The Challenge of Suicide in the United States

A Stubbornly Growing Public Health Problem

Melinda Moore, PhD
Department of Psychology
Eastern Kentucky University
Tracking the Challenge of Suicide

The “epidemiology” of suicide and related concerns

- **2001** • **2002** • **2004** • **2006** • **2008** • **2010** • **2012** • **2014** • **2016** • **2018**

1. **First national plan to address suicide prevention**
2. **CDC Violent Death Reporting System**
3. **National Action Alliance for Suicide Prevention**
4. **US Surgeon General Action Alliance revised goals & objectives**
5. **NVDRS Data on Suicides In all 50 states**
US suicide rates continue to climb over the past 25 years...
Crude Rates of Suicide

United States 2017

States with **lowest** rate per population:

- Washington, D.C.
- New York
- New Jersey
- Massachusetts
- Maryland

Data source: National Center for Health Statistics (NCHS); National Vital Statistics System, Center for Disease and Control Prevention (CDC)
Challenges We Face in the US

2017 data

Deaths by suicide

47,173

MALES: 36,779

FEMALES: 10,389

Data source: National Center for Health Statistics (NCHS); National Vital Statistics System, Center for Disease and Control Prevention (CDC)
### 10 Leading Causes of Death by Age Group 2017

<table>
<thead>
<tr>
<th>Rank</th>
<th>Cause</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Short Gestation</td>
<td>3,749</td>
<td>7,148</td>
<td>7,982</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Maternal Pregnancy Comp.</td>
<td>1,432</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>SIDS</td>
<td>1,363</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Unintentional Injury</td>
<td>1,317</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Placenta Cord Membranes</td>
<td>843</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Bacterial Sepsis</td>
<td>592</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Circulatory System Disease</td>
<td>449</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Respiratory Distress</td>
<td>440</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Neonatal Hemorrhage</td>
<td>379</td>
<td>1,137</td>
<td>5,379</td>
<td>4,057</td>
<td>3,591</td>
<td>5,676</td>
<td>599,108</td>
<td>599,108</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Producer:** National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

**Data Source:** National Center for Health Statistics (NCHS), National Vital Statistics System
Methods for Suicide Related Deaths (2017)

Firearm
50.6%

Suffocation
27.7%

Drug Poisoning
10.8%

Non-Drug Poisoning
3.1%

Fall
2.4%

Cut/Pierce
1.8%

Other specified And Classified
1.4%

Drowning
1%

Other...
0.4%

Data source: National Center for Health Statistics (NCHS); National Vital Statistics System, Center for Disease and Control Prevention (CDC)
Suicidal Ideation and Behavior in the US in 2017

Approximately 1.4M Adults Attempted Suicide and 10.6M Experienced Serious Suicidal Thoughts

Suicidal Ideation and Behavior in the US in 2017

Approximately 1.4M Adults Attempted Suicide and 10.6M Experienced Serious Suicidal Thoughts

<table>
<thead>
<tr>
<th></th>
<th>THOUGHTS</th>
<th>PLANS</th>
<th>ATTEMPTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>3.6M</td>
<td>1.3M</td>
<td>.65M</td>
</tr>
<tr>
<td>26-49</td>
<td>4.3M</td>
<td>1.2M</td>
<td>.43M</td>
</tr>
<tr>
<td>50+</td>
<td>2.8M</td>
<td>.7M</td>
<td>.3M</td>
</tr>
</tbody>
</table>

The often overlooked challenge of suicidal ideation:

A population that is:

- **7.6x larger** than the population who make suicide attempts;
- **225.5x larger** than the population who die by suicide

(Jobes & Joiner, 2019).
Responding to Suicidal Ideation

What is the best way to help this massively large population?

Is hospitalization the only recourse?

Why not consider effective outpatient care for people who are experiencing suicidal ideation?
7.4% of Adolescents in Grades 9-12 Reported Making at Least One Attempt
US High School Student Suicide Ideation and Behavior 2017

Past 12 months

Percentage of High School Students Reporting Suicidal Behavior

Source: Youth Risk Behavior Surveillance System, 2017
3,977 had suicidal behavior
116 died by suicide
459 attempted suicide
3,402 reported suicidal ideation

Junior enlisted, female or age 17-24
higher rates of suicide attempts and suicidal ideation

Source: Army Public Health Center (APHC) Annual Report Surveillance of Suicidal Behavior Publication (SSPB) for 2017
US Veteran Suicide Rates
From 2005-2016, by Age

Source: VA National Suicide Data Report 2005-2016; Office of Mental Health and Suicide Prevention, September 2018
Suicidology

The study of suicide prevention
“Suicide occurs when the psychache is deemed by that person to be unbearable.”

