“Common Elements”
of Suicide-Specific Interventions for Youth

Christa D. Labouliere, Ph.D.
Suicide Prevention – Training, Implementation, & Evaluation Program
Center for Practice Innovations, New York State Psychiatric Institute
In collaboration with the New York State Office of Mental Health
Suicide Risk in Youth

- Suicide is the 2\textsuperscript{nd} \textit{leading cause of death} for youth aged 10-24 in the US, killing over 6700 young people per year\textsuperscript{1}
  - More deaths per year than \textit{all natural causes combined} and steadily increasing

- For every youth that dies by suicide, \textit{25x} as many youth make attempts\textsuperscript{1}

- Suicidal thoughts/behaviors have \textit{serious, long-term developmental consequences}
  - Suicidal youth often have psychiatric conditions and experience social, academic, and occupational impairment that can derail their developmental trajectory
  - These issues typically do not resolve without quality treatment

- Special strategies are needed to help suicidal children and adolescents
Suicide-Specific Interventions in Context

Population Prevention
- Public Health Approaches
  - Awareness Campaigns
  - “Upstream” Prevention

Identification of Risk
- Gatekeeper Training
- Screening
- Comprehensive Risk Assessment
- Clinical Formulation & Triage
- Referral

Brief Interventions
- Safety Planning Intervention
- Means Reduction Counseling
- Universal Precautions / Crisis Information
- Structured Follow-Up & Monitoring
- Treatment Engagement Strategies
- Non-Demand Caring Contacts

Hospitalization
Medication Management
Case Management

Psychotherapeutic Interventions
- Mental Health Conditions
- Suicide-Specific Treatments
Some resources to help:
- http://www.sprc.org/resources-programs
- https://www.samhsa.gov/ebp-resource-center
- https://zerosuicide.sprc.org/toolkit/treat

There are a number of therapies that have been found to be effective with suicidal youth:
- Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)*
- Dialectical Behavior Therapy for Adolescents (DBT-A)*
- Collaborative Assessment and Management of Suicidality (CAMS)*
- Attachment Based Family Therapy (ABFT)
- Family Intervention for Suicide Prevention (FISP)
- Problem-Solving Therapy (PST)
- Multisystemic Therapy with Psychiatric Support (MST)
- Attempted Suicide Short Intervention Program (ASSIP; young adults only)
Why don’t more youth receive suicide-specific interventions?

- Only 43% of NYS clinicians have received ANY training in suicide-specific interventions (and this number drops further for youth-specific interventions)
  - The majority of those who have received formal training in suicide-specific interventions have only attended brief, didactic in-services or webinars (<4 hours)
  - Suicide-specific treatments are rarely taught in graduate programs and the majority of professionals in the field have minimal exposure to these therapies
  - Training in these modalities take several days of in-person training (plus months of practice cases and supervision) and often cost thousands of dollars
  - Far less is known about which interventions work for youth than adults
If obtaining expertise in suicide-specific treatments is not feasible, what do we do instead?

- Treat youth in the *least restrictive setting* necessary to maintain safety
  - Take whatever action is needed to maintain safety
  - Explore options across the full spectrum of care

- For longer-term treatment, *treat suicidal thoughts and behaviors directly*, using the skills already in your repertoire from any orientation
Common Elements of Suicide-Specific Interventions with Youth

- Common elements that can be integrated into *any clinician’s* practice that will improve care for their suicidal clients
  - Targeting suicidal behavior directly as the #1 priority
  - Talking about suicidal thoughts and behaviors directly
  - On-going risk assessment and monitoring of suicidal thoughts and behavior
  - Revision of the safety plan based on client’s feedback
  - Reducing access to lethal means
  - Awareness of high risk periods
  - Understanding factors leading up to/following the suicidal crisis to better address these issues in treatment planning (functional analysis)
Developing a strong therapeutic alliance with the youth and family

Actively working to engage the youth in treatment and increase motivation

Process feelings around help-seeking and role-play help-seeking behaviors

Involve family members in treatment
  ▪ Parents need to work on improving skills themselves to help their children
  ▪ Help maintain safety in the home and school environment
  ▪ Improves effectiveness of means reduction and safety planning

Treating other issues that increase suicide risk - e.g. substance abuse, bullying

Teach coping skills:
  ▪ For distraction, self-soothing to survive a crisis
  ▪ Also other skills that may help prevent crises – e.g., communication skills, help-seeking, emotion regulation, mindfulness, problem-solving
Treating youth *ALWAYS* means treating a system

- Underlying psychiatric issues are often influenced by the family environment and dynamics
- Supervision and monitoring will be needed to keep the home environment safe

**Individual treatment of the youth alone is rarely effective**

- This typically means also working with parents, but can also involve other important adults in the youth’s life (e.g., foster parents, grandparents, older siblings, other adults in the home)
- Adults in the youth’s environment need to learn how to best protect their child and act as both external informants and co-therapists
- If parents are unable or unwilling, another trusted adult should be involved
- When appropriate, involving schools and broader social systems is also important
It is critically important, but challenging, to strike a balance between validation of both the youth and family.

