



Complete Summary

GUIDELINE TITLE

Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. Washington (DC): American Academy of Child and Adolescent Psychiatry; 2000 Oct 17. 55 p. [189 references]

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COMPLETE SUMMARY CONTENT

- SCOPE
- METHODOLOGY - including Rating Scheme and Cost Analysis
- RECOMMENDATIONS
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- IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

Suicide and suicidal behavior

GUIDELINE CATEGORY

- Counseling
- Evaluation
- Prevention
- Risk Assessment
- Treatment

CLINICAL SPECIALTY

Emergency Medicine
Family Practice
Internal Medicine
Pediatrics
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To aid clinicians in the assessment and treatment of children and adolescents exhibiting suicidal behavior or harboring suicidal ideation

TARGET POPULATION

Children and adolescents with suicidal behavior

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment of Suicidal Patients

1. Evaluation of suicidal behavior, determination of risk for death or repetition, and assessment of underlying diagnosis or promoting factors

Treatment

1. Acute management including hospitalization, "no-suicide contracts", and referral for full evaluation
2. Psychotherapies including cognitive-behavioral therapy, interpersonal therapy, dialectical behavioral therapy, psychodynamic therapy, and family therapy
3. Psychopharmacology
 - Selective serotonin reuptake inhibitors, such as fluoxetine
 - Tricyclic antidepressants (only as second-line treatment)
 - Benzodiazepines (prescribed with caution)
 - Phenobarbital (prescribed with caution)
 - Lithium, valproate, and other mood stabilizers as treatment for bipolar disorder or other major affective disorders

Prevention and Counseling

1. Crisis hot lines
2. Public health measures, such as restricting young people's access to firearms
3. Suicide-awareness programs
4. Self-completion questionnaires

5. Risk factor identification (direct screening programs)
6. Counseling of news media on dangers of excessive coverage of suicides
7. Post-suicide counseling and interventions for friends and family

MAJOR OUTCOMES CONSIDERED

- Suicide rates
- Attempted suicide rates
- Suicide risk
- Suicide ideation and behavior
- Reliability and predictive value of suicide scales and other instruments for predicting suicide
- Treatment compliance

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature on child and adolescent suicidal behavior has burgeoned since the early 1980s. Journal articles and books published from 1980 through February 2000 were reviewed via a National Library of Medicine Medline search of the topics "suicide" and "suicidal behavior" in children and adolescents. There were over twenty thousand publications listed in PsychINFO, HealthSTAR, and Medline during this period. Only the most relevant articles are cited due to space constraints. Key references are marked with an asterisk under References. The authors also drew from their clinical knowledge and experience, writing, and research in this subject area.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The validity of scientific findings was judged by design, sample selection and size, inclusion of comparison groups, generalizability, and agreement with other studies

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Clinical consensus was determined through extensive review by the members of the Work Group on Quality Issues, child and adolescent psychiatry consultants with expertise in the content area, the entire Academy membership, and the Academy Assembly and Council.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

[MS] "Minimal Standards" are recommendations that are based on substantial empirical evidence (such as well controlled, double-blind trials) or overwhelming clinical consensus or legal and regulatory requirements. Minimal standards are expected to apply more than 95 percent of the time, i.e., in almost all cases. When the practitioner does not follow this standard in a particular case, the medical record should indicate the reason.

[CG] "Clinical Guidelines" are recommendations that are based on empirical evidence (such as open trials, case studies) and/or strong clinical consensus. Clinical guidelines apply approximately 75 percent of the time. These practices should always be considered by the clinician, but there are exceptions to their application.

[OP] "Options" are practices that are acceptable, but not required. There may be insufficient empirical evidence to support recommending these practices as minimal standards or clinical guidelines. In some cases they may be indicated, but in other cases should be avoided. If possible, the practice parameter will explain the pros and cons of these options.

[NE] "Not Endorsed" refers to practices that are known to be ineffective or contraindicated.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Four individuals are acknowledged by name for their review of the practice parameter. The full text of this parameter was reviewed at the 1999 Annual Meeting of the American Academy of Child and Adolescent Psychiatry. The full text was approved by the Academy Council on October 17, 2000.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations are identified as falling into one of four categories of endorsement. These categories, which are defined at the end of the "Major Recommendations" field, indicate the degree of importance or certainty of each recommendation.

