Suicide Prevention in Pediatrics
Focus on Trends in Adolescent Suicide

Greg A Marley, LCSW
Maine Suicide Prevention Program
In partnership with: NAMI Maine
Education, Resources and Support—It's Up to All of Us.

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Maine Suicide Prevention Program
A program of the Maine Center for Disease Control and Prevention since 1998

Statewide Activities Include:

- **Data** collection, analysis & dissemination of **print materials**
  - *SAMHS's* The Maine Prevention Store: https://www.maineprevention store.com/
- **Training** and consultation on suicide prevention and assessment to a wide range of partners statewide.
- **Technical Assistance** for schools and organizations addressing suicide risk or coping with a suicide loss.
- Specific programing for healthcare systems, youth-serving organizations and the recovery community.
- Virtual *Beyond the Basics in Suicide Prevention Conference*, October 1, 2020

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Introduction

- When you experience the suicide of a youth, it is a devastating loss of life deeply impacting family, friends, staff and the community.
- A suicidal crisis is almost always transient and treatable
- Suicide is "the most preventable form of death in the US today." (David Sacher, former US Surgeon General)
- Having the tools and processes in place prepares you to be a prevention and intervention resource.

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Suicide in the United States, 2018

- **48,344** Americans died by suicide in 2018; about 1 person every 11 minutes[1]
- Suicide deaths are **2.6 times** the number of homicides (homicides=18,830) [1]
- **10th** leading cause of death across the lifespan[1]
  - **2nd** leading cause of death for **10-34** year olds
- Males account for **78%** of suicide deaths[1]
- Approximately 6000 Veterans die by suicide each year; accounting for **14%** of all suicides annually[2]
- Since 2009, suicides have **exceeded** motor vehicle crash related deaths[1]

1. U.S. CDC WISQARS Fatal Injury Data, 2018 update. Accessed July 2020; https://www.cdc.gov/injury/wisqars/index.html
2. 'VA National Suicide Data Report, 2005-2016' report, September 2018, U.S. Department of Veteran Affairs.

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Suicide in Maine, 2016-2018

- **257 suicide deaths per year on average**[1]
  - 9th leading cause of death among all ages (previously 10th, 2012-2014)
  - 2nd leading cause of death ages 15-34
  - 4th leading cause of death ages 35-54
- More suicide deaths in Maine than homicides and motor vehicle traffic deaths[1]:
  - **13.5x** homicide deaths (770 suicide deaths vs 57 homicides)
  - **1.6x** motor vehicle deaths (770 suicide deaths vs 495 motor vehicle traffic deaths)

1. U.S. CDC WISQARS Fatal Injury Data, 2018 update. Accessed July 2020 ; https://www.cdc.gov/injury/wisqars/index.html

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Suicide in Maine, 2016-2018

- Every **1.4 days** someone dies by suicide in Maine[1]
  - **Every other week** a young person (10-24 years) dies by suicide
- Approximately **4** female attempts per every **3** male attempts[2]
- **Firearms** most prevalent method of all suicide deaths (**53%**) [1]
  - Among youth ages 10-24 years, **57%** of suicide deaths by firearms

1. U.S. CDC WISQARS Fatal Injury Data, 2017 update. Accessed July 2020; https://www.cdc.gov/injury/wisqars/index.html
2. Maine Hospital Inpatient Database, Maine Health Data Organization, 2016-2018.

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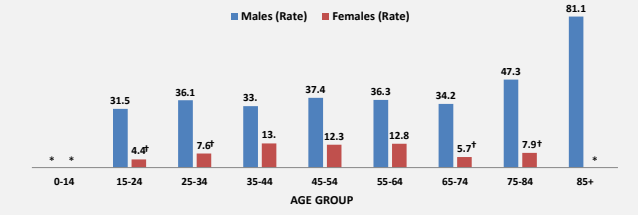
Age-specific Death Rates, by Age & Sex, Maine, 2016-2018

(3 years combined)



Data source: US CDC WISQARS Fatal Injury Data. *Rates for both males and females ages 0-14 and for females ages 85+ are suppressed due to small numbers (fewer than 10 deaths in 2016-2018 combined). †Rates based on 20 or fewer deaths may be unstable. Use with caution.

