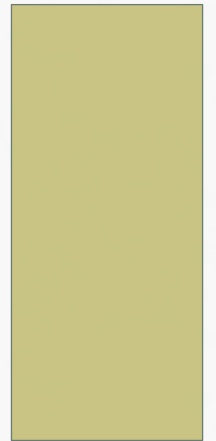


SUICIDE PREVENTION

MARY WHERRY AND MISTY VAUGHAN ALLEN



NATIONAL KEY FACTS

- Suicide is the 10th leading cause of death
- Between 2001 and 2009, more than 33,000 Americans died each year as a result of suicide—more than one person every 15 minutes
- More than 8 million adults report having serious thoughts of suicide in 2011; 2.5 million report making a suicide plan and 1.1 million report a suicide attempt
- Almost 16 percent of students in grades 9 to 12 report having seriously considered suicide and 7.8 percent report having attempted suicide one or more times in the past 12 months

NATIONAL MILESTONES

1998 RENO CONFERENCE

NATIONAL MILESTONES IN SUICIDE PREVENTION

1958: First suicide prevention center opens in Los Angeles, California.

1967: National Institute of Mental Health (NIMH) establishes Center for Studies of Suicide Prevention.

1971: The journal *Suicide and Life-Threatening Behavior* publishes its first issue.

1976: AAS establishes crisis center certification program and certifies its first crisis center.

1989: Suicide Awareness Voices of Education (SAVE) holds its first national suicide awareness memorial in St. Paul, Minnesota.

1989: U.S. Department of Health and Human Services (HHS) publishes *Report of the Secretary's Task Force on Youth Suicide*.

1989: AAS holds its first "Healing After Suicide" conference.

1960: International Association for Suicide Prevention founded.

1968: First national conference on suicidology held in Chicago, Illinois.

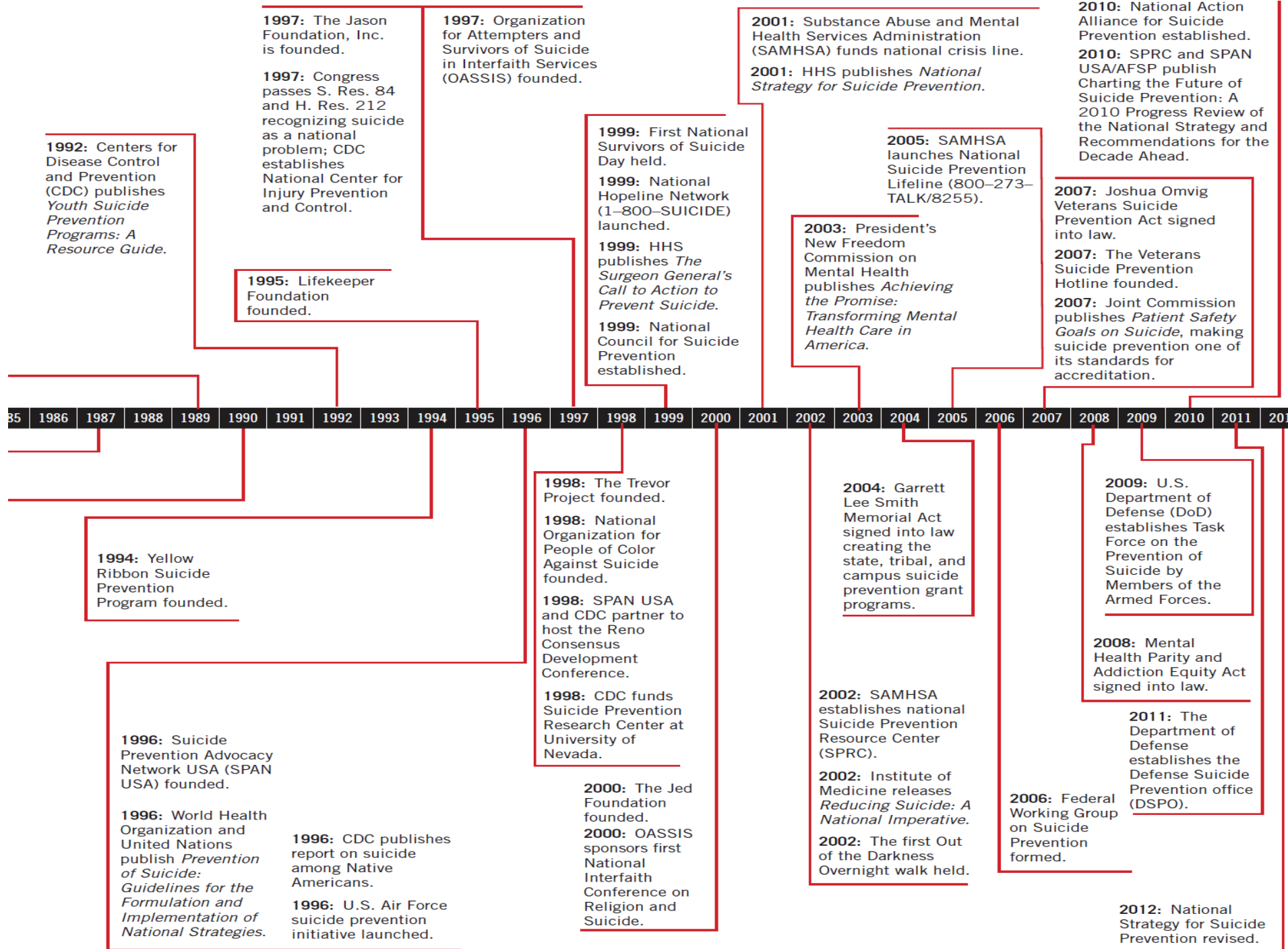
1968: American Association of Suicidology (AAS) founded.

1973: NIMH publishes *Suicide Prevention in the 70s*.

1987: American Foundation for Suicide Prevention (AFSP) founded.

1990: SAVE is incorporated.

1958 1959 1960 1961 1962 1963 1964 1965 1966 1967 1968 1969 1970 1971 1972 1973 1974 1975 1976 1977 1978 1979 1980 1981 1982 1983 1984



Key Points From Reno, Nevada, Conference

- 1.) Suicide prevention must recognize and affirm the value, dignity, and importance of each person.
- 2.) Suicide is not solely the result of illness or inner conditions. The feelings of hopelessness that contribute to suicide can stem from societal conditions and attitudes. Therefore, everyone concerned with suicide prevention shares a responsibility to help change attitudes and eliminate the conditions of oppression, racism, homophobia, discrimination, and prejudice.
- 3.) Some groups are disproportionately affected by these societal conditions, and some are at greater risk for suicide.
- 4.) Individuals, communities, organizations, and leaders at all levels should collaborate to promote suicide prevention.
- 5.) The success of this strategy ultimately rests with individuals and communities across the United States.

FEDERAL POLICIES

- Garrett Lee Smith Memorial Act Programs
- Military and Veteran Suicide
- Mental Health Parity
- Other Legislative Priorities (Examples)
 - American Indian/Alaska Native Youth Suicide Prevention
 - Bridge Barriers
 - Crisis Intervention Centers
 - Depression Centers of Excellence
 - LGBT Suicide Prevention
 - National Violent Death Reporting System
 - Suicide Prevention Research

STATE POLICY FOR ALL STATES

- State Suicide Prevention Initiatives and Plans
- Suicide Prevention Training for School Personnel
- Anti-Bullying and Anti-Cyberbullying Policies
- Mental Health Parity and Access to Affordable Mental Health Treatment
- Access to Firearms for Persons at Risk for Suicide

