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Article

Help Seeking and Engagement for Young Men Aged 18 to 30 Years in Suicidal Crisis: a Prospective Cohort Study

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Abstract: Due to the continuing high suicide rates among young men, there is a need to understand help-seeking behaviour and engagement with tailored suicide prevention interventions. The aim of this study was to explore help-seeking behaviour and engagement for young men aged 18 to 30 years who attended a therapeutic centre for men in a suicidal crisis. In this prospective cohort study, data were collected from 546 men who were referred into a community-based therapeutic service in North West England. Of the 546 men, 337 (52%) received therapy; 161 (48%) were aged between 18 and 30 years (mean age 24 years, SD=3.4). One third (n=54; 34%) of the men were seen within 48 hours of their referral. Analyses included baseline differences, symptom trajectories for the CORE-34 Clinical Outcome Measure (CORE-OM) and engagement with the therapy. For the CORE 34 there was a clinically significant reduction in mean scores between assessment and discharge ($p<0.001$), with all outcomes demonstrating a large effect size. Future research needs to assess the long-term effects of help-seeking using a brief psychological intervention for young men in order to understand whether the effects of the therapy are sustainable over a period of time following discharge from the service.

Keywords: suicide; men; help-seeking; engagement; community-based intervention

1. Introduction

With over 800,000 people dying by suicide each year worldwide [1], suicide remains a significant, yet preventable public health risk. Suicide is a leading cause of mortality for young men in most high and middle-income countries [2]. Over the past decade, the rate of suicide among young men has statistically increased by 27.9% from 6.1 deaths per 100,000 males to 7.8 deaths per 100,000 [3]. For young males in England, hospital admissions because of self-harm have also significantly increased during the same period by 6.8% (from 196.8 admissions per 100,000 in 2012 to 2013, to 210.2 admissions per 100,000 in 2018 to 2019) [3]. The reasons for a change in the

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national rate of suicide are complex and will rarely be due to one factor alone. Among young people for example, adverse childhood experiences, academic pressures, bereavement, self-harm, and exposure to harmful online content, will all be important [4].

Suicide risk factors specific to young men include psychiatric illness, substance misuse, ethnic origin, lower socio economic status, rural residence, and single marital status [2, 5]. Population-level factors include unemployment, social deprivation, and media reporting of suicide [2]. To date, research and policy concerning young male suicide risk has tended to focus on the male tendency to conceal mental distress as the impediment to intervention. While young men should be educated regarding known risk factors for suicide, it should be noted that these risk factors may occur in varying levels and that suicidal behaviour is not limited to those in identified high-risk groups [6]. From a preventive standpoint, due to high suicide rates among young men, there is a need to understand more of the complexity that places men in particular at risk [7]. In particular, there is a need to understand more of the psychological characteristics and mechanisms, such as entrapment, helplessness, social isolation, self-esteem, that regulate the dynamics of suicide in young individuals [8-13]. Previous studies have highlighted a dynamic model for how young men were entrapped in what they may have experienced [14]. Others have noted that the suicidal act was understood as a "triggered event" related to a previous significant event close in time, such as a breakup with a girlfriend or a separation from family [4, 14]. However, these studies were retrospective and relied on third party information from those bereaved by suicide and to date there is limited research on men who are in contact with services for suicidal ideation [15].

The main focus in suicide prevention strategies in many countries is the identification and treatment of mental disorder, depression in particular [16]. However, there is growing evidence that many suicides are not proceeded by symptoms of serious mental disorder [17-18]. Furthermore, a major challenge for suicide prevention is that most people who take their own lives are not in contact with mental health services at the time of their death and often do not seek help from any health professionals at the time they actually make the decision to end their life [17-18]. Due to high suicide rates and low rates of help-seeking in suicidal crises, young men, in particular, are of great concern [15, 19-20]. From a preventive perspective, there is an alarming call to go beyond the medical model and explore the signs that might indicate danger of suicide in the near term, including resistance against help-seeking among young men [21-23]. Psychological autopsy studies have highlighted the association of mental health disorders for many youth suicides however they also report low rates of contact with mental health services prior to death [24-25]. Young men have been reported to seek help from primary or specialist healthcare services less than other population groups prior to suicide [20, 26]. The reluctance to seek help when faced with symptoms of emotional or psychological distress has been highlighted in the wider literature [15, 27].