Assessment

Assessment of suicidal patients requires an evaluation of the suicidal behavior and determination of risk for death or repetition, as well as an assessment of the underlying diagnoses or promoting factors.

Identification of Risk

Clinicians should be aware of which adolescent suicide attempters are at greatest risk for later suicide (see Table 2 in the original guideline document) [MS]. These are older (sixteen- to nineteen-year-old) male adolescents; adolescents of either gender, regardless of age, with a current mental disorder or disordered mental state, such as depression, mania or hypomania, or mixed states, especially when complicated by comorbid substance abuse, irritability, agitation, or psychosis. Attempters who have made prior suicide attempts, used a method other than ingestion or superficial cutting, and those who still want to die are also at higher risk.

Clinicians should ascertain the suicidality of depressed adolescents (i.e., whether and how often they think about suicide and whether they have ever attempted suicide). If suicidal ideation or recent suicidal behavior is present in a depressed teen, they should continue to be monitored [MS].

Assessment information should always be drawn from several sources, including child or adolescent, parents or guardians, school reports, and any other individuals close to the child. Structured or semi-structured suicide scale questionnaires, whether delivered by the clinician or self-completed by the child or adolescent, have limited predictive value. They may complement but should never take the place of a thorough assessment or substitute for any aspect of assessment.

Treatment

Treatment must encompass the acute management of suicidal behavior as well as treatment of associated mental disorders.

Acute Management

Emergency room and other crisis staff should establish a relationship with the suicidal individual and family and establish the importance of treatment [MS].

Although there have been no randomized controlled trials to determine whether hospitalizing high-risk suicide attempters saves lives, clinicians should be prepared to admit suicide attempters who express a persistent wish to die or who have a clearly abnormal mental state [MS]. Inpatient treatment should continue until their mental state or level of suicidality has stabilized [MS].

Regardless of the apparent mildness of the patient's suicidal behavior, the clinician must obtain information from a third-party. Discharge can be considered if the clinician is satisfied that adequate supervision and support will be available over the next few days, and if a responsible adult has agreed to "sanitize" the environment by securing or disposing of potentially lethal medications and firearms [MS].

The most common method used by adolescents to commit suicide in the United States is with a firearm. Ingestion of medication is the most common method adolescents use to attempt suicide. Availability and presence in the home of firearms and lethal medication must be determined during assessment, and parents must be explicitly told to remove firearms and lethal medication [MS]. It is valuable for the clinician to warn the adolescent (and their parents) about the dangerous disinhibiting effects of alcohol and other drugs [CG].

The value of "no-suicide contracts", in which the child or adolescent agrees not to engage in self-harming behavior and to tell an adult if he or she is having suicidal urges, is not known. The child or adolescent might not be in a mental state to accept or understand the contract, and both family and clinician should know not to relax their vigilance just because a contract has been signed.

If possible, an appointment should be scheduled for the child or adolescent to be seen for a fuller evaluation before discharge from the emergency room. If this is not possible, a telephone contact for parent or other caretaker should be obtained and a procedure set up clinical staff, if they have not been contacted by the parent within a reasonable period of time, to themselves initiate the contact [MS].

The clinician treating the suicidal child or adolescent during the days following an attempt should be available to the patient and family (for example, receive and make phone calls outside of therapeutic hours) or have adequate physician coverage if away [MS], have experience managing suicidal crises [MS], and have support available for him or herself [CG].

Once a therapeutic alliance is established and the adolescent attends the first treatment sessions, he or she is more likely to continue treatment.

Psychotherapies

Psychotherapy, an important component of treatment for the mental disorders associated with suicidal behavior, should be tailored to a child's or adolescent's particular need [MS]. Cognitive-behavioral therapy (CBT), interpersonal therapy

(ITP-A), dialectical behavioral therapy (DBT), psychodynamic therapy, and family therapy are all options [OP].

