ICRC-S

Injury Control Research Center for Suicide Prevention

The Intersection of Suicide Research and Public Health Practice: Laying the Foundation for Partnership

Presenters: Eric D. Caine, M.D. and Elly Stout, M.S.
Moderator: Ann Marie White, Ed.D.

Audio will begin at 2:00PM ET

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Meeting Orientation

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The Intersection of Suicide Research and Public Health Practice: Laying the Foundation for Partnership

Ann Marie White

Polls


Suicide Prevention Research
Activities & Priorities
Injury Control Program
Activities & Programs
Suicide Prevention Research
Activities & Priorities
Injury Control

Challenges for Suicide Prevention 2013

Eric D. Caine, MD

Injury Control Research Center for Suicide Prevention &

Center for the Study and Prevention of Suicide,

University of Rochester Medical Center, Rochester, NY;

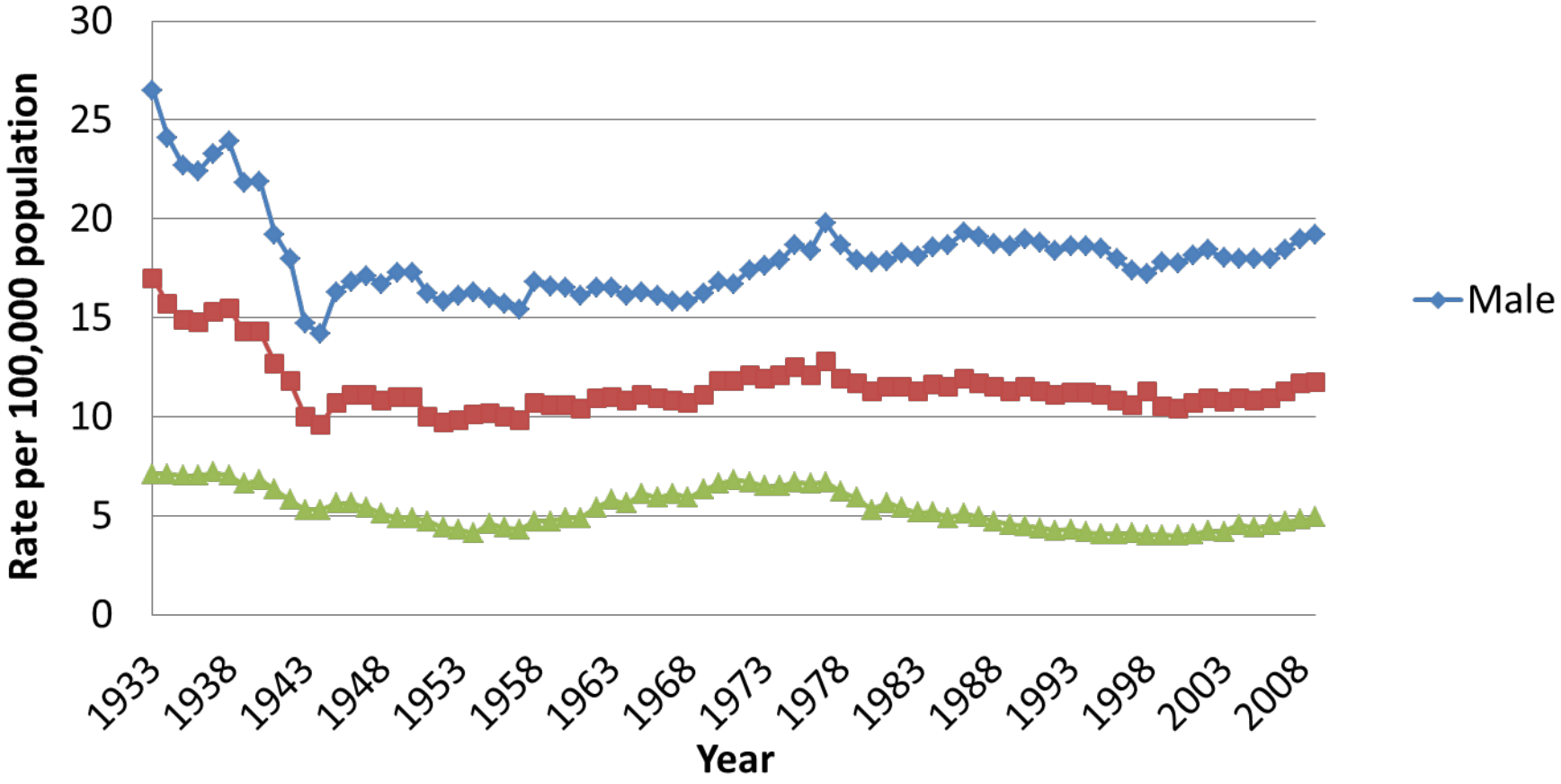
VA Center of Excellence for Suicide Prevention,

Canandaigua, NY

The conundrum….needles in the haystack!

- The suicide rate of *~12 per 100,000 per year* in the general population = 0.12 per 1000, or 0.012 per 100. That means probabilistically, you can say with ~99.9% likelihood that no person from the general population will kill him/herself imminently.
- If the suicide rate is *~500 per 100,000* among clinically depressed people, it is ~5 per 1000, or ~0.5 per 100 depressed individuals. That means probabilistically, you can say with ~99.5% likelihood that no depressed person will kill him/herself imminently.

Suicide among all persons by sex – United States, 1933-2009



Source: CDC vital statistics

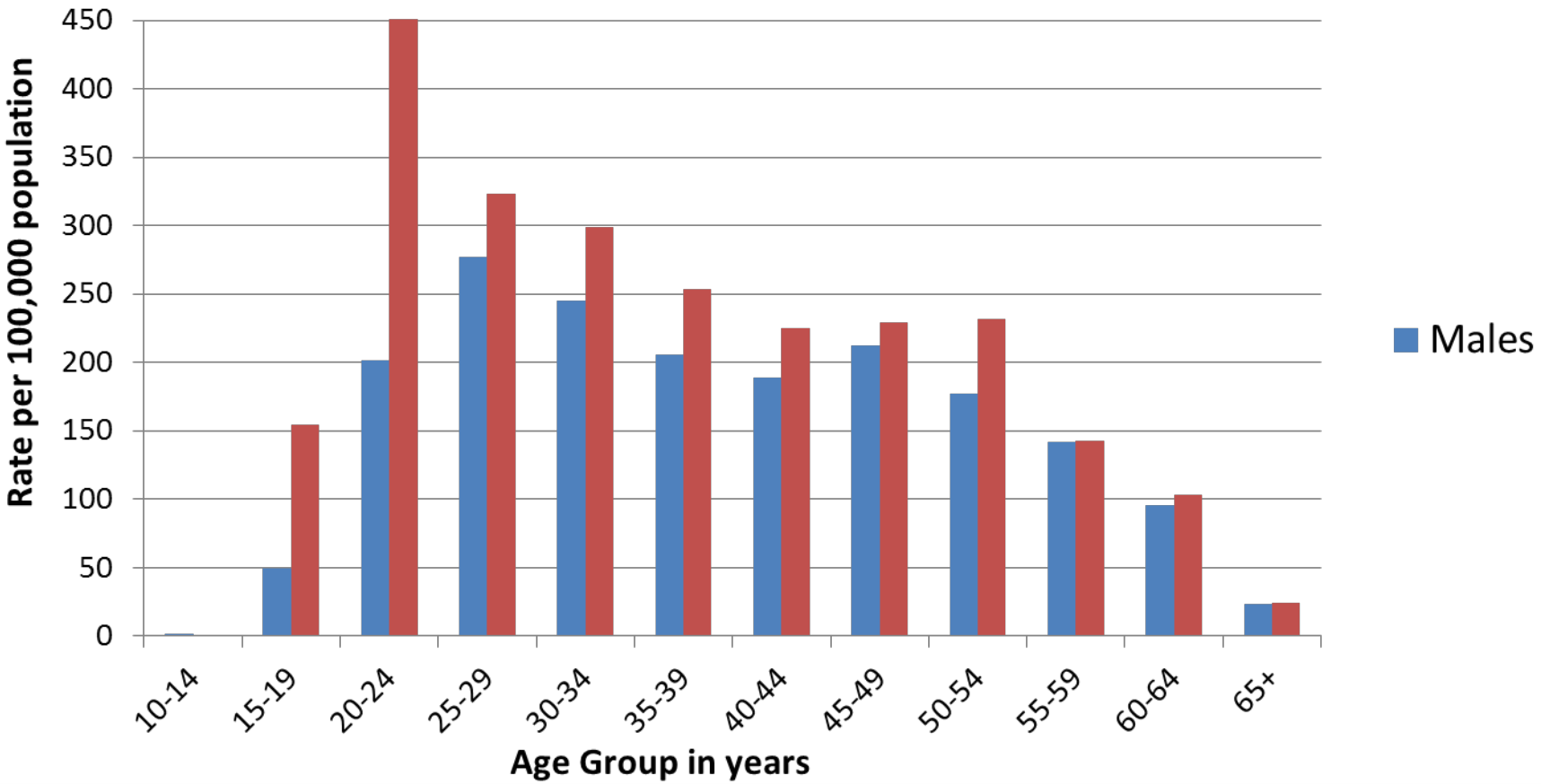
Provided by Crosby, US CDC

CHALLENGE 1. An inability to discriminate the relatively few true cases from the numbers of **'FALSE POSITIVE'** cases.

"Risk Factors" for suicide do not predict outcomes!

- Suicide "risk factors" were derived *retrospectively* using psychological autopsy methods.
- There were not prospective or hypothesized.
- Common features cannot predict rare events! When someone has all of the risk factors, the chances of suicide are *very small*.
- Suicide "risk factors"are *clinical features, and perhaps, contributing factors*.

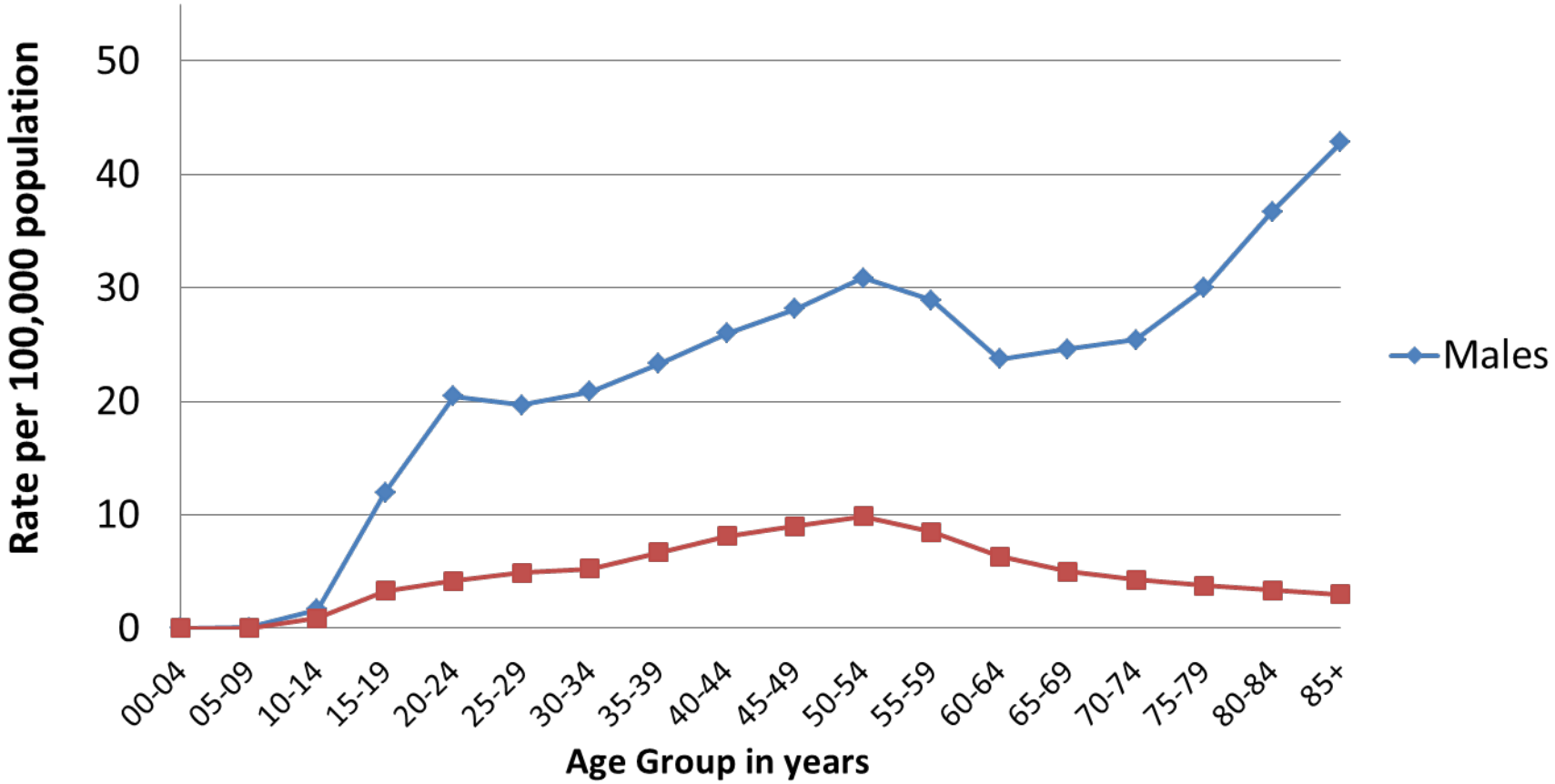
Self-inflicted injury among all persons by age and sex – United States, 2010