In terms of emotional difficulties and help-seeking, men seem to have higher thresholds than women; particularly when focusing on gender roles [28]. Previous research has highlighted that many young men who attempted to hide their difficulties and emotions from family and friends, due to not adhering to their expected gender role of masculinity [29]. Additionally, the complexities in men's mental health help-seeking emphasise some males who are seemingly in care are lost to suicide [30]. For example, population-based analyses of health care contacts among Canadian suicide decedents in Toronto reported that while 10% of men (n=200) were not connected to any

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form of medical care in the year prior to their suicide, over 60% (n = 1792) had accessed professional mental health care in the year before their death [31]. Thus highlighting the inadequacies of care and the dire consequences of those shortcomings [32-33]. Men with suicidal histories described fragmented mental health care pathways that were beleaguered with negative experiences of service providers and health care systems to the extent that most participants' service use was involuntary [32]. Men reported discomfort disclosing emotional distress to therapists, and sometimes when desperation prompted their self-disclosures about suicidality, they suggested judgement, mislabelling and an underestimation of their needs. This lack of interest and decreased therapeutic alliance, tended to influence men to discontinue therapy and/or opt to self-manage their mental illness [32]. However, over time a generational change and shifting values have been noted, as some men whose culturally informed 'strength-based' masculine ideals to disclose mental illness, vulnerability and the acceptance of help have changed [33-35]. Other studies have operationalised such ideas as affirming men's help-seeking as courageous and strength-based in tailoring male suicide prevention programs accordingly [2].

Previous findings suggest that existing suicide prevention services are incompatible to the needs and preferences of men who are experiencing suicidal distress [26, 36-38]. While significant challenges have remained for identifying men at risk of suicide, the importance of building effectual services, for addressing men's self-silencing, enhancing awareness of their own risk status is vital for reducing male suicide. Moreover, the limits of current services confirm the need to better diversify and tailor services to bridge men's health inequities amid norming men's mental health help-seeking [39-40]; particularly, within community settings [6]. Community-based suicide prevention initiatives can enhance the potential of providing support to young men in crisis, through specific provisions for developing openness in communication and responsiveness, and improved education about suicide risk. Recent research has suggested that men particularly have the need to receive support from a trusted individual, preferably in an informal setting [41]. Facilitating rapid access to a community-based centre could overcome problems associated with poor help-seeking behaviours and communication of suicidal distress among young men. It would also offer the desired informal setting, which would be a much-needed lifeline to men in suicidal crisis that cannot be provided by conventional primary care, or emergency departments where it has been reported that young men may have felt judged and not listened to prior to suicide. Brief psychological interventions have been shown to be effective in the prevention of suicide [42-43]. While some have reported promising findings such as the Atlas wellbeing pilot, which reported positive improvements in psychological wellbeing including anxious mood and stress [44], there remains a paucity of evaluative studies. Subsequently, a knowledge gap between what researchers and practitioners reliably know works in suicide prevention interventions for men in a community setting exists.

This paper aimed to evaluate the effectiveness of an innovative suicidal crisis centre for men and compare the differences between help-seeking, engagement and outcomes for younger and older men. Uniquely this service, the first of its kind in the UK, delivers a clinical intervention within a community setting for men in suicidal crisis.

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2. Materials and Methods

Participants

This is a prospective cohort study of young men experiencing a suicidal crisis who had been referred to the James' Place Service between 1st August 2018 to 31st July 2020 (n=546). Referrals came from Emergency Departments (ED), Primary Care, Universities, or self-referrals. Ethical approval was granted by the Liverpool John Moores University (Reference: 19/NSP/057) on 3rd December 2018 and written consent was gained from men using the service at their initial welcome assessment at the James Place Service..

The James' Place model

James' Place is a community-based service delivering a clinical intervention for men in crisis based in North West England. Public and patient involvement has been enbedded within the service since inception. For more details please see the James Place report [43]. James' Place delivers an intervention based on three theoretical models: Interpersonal Theory of Suicide [45], The Collaborative Assessment and Management of Suicidality [46] and The Integrated Motivational-Volitional Theory of Suicide [47-48]. All three approaches include working alongside the suicidal person to co-produce effective suicide prevention strategies and safety planning [49]. Partnerships across the city enabled men to be referred to James' Place from ED, Primary Care, local universities or via self-referrals. Clients were offered the James' Place model that included approximately 10 sessions of therapy; however, the number fluctuated dependent on each client's individual needs. Experienced therapists who were trained to deliver the James Place model provided sessions. More detailed outcomes for the service re available in two published reports [43, 50].

