Suicide Prevention for Youth and Families in Healthcare Settings

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Disclosures

- No actual or potential commercial conflicts of interest

Learning Objectives

1. Review current state of youth suicide
2. Increase familiarity with philosophy of least restrictive care
3. Describe the role of different healthcare settings and providers to prevent suicide
4. Identify gaps and solutions for suicide prevention in healthcare settings.

Youth Suicide: Definitions

Behavior	Definition	Estimates (past year)
Suicide Attempt	Behavior with potential for harm & intent to die	10%
Interrupted Attempt	Person is interrupted from engaging in dangerous act by someone else	
Aborted Attempt	Person takes steps to harm themselves and stops	
Non-Suicidal Self-Injury	Injurious act without intent to die	
Suicidal ideation	Thinking about killing self; ranges from passive (wish to be dead) to active and persistent	22% seriously considered

Xiao et al., 2022; AFSP, 2022; YRBSS, 2023

Suicide Risk and Prevention: Current State

- **Suicide is a leading cause of death among 10–24-year-olds in the United States[1]**
  - Death by suicide is more common than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and lung disease **combined**
- **In 2021, approximately 22% of U.S. high school students reported having seriously considered attempting suicide and 10% attempted suicide[2]**
- **Provisional data from CDC shows death by suicide in 2022 is highest recorded[1]**

Suicide Rate Increases:

