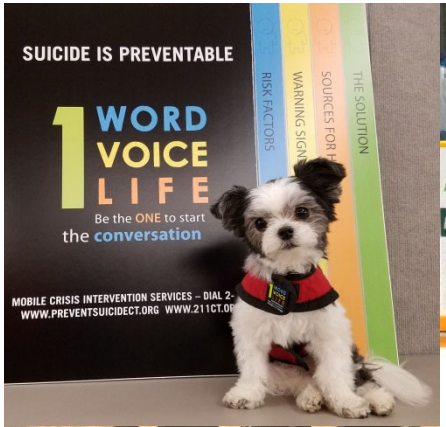
SUICIDE IS PREVENTABLE
1 WORD VOICE LIFE
Be the ONE to start the conversation
RISK FACTORS
WARNING SIGNS
SOURCES FOR HELP
THE SOLUTION
MOBILE CRISIS INTERVENTION SERVICES – DIAL 2-
WWW.PREVENTSUICIDECT.ORG WWW.211CT.OR


1 WORD VOICE LIFE
Be the ONE to start the conversation
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www.preventsuicidect.org
www.empsct.org


SUICIDE IS PREVENTABLE.
FOR HELP
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AND PRESS 1
Outside CT Dial
800.273.8255
PREVENTSUICIDECT.ORG
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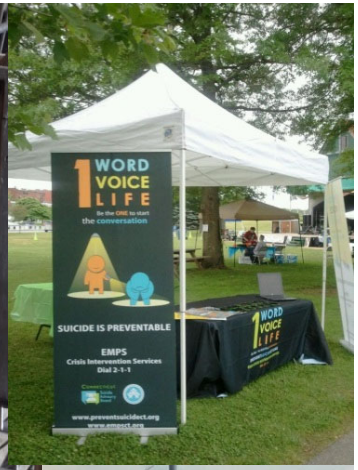
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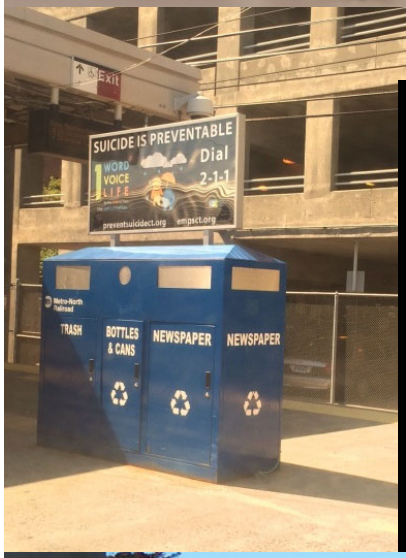
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BOTTLES & CANS
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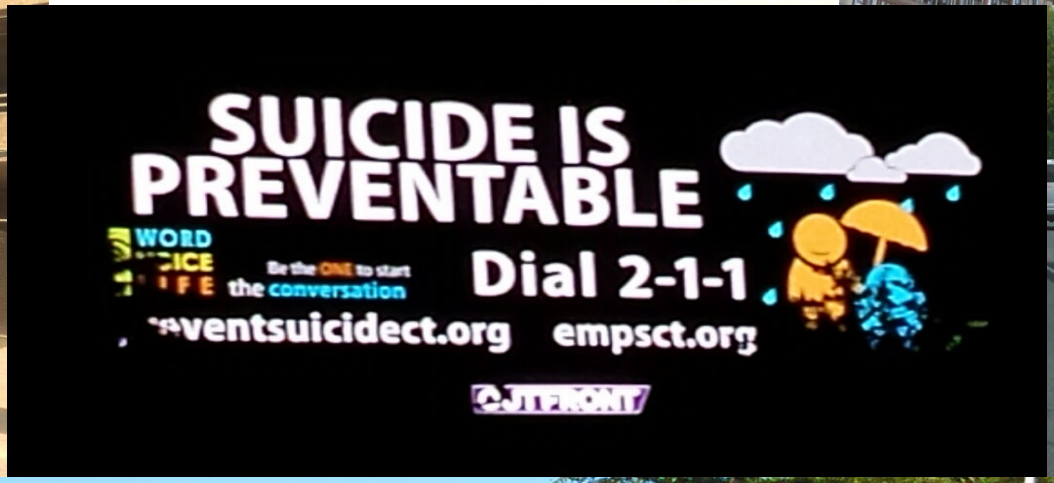
NEWSPAPER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2214
1 WORD VOICE LIFE
Be the 1 to start the conversation
www.preventsuicidect.org
CALL 2-1-1
Mobil
Mart
ATM


