Tips in Managing Borderline Personality Traits in a Pediatric Health Care setting

MANAGING SUICIDAL AND SELF HARMING YOUTH IN A PEDIATRIC SETTING

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Land acknowledgement

- I acknowledge that we are situated on the unceded traditional territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səlilwətaɬ (Tsleil-Waututh) Nations.
- Personal action steps towards reconciliation from a Child Psychiatry perspective
  - *Trauma informed approach acknowledging impact of colonialization, Child welfare policies, including residential schools on families and children*
  - *Regular use of Jordon's Principle*
  - *Facilitate access to DBT for aboriginal communities*
  - *Regular use of aboriginal liaison worker at Surrey Memorial Hospital*
  - *Advocate for psychiatry representation at indigenous Child and Youth Mental Health teams*
  - *Advocate for expedited FASD assessments and FASD supports*

Experience

- MD, UBC
- Psychiatry Residency, UBC
- Child and Adolescent Psychiatry Fellowship, UBC
- Extended training in DBT during fellowship Vanpsych
- DBT practice at Vanpsych = 4.5 years
- Acute in patient child and adolescent psychiatry practice Surrey Memorial Hospital: on call, short and long stay wards = 4.5 years
- Medical lead of out patient Child and Adolescent Psychiatry Program Fraser Health

Conflict of interest

- Vanpsych Dialectical Behavioural Therapy
- No monetary compensation or benefit from this presentation
- No research currently under way

Tips in Managing Borderline Personality Traits in a Pediatric Health Care setting

- We will discuss suicidal and self harming behaviours and how to manage them in a pediatric setting
- You will be provided with a brief introduction to Borderline Personality Traits that can be manifested in Adolescents
- We will discuss when to consider these traits vs. other mental health problems
- I will introduce tools to determine when to seek consultation
- We will discuss options for longitudinal care

FULL TEXT ARTICLE

Evidence-Based Youth Suicide Prevention and Intervention in Pediatric Primary Care Settings

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Approach

- Ongoing education for primary care providers around suicide and self harm.
- Epidemiology
- Screening
- Assessment
- Management
- Community resources

Suicide risk in adolescents

- What is it?

Suicide risk in adolescents

- Suicidal Ideation and self harm is high in adolescence.
  - *Higher among females*
- Death by suicide rates are low in adolescence.
  - *Lower among females.*

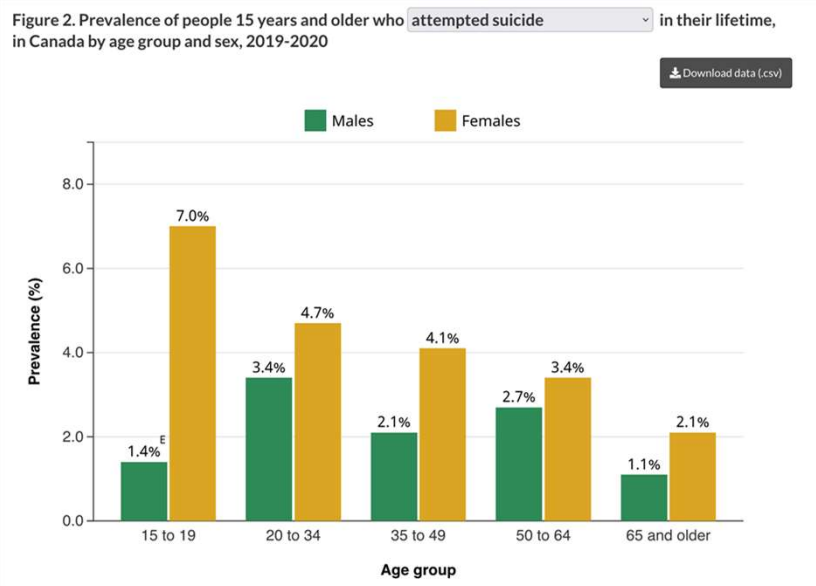


Figure 2. Age-specific self-harm hospitalization rates per 100,000 people aged 10 years and older in Canada by age group and sex, April 1, 2021 to March 31, 2022

