Washington University in St. Louis
Brown School

The Ethical Case for Prioritizing Suicide Prevention in Training, Practice, and Systems

Ryan R. Lindsay, MSW, LCSW
Associate Professor of Practice
Brown School
Washington University in St. Louis

Objectives

1. Describe the problem of suicide
2. Identify ethical principles relevant to suicide prevention
3. Identify strategies for upholding an ethical mandate of addressing the problem of suicide in training, practice, and systems
4. Explain how to use existing Codes of Ethics, including NBCC and NASW, to inform trainings, practice and systems regarding prioritizing suicide prevention

What is the cost of suicide?

The Significance of Suicide

- Global emotional, economic, and societal costs are significant but difficult to quantify
- Estimated economic burden in the U.S. is between $44-93.5 billion annually
- ~800,000 losses to suicide each year globally[1]
- ~9.8 million US adults think about suicide each year[2]
- ~2.8 million US adults make a plan to end their life each year[2]
- ~1.3 million US adults attempt suicide each year[2]
- In 2017 47,173 people died by suicide in the US[3]
- In 2017 14,717 youth and young adults 10-34 died by suicide[3] ; 31.2% of all deaths

1. World Health Organization. (2014). Preventing Suicide: A global imperative. Geneva, Switzerland:WHO
2. Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2019 May 28].

The Significance of Suicide

- 2nd leading cause of death for youth and young adults[3]
- 90% of those who die by suicide meet criteria for at lease one mental disorder[4]
- 20% of children and adolescents meet criteria for a mental disorder at any given time[5]
- 60-70% of youth meeting criteria for any mental disorder do not utilize any mental health service[6]
- ~20% of youth who die by suicide accessed specialty mental healthcare in the previous year
- only 7.5% accessed specialty mental health care in the month prior to their death
- Most youth who meet criteria for any mental disorder do not know it[6]

1. World Health Organization. (2014). Preventing Suicide: A global imperative. Geneva, Switzerland:WHO
2. Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2007) [cited 2019 May 28].

Suicide as a Public Health Problem

Suicide Prevention Efforts	Suicide Risk Assessment, Intervention, and Management	Suicide Postvention Efforts
Target Audience: *Community and Population Level Interventions: Schools, Communities, State and Federal Initiatives*	**Target Audience:** *Social Workers, Counselors, Nurses, Physicians, Mental Health and other Health Professionals*	**Target Audience:** *Community and Population Level Interventions: Schools, Communities, State and Federal Initiatives*
Functions: *Awareness* *Screening* *Referral* *Promote Help-Seeking*	**Functions:** *Suicide Risk Assessment* *Intervention* *Management*	**Functions:** *Grief/loss supportive services* *Healing efforts* *Preventing contagion* *Promoting Help-Seeking and Connecting to Resources*
Structural Strategies: *Policies* *Implementation Plan* *Procedures* *Protocols*	**Structural Strategies:** *Policies* *Implementation Plan* *Procedures* *Protocols*	**Structural Strategies:** *Policies* *Implementation Plan* *Procedures* *Protocols*

Academic, State and Local, Federal Agencies, Global Partners engaged in research to better understand the phenomenon of suicide

The Ethical Case for Suicide Prevention as Standard Care

Background

- Nearly 1/3 of individuals who die by suicide have had contact with a mental health provider in the previous year of death
- Nearly 1/5 of individuals who die by suicide have had contact with a mental health provider in the past month
- Nearly 90% of individuals who die by suicide meet criteria for at least one mental health disorder

Background

- Mental health professionals (master’s level and higher) will encounter individuals at-risk for suicide
- Mental health professionals are assumed by others to have adequate training in suicide risk assessment, intervention, and management
- Most training in suicide prevention is informal, through supervision process, and rarely includes standardized and evidence-based training programs

Washington University in St. Louis
BROWN SCHOOL

How often do we encounter individuals at-risk for suicide?

292
Suicide and Life-Threatening Behavior 42(3) June 2012
© 2012 The American Association of Suicidology
DOI: 10.1111/j.1943-278X.2012.00090.x

Preventing Suicide through Improved Training in Suicide Risk Assessment and Care: An American Association of Suicidology Task Force Report Addressing Serious Gaps in U.S. Mental Health Training

William M. Schmitz Jr., PsyD, Michael H. Allen, MD, Barry N. Feldman, PhD, Nina J. Gutin, PhD, Danielle R. Jahn, MA, Phillip M. Kleespies, PhD, Paul Quinnett, PhD, and Skip Simpson, JD

There are twice as many suicides as homicides in the United States, and the suicide rate is rising. Suicides increased 12% between 1999 and 2009. Mental health professionals often treat suicidal patients, and suicide occurs even among patients who are seeking treatment or are currently in treatment. Despite these facts, training of most mental health professionals in the assessment and management of suicidal patients is surprisingly limited. The extant literature regarding the frequency with which mental health professionals encounter suicidal patients is reviewed, as is the prevalence of training in suicide risk assessment and management. Most importantly, six recommendations are made to address the longstanding insufficient training within the mental health professions regarding the assessment and management of suicidal patients.

- **97% of psychologists** in training stated they provided care to at least one person with suicidal behavior (Kleepies et. al, 1993)
- **87% of social workers** encountered a client with suicidal behavior in the past year (Feldman & Freedenthal, 2006)
- **55% of clinical social workers** experienced a client attempt suicide (Sanders, Jacobson, & Ting, 2008)
- **50% of psychiatrists and psychiatry residents** lost at lease one patient to suicide (Risk et al., 2004)
- **Between 22-30% of psychologists, social workers, and counselors** have lost a client to suicide (Chemtob et al, 1988; Jacobson et al, 2004; McAdams & Foster, 2000)

2012 National Strategy for Suicide Prevention Priorities

1. Healthy and empowered individuals, families, and communities
2. **Clinical and community preventative services**
3. Treatment and support services
4. Surveillance, research, and evaluation

Goal 7: provide training to community and clinical service providers on the prevention of suicide and related behaviors

Objective 7.3: develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education

Objective 7.4: promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies

U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

Licensing and Accrediting Bodies

- Most states do not require healthcare professionals (behavioral health included) to have training in suicide risk assessment, intervention, and management
  - ~11 States require training for mental health professionals
  - ~3 States expanding the definition of mental health professional to include nurses and physicians
- Those that do vary widely in their scope
  - Missouri HB 1719 establishes 2 hours of initial suicide prevention training, and 2 hours of continuing education hours
  - Other states require only 1 hour, and others require 6 hours
- Accrediting bodies have made strides to tighten suicide prevention requirements for healthcare organizations
  - 2015- Council On Accreditation
  - 2016- The Joint Commission
  - 2016- Commission on Accreditation of Rehabilitation Centers

Codes of Ethics

- National Association of Social Workers (NASW)
- National Board for Certified Counselors (NBCC)
- American Nurses Association
- American Medical Association
- American Psychological Association
- American Psychiatric Association

National Association of Social Workers

National Association of Social Workers Code of Ethics

Value: *Service*
Ethical Principle: Social Worker's primary goal is to help people in need and to address social problems

Suicide is a major public health problem leading to almost 48,000 deaths per year in the US. Approximately 50% of those deaths are caused by guns. Evidence-based polices must be developed, implemented and evaluated. Social workers have a ethical mandate to protect those at-risk of suicide.

Value: *Social Justice*
Ethical Principle: Social workers challenge social justice

Disparities in outcomes linked to structural and systemic racism, discrimination, and oppression must be dismantled. The wide variation in competency to engage, assess, intervene, manage, and treat individuals at-risk for suicide leads to health disparities. The absence of core competencies across all mental health professional training programs lead to widening gaps in access and quality of mental health providers to respond to individuals and communities at-risk for suicide.

National Association of Social Workers Code of Ethics

Value: *Dignity and Worth of the Person*
Ethical Principle: Social workers respect the inherent dignity and worth of the person

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers are to promote clients' socially responsible self-determination; however, have a mandate to intervene when the capacity of an individual is unable to competently and holistically assess the impact of one's own behavior. A mandate to intervene exists.

