13th Annual South Bay EDAP Conference
Pediatric Emergencies
By the Sea

CARING FOR YOUNG PATIENTS WITH SUICIDE RISK

Richard Lieberman MA, NCSP
Loyola Marymount University
Richard.lieberman@lmu.edu

Objectives

- Learn a process for care and discharge of a youth at risk for suicide
- Learn to utilize ED screening tools to assess youth at risk for suicide
- Work collaboratively with parents/guardians in assessing risk and providing interventions and resources for ongoing care
- Work with patients in developing safety plans

International Symposium on Youth Suicide

- Alarming increases
- Media sensationalism of suicide
- Clusters of suicides occur
- Students are under extreme pressure
- Guns are too available
- ***Schools are the best place to intervene***

Just the facts

- Suicide is the second leading cause of death for 10-24 year olds in the US (CDC, 2015).
- Almost one in ten youth and adult deaths by suicide in the US occur in California.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, **COMBINED.**
- Each day in our nation, there are an average of over 5,240 attempts by young people grades 7-12.

Myths/facts of youth suicide

- Talking about suicide does not increase risk
- While depression is a risk factor for suicide most people with depression do not attempt suicide and many people who engage in suicidal behavior are not depressed.
- Young people show warning signs
- Although research on suicide of children below the age of 12 is limited, this is a very vulnerable population to experiencing suicidal thoughts and risky behaviors
- Suicide is preventable

Youth Suicide in US: 2015
National trends

- 44,193 all ages (13.8)/33,994 males (21.5)
- 5900 youth aged 10-24 (12.5)
- 2rd leading cause of death for youth age 10-24
- Middle aged rate: 45-64 (19.6)

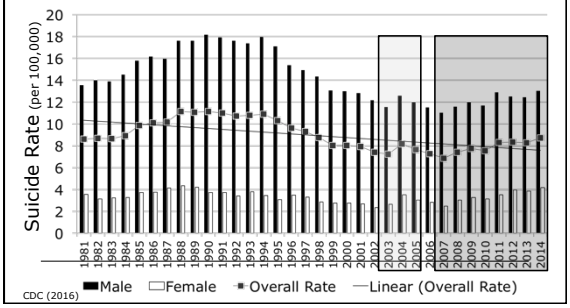
STEADY INCREASES SINCE 2007

- Most common method 49% firearms but among male youth was 52%

(female: 28% firearms & 44% suffocation).

Statistics & Demographics

Teen Suicide Rates:1981-2014 (15-19 yrs)



CDC (2016)

High risk youth: Cultural issues

- Hispanic youth
  - Latina
  - Highest in reporting of suicidal thoughts and behaviors
- African American youth
  - The suicide rate among children ages 5 to 11 doubled 1993-2013 .
- Native American/Alaskan Native youth
  - Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide.

Risk factors of youth suicide

- There is no single predictor of youth suicide
- Risk factors come together in a perfect storm
  - Alcohol & substance abuse*
  - Accessibility to means (firearms)*
  - Depression/Co-morbidity*
  - Previous suicidal behaviors
  - History of trauma or exposure to suicide*
  - Hopelessness
  - Impulsivity
  - NSSI

Youth Risk Behaviors: 2015 Los Angeles

Youth Risk Behavior Surveillance Survey High School

	US
30.4% felt sad or hopeless	29.9
14.1% seriously considered suicide	17.7
12.9% made a plan	14.5
8.4% made one or more attempts	8.6
2.1% actually got to medical help	2.8

In Los Angeles only one out of four kids who attempt suicide get to help
The other three wake up and go to school the next day

High risk youth

- Exposed to suicide
- Bullies and victims
- Lesbian, gay, bisexual, or transgender
- Depressed
- NSSI
- Traumatized
- Alcohol/substance abuse
- Homeless/Runaway children
- Children in foster care

High risk youth: Those exposed to suicide

- Research based estimate suggests that for each death by suicide ***147 people are exposed*** (6.3 million annually), and among those, ***18 experience a major life disruption*** (loss survivors; earlier, non-research based estimates were 6)
- A loss by suicide can be a traumatic loss

High risk youth: Bullies & Victims

- Children who have been bullied have reported a variety of behavioral, emotional and social problems.
- Highest risk has been both bully/victim
- Key factor is pre-existing psychopathology
- Some gender differences in response to bullying
- High risk groups include: LGBT, Disabled, Race & Religion

High risk youth: LGBT

- Higher rates of family rejection & peer victimization
  - 3X more likely to report suicidal ideation
  - 8X more likely to have attempted suicide
  - 6X more likely to have higher levels of depression
  - Compared to non-LGB youth LGB youth suicide attempts *may* be more serious

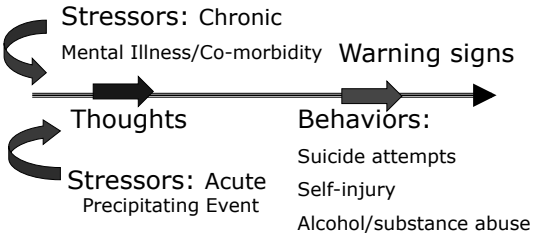
High risk youth: Depressed youth

- 30% youth in Los Angeles report feeling so sad or hopeless over the past year that they affected their daily activities.
- The majority do not receive services
- Co-occurring disorders
- Ignited by precipitating events
- Effective treatments include talk therapy and medications

