Division of Mental Health & Addiction Services

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Excerpts of New Jersey Adult Suicide Prevention Plan 2014-2017 Updated According to 2012 National Strategy for Suicide Prevention

Overview of Prioritized Goals, Rationales and Objectives

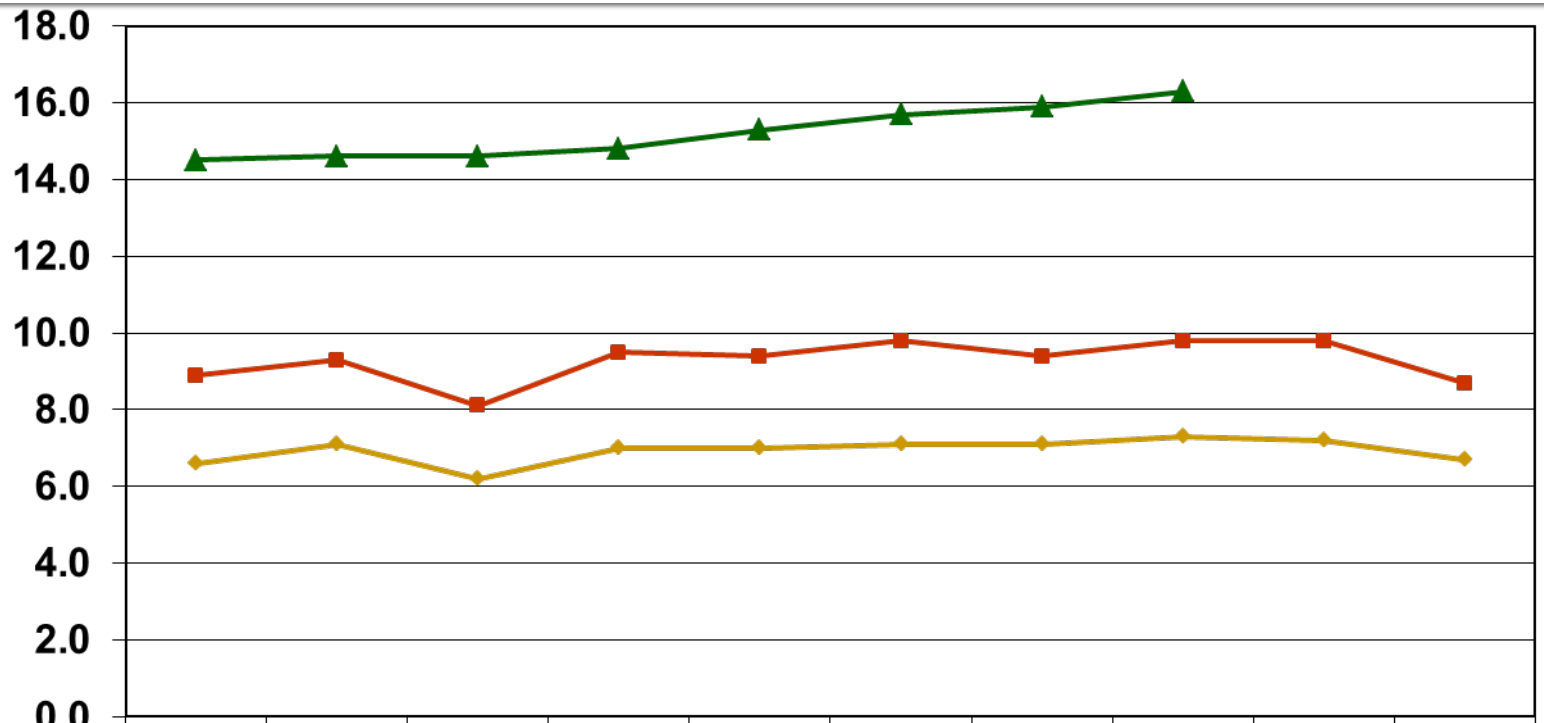
Maria Kirchner, PhD, DMHAS
Al Glebocki, MA, DRCC, DMHAS

Significance

- Suicide is a serious public health problem → 10th leading cause of death
- Roughly 35000 Americans die by suicide every year (2011 → 39,518)
- In 2009, the number of deaths from suicide surpassed the number of deaths from motor vehicle crashes in the United States
- On average 1 person kills her/himself every 13.7 minutes
- On average 1 older (65+) person kills her/himself every 1 h, 28 minutes
- For every suicide death there are estimated 8 to 30 attempts
- The number of suicides in NJ is lowest in the country (national average is 12 per 100,000; NJ 8.2%; Alaska 22.1% in 2010)

