HAUTE AUTORITÉ DE SANTÉ

RECOMMENDING BEST PRACTICES

SUMMARY

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

A&E

Validated by the HAS Board on 9 September 2021

Key points

- Suicidal thoughts in children and adolescents must not be trivialised.
- The detection of suicidal children or adolescents admitted to emergency departments is based on direct screening for suicidal ideation in the patient and/or the use of the BITS test to facilitate such screening.
- Talking about suicide does not trigger suicidal thoughts or encourage suicide attempts.
- The assessment of a suicide crisis in children or adolescents is based on evaluation of the degree of urgency and vulnerability.
- The emergency department management of children and adolescents having attempted suicide or with suicidal ideation is the dual responsibility of both emergency physicians and child or other psychiatrists.
- The decision to hospitalise or provide outpatient care for a suicidal crisis in a child or adolescent should be taken by a trained physician.
- In life-threatening situations, the medical decision to hospitalise can be made regardless of the wishes of the child or adolescent.
- A discharge letter is sent to partner professionals who will ensure the continuation of the patient's care, within the regulatory framework of shared medical confidentiality, and in consultation with the child/adolescent and their legal representative.
- Include children or adolescents having made a suicide attempt in an appropriate monitoring and re-contact system.

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

Screening strategies

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

- When a child or adolescent is admitted to an emergency department for mental health problems, or when such problems are revealed during interview, routinely question the child or adolescent about the existence of current, recent or past suicidal thoughts and behaviour. If required, tools such as the ASQ instrument can be used (see box below).
- For all other reasons for emergency department admission of children and adolescents, use the *Bullying Insomnia Tobacco Stress* (BITS) test (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 ASQ instrument, for which the questions are listed in the box below.

Table 1. BITS questions

Theme	Question	Response	Score
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 life 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. Be clear and explicit when talking about the issue.

Professional and relational context

The emergency department management of children and adolescents having attempted suicide or with suicidal ideation is the dual responsibility of both emergency physicians and child or other psychiatrists. Consequently, the following recommendations are made:

- Emergency department teams and psychiatric teams should work together continuously and closely throughout the duration of the ED stay of children and adolescents with suicidal ideation or suicide attempts;
- All ED professionals should receive training in the reception and care of children or adolescents who have attempted suicide or are suicidal.

In addition, it is recommended that a "lead" professional be designated for any child or adolescent with suicidal ideation or suicide attempts, i.e., a contact person who is easily accessible, who organises and coordinates personalised care and who guarantees the coherence of the care pathway.

It is recommended that particular attention be paid to the reception, information, confidentiality and support of families throughout the ED stay of children and adolescents with suicidal ideation or suicide attempts.

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:

- Wherever possible, question the child or adolescent alone at least once;
- Wherever possible, supplement this questioning by collecting information from the holder(s) of parental responsibility;
- Supplement this questioning with other information sources, protecting medical confidentiality (school nurse and/or doctor, general practitioner, paediatrician, etc.);
- 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;
- Where 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 safe-guard 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* 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;
- Following a suicide attempt: analysis of the attempted suicide and the intention to repeat it;
- 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.

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) and 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, presence of parent-child relationship difficulties, conflicts within the family, neglect or abuse);
  - Existence of bullying by peers;
  - 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.

Outpatient or hospital care?

In an emergency context, it is reiterated that the decision to hospitalise or provide outpatient care for a suicidal crisis in a child or adolescent should be taken by a trained physician.

The decision should integrate various criteria:

- The degree of suicidal urgency or vulnerability;
- The age of the child or adolescent;
- The wishes of the child or adolescent and holders of parental responsibility;
- The objectives in terms of assessment, care, support and maintenance of coherence of the care pathway (particularly in the event of multiple suicide attempts);
- The quality of the environment and its capacity to protect the child or adolescent;
- The outpatient resources available, their structure and their responsiveness;
- For children and adolescents having made a suicide attempt, the existence of a somatic risk.

It is reiterated that in life-threatening situations, the medical decision to hospitalise can be made regardless of the wishes of the child or minor adolescent. If at least one parent is opposed to this despite the physician's efforts to convince them, the situation may fall under the jurisdiction of the child welfare services and may justify the drafting of a judicial report to the Public Prosecutor with a view to a temporary placement order in hospital.

If a decision is made to hospitalise the patient, the department to which they are referred depends on their age and the presence of any somatic risk:

- For children, hospitalisation in a paediatric service, with the intervention of the liaising child psychiatry service or admission to a paediatric psychiatric service should be favoured;
- For adolescents, admission to a dedicated unit (adolescent paediatric, medical or psychiatric unit) should be favoured. Hospitalisation in an adult psychiatric unit should be avoided as far as possible. However, if this is necessary, care in this unit should be specifically adapted.
- In the event of a somatic risk, the child or adolescent should systematically be admitted to a paediatric or medical service, with the intervention of the child psychiatry service or the liaising psychiatric service.

If outpatient care is decided on, the following recommendations are made:

- 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;
- Make sure that a follow-up appointment is made before the patient is discharged from the emergency department;
- For children and adolescents having made a suicide attempt, include them in a monitoring and re-contact system and supply the corresponding resource cards.

On discharge from the emergency department

For each child or adolescent discharged from the emergency department following a suicide attempt, even in the absence of hospitalisation, the following recommendations are made:

- In order to guarantee continuity of care, within the regulatory framework of shared medical confidentiality, and in consultation with the child/adolescent and their legal representative, send a discharge letter to partner professionals who will ensure the continuation of the patient's care;
- Include the patient in a monitoring and re-contact system appropriate to children and adolescents having made a suicide attempt.

This document presents the main pointsof the publication: **Suicidal thoughts and behaviour in children and adolescents: prevention, detection, assessment, management**, **September 2021**
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