Suicide Prevention and Risk Reduction: What Mental Health Practitioners Need to Know

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Produced by the Alabama Department of Public Health
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Faculty

Paul G. Quinett, Ph.D
Clinical Psychologist
President and CEO of the QPR Institute

Program Objectives

- **Describe suicide prevention and risk assessment.**
- **Describe the latest research on the scope of suicide.**
- **Recommend strategies for prevention and risk reduction.**

Program Objectives

- **Describe the risk relationship between mental illness and substance abuse to suicide attempts and completion.**
- **Describe implications for management and practice using a framework of practical strategies.**
- **Describe risk assessment strategies and a systemic approach to risk reduction.**

Global Violence-Related Deaths

- **One million people die by suicide**
- **10-20 million attempt**
- **Leading cause of death in 1/3 of all countries**
- **1/2 of all violence-related deaths**
- **More die by suicide each year than from all armed conflicts around the world**

From the Surgeon General

"Suicide is our most preventable form of death."

Scope of the Problem

- Range: ideations, attempts, deaths
- 31,483 completed suicides in US (2003)
- Suicide rates are trending down, not rising
- Rates vary widely by race, gender, geography, ethnicity, but all deaths have commonalities

Big Picture Adult Numbers

- Think, plan, attempt, die
- 10 million adults think about suicide each year
- 1.2 million plan a method (gun, MVA, etc.)
- 750,000 attempt (minimum count)
- Approximately 30,000 die

Big Picture Adult Numbers

- Suicide is 11th cause of death overall
  - Third for young people (rate has almost tripled since 1950s – unexpected upturn 2003-2004.
  - First for young people in some states

Mental Illness and Suicide

- Over 90% of all people who die by suicide are suffering from a major psychiatric illness or substance abuse disorder, or both.
- More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.
- Effective, accessible, and competent care could save thousands of lives.

Intention and Suicide

- "There are ways of killing yourself without killing yourself."
  - Tony Manero, Saturday Night Fever, on the "suicide" of his friend.
- Many premature deaths are also preventable.
- ILTB = Intentional Life Threatening Behavior

What Is a Suicide Attempt?

- "Any potentially self-injurious action, with a nonfatal outcome, for which there is evidence, either explicit or implicit, that the individual intended to kill himself or herself."
  - From Carol, Berman, Maris, et. Al., Journal of Suicide and Life-Threatening Behavior, 1996 (controversial def.)

Suicide Attempts

- Most don't die in their attempt
- Youth: 100 - 200 attempts per 1 completion
- Elder: 4 attempts per 1 completion
- Average: 25 attempts per 1 completion
- 5 million Americans have attempted
- Reporting problem
  - Under reporting
  - Unknown (don't ask, don't tell)

Need for Surveillance Data

- We really do not know the full scope of suicidal behaviors, self-inflicted injuries, risk-taking activities that lead to premature morbidity and mortality.
- But we do know where those identified end up…. With us!

Why Now?

- The problem isn't going away: with every cure for a disease, preventing suicide moves up the healthcare to-do list
- Since 9/11, 150,000 have died
- 900,000 new survivors since 9/11
- WHO's death and disability ranking (depression)
- Emergent federal, state and grassroots local leadership

What Happened?

- Suicide is no longer a sin or crime (religious leadership emerged)
- The Happy Rockefeller effect took hold and the survivor movement began
- 1998 and the birth of a national strategy
- Society is changing – AFSP 40 marches
- The buzz is on

Why Now?

- The cause is right, the mission clear.
- The tools are available.
- Doing nothing is measured in lives lost.
- Evidence is in: Kendra's Law: OMH New York – 55% reduction in suicidal behaviors over 5 years (assisted outpatient program) and the US Air Force study (more later)
- "It is always the right time to do the right thing." - Martin Luther King, Jr.

From The Top

- In early 2007 SAMHSA plans to announce the chairperson and convener for the Executive Steering Committee, which will oversee the implementation of the National Suicide Prevention Plan.
- Two bills to prevent veteran suicide just introduced.
- The tipping point is here.

What Else Is Different?

- We know mentally healthy people don't kill themselves
- Dramatic new knowledge to prevent suicide and suicide attempts
- If recovery is possible, suicide is preventable
- 78% of Americans believe many suicides are preventable
- 86% of Americans believe we should invest in suicide prevention

Our Problem? Fatalism, Wrong Beliefs and the Status Quo

- "You can't help the mentally ill and suicide is inevitable."
- "If they really want to kill themselves you can't stop them."

