Suicidal ideation and behaviour

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Abstract
Suicide is a leading cause of death among Canadian adolescents. The present practice point provides paediatricians and child health professionals with a framework for assessing the adolescent with suicidal thoughts and/or behaviours. The epidemiological context, general considerations and practical suggestions for how to approach the suicidal adolescent are reviewed. Paediatricians can and should screen youth for mental illness and significant psychosocial stressors. Early identification and treatment of mental illness are important ways in which paediatricians can assist in self-injury prevention for adolescents who are considering suicide.

Key Words: Adolescents; Mental health; Prevention; Risk assessment; Suicide

Context
Suicide is the second most common cause of death among Canadian adolescents, representing one-quarter of all deaths among youth 15 to 19 years of age in 2011.[1] The incidence of suicide attempts peaks in adolescence. It is estimated that for every completed suicide there are as many as 20 suicide attempts.[2] Males are more likely to die from suicide; however, females are three to four times more likely to attempt suicide.[3] First Nations, Métis and Inuit adolescents are at particular risk of suicide, with four to five times greater rates of suicide in these populations compared with non-Aboriginal youth.[1][3]

Suicide among prepubertal children is rare,[1] although suicidal thoughts and attempts occur. Physicians can play an important role in the assessment and management of suicidal adolescents, both as trusted family advisors regarding child health concerns and as front-line clinicians in acute care settings. As such, paediatricians and primary care clinicians need to know how to assess suicidal ideation and behaviour among children and adolescents, and identify those at greatest risk for suicide. The objective of the present practice point is to provide practical, accessible information for health care professionals regarding the assessment of suicidal ideation and behaviour, and the factors associated with increased risk of suicide. Because the incidence of suicide attempts and completed suicide in the adolescent age group is considerably higher than that in younger children, the present practice point focuses on the adolescent assessment.

General considerations
Assessment of the suicidal individual requires assessment of the suicidal behaviour, the mental health history and context in which it has occurred, and evaluation of the underlying precipitating, promoting and protective factors in the adolescent’s environment. In addition to interviewing the adolescent alone, collateral information from parents and others who know the patient or the context well should be obtained. Adolescents should be informed of the limits to confidentiality as early in the assessment as possible. Although protection of the right to privacy is important, confidentiality is not absolute. Clinicians must use their judgement to determine whether the level of risk to the adolescent’s life warrants the breach of the adolescent’s confidentiality to obtain necessary collateral information.

Clinicians should screen for the presence of the following risk factors, which are known to be associated with increased risk of suicide:

Mental illness
Mental illness is an important risk factor for adolescent suicide.[4][5] A history of mental illness is present in up to 90% of adolescents who have died by suicide.[6][7]
Depression is most strongly associated with suicidal ideation and behaviour; however, other mental disorders, including substance use disorders, conduct disorder and other less common disorders (for example, bipolar disorder, psychotic disorders) also confer increased risk of suicide. The potential risk of suicidal behaviours among adolescents currently treated with a selective serotonin reuptake inhibitor may be considered. The reader is directed to the Canadian Paediatric Society’s position statement, ‘Use of selective serotonin reuptake inhibitor medications for the treatment of child and adolescent mental illness’, for further discussion of this topic. Although onset of mental illness frequently occurs in the adolescent years, it may be ≥10 years before identification and treatment initiation. Clinicians should screen suicidal adolescents for mental illness and inquire about a history of psychiatric disorders. Health care practitioners should consider referring adolescents with potential or confirmed mental illness for psychiatric assessment.

Prior deliberate self-harm or suicide attempt
A previous suicide attempt is one of the strongest predictors of suicide during adolescence, and lifelong. The presence of deliberate self-harm behaviour (eg, cutting, burning) has also been associated with increased suicidal risk. However, self-harm behaviours may or may not be associated with suicidal intent. Clinicians should ask adolescents if their self-harm behaviours are made with intent to cope with emotional pain or with suicidal intent. In addition, clinicians should inquire about a history of previous self-harm and suicidal behaviour.

Impulsivity
Adolescents who act impulsively are at greater risk of acting on suicidal thoughts and using more lethal means to attempt suicide. Clinicians should screen suicidal adolescents for a history of impulsive behaviour (eg, physical aggression, risk-taking behaviours).

Precipitating factors
It is important to understand the factors that precipitated the suicidal thoughts or attempt to be able to address these stressors, or the adolescent’s reaction to them, directly. Stressors leading to feelings of rejection, inadequacy, humiliation, shame and loss are particularly salient. Common precipitants of suicidal behaviour among adolescents include the break-up of a romantic relationship, conflict with family or peers, recent or impending academic disappointment, bullying (including cyberbullying over social media), disclosure of homosexual orientation, and legal involvement or impending court proceedings. Among adolescents with a history of physical or sexual abuse, situations or interactions that have triggered memories or feelings associated with past abuse are also associated with increased suicidal behaviour. Finally, the clinician should inquire about exposure to suicide via the media or people known to the adolescent, because this is associated with increased suicidal behaviour.

Family factors
Family conflict, and poor child-parent communication in particular, are associated with increased suicidality among adolescents. Parental mental illness and family history of suicide are also risk factors for adolescent suicidal behaviour. Clinicians should include family psychiatric history in their assessment and ask about communication and conflict within the family to determine the degree to which family factors may either exacerbate or support the adolescent’s mental state.

Lack of connection to psychosocial support
A supportive environment is essential to stabilize an adolescent’s mental state; the lack of a clear follow-up plan with appropriate psychosocial support may be an indication for hospitalization. Evaluation of psychosocial context includes consideration of environmental factors (for example, adolescents living in First Nations, Métis and Inuit communities are at increased risk for suicide) and availability of support. The absence of a solid follow-up plan that ensures mental health monitoring and psychosocial support is an important risk factor for the clinician to consider in the assessment of a suicidal adolescent.

