Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Detecting and Treating Suicidal Ideation in All Settings

Richard McKeon, Ph.D.
Chief, Suicide Prevention Branch
Preventing suicide
A global imperative
National Strategy for Suicide Prevention
National Action Alliance for Suicide Prevention

VISION
The Action Alliance envisions a nation free from the tragic experience of suicide.

MISSION
To advance the NSSP by:
- Championing suicide prevention as a national priority
- Catalyzing efforts to implement high priority objectives of the NSSP
- Cultivating the resources needed to sustain progress

GOAL
To save 20,000 lives in five years
Deconstructing Suicide Deaths in the U.S.

✓ = Already Modeled

- **Firearm Deaths** (51% of all suicides) 19,392
- **Motor Vehicle CO Poisoning Deaths** ~735
- **Jail and Prison Inmates** ~500
- **Active Duty Military** ~300
- **Military Veterans** ~8360
- **Accessed healthcare within 30 days of death** ~17,100
- **Seen in Emergency Department for suicide attempt in past year** ~7,800

Data Sources:
1. CDC WISQARS 2010
2. CDC WONDER 2010
4. DoDSER CY 2011 Report
5. Trofimovich et al 2012
6. Department of Veterans Affairs 2012
7. CDC WISQARS 2010 & Owens et al, 2002
Healthcare Settings

- Mental health (Zero Suicide)
- Substance Abuse (TIP 50)
- Emergency Departments and Crisis Services
- Primary Care-Institute for Family Health, Pa GLS CHOP
The Zero Suicide Movement
Zero Suicide…

- Makes suicide prevention a core responsibility of health care.
- Applies new knowledge and proven tools for suicide care.
- Supports efforts to humanize crisis and acute care.
- Is a systematic approach in health systems, not “the heroic efforts of crisis staff and individual clinicians.”
Defining the Problem: Health Care Needs to Improve Suicide Safety

- 45% of people who died by suicide had contact with primary care providers in the month before death. Among older adults, it’s 78%.

- 25% of men and 50% of women who die by suicide had recent mental health contact (NVDRS)

- South Carolina: 10% of people who died by suicide were seen in an emergency department in the two months before death.
Defining the Problem: Behavioral Health Care Needs to Improve Suicide Safety

- **Ohio**: Between 2007-2011, 20.2% of people who died from suicide were seen in the public behavioral health system within 2 years of death.

- **New York**: In 2012 there were 226 suicide deaths among consumers of public mental health services, accounting for 13% of all suicide deaths in the state.

- **Vermont**: In 2013, 20.4% of the people who died from suicide had at least one service from state-funded mental health or substance abuse treatment agencies within 1 year of death.
The Elements of Zero Suicide in a Health Care Organization

Create a leadership-driven, safety-oriented culture

Pathway to Care
- Identify and assess risk
  - Screen
  - Assess
- Evidence-based care
  - Safety Plan
  - Restrict Lethal Means
  - Treat Suicidality and MI
- Continuous support as needed
  - Electronic Health Record

Develop a competent, confident, and caring workforce

Continuous Quality Improvement
A System-Wide Approach Saved Lives: Henry Ford Health System

Launch: Perfect Depression Care

Suicide Deaths/100k HMO Members

1999 2001 2003 2005 2007 2009 2011
LEAD
Resource: Zero Suicide Organizational Self-Study

ZERO SUICIDE ORGANIZATIONAL SELF-STUDY

<table>
<thead>
<tr>
<th>Name of Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>City, State</td>
</tr>
<tr>
<td>Date Study Completed</td>
</tr>
</tbody>
</table>

**Team members completing study:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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</table>

**Background:**
The organizational self-study is designed to allow you to assess what components of the comprehensive Zero Suicide approach your organization currently has in place. The self-study can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan. Later in your implementation efforts, the self-study can be used as a fidelity check to determine how closely the components of the Zero Suicide model are being followed and as an opportunity to identify areas for improvement. We recommend taking the self-study at launch and then at 12-month intervals.
ZERO SUICIDE WORKFORCE SURVEY QUESTIONS

The Zero Suicide Workforce Survey is the ideal tool to use to assess staff knowledge, practices, and confidence. To administer the Zero Suicide Workforce Survey in your organization, submit a request through the Zero Suicide toolkit in the train section.

