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Prevention of suicidal behaviours in children and adolescents – practical guidance for primary care physicians

Zapobieganie zachowaniom samobójczym dzieci i młodzieży – praktyczne wskazówki dla lekarza POZ

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Abstract

The growing problem of suicidal behaviours among children and adolescents poses a major challenge for society. It is important to notice and identify warning signs that may indicate a mental health crisis, and to implement appropriate management. This paper provides guidance for primary care physicians on the problem of mental health crisis in paediatric patients. The aim of the study was to present diagnostic and therapeutic approaches in children and adolescents with mental health deterioration. We present a new model of mental health care system for children and adolescents in Poland based on reference level I, II, and III centres. The study used police statistics, guidelines, research papers and expert opinions. A retrospective analysis of statistical data was conducted, based on which an increasing number of suicide attempts among children and adolescents was observed. It was also found that girls were more likely to commit suicide attempts, whereas completed suicides were more common among boys. Furthermore, warning signs of a mental health crisis, the so-called red flags, were identified, and a list of current child and adolescent mental health centres with contact details attached. The escalating phenomenon of suicidal behaviours among children and, at the same time, the limited access to child psychiatry specialists makes the education of paediatricians and the patient's immediate environment essential. Vigilant medical staff is often the only way to provide patients and their relatives with prompt and professional care.

Keywords: children, suicide, paediatrics, child and adolescent psychiatry

Streszczenie

Rosnący problem zachowań samobójczych wśród dzieci i młodzieży stanowi poważne wyzwanie dla społeczeństwa. Istotne jest zauważenie i zidentyfikowanie sygnałów ostrzegawczych mogących świadczyć o kryzysie zdrowia psychicznego oraz wdrożenie odpowiedniego postępowania. Niniejsza praca zawiera wskazówki dla lekarza podstawowej opieki zdrowotnej dotyczące problemu kryzysu zdrowia psychicznego pacjentów pediatrycznych. Celem pracy jest omówienie metod diagnostycznych i postępowania w sytuacji pogorszenia stanu psychicznego u dziecka lub nastolatka. Przedstawiono w niej nowy model systemu ochrony zdrowia psychicznego dla dzieci i młodzieży w Polsce w oparciu o ośrodki I, II i III stopnia referencyjności oraz opisano właściwe postępowanie lekarza po zachowaniu samobójczym pacjenta. W pracy wykorzystano statystyki policyjne, wytyczne, prace badawcze i opinie ekspertów. Dokonano retrospektywnej analizy danych statystycznych, na podstawie których zaobserwowano rosnącą liczbę prób samobójczych wśród dzieci i młodzieży, oraz odnotowano, że próby samobójcze są częstsze wśród dziewcząt, a samobójstwa dokonane – wśród chłopców. Ponadto wyszczególniono sygnały ostrzegawcze kryzysu zdrowia psychicznego, tzw. czerwone flagi, oraz przedstawiono aktualny spis ośrodków zdrowia psychicznego dzieci i młodzieży wraz z danymi teleadresowymi. Przytoczono skale i schematy postępowania w celu poszerzenia wiedzy i usprawnienia pracy lekarza podstawowej opieki zdrowotnej. Rosnąca liczba zachowań samobójczych wśród dzieci oraz ograniczony dostęp do specjalistów psychiatrii dziecięcej sprawiają, że edukacja lekarzy pediatrów i najbliższego otoczenia pacjenta jest niezbędna. Czujny i spostrzegawczy personel medyczny może zadecydować o szybkim objęciu pacjentów oraz ich bliskich profesjonalną opieką.

Słowa kluczowe: dzieci, samobójstwo, pediatria, psychiatria dzieci i młodzieży

INTRODUCTION – SUICIDAL BEHAVIOURS AMONG PAEDIATRIC PATIENTS

Suicide is the second leading cause of death among young people in Poland[1]. In recent years, there has been an almost two-fold increase in suicidal behaviours among individuals under 19 years of age. The 2020–2021 data for the age group 7–12 years indicate an almost 300% increase in the incidence of suicide attempts (Fig. 1)[2]. Many risk factors and alarming symptoms indicative of deteriorated mental state of children have been identified. Paediatricians play an important role in their identification[3]. Risk factors include, among others, a previous suicide attempt or suicidal ideations, a history of mental illness (mood and psychotic disorders in particular) or other chronic conditions, dependence on or experimenting with psychoactive substances, school and family factors (including attempted and completed suicides in the patient's closest environment), as well as mental trauma, e.g. sexual abuse[4–6].

Attempted suicides are more common among girls and young women, while completed suicides are more likely to occur among boys and young men, both in Poland and globally. An increased risk of suicide is also observed in the group of sexual minorities, as well as adolescents suffering from gender dysphoria[7].

A US team of experts in primary health care and prevention demonstrated sufficient efficacy of mental health screening and suicide risk assessments conducted during routine medical appointments[8]. Identification of red flags allows for rapid initiation of appropriate therapeutic and, if necessary, pharmacological interventions in collaboration with specialists.

