Maine Suicide Prevention Program

Statewide Activities Include:

- Data collection, analysis & dissemination of print materials through SAMHS IRC
- Training on suicide prevention and assessment to a wide range of partners including Primary Care
- Technical Assistance for organizations in integration of suicide prevention, management and postvention
- Website: www.maine.gov/suicide
- Annual Beyond the Basics conference May 6, 2016

Introduction

- For clinicians, the risk of suicide is a specter that haunts practice. When you experience the suicide of a client, it:
  - Is a devastating loss of life
  - Leaves a crater of distress in its wake washing over
    - Family,
    - Friends, community
    - Treatment providers
  - Is easily perceived as a failure of treatment or supports
- Efforts to prevent suicide save more than lives.
What the Statistics Tell Us

Suicide in the US, 2014

- 42,773 Americans died by suicide; about 1 person every 12.3 minutes
- Suicide deaths 3 times the number of homicides (homicides=13,472)
- 10th leading cause of death across the lifespan
  - 2nd leading cause of death for 15-34 year olds
- Men account for 77.5% suicides
  - 3 Female attempts per male attempt
- Veterans account for 20% of suicides
- Since 2009, suicides have exceeded motor vehicle crash related deaths

Suicide in Maine, 2012-2014

- 2nd leading cause of death ages 10-34
- 4th leading cause of death ages 35-54
- Suicide deaths 8x homicide deaths
- Every 1.6 days someone dies by suicide
- Every 2 weeks a young person dies (<25)
- 225 suicide deaths per year on average
- Firearms most prevalent method of suicide (54%)
Youth Suicide in Maine 2011-2016

- Maine saw 43 suicides among youth 13-18
  - 28% Female
  - 72% Male
- Hanging was the most common means of teen suicide with firearms second.
- Nationally, there was a significant increase in teen suicides 2008-2014
- By contrast, US unintentional deaths and homicides have decreased over the same timeframe.
- Rates are higher and more gender differentiated in 19-24 y/o.

*Data from US CDC WISQARS and Maine Office of Chief Medical Examiner*

Average Annual Suicide Deaths, by Age & Sex, Maine, 2012-2014

Suicide Attempts- A Strident Call for Help

- A suicide attempt may be the first overt sign that someone is struggling!
- A call for Help
  - Often trigger being seen by a provider!
- Estimates 25 attempts for every suicide death
  - 200:1 for adolescents
- Ask about a history of suicide, especially for a depressed patient

*A past suicide attempt is most predictive of future suicide behavior.*
Suicidal Thoughts and Attempts, by Sex and Sexual Orientation, Maine HS Students, 2015

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<th>Prevalence (%)</th>
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<td>Total</td>
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<tr>
<td>Males</td>
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Data source: Maine Integrated Youth Health Survey (MIYHS), 2015

Self-Injury and Suicide

- Self injury (non-suicidal) is an unhealthy way to cope with strong negative emotions.
  - Rapid return to emotional calm
  - Because it works it can become repetitive
- 24% of HS girls and 12% of boys report SI on the past 12 months.
- Self injury may be the most predictive of suicide risk in adolescents!
- Significant increase in risk of suicide ideation and attempts.

Self-Injurious Behavior among Maine HS Students, by Sex and Sexual Orientation 2015

(Students reporting at least one incident of self-injury past 12 months

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<td>Bisexual</td>
<td>37.1</td>
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</table>

Data source: Maine Integrated Youth Health Survey (MIYHS), 2015
Working toward Zero Suicide Within a System of Care

Systematic Suicide Care Plugs the Holes in Health Care

Moving toward Zero Suicide within a Healthcare System

The Henry Ford Healthcare System lowered their suicide rates by 80% during a period when suicide rates were rising:

- Creating a leadership-driven safety-oriented culture that commits to dramatically reducing suicide among people under care,
- Developing a caring, prepared, competent workforce,
- Systematically identifying and assessing suicide risk,
- Ensuring every person has a pathway to care – a pathway that involves every component of the health system,
- Using effective, evidence-based treatment, including collaborative safety planning,
- Assuring continuing contact for those seen as at risk.
Impact of “Perfect Depression Care” over time

![Graph showing the decrease in suicides per 100,000 HMO patients from 2000 to 2010.]

Developing a Suicide-Informed Practice

- All staff see suicide prevention as part of their work.
- Staff are trained and supported for their specific role.
- Protocols are in place guiding identification, assessment, management of risk:
  - Screening is done to help identify those at risk
  - A standardized assessment tool (& process) is used across the practice
  - Patients assessed as at risk for suicide receive appropriate treatment
  - Collaborative Safety planning is a practice norm
  - Continuity of care is assured through proactive follow-up for those identified as at risk.

Populations at Increased Risk for Suicide

- People living with mental illness
- Men: 80% of suicides
- Veterans and Active Military: PTSD & TBI implications; 20% of all suicides
- Chronic Illness and Mental Illness
- LGBTQ: attempts higher
### Mental Health Disorders and Suicide

- Studies in the last 50 years report consistent outcomes:
  - 90% of people who die by suicide are suffering from one or more diagnosable psychiatric disorders:
    - Major Depressive Disorder
    - Bipolar Disorder, Depressive phase
    - Anxiety Disorders
    - Alcohol or Substance Abuse*
    - Schizophrenia and emergent psychosis
    - Eating Disorders (anorexic)
    - Personality Disorders such as Borderline PD

### Assessment of Suicidal Behavior

### What is Your Reaction When Your Client Talks About Suicide?

- Personal
- Professional
  - What are your concerns?
  - How do you know when you’ve done enough?
- When I ask her about suicide, I’m thinking...
- How do you take care of yourself?
Assessment Tools

Putting the information together to determine level of risk

Decisions on Clinical Tools & Documentation

- What tools will be used as a depression screen and available for indicating suicide screening need?
- What will you use as a suicide screening/assessment tool?
  - C-SSRS screen and assessment version across all programs?
  - Additional inpatient assessment questions?
  - Other...
- Will a standardized safety-planning tool be used?
- How will you track patients in need of follow-up or having a history of suicide attempts?
  - Clinical care outreach?
- How will elements be documented and how will access to information be managed to ensure staff readiness?