Our Problem? Fatalism, Wrong Beliefs and the Status Quo

- Not! 515 would-be jumpers from the Golden Gate followed for 25 years – 94% died of natural causes or were still alive
- What kills people? The 3 S's:
  - Silence, Stigma, Shame

The Golden Gate Bridge

- Icon – 220 feet, 75 mph – 26 survivors of more than 1,300 deaths
- One fatality every 15 days
- Sara Brinbaum 88 and Roy Raymond 93 (VS)
- Safety net controversy / Eiffel Tower and Empire State Bldg
- Jumpers who did not die
- Is there a change in the wind?

A Plan: The National Strategy

- Prevent premature deaths due to suicide across the life span.
- Reduce the rates of other suicidal behaviors.
- Reduce the harmful after-effects associated with suicidal behaviors and their impacts on others.

A Plan: The National Strategy

- Promote opportunities and settings to enhance resiliency, resourcefulness, respect and interconnectedness for individuals, families and communities.

11 Major Goals

- Promote awareness that suicide is a preventable public health problem.
- Develop broad support for suicide prevention.
- Develop and implement SP strategies for consumers of health services.
- Develop and implement SP programs.
- Promote means restriction.

11 Major Goals

- Implement training for recognition of at-risk behavior and delivery of effective treatment.
- Develop and promote effective clinical care.
- Improve access to services.
- Improve reporting in the media.
- Promote and support research.
- Improve and expand surveillance systems.

IOM Preventing Suicide Recommendations: Strategies

- Research centers, violent death surveillance systems
- Improved use of screening tools to identify depression, substance abuse, child abuse, impulsivity and relationship stresses
- Referral by PCPs of suicidal patients or those with multiple risk factors to mental health professionals

IOM Preventing Suicide Recommendations: Strategies

- Professional in-service training of health care providers in suicide risk, detection and intervention
- Modifying the curriculum of medical and nursing schools to include the study of suicidal behavior

Why Us?

- Clinical providers and their employers are charged with doing a better job (Goal 6).
- Families are being taught suicide is preventable, so "Why did my brother die after I brought him to your hospital, mental health center or substance abuse treatment program?"
- Lawsuits against us are on the rise.

Goal 6: "Implement training for recognition of at-risk behavior and delivery of effective treatment"

- Who is qualified to conduct a suicide risk assessment?
- What are these qualifications?
- When is the risk assessment done? How often?

Goal 6: "Implement training for recognition of at-risk behavior and delivery of effective treatment"

- Where are staff trained in recognition of at-risk behavior?
- How is this risk assessment documented?

Joint Commission Patient Safety Goal 2007

- Requirement 15A, hospitals are expected to:
  - a) Identify suicidal patients and conduct suicide risk assessments of those identified
  - b) See to the patient's immediate safety needs and appropriateness of setting

Joint Commission Patient Safety Goal 2007

- Requirement 15A, hospitals are expected to:
  - c) Provide information regarding crisis hotline information to patients and their families.

The Relationship of Mental Illness and Substance Abuse to Suicide

"Suicide is a national public health problem."

David Satcher, M.D. Former Surgeon General of the United States

Preventing Suicide Is Largely About Identifying and Treating Mood Disorders, Alcoholism and Co-occurring Disorders

- WHO aims to target:
  - Mood disorders
  - Schizophrenia
  - Alcoholism

Preventing Suicide Is Largely About Identifying and Treating Mood Disorders, Alcoholism and Co-occurring Disorders

- World evidence for treatment effectiveness suggests suicide rates can be substantially reduced in all these categories, if we can find them before they die.

Epidemiology: Interesting But Not Clinically Useful

- Suicide rates vary across cultures, racial groups, age groups, time and by geography.

Epidemiology: Interesting But Not Clinically Useful

- Major risk factors: Mental disorders, hopelessness, impulsive and/or aggressive tendencies, history of trauma or abuse, major physical illnesses, previous suicide attempt, family history of suicide, etc. (see NSSP for complete lists of risk and protective factors)

Epidemiology: Interesting But Not Clinically Useful

- What you need to know: 90-95% of all completed suicides have an Axis I disorder.

Is Suicide Primarily: "Mental Health Territory?"

- Lifetime Suicide risk for Schizophrenic, Affective and Addiction Disorders:
- Method: review of 83 mortality studies:
  - Schizophrenia……4%
  - Affective Disorders……6%
  - Addiction Disorders…...7%

MDD and Suicide

- Lifetime risk: 2-6%
- 98% of completers are seriously depressed.
- Most die while off medication.
- Adherence to meds is essential to safety.
- For severe, agitated and suicidal depressions, electroconvulsive therapy may be the best choice.

