



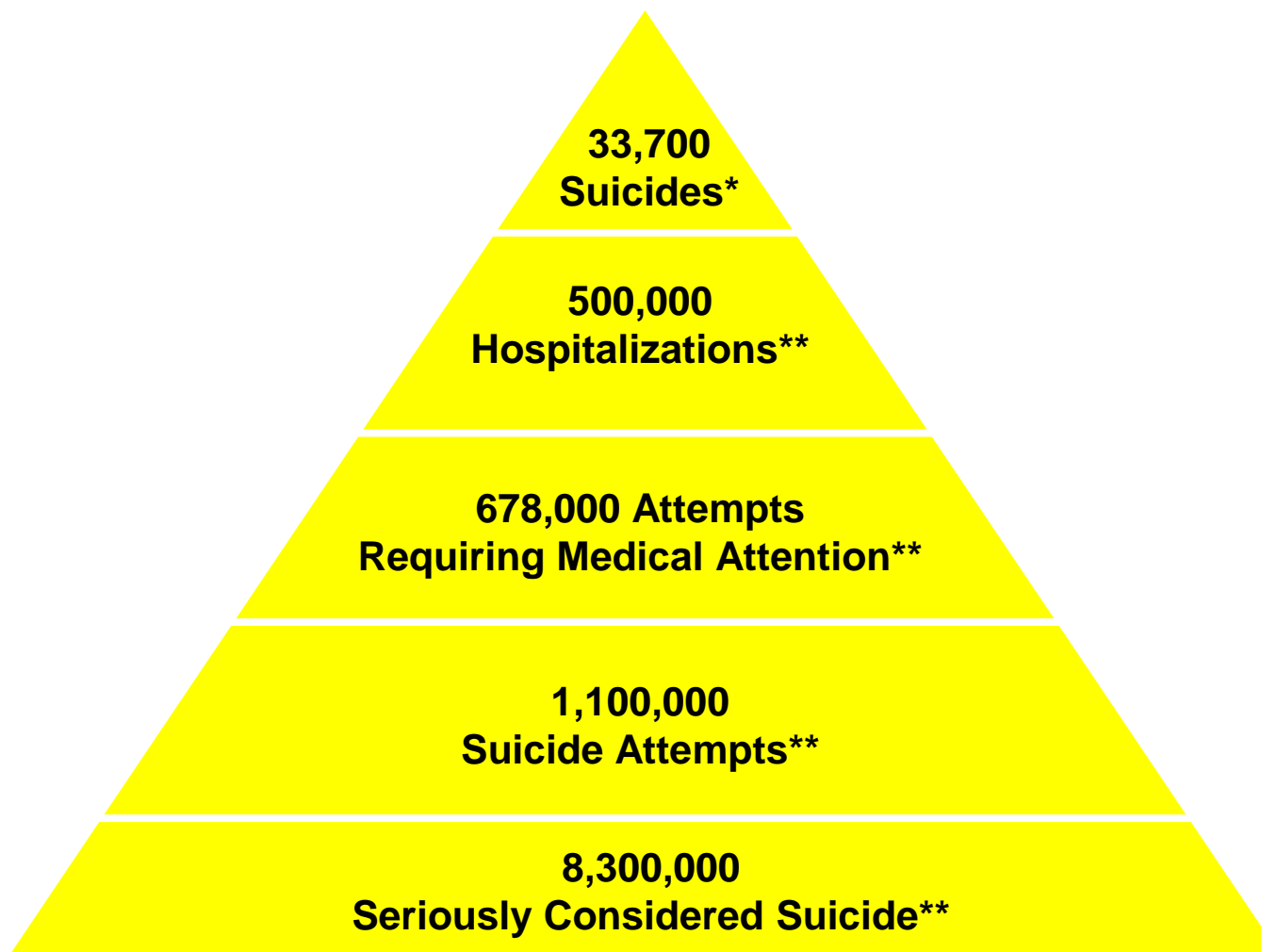
**Orientation Briefing:
Executive Committee
National Action Alliance for Suicide Prevention**

Adapted for NASMHPD by Mike Hogan

Originally Developed and Presented to EXCOM by David Litts, O.D., SPRC



Pyramid of Suicidal Behaviors--U.S.



