Preventing Suicide Through Practice Readiness

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American Foundation for Suicide Prevention

The responsibility of the medical and behavioral health professional community to assess, intervene, and monitor suicidal behavior presents a significant opportunity to save lives. Such a burden becomes especially daunting if we are ill-prepared for such a situation.

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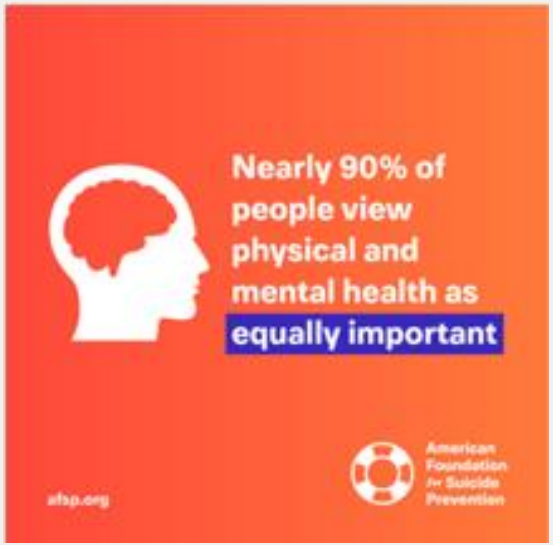
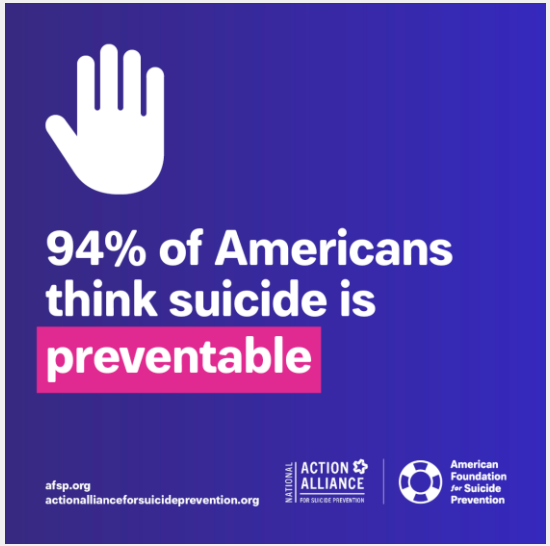
National and State Trends

According To A Recent AFSP-Sponsored Harris Poll





Language Matters

Avoid

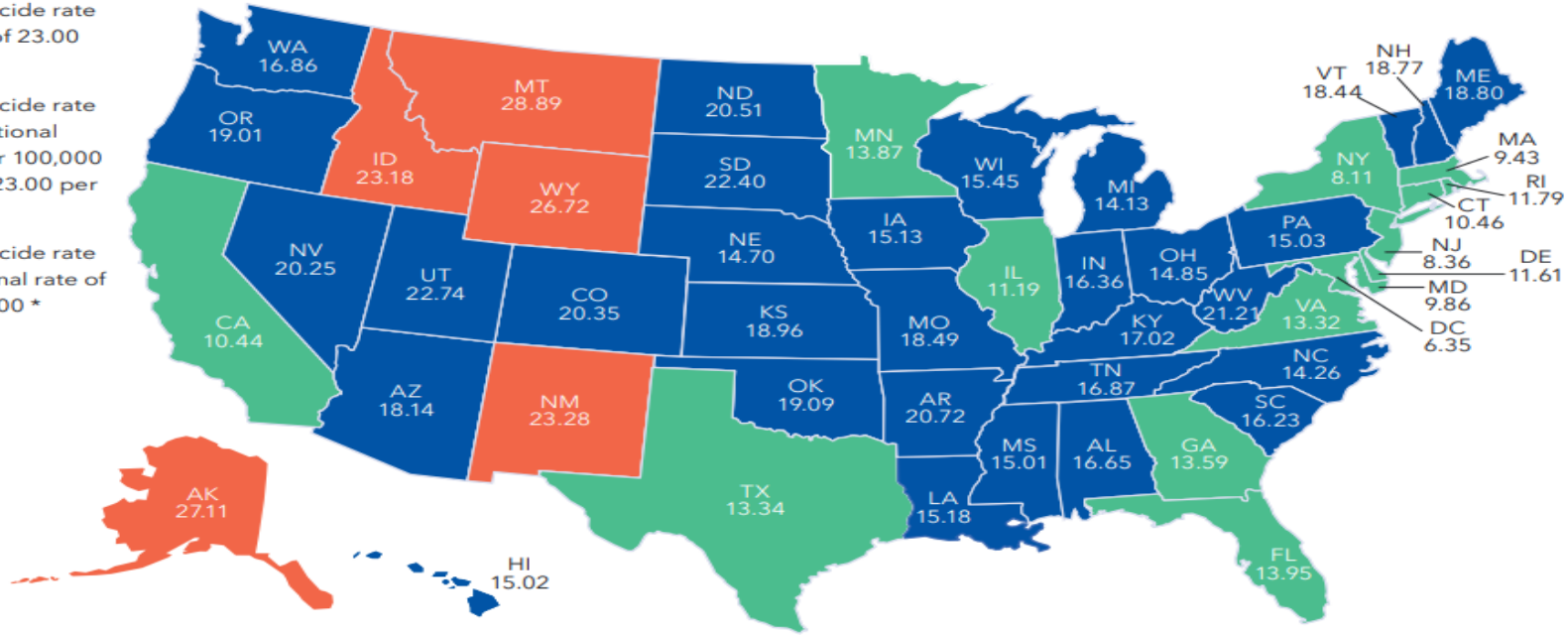
- Commit suicide
- Successful/failed attempt

Say

- Died by suicide
- Attempted suicide

Suicide Facts & Figures:
United States 2019

- States with a suicide rate above the rate of 23.00 per 100,000 *
- States with a suicide rate between the national rate of 14.00 per 100,000 and the rate of 23.00 per 100,000 *
- States with a suicide rate below the national rate of 14.00 per 100,000 *



*Data from the Centers for Disease Control and Prevention, 2017. Find additional citation information at afsp.org/statistics.

