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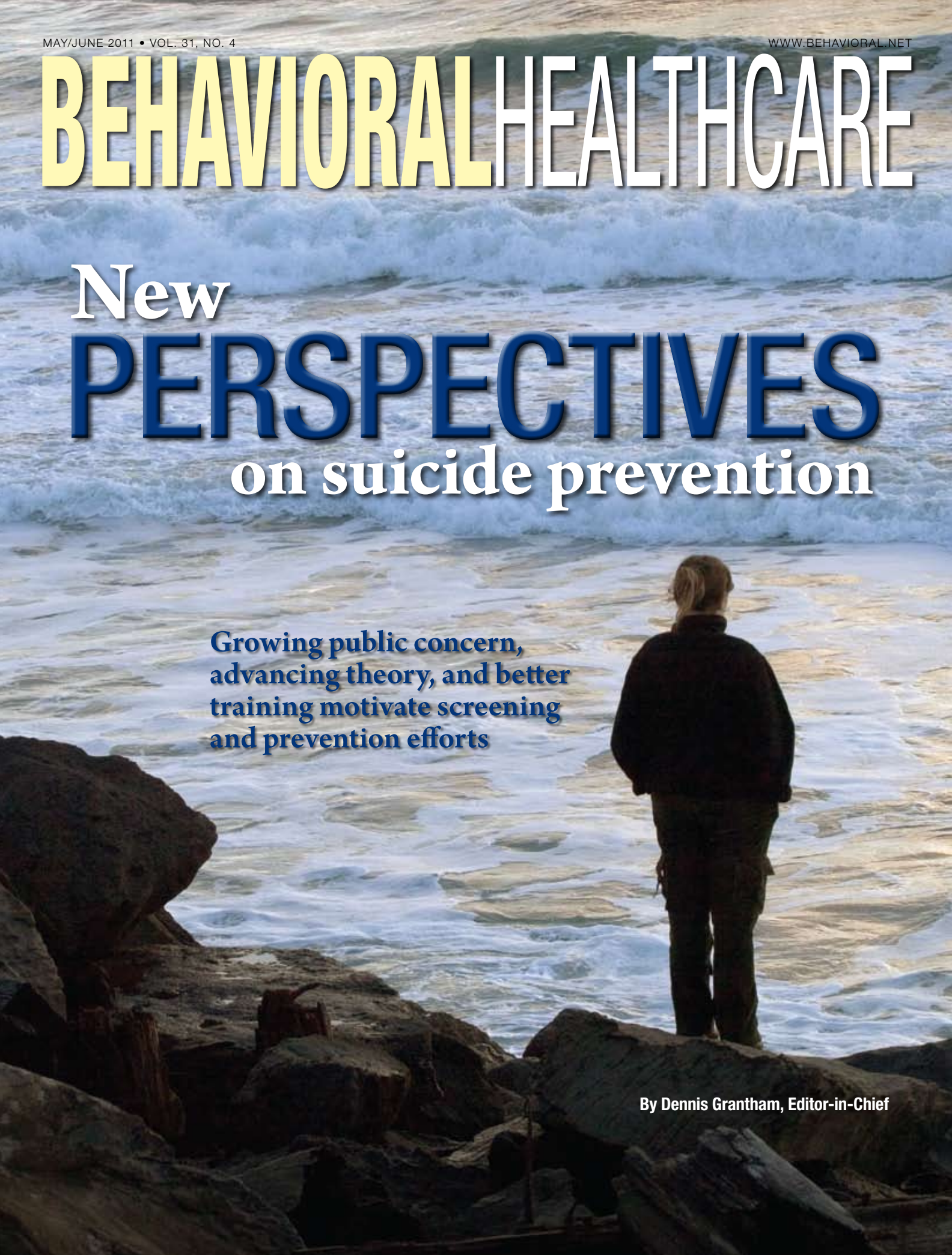
New PERSPECTIVES on suicide prevention



Growing public concern, advancing theory, and better training motivate screening and prevention efforts

By Dennis Grantham, Editor-in-Chief

Some 12 years ago, on July 28, 1999, Surgeon General David Satcher, MD, PhD, joined Tipper Gore in releasing "The Surgeon General's Call to Action to Prevent Suicide," a document[1] that called for a national suicide-prevention strategy and announced 15 major recommendations around three principles:

Awareness: *"We must promote public awareness that suicides are preventable … enhance resources in communities for suicide prevention programs and … reduce the stigma associated with mental illness that keeps many people from seeking the help that could save their lives."*

