Suicide Care in Systems Framework: National Action Alliance Clinical Care and Intervention Task Force

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Texas Suicide Prevention Symposium
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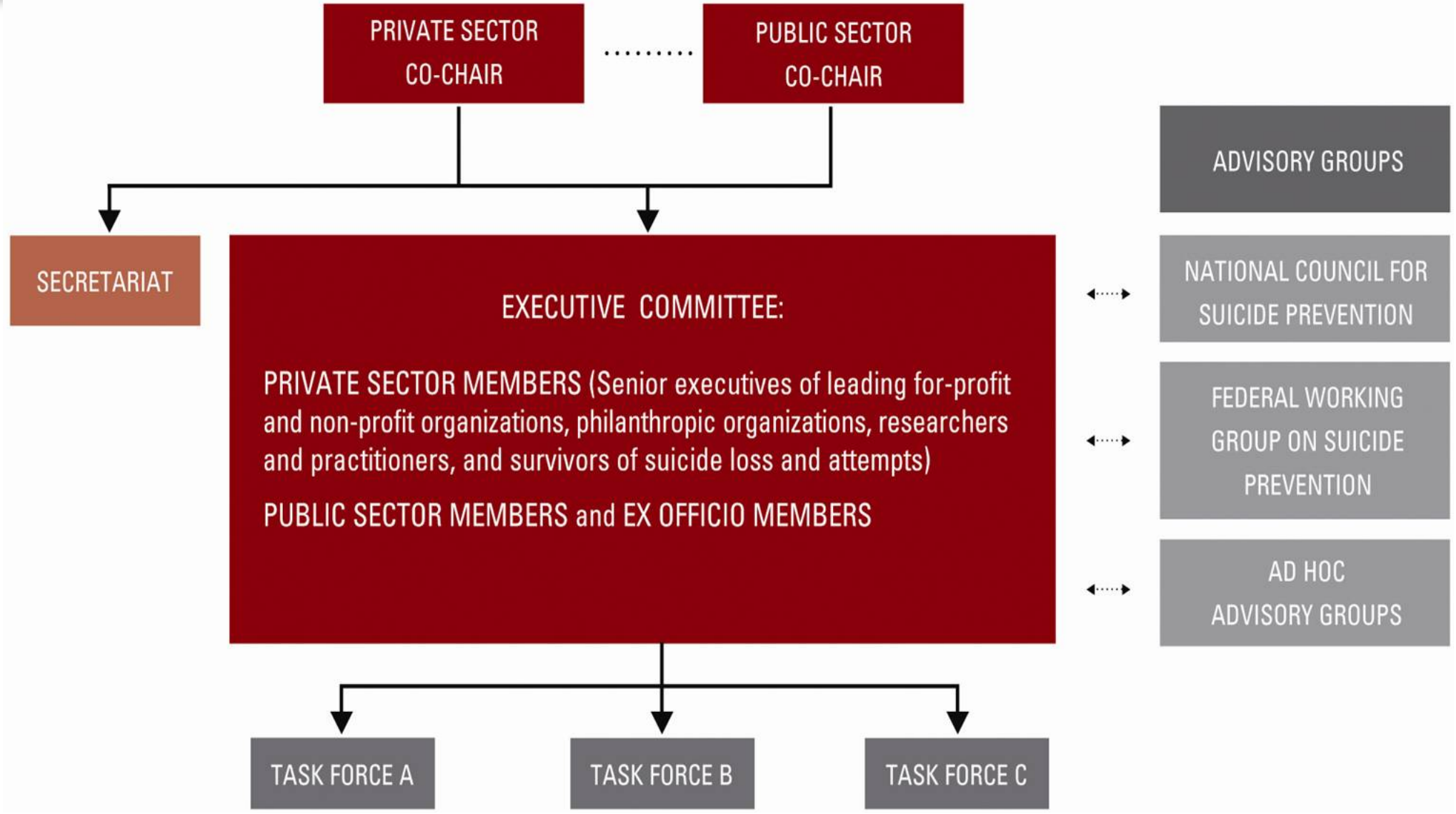
Ending Suicide in Healthcare Settings:
How many deaths are acceptable?
What are our next steps to save lives?

AAS Conference – April 2012

David Covington, LPC, MBA

Action Alliance Organization



Task Forces

Clinical Care & Intervention Task Force

- Mission
  - Improve suicide prevention and intervention practices in specialty behavioral health settings
  - Articulate clinical care and intervention strategies for specialty and general health plans
  - Propose standards and essential elements for suicide prevention that might be recommended to national accrediting bodies and for inclusion in state and federal guidelines

What is a "System of Care"?

- System of care:
  - Any entity serving a defined population
  - Has shared leadership, policy, or other structures that enable changes across subunits
- What qualifies as a system? Examples:
  - Healthcare or behavioral health systems
  - Networks of providers
  - Military branches, college campuses (though our focus is healthcare)
  - Many lessons also apply to smaller units (e.g., EDs, multi-provider practices, etc.)

Case Examples

FOUR SYSTEMS

- U.S. Air Force
- Henry Ford Health Systems
- Magellan Maricopa Collaborative
- Veteran's Administration

