REDUCING SUICIDES AND NONFATAL ATTEMPTS BY 20% IN 5 YEARS: A DISCUSSION ABOUT THE NATIONAL SUICIDE PREVENTION RESEARCH AGENDA ASPIRATIONAL GOALS

PHILLIP SATOW, MA CO-LEAD, NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION'S RESEARCH PRIORITIZATION TASK FORCE
CINDY CLAASSEN , PhD ASSOC PROF, UNIVERSITY OF NORTH TEXAS HSC
SHERRY MOLOCK, PhD NIMH SENIOR ADVISOR OF OUTREACH & ENGAGEMENT RESEARCH
JANE PEARSON, PhD CHAIR, NIMH SUICIDE RESEARCH CONSORTIUM
CHELSEA BOOTH, PhD 2011 PRESIDENTIAL MANAGEMENT FELLOW

for the

RESEARCH PRIORITIZATION TASK FORCE

Educational Objectives:

At the end of this workshop, audience members will be able to:

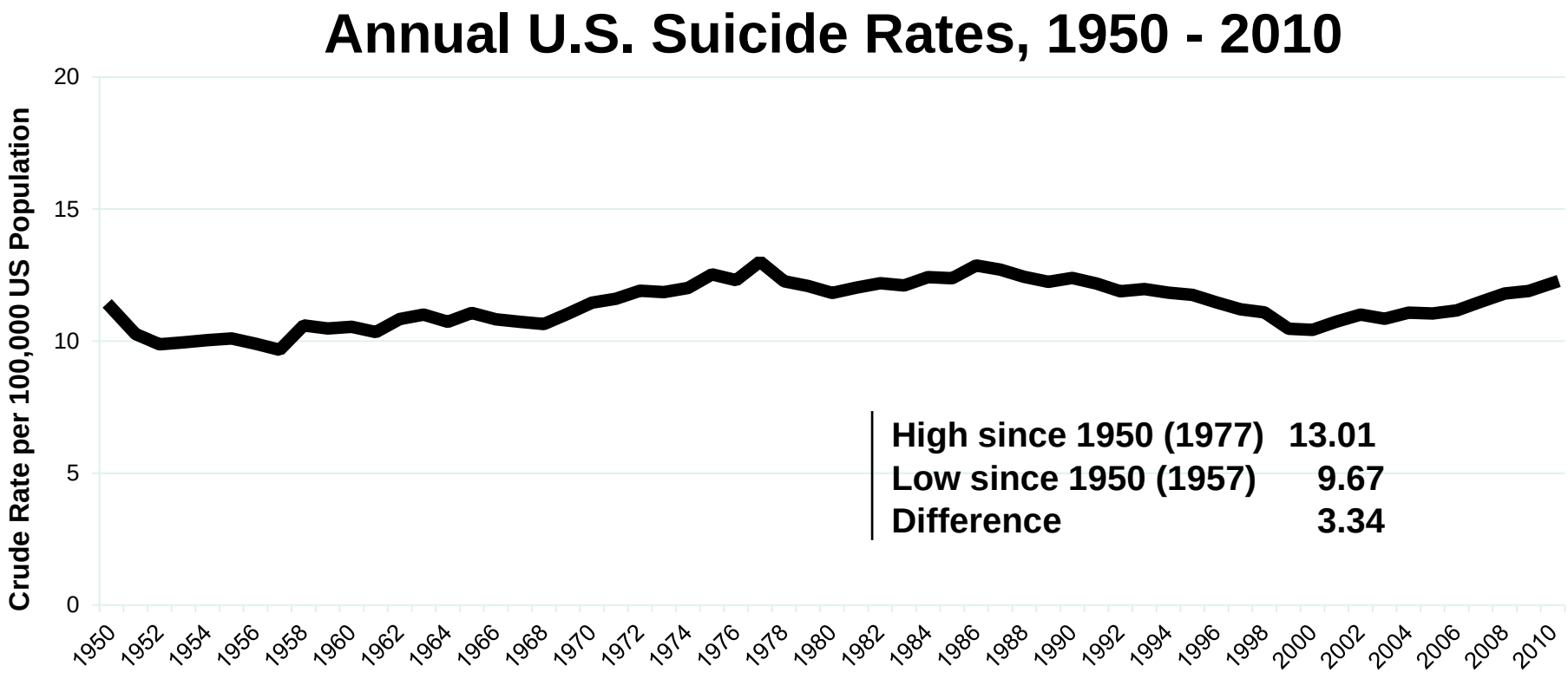
1. **Describe the overall goal of the National Action Alliance for Suicide Prevention's Research Prioritization Task Force (RTF).**
2. **Identify three aspirational goals being considered for inclusion in the research agenda and explain the process by which these aspirational goals were selected.**
3. **Explain how meeting each of these goals could contribute substantially to reducing suicidal acts in the U.S.**

Presentation One:

OVERVIEW OF THE RESEARCH AGENDA DEVELOPMENT PROCESS & DISCUSSION OF THE RESEARCH PRIORITIZATION TASK FORCE GOAL

PHILLIP M. SATOW, CO-LEAD, RESEARCH PRIORITIZATION TASK FORCE

“A More Difficult Public Health Problem”



Relatively Intractable Suicide Rates

Sources: *(1950-1980) US Census Bureau, Statistical Abstracts of the United States, US Census Bureau: Washington, D.C.; (1981-2007) CDC. Web-based Injury Statistics Query and Reporting System (WISQARS) [Online].*

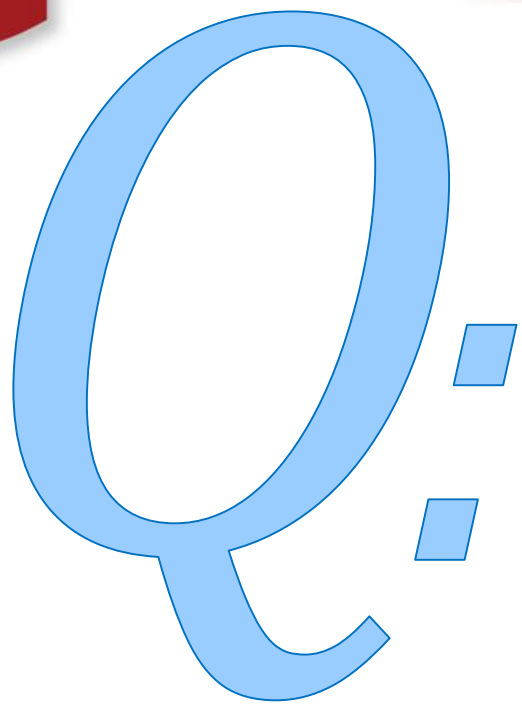
A US SUICIDE PREVENTION RESEARCH AGENDA

National Strategy for Suicide Prevention
A collaborative effort of SAMHSA, CDC, NIH & HSRA

GOAL 10. PROMOTE AND SUPPORT RESEARCH ON SUICIDE AND SUICIDE PREVENTION

Objective 10.1: By 2002, develop a national suicide research agenda with input from survivors, practitioners, researchers, and advocates.

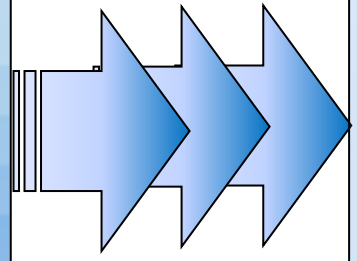
DHHS. 2001. "National Strategy for Suicide Prevention." Retrieved Dec 1, 2006, from http://mentalhealth.samhsa.gov/suicideprevention/strategy.asp.



Given $10,000,000, $50,000,000 or even $100,000,000 for incremental suicide research, how should it be used?

A New Research Paradigm Focused on Allowing Better Prioritization and Use of Resources

Create a paradigm focused on prioritization of research efforts.



Use the prioritization scheme to inform allocation of scarce resources.

A New Paradigm for Suicide Prevention Research

FACT: **Approximately $40,000,000 is expended for suicide prevention research each year in the USA.**

Priorities for the future?

Source: National Institutes of Health *Research Portfolio Online Reporting Tools (RePORT),* Suicide Categorical Funding, FY08= $39 million; FY12= $49 million http://report.nih.gov/categorical_spending.aspx

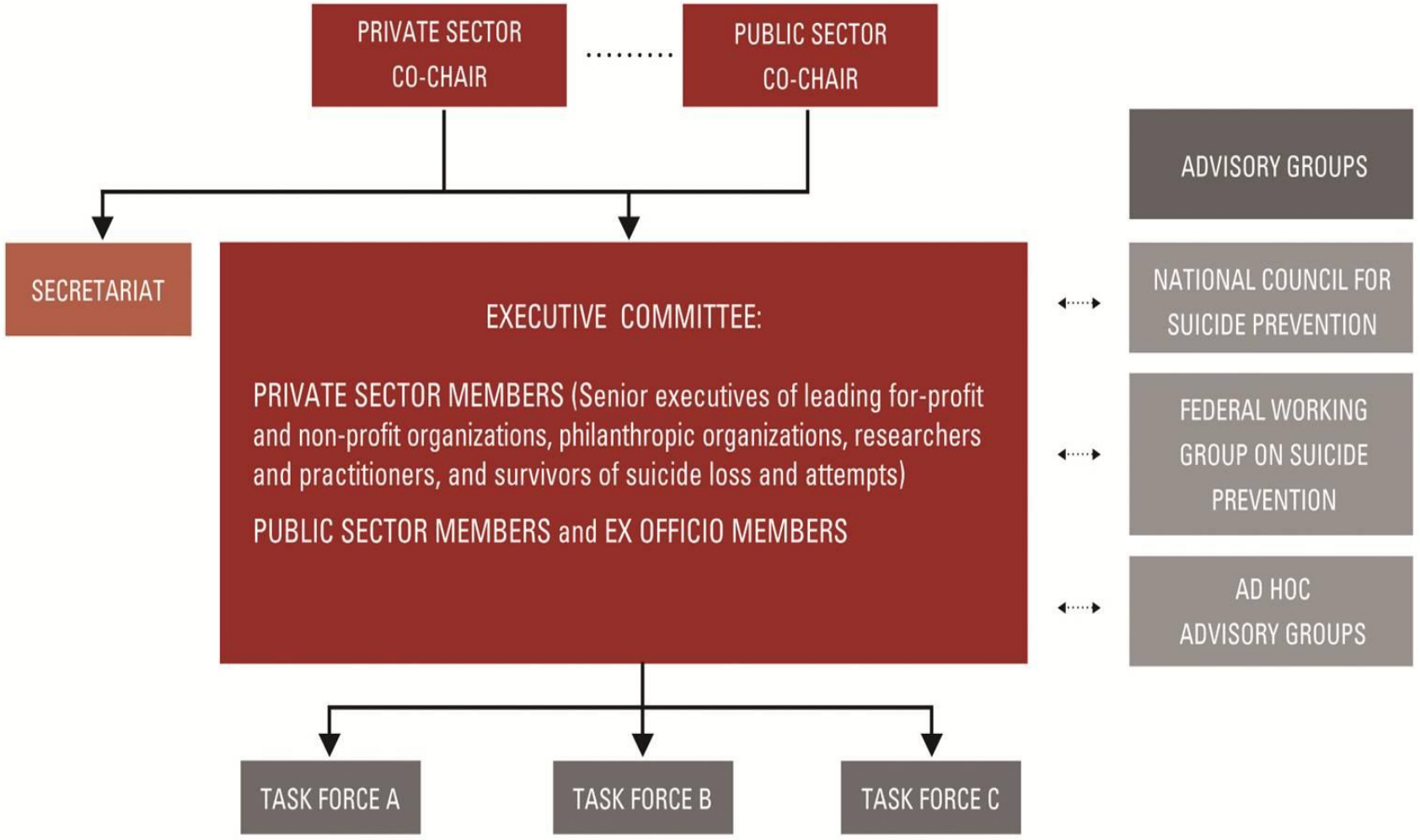
How Do We Make Progress in Suicide Research?