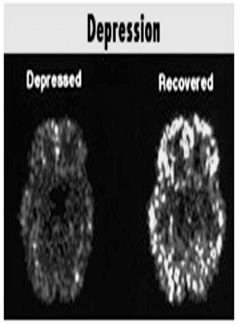
MDD and Suicide

- Family/patient education: MMD is a potentially fatal illness and death is a possible result of not following medical advice.
- Benzodiazepines are often underutilized.

Neurobiological Changes in Severe Suicidal Depression

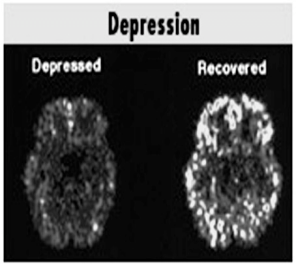
- Loss of gray matter
- Impaired prefrontal cortical response to serotonin release
- Dopamine deficit
- Serotonin hypofunction in the PFC correlates to higher suicidal intent and planning and lethality of suicide attempt

Pharmacotherapy for Depression



- PET scan depicts a depressed patient's brain prior to treatment, after successful treatment, scan reveals greatly increased activity in the prefrontal cortex.

Warning, Do Not Use the Brain on the Left to Make a Life or Death Decision.



A Note on Antidepressants

- TCAs deadly in overdose
- SSRI's not deadly in overdose
- Lots of TCAs prescriptions = more suicides
- Lots of SSRIs prescriptions = fewer suicides
  - EU, Australia, Scandinavia, USA

Bipolar Disorder and Suicide

- #1 cause of premature death, 1-2% per year.
- 30 studies 9 - 46% x = average 19%.
- Highest attempt rate:
  - General Population = 1%
  - Major Depressive Disorder = 20%
  - Bipolar Disorder = 25% - 50%

Bipolar Disorder and Suicide

- Highest risk windows
  - Early in illness - denial phase - during mixed states
  - While experiencing depressive mania
- Lithium 6X anti-suicide effect and impacts aggression and impulsivity
- Psychotherapy and mood stabilizers prevent suicide better than mood stabilizers alone

Suicide and Schizophrenia

- Ten to 15% complete suicide (best estimated of lifetime risk: 5%).
- Leading cause of death in patients under 35.
- Negative symptoms associated with increased risk.
- 20 to 40% make a suicide attempt.

Suicide and Schizophrenia

- Finland National Study (1997) - 7% of all suicides met DSM-IV criteria for schizophrenia (N=92). Of these 92, 64 were also depressed.
- Suicides occur during active phases of the illness.

A Note On Clozapine

- Only atypical antipsychotic
- Most effective for negative symptoms
- Best for Rx resistant, has antidepressant and mood stabilizing effect
- Clozapine reduced suicide events by 25% compared to olanzapine
- Clozapine 2 yr NNT of 13 to prevent 1 attempt

Or is Suicide Also: Addictions Territory?

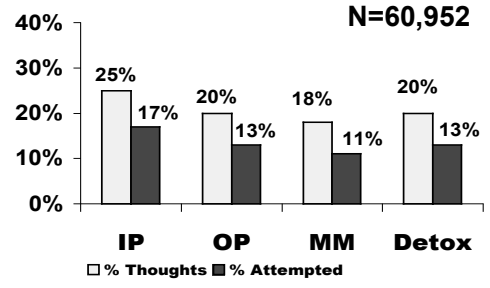
- Alcohol strongest predictor of completed suicide over 5-10 years after attempt, OR= 5.18…vs. demog or psych disorders
- 40-60% of completed suicides across USA/Europe are alcohol/drug affected (state variable).

Or is Suicide Also: Addictions Territory?

- Higher suicide rates (+8%) for ages 18 to 21 year olds in states with a legal drink age of 18 years versus states in which the legal drinking age is 21.

Lifetime Suicide Thoughts/Attempts

ASI data, TRI database-04



Refer Them All?

- If you treat addictive disorders, do you intend to refer every consumer who screens position for suicide to mental health?
- If yes, are you prepared to send 25% of your budget to mental health providers?