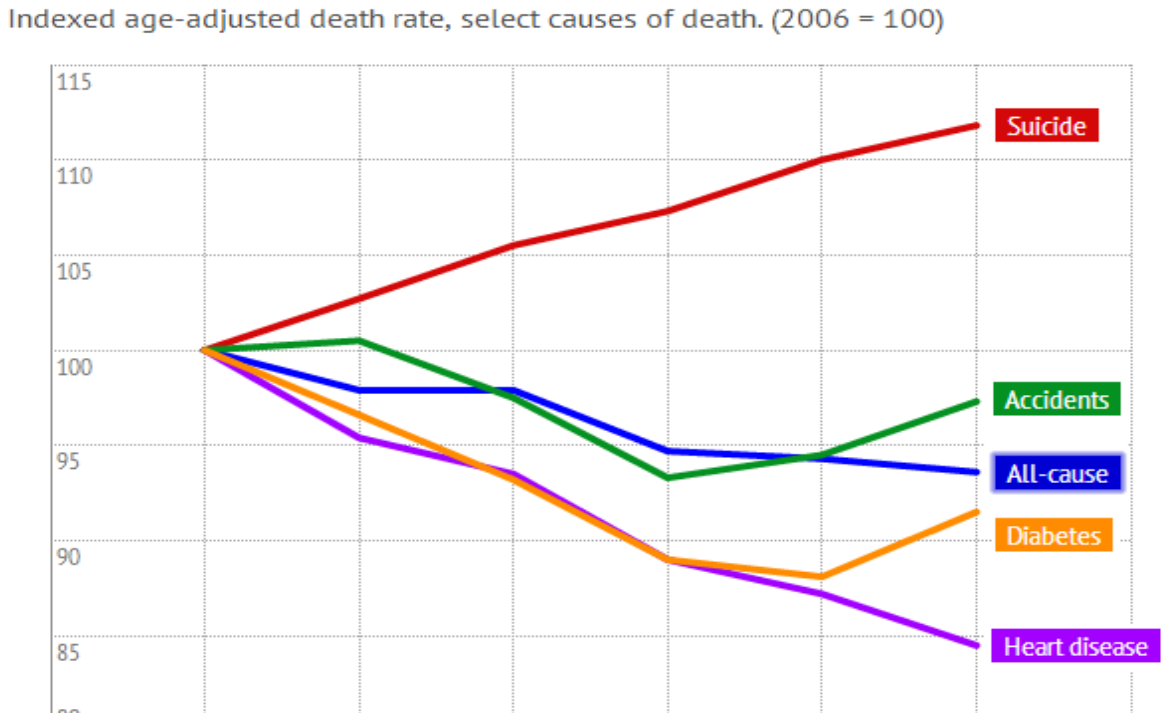
16% for all ages from 2011-2022

33% for all ages from 1999-2019

57% for 10-24 from 1999-2019

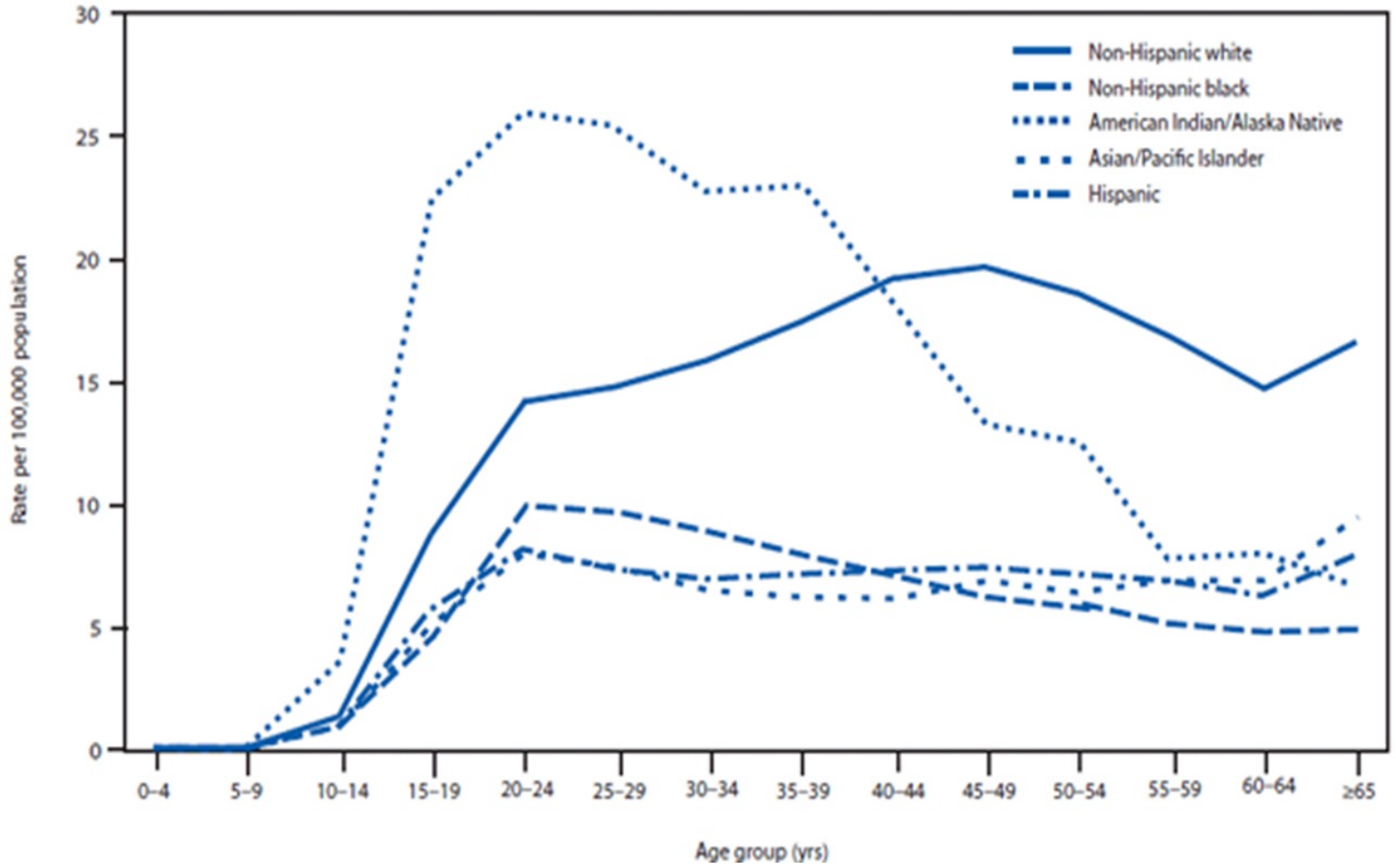
[1](CDC, 2023
[2]NAMI, 2023

Select Causes of Death from 1999-2019



Source. CDC Vital Statistics. 2020

Background and Significance



[1](CDC, 2020)
[2](Ahmedani et al., 2019)
[3](IOM 2001)
[4](Doupnik et al.; 2020)

Background and Significance

Suicide Death Rates by Demographics and Location, 2011 to 2021

Race/Ethnicity	2011 Suicide Death Rate/100,000 population	2021 Suicide Death Rate/100,000 population	Percentage Change from 2011 to 2021
White	15.5	17.4	12.3
Black	5.5	8.7	58.2
Hispanic	5.7	7.9	38.6
Asian or Pacific Islander	6.0	7.0	16.7
American Indian or Alaska Native	16.5	28.1	70.3

Age	2011 Suicide Death Rate/100,000 population	2021 Suicide Death Rate/100,000 population	Percentage Change from 2011 to 2021
12 to 17	4.4	6.5	47.7
18 to 25	13.0	18.1	39.2
26 to 44	15.5	18.8	21.3
45 to 64	18.6	17.6	−5.4
65+	15.3	17.3	13.1

Sex	2011 Suicide Death Rate/100,000 population	2021 Suicide Death Rate/100,000 population	Percentage Change from 2011 to 2021
Males	20.0	22.8	14.0
Females	5.2	5.7	9.6