Overall U.S. rates of suicide deaths have not decreased appreciably in 50 years. Each year, over 678,000 individuals report that they received medical attention for a suicide attempt; each year, more than 30,000 individuals die by suicide.

RTF Goal: To develop an agenda for research that has the potential to reduce morbidity (attempts) and mortality (deaths) each, by at least 20% in 5 years, and 40% or greater in 10 years, if fully implemented.

http://actionallianceforsuicideprevention.org/wp-content/themes/twentyten/images/pdfs/taskforces/RP_12goals.pdf

Action Alliance for Suicide Prevention



http://actionallianceforsuicideprevention.org/?page_id=359

Research Prioritization Task Force Members

PHILLIP SATOW, MA—CO-LEAD PRIVATE SECTOR; EXCOM REPRESENTATIVE FROM NATIONAL COUNCIL ON SUICIDE PREVENTION; CO-FOUNDER AND BOARD PRESIDENT, JED FOUNDATION

THOMAS INSEL, MD—CO-LEAD PUBLIC SECTOR; DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH

ALAN (LANNY) BERMAN, Executive Director, American Association of Suicidology (AAS); President, International Association for Suicide Prevention (IASP)

MARY DURHAM, Vice-President, The Center for Health Research, Kaiser Permanente

SAUL FELDMAN, Chairman Emeritus, United Behavioral Health

THOMAS FRIEDEN, Director, U.S. Centers for Disease Control and Prevention (CDC)

ROBERT GEBBIA, Executive Director, American Foundation for Suicide Prevention (AFSP)

MICHAEL HOGAN, Commissioner, New York State Office of Mental Health

DAVID GROSSMAN, Medical Director, Preventive Care, Group Health Research Institute

DANIEL J. REIDENBERG, Executive Director, Suicide Awareness Voices of Education (SAVE); Managing Director, National Council for Suicide Prevention

Over 20 NIMH, NIDA, CDC, VA, and DOJ, staff and contractors help support the Research Task Force, and serve as liaisons with other task forces

CORE VALUES & OPERATING PRINCIPLES:

CORE VALUES: Through this research agenda development process, the Task Force seeks to produce a final agenda in which the **very best science is represented as the highest priority**. The Task Force seeks to do this by using procedures that promote inclusiveness, innovation and accountability.

THE GENERAL PRINCIPLES guiding the process are:

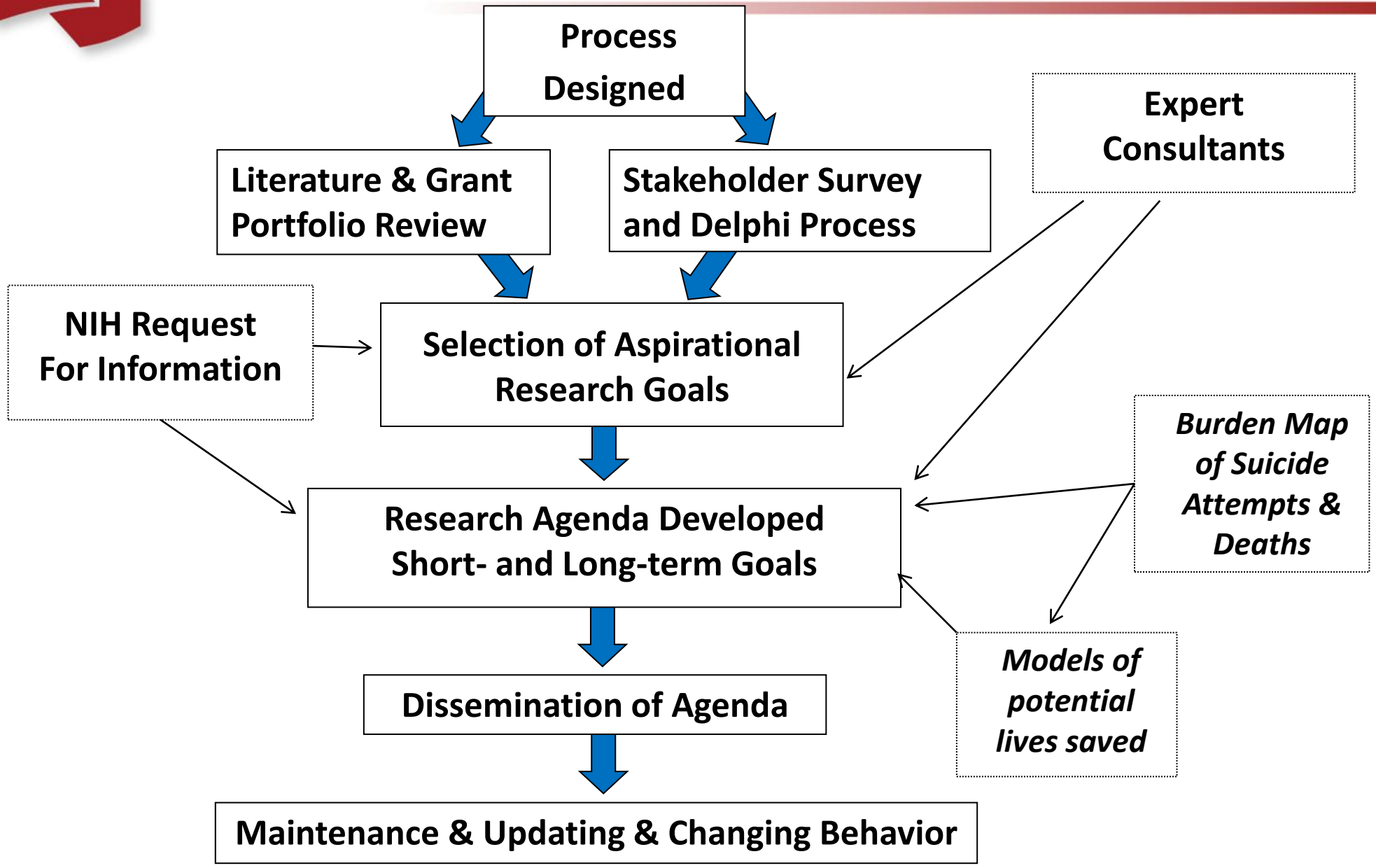
- **Timeliness:** We will take relatively prompt steps to meet established timelines.
- **Accuracy:** We will proceed in a way that minimizes the possibility of bias, inconsistencies or errors once the process has been completed.
- **Balanced Input:** We will design an input system with optimal variation in the choice of stakeholder groups surveyed.

CORE VALUES & OPERATING PRINCIPLES (CONTINUED):

- **Adequate Sampling:** We will provide for an adequate sampling approach for stakeholder groups.
- **Critical Review:** We will give due consideration to what suicide research already has been completed and identify the important gaps that currently exist.
- **Structured Decision-Making:** We will develop plans for prioritization of research topics.
- **Transparency and Public Access:** We will build transparency into the process by ensuring public access to agendas and minutes and a way for unsolicited input to be received and considered.
- **Adequate Dissemination**: We will implement a plan for dissemination of information on the agenda development process and on the final agenda.
- **Behavioral Change:** We will encourage both funding agencies and suicide prevention scientists to consider and respond to key ideas in the final agenda and to adjust their priorities accordingly.
- **Long-term Maintenance:** We will create protocols to ensure that the agenda becomes a "living document."

http://actionallianceforsuicideprevention.org/task-force/research-prioritization

Research Prioritization Task Force Agenda Development Process



http://actionallianceforsuicideprevention.org/task-force/research-prioritization

Key Concepts in Research to Reduce Suicide Burden

1. **Develop a list of high-priority goals which – if met – will substantially reduce suicide burden**

2. **Define and articulate viable research pathways through which these goals can be realized**
   - **Identify and sequence the studies required to reach each goal**
   - **Address the most critical methodological barriers to achieving these goals**

3. **Disseminate the final agenda and cultivate the funding streams necessary to support this research**

PROJECTED TIMELINE FOR AGENDA DEVELOPMENT

Feb 2012	**Stakeholder analyses and brief summary completed**
	Aspirational goals prioritized
	RFI [Request for Information] issued
Mar 2012	**Portfolio analyses web platform built; portfolio data collected**
	Qualitative analyses of stakeholder survey
	Literature review begins
April 2012	**Burden maps / populations and surveillance resources refined**
May 2012	**Experts invited to consultation/writing tasks**
	RFI input reviewed and summarized
June 2012	**Portfolio analyses completed; targeted literature review completed**
July 2012	**Drafts of logic models and format of agenda developed;**
	materials assembled for experts
Sept 2012	**Experts initial in person meeting**
	Experts multiple webinars to review logic models, evidence, identify gaps, draft short and long-term research objectives
Dec 2012	**Experts final meeting to review draft agenda**
Feb 2013	**Final Research Prioritization Report completed**

STAKEHOLDER SURVEY

Stakeholder Survey process

1. Idea Generating Round
2. Initial Ranking & Rating Round
3. Discussion Round
4. Final Ranking & Rating Round

TIER	GOALS
1	AG9 - Prevent Re-attempts
1	AG10 - Continuity of Care
1	AG3 - Provider Training
1	AG4 - Affordable Care
2	AG7 - Ideator Treatment
2	AG11 - Risk & Protective Factors
2	AG12 - Reduce Stigma
2	AG1 - Community-Level Interventions
2	AG6 - Predict Imminent Risk
>2	AG8 - Improved Biological Treatments
>2	AG2 - Access to Lethal Means
>2	AG5 - Assess Lifetime Risk