Alcohol Abuse and Suicide

- Major risk factors: male, long-term drinker, co-morbid psychiatric disorder
- Intoxication impairs judgment and increases impulsivity and aggressiveness
- Co-morbidity increases risk
- Highest risk group: MDD and alcoholism

Alcohol Abuse and Suicide

- Alcoholism erodes protective factors: loss of job, health, home, money, family and friends
- Alcohol myopia: inability to access the consequences of one's actions (the stupid effect)

What Do We Know About Suicide in Prospective Age-matched Alcoholic Populations

- 4.5% of alcoholics attempted suicide within 5 years of DX (age 40.. n=1,237)
- 0.8% in non-alcoholic matched comparison group (age 42..n=2,000)
- p< .001...7X increased risk

Methamphetamine Users (n= 1,016) Lifetime Suicide Attempts and Behavior Problems

ASI Item	Overall	Male	Female	Test Statistic*
Attempted Suicide (%)	27%	13%	28%	35.42**
Violent behavior problems (%)	43%	40%	46%	3.29***
Assault Charges (mean number)	0.29	0.46	0.15	4.46**
Weapons charges (mean number)	0.13	0.21	0.07	4.09**

Substance Induced Depression: Severity/Dangerousness

- Henriksson, et al (1993)- 43% of completed suicides had alcohol dependence. 48% of these were also depressed. 42% had a personality disorder.

Substance Induced Depression: Severity/Dangerousness

- Elliot, et al (1996)- patients with medically severe suicide attempts had a statistically higher prevalence or substance-induced mood disorder.
- Pages K et al (1997)- Higher degrees of Sub + Dep related to higher severity suicide ratings.

Traumatic Brain Injury

- Blast is the most common wounding etiology our returning war fighters
- 50-60% of those exposed to blasts sustain a brain injury (Walter Reed Army Medical Center)
- Depression, PTSD and alcohol use common

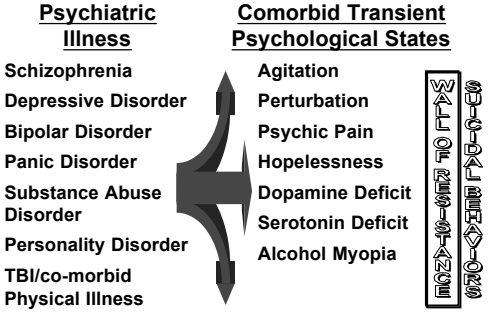
Traumatic Brain Injury

- Simpson and Tate post-injury TBI community sample study (2002):
  - 23% had significant suicidal ideation
  - 18% made a suicide attempt
- Life time risk of suicide 3-4 times higher

Five Acute Suicide Risk Factors

- Severe psychic anxiety/turmoil
- Incessant rumination
- Global insomnia
- Delusions of gloom and doom
- Recent alcohol use (with or without alcoholism)

Disease Management Model For Suicidal Patients



Treatment Works

- Cognitive therapy reduces youth suicide attempts by 50%.
- Youth suicide rates lower in counties with high SSRI use.

Treatment Works: Lithium and Suicide

• Treatment status	Suicidal acts/100 pt yrs
– Before Rx	2.30
– During Rx (maintenance)	0.355
– After Discontinuing Rx	4.86
• Rapid discontinuing	4.95 (1 year)
• Gradual taper	2.55 (1 year)
– First year off Rx	7.11
– Later years off	2.29

Mental Health Treatment Works

- Sober people up
- Treat anxiety aggressively to rapidly reduce psychic pain and suffering
- Treat quickly
- Treat well and use what works
  - Right medications
  - CBT for depressive hopelessness
  - DBT for Axis II consumers

Addiction Treatment Works

Cohort	Suicide Attempts	
	Year prior	Year after
Adults		
> age 25 (n=3,524)	23%	4%
age 18-24 (N=651)	28%	4%
Adolescents (n=236)	23%	7%

Take Home Messages

- Most dangerous diagnosis: alcoholism and major depressive disorder
- Three common clinical pathways: serotonin deficit, dopamine deficit, and alcohol in blood stream
- Co-occurring disorders kill
- There is no safety without sobriety

Policy Implications For The Mental Health System

- Most or all acute psych units need to be Dual DX units, but how many are?
- Greatly increased addictions training in psychiatrists, psychologists, nurses, and other staff.
- Revise the Length of Stay, Payment and Managed Care policies which drive misdiagnosis and mistreatment.

Policy Implications For The Mental Health System

- Researchers need to use instruments like the PRISM and factor substance use issues into analyses of suicide and other problem behaviors.

Policy Implications for Substance Abuse Treatment Systems

- 25% of consumers have been or are suicidal.
- National Strategy calls for better detection and treatment by CD professionals.

Policy Implications for Substance Abuse Treatment Systems

- CD treatment is effective in reducing suicidal behavior.
- CD professionals need skills and competencies to address suicidal consumers.

