Suicidality in Youth:
Risk Factors, Assessments, and Interventions

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Disclosure (Past 12 Months)

- No biomedical financial interests
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Off-Label Use

- Medications discussed in this presentation are off-label for the acute and maintenance treatment of major depression in youth, with the exception of fluoxetine and escitalopram

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Youth Risk Behavior Survey (2011 – 2021)

The Percentage of High School Students Who:*	2011 Total	2013 Total	2015 Total	2017 Total	2019 Total	2021 Total	Trend
Experienced persistent feelings of sadness or hopelessness	28	30	30	31	37	42	
Experienced poor mental health†	–	–	–	–	–	29	–
Seriously considered attempting suicide	16	17	18	17	19	22	
Made a suicide plan	13	14	15	14	16	18	
Attempted suicide	8	8	9	7	9	10	
Were injured in a suicide attempt that had to be treated by a doctor or nurse	2	3	3	2	3	3	

*For the complete wording of YRBS questions, refer to the appendix.
†Variable introduced in 2021.

The Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf; p61.

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Youth Risk Behavior Survey

- 10% of female students attempted suicide (2 times as likely as male students)
- 20% of LGBTQ+ students attempted suicide (4 times as likely as heterosexual students)
- Black students were more likely than Asian, Hispanic, and White students to attempt suicide

The Youth Risk Behavior Survey Data Summary & Trends Report: 2011–2021.
https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf.

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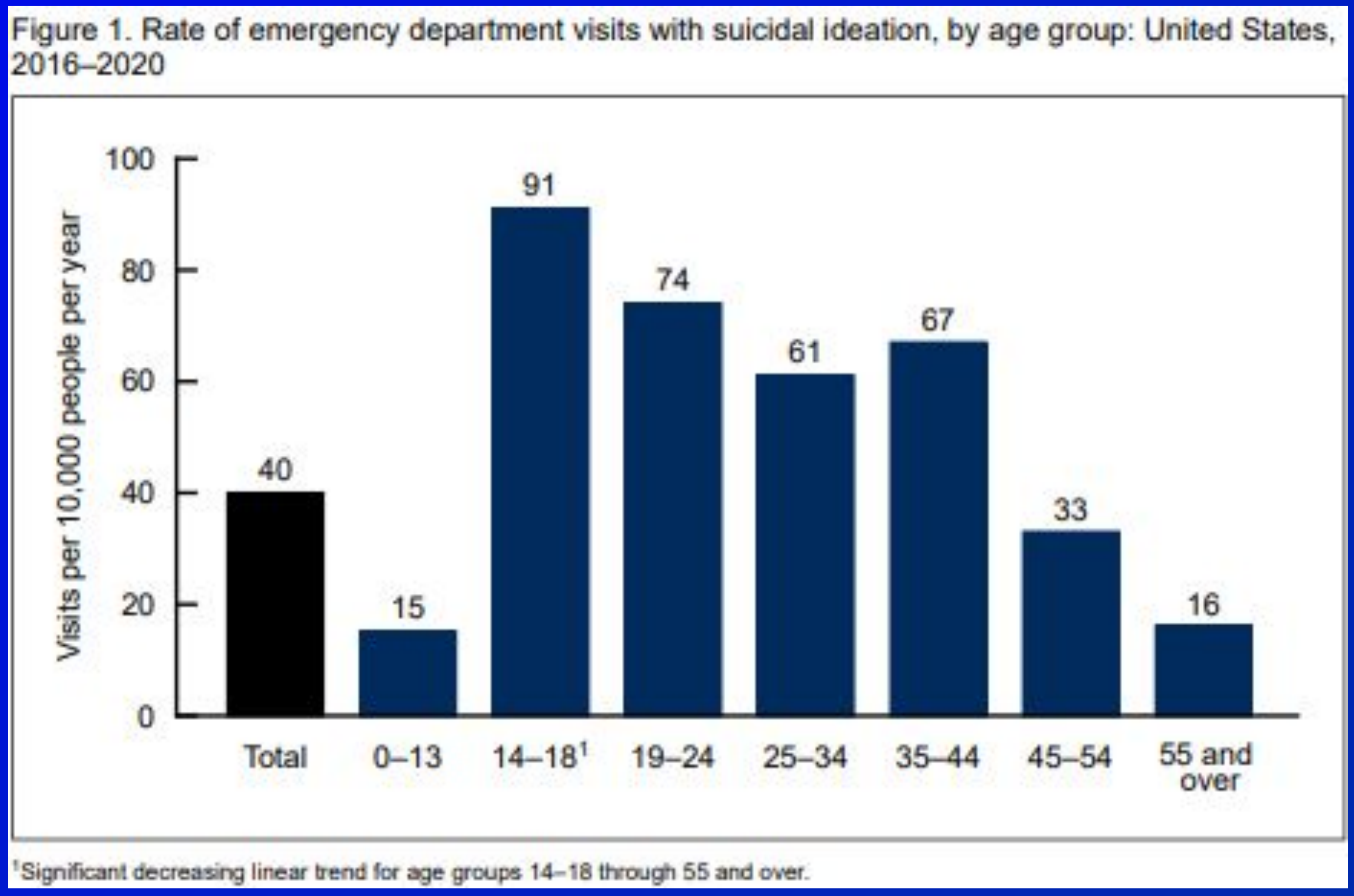
Emergency Department Visits With Suicidal Ideation: United States, 2016- 2020



Strashny, Alexander et al. "Emergency Department Visits With Suicidal Ideation: United States, 2016- 2020." NCHS data brief ,463 (2023): 1-8.