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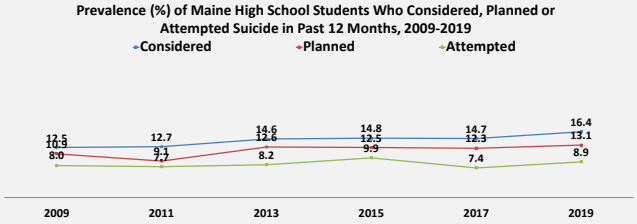
Since 2009, there has been a significant increase in suicide ideation among Maine high school students.



Data source: Maine Integrated Youth Health Survey (MIYHS), 2009-2019.

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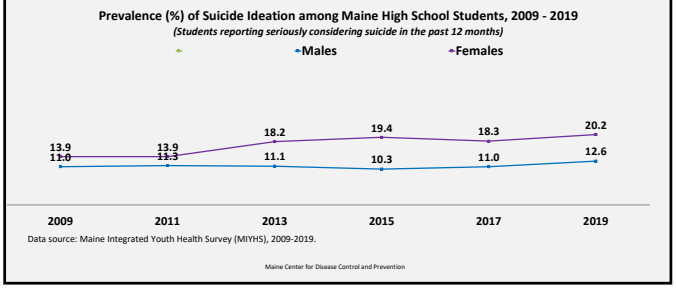
Female students are driving the increase of suicide ideation among Maine high school students.



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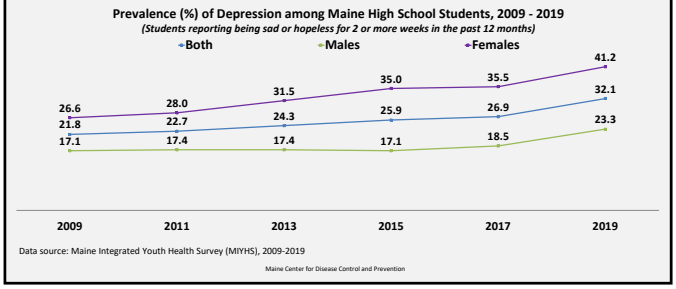
The significant increase in depression among Maine high school students between 2009 and 2019 was mostly driven by female students.



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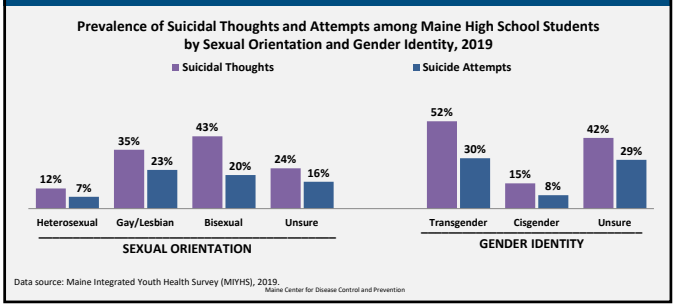
Gay/lesbian and bisexual students are more likely to consider and attempt suicide as well as students who are transgender or unsure of their gender identity.



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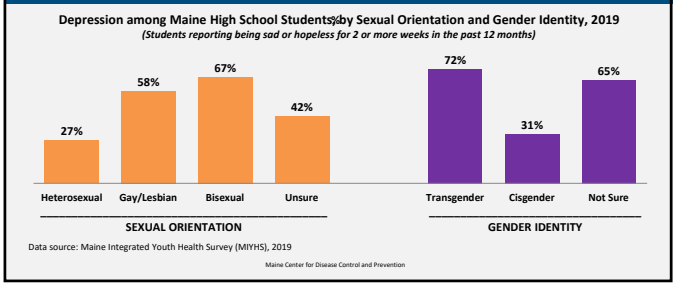
Gay/lesbian, bisexual and transgender students as well as those unsure of their gender identity are more likely to report depressive symptoms.



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Trends in Suicidal Behavior in School-Age Youth

- In general, suicide risk increases with age through adolescence and young adulthood.
- Nationally and in Maine we have seen an increase in suicide in youth under age 15. Significantly, girls have shown more marked increase than boys.
- This is also reflected in disparate increases and higher rates of depression, anxiety and NSSI among girls.
- School staff generally report increased signs that their students are under greater levels of stress and show reduced ability to cope with the stresses.
- Geographic or school district boundaries are increasingly more porous and fluid in this age of social media.

