Suicide Prevention in Pediatric Health Care Settings

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KEYWORDS

• Suicide • Prevention • Pediatric • Youth

KEY POINTS

- Suicidal thoughts and behaviors are prevalent among youth.
- Research has highlighted disparities in suicide risk.
- Evidence-based practices for suicide screening, assessment, and brief intervention exist, but there are barriers to implementing these practices in health care settings.

INTRODUCTION

Definitions

Suicide is a major public health problem. There are a range of actions that encompass suicidal ideation and behaviors, and it is important for clinicians to understand these differences when assessing patients (**Table 1**). For example, for suicidal ideation with a plan, a youth may have a thought to run into the street and get hit by a car to die while another youth may have a thought to access the household firearm to kill himself or herself. Suicide intent can be challenging to determine with younger children; thus a provider must rely on the child's thoughts and behaviors.[4] An example of an interrupted suicide attempt may be a youth having a plastic bag in their hand in his or her room

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Table 1
Definitions for suicidal ideation and behaviors

Suicidal Ideation and Behaviors	Definitions
Suicidal ideation	Thoughts of harming or killing oneself, includes a range of wishes of death to suicidal ideation with intent and plan[1–3]
Suicide intent	How likely someone is to act on their suicidal thoughts[4]
Suicide attempt	Potentially fatal, self-inflicted destructive behavior with the explicit or inferred intent to die, can be interrupted by some outside circumstances, or the youth can stop the attempt himself or herself[1,2,5]
Suicide	Fatal, self-inflicted destructive behavior with explicit or inferred intent to die[1,2]

to put over his or her head and his or her parent coming into the room. For another youth, this may be running the car in the garage and a friend calling him or her on the cell phone, and he or she stops the attempt. Also included in a suicide attempt is preparatory behavior toward imminently making a suicide attempt. This can include writing a suicide note or giving things away, or gathering a specific method, such as collecting pills or a rope.

The language used to discuss and impart information about suicide risk has changed over time. There have been efforts to eliminate words and phrases that are offensive, imprecise, or biased. Words recommended for removal from suicide nomenclature include completed suicide, nonfatal suicide, failed attempt, successful suicide, suicidality, suicide gesture, manipulative act, and suicide threat.[6] In addition, it is important to avoid saying committed suicide as that term indicates suicide is a sin or a crime and reinforces stigma. It is preferable to state died by suicide.[7]

Current Trends

Suicide is the second leading cause of death for young people ages 10 to 24 years of age.[8] A study examining suicide deaths among 5- to 24-year-olds in the first 10 months of the coronavirus disease 2019 (COVID-19) pandemic in 2020 showed an excess of 212 suicide deaths associated with the pandemic.[9] Furthermore, groups that had higher suicide deaths than expected were males, 5- to 12-year-olds, 18- to 24-year-olds, non-Hispanic American Indian/Alaskan Native (AI/AN) youth, and non-Hispanic Black youth. Another study of 10- to 17-year-old youth who died by suicide in 2020 and 2021 demonstrated 990 deaths, with an average age of 14.9 years and the majority being non-Hispanic White and male.[10]

Research on youth suicide is growing. According to National Survey on Drug Use and Health, which is a survey of US households, among adolescents aged 12 to 17 in 2020, 12.0%, had serious thoughts of suicide; 5.3% made a suicide plan, and 2.5% attempted suicide within a year.[11] Data from the Adolescent Behaviors and Experiences Survey, which was conducted during January to June 2021 to assess student behaviors and experiences during the COVID-19 pandemic, showed that 19.9% of students had seriously considered attempting suicide, and 9.0% made a suicide attempt in the 12 months prior to the survey.[12] Using the nationally representative sample of high school students, the Youth Risk Behavior Survey (YRBS) demonstrated significant increases from 2011 to 2021 for serious thoughts of suicide, suicide plan, and suicide attempts; however, suicide attempts with injury did not change in this time period.[13] These statistics and trends clearly highlight the high prevalence of suicide-related thoughts and behaviors.