1 WORD VOICE LIFE
Be the 1 to start the conversation
www.preventsuicidect.org
CALL 2
DO NOT ENTER
Suicide Advisory Board

Connecticut Suicide Advisory Board

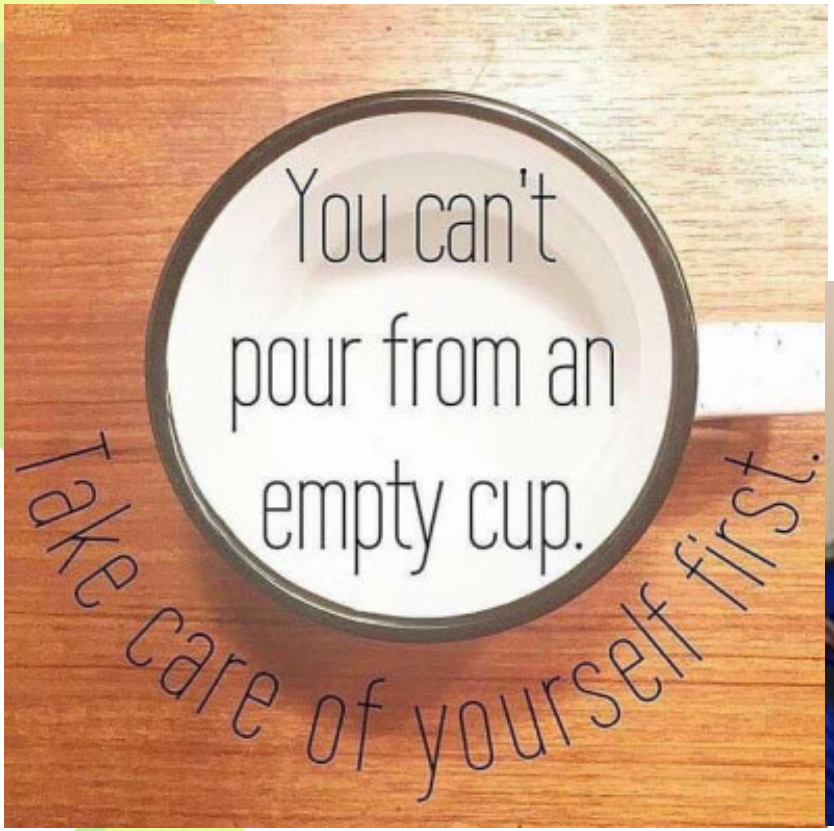
Andrea Iger Duarte, MSW, MPH, LCSW
Suicide Prevention Project Director
CT Department of Mental Health and Addiction Services
Co-Chair, CTSAB

Zero Suicide in Healthcare

CT Zero Suicide Learning Community

October 28, 2020

Self-Care & Peer Support



Stronger Together!

CONNECTICUT Suicide Advisory Board

10/28 CT ZSLC Agenda

- Welcome
- Announcements
- ZS refresher
- Survey Review
- Closing

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Announcements

- State Plan 2025
- New CDC Grant
- Completed Pilots
- SOSA Training in December
- Postvention

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Postvention Resources for the Health and Behavioral Healthcare Settings

- **www.preventsuicidect.org/resources/healthbehavioralcare**
  - After a Suicide: Postvention in Health and Behavioral Healthcare Settings
  - After a Suicide: The Zero Suicide Approach to Postvention in Health and Behavioral Healthcare Settings
  - Impact of Suicide on Professional Caregivers: A Guide for Managers and Supervisors
  - Suicide in Parking Facilities: Prevention, Response, and Recovery

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10 Leading Causes of Death, Connecticut
2018, All Races, Both Sexes

	Age Groups										
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 28	Unintentional Injury ---	Malignant Neoplasms ---	Malignant Neoplasms ---	Unintentional Injury 140	Unintentional Injury 309	Unintentional Injury 324	Malignant Neoplasms 357	Malignant Neoplasms 1,132	Heart Disease 6,101	Heart Disease 7,205
2	Short Gestation 26	Malignant Neoplasms ---	Unintentional Injury ---	Unintentional Injury ---	Suicide 40	Suicide 46	Malignant Neoplasms 93	Unintentional Injury 344	Heart Disease 683	Malignant Neoplasms 4,812	Malignant Neoplasms 6,472
3	Maternal Pregnancy Comp. 23	Congenital Anomalies ---	Anemias ---	Heart Disease ---	Malignant Neoplasms 19	Malignant Neoplasms 40	Heart Disease 86	Heart Disease 290	Unintentional Injury 293	Chronic Low. Respiratory Disease 1,280	Unintentional Injury 2,054
4	SIDS ---	Heart Disease ---	Congenital Anomalies ---	Homicide ---	Homicide 15	Heart Disease 33	Suicide 52	Suicide 95	Liver Disease 122	Cerebro-vascular 1,251	Chronic Low. Respiratory Disease 1,427
5	Unintentional Injury ---	Nephritis ---	Heart Disease ---	Cerebro-vascular ---	Heart Disease ---	Homicide 31	Homicide 18	Liver Disease 63	Chronic Low. Respiratory Disease 112	Alzheimer's Disease 978	Cerebro-vascular 1,388
6	Placenta Cord Membranes ---	---	Influenza & Pneumonia ---	Chronic Low. Respiratory Disease ---	Congenital Anomalies ---	Septicemia ---	Liver Disease 18	Diabetes Mellitus 39	Diabetes Mellitus 109	Influenza & Pneumonia 677	Alzheimer's Disease 986
7	Circulatory System Disease ---	---	Parkinson's Disease ---	Influenza & Pneumonia ---	Eight Tied ---	Diabetes Mellitus ---	Diabetes Mellitus 13	Cerebro-vascular 38	Suicide 98	Unintentional Injury 627	Influenza & Pneumonia 757
8	Hydrops Fetalis ---	---	---	Suicide ---	Eight Tied ---	Liver Disease ---	Cerebro-vascular 12	Chronic Low. Respiratory Disease 28	Cerebro-vascular 82	Diabetes Mellitus 541	Diabetes Mellitus 708
9	Four Tied ---	---	---	---	Eight Tied ---	Complicated Pregnancy ---	Influenza & Pneumonia ---	Influenza & Pneumonia 23	Septicemia 61	Nephritis 532	Nephritis 612
10	Four Tied ---	---	---	---	Eight Tied ---	Congenital Anomalies ---	Two Tied ---	Two Tied 18	Nephritis 58	Septicemia 488	Septicemia 574

Note: For leading cause categories in this State-level chart, counts of less than 10 deaths have been suppressed (---).

Produced By: 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

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CT looks different than US and NE. Suicide is the 11th not 10th cause of death in CT. The ranking of 55-64 yo is 7th not 8th in CT.

The 10-14 yo ranking fluctuates annually between 2nd and 8th due to small numbers of deaths. The 2015-2018 average for 10-14 yo was 2.5 deaths.

Suicide Facts & Figures:
Connecticut 2020

On average, one person died by suicide every 21 hours in the state.

More than three times as many people died by suicide in Connecticut in 2018 than in alcohol related motor vehicle accidents.

