# Approach to the Suicidal Adolescent in a Rural Emergency Department

Dr. Jennifer Russel

April 28, 2022| 0800-0900

THE UNIVERSITY OF BRITISH COLUMBIA
Continuing Professional Development
Faculty of Medicine

# LAND ACKNOWLEDGMENT

We acknowledge that we work on the traditional, ancestral and unceded territory of the Skwxwú7mesh (Squamish), xʷməθkwəy̓əm (Musqueam), and Sḵwx̱wú7mesh/Selilwitulh (Tsleil-Waututh) Nations.

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My family is initially from Scotland, and my grandmother moved to Montreal, where my Mother was born. I grew up in Toronto and moved to Vancouver in 2010. I identify as a white settler. I am a mom to two boys, a wife, sister, daughter and friend. I use she/her pronouns.
I am a child and adolescent psychiatrist and social worker, who has primarily worked in urban areas.  I am passionate about equity in health care, and am working towards improving our ability to care for our provinces' children and youth.

# PRESENTER DISCLOSURES

**Name:** Jennifer Russel

**Relationships with commercial interests:**

- Grants/Research Support: none
- Speakers Bureau/Honoraria: none
- Consulting Fees: TEND
- Other: Associate Head of Mental Health at BCCH and Women's
    - Psychiatrist on the Compass team
    - Program Director of Child and Adolescent Psychiatry Residency Program UBC

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# MITIGATION OF BIAS

**Urban Physician:**

- Grew up in Downtown Toronto
- Trained primarily in urban centres and continue to work at BCCH
- Have traveled to rural remote BC
- Have run this case by rural physicians

**Stigma of Mental Health Issues:**

- Acknowledge that this is still prevalent in all areas of health care
- Us versus them phenomena

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# POLL QUESTION

**How comfortable do you feel managing the suicidal adolescent in the ER?**

A. Bring it on – these cases are the reason I went into medicine
B. I feel OK managing these cases, but could use more support
C. I am anxious managing these cases
D. I dread these cases and feel unsupported and/or unprepared

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# A NOTE ON STIGMA

- Mental Illness related Stigma is real in Canada
- It is a barrier to accessing treatment and recovery
- People with lived experience have reported feeling "devalued, dismissed and dehumanized" when seeking care

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*"The pervasiveness with which negative interactions are reported suggests the problem is not isolated to a few insensitive providers but is more systemic in nature- that it is a problem with how healthcare culture prioritizes and perceives persons with mental illness"*

Knaak, Mantler, Szeto. Healthcare Management Forum 2017, Vol. 30(2) 111-116.

# STIGMA CONT'D

- Certain disorders – such as personality disorders are "particularly rejected by healthcare staff"
- Felt to be difficult, manipulative, and less deserving of care

*"See the illness ahead of the person"*

- Burnout and Compassion Fatigue are contributing factors

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Knaak, Mantler, Szeto. Healthcare Management Forum 2017, Vol. 30(2) 111-116.

# LEARNING OBJECTIVES

- Develop approaches to an emergency presentation of a suicidal adolescent in a rural emergency department
- Review non psychopharmacological management
- Review psychopharmacological management
- Discuss complexities of rural/remote setting
- Discuss the impact of these cases on the provider

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# MENTAL HEALTH AND THE PANDEMIC

- 1 in 4 youth globally are experiencing clinically elevated depression symptoms
- 1 in 5 youth globally are experiencing clinically elevated anxiety symptoms
- Rates are double pre-pandemic estimates

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Racine et al., 2021

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Search All AAP

Advocacy | Blueprint for Children | Advocacy Issues | State Advocacy Focus | Advocacy Resources

# AAP-AACAP-CHA Declaration of a National Emergency in Child and Adolescent Mental Health



**A declaration from the American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry and Children's Hospital Association:**

As health professionals dedicated to the care of children and adolescents, we have witnessed soaring rates of mental health challenges among children, adolescents, and their families over the course of the COVID-19 pandemic, exacerbating the situation that existed prior to the pandemic. Children and families across our country have experienced enormous adversity and disruption. The inequities that result from structural racism have contributed to disproportionate impacts on children from communities of color.

