# Welcome!

- All participants are muted with webcams off
- Please ask us questions and/or provide constructive comments
  - Ask questions in the Q&A
  - Provide comments in the chatbox
- This session is being recorded
- We will send the recording and slides in a follow up email
- If you need a Certificate of Attendance, please email Meghan King at mking@wapc.org

# SUICIDE & SELF-HARM IN ADOLESCENTS:

## A DISCUSSION WITH EMERGENCY SERVICES


Kelly Kerby, MA, LMHC, SUDP
Mental Health Therapist
Seattle Children's

Curtis Elko, PharmD, CSPI
Certified Specialist in Poison Information
Washington Poison Center

Moderated by Alex Sirotzki, MPH & Meghan King, MPH, Public Health Educators, Washington Poison Center

# A nationwide concern

- Suicide is 2nd leading cause of death among adolescents and young adults (ages 10-24)
- Over the last decade, suicide deaths in youth (ages 14-18) have increased over 60%

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# Ideation & attempts in high school students

- **19%** reported they seriously considered suicide
- Ideation significantly higher among:
  - Female students (24%)
  - LGB students (47%)
- **9%** reported having attempted suicide
- Attempts highest among:
  - Female students (11%)
  - LGB students (23%)

*Source: Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019*
*https://www.cdc.gov/mmwr/volumes/69/su/su6901a6.htm*

# Self-poisoning among adolescents

- Intentional self-poisoning is the leading type of suicide attempt for adolescents
  - 3rd leading cause of suicide deaths
- Adolescent suicide attempts by self-poisoning doubled from 2000 to 2018:
  - 40,000 attempts to 80,000 attempts
  - Likely an underrepresentation
- Other exposure reasons in these age groups didn't increase
  - Suggests increase isn't tied to utilization/awareness of PCs

# Washington Poison Center data


- No mandate  = underrepresentation of exposures
- Our data tells many possible stories
  - Changing awareness
  - Changing accessibility
  - Societal changes/large scale traumas
- We don’t how many of these cases are repeats

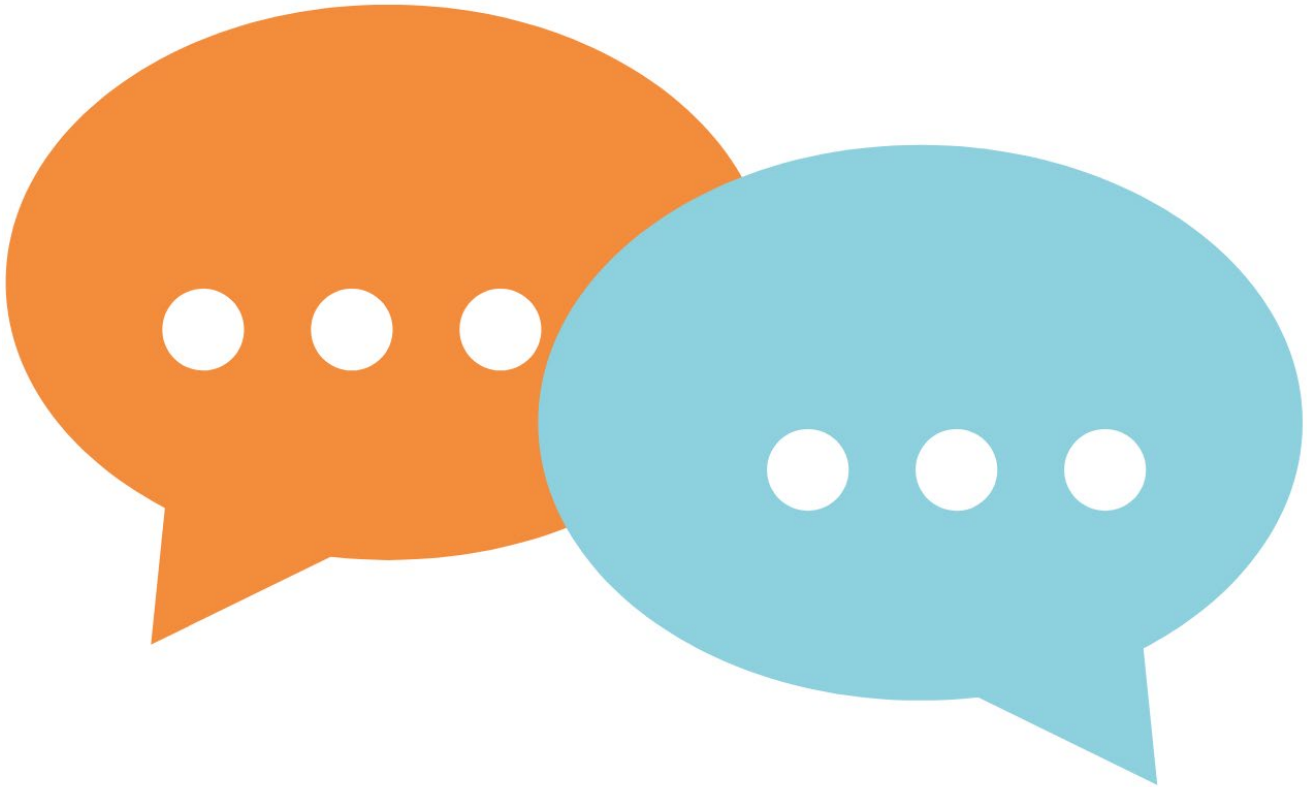
# Introducing our panelists

**Kelly**

*Mental Health Therapist, Co-Occurring Disorders*
Child Psychiatry Department
Seattle Children's Hospital

**Curtis**

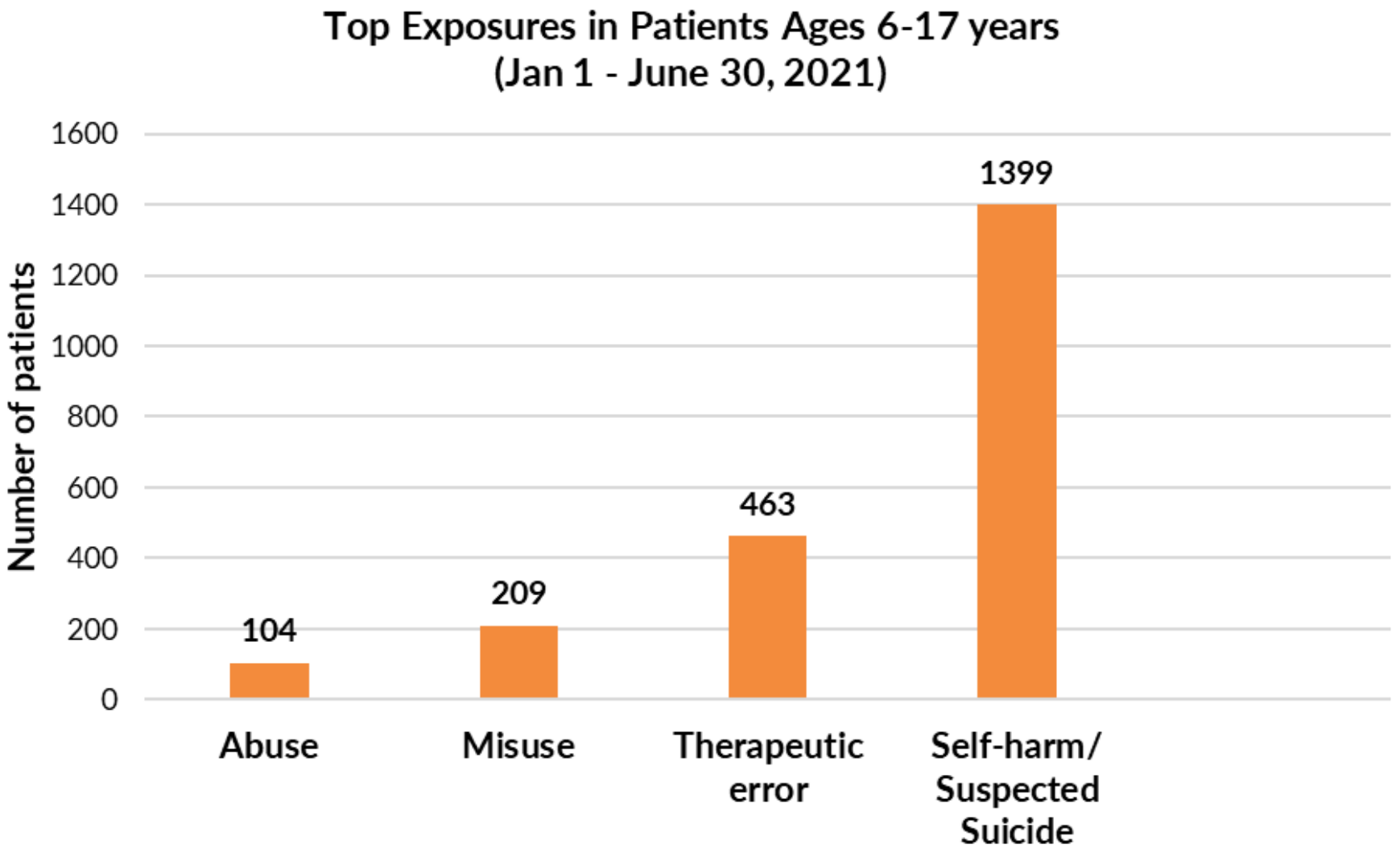
*Certified Specialist in Poison Information*
Washington Poison Center