High risk youth: NSSI

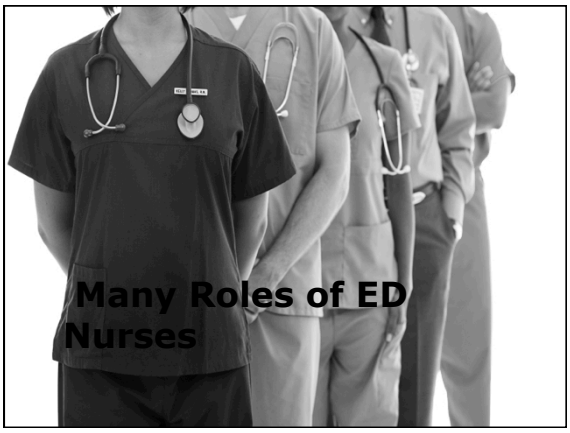
- Maladaptive coping strategy
- Generally assess at low risk for suicide
- Episodic associated with emotional regulation
- Repetitive NSSI associated with history of trauma, ACEs
- Suicidal risk increases with number of years engaging in self injurious behaviors and number of methods
- Treatment: Dialectical Behavior Therapy

Continuum of Self-destructive Behavior



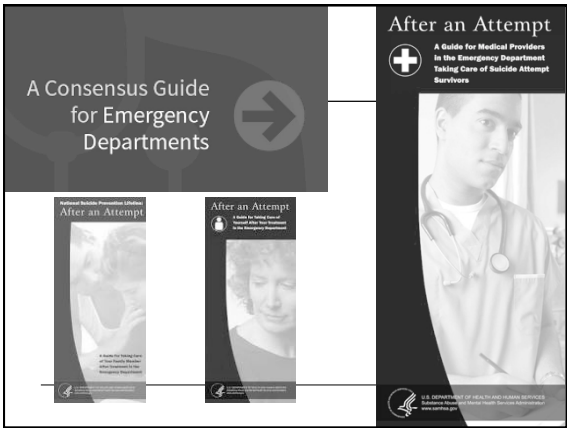
Risk factors of youth suicide

- Situational crises: **Precipitating events**
  - Loss (Death, divorce, transience, romance, dignity)
  - Victimization/exposure to violence
  - School crisis (disciplinary, academic)
  - Family crisis (abuse, domestic violence, running away, argument with parents)
  - Suicide in community



Many roles of the ED Nurse

- ❑ Responding to medical needs
- ❑ Connecting w/patients
- ❑ Educating
- ❑ Comforting/Reassuring
- ❑ Advocacy
- ❑ Gatekeeper:3 Distinct Groups at Risk
  - ❑ Those who present w/transparent ideation & attempts
  - ❑ Those who attend w/psychiatric problems
  - ❑ Those w/physical problems who have suicide risks



Brief suicide prevention interventions

- ❑ Assessing suicide risk
- ❑ Brief patient education
- ❑ Safety planning
- ❑ Lethal means counseling
- ❑ Rapid referral
- ❑ Caring contacts

Protective Factors

- ❑ Strong individual coping and problem-solving skills
- ❑ Strong sense of belonging and connection
- ❑ Interpersonal competence/success
- ❑ **Family warmth, stability, support and acceptance**
- ❑ **Positive connections at school**
- ❑ Spirituality & religious involvement
- ❑ **Access to mental health care & awareness of crisis hotline resources**

Assessing suicide risk

- ☐ Patient Safety Screener (PSS)
  - ■ To be administered by primary nurse
- ☐ Patient Safety Secondary Screener
  - ■ Deciding on Mental Health consultation
  - ■ "YES" to current suicidal ideation or previous suicidal behaviors/attempt
- ☐ Consult with parent/guardian or other collaterals
- ☐ Weigh risk vs. protective factors

Brief patient education

- ❑ Discuss the condition, risk and protective factors
- ❑ Types of treatment and treatment options
- ❑ Medication instructions
- ❑ Home care
- ❑ Lethal means restriction instructions for parent
- ❑ Follow up recommendations and resources

Safety planning

- ☐ Utilize safety planning
  - Therapy appointments
  - Medication management
  - Identify circle of care of adults/peers
  - Promote help–seeking behaviors
  - Promote communication skill building
  - Provide relevant hotlines/websites/ resources

Safety Planning: App Resources

A Friend Asks App
www.jasonfoundation.com

MY3 App
www.my3app.org

Lethal Means Counseling

- ☐ Assess access to firearms or other lethal means
- ☐ Lethal means counseling guidelines for clinicians from:
- ☐ Means Matter
  https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/

Rapid referral

- ❑ During the ED visit, schedule an outpatient mental health appointment for the patient within seven days of discharge
- ❑ Refer the patient for a follow up with a primary care provider.

Caring contacts

- ❑ Follow up with discharged patients via postcards, letters, email, text or phone calls
- ❑ These communications can be effective even if automated!

Q: Can ED providers share patient health information with others?

- A: Yes. For patients with concerning risk factors who minimize or deny suicide risk, it may be life-saving to contact collaterals for corroborating information. First request the patient's permission to contact friends, family, or outpatient treatment providers. If the patient declines to consent after reasonable attempts have been made to request permission, ***there are circumstances in which collaterals may be contacted without the patient's permission. HIPAA permits such contacts when the clinician, in good faith, believes that the patient may be a danger to self or others.***

Discharge planning checklist

- ❑ Patient involved in planning
- ❑ Follow up appointment scheduled
- ❑ Discharge plan reviewed verbally and understood by patient
- ❑ Barriers and solutions discussed
- ❑ Crisis center phone number provided
- ❑ Access to lethal means reviewed and discussed
- ❑ Written instructions and education materials provided
- ❑ Relevant health information transmitted to referral providers

Suicide Prevention: Hotlines

Suicide Prevention: Hotlines