The total deaths to suicide reflected a total of 6,798 years of potential life lost (YPLL) before age 65.

Suicide cost Connecticut a total of **$410,800,000** combined lifetime medical and work loss cost in 2010, or an average of **$1,163,740 per suicide death**.

11th leading cause of death in Connecticut

2nd leading cause of death for ages 10-34

4th leading cause of death for ages 35-54

7th leading cause of death for ages 55-64

17th leading cause of death for ages 65+

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Connecticut	**419**	**10.54**	**45**
Nationally	48,344	14.21	

CDC, 2018 Fatal Injury Reports (accessed from www.cdc.gov/injury/wisqars/fatal.html on 3/1/2020).

afsp.org/statistics

American Foundation for Suicide Prevention

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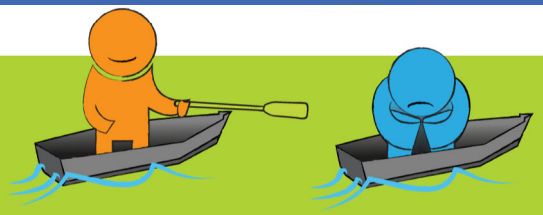
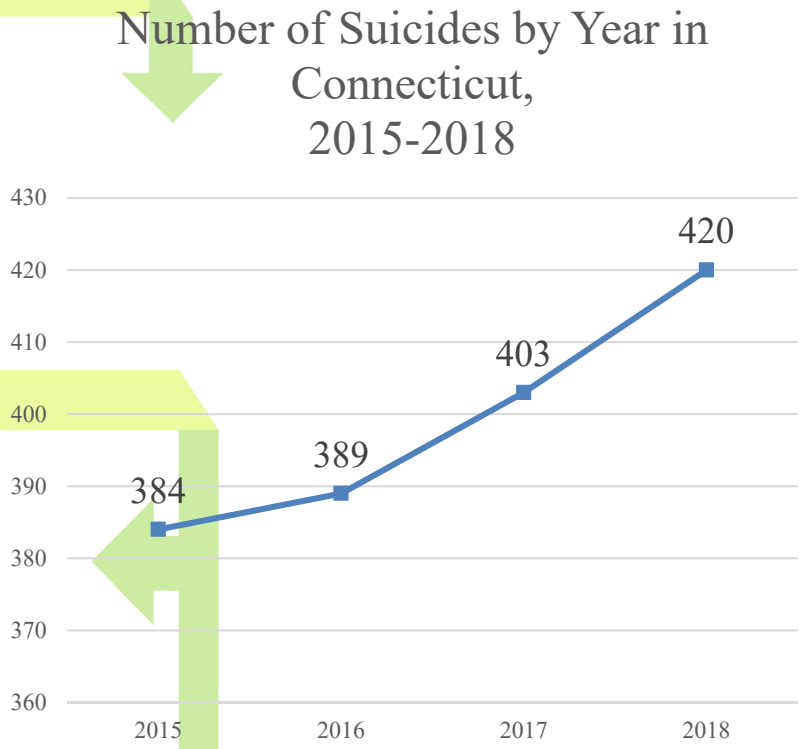
CT has ranked among the 8 lowest states and DC for many years.

CT ranks 45th based on 2018 data.

