Behavioral Health Emergencies

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Learning objectives

Review epidemiology of youth death and suicide risks

Introduce and discuss screening tools to help providers make safe disposition plans.

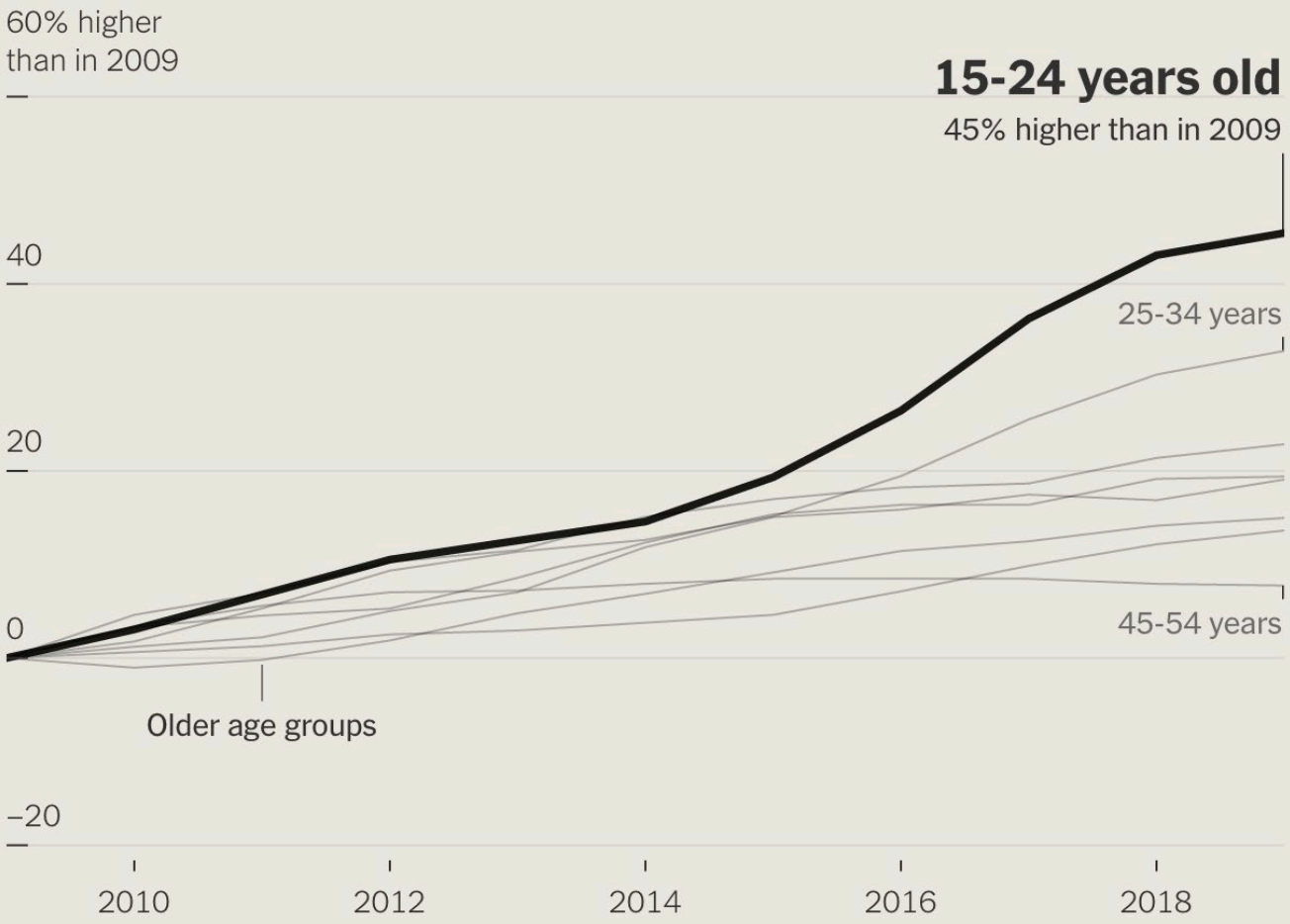
Define trauma informed care and learn about how one major children's hospital is addressing it


968 × 681

Children with psychiatric needs are overwhelming hospital emergency departments in CT