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Suicide Facts & Figures:
South Carolina 2019 *

On average, one person dies by suicide every 10 hours in the state.

More than twice as many people died by suicide in South Carolina in 2017 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflect a total of 16,861 years of potential life lost (YPLL) before age 65.

Suicide cost South Carolina a total of **$748,610,000** combined lifetime medical and work loss cost in 2010, or an average of **$1,175,213 per suicide death**.

*Based on most recent 2017 data from CDC. Learn more at afsp.org/statistics.

10th leading cause of death in South Carolina

2nd leading
cause of death for ages 15-34

4th leading
cause of death for ages 35-54

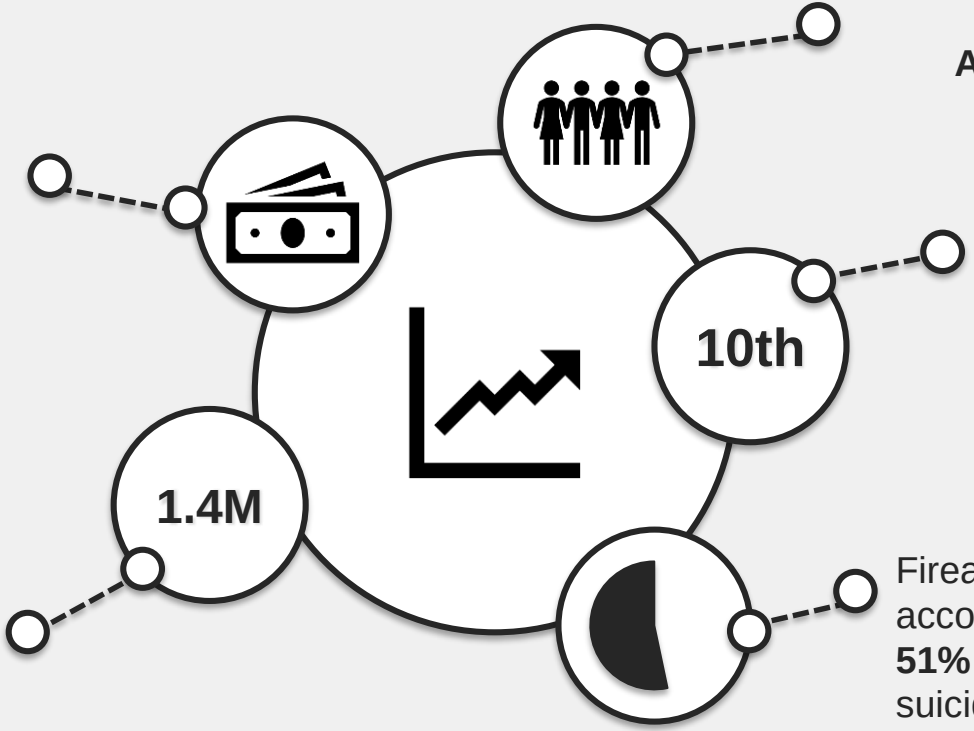
9th leading
cause of death for ages 55-64

17th leading
cause of death for ages 65 & older

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
South Carolina	**838**	**16.23**	**26**
Nationally	47,173	14.00	

Scope of the Problem



In 2017, **47,173 Americans died by suicide**

Suicide & self-injury **cost the US over $69 billion** per year

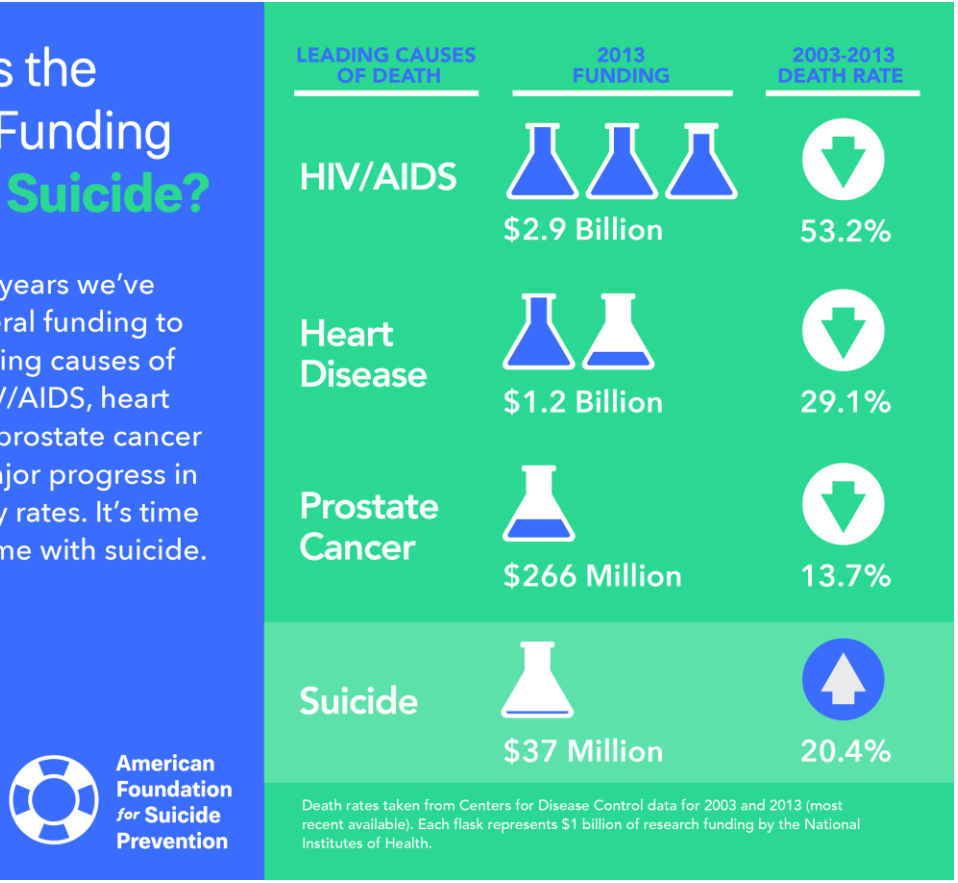
Suicide is the **10th leading cause of death**