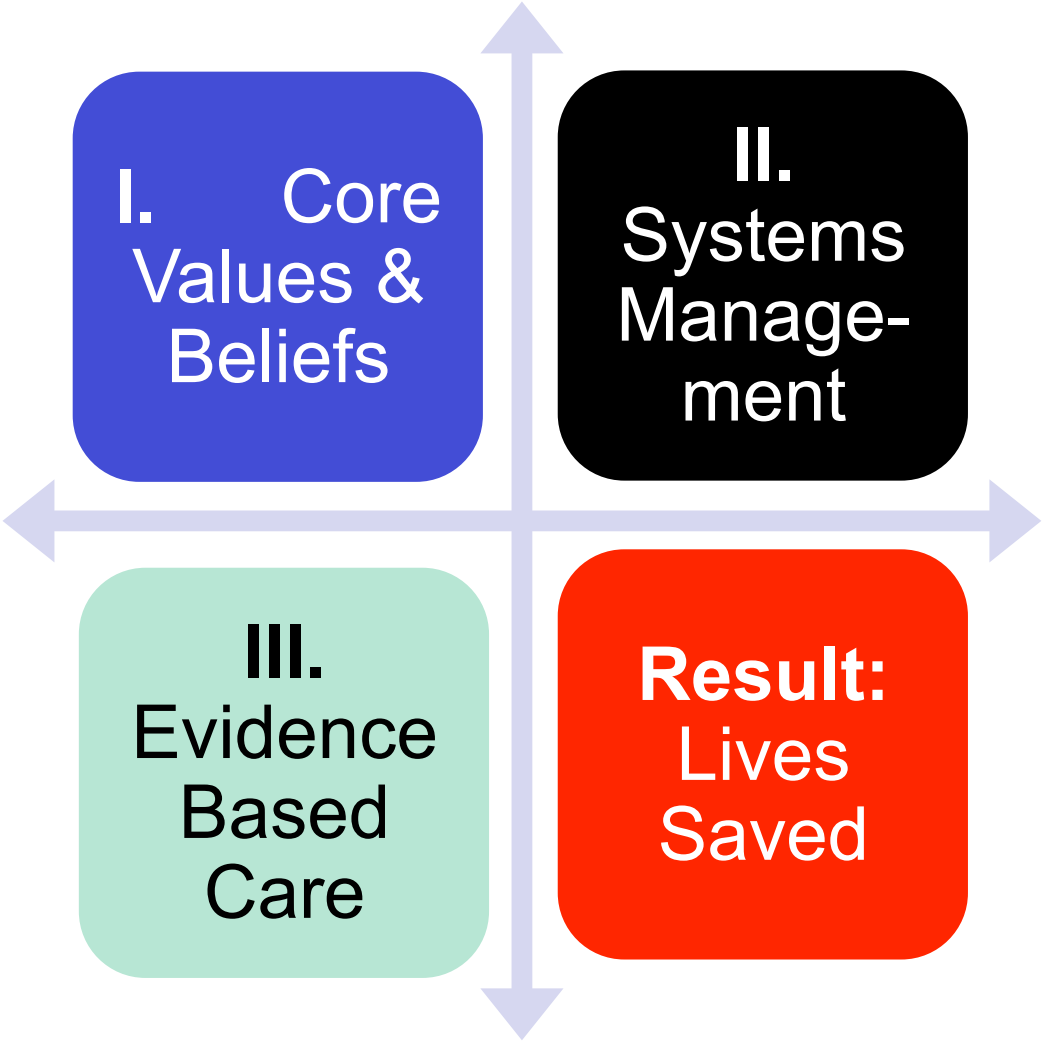
ONE NETWORK

- National Suicide Prevention Lifeline

Lessons Learned

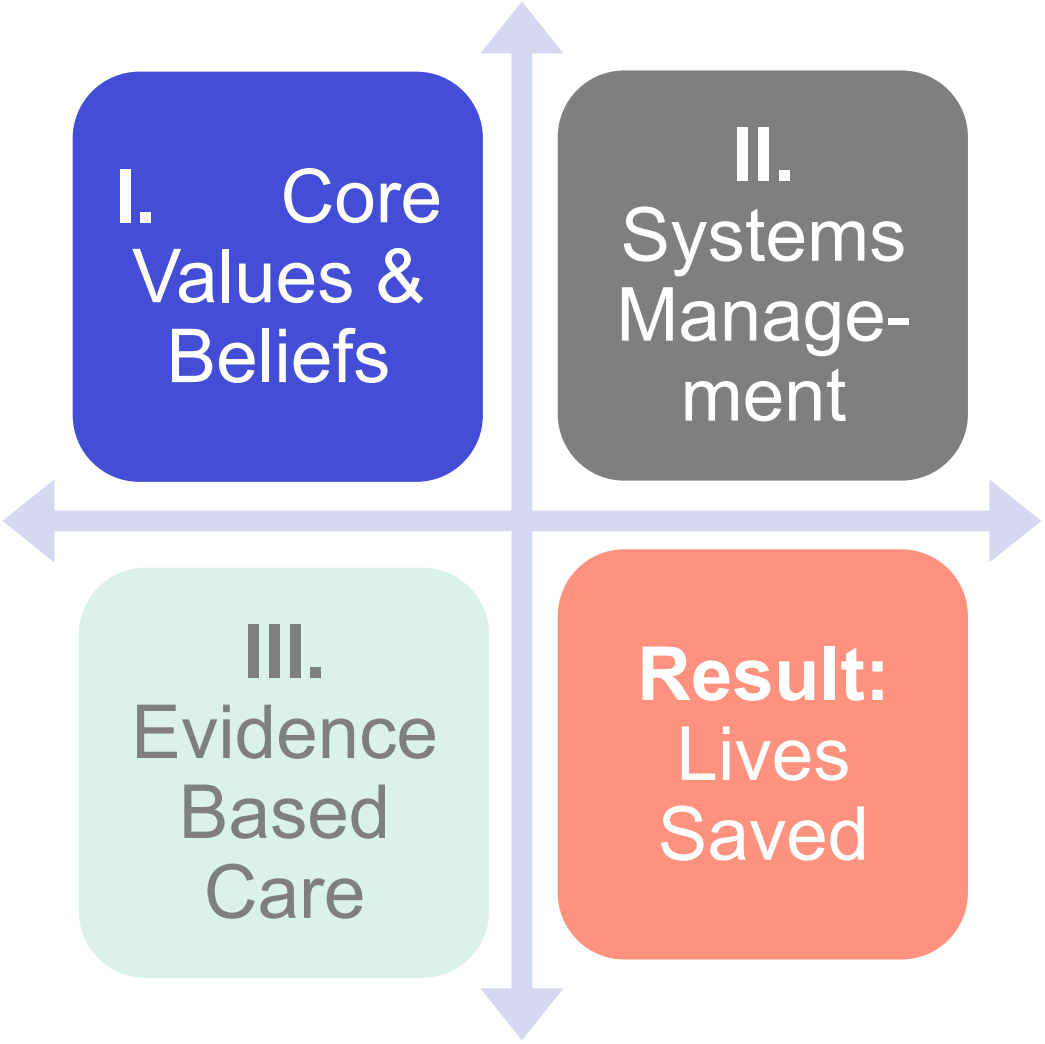
Shift in Perspective from:	To:
Accepting suicide as inevitable	Every suicide is preventable
Stand alone training and tools	Overall systems and culture change
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification and interventions
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care
"If we can save one life…"	"How many deaths are acceptable?"

