Suicide Screening in Adolescents

Guideline developed by Tracie L. Pasold, Ph.D., in collaboration with the ANGELS team. Last revised by Tracie L. Pasold, Ph.D. November 19, 2018.

Definitions, Assessment and Diagnosis

Definitions

- Suicidal Ideation refers to recurring thoughts of or preoccupation with suicide including thinking about, considering, or planning suicide.
- A suicide attempt refers to self-induced injury that is nonfatal that was instigated by any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.
- Suicide refers to death caused by self-inflicted injury with any intent to die as a result of the behavior.

Assessment and Diagnosis

Assessment for Suicide Potential

In Arkansas, suicide is the fifth leading cause of death for 10 to 14 year-olds and the third leading cause of death for 15 to 24 year-olds.[1,2] Pediatricians play a fundamental role in identifying and managing youth with suicidal behavior particularly because they are functioning on the front lines in primary care. The American Academy of Pediatrics recommends that pediatricians become knowledgeable about the numerous risks for suicide and achieve an adequate level of comfort with screening for these risks and performing suicide assessment.[3] Assessment for suicide potential should be performed if any of the associated risk factors are present; thus, knowledge of the factors associated with suicide risk is imperative. The risk factors that lead to a significant increase in suicidal ideation and attempts are numerous and include:[1-7]

- Age: older adolescents, ≥16 years, are more at risk of death due to suicide; however, 40% of youth who attempted suicide were in elementary or middle school at the time of their first attempt.
- Gender: 4 times as many males ages 15-19 die by suicide, though females attempt suicide 2 to 3 times more often than males.
- Ethnicity: Though individuals across all racial/ethnic backgrounds are at risk, American Indian, Alaskan Native, Latina/Latino youth have elevated rates of attempted and completed suicides.

GENETICS/HISTORY

- History of prior suicide attempts is indicated to be one of the strongest predictors of completed suicides with 25% to 50% of adolescent suicide victims having had a history of previous suicide attempts.
- Family history of suicide; familial suicide, particularly by a first degree relative, increases risk by three or more times.

ENVIRONMENTAL FACTORS

- Family functioning: parental conflict, distress, dysfunction, violence, parental mental health problems found to be a prominent predictor of adolescent suicidal ideation
- Socioeconomic status: those from disadvantaged social economic status are at higher risk for suicide.
- Prolonged, chronic stress
- Stressful life event or loss
- Exposure to violence
- Victim or perpetrator of direct or cyber bullying[8,9]
- Sexual or physical abuse or neglect[10]
- Easy access to lethal methods
- Exposure to the suicidal behavior of others; experience or awareness of an adolescent suicide has been found to increase risk with up to 5% of adolescent suicides related to this kind of exposure[11, 12]

PSYCHOLOGICAL/PHYSICAL HEALTH FACTORS

- Depression or other mental illness; majority of adolescent suicide victims had a psychiatric disorder with 63% displaying identifiable symptoms for at least a year prior to their death; as many as 60% of adolescent suicide victims had a depressive disorder at the time of death.
- Alcohol or drug use/abuse; substance use disorders have been indicated to increase risk of suicide attempts by as much as 6 times.
  Incarceration, legal involvement
- Poor social support, social isolation/rejection
- Aggression or disruptive behavior
- Impulsivity
  Youth in the child welfare system
- Learning problems/disabilities, decline in academic performance, academic failure
- Sexual orientation: lesbian, gay, bisexual, and transgendered adolescents have higher rates of suicide[13]
- Adoption status[14]
- Video game and/or internet use that exceeds five hours a day[15]
- Serious and/or chronic physical health conditions including pain
- Concussion, traumatic brain injury

Signs & Symptoms

Signs and symptoms associated with suicide tend to be similar to symptoms of depression and include:[16,17]

- Changes in eating and sleeping habits
- Talking about being a burden on others, that life will never get better, that the pain they are experiencing is too much to bear, or that there is no reason to live