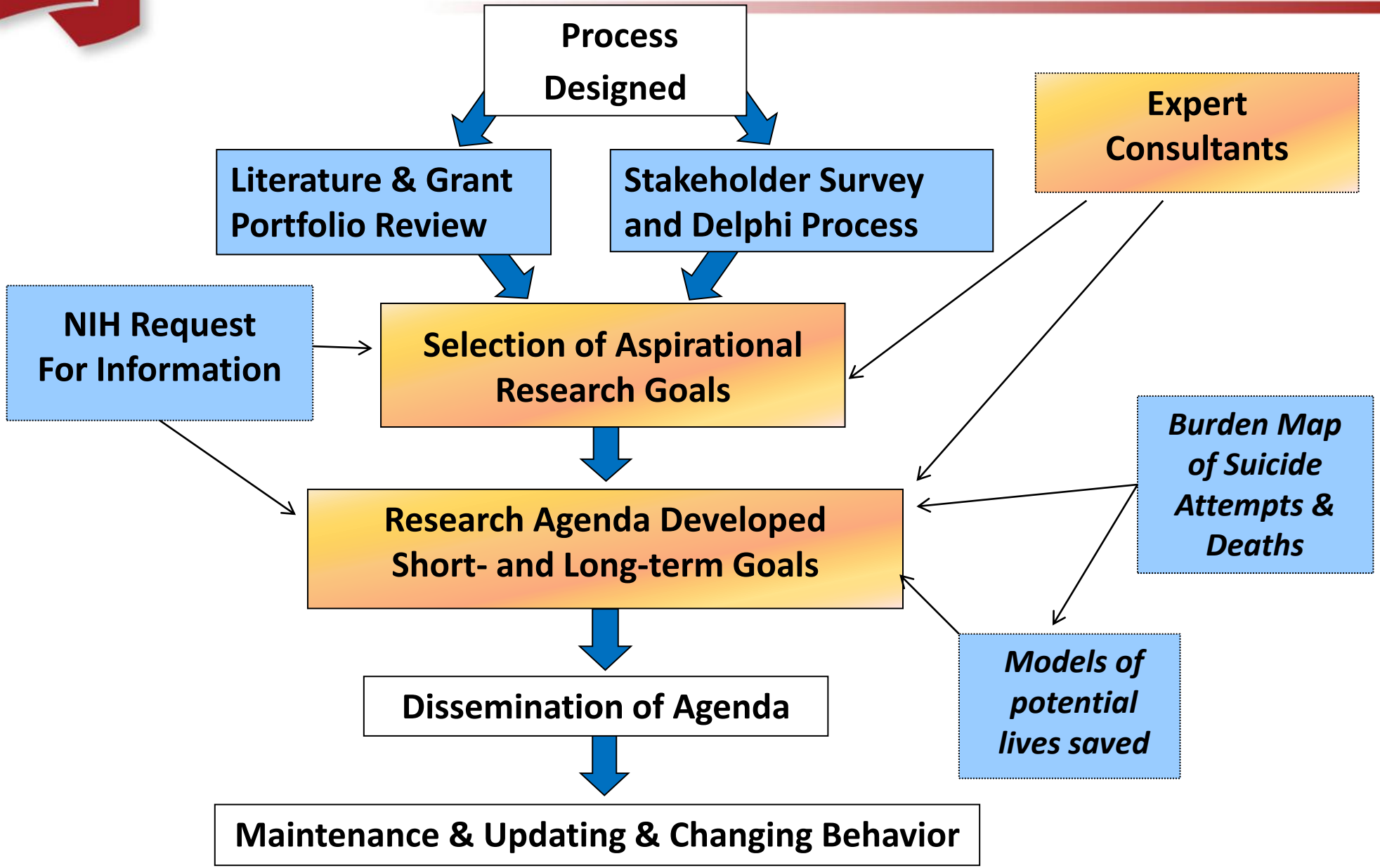
http://actionallianceforsuicideprevention.org/task-force/research-prioritization

Presentation Two:

NEXT STEPS & ASPIRATIONAL GOAL ILLUSTRATION: POPULATION-BASED RISK-REDUCTION / RESILIENCE-BUILDING

JANE PEARSON, PhD, NATIONAL INSTITUTE OF MENTAL HEALTH
CHELSEA BOOTH, PhD, 2011 PRESIDENTIAL MANAGEMENT FELLOW

Research Prioritization Task Force
Agenda Development Process



http://actionallianceforsuicideprevention.org/task-force/research-prioritization

NEXT STEPS

Step One: Selection of Goal Statements

1. *Systematically **identify empirically-validated interventions and prevention initiatives** (e.g., universal, selected and indicated) for various subpopulations.*
2. ***Develop a grant portfolio data extraction tool** that classifies and systematically organizes information about the research targets being addressed by currently-funded suicide prevention scientists.*
3. ***Prioritize research goals that are practical and widely recognized by diverse groups of stakeholders** as important to burden reduction.*
4. ***Identify and solve the most important "methodological roadblocks"** hindering intervention and prevention research and **support the most promising new conceptual models** in suicide prevention science.*

Step Two: Identifying and Sequencing Research Pathways

1. ***Quantify burden** within boundaried populations for each research goal.*
2. ***Characterize the state of intervention development** for each goal with logic models.*
3. ***Quantify the potential burden reduction associated with specific classes of interventions** by relative accessibility of boundaried population group.*

STAKEHOLDER SURVEY

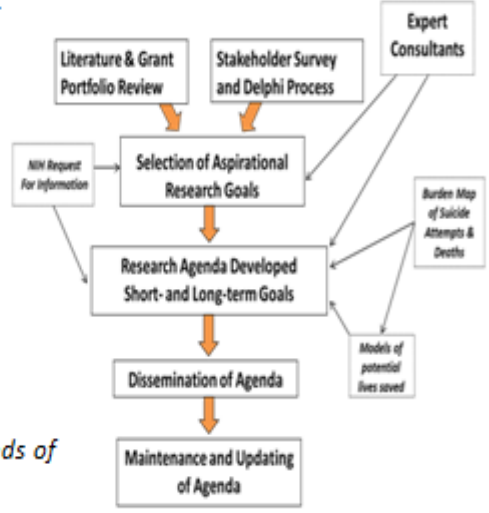
BRIEF SUMMARY OF FINDINGS

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION RESEARCH PRIORITIZATION TASK FORCE

STAKEHOLDER SURVEY RESULTS[1]

BACKGROUND: *The goal of the National Action Alliance Research Task Force (RTF) is to develop a research agenda that reduces suicidal attempts and suicides by 20 percent each within five years, and by 40 percent or greater within 10 years if the research agenda is fully implemented.*

FIG. 1: RTF AGENDA DEVELOPMENT PROCESS

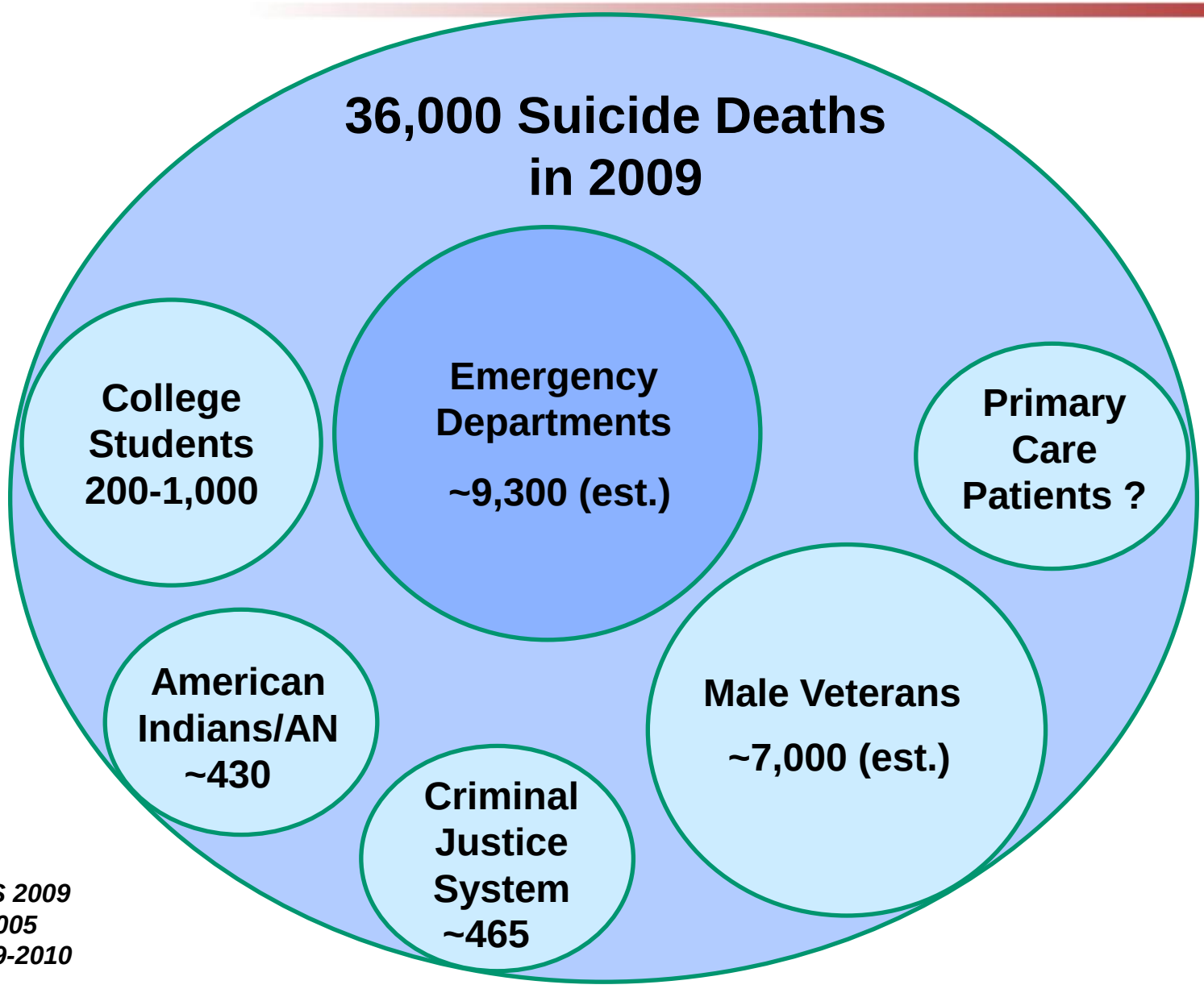


Three types of information-gathering processes *will be used to provide input into the RTF suicide prevention research agenda:*

- ***Ongoing Studies Grant Portfolio Review.*** *A review of the scientific studies currently underway will be used to develop a working knowledge of the research targets being addressed by suicide prevention scientists*
- ***Critical review of the scientific literature****: Literature reviews will be used to identify empirically-validated interventions and prevention strategies for various subpopulations.*
- ***Constituent Input****: Feedback from suicide attempters, relatives and close friends of individuals who have died by suicide, healthcare providers, policy-makers/administrators and suicide prevention researchers in the form of a* ***"Stakeholder Survey"*** *will be used to identify the biggest scientific challenges in doing suicide research. The final results from the* ***Stakeholder Survey*** *will be used to understand the perspectives of many different stakeholder groups about the most important goals for suicide research. In addition, input through a* ***Request for Information***

http://grants.nih.gov/grants/guide/notice-files/NOT-MH-12-017.html

BURDEN MAP



Data Sources:

- *CDC WISQARS 2009*
- *CDC NVDRS 2005*
- *U.S. Army 2009-2010*
- *Schwartz 2011*
- *Bureau of Justice Statistics 2008-2009*

LITERATURE & GRANT PORTFOLIO REVIEW PROCESSES

Literature Reviews: The quality of systematic reviews will be evaluated using Cochrane protocols, and newer studies will be evaluated for the following factors:

a) evidence level/study design strength (e.g., randomized controlled trial, case study, observational),
b) type of prevention approach,
c) measurement of outcome (odds ratio, incidence) and effect size,
d) duration of follow up,
e) characteristics of research subjects (demographic, geographic), and
f) type of suicidal behavior studied (ideation, attempts, deaths).

Grant Portfolios: Online tool that uses a common language and a common classification system to classify and systematically organize information about the research portfolios of over twenty-five organizations that fund suicide prevention research in the United States to identify funding priorities over time.

NIH REQUEST FOR INFORMATION

Request for Information (RFI): A Call to Identify Key Methodological Roadblocks and Propose New Paradigms in Suicide Prevention Research

Notice Number: NOT-MH-12-017

Key Dates

Release Date: February 17, 2012
Response Date: April 27, 2012

Issued by

National Institute of Mental Health (NIMH)
National Institute on Drug Abuse (NIDA)
National Institute of Alcohol Abuse and Alcoholism (NIAAA)

Purpose

The National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), and National Institute on Alcohol Abuse and Alcoholism (NIAAA) are seeking input to identify the types of research tools needed to support rapid advancement in suicide prevention research. Specifically, this request asks interested parties to provide input on the following topics: a) the key methodological roadblocks that currently exist in suicide prevention research, and b) new paradigms and theoretical models with the potential to spark innovative research. A methodological roadblock is defined as a critical, unresolved challenge that is clearly limiting progress along an important suicide prevention research pathway. New research paradigms and theoretical models are novel ways of thinking about suicidal behavior and avenues for its prevention.

