NEW YORK STATE | Office of Mental Health

OMH News

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ANN MARIE T. SULLIVAN, M.D.
Commissioner

Suicide PREVENTION:
Through Collective Action, There is Hope

Nothing is more precious than a human life. As mental health professionals, it's our responsibility to do all that we can to convince clients who are considering suicide that life is worth living and that there is indeed hope for recovery.

September 2016 is National Suicide Prevention Awareness Month. While other leading causes of death in the United States – such as heart disease, stroke, and cancer – have been in decline since 1999, the rate of suicide has increased by more than 24%.

During the past decade, there have been more deaths nationally by suicide each year than by car accidents, homicides, and breast cancer. The problem is growing ever more urgent and it's a problem every state is challenged to solve.

To learn more about Suicide Prevention Awareness Month, visit: http://www.nami.org/Get-Involved/Awareness-Events/Suicide-Prevention-Awareness-Month.

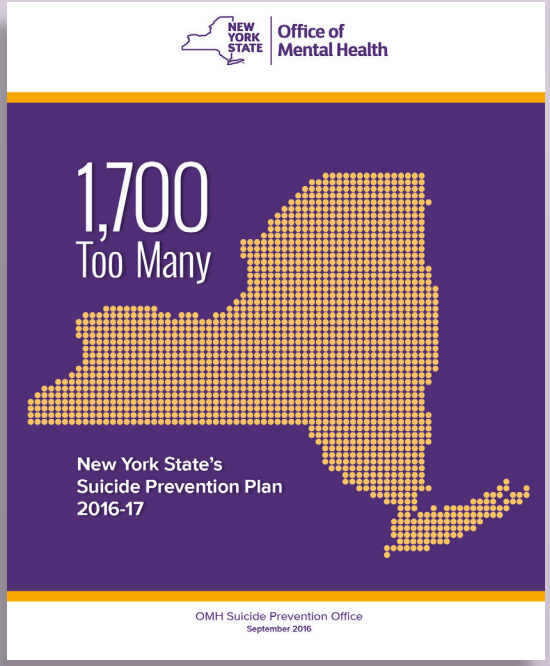
Preventing suicide is essential to every program and activity operated or funded by the New York State Office of Mental Health. This month, OMH is launching a comprehensive Suicide Prevention Plan through its Suicide Prevention Office. It's an initiative to reduce suicides among New Yorkers, including consumers of mental health services, by integrating suicide prevention into healthcare settings and providing suicide prevention training to healthcare providers.

This initiative is part of the National Strategy for Suicide Prevention (NSSP). New York is one of only four states to receive a grant to advance the NSSP.

According to the latest information from the U.S. Centers for Disease Control (CDC), 1,700 people in New York State died by suicide in 2014. As the title of the Suicide Prevention Office's Plan (see cover at right, article on Page 4) indicates, this is *1,700 Too Many.*

In this edition of *OMH News,* we'll discuss New York State's plan to advance suicide prevention and ultimately save lives.

Please share your thoughts with us at omhnews@omh.ny.gov.



Zero Suicide:
Commitment to Closing the Gaps

The Zero Suicide Initiative is a commitment to suicide prevention in health and behavioral health care systems.

It was an outgrowth of the 2012 National Strategy for Suicide Prevention and was developed by the National Action Alliance for Suicide Prevention. The Action Alliance is a public-private partnership focused on suicide prevention.

Principles

The Zero Suicide model is based on three observations:

- Most suicide deaths occur among people recently discharged from care. Suicide prevention must be a core responsibility of healthcare systems.
- New knowledge about detecting and treating suicidality is not commonly used. We must apply new knowledge to clinical practice.
- Suicide prevention in healthcare requires a systematic, clinical approach. Not the "heroic efforts of crisis staff and individual clinicians."

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

To learn more about Zero Suicide, visit: http://zerosuicide.sprc.org.

To achieve the goal of Zero Suicide, there must be a commitment to quality improvement, patient safety, and to the safety and support of clinical staff. This commitment, however, is not solely the responsibility of clinical practitioners. To be successful, it must be an obligation of everyone connected with the health care and mental health systems.

Essential Elements

After researching successful approaches to suicide reduction, the Action Alliance's Clinical Care and Intervention Task Force identified seven essential elements of suicide care:

- **Lead –** Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.

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- **Train –** Develop a competent, confident, and caring workforce.
- **Identify –** Systematically identify and assess suicide risk among people receiving care.
- **Engage –** Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- **Treat –** Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- **Transition –** Provide continuous contact and support, especially after acute care.
- **Improve –** Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Seven essential elements of suicide care.

Implementation in New York State

New York State is calling for the implementation of Zero Suicide beyond behavioral health into the broader health care system, into settings such as primary care and emergency departments — settings that are in frequent contact with suicidal individuals.

In the late fall of 2016, OMH is initiating the largest-scale Zero Suicide implementation project in the nation. Nearly 200 state-operated or community-licensed mental health clinics that serve a high-risk population are participating in a two-year project that integrates principles of Zero Suicide.