Suicide Risk Management: What You Need to Know

- Nature of suicide
- Suicide risk episodes
- Current status of suicide risk assessment
- Best practice vs. worst practice
- Practical risk management

Nature of the Suicide and Joiner's New Theory

- Psychic suffering (Psyche-ache)
- Hopelessness
- Unbearable mental anguish
- Cognitive constriction
- Grossly impaired problem solving ability

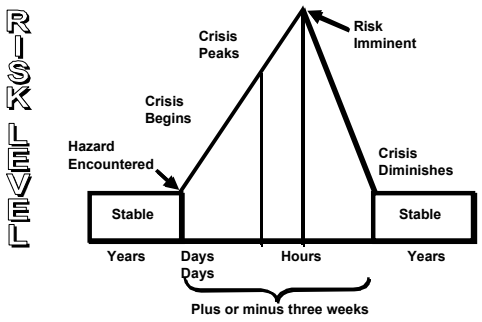
Nature of the Suicide and Joiner's New Theory

- Feeling a burden to others
- Thwarted belongingness
- Acquired capacity for self-injury and habituation to pain

Planned Vs. Impulsive Suicides

- Suicidal acts are often impulsive. In one study 24% of attempters reported they took less than 5 minutes from idea to act, and 70% took approximately one hour.
- Suicidal crisis are usually temporary; survive the moment, live forever.
- Most who attempt do not go on to die by suicide.

Suicide Crisis Episode



Wall of Resistance to Suicide

Counselor or Therapist	Duty to others	Others?
Good Health	Medication Compliance	Fear
Job Security or Job Skills	Responsibility for Children	Support of Significant Other
Difficult Access to Means	A Sense of Hope	Positive Self-esteem
Pet(s)	Religious Prohibition	Calm Environment	AA or NA Sponsor
Best Friend(s)	Safety Agreement	Treatment Availability
-- Sobriety --		

Protective Factors

Suicide Threats: Then and Now

- Then: Anyone threatening suicide was hospitalized
- Now: No one threatening suicide is hospitalized unless he has a gun to his head or she has an OD on board

Suicide Threats: Then and Now

- "It's not, 'Are you suicidal?' It's 'Are you really, really, really suicidal?" Director of a large County Mental Health
  - Question: What does "really, really, really" mean?

Suicide Risk Assessment

- Prediction is complex and difficult
- Prognosis vs. prediction
- Challenge of a low probability event
- Behavior is threshold sensitive
- Behavior is context sensitive
- Behavior relationship sensitive
- Summation of risk factors not helpful
- Screening tools can get you in trouble
  - Prediction is best done in reverse

Suicide Risk Assessment: What you Need to Know

- Screens for suicide produce large numbers of false positives (will not die by suicide).
- Positive screens require assessments.

Suicide Risk Assessment: What you Need to Know

- There are no useful psychological tests or methods to predict suicide attempt (NIMH).
- The summation of risk factor approach is too nonspecific and weak in predicting individual suicide.

Prediction vs. Standard of Care

- You are not required to predict the future, but you are required to try (assess risk).
- Note: 40% of clinical decisions at major academic medical centers are not based on research evidence.

Current Thinking On Suicide And Risk

- The greater the number of losses, the greater the risk.
- No good evidence for sexual orientation as an independent risk factor for suicide.
- Personally humiliating events may trigger suicidal behavior in non-mentally ill people.
- The single greatest risk is untreated mental illness.

Current Status Of Suicide Risk Assessment

- National Survey: Almost all clinicians rely on clinical interview (Jobes, Eyman & Yufi, 1995).
- No known test will predict suicide.
- Screening inventories useful but…risk detection is job one.
- 75% of suicides see a physician within a week to a month before their death (NIMH: opportunities missed)

Current Status Of Suicide Risk Assessment

- Current methods produce large numbers of false positives.
- Summation of risk factor approach:
  - Not clinically useful.
  - Too nonspecific to be helpful.
  - Inefficient and weak in predicting individual suicide.

Current Status Of Suicide Risk Assessment

- 67% - 91% of completers made no previous attempt (Coe, 1963 and Dorpat, 1960).
- Lots of risk goes unrecognized.

Unrecognized Risk

- 60% of suicide completers had no contact with a mental health professional and no prior suicide attempt.
- 60% to 90% of all suicide completers had communicated explicit intent to a significant other during the period prior to death.

Unrecognized Risk

- 75% to 80% had a non-psychiatrist physician contact within six months.
- 93% of completers had an Axis I diagnosis.
- One-sixth of all completers are in current treatment with a mental health provider.

What Do We Know?