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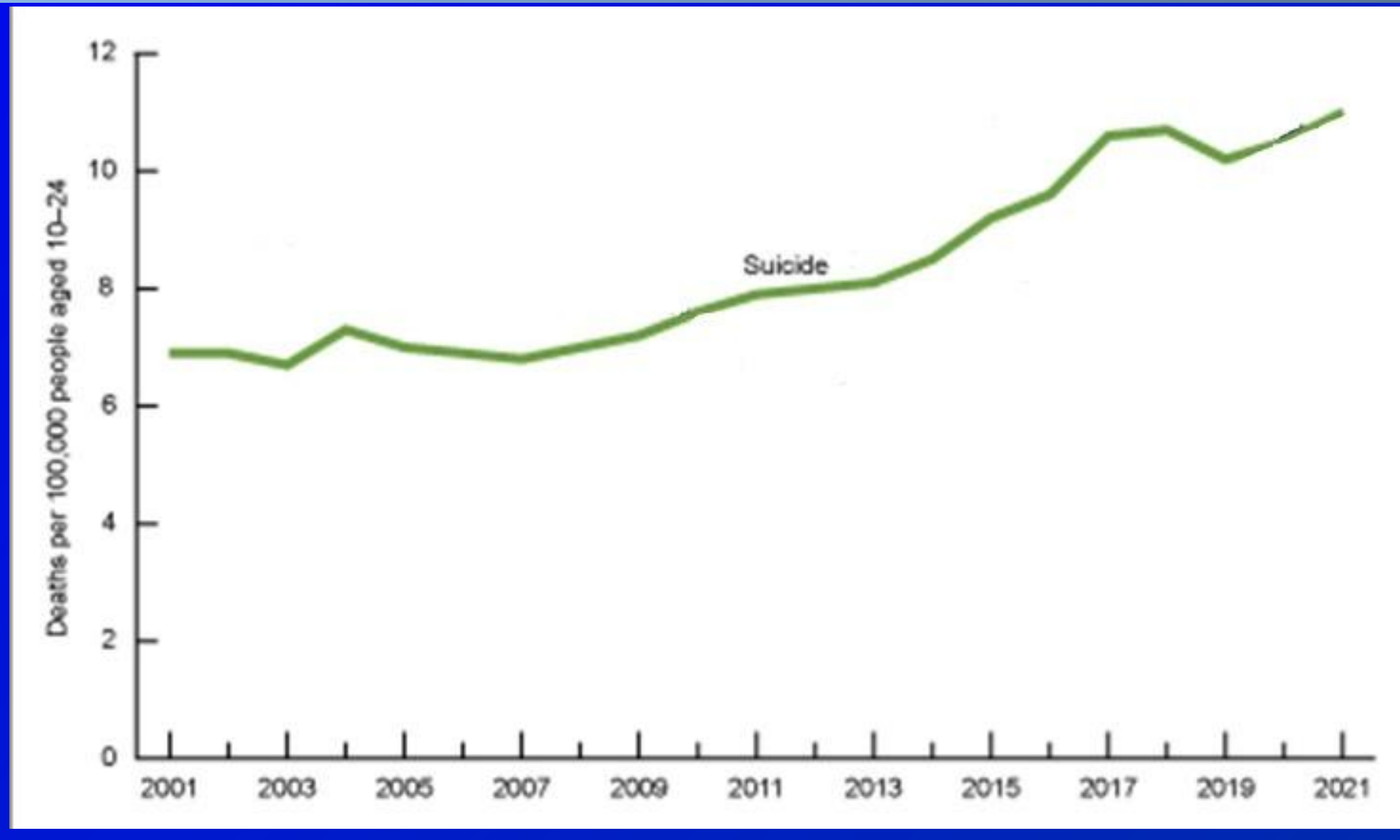
Suicide death rates aged 10-24: United States, 2001 - 2021



No statistically significant trend from 2001–2007, then significant increasing trend from 2007–2021 ($p < 0.05$).

Curtin SC, Garnett MF. Suicide and homicide death rates among youth and young adults aged 10–24: United States, 2001–2021. NCHS Data Brief, no 471. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: https://dx.doi.org/10.15620/cdc:128423

****Second leading cause of death in this age group**

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Number of Suicides in United States, 2022

Age Group	Number
10 – 14	493
15 – 24	6036

Curtin, Sally C.;Garnett, Matthew F.;Ahmad, Farida B.; Provisional Estimates of Suicide by Demographic Characteristics: United States, 2022. U.S. Department of Health and Human Services; Centers for Disease Control and Prevention; National Center for Health Statistics (U.S.); National Vital Statistics System. 11/29/2023; Series : VSRR; no 34. https://stacks.cdc.gov/view/cdc/135466

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Psychosocial Risk Factors for Suicidality in Children and Adolescents

- Psychosocial factors
  - Depression
  - Anxiety
  - Previous suicide attempt
  - Drug and alcohol use
  - Comorbid psychiatric disorders
- Stressful life events
  - Family problems
  - Peer conflicts
- Personality traits
  - Impulsivity

Carballo, J J et al. "Psychosocial risk factors for suicidality in children and adolescents." European child & adolescent psychiatry vol. 29,6 (2020): 759-776. doi:10.1007/s00787-018-01270-9

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Network Analysis of Factors in Adolescent Suicidal Behavior

- Risk Factors
  - Depressive symptomatology
  - Bullying
- Protective Factors
  - Self-esteem
  - Personal well-being

Fonseca-Pedrero, Eduardo et al. “Risk and Protective Factors in Adolescent Suicidal Behaviour: A Network Analysis.” International journal of environmental research and public health vol. 19,3 1784. 4 Feb. 2022, doi:10.3390/ijerph19031784

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Cyberbullying and Suicidality

- Victims of cyberbullying compared to nonvictims

Odds Ratio	Suicidality
2.3	Self-harm
2.1	Suicidal behavior
2.6	Attempt suicide

- Victimization by cyberbullying more strongly associated with suicidality than traditional bullying
- Hopelessness mediated relationship between cybervictimization and suicidal ideation

- Azami, Mohammad Saeed, and Farhad Taremian. Scandinavian journal of child and adolescent psychiatry and psychology vol. 8 101-109. 3 Sep. 2020, doi:10.21307/sjcapp-2020-010
- John, Ann et al. Journal of medical Internet research vol. 20,4 e129. 19 Apr. 2018, doi:10.2196/jmir.9044
- Wang, Xingchao, and Shiyin Wang. Journal of youth and adolescence vol. 52,5 (2023): 996-1009. doi:10.1007/s10964-022-01726-x

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Social Media Use and Self-Injurious Thoughts and Behaviors

- Systematic review and meta-analysis
- Examined association between social media and suicidal ideation, plans, attempts and nonsuicidal self-injury
- Findings
  - Medium effect size for specific social media type (cybervictimization, self-injurious thoughts and behavior social media)
  - No association between frequency of social media use and self-injurious thoughts and behaviors

Nesi, Jacqueline et al. "Social media use and self-injurious thoughts and behaviors: A systematic review and meta-analysis." Clinical psychology review vol. 87 (2021): 102038. doi:10.1016/j.cpr.2021.102038

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Prevalence and Correlates of Suicide and Nonsuicidal Self-injury in Children

- Systematic literature review and meta-analysis of preadolescent suicide and nonsuicidal self-injury

Lifetime Prevalence	
Suicidal ideation	15.1%
Suicide attempts	2.6%
Nonsuicidal self-injury	6.2%
Suicide	0.79 per 1 million children

Liu, Richard T et al. "Prevalence and Correlates of Suicide and Nonsuicidal Self-injury in Children: A Systematic Review and Meta-analysis." JAMA psychiatry vol. 79,7 (2022): 718-726. doi:10.1001/jamapsychiatry.2022.1256

Con't

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Correlates of Suicide and Nonsuicidal Self-injury in Children

- Risk Factors
  - Depression
  - Child Maltreatment
  - Male sex
  - Attention-deficit hyperactivity disorder
- Protective Factor
  - Parental Support

Liu, Richard T et al. "Prevalence and Correlates of Suicide and Nonsuicidal Self-injury in Children: A Systematic Review and Meta-analysis." JAMA psychiatry vol. 79,7 (2022): 718-726. doi:10.1001/jamapsychiatry.2022.1256
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Parent-Adolescent Agreement About Adolescents' Suicidal Thoughts

- 5137 adolescents and parent/stepparent clinical interviews with questions about adolescents' lifetime suicidal thoughts
- Results
  - 50% of parents unaware of adolescents' thoughts of killing themselves
  - 75% of parents unaware of adolescents' recurrent thoughts of death
  - 67% of adolescents denied thoughts of death reported by parents

Jones, J. D., et al. of Pediatrics. 2019 143(2).