Source: CDC WISQARS NEISS

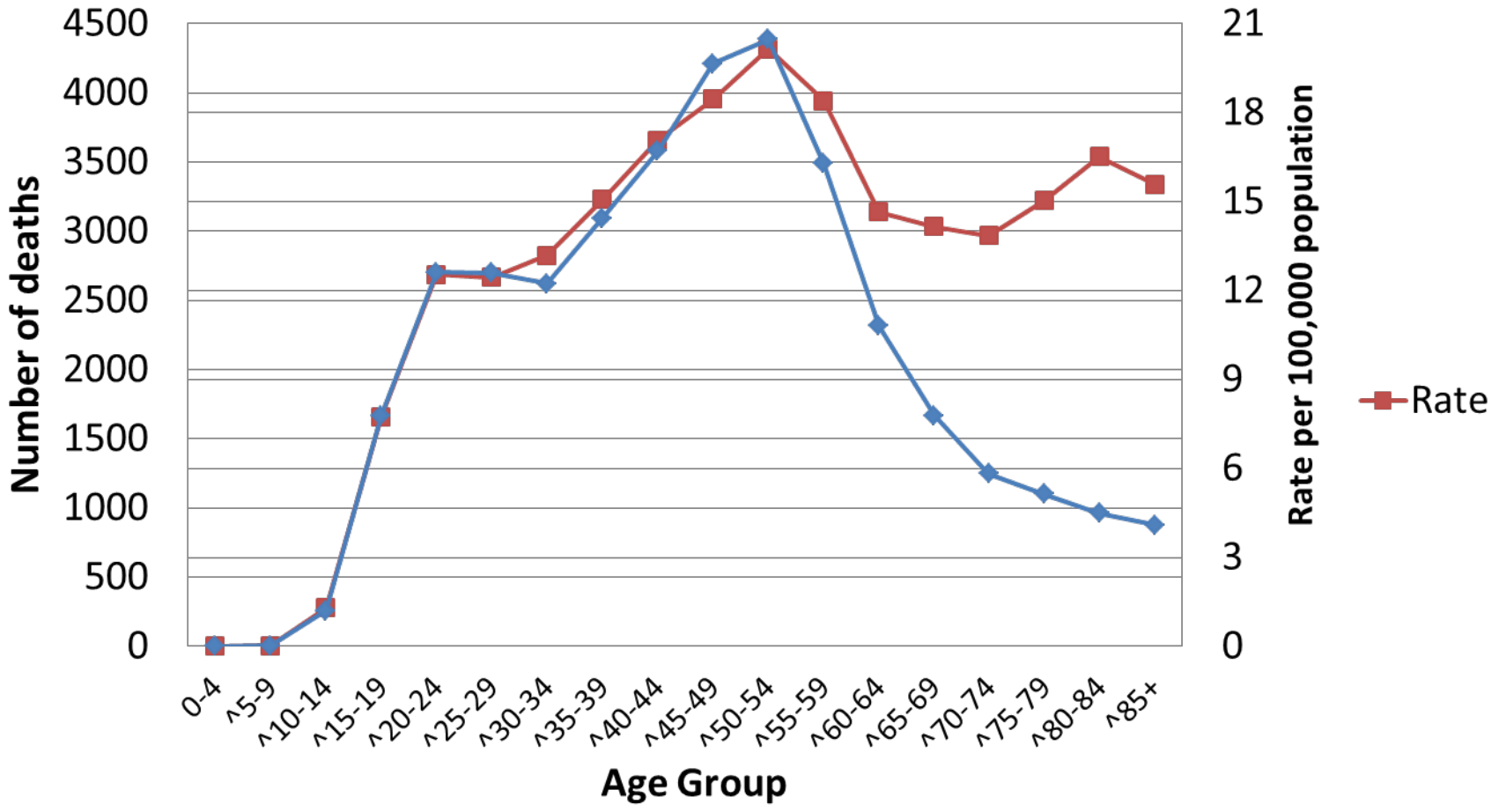
Provided by Crosby, US CDC

Suicide rates among all persons by age and sex – United States, 2009



Source: CDC vital statistics Provided by Crosby, US CDC

Suicides and suicide rates among all persons – United States, 2009



Source: CDC vital statistics

Provided by Crosby, US CDC

The Language of Prevention applied to Suicide and Attempted Suicide – *Indicated*

Intervention terminology	Approach	Target	Objectives	Examples of potential prevention efforts
Indicated Preventive Interventions ("Proximal" Prevention Efforts)	High Risk	Identify ***high-risk individuals with detectable symptoms.*** Future: Include asymptomatic individuals bearing defined risk markers.	Treat individuals with precursor/ prodromal signs and symptoms to prevent emergence of full- blown disorder.	1) Increase detection and treatment for depressed elders in primary care. 2) Lithium maintenance for persons with recurrent bipolar disorder. 3) Use targeted psychoRx to treat suicidal thoughts and behaviors. **4) Engage previously suicidal patients who could be 'lost' to care!**

The Language of Prevention applied to Suicide and Attempted Suicide – *Selective*

Intervention terminology	Approach	Target	Objectives	Examples of potential prevention efforts
Selective Prevention Interventions	High Risk	Identify ***groups*** bearing a significantly higher-than-average risk of developing mental disorders, substance use disorders, and adverse outcomes.	Prevent disease through addressing population-specific characteristics that place individuals at higher-than-average risk	1) Community programs contact isolated elders. **2) Court-based programs:** (a)Provide services support for *safety planning* to victims of domestic violence. (b) Deploy engagement interventions for criminal defendants with substance use disorders. 3) Vigorously treat elders with chronic pain syndromes and functional limitations.

Preventive (selective) and therapeutic (indicated) interventions for people with "risk factors" are clinically indicated and highly desirable.

However, *it has yet to be demonstrated that these efforts reduce deaths due to suicide*.

CHALLENGE 2. The large numbers of **'FALSE NEGATIVE'** individuals who escape preventive detection or disappear from clinical settings before killing themselves.

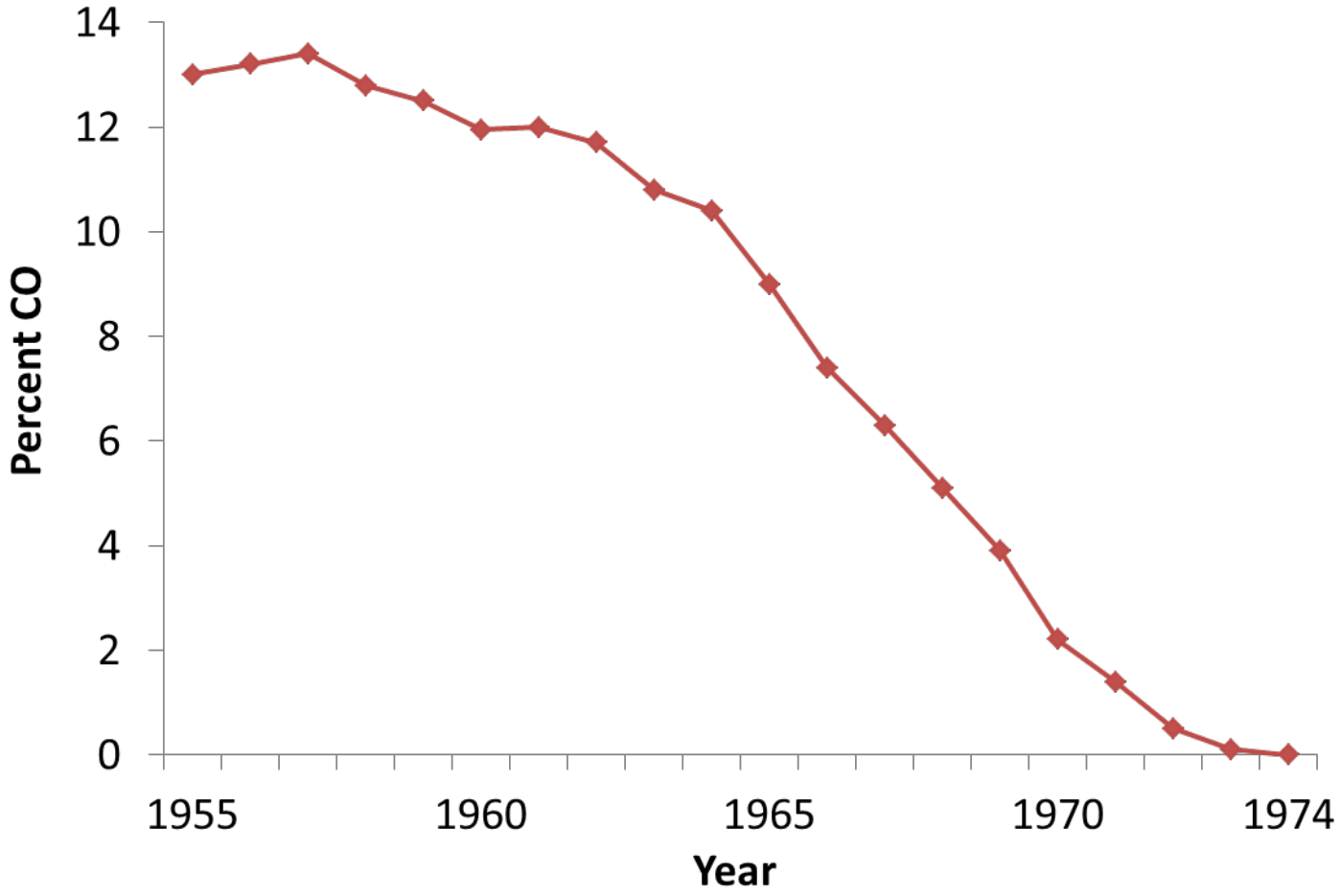
The Language of Prevention applied to Suicide and Attempted Suicide – *Universal*

Intervention terminology	Approach	Target	Objectives	Examples of potential prevention efforts
Universal Prevention Interventions ("Distal" Prevention Efforts)	Population	Implement sweeping, **broadly directed initiatives to entire populations, not based upon individual risk.** Develop programs that reach asymptomatic individuals.	Prevent disease through reducing risk, and enhancing protective or mitigating factors across broad groups of people.	1) **Means Restriction** (firearm safety, pill packaging, bridge barriers) 2) Alcohol & substance use prevention & control 3) Develop effective violence reduction programs among men, ages 16-34 years. 4) **Hotlines** to enhance access to care 5) Remove insurance barriers & other impediments to treatment

The Coal Gas Story

(Kreitman, 1976)

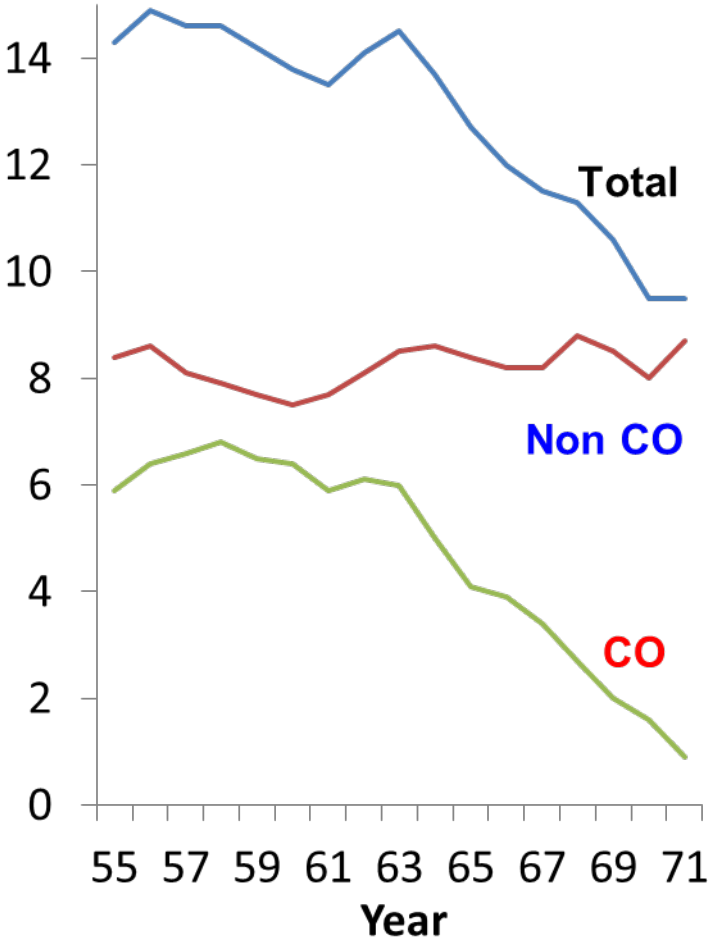
Percentage of CO in domestic gas, United Kingdom 1955-74

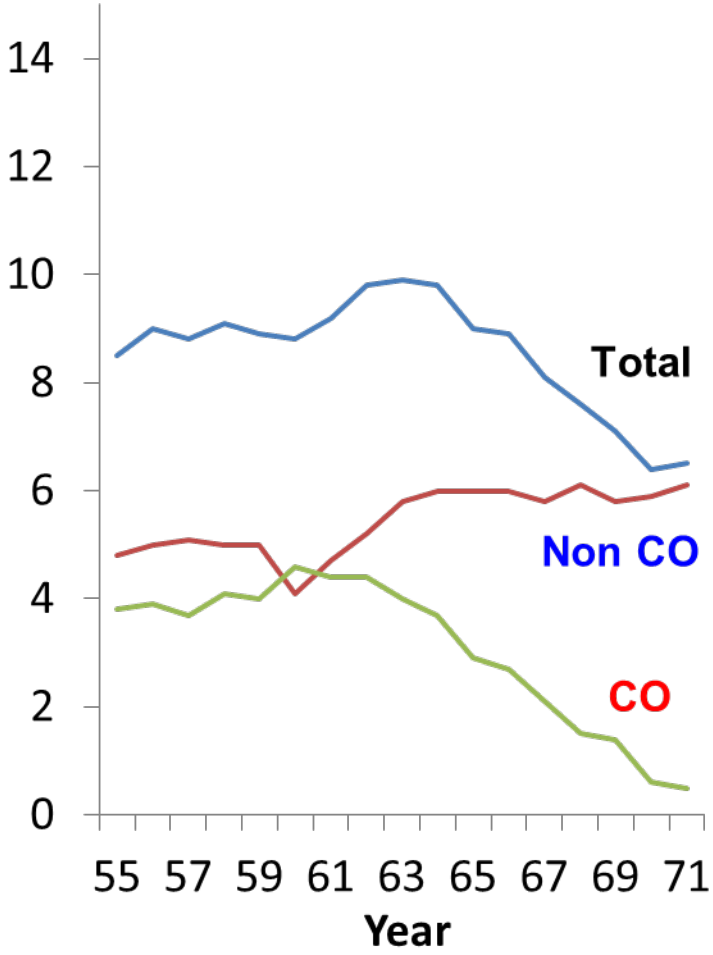


The Coal Gas Story

(Kreitman, 1976)

Sex-specific suicide rates by mode of death: England & Wales





***Means matter* and so does means restriction!**

Major national trends vary with the availability of new or different methods, and means restriction can occur at a level where the impact of 'detection failure' is mitigated.

