Suicide Prevention in Children and Adolescents

November 9, 2016

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Questions?
Contact Kim Slouf – sloufk@email.chop.edu
Disclosure Statement

There are no financial relationships or financial affiliations to disclose.
Today’s Moderator

Flaura Winston, MD, PhD
Senior Advisor, Violence Prevention Initiative
Scientific Director & Founder, Center for Injury Research and Prevention
Attending Physician
Sponsored by CHOP’s Violence Prevention Initiative

A CHOP-wide effort to interrupt the cycle of violence. VPI builds on years of hospital and community partnership and research to provide the right care to the right children at the right time. Visit us at: chop.edu/violence or on our @CHOP community
VPI Goal for Today

What can you do to **address** and **prevent** suicide among your patients?
**Adolescent Suicides**

Among children aged 10 to 14, death by suicide is now more common than death from traffic accidents.

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Source: National Center for Health Statistics

By The New York Times

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Having Technical Difficulties?

Please check your latest email from WebEx. It will contain link to download WebEx Manager.

The audio for today’s webinar is accessed through your computer’s speakers. Please turn them on.
Webinar Agenda

1. Current state of depression/suicide for youth
2. Screening options available
3. Next steps with a positive screen
4. How to manage challenges
Today’s Participants

• Physicians and nurses
• Social workers
• Mental health providers
• Educators
• Administrators
• Counselors
• ____________________
• ____________________
• ____________________

Violence Prevention Initiative

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Today’s Presenters

Jeremy Esposito, MD, MSEd
Attending Physician, Emergency Dept.
VPI Fellow

Anik Jhonsa, MD
Attending Psychiatrist
Medical Director, Emergency Psychiatric Services
Current State of Depression and Suicide

24% increase of suicide rates for all age groups from 1999-2014

2013 Youth Risk Behavior Survey

- Felt sad or hopeless almost every day for at least 2 weeks:
  - Boys: 39%
  - Girls: 21%

- Planned suicide attempt:
  - Boys: 10%
  - Girls: 17%

- Attempted suicide:
  - Boys: 5%
  - Girls: 11%

- Required medical attention:
  - Boys: 2%
  - Girls: 4%

www.cdc.gov
AAP Clinical Report, July 2016

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### 10 Leading Causes of Death by Age Group, United States - 2012

<table>
<thead>
<tr>
<th>Rank</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
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<td>Suicide 8,848</td>
<td>Diabetes Mellitus 12,393</td>
<td>Alzheimer’s Disease 82,690</td>
<td>Unintentional Injury 127,792</td>
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<td>8</td>
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</tbody>
</table>
# 10 Leading Causes of Death by Age Group, United States - 2014

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<td>Cerebrovascular 45</td>
<td>Cerebrovascular 43</td>
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<td>Cerebrovascular 1,745</td>
<td>Chronic Low. Respiratory Disease 4,402</td>
<td>Suicide 7,527</td>
<td>Influenza &amp; Pneumonia 44,836</td>
</tr>
</tbody>
</table>

**www.cdc.gov**

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Common Causes of Death

- Cancer
- Asthma
- Cystic Fibrosis
- Heart Disease
- Kidney Disease

- Influenza
- IBD
- Stroke
- Diabetes
- Liver Disease

Suicide kills more patients age 15-24 than causes 4 through 24 combined!

Data courtesy of SAMHSA

*NH/OPI = Native Hawaiian/Other Pacific Islander
**AI/AN = American Indian/Alaska Native
Depression

1:1 male to female ratio through childhood

1:2 male to female ratio in adolescents

After puberty, risk of depression increases by a factor of 2-4, particularly in females

Children are better reporters of internalizing symptoms (mood, anxiety)

Birmaher 1996
Angold et al. 1998
Major Depressive Disorder (MDD): Criteria

• Five (or more) of the following symptoms present during the same 2-week period and represent a change from previous functioning;

• At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure

*Note:* Do not include symptoms that are clearly attributable to another medical condition
MDD Criteria