Psychopharmacology

As with psychotherapies, psychopharmacology to treat suicidal behavior should be tailored to a child or adolescent's placement specific needs. Lithium greatly reduces the rate of both suicides and suicide attempts in adults with bipolar disorder. Discontinuing lithium treatment in bipolar patients is associated with an increase in suicide morbidity and mortality.

Selective serotonin reuptake inhibitors reduce suicidal ideation and suicide attempts in non-depressed adults with cluster-B personality disorders. They are safe in children and adolescents, have low lethality, and are effective in treating depression in non-suicidal children and adolescents. There have been some reports that selective serotonin reuptake inhibitors may have a disinhibiting effect (especially in patients with selective serotonin reuptake inhibitor-induced akathisia) and increase suicidal ideation in a small number of adults not previously suicidal. Further controlled research is necessary to determine whether there is an association in children and adolescents. However, it would be prudent to carefully monitor children and adolescents on selective serotonin reuptake inhibitors to insure that new suicidal ideation or akathisia are noted [MS].

Tricyclic antidepressants should not be prescribed for the suicidal child or adolescent as a first line of treatment [NE]. They are potentially lethal, because of the small difference between therapeutic and toxic levels of the drug, and have not been proven effective in children or adolescents.

Other medications that may increase disinhibition or impulsivity, such as the benzodiazepines and Phenobarbital, should be prescribed with caution [OP]. Any and all medications prescribed to the suicidal child or adolescent must be carefully monitored by a third party and any change of behavior or side-effects immediately reported [MS].

Prevention

Public health approaches to suicide prevention have targeted the suicidal child or adolescent, the adults who interact with them, their friends, pediatricians, and the media.

Teens may be made aware of the existence of crisis hot lines [OP]. Although widely used, early studies, hampered by methodological deficiencies, failed to show that hot lines reduce the incidence of suicide. But it would be wise to assume that their value remains untested. Research has uncovered some hot-line deficiencies, but new studies are needed to see if correcting these problems can increase their effectiveness.

Public health measures, such as restricting young people's access to firearms may result in a short-term reduction in the rates of suicide, but there is not yet evidence that this effect would be lasting [OP]. Raising the minimum legal

drinking age for young adults appears to reduce the suicide rate in the affected age group.

Suicide-awareness programs in schools frequently minimize the role of mental illness and, although designed to encourage self-disclosure by students or third-party disclosure by their friends, have not been shown to be effective either in reducing suicidal behavior or increasing help-seeking behavior.

Because curriculum-based suicide awareness programs disturb some high risk students, a safer approach might be to focus on the clinical characteristics of depression or other mental illnesses that predispose to suicidality. In the absence of evidence to the contrary, talks and lectures about suicide to groups of children and adolescents drawn from regular classes should be discouraged [NE]. This is because of their propensity to activate suicidal ideation in disturbed adolescents whose identity is not usually known to the instructor. Screening or suicide education programs for teens that do not include procedures to evaluate and refer identified ideators or attempters are not endorsed [NE]. Direct screening programs may identify those with underlying risk factors to a clinician for further evaluation [OP].

Primary practitioners, counselors, or others who may lack the time, resources, or training to evaluate a child's or teen's mental state should make use of self-completion questionnaires to screen for depression, suicidal preoccupations, and previous suicidal behavior in their office [CG]. There is ample evidence that teens in mid to late adolescence—the group that is at greatest risk for suicide attempt and completion—will, if asked directly, reveal this information. This practice can be especially recommended to family practitioners, pediatricians, school counselors, juvenile-justice professionals, and psychologists who wish to survey their populations for teens at high risk for suicide. Those identified as being at risk should be referred for further evaluation and treatment, if necessary, and receive support and follow-up (i.e., phone calls, case manager if available) during the transition period.

Clinicians engaged in public health practice should be able to advise media reporters and editors on the dangers of excessive coverage of individual suicides [OP].

Finally, primary care physicians and gatekeepers should be trained to recognize risk factors for suicide and suicidal behavior and, when necessary, refer to a mental health clinician [CG].

