SUICIDE PREVENTION

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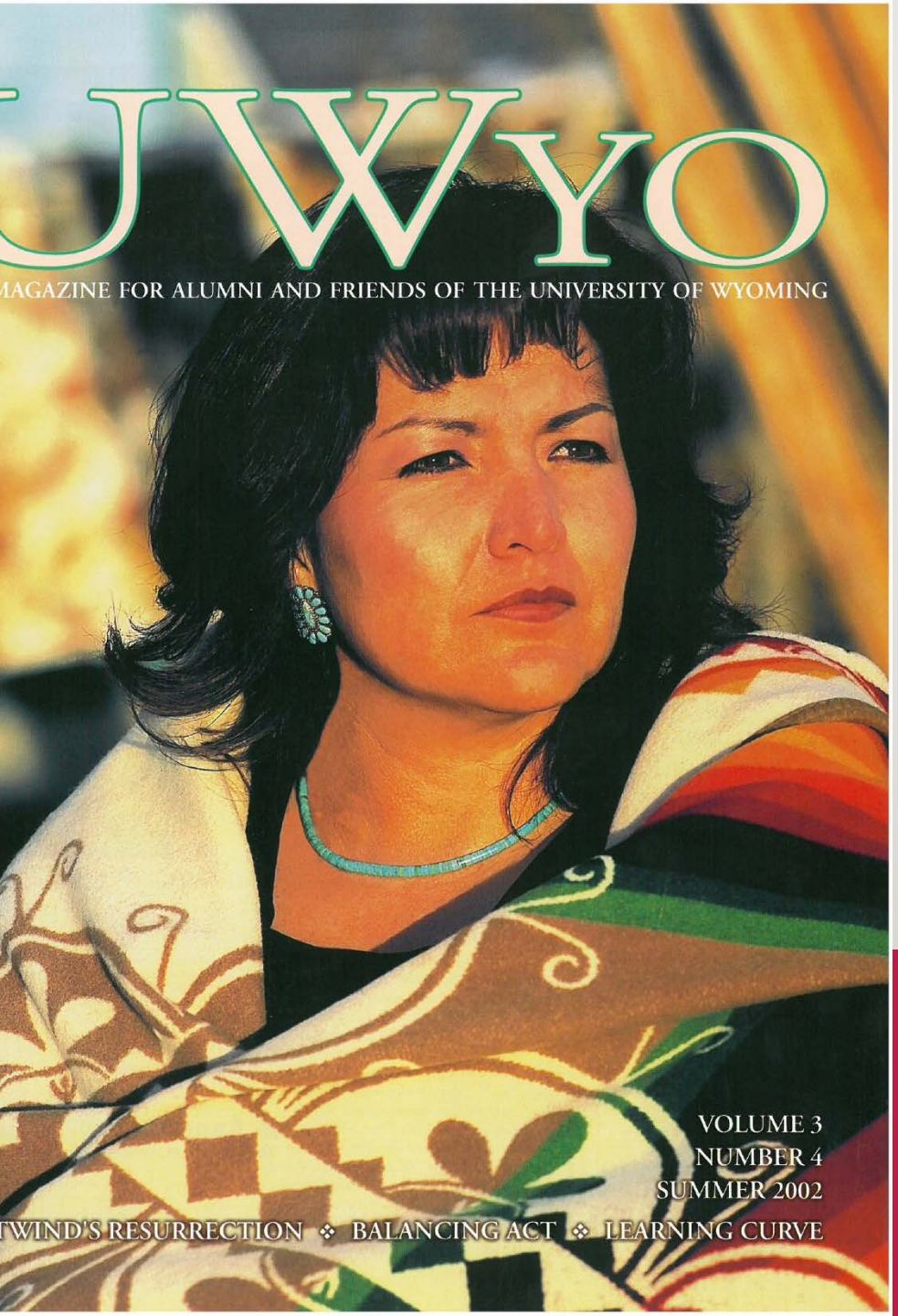
ACKNOWLEDGEMENT OF COUNTRY

- Lived Expertise
- Gratitude
- Self-care
- Preface


UWYO
MAGAZINE FOR ALUMNI AND FRIENDS OF THE UNIVERSITY OF WYOMING
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SUMMER 2002
TWIND'S RESURRECTION ❖ BALANCING ACT ❖ LEARNING CURVE

WHO AM I?

“Statistics are merely aggregate numbers
With the tears wiped away.”

~Dr. Irving Selikoff

LITTLE EAGLE/ JOHN DESHAW 1968-1985

INTRODUCTIONS

- Name
- Role/organization
- Tribal affiliation
- (Optional) How has the issue of suicide shown up in your life?
- Burning Question

GOALS

1. Reducing fear
2. Hot topics
3. Comprehensive framework
4. Risk Formulation
5. Managing Safety and promoting well-being
6. Assessment Tool