This Request for Information (RFI) is issued as an invitation to interested parties to contribute these specific methodological challenges and new conceptual paradigms for inclusion in a compendium of ways to facilitate suicide prevention research progress.

http://grants.nih.gov/grants/guide/notice-files/NOT-MH-12-017.html

FINAL AGENDA PROTOTYPE

Overview Question: EX: What interventions prevent individuals from suicidal behavior?

- Specific Question #1
- Specific Question #1

What Do We Know?

- (2 – 3 paragraph summary, written in non-technical language)

What Do We Need?

- (2 – 3 paragraph summary, written in non-technical language)

Aspirational Goal:

Research Opportunities:

- Bulleted, specific research targets

Short-Term Objectives:

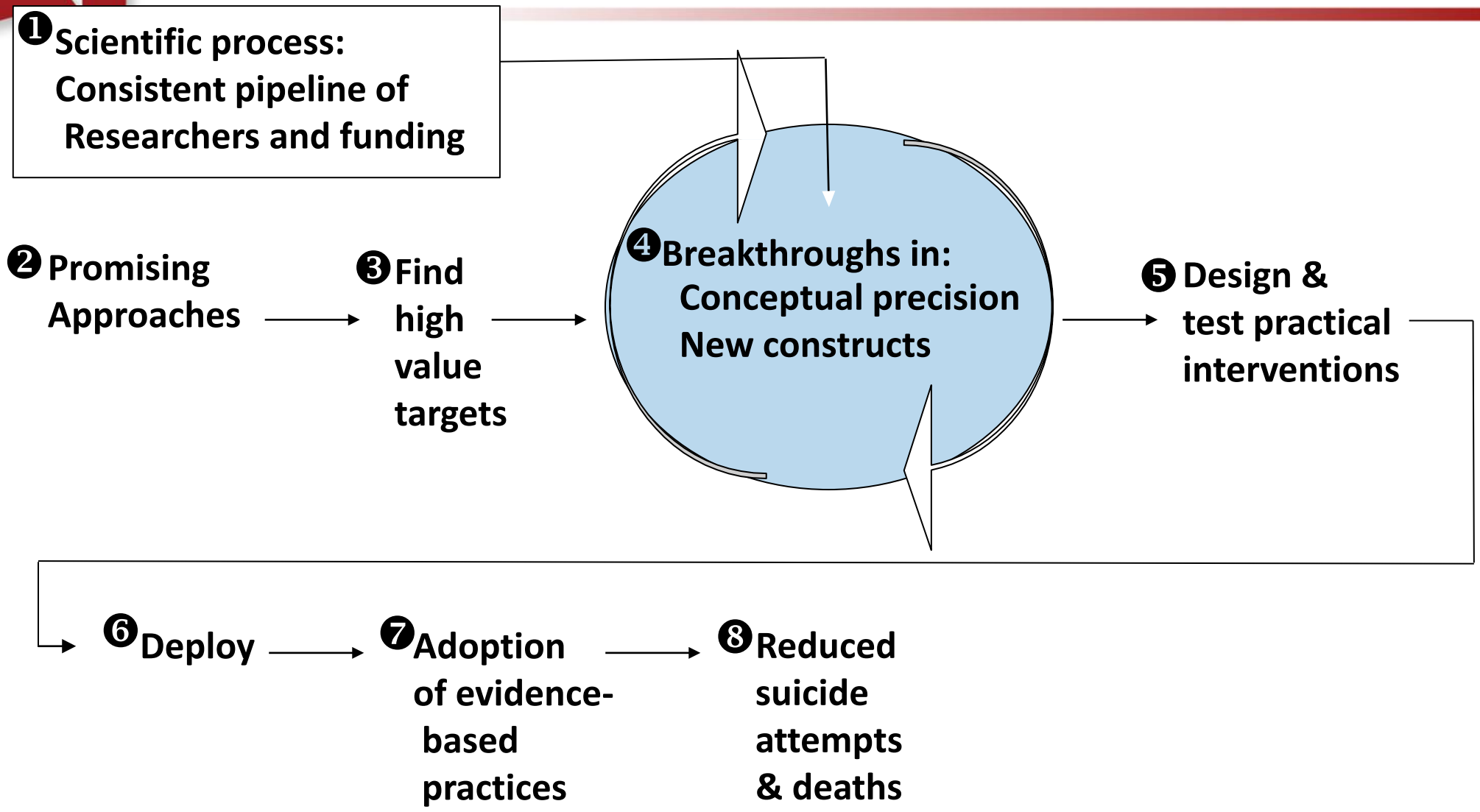
Long-Term Objectives:

POPULATION-BASED RISK-REDUCTION / RESILIENCE-BUILDING

Aspirational Goal 1:

Prevent the emergence of suicidal behavior by developing and delivering the most effective prevention programs to build resilience and reduce risk in broad-based populations.

Flow Diagram for Creating Research that Impacts the Rate of Repeat Suicide Attempts



Research Task Force (2012). "The United States' National Action Alliance for Suicide Prevention Research Task Force Agenda Development Process ," *in preparation.*

AG 1 Presentation Overview

Questions to be answered:

1. What potential reduction in suicide burden would be associated with attaining AG1?
2. What breakthroughs would need to occur to facilitate attainment of AG1?
3. What intervention research would have to be completed in order to meet AG1?
4. What advancements toward AG1 are feasible in a 5 – 10 year time frame?

Burden Example: What is the Suicide Attempt Burden for College Students?

National Survey on Drug use And Health (NSDUH), 2008 and 2009

Full time college students age 18+ who reported attempting suicide in past year

N= 64,000

Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality

http://www.oas.samhsa.gov/nhsda.htm

Round Zero Suggestions

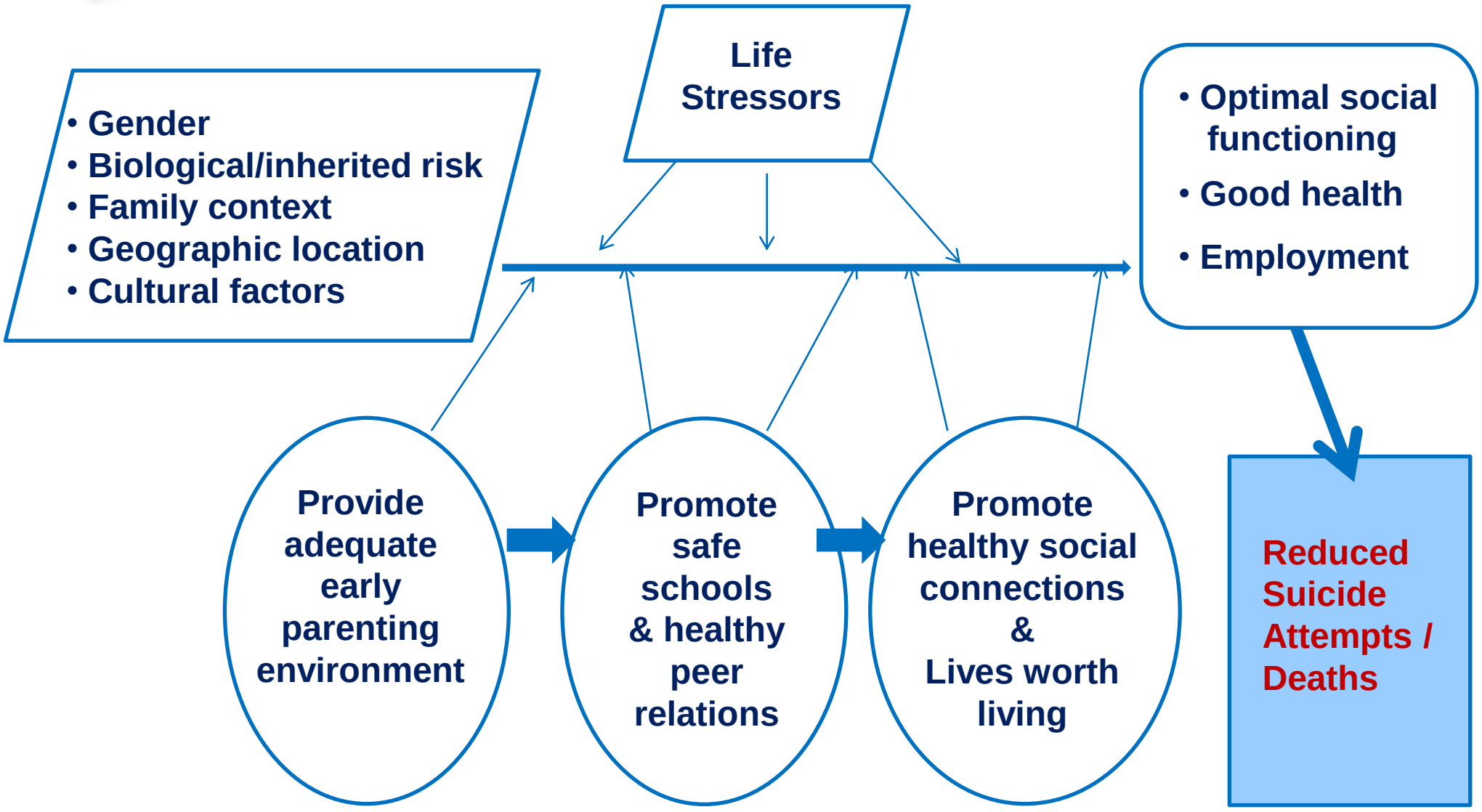
Round zero suggestions for this goal pertaining to a college youth

Since 80% of suicidal students do not seek help from health services on campus, what can be done to inspire them to seek help (*Survivor*)

Evaluate an effective training program for peer support to prevention suicide that can be introduced as part of orientation programs for all students entering educational programs beyond high school (*Policy/Administrator*)