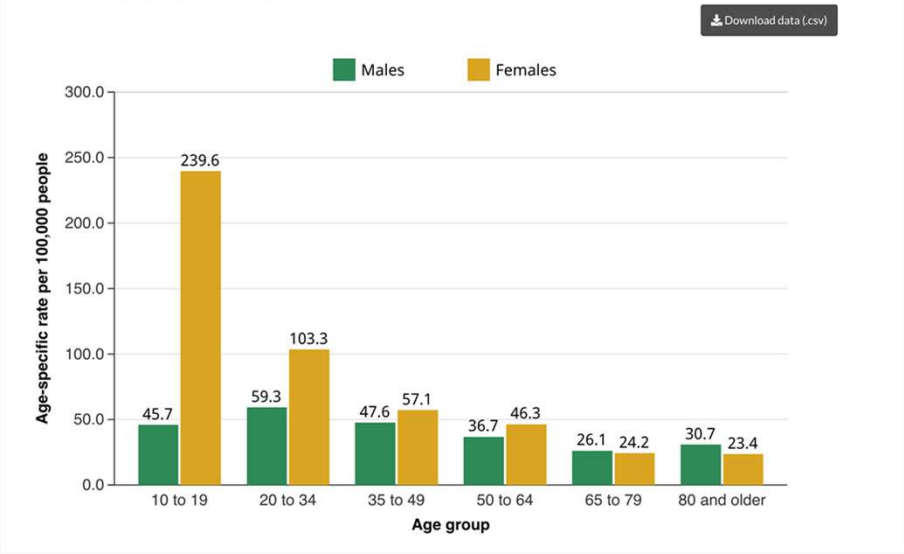
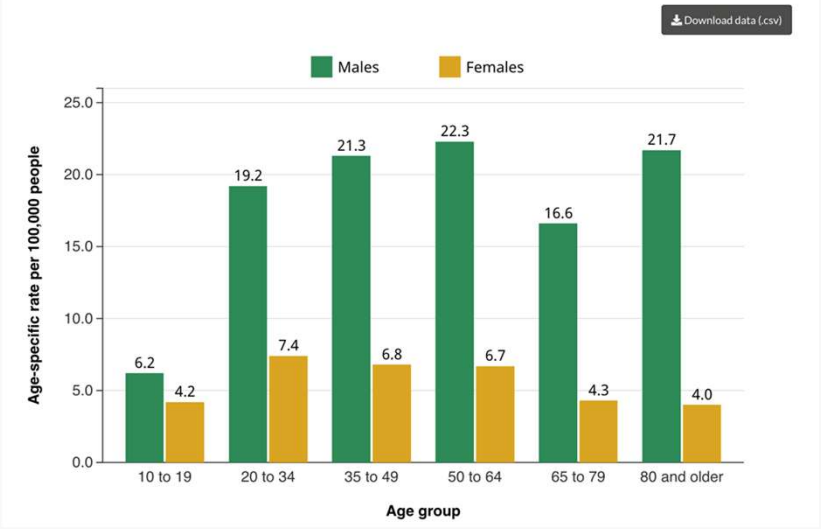
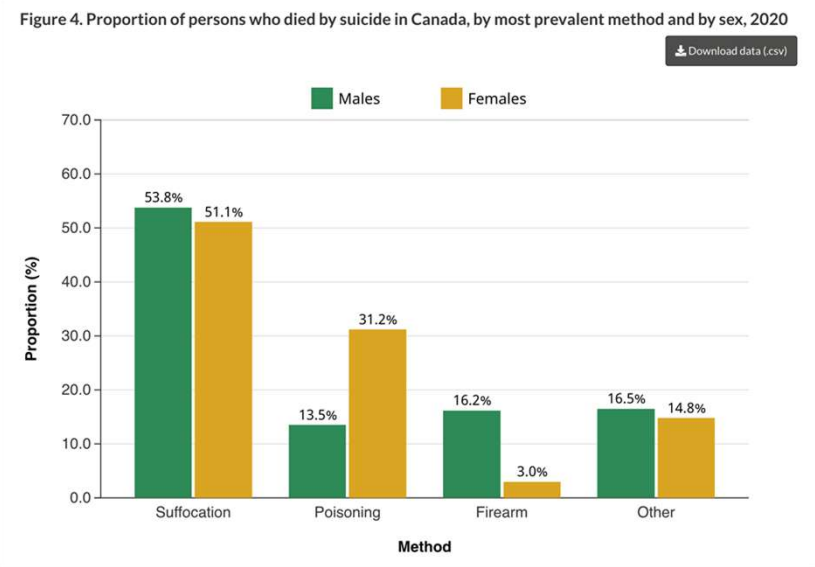