The New York State Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), a web-based application, will be used to support the project and measure outcomes. Clinic staff are receiving training and technical assistance in evidence-based practices from the Center for Practice Innovations' Suicide Prevention-Training, Implementation and Evaluation (SP-TIE) group.

Community coalitions are also playing a role in spreading Zero Suicide. A coalition in Erie County, for example, held a successful event in 2015 attended by more than 70 primary care providers who had the opportunity to learn about county-level suicide data from the medical examiner, and to hear from both the health and mental health commissioners' commitment to work together to reduce deaths.

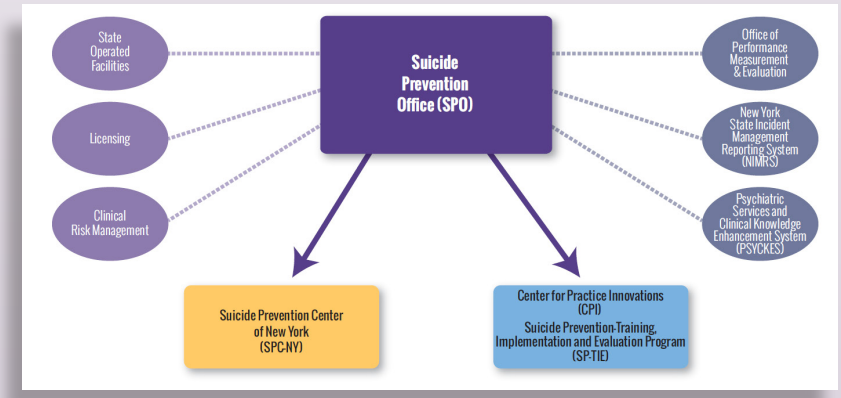
The event also provided practical tools on screening and referral of suicidal patients. This year, the event will include a 45-minute Question, Persuade, and Refer training tailored to primary care providers.

New York's Plan:
A Three-Part Statewide Strategy for Suicide Prevention

The OMH Suicide Prevention Office has developed a three-part strategy for reducing the number of suicides and attempts in New York State. Its report, *1,700 Too Many: New York State's Suicide Prevention Plan, 2016-17*, describes a strategy to build on current health, behavioral health, and community programs and develop data for evaluation.

Strategy One: Redesigning Health Care to Prevent Suicides

Care of suicidal individuals has tended to focus on mental health diagnoses and services. The Suicide Prevention Office report calls for a shift in current clinical practice, in which standards of care focus on preventive engagement and the explicit goal of reducing suicides. This would call for systematic screening to improve detection, recognizing that many individuals may be "one acute stressor away" from suicide, even if they don't report feeling suicidal at the time of an assessment. It also calls for improvements in the care of the chronically suicidal.



OMH Suicide Prevention Organization Chart. Services are designed to work as an interconnected web throughout the state.

By some estimates, nearly 73% of people who have attempted or died by suicide were seen in an outpatient mental health setting less than six months prior. More than 60% had outpatient contact less than 30 days prior. This is an indication for New York State to focus on expanding the Zero Suicide Initiative (see article on Page 2) to outpatient clinics, primary care settings, and emergency departments – settings that are in frequent contact with suicidal individuals.

Clinicians who work in these community clinics have reported that they're not comfortable asking their clients direct questions about suicide and are eager for training to assess, intervene, and treat suicidal clients. In response, OMH is offering a host of trainings on different aspects of suicide prevention and is advancing safer care through licensing standards, direct provider communication, and training support. Support for outpatient public mental health clinics that are implementing the Zero Suicide Initiative will be available through the PSYCKES Suicide Prevention Continuous Quality Improvement Project.

This strategy also calls for making peers who are suicide attempt survivors or have experience with suicide loss an important part of the process – not only by offering an example of hope for clients feeling isolated and helping to reduce stigma, but by informing the design of supports that can help.

Strategy Two: Focusing on How Suicide Attempts Develop

The second strategy calls for increasing efforts to intervene at the earliest stages of suicidal crises and even preventing individuals from becoming suicidal in the first place.

Community settings offer opportunities to detect and intervene with high-risk populations, including people who may not have been easily reached through the health and behavioral healthcare systems.

New York State provides support for community coalitions that harness the passion and power of local families, schools, businesses, neighborhoods, faith communities, friends, and local government, to work together as the "backbone" of a local suicide prevention infrastructure. New York State is already providing guidance and technical assistance to schools to help youths develop the skills for lifelong resilience to suicide risk through the

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evidenced-based programs of "Creating Suicide Safety in Schools," "Sources of Strength," and "Lifelines Trilogy" (see article on Page 8).

Research indicates that additional suicides can occur after a friend or family member takes their own life. To help stop this cycle, this strategy calls for the use of "postvention" – intervening with those affected by a suicide. New York State is coordinating with the Suicide Prevention Center of New York on a statewide taskforce to develop a consistent approach to postvention on the community level.

They are developing a toolkit for community stakeholders and a guidance document on the principles of a solid response. This program would provide education for recognizing warning signs for suicide and offering instructions on responding appropriately and connecting a suicidal individual with a mental health professional.