Change in U.S. Suicide Death Rates in the Past Decade

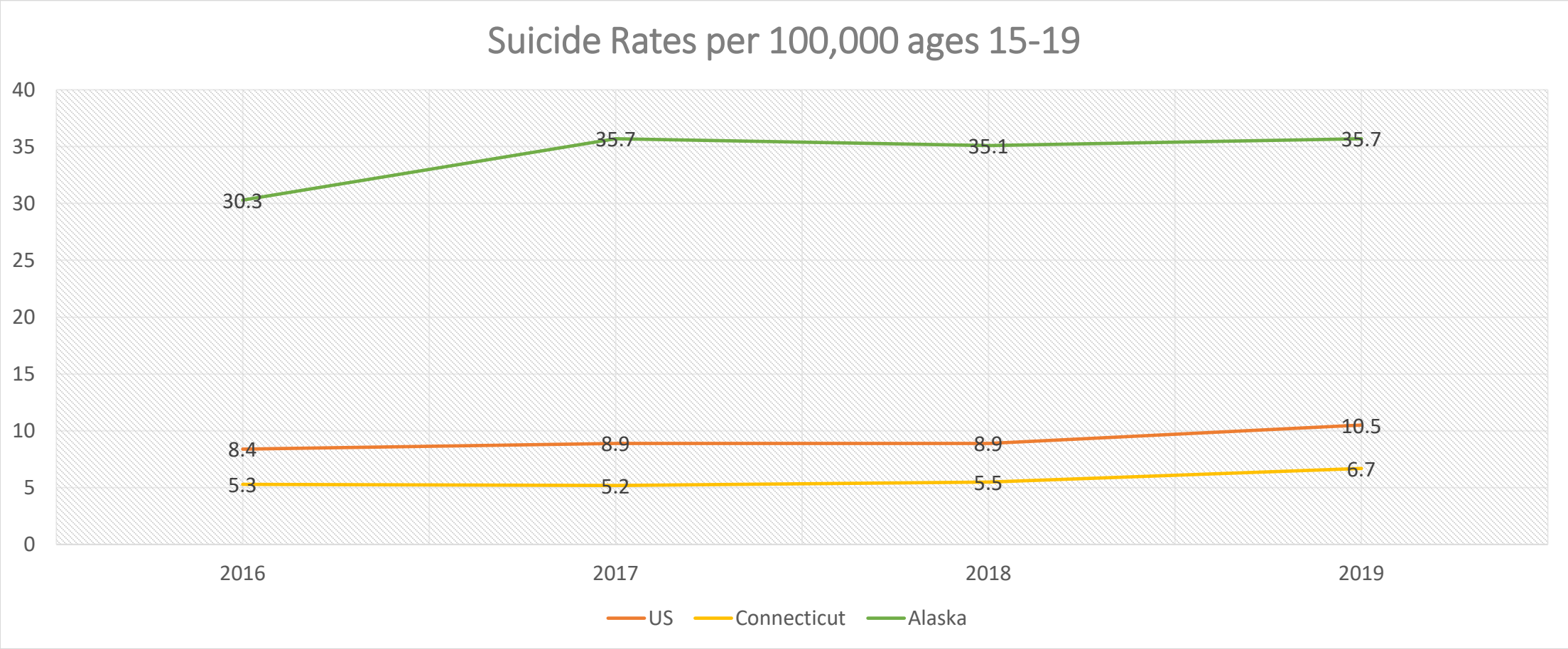
While those ages 45 to 54 had the highest suicide rate in 2019, the greatest percentage increase in the decade leading up to 2019 was among those ages 15 to 24.