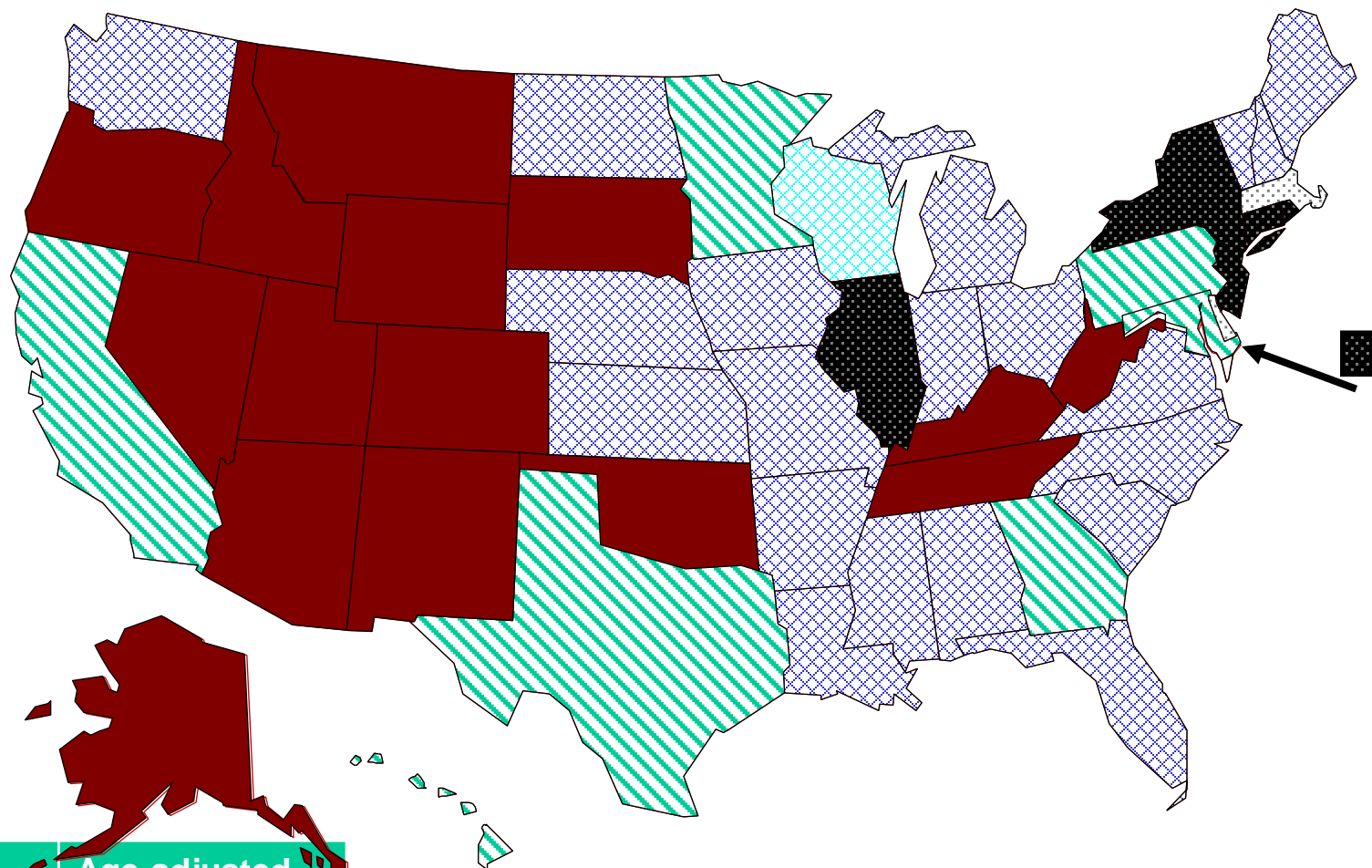
Source:

* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Available from: www.cdc.gov/injury/wisqars/index.html.

**Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2009). *The NSDUH Report: Suicidal Thoughts and Behaviors among Adults*. Rockville, MD.



Age-Adjusted Suicide Rates Among All Persons by State -- United States, 2006 (U.S. Avg. 10.95)



State (Lowest & Highest)	Age-adjusted Rate (per 100k)
New Jersey	6.7
Alaska	22.1



Source: Centers for Disease Control and Prevention (CDC) vital statistics



Demographics

- Suicides:
 - Male : female = 4:1
 - Elderly white males -- highest rate
 - Working aged males – 60% of all suicides

- Attempts:
 - Female>>male
 - Rates peak in adolescence and decline with age
 - Concern: Latina youth and LGBT

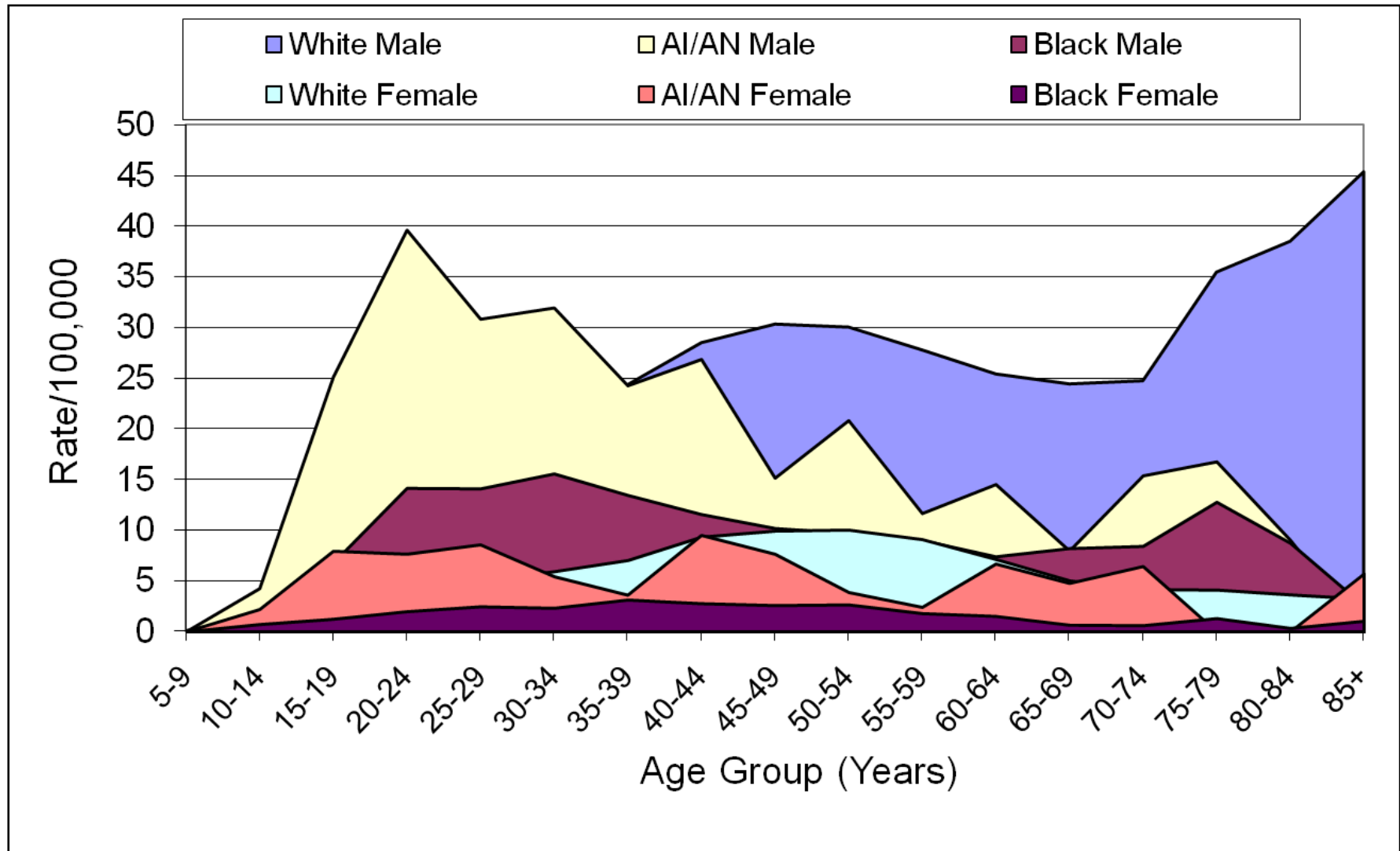
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Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html.



