Adolescent Suicidality: Assessment and Prevention

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Disclosures

- I have no relevant relationships in ineligible companies to disclose within the pas 24 months. (Note: Ineligible companies are defined as those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.)

Learning Objectives

- Identify adolescents at risk for suicidality.
- Apply current methodologies for assessment and treatment of suicidal adolescents.
- Describe suicide prevention strategies that can be utilized with adolescent patients.

Magnitude of the Problem: United States

- Adolescents (age 12-19) have higher risk of suicide than adults (<65)
- Suicide is the 2nd leading cause of death in this age group
- High school aged youths (14-18 years old)
  - 2018: 2,039 suicides, approximately 95,000 ED visits for self-harm injuries
  - From 2009-2018 suicide rates increased by 67%, from 6.0 to 9.7 per 100,000

2019 Youth Risk Behavior Survey

- Collected by CDC
- Students grades 9-12
  - 1 in 5 (18.8%) considered suicide
  - 1 in 6 (15.7%) had a plan
  - 1 in 11 (8.9%) had attempted ≥ 1 time

Suicide Data: United States

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2019 data from the CDC, the most current verified data available at time of publication (January 2021).

47,511 Americans died by suicide making it the **10th leading cause of death**.

- **2nd** leading cause of death for ages 10-34
- **4th** leading cause of death for ages 35-44
- **36.6%** of people who died by suicide were 55 or older

12 million Americans have serious thoughts of suicide.

1.379 million Americans attempted suicide.

54% of Americans have been affected by suicide in some way.

Men died by suicide **3.63x** more often than females.

Females were **1.66x** more likely to attempt suicide.

60.29% of firearm deaths were suicides.

50.39% of all suicides were by firearms.

In 2019, the suicide rate was **1.5x higher for Veterans** than for non-Veteran adults over the age of 18.

90% of those who died by suicide had a diagnosable mental health condition at the time of their death.

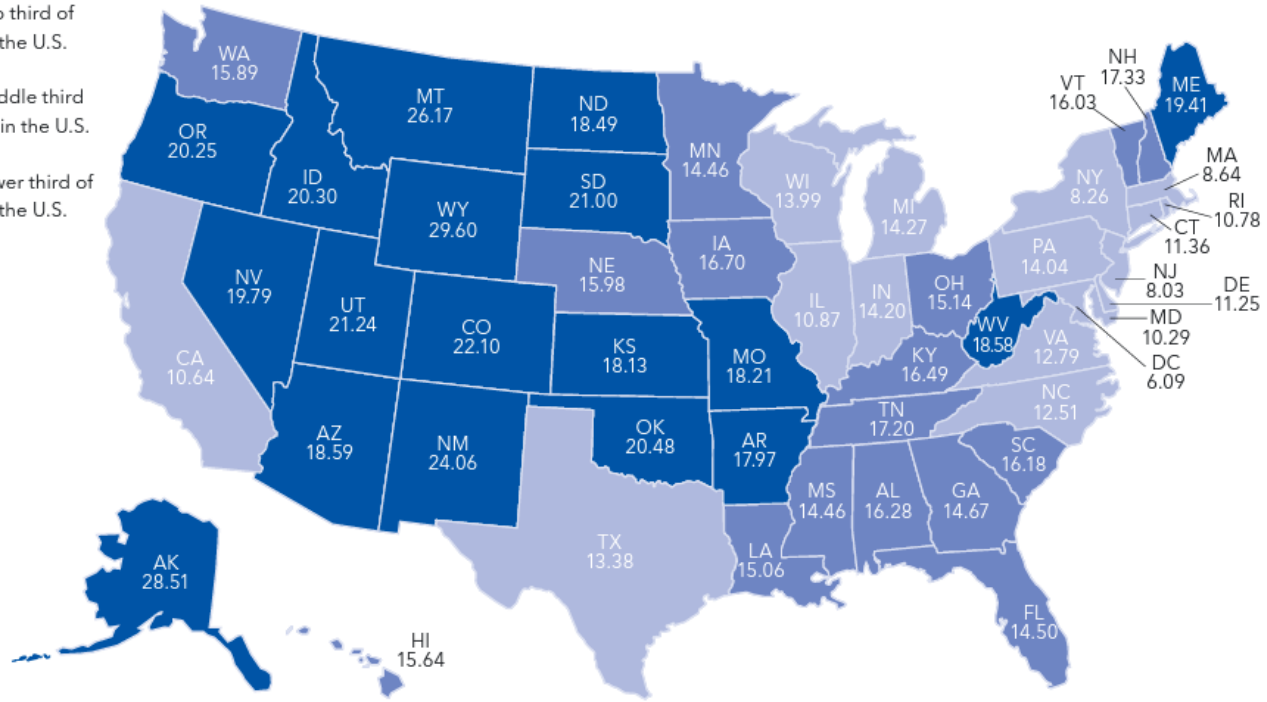
Among adults with a diagnosed mental health condition **43.8%** did not receive mental health services in the past year.