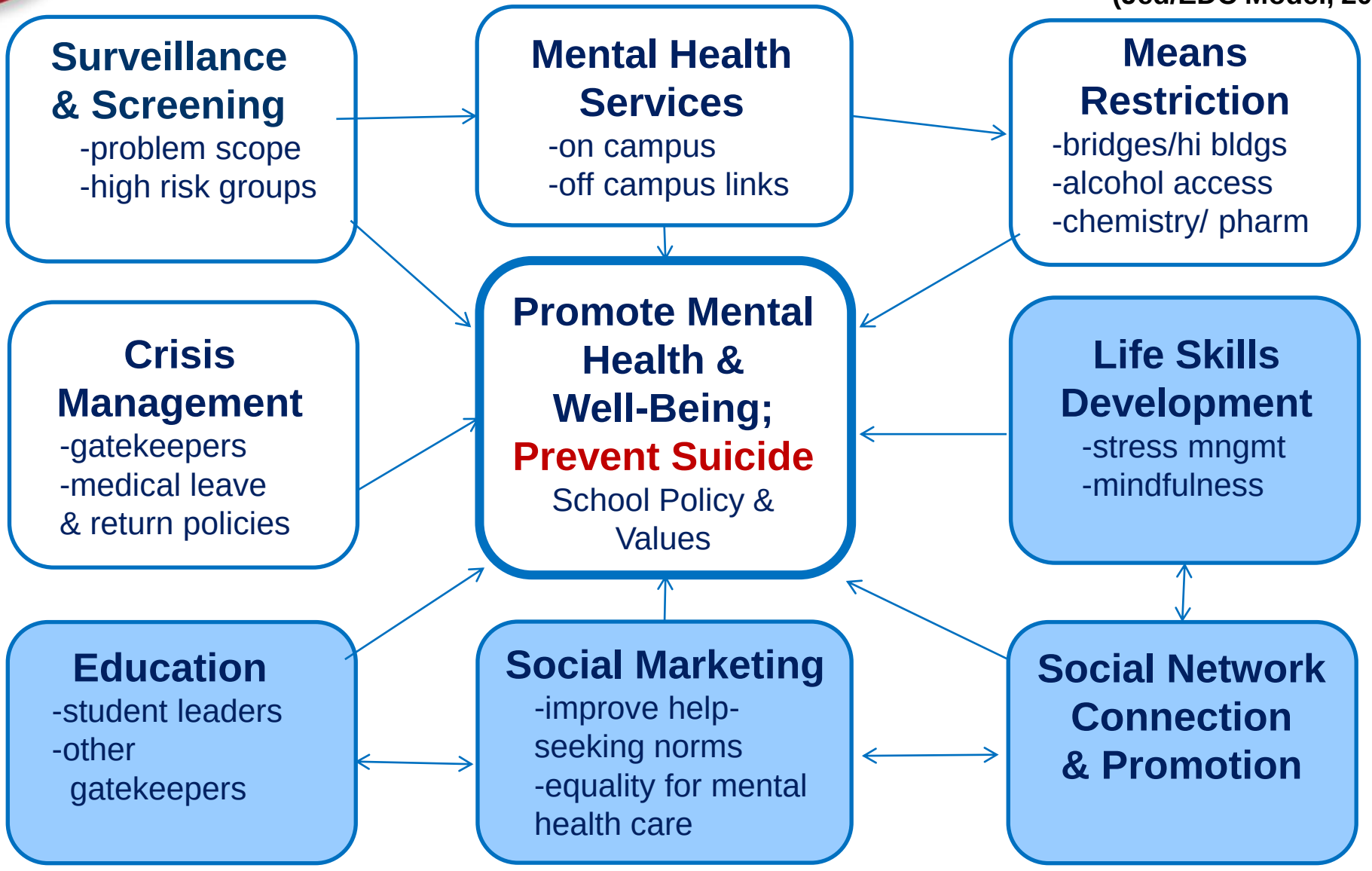
Educate service providers– doctors, teachers, college professors, police, etc about not fearing to talk about suicide…. Too many fear they will say something wrong (*Provider*)

Develop Overall Logic Model of Processes Believed to Produce Resilience



Literature Review Example:
Elements of a Comprehensive Suicide Prevention Program for Colleges and Universities

(Jed/EDC Model, 2004)

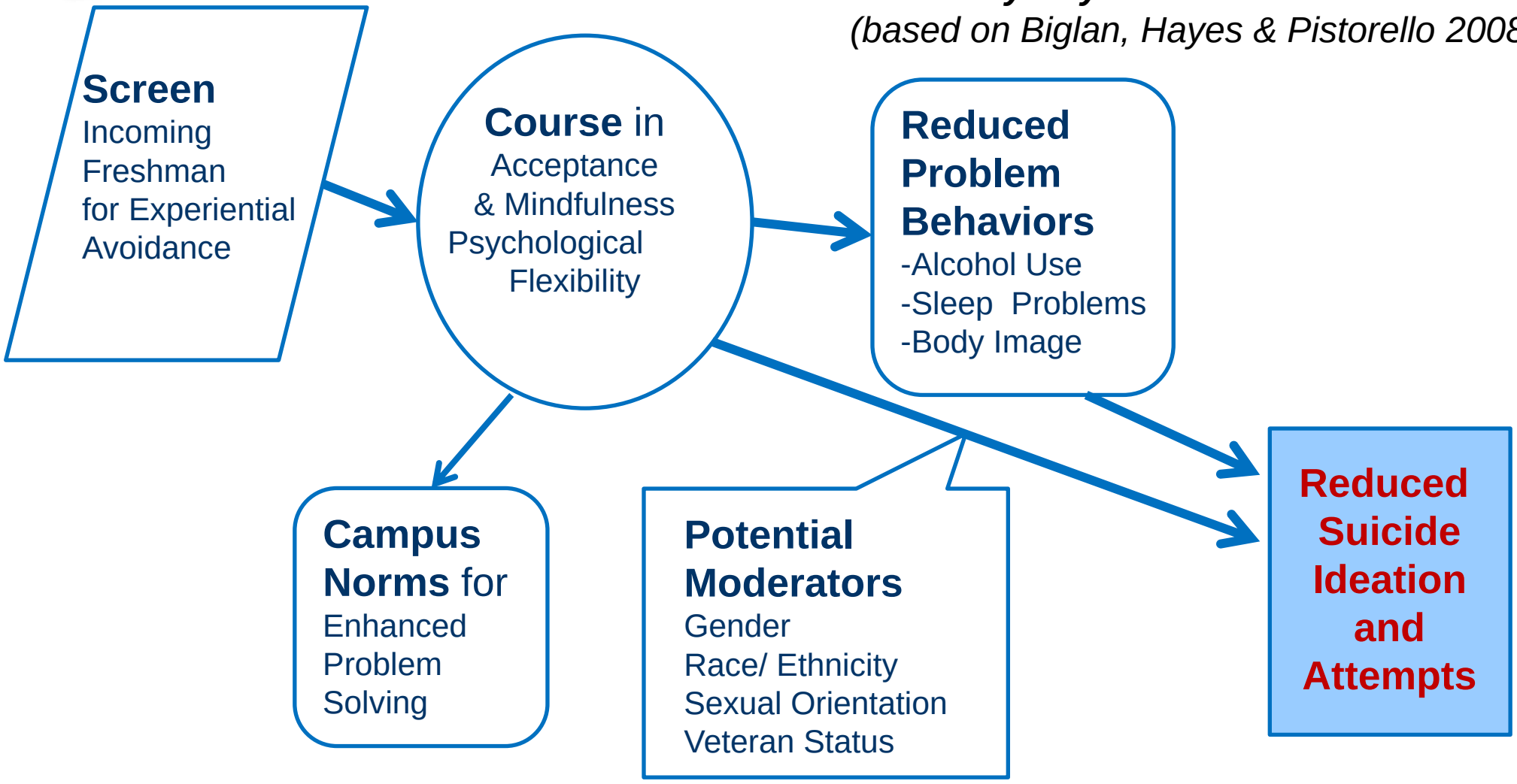


Suicide Prevention Resource Center. (2004). Promoting mental health and preventing suicide in college and university settings. Newton, MA: Education Development Center, Inc.. Online at: http://www.sprc.org/sites/sprc.org/files/library/college_sp_whitepaper.pdf

Intervention Example:

Life Skills Development Intervention

NIMH Grant by Hayes & Pistorello MH083740
(based on Biglan, Hayes & Pistorello 2008)



Level of evidence? Ready for Dissemination?

NIMH Grant by Hayes & Pistorello MH083740; Biglan, Hayes & Pistorella (2008),Prevention Science 9(3); 139-152

Presentation Three:

TRAINING HEALTHCARE PROVIDERS

SHERRY DAVIS MOLOCK, PhD
ASSOCIATE PROFESSOR, GEORGE WASHINGTON UNIVERSITY
CHELSEA BOOTH, PhD
2011 PRESIDENTIAL MANAGEMENT FELLOW

Aspirational Goal #3

- To improve the quality of treatment across settings by training healthcare providers and other community-based gatekeepers to identify, intervene, and follow-up appropriately with high-risk suicidal individuals.

TIER	GOALS
1	AG9 - Prevent Reattempts
1	AG10 - Continuity of Care
1	**AG3 - Provider Training**
1	AG4 - Affordable Care
2	AG7 - Ideator Treatment
2	AG11 - Risk & Protective Factors
2	AG12 - Reduce Stigma
2	AG1 - Community-Level Interventions
2	AG6 - Predict Imminent Risk
>2	AG8 - Improved Biological Treatments
>2	AG2 - Access to Lethal Means
>2	AG5 - Assess Lifetime Risk

Aspirational Goal 3 – Presentation Overview

Goal: To improve the quality of treatment across settings by training healthcare providers and other community-based gatekeepers to identify, intervene, and follow-up appropriately with high-risk suicidal individuals

Questions to be answered:

1. **What potential reduction in suicide burden would be associated with attaining AG3?**
2. **What breakthroughs would need to occur to facilitate attainment of AG3?**
3. **What intervention research would have to be completed in order to meet AG3?**
4. **What advancements toward AG3 are feasible in a 5 – 10 year time frame?**

Round Zero Suggestions to Achieve Aspirational Goal 3

- **Suicide Education in Graduate Training Programs**
  - *To offer best practices suicide prevention training to all mental health professionals. To require all primary care physicians to take best practices suicide prevention training suicide prevention should now be made part of the curriculum for all mental health professionals and physicians. They need to be able to meet a client where he is instead of treating him like a hot potato*.
- **Training Beyond Mental Health Professionals**
  - *Increase education of QPR to healthcare workers, teachers, clergy, law enforcement, funeral directors and bereavement [counselors] and support group leaders, AA, PTA, Girl and Boy Scouts, … Development of a simple, but direct means of assessment and education for healthcare providers to use on admission and discharge from any inpatient or outpatient setting and for all staff involved in physician office settings and telephone/reception staff/appointment setters*.

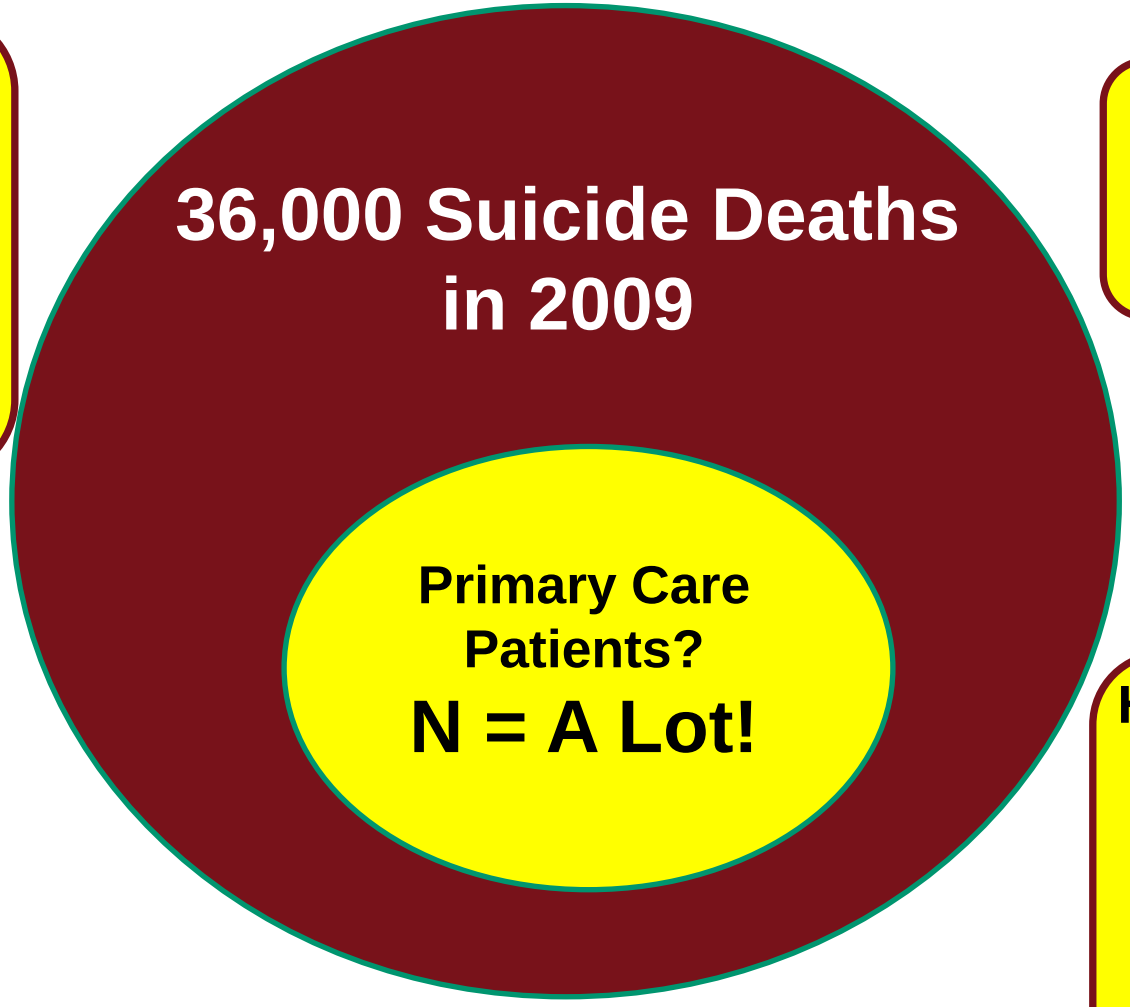
Round Zero Suggestions to Achieve Aspirational Goal 3