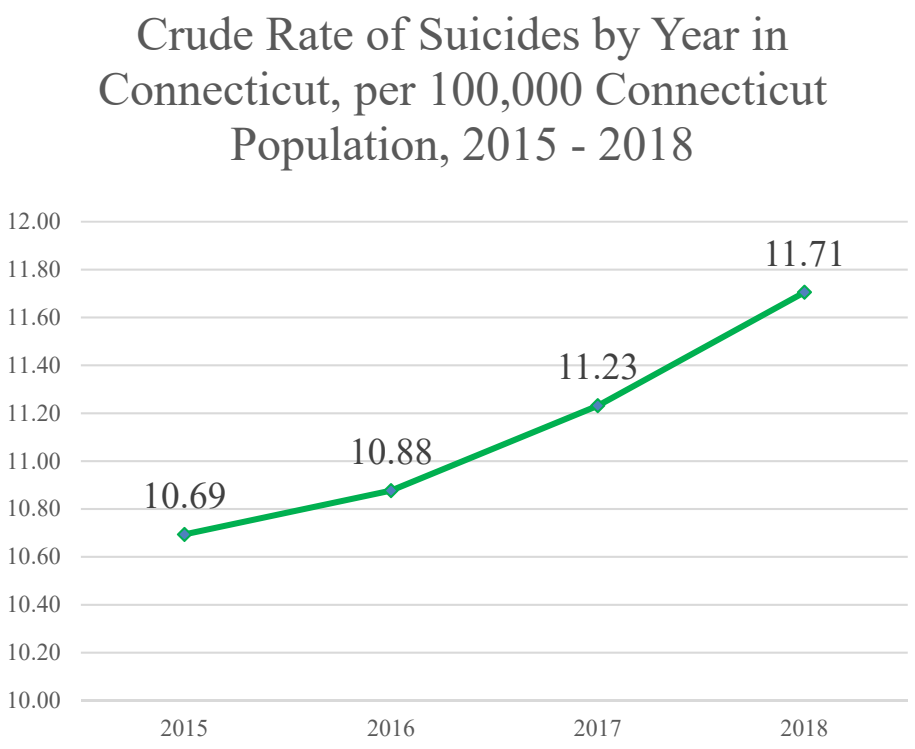


CT Suicide Trends: 2015 - 2018

CTVDRS



Data Source: CT Violent Death Reporting System



Data Source: CT Violent Death Reporting System

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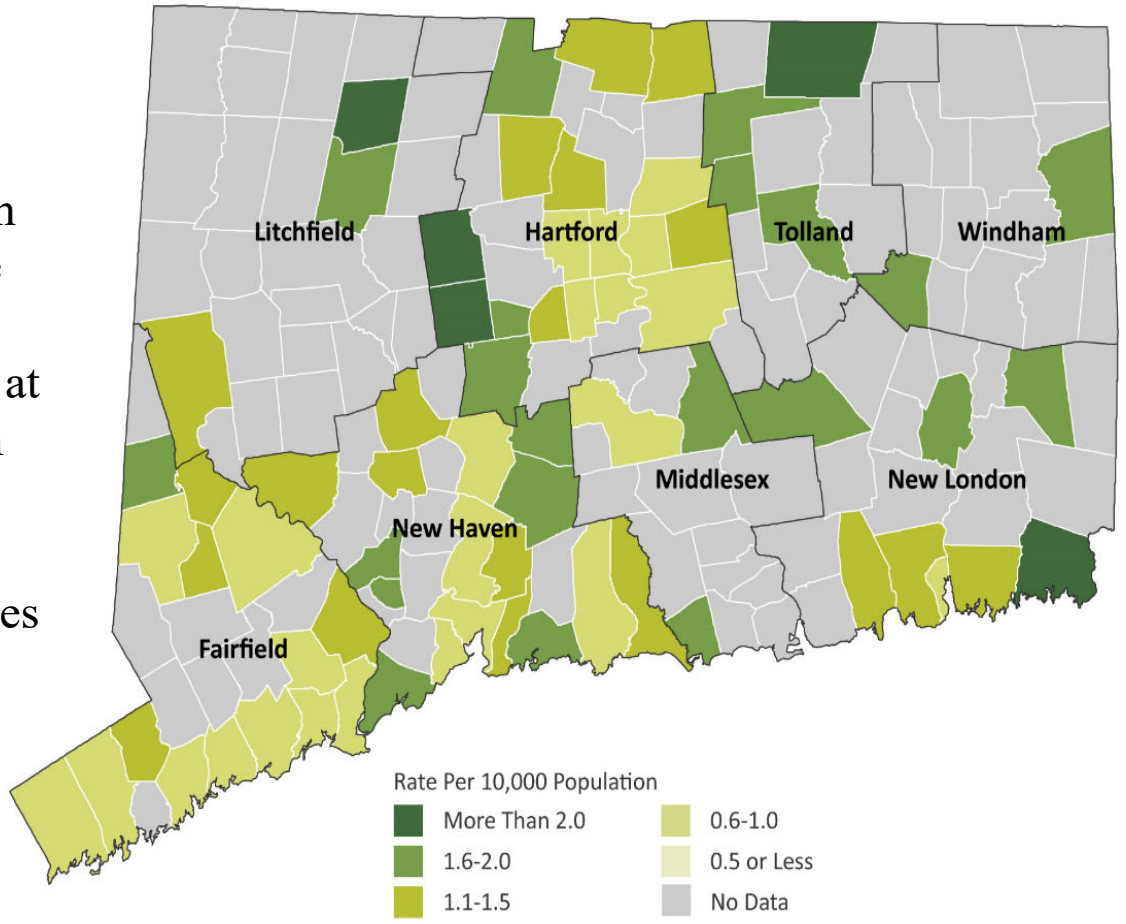
Rates of Suicide in Connecticut Towns 2015 to 2018

CTVDRS

- Rate per 10,000 CT town population
- Calculated rates on 4 year sum of people who died by suicide
- Rate calculated for town with at least 8 suicide deaths between 2015 and 2018
- If the 4-year number of suicides is less than 8, the death rate is greyed out



Data Source: CT Violent Death Reporting System

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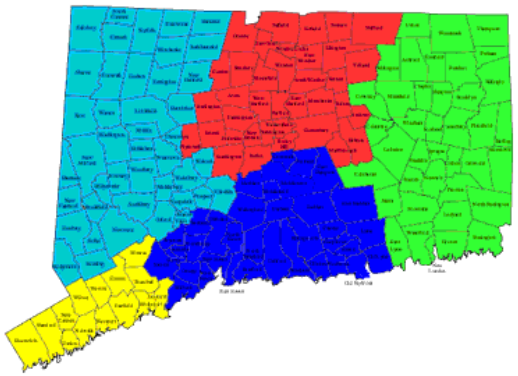
Suicide Rates by Suicide Advisory Board Regions, 2015-2018

CTVDRS



CT Violent Death Reporting System (2018) CTVDRS
Top Five Known Circumstances by Specific Age Categories

Ages < 25	Ages 25 - 64	Ages > 64
Perceived to have Depressed Mood	Perceived to have Depressed Mood	Perceived to have Depressed Mood
History of Ever Receiving Mental Illness or Substance Abuse Treatment	History of Ever Receiving Mental Illness or Substance Abuse Treatment	History of Ever Receiving Mental Illness or Substance Abuse Treatment
Currently Diagnosed with a Mental Health Problem	Currently Diagnosed with a Mental Health Problem	Currently Diagnosed with a Mental Health Problem
Currently Receiving Mental Health/Substance Abuse Treatment	Currently Receiving Mental Health/Substance Abuse Treatment	Contributing Physical Health Problem*
History of Attempted Suicide	Alcohol and/or Other Substance Abuse Problem at Time of Death	Currently Receiving Mental Health/Substance Abuse Treatment