Assessing Risk using Columbia Suicide Severity Rating Scale (C-SSRS)

- An evidence-based screening tool with applications as an assessment instrument
- Valid and reliable with many populations
- Level of information based upon clinical conversation guiding response
- Enables more nuanced estimation of risk
- Versions available for use with children/adolescents.
- Used in primary care, inpatient settings, EDs, by Crisis teams...
Suicide Assessment Interview
(C-SSRS model inquiry; Screen Version)

• Suicidal Ideation
  – “Have you wished you were dead or wished you could go to sleep and not wake up?”
  – “Have you actually had any thoughts of killing yourself?”
• Planning
  – “How have you been thinking about how you might kill yourself?”
• Intent
  – “Have you had these thoughts and had some intention of acting on them?”
  – “Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?”
• History of suicidal Behavior
  – “Have you ever done anything, started to do anything, or prepared to do anything to end your life?”
  – “If yes, when, how long ago and details of the event(s)?”

*Over the past week or since the last visit

C-SSRS Full Assessment

• If C-SSRS screen indicated suicide risk, complete a full assessment to determine level of risk and corresponding level of care needs,
  – First 6 questions are same as screen version, but add frequency and intensity & ask more detailed information
  – Suicide attempt history and para suicidal behavior history and details including self-injurious behavior done without suicidal intent
  – Most recent, most severe, trend toward increasing severity of damage...
  – Details about any attempts that were aborted by self or interrupted by others,
  – A detailed assessment of current preparatory actions including acquisition or availability of lethal means, rehearsal, writing a note…
  – An assessment of potential lethality of means and methods identified

Short-term (Acute) Risk Factors and Symptoms

• Current depression, self-rated level of depressive Sx.
• Acute psychic distress (including anxiety, panic and especially agitation)
• Extreme humiliation/disgrace, shame, despair, loss of face
• Acute Hopelessness / Demoralization
• Desperation/sense of ‘no way out’
• Inability to conceive of alternate solutions
• Breakdown in communication/loss of contact with significant others (including therapist)
• Impulsivity/aggression
Acute Drivers of Suicide Risk in Adolescents

In an individual already vulnerable:
• Losses; especially relationship break-up
• Legal issues, exposure, disgrace
• Gender and sexual orientation-related stressors
• Acute, excessive substance use
• Family conflict/discord

Resources for Help

To address the Crisis
• Statewide Crisis Hotline (888-568-1112)
• Hospital emergency room
• 911

For follow-up support
• Imbedded Behavioral Health
• Practice specialist (eg. Psych Nurse...)
• Evaluation for medication management
• Referral to community counselors/therapist

Who can you consult with for questions and concerns?

Safety Planning and Follow-up
Collaborative Safety Planning

A Safety plan is a written list of coping activities personal, social and professional resources **developed with a person**, for use during a crisis:

• A time to work with a person willing, ready & able to engage in planning for their safety
• Allows exploration of personal and social resources and the ability to mobilize them.
• An opportunity for collateral contact
• A time for securing lethal means!

See also VA Safety Plan Quick Guide for Clinicians

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Ensure Collaborative Safety Planning

• For all people identified as at risk for suicide
• For those transitioning levels of care with identified risk
• To engage the patient in the work ahead.
• As a tool for self-management
• As a tool to track progress

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As many as 70 percent of suicide attempters of all ages will never make it to their first outpatient appointment. Across all studies, the rate for non-attendance is about 50 percent.

Efforts to improve suicide assessments, follow-up and continuity of care and to forestall readmission should target higher-risk patients prone to disengagement and non-adherence.

David Knesper, MD
Follow-up Care after the Crisis

- For a person at increased suicide risk, close follow-up is a vital and integral part of care.
- Studies support the benefit of follow-up contact in reducing the incidence of future suicide attempts.
  - Presents the opportunity to assess for improvement or lack of improvement
  - Allows for altering treatment and supports in accordance.
- A practice tracking system can be an effective tool to ensure needed follow-up is scheduled and documented. A flagging system...

Ensuring Engagement and Follow-up

- Decision-making on the identification of someone at increased risk:
  - Suicidality as reason for referral
  - Discharge from inpatient w/ suicidal risk
  - Transitions in treatment LOC or provider
  - History of suicide attempts
  - ...
- What are the elements of proactive engagement and follow-up?
  - Scheduled f/u visit within prescribed timeframe
  - Flagging system for missed appointments or for no-shows
  - Active outreach (care management function?)
  - Options for phone outreach or care management

Questions?
Where to Go From Here

MSSP and NAMI Maine training and technical support available:

• Training:
  – Protocol Development training and TA sessions
  – Practice-based "Lunch and Learn" sessions
  – Suicide Assessment for Clinicians
  – Annual Beyond the Basics Conference May 6, 2016

• Technical Assistance
  – Developing and implementing protocols
  – Choosing and implementing clinical and management tools
  – Support after a suicide loss

Contact Information

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  mssp@namimaine.org

• Sheila Nelson, MSPP Program Coordinator Sheila.Nelson@maine.gov
  Phone: 207-287-5359

"Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has."
Margaret Mead
Before You Leave…

Any Questions?

Thank You . . .
For learning about suicide prevention

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