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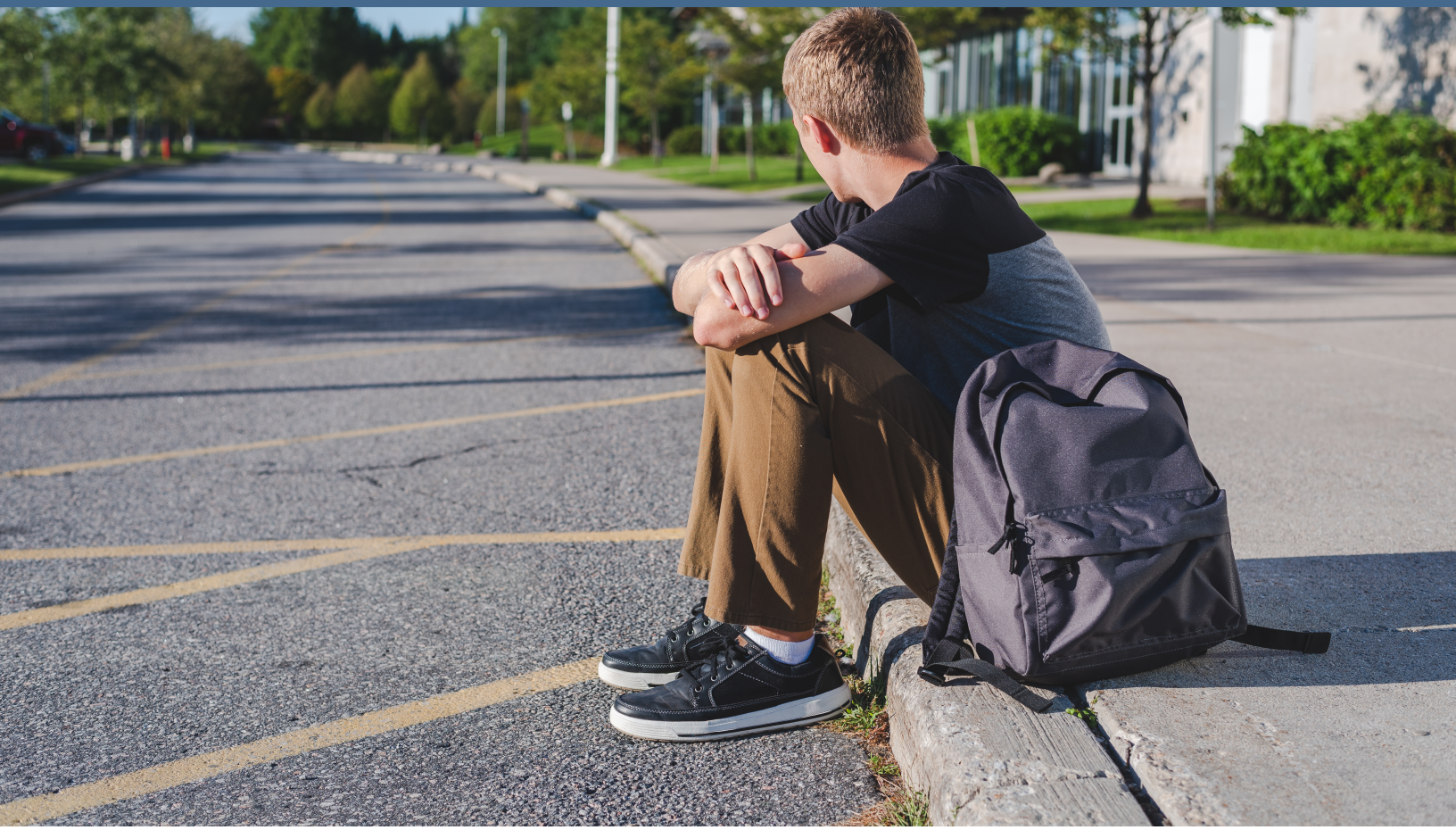
Exploring and Preventing Youth Suicide



What are Suicidal Behaviors?

Suicidal behaviors refer to any conduct engaged in with the intent to die and consists of suicidal ideation, a suicide plan, suicide attempts, and death by suicide. Suicidal ideation refers to the presence of thoughts and ideas of engaging in a behavior with the purpose of killing oneself. Suicidal ideation can be a range of contemplations, wishes, and persistent preoccupation of one's mind with thoughts of death or dying. A suicide plan refers to taking the extra step of formulating a plan of action through which one expects to carry out the attempt. Suicide attempt refers to engaging in a potentially self-injurious behavior with the intent to die by suicide.