SECTION 1: OVERCOMING FEAR & BIAS

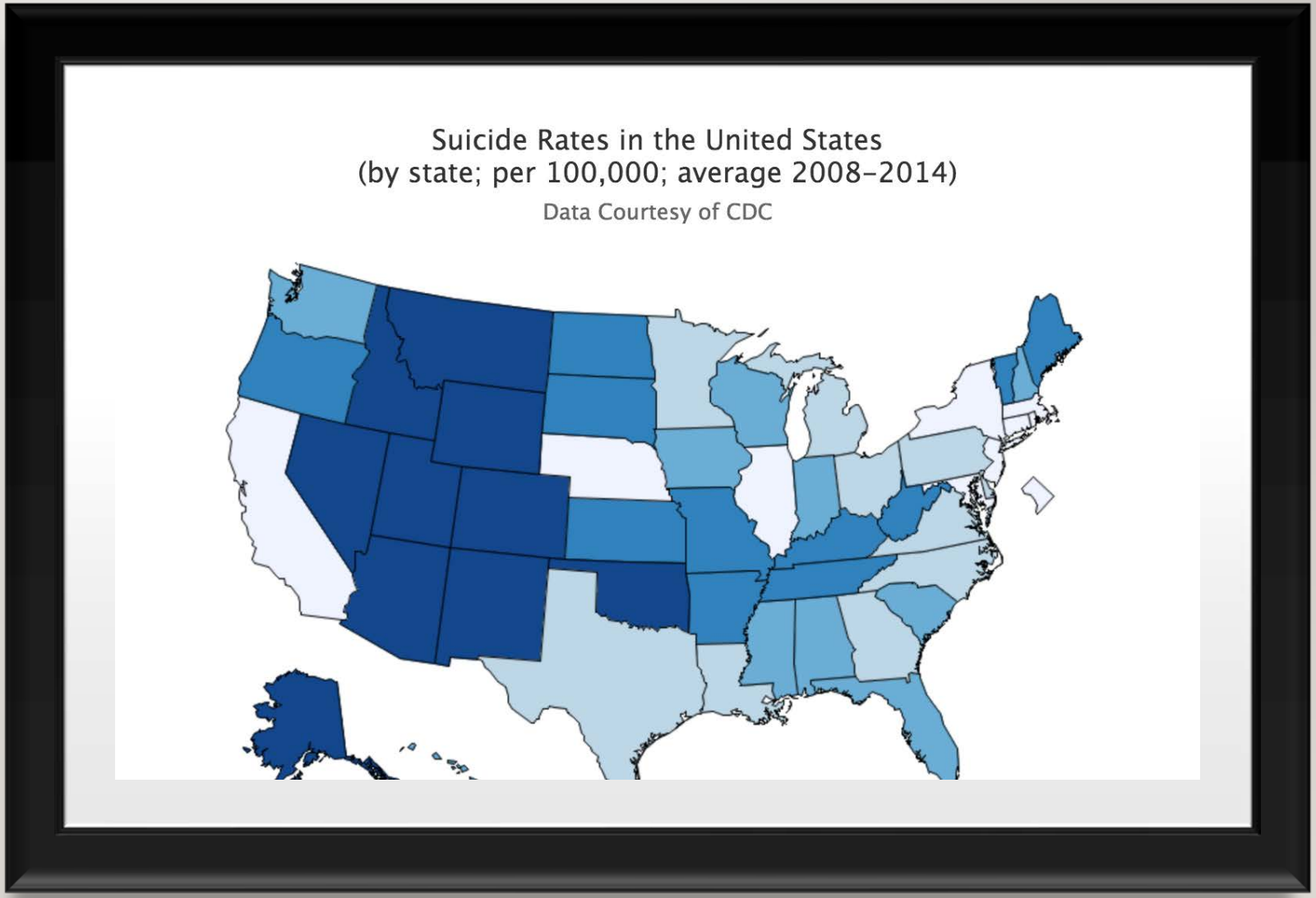
STARTING WITH OURSELVES

- #1 FEAR = SUICIDE OF CLIENT, 97% OF CLINICIANS
- ONE OUT OF EVERY FIVE MENTAL HEALTH SERVICE PROVIDERS WILL EXPERIENCE A CLIENT SUICIDE EACH YEAR

REFLECTION EXERCISE

- OUR OWN PERSONAL EXPERIENCE WITH SUICIDE
- CLINICIANS AS SUICIDE LOSS SURVIVORS
- CLINICIANS AS SUICIDE ATTEMPT SURVIVORS
- CLINICIANS AS PEOPLE LIVING WITH SUICIDAL THOUGHTS AND FEELINGS
- CLINICIANS AS PERSONAL CAREGIVERS FOR OTHERS
- CONFIDENTIALITY AND SAFE PLACE

SECTION 2: HOT TOPICS IN SUICIDOLOGY



Leading Causes of Death in the United States (2016)