Value: *Importance of Human Relationships*
Ethical Principle: Social workers recognize the central importance of human relationships.

Social workers are compelled to inform clients and constituents of their commitment to confidentiality and the limitations of this commitment, specifically when it comes to harm to self. Social workers must work to engage clients in a manner conducive to long-term relationships; however, recognize the limitations and potential impact on the relationship in the context of suicide.

National Association of Social Workers Code of Ethics

Value: *Integrity*
Ethical Principle: Social workers behave in a trustworthy manner

Social workers must act honestly and responsibly in their professional roles. This means that social workers must be honest about the boundaries of confidentiality, their mandate to intervene in the context of a suicidal client, and the potential and authority to enact legal methods to involuntarily hospitalize a person when their capacity is significantly impaired and the person presents a real and imminent danger to self.

Value: *Competence*
Ethical Principle: Social workers practice within their areas of competence and develop and enhance their professional expertise.

Given the low rate of exposure to formal training in suicide risk assessment, intervention, management, and treatment, only about 20% of programs in social work provide such formal curriculum, a call for establishing suicide prevention competencies as a core competency by the Council on Social Work Education and by individual programs are needed to ensure students are prepared. Continuing education opportunities must incorporate evidence-based assessment, intervention, management, and treatment strategies.

NASW Ethical Standards

1. Social Workers' Ethical Responsibilities to Clients

1.01 Commitment to Clients:
Although social workers' primary responsibility is to promote the well-being of clients in general, on limited occasions, our legal and ethical responsibilities supersede the loyalty to the client, specifically when it comes to threats to self, others, and in cases of suspected child or elderly abuse.

1.02 Self-Determination:
Although social workers respect and promote the right of clients to self-determination, social workers may limit this right when actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others.

1.03 Informed Consent:
Social workers must inform clients, especially involuntary clients, of the nature and extent of services and the extent of clients' right to refuse services, and the impact of this refusal. This specifically refers to social workers capacity to in interventions that interfere with client self-determination.

1.04 Competence:
Social workers must provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience. Other relevant professional experience. What is the minimum standard of competence for suicide risk assessment, intervention, management, and treatment?

National Board for Certified Counselors

National Board for Certified Counselors Code (NBCC) of Ethics

Directive: NCCs take appropriate action to prevent harm

1. Expectations and Limitations of Confidentiality:
Although counselors' primary responsibility is to promote the well-being of clients in general, on limited occasions, our legal and ethical responsibilities supersede the loyalty to the client, specifically when it comes to threats to self, others, and in cases of suspected child or elderly abuse.

13. Supervisor Intervention in Cases of Incapacity or Incompetence:
Counselors engaged in supervision process must intervene in the event when competency of the trainee is in question. This directly relates to a requirement to intervene with trainee's assessment and treatment plan of a client experiencing a suicidal crisis or behavior.

Directive: NCCs provide only those services for which they have education and qualified experience.

22. Competence:
Counselors must provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience. Other relevant professional experience. What is the minimum standard of competence for suicide risk assessment, intervention, management, and treatment?

National Board for Certified Counselors Code (NBCC) of Ethics

24. Counselors Should Seek Professional Consultation
When faced with client presentation that is outside their scope of education, training, and supervised practice (suicidal crisis) experience should seek consultation from qualified and experienced counselors (competency in suicide prevention strategies)

31. Counselors Should Seek Qualified Consultation
Counselors should seek consultation form individuals who have knowledge, skills, and competencies in suicide prevention strategies that are evidence-based and reflects the current state of the science in the field.

AMA CODE OF MEDICAL ETHICS

AMA PRINCIPLES OF MEDICAL ETHICS*

Preamble

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

Principles of medical ethics

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

American Nurses Association Code of Ethics for Nurses

Provision 1	The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
Provision 2	The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.
Provision 3	The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.
Provision 4	The nurse has authority, accountability and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to provide optimal patient care.
Provision 5	The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
Provision 6	The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
Provision 7	The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.
Provision 8	The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.
Provision 9	The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

Source: American Nurses Association. (2015). *Code of ethics with interpretative statements.* Silver Spring, MD: Author. Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics-For-Nurses.html

What is Consistent Across Professions?

- Competency Standards
- Do No Harm
- Confidentiality with Exceptions
- Protect Safety of Client
- Use of Evidence-Based Interventions
- Integrity of Profession

All directly or indirectly reference competencies in suicide prevention strategies

Comprehensive Suicide Prevention Competencies for Training Programs

Knowledge	Skills
Definitions of Suicidal Behavior	Identify behaviors
Who dies by suicide?	Identify individuals and communities
Why do people die by suicide?	Understand the phenomenon
Personal relationship to suicide to reduce bias (over/under assessing)	Identify affective and cognitive responses that may interfere with judgment
Risk Factors	Assessing variation of risk
Protective Factors	Assessing variation of protection
Suicide Risk Assessment and Formulation	Assessing risk states vs. risk status
Interventions for reducing risk of suicide	Intervening to prevent suicide now and near future (safety planning/ CALM)
Strategies for managing suicide risk in the moment and across time	Development of safety plan and documenting decision making
Treatments for suicidal behavior	Therapeutic interventions that reduce suicide (for referral)
Suicide prevention and postvention frameworks, models, and interventions	Understand Public health models that employ universal, selective, and indicated methods
System and Organizational models and frameworks	Zero Suicide models

Who dies by suicide?

10 Leading Causes of Death by Age Group, United States – 2017

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 4,580	Unintentional Injury 1,267	Unintentional Injury 718	Unintentional Injury 860	Unintentional Injury 13,441	Unintentional Injury 25,669	Unintentional Injury 22,828	Malignant Neoplasms 39,266	Malignant Neoplasms 114,810	Heart Disease 519,052	Heart Disease 647,457
2	Short Gestation 3,749	Congenital Anomalies 424	Malignant Neoplasms 418	Suicide 517	Suicide 6,252	Suicide 7,948	Malignant Neoplasms 10,900	Heart Disease 32,658	Heart Disease 80,102	Malignant Neoplasms 427,896	Malignant Neoplasms 599,108
3	Maternal Pregnancy Comp. 1,432	Malignant Neoplasms 325	Congenital Anomalies 188	Malignant Neoplasms 437	Homicide 4,905	Homicide 5,488	Heart Disease 10,401	Unintentional Injury 24,461	Unintentional Injury 23,408	Chronic Low. Respiratory Disease 136,139	Unintentional Injury 169,936
4	SIDS 1,363	Homicide 303	Homicide 154	Congenital Anomalies 191	Malignant Neoplasms 1,374	Heart Disease 3,681	Suicide 7,335	Suicide 8,561	Chronic Low. Respiratory Disease 18,667	Cerebro-vascular 125,653	Chronic Low. Respiratory Disease 160,201
5	Unintentional Injury 1,317	Heart Disease 127	Heart Disease 75	Homicide 178	Heart Disease 913	Malignant Neoplasms 3,616	Homicide 3,351	Liver Disease 8,312	Diabetes Mellitus 14,904	Alzheimer's Disease 120,107	Cerebro-vascular 146,383
6	Placenta Cord. Membranes 843	Influenza & Pneumonia 104	Influenza & Pneumonia 62	Heart Disease 104	Congenital Anomalies 355	Liver Disease 918	Liver Disease 3,000	Diabetes Mellitus 6,409	Liver Disease 13,737	Diabetes Mellitus 59,020	Alzheimer's Disease 121,404
7	Bacterial Sepsis 592	Cerebro-vascular 66	Chronic Low. Respiratory Disease 59	Chronic Low Respiratory Disease 75	Diabetes Mellitus 248	Diabetes Mellitus 823	Diabetes Mellitus 2,118	Cerebro-vascular 5,198	Cerebro-vascular 12,708	Unintentional Injury 55,951	Diabetes Mellitus 83,564
8	Circulatory System Disease 449	Septicemia 48	Cerebro-vascular 41	Cerebro-vascular 56	Influenza & Pneumonia 190	Cerebro-vascular 593	Cerebro-vascular 1,811	Chronic Low. Respiratory Disease 3,975	Suicide 7,982	Influenza & Pneumonia 46,862	Influenza & Pneumonia 55,672
9	Respiratory Distress 440	Benign Neoplasms 44	Septicemia 33	Influenza & Pneumonia 51	Chronic Low. Respiratory Disease 188	HIV 513	Septicemia 854	Septicemia 2,441	Septicemia 5,838	Nephritis 41,670	Nephritis 50,633
10	Neonatal Hemorrhage 379	Perinatal Period 42	Benign Neoplasms 31	Benign Neoplasms 31	Complicated Pregnancy 168	Complicated Pregnancy 512	HIV 831	Homicide 2,275	Nephritis 5,671	Parkinson's Disease 31,177	Suicide 47,173