Data on Youth Suicide

During 2018, a total of 48,344 persons died from suicide, and suicide was the 10th leading cause of death overall in the United States, accounting for approximately 1.7% of all deaths . Among high school–aged youths (14–18 years), 2,039 suicides occurred that year, making it the second leading cause of death for this age group after unintentional injuries. Suicide accounted for approximately 33.9% or approximately one of every three injury-related deaths among this age group . During 2009–2018, suicide rates among youths aged 14–18 years increased by 61.7% from 6.0 to 9.7 per 100,000 population. In the United States suicide is the second leading cause of death among youth's age 10-24 (CDC-YRBS,

Although suicide is a major public health problem, many more youths make suicide attempts and struggle with suicidal ideation. For example, during 2018, according to data from a nationally representative sample of emergency departments (EDs), approximately 95,000 youths aged 14–18 years visited EDs for self-harm injuries (Ivey-Stephenson. 2020).

The above emergency department data makes it glaringly evident how many youths are at risk for suicide as a result of experiencing suicidal ideation, making suicide plans, and attempting suicide, making a focus on nonfatal suicidal behavior a crucial public health priority. During 2009–2019, trends in suicide attempts among adolescents increased overall and among many demographic groups. Prevalence estimates of suicidal ideation, suicide plans, attempts, and attempts requiring medical treatment were highest among sexual minority youths and youths who reported having had sexual contact with the same or with both sexes. Regarding differences by race/ethnicity, black students had the

highest prevalence estimates for attempted suicide. Factors at the individual, relationship, community, and societal levels likely contribute to the differences in suicide attempts among different racial/ethnic groups and sexual minority youths and the differences observed by sex and grade (Ivey-Stephenson, 2020).

Depression is one of the leading causes of suicide attempts. Mental health disorders or addictive behaviors are associated with 90% of suicide. One in ten youth suffer from mental illness serious enough to be impaired, yet fewer than 20% of those receive treatment (The Jason Foundation, 2021).

The Center for Disease Control Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults.Some of their findings on youth suicide in 2019 included (CDC-YRBS, 2019):

- 19% of all high school students and about 24% (1 in 4) of female students had seriously considered attempting suicide during the past year. Moreover, many students had also seriously considered attempting suicide during the past year from 2009 through 2019, when the rate was about 1 in 5 sudents.
- 16% of high school students had made a suicide plan during the past year. Data indicated that more students had made a suicide plan during the past year from 2009 through 2019.
- 9% of high school students had attempted suicide one or more times during the past year. More students had attempted suicide during the past year from 2009 through 2019. Female students and black students attempted suicide more than other groups.
- 3% of high school students were injured in a suicide attempt that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse during the past year. There was no change in the percentage of students being injured in a suicide attempt during the past year from 2009 through 2019.

Historically it was said that for every completed suicide there were 6 people directly impacted by the loss. While this seemed like a low number it was not until Cerel research group set about to debunk this myth that we learned the breadth of impact a suicide completion has. She and her team found that in truth, for every suicide death

there are up to 135 people who are exposed to that one suicide. The researchrs also found an association between poor psychiatric outcomes among those exposed to suicide and their perceived closeness to the decedent regardless of their familial relationship. These study results inform clinicians when inquiring about a patient's suicide exposure history. The findings indicate that more people are exposed to suicide than previously thought and the psychiatric impact can be greater among those who perceive themselves close to the person who dies by suicide. It is estimated that 50% of the population has been exposed to a suicide in their lifetime (Cerel, 2018).

Risk and Protective Factors

Risk Factors

Risk factors are characteristics that make it more likely that someone will consider, attempt, or die by suicide. While they are important to be aware of, risk factors cannot cause or predict a suicide attempt.

- **Mental Disorders:** particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders. About 90% of people who commit suicide have suffered from at least one mental disorder. Criteria for depression were found in 50–65% of suicide cases, more often among females than malesn (Bilsen, 2018).
- **Alcohol and other substance use disorders:** substance abuse, and more specifically alcohol misuse, is strongly associated with suicide risk, especially in older adolescents and males (Bilsen, 2018).
- **Hopelessness:** a lack of positive expectations for one's future, as opposed to the presence of negative expectations, is indicative of future suicidal behavior among adolescents (Wolfe, 2019). In 2019, about 37% of high school students had experienced periods of persistent feelings of sadness or hopelessness during the past year. These persistent characteristics were defined as feeling so sad or hopeless almost every day for two weeks or more in a row that the students stopped participating in their usual activities. More students had experienced persistent feelings of sadness or hopelessness from 2009 through 2019. Almost half of female students experienced persistent feelings of sadness or hopelessness in 2019 (CDC-YRBS, 2019).

