Youth Suicide: Evidence-Based Clinical and Community Level Prevention Strategies

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Goals for Today

- Provide updated prevalence of suicide in the U.S.
  – General population and adolescents
- Discuss theoretical models of suicide
  – Contemporary models applied to adolescents
  – Models specific to minority youth
- Provide direction on how these models can be applied clinically
  – Zero Suicide's minimum standard of care
  – Empirically validated tools to consider using

Scope of Suicide in the United States

44,965

11.7 minutes

Rank & Cause of Death	Rate	Deaths
1 Diseases of heart (heart disease)	196.6	635,260
2 Malignant neoplasms (cancer)	185.1	598,038
3 Accidents (unintentional injury)	49.9	161,374
4 Chronic lower respiratory diseases	47.8	154,596
5 Cerebrovascular diseases (stroke)	44.0	142,142
6 Alzheimer’s disease	35.9	116,103
7 Diabetes mellitus (diabetes)	24.8	80,058
8 Influenza & pneumonia	16.0	51,537
9 Nephritis, nephrosis (kidney disease)	15.5	50,046
10 Suicide [Intentional Self-Harm]	**13.9**	**44,965**
11 Septicemia	12.6	40,613
12 Chronic liver disease and cirrhosis	12.6	40,545
13 Essential hypertension and renal disease	10.3	33,246
14 Parkinson's disease	9.2	29,697
15 Pneumonitis due to solids and liquids	6.1	19,715
- All other causes (Residual; > 15)	169.1	546,313
Homicide (ranks 16th)	6.0	19,362

Cause	Number	Rate
All Causes	32,575	74.9
1-Accidents	13,895	31.9
2-Suicide	5,723	13.2
3-Homicide	5,172	11.9
| 10-14 yrs	436	2.1
| 15-19 yrs	2,117	10.0
| 20-24 yrs	3,606	16.1

U.S.A. Suicide Rates 2006-2016

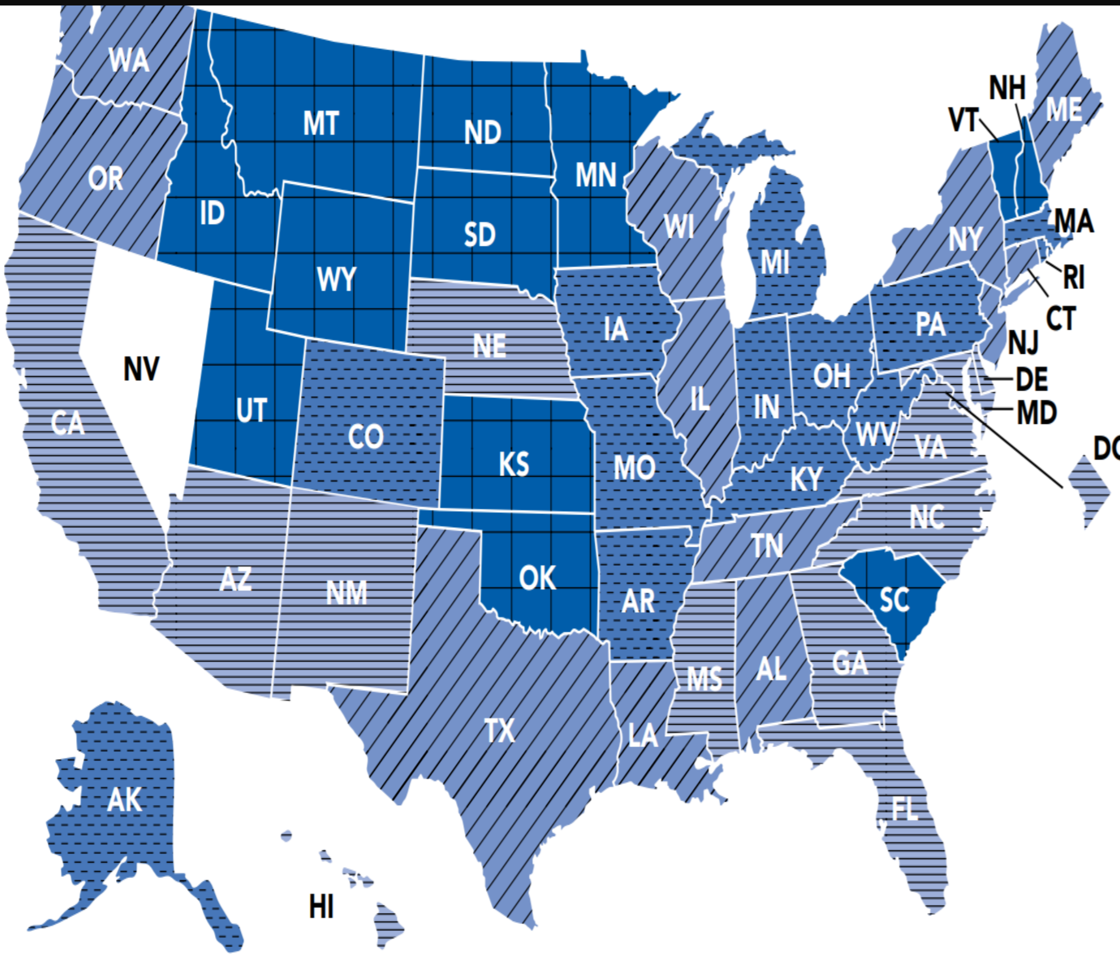
(Rates per 100,000 population)

Group/ Age	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Group/ Age
5-14	0.5	0.5	0.6	0.7	0.7	0.7	0.8	1.0	1.0	1.0	1.1	5-14
15-24	9.9	9.7	10.0	10.1	10.5	11.0	11.1	11.1	11.6	12.5	13.2	15-24
25-34	12.3	13.0	12.9	12.8	14.0	14.6	14.7	14.8	15.1	15.7	16.5	25-34
35-44	15.1	15.6	15.9	16.1	16.0	16.2	16.7	16.2	16.6	17.1	17.4	35-44
45-54	17.2	17.7	18.7	19.3	19.6	19.8	20.0	19.7	20.2	20.3	19.7	45-54
55-64	14.5	15.5	16.3	16.7	17.5	17.1	18.0	18.1	18.8	18.9	18.7	55-64
65-74	12.6	12.6	13.9	14.0	13.7	14.1	14.0	15.0	15.6	15.3	15.4	65-74
75-84	15.9	16.3	16.0	15.7	15.7	16.5	16.8	17.1	17.5	17.9	18.2	75-84
85+	15.9	15.6	15.6	15.6	17.6	16.9	17.8	18.6	19.3	19.4	19.0	85+
65+	14.2	14.3	14.8	14.8	14.9	15.3	15.4	16.1	16.7	16.6	16.7	65+
Total	11.1	11.5	11.8	12.0	12.4	12.7	12.9	13.0	13.4	13.8	13.9	Total
Men	17.8	18.3	19.0	19.2	20.0	20.2	20.6	20.6	21.1	21.5	21.8	Men
Women	4.6	4.8	4.9	5.0	5.2	5.4	5.5	5.7	6.0	6.3	6.2	Women
White	12.4	12.9	13.3	13.5	14.1	14.5	14.8	14.9	15.5	15.8	15.9	White
Nonwh	5.5	5.6	5.7	5.8	5.8	5.8	6.1	6.0	6.0	6.3	6.8	NonWh
Black	4.9	4.9	5.2	5.1	5.1	5.3	5.5	5.4	5.5	5.6	6.1	Black
45-64	16.0	16.7	17.5	18.0	18.6	18.6	19.1	19.0	19.5	19.6	19.2	45-64

Suicide rates rose across the US from 1999 to 2016.

Increase 38 - 58%
Increase 31 - 37%
Increase 19 - 30%
Increase 6 - 18%
Decrease 1%

SOURCE: *CDC's National Vital Statistics System; CDC Vital Signs, June 2018.*



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75-84	15.9	16.3	16.0	15.7	15.7	16.5	16.8	17.1	17.5	17.9	18.2	75-84
85+	15.9	15.6	15.6	15.6	17.6	16.9	17.8	18.6	19.3	19.4	19.0	85+
65+	14.2	14.3	14.8	14.8	14.9	15.3	15.4	16.1	16.7	16.6	16.7	65+
Total	11.1	11.5	11.8	12.0	12.4	12.7	12.9	13.0	13.4	13.8	13.9	Total
Men	17.8	18.3	19.0	19.2	20.0	20.2	20.6	20.6	21.1	21.5	21.8	Men
Women	4.6	4.8	4.9	5.0	5.2	5.4	5.5	5.7	6.0	6.3	6.2	Women
White	12.4	12.9	[illegible]	[illegible]	14.1	[illegible]	14.8	14.9	[illegible]	[illegible]	15.9	White
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65-74	12.6	12.6	13.9	14.0	13.7	14.1	14.0	15.0	15.6	15.3	15.4	65-74
75-84	15.9	16.3	16.0	15.7	15.7	16.5	16.8	17.1	17.5	17.9	18.2	75-84
85+	15.9	15.6	15.6	15.6	17.6	16.9	17.8	18.6	19.3	19.4	19.0	85+
65+	14.2	14.3	14.8	14.8	14.9	15.3	15.4	16.1	16.7	16.6	16.7	65+
Total	11.1	11.5	11.8	12.0	12.4	12.7	12.9	13.0	13.4	13.8	13.9	Total
Men	17.8	18.3	19.0	19.2	20.0	20.2	20.6	20.6	21.1	21.5	21.8	Men
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White	12.4	12.9	13.3	13.5	14.1	14.5	14.8	14.9	15.5	15.8	15.9	White
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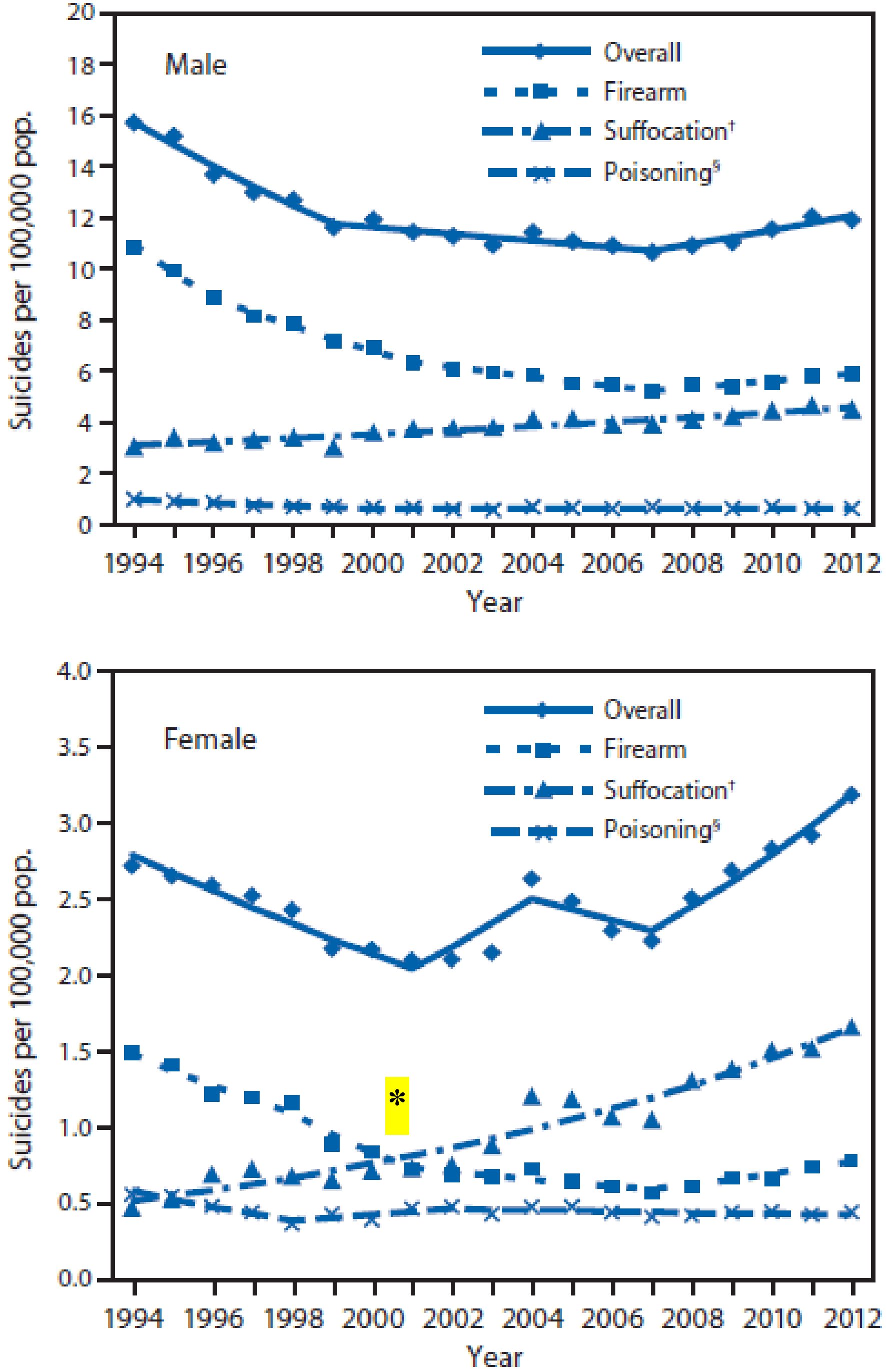
Black	4.9	4.9	5.2	5.1	5.1	5.3	5.5	5.4	5.5	5.6	6.1	Black
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	45-64