Rurality	2011 Suicide Death Rate/100,000 population	2021 Suicide Death Rate/100,000 population	Percentage Change from 2011 to 2021
Non-metro	16.1	20.2	25.5
Metro	12.1	13.6	12.4

[1]KFF Analysis of CDC WONDER, , 2011-2021

Suicide Prevention in Healthcare Settings

92% of those who die by suicide had healthcare contact in the last year, and over 50% who die by suicide had contact with a healthcare provider within one month prior to suicide[1]

National guidelines recommend all medical settings screen for suicide risk

Mental health related visits to emergency departments have increased since pre-pandemic

Many healthcare systems do not have processes in place to proactively respond to suicide risk

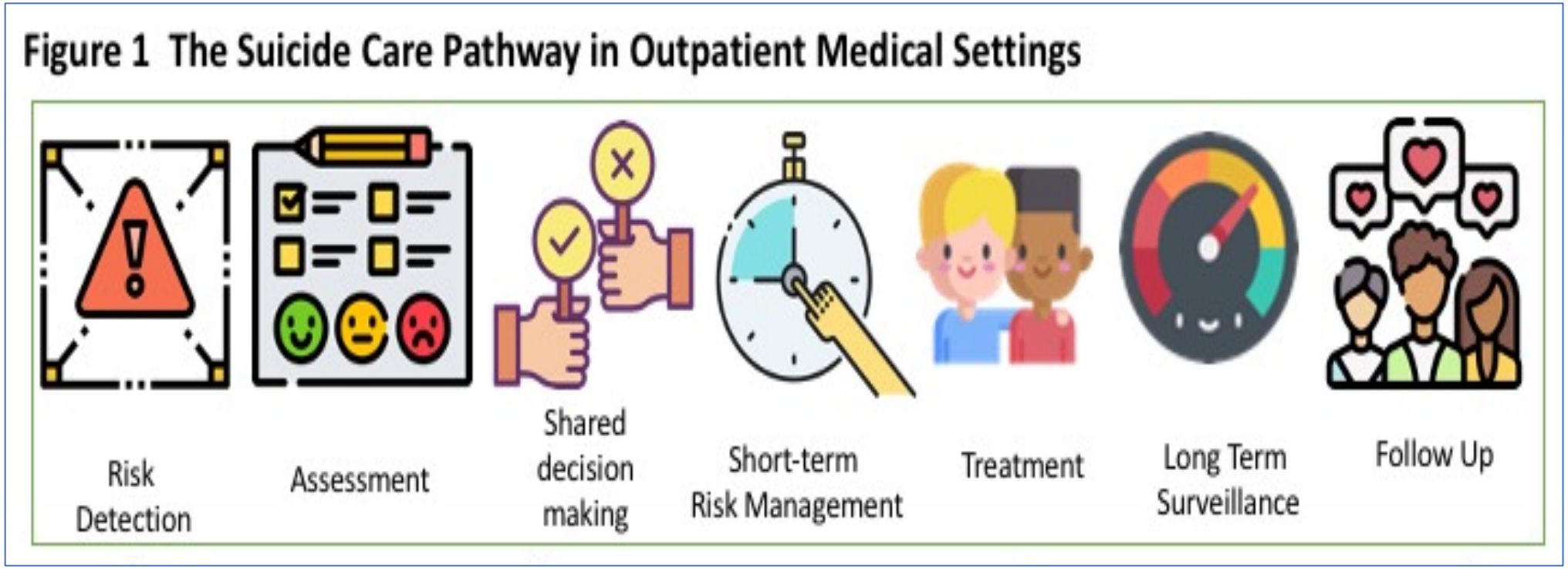
Screening with follow-up reduces suicide attempts and suicide deaths

Pediatric healthcare settings have a responsibility to develop processes for identifying, managing, and treating suicide risk

[1]Ahmedani et al., 2019; AFSP, 2023

Role of Healthcare Providers and Settings in Reducing Suicide

Pathways for Suicide Care



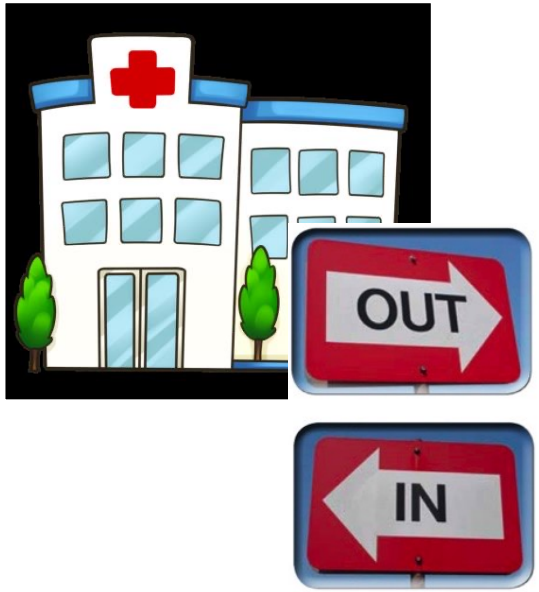
Least Restrictive Care

- Providing the best available care in the least restrictive setting
  - Goal: reduce suicide risk and identify and address underlying concerns driving suicidal thoughts and behaviors