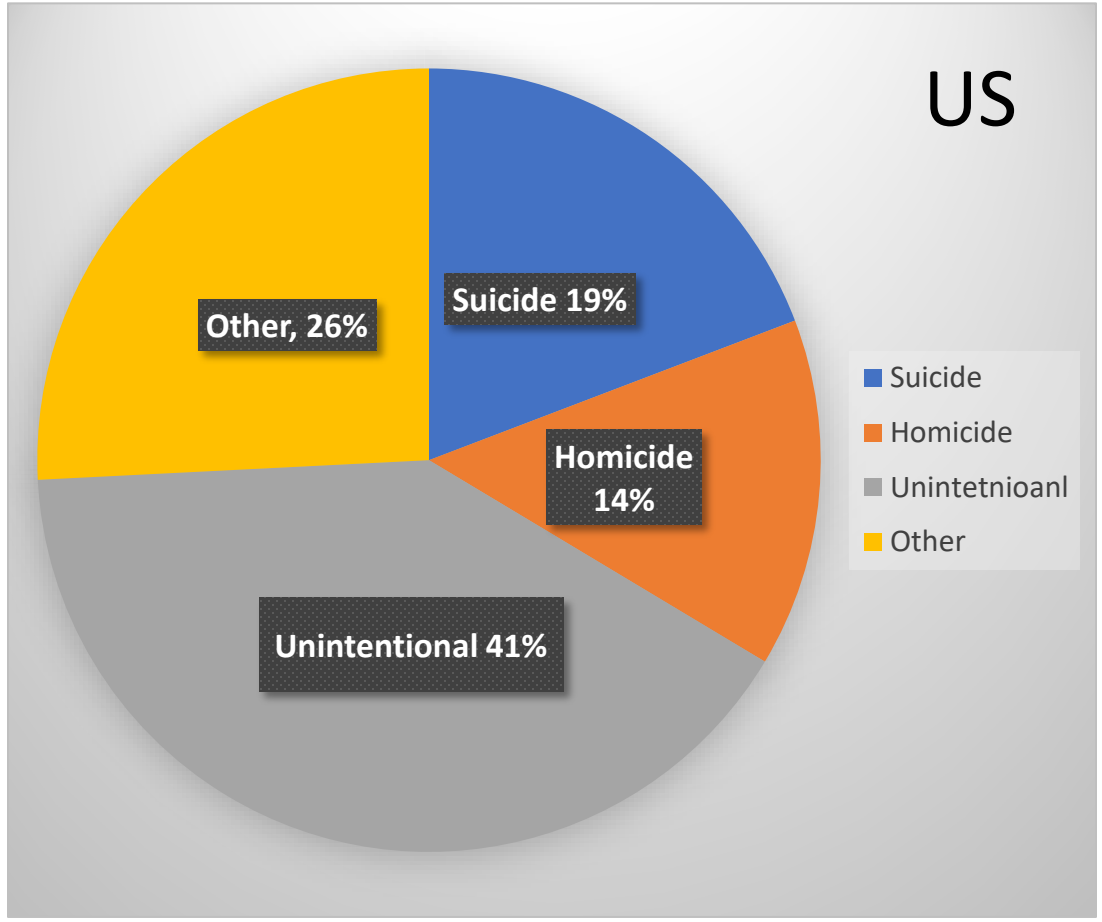
Source: Centers for Disease Control and Prevention. Note: The chart shows the percentage change in suicide deaths per 100,000 people in the United States for each age group. Each line is based on a three-year rolling average. Data for those ages 14 and younger are not included because their suicide rate is very low.