- Withdrawing from friends, family, and other social activities, wanting to be left alone
- Giving away or discarding possessions, discussing their own funeral and what they would like done with their remains
- Talking about suicide
- Preoccupation with death, dying, or violence (e.g., excessive focus on music, video games, television shows, books, internet sites, or art that center around death and dying)
- Increase in violent tendencies, gestures, or behaviors
- Defiant behavior, running away
- Increased drug and/or alcohol use
- Mood swings that tend to go from depressed to suddenly happy and cheerful Feeling hopeless, helpless, worthless
- Inappropriate shame, guilt
- Irritability, agitation
- Unusual neglect of personal appearance, poor hygiene
- Obvious changes in personality
- Complaining of physical symptoms (e.g., stomach ache, headache, fatigue) No
- longer interested in activities that used to be enjoyable
- Low self-esteem, makes negative statements about self Signs
- of psychosis (e.g., hallucinations, delusions)

Suicide Ideation

If suicidal ideation is detected, follow through with assessment of: The

- existence of a plan
- Details of a plan
- Level of intent to follow through with plan
- Means to follow through with plan (access to and/or acquisition of tools) The
- perceived outcomes of attempting suicide

Specific Questioning

Specific questioning is recommended to include:[4]

- Have you ever thought about hurting yourself? If so, when? Have
- you ever tried to hurt yourself? If so, how? When?
- Special note: self-harming behaviors such as cutting are important to assess. Self-injury can be a form of coping and not a direct suicide gesture. Assessment and treatment plan should be appropriate given the function of the behavior. Individuals who engage in self-injury do have a higher incidence of suicide attempts.
- Have you ever thought about killing yourself? If so, when?
- Have you ever had a plan to kill yourself? If so, what was your plan? When? Have
- you ever tried to kill yourself? If so, what did you do? When?

Further questioning could include:

- Do you have access or can you get access to what you would need to carry out your plan?
- How strong is your desire to die right now (0-10 scale)?
- Are there reasons you would not follow through with your plan to end your life? What are they?

- How confident are you that you can keep yourself safe (0-10 scale)?
- In the future if you had these thoughts, what could you do? Who could you talk to? What
- do you do to help yourself feel better when you are upset?

Management

Routine assessment

Suicidal ideation can be assessed through direct questioning or through completion of self-report questionnaires. Using both methods may be ideal particularly with adolescents as they tend to be more likely to disclose on self-report questionnaires compared to direct questioning. Routine assessment of adolescents in primary care is recommended as the reference standard of care and important in suicide prevention.[18]

- The National Strategy for Suicide Prevention put forth by the Office of the US Surgeon General and the National Action Alliance for Suicide Prevention recommends preventative suicide risk screening by primary care and other health care providers as the minimum standard of care in all federally supported primary care settings.[19]
- The American Academy of Pediatrics Task Force on Mental Health recommends best practice for screening for suicide to be direct questioning and use of validated self-report measures.[20]
- U. S. Preventative Services Task Force recommends annual depression screening for all 12 to 18 year olds.[21]
- Establishing clear and manageable protocols that detail actions to take in the follow-up after screening, as well as promoting competence among medical professionals in their ability to manage this issue in the primary care setting, have been determined to be imperative.[22]
- A number of instruments have been found to be useful in identifying suicide risk and can be used across settings, including inpatient, outpatient, psychiatric and nonpsychiatric; for example, the PHQ-9 has been found to be particularly effective in identifying suicide risk among patients in primary care settings.[23] Other valid instruments are listed below:
    - Columbia – Suicide Severity Rating Scale (C-SSRS)
    - Adapted-SAD PERSONS Scale (A-SPS) designed for use with children and youth
    - Inventory of Suicide Orientation-30 (ISO-30) for use with adolescents
    - Measure of Adolescent Potential for Suicide (MAPS)
    - Patient Health Questionnaire-9 (PHQ-9): a nine-item instrument developed within the PRIME-MD set of instruments; designed for use in primary care and nonpsychiatric settings.
    - Suicidal Behaviors Questionnaire for Children (SBQ-C): a 4-item instrument that assesses suicidal ideation and behaviors in children younger than age 10.
    - Suicide Ideation Questionnaire (SIQ) for grades 10-12 Suicide
    - Ideation Questionnaire JR (SIQ-JR) for grades 7-9
    - The National Institute of Mental Health (NIMH) offers the Ask Suicide-Screening Questions (ASQ) toolkit as a useful resource specifically for medical settings (Emergency Department, Inpatient Medical/Surgical Unit, Outpatient primary care/specialty clinics) to assist in identifying youth age 10 to 21 years who are at risk for suicide[24] The toolkit includes the ASQ, directions for use, a guide that provides directives when a suicide screen is positive, information for nurses, resources for parents/patients and educational videos.
- The American Academy of Pediatrics endorses primary care provider screening of youth for depression. The following instruments are used in primary care settings to assess for symptoms

associated with depression in youth: [25]