Intervention: *"We must complete our work . . . on a National Strategy for Suicide Prevention … eliminate barriers in public and private insurance programs for provision of quality mental and substance abuse disorder treatments. We must institute training about suicide risk assessment, treatment, management and aftercare for all health, mental health, substance abuse and human service professionals … [and] develop and implement effective training programs … on how to recognize, respond to, and refer people who show signs of suicide risk …*

Methodology: *"We need to enhance research to understand risk and protective factors related to suicide … and increase research on effective suicide prevention programs, clinical treatments … and culture-specific interventions."*

Though much has been accomplished in the intervening years in all of these areas, public understanding about deaths due to suicide and the importance of suicide prevention as a public health issue languished until the Pentagon was forced to comment on rising suicide rates in the U.S. military some years ago. Since that time, the number of military deaths due to suicide has exceeded those from combat in Iraq and Afghanistan combined.

While these suicides are no more or less tragic than any of the other 35,000 suicides that occur annually in the United States (or the nearly one million that occur worldwide), they have proved to be much harder to dismiss or ignore, since they involve volunteers whom our society recognizes as selfless, courageous, and capable.

Katie Ayotte, a past community member of Magellan of Arizona's governing board, emerged as a champion of peer-led, attempt survivor support groups when she shared the story of her own unsuccessful 2008 suicide attempt. David Covington, Magellan of Arizona's chief of adult services, says that her experience of the value of caring staff and involved family, combined with an emphasis on resiliency and natural supports, underlined the value of the clinical care management model. "Peer champions like Katie have made all the difference in our understanding of how preventable suicide really is," he adds.

It's impossible to ignore these deaths or to easily dismiss them with the suicide mythology and stigma of the past: that they were determined to end their lives and couldn't be helped, that their deaths should not be talked about or remembered, that their behavior was cowardly or shameful.

A nagging fact

Apart from the military sphere, many others, motivated by painful experience with suicide and its aftermath, have struggled and researched quietly to build a theoretical framework that applies broadly and helps clinicians make more timely and accurate assessments of risk.

Thomas Joiner, PhD, a professor of psychology at Florida State University, is one of those people. The 1990 suicide death of his father, a well-regarded and successful businessman, forced Joiner to confront "a nagging fact" that left him "unsatisfied with existing theories."

The nagging fact, which he confronts in the prologue to his 2005 book, *Why People Die by Suicide*, was "the idea that suicide is a shameful act of weakness." This idea did not square with his personal experience: "My dad was not weak in any sense of the word," he asserts, noting that although the former Marine sergeant clearly suffered from a mood disorder (seen only in retrospect), he had a "stoic toughness about him that seemed to inure him to pain."

Joiner's search for a more precise understanding of suicide's causes led him to a theoretical framework for what has since become known as the "interpersonal theory of suicide." This theory is built on three factors: a perceived sense of burdensomeness—that one has become ineffective or burdensome in the eyes of loved ones; a perception that one is isolated and no longer "belongs" or is needed; and an acquired capability to hurt oneself. When it comes assessing and predicting actual suicide risk, Joiner says that it is the third factor—capability—that makes his framework different from its predecessors.

Capability requires two things: the know-how to cause one's death and an odd but real "fearlessness"[2] that enables one to use it, despite the pain involved. Joiner maintains

Golden Gate Bridge

Famous for its iconic beauty, the Golden Gate Bridge is sometimes described as a "magnet" for suicidal "jumpers." In part because of a popular suicide myth that "if you stop them in one place, they'll go to another," the bridge has yet to install a safety net system, despite 1,500 suicides over a 50-year period. Interestingly, a 1978 study that examined this myth of suicide's inevitability found that, of 515 people who were prevented from committing suicide on the Golden Gate Bridge over a 34 year period, more than 90 percent were still alive or if dead, died of non-violent causes.[6]

that fearlessness is acquired through a kind of conditioning. Examples include the tolerance of repeated, painful physical trauma or the repeated rehearsal of disturbing or suicidal thoughts or behaviors, both of which serve to reduce their initial emotional or physical impact over time.

In an interview, Joiner called an attempted act of suicide a kind of "perfect storm."[2] He asserts that for an attempt to take place, all three of these factors must be present in an individual, converging powerfully and simultaneously. He notes that while many individuals may experience profound feelings of burdensomeness and isolation, leading to thoughts of suicide or a wish for death, few act on their feelings. SAMHSA reports that of the eight million Americans who have serious suicidal thoughts each year, 1 million make attempts and of these, just 35,000 (not quite one in 30) succeed.