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Common Screening Instruments for Suicidality in Youth

- Ask Suicide-Screening Questions (ASQ)
  - 4 item scale
- Columbia Suicide Severity Rating Scale (C-SSRS)
  - 6 item Triage Version

Horowitz, Lisa M et al. "Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department." Archives of pediatrics & adolescent medicine vol. 166,12 (2012): 1170-6. doi:10.1001/archpediatrics.2012.1276

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ASQ
Ask Suicide-Screening Questions

asQ

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** Yes No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** Yes No
3. **In the past week, have you been having thoughts about killing yourself?** Yes No
4. **Have you ever tried to kill yourself?** Yes No

   If yes, how? ______________________ When? ______________

If the patient answers yes to any of the above, ask the following question:

5. **Are you having thoughts of killing yourself right now?** Yes No

   If yes, please describe: ______________________

NIH National Institute of Mental Health

- Horowitz LM, Bridge JA, Teach SJ, Ballard E, Klima J, Rosenstein DL, Wharff EA, Ginnis K, Cannon E, Joshi P, Pao M. Ask Suicide-Screening Questions (ASQ): A Brief Instrument for the Pediatric Emergency Department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. Horowitz LM, Snyder DJ, Boudreaux ED, He J-P, Harrington
- CJ, Cai J, Claassen CA, Salhany JE, Dao T, Chaves JF, Jobes DA, Merikangas KR, Bridge JA, Pao M, Validation of the Ask Suicide-Screening Questions (ASQ) for Adult Medical Inpatients: A Brief Tool for All Ages. Psychosomatics. 2020. doi:10.1016/j.psym.2020.04.008

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Columbia Suicide Severity Rating Scale (C-SSRS) Triage Version

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, 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, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, etc. **If yes, was this within the past 3 months?**		High Risk

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

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Suicide-Related Factors in Youth

- Firearms most common method of suicide
- Mental health problem, especially depression
- Interpersonal or life stressor
- Alcohol use

Liu, Grace S et al. “Surveillance for Violent Deaths - National Violent Death Reporting System, 48 States, the District of Columbia, and Puerto Rico, 2020.” Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C. : 2002) vol. 72,5 1-38. 26 May. 2023, doi:10.15585/mmwr.ss7205a1

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Firearms and Youth Suicide

- Firearms were used in 39% of suicides in 10–14-year-olds and 55% of suicides in 15–24-year-olds in 2021
- 28% of youth at risk for suicide reported a firearm at home
- 12% of parents report a child can access their guns
- 33% of adolescents report they can access a loaded gun in their household in less than 5 minutes

1 - Peterson, Cora et al. "WISQARS Cost of Injury for public health research and practice." Injury prevention : journal of the International Society for Child and Adolescent Injury Prevention vol. 29,2 (2023): 150-157. doi:10.1136/ip-2022-044708
2 - Lowry, Nathan J et al. "Firearms Access among Pediatric Patients at Risk for Suicide." Archives of suicide research : official journal of the International Academy for Suicide Research vol. 27,3 (2023): 1105-1114. doi:10.1080/13811118.2022.2106924
3 - Berrigan, John et al. "Parental Perceptions of Their Children's Access to Household Firearms." The Journal of pediatrics vol. 255 (2023): 154-158. doi:10.1016/j.jpeds.2022.10.045
4 - Salhi, Carmel et al. "Parent and Adolescent Reports of Adolescent Access to Household Firearms in the United States." JAMA network open vol. 4,3 e210989. 1 Mar. 2021, doi:10.1001/jamanetworkopen.2021.0989

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Firearm Discussion and Suicidal Youth

- Ask about presence and access of guns at home
- Inquire about gun access at relative's home, friends
- Remove firearms from home
- Secure storage of firearms
  - gun locked, unloaded, ammunition stored separately

Bhatt, Apurva et al. "Rising Rates of Adolescent Firearm Suicide and the Clinician's Role in Addressing Firearms." Journal of the American Academy of Child and Adolescent Psychiatry vol. 62,6 (2023): 614-617. doi:10.1016/j.jaac.2022.07.820

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FDA Approval for Acute Treatment of Major Depressive Disorder

Medication	Ages
Fluoxetine (3 studies)	8-17
Escitalopram (1 study)	12-17

Prozac Prescribing Information. Lexapro Prescribing Information.

Emslie GJ et al. *Arch Gen Psychiatry*, 1997; 54:1031–1037; Emslie GJ et al, *J Am Acad Child Adolesc Psychiatry*, 2002;41:1205–1215. Treatment for Adolescents with Depression Study (TADS) Team. *JAMA*, 2004; 292:807–820. Emslie GJ et al; *J Am Acad Child Adolesc Psychiatry*. 2009; 48:721–729.

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Treatment Resistant Depression Algorithm

SSRI*
fluoxetine/escitalopram

If no response maximum dose, minimum 8 wks

Alternate SSRI*
fluoxetine/escitalopram/citalopram/sertraline

Partial response

Augment atypical antipsychotic, lithium or bupropion

If no response maximum dose, minimum 8 wks

Different class of antidepressant
bupropion/venlafaxine/duloxetine/desvenlafaxine/vilazodone/vortioxetine

Partial response

Augment atypical antipsychotic or lithium

Wagner KD, 2019

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* Add CBT

Controlled Trial of Esketamine for Adolescent Major Depression and Suicidal Ideation

- 54 inpatient adolescents with major depression and suicidal ideation randomized to 3 infusions of esketamine (0.25 mg/kg) or midazolam (0.02 mg/kg) over 5 days
- Findings
  - Significantly greater improvement in suicidal ideation and intensity in esketamine group

	Anti-suicidal Response Rate	Antidepressant Response Rate
Esketamine	**69%**	**62%**
Midazolam	**53%**	**53%**

Zhou, Yanling et al. (2023). Effect of Repeated Intravenous Esketamine on Adolescents With Major Depressive Disorder and Suicidal Ideation: A Randomized Active-Placebo-Controlled Trial. Journal of the American Academy of Child and Adolescent Psychiatry, S0890-8567(23)00373-8. Advance online publication. https://doi.org/10.1016/j.jaac.2023.05.031

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Evidence – Based Interventions for Suicidality in Youth

- Dialectic Behavioral Therapy – Adolescent
- Cognitive – Behavioral Therapy
- Mentalization – Based Therapy

- Ougrin, Dennis et al. “Therapeutic interventions for suicide attempts and self-harm in adolescents: systematic review and meta-analysis.” Journal of the American Academy of Child and Adolescent Psychiatry vol. 54,2 (2015): 97-107.e2. doi:10.1016/j.jaac.2014.10.009
- Busby, Danielle R et al. “Evidence-Based Interventions for Youth Suicide Risk.” Current psychiatry reports vol. 22,2 5. 18 Jan. 2020, doi:10.1007/s11920-020-1129-6

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Common Elements in Treatments for Youth Suicide Attempts and Self-harm