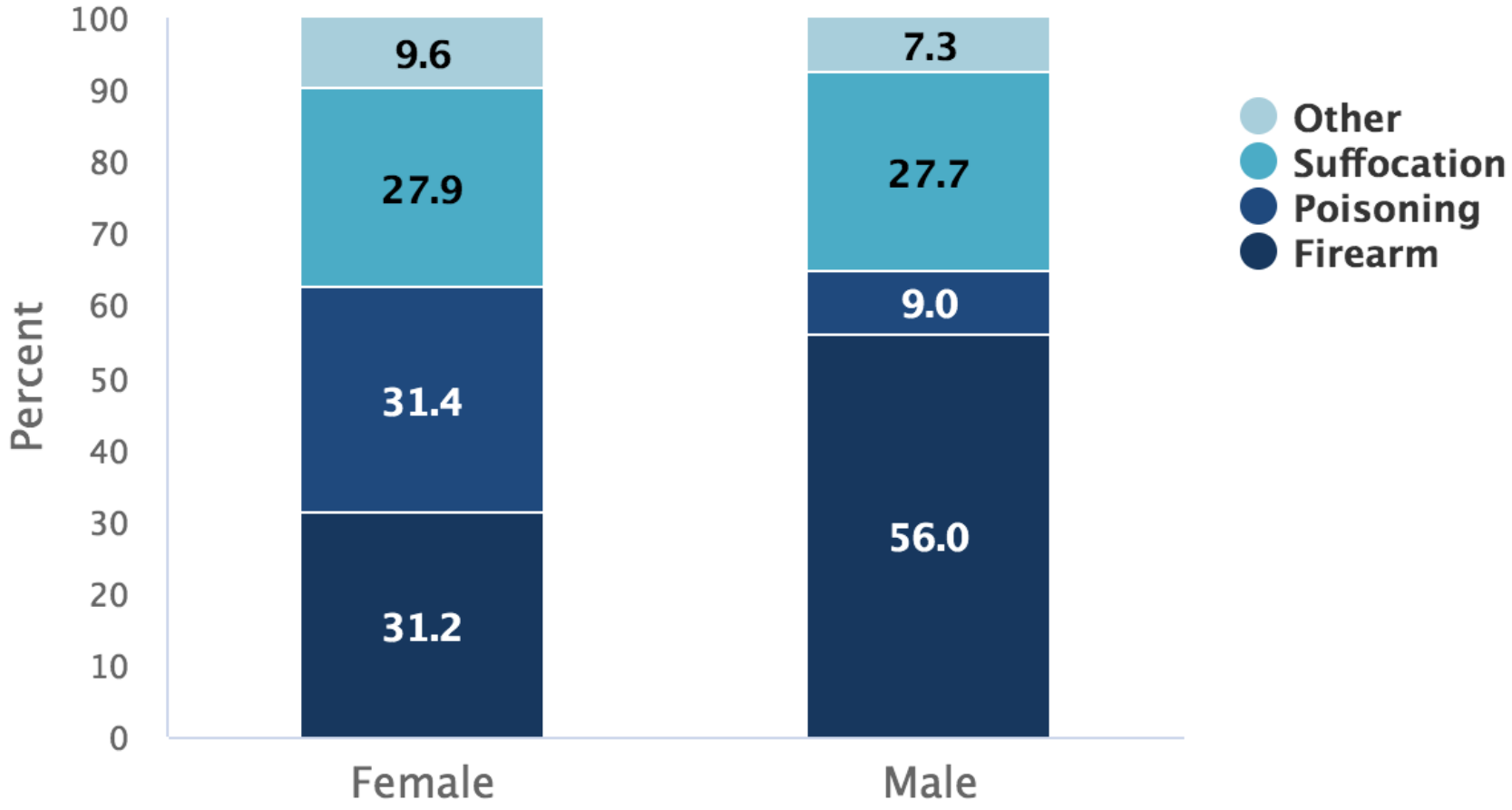
Data Courtesy of CDC

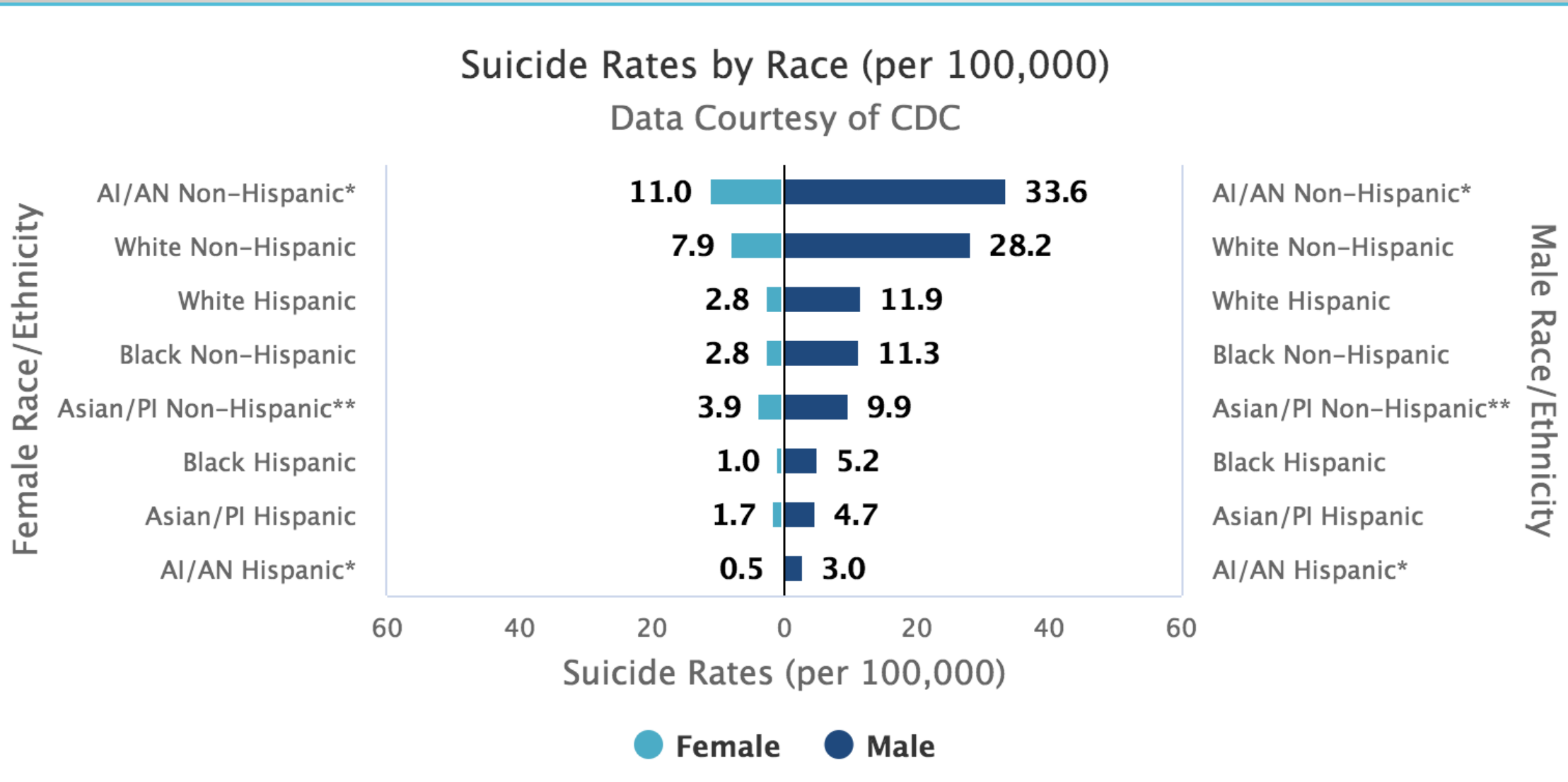
	Select Age Groups							
Rank	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	CLRD 131,002	Unintentional Injury 161,374
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	CLRD 17,810	Cerebro-vascular 121,630	CLRD 154,596
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575	Cerebro-vascular 1,851	CLRD 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
	Influenza	Influenza	HIV	HIV	Septicemia	Septicemia	Nephritis	Nephritis