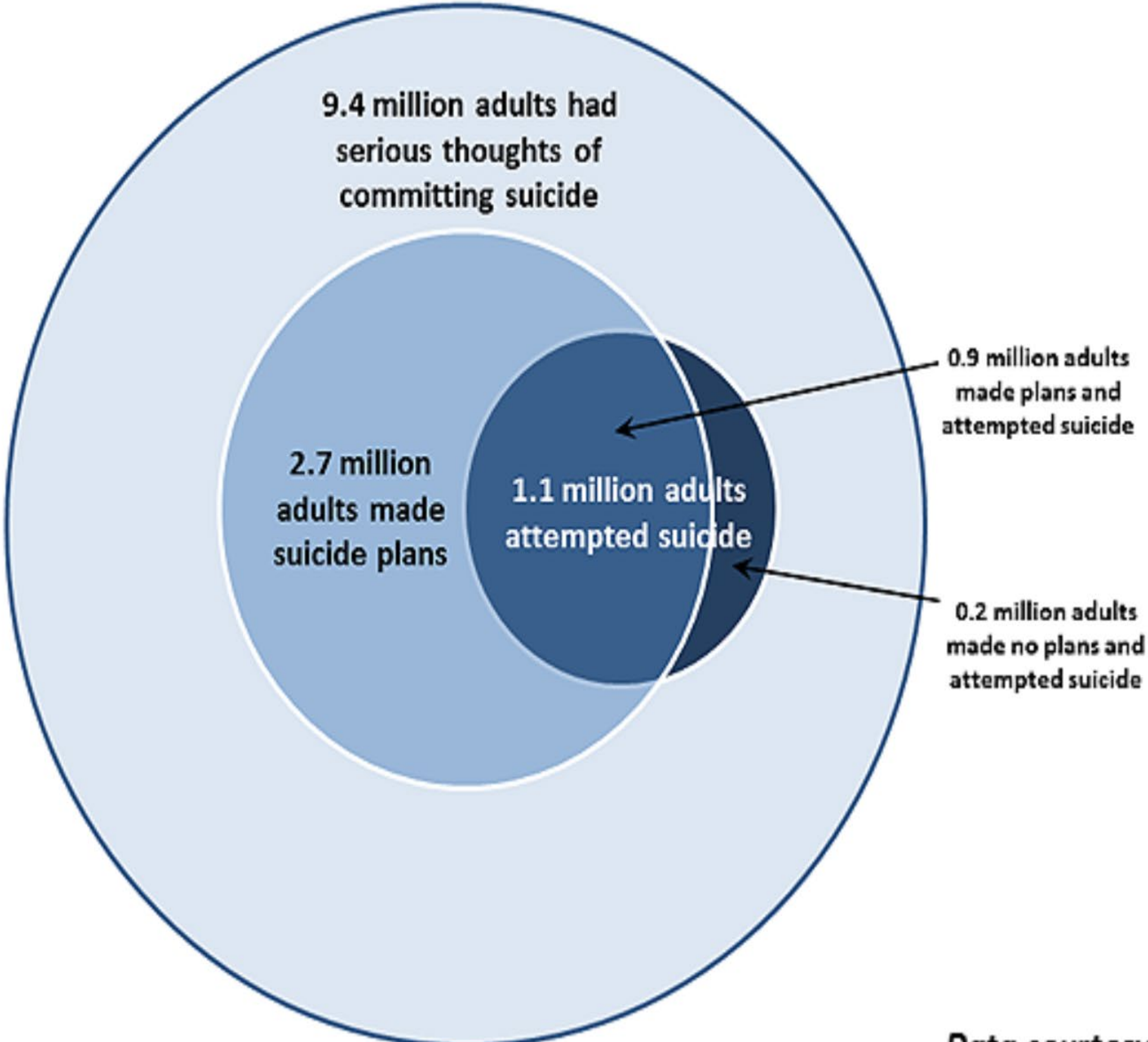
FIGURE. Age-adjusted suicide rates among persons aged 10–24 years, by sex and mechanism — United States, 1994–2012*



*Suffocation surpasses firearm suicides

Prevalence of Suicidal Thoughts and Behaviors

- 81% of suicide deaths ages 10-24 are male
- High school students:
  - 15.8% history of active suicidal thoughts
  - 12.8% history of planning
  - 7.8% attempt
  - 2.4% report attempt that needed medical intervention



Data courtesy of SAMHSA

Why do youth die by suicide?

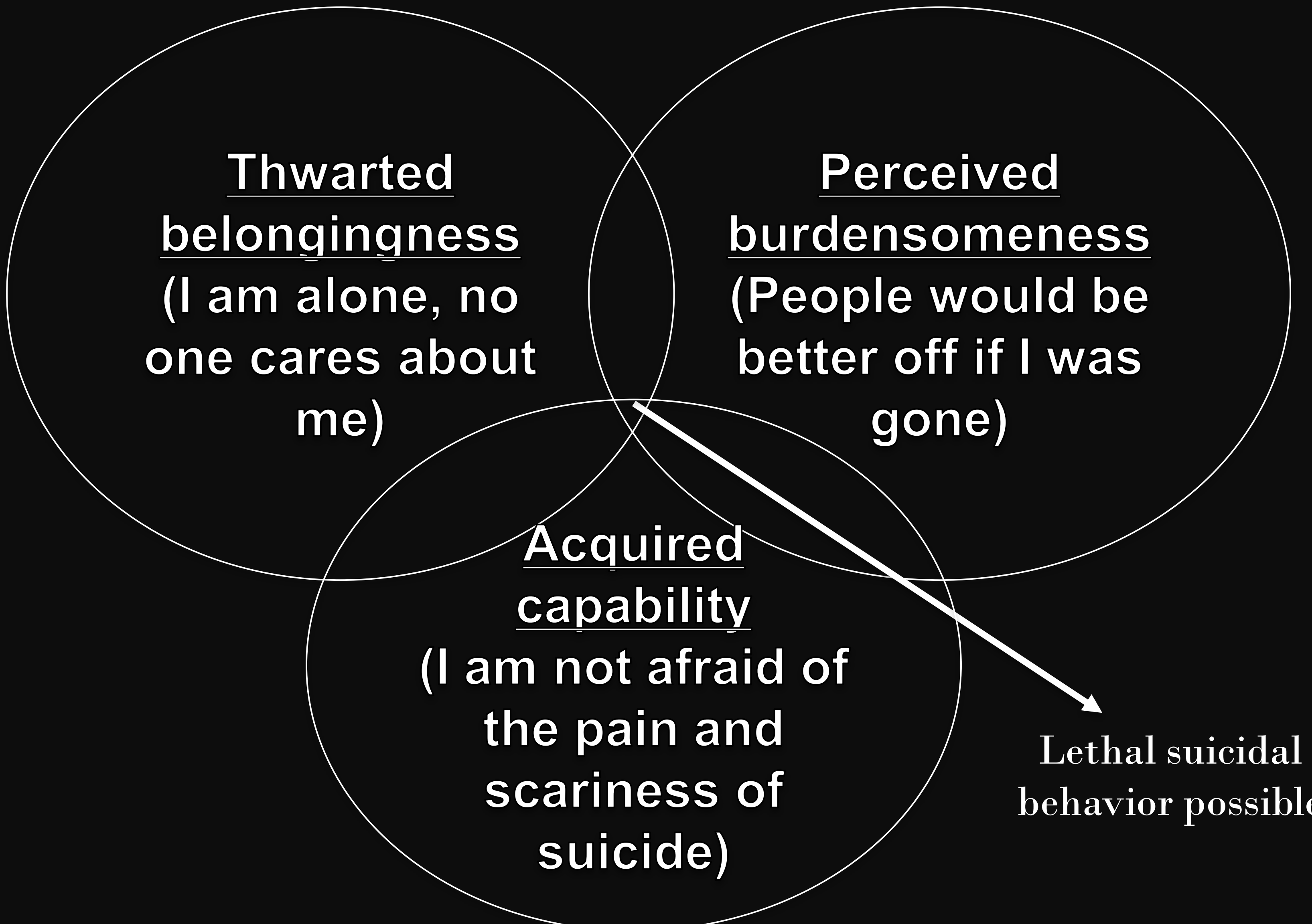
Interpersonal Theory of Suicide

<u>Thwarted belongingness</u> (I am alone, no one cares about me)

<u>Perceived burdensomeness</u> (People would be better off if I was gone)

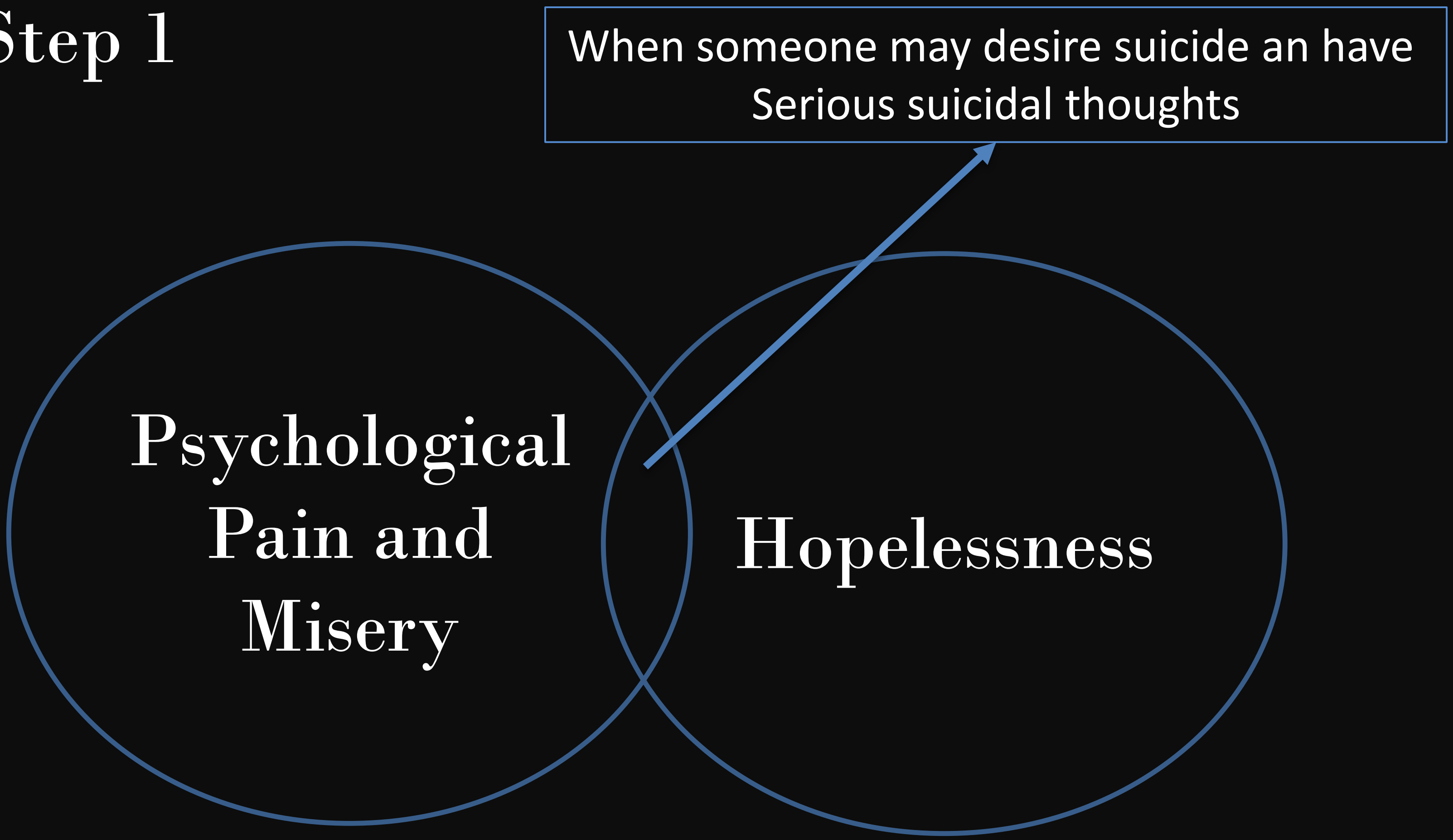
When someone may desire suicide an have Serious suicidal thoughts