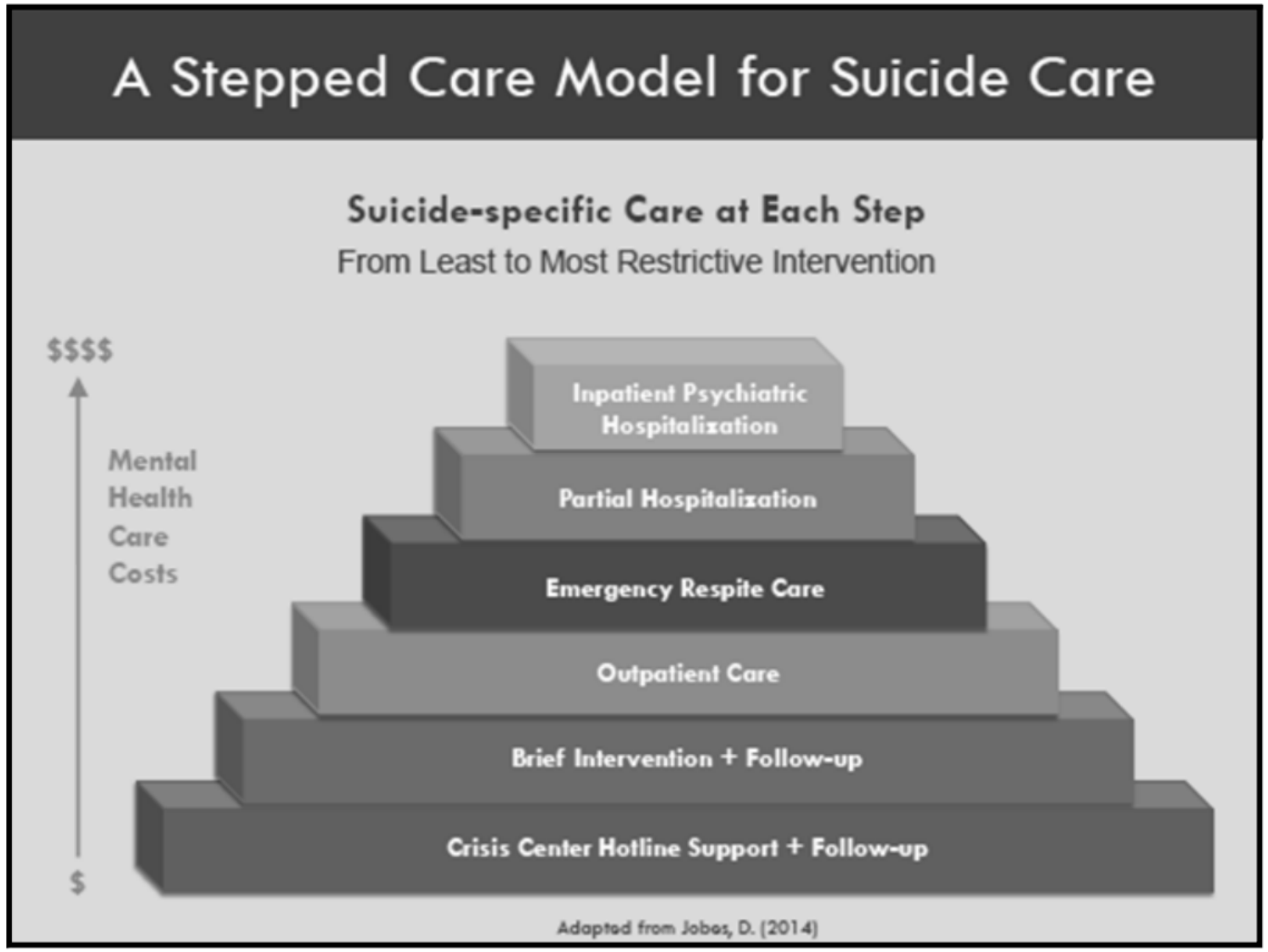
- Why?

