Improving the Lives of Ethnoracially Minoritized Youth: Integrating Sociocultural Risk and Protective Factors In Suicide Prevention.

- **Presented By:** Jocelyn I. Meza, Ph.D
- **Affiliations:** [a]University of California, Los Angeles; Department of Psychiatry and Biobehavioral Sciences.

Disclaimers

- The opinions expressed in this presentation and on the following slides are solely of the presenter and not necessarily those of UCLA-David Geffen School of Medicine.

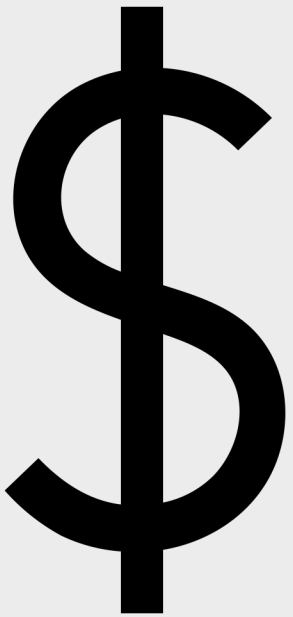
- This presentation may contain copyrighted material which has not been specifically authorized by the copyright owner. This presentation operates under the assumption that material presented is for “fair use” purposes. If you wish to use the presented copyrighted material for purposes that go beyond “fair use” please obtain permission from the copyright owners.

- This presentation is for educational purposes only and should not be replicated, shared, or modified without permission of the authors/presenters.

Financial Disclosures

Dr. Meza has received funding from:

- Patient-Centered Outcomes Research Institute (PCORI) (2022-2027)
- American Psychology- Law Society (2021-2022)
- National Academy of Sciences Ford Foundation (2017-2018)
- National Science Foundation (NSF) (2014-2017)



Roadmap of Presentation

Highlight scope of the problem

Report significant disparities

Review current sociocultural risk and protective factors

Discuss possible solutions for equitable suicide prevention

Learning Objectives

Identify

Identify current treatment gaps and structural biases that have limited the advancement of suicide interventions for BIPOC communities.

Analyze

Analyze possible solutions to suicide related care for BIPOC communities with a special emphasis on youth.

Learn

Learn how to provide anti-racist clinical care & learn how to involve diverse communities in building equitable suicide intervention strategies that work.

SCOPE of the PROBLEM

10 Leading Causes of Death, United States
2019, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 4,301	Unintentional Injury 1,149	Unintentional Injury 714	Unintentional Injury [illegible]	Unintentional Injury [illegible]	Unintentional Injury [illegible]	Unintentional Injury 24,070	Malignant Neoplasms 35,587	Malignant Neoplasms 111,765	Heart Disease 531,583	Heart Disease 659,041
2	Short Gestation 3,445	Congenital Anomalies 416	Malignant Neoplasms 371	Suicide 534	Suicide 5,954	Suicide 8,059	Malignant Neoplasms 10,695	Heart Disease 31,138	Heart Disease 80,837	Malignant Neoplasms 435,462	Malignant Neoplasms 599,601
3	Unintentional Injury 1,266	Malignant Neoplasms 285	Congenital Anomalies 192	Malignant Neoplasms 404	Homicide 4,774	Homicide 5,341	Heart Disease 10,499	Unintentional Injury 23,359	Unintentional Injury 24,892	Chronic Low. Respiratory Disease 133,246	Unintentional Injury 173,040
4	SIDS 1,248	Homicide 284	Homicide 155	Homicide 191	Malignant Neoplasms 1,388	Malignant Neoplasms 3,577	Suicide 7,525	Liver Disease 8,098	Chronic Low. Respiratory Disease 18,743	Cerebro-vascular 129,193	Chronic Low. Respiratory Disease 156,979
5	Maternal Pregnancy Comp. 1,245	Heart Disease 133	Heart Disease 91	Congenital Anomalies 189	Heart Disease 872	Heart Disease 3,495	Homicide 3,446	Suicide 8,012	Diabetes Mellitus 15,508	Alzheimer's Disease 120,090	Cerebro-vascular 150,005
6	Placenta Cord Membranes 742	Influenza & Pneumonia 122	Chronic Low. Respiratory Disease 69	Heart Disease 87	Congenital Anomalies 390	Liver Disease 1,112	Liver Disease 3,417	Diabetes Mellitus 6,348	Liver Disease 14,385	Diabetes Mellitus 62,397	Alzheimer's Disease 121,499
7	Bacterial Sepsis 603	Perinatal Period 57	Influenza & Pneumonia 52	Chronic Low. Respiratory Disease 81	Diabetes Mellitus 248	Diabetes Mellitus 887	Diabetes Mellitus 2,228	Cerebro-vascular 5,153	Cerebro-vascular 12,931	Unintentional Injury 60,527	Diabetes Mellitus 87,647
8	Respiratory Distress 424	Septicemia 53	Cerebro-vascular 37	Influenza & Pneumonia 71	Influenza & Pneumonia 175	Cerebro-vascular 585	Cerebro-vascular 1,741	Chronic Low. Respiratory Disease 3,592	Suicide 8,238	Nephritis 42,230	Nephritis 51,565
9	Circulatory System Disease 406	Cerebro-vascular 52	Septicemia 36	Cerebro-vascular 48	Chronic Low. Respiratory Disease 168	Complicated Pregnancy 532	Influenza & Pneumonia 951	Nephritis 2,269	Nephritis 5,857	Influenza & Pneumonia 40,399	Influenza & Pneumonia 49,783
10	Necrotizing Enterocolitis 354	Benign Neoplasms 49	Benign Neoplasms 31	Benign Neoplasms 35	Cerebro-vascular 158	HIV 486	Septicemia 812	Septicemia 2,176	Septicemia 5,672	Parkinson's Disease 34,435	Suicide 47,511

Produced By: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

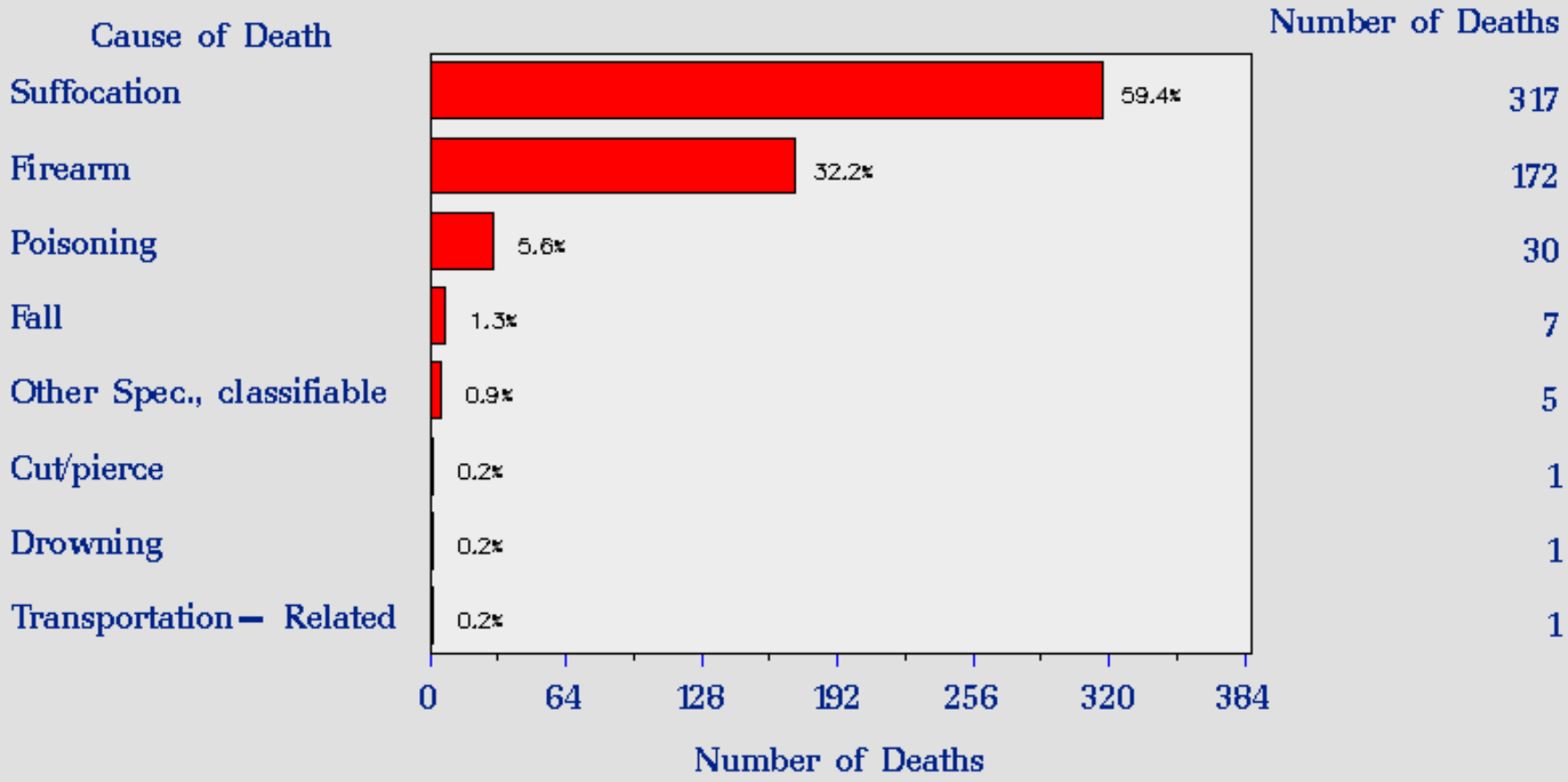
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2019, United States