Interpersonal Theory of Suicide



3-Step Theory (3ST)

- Step 1



3-Step Theory (3ST)

- Step 2

Suicidal thinking intensifies and may result in planning or confidence in future suicide attempt

Psychological Pain and Misery > Connection

Connection = broadly defined (social, spiritual, personal meaning)

3-Step Theory (3ST)

- Step 3

Suicide attempt will occur when an individual has the capacity to make one

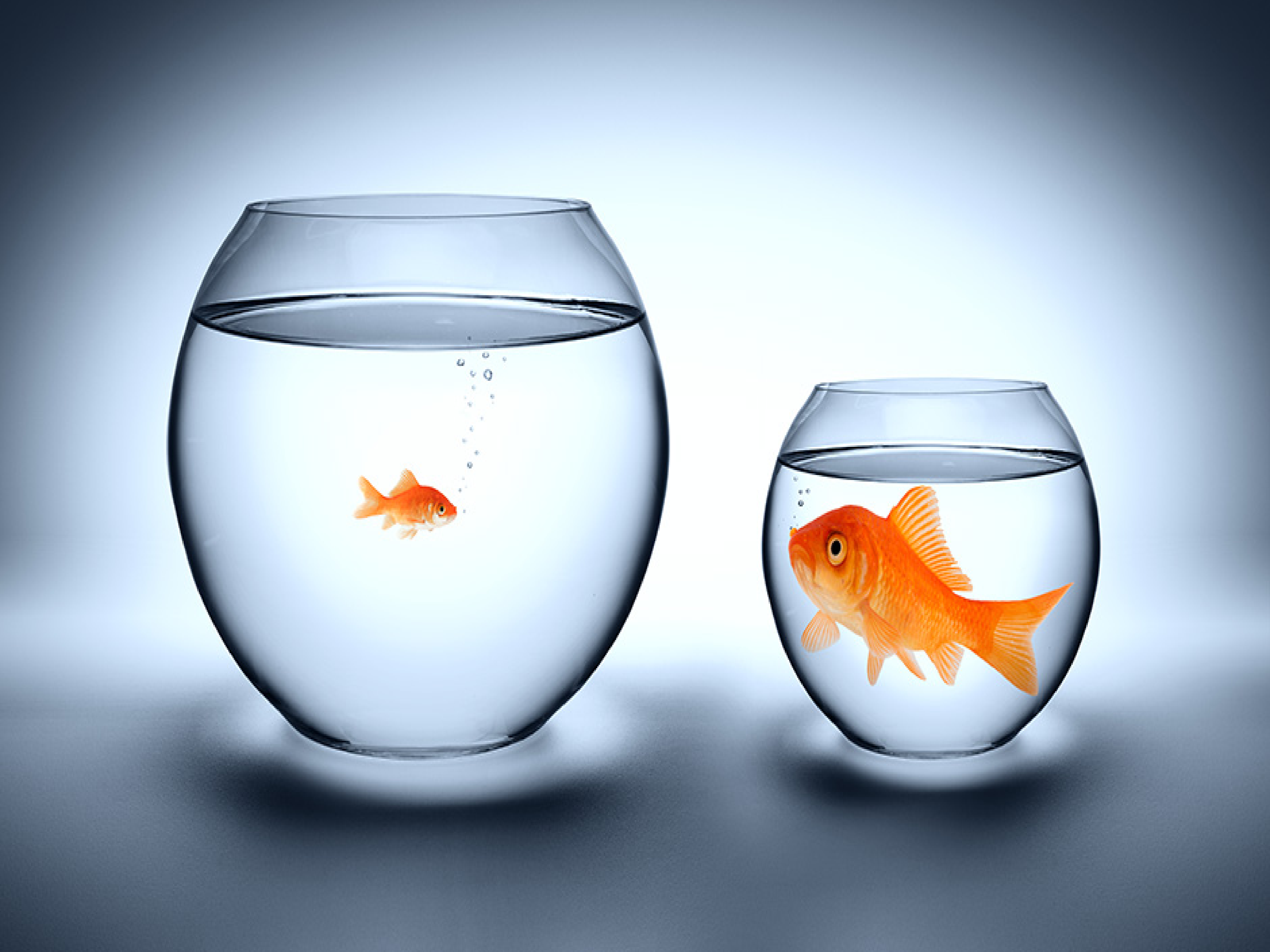
Dispositional Capacity
(pain sensitivity, fearlessness)

Acquired Capacity
(fearlessness, painful and provocative event exposure)

Practical Capacity
(owning and having familiarity with means for suicide)

Take Home

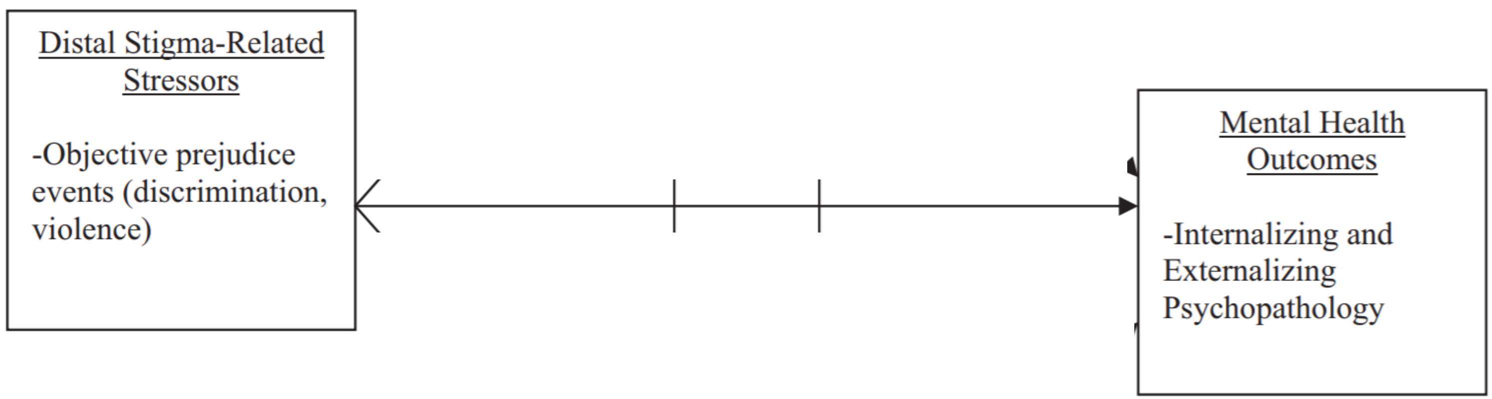
- Rare event, but increasing in prevalence
- It is very “hard” to make a fatal attempt
  - Most having thoughts will attempt and very few will die
  - Most who make one attempt do not make another attempt
- We are often are cued in on what predicts suicidal thoughts but less so suicide attempts



Psychological Mediation Framework

Figure 2. Integrative mediation framework of group-specific and general psychological processes.

Psychological Mediation Framework



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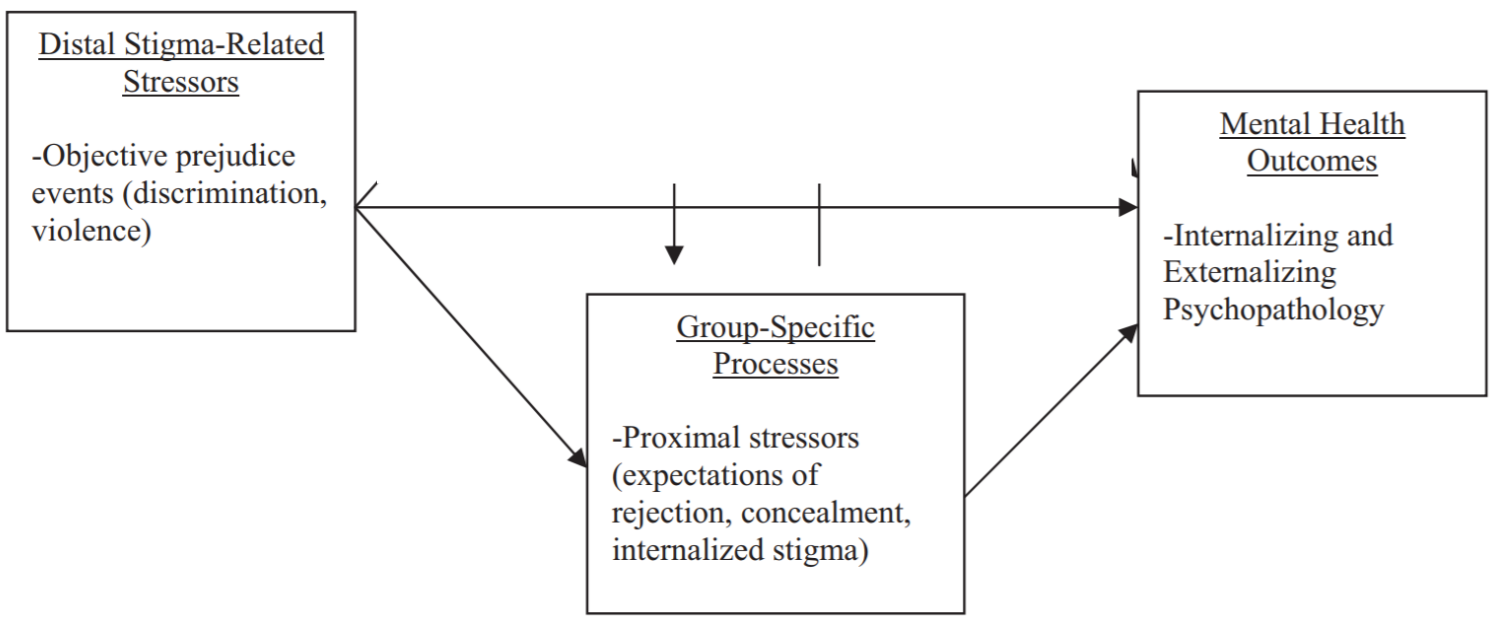