Ahmedani & Vannoy, 2014; Ward-Ciesielski & Rizvi, 2021; Forte et al., 2019

Least restrictive intervention



Moving our systems from this…



Jobes, 2014; 2018

…towards this

Elements of Suicide Specific Care

Strengthen access to and delivery of suicide specific care

- Ongoing monitoring of suicide risk
- Treating suicidal thoughts and behaviors directly
- Anticipate future crises and plan for alternative coping
- Seek consultation
- Provide care coordination

Create protective environments

- Identify and support people at risk
- Reduce access to lethal means
- Promote connectedness
- Teach coping and problem-solving skills

Identify

Assessing for youth suicide

- American Academy of Pediatrics recommends:
  - ***Youth ages 12+:** Universal screening
  - **Youth ages 8-11**: Screen when clinically indicated
  - **Youth under age 8:** Screening not indicated. Assess for suicidal thoughts/behaviors if warning signs are present

HOW to ask about suicide

LEARN® SAVES LIVES Suicide Prevention Tips

- LOOK FOR SIGNS
- EMPATHIZE & LISTEN
- ASK DIRECTLY ABOUT SUICIDE
- REMOVE THE DANGERS
- NEXT STEPS

FOREFRONT SUICIDE PREVENTION

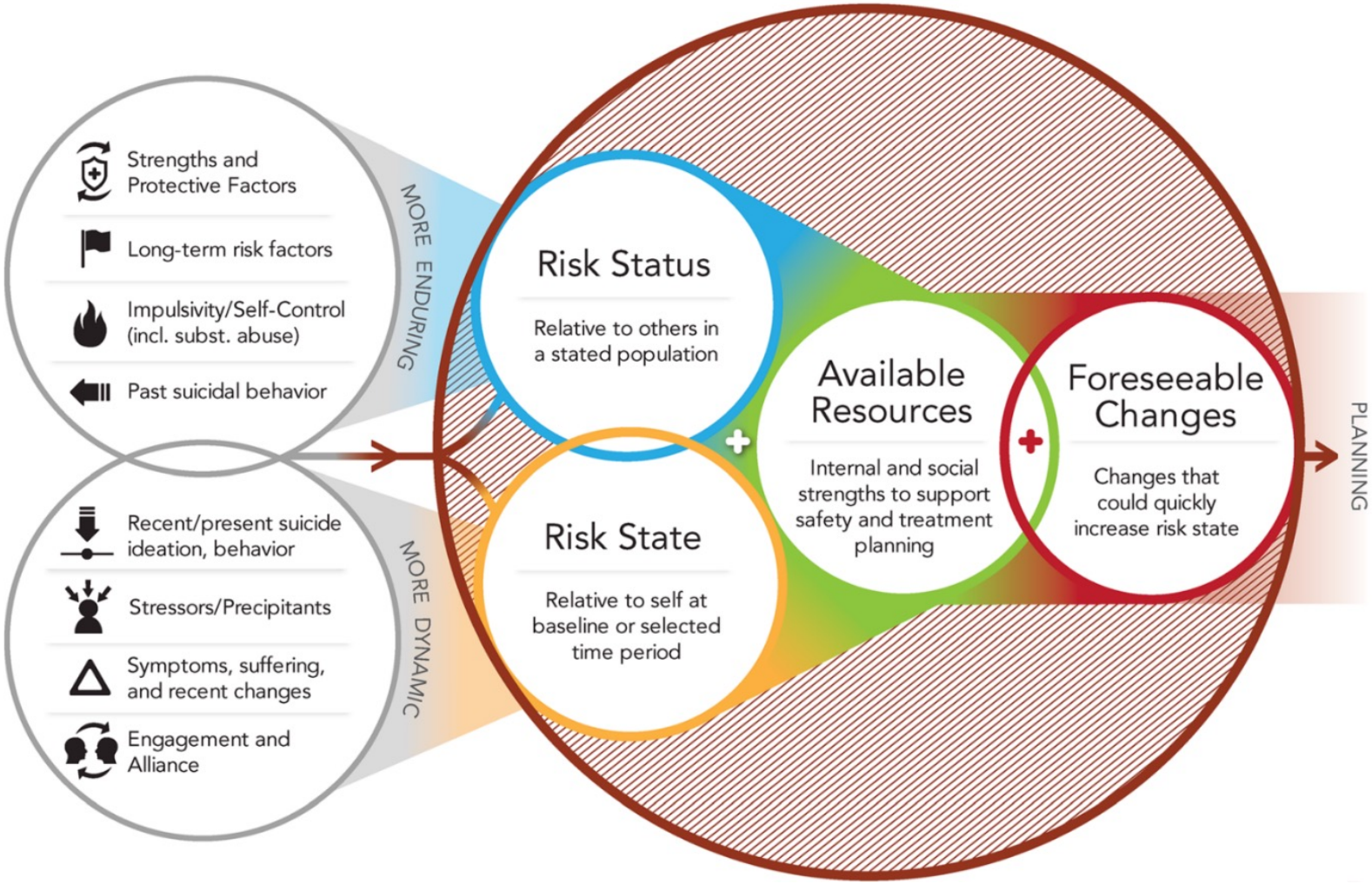
https://intheforefront.org/

How to screen?