Suicide

Ages 10–14, All Races, Both Sexes

Total Deaths: 534



WISQARS™ Produced by: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

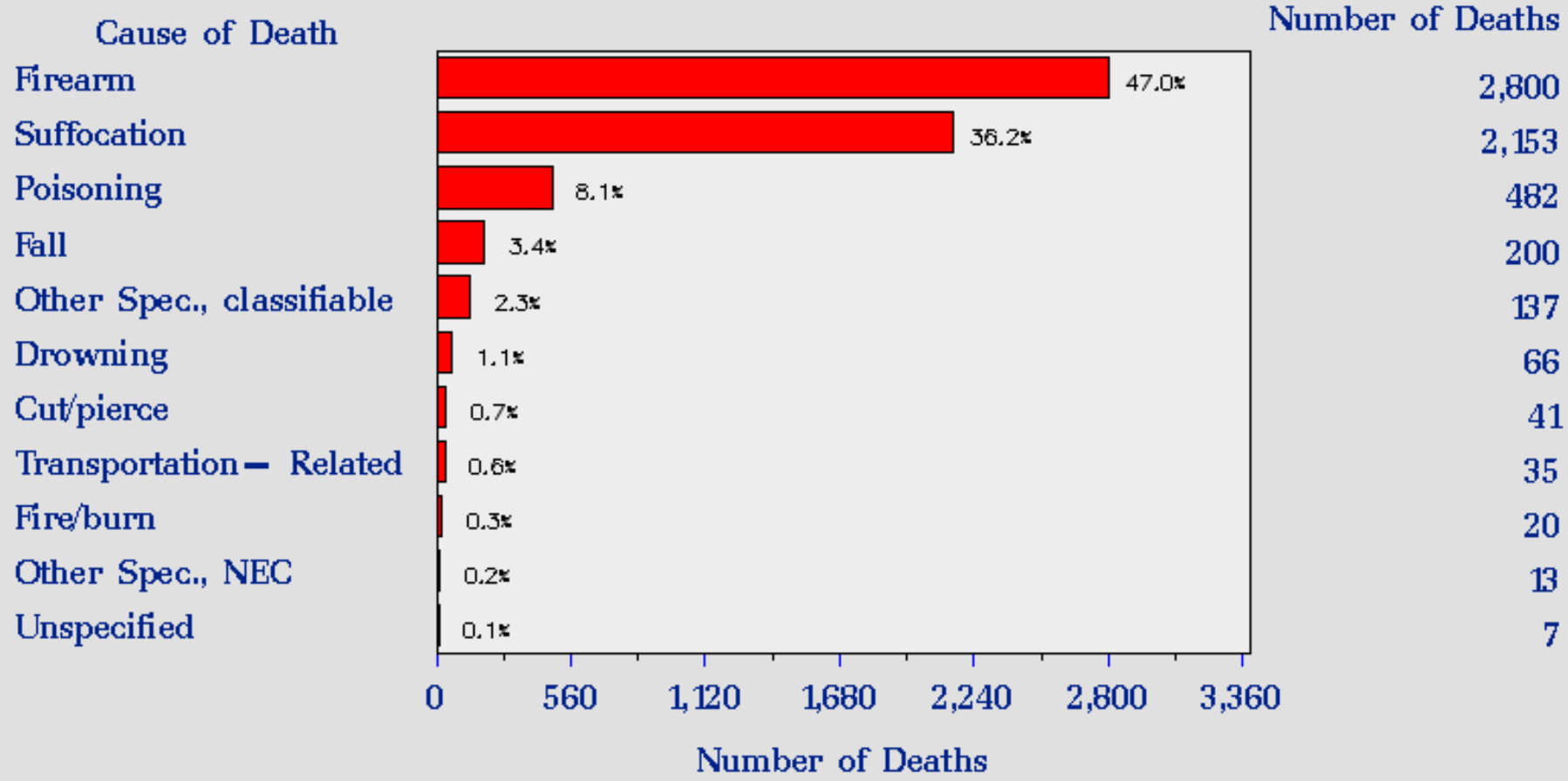
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

2019, United States

Suicide

Ages 15–24, All Races, Both Sexes

Total Deaths: 5,954



NEC means Not Elsewhere Classifiable.

WISQARS™ Produced by: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Cost of Injury for Youth Ages 10-24 in 2019

Mechanism	Intent	Deaths	Medical Costs		Value of Statistical Life		Combined Costs	
			Total	Average	Total	Average	Total	Average
Cut/Pierce	Suicide	42	$385,260	$9,173	$468.00 M	$11.14 M	$468.39 M	$11.15 M
Drowning	Suicide	67	$277,224	$4,138	$772.70 M	$11.53 M	$772.98 M	$11.54 M
Fall	Suicide	207	$1.25 M	$6,044	$2.44 B	$11.81 M	$2.45 B	$11.81 M
Fire/Flame	Suicide	20	$513,304	$25,665	$214.00 M	$10.70 M	$214.51 M	$10.73 M
Firearm	Suicide	2,972	$17.69 M	$5,952	$35.87 B	$12.07 M	$35.89 B	$12.08 M
Drug Poisoning	Suicide	401	$4.31 M	$10,738	$4.87 B	$12.15 M	$4.88 B	$12.16 M
Non-Drug Poisoning	Suicide	111	$459,197	$4,137	$1.26 B	$11.31 M	$1.26 B	$11.32 M
Suffocation	Suicide	2,470	$20.82 M	$8,428	$31.23 B	$12.65 M	$31.25 B	$12.65 M
Transport Related-Overall	Suicide	36	$104,586	$2,905	$447.20 M	$12.42 M	$447.30 M	$12.43 M
Other specified and classifiable	Suicide	142	$886,150	$6,240	$1.74 B	$12.27 M	$1.74 B	$12.28 M
Other specified / NEC	Suicide	13**	$179,735	$13,826	$145.30 M	$11.18 M	$145.48 M	$11.19 M
Unspecified	Suicide	7**	$6,936	$991	$81.10 M	$11.59 M	$81.11 M	$11.59 M

Notation: ** indicates unstable value (<20 deaths); -- indicates suppressed value (<10 deaths in sub-national geographic areas or nonfatal injury counts based on <20 unweighted count, <1,200 weighted count, or coefficient of variation of the estimate >30%);

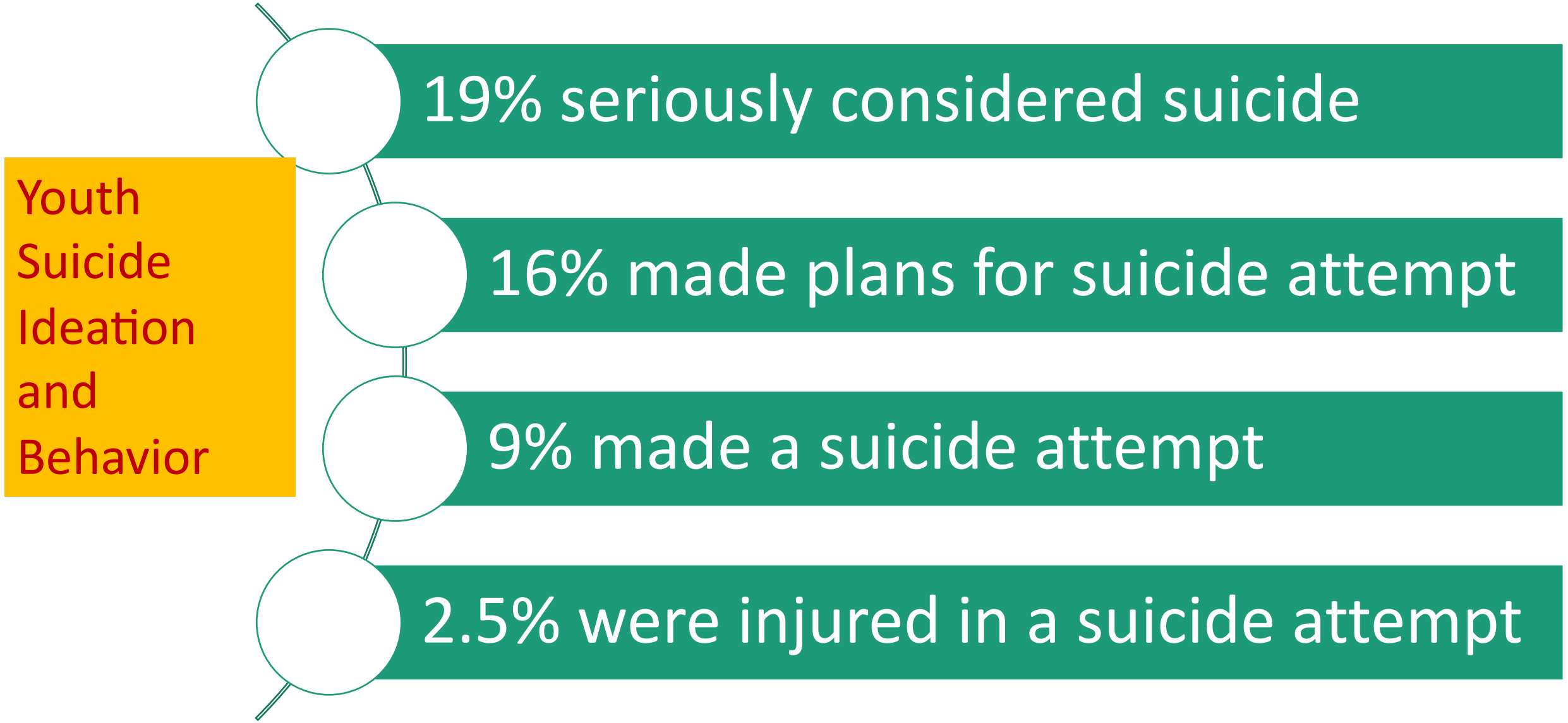
Abbreviations: $B = Billions; $M = Millions; ED = Emergency department; NEC = Not elsewhere classified; MV = Motor vehicle

Currency year and time horizon: Costs are 2019 USD. Medical costs for injury deaths refer to medical care associated with the fatal event. Medical, work loss, and quality of life loss costs for nonfatal injuries refer to the 1 year following the ED injury visit.