The application and impact of means restriction are limited by ecological factors (e.g., hanging; jumping from buildings) and social forces (e.g., firearm access in USA).

Challenge 3. The inability of clinical and social service providers to **REACH** many potentially lethal individuals. They live beyond the walls of the clinical world (…in which we work).

Two fundamental differences between selective & indicated preventive interventions and clinical treatments!

1. Public health preventive interventions ***reach into communities to find and engage those who require treatment.*** They do not wait for patients to come to the door of the clinic.

2. To be most effective, public health approaches should involve 'co-owning' community partners.

Site – Population Approaches (social geography)

Sites	Populations potentially captured	Populations likely to be missed
Middle and High Schools	Adolescents attending school	School dropouts; youth in legal trouble
Universities	Vulnerable individuals with new onset or recurrent mental disorders	Young adults not pursuing further education, or unemployed
Organized Work Sites	Those employed in organized work sites, men and women in the middle years	Workers in small businesses, union/hiring halls, day labor, unemployed workers, immigrant and migrant labor, day labor, underground workers
Medical Settings	Those with health insurance; those that are willing to access traditional medical settings	Un/under insured; low "utilizers" of health care (men); utilizers of nontraditional health care
Community NGOs (e.g., United Way)	Those targeted for service by the NGO funding source; those in private homeless shelters	Anyone outside perceived scope of agency
Religious/Faith Organizations	Those who attend on a regular basis	Non-participants and those that drop out

Site – Population Approaches (social geography)

Sites	Populations potentially captured	Populations likely to be missed
Courts/Criminal Justice/Jails	Perpetrators/victims of domestic violence, probationers, prisoners	Failure to gain access for mental health and chemical dependency services for those identified through CJ settings
Local Government Agencies	Recipients from County-level social service and health departments; those in homeless shelters, county supervised housing; government food banks	Those who do not access services from local Health Dept clinics or Department of Social Services
State Government Agencies, Medicaid	Unemployed workers seeking services, the mentally ill in state housing; state operated mental health centers and clinics, including high risk populations such as SMI and CD patients in clinics; Medicaid recipients	Chronically unemployed, migrants not eligible for services
Federal Agencies, Medicare, Social Security, in collaboration with States—REGULATORY IMPACT	Elders, Medicaid recipients, high risk families	Broad swaths of the general population – e.g., people living in underserved rural & urban areas

High-risk Groups and Sites to Contact Them (tracking social ecology)

High-risk groups	Sites	Potential interventions	Comments
High Risk Youth— "drop outs," violent youth, & foster care youth	Community centers, police, jails, foster services; alternative schools	Comprehensive family and youth services, integrated across community and gov't systems	**Missed in schools**; requires careful integration and coordination not evident in most communities; funding issues central, including insurance barriers
People with severe, persisting mental disorders	Mental health treatment settings; courts, jails, prisons,	Fostering of early interventions; assertive community treatments; linkages among courts, clinics, and other agencies	Available medication interventions must be embedded into comprehensive systems of care and assertive community follow-up; "Project Link" example—coordination of housing, courts, and mental health settings critical to success
Men with alcohol and substance disorders; perpetrators of domestic violence; victims of DV	CD treatment settings; courts & jails	Integration of mental health and prevention services into CD programs; court integrated mental health services	Dependent on development of integrated MICA services; rapid access to care for those in need crucial; insurance barriers are paramount obstacle

High-risk Groups and Sites to Contact Them (tracking social ecology)

High-risk groups	Sites	Potential interventions	Comments
Depressed Women and Men	Primary care settings	Enhanced detection, treatment, and follow up of emerging symptoms	Requires education of care providers re recognition and treatment; subsyndromal conditions important
Elders with Pain, Disability, Depression	Primary care offices, residential settings; Agency on Aging outreach programs	**Pre-emptive treatment of pain and increasing medically related disability**	Can miss socially isolated elders and elders who do not express their needs openly
Suicidal people—may be counted as well among other groups, but also include patients with personality d/o, varying mood disturbances, and CD problems	ERs, ICUs, inpatient psych. and medical services – ***need for novel approaches to case identification and follow-up***	Community outreach for contacting "no-shows," reminder cards, assertive case management; surveillance as case identification	Those high in ideation and attempts in the context of personality disorders often are 'frequent fliers' to ERs who fail to use standard systems of care; major ethical questions; INSURANCE BARRIERS ARE PARAMOUNT OBSTACLE

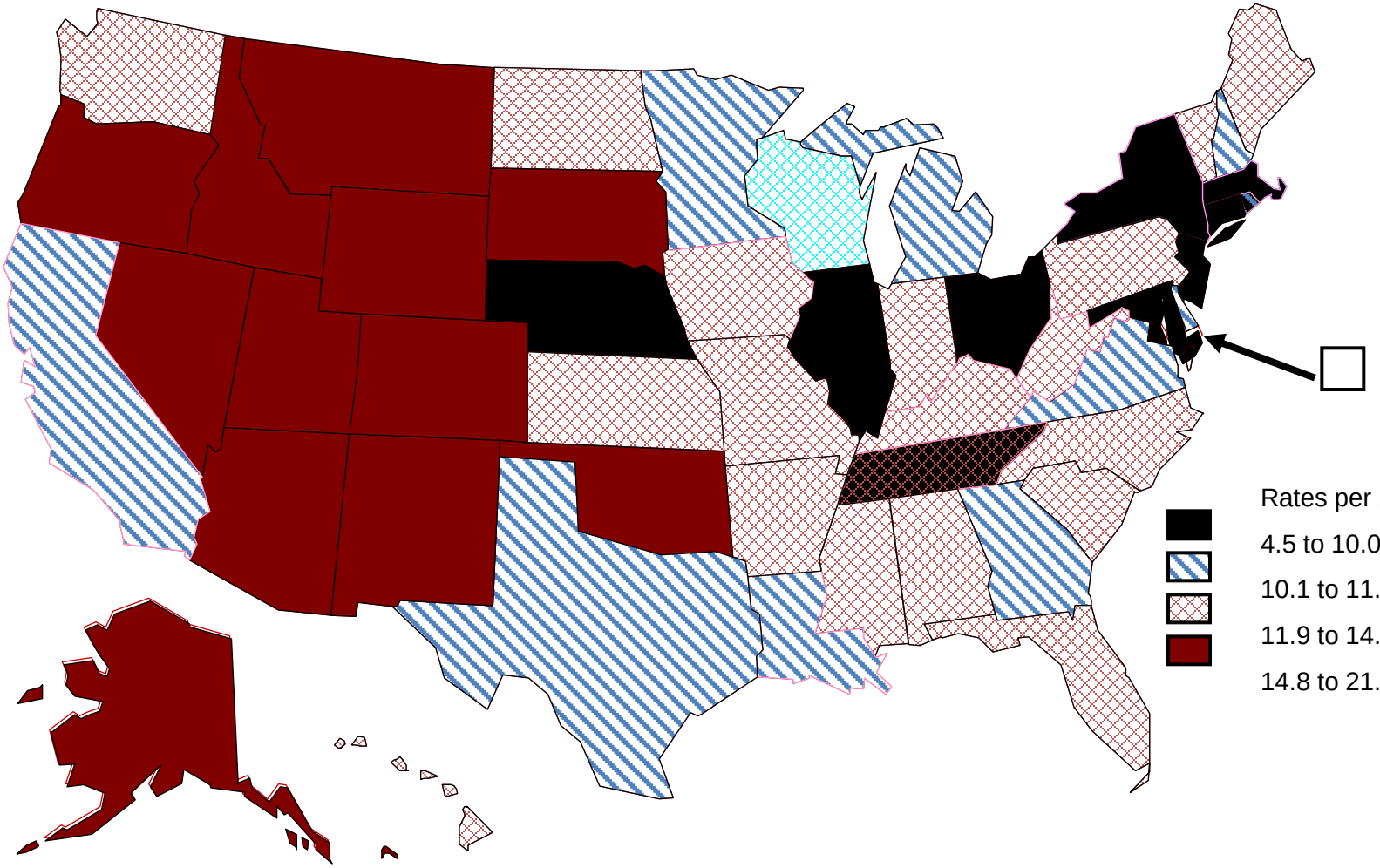
Mosaic…

…is the art of creating images with an assemblage of small pieces of colored glass, stone, or other materials. Small pieces, normally roughly quadratic, of stone or glass of different colors…are used to create a pattern or picture.

Suicide prevention efforts must form a ***mosaic*** built within the contexts of local ***geography*** and the ***social ecology*** of populations – and individuals—as well as their families and their communities. ***This mosaic cannot be built or effectively sustained outside the domains of people's lives!***

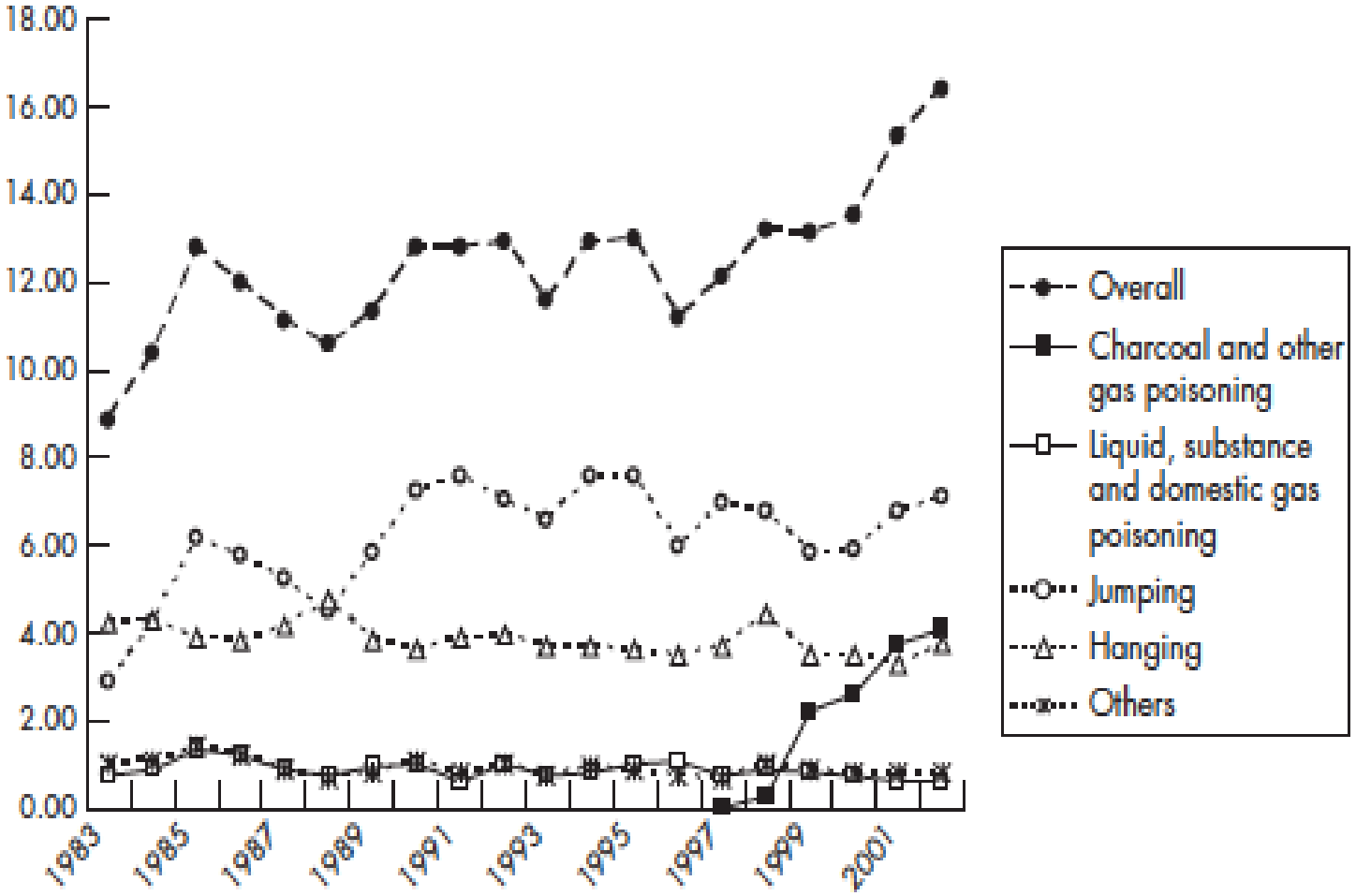
CHALLENGE 4. Insufficient knowledge & theory regarding the **psychological, biological, social, and cultural factors** that contribute to suicide risk among diverse populations and groups – varying according to age, race, gender and sexual orientation, residential geography, and socio-cultural and economic status. Lack of understanding how **protective** factors 'act' in the face of risks.

