Rady Children's Hospital San Diego

# Suicide Prevention

Contributors:
Sandy Mueller, MSW, Director Social Work
Glenn Billman, MD, Chief Quality Officer
Revision: 2018

# Suicide is a pediatric public health problem

- Each year, approximately 149,000 youth between the ages of 10 and 24 receive medical care for self-inflicted, and approximately 4400 lives are lost each year.
- The top three methods used in suicides of young people include firearm (46%), suffocation (37%), and poisoning (8%)

# Who is at risk for suicide?

- Boys are more likely than girls to die from suicide.  Ages 10 to 24 age group: 84% versus 16%.
- Native American/Alaskan Native and Hispanic youth having the highest rates of suicide-related fatalities.

# Healthcare professionals have a role is assessing risk

- 50% of all adolescents who attempt suicide "come to medical attention" in the month before their attempt. [2]
- Many were never evaluated for suicide risk. Important to look for evidence of suicidal ideation in ALL patients. [3]
- Patients may not spontaneously report suicidal ideation, but 70% communicate their intention to significant others. [3]
- The American Academy of Pediatrics recommends that pediatricians screen for suicidality "in routine history-taking throughout adolescence, preferably at both acute care and routine care visits." [4]

# Risk Factors

May not always indicate imminent risk for suicide but refer to a person's susceptibility to suicidal thoughts or ideation, gestures, and attempts.

- History of previous suicide attempt
- Friend/Family suicide or attempted suicide
- Physical, emotional, sexual abuse
- Bullying
- Ongoing drug/alcohol use
- Depression/Anxiety
- School problems or changes in grades
- Pregnancy
- Sexuality/Sexual identity issues
- Chronic family problems – financial, divorce
- Chronic Illness

# Warning Signs

Warning signs associated with acute suicide risk. The following signs suggest of **imminent threat** of harm to oneself exists.

- Behavior Changes, severe anxiety/panic or extreme agitation
- Increase Alcohol/Drug use
- Difficulty with sleep/Insomnia
- Dramatic changes in personal appearance
- Communicating intent to kill or harm self or other suicide "talk"
- Actively looking for ways to kill oneself
- Withdrawing from family, friends, society
- Risk taking behavior or activities
- Dramatic mood changes
- Preoccupation with death/dying
- Giving away special possessions
- Loss of pleasure in usual activities

# RCHSD Depression Screening: PHQ-A

- Outpatient and Inpatients between 11–17 are screened using the **Pediatric Health Questionnaire** modified for Adolescents (PHQ-A). The 9 - item survey provides a severity of depression score.
- Clinic and Inpatient staff administer the survey.
- Each item asks the child to rate the severity of his or her depression symptoms during the **past 7 days**.
- The severity score guides patient and family education, PCP communication, and inclusion on the problem list.
- Patients who report thoughts of hurting themselves receive additional evaluation using the CSSRS.

# RCHSD Suicide Screening: CSSRS

- The **Columbia Suicide Severity Rating Scale**, or C-SSRS, is a suicidal ideation scale for children ages 11 and up. It rates an individual's degree of suicidal ideation on a scale, ranging from "wish to be dead" to "active suicidal ideation with specific plan and intent.“
- Clinic and inpatient staff administer the CSSRS. Social Work evaluates the results, and determines next steps.

# Physician Involvement:

- Be Aware and be supportive of the initiative to detect patients who are considering hurting themselves or others.
- Ensure identified at-risk patients are evaluated by psychiatry or social work.
- Address the patient's immediate safety needs and most appropriate setting for treatment.