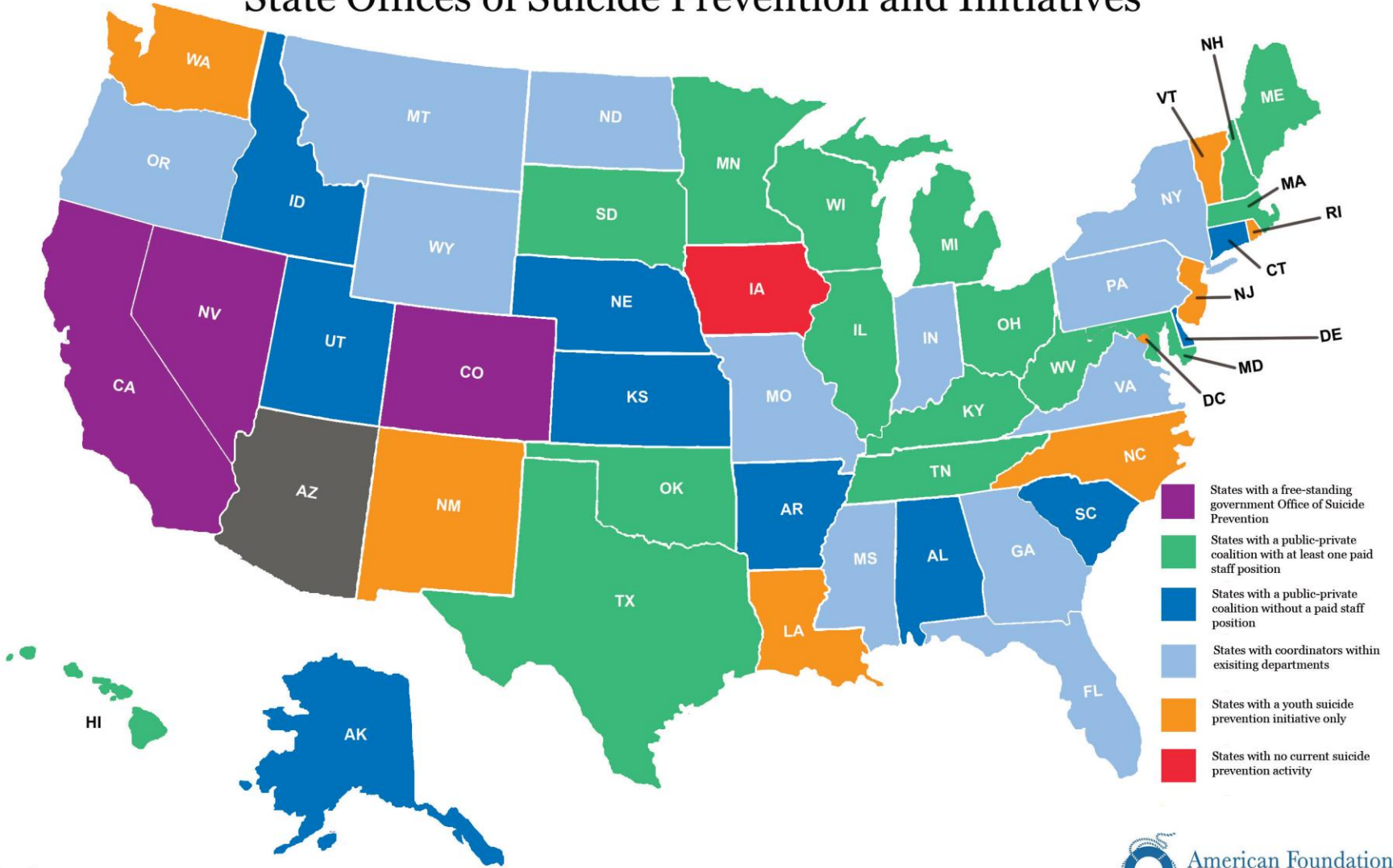
STATE SUICIDE PREVENTION INITIATIVES AND PLANS

- Effective Plans:
 - Address suicide prevention across the lifespan
 - Are fully implemented
 - Are funded, sustainable and evaluated
- States are split into six different categories specific to Initiatives:
 - States with a free-standing state government Office of Suicide Prevention
 - States with a Public-Private coalition with at least one paid staff position
 - States with a Public-Private Coalition without a paid staff position

STATE SUICIDE PREVENTION INITIATIVES AND PLANS (CONT)

- States with Coordinators within existing Departments
- States with a Youth Suicide Prevention Plan/Initiative Only
- States with no Suicide Prevention Activity
- States without enough information to categorize

State Offices of Suicide Prevention and Initiatives



October 2012

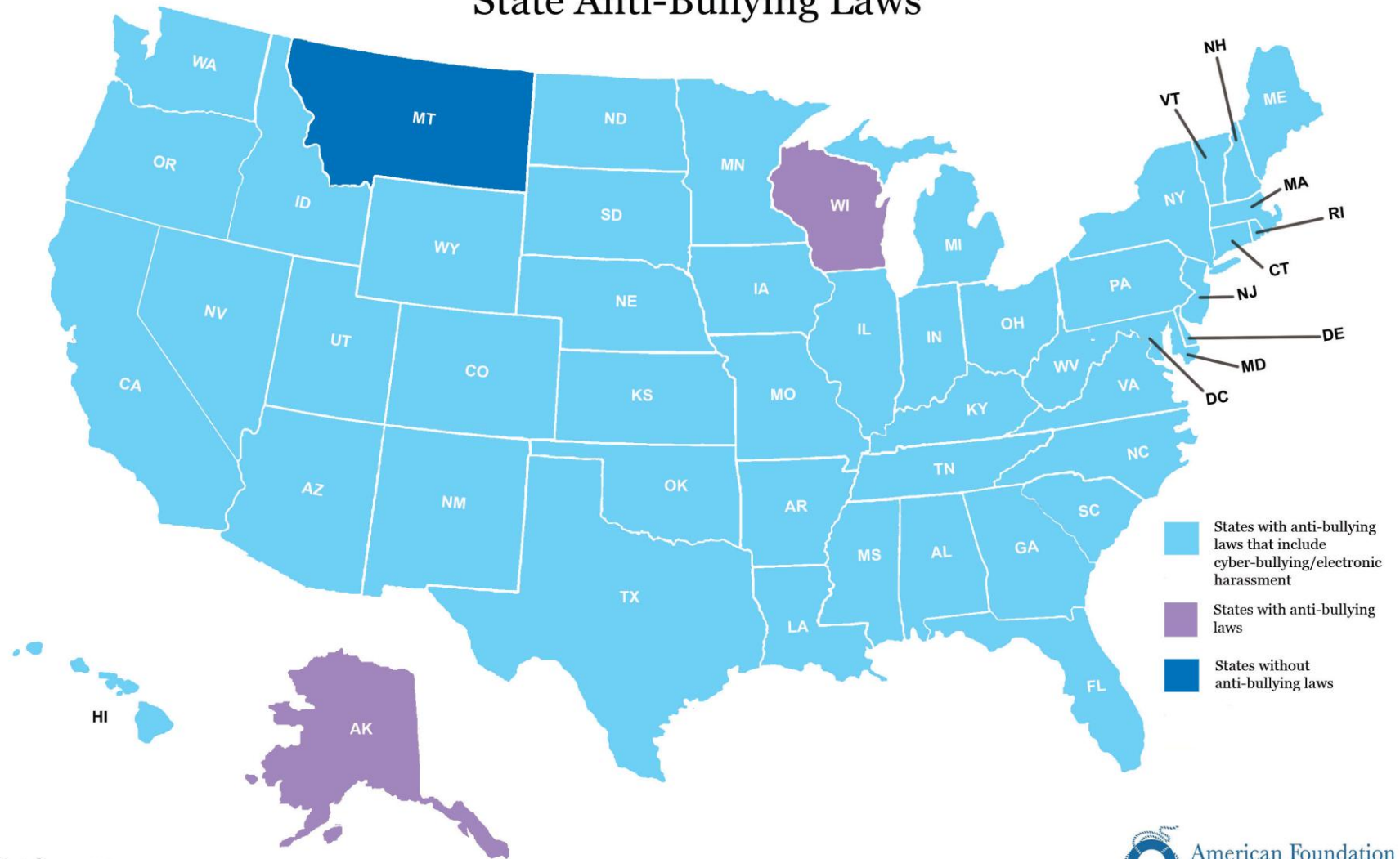
SUICIDE PREVENTION TRAINING FOR SCHOOL PERSONNEL

- Skill building to understand suicide risk
- Competent to identify and assist vulnerable youth in seeking help

ANTI-BULLYING AND ANTI-CYBERBULLYING POLICIES

- Historical tolerance for bullying
- Modern awareness that bullying and suicide have a complex relationship with each other
- Vulnerable youth are at increased risk for self harm and bullying can be a contributing factor to suicide
- Resources available:
 - Stopbullying.gov
 - US Department of Education Research Brief on Bullying and Suicide
 - US Department of Education, Community Action Toolkit “Bullying and Suicide: Cautionary Notes”

State Anti-Bullying Laws



October 2012

MENTAL HEALTH PARITY AND ACCESS TO TREATMENT

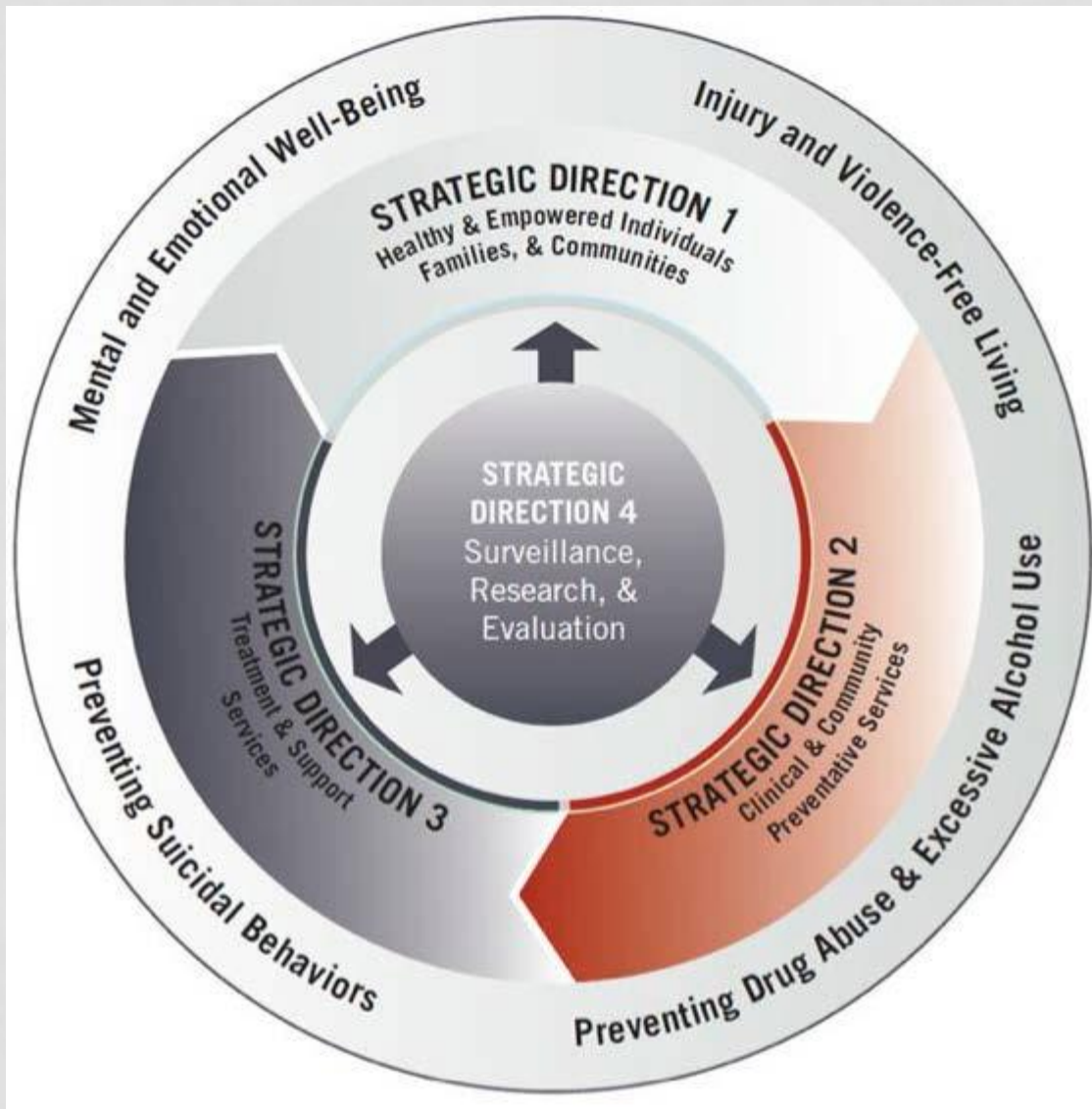
- Coverage improves access
- Access to services has the potential to significantly reduce the number of suicides
- The majority of those who die by suicide have a diagnosable and treatable mental illness (MI) at their time of death
- Substance use disorders (SUD), especially with a co-morbid condition of depression, significantly increase suicide risk
- MI and SUD are recognizable and treatable