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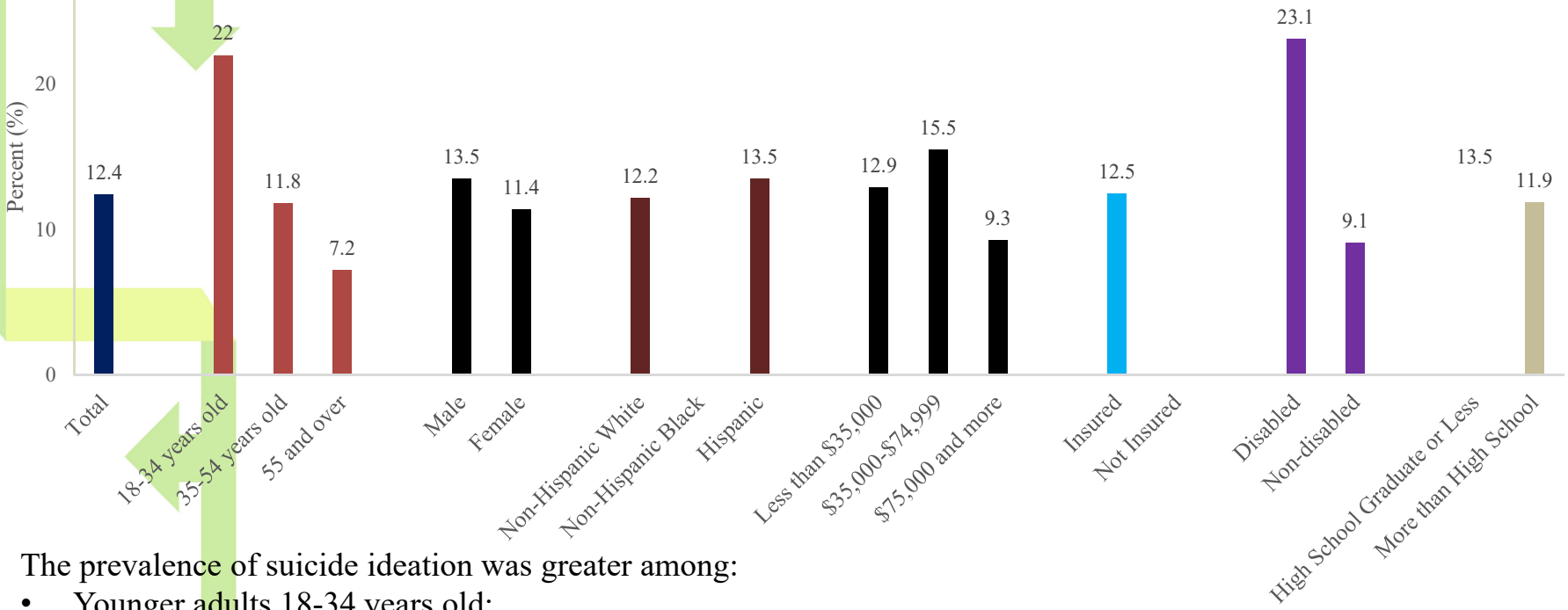
* Includes Health Problems and Chronic Pain/Illness.

Suicide Ideation, CT 2018

- In 2018, the prevalence of suicide ideation among Connecticut adults was 12.4%, while suicide attempts was 3.8%;
- About 1 in 3 adults who ever thought of suicide had attempted suicide.



The prevalence of suicide ideation was greater among:

- Younger adults 18-34 years old;
- Adults with annual incomes $35,000-$74,999 (15.5%) compared to adults with incomes at least $75,000 (9.3%);
- Disabled adults.

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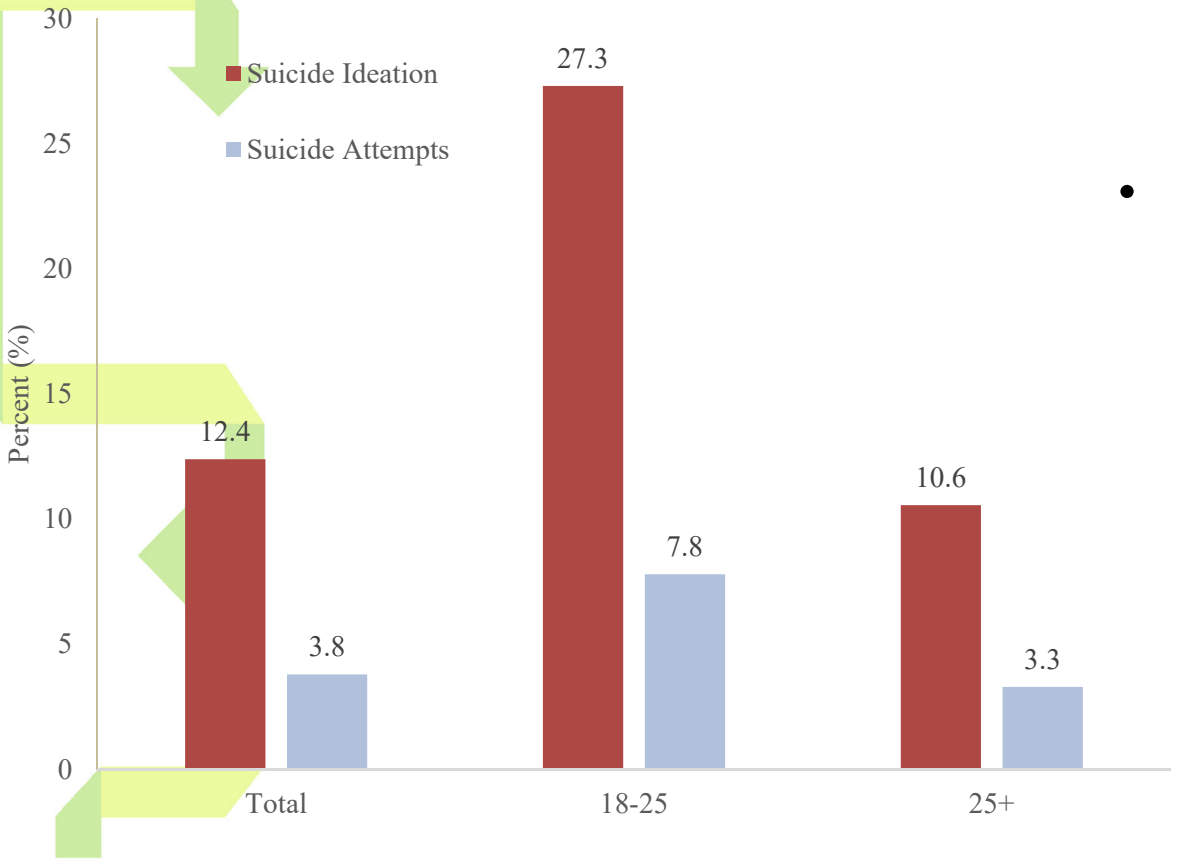
Data Source: Behavioral Risk Factor Surveillance System

Suicide Ideation and Attempts by Age among CT Adult Residents, 2018



- In 2018, CT adults 18-25 years old are 2.5 times more likely to have suicide ideation and attempt suicide, compared to adults 25 years and over.

