Ask the Shrink:
Addressing Suicide Prevention in Pediatric Primary Care

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It’s brave to #AskForHelp
Funder & Partners

New Jersey Department of Children and Families

Hackensack Meridian Health

Cooper University Health Care

Atlantic Health System
Goryeb Children’s Hospital

St. Joseph’s Health
ST. JOSEPH’S CHILDREN’S HOSPITAL

American Academy of Pediatrics
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New Jersey Chapter
There Are No Disclosures
Goals for Today:

- **Recognize the medical and psychiatric needs** of the suicidal child and/or adolescent and **identify risk and protective factors** associated with suicide and suicide prevention.
- **Implement mental/behavioral health screening** tools to identify patients at risk for suicide.
- **Integrate effective strategies for addressing depression** into pediatric primary care for children, adolescents and their families.
- ** Appropriately refer patients who have positive screens** for mental and behavioral health, specifically related to the risk of suicide, for additional services that will further address the issues.
- **Utilize effective strategies** to work closely with families and other health care professionals in the management and follow-up of those patients at risk for or who have attempted suicide.
Case Study: Patient 1

Bob, a 15-year-old White male 9th grader comes to your office with anxiety, depression, and ADHD, combined presentation that was diagnosed in early grade school.

You have provided on-going care since he was an infant and recently increased his extended release amphetamine salts (A-XR) to 20mg daily with minimal benefit for his recent extreme difficulty concentrating.

Your notes indicate that he had three psychiatric hospitalizations, the first two almost 3 years before, after abusing decongestants and accidentally overdosing to get high.

He had admitted regularly using marijuana at the time and repetitively cutting himself to relieve an inner pain.

You knew he had failed 7th grade due to his substance abuse and depression then did well in the 8th grade academically and socially, after the last hospitalization 2 years ago for severe depression and suicidal ideation (SI).

You did his routine screening with the PSC and PSC-Y-37. Both indicated significant problems with concentration, anxiety and depression.
Jane, a 17-year-old Hispanic high school junior comes to your practice as a new patient for overwhelming anxiety. Her grades have been dropping and she desperately wants to get rid of the dread of failing that has kept her from going to school, in being able to go out with her friends, and in being able to fall asleep. She had a course of Prozac a few years ago prescribed by her pediatrician that had helped. Talking counseling at the time had not. On the PSC and PSC-Y-37, anxiety and problems concentrating were prominent. On the PSC-Y-37 she indicated prior suicide attempts but no current suicidal ideation.
Data on Child and Adolescent Suicide

• Suicide is the **second leading cause of death** for children, adolescents, and young adults age 5-to-24-year-olds.

• The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression.

• Among younger children, suicide attempts are often impulsive. They may be associated with feelings of sadness, confusion, anger, or problems with attention and hyperactivity.
Depression is a major cause of suicide attempts

Some depression triggers for youth include:

- Being bullied
- Stressful life event or loss
- Summer ending
- Going back to school
Suicidal Behavior in ADHD
Daviss & Diler, 2014

- ADHD and comorbid problems common in clinical practice
- Predictors of suicidality in adolescents with ADHD, suicidal behavior was linked with
  - Depression,
  - Parent-child conflict,
  - Victimization trauma, and
  - Social impairment
- These modifiable factors found in cross-sectional study may be useful in identifying youth aged 11 – 18 years at risk for suicide
  - Represent targets for psychosocial or pharmacological treatment
Prevalence

- Firearms consistently the leading mechanism of suicide in males;
- Since 2001 suffocation surpassed firearms as the leading mechanism in females.
- Rates of firearm suicides decreased over the years spanned by the analysis,
- Suicide by suffocation increased in all age groups (10–14 years, 15–19 years, and 20–24 years), all ethnic groups, and all regions of the country.
- Poisoning, the third leading method, much less common than firearms or suffocation. CDC 2015
Emphasis is on **Prevention** not **Prediction**

- There is no documented way to predict who will and who will **not** go on to attempt suicide and overall.

- Actuarial methods, clinical judgement and self-report methods are inherently flawed and will not capture everyone who is at **imminent** risk.

- **Clinical judgment is the key factor to prevention.** What can and cannot be modified at this moment.