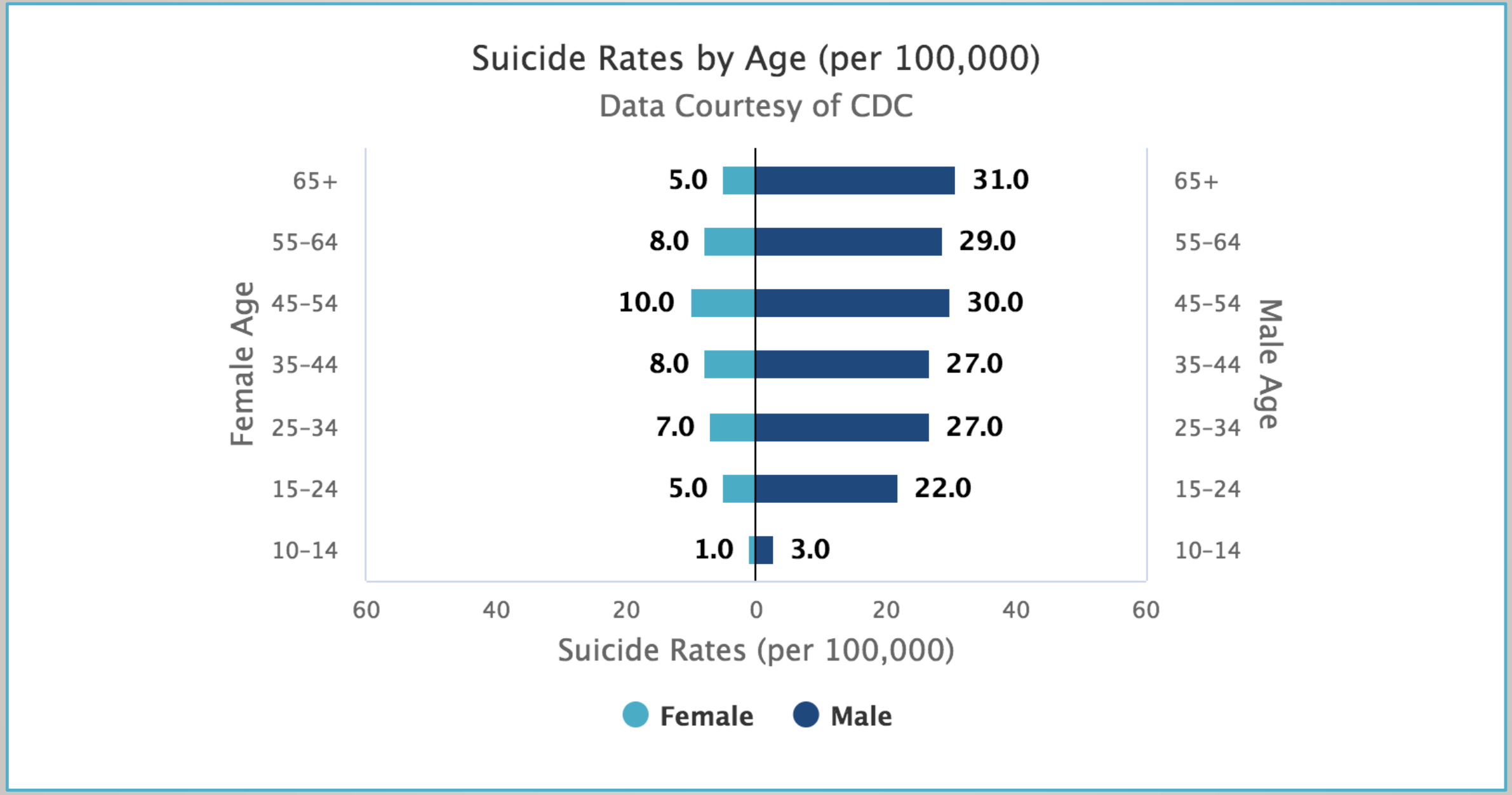
Suicide by Method (2016)	
Data Courtesy of CDC	
Suicide Method	**Number of Deaths**
Total	44,965
Firearm	22,963
Suffocation	11,642
Poisoning	6,698
Other	3,662

Percentage of Suicide Deaths by Method in the United States (2017)

