Screening, Interviewing and Managing the Suicidal Child or Adolescent

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Session 116
3:10 – 4:25 pm
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Speaker Introductions

• Dr. Pam Lusk is a PMHNP practicing in a large rural pediatric practice as the integrated behavioral health NP. Pam attended Arizona State University for her DNP and PMHNP. She is the director of The Ohio State University College of Nursing-Child and Adolescent Online Mental Health Continuing Education Program. Dr. Lusk has received competency-based training in suicide prevention and has attended Mental Health First Aid for Youth.
• Dr. Jessica Kozlowski is a pediatric nurse practitioner practicing in a Federally Qualified Health Center in Florida. Dr. Kozlowski earned her DNP at Brandman University and her BSN from University of Florida. She routinely screens, assesses and manages children and teens in primary care with common mental health concerns. Dr. Kozlowski has published her work providing an evidence-based Cognitive Behavioral Skills Building Program with children with significant anxiety. She also teaches and precepts PNP and DNP students.

Disclosures

Pam Lusk has no conflicts of interest to disclose.
Jessica Kozlowski has no conflicts of interest to disclose.

Learning Objectives

• Discuss the urgent need to prepare NPs to address the increasing numbers of suicidal teens and children
• Identify the screening instruments now recommended for practice to assess depression and suicidality in youth.
• Discuss effective interviewing strategies to maximize time and assess the pediatric patient for thoughts of death and suicide
• Discuss evidence-based interventions for depression and suicidal ideation that can be implemented in primary care practice
• Discuss the use of antidepressant medication and the “black box warning” with children and adolescents.

CDC Centers for Disease Control and Prevention

According to a recent CDC report,

The suicide rate for children ages 10 - 14 nearly tripled from 2007 to 2017
The number of 12 – 17 year old who experienced a major depressive episode in the past year increased by more than 50%
Only about 50% of teens with depression are diagnosed and 2 in 3 depressed teens don’t get treatment

(Health.usnews.com 12 - 17 - 19)
The prevalence of mental health disorders among young people in this country approximates that of adults, and their impact may be even greater in youth because they strike during critical periods of educational, emotional and social development.

Fifty percent of mental health disorders begin before age 14 and 75% before age 24, affecting the learning and school experience for all children. Depression prevalence is 12.8% of the U.S. population aged 12 to 17 (adolescent depression).

Depressive Disorders in Children and Teens

The common feature of depressive disorders is the presence of sad, empty or irritable mood, which is associated with somatic and cognitive changes that interfere with functioning at home, in school and/or with peers.

Depression is loss of vitality. (energy, initiative, interest)

In youth irritability and anger are symptoms.

The Teenage Brain: Developmental considerations

Why youth are at increased risk for SI

"The problem for teens is that their undeveloped frontal cortex means they have trouble seeing ahead, or understanding the consequences of their independent acts, and are therefore ill-equipped to weigh the relative harms of risky behavior" (Jensen, 2015 p. 104).

Amygdala driven – Romeo & Juliette

More susceptible to suggestion: copycat self-harm and even suicide

Impulsive – unable to see past the pain and suffering

Suicide is Multifactorial

Cognitive - “This is hopeless. I am a burden. No one will care”
Behavioral - Substance use, social withdrawal, preparations
Emotional - Depression, Anger, Guilt
Physical - Agitation, Insomnia, Pain

Activating Event: Relationship problem, Financial stress, Perceived loss, Physical sensation, Negative memories

NSSI - Non-Suicidal Self Injury – elevated risk for Suicide
Suicide-specific cognitions: perceived burden, “better off without me” self-hatred, “I deserve to be punished” perceived incompetence – “I always fail” “I can’t handle this”
Primary Care Practice 1st Visit

- Screen with **PHQ 9** at every visit (ages 11 – 17)
  - If positive for SI add the **ASQ**
  - Plan for safety: Hospitalization or Patient Safety Plan Template
- Clinical interview – ask directly about symptoms of
  - Depression, family history of mood disorders, listen for:
    - Hopelessness, feeling like a burden, WEAPONS access?

If Diagnosis is Depression or MDD, discuss with family and child/teen the symptoms of depression as a treatable medical condition

Present the Evidence-Based Treatment Options, Support and Monitoring, Therapeutic Interventions-CBT

If antidepressant indicated, assess preferences. Discuss adverse effects possible, and Black Box Warnings

Discuss action of SSRI, expected response, 4 weeks till full response, Med monitoring (NSSI)

My clinical experience:

Parents/teens are feeling exasperated, exhausted and feeling helpless. They badly want help/direction NOW

Instill hope - MDD is a treatable medical condition, not a character flaw. Sometimes runs in families

If the child/teen is suffering from symptoms of MDD:

“From my education and experience, you don’t have to feel this bad”

Following them very closely - seeing or checking in with them frequently mitigates Black Box risk.

