12th Annual Summer Institute

Suicide Is Preventable: The Next Phase in Addressing Suicide Intervention and Prevention among Individuals with SMI

Shareh Ghani, M.D., Magellan Health Services of Arizona
Katie Ayotte, TERROS
Suicide prevention efforts tend to focus on “at-risk” groups (rates greater than general population)

- White Males 65+: 3-4x
- Veterans/Military: 2-4x
- Alaskan Natives/American Indians (AN/AI): 2-4x
- Lesbian, Gay, Bisexual, Transgender (LGBT) Youth: 2-3x

We should focus intervention on those at highest risk

- Individuals with Serious Mental Illness (SMI): 6-12x

Additional Information:

- **White Males 65+**
  The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85. [http://bit.ly/men-s](http://bit.ly/men-s)

- **Veterans/Military**
  In 2010, USA Today reported the current U.S. Army suicide rate at 22 per 100,000 [http://usat.ly/army-s](http://usat.ly/army-s), but the Fort Hood rate was 47 per 100,000. [http://bit.ly/ft-s](http://bit.ly/ft-s)

- **AN/AI**
  In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. USA Today reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. [http://usat.ly/an-ak](http://usat.ly/an-ak)

- **LGBT Youth**
  The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate. [http://bit.ly/wik-lgbt](http://bit.ly/wik-lgbt)

- **Individuals with SMI**
  In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King’s Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness. [http://bit.ly/SMI-suicide-12x](http://bit.ly/SMI-suicide-12x)

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.
The average YPLL for these deaths was 40 years per person, with immeasurable losses in personal connections and community contributions.

The cumulative Years of Potential Life Lost (YPLL) for the 37 people who died by suicide in FY2010 totaled **nearly 1,500 years**.
The Golden Gate Bridge has been the site of a suicide nearly every two weeks for the past seventy years. In 2006, the Bridge Authority decided to finally eliminate these deaths.

Nationally, public sector behavioral health has not yet determined that we must design and implement the equivalent of a programmatic suicide deterrent system.
The Maricopa County Programmatic Suicide Deterrent System (Six Essential Elements)

A community collaborative steering committee meets quarterly, a task force meets monthly and six targeted workgroups meet as needed to design and implement the project.

- All-staff Suicide Intervention Training (ASIST)
- Attempt Survivor Peer Support Groups
- Clinical Care & Interventions
- Family Engagement
- Community Integration
- Race/Ethnicity Best Practices

Magellan Health Services of Arizona - February 2010
Public sector behavioral healthcare has viewed suicide prevention as peripheral, not core business

SPRC (August 2010) – “Charting the Future: A Progress Review”
SPRC examined 11 professional groups including psychology, social work, psychiatric nursing, and counseling and found only one had increased attention on suicide since the 2001 National Strategy called for improved training. Accreditation standards give scant attention.

Forbes (September 2010) – “The Forgotten Patients”
The mental health industry ignores the 35,000 a year who die by suicide. The DSM-IV offers no advice on how to assess suicide risk. The NIH is spending a paltry $40 million in 2010 for studying suicide versus $3.1 billion for AIDS research.

Each dot represents five behavioral healthcare workforce staff who responded to the Maricopa County RBHA Survey (2009 & 2010)
## Equipping Maricopa’s Work Force for Suicide Intervention

(2-Day ASIST Training)

