PedsCases Podcast Scripts

This is a text version of a podcast from Pedscases.com on the "Approach to Suicidal Ideation and Behaviour." These podcasts are designed to give medical students an overview of key topics in pediatrics. The audio versions are accessible on iTunes or at www.pedcases.com/podcasts.

Approach to Suicidal Ideation and Behaviour

Hi everyone, my name is Colin Siu and I'm a medical student at the University of Alberta. This podcast was developed with Dr. Melissa Chan, a pediatric emergency physician and Clinical Lecturer at the University of Alberta and Stollery Children's Hospital in Edmonton, Alberta, Canada.

This podcast will focus on the approach to the adolescent patient that presents with a suicide attempt.

Case Overview

We will start with a case. You are on your pediatric emergency elective and your preceptor asks you to see a 16 year old female that presented with a reported suicide attempt. Earlier this evening, she texted her mom, telling her that she had just taken a handful of Tylenol. The patient's mother subsequently called an ambulance which brought the patient to the Emergency Department. It is approximately five hours post-event and she is now medically stable and responsive to questions. A physical exam was completed and bloodwork was drawn. Your preceptor asks you to talk to the patient to learn more about what happened. What are some of the questions that you would like to ask your patient? How will you decide whether to admit the patient, observe the patient in the Emergency Department, or discharge the patient? If you discharge the patient, what are some important things to consider? We will revisit this case at the end of this podcast.

Objectives

The objectives of this podcast are to:

1) Develop a general approach to interviewing an adolescent patient who presents with a suicide attempt or self-harm behaviour.
2) Identify risk factors for suicidal ideations and future suicide or self-harm attempts.
3) Discuss key steps in determining the appropriate management of these patients including whether to admit to hospital or discharge home.

Developed by Colin Siu and Dr. Melissa Chan for PedsCases.com.
March 14, 2016

Introduction

Suicide is the second most common cause of death in adolescents in Canada. Notably, First Nations, Inuit and Metis populations are at a 4 to 5 times greater risk of attempting suicide than their non- Aboriginal counterparts. Lesbian, gay, bisexual, transgender and queer youth are also at an increased risk of suicide.

Introduction to Assessing Suicidal Behaviour

With a patient who has suicidal ideations or a history of a previous suicide attempt, it is important to assess current suicidal behaviour, obtain a detailed mental health history, and to understand precipitating, promoting and protective factors in the adolescent's life. It is important to interview the adolescent alone but to supplement information gleaned from this interaction with collateral information from parents, friends, and other individuals involved in the adolescent's medical, emotional, and social history especially around topics of depression, drug use and stressors. At the beginning of your interview, you must clearly outline the limits of confidentiality. It is useful to explain the limits of confidentiality with the patient's parents present before asking them to leave, so that they too are aware of these limits. All information shared by the patient is confidential except in three situations where confidentiality may have to be breached to ensure the patient's safety. These three situations are: 1) where there is a risk of a third party harming the patient 2) where the patient may be at risk of self-harm, and 3) where the patient may be at risk of harming others. It is important to note that contrary to popular belief, there is no data that indicates that inquiring about suicidal thoughts precipitates suicidal behaviour. It should be emphasized to parents and patients that the questions and fact-gathering process is not to assign blame but rather to better understand the situation.

A common question is whether screening tools are helpful in evaluating current suicidality. There has been some evidence for screening tools such as the Columbia Suicide Severity Rating Scale in the pediatric population but screening tools should never replace clinical assessment. Any adolescent with a high screening score should receive a clinical assessment. Screening tools may be useful in outpatient situations where they can act as a preliminary evaluation of an outpatient's risk of suicide.