- **Acceptability of Training & Integration of Training into Health Care Systems**
  - *Strengthen the research on suicide prevention practices. Gatekeeper training is a widely used [intervention] but it is unclear to what degree it is successful in prevention suicide. If its not, our time and effort might be better spent elsewhere. Henry Ford Health Systems has recently gone 2 1/2 years without a suicide among their MH clients by implementing "perfect depression care"; this should be research to determine what elements may be most efficacious and encourage replication*.

What potential reduction in suicide burden would be associated with attaining AG3?

Focus on Primary Care Systems

Across all ages, average of 45% of pts saw PCP within one-month before suicide death (Luoma et al. 2002)

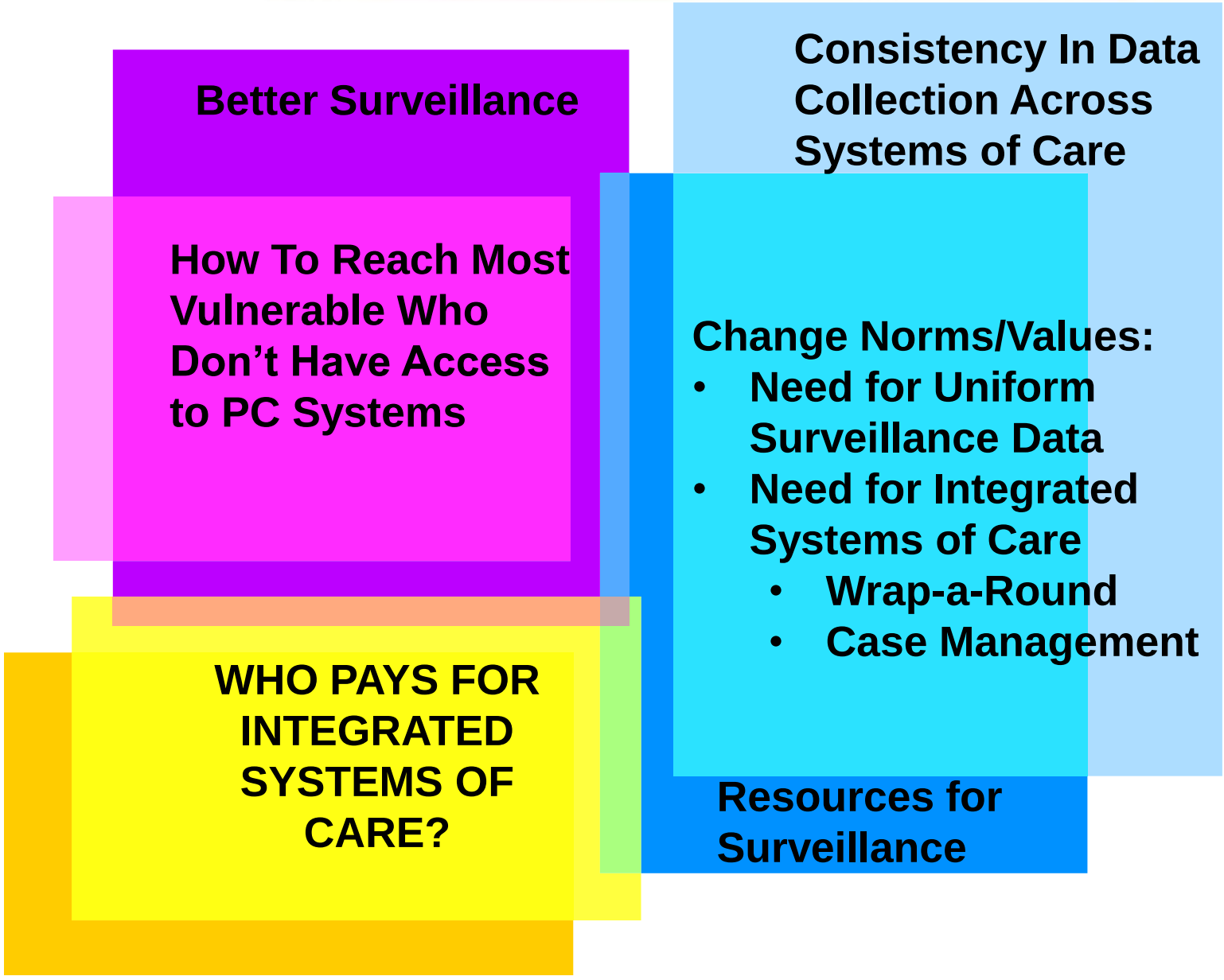


Burden = 45%
45% of 36,000
16,200?

How many of the 36,000 persons who died by suicide were seen in PCP settings?

Luoma , Martin and Pearson (2002) contact with Mental Health and Primary Care Providers before Suicide: A Review of the Evidence. American Journal of Psychiatry, 159(6) 909-915
CDC. (2011). "Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]." Retrieved Apr, 2012, Available at: URL: www.cdc.gov/ncipc/wisqars.

What breakthroughs would we need to achieve AG3?



What Intervention Research Would Need to Be Completed to Achieve AG3?

Feasibility -- Fidelity --

Process -- Impact

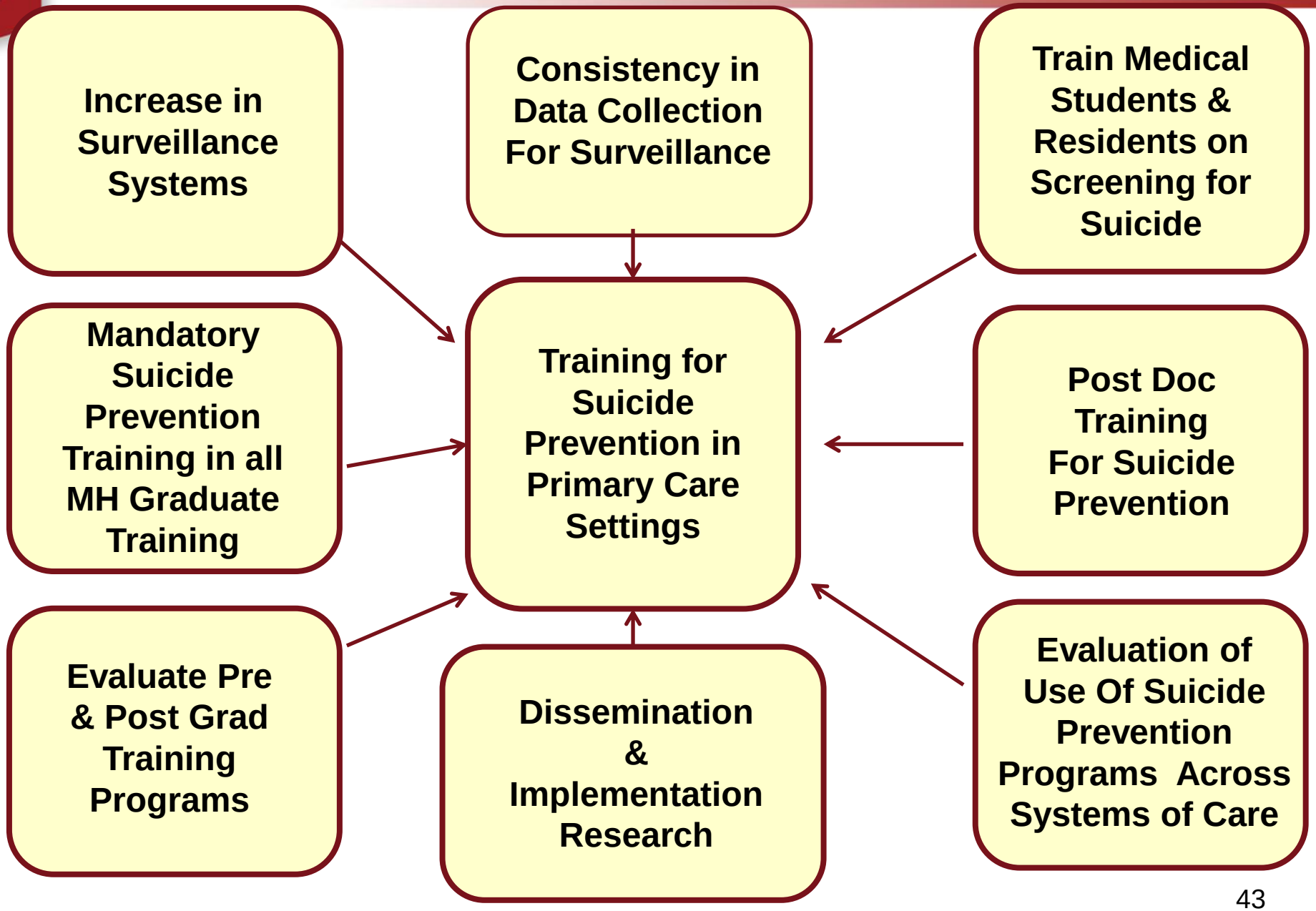
What are Most Effective Ways to Train Medical Students & PCP on Suicide Prevention

Implementation, Dissemination, Adoption & Sustainability of Suicide Prevention Practices Across Multiple Systems of Care

