Surveillance Success Stories

KENTUCKY

The Need for Data

In 2012, the clinical director of Kentucky's Department for Behavioral Health, Development, and Intellectual Disabilities (DBHDID) attended a presentation of the National Action Alliance for Suicide Prevention's *Suicide Care in Systems Framework* at the annual National Association of State Mental Health Program Directors meeting. Inspired by the presentation, he approached the Program Director of Kentucky's Garrett Lee Smith (GLS) grant (also the state Suicide Prevention Coordinator) to find out how their state could pursue the approach outlined in the *Framework*. They decided to look at data as a first step in enhancing the ability of Kentucky's state psychiatric hospitals and community mental health centers (CMHCs) to prevent suicide.

Getting the Data

DBHDID and the state Office of Vital Statistics negotiated a memorandum of understanding to share data monthly between the departments. This allowed DBHDID to get a more accurate picture of suicide deaths of CMHC and state psychiatric hospital patients in Kentucky. The agreement was facilitated by the support of the secretary of the Cabinet for Health and Family Services—the agency that houses both DBHDID and the Office of Vital Statistics.

Analyzing the Data

Using the data from the Office of Vital Statistics, DBHDID identified suicide deaths among patients who had received mental health services from a CMHC or state psychiatric hospital in the year before their death. These clients were found by matching social security numbers between the two data sources.

What Kentucky Learned

Cross walking the DBHDID data and the Vital Statistics data revealed that, from 2007 to 2013:

- 24 to 30 percent of people who died by suicide in Kentucky in any given year had received services from the public behavioral health system in the 12 months before their death.
- Of those patients who died by suicide:
  - About three quarters were men;
  - Most were between 30 and 49 years of age; and
  - Among state psychiatric hospital patients, most suicide deaths occurred more than four months after admission.
- Clients served by CMHCs died by suicide at a rate of 80 per 100,000, while clients with at least one state psychiatric hospital admission died by suicide at a rate of 340 per 100,000. (The national average during this same period was 12 per 100,000).

DATA RESOURCES

Locating and Understanding Data for Suicide Prevention (online course): http://training.sprc.org/

Zero Suicide Toolkit: http://zerosuicide.sprc.org/

Data-Based Planning for Effective Prevention: State Epidemiological Outcomes Workgroups (SAMHSA): http://go.edc.org/Data1

Improving Data Collection Across the Health Care System: http://go.edc.org/Data2

National Violent Death Reporting System: Stories from the Frontline of Violent Death Surveillance: http://go.edc.org/Data3

Kentucky receives funding for its suicide prevention efforts through the Garrett Lee Smith Suicide Prevention Act, which is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), and technical assistance from SAMHSA and the Suicide Prevention Resource Center (SPRC) at EDC.

KENTUCKY DATA ANALYSIS RESULTS

"The data showed that 24–30 percent of those who died by suicide had touched our community mental health system. This is compelling data. It made us look at how we can do a better job."

—Jan Ulrich, State Suicide Prevention Coordinator, Kentucky

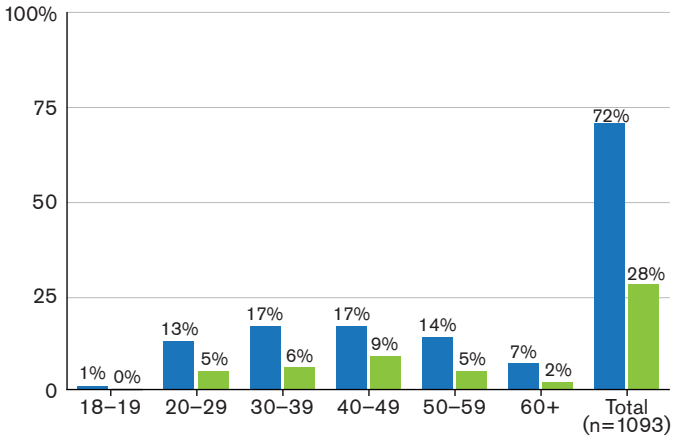
What Comes Next?

DBHDID and the Kentucky GLS grant team have used this data to build support for Zero Suicide in their state behavioral health system. A critical next step was a survey of CMHC and state psychiatric hospital staff on their training in suicide assessment. This survey found that many behavioral health clinicians felt they lacked the skills (43%) and did not have the support necessary (33%) to effectively engage with and treat suicidal individuals.

Kentucky has continued to move forward in improving suicide care in these systems by:

- Training public and private sector clinicians in assessing and managing suicide risk;
- Piloting Zero Suicide organizational self-assessments in CMHCs to identify priority areas for Zero Suicide implementation;
- Adding Kentucky Violent Death Reporting System data to the crosswalk to get more details on the circumstances of suicide deaths of patients served by the state system; and
- Regularly repeating the crosswalk to track suicide rates among public behavioral health clients and evaluate the effectiveness of prevention efforts in the system.

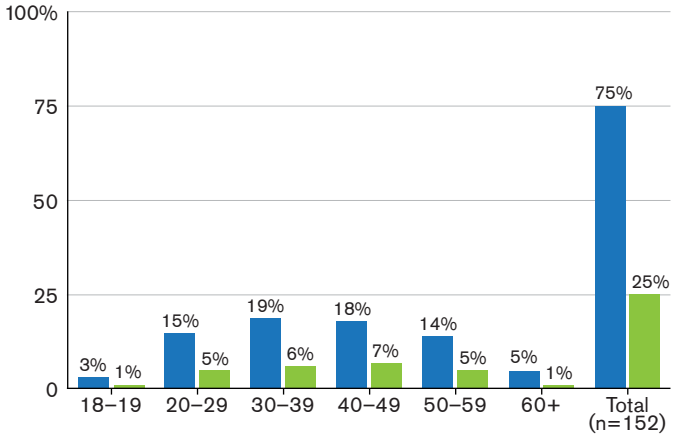
Sex and Age of Community Mental Health Center Patients Who Died of Suicide within 12 Months of Receiving Services, 2007–2013*



**2013 includes partial year vital statistics data. Client deaths are included in this report if they occurred during the same fiscal year as their CMHC services or up to one year after the end of the year. If the client was seen in more than one region or if he or she provided more than one birth date (which resulted in a different age group), he or she would be counted for each instance.*

Male Female

Sex and Age of State Psychiatric Hospital Patients Who Died of Suicide within 12 Months of Receiving Services, 2007–2013**



***2013 includes partial year vital statistics data. Patient deaths are included in this report if they occurred during the same fiscal year as their hospital admissions or up to one year after the end of the year. If a patient was seen in more than one hospital or if he or she provided more than one birth date (which resulted in a different age group), he or she would be counted for each instance.*

If you have questions or would like to learn more about how Kentucky created its surveillance network, contact:

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