21 Psychiatric Emergencies in Child and Adolescent Psychiatry

Essential Concepts

- The top priority is to minimize the acute risk of the child or adolescent causing harm to himself or others.
- Ask the child or adolescent directly about suicidal and homicidal thoughts and intent.
- The youth may minimize risk of dangerousness. Be sure to get history from multiple sources in your assessment.
- Is there concurrent substance use?
- Is there an acute psychiatric disorder that requires treatment, such as psychotic or manic symptoms?

CLINICAL DESCRIPTION

The suffering of children and youth in the throes of a psychiatric emergency is palpable. They frequently feel desperate and hopeless. Suicidal ideation, suicide attempt, or seriously out of control behavior are the most common child and adolescent psychiatric emergencies and will be the focus of the chapter (Table 21.1).

In assessing children and youth in crisis, you are faced with the difficult decision regarding the management of these patients, such as when to recommend (or require) hospitalization, how to facilitate acute outpatient treatment, dealing with recurrent suicide attempts, and ameliorating the social chaos that often surrounds these youth. These decisions are taxing even for experienced physicians. Assessing and providing stabilization for youth in psychiatric crisis are critical skills for all child and adolescent psychiatrists (Table 21.2).

TABLE 21.1. Types of Psychiatric Emergencies for Children and Adolescents

Suicidal ideation, intent, gesture, or attempt
Serious aggression toward others or threats of violence (including firesetting or sexual perpetration)
Psychosis or mania
Acute anxiety or panic
Conversion symptoms
Anorexia nervosa or bulimia nervosa
Running away or high-risk behaviors
Delirium or acute mental status change
Substance abuse
Victim of physical or sexual assault or abuse
Acute school refusal

TABLE 21.2. Essential Emergency Child and Adolescent Psychiatric Assessment

1. Rule out an acute medical issue (such as overdose, intoxication, head trauma, or other).
2. Demographics—age, residence, caretakers.
3. Presenting complaint—details of the events that precipitated the crisis assessment.
4. History of present illness—symptoms have presented for how long? How severe? Acute stressors. Get information from multiple sources (youth, parent/guardian, teachers or others, as appropriate).
5. Psychiatric history—prior treatment, taking medications, psychiatric symptoms (depression, suicide attempts, psychosis, aggression, substance abuse).
6. Risk assessment—suicidal thoughts, prior attempts, intent, what means, physical or sexual abuse, recent stressors, access to means (firearms, medication, etc.), homicidal thoughts, revenge fantasies, level of impulse control.
7. Developmental history—learning issues, friends, regression in functioning.
8. Family situation—living situation, communication in the family, abuse, neglect, or substance use in the family, family support, supervision, firearms or other dangers in the home.
9. Family genetic history of psychiatric illness, suicide, incarceration, learning issues.
10. Medical history—current or prior acute or chronic illness, medication.

(Continued)

TABLE 21.2. Essential Emergency Child and Adolescent Psychiatric Assessment (*continued*)

11. Mental status exam—with focus on thought process, psychosis, organicity, hopelessness, insight and judgment, motivation for help, ability to form alliance, acute psychiatric status (review of psychiatric symptoms, including neurovegetative symptoms, psychosis, mania, obsessive thoughts, etc.), suicidal thoughts, and thoughts of revenge.

KEY POINT

Youth may say that they are "fine" and minimize the risk of their violent or suicidal behavior once they are calm. You must check with others to determine how serious the behavior was. Even if the youth has calmed, if the behavior put him or her in serious danger, acute treatment in the hospital or other intensive treatment setting may be required.

TIP

An emergency evaluation must be brief and focused. Assess immediately for the acute potential for the child hurting himself or others. Rule out acute intoxication, overdose, or medical illness with a change in mental status (such as delirium or psychosis). Ensure that the patient is safe and contained as you get the remainder of the information required.

KEY POINT

Risk factors are cumulative for predicting suicide. The severity of stressors is also important in predicting suicidal behavior, especially severe acute stressors.