CORE-34 Clinical Outcome Measure (CORE-OM).

The CORE-OM is a client self-report questionnaire, which is administered before and after therapy. The client was asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point Likert scale ranging from 'not at all' to 'most of the time'. The 34 items cover four dimensions; subjective well-being, problems/symptoms, life functioning, and risk/harm, producing an overall score called the global distress (GD) score. Comparison of the pre and post therapy scores offer a measure of 'outcome' (i.e. whether or not the clients level of distress has changed, and by how much).

CORE-OM data are routinely collected by psychological therapy services [51]. Recent research has shown that participants find the CORE-OM useful in assessing psychological distress and progress within treatment [52]. The measure shows good reliability and convergent validity with other measures used in psychiatric or psychological settings [53-54]. Connell and colleagues [55] published benchmark information and suggested a GD score equivalent to a mean of 10 or above was an appropriate clinical cut-off, demonstrating a clinically significant change, while a change of greater than or equal to 5 was considered reliable.

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Assessment of psychological, motivational and volitional factors

A range of psychological, motivational and volitional factors that play a role in suicidality were assessed. These were informed by leading evidence based models of suicidal behaviour, which the JPM is based upon. In addition, the referrer to the service and the precipitating factors to the suicidal crisis were recorded.

Feedback was sought from men once discharged from the service via an anonymised questionnaire. It should be noted that some of the secondary outcomes are subjective due to referrer or therapist interpretation. Additionally, the men often completed the CORE-OM in the presence of the therapist which may have caused further interpretation bias. However, the sessions at James' Place provided an environment where clients felt comfortable and at ease, reducing any sense of pressure. With regards to the secondary outcomes, therapists were trained on recognising the outcomes to reduce subjectivity and recorded this information at the time of consultation thus reducing recall bias.

Data analysis

Our sample size was predetermined based on the number of men using the service in the first two years since opening. Data was analysed using SPSS 26 [56]. To examine client outcomes repeated measures general linear models were used to compare pre- and post - treatment data. Magnitude of effect sizes (r) were established using the Cohen criteria for r of 0.1 = small effect, 0.3 = medium effect and 0.5 large effect.

Descriptive statistics were carried out to illustrate the socio demographics of the sample. Manovas were conducted to establish differences between groups on the core outcome measures at assessment and discharge. Young men were defined as 18-30 years old, and the older men category relates to men 31 years old and over.

For referrals, these were coded as Secondary Care (Mental Health Practitioners, Crisis and Urgent Care, A&E), Primary Care (GPs, Nurses, support workers, IAPT, Occupational Health, and Student wellbeing services). Self-referrals (individual/family member), and Other (voluntary organisations, and charities).

Clinical records from the service were available for the entire sample. However, the records only captured entries made in clinical records; unrecorded clinical activity or missing information from referral documents therefore unavailable. For the purposes of this study, only the presence of each factor within each client's clinical records was used for the analysis. It is possible this strategy may have led to underestimation of some factors, for example sexual orientation. Where clients are noted to have completed the intervention, this indicates that the therapy was complete, but does not necessarily indicate that the discharge Core measure was complete.

3. Results

Between 1st August 2018 and 31st July 2020, James' Place received 546 referrals from ED, Primary Care, Universities or self-referrals. Of those, 417 (76%) attended for a welcome assessment

