Suicidal Children in the Emergency Department

Strategies to Evaluate and Manage within a Strained System

REBECCA MARSHALL, MD, MPH

OREGON HEALTH & SCIENCE UNIVERSITY

DOERNBECHER CHILDREN'S *Hospital*

Outline

1. Oregon's mental health system of care for youth
2. Overview of youth suicidality
3. Assessment of suicidality in the ED
4. Determining disposition
5. Discussion

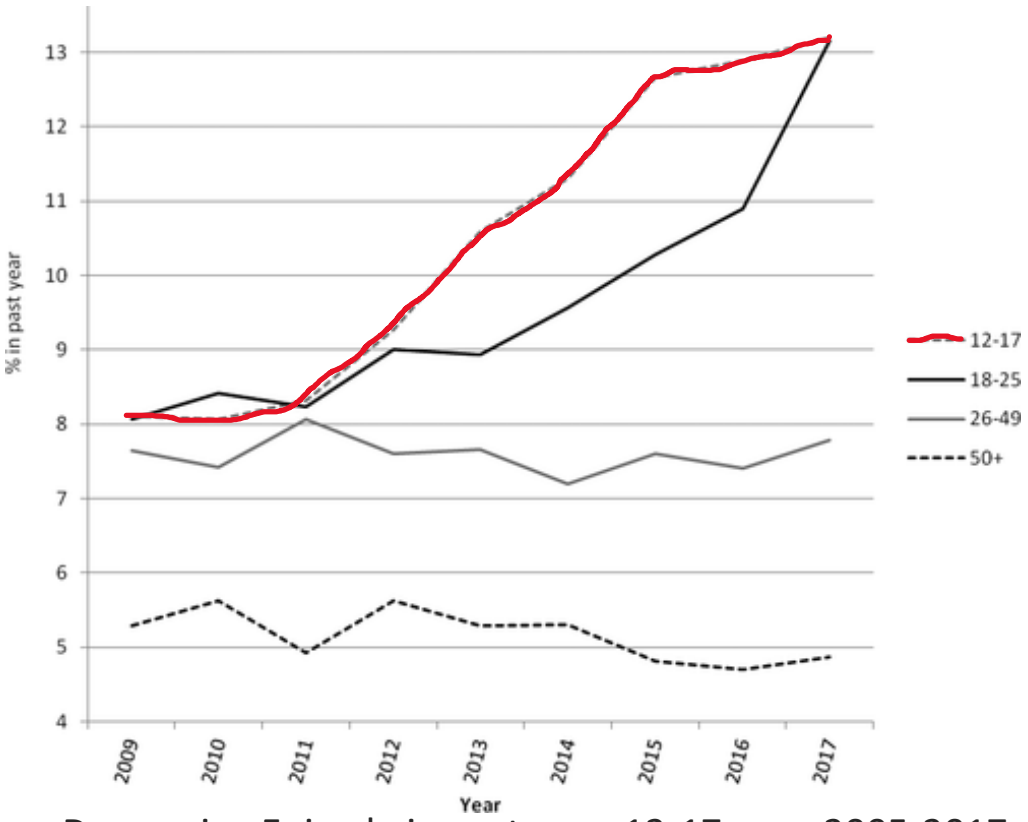
CHILD AND ADOLESCENT MENTAL HEALTH OVERVIEW OF OREGON'S SYSTEM OF CARE

The State of Children's Mental Health

1 in 5 children 3-17 y.o. has a diagnosable mental health disorder

Est 1 in 7 children has experienced abuse or neglect

Rates of anxiety, depression, eating disorders, suicidality are increasing



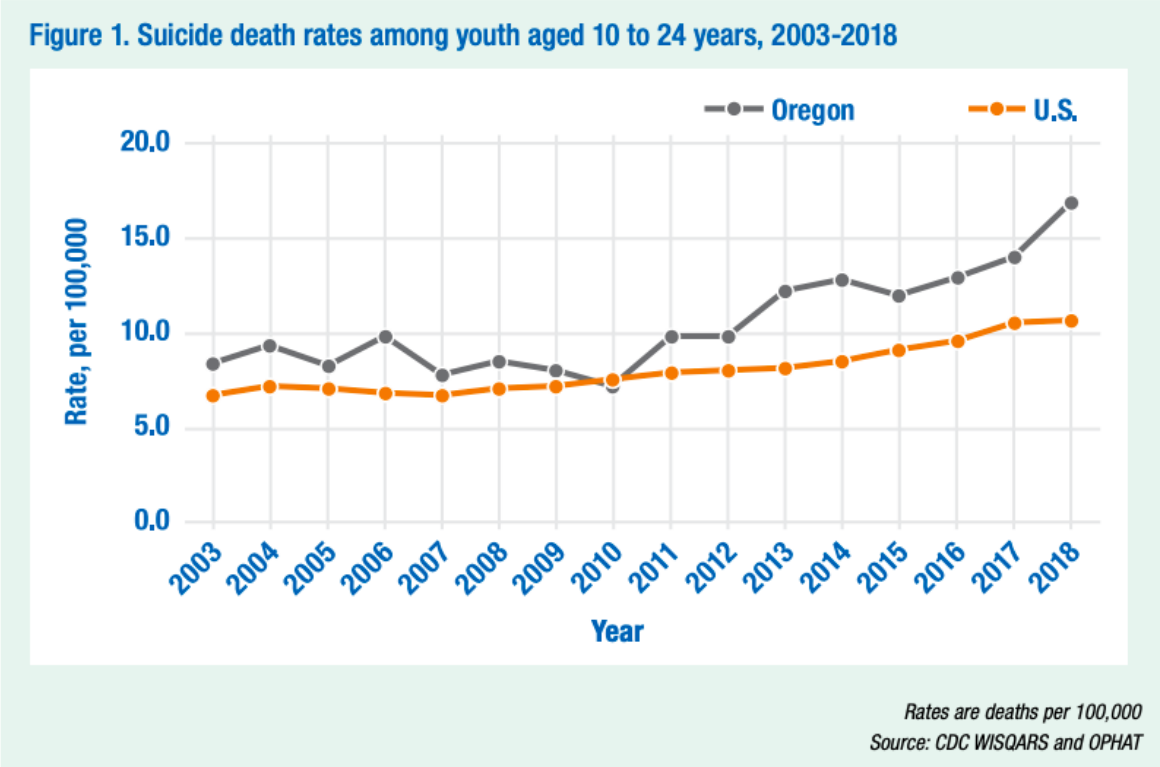
Depressive Episode in past year, 12-17 y.o., 2005-2017