73.1% of the United States did not have enough mental health providers to serve residents in 2020, according to federal guidelines.

See full list of citations at **afsp.org/statistics**.

Suicide Data: United States

- States in the top third of suicide rates in the U.S.
- States in the middle third of suicide rates in the U.S.
- States in the lower third of suicide rates in the U.S.



See full list of citations at **afsp.org/statistics**.

COVID-19 and Adolescent Suicide

- Among children and adolescents, average weekly number of ED visits for suspected suicide attempts have increased compared to 2019
  - 22.3 % higher in summer 2020
  - 39.1% higher in winter 2021
- No increase in deaths
- Increase most evident in females
- May be particularly affected by mitigation measures
- Increased barriers to mental health treatment, increased substance abuse
- Anxiety about family health and economic problems

Risk Factors for Suicide in Adolescents

Static risk factors

Dynamic risk factors

Special population considerations

Static Risk Factors

- Ages 12–19 years old
- Male gender
- LGBTQ sexual orientation
- Family history of:
  - Psychiatric illness
  - Suicide
- Personal history of:
  - Suicide attempt(s)
  - Any nonsuicidal self injury (NSSI)
    - NSSI with severe medical complications
    - NSSI methods other than cutting or drug overdose on first attempt
  - Abuse (physical and/or sexual)
  - Witness to violence, suicidal behavior, or suicide

Dynamic Risk Factors

- Current psychiatric disorder
  - Depression most common
- Psychological symptoms:
  - Insomnia
  - Burdensomeness
  - Impulsivity
  - Active suicidal ideation
- Access to lethal means:
  - Firearms
  - Means for suffocation
- Interpersonal conflicts:
  - Parents
  - Romantic Partner
- Bullying:
  - Victim
  - Perpetrator
  - Both
- Legal trouble/incarceration
- Current substance abuse
- Social isolation

Special Population Considerations: LBGTQ

- May feel they do not belong to meaningful relationships and groups and is a burden to others
- Marginalized identities experience chronic stress due to stigmatizing social contexts
- Disproportionately victimized in school
- Increased levels of depression
- Higher risk for problematic drug use
- Higher prevalence of suicidal ideation and attempts compared to non-LGBTQ peers