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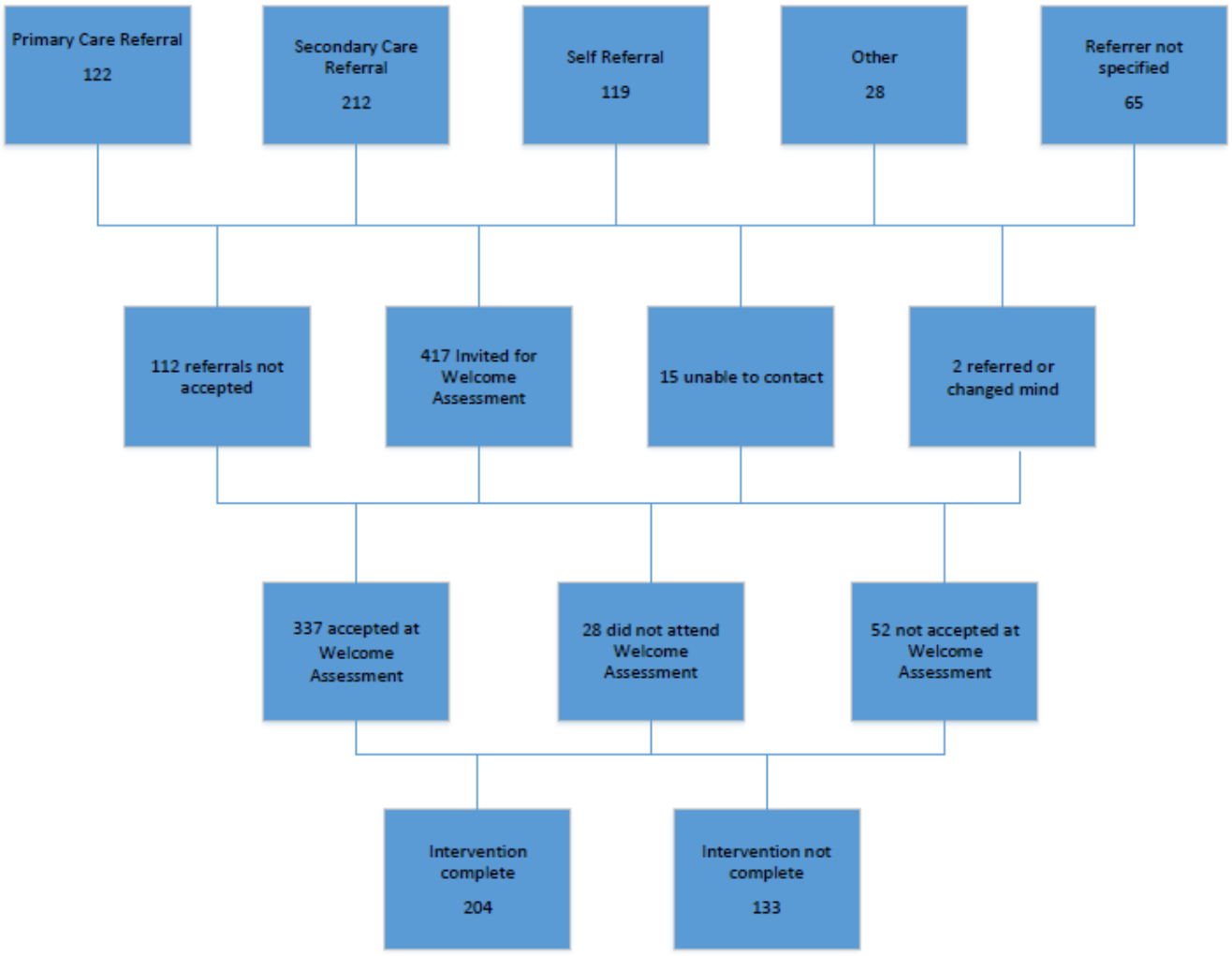
and 337 (81%) went on to engage in therapy (see Figure 1). The mean age was 34 years (range 18-66 years). Of the 337 men, 161 (48%) were aged between 18 and 30 years (mean age 24 years, SD=3.4). The speed with which men were first seen by the service was similar for both younger and older men (Table 1). There were no significant differences on core measures related to the variation in the speed of when men were first seen at the service ($p>.05$).

Figure 1. Flow diagram of the referral for men using James Place in Years 1 and 2



Most of the young men were white British (73%), single (63%), living with family (20%) and employed (34%). One third (34%) of the young men were seen within 48 hours of their referral. Younger men were less exposed to suicidality within their lives compared to older men (30% v 39%). Both, younger and older men, had similar histories of suicide attempts or self-harm (75% v 74%). Baseline characteristics are given in Table 2. In terms of ethnicity, relationship status, sexual orientation, employment status and the CORE 34 clinical outcomes measure, no significant differences were noted for both groups.

Table 1. Variation in speed with which men were first seen by the James' Place service

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Variation	18-30 (N = 161)	31+ (N=176)
Welcome Assessment Within 48 hours	55 (67%)	80 (70%)
Later due to client choice	11 (13%)	15 (13%)
Later due to therapist availability	7 (9%)	11 (10%)
Reason Unknown	9 (11%)	8 (7%)
Unknown variation status*	79 (49%)	62 (35%)

*this data was not collected in year one.

CORE-34 Clinical Outcome Data (CORE-OM).