Bitsko RH et al. Epidemiology and impact of healthcare provider diagnosed anxiety and depression among US children. *J Dev Behav Peds. 2018*

The State of Children's Mental Health

The number of children dying from suicide is increasing

Among 10-24 y.o., suicide is the leading cause of death in OR and 2nd leading cause of death in US



WISQARS) [online]. 2005. www.cdc.gov/injury/wisqars

Mental Health in EDs

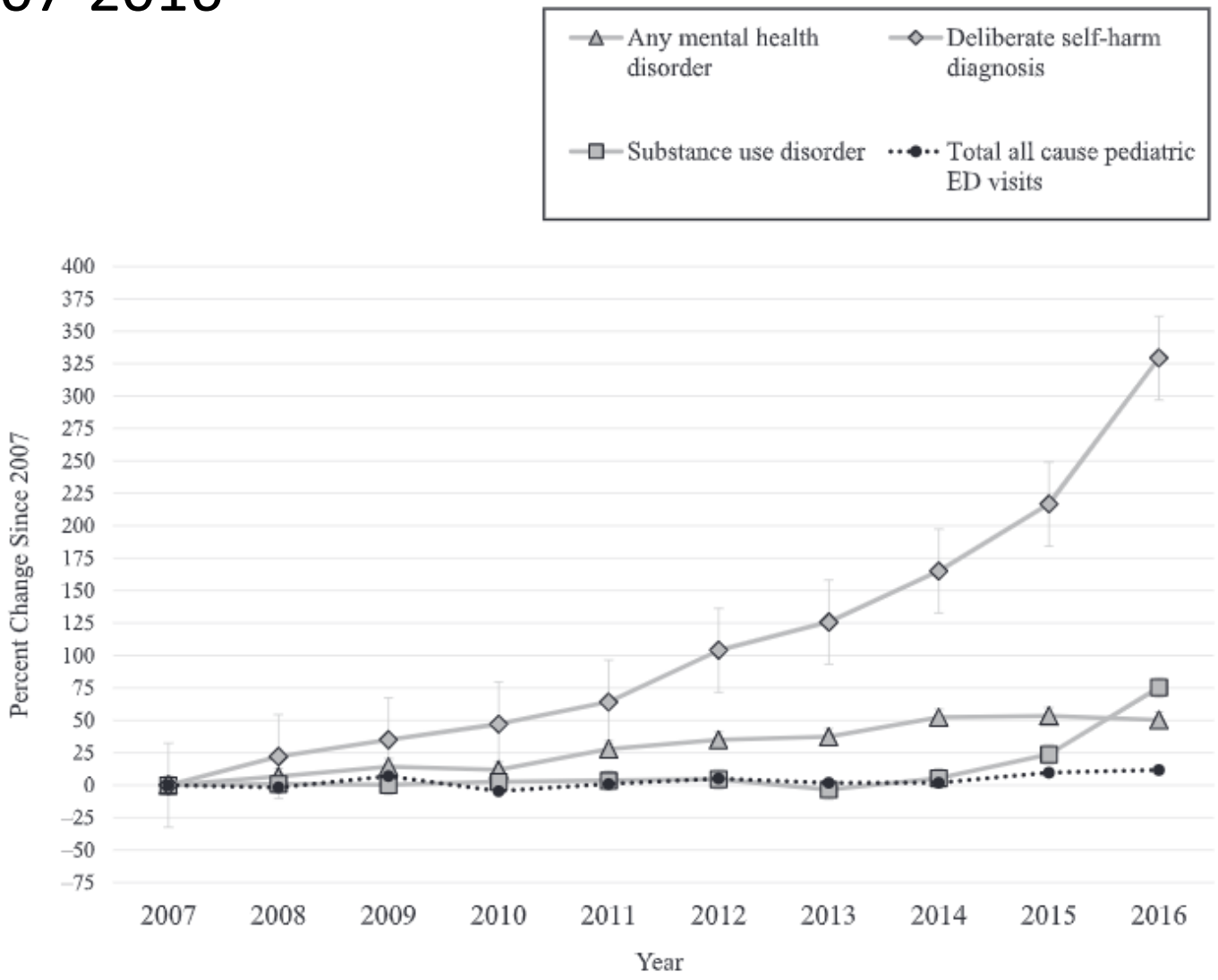
National PED visits for suicidal ideation increased from **580,000 in 2007** to **1.12 million in 2015**

16% of patients were seen by a mental health professional during their visit

Burstein B, Agostino H, Greenfield B. Suicidal Attempts and Ideation Among Children and Adolescents in US Emergency Departments. *JAMA Pediatr.* 2019;173(6):3.

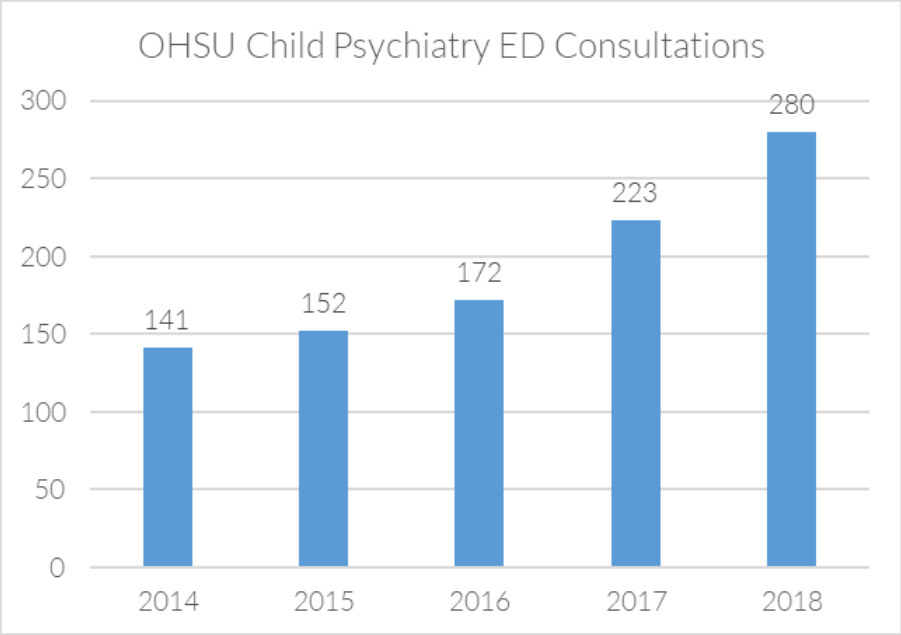
Kalb LG, Stapp ED, Ballard Ed, Holinque C, Reefer A, Riley A. Trends in psychiatric emergency department visits among youth and young adults in the US. Pediatrics. 2019;143(4).