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

- 10th leading COD
- 2nd leading COD for 10-34 year olds
- 4th leading COD for 35-54 year olds
- 31.2% of all deaths by suicide in youth and young adulthood

Washington University in St. Louis

Brown School

10 Leading Causes of Injury Deaths by Age Group Highlighting Unintentional Injury Deaths, United States – 2017

Rank	Age Groups										Total
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	
1	Unintentional Suffocation 1,106	Unintentional Drowning 424	Unintentional MV Traffic 327	Unintentional MV Traffic 428	Unintentional MV Traffic 6,697	Unintentional Poisoning 16,478	Unintentional Poisoning 15,032	Unintentional Poisoning 14,707	Unintentional Poisoning 10,581	Unintentional Fall 31,190	Unintentional Poisoning 64,795
2	Homicide Unspecified 139	Unintentional MV Traffic 362	Unintentional Drowning 125	Suicide Suffocation 280	Unintentional Poisoning 5,030	Unintentional MV Traffic 6,871	Unintentional MV Traffic 5,162	Unintentional MV Traffic 5,471	Unintentional MV Traffic 5,584	Unintentional MV Traffic 7,667	Unintentional MV Traffic 38,659
3	Unintentional MV Traffic 90	Homicide Unspecified 129	Unintentional Fire/Burn 94	Suicide Firearm 185	Homicide Firearm 4,391	Homicide Firearm 4,594	Suicide Firearm 3,098	Suicide Firearm 3,937	Suicide Firearm 4,219	Suicide Firearm 5,996	Unintentional Fall 36,338
4	Homicide Other Spec., Classifiable 76	Unintentional Suffocation 110	Homicide Firearm 78	Homicide Firearm 126	Suicide Firearm 2,959	Suicide Firearm 3,458	Suicide Suffocation 2,562	Suicide Suffocation 2,294	Unintentional Fall 2,760	Unintentional Unspecified 5,125	Suicide Firearm 23,854
5	Undetermined Suffocation 56	Unintentional Fire/Burn 95	Unintentional Suffocation 36	Unintentional Drowning 110	Suicide Suffocation 2,321	Suicide Suffocation 3,063	Homicide Firearm 2,561	Suicide Poisoning 1,604	Suicide Suffocation 1,631	Unintentional Suffocation 3,920	Homicide Firearm 14,542
6	Unintentional Drowning 43	Unintentional Pedestrian, Other 88	Unintentional Other Land Transport 25	Unintentional Other Land Transport 66	Unintentional Drowning 469	Undetermined Poisoning 887	Suicide Poisoning 1,089	Homicide Firearm 1,447	Suicide Poisoning 1,459	Adverse Effects 2,902	Suicide Suffocation 13,075
7	Undetermined Unspecified 37	Homicide Other Spec., Classifiable 49	Homicide Suffocation 15	Unintentional Fire/Burn 56	Suicide Poisoning 463	Suicide Poisoning 788	Undetermined Poisoning 792	Unintentional Fall 1,248	Homicide Firearm 824	Unintentional Poisoning 2,871	Unintentional Suffocation 6,946
8	Homicide Suffocation 26	Homicide Firearm 44	Homicide Cut/pierce 14	Suicide Poisoning 39	Undetermined Poisoning 280	Unintentional Drowning 479	Unintentional Fall 522	Undetermined Poisoning 887	Unintentional Suffocation 811	Unintentional Fire/Burn 1,278	Unintentional Unspecified 6,606
9	Unintentional Natural/ Environment 18	Unintentional Natural/ Environment 34	Unintentional Firearm 14	Unintentional Poisoning 39	Homicide Cut/pierce 266	Homicide Cut/Pierce 404	Unintentional Drowning 397	Unintentional Drowning 451	Adverse Effects 773	Suicide Poisoning 1,111	Suicide Poisoning 6,554
10	Three Tied 16	Unintentional Firearm 31	Two Tied 13	Unintentional Suffocation 35	Unintentional Fall 212	Unintentional Fall 351	Homicide Cut/Pierce 337	Unintentional Suffocation 441	Undetermined Poisoning 732	Suicide Suffocation 919	Adverse Effects 4,459

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System.
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.

Centers for Disease Control and Prevention
National Center for Injury Prevention and Control