For all subscales of the CORE 34 there was a statistically significant reduction in mean scores between assessment (n=322) and discharge (n=129), (F (1) = 571.75, p=<.0001, partial eta squared = .80) demonstrating a large effect size (Table 3). There was a clinically significant change for 39% of men using the service, with mean scores reducing by 10 or above, indicating a level of distress classed as healthy. Two percent of men demonstrated a reliable change with a reduction of five or more in the clinical distress scores following therapy and 2% showed no clinical change. No significant differences were reported between younger and older men on distress scores (F = (2, 140) 1.55, p>.05), either at initial assessment (p>.05) or discharge (p>.05) but younger men showed lower levels of distress at initial assessment and lower levels of wellness than older men at discharge.

Table 2. Demographics characteristics of the men help-seeking at James' Place

Demographic	18-30 years N=161 (%)	31+ N=176 (%)	Significance against Core outcomes
Ethnicity			p=.80
White British	116 (72)	140 (79)	
Other	26 (16)	10 (6)	
Missing	19 (11)	26 (14)	
Relationship Status			p=.84
Single	101 (63)	66 (38)	
Married	0 (0)	36 (20)	
In a relationship	10 (6)	10 (6)	
Divorced	0 (0)	6 (3)	

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Separated	1 (1)	12 (7)	
Widowed	0 (0)	1 (1)	
Missing	49 (30)	45 (25)	
Sexual Orientation			p=.32
Heterosexual	35 (83%)	35 (81%)	
Homosexual	5 (12%)	7 (4%)	
Bisexual	2 (5%)	1 (1%)	
Missing	119	133	
Employment Status			p=.94
Employed	54 (34%)	73 (42%)	
Unemployed	41 (26%)	50 (28%)	
Students	33 (21%)	14 (8%)	
Missing	33	39	

However, it is worth noting that the mean score for all age groups fell within the severe distress category of the Core OM at assessment and mild or healthy levels at discharge. There was no discharge score for 57% of the men who were engaged in the service due to some not attending their final sessions and others not completing the questionnaire following their final session.

Table 3. Descriptive data for Core OM measures by age group

CORE 34 measure	**18-30 Mean**	**18-30 SD**	**31+ Mean**	**31+ SD**
Initial Distress (N=322)	85.30	17.17	87.47	18.34
Discharge Distress (N=129)	37.61	22.09	32.21	23.33

Help-Seeking for men in suicidal crisis

Table four highlights the types of services men were referred from prior to attending at James' Place. The majority of referrals came from secondary (37%) and primary care (23%). The proportion of men referred from each type of service does not differ by age (p>.05). No significant differences were reported between younger and older men who attended the welcome assessment or not (p>.05).

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Precipitating factors related to the current suicidal crisis for the men help-seeking were recorded by the referrer or James' Place for men who were self-referring (see Appendix A: Supplementary Table A). For young men the most commonly reported factors were relationship breakdown (n=43), family problems (n=34), university (n=24), work (n=23), bereavement (n=21) and debt (n=18). Older men had similar or higher levels of precipitating factors than younger men for all except university stress (15% v 1%). There was no relationship between the precipitating factors and the levels of general distress found at initial assessment (p>.05). There were no significant differences in general distress between those with and without each precipitating factor (p>.05) at initial or discharge assessment, and no significant relationship between any of the precipitating factors and distress scores (p>.05).

The psychological factors significantly affecting older men compared to younger men were entrapment (46% v 62%; p<.05), defeat (33% v 52%; p<.01), not engaging in new goals (38% v 47%; p<.05) and positive attitudes towards suicide (14% v 18%; p<.001). Both younger and older men were commonly affected by rumination (77% v 78%), past suicide attempts or self-harm (75% v 74%), thwarted belongingness (71% v 71), humiliation (51% v 67%) and impulsivity (44% v 51%) (see Appendix B: Supplementary Table B).

Engagement with therapy

For both younger and younger men, the mean number of sessions engaged with therapy was six, ranging between 1-18 sessions. Younger men completed the full intervention more compared to older men (64% v 59%). However, there were no significant differences (p>.05). Younger men were less likely to be referred onward to another service (7% v 15%). Both groups were most commonly referred to a psychological talking therapy for men and older men were also referred to addiction and debt services.