Data sources:

- National Center for Health Statistics-CDC annual mortality data files for WISQARS Fatal data.
- National Electronic Injury Surveillance System-All Injury Program for WISQARS Nonfatal data, an estimated number of hospital visits for injury care that start in an emergency department based on a U.S. nationally representative probability sample of hospitals.
- Pacific Institute for Research and Evaluation (2020) for nonfatal injury quality of life loss.
- U.S. HHS Office of the Assistant Secretary for Planning and Evaluation (2016) for value of statistical life and monetized quality of life loss.
- Journal articles for fatal and nonfatal medical costs and nonfatal injury work loss costs by injury type and description of how costs were assigned to WISQARS injury records.

Produced by: National Center for Injury Prevention and Control, CDC.



Estimates from the Youth Risk Behavior Survey (YRBS), 2019

Scope of the Problem

- Significant racial/ethnic disparities:
  - Particularly, for Native American/Alaskan Native youth, increasing rates among Black and Latinx youth, with the highest increase among Black girls (Sheftal et al., 2022).

	Nationwide (overall)	Non-Hispanic White	Non-Hispanic Black	Hispanic/Latinx
Seriously Thought About Suicide	18.8%	19.1%	16.9%	17.2%
Planned for Suicide	16%	15.7%	15%	14.7%
Suicide Attempts	9%	7.9%	11.8%	8.9%
Female Suicide Attempts	--	9.4%	15.2%	11.9%
Male Suicide Attempts	--	6.4%	8.5%	5.5%
Near Lethal Attempts that Resulted in Injury, Poisoning or Overdose	--	2.1%	3.3%	3.0%

Note: Data from High School Youth Risk Behavior Survey, 2019.

American Indian/Alaska Native/Indigenous Youth

- AI/AN boys and girls ages 10 to 19 have the highest rate of suicide across all race/ethnicities (CDC, 2020).
- Suicide is *the* leading cause of death among AI/AN youth ages 15-19 years.
- AI/AN high school youth have the highest percentages of suicidal thoughts, plans and behaviors (*Ivey-Stephenson et al., 2020*).
  - Suicide ideation: 28.6% in AI/AN youth vs to 19.1% of White youth
  - Suicide attempt: 16.9% in AI/AN vs. 7.9% of White youth

Asian American, Pacific Islander, and Native Hawaiian Youth

- In 2019, Asian adolescents reported a 12-month prevalence of 16.9% for suicidal ideation & 9.2% for suicide attempt.

- Very few studies report data on self-injurious thoughts and behaviors for Asian/Asian American youth; data do not provide a comprehensive picture concerning suicide prevalence and trends among Asian American, Pacific Islander, and Native Hawaiian youth.

Rates of Death by Suicide

1. Age-adjusted suicide rate in the U.S. has increased by 33% from 1999-2017.
2. Latinx and Black females ages 15-24 have had the greatest increases in suicide deaths, 133% and 125%, respectively, compared to an 88% increase among White and 61% among Asian females in that age group.
3. Black youth ages 5-12 have a suicide rate that is roughly **two times** higher than White children of the same age group.

Rising Trends in Black Youth Suicide

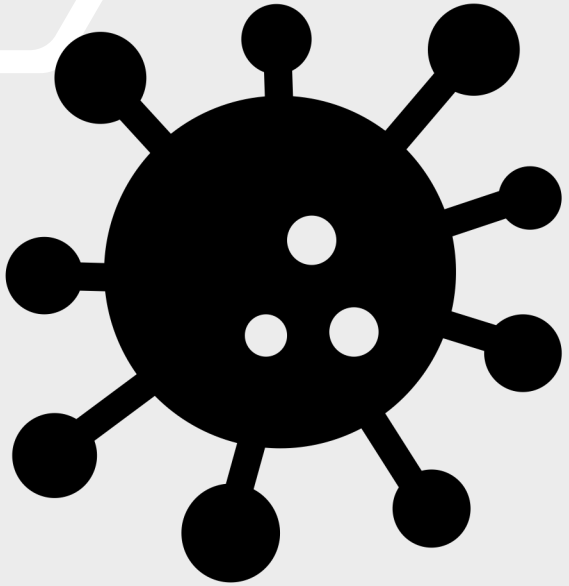
Author	Year	Age	Suicide Rate
Centers for Disease Control and Prevention, 1998[20]	1980-1995	10-19	Increased by 114% for Black youth
Bridge et al., 2015[4] Bridge et al., 2018[8]	1993-1997, 2008-2012	5-11	Increased in Black children Decreased in White children
Price and Khubchandani, 2019[21]	2001-2017	13-19	Increased in Black youth by 60%
Lindsey et al., 2019[22]	1991-2017	10-19	Positive trend in Black adolescent boys
Sheftall et. al. 2019[5]	1991-2017	10-19	Positive trend in Black adolescent boys

Increasing Rates for Suicide Among BIPOC Youths Have Been Reported Since the 60's!

- American Indian/Alaska Native/Indigenous Youth
  - Age of highest risk 15-25, especially since 1966 (noted stable increases in decades after that; *McIntosh, 1983*)
  - Significant differences across tribes
- Latinx
  - YRBS Data from 1997-1999 indicate that the highest rates of suicide attempts in the US were among Latino adolescents (*Canino & Roberts, 2001*).

Scope of the Problem

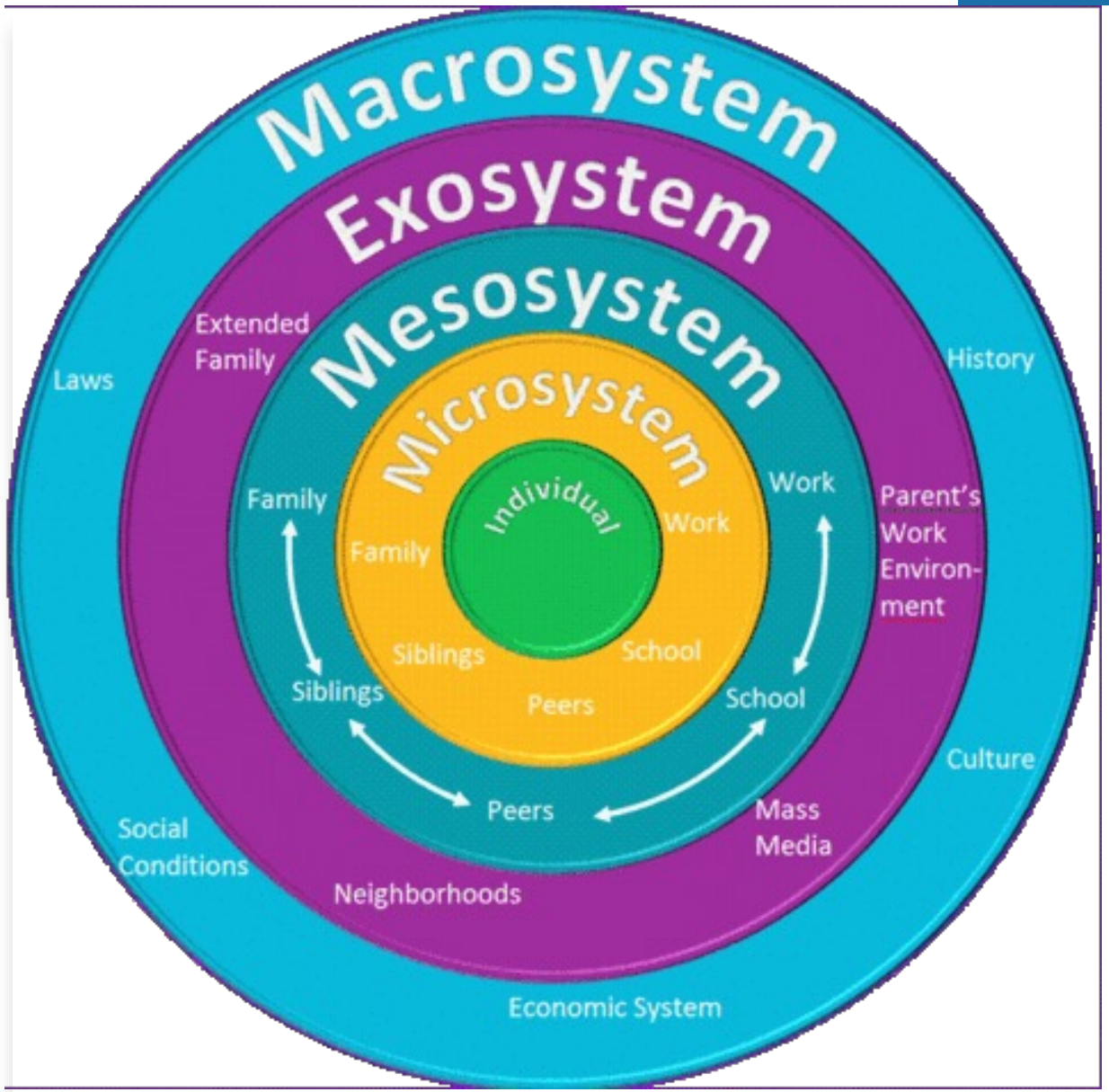
- COVID-19 associated with high rates of suicidal ideation & suicide attempts in youth presenting to emergency departments and other mental health services (*Asarnow & Chung, 2021; Yard et al., 2021*).
  - CDC data identified sharp rise in suicide attempts among teen girls during COVID pandemic (*51% increase*)



How can we disrupt these disparities?

WHAT is driving these inequities?

What we know about suicide is largely decontexualized



The work of suicide prevention is "grounded in the assumption that people live in a world that believes their life matters. Many people of color, however, do not see that world as their own. On a practical, daily level [society] gives explicit and implicit messages that it's white lives that matter and not Black lives or brown or Indigenous lives."