In 2017, **1.4M suicide attempts**

Firearms accounted for **51%** of all suicide deaths

Where is the Federal Funding to Fight Suicide?

In the last 10 years we've invested federal funding to research leading causes of death like HIV/AIDS, heart disease, and prostate cancer and made major progress in their mortality rates. It's time we do the same with suicide.



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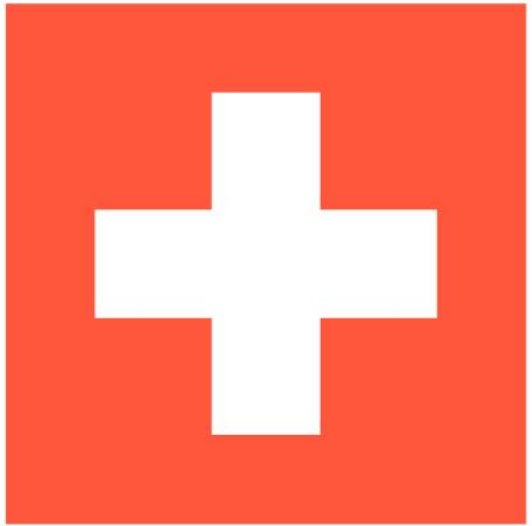


Suicide
is a **health**
issue.

Suicide
can be
prevented.

Safety Planning

- Clinical intervention → strategies & resources to use during a suicidal crisis
- Safety Plan is a brief intervention (20-45 min)

MY3 App

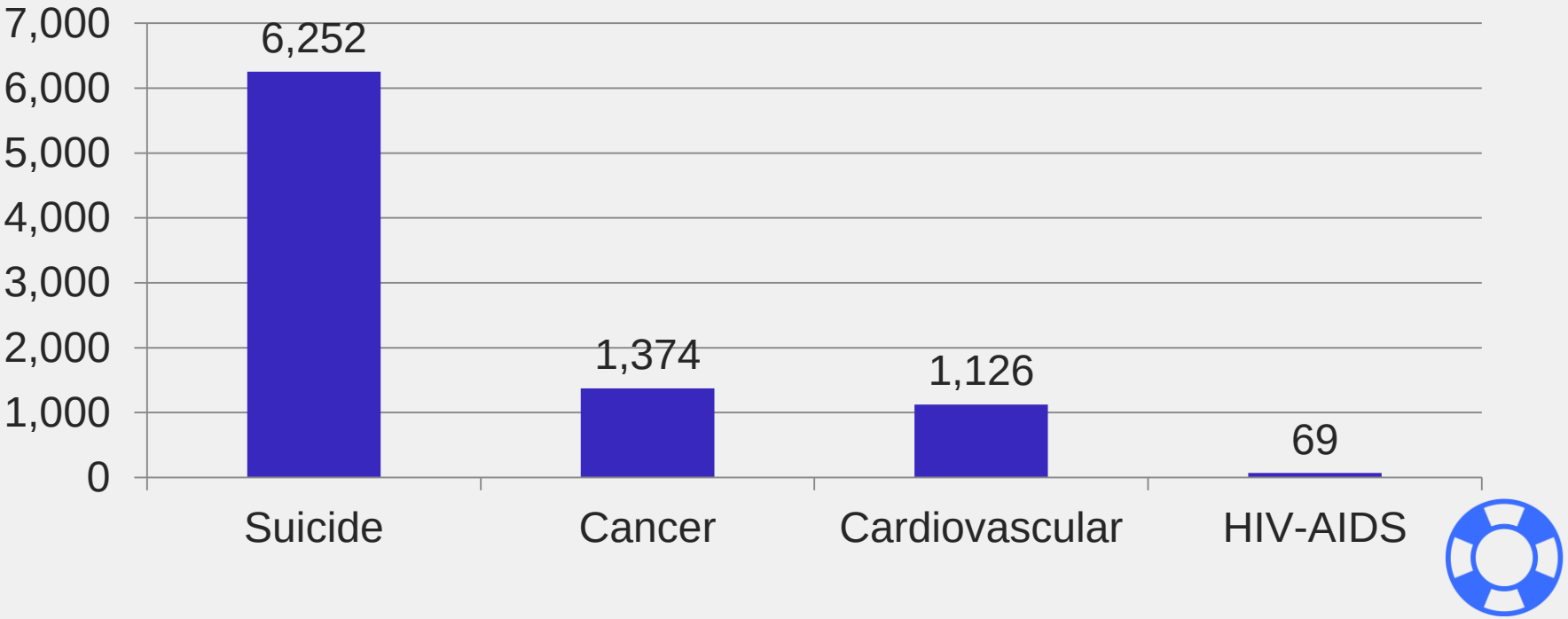
Limiting Access to Lethal Means Saves Lives