Age-adjusted suicide rates among all persons by state – United States, 2009 (U.S. avg 11.8)



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

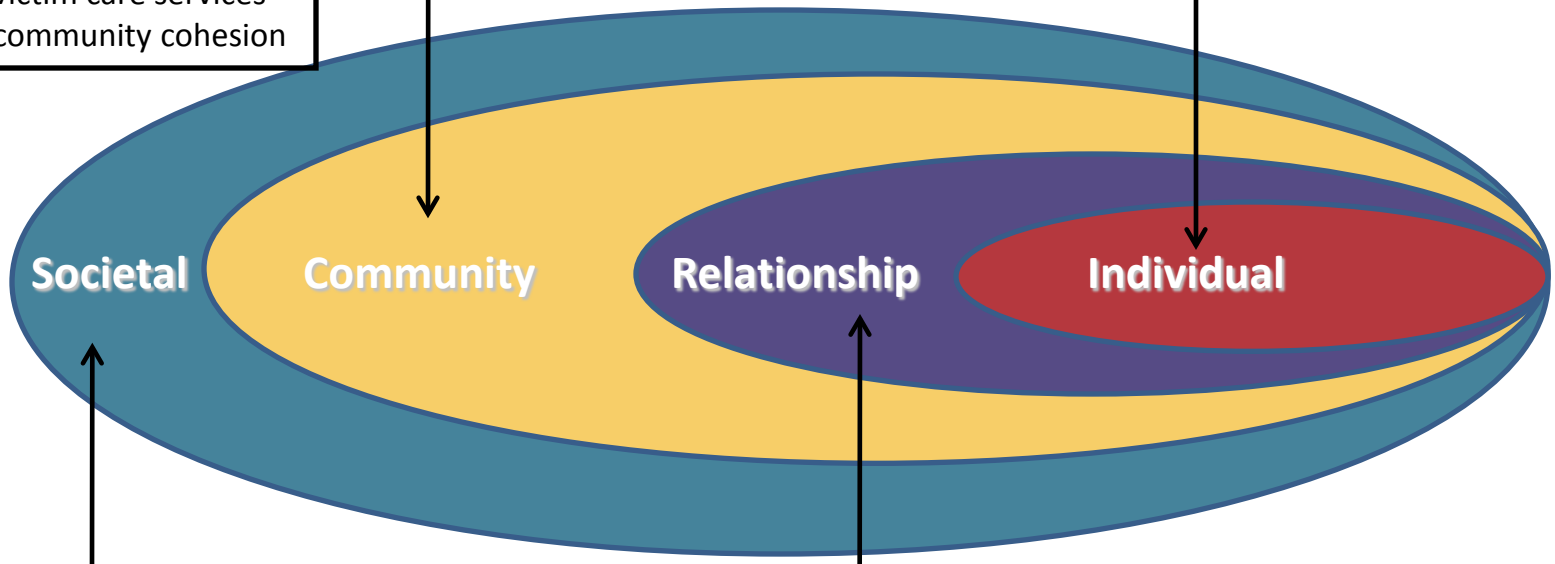
Overall and Method-Specific Suicide Rates, Hong Kong, 1983-2002 (Liu et al, JCEH 2007)



Ecological model: Shared risks for interpersonal violence and suicide in the United States (modified by Caine from Krug et al, eds: *World Report on Violence and Health.* WHO, 2002)

Poverty
High crime levels
High residential mobility
High unemployment
Local illicit drug trade
Weak institutional policies
Inadequate victim care services
Inadequate community cohesion

Psychological/personality disturbance (d/o)
Alcohol/substance abuse
Victim of child maltreatment or current abuse
Violent behavior—past or current
Suicidal behavior—past or current
Access to lethal means



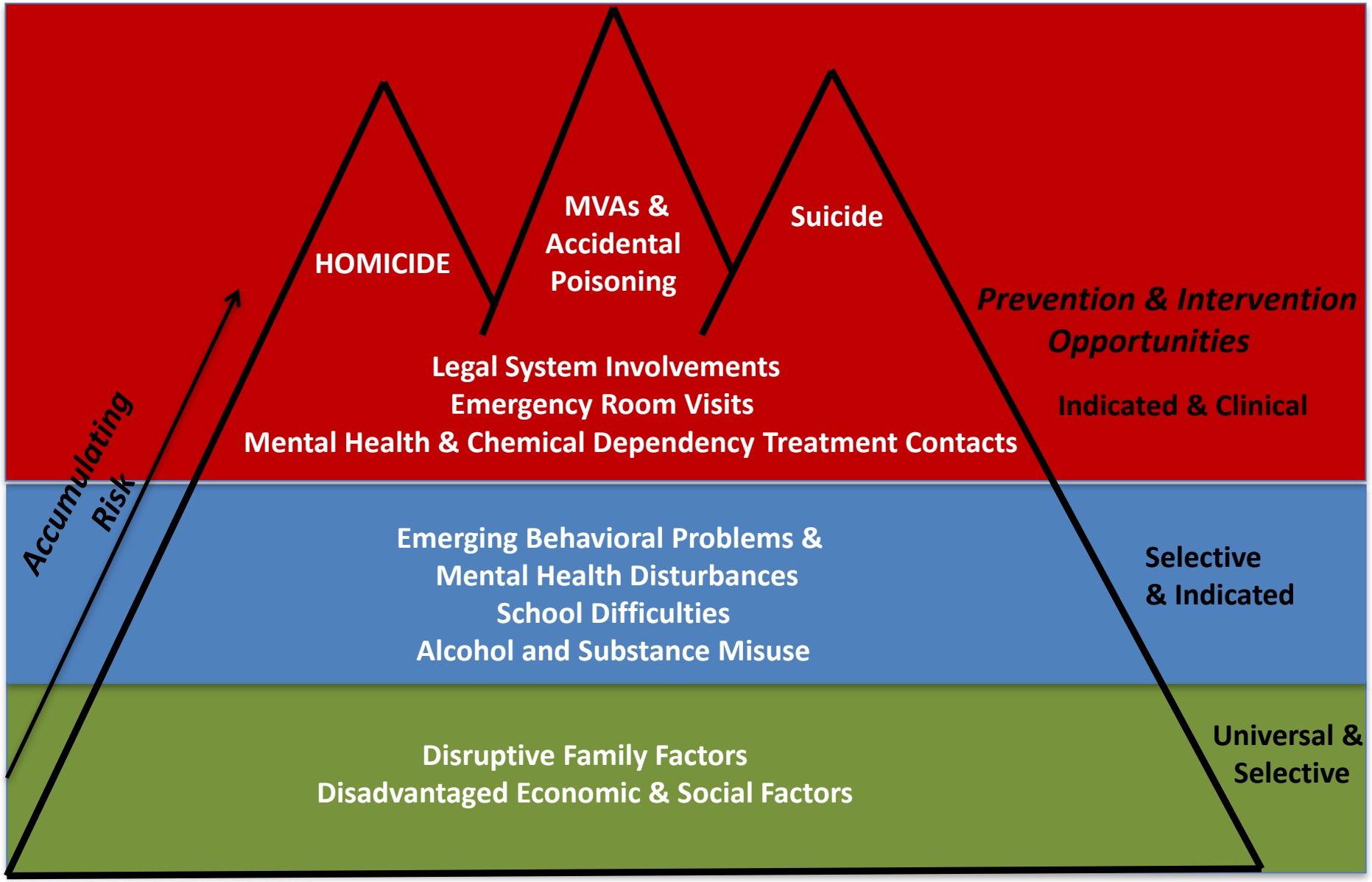
Unstable social infrastructure
Economic insecurity
Discrimination: gender; race; other
Policies that increase inequalities
Poverty
Weak economic safety nets
Cultural norms that support violence
Access to lethal methods (firearms)

Exposure to poor parenting or violent parental conflict
Fractured family structures
Family history of suicide
Current relationship/marital turmoil—participant in intimate violence
Financial, work stress; under- or unemployed
Friends & family that engage in violence

CHALLENGE 5. The **lack of coordinated strategies** of suicide prevention that can deal effectively with **myriad local, regional, state, and national agencies and organizations** that could, in theory, play a role in preventing suicide.

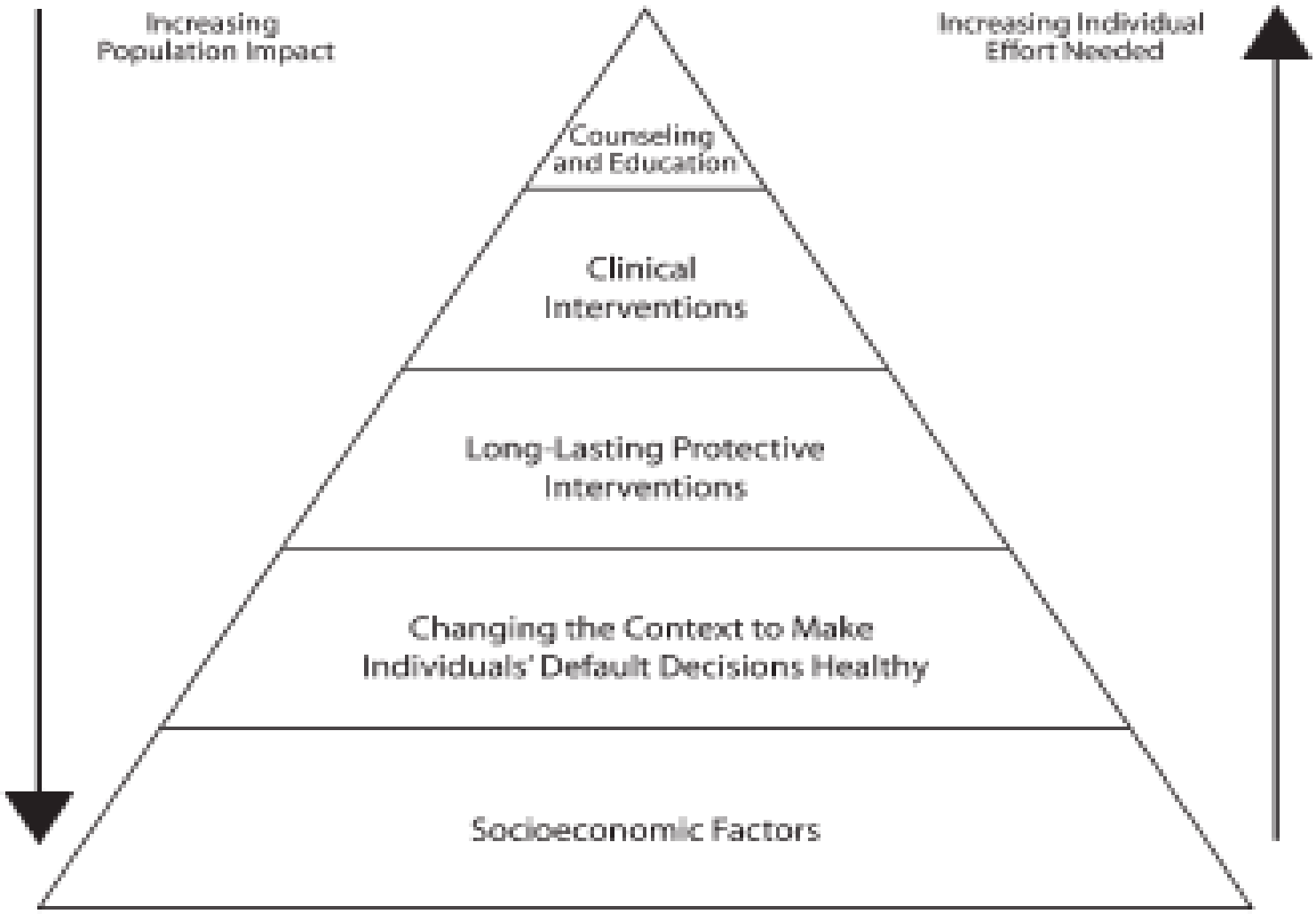
Premature Death in Early Adulthood

Common Developmental Contexts for Different Adverse Outcomes



Caine et al, 2011

The Health Impact Pyramid



Frieden TH: A Framework for Public Health—The Health Impact Pyramid. Am J Public Health 2010; 100:590-595.

Looking to the future: What will be the ***speed bumps*** for suicide prevention?

Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

ICRC-S

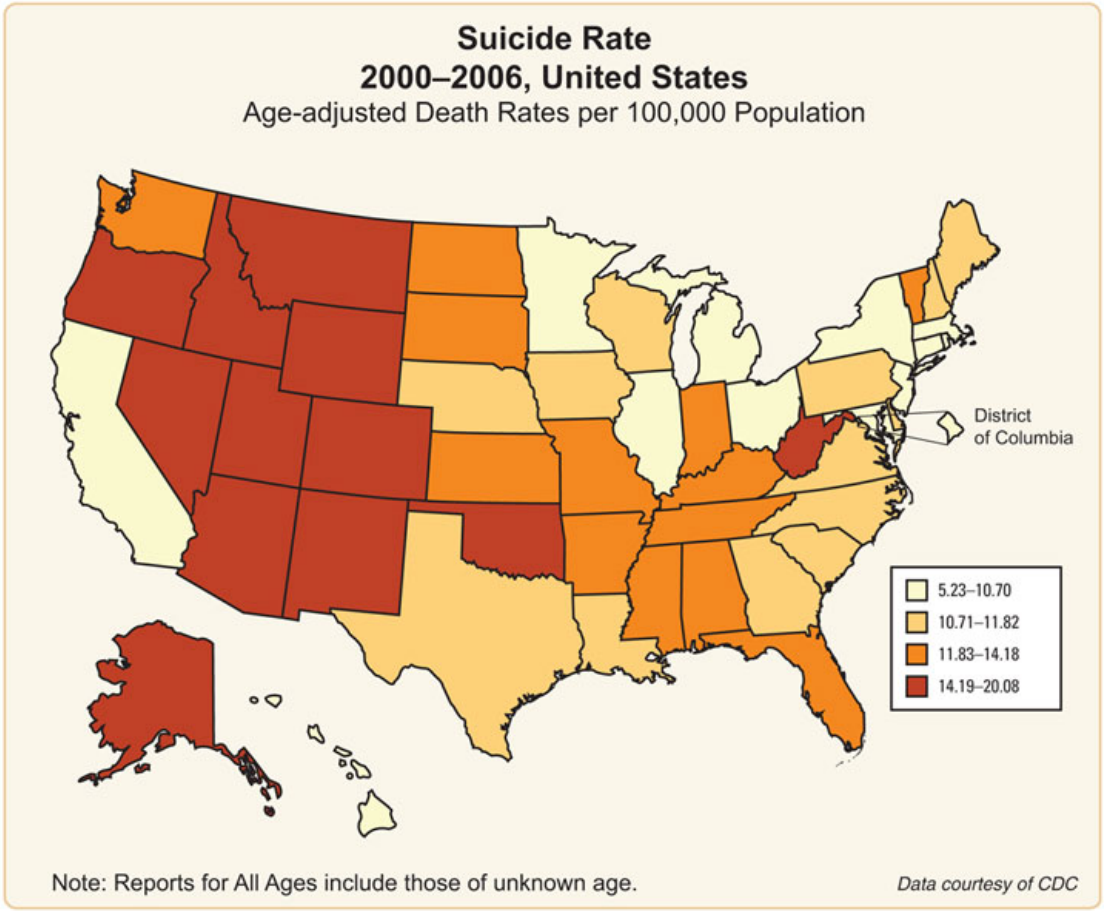
EDC Learning transforms lives.