EPIDEMIOLOGY OF SUICIDAL EVENTS AMONG CHILDREN AND ADOLESCENTS

The 1999–2022 police statistics have shown a significant increase in the incidence of suicide attempts among children and adolescents, most pronounced in the age group 13–18 years. A gradual increase in the number of suicide attempts has been noticeable since 2013 (Fig. 1). It is worth emphasising, however, that the method for data collection and processing was changed at that time. Suicide attempts are now recorded immediately after they are committed, which was previously done after an investigation. The number of completed and attempted suicides nearly doubled in 2021 (1,496 vs. 843 in 2020). The 2022 police report showed 2,093 suicide attempts by children and adolescents up to 18 years of age (including 2,008 aged 13–18 years). This is 171% more compared to 2018 and 486% more than in 2013 (Fig. 1).

The number of suicide attempts remained relatively stable between 1999 and 2013 (about 300 annually) (Fig. 1). At the same time, it should be noted that there has been a downward trend in the number of suicide deaths since 1999, with a slight increase since 2019 (Fig. 2). For comparison, up to 79% of suicide attempts by children and adolescents ended in death in 1999 compared to 7% in 2022 (Fig. 3). This may suggest that suicidal actions are a form of cry for help, and not necessarily a result of an actual desire to take one's own life.

WARNING SIGNS OF MENTAL CRISIS IN A PAEDIATRIC PATIENT

The assessment of a child's health begins the moment they enter the doctor's office accompanied by their parent. Careful observation of a child's or adolescent's behaviour (posture, facial expressions, gestures, and utterances) enables to gather valuable information about their mental health. It is important to know the so-called red flags, or warning signals that should arouse concern and elicit an appropriate response from the doctor.

The clinical picture of depression in a paediatric patient varies. The symptoms may include lowered mood and/

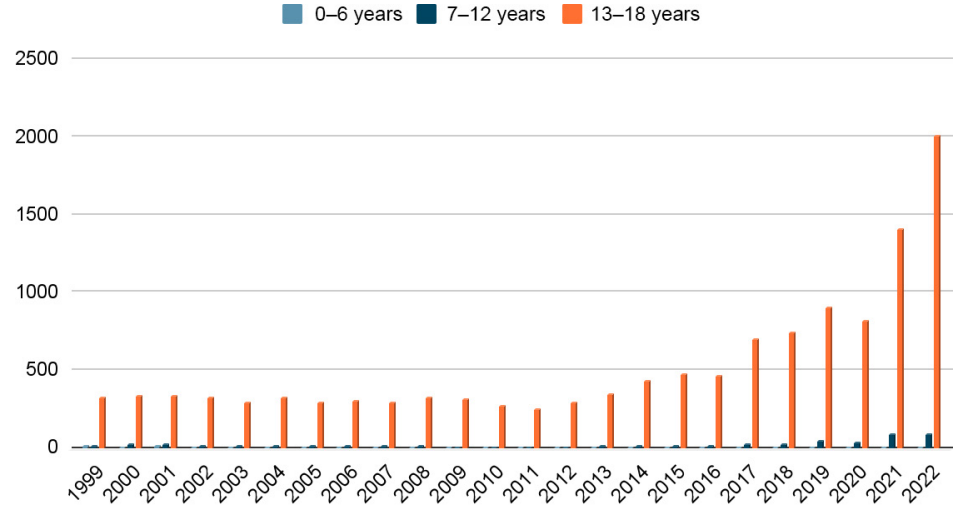

Fig. 1. Total suicide attempts between 1999 and 2022, with classification into three age groups <18 years[2]

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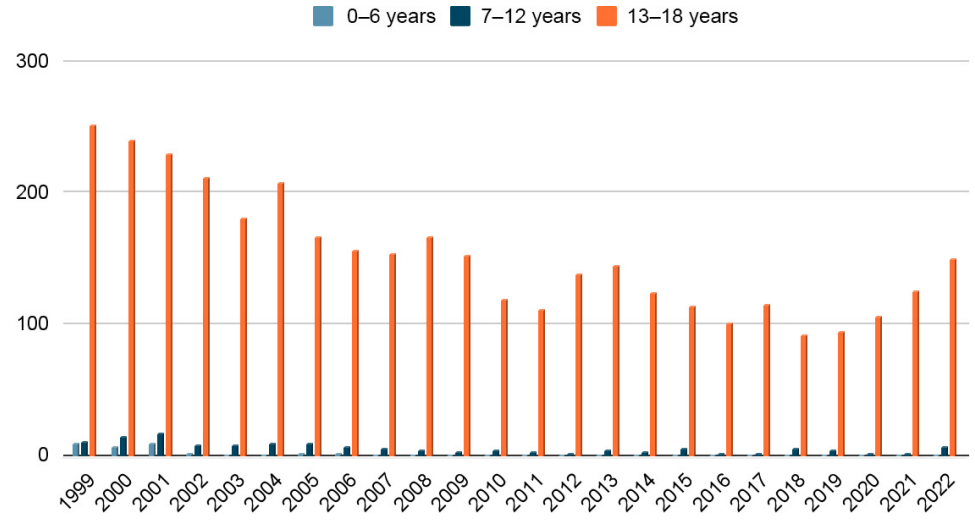