This worsening crisis in child and adolescent mental health is inextricably tied to the stress brought on by COVID-19 and the ongoing struggle for racial justice and represents an acceleration of trends observed prior to 2020. Rates of childhood mental health concerns and suicide rose steadily between 2010 and 2020 and by 2018 suicide was the second leading cause of death for youth ages 10-24. The pandemic has intensified this crisis: across the country we have witnessed dramatic increases in Emergency Department visits for all mental health emergencies including suspected suicide attempts.

The pandemic has struck at the safety and stability of families. More than 140,000 children in the United States lost a primary and/or secondary caregiver, with youth of color disproportionately impacted. We are caring for young people with soaring rates of depression, anxiety, trauma, loneliness, and suicidality that will have lasting impacts on them, their families, and their communities. We must identify strategies to meet these challenges through innovation and action, using state, local and national approaches to improve the access to and quality of care across the continuum of mental health promotion, prevention, and treatment.

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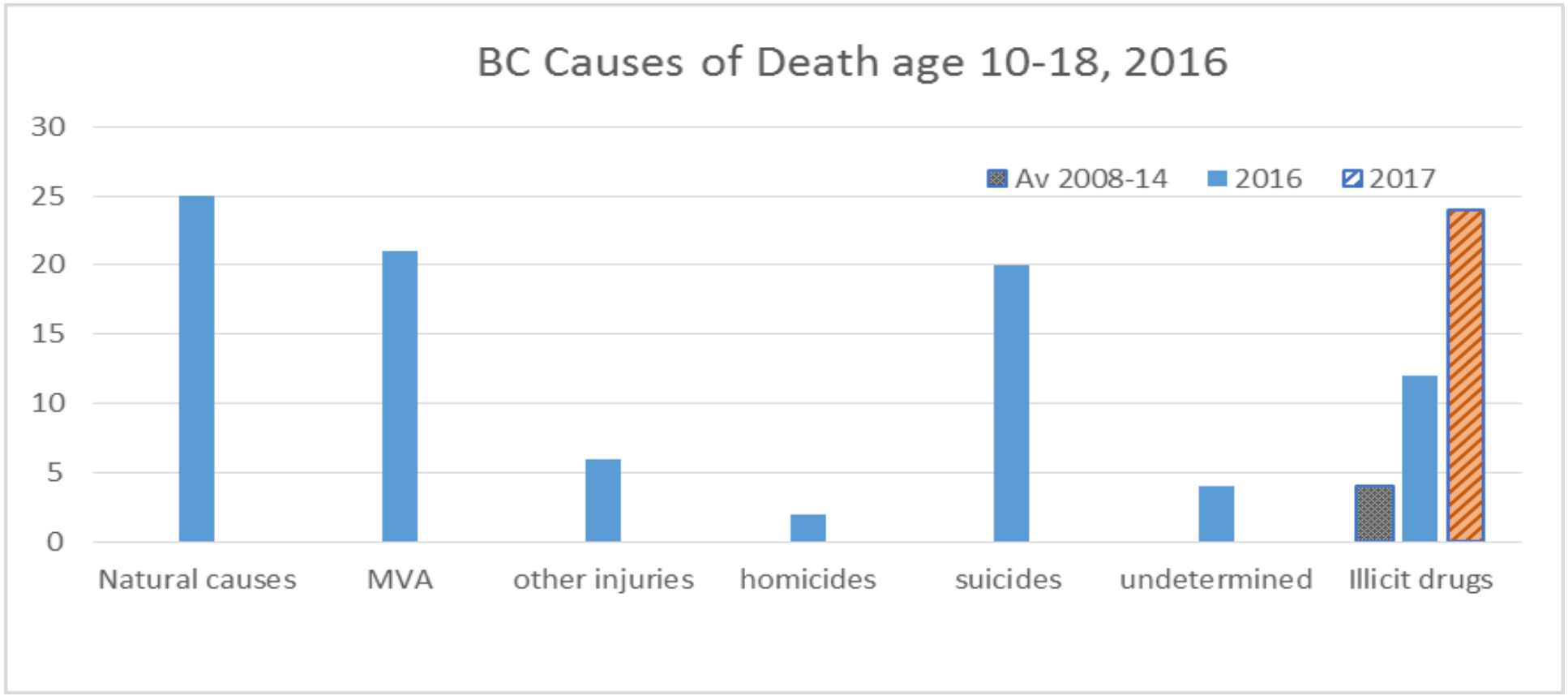
# EPIDEMIOLOGY — CHILD DEATHS IN BC