Figure 3. Age-specific suicide mortality rates per 100,000 people who died by suicide in Canada by year and sex, 2020





Death by suicide in Canada 2022

Age 4-9 2022

- All causes 214
- Death by suicide = 0 .
  - *14th leading cause of death*

Death by suicide in Canada 2022

Age 10-14 2022

- All causes 265
- Death by suicide - 26 deaths
  - *4th leading cause of death*

Death by suicide in Canada 2022

Age 15-19

- All causes 799
- Death by suicide - 158
  - *2nd leading cause of death*
  - *Accidents caused 203.*

And don't panic…

- Use a clinical approach to help guide you.
  - *Suicide risk assessment*
  - *Differential Diagnosis*
  - *Safety planning*
  - *Connection with supports*
  - *Treatment as indicated by the Differential Diagnosis*

Suicide risk assessment

- "Suicide risk assessment is a multifaceted process that involves learning about a person, recognizing and addressing their needs and stressors, and working with them to mobilize their strengths and supports. It is an integral part of a holistic therapeutic process that creates an opportunity for discussion between the individual (including their family) and a care provider and considers other supports. The purpose of suicide risk assessment is not to predict suicide. It is rather to assess and reduce the risk of suicide, inform treatment planning, and promote wellness and recovery by gathering information on suicidal ideation and behaviour. The assessment of suicide risk is commonly based on identifying and appraising warning signs, risk and protective factors, the individual's medical and mental health history, their acute condition, access to lethal means, and available support networks."

Mental Health Commission of Canada

Bottom line:

- Suicide risk assessment is a skill that informs clinical judgement making
- Risk assessment tools do not replace clinical judgement
- But they can help organize clinical judgement
- Our job is not to predict suicide – that is impossible
- Our job is to identify risk of suicide and to minimize risk it if clinically possible

Risk assessments

- Screening
- Assessment

Screening

- Universal screening recommended
- The important thing is to ask and document
- Screening tools:
  - *"Ask Suicide Screening Questions" NIH*
  - *Columbia Suicide Severity – Screen Version/Columbia Protocol*

- Busby et al 2023.

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ❍ Yes ❍ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ❍ Yes ❍ No
3. **In the past week, have you been having thoughts about killing yourself?** ❍ Yes ❍ No
4. **Have you ever tried to kill yourself?** ❍ Yes ❍ No

   If yes, how? _____

   When? _____

If the patient answers **Yes** *to any of the above, ask the following acuity question:*

5. **Are you having thoughts of killing yourself right now?** ❍ Yes ❍ No

   If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- **If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:**
  - ☐ **"Yes"** to question #5 = **acute positive screen** (imminent risk identified)
    - **Patient requires a STAT safety/full mental health evaluation.**
    - **Patient cannot leave until evaluated for safety.**
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ **"No"** to question #5 = **non-acute positive screen** (potential risk identified)
    - **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. If a patient (or parent/guardian) refuses the brief assessment, this should be treated as an "against medical advice" (AMA) discharge.**
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline, 988
- 24/7 Crisis Text Line: Text "HOME" to 741741

asQ Suicide Risk Screening Toolkit | NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH) | NIH | 3/6/2024

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?*	**YES**	**NO**
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** *Was this within the past three months?*		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

Screening ⇨ Assessment

- ASK Suicide screening tool
  - *Brief Suicide Safety Assessment*
- Columbia Suicide Severity Rating Scale Screen
  - *CSSRS*

SAFE-T

- Screen and evaluation in one
- (not validated) but a nice framework
- And there's a pocket card!