Data Courtesy of CDC




Suicide Rates by Race (per 100,000)
Data Courtesy of CDC
Female Race/Ethnicity
Male Race/Ethnicity
AI/AN Non-Hispanic*
White Non-Hispanic
White Hispanic
Black Non-Hispanic
Asian/PI Non-Hispanic**
Black Hispanic
Asian/PI Hispanic
AI/AN Hispanic*
11.0
7.9
2.8
2.8
3.9
1.0
1.7
0.5
33.6
28.2
11.9
11.3
9.9
5.2
4.7
3.0
60
40
20
0
20
40
60
Suicide Rates (per 100,000)
Female
Male
*AI/AN = American Indian / Alaskan Native, **PI = Pacific Islander


Suicide Rates by Age (per 100,000)
Data Courtesy of CDC
Female Age
65+
55-64
45-54
35-44
25-34
15-24
10-14
5.0
8.0
10.0
8.0
7.0
5.0
1.0
31.0
29.0
30.0
27.0
27.0
22.0
3.0
Male Age
60
40
20
0
20
40
60
Suicide Rates (per 100,000)
Female
Male

CONNECTION BETWEEN MENTAL HEALTH AND SUICIDE

- Mood Disorders (esp. Major Depression and Bipolar Disorder)
- Substance Use Disorders
- PTSD (Especially w/ Anger and Impulsivity)
- Schizophrenia
- Borderline Personality Disorder
- Eating Disorder

ALCOHOL AND SUICIDE

- Alcohol use in groups can facilitate connection
- Self-medication
- Disinhibiting: difference between thought and attempt (Alcohol in the blood of about 1/3 of suicide)
- About 40 % of people treated for alcohol dependence report at least one suicide attempt
- Among people dependent on alcohol, lifetime risk of suicide 10-15%
- Findings vary by cultural attitudes.

ALCOHOL AND SUICIDE STATISTICS

120 times more likely to commit suicide than non drinkers

+

40 Seconds every 40 seconds someone dies by suicide

=

29 Percent 20% of Suicide victims had alcohol in their blood

OPIODS & SUICIDE

- Non-cancer pain is linked to increased suicide risk
- Increased dose of opioids was found to be a marker of increased suicide risk (even when relevant demographic and clinical factors were statistically controlled)
- Many overdoses may be suicides
- Quality of life and management of pain poor for long-term opioid use.

ADDITIONAL FORMS OF TRAUMA & SUICIDE

- Childhood Trauma (ACEs) physical, emotional, sexual abuse and physical neglect)
- Veterans
  - Military sexual trauma
  - Combat trauma – frequent intensity
  - Moral injury/guilt

  Historical

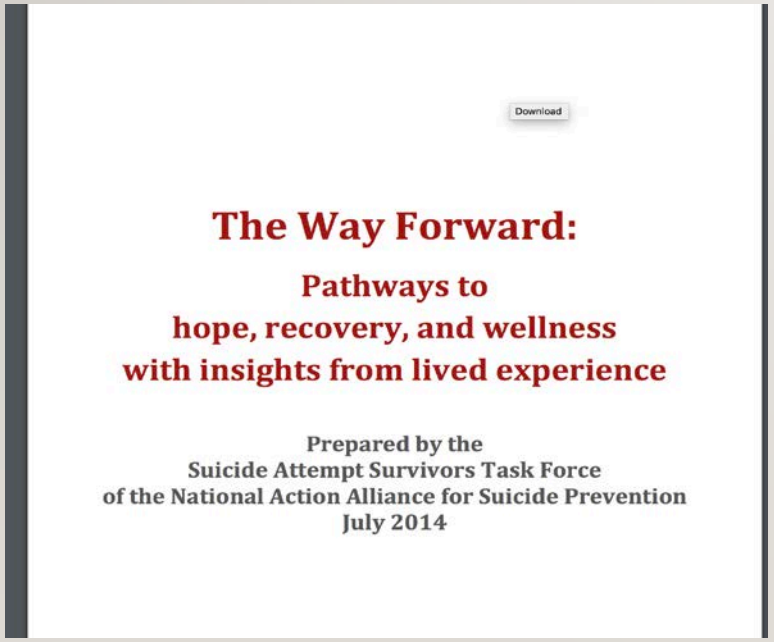
  Sand Creek Massacre November 29, 1864 by the US Army Third Colorado Calvary

WORDS TO SAY INSTEAD

SAY THIS	INSTEAD OF THIS
• Died of Suicide	• ~~Committed Suicide~~
• Suicide Death	• ~~Successful Attempt~~
• Suicide Attempt	• ~~Unsuccessful Attempt~~
• Person Living with Suicidal Thoughts or Behavior	• ~~Suicide Ideator or Attempter~~
• Suicide	• ~~Completed Suicide~~
• (Describe the Behavior)	• ~~Manipulative, Cry for Help, Suicidal Gesture~~
• Working With	• ~~Dealing with Suicidal Person~~

