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Suicide Prevention as a Core Priority in Healthcare: Zero Suicide and Suicide Safe Care

Richard McKeon Ph.D. SAMHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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Behavioral Health is Essential To Health

Prevention Works

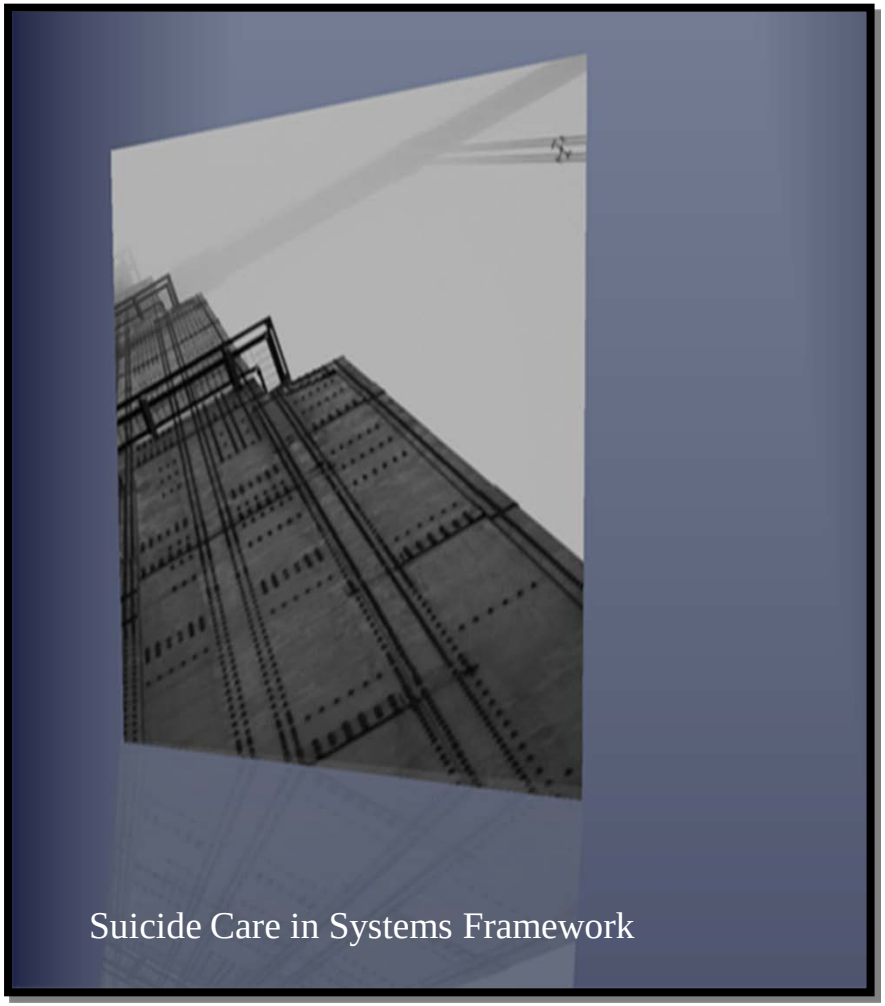
Treatment is Effective

People Recover

2012 National Strategy for Suicide Prevention:
GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General
and of the National Action Alliance for Suicide Prevention

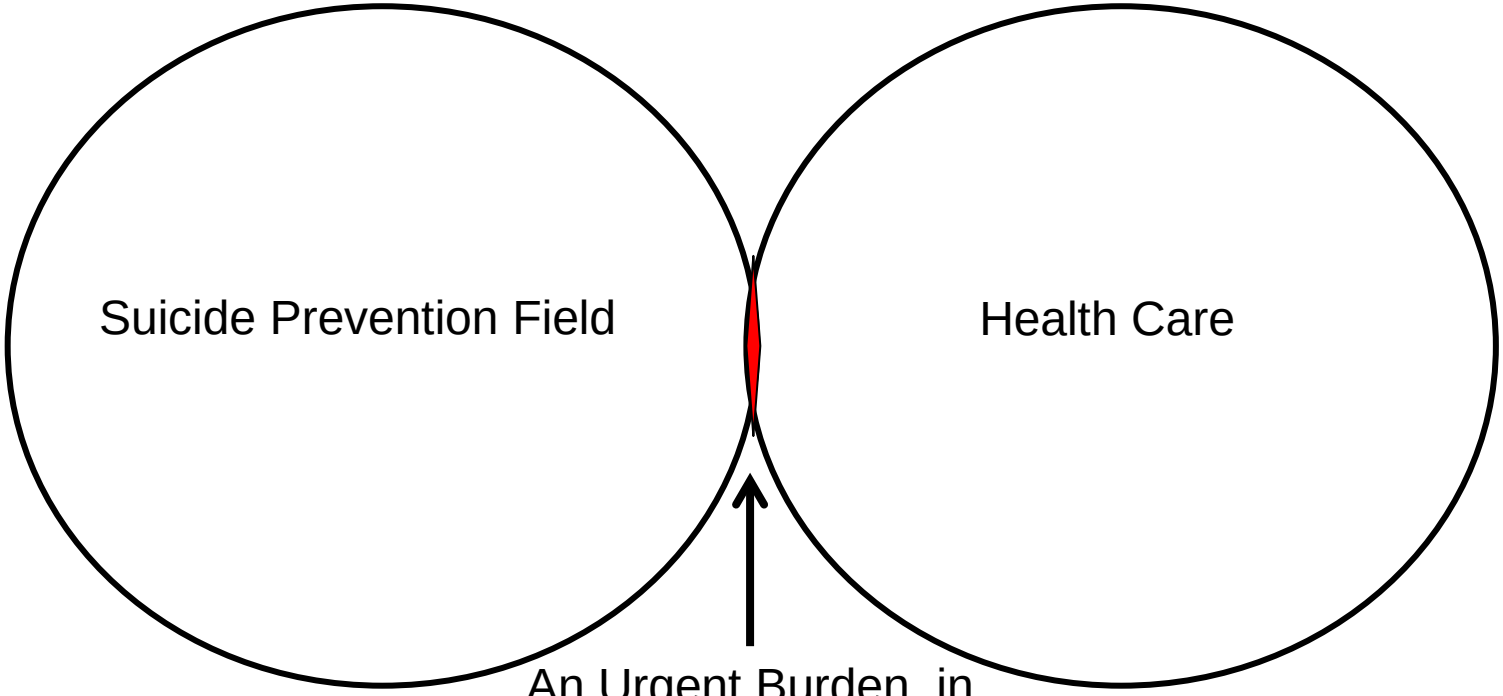
What Is Zero Suicide?