Systems of Care Framework



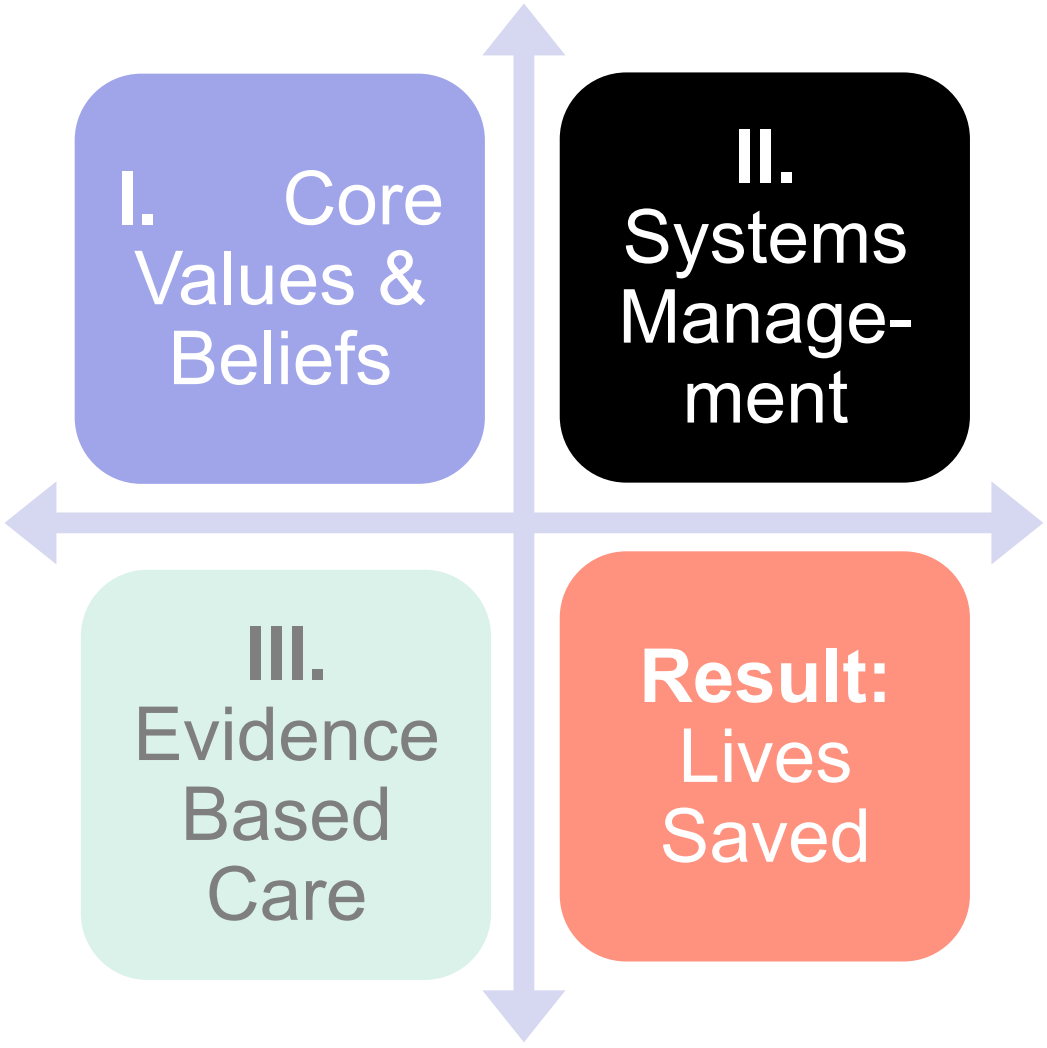
- High Reliability – Aviation goal zero commercial crashes
  - Don't train only the pilots; instead, all procedures & systems target success
- Health Systems – Eliminate:
  - Wrong-site, patient surgery
  - Inpatient falls
  - Medication Errors
- Crossing the Quality Chasm

I. Core Values & Beliefs



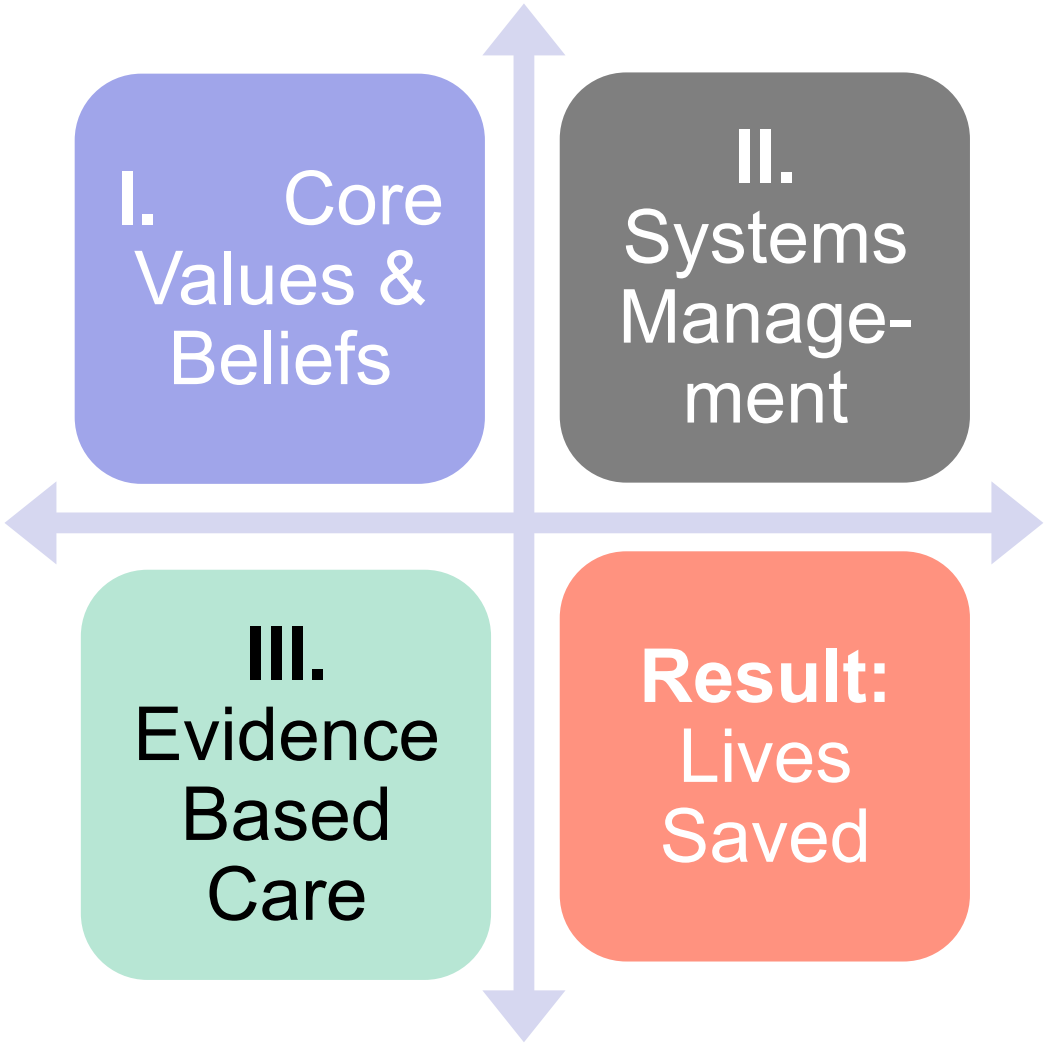
- Current science: Suicide is preventable
  - Those who die by suicide have intense ambivalence
  - Caring saves lives
- Last decade:
  - Increased research on effective interventions
  - Development of standardized risk assessments & standards
  - Systems successes