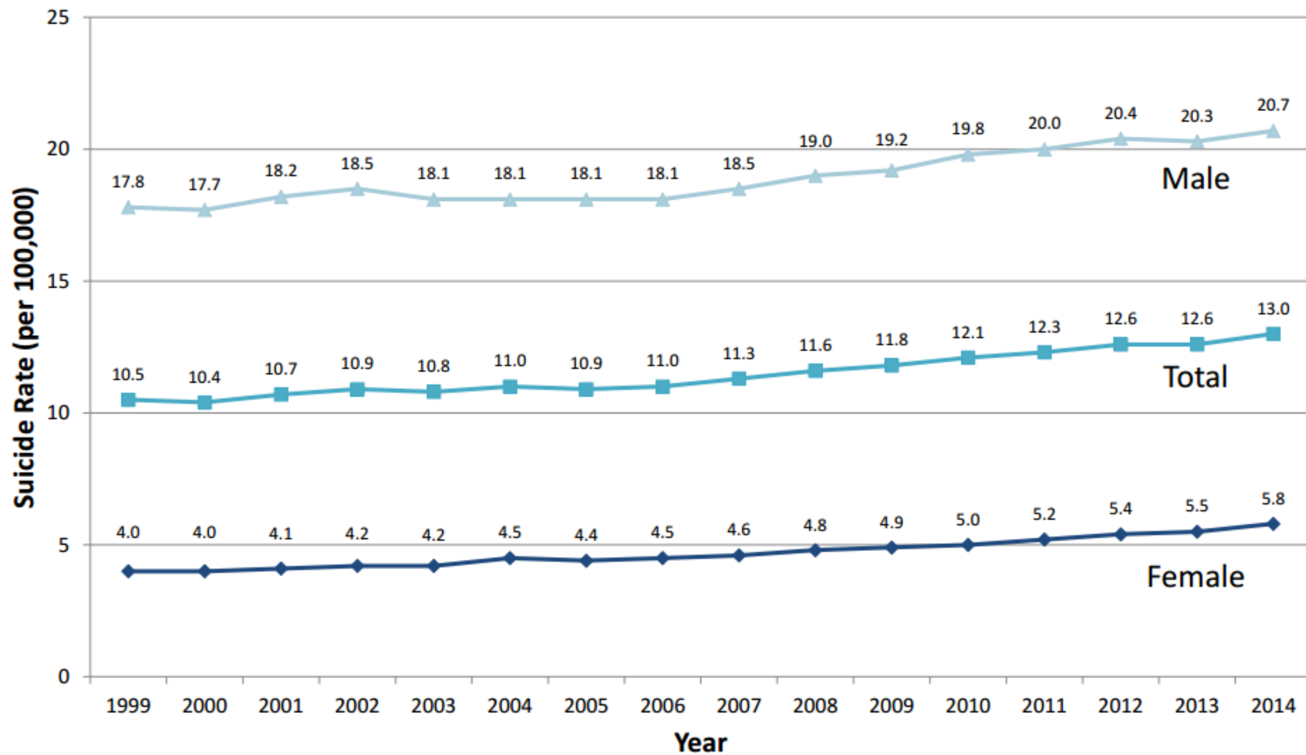
10 – 14 year olds

1. Suffocation
2. Firearm
3. Poisoning

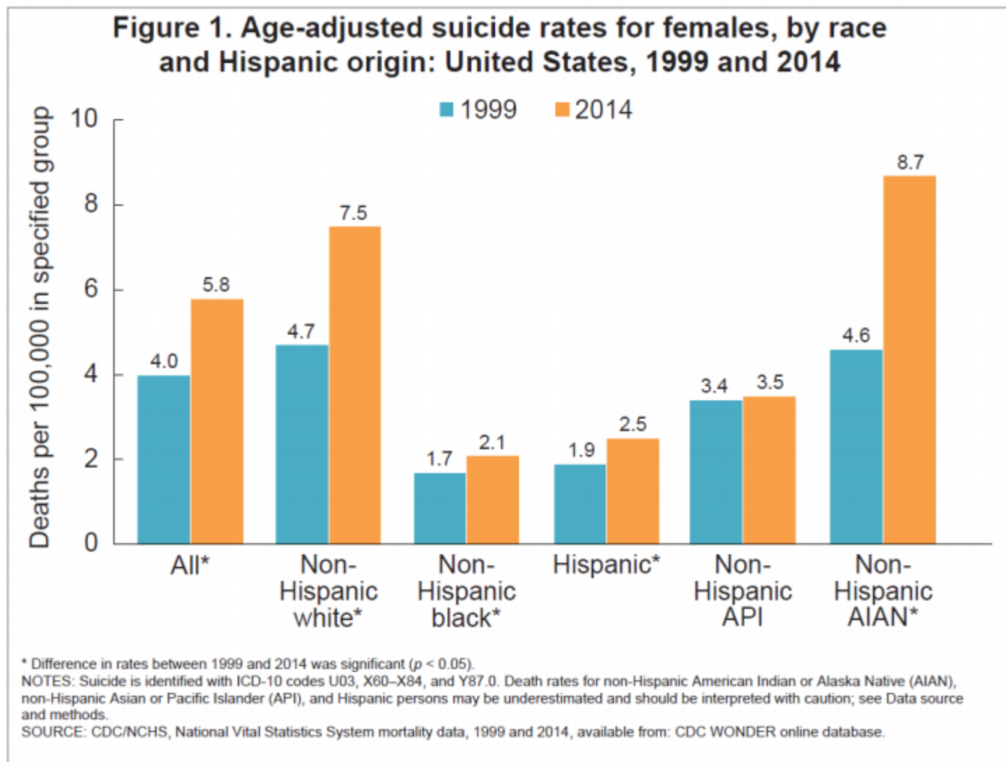
15-65+ year olds

1. Firearm
2. Suffocation
3. Poisoning

Washington University in St. Louis
Brown School

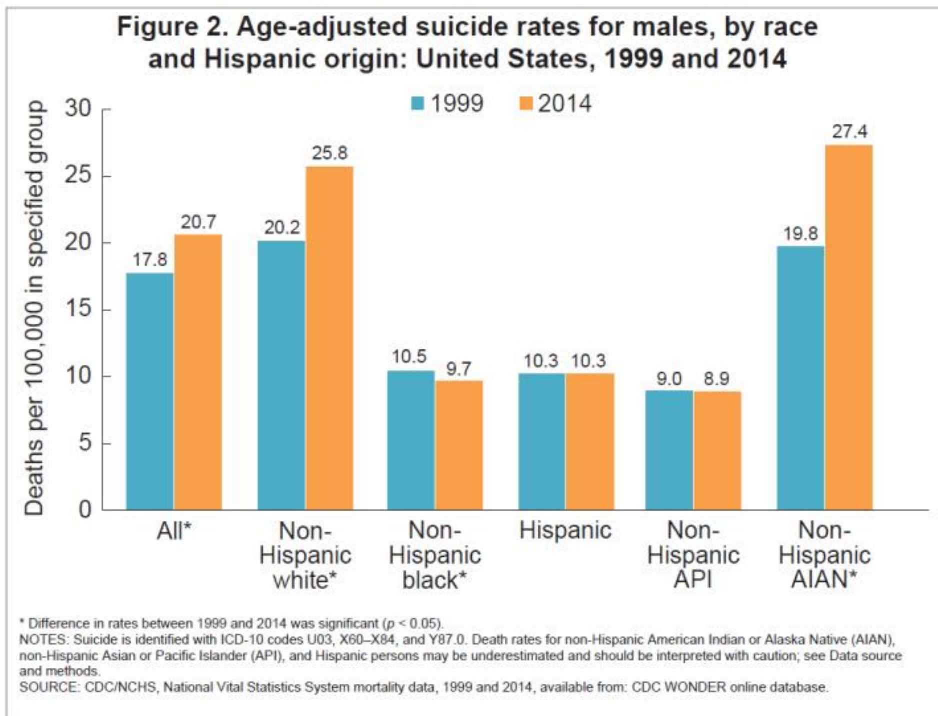


Rates of Suicide Intersecting with Race and Gender- Female



- American Indian and Alaska Native females highest rate of suicide
- Non-Hispanic white females 2nd highest rate
- Across all racial groups for females, the rate of suicide increased between 1999-2014

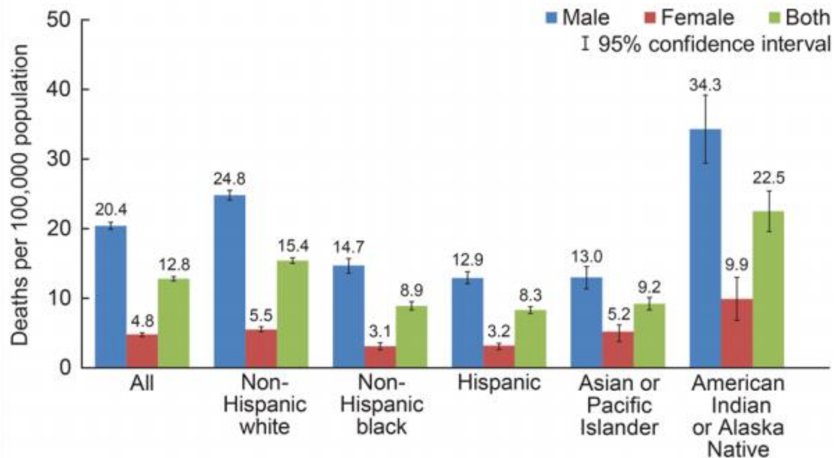
Rates of Suicide Intersecting with Race and Gender- Male



- American Indian/Alaska Native males highest rate of suicide
- Non-Hispanic white males have 2nd highest rate
- Across most racial groups, suicide rates increased between 1999-2014
- Exceptions: black males and Asian or Pacific Islander males

Washington University in St. Louis
Brown School

Youth Suicide Rates Intersecting with Race and Gender



Overall: Youth Suicide Rates Across Racial Groups

- American Indian/Alaska Native youth highest rate of suicide
- Non-Hispanic white youth second highest rate
- Asian or Pacific Islander youth third highest rate

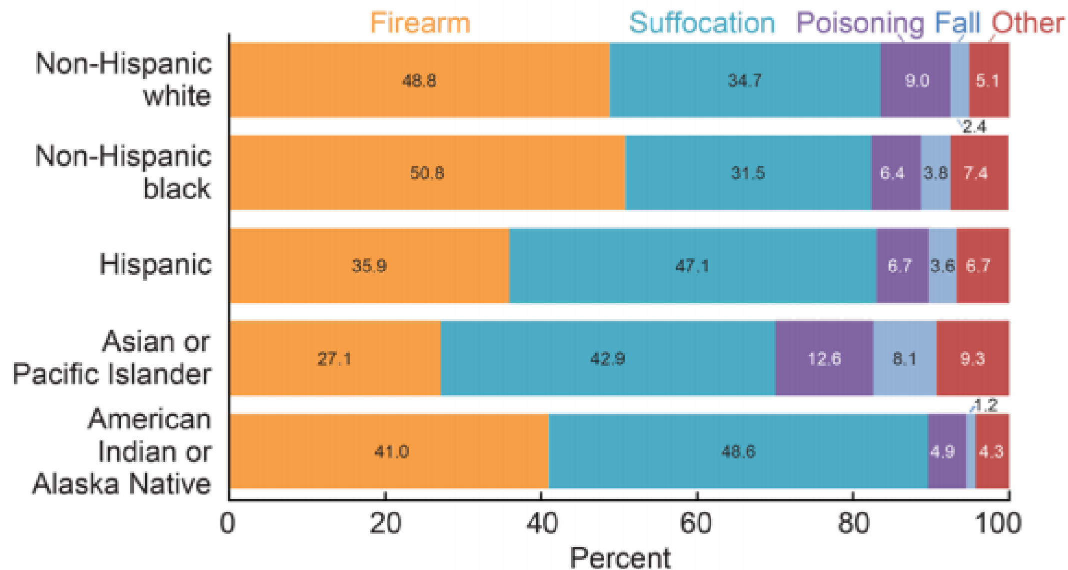
Intersecting Race and Gender in Youth

Female Youth

- American Indian/Alaska Native youth highest rate of suicide
- Non-Hispanic white youth 2nd highest rate of suicide
- Asian or Pacific Islander youth 3rd highest rate of suicide.

