Responding to Adolescents at Risk of Suicide:
Implications of the Ideation-to-Action Framework

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Though suicide is the second leading cause of death among adolescents, it continues to be difficult to predict. Recent research has led to the development of the ideation-to-action framework, which provides a new conceptualization of suicide risk. The implications of this approach for assessment and intervention in medical settings are discussed.

In 2017, the most recent year data are available, 3,007 Americans aged 10-19 died by suicide, equaling a rate of 7.2 per 100,000 [1]. The magnitude of the adolescent lives lost is disturbing, and it continues an upward trend of adolescent suicide deaths that stretches back more than a decade. Suicide mortality rates among young people in the United States have increased by more than 50% since 2010, a significant spike that followed a period of slow and steady increase dating back to 2000. These national trends have been mirrored in North Carolina as well [2]. Between 1999 and 2017, 1,087 North Carolinians aged 10-19 lost their lives to suicide, making it the second leading cause of death among youth in both the state and the nation. Nationally, North Carolina ranks 37th in youth suicide rate [2]. Thus, youth in our state are neither at increased risk compared to other states, nor have we been immune to the increases in adolescent suicide deaths in recent years. Regardless of the objective data, loss of life from youth suicide and the devastation it inflicts on peers, families, schools, and communities is difficult to quantify (Figure 1).

Challenges of Suicide Screening in Health Care Settings

Despite the tragic outcomes, assessment of suicide risk in health care settings remains relatively rare [3, 4]. In fact, evidence supporting the effectiveness of suicide screening and risk assessment practices is decidedly mixed [5]. Limitations in currently available screening practices include inadequate predictive validity for subsequent suicidal behavior, large numbers of false positive screens, and little substantiation of significant benefits of early detection. These limitations were outlined by conclusions of the US Preventive Services Task Force, which was not able to conclude that the corpus of evidence was robust enough to assess the ratio of benefit to harm for use of systematic suicide screenings, particularly for adolescents [5]. This conclusion was reached despite ample evidence refuting the myth that asking about suicide might actually increase risk.

Though these findings may be surprising and somewhat dismaying, they underlie an issue that has been evident to suicide researchers for a number of years: the predictors of risk for suicidal ideation (ie, self-report of suicidal thoughts) are not adequate to determine who will go on to act upon those thoughts with suicidal behavior (ie, actions performed with some intent to end one's own life). This finding is particularly problematic; estimates have indicated that more than 92% of individuals who reported thinking about suicide did not go on to make an attempt in the subsequent two years [6]. Static risk factors such as gender, age, race/ethnicity, past attempts, adverse childhood events, and family history, as well as dynamic factors such as current diagnosis of a mental illness, low levels of social connectedness, feelings of burdensomeness, and negative major life events may be related to suicidal ideation and behavior. However, none of these factors are particularly predictive of *which* individuals with ideation will make a suicide attempt. Suicidal ideation is innately disturbing itself, but behaving in response to these thoughts is what ultimately leads to the irreparable tragedy of suicide. Consequently, more recent approaches to risk prediction have proposed that the process by which individuals move from thinking about suicide to acting on those thoughts be treated as a unique process that is separate from ideation. This approach is known as the ideation-to-action framework [7].

Ideation-to-Action Framework: A New Approach to Understanding Suicide

Though several models have been proposed to explain the process that occurs between ideation and attempt [8], evidence has not yet been generated that conclusively supports one model over the others. However, these models share the common feature that some additional capacity beyond simply thinking about suicide must be present in

