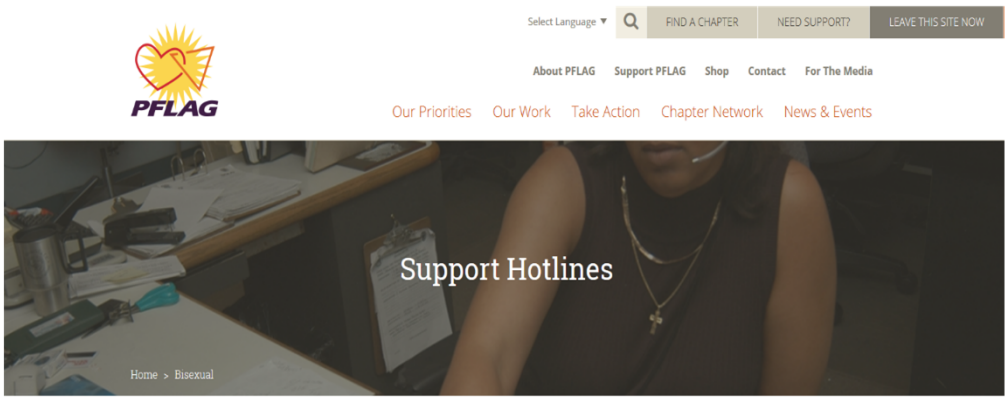
3 CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4 DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5 DOCUMENT
Assessment of risk, rationale, intervention and follow-up

NATIONAL SUICIDE PREVENTION LIFELINE
1.800.273.TALK (8255)

FOR LGBTQ+ YOUTH & FAMILIES
https://pflag.org/hotlines



ACTIVELY SUICIDAL/NEEDS ADMISSION

Make immediate referral to mental health provider or emergency services if severe depression, psychotic, or suicidal ideation/risk is evident.

- Already have practice plan
- If have IBH, page them
- Call 911, mental health deputies, local mental health hotline, police or EMS as needed
- Hospital emergency department
- Local mental health authority if have intake site
- Psychiatric hospital

Let family know what to expect, including your role

CARE COORDINATION

- Post hospitalization if occured
- Communication between behavioral health, primary care, family, & school
- Clarify duration therapy &/or medication
- Ongoing screening

PRACTICE RECOMMENDATIONS

- *Follow best practices workflow*
  - Use validated tools & structured interviews
  - Have plan for + screens
  - Harm in not treating
  - Utilize compassion, optimism, and close f/u
- *Practice self-care; acknowledge when cases are difficulty; talk about with your team*

SOCIAL MEDIA POLL QUESTION

What social media sites/apps are youth using most frequently?

1. Twitter
2. Instagram
3. Snapchat
4. Pinterest
5. YouTube
6. Facebook

WHAT ADOLESCENTS WANTED TO INCLUDE IN THIS TALK

- Using 'Meme Culture' as an outlet for stress and depression.
- Engaging adolescents in healthy "Self-Talk"
- "Teenagers are masters at disguising their depression… Across both physiological and mental illness: kids have really long compensatory phases before they suddenly crash"

MEMES

me: hmm what happens if i forcibly bend this thing

thing: *breaks*

me:

me about to bombard my friends and family with love and affection

dried apricot hater
@aaannnyyyaaaa
Follow

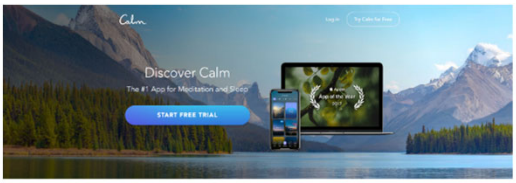
me: sees a fluffy dog
me to me: steal him