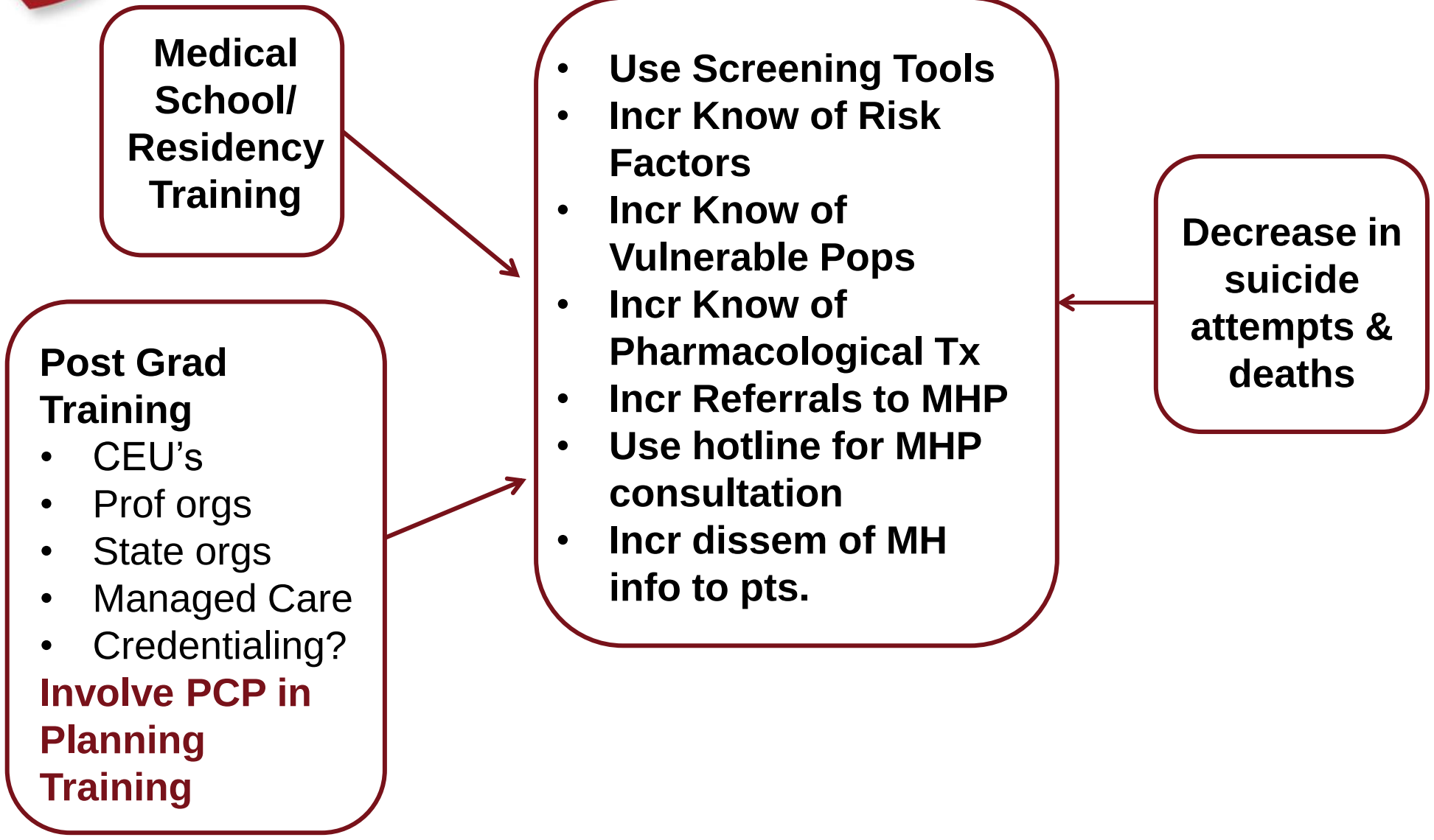
Most Effective Models of Delivery of Care Across Different Type of Care Systems:

- **Private Insurance**
- **Medicaid/Medicare**
- **VA**
- **Managed Care**

What Advancements toward AG3 are Feasible in 5-10 Years?



Literature Review: Elements of a Training Program for Primary Care Providers (PCP) (van der Feltz-Cornelis, et al., 2011)



van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V, Volker D, Roskar S, Grum AT, et al. Best practice elements of multilevel suicide prevention strategies: A review of systematic reviews. Crisis: The Journal of Crisis Intervention and Suicide Prevention, Vol 32(6), 2011, 319-333.

Presentation Four:

EFFECTIVE CARE FOR ATTEMPTERS

CINDY CLAASSEN, PhD, ASSOCIATE PROFESSOR, UNTHSC

CHELSEA BOOTH, PhD, 2011 PRESIDENTIAL MANAGEMENT FELLOW

STAKEHOLDER SURVEY

Stakeholder Survey process

1. Idea Generating Round
2. Initial Ranking & Rating Round
3. Discussion Round
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TIER	GOALS
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http://actionallianceforsuicideprevention.org/task-force/research-prioritization

Aspirational Goal 9 – Presentation Overview

Goal: Prevent repeat suicide attempts by improving follow-up care after a suicide attempt.

Questions to be answered:

1. **What potential reduction in suicide burden would be associated with attaining AG9?**
2. **What breakthroughs would need to occur to facilitate attainment of AG9?**
3. **What intervention research would have to be completed in order to meet AG9?**
4. **What advancements toward AG9 are feasible in a 5 – 10 year time frame?**

Back-of-the-Envelope Calculations:

POTENTIAL REDUCTION IN SUICIDE BURDEN

"Self-harm increases the likelihood 50- and 100-fold that the person will die by suicide within a 12-month period." (NICE Pathway, 2012)

In 2009 there were:

(NSDUH)

- **An estimated 1.0 million self-reported US adult suicide attempters.**
  - **An estimated 678,000 adults who reported they received medical care for a suicide attempt.**

(NEISS-AIP)

- **An estimated 325,242 adult patients treated in EDs for a known self harm episode.**
- **An additional 36,909 individuals who died by suicide.**

NSDUH Survey, SAMHSA, Center for Behavioral Health Statistics and Quality; http://www.oas.samhsa.gov/nhsda.htm. CDC. (2011). "Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]." Retrieved Apr 2012, Available at: URL: www.cdc.gov/ncipc/wisqars.

Back-of-the-Envelope Calculations:

POTENTIAL REDUCTION IN SUICIDE BURDEN

Burden in Boundaried (Accessible) Populations:

"High-Yield" Environments in which to Identify and Treat Suicide Attempters

- **Emergency Departments**
  - **Approximately 80% of all medically identified and treated suicide attempters receive immediate their post-attempt care in the emergency department or an inpatient setting**

- **Inpatient Psychiatric Units**
  - **25-50% of all medically-treated suicide attempting patients experience some amount of inpatient psychiatric care after a suicide attempt.**

Claassen, C., T. Carmody, et al. (2008). "Do Geographic Regions with Higher Suicide Rates also have Higher Rates of Nonfatal Intentional Self Harm? " Suicide and Life-Threatening Behavior 38(6): 637-649.; Claassen, C. and M. Trivedi (2006). "Data points: Rates of nonfatal intentional self-harm in nine states, 2001." Psychiatric Serv 57(3): 313.

Back-of-the-Envelope Calculations:

POTENTIAL REDUCTION IN SUICIDE BURDEN

Among those who experience a nonfatal suicide attempt:

- **In US data, an estimated 8 – 14% of medically-treated (ED + Inpt) suicide attempters present to an ED or Inpatient setting for treatment of a reattempt within 12 months (26,019—45,534), so this is the absolute upper limit of attempts that could be eliminated with a 100% effective reattempt prevention strategy implemented in this setting.**

Among those who go on to die by suicide:

- **Approximately 15% of persons who die by suicide have been treated for a nonfatal self harm event in the emergency department within the 12 months prior to death (5,536).**

A 100% effective intervention that prevented reattempts uniformly implemented in these environments would yield a reduction in national suicide and suicide attempt rates of 15% and 4%-7%, respectively.

Claassen et all. (2012) Does the Nature of Post-Suicide Attempt Medical Treatment Impact the Risk of Repetition?, submitted. Hawton, K., S. Harris, et al. (2003). "Deliberate self-harm in Oxford, 1990-2000: A time of change in patient characteristics." Psychological Medicine 33: 987-995.; Gairin, I., House, A. & Owens, D. (2003) Attendance at the accident and emergency department in the year before suicide: retrospective study. British Journal of Psychiatry, 183, 28^33.

FEEDBACK FROM STAKEHOLDER SURVEY

1) **Overwhelmingly pessimistic view of current standard of care provided to suicide attempting individuals:**
   - "Current insurance policies discourage the collaboration between inpatient and outpatient teams." (researcher)
   - "The mental health care in this country is fragmented and plagued by poor handoffs of care. This is accentuated by the shortage of behavioral health clinicians in many areas of the country." (provider)
   - "I believe that the fragmented, bureaucratized and impersonal mental health delivery system in the US fails, by and large, to help promote human connectedness between distressed, suicidal patients and their families, larger social networks, and the mental health delivery system itself." (provider)
   - **"What worked for me . . . had everything to do with steering clear of the mental health system. Seriously. The more you have a stake in the world, from jobs to social relationships, the more you have a reason to stay alive. The more you are sucked into the mental health system, the more your chances of meaningful education and employment and social relationships are reduced. (suicide attempt survivor)**

FEEDBACK FROM STAKEHOLDER SURVEY

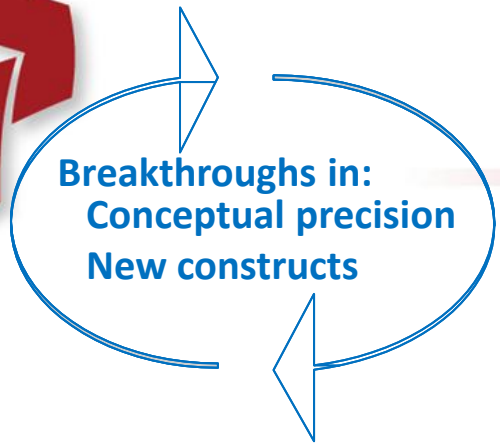
2) **Specific, serious objections to involuntary hospitalization as it is now used:**

- "The enormous distinction between people who need to be able to articulate suicidality (and retain control over the possibility of suicide in order to actually stay alive) and the people who end up really killing themselves (who in my experience don't telegraph it and take careful steps to hide their suicidality) needs to be really understood. **The former are harmed and damaged by involuntary treatments they call on themselves by their proclamations . . ; the latter, who might actually be helped by limited involuntary treatment, slip through the din created by the former group and we lose them forever." (Suicide attempt survivor)**

