Integration of Opioid and Suicide Identification, Prevention and Care: A SAMHSA Perspective

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SAMHSA- 11/4/2019

National Institute of Mental Health

Disclaimer

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CDC Vital Signs: Suicide rising across the U.S. More than a mental health concern

CDC Vitalsigns™

Suicide rising across the US

More than a mental health concern

45K Nearly 45,000 lives lost to suicide in 2016.

↑30% Suicide rates went up more than 30% in half of states since 1999.

54% More than half of people who died by suicide did not have a known mental health condition.

Suicide is a leading cause of death in the US. Suicide rates increased in nearly every state from 1999 through 2016. Mental health conditions are often seen as the cause of suicide, but suicide is rarely caused by any single factor. In fact, many people who die by suicide are not known to have a diagnosed mental health condition at the time of death. Other problems often contribute to suicide, such as relationship problems or loss, substance use disorders, physical health problems, and job, money, legal, or housing stress. Government, public health, healthcare, business, education, media and community organizations working together is important for preventing suicide. Public health departments can bring together these partners to focus on comprehensive state and community efforts with the greatest likelihood of preventing suicide.

States and communities can:

- Identify and support people at risk of suicide.
- Teach coping and problem-solving skills to help people manage challenges with their relationships, jobs, health, or other concerns.
- Promote safe and supportive environments. This includes safely storing medications and firearms to reduce access among people at risk.
- Offer activities that bring people together so they feel connected and not alone.
- Connect people at risk to effective and coordinated mental and physical healthcare.
- Expand options for temporary help for those struggling to make ends meet.
- Prevent future risk of suicide among those who have lost a loved one to suicide.

Want to learn more? Visit: www.cdc.gov/vitalsigns

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control

June 12, 2018

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Weekly / Vol. 67 / No. 22 June 8, 2018

Vital Signs: Trends in State Suicide Rates — United States, 1999–2016 and Circumstances Contributing to Suicide — 27 States, 2015

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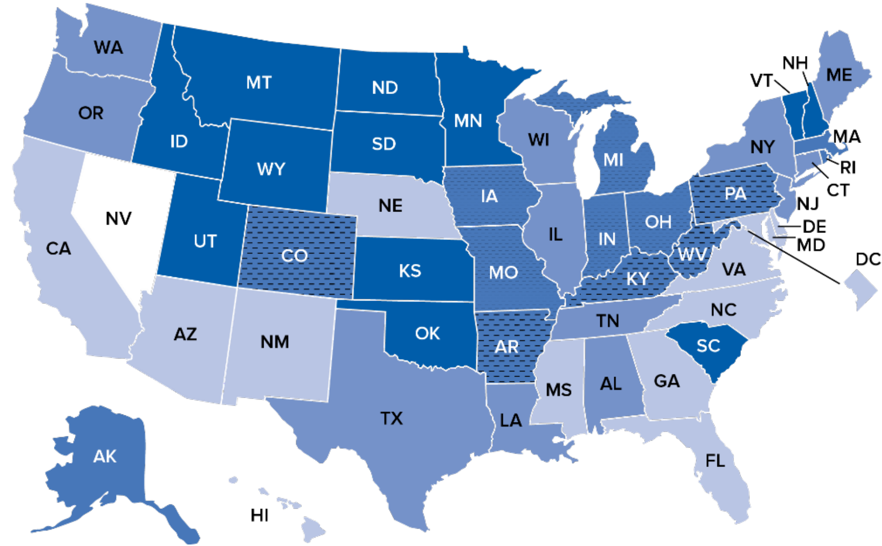
Deborah M. Stone, ScD, MSW, MPH
Behavioral Scientist

PROBLEM: SUICIDE RATES INCREASED IN ALMOST EVERY STATE.

Suicide rates rose across the US from 1999 to 2016.



SOURCE: CDC's National Vital Statistics System; CDC Vital Signs, June 2018.

