

**Project Echo for Pediatric Care 2018-2020
Assessment and Treatment Planning for Youth Presenting with Suicidality
May 16, 2019
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Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Pediatric emergency care professionals

Objectives:

As a result of this educational regularly scheduled series, learners will be able to:

1. Utilize new skills and guidelines determined to be safe for children when accessing pediatric trauma.
2. Identify proper tools and standardized practices in order to improve the diagnosis and treatment of pediatric patients.
3. Define roles and responsibilities of team members who triage pediatric emergencies in order to identify communication strategies that result in effective patient care.

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Suicide Evaluation of Pediatric Emergency Room Patients

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Disclosures

- I own stock in Johnson & Johnson
- No speakers bureaus nor industry work.

Case

- Nancy is a 15 year old girl who presents to the ED with her mother and father after she took 10 extra-strength acetaminophen. She did this impulsively in her bedroom—after her boyfriend blocked her on Instagram. She initially hoped to die, but soon became frightened, and vomited. Her mother heard, came to investigate, and they all subsequently came to the ED.

FIVE QUESTIONS RAISED BY NANCY

Objectives:

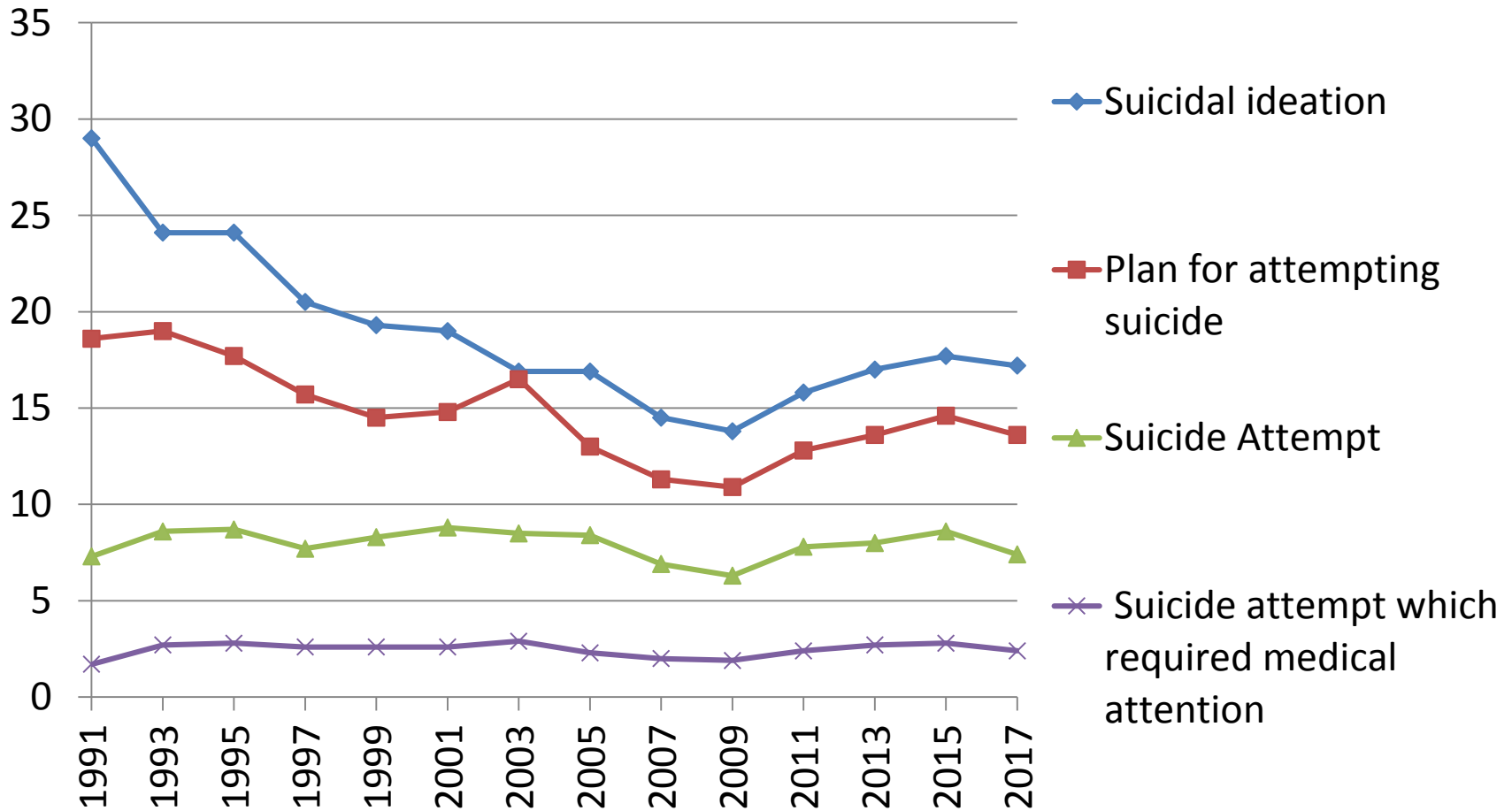
- Know the risk factors for suicide attempts and completed suicide in children and adolescents.
- Review screening for suicidality.
- Describe safety planning and potential treatments for children at risk of harming themselves.
- Be aware of the suicide/safety assessment recommendations published by major organizations.