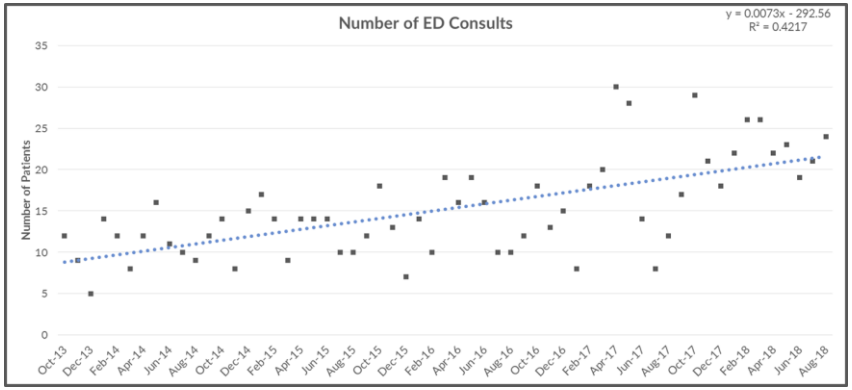
Pediatric ED Visits among Mental Health Subgroups 2007-2016



CB Low et al. Children's Mental Health Emergency Department Visits 2007-2016. Pediatrics (2020)

Child Psychiatry Consults in OHSU ED





Oregon Psychiatric Care for Youth

Outpatient

- Standard Outpatient
- Intensive outpatient
- Day treatment or "partial hospitalization"

Inpatient

- Residential
- Subacute
- Acute
- State hospital for children (SCIP)
- State hospital for adolescents (SAIP)

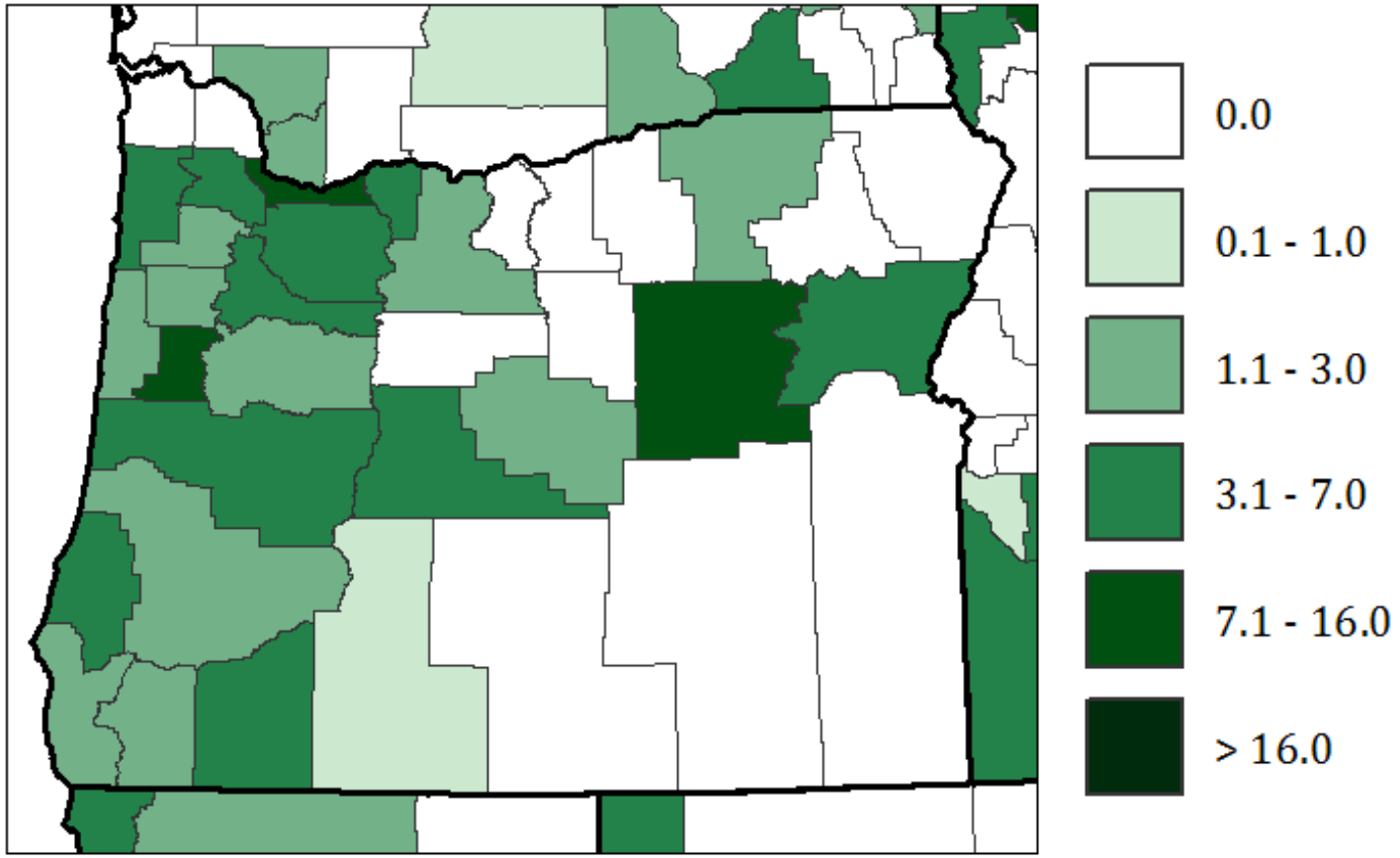
Outpatient Mental Health Care

- Highly variable by county
- Highly variable by insurance
- Limited intensive services, esp. for private insurance
  - New level of care introduced
- Limited services in rural counties
  - few therapists;
  - few if any CAP