Groups considered "at risk" for suicide

Seen through Joiner's lens, the elevated suicide risk for veterans and members of the U.S. military is frightening, but logical. Members of the military are trained in the use of deadly force and conditioned to act with purpose and courage, even in the face of injury or death. Many hold that men's familiarity with arms, thought to be gained through their high levels of involvement with military service, explains why they have been far more likely than women to make a successful suicide attempt, often using a gun. However, research with military women suggests that this gender-based difference closes for women who have received weapons training.[3]

But suicide is, and has been, far more than a military problem—and it has been so for a long time. As noted, some 35,000 American deaths are ruled as suicides each year—a rate of 11.5 per 100,000 people in the general population for 2007—while thousands more deaths ruled as accidental could in fact be suicides in disguise. Suicide is among the leading causes of death for young and old alike and the rate of suicide has remained essentially unchanged in the first decade following the Surgeon General's announcement in 1999 and the release of the National Suicide Prevention Strategy (NSSP) in 2001.

Magellan Health Services of Arizona CEO Richard Clarke, PhD (left) and David Covington, chief of adult services, led the effort to create the Programmatic Suicide Deterrent System, an initiative that aims to end suicides among the 80,000 people enrolled in Maricopa County's public behavioral health system.

The NSSP recommends the development of targeted suicide-prevention strategies for these special populations, which also include racial and ethnic minorities as well as the survivors or previous suicide attempts (see figure 1). While the August 2010, NSSP Progress Review notes that "the disabled" were omitted from mention as a special population in the NSSP document, it acknowledges that suicide among the disabled is an emerging issue that warrants further study.[4]

Of concern to some, particularly in behavioral health, is the fact that individuals with serious mental illness, a group with a suicide rate significantly higher than all of the "at-risk" groups above, is not considered an NSSP special population either, despite the fact that they, as a group, have a suicide rate that is far higher than the at-risk groups listed above, an estimated 12-13 times that of the general population, according to studies.[5]

"Why are these people dying?"

This fact hit home just over two years ago for Richard Clarke, PhD, CEO of Magellan of Arizona, the regional behavioral health authority (RBHA) that has provided care for some 21,000 individuals with serious mental illness in Phoenix and Maricopa County since September 2007.

As part of a review of "adverse incidents" in early 2009, Clarke requested seven randomly selected charts involving RBHA patients who had recently died. "This is one of a few things that I normally do to get a feel for what is happening for the people in the system," he explains.

Clarke found that six of the seven deaths were the result of suicide. "I was shocked. All six of these were young, between 30 and 40 years of age."

Instinctively, he looked for red flags or signs of trouble, but found none. "All of these suicides," he found, "had happened under circumstances that would be considered 'good service.' Clients were going to appointments, seeing their doctors, and doing their homework. The clinicians were doing their work, conducting their risk assessments, providing good care. And, yet, these six individuals—all in the prime of life—committed suicide."

As the review continued, "I started thinking, 'What is it about the system? What's going on? Why are these people dying?'" Gradually, a picture began to take shape: "Individuals were leaving [appointments] and going home, isolated and alone. They weren't involved in com-

GROUP	RISK (relative to general population**)
LGBT Youth	2-3x
Alaskan Natives/Native Americans	2-4x
Military members and Veterans	2-4x
White males aged 65 or older	3-4x
Individuals with serious mental illness	12-13x

***Estimates of suicide risk can vary. Estimates may include the risk of suicide attempts as well as actual suicides.*

Figure 1: Groups at elevated risk for suicide

Suicide and Suicide Prevention

According to the "interpersonal theory of suicide" advanced by Florida State University professor Thomas Joiner, PhD, in 2005, three elements, occurring simultaneously, predict suicide attempts:

1) Perceived feeling of burdensomeness
2) Perceived feeling of isolation, failure to belong
3) Capability to commit self-harm, comprised of know-how and fearlessness

A fourth factor, long advocated by many suicidologists, is that individual risk for suicide may be reduced or increased based on biopsychosocial, environmental, and sociocultural "risk" and "protective" factors.