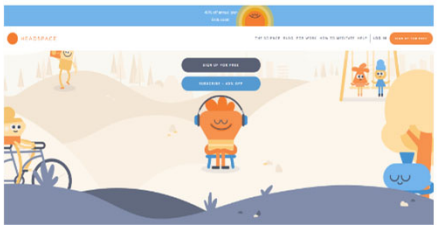
22,519 31,802

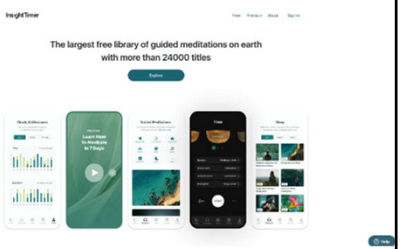
4:42 AM - 6 Nov 2016

Engaging Youth Through Social Media

- How can we use social media
- Texting
- Outreach







Questions

FMX

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Mental Health Screening

- https://www.cdc.gov/features/yrbs/index.html 2017 YRBS
- https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-children-and-adolescents-screening1
- For Pediatric Symptom Checklist
  - http://www.massgeneral.org/psychiatry/services/psc_home.aspx http://www.brightfutures.org/mentalhealth/pdf/professionals/ped_sympton_chklst.pdf
- For PHQ9 http://www.depression- primarycare.org/images/pdf/phq_9_eng.pdf
- For CRAFFT http://www.ceasar-boston.org/clinicians/crafft.php
- For SCARED (anxiety) https://sspediatricassociates.com/Forms-and-Policies/Forms/Behavioral,-Mental-Health-Assessment-Forms/SCARED-form-Parent-and-Child-version.aspx
- For Center for Epidemiological Studies Depression Scale for Children https://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

Mental Health Screening - 2

- http://www.possibilitiesforchange.com/raaps/ RAAPS Screening
- Chart comparing mental health screening tools https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf
- HEEADSSS examples http://www.bcchildrens.ca/youth-healthclinicsite/documents/headss20assessment20guide1.pdf & http://www.contemporarypediatrics.com/sites/default/files/legacy/mm/Resource-Centers/GettingintoTeensHeads.pdf
- https://www.aafp.org/afp/1998/1101/p1617.html SIGECAPS
- https://doi.org/10.1016/j.jadohealth.2019.04.018 Editorial on screening Journal of Adolescent Health

Key Resources Assessment & Management Adolescent Depression in Primary Care

- Zuckerbrot RA, Cheung A, Jensen PS, et al. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part I. Practice Preparation, Identification, Assessment, and Initial Management. Pediatrics.2018;141(3):e20174081
- Cheung AH, Zuckerbrot RA, Jensen PS, et al. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): Part II. Treatment and Ongoing Management. Pediatrics. 2018;141(3):e20174082
- http://www.glad-pc.org/ Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Toolkit

Depression Treatment

- Antidepressant medication information for caregivers https://www.nimh.nih.gov/health/topics/child-and-adolescent-mental-health/antidepressant-medications-for-children-and-adolescents-information-for-parents-and-caregivers.shtml
- Antidepressant use in pediatric patients https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Pharmacy-Education-Materials/Downloads/ad-pediatric-factsheet.pdf
- Pediatric Psychopharmacology for Treatment of ADHD, Depression,and Anxiety http://pediatrics.aappublications.org/content/pediatrics/136/2/351.full.pdf
- Effectivechildtherapy.org What evidence supports what mental health therapy
- https://www.aacap.org American Academy of Child & Adolescent Psychiatry- has information for families and treatment recommendations for physicians
- https://jamanetwork.com/journals/jama/fullarticle/199274 TADS

DEPRESSION RESOURCES TEENS & FAMILIES

https://www.helpguide.org/articles/depression/teenagers-guide-to-depression.htm

https://www.aacap.org/

https://kidshealth.org/en/teens/depression.html

Has Spanish and oral

https://familydoctor.org/depression-in-children-and-teens/

Bullying Resources

- McClowry, R. J., Miller, M. N., & Mills, G. D. (2017). What family physicians can do to combat bullying. https://www.aafp.org/afp/2018/0201/p187.html
- Van Geel M, Vedder P, Tanilon J. Relationship Between Peer Victimization, Cyberbullying, and Suicide in Children and Adolescents A Meta-analysis. *JAMA Pediatr.* 2014;168(5):435–442. doi:10.1001/jamapediatrics.2013.4143
- https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Pages/Connected-Kids.aspx Connected Kid includes a Clinical Guide and 21 handouts for parent and teen topics such as bullying, discipline, interpersonal skills, parents, suicide and television violence.
- https://www.stopbullying.gov/
- https://www.helpguide.org/articles/abuse/bullying-and-cyberbullying.htm

Suicide Prevention

- http://www.sprc.org/ Suicide Prevention Resource Center. Has hotline # and Suicide Assessment Five-step Evaluation and Triage for Mental Health Professionals
- http://www.heardalliance.org/wp-content/uploads/2011/04/Suicide-Risk-Assessment-SAD-Persons.pdf
- www.sprc.org/library/SafetyPlanTemplate.pdf and Search Developing effective safety plan for suicidal youth-Star Center
- https://pflag.org/hotlines comprehensive for LGBTQ+ youth and families