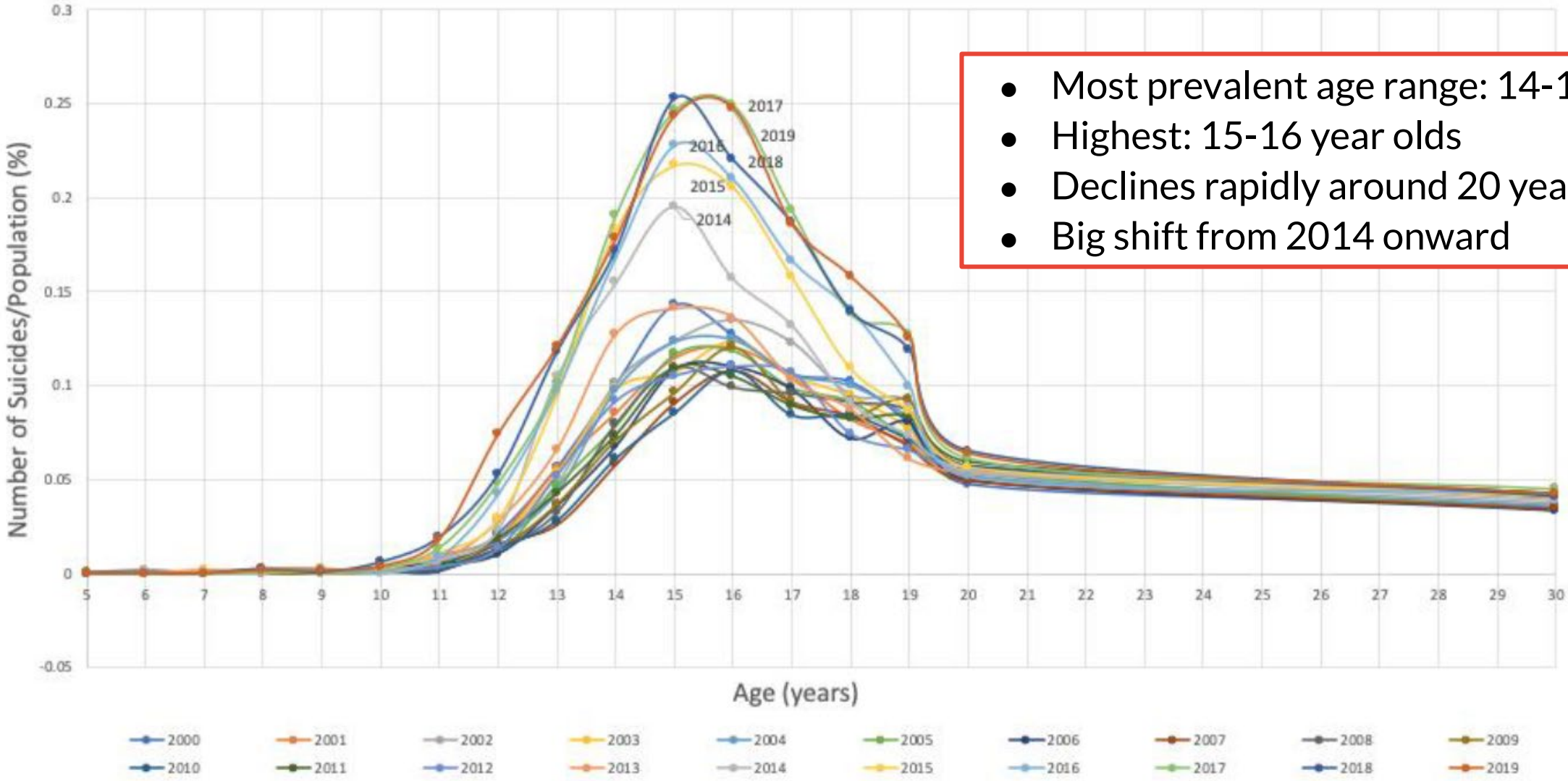
Why is this topic important to talk about?

# Trends in Washington

# Top Adolescent Exposure Categories (2021)



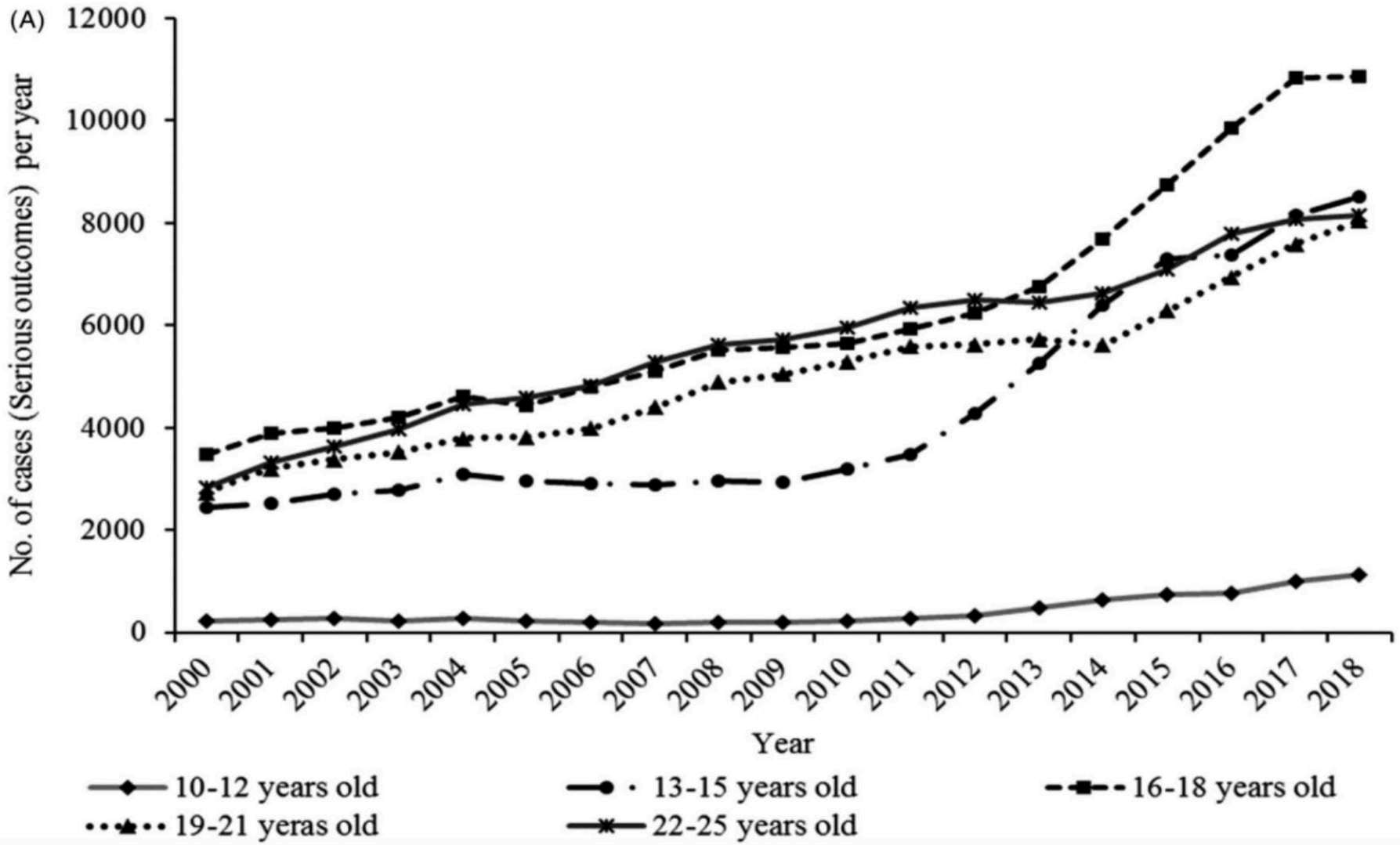
# Washington self-harm/suspected suicide cases from 2000-2019 in patients ages 5-30 years