LIVED EXPERTISE

BOOK

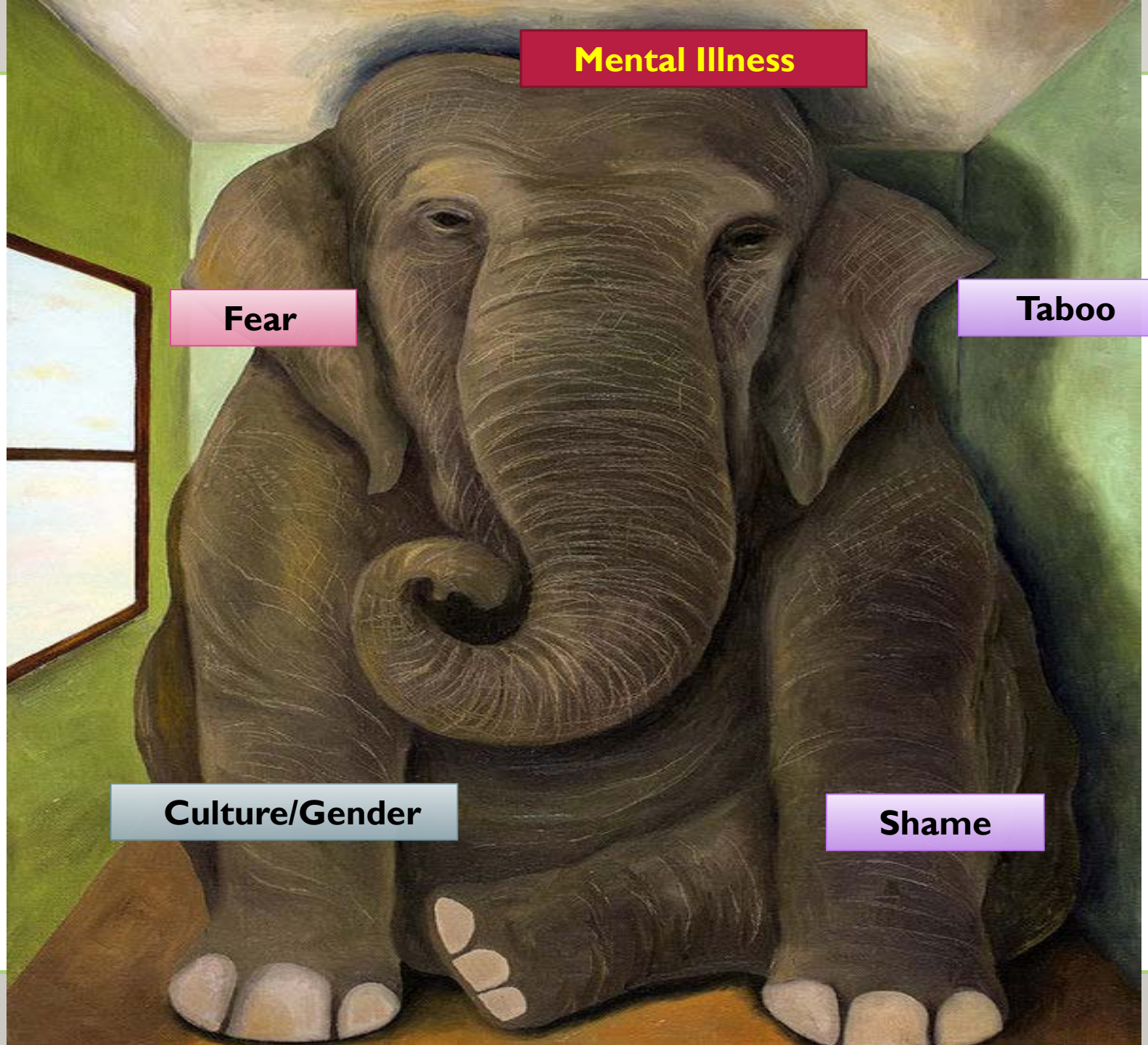


YOUTUBE

- https://www.youtube.com/user/DrMahogany/videos

LIVED EXPERIENCE TO HELP PREVENT SUICIDE

- https://youtu.be/jm8DZdbRfFY
- https://youtu.be/rrehU_DWgEM


Mental Illness
Fear
Taboo
Culture/Gender
Shame

“IF ZERO IS NOT THE RIGHT GOAL, THEN WHAT NUMBER IS?”

HOW'D THEY DO THAT?

SPECIAL REPORT

Zero Suicide
The Dogged Pursuit of Perfection in Health Care

» David W. Covington, LPC, MBA, and Michael F. Hogan, PhD

"Is it rational to pursue zero suicide among patients in health care?" This question was posed by Mokkenstorm and colleagues[1] as they addressed objections that the science and published results aren't yet in. Growing evidence, however, demonstrates remarkable success at reducing the number of lives lost to suicide in health care systems that have committed to the systematic "suicide care" approach known as "Zero Suicide."

Psychiatric leadership is essential to the success of efforts toward zero suicide. More than a slogan, the approach applies evidence about what works in the detection, treatment, and management of individuals with intense suicidality within a culture

liability organizations aggressively pursue perfection, an approach, for example, that has driven commercial aviation in the US to achieve remarkable levels of safety in air travel. This approach is characterized by a deference to front-line expertise, a preoccupation with learning about failures and "near misses" and a relentless focus on the target of zero defects.

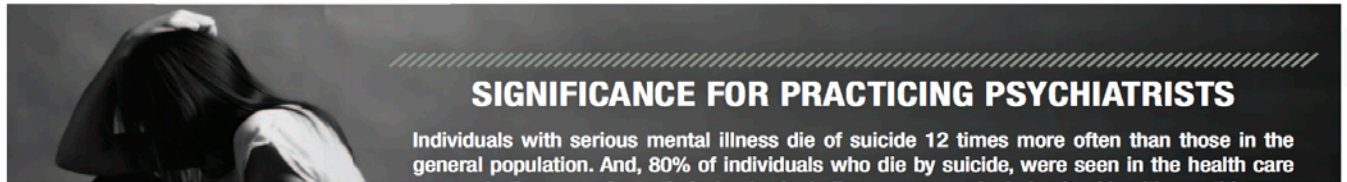
The Henry Ford Health System (HFHS) in Detroit was the first to apply these concepts in behavioral health care, which focused on the relentless assessment of suicidality across their continuum of psychiat-

This success did not occur in the context of the rigors of a funded research project but as part of an intensive "commitment to radical quality" within usual health care. The results are clearly impressive and demand attention. At the same time, the effort was not a randomized trial. Some have discounted the results, minimizing the approach as "clever sloganeering" and repackaging. One implication clearly is the need to complete the science and verify the results of applying new knowledge to the care of suicidal individuals.

