

It Takes a Community to Prevent Suicide: What is Zero Suicide Concept and Practice? Part 1

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Learning Objectives

- 1. Identify vulnerability factors for risk of suicide
- 2. Describe two goals from the National Strategies for Suicide Prevention
- 3. Identify the components for the pathway to care for suicide

Disclaimer

- Dr. Bereiter and Laura Rombach have no financial relationship to this program

Suicide Prevention Webinar Series

The Suicide Prevention Webinar Series is presented through the National Strategy of Suicide Prevention in New Mexico grant

In collaboration with the University of New Mexico, State of New Mexico, Human Services Department, Behavioral Health Services Division and Indian Health Services

Goals

2012 National Strategy for Suicide Prevention

- 8. Promote suicide prevention as a core component of health care services
- 9. Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors

Rates of Suicide in the United States

- Nearly 40,000 people in the United States die from suicide annually
- The suicide rate has been rising over the past decade
- Much of the increase is due to suicides in mid-life
- The highest number of suicides among both men and women occurred among those aged 45 to 54
- There are 3.6 male suicides for every female suicide
- From 1999 to 2010, the age-adjusted suicide rate for adults aged 35 to 64 in the United States increased significantly (28.4%). Half of these deaths occur by use of a firearm
- The highest rates of suicides (suicides per 100,000) occurred among men aged 75 and up and among women aged 45 to 54

Substance Abuse and Mental Health Services

Administration 2014

- For what age range is suicide the 2nd leading cause of death?

18-24 years old

25-34 years old

35- 50 years old

51-70 years old

Rates of Suicide in the United States

- Suicide is the second leading cause of death for persons ages 25 to 34 years old in the United States
- Suicide is the third leading cause of death in persons 15-24 years old in the United States
- Suicide is the tenth leading cause of death (all ages) in the United States.

Suicide Prevention Toolkit for Rural Primary Care

Question 1

- Approximately ____% of suicide victims in New Mexico had a diagnosable behavioral health condition
 - 25%
 - 50%
 - 70%
 - 90%

New Mexico

- Approximately 90% of suicide victims in New Mexico had a diagnosable behavioral health condition, most commonly a mood or substance use disorder (IBIS, 2012)
- New Mexico's suicide rate is consistently among the highest in the nation (comprising 2.4% of all deaths compared to 1.2% in the U.S.)
- Deaths from suicide in 2012 occurred most frequently among non-Hispanic whites (63%) and males (76%)
- More men between the ages of 45 and 54 years old (16% of all suicides) committed suicide than any other age group

Most vulnerable

The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves (non-suicidal self-injury)
- People who have previously attempted suicide
- People with medical conditions
- People with mental and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife and older men

American Indian and Alaska Native

- In 2011, the suicide rate among American Indians and Alaska Natives ages 10 to 24 years was 21.3 per 100,000,
 - more than twice the suicide rate for people of the same age (white non-Hispanics)
 - more than 4 times the suicide rate for people in several other groups (SAHMSA)
- The male-to-female ratio of completed suicides was 3.256 to 1

American Association of Suicidology Fact Sheet Based on 2011)data (2014)

American Indian and Alaska Native-Continued

- In 2010 American Indian and Alaska Native high school students reported rates of suicide attempts nearly twice that of the general population of U.S. high school students
 - (14.7% vs. 7.8%). (SAMHSA)
- In 2011 459 American Indians and Alaska Natives died by suicide in the U.S.
 - (rate of 10.59 per 100,000 compared to the rate of 12.68 per 100,000 overall population)

Military

- There are approximately 23.4 million veterans in the United States, and about 2.2 million military service members and 3.1 million immediate family members.
- The Army suicide rate reached an all-time high in 2012
- In the 5 years from 2005 to 2009, more than 1,100 members of the Armed Forces took their own lives, an average of 1 suicide every 36 hours.

SAMHSA web site

Comorbidity

- More than 90% of people who dies by suicide have a mental health disorder or substance abuse disorder or both
- More than 50% of suicides are associated with a major depressive disorder
- Approximately 25% of suicides are associated with a substance abuse disorder
- Ten percent of suicides are associated with psychotic disorders

Alcohol and Drug Abuse and Suicide

- Alcohol and drug abuse are second only to depression and other mood disorders as the most frequent risk factors for suicide
- In 2008, alcohol was a factor in approximately one-third of suicides reported in 16 states
- In 2011, there was a 51% increase in drug-related suicide attempt visits to hospital emergency departments among people aged 12 and older (SAMHSA)

Suicide Attempts and Ideation

- There are more than 25 attempted suicides for each suicide death.
- In 2013, an estimated 9 million adults (3.9%) aged 18 or older had serious thoughts of suicide in the past year.
 - Highest among people aged 18 to 25
 - Followed by people aged 26 to 49
 - Then by people aged 50 or older
- Among high school students, more than 17% (ninth

Question 2

- How many people saw their primary care doctor in the month prior to death by suicide?
- 20%
- 30%
- 50%
- 75%

Rates of Suicide After Seeing a Provider

- 50% of people who die by suicide had contact with their primary care providers in the month prior to their suicide
- 80% of people who die by suicide had contact with their primary care provider in the year prior to their death
- 20% of people who die by suicide saw a behavioral health provider within the month before they died
- 10% of people who die by suicide visited the Emergency Department within 2 months before they died

What is Zero Suicide

“IF WE WERE PROVIDING PERFECT DEPRESSION CARE MAYBE
OUR PATIENTS WOULDN'T KILL THEMSELVES”