Screening for Risk Factors for Suicide

In situations where suicidal ideations or attempts are suspected or actively voiced by the patient, screen for other risk factors associated with an increased risk of suicide. Risk factors include mental illness, especially depression, but also substance use disorders, conduct disorders, anxiety disorders, bipolar disorders, and psychotic disorders. Pain attacks have also been shown to increase risk in females while aggression increases risk in males. As clinical depression often occurs hand in hand with suicidal ideations, look for signs of depression such as a depressed mood most of the time, anhedonia or the inability to feel happy, weight loss or gain, changes in sleep habits, restlessness or slowed movements, increased fatigue, feelings of worthlessness

or guilt, low self-esteem, hopelessness about the future, an inability to concentrate and being irritated or upset about small things.

Good questions to ask to assess clinical depression include: “Do you find yourself sad, irritable or worried a lot?” “Have you found yourself less interested in any activities that you liked in the past?” That being said, it is more common in the adolescent population, relative to the adult population, for suicidal ideation to present as psychosomatic or behavioural problems such as headaches, abdominal pain, weight loss, dizziness, syncope, truancy, social isolation, deterioration in academic performance, running away from home, defiance of authority figures, self-destructive behaviour, vandalism, alcohol or drug use and changes in sexual behaviour. It should also be noted that some literature suggests a link between selective serotonin reuptake inhibitor (SSRI) use and suicidal ideations. Any adolescent with confirmed or suspected mental illness and concurrent suicidal ideations should be referred for psychiatric assessment.

A key risk factor is previous suicide attempts. In particular, previous lethal attempts such as strangulation are worrisome. For patients with previous suicide attempts, it is crucial to ask about the method of previous attempt, the expected outcome, steps that were taken to decrease the likelihood of being discovered, feelings of anxiety or regret that led to help-seeking behaviour, and circumstances that led to parental or caregiver awareness of the attempt. Lastly, take time to evaluate whether previous attempts were impulsive or planned and the lethality of the methods selected.

Other risk factors for suicide include impulsivity indicated by physical aggression and risk-taking behaviour, family factors including family conflict, poor parent-child communication, parental mental
illness and familial history of suicide, lack of psychosocial support, living outside of the home in correctional facilities or group homes and history of abuse. Being of the male gender and living alone also increases one’s risk.

When teenagers exhibit self-harming behaviours such as cutting or burning, this may or may not be associated with increased risk of suicide. Self-harming behaviour is often the patient’s mechanism to cope with emotional pain. Adolescents should be asked about motivations which led to these activities before one assumes that these were done with the intent to end life.

Lastly, try to understand and address precipitating factors. Precipitating factors are often stressors that lead to feelings of rejection, inadequacy, shame, humiliation and loss. A good mnemonic to remember for screening precipitating factors is that of HEADS. H is for Home and Environment; common stressors in this category include social conflict and legal system involvement. E is for Education and Employment; stressors here include recent or upcoming academic failure and bullying including cyberbullying over social media. A is for Activities or hobbies. D is for Drugs. Lastly, S is for sexuality, suicidality and depression; common stressors in this category include breaking up with a partner and disclosure of homosexual orientation. Among those with any history of physical or sexual abuse or neglect, it is important to suss out any potential triggers.

Developed by Colin Siu and Dr. Melissa Chan for PedsCases.com.
March 14, 2016

The literature has shown that exposure to suicide via media or close contacts may increase an individual's risk of attempting suicide.

Do not forget to ask about protective factors against suicide. Identifying protective factors will help formulate a management plan for the patient, and will aid in counselling the patient. Key protective factors include strong peer or family relationships, effective mental health care and good problem solving skills.

Assessing a Recent Suicide Attempt and Current Suicidality

As with all assessments in the emergency department, ensure the patient is hemodynamically stable by checking the vital signs. In particular, the patient should be neurologically stable at the time of the interview. Intoxicated patients should be given time to clear any psychoactive substances before interview initiation. In assessing a recent suicide attempt and current suicidality, aim to address three main topics: suicidal ideation, suicidal intent and suicide plan.