Male Youth

- American Indian/Alaska Native youth highest rate of suicide
- Non-Hispanic white youth 2nd highest rate of suicide
- Non-Hispanic black youth 3rd highest rate of suicide



Top 3 Causes of Death:

1. Firearms
2. Suffocation
3. Poisoning

Non-Hispanic white and black young adults:

1. Firearms
2. Suffocation

Hispanic/API/AIAN

1. Suffocation
2. Firearms

What is suicidal behavior?

Definitions

Suicide: the act of intentionally ending one's own life

Nonfatal suicidal thoughts and behaviors:

✓ **suicide ideation**: thoughts of engaging in behavior intended to end one's life

✓ **suicide plan**: the formulation of a specific method through which one intends to die

✓ **suicide attempt:** engagement in potentially self-injurious behavior in which there is at least some intent to die

✓ **Nonsuicidal self-injury**: self-injury in which a person has no intent to die

Washington University in St. Louis
Brown School

Flowchart for Surveillance Definitions for Self-Directed Violence

Crosby AE, Ortega L, Melanson C. Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2011

Self-Directed Violence (SDV)

- Suicidal Self-Directed Violence
  - Fatal (Suicide)
  - Non-Fatal
    - Suicidal SDV with or without Injury (suicide attempt) e.g., Interrupted (by self or other)
    - Other Suicidal Behavior e.g., Preparatory
- Undetermined Self-Directed Violence
  - Fatal
  - Non-Fatal
    - Undetermined SDV with or without Injury e.g., Interrupted (by self or other)
    - Other Undetermined SDV e.g., Preparatory
- Non-Suicidal Self-Directed Violence
  - Fatal
  - Non-Fatal
    - Non-Suicidal SDV with or without Injury e.g., Interrupted (by self or other)
    - Other Non-Suicidal SDV e.g., Preparatory

Defining Suicidal Behavior

Suicide-related behavior: "*all self-inflicted life-threatening behaviors in which a person intended to harm or kill him or herself, and which could, whether intentional or not, result in the person's death*"- McLaughlin (2007)

This includes the following:

- ✓ Suicidal thoughts
- ✓ Suicidal images
- ✓ Suicidal urges
- ✓ Suicidal planning
- ✓ Suicidal intent
- ✓ Suicidal attempt

Defining Non-Suicidal Self-Injury

”the intentional destruction of one’s own body tissue without suicidal intent and for purposes not socially sanctioned” – Nock, 2009

NSSI is

- Intentional
- Physical
- Differentiated from repetitive behaviors such as those seen in autism
- Suicide attempts- definitional distinction based on lack of intention to die
- Functional differences from suicidal behavior

NSSI is not

- Tattooing
- Culturally or religiously sanctioned behaviors (act of religious mortification)
- Piercing

Differences Between Suicide Attempt & Non-Suicidal Self-Injury

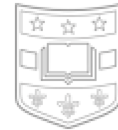
	NSSI	Suicide Attempt
Intent	To stop, avoid, or change emotional experience	To end life, complete stop the pain
Form/Method	Non-lethal; cutting, burning, punching, scratching	Lethal: firearm, suffocation, jumping, pills
Frequency	Often, repetitive, multiple episodes	1 or 2 times (small minority of frequent attempters)
Experience	Multiple methods	Single methods
Psychological State	Highly distressed but intermittent, intense, intolerable but episodic	Unendurable and persistent pain, unrelenting nature, psychic ache
Cognitive State	Disorganized, rapid thoughts	Inflexible thinking, hopelessness and helplessness
Behavioral State	Isolated, done in secrecy, often engaged with supports	Withdrawn, isolated, does not engage with supports

Why does it matter to differentiate between suicidal ideation or attempts and non-suicidal self-injury?

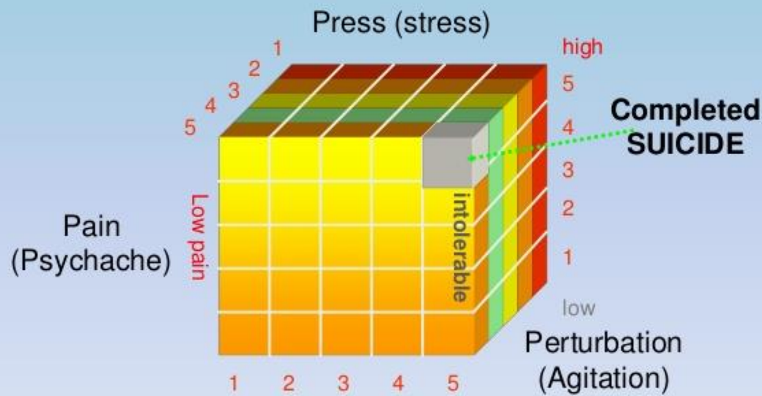
- The behaviors are functionally related but separate phenomenon
- It impacts clinical recommendations and interventions
- One has the potential to be imminently lethal
- Not all individuals who engage in non-suicidal self-injury also have suicidal ideation
- Referrals need to targeted towards expertise

Why do people die by suicide?

Why do people die by suicide?



- Suicide is a goal directed **behaviour** to address unbearable **pain**.
- Pain + **Hopelessness** → thoughts of suicide (ideation).
- **Connectedness** prevents enaction.
- If pain > connectedness → **plan.**
- Whether this leads to death is dependent upon **capability or access to means.**
- If total capability > fear of attempting →attempt.

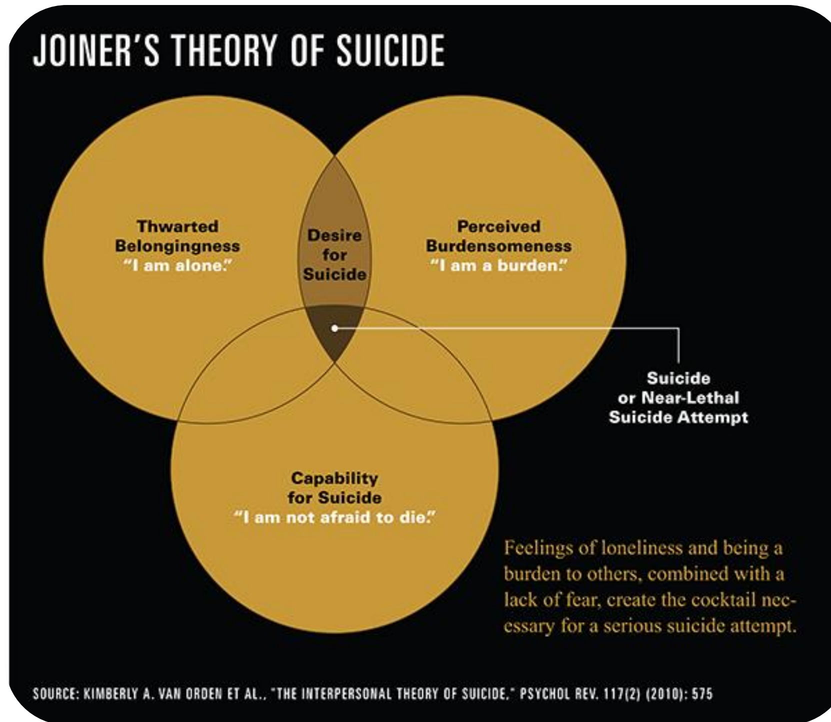


1. Unbearable psychological pain
2. Unrelenting psychological pressures or stress
3. Unrelenting agitation

- Cements the idea that suicidal behaviors are situation-specific.
- Takes us out of one-dimensional thinking of lists of risks and protective factors.
- Suicide as a solution to psychological pain

Note. Adapted from Shneidman's cubic model of pain-press-perturbation. From "A Psychological Approach to Suicide," by E.S. Shneidman, 1987, T.E. Ellis (Ed.), *Cognition and Suicide: Theory, Research, and Therapy.* Washington, D.C.: American Psychological Association.

