

SUICIDE PREVENTION: Hope Into Action

Monmouth County DMH, October 2016

Christine Moutier, M.D.
Chief Medical Officer



AMERICAN FOUNDATION FOR
Suicide Prevention

Disclosures

Disclosures/conflicts

- None
(AFSP funds 25% of suicide studies)

Acknowledgments

- Yeates Conwell
- David Jobes
- Matthew Nock
- Greg Brown
- David Brent

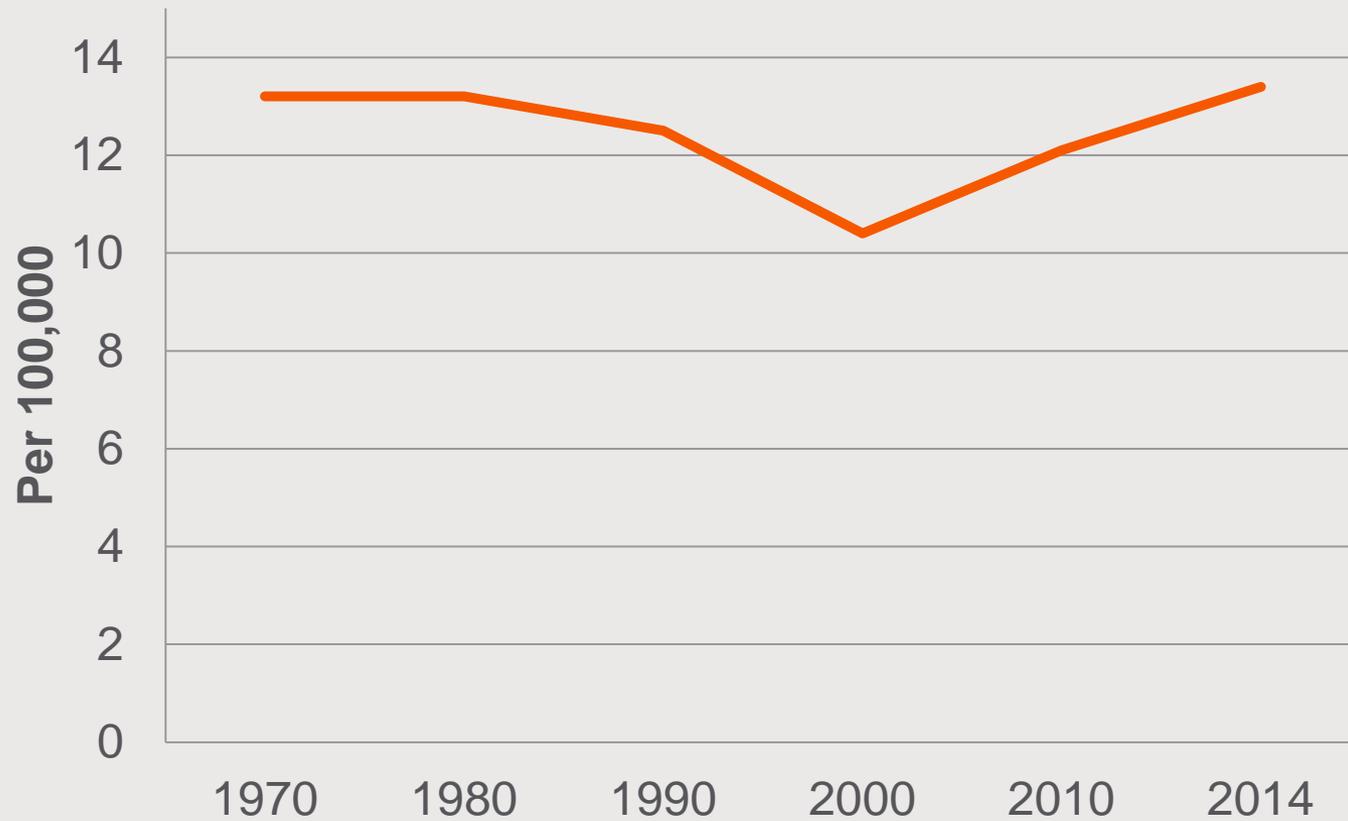
Game Plan

- Suicide, a public health problem
- Understanding suicide
- Clinical care to reduce risk
 - Risk detection
 - Taking action
 - Innovations in treatment