Epidemiology of Suicidality

In the United States, approximately 2 million teenagers attempt suicide each year, while 2,000 die of suicide. Suicide is the 3rd leading cause of death for those aged 14 to 18, and the 12th leading cause of death among children aged 13 and younger. Firearms are the most common method of suicide, followed by hanging, jumping, carbon monoxide poisoning, and self-poisoning. Firearms are clearly the most lethal method of suicide attempt, being 200 times more likely than drug overdose to end in death. The use of alcohol combined with access to firearms has emerged as the major factor differentiating completed suicides from attempts.

The Centers for Disease Control and Prevention found that 19% of high school students had "seriously considered suicides," with nearly 15% having made a specific plan, 9% having made an attempt, and 2.6% having made a medically serious attempt. Thus, suicidality is of epidemic proportions. Females tend to contemplate suicide or attempt suicide more often, whereas males tend to complete suicide more often, using more lethal means. In males, a history of suicidal behavior increases the risk of completed suicide. In females, the association is present, but not as strong. There was a marked increase in suicide rates in the several decades prior to 1990. The good news is that the numbers of completed suicides in teens has declined over the past decade.

Etiology and Risk Factors

Although the exact etiology of suicide is unknown, multiple risk factors have been identified, as summarized in Table 21.3. Most, although not all, suicidal youth have a major psychiatric disorder—usually a mood disorder, although substance abuse, conduct disorder, and psychosis increase risk as well. Youth who are struggling with issues of sexual orientation may be highly stressed and at increased risk of self-harm.

CLINICAL VIGNETTE

This is an excerpt from an interview of a 16-year-old young woman whom a resident is evaluating in outpatient crisis clinic for suicidality. She told a counselor at school that she wanted to kill herself, and the resident was asked to "clear her" before she was allowed to return to school. Her parents and teachers report that she has seemed depressed and withdrawn over the past month. She broke up with her boyfriend of 6 months the week before. The family is appropriately concerned about her and has been trying to get her in to see a child and adolescent psychiatrist, but the appointment is still another 3 weeks away. When you meet the girl, she appears irritable and dysphoric.

Interviewer: *You told your school counselor that you were feeling suicidal. Tell me about that.*
Youth: *What's the use, anyway?*
Interviewer: *How long have you been feeling this bad?*
Youth: *A very long time. But it got worse when I found out my boyfriend was cheating on me. It seems that I can't trust anyone.*
Interviewer: *You must have been very hurt.*
Youth: *Yeah, I guess you could say that.*
Interviewer: *So hurt you wanted to die?*
Youth: *It's not just that. It seems like there is no hope. My grades are slipping. I have disappointed my parents. My best friend moved away last year. I just can't take it anymore.*

TABLE 21.3. Essential Risk Factors for Suicidality

1. History of suicidality (past attempts predict future suicidality)
2. Lethality of suicide attempt or intent
3. Psychiatric disorders that fuel suicidality
   - Bipolar disorder
   - Depression
   - Substance abuse
   - Psychosis
   - Conduct disorder, especially impulsive/aggressive
4. Personality traits
   - Impulsivity
   - Aggression
   - Perfectionism/Inflexibility
   - Hopelessness
5. Family factors
   - Parental mood disorders, suicidality, substance abuse
   - Family conflict and poor communication
   - Poor supervision and poor support
6. Acute stressors
   - Loss—romantic, parents, peers, prestige
   - Disciplinary crisis
   - Legal involvement/incarceration
   - School failure
7. Access to means
   - Firearms
   - Other highly lethal means
   - Inadequate supervision

From there, the resident asks more specific questions about suicidal plans, intent, and psychiatric symptoms (neurovegetative symptoms of depression, substance use, psychotic symptoms, etc.). Concern about the level of hopelessness precipitated her admission to an adolescent psychiatric inpatient unit for acute treatment and stabilization.

TIP

A word about confidentiality: Suicidality and homicidality cannot be kept confidential. If you have reason to believe a child or youth is in danger, you must ensure treatment. Rarely, but occasionally, this may mean involuntary commitment for treatment. A need to notify may be required if the youth is homicidal.