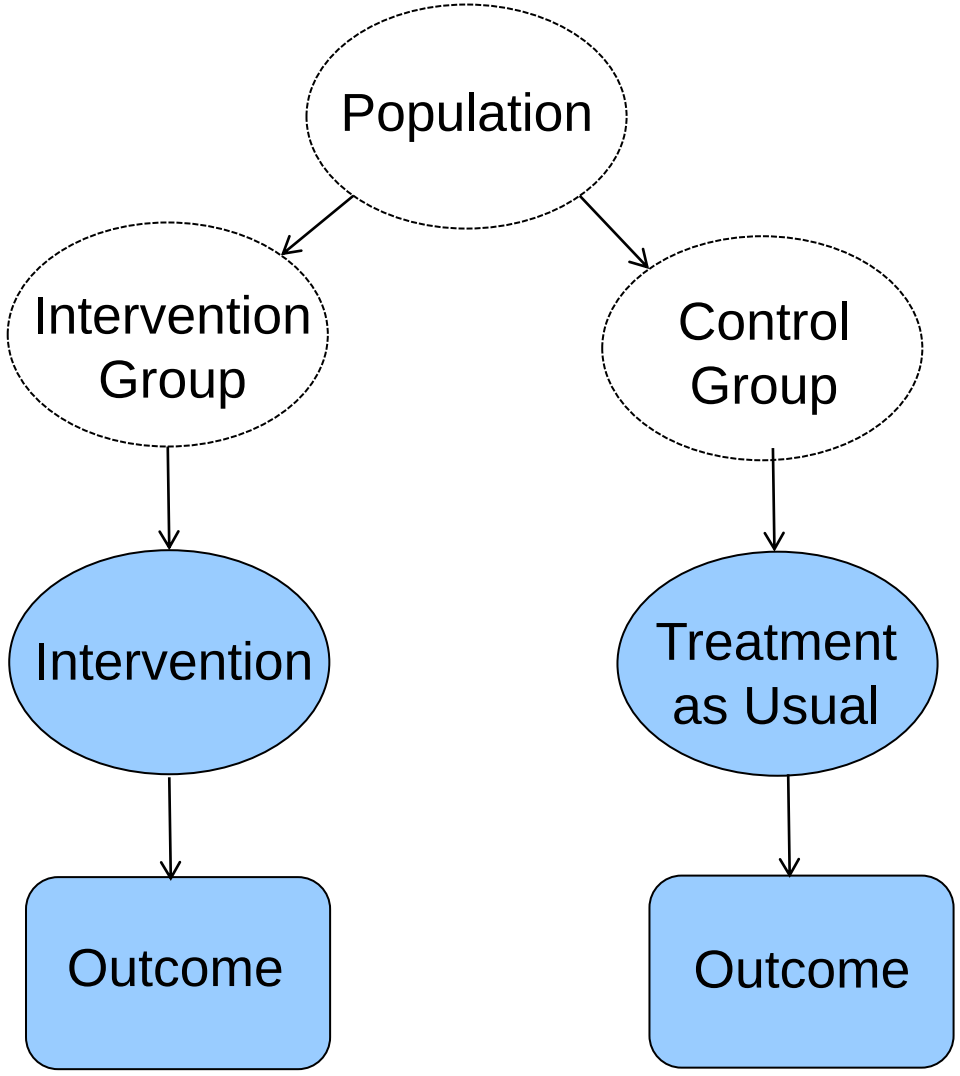
3) **The dilemma the family faces when the attempter comes home:**

- "Families and caregivers [of] an attempter need to be educated about suicide and need to be made aware of the suicide risks and warning signs to watch for. They also need to be provided with information and resources on what to do should their loved ones become suicidal again after they have been released from the hospital. **Ignorance can be lethal." (Suicide attempt survivor)**

BREAKTHROUGHS NEEDED



1) **Policy Research – Confidentiality, Communication & Consent**
2) **More precise understanding of risk states / conditions – when & how long does imminent risk, near-term risk, high risk last?**
3) **Improved instruments by which to measure outcomes**
4) **Statistical techniques that can address rare events and/or validated proxies for outcomes of interest**



Kapur: National guideline for prevention of suicide attempts. 2012. Online at: Source: http://guidance.nice.org.uk/CG133/Guidance . Nock et al 2008. Suicide and suicidal behavior. Epidemiol Rev (2008) 30 (1): 133-154.

NICE, 2012 Suicide Risk Assessment Measures Review

Scale (Cut-Off)	Sensitivity	Specificity	Positive Predictive Validity	Negative Predictive Validity	Prevalence (%)
Suicide Intent Scale (10 men)	76.7	48.8	4.2	98.6	30/1049
Suicide Intent Scale (14 women)	66.7	75.3	4	99.2	24/1440
Beck Hopelessness (9)	77	42	8	96.5	13/212

Sensitivity: *Proportion of those who go on to repeat self harm who have been identified as high risk on basis of scale score.*

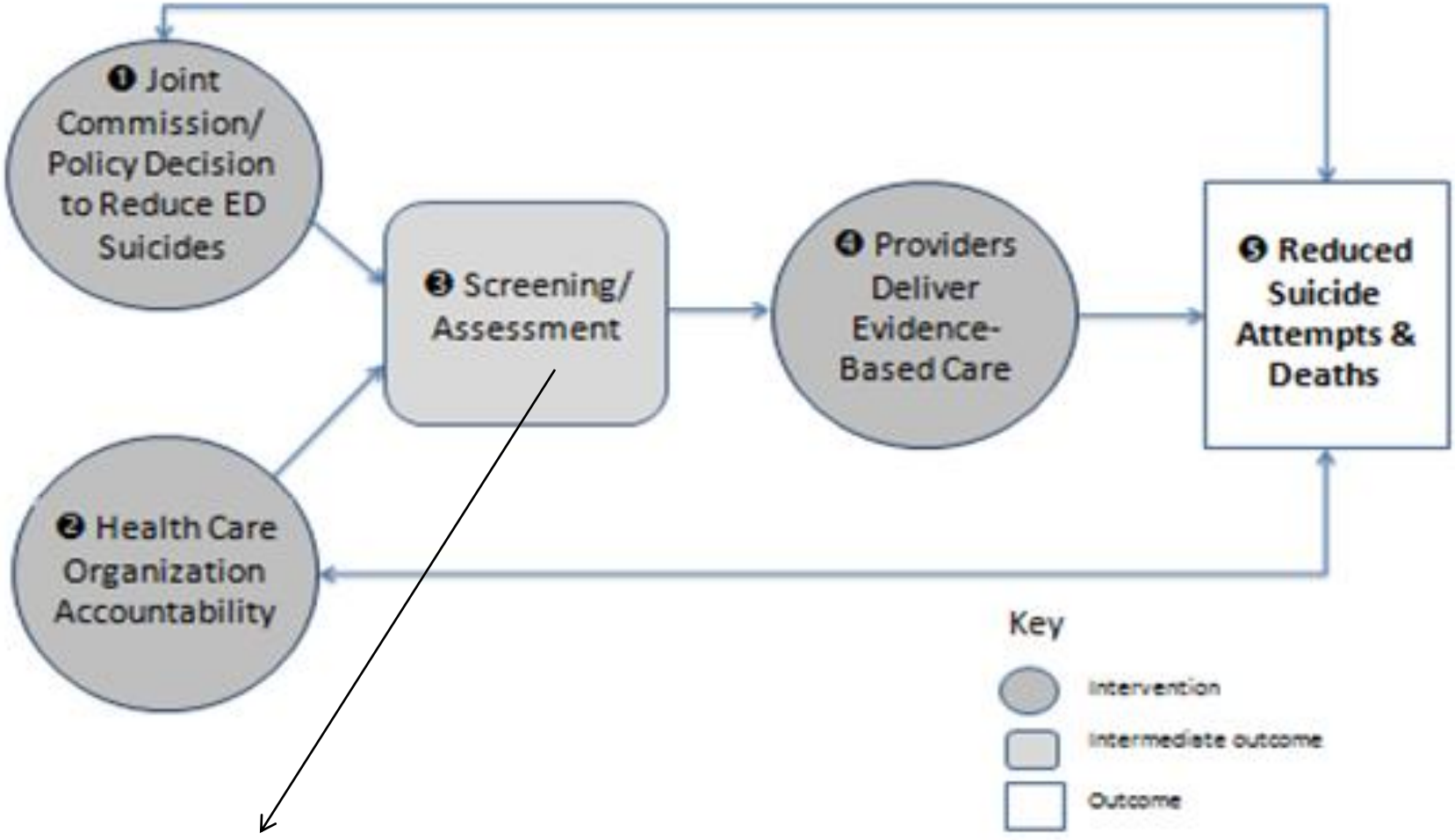
Specificity: *Proportion of those who do not go on to repeat self harm who have been identified as low risk.*

Positive predictive validity: *Probability that a person with a positive score really has self-harmed.*

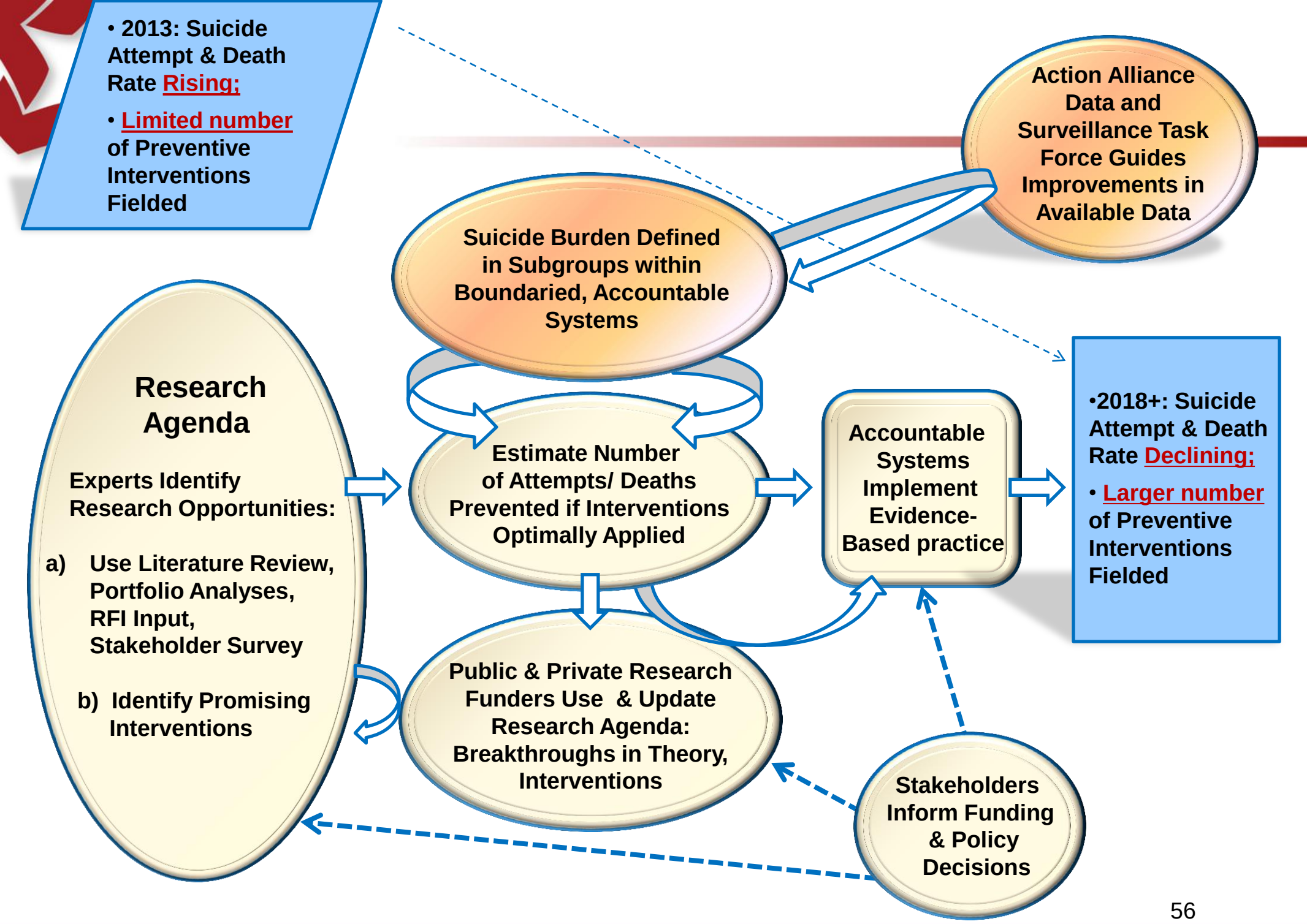
Negative predictive validity: *Probability that a person with a negative test really is free of self harm.*

Source: http://guidance.nice.org.uk/CG133/Guidance

LOGIC MODEL FOR ED-BASED INTERVENTION RESEARCH



(Screening to identify ED patients who acknowledge any level of suicidal ideation.)



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