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Contagion Risk in Adolescents

- Suicide Contagion: refers to the influence of a known suicide or suicides on others; especially those who emotionally connect with the victim or their circumstances.
  - Most prominent in populations of adolescents or young adults.
  - The suicide death of a prominent celebrity can increase suicide rates broadly
  - **Youth 15-19 may be 2-4 times more prone to suicide contagion.**
  - **Middle school youth are likely even more contagion risk!**
  - **Social media use strongly influences contagion risk.**
- Contagion may lead to suicide clusters.
- The way in which a suicide death is handled in the media or within a school or organization can limit the degree of contagion

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Suicide Attempts

- A suicide attempt may be the first overt sign that someone is struggling!
- A call for Help
  - Often trigger being seen by a provider!
- Estimates 25 attempts for every suicide death
  - 200:1 for adolescents
- ***A past suicide attempt is most predictive of future suicide behavior.***
- The response made to a suicide attempt strongly impacts future risk!

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Self-Injury and Suicide

- Non-Suicidal Self Injury (NSSI) is an unhealthy way to cope with strong negative emotions.
  - Overwhelms neural pathways holding emotional pain with physical pain
  - Rapid return to emotional calm
  - *Because it works it can become repetitive and habitual*
- 25% of Maine MS/HS girls and 12% of boys report SI on the past 12 months.
- Higher rates in LGB youth; transgender youth report 58% (2019 MIYHS data).
- Similar college rates.
- ***Self Injury may be the most predictive of suicide risk in adolescents!***
- Significant increase in risk of suicide ideation and attempts.

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The Paradox: Self Injury and Suicide

- Self Injury often seen as a way to avoid suicide, but:
- Is often linked to suicidal ideation, AND
- Those who self injure are:
  - 9 times more likely to report suicide attempts
  - 6 times more likely to report a plan and
- Recent self-injury may be the most predictive of future suicide risk
- Maine Youth who report making a suicide attempt in the past year are at significant risk for self-injury (MIYHS Data, 2013)
  - 24% report occasional self-injury
  - 53% report repetitive self injury
- ***Self Injury requires assessment and treatment!***

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Mental Illness as a Risk Factor for Suicide

"Depression predicts suicide ideation, but not suicide plans or attempts among those with ideation. Instead, disorders characterized by severe anxiety/agitation (e.g., PTSD) and poor impulse-control (e.g., conduct disorder, substance use disorders) predict which suicide ideators go on to make a plan or attempt." Nock 2009

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Comorbidity Issues in Adolescent Suicidality

- 96% of attempters and 89% of ideators met criteria for 1 or more DSM-IV disorder(Nock et al, 2103)
- Most common Dx. MDD, phobias, ODD, substance use Dx , and CD.
- DX with greatest predictor for suicide attempts include MDD, PTSD, eating disorders and Bipolar Dx.
- Highest risk for attempts among ideators with Dx characterized by high anxiety, agitation and poor behavior control.

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LGBTQ Youth/Young Adults

- Suicide attempt rates 3-4 times their peers
- Increase due to societal stigma and rejection
- Critical risk factors include rejection, depression, anxiety, chronic stress, abuse, victimization, bullying, etc…
- Rejection by family can increase risk up to 8X
- Family acceptance and school safety are strong protective factors
- Cultural competence is important in prevention

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Adolescent Warning Signs for Suicide

Is the youth (up to age 24) :

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe/overwhelming emotional pain or distress
- Showing worrisome behavior or changes particularly in the presence of the above warning signs.
  - **Specifically:**
    - Withdrawal from or changes in social connections
    - Recent increased agitation or irritability
    - Anger or hostility that seems out of character or context
    - Changes in sleep (increased or decreased)
    - Changes in daily Hygiene… *AAS Consensus group, 2014*

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Working toward Suicide Safer Care