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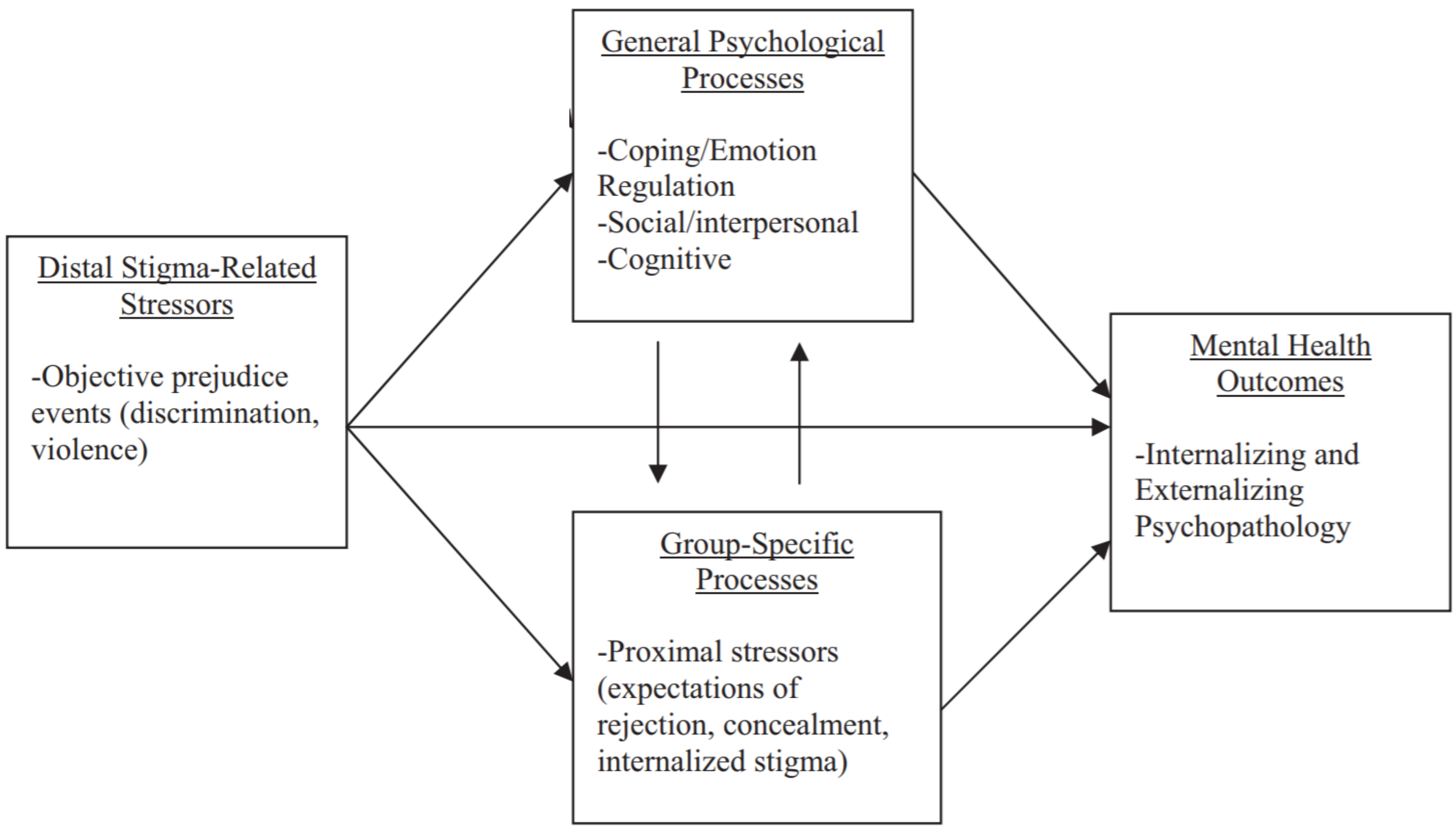

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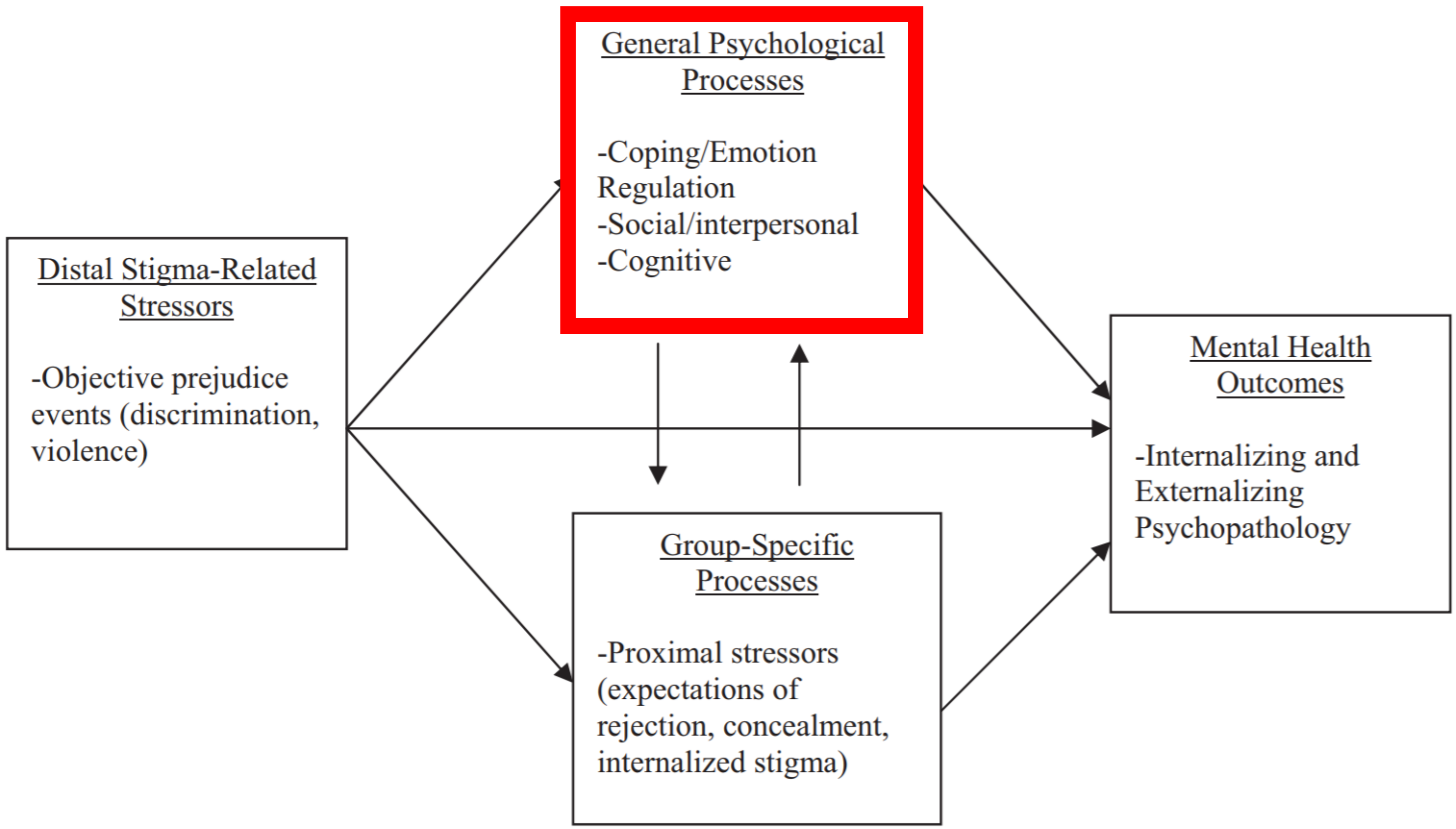

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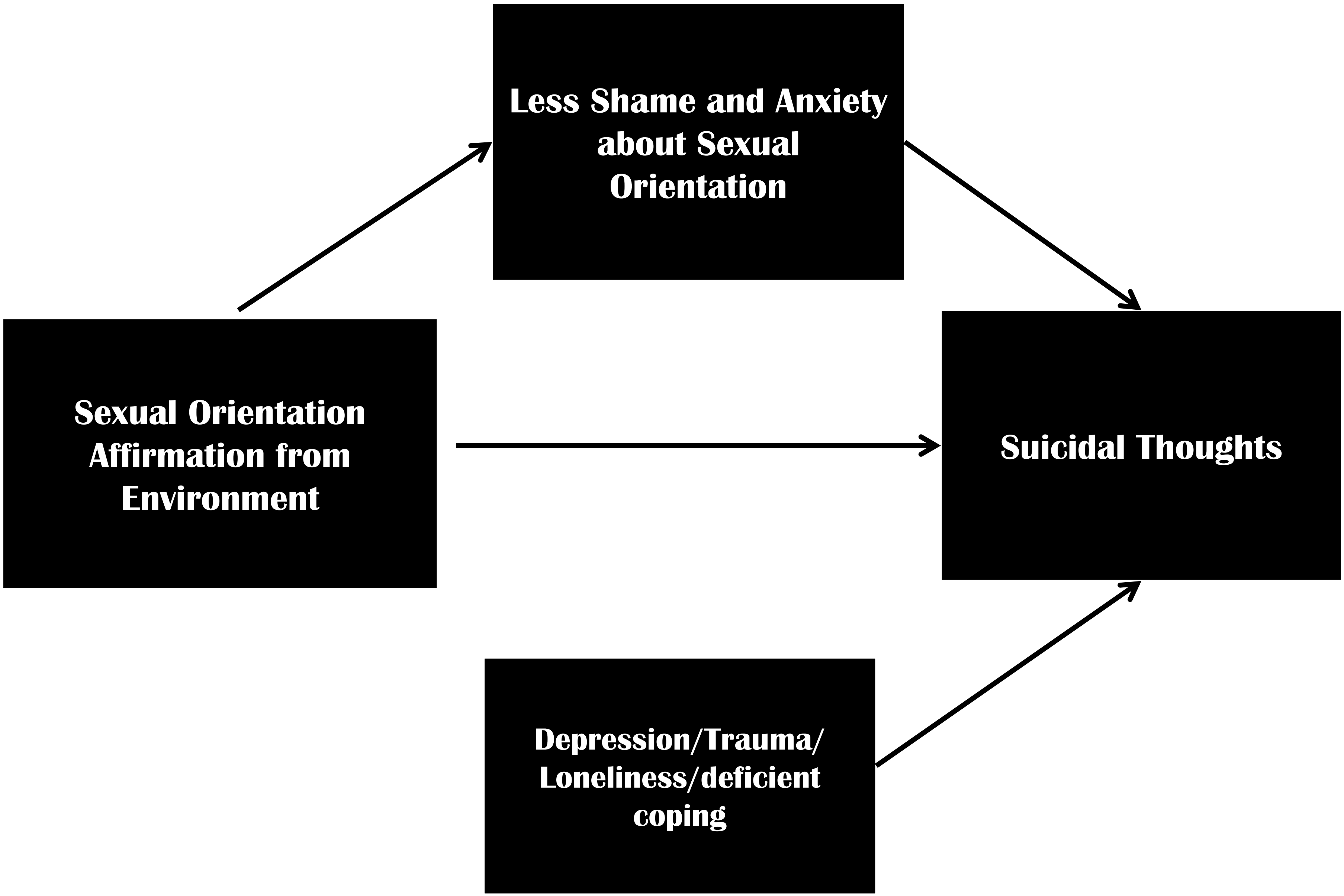
Lesbian, Gay, Bisexual Youth