- Most people who inherently have risk factors for suicide will **not** engage in suicidal behaviors.
Routine Screening for Suicide Risk in Primary Care
LeFevre Annals Intern Medicine 2014,160:719–726

- Recommendation statement from U.S. Preventive Services Task Force
- Clinicians be aware of psychiatric problems in patients and ask those with problems about suicidal ideation and refer for psychotherapy, pharmacotherapy, or case management.
- Adolescents should be screened for depression when appropriate systems are in place for its diagnosis, treatment, and follow-up.
Warning Signs

• A warning sign does not mean automatically that a person is going to attempt suicide, but it should be responded to in a serious & thoughtful manner

• Do not dismiss a threat or self-harm as a cry for attention!
  ▪ Non-suicidal self-injury has many functions, only one of which is to communicate distress

• Children and adolescents thinking about suicide may make openly suicidal statements or comments such as, "I wish I was dead," or "I won't be a problem for you much longer." *

What kinds of warning signs are cause for concern?
Specific Warning Signs

• Change in eating and sleeping habits
• Withdrawal from friends, family, and regular activities
• Violent actions, rebellious behavior, or running away
• Drug and alcohol use
• Unusual neglect of personal appearance
• Marked personality change
• Persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
• Frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
• Loss of interest in pleasurable activities
• Not tolerating praise or rewards
• Self-harm with no suicide intent
A teenager who is contemplating suicide may:

• Complain of being a bad person or feeling rotten inside
• Give verbal hints with statements such as: I won't be a problem for you much longer, Nothing matters, It's no use, and I won't see you again
• Put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
• Become suddenly cheerful after a period of depression
• Have signs of psychosis (hallucinations or bizarre thoughts)
## Y-PSC-37 Teen Screen

### A Survey From Your Healthcare Provider — PSC-Y

<table>
<thead>
<tr>
<th>Name</th>
<th>Date</th>
<th>ID</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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**Please mark under the heading that best fits you or circle Yes or No**

<table>
<thead>
<tr>
<th></th>
<th>Never 0</th>
<th>Sometimes 1</th>
<th>Often 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complain of aches or pains</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Spend more time alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Tire easily, little energy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4. Fidgety, unable to sit still</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Have trouble with teacher</td>
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<td></td>
<td></td>
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<tr>
<td>6. Less interested in school</td>
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<td></td>
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<tr>
<td>7. Act as if driven by motor</td>
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</tbody>
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#### Q 36 or Q 37

- **During the past three months, have you thought of killing yourself?**
  - Yes
  - No

- **Have you ever tried to kill yourself?**
  - Yes
  - No

### Note

- The sub scores do not impact the overall score; they are for interpretation purposes only.

### Plan for Follow-up

- [ ] Annual screening
- [ ] Return visit w/ PCP
- [ ] Referred to counselor
- [ ] Referred to counselor
- [ ] Parent declined
- [ ] Already in treatment
- [ ] Referred to other professional

### Source

Pediatric Symptom Checklist — Youth Report (PSC-Y)
How to address a positive response to Q 36 & 37 on the Y-PSC-37

• Utilize a step by step evaluation of severity of suicidal ideation by checking-in on the following:
  • Does the patient have a plan (How would he or she do it)?
  • Does the patient have the means to carry out suicide (i.e. access to gun, knife, medication, rope, etc.)
  • Does the patient have the urge or intent to harm themselves?
• Provide information regarding 24/7 suicide hotlines
• Provide location and contact information for local crisis center or respective county's Child Mobile Response Crisis Unit
• Have parents take child/adolescent to emergency room if you feel patient is in danger of hurting themselves or suggest they call 911/ Children's Mobile Response
DO ASK Open-ended Questions

• “In what situations do you think it’s okay to take your own life?”
• “If you were dead, who do you think would miss you?”
• “What do you hope will soon be different?”
• “You said that you thought about killing yourself last week. What stopped you?”

Asking questions in this manner will get the patient to tell you the reasons that they want to live.

➤ Remember: Patient ambivalence buys you and them time to come to another way of thinking.
Validate and Normalize

• Overcoming a client’s anxiety or hesitancy by letting them know that others have experienced the same thoughts, feelings, or behaviors.

Underlying Principles:
• Patients are more apt to give valid details if they think their experience is “normal.”
  ➢ Example:

  “Many of my patients tell me that, at times, the pain of their depression can be so great that they have thoughts of wanting to kill themselves. Have you ever had any thoughts like that?”

• Avoid correcting their thinking as it will only shut them down more. Validate their pain and experience.
Involving Parents/Guardians

• Does the patient’s family know about their suicidal thoughts? If not, what is the patient’s hesitation?