- Surveys show most clinicians use an interview format, not psychometrics.
- There is no consensus practice standard or tool.
- Review the APA's Practice Guidelines for comprehensive review.
- Get some training.

Goal 6: "Implement Training for Recognition of At-risk Behavior and Delivery of Effective Treatment"

- Who is qualified to conduct a suicide risk assessment?
- What are these qualifications?
- When is the risk assessment done? How often?

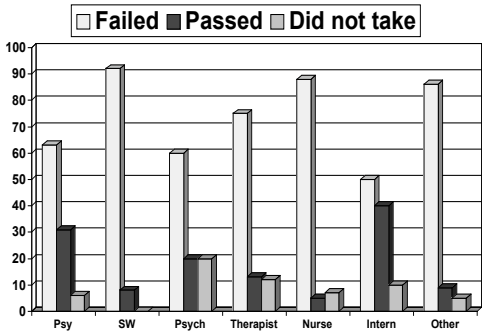
Goal 6: "Implement Training for Recognition of At-risk Behavior and Delivery of Effective Treatment"

- Where are staff trained in recognition of at-risk behavior?
- How is this risk assessment documented?

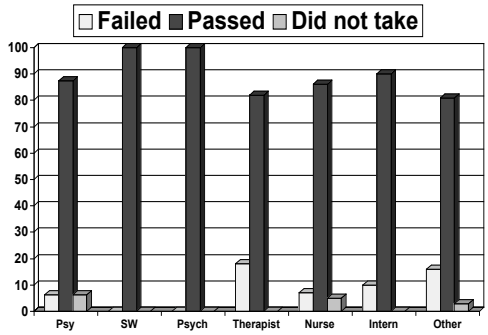
What Do Clinicians Know?

- 1,100 MHPs practicing in 13 states.
- Standardized 25-item quiz (SRMI) covering suicide statistics, risk and protective factors, risk management and safety practices in clinical settings.
- Findings have been twice replicated (N>500 in >50 clinical settings)
  - We wish to thank the Devereux Foundation for contributing to this database.

Pre-Test Results by Job Title



Post-Test Results by Job Title



Raising the Bar Beyond the Current Standard of Practice

- You are required to perform an adequate assessment, not to predict suicide.
- The standard of care is legally defined, not ideal (statutory language varies state to state).

Raising the Bar Beyond the Current Standard of Practice

- Standards of care are minimum, not maximum.
- Medical custom vs. reasonable and prudent.
- We can do better.

The Road to Suicide Is Festooned With PINS –All Available on Observation or Query

- Fleeting thoughts of suicide
- Preoccupation with death
- Persistent, severe thoughts of suicide
- Pursuit of means of suicide

The Road to Suicide Is Festooned With PINS –All Available on Observation or Query

- Practice to build familiarity with means
- Verbal (written) threats & "Dire warnings"
- 3rd party reported behaviors
- Non-fatal attempts

Worst Clinician in the World!

- Suicide is not spoken here, so no query was ever made.
- Assessment appears skimpy (e.g., "Denies SI, HI and CFS.")
- Skimpy assessment plus reliance on no-suicide contract ("He promised me he wouldn't.")
- Assessment present but written in Sanskrit (inscrutable handwriting).
- Assessment is not communicated to others.

Best Clinician in the World!

- Treats all threats as genuine (until proven otherwise).
- Gets all the data and the PINS.
- Understands the context.
- Assesses clinical status thoroughly.
- Documents all actions taken and why.
- Documents all actions not taken and why.
- Communicates the risk to others.

Thomas Gutheil, MD

"If it isn't written down, it didn't happen."

Final Notes

- Get help from your friends (consultation).
- Don't be afraid to "slap them in irons."
- Share the work, it's just too much fun to do all by yourself.
- Chart well, sleep well.

Institutionalizing Suicide Risk Reduction: A Systems Approach

First presented to the American Psychiatric Association Task Force on Patient Safety

Chantilly, Maryland

(statistics updated 2004)

Personal Perspective

- Question: "Why did this patient die by suicide?"
  - Fatality reviews
  - Psychological autopsy
  - Motive
  - Method
  - Opportunity
- People or systems?

A Vision for the Future

- Why does Homer Simpson work in a nuclear power plant?
- What is the IHI initiative?
- If not student safety, what matters more?
- What is a HRO?

HRO = Highly Reliable Organization Karl E. Weick, Ph.D.

- Failure is not an option/people die.
- Mindfulness and detection of weak signs.
- Non response to trouble fosters disaster.

HRO = Highly Reliable Organization Karl E. Weick, Ph.D.