"Risk" factors include:

- Mental, alcohol, or substance use disorders
- History of trauma or abuse
- Past suicide attempt(s) or family history of suicide
- Job, financial, or relationship loss
- Easy access to lethal means
- Lack of social supports
- Stigma associated with help-seeking behavior
- Barriers to accessing treatment

"Protective" factors include:

- Easy access to effective clinical care for mental, physical and substance use disorders
- Restricted access to highly lethal means
- Strong connections to family and community support
- Ongoing medical, mental health care relationships and support
- Skills in problem solving and non-violent conflict resolution
- Cultural and religious beliefs that support self preservation

munity activities. Their families, especially their parents, weren't surrounding them with support." And, while office-based care met standards, Clarke found that "we weren't reconnecting with [clients] between appointments."

"I can talk with my therapist about anything, except …"

The following Monday, Clarke held an emotional meeting with Magellan of Arizona's managers. "I told them I wanted to see a plan that would reduce the risk of patient suicides to zero," he says. An internal team, headed by Magellan of Arizona's chief of adult services, David Covington, began to consider the implications.

One thing that emerged almost immediately was that, too often, the system's connections with "suicidal" clients were broken during treatment. Covington maintains that "the culture of community mental health nationally [has seen] crisis intervention/suicide prevention as a specialty, a secondary rather than a core element of the mission." As a result, this expertise "is often not there among those who deliver care, the ones that have a day-to-day relationship with the client." He says that this results in a dynamic that teaches clients that "I can talk with my therapist about everything—except suicide."

A study at Magellan of Arizona found that about half of staff felt they lacked the training needed to confidently support a patient expressing thoughts of suicide. "It wasn't so much a liability concern as it was a fear of the topic," says Covington. He believes that this fear has prompted therapists to refer more clients to specialists, as well as more involuntary detentions and committals. Of course, either of these actions risks breaking the therapeutic relationship and can further isolate the client.

Focus groups that included the targets of those referrals, on-call psychiatrists at local emergency rooms, found that these physicians expressed similar concerns, asking therapists to limit their referrals and challenging them to learn techniques that would let them "get down there in the pain" with their suicidal clients.

Suicide is among the leading causes of death for young and old alike and the rate of suicide has remained essentially unchanged in the first decade following the Surgeon General's announcement in 1999 and the release of the National Suicide Prevention Strategy (NSSP) in 2001.

Clarke saw a similar dynamic: "There are always pockets of expertise in a system," he says, "and it can be easy for people to say, 'This is a specialty thing that someone else has to do, not us.'" But he also recognized that "if [suicide prevention] has to be a core responsibility of every provider in the community, we don't want this expertise to be confined to these small pockets."

Suicide deterrence system involves community resources

For that reason, the Magellan team and 12 of the largest Phoenix-area community behavioral health provider agencies agreed that all employees — some 2,100 employees at more than 30 regional locations—would receive LivingWorks Education's two-day ASIST (Applied Suicide Intervention Skills Training) training program. This group includes all staff working with individuals who have been determined to have a serious mental illness. As of press time, this year-long training process is complete.

But even as employees learned new skills, the team recognized that, as Clarke put it, "behavioral health can't do it alone. We need a public health approach." They found it with the help of Magellan of Arizona's community steering team, which included a variety of state and local

politicians, judicial and law enforcement personnel and representatives of groups and organizations.

Ultimately, the plan, which Covington now calls a "programmatic suicide deterrent system" to reflect its ambitious risk-reduction objective, encompassed not only the ASIST training, but five additional elements:

- Attempt survivor peer support groups
- Family engagement
- Community integration
- Racial/ethnic best practices
- A new, system-wide model of care

From a systems perspective, Clarke recognized that the organization's model of care—case management—"clearly wasn't the most effective model for suicide prevention" because it permitted the primary client contact—the care manager—to be a somewhat detached "broker" of care, rather than a partner or "co-pilot" with the client. So, instead of "creating therapeutic opportunities" through a strong therapist-client relationship, Clarke felt that the case management model facilitated more referrals, layered on more relationships for the client, and led to more involuntary detentions and admissions.

A new model of care

At Clarke's request, the Magellan of Arizona team undertook a study to evaluate the relative strengths of eight models of care. They recommended adoption of the clinical care management model as the best for supporting the objective of suicide prevention. This model builds a stronger client-therapist relationship because it combines the care coordination role with the primary behavioral health counseling role.