Youth Trends

Mental Health Literacy in America

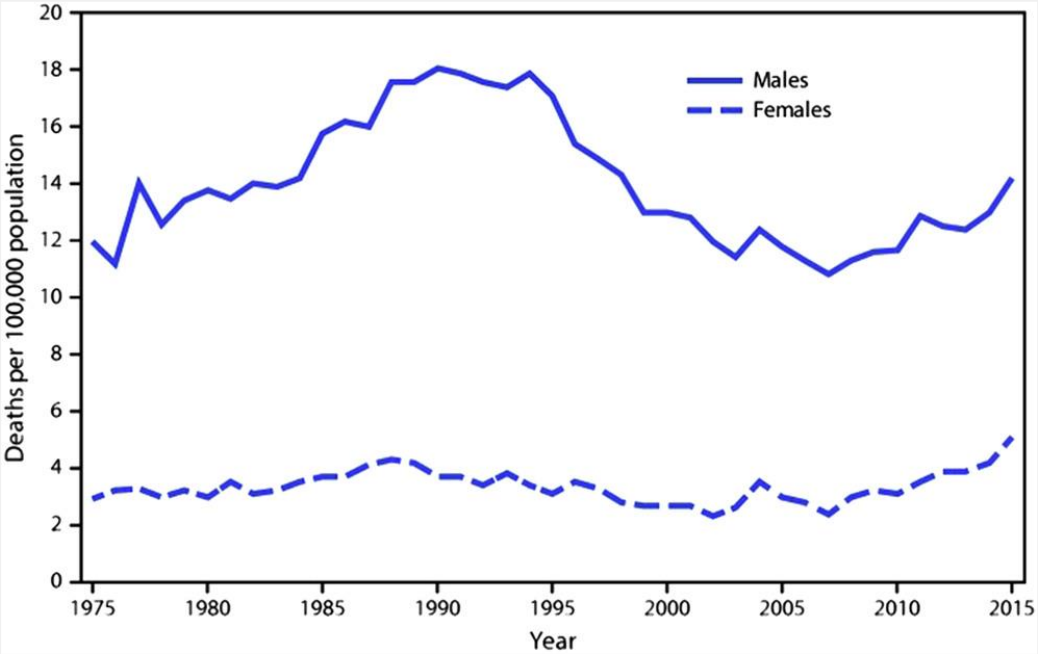
- 1 in 4 Americans have a MHC lifetime
- 50% MHC onset by age 14; 75% by age 24
- <50% receive treatment
- 1 in 3 college students “so depressed-difficult to function”
- Only half of those who seriously consider suicide disclose to anyone with 2/3 only tell a peer

Suicide Takes More Youth Lives Than Other Health Outcomes (15-24 yo)



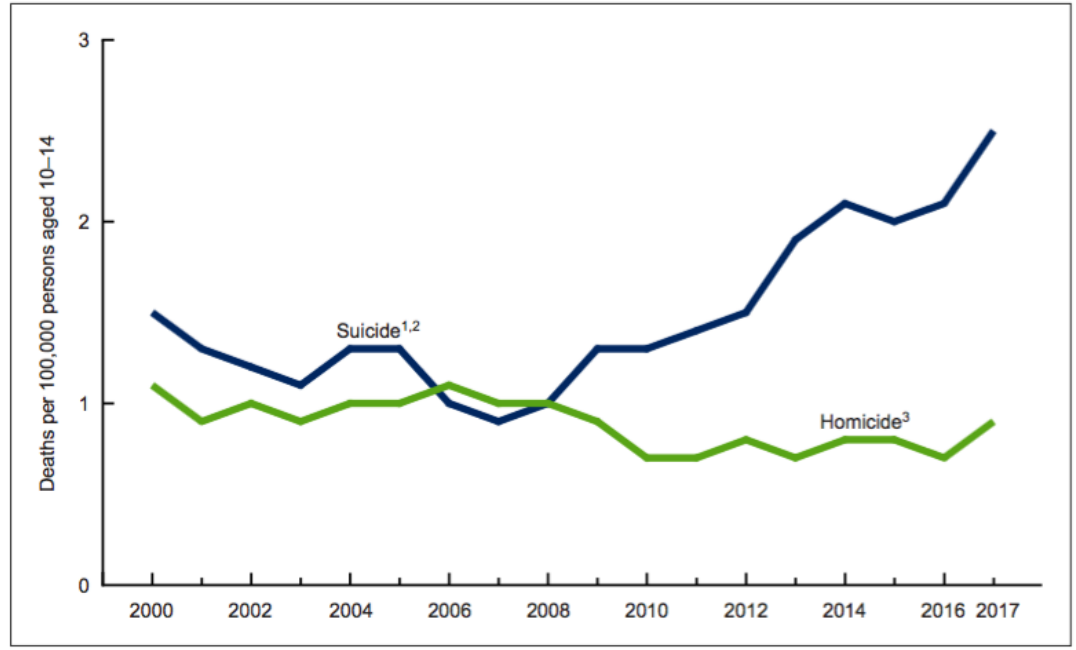
National Vital Statistics Report, CDC 2017

Suicide Rates Adolescents 15-19 (4 decades)



QuickStats. Suicide Rates for Teens Aged 15–19 Years, by Sex—United States, 1975–2015. MMWR Morb Mortal Wkly Rep. 2017;66:816.

