Suicide Assessment and Documentation in Children and Adolescents

A Carlat Webinar

Sandra Hyams, APRN, PMHNP

Sandra Hyams, APRN, PMHNP

John Peter Smith Hospital
Acclaim Multi-Specialty Group

Conflicts and Disclosures

None

C

Learning Objectives

After the webinar, clinicians should:

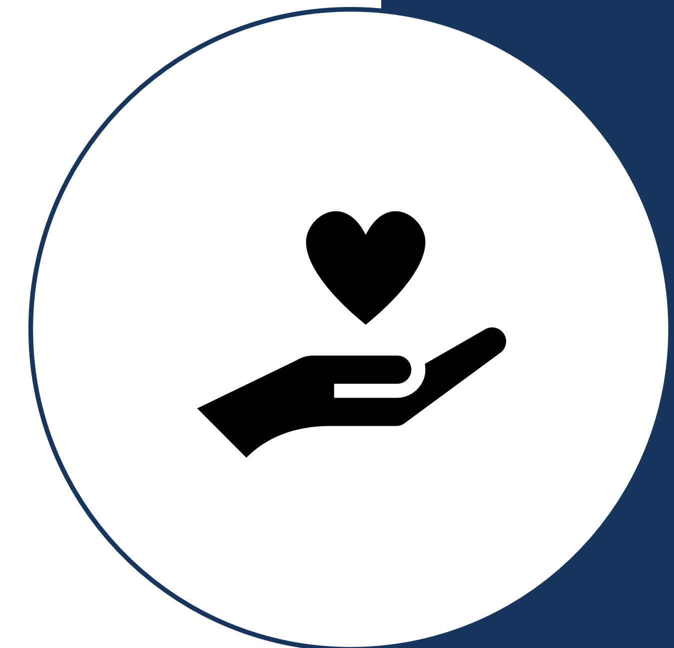
1. Understand epidemiology of suicide in children and adolescents in the United States
2. Develop competency in suicide assessment in the pediatric population
3. Explain the role and importance of documentation in suicide assessment of children and adolescents
4. Summarize some of the current research findings in psychiatric treatment

C

Why are we talking about pediatric suicide now?

Why are we talking about pediatric suicide now?

- Overall suicide rates have been increasing in children and adolescents over the last 20 years
- Many children and adolescents have warning signs
- Suicide is preventable



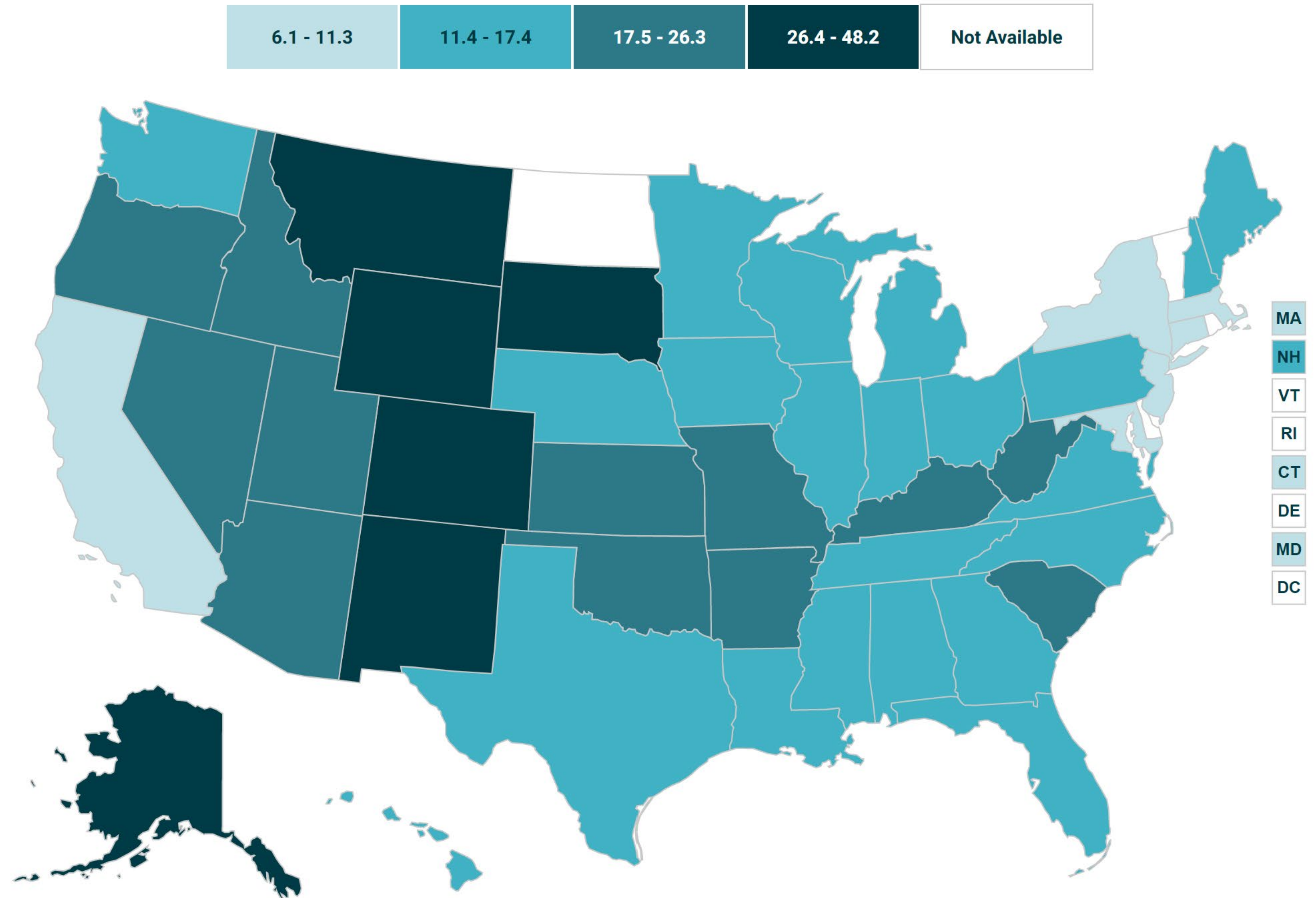
https://ourworldindata.org/suicide#suicide-rates-by-age
https://www.mhanational.org/child-and-adolescent-suicide (warning signs)

