Suicide in children and adolescents

Learning objectives

- Describe suicidal ideation and behaviors in childhood and adolescence and their basic treatment and intervention options.

I survived a suicide attempt

https://www.youtube.com/watch?v=Vetf9eu3Lbw&rco=1

Hypothetical rant by an agency caseworker[1]

What a week. First, Frequent Flyer Harry successfully commits suicide after years of failed attempts. I was shocked because just last week, he said “no” when I asked him if he had any thoughts of hurting himself. I always felt like he was just attention seeking. Then the associate director is like, “You have to review Harry’s chart for the past year.” And in my head, I’m like, “I’d rather kill myself.” Then the unit director shoots us an e-mail to be on the lookout for copycat suicides. I can’t say “no,” because that would basically be career suicide. The irony is that Harry found a permanent solution to a temporary problem, and my chart review is a temporary solution to a permanent problem....

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Hypothetical rant by an agency caseworker[1]

What a week. My long-term client, Harry, died by suicide after several previous attempts. Despite many efforts to explore the reasons for his past attempts, he still could not communicate his pain any other way. I was shocked because just last week, he said "no" when I asked him if he had any thoughts of killing himself. Then the associate director said, "You have to review Harry's chart for the past year." And in my head, I thought, "I'd rather do anything other than chart review." Then the unit director sends us an e-mail to be on the lookout for other people who are suicidal. I can't say "no," because then I wouldn't be considered for the supervisor position. It is ironic that Harry killed himself in part because he thought no one cared if he lived or died, and yet his death has been devastating for so many people. Instead of reaching out to these folks, I'm stuck inside doing chart review.

Suicide statistics

- Suicide is the **2nd leading cause of death** for ages 10-34 years[2]
- Suicide risk is highest in the **first three months after psychiatric hospitalization** if suicidality was the reason for admission[3]
- Of youth with Major Depressive Disorder or Dysthymia:
  - Up to 85% will have suicidal ideation
  - Up to 32% will make a suicide attempt by early adulthood
  - 2-7% will die by suicide[4]

Suicide deaths and rates per 100,000 by age group, 2017-2021[2]

Age group	Deaths	Crude rate
5 to 9	55	0.05
10 to 14	2,826	2.68
15 to 19	11,664	10.97
20 to 24	19,343	17.82
Total	33,888	8.03

Contact with health care prior to death[5]

- 38% of 0-19-year-olds who died by suicide saw a healthcare provider in the **month** prior to their death
  - Only 16% saw a mental health provider
- 77% of 0-19-year-olds who died by suicide saw a healthcare provider in the **year** prior to their death
  - Only 32% saw a mental health provider
- Universal screening in medical and psychiatric populations identifies youth at risk for suicide[6]

How and when to start screening

- Best option: Consistently use a validated tool
- If not using a validated tool, ask directly about suicide and keep it simple
- Identify who conducts the screening, follow up questions, and safety planning
- Have a protocol for after a positive screening

"Given a review of suicidality in children under 12, we believe screening for suicide should be conducted in at-risk youth starting at the age of 10; and as low as age 8, if the child is presenting to a healthcare provider for a mental health problem."[7]

Suicide screening vs. assessment[8]

- **Screening**: A procedure in which a standardized instrument or protocol is used to identify individuals who **may** be at risk for suicide

- **Assessment**: A more comprehensive evaluation done by a clinician to **confirm** suspected suicide risk, estimate the immediate danger to the patient, and decide on a course of treatment

Ask Suicide Screening Questions (ASQ)