- **Impulsive and/or aggressive tendencies:** a suicidal process can take weeks, months or even years, while the fatal transition from suicidal ideation and suicide attempts to an actual completed suicide often occurs suddenly, unexpectedly and impulsively, especially among adolescents. Difficulties in managing the various, often strong and mixed emotions and mood fluctuations accompanying the confrontation with new and ever-changing challenges in different domains is another risk factor for youth suicide (Bilsen, 2018).

- **Home Environment:** lack of cohesion, high levels of violence and conflict, a lack of parental support and alienation from and within the family can increase suicide risk (The Jason Foundation, 2021).

- **History of Trauma or Abuse:** Approximately 40% of youth suicides are associated with an identifiable precipitating event, such as the death of a loved one, loss of a valued relationship, parental divorce, or sexual abuse (The Jason Foundation, 2021).

- **Previous Suicide Attempt(s):** 25–33% of all cases of suicide were preceded by an earlier suicide attempt, a phenomenon that was more prevalent among boys than girls. In prospective studies, it was found that 1–6% of people attempting suicide die by suicide in the first year (Bilsen, 2018)

- **Family History of Suicide:** It is estimated that in 50% of youth suicide cases, family factors are involved. One important factor is a history of mental disorders among direct family members themselves, especially depression and substance abuse. It is not clear whether these disorders directly influence the suicidal behavior of the child, or rather do so indirectly, through mental disorders manifested in the child as a result of this family context. Researchers also found an augmented presence of suicidal behavior among family members of young people who have committed suicide (Bilsen, 2018).

- **Loss of Relationship(s):** This could be a romantic relationship breakup, friendship termination or the loss of an important person through death or divorce (Bilsen, 2018).

- **Easy Access to Lethal Means:** Half of all suicide deaths in the United States are from firearms. Suicidal thoughts are often transient and suicidal behavior is often impulsive. In households in which firearms are locked and/or unloaded, there is less likelihood of a completed suicide. Restricting access to lethal means in those at risk for suicide is one of the most effective means of reducing suicide rates.

Restricting access to guns reduces the number of suicides, without an increase in suicides by alternative means (Stop A Suicide Today, 2021).

- **Local Clusters of Suicide:** Contagion suggests a kind of infectious disease, precluding “infected” persons' ability to act and decide for themselves. Imitation refers to learning by modeling, and the acquisition of new patterns of behavior through observation of the model's behavior (Bilsen, 2018). Exposure to others who have died by suicide (in real life or via the media and Internet) can play a role in increased suicide attempts due to imitation. (Suicide Prevention Lifeline, 2021).
- **Lack of Social Support and Sense of Isolation:** School problems and academic stress was found in 14% of suicide cases. Youngsters who are “drifting,” neither attending school nor having a job, have substantially more risk of suicide, due to a lack of structure and predictability (Bilsen, 2018).
- **Bullying:** Youth who experience school bullying and cyberbullying victimization are at a higher risk of suicidal ideation (Baiden & Tadeo, 2020). In a study of youth who presented at two Kingston hospital emergency departments for psychiatric issues, 77% reported being bullied in their lifetime (as compared to 33% of the general youth population of Canada who have reported being bullied) (Alavi, 2017).
- Sexual Orientation: The experience of discrimination, isolation, and relationship conflicts with family, friends, and others because the young person is gay or lesbian is a known risk factor (Better Health, 2021).

Protective Factors

The Suicide Prevention Resource Center (2021) identifies the following protective factors:

- **Effective Behavioral Health Care:** Care that is evidenced-based and focused on suicidal thoughts and behaviors while also addressing any underlying mental health and/or substance use disorders
- **Connectedness:** Positive and supportive social relationships (individuals & family), social and community connections can help buffer the effects of risk factors in people’s lives.

- **Life Skills:** This includes critical thinking, stress management, conflict resolution, problem-solving, and coping skills. Resilience is a related concept that includes traits such as a positive self-concept and optimism in addition to life skills. It is sometimes described as the ability to adapt to stress and adversity.
- **Positive School Experiences:** The belief by students that adults & peers in school care about their learning as well as about them as individuals serves as a protective factor.
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide

Warning signs

Four out of five teens who attempt suicide have given clear warning signs (The Jason Foundation, 2021). This makes it extremely important for those who work with adolescents to be able to recognize and respond to warning signs. Warning signs are particularly relevant if the behavior is new, has increased, or seems related to a painful event, loss, or change. These include:

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, like searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating oneself
- Showing rage or talking about seeking revenge
- Extreme mood swings (Suicide Prevention Lifeline, 2021).

- Participating in destructive, dangerous, or life-threatening behaviors; risk-taking
- Increased frequency & intensity of self-harm (Better Health, 2021)

Myths and Facts Regarding Youth Suicide

Myth: Young people who talk about suicide never attempt to take or actually take their own lives. They are just seeking attention.