Suicide Rates Age 10-14 (2000-2017)



Access data table for Figure 2 at: https://www.cdc.gov/nchs/data/databriefs/db352_tables-508.pdf#2. SOURCE: NCHS, National Vital Statistics System, Mortality.

UNDERSTANDING SUICIDAL BEHAVIOR

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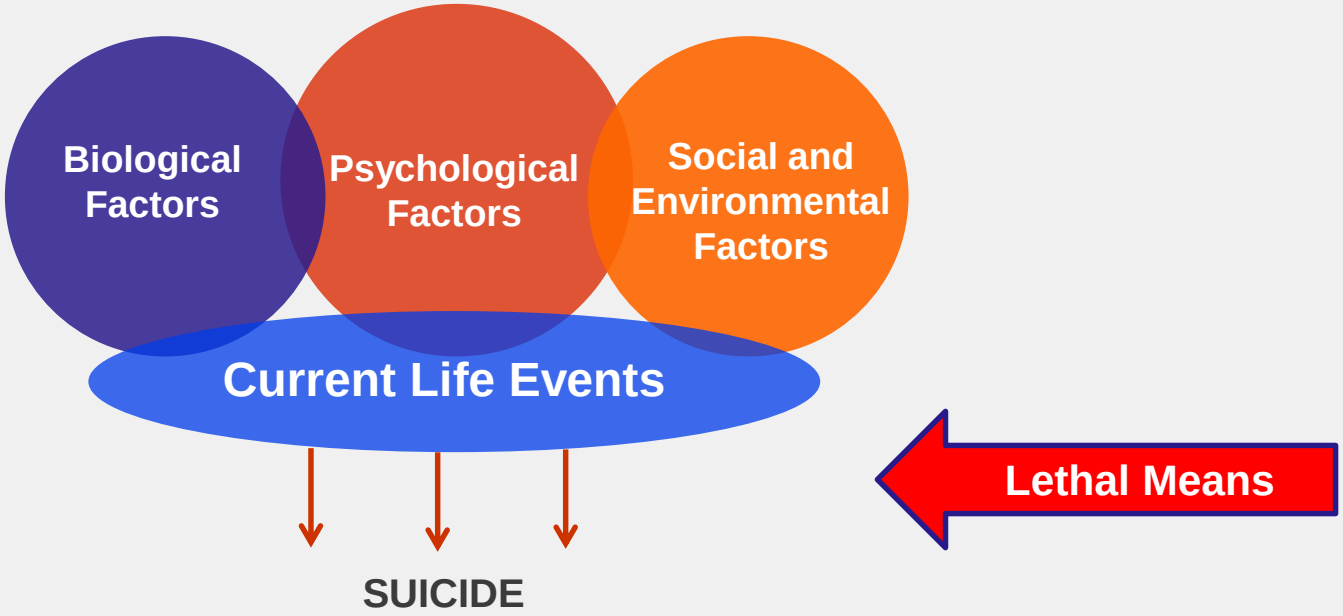
Interacting Risk and Protective Factors



Suicide isn’t a single cause-effect phenomenon.

Risk Factors for Youth Suicide

- Mental health conditions
- Substance use
- Childhood trauma/ACEs
- Genes- stress/mood
- Previous attempt
- FH suicide
- Parent SA/MHC/Addiction
- Non-suicidal self-injury
- Aggression/impulsivity
- Access to lethal means
- Suicide exposure
- Rigid cognitive style, perfectionism
- Precipitating event (disrupted relationship, bullying/bullier)
- Parent/child discord
- LGBTQ rejection

Protective Factors

- Social support
- Connectedness
- Mental healthcare
- Strong therapeutic alliance
- Environment promotes
- Self-regulation (Good Bhv Game)
- Problem solving skills
- Cultural/religious beliefs
- Biological/psychological resilience
- Family modeling
- Coping skills

Batty GD. *Transl Psychiatry*. 2018

ADDRESSING SUICIDE AS A PUBLIC HEALTH OUTCOME

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Science is providing interventions that reduce suicide risk.


NIMH
National Institute
of Mental Health


PROJECT
2025
AFSP.ORG/PROJECT2025


CDC


Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov


NATIONAL
Action Alliance
FOR SUICIDE PREVENTION
aetna

The Four Critical Areas

Firearms

Healthcare Systems

Emergency Departments

Corrections Systems

Contact with HCP Before Suicide

We are missing opportunities to detect risk and give care

When suicide risk increases, many present to clinic, ED, inpatient

Among 10-19 yo suicide decedents **38% saw HCP within month of suicide death**

Ahmedani et al. Health care contacts in the year before suicide. J Gen Int Med 2014