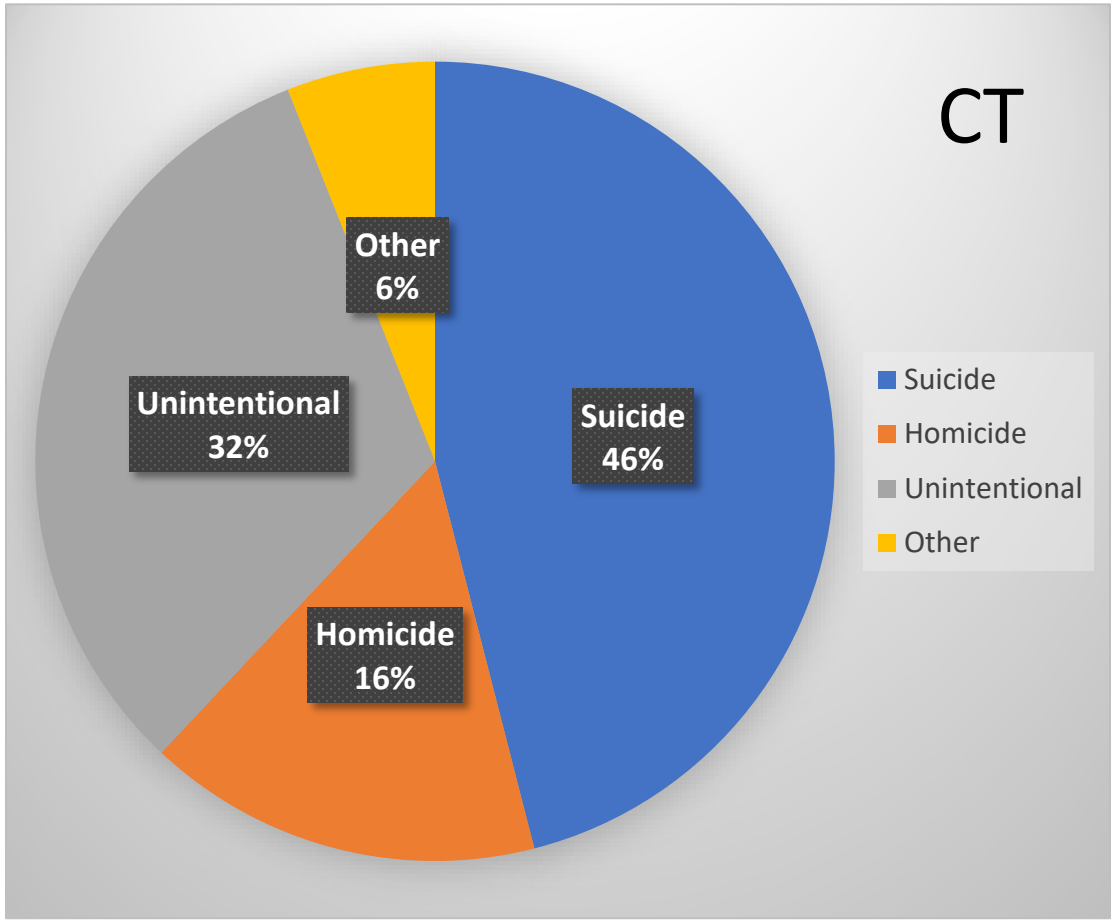
Suicide Rates

US versus Connecticut



Top % Causes of Death In Adolescents US versus Connecticut





Modifiable and non-modifiable factors for suicide

- Non-modifiable
  - Bipolar disorder
  - Mood disorder with co-morbidity
  - Family history of suicide
  - Stressful life events
- Modifiable factors
  - No behavioral health treatment
  - Poor parent-child communication
  - School problems
  - **Availability of firearms in home**
    - Brent et al 1988
    - Gould et al 1996

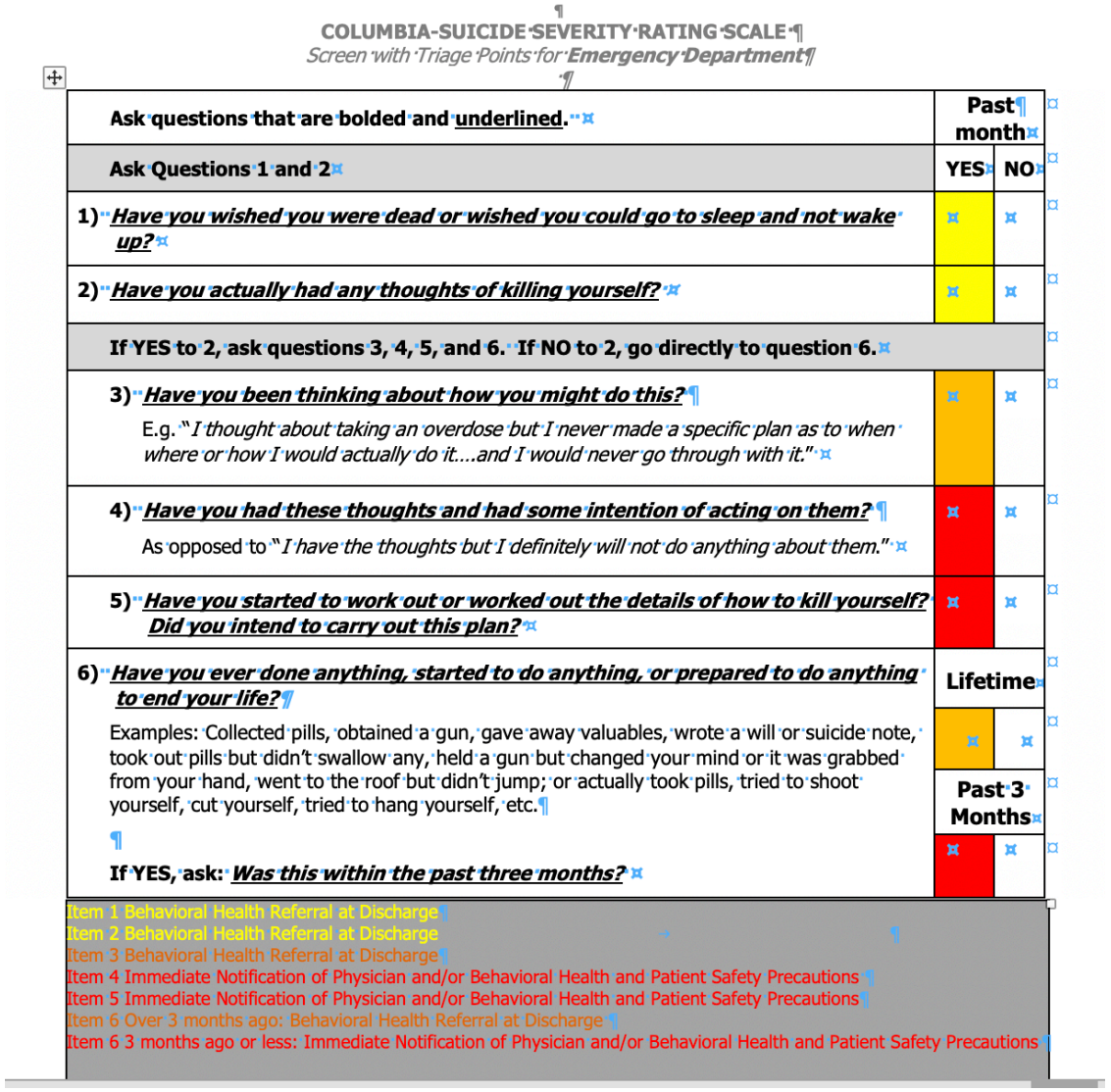
Caution in interpreting risk factors for suicide