Jonathan Singer, Previous President of the AAS,

Associate Professor, Loyola University Chicago

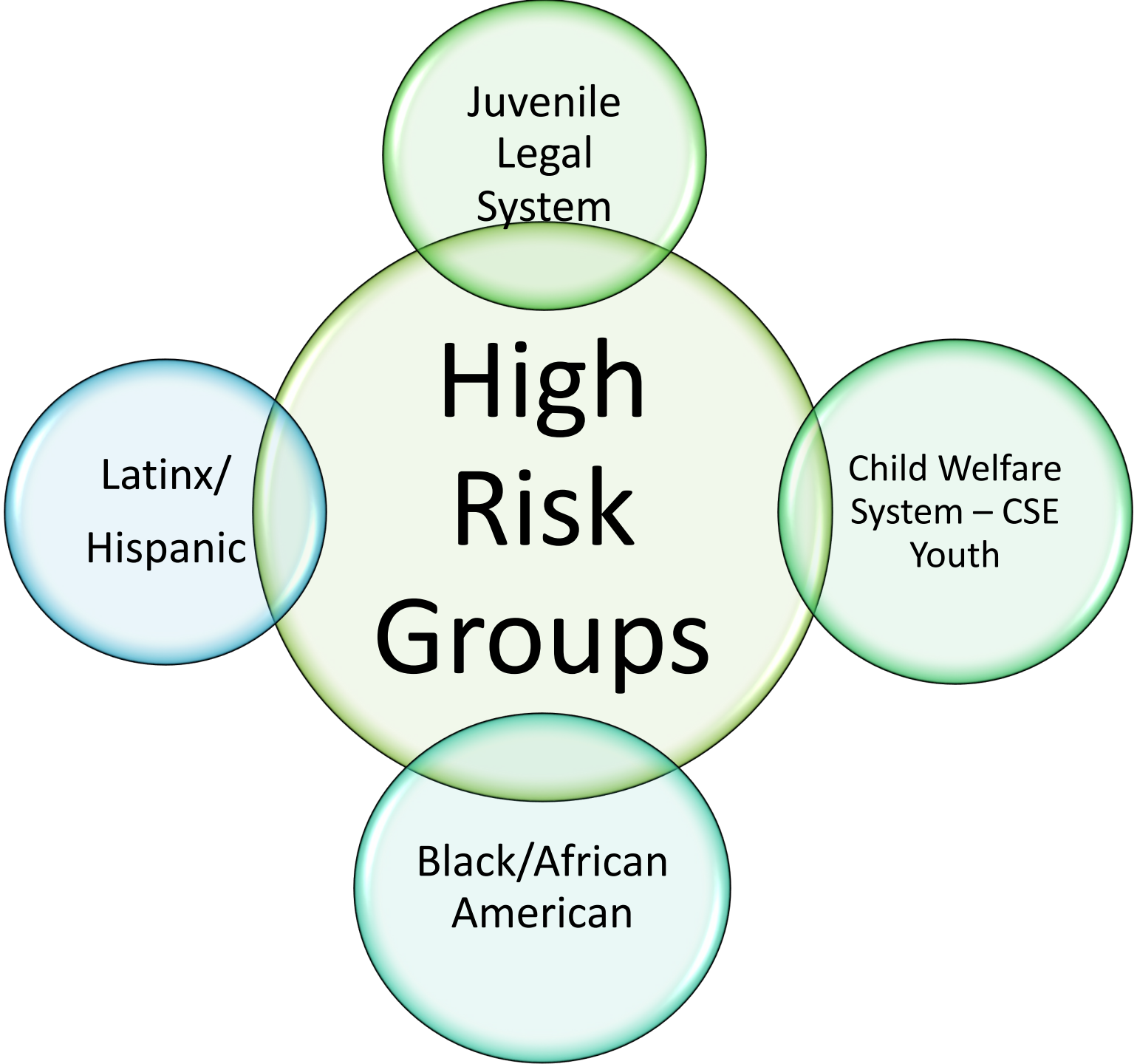
Figure 2.
Public health model of suicide prevention

World Health Organization. Preventing suicide: a global imperative. Geneva: WHO, 2014.

Suicide Prevention

Enhance Protective Processes

Risk Reduction


Juvenile Legal System
High Risk Groups
Latinx/ Hispanic
Child Welfare System – CSE Youth
Black/African American

Latinx Youth Risk and Protective Factors

Heterogenous Group	Different Immigration Histories Across the U.S.	Generational Status
• Cuban, Mexican, Guatemalan, Honduran, Puerto Rican etc...	• Mexican-descent in Los Angeles vs. Puerto Rican in New York	• 1st vs. 5th Generation (i.e., Latinx Paradox)

Risk Factors for Suicide Among Latinx Youth

- **Individual Level:**
  - Ethnic-Identity
    - Lower levels of ethnic identity attachment were related to ***greater*** suicide risk (Oakey-Frost et al., 2021).

Ethnic Identity and Suicide Risk among Hispanic/Latinx Young Adults

FIGURE 1. *Mediational model for interpersonal components of the Interpersonal-Psychological Theory of Suicide (IPTS) mediating the relation of in-group attachment to suicidality. Standardized path estimates (i.e., standardized regression coefficients) are presented.* *p <.05, **p <.01, ***p <.001.

- **Individual Level:**
  - Gender
    - Conflicting gender expectations for teen boys and girls related to suicide attempts (Humensky et al., 2017).
    - Increasing autonomy & violation of gender expectations (i.e., chores around the house) lead to conflicts with parents that triggered suicide attempts (Zayas et al., 2010).
  - Generational status
    - Second and third generation more likely than first-generation to attempt suicide (Baumann et al., 2010; Peña et al., 2008)
  - Migration
    - Girls with histories of attempts reported acculturative stress (Gulbas & Zayas, 2015).
    - Large acculturation gaps and immigration stress significantly associated with suicide attempts among Latinas (Cervantes et al., 2014).

Family/Peer Level:

Peers

- Intimate Partner Problems: gender traditional values (Lee & Wong, 2020)

Family/Parents

- Parental incarceration was associated with higher odds of SI (Forster et al., 2019)
- 9th-grade Latinx students who report an inability to communicate with parental figures are **2-3xs** more likely to have SI than their peers who report open communication with parental figures (Garcia et al., 2008)
- Incongruence in academic aspirations between suicidal youth and their parents (Hausmann-Stabile et al., 2013).

Intergenerational Acculturation Conflict (Meza et al., 2022).

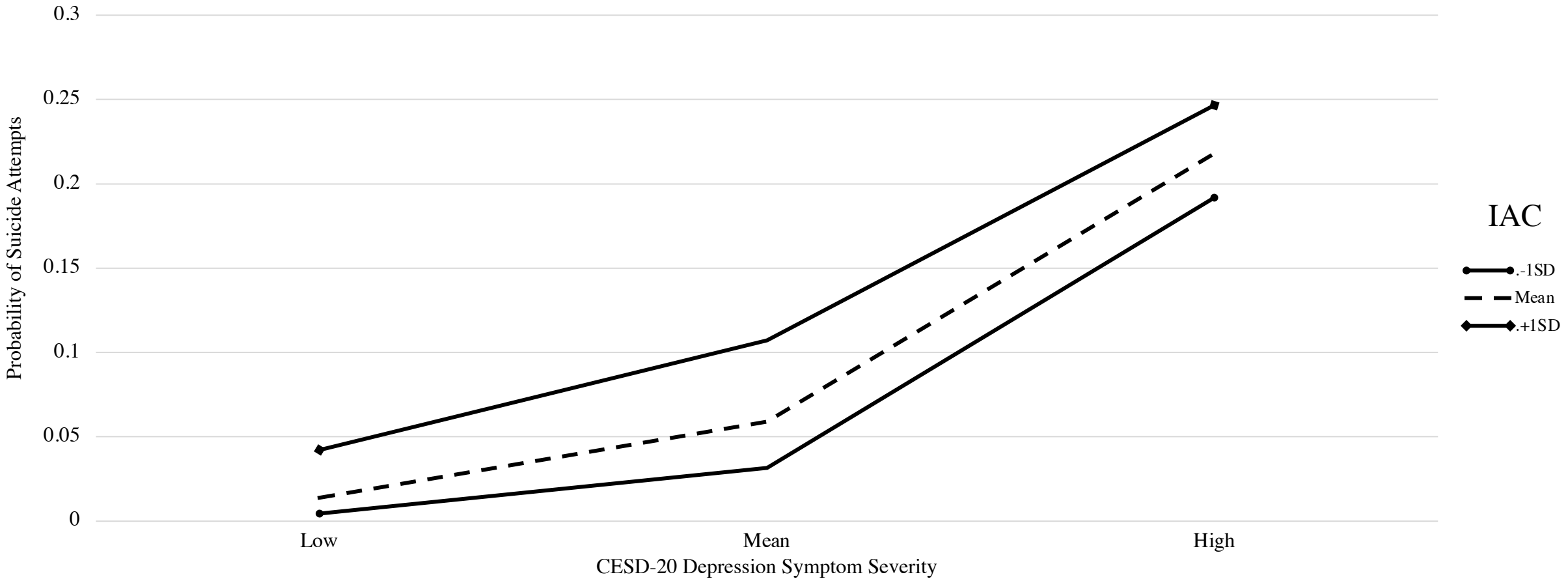


Figure 2. Interaction of depression symptom severity and Intergeneration Acculturation Conflict (IAC) on the probability of suicide attempt in the last 12-months.