SUICIDE:
A PUBLIC HEALTH
PERSPECTIVE

U.S. Suicide Rate

1970-2014

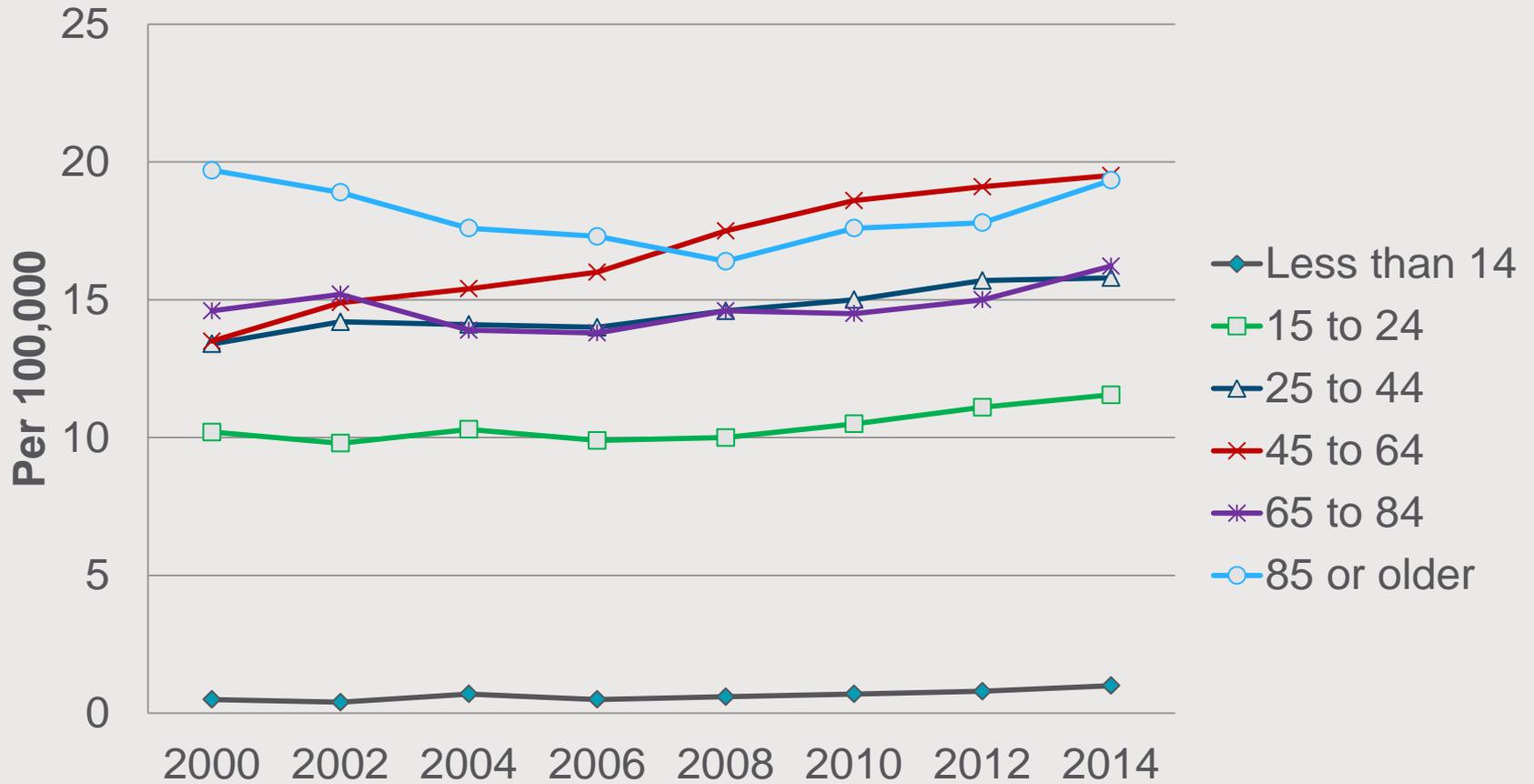


U.S. Suicide Facts

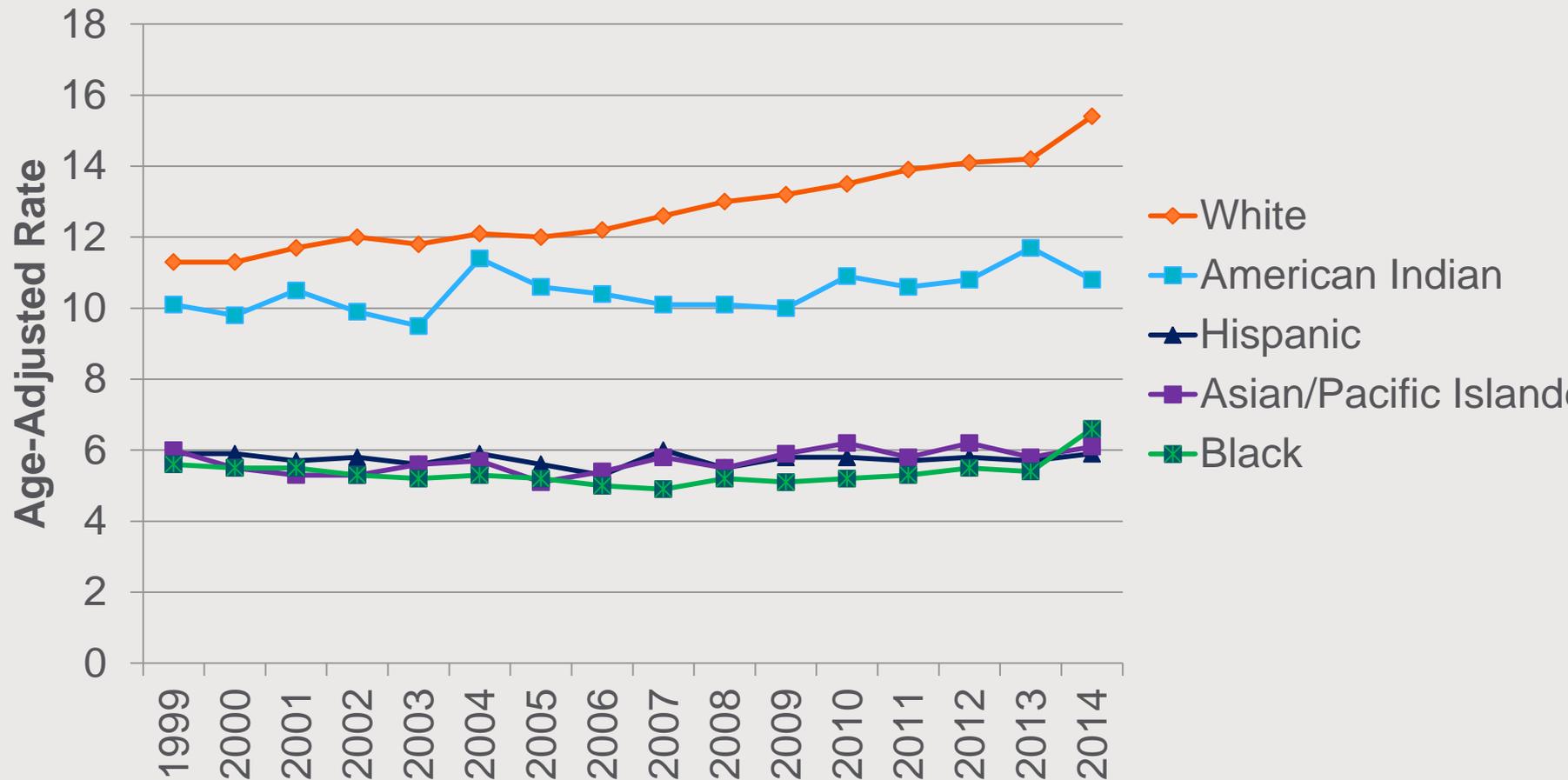
2014 U.S. CDC

- 42,773 suicides
- 117.2/day, every 12.3 min in U.S.
- 10th leading cause of death in U.S.
 - 2nd for 15-34 yr, 4th for adults 24-64 yr
- Regional & demographic differences
- For every death ~25 suicide attempts
 - *Over 1.3M adults attempt annually*
- 60% of Americans experience loss to suicide

