SUICIDE PREVENTION

NCSL Veterans Committee

August 3, 2015
GOALS FOR TODAY

• Background on suicide prevention legislation
• Update on this issue in our state and nation
• Veteran’s perspective
• Legislative implementation updates and strategies
HOW DID OUR WORK BEGIN

• Approached to work on this issue
• Higher rate than the national average
• DOH 23% of suicides are men and women who have served our country
WA SUICIDE PREVENTION BILLS

• 2012 HB 2366
• 2013 HB 1336
• 2014 HB 2315
• 2015 HB 1424 & 1138
2012 HB 2366

• Required mental health & chemical dependency counselors to receive six hours of training in suicide assessment, treatment and management.

• Required DOH to study the effectiveness of training on professionals and review what current coursework institutions provide in this area.
2013 HB 1336

• Required counselors, school nurses, psychologists and SW to receive three hours of training in suicide screening & referral.

• Required schools to develop protocol to identify students who are struggling and add steps in crisis plan on how to respond when students are suicidal.

• Requires school districts to establish formal partnerships with local mental health agencies for consultation and referral.
2014 HB 2315

• Required medical professionals to receive six hours of training in suicide assessment, treatment and management.
• DOH to develop and oversee model list of trainings.
• DOH to convene statewide committee to establish a state plan to prevent suicide.
2015 HB 1424 & 1138

• 1424 Required that training in suicide assessment, treatment and management contain content specific to treating veterans.

• 1138 Reviews suicide prevention efforts in Higher Education
KEY STRATEGIES

• Robust stakeholder process
• Strong testimony from professionals and survivors
• Funding mechanism
• Use of powerful data
MOVING FROM LEGISLATION TO IMPLEMENTATION

Not as easy as it might seem
FOR CONSIDERATION:

• What training programs already exist to meet the legislative mandate?
• Are there trainers available locally to deliver any selected in-person programs?
• When selecting an existing training program or developing a new one, who decides what content must be included?
• What training modality will work best for your particular audience – online, in-person or some combination?
• Should the selected training program have evaluation data to support its efficacy and/or should it have been peer reviewed?
MORE TO CONSIDER.....

• How are continuing education units approved?

• How does the legislative mandate get communicated to the intended audience?

• How does the intended audience hear about the training opportunities? Is there a centralized clearinghouse/website?

• Is there – or should there be – a feedback loop to the legislature about the training outcomes?
Preventing Veteran Suicide

Creating bands of safety for our veterans using social network theory and education…

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In service, our band of brothers is a squad, a platoon, or company... except for air support, these are the only people who can keep you safe...
Sometimes it is only 1 or 2 people who have your back while serving. These are your battle buddies...
But once you are mustered out of service, who has your back? Who keeps you safe?

FAMILY!
FRIENDS!
CO-WORKERS
And who else keeps you safe?

Healthcare professionals
To create bands of safety to prevent veteran suicide all these people... need to be trained in what to look for, what to say, and what to do....

Without education and training they cannot help create a circle of safety for our veterans.
After a veteran suicide; it is not enough to say…

• “He or she should have asked for help.”

• “He had the crisis line number, because I gave it to him.”

• “She could have gone to the VA.”
We have to...

Rethink our approach and solve three problems...
Problem # 1: *Suicidal male vets don’t ask for help, and neither do female vets*

- No published studies to show that any social marketing strategy works to improve male help-seeking behavior.

- Being male and a warrior – and/or a female warrior - may be the greatest barrier to help seeking behavior.

- If we keep waiting for veterans to ask for help they will just keep killing themselves.
A failed strategy...

*It takes the courage of a warrior to ask for help.*

No studies to support this effort and cost...

Question: Does this blame the victim?
Please, accept reality...

Veteran suicide *will not be prevented* by passive availability of counseling services, crisis call numbers, posters, wallet cards, or encouragement to ask for help...

Some will call, some will ask for help, but most will not.

The next veteran suicide *might be* prevented by trained observers *already in the social network* to recognize suicide warning signs and implement immediate life-saving interventions.
Question

Why does it take a million sperm to fertilize a single human female egg?
Warrior Psychology and Survivor Rules

1. Do not get lost

2. If lost, do not ask for help from strangers

3. The cost of asking for help is capture, torture, slavery, and often death
Question

“Why did Moses wander in the desert for 40 years?