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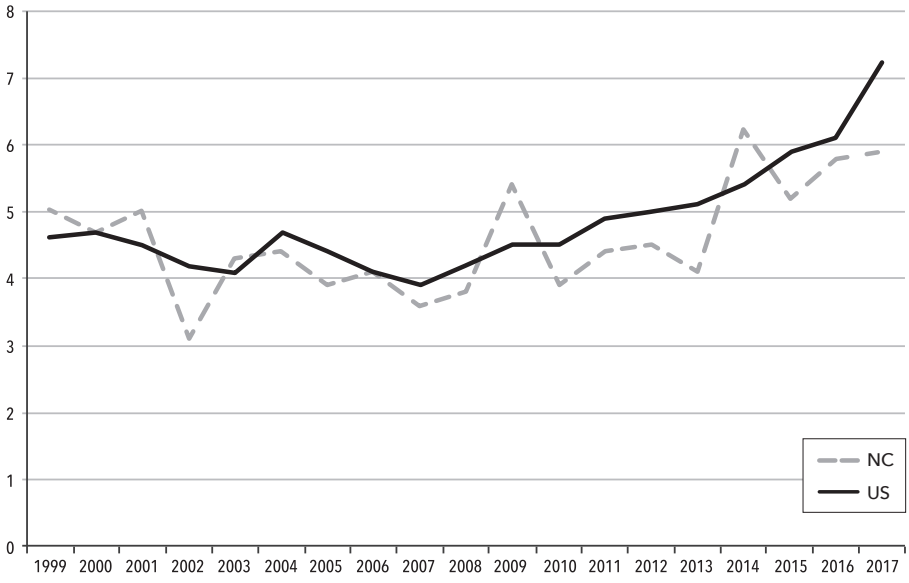
FIGURE 1.
Suicide Rate, Age 10-19 (per 100,000)



Source. Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017. CDC WONDER Online Database website. http://wonder.cdc.gov/ucd-icd10.html. Published December, 2018. Accessed December 23, 2019.

order for an individual to make an attempt. These capacities may be a combination of dispositional factors (eg, impulsivity, pain tolerance, acquired fearlessness of injury and death) or situational (eg, access to means, immediate level of intent), and importantly they appear to ebb and flow in unpredictable ways over time in their capability to provoke a suicide attempt.

Irrespective of the specific mechanisms that engender the capacity for a suicide, divorcing risk of ideation from risk of attempt still can help make sense of otherwise puzzling findings regarding the unpredictable nature of suicide attempts. For example, though it is sometimes assumed that suicide attempts typically result from planful behaviors motivated by strong intent to die, this frequently does not appear to be the case. Instead, many if not most suicide attempts appear to quickly follow thoughts about an attempt. In one study of suicide attempters, nearly half reported that less than 10 minutes passed between the onset of that episode of suicidal thoughts and the actual attempt, and the duration between initial thoughts and the attempt was not related to a trait measure of impulsivity [9]. Thus, while episodes of suicidal ideation may come and go over a period of days, weeks, months, or even years, the transition from ideation to action is frequently quick. This notion is further supported by research that has identified adolescent suicide attempters who reported making no plan before attempting [10].

Additionally, the role of self-reported intent may not be as strongly predictive of behavior as we might presume. Studies have demonstrated that there is significant variability in intent to die among individuals who attempt suicide, and the relationship between intent and the potential lethality of an attempt is tenuous in adolescents [11]. The lethality of a suicide attempt may be more closely related to the means for suicide available to the individual than the individual's intent to die [12]. Taken together, these findings suggest a separate and more complex process that bridges thoughts about suicide and suicide attempts.

Implications for Adolescent Suicide Prevention in Clinical Practice

These recent models of suicide risk warrant both causes for concern with current risk assessment practices and reasons to be optimistic that more effective prevention methods may be on the horizon. Concerns about the lack of predictive power of traditional suicide risk screeners appear to be well founded, and these shortcomings can be explained in large part by their overwhelming tendency to equate ideation risk with attempt risk while ignoring the factors that bridge these states. Many screening and risk assessment models utilize five central factors to estimate risk: presence of associated risk factors such as mental illness, current stressors, or demographic factors; presence of suicidal ideation; whether the individual has developed a suicide plan; whether the individual has engaged in suicide-related behaviors (either past suicidal behaviors or behaviors related to current plans, such as gathering means); and the individual's estimation of intent to carry out an attempt. Frequently, a hierarchical risk structure is either implied or explicitly articulated, in that the presence of more of these factors is equated to higher probabilities of the individual making an attempt.

According to emerging ideation-to-action research, this conclusion is unreliable at best. Instead, risk for suicide

Moran Bates sidebar

attempt appears to be very dynamic. Intent may change from hour to hour or even minute to minute and is at best weakly related to the potential lethality of an attempt, meaning that conclusions about risk level may only be valid for brief periods of time, if at all. Therefore, the reality is that risk hierarchies may do more to allay the anxiety of practitioners than effectively predict the future behavior of at-risk adolescents.