• How do they think their family would react?

• Let the patient know why you think it is in their interest to enlist their family’s aid.

• Let consumer decide how much they are comfortable sharing

“How would you like your family to ask if you are feeling like things are getting really bad?”
Tips for Working with Parents

- Prioritize interacting with them in positive ways and become involved and aware of child's friends.
- Increase their involvement in positive, life-affirming experiences.
- Monitor appropriately child’s whereabouts and communications (i.e., texting, Facebook, Twitter) with the goal of keeping them safe.
- Do whatever possible to eliminating the means for suicidal behavior in the home.
- Communicate regularly with other parents in the community and with the child’s school to ensure optimal safety and care for the child in the school setting.
- Talk with your child about your concerns and ask directly about suicidal thoughts.
How to Handle an Urgent Situation

- **As defined by NJ Children’s System of Care:** “An emergency is considered to be any serious and sudden medical, emotional, or behavioral health situation that, if not given immediate professional attention, could lead to your child being severely harmed or possibly harming someone else.”

- For potentially suicidal/homicidal children, take into consideration a history of suicidal/homicidal actions, current intent, a plan and means to carry out the action.

- Urgent situations, where the situation is not immediately life-threatening, should be referred to Perform Care, who will determine the appropriate level of response. At their discretion, Mobile Response may be sent to the family home or your office to provide face-to-face crisis services. This should not be used for an imminent situation.

- When you are faced with a psychiatric emergency, please refer to Psychiatric Emergency Screening Services (PESS), your nearest emergency room, or 911. When in doubt, call PESS who can direct you on the appropriate next step.
Psychiatric Emergency Screening Service (PESS) and Designated Screening Centers

- The Division of Mental Health and Addiction Services has designated screening services for every county in New Jersey.
- The purpose of PESS is to provide mental health evaluations, crisis intervention counseling, and support to individuals to assess for the most clinically appropriate intervention.
- PESS is available 24 hours a day, 365 days a year to individuals in crisis who require immediate attention.
- For a complete list of screening centers: https://www.nj.gov/health/integratedhealth/dmhas/suicide_prevention.shtml

*When PESS services are requested for a minor, parent/guardian consent is required.*
When to utilize a Hospital Emergency Department

Other examples which may result in serious danger to self or others and cannot wait until the next day for an evaluation:

- Child talking about killing himself or others,
- Threats of doing harm at a school,
- Got high or drunk, stole a car and gets into an accident (was this a suicide attempt?)
- Threatening or intimidating to family members
- Threatening a teacher, another student, or any person,
- Anytime when immediacy of risk and intent is not yet known, but outcome might be too serious to wait (threatening or talking about jumping off a bridge, severe depression, not eating or sleeping, not getting out of bed, wishing to be dead, etc.)
- Taking action to look up information on the internet how to make a noose to hang himself, how many pills to take to die, etc.
How do I decide whether to call for ambulance or allow parents to drive the youth to the emergency department?

- This is a tough decision and you will want to weigh the facts before you make a recommendation to the parent about the mode of transportation to the Emergency Department.

- It’s a good idea to discuss your concerns with the parent to decide if it is reasonable to allow the parent to drive the patient to the hospital or if the police should be called to transport the patient to the hospital.

- Talk with the parent about safety as the primary concern, when dealing with a youth whose:
  - behavior is out of control
  - behavior is unpredictable for that child
  - uncooperative
  - is intoxicated

- Generally it is best to err on the side of caution. If parents insist on transporting child to closest ED, contact local police to have them provide escort and ensure that child gets there.
What if parents don’t agree?

- Be sure to have an office policy around these situations and adhere to this policy for everyone’s safety
- Make the best professional decision based on your knowledge of the patient and family
- Reference the NJ Children’s System of Care emergency resources
How can your local Hub help?

- The Hub is not a crisis center but can offer guidance and contact information for emergency services.
- The Hub recommends that all physicians collaborate with the child and parent/caregiver when assessing the nature of these situations.
- In urgent situations, the Hub staff members and psychiatrists are available for consultation services to assist in determining level of care or appropriate referrals.
- Do not refer to the Hub if the child is in imminent risk of harming themselves or someone else. Refer to Psychiatric Screening Centers, Emergency room, or 911.

When in doubt call your regional Hub, Psychiatry Emergency Screening Services (PESS) or Perform Care for further assistance.
Thank You!

Questions?

Please contact:

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