Because he had to ask this guy for directions...
Four primary human fears: spiders, snakes, heights, and strangers
Solution # 1

• Rethink how human evolution led to warriors, winning, and success on the battlefield
• Play to ancient warrior roles and responsibilities
• Serve vets *where they are*

_Every vet who has to ask for help from a stranger hears banjo music_
From Theory to Practice

• Understand Warrior Psychology

• Understand and Apply Social Network Theory

• Use evidence-based tools that actually work at the community and family level
But 1st let’s change terms…

• _Asking_ for help = weak, stupid, and incompetent

• _Accepting_ help = you are strong, but not quite strong enough to lift a car out of a ditch or drag whole elk back to hunting camp…

Accepting help creates “repayment reciprocity” - a good thing that stitches together the fabric of everything from military units to entire communities

  IN HELP SEEKING THERE ARE GENDER DIFFERENCES…
Help-seeking OK
Help-seeking not OK
Help-accepting OK
Help-accepting OK
Problem # 2  *Too few eyes on the problem*

Those vets most at risk for suicide are the *least likely* to ask for help.

*Each person trained to recognize and refer at-risk vets to competent care providers means one more band of safety.*
The “chain of survival” for surviving a life-threatening crisis begins with early symptom recognition and quick bold action by someone trained in what to do.

Current recommendation for cardiac arrest?
Don’t wait for the EMTs, START CPR!

Current recommendation for a suicide crisis?
Don’t wait for a mental health professional to show up, START QPR!

QPR = CPR (Question, Persuade, Refer)

Gatekeeper training in how to recognize and respond to suicide warning signs
The new program QPR for Vets…

... is designed to train as many people as possible already in the veteran’s life to recognize symptoms of distress and to act boldly and quickly with a safe and effective evidence-based intervention.

Why?
Because the more people who recognize that a vet is in crisis the greater the odds are that he or she will survive.
Your heart attack is today at 4 PM...

What city should you be in if you hope to survive an out-of-hospital cardiac event?

• Average US city = survival rate is less than 10%

• Best city in the US = 62% (*think thousands of trained observers*)

IT’S ALL ABOUT SURVEILLANCE and A QUICK, BOLD, INFORMED RESPONSE!
Lucky you!
You’re sitting in the best trained city in the world!
1 in 4 adults knows CPR = 10X greater odds of surviving
Very best place?
72% survive a cardiac arrest ... Why?
Because you are under constant surveillance and every employee knows CPR and how to use AEDs (automatic external defibrillators)
Solution to problem # 2

Train as many people in the vet’s social and community service network as possible in how to recognize and respond suicide warning signs... Think millions not thousands.

We need to train....
FAMILY!
FRIENDS!
CO-WORKERS
Healthcare professionals
Police, Fire Fighters, EMTs and the court system
But Houston, we have a problem...
Problem # 3 The healthcare professional training deficit: a systemic failure to detect, assess, treat and manage suicide risk

- Old medical saw: You can’t treat an illness you don’t know.

- Old medical saw: *If you don’t want to know if your patient has a fever, don’t take her temperature.*

- New medical saw: *If you don’t want to know if your patient is suicidal, don’t ask.*
Risk denial on a grand scale

• Healthcare professionals cannot assess, treat, or manage risk they don’t know about

• When a patient hints that suicide might be a good solution to their suffering, saying nothing can interpreted as “permission to proceed.”

• No professional can help a suicidal patient if they can’t even say the word. I ask the doctors I train, “Which is easier, a DRE or screening for suicide risk?”
Does you doctor know you want to kill yourself?

What are the odds of being asked if you are thinking of killing yourself when you are thinking of killing yourself?

• 50% in mental health care

• Less than 35% in primary care... and that’s even when your doctor knows you are depressed.

DON’T ASK, DON’T TELL, DON’T WORK
When you go home ...

Ask your state mental health leadership ...

“How many of our citizens and veterans die by suicide while in active or recent care with a healthcare professional licensed to practice in our state?”

Then ask yourself, “What is the acceptable number of veterans in active or recent care who die by suicide?”

Then please Google “zero suicide” to see what’s coming..

Also Google: SPRC Surveillance Stories to see what KY and VT have done...
Solution # 3: Don’t wait, mandate training!

- For 10 years calls for training in suicide prevention from the Institute of Medicine and the National Strategy for Suicide Prevention have been ignored (AAS White Paper on the national training deficit)

- Expect strong resistance against any mandated training... I call it willful risk blindness by providers, their membership organizations, and their training institutions.
- They will say, “We already know and teach this stuff.”