(Evidence supports phone calls to check in as very effective)

Using GLAD-PC Toolkit (2018), will increase confidence you are providing the best, evidence-based care.
GLAD-PC: Initial Management of Depression

- Clinician should educate and counsel families and patients on depression and management options.
- Clinicians should develop a treatment plan with patients and families with specific treatment goals.
- All management should include the establishment of a safety plan which includes restricting lethal means, engaging a third party, and developing a crisis plan (App My3).

www.glad-pc.org/ GLAD-PC Toolkit

Helpful Practice Handouts in GLAD-PC Toolkit

- What to discuss with Adolescents and Parents about Depression (for Primary Care)
- Family Support Action Plan (What Parents can do to help their Teens)
- Assessment of High-Risk Teen Suicide Attempters
- Educational Handouts Adolescents (Depression, Sleep, Medication)
- Dosing of SSRIs Evidence to support choice of SSRI
- Screening tools for practice (PHQ, Strengths and Difficulties Questionnaire, Pediatric Symptom Checklist)
- DSM5 Criteria for Mood Disorders
- Guide to Coding & Billing

GLAD-PC (2018)

Treatment and Ongoing Management (ages 10-21 yrs.)

1) Active Monitoring of mildly depressed youth
2) Treatment with evidence-based medication and other psychotherapeutic approaches for mod/severe depression
3) Close monitoring of side effects
4) Consultation and co-management with Mental Health Spec.
5) Ongoing tracking of outcomes

Mild to Moderate Depression

- AAP Active support and monitoring for 6 – 8 weeks
- Psychotherapeutic Interventions: CBT has strongest evidence for child/teen depression
- CBT Based Worksheets from: NAPNAP publication by Melnyk, & Jensen, “Practical Guide to Child & Adolescent Mental Health Screening…..”
- or email me at lusk.53@osu.edu


- Overall, both individual clinical trial evidence and evidence from systematic reviews still support the use of antidepressants in adolescents with MDD
- Bridges, et al. (2007) concluded that 6 times more teenagers would benefit from treatment with antidepressants than would be harmed
- Fluoxetine has the strongest evidence to support it’s use in adolescents
In addition to the boxed warning and other information in professional labeling on antidepressants, MedGuides are being prepared for all of the antidepressants to provide information about the risk of overdose during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases. This monitoring should include daily observation by families and caregivers and frequent communication with the prescriber.

Pediatric patients being treated with antidepressants for any indication should be closely observed for clinical worsening, as well as symptoms of agitation, irritability, suicidality, and unusual changes in behavior, especially for other psychiatric indications in children. Patients should be evaluated periodically for evidence of clinical worsening and suicidality, includinglibido, depression, agitation, anxiety, irritability, impulsive behavior, and obsessive-compulsive symptoms.

Today the Food and Drug Administration (FDA) directed manufacturers of all antidepressant drugs to revise the labeling for their products to include a boxed warning and expanded warning statements that alert health care providers to an increased risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these drugs, which include additional information about new studies of antidepressants. FDA also informed these manufacturers that it has determined that a Patient Medication Guide (MedGuide), which will be given to patients receiving the drugs to advise them of the risk and precautions that can be taken, is appropriate for these drug products. These labeling changes are consistent with the recommendations made to the Agency at a joint meeting of the Psychopharmacologic Drugs Advisory Committee and the Pediatric Drugs Advisory Committee on September 13–14, 2004.

The risk of suicidality for these drugs was identified in a combined analysis of 24 trials involving 4,400 patients being treated with antidepressants, including the serotonin reuptake inhibitors (SSRIs) and others, in children and adolescents with major depressive disorder (MDD), obsessive compulsive disorder (OCD), or other psychiatric disorders. In this analysis, suicidality was measured using the Children's Aquinciley Suicidality Rating Scale (CAS), and a composite endpoint of suicidal ideation (SI) and suicide attempt (SA) was used. The average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials. Based on these data, FDA has determined that the following points are appropriate for inclusion in the boxed warning:

- Patients and families should be notified of a risk of increased suicidality, especially during the initial few months of a course of drug therapy, or at times of dose changes, increases or decreases.
- Patients and families should be advised to contact their prescriber for additional information about the results of pediatric studies.
- FDA has determined that a Patient Medication Guide (MedGuide), which will be given to patients receiving the drugs to advise them of the risk and precautions that can be taken, is appropriate for these drug products.
- These labeling changes are consistent with the recommendations made to the Agency at a joint meeting of the Psychopharmacologic Drugs Advisory Committee and the Pediatric Drugs Advisory Committee on September 13–14, 2004.