- Depressed mood (irritability in children)
- S: **Suicidal** thoughts
- I: Lack of **Interest** (anhedonia)
- G: Feelings of **Guilt** or hopelessness
- E: Decrease in **Energy**
- C: Decrease in **Concentration**
- A: Change in **Appetite** (hyper or hypophagia)
- P: **Psychomotor** agitation or retardation
- S: Change in **Sleep** (increase or decrease)
• Responses to a significant loss may resemble a depressive episode
  – intense sadness, rumination about loss, insomnia, poor appetite, and weight loss

• Exercise clinical judgement when assessing normal response to significant loss vs MDD
Suicide Risk Factors

- Family history
- Substance abuse
- Intoxication
- Access to firearms
- Gender
- Serious or chronic medical illness

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Suicide Risk Factors

- Prolonged Stress
- History of trauma or abuse
- Isolation
- Recent tragedy or loss
- Age
- Agitation and sleep deprivation

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Current Issues

Black Box Warning (2004)

• FDA introduced warning for SSRI use in adolescents
• SSRI prescribing has reduced, showing relative reductions of:
  o 31.0% among adolescents,
  o 24.3% among young adults
  o 14.5% among adults
What is the Black Box Warning?

• Meta-analyses of 372 randomized trials involving about 100,000 patients

• Increase in suicidal thoughts from 2% at baseline to 4%

• **No increase** in suicide attempts or completed suicides
Since Black Box Warning

• Reported 22% increase in suicide attempts among adolescents and a 34% increase among young adults
• Decrease in frontline screening and treatment of depression may have played role
Reduction in new diagnosis of depression:
- ↓ 44% among children
- ↓ 37% among young adults
- ↓ 29% among all adults

- Does not correlate with a decrease in prevalence but only a decrease in primary care providers diagnosing depression on their own.
Is Screening Dangerous?

Does asking about suicide increase risk of thoughts/ideation?

• Asking about suicide **DOES NOT** lead to any increase in action

• Asking can **reduce** suicidal thoughts in patients

Dazzi et al., 2014
Screening for Depression and Suicide

• **US Preventive Services Task Force**
  - Recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years when adequate systems are in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up

• **American Academy of Pediatrics**
  - Recommends screening for depression in patients 11-21 years of age
  - Recommends routinely screening for suicide

USPSTF, Feb 2016
AAP Clinical Report, July 2016
Suicidality is a medical emergency!

Depression is disabling

75% seek medical care within 1 year prior to completing suicide

40% make contact with PCP within a month prior to suicide

Miller and Druss, 2003
Pirkis and Burgess, 1998
Screening in the CHOP ED

• Behavioral health screening has been implemented since 2009

• Studies at CHOP and other ED sites suggest screening is feasible and valid

Fein et al, Dec 2010
Screening in the CHOP ED

Behavioral Health Screen (BHS-ED)

• Electronic screen given to all patients ≥14 years of age
• 50 questions; 10 minutes
• Screens for depression, suicidality, trauma, substance use, gun safety
• 280 – 370 screens completed per month
BEHAVIORAL HEALTH SCREENING
RESULTS

Form Version: Emergency Department
Screening Date: 05/31/2013
Screening Location: Study ED Facility
Screened By: charge me
Staff Email: mbriner@mdlogix.com, john@mdlogix.com

Patient

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>11111</td>
<td>07/08/1998</td>
</tr>
<tr>
<td>MR. #</td>
<td>DOB</td>
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</table>

INSTRUCTIONS
Review report before meeting with the patient. Review results with patient and follow standard care procedures, including referral, if necessary. Place results report in medical chart.

SCALES (All scales are 0 - 4. 0 = no risk and 4 = highest risk.)

