UnityPoint Health

Preventing Youth Suicide: What will it take?

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Sensitivity Statement

- This presentation includes information and discussion about the very serious problem of youth suicide.
- Please support each other by holding our discussion with sensitivity. .
- For people in this room; this presentation is personal – approximately 1 out of every 7 people knew someone who completed suicide (CDC).
- For some people in this room; this presentation may be traumatic. People have lost family, friends or students to suicide.

UnityPoint Health

Mission

"Improve the health of the people and communities we serve."

Mental Health

The CDC describes mental health disorders among children and youth as,

"serious changes in the ways children typically learn, behave, or handle their emotions."

Plan/Goal

- Review facts about suicide and youth suicide.
  - Separate Myths about suicide from Facts.
- Prevention
  - Identify/review high risk factors
  - Discuss effective communication skills for intervening with suicidal youth

Knowledge & Attitudes

On one side of index card – write response to following.

1. List 3-5 risk factors that would raise concern about a youth other than direct statements of intent or ideation.
2. On scale 0-5 (0=low comfort, 5=high comfort) how comfortable and confident am I to ask a young person about suicidal ideation?
3. Who (name and #) do I involve for support when I have identified a potentially suicidal youth?

The Challenge

- 70 – 80% of youth with mental health problems are identified in one of two places – doctor's office or schools.
- Only 1 of every 3 or 4 youth referred to specialty mental health; actually arrive.
- Untreated mental health problems of childhood and adolescence translate to ineffective school rooms, increased long term health risks & inter-generational family dysfunction.
- 50% or more of lifetime diagnosis of mental illness begins by age 14 & there is an average of 10 years between emerging symptoms and an accurate diagnosis and treatment.

The Challenge

- In 2013, number of people in the United States who died by suicide = 41,149.
- 113 deaths per day at a rate of one completion every 13 minutes
- 20 – 24% lifetime prevalence of SI in adolescents 12-17 years of age
- Suicide is the 2nd leading cause of death for people aged 10-24 (CDC – 2016) 1. Unintentional injury 3. Homicide
- 2nd leading cause of death among 15 – 19 year olds in Iowa
- 4,600 youth die by suicide each year

The Challenge

- Older youth more likely to die
  - 7.8 / 100,000 of 15-19 y/o
  - 1.3 / 100,000 of 10-14 y/o

- LGBTQ youth who come from highly rejecting families are 8.4 times more likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.

- Teenage girls 3x more likely to attempt; boys 2x more likely to complete.

- 1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year.

Suicide Facts – Iowa Youth Survey

6181 respondents – Polk Co

- IYS Polk Co (2014) –
  - **Yes** – "made a plan for how to kill themselves?"
    - 4% (86) of 6th grade respondents
    - 9% (181) of 8th grade respondents
    - 9% (180) of 11th grade respondents
- IYS Polk Co (2014)
  - **Yes** – "tried to kill myself?"
    - 2% (43) of 6th grade respondents
    - 4% (80) of 8th grade respondents
    - 3% (60) of 11th grade respondents

Suicide Facts

Communication about suicide is often NOT made to professionals.

- In one psychological autopsy study, only 18% of completers told professionals of intentions.

- In a study of suicidal death in hospitals:
  - 77% denied intent on last communication
  - 28% had “no suicide” contracts with their caregivers

- Research does **not** support the use of no-harm contracts (NHC) as a method of preventing suicide; rather we need to work hard to develop safety plans involving family.
- Suicidal youth are reluctant to seek help; significant opportunity for prevention efforts.

Myth vs. Fact

- **MYTH:**

  Youth who threaten suicide don't complete suicide, i.e. playing a game.

- **FACT:**

  Most youth who die by suicide have given warnings to family and/or friends of their intentions. Always take any comment about suicidal ideas or attempts seriously.

Myth vs. Fact

- **MYTH:**

  Suicidal youth are fully intent on dying.

- **FACT**:

  Most people, especially youth considering suicide are undecided about living or dying, “suicidal ambivalence.” A part of them wants to live; however, death seems like the only way out of their pain, suffering or situation. They may allow themselves to "gamble with death," leaving it up to others to save them.

Myth vs. Fact

- **MYTH:**

  Asking a depressed person about suicide will plant the idea and push him/her to attempt suicide.

- **FACT:**

  Research & experience indicate that people already isolated and struggling, especially with depression; already have suicidal thoughts. Talking about SI does **not** increase the risk of attempt.

Myth vs. Fact

- **MYTH:**

  Suicide occurs in great numbers around holidays in November and December.