- Most prevalent age range: 14-18 year olds
- Highest: 15-16 year olds
- Declines rapidly around 20 years old
- Big shift from 2014 onward

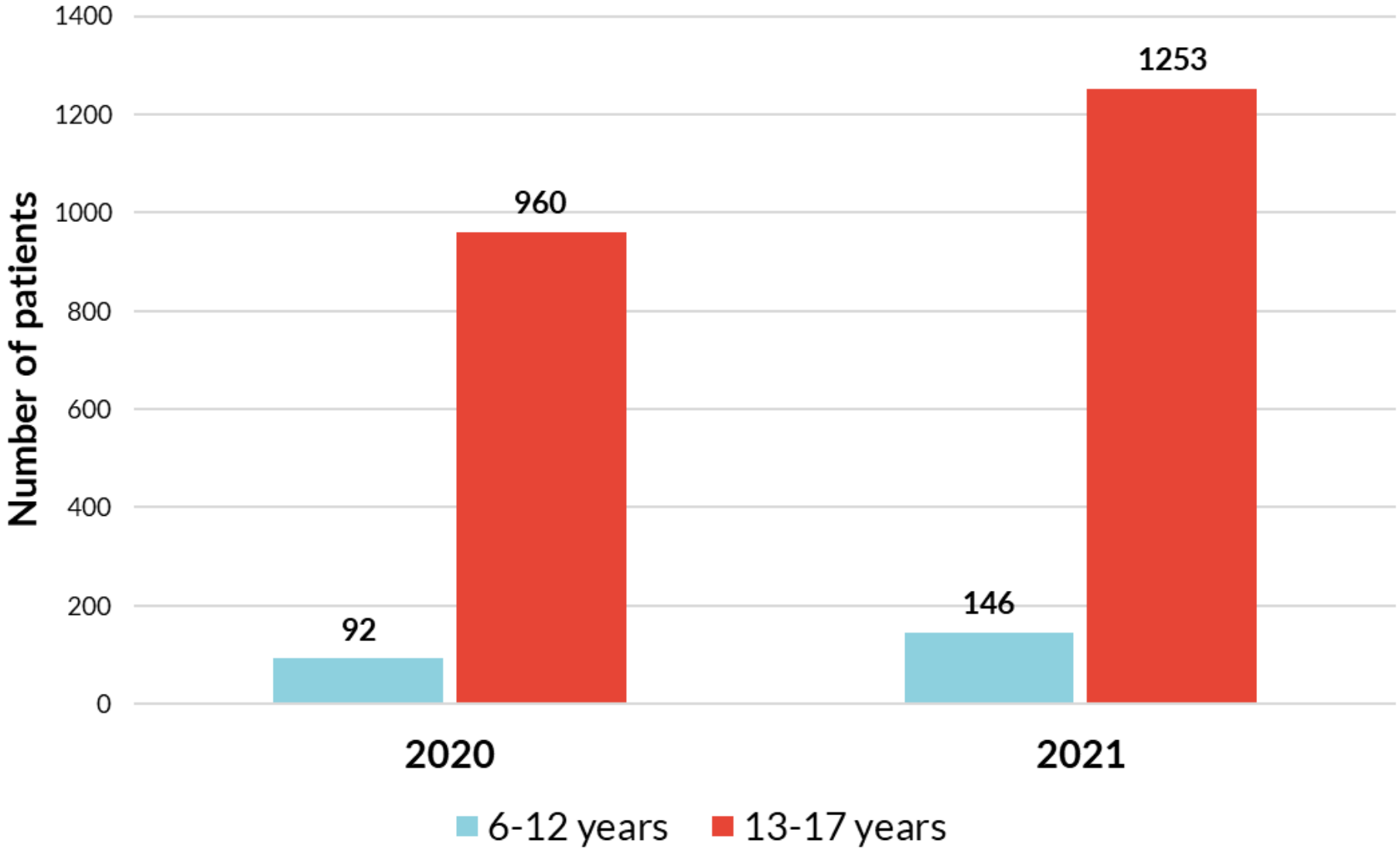
Analysis by Kaleigh Morgan, P4 Creighton University in *Suicidality Trends in Washington State* (2020)