- Both individual and family treatment
- Therapeutic alliance with youth and parents
- Individualized tailoring of treatment
- Skills training (emotional regulation skills) and safety planning
- Lethal means restriction counseling

Meza, Jocelyn I et al. "Practitioner Review: Common elements in treatments for youth suicide attempts and self-harm - a practitioner review based on review of treatment elements associated with intervention benefits." Journal of child psychology and psychiatry, and allied disciplines vol. 64,10 (2023): 1409-1421. doi:10.1111/jcpp.13780

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Safety Planning Interventions with Youth

- Recognize warning signs of suicidal thinking
- List of Coping Strategies
- Sources of Support
  - Parents, Friends, Relatives
- Identify person to contact if suicidal
  - Parent, Relative, School counselor
- Mental health contacts
  - 988 Suicide & Crisis Lifeline

Barbara Stanley, Gregory K. Brown. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk, Cognitive and Behavioral Practice. Volume 19, Issue 2, 2012, Pages 256-264, ISSN 1077-7229, https://doi.org/10.1016/j.cbpra.2011.01.001.

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988 Suicide & Crisis Lifeline

Need Support Now?

If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat 988lifeline.org.

https://www.samhsa.gov/find-help/988

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QR Code in Safety Planning

- QR Code that has contact information for mental health resources
- Clinicians who want to develop their own safety plan, instructions to create a QR Code are provided in article.

Save the *988 Suicide & Crisis Lifeline* and other mental health resources as a contact on your phone by scanning this QR code!

Zimmer, Thomas, and Paresh Patel. “Meeting Youth Where They Live: How to Use a QR Code in Safety Planning.” Journal of the American Academy of Child and Adolescent Psychiatry vol. 62,9 (2023): 947-948. doi:10.1016/j.jaac.2023.01.025

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American Academy of Child and Adolescent Psychiatry (www.aacap.org)

FAMILIES/YOUTH

- Facts for Families
- Resource Centers
  - Resources for Clinicians
  - ADHD Resource Center
  - Anxiety Resource Center
  - Autism Resource Center
  - Bipolar Disorder Resource Center
  - Bullying Resource Center
  - Trauma and Child Abuse Resource Center
  - Climate Change & Youth Mental Health Resource Center
  - Conduct Disorder Resource Center

Updated January 2024

Choose a topic:

----- Choose One -----

About

Suicide is a serious and growing problem among children and adolescents. Each year, thousands of young people die by suicide. Suicide is the second leading cause of death for 10-to-14 year-olds.

The majority of children and adolescents who attempt suicide have a significant mental health disorder, usually depression.

Among younger children, suicide attempts are often impulsive. They may be associated with feelings of sadness, confusion and anger.

Among teenagers, suicide attempts may be associated with feelings of stress, self-doubt, pressure to succeed, financial uncertainty, disappointment and loss. For some teens, suicide may appear to be a solution to their problems.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed.

Parents, teachers and friends should always err on the side of caution and safety. Any child or adolescent with suicidal thoughts or plans should be evaluated immediately by a trained and qualified mental health professional.

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SUICIDE ACROSS THE BOARD: RISK FACTORS, ASSESSMENT, AND INTERVENTIONS IN ADULTS

APA ANNUAL MEETING 2024

Douglas Jacobs, MD
Associate Professor of Psychiatry, Part-time, Harvard Medical School
Co-director, Stanford Suicide Course, October 30, 2024
https://cme.stanford.edu

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ACKNOWLEDGEMENTS/DISCLOSURES

- Dr. M.K. Benheim, a psychologist, is Director of Research for Stop A Suicide Today and has made significant contributions to the material presented in this lecture.
- Dr. M. Pinheiro: 4th year resident at MGH/McLean Psychiatry Residency Program, accepting a position as Staff Psychiatrist at McLean Hospital and Instructor at Harvard Medical School.
- Dr. Sulzer: graduate of Connecticut School of Medicine and Harvard South Shore Psychiatry Residency Program now practicing at MGH in the outpatient psychiatry department and appointment as a Harvard Instructor.
- Dr. Jacobs, nor any of the above professionals have any financial disclosures.

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STATEMENT OF INTENT

The information in this lecture is not to be construed or to serve as the standard of care. Standards of psychiatric care are determined on the basis of all clinical data available for an individual patient and are subject to clinical change as scientific knowledge and technology advance and practice patterns evolve. Adherence to the information presented will not ensure a successful outcome for every individual.

Moreover, this lecture does not include all proper methods of assessment/treatment and may exclude other acceptable methods aimed at the same results. The ultimate judgment regarding a particular suicide assessment, treatment plan, or clinical procedure must be made by the clinician, treatment team, and consultant (if indicated) in light of clinical data presented by the patient and the diagnostic and treatment options available at the time of evaluation.

Adapted from APA ' Practice Guidelines " Assessment and Treatment of Patients with Suicidal Behaviors. (2003)

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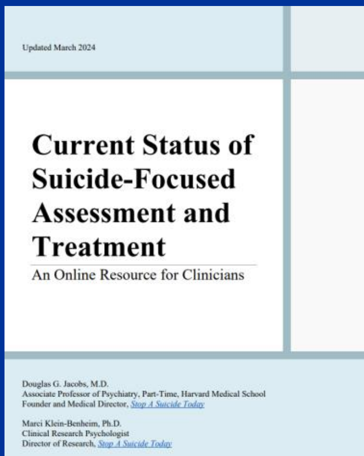
ONLINE RESOURCE AND REFERENCES

References related to the information in these slides is available in Jacobs and Klein-Benheim's, "Current Status of Suicide-Focused Assessment and Treatment: An Online Resource for Clinicians." The online resource is available at no cost at https://stopasuicide.org/online-resource-for-clinicians



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Clinical Research Psychologist
Director of Research, Stop A Suicide Today

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FACTS & FIGURES 2021/2022

- Suicides are more common in U.S. than at any time since dawn of WW II. There were **49,499** suicides in the U.S. in 2022, a 3% increase compared to 2021.
- Largest increases were seen in older adults; rates rose nearly 7%, ages 45-64, and 8% over 65-white men in particular-importantly, there was an 8% drop in youth suicides (ages 10-24) perhaps due to increased attention to youth mental health issues.
- **12.3 million** adults reported having serious thoughts of suicide (2021).
- **3.5 million** adults reported making a suicide plan; **1.7 million** made a non-fatal suicide attempt (2021).
- Underlying factors included **psychiatric illness** (though diagnosis not found in ~half of cases), **relationship problems, recent crises**, and **intolerable mental pain** (2021).
- **3 out of 4** persons who died by suicide were not in treatment at time of death, 50% never had psychiatric contact.

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FACTS & FIGURES (CONTINUED)

- **54% to 95%** have psychiatric illness
- **4:1** male to female for suicides
- **3:1** female to male for attempts
- **60%** die on first attempt
- **55%** die by firearms
- **70%** communicate intention to significant other
- **5%** suicides occur in a hospital setting/grounds

American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American Journal of Psychiatry*, *160*(11), 1-117.