Leading Cause of Death in the United States for Select Age Groups (2020)
Data Courtesy of CDC

Rank	5-9	10-14	15-24	25-34	35-44	45-54	55-64	All Ages
1	Unintentional Injury 685	Unintentional Injury 881	Unintentional Injury 15,117	Unintentional Injury 31,315	Unintentional Injury 31,057	Malignant Neoplasms 34,589	Malignant Neoplasms 110,243	Heart Disease 696,962
2	Malignant Neoplasms 382	**Suicide 581**	Homicide 6,466	**Suicide 8,454**	Heart Disease 12,177	Heart Disease 34,169	Heart Disease 88,551	Malignant Neoplasms 602,350
3	Congenital Anomalies 171	Malignant Neoplasms 410	**Suicide 6,062**	Homicide 7,125	Malignant Neoplasms 10,730	Unintentional Injury 27,819	COVID-19 42,090	COVID-19 350,831
4	Homicide 169	Homicide 285	Malignant Neoplasms 1,306	Heart Disease 3,984	**Suicide 7,314**	COVID-19 16,964	Unintentional Injury 28,915	Unintentional Injury 200,955
5	Heart Disease 56	Congenital Anomalies 150	Heart Disease 870	Malignant Neoplasms 3,573	COVID-19 6,079	Liver Disease 9,503	CLRD 18,816	Cerebro-vascular 160,264
6	Influenza & Pneumonia 55	Heart Disease 111	COVID-19 501	COVID-19 2,254	Liver Disease 4,938	Diabetes Mellitus 7,546	Diabetes Mellitus 18,002	CLRD 152,657
7	CLRD 54	CLRD 93	Congenital Anomalies 384	Liver Disease 1,631	Homicide 4,482	**Suicide 7,249**	Liver Disease 16,151	Alzheimer's Disease 134,242
8	Cerebro-vascular 32	Diabetes Mellitus 50	Diabetes Mellitus 312	Diabetes Mellitus 1,168	Diabetes Mellitus 2,904	Cerebro-vascular 5,686	Cerebro-vascular 14,153	Diabetes Mellitus 102,188
9	Benign Neoplasms 28	Influenza & Pneumonia 50	CLRD 220	Cerebro-vascular 600	Cerebro-vascular 2,008	CLRD 3,538	**Suicide 7,160**	Influenza & Pneumonia 53,544
10	**Suicide 20***	Cerebro-vascular 44	Complicated Pregnancy 191	Complicated Pregnancy 594	Influenza & Pneumonia 1,148	Homicide 2,542	Influenza & Pneumonia 6,295	Nephritis 52,547
11	Septicemia 18*	COVID-19 32	Cerebrovascular 188	Influenza & Pneumonia 578	Septicemia 979	Influenza & Pneumonia 2,511	Septicemia 6,242	Liver Disease 51,642
12	COVID-19 17*	Benign Neoplasms 27	Influenza & Pneumonia 185	HIV 468	Nephritis 859	Septicemia 2,510	Nephritis 6,213	**Suicide 45,979**

CDC. Leading Cause of Death in the United States. 2020
https://www.nimh.nih.gov/health/statistics/suicide

Suicide deaths per 100,000 for ages 15-24



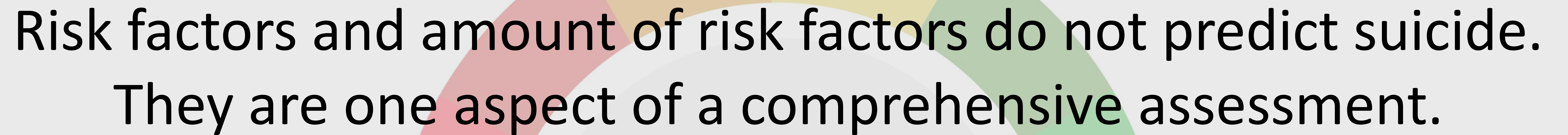
http://statehealthcompare.shadac.org/map/216/suicide-deaths-per-100000-people-by-age#147/32/248

Who Presents and Who Is at Risk?