Definitions

- Suicide Attempt
 - Any potentially self-injurious behavior where there is some evidence that the person intended to die, or where any reasonable person would consider the person's life in danger.

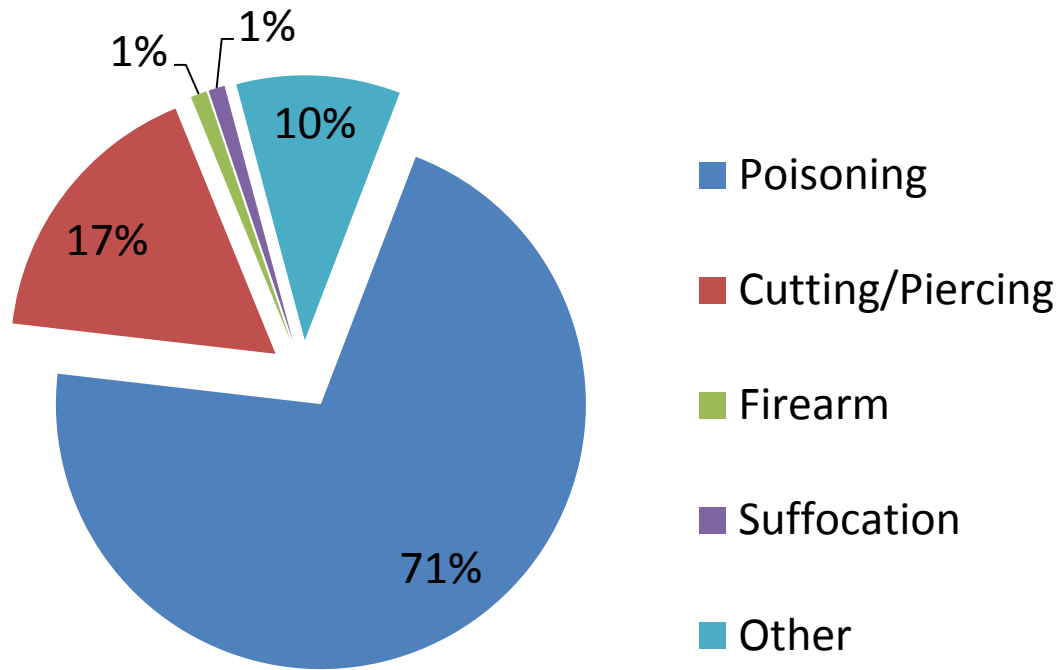
**WHY DOES THIS STORY SOUND SO
FAMILIAR?**

% of High School Youth who report having had, in the prior 12 months:



Suicide Attempts

- About 2 million US adolescents attempt suicide yearly.
- About 700,000 of them receive medical attention.
- 80-90% have a psychiatric disorder