- THEY DON’T! (happy to send you evidence)

- Inadequate training puts our veterans at unnecessary and avoidable risk. This must end!

- Only in Washington, and now Kentucky, is the public’s health and safety from death by suicide being addressed through legislation targeting providers...
A vet in Washington State now has a better chance of surviving a suicide crisis
A few bands of safety…
More eyes on the problem

Vet in Crisis

PCP/MPH

Best Friend

Adult Children

Employer

Spouse

Co-worker
To prevent the next veteran suicide…. 

... we need as many *bands of safety* as possible

- *Everybody* can be a gatekeeper and everyone become part of the solution....

- We must leverage science and technology to accomplish this mission...
Enough talk, let’s act!

- We know the order of march
- We know who to train 1st, 2nd, and 3rd
- We know what to teach them to do (best practices)
- We know where to teach them (online/classroom)
- We have evidence that interventions work
- We have the measures to monitor our outcomes
- We have leadership -- all we need is a “go!”
“Things do not happen. Things are made to happen.”

John F. Kennedy
Thank you!

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Contact me directly at pquinnett@mindspring.com
See my blog on veteran suicide at: http://onsuicide.com/2014/07/02/22/
Free e-book
Complimentary QPR for Vets training on request
QPR is one of the most widely taught and most researched suicide prevention intervention training program in the world.
Diffusion of an Innovation

The QPR Gatekeeper Training for Suicide Prevention originated in 1996, and since then, more than 2,500 organizations and communities (including private companies, colleges and universities, mental health departments, and the military) have implemented the training. There are more than 6,000 certified instructors, and they have delivered the intervention to more than 1,500,000 people in all 50 States, the District of Columbia and Puerto Rico, as well as in Australia, Canada, New Zealand, South Korea, and 10 European countries.
RESEARCH

• QPR listed in the National Registry of Evidence-based Practices and Policies as universal intervention @ http://nrepp.samhsa.gov/ViewIntervention.aspx?id=299

• 15 studies, $15 million in federally-funded research, 3 random clinical trials. Four other studies underway.

• Evaluated in comparative effectiveness research studies – no adverse effects, concerns, or unintended consequences
Vet Related QPR Research

- Department of Veterans Affairs (VA) staff, including clinical providers (e.g., psychologists, social workers) and nonclinical staff (e.g., administrative staff, community outreach workers), from a national program of 209 community-based VA counseling centers were offered QPR gatekeeper training during scheduled regional conferences. Immediately after QPR gatekeeper training, clinical providers and nonclinical staff had higher declarative knowledge scores ($p < .0001$) and higher perceived knowledge scores ($p < .0001$) relative to scores before training. These findings were associated with medium effect sizes (Cohen's $d = 0.53$ and $0.54$, respectively).
Summary Impacts and Methods

- Increased knowledge, confidence and gate keeping skills
- Increased declarative knowledge
- Increased perceived knowledge
- Increased self-efficacy
- Increased diffusion of gate keeping training information
- Increased gatekeeper skills (ability to engage in active listening, ask clarifying questions, make an appropriate referral)

**Methods:** Three randomized studies conducted in school, outpatient and workplace settings examined the impact of the Question, Persuade, Refer (QPR) training on stratified samples of (1) 340 teachers and parents in a US public school community and (2) 602 community based counseling center staff from the US Department of Veteran Affairs. One study included a 1-year average follow-up assessment and a second study included a 3-month follow-up assessment.
One act of courage — A true story from the leader of a crisis team to a Certified QPR Instructor...

I wanted to send you an email about a life that was probably saved thanks to QPR training.

Last week my friend called and said she was very concerned about a life-long family friend. He sent her a very emotional series of texts that were very odd for him to send given his normal personality. He stated that he was struggling, very depressed and "lost".

I was extremely concerned and I insisted that my friend immediately call him back and ask him if he was thinking about committing suicide. She was very uncomfortable with doing this but I demanded that she call him, to the point that I just about hung up on her so she could make the call.

When she called me back a few hours later, she told me that when she asked him if he was thinking about killing himself he opened up to her and said that he in fact was. (He is now in outpatient treatment).

I can say without certainty that had I not had the QPR training I never would insisted like I did that she call him back immediately and ask him directly if he was considering suicide.

I wouldn't have known to do that. I'm fairly certain that without this intervention, especially based on his texts to her, that he would have killed himself.

So THANK YOU, for the training.