II. Systems Management



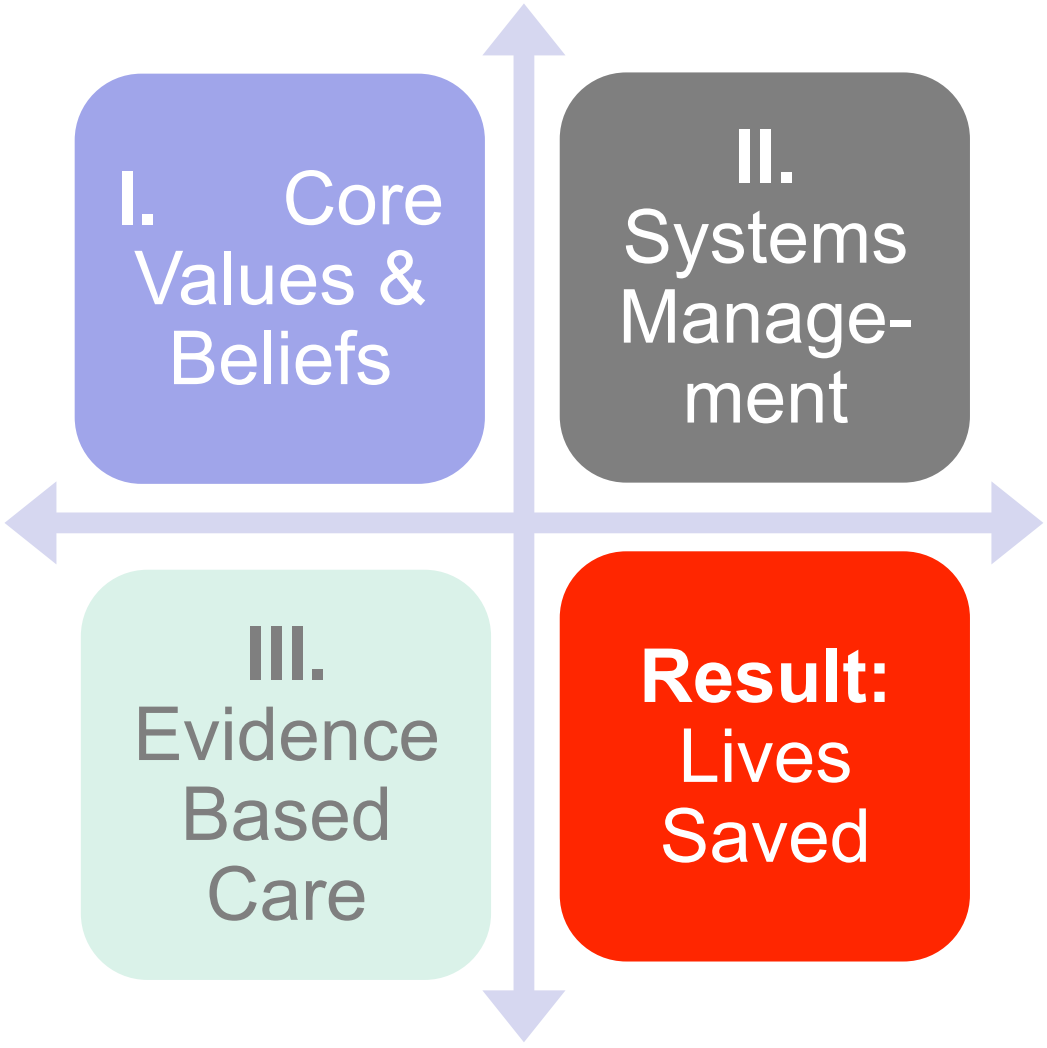
- Robust Performance Improvement
  - Workforce Development
  - Standardized Clinical Care
    - ✓ Screening & Assessment
    - ✓ Stratification of Risk
    - ✓ Regimen of Key Interventions
      - Access to Care
      - Means Restriction
      - Follow-up
  - Transparent Reporting & Feedback Loops, Commitment to Improvement

III. Evidence Based Clinical Care



- "Productive Interactions" – Therapeutic relationships based on engagement and collaboration
- Treat suicide risk directly (not just underlying diagnosis)
- Evidence based care
- Involuntary hospitalization is minimized, considered a safety measure and possible sign of community care defects

Accountability for Results: Lives Saved



- Timely public reporting of suicide deaths
  - Measure & Report
  - Feedback Loop