> **Fact: Anyone talking about suicide should always be taken seriously.**

Myth: Once individuals are intent on suicide, there is no way to stop them. They will be suicidal forever.

> **Fact: Even the most severely depressed person has mixed feelings about death, wavering until the very last moment between wanting to live and wanting to die. Most suicidal people do not want death; they want the pain to stop. The impulse to end it all, however overpowering, does not last forever.**

Myth: Suicidal thoughts and behaviors are hereditary.

> **Fact: While suicidal thoughts and behaviors tend to run in families, they are not hereditary. It is important for individuals experiencing suicidal thoughts to know that there are options other than ending their lives.**

Myth: All suicidal young people are depressed.

> **Fact: While depressed mood is common, this is not true for everyone who attempts or commits suicide.**

Myth: A marked and sudden improvement in mental state following a crisis indicates the suicide risk is over.

> **Fact: When there have been signs of a possible suicide attempt, a sudden improvement in mood may in fact indicate that the person has finally decided to complete the act and is feeling a sense of relief** (Better Health, 2021).

Myth: Screening for suicide risk will make students kill themselves.

> **Fact: Asking students about suicide does not increase risk and it actually opens the door for the opportunity to discuss suicide, self-harm and mental health, often helping to relieve the distress the person is feeling** (Erbacher & Singer, 2017).

Intervention and Prevention Strategies

Assessment

The first step in effective suicide prevention is to identify those who need help. The Columbia-Suicide Severity Rating Scale (C-SSRS), is a well-respected, evidence supported, suicide risk assessment. The questions use plain and direct language, which is most effective in eliciting honest and clear responses. The answers help identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. The Columbia protocol is simple to use and does not require mental health training. The scale was created to provide a tool that was accessible to all while still being effective. It is free to use and additional training is available on the website. The C-SSRS has been modified from the original full scale to a straight-forward simplified version that still effectively assesses risks, needs, and level of referral. See appendix A for the Columbia Protocol and appendix B for the full C-SSRS (The Columbia Lighthouse Project, 2021).

The 6 Questions of Columbia Protocol:

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?
3. If they answer YES to 2, ask 3-6. If they answer NO, ask 6. ALWAYS ASK QUESTION 6
4. Have you thought of how you might do this?
5. Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?
6. Have you started to work out, or worked out the details of how to kill yourself? Do you intend to carry out this plan?
7. Have you done anything, started to do anything, or prepared to do anything to end your life?

   Examples: Collected pills, obtained a gun, given away valuables, written a will or

suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.

Scoring: Any yes: the person should seek a behavioral health referral. If there is a yes on 4,5,6 the person should seek immediate help by going to the ER, calling 911, or calling/ texting the National Suicide Helpline. It is critical to stay with the person until an evaluation is complete.

Safety Planning

Another key aspect of suicide prevention is safety planning. A suicide safety plan is a specfic written list of coping strategies and resources that can help individuals know what to do when they are experiencing an acute suicidal crisis. The concept behind the safety plan is to have a well thought-out strategy of what to do in an emergency because the person who is in crisis and at acute risk of suicide may be in an impaired state and may have difficulty generating solutions. The safety planning intervention helps individuals identify ways to distract themselves in order to buy time between suicidal urges and lethal actions. This collaborative plan between the clinician, the patient, and the patient's family (should the patient choose to have them involved). It is a living document that can be modified over time as circumstances change.

A typical safety plan will cover the following areas (Stop A Suicide Today, 2021):

1. Recognizing warning signs of suicide risk in oneself
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as 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

The Stanley-Brown Safety Plan Intervention covers safety planning on one sheet that is easy to fill out and access at times of need. This form, which is in Appendix C and can be accessed on Stanley & Brown’s website, includes free training to learn more on

completing safety plans. Especially when working with youth, a mobile safety plan may be easier to access for them since most have their cell phones with them at all times. Additionally, it may be more convenient and subtle to pull out one's phone to review a safety plan during a time of need than a piece of paper. The New York State Office of Mental Health, in collaboration with Drs. Stanley and Brown, have created a Safety Plan App called The Stanley-Brown Safety Plan which can be found in the Apple App Store. The goal of safety planning is to enable individuals to become more aware of their personal warning signs that a suicidal crisis is beginning or escalating so that they can take action before they are in danger of acting on their suicidal feelings.

Care Coordination

Presenting to a hospital with self-harm significantly predicts subsequent suicide in youth; with the period immediately following discharge from psychiatric inpatient treatment being associated with the highest risk for suicide. The period following hospital discharge therefore provides a crucial opportunity for intervention. Suicidal ideation is a necessary precursor to suicide attempt and as such also requires intervention (Robinson, 2018).