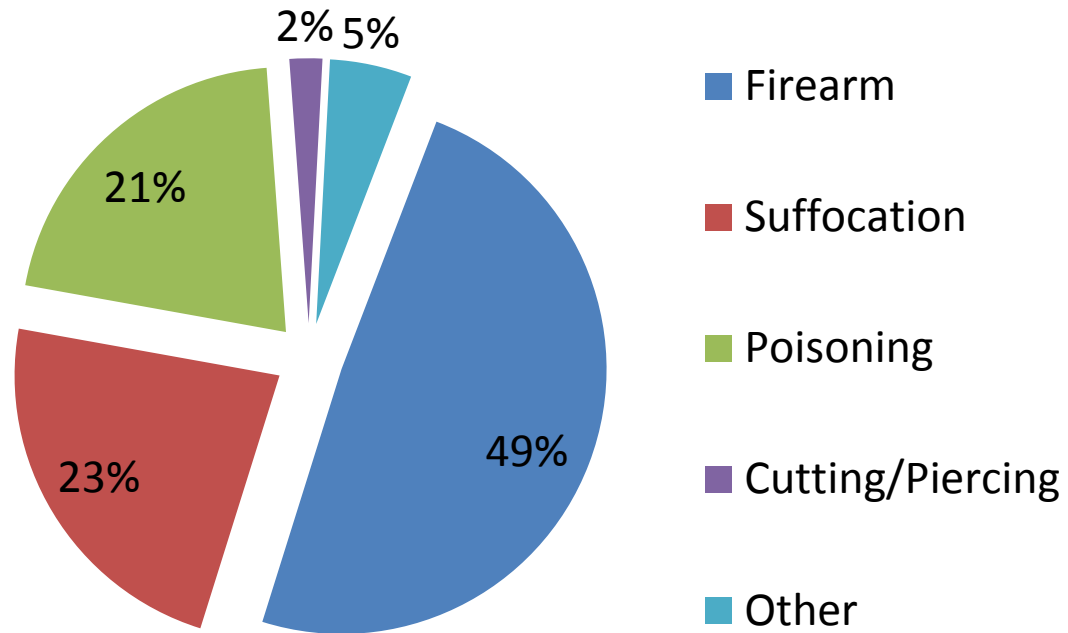


Methods of Attempted Suicide in Wisconsin 1995-2005

Suicide Attempters

- Data comes with caveats as many attempters do not present for evaluation.
- 2:1 Female: Male ratio
- Sexual minorities are at 2-7 fold increased risk of attempting suicide, but bullying and prevalent substance abuse are confounding variables.
- The use of ethnicity to predict risk varies by community, year and sub-population.
- Family or relationship disturbances are common precipitating factors.

**HOW ARE THOSE WHO DIE FROM
SUICIDE DIFFERENT FROM
ATTEMPTERS?**



Methods of Completed Suicide in Wisconsin 1995-2005

Suicide Statistics

- Third leading cause of death (after accidental injury and homicide)
- Approximately 2000 youth commit suicide each year
- This is a tiny fraction of attempts!
- After peaking in the late eighties, rates have been trending down.
- 4:1 Male: Female ratio in completers.
- More likely to have a firearm at home.

**WHAT SHOULD WE DO WITH
NANCY?**

Suicide Attempt: Initial Evaluation

- Medically stable, not intoxicated
- Maintain safety of patient, staff, environment
 - Use a stripped-down exam room (without fixtures if available).
 - Please don't use haloperidol.
 - Midazolam or lorazepam, beware activation

Medication	Oral liquid/ODT	IM
Risperidone	0.25-0.5 mg/day	NA
Olanzapine	2.5-5 mg/day	5mg children, 10mg adolescents
Ziprasidone	Not recommended	5mg children, 10mg adolescents

Suicide Attempt: Initial Evaluation

- History
 - Obtaining collateral information is the standard of care.
 - A detailed description of the attempt is important, particularly how the patient came to medical attention.
 - Most teens will tell you what happened.
 - There are numerous research questionnaires, none can currently be recommended for clinical use.
 - Inability to contract for safety is non-reassuring.

Suicide Attempt: Initial Evaluation

- Physical Exam
 - Check for cutting, other self-injury
- Laboratory Evaluation
 - Dictated by clinical presentation
 - Youth are often unreliable historians regarding the extent or ingredients in an ingestion
 - Urine drug screen and β -HCG are helpful for discharge planning

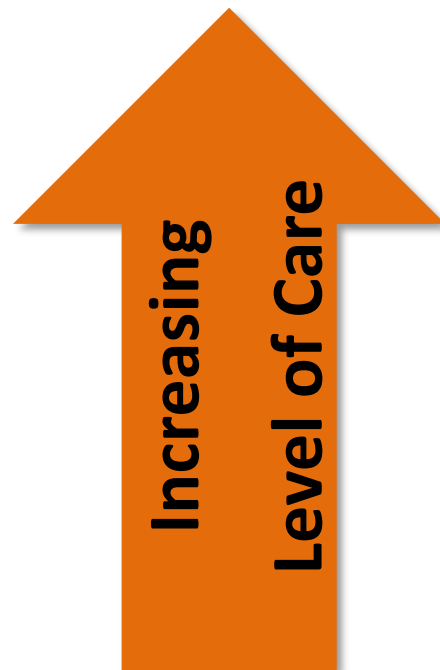
**THE REAL QUESTION WAS “ADMIT
OR NOT?”**

Predicting Suicide



Levels of Care

- Inpatient Medical Care
- Involuntary Inpatient Psychiatric Care
- Inpatient Psychiatric Care
- Partial Hospitalization/Day Treatment
- In Home Therapy
- Intensive Outpatient
- Prompt Mental Health Follow-up
- Prompt Primary Care Follow-up
- Go back to school tomorrow



Disposition Decision

Assess the severity of the child's presentation.

Assess the biological, psychological, and social risk factors.

Determine which, if any, risk factors can be substantially altered.

Is the child connected with mental health services?

What is the least restrictive option available to appropriately modify acute risk factors?