International Support for a Systems Approach

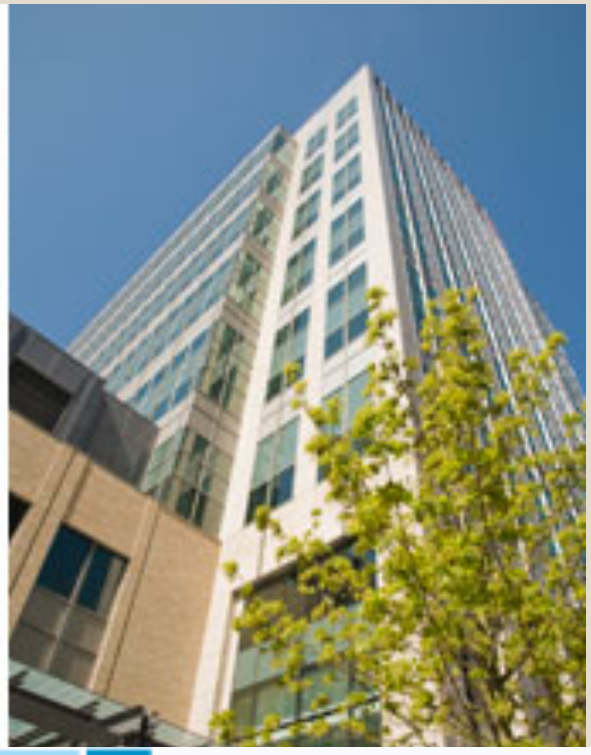
- *"**Services that had implemented seven to nine recommendations had a significantly lower suicide rate than those implementing fewer**"*
- Powerful impact of a comprehensive approach
  - p< .005
  - Suicide death rate 17% lower under comprehensive approaches (in U.S. equates to 6,000 lives)
- Some recommendations appear most significant: having a 24 hour crisis team, having a dual diagnosis policy, and post suicide multidisciplinary review

What Actions To Achieve Our Vision?

- Task Force Actions:
  - Promote Report and Recommendations
  - Submitted CMS Healthcare Innovations Challenge Grant to Refine, Disseminate and Implement Model
- What We Ask
  - Find Innovator/Early Adopter Systems and Leaders who will Implement a Systems Approach and Commit to Working Toward Zero Suicide for Their Members
  - Federal and Funder Support to Disseminate and Test the Commitment

Academic's Perspective on Treatment Research and Policy for Suicide Prevention

Kate Comtois, PhD, MPH
University of Washington



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EVIDENCE-BASED CLINICAL CARE PRACTICE: COMPREHENSIVE QUALITY CARE TO SAVE LIVES

3. **Treating suicide risk** – ***Treatment of persons with suicide risk should be carried out in the least restrictive setting using research-guided practice techniques.*** While the Task Force recommends the use of evidence-based practice (i.e., research-driven practice based on randomized clinical trial designs), it recognizes the relative paucity of such research to guide practice. In a best practices overview report written for Veterans Affairs' providers (authored by Drs. David Jobes, Mark De Santis and Donald Myrick), the authors found only 49 randomized clinical trials in the world's literature. (The report is found in Appendix C.) In this review, the authors make the following observations:

EVIDENCE-BASED CLINICAL CARE PRACTICE: COMPREHENSIVE QUALITY CARE TO SAVE LIVES

- There is limited evidence of the overall efficaciousness of **pharmacotherapy-only** treatment for suicidal risk;
- Similarly, there is limited evidence to support the widespread use of **inpatient psychiatric hospitalization** for suicidal patients;
- **Follow-up interventions and case management treatment** have demonstrated a significant impact on reducing suicide behaviors including deaths;

EVIDENCE-BASED CLINICAL CARE PRACTICE: COMPREHENSIVE QUALITY CARE TO SAVE LIVES

- **Thus far, certain coping oriented psychotherapies have** the most research support for effectively treating suicidal risk. In particular, the research supports highly-structured, problem solving approaches. The following evidence-based approaches are highlighted in the overview report:

  - ***Dialectical Behavior Therapy –*** the most thoroughly studied and efficacious psychotherapy for suicidal behavior
  - ***Cognitive Therapy*** – the next most studied and supported suicide-relevant psychotherapy
  - ***Other Promising Interventions*** – The authors cited two other interventions that exhibit strong correlational support and are now being studied in randomized clinical trials – ***Safety Planning Intervention*** and ***Collaborative Assessment and Management of Suicidality***

GOOD NEWS: There are now 26 RCT's underway!

Community Based Cognitive Therapy for Suicide Attempters (PI: A. Beck)

Sample: 140 adults who had been recently hospitalized after a suicide attempt

Design: Randomized Clinical Trial

Experimental: Cognitive Therapy (CT) and Enriched Care (EC)

Comparison: Enhanced Care (EC)

Primary Outcomes: Suicide Attempts, Suicide Risk Factors (Depression, Suicidal Ideation, Hopelessness), Use of Social/Medical Services

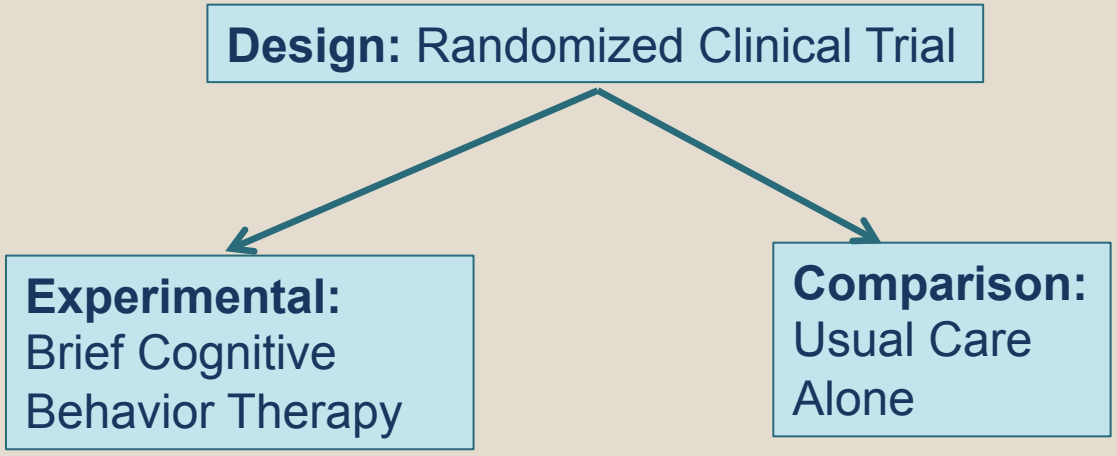
Assessed at: 1, 3, 6, 12, 18 and 24 month follow-ups

Progress to Date: Completed enrollment and follow-up of 140 participants. Analyzing data

Funded by: National Institute of Mental Health (NIMH)

Brief Cognitive-Behavior Therapy for Suicidal Soldiers (Contact PI: Rudd)

Sample: 150 suicidal Soldiers with recent suicide attempt or current suicidal ideation with intent to die.