The period of greatest risk of suicidal behavior is after discharge from the emergency department or from an inpatient hospital unit. Eighty percent of suicide deaths following a nonfatal suicide attempt happen within 1 year (Mann, 2021). Research showed that follow-up contact interventions as simple as sending postcards prevented suicide attempt in two of four studies. Additionally, enhancing treatment engagement and adherence after an emergency department visit or hospital stay through follow-up contact calls reduced attempts or ideation in four of five studies. These interventions are scalable, as shown by a multinational study reporting that psychoeducation paired with telephone or in-person contact reduced the suicide rate over 18 months among suicide attempters. A cohort comparison study of safety planning interventions, administered in the emergency department with follow-up telephone contact, produced a 45% reduction in suicidal behaviors compared with treatment as usual (Mann, 2021).

Continuity of care is an important goal due to the relatively low rates of follow-up treatment seen among patients presenting with suicide ideations and suicide attempts. Brief emergency interventions generally aim to mobilize protective processes in the youth and the environment, and the response of patients and parents/caregivers during these interventions provide opportunities to further assess youth safety and the ability

of parents to keep the youth safe. More specifically, these intervention/assessment approaches focus on assessing and strengthening characteristics of the youth and environment (eg, mobilize hope and reasons for living, engage in safety planning process, problem solving as needed, increasing safety within the environment, lethal means counseling, and counseling on substance use-related disinhibition). They also focus on providing support for continuity of care (eg, rapid referral/appointment scheduled, enhancing motivation for treatment, addressing treatment barriers, caring contacts) and can be integrated within a care process and triage model when there is a potential for discharge home (Asarnow et al., 2018).

In the United States mental health care remains difficult to access, and care coordination has been included as a component of many interventions due to the complexity of navigating mental health care systems. Care coordination helps promote connectedness via engagement with health care clinicians, mental health care and with the patient's community. Care coordination increases engagement with post-acute care (Doukim, 2020).

Treatment Strategies

Treatment may include medications, psychotherapy or a combination of both. Typical antidepressant medications prescribed are selective serotonin reuptake inhibitors (SSRIs). Examples of SSRI's include Prozac, Zoloft, Celexa, Paxil & Lexapro.

In the early to mid-2000s the FDA instigated "black box" warnings for adolescents prescribed anti-depressants stating there may be a timeframe in which the medications increase the risk suicide. However, experts have fount that, "Contrary to earlier FDA findings, SSRIs may work without increasing risk of treatment-emergent suicidal ideation or behavior, even in youths . Longitudinal pharmacoepidemiological studies in adolescents, young adults, and older adults have found that the greatest risk for a suicide attempt was in the month before antidepressant medication began; after the medication was initiated, the risk declined progressively over months" (Mann et al., 2021).

The FDA-directed black box warnings regarding a possible increase in the risk of suicidal thinking and behavior in children, adolescents, and young adults (<25 years) treated with antidepressant medications led to decreased antidepressant prescribing. These warnings were based on evidence reviews indicating a small increase in rates of suicidal

ideations and suicide attempts following antidepressant treatment. Analyses of risk differences for “clinical response” and for “suicidal ideation and attempts,” however, suggest that benefits of antidepressant treatment are greater than risks, with 4% to 11% more depressed youths benefiting from antidepressants versus experiencing a suicidal event. Finally, in contrast to the clinical trials that generally excluded patients with high suicide risk, results of larger and more representative pharmacoepidemiologic studies point to a protective effect of antidepressant treatment, with several studies indicating lower suicide rates with higher antidepressant use (Asarnow et al., 2018).

Given the collective evidence, the American Academy of Child and Adolescent Psychiatry recommends treatment for depression using medication and psychotherapy treatments supported by the evidence. As well, based on these indications, combined medication and psychotherapy treatment is considered the most efficacious option. Similarly, the Society for Adolescent Medicine (SAM) supports appropriate use of antidepressant medications in the treatment for adolescents with depression and the need to balance the risk of suicidality and clinical need (Asarnow et al., 2018).

When considering psychotherapeutic interventions, cognitive behavioral therapy has the greatest amount of research supporting its effectiveness. However, there are a number of other evidence based psychotherapy treatments that have shown positive results with youth struggling with suicidal ideations.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) is a psychological treatment that addresses faulty or unhelpful thoughts and behaviors. The goal is to build skills to better cope with distress. Studies show that CBT can reduce suicidal thoughts, attempts, and hopelessness. CBT appears to be especially effective in reducing suicidal behavior when the treatment specifically targets suicidal thoughts and behaviors (as opposed to thoughts and behaviors related to depression or mental illness in general) (Stop A Suicide Today, 2021).