<table>
<thead>
<tr>
<th>Agency</th>
<th># Trained</th>
<th>Target*</th>
<th>% Trained</th>
<th>#2-Day Sessions</th>
<th>Next Training</th>
<th># T4T</th>
</tr>
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<tbody>
<tr>
<td>TERROS</td>
<td>470</td>
<td>450</td>
<td>104%</td>
<td>19</td>
<td>7/12</td>
<td>5</td>
</tr>
<tr>
<td>Southwest Network</td>
<td>317</td>
<td>304</td>
<td>104%</td>
<td>26</td>
<td>N/A</td>
<td>4</td>
</tr>
<tr>
<td>CHOICES</td>
<td>273</td>
<td>235</td>
<td>116%</td>
<td>25</td>
<td>N/A</td>
<td>2</td>
</tr>
<tr>
<td>Valle Del Sol</td>
<td>115</td>
<td>129</td>
<td>89%</td>
<td>6</td>
<td>TBD</td>
<td>2</td>
</tr>
<tr>
<td>Quality Care / FIC</td>
<td>158</td>
<td>200</td>
<td>79%</td>
<td>5</td>
<td>TBD</td>
<td>3</td>
</tr>
<tr>
<td>Partners In Recovery</td>
<td>153</td>
<td>185</td>
<td>83%</td>
<td>7</td>
<td>TBD</td>
<td>2</td>
</tr>
<tr>
<td>People Of Color</td>
<td>89</td>
<td>129</td>
<td>69%</td>
<td>6</td>
<td>TBD</td>
<td>2</td>
</tr>
<tr>
<td>Community Bridges</td>
<td>257</td>
<td>200</td>
<td>129%</td>
<td>11</td>
<td>7/27</td>
<td>3</td>
</tr>
<tr>
<td>Ebony House</td>
<td>14</td>
<td>25</td>
<td>56%</td>
<td>0</td>
<td>TBD</td>
<td>0</td>
</tr>
<tr>
<td>Jewish Family</td>
<td>92</td>
<td>135</td>
<td>68%</td>
<td>1</td>
<td>TBD</td>
<td>2</td>
</tr>
<tr>
<td>NOVA</td>
<td>49</td>
<td>49</td>
<td>100%</td>
<td>0</td>
<td>N/A</td>
<td>0</td>
</tr>
<tr>
<td>SWBH</td>
<td>122</td>
<td>125</td>
<td>90%</td>
<td>2</td>
<td>TBD</td>
<td>4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2,109</strong></td>
<td><strong>2,166</strong></td>
<td><strong>98%</strong></td>
<td><strong>108</strong></td>
<td><strong>29</strong></td>
<td></td>
</tr>
</tbody>
</table>

The November 2009 workforce survey demonstrated that nearly 10% of the Maricopa workforce received the two-day ASIST training prior to this initiative (n=152). The data in this slide covers only additional staff newly trained in ASIST in December 2009 and later.
ASIST suicide intervention training is changing the culture of community behavioral healthcare

Learn advanced suicide intervention and first aid skills

ASIST

Applied Suicide Intervention Skills Training
A 2-day workshop at either Southwest Network or Choices

Many who consider suicide would prefer to find a way to live.

38% of the Maricopa behavioral health workforce reports someone in their care has died by suicide (19% more than once)

<table>
<thead>
<tr>
<th>Workforce Survey</th>
<th>2009 AZ</th>
<th>2010 GA</th>
<th>2010 AZ</th>
<th>‘10 vs. ’09 Δ</th>
<th>‘10 vs. GA Δ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample</td>
<td>1,630</td>
<td>1,550</td>
<td>665</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td>14%</td>
<td>10%</td>
<td>41%</td>
<td>↑ 187%</td>
<td>↑ 289%</td>
</tr>
<tr>
<td>Skills</td>
<td>15%</td>
<td>10%</td>
<td>34%</td>
<td>↑ 131%</td>
<td>↑ 247%</td>
</tr>
<tr>
<td>Supports</td>
<td>18%</td>
<td>14%</td>
<td>35%</td>
<td>↑ 97%</td>
<td>↑ 151%</td>
</tr>
</tbody>
</table>

Above: Comparison of the 2009 Maricopa County and 2010 Georgia statewide with the 2010 Maricopa County ASIST trained respondents shows significant increases in “completely agree” responses.