ACCESS TO FIREARMS FOR PERSONS AT RISK FOR SUICIDE

- Firearms are used in over half of all completed suicides nationally
- Firearm suicides outnumber firearm homicides almost 2 to 1 nationally
- Reducing access to firearms for persons at risk for suicide is important public policy
- Reducing access to firearms gives people time – time to change their minds, time for someone to intervene, time to seek help
- Voluntary safe storage of firearms; public education on gun safety; eliminate barriers to mental health care

2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION

- US Surgeon General and the National Alliance for Suicide Prevention
- Revised in 2012 to reflect major developments in suicide prevention, research and practice
- Four strategic directions:
 - Create supportive environments promoting healthy and empowered individuals, families and communities (4 goals, 16 objectives)
 - Enhance clinical and community preventive services (3 goals, 12 objectives)
 - Promote the availability of timely treatment and support services (3 goals, 20 objectives)
 - Improve suicide prevention surveillance collection, research, and evaluation (3 goals, 12 objectives)



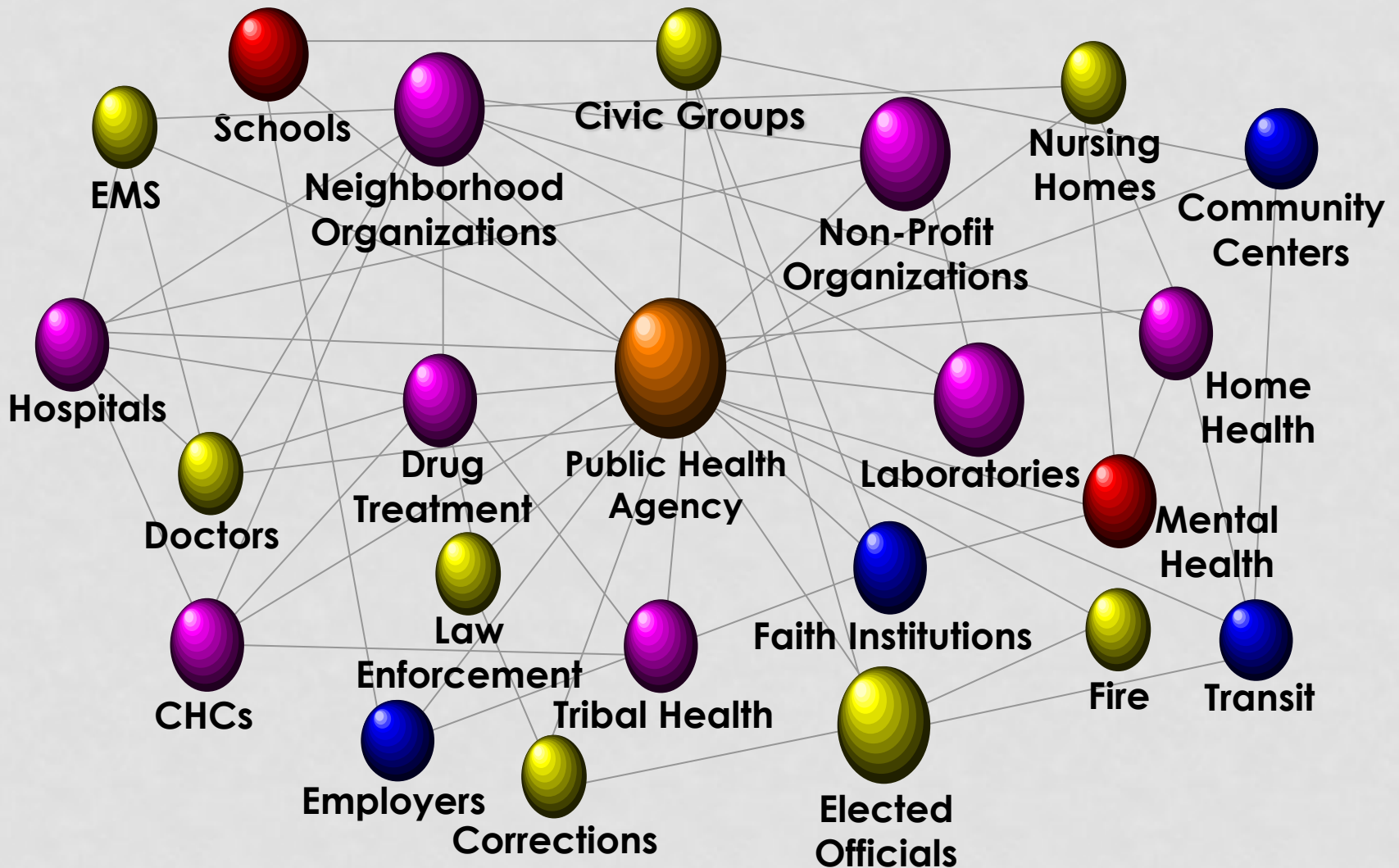
SUICIDE IS A PUBLIC HEALTH ISSUE



SUICIDE PREVENTION ACTIVITIES ALIGN WITH OTHER INJURY PREVENTION ACTIVITIES IN PUBLIC HEALTH

- Injury Prevention in public health is focused on mitigating harm
- This is accomplished through a number of avenues
- Integration of activities among federal and state agencies, e.g. DPBH integration
- Partnering between the Executive and Legislative Branches of government to develop supportive public policy and enforcement activities

PUBLIC HEALTH SYSTEM



PUBLIC HEALTH APPROACH

- Five Steps:
 - Surveillance: What is the problem?
 - Risk Identification: What is the cause?
 - Intervention: What works?
 - Implementation: How do you do it?
 - Outcome Measurement: Did it work?

CDC ACTIVITIES RELATED TO SUICIDE PREVENTION

- Violence prevention activities guided by Four Key Principles:
 - Emphasis on primary prevention
 - Commitment to developing a rigorous science base
 - Cross cutting perspective – many disciplines/perspectives
 - Population approach

CDC STRATEGIES

- Four general priorities:
 - Measuring impact
 - Creating and evaluating new approaches to prevention
 - Applying and adapting effective practices
 - Building community capacity for implementing prevention strategies

CDC RESOURCES

- Preventing Suicide: Program Activities Guide
- Strategizing for Suicide Prevention
- Effective and Promising Programs
 - Best Practices Registry: Suicide Prevention Resource Center
 - SAMHSA's National Registry of Evidence-Based Programs and Practices
- Reviews of Preventive Interventions
- Strategic Direction for the Prevention of Suicidal Behavior
- State Suicide Prevention Planning: A CDC Research Brief

FFY14 FUNDING FOR SAMHSA

- Expands mental health services especially for children and youth
- “Now is the Time” – President’s Plan
 - Expands and Improves mental health services across many critical areas
 - New proactive services designed to identify children with mental health conditions
 - Project AWARE (Advancing Wellness and Resilience in Education)
 - Mental Health First Aid training for teachers
 - Train thousands of additional mental health professionals to serve students and young adults (HRSA collaborative)
 - The Minority Fellowship Program
 - Healthy Transitions
 - Increased mental health and substance abuse block grants
 - Created a Tribal Behavioral Health Grant program to address suicide and related substance abuse prevention needs in tribal communities
 - Increased Funding for the Primary Behavioral Health Care Integration grant program
 - Prevention and Public Health Fund dollars to enhance suicide prevention efforts including those to support the implementation of the National Strategy for Suicide Prevention