Suicide Rates by Age, Race, and Gender United States, 2007



Source:
National Center for Health Statistics
Note: Non-Hispanic Ethnicity



Moving Beyond the Demographics

- **Suicides:**
 - Male : female = 4:1
 - Elderly white males -- highest rate
 - Working aged males – 60% of all suicides
 - **Concern for SMHA's : People with serious mental illness: rate 6-12x;
People with health concerns: 50%+ of suicides w/in 30 days of PCP visit**

- **Attempts:**
 - Female>>male
 - Rates peak in adolescence and decline with age
 - Concern: Latina youth and LGBT

Source:

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009).

Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html.

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

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>

Veterans/Military

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

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>

Individuals with SMI

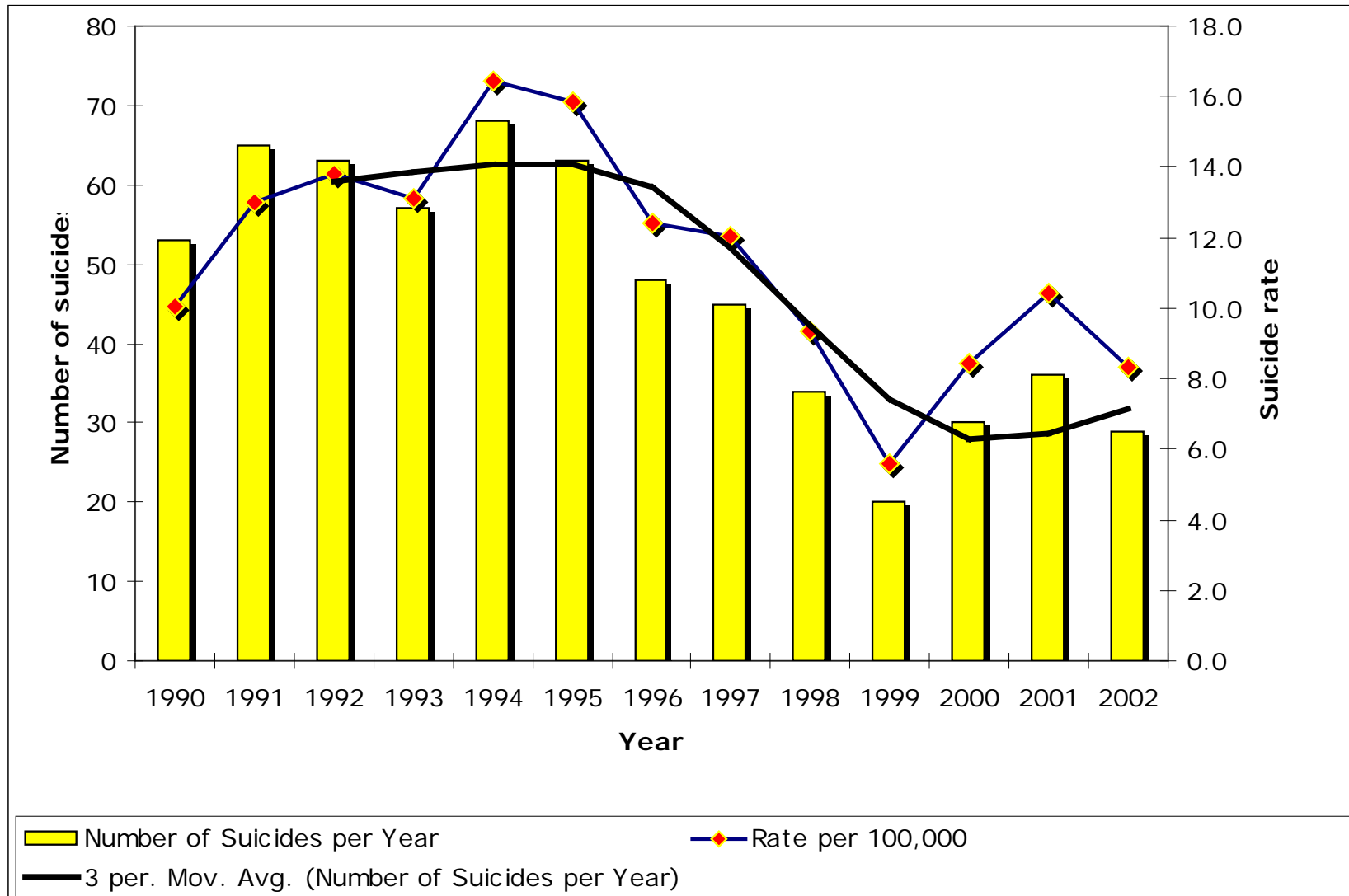
In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness.