- **Suicide Screeners**:
  - **Step 1**: Ask Suicide Screening Questions (ASQ)
  - **Step 2**: Assess level of risk with *either*
    - Brief Suicide Safety Assessment (BSSA)
    - Columbia Suicide Severity Rating Scale(C-SSRS)

- **Steps for Screening and Follow-up**:
  - Complete screening (ASQ)
    - If indicated, complete follow up screener (BSSA or C-SSRS)
  - Formulate risk
  - Determine next steps:
    - Safety planning
    - Lethal means restriction
    - Disposition planning

Risk Formulation



Pisani, A. R., Murrie, D. C., & Silverman, M. M. (2016). Reformulating suicide risk formulation: from prediction to prevention. *Academic psychiatry*, *40*(4), 623-629.

Treat

Interventions and Considerations to Decrease Risk

- Counseling on access to lethal means
- Crisis Prevention/Safety Planning
- Increase frequency or level of care
- Increase monitoring and supervision
- Seek consultation

Reducing Access to Lethal Means

Managing Safety at Home

The interval between thinking about and acting on suicidal urges is sometimes a matter of minutes.

- Lethal means safety is about creating space between suicidal individual and dangerous objects, to “buy time”
- Approach to lethal means counseling as a collaborative process
- Can be helpful to explain that lethal means safety is not about lack of trust but rather about responding appropriately to how the suicidal mindset works
- For every means of suicide the patient has considered, develop and document a mitigation plan

Lethal Means Safety

Additional Training Opportunities

Provider should focus lethal means coaching on:

1. Firearms
2. Medications
3. Any means mentioned by the patient

Counseling on Access to Lethal Means (CALM) free online course: Counseling on Access to Lethal Means (edc.org) (recommend that all clinicians complete this training)

Firearms, Culture, & Suicide Care: https://www.apsafe.uw.edu/targeted-interventions (more in-depth, optional training around working collaboratively with firearm owners)

Safety Planning

The Safety Planning Intervention: Brief clinical intervention that results in a prioritized written list of:

- Warning signs
- Coping strategies, and
- Resources to use during a suicidal crisis.

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

STEP 2: INTERNAL COPING STRATEGIES – THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON:

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Place: _____ 4. Place: _____

STEP 4: PEOPLE WHOM I CAN ASK FOR HELP DURING A CRISIS:

1. Name: _____ Contact: _____
2. Name: _____ Contact: _____
3. Name: _____ Contact: _____

STEP 5: PROFESSIONALS OR AGENCIES I CAN CONTACT DURING A CRISIS:

1. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
2. Clinician/Agency Name: _____ Phone: _____
Emergency Contact : _____
3. Local Emergency Department: _____
Emergency Department Address: _____
Emergency Department Phone : _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

STEP 6: MAKING THE ENVIRONMENT SAFER (PLAN FOR LETHAL MEANS SAFETY):

1. _____
2. _____

(Brown, Stanley, & Green, 2019)

Target Population

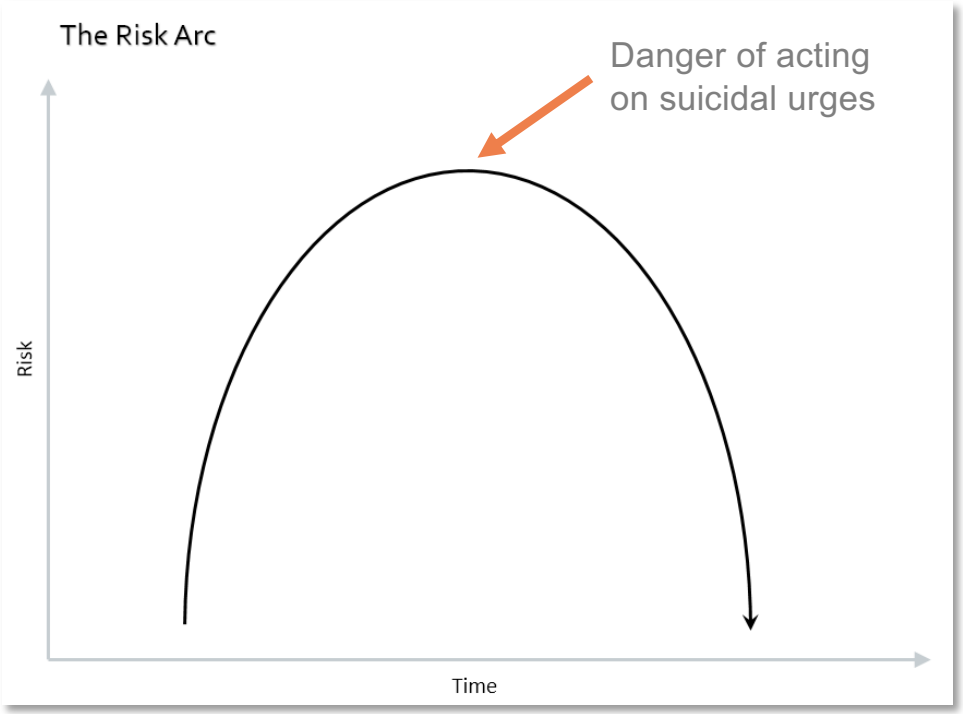
Who is the Safety Planning Intervention most appropriate for?