The psychiatric experts: Stephen Stahl, MD

Prescriber's Guide: 2019 Child/Adolescent

- Many prescribers and parents feel caught in a dilemma whether to treat with antidepressants or not:
  - It is important to consider risks of not treating in addition to risks of treating.
  - This is a very emotionally laden decision for prescribers and parents.
- Suicidality is a confusing term that seems to imply symptoms progressing to the act of suicide, however, symptoms of suicidality are not proven to cause more completed suicides, and in controlled trials there were no completed suicides.
- Suicide is often impulsive and not predictable. Substance Use adds to risk.
- In reality there are two patients when treating a child/adolescent: The child/adolescent and the caregiver. Both have different needs for information & explanation.
- Many studies show that the black box warning led to a decline in the diagnosis and treatment of child/adolescent depression with antidepressants and an increase in completed suicides in this age group.
- Stahl cont.
Other studies show that serious suicidal behavior is greatest the month prior to treatment with antidepressants, so referral and initiation needs to be started earlier. The same studies also show that the risk of serious suicidal attempts may be higher during the first week of treatment from antidepressants, so vigilance to this behavior in the interval before the antidepressants have a chance to start working is advised. (explain why there is often 4 weeks till full response) Whenever possible treat with one medication at a time.

Have clear goals and expectations for therapeutic response “I just feel like myself again” “No, the depression isn’t so much anymore”

Fluoxetine (Prozac) and escitalopram (Lexapro) are the only SSRIs with FDA approval for use in adolescents with depression. Ask what relatives have depression, and what worked for them (including medication). 

Talking with patients and parents

- How the choice of antidepressant is made: Explanation: trying on shoes.
- (gene site type tests – new issue 23 & me – self stopping medications after reports)
- Adverse effects SHT in gut. Headaches [worse with Effexor, Paxil and duloxetine – brain zaps]
- Activation – first onset of Mania
- What about Black Box Warning?

Evidence-Based Pharmacotherapy

Evidence-Based RISK assessment - NIMH

- PhQ 9 for adolescents ages 11-17
- if positive
  - AsQ with 6 steps
    - Including
    - Stanley Brown Patient Safety Plan
    - and determining the safest disposition.
Listen for/ ask what is the thought they have when having the suicidal ideation: “I am a burden”, “I can’t take this pain anymore”, “I can’t handle all that is going on now”, “nothing will ever get better”. (hopelessness/ helplessness)

NIMH Toolkit will walk you through the Suicide Risk assessment

Sample Safety Plan

<table>
<thead>
<tr>
<th>Step 1:</th>
<th>Seeing signs (thoughts, images, mood, situation, behavior) that a crisis may be developing</th>
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Step 2: Identifying the strategies - things that can be done to talk the problem off without compromising another person's information techniques, physical settings.

Sample Safety Plan

<table>
<thead>
<tr>
<th>Step 2</th>
<th>People and social settings that provide distraction</th>
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Step 3: People whom I can ask for help

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Include a trusted colleague in the decision re: suicide risk/ disposition

In Mental Health First Aid for Youth, all participants practice Asking, “Are you thinking of killing Yourself?”

High Risk – Just discharged from Inpatient Psychiatric Unit

High Risk – someone close died by suicide
5. Determine disposition
After completing the assessment, choose the appropriate disposition plan. If possible, nurse should follow-up with a check-in phone call (within 48 hours) with all patients who screened positive.

Emergency psychiatric evaluation: Patient is at imminent risk for suicide (current suicidal thoughts). Send to emergency department for extensive mental health evaluation (unless contact with a patient’s current mental health provider is possible and alternative safety plan for imminent risk is established).

Further evaluation of risk is necessary: Review the safety plan and send home with a mental health referral as soon as patient can get an appointment (preferably within 72 hours). Patient might benefit from non-urgent mental health follow-up: Review the safety plan and send home with a mental health referral.

No further intervention is necessary at this time.

For all positive screens, follow up with patient at next appointment.

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

Post your local emergency / crisis numbers directions at all your phones (front office often gets the calls first)

Knowledge your organization’s policy for patients at risk: SI, HI, unable to care for self

Ending the visit
• Instill Hope
• Collaboratively establish a goal - give an assignment – to report back next visit
• Establish a working relationship as coordinator of the team
• Make referrals as indicated:
  • The intensity of the services should match the intensity of the young person’s needs.
  • Provide information: establish crisis plan, provide contact numbers

For all positive screens, follow up with patient at next appointment.

Evidence-based management is so effective!

NIMH TOOLkit

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown
bhs2@columbia.edu or gregbrown@mail.med.upenn.edu

Resources for practice
• GLAD-BC Toolkit  www.glad-pc.org/
https://pediatrics.aappublications.org/content/141/3/e20174082
• NIMH Ask Suicide Questions toolkit
• Patient Safety Plan Template
https://suicidepreventionlifeline.org/wp_/08/Brown_Stanleysafetyplantemplate.pdf
References


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