From https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/child-mortality-2016.pdf

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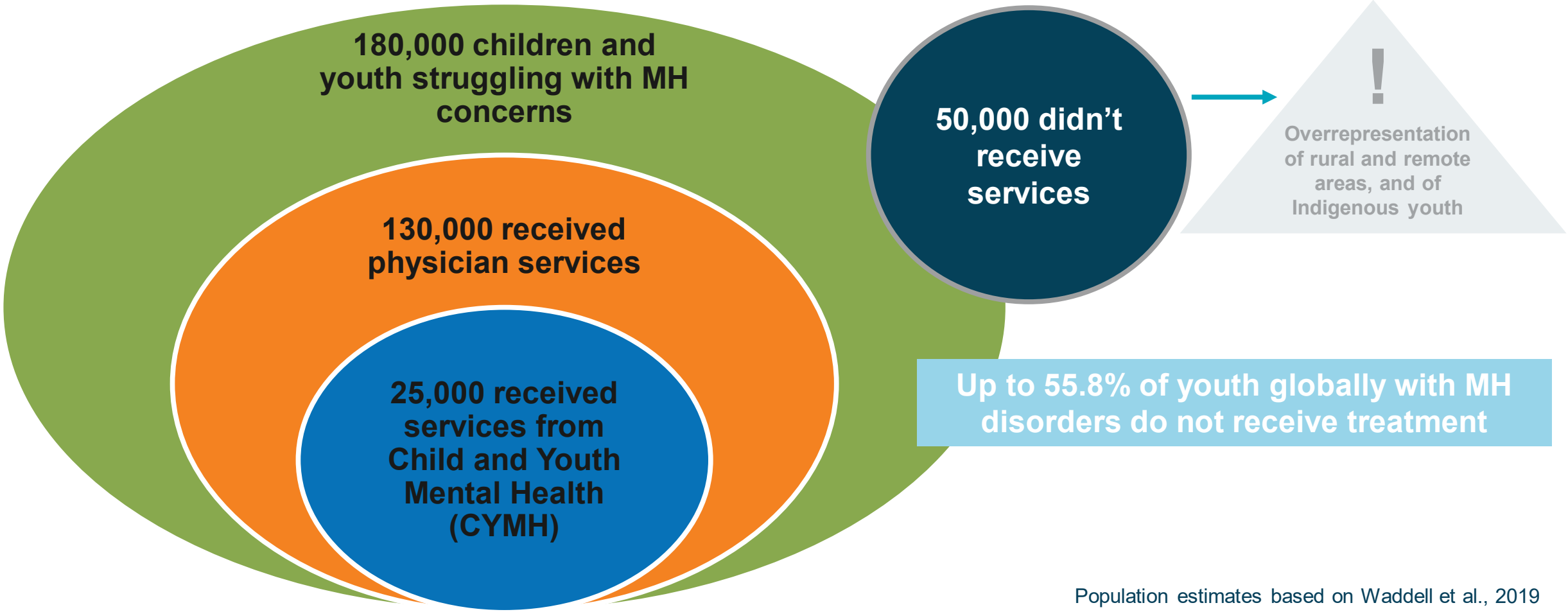
# BC Children's Hospital Mental Health

## VISION

All children, youth & their families in BC receive high-quality, evidence-based mental health & substance use services when they need them, regardless of where they live

# Gaps in Child and Youth Mental Health Care in B.C.




**Up to 55.8% of youth globally with MH disorders do not receive treatment**

Population estimates based on Waddell et al., 2019
Barican et al., 2020

# Impact of Colonization on Children and Youth in British Columbia cannot be overstated

# MOST PSYCHIATRIC DISORDERS IN YOUTH ARE TREATABLE

- Most psychiatric disorders in children and youth respond well to treatment (ADHD, anxiety, mood disorders, eating disorders and substance use).
- However, many children and youth in BC (and their families) struggle to access timely psychiatric assessment and care.
- As a result, our young people are not getting the treatments they need when they need them.
- Without comprehensive psychiatric assessments, many treatable underlying mental health disorders are not addressed according to current treatment guidelines.