Fig. 2. Completed suicide attempts between 1999 and 2022, with classification into three age groups <18 years[2]

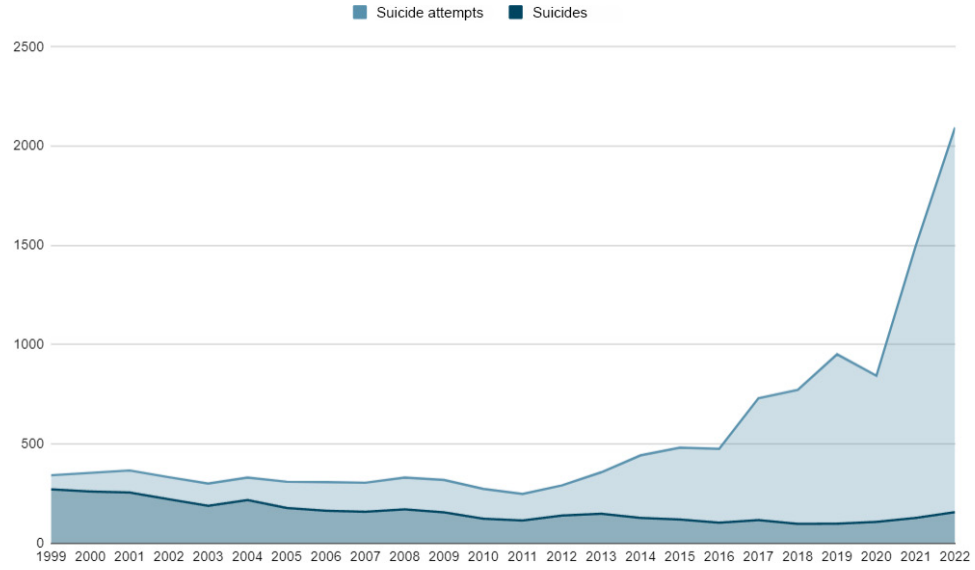

Fig. 3. Quantitative comparison of total and completed suicide attempts in the years 1999–2022 without division into age groups ≤18 years[2]

or irritability, loss of energy and/or psychomotor agitation, and poor concentration[9]. A child or adolescent may lose interest in everyday activities and experience sleep disorders (both insomnia and hypersomnia)[10]. These symptoms may in turn affect school performance, causing frequent absence or lateness, compromising academic performance and/or relationships with peers[11]. The patient may report a sense of hopelessness, helplessness or guilt, low self-esteem, leading to isolation or provocative behaviours[12]. Weight loss or weight gain may also occur. Somatisation, including abdominal pain, headaches and constipation that do not respond to treatment may be warning signs of a worsening mental state, is common among children and adolescents[13]. Depressive symptoms are among the warning signs indicating that a child or adolescent may attempt suicide. Red flags in the prevention of suicide in children and adolescents, i.e. suicidal ideations, self-harm, planning how to commit suicide or expressing a desire to die, require immediate intervention (Tab. 1).

DIAGNOSTIC METHODS IN MOOD DISORDERS AND ASSESSMENT OF SUICIDAL RISK

Various tools are used to objectively screen for a mental health crisis. The Children's Depression Inventory (CDI 2) can be used to assess depressive symptoms in children, while the Beck Depression Inventory (BDI-II) may be utilised in older adolescents and adults. Both tools are intended for use only by psychologists and other professionals who have completed training in psychometrics[5,16]. The simplified Columbia-Suicide Severity Rating Scale (C-SSRS) is a screening tool for suicidal behaviours, particularly popular in the United States[17] (Fig. 4). The Patient Health Questionnaire-9 (PHQ-9) (Fig. 5), which consists of 9 main items and 1 additional item, can be used for

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Red flags in child and adolescent suicide prevention
• Sudden change in behaviour • Feeling of purposelessness, hopelessness • Feeling of guilt • Sleep disturbances • Giving personal belongings away, deleting online profiles • Feeling trapped • Depressive symptoms • Withdrawal • Apathy • Recent experience of loss • Substance abuse • Anger • Unusual preoccupation with death • Unstable mood • Fear and anxiety • Acute/chronic exposure to trauma • Expressing suicidal thoughts, self-harm • Recklessness

Tab. 1. Red flags in child and adolescent suicide prevention[13–15]

prompt assessment of the mental well-being of both children and adults in primary care settings. The obtained score should be interpreted as follows:

- <5 – no depression;
- 5–9 – mild depression;
- 10–14 – moderate depression;
- 15–19 – moderately severe depression;
- >20 – severe depression[19].

INTERVENTION – WHAT CAN BE DONE AT THE LEVEL OF PRIMARY CARE?