# Self-poisoning suicide attempts in the U.S. among 10-25 year olds (2000-2018) by year

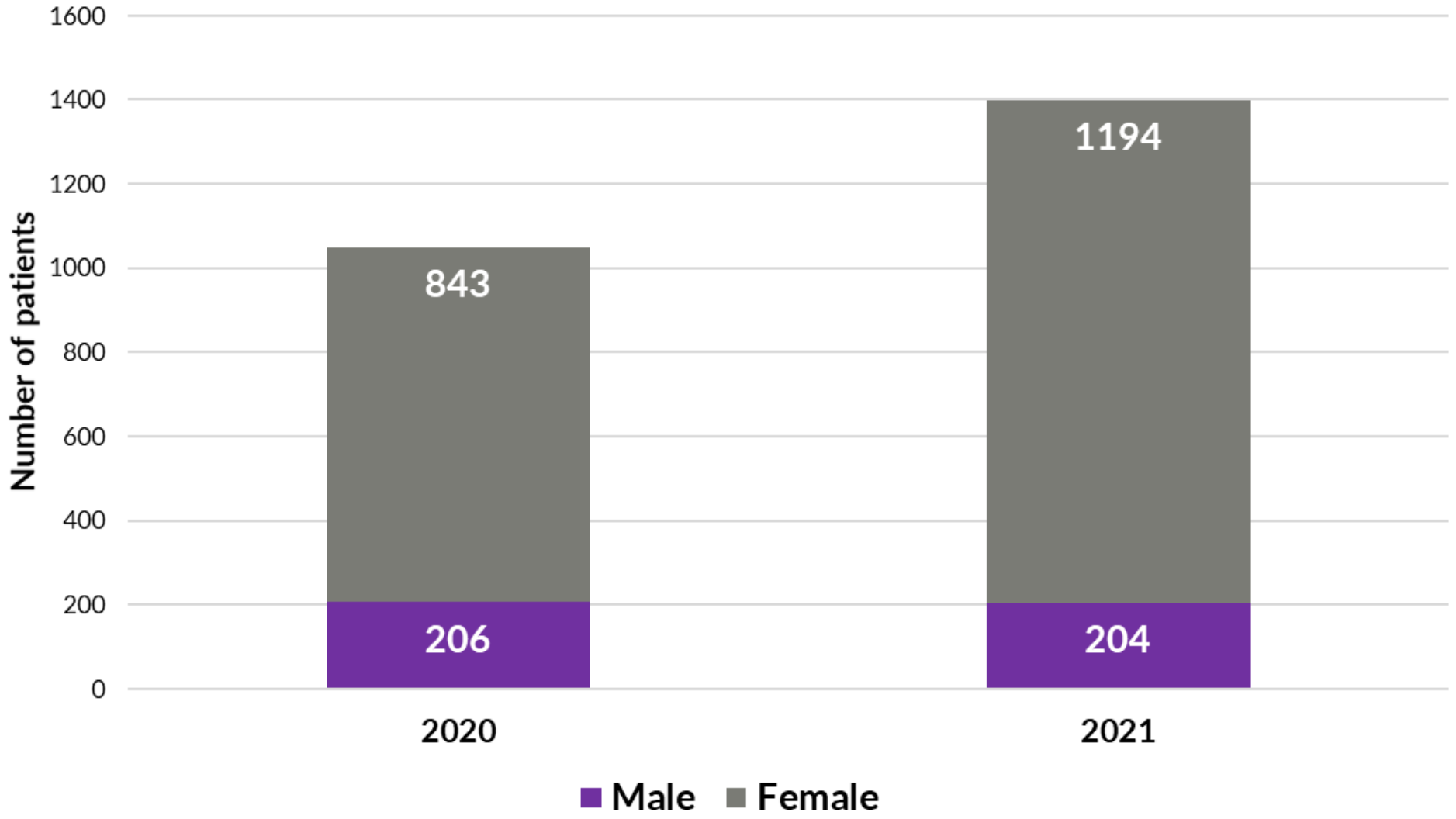



*Data from National Poison Data System*

# Washington self-harm/suspected suicide cases by age and year (Jan 1 – June 30 of 2020 & 2021)

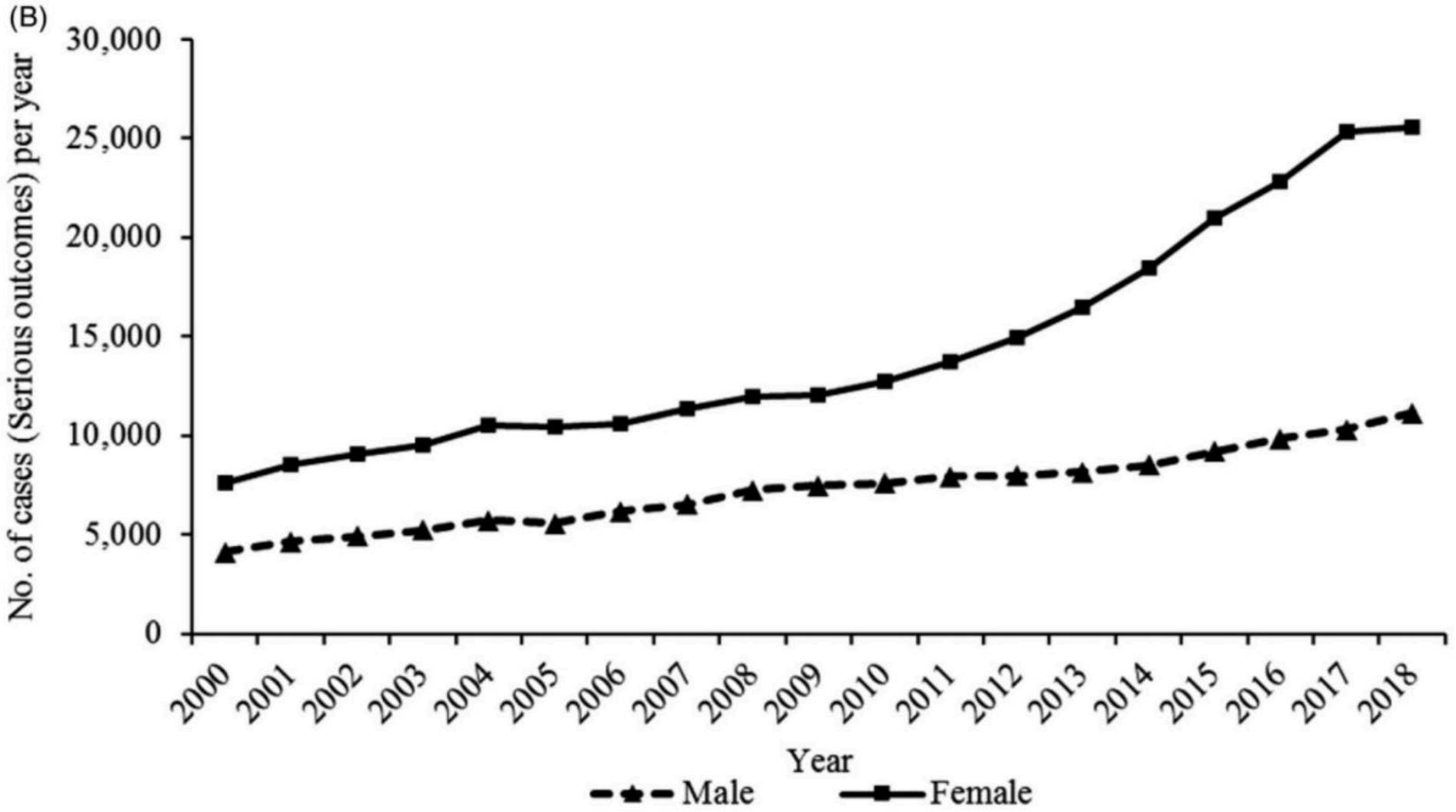