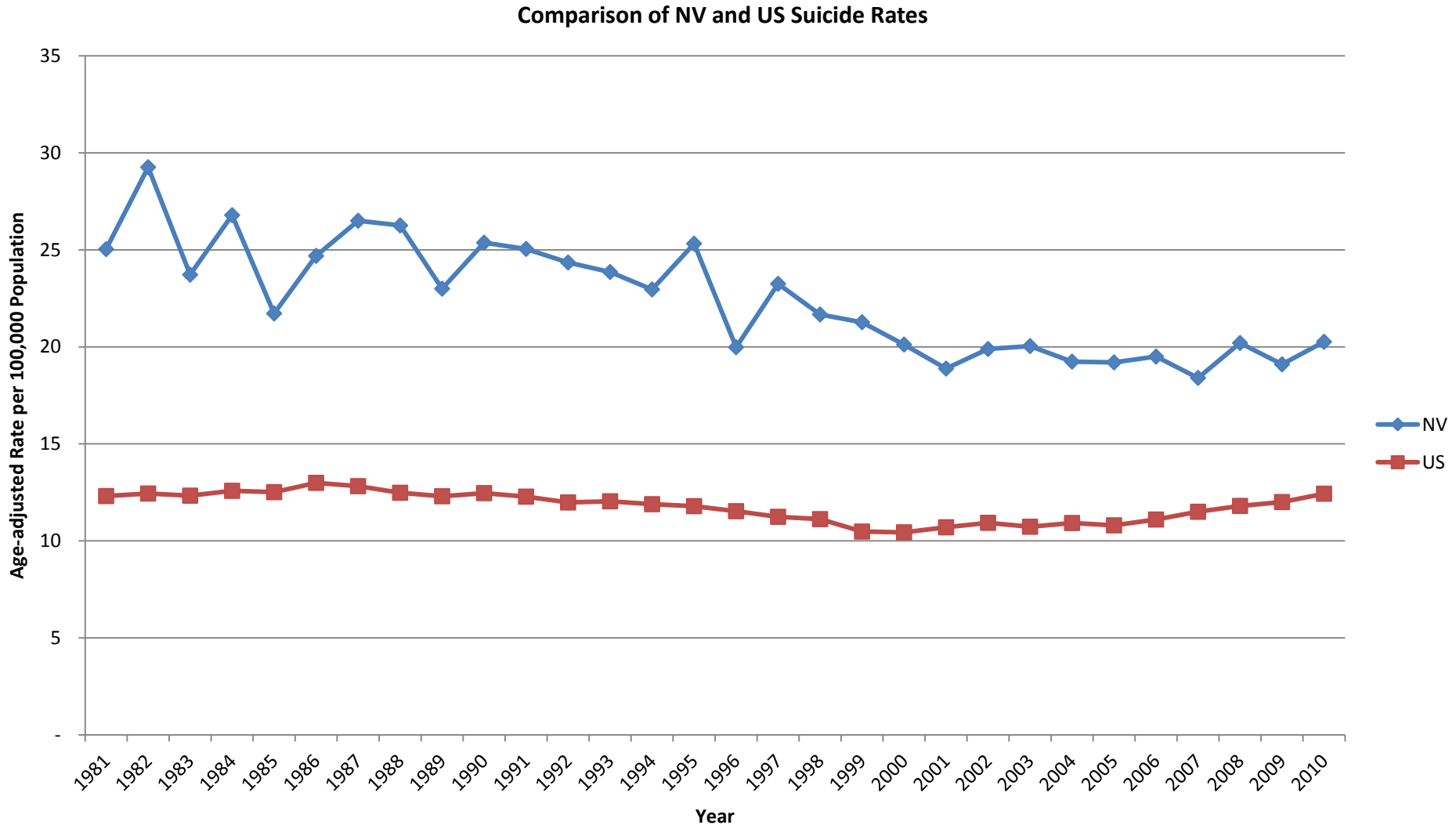
HISTORY OF SUICIDE PREVENTION EFFORTS IN NEVADA

- 2003 Suicide prevention legislation (SB49, SB36, SCR 3, 4, & 5) adopted in Nevada
- 2005 Nevada Coalition for Suicide Prevention established; State of Nevada receives Cohort 1 Garrett Lee Smith grant \$1.2 million;
- 2005 Nevada Office of Suicide Prevention established;
- 2007 Nevada Suicide Prevention Plan released;
- 2008-2011 Three Garrett Lee Smith Awards come to Nevada (ITCN/IHBN, OSP and Pyramid Lake Paiute Tribe; 4 MSPI grants awarded to NV tribes;
- 2009 State of Nevada awarded Garrett Lee Smith grant for \$1.5 million, funding ended June 2013;
- 2013 Fund for a Healthy Nevada funds office and two state positions added;

FACTS ABOUT SUICIDE IN THE U.S.

- From 2008-2010, the number of suicide deaths was double that of homicide deaths;
- In 2010, more than 38,000 people died by suicide;
- Every suicide death leaves, on average, six survivors;
- Among 15 -24 year olds, suicide is the third leading cause of death;
- Among 15-24 year olds, there are 100-200 attempts for every completed suicide;
- Among seniors citizens, there are 4 attempts for every completed suicide;

Suicide Rates in Nevada and the US --1999-2010



FACTS ABOUT SUICIDE IN NEVADA

- In 2010, suicide was the 6th leading cause of death; Nationally, suicide is 10th;
- Suicide is 2nd leading cause of death for Nevadans 15-34;
- More Nevadans die by suicide than by homicide or motor vehicle crashes;
- Youth have the 2nd highest attempt rates in Nevada;

Source: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

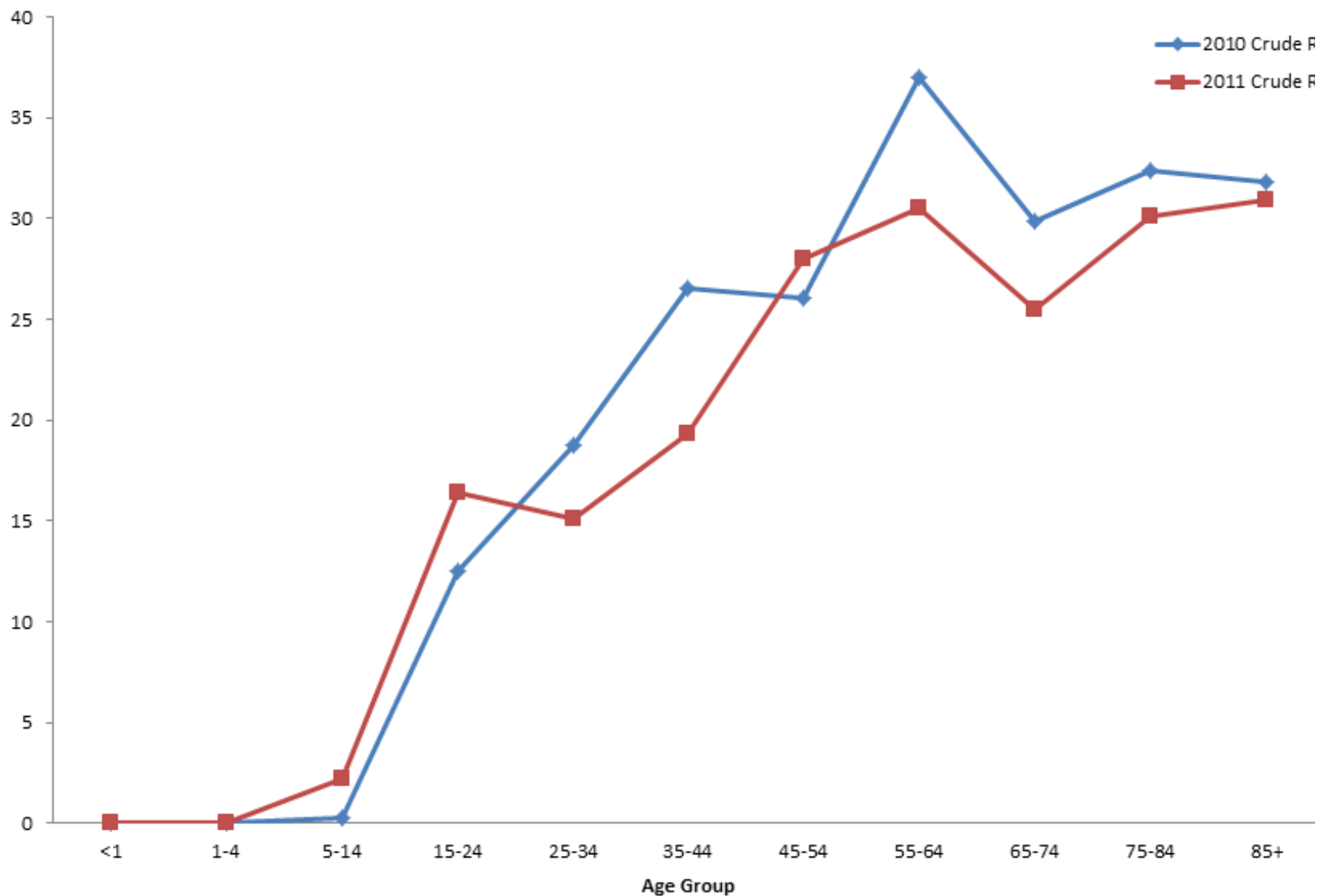
FACTS ABOUT SUICIDE IN NEVADA

- NV youth ages 10-19 averaged the 10th highest rate in the nation for 1999-2009 with 6.27/100,000;
- Males make up 80% of suicide deaths at an average rate of 33.3 per 100,000;
- Native American Youth have one of the highest rates of suicide.
- Firearms are used in 53% of suicide deaths.
- Female Nevada veterans are 3 times more likely to die by suicide than the general Nevada female;
- Veterans comprise an estimated 20-25% of all completed suicides;

Source: Office of Statistics and Programming, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