Strategy Three: Smarter Suicide Prevention with Data

Because of the volatile nature of suicide, it's crucial for mental health providers to have access to helpful information as soon as possible. This, in turn, requires data to be collected, processed, and reported quickly. New York State is fortunate to have a good foundational upon which to build.

The New York State Incident Management Reporting System (NIMRS) is a web-based platform that tracks incidents at all state-operated and OMH-licensed provider programs and provides a detailed information on suicidal behavior in a more timely fashion than death certificate-derived data, which can take up to two years before they are available.

In 2015, OMH followed the example of other states and crossed NIMRS Medicaid data with information on the use of emergency department, hospitalization, and outpatient behavioral health services prior to death.

New York also recently started participating in the National Violent Death Reporting System, a CDC-supported program that requires participating states to combine data from death certificates, coroner or medical examiner reports, and police investigations. Secondary sources include data from child fatality reviews, intimate partner violence reviews, crime labs, supplementary homicide reports, and hospital data.

1,700 Too Many

First Annual Statewide Suicide Prevention Conference
September 12-13th, 2016, in Albany, New York

1,700 Too Many will be a forum for the suicide prevention community across New York State to:

- Introduce attendees to the New York State Suicide Prevention Plan;
- Facilitate communication and exchange of ideas, programs, research and projects; and
- Recognize individuals and organizations for their outstanding leadership and contribution to New York State suicide prevention at the SPC-NY's Annual Award Ceremony.

Suicide Prevention Council

A core group of New York State suicide prevention stakeholders will convene at the end of the conference to review progress to date, provide feedback, and make recommendations on how to strengthen the New York State Suicide Prevention Plan.

The inaugural Statewide Suicide Prevention Conference will be a forum to promote collaboration in research, surveillance, clinical, and community interventions. For details, visit: http://www.preventsuicideny.org/2016-nys-conference.

The goal is to develop an alert system so that providers caring for any individual with a NIMRS-recorded suicide attempt in the prior year can receive a notification of the past attempt, so that the provider can increase their engagement and monitoring in light of the increased risk. New York State is creating a portal for providers and regulators to access summaries of NIMRS suicide attempts.

An enhancement to the PSYCKES application will also allow a suicide attempt history to be flagged, give providers access to safety plans, and notify them about emergency department visits and hospitalizations.

Collecting and sharing this data will help to support research and advance ethical suicide prevention. Advances in technology offer the ability to overcome the current lack of timely data analysis. Combining data from these various sources can offer a means of generating more accurate risk profiles at the individual level and timely interventions that can be tested.

Community:
Coalitions Support Local Suicide Prevention Efforts

Effective suicide prevention starts with creating stable environments in communities and schools. New York State has been providing guidance and technical assistance to support programs on the local level that help youths develop skills for lifelong resilience to suicide risk.

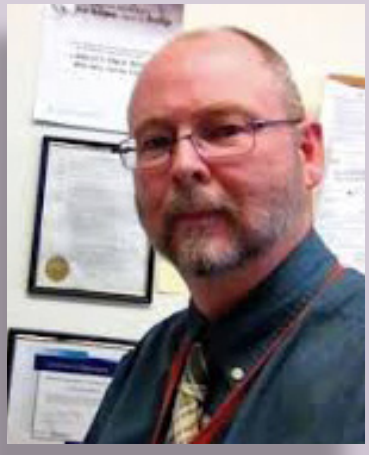
Suicide Prevention Center

In 2009, OMH founded the Suicide Prevention Center of New York (SPC-NY) to develop a strong community network to promote suicide prevention in schools, training for early identification, and support for individuals. Run by the Research Foundation for Mental Hygiene with funding from OMH, SPC-NY has supported the growth of suicide-prevention coalitions in 44 counties, training more than 30,000 people since 2012. SPC-NY has worked with OMH field offices and local organizations to mobilize in response to suicides, coordinating activities of citizens, community leaders, advocates, public health officials, mental health leaders, survivors of suicide attempts and families who have lost loved ones to prevent additional suicides in that community.

To learn more about the Suicide Prevention Center of New York State, visit: http://www.preventsuicideny.org.

SPC-NY helps providers and systems connect with each other, providing information on new developments and sharing best practices, new tools, and resources.

Building Coalitions



Garra Lloyd-Lester

"Suicide prevention is a public health issue. It's everybody's business to save a life," said Garra Lloyd-Lester, SPC-NY Associate Director. "A coalition can play an important role in pulling together a community's resources, bringing together a diverse stakeholder group committed to reducing suicide deaths in their communities."

Coalitions commonly include crisis help lines, local coroners or medical examiners, law enforcement and corrections, school administrators, clergy, health and behavioral health care providers, funeral directors, probation administrators, domestic violence and social services agency representatives. "We try to reach that segment of the population which might not cross path with mental health professionals," Lloyd-Lester said.

Two of the larger coalitions in the state are in Erie and Monroe counties. The Erie County partnership has included recent support from local public television station WNED and has also received preliminary support from the Buffalo Bills football team. Regular coalition participants include primary care physicians, local schools, and law enforcement.

The Monroe County Coalition was launched in April as part of SPC-NY's Coalition Academy and already has a diverse number of involved key stakeholders.