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

ASQ next steps

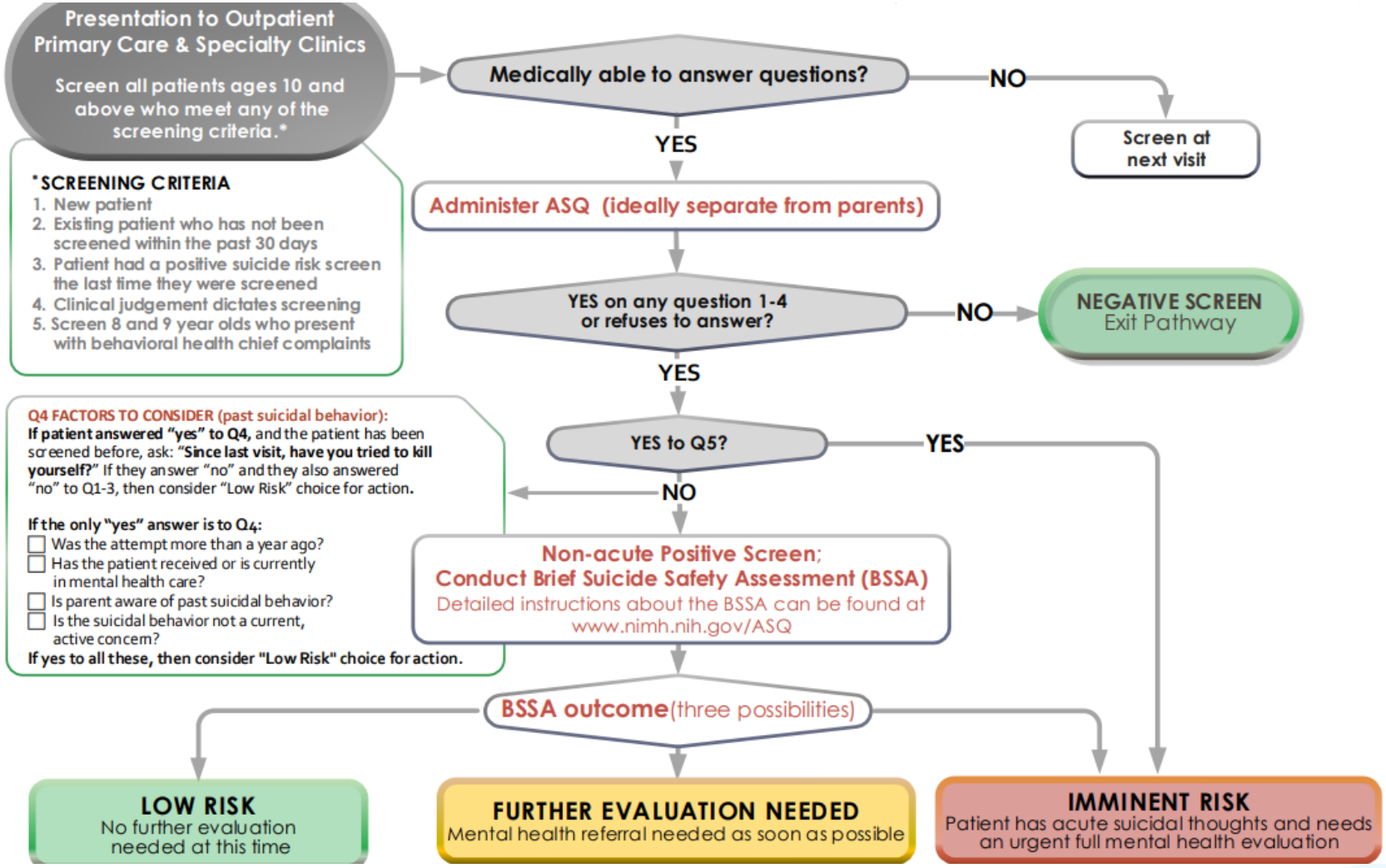
- If patient answers “No” to all questions 1 through 4, screening is complete. No intervention is necessary.

- 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:

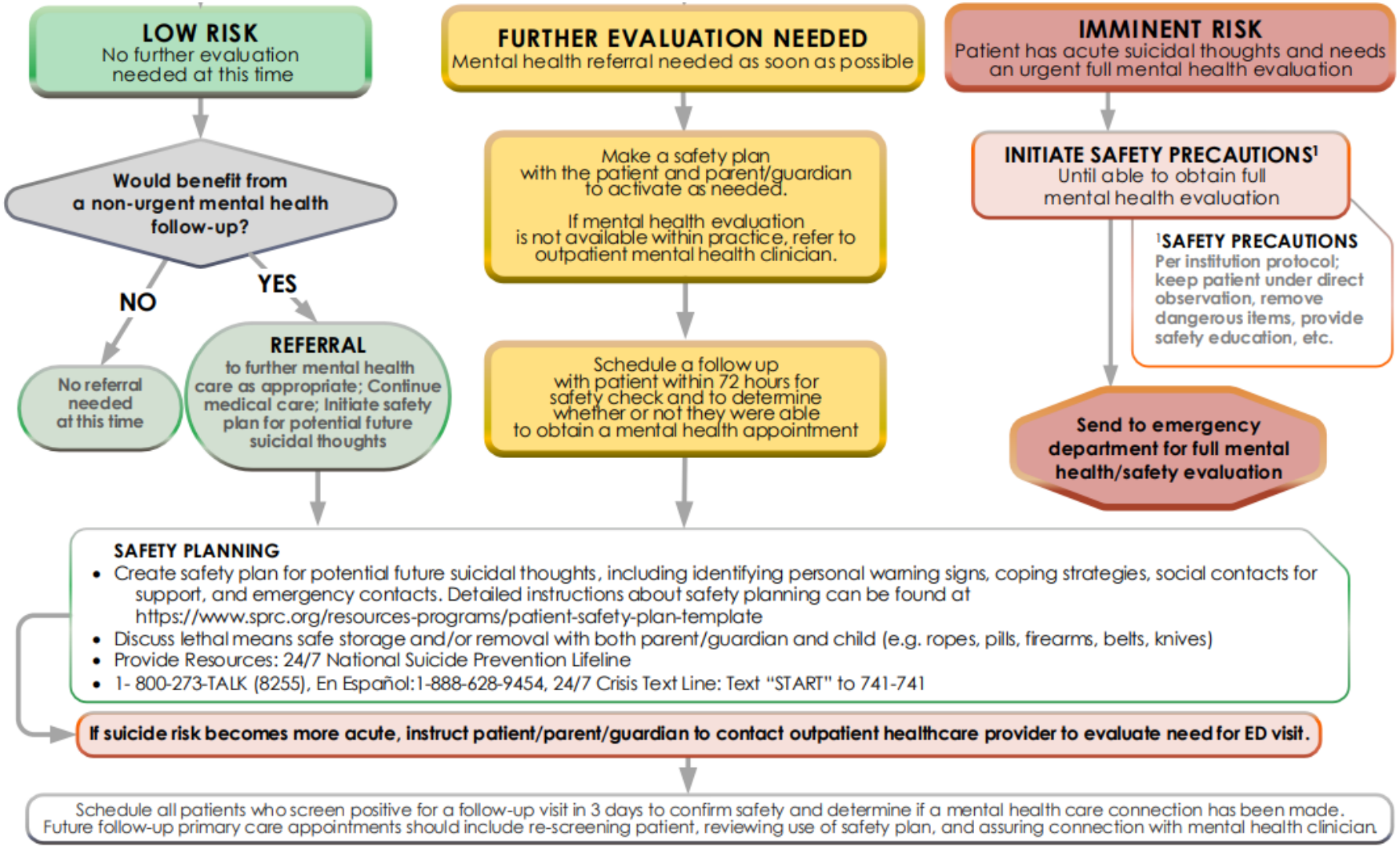
  - **“Yes” to question #5 = acute positive screen (imminent risk identified)**
    - Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s 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 guardian refuses the brief assessment, this should be treated as an “against medical advice” discharge.
    - Alert physician or clinician responsible for patient’s care.

ASQ youth suicide risk screening pathway: outpatient primary care and specialty clinics



ASQ youth suicide risk screening pathway: outpatient primary care and specialty clinics



ASQ toolkit: resources for outpatient primary care and Specialty Clinics

- Brief Suicide Safety Assessment Guide
- Brief Suicide Safety Assessment Worksheet
- ASQ Suicide Risk Screening Tool
- Outpatient Suicide Risk Clinical Pathway
- Mental Health Resources
- Script for Nursing Staff
- Parent/Guardian Flyer
- Links to Videos
- Information Sheet

Columbia Suicide Severity Rating Scale (C-SSRS) Screen with Triage Points for Primary Care

Questions	Past Month	
Ask Questions 1 and 2	Yes	No
1) Have you wish 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 question 2, answer questions 3, 4, 5, and 6. If **NO** to question 2, go directly to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on 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?	**Lifetime**	
IF YES, was this within the past three months?	**Past 3 months**	

Common concerns about suicide screening

- What do parents and patients think about suicide screening?
  - **Vast majority think it's a good idea.[9,10,11,12]**
- Can asking about suicide put the idea in someone's head?
  - **Studies demonstrate that it doesn't.[13]**
- This is going to take too long. We don't have time for suicide screening.
  - **Universal screening with C-SSRS or ASQ did not increase emergency department wait times or overburden the healthcare system.[14,15,16,17]**

Interviewing validity techniques (1 of 2)[18]

Technique	Description	Example
Behavioral Incident	Ask directly about specific details. Ask what happened next.	• *Exactly how many pills did you take?* • *What happened next?*
Shame Attenuation	Non-invasively inquire about behaviors many patients would be hesitant to discuss because of shame or guilt.	• *With all the tremendous financial stress you've been under, have you found that you felt it necessary to steal just to get food on the table?*
Gentle Assumption	Frame question by assuming behavior has occurred, rather than asking IF it has occurred.	• *What other street drugs have you used?* • *What other ways of killing yourself have you thought about?*

Interviewing validity techniques (2 of 2)[18]