Psychiatrists, 2015

Number per 10,000 children aged 0-17 years

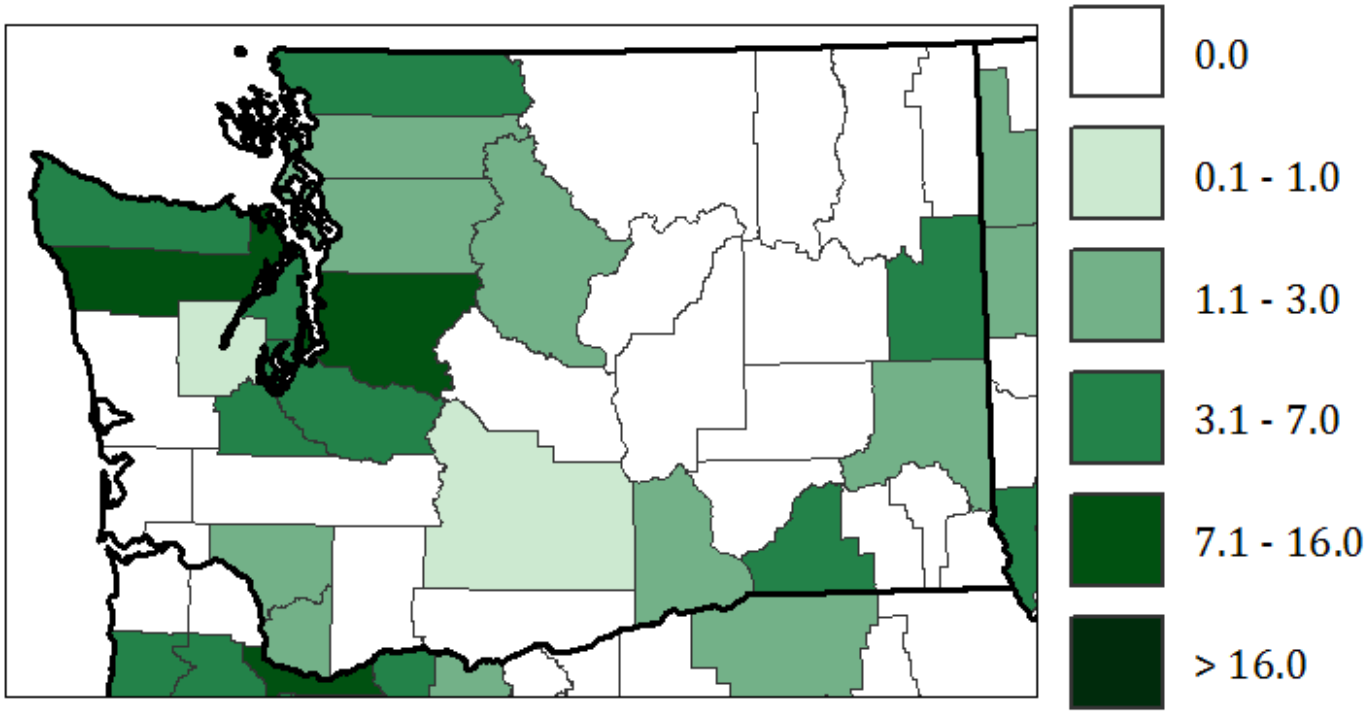
OREGON



Psychiatrists, 2015

Number per 10,000 children aged 0-17 years

WASHINGTON



Inpatient Mental Health Care

Statewide bed tally

Acute: 2 programs (44 beds)

Subacute/residential: 4 programs (~225 beds)

Over past 20 years:

- No increase in psychiatric beds
- Residential and group home (DD) beds have decreased by appox. 200 beds

OHSU

Pediatric Boarding

2020 Review in *Pediatrics*

- *Average* ED boarding times ranged from 5 to 41 hours
- Boarding in the ED occurred in 23% to 58% of youth with mental or behavioral health concerns

McEnany FB et al. Pediatric mental health boarding. Pediatrics Oct 2020, 146 (4) e20201174; **DOI:** 10.1542/peds.2020-1174