“Suicide is caused by psychache. Psychache refers to the hurt, anguish, soreness, aching, psychological pain in the psyche, the mind.”

Common Myths about Suicide

Asking someone about suicide or talking about it will lead to or encourage suicide

Fact: Asking about it reduces stigma and will aid in prevention

Depression causes people to become suicidal

Fact: Not everyone with depression becomes suicidal, and there are high rates of suicidal thoughts and behaviors with other diagnoses
Common Myths about Suicide

Suicide cannot be prevented if a person is intent on ending their life

**Fact:** Most suicidal people do not want to be dead, they want to be out of the pain they are experiencing

Suicides often happen impulsively or “out of the blue”

**Fact:** Most suicidal people said something or dropped hints about their state of mind
Common Myths about Suicide

Once someone is suicidal, they will always be suicidal

**Fact:** Active suicidal thinking is often short-term and situation specific

People who threaten suicide are just looking for attention

**Fact:** People who discuss suicide are often seeking help not attention

Young children (ages 5-12) cannot be suicidal

**Fact:** About 30-35 children under the age of 12 in the US end their life by suicide
## Common Myths about Suicide

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization is the best and only option for treatment for suicidal people</td>
<td>Hospital stays often do not offer effective suicide-focused treatment and may lead to a higher risk of attempt or completed suicide in the week/months/years after discharge</td>
</tr>
<tr>
<td>Medications are effective for reducing suicidal ideation and behavior</td>
<td>Data on the effectiveness of medication for suicidal risk are limited or mixed at best</td>
</tr>
</tbody>
</table>
Models for Understanding Suicidal Behavior
Shneidman’s Cubic Model of Suicide

Press (stress)

Completed Suicide

Perturbation

Pain (Psychache)
Joiner’s Interpersonal Theory

Perceived Burdensomeness

Thwarted Belongingness

Serious Attempt or Death by Suicide

Those Who Are Capable of Suicide
Conceptualizing Risk
Hundreds of unidentified risk factors that cannot be differentiated between those that are thinking about suicide and those who may or may not attempt suicide.
What are Some Key Risk Factors?

Wortzel & Brenner, 2012

- History of prior suicide attempt(s)
- Chronic psychiatric conditions
- History of substance abuse/dependence
- Chronic suicidal ideation
- Chronic medical condition/pain
- Limited or no sense of belongingness

- Perceived burdensomeness
- Limited coping skills
- Unstable or turbulent psychosocial stressors
- Limited ability to identify reasons for living
- Trait impulsivity and/or aggression
What are Some Warning Signs?

By American Association of Suicidology Consensus

- Ideation
- Substance Use/Abuse (increasing amounts; NOT intoxication)
- Purposelessness
- Anxiety/Agitation
- Trapped
- Hopelessness
- Withdrawal
- Anger
- Recklessness
- Mood Changes
What is DRIVING this person’s suicide risk?

Direct Drivers

Examples include:
- Relationship breakup,
- sexual trauma,
- self-hatred,
- bankruptcy,
- unbearable violation of the law,
- loss of parental custody

(Jobes et al., 2011; Tucker et al., 2015)
What is DRIVING this person’s suicide risk?

Examples include:
- negative life events,
- psychosocial stressors,
- isolation,
- alcohol use,
- or psychiatric illnesses

Indirect Drivers
What is Clinical Suicidology?

Clinical theories
The clinical assessment
The clinical treatment
Professional training
Suicide-specific clinical risk management
Ethical and legal considerations
Intervention and Treatment of Suicidal States
Persistent Challenges

• Over-reliance on psychiatric hospitalizations

• Over-reliance on psychotropic medications

• Little use of effective and proven suicide-specific treatments
The Importance of Stabilization Planning

• No use of contracts

• Patient will do vs. won’t do

• Stanley and Brown’s (2012) “Safety Plan Intervention”

• “Crisis Response Planning” (Rudd, Joiner, & Rajab, 2003)

• The “CAMS Stabilization Plan” is a key determiner of outpatient vs. inpatient care (Jobes, 2016)
Safety Planning Intervention
(Stanley & Brown, 2008; 2012)

• Evidenced-based strategies

• A collaboratively developed prioritized written plan
  • Helps individuals identify personal warning signs
  • Lists internal & external coping strategies
  • Identifies sources of support-peer, family, superiors, professionals
  • Provides guidance on making one’s environment safe

• Adopted nationwide across VAMCs
• Recognized by Best Practice Registry for Suicide Prevention
• Requires minimum of training
VA Safety Plan

SAFETY PLAN: VA VERSION

Step 1: Warning signs:
1. 
2. 
3. 