The key role of a primary care physician in the prevention of suicidal behaviours is to identify patients who present or may present with depressive behaviours (knowledge of the above-mentioned red flags). Children and adolescents should be screened during routine check-ups and meticulous medical documentation should be kept, including an assessment of mood, manner of speech and behaviour during the visit[20]. At this point, interviews, especially with the child's parents, and their insights on changes in the child's behaviour, as well as information provided by teachers, are essential. Since a younger child will not always be able to describe their emotional state, special attention should be paid to somatic symptoms such as abdominal pain, headaches and constipation. In the case of adolescents, a short conversation about their well-being, difficult situations experienced and perception of themselves within the peer group and family may be held in the absence of parents. The patient should be undressed for physical examination so that attention can be paid to possible signs of self-destructive behaviours, e.g. scars from self-harm. The risk of mental health problems is particularly high in children with:

- underlying disease (e.g. psoriasis, diabetes mellitus);
- pathological obesity

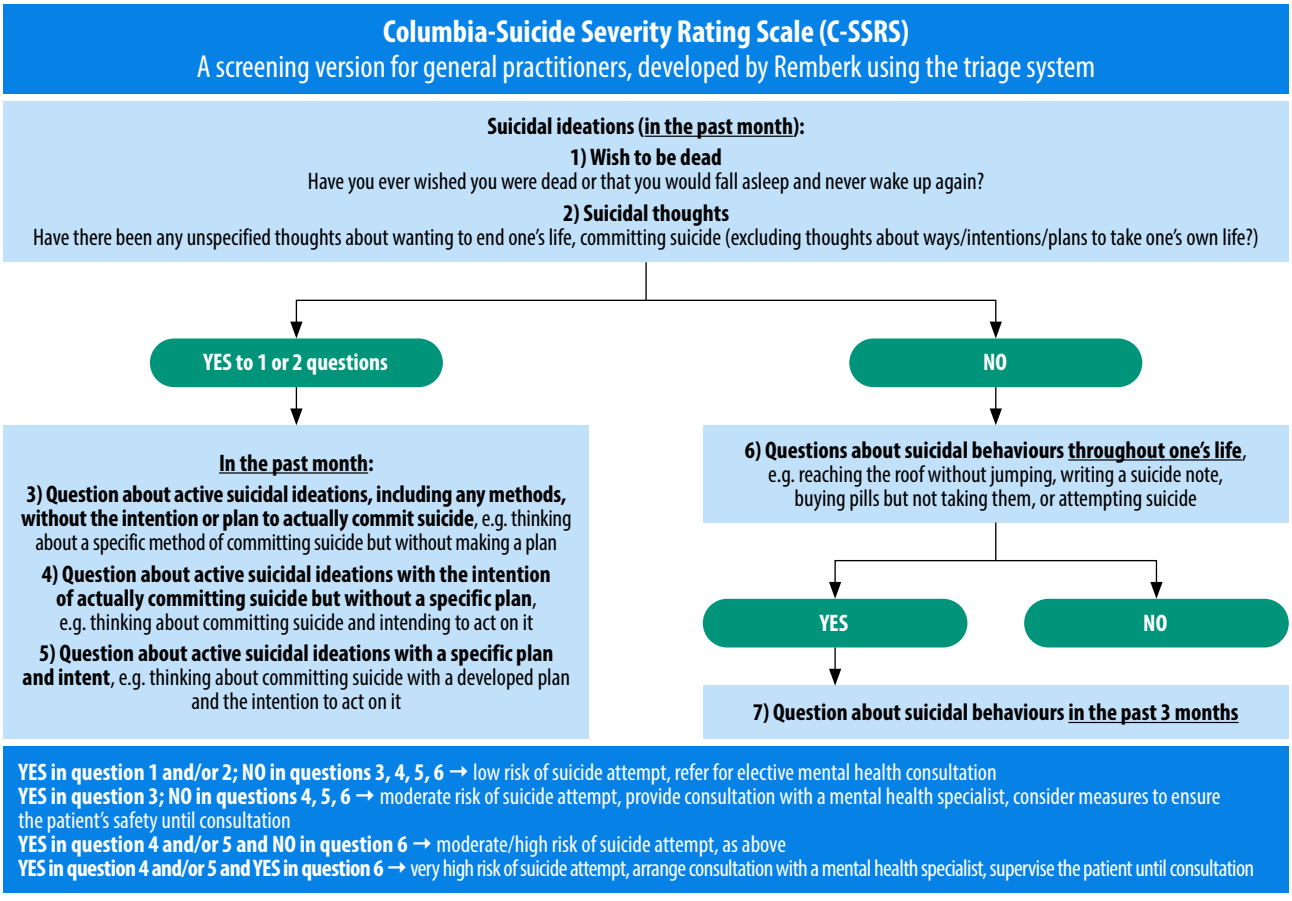

Fig. 4. Columbia-Suicide Severity Rating Scale (C-SSRS)[18]