First, with suicidal ideation, ask about the frequency, intensity and quality of suicidal thoughts. Intensity is related to the patient's level of preoccupation with the thoughts. As well, clarify whether the thoughts are passive or active. An example of a passive thought is: "If I died tomorrow, it would be okay." An example of an active thought is: "I am going to end my life tomorrow" Further, ask about how patients manage their suicidal thoughts and whether they believe their situation will improve in the future. Hopelessness is a significant risk factor for suicide attempts. Questions that may help you in better understanding a patient's suicidal ideations include: "Do things ever go so bad for you that you think about dying?" "Do you ever think about ending your life?" How often do these thoughts cross your mind?" "How long do these thoughts last?" "When you have a thought like this, is it hard to distract yourself?"

Second, ask about suicidal intent. Questions that may help you in evaluating intent include: "Have you ever considered acting on your thoughts?" "Do you want to end your life?" "Did you ever do something that you knew was dangerous so that you could get hurt or killed?" "Did you ever try to hurt yourself?" "What has stopped you from ending your life?" Try to understand the motivational feelings behind previous suicide attempts which may include: wanting to gain attention, to cause a change in interpersonal relationships, to join a dead relative, to avoid a situation or to exact revenge. If these motivations have not been satisfied by the previous attempt, future attempts may re-occur.

Lastly, ask if patients have formulated a suicidal plan. If they have a plan to end their life, inquire about the details. Questions that may be considered include: "How would you end your life?" "How close have you been to ending your life?" "Did you do anything to get ready to kill yourself?" If a plan is identified, evaluate whether adolescents have the means to carry out said plan.

Management of the Adolescent with a Recent Suicide Attempt

It is essential to establish a follow-up plan with psychosocial support for adolescents with a recent suicide attempt prior to discharge. First and foremost, ensure that the patient is willing to follow-up with mental health and that they see this connection as being positive and supportive. Discharge should only be considered if you believe the patient can be safe at home until their appointment with a mental health professional. Literature around the efficacy of patient-physician safety contracts in preventing suicide attempts are mixed but may be considered in discharge planning. A contract of safety is usually a verbal agreement made between by the patient and the physician in which the patient agrees to not attempting suicide before their first mental health visit.

If the decision has been made to discharge a patient, confirm that a follow-up appointment is booked for the patient prior to discharge, and that patient and parents fully understand and are comfortable with the outpatient management plan. In your management plan, assist patients with identifying protective factors in their life and encourage them to plan tangible actions to strengthen these protective factors. Encourage the adolescent to communicate any suicidal thoughts they may have with an adult at home that they trust. Parents and guardians should similarly be encouraged to have open communication with the patient about any negative feelings and suicidal thoughts. Parents should also be made aware of local crisis telephone lines and situations in which to come back to the hospital for re- evaluation. An emergency communication plan should also be established with the patients' guardians and activated in any cases of patient deterioration.

Parents and caregivers should agree to safe-proofing their house which includes ensuring that all medications are kept in a secure location and all firearms are removed from the house. These safe- proofing measures should be in place until the patient is able to connect with their mental health liaison. Parents and patients should be made aware of the disinhibiting effects of alcohol. If a patient has a permanent expressed desire to die or an abnormal mental state, the patient should be hospitalized until a full psychiatric evaluation can be completed. Lastly, physicians should become familiar with community mental health resources and be able to make appropriate referrals to community resources as needed.

Conclusion

Now let's review our clinical case. You are about to see your patient: a 16 year old female with a suspected suicide attempt via a Tylenol overdose. It is 5 hours past the suspected event and all her vitals are stable, bloodwork results are pending. You enter the room and review the limits of confidentiality with the patient and her mom. You then ask her mom to step out of the room while you conduct the rest of your interview. You begin with an open-ended question asking if you could learn more about her story. She confides in you that she's been sleeping more in the last 3 months, does not have much of an appetite and thus only eats 1 or 2 meals a day, has been feeling less energetic lately and no longer wants to continue her participation on the cheerleading team. When

you ask her if anything has changed in the last couple of months, she hesitates for a bit. She then tells you that things at school have not been going so well. She has received some mean messages from classmates about her weight and how she should not be a cheerleader.