<table>
<thead>
<tr>
<th>Description</th>
<th>Score</th>
<th>* Clinical Significance</th>
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</thead>
<tbody>
<tr>
<td>Depression</td>
<td>0.30</td>
<td>Mild Depression</td>
</tr>
<tr>
<td>Suicide Ideation - Lifetime</td>
<td>0.00</td>
<td>No History</td>
</tr>
<tr>
<td>Suicide Ideation - Current</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Traumatic Distress</td>
<td>0.00</td>
<td>Not Significant</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>0.00</td>
<td>Not Significant</td>
</tr>
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</table>

RISK BEHAVIORS

<table>
<thead>
<tr>
<th>Description</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a gun in your home?</td>
<td>Yes</td>
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</table>
Percentage of Behavioral Health Screens Each Month with Severe Depression or Current Suicide (2015)
Initial Workflow

Patients complete BHS

Result printed**

Concerning BHS result

Social Work consulted

Psychiatry consulted

Follow up**

Documentation ED note**

SW/Psych note

Call PCP**

Disposition

Discharge summary**

** potential areas of improvement
Focus on discharged patients with non-psychiatric chief complaints and severe depression or suicide risk on BHS-ED

- Chart reviews revealed poor ED documentation and communication to PCPs; multiple return visits
- Increase psych burden felt throughout

Interventions
- Electronic alert and smart text created
- Meetings and feedback to CHOP PCPs
- Regular EM division meetings
- Clinical pathway updates
A Behavioral Health Screen has been completed for this patient. Please view the screen by clicking on the hyperlink at the bottom of this alert.

**Severe Depression or Current Suicide Risk:**
- Clarify with patient and call Social Work if concerned.
- If Discharged, notify the PCP.
  - CHOP PCP patients: send an **EPIC in-basket message** to the pool for the practice (click for instructions) and cc: the PCP.
  - Non-CHOP PCP: call the PCP office and document this in your note.

**All Patients**
- Ensure any referrals and follow-up are included in discharge paperwork. Use the "**ED Psychiatric**" discharge SmartSet.
- Document actions in the **Disposition section of your note** by typing the smart phrase: **.EBDBHSNoteText**

**Acknowledge reason:**

- BHS reviewed and documentation complete

[Click here to view completed Behavioral Health Screen](#)

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**Behavioral health:** A Behavioral Health Screen (BHS) was completed and reviewed by ED staff. Based on the BHS Results, consultants evaluated the patient.

Admitted: The patient will be admitted to an inpatient team to receive continued care. Please see the Media section in EPIC for the completed BHS.

Transferred: The patient will be transferred to an inpatient psychiatric facility for continued care. Please see the Media section in EPIC for the completed BHS.

Discharged: The patient will be discharged with follow up recommended. An attempt to notify the PCP was made. Instructions were given to the patient on discharge paper.

Based on the BHS results, no acute intervention is needed. Please see the Media section in Epic for the completed BHS.

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Other
Severe Depression
Current Suicidality

BHS Results
January 2015 – March 2016

3154
1459
348
BHS Results
January 2015 – March 2016

• 783 charts reviewed manually
• 75% presented with a non-psychiatric complaint
• 86% were discharged from the ED
Most Common Non-Psychiatric Chief Complaints

- Abdominal Pain: 14%
- Chest Pain: 12%
- Headache: 11%
- Back Pain: 3%
- Sore Throat: 3%

Positive BHS screen
Did the ED Clinician Attempt to Contact the PCP?

2015
Results

• Documentation of BHS results increased, present in 90% of non-psychiatric patients after the alert implementation in April 2015 compared to 78% at baseline

• 76% of PCPs within our primary care network acknowledged ED communication of BHS follow-up since October 2015
Screening in Primary Care

- Care for mental health patients may be improved when we increase our knowledge, skills, and comfort
- May require a culture change
Screening in Primary Care: Getting Started

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Map out the current process and anticipate challenges</td>
<td>What is the best way to screen at your practice?</td>
</tr>
<tr>
<td>What are the available resources?</td>
<td>Do you need additional resources and/or training?</td>
</tr>
<tr>
<td>How will colleagues help each other?</td>
<td>How will your follow up with patients?</td>
</tr>
</tbody>
</table>