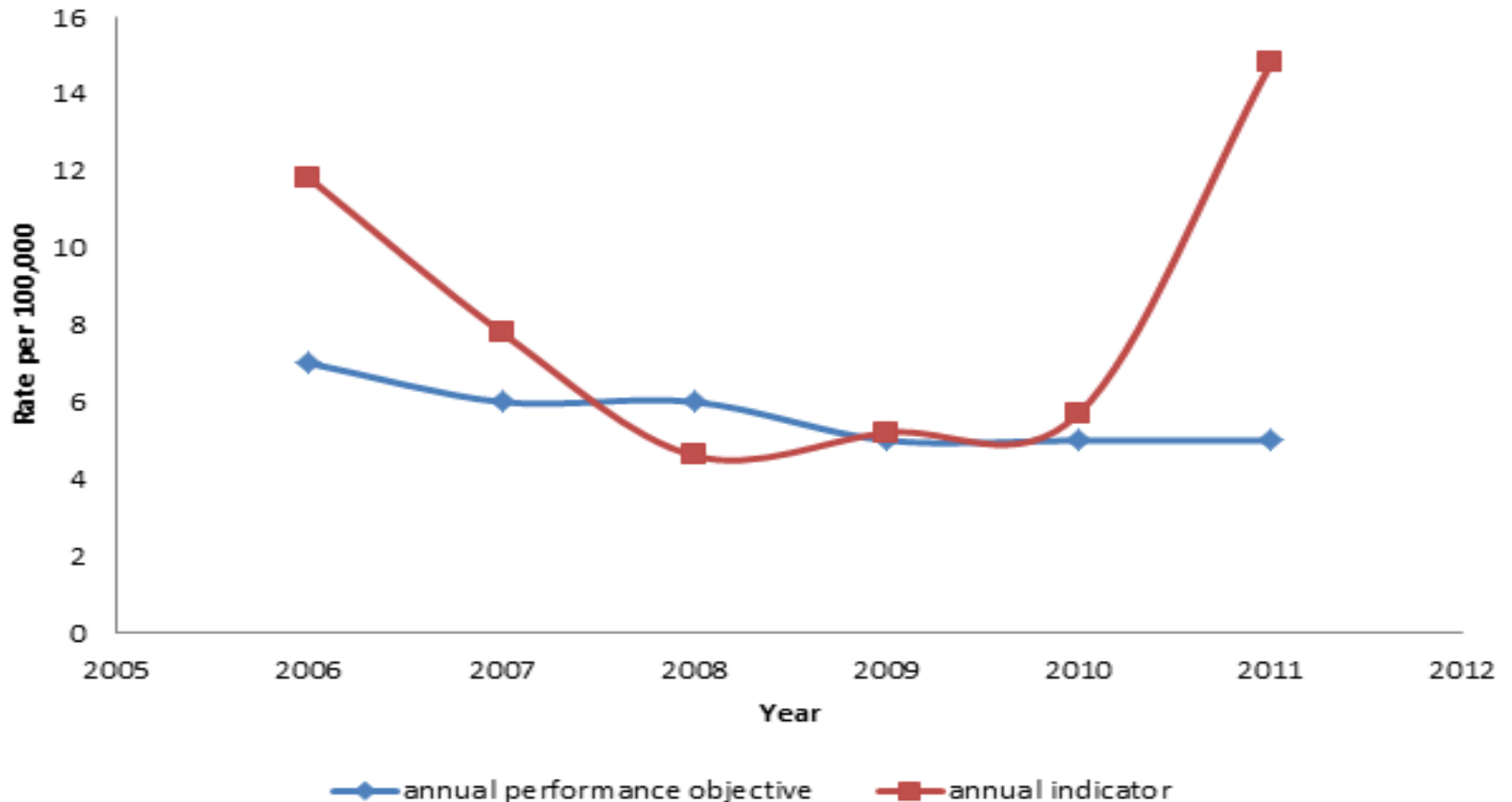
Death Counts and Crude Rates by Age Group and Year of Death, Nevada Residents, 2010-2011*

*Note: Data are not final and are subject to changes.



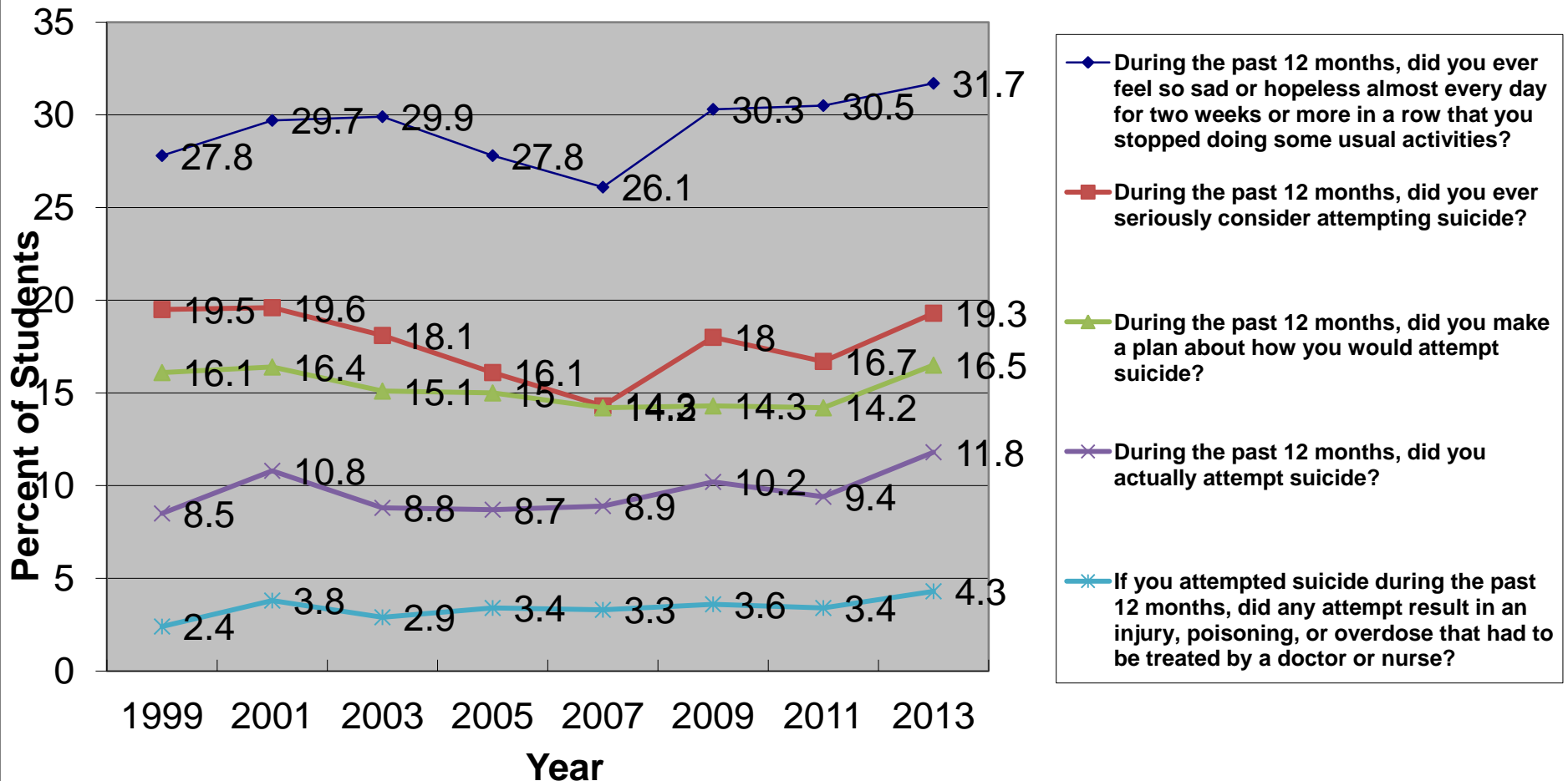
TEEN SUICIDE DEATHS 2011

PERFORMANCE MEASURE # 16 The rate (per 100,000) of suicide deaths among youths aged 15 through 19.