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts, or self-injurious behavior
- ✓ **Current/past psychiatric disorders:** especially mood disorders, psychotic disorders, alcohol/substance abuse, ADHD, TBI, PTSD, Cluster B personality disorders, conduct disorders (antisocial behavior, aggression, impulsivity)
  Co-morbidity and *recent onset of illness increase risk*
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Family history:** of suicide, attempts, or Axis 1 psychiatric disorders requiring hospitalization
- ✓ **Precipitants/Stressors/Interpersonal:** triggering events leading to humiliation, shame, or despair (e.g, loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). Intoxication. Family turmoil/chaos. History of physical or sexual abuse. Social isolation
- ✓ **Change in treatment:** discharge from psychiatric hospital, provider or treatment change
- ✓ **Access to firearms**

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance
- ✓ **External**: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration—in last 48 hours, past month, and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun) vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious.
  Explore ambivalence: reasons to die vs. reasons to live
- * *For Youths:* ask parent/guardian about evidence of suicidal thoughts, plans, or behaviors, and changes in mood, behaviors, or disposition
- * *Homicide Inquiry:* when indicated, esp. in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above

4. RISK LEVEL/INTERVENTION

- ✓ **Assessment of risk** level is based on clinical judgment, after completing steps 1–3
- ✓ **Reassess** as patient or environmental circumstances change

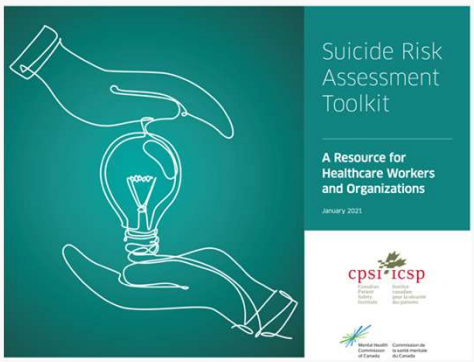
RISK LEVEL	RISK/PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent, or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT Risk level and rationale; treatment plan to address/reduce current risk (e.g., medication, setting, psychotherapy, E.C.T., contact with significant others, consultation); firearms instructions, if relevant; follow-up plan. For youths, treatment plan should include roles for parent/guardian.

Canadian Tools

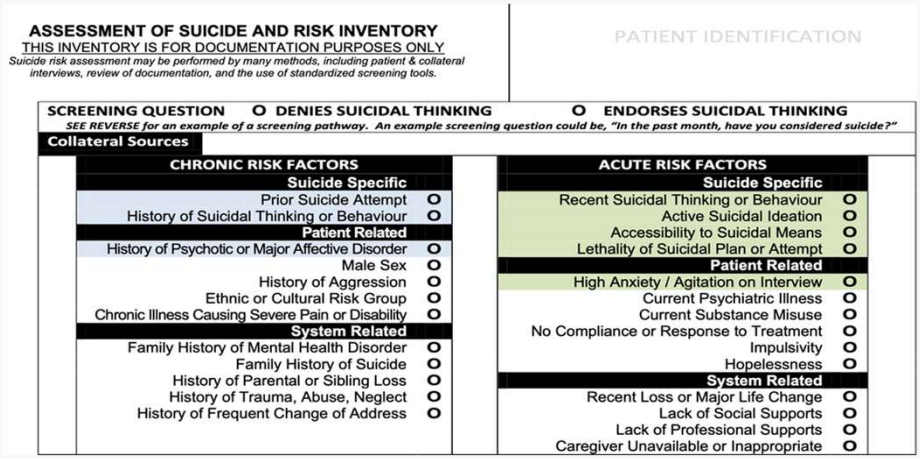
- Mental Health commission of Canada – recommends scales already mentioned.



