SUMMARY

Suicidal thoughts and behaviour in children and adolescents: prevention, detection, assessment, management

Frontline care resources

Validated by the HAS Board on 9 September 2021

Key points

- Children and adolescents having made a recent suicide attempt or presenting a high degree of suicidal urgency must be referred to an emergency department. Those presenting a moderate to low degree of suicidal urgency should be referred to a second-line care resource.
- Suicidal thoughts in children and adolescents must not be trivialised.
- In the primary care setting, the detection of suicidal children or adolescents is based on active listening and direct questioning of the patient and/or the use of the BITS test to facilitate such screening.
- Talking about suicide does not encourage suicide attempts.
- The assessment of a suicide crisis in children or adolescents is based on evaluation of the degree of urgency and vulnerability.

Detection of children or adolescents who are suicidal or present a suicide risk

To more effectively identify children and adolescents at risk of suicidal behaviours:

- **When a child or adolescent consults for mental health problems**, or when such problems are revealed during the consultation, routinely question the child or adolescent about the existence of current, recent or past suicidal thoughts and behaviour. If required, tools such as the *Ask Suicide-Screening Questions* (ASQ) instrument can be used (see box below).
- **For all other consultations** of children and adolescents, use the *Bullying-Insomnia-Tobacco-Stress Test* (BITS) (cf. Table 1), particularly in adolescents over 12 years of age, to screen for recent or past suicidal thoughts and behaviour.

  For each theme, the highest score is retained. From a score of 3 out of 8, it is recommended that the child or adolescent be questioned about the presence of current, recent or past suicidal thoughts or behaviour, if necessary using tools such as the *Ask Suicide-Screening Questions*.

Table 1. BITS questions

Theme	Question	Response	Rating
Insomnia	Do you often have insomnia, sleep disturbances? Nightmares?	Insomnia, sleep disturbances	1 point
		Nightmares	2 points
Stress	Do you feel stressed by schoolwork or family environment? By both?	Stressed by schoolwork or family environment	1 point
		Stressed by schoolwork and family environment	2 points
Bullying	Have you recently been bullied or victimised at school, by telephone or online? And outside of school?	Bullied or victimised at school, by telephone or online	1 point
		Bullied or victimised outside of school	2 points
Smoking	Do you sometimes smoke? Every day?	Occasional smoking	1 point
		Daily smoking	2 points

ASQ questionnaire

1. In the past few weeks, have you wished you were dead?
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?
3. In the past week, have you been having thoughts about killing yourself?
4. Have you ever tried to kill yourself?

If the patient answers yes to any of the above, ask the following question:

5. Are you having thoughts of killing yourself right now?

Asking children or adolescents if they have suicidal thoughts does not put such thoughts or ideas into their heads and does not encourage suicide attempts. It is recommended to be clear and explicit when talking about the issue.

Assessment of a suicide crisis in children and adolescents

With regard to the procedures for assessing suicide crises in children and adolescents, the following recommendations are made:

- Question the child or adolescent alone at least once;
- Wherever possible, supplement this questioning by collecting information from the holder(s) of parental responsibility;
- Create a favourable context: appropriate place, empathetic, non-judgmental, kind approach, protection of confidentiality;
- Adapt the assessment to the developmental level of the child or adolescent;
- Always consider the child or adolescent's environment, particularly their interactions with their family and peers;
- Work on the assessment with family members and, for the child and adolescent concerned, with social and educational advisors, laying the foundations for a therapeutic alliance;
- If necessary, supplement the initial assessment with subsequent interviews, the timing of which should be inversely proportional to the estimated degree of urgency and vulnerability.

If adolescent minors object to their parents (holders of parental responsibility or legal guardian if applicable) being contacted, the clinician should endeavour to obtain the minor's consent to this consultation in accordance with Article L1111-5 of the French Public Health Code. In the event that the minor maintains their opposition, the clinician may implement the necessary intervention to safeguard their health or safety, including referral and placement for their protection. In this case, the minor is accompanied by an adult of their choice.

In the assessment of suicide crises, it is proposed that a distinction be made between:

- The suicidal urgency, which corresponds to the probability of the person adopting potentially lethal suicidal behaviour in the short term.
- The suicidal vulnerability, which corresponds to the probability of the person adopting suicidal behaviour in the medium and/or long term.

Assessment of suicide crises in children and adolescents is a clinical procedure. Validated standardised assessment tools, such as the *Columbia Suicide Severity Rating Scale* (see annex) can serve as a guide but cannot replace clinical decision-making.