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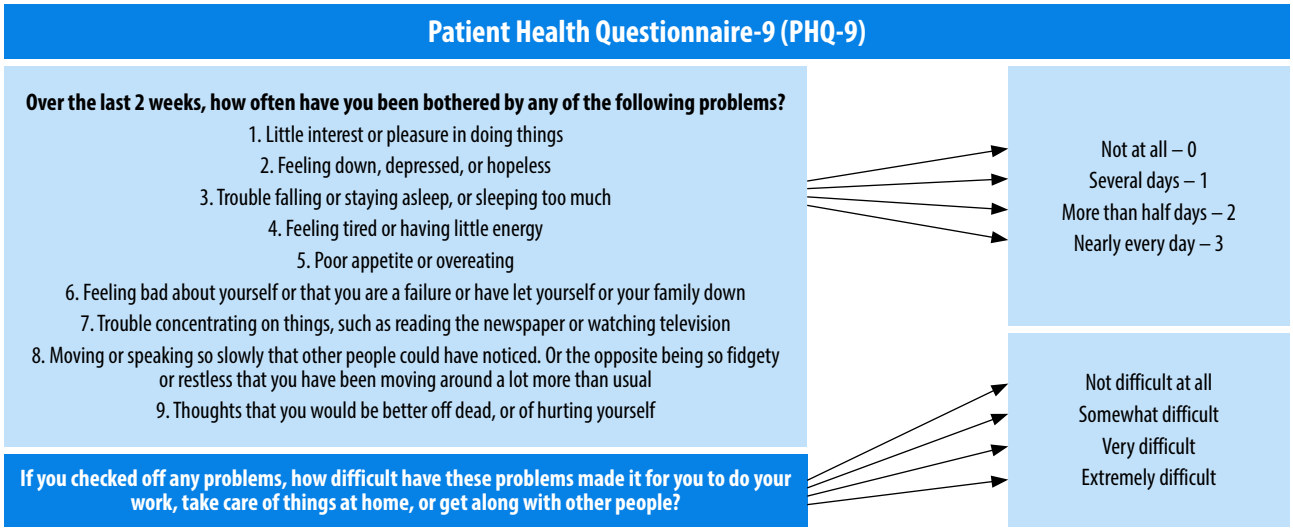

Fig. 5. Patient Health Questionnaire-9 (PHQ-9)[19]

- family history of alcoholism;
- parental psychosocial neglect;
- previous suicide attempts;
- mental illness;
- family history of depression or suicide;
- broadly understood social stigma due to ethnic background, religion, culture, socio-economic status, sexual orientation, etc.;
- history of mental trauma;
- experience of physical violence or sexual abuse;
- sleep disorders;
- abuse of alcohol or psychoactive substances[21,22].

Once mental disorder is diagnosed, it is necessary to assess whether it poses a direct threat to their life and whether the patient poses a threat for others. If the patient reports persistent suicidal ideations with intent, in the presence of other risk factors for a suicide attempt, especially insufficient parental cooperation and care, an emergency medical team should be called and the patient should be referred to the psychiatric ward for children and adolescents. If, however, the patient presents with mild suicidal ideations without intent, and is provided with good parental care, the intervention can be implemented gradually; a psychological consultation should be recommended (it is advised that such consultation be delivered by a clinical psychologist) or a consultation with a psychiatrist in the case of concomitant symptoms of mood or anxiety disorders. Based on the diagnostic workup, further treatment will be chosen, e.g. psychotherapy or other psychological interventions.

A CHANCE FOR PROMPT HELP – A MENTAL HEALTH CARE SYSTEM MODEL

The mental health care system for children and adolescents offers care through the following institutions:

- reference level I – a centre for community psychological and psychotherapeutic care for children and adolescents, employing clinical psychologists, psychologists, psychotherapists and community therapists rather than psychiatrists;
- reference level II – mental health centres and clinics for children and adolescents, psychiatric day wards for children and adolescents;
- reference level III – facilities offering highly specialised 24-hour psychiatric care for children and adolescents.

Depending on the child's needs, care is delivered at an appropriate reference level (Fig. 6). The treatment of a patient in a mental health crisis depends on the symptoms experienced and the risk of suicide (Fig. 7).

According to the new act on the protection of mental health in children and adolescents, there should be one or two level I centres in each municipality (depending on the number of inhabitants) and, independently, one centre in the district. Care may be provided both at the primary care level and directly from the patient's home. No prior registration or referral are needed to obtain support. It is worth informing the patient and their parents about the availability of such institutions and instructing them on how they can use this type of care.

Patients usually report to the centre by attending a visit or via telephone, and then, based on patient information, a date for the diagnostic visit is set. In urgent cases, intervention is done on a priority basis, usually within a maximum of 72 hours. In less urgent cases, the first psychological appointment usually takes place within 7 days of reporting to a reference level I centre. During the appointment, an attempt is made to establish a preliminary diagnosis and to construct a treatment plan that includes individual, family or group psychotherapy, interventions in the community and other forms of psychological care. If pharmacotherapy is necessary, the diagnosing psychologist refers the child to a second referral centre (where a psychiatrist is available), or a tertiary referral centre (especially in the case of a high suicidal risk)[18].