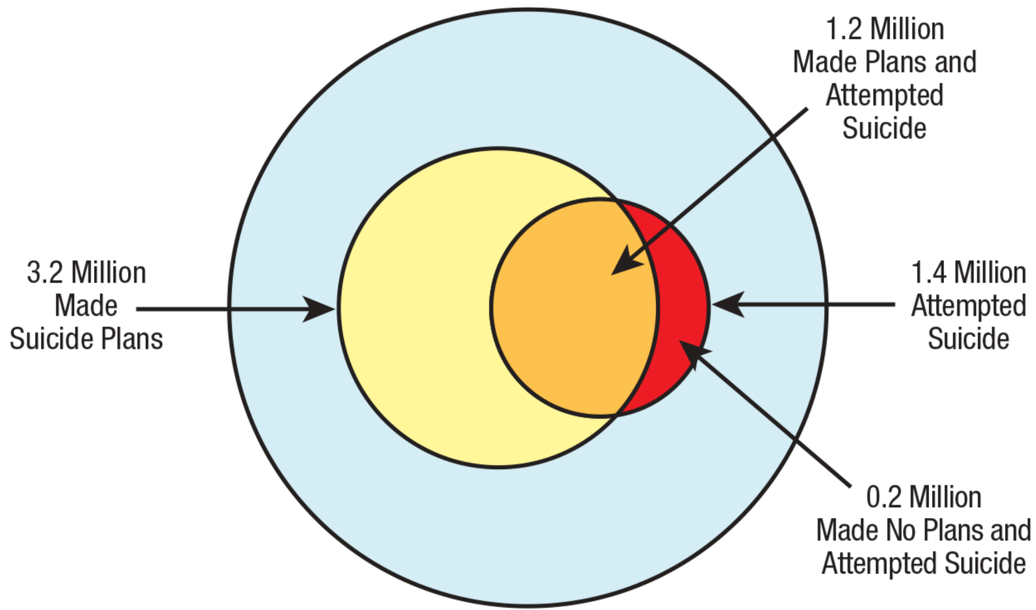
Leading causes of death for selected age groups – United States, 2016

Rank	10-14 years	15-19 years	20-29 years	30-39 years	40-49 years	50-59 years
1	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Unintentional Injuries	Malignant Neoplasms
2	**Suicide**	**Suicide**	**Suicide**	**Suicide**	Malignant Neoplasms	Heart Disease
3	Malignant Neoplasms	Homicide	Homicide	Malignant Neoplasms	Heart Disease	Unintentional Injuries
4	Homicide	Malignant Neoplasms	Malignant Neoplasms	Heart Disease	**Suicide**	Liver Disease
5	Congenital Malformations	Heart Disease	Heart Disease	Homicide	Liver Disease	Chronic Lower Respiratory Ds
6	Heart Disease	Congenital Malformations	Diabetes Mellitus	Liver Disease	Diabetes Mellitus	Diabetes Mellitus
7	Chronic Lower Respiratory Ds	Chronic Lower Respiratory Ds	Congenital Malformations	Diabetes Mellitus	Cerebro-Vascular	**Suicide**
8	Cerebro-Vascular	Cerebro-Vascular	Complicated pregnancy	Cerebro-Vascular	Homicide	Cerebro-Vascular

Source: CDC vital statistics

FFR1.58

Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older: Numbers in Millions, 2017