- The health care professional should use care in interpreting fixed risk factors, however, because risk factors are common, whereas suicide is infrequent.
- **Of importance, the lack of most risk factors does not make an adolescent safe from suicide.**
- If you are worried that a child is suicidal, then **you should just ask.**

PHQ9-Screening for depression and suicide

		Not at all	Several days	More than half the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Columbia Screen for Suicidality (CSSRS)



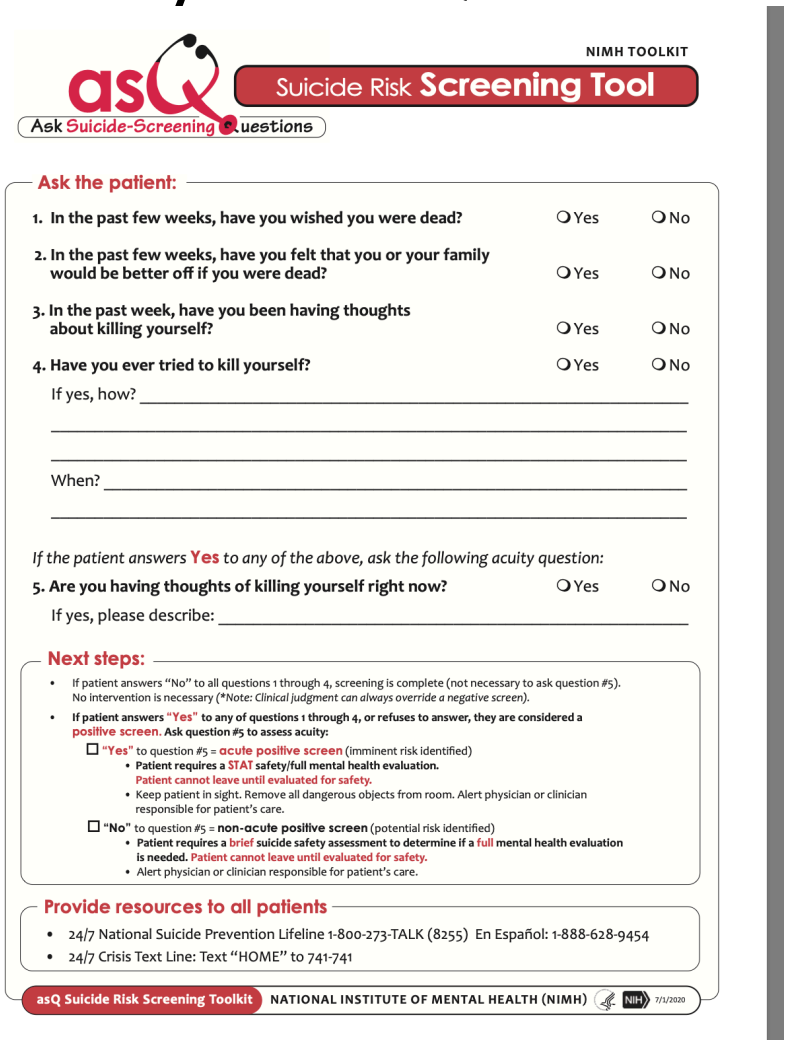
COLUMBIA-SUICIDE SEVERITY RATING SCALE

*Screen with Triage Points for **Emergency Department***

Ask questions that are bolded and underlined.	**Past month**	
Ask Questions 1 and 2	**YES**	**NO**
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**Lifetime**	
	Past 3 Months	
If YES, ask: *Was this within the past three months?*		

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Referral at Discharge
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Referral at Discharge
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

Suicidality Severity: ASQ



NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

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

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (**Note: Clinical judgment can always override a negative screen*).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 7/1/2020

Case

- 15-year-old
- Depressed mood due to bullying by classmates
- Wrote “I want to die” on arm
- School sent to ED
- SW clears patient for discharge
- You talk to the patient and family and learn there are firearms in the home

What can we do to reduce the risk of firearm injury

- We can just ask parents.
- Parents who own firearms are okay with pediatricians asking about firearms.
  - Self administered survey of 1363 parents in IL, MO
  - 12.8% of parents said pediatrician asked about firearms.
  - 36% parents had firearms; of these
    - 71.1% said pediatricians should ask about safe storage.
    - 22% would ignore advice to not have firearms for safety reasons.
    - 13.9% would be offended by such advice.
      - Garbutt et al. What parents are willing to discuss with their pediatricians about firearm safety? A parental survey. *J Pediatrics 2016; 179: 166-171*