Social/Community Level:

Subtle forms of discrimination (microaggressions) associated with SI among Latinx adolescents (Madubata et al., 2022)

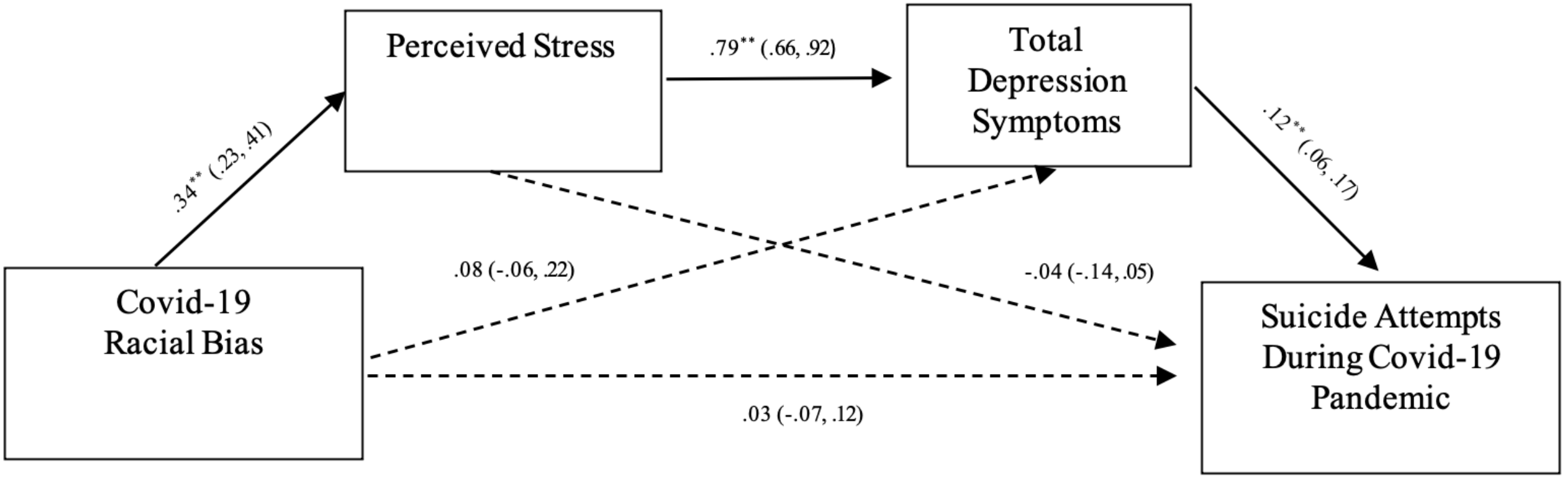
Meta analysis: Discrimination was associated with increased suicidality among Latinx adolescents & association was stronger for girls versus boys (Vargas et al., 2021).

Exposure to violence in community related to “acquired capability” for suicide (Gulbas et al., 2019)

Experiencing marginalization and discrimination is associated to “thwarted belongingness” (Gulbas et al., 2019)

Perceived racial bias (Covid-19 related) associated with suicidality among Mexican-descent emerging adults (Meza et al., in preparation).

Figure 1.



Note: Serial multiple mediation model for the association between racial bias and suicide attempts during the Covid-19 pandemic, via perceived stress and depression symptoms. Covariates included: age and gender. * $p < 0.01$, ** $p < 0.001$. Serial multiple mediation model with unstandardized regression coefficients and 95% bias corrected confidence intervals. Significant pathways highlighted in bold.

Protective Factors for Latinx Suicide

"Buffers"

Individual Level:

Higher affective ethnic identity reduced the odds of SA (Forster et al., 2019).

Odds of death by suicide **decrease by 6.1** among Latinx individuals in their twenties who are part of a religious community (Barranco, 2016).

Family/Peer Level:

Familism protects teens from suicide (Peña et al., 2011)**

Higher levels of mother-daughter mutuality served as a protective factor for SI and SA among Latinas (Zayas et al., 2011).

A school adult believing they would be successful was protective for Latina girls (Hall et al., 2018).

Tight-knit families have lower incidence of suicide attempts (Peña et al., 2011)

Community/Social Level:

- Political activism (Hope et al., 2018)
  - “Political activism serves as a protective factor to mitigate the negative effect of R/E discrimination on stress and depressive symptoms for Latinx students.”
- Cultural diversity and inclusion reminder reduced Latino students' stress responses (Sladek et al., 2020).

Contextualizing Black Youth Suicide

Forms of Racial/Ethnic Discrimination and Suicidal Ideation

- Subtle forms of discrimination were associated with suicidal ideation over time for African American youth aged 14-17, above and beyond the effects of depressive symptoms.

- Subtle discrimination may affect:
  - Individual's self- esteem
  - Provoke increased threat vigilance
  - Feelings of rejection
  - Physiological stress responses

(Madubata et al., 2019)

Discrimination and suicidality among racial and ethnic minorities in the United States

- Individuals who reported highest levels of discrimination had greater odds to report
  - Lifetime suicidal thoughts
  - Plans of suicide
  - Attempts of suicide

- Black youth had the highest score on the scale of discrimination, compared to Asian and Latinx.

(Oh et al., 2018)

Understanding Differential Risk Factors

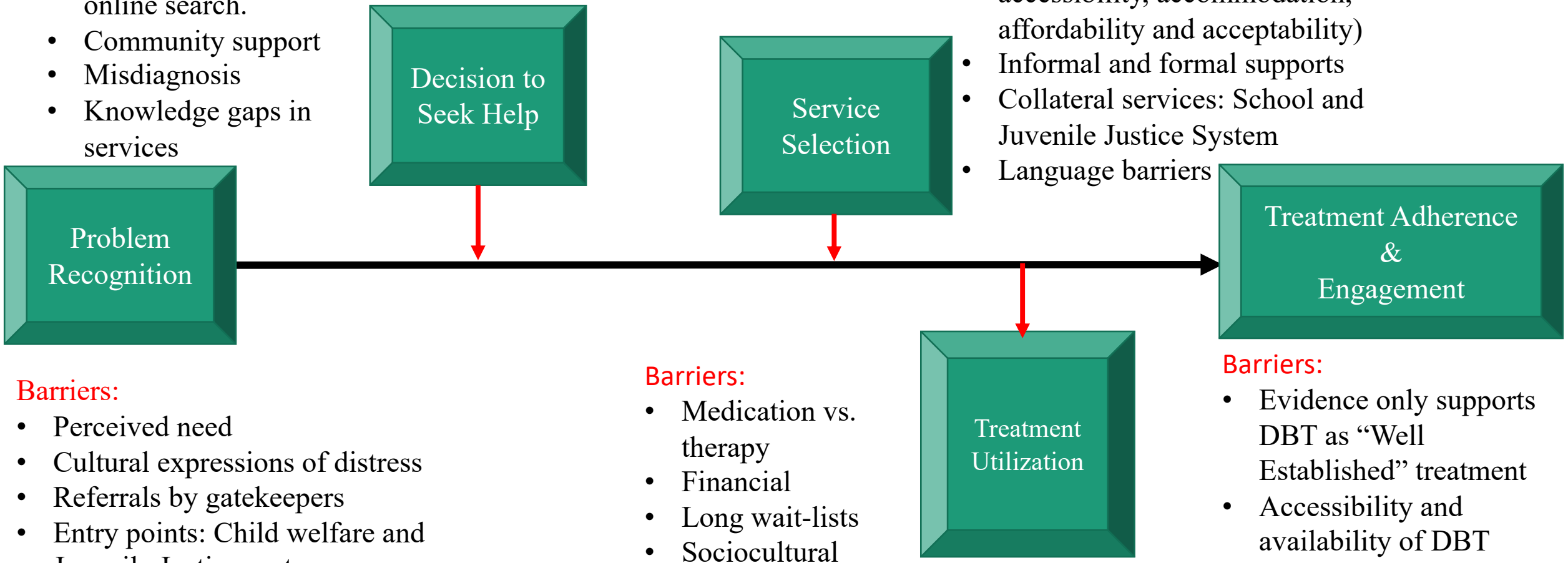
- Black youth disproportionately exposed to
  - Underserved neighborhoods with highest concentrations of poverty
  - Disparities in access to behavioral health services
  - Structural racism and discrimination
  - Increasing involvements in child welfare and juvenile justice

Evidence-Based Risk and Protective Factors for Black and Latinx Youth Suicide

	Black Youth	Latinx Youth
Risk Factors	Experiencing racial discrimination/microaggressions Parental conflict Increased acculturation into "White society" Barriers to accessing evidence-based mental health care Stigma Systemic racism Poverty/poverty concentrations Death or loss of loved one Living in home with a firearm Community/neighborhood violence Trauma/adverse childhood experiences	Ethnic identity (low attachment) Conflicting gender expectations Second/third generation status Acculturative stress Intergenerational acculturation conflict with caregiver/parent Inability to communicate with caregiver Incongruence in academic expectations Parental incarceration Experiencing racial/ethnic discrimination/microaggressions Community violence Perceived racial bias
Protective Factors	Religiosity/spirituality (i.e., participation in organized religious practices) Social and emotional support Strong Black identity Cultural cohesion Strong academic performance Sense of connectedness Positive self-esteem Access to evidence-based mental health care	Higher affective ethnic identity Part of religious community Familism High mother-daughter mutuality (connectedness and communication) High cohesion and low conflict in family Engaging in political activism

