ACUTE MANAGEMENT OF CHILD AND ADOLESCENT SUICIDALITY

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Financial Disclosure

I have no relevant financial relationships with any commercial interests.



Review statistic on suicide in children and adolescents nationally and in Colorado.

2

Discuss screening of suicidality in children and adolescents, including identification of risk and protective factors.

3

Identify brief interventions for suicidality and strategies for making decisions on levels of psychiatric care.

Objectives

2016 1,39.9 10 Deaths per 100,000 in specified group 8 ¹7.6 ²6.2 ¹6.2 6 ¹5.4 5.4 4.2 4.0 4.0 3.0 ¹1.7 0.6 10-14 15-24 25-44 45-64 65-74 75 and over Age group

Figure 2. Suicide rates for females, by age group: United States, 2000 and 2016

NOTES: Suicides were identified using International Classification of Diseases, 10th Revision, underlying cause-of-death codes: U03, X60-X84, and Y87.0. Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db309_table.pdf#2. SOURCE: NCHS, National Vital Statistics System, Mortality.

¹Significantly higher than 2000 rate, p < 0.05.

²Significantly higher than rates for all other age groups in 2000, p < 0.05.

 $^{^{3}}$ Significantly higher than rates for all other age groups in 2016, p < 0.05.

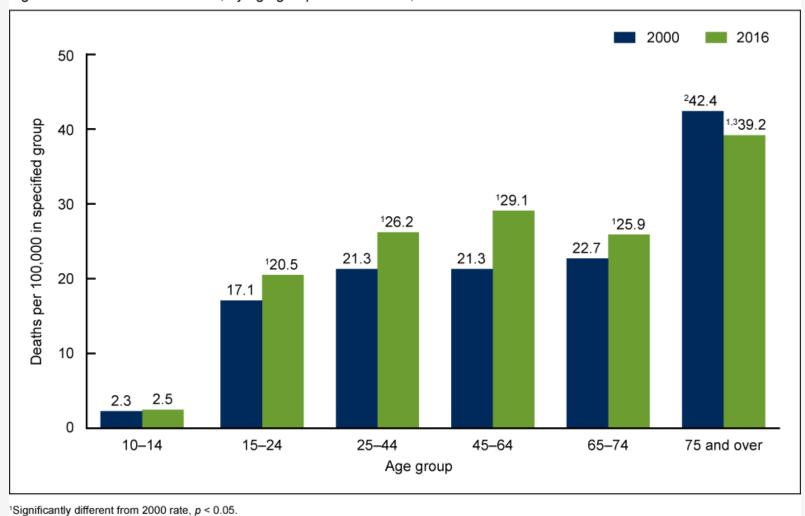


Figure 3. Suicide rates for males, by age group: United States, 2000 and 2016

NOTES: Suicides were identified using International Classification of Diseases, 10th Revision, underlying cause-of-death codes: U03, X60-X84, and Y87.0. Access data table for Figure 3 at: https://www.cdc.gov/nchs/data/databriefs/db309_table.pdf#3.

SOURCE: NCHS, National Vital Statistics System, Mortality.

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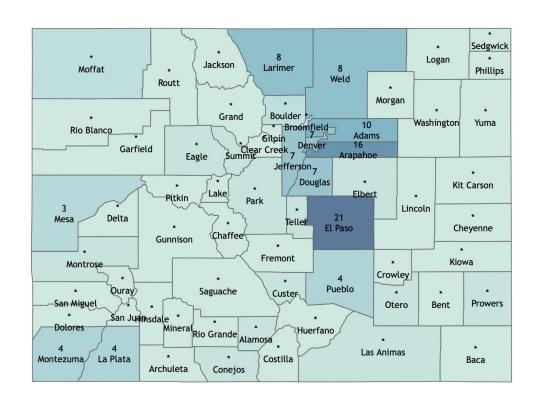
Suicides in Colorado: Counts

Colorado Vital Statisitics Program, (death certificate)

Select years:

Select method used to inflict the fatal injury:

All methods



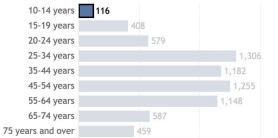
Total suicides for selected populations and years:

116

Number of suicides by demographics

Click on one or more subgroups below to filter all other charts to that group(s); click again to deselect

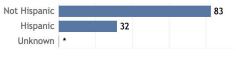




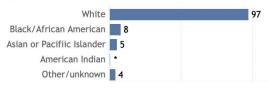
by sex



by ethnicity



by race



Suicides in Colorado: Counts

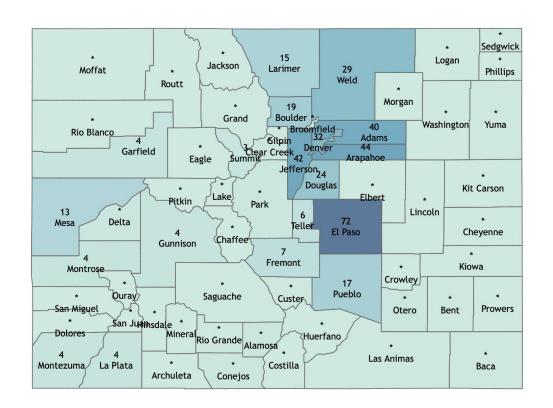
Colorado Vital Statisitics Program, (death certificate)

Select years:

2014

Select method used to inflict the fatal injury:

All methods



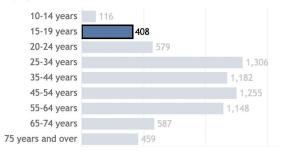
Total suicides for selected populations and years:

408

Number of suicides by demographics

Click on one or more subgroups below to filter all other charts to that group(s); click again to deselect

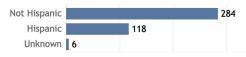
by age



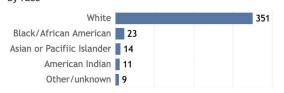
by sex



by ethnicity

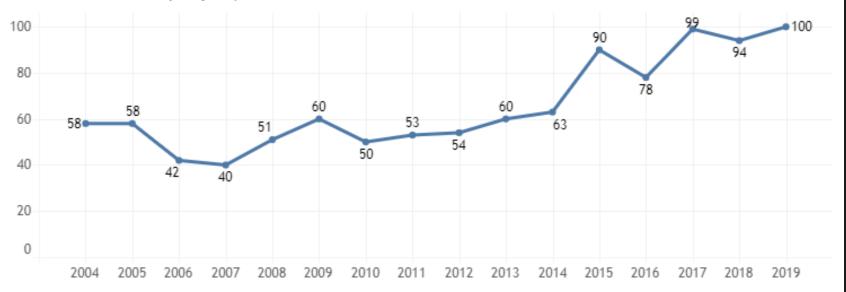


by race



<u>Selected population for all charts on this page</u>
Age: 10-14 years & 15-19 years, Sex: All, Ethnicity: All, Race: All, Marital status: All, Veteran status: All, Method: All methods, County: All

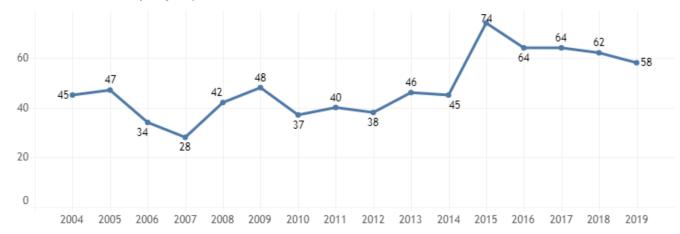
Number of suicides per year, 2004-2018



Selected population for all charts on this page

Age: 10-14 years & 15-19 years, Sex: All, Ethnicity: Not Hispanic, Race: All, Marital status: All, Veteran status: All, Method: All methods, County: All