Primary Outcomes: Suicide Attempts
Assessed at: 3, 6, 12, 18, & 24 months

Progress to Date: 100 randomized (as of April 3)

Funded by: Military Operational Medicine Research Program (MOMRP)

Blister Packaging Medication to Increase Treatment Adherence and Clinical Response: Impact on Suicide-related Morbidity and Mortality (Contact PI: Gutierrez)

Sample: 430 Veterans receiving care post-discharge from inpatient psychiatry, outpatient mental health, substance abuse treatment program or PTSD treatment

Design: Randomized Clinical Trial

Experimental:
Receive VA dispensed medications in blister packs

Comparison:
Receive VA dispensed medications in standard pill vials

Primary Outcomes: Treatment Adherence and Self-Directed Violence
Assessed at: Monthly follow-up assessments for 12 months

Progress to Date: Enrolled 95 participants

Funded by: Military Operational Medicine Research Program (MOMRP)

Suicide Assessment and Follow-up Engagement: Veteran Emergency Tracking (SAFE VET)

Holloway (Contact PI) Brown, Brenner, Currier, Knox & Stanley

Sample: 600 Veterans with suicidal ideation who are evaluated and discharged from VA Emergency Departments (ED) or Urgent Care (UC)

Design: Cohort Comparison Open Trial

Experimental (Safe Vet ED or UC)
Safety Planning, Follow-up Telephone Services

Comparison (Control ED or UC):
Usual Care

Primary Outcomes: Mental Health/Substance Abuse Treatment Attendance, Mental Health Hospital Admissions, Suicidal Ideation and Behaviors, Suicide-Related Coping
Assessed at: 1, 3, and 6 month follow-ups

Progress to Date: 179 participants enrolled, 42 completed study

Funded by: Military Operational Medicine Research Program (MOMRP) & VA

Efficacy of Dialectical Behavior Therapy vs. Collaborative Assessment and Management of Suicidality on deliberate self-harm in patients with self-harm acts and borderline personality traits (Contact PI: Prof. Merete Nordentoft, Denmark)

Sample: N= 160: 18-65 years, recent suicide attempt (within 1 month before first contact), at least two criteria of the borderline personality disorder (DSM-IV).

Design: Randomized Clinical Trial (Parallel group, Superiority trial)

Experimental:
16 weeks of Dialectical Behavior Therapy (DBT)

Comparison:
Maximum of 16 weeks of -CAMS informed supportive psychotherapy

Primary Outcomes: Numbers of deliberate self-harm (degree of intention).
Secondary outcomes: Suicide ideation, suicide intent, severity of borderline personality disorder, depressive symptoms, anger, impulsivity, self-esteem, hopelessness, and consumption of hospital services.
Assessed at: Baseline (week 0), week 17, 28 and 52.

Progress to Date: Trial is ongoing and results are expected Spring 2014

Funded by: The Lundbeck Foundation, Capital Region of Denmark and University of Copenhagen.

A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans (Contact PI: Ghahramanlou Holloway)

Sample: 186 inpatients with suicide ideation and/or attempt admissions

Design: Randomized Clinical Trial

Experimental:
Post Admission Cognitive Therapy (PACT) provided during inpatient treatment

Comparison:
Usual Care during inpatient treatment

Primary Outcomes: Suicide attempts
Assessed at: x

Progress to Date: 40 out of 186 recruited

Funded by: Military Operational Medicine Research Program (MOMRP)

Caring Letters for Military Suicide Prevention: A Randomized Controlled Trial (Contact PI: Luxton)

Sample: 4730 active duty Service Members and Veterans at 5 sites who are admitted to a psychiatric unit

Design: Randomized Clinical Trial

Experimental:
Caring Emails for two years on a planned schedule

Comparison:
Treatment as Usual

Primary Outcomes: Death by suicide as well as behavioral health utilization, suicide attempts, and re-hospitalizations

Assessed at: 2 years and via National Death Index (NDI-Plus) records and Social Security Administration Master Deaths Files (SSA MDF)

Progress to Date: 9 participants randomized (as of March 2012)

Funded by: Department of Defense

Brief skills training intervention for suicidal individuals (Contact PI: Ward-Ciesielski)

Sample: Suicidal individuals who are non-treatment-seeking (i.e., are not currently receiving mental health treatment and have not been in treatment for the last year)

Design: Randomized Clinical Trial

Experimental:
Brief, one-time, DBT skills-based intervention

Comparison:
Relaxation training

Primary Outcomes: Suicidal ideation and emotion dysregulation
Assessed at: Follow-up by phone at 1 week, 1 month, and 3 months

Progress to Date: 3 participants enrolled

Funded by: NIMH Individual National Research Service Award (NRSA)

Operation Worth Living (OWL) (Contact PI: Jobes)

Sample: 150 suicidal Soldiers (with or without a suicide attempt)

Design: Randomized Clinical Trial

Experimental:
Usual Care organized by the Collaborative Assessment and Management of Suicidality (CAMS)

Comparison:
Usual Care Alone

Primary Outcomes: Suicidal Ideation and Suicide Attempts
Assessed at: 1, 3, 6 and 12 month follow-up

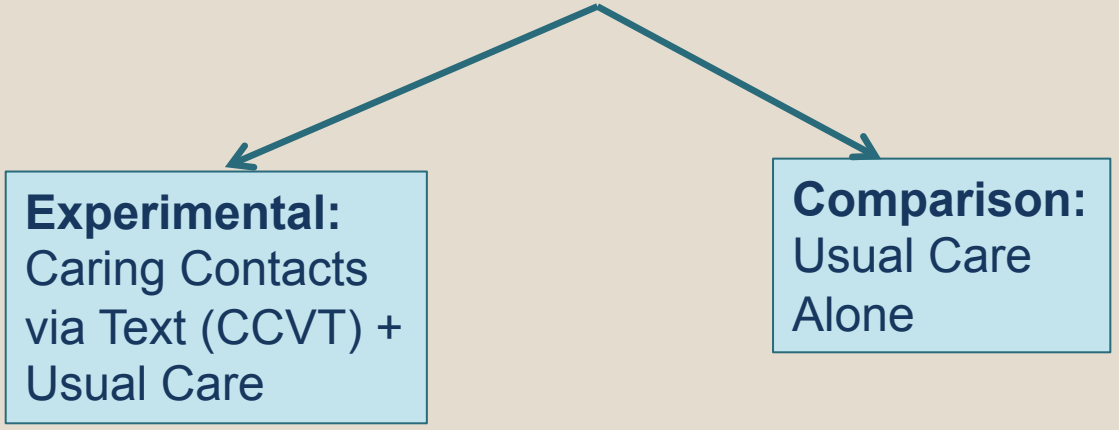
Progress to Date: Training Phase – 1st recruitment starts May 7