Meza, Patel & Bath, 2022

Integrated Model of Barriers to Mental Health Services Among BIPOC Youth



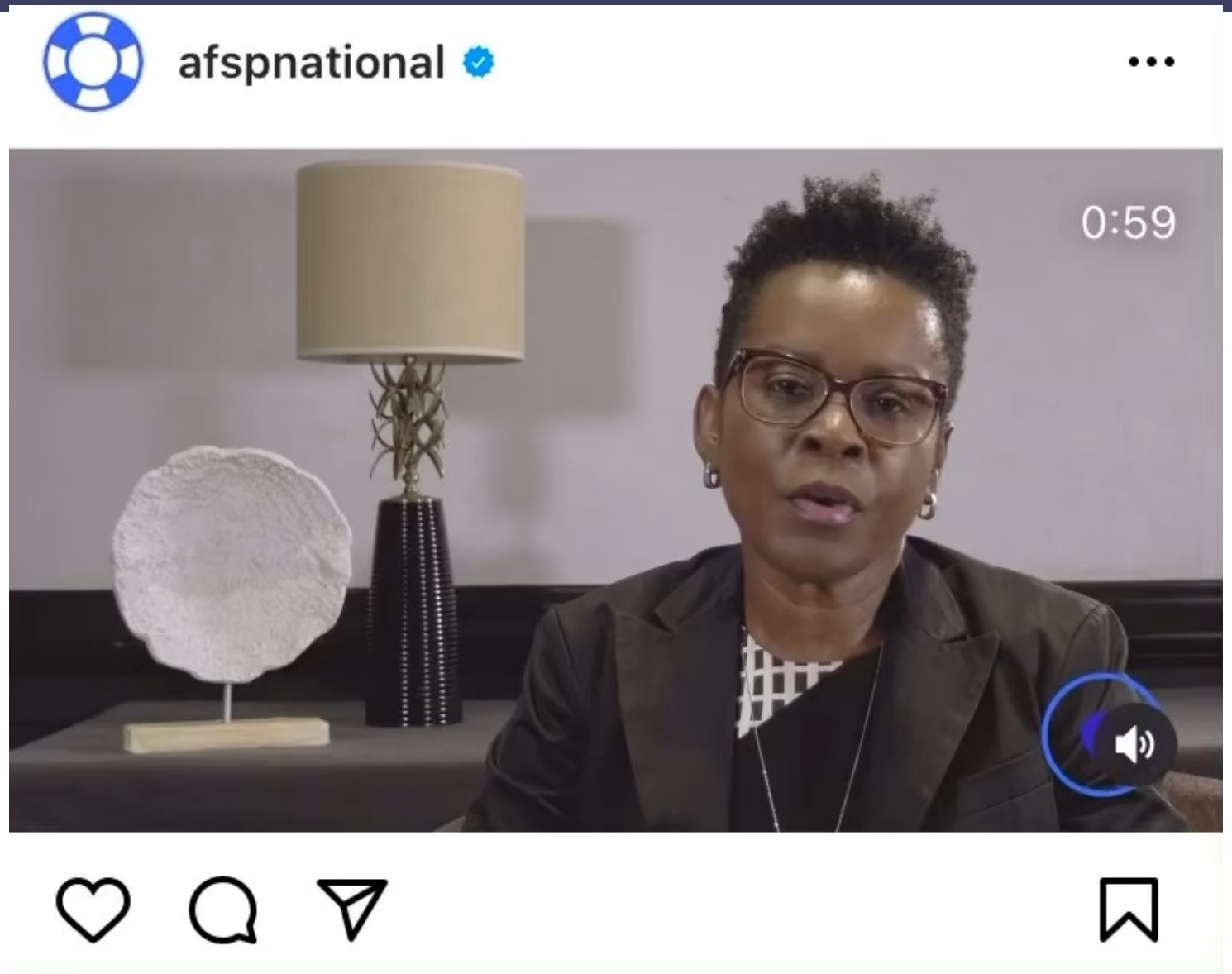
Barriers:
- Search for care
- Access to internet for online search.
- Community support
- Misdiagnosis
- Knowledge gaps in services

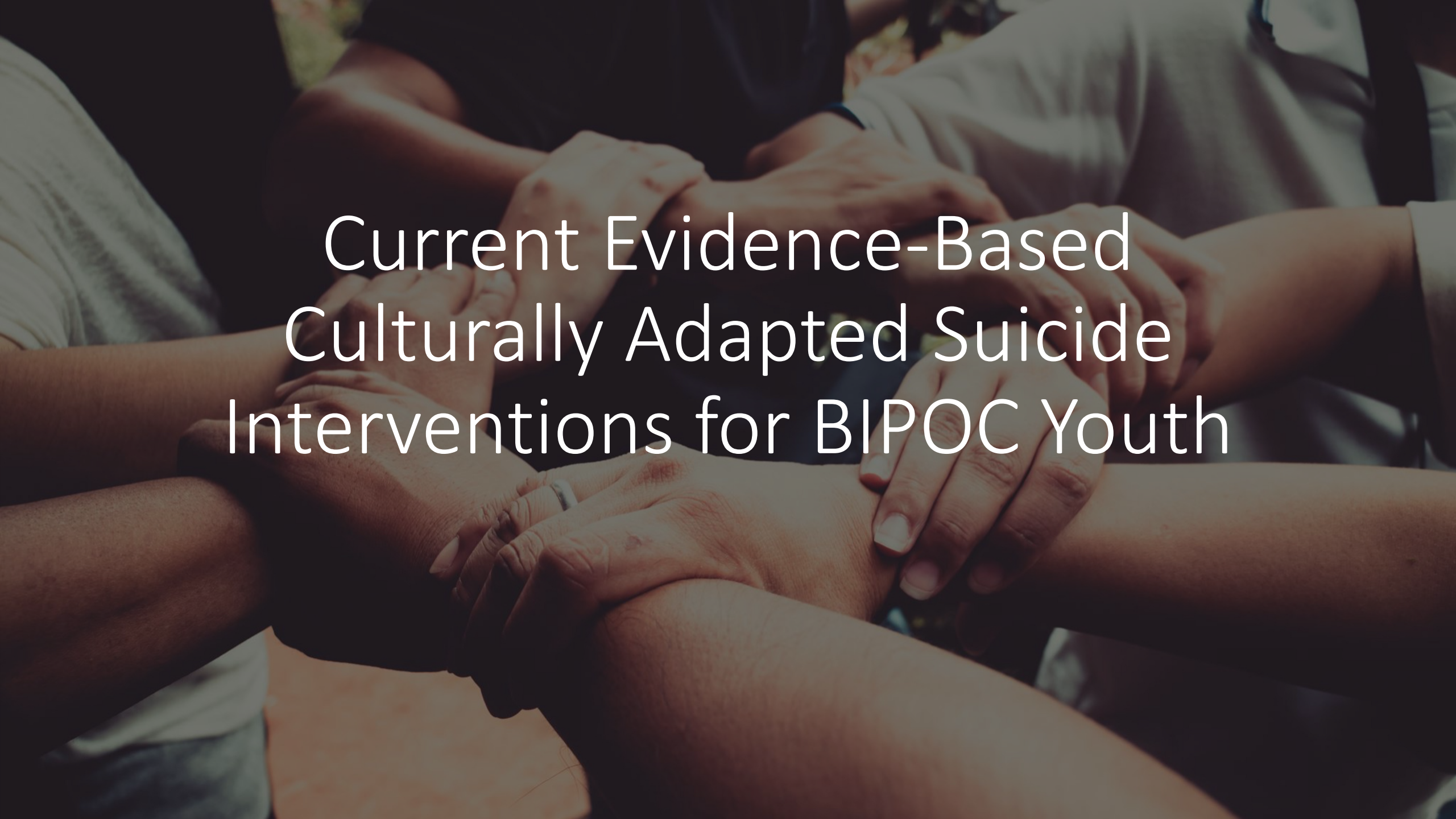
Barriers:
- Perceived need
- Cultural expressions of distress
- Referrals by gatekeepers
- Entry points: Child welfare and Juvenile Justice systems, School, Emergency Department, Primary Care

Barriers:
- Fit between patient's needs and systems availability (availability, accessibility, accommodation, affordability and acceptability)
- Informal and formal supports
- Collateral services: School and Juvenile Justice System
- Language barriers

Barriers:
- Medication vs. therapy
- Financial
- Long wait-lists
- Sociocultural barriers (i.e., medical mistrust)

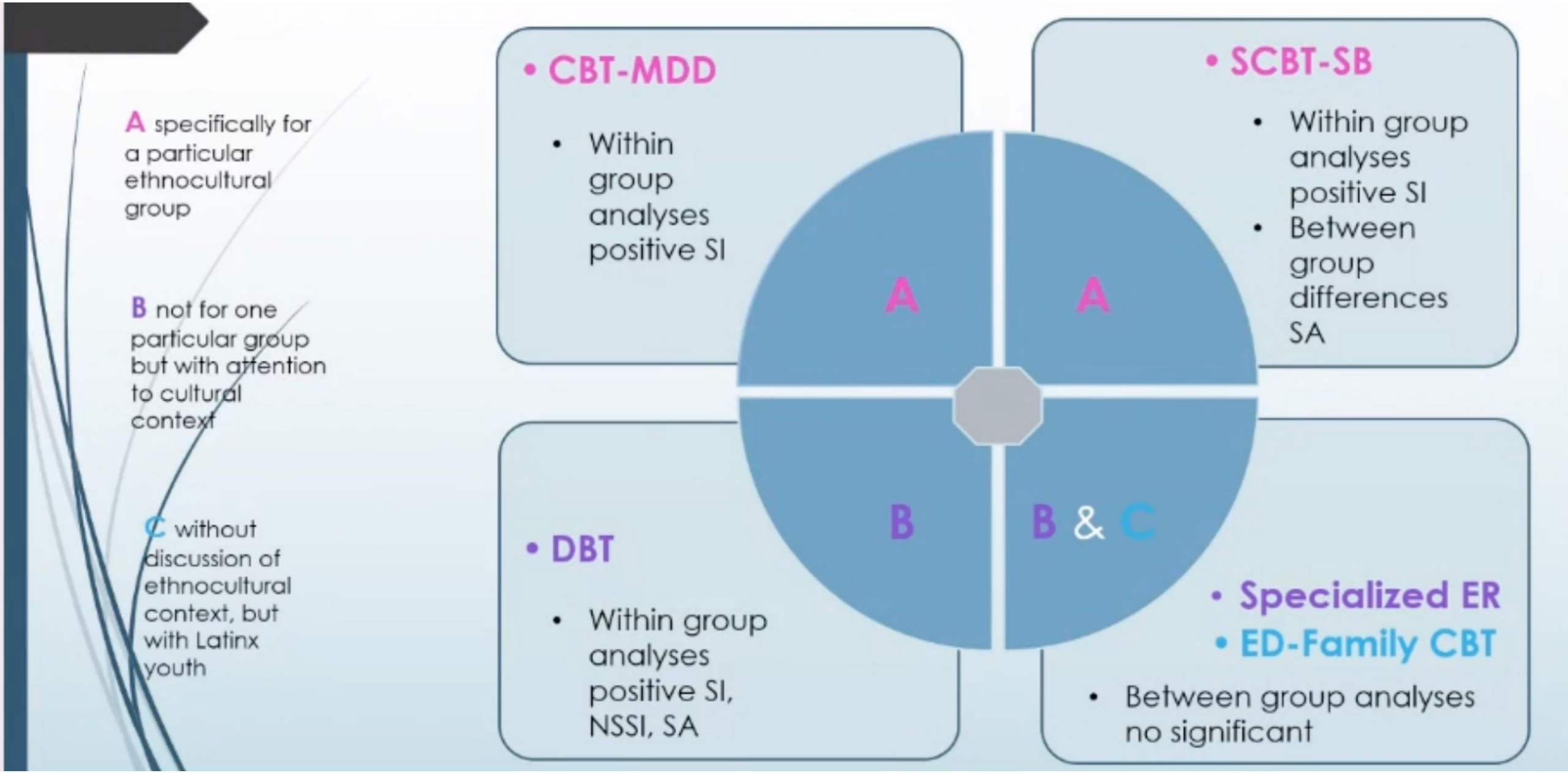
Barriers:
- Evidence only supports DBT as "Well Established" treatment
- Accessibility and availability of DBT clinicians of color
- Initiation of care and continuity