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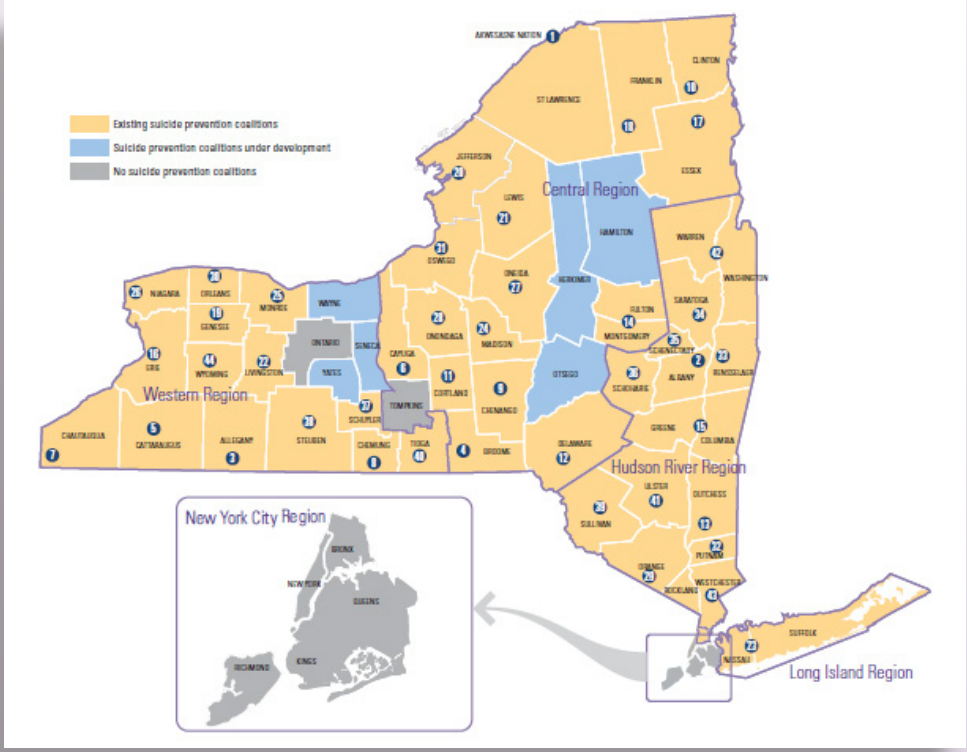
"In smaller, rural communities, coalitions are finding ways to engage the community in non-traditional ways and locations," Lloyd-Lester said. "In some areas, the local diner may be the center of activity. This realization was the genesis for a local initiative called the 'Cup of Joe' program."

The "Cup of Joe" program is intended to reach out to middle-aged men – a demographic that has been identified as at a higher risk for suicide – in a non-confrontational, respectful manner.

It offers coupons for free coffee and provides information about mental health, and access to services. Some coalitions have also put mental health access information on diner placemats.



Suicide prevention coalitions in New York State.

Coalition Academy

For counties that have coalitions, SPC-NY is offering a Coalition Academy; a structured approach to enhance the work they are doing. The Coalition Academy offers existing coalitions eight modules of unique content using in-person and web-based facilitation, individualized technical assistance as requested and access to a web-based library of best practice tools.

For counties without coalitions, SPC-NY has developed a structured process designed to provide the necessary framework and supports to develop a local coalition. Assisting localities to develop the infrastructure and capacity to effectively address the burden of suicides is the primary role of the SPC-NY Suicide Prevention Coalition Academy.

Currently, 41 coalitions, including six new coalitions, are participating in this year's academy, which ends on December 1, 2016.

SPC-NY has provided small amounts of seed money for coalitions to further support the development and enhancement of the work being done at the community level. Funding for counties outside of New York City was made available this year. Planning for increasing capacity and infrastructure for suicide prevention activities in the New York City in 2017, including associated funding, will start in the final quarter of 2016.

Sign for the Cup of Joe program in Wyoming County.

Education:
Developing Suicide Awareness in Schools

According to research, nearly 14% of high school students in New York State reported seriously considering suicide in the past year, and 7% said they had attempted it. Although there is growing awareness of the issue and the opportunity to respond, school-based mental health professionals report feeling under-prepared.

Pat Breux

"Counselors can't do it by themselves, nor can the teachers," said Pat Breux, SPC-NY State Coordinator of School and Youth Initiatives. "We know the issue of suicide is raising concern for schools. But we also know that schools are a good place to start the process of intervention. We look at suicide safety in school through a solidly public health lens. It is about creating suicide-safer environments. Schools are communities where everyone has a role to play — teachers, staff, students, administrators, counselors, parents, and even school boards and community organizations. We provide a framework on which to integrate best practices and evidence-based programs."