U.S. Suicide Rates by Age

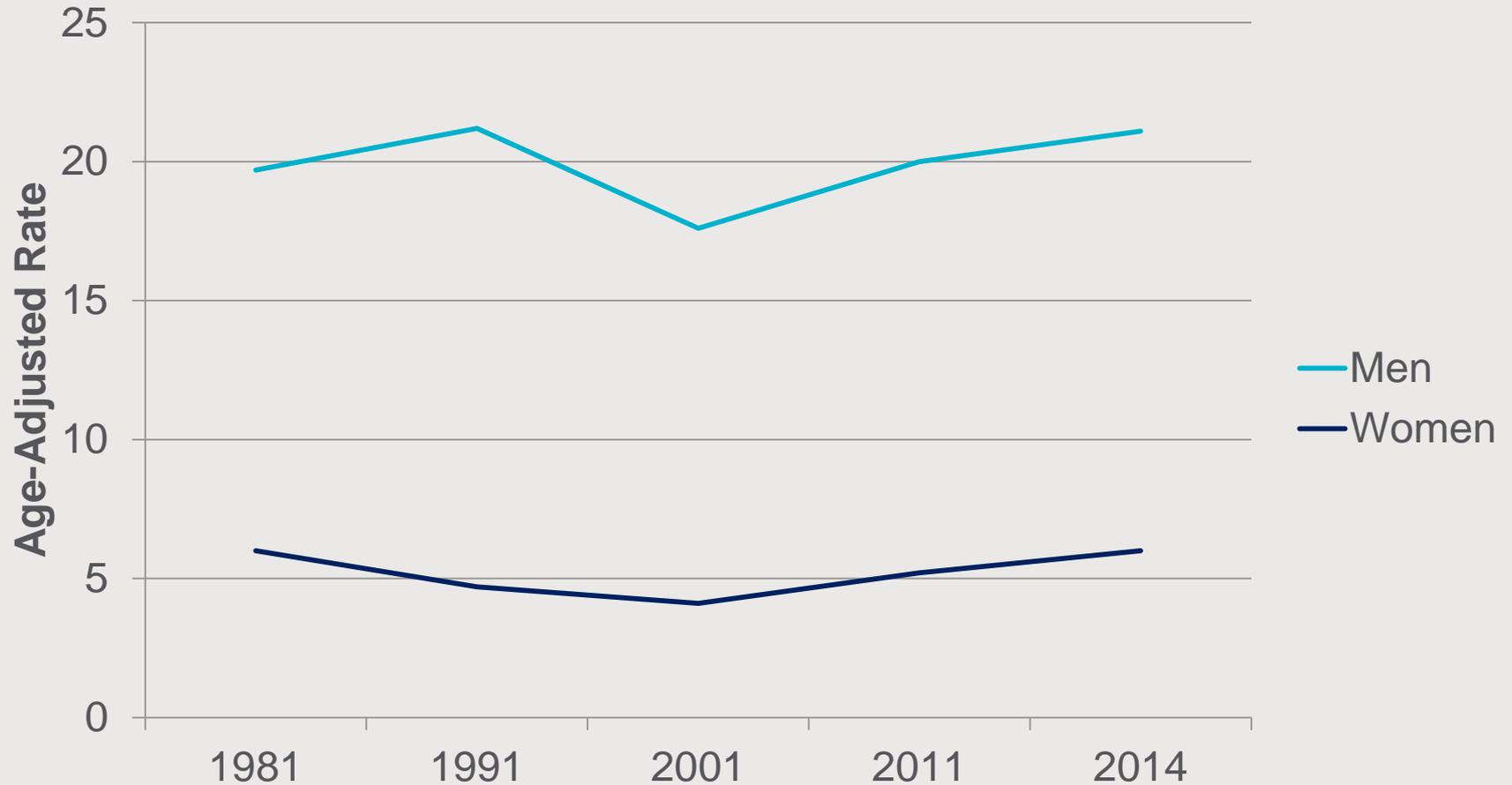


Suicide Rates by Race/Ethnicity 1999-2014



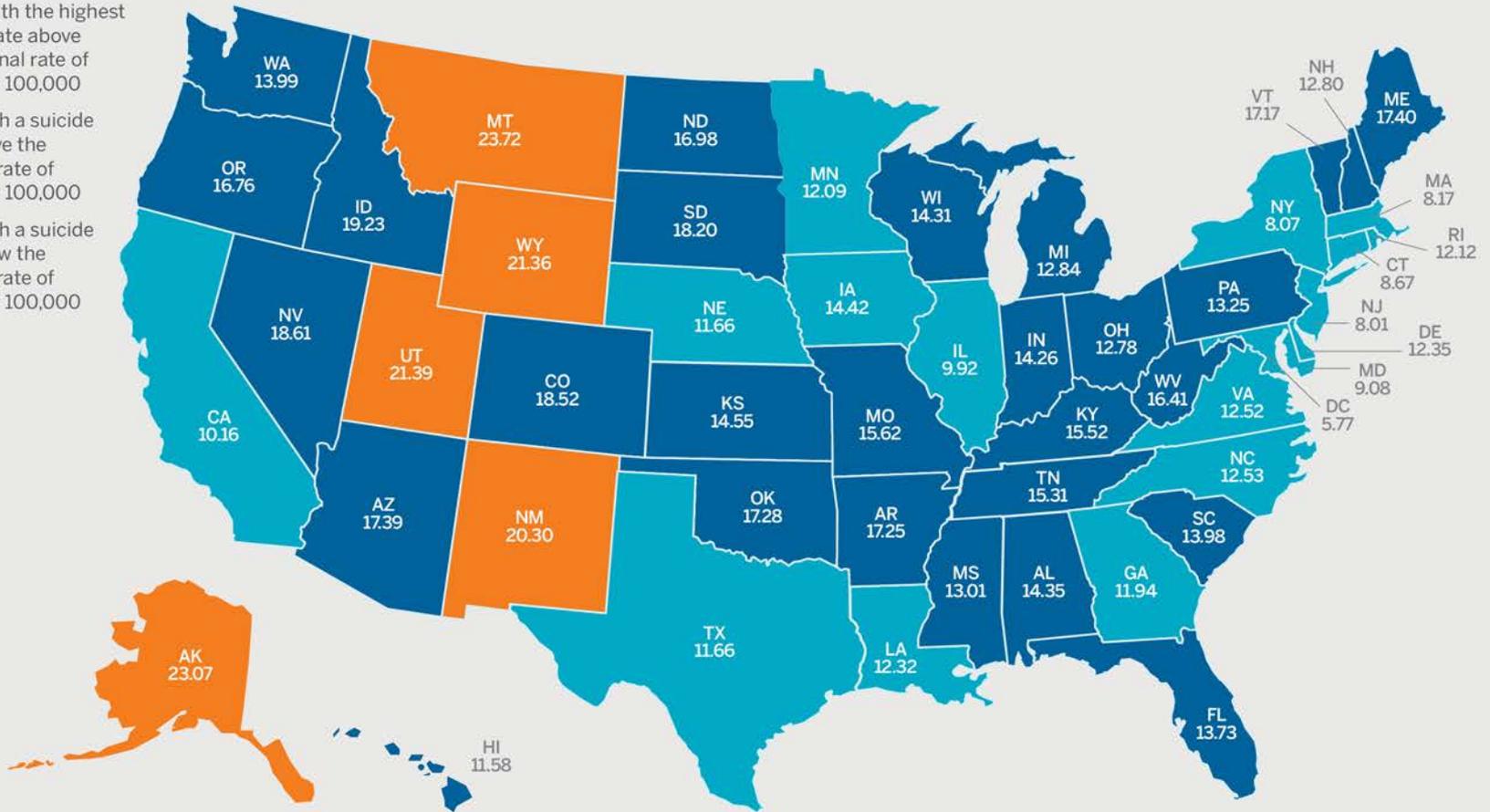
Suicide Rates by Sex

1981-2014

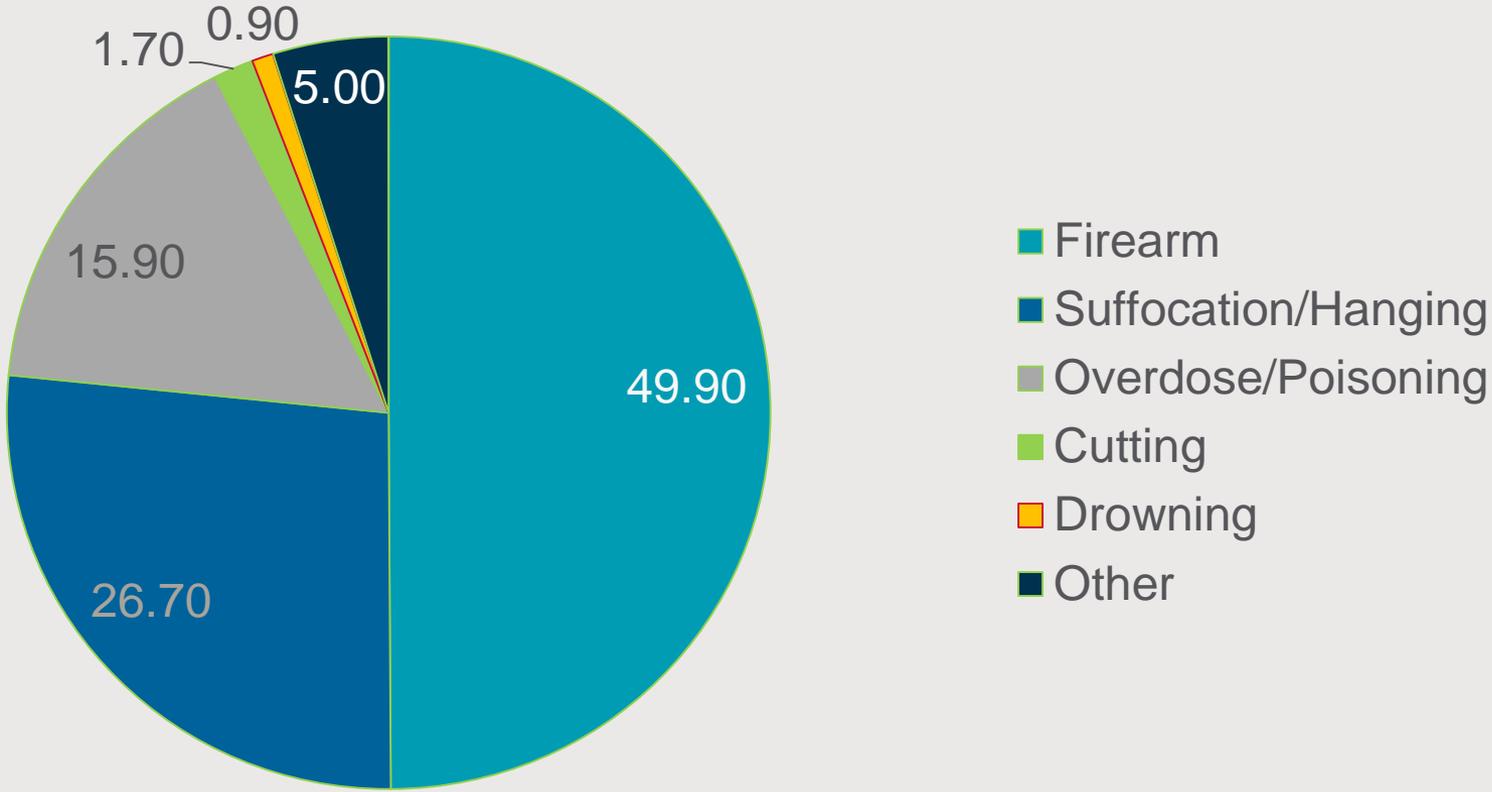


Suicide Death Rates

- States with the highest suicide rate above the national rate of 12.57 per 100,000
- State with a suicide rate above the national rate of 12.57 per 100,000
- State with a suicide rate below the national rate of 12.57 per 100,000



Methods of Suicide Death in U.S.



CDC 2014

Means Matter: Lethality

	Fatal	Nonfatal	Total	% Fatal
Firearm	16,869	2,980	19,849	85%
Suffocation	6,198	2,761	8,959	69%
Poisoning/overdose	5,191	215,814	221,005	2%
Fall	651	1434	2,085	31%
Cut/pierce	458	62,817	63,275	1%
Other	1,109	35,089	36,198	3%
Unspecified	146	2097	2,243	7%
Total	30,622	322,991	353,613	9%

Ideation, Attempts, Death

- YOUTH (YBRS)

14.5% of high school age youth report SI in past year (Cash, Bridge 2009)

7% report at least one suicide attempt in past year

In youth, attempt to death ratio is 100-400:1

- In ADULT community samples

Serious thoughts of suicide in past year

7.5% (18-25 yo); 4.0% (26-49 yo); 2.7% (>50 yo) (2014 Natl Surv)

13.5% SI in lifetime; 4.6% SA lifetime (Kessler 1999 ECA Study)

In adults, attempt to death ratio is estimated 30:1 (4:1 for elderly)

Ideation, Attempts, Death

- The risk of suicide is elevated (by ~100 fold) in the 6-12 months following an attempt
- 30-40% of persons who die by suicide have made a previous attempt

Contact with Healthcare Providers

When suicide risk increases, many seek help

64% who attempt suicide visit a doctor in the month before their attempt, 38% in the week before