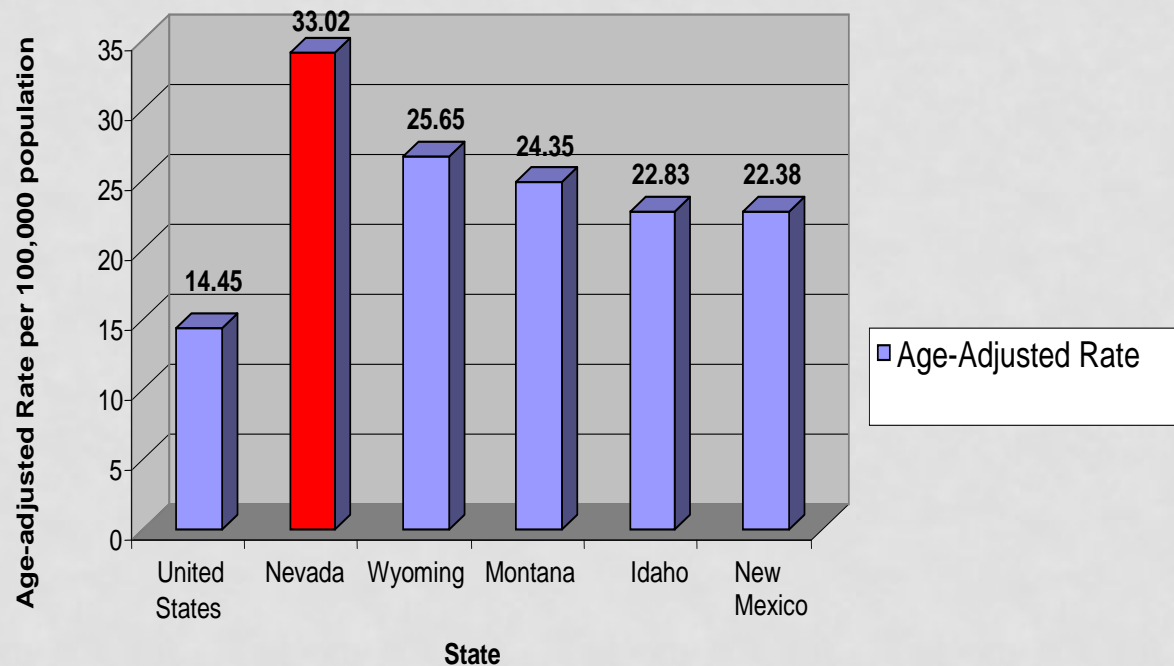
Youth Risk Behavior Survey

Nevada Youth Risk Behavior Survey: 1999-2013



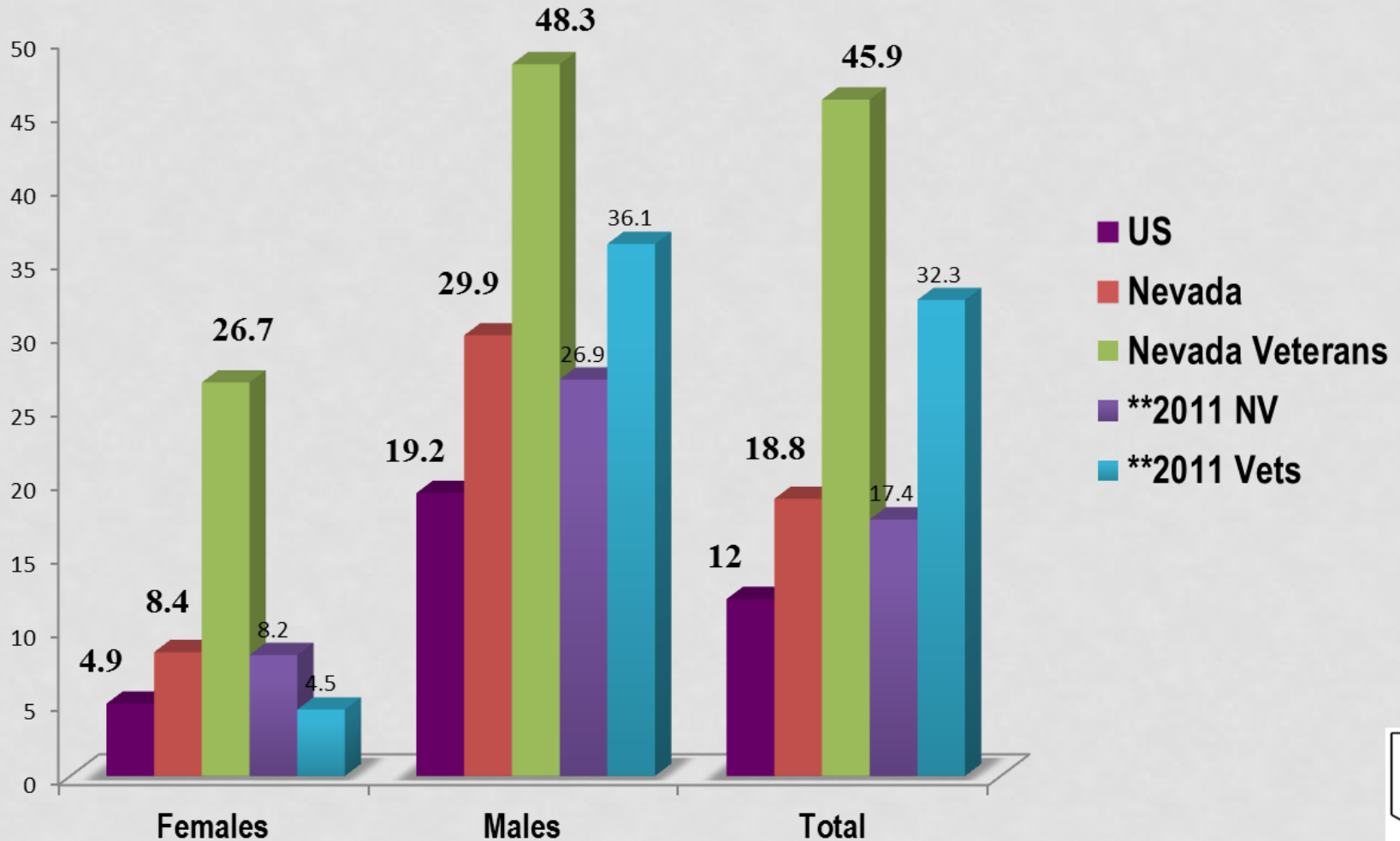
OLDER NEVADANS IN CRISIS

States with Highest Average Suicide Rates in the U.S from 1999-2009: Ages 60-85+



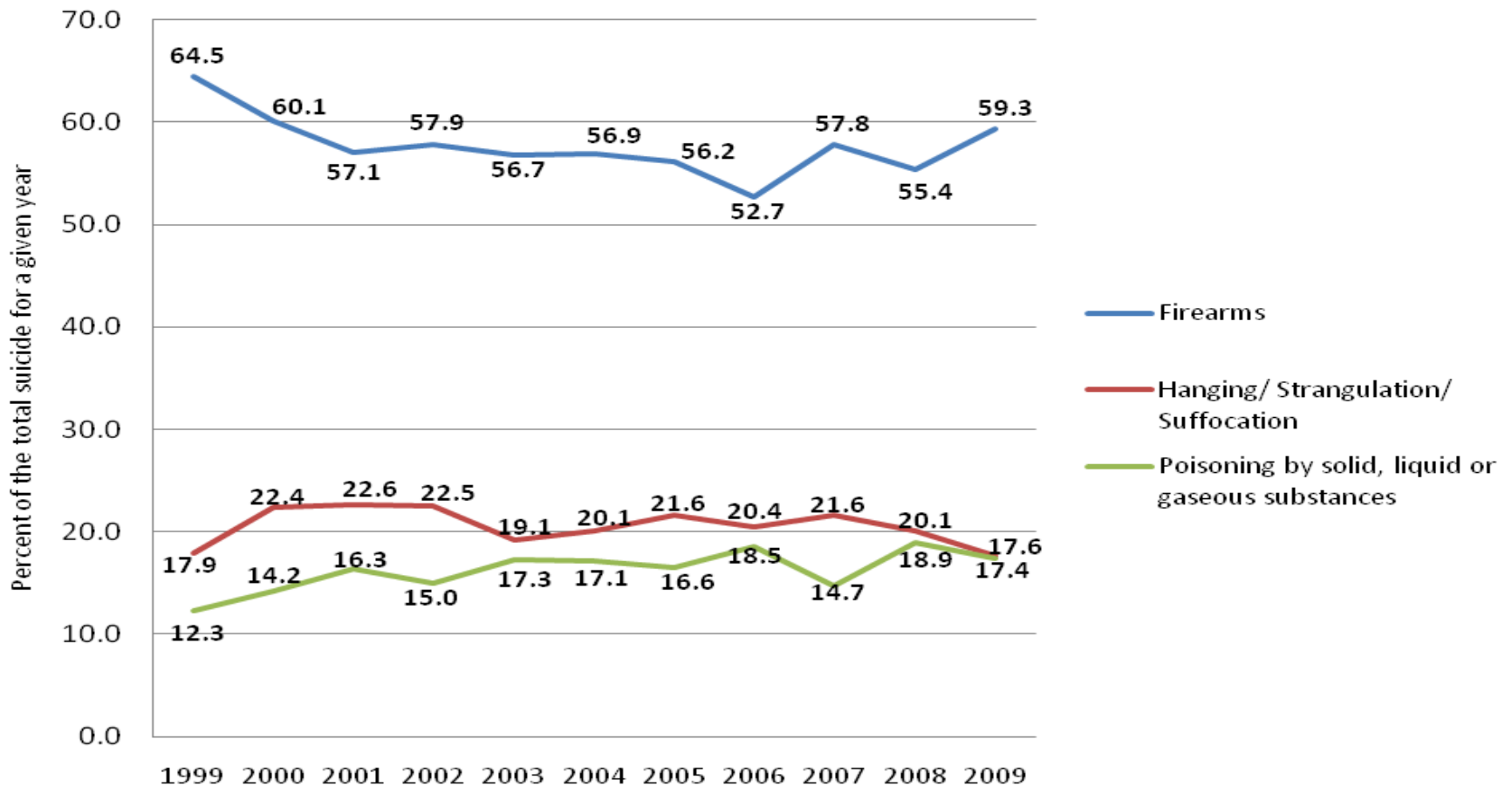
Source: CDC, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online] (2012).