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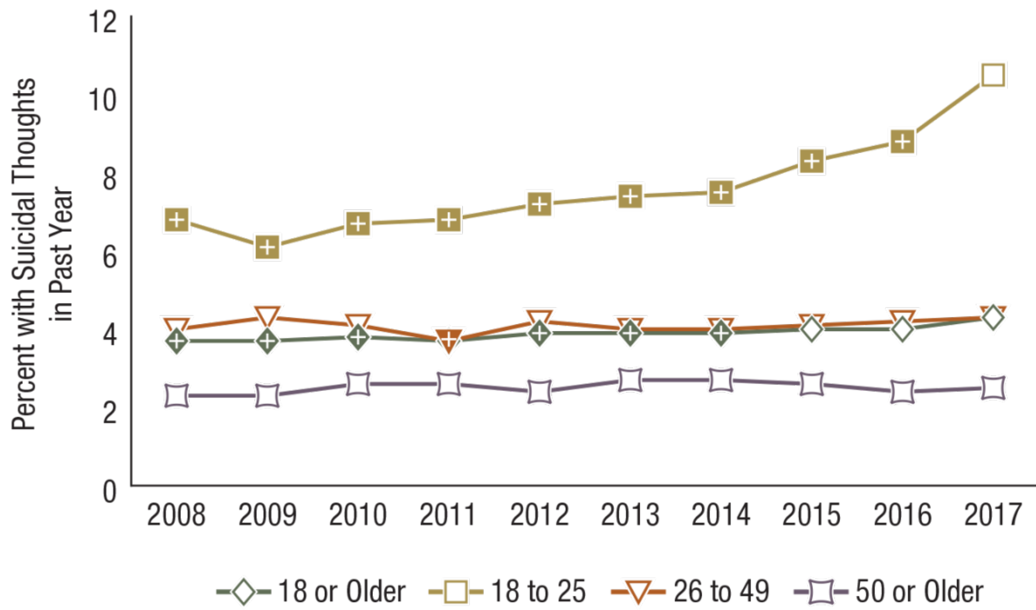
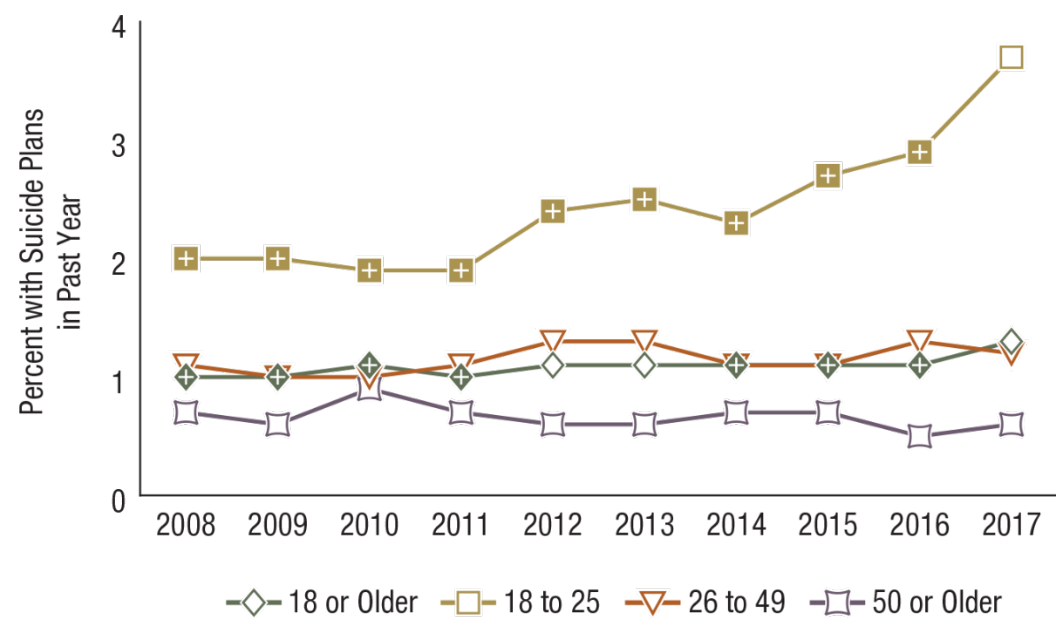
Suicidal Thoughts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	3.7+	3.7+	3.8+	3.7+	3.9+	3.9+	3.9+	4.0	4.0	4.3
18 to 25	6.8+	6.1+	6.7+	6.8+	7.2+	7.4+	7.5+	8.3+	8.8+	10.5
26 to 49	4.0	4.3	4.1	3.7+	4.2	4.0	4.0	4.1	4.2	4.3
50 or Older	2.3	2.3	2.6	2.6	2.4	2.7	2.7	2.6	2.4	2.5

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

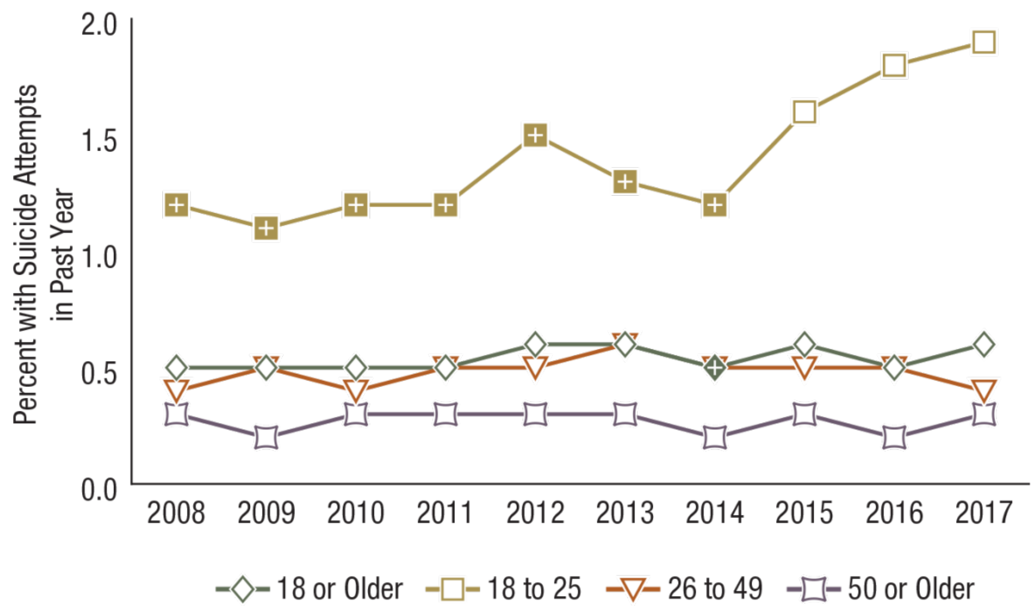
Suicide Plans in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017



Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	1.0+	1.0+	1.1+	1.0+	1.1	1.1	1.1+	1.1+	1.1+	1.3
18 to 25	2.0+	2.0+	1.9+	1.9+	2.4+	2.5+	2.3+	2.7+	2.9+	3.7
26 to 49	1.1	1.0	1.0	1.1	1.3	1.3	1.1	1.1	1.3	1.2
50 or Older	0.7	0.6	0.9	0.7	0.6	0.6	0.7	0.7	0.5	0.6

+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Suicide Attempts in the Past Year among Adults Aged 18 or Older, by Age Group: Percentages, 2008-2017

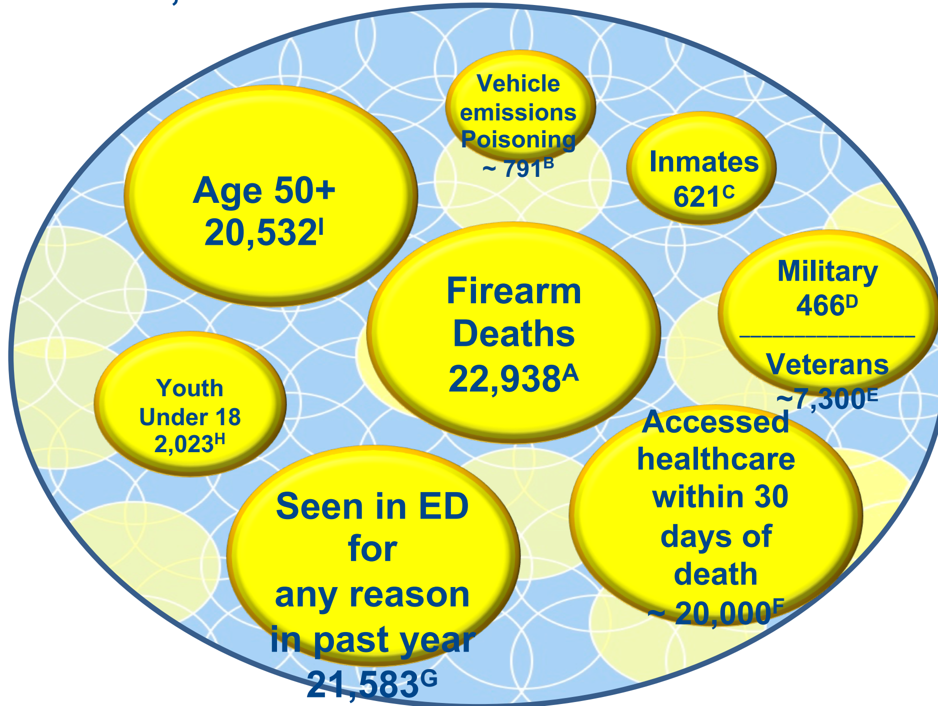


Age Group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
18 or Older	0.5	0.5	0.5	0.5	0.6	0.6	0.5+	0.6	0.5	0.6
18 to 25	1.2+	1.1+	1.2+	1.2+	1.5+	1.3+	1.2+	1.6	1.8	1.9
26 to 49	0.4	0.5	0.4	0.5	0.5	0.6	0.5	0.5	0.5	0.4
50 or Older	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.3

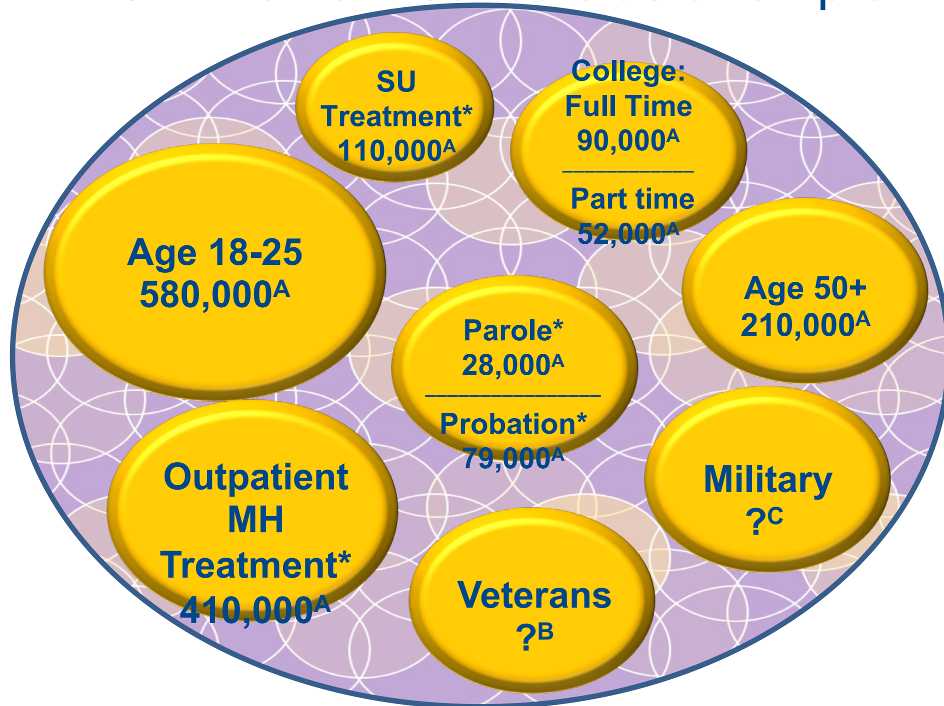
+ Difference between this estimate and the 2017 estimate is statistically significant at the .05 level.