Factors Suggesting High Acute Risk

Agitation

Continued Intent to Die

The attempt was highly likely to be lethal

- Mechanism
- Efforts to avoid detection
- Realistic and detailed plan

Hopelessness

Active depression,
mania or psychosis

Active substance use

Homeless, runaway or
otherwise living alone.

Empirically Known Risk Factors: Biological

- Prior attempt(s), number, severity
- Male sex
- >16 years old
- Mood disorder
 - 27x risk with major depression
 - Duration of depression
 - Early age of depression onset
 - 9x risk with bipolar*

Empirically Known Risk Factors: Biological

- Substance use
- Disruptive behavior disorder, in boys
- Anxiety disorder
 - Panic attacks increase risk of suicide attempt for girls
- Functional impairment/injury
- Family history of suicide attempt.

Empirically Known Risk Factors: Psychological

- Hopelessness
- Poor problem-solving skills
- Low self-esteem
- Negative/Rigid Personality
- Impulsiveness

Empirically Known Risk Factors: Social

- Abuse
 - 15-20% of female attempters have been abused
- Living Alone
- Negative Emotional Life Stressors
 - Recent loss of relationship
 - Anniversary of a loss
 - Suicide in a close contact (contagion effect)
- Ineffective communication with parents
- Critical parents, lack of warmth
- Violence at home
- Parental mental illness

Protective Factors

- Social Problem Solving
- Positive Self Esteem
- Cohesive, adaptable family
- Family support
- Resilience
- Less well supported
 - Religion
 - Friend support
 - Actively in treatment with a mental health provider

**HOW DO I DEVELOP A SAFETY
PLAN?**

Safety Planning

- Assure removal of firearms
- Securing other means of harm (poisons, sharps, etc) at home.
- Verify who will be with the child, providing for physical security until follow-up.
- Establish a clear follow-up plan, preferably with a prompt appointment scheduled prior to leaving the ED.
- Ideally, establish a procedure for verifying that discharged patients attended follow-up.
- Contact information for assistance if the family needs help maintaining safety. (Often, 911)

Safety Plan: Parents

- Discuss how the parents will monitor the child until follow-up.
- Parents should have the safety plan and emergency contact numbers
- Parents should be coached about maintaining good lines of communication about suicidal thoughts or behaviors.
- Parents should be encouraged to scale back family conflict until the youth's suicidality is improved.

Safety Planning: Safety Plans

- Available at SPRC.org
1. Help the teen identify warning signs of impending suicidality
 2. Have the teen list internal resources/coping strategies they can use to stay safe.
 3. List people and social activities that are good distractions from low moments.
 4. List supportive people the teen can reach out to, including contact information.
 5. List health care providers and emergency resources to contact if the prior steps are not working.

WHAT ABOUT GUIDELINES?

The Guidelines are Aging

- AACAP guideline is from 2001
- APA guideline is from 2003
- AAP guideline is from 2007
- AAFP does not appear to have one

Guidelines:

- Assess all teens for suicidal ideation
 - Independently from parents
 - Written screening instruments can help, but are optional
- If there is a high acute risk, immediate further evaluation is warranted.
- Always obtain collateral information.
 - “Children and adolescents should never be discharged from the emergency service without the child’s or adolescent’s caretaker having verified the child’s or adolescent’s account” —AACAP
- Get rid of guns and lock up poisons.
- Treat with the least restrictive environment that can safely begin to change risk factors.
- Document your consideration of risk and protective factors.

**WHAT PROVEN TREATMENTS ALTER
THESE RISK FACTORS?**

Biological Therapies

- Medication treatment focuses on relieving underlying mental illness.
- SSRI medications are safe and effective for reducing depression.
 - However, they take 4-6 weeks to work and can have nuisance side effects.
 - SSRIs should not be started in an emergency setting, except in the rare instance that an iron-clad follow-up plan is in place.
- The only psychiatric medications proven to reduce suicide are lithium and clozapine.

Psychological Therapies

- Cognitive-Behavioral Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Dialectical-Behavioral Therapy (DBT)
- Multisystemic Family Therapy (MST)
- All shown to be effective in reducing depression symptoms in youth.
- DBT is being studied to see if it reduces suicide attempts in youth.
- There is a specific CBT from the TASA study that looks promising to reduce suicide attempts, but needs further study.

Social Interventions

- Inpatient hospitalization has not been subject to examination by randomized controlled trial.
- Hospitalization can be used to
 - Start medication
 - Distance the child from a stressful situation
 - Establish more effective family communication
 - Establish outpatient treatment follow-up
- Most teens are scared of the “psych ward” but will be relieved when given accurate information.

Social Interventions

- School screening can prevent suicide by identifying treatable mental illness.
- School debriefing or mass counseling after a completed suicide can *increase the likelihood of contagion-effect attempts*.

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