NEVADA VETERANS



NEVADA TRENDS BY MEANS

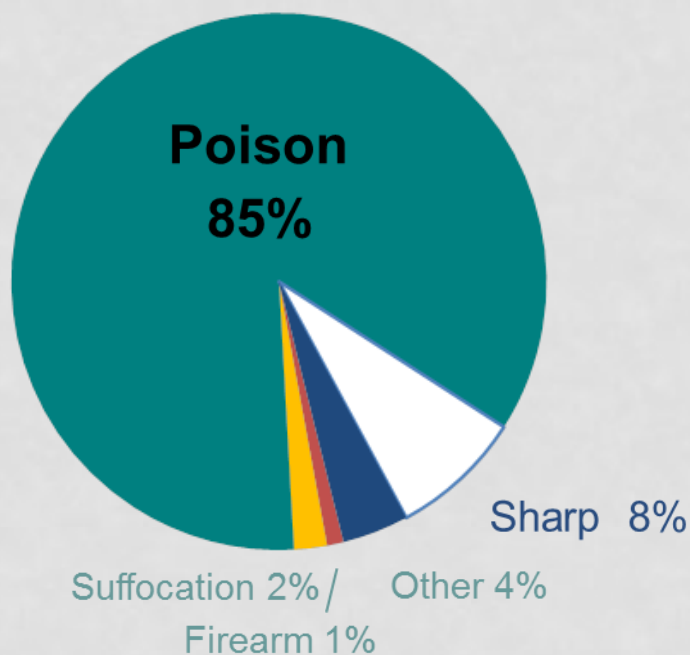
Suicide Trends in Nevada by 3 leading Method



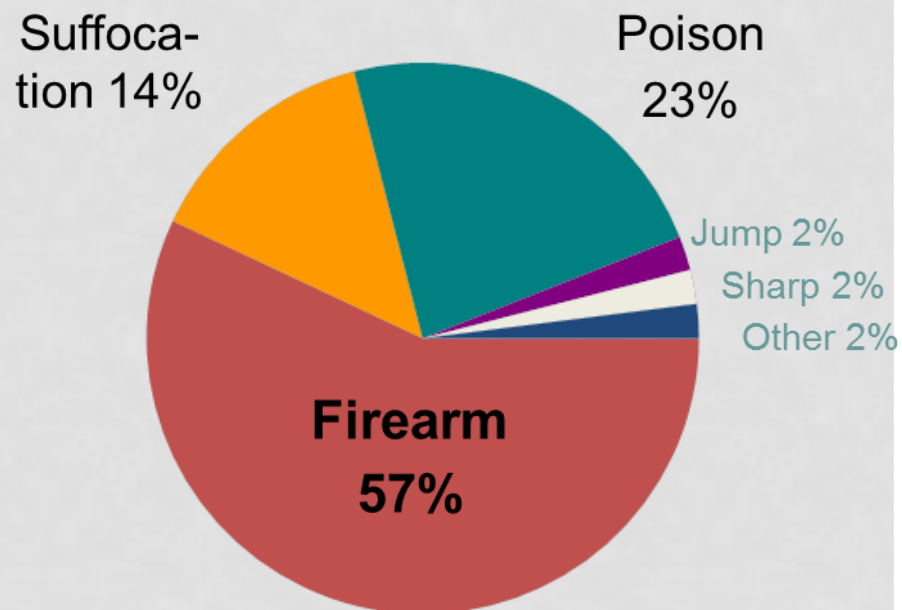
SELF-INJURY CASE FATALITY RATES



METHODS OF SELF-INJURY, NEVADA



Nonfatal Inpatient



Suicide

TRENDS IN NEVADA

- a decline in the male suicide rate contrary to U.S.
- stable female suicide rate when suicide among females is increasing nationally;
- decline in the Caucasian suicide rate contrary to U.S.

RISK FACTORS

- Certain mental disorders:
 - Depression
 - Bipolar Disorder
 - Anxiety Disorders
 - Schizophrenia
 - Conduct Disorder (in youth)
 - Psychotic Disorders
 - Impulsivity and aggression, related to a mental health diagnosis

RISK FACTORS

- Alcohol or substance dependence or abuse
- Problem gambling
- Previous suicide attempt(s)
- Family history of attempted or completed suicide
- Serious medical condition or pain

American Foundation for Suicide Prevention, 2013

National Council on Problem Gambling

RISK FACTORS

- A highly stressful life event such as losing someone close, financial loss, or trouble with the law
- Prolonged stress due to adversities such as unemployment, serious relationship conflict, harassment or bullying
- Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide (contagion)
- Access to lethal methods of suicide during a time of increased risk

KEY RISK FACTORS BY AGE

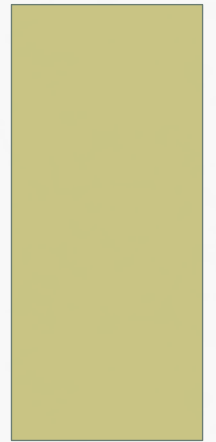
- Older adults: Death of a loved one, physical illness, uncontrollable pain, fear of burdening family members, social isolation, major changes in social roles
- Middle age: Relationship problems, legal problems, financial hardship, substance abuse and job stress
- Youth: Contagion, substance abuse, impulsive aggressive personality disorders, stressful life events, family factors

PROTECTIVE FACTORS

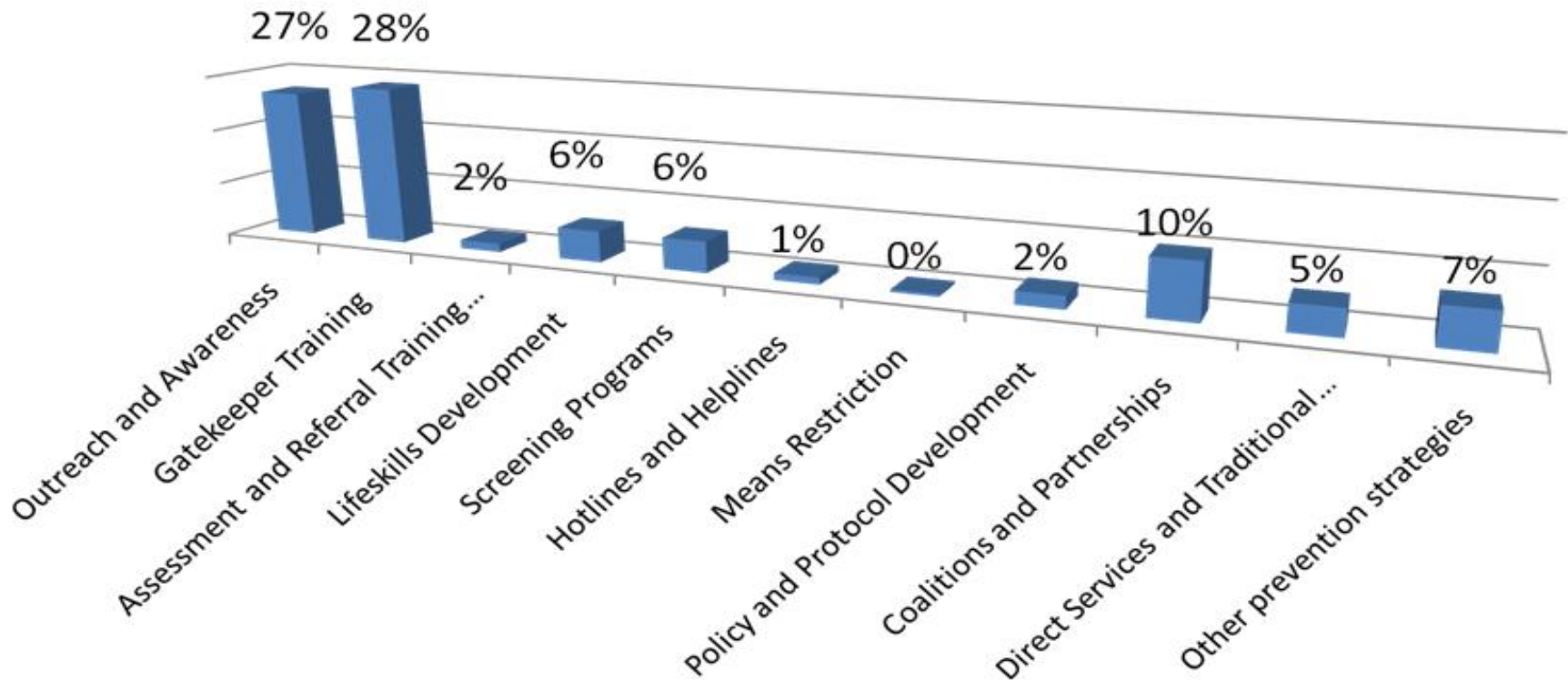
- Receiving effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal means of suicide
- The skills and abilities to solve problems
- Connectedness – positive connections with family, peers, community and social institutions that foster resilience
- Support through ongoing medical and mental health care relationships
- Cultural and religious beliefs that discourage suicide and support self preservation