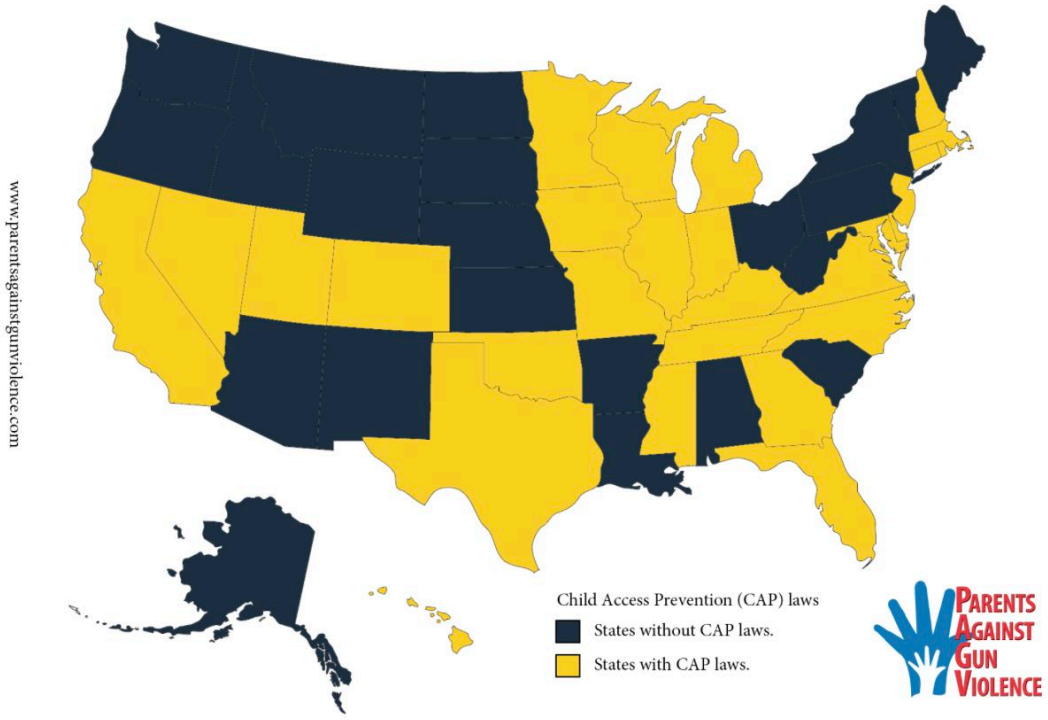
There is no law that says physicians cannot ask about firearms

- In 2011, Firearms Owners Privacy Act was passed in Florida.
  - It targeted pediatricians who asked parents about firearms in the home.
  - Under its provisions, physicians could be punished with a fine of up to $10,000, and could lose their medical licenses for discussing firearms with patients.
- In 2014, a three-judge panel of the 11th U.S. Circuit Court of Appeals upheld its constitutionality.
- In 2017, in a 10-1 decision, the full panel of the 11th U.S. Circuit Court of Appeals found that the act violated the First Amendment rights of physicians.
- At least ten other states have introduced similar bills, though none have passed.
    - https://www.npr.org/sections/thetwo-way/2017/02/17/515764335/court-strikes-down-florida-law-barring-doctors-from-discussing-guns-with-patient

Effective firearm legislation for children

- Child Access Prevention Laws are an effective way to reduce firearm injury in children.
- Mandate the safe storage of firearms to prevent access by minors and impose criminal liability on adults who fail to prevent access.
- May lead to safer storage of firearms, and are associated with reduced rates of youth suicides.

- Parikh K et al Pediatric Firearm-Related Injuries in the United States. Hospital Pediatrics 2017: 7-16.
- Hepburn, L et al. The effect of child access prevention laws on unintentional child firearm fatalities, 1979-2000. *Journal of Trauma.* 2006; 61:423-28.
- GrossmanDC,MuellerBA,RiedyC,etal.Gunstoragepracticesandriskofyouthsuicide and unintentional firearm injuries.JAMA. 2005;293(6):707-714.



Map illustrating states with CAP laws and states with no CAP laws

Ethan’s Law

- In a home with someone younger than 18 years old:
  - Firearm must be stored:
    - Locked
    - Unloaded
    - Ammunition separate from firearm
    - “Triple Safe” Method of firearm storage

Extreme Risk Protection Orders

- Connecticut has an extreme risk protection order law which allows for the removal of firearms and prohibits future acquisition of firearms where individuals pose a risk of injury to themselves or others.
- In Connecticut, a state's attorney, assistant state's attorney, or any two police officers who "have probable cause to believe that a person poses a risk of imminent personal injury to himself or herself or to another person" may file a complaint to any Superior Court judge for a risk protection order.
- A risk protection order prohibits a person from "acquiring or possessing a firearm or other deadly weapon or ammunition."
- If there is probable cause to believe that the person already possesses one or more firearms or deadly weapons and that those firearms or deadly weapons and that those weapons are within or upon a particular place or person, the judge shall also issue a warrant for law enforcement to search that place and/or person and take the weapon(s) into custody.