Lesbian, Gay, Bisexual Youth

Suicide

Suicidal Thoughts

Depression/Trauma/ Loneliness/deficient coping


RISK


LOW RISK
HIGH RISK
NO RISK

Minimum Standard of Care

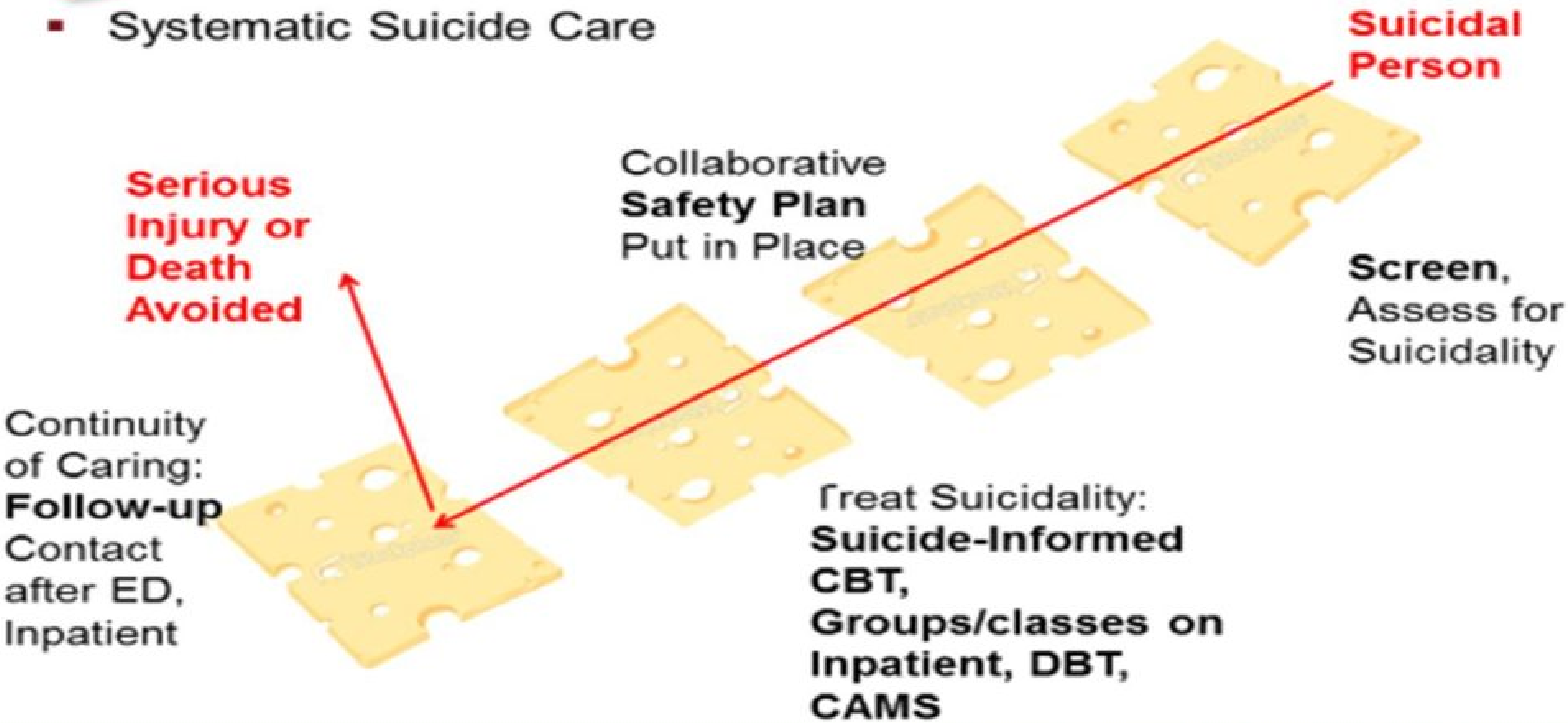
ZERO Suicide

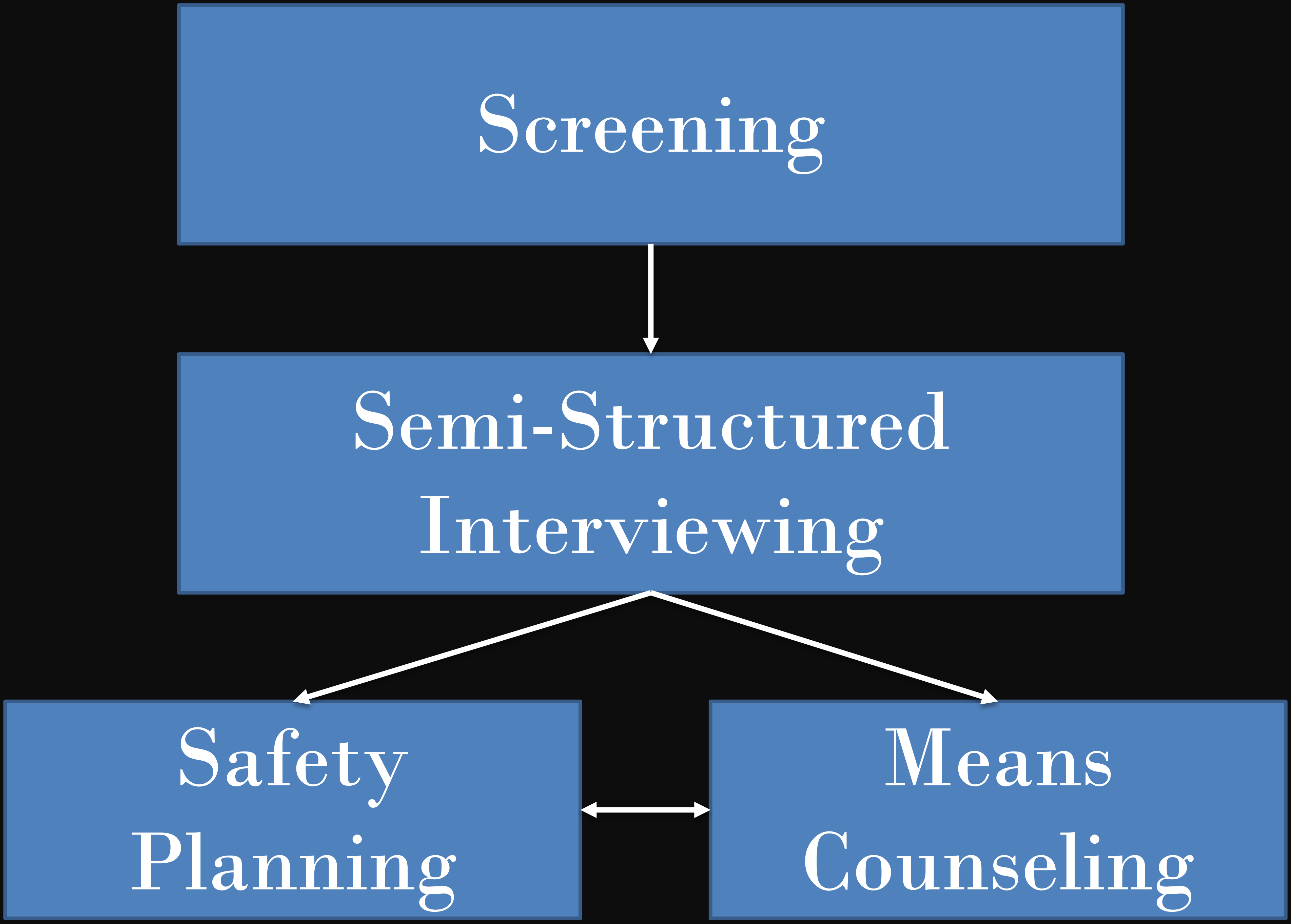
IN HEALTH AND BEHAVIORAL HEALTH CARE

Substance Abuse and Mental Health Services Administration (SAMHSA)

Systematic Suicide Care Plugs the Holes in Health Care

- Systematic Suicide Care




Screening
Semi-Structured Interviewing
Safety Planning
Means Counseling

Screening

Broad Symptom Measures with Critical Items

- Suicidal ideation
- Hopelessness
- Non-Suicidal Self-Injury (NSSI)
- Psychological misery/pain

Child/Adolescent

Behavior Assessment System for Children

Child Behavior Check List

Screening

<u>**Narrow Symptom Measures (Brief)**</u>

- Depression
  - Critical item
  - Total score/clinical cut-offs

<u>Child/Adolescent</u>

Child Depression Inventory (CDI)

Patient Health Questionairre-9


WARNING
WARNING
WARNING
WARNING
WARNING
WARNING
WARNING

Association between suicidal ideation and suicide: meta-analyses of odds ratios, sensitivity, specificity and positive predictive value*

Catherine M. McHugh, Amy Corderoy, Christopher James Ryan, Ian B. Hickie and Matthew Michael Large

Background

The expression of suicidal ideation is considered to be an important warning sign for suicide. However, the predictive properties of suicidal ideation as a test of later suicide are unclear.

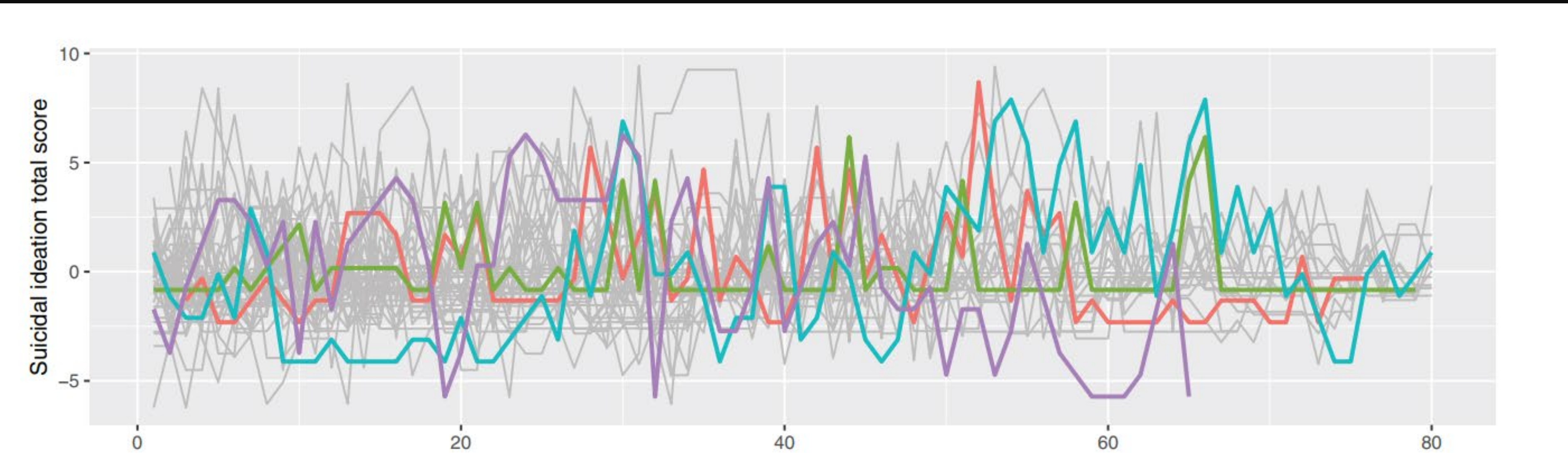
Conclusions

Estimates of the extent of the association between suicidal ideation and later suicide are limited by unexplained between-study heterogeneity. The utility of suicidal ideation as a test for later suicide is limited by a modest sensitivity and low PPV.