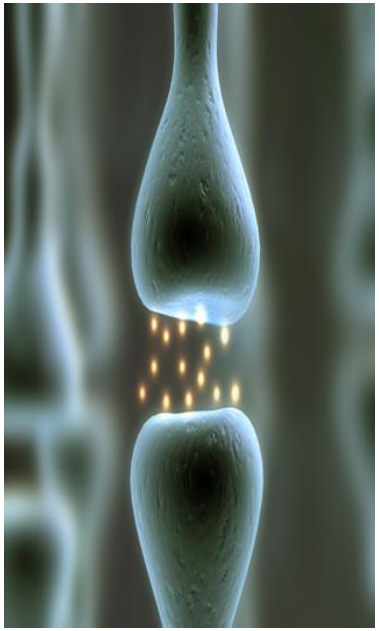
- **FACT:**

  Highest rates of suicide are in March and April; while the lowest rates are in December.

Risk Factors – Mental Health

Psychiatric Disorders - Psych autopsy studies done in various countries over 50+ years report very similar outcomes:

- **90% of people who die by suicide are suffering from one or more psychiatric disorders:**
  - Depression*
    - Major Depression
    - Bipolar Depression
  - Anxiety Disorders, e.g. PTSD, OCD
  - Alcohol abuse and dependence
  - Drug abuse and dependence
  - Schizophrenia, paranoid type
- **For youth these disorders are compounded by developmental psychology:**
  - Maturational imbalance – teen reward focused behavior outpaces inhibitory control.
  - NSSI – (non suicidal self injury)
  - Emotional immaturity/incompetence. Lack of perspective.



*Especially male youth when combined with alcohol and drug abuse and conduct d/o.

Risk Factors – Environment

Means/Relational Risk Factors

- **Lethal Means** – Access?
  - Top three methods used by young people include: firearm, strangulation, poisoning
  - Gun safes
  - Trigger locks
  - Separation of gun and ammunition

- **Recent loss** – death or breakup
- **Social media** – relational influence contributes to perception and experience of isolation – we can't control others use of social media – we can strongly influence or even control access and use of the device.
- **Gender** – males more often complete
- **Family Distress** – separation or divorce
- **Contagion** - Local clusters of suicide that have a "contagious influence"

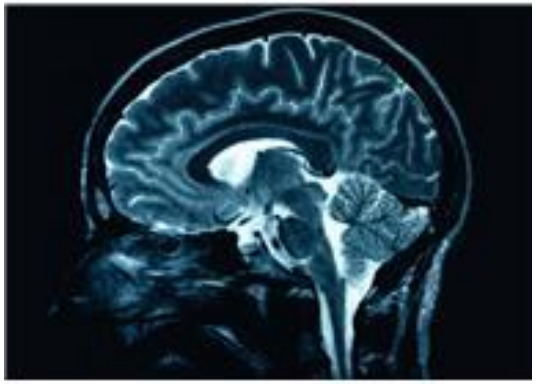
Risk Factors - Trauma

Adverse Childhood Experiences – ACEs

- Drs. Robert Anda & Vince Felitti conducted research in partnership with Kaiser Permanente linking Adverse Childhood Experiences (ACEs) i.e., trauma; with impaired brain development and a lifetime of health care implications.
- Started in 1995 – over 10 years and 17,000 participants.
- Iowa ACEs 360 – surveyed over 6,000 Iowans in 2012.
- Prioritizes the question, “what happened to you?” vs. “what’s wrong with you?”

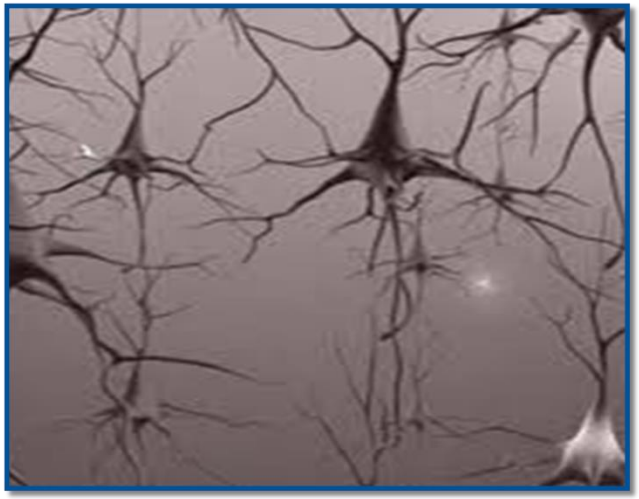
Trauma & the developing brain

V pattern brain development – stem, mid brain, cerebral cortex – repeated toxic stress leads to increased cortisol and impaired cortical functioning.



