HEALTH AFFAIRS BLOG

Suicide Prevention: Access To Behavioral Health Services Lacking

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Suicide is a leading cause of death in the United States. From 2000 to 2014, it was the third most common cause of death among 10 to 24 year olds, the second most common cause of death among 25 to 34 year olds, and the tenth most common cause of death for all ages. The medical and work-loss costs of completed suicide are estimated to be over $51 billion. Suicide can have a devastating effect on the family and friends of the deceased. Depending on their relationship to a person who has committed suicide, those left behind are at greater risk for mental illness, substance use, and suicide.

Self-inflicted injuries not resulting in death are also common and costly. There were nearly 500,000 visits to the emergency department in 2013 for injuries where the patient caused self-harm. Those encounters cost over $10 billion in medical cost and lost productivity.

There is a great deal of interest in providing suicide prevention services and treatments for people who are at risk for suicide. The President's budget for the Department of Health and Human Services for fiscal year 2017 proposes $500 million in new funding for investments in behavioral health, including suicide prevention.

In their *Health Affairs* article, Michael Hogan and Julie Grumet note that many individuals with suicidal behavior had recent contact with the health care system, and that screening, treatment, and support can reduce suicides.

What Does the Research Say?

To better understand the health care system use of individuals experiencing suicidal or self-harm behavior, we examined MarketScan commercial and Medicaid health care insurance claims data. We identified individuals who had an emergency department visit in calendar year 2014 that was due to suicide or self-inflicted injury. We then examined the services they received in the 90 days prior to the emergency department visit separately by whether the person had commercial or Medicaid insurance.

Table 1. Health Care Utilization in the 90 days prior to an Emergency Department Visit with an Intent-to-Harm-Self Code, 2014

	MEDICAID	COMMERCI
Number of individuals in dataset with an intent-to-harm-self ED visit	**24,590**	**22,983**
Individuals with ≥1 antidepressant or anxiolytic prescription drug fill	**43.5%**	**45.6%**
Individuals with a primary care visit with a behavioral health diagnosis	**13.9%**	**18.9%**
Individuals with a primary care visit *without* a behavioral health diagnosis	**21.0%**	**26.9%**
Individuals with a specialty visit with a behavioral health diagnosis	**7.2%**	**17.2%**
Individuals with a non-intent-to-harm-self emergency department visit with a behavioral health diagnosis	**23.8%**	**11.6%**
Individuals with a non-intent-to-harm-self emergency department visit *without* a behavioral health diagnosis	**20.8%**	**12.1%**

These statistics demonstrate that some individuals who engage in self-harm behavior have contact with the health care system and are receiving behavioral health treatment. Over 40 percent had an antidepressant or anxiolytic prescription drug filled; 19 percent of the patients with commercial insurance and 14 percent of the Medicaid patients saw a primary care physician for a behavioral health condition. Those individuals might benefit from the provision of more intense services from their providers to prevent a self-harm event requiring emergency department services from occurring. The people who saw a primary care physician for a reason other than behavioral health might particularly benefit from screening.

There is opportunity for individuals with self-harm potential to be more engaged with the health care system. Over 80 percent of individuals who had an emergency department visit for self-harm did not receive treatment from a specialty behavioral health provider in the 90 days before their emergency department visit. Approximately 20 percent of Medicaid beneficiaries and 10 percent of individuals with commercial insurance had emergency department visits before their intent-to-harm-self emergency department visits. Those encounters represent an opportunity for screening and connection with behavioral health treatment. Recent research has shown that screening for suicide risk in emergency departments almost doubles identification of patients thinking about suicide.

Barriers to Behavioral Health Services

There are a number of barriers that could be keeping individuals from receiving services that would reduce their likelihood of engaging in self-harm behavior. The differences in the use of services by individuals with commercial and Medicaid insurance indicates that access to care is one of those barriers. The commercially insured were more likely to have a primary care visit, specialty care visit, and prescription drug filled for a behavioral health medication prior to an intent-to-harm-self emergency department encounter. People with Medicaid were more likely to have an emergency department encounter.

Hogan and Grumet note that insurance expansion under the Affordable Care Act and parity legislation have reduced financial barriers to treatments that reduce self-harm behaviors. The statistics in Table 1 indicate that some important barriers remain, potentially including patient awareness of services that are available to them and provider acceptance of insurance.

After a patient has experienced a self-harm event, it is important that he or she receive services to prevent a recurrence of self-harm behavior. Recent Substance Abuse and Mental Health Services Administration (SAMHSA) data has shown that 3 percent of adults who attempt suicide will, within a year, die by suicide. Among those over age 45 with less than a high school education, 16 percent will die by suicide within a year. Table 2 identifies the services patients with commercial and Medicaid coverage

received in the 90 days following an emergency department encounter for self-inflicted injury.

Table 2. Health Care Utilization in the 90 days Following an ED Visit With

An Intent-to-Harm-Self Code, 2014

	MEDICAID	COMMERCIL
Individuals with ≥1 antidepressant or anxiolytic prescription drug fill	**55.3%**	**59.7%**
Individuals with a primary care visit with a behavioral health diagnosis	**17.9%**	**23.5%**
Individuals with a primary care visit without a behavioral health diagnosis	**19.3%**	**22.2%**
Individuals with a specialty visit with a behavioral health diagnosis	**4.1%**	**26.7%**
Individuals with an intent-to-harm-self emergency department visit	**14.0%**	**10.5%**
Individuals with a non-intent-to-harm-self emergency department visit with a behavioral health diagnosis	**21.3%**	**11.4%**
Individuals with a non-intent-to-harm-self emergency department visit without a behavioral health diagnosis	**16.6%**	**8.8%**

The use of antidepressants and anxiolytics following an intent-to-harm-self emergency department encounter is higher than before the encounter, but over 40 percent of patients with Medicaid and commercial insurance do not fill a single behavioral health prescription in the 90 days following the encounter. Many patients do not see a primary care or specialty provider, and 14 percent and 11 percent of Medicaid and commercially insured patients, respectively, return to the emergency department with an intent-to-harm-self diagnosis within 90 days.

The higher use of the emergency department by Medicaid beneficaries may be related to their lower use of behavioral health prescription drugs, primary care, and specialty care. These statistics, including the very low rate of specialty behavioral health care

following an episode of self-harm, illustrate the need for more effective care transitions and active outreach to those who self-harm following emergency department discharge.

Mobile health technologies may be useful as a means of providing additional resources and support that can augment traditional services providers give to patients at risk for engaging in self-harm behavior. Further research is needed to evaluate these technologies and to determine which interventions are most effective for which patients. Telepsychiatry has been shown to benefit patients, but reimbursement limitations are a barrier to its expanded use. Making proactive telephonic outreach a reimburseable service holds promise as a means of providing help to individuals considering or engaging in self-harm.

Hogan and Grumet's article makes the important points that suicide rates are rising, treatments are available, effective, and increasingly covered by insurance, and health care encounters are opportunities to identify and assist patients who are contemplating self-harm. These statistics can serve as a baseline and a guide as the health care system strives to increase the evidence-based services received by patients at risk for self-harm.