SUICIDE IS PREVENTABLE

Suicide Rates in NJ, 2003-2012*



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
All Suicide (NJ)	6.6	7.1	6.2	7.0	7.0	7.1	7.1	7.3	7.2	6.7
Adult Suicide (NJ)	8.9	9.3	8.1	9.5	9.4	9.8	9.4	9.8	9.8	8.7
Adult Suicide (US)	14.5	14.6	14.6	14.8	15.3	15.7	15.9	16.3		

All Suicide (NJ) Adult Suicide (NJ) Adult Suicide (US)

**New Jersey resident deaths, adults are ages 25 and older; data are as of 5/21/2014*

Suicide, Age and Gender

		2009		2010		2011		2009-2011	
		N	Rate	N	Rate	N	Rate	N	Rate
Males									
	25-34	77	14.0	58	10.5	69	12.3	204	12.2
	35-44	96	15.5	84	13.9	99	16.6	279	15.3
	45-64	227	19.7	237	20.2	199	16.7	663	18.8
	65+	60	12.3	99	20.0	91	18.0	250	16.8
Total		460	16.0	478	16.5	460	16.0	1398	16.2
Females									
	25-34	9	**	16	**	20	3.6	45	2.7
	35-44	29	4.5	29	4.6	30	4.9	88	4.7
	45-64	55	4.5	66	5.2	62	4.9	183	4.9
	65+	16	**	13	**	23	3.3	52	2.5
Total		109	3.5	124	3.9	135	4.3	368	3.9
All Adults	25+	569	9.4	602	9.8	595	9.8	1,766	9.7

Prevention

Three types of prevention strategies

- **Universal → entire population**
- **Selective → subgroups at risk**
- **Indicated → identified individuals**

Prevention

- No single prevention strategy will prevent suicide
- Prevention efforts have to be comprehensive and coordinated across organizations and systems at the national, state, and local level.
- They must involve a wide range of partners and draw on a diverse set of resources and tools.
- Everyone—government, business, academics, health care industry, communities, and individuals—has a role in helping to prevent suicide.

Risk Factors

Static/historical

- History of suicide attempts (also family members)
- Mental illness
- Gender, age
- LGBTQ
- History of trauma (PTSD) including bullying
- Lack of social support, living alone
- Unemployment/decrease in economic status
- Loss of a loved one, anniversary of important losses
- Struggle with cultural adjustment

Dynamic

- Current suicidal ideation, intent, plan
- Availability of lethal methods
- Impulsivity
- Worthlessness, hopelessness, helplessness
- Serious medical problems/disabilities
- Serious acute or chronic physical pain
- Severe psychic pain, anxious ruminations
- Command hallucinations

Protective Factors

- Reasons for living (meaning & plans)
- Children/family/social supports
- Supportive community environment
- Moral/religious belief system
- Availability of medical and behavioral health care
- Coping/problem solving skills

National Strategy for S. Prevention: Goals and Objective for Action

- This 2012 updated document consists of 13 goals and 60 objectives (former 11 + 68)
- They are meant to work together in a synergistic way to

✓ **promote wellness,**
✓ **increase protection,**
✓ **reduce risk, and**
✓ **promote effective treatment and**
✓ **recovery.**

Prioritized Goals for NJ Adult SPP

- Goal # 5:

Strengthen, develop, implement, and monitor effective suicide prevention programs that promote wellness and prevent suicide and related behaviors.

- Goal # 7:

Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

NJ Adult Suicide Prevention Committee

- DMHAS Suicide Prevention Committee
- Developed plan was introduced to Stakeholders (May 2014)
- Goals were prioritized (Fall 2014)
- Advisory Council was formed (Dec. 2014)
- Workgroups for each prioritized goal have been working on action steps and outcome measures (ongoing)

Prioritized Goals for NJ Adult SPP

- Goal # 8:

Promote suicide prevention as a core component of health care services.

- Goal # 9:

Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors

Goal 5 Objectives

1. Encourage behavioral health providers and local communities to develop, implement and evaluate effective suicide prevention programs tailored to meet the unique needs of identified at risk groups.