Identifying Areas of High Need and/or Opportunity

44,965 annual suicide decedents



1.3 million annual suicide attempts



Data Sources:

A. CDC WISQARS 2016
B. CDC WONDER 2014
C. Bureau of Justice Statistics 2014
E. Department of Veterans Affairs 2016
F. Luoma et al, 2002; Ahmedani et al 2014
G. Ahmedani, 2018. Personal communication
H. CDC WISQARS 2016

Data Sources:

A. National Survey on Drug Use and Health
B. In progress
C. In progress

Substance Use and Suicide

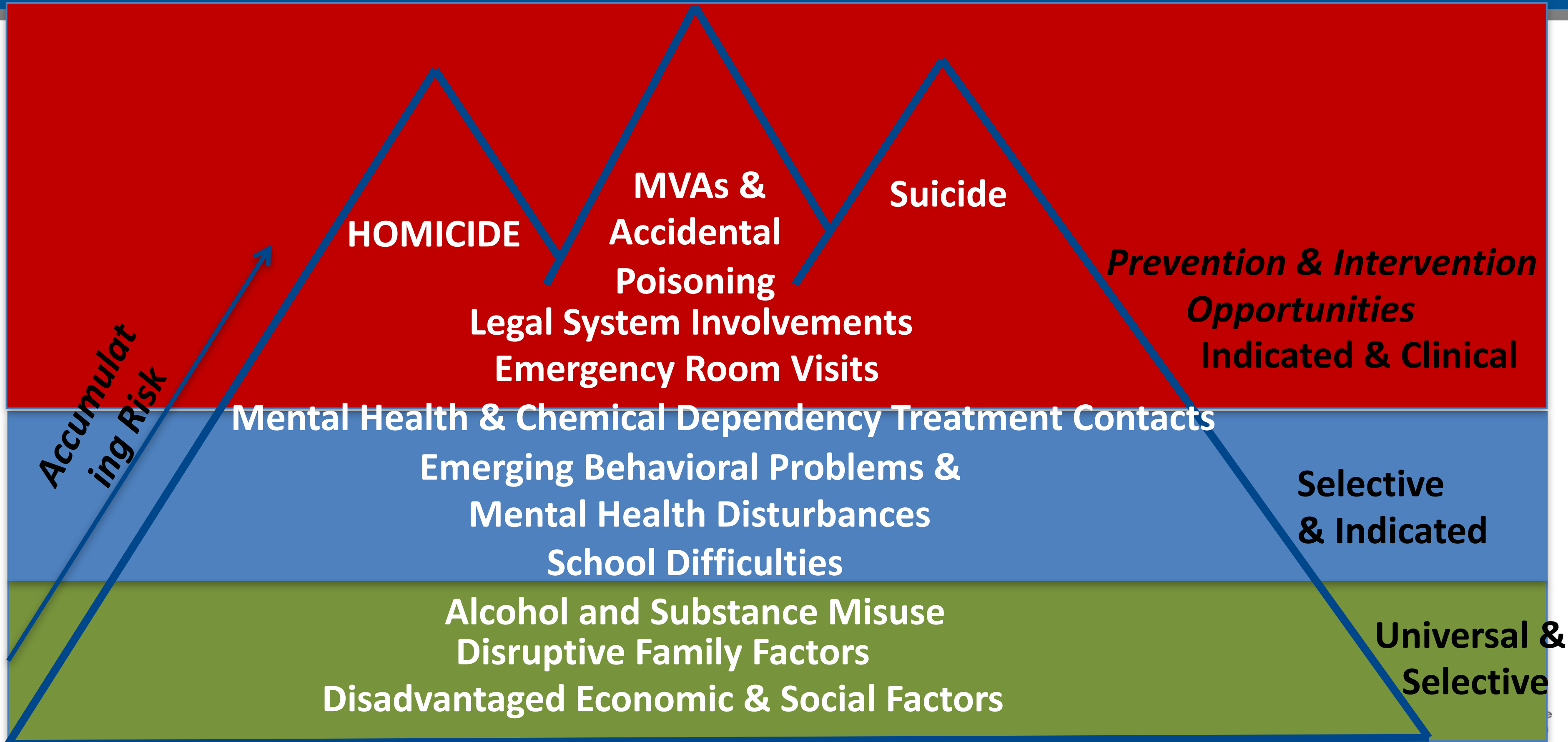
- Data from 17 states NVDRS
- 22% of suicides involve alcohol intoxication, (30-40% of suicide attempts)
- Opiates, including heroin and prescription painkillers present in 20% of U.S. suicide deaths.
- Marijuana-10%,cocaine-4%,amphetamines-3%