"Initially [clinical care management] costs more," says Clarke, "because it involves getting everyone trained up." But over time, it works better," he says, because it provides more direct personal engagement and clinical intervention while reducing specialty referrals. Relative to case management, Clarke says that clinical care management better "collapses the system," while enabling the client to "work from the same story," instead of having to repeat the story again and again as other caregivers pass in and out of the care process.

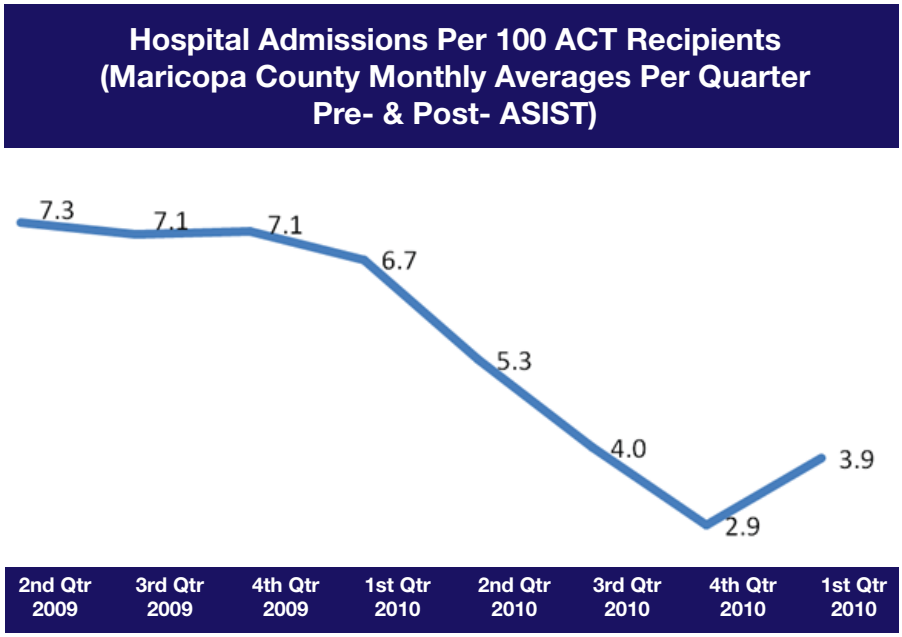


Figure 2: Inpatient hospital admissions per 100 recipients of Assertive Community Treatment, compiled by Magellan of Arizona.

The new care model also better fits with SAMHSA's December 2010 "Policy for Helping Callers at Imminent Risk," the approach used with callers on the National Suicide Prevention Lifeline. This policy suggests that a combination of stronger personal engagement, collaboration, and follow-up with the caller can reduce the need for "active rescues" and unnecessarily hospitalizations.

Clarke reports that initial feedback is promising, with dramatic increases in the confidence of staff, subsequent to ASIST training, in their abilities to "engage and assist those with suicidal desire or intent." In 2009, the project steering committee hypothesized that more relationship-based and open, honest discussions of suicide would result in decreased involuntary hospitalization rates. Data from Maricopa County's 14 Assertive Community Treatment teams show reductions in inpatient admission rates of nearly 50 percent since ASIST training became required for all ACT staff (see figure 2).

To date, Magellan of Arizona credits the suicide deterrence program with helping to reduce the rate of suicide deaths in Maricopa County by individuals with serious mental illness by 38 percent from the fiscal year 2008 (its first full year of operations in the region) through the first nine months of its 2011 fiscal year. "While we are encouraged that we are moving in the right direction," says Clarke, "we will not be content until we have eliminated suicide deaths for those enrolled in our care." ■

Resources:

Joiner, Thomas. Why People Die by Suicide. Harvard University Press, 2005.

1. The Surgeon General's call to Action to Prevent Suicide. Viewed at www.surgeongeneral.gov/library/calltoaction/calltoaction.pdf.
2. Wise Counsel Interview Transcript: An interview with Thomas Joiner, PhD, on why people commit suicide. http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=25166&cn=9
3. APA 2009: Young Women Veterans at High Risk for Suicide. Viewed at http://www.medscape.com/viewarticle/703424.
4. Charting the future of suicide prevention: A 2010 review of the National Strategy and Recommendations for the Decade Ahead. Prepared by the Suicide Prevention Resource Center (SPRC) and Suicide Prevention Action Network USA (SPAN USA), August 2010, pg. 38.
5. "People with Severe Mental Illness 12 Times More Likely to Commit Suicide." Viewed at http://www.sciencedaily.com/releases/2010/12/101206161740.htm.