45% saw PC within month of suicide death

20% saw MHP within month of suicide death

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: review of the evidence. *Am J Psychiatry* 2002

#20x2025

**AFSP has set a bold goal to
reduce the U.S. annual rate
of suicide 20% by 2025**

Walk All Night to Fight Suicide



SAN FRANCISCO • MAY 21

NEW YORK CITY • JUNE 4

The Overnight



AMERICAN FOUNDATION FOR
Suicide Prevention

TheOvernight.org



Out of the
DARKNESS™

American Foundation for Suicide Prevention

CAMPUS WALKS

Be the Difference.

Walk to Fight Suicide

Join thousands of students across the country raising money to bring mental health conditions out of the darkness.



AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org/walk

WALK. VOLUNTEER. DONATE.

Investing in Science

“There is every reason to expect that a national consensus to declare war on suicide and to fund research and prevention at a level commensurate with the severity of the problem will be successful, and will lead to highly significant discoveries as have the wars on cancer, Alzheimer’s disease, and AIDS.”

- *Institute of Medicine, Reducing Suicide: A National Imperative (2002)*

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.



AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org

LEADING CAUSES
OF DEATH

2013
FUNDING

2003-2013
DEATH RATE

HIV/AIDS



\$2.9 Billion



53.2%

Heart
Disease



\$1.2 Billion



29.1%

Prostate
Cancer



\$266 Million



13.7%

Suicide



\$37 Million



20.4%

Death rates taken from Centers for Disease Control data for 2003 and 2013 (most recent available).
Each flask represents \$1 billion of research funding by the National Institutes of Health.