Outcomes: Recipients, Workforce & Public Stewards
In 2011, Magellan is launching suicide attempt survivor peer supports groups

In an early Maricopa suicide task force meeting, Katie Ayotte revealed that she had recently made a suicide attempt. The group was riveted as Katie explained how her peers, clinical team, family and community engaged her on a deep personal level around this attempt. Over the past 18 months, Katie has translated this experience into becoming a national leader in stigma reduction and peer empowerment. She strongly believes in repealing the “don’t ask, don’t tell” shadows and darkness that surround the subject of suicide. She has told her story publically with the same frank and open manner that one would talk about diabetes or heart disease. Katie will be part of the implementation of Attempt Survivor Support groups in 2011.

“The only documented effective intervention for suicide prevention is caring.”

Dr. Thomas Joiner
Why People Die by Suicide
The Action Alliance is supported by a grant (1 U79 SM059945-01) from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS)
“The Army has been working to be a leader in suicide intervention and prevention. That’s why I’m grateful to serve as co-chair of the Action Alliance, and for the opportunity to partner with leaders across the public and private sectors to further develop resources and programs. This collaboration is an important foundation for the nation’s suicide prevention efforts.”

JOHN MCHUGH, SECRETARY, United States Army

- Suicide is a serious and preventable public health problem.
  
  Suicide takes life without regard to age, income, education, social standing, race, or gender. Overall, suicide is the 11th leading cause of death for all Americans, the 2nd leading cause of death for adults ages 25-34, and the 3rd leading cause of death for youth ages 15-24. The legacy of suicide continues long after the death, impacting bereaved loved ones and communities.

  Fortunately, there is strong evidence that a comprehensive public health approach is effective in reducing suicide rates. In fact, suicide rates have been declining among both American youth and elders for well over a decade; two groups on which the nation has focused most. There are other population groups, though, for which the death toll is rising.

- The time to change those statistics is now.

FOR THE PUBLIC
STAY CONNECTED

You can help
The National Action Alliance has boldly set forth a vision to set our nation free from the tragedy of suicide.

To reach this vision will require substantial changes – if not transformation – of how this nation prevents suicide globally and intervenes with those at risk of suicide.

As major contributors to suicide prevention and intervention, public and behavioral health systems must make dramatic changes in how they perceive and address suicide.
The National Action Alliance Task Force has designated the creation of three workgroups whose mission is to develop recommendations aimed at preventing suicide:

1. Suicide risk assessment and stratification
2. Clinical intervention and access to care
3. Family engagement and education
Task Force and Workgroup Leaders

• Taskforce
  - Mike Hogan: Commissioner of mental health for the state of New York
  - David Covington: Chief of Adult Services at Magellan

• Suicide Risk and Stratification Workgroup
  - Dr. Shareh Ghani: adult medical director at Magellan

• Clinical Interventions and Access to Care Workgroup:
  - Fred Meservy: director of the Suicide Prevention Center of NY

