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.

Suicide in the United States, 2018

- 48,344 Americans died by suicide in 2018; about 1 person every 11 minutes1
- Suicide deaths are 2.6 times the number of homicides (homicides=18,830)1
- 10th leading cause of death across the lifespan1
- 2nd leading cause of death for 10-34 year olds
- Males account for 78% of suicide deaths1
- Approximately 6000 Veterans die by suicide each year; accounting for 14% of all suicides annually2
- Since 2009, suicides have exceeded motor vehicle crash related deaths1

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Suicide in Maine, 2016-2018

- 257 suicide deaths per year on average\(^1\)
  - 9\(^{th}\) leading cause of death among all ages (previously 10\(^{th}\), 2012-2014)
  - 2\(^{nd}\) leading cause of death ages 15-34
  - 4\(^{th}\) leading cause of death ages 35-54

- More suicide deaths in Maine than homicides and motor vehicle traffic deaths\(^2\):
  - 13.5x homicide deaths (770 suicide deaths vs 57 homicides)
  - 1.6x motor vehicle deaths (770 suicide deaths vs 495 motor vehicle traffic deaths)


\(^2\) 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)

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

- Every 1.4 days someone dies by suicide in Maine\(^3\)
  - 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


\(^2\) Maine Hospital Inpatient Database, Maine Health Data Organization, 2016-2018.


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Prevalence (%) of Maine High School Students Who Considered, Planned or Attempted Suicide in Past 12 Months, 2009-2019

- Considered
- Planned
- Attempted

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

- Considered
- Planned
- Attempted

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

Maine Center for Health Statistics and Information
Female students are driving the increase of suicide ideation among Maine high school students.

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>11.0</td>
<td>11.0</td>
</tr>
<tr>
<td>2011</td>
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<tr>
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<td>2015</td>
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<tr>
<td>2017</td>
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<td>10.8</td>
</tr>
<tr>
<td>2019</td>
<td>10.6</td>
<td>11.0</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Year</th>
<th>Males</th>
<th>Females</th>
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</thead>
<tbody>
<tr>
<td>2009</td>
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<td>10.6</td>
<td>11.0</td>
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</tbody>
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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.

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

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Gender Identity</th>
<th>Suicidal Thoughts</th>
<th>Suicide Attempts</th>
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</thead>
<tbody>
<tr>
<td>Heterosexual</td>
<td>Males</td>
<td>12%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>7%</td>
<td>23%</td>
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<tr>
<td>Gay/lesbian</td>
<td>Males</td>
<td>30%</td>
<td>43%</td>
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<tr>
<td></td>
<td>Females</td>
<td>20%</td>
<td>26%</td>
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<tr>
<td>Bisexual</td>
<td>Males</td>
<td>16%</td>
<td>10%</td>
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<tr>
<td></td>
<td>Females</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Unsure</td>
<td>Males</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td>Transgender</td>
<td>Males</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>30%</td>
<td>42%</td>
</tr>
<tr>
<td>Cisgender</td>
<td>Males</td>
<td>15%</td>
<td>8%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>15%</td>
<td>8%</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Gender Identity</th>
<th>Depression</th>
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<tr>
<td>Heterosexual</td>
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<td>58%</td>
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<tr>
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<td>Gay/lesbian</td>
<td>Males</td>
<td>67%</td>
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<td></td>
<td>Females</td>
<td>47%</td>
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<td>Bisexual</td>
<td>Males</td>
<td>67%</td>
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<tr>
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<td>Females</td>
<td>47%</td>
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<tr>
<td>Unsure</td>
<td>Males</td>
<td>65%</td>
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<tr>
<td></td>
<td>Females</td>
<td>65%</td>
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<tr>
<td>Transgender</td>
<td>Males</td>
<td>72%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>72%</td>
</tr>
<tr>
<td>Cisgender</td>
<td>Males</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>35%</td>
</tr>
<tr>
<td>Not Sure</td>
<td>Males</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Females</td>
<td>65%</td>
</tr>
</tbody>
</table>
**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.

**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.

**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!

**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.
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!

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

Comorbidity Issues in Adolescent Suicidality

- 96% of attempters and 89% of ideators met criteria for 1 or more DSM-IV disorder(Nock et al, 2003)
- 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.

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
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:
    o Withdrawal from or changes in social connections
    o Recent increased agitation or irritability
    o Anger or hostility that seems out of character or context
    o Changes in sleep (increased or decreased)
    o Changes in daily Hygiene... AAS Consensus group, 2014

Working toward Suicide Safer Care

Systematic Suicide Care Plugs the Holes in Health Care

Develop Collaborative Safety Plans with Lethal Means Restriction

Screen, then Assess for Suicidality

Directly Treat Suicidality: Suicide-Informed CBT, DBT, CAMS, Support

Assure Excellent Follow-up, and Stay in Touch

Suicidal Person

Death or Serious Injury Avoided

21 22 23 24

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

Thomas Kuhn

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?

Assessing the Information

Putting the information together to determine level of risk.

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...
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 documented and how will access to information be managed to ensure staff readiness?

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?”
  - “Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”
- Intent
  - “Have you had these thoughts and had some intention of acting on them?”
- 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
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.

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)
  - 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

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

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

Wahlberg et al 2016
 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.

Additional Online Training

• Assessment of Suicidal Risk Using the C-SSRS
  [Link](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

Questions or Comments?

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?
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.

Safety Planning and Follow-up

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

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!
### 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

**Crisis Plan Apps**

**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
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

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

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

Questions?