Public Health Approach

Expand community interventions

- All citizens, e.g., Mental Health First Aid
- Teachers, first responders
- Upstream, e.g., Good Behavior Game

Improve Clinical interventions

- Develop screening & treatments, suicide reduction
- Training and accessibility

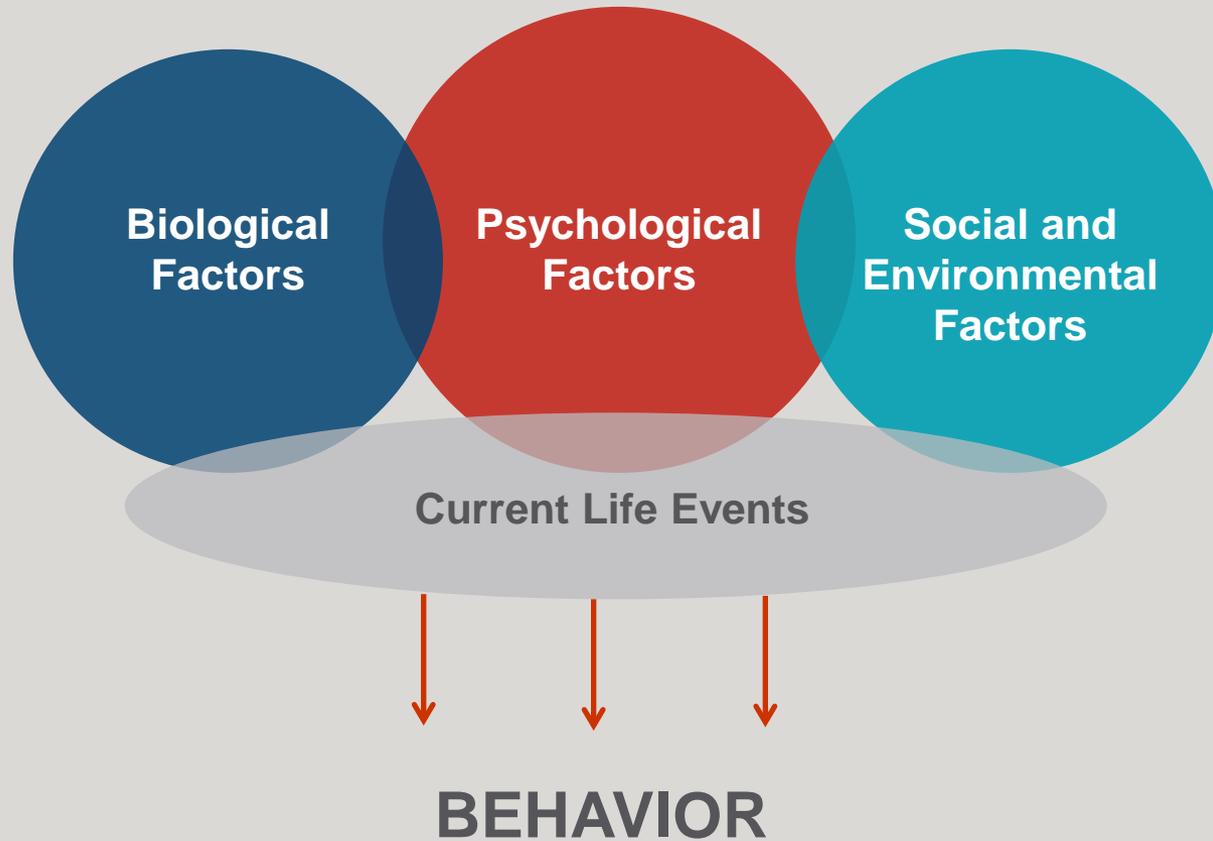
Reform Policy

- Increase access to mental health care
- Limit access to lethal means

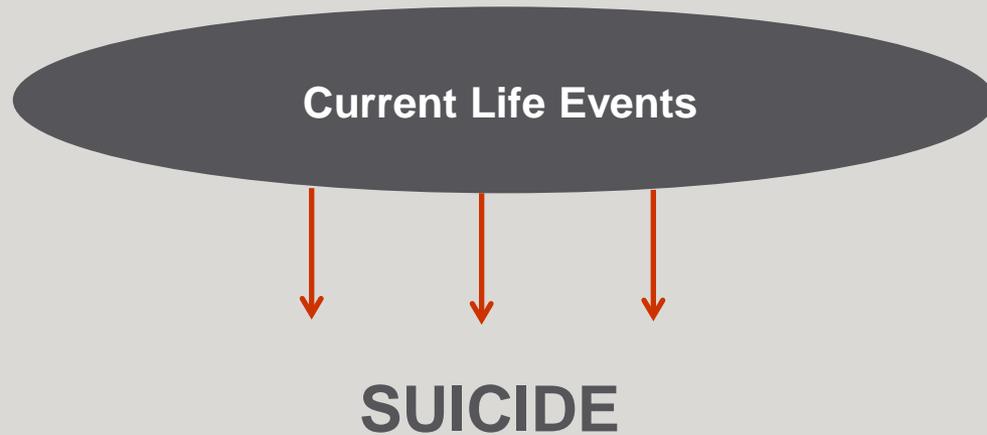
UNDERSTANDING SUICIDE:

Why does it occur

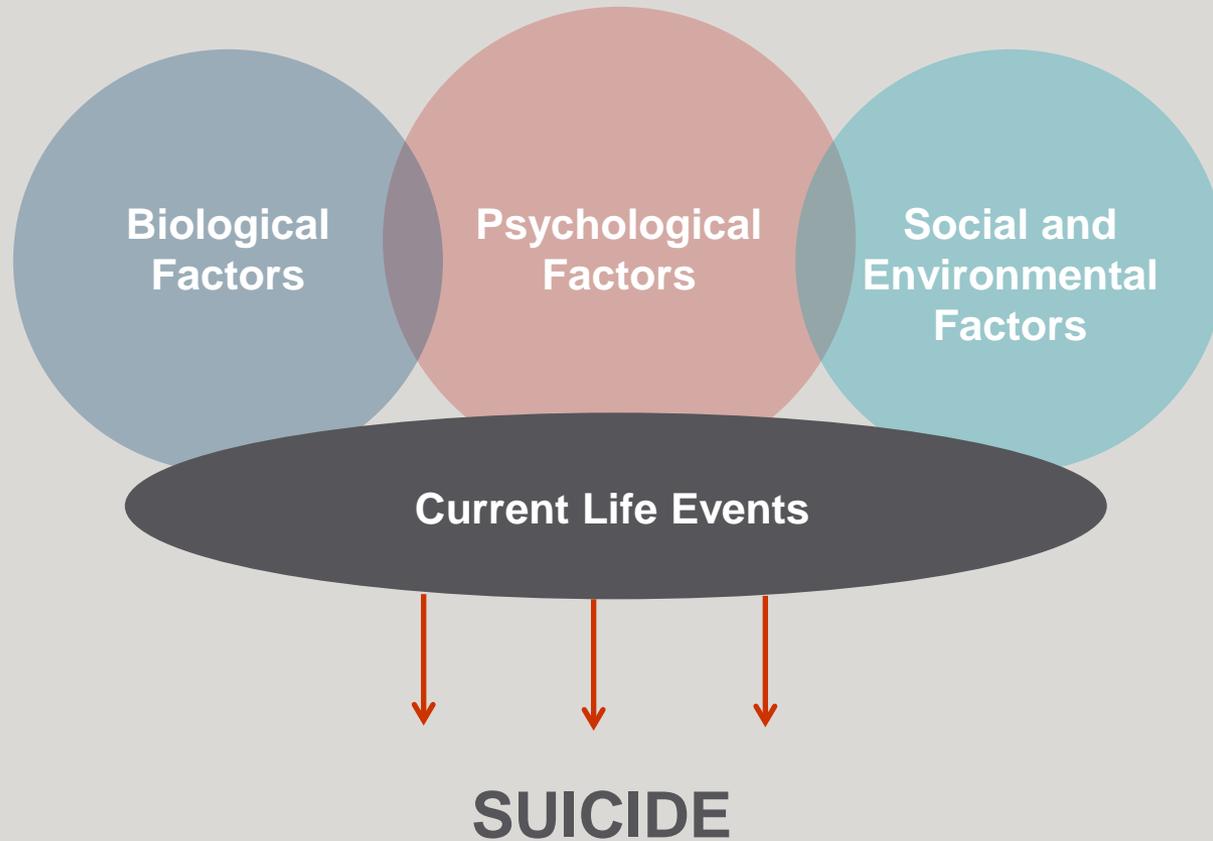
Interacting Risk and Protective Factors



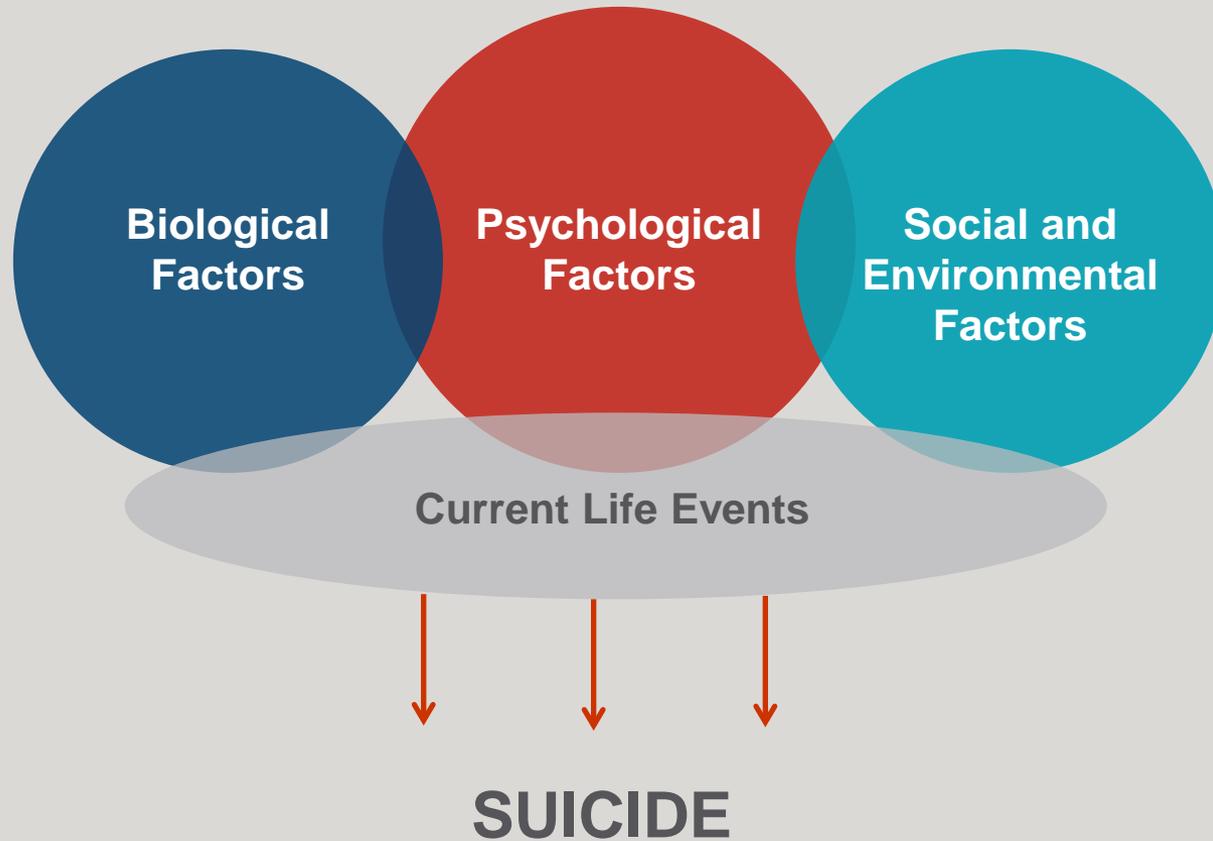
Interacting Risk and Protective Factors



Interacting Risk and Protective Factors



Interacting Risk and Protective Factors



Risk Factors for Suicide

- Mental illness
- Previous suicide attempt
- Serious physical illness/chronic pain
- Specific symptoms
- Family history of mental illness and suicide
- H/O childhood trauma/ ACEs
- Shame/despair
- Aggression/impulsivity
- Triggering event
- Access to lethal means
- Suicide exposure
- Inflexible thinking
- Genes - stress and mood

Protective Factors

- Social support
- Connectedness
- Strong therapeutic alliance
- Accessing mental health care
- Positive attitude toward MH treatment
- Coping skills
- Problem solving skills
- Cultural beliefs
- Religious affiliation
- Biological/psychological resilience

Research Shows: Mental Health Matters

- >9 out of 10 cases of suicide - mental illness
 - Mood disorders (60%), substance use disorders (20%), psychosis (15%), PDs (10%), anxiety disorders and PTSD
 - Comorbidity common, increases risk when unmanaged
 - But most with mental illness don't die by suicide, therefore other factors are critical as well
- Substance use critically important
 - 3 in 10 people who die by suicide - high BAL
- Better depression care can save lives

Research Shows: **Means Matter**

- Restricting access to lethal means saves lives and drives down rates for entire regions
- Lethal means counseling in clinical settings is recommended

Research Shows: Timing Matters

- Intense suicidal urge is short
- Some attempts impulsive, many planned
- Transitions are high risk times
- Risk is dynamic, ambivalence relevant

CLINICAL CARE

that reduces suicide risk

The Joint Commission SEA 56

Detecting and caring for suicidal patients in all healthcare settings

February 28, 2016

“Many communities and HC orgs presently do not have adequate suicide prevention resources, leading to low detection and treatment of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their work flow and disrupt their schedule for the day to find treatment and assure safety for these patients.”

Suicide risk assessment is putting the pieces together to inform your overall picture of the patient's risk.