ENTRANCE
MENTAL HEALTH
TREATMENT
CENTER

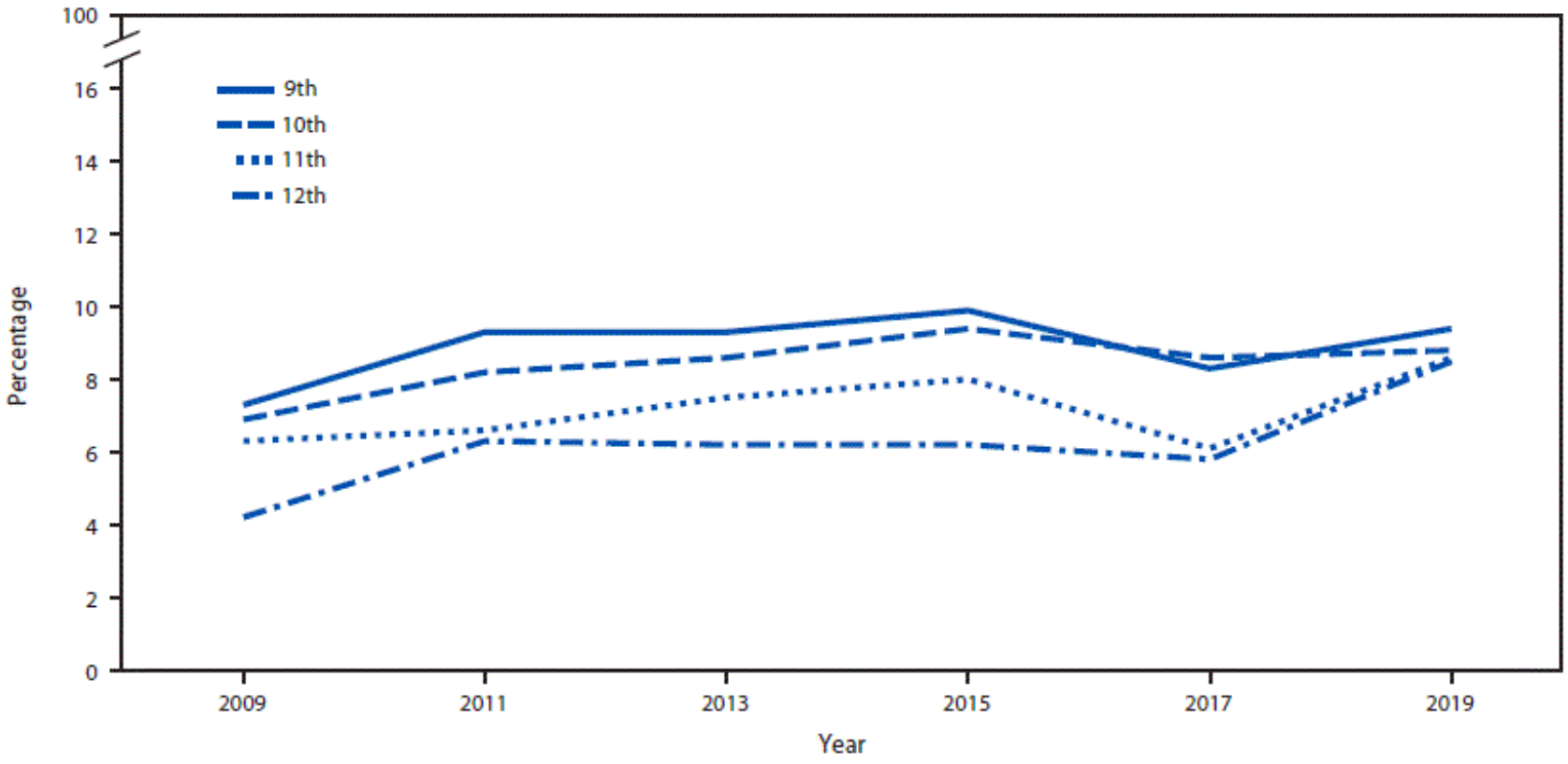
Initiatives to Improve Care

- Crisis and Transition Services (CATS) in some counties
- Intensive In-Home Behavioral Health Services
- Initiatives to pilot mobile crisis services for youth
- 2 new partial hospitalization programs
- Increased funding for school-based services
- Increased funding for DD services

SUICIDALITY IN CHILDREN AND ADOLESCENTS

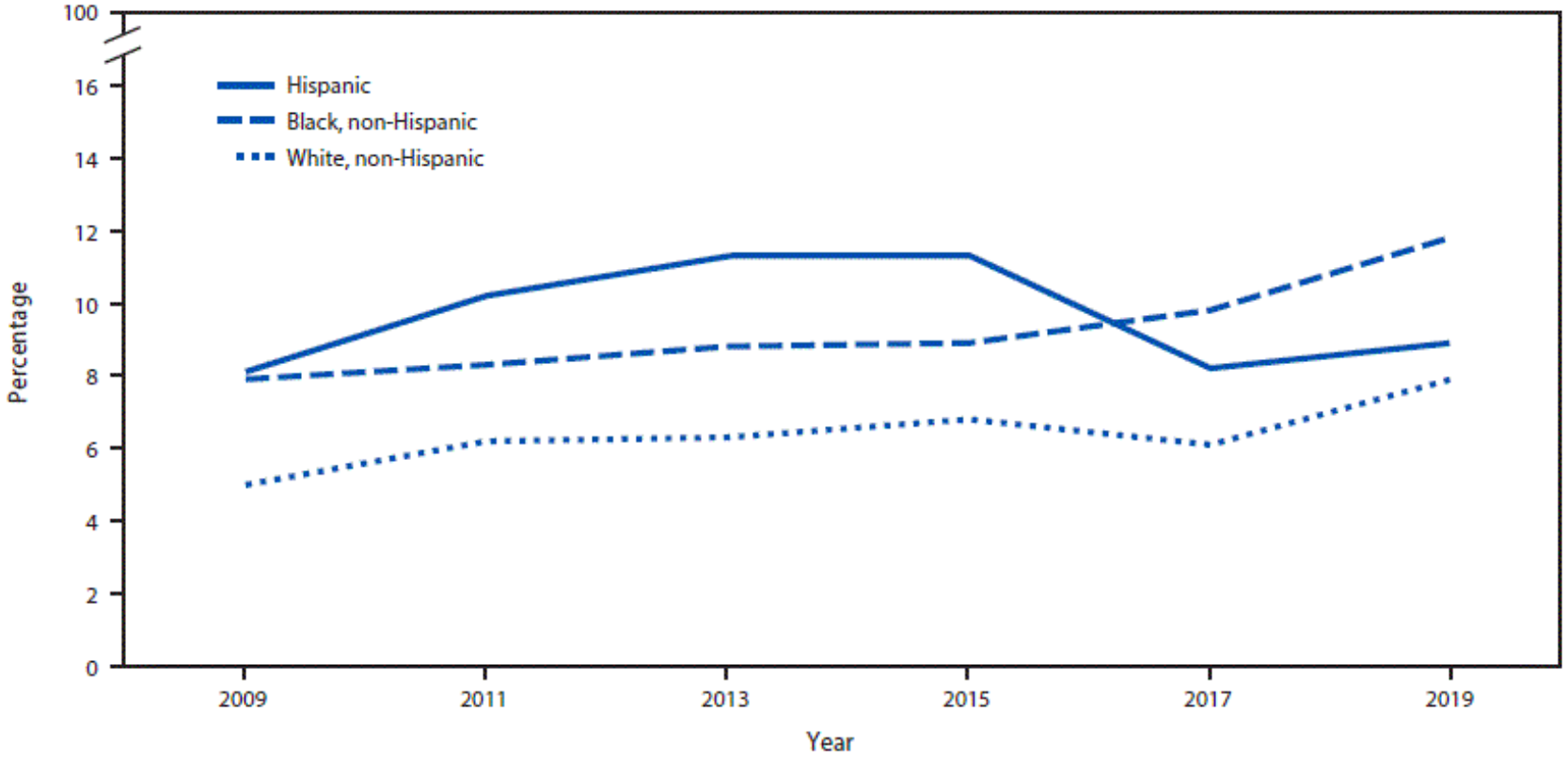
OHSU

Percentage of high school students who attempted suicide during the 12 months before the survey, by grade (2019)