Number of suicides per year, 2004-2018

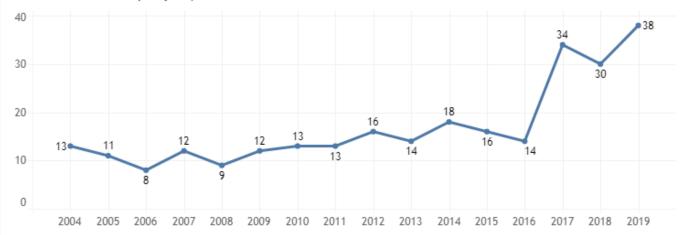


Selected population for all charts on this page

Age: 10-14 years & 15-19 years, Sex: All, Ethnicity: Hispanic, Race: All, Marital status: All, Veteran status: All,

Method: All methods, County: All

Number of suicides per year, 2004-2018



SUICIDALITY SCREENING TOOLS



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 N	National Institute of Mental Health

After administering the asQ -

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5).
 No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- 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 for safety.
 - 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. Patient cannot leave until evaluated for safety.
 - Alert physician or clinician responsible for patient's care.

SAFE-T Protocol with C-SSRS (Columbia Risk and Protective Factors) - Recent

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead Have you wished you were dead or wished you could go to sleep and not wake up?	
2) Current suicidal thoughts Have you actually had any thoughts of killing yourself?	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) Have you been thinking about how you might do this?	
4) Suicidal Intent without Specific Plan Have you had these thoughts and had some intention of acting on them?	
5) Intent with Plan Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	
C-SSRS Suicidal Behavior: "Have you ever done anything, started to do anything, or prepared to do anything to end your life?"	Lifetime
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Past 3 Months
If "YES" Was it within the past 3 months?	

Activating Events:	Clinical Status:
□ Recent losses or other significant negative event(s) (legal,	□ Hopelessness
financial, relationship, etc.)	□ Major depressive episode
□ Pending incarceration or homelessness	☐ Mixed affect episode (e.g. Bipolar)
□ Current or pending isolation or feeling alone	□ Command Hallucinations to hurt self
Tonaton ant Mistage	□ Chronic physical pain or other acute medical problem (e.g. CNS
Treatment History:	disorders)
□ Previous psychiatric diagnosis and treatments	□ Highly impulsive behavior
□ Hopeless or dissatisfied with treatment	□ Substance abuse or dependence
□ Non-compliant with treatment	☐ Agitation or severe anxiety
□ Not receiving treatment	□ Perceived burden on family or others
□ Insomnia	□ Homicidal Ideation
	□ Aggressive behavior towards others
Other:	☐ Refuses or feels unable to agree to safety plan
	□ Sexual abuse (lifetime)
	□ Family history of suicide
<pre></pre>	

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)		
Internal: □ Fear of death or dying due to pain and suffering □ Identifies reasons for living □	External: Belief that suicide is immoral; high spirituality Responsibility to family or others; living with family Supportive social network of family or friends Engaged in work or school	

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and
Behavior)

C-SSRS Suicidal Ideation Intensity (with respect to t	he most severe ideation 1-5 identified above)	Month
Frequency		
How many times have you had these thoughts?		
(1) Less than once a week (2) Once a week (3) 2-5 times in wee	ek (4) Daily or almost daily (5) Many times each day	
Duration		
When you have the thoughts how long do they last?		
	(4) 4-8 hours/most of day	
	(5) More than 8 hours/persistent or continuous	
(3) 1-4 hours/a lot of time		
Controllability		
Could/can you stop thinking about killing yourself or w	vantina to die if vou want to?	
	4) Can control thoughts with a lot of difficulty	
	5) Unable to control thoughts	
	0) Does not attempt to control thoughts	
Deterrents		
Are there things - anyone or anything (e.g., family, reli	igion, pain of death) - that stopped you from wanting to die or acting on	
thoughts of suicide?		
(1) Deterrents definitely stopped you from attempting suicide	(4) Deterrents most likely did not stop you	
(2) Deterrents probably stopped you	(5) Deterrents definitely did not stop you	
(3) Uncertain that deterrents stopped you	(0) Does not apply	
Reasons for Ideation		
What sort of reasons did you have for thinking about v	wanting to die or killing yourself? Was it to end the pain or stop the way	
you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention,		
revenge or a reaction from others? Or both?		
(1) Completely to get attention, revenge or a reaction from others	s (4) Mostly to end or stop the pain (you couldn't go on	
(2) Mostly to get attention, revenge or a reaction from others	living with the pain or how you were feeling)	
(3) Equally to get attention, revenge or a reaction from others	(5) Completely to end or stop the pain (you couldn't go on	
and to end/stop the pain	living with the pain or how you were feeling)	
	(0) Does not apply	
	Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

"The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior."