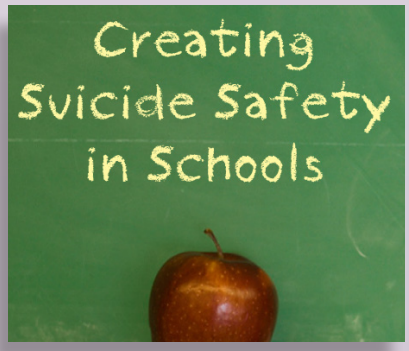
OMH is supporting three programs in schools to help make students, teachers, and parents aware of resources that can help suicidal youths:

- **Sources of Strength** uses the influence of adolescent peer leaders, working with adults, to provide guidance. In high schools, peer leaders are trained to develop positive coping techniques and share them through their social interactions, with the goal of helping youth who are suicidal to connect with adults who can help. A study on Sources of Strength in 18 high schools found the program brought about changes in the schools' environment after four months. With support from OMH, a team from the University of Rochester, led by Professor Peter Wyman has focused on bringing Sources of Strength to schools in rural communities, where mental health resources are lacking and youth suicide rates are highest. Activities have included poster campaigns, cafeteria activities, and videos for social media. Approximately 23,000 high schools students in New York State have been introduced to Sources of Strength since 2008.

SOURCES OF STRENGTH

For information visit: https://sourcesofstrength.org.

- **Creating Suicide Safety in Schools** is framework, most often presented as a full-day workshop, designed to help schools assess their current school environment, learn about best practices in school-based suicide prevention, explore and evaluate free and low-cost evidence based programs, and make a customized plan to improve their prevention or response readiness. The framework looks at elements such as staff training, parent engagement, student education, policies and procedures for helping a student at risk, crisis team preparedness for responding after a death, and support from community resources.



For information visit: http://www.sprc.org/resources-programs/creating-suicide-safety-schools.

- The **Lifelines Trilogy** of workshops educates administrators, faculty, staff, parents, and students about suicide and their roles in suicide prevention, intervention, and postvention. Follow-up studies have shown that the program has increased the likelihood that school communities can more readily identify potentially suicidal youths, know how to initially respond to them, and how to rapidly obtain help for them.

For information, visit: http://www.hazelden.org/web/public/lifelines.page.

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"We've been working with school administrators to help them create an environment to make our schools safer," said Silvia Giliotti, OMH Downstate Suicide Prevention Coordinator. "We help to train faculty and staff to recognize suicidal behaviors and refer students to resources to help them. We help them develop strong social and emotional counseling skills to make students resilient, and integrate suicide prevention into the health curriculum."

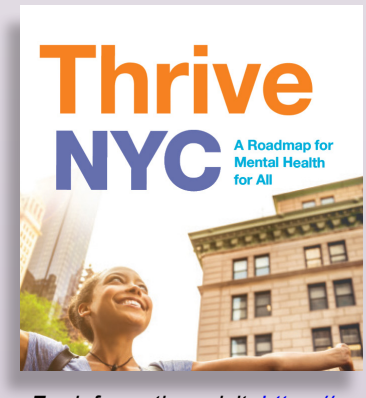
Silvia Giliotti

"If they do have risks," Giliotti added, "we look at whether they have a plan to address them. Too often, a school that's unprepared will call 911 or the police, but they may not know what to do in the interim. We help them develop the tools and procedures to provide immediate help to students who are at-risk. Should a student die by suicide, we help them manage the crisis and provide grief support in order to prevent further suicides from occurring."

STARS and ThriveNYC

For the past several years, OMH has worked with the New York City Office of School Health on the **Screening At Risk Students (STARS)** program. STARS trains school nurses in "safeTALK," a program to teach participants to recognize and engage persons who might be having thoughts of suicide and connect them with community resources trained in suicide intervention – and in the Columbia Suicide Severity Rating Scale.

As part of the City of New York's **ThriveNYC Mental Health Roadmap** program, 92 mental health consultants will be hired by the fall and will be trained in Creating Suicide Safety in Schools. This will allow the program to potentially reach between 920 and 1,000 schools, and 650,000 students and their families.

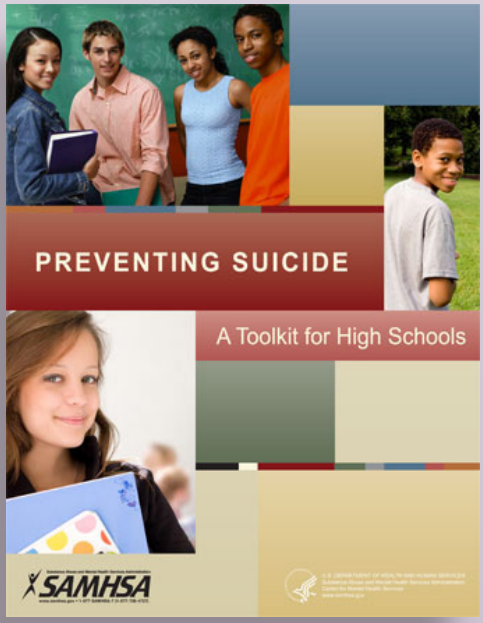


For information, visit: https://thrivenyc.cityofnewyork.us.

Family Support

"Parents are an integral part of this network of support," Breux said. "There's nothing in the 'parent handbook' on what to do if your child is considering suicide. It's important to prepare families to have these conversations early on. In many cases, if parents don't get this information from schools, they might not find it on their own."

"With these programs" Breux added, "we're developing the kinds of networks and partners to make universal access to best practice in comprehensive school based suicide prevention a reality."