National Action Alliance for Suicide Prevention task force

In 2010, when a task force commissioned by the National Action Alliance for Suicide Prevention and Dr Richard McKeon of the Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services, studied the HFHS story, comprehensive evaluations of good suicide care were not yet available.[6] The task force quickly learned that usual care is disastrous when it comes to preventing loss of life by suicide. By 2010, striking evidence of the impact of good care was starting to emerge, such as the study by Motto and Bostrom[7] showing that "caring letters" to individuals who had been hospitalized following an attempt dramatically reduced subsequent attempts and deaths.

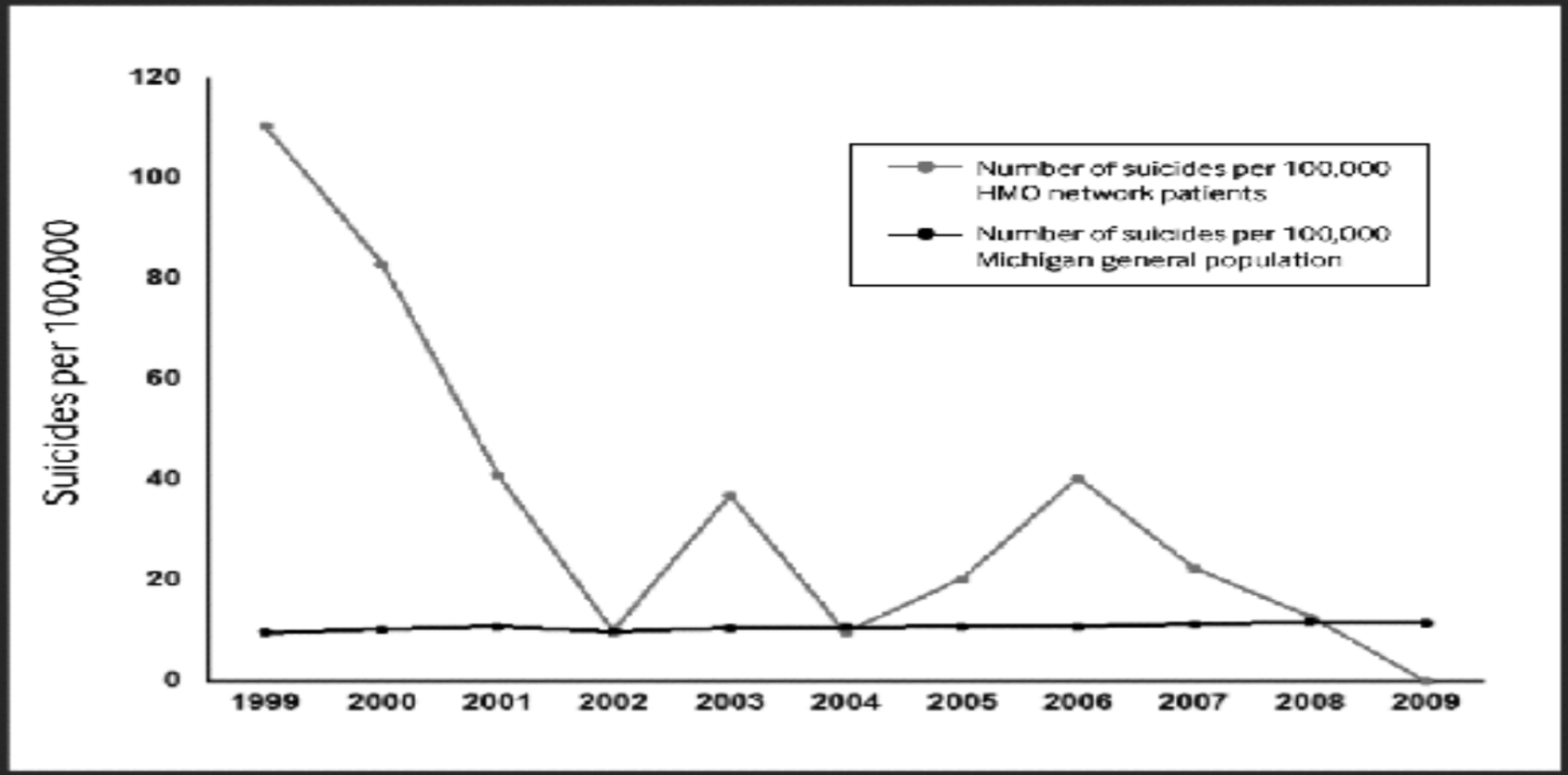
In 2010, *Forbes* magazine published an article asserting that few



SIGNIFICANCE FOR PRACTICING PSYCHIATRISTS

Individuals with serious mental illness die of suicide 12 times more often than those in the general population. And, 80% of individuals who die by suicide, were seen in the health care

Improved Suicide Rates Among Henry Ford Medical Group HMO Members



C. Edward Coffey MD / Henry Ford Health System; National Vital Statistics Reports.

Medical News & Perspectives

May 19, 2010

Depression Care Effort Brings Dramatic Drop in Large HMO Population's Suicide Rate

Tracy Hampton, PhD

JAMA. 2010;303(19):1903-1905. doi:10.1001/jama.2010.595

While physicians and other health care workers may not be able to predict which of their patients will attempt suicide, they can implement preventive strategies that markedly lower the risk of such tragedies. Now, one pioneering program has demonstrated the importance of pursuing 2 key approaches at once: carefully assessing patients for risk of suicide and adopting measures to reduce the likelihood that a patient will attempt suicide.

