ADVANCING PREVENTION PROJECT

Prevention Agenda "Promote Mental Health and Prevent Substance Abuse" Priority Factsheet*

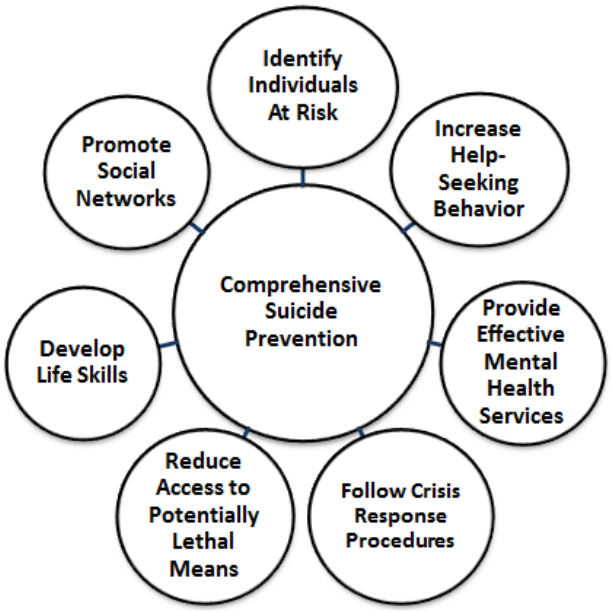
Goal 2:3 Prevent suicides among youth and adults

AIM: Use a comprehensive approach to prevent suicides among youth and adults

Many suicides are preventable. It was the 11th leading cause of death in 2013 in New York State.[1] While suicide is a risk for a very small number of people with mental illness, it is among the top five leading causes of death among children and adults aged 10-44, and the 7th leading cause of death among 45-64 year olds.[1] Public health approaches include "upstream interventions" that increase resilience and effective coping with improved detection of the at-risk population and clinical approaches that offer an effective system of care for those who need mental, emotional, and behavioral health services. There are many risk and protective factors for suicide. Therefore, suicide prevention needs a comprehensive approach that addresses risk and protective factors[2] (see Table 1) to achieve positive outcomes (see Sample Logic Model in Table 2).

A Comprehensive Approach to Suicide Prevention[3] Involves seven key strategies:

1. Identifying Individuals at Risk
2. Increasing Help-seeking Behavior
3. Provide Effective, "Suicide Safe" Mental Health Services
4. Follow Crisis Response Procedures
5. Reduce Access to Lethal Means
6. Develop Life Skills
7. Promote Social Networks



* Developed by the New York State Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services with the University of Rochester Medical Center Injury Control Research Center for Suicide Prevention, the Education Development Center and the New York Academy for Medicine.

ACTION	
Recommended Steps	**Brief Description**
1. Identify Individuals at Risk	• Share data on suicide, suicide attempt , and prevention efforts • Offer Gatekeeper training.[4] • Screen for suicide risk in primary care; or substance abuse programs. Include links/coordination with OMH Early Recognition and Screening (ERS) • Reach out to groups that have a higher risk for suicide or suicide attempts than the general population including: men in midlife and older men; young American Indians and Alaska Natives; people bereaved by suicide; people in justice and child welfare settings; people who intentionally hurt themselves (non-suicidal self-injury); people who have previously attempted suicide; people with medical conditions; people with mental and/or substance use disorders; People who are lesbian, gay, bisexual, or transgender; members of the military and veterans.[5]
2. Increase help-seeking behaviors	• Promote National Suicide Prevention Lifeline, 1-800-273-8255, through safe and effective public messages, systems navigation and enhancing accessibility. Accessibility entails following crisis procedures, developing life skills, promoting social networks and assisting with overcoming barriers, and linking with countywide prevention coalitions. • Use mobile applications, such as my3app, promoting services among specific populations and peer referrals. • Utilize tele-mental health, rural outreach initiatives.
3. Provide Effective, "Suicide Safe" Mental Health Services	• Develop a Memorandum of Understanding (MOU) among health and behavioral health providers to reduce suicide deaths toward the effort to make New York a model "Zero Suicide" State.[6] • Train all staff, clinical and non-clinical, to respond effectively to clients at risk for suicide within the context of their roles. • Screen and assess every patient for suicidal thoughts and behaviors. • Regularly engage at-risk individuals in the development of a suicide care management plan. • Explicitly target suicidal thoughts and behavior in treatment with evidence-based and best practices. • Follow patients safely through transitions in care. • Utilize data to continuously improve the care of those at risk.
4. Follow crisis response procedure	• Develop and practice crisis response protocols, mobile crisis response teams, develop postvention policies. Postvention activities following a suicide help alleviate the suffering and emotional distress of the survivors, and prevent additional trauma and contagion.[7] A number of communities have postvention and trauma response teams. Training and support for development is available through the Suicide Prevention Center of New York. • Train community leaders such as schools, employers, and media, on responding to suicides and suicide attempts.