SUICIDE AND SUBSTANCE ABUSE

- Substance abuse is second only to mood disorders in its association with suicide
- Comorbidity increases the risk even further
- Suicide mortality can be impacted by changes in alcohol control policy
- Drinking age increase associated with decreased mortality-estimate 600 lives saved annually

NIH National Institute of Mental Health

Common Risk Factors for Premature Death

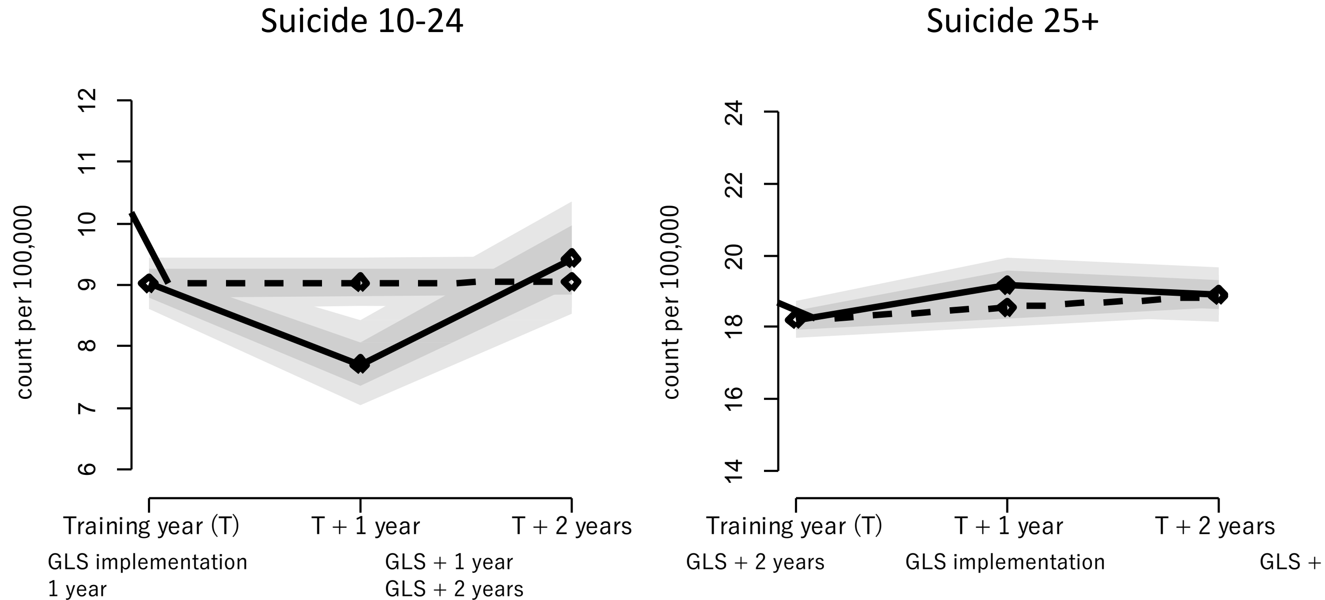


The Garrett Lee Smith (GLS) Suicide Prevention National Outcomes Evaluation is supported through contract no. HHSS283201200007I/HHSS28342002T (reference no. 283-12-0702) awarded to ICF International by the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

THE IMPACT OF GLS SUICIDE PREVENTION PROGRAM ON YOUTH SUICIDAL BEHAVIOR

Lucas Godoy Garraza (ICF International); Christine Walrath (ICF International); David Goldston (Duke CSSPI); Hailey Reid (ICF International), Richard McKeon (SAMHSA)

Results: Difference in Suicide Mortality



Solid lines represent the estimated outcome trajectory following GLS training implementation. Dashed lines represent the estimated outcome trajectory during the same period had GLS not been implemented. 90% and 50% confidence intervals around the trajectory are represented by dark gray and light gray, respectively.

