Suicide & Self-Harm in Youth: Treatment, Care Delivery, & Prevention

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  - CCR921708

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- Klingenstein 3rd Generation, Scientific Advisory Board

- Consultation & Trainings on Suicide/Self-Harm Prevention & Depression Care
UCLA-Duke Center for Trauma-Informed Adolescent Suicide Self-Harm & Substance Abuse Treatment & Prevention (ASAP)

**Mission:** To raise the standard of care and improve access to evidence-based services for suicide, self-harm, and substance abuse prevention among traumatized children, their families and communities throughout the United States.

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UCLA
David Goldston, PhD
Duke
SAMHSA, U79 SM080041
Presentation Goals

1. Treatment and Care Delivery
2. Nationwide Suicide Prevention
Treatment & Care Delivery
Usual Care Process: Suicidal Episode

Youth with Suspected SU/SH Risk

Safety Precautions → Medical Care & Clearance → Behavioral Health Care Consultation

Disposition
- Inpatient Care
- Discharge Home With Outpatient Referral

~50% Receive Outpatient Follow-Up Care
~20% in some settings


Emergency/Acute Care
Family Intervention for Suicide Prevention (FISP)


IMPROVED CONTINUITY OF CARE
National Registry of Evidence Based Practices.

Funding: CCR921708, Centers for Disease Control and Prevention.
FISP Brief Single Session Intervention

Goals

➢ Improve continuity of care following ED discharge, ~50% receive outpatient follow-up care, ~ 20% in some settings*

➢ Increase safety

➢ Improve family support and protective monitoring

➢ Improve youth functioning


FISP: Therapeutic Assessment

1. Behavioral assessment of imminent risk
2. Increase hope, reasons for living
3. Developmentally informed safety planning process
4. Increase protective support
5. Lethal means counseling
6. Counseling on substance use related disinhibition
7. Caring follow-up contacts to support linkage to treatment
FISP-IMPROVED CONTINUITY OF CARE EMERGENCY SETTINGS

Linked to Follow-Up Care

- FISP: 92%
- UC-E: 76%
- UC-National: 50%
- ED-Lo: 20%

Treatment and Care Delivery
Care Process: FISP Model

Youth with Suspected SU/SH Risk → Safety Precautions → Medical Care & Clearance

Behavioral Health Care Consultation

Therapeutic Assessment/Intervention
1. Increase Hope, Reasons for Living
2. Safety Plan Process
3. Increase Protective Support
4. Lethal Means Counseling
5. Counseling on Substance Use Related Disinhibition

1. Schedule follow-up appointment or supported referral
2. Caring contacts
3. Trouble shoot barriers to care

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Outpatient Treatment Nonsignificant Effect on Clinical Outcomes
Instrumental Variable Analysis Modeling Linkage to Any Community Outpatient Treatment (TAU) Post-ED/Hospital Discharge and Clinical/Functioning Outcomes

<table>
<thead>
<tr>
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<th>Treatment Equation</th>
<th>Outcome Equation</th>
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<tbody>
<tr>
<td></td>
<td>Coefficient</td>
<td>SE</td>
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<tr>
<td>SUICIDAL BEHAVIOR</td>
<td></td>
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<tr>
<td>Treatment</td>
<td>-1.80</td>
<td>3.40</td>
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<tr>
<td>FISP</td>
<td>0.83</td>
<td>0.33</td>
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Asarnow et al, Psychiatric Services, 2011
Treatment: What did we know before JCPP Special Issue?

- Meta-analysis, 19 RCTs, 2,176 youths, through May 2014. Small statistically significant effect for therapeutic interventions vs. TAU for reducing self-harm across diverse interventions. Effect primarily for NSSI, no significant overall effect on SAs.

- 3 RCTs show that CBT with strong combined individual and family component lead to reduced suicide attempt rate relative to comparator conditions: I-CBT; SAFETY; DBT.

- 2 separate demonstrations that DBT is effective for decreasing self-harm in adolescents.

References:

3-year follow-up of RCT with suicidal and self-harming adolescents (N=77) with BPD features having received DBT-A or Enhanced usual care

All treatments delivered at Child and Adolescent outpatient clinics in Oslo, Norway

DBT-A participants had a persistently stronger long-term reduction in self-harm behavior over all follow-up intervals

Reduction in hopelessness during the active treatment phase was a mediator of the long-term reduction in frequency of self-harm
Both Groups Improved Over Time

Treatment of Suicidal & Self-Injurious Adolescents with Emotional Dysregulation: CARES

- 2 Site Study of DBT vs. Individual and Group Supportive Therapy (Multiple PI)
- Seattle: Linehan & McCauley
- Los Angeles: Berk & Asarnow
- Statistician: Robert Gallo

NIMH MH093898
Greater Reduction in Suicide Attempts Among DBT vs. IGST Youths: 6 Months

OR 0.30; 95% CI 0.10, 0.91, p < .05

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<tr>
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<th>IGST</th>
<th>DBT</th>
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<tr>
<td>0</td>
<td>78.5%</td>
<td>90.3%</td>
</tr>
<tr>
<td>1</td>
<td>13.9%</td>
<td>8.3%</td>
</tr>
<tr>
<td>≥ 2</td>
<td>7.7%</td>
<td>1.4%</td>
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Generalized linear mixed-effects model for ordinal data (Hedeker & Mermelstein, 2000).
DBT: higher rates of clinically significant change (Absence of SH)

<table>
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<tr>
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<th>6-Months</th>
<th>12-Months</th>
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<tbody>
<tr>
<td>IGST</td>
<td>27.6%</td>
<td>32.2%</td>
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<tr>
<td>DBT</td>
<td>46.5%</td>
<td>51.2%</td>
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<tr>
<td>Difference</td>
<td>18.9%</td>
<td>19%</td>
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<tr>
<td>$\chi^2(1)=$</td>
<td>6.67, p=.011</td>
<td>6.44, p=0.012</td>
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Independent Replication Needed!