Funded by: Military Operational Medicine Research Program (MOMRP)

Military Continuity Project (Contact PI: Comtois)

Sample: 800 suicidal Soldiers and Marines (with or without a suicide attempt)

Design: Randomized Clinical Trial



Primary Outcomes: Suicidal Ideation and Suicide Attempts
Assessed at: 12 month follow-up

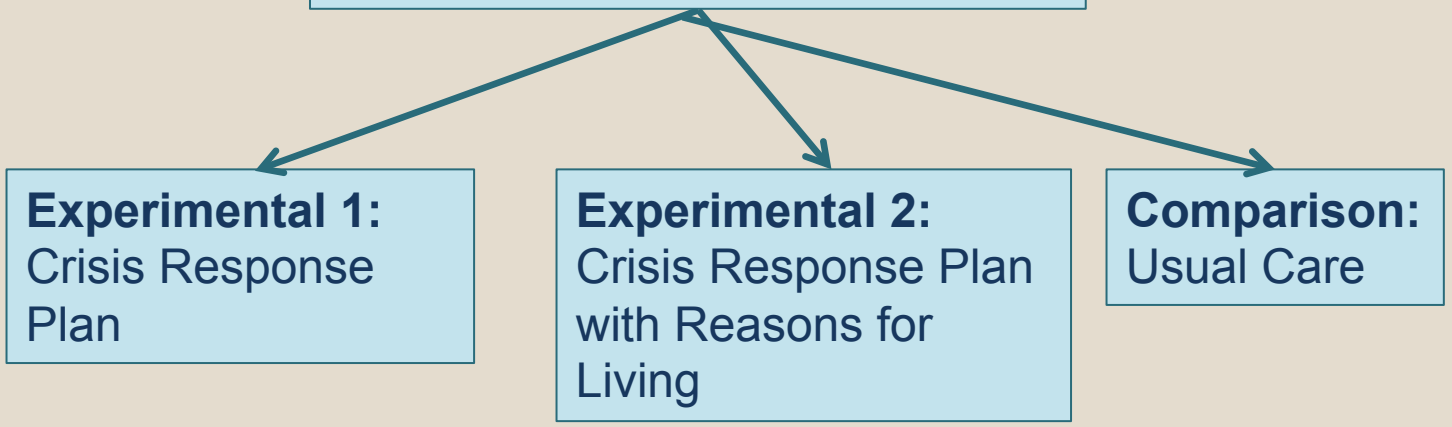
Progress to Date: Under IRB Review

Funded by: Military Suicide Research Consortium (msrc.fsu.edu)

Brief Interventions for Short-Term Suicide Risk Reduction in Military Populations (Contact PI: Bryan)

Sample: 360 active duty suicidal Soldiers with recent suicide attempt or current suicidal ideation with intent to die who are receiving emergency interventions at the initial point of contact within mental health

Design: Randomized Clinical Trial



Primary Outcomes: Suicide Attempts
Assessed at: 1, 3, & 6 months

Progress to Date: Under IRB Review

Funded by: Military Suicide Research Consortium

Motivational Interviewing to Prevent Suicide in High Risk Veterans (Contact PI: Britton)

Sample: 112 psychiatrically hospitalized Veterans who are at high-risk for suicide

Design: Randomized Clinical Trial

Experimental:
Motivational Interviewing to Address Suicidal Ideation (MI-SI)

Comparison:
Treatment as Usual

Primary Outcomes: Suicidal ideation and treatment engagement
Assessed at: 1, 3, and 6 months post discharge

Progress to Date: Due start April 2012

Funded by: VA CSR&D Career Development Award

A Behavioral Sleep Intervention for the Prevention of Suicidal Behaviors in Military Veterans (Contact PI: Bernert)

Sample: Suicidal Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans

Design: Randomized Clinical Trial

Experimental:
Military Sleep-based Preventive Intervention (Cognitive Behavioral Therapy for Insomnia and Imagery Rehearsal Treatment)

Comparison:
Treatment as Usual

Primary Outcomes: data was collected from a sleep diary as well as empirically supported assessments

Assessed at:

Progress to Date: Unknown

Funded by: Military Suicide Research Consortium

Virtual Hope Box (Contact PI: Bush)

Sample: N=10-25 OIF/OEF service veterans at high risk of self-harm and suicide attending DBT Program at the VAMC Portland Mental Health Clinic

Design: Phase 1: Smartphone app development and usability testing. Phase 2: Primarily descriptive at case level, employing cross-over, counterbalanced design

Experimental: Virtual Hope Box (VHB) delivered via patient's own smartphone

Comparison: Physical (conventional) Hope Box (PHB)

Primary Outcomes: Usability, utility and feasibility of VHB, satisfaction and preference with VHB

Assessed at: 6-8 weeks and 12-14 weeks (after each PHB or VHB trial)

Progress to Date: Phase 1 almost completed- VHB developed and tested for usability. Phase 2 IRB approved, VA study coordinator hiring in progress.