The Joint Commission
Natl Pt Safety Goal on Suicide Prevention

RELEASED JULY 1, 2019

- Clear steps for hospitals, EDs and BHOs to take
- Emphasis on organization's SP *program* rather than just screening or referral
- 7 elements of performance (EPs)

www.jointcommission.org/topics/suicide_prevention_portal.aspx

Steps Health Systems Can Take

- Provide SP education to all staff
- Routine MH and SI screening/assessment
- Safety Planning & Lethal Means Counseling
- Involve family as appropriate, whenever possible
- Put ‘Caring Contacts’ in place systematically
- Document actions taken
    - Referral to BH, communication with family
    - Safety Plan completed, provided Lifeline, Crisis Text Line
    - Counseled on lethal means removal

AAP Resources

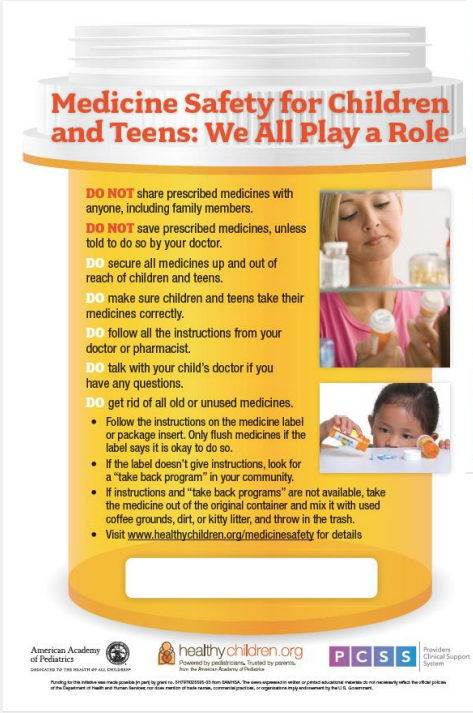
Suicide Prevention Webpage
- Clinical and family resources
- AAP Policy
- Sample social media posts

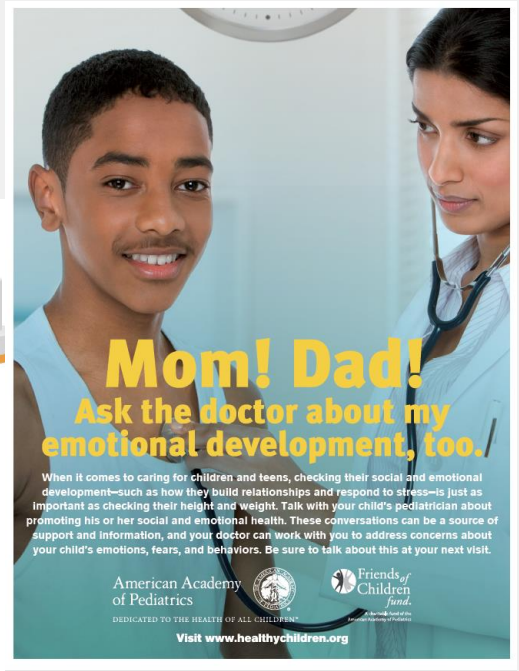
Screening/Assessment Tools
- Pt Health Questionnaire (PHQ-9)
- PHQ-Adolescent version
- Ask Suicide Screener (ASQ)

Resources

Office posters

Motivational Interviewing videos:
- Self-harm and Suicide
- Depression





Addressing Youth Suicide Prevention: A Factsheet for Primary Care Clinicians

Background:

Suicide is the 2nd leading cause of death among US youth ages 15-24
Pediatricians can take important steps to protect children and families in their practice

Screening for Suicide Risk:

Choose a validated screening tool:
-Ask Suicide-Screening Questions (asQ)
-PHQ-9 Modified for Adolescents (PHQ-A)
-Columbia Suicide Severity Risk Scale (CSSRS)
Understand how to score and document results
Design a workflow for screening

Managing a Positive Screen:

Assess level of risk and intervene accordingly
-Low Risk: counsel, refer, follow-up
-Moderate Risk: counsel, refer, develop Safety Plan, follow-up
-Severe Risk: counsel, ensure parents/caregivers closely monitor child, remove lethal means, develop Safety Plan, make a crisis referral, follow-up

Counseling about Lethal Means:

Ask about access to lethal means, including firearms, medication, knives, and suffocation devices
Counsel about the importance of restricting access:
-Remove firearms from home
-Lock away medication
-Monitor belts, ropes, other suffocation devices

Ongoing Care and Follow-Up:

Help patient make a Safety Plan
-Share with parents/caregivers
-Store in EHR and send a copy home
-Templates are available
Make appropriate outpatient and/or crisis referrals
Make a "caring contact" phone call to follow-up with child and caregiver

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

Source: *Youth Suicide Prevention, A Guide for Primary Care Clinicians who Provide Care to Children and Teens.* This document was made possible, in part, by support from the National Technical Assistance Network for Children's Behavioral Health at the University of Maryland, funded by the Center for Mental Health Services (CMHS) at the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA) through Contract #HHSS280201500001C. The views, opinions, and content expressed in this document do not necessarily reflect the views, opinions, or policies of the CHCS, SAMHSA, or HHS.