Personalizing Treatment: Can we Match Youths to Treatments That Will Be Most Beneficial?

Prevention Can Save Lives
Garrett Lee Smith Memorial Program (GLS): Suicide Mortality Outcomes for State & Tribal Program

1. **An estimated 882 deaths avoided/lives saved between 2007 and 2015 through implementation of GLS program.**

2. Total impact was stronger with longer periods of implementation

3. Program effects faded when programs were discontinued

4. Importance of persistent implementation and continued funding of comprehensive, community-based youth suicide prevention programs, like the GLS program

Long-term impact of the Garrett Lee Smith Youth Suicide Prevention Program on youth suicide mortality, 2006–2015. Estimated effect of GLS on youth suicide mortality rate per 100,000 following the start of program activities in counties exposed to GLS activities during one, two, three, and four consecutive years (Year 0: first year of GLS activity)

School- Based Preventive Interventions Can Make a Difference: Saving & Empowering Young Lives in Europe (SEYLE) Study

Youth Aware of Mental Health Intervention Led to Lower Rate of Incident Suicide Attempts Relative to Control Condition

Nationwide Suicide Prevention


Without Preventive Intervention: Who Attempts Suicide Over 12 Months?

- Previous SA
- SI- 12 months earlier
- Deliberate Self Injurious Behavior- 12 months earlier
- Health risk behavior- 12 months earlier
- SI + HRB
- SI + D-SIB
School-Based Suicide Prevention Interventions May Weaken Effects of Risk Factors: SEYLE

Multinational Study of Adolescents

- Health risk behaviors and self-injury predicted repeated suicide attempts among control/no-intervention group
- Three SEYLE interventions attenuated the combined effect of ideation and self-injury on likelihood of suicide attempts
- Youth Aware of Mental Health program (YAM) diminished the direct effect of health risk behaviors on the likelihood of suicide attempts

Barzilay et al. and SEYLE Consortium, 2019
Take Home Points

• Identifying youths at risk is critical first step- current data point to value of brief screeners and innovative new directions, screening is useful when resources are available to care for youths identified as at-risk

• Treatments that work have been identified. DBT has demonstrated efficacy for reducing SH in 2 RCTs, and other approaches have shown promise in single RCTs for reducing SAs. We have evidence to guide effective treatment.

• While not every suicide can be prevented, we can reach for zero and suicides can be prevented. Nationwide suicide prevention strategies can and do work. We have an evidence base to guide us in reducing suicide rates. Implementation is a challenge for now and the future.
Process of Care: Suicide Prevention Services

- Identify High Risk Youths
- Therapeutic Assessment
  - SAFETY-Acute/FISP
- Motivational Enhancement
- Schedule follow-up appointment or supported referral
- Caring contacts
- Trouble shoot barriers to care

Link to Treatment

When Safe

- Outpatient Evidence-Based Treatment
- As Needed Intensive Community Care

When Unsafe

- Hospital/Inpatient

Take Home Points

- Reducing access to the means of suicide (e.g. firearms, pesticides, certain medications) can reduce the risk that suicidal/self-harm urges will result in death.
- Alcohol and drug use policies to reduce the harmful use of alcohol and drugs can make a difference.

| Self-Harm Predicts Premature Death by Suicide & Other Unnatural Causes |
|--------------------|-----------------|-----------------|------------------|
|                    | SH Cohort Rate /100,000 | Comparator Rate /100,000 | Hazard Ratio     |
| Unnatural Causes   | 3.56             | 0.45             | 9.31 (5.85, 14.81) |
| Suicide            | 1.65             | 0.11             | 18.67 (8.32, 41.87) |
| Alcohol/Drug Poisoning | 1.40             | 0.04             | 38.20 (13.23, 110.28) |
| Accident           | 1.52             | 0.30             | 5.96 (3.08, 11.53)   |

Lock and Protect

Sometimes kids go through times when they feel stressed, down, alone, and hopeless.

When kids are very upset, risk for suicide and harming themselves increases.

You can protect your child during these times by being there for them and doing all you can to stop them from getting guns, drugs, or other things that could lead to death.

This tool can help you to make decisions about how to best protect your child.

Get Started

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13 Reasons Why: Environmental Exposure that Permeated Culture

1. Time series studies showing increased rates of suicide deaths and ED visits for suicidal episodes following release.

Release of 13 Reasons Why associated with significant increase in monthly suicide rates among U.S. youth ages 10-17 years

Suicide Rates Increase During Adolescence

Number of suicides globally in young people, 2016

Source: WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/estimates)
Childhood to Adolescence
Comparison with Declines in Other Leading Causes of Death: Decline in Deaths from Motor Vehicle Traffic Injuries

Differences in death rates for suicide and motor vehicle accidents are not statistically different, p<.05.
SAFETY: Can Families & Communities, Function Like Protective Seatbelts?
Thank You
???