- Every warning sign requires decisive action (confront the unexpected).
- Fixation on failure is good.
- Bottom-to-top staff input into safety.

Do You Work in an HRO?

- How is a mental health center or hospital like:
  - A hospital operating room?
  - An aircraft carrier flight crew?
  - A nuclear power plant?
  - An air traffic control center?
  - A NASA launch crew?

Most Dangerous Place in the World?

- WWII aircraft carrier under attack – whirling propellers, volatile fuel, armed bombs, planes landing and taking off, taking fire
- Even slight mistakes invite catastrophe
- Teamwork, choreography, ballet-like precision
- Disaster is waiting everywhere
- Deckhand Bugilone's heroic belly slide

Highly Reliable Organizations

- HROs are not fooled by success.
- HROs trust their experts (the front line people in daily contact with students).
- HROs train everyone to identify and report possible problems.

Highly Reliable Organizations

- HROs have a smooth, practiced, crisis response plan when a student is identified as in trouble.
- HROs have a smooth, practiced, crisis response plan when something bad happens.

QPR Institute's Systems Approach to SRR

- QPR stands for Question, Persuade and Refer, an emergency mental health intervention that teaches lay and professional Gatekeepers to recognize and respond positively to someone exhibiting suicide warning signs and behaviors.

Why QPR?

- Each letter in QPR represents an idea and an action step.
- QPR intentionally rhymes with CPR – another universal emergency intervention.
- QPR is easy to remember .
- Asking Questions, Persuading people to act and making a Referral are established adult skills.

QPR Theory

- Assumption: passive systems don't work
- Those most at risk for suicide:
  - Tend not to self-refer for treatment
  - Tend to be treatment resistant
  - Often abuse drugs and/or alcohol
  - Dissimulate their level of despair
  - Go undetected
  - Go untreated and remain at risk

QPR Theory

- Most suicidal people send warning signs.
- Warning signs can be taught.
- Gatekeepers can be trained to recognize suicide warning signs and intervene with someone they know.
- Gatekeepers must be fully supported by policy, procedure and professionals in their community.

Highly Reliable School

- Training matches level of duty
- Everyone is trained
- Training is mandatory
- Competency must be demonstrated

200 Fatality Reviews What Did We Learn?

- "Don't ask, Don't tell, Don't work"
- Suicide risk was not detected
- Inadequate risk information was collected
- Third party suicide risk data not available

200 Fatality Reviews What Did We Learn?

- Third party suicide risk data not sought
- Family risk observation input minimized, denied or ignored
- No evidence of a competent, frank interview regarding self-destruction

What More Did We Learn?

- Suicide risk identified at intake seldom reassessed
- Inadequate documentation (e.g., "0SI" or "Patient contracts.")
- Suicide risk not reassessed at high-risk transitions

What More Did We Learn?

- Inadequate supervision/consultation
- Means restriction failures (FMEA)
- Monitoring failures (backup failures)
- Poor discharge planning
- Postvention failures

Found Three Basic Errors

- TYPE 1: Failure to detect suicide risk
- TYPE 2: Failure to assess and reassess suicide risk
- TYPE 3: Failure to establish and monitor a suicide risk management plan

To Reduce These Errors We

- Built an A team – surveyed national experts
- Reviewed the literature on mitigating suicide risk
- Created training content designed for clinical providers by specialty
- Developed content matter quiz items

To Reduce These Errors We

- Created standardized training programs
- Developed core competency measures for credentialing process
- Developed, tested and delivered mandatory training to all staff

- QPR Booklet and Card
- The Tender Leaves of Hope booklet
- Helping a Child Survive a Suicide Crisis brochure
- Training materials (from our photos or website)
- Credentialing criteria
- User's Manuals
- Web-enabled training

Spokane Mental Health and Then to the Devereux Foundation – 7+ Years With the Program

- Research based
- Multidisciplinary/peer reviewed
- Recognized by Joint Commission in multiple publications (e.g., Patient Safety, Nov. 2006)
- Received the Negley Award (MHCA)
- Reviewed by expert clinicians and lawyers

The Devereux Experience

- Devereux Goal 3 - Formally Assess all Clients for Suicide Risk
  - At admission
  - At discharge
  - At significant transitions during treatment
    - Change in risk factors
    - Change in placement/caregivers
- Documented in core clinical record

Devereux Results

- No suicides following proper QPRT in active patients over 4 years with average daily census = 17,000. (Note low base rate)
- Crisis Response Plans improved staff response.