Extreme Risk Protection Order

- Probable cause may be based on:
  - Recent threats or acts of violence directed towards self or others;
  - Recent acts of cruelty to animals;
  - Reckless use, display or brandishing of a firearm or other deadly weapon;
  - A history of use, attempted use or threatened use of physical force against others;
  - Illegal use of controlled substances or abuse of alcohol; or
  - Involuntary confinement to a hospital for persons with psychiatric disabilities.

Extreme Risk Protection Order

- Connecticut law also allows for a family or household member or a medical professional with a good faith belief that a person poses a risk of imminent personal injury to himself or herself or another person to apply to a court for a risk order protection investigation.
- If the court finds that there is such a good faith belief, it shall order a risk protection order investigation to determine if there is such a risk. Law enforcement then investigates whether there is a risk of imminent personal injury.
- The subject of the investigation is ineligible to purchase or receive a firearm during the pendency of the investigation.
- If following the investigation there is probable cause to believe there is such a risk, the law enforcement agency shall seek a risk protection order and, if appropriate, a warrant for firearms, ammunition, and other deadly weapons. [8]

Extreme Risk Protection Order

- From 1999 to 2013, Connecticut courts issued 762 risk warrants.
  - 92% were men.
  - 61% risk to self.
  - 32% risk to someone else.
- It has been estimated there was 1 suicide prevented for every 11 firearms seized.
  - Swanson J et al. IMPLEMENTATION AND EFFECTIVENESS OF CONNECTICUT'S RISK-BASED GUN REMOVAL LAW: DOES IT PREVENT SUICIDES? LAW AND CONTEMPORARY PROBLEMS [Submitted: August 24, 2016

Overview

- What are adverse childhood experiences, toxic stress and traumatic events?
- Traumatic events and risk for Post Traumatic Stress Disorder (PTSD)
- Interventions to prevent PTSD
- Pediatric Trauma Referral Program

A Broader View of Adverse Childhood Experiences

- The original 10-item ACE inventory asked about childhood physical, sexual and emotional abuse, physical and emotional neglect, exposure to domestic violence, household substance abuse and mental illness, parental incarceration, and parental divorce.
- However, these items were not chosen through any systematic empirical process of selecting the best predictors of negative outcomes.
  - It is not clear if just these early-identified ACEs are the most predictive set of adversities among all potential adverse experiences.
  - Subsequent research has pointed to important domains of adversity that were not covered by the original ACE inventory, such as forms of peer victimization, witnessing community violence, and unintentional injury.