Suicide prevention materials for use in high schools. Visit: http://www.samhsa.gov.

Substance Use:
Integrating Suicide Prevention into Substance Use Disorder Treatment

Recent CDC data shows that the national rate of death by suicide is at its highest in 30 years, increasing by 32% during the past decade. Suicide is one of the few causes of death – along with drug overdoses and alcohol-related liver disease – which is on the rise.


Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)
IN BRIEF
2016

SUBSTANCE USE AND SUICIDE: A NEXUS REQUIRING A PUBLIC HEALTH APPROACH

Suicide is a serious and preventable public health problem in the United States. Collaboration among prevention professionals across behavioral health fields has the potential to reduce suicide rates. While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicide attempts. This "nexus" between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates.

This *In Brief* summarizes the relationship between substance use and suicide and provides state and tribal prevention professionals with information on the scope of the problem, an understanding of traditional barriers to collaboration and current programming, and ways to work together on substance misuse and suicide prevention strategies.

SCOPE OF THE PROBLEM

nearly 1 in 12
Nearly 1 in 12 adults in the U.S. has a substance use disorder.

41,000+
More than 41,000 deaths a year in the U.S. result from suicide.

20%
Opiates, including heroin and prescription painkillers, are present in 26% of suicide deaths in the U.S.

Rates of suicide in the U.S. are almost four times higher for men than for women.
4x higher

22%
22% of deaths by suicide in the U.S. involve alcohol intoxication.

A Problem in Tandem

Substance use is a major risk factor for suicide. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), alcohol misuse or dependence increases suicide risk tenfold, and injection drug use increases the risk fourteenfold. When examining suicide deaths, alcohol intoxication is present 22% of the time and opioids are present 20% of the time. About 30% to 40% of non-fatal suicide attempts involve alcohol intoxication.

"It's clear that efforts to prevent suicide should target populations with problem substance use," said Brett Harris, DrPH, Project Manager for the OMH Suicide Prevention Office. "New York State has a large network of substance use disorder treatment programs, through which we can reach this population. We know that the individuals who work at these clinics would greatly benefit from education and training so that they can better identify patients with suicidal thoughts or behaviors and provide or connect them to appropriate treatment."

For information, visit: http://store.samhsa.gov/shin/content/SMA16-4935/SMA16-4935.pdf.

Working Together to Save Lives

OMH received a three-year National Strategy for Suicide Prevention grant to provide education, training, and assistance with implementation and evaluation of suicide-safer care protocols and procedures in Erie and Monroe counties, as guided by the Zero Suicide model (see article on Page 2).

Partnering with OMH on this endeavor is the Suicide Prevention – Training, Implementation, and Evaluation (SP-TIE) program of the Center for Practice Innovations at the New York State Psychiatric Institute, Columbia University.

One of the goals of the grant is to prevent suicide among substance using populations. To achieve this goal, OMH approached the New York State Office of Alcoholism and Substance Abuse Services (OASAS) about conducting a suicide safer care learning collaborative for its substance use disorder treatment providers. OASAS recognized the need and was eager to partner with OMH and SP-TIE.

"Addressing the connection between substance use and suicide is essential for our treatment programs," said Brenda Bannon, OASAS Ad-

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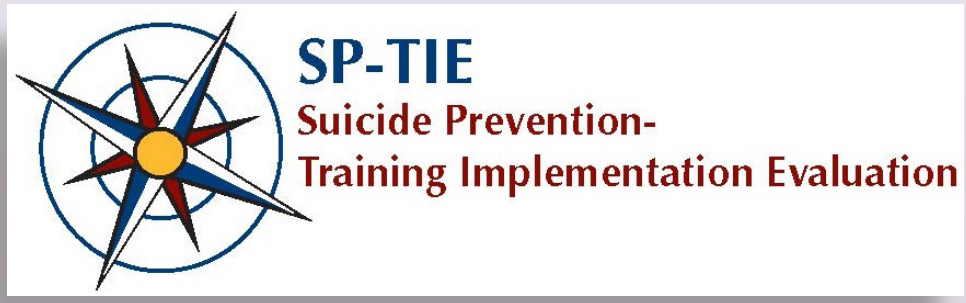
dictions Program Specialist. “Currently there is a need for a standard, evidence-based protocol for identifying, assessing, and treating suicide risk among our patients. We want our providers to not be afraid of treating patients with suicidal thoughts or behaviors, and we want to give our providers more information, guidance, and training. This learning collaborative can help address this need.”

The goals of the learning collaborative are to introduce the Zero Suicide model to outpatient substance use disorder treatment providers in Erie and Monroe counties, to provide concrete training and tools that substance use disorder clinics could use to improve critical aspects of suicide-safer care — such as screening, assessment, and interventions — and to learn from early-adopter clinics the best manner in which these strategies could be tailored to the unique setting of substance use disorder clinics.



For information, visit: http://practiceinnovations.org/Initiatives/Suicide-Prevention.