- Part of the National Strategy for Suicide Prevention
  http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/
  - GOAL 8: Promote suicide prevention *as a core component of health care services*, to include promoting "zero suicides" (8.1), continuity of care (8.4), coordinating services (8.7), and developing collaboration (8.8).
  - GOAL 9: Promote and implement *effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors*

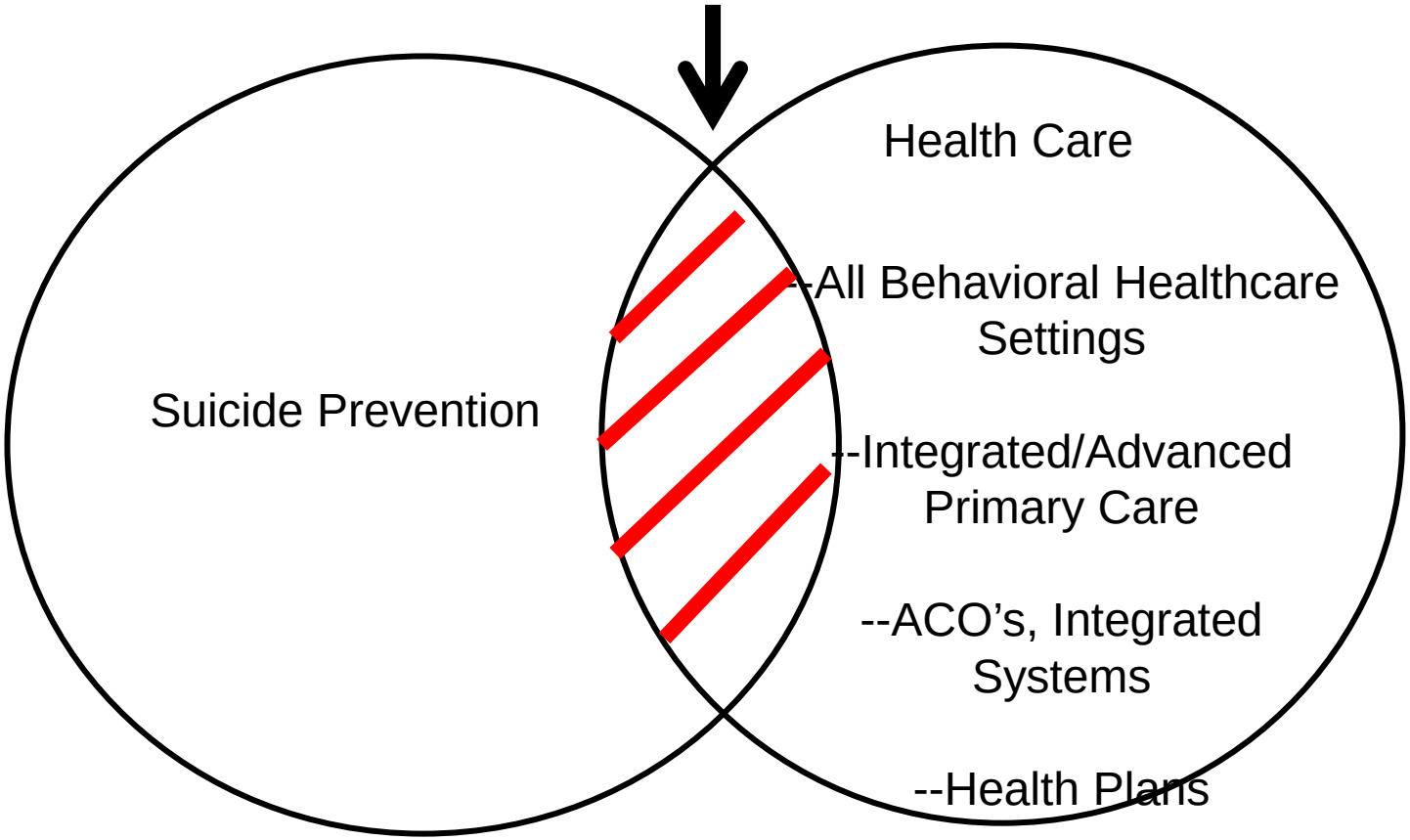
Why ZeroSuicide in *Health Care*?

We Need A Healthcare Focus on Suicide Prevention, and
A Suicide Prevention Focus on Healthcare
Until Now, We Have Neither



What is Different in Zero Suicide?

A ***Core*** Healthcare Focus on Suicide Prevention, and
A Suicide Prevention Focus on Healthcare

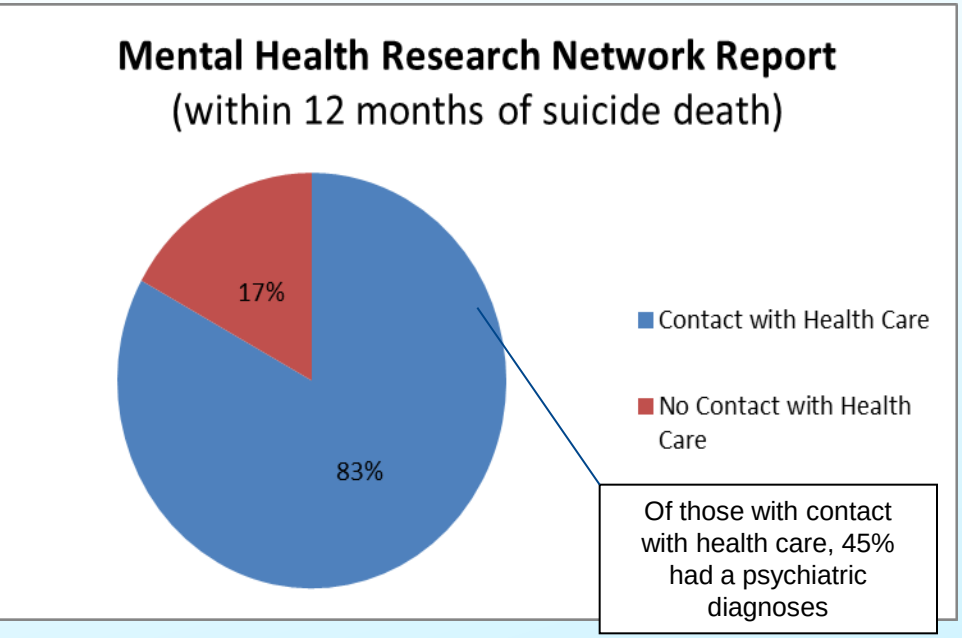


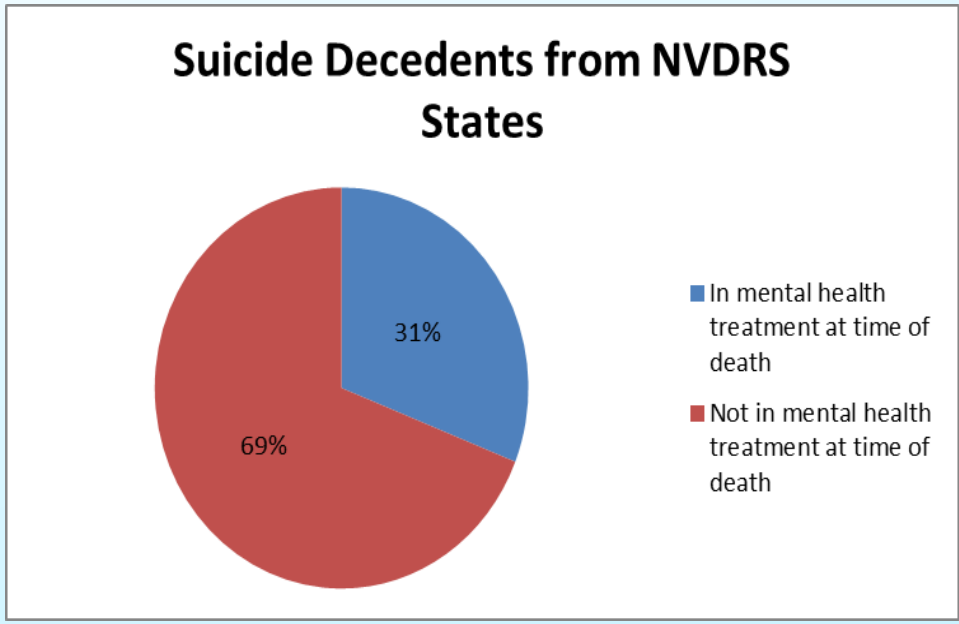
Why Suicide Prevention in Health Care? *Risks* and *Solutions* are there