You ask her about what prompted the event earlier this evening. She tells you that she was at school today and heard people talking about her behind her back. This was the first time that this has happened to her. Also, she feels like the other cheerleaders were staring at her during practice and no one talked to her. She was incredibly upset and when she got home, she found a bottle of Tylenol on the counter as her mom had just taken one for a migraine in the morning. She says that she took a handful of Tylenol because she just wanted to get away from it all. About half an hour after, she felt really nauseous and sick. She admits that at that time, she regretted her actions and that was why she texted her mom. She denies any previous substance use including alcohol, any prior episodes of self-harm or suicide attempts, and says that she never thought of committing suicide before today. She indicates that she does not currently have any thoughts of committing suicide and does not have a plan for any future suicide attempts. She agrees to a contract of safety with you and thinks that she could try talking to the community mental health team tomorrow.

Based on her history, you decide that she does not require hospitalization. Unfortunately, the in-hospital mental health team is already off for the night so you arrange for an outpatient referral to the community mental health team tomorrow. In addition, you arrange for an outpatient psychiatry referral specifically around a suspected eating disorder diagnosis. You discuss the arrangements with the patient and her parents and they are agreeable to the plan. The patient's mom also agrees to staying home tomorrow and watching over her daughter until the appointment at noon tomorrow. Her parents are aware of the disinhibiting effects of alcohol, will safeguard all medications in the house, do not have firearms within their house, and understand the resources that are available if the patient's condition deteriorates. While you are discussing the plan, blood work results return and the patient's blood acetaminophen levels are plotted against the Rumack-Matthew nomogram. Based on the plotted nomogram, there is no significant risk of hepatic toxicity and N-acetyl-cysteine is not indicated. Your patient is subsequently discharged after 2 hours.

Lastly, let's end by reviewing some key points from this podcast:

1) Always try to interview the adolescent patient without any other family members or friends in the room. Remember to explain the limits of confidentiality.
2) Remember to screen for risk factors of suicide including depression, use the HEADS screen to quickly assess for stressors in adolescents' lives.
3) To assess a recent suicide attempt and current suicidality, ask questions around the topics of suicidal ideations, intent and plan.
4) The decision about whether to discharge, observe, or admit a patient depends on your evaluation of whether the patient would be safe in the community until their outpatient mental health visit and whether the patient is currently suicidal.

Developed by Colin Siu and Dr. Melissa Chan for PedsCases.com.
March 14, 2016

5) If you decide on discharging the patient, it is important to ensure they have adequate follow-up and that patients and parents are aware of measures that they can take to ensure the safety of the patient until the mental health appointment.

Thanks for listening to this podcast. If you would like more information about the HEADS screen, take a listen to our podcast on an approach to adolescent history taking.

References

Korczak D. Suicidal ideation and behaviour. Canadian Pediatric Society; 2015.

Shaffer D, Pfeffer C. Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior. Journal of the American Academy of Child & Adolescent Psychiatry. 2001;40(7):24S-51S. doi:10.1097/00004583-200107001-00003.

Shain B. Suicide and Suicide Attempts in Adolescents. Pediatrics. 2007;120(3):669-676. doi:10.1542/peds.2007-1908.

Wintersteen M, Diamond G, Fein J. Screening for suicide risk in the pediatric emergency and acute care setting. Current Opinion in Pediatrics. 2007;19(4):398-404. doi:10.1097/mop.0b013e328220e997.

Zuckerbrot R, Cheung A, Jensen P, Stein R, Laraque D. Guidelines for Adolescent Depression in Primary Care (GLAD-PC): I. Identification, Assessment, and Initial Management. Pediatrics. 2007;120(5):e1299- e1312. doi:10.1542/peds.2007-1144.

BCGuidelines.ca. Anxiety and Depression in Children and Youth - Diagnosis and Treatment - Province of British Columbia. 2015. Available at: http://www2.gov.bc.ca/gov/content/health/practitioner- professional-resources/bc-guidelines/anxiety-and-depression-in-youth. Accessed October 9, 2015.

Developed by Colin Siu and Dr. Melissa Chan for PedsCases.com.
March 14, 2016