- Sometimes it can be useful to meet with the family separately to give them a space to process their feelings not directly in front of the youth.
- Validate family members for being frightened/frustrated/hostile when they feel that the youth has “no reason to be depressed” or “is doing it for attention”.
- At the same time, family members must be provided with psychoeducation and lead to a place of understanding so they can assist their child:
  - Provide psychoeducation about mental illness.
  - Use family members’ understanding/wording to reframe and emphasize the problematic situation/risk (e.g. “getting attention” by being suicidal is a serious problem).
Psychoeducation

Provide *psychoeducation* about suicidal thoughts and behaviors and suicide-specific interventions to both youth and their families

- Explain the difference between NSSI and suicidal behavior
- Suicide ideation should never be ignored or downplayed
- Suicide risk fluctuates over time, so enhanced interventions are needed during high risk time and will then be reduced
- Discuss treatment options and both youth and family *expectations* for treatment
  - Others have felt this way, but treatment helps
  - Getting better is a process which may take time and will require hard work and honesty
  - Family will likely need to be involved
  - Different levels of care available and rationale
- Refer youth and their families to *reliable* sources on mental health and youth suicide risk
Crisis Narrative

- Obtain a detailed description of the suicidal crisis (e.g., recent suicide attempt or intense instance of suicidal ideation)
  - Ask client to “tell the story” of the suicidal crisis, including what happened before, how the crisis escalated, and how the crisis dissipated and what happened after

- If you don’t obtain a crisis narrative or provide psychoeducation, safety planning is less likely to work
  - Listening during the crisis narrative will give you critical information on warning signs, coping skills, how the crisis escalated and resolved, etc.
  - Vague or generic safety plans do not work □ Get specific examples
  - Listening and letting the client feel heard is a powerful intervention
Engage the youth and their family in collaborative treatment planning that:

- Directly addresses suicidal thoughts/behaviors and NSSI as the top priority
- Reduces modifiable risk factors and enhances modifiable protective factors identified during risk assessment
- Helps the youth and their family to cope better with risk factors that are not modifiable
- Ameliorates psychiatric symptoms
- Helps the youth to more successfully navigate family, social, and school settings

Remember: Youths’ goals are often different than the clinician’s or the family’s goals. Listen, validate the youth and family’s experiences, and then work collaboratively to find a compromise that address everyone’s needs
“Drivers” of Suicidal Thinking

- Ask the youth:
  - What things make you feel suicidal?
  - What would have to change for you to stop feeling suicidal?
  - What would you need to have a life worth living?

- If there are many, collaboratively pick 2-3 drivers to focus on first

- Come up with short-term (“first steps”) and long-term (“treatment goals”) ways to target these drivers

**Driver:** I have no friends

**Short-Term:** Join support group or extracurricular

**Long-Term:** Improve social skills & assertiveness; reduce isolation

Source: Jobes (2006)
Reasons for Living and Dying

- Work with patient to identify reasons for dying
  - Rank order
- Identify reasons for living
  - Rank order
- Summarize the lists and ask patient for their reactions to doing this exercise
- This is useful for beginning the discussion about treatment goals
  - Overall purpose of treatment is to reduce reasons for dying and increase reasons for living

Source: Linehan (1993)
Hope Kit

- Construct a Hope Kit or Survivor Kit
  - Pictures
  - Letters
  - Poetry
  - Prayer Card
  - Coping Cards
  - Meaningful mementos or tokens
  - Container can be anything as long as it is easily accessible (e.g., shoebox, folder, phone app)
Problem-Solving: The I.T.C.H.

- Identify the problem
- Think about possible solutions
- Choose a solution to implement
- How well did it work?

Choose one problem (may need to prioritize)
Define it in concrete, specific terms

“I’m a failure.”
“I’m struggling with assignments in chemistry and am afraid I’ll do poorly in the course”

Source: Munoz et al., 2000 (http://medschool2.ucsf.edu/latino/cbtdengl.aspx)
Problem-Solving: The I.T.C.H.

- Identify the problem
- Think about possible solutions
- Choose a solution to implement
- How well did it work?