The current paper advances knowledge of the association between suicidal ideation and suicide by reporting the pooled sensitivity and specificity of suicidal ideation for suicide. The main finding is the limited sensitivity of suicidal ideation for suicide, such that approximately 60% of people who go on to die by suicide have not expressed suicidal ideation at a specified earlier

~64% of attempters have seen a provider in the month prior to attempt
~38% have seen a provider in the week prior

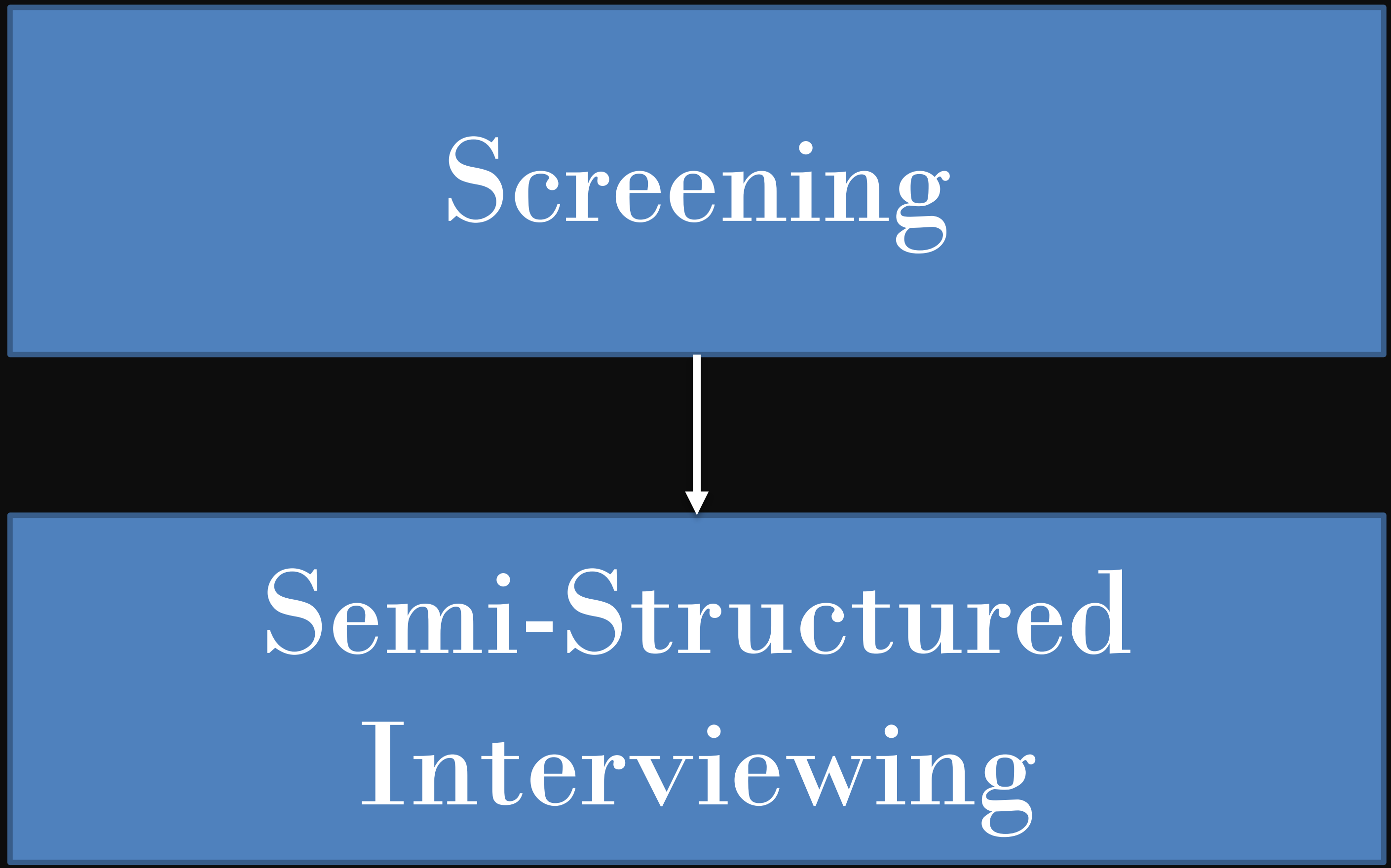
~75%



suicidal ideation? Participants in Study 1 were 54 adults who had attempted suicide in the previous year and completed 28 days of ecological momentary assessment (EMA; average of 2.51 assessments per day; 2,891 unique assessments). Participants in Study 2 were 36 adult psychiatric inpatients admitted for suicide risk who completed EMA throughout their time in the hospital (average stay of 10.32 days;

For nearly all participants, suicidal ideation varied dramatically over the course of most days: more than 1-quarter (Study 1 = 29%; Study 2 = 28%) of all ratings of suicidal ideation were a standard deviation above or below the previous response from a few hours earlier and nearly all (Study 1 = 94.1%; Study 2 = 100%) participants had at least 1 instance of intensity of suicidal ideation changing by a standard deviation or more from 1 response to the next. (b) Across both studies, well-known risk factors for

suicidal ideation such as hopelessness, burdensomeness, and loneliness also varied considerably over just a few hours and correlated with suicidal ideation, but were limited in predicting short-term change in suicidal ideation. These studies represent the most fine-grained examination of suicidal ideation ever conducted. The results advance the understanding of how suicidal ideation changes over short periods and provide a novel method of improving the short-term prediction of suicidal ideation.


Screening
Semi-Structured Interviewing

Adult

Columbia Suicide Severity Rating Scale

Self-Injurious Thoughts and Behaviors Interview

Semi-Structured Interviewing

Child/Adolescent

Columbia Suicide Severity Rating Scale

Self-Injurious Thoughts and Behaviors Interview

Semi-Structured Interviews

Columbia Suicide Severity Rating Scale

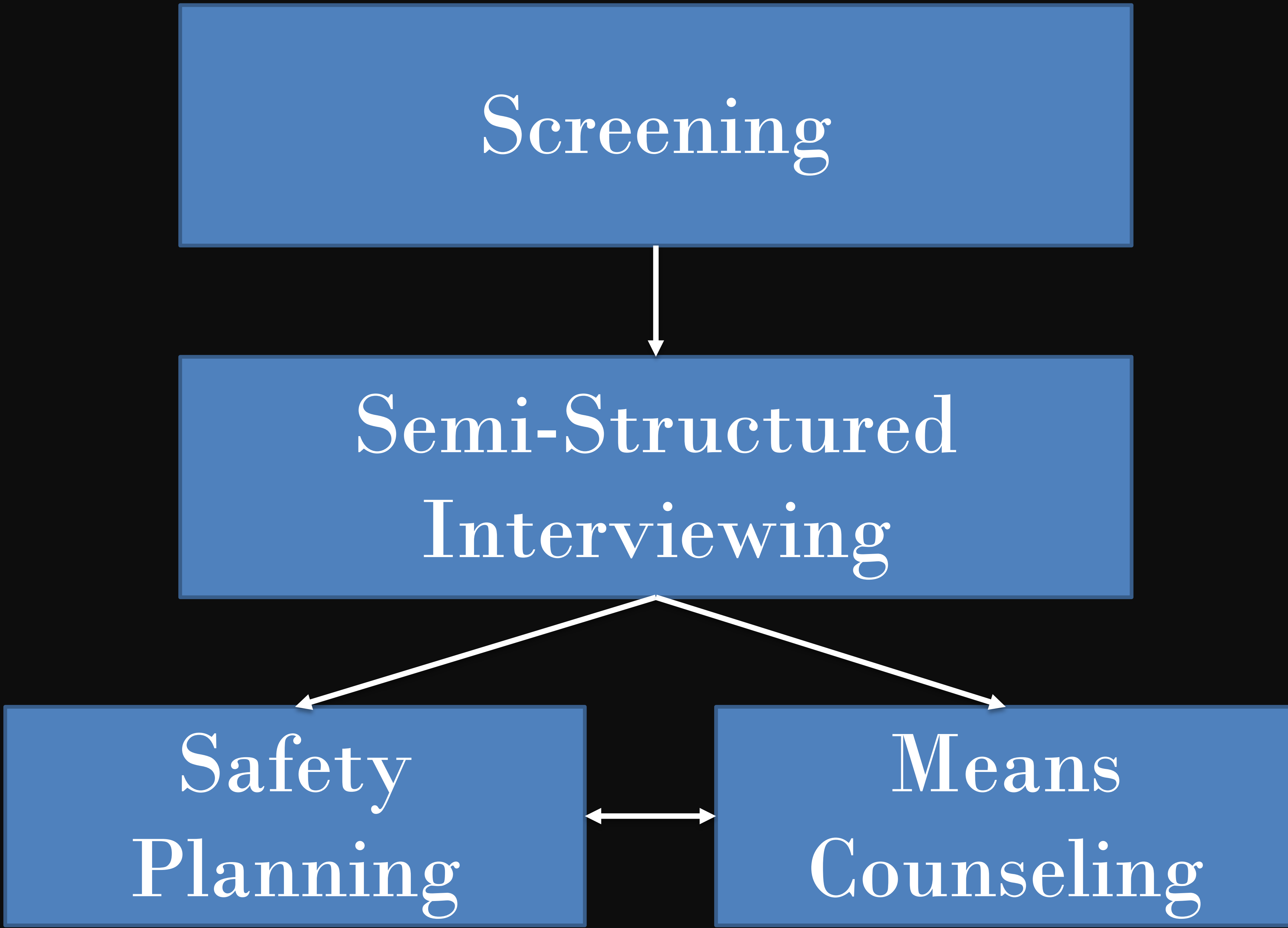
- Fairly brief (screener), good current presentation

http://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf

Self-Injurious Thoughts and Behaviors Interview (SITB-I)

- Comprehensive suicide/NSSI interview
- Brief version as well

http://nocklab.fas.harvard.edu/tasks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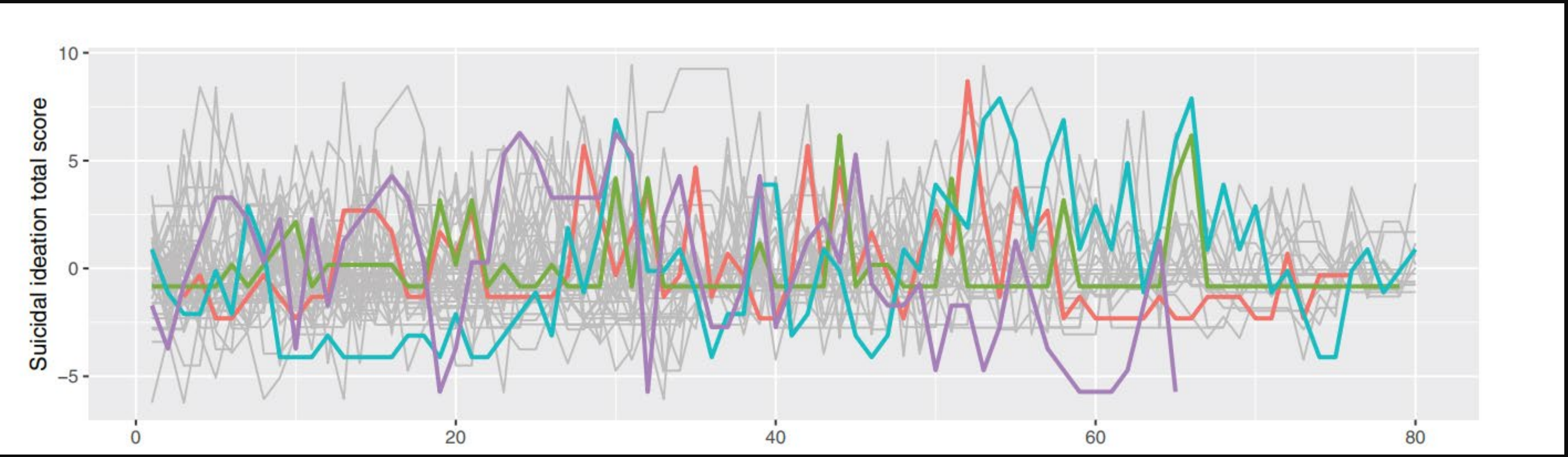


“Given the presence of both long and short-term processes, we recommend that clinicians thoroughly assess lifetime suicidal ideation and help patients with a suicide history create safety plans (Stanley & Brown, 2012) to prevent or slow down the typically rapid progress down the pathway to suicide… people may not have access to their own degree of risk days or perhaps even hours prior to attempting.”

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. ______________________________
2. ______________________________
3. ______________________________

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. ______________________________
2. ______________________________
3. ______________________________

Step 3: People and social settings that provide distraction:

1. Name______________________________ Phone______________________
2. Name______________________________ Phone______________________
3. Place________________________ 4. Place________________________

Step 4: People whom I can ask for help:

1. Name______________________________ Phone______________________
2. Name______________________________ Phone______________________
3. Name______________________________ Phone______________________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name__________________________ Phone______________________
   Clinician Pager or Emergency Contact # ______________________________
2. Clinician Name__________________________ Phone______________________
   Clinician Pager or Emergency Contact # ______________________________
3. Local Urgent Care Services______________________________
   Urgent Care Services Address______________________________
   Urgent Care Services Phone______________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. ______________________________
2. ______________________________

The one thing that is most important to me and worth living for is:

____

Original Investigation

ONLINE FIRST

July 11, 2018

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

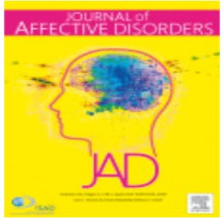
Barbara Stanley, PhD[1,2]; Gregory K. Brown, PhD[3]; Lisa A. Brenner, PhD[4,5]; et al

Author Affiliations

JAMA Psychiatry. Published online July 11, 2018. doi:10.1001/jamapsychiatry.2018.1776

Patients who visited the emergency department for suicide-related concerns and received the Safety Planning Intervention with structured follow-up telephone contact were half as likely to exhibit suicidal behavior and more than twice as likely to attend mental health treatment during the 6-month follow-up period compared with their counterparts who received usual care following their ED visit.