The example comes from a quality-improvement initiative that succeeded in substantially bringing down the rate of suicide in a population of about 200 000 members of a large health maintenance organization (HMO). Through the second quarter of last year, the Perfect Depression Care program of the Behavioral Health Services (BHS) division of the Henry Ford Health System resulted in 9 consecutive quarters without any suicides, a dramatic contrast to the annual rate of 89 suicides per 100 000 members at baseline and approximately 230 suicides per 100 000 individuals expected in a patient population. The work has won several awards, including the Joint Commission's Earnest Amory Codman Award and the Gold Achievement Award from the American Psychiatric Association.

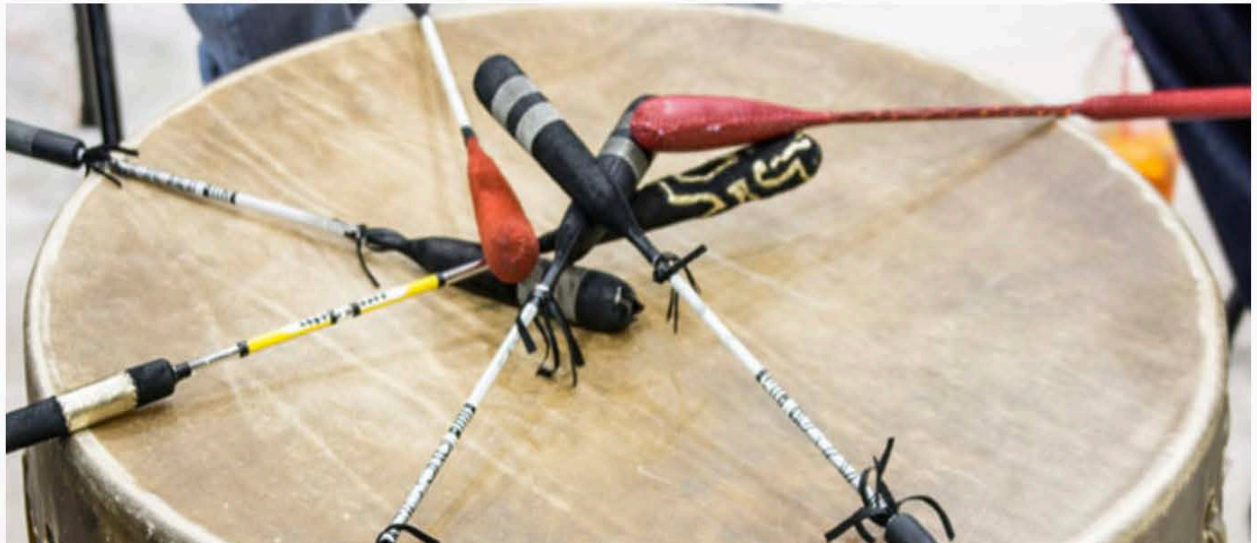
SIGNIFICANCE OF FINDINGS: 3 ESSENTIAL STEPS

- Starting a conversation about suicide is the crucial first step.
- Completing a collaborative safety/crisis plan that includes counseling to help reduce and manage access to lethal means.
- Delivering direct treatment targeting suicidality and extended care into follow-up.
- Model is being implemented globally.
- Largest-scare study of crisis planning to date, Stanley/Brown Safety Planning reduced suicidal behavior by 50%.

ZERO SUICIDE IN HEALTH AND BEHAVIORAL HEALTH CARE

- Commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies.
- Core proposition that suicide deaths for people under care are preventable and that the goal of zero suicides
- Aims to improve care and outcomes for individuals at risk of suicide in healthcare systems.

Hope for Life Day Toolkit



SECTION 3: COMPREHENSIVE APPROACH

UPSTREAM APPROACHES

Goals:
- ✓ Build Protective Factors
- ✓ Prevent Problems

- Define Purpose
- Promote Social Networks
- Mental Health Literacy
- Life Skills
- Lived Experience Stories

MIDSTREAM

Goals:
- ✓ Early Identification
- ✓ Link to care

- Gatekeeper Training
- Screening
- Promote Spectrum Help-Seeking/Help Giving including Peer Support
- Accessible Quality Mental Health Services

DOWNSTREAM

Goals:
✓ Manage crises
✓ Restore functioning

- Reduce Access to Lethal Means
- Dignity and Empowerment
- Grief and Trauma Support

"PLACE YOUR HAND OVER YOUR HEART, CAN YOU FEEL IT? THAT IS CALLED PURPOSE. YOU'RE ALIVE FOR A REASON SO DON'T EVER GIVE UP."

ANDY RAE

NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-8255

CRISIS TEXT LINE

TEXT "HOME" TO 741741

ONLINE RESOURCES

SUICIDEPREVENTIONLIFELINE.ORG

QUESTIONS?

- Don’t forget to practice your self-care
- And join us in the next segment when I will get into prevention more and some treatment briefly.
- Ha hou for your time to listen. And please share and take action in your community.
- Help our people, they need you