afspnational
0:59



Current Evidence-Based Culturally Adapted Suicide Interventions for BIPOC Youth

- Test interventions with more diverse groups
  - We need to ensure that interventions are culturally appropriate and accessible to youth of color.
    - Yovanksa Duarte-Velez' Socio-Cognitive Behavior Therapy for Suicidal Behaviors for Latino youth
      - Duarté-Vélez, Y., Jimenez-Colon, G., Jones, R. N., & Spirito, A. (2022). Socio-Cognitive Behavioral Therapy for Latinx Adolescent with Suicidal Behaviors: A Pilot Randomized Trial. *Child Psychiatry & Human Development*, 1-14.
      - Robinson, W. L., Whipple, C. R., Jason, L. A., & Flack, C. E. (2021). African American adolescent suicidal ideation and behavior: The role of racism and prevention. *Journal of community psychology*.



Duarté-Vélez, Y., Vélez-Grau, C., & Álvarez, K. (2021). Psychosocial Treatments for Ethnoculturally Diverse Youth with Suicidal Thoughts and Behaviors. *Handbook of Youth Suicide Prevention*, 315-347.

Socio Cognitive Behavior Therapy for Suicidal Behaviors (SCBT-SB)

- SCBT-SB is the 1st psychosocial treatment for Latinx youth with positive evidence on reducing internalizing symptoms and suicide attempts in an RCT.
- Key components:
    1. CRISIS Module (understanding the crisis, chain analysis, safety planning, and *adolescent identity*)
    2. Thoughts
    3. Emotional Regulation
    4. Activities
    5. Social Interactions

Intervention was grounded in ecological, developmental, and gender perspectives.

African American adolescent suicidal ideation and behavior: The role of racism and prevention.

- The *Adapted-Coping with Stress Course* (*A-CWS),* was developed to address the cultural nuances of African American adolescents.
  - 15-session cognitive-behavioral, group-based preventive intervention
  - Aims to enhance adaptive coping skills and reduce suicidal ideation, by incorporating strategies that counter stressors associated with systemic racism that burden Black youth.
  - Results indicated that the adolescents were very favorable and receptive to the *A-CWS* intervention and that the intervention could be conducted feasibly.
  - Used CBPR and included cultural/contextual adaptation

Robinson, W. L., Whipple, C. R., Jason, L. A., & Flack, C. E. (2021). African American adolescent suicidal ideation and behavior: The role of racism and prevention. *Journal of community psychology*.

FIGURE 1 Example of culturally and contextually relevant illustration created for the *A-CWS* intervention. A-CWS, adapted-coping with stress

Robinson, W. L., Whipple, C. R., Jason, L. A., & Flack, C. E. (2021). African American adolescent suicidal ideation and behavior: The role of racism and prevention. *Journal of community psychology*.

FIGURE 2 Example of culturally and contextually relevant illustration created for the *A-CWS* intervention. A-CWS, adapted-coping with stress

Robinson, W. L., Whipple, C. R., Jason, L. A., & Flack, C. E. (2021). African American adolescent suicidal ideation and behavior: The role of racism and prevention. *Journal of community psychology*.

Culturally Responsive Care for Suicidal BIPOC Youth

Clinical Recommendations for Culturally Responsive Suicide Interventions for BIPOC Youth and Families

Meza et al., 2022

Engage family unit and youth in ALL aspects of care (assessment, treatment planning, treatment delivery) and if possible other supportive adults in the youth's immediate context (i.e., teachers, coaches).

Provide youth and family members with culturally-relevant psychoeducation on risk factors associated with suicide. Spend time to debunk myths about suicide while also validating stigma associated with seeking care and the barriers to accessing care.

Reinforce and praise help-seeking behavior among youth and families of color. Be flexbile with "therapy termination rules" and provide families with "caring contacts" to help problem-solve treatment non-adherence.

Integrate strenght-based approaches whenever possible, and importantly during SAFETY plans.

Clinical Recommendations for Culturally Responsive Suicide Interventions for BIPOC Youth and Families

When providing lethal means counseling, tailor your psychoeduation around the different methods common for a particular racial/ethnic group. You can find the leading methods for suicide deaths by age and race/ethnicity here: https://www.cdc.gov/injury/wisqars/index.html

Disclose your own intersectional identities with your clients and encourage them to reflect on and share about their different intersecting identities. This is particularly important for adolescents that are still developing their sense of self.

If providing manualized treatments in your clinic, make sure to be flexible in your delivery and adapt the skills to the problem areas that the youth is presenting with. If your manual does not offer skills for resisting and coping with racism/racial trauma, look for other treatments developed to address these areas and get some trianing in those modealities.

Distress tolerance/skills for coping with stress should be expanded to include coping with environmental stressors (e.g., racism, community violence).

Questions

Cultural Assessment of Risk for Suicide measure (CARS; Chu et al., 2013)

- Family Conflict & Social Support: “I feel connected to, like I am a part of, a community.”
- Sexual Minority Stress: “I was rejected by a family member or friend after telling him/her my sexual or gender orientation.”
- Acculturative Stress: “Adjusting to America has been difficult for me.”
- Idioms of Distress: Emotional/Somatic (IOD-ES): “When I get angry at something or someone, it takes me a long time to get over it.”
- Idioms of Distress-Suicidal Actions “I have, without anyone’s knowledge, thought of suicide in the past.”
- Nonspecific Minority Stress: “People treat me unfairly because of my ethnicity, sexual, or gender identity.”
- Cultural Sanctions: “My family, culture, or religion is against the idea of suicide.”

News Release

Pediatric and Suicide Prevention Experts Partner to Create Blueprint for Preventing Youth Suicide

The American Academy of Pediatrics and American Foundation for Suicide Prevention outline recommendations for pediatric health clinicians, community members, families, and peers on identifying and supporting children and adolescents at risk for suicide

ITASCA, IL – Rates of attempted suicide and suicidal thoughts among youth have risen in recent years, and suicide is the second leading cause of death among people ages 10-24 in the United States. This trend has been exacerbated by stressors related to the COVID-19 pandemic. The devastating – and preventable – losses in life reveal real-time gaps in the nation's mental health services and disparities in access to treatment.

To address these needs, the American Academy of Pediatrics (AAP) and American Foundation for

For Release:
3/2/2022

Media Contact:
Lisa Black
630-626-6084
lblack@aap.org

Link to access Blueprint: www.aap.org/suicideprevention

What to do when facing a lack of community resources

Many areas lack sufficient access to mental and behavioral health supports. This is a systemic challenge that requires long-term, appropriately resourced solutions.

When mental health care is unavailable, clinicians and office staff can help families consider alternative options such as telehealth services, school-based behavioral health services, or follow-up appointments with the pediatrician until mental health services can be arranged.

Alternative strategies include:

- Safety planning and lethal means safety counseling can be conducted in your practice during the visit to help ensure safety during long wait times for mental health intervention
- Telehealth can be used to increase youth access to mental and behavioral health care
    - Promote telehealth access to all families by using a modality that is mobile-friendly and using multiple languages, interpreters, and assistive technology to facilitate visits
    - Note: Accessibility of telehealth is dependent on the availability of reliable broadband and network access and state laws, which may vary by geographic region. For an overview of state telehealth laws, click here

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

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

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

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

1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

https://suicidesafetyplan.com/forms/

Step 1a: Provide time and space for individual narrative. (Creating cultural safety)

Step 1b: Discuss racial/ethnic identify

Step 1c: Assess for individual and cultural strengths/protective factors (Socioecological perspective)

Step 1d: Proceed to Safety Plan ("Personal Plan")

https://suicidesafetyplan.com/forms/

STANLEY - BROWN SAFETY PLAN

STEP 1: WARNING SIGNS:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

STEP 3: PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION:

