- States of Despair Briefing-8/22/18
- Richard McKeon Ph.D.Chief, Suicide Prevention Branch
- SAMHSA

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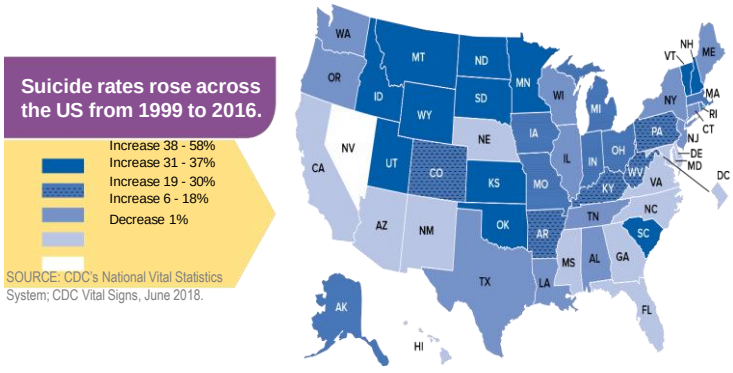
45K Nearly 45,000 lives lost to suicide in 2016.

↑**30%** Suicide rates went up more than 30% in half of states since 1999.

RESULTS More than half of people who died by suicide did not have a known mental health condition.

PROBLEM SUICIDE RATES INCREASED IN ALMOST EVERY STATE.



Leading causes of death for selected age groups – United States, 2016

Rank	10-14 years	15-19 years	20-29 years	30-39 years	40-49 years	50-59 years
1	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Malignant Neoplasms
2	**Suicide**	**Suicide**	**Suicide**	**Suicide**	Malignant Neoplasms	Heart Disease
3	Malignant Neoplasms	Homicide	Homicide	Malignant Neoplasms	Heart Disease	Unintentional Injuries
4	Homicide	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	**Suicide**	Liver Disease
5	Congenital Malformations	Heart Disease	Heart Disease	Homicide	Liver Disease	Chronic Lower Respiratory Ds
6	Heart Disease	Congenital Malformations	Diabetes Mellitus	Liver Disease	Diabetes Mellitus	Diabetes Mellitus
7	Chronic Lower Respiratory Ds	Chronic Lower Respiratory Ds	Congenital Malformations	Diabetes Mellitus	Cerebro-Vascular	**Suicide**
8	Cerebro-Vascular	Cerebro-Vascular	Complicated pregnancy	Cerebro-Vascular	Homicide	Cerebro-Vascular

Source: CDC vital statistics

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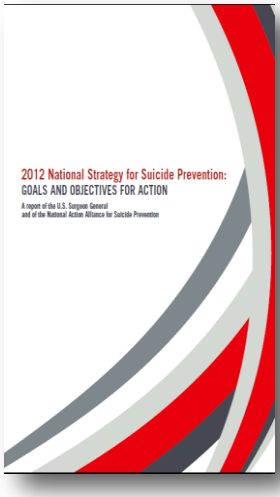
National Strategy for Suicide Prevention



- Developed by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention
- The National Strategy for Suicide Prevention (NSSP) is a comprehensive , multi-sectoral strategy to reduce suicide in America.
- Details 13 goals and 60 objectives for reducing suicide over 10 years, including:
  - Integrating suicide prevention into health care policies
  - Encouraging transformation of health care systems to prevent suicide
  - Changing the way the public talks about suicide and suicide prevention
  - Improving the quality of data on suicidal behaviors to develop increasingly effective prevention efforts

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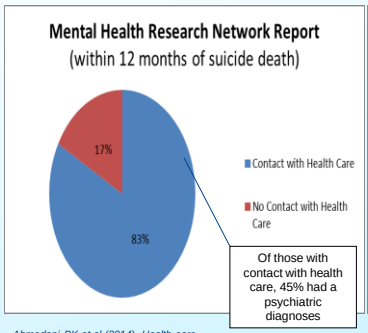
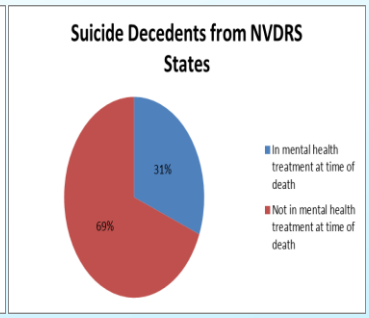
You can't fix what you can't measure….