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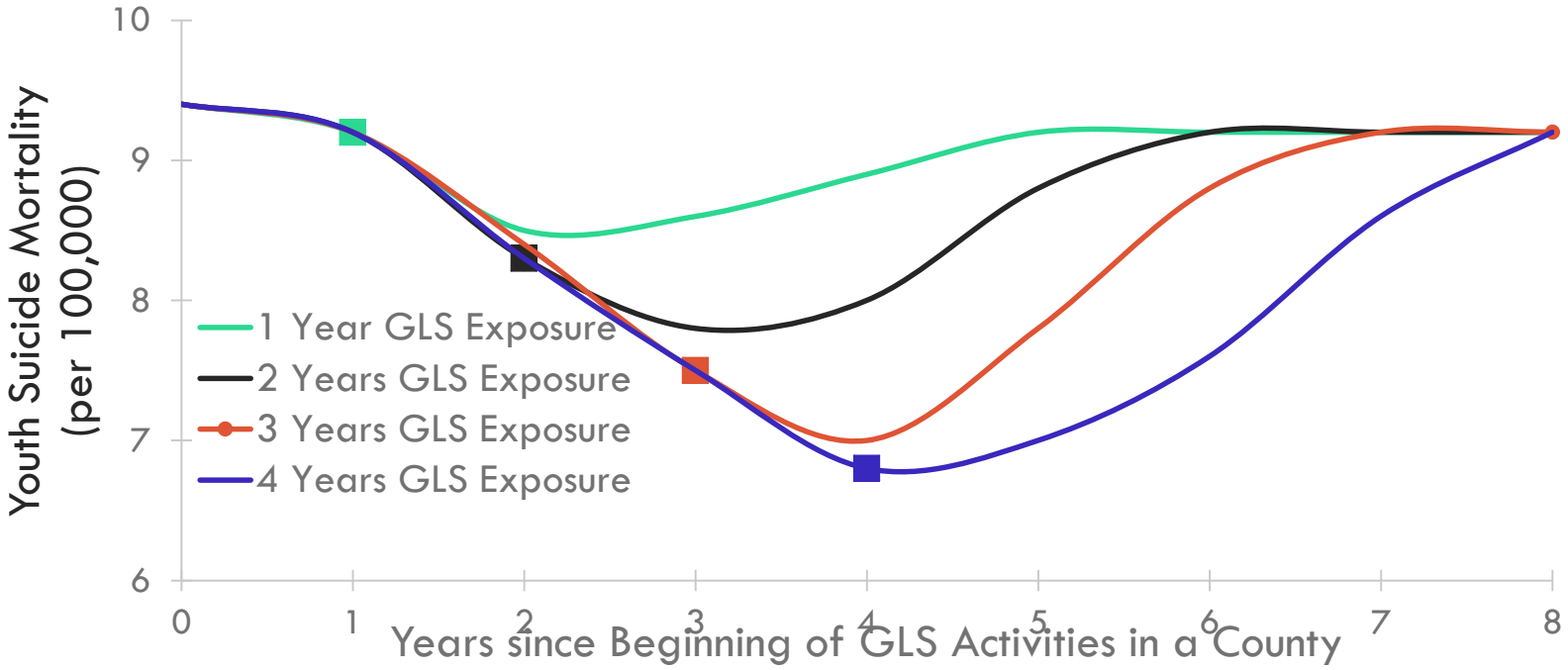
GLS Grants: Long-term impact youth suicide mortality



- ✓aap.org
- ✓afsp.org
- ✓www.jointcommission.org/topics/suicide_prevention_portal.aspx
- ✓https://www.nimh.nih.gov/ASQ
- ✓SeizeTheAwkward.org

Together we can save lives and improve the quality of many more.

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Discussion

Thank You!

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References

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2. Brahmbhatt. Kurtz, Afzal…Horowitz, et al. Suicide risk screening in pediatric hospitals: clinical pathways to address a global health crisis. Psychosomatics 2019; 60(1):1-9.
3. The Joint Commission NPSG 15.01.01 July 1, 2019 https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_11_27_18_FINAL.pdf
4. Cavanagh, J. T., A. J. Carson, M. Sharpe, and S. M. Lawrie. 2003. Psychological autopsy studies of suicide: A systematic review. Psychological Medicine 33(3):395-405.
5. Turecki G and Brent DA. Suicide and suicidal behavior. Lancet 2016 March 19; 387: 1227-1239
6. Luxton DD, June JD, & Comtois KA. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis* 2013;34(1): 32-41
7. Brent DA. Master Clinician Review: Saving Holden Caulfield: Suicide Prevention in Children and Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2019;58(1):25 – 35.

Breakout Sessions/Roll Play

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Scenario: Pediatric Patient

- Morgan (14) brought in by mother to evaluate her infected thigh wound
- Alert, oriented, takes no meds.
- Vital signs within normal limits.
- Morgan states she was preparing a sandwich and “the knife slipped”.
- Has similar, healed wound on other thigh; shrugs shoulders and does not respond to inquiry about injury.
- Mother worried because Morgan has missed a lot of school lately after parents’ recent marital breakup. A few days ago Morgan said they “just can’t take it anymore”.

How would this information relate to Morgan’s responses to the Patient Safety Screener?