Assessment Strategies and Intervention

Risk assessment

Risk management

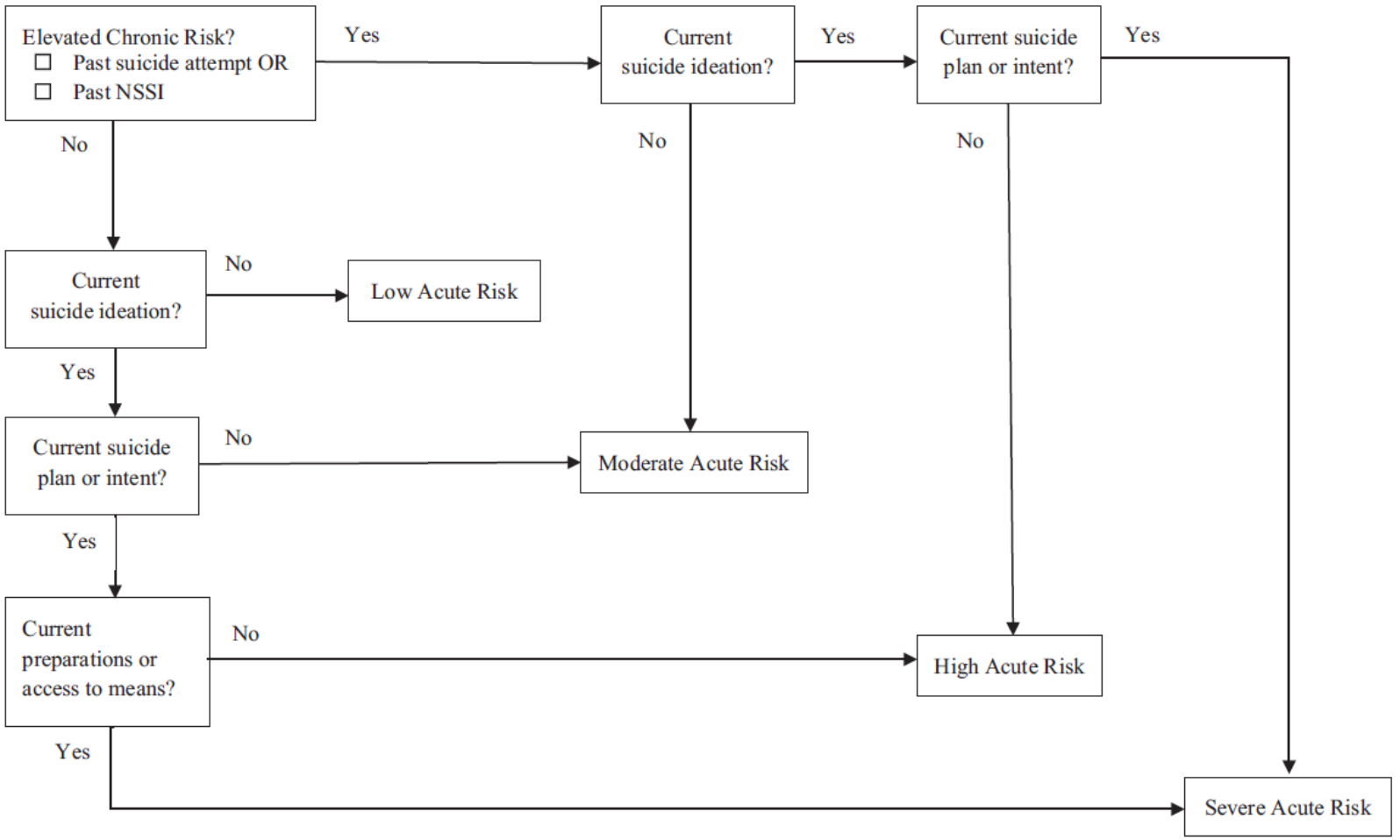
Determine level of risk

Assess resources available

Suicide Risk Assessment

- Assessing for suicide risk does not increase suicidal behaviors
- When introducing the topic, normalize the experience of suicidal thoughts and behaviors
  - Avoid using the word “suicide”
  - Discuss in matter-of-fact manner
  - Lowers defenses in patient
  - Leads to more open disclosure
- Important to make sure that patient understands limits of confidentiality
- Adolescents may be more comfortable discussing without caregivers present

Assessing Acute Suicide Risk



Pettit JW et al. Assessment and Management of Suicide Risk in Children and Adolescents. *Cognitive and Behavioral Practice*. 2018; 25: 460-472.

Other Variables to Consider

- A higher risk designation may be appropriate if present:
  - Recent negative life events
  - Substance abuse problems
  - Sleep disturbances
  - Aggressive behaviors
  - Family history of suicide
  - History of sexual abuse
  - Impulsivity