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

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

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

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

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

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

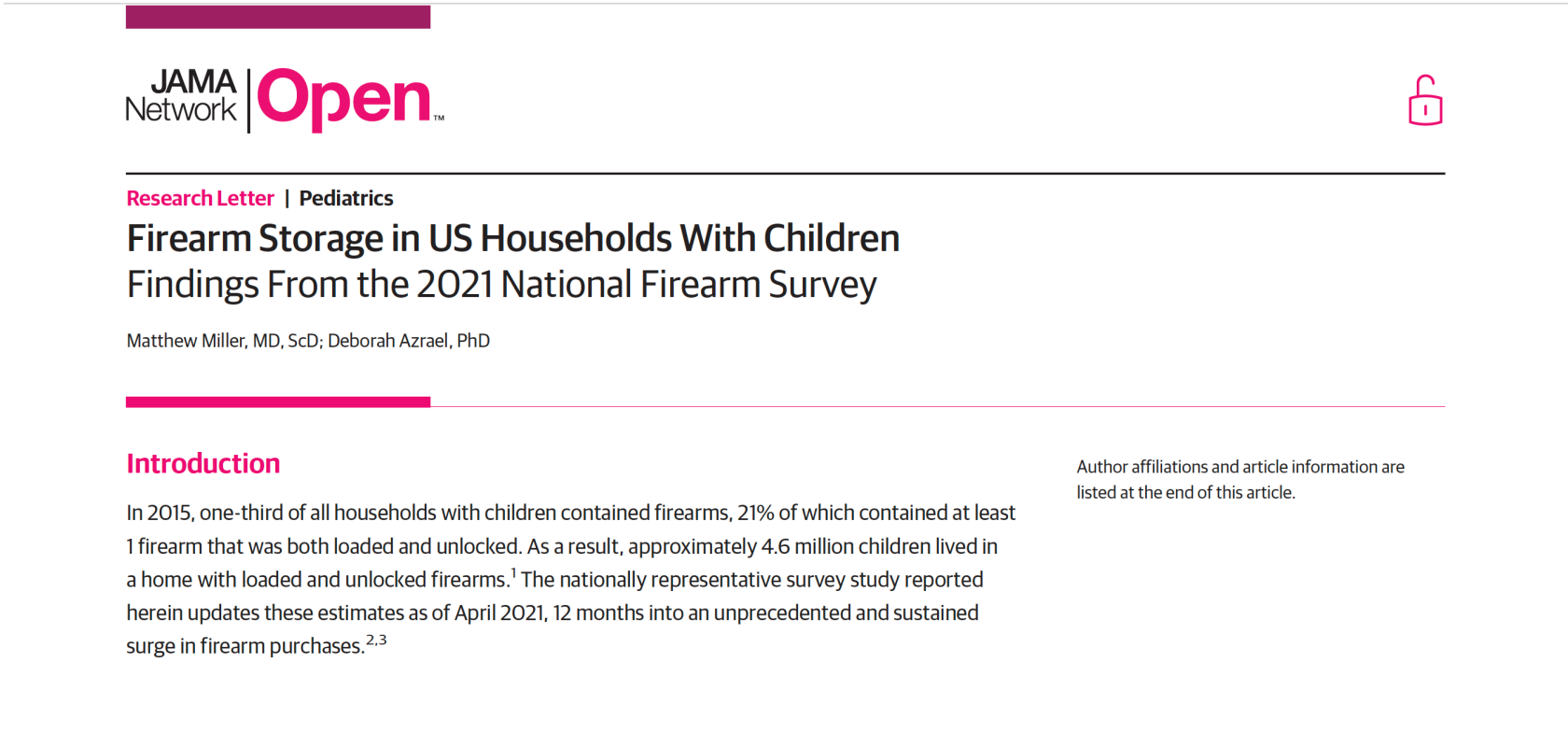
1. _____
2. _____

Stanley-Brown
Safety Planning Intervention

Lethal Means Counseling

- Think about the different methods and how they vary across race/ethnicity, gender and age.
- Use available “decision aid tools” available with parents/caregivers to narrow down methods and strategies for keeping youth safe.

The American Academy of Pediatrics recommends that all firearms in households with children should be unloaded and in locked storage, with ammunition stored separately.



JAMA Network | Open

Research Letter | Pediatrics

Firearm Storage in US Households With Children
Findings From the 2021 National Firearm Survey

Matthew Miller, MD, ScD; Deborah Azrael, PhD

Introduction

In 2015, one-third of all households with children contained firearms, 21% of which contained at least 1 firearm that was both loaded and unlocked. As a result, approximately 4.6 million children lived in a home with loaded and unlocked firearms.[1] The nationally representative survey study reported herein updates these estimates as of April 2021, 12 months into an unprecedented and sustained surge in firearm purchases.[2,3]

Author affiliations and article information are listed at the end of this article.

Decision Aid Tools: Helping Parents/Caregivers

'Lock to Live': development of a firearm storage decision aid to enhance lethal means counselling and prevent suicide

Marian E Betz,[1] Christopher E Knoepke,[2,3] Bonnie Siry,[1] Ashley Clement,[1] Deborah Azrael,[4] Stephanie Ernestus,[5] Daniel D Matlock[3,6,7]

ABSTRACT

Objectives We sought to (1) clarify decision needs among suicidal adults with home firearm access; (2) identify accurate, unbiased and acceptable approaches for content and messaging; and (3) develop a tablet-delivered decision aid for firearm storage options.

Methods Following international standards, we used stakeholder interviews to develop a decision aid for the decision, 'what option(s) to choose to reduce home access to firearms for an adult at risk of suicide'. Participants were adults with personal or family history of suicidal ideation or behaviours, firearm ownership or employment in a firearm range or store, involvement in suicide prevention field, or work as emergency department or other healthcare provider.

Results Through 64 interviews, we created the 'Lock to Live' decision aid, which includes (1) introduction specifying the decision, (2) clarification of preferences and logistics, (3) table of storage options and (4) summary with specific next steps. The final tool had high user acceptability.

Conclusions Should the 'Lock to Live' decision aid prove useful in a pilot feasibility trial and subsequent testing, it could enhance lethal means counselling and help prevent firearm suicide.

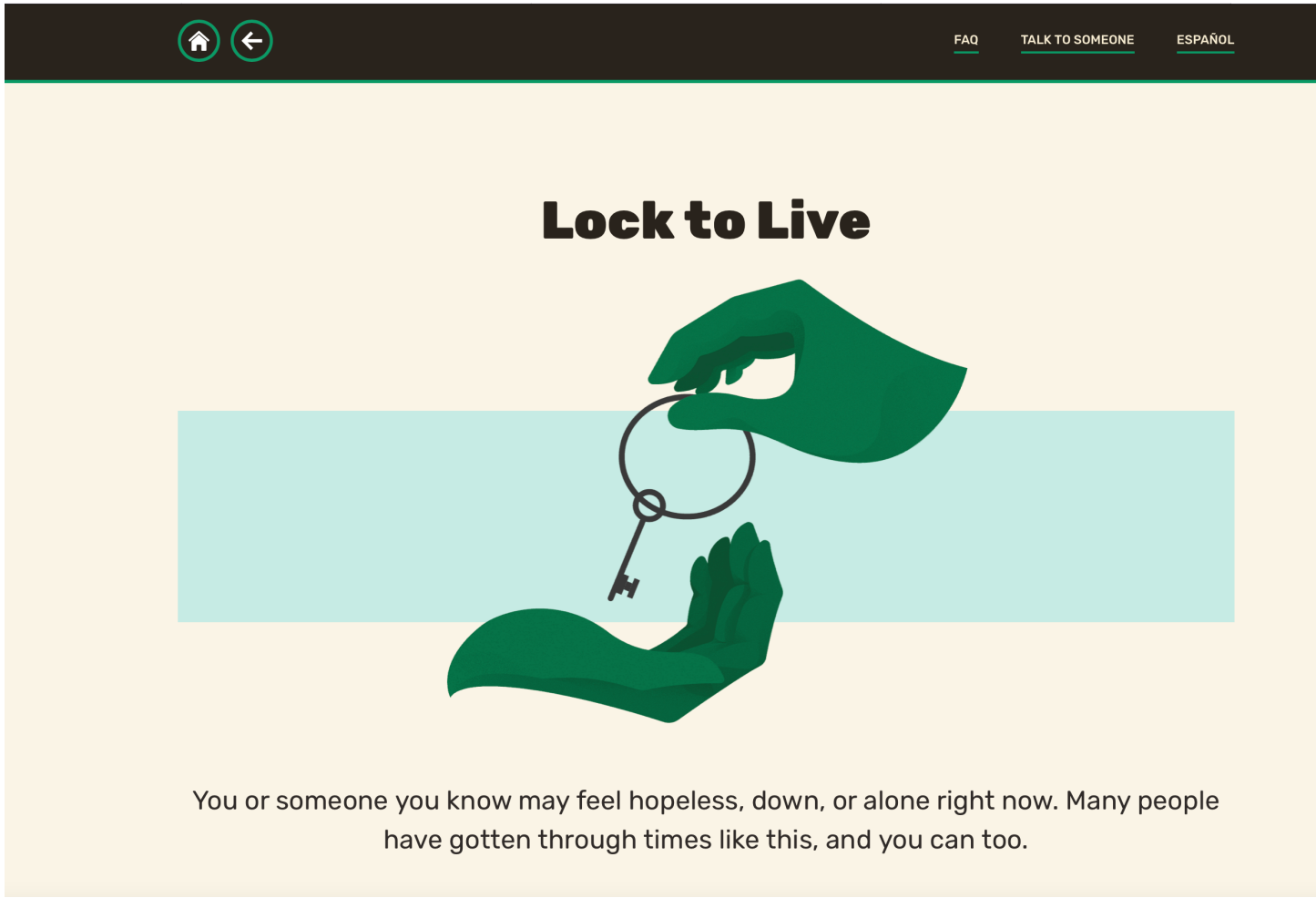
Given both the importance of firearm LMC and impediments in EDs, it is critical to explore ways of increasing counselling feasibility and patient engagement. A potent model is decision aids (DAs): tools that facilitate complicated health-related decisions by identifying the decision to be made, describing risks and benefits of options, assisting the patient in clarifying personal values and activating the patient for decision-making.[16] DAs have been shown to increase patient knowledge, decrease decisional conflict and positively affect patient–provider communication.[17]

Guided by DA theory and development standards, we used a multistakeholder, iterative, user-centred approach to simultaneously (1) clarify decision support needs among ED patients with suicide risk and home firearm access; (2) identify content and messaging approaches which are accurate, unbiased and acceptable to many stakeholders; and (3) develop a tablet-delivered, encounter-based DA describing firearm storage options.

METHODS

Study design and participants

As customary in DA development informed by international standards,[18] our design began with



https://lock2live.org