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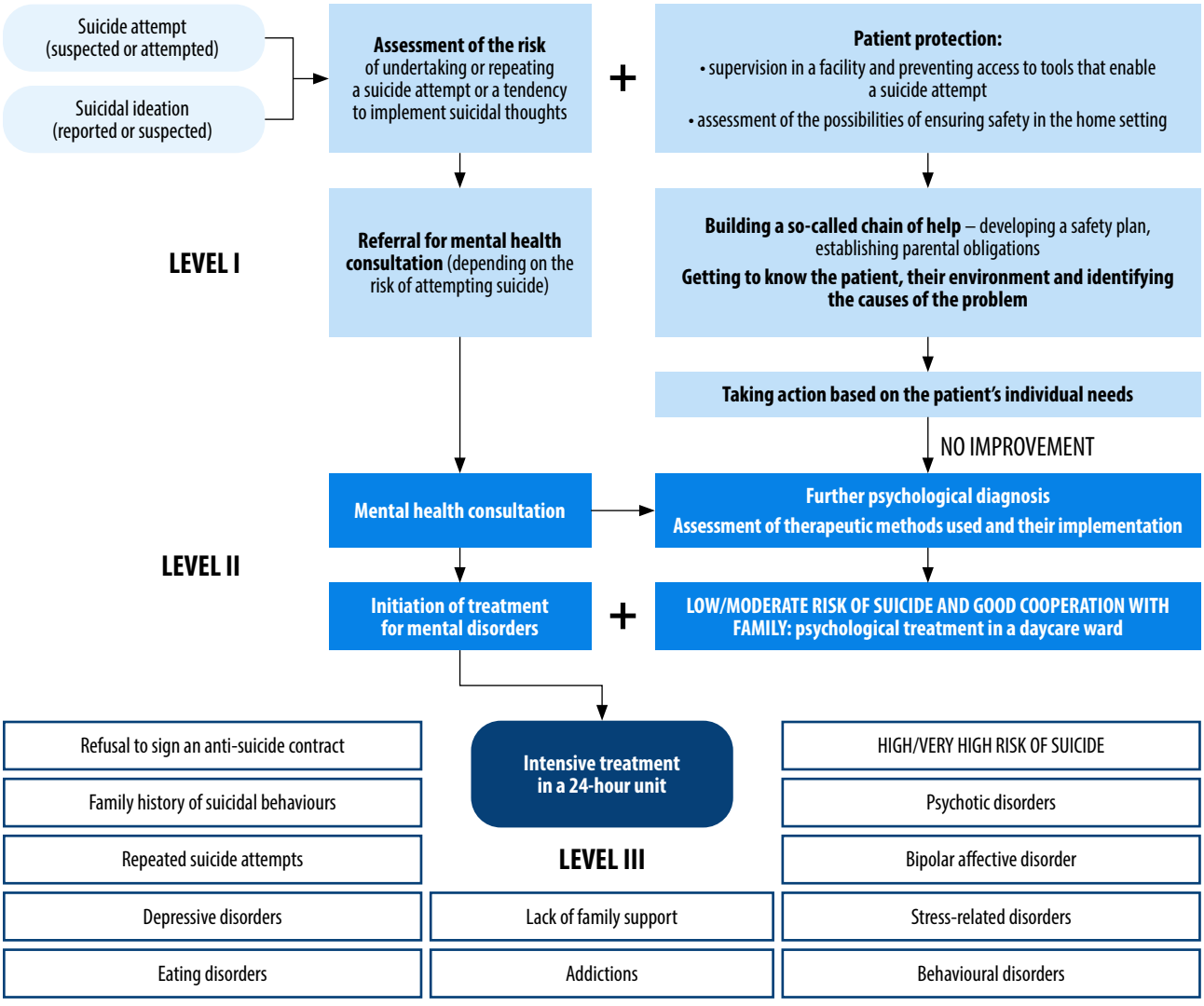

Fig. 6. Management of paediatric patients at risk of committing suicide based on the "Organisational and substantive standards for entities of the new model of the mental health care system for children and adolescents"[18]