- Previous suicide attempt
- Family history of suicide or other mental health
- Hopelessness
- Recent loss
- Depression and other psychiatric illnesses including trauma
- Substance use
- Behavior problems
- Local epidemics of suicide
- Access to lethal means
- Bullying
- LGBTQ

C

AFSP, 2020 https://afsp.org/risk-factors-protective-factors-and-warning-signs
Risk and protective factors for youth https://youth.gov/youth-topics/youth-mental-health/risk-and-protective-factors-youth



Risk factors and amount of risk factors do not predict suicide. They are one aspect of a comprehensive assessment.

RISK

NIMH. Suicide https://www.nimh.nih.gov/health/statistics/suicide.shtml#part_154969

Warning Signs

- Changes in normal behavior
- Changes at school
- Changes in mood
- Preoccupation with death
- Hopelessness

Rudd MD et al, Suicide Life Threat Behav 2006;36(3):255-262

How long for a suicidal crisis?

- Numerous studies show that near lethal suicide often is impulsive, especially in the pediatric population
- In a Houston study (Simon et al., 2005) of 152 survivors of nearly lethal suicide attempts ages 13-34, the study found that **1 in 4 deliberated less than 5 min**

Duration of Suicidal Deliberation:

24% said less than 5 minutes
24% said 5-19 minutes
23% said 20 minutes to 1 hour
16% said 2-8 hours
13% said 1 or more days

Simon OR, Suicide Life Threat Behav 2001;32(1 Suppl):49-59

Similarities & Differences in Risk Factors by Age

2016 Study by Sheftall of Nationwide Children's Hospital looked at national data on children (ages 5 to 11) and young adolescents (ages 12 to 14) who died from suicide between the years 2003 and 2012.

It compared differences of the two age groups.

Child	Adolescent
ADHD	Depression
Black	Less correlation with ethnicity
Suffocation most common method (81% used this method)	Suffocation also first likely method. But much higher rate of firearms involved

Similarities
Boys are more likely to die by suicide, Girls are more likely to attempt
Most suicides occurred between noon and midnight
Only 1/3 of youth told anyone about suicidal thoughts

C

Sheftall AH et al, Pediatrics 2016;138(4):e20160436de

WE NEED TO ASK!

- Numerous studies do not support the idea that youth get increased suicidal thoughts by asking questions about suicide
- Developmentally, kids begin to understand permanence of death with suicide at age 10
- Screenings are an effective way to SCREEN for depression and/or suicidality
- Once a patient screens positively, what’s next?

C

Dazzi T et al, Psychol Med 2014;44(16):3361-3363

Suicide/Safety Assessment

Clinical Interview is the most evidenced-based way to assess children and adolescents that have suicidal thoughts or have a history of suicidality for safety

Keys to a Good Suicide Assessment

Be Direct
Be Specific
Non-judgmental
Transparent
Keep your cool!

C

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans, behavior, and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention, and follow-up

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov

SAMHSA 2009: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

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**

SAMHSA 2009: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

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

C

SAMHSA 2009: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

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

C

SAMHSA 2009: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

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.)

SAMHSA 2009: https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4432.pdf

Key Actions

1. Always offer to interview child alone
2. Inform patient PRIOR to suicide inquiry what safety issues have to be reported to guardian or others
3. If under 18, contact guardian to:
   a) Gain collateral info
   b) Inform of safety concerns and give recommendations

Keys to Documentation

1. Have a template that helps prompt you
2. Use quotes
3. Address future-oriented thinking
4. Document anyone you contacted for collateral
5. Include a safety plan

C

Always educate and document about restricting access to means including firearms, sharps, and medications

Suicide by Method (2020) Data Courtesy of CDC	
Suicide Method	**Number of Deaths**
Total	45,979
Firearm	24,292
Suffocation	12,495
Poisoning	5,528
Other	3,664

Conclusions

- Suicide is a leading cause of death in young people and is steadily rising
- Comprehensive Assessment is key to evaluation of suicidality in children
- Documentation should include:
  - Risk Factors
  - Protective Factors
  - Suicidal Inquiry
  - Interventions and Why
  - Restricting Means

Images: ©Shutterstock/CanstockPhoto/Microsoft 365