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:
1. 
2. 
3. 

Step 3: People and social settings that provide distraction:
1. Name_________________ Phone_________________
2. Name_________________ Phone_________________
3. Place_________________ 4. Place_________________

Step 4: People whom I can ask for help:
1. Name_________________ Phone_________________
2. Name_________________ Phone_________________
3. Name_________________ Phone_________________

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name_________________ Phone_________________
   Clinician Pager or Emergency Contact #_________________
2. Clinician Name_________________ Phone_________________
   Clinician Pager or Emergency Contact #_________________
3. Local Urgent Care Services
   Urgent Care Services Address_________________
   Urgent Care Services Phone_________________
4. VA Suicide Prevention Resource Coordinator Name_________________
   VA Suicide Prevention Resource Coordinator Phone_________________
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:
1. 
2. 

Study Subjects:
• 97 Active Duty Soldiers
• Active suicidal ideation or history of suicide attempt
• Voluntarily presented for emergency mental health care

Interventions:
• Contract for Safety
• Standard Crisis Response Plan
• Enhanced Crisis Response Plan
The importance of discussing the Lifeline and lethal means safety

1. Always provide Lifeline number
2. Consider providing your own number
3. Always discuss access to lethal means
4. Verify that means have been secured (possibly through a third party)

Potentially lethal means available in the home at the time of the attempt:

- 75% prescription medication
- 86% OTC medications
- 2% street drugs
- 95% had some medication available at time of SA
- 25% firearms
Caring Contact and Follow-Up Intervention for Suicidal States

- Final (and low-cost) non-clinical intervention
- Discovered by Jerome Motto, M.D.
- Effective for reducing suicide attempts and deaths
- Effective among treatment-rejecting suicidal patients
Dear Patient’s Name:

“It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you.”

(signed by attending M.D.)
Mann et al (2005): Treating mood and the underlying psychiatric disorder is “...a central component of suicide prevention.”

Un-replicated RCT evidence for lithium (Tondo et al., 2001) and clozapine (Meltzer et al., 2003—only FDA approved Rx).

**RCT’s not finding** a SSRI effect on suicide ideation/behavior:
- Gunnell et al (2005)
- Fergusson et al (2005)

**RCT’s that did find** a SSRI effect on suicide ideation/behavior:
- Zisook et al (2011)
- Gibbons et al (2012)
6. To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality. Traditionally, behavioral health clinicians often have treated the underlying depression or other mental health disorders in patients but have not directly addressed suicide risk. Providing direct treatment of suicide risk using evidence-based interventions is vital. Hospitalization is often necessary for a patient’s immediate safety, but hospitalization used solely as a containment strategy may be ineffective or counterproductive and considered by the patient as a disincentive or penalty for expressing suicidal thoughts. Evidence-based clinical approaches that help to reduce suicidal thoughts and behaviors include: 1) Cognitive Therapy for Suicide Prevention (CBT-SP), 2) the Collaborative Assessment and Management of Suicide (CAMS), and 3) Dialectical Behavior Therapy (DBT). In addition, Caring Contacts has a growing body of evidence as a post-discharge suicide prevention
Hospitalization:

Not Always a Good Intervention for Suicidal States

The majority of suicides post-hospitalization occur **within the first month** after discharge.

Rates of suicide after discharge is **more than 100 times** the rate of the general population.

Compliance with routine treatment after discharge has been found to be **less than 40%**.

Only **25-50%** attend an appointment for outpatient treatment.

Issues with Hospitalization

Approximately 1500 suicides take place within hospital facilities in the USA each year.

One third of these take place while the patient is on 15-min checks.

Evidence-Based Treatments for Suicidality

- 90+ RCT's with suicidal ideation and behavioral outcomes
- No support for inpatient hospitalization
- Increased risk of suicide post-discharge
- Handful of treatments with single RCT support

- Suicide-specific interventions with replicated and independent RCT support:
  - Dialectical Behavior Therapy (DBT)
  - Two types of suicide-specific CBT (CT-SP & BCBT)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up “caring contact”
Cognitive Therapy for Suicide Prevention (CT-SP)

Methods:

- Identifying thoughts, images, core beliefs
- Emphasis on “suicidal mode”
- Develop adaptive ways of coping with stressors
- Relapse prevention task

Brief Cognitive Behavior Therapy (BCBT)

Treatment of Suicidal States

Methods

**Phase I:** Brief Cognitive Behavioral Therapy

**Phase II:** Assessment of suicidal behaviors and develop strategies

**Phase III:** Apply strategies to reduce vulnerability to using suicide to cope

**Phase IV:** Relapse prevention task conducted

The Collaborative Assessment and Management of Suicidality (CAMS)

A Treatment Framework that Provides Risk Assessment, Stabilization Planning, and Treatment of Patient-Defined Suicidal Drivers
Why CAMS?