- Half of the people who die by suicide saw an MD in previous month
- South Carolina: 10% of all people who died by suicide had been in ED in previous 60 days
- Risks are great among people receiving mental health care:
  - Risk among people with depression and other mental health problems are 4-20x general population
  - Kentucky: 20% of all suicides in state among people who got any MH care (claims/deaths crosswalk)
  - NYS: 226 reported suicides in public MH system in 2012 (15% of estimated 1500 suicide deaths in NYS)
- But…solutions are emerging!

You can't fix what you can't measure….

Perhaps a third of all suicide decedents accessed care prior to death, but few U.S. health care systems track suicide outcomes.

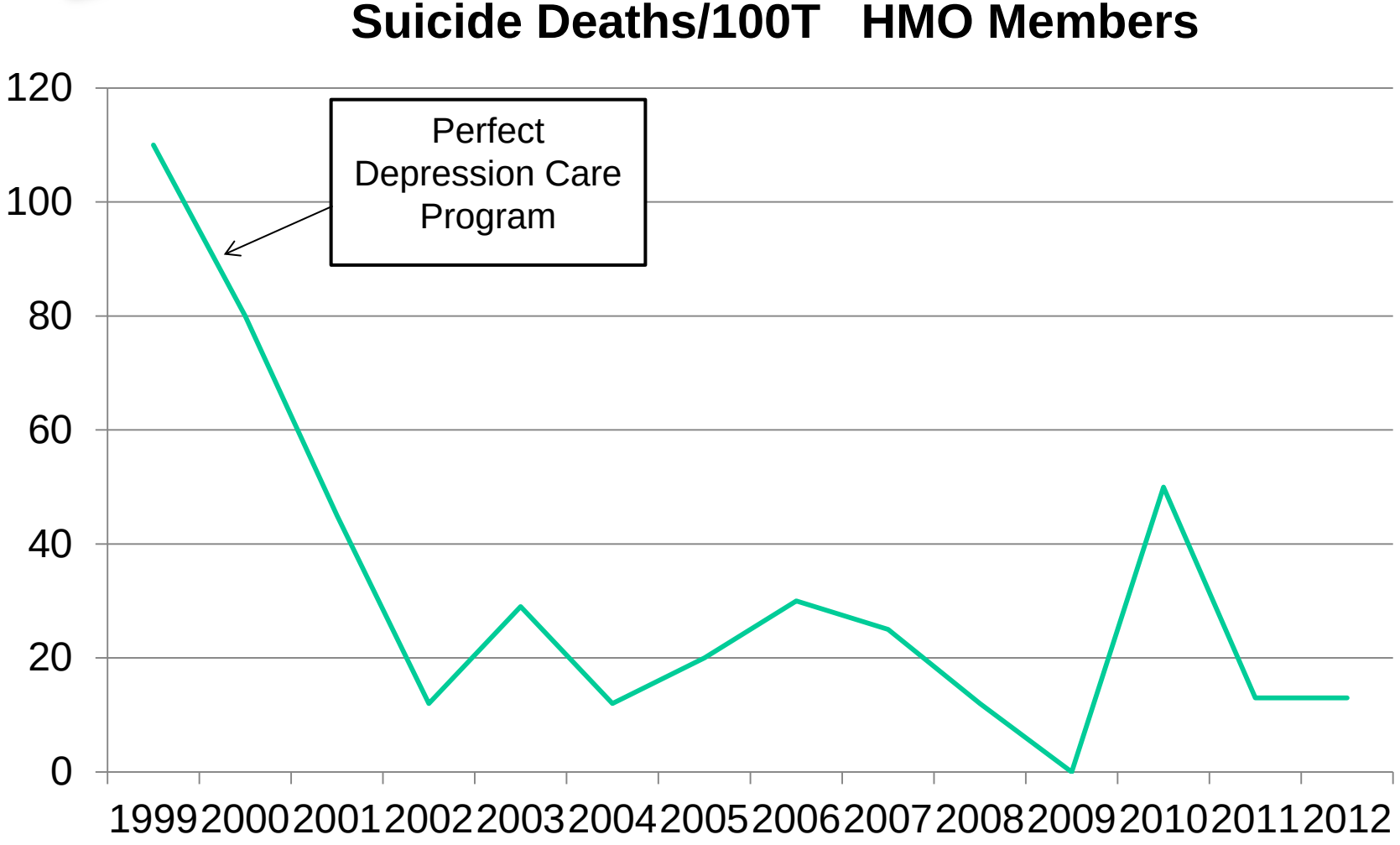




Ahmedani BK et al (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, online Feb 25. DOI: 10.1007/s11606-014-2767-3.

Karch, DL, Logan, J, McDaniel, D, Parks, S, Patel, N, & Centers for Disease Control and Prevention (CDC). (2012). Surveillance for violent deaths—national violent death reporting system, 16 states, 2009. Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, DC: 2002), 61(6), 1-43.

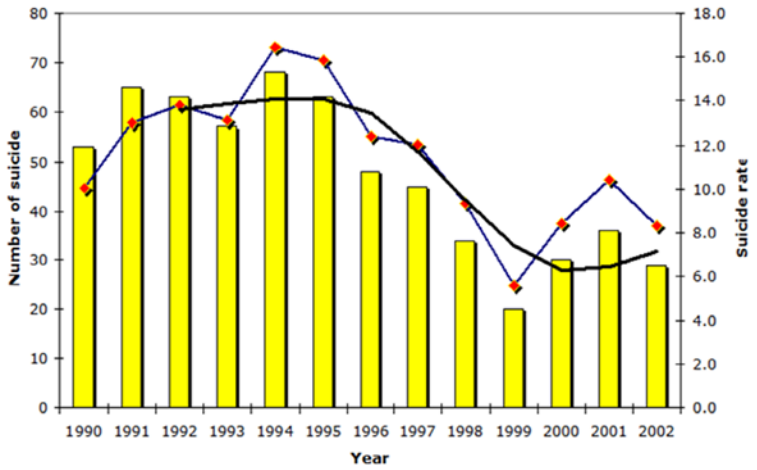
Henry Ford Health System



Why Do We Need A *Systematic, Clinical* Approach?