Washington University in St. Louis
Brown School



1. The emotional or affective experience of loneliness
2. The cognitively rigid belief of burdensomeness
3. The increased capacity for suicide
4. Desire for suicide

Thomas Joiner's (2005) interpersonal-psychological theory of suicidal behavior argues that, in order to enact self-harm, an individual must habituate to physical pain and the fear of death

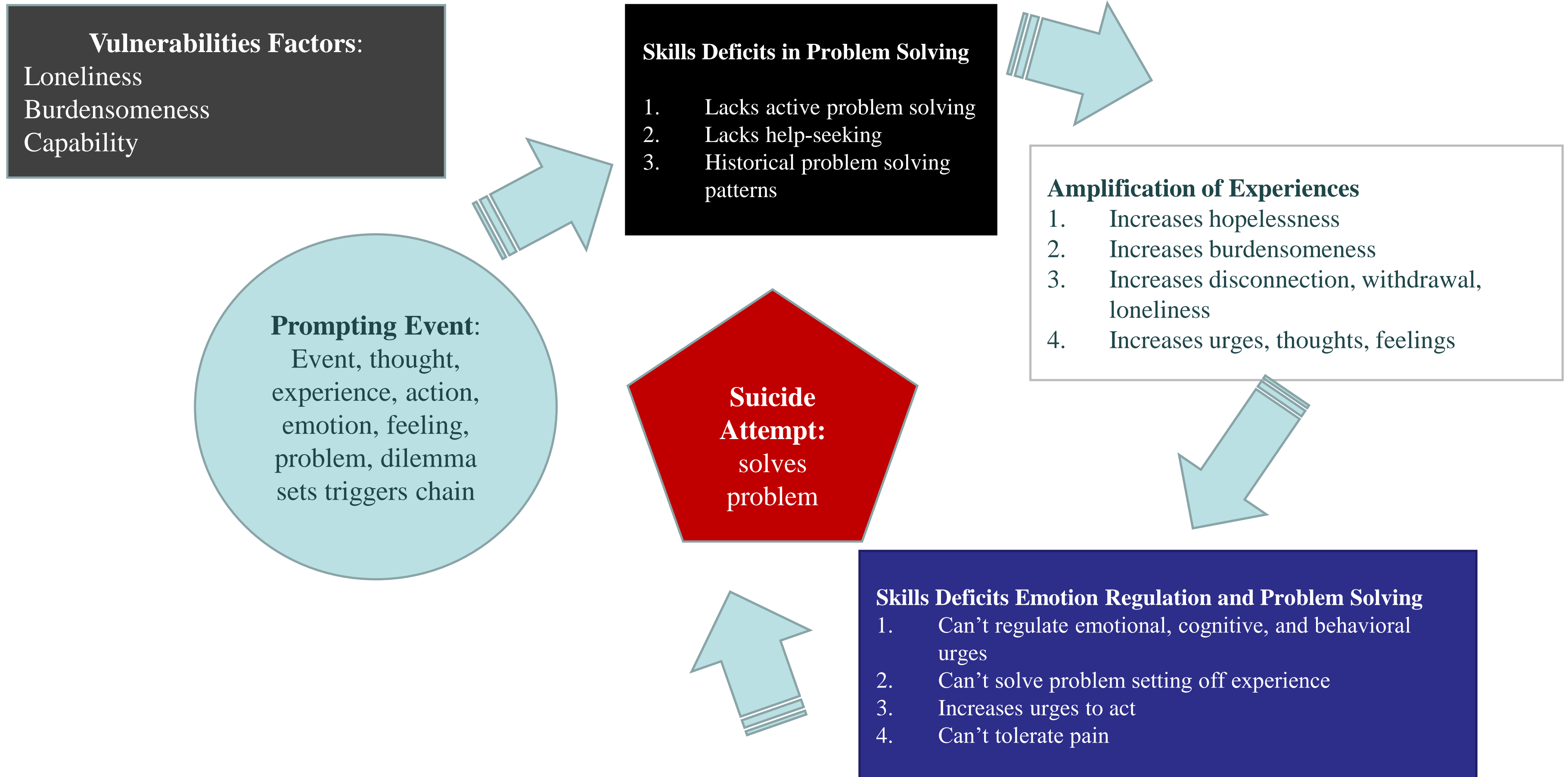
http://newsweekpakistan.com/the-suicide-epidemic/

David Rudd

Fluid Vulnerability Model

- Suicidal episodes are time-limited
- Risk factors that both trigger a suicidal episode and determine the duration and severity of an episode are fluid
- Imminent risk cannot endure beyond periods of heightened arousal
- Baseline risk varies from person to person

Marsha Linehan, 1993



Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

What factors put individuals at risk for suicide?

What factors protect individuals from suicide?

Types of Assessment of Suicidal Behavior

Long-Term Risks

Understanding the long-term risk factors that increase the likelihood of suicidal behavior. This provides an overall picture of how a person, in the long-term, falls into a group at various risks for suicide.

Short-Term Risks

The direct and indirect behavioral indicators or circumstances that increase the immediacy and predictability of suicidal behavior.

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Robyn

Robyn is a 20 year-old cis-gender white female who has been in outpatient therapy with her provider for the past 9 months. Robyn has a history of non-suicidal self-injury but has not engaged in this behavior for the past 4 months. Robyn is a college student at an elite, highly competitive private university where she is studying engineering- mostly at the urging of her parents who feel she needs to engage in a profession where there are lots of job opportunities. Robyn lives on campus with three female roommates and states that she isn't close to any of them, although they will occasionally hang out together.

Robyn was diagnosed with obsessive-compulsive disorder when she was 13 years old and received a course of treatment. She lives daily with high levels of anxiety, though mostly showing up in social situations and interpersonal relationships.

She was diagnosed with depression when she was in high school along with an eating disorder. She states that her symptoms are mostly under control and mostly show up during times of high stress, like finals weeks or when relationships go south.

Robyn states that she experiences thoughts of suicide multiple times per week and describes them as a 3 intensity on a scale between 0-5, 5 being most intense. She has two past suicide attempts by overdose- psychiatric medications the first time and random pills the second time- the second resulting in a medical stay of 3 days to stabilize. She stated that after this second attempt she never wanted to put her parents through that again and therefore has sworn off attempting suicide. However, she does admit she has recently been wavering on this commitment.

Robyn arrives for her weekly appointment and you are reviewing how the previous week has gone. You notice that she has reported that the intensity of her suicidal thoughts and urges have both increased to a 4 out of 5 beginning three days ago. She reports her intent to act on her suicidal thoughts and urges is a 2, which is the first time this has occurred in the past 6 months- although she frequently reports thoughts and urges, her intent has always been at a 0.