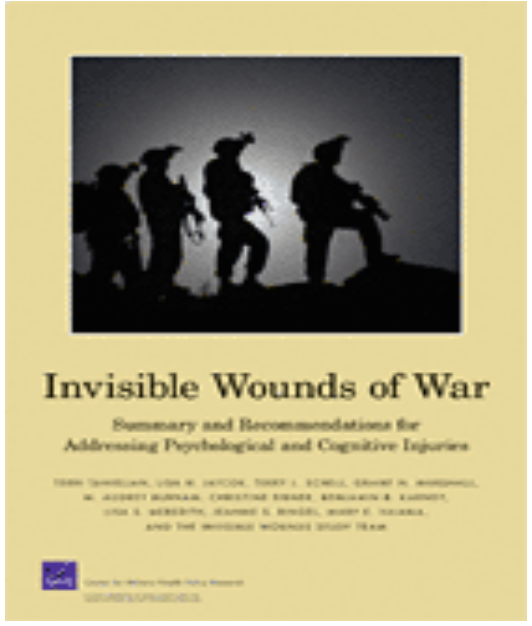
Funded by: Military Operational Medicine Research Program (MOMRP)

Conclusion

- **While the empirical literature has been limited, we can look forward to**
  - More results
  - More rigorous results
  - Many young investigators bringing innovative ideas and treatments through development into full clinical trials

Practice Guidelines for Civilian Providers

A Unique Perspective



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University of Utah

NATIONAL CENTER FOR VETERANS STUDIES
THE UNIVERSITY OF UTAH

5 Things that Save Lives

1. Easy to understand treatment model

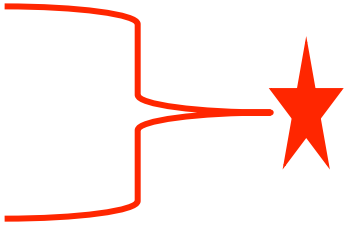
- Identifying developmental history, early skill development/deficiencies related to current functioning
  - Susceptibility expressed through "triggering"
- Three targets
  - Thoughts (and core beliefs)
    - Motivation for dying
  - Feelings (physiological/emotional)
  - Behavior (increasing adaptive)

2. A focus on treatment compliance

- Specific interventions and techniques to target poor adherence and motivation
  - Usually a function of poor skills
  - Phone calls and texts for encouragement
- Clear directions about *what to do* if non-adherence emerges

3. Focus on skills-building

- Identification of skills deficits with opportunity for skills building and practice
  - Emotion Regulation
  - Interpersonal



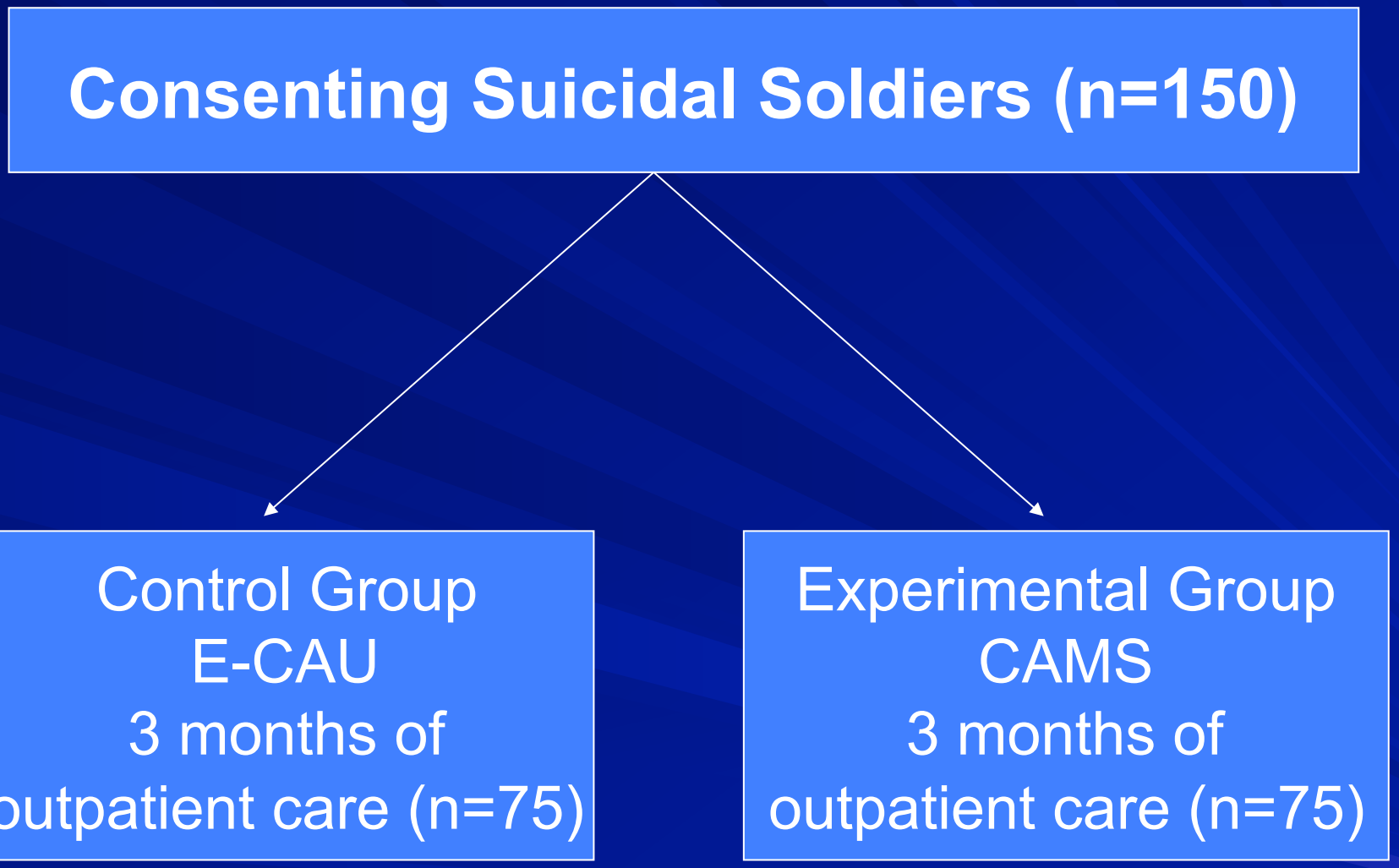
- Clear understanding of "what is wrong" and "what to do about it"
- Separate from identity

4. Taking Personal responsibility

- Emphasis on patient self-reliance and self-management
  - *Commitment to Treatment Statement*
  - *Crisis management/safety plan*
- Patients assume high level of responsibility for their care, including crisis management

5. **Easy access to treatment and crisis services**
   - Clear plan of action for emergencies
     - Crisis management/safety plan
   - Dedication of time to practicing skills necessary to identify true crisis, using crisis plan, and using external support services judiciously

OWL Design and Methodology



Dependent Variables: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)