- There's no "single path" suicide prevention solution that is adequate and many common approaches *won't reach most people at the greatest risk*
  - We have missed some lessons from our greatest suicide prevention success:

U.S. AIR FORCE



  - We have to *reach everyone at risk:* An identified ("boundaried") population, and a way to reach them
- We have (new) solutions to keep intensely suicidal people alive, and help them heal. They involve excellent, *suicide safe* mental health care: a ZeroSuicide approach

What is Zero Suicide?

- A priority of the National Action Alliance on Suicide Prevention based on its Clinical Care Task Force
- A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems
- A focus on safety and error reduction in healthcare
- A set of best practices and tools for health systems and providers
- An aspirational goal that says we are determined to do all we can to keep all those in our care safe.
- An effort to combat fatalism and fear of blame for suicide deaths in our healthcare systems.

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?"

What is Zero Suicide?

"Over the decades, individual (mental health) clinicians have made heroic efforts to save lives… but systems of care have done very little."

- Dr. Richard McKeon
SAMHSA

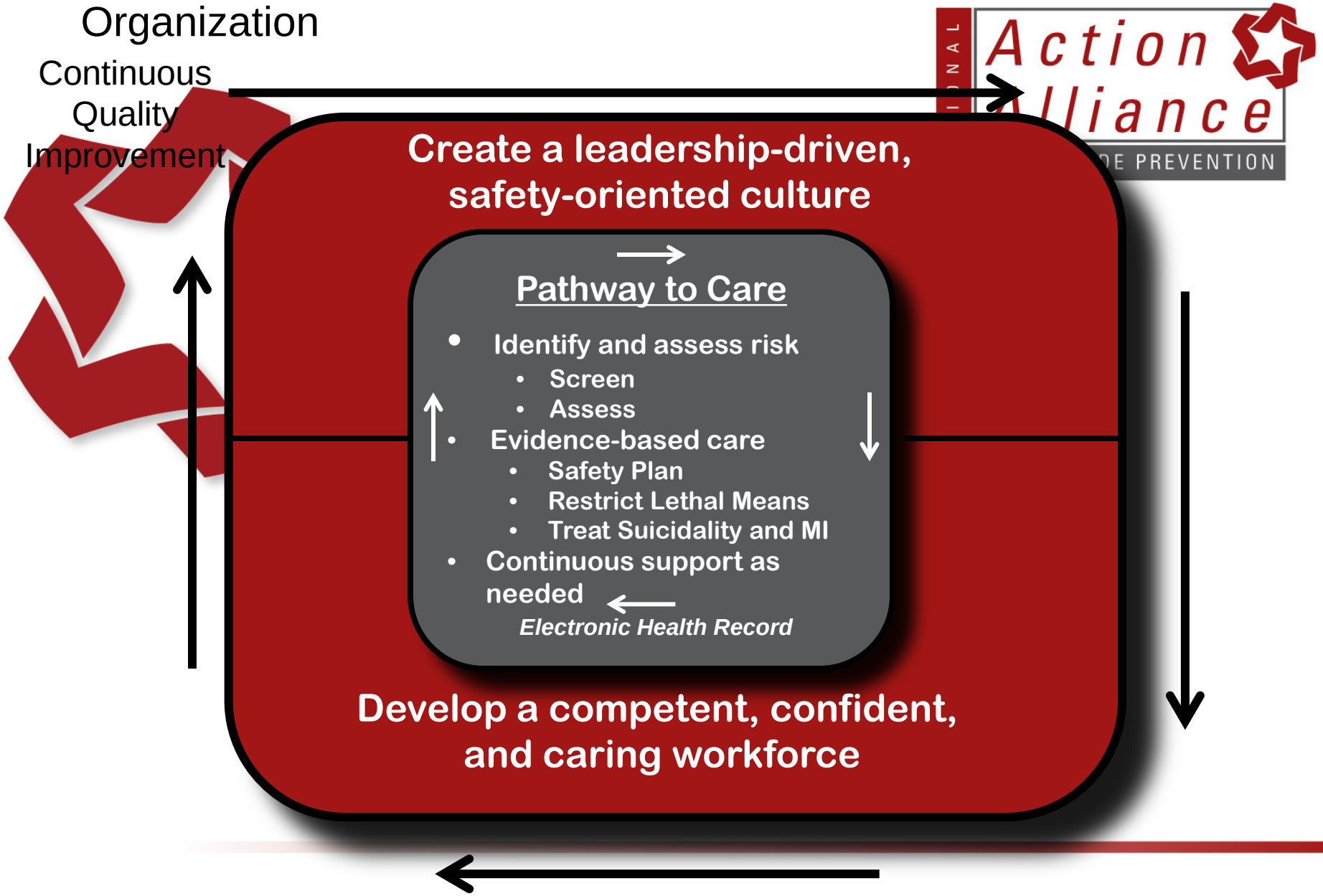
"Suicide represents a worst case failure in mental health care. We must work to make it a 'never event' in our programs and systems of care."

- Dr. Mike Hogan
New York State Office of Mental Health

Zero Suicide/Suicide Safe Care

- Suicide prevention is too challenging to be accomplished without sustained, systematic effort. It must be a core priority and has definable dimensions . Expecting individual clinician's to predict suicide and than blaming them is neither helpful nor sufficient.
- Don Berwick- Every system is perfectly designed to get the results its gets.

The Elements of ZeroSuicide in a Health Care Organization



Essential Dimensions of Suicide Care

- Leadership driven, safety oriented culture committed to dramatically reducing suicide among people under care and includes the voices of suicide loss survivors and those who have attempted suicide or experienced a suicidal crisis.
- Systematically identifying and assessing suicide risk levels among people at risk.

Essential Dimensions of Suicide Care

- Ensuring every person has a pathway to care that is both timely and adequate to meet their needs.
- Developing a competent, confident and caring workforce.
- Using evidenced based care including collaborative safety planning, reducing access to lethal means, and effective treatment of suicidality

Essential Dimensions of Suicide Care

- Continuing contact and support, especially after acute care.
- Applying a data driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