There are notable other trends. Youth suicide rates increase with age and boys are more likely to die by suicide than girls.[14] However, suicidal ideation and attempts are higher among girls than boys.[12] In the YRBS, the percentage of girls who seriously considered attempting suicide, made a suicide plan, and attempted suicide increased from 2011 to 2021.[13] Current research is showing that firearms are the most frequent mechanism of suicide, with hanging and poisoning being also widely used.[9,10]

There are health disparities in suicidal ideation and behaviors. Recent research has highlighted trends among youth of color that warrant attention. For example, a study of suicide deaths among Black youth (ages 5–17 years) highlighted a significant trend of increasing deaths for boys (2.8%) and girls (6.6%) from 2003 to 2017.[15] Similarly, AI/AN youths ages 5 to 24 years were also identified as a group whose suicide death rates increased during 2020.[9] The YRBS recent data from 2011 to 2021 found a few trends:

Black, Latino, and White students who seriously considered attempting suicide and made a suicide plan increased.

Black and White students who attempted suicide increased.

Asian students who attempted suicide decreased.[13]

Finally, LGTBQ (lesbian, gay, transgender, bisexual, questioning) youths have been identified as a high-risk group for suicidal ideation and behavior. The Trevor Project's national survey on LGBTQ youth showed that 45% of LGBTQ seriously considered suicide in the past year, and that rate was more than 50% for transgender and nonbinary youth specifically.[16] Recent YRBS data also demonstrated that LGBTQ students and students who had any same-sex partners were more likely than their peers to attempt suicide.[13] Increased awareness and understanding of the prevalence rates and trends of suicidal ideation and behaviors for youth of color and LGTBQ youth are needed so that appropriate screening and interventions can be implemented.

SUICIDE SCREENING, ASSESSMENT, AND INTERVENTIONS

Evidence-based practices for suicide prevention, including screening, assessment, and brief intervention,[17–19] have been developed and deployed across various health care settings.[20,21]

Suicide Screening Tools

Suicide screening for youth has been conducted in several settings, including emergency departments (EDs), primary care, and schools. There are publicly available tools that screen for suicide risk.[17,22] For example, the Ask-Suicide Screening Questions (ASQ) tool has been validated and used in various medical settings, such as EDs,[17] inpatient medical and surgical units,[23] and outpatient specialty and primary care clinics.[24] In primary care, depression screeners such as versions of the Patient Health Questionnaire (PHQ) that include questions around suicidal ideation have been administered,[25–27] in accordance with guidelines recommending universal adolescent depression screening in this setting beginning at age 12.[28,29] By default, as with the PHQ, adherence to these depression screening guidelines often results in suicide screening, given that suicide risk questions are embedded within many depression screeners. Additionally, some settings have implemented both a depression screener that incorporates questions about suicidal thoughts and behaviors and a suicide-specific screener to further gauge risk.[30] Importantly, depression screening does not detect all youth at risk for suicide who would be considered at risk on a suicide-specific screener.[31]

Unlike adolescent depression screening guidelines, it should be noted that guidelines for screening adolescents for suicide risk have been more mixed.[29,32] For instance, whereas the US Preventive Services Task Force concluded that the evidence was insufficient to recommend routine screening for suicide risk in children and adolescents in primary care, the American Academy of Pediatrics (AAP) has recommended universal suicide screening for youth ages 12 and older in clinical settings.[32] The Joint Commission requires individuals age 12 and older who are being evaluated or treated for a behavioral health condition as their primary reason for care to be screened for suicidal ideation using a validated tool. Further research examining the effectiveness of suicide screening for promoting risk identification and follow-up across pediatric health care settings, including more research involving suicide-specific tools, will be important for helping to guide best practices for youth suicide screening implementation.