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ZEROSuicide

Transforming systems for safer suicide care.

www.zerosuicideinstitute.com
www.zerosuicide.com

Suicide

ZEROSuicide

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www.zerosuicide.com

"When you design for zero, you surface different ideas and approaches that, if you're only designing for 90 percent, may not materialize. It's about purposefully aiming for a higher level of performance."

Thomas M. Priselac
Cedars-Sinai Medical Center

National Patient Safety Goal 15.01.01: Reduce the Risk for Suicide

The Joint Commission

Prepublication Requirements

• Issued November 26, 2018; updated February 20, 2019 •

Joint Commission Requirement

Revisions to the National Patient Safety Goal on Reducing the Risk for Suicide

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Please note: Where applicable, this report shows current standards and EPs first, with deleted language struck-through. Then, the revised requirement follows in bold text, with new language underlined.

APPLICABLE TO THE BEHAVIORAL HEALTH CARE ACCREDITATION PROGRAM

Effective July 1, 2019

NPSG.15.01.01

~~Identify individuals at~~ risk for suicide.

Reduce the risk for suicide.

Element(s) of Performance for NPSG.15.01.01

~~1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.~~ R D

**1. The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).
Note: Noninpatient behavioral health care settings and unlocked inpatient units do not need to be ligature-resistant. The expectation for these settings is that they conduct a risk assessment to identify potential environmental hazards to individuals served; identify individuals who are at high-risk for suicide; and take action to safeguard these individuals from the environmental risks (for example, removing objects from the room that can be used for self-harm and continuous monitoring in a safe location while awaiting transfer to higher level of care).** R D

~~2. Address the immediate safety needs and most appropriate setting for treatment of the individual served.~~ R

"The new and revised requirements address:

- » Environmental risk assessment and action to minimize suicide risk
- » Use of a validated screening tool to assess patients at risk
- » Evidence-based process for conducting suicide risk assessments of patients screened positive for suicidal ideation
- » Documentation of patients' risk and the plan to mitigate
- » Written policies and procedures addressing care of at-risk patients, and evidence they are followed
- » Policies and procedures for counseling and follow-up care for at-risk patients at discharge
- » Monitoring of implementation and effectiveness, with action taken as needed to improve compliance"

What's different about Zero Suicide?

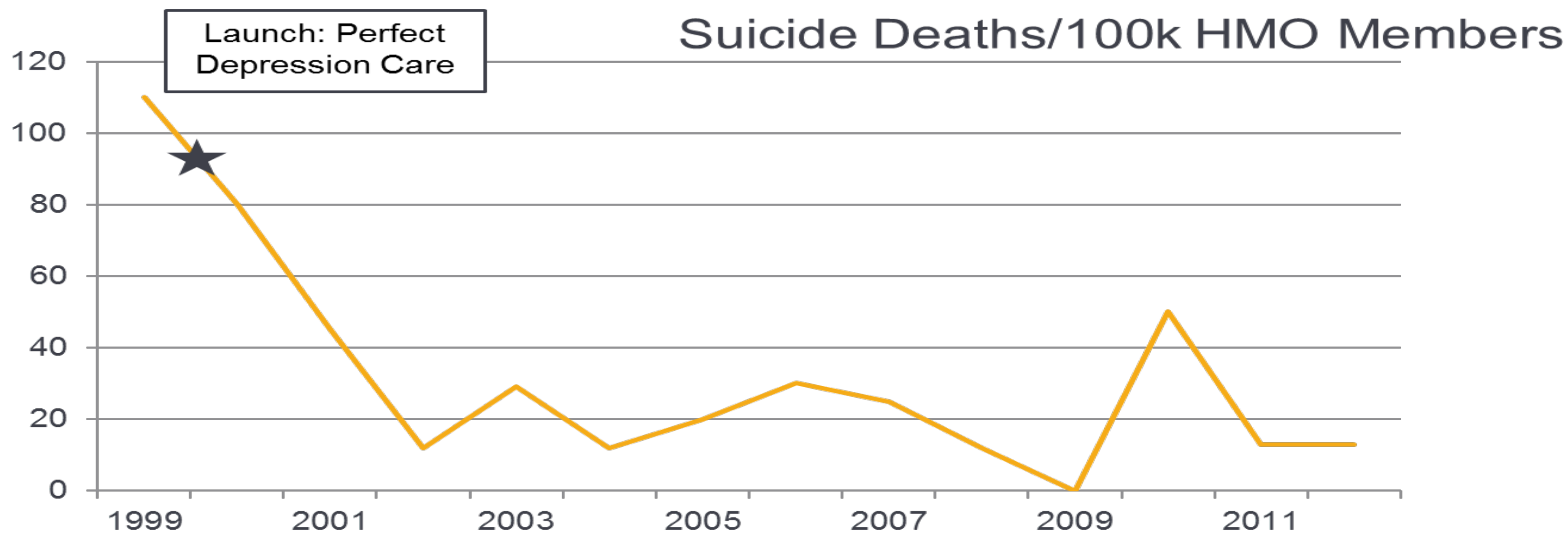
» Suicide prevention is accepted as a core responsibility of health care