Journal of Affective Disorders
Volume 212, 1 April 2017, Pages 64-72



Research paper

Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army Soldiers: A randomized clinical trial ☆

Craig J. Bryan [a, b], Jim Mintz [c], Tracy A. Clemans [a, b], Bruce Leeson [d], T. Scott Burch [d], Sean R. Williams [a, b], Emily Maney [a, b], M. David Rudd [a, e]

⊞ Show more

https://doi.org/10.1016/j.jad.2017.01.028

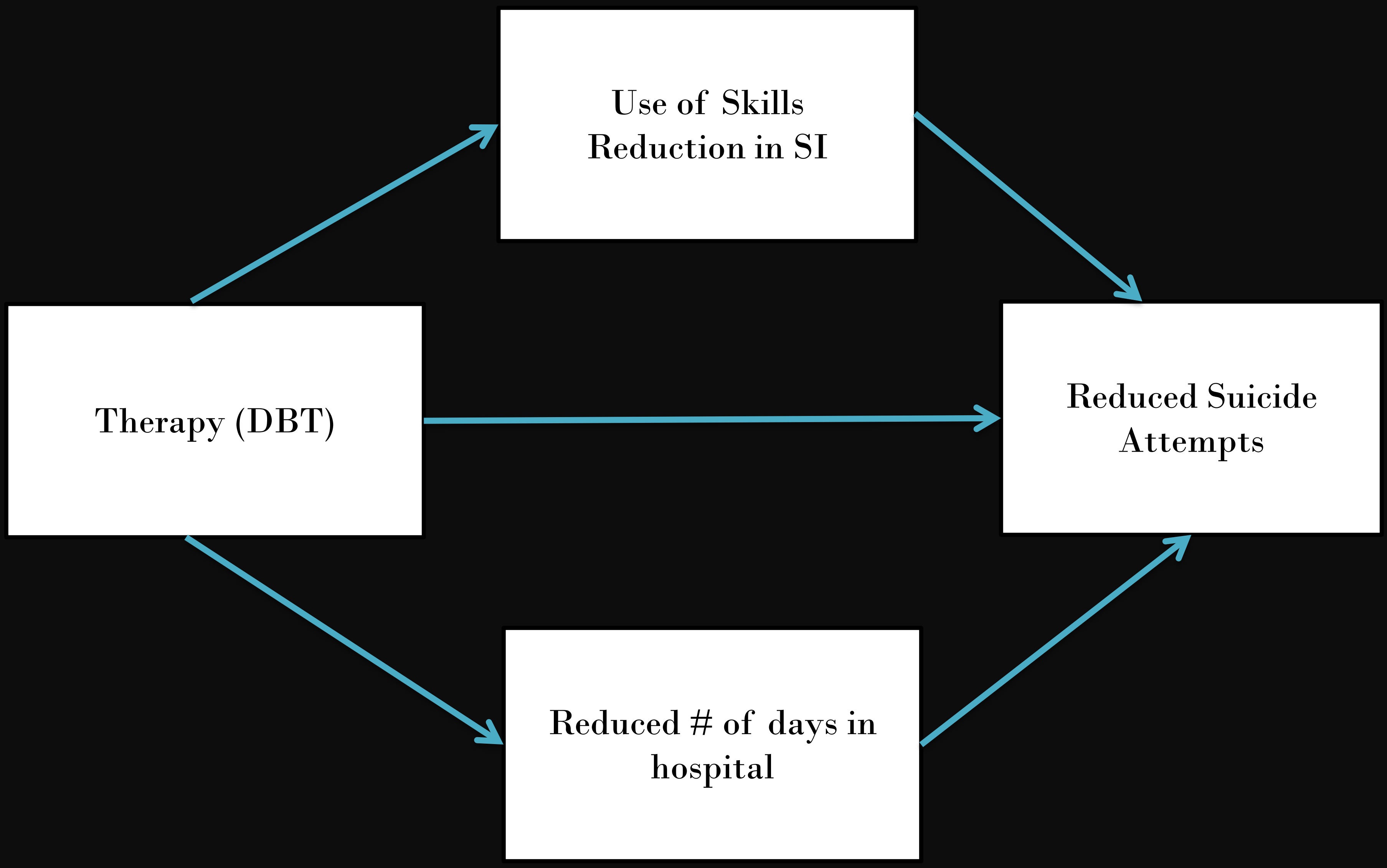
Crisis response planning was associated with significantly faster decline in suicide ideation ($F(3,195)=18.64$, $p<0.001$) and fewer inpatient hospitalization days ($F(1,82)=7.41$, $p<0.001$) following 6 month follow-up. Over 80% still had a physical copy of the plan at follow-up.

<u>Suicide Attempt</u>:
Crisis response: 5%
Suicide contract: 19%

Inpatient Hospitalization

Risk Factor?

- No evidence that inpatient hospitalization decreases likelihood for later suicidal behavior
- 48-72 hour window post-discharge
- Longitudinal studies:
  - Significant predictor of death by suicide even when adjusting for other risk factors
- Inpatient hospitalization ≠ Treatment


Use of Skills
Reduction in SI
Therapy (DBT)
Reduced Suicide
Attempts
Reduced # of days in
hospital

See the Resource Sheet for More Training Resources

Safety Planning

Tips for Means Safety with Teenagers

- Only person who can guarantee safety is the youth (not the parents or facility)
  - Do not only consider "tightening the safety net" at home
  - Collaborate (don't prescribe) on a plan with the youth, one they may actually use
  - Have the youth communicate the plan with adults

- Only youth knows who can be a support and who they trust

Beyond Safety Planning

- What do you do for a youth that leaves your facility?
  - Family leave/weekends
  - Discharge back to the family

Original Investigation

ONLINE FIRST

July 11, 2018

Comparison of the Safety Planning Intervention With Follow-up vs Usual Care of Suicidal Patients Treated in the Emergency Department

Barbara Stanley, PhD[1,2]; Gregory K. Brown, PhD[3]; Lisa A. Brenner, PhD[4,5]; et al

» Author Affiliations

JAMA Psychiatry. Published online July 11, 2018. doi:10.1001/jamapsychiatry.2018.1776

Patients who visited the emergency department for suicide-related concerns and received the Safety Planning Intervention with structured follow-up telephone contact were half as likely to exhibit suicidal behavior and more than twice as likely to attend mental health treatment during the 6-month follow-up period compared with their counterparts who received usual care following their ED visit.

SAFE-VET

- https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/1075-notes.pdf

- Risk assessment + safety plan + weekly case management calls until engaged in care

Caring Contacts

- Non-demand letters expressing care and support
  - Sent following first meeting

- Born from the sending of non-demand letters to military personnel

Implementation

Hunter Area
Toxicology Service

Dear

It has been a short time since you were here at the Newcastle Mater Hospital, and we hope things are going well for you.

If you wish to drop us a note we would be happy to hear from you.

Best wishes,

Dr Andrew Dawson

Dr Ian Whyte

Newcastle Mater Misericordiae Hospital
Locked Bag 7, Hunter Regional Mail Centre NSW 2310
Phone: 49 211 283 Fax 49 211 870

Professional Psychology: Research and Practice

http://dx.doi.org/10.1037/pro0000134

Implementation Methods for the Caring Contacts Suicide Prevention Intervention

Mark A. Reger
VA Puget Sound Health Care System, Tacoma, Washington, and University of Washington

David D. Luxton
University of Washington

Raymond P. Tucker
VA Puget Sound Health Care System, Tacoma, Washington, and Oklahoma State University

Katherine Anne Comtois
University of Washington

Angela D. Keen
VA Veterans Integrated Service Network, Pittsburgh, Pennsylvania

Sara J. Landes
Central Arkansas Veterans Health Care System, Little Rock, Arkansas, and University of Arkansas for Medical Sciences

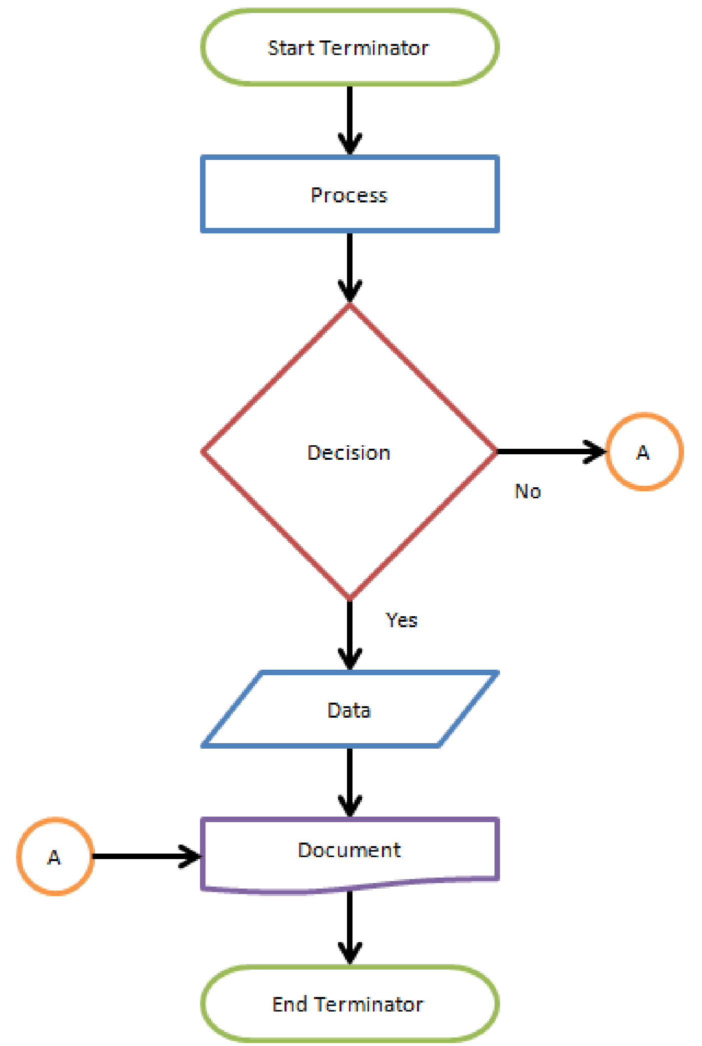
Bridget B. Matarazzo
Rocky Mountain Mental Illness Research Education Clinical Center, Denver, Colorado, and University of Colorado

Caitlin Thompson
Mental Health Services, Washington, DC, and University of Rochester