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# CASE #1

Jayne

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# JAYNE

- 15 year old youth presents to rural ER
- Her teacher called her Mom to say that she had posted comments online that she was going to “kill herself for real tonight”
- Jayne had a previous suicide attempt by taking 8 Advil two days ago
- She lives with her family
- Her Aunt had bipolar disorder, died of suicide last year
- Her Mother is very worried and wants her admitted to hospital

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# JAYNE CONT'D

- When you meet with Jayne she initially denies any mental health symptoms and gets agitated wanting to leave
- When confronted with her Instagram post, she says she was just upset because of a conflict with her boyfriend but is fine now and they are back together (she is texting him during the interview)
- Her Mother found a suicide note in her room, and a bottle of acetaminophen with 30 tablets missing

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# JAYNE CONT'D

- Jayne wants to leave, but her mother is very worried
- A conflict ensues in the emergency department where Jayne throws her cell phone at her mother
- Jayne becomes extremely dysregulated and starts screaming and threatening to kill herself if you don't let her go
- Her Mother is worried and tells you she has been trying to get help for Jayne for months but it is hard to access care

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# JAYNE CONT'D

- During the argument between Mom and Jayne, an elder is brought in with a broken hip
- There is a child waiting for stiches after falling at school
- You are the only physician on overnight, with one nurse in the ER
- There is no place to admit Jayne in your hospital — she could be held in the ER

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# OVERVIEW

- Acute Management
- Short Term Management
- Long Term Management

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# ACUTE MANAGEMENT

- Assess Medical Stability
- Concern re overdose
- Certification
  - Safety of self
  - Safety to others
  - Risk of significant decompensation
- Who is there to support the youth in crisis

Importance of Trauma Informed Practice — what does this mean in Mental Health?

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# KEY PARTS OF THE INTERVIEW

- Identifying data – who is this youth, and who is close to them?
- Why did they present today?
- **MADS** – mood (depression and bipolar), anxiety, drugs, suicide
- **HEADS** exam – home/employment, education, activities, drugs, sex, suicide
- What does the youth want out of the visit? What is a successful outcome for them?

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# OVERVIEW

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# GETTING THROUGH THE NIGHT

- Resources vary from community to community
- Importance of Developmental and Culturally safe care
- Can you send the youth home?
  - Assess the risk (active suicidal ideation, psychosis, medical stability)
  - What is the home environment like?
  - What is the emergency department like?
  - Risk – Benefit analysis of what is best for this youth and family

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Importance of Shared Decision Making –

call and review if needed (604-875-2345, ask for the attending on call)

# SENDING A YOUTH HOME

- Creation of an individual safety plan which includes family or trusted adults
- A plan for what happens if things deteriorate at home
- What is the follow up plan for this youth to get ongoing care?
- Medications that can be used for stabilization in the short term

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Importance of Shared Decision Making –
call and review if needed (604-875-2345, ask for the attending on call)

# SAFETY PLAN

- Create a unique safety plan for each youth and family
- The family can work on this together, or with staff
- Identify and build on current supports
- Make sure that it is realistic
- Be creative – engage with the youth about what works for them
- Add in crisis services in your area

## my safety plan

**If I feel stressed and/or unsafe I will...**

1. Use my tools to feel better, which are...
   - 
   - 
   - 
   - 
   - 
   - 

2. Speak to a trusted adult...

   Name: Phone: Name: Phone:

   Ways I would like them to support me are: Ways I would like them to support me are:
   - 
   - 
   - 
   - 

3. Call my community team...

   Name: Role: Phone:

   Name: Role: Phone:

4. Call my local crisis line:
   - Crisis Centre BC: 1-800-SUICIDE (1-800-784-2433)
   - 310 Mental Health Support: 310-6789 (no area code required)
   - 24 hour Crisis line: 604-872-3311 (Greater Vancouver)
   - Kids Help Line: 1-800-668-6868 or KidsHelpPhone.ca
   - www.youthinbc.com online chat available from 12:00 noon until 1:00 am
   - Other:

5. Go somewhere I feel safe...
   - 

6. Go to the Emergency Room at the nearest hospital

**7. If I can't get to the hospital safely, I will call 911**

An important person in my life is...

Something I enjoy doing is...

One thing I'm looking forward to doing is...