• Incorporates risk assessment, tracking and treatment framework
• Responsive to ethical and malpractice considerations
• Meets the need to avoid hospitalization
• Highly effective in reducing suicidal ideation
• Focuses on suicide as a presenting problem

• Evidence indicates that active and chronic suicidal states are being treated and managed
• Evidence indicates that patients like CAMS and are less likely to be hospitalized
• Reduces costs of treatment, time lost in recovery for patients
CAMS for Suicidal Ideation

CAMS Framework™ is an assessment and treatment plan:

• Understand the direct and indirect drivers of suicidal ideation
• CAMS Assessments™ - assess what might be the best way to support the patient
• Develop a Stabilization Plan to provide resources for the patient
• CAMS Treatment™ - develop a treatment plan to address the direct and indirect drivers of suicidal ideation
• Provide a framework to shape treatment to target and treat the drivers of suicidal ideation
First session of CAMS—Suicide Status Form (SSF) Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation
### CAMS Interim Tracking Sessions

- **Section A (Demographics)**
  - Name
  - Date of Birth
  - Initials
  - Phone Number

- **Section B (History of Suicide Risk)**
  - Date of First Suicidal Thought
  - Date of First Attempt
  - Date of First Treatment

- **Section C (Suicide Risk Factors)**
  - Personal History: Self-harm, Suicide Attempts, Frailty
  - Family History: Suicide, Frailty, Medication

- **Section D (CAMS Risk Assessment)**
  - Risk Level: Low, Moderate, High
  - Treatment Plan: Individual, Group, Family

- **Section E (Follow-up)**
  - Date of Next Session
  - Referral to Other Services

### CAMS Outcome/Disposition Session

- **Section A (Patient Demographics)**
  - Name
  - Date of Birth
  - Initials
  - Phone Number

- **Section B (History of Suicide Risk)**
  - Date of First Suicidal Thought
  - Date of First Attempt
  - Date of First Treatment

- **Section C (Suicide Risk Factors)**
  - Personal History: Self-harm, Suicide Attempts, Frailty
  - Family History: Suicide, Frailty, Medication

- **Section D (CAMS Risk Assessment)**
  - Risk Level: Low, Moderate, High
  - Treatment Plan: Individual, Group, Family

- **Section E (Follow-up)**
  - Date of Next Session
  - Referral to Other Services
Summary of CAMS Research Findings to Date

Across 8 published non-randomized clinical trials of CAMS, 1 meta-analysis, 4 published randomized controlled clinical trials, and 2 unpublished RCT’s (a total of 70+ publications):

- Reduces suicidal ideation in 6-8 sessions
- Reduces overall symptom distress, depression, hopelessness, and changes suicidal cognitions
- Increases hope and improves clinical retention to care
- Patients like CAMS and the process of doing CAMS
- Works better with less severe patients at baseline presentation
- Decreases ED visits among certain subgroups
- A promising impact on self-harm behavior and suicide attempts
- Relatively easy to learn
CAMS Adaptations

- University and college counseling centers
- Community mental health (in US and abroad)
- Military treatment facilities (U.S. Air Force and Army)
- Veterans Affairs, standard use and CAMS-Group (CAMS-G)
- Outpatient, respite care, inpatient care across Oklahoma
- Native American use within tribes (use of native medicine)
- CA prison system (telehealth); GA juvenile justice system
- Suicidal teens and suicidal children (5-12 years of age)
- Employee Assistance Programs
- Private clinical practices
Ethical and Legal Considerations
Suicide-Related Malpractice Liability

Malpractice tort litigation for wrongful death secondary to a patient suicide is pursued by plaintiffs (e.g., surviving family) who assert that the provider breached the “standard of care.”

The Standard of Care is operationally defined as what a reasonably prudent practitioner who is similarly trained, in a similar settings, with a similar patient would do.

Standard of Care is defined by expert witnesses who examine subpoenaed records, interrogatories, and depositions.
Suicide-Related Malpractice Liability

The plaintiff has the burden of proof to establish that the practitioner:

- Failed to assess the risk (i.e., foreseeability)
- Failed to appropriately treat the risk
- Failed to follow-through on risk over the course of treatment

Enhanced Clinical Documentation - Reducing the Risk of Malpractice

- The SSF is used in every session
- CAMS medical record documentation is collaboratively completed with the patient
Suicide Prevention Resources in the US
Thank You!

Find us online at:
www.cams-care.com