What gets fired, gets wired. Networks strengthen, or get pruned based on our experience. The brain mirrors our experience, then in turn our actions reveal our brain architecture.

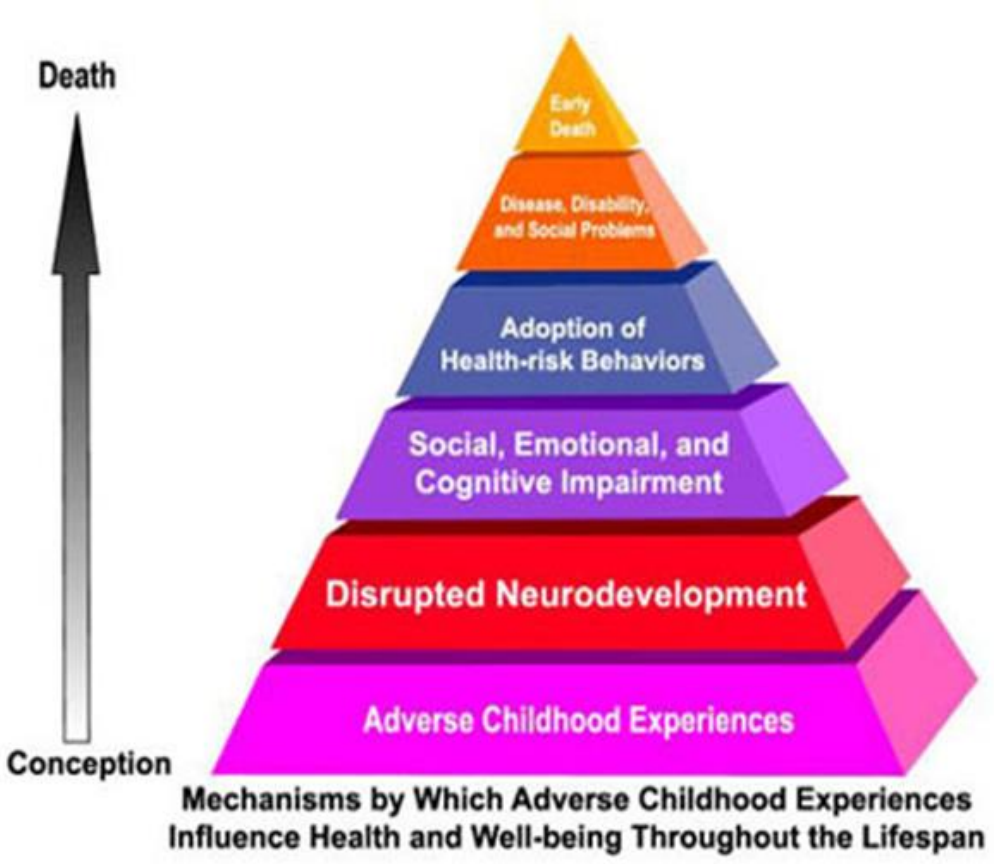
Estimate that 1/3 of this process is genetic, 2/3 relational. ***How we treat each other, matters.***



ACEs accentuate maturational imbalance – teen reward focused behavior outpaces inhibitory control. Too much acceleration without well developed braking system.

Adverse Childhood Experiences

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- ETOH or drug abuser in household
- Incarcerated household member
- Family member who is chronically depressed, MI, institutionalized, suicidal
- Mother treated violently
- One or no parents
- Physical neglect
- Emotional neglect



Mechanisms by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

ACE Findings…

"Compared with people who have zero ACEs, people with an ACE score of 4 or more are twice as likely to be smokers, 12 times more likely to attempt suicide, seven times more likely to be alcoholic, and 10 times more likely to inject street drugs. Compared to people with zero ACEs, people with an ACE score of 6 are more likely to have a shorter lifespan – by 20 years.

Research explains the link by showing how the toxic stress of trauma harms the structure and function of children's developing brains, how it embeds in our bodies, and how parents can pass it on to children. Ongoing research is demonstrating that building resilience can help people heal, and that systems (families, schools, faith) can stop traumatizing already traumatized people."

Risk Factors – Precipitating Events

Precipitating Event Risk Factors

- Academic stress
- Bullying – cyber or personal
- Relationship loss
- Peer group changes
- Athletic failure
- Parental divorce
- Others??