<http://bit.ly/SMI-suicide-12x>

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.



Redefining What Can Be Done I: U.S. Air Force Program



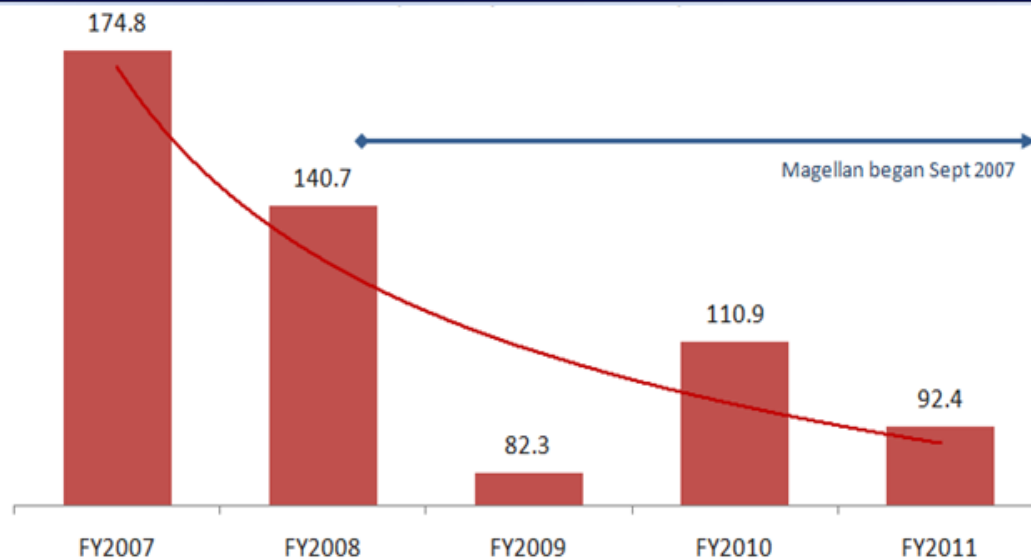
Source:

Knox, K, et al., Risk of Suicide and related adverse outcomes after exposure to a suicide programme in the US Air Force: cohort study. British Medical Journal, December 13, 2003.



