Emergency Room Intervention for Adolescent Females
Last update – 4/3/2009

Description
The primary goal of the Emergency Room Intervention for Adolescent Females Program (ERIAFP) is to increase participation in and the effectiveness of post-attempt, outpatient therapy for adolescent females and their parents. The program seeks to improve the family’s experience in the emergency room (ER) following the suicide attempt by reducing negative factors associated with or projected onto the ER staff due to the confusion and emotions of the family.

The initial phase of the protocol is a series of trainings for six different ER staff types: physicians, residents, psychiatric staff, nurses, security personnel and intake/discharge clerks. The trainings use a series of common role play skits and facilitated discussions tailored to the activities and likely conversations each staff type might have with the teen or her parents. Each role play series give the staff chances to practice appropriate, sensitive responses for a frightened teen or her parents.

In addition, each set of exercise is designed to:
- increase rapport between ER staff, the adolescent teen and her family;
- instill common knowledge and communications about the treatment path following a suicide attempt in the ER;
- remove or reduce cultural and communication barriers;
- support the family instead of blaming them;
- enhance family’s feeling of respect and privacy by the ER staff
- increase family knowledge & decrease confusion by providing education, especially non-written info about the suicide
- value both the parents & teen and reinforce mutual regard and positive communications between parent & teen
- increase coordination and collaboration between ER staff
- make the importance of follow-up therapy a theme of all ER communications

The second component of ERIAFAQ is delivered to the family in the ER as a videotaped “soap opera” (in Spanish and dubbed in English). The 20 minute video tape shows several vignettes about the emergency room process following a suicide attempt by their teen. The final phase is a brief family crisis intervention led by a qualified family therapist, the last stage of the ER treatment trajectory. At every opportunity throughout the family’s trip through the ER, the importance of attending and completing the six session, outpatient follow-up treatment program is emphasized.

While not specifically part of the ERIAFAQ, the program authors described the following treatment protocol for post-attempt teen girls and their parents. Other successful post-attempt therapies could be successfully substituted. The goal of ERIAFAQ is simply to get the teen and her family to therapy and to complete it.

Recommended therapy goals
- decrease the idea and use of suicide to solve problems
- increase conflict resolution and negotiation skills for family disputes
• increase early return to therapy when new crisis arise

Recommended therapy objectives
• increase understanding of the connection between thoughts, emotions and behaviors
• Counter irrational beliefs
• improve problem solving, self-esteem and self-efficacy
• increase negotiation between family members
• ensure that new skills are practiced in real life

ERIAFP Characteristics
• Population
  o Gender – females in urban areas
  o Ages – 13 – 25 years old (youth); 26-55 years old (parents)
  o Races – Hispanics & Latinos; has been implemented in Israel and Nicaragua and with Native Americans in the US.
• Risk, Protective & Causal Factors
  o Attempted suicide
  o Family conflict, poor communications
  o Negative perception of therapy
• IOM Category (level of care)
  o Indicated – multiple risk factors for suicide, future attempts

Effectiveness
Compared with the adolescent females in the usual care group, the teen females who participated in the ERIAFP:
• were significantly more likely to visit the outpatient clinic for treatment following discharge from the emergency room;
• attended more outpatient treatment sessions;
• were three times more likely to complete the outpatient treatment program;
• showed significantly lower symptoms of depression;
• had lower clinical depression ratings at 1 month post intervention and at 18 months post intervention;
• reported less suicidal ideation within 1 month following the emergency room visit. There was no difference between the intervention and usual care groups at 18 months post intervention.

Compared with the mothers in the usual care group, mothers who participated in the ERIAFP:
• reported lower levels of depression for themselves within 1 month following the emergency room visit. There was no difference between the intervention and usual care groups at 18 months post intervention;
• reported more positive attitudes toward treatment for themselves within 1 month.

Program delivery
The initial phase of the program is an intensive training protocol for six ER staff types. Once trained, the protocol is delivered over four hours in the ER. The treatment trajectory that follows is based on the ER where the program was originally developed, however, the core six staff groups are typical of ERs and the elements should be easily adaptable. The initial contact is the Intake clerk at the emergency
department, followed by the ER physician for medical treatment for the physical ramifications of the suicide attempt. Hospital residents and ER nurses deliver much of the information and education designed to reduce confusion and to increase the family’s understanding of suicide. The security staff is on hand throughout the ER trip to prevent further attempts at self-harm as well as physical incidents between the attempter and her parents or the ER staff. The final therapeutic contact is with the psychiatric staff that conducts the brief family crisis intervention, and the discharge clerk concludes the hospital’s business affairs with the family. Throughout the ER trajectory, all staff members strive to treat the family compassionately and respectfully while emphasizing the importance of following through with the outpatient treatment process.

Considerations for use in Idaho
ERIAFP is a well reasoned and research-based program to increase adolescent female suicide attempters and their families’ participation in a follow-up treatment program. Individual ERs could add ERIAFP to existing standards and clinical pathways for relatively little cost. However, the lack of a centralized hospital system makes statewide implementation difficult and adequate quality assurance to maintain the program across the state unlikely. However, the concepts and protocols are straightforward and could be implemented at any level from community clinics to regional hospitals and should produce similar gains in post-attempt treatment compliance. Perhaps the biggest limitation for implementation of ERIAFP in Idaho is the lack of post-attempt treatment services for adolescent suicide attempters, especially in the rural and frontier counties.

Training & costs
A training of trainers can be provided by the developer for $1,500 a day. A free, public-domain training manual is available online at http://chipts.ucla.edu/interventions/manuals/interer.html. While the manual extensively details the training sessions for each of the six ER staff types, it appears to be the training protocol used in the original research. However, it is likely that a skilled facilitator or therapist could implement the program with the manual alone.

The training costs consist of the original staff training time and materials and the cost of working with the teen and her family in the ER. The program developer recommends a dedicated .3 FTE trainer to work with the staff over a six month period. That may be excessive, especially since many of the sensitivity practices recommended are now part of standard medical services. It may be possible for a well-run ER system that already has regular training and in-services to add the core of ERIAFP for relatively little cost.

Implementation cost essentially cover approximately four hours of time directly working with each teen and her family, including the education and information sessions, video and brief family therapy.

Dissemination & support
The training manual for ER staff is in the public domain. However, the manual is a collection of well written training protocols from the original experiment, and is somewhat difficult to interpret. While there is a trainer of trainers training, direct support by the program author does not appear to be available. However, the primary author’s contact information may be found below.

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Other program synopses
- Oregon Plan for Youth Suicide Prevention:

Selected Bibliography