2. Expand and improve education of suicide prevention to increase knowledge regarding evidence-based practices and best practices for suicide prevention, intervention and postvention for schools, colleges and universities, work sites, psychiatric hospitals, correctional institutions, aging programs, and family and community-based organizations.

Goal 5 Objectives

3. In coordination with the DMHAS' Disaster and Terrorism Branch, mobilize available resources to communities and/or individuals negatively affected by natural and/or man-made disasters and terroristic attacks (e.g., 9/11, hurricanes, flooding, fire).

4. Increase access to care by effective coordination of and linkages between programs that provide services addressing mental health, substance use, and physical health.

5. Continue to promote and enhance the NJ Suicide Prevention HOPELINE (855-NJ-HOPELINE or 855-654-6735.

Goal 7 Objectives

1. Provide training to mental health and substance use providers on the recognition, assessment, and management of at-risk behavior, identification of persons at risk and delivery of effective clinical care for people with suicide risk; including referral to community-based services.

2. Provide education for physicians, primary care physicians, physician assistants, nurse practitioners, nurses, social workers, psychologists, counselors and other primary care providers on the identification of depression and substance use and their relationship to suicide risk

Goal 7 Objectives (con't)

3. Provide education for clergy, teachers and other educational staff, correctional workers, and attorneys on how to identify and respond to persons at risk for suicide.

4. Provide educational programs for family members of persons evaluated to be at risk.

5. Develop and implement protocols and programs that will guide a collaborative approach for clinicians and clinical supervisors, first responders, crisis staff and others to manage care of at risk individuals until the risk is reduced.

Goal 8 Objectives

1. Promote the adoption of "zero suicides" as an aspirational goal by health care and community support systems for at risk populations.

2. Increase the number of state and local agencies, professional (including primary care), volunteer, faith-based communities and other groups that integrate suicide prevention activities into their ongoing activities.

Goal 8 Objectives (con't)

3. Work with all appropriate state departments and health and social services programs for at-risk populations to develop and implement protocols for effective, efficient, and culturally competent mental health and substance use services.

4. Define and implement screening and linkage guidelines with mental health and substance use service providers including schools, colleges, hospital inpatient settings, correctional institutions and programs, and primary care sites.

Goal 8 Objectives (con't)

5. Promote timely access to assessment, intervention, and effective care for individuals at risk for suicide using resources such as crisis hotlines, online crisis chats, mobile screening teams, etc.

6. Promote continuity of care and the safety of all patients treated for suicide risk in emergency departments and hospital inpatient units.

Goal 8 Objectives (con't)

7. Encourage health care delivery systems to assess and evaluate all suicide attempts and suicides to identify systemic issues where improvements can be made.

8. Develop collaborations between emergency departments and other health care providers to provide alternative to emergency department care and hospitalization when appropriate and promote rapid follow-up after discharge.

Goal 9 Objectives

1. Adopt, promote, disseminate and implement evidence-based best practice guidelines and uniformed procedures and/or policies on suicide risk assessment and treatment of suicidality across all settings that provide health care services.

2. Establish, disseminate and implement clinical practice guidelines for treatment providers to ensure that all services are patient-centered, recovery-oriented, and provide continuity of care.

Goal 9 Objectives

3. Decrease barriers to the safe disclosure of suicidal thoughts and behaviors for all at-risk individuals and treatment providers.

4. Foster education for family members and significant others of individuals at risk for suicide to ensure the continuity of their care.

5. Adopt, promote, disseminate and implement policies and procedures for suicide risk assessments and interventions to promote safety and prevent suicide among individuals receiving mental health and substance use treatment.

Goal 9 Objectives (con't)

6. Develop standardized suicide risk assessment and treatment protocols that emphasize person-centered and stepped approaches for use in emergency departments based upon risk profiles.

7. Develop documentation guidelines for psychiatric assessment and treatment interventions for at-risk individuals and provide technical assistance for their implementation

Access to the NJ Adult SP Plan and Other Resources

NJ Adult Suicide Prevention Plan (incomplete): http://www.sprc.org/states/new-jersey

Suicide Prevention Resource Center: http://www.sprc.org/

The National Action Alliance for Suicide Prevention: http://actionallianceforsuicideprevention.org/

The Injury Control Research Center for Suicide Prevention: http://suicideprevention-icrc-s.org/

- Al Glebocki, MA: al.glebocki@dhs.state.nj.us
- Maria Kirchner, PhD: maria.kirchner@dhs.state.nj.us