Clinical Decision making

- Chronic vs. Acute
- Modifiable vs. non-modifiable

ASARI by Dr. Tyler Black



ASSESSMENT OF SUICIDE AND RISK INVENTORY

THIS INVENTORY IS FOR DOCUMENTATION PURPOSES ONLY

Suicide risk assessment may be performed by many methods, including patient & collateral interviews, review of documentation, and the use of standardized screening tools.

PATIENT IDENTIFICATION

SCREENING QUESTION O **DENIES SUICIDAL THINKING** O **ENDORSES SUICIDAL THINKING**

SEE REVERSE for an example of a screening pathway. An example screening question could be, "In the past month, have you considered suicide?"

Collateral Sources

CHRONIC RISK FACTORS		ACUTE RISK FACTORS	
Suicide Specific		**Suicide Specific**	
Prior Suicide Attempt	O	Recent Suicidal Thinking or Behaviour	O
History of Suicidal Thinking or Behaviour	O	Active Suicidal Ideation	O
Patient Related		Accessibility to Suicidal Means	O
History of Psychotic or Major Affective Disorder	O	Lethality of Suicidal Plan or Attempt	O
Male Sex	O	**Patient Related**	
History of Aggression	O	High Anxiety / Agitation on Interview	O
Ethnic or Cultural Risk Group	O	Current Psychiatric Illness	O
Chronic Illness Causing Severe Pain or Disability	O	Current Substance Misuse	O
System Related		No Compliance or Response to Treatment	O
Family History of Mental Health Disorder	O	Impulsivity	O
Family History of Suicide	O	Hopelessness	O
History of Parental or Sibling Loss	O	**System Related**	
History of Trauma, Abuse, Neglect	O	Recent Loss or Major Life Change	O
History of Frequent Change of Address	O	Lack of Social Supports	O
		Lack of Professional Supports	O
		Caregiver Unavailable or Inappropriate	O

OK NOW YOU ARE SAFE…

- Now What?

Differential Diagnosis and approach

Presentation	Approach
Situational Stressor	Problem Solve
Borderline personality traits	DBT strategies
Depression	SSRI and/or CBT
Anxiety	SSRI and/or CBT
Psychosis	ED or EPI (urgent)
Neurodevelomental	Behavioural consultation +/- medical management of behaviours

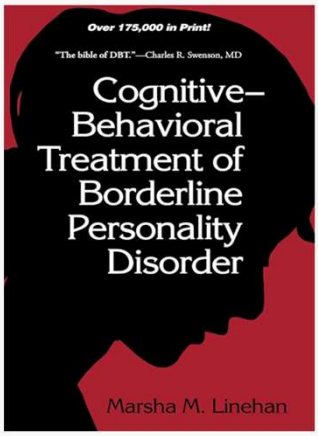
Borderline Personality Traits

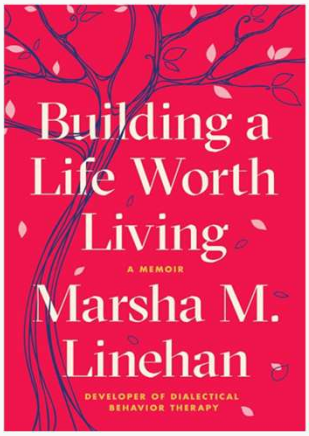
- BPD = 5 of:
  - *Chronic instability of self*
  - *Intense difficulties in interpersonal relationships*
  - *Impulsivity and risk taking behaviours*
  - *Affective instability*
  - *Frantic efforts to avoid real or imagined abandonment*
  - *Recurrent self harming or suicidal behaviour*
  - *Chronic feelings of emptiness*
  - *Transient paranoid ideation or dissociative symptoms.*
  - *Intense anger*

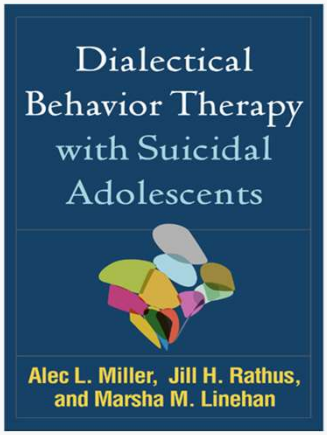
Almost every teenager has some of these. When does is become a problem?