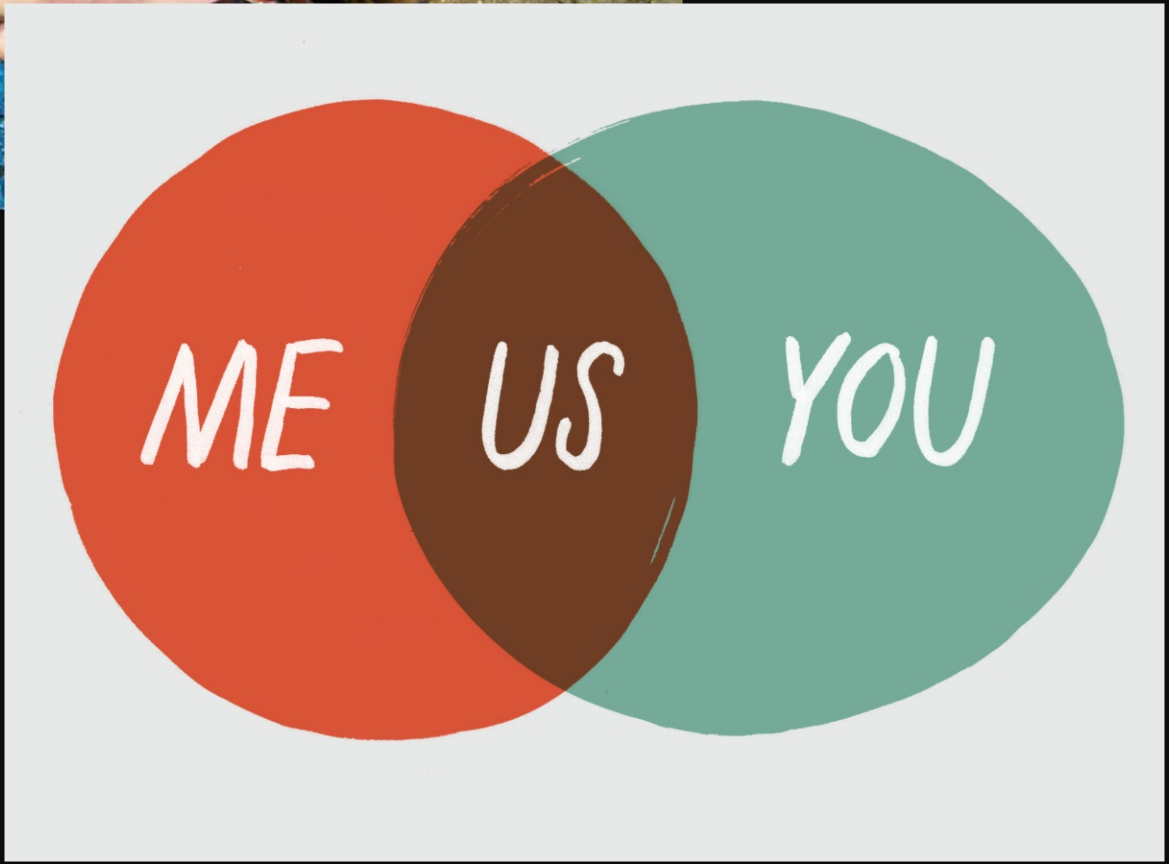
Take Home

- Brief screening with “critical items”
- Standardized suicide risk interviewing
  - Great free ones out there
  - Careful to rely on just “yes” to suicidal thoughts
- Safety planning and means safety counseling
  - Further ideographic assessment
  - Fluoride in the water for crisis coping
  - If deployed like a no suicide contract, likely just as iatrogenic
- Follow-up appears to be important
  - Case management calls
  - Caring Contacts

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE


Start Terminator
Process
Decision
No
A
Yes
Data
A
Document
End Terminator


ATTITUDE
IS
EVERYTHING


ME
US
YOU


I can't
do it


FRAGILE

Long-Term Suicide Prevention

Psychosocial Interventions

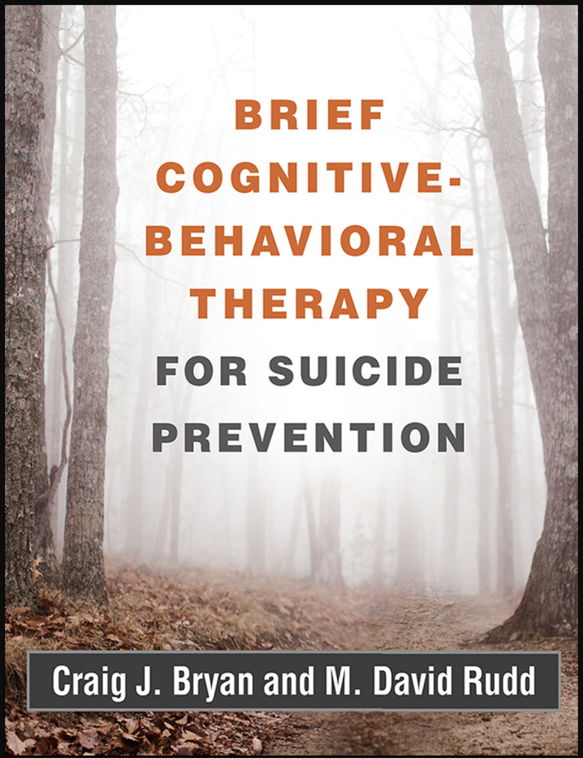
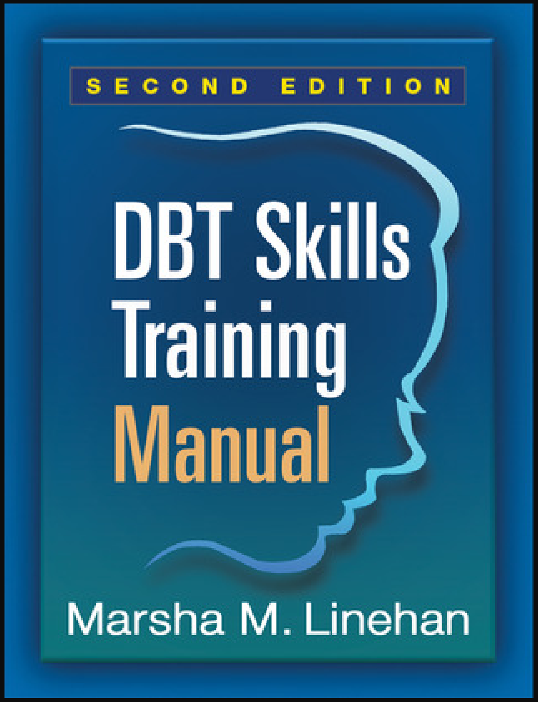
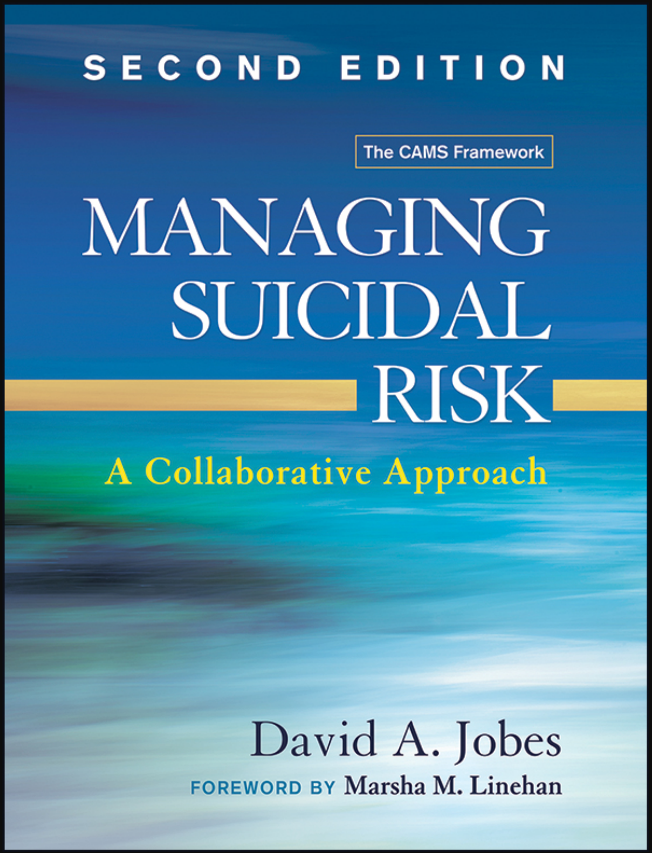
Replicated RCT Support

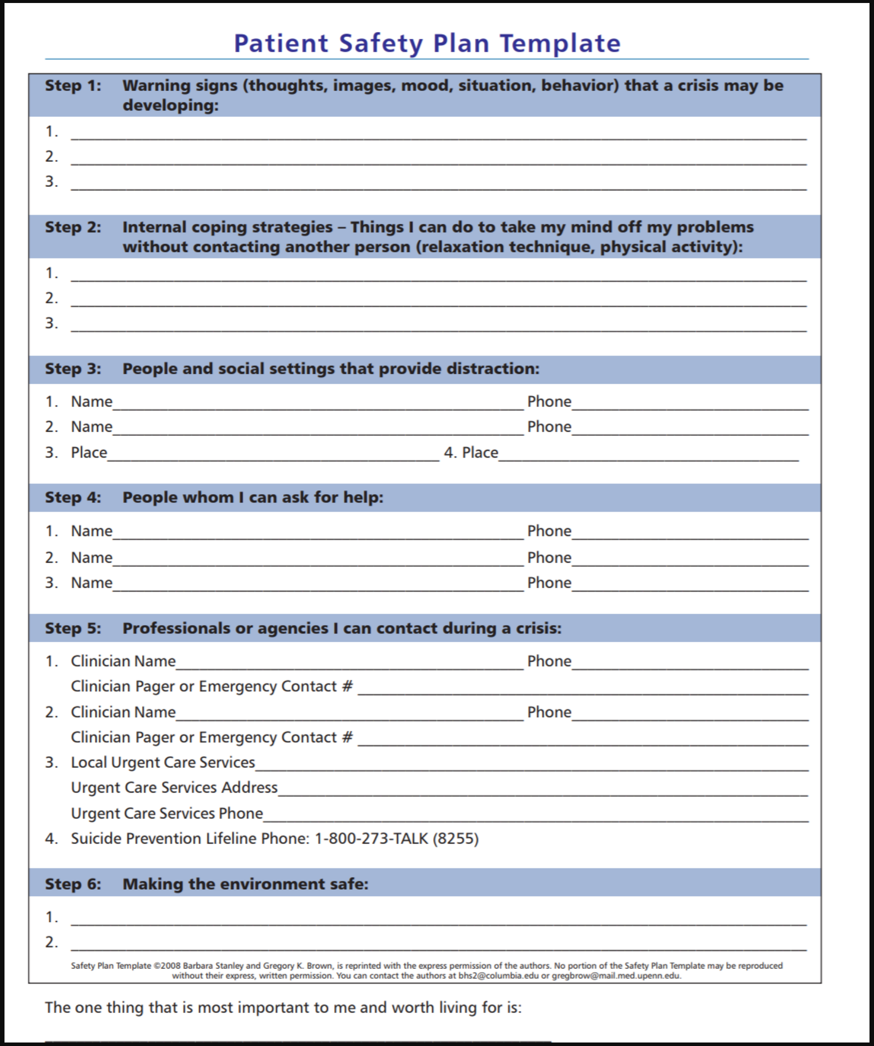
- Dialectical Behavior Therapy (DBT)
- Cognitive Therapy for Suicide Prevention (CT-SP & B-CBT)
- Collaborative Assessment and Management of Suicidality (CAMS)

Consistency Across All Three

- Collaborative yet firm relationship with patient
- Suicide-specific
  - Assessment
  - Case conceptualization
  - Management (safety planning)
  - Treatment
- Focus on both coping or "surviving" AND building a life worth living
- All have adaptations for inpatient treatment, intensive outpatient treatment, etc.

Residential Facilities


BRIEF
COGNITIVE-
BEHAVIORAL
THERAPY
FOR SUICIDE
PREVENTION
Craig J. Bryan and M. David Rudd

SECOND EDITION
DBT Skills
Training
Manual
Marsha M. Linehan

SECOND EDITION
The CAMS Framework
MANAGING
SUICIDAL
RISK
A Collaborative Approach
David A. Jobes
FOREWORD BY Marsha M. Linehan



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. ____________________
2. ____________________
3. ____________________

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. ____________________
2. ____________________
3. ____________________

Step 3: People and social settings that provide distraction:

1. Name____________________ Phone____________________
2. Name____________________ Phone____________________
3. Place____________________ 4. Place____________________

Step 4: People whom I can ask for help:

1. Name____________________ Phone____________________
2. Name____________________ Phone____________________
3. Name____________________ Phone____________________

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name____________________ Phone____________________
   Clinician Pager or Emergency Contact # ____________________
2. Clinician Name____________________ Phone____________________
   Clinician Pager or Emergency Contact # ____________________
3. Local Urgent Care Services____________________
   Urgent Care Services Address____________________
   Urgent Care Services Phone____________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. ____________________
2. ____________________

The one thing that is most important to me and worth living for is:

____

Thanks For Your Time!

Mitigation of Suicidal Behavior (MOSB) Laboratory

Home Our Research Our Team Resources

rtucker1@lsu.edu

https://rtucker13.wixsite.com/mosblab