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# KEEPING A YOUTH OVERNIGHT

- Voluntary or Certified
- How to support the youth in hospital
  - Are there people who can support the youth overnight (trusted adults)?
  - Warm blankets, food, connection with health care workers
  - Installation of Hope – most of these youth get better
  - Medications that can support the youth in hospital
  - Encouraging connection with supports
- Connection with Regional supports to get direct assessment
  - Megan Crawford in the North
  - Connect with Compass

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# OVERVIEW

- Acute Management
- Short Term Management
- Long Term Management

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# Service Overview

**WHAT**
- Provider support program

**WHO**
- Psychiatrists
- Psychologist
- Social Workers
- Nurse Clinicians
- Registered Clinical Counselors
- Indigenous Care Coordinator

**FOR WHOM**
- Physicians & Primary Care Providers
- Pediatricians, Psychiatrists & other specialists
- MH/SU clinicians (CYMH, SW, Psychologists)
- Nurses & Nurse practitioners
- Community Carers (Indigenous Elders, Youth Workers)
- School Counsellors
- Case Managers

**WHEN**
- Mon-Fri, 9 a.m. - 5 p.m.

**Core services**

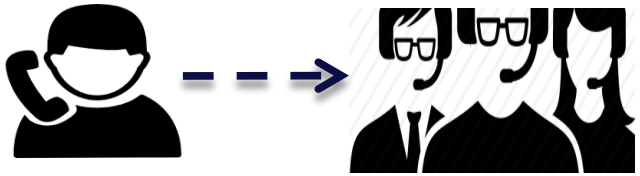
Telephone consultation

Service navigation

Training & education

# What to Expect When you Call Compass

## *1) Community Provider Calls Compass*



**Telephone-based consultation with seasoned clinician**

- Diagnostic clarification
- Support with screening
- Treatment planning
- Resource/service navigation

## *2) Compass Provider Schedules Further Consultation(s) as needed*

**Booked telephone or video consultation for additional support as needed**

- Additional support with the above
- Specialized support as needed, such as:
  - Medication consultation
  - Therapeutic consultation (e.g., CBT, DBT, ERP)

## *3) Direct Assessment Scheduled IF needed*

**Video-based direct assessment with the patient, guardians, and community providers**

- Focused assessment to target a specific question
- Comprehensive in-depth assessment for diagnostic clarity or support with treatment planning

# APPROACH TO THE AGITATED YOUTH

## Guiding Principles

- An approach to patient care that provides the safest, most necessary care is by definition compassionate.
- Safety always comes first
- Safety events can be traumatic to patients, families, and staff
- Disorganized approaches to safety events can prolong the trauma and may result in injury
- Child/youth &/or family/substitute decision maker preference should be taken into consideration whenever possible

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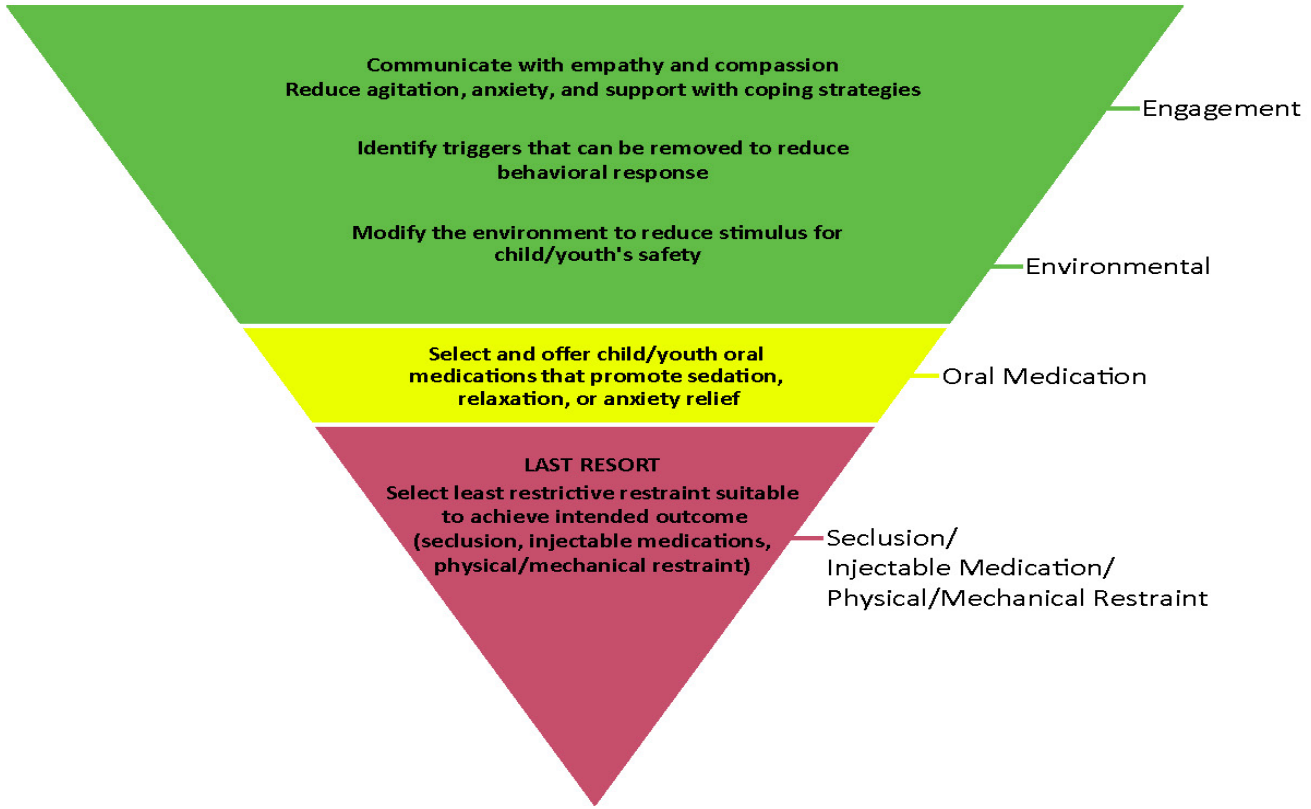
# Safety is the Priority