Brief Assessment and Interventions

Following a positive suicide screen, a brief suicide safety assessment is typically recommended to better understand risk and inform follow-up care, unless the patient is clearly at imminent risk based on his or her screening and needs an emergency evaluation.[32] Commonly used, evidence-based suicide assessment tools include measures such as the Columbia Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T).[18,33] A suicide assessment involves querying about suicidal ideation and behaviors, as well as protective factors such as reasons for living. By assessing risk and protective factors, the clinician can then determine next steps, such as whether to send the patient home or to emergency or crisis services. Trainings in suicide assessment tools are available online.[34]

Recent meta-analytic findings of studies involving youth and adults demonstrated that brief suicide prevention interventions were associated with lower odds of subsequent suicide attempts and increased likelihood of linkages to follow-up care.[35] Brief suicide prevention interventions mentioned in the meta-analysis included brief contact interventions (eg, telephone calls, letters, and postcards), care coordination (ie, bidirectional communication between the referring clinical team and the mental health care team receiving the referral), safety planning interventions, and other brief interventions (eg, therapies focused on problem-solving skills, techniques informed by motivational interviewing). The Safety Planning Intervention (SPI) is a commonly used brief intervention for addressing suicide risk.[19] The SPI includes several components:

Recognizing warning signs
Using internal coping strategies
Engaging in social settings and with specific people who can serve as a distraction
Reaching out to family or friends for help with the crisis
Contacting mental health professionals or agencies
Lethal means restriction (ie, making the environment safe)

The SPI is often implemented with adolescents and adults and was recently adapted to be a dyadic/triadic intervention for youths ages 6 to 12 and their caregivers.[36] Importantly, the SPI should be distinguished from no-suicide contracts (ie, an agreement between a clinician and patient in which the patient agrees not to harm or kill himself or herself and/or to seek help when experiencing suicidal thoughts), as experts have spoken out against no-suicide contracts given the lack of empirical support for their effectiveness in clinical settings.[37]

There is limited research concerning whether these interventions are effective with racially/ethnically diverse youth. For example, a care coordination intervention conducted in pediatric EDs was not as effective in linking youth of color with follow-up mental health care as with white youth.[38]

ADDRESSING BARRIERS

There are long-standing barriers for pediatric providers, patients, and families around identifying and managing concerns for suicide. Although there has been progress in recent years, there is a long way to go in order to overcome challenges faced across pediatric clinical settings and as a nation. Some barriers include mental health stigma, limited mental health specialists, a lack of linguistically and culturally concordant mental health providers, long wait times for evidence-based services, poor follow-up systems, lack of transportation, insurance and cost difficulties, and limited behavioral health training for general pediatricians and medical subspecialists.[39,40] One study found that for primary care settings, time constraints and competing demands were consistent barriers among clinicians and leaders, while those in specialty mental health settings reported challenges with coordinating services with schools and other community providers.[41] Additionally, many similarities in barriers were noted across evidence-based practices for suicide prevention (ie, screening, assessment, and brief intervention) and across settings (ie, primary care and specialty mental health).[41]

Local mental health services and pediatric settings will vary, but there are common steps and standards of care that can be implemented to address barriers and avoid disparities. In recent years, resources have been developed by experts to help pediatric providers integrate behavioral health practices into patient care. For example, the AAP published a mental health toolkit for pediatricians in 2021 that includes several resources to prepare practices to integrate suicide screening, assessment, and brief interventions.[42] Organizations such as Zero Suicide Institute, American Foundation for Suicide Prevention (AFSP), and Suicide Prevention Resource Center provide comprehensive guidance to improve suicide prevention and have resources to help if a patient or loved one dies by suicide.[43–45] One resource within the Zero Suicide Institute includes an organization self-study that can be used as an initial step for practices and health systems as they evaluate their current practices. Additionally, health care systems have implemented clinical pathways to help providers and minimize variability in care.[46]