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Screening Considerations

• **Acceptable** (*what families want*)
  – Thorough and sensitive; non-judgmental; no stigma; privacy

• **Efficient** (*what providers want*)
  – Integrated into clinical care; clear and concise presentation of results; mechanism for referrals

• **Effective**
  – Useful questions; important domains

• **Reliable**
  – Valid
Screening Options

• Interview the patient
• Screening tools
• Universal – given regardless of risk factors or symptomatic presentation
• Targeted – given only to those with particular symptoms or risk factors
Interviewing the Patient

- Reliance on chief complaints and standard physician interview under-identifies depression
- Talk to the patient alone
- Safety takes precedence over confidentiality
Interviewing the Patient

• HEADSSS
  – Home
  – Education/employment
  – Activities
  – Drugs
  – Sexuality
  – Suicide/depression
  – Safety

• Bright Futures Surveillance Questions
Screening Tools

- Patient Health Questionnaire (PHQ-9; PHQ-2)
- Pediatric Symptom Checklist-17 items (PSC-17)
- Columbia Suicide Severity Rating Scale
Example: PHQ-9

<table>
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<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
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<td>5-9</td>
<td>Minimal Symptoms*</td>
<td>Support, educate to call if worse, return in one month</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ++</td>
<td>Support, watchful waiting</td>
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<tr>
<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major Depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>&gt;20</td>
<td>Major Depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>
Managing Positive Screens

• Assess:
  – Acute risk: INTENT
  – Individual coping resources
  – Accessible support systems
  – Attitudes of the adolescent and family toward intervention and follow-up

• Home environment screens
  – Access to lethal means (firearms, medications, knives, etc.)
Managing Positive Screens

• **High-risk factors**
  – Plan or recent attempt
  – Stated current intent
  – Recent SI with current agitation or severe hopelessness
  – Impulsivity and dysphoric mood

• **Lower risk**
  – Desire to receive help
  – Family support
Managing Positive Screens

• High risk for suicide
  – **Immediate** mental health referral via hospitalization, transfer to ED, or same-day mental health appointment
  – What is available to you?

• Low risk
  – Should receive close follow-up
  – Mental health referral if severe depression

• All
  – Lock up firearms and prescriptions/toxins
Safety Contracts Against Suicide

- Not proven to be effective in preventing suicidal behavior
  - may be helpful in assessing risk
- Encourage safety plans with family
Other Challenges

• Know that laws are different in each state
• Ask colleagues about their successes (e.g., social work, co-locations of mental health care)
• What system will you and your practice have in place for follow-up?
Depression Categories

**Mild:** Minimal symptoms, can function normally, may affect quality of life

**Moderate:** Higher number of symptoms, difficulty functioning normally

**Severe:** Most or all symptoms, great difficulty or inability to do daily activities
Treatment Options

• For **mild depression** standard of care is psychotherapy alone

• For **moderate depression** may respond to psychotherapy but also could benefit from an SSRI

• For **severe depression** combination of SSRI plus psychotherapy is indicated
Psychotherapy

• **Cognitive Behavioral Therapy (CBT)** and **Interpersonal Therapy (IPT)** have been shown to have the largest evidence base for treatment of moderate to severe depression in adolescents.

• Mild depression equally responsive to supportive psychotherapy.
Conclusion

Suicide is a public health crisis

Screening reduces risk and improves outcomes

There are tools available to help providers screen

It is important to get patients into care


Miller CL, Druss BG, Dombrowski EA, & Rosenheck RA (2003). Barriers to primary medical care among patients at a community mental health center. *Psychiatric Services.* 54(8), 1158-1160


www.uspreventiveservicestaskforce.org
References


Questions and Discussion

• Please type your questions into the text box in the bottom right of your screen
• Only moderator and presenters can see your questions
Thanks!

Please take a few minutes to complete survey after webinar closes

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Anik Jhonsa
JhonsaA@email.chop.edu