## The RIGHT approach at the RIGHT time




- Document assessments, interventions and rationale
- Debrief with child/youth, family and staff
- Initiate a review process whenever restraint is used, to minimize future use and for quality improvement

# EMERGENCY RESTRAINT USE

1. Engagement/De-escalation
2. Environmental modification strategies
3. Oral medications
4. Seclusion/Injectable medications/Physical/Mechanical restraints

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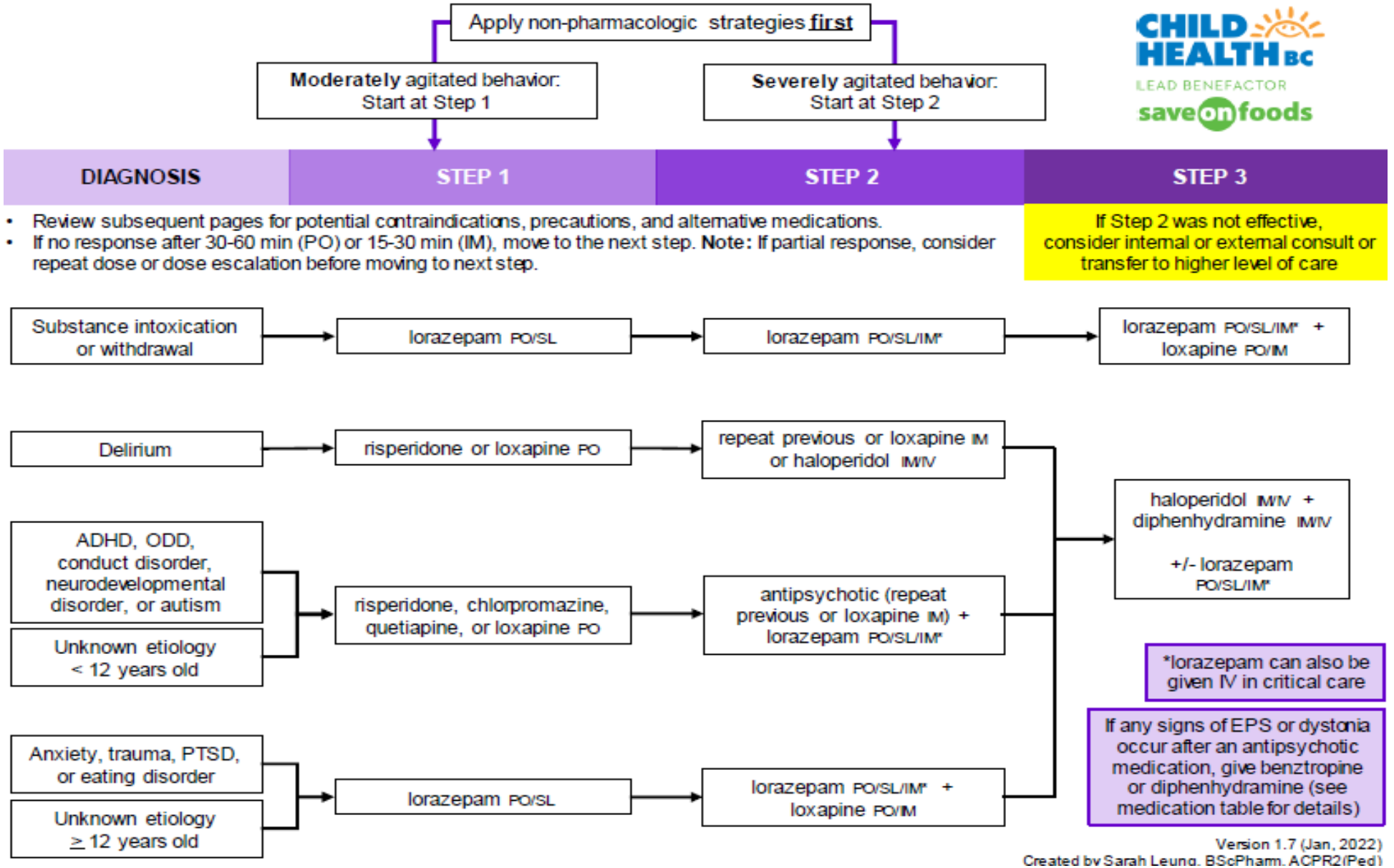
Children and youth should be assessed at minimum