VETERANS ADMINISTRATION RESEARCH

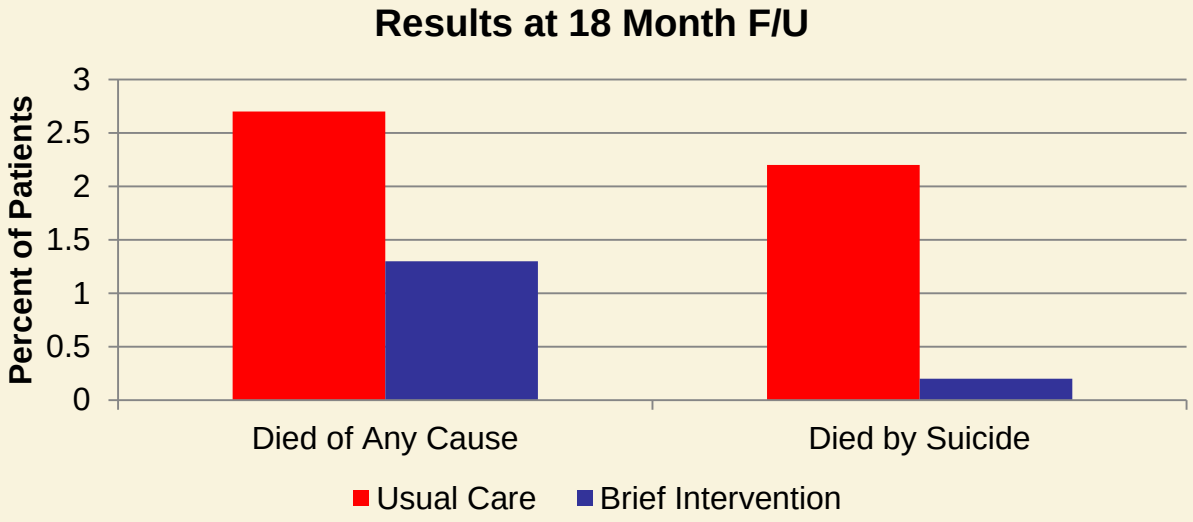
- In a study of almost 900,000 veterans who received treatment for depression between 1999-2004, suicide rates were highest in the 12 weeks following inpatient discharge (Valenstein et al, 2008)
- Researchers conclusions; “To have the greatest impact on suicide, health systems should prioritize prevention efforts following psychiatric hospitalizations.”
- Improving post discharge care transitions is central to the National Strategy for Suicide Prevention.

MISSED OPPORTUNITIES = LIVES LOST

- **About 50% of suicide attempters fail to attend treatmen**t post-discharge (Tondo et al, 2006).
- Only 52% of adult Medicaid recipients seen in EDs for a suicide attempt received received outpatient follow up within 30 days (Olfson et al, 2011)

The WHO Multisite Intervention Study on Suicidal Behaviors

- Fleischmann et al (2008)
  - Randomized controlled trial; 1,867 suicide attempt survivors from five countries (all outside US)
  - Brief (1 hour) intervention as close to attempt as possible
  - 9 F/u contacts (phone calls or visits) over 18 months



International Efforts

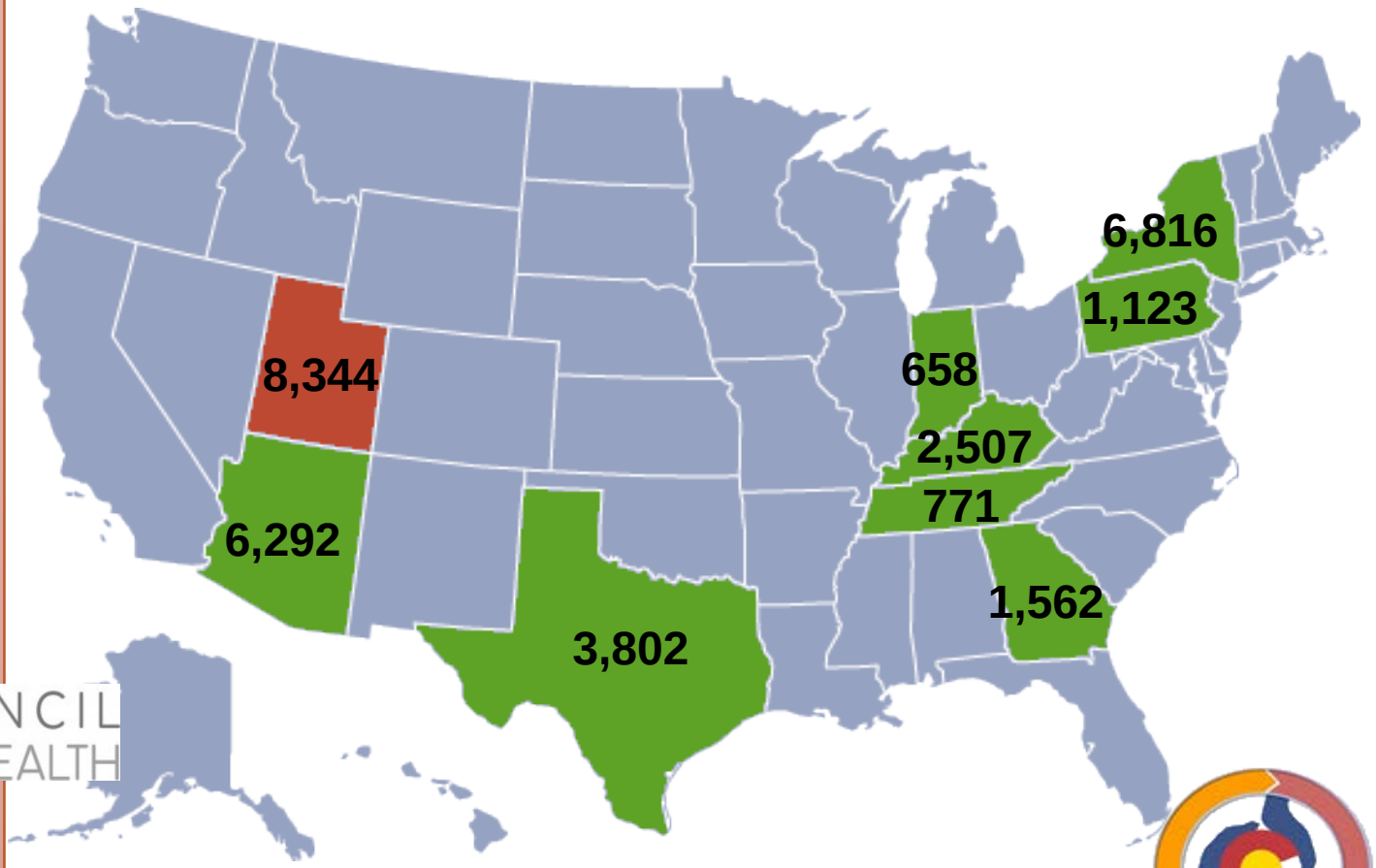
- England—Reduction in suicides in communities that implemented recommendations
- Largest reductions in when 24 hr community crisis care, proactive outreach available
- Follow-up within 7 days of IPU discharge
- Taiwan—Follow-up after suicide attempts led to 63% reduction in suicides.

National Survey of 30,000 MH Professionals Across Nine States

ZS Advisory Board (Mike Hogan & David Covington Co-leads)

Learning Collaborative, Julie Goldstein-Grumet

Learning Collaborative, Meena Dayak



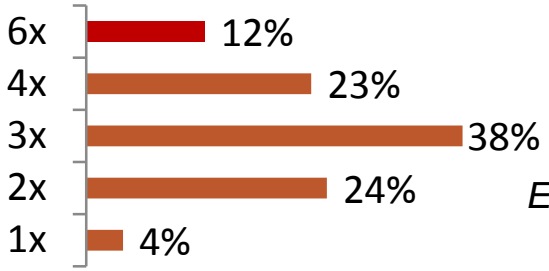
The Survey Results

Role	#
Counselor	2,421
Social Worker	2,361
Physician	416
Nurse	1,371
Case Manager	3,312
Para-professionals	826
Certified Peer Staff	479
Administrator	2,640
Support Staff	3,409

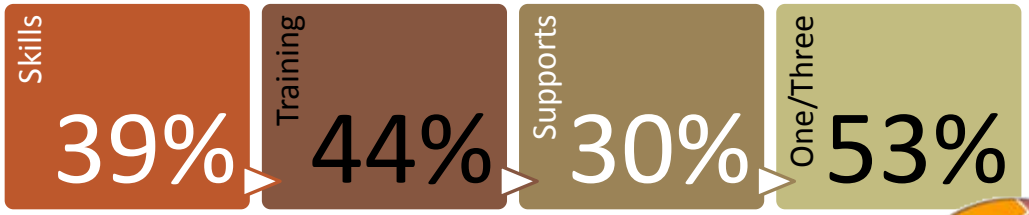
Over 6,000 report a patient has died by suicide (27%).