Stone et al. (2018). Vital signs: Trends in state suicide rates—United States, 1999–2016 and circumstances contributing to suicide—27 states, 2015. MMWR. Morbidity and Mortality Weekly Report, 67(22), Article 22.

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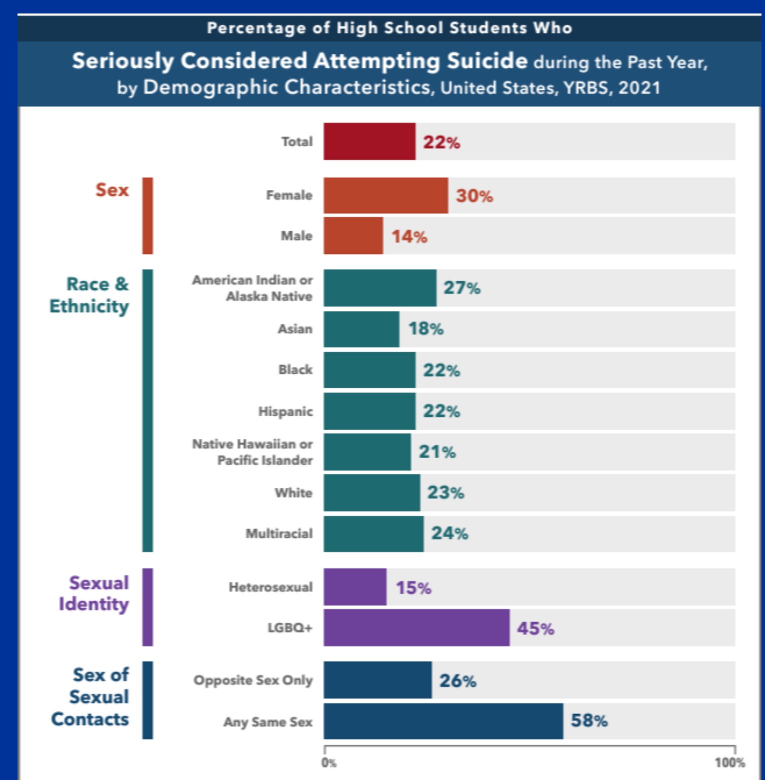
SUICIDAL THOUGHTS AMONG YOUTH BY POPULATION

Medical leadership for mind, brain and body.

- Data for adult sexual minorities is limited; 2020 data suggests suicide attempts in prior 12 months reduced with age in LGBTQ+ populations (5.5% in ages 18-25 versus 2.2% in ages 26-49)
- 45% of LGBTQ+ youth aged 13-18 had seriously considered suicide in the past year; 3 times the risk in the general population;16% of these 13-18-year-olds had made a suicide attempt
- These findings highlight the importance of stratifying risk of suicide in more vulnerable populations

CDC Youth Risk Behavior Survey: Data Summary and Trends Report
https://www.cdc.gov/suicide/facts/disparities-in-suicide.html



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SUICIDE ASSESSMENT

The estimation of suicide risk, at the culmination of the suicide assessment, is the **quintessential clinical judgment**, since **no study** has identified one specific risk factor or set of risk factors as **predictive** of suicide or other suicidal behavior.

American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American Journal of Psychiatry, 160*(11), 1-117.

Fochtman LJ, Jacobs D G. Suicide Risk Assessment and Management in Practice:The Quintessential Clinical Activity.Acad Psychiatry 2015;39:490-491

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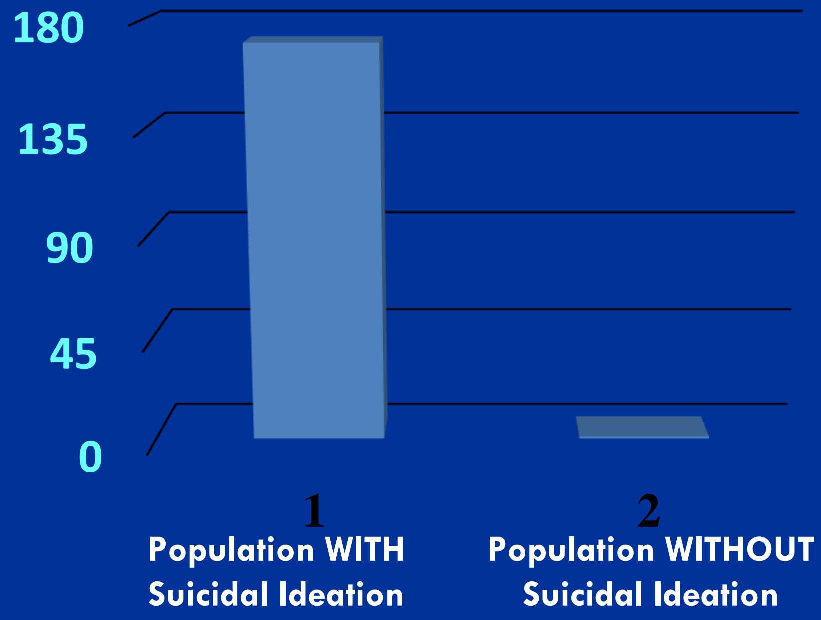
SUICIDE RISK IN PERSONS WITH VS. WITHOUT SUICIDAL IDEATION (ANNUAL)



American Psychiatric Association. (2003). Practice guideline for the assessment and treatment of patients with suicidal behaviors. *American Journal of Psychiatry, 160*(11), 1-117.

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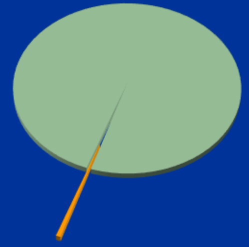
ANNUAL OUTCOME OF SUICIDE IN ADULTS WITH SUICIDAL IDEATION*

99.64% No Suicide



0.36% Suicide

Total Suicides	=	44,298
Prevalence of SI	=	12.3 Million

Approximation

SAMHSA, 2023; ; Stone et al., 2023

Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. (2021). Web-based Injury Statistics Query and Reporting System [online]. Retrieved from www.cdc.gov/ncipc/wisqars.

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FROM THE DSM-5…

- *"Diagnosis of a mental disorder should have clinical utility…However, the diagnosis of a mental disorder is not equivalent to a need for treatment.* ***Need for treatment is a complex clinical decision that takes into consideration symptom severity, symptom salience (e.g., the presence of suicidal ideation), the patient's distress (mental pain)…"***
- *"Clinicians may thus encounter individuals whose symptoms do not meet full criteria for a mental disorder but who demonstrate a clear need for treatment or care.* ***The fact that some individuals do not show all symptoms indicative of a diagnosis should not be used to justify limiting their access to appropriate care."***

(DSM-5-TR, 2022, p. 14)

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SAFE-T:
SUICIDE ASSESSMENT FIVE-STEP EVALUATION & TRIAGE

Douglas G. Jacobs, M.D.

- Developed (by DGJ) in 2006 with a grant from SAMHSA, thus in public domain
- Distributed as the SAFE-T pocket card-see QR code
- Currently used in multiple clinical settings
- Used as a stand-alone protocol, or in conjunction with the C-SSRS
- Has been adapted for utilization in an EMR (Epic)

AMERICAN PSYCHIATRIC ASSOCIATION
Medical leadership for mind, brain and body.