Keep the goal in mind

The goal: Assess, care and determine what actions to take to keep the person safe

- The goal of suicide risk assessment is NOT to predict whether a person will die by suicide, but to continue to care and support
- The action you take depends on the present level of risk

Suicide Risk Assessment

Formal SRA is best done by MH professional
Must go further than asking about current SI

- ✓ SI, planning, access to means, gathering means
- ✓ Past or current suicidal behavior
- ✓ Other Risk and Protective Factors
- ✓ Treatment including medications
 - Alliance, adherence, impact, side effects
- ✓ Social supports
- ✓ Substance use
- ✓ Hopes and aspirations for the future
- ✓ Need for hospitalization or other crisis intervention

In Non-Mental Health Settings, it is now recommended to:

1. Detect Risk

- ✓ 1. Screen for depression and other changes in mental health
- ✓ 2. If endorses SI, probe its history, **intent/plan**
- ✓ 3. If + plan & intent, ask abt means
- ✓ 4. Ask about supports

2. Take Action: Continue to Care

Acute suicidal crisis

- ✓ Do not leave unattended
- ✓ Immed access care (ED, mobile crisis, 911, respite)
- ✓ Involve family when possible

Risk is present but not acute

- ✓ Express concern
- ✓ Refer to psych (within 1-2 weeks)
- ✓ Give **Lifeline # 1-800-273-TALK** (pt & family)
- ✓ Safety Plan
- ✓ Urge removal of lethal means
- ✓ Follow-up

Consider consulting a colleague

Consider suicide-specific treatment intervention

Safety Planning Intervention

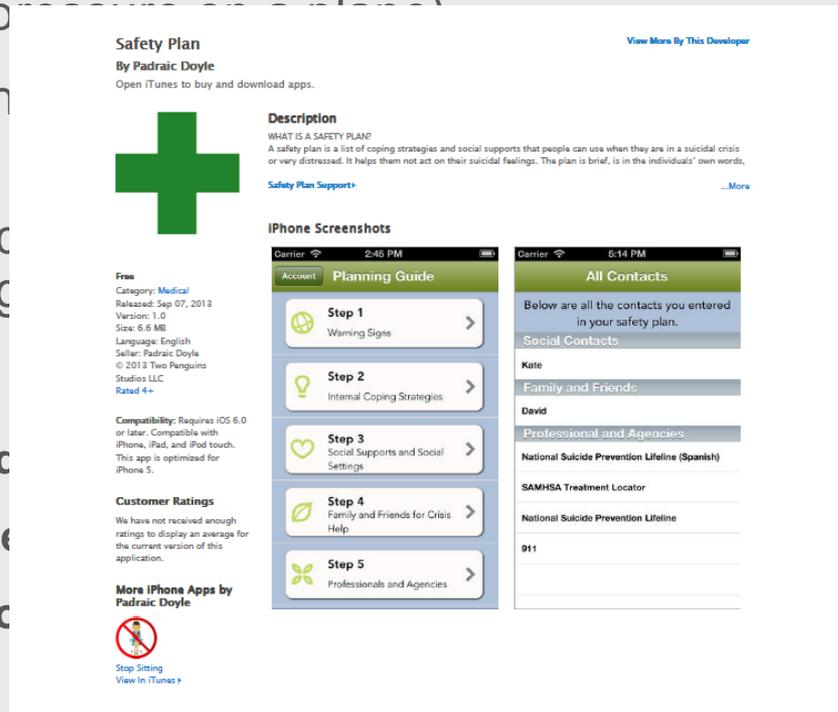
(Stanley & Brown, 2008; 2012)

Similar to other emergency plans (e.g., do x, y and z in a certain order in case of low cabin pressure or turbulence)

Compilation evidence (no support)

A *collaboratively* developed during or preceding

- Helps individuals identify
- Lists internal & external
- Identifies sources of
- Provides guidance



restriction, social

can be used

I crises

ionals

Conveys that suicidal feelings and urges can be “survived” and controlled

Adopted nationwide across VAMCs for high suicide risk Veterans

“Contracting for Safety”

- Use of patient promise/agreement to not harm
- Despite lack of empirical support, commonly used by mental health professionals (up to 79%)
- **Not recommended** for multiple reasons
 - No medicolegal protection
 - Negatively influences provider behavior
 - Not patient-centered

Steps organizations can take

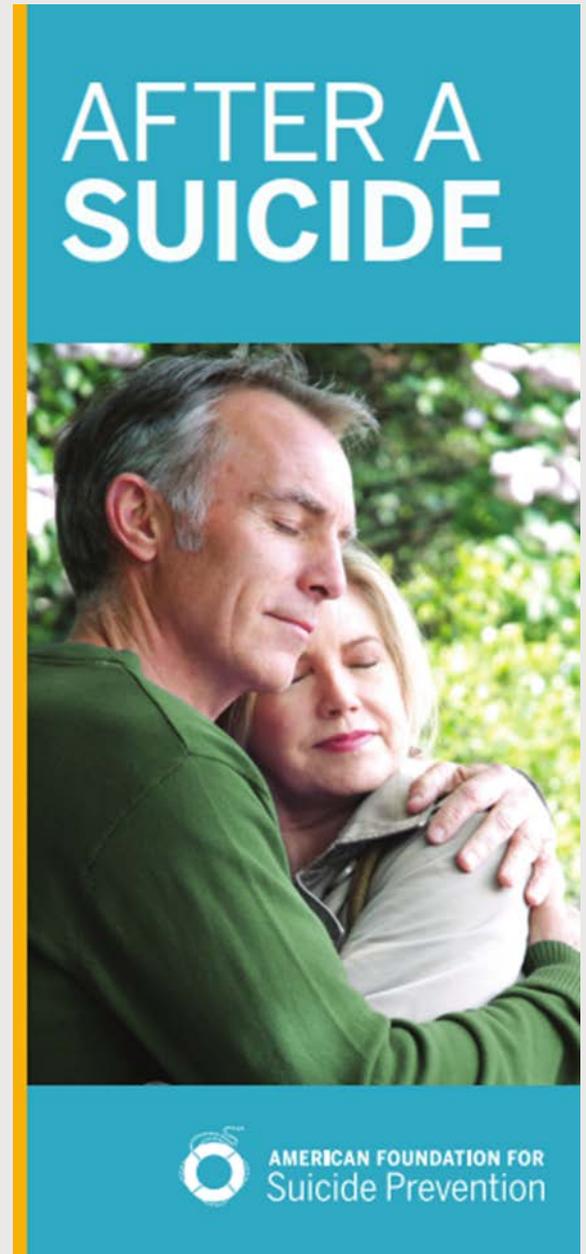
- Put CARING CONTACT in place systematically
- Provide education to all staff, Lethal Means Cnsling
- Ask pt for consent to involve fam at the start of tx
- Routine screening/assessment
- Document actions taken
 - Referral to BH, communication w family
 - Safety Plan completed, provided Lifeline #
 - Counseled on lethal means removal