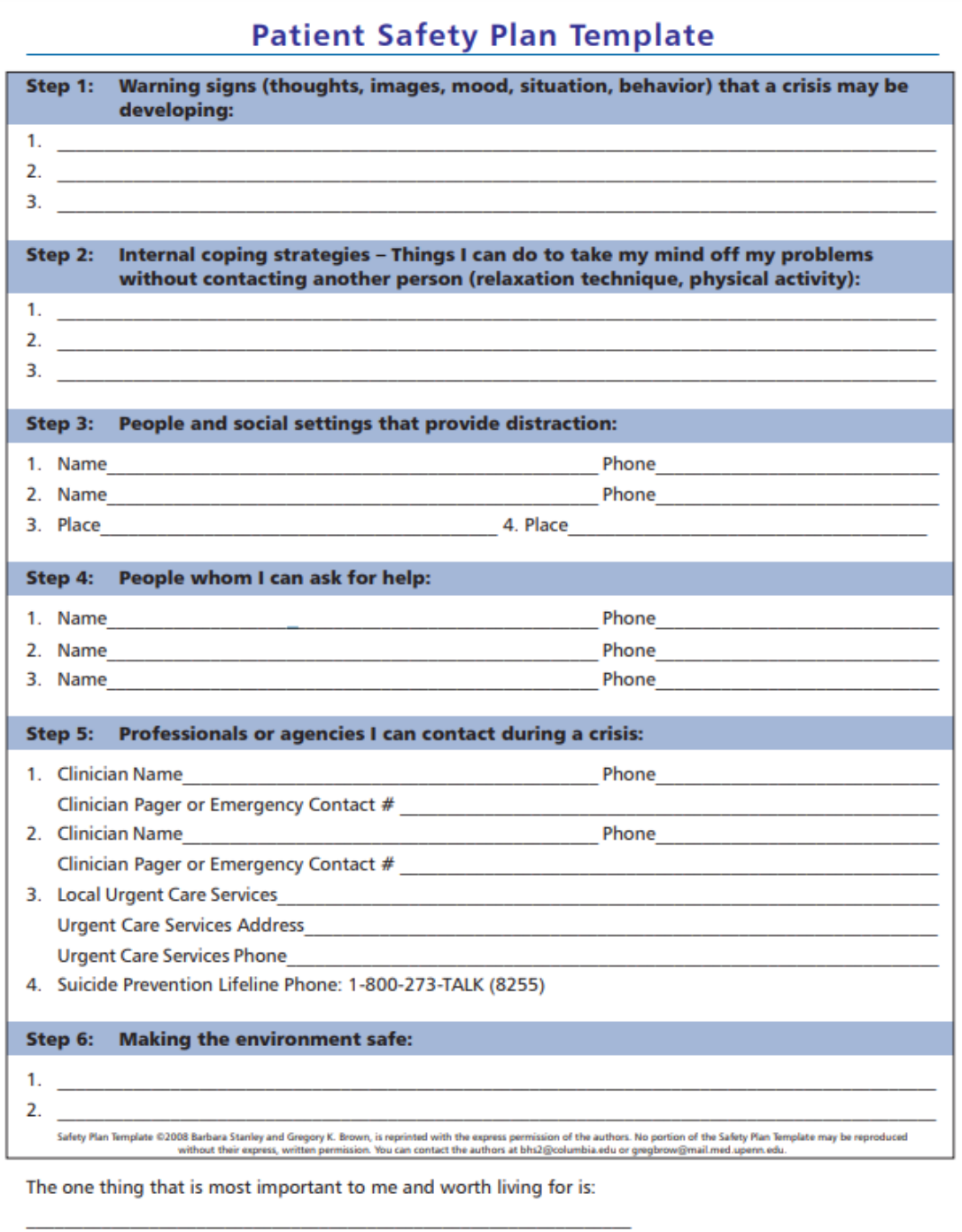
Risk Management: Safety Planning

- Safety (no-suicide) contracts not sufficient
- Safety plan includes:
  - Recognizing signs that symptoms are worsening
  - Initiating coping strategies
  - Make use of social contacts to help distract from thoughts of suicide
  - Contacting family members to deal with the crisis
  - Contacting mental health professionals
  - Reduce access to lethal means

Safety Plan Example

https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org



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:

_____

Professional Resources

- National Suicide Prevention Lifeline 1-800-273-8255
- EMPACT (480) 784-1500 or 1-866-205-5229
- Teen Lifeline (602) 248-TEEN (8336) or 1-800-248-TEEN
- Text- or chat-based crisis intervention services
  - http://www.crisistextline.org
  - http://www.crisischat.org
- The Trevor Project: phone, text and chat-based crisis intervention for LGBTQ youth
  - 1-866-488-7386
  - http://www.thetrevorproject.org