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SAFE-T:

SUICIDE ASSESSMENT FIVE-STEP EVALUATION & TRIAGE

1. Identify risk factors
2. Identify protective factors
3. Conduct a specific suicide inquiry
4. Determine level of risk and choose appropriate intervention
5. Document level of risk, rationale, intervention, and follow-up

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SUICIDE: CLINICAL PERSPECTIVE

Suicide

- Substance Disorder/Use
- Psychiatric Illness, esp. Comorbidity
- Suicide-specific Symptoms/Attitudes
- Personality Disorder/ Traits
- Neurobiology
- Family History
- Suicidality
- Life Stressors
- Access to Weapons
- Severe Medical Illness
- Psychodynamics/ Psychological Vulnerability

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THE ASSESSMENT OF RISK- MOVING BEYOND TRADITIONAL RISK FACTORS

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CRITIQUE OF RISK FACTORS 2016 META-ANALYSIS

- Included 365 studies
- Prediction of STB* based upon suicide risk factors have **not improved** in 50 years
- Prediction was only **slightly better** than chance for all outcomes
- Suggests research literature's primary value is in evaluating **long-term risk**
- The present results **do not mean that widely used STB risk guidelines are invalid or useless…**

*STB = suicidal thoughts and behaviors

Franklin, J. et al. (2016, November 14). Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research. *Psychological Bulletin*. Advance online publication. http://dx.doi.org/10.1037/bul0000084

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RISK FACTORS CATEGORIES FOR SUICIDE DEATH

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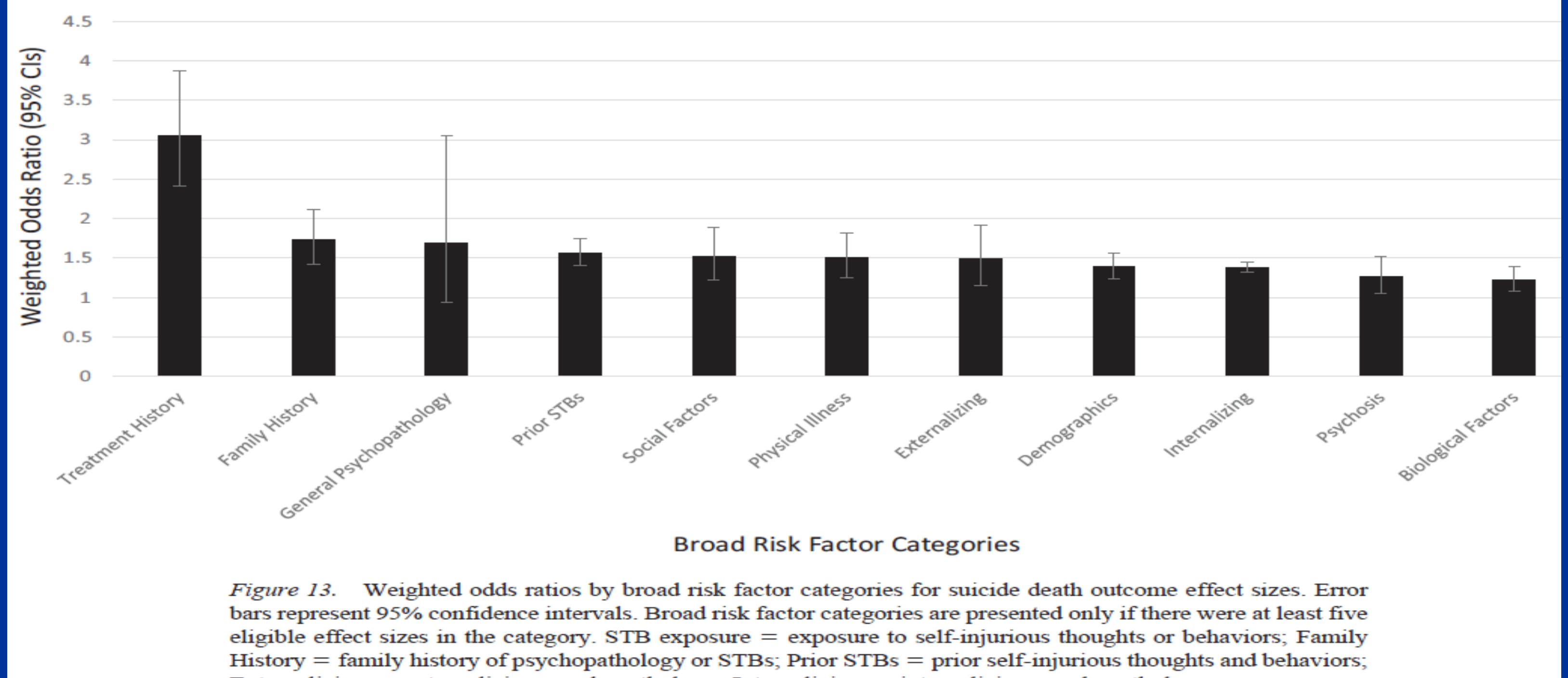

Figure 13. Weighted odds ratios by broad risk factor categories for suicide death outcome effect sizes. Error bars represent 95% confidence intervals. Broad risk factor categories are presented only if there were at least five eligible effect sizes in the category. STB exposure = exposure to self-injurious thoughts or behaviors; Family History = family history of psychopathology or STBs; Prior STBs = prior self-injurious thoughts and behaviors; Externalizing = externalizing psychopathology; Internalizing = internalizing psychopathology.

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NIMH COLLABORATIVE DEPRESSION STUDY

A landmark prospective study from 1978-1982 that consisted of 954 patients with Major Affective Disorder that examined suicides **within 1 year** of initial enrollment in contrast to features observed in those suicides that occurred **2-10 years** after clinical enrollment.

Clinical features associated with **early suicide** (within 1 year):

- **Psychic anxiety**
- **Panic attacks**
- **Anhedonia**
- **Moderate alcohol abuse**
- **Global insomnia**

Clinical features associated with **late suicide** (2-10 years):

- **Suicidal thoughts**
- **Suicidal behaviors**

Fawcett et al. (1990). *Am J Psychiatry*. 147:1189-1192

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JOINER'S INTERPERSONAL THEORY

Desire

- **Thwarted Belongingness***
  - ➢ Need to belong
  - ➢ Desire for connection
- **Perceived Burdensomeness***

Capability

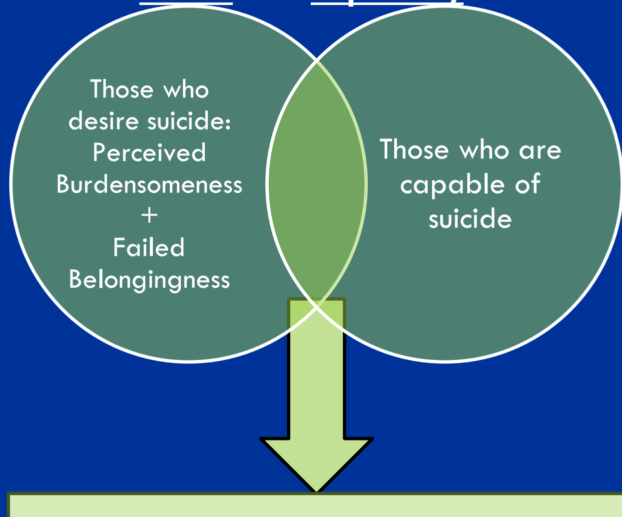
- **Habituation to/tolerance of pain**

  as it relates to prior/repeated attempts
- **Fearlessness**
  - ➢ re: death/suicidality,

    including actual (ie-aborted attempts)

and **mental practice**

Why do people die by suicide? Because they can, and because they want to—because they develop both the desire and capability to do so**



*Suggestive of SI independent of depression
*Joiner, T. *Why people die by suicide*. Harvard University Press (2005)
**Joiner, T. et al. *The Interpersonal Theory of Suicide*. American Psychological Assoc. (2009).