The Learning Collaborative began at the end of June and will run for one year, meeting monthly. One clinical supervisor and one upper-level administrator from six different organizations are participating. Sessions include didactic content, discussions, and implementation assistance on how to promote organizational culture change, identify suicide prevention current practices, discuss ways to adjust protocols, troubleshoot ways to overcome barriers to optimal care, and provide training and support for implementing the Zero Suicide model.

Two-Way Learning Process

This collaborative is a two-way learning process. “This is the first suicide prevention learning collaborative in the nation for substance use disorder treatment providers,” Harris said. “We have a lot to learn about how to implement Zero Suicide into these settings, and this project is a vehicle for doing so.”

Harris and Bannon are excited to be teaming with SP-TIE on this project so that they can learn from each other, as well as from the participants.

“SP-TIE’s involvement in this learning collaborative complements the unique expertise offered by OMH and OASAS,” said Christa Labouliere, PhD, Suicide Prevention Specialist for SP-TIE. “The breadth of this team’s expertise will not only provide an optimal learning experience for participants but will help develop a cohesive model for other New York State counties and for other states.”

This project aligns with the first domain of OMH’s newly released 2016-17 State Plan for Suicide Prevention: “Prevention in Health and Behavioral Healthcare Settings – New York State Implementation of Zero Suicide.” The team plans to use what they learn from this collaborative to develop a statewide strategy for training substance use disorder treatment providers to deliver appropriate suicide-safer care to their patients and to disseminate lessons learned to a nationwide audience concerned about substance use and suicide prevention.

Research:
Seeking to Prevent Firearm Suicides

Social policy initiatives have the potential to reduce the number of suicide by firearms in the United States, according to researchers from New York State Psychiatric Institute (NYSPI) and Columbia University Medical Center (CUMC).

The study found a correlation between higher per-capita gun ownership and higher national firearm suicide rates throughout the world between 1980 and 2015, and that efforts to restrict access to firearms can lower firearm suicide rates.

J. John Mann, M.D

Ownership is a Factor

The report, *Prevention of Firearm Suicide in the United States: What Works and What Is Possible,* was published in the July 22, 2016, edition of the *American Journal of Psychiatry*. Its authors are J. John Mann, M.D., the Paul Janssen Professor of Translational Neuroscience (in Psychiatry and in Radiology) at CUMC and director of the Molecular Imaging and Neuropathy division at NYSPI; and Christina A. Michel, Research Coordinator at Columbia University Department of Psychiatry and NYSPI.

"We were motivated to conduct this study by the very high rate of firearm suicide in the United States and a desire to do something about it," Mann said. "Half of all suicides in the nation use firearms."

Research found that firearms accounted for 33,599 total deaths in 2014 – this figure included suicides, homicides, accidents, and deaths by undetermined cause. Of the 42,773 suicides that year, nearly half involved a firearm. From 2000 to 2002, the 15 states with the highest household firearm ownership experienced almost twice as many suicides as the six states with the lowest firearm ownership. They found this difference in overall suicides is largely accounted for by the difference in firearm suicides.

Time is Crucial

Because many who had attempted suicide reported taking less than eight hours between making their decision and the actual attempt, they're more likely to use a method that is at hand, such as a firearm. Firearms are widely available to those at risk of suicidal or homicidal behaviors in the United States, with 38% of households owning at least one gun. Restricting access to a firearm could allow a crisis to pass or lead to in an attempt with a method that is less lethal.

The study said that about 90% of those who survived a suicide attempt, do not go on to die by suicide later in life. Therefore, surviving a suicide crisis gives someone a strong chance of long-term survival. It also indicated that that reducing availability and access to firearms has lowered firearm suicide rates. For every 10% decline in household firearm ownership rate, there was 4.2% decline in firearm suicide rate and a 2.5% decline in overall suicide rate.

Means of Reducing Risk

Since the means used in other nations to control gun ownership aren't possible in the United States, the researchers urgently suggest-

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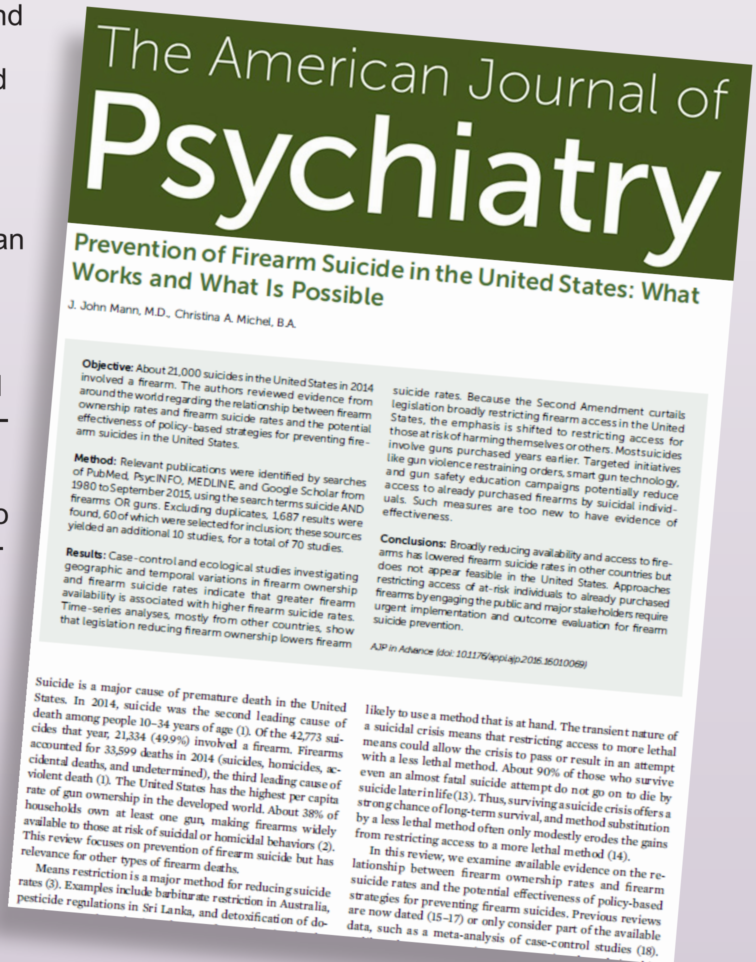
ed other means to reduce the risks of suicide by firearm. They found that keeping guns locked and unloaded and locking ammunition or storing it in a different part of the house reduces the risk of suicide by 55% to 73%.