Cognitive behavioral therapy decreases suicidal behavior risk in adults and adolescents with depression and it halved suicide reattempt rates in patients presenting to an emergency department after a recent suicide attempt compared with treatment as usual. CBT for suicidal individuals is designed to help high-risk individuals apply more effective coping strategies (e.g., cognitive restructuring) in the context of stressors and problems that trigger suicidal behaviors. Therapists also are trained to identify patient-

specific factors that promote suicidal behaviors. In substance use disorders, CBT has been reported to reduce attempt frequency compared with treatment as usual in adolescents. CBT may work by improving negative problem orientation and emotion regulation, reducing impulsiveness, and attenuating suicidal ideation (Mann, 2021).

Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) combines methods of CBT with skills-training and mindfulness meditation techniques to improve emotion regulation, interpersonal relationships, and the ability to tolerate distress. Several recent studies have found DBT to be an effective treatment for reducing repeat suicide attempts in highly suicidal patients, including adolescents. A cornerstone of DBT is the idea that the patient can build a life worth living, even when the individual has many problems and wishes to die. (Stop a suicide, 2021)

Dialectical behavior therapy (DBT) for borderline personality disorder in adolescents, college students, and adults prevents suicide attempts and hospitalization for suicidal ideation and lessens medical consequences of self-harm behaviors compared with treatment as usual. Treatment dose may be a factor because a single session of DBT was not found to reduce suicidal ideation, whereas most effective studies employed a 20-week DBT intervention (Mann, 2021).

Originally developed and tested for treating suicidal adults with borderline personality disorder, DBT for adolescents includes individual psychotherapy with some family sessions, multifamily group skills training with adolescents and parents, therapist availability for phone coaching 24 hours daily for youths and parents, and weekly therapist consultation teams to support therapists in doing the best they can to provide effective treatment and stay within the treatment model (Asarnow et al., 2018).

Collaborative Assessment and Management of Suicidality

Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic approach specifically targeted toward reducing suicide risk (Stop A Suicide Today, 2021). CAMS focuses on identifying risk factors and “drivers” of suicidal ideation and intent (i.e., specific thoughts, feelings, and behaviors that are leading or contributing to the patient’s suicidal ideation). A main element is the use of the Suicide Status Form (SSF), which contains open-ended questions about psychological pain, stress, hopelessness, reasons

for living, and other such variables. CAMS is a collaboration between the clinician and the patient, who decide together how to manage the client's suicidality. Clinicians work to understand the struggle of the suicidal patient with empathy and without judgment.

CAMS is an evidence-based approach. Studies, including randomized controlled trials, have shown that this therapeutic approach can reduce suicidal ideation, symptom distress, depression, hopelessness, and emergency department visits for suicidal behavior in a variety of populations. In addition, there is growing evidence that it can treat self-harm and suicide attempts (Stop A Suicide Today, 2021).

Interpersonal Therapy

Interpersonal therapy (IPT) is an evidence-based treatment for depression that can be helpful for some individuals experiencing suicidal ideation. IPT is based on the understanding that personal relationships and life events can both impact and be impacted by mood (Stop A Sucide Today, 2021). IPT aims to improve communication skills and strengthen social support networks. IPT also focuses on developing more realistic expectations and better coping strategies (Stop A Sucide Today, 2021).

Multisystemic Therapy

Research also indicates advantages of intensive community-based treatment, such as multisystemic therapy (MST). A randomized controlled trial (RCT) that compared MST to hospitalization among children and adolescents presenting with acute psychiatric emergencies found better outcomes and fewer suicide attempts and self harm in youths receiving MST. These data combined with excessive burdens on our emergency departments, particularly in rural and remote regions, have contributed to interest in developing prehospital programs such as urgent care and crisis teams (Asarnow et al., 2018).

The proven effective way to address high-risk suicidal juveniles includes not only personalized mental health treatment, but engagement with families, schools and communities—an intensive, multilateral juvenile intervention that focuses on both internal and external risk factors. Multisystemic Therapy (MST) is family-, school- and community-focused, helping to build three critical support networks that can, quite literally, save lives. This is critical since preventing youth suicide isn't only about mental

health—it's about creating strong homes, supportive schools and inclusive communities (MST Services, 2018).

Psychodynamic Psychotherapy

Psychodynamic psychotherapy helps patients improve self-esteem and interpersonal relationships by understanding and working through the way in which past experiences have shaped current feelings and behavior. There is increasing evidence that psychodynamic therapies are effective for a wide range of mental health conditions, and that they can help to reduce suicidal behavior. Psychodynamic psychotherapists often integrate techniques from CBT and DBT in an empathic frame that is flexible in addressing the patient's problems (Stop A Sucide Today, 2021).