- Children's Depression Inventory (CDI): a 27-item self-report questionnaire that assesses symptoms associated with depression in youth ages 7 – 17.
- Center for Epidemiological Studies – Depression Scale for Children (CES-DC): a 20-item instrument that assesses symptoms associated with depression in youth ages 12-18.
- Pediatric Symptom Checklist: A 35-item self-report questionnaire for youth ages 3-16.
- Short Mood and Feelings Questionnaire (SMFQ): a 13-item instrument that assesses emotional functioning in youth ages 6 – 17.
- Reynolds Adolescent Depression Scale (RADS): a 30-items survey assessing symptoms associated with depression among youth ages 13-18.
- Reynolds Child Depression Scale (RCDS): a 30-item survey instrument assessing symptoms associated with depression among youth ages 8-12.

Youth Interviews

If the need for further assessment is warranted, youth should be interviewed separately from the parent to offer them the privacy they may need to express themselves openly.

- Information should also be sought from parents and other appropriate individuals.
- Safety takes precedence over confidentiality; if the youth is at risk of harm to self or others, necessary action needs to be taken.
- Assess access to resources needed to carry out any self-harming plan and remove access to these means; involvement of parents/caregivers in the safety plan will be important.
- Assess coping resources, available support systems, and youth and parent attitude toward obtaining treatment.

Suspected Risk for Self-Harm

If risk assessment results in determination of any suspected risk for self-harm:

- Further evaluation immediately by a mental health professional is warranted and should be arranged to take place during the office visit.
- Immediate assessment options could include referral for a same-day appointment with a mental health professional, hospitalization, referral to the nearest hospital emergency room for further psychiatric evaluation for need for placement in a psychiatric facility for stabilization.
- The youth should be referred for psychotherapy services and psychiatric evaluation for necessity of medication to address psychological functioning.
  Maintaining contact with the suicidal adolescent and collaboration with mental health providers ensures continuity of care and has been shown to increase adherence to treatment recommendations.
- If antidepressant medications are prescribed and/or doses are changed, following the Food and Drug Administration's (FDA) black-box warning of increased risk of suicidal ideation and resulting recommendation to closely monitor symptoms for worsening and/or suicidal ideation is imperative.[26]

Risk for Self-Harm Not Imminent

Recommendations for situations when risk for self-harm is not imminent:

- It remains important to develop a safety plan that includes resources that can be sought out if risk for self-harm should develop (e.g., identify at least one adult the child can talk to, provide

hotline information, and provide a list of coping skills). Referrals for counseling services would be beneficial in an effort to prevent any identified emotional and/or behavioral symptomology from progressing.

- Whether there is imminent risk or not, displaying and/or providing the following phone numbers as a resource to youth to access in times of need could save a life:
  Arkansas Crisis Center: (888) 274-7472
  National Suicide Prevention Lifeline: (800) 273-TALK (8255)

This guideline was developed to improve health care access in Arkansas and to aid health care providers in making decisions about appropriate patient care. The needs of the individual patient, resources available, and limitations unique to the institution or type of practice may warrant variations.