Redefining What Can Be Done II: A Public Mental Health System

The Maricopa Suicide Intervention Project believes every suicide is preventable



Suicide rate per 100,000 for individuals with SMI enrolled in Maricopa County RBHA

Maricopa BH Active BH Recipients	FY2007	FY2008	FY2009	FY2010	FY2011	Reduction
Suicide Rate						
<i>SMI</i>	174.8	140.7	82.3	110.9	92.4	46%
<i>Child</i>	5.4	10.6	0.0	4.3	0.0	73%
<i>GMH/SA</i>	58.1	25.0	32.4	37.8	27.0	44%
Total BH	77.2	52.8	35.8	47.5	36.6	48%

Note: FY2011 projection based upon June through December 2010 data.



“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

Clinical Excellence Logic Map



In the Community is
Success - Involuntary
Detainment is System
Failure *

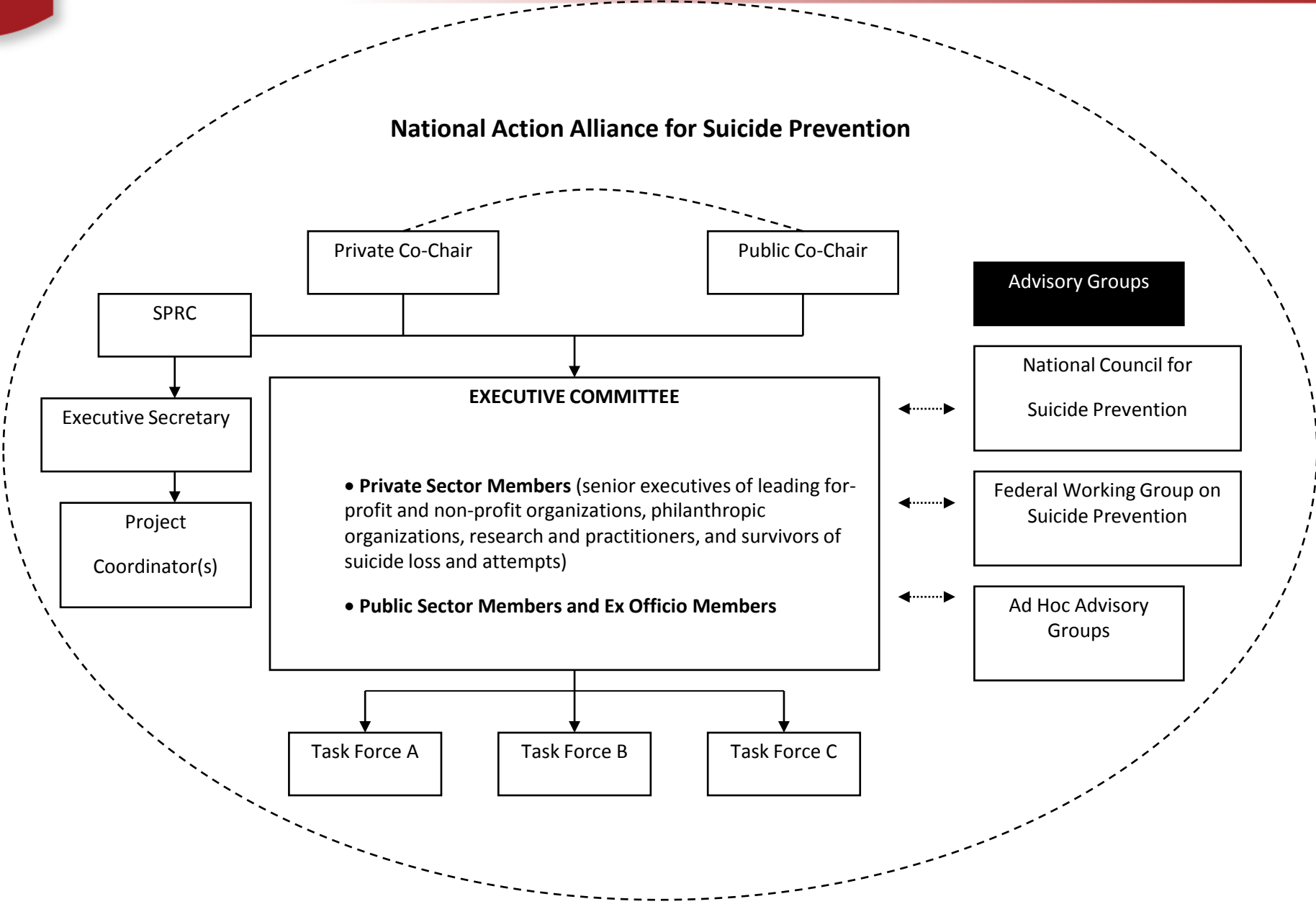


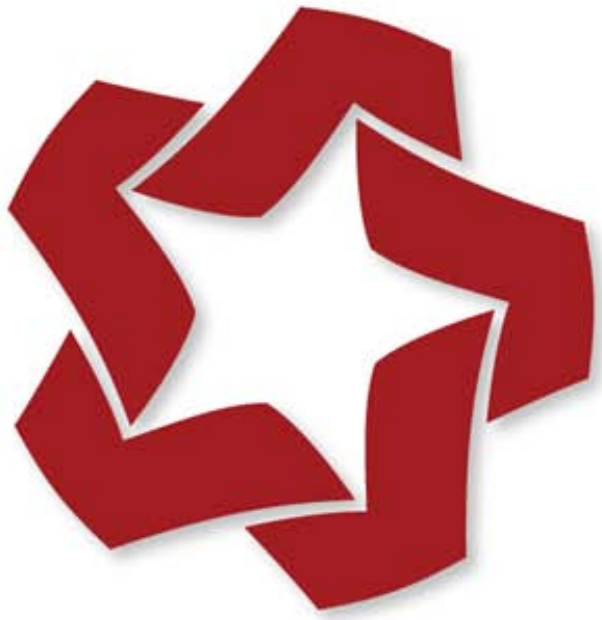
National Action Alliance for Suicide Prevention

- Launched Sept 10 2010 (World Suicide Prevention Day)
 - Secretaries Sibelius and Gates, Pam Hyde
 - Co-chairs: Army Secretary John McHugh, Sen. Gordon Smith
- Vision: A nation free of the tragic experience of suicide
- Mission: To advance the National Strategy for Suicide Prevention (NSSP) by:
 - championing suicide prevention as a national priority
 - Revising, and catalyzing efforts to implement high priority objectives of the NSSP
 - cultivating the resources needed to sustain progress



Action Alliance Organization





Task Force Briefing Clinical Care & Intervention

**EXCOM Meeting
18 May 2011**

**Michael Hogan, PhD – NYS Office of Mental Health
David Covington, LPC, MBA – Magellan Health Services**