Dialectical Behavioural Therapy (Resources)

Evidence based treatment for youth with suicidal and self harming behaviours







Problematic Borderline personality traits

- Suicidal and Self Harming behaviours
- Inability to sustain relationships (family and friends)
- Dangerous impulsive behaviours

Treatment

- Dialectical Behavioural Therapy (DBT) by Marsha Linehan
  - *Building a life worth living*
- Note: Many people grow out of these traits, and so treating co morbid conditions can also be helpful if DBT not available.
- Using a bit of a DBT approach can be helpful.

Structure of DBT

- Consultation team
- Group skills class
  - *Mindfulness*
  - *Distress Tolerance*
  - *Emotion Regulation*
  - *Interpersonal Effectiveness*
- Individual coaching
  - *Motivates the youth to use the skills in their life*
- Phone coaching
  - *24/7*
  - *To help generalize skills*

Core Dialectic of DBT

- Acceptance  Change

Dialectical Behavioural Therapy

- Acceptance
  - *validation*
  - *Attachment based parenting*
- Change
  - *learning theory/behavioural strategies*
  - *Important to consider learning theory in regards to treatment.*
  - *Too much attention to suicidal and self harming threats can reinforce the behaviour. Not taking it seriously enough can be invalidating.*

Clinical approaches (tone)

- Dialectical Behavioural Therapy
  Validate
  - Validate the valid: feelings, truths, the unsaid, normal responses.
  - DON'T VALIDATE THE INVALID!!!
  - *Change*
    - Behavioural strategies include extinguishing maladaptive behaviour, reinforcing adaptive behaviour.
    - Irreverence: Removal of warmth in the context of suicidal threats - removes reinforcement of suicidal gestures
      - *Shocking statement, at times humorous to throw the patient off balance*
      - *Helps to challenge rigid thinking*
      - *"I hate doing therapy with dead people – totally boring"*
      - *"No PNE if you are dead!"*
      - *The key is not to be judgmental toward the patient.*

Clinical Pearls in approaching a suicidal youth

- Interview with youth and parent first
  - *Assess their attachment/capacity to work together*
  - *Remember limits of confidentiality*
  - *Ask simple identification questions*
    - Ie: school, extra-curricular activities, professional supports etc.
  - *This helps to establish the protective factors*

Interview with youth

- *Assess future orientation and protective factors early*
  - *"So you are in grade 12, what are your plans for after graduation?*
  - *"What do you have planned for Halloween this year"*
- *Screen for SI/SH, if positive for SI:*
  - Brief Behaviour analysis
    - *Identify the problem, and try to solve the problem*

Behaviour Analysis

- Vulnerabilities
  - *Sleep, intoxication, school stress, break up etc.*
- Prompting event
- Behaviour (and feelings)
- Consequences

Interview with youth

- Screen for comorbid psychiatric conditions
  - *Psychosis*
  - *Mania*
  - *Depression*
  - *Anxiety (GAD, SAD, Panic)*
  - *Trauma*
  - *OCD*
  - *ED*
  - *Substance*
  - *Neurodevelopmental*
  - *ADHD (not acute)*

Interview with parent

- Gather basic information fist (this is containing for them)
  - *Med Hx*
  - *Allergies*
  - *Medications*
  - *Past psychiatric Hx*
  - *Family psychiatric Hx*
  - *Birth and Developmental Hx*
  - *Social Hx*
    - MCFD involvement?
    - School?
  - *Then get a sense of what they are worried about. Fact check the behaviour analysis*
  - *Fact check the ROS.*