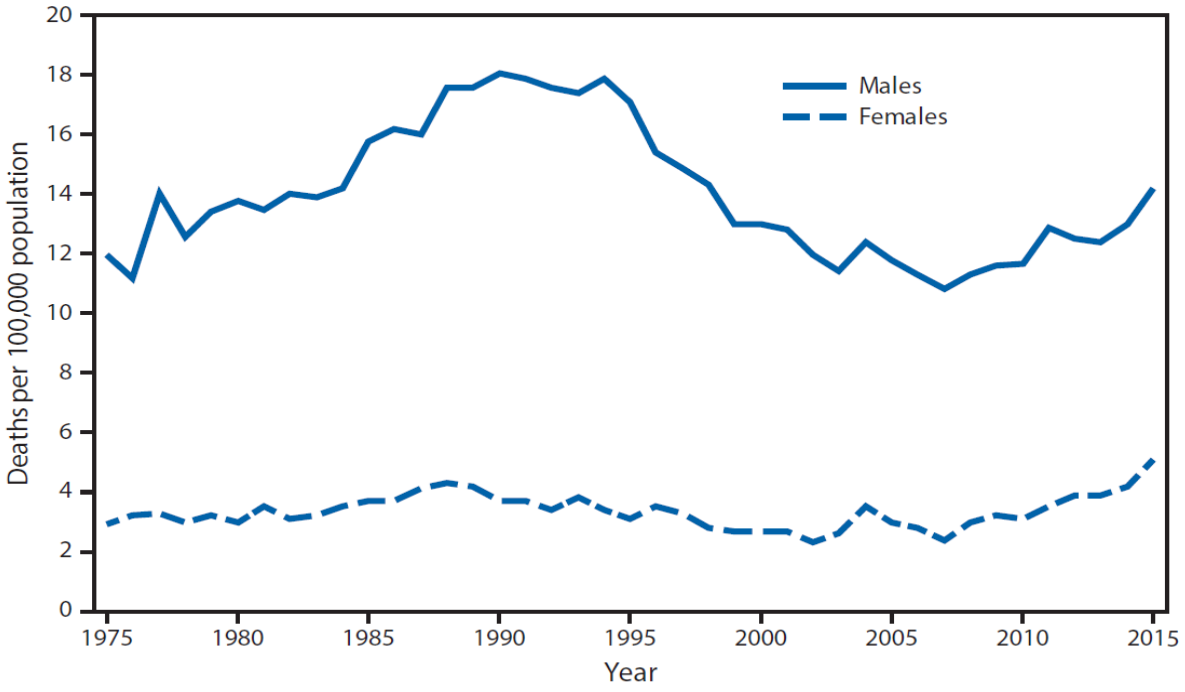
Ivey-Stephenson AZ, Demissie Z, Crosby AE, et al. Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019. MMWR Suppl 2020;69(Suppl-1):47–55. DOI: http://dx.doi.org/10.15585/mmwr.su6901a6external icon.

Percentage of high school students who attempted suicide during the 12 months before the survey, by race/ethnicity



FROM THE NATIONAL CENTER FOR HEALTH STATISTICS

Suicide Rates*,† for Teens Aged 15–19 Years, by Sex — United States, 1975–2015



* Rates are per 100,000 population. † Suicides are identified with *International Classification of Diseases* (ICD) *8th Revision* codes E950–E959 for 1975–1978; ICD 9th revision codes E950–E959 for 1979–1998; and ICD 10th revision codes U03, X60–X84 and Y87.0 for 1999–2015. In 1975, in the United States, there were 1,289 suicides among males and 305 suicides among females aged 15–19 years. In 2015, there were 1,537 suicides among males and 524 among females aged 15–19 years.

CDC. National Vital Statistics System, mortality data. https://www.cdc.gov/nchs/nvss/deaths.htm.

By Ashley Welch CBS News *November 21, 2017, 11:42 AM*

What's behind the rise in youth suicides?

Suicides and suicide attempts have been rising among children and teens. Getty Images

A spate of suicides among unusually young people has made headlines in recent weeks. Earlier this month, an 11-year-old girl from South Carolina shot herself to death because she was being bullied at school.
The girl, Toni Rivers, told five of her friends that "she just couldn't do this anymore, and she was going home, and she was killing herself," her aunt, Maria Petersen, told CBS affiliate WTOC-TV.

Just a few days earlier, police reported that a 12-year-old boy jumped from an overpass above Interstate 66 in northern Virginia and landed on a car. He was critically injured and the driver was killed.

What's behind the rise in youth suicides?

A few common hypotheses:

- Increase in media exposure
- Sleep disruption
- Opioid epidemic
- Contagion
- Less time outside

OHSU CAP Consult model

* Initial evaluation + recs for ongoing care in ED, PICU, medical floors

* Staffing:
  - Attending CAP
  - CAP fellow
  - Social worker x2
  - Care coordinator

* CAP available daily in PED and 24/7 by phone

* After-hours: ED, MD and SW assess
  - If psychiatry assessment needed, patient kept in ED until next day

* If > 3 psychiatry patients in ED, 1+ patient transfers to medical unit

Assessing Suicidal Youth

Key Practices in Suicide Safety

1. Don’t be afraid to talk about suicide and safety
2. Gather information
   - Screening
   - Assessment of risk factors
3. Involve the family
4. Plan disposition carefully

1. Talk about suicide and safety

- Asking about suicidality does not increase risk.
- Be curious about your patient's thoughts and experiences
- Validate their struggles
- Offer hope that things can get better
- Involve the family
- Educate about mental health, suicide risk and safety, and the system of care

2. Gather Information : Suicide Screening

Why

- Standardized approach

- May “catch” youth who would otherwise be missed

- Some can be used as assessment tool as well

- Recommend screening all youth age 10 and up (depending on screening tool)

2. Gather Information : Suicide Screening

Validated screening tools :

-Risk of Suicide Questionnaire (RSQ)