Perhaps a third of all suicide decedents accessed care prior to death, but few U.S. health care systems track suicide outcomes.





Ahmedani BK et al (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, online Feb 25. DOI: 10.1007/s11606-014-2767-3.

Karch, DL, Logan, J, McDaniel, D, Parks, S, Patel, N, & Centers for Disease Control and Prevention (CDC). (2012). Surveillance for violent deaths—national violent death reporting system, 16 states, 2009. Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, DC: 2002), 61(6), 1-43.

NIH National Institute of Mental Health

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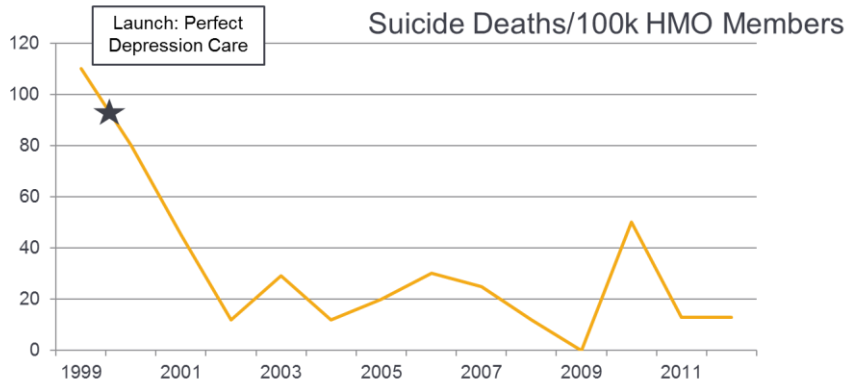
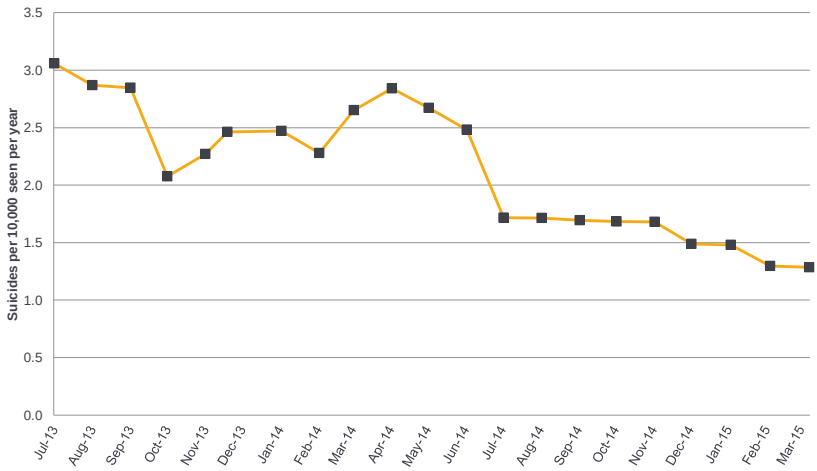
A System-Wide Approach Saved Lives: Henry Ford Health System



8 ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE

Zero Suicide at Centerstone: Results

Annual Suicides per 10,000 Clients Seen (Rolling 12 months)



9 ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE

The Garrett Lee Smith (GLS) Suicide Prevention National Outcomes Evaluation is supported through contract no. HHSS283201 2000071/HHSS283420002T (reference no. 283-12-0702) awarded to ICF International by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

ICF INTERNATIONAL

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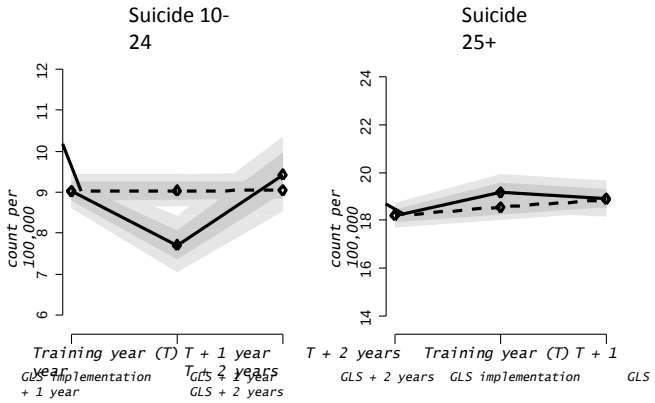
THE IMPACT OF GLS SUICIDE PREVENTION PROGRAM ON YOUTH SUICIDAL BEHAVIOR