SAMHSA

The Public Health Approach to Suicide Prevention

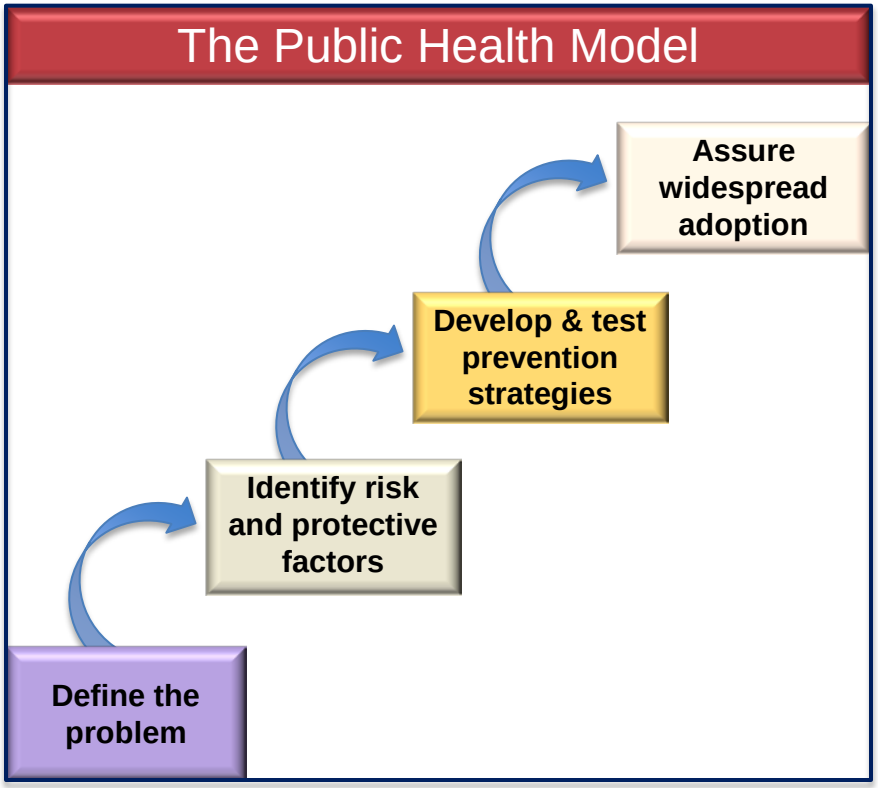
ICRC-S Webinar
January 9, 2013

Elly Stout, M.S.
Prevention Support Program Manager, SPRC

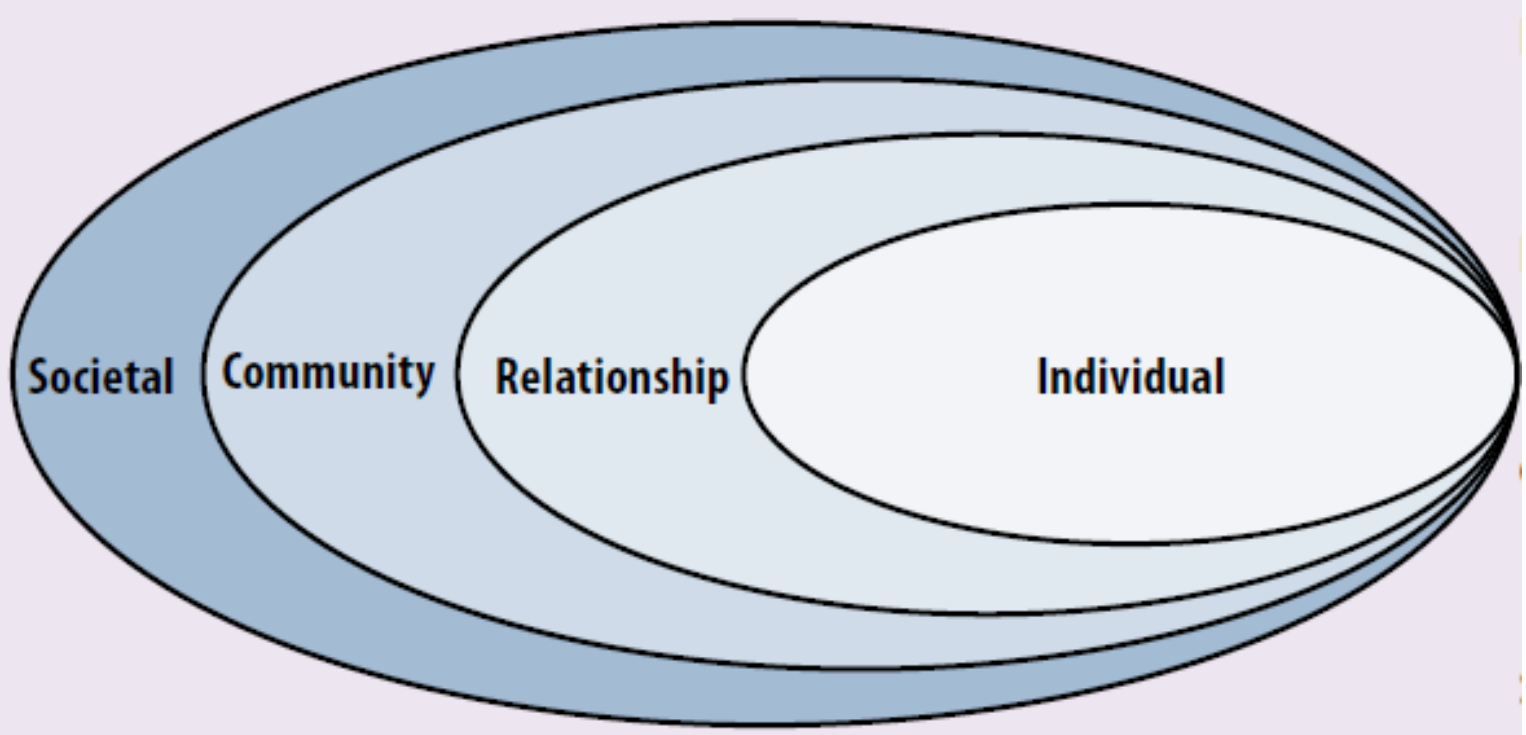


Key Elements of a Public Health Approach

- ✓ Population focus
- ✓ Starts and ends with data
- ✓ Primary, secondary, tertiary prevention
- ✓ Aim: reduce morbidity and mortality

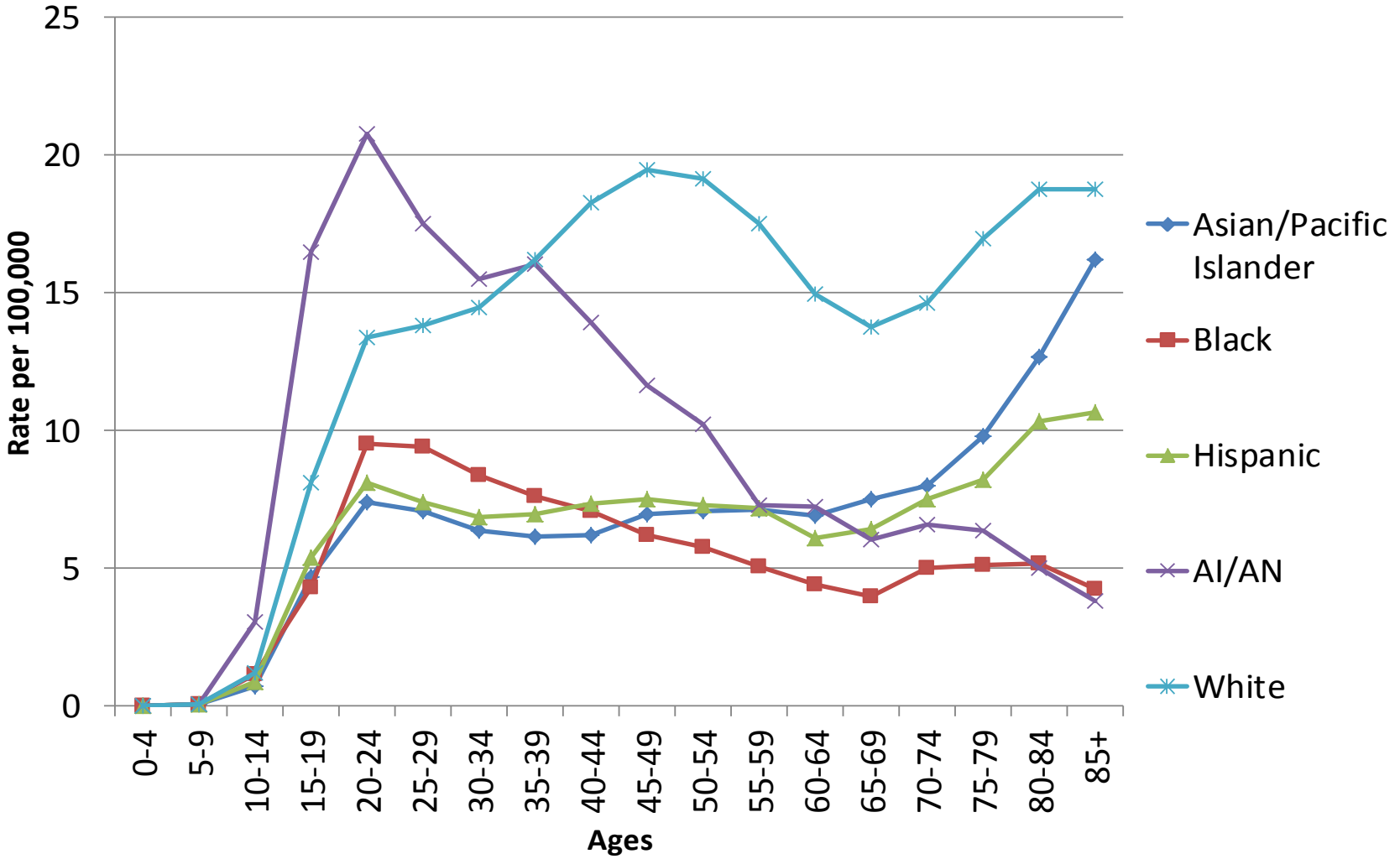


Beyond Individual Behaviors



Define the problem

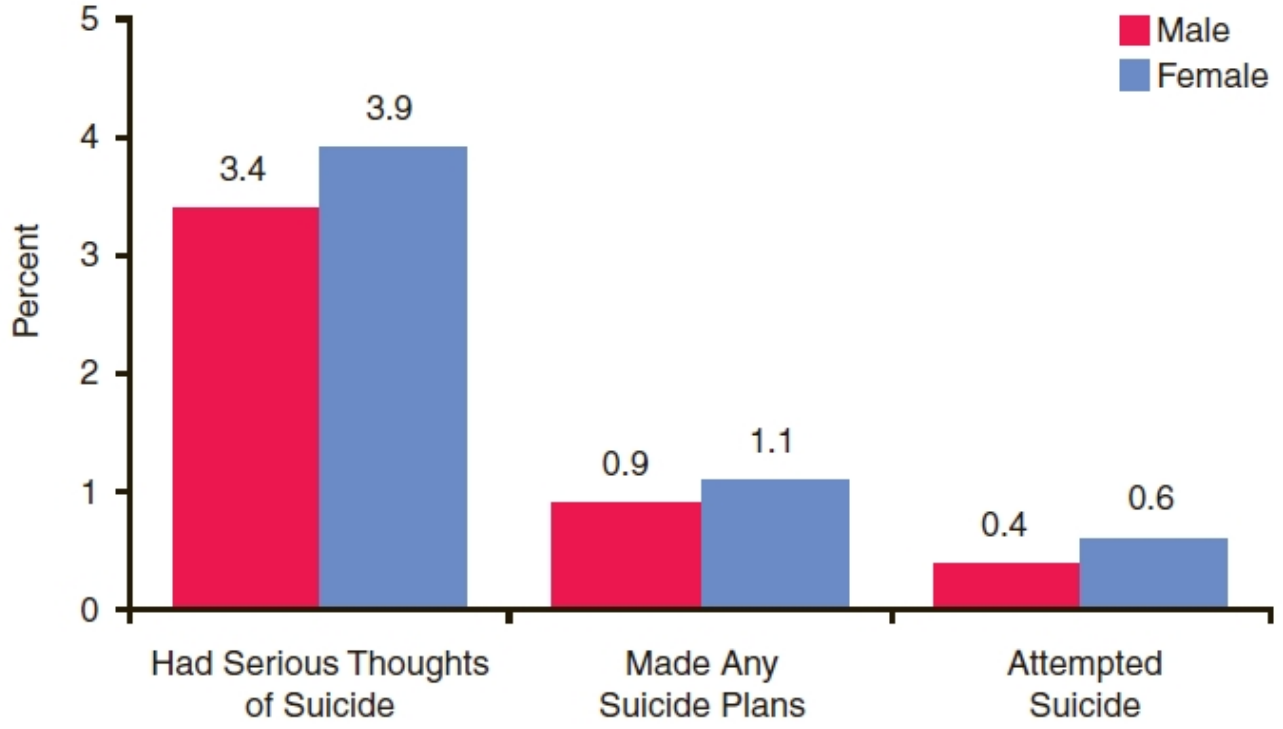
Suicide in the United States 2000-2010



Source: CDC WISQARS Fatal Injuries Report,2000-2010

Define the problem

Figure 2. Suicidal Thoughts and Behaviors in the Past Year among Adults, by Gender: 2008



Source: 2008 SAMHSA National Survey on Drug Use and Health (NSDUH).