Table 4. The types of services referring into the James' Place service by age group of men

Referrer	**18-30 (N = 161)**	**31+ (N=176)**
Secondary Care	57 (35%)	66 (38%)
Primary Care	42 (26%)	35 (20%)
Self-Referral	28 (17%)	45 (26%)
Other	7 (4%)	12 (7%)
Not specified	27 (17%)	18 (10%)

Note: p>.05

4. Discussion

Main findings

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To our knowledge, this is the first study exploring help-seeking and engagement by young men in a suicidal crisis. Attendance at an innovative targeted community-based therapeutic service, showed a significant reduction in general distress from assessment to discharge was found. There were no significant differences in the help-seeking behaviours, engagement or therapeutic effectiveness of the model between younger and older men. In addition, the findings relating to the psychological, motivational and volitional factors offer further support for the utility of the IMV model [47, 48], CAMS [46] and Joiner's [45] model for understanding suicidal behaviour. Young men commonly reported many of the key factors in these models at the time of their suicidal crisis (e.g. feelings of defeat, entrapment, thwarted belongingness, hopelessness, humiliation, social isolation and experiences of rumination). With regard to precipitating factors of the suicidal crisis, our research supports that social aspects which increase suicide risk, particularly for young men, such as relationship breakdown and family problems [2, 57, 58, 59, 60], being the most common factors within our sample. Both groups of men engaged with therapy at similar levels and on average attend for six sessions (range 0-18). Younger men were less likely to be referred onward to another service that men over 30 years. Overall, the study has demonstrated the benefits of a rapid access tailored intervention for young men in suicidal crisis.

Strengths and limitations

This research has a number of key strengths, with James' Place being the first community based therapeutic suicide prevention centre in the UK. Previous studies [4,8-13] have been typically retrospective and included information from third parties such as bereaved family members; this quantitative prospective study accessed information about young men at the time of their suicidal crisis. It's novel and timely findings can inform future service implementation to reach a male population group that is at high risk of suicide [41] and who are less likely to seek help [15]; thus filling an important gap in service provision that traditional care pathways are not always able to reach.

A further strength of this study is the light it sheds on the specific precipitating factors leading young men into a suicidal crisis. The present findings point to the importance of informing/educating wider stakeholders such as the general public, work places, military services, schools/ universities, as well as GPs, about community based services that can help to reduce suicidal thoughts and behaviour in men. Similar to previous studies [4,7,14,23], the findings emphasise that help is required that goes beyond the medical model as many of the reported factors that led to the suicidal crisis in this group of young men were relationship or family breakdowns, university stress and debt. One out of five of the presenting young men at the service were students from local universities; thus highlighting the risk of this vulnerable at-risk population and the need for tailored interventions within higher education institutions [4].

However, these findings should be interpreted in the context of some methodological limitations. The first issue is that of missing data. Whilst this is to be expected due to attrition and establishing processes in the first few years of running a new service, it has been a valuable learning point for improving the service going forward. Having monitoring and evaluation built into the service from the start has enabled timely evidence and data to be fed back. This had led to the

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implementation of clinical data systems; thus providing evidence for the need of funding a costly resource to improve data collection.

With regard to sampling, it is important to note that only records for men who were seen by the service were sampled, therefore the results may not reflect the information for men who did not have contact with the service who may also have been in suicidal crisis. Thus, it is difficult to draw firm aetiological conclusions from this data. This, however, was a deliberate decision in the design phase of this study, as one of the main aims was to examine the pilot stage of feasibility of the service for younger and older men. This was to ensure that the relevant population of men were being reached and referred into the service, and that the service being provided was efficient and safe for men in helping to reduce their suicidal distress. Due to the significant reduction in clinical risk for most of the men of all ages who used the service, we think these findings are even more striking.

This study was conducted in a service in the North-West of England. Therefore, care must be taken when attempting to generalise these findings to other geographical regions. This region is reported to have the highest rate of suicides in the UK [3] which may have influenced the study findings when comparing to regions where the suicide rate is much lower. The higher rates of suicide may be reflective of the health inequalities reported by the Public Health England [PHE] report [61]. The life expectancy across this region is lower compared to that of most of England; thus increasing the importance of such interventions. Previous research has demonstrated that the provision of community-based services for those in suicidal distress is lacking [26, 36-38]. The findings of the current study support that this type of service provision within a community setting can play a significant role in reducing suicidality for men.

5. Conclusions

Our results support the use of the James' Place model for men in suicidal distress to aid in potentially preventing suicides in this high-risk group of the population and highlights the heightened distress among university students. A move away from the traditional medical model and the implementation of community-based tailored crisis services for men should be an essential part of any suicide prevention strategy. Future research needs to assess the long-term effects of the model for young men in order to understand whether the effects of the therapy are sustainable over a period of time following discharge from the service.