Once	• 3,314 / 15%
More than once	• 2,792 / 13%

SMI Suicide Rate vs. General Population

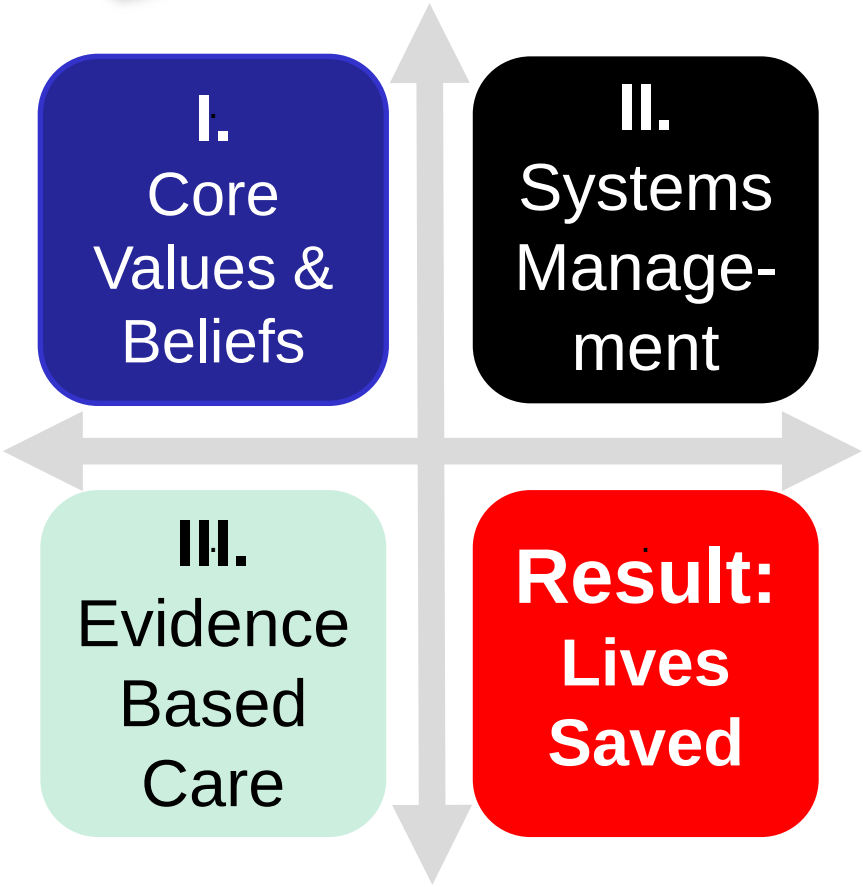


I have the _____ to engage and assist those who are suicidal.



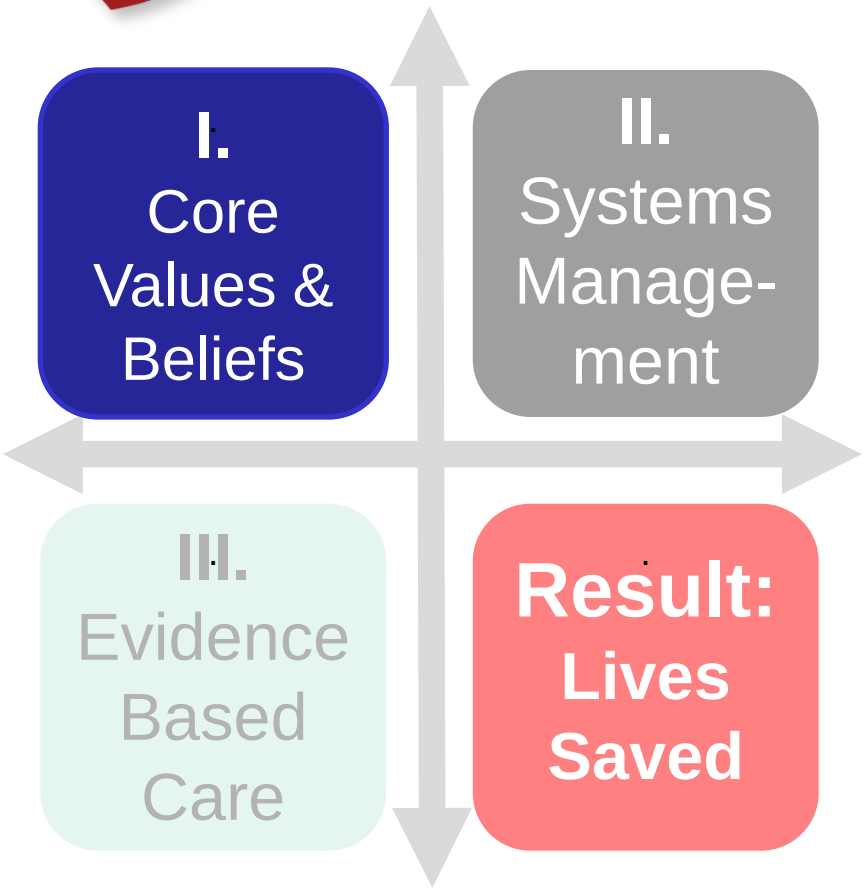
Endorsed Don't Know, Disagree, or Completely Disagree