Psychodynamic psychotherapies for borderline personality disorder have been found to prevent suicidal or self harm behavior in most controlled studies. There are no replicated studies of other types of psychotherapeutic interventions showing prevention of suicidal behavior. Even if psychotherapies were effective, only CBT appears to be scalable (Mann, 2021).

How can parents, schools, and communities help?

Parents

Ways in which parents and peers may help a youth experiencing suicidal thoughts include (Better Health, 2021):

- Listen and encourage them to talk and show that you are taking their concerns seriously.
- Tell or show the person that you care.
- Acknowledge their fears, despair or sadness.
- Provide reassurance, but do not dismiss the problem.
- Ask if they are thinking of hurting themselves or taking their own life, and if they have a plan.

- Ensure they do not have access to lethal weapons or medications.
- Stay with the person if they are at high risk of suicide.
- Immediately tell someone else, preferably an adult.
- Seek help from professionals, and offer to provide support.
- Let them know where they can get support.
- Provide contact numbers and assist them to call if necessary.

Things to avoid may include (Better Health, 2021):

- Interrupting with stories of your own
- Panicking or becoming angry
- Being judgmental
- Telling them all the things they have to live for
- Offering too much advice

Parents and other adults who work with adolescents should familiarize themselves with the Columbia Protocol 6 questions so they are comfortable asking them should the need arise.

Schools

School environmrnts are ideal settings in which to identify and respond to youth suicide risk. Students spend more waking hours in schools than any other setting, including home. Students are in contact with peers, staff, and skilled mental health professionals, all of whom can be trained to identify and respond to youth suicide risk (Erbacher & Singer, 2017).

Mann et al. (2021) found that mental health education resulted in less suicidal behavior and less suicidal ideation. A key factor appears to be the population targeted for education. Targeting high school students was found to prevent student suicide attempts, whereas studies targeting teachers and parents did not find any benefits. A system-level approach, involving the application of a combination of education, training, and screening, shows promise in lowering suicide risk. The education piece should target

students as well as gatekeepers such as teachers, counselors, parents & primary care physicians (Mann, 2021).

Community

Community conversations may be driven for a variety of different reasons. Three key areas with core principles that have been identified by Conversations Matter (2021), a community resource for suicide discussions, include the following:

- **Prevention Focused Community Conversations** are focused on educating the community on stigmas and how to address them, shifting conversations from judgmental to supportive, and educating on risk and protective factors. It is a fact focused conversation to help the community have a better general understanding about suicide.
- **Intervention Focused Community Conversations** are helping members recognize risk factors and warning signs, teaching know how to ask a loved one, friend or colleague if they are having suicidal thoughts, and how to offer support and get the help the person might need.
- **Postvention Focused Community Conversations** happen after there has been a suicide death in the community. These should be handled sensitively as you may not know who has been adversely affected by a suicide death and their particular vulnerabilities at the moment. There is also a delicate balance between "ensuring that suicide is not being made secret or something that is shameful and ensuring suicide is not glamourized or presented as a way of dealing with problems." Ensure that information about a suicide death and the community/school/ workplace response is provided by consistent spokesperson/s with a connection to the community/school/workplace. In addition, make sure that community forums avoid focusing on the specific suicide event, but rather concentrate on understanding bereavement, promoting support and care for those affected, and encouraging help-seeking. Community forums occurring soon after a suicide death should consider the audience members and their needs to ensure that any prevention messages presented (e.g. we can prevent suicide if we know the warning signs) do not increase feelings of guilt and distress in those directly affected.

For all community presentations, it is recommended and best practice to have a presenter along with a support person who can step out with attendees should someone have an emotional response to the materials being discussed.

Other Community Considerations

A comprehensive approach seeks to prevent suicide risk, identify and support youths at increased risk, prevent attempts and reattempts, and help survivors of suicide loss. Other community strategies for a comprehensive approach to suicide prevention include (Ivey-Stephenson, 2020):

- Preventing adverse childhood experiences (e.g., child maltreatment) to help reduce suicide risk among adolescents through strategies that promote safe, stable, nurturing relationships and environments in childhood.
- Supporting families by strengthening economic supports and teaching coping and problem-solving skills among children, adolescents, and their parents.
- Promoting connectedness between youths and their schools, teachers, peers, and family.
- Creating protective environments in schools and at home (e.g., limiting access to lethal means among students at risk such as medications and firearms).
- Promoting help-seeking behaviors; reducing stigma; and training teachers and adults in recognizing signs of suicide and responding effectively through referrals to evidence-based treatment (e.g., cognitive-behavioral therapy).
- Finally, schools and the media should respond to and report on suicides in ways that are supportive and responsible (e.g., not sensationalizing deaths), thereby avoiding additional suicides (i.e., suicide contagion)

How are self-harm and suicide-related?