Current practices regarding the detection of and response to suicide risk are severely flawed. However, practitioners who work with adolescents should be prepared to respond to suicide risk regardless of whether standardized screenings or assessments are used; these situations frequently arise on their own. What, then, should providers do when suicidal ideation is encountered? The primary conclusion that can be reached is that rather than attempting to distinguish between high risk and low risk based on traditional predictors, we should instead focus on determining whether risk is imminent or not and respond accordingly. Individuals who express imminent risk (eg, voice immediate intent and/or the inability to keep themselves safe in the immediate future) should be provided with a more intensive level of care immediately, up to and including hospitalization in crisis stabilization units. In North Carolina, these services most frequently are accessed through local mobile crisis management services or referral to emergency departments.

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Individuals who express non-imminent suicide risk (eg, endorse ideation but no immediate intent to act) may not require hospitalization, but still should be taken seriously regardless of the number of risk factors present. In short, detection of any suicide risk should prompt intervention, and recommendations for interventions in medical settings follow.

Responding to Adolescent Suicide Risk in Medical Settings

Interventions intended to reduce risk of suicide death can be classified into two types: those that seek to treat the underlying issues related to suicidal thoughts and behaviors, and those intended to mitigate risk in times of acute crises. The former is largely the domain of specialty mental health care professionals, but the latter can be done effectively by medical providers without a mental health background. In addition to referral for specialty mental health services (particularly to providers practicing cognitive behavioral therapy), two brief interventions are available that are particularly responsive to the dynamic nature of suicide attempt risk. The first involves working with families to reduce the at-risk individual's access to lethal means of suicide. Perhaps the best-known example of this type of lethal means counseling intervention is the Counseling on Access to Lethal Means (CALM) program, which helps clinicians develop a

plan with families to create time and distance between the at-risk adolescent and access to any firearms and dangerous medications [13]. These plans are developed through a conversational style that borrows heavily from motivational interviewing techniques and focuses on voluntary safe storage of these items. Research suggests that parents of at-risk adolescents are very receptive to these conversations and report following through with plans for means reduction [14].

CALM is thought to work through several mechanisms that are consistent with ideation-to-action framework. Firstly, given that suicide crises frequently appear to be brief in duration, reducing or even delaying access to lethal means of suicide might give the adolescent time to reconsider or calm down. Secondly, not all methods of suicide are equally lethal. Death rates in suicide attempts involving firearms are particularly high. If firearms are not available, adolescents who attempt suicide with another method have much higher chances of surviving, an especially important factor given the very high rate of long-term survival among survivors of suicide attempts [15]. Thirdly, individuals who initiate a suicide attempt may change their mind during the attempt, seek intervention immediately after an attempt, or have the attempt interrupted by others. When irreversible methods such as firearms are used, the initiation of the attempt (ie, pulling the trigger) is also usually the tragic conclusion of the attempt; there is no time for intervention or a change of heart.

The second intervention that focuses on mitigating risk during acute crises is the safety planning intervention (SPI) [16]. SPI helps suicidal adolescents to develop coping strategies that can be utilized in a future crisis whenever it occurs. Providers work with at-risk adolescents to identify a) signs of worsening mood or impending crisis; b) internal coping strategies to improve mood; c) social supports or settings that can distract from suicidal urges; d) individuals who can be sought out to help deescalate a crisis; e) contact information for mental health professionals and crisis resources; and f) ways to reduce access to lethal methods of suicide (reinforcing the goals of CALM). These coping strategies are recorded on a worksheet in order of priority and copies are given to the adolescent, providing concrete plans for preventing a crisis and staying safe should one occur. More recently, smartphone apps have been developed to facilitate SPI use.

Conclusions

Though accurate and reliable methods for predicting adolescent suicide remain elusive, the ideation-to-action framework provides strong rationale for assessment and intervention strategies that focus on mitigating risk during acute suicide crises in addition to traditional treatment approaches. Medical providers are encouraged to incorporate these practices.

For more information on CALM and access to free online training, visit https://www.sprc.org/resources-programs/calm-counseling-access-lethal-means. For more information on SPI and access to supporting materials, visit http://www.suicidesafetyplan.com/. NCMJ

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