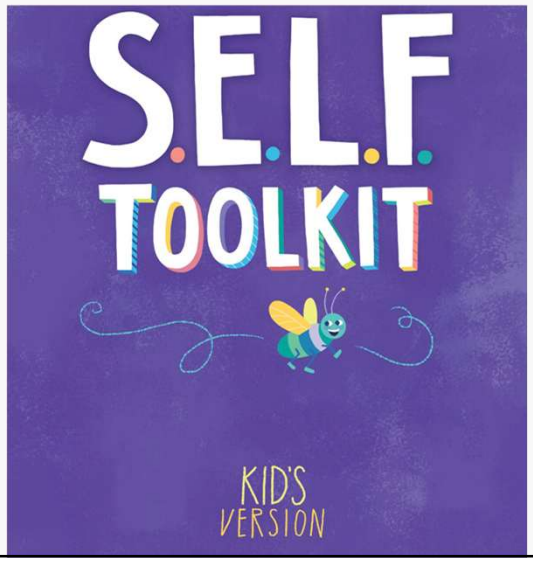
Short term Interventions

- Safety Planning
- Motivational Interviewing to help with engagement
- Remove lethal means (typically with parents)
  - *Yes: you buy a safe for all pills in your house, even your vitamins….*
- Parent support
  - *Sachbear*
    - https://sashbear.org/
    - Family connections program
  - *DBT parenting groups Middle Path Parenting*
    - CYMH, Vanpsych
- Close follow up or follow up phone calls

Safety Planning Components

- Written Safety plan document
  - *Individualized to patient risk factors*
    - warning signs, narrative of suicidal ideation
  - *Identifies internal coping strategies*
    - ie: distraction, self sooth, asking for help, garnering hope
  - *Engagement of support system*
    - Identify support system – professional and personal
  - *Connection with Mental Health support*
    - Crisis lines, urgent clinics
  - *Removal of lethal means*
    - Be careful with cutting and razors
    - But remove firearms, and pills.
  - *Close follow up and phone calls*

Kelty Mental Health SELF toolkit



Safety Plan for Passes

Date/time leaving:
Date/time returning:

Our plans for this pass are...
- Where we are staying:
- Who we will be with:
- What we are going to do together:

My stressors might be...
-
-
-

My early warning signs are...
-
-
-

My TOOLS to Feel Better are...

If we need more support we will call the unit's safety phone for support...
-
-

Staff will help us over the phone and if we need to, we can return to [illegible]

If we need emergency support we will call 911.

STAY SAFE and HAVE FUN!

My Safety Plan

If I feel stressed and/or unsafe I will...

1. Use my tools to feel better, which are...
   -
   -
   -
   -
   -
   -

2. Speak to a trusted adult...

   Name: Phone:

   Ways I would like them to support me are:
   -
   -

   Name: Phone:

   Ways I would like them to support me are:
   -
   -

3. Call my community team...

   Name: Role: Phone:

   Name: Role: Phone:

4. Call my local crisis line:
   - Crisis Centre BC: 1-800-SUICIDE (1-800-784-2433)
   - 310 Mental Health Support: 310-6789 (no area code required)
   - 24 hour Crisis line: 604-872-3311 (Greater Vancouver)
   - Kids Help Line: 1-800-668-6868 or KidsHelpPhone.ca
   - www.youthinbc.com online chat available from 12:00 noon until 1:00 am
   - Other:

5. Go somewhere I feel safe...
   -

6. Go to the Emergency Room at the nearest hospital

7. If I can't get to the hospital safely, I will call 911

An important person in my life is...

Something I enjoy doing is...

One thing I'm looking forward to doing is...

When to refer

- When risks outweigh protective factors
  - *Clinical judgement*
- Unable and/or unwilling to safety plan
- Major psychopathology
  - *Psychosis, mania (emergency)*
  - *Depression, anxiety*
  - *Substance use*

Who to refer to

- Compass Clinic BCCH (for provider support)
- EPI or the ED for psychosis or mania
- Short term assessment teams
  - *CART – Vancouver*
  - *START – Fraser Health*
- Child and Youth Mental Health Teams
  - *Vancouver has a comprehensive DBT program, many others have attenuated programs*
- Comprehensive DBT programs (For severe pathology)
  - *Vancouver DBT Centre*
  - *Vanpsych*
  - *Wisemind*
  - *DBT Centre of the Fraser Valley*

? Questions?

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