Treatment

Treatment of children and adolescents with acute psychiatric emergencies is multimodal, with the first requirement of ensuring safety. Tables 21.4 and 21.5 provide a treatment decision tree and appropriate treatment interventions for suicidal youth.

TABLE 21.4. Treatment Decision Tree for Suicidal Youth

1. Suicide attempt
   - Emergency room and crisis stabilization
   - Hospitalize on psychiatric unit
2. Suicidal ideation with plan or suicidal ideation with highly lethal thoughts
   - Urgent outpatient psychiatric assessment if interim safety can be ensured
   - Parents must agree to supervise adequately and to secure lethal means of self-harm in home while awaiting urgent outpatient assessment
   - Emergency room evaluation if interim safety cannot be ensured
3. Suicidal ideation without a plan
   - Routine psychiatric assessment if within reasonable time, if parental supervision is adequate, and if removal of means of self-harm ensured
   - Urgent psychiatric assessment if due to exacerbated psychiatric disorder, or if routine appointment not readily available, or if parent cannot adequately supervise or secure means of self-harm

TABLE 21.5. Treatment Essentials for Suicidal Youth

1. Identification and development of a continuum of interventions, including use of emergency room, crisis services, inpatient unit, outpatient services, "wrap around" services, and respite care
2. Development of a treatment team that includes various providers: primary care provider, primary mental health clinician and/or child and adolescent psychiatrist, school counselor, and other clinicians as needed and available
3. Active diagnosis and aggressive treatment of psychiatric illness
4. Individual therapies emphasizing the development of problem-solving skills and impulse control, cognitive-behavioral therapies, and dialectic behavioral therapy, as appropriate
5. Family interventions, emphasizing the development of nonviolent conflict resolution and enhanced communication skills
6. "Harm reduction" through modifications of stressful life obligations such as school schedule
7. Development of family and community resources; emphasize community supports for youth with psychiatrically compromised parents or from unsupportive homes

KEY POINT

Suicide prevention strategies include those designed to increase recognition of youth at risk and facilitate referral to mental health services, as well as those designed to address risk factors. Education, screening, peer support programs, school and community gatekeeper training, crisis services/hotlines, and interventions after a suicide to prevent "contagion" are current methods used to decrease the risk of suicide in the population.

TIP

Ask what the youth aspires to do. If he or she is forward thinking, that is a good prognostic sign.

TIP

Recently devised youth self-report scales for assessing suicidality which may be useful include the Columbia Suicide Screen

(CSS), Reasons for Living Inventory for Adolescents (RFL-A), and the Child and Adolescent Suicide Potential Index (CASPI).

Treatment of Aggression

Violent and out-of-control behavior is another common psychiatric emergency. Utilize the assessment above for determination of acute dangerousness. Treatment essentials are elaborated in Table 21.6.

TABLE 21.6. Treatment Essentials for Violent Youth

1. Determine cause of out-of-control and violent behavior. Ensure there is not an organic delirium or acute substance intoxication.
2. If the child is at acute risk of harm to self or others, safe and appropriate use of seclusion or restraint or medications (commonly an atypical antipsychotic with or without a benzodiazepine or diphenhydramine may be used).
3. Hospitalize if there is overt threat or aggression, especially with access to weapons, active psychosis, or inability to calm. Even if the aggressive behavior resolves in the emergency room, the risk for harming others in the home (e.g., a baby) and for a rapid re-escalation of aggressive behavior must be determined.
4. After safety is ensured, the goal of treatment is to address the underlying cause of out-of-control behavior. Use medication therapy, anger management training, parent-management training, and other interventions on a longer term basis.
5. If hospitalization is not immediately required, formulate a safe disposition plan, including rapid follow-up care and assessment of the need for child protective service involvement for acute issues in the family.
6. Ensure follow-up for regular treatment with a multimodal and multidisciplinary team.
7. Rating scales, such as the Overt Aggression Scale (OAS), may be helpful for ongoing monitoring of aggressive potential.