# Washington self-harm/suspected suicide cases in ages 6-17 years by gender and year (Jan 1 – June 30 of 2020 & 2021)

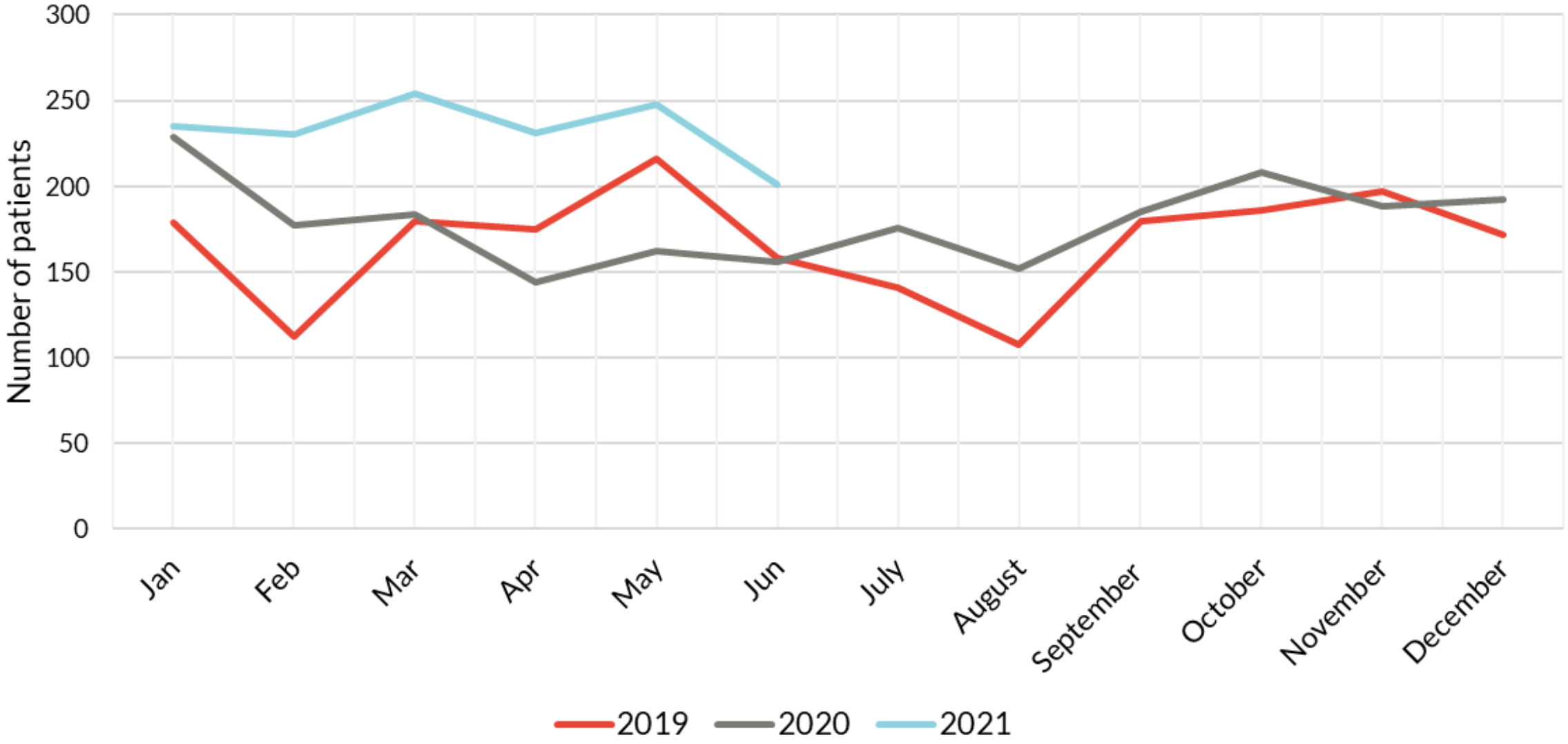


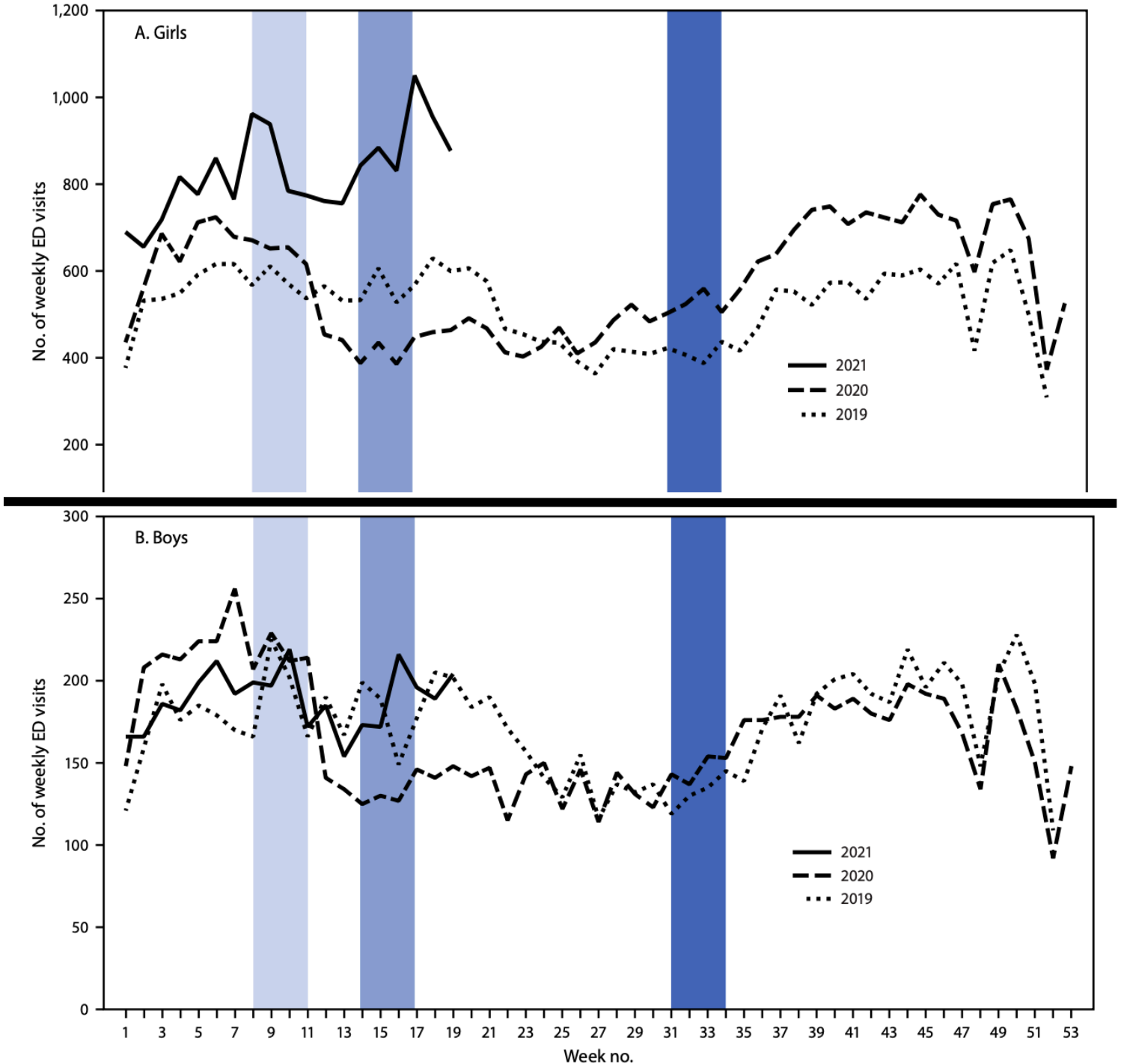
# Self-poisoning suicide attempts in the U.S. among 10-25 year olds (2000-2018) by gender