• Family Engagement and Education Workgroup:
  - Chris Damle, senior director of adult services at Magellan
<table>
<thead>
<tr>
<th>SETTING</th>
<th>CURRENT PRACTICE</th>
<th>RAISING THE BAR</th>
<th>OPTIMAL VISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIMARY CARE AND GENERAL MEDICAL SETTINGS</td>
<td>1. There is a National recommendation to screen for depression (such as the PH-Q 9) and ETOH; however practice is rare. 2. There is no national recommendation to screen for suicide in Primary Care settings. 3. Resources are available, such as Teen Screen and HHS-SAMHSA SAFE-T cards, but implementation of existing recommendations is poor. 4. PCP’s time is limited to focusing on the presenting problem, so a suicide risk screen isn’t a priority.</td>
<td>1. Follow Nat’l recommendations to screen for depression by implementing a simple screening tool, such as the PH-Q 9 modified (teen version), which includes 3 questions related to suicide risk. 2. The screen should be completed at the initial visit, when the patient completes the intake questionnaire, and at a minimum, at annual visits. 3. Triggers to give the screen more frequently will be explored. 4. A positive screen would lead the medical staff to consider a variety of potential action steps and interventions.</td>
<td>1. Every patient is screened for suicide risk. Frequency needs to be explored. 2. If there is a positive yield on the screen, a more comprehensive assessment is conducted, using at a minimum the factors of desire, intent, and capability. 3. PCP’s are provided with a Toolkit to assist the practice of suicide risk assessment and identity follow-up steps. SAMHSA toolkit and Teen Screen are examples. 4. Trainings identified as best practices for PCP personnel occur with ongoing frequency. 5. National Policies and Procedures should be developed to promote use of best practices and consistency among clinicians in this setting.</td>
</tr>
<tr>
<td>SETTING</td>
<td>CURRENT PRACTICE</td>
<td>RAISING THE BAR</td>
<td>OPTIMAL VISION</td>
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</tr>
</tbody>
</table>
| **EMERGENCY DEPARTMENTS AND MEDICAL/SURGICAL SETTINGS** | 1. The ‘Is your patient suicidal?’ poster (publication of the Suicide Prevention Resource Center) is recommended but not commonly placed in ED’s.  
2. There is wide variance between and within ED’s and their protocols surrounding suicide risk screening and assessment.  
3. ED’s may utilize in-house psychiatric staff or social workers, outside crisis agencies, or other behavioral health professionals to provide suicide risk assessments.  
4. Providers may be litigation wary and therefore reluctant to assess suicide risk. | 1. The ‘Is your patient suicidal’ poster to be placed in all EDs, easily viewed by staff.  
2. Each ED to develop and implement P and P for suicide risk assessment.  
3. A brief suicide risk screen or questions addressing suicidality should be added to the initial intake questionnaire for all patients.  
4. A positive screen leads to a behavioral health consult – whether in-house or otherwise.  
5. Basic training in suicide assessment and intervention is provided to ED personnel. | 1. National Policies and Procedures should be developed to promote use of best practices and consistency among staff in ED’s.  
2. Every patient is screened for suicide risk and if positive, person is further evaluated, using at a minimum the factors of desire, intent, and capability.  
3. Trainings identified as best practices for ED personnel occur with ongoing frequency. |
National Action Alliance for Suicide Prevention

• Clinical Interventions and Access to Care Workgroup: Governing Principles

  - Every health care and behavioral health care program should have written policies and procedures describing to all staff how suicide prevention and intervention will be addressed in that setting.

  - To the degree possible, programs should employ evidence-based strategies for addressing suicide.

  - Organizations should continuously evaluate their suicide prevention and intervention services for quality improvement

  - Organizations must build flexibility into their response systems
National Action Alliance for Suicide Prevention

• Tools to nurture and sustain effective change
  – Effecting the changes that advance the vision of eliminating the tragedy of suicide requires organizations and communities to accept the challenge and diligently put in place the processes that will save lives
  – Education, training and technical assistance will also be critical to effectuating change.
The Maricopa Suicide Intervention Project believes every suicide is preventable.

“Magellan holds two core beliefs: First, every suicide is preventable and second, future deaths are avoidable. We have reduced the suicide rate by nearly 50%, but we will not rest until we have eliminated suicide deaths for those we serve.”

Dr. Richard Clarke
Magellan of Arizona CEO
Effective suicide intervention results in fewer inpatient admissions, less intrusion and lower costs.

In the December 2010 “Policy for Helping Callers at Imminent Risk,” SAMHSA emphasizes the need to reduce unnecessary hospitalizations and “active rescues” through stronger engagement, collaboration and follow-up.

Maricopa County Assertive Community Treatment Team (ACT) Inpatient Utilization Per 100

Since the beginning of 2010, the ACT system Level I inpatient utilization rate has declined 51%.

Outcomes: Recipients, Workforce & Public Stewards
Questions?