988

- 7/16/20 FCC adopted to rule to establish 988 as nationwide 3-digit number
  - Requires phone service providers to route all 988 calls to national suicide hotline by 7/16/22
  - 11/18/21 FCC adopted Second Report and Order to add ability to text to 988

NOT YET AVAILABLE

Treatment Options

- Inpatient vs. outpatient
- Psychotherapy
- Role of telehealth
- Adjunctive pharmacotherapies

Inpatient Psychiatric Hospitalization

- Nearly always indicated for adolescents with high acute risk
- Pending hospitalization, need constant observation
- Involuntary hospitalization may be necessary
  - If parent/guardian not present or disagree with clinician
  - Maintain autonomy to consent for treatment, unless necessary for stabilization during a crisis

- Indications of high risk:
  - Attempt with highly lethal method or included steps to avoid detection
  - Ongoing ideation or disappointment attempt not successful
  - Inability to discuss attempt or precipitating factors, safety planning
  - Underlying psychiatric disorders
  - Agitation
  - Impulsivity
  - Poor social support

Acute Outpatient Treatment

- Usually best option for low/moderate risk individuals
  - Medically stable
  - Happy to be alive
  - Without specific plan
- Contingent upon a safety plan
- Secure mental health follow-up within 48 hours
- Instruct family members to seek emergency treatment (crisis outreach, ED, 911) if patient decompensates

Psychotherapy

- General principles
  - Address family interactions/increase nonfamilial support
  - Target alcohol and substance abuse if indicated
  - Discuss motivation for treatment
  - Initiate treatment quickly if crisis recurs
- Cognitive-behavioral therapy (CBT)
- Dialectical behavior therapy (DBT)
- Family therapy
- Mentalization based therapy

CBT

- Typically spans 10-12 outpatient sessions
- 3 phases:
  1. Suicide risk assessment, develop treatment plan, create crisis plan/safety plan, training focused on emotion regulation and crisis management
  2. Identify and challenge patient's maladaptive beliefs and self-statements which contribute to suicidal behaviors
  3. Relapse prevention and consolidation of skills to prepare to manage stressful situations in the future
- Shown to reduce suicidal behavior by 50% or more

DBT

- Multicomponent cognitive-behavioral treatment
- Targets treatment engagement and the reduction of self-harm and suicide attempts
- Focuses on teaching skills for enhancing emotion regulation, distress tolerance, and building a life worth living
- Includes weekly sessions of individual therapy, group therapy and family therapy
- Clinical trials show reduction of self-harm and suicide attempts at 6 12 months, 3 years

Family Therapy

- Often combined with other treatment
- Open-label randomized trials indicate reduction in suicidal ideation and behavior

Mentalization Therapy

- Focuses upon impulsivity and affect regulation
- In one trial, reduction of depressive and borderline symptoms was greater with active treatment
  - Combine weekly individual therapy and monthly family therapy
  - Mentalization appeared to improve self-harm outcomes by improving the quality of attachment between adolescents and their parents
  - Improved the ability to conceptualize actions in terms of thoughts and feelings

Role of Telehealth

- COVID-19 pandemic revealed weak points in US healthcare system
- Mental health providers rapidly transitioned to telehealth services
  - Surge in demand for care
  - Decreased numbers of providers
- Telehealth may offer advantages in providing care to adolescents
  - Prefer “online” sessions
  - Allow parent to have greater participation
  - Facilitate nonhospital treatment opportunities

Pharmacotherapy

- No indication for emergent administration of antidepressants
- Pharmacotherapy based on treatment of underlying disorder
  - Unipolar depression
    - Fluoxetine first line
    - Sertraline, venlafaxine second line
    - Bupropion or duloxetine third line (plus referral to adolescent psychiatrist)
  - Bipolar disorder
    - Second generation antipsychotics first line (aripiprazole, asenapine, olanzapine, quetiapine, risperidone, or ziprasidone)
    - Lithium if treatment resistant
    - Treatment combinations if refractory
      - Second generation antipsychotic + lithium
      - Second generation antipsychotic or lithium + antiepileptic (divalproex, lamotrigine, carbamazepine)