» Patient deaths by suicides are not treated as inevitable

» Emphasizes data, best practices, and continuous quality improvement

» A systematic clinical approach in health systems, not "the heroic efforts of crisis staff and individual clinicians."

A System-Wide Approach Saved Lives: Henry Ford Health System



ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE
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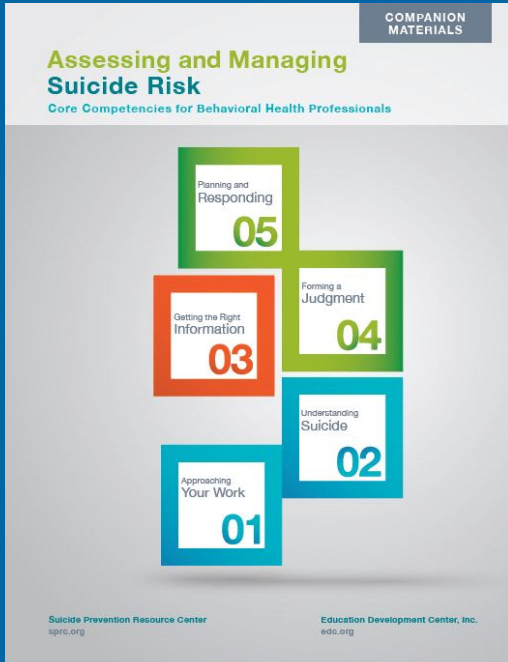
Assessing and Managing Suicide Risk



http://www.sprc.org/training-events/amsr

TIP 50

TIP 50: *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*

- High prevalence of suicidal thoughts and attempts among persons with SA problems who are in treatment.
- TIP 50 helps
  - SA counselors work with adult clients who may be suicidal
  - Clinical supervisors and administrators
- Free at: http://store.samhsa.gov/product/SMA09-4381
- Training video: SAMHSA YouTube channel

NIH National Institute of Mental Health

Suicide Assessment Five-step Evaluation Triage

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- SAFE-T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05-15-06.pdf

ACKNOWLEDGEMENTS

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National Suicide Prevention Lifeline
1.800.273.TALK (8255)

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www.sprc.org

www.mentalhealthscreening.org

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow-up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

Suicide Prevention App for Health Care Providers

Free for Apple® and Android™ mobile devices

<u>Suicide Safe Helps Providers</u>:

- Integrate suicide prevention strategies into practice and address suicide risk
- Learn how to use the SAFE-T approach
- Explore interactive sample case studies
- Quickly access and share information and resources
- Browse conversation starters
- Locate treatment options

Learn more at bit.ly/suicide_safe.

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Improving Post Discharge Safety

- The Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE) demonstrated reduction in suicidal behavior for suicidal people discharged from EDs doing telephonic follow up.
- White Mountain Apache/Johns Hopkins University Center for American Indian Health
  - Almost 40% reduction in suicides from 2006-2012
  - Centerpiece is tribally mandated reporting and follow up

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Improving Post Discharge Safety Cont.

- Safe-Vet- Safety planning in the Emergency Room for suicidal veterans combined with telephonic follow up led to
- 50% reduction in suicidal behavior compared to tau
- Twice as many veterans connecting to outpatient behavioral health care
- SAMHSA evaluation studies show that 90% of suicidal callers report that follow up phone calls helped them stay safe and not kill themselves

NATIONAL
SUICIDE
PREVENTION
LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Suicide and Opioids : Critical Issues

- Many opioid overdose deaths labeled as accidental may be suicides. Estimates differ.
- For some deaths may not be possible to determine intent.
- Non-fatal overdoses, whether intentional or not, may require similar responses i.e. medical care for the overdose, assessment for suicide risk and substance abuse, and rapid follow up.
- How should suicide screening be best integrated into substance abuse screening?
- How can suicide care be best integrated into substance abuse treatment ?
- How can we assist communities heavily impacted by both suicide and opioids?
- What is the impact of chronic and acute pain, opioids, and suicide?
- How can we alter the developmental trajectories that lead to both types of tragic outcomes?
- Are there common factors driving up these deaths of despair?

Thank you.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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