Assessment of a suicide crisis

➔ **The assessment of suicidal urgency**:

- Assessment of the level of distress or psychological pain;
- Characterisation of suicidal thoughts: active or passive nature, intensity, frequency, duration, controllability;
- Investigation for the presence of suicide plans (method, date and circumstances), if applicable, supplemented by:
  - assessment of the degree of sophistication of plans: degree of precision in choice of method envisaged, precision and proximity of date, anticipation of circumstances, etc.,
  - assessment of the degree of danger of the plans: availability and lethality of the method envisaged, probability of the scenario;
- Assessment of the degree of suicidal intentionality: strength of intention to commit suicide, seeking help or otherwise, attitude to proposed treatments, ability to project into the future;
- Investigation of dissuasive factors (for example, family, pet, etc.).

It is recommended never to under-estimate suicidal urgency.

➔ **Assessment of suicidal vulnerability**, inferred from consideration of the individual's risk and protective factors.

- Risk factors:
  - Personal history of suicide attempts and self-harming;
  - Family history of suicide attempts and suicide and mental health problems;
  - Existence of a psychiatric disorder and/or substance use-related disorder (in particular alcohol and other psychoactive substances), as well as certain psycho-affective and behavioural characteristics (impulsivity, emotional disturbance, attachment insecurity);
  - Existence of a physical health problem or chronic illness;
  - Family problems (in particular, lack of family cohesion, parent-child relationship difficulties, conflicts within the family and neglect or abuse);
  - Existence of bullying by peers (particularly on social media);
  - Any other psychological, physical or sexual abuse;

- Populations with an increased risk: LGBT, migrants, unaccompanied minors, young people in care;

– Protective factors:
  - Family-related protective factors: family cohesion, quality of parent-child relationship, parental investment in learning and schoolwork;
  - Social support;
  - Spirituality and religious beliefs;
  - Coping strategies: ability to seek help, problem-solving abilities, academic investment;
  - ➔ Assessment of evolution of the suicide crisis (duration, evolution of intensity of suicidal thoughts, existence of precipitating factors, etc.);
  - ➔ Assessment of the child or adolescent's developmental level, particularly in terms of emotion-regulating capacities, verbalisation and conception of death.

Referral of children or adolescents with suicidal ideation or suicide attempts

The expression of suicidal thoughts in children or adolescents must never be ignored or trivialised.

Any child or adolescent having made a **recent suicide attempt** must be referred to an emergency department, irrespective of the current degree of suicidal urgency.

If the child or adolescent has **suicidal thoughts but has not made a recent suicide attempt**, the measures to be taken depend on assessment of the suicidal urgency:

- If the suicidal urgency is high, the child or adolescent is referred to an emergency department;
- If the suicidal urgency is low to moderate, the child or adolescent is referred to a second-line outpatient care resource (such as a mental health medical centre, a mental health centre aimed at children and adolescents, a non-hospital psychiatrist, or, depending on the area, an adolescent support centre);
- Except in high-urgency situations, a reassessment may be performed after two or three days in order to specify the degree of urgency and vulnerability:
  - Ask the family to remove all lethal methods or ensure they are kept out of reach;
  - Inform patients and their families of what to do in the event of worsening of the current suicide crisis or the occurrence of a new crisis;
  - Inform patients and their families of the disinhibiting effect of alcohol and other substances;

Frontline caregivers are advised to put together a list of contacts in advance, identifying general and specialised emergency services, mental health medical centres, mental health centres aimed at children and adolescents, private psychiatrists, adolescent support centres in their sector, as well as their care delivery conditions.

In the event of any doubts or questions, call the national suicide prevention helpline (**31 14**).

Appendix. *Columbia Suicide Severity Rating Scale*

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; *et al.*, J. Evaluation Lifetime/Recent. Version of 14/01/09.

SUICIDAL IDEATION

Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	Since Last Visit
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you thought about being dead or what it would be like to be dead?*** ***Have you wished you were dead or wished you could go to sleep and never wake up?*** ***Do you wish you weren't alive anymore?*** If yes, describe:	Yes ☐ No ☐
2. Non-Specific Active Suicidal Thoughts General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you thought about doing something to make yourself not alive anymore?*** ***Have you had any thoughts about killing yourself?*** If yes, describe:	Yes ☐ No ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)? What did you think about?*** If yes, describe:	Yes ☐ No ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do?*** ***This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.*** If yes, describe:	Yes ☐ No ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?*** ***What was your plan?*** ***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?*** If yes, describe:	Yes ☐ No ☐

INTENSITY OF IDEATION

The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe
Frequency ***How many times have you had these thoughts?*** ***Write response***_____ (1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Since Last Visit**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Did you do anything to try to kill yourself or make yourself not alive anymore? What did you do?*** ***Did you hurt yourself on purpose? Why did you do that?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to make yourself not alive anymore when you _____?*** ***Or did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐
Has subject engaged in Self-Injurious Behavior, intent unknown?	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted Attempt or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of preparatory acts _____
Suicide: Death by suicide occurred since last assessment.	**Yes** ☐ **No** ☐
	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____

 C-SSRS-Evaluation Lifetime/Recent (Version of 14/01/09)

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