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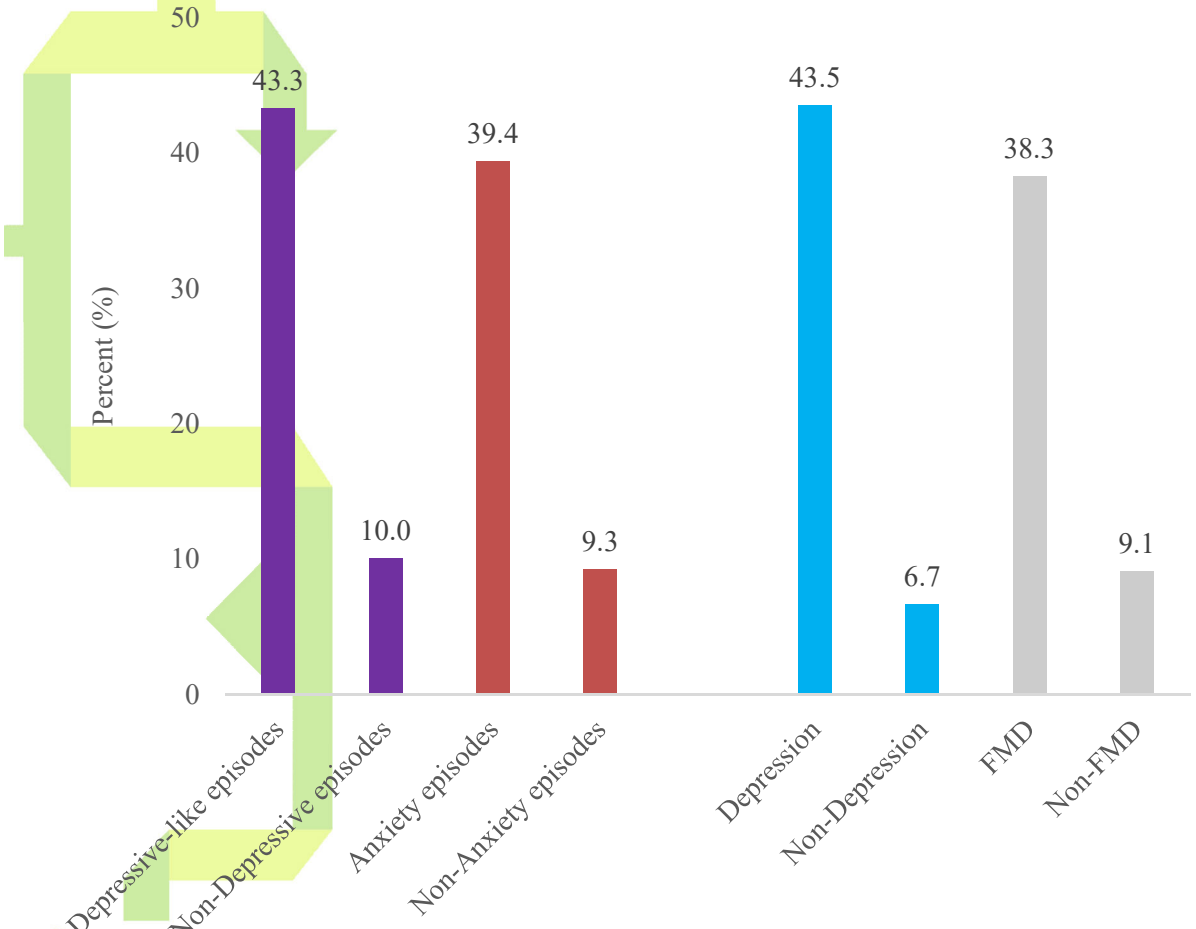
Data Source: Behavioral Risk Factor Surveillance System

Mental Illness with Suicide Ideation, CT 2018



- CT adults with mental illness (depressed, anxiety, depression, FMD) are 4 times more likely to have suicide ideation.

- ***Depressive-like episodes***: *adults who have been bothered by feeling down, depressed or hopeless for more than half the days or nearly every day in the past 2 weeks;*

- ***Anxiety episodes***: *adults who have been bothered by feeling nervous, anxious or on edge for more than half the days or nearly every day in the past 2 weeks.*

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Data Source: Behavioral Risk Factor Surveillance System

What is Zero Suicide, and Why?

> *It is critically important to design for zero even when it may not be theoretically possible. When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent may not materialize. It is about purposefully aiming for a higher level of performance.*
>
> Thomas Priselac, CEO
> Cedars Sinai Medical Center

- Founded on the fact that suicide prevention is a core responsibility of health care, and that suicide deaths are preventable.
- A systematic clinical approach in health systems is critical to prevent suicide, not "the heroic efforts of crisis staff and individual clinicians."
- ZS presents both a bold goal and an aspirational quality improvement challenge for health and behavioral health care systems.
- ZS is a methodology to eliminate suicide with the state of mind that one suicide is too many.
- ZS provides a framework for systematic, clinical suicide prevention that includes safety and error reduction, and a set of best practices and tools.