Key high-risk groups

Define the problem

- ✓ Individuals in justice and child welfare settings
- ✓ Specific populations:
  - American Indian/Alaska Native
  - Lesbian, gay, bisexual, and transgender
  - Members of the armed forces and veterans
  - Men in mid-life
  - Older men
- ✓ Individuals who:
  - engage in non-suicidal self-injury
  - have been bereaved by suicide
  - have a medical condition(s)

Source: U.S. Department of Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action.* Washington, DC: HHS, September 2012.

Identify risk and protective factors

Risk and Protective Factors

Main Risk Factors

- Prior suicide attempt(s)
- Substance abuse
- Mood disorders
- Access to lethal means

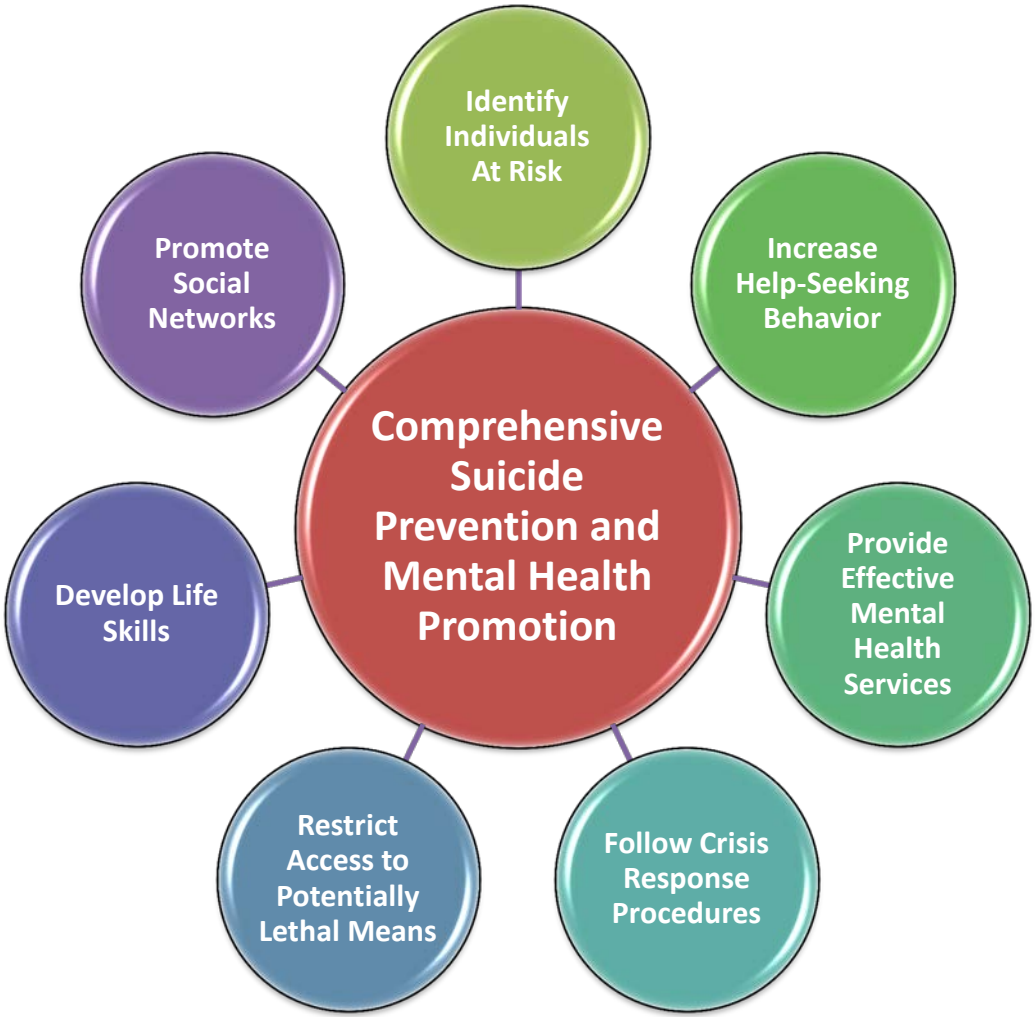
Main Protective Factors

- Effective mental health care
- Connectedness
- Problem-solving skills
- Contacts with caregivers

Source: SPRC & Rodgers, P. (2011). Understanding Risk and Protective Factors for Suicide: A Primer for Preventing Suicide. Suicide Prevention Resource Center, Inc.