<https://www.youtube.com/watch?v=7teSz9YqOrY>

Ed Coffey, CEO Behavioral Health System

Zero Suicide

- Providing good depression care
- Audacious goal
- Create a just culture that is supportive and not punitive if the goal is not reached
- Reducing rate of suicides

What is a Zero Suicide Culture

- Originally developed as an approach to suicide prevention in health care organizations
 - Proposes that suicide deaths are preventable for people under care
 - Commitment to patient safety
 - Relies on a system wide approach

Essential Elements of Suicide Prevention for Healthcare Systems

Part One

- ❖ Lead
- ❖ Train
- ❖ Identify
- ❖ Engage

Covered in Part Two

- ❖ Treat
- ❖ Transition
- ❖ Improve

Lead

- Leadership supported
- Safety oriented culture
- Committed to reducing suicide among people under care
- Immediate access
- Seamless care
- Written policies and procedure

Lead

- **It takes a community to prevent suicide**
- Schools
- Police
- First responders
- Peers
- Family members
- Hospitals
- Behavioral health providers
- Survivors
- Health care providers

Train

- Standardized screening and assessment
 - Depression and other mental health problems
 - Substance abuse
 - Suicidality
- Engaging persons at risk
- Collaborative safety plan – means restriction, communicating with family members.
- Intervention and treatment using evidenced based practices
- Follow up process

Identify

Standardized suicide screening of all members enrolled in active behavioral healthcare services.

Including Emergency Rooms and Primary Care

- Why is this important?

Identify

- Stratification of the risk, as indicated by the assessment, into low, medium or high risk
 - Use validated screening tool
 - Protective factors
 - Past suicide attempts

What Would Perfect Depression Care Look Like? -Pathways to care

- Standardized suicide screening
- Formal assessment
- Stratification of the risk
- Engagement
- Follow-up contact

Engage

Engagement of the patient or client in best-practice interventions geared to risk level.

- The time after acute care is critical- follow up
 - Warm hand off for transitions
 - Phone call follow up
 - Postcards or letters
 - Home visits
- Follow up

Example- Emergency Department

- Suicidal patient comes to Emergency Department
 - Screened for depression with a standardized screening tool (PHQ-9)
 - Screened for alcohol use with a standardized screening tool (AUDIT-C)
 - Screened for drug use with a standardized screening tool (DAST 10)
- Endorses Suicidal Ideation
 - Assessed with a standardized suicide assessment tool (CSSRS)
 - Level of suicidal risk identified

Example- Emergency Department—Level of Suicidal Risk

— Low risk—

- safety plan
- follow up phone call

— Medium risk—

- safety plan
- referred to outpatient behavioral health services,
- follow up phone call

Example- Emergency Department—Level of Suicidal Risk- Continued

- High risk—
 - admitted to psychiatric hospital,
 - Stabilized, treated, safety plan at discharge
 - discharged with referral to outpatient behavioral health service
 - communication between inpatient and outpatient services
 - follow up phone call
 - connect/check in with patient
 - ensure patient made it to outpatient follow up

Example- Outpatient Behavioral Health

- All patients screened for depression and suicidal ideation at every visit with standardized assessment (PHQ-9)
- Patients with substance use also screened with standardized assessments for alcohol and substance use
- Patient/client endorses Suicidal Ideation
 - Suicidality assessed further with CSSRS
 - Level of risk identified
- Low risk---safety plan, include follow up phone call

Example- Outpatient Behavioral Health- Continued

- Medium risk
 - consider internal consultation
 - session with therapist
 - safety plan
 - follow up phone call
- High risk-
 - Internal consultation
 - refer to hospital for further assessment and treatment

Example--Primary Care Setting

- Screen all patients for depression with PHQ-3 (PHQ-2 plus question about suicidality)
- Patient screens positive on PHQ-3
 - Screen for suicidal ideation (with phQ-9)
- Patient screens positive for suicidal ideation

Example--Primary Care Setting-Referral Options

- Several options exist:
 - Refer to Behavioral Health for further evaluation/management
 - Refer to Emergency Department
 - Consult behavioral health long distance if local services not available
 - Assess suicidality further with CSSRS and determine level of risk
 - Develop safety plan with patient
 - Low risk patients may not require referral

To be continued...

April 13, 2015, 12-1 pm (MST) It Takes a Community to Prevent Suicide: Can Zero Suicide be Achieved? Part Two

- Treatment
- Transition
- Improve
- How to get started

Suicide Prevention Webinars

- April 20, 2015, 12-1 pm (MST) The Community Readiness Survey and CONNECT Suicide Prevention, Intervention and Postvention Best Practice Model: Mobilizing Communities for Change
- April 27, 2015, 12-1 pm (MST) Using Evidenced Based Practice: An Overview of Cognitive Behavioral Therapy for Suicide Prevention
- May 18, 2015, 12-1 pm (MST) Screening and Safety Planning for People at Risk of Suicide

Resources

- Suicide Prevention Resource Center - <http://www.sprc.org/>
 - American Indian and Alaska Native Suicide Prevention Programs
 - Garrett Lee Smith State/Tribal Suicide Prevention Program
- Action Alliance for Suicide Prevention- <http://zerosuicide.actionallianceforsuicideprevention.org/>
- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- Military One Source <http://www.militaryonesource.mil/>
- Columbia-Suicide Severity Rating Scale Training <http://www.cssrs.columbia.edu/>
- CALM-Counseling on Access to Lethal Means http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means