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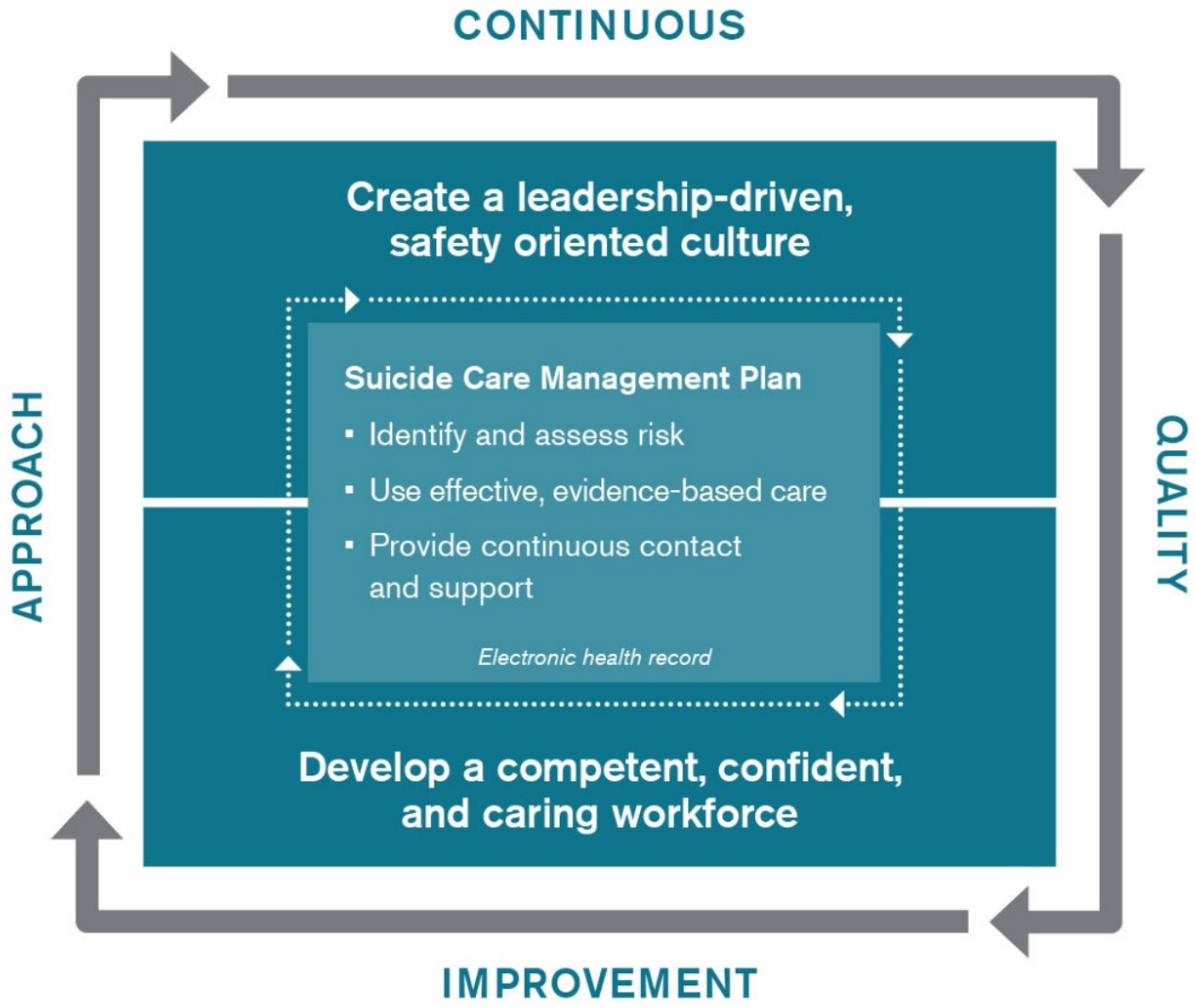
ZS is a CQI Approach



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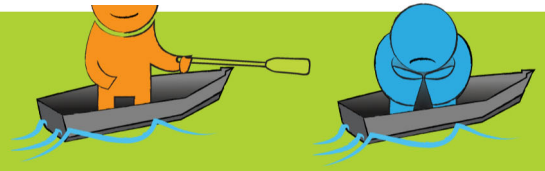


7 ZS Elements

LEAD
system-wide culture change committed to reducing suicides

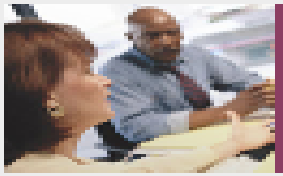
TRAIN
a competent, confident, and caring workforce

IDENTIFY
patients with suicide risk via comprehensive screenings

ENGAGE
all individuals at-risk of suicide using a suicide care management plan

TREAT
suicidal thoughts and behaviors using evidence-based treatments

TRANSITION
individuals through care with warm hand-offs and supportive contacts



IMPROVE
policies and procedures through continuous quality improvement

Applying Zero Suicide Gold Standards for Systematic Suicide Care Plugs Holes

- Systematic Suicide Care

Person at risk of suicide

Identify persons at risk using suicide-specific screening and assessment tools.

Engage person on a suicide care management plan.

Treat suicidality with effective approaches that address suicide specifically.

Transition person between levels of care safely and with support. Collaborative Safety Plan and Follow-up efforts.

Person's Serious Injury or Death Avoided

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James Reason's "Swiss Cheese Model" of accident causation

Implementing ZS

- Self-Care is not selfish.
- Talk with those who are already on this path. Learn from others' successes and challenges.
- Use ZS Toolkit. Don't reinvent the wheel.
- Engage strategic partners, champions and key stakeholders. Collaboration is key, and silos are barriers.
- Peer Support among staff and patients is priority.