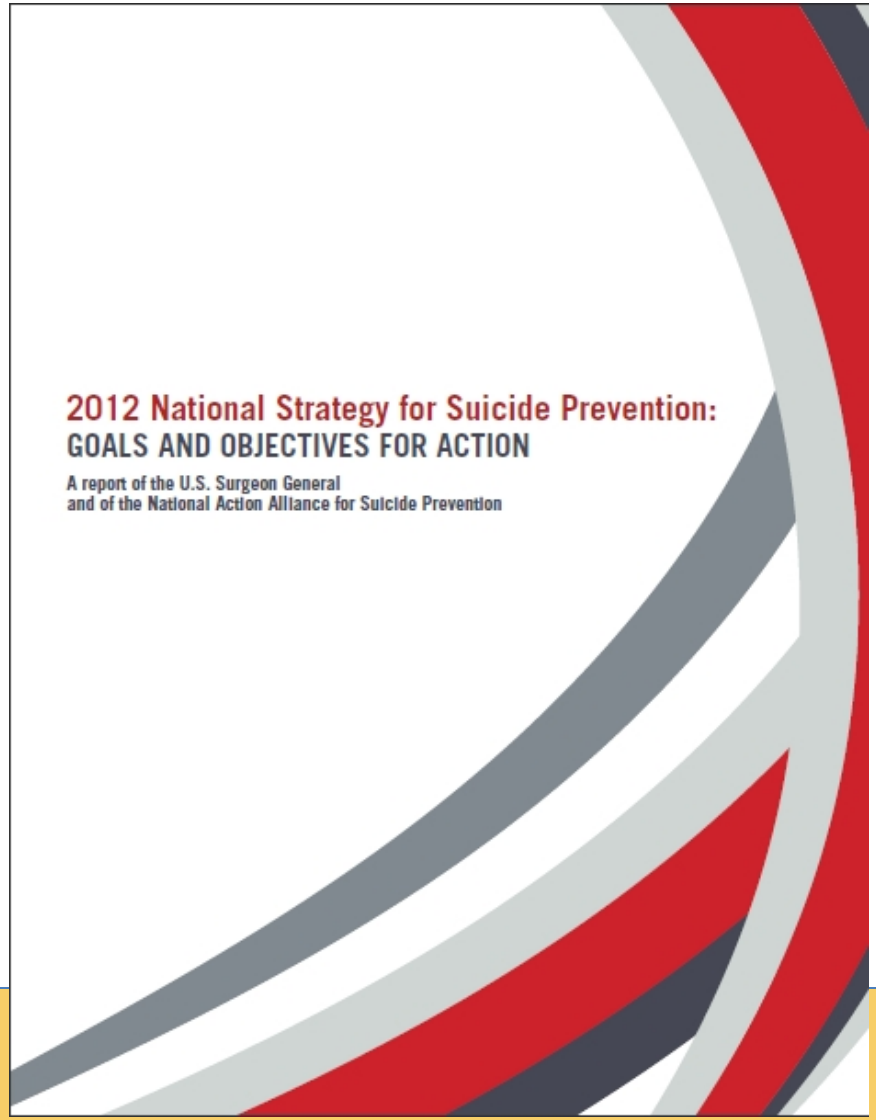
Develop & test prevention strategies

Suicide Prevention Strategies



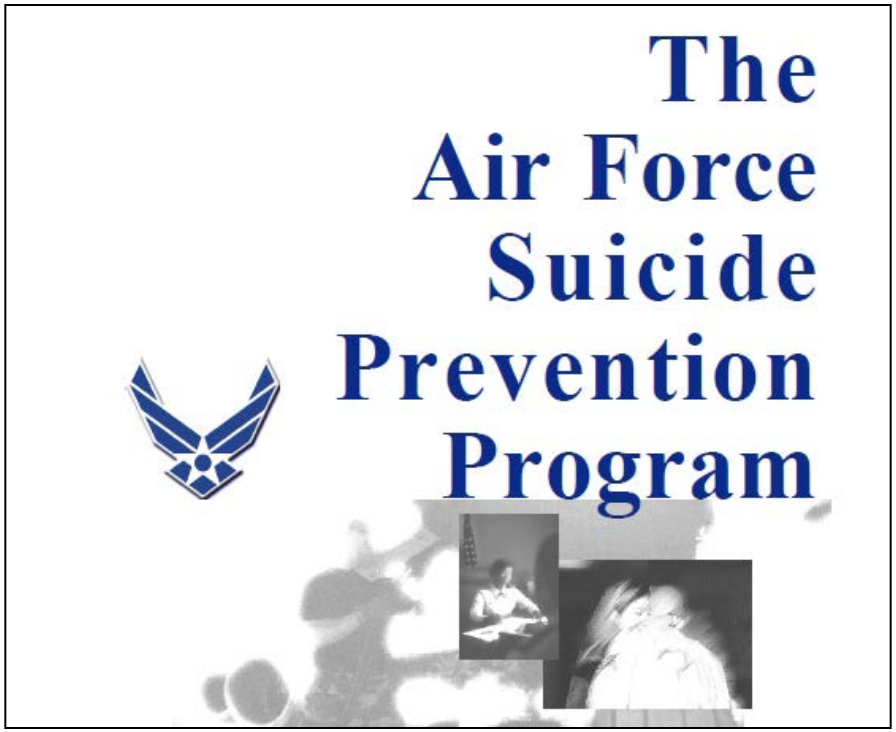
Develop & test prevention strategies

New National Strategy for Suicide Prevention

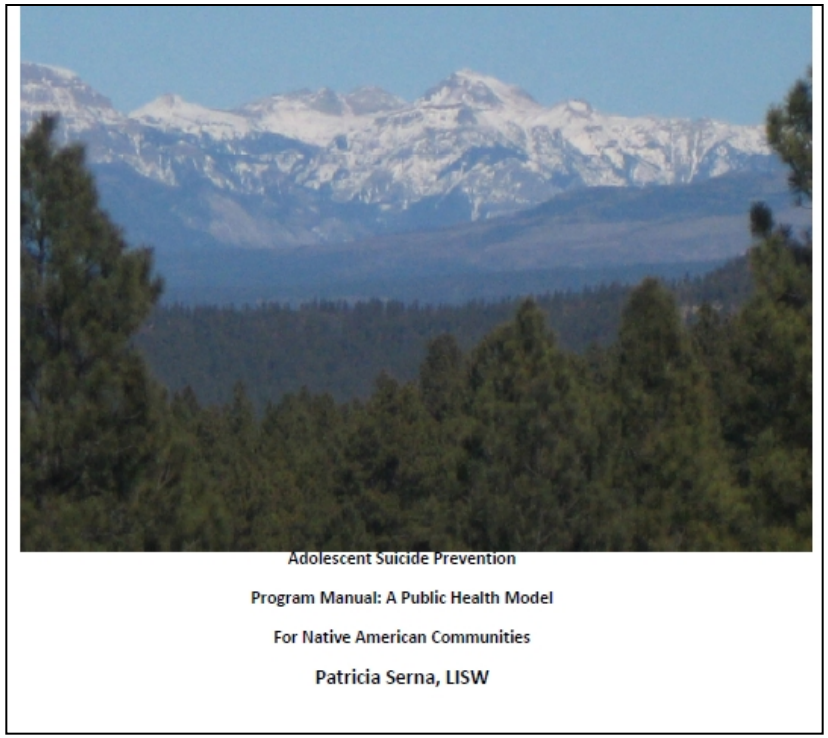


Evidence-Based Public Health Programs

Air Force Suicide Prevention Program



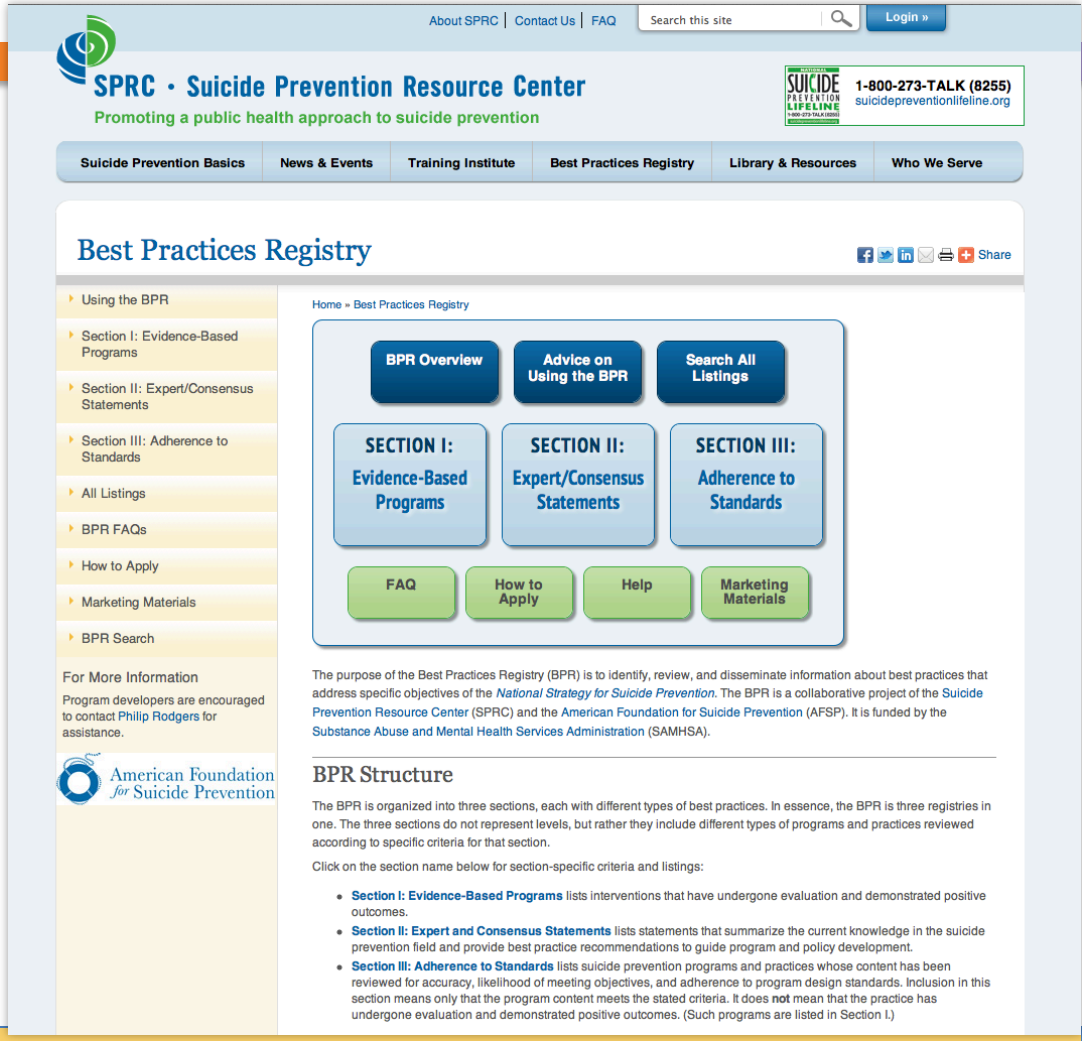
Model Adolescent Suicide Prevention Program



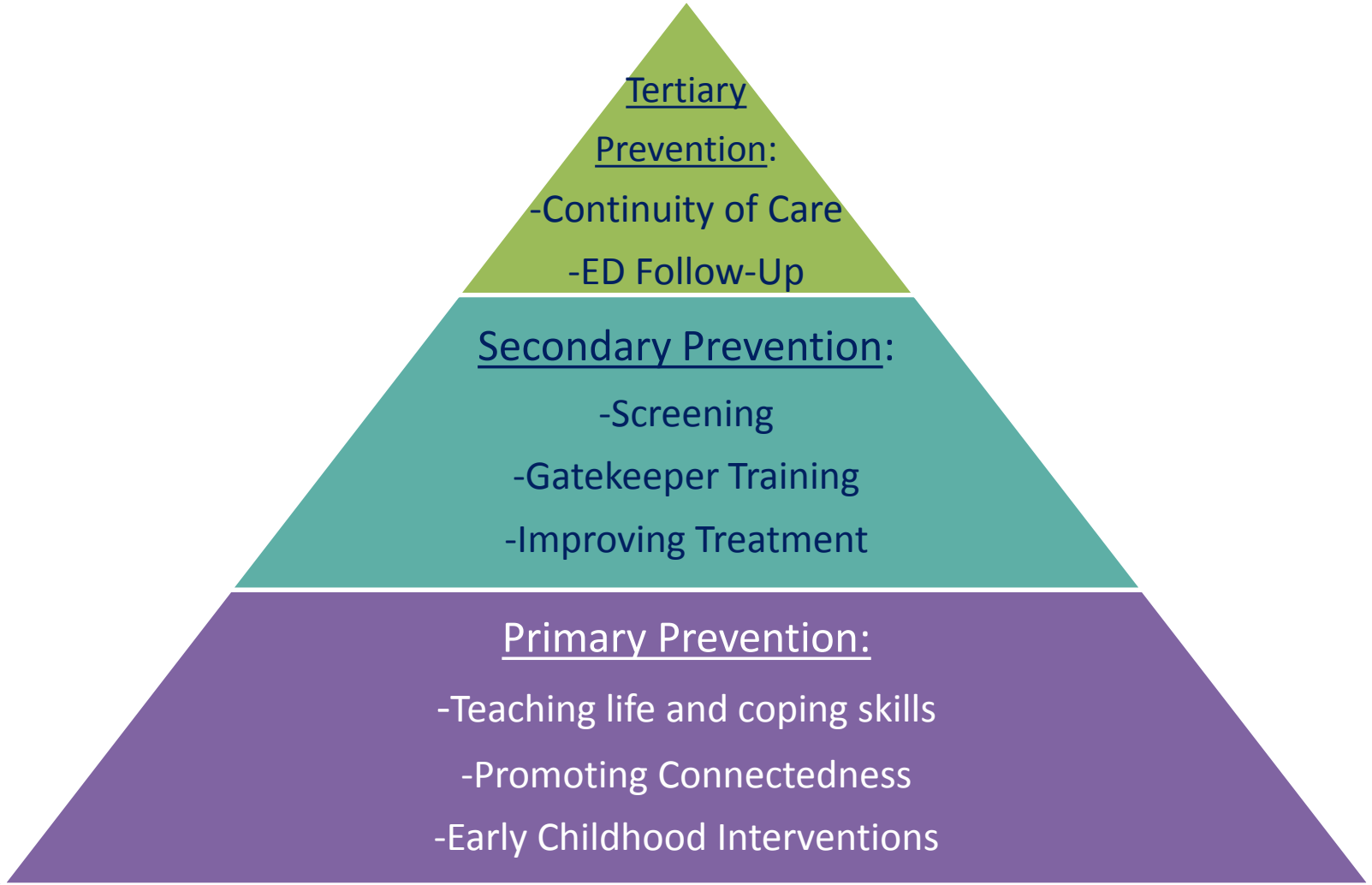
Assure widespread adoption

SPRC/AFSP Best Practices Registry

- ✓ Section I: NREPP (evidence-based)
- ✓ Section II: Consensus Statements
- ✓ Section III: Adherence to standards



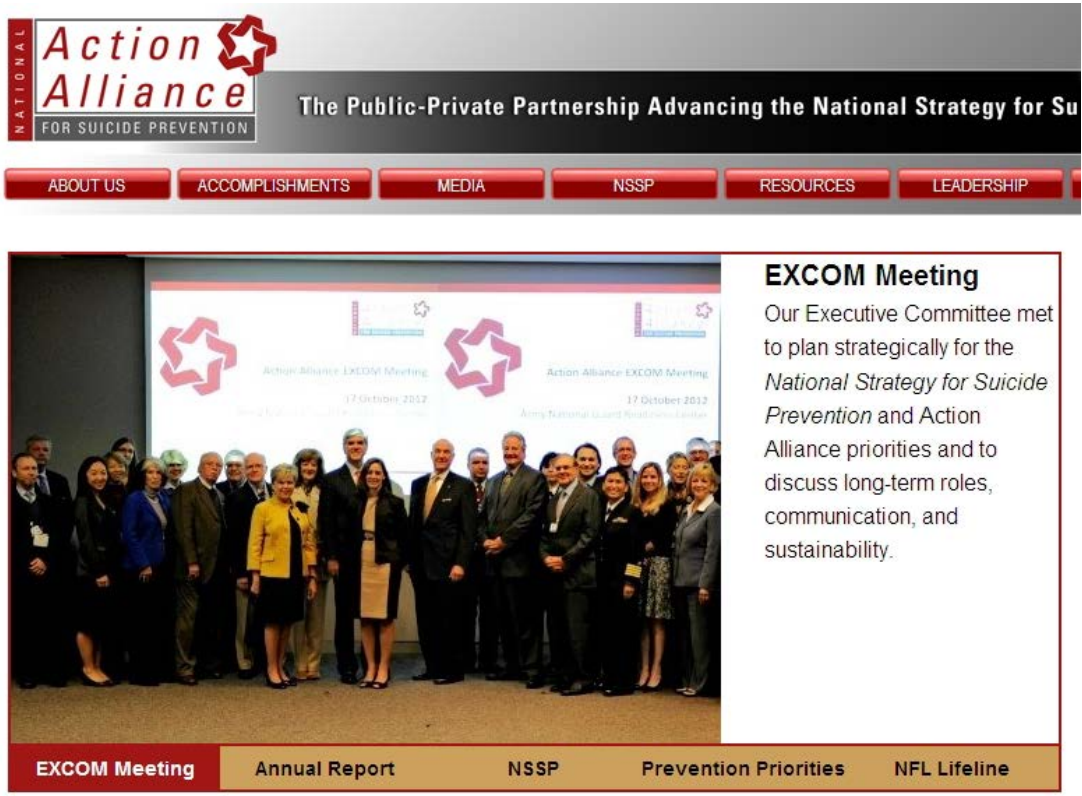
Public Health Intervention Levels



Collaboration in Suicide Prevention

"Each and every one of us has a role to play in preventing suicide and promoting health, resilience, recovery and wellness for all."

- NSSP, 2012



State and Local Efforts

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SPRC · Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

Suicide Prevention Basics | News & Events | Training Institute | Best Practices Registry | Library & F

Who We Serve

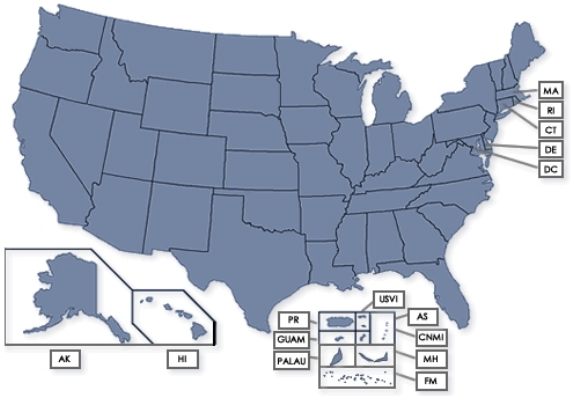
- For Professionals
- For Providers
- Grantees
- States & Communities
  - State Contacts
  - State Suicide Prevention Plans
  - Who's working on topics I care about?
  - From the Field
- American Indian/Alaska Native
- Colleges and Universities

Home » States

States and Communities

What's going on in my area?

Connect with state and local contacts, resources, events, and more. Click on a state or territory below to learn more.



Home » States » Montana

Montana

Website: Montana Office of Suicide Prevention

Materials

- Montana Strategic Suicide Prevention Plan
- EMS Community Planning and Integration Guide
- Montana State Hospital Policy and Procedure: Suicide Precautions
- Montana Suicide Survivor Support Groups

Organizations

NAMI Montana

Montana Children's Initiative
Phone: (406) 256-3585

Montana Chapter, American Foundation for Suicide Prevention
Contact: Joan Nye, Co-Chair
Phone: (406) 322-8587

Critical Illness and Trauma Foundation
Phone: (406) 585-2659

Recent Developments and Legislation

2011
The Office of Suicide Prevention has broadly distributed toolkits and resources to schools, primary care practices, senior living communities, cosmetologists, funeral homes, and colleges.

2011
The state has distributed over 4,000 gunlocks over the past two years to 7 county

Need Program Assistance?

Contact us for assistance with your suicide prevention efforts.

Upcoming Events

There are no current events available for this state.

View the full events calendar.

State Contacts

Questions about suicide prevention in this state? Contact:

Karl Rosston, LCSW
Suicide Prevention Coordinator
Montana Department of Public Health and Human Services
555 Fuller
P.O. Box 202905
Helena MT 59620
Email: krosston@mt.gov
Phone: (406) 444-3349

Emerging Issues in Suicide Prevention

- ✓ Upstream approaches
- ✓ 'Moving the needle'
- ✓ Integration/connection with health systems
- ✓ Safe and effective communications
- ✓ Building the evidence base
- ✓ Building partnerships across sectors

Resources

- ✓ Suicide Prevention Resource Center: www.sprc.org
- ✓ Best Practices Registry for Suicide Prevention: http://www.sprc.org/bpr
- ✓ National Action Alliance for Suicide Prevention: http://actionallianceforsuicideprevention.org/
- ✓ National Strategy for Suicide Prevention 2012: http://store.samhsa.gov/home (search for Suicide Prevention)

References

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- U.S. Department of Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012.