Antidepressants and Suicidality

- Appears to be slight risk of suicidal thoughts and behaviors (but not completed suicide) in children and adolescents
  - Comes from randomized, observational and population-based studies
  - Overall rare, causality difficult to establish
- FDA black box warning
  - 2004: children and adolescents
  - 2007: expanded to include adults younger than 25
- Risk of anti-depressant related suicidality weighed against benefits of treatment and long-term risk of suicide in untreated depression
- Start on low doses and closely monitor

Suicide Prevention

- Create protective environments
- Promote connectiveness
- Teach coping and problem-solving skills
- Identify and support people at risk
- Lessen harms and prevent future risk

Creating Protective Environments

- Reduce access to lethal means, safe storage practices
  - The interval between deciding to act and attempting suicide can be as short as 5 or 10 minutes
  - People tend not to substitute a different method when a highly lethal method is unavailable or difficult to access
- Routine suicide prevention training
  - Standardized screening and assessment
  - Observation
  - Emergency response protocols
- Reduce drug and alcohol use

Promote Connectiveness

- Sociologist, Emile Durkheim (1897): weak social bonds, i.e., lack of connectedness, were among the chief causes of suicidality
- Connectiveness
  - Decreases isolation, builds belongingness
  - Encourages adaptive coping behaviors, builds resilience
  - Better access to support
- Peer norm programs
- Community engagement activities

Teach Coping and Problem-Solving Skills

- Prepare to adapt to stress and adversity
- Social-emotional learning programs
  - Provide skills to resolve problems
  - Often delivered in school settings to all students or focused on high-risk students
- Parenting skill and family relationship programs
  - Strengthen parenting skills
  - Enhance positive parent-child interactions
  - Improve children’s behavior and emotional skills

Identify and Support People at Risk

- Attention to vulnerable populations
- Gatekeeper training
  - Training to help identify people at risk
  - Teachers, coaches, clergy, emergency responders, health care providers
- Crisis intervention
  - Connect person in crisis to trained volunteers or professionals
  - Intended to impact key risk factors for suicide (depression, hopelessness, mental health care utilization)
- Treatment for people at risk
  - Psychotherapy
  - Licensed providers

Lessen Harms and Prevent Future Risk

- Care and attention to the bereaved
- Postvention
  - Implemented after a suicide
  - Debriefing, counseling, support groups
  - Surviving friends, family, close contacts
- Safe reporting and messaging about suicide
  - Avoid sensationalizing of events
  - Inclusive of:
    - suicide prevention messages
    - Stories of hope and resilience
    - Risk and protective factors
    - Links to resources

Youth Suicide Prevention Efforts

- Community-based
  - https://zerosuicide.edc.org/
  - https://www.azahcccs.gov/AHCCCS/Initiatives/suicideprevention/index.html#maricopa
- School-based
  - https://www.azahcccs.gov/AHCCCS/Initiatives/suicideprevention/training_for_schools.html

Conclusion

- Suicide is a serious public health concern
- Rates are increasing
- Understand identification of individuals at risk, how to manage risk, and approach treatment
- Continue pushing towards prevention

CME Question 1

Which of the following is correct concerning safety plans?

a. The patient signs a no suicide contract.

b. The patient identifies warning signs a crisis may be developing.

c. It requires immediate inpatient hospitalization.

d. Safety plans are not necessary for low risk patients.

CME Question 2

Which statement is true regarding the use of pharmacotherapy in suicidal adolescents?

a. Antidepressants should be started emergently.

b. Second generation antipsychotics are the treatment of choice in adolescents with unipolar depression.

c. Antidepressant use is linked to increased cases of completed suicide in adolescents.

d. The risk of anti-depressant related suicidality should be weighed against benefits of treatment and long-term risk of suicide in untreated depression.

CME Question 3

What is considered a static risk factor for adolescent suicidality?

a. Access to lethal means

b. Impulsivity

c. LGBTQ sexual orientation

d. Substance use

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Questions?

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