****Providing good care & doc = medicolegal protection***

Prevention Resources



Pt/Fam Resources



INNOVATION IN SUICIDE SPECIFIC TREATMENT

Innovation in Treatment

- Suicide-specific treatments
- Brief interventions
- The increasing role of technology
- Matching different suicide-specific interventions and doses of care to different suicidal states across different settings
- Least restrictive, evidence-based, and cost-effective

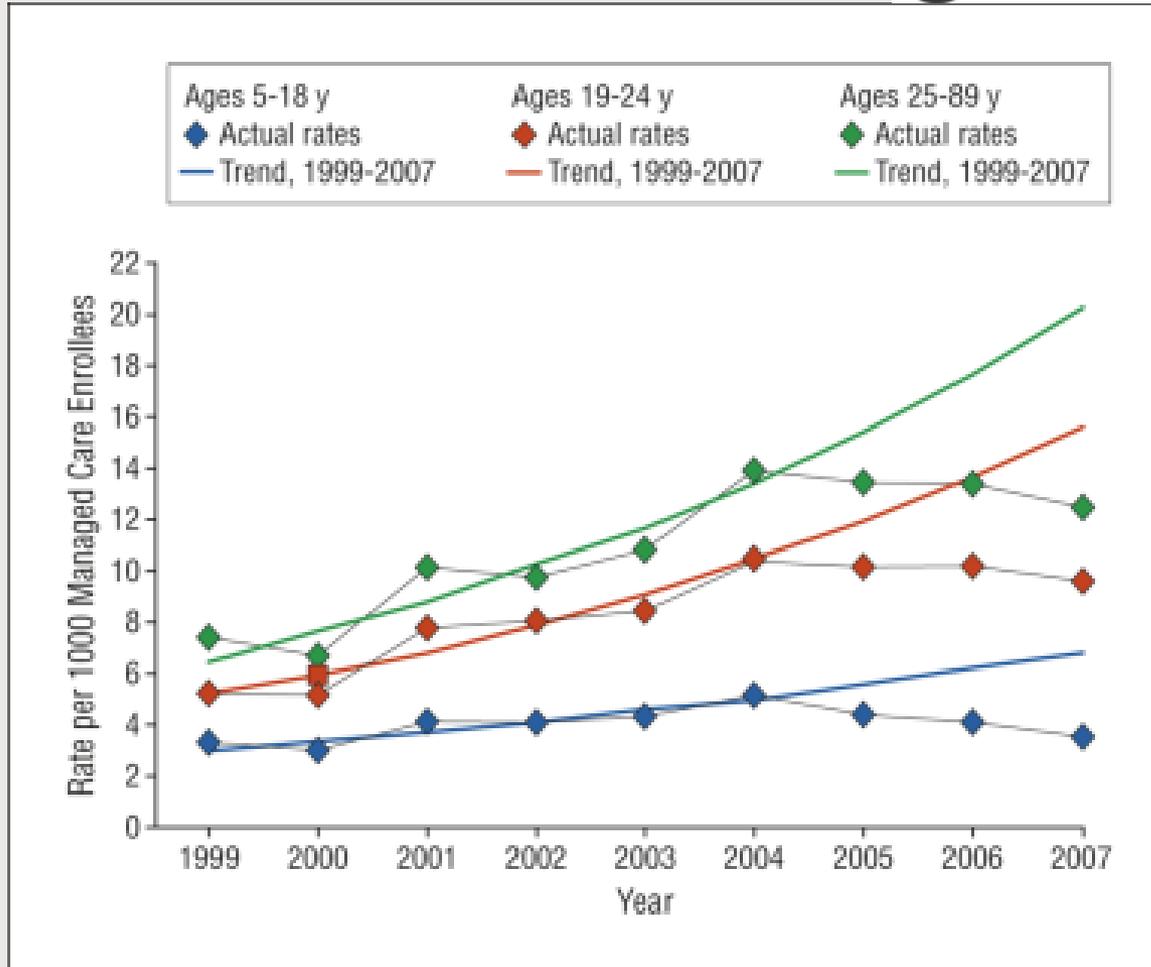
Medications

- Maximize management of primary condition(s)
- Suicide specific considerations
 - Lithium for mood disorders
 - Clozapine for schizophrenia (only FDA)
- Antidepressants
 - Pharmaco-epidemiologic study (Gibbons, Mann 2006)
 - Counties w/ higher AD Rx~lower suicide rate
 - Monitor closely in youth <24
- On the horizon- Ketamine
 - FDA “Breakthrough Therapy” designation

FDA Black Box and SSRIs

- Events were mostly increases in suicidal ideation, some attempts, no deaths; most events in first 4 weeks
- Occurred in 3-4% of SSRI vs. 2-3% of placebo, excess ONLY in those <25 years
- Agitation as s.e. should be monitored closely esp early
- Other studies find regional SSRI Rx inversely related to regional suicide rates
- Suicide attempts are highest prior to receiving antidepressant medication

From: Persisting Decline in Depression Treatment After FDA Warnings



PHARMetrics Patient Centric Database population rates of major depressive disorder (actual and predicted) by age group (male and female individuals combined).

Lithium

- Strong protective effect across >50 studies
- **Reduces suicide rate 60-80%**
 - Compared with placebo and other meds
- Attempt rate even more dramatically reduced
- Unipolar **MDD** and **bipolar disorders**
- Mechanism unclear
 - Possibly via reduction aggression and impulsivity

Suicide Specific Interventions

- Dialectic Behavioral Therapy **DBT** (*Linehan*)
- Cognitive Behavioral Therapy **CBT-SP** (*Beck, Brown*)
- Collab Assmt & Mngemt Suic **CAMS** (*Jobes, Comtois*)
- Attachment Based Family Tx **ABFT** (*Diamond*)
- Attempted Suicide Short Int **ASSIP** (*Michel, Gysin-Maillart*)
- Safety Planning Intervention **SPI** (*Stanley, Brown*)
- Online and tech resources
 - nowmattersnow.org online **DBT** (*Whiteside*)
 - CBT video games (*Christensen*)
 - SPI apps (*Stanley, Brown*)

Clinical Pearls

- **Slow down the pace** to get the narrative
 - The patient's "logic" is important
- **Suicide Risk Assessment** goes further than SI/plan
 - **Consider other factors** – past hx, ambivalence, prior suicide attempt, support, hope/pain, FH
- **Follow up** closely
- **Caring contact matters**
- Consider **suicide specific therapy** referral
- Consider **medications** to reduce suicide risk

We are not expected to be able to predict suicide; we are expected to take reasonable steps toward prevention when suicide is a foreseeable outcome for a patient.

**Translating evidence
into practice
saves lives
and improves many
more.**

HOPE INTO ACTION

Contact:

Christine Moutier, M.D.

cmoutier@afsp.org



**AMERICAN FOUNDATION FOR
Suicide Prevention**

afsp.org

#StopSuicide

