Suicidality in adolescents

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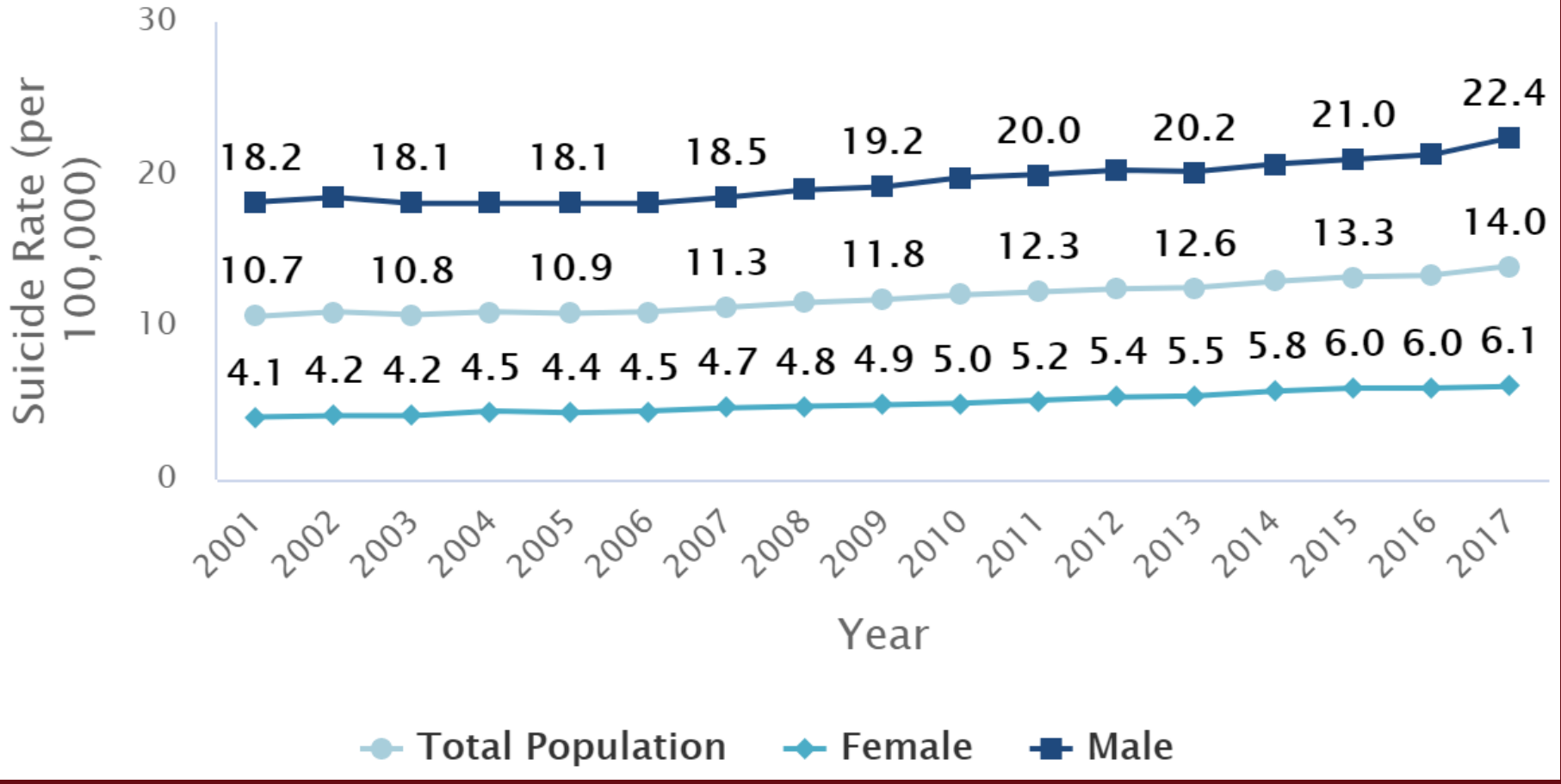
Age-Adjusted Suicide Rates in the United States (2001-2017)

Data Courtesy of CDC



Substance use!

Recent discharge from hospital

Warning signs of suicide

- Obsession with death or frequent conversations about death
- Direct or indirect threats of suicide
- Hints about life not worth living – “hopeless”, “helpless”, “I shouldn’t be here”, “it’d be better off if I wasn’t around”
- Intense and overwhelming guilt, shame, rejection
- Sudden mood improvement after period of depression that is out of the ordinary for individual
- Increased irritability
- Changes in eating or sleeping
- Changes in personality or demeanor
- Changes in school performance or involvement in other extracurricular activities
- Putting affairs in order (getting rid of important possessions)

When should I screen for suicide risk?

- Myth: asking about suicide gives an individual thoughts / ideas

- Suicide screening should be routine!
  - Preventative
  - Models to parents about discussing with youth
  - Demonstrates to youth that it's OK to talk about it

Initial suicide risk screen

If NO to all items

End screen & provide resources & education

If YES to any items

Additional risk assessment

Safety Plan

Determine Disposition

Necessary referrals / action

Documentation & follow-up

Initial suicide risk screen

asQ

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 question:

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

   If yes, please describe: _____

NIH National Institute of Mental Health

Additional suicide risk assessment

1. Praise Patient	· Validate them for sharing
2. Assess with patient alone	· Ideation: frequency, intensity, duration, note if current ideation (i.e., within past 48 hours) · Suicide plan, intent, previous behaviors/attempts · Warning signs: changes in sleep/appetite, mood, isolation, etc. · Risk factors: recent break-up or loss, family conflict, significant life change, family history, recent hospital discharge
3. Assess with parent & patient	· Share with parent · Re-assess warning signs, risk factors with parent report
4. Safety Plan (NOT safety contract)	· Identify people they will tell if having thoughts · Identify coping strategies · Determine means restriction (removal of firearms access, medications, other lethal items) · Ask patient: Do you think you need help to keep yourself safe?

Intervention	Risk & Protective Factors	Suicidality
ED referral	· Acute psychiatric symptoms, acute precipitating event · NO current mental health provider · Patient/parent doesn't feel they can stay safe	· Current and/or intense ideation with plan and intent · Past suicide behavior or attempt
Immediate mental health referral or connection to provider	· Non-acute psychiatric symptoms · Safety plan with coping strategies & contacts identified	· Suicidal ideation with plan but no intent or behavior
Non-urgent mental health referral / follow-up	· Safety plan in place · Risk factors modifiable · Few warning signs	· Thoughts of death, no plan, intent, or behavior

Provider Resources

- NIMH asQ Suicide toolkit
  - https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials/index.shtml
- Suicide Resource Prevention Center
  - https://www.sprc.org/
- SAMHSA suicide resources
  - https://www.samhsa.gov/find-help/suicide-prevention

Patient / Parent Resources

- National Suicide Prevention Lifeline
  - 1-800-273-TALK (8255)
- 24/7 Crisis Text Line
  - Text “HOME” to 741-741
- Covenant House Nine Line
  - 1-800-999-9999