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MENTAL PRACTICE

- Vivid preoccupation regarding one's suicide represents a form of mental practice.
- Involves:
  - ➢Seeing one's death by suicide in their mind's eye
  - ➢Watching a clear and vivid video of their own death
- May be helpful in understanding/assessing those at risk of dying by suicide on their first attempt (60%).

Joiner, T. *Why people die by suicide*. Harvard University Press (2005), page 81.

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SUICIDE-SPECIFIC SYMPTOMS/ATTITUDES

Beyond Traditional Risk Factors:

- Intolerable mental pain
- Thwarted belongingness
- Feeling like a burden
- Loss of fear of death
- Anhedonia
- Global insomnia
- Severe/psychic anxiety
- Panic attacks
- Lack of remorse following a suicide attempt
- Entrapment/Hyperarousal
- Mental Practice

Don't be misled by future planning!

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PROTECTIVE FACTORS (REASONS FOR LIVING)

- √ Sense of responsibility to family
- √ Moral objections (religious beliefs)
- √ Positive coping skills
- √ Positive social support
- √ Positive therapeutic relationship
  - **Not studied as rigorously as risk factors**
  - **Even if present, may not counteract acute suicide risk**
  - **Patients' support system can also be a cause of stress**
- √ Fear of death/suicide
- √ Fear of social disapproval

Linehan, Marsha M. et al. Reasons for Staying Alive When you are Thinking of Killing Yourself: Inventory of Reasons for Living. *Journal of Consulting and Clinical Psychology* (1983), Vol. 51, No. 2T276-286

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EPIC SAFE-T PROTOTYPE

Risk Factors

Psychiatric Disorder(s):

+ mood disorder	+ post traumatic stress disorder	+ acute stress disorder	+ substance use disorder
+ psychotic disorders	+ cluster B personality traits	+ recent diagnosis with psychiatric illness	+ CNS disorders

Mood Disorder

+ major depressive disorder	+ bipolar disorders	+ substance-induced mood disorder

CNS Disorder

+ TBI	+ stroke	+ neurocognitive disorder/dementia	+ seizure disorder

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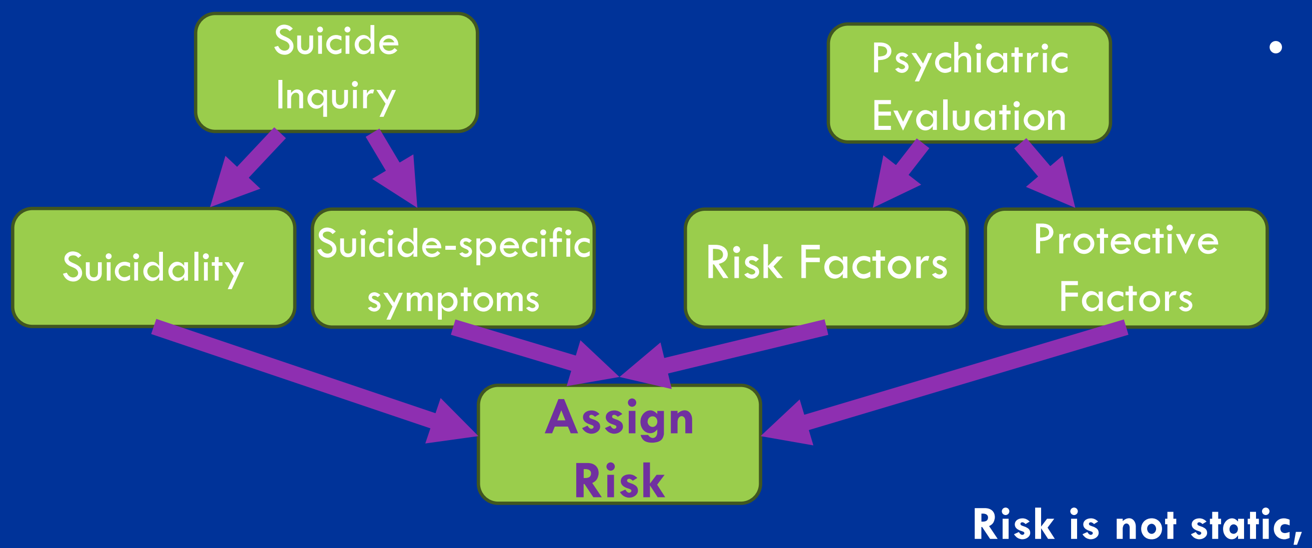
ASSIGNMENT OF RISK



- Based on **clinical judgment,** after considering:
  - Suicide specific inquiry/symptoms
  - Relevant risk / protective factors

Risk is not static,
but dynamic and needs to be **reassessed** as patient/environmental circumstances change

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CARES-8 – THE QUINTESSENTIAL JUDGMENT

Douglas G. Jacobs, M.D. and Carsen N. Sulzer, M.D.

- Clinical
- Assignment for the
- Risk
- Estimate of
- Suicide-8©

- Psychiatric Disorders
- Suicidality
- Suicide-specific symptoms
- Reasons for living
- Status of important connections
- Psychiatric treatment
- Psychosocial stressors
- Access to lethal means

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CARES-8 – THE QUINTESSENTIAL JUDGMENT