A multidisciplinary approach is needed as pediatric clinical settings and health systems work to improve their current practices around suicide prevention. The AAP, AFSP, and National Institute of Mental Health recently created a Blueprint for Youth Suicide Prevention to help pediatric clinicians get started and advocate for change.[47] Each clinical setting, including pediatric hospitals, EDs, primary care sites, medical subspecialists, and pediatric behavioral health services, can identify suicide prevention champions to help gather resources, review the current care model, and plan for improved interventions. Input from a diverse team at the onset is ideal in order to get insight from all contributors, expedite solutions, and ensure diversity, equity, and inclusion. Pediatric clinicians, nurses, social workers, mental health providers, and patients and families with lived experience are examples of contributors to include in planning and monitoring practices. Other contributors could include quality improvement experts, as well as school and community members. A major overhaul of processes or initial interventions may take time. Pediatric clinicians are already under time constraints, and in order to incorporate the

planning and training needed for effective change, protected time for frontline experts and other participants is essential. There are examples of successful integrated behavioral health initiatives when teams work together in clinical settings like primary care and the ED, especially when resources are provided and using quality improvement measures.[48,49] Each clinical setting can and must start somewhere.

CASE EXAMPLE

The following case is an example of integrating behavioral health care within clinical settings and communicating follow-up needs in the patient's medical home.

A 14-year-old boy with a past history of cardiac disease presents to ED with intermittent chest pain for 3 days. At triage, he seems to be in distress and is placed in a room. After initial evaluation and interventions, he is medically cleared. As part of the ED workflow, the ASQ is implemented and positive. The medical team talks to the patient alone, discusses concerns, and reviews the next steps. A behavioral health clinician assesses the patient, uses the C-SSRS, and determines that outpatient mental health services are appropriate. A safety plan is completed and lethal-means restriction is discussed prior to discharge. The ED communicates the suicide risk and follow-up recommendations to the patient's primary care provider, because it can be difficult for patients and families to access mental health care. The primary care site has integrated behavioral clinicians who reach out to the patient and family within 2 days after ED discharge to check in. The family reports being on a 4-month wait list for an outpatient mental health provider, and they make an appointment at the primary care site to bridge care until long-term behavioral health services are established. The primary care team is able to consult a psychiatrist via a telehealth visit to discuss medication management, and the patient visits the office every 2 weeks for symptom monitoring and brief, therapeutic interventions with a trained social worker until outpatient therapy is established.

SUMMARY AND FUTURE DIRECTIONS

With the growing personal and public health toll of youth suicide, it is essential that health care systems are prepared to address youth suicide risk across the various clinical settings where children and adolescents are likely to present. Fortunately, evidence-based practices for suicide screening, assessment, and brief intervention are available, and now focus should be on ways to partner with providers, health system leaders, patients, and families to determine optimal ways to consistently implement and sustain best practices for suicide prevention in health care settings. In particular, centering the voices of youth and families from historically marginalized backgrounds in the design and implementation of suicide prevention practices will be key for ultimately reducing health inequities. Integrated care models are a key avenue for fostering multidisciplinary collaboration around caring for youth with suicidal thoughts and behaviors.[48,49] Given limited resources (eg, staff) and time are commonly cited barriers to implementing evidence-based practices in health care settings,[50] looking for opportunities to task-shift and use digital mental health tools may be necessary for increasing the reach of suicide prevention efforts. Additionally, novel predictive modeling approaches for identifying suicide risk that utilize screening results and electronic health record data warrant further investigation.[51] Because several strategies are required to successfully implement suicide prevention practices in health care settings, yet those strategies are often under-reported in efficacy and effectiveness research, increases in transparent reporting about what it takes to

implement suicide prevention practices will be critical for accelerating research-to-practice implementation.[52] The increased focus on youth mental health, particularly in the context of the COVID-19 pandemic, can pave the way for key prevention and intervention programming. Maintaining the momentum around these issues will be critical for saving young lives.

CLINICS CARE POINTS

- Suicide screening and assessment can be conducted in a variety of pediatric settings.
- There are resources for pediatric clinicians to prepare and build suicide prevention practices, such as the AAP Mental Health Toolkit.

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