Lucas Godoy Garraza (ICF International); Christine Walrath (ICF International); David Goldston (Duke CSSPI); Hailey Reid (ICF International), Richard McKeon (SAMHSA)

Results: Difference in Suicide Mortality



Solid lines represent the estimated outcome trajectory following GLS training implementation. Dashed lines represent the estimated outcome trajectory during the same period had GLS not been implemented. 90% and 50% confidence intervals around the trajectory are represented by dark gray and light gray, respectively.

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Improving Post Discharge Safety

- The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) and the SAFE-VET evaluation demonstrated reduction in suicidal behavior for suicidal people discharged from EDs using telephonic follow up.
- DOD study of follow up using text showed similarly positive results.
- SAMHSA evaluation studies of follow up calls to suicidal Lifeline callers showed 90% felt helped keep them safe.

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Resource: Safety Planning Intervention

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Access at: www.zerosuicide.com

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Suicide Assessment Five-step Evaluation Triage

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- SAFE–T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf

ACKNOWLEDGEMENTS

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- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

www.sprc.org www.mentalhealthscreening.org

SAFE–T

Suicide Assessment Five-step Evaluation and Triage

1. IDENTIFY RISK FACTORS — Note those that can be modified to reduce risk
2. IDENTIFY PROTECTIVE FACTORS — Note those that can be enhanced
3. CONDUCT SUICIDE INQUIRY — Suicidal thoughts, plans behavior and intent
4. DETERMINE RISK LEVEL/INTERVENTION — Determine risk. Choose appropriate intervention to address and reduce risk
5. DOCUMENT — Assessment of risk, rationale, intervention and follow-up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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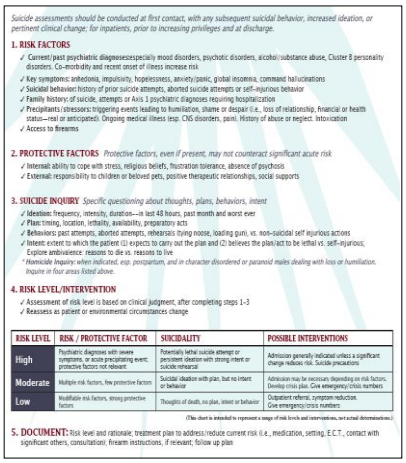
Suicide Assessment Five-step Evaluation Triage



Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ Current/past psychiatric diagnoses especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
- ✓ Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ Family history: of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ Internal: ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ External: responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ Ideation: frequency, intensity, duration—in last 48 hours, past month and worst ever
- ✓ Plan: timing, location, lethality, availability, preparatory acts
- ✓ Behaviors: past attempts; aborted attempts, rehearsals: living noose, loading guns, vs. non-suicidal self injurious actions
- ✓ Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live
- ✓ *Homicide Inquiry: when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- ✓ Assessment of risk level is based on clinical judgment, after completing steps 1-3
- ✓ Reassess as patient or environmental circumstances change

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary, depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan

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Suicide Prevention App for Health Care Providers

Free for Apple® and Android™ mobile devices

<u>Suicide Safe Helps Providers</u>:

- Integrate suicide prevention strategies into practice and address suicide risk
- Learn how to use the SAFE-T approach
- Explore interactive sample case studies
- Quickly access and share information and resources
- Browse conversation starters
- Locate treatment options

Learn more at **bit.ly/suicide_safe.**

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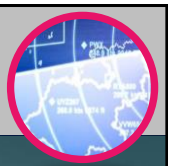
NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

What is the Crisis Now model?

Call Center Hub

Mobile Crisis

Crisis Facilities



"Air Traffic Control" Crisis Call Center Hub Connects and Ensures Timely Access and Data

Thank you.

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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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1-877-SAMHSA-7 (1-877-726-4727) ● 1-800-487-4889 (TDD)

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