- Brainstorm
- Encourage patient to refrain from evaluating solutions yet
- Let them take the lead
- Don’t judge

“*I could ignore it and hope for the best*”

“I could get a tutor”

“I could ask the teacher for help”

“I could study with a friend”

“I could quit school and join the circus”

Source: Munoz et al., 2000 (http://medschool2.ucsf.edu/latino/cbtdengl.aspx)
Problem-Solving: The I.T.C.H.

- Identify the problem
- Think about possible solutions
- Choose a solution to implement
- How well did it work?

- Evaluate the solutions you’ve generated (using pros and cons, etc.)
- Pick the ones that seem most likely to work (and least likely to cause problems)
- Identify the steps needed to implement your chosen solution(s)

“I could ignore it and hope for the best”
“I could get a tutor”
“I could ask the teacher for help”
“I could study with a friend”
“I could quit school and join the circus”

Source: Munoz et al., 2000 (http://medschool2.ucsf.edu/latino/cbtdenl.aspx)
Problem-Solving: The I.T.C.H.

- Identify the problem
- Think about possible solutions
- Choose a solution to implement
- How well did it work?

- Evaluate how well your solution(s) worked
  - Well: Continue using these strategies
  - Not so well: Return to step 1
  - May need to redefine the problem or brainstorm more solutions

Source: Munoz et al., 2000 (http://medschool2.ucsf.edu/latino/cbtdengl.aspx)
Monitoring with Youth

- Encourage family members to update you with any changes between sessions
- Provide psychoeducation about monitoring and supervision needs, and discuss the difference between traditional supervision for a youth of a given age and what will be needed when on suicide watch
  - Depending on the level of risk, being alone after school or even shutting their bedroom door may not be appropriate
  - Increased monitoring and means reduction needs to be balanced with the youth’s psychosocial needs – The goal is to keep the youth safe, not to punish them with "lockdown"
  - Conflicts between safety and the youth’s privileges/freedom should be actively problem-solved but err on the side of caution
  - Remind the youth and family that suicide risk waxes and wanes, so these measures are only temporary
- Recruit other adults to help monitor the youth in the home, school, and community environment
- It’s not all about adults! If possible, youth should be engaged in decision-making and taught to self-monitor, self-disclose, and engage in help-seeking
Outreach Contact with Youth

- Phone outreach after a missed appointment or care transitions (or between sessions when you are concerned about a youth) is **strongly recommended**
  - Call or text the youth first, and if you cannot reach them, notify the family
  - Inform youth clients that their family will be notified if they miss a session or if you cannot determine whether they are safe
    - It is preferable if the youth agrees to this policy, but permission is not required
  - Establish a plan with family members from the beginning of treatment on when, how, and who should be contacted
  - Know and communicate your clinic’s policy about texting and social media

- Phone outreach is NOT just rescheduling the appointment
  - Shows the client and their family that you are concerned and care enough to check on him or her
  - Assess the client’s current mood and level of risk
  - Provide interventions as needed
    - Revise/problem-solve the use of the safety plan
    - Teach/refine skills in vivo
    - Involve family members and rescue in the case of imminent risk
  - Encourages re-engagement with treatment
Consultation and Support

- Seek additional support *for yourself*
  - Suicidal youth can be challenging and anxiety-provoking. When in doubt, seek consultation or additional supervision for your high risk clients

- Seek additional support *for your client*
  - Increase clinical contact and outreach
  - Know what other resources your organization or community offers, and refer your client to them as appropriate (e.g., psychiatric consult, peer support, respite care)
  - Make sure to have contact information for the individual’s other providers
  - Take a “team” approach with other providers and reach out when necessary to coordinate safety efforts
  - During care transitions, call other providers to provide a “warm handoff”

- Share resources for *family members*
  - Be aware of resources provided both by your agency and in your community, such as respite care, support groups, NAMI chapters, etc.
  - If appropriate, encourage family members to seek professional help for support
  - Always assess need for adjunctive therapy (e.g. family therapy, multi-family groups)
Resources for Youth and Families

**JED Foundation**:  www.jedfoundation.org

**Trevor Project**:  http://www.thetrevorproject.org

**American Foundation for Suicide Prevention**:  www.afsp.org

**Suicide Prevention Resource Center**:  www.sprc.org

**Lifeline/Crisis Text Line**:  
  https://suicidepreventionlifeline.org/help-yourself/youth
  https://www.crisistextline.org

**Other Online Resources**:  
  http://youth.gov/youth-topics/youth-suicide-prevention
  https://save.org/what-we-do/education/leads-for-youth-program
  www.youcannotbereplaced.com
  www.itgetsbetter.org