Technique	Description	Example
Symptom Amplification	Gathers accurate information, even if patient minimizes. Suggest a specific number, and aim high.	• *How many pills did you take? 100?* • *How many times did you hit your son? 30? 40?*
Denial of the Specific	Requires patient to affirm or deny specifics, instead of general questions.	• *Have you thought about hanging yourself?* • *What about overdosing?* • *Have you thought about using a gun?*
Normalization	Let the patient know others have similar experiences	• *Sometimes when other people are feeling as depressed as you are, they think about killing themselves. Have you had thoughts like that?*

Safety Planning Intervention[19]

What safety planning is

- A written, prioritized list of coping strategies and sources of support that a person can use to alleviate a suicidal crisis
- An intervention for people at increased risk for suicide to decrease suicidal behaviors and increase treatment engagement[20]

What safety planning is not

- An intervention for patients at imminent risk of death
- A substitute for treatment
- A “No-suicide” or “no-harm” “contract”
- [Just] A form to fill out

Steps of safety planning

1. Warning signs
2. Internal coping strategies (i.e. Solo activities)
3. People and social settings that provide distraction
4. People whom I can ask for help
5. Professional or agencies I can contact during a crisis
6. Making the environment safe

Step 1: warning signs

- **Explain the step**: Step 1 of the Safety Plan is to identify your personal warning signs of a crisis. Knowing and recognizing these signs in yourself can remind you to use the Safety Plan.

- **Ask**: What do you notice yourself thinking or feeling right before making an attempt?

- **Check for barriers and problem solve**: Do you think you will be able to recognize when these warning signs occur? Do any of these need to be more specific?

Type of Warning Sign	Example
Thoughts	I'm a failure.
Emotions	Ashamed, hopeless
Physical Sensations	Headache, clenched jaw
Behaviors	Drinking alone.
Thinking processes	Having racing thoughts.

Step 2: internal coping strategies (i.e. Solo activities)

- **Explain the step**: Step 2 of the Safety Plan is identifying activities to take your mind off suicidal thoughts. In this step we're looking for things you can do without contacting another person.

- **Ask**: What activities could you do by yourself to help take your mind off your problems even for a little while?

- **Check for barriers and problem solve**: How likely do you think it is you would be able to do this step during a time of crisis? What might prevent you from thinking of these activities or doing these activities even after you think of them?

Step 3: people and social settings that provide distraction

- **Explain the step**: Step 3 of the Safety Plan is to identify people and social settings that can help distract you from suicidal thoughts.

- **Ask**: Are there places that you can go to that can help take your mind off your problems? Is there someone who, when you're talking to them, you lose track of time?

- **Check for barriers and problem solve**: How likely would it be for you to reach out to [person] during a crisis? What might stop you from going to [specific place]?

Step 4: people whom I can ask for help

- **Explain the step**: In Step 4 of the Safety Plan, we list people you can talk to about thoughts of suicide.

- **Ask**: Who do you think you could contact for help during a crisis?

- **Check for barriers and problem solve**: What might stop you from calling [person] if you're in crisis?

Step 5: professional or agencies I can contact during a crisis

- **Explain the step**: Step 5 lists professionals who can assist during a crisis.

- **Ask**: Who are the mental health or medical professionals we should put on your safety plan?

- **Check for barriers and problem solve**: What might stop you from calling [person] if you're in crisis?

Step 6: making the environment safe

- **Explain the step**: Step 6 of the Safety Plan involves taking steps to reduce your access to lethal means. The harder it is to get to [method of suicide], the more time there is for you to think about other coping strategies to help you stay safe.

- **Ask**: What steps are you willing to take to make your environment safer for you during a crisis? Do you have access to firearms? How are firearms and ammunitions stored?

- **Check for barriers and problem solve**: Who can help dispense your medication? Is there someone you trust to hold onto your guns while [Patient] is in treatment?

Rationale for lethal means reduction[21]

- Many suicide attempts occur with little **planning during a short-term crisis**.
- Intent isn't all that determines whether an attempter lives or dies; means also matter.
- 90% of attempters who survive do not go on to die by suicide later.
- **Firearms** used in youth suicide **usually belong to a parent.**
- Reducing access to lethal means saves lives.

Resources (1 of 2)

- PRISM Primary Care Suicide Prevention Protocol Development Guide
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- NIMH Ask Suicide-Screening Questions (ASQ) Toolkit
- Stanley-Brown Safety Plan Template
- Safety plan treatment manual to reduce suicide risk: Veteran version
- Safety Planning Guide: A Quick Guide for Clinicians
- Safety Planning for Youth Suicide Prevention online course

Resources (2 of 2)

- Itzhaky, Liat & Stanley, Barbara. (2022). The Safety Planning Intervention for Children (C-SPI): Rationale and Case Illustration. Cognitive and Behavioral Practice.
- Counseling on Access to Lethal Means online course
- Harvard School of Public Health Means Matter

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