every hour if needing restraint or seclusion

# Appendix C-1: Guideline for Pharmacologic Management of Acute Agitation in Pediatric Patients




Version 1.7 (Jan, 2022)
Created by Sarah Leung, BScPharm, ACPR2(Ped)

## Appendix C-3: MEDICATIONS FOR ACUTE AGITATION

| Name | Usual Dose (for acute episode) | Action | Adverse Effects | Contraindications |
|---|---|---|---|---|
| **Benztropine** | **EPS:** 0.5-1 mg/dose PO/IM<br>Max: 0.1 mg/kg/24h or 6 mg/24h<br>**Acute dystonia:** 1-2 mg/dose IM/IV | Anticholinergic | Sedation, dry mouth, blurred vision, tachycardia, constipation, urinary retention. | **Avoid:** Age < 3 years (use diphenhydramine), anticholinergic delirium<br>**Caution:** Ileus, narrow angle glaucoma |
| **Chlorpro-mazine** | 0.5-1 mg/kg/dose PO<br>(round to nearest 12.5 mg)<br>Max: 50 mg/dose | FGA,<br>low potency | Postural hypotension, tachycardia, QTc prolongation, lowered seizure threshold. Less risk of EPS vs. haloperidol, but more anticholinergic effects. | **Avoid:** Seizure disorders, anticholinergic delirium<br>**Caution:** Cardiac conditions, other QTc prolonging medications |
| **Clonidine** | 1 mcg/kg/dose PO<br>Max: 50 mcg/dose | Alpha-2 agonist | Dizziness, hypotension, bradycardia. | **Avoid:** Hypotension, bradycardia<br>**Caution:** Anticholinergic delirium |
| **Diphen-hydramine** | 1 mg/kg/dose PO/IM/IV (round to nearest 5 mg). Max: 50 mg/dose. Given with haloperidol to prevent dystonic reaction. Use IM/IV route for treating acute dystonia. | Anticholinergic, used to treat agitation or EPS/dystonia | Sedation, dry mouth, blurred vision, tachycardia, constipation, urinary retention. QTc prolongation in high doses. Paradoxical excitation can occur; more common in younger children and those with neurodevelopmental disorders. | **Avoid:** Anticholinergic delirium<br>**Caution:** Ileus, narrow angle glaucoma |
| **Haloperidol** | 0.025-0.075 mg/kg/dose PO/IM/IV<br>Max: 5 mg/dose | FGA,<br>high potency | High incidence of EPS and dystonic reactions in children and adolescents. IM route may have higher risk of dystonia, and IV route may have higher risk of QTc prolongation. Hypotension, lowered seizure threshold. Minimal anticholinergic effects. | **Avoid:** Cardiac conditions (particularly arrhythmias or prolonged QTc), other QTc prolonging medications<br>**Caution:** Seizure disorders |
| **Lorazepam** | 0.025-0.1 mg/kg/dose PO/SL/IM<br>(round to nearest 0.25 mg)<br>Max: 2 mg/dose *(higher doses may be required for stimulant overdose or substance withdrawal; max single dose 4 mg)* | Benzodiazepine | Confusion, mild cardiovascular suppression. Higher risk of respiratory depression when combined with opioids. Paradoxical excitation can occur; more common in younger children and neurodevelopmental disorders. | **Avoid:** Respiratory depression<br>**Caution:** Patients taking opioids |
| **Loxapine** | 0.1-0.2 mg/kg/dose PO/IM (round to nearest 2.5 mg)<br>Max: 25 mg/dose | FGA, moderate potency | Moderate incidence of EPS and dystonic reactions, moderate anticholinergic effects. | **Caution:** Cardiac conditions, seizure disorders, other QT prolonging medications, anticholinergic delirium |