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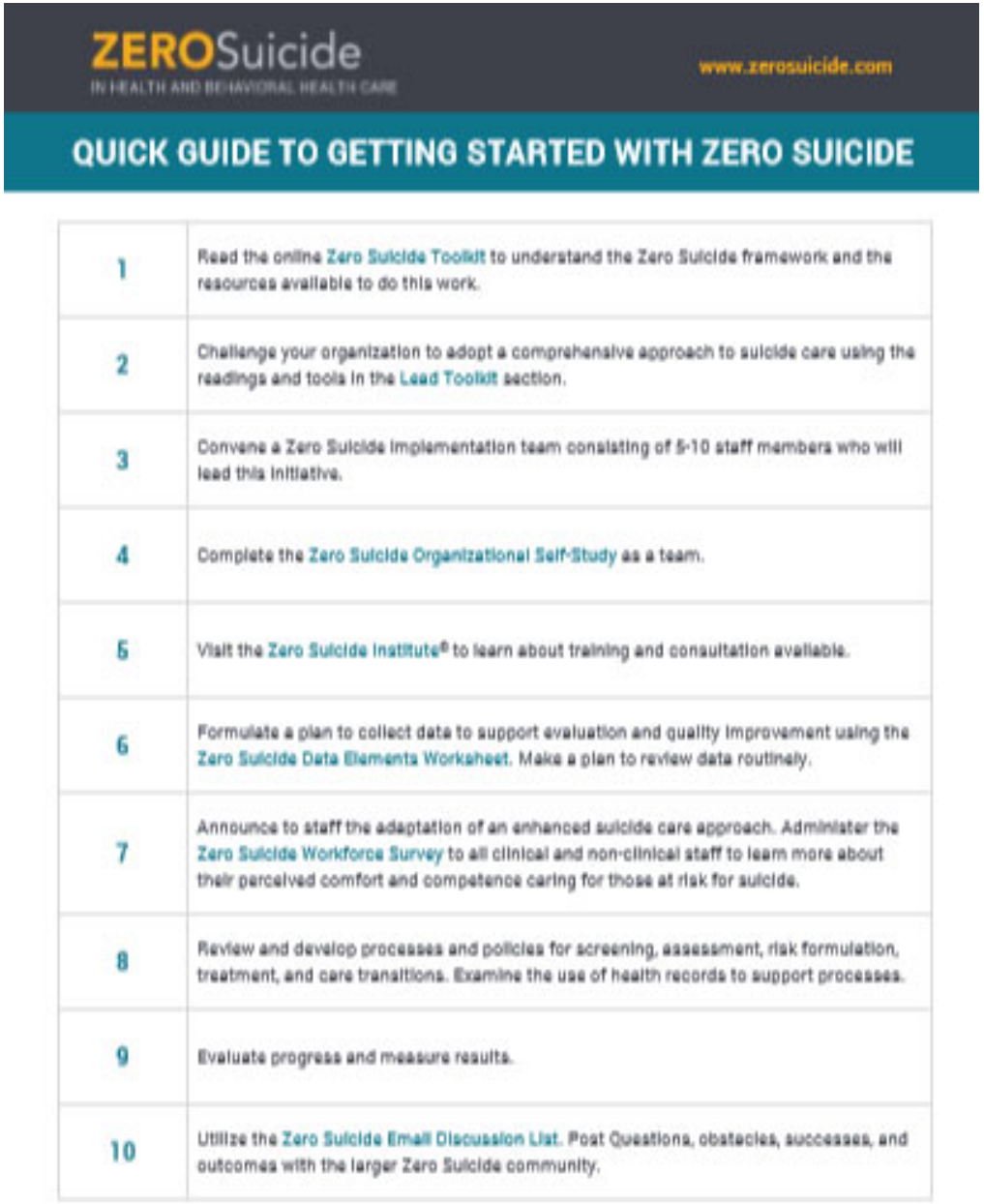

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE
www.zerosuicide.com

QUICK GUIDE TO GETTING STARTED WITH ZERO SUICIDE

1	Read the online Zero Suicide Toolkit to understand the Zero Suicide framework and the resources available to do this work.
2	Challenge your organization to adopt a comprehensive approach to suicide care using the readings and tools in the Lead Toolkit section.
3	Convene a Zero Suicide implementation team consisting of 5-10 staff members who will lead this initiative.
4	Complete the Zero Suicide Organizational Self-Study as a team.
5	Visit the Zero Suicide Institute® to learn about training and consultation available.
6	Formulate a plan to collect data to support evaluation and quality improvement using the Zero Suicide Data Elements Worksheet. Make a plan to review data routinely.
7	Announce to staff the adaptation of an enhanced suicide care approach. Administer the Zero Suicide Workforce Survey to all clinical and non-clinical staff to learn more about their perceived comfort and competence caring for those at risk for suicide.
8	Review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transitions. Examine the use of health records to support processes.
9	Evaluate progress and measure results.
10	Utilize the Zero Suicide Email Discussion List. Post questions, obstacles, successes, and outcomes with the larger Zero Suicide community.

EDC Learning transforms lives.

5.19.2017

CT SUICIDE ADVISORY BOARD: Zero Suicide Learning Community

Purpose: Support Goal 3 of CT PLAN 2020 (NSSP 8)
Promote suicide prevention as a core component of health care services through adoption of the Zero Suicide approach within health and behavioral health systems and beyond their walls to surrounding communities.

System LC Participation WIFM:

- Monthly forum on ZS dimensions and related evidence-based strategies (EBs)
- Listserve to facilitate communication
- CT and national resources and technical assistance/guidance
- Access to training and workforce development resources/opportunities
- Encouragement and peer to peer support to adopt the approach and EBs

Meets: Bi-Monthly via virtual platform (next 12/23 at 9 AM- Caring Cards Pilot)

Hosts: The CTSAB and the Institute of Living/Hartford Hospital (National 2015 Zero Suicide Academy graduates), in partnership with the CT Hospital Association.

CONNECTICUT Suicide Advisory Board

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