5. Reduce Access to Lethal Means	• Implement and enforce policy/legislative initiatives such as amending insurance companies' enforcing the mandatory 90-day prescription policies. • Suicide-proof your home. • Implement projects like Gun Shop Project (e.g. New Hampshire Safety Coalition), and Prescription drug drop boxes in community. • Counsel on Access to Lethal Means (CALM) training for mental and behavioral health providers, Emergency Department personnel, and substance use disorder providers. See http://www.sprc.org/bpr/section-III/calm-counseling-access-lethal-means for more information.
6. Develop Life Skills	• Resume workshops, training for employment, financial literacy training. • Assist in securing housing, resolving marital and parenting conflicts. • Offer training in self-regulation skills, relaxation, stress-reduction, resiliency, recognizing triggers, and mobile apps that help with self-care. • Use State 211 service as a starting point for locating the resources.
7. Promote social networks	• Positive social norms campaigns to support a culture of connectivity. • Engaging schools in supporting children socially, and involving faith communities to promote belongingness. • Creating connectedness for at-risk individuals through support groups and social events for individuals (and their families).

Example: Preventing Suicide for Senior Living Communities[3,8]

A comprehensive program in a senior living facility might include the following components:

1. Training for staff on recognizing depression, substance abuse, and other risk factors.
2. Education campaign for residents and their families about when and how to seek help for emotional issues.
3. Identification of appropriate mental health services to which residents can be referred.
4. Developing and disseminating crisis response protocols.
5. Proper storage of medication.
6. Health and wellness, arts, mentoring, and spiritual activities for residents.
7. Friendship tables and other activities promoting social interaction among residents.

For more information, read *Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities*[8]

Overarching Objective 2.3[9]

Objective 2.3.1: By December 31, 2017, reduce suicide attempts by New York adolescents (youth grades 9 to 12) who attempted suicide one or more times in the past year by 10% to no more than 6.4%. (Baseline: 7.1 suicide attempts per 100, 2011 YRBS) – Tracking Indicator

Objective 2.3.2: By December 31, 2017, reduce the age-adjusted suicide mortality rate by 10% to 5.9 per 100,000. (Baseline: 6.6 per 100,000, Bureau of Biometrics 2007-2009) - Tracking Indicator

Short-Term Performance Measures[10,11]

Consider tracking 3-5 process measures, and at least one intermediate outcome measure.

Examples of Intermediate Outcome Measures

- Percent of people screening for suicide risk or mental health and substance abuse problems.
- Extent to which individuals feel comfortable identifying and referring individuals at risk.
- Extent to which individual seeks out or makes use of treatment and resources.
- Extent of supportive relationships.
- Number and/or percent of community members who restrict practice restricting means:
    - guns stored at gun club;
- Number and/or percent of organizations that partner on policies to restrict means. For example:
    - Attempts with motor vehicle exhaust less likely to prove fatal
    - Documentation or stories that illustrate that the changes prevent attempts
    - Number of policies (organizational or legislative) developed, implemented or enforced such as training incorporated for non-health care personnel such as defense attorneys, creditors

Examples of Process Measures

Identifying Individuals at Risk:

- Number and/or percent of agencies with which you have data sharing agreements for individuals who have attempted suicide, died by suicide, or expressed suicidal ideation.
- Number and/or percent of specified individuals (school employees, community members, students, etc.) trained as gatekeepers using specified program (ASIST, QPR, etc.).
- Number and/or percent of specified professionals (primary care, substance use disorder treatment, social workers, school counselors trained in specific screening for suicide risk.

Increasing Help-seeking behavior:

- Number and/or percent reached through public messages that promote help-seeking behavior.
- Number and/or percent of calls/visits to the lifeline or other crisis service program.
- Number and/or percent of downloads of crisis service programs or information.

Provide Effective Mental Health Services:

- Percent of screenings that result in a referral.
- Percent of referrals that result in an appointment.
- Number and/or percent of specific providers trained to effectively treat a suicidal patient.
- Hospitals install collapsible shower rails and reduce other points of ligature in psychiatric wards.
- Number of communities that introduce legislation to impact means restriction.

Follow Crisis Response Procedures:

- Number and/or percent of types of agencies that have a crisis response protocol.

- Number and/or percent of specified groups of individuals trained in crisis response protocols.
- Number and/or percent of deployments of crisis response teams.

Examples of Long-Term Performance Measures (Data source)

- Percent suicide ideation (survey).
- Percent attempted suicides (surveys).
- Percent hospitalized for attempted suicide (survey, YRBS).
- Rate of suicides by specific lethal means (vital records).