Systems of Care Framework



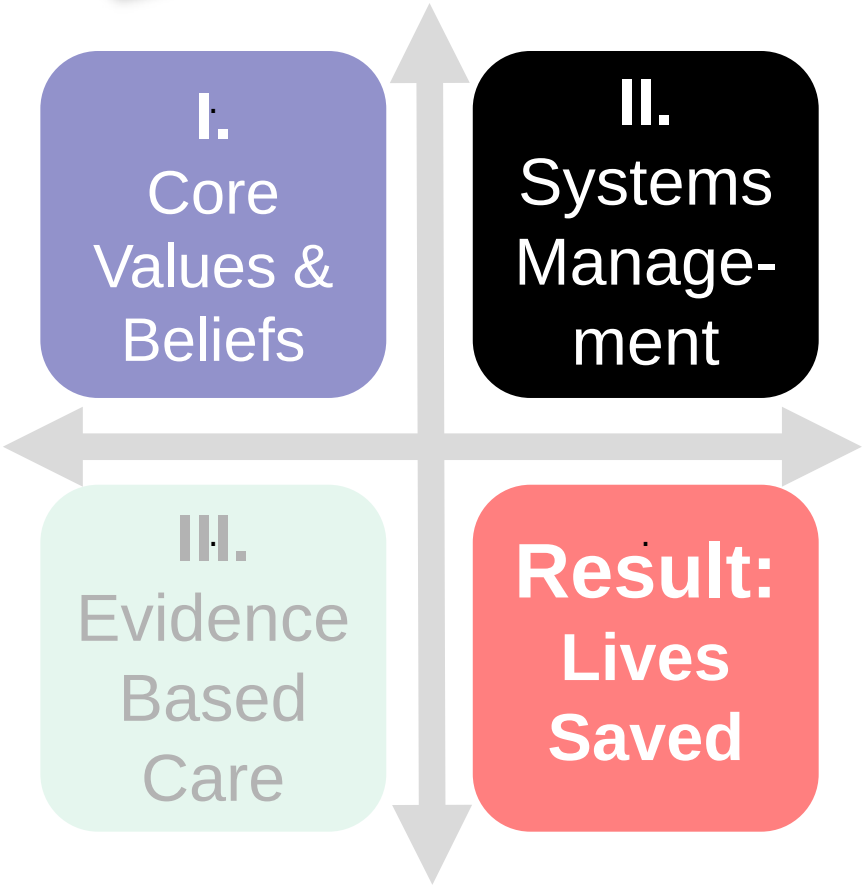
- High Reliability – Aviation goal zero commercial crashes
  - Don't train only the pilots; instead, all procedures & systems target success
- Health Systems – Eliminate:
  - Wrong-site, patient surgery
  - Inpatient falls
  - Medication errors
- Crossing the Quality Chasm

I. Core Values & Beliefs



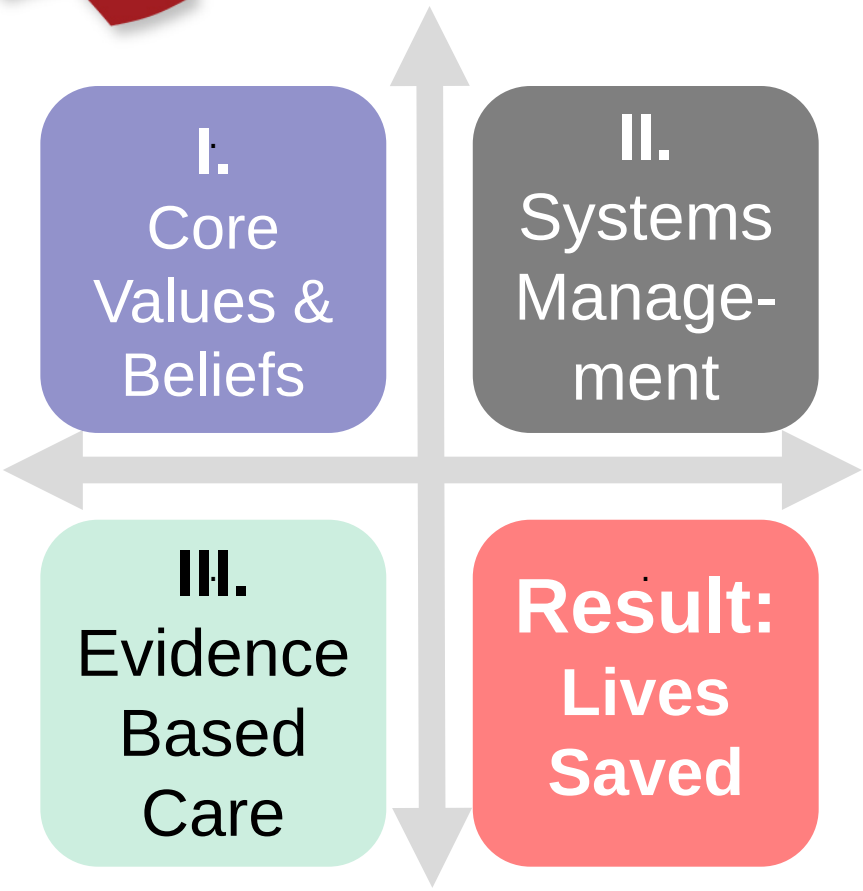
- Current science: Suicide is preventable
  - Those who die by suicide have intense ambivalence
  - Caring saves lives
- Last decade:
  - Increased research on effective interventions
  - Development of standardized risk assessments & standards
  - Systems successes

II. Systems Management



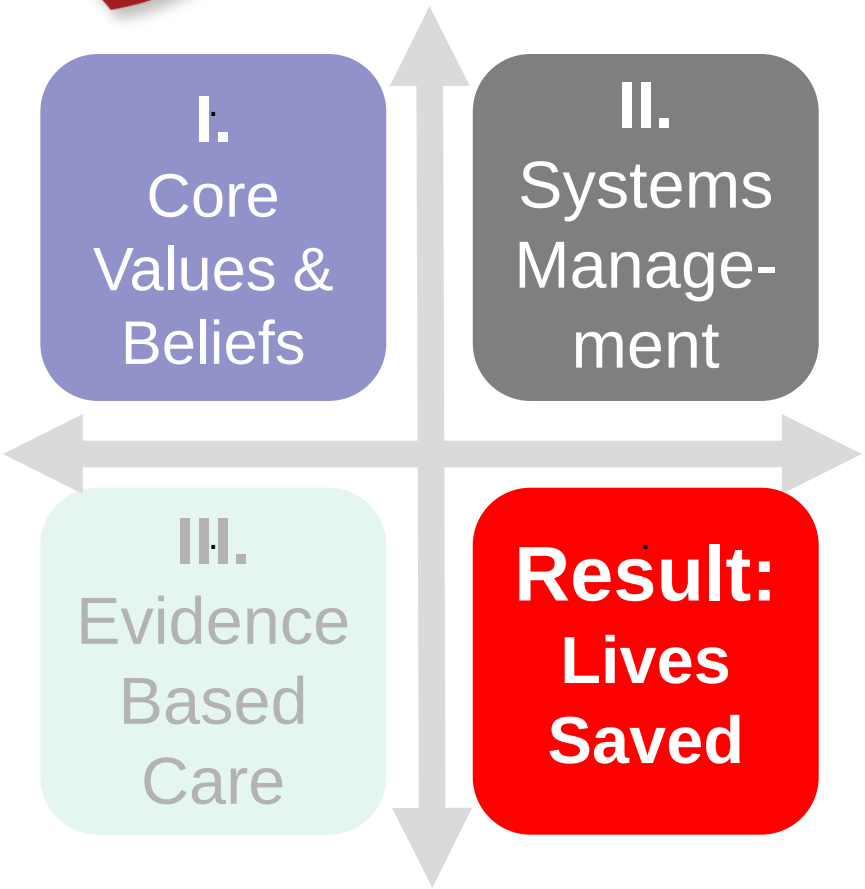
- Robust Performance Improvement
  - Workforce Development
  - Standardized Clinical Care
    - ✓ Screening & Assessment
    - ✓ Stratification of Risk
    - ✓ Regimen of Key Interventions
      - o Access to Care
      - o Means Restriction
      - o Follow-up
  - Transparent Reporting & Feedback Loops, 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 a last resort, considered a safety measure and possible sign of community care defects

