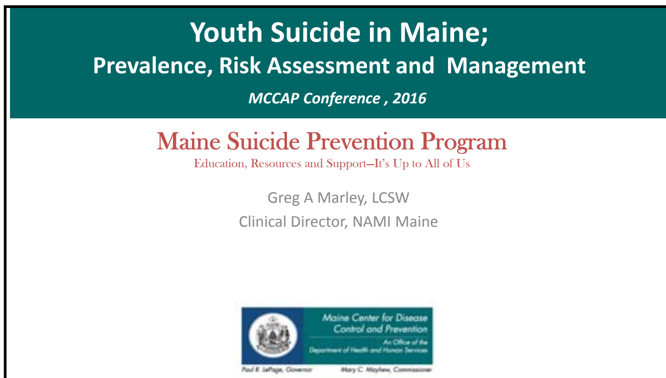


Maine Suicide Prevention Program

A program of the Maine Center for Disease Control and Prevention since 1998

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

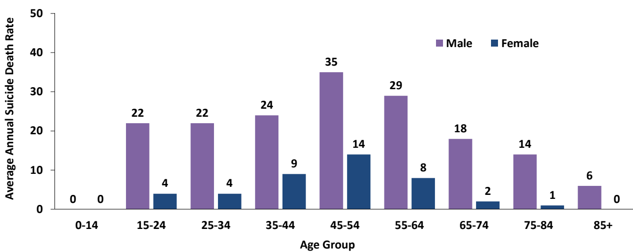
- 2nd leading cause of death ages 10-34
- 4th leading cause of death ages 35-54
- Suicide deaths 8x homicide deaths
- Every 1.6 days someone dies by suicide
- Every 2 weeks a young person dies (<25)
- 225 suicide deaths per year on average
- Firearms most prevalent method of suicide (54%)

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

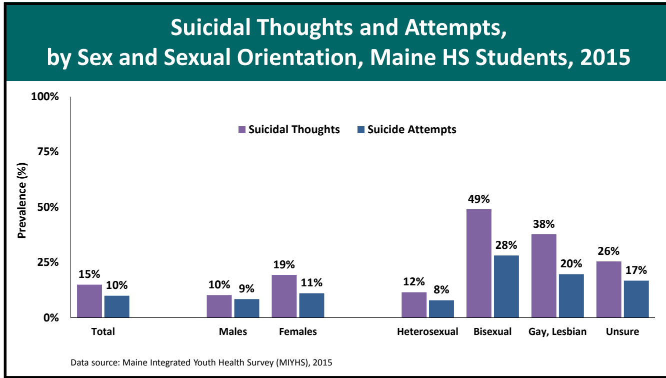


Data source: US CDC WISQARS Fatal Injury Data, National Vital Statistics System (NVSS)

Suicide Attempts- *A Strident Call for Help*

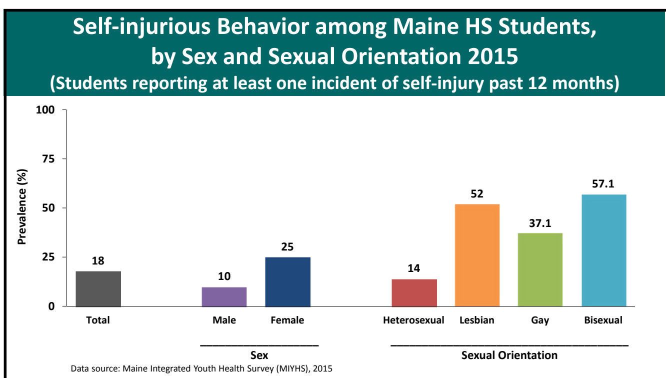
- A suicide attempt may be the first overt sign that someone is struggling!
- A call for Help
  - Often trigger being seen by a provider!
- Estimates 25 attempts for every suicide death
  - 200:1 for adolescents
- Ask about a history of suicide, especially for a depressed patient

A past suicide attempt is most predictive of future suicide behavior.

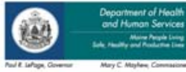


Self-Injury and Suicide

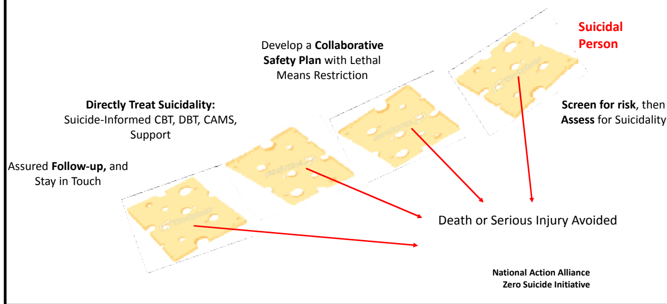
- Self Injury (non-suicidal) is an unhealthy way to cope with strong negative emotions.
  - Rapid return to emotional calm
  - Because it works it can become repetitive
- 24% of HS girls and 12% of boys report SI on the past 12 months.
- Self Injury may be the most predictive of suicide risk in adolescents!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



Working toward Zero Suicide Within a System of Care



Systematic Suicide Care Plugs the Holes in Health Care

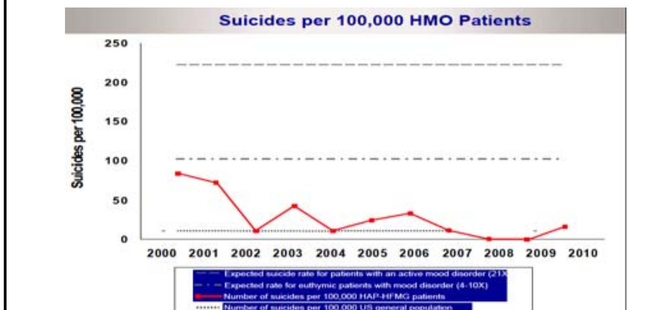


Moving toward Zero Suicide within a Healthcare System

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



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**
  - *"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

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

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 wi. 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

- Greg A. Marley, LCSW Clinical Director, NAMI Maine
  gmarley@namimaine.org 207-677-5767 x. 2302
- Matt Bray -For Training Program Inquiries: 207-622-5767 x.2318
  mssp@namimaine.org
- Sheila Nelson , MSPP Program Coordinator Sheila.Nelson@maine.gov
  Phone: 207-287-5359

Before You Leave…

Any Questions?

Thank You . . .

For learning about suicide prevention

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