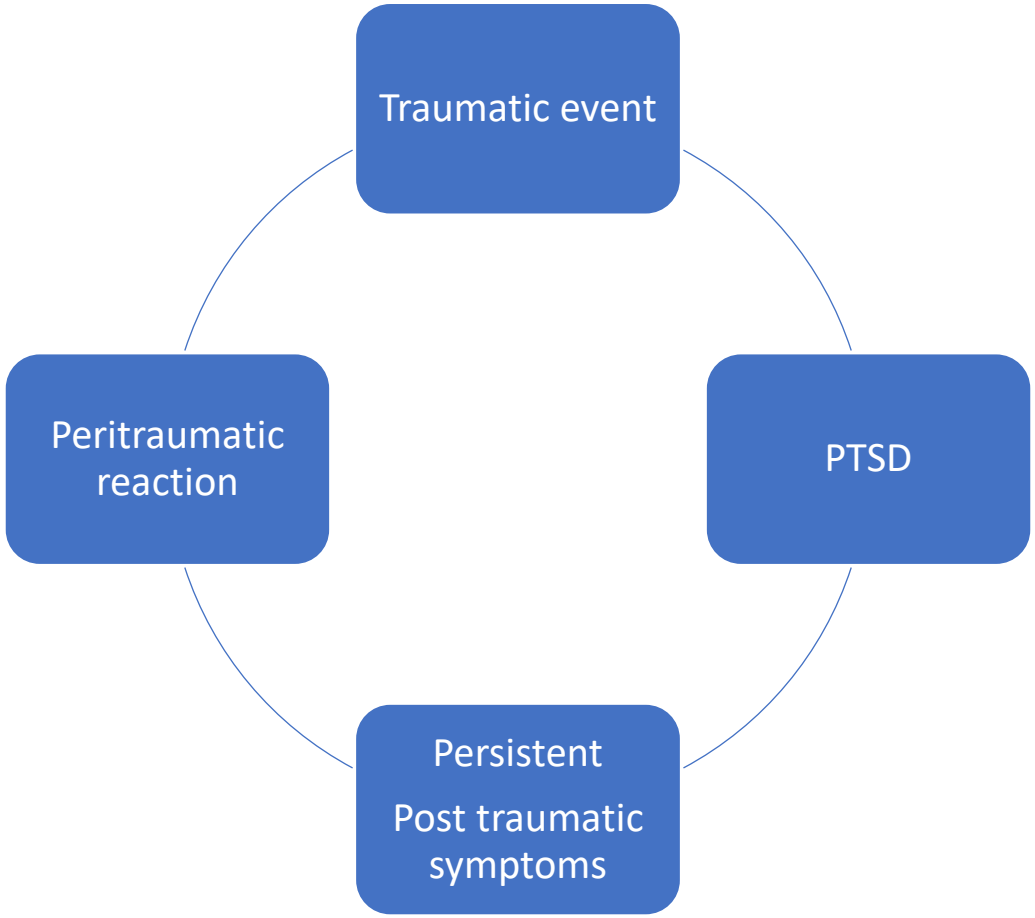
Traumatic events and PTSD

- There are health consequences of exposures to stressful conditions in childhood.
- Children can be traumatically overwhelmed by unexpected events, such as interpersonal violence, child abuse, assaults, unintentional injuries, natural disasters as well.
- These events can be termed toxic stress, traumatic events, or adverse childhood experiences.
- Children who are traumatically overwhelmed by these unexpected events are at risk for PTSD.
  - About 11% of exposed children will develop PTSD within a year of the traumatic event.

What happens after a traumatic event?

- **Peritraumatic** stress reactions refer to the different stress-associated behavioral, emotional, cognitive, and physiological symptoms during and immediately following a traumatic event (e.g., fear of dying and of additional threats to safety, emotional dysregulation, avoidant behaviors, sleep and eating difficulties, tachycardia, sweating, shaking, dizziness, dissociative symptoms.)
- For an event to be considered ‘traumatic’, the individual must have experienced a threat to their life, sustained a serious injury or the person’s physical integrity must have been otherwise threatened.
- This event must also have elicited fear, helplessness, or horror.

What happens after a traumatic event?



Screening in the Children's ED

- Patients younger than 18 years old account for over one-quarter of all trauma-related injury Emergency Department (ED) visits in the US.
- Such events include motor vehicle crashes (MVCs), animal bites, physical and sexual assault, firearm injury and interpersonal violence.
  - Similarly, survivors of such physical injuries are at risk for PTSD in the year following the injury.
- The Pediatric Emergency Department (PED) is an ideal setting for children with potentially traumatic events (PTEs) to receive follow-up evaluation for symptoms of post-traumatic stress and interventions to prevent PTSD.

Children's ED Trauma Referral Program

- The PED Trauma Referral Program at Yale New Haven Children's Hospital was established to identify children with traumatic events to offer screening for post-traumatic stress symptoms after ED discharge.

- Children with post-traumatic stress symptoms are offered referral to the Yale Child Study Center Trauma Clinic, which provides the Child and Family Traumatic Stress Intervention (CFTSI), an evidence-based intervention designed for the early phase of traumatic response, as well as other evidence-based, trauma-focused, behavioral health treatments.

Children's ED Referral Process

- In the PED, several targeted interventions have been implemented to improve provider recognition and referral of children with traumatic events for post-traumatic stress symptom screening.
  - 1) Provider education as to the benefit of referral of patients for post-traumatic stress symptom screening after ED discharge.
  - 2) Creation of a simplified referral process in the Electronic Medical Record. (EMR)
  - 3) A Best Practice Advisory (BPA) in the EMR which alerted providers that the patient was eligible for referral.
  - 4) Feedback to providers as to patient disposition (e.g. had post traumatic stress symptoms, accepted a behavioral health referral)

What is CFTSI?

- CFTSI is a brief (5-8 session), evidence-based early intervention for children 7 to 18 years old that reduces traumatic stress reactions and the onset of PTSD.
- CFTSI is implemented within 30-45 days following a traumatic event or the disclosure of physical or sexual abuse.
- CFTSI is used successfully with children with extensive trauma histories.
- The goal of CFTSI is to decrease post-traumatic stress reactions and onset of PTSD by increasing communication and family support.
- **Targeted Populations:**
- 7-18; both males and females; for parents and children who may have complex trauma histories

Case

- 8-year-old
- Witnessed father shoot and kill himself
- Brought by police to ED

Take home points

- Anyone can assess an adolescent for depression and suicidality using PHQ9, CSSRS and ASQ
- Any patient with a behavioral health concerns should have lethal means assessment and safety plan, including for firearms
- Any child with an unexpected traumatic event is at risk for post-traumatic stress symptoms; a minority will go on to full blown PTSD
- CFTSI can reduce the risk of PTSD in children with traumatic events and persistent post traumatic stress symptoms