Devereux Results

- QPRT has helped identify clients at risk
  - Client with autism
  - Dispelled myths about individuals with MR
  - Established standard of care
- QPR heightened staff awareness and increased confidence
- Helped avert 4 staff suicides (5,000 plus staff)

Before You Begin Ask Seven Key Questions

- Current beliefs about consumer suicide?
- Is patient suicide ever a medical error?
- Do near misses count?
- Does safety come first?

Before You Begin Ask Seven Key Questions

- Do current systems promote errors?
- Is there an acceptable error (suicide) rate?
- Is there a patient safety/suicide prevention committee?

Consider That It Might Just Be Rocket Science

- Systems approach
- Forced functions (VA EMR)
- Failure Mode Effect Analysis (FMEA)
- Error proofing
- Why? vs. What if?
- Root Cause Analysis (RCA)
- QI and Report to Governance

National Center for Patient Safety Things We Need to Fix

- Based on 400 root cause analyses
  - Last contact:
    - Outpatient mental health: 42%
    - Inpatient mental health: 25%
    - Outpatient primary care: 25%

National Center for Patient Safety Things We Need to Fix

- Total: 78% of outpatient suicides were seen by a professional within 1 month of death
- Missed opportunities to query and assess?

Things to Do Today

- What are your policies and procedures for the assessment and treatment of suicidal patients?
- Who is qualified to do what?
- How is patient risk information communicated between staff?
- Are staff adequately trained?
- Do you have a patient safety position, and is this person responsible for suicidal patient safety?

- "Suicide prevention is violence prevention…and it can be done."
  - Look at what the Air Force did

BMJ/Results (USAF)

Outcome	Relative Risk (RR) and 95% CI	Risk Reduction (1-RR)	Excess Risk (RR-1)
Suicide	.67 [.5702, .8017]	↓ 33%	--
Homicide	.48 [.3260, .7357]	↓ 51%	
Accidental Death	.82 [.7328, .9311]	↓ 18%	--
Severe Family Violence	.46 [.4335, .5090]	↓ 54%	--
Moderate Family Violence	.70 [.6900, .7272]	↓ 30%	--
Mild Family Violence	1.18 [1.1636, 1.2040]	--	↑ 18%

Believe It Will Happen and It Will

- "The time is always right to do what is right."
  - Martin Luther King, Jr.
- "Once we understand, we care, and once we care, we can change."
  - President Jimmy Carter

Contact Information

- Paul Quinnett: 509-235-8823 www.qprinstitute.com
- Full references on request (see our web site section, "Concerned about patient safety?"
- Please visit our web site and download the free e-book: Suicide: the Forever Decision and share it widely.

Advanced Online Training for School Counselors, Psychologists, Nurses and Social Workers From EWU

- Suicide risk detection, assessment and management training
- University based - CEU or college credit
- APA approved (6 hours)

Advanced Online Training for School Counselors, Psychologists, Nurses and Social Workers From EWU

- Blended DVD, study guide, + online
- Certificate
- $159, discount for volume
- Contact EWU via www.qprinstitute.com

New EWU-QPR Gatekeeper Training Online Features

- Multi-media, interactive, broad-band delivery
- Self-paced learning from work or home
- Annual refresher training
- Crisis driven on demand access 24/7

New EWU-QPR Gatekeeper Training Online Features

- Simplified tracking of staff participation
- Data base management to measure outcomes
- Program content updated with new research

New Initiatives and the Future

- QPR as classroom clinical lab or assignment
- Undergraduate and graduate college credits and Continuing Education Units (CEUs) via distance learning
- SP Certificate program on campus at Eastern Washington University

New Initiatives and the Future

- Outcome data base management options for large organizations (e.g. training status reports)
- Research on role-play (simulation) effectiveness in Gatekeeper skill acquisition and maintenance

Coming in 2007

- QPR-Korea – launched and will grow
- QPR Spanish edition (Cuba, Argentina)
- QPR-Australia
- QPR Foundation
- QPR for Cops/Firemen/EMTs/Agents
- Research on role-play, new video content
- Subscription service
- QPR for business

Accreditations/Endorsements

- QPR programs are officially endorsed and used by the health and mental health leadership in the following states: Virginia, Tennessee, Kentucky, Montana, Georgia, Oklahoma, Oregon, South Carolina, Colorado, Wisconsin, Alaska, Florida, Missouri and others.

Accreditations/Endorsements

- QPR is currently taught on more than 75 college and university campuses in US and Canada
- Official gatekeeper program for US Army… elements of Air Force, Marines, and Navy

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Our Belief

- We must train hundreds to save one, thousands to save hundreds, and millions to save thousands… only faith, hope, and technology can get us there.