References

1. Arkansas Department of Health Injury Prevention Suicide. https://www.healthy.arkansas.gov/news/detail/suicide-the-leading-cause-of-violent-death-in-arkansas. Accessed November 10, 2018.
2. Centers for Disease Control and National Suicide Statistics at a Glance. http://www.cdc.gov/ViolencePrevention/suicide/index.html Accessed November 10, 2018.
3. Shain BN. Suicide and suicide attempts in adolescents. Pediatrics 2016;138(1): e20161420; DOI 10.1542/peds.2016-1420.
4. Pfeffer C. Assessing suicidal behavior in children and adolescents. In R. A. King and A. Apter (eds) Suicide in Children and Adolescents. New York: Cambridge University Press; 2003:211-26.
5. Cash SJ, Bridge JA. Epidemiology of youth suicide and suicidal behavior. Curr Opin Pediatr 2009;21(5):613-9.
6. Shain BN. Suicide and suicide attempts in adolescents. Pediatrics 2007;120(3):669-76.
7. Karch DL, Logan J, McDaniel DD, Floyd CF, Vagi KJ. Precipitating Circumstances of Suicide Among Youth Aged 10-17 Years by Sex: Data From the National Violent Death Reporting System, 16 States, 2005-2008. J Ado Heal 2013; 53(1):S51-S53.
8. Brunstein Klomek A, Marrocco F, Kleinman M, Schonfeld IS, et al. Bullying, depression, and suicidality in adolescents. J Am Acad Child Adolesc Psychiatry 2007;46(1):40-9.
9. Hinduja S, Patchin JW. Bullying, cyberbullying, and suicide. *Arch Suicide Res*. 2010;14(3):206–221pmid:20658375.
10. Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. Child Abuse Negl 2008;32:607–19.
11. Swanson SA, Colman I. Association between exposure to suicide and suicidality outcomes in youth. *CMAJ*. 2013;185(10):870–877pmid:23695600.
12. Gould MS, Kleinman MH, Lake AM, Forman J, Midle JB. Newspaper coverage of suicide and initiation of suicide clusters in teenagers in the USA, 1988-96: a retrospective, population-based, case-control study. *Lancet Psychiatry*.2014;1(1):34–43pmid:26360401.
13. Mustanski, B & Liu, RT A Longitudinal Study of Predictors of Suicide Attempts among Lesbian, Gay, Bisexual and Transgender Youth. *Arch Sex Beh* 2013; 42(3): 437-448.
14. Keyes MA, Malone SM, Sharma A, Iacono WG, McGue M. Risk of suicide attempt in adopted and nonadopted offspring. *Pediatrics*.2013;132(4):639–646pmid:24019414.
15. Messias E, Castro J, Saini A, Usman M, Peeples D. Sadness, suicide, and their association with video game and internet overuse among teens: results from the youth risk behavior survey 2007 and 2009. *Suicide Life Threat Behav*.2011;41(3):307–315pmid:21463355.
16. American Foundation for Suicide Prevention. Suicide Risk Factors and Warning Signs. http://afsp.org/about-suicide/risk-factors-and-warning-signs/ Accessed November 10,

2018.
17. American Academy of Child and Adolescent Facts for Families #10: Teen suicide. http://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx. Accessed November 10, 2018.
18. Greydanus DE, Calles J Jr. Suicide in children and adolescents. Prim Care 2007;34(2):259-73.
19. 2012 National Strategy for Suicide Prevention https://www.ncbi.nlm.nih.gov/pubmed/23136686 Accessed November 10, 2018..
20. American Academy of Pediatrics Task Force on Mental Health. Pediatrics

2010;125(S3):S133-9.
21. US Preventative Services Task Force. Screening for Child and Adolescent Depression in Primary Care Settings. http://www.uspreventiveservicestaskforce.org/uspstf09/depression/chdeprart.htm. Accessed November 10, 2018..
22. Taliaferro LA, Hetler J, Edwall G, Wright C, et al. Depression screening and management among adolescents in primary care: factors associated with best practice. Clin Pediatr (Phila) 2013;52(6):557-67.
23. Simon GE, Rutter CM, Peterson D, Oliver M, et al. Does response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt of suicide death? Psychiatr Serv 2013;64(12):1195-1202.
24. National Institute of Mental Health. Ask Suicide-Screening Questions (ASQ) Toolkit. https://www.nimh.nih.gov/labs-at-nimh/asq-toolkit-materials/index.shtml. Accessed November 10, 2018.
25. Williams SB, O'Connor E, Eder M, et Screening for Child and Adolescent Depression In Primary Care Settings: A Systematic Evidence Review for the U.S. Preventive Services Task Force [Internet]. Rockville(MD): Agency for Healthcare Research and Quality (US); 2009 Apr. (Evidence Syntheses, No. 69.) 1, Introduction. Available from: http://www.ncbi.nlm.nih.gov/books/NBK35129/.
26. US Food and Drug Administration. FDA public health advisory: suicidality in children and adolescents being treated with antidepressant medications. Available at: www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm155488.htm. Accessed November 10, 2018.