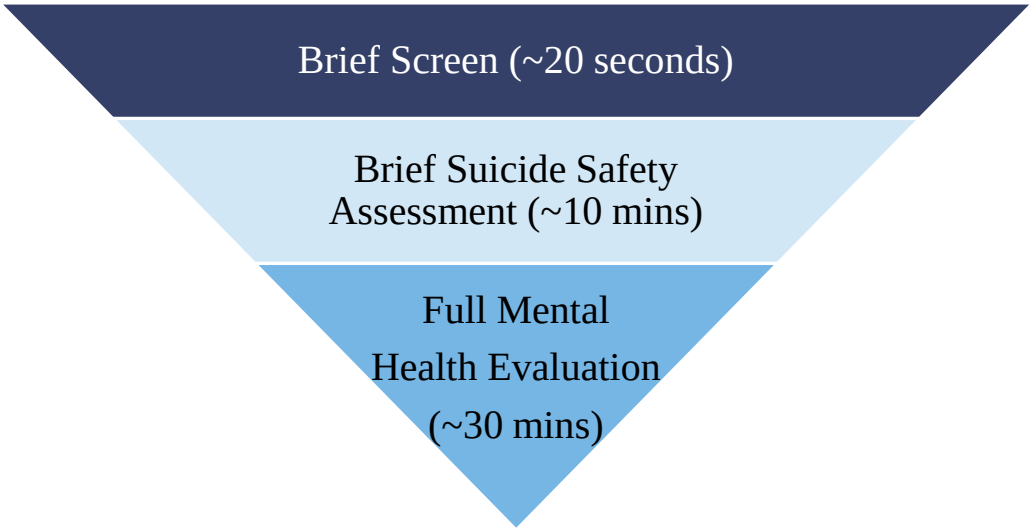
-Behavioral health screening

-Columbia Suicide Severity Rating Scale (CSSRS)

-Ask Suicide-Screening Questions (ASQ)

Universal Youth Suicide Screening Clinical Pathway

Clinical Pathway- 3-tiered system



NIH National Institute of Mental Health

Brahmbhatt, Kurtz, Afzal…Horowitz, et al. (2018) *Psychosomatics*

Ask the patient:

1. In the past few weeks, have you wished you were dead?	❍ Yes	❍ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?	❍ Yes	❍ No
3. In the past week, have you been having thoughts about killing yourself?	❍ Yes	❍ No
4. Have you ever tried to kill yourself?	❍ Yes	❍ No

If yes, how? _____

_____

_____

When? _____

_____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

5. Are you having thoughts of killing yourself right now?	❍ Yes	❍ No

NIH National Institute of Mental Health

Horowitz, Bridge, Teach, Ballard…Pao, et al. (2012) *Arch Pediatr Adolsc Med*

What is the purpose of the BSSA?

- To help clinician make “next step” decision
- 4 Choices
  - **Imminent Risk**
    - **Emergency psychiatric evaluation:** Patient is at imminent risk for suicide (current suicidal thoughts “right now”). Initiate suicide safety precautions and request emergency mental health evaluation
  - **High Risk**
    - **Further evaluation of risk is necessary**
    - **Inpatient medical surgical:** Patient will require a further mental health evaluation from a mental health clinician before discharge
    - **Outpatient medical setting:** Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours).
  - **Low Risk**
    - **Not the “business of the day”**
    - **Patient might benefit from non-urgent mental health follow-up:** Review the safety plan and send home with a mental health referral.

    OR
    - **No further intervention is necessary at this time.**

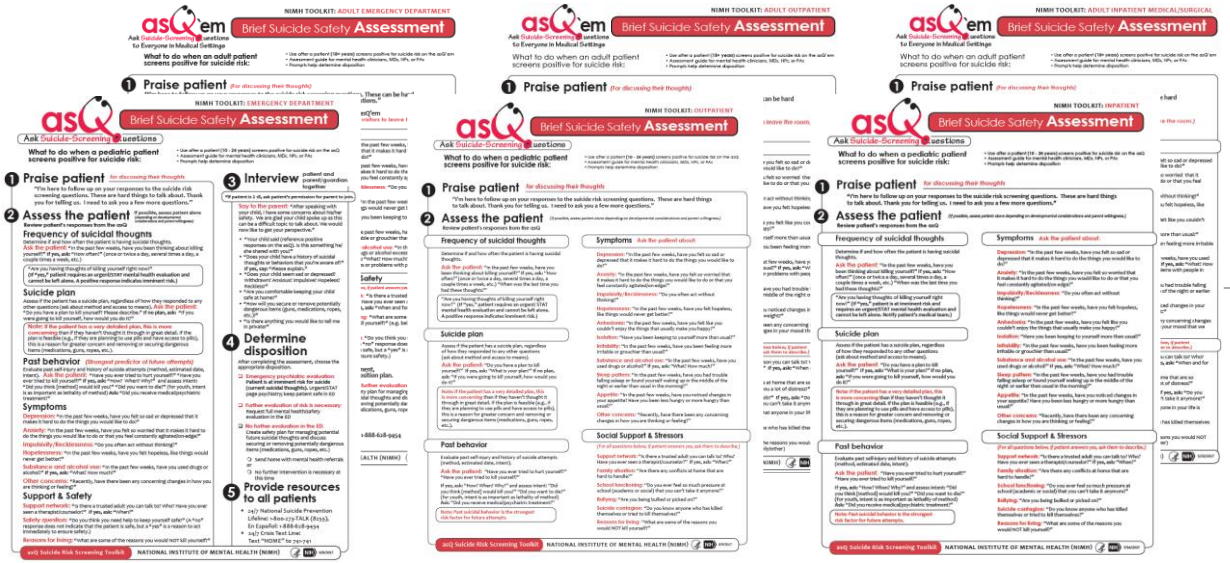
Brief Suicide Safety Assessment

Train staff (social worker, NP, MD, PA, or other trained clinical professional) to administer the BSSA

Should take about 10 minutes to complete

Brief Suicide Safety Assessment

- BSSA and Worksheets available for Youth and Adults
  - Emergency Departments
  - Inpatient Medical/Surgical Unit setting
  - Outpatient settings



Responding to a positive screen

2. Gather Information : Assess risk

- Meet first with youth alone, then with youth and parent together
- Observe the child and their affect as you assess
- Remember:
  - Risk factors are common; suicide is not
  - No risk factors does not mean child is not at risk
  - Also listen to your clinical judgement and “gut feeling”

Fixed risk factors

Family history of suicide

Male gender

Lesbian, gay, bisexual, transgender, queer

History of abuse

Previous attempt

Recent adverse or stressful life events (past year)

In foster care or adopted

Personal (modifiable) risk factors

- Sleep disturbance
- Depression
- Bipolar disorder
- Intoxication
- Substance use disorder
- Psychosis
- PTSD
- Panic attacks
- Hx aggression, impulsivity, severe anger, pathologic internet use

Protective factors

Sense of responsibility to family

Life satisfaction

Social support; belongingness

Coping skills

Problem-solving skills

Strong therapeutic relationship

Reality testing ability

Religious faith

Restricted means

Ask about the patient's suicidal thoughts

"In the past few weeks, have you been thinking about killing yourself?"