Scenario: Pediatric Patient

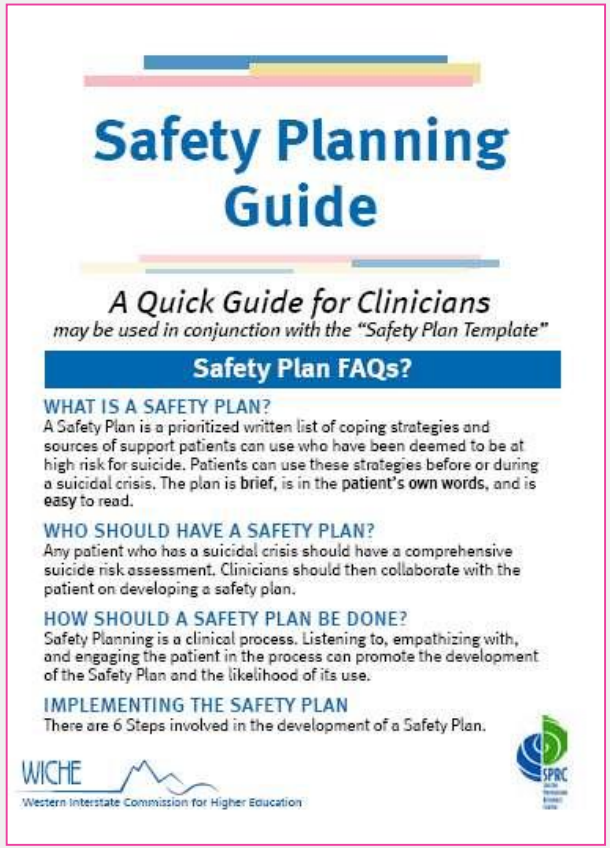
Provide resources to all patients
24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255)
24/7 Crisis Text Line: Text "HOME" to 741-741

- Pair up
- Treat the patient with empathy/pay attention to your body language
- Ask all questions exactly as worded
- Do not combine or re-word questions
- Avoid negative phrasing, such as "You haven't ever attempted to kill yourself, have you?"
- Do not infer a "No" based on presenting complaint or other clinical impression.
- Apply protocols for further suicide evaluation and management as appropriate

Ask the patient (PSS-3):

- ***1. Over the past 2 weeks, have you felt down, depressed, or hopeless?*** ☒ Yes ☐ No ☐Refused ☐Patient unable to complete
- ***2. Over the past 2 weeks, have you had thoughts of killing yourself?*** ☒ Yes ☐No ☐ Refused ☐ Patient unable to complete
- ***3. Have you ever attempted to kill yourself?*** ☐ Yes ☒No ☐ Refused ☐ Patient unable to complete . . .
- 3a. If Yes to item 3, ask: ***When did this last happen?*** ☐ Within the past 24 hours (including today) ☐ More than 6 months ago ☐ Within the last month (but not today) ☐Refused ☐ Between 1 and 6 months ago ☐ Patient unable to complete

Safety Planning



Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

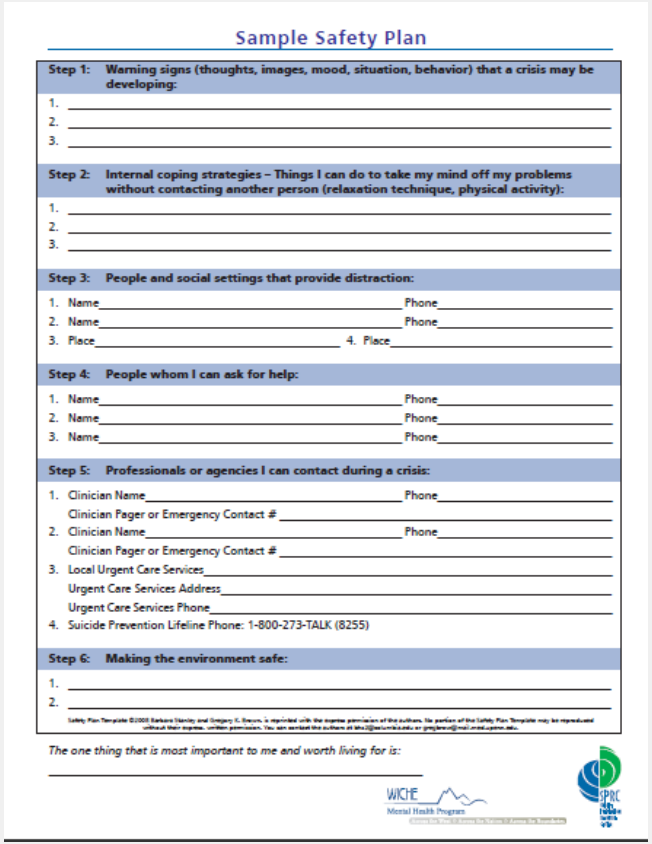
HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE
Western Interstate Commission for Higher Education



Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

WICHE Mental Health Program

http://www.sprc.org/library/SafetyPlanningGuide.pdf

"How will you know when the safety plan should be used?"

"What can you do on your own if you become suicidal again, to help yourself not to act on your thoughts or urges?

"Who helps you feel good when you socialize with them?"

"Among your family or friends, who do you think you could contact for help during a crisis?"

"Who are the mental health professionals that we should identify to be on your safety plan?"

"What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?"

SAFETY PLAN

Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:

1. Play the guitar
2. Watch sports on television
3. Work out

Step 3: Social situations and people that can help to distract me:

1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

Step 4: People who I can ask for help:

1. Name Mother Phone 333-8666
2. Name AA Sponsor (Frank) Phone 333-7215

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name Dr John Jones Phone 333-7000
   Clinician Pager or Emergency Contact # 555 822-9999
2. Clinician Name Phone
   Clinician Pager or Emergency Contact #
3. Local Hospital ED City Hospital Center
   Local Hospital ED Address 222 Main St
   Local Hospital ED Phone 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3.

Scenario: Key Points

- Patient denies previous suicidal behavior
- Patient denies current injury represents a suicide attempt
- Patient's mother provides key information

Suicide Risk Screening Protocol:

Although this may be a "negative screen," because there is additional information suggestive of suicide risk, this indicates the need to follow standard risk management protocols. Behavioral health evaluation recommended. Suicide prevention and mental health discharge resources. Safety plan recommended.