*Data from National Poison Data System*



# Washington monthly suspected suicide/self-harm cases in ages 6-17 years



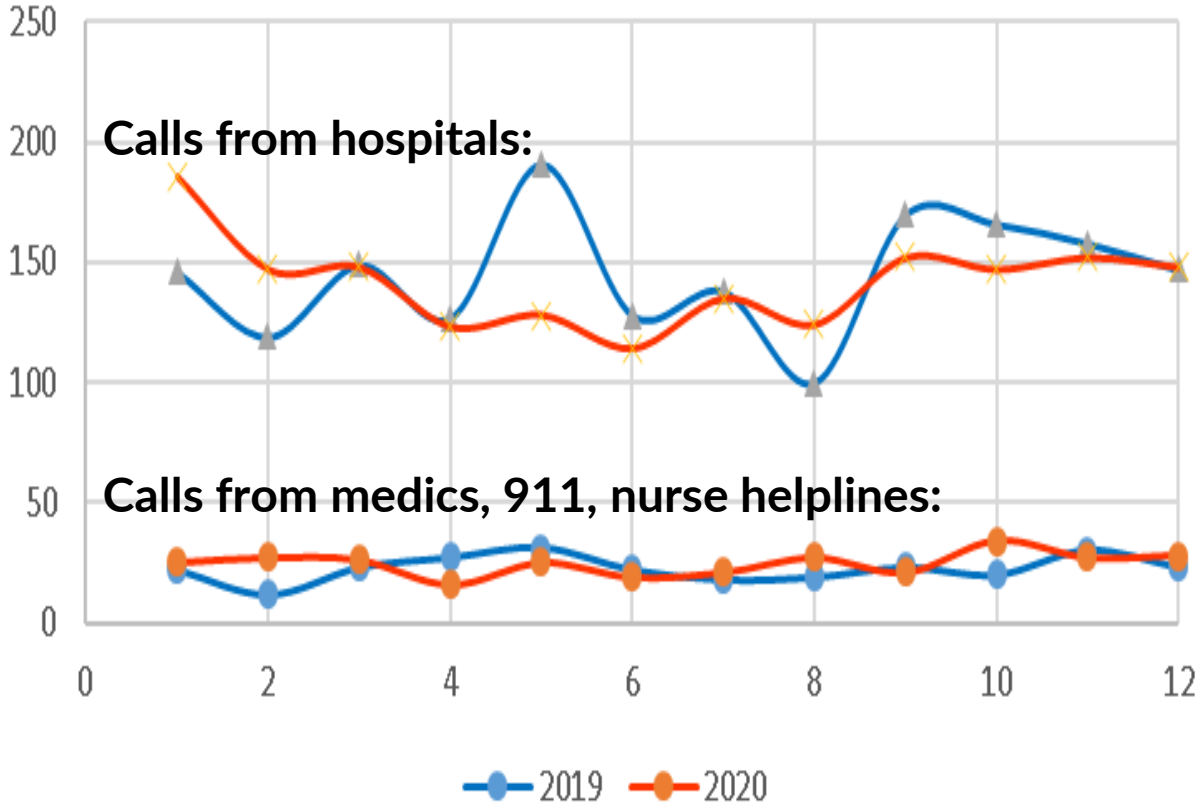



National ED visit data reflects similar trends:

- Drop in visits for suspected suicide attempts during spring 2020 (March – end of April 2020)
- Beginning in May, visits began to increase

*Numbers of weekly emergency department visits for suspected suicide attempts among adolescents aged 12–17 years, by sex — National Syndromic Surveillance Program, United States, January 1, 2019–May 15, 2021*

# Call site for WA suspected suicide cases (ages 6-19 years)



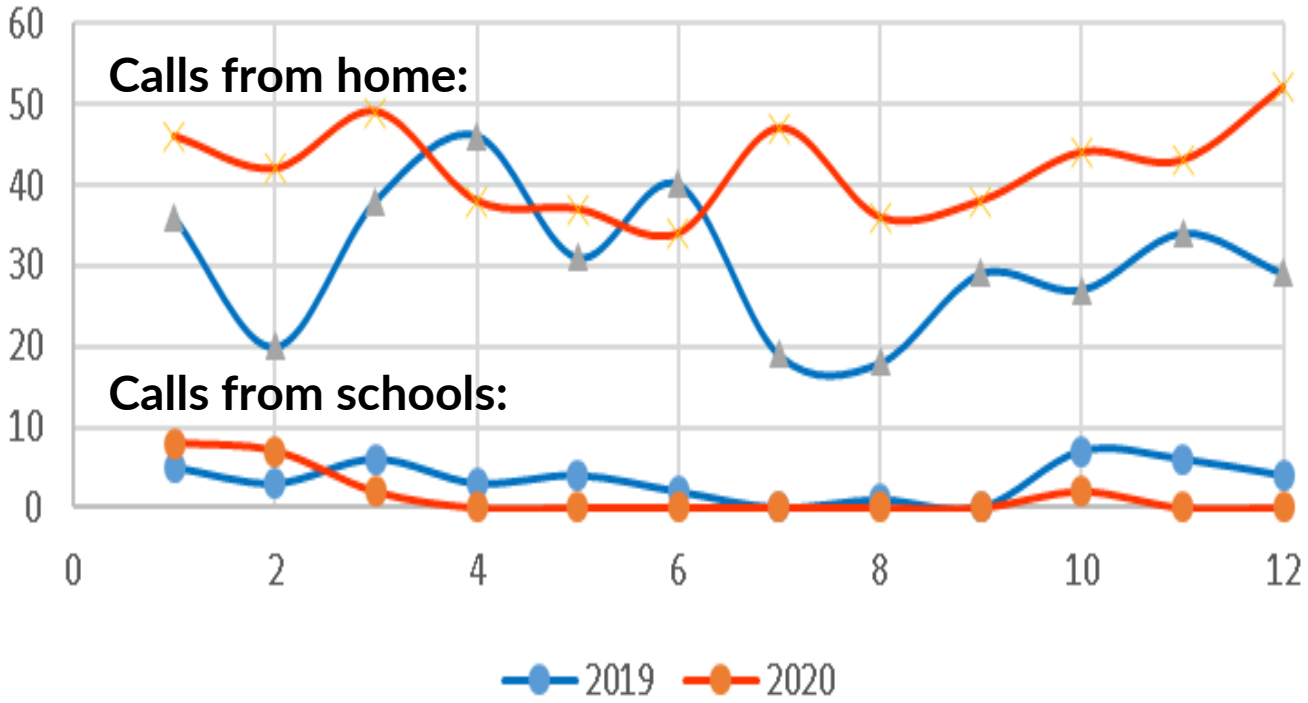



**Table 3.** Top 20 Substance groups reported in Suicide cases in ages 10–25 years old.

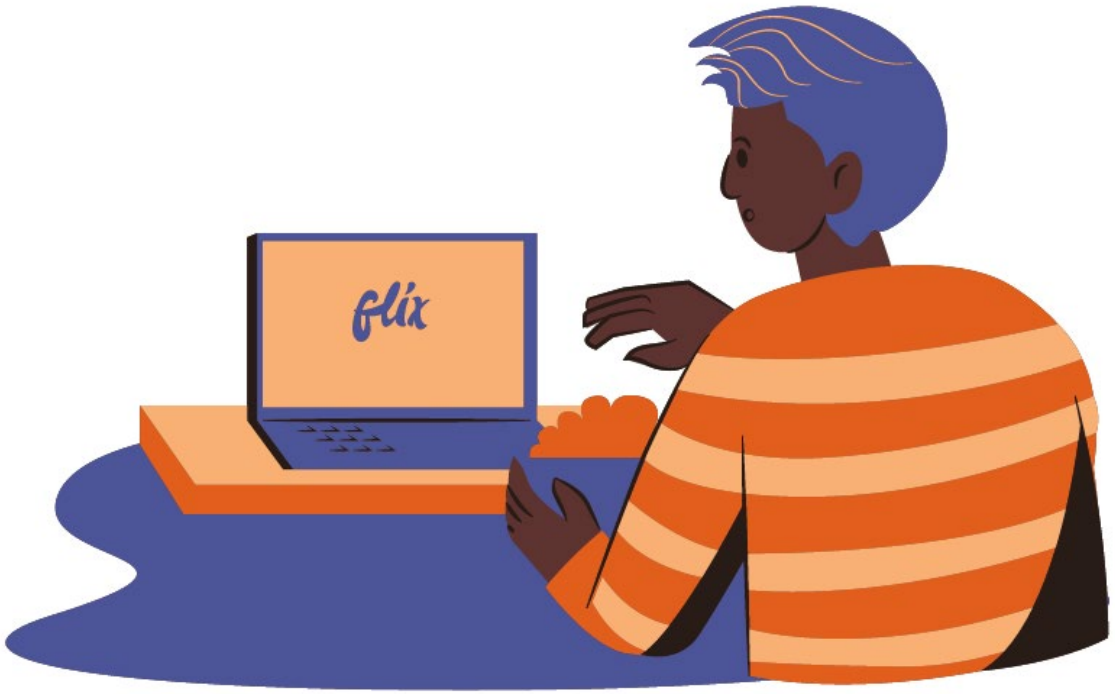
| Substance group | Number of cases (% of total cases) | Number of cases with serious outcome (% of total serious outcome) | Percent of substance group with serious outcome |
|---|---|---|---|
| OTC analgesics | 743,091 (27.5%) | 153,361 (37.3%) | 20.6 |
| Antidepressants | 412,736 (15.5%) | 135,314 (32.9%) | 32.8 |
| Sedatives/hypnotics | 208,938 (7.7%) | 61,420 (15%) | 29.4 |
| Antihistamines | 169,787 (6.3) | 59,859 (14.6%) | 35.3 |
| Antipsychotics | 166,515 (6.2%) | 62,984 (15.3%) | 37.8 |
| Alcohols | 120,420 (4.5%) | 39,759 (9.7%) | 33.0 |
| Anticonvulsants | 116,091 (4.3%) | 40,051 (9.8%) | 34.5 |
| Opioid analgesics | 107,105 (4%) | 31,858 (7.8%) | 29.7 |
| Cold and cough preparations | 106,106 (3.9%) | 30,277 (7.4%) | 28.5 |
| ADHD medications | 67,852 (2.5%) | 33,618 (8.2%) | 49.6 |
| Antimicrobials | 56,591 (2.1%) | 11,579 (2.8%) | 20.5 |
| Muscle relaxants | 55,411 (2.1%) | 20,781 (5.1%) | 37.5 |
| Cleaning substances (household) | 48,087 (1.8%) | 6281 (1.5%) | 13.1 |
| Cardiovascular medications | 46,915 (1.7%) | 19,269 (4.7%) | 41.1 |
| Stimulants and street drugs | 37,639 (1.4%) | 17,149 (4.2%) | 45.6 |