<ORGANIZATION NAME> is making a commitment to improve care for our clients who are at risk for suicide. This survey is part of an overall organizational mission to adopt a system-wide approach to caring for individuals who are suicidal. The results of this survey will be used to help us determine the training needs of our staff.

All responses are anonymous. Please answer items honestly so that we can best serve both our staff and clients. Please be thoughtful about your answers even if you do not work directly with suicidal clients. We believe that suicide prevention is a shared responsibility among everyone in our organization. Unless otherwise indicated, please mark only one answer. It is anticipated that this survey will take you 5-15 minutes to complete. By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

We thank you in advance for your participation and for your dedication to this important issue!
Resource: Zero Suicide Work Plan Template

ZERO SUICIDE WORK PLAN TEMPLATE

This template should be used by an implementation team after completing the Zero Suicide Organizational Self-Study. It is organized by element of the Zero Suicide model and does not have to be completed all at once. To go directly to a particular element, click the link in the table of contents below.

Table of Contents

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<tr>
<td>Train</td>
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<tr>
<td>Identify</td>
<td>5</td>
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<tr>
<td>Engage</td>
<td>7</td>
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<tr>
<td>Treat</td>
<td>9</td>
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<tr>
<td>Transition</td>
<td>10</td>
</tr>
<tr>
<td>Improve</td>
<td>11</td>
</tr>
</tbody>
</table>
TRAIN
# Resource: Suicide Care Training Options

## Suicide Care Training Options

### Suicide Risk Detection and Referral (Page 1 of 2)

<table>
<thead>
<tr>
<th>Training Name</th>
<th>Length &amp; Format</th>
<th>Program Highlights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied Suicide Intervention Skills Training (ASIST) (LivingWorks)</td>
<td>2 days (14 hours) In person</td>
<td>- Workshop emphasizes teaching suicide first aid to help a person at risk stay safe and seek further help as needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Standardized, customizable, and delivered by two trainers</td>
</tr>
<tr>
<td><a href="http://www.livingworks.net/programs/assist">www.livingworks.net/programs/assist</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connect Suicide Prevention/Intervention Training (National Alliance on Mental Illness: New Hampshire)</td>
<td>1- to 4-hour options In person</td>
<td>- Training uses the socio-ecological model</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Examines suicide prevention and intervention in the context of the individual, family, community, tribe (if applicable), and society</td>
</tr>
</tbody>
</table>
SAMHSA funded training resources

- Suicide Prevention Resource Center, www.sprc.org Assessing and Managing Suicide Risk (AMSR)

- SAFE-T Card and SuicideSafe app walks clinicians through a suicide risk assessment
Resource: Using the C-SSRS

Access at: www.zerosuicide.com
ENGAGE
Resource: Safety Planning Intervention

Access at: www.zerosuicide.com
Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com
Treat Suicidality Directly

• Both treating suicidality directly as well as treating underlying conditions is crucial.
• There are now multiple RCT’s showing reductions in suicidal behavior. All focus directly on suicidality.
• DBT, CBT, CAMS
• CBT for insomnia can reduce suicidal ideation
Improving Care Transitions

• There are lethal gaps in many systems.
• Period after IPU and ED discharge is one of high risk, particularly the first 30 days.
• Rates of follow up care are poor.
• Intervention during this time has been shown to save lives and reduce suicidal behavior.
Major International Efforts Have Reduced Suicides

• Taiwan-nationwide effort to intervene with those who have attempted suicide, 50,000+

• 63.5% reduction in suicide attempts among those who accepted the program. Those who refused but then persuaded 22% reduction.