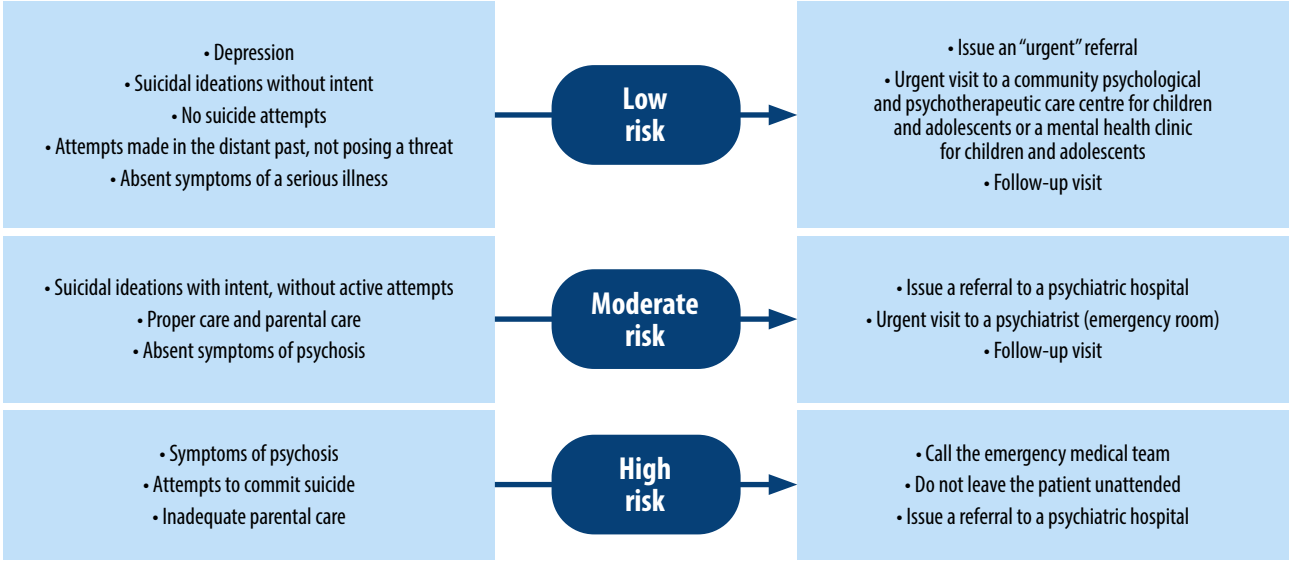

Fig. 7. Management depending on the risk of suicide based on the "Organisational and substantive standards for entities of the new model of the mental health care system for children and adolescents"[18]

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Voivodeship	Name	Address	Contact
Lower Silesian	J. Gromkowski Regional Specialist Hospital	Koszarowa 5, 51-149 Wrocław	+48 71 392 53 56
	Milicz Medical Centre	Grzybowa 1, 56-300 Milicz	+48 71 384 67 54 ext. 736
	Provincial Hospital for the Nervous and Mentally Ill in Bolesławiec	Aleja Tysiąclecia 30, 59-700 Bolesławiec	+48 571 306 307
Kuyavian-Pomeranian	Provincial Hospital for the Nervous and Mentally Ill in Świecie	Sądowa 18, 86-100 Świecie	+48 52 330 83 48
	L. Rydygier Provincial Hospital	św. Józefa 53–59, 87-100 Toruń	+48 56 679 57 63
	Dr. W. Biegański Regional Specialist Hospital in Grudziądz	Rydygiera 15–17, 86-300 Grudziądz	+48 56 641 45 20
	Antoni Jurasz University Hospital No. 1 in Bydgoszcz	Marii Skłodowskiej-Curie 9, 85-094 Bydgoszcz	+48 52 585 72 52
Lublin Voivodeship	Prof. M. Kaczyński Neuropsychiatric Hospital (independent public health care institution)	Abramowicka 2, 20-442 Lublin	+48 81 728 63 31
	Independent Public Clinical Hospital No. 1 in Lublin	Głuska 1, 20-439 Lublin	+48 81 745 33 94
Lubuskie Voivodeship	Independent Public Health Care Facility, Children and Youth Treatment Centre in Zabór	Zamkowa 1, 66-003 Zabór	+48 68 327 40 96, +48 68 327 40 48
Lodz Voivodeship	Central Teaching Hospital of the Medical University in Łódź	Czechosłowacka 8/10, 92-216 Łódź	+48 42 675 77 16
	J. Babiński Independent Public Health Care Complex in Łódź	Aleksandrowska 159, 91-229 Łódź	+48 42 652 94 01
	Provincial Psychiatric Hospital in Warta	Sieradzka 3, 98-290 Warta	+48 43 829 40 13 ext. 253
Lesser Poland	St. Louis Regional Specialised Children's Hospital in Kraków	Strzelecka 2, 31-503 Kraków	+48 12 619 86 92
	University Clinical Hospital in Kraków	Mikołaja Kopernika 36, 31-501 Kraków	+48 12 424 87 40
	Józef Babiński Clinical Hospital, Independent Public Healthcare Institution	Babińskiego 29, 30-393 Kraków	+48 12 652 44 23
Masovian Voivodeship	Institute of Psychiatry and Neurology	Sobieskiego 9, 02-957 Warszawa	+48 22 458 26 31
	Mazovian Neuropsychiatry Centre	3 Maja 127, 05-420 Józefów	+48 22 468 25 57, +48 22 468 25 85
	University Clinical Centre of the Medical University of Warsaw	Żwirki i Wigury 63A, 02-091 Warszawa	+48 22 460 80 00
Opole Voivodeship	St. Jadwiga Provincial Specialist Hospital	Wodociągowa 4, 45-221 Opole	+48 77 541 42 00, +48 77 541 42 37
Subcarpathian Voivodeship	Medical Centre in Łańcut Sp. z o.o. (limited liability company)	Paderewskiego 5, 37-100 Łańcut	+48 17 224 01 32, +48 17 224 01 48
Podlaskie Voivodeship	Child and Adolescent Mental Health Centre (University Clinical Hospital)	Michała Wołodyjowskiego 2, 15-369 Białystok	+48 85 745 07 88
Pomeranian Voivodeship	Prof. Tadeusz Bilikiewicz Provincial Psychiatric Hospital in Gdańsk	Srebrniki 11, 80-282 Gdańsk	+48 58 524 76 67, +48 58 524 76 19
	Stanisław Kryzan Hospital for the Nervous and Mentally Ill	Skarszewska 7, 83-200 Starogard Gdański	+48 58 562 06 00 ext. 2217, 2182, 2267 or 2323
Silesian Voivodeship	Paediatrics Centre in Sosnowiec	Gabrieli Zapolskiej 3, 41-218 Sosnowiec	+48 32 720 77 00 ext. 155
	Neurosis Therapy Centre for Children and Adolescents	Mikołowska 208, 43-187 Orzesze	+48 32 326 08 58
	Emil Cyran Province Neuropsychiatric Hospital in Lubliniec	Grunwaldzka 48, 42-700 Lubliniec	+48 34 353 29 21
	Paediatric Hospital in Bielsko-Biała	Sobieskiego 83, 43-314 Bielsko-Biała	+48 33 828 40 37
Świętokrzyskie Voivodeship	Świętokrzyskie Psychiatric Centre in Morawica	Kusocińskiego 59, 25-045 Kielce	+48 41 366 97 14
Warmia-Masuria Voivodeship	Provincial Complex of Psychiatric Health in Olsztyn	Wojska Polskiego 35, 10-228 Olsztyn	+48 89 678 53 81
Wielkopolskie Voivodeship	HCP Medical Center, St. John Paul II Hospital	28 Czerwca 1956 r. nr 194, 61-485 Poznań	+48 61 227 43 38
	Karol Jonscher Clinical Hospital of the Karol Marcinkowski Medical University in Poznań	Szpitalna 27/33, 60-572 Poznań	+48 61 849 14 00
West Pomeranian Voivodeship	Zdroje Hospital	Mączna 4, 70-780 Szczecin	+48 91 880 64 54