- Individuals at increased risk for suicide but *not* requiring immediate rescue
- Individuals who have a history of suicidal behavior including:
  - Suicide attempts
  - Interrupted attempts by self or others
  - Individuals who have made preparations or plans for suicide
- Recent history of suicidal ideation
- Otherwise determined to be at risk for suicide
- Can be used with children, adolescents, and adults

We recommend a safety or crisis plan for any patient that has active, current ideation or a suicide attempt within the past year

Why do we Safety Plan?

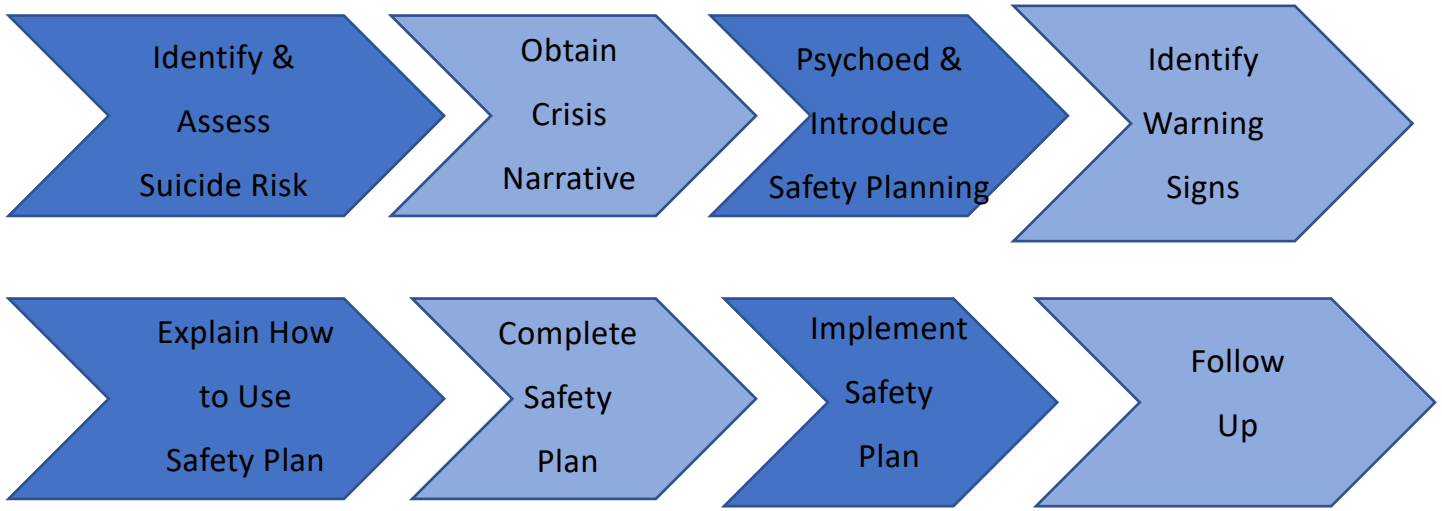
- Designed to manage acute suicide risk
- Individuals may have trouble recognizing when a crisis is beginning to occur
- Problem solving and coping skills diminish during crisis
- Therefore, we should plan ahead for crisis
- Development of an **effective** safety plan requires first understanding the person's unique experience



Brown, Stanley, & Green 2019

Safety Planning Intervention Tasks

The Safety Planning Intervention is more than simply completing the form!



(Brown, Stanley, & Green, 2019)

Narrative Interview of the Suicidal Crisis

GOALS:

1. Help individuals tell their story about what contributed to and led up to escalations in suicidal crisis.
    1. Focuses on a specific suicidal crisis and less on historical vulnerabilities
    2. Helps to build rapport & provide important validation.

