Suicide Evaluation in the Pediatric Emergency Setting

Adrian Jacques H. Ambrose, MD*, Laura M. Prager, MD

KEYWORDS

• Pediatric suicide • Adolescent suicide • Screening tools • Suicide evaluation
• Emergency department setting

KEY POINTS

- Suicide is 1 of the top 3 leading causes of death in the pediatric population and a serious public health concern.
- There are evidence-based screening tools for suicide in the pediatric population; however, predicting suicide risks can be a difficult task.
- The emergency department is an essential source of mental health care for children and adolescents.
- The emergency department may serve as an important opportunity for suicide screening and subsequent targeted interventions and resource management.
- More research is needed in emergency department-based screening algorithms and evidence-driven interventions in the pediatric population.

INTRODUCTION

Suicide has consistently been 1 of the top 3 leading causes of death for youth between 10 and 24 year old since 2008. In young adults between 15 and 24 years old, suicide was the second leading cause of death from 2011 to 2015.[1] In addition, suicide rates have been increasing in this age group in both rural and urban settings.[2] According to the national Youth Risk Behavior Survey, high school students have been reporting significantly higher percentages of high risk suicidal behaviors since 2009, with nearly 1 in 4 female high school students reporting in 2015 that they "seriously considered attempting suicide" within the past year.[3]

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Department of Psychiatry, Division of Child and Adolescent Psychiatry, Harvard Medical School, Massachusetts General Hospital, Suite 6A, 55 Fruit Street, Boston, MA 02114, USA
* Corresponding author.
E-mail address: Adrian.Ambrose@mgh.harvard.edu

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Abbreviations

ED Emergency department
EM Emergency medicine

The emergency department (ED) often serves as a crucial site of care—to identify risk factors, provide interventions, and facilitate further treatment—for individuals with a high risk of self-harm. In adults aged 18 and older, the rate of ED visits relating to suicidal ideation has been steadily increasing since 2006; in 2013, approximately 1% of all ED visits were due to suicidal ideation.[4] Compared with other age groups presenting to the ED with suicidal ideation, youths were mostly likely to present concurrently with self-inflicted injuries (7.6% for males; 11.1% for females).[4] However, suicidal ideation or other mental health issues may not be the chief complaint and may not be disclosed during an ED visit. One study estimated that only 3% of patients who later reported suicidal ideation specifically indicated mental health chief complaints on their initial ED visit.[5] Parents or guardians are often not aware of their adolescent's mental health needs and high-risk behaviors, including nonlethal self-injuries and suicidal attempts and, therefore, may also fail to share this information with providers.[6–8]

Although most mental health problems diagnosed in adulthood begin in adolescence, a significant portion of these youths do not receive mental health care.[9] In 3 large national surveys, only one-fifth of youths aged 6 to 17 years old who were screened to need mental health services actually received mental health care.[10,11] However, because more than one-third of individuals 16 years and older who completed suicide presented to the ED in the preceding year, EDs seem like an ideal setting to screen young people for suicide risk.[12] A recent study demonstrated that screening pediatric patients in ED setting was acceptable to parents and did not significantly change the duration of stay in the ED.[13] Therefore, screening all pediatric patients, regardless of presenting complaints, for suicide risk in the ED setting may lead to better identification of and more timely intervention for this "hidden" high-risk cohort of patients.

SUICIDE SCREENING IN THE EMERGENCY DEPARTMENT

Given that the ED can be the primary source of health care for more than a million adolescents nationwide, emergency medicine (EM) staff, especially pediatricians who are likely to be the first point of contact, should consider screening for suicide risk during their initial evaluation.[14] Nevertheless, 1 study found that EM clinicians rarely screen for mental illness and, when they do, they base their questions on their own instincts rather than on evidence-based methods. In this study, respondents indicated that the greatest obstacle to mental health screening was time, followed by a lack of an appropriate screening tool.[15] Furthermore, the concept of suicide risk screening for adolescent patients who present to EDs with any complaints (ie, universal screening) remains under debate. Although the Joint Commission on Accreditation of Healthcare Organizations guidelines mandate suicide screening for patients in psychiatric EDs, and for all patients who present with a psychiatric chief complaint (ie, targeted screening) surprisingly, no such mandate exists for EM staff to screen adolescents who present with medical complaints alone.[16] In fact, the US Preventive Services Task Force published guidelines emphasizing that the evidence base is not sufficient either to justify or to support the need for universal suicide screening in this