Long-Term Risk Factors

- ❑ Prior Attempts
- ❑ History of medically serious attempts
- ❑ **Diagnosis of depression**, bi-polar disorder, schizophrenia, borderline personality disorder
- ❑ Multiple psychiatric diagnoses (3+ in high risk category)
- ❑ Cognitive impairment
- ❑ History of impulsivity
- ❑ Family member died by suicide
- ❑ **History of childhood sexual abuse**
- ❑ Physical illness
- ❑ Past hospitalization for psychiatric issues

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Short-Term Risk Factors

- Current Attempt
- Recent psychiatric hospital discharge
- Current hopelessness
- Current helplessness
- Panic and significant anxiety
- Non-suicidal self-injury
- Extreme cognitive rigidity-no flexibility in thinking and problem solving
- Rejection from loved one
- Socially ostracized
- Current psychotic symptoms/Acute psychosis
- Current drug or alcohol use
- Intense levels of agitation
- Actively making death arrangements
- Lethal methods available
- Likely to be alone; currently socially isolated
- Recent unemployment
- Recent medical/physical illness diagnosis

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Indicators of Imminent Risk

- Active Thoughts of Suicide with intent to act
- Statements indicating intent to act
- Active planning, hiding, preparing
- Active NSSI
- Dissatisfaction with current help
- Acutely hopeless (will never change)
- Acutely helpless (nothing will work)
- Current psychomotor agitation
- Insomnia, particularly early morning
- Suicide note written or in progress
- Methods are immediately available and lethal
- Currently intoxicated
- Taking precautions against discovery
- Engaged in deception or concealment of timing
- 1st 24 hours of being jailed

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

Protective Factors

- Actively making plans for the future
- Verbalizes hope for the future
- Displays self-efficacy in problem area
- Shows attachment to life
- Has responsibilities to kids, family, or others
- Embedded in protective social network/family
- Attached to therapy or at least one provider
- Belief that suicide is immoral or will be punished by God
- Hopeful that the current treatment direction will be effective
- Hopefulness in general
- Taking steps to engage in treatment or seeking help

Note. Adapted from Linehan, M.M. (1993). Cognitive Behavioral Treatment of Borderline Personality Disorder. New York, NY: Guilford Press.

What is Robyn's Risk?

Low? Medium? High?

How does this change if Robyn's demographics change?

- African American gay male
- American Indian heterosexual female
- Transgender female
- 50 year-old cis-gender male

How can we move from a model of trying to predict suicide to a model designed to prevent suicide?

Washington University in St. Louis

Brown School

BJPsych The British Journal of Psychiatry (2016) 209, 277–283. doi: 10.1192/bjp.bp.115.170050

Review article

Predicting suicide following self-harm: systematic review of risk factors and risk scales†

Melissa K. Y. Chan, Henna Bhatti, Nick Meader, Sarah Stockton, Jonathan Evans, Rory C. O'Connor, Nav Kapur and Tim Kendall

Background
People with a history of self-harm are at a far greater risk of suicide than the general population. However, the relationship between self-harm and suicide is complex.

Aims
To undertake the first systematic review and meta-analysis of prospective studies of risk factors and risk assessment scales to predict suicide following self-harm.

Method
We conducted a search for prospective cohort studies of populations who had self-harmed. For the review of risk scales we also included studies examining the risk of suicide in people under specialist mental healthcare, in order to broaden the scope of the review and increase risk scales (Beck Hopelessness Scale (BHS), Suicide Intent Scale (SIS) and Scale for Suicide Ideation). Where meta-analyses were possible (BHS, SIS), the analysis was based on sparse data and a high heterogeneity was observed. The positive predictive values ranged from 1.3 to 16.7%.

Conclusions
The four risk factors that emerged, although of interest, are unlikely to be of much practical use because they are comparatively common in clinical populations. No scales have sufficient evidence to support their use. The use of these scales, or an over-reliance on the identification of risk factors in clinical practice, may provide false reassurance and is, therefore, potentially dangerous. Comprehensive

"The idea of risk assessment as risk prediction is a fallacy and should be recognized as such. We are simply unable to say with any certainty who will and will not go on to have poor outcomes. People who self-harm often have complex and difficult life circumstances, and clearly need to be assessed- but we need to move away from assessment models that prioritize risks at the expense of needs" – Chan et. al.

Key Findings:

- Four risk factors emerged as associated with higher risk of dying by suicide following index episode
  - Previous self-harm
  - Suicidal intent
  - Presence of physical health issues
  - Male gender
- Scales should not be used in clinical practice as the sole assessment of risk as they have little predictive value
  - Beck Hopelessnes Scale
  - Suicide Intent Scale
  - Scale for Suicide Ideation

Washington University in St. Louis
BROWN SCHOOL

PLOS | ONE

RESEARCH ARTICLE

Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time

Matthew Large[1,2]*, Muthusamy Kaneson[3], Nicholas Myles[4], Hannah Myles[5,6], Pramudie Gunaratne[2], Christopher Ryan[7,8]

1 School of Psychiatry, University of New South Wales, Randwick, Australia, 2 Prince of Wales Hospital, Randwick, Australia, 3 Faculty of Medicine, University of New South Wales, Randwick, Australia, 4 The Queen Elizabeth Hospital, Woodville South, Australia, 5 Discipline of Psychiatry, School of Medicine, The University of Adelaide, SA, Australia, 6 Country Health SA Mental Health, SA, Australia, 7 Discipline of Psychiatry and Centre for Values Ethics and the Law in Medicine, University of Sydney, Sydney, Australia, 8 Department of Psychiatry, Westmead Hospital, Westmead, NSW, Australia

* mmbl@bigpond.com

"It remains to be seen if methods can be developed to consistently and clearly distinguish high-risk from lower-risk patients. However, it should not be forgotten that the ultimate utility of risk categorization depends on its potential for application" – Large et. al.

Key Findings:

- Our methods over 40 years have not improved much
- 95% of those identified as "high-risk" did not die by suicide
- 50% of those who died by suicide were assigned "low-risk"
- The presence of multiple risk factors does not greatly exceed the association between individual risk factors and suicide

Predicting Probability of Suicide Attempts vs. Adopting A Suicide Prevention Oriented Approach

Predicting the Probability of Suicide Attempts:

- Difficult to predict at the individual level
  - Lack of reliable measures or instruments
  - Complicated process with little validity and reliability across clinician assessment
  - The stakes are very high
- Requires the clinician to take all the responsibility
- Leads to “better safe than sorry” mentality

Predicting Probability of Suicide Attempts vs. Adopting A Suicide Prevention Oriented Approach

Adopting a Suicide Prevention Oriented Approach:

- Integrates multiple factors to weigh the current risk status versus risk state, the existence of available resources, and the predictability of foreseeable changes
- Heavy emphasis on safety planning as a means of suicide prevention and matching intervention plans with current risk state