Tab. 2. 24-hour child and adolescent psychiatry departments in Poland, along with contact details[25]

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A list of all centres along with their contact details can be found on the following website: https://www.nfz.gov.pl/dla-pacjenta/informacje-o-swiadczeniach/ochrony-zdrowia-psychicznego-dzieci-i-mlodziezy/. It should be noted that parental consent is required to use the services in the case of patients <18 years of age.

CURRENT ACCESS TO CHILD PSYCHIATRY DEPARTMENTS AND CLINICS

There are currently 571 child and adolescent psychiatry specialists in Poland[23]. The ratio of child psychiatrists to the number of paediatric patients with mental health needs is unfavourable, which translates into long waiting time to access paediatric psychiatric services[24].

In Poland, 24-hour psychiatric care is offered by slightly more than 30 child and adolescent psychiatry departments (Tab. 2)[25]. Children and adolescents are referred to these departments on an elective basis (e.g. for diagnostic purposes) or urgently. Suicidal ideations, intentions or attempts are the main reason for emergency admissions. Due to the growing number of suicidal behaviours among paediatric patients, emergency admissions predominate, as a result of which the waiting time for elective hospital admissions may extend to many months.

Although 24-hour child and adolescent psychiatry departments operate in every province, the demand for hospitalisation in such units significantly exceeds their capacity. In many departments, the number of hospitalised children exceeds the bed limit, which may create problems related to the insufficient number of medical personnel in relation to the needs[22]. Importantly, however, 24-hour departments ensure pharmacological and psychotherapeutic care, as well as organise schooling.

In addition to 24-hour departments, there are also day care units in Poland, where children and adolescents may stay from morning to afternoon, with access to group and individual therapies, nursing and medical care, as well as pharmacotherapy. These facilities also offer access to compulsory schooling, workshops and sociotherapy[26].

CONCLUSIONS

The growing trend of suicidal behaviours among children and adolescents should draw greater social attention. Limited access to child and adolescent psychiatry specialists is a significant problem that limits the possibilities of helping young patients with mental health crisis. The vigilance of the patient's closest environment (including family, school teachers) is essential, and so is the ability of primary care physicians to recognise warning signals. An appropriate response and referral of the child to psychological and psychiatric units can significantly reduce the number of suicide attempts. At the same time, it is important to offer care for both the patient and their family after a suicide attempt to prevent further such events in the future.

Conflict of interest

The authors do not report any financial or personal connections with other persons or organisations which might negatively affect the contents of this publication and/or claim authorship rights to this publication.

Author contribution

Original concept of study: AWM, EPG, AK, MG, AJ. Collection, recording and/or compilation of data: AWM, EPG, AK, MG. Analysis and interpretation of data: AWM, EPG, AK, MG. Writing of manuscript: AWM, EPG, AK, MG. Critical review of manuscript: AWM, EPG, AK, MG, AJ, KR, KKBD. Final approval of manuscript: AWM, EPG, AK, MG, AJ, KR, KKBD.

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