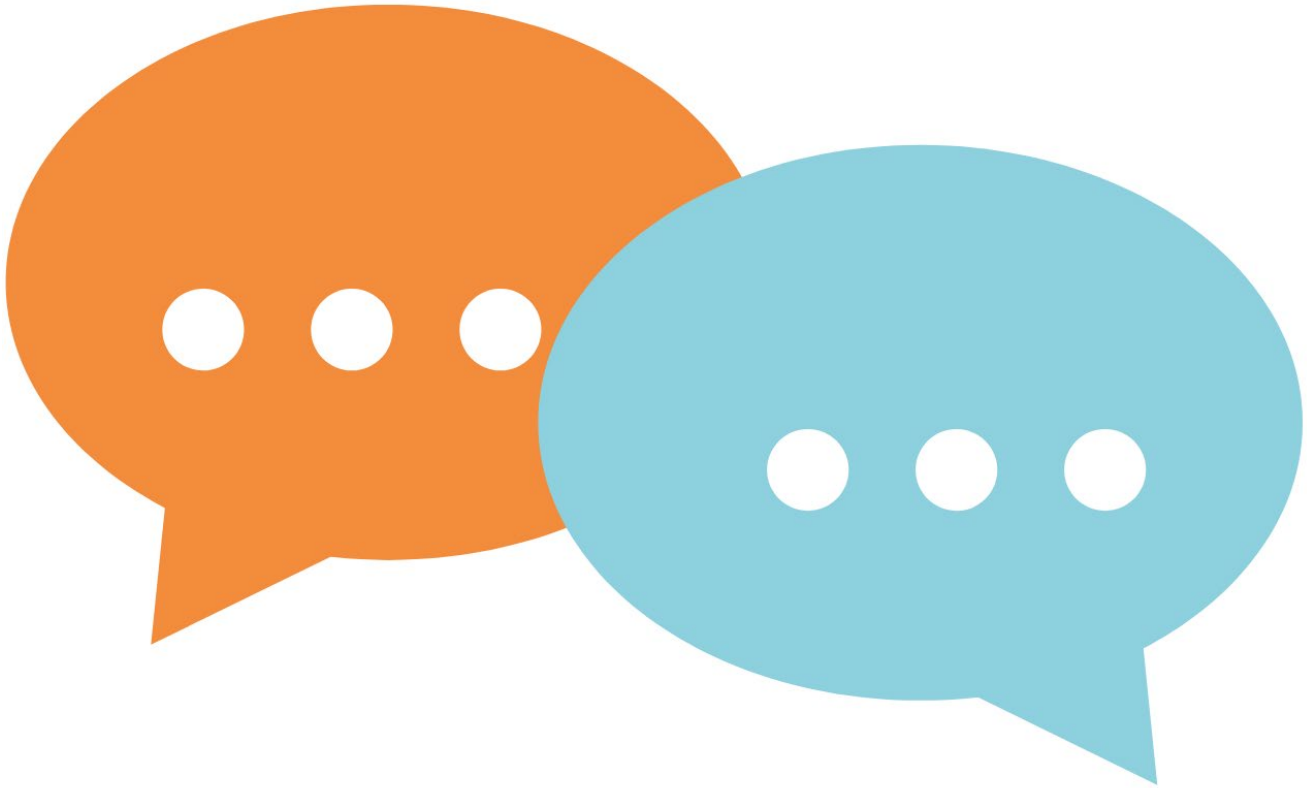
*Data from National Poison Data System*

# Behind the numbers

# Why is this happening?

- Increased use of social media and technology?
- Opioid crisis?
- Life trauma?
- “School Problems”
- Exposure to other suicide deaths? (suicide contagion)

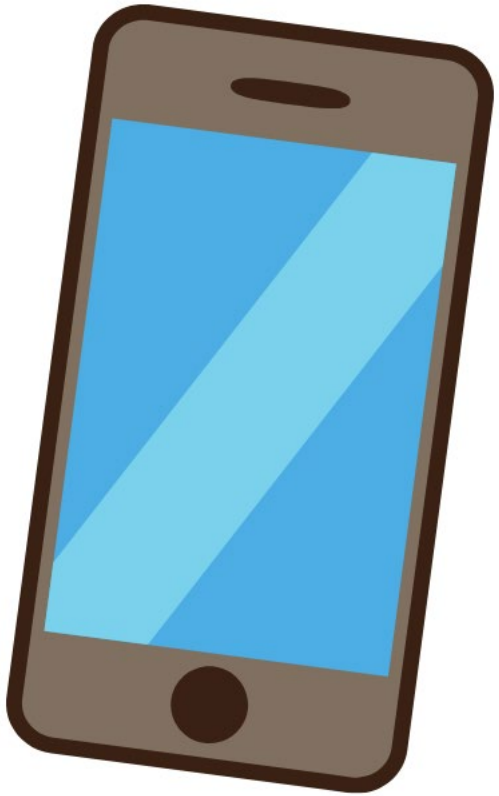




What is your main goal when working on an adolescent intentional case?

# Non-EMS/Non-HCF Situations

- Call is with the patient themselves
  - Attempt to shift the call to the parent or other guardian
- Call is from someone else
  - Parent/Guardian
  - Other family member
- Friend
- School → contact with parent/guardian and/or 911
  - Administrator, teacher
  - School Nurse (or Health Aid)



# EMS

- Tend to be brief, just the facts
- Do they need to be transported?
- Difficult to address when supposedly nontoxic amount/substance

# In the Emergency Room (post waiting area)

- **Step One:** The patient is first seen by Emergency Room medical staff.

# At the hospital: Poison Center involvement

- Provide medical treatment recommendations for patient welfare
- Provide monitoring parameters for toxicity and effect of treatment
- Provide an estimate of the likelihood for further harm or the need for further medical treatment and monitoring
- Medical clearance of patient → typically is the end of poison center role

# In the Emergency Room

- **Step Two:** The medical provider will put in an order for a *Mental Health Evaluation* and will verbally hand off to the Mental Health Team.
- **Step Three:** The next available mental health evaluator will review the chart and any paperwork filled out by the patient or family.