Postvention

After a suicide, the relative, friends, and teachers of the child or adolescent who committed suicide may benefit from intervention to facilitate grieving, reduce guilt and depression, and decrease the effects of guilt and trauma. There may also be a call to intervene to minimize the risk of imitative or copy-cat suicides, but there is no agreement about how this should be done [CG].

Definitions:

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CLINICAL ALGORITHM(S)

An algorithm is provided that suggests how suicide occurs and highlights types of targeted preventive interventions.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Decreased suicide rates
- Decreased suicide attempts
 - In a meta-analysis of adult studies, researchers found that lithium maintenance treatment greatly reduces (8.6 fold) the recurrence of suicide attempts in adults with bipolar or other major affective disorders.
 - Studies in depressed adults have found that selective serotonin reuptake inhibitors reduce suicidal ideation and separately reduce the frequency of suicide attempts in non-depressed patients with cluster-B personality disorders with a past history of suicide-attempt behavior.
 - Psycho-educational counseling may reduce the risk for suicidal behavior in these circumstances

- Increased treatment compliance
 - One researcher described a brief emergency room crisis intervention procedure for adolescent attempters that resulted in improved compliance for at least the first outpatient follow-up visit.
- Improved symptoms
 - Cognitive-behavioral therapy has been shown to be an effective intervention for depressive symptoms

Subgroups Most Likely to Benefit:

High-risk groups are identified in tables 1 and 2 of the original guideline. In general, adolescent males (age 16 or over) are at highest risk, especially if they are previous suicide attempters.

POTENTIAL HARMS

- Lethal overdoses
 - Lithium prescriptions for children and adolescents require careful third-person supervision, as overdoses may be lethal.
 - Tricyclics should not be prescribed for the suicidal child or adolescent as a first line of treatment, because of their greater lethal potential
- Induction of suicidal ideation
 - In the past decade there has been much controversy over whether the selective serotonin reuptake inhibitor antidepressants can induce suicidal ideation and/or behavior in a small number of cases
 - One must be careful about the risk of inducing suicidal ideation or behavior through psychopharmacological activation or disinhibition.
- Akathisia
 - Some patients have been reported to have experienced akathisia after starting treatment with fluoxetine
- Reduced self-control
 - Clinicians should be cautious about prescribing medications that may reduce self-control, such as the benzodiazepines, and phenobarbital.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Practice parameters are strategies for patient management, developed to assist clinicians in psychiatric decision-making. This parameter, based on evaluation of the scientific literature and relevant clinical consensus, describe generally accepted approaches to assess and treat specific disorders or to perform specific medical procedures.

This parameter is not intended to define the standard of care; nor should they be deemed inclusive of all proper methods of care or exclusive of other methods of care directed at obtaining the desired results. The ultimate judgment regarding the care of a particular patient must be made by the clinician in light of all the circumstances presented by the patient and his or her family, the diagnostic and treatment options available, and available resources. Given inevitable changes in

scientific information and technology, these parameters will be reviewed periodically and updated when appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 Oct 17

GUIDELINE DEVELOPER(S)

American Academy of Child and Adolescent Psychiatry - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Child and Adolescent Psychiatry (AACAP)

GUIDELINE COMMITTEE

Work Group on Quality Issues

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

This parameter was developed by:

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

As a matter of policy, some of the authors to these practice parameters are in active clinical practice and may have received income related to treatments discussed in these parameters. Some authors may be involved primarily in research or other academic endeavors and also may have received income related to treatments discussed in these parameters. To minimize the potential for these parameters to contain biased recommendations due to conflict of interest, the parameters were reviewed extensively by Work Group members, consultants, and Academy members; authors and reviewers were asked to base their recommendations on an objective evaluation of the available evidence; and authors and reviewers who believed that they might have a conflict of interest that would bias, or appear to bias, their work on these parameters were asked to notify the Academy.

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available (to members only) from the [American Academy of Adolescent and Child Psychiatry \(AACAP\) Web site](#).

Print copies: Available from AACAP, Communications Department, 315 Wisconsin Avenue, NW, Washington, DC 20016. Additional information can be obtained through the [AACAP Publication Catalog for Parameters](#).

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 12, 2002. The information was verified by the guideline developer on May 1, 2002.

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