| **Methotri-meprazine** | **Child:** 0.125 mg/kg/dose PO<br>**Adolescent:** 2.5-10 mg/dose PO<br>**Child & Adolescent:** 0.06 mg/kg/dose IM/IV (round to nearest 2.5 mg) | FGA,<br>low potency | Sedation, anticholinergic effects, postural hypotension. Less risk of EPS vs. haloperidol, but more anticholinergic effects. | **Avoid:** Hypotension, anticholinergic delirium<br>**Caution:** Seizure disorders, cardiac conditions, other QTc prolonging medications |
| **Olanzapine** | 2.5-10 mg/dose IM<br>Max: 3 doses or 20 mg/24h, given 2-4 h apart<br>(onset of PO route too slow for PRN use in acute agitation) | SGA | Postural hypotension (monitor before each IM dose), anticholinergic effects, lowered seizure threshold, akathisia. Minimal risk of QTc prolongation. | Do NOT combine IM route within 1 hour of parenteral benzodiazepine; reported cases of respiratory depression and death.<br>**Avoid:** Hypotension, anticholinergic delirium<br>**Caution:** Seizure disorders |
| **Quetiapine** | **Child:** 12.5-50 mg/dose PO<br>**Adolescent:** 25-100 mg/dose PO | SGA | Sedation, dizziness, postural hypotension, tachycardia, QTc prolongation, anticholinergic effects, lowered seizure threshold. Lower risk of EPS than other agents. | **Avoid:** QTc prolongation, hypotension, anticholinergic delirium<br>**Caution:** Cardiac conditions, other QTc prolonging medications, seizure disorders |
| **Risperidone** | **Child:** 0.125-0.5 mg/dose PO<br>**Adolescent:** 0.25-1 mg/dose PO | SGA | Postural hypotension, EPS (in higher doses), lowered seizure threshold, akathisia. Minimal risk of anticholinergic effects. | **Caution:** Seizure disorders, cardiac conditions, CYP2D6 inhibitors (e.g. fluoxetine) – consider dose reduction with repeat/regular dosing of risperidone |

**FGA – First generation antipsychotic; SGA – Second generation antipsychotic**

# KEY POINTS

- Restraints and Seclusion events should be debriefed by the team – just like another CODE or Trauma
- These events should be practiced/simulations

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# POLL QUESTION

**How comfortable do you feel managing the suicidal adolescent in the ER?**

A. Bring it on – these cases are the reason I went into medicine

B. I feel OK managing these cases – but could use more support

C. I am anxious managing these cases

D. I dread these cases – and feel unsupported and/or unprepared

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# JAYNE

- Jayne was kept overnight in the hospital and given a small dose of quetiapine to help her sleep
- Her Mom stayed with her, and she was voluntary
- The team called Compass who supported the ED physician in connecting with their local team
- Jayne was much more settled the next day, she created a safety plan with her Mom
- They are following up with their GP, local team, and Compass support if needed

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# CASE #1 Q&A

## POST YOUR QUESTIONS IN THE CHATBOX

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# RESOURCES MENTIONED

- Child Health BC Least Restraint Practical Summary and Tools – January 2022
- Trauma Informed Practice Guide
- San’yas program website
- Provincial Violence Prevention Curriculum
- Kelty Mental Health

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