If yes…

"How often?"

"When was the last time you had these thoughts?"

"Do you think you would act on these thoughts?"

"Are you having thoughts of killing yourself right now?"

If patient is having current suicidal thoughts

- Requires urgent mental health evaluation
- Make sure an adult is present with patient *at all times* until evaluation occurs.

Assess if patient has a suicide plan

"Do you have a plan to kill yourself?"

If yes, ask: "What is your plan?"

If no, ask: "If you were going to kill yourself, how would you do it?"

--very detailed is more concerning

--more feasible is more concerning (e.g., planning to use pills and has access to pills)

Evaluate prior suicidality + self-harm

Ask: “Have you ever tried to hurt yourself?”; “Have you ever tried to kill yourself?”

If yes: “How? When? Why?”

Assess intent:

Ask**:** “Did you think you would die?” “Did you want to die?”

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

Ask about mental health symptoms

"In the past few weeks, have you…"

Depression

"…felt so sad or depressed that it makes it hard to do the things you would like to do?"

Anxiety

"…felt so worried that it makes it hard to do things or feel constantly agitated/on-edge?"

Hopelessness

"…felt hopeless, like things would never get better?"

Anhedonia

"…felt like you couldn't enjoy things that usually make you happy?"

Isolation

"…been keeping to yourself more than usual?"

Irritability

"…been feeling more irritable than usual?"

Substance and alcohol use

"…used drugs or alcohol? "

If yes, ask: "What? How much?"

Sleep pattern

"…had trouble falling asleep or found yourself waking up in the middle of the night or earlier than usual in the am?"

Appetite

"…noticed changes in your appetite? Have you been less or more hungry than usual?"

Impulsivity/Recklessness

"Do you often act without thinking?"

Other concerns:

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

Ask about social supports + stressors

Support network: “Is there a trusted adult you can talk to? Have you ever seen a therapist/counselor?”

Family situation: “Are there conflicts at home that are hard to handle?”

School functioning: “Do you ever feel so much pressure (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?”

Stressors /losses: “Have there been any big stressors or losses in your life recently?”

Reasons for living: “Are there reasons you would NOT kill yourself?”

3. Involve the family

Involve the family to:

-assess the patient's symptoms and safety

-determine disposition

-safety plan including lethal means restriction

-provide psychoeducation

-provide support and reassurance that you will help their child get help

Interview patient with parent

If patient is ≥ 18 years, ask patient's permission for parent/guardian to join.

Ask parent about child/adolescent's:

- History of suicidal thoughts or behavior
- Mental health symptoms
- Sleep
- Substance use
- Family history of suicide attempts or suicides
- Recent stressors
- Presence of safe trusted adults
- Safety risks in the home (guns, medications, etc.)

4. Determine disposition

Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Refer to inpatient or coordinate with current provider to develop alternative safety plan.

Further evaluation of risk : Review the safety plan and send home with a mental health referral ASAP (preferably within 72 hours).

Non-urgent mental health follow-up: Review the safety plan and send home with a mental health referral.

No further intervention needed.

4. Determine disposition

With all positive screens:

-- Follow-up within 48 hours (phone call)

-- Alert PCP or other provider to follow up at next appointment

When *not* to discharge

- Patient is suicidal, not engaging in safety planning
- Patient is suicidal due to family situation/home feels unsafe
- Patient is suicidal, not thinking clearly (high, psychotic)
- Patient is cagey/evasive and has significant risk factors OR you do not believe the patient can remain safe
- Patient's family feels they cannot keep the patient safe

4. Determine disposition: Safety planning

Involve parent/guardian

Helps patient plan how to manage future suicidal thoughts.

not ”safety contract” or “contracting for safety”

“Our first priority is keeping you safe. Let’s develop a safety plan for when you have suicidal thoughts.”

Safety Plan

Safety Concern: I am having thoughts of killing myself

Triggers that make me feel unsafe (list 3): Feeling lonely, getting bullied on Instagram, fighting with mom

Coping skills to improve my state of mind (list 3): Writing in my journal, going for a walk, petting my dog

Social situations and people that distract me and decrease distress (list 2): Playing online games with my cousin, watching a movie with my best friend

People I can ask for help (list 2): Aunt Jane, my English teacher

Professional/Agencies I can contact during a crisis: 1. Multnomah County Crisis Line/503.988.4888;
2. Portland Emergency Services: 503.823.3333 or 9-1-1; 3. Go to the nearest Emergency Department

To support safety, caregiver will do to following: Say: "Research has shown that limiting access to dangerous objects saves lives. How will you secure or remove these potentially dangerous items (guns, medications, ropes, etc.)?"
1. Provide sight and sound supervision.
2. Remove any objects of harm (lock up meds in lock box)
3. Lock up ammunition separately from gun (in gun safe)

What is one thing that is most important to me and worth living for: My family

4. Determine disposition: Lethal means restriction counseling

4. Determine disposition: Lethal means restriction counseling

- Youth in homes with guns and ammunition have increased suicide rates
- When clinicians recommend that parents restrict access to guns and medications, most do.
- Counsel parents to remove firearms from the home or lock guns and ammunition in separate places
- Parents should restrict access to prescription/OTC meds and alcohol

Medication Lockboxes

http://www.lockmed.com

- Can also use a toolbox and padlock
- a padlock on a kitchen cabinet
- Do not store medications in a car, purse, on top shelf of kitchen cupboard

- If patient is referred to inpatient, patient may improve while boarding…
- …Sleep, time away from home, or therapeutic interventions may enable safe discharge
- Invite outpatient therapist or psychiatrist to visit patient in ED
- If patient isn't sleeping, a short-term sleep medication may help stabilize (i.e. melatonin, trazodone, low-dose mirtazapine)

Lessons from OHSU

- Help the family reach out for support: natural supports (family, religious community, friends) or support networks (NAMI, Oregon Family Support Network, Oregon Family-To-Family)
- Help the youth identify non-parent adult support: teacher, school counselor, older family member, religious leader, sports coach, etc.
- Ask yourself, “what has changed from when the patient came in?”

Lessons from OHSU

Thank you!

DOERNBECHER
CHILDREN'S
Hospital