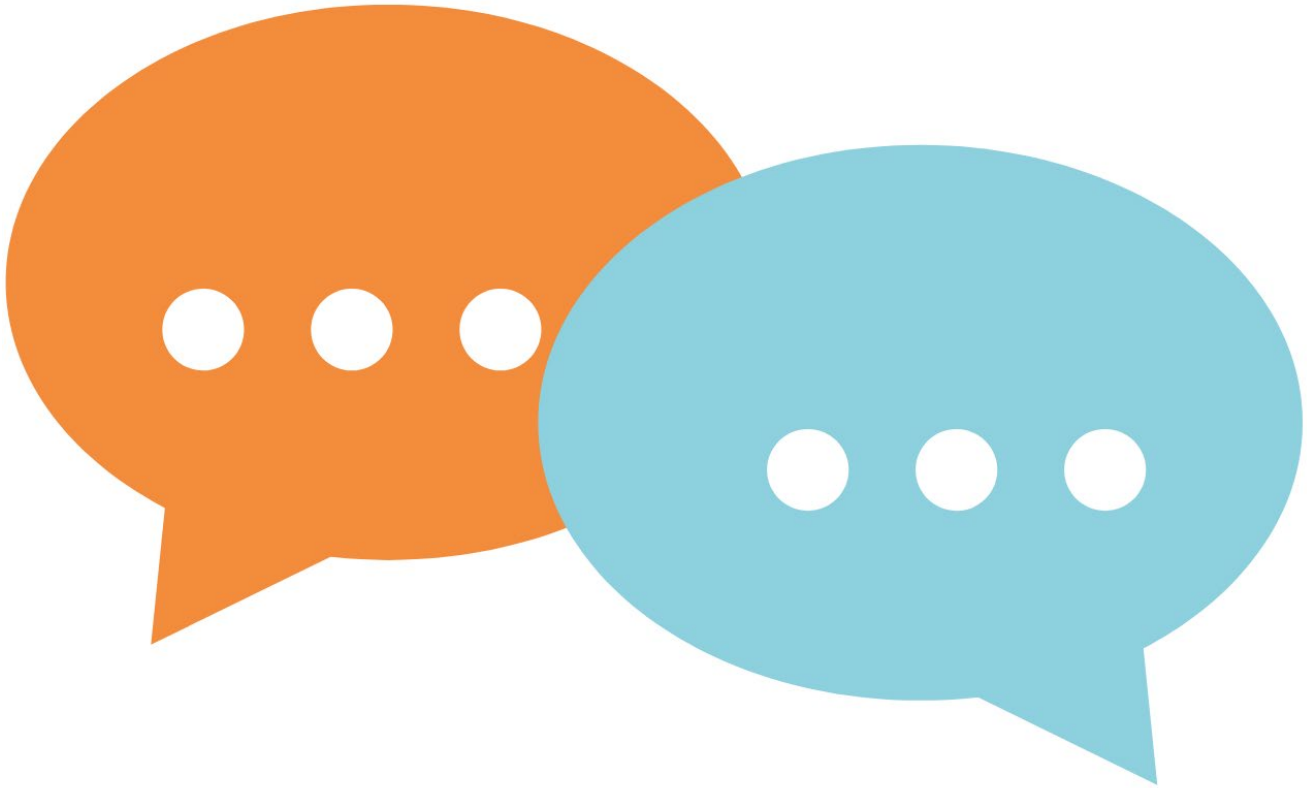
*The evaluator may attempt to contact any outside providers working with the patient (therapist, wise team, treatment agency, psychiatrist).*

# In the Emergency Room

- **Step Four:** Interview the patient/caregiver.
- **Step Five:** Discuss the case with the Mental Health Team to determine if they need admission to the hospital or if they can crisis plan and discharge home with resources.

# Criteria for admission to acute psychiatric unit

- **Suicidal**
  - The crisis has not passed
  - Currently a danger to themselves
  - Verbalize or believe they will be a danger if they return home or have an opportunity to harm themselves
- **Homicidal**
- **Grave disability/loss of functioning**



How do your services fit in with mental and behavioral healthcare for youth?

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# Poison Center

## We CAN…

- Provide medical advice
  - What to do
  - How long to monitor
  - When are they medically clear
- Send in to ED for first touch with mental health services

## We CANNOT…

- Require anyone to do anything
- Assist with a mental health crisis (i.e., we are not a crisis line)
- Provide referrals to services beyond the ED/HCF
- Provide mental health assessments
  - Find out WHY the attempt was made

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# Emergency Room

## We CAN…

- Admit to an acute psychiatric facility
- Make a referral to CCORS
- Make a referral to the Crisis Care Clinic at Children's - but Patient's have to qualify, and the clinic has to have an open appointment
- Create a Crisis Prevention Plan and provide a lockbox

## We CANNOT…

- Rx. psychiatric medication
- Give a referral to Seattle Children's Outpatient Clinics
- Refer to a Psychiatrist
- Provide an appointment with an Outpatient Therapist, Psychiatrist, or Partial Hospitalization Program
- Provide respite (officially)

# Children's Crisis Outreach Response System (CCORS)

- Who is eligible?
  - Children and youth not enrolled in the King County Mental Health Plan (KCMHP) who are:
    - up to age 18 and
    - who live in King County
    - their identified caregivers and families
- Mobile crisis outreach
- Non-emergent outreach appointments
- Crisis stabilization services
  - Based on the family's needs, in-home support is available for up to 8 weeks following the initial acute crisis
- Access to CCORS is available through the Crisis Clinic at 206-461-3222 or 1-866-4CRISIS

# Emergency Room

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# Partial Hospitalization Programs

- Thira (females only), Bellevue:
  (Offers PHP and IOP)
  10 hours a day, 5 days a week, 2-6 weeks
  425-454-1199

- Fairfax adolescent PHP, Kirkland:
  (PHP virtual only)
  3-week rotating schedule
  425-284-8300

- Rogers Behavioral Health
  1215 114th Avenue SE
  Bellevue, Washington 98004
  888-964-1358

- Imagine Northpoint the Evergreen Bellevue
  13037 NE Bel-Red Rd Suite 102A
  Bellevue, WA 98005
  877-584-6395

- Pathlight Mood & Anxiety Center (formerly named Insight Behavioral Health)
  (Offers PHP and IOP. IOP is virtual only)
  Downtown Seattle
  866-742-9127

# Partnership Access Line (PAL)

- The Partnership Access Line (PAL) supports primary care providers (doctors, nurse practitioners and physician assistants) with questions about mental health care such as diagnostic clarification, medication adjustment or treatment planning. Child and adolescent psychiatrists are available to consult during business hours.

- Call 866-599-7257 Monday through Friday, 8 a.m. to 5 p.m., Pacific time, to be directly connected to a PAL child and adolescent psychiatrist.

# Washington's Mental Health Referral Service for Children and Teens

- Washington's Mental Health Referral Service for Children and Teens connects patients and families with evidence-supported outpatient mental health services in their community. This free, telephone-based referral service is funded by Washington Healthcare Authority and operated by Seattle Children's.

- The Mental Health Referral Service will provide thorough mental health referrals for children and teens 17 and younger from across Washington.

- Call 833-303-5437, Monday through Friday from 8 a.m. to 5 p.m. PST, to connect with a referral specialist.

* Insurance companies sometimes have case managers to help find resources as well.

# Less Restrictive Options

- Staying with a trusted adult relative or friend during crisis
- Partial Hospitalization Program or Intensive Outpatient
- Increasing supervision and safety sweeping
- Focusing on what is most important (not the same as decreasing expectations, more like meeting child where they are at while still trying to maintain functioning)
- Increasing structure, routine, activities of daily living (ADLs)
- Shelter or CCORS respite bed (typically 48 hours)
- Call your PCP for an emergency appointment just like if a child was physically ill

# Questions?

# Final questions

- What do you wish people knew about adolescent exposures?
- What is one action step you'd like to see people take?
- What gives you hope with this kind of work?

# Sources


- Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019 https://www.cdc.gov/mmwr/volumes/69/su/su6901a6.htm
- Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015 https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a1.htm
- Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021 https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm
- Henry A. Spiller, John P. Ackerman, Gary A. Smith, Sandhya Kistamgari, Alexandra R. Funk, Michael R. McDermott & Marcel J. Casavant (2020) Suicide attempts by self-poisoning in the United States among 10–25 year olds from 2000 to 2018: substances used, temporal changes and demographics, Clinical Toxicology, 58:7, 676-687, DOI: 10.1080/15563650.2019.1665182

# Overdose Prevention, Harm Reduction, & Treatment

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please email Meghan King at mking@wapc.org

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