SUCCESSSES

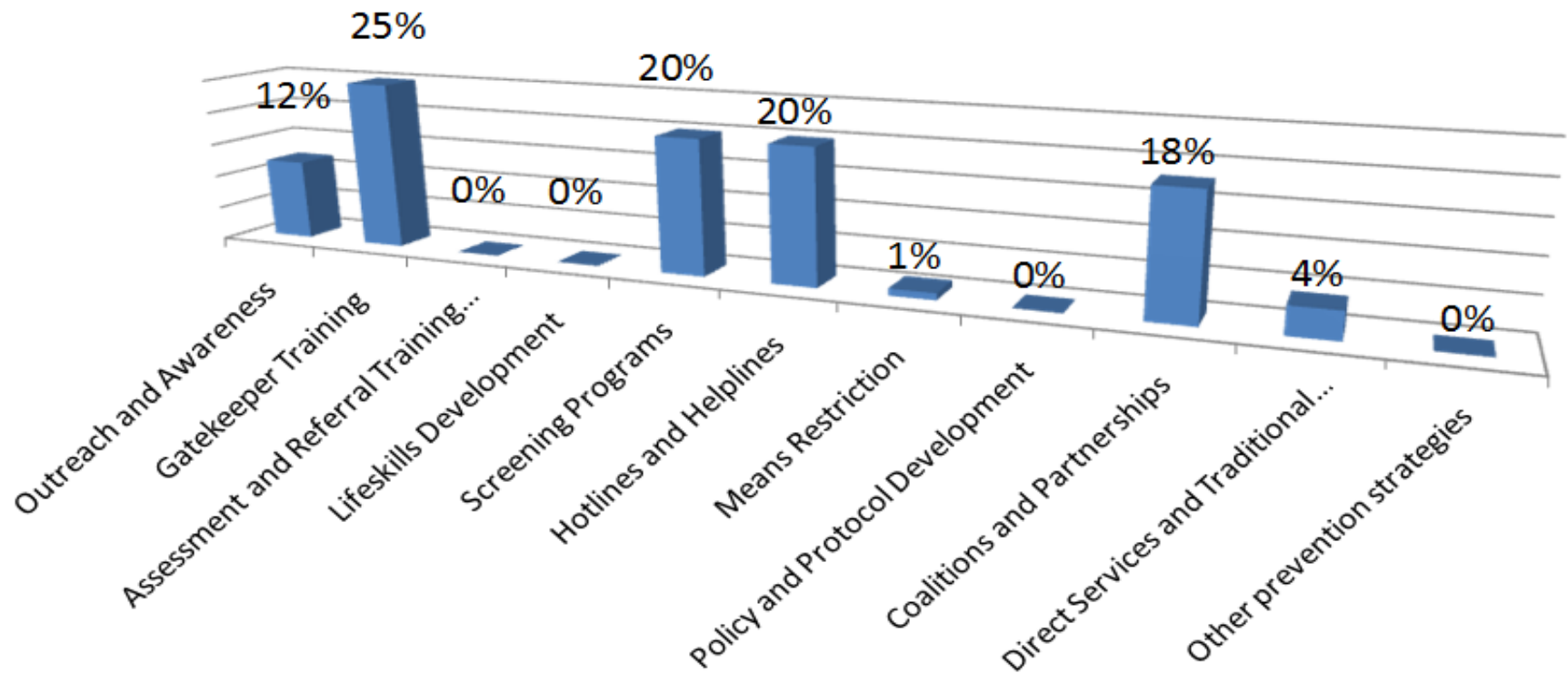
OFFICE OF SUICIDE PREVENTION



PREVENTION STRATEGIES: PROJECT EXPENDITURES COHORT INFORMATION



PREVENTION STRATEGIES: PROJECT EXPENDITURES, NEVADA



OSP: PUBLIC/PRIVATE PARTNERSHIPS

- Increase in number of local or regional groups that collaborate with the Office of Suicide Prevention to implement the state plan
- Community planning
- Mental Health Promotion—Mental Health First Aid and Youth Mental Health First Aid trainings

NV SUICIDE PREVENTION HOTLINE

History

Using the GLS federal grant award, OSP has partnered with Crisis Call Center to implement the nation's first 24-hour, text-based crisis intervention service: TextToday;

Call volume of Crisis Call Center's Suicide Prevention Hotline continues to increase with 28,051 calls in 2009 to over 32,000 contacts in 2013;

OSP: COMMITTEE TO REVIEW SUICIDE FATALITIES

2013 AB 29 passed, NRS 439.5102

- collaborative, cross-jurisdictional forum to determine trends and risk factors
- Reporting on trends and patterns in current time
- evaluate the prevalence of other contributing factors for preventable deaths, focusing on higher risk groups such as service members, veterans, older adults and Native Americans
- elevate the evaluation of and reporting on high risk factors, current practices, gaps in systematic responses and barriers to safety
- improve data relative to investigating reported suicide deaths

SERVICE MEMBERS, VETERANS AND THEIR FAMILIES

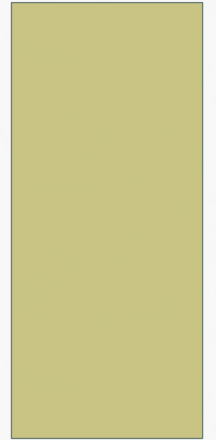
- Strategic Plan for Service Members, Veterans and their Families
- Governor's Veterans Suicide Prevention Council
- Participating in upcoming policy academy to implement our goals for helping military and veterans' families

REDUCING ACCESS TO LETHAL MEANS

- Suicide Proof Your Home campaign-2012 through the Executive Committee to Review the Deaths of Children public awareness funding;
- Reducing Access To Lethal Means—2013 through the Executive Committee to Review the Deaths of Children public awareness funding;
 - 11 Commandments of Gun Safety
 - Lok it Up

OPPORTUNITIES

OFFICE OF SUICIDE PREVENTION



WHAT IS WORKING

- Evidence-based screening in school, primary care and emergency departments
- Specific treatment care paths
- Open access to appointments
- Careful attention to transitions
- Informed, engaged youth and families
- Shared IT for decision support and communication
- Aggressive follow-up

ZERO SUICIDE

Suicide as a Never Event:

*Setting the Stage for Change
in Public & Behavioral
Health Care Environments*



Suicide Care in Systems Framework.
Covington D, Hogan M, et al.
Clinical Care & Intervention Task
Force Report, NAASP. 2011; 1-26,
Final Draft.

AIR FORCE SUICIDE PREVENTION INITIATIVE (1996 – 2002)

- The suicide rate dropped by one-third
- Strong commitment from top leadership demonstrated through consistent and effective communication
- Skills and information training on suicide intervention for all Air Force members, varying in intensity based upon rank and level of responsibility
- Creating the first privileged communication for suicidal personnel
- Encouraging the responsibility of all Air Force members to care for one another – “buddy care”

HENRY FORD HEALTH SYSTEM (2001 - PRESENT)

- Suicide Rate decreased by 75%. No suicide deaths for ten consecutive quarters
- Partnership with patients via advisory council for design of the program throughout treatment planning and care process
- Planned care model, stratification of risk into three levels with specific interventions, including emphasis on means restriction
- Established and maintained all clinician competency and training in Cognitive Behavioral Therapy (CBT)
- Robust performance and quality improvement techniques
- Improved access to immediate care for patients, including drop-in group medication appointments, advanced same day access to care and e-mail “visits”

PRIMARY CARE PROVIDERS

- Often the first and only medical contact of suicidal patients
- NIMH: Primary care physicians saw 70% or more of elderly suicide victims within a month of their death
- Only detected 1 out of 6 patients who later died by suicide



PRIMARY CARE AND YOUTH

- 70% of adolescents see a physician once a year.
- only 23% of physicians screen for mental health disorders
- only 34% of youth report that their doctor talks to them about their emotional health.
- Pediatricians tend to under identify children with mental health problems.
- As many as 2 in 3 depressed youth are not identified by their primary care clinicians and do not receive any kind of care.
- Over 2 million youth aged 12-17 have major depression each year.
- As many as 83% of adolescents in primary care settings who have attempted suicide are not recognized as suicidal by their primary care physician.

COSTLY GAPS: CONTINUITY OF CARE

- U.S. E.D. visits: More attempts (49% increase), fewer admissions for attempts (35% less) (Larkin et al, 2008)
- Fewer outpt. resources, longer waits: 76% of ED directors report lack of community referrals (Baraff et al, 2006)
- About 50% of suicide attempters fail to attend treatment post-discharge (Tondo et al, 2006)
- Over 1/3 re-attempt or die by suicide within 18 months post discharge (Beautrais, 2003)
- > 1 of 20 ED visits are suicide attempts (Baraff et al 2006)
- 50% costs for suicide attempt patient admissions= readmissions (Beautrais 2005)

Source: Draper, National Suicide Prevention Lifeline, 2012

DISCHARGE FOLLOW UP



SUICIDALITY

- WHO Study, 2008: 800 attempters FU from 8 EDs around the world, 9 contacts, 18 mos. = 9x fewer suicides than control group
- Vaiva et al, 2006: Phone FU 1 month after ED discharge significantly reduced suicide attempts
- DeLeo, 2002: Telecheck FU in Italy reduced suicide rate 6x among elderly women
- (Motto, 1976): Letters (24 over 5 yrs) sent to 389 attempters post-discharge sig. reduced suicides
- (Carter 2005): Postcard follow-ups over 1 yr. to 378 attempters reduced attempts 50%
- Over 800 attempters from 8 hospitals around the world
- Received brief ED psycho-ed session before discharge, + 9 post-discharge contacts (telephone and face-2-face) for 18 months

Source: Draper, National Suicide Prevention Lifeline, 2012

REDUCING ACCESS IS PREVENTION

- 1 in 4 said they deliberated less than 5 minutes
- 9 out of 10 deliberated less than a day
 - - 24% said less than five minutes
 - - 24% said 5-19 minutes
 - - 23% said 20 minutes to 1 hour
 - - 16% said 2-8 hours
 - - 13% said 1 or more days

Source: Simon, T.R., Swann, A.C., Powell, K.E., Potter, L.B., Kresnow, M., and O'Carroll, P.W. Characteristics of Impulsive Suicide Attempts and Attempters. SLTB. 2001; 32(supp):49-59.

PRACTICAL STEPS

1. Change policy: Add "Lethal means counseling" protocols to providers' and gatekeepers' existing suicide prevention protocols.
2. Train providers and gatekeepers how to conduct lethal means counseling.
3. Change information systems to cue providers to educate families.
4. Expand options in the community for temporary storage or disposal of firearms for families requesting these services.

UPSTREAM PREVENTION

- Why is upstream suicide prevention important?
- What evidence supports upstream approaches?
- What are the barriers of upstream approaches?
- How can Nevada move forward with upstream suicide prevention?

CONNECTEDNESS

“Much of the work of suicide prevention must occur at the community level, where human relationships breathe life into public policy ...”

-- Dr. David Satcher
in the Preface of the National Strategy
for Suicide Prevention (1998)