Clinical Assignment for the Risk Estimate of Suicide-8©

1 Psychiatric Disorders
- 54-90%
- Include SUDs/abuse and relevant medical/neuro Dx

2 Suicidality
- Current ideation, behavior, lethality
- Episode of worst ideation
- Chronology of method change

3 Suicide-Specific Symptoms
- Shame, rage, humiliation
- **Psychological pain**

4 Reasons for Living
- Coping skills
- Responsibilities
- Fear of death
- Moral objections
- Fear of disapproval

5 Status of Important Connections
- Significant others
- Therapeutic relationships

6 Psychiatric Treatment
- Current status
- Hospitalization
- Transition of care

7 Psychosocial Stressors
- Theme of loss
- Trauma

8 Access to Lethal Means
- Availability of firearms
- Researching
- Acquiring lethal means

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INTERVENTIONS

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EVIDENCE-BASED TREATMENT

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Antidepressants	A mainstay of treatment of suicidal pts with depressive illness/symptoms. Black Box warning<25; protective effect>30, most pronounced >65
Mood Stabilizers	Lithium has demonstrated evidence for reduction of suicides and attempts with long-term maintenance for BPAD, MDD, and post partum psychosis; VPA, <suicide related mortality, BPAD-more research needed
Ketamine	Low doses of racemic ketamine and esketamine can be an efficient treatment for suicidal ideation.
Antipsychotics	Clozapine reduces suicidality in patients with schizophrenia or schizoaffective disorder.
Antianxiety Agents	Benzodiazepines may reduce suicide risk by treating severe anxiety/agitation/insomnia.
Medication for Addiction	Methadone and buprenorphine to treat opioid use disorder can mitigate suicide risk in this population; buprenorphine-variable dose response-low=TRD, ultra low, may reduce suicidal behavior
Brain Stimulation Techniques	ECT, rTMS, MST used for suicidal patients with treatment resistant depression who require a rapid treatment intervention. Shows evidence for short-term reduction of suicidal ideation.
Psychotherapy	Evidence-based treatments include CBT, CT-SP, BCBT, DBT, CAMS, and MBCT. Interpersonal therapy and psychodynamic psychotherapy may also be of benefit in decreasing suicidal behavior.

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Ketamine

- Evidence suggests short term reduction in suicidal ideation with racemic ketamine and the esketamine enantiomer in patients with MDD
- In 2019, the FDA approved esketamine for the adjunctive treatment of treatment resistant MDD with acute suicidal behavior (Office of the Commissioner, 2019) based on data collected through the Aspire Trials
- Esketamine may only be administered at registered centers enrolled in REMS

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Psychedelics

- Psylocibin: Schedule I substance under Controlled Substances Act, not FDA approved treatment
  - Original studies reported improvement in depression and anxiety ratings particularly in cancer patients.
  - Two recent studies reported significant improvement over placebo in refractory and non refractory depression. Studies thus far suggest psylocibin does not worsen suicidality
- MDMA: Schedule I substance under Controlled Substances Act, not FDA approved treatment
  - Ongoing investigation suggests MDMA assisted therapy may be a helpful approach for patients with severe PTSD
  - Studies thus far suggest MDMA does not worsen suicidality

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Dialectical Behavioral Therapy (DBT)

- Combines methods of CBT with skills training , mindfulness, and distraction
- Designed to improve emotion regulation, interpersonal skills, and distress tolerance
- Originally developed to treat suicidal behavior in women with borderline personality disorder but its use has now expanded to other populations and disorders

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RISK MANAGEMENT ISSUES

- Despite best efforts at suicide assessment and treatment, suicides can and do occur in clinical practice
- Approximately, 12,000-14,000 suicides per year occur while in treatment; 2,500-3,000 in hospital settings
- To facilitate the post-suicide process:
  - Consult risk managers
  - Ensure that the patient's records are complete; document late entries
  - Be available to assist grieving family members
  - Remember the medical record is still official and confidentiality still exists
  - Seek support from colleagues/supervisors

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OUTPATIENT TREATMENT

- ✓ Thoroughness and quality of diagnostic assessment, treatment plan, documentation
- ✓ Was the frequency of visits responsive to the patient's current mental status?
- ✓ Was there appropriate knowledge of and involvement of the patient's support system?
- ✓ If decision was made not to admit, was there an appropriate alternative treatment plan in place?
- ✓ Was communication established with co-treaters? (collaborative or supervisory)
- ✓ Were there plans in place for coverage?
- ✓ Were phone calls handled and documented appropriately?
- ✓ Were inquiries made regarding availability of suicide methods and whether any preparations had been made "in furtherance of the act"?
- ✓ Were firearms/lethal means restrictions instructions given and documented?
- ✓ Were current medications appropriately prescribed (e.g., refills noted)?
- ✓ Were consultants considered(and documented)

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INPATIENT TREATMENT

- ✓ Have prior/current records/treaters been requested/contacted?
- ✓ Have significant others been interviewed and involved?
- ✓ Response to change/deterioration in clinical condition
- ✓ Communication with inpatient staff (written and verbal)
- ✓ Is the level of suicide precautions appropriate to clinical assessment?
- ✓ Are preparations for discharge in order?

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AFTERCARE AND SAFETY PLANNING

Discuss with patient *

- Reasons for living
- Triggers
- Warning signs
- Coping strategies
- Identify outpatient support system: family/friends
- Ask about availability of weapons
- Refer/arrange/contact outpatient provider*

Provide family/friends with discharge instructions*

- Inform patient and family about uneven recovery
- Discuss the importance of medication adherence
- Inform them of increased suicide risk after d/c
- Inform family/friends about signs of increased suicide risk, especially sleep disturbance/anxiety
- Provide emergency phone numbers and instructions on when to go to the ED
- Provide prescriptions and follow-up appointment

*When appropriate

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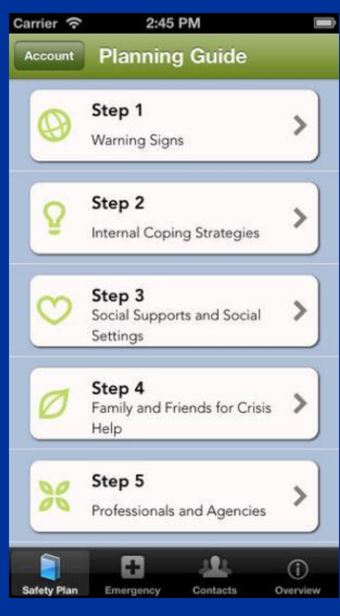
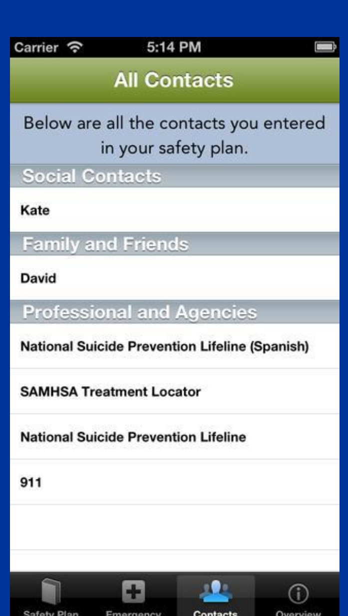
OVERVIEW OF SAFETY PLANNING

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support and distraction from the crisis
4. Contacting family members or friends who may help resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means





Stanley, B. & Brown, G. (2011) Safety planning intervention: A brief intervention to mitigate suicide risk. Cognitive and Behavioral Practice, 19(2), 256-264.

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CURRENT STATUS OF SUICIDE-FOCUSED ASSESSMENT AND TREATMENT:
An Update for Professionals

October 30, 2024
11:30 AM–5:30 PM (EDT)
8:30 AM-2:30 PM (PDT)

Course Directors:

Alan F. Schatzberg, M.D.
Stanford University School of Medicine

Douglas G. Jacobs, MD
Harvard Medical School

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