Next Steps and Lessons Learned

LESSONS LEARNED

- We started out seeking training and tools, but found “upstream” forces more powerful (e.g., culture, core values and systems)
 - USAF
 - Henry Ford Health Systems
 - Magellan Maricopa
- Suicide results from deficits in health/mental health care, including no mental health in primary care, poor follow-through in mental health
- Suicide Prevention has focused on clinical interventions, but our review suggests systems must be retooled. We focus on “bordered populations” where leverage and accountability exist



Questions/Issues for EXCOM Discussion

- We raised these questions for the EXCOM:
 1. We have focused on initiatives with a “boundaried population,” where a “zero-defect” approach could be adopted (HFHS, Maricopa). This is an innovative/radical approach to suicide prevention, offering the opportunity to define suicide as a “never event” in health settings and systems (like wrong-site surgery). What is the EXCOM’s feedback on this primary direction?
Go For It!
 2. Our target audience is broader than BH and includes general health plans and primary care. Who are key people to add to our task force?



Suicide Prevention: What SMHA Directors Should Do

- Ensure you have a champion
 - On staff?
 - In community
- Manage direct responsibilities well:
 - Inpatient (NPSG)
 - “Install” Suicide Prevention in Health Reform
 - Health Homes
 - In SMHA System: Plans, Integrated Providers
 - Primary Care
 - Assure liaison to Lifelines
- Lead from the front, with heart and strategy

Thank you!