Severe distress and emotional pain can also manifest in other unhealthy ways. Self-harm, intentionally inflicting pain on one's self, is a negative coping mechanism and emotional outlet. Each year, approximately 1 in 5 females and 1 in 7 males hurt themselves on purpose (CHOP, 2021). There is a multitude of reasons why adolescents self-harm, including desperation, anger, anxiety, a cry for help, and the desire to "feel

something" in those who may feel otherwise "numb" to emotions. While these individuals are at a higher risk of suicide, self-injury is often unrelated to suicidal ideation. One of the most common forms of self-injury is cutting, the act of making small cuts on one's body. Like other forms of self-harm, some youth report that this provides a sense of relief from overwhelming negative feelings. Self-harm should be taken seriously (CHOP, 2021).

Self-injury behaviors include head banging, cutting, burning, biting, erasing, and digging at wounds. These behaviors are becoming increasingly common among youth, especially young females. While self-injury typically signals the occurrence of broader problems, the reason for this behavior can vary from peer group pressure to severe emotional disturbance. Although help should be sought for any individual who is participating in self-injury, an appropriate response is crucial. Because most self-injury behaviors are not suicide attempts, it is important to be cautious when reaching out to the youth and not to make assumptions (The Jason Foundation, 2021).

There is also a need to pay attention to signs of non-suicidal self-injury (NSSI), such as carving, cutting, burning or punching oneself or objects. NSSI is more common among adolescents and young adults than among older age groups (15-20% vs. 6%). Although by definition NSSI is intentional self-injury without the intent to die, having a history of NSSI puts one at higher risk of suicide attempt and suicide death (Stop A Suicide Today, 2021).

Conclusion

Suicide ideation and completion continues to be serious issue among all age groups, and young people are amongst the most vulnerable. Aolescence offers a developmental window when early effective intervention may prevent potentially deadly patterns from becoming established, and for those who work with adolescents and/or their parents, the hope is that early recognition and intervention can prevent suicidal behavior and premature deaths (Asarnow et al., 2018). It is imperative that those who are in the greatest positions to help young people who are struggling have the ability to recognize when they are at-risk and have the supports and resources in place to intervene. Risk and protective factors for suicide must be examined and gatekeepers need to be aware of the warning signs. Only then will they have the capacity and ability to connect youth at risk for suicide with valuable prevention and postvention resources and services.

Appendix A: Columbia Protocol - 6 Questions

	Past 1 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, answer questions 3, 4, 5 and 6 If **NO** to 2, go directly to question 6		
3) Have you thought about how you might do this?		
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act 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*: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.		**High Risk**

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

Any YES indicates that someone should seek behavioral healthcare.
However, if the answer to 4, 5 or 6 is YES, seek immediate help: go to the emergency room, call 1-800-273-8255, text 741741 or call 911. STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

Appendix B: Columbia Suicide Severity Risk Scale (C-SSRS)

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime Recent

Version 1/14/09 m9/12/17 m5/3/21

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in ***The Columbia Suicide History Form****, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M.A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.]* Standardized Evaluation in Clinical Practice*, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject 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?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"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 do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u>, as opposed 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?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation*** Recent - ***Most Severe Ideation:*** _____ _____ ***Type # (1-5)*** ***Description of Ideation***	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____

Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**

Actual Attempt:	**Yes**	**No**	**Yes**	**No**
A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.	☐	☐	☐	☐
Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.				
Have you made a suicide attempt?				
Have you done anything to harm yourself?				
Have you done anything dangerous where you could have died?				
What did you do?	Total # of		Total # of	
Did you_____ as a way to end your life?	Attempts		Attempts	
Did you want to die (even a little) when you_____?				
Were you trying to end your life when you _____?	═══		═══	
Or Did you think it was possible you could have died from_____?				
Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better,				
get sympathy, or get something else to happen)? *(*Self-Injurious Behavior without suicidal intent)				
If yes, describe:				
Has subject engaged in Non-Suicidal Self-Injurious Behavior?				
	Yes	**No**	**Yes**	**No**
	☐	☐	☐	☐

Interrupted Attempt:	**Yes No**		**Yes No**	
When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).*	☐	☐	☐	☐
Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.				
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?				
If yes, describe:	Total # of interrupted		Total # of interrupted	
	═══		═══	

Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____	**Yes No** ☐ ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes No** ☐ ☐ Total # of preparatory acts _____	**Yes No** ☐ ☐ Total # of preparatory acts _____

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Appendix C: Stanley- Brown Safety Plan Intervention

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

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

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

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

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