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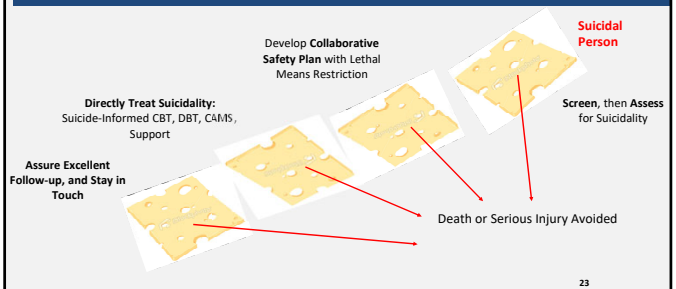
Systematic Suicide Care Plugs the Holes in Health Care



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Developing a Suicide-Informed Practice

- All staff see suicide prevention as part of their work.
- Training and support is available for their roles.
- **Protocols** are in place guiding screening, identification, assessment, management of risk
  - A standardized **assessment** tool is used
  - **Referrals** are made for treatment as indicated
  - **Collaborative Safety planning** is used as a management tool
  - Continuity of care is assured through **proactive follow-up** for those identified as at risk.

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Asking About Suicide

"The answers you get depend upon the questions you ask."

Thomas Kuhn

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What is Your Reaction When Your Patient Talks About Suicide?

- Personal
- Professional
  - What are your concerns?
  - How do you know when you've done enough?
- When I ask her about suicide, I'm thinking…
- Who else needs to be involved?
- How do you take care of yourself?

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Asking About Suicide
Overcoming Societal Reluctance

- Talk about suicide directly and without hesitation.
- Ask using concrete and direct language.
  - Are you thinking about dying today?
  - How often do you consider killing yourself?
  - Are you suicidal? Do you have a plan?
- Vague or indirect questions elicit vague responses:
  - Are you thinking of hurting yourself?
  - Do you feel safe?
  - "You're not going to kill yourself, are you?"
- When in doubt about the answer, repeat the question differently. Not badgering, but gently persistent…

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Assessment Tools

Putting the information together to determine level of risk.

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Decisions on Clinical Tools & Documentation

- What tools will be used as a depression/anxiety screen and available for indicating suicide screening need?
- What will you use as a **suicide screening/assessment tool**?
  - C-SSRS screen and assessment version across all programs?
  - Additional inpatient assessment questions as applicable?
  - Other…
- Will a standardized **safety-planning tool** be used?
- How will you track patients in need of **follow-up** or having a history of suicide attempts?
  - Clinical care coordination outreach?
- How will elements be d**ocumented** and how will access to information be managed to ensure staff readiness?

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Suicide Assessment Interview
(C-SSRS model inquiry; Screen Version)

- **Suicidal Ideation**
  - *"Have you wished you were dead or wished you could go to sleep and not wake up?"*
  - *"Have you actually had any thoughts of killing yourself?"*
- **Planning**
  - *"Have you been thinking about how you might kill yourself?"*
- **Intent**
  - *"Have you had these thoughts and had some intention of acting on them?"*
  - *"Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?"*
- **History of suicidal Behavior**
  - *"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*
  - "If yes, when, how long ago and details of the event(s)?"

***Over the past week or since the last visit**

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SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past week	Past month	
Ask questions that are in bolded and underlined. The rest of the information at each question is for staff information only.	Yes/No	Yes	NO
Ask Questions 1 and 2			
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***			
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, *"I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan."* ***Have you had any actual thoughts of killing yourself?***			
If YES to 2: Ask Question 3			
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. *"I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might kill yourself?***			
If NO to 2 or NO to 3, skip to Question 6 and stop there **If YES to Question 3, ask Question 4, 5 and 6**			

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4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?***			
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***			
6) Suicide Behavior Question ***"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** r Over a year ago? r Between three months and a year ago? r Within the last three months? r Within the past week?			

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Using the C-SSRS Screen

- If the answer to the first 2 questions is ***NO***:
  - Ask the final question about Suicide Behavior to rule out history.
  - A NO answer on Q-6 finishes the screen.
- If either of 1 or 2 ***YES***, ask questions 3,4,5 and 6.
- AN increase in yes answers indicates an increased risk. Presence of current or recent intent and plan indicates a full assessment is needed.
  - Complete full assessment or refer for crisis assessment of suicidality