• English National Strategy- 24 hours crisis care strongly associated with reduction in suicides.

• Proactive outreach and discharge f/u 7 days
• Fleischmann et al (2008)
  – *Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)*
  – *Brief (1 hour) intervention as close to attempt as possible*
  – *9 F/u contacts (phone calls or visits) over 18 months*

Results at 18 Month F/U
## Clients’ Perceptions of Care: Cohort II (preliminary)

"To what extent did the follow-up call(s) stop you from killing yourself?"

<table>
<thead>
<tr>
<th>Response</th>
<th>Callers (n=283)</th>
<th>Hosp. Clients (n=70)</th>
<th>Total (n=353)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A lot</td>
<td>60.8%</td>
<td>51.4%</td>
<td>58.9%</td>
</tr>
<tr>
<td>A little</td>
<td>22.6%</td>
<td>14.3%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Not at all</td>
<td>16.6%</td>
<td>32.9%</td>
<td>19.8%</td>
</tr>
<tr>
<td>It made things</td>
<td>0.0%</td>
<td>1.4%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

(17 callers, 2 hosp. clients had missing data)
Resource: Structured Follow-up and Monitoring

Access at: www.zerosuicide.com
IMPROVE

LEAD    TRAIN    IDENTIFY    ENGAGE    TREAT    TRANSITION    IMPROVE
Perhaps a third of all suicide decedents accessed care prior to death, but few U.S. health care systems track suicide outcomes.


### Resource: Zero Suicide Data Elements Worksheet

Today's date: __________

Three-month reporting period (DD/MM/YY to DD/MM/YY): __________

Name of organization: __________

Name of person completing worksheet: __________

**Recommended Measures:**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Screening</td>
<td>Number of clients who received a suicide screening during the reporting period</td>
<td>Number of clients enrolled during the reporting period</td>
</tr>
<tr>
<td>2 Assessment</td>
<td>Number of clients who screened positive for suicide risk and had a comprehensive risk assessment (same day as screening) during the reporting period</td>
<td>Number of clients who screened positive for suicide risk during the reporting period</td>
</tr>
<tr>
<td>3 Safety Plan Development</td>
<td>Number of clients with a safety plan developed (same day as screening) during the reporting period</td>
<td>Number of clients who screened and assessed positive for suicide risk during the reporting period</td>
</tr>
<tr>
<td>4 Lethal Means Counseling</td>
<td>Number of clients who screened and assessed positive for suicide risk and were counselled about lethal means (same day as screening) during the reporting period</td>
<td>Number of clients who screened and assessed positive for suicide risk during the reporting period</td>
</tr>
</tbody>
</table>
Mortality After Recent Suicide Attempts

- SAMHSA NSDUH data
- Significant post non-fatal attempt suicide mortality - 3.2%
- Higher among men than women
- 45 and older with less than a high school education - 16%
- 40.6% had any outpatient mental health treatment, 15.8% had 1-4 visits,
Resources and Tools

www.ZeroSuicide.com
The Garrett Lee Smith (GLS) Suicide Prevention National Outcomes Evaluation is supported through contract no. HHSS283201000071/HHSS28342002T (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).

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.
Results: Difference in Nonfatal Attempts

*Solid lines represent the estimated trajectory of the outcome following GLS implementation. Dashed lines represent the estimated trajectory of the outcome during the same period had GLS not been implemented. 90% and 50% confidence intervals around the difference in the trajectories are represented by dark gray and light gray, respectively.*
National Suicide Prevention Lifeline

- Joint Commission recommends giving those with suicidal ideation the Lifeline number -1-800-273-TALK (8255)
- Link to Veterans Crisis Line
- 160+ local crisis centers
- Local Lifeline crisis centers are a vital partner for suicide prevention-talk to them, support them, partner with them
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