Contacts

Suicide Prevention Center[12] in your region for more information.

New York State Regional Trauma Centers[13] for listing for regional trauma centers

Table 1: Risk and Protective Factors for Suicide Prevention

Risk Factors:

Biopsychosocial Risk Factors

- Mental disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Some major physical illnesses
- Previous suicide attempt
- Family history of suicide

Environmental Risk Factors

- Job or financial loss
- Relational or social loss
- Easy access to lethal means
- Local clusters of suicide may have a contagious influence

Social Cultural Risk Factors

- Lack of social support and sense of isolation
- Stigma associated with help-seeking behavior
- Barriers to accessing MEB health services
- Certain cultural and religious beliefs

Protective Factors:

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self- preservation

Table 2: Example of Theory of Change Logic Model for Suicide Prevention

Each community may need to adapt this model for their communities

Inputs	Interventions	Outputs	Outcomes	Impact
Identifying clear shared purpose and goals with community partners Evidence-based and best practices, programs, policies and curriculums researched Data, metrics and tools to measures suicide, attempted suicides and contributing factors Technical support on suicide prevention interventions to organizations Assessments of current efforts and resources to support suicide prevention Supporting key stakeholders on a comprehensive approach to suicide prevention	• Offer training to gatekeepers to identify individuals at risk • Reduce barriers to mental emotion behavioral (MEB) health services • Increase quality of mental health services • Increase integration with other services • Identify, develop, implement and/or enforce polices that reduce access to lethal means • Set up and utilized mechanisms to collect data and information on progress toward achieving objectives • Implement policies that strengthen social networks • Offer training to strengthen life skills • Work with media to decrease stigma for seeking help	• # or % of individuals at risk referred for help • # or % of individuals seek help • # or % of providers who complete evidence-based training for effective mental health services that includes • # or % of personnel who follow crisis response procedures • # of policies introduced that access to lethal means • # or % on individuals who completed life skills training • # or % of individuals who indicated they have increased social networks	**<u>Public Policies</u>** • Reduced access to lethal means • Increased access to effective mental health services **<u>Supportive environments</u>** • Strengthened social networks • Increased referrals and access to services for those seeking help **<u>Community Level</u>** • Strengthened life skills of community members (university and targeted) • Decreased stigma for seeking help	1. Increase access to health services (MEB and physical health) 2. Decreased suicide attempts 3. Reduced suicide rates 4. Integration of MEB health with other services such as physical health, education, social services 5. Increased quality of MEB health services

Assumptions that outputs will achieve outcomes:

- Stakeholders and communities generally agree that suicide is preventable.
- Organizational partners and communities believe that everyone, not only medical personnel or experts, have an important role in prevention suicides.

[1] New York State Department of Health. Vital Statistics of New York. http://www.health.ny.gov/statistics/vital_statistics/

[2] Suicide Prevention Resource Center. Risk and Protective Factors for Suicide. http://www.sprc.org/sites/sprc.org/files/library/srisk.pdf

[3] Suicide Prevention Resource Center. Suicide Prevention Basics. http://www.sprc.org/basics/about-suicide-prevention/comprehensive

[4] SPRC. Comparison Table of Suicide Prevention Gatekeeper Training Programs. http://www.sprc.org/sites/sprc.org/files/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf

[5] Centers for Disease Control and Prevention. Suicide Facts at a Glance. http://www.cdc.gov/ViolencePrevention/pdf/Suicide_DataSheet-a.pdf

[6] Suicide Prevention Resource Center. Zero suicide in health and behavioral healthcare. http://zerosuicide.sprc.org/

[7] SPRC. Glossary of Suicide Terms. http://www.sprc.org/basics/glossary

[8] Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities. http://store.samhsa.gov/product/Promoting-Emotional-Health-and-Preventing-Suicide/SMA10-4515

[9] New York State Department of Health. Promote Mental Health and Prevent Substance Abuse. Goals and Objectives. http://www.health.ny.gov/prevention/prevention_agenda/2013-2017/plan/mhsa/goals_objectives.htm#1rationale

[10] Adapted from Rand Suicide Prevention Evaluation Toolkit. http://www.rand.org/pubs/tools/TL111.html

[11] Barber CW, Mathew MJ, Reducing a Suicidal Person's Access to Lethal Means of Suicide. A Research Agenda. American Journal of Preventive Medicine 2014;47(3S2):S264–S272. http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Reducing%20a%20Suicidal%20Persons%20Access%20to%20Lethal.pdf

[12] Suicide Prevention Center of New York State http://www.preventsuicideny.org/

[13] New York State Department of Health, New York State Trauma Centers. http://www.health.ny.gov/professionals/ems/trauma2.htm

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PREVENTION AGENDA
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