From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
High Suicide Risk Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) Or Suicidal behavior within past 3 months (C-SSRS Suicidal Behavior)	 Initiate local psychiatric admission process Stay with patient until transfer to higher level of care is complete Follow-up and document outcome of emergency psychiatric evaluation
Moderate Suicide Risk Suicidal ideation with method, WITHOUT plan, intent or behavior in past month (C-SSRS Suicidal Ideation #3) Or Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) Or Multiple risk factors and few protective factors	 Directly address suicide risk, implementing suicide prevention strategies Develop Safety Plan
Low Suicide Risk Wish to die or Suicidal Ideation WITHOUT method, intent, plan or behavior (C-SSRS Suicidal Ideation #1 or #2) Or Modifiable risk factors and strong protective factors Or No reported history of Suicidal Ideation or Behavior	□ Discretionary Outpatient Referral



Psychiatric Crisis Intervention

- Safety Planning Intervention (SPI)
 - Triggers/warning signs
 - Coping strategies
 - Social contacts (distraction)
 - Emotional support
 - Professionals and agencies
 - Means restriction

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1
2
3
Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity): 1
2.
3
Step 3: People and social settings that provide distraction:
1. NamePhone
2. NamePhone
3. Place4. Place
Step 4: People whom I can ask for help:
1. NamePhone
2. NamePhone
3. NamePhone
Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician NamePhone
Clinician Pager or Emergency Contact #
2. Clinician NamePhone
Clinician Pager or Emergency Contact #
Local Urgent Care Services
Urgent Care Services Address
Urgent Care Services Phone
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)
Step 6: Making the environment safe:
1
2.
Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express permission. Completing and submitting the form on this web page http://www.subcidesafetyplan.com/Page-8-html constitutes permission to use the template.

Coping and Safety Plan

\mathbf{S} elf-Awareness

These things may lead to strong feelings:

These are signs that I am feeling at risk of being unsafe (situations, thoughts, images, thinking styles, moods, or behaviors):

Action

When I am feeling unsafe, I will take care of myself by using these coping skills:

\mathbf{F} riendly People

I will go to these people to stay connected, or to distract myself:

Emotional Support

I will share my feelings with these friends or relatives, and I will ask them for help:

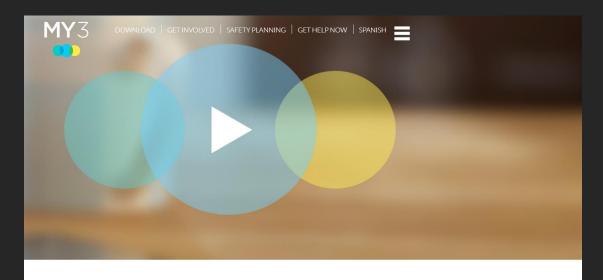
Turn to Professionals

When nothing else seems to be helping, I will call on these professionals:

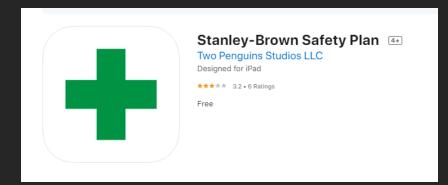
- National Suicide Prevention Line: 1-800-273-8255
- Colorado Crisis Hotline: 1-844-493-TALK (8255) or text TALK to 38255
- Crisis Text Line: Text Got5 to 741741
- Call 911

\mathbf{Y} es! I can get through this!

If I find myself unable or unwilling to follow these steps, I will remind myself:



MY3 LETS YOU STAY CONNECTED WHEN YOU ARE HAVING THOUGHTS OF SUICIDE





QUESTIONS AND DISCUSSION