Author Contributions: Substantial contributions to the conception or design of the work (PS, JC, and JB); acquisition of the data (PS, JC, CH and JB); data extraction (PS, JC, and JB); statistical analyses (JC); interpretation of the data (all authors); drafting the work (PS, CH and JC); revising it critically for important intellectual content (all authors); final approval of the version to be published (all authors); agreement to be accountable for all aspects of the work (all authors). The corresponding author attests that all listed authors meet authorship criteria and that no others meeting the criteria have been omitted. PS and JB act as guarantors.

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Appendix A

Supplementary Table A.

Appendix B

Supplementary Table B.

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Appendix A

Table 4 – Precipitating factors to the suicidal crisis

Precipitating factor	18-30 (N = 161)	31+ (N=176)	Significance against Core measure
Relationship breakdown	43	40	.13
Debt & Financial issues	18	38	.40
Family problems	34	45	.16
University Stress	24	2	.65
Work stress	23	32	.36
Bereavement	21	34	.07
Mental health	11	11	.41
Drug Misuse	10	9	.45
Alcohol misuse	10	12	.81
Victim of past abuse/trauma	9	27	.33
Legal Problems	6	9	.20
Perpetrator of a crime	5	3	.22
Gambling	3	5	.91
Housing issues	5	7	.18
Physical health	5	14	.48
Victim of bullying	4	4	.19
Sexuality	5	3	.12
Victim of crime	2	5	.83
Bereavement by suicide	3	7	.99
Relationship problems	4	9	.78
Concerns about others health	2	0	.58
Related to Covid-19/lockdown	2	6	.46
Caring responsibilities	0	3	.70
Other	0	2	

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Appendix B: Table 5. IMV Model factors

IMV Model factor	18-30 (N = 161)	31+ (N=176)	Significance against Core
Defeat	47 (33%)	82 (52%)	.01*
At discharge	9 (6%)	14 (8%)	.90
Hopelessness	16 (11%)	15 (10%)	.98
At discharge	1 (1%)	0	.96
Humiliation	73 (51%)	105 (67%)	.64
At discharge	12 (8%)	28 (18%)	.76
Entrapment	65 (46%)	97 (62%)	.02*
At discharge	19 (14%)	26 (17%)	.01*
Social problem solving	31 (22%)	43 (27%)	.61
At discharge	27 (19%)	48 (31%)	.71
Coping	27 (19%)	38 (24%)	.86
At discharge	70 (49%)	80 (51%)	.48
Memory Biases	54 (38%)	79 (50%)	.07
Rumination	110 (77%)	123 (78%)	.82
At discharge	45 (32%)	63 (40%)	.44
Thwarted Belongingness	101 (71%)	111 (71%)	.40
At discharge	40 (28%)	47 (30%)	.16
Burdensomeness	67 (47%)	77 (49%)	.74
At discharge	0	0	.06
Absence of positive future thinking	66 (47%)	87 (44%)	.41
At discharge	11 (8%)	23 (15%)	.03*
Unrealistic goals	20 (14%)	21 (14%)	.79
At discharge	12 (9%)	9 (6%)	.12
Not engaging in new goals	53 (38%)	73 (47%)	.02*
At discharge	19 (14%)	27 (18%)	.33
Social norms	7 (5%)	14 (9%)	.73
Resilience	20 (14%)	38 (25%)	.82
At discharge	43 (31%)	64 (42%)	.21
Social support	66 (47%)	82 (53%)	.12
At discharge	47 (33%)	69 (45%)	.02*
Social isolation	12 (9%)	6 (4%)	.69
Positive attitudes towards suicide	19 (14%)	28 (18%)	.001*
Suicide plan	18 (13%)	14 (9%)	.45
At discharge	1 (1%)	4 (3%)	.09
Exposure to suicidality	42 (30%)	60 (39%)	.91
Impulsivity	62 (44%)	79 (51%)	.95
Pain tolerance	12 (9%)	23 (15%)	.47
Fearlessness of death	18 (13%)	30 (20%)	.07
Imagery of death/suicide	50 (36%)	53 (34%)	.73
At discharge	12 (9%)	16 (10%)	.71

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Past suicide attempt or self-harm	113 (75%)	121 (74%)	.35

*p<.05