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C-SSRS Full Assessment

- If C-SSRS screen indicates suicide risk, complete assessment version to determine level of risk and level of care needs,
- Suicidal Behavior
  - Suicide attempt history and para suicidal behavior history and details including **self-injurious behavior** done without suicidal intent (NSSI)
  - **Actual Attempt made:** Most recent, most severe and trend toward increasing severity of damage…
  - Details about attempts **aborted** by self or **interrupted** by others,
  - A detailed assessment of recent **preparatory actions** including acquisition or availability of lethal means, rehearsal, writing a note…
  - An assessment of lethality, **level of damage** of attempt made,
  - **Potential lethality** of means and methods identified or used; even if no damage

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Short-term (Acute) Risk Factors and Symptoms- Psychological States

- Current **depression,** self-rated level of depressive Sx.
- **Acute psychic distress** (including anxiety, panic and especially agitation)
- **Extreme humiliation/disgrace**, shame, despair, loss of face
- **Acute Hopelessness / Demoralization**
- **Desperation**/sense of 'no way out'
- Inability to conceive of alternate solutions/**problem-solve**
- **Breakdown in communication**/loss of contact with significant others(including therapist)
- **Impulsivity/aggression**

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Impulsivity and Suicide

- Impulsive personality or other factors increasing impulsivity.
- Many studies have shown increased impulsive behaviors before suicide attempts or deaths.
- A study noted that 24% of attempt survivors had spent less than 5 minutes between the decision to attempt suicide and the actual attempt
- Another study found that in 50% of adolescent suicide attempts: a "stressor" occurred within 24 hours of the attempt
- Important consideration with co-morbidities such as ADHD, anxiety, rage, substance abuse and Mood Disorders
- Access + impulsivity means increased risk

Waldvogel et al 2008

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Anxiety

- Anxiety symptoms (independent of an anxiety Dx.) associated with suicide risk:
  - Panic Attacks
  - Severe Psychic Anxiety (subjective anxiety)
  - Agitation
- In a review of inpatient suicides 79% met criteria for severe or extreme anxiety or agitation.
- Several studies show independent connection between anxiety and suicidal behavior.

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Additional Online Training

- Assessment of Suicidal Risk Using the C-SSRS http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/cssrs_web/course.htm
- This free, online training from the New York State Office of Mental Health and Columbia University provides an overview of the instrument and teaches how and when to administer it in real world settings.
- Practitioners outside of New York State are not eligible to receive a certificate of completion

Other online trainings available-Handout

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Questions or Comments?

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Resources for Help

To address the Crisis

- **Statewide Crisis Line (888-568-1112)**
- **National Suicide prevention Lifeline 800-273-8255**
- Hospital emergency room
- 911

For follow-up, support & information

- NAMI Maine's Teen Support Text Line
- Evaluation for medication management
- Referral to community counselors/therapist
- Other…. ?

With whom can you consult for questions and concerns?

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When to Call or Text Crisis

- "Call early, call often"
- Crisis clinicians are:
  - Available 24 / 7 by phone call or text through a statewide center.
  - Clinicians available regionally to come to your location or meet in a safe place for an assessment
  - Gatekeepers for admission into a hospital
- Call or Text for a phone consult when you are:
  - Concerned about someone's mental health
  - Need advice about how to help someone in distress
  - Worried about someone and need another opinion
- The initial contact is free

1-888-568-1112
MAINE CRISIS LINE
CALL. TEXT. CHAT.

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Safety Planning and Follow-up

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Collaborative Safety Planning

A Safety plan is a written list of coping activities, personal, social and professional resources **developed with a person**, for use after the initial crisis:

- More than "*Assess and refer*" for those not hospitalized
- Safety planning is work with a person willing, ready & able to engage in planning for their safety
- Allows exploration of personal and social resources and the ability to mobilize them.
- An opportunity for collateral contact
- A time for securing lethal means!

See also VA Safety Plan Quick Guide for Clinicians

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7 Steps of Safety Planning
Handout

- Step 1: Recognize warning signs
- Step 2: Engage internal coping strategies
- Step 3: Connect with people and places that can serve as a distraction from suicidal thoughts and who offer support
- Step 4: Identify and engage family members or friends who may offer help and support
- Step 5: Identify professional resources
- Step 6: Reduce the potential for use of lethal means
- Step 7: Acknowledge what is worth living for!