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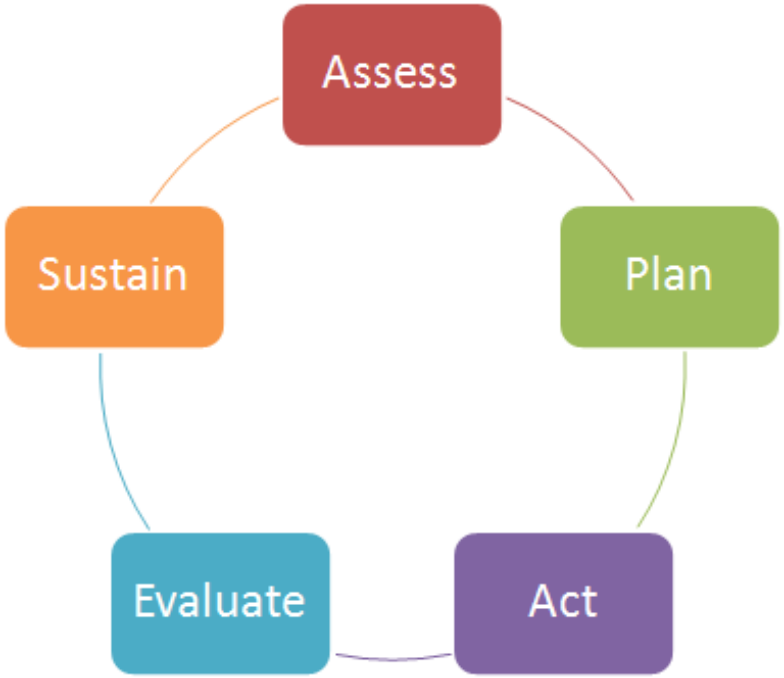
Summary

- Merits and Frameworks of a Public Health Approach to Suicide Prevention and Research
  - Ecological orientation
- Application
  - Collaboration
  - Partnerships between fields growing
- Current Challenges, Promising Directions, Pressing Questions
  - “Upstream” approaches as suicide prevention

Designing Effective Public Health Systems for Suicide Prevention: Collaboration and Partnership

A. Example Community Health Improvement Model



The Community Tool Box.
http://sitefinity.myctb.org/en/takingactioninthecommunity.aspx

B. Prevention System or Health Services Partnership Models Embedded in Science (e.g., Communities that Care, PROSPER, Centers of Excellence, etc.).

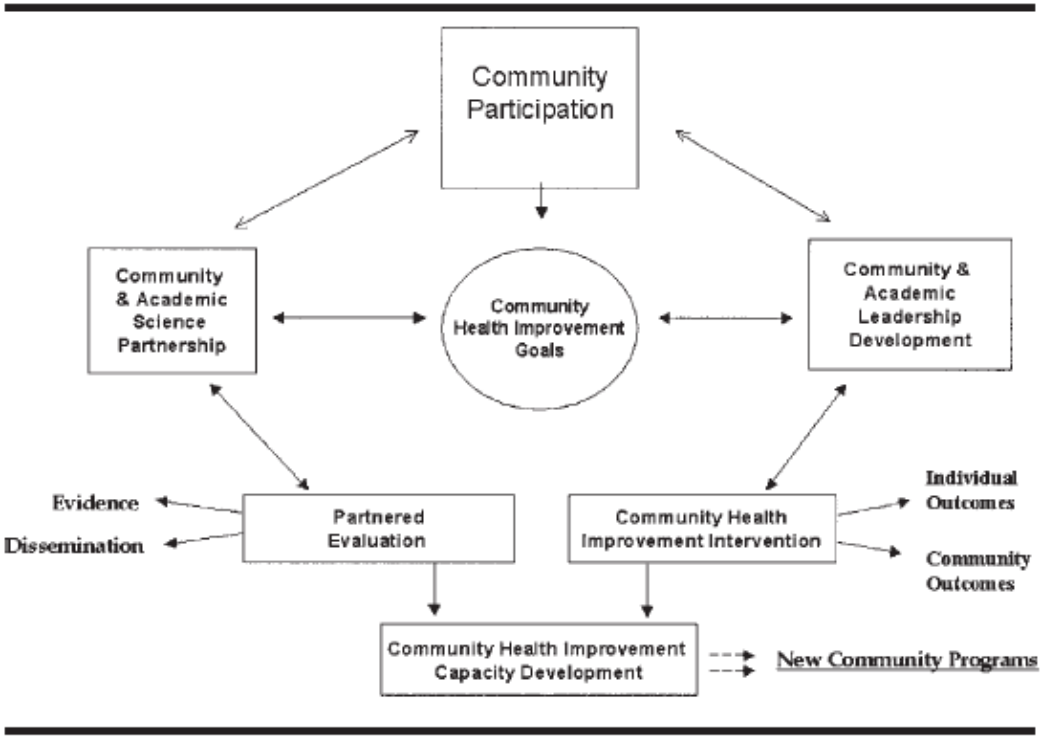
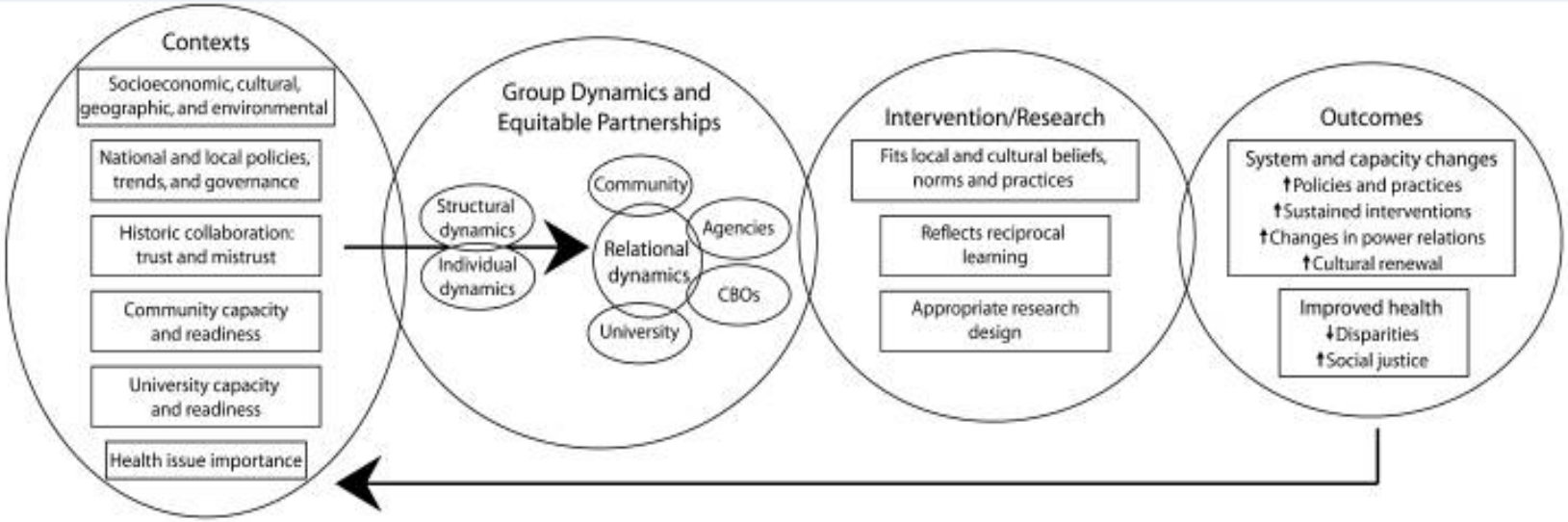


Fig 1. Model: Community Health Improvement Collaborative

The above model is from Wells, K. et al (2006). Building and Academic-Community Partnered Network for Clinical Services Research: The Community Health Improvement Collaborative (CHIC). Ethnicity & Disease, 16, S1-3-17.

Conceptual Logic Model of Community-based Participatory Research (CBPR)



Contexts

Socioeconomic, cultural, geographic, political-historical, and environmental factors

Policies and trends: national and local governance and political climate

Historic degree of collaboration and trust between university and community

Community capacity, readiness, and experience

University capacity, readiness, and reputation

Perceived severity of health issues

Group Dynamics

Structural Dynamics

Diversity

Complexity

Formal agreements

Real power and resource sharing

Alignment with CBPR principles

Length of time in partnership

Relational Dynamics

Safety

Dialogue, listening, and mutual Learning

Leadership and stewardship

Influence and power dynamics

Flexibility

Self and collective reflection

Participatory decision making and negotiation

Integration of local beliefs to group process

Task roles and communication

Individual Dynamics

Core values

Motivations for participating

Personal relationships

Cultural identities and humility

Bridge people on research team

Individual beliefs, spirituality, and meaning

Community reputation of PI

Intervention/Research

Intervention adapted or created within local culture

Intervention informed by local settings and organizations

Shared learning between academic and community knowledge

Research and evaluation design reflects partnership input

Bidirectional translation, implementation and dissemination

Outcomes

CBPR System and Capacity Changes

Changes in policies and practices in universities and communities

Culturally based and sustainable interventions

Changes in power relations

Cultural revitalization and renewal

Empowerment

- Community voices heard
- Capacities of advisory councils
- Critical thinking

Health Outcomes

Transformed social and economical conditions

Reduced health disparities

ICRC-S

Wallerstein N, Oetzel J, Duran B, Tafoya G, Belone L, Rae R. What predicts outcomes in CBPR?: Minkler M, Wallerstein N, editors. Community Based Participatory Research for Health: Process to Outcomes 2nd ed San Francisco, CA: Jossey-Bass; 2008:371–92.

CBPR Development in Suicide Prevention Teams: Training Evaluation Model

Partnership Agency
Quality of interaction
Community implementation of research
Community-centeredness
Application of CBPR principles

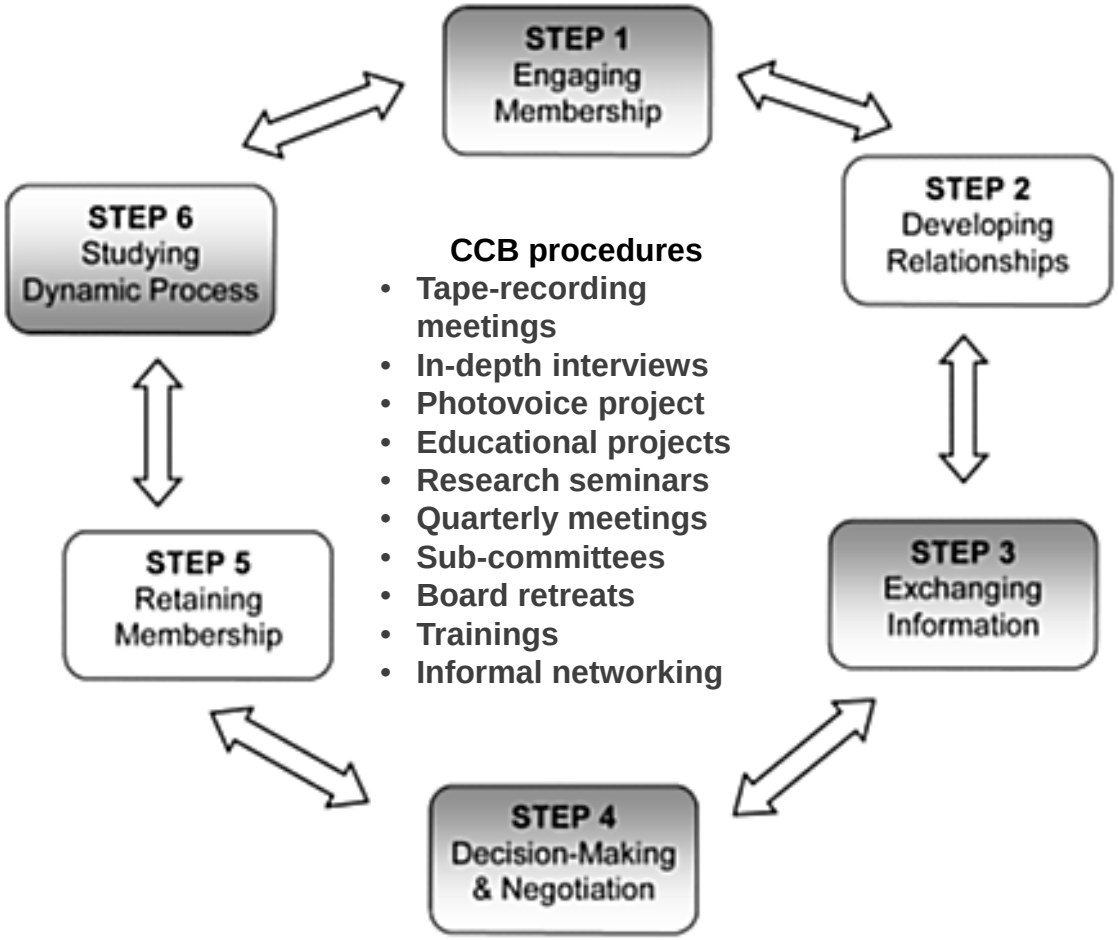
Personal Knowledge & Capabilities
Scientific content expertise
Positive relationships
Grantsmanship
Community-engaged research

Post-training

Partnership Benefits
- Recognized value of collaboration
- Knowledge of community
- Research objectives met
- Observed measures of team success (e.g., grants, publications)

White, A.M. et al. (submitted). Exploring benefits of training academic-community research teams: Rochester's suicide prevention training institutes of 2007-2010. *Progress in Community Health Partnerships.*

Steps to Effective Coalitions: Working to Influence Prevention Outcomes



Pinto, R. et al (2011). Exploring group dynamics for integrating scientific and experiential knowledge in Community Advisory Boards for HIV research. *AIDS Care*, 1-8.

Your Partnerships:
Be Prepared to Emphasize and Present …

- How is community defined?
- How is collaboration maintained?
- What best practice of community engagement, including characteristics of your academic-community partnerships, do you pass on?
- What are essential elements of CBPR implementation?
- How is partnership success monitored?

Adapted from : Viswanathan M, Ammerman A, Eng E, et al. Community-based Participatory Research: Assessing the Evidence. Rockville (MD): Agency for Healthcare Research and Quality (US); 2004 Jul. (Evidence Reports/Technology Assessments, No. 99.) Available from: http://www.ncbi.nlm.nih.gov/books/NBK37280

In Closing…

“ To be effective [in Suicide Prevention] takes the involvement of a broad coalition of state and community agencies” - NYS

“…prevention should be woven into all aspects of our lives”
– 2012 National Strategy for Suicide Prevention