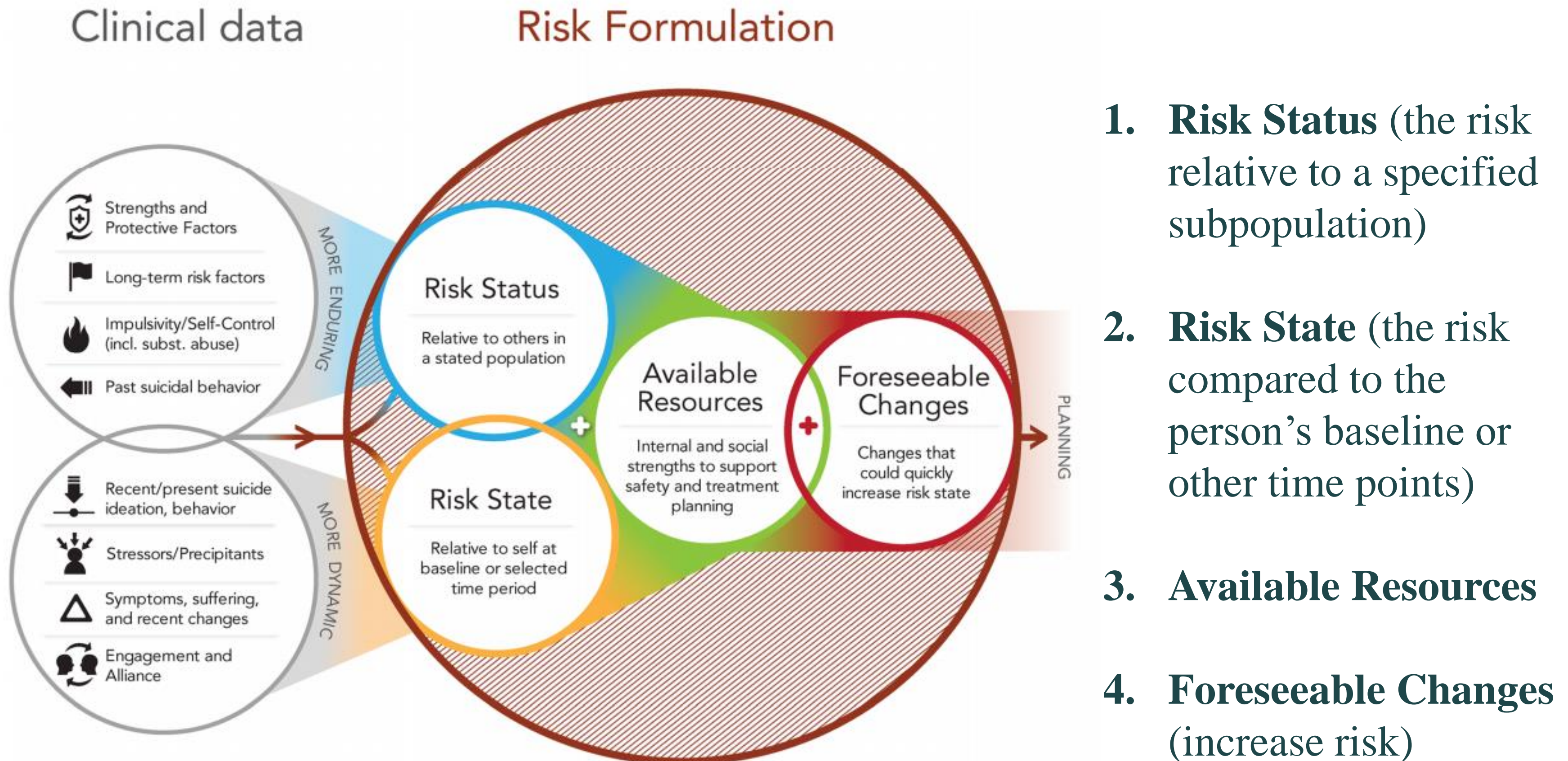


Fig. 1 Prevention-oriented risk formulation

1. **Risk Status** (the risk relative to a specified subpopulation)
2. **Risk State** (the risk compared to the person's baseline or other time points)
3. **Available Resources**
4. **Foreseeable Changes** (increase risk)

Figure from Pisani, A.R., Murrie, D.C., & Silverman, M.M. (2016). Reformulating suicide risk formulation: from prediction to prevention. Academy of Psychiatry, 40: 623-629.

Washington University in St. Louis
Brown School

Assess

Suicidal Thoughts and Urges

Assess the presence of suicidal ideation:
“are you having thoughts of ending your life?

Assess intensity of suicidal ideation:
“on a scale of 0-10, how intense are your current thoughts to end your life?

Assess duration of suicidal ideation:
“when thoughts of suicide pop into your mind, how long do they typically stick around?”

Assess intensity of suicidal urges:
“on a scale of 0-10, how intense are your current urges to end your life?”

Plan and Intent

Assess the presence of a plan:
“have you thought of a plan to end your life?

Assess specificity of plan:
“When/Where/How would you plan to end your life?

“have you taken precautions so that if you act, no one can stop you or interfere or save you?”

Assess intensity of intent:
“how intent are you in carrying out your plan to end your life?”

“on a scale of 0-10, how intent are you in acting on this plan?”

Access to Means

Assess the presence of means:

“do you have access to a gun? Do you have access to lethal dosages of medications? Do you have access to poisons?”

Assess for presence of means for any previous suicide attempts:

“in the past, how did you attempt to end your life?”

REMOVE ACCESS TO MEANS!

Always remove/restrict access to the means

Never leave a person isolated who is at high risk

Setting the context for talking about suicide

- Be calm, use a nurturing voice, be patient, & go slowly
- If you are anxious, they will be more anxious too
- Talk openly and matter-of-factly about the topic
- Talk about suicide as a response to a problem that needs solving
- Maintain that suicide is an ineffective solution to solving the problem
- Involve others so you are not alone in the process/seek consultation as needed
- Validate the pain the person is in, but not the solution
- Be direct but not threatening: Are you thinking about ending your life?
- Be willing to negotiate when appropriate
- Ambiguity is typical, but ambiguous answers are not acceptable

Guidelines for Suicide Intervention

- Help the person articulate the problem setting off suicidal thoughts or urges
- Stay focused on the main issue- we can't solve all of their problems
- Emphasize the temporary nature of the problem or experiences
- Explore possible alternative solutions
- Aim to resolve immediate crisis
- Aim to reduce current intensity

Remember:

- we can't solve all of their problems in the moment
- We can't promise their pain will go away
- We may not know a better way to solve the problem, but insist there is one out there if you continue to search

Washington University in St. Louis
Brown School

SUICIDE RISK ASSESSMENT AND SAFETY PLAN

Complete in immediate response to identified safety factors:

A. What are the factors/events that put the individual at risk?

Long-term Risk Factors	*Yes*	*Short-Term Risk Factors*	*Yes*
Prior Suicide Attempt	☐	Recent suicide attempt	☐
History of medically serious attempt	☐	Recent psychiatric hospitalization	☐
Psychiatric Hospitalization	☐	Extreme cognitive rigidity	☐
Diagnosis of depression, bi-polar, schizophrenia, borderline personality disorder	☐	Current sleep problems - Difficulties falling asleep - Difficulties staying asleep - Early morning awakening	☐
Presence of 3 or more psychiatric diagnoses	☐	Current levels of expressed hopelessness	☐
Cognitive impairment, decreased concentration/indecision	☐	Current levels of expressed helplessness	☐
History of impulsivity	☐	Presence of panic or significant anxiety	☐
Family member died by suicide	☐	Current psychotic symptoms	☐
History of childhood sexual abuse	☐	Current drug/alcohol use	☐
Unemployed or financial strain	☐	Making death arrangements	☐
Physical illness	☐	Access to lethal methods	☐
Notes:		Isolated and alone	☐
		Recent loss, unemployment, or change in social status, or recent physical illness diagnosed	☐

Imminent Risk Factors	*Yes*	*Protective Factors*	*Yes*
Strong suicidal thoughts	☐	Actively making plans for the future	☐
Suicidal threats	☐	Verbalizes hope for the future	☐
Suicide planning or preparation	☐	Displays self-efficacy in problem area	☐
Presence of NSSI	☐	Shows attachment to life	☐
Dissatisfaction with help	☐	Has responsibilities to children, family, pets, others	☐
Suicide not written	☐	Attached to therapist or provider	☐
Precautions against discovery	☐	Belief suicide is immoral or will be punished	☐
1st 24 hours of imprisonment/jail	☐	Hopeful that current treatment will work	☐
Other	☐	Hopefulness in general	☐
Notes:		Taking steps to engage in treatment or help seeking	☐
		Other	

Plan

1. Identify long-term, short-term, and imminent risks for suicide
2. Identify protective factors
3. Identify triggers, patterns, events, or situations likely to increase the likelihood of increasing urges or intent to act on suicidal thoughts/urges
4. Develop an action plan to ensure safety (who, what, when, where, and how)
5. Provide resource and support contact information
6. Obtain strong commitment to following plan, brainstorm barriers to implementation, problem solve barrier
7. **Limit access to means**

Clinical Decision Making: Determining Clinically Effective Interventions

- Strong safety planning can often be the most effective intervention
- Police and ambulance involvement
- Emergency Rooms
- Inpatient Psychiatric Stay
- Support and Monitoring by family
- Recommendation for follow-up with current mental health provider
- Communication with family, confidentiality, and safety planning
- The tricky thing about assessing risk- it isn't very reliable

Management of Suicidal Behaviors

- Organizations should have a suicide prevention policy, procedure, or protocol
- Always follow the policy that an agency delineates
- Review policies and practices regularly; require booster sessions frequently
- Document the process from start to finish
- Document the justification for referral to an emergency room

Practice Wisdom

- Individuals struggling with suicidal behavior are strong
- Anxiety & Fear are normal experiences for an assessor
- Practice, Practice, Practice
- Survival rate is extremely high- there is reason for hope