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THE CHECKUP

Kids' Suicide-Related Hospital Visits Rise Sharply

From 2008 to 2015, the proportion of emergency room and hospital encounters for suicide-related diagnoses almost tripled.

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About five years ago, pediatricians at Vanderbilt University Medical Center in Nashville found that more and more of their inpatient beds at the children's hospital were occupied by children and adolescents with mental health issues, especially those who had come in because of suicide attempts, or suicidal thoughts. These patients were known as "boarders": They were waiting for psychiatric placement because it wasn't safe for them to go home.

The doctors wondered whether the problem was specific to their city, perhaps reflecting scarce local resources. But in a new study in the journal Pediatrics, they found that this same pattern held true around the country over the period from 2008 to 2015.

"What we find nationwide is that over the last decade, the numbers of kids being admitted or seeking help in the emergency department or hospital for suicidal ideation or attempts have dramatically increased," said Dr. Gregory Plemmons, an associate professor of pediatrics at the Monroe Carell Jr. Children's Hospital at Vanderbilt and the first author on the study. In fact, over the study period, the proportion of emergency room and hospital

encounters for these suicide-related diagnoses almost tripled, from 0.66 percent in 2008 to 1.82 percent in 2015. And the rate of increase was highest among adolescent girls.

Seeking help for depression, or for suicidal thoughts, is actually a good thing, much better than not seeking help, but the increase is part of a disturbing trend of rising distress among adolescents. Suicide is the second leading cause of death in young people, after unintentional injury, starting with the 10 to 14 age group, continuing through 15- to 24-year-olds (and also the next group, ages 24 to 34). Suicide rates have been rising in the United States, with especially notable increases among young women; in 2016, the Centers for Disease Control and Prevention announced that middle school students were as likely to die from suicide as from traffic accidents.

In the new study, the researchers noted a strong temporal relationship between the school year and the frequency of the encounters for suicidal thoughts or actions; the rate dropped sharply in the summer, which is notably different, Dr. Plemmons said, from the pattern in adults, where July and August are higher risk months. Performance anxiety or social pressures could be factors, Dr. Plemmons said, and schools can potentially play a role in identifying kids at risk, and in delivering treatment.

Even after suicide attempts, many adolescents who are seen in emergency departments do not get mental health evaluations, said Dr. Ruth S. Gerson, assistant professor of child and adolescent psychiatry at N.Y.U. Langone Health, and the co-editor of "Helping Kids in Crisis." Instead, they are treated medically, and then released. Medical doctors often don't have the support or the training, she said, to do the mental health assessment and stabilization. And when people don't get that mental health assessment in the emergency room, they are at increased risk of making another suicide attempt.

Although suicide ranks just after trauma as a leading cause of death, there are many high-level pediatric trauma centers but very few dedicated pediatric psychiatry emergency rooms, Dr. Gerson said. She is the director of one such facility, the Bellevue Hospital Center Children's Comprehensive Psychiatric Emergency Program, where some 2,400 children and adolescents are evaluated every year. Every child who comes in gets a complete mental health evaluation, which can include not only talking to the child and the parents, but also to the outside therapist, the pediatrician and the school.

"We bring all this information back to the child and parent and make a safety plan," Dr. Gerson said. "A portion we admit to inpatient, but we also have access to immediate outpatient care which lets us do intensive therapy even without admitting the child to the hospital."

But many places don't have the ability to do that assessment or arrange that care. There has not been enough of an investment in children's mental health, Dr. Gerson said, either in high quality outpatient care or inpatient beds, given the magnitude of the problem. There is "really poor access to outpatient care, particularly quick access," she said. "People get admitted and end up boarding because there's no other option."

It is also widely understood in the pediatrics community that there are not enough mental health workers available to our patients, not enough outpatient therapists and not enough inpatient beds. "We're lobbying every day for more facilities, more beds, more mental health providers," Dr. Plemmons said. Many adolescents with depression do not look for help, and many don't have access to mental health specialists; the American Academy of Pediatrics published guidelines earlier this year for primary care pediatricians dealing with adolescent depression, and recommended screening all children 12 and up.

Some experts worry that the suicide theme in the Netflix series "13 Reasons Why," which recently debuted a new season, may contribute to what is known as suicide contagion.

"I would recommend to parents either ideally don't have your kid watch '13 Reasons Why,' or other shows with graphic depictions of suicide or self-harm," Dr. Gerson said in an email. But "if your kid wants to watch it, watch it together — the whole series, not just one episode — and talk about what you see, so you can help your kid understand and process anything that is upsetting or triggering."

"If kids are saying, I'm thinking about suicide, or I wish I didn't exist, or I wish I didn't wake up — take that seriously," Dr. Gerson said. Parents should try not to panic, she said, because if they get very emotional, their children may worry about hurting or disappointing them and stop talking.

"Stay calm. Ask, 'Tell me more about what you're thinking,' show the kid you're taking it seriously," she said. "I see parents who in a very well-intentioned way will say things like, 'Oh no, honey, everything's fine, let's think about the good things.'" And again, that may make a distressed child clam up.

Parents who have reason to be concerned must find a way to get the child evaluated. That doesn't have to mean the emergency room; you can start by calling your pediatrician. But a parent will have to decide whether the child "is able to be safe in that process — emotionally stable enough that they can drive with you to the pediatrician's office — or is your child really in distress at this moment and you need to call 911."

"It's pretty important if this is the first time you're hearing about this from your child that a professional should evaluate them," said Dr. Stephanie Kennebeck, an associate professor of clinical pediatrics at Cincinnati

Children's Hospital and the author of a recent review on suicidal behavior in children and adolescents.

In their medical center, she said, and in many others, a psychiatric response line offers parents a chance to talk it over on the phone to help decide whether or not to bring the child in. But again, if the child is violent or the parent is frightened, call for help in de-escalating the situation and ensuring safe transport: "If the child is in imminent aggressive or physical risk, it's totally reasonable to call 911."

After a full mental health assessment, Dr. Kennebeck said, deciding which children need to be hospitalized comes down to a question of safety. Can the child say, "I was feeling suicidal earlier but now I am feeling safe with you"? Does the parent feel able to control the environment and keep the child safe?

"The No. 1 thing that I learned is that asking about these thoughts in no way makes someone that way," Dr. Plemmons said. "I think there's a huge fear that there's a suggestive power, and that has not been shown to be the case." Instead, he said, "talking about it and destigmatizing it is hugely important."

"We know there are therapies and treatments that work, and we know that small things really, really make a difference for kids," Dr. Gerson said. "They really just need us to listen and say, 'I'm sorry you're hurting; we're going to find a way to get you some help."

She noted that parents should make clear to their child, "I really want to know how to help you best. I know this is something a lot of kids struggle with. I'm not mad at you. We're going to figure out how to get through this together."

For help, call the National Suicide Prevention line, 1-800-273-8255.