The researchers said that more legislative and social action will be required than has been seen so far. Researchers suggested targeted legislation, such as gun violence restraining orders, which can prevent at-risk individuals from having access to guns or allow law enforcement to confiscate firearms. Smart gun technology, such as fingerprint recognition can limit the use of a gun to its owner and other permitted users.

Researchers also called for educating the public and major stakeholders through social marketing initiatives to change public perceptions about gun ownership, use, and safety. The researchers added that society must place a higher value on gun safety in order to better protect depressed and suicidal individuals. All such initiatives must be accompanied by systematic evaluation of their effectiveness.

“Because methods exist for reducing firearms, it raises the question of what can be done in the United States about this terrible mortality,” Mann added. “We believe that the solutions we propose can work in the United States if there’s sufficient will to implement these proposals.”OMH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Prevention of Firearm Suicide in the United States: What Works and What Is Possible

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Objective: About 21,000 suicides in the United States in 2014 involved a firearm. The authors reviewed evidence from around the world regarding the relationship between firearm ownership rates and firearm suicide rates and the potential effectiveness of policy-based strategies for preventing firearm suicides in the United States.

Method: Relevant publications were identified by searches of PubMed, PsycINFO, MEDLINE, and Google Scholar from 1980 to September 2015, using the search terms suicide AND firearms OR guns. Excluding duplicates, 1,687 results were found, 60 of which were selected for inclusion; these sources yielded an additional 10 studies, for a total of 70 studies.

Results: Case-control and ecological studies investigating geographic and temporal variations in firearm ownership and firearm suicide rates indicate that greater firearm availability is associated with higher firearm suicide rates. Time-series analyses, mostly from other countries, show that legislation reducing firearm ownership lowers firearm suicide rates. Because the Second Amendment curtails legislation broadly restricting firearm access in the United States, the emphasis is shifted to restricting access for those at risk of harming themselves or others. Most suicides involve guns purchased years earlier. Targeted initiatives like gun violence restraining orders, smart gun technology, and gun safety education campaigns potentially reduce access to already purchased firearms by suicidal individuals. Such measures are too new to have evidence of effectiveness.

Conclusions: Broadly reducing availability and access to firearms has lowered firearm suicide rates in other countries but does not appear feasible in the United States. Approaches restricting access of at-risk individuals to already purchased firearms by engaging the public and major stakeholders require urgent implementation and outcome evaluation for firearm suicide prevention.

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Suicide is a major cause of premature death in the United States. In 2014, suicide was the second leading cause of death among people 10–34 years of age (1). Of the 42,773 suicides that year, 21,334 (49.9%) involved a firearm. Firearms accounted for 33,599 deaths in 2014 (suicides, homicides, accidental deaths, and undetermined), the third leading cause of violent death (1). The United States has the highest per capita rate of gun ownership in the developed world. About 38% of households own at least one gun, making firearms widely available to those at risk of suicidal or homicidal behaviors (2). This review focuses on prevention of firearm suicide but has relevance for other types of firearm deaths.

Means restriction is a major method for reducing suicide rates (3). Examples include barbiturate restriction in Australia, pesticide regulations in Sri Lanka, and detoxification of do-

likely to use a method that is at hand. The transient nature of a suicidal crisis means that restricting access to more lethal means could allow the crisis to pass or result in an attempt with a less lethal method. About 90% of those who survive even an almost fatal suicide attempt do not go on to die by suicide later in life (13). Thus, surviving a suicide crisis offers a strong chance of long-term survival, and method substitution by a less lethal method often only modestly erodes the gains from restricting access to a more lethal method (14).

In this review, we examine available evidence on the relationship between firearm ownership rates and firearm suicide rates and the potential effectiveness of policy-based strategies for preventing firearm suicides. Previous reviews are now dated (15–17) or only consider part of the available data, such as a meta-analysis of case-control studies (18).

For information on this research, visit: http://ajp.psychiatry-online.org/doi/full/10.1176/appi.ajp.2016.16010069.