Suicide Prevention, Interventions and Management

Anita Everett MD, DFAPA
Chief Medical Officer
SAMHSA

SAMHSA
Austin, TX • June 2017
Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).

About SAMHSA

- One of several agencies in the HHS family of agencies
- The 21st Century Cures Act (Dec 2016) elevated SAMHSA leadership to the Assistant Secretary level
- Activities: Block grant, grants and contracts, congressionally mandated
- General organization:
US Suicide Rates are Rising

Figure 1. Age-adjusted suicide rates, by sex: United States, 1999 - 2014

Rates of ED visits with Suicidal Ideation

SAMHSA resources:
- Toolkit
- Children
- Adults
- SUD
- College Campus
- American Indian Resources
Deconstructing Suicide Deaths in the U.S.

- Firearm Deaths (51% of all suicides) 19,392
- Motor Vehicle CO Poisoning Deaths ~ 735^1
- Active Duty Military ~ 300
- Jail and Prison Inmates ~ 500
- 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
5. Inremnouh et al 2012
6. Department of Veterans Affairs 2012
7. CDC WISQARS 2010 & Greens et al, 2002

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.

- Mental Health Research Network Report (within 12 months of suicide death)
  - 17% Contact with Health Care
  - 83% No Contact with Health Care

- Suicide Decedents from NVDRS States
  - 69% Not in mental health treatment at time of death
  - 31% In mental health treatment at time of death


Special Note: Deaths of Despair

Increased mortality rates among white Americans aged 45-54 with a high school education or less. (Brookings Institution)

Recent Focus: Zero Suicide

“We want to make healthcare Suicide Safe”
Zero Suicide...

- Makes suicide prevention a core responsibility of health care.
- Applies new knowledge and 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.”

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

![Graph showing decrease in suicide deaths per 100k HMO members from 1999 to 2011, with a note about the launch of a system-wide approach to depression care.](chart.png)
Reducing Suicide

Utah:
- Reversed an alarming increasing trend
- Part of Medicaid Improvement Plan
- In their legislative suicide prevention report they state “we are committed to becoming a Zero Suicide System of Care”

Centerstone:
- Nation’s largest provider of community-based behavioral healthcare
- Tennessee saw a 64% reduction in suicides in the first 10 months of using the C-SSRS.

The Marines:
- Helped lead to a 22% reduction in suicides in 2014
- Top-down rollout at 14 Marine Bases and training for all support staff
- Lowest suicide rate of any branch of the armed forces

Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

“The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.”
Best Practices in Suicide Care for Health Care Systems and Providers

Virna Little, PsyD, LCSW-r, MBA, CCM, SAP
Senior Vice President Psychosocial Services/Community Affairs
The Institute for Family Health

#ZeroSuicide
@ZSInstitute
Zero Suicide is...

- Embedded in the *National Strategy for Suicide Prevention* and *Joint Commission Sentinel Event Alert #56*.

- A focus on error reduction and safety in health care.

- A framework for systematic, clinical suicide prevention in behavioral health and health care systems.

- A set of best practices and tools including [www.zerosuicide.com](http://www.zerosuicide.com)
2012 National Strategy for Suicide Prevention:

GOALS AND OBJECTIVES FOR ACTION

- A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

- GOAL 8: Promote suicide prevention as a core component of health care services.

- GOAL 9: Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors.

Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

“The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.”
45% of people who died by suicide had contact with primary care providers in the month before death.

19% of people who died by suicide had contact with mental health services in the month before death.

South Carolina: 10% of people who died by suicide were seen in an emergency department in the two months before death.
Leadership Commitment and Culture Change

- Leadership makes an explicit commitment to reducing suicide deaths among people under care and orients staff to this commitment.

- Organizational culture focuses on safety of staff as well as persons served; opportunities for dialogue and improvement without blame; and deference to expertise instead of rank.

- Attempt and loss survivors are active participants in the guidance of suicide care.

A focus on patient safety and error reduction

Without improved suicide care, people slip through gaps

Adapted from James Reason’s “Swiss Cheese” Model of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

SUICIDAL PERSON

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents

THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan

SUICIDAL PERSON

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

- Collaborative Safety Plan

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior

SUICIDAL PERSON

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
What is Different in Zero Suicide?

- Suicide prevention is a core responsibility of health care

- Applying new knowledge about suicide and treating it directly

- A systematic clinical approach in health systems, not “the heroic efforts of crisis staff and individual clinicians.”
Quality Improvement and Evaluation

- Suicide deaths for the population under care are measured and reported on.

- Continuous quality improvement is rooted in a just safety culture.

- Fidelity to the Zero Suicide model is examined at regular intervals.
Screening and Assessment

• Screen specifically for suicide risk, using a standardized screening tool, in any health care population with elevated risk.

• Screening concerns lead to immediate clinical assessment by an appropriately credentialed, “suicidality savvy” clinician.

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “×” to indicate your answer)

<table>
<thead>
<tr>
<th>Item</th>
<th>Never</th>
<th>Slightly</th>
<th>Moderate</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
PHQ-9, Item 9

9. Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

- Not at all
- Several days
- More than half the days
- Nearly every day

Columbia - Suicide Severity Rating Scale (Screening Version)

**In the past month**
1. Have you wished you were dead or wished you could go to sleep and not wake up?
2. Have you actually had any thoughts of killing yourself?

**If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.**

3. Have you been thinking about how you might kill yourself?
4. Have you had these thoughts and had some intention of acting on them?
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?
6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?
Safety Planning and Means Restriction

⇒ All persons with suicide risk have a safety plan in hand when they leave care that day.

– Safety planning is collaborative and includes:
  » aggressive means restriction
  » communication with family members and other caregivers
  » regular review and revision of the plan
Safety Planning Intervention (Stanley & Brown)

1. Warning signs
2. Internal distraction
3. External distraction
4. Social support
5. Professional support
6. Means reduction

Resource: Safety Planning Intervention

Access at: www.zerosuicide.com
Lethal Means Restriction

- Means restriction included on all safety plans
- Contacting family to confirm removal of lethal means is required, standard practice
- Training provided to staff
- Means restriction recommendations reviewed regularly

Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com
Effective, Evidence-Based Treatment

Care directly targets and treats suicidality and behavioral health disorders using effective, evidence-based treatments.
Discussion at Tables

- What is the general approach to providing evidence-based treatment for suicide in your organization?
- What type of training does staff receive on how to develop a collaborative safety plan?
- What type of training does clinical staff receive on means restriction?
- Where do you see room for improvement in your training practices?
Resources and Support

- Listserv: [http://zerosuicide.sprc.org/get-involved](http://zerosuicide.sprc.org/get-involved)
- Implementation Toolkit: ZeroSuicide.com
- Organizational Self-Study:
  - nowmatters.now.org

Thank You!

**Anita Everett**  
Chief Medical Officer  
240/276-2001  
Anita.everett@samhsa.gov

**Virna Little, PsyD, LCSW-r, MBA, CCM, SAP**  
Senior Vice President Psychosocial Services/Community Affairs  
The Institute for Family Health  
Vlittle@institute.org