Assessing a recent suicide attempt and current suicidality
Assessment of 1) the adolescent’s thoughts about suicide and 2) the suicide attempt itself are central components of the evaluation. Intoxicated adolescents with suicidal ideation and behaviour should be assessed following clearance of the psychoactive substances, which may affect the mental status examination.

1) There are several aspects of suicidality for health providers to consider when interviewing the adolescent:
**Ideation**
Clinicians should ask about the frequency, intensity and quality of the suicidal thoughts that the adolescent has experienced, recognizing that these may fluctuate over time. Frequency refers to the number of times (eg, daily, weekly) that suicidal thoughts occur, whereas intensity refers to their degree of preoccupation with these thoughts when they do occur. Adolescents may experience passive thoughts of death (eg, “If I died I would be okay with it” or “I wish I could just go to sleep and never wake up”) or active suicidal ideation (eg, “I’m gonna end it”). Questions probing suicidal ideation may include:

- “Do things ever get so bad for you that you think about dying?”
- “Do you ever think about ending your life?”
- “How often do thoughts like that happen?”
- “How long do the thoughts last?” and
- “When you have a thought like that, how difficult is it for you to distract yourself?”

The number and variety of coping strategies that the adolescent uses to manage suicidal thoughts, and their perceived effectiveness, should also be elicited. Of key importance is the degree to which an adolescent lacks hope that his/her situation and feelings will improve in the future (eg, “Do you have hope that things will get better?”). The presence of significant hopelessness should alert the clinician to increased suicidal risk.

**Intent**
Among adolescents experiencing suicidal ideation, the presence of suicidal intent should be assessed. Questions regarding suicidal intent may include:

- “Have you ever thought of acting on your thoughts?”
- “Do you want to end your life?”
- “Have you thought that you might try and end your life?”

Eliciting the adolescent’s reasons for living (eg, “What has stopped you from ending your life?”) or ambivalence with respect to their suicidal thoughts is also an important part of the individual assessment.

**Plan**
Paediatricians should ask adolescents who endorse suicidal ideation whether they have a plan to end their life and ascertain the details of their plan, if present. Questions probing the presence and details of a plan may include:

- “How would you end your life?”
- “What have you thought of doing to end your life?”
- “How close have you come to <insert plan; eg, taking an overdose>?”

For an identified plan, paediatricians should determine whether the adolescent has access to the means necessary (eg, firearms, medications) to carry out his/her plan.

2) When taking a history about the suicide attempt, the clinician should determine:

- The method of the attempt;
- Whether it was impulsive or planned;
- The lethality of the method used;
- The anticipated outcome;
- Steps taken to decrease the likelihood of being discovered (if any); and
- In the case of poisoning or substance misuse, feelings of anxiety or regret that led the adolescent to seek help following the attempt. The circumstances that led to parental awareness of the attempt and medical attention should also be elicited.

Ultimately, the paediatrician must determine, based on data gathered from the evaluation of the adolescent, the family and other collateral sources, the environmental context, and available supportive resources, the most appropriate avenue for adolescent care. Adolescents who are appropriate for outpatient management should receive clear instruction regarding the importance of communicating suicidal thoughts or behaviours to identified trusted adults; the need for mental health follow-up care; the availability of local crisis services and telephone lines; and use of the emergency department if necessary.

Parents and/or guardians should be encouraged to allow open communication with the adolescent, particularly regarding negative feeling states and suicidal thoughts, and to ensure the home environment
is safe. In addition to supportive family and friends, mental health supports may include a counsellor at school, at a health clinic or community health centre (including urgent mental health services), a physician or a private therapist. Because adolescent-specific mental health supports are limited in some communities, clinicians must assess the type and availability of mental health support available to the adolescent in their community and ascertain that (i) the adolescent is willing to follow up with this individual, and (ii) the adolescent views the connection as positive and supportive. Adolescents judged to be at substantial risk of suicide should be referred for psychiatric evaluation and, if necessary, for assessment in the emergency department and hospitalization.

**Screening tools**

Several validated suicide scales are available. The Columbia Suicide Severity Rating Scale is one example of a widely used, brief, self-administered scale that can be administered by non-mental health professionals. These may be useful screening tools; however, these measures should not replace clinical assessment. Any child or adolescent scoring high on a suicide scale should receive clinical evaluation.

**Summary**

Suicide is a leading and preventable cause of death among Canadian children. Adolescents who have attempted suicide are a high-risk group who require assessment of their mental state including current suicidal thoughts and behaviours, and assessment of the key risk factors known to be associated with eventual suicide. Of adolescents who die as a result of suicide, most are struggling with mental illness. Paediatricians have an important role in identifying and facilitating treatment for mental illness.

**Selected resource list**

- Canadian Mental Health Association. For information on youth mental health and how to contact Canadian Mental Health Association locations, go to: www.cmha.ca/mental-health/your-mental-health/youth/
- Children’s Mental Health Ontario has information for clinicians and families, with contact details for children’s mental health organizations in Ontario: www.kidsmentalhealth.ca
- Kids Help Phone is a free, national, bilingual anonymous 24-hour helpline for teens. Their website has resources and information on common mental health topics for adolescents: www.kidshelpline.ca/Teens/Home.aspx
- Information for parents and caregivers about adolescent mental health topics, including self-harm and safety: http://headspace.org.au/family/category/parent-information#categories
- Helpful reviews of nonsuicidal self-injury and evidence-based treatment approaches:

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**References**

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