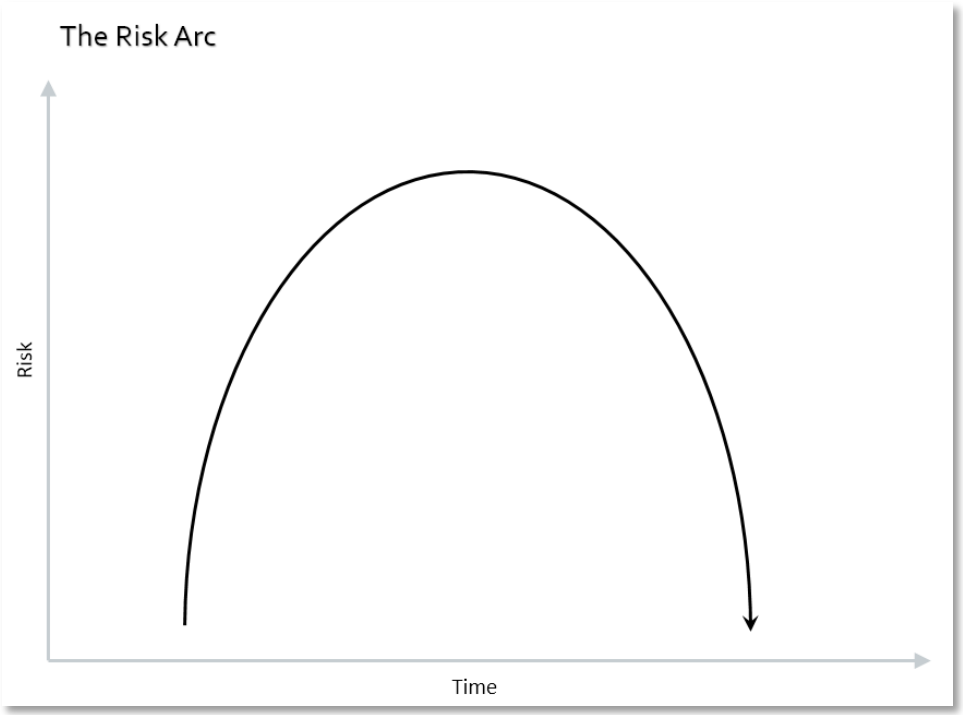
2. Help individuals identify events (triggers) and personal warning signs that indicated the beginning or escalation of the crisis.

3. Help individuals visualize and describe how suicidal risk increases and then decreases over time; and that unbearable pain is time-limited.

4. Help individuals understand how identifying key aspects of their acute suicide risk periods provides an opportunity to cope before acting on suicidal urges.

Psychoeducation to Introduce Safety Planning

- Use the suicide risk arc to illustrate that suicidal feelings are temporary and do not remain constant– these urges rise and fall
- The safety plan is an important tool that helps youth to resist acting on suicidal thoughts/urges
- Safety plan as a short-term solution that “buys you time” during crisis moments, giving suicidal thoughts time to diminish and become more manageable
- Complete psychoeducation with both patient and caregivers



Brown, Stanley, & Green 2019

Components of a Safety Plan

A variety of different templates and approaches are used.

Core components regardless of the template include:

- ✓ Obtain crisis narrative
- ✓ Psychoeducation about suicidal thoughts and behaviors.
- Discussion of warning signs – thoughts, feelings, and actions that indicate (internally and/or externally) that a crisis may be starting
- Healthy coping strategies or skills that the patient can do on their own
    - People or places that can help to distract
- Identification of trusted adult(s) that the teen agrees to alert when they need help
    - What the patient would like this adult to do when they need help
    - Crisis lines

Gaps and solutions for suicide prevention in healthcare settings

Current Challenges in Suicide Prevention in Healthcare Settings

1. **Underreporting and Stigma:** Many cases of suicidal ideation or attempts go unreported due to stigma associated with mental health issues

2. **Limited Training:** non mental health healthcare professionals often lack sufficient training in recognizing, assessing, and managing suicidal patients.

3. **Inadequate Screening:** Routine suicide risk screening is still not consistently implemented in all healthcare settings.

4. **Lack of Continuity of Care:** Lack of discharge planning and follow-up care is often insufficient.

5. **Communication Breakdown:** Poor communication and collaboration among different healthcare providers and departments can hinder a comprehensive approach to suicide prevention.

Potential Solutions

1. **Enhanced Training:** Providing comprehensive training to all healthcare professionals on recognizing and responding to suicidal patients.
2. **Screening Protocols:** Develop and implement standardized suicide risk screening protocols for all patients in healthcare settings.
3. **Integration of Mental Health:** Integrate mental health services within primary care and other medical settings to ensure a holistic approach to patient care.
4. **Stepped care:** Implement stepped care best practice approaches for suicide prevention.
5. **Crisis Helplines:** Promote easy access to crisis helplines and resources for patients who may need immediate support.
6. **Collaborating across agencies, specialties, and settings:** Improving cross-system collaboration can enhance feasibility of discharge plans by facilitating easier connection to mental health resources for at-risk patients.

In summary

- Youth suicide rates continue to increase nationally and locally
- Least Restrictive Care supports patients and healthcare providers
- There is a need for system-wide approaches to behavioral health and suicide screening efforts.
- Healthcare settings and clinicians can help by implementing:
  - Universal screening and assessment
  - Brief intervention (safety planning, lethal means restriction)
  - Stepped care suicide prevention models

Thank you!

Questions?

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