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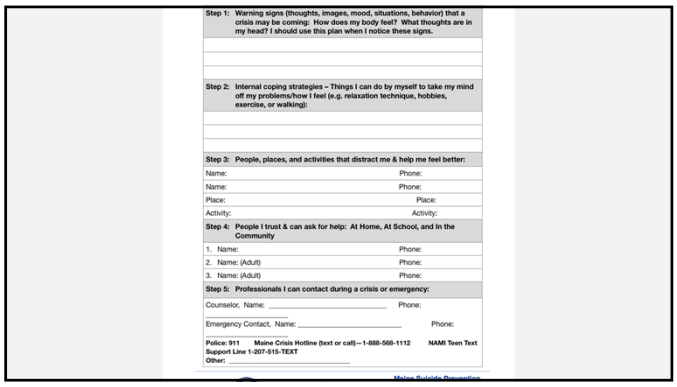

Step 1: Warning signs (thoughts, images, mood, situations, behavior) that a crisis may be coming: How does my body feel? What thoughts are in my head? I should use this plan when I notice these signs.	
Step 2: Internal coping strategies – Things I can do by myself to take my mind off my problems/how I feel (e.g. relaxation technique, hobbies, exercise, or walking):	
Step 3: People, places, and activities that distract me & help me feel better:	
Name:	Phone:
Name:	Phone:
Place:	Place:
Activity:	Activity:
Step 4: People I trust & can ask for help: At Home, At School, and in the Community	
1. Name:	Phone:
2. Name: (Adult)	Phone:
3. Name: (Adult)	Phone:
Step 5: Professionals I can contact during a crisis or emergency:	
Counselor, Name:	Phone:
Emergency Contact, Name:	Phone:
Police: 911 **Maine Crisis Hotline (text or call)—1-888-568-1112** **NAMI Teen Text Support Line 1-207-515-TEXT**	
Other:	

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Lethal Means Restriction

Securing Access to Lethal Means

- ***Always ask about the presence of firearms***, alcohol, drugs and medication (or other means as identified)
- Work with collateral contacts as needed to secure lethal means.
  - Family &/or parents/ friends (adult)
  - Police
- Document the query, the response and the plan.
- Access should be made as difficult as possible

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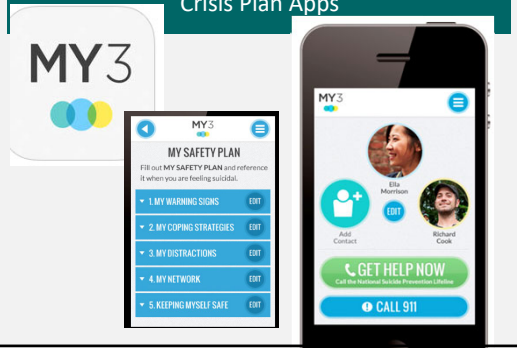
Crisis Plan Apps



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Assured Follow-up is Vital

As many as 70 percent of suicide attempters of all ages will never make it to their first outpatient appointment. Across all studies, the rate for non-attendance is about 50 percent.

Efforts to improve suicide assessments, follow-up and continuity of care and to forestall readmission should target higher-risk patients prone to disengagement and non-adherence.

David Knesper, MD

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Working with the Family

- What triggers parent/family contact and whose role?
- Build an alliance of shared goals
- A key partner in assessment, safety-planning and follow-up
- Get their buy-in for referral recommendations
- Educate, support and follow-up
- Expect cooperation but be prepared for denial and anger

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Acknowledgements

This training was developed with resources and materials adapted from many sources in the US, including:

Action Alliance for Suicide Prevention: Zero Suicide Initiative
American Foundation for Suicide Prevention
American Association of Suicidology
Columbia University C-SSRS
American Psychiatric Assoc.- APA guidelines
Maine Suicide Prevention Program
National Alliance On Mental Illness of Maine

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Maine Suicide Prevention Program

Education, Resources and Support—It's Up to All of Us

- Greg A. Marley, LCSW Clinical Director, NAMI Maine
gmarley@namimaine.org 207-622-5767 x 2302
- Training Program Inquiries: Gretchen Swain,
mspp@namimaine.org 207-622-5767 x 2318
- Sheila Nelson, MSPP Program Coordinator
Ph: 207-287-5359

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Questions?

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