Prevention

"Prevention may be a matter of a caring person with the right knowledge being available at the right place at the right time."

- American Foundation for Suicide Prevention

Prevention

Prevention is not someone's job; it's everyone's responsibility.

- Parents – Extended Family
- Healthcare Professionals
  - Physicians, nurses, nurse practitioners, physician assistants
- Mental Health Professionals
  - Psychologists, Social Workers, MFTs, MHCs
- Primary and Secondary School Staff
  - Principals, Teachers, Counselors, Nurses
- Other Gatekeepers
  - Religious Leaders, Police, Fire, Coaches

Prevention – What to do…

- Learn to look for risk factors:
  - Mental health disorders, e.g. depression
  - Environmental, e.g. lethal means
  - Trauma , e.g. ACEs, abuse
  - Precipitating Events, e.g. bullying
- Past Attempts – already "crossed the line" (40-50% more likely to attempt – descends over time – NIMH).
  - NSSI – Non Suicidal Self Injury
- Take it seriously, at a minimum 50 – 75% of completers gave some warning sign to friends/family (AFSP).
- **Be <u>willing</u> and <u>able</u> to Listen – "stability" vs. "change" response – hearing the ambivalence.**
  - Beware using clichés

Prevention - What to do…

You do not need to solve all of the problems – *just engage them.* Questions to ask:

- Are you thinking about suicide?
- What thoughts or plans do you have?
- Are you thinking about harming yourself, ending your life?
- How long have you been thinking about suicide?
- Have you thought about how you would do it?
- Do you have access to __? (Insert the lethal means they have mentioned)
- Do you really want to die? Or do you want the pain to go away?

What to do…

IS PATH WARM?

- **I**deation – does person report thoughts of wanting to kill themselves or die?
- **S**ubstance Abuse – does the person use substances and to what degree?
- **P**urposelessness – lacking future orientation or "reason to live"
- **A**nger – is the person frequently irritable?
- **T**rapped – is the person experiencing "tunnel vision" and sees no alternative to their pain?
- **H**opelessness – negative sense of self, they can see a future – but its hopeless.
- **W**ithdrawing – isolation.
- **A**nxiety – agitated, unable to sleep, etc.
- **R**ecklessness – engaging in high risk behaviors.
- **M**ood change – does the person report dramatic mood shifts – instability?

What to do…

- **If you are with someone you believe is at risk of imminent harm:**
  - Do not leave the person **and** summon help, unless…
  - Right now – put 1-800-273-talk (8255) in your contacts.
  - Restrict access to lethal means (e.g. weapons, pills, hanging, etc.)
  - Ask the question – "Are you thinking about killing yourself?" Patiently - wait and listen for the response.
  - Get the person to a Behavioral Access facility, ER or call 911.

Selected Sources

CDC, NCIPC. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010) {2013 Aug. 1}. Available from:www.cdc.gov/ncipc/wisqars.

Family Acceptance Project™. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. Pediatrics. 123(1), 346-52.

CDC. (2015). Youth Risk Behavior Surveillance – United States, 2015. Atlanta, GA: U.S. Department of Health and Human Services.

CDC. (2011). Youth Risk Behavior Surveillance – United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services.

Nock, M.K., Borges, G. Bomet, E.J. Alonson, J. Angermeyer, M., Beautrais, A. Williams, D. (2008). Cross national prevalence and risk factors for suicidal ideation, plans, and attempts in the WHO World Mental Health Surveys. British J. of Psychiatry, 192, 98-105.

Robinson, J., Cox, G., Malone, A., Williamson, M., Baldwin, G., Fletcher, K., O'Brien, M. (2013). A systematic review of school based interventions aimed at preventing, treating, and responding to suicide related behavior in youth people. Crisis, Vol. 34(3): 164-182.

Englander, E., (2012). Spinning our wheels: Improving our ability to respond to bullying and cyberbullying. Child Adol Psychiatry Clin N Am 21, 43-55.

Resources

- Urbandale Student Assistance Program 244-6090
- Urbandale District Coordinator – Michelle Hamilton 402-8538
- Suicide Prevention Lifeline - 1-800-273-8255
  www.suicidepreventionlifeline.org
- National Institute for Mental Health
  www.nimh.gov
- American Foundation for Suicide Prevention
  www.afsp.org
- Society for Prevention of Teen Suicide
  www.spts.org
- National Center for Health Statistics
  www.cdc.gov/nchs
- Substance Abuse & Mental Health Services Administration –
  www.samhsa.gov

Thank you! Questions?