Accountability for Results: Lives Saved

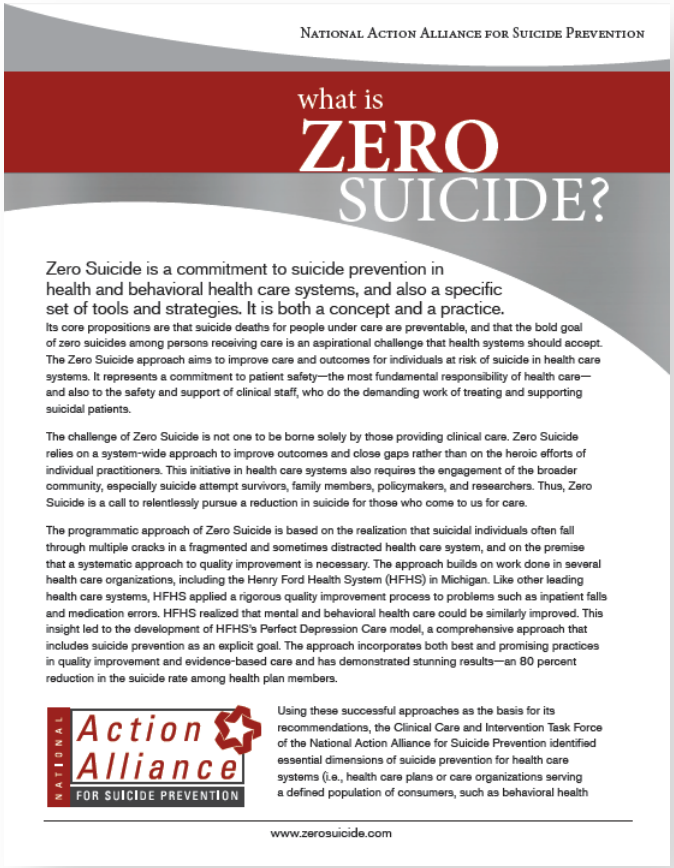


- Timely public reporting of suicide deaths
  - Measure & Report
  - Feedback Loop

Zero Suicide: State Efforts and Partners

Organization	State
Magellan of Arizona	Arizona
Alhambra Hospital (UHS)	California
Charlotte Behavioral Health Care	Florida
Bloomington Meadows (UHS)	Indiana
Community Health Network	Indiana
Centerstone	Indiana, Tennessee
Kansas Gov's Behavioral Health Services Planning Council	Kansas
Kentucky Dept for Behavioral Health	Kentucky
Brentwood (UHS)	Louisiana
Henry Ford Health System, Behavioral Health Services	Michigan
Institute for Family Health	New York
Montefiore Comprehensive Family Care Services	New York
New York Office of Mental Health	New York
Brynn Marr Hospital (UHS)	North Carolina
State Govt, DHHS, Div of Public Health	North Carolina
Coleman Health	Ohio
Oklahoma Department of Mental Health and Substance Abuse Services	Oklahoma
Oregon Public Health Division	Oregon
Texas Department of State Health Services	Texas
Utah Division of Substance Abuse and Mental Health	Utah
Group Health Research Institute	Washington
WI Dept of PH Services	Wisconsin

Resources: “What is Zero Suicide?”



National Action Alliance for Suicide Prevention

what is
ZERO
SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system, and on the premise that a systematic approach to quality improvement is necessary. The approach builds on work done in several health care organizations, including the Henry Ford Health System (HFHS) in Michigan. Like other leading health care systems, HFHS applied a rigorous quality improvement process to problems such as inpatient falls and medication errors. HFHS realized that mental and behavioral health care could be similarly improved. This insight led to the development of HFHS's Perfect Depression Care model, a comprehensive approach that includes suicide prevention as an explicit goal. The approach incorporates both best and promising practices in quality improvement and evidence-based care and has demonstrated stunning results—an 80 percent reduction in the suicide rate among health plan members.

National Action Alliance for Suicide Prevention

Using these successful approaches as the basis for its recommendations, the Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential dimensions of suicide prevention for health care systems (i.e., health care plans or care organizations serving a defined population of consumers, such as behavioral health

www.zerosuicide.com

- Describes the history of the initiative
- Lists the seven core dimensions
- Explains where to get more information

Resources: Online Toolkit

National Action Alliance for Suicide Prevention

The Public-Private Partnership Advancing the National Strategy for Suicide Prevention

Zero Suicide in Health Care | Zero Suicide Advisory Group

Identifying and Assessing Suicide Risk Level

Screening for suicide risk should be a universal part of primary care, hospital and emergency department care, behavioral health care, and crisis response intervention. Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, means availability, presence of acute risk factors, history of suicide attempts, and level of risk.

Screening

General Medical Settings

The primary care setting is presents an excellent opportunity for suicide prevention. The Western Interstate Commission for Higher Education (WICHE), in partnership with the Suicide Prevention Resource Center (SPRC), offers a comprehensive toolkit for primary care practices.

Up to 76 percent of Americans who die by suicide had contact with their primary care provider in the month prior to their death.

Physicians and nurses may be concerned about asking patients about suicidal thoughts and behavior of without resources to help them respond to identified risk. It is essential that primary care practices and hospitals have access to behavioral health support for patients that have positive responses to suicide screens. Such support can be forged from local mental health providers or could be provided by telephone or online by crisis service organizations. State and local government health and mental health organizations can help provide the impetus for forging critical local relationships.

Recently, Medicare added procedure codes for a 15-minute screen for depression for Medicare patients. Such a screen could cover the first two questions below, and we recommend adding a third, direct question about suicide:

Zero Suicide Tool Kit

- About the Toolkit
- Zero Suicide Culture
- Pathway to Care
- Competent Workforce
- Suicide Risk Level
- Evidence-based Care
- Contact After Care

Quick Links

- Assessment Tools
- Clinical Decision Support
- Columbia-Suicide Severity Rating Scale
- Driving Suicides to Zero
- Is Your Patient Suicidal?
- Primary Care Tooklit
- Screening Tools

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

Get Started

Resources: Tools

Organizational Self-Assessment for Suicide Safer Care/Zero Suicide

Ex. Systematically identifying and assessing suicide risk levels: How does the organization screen suicide risk in the people we serve?

1	2	3	4	5
There is no use of a validated suicide screening measure.	A validated screening measure is utilized at intake for a identified subsample of individuals (e.g., crisis calls, adults only, behavioral health only)	A validated screening measure is utilized at intake for all individuals receiving care from the organization.	A validated screening measure is utilized at intake and when concerns arise about risk for all individuals receiving care from the organization.	A validated screening measure is utilized at intake and when concerns arise about risk for all individuals receiving care from the organization. Suicide risk is reassessed or reevaluated at every visit for those at risk.

Work Force Readiness Survey

Zero Suicide Workforce Survey

Survey Overview. Our organization is making a commitment to improve our care for our clients who are at risk for suicide. The results of this survey will be used to help us determine the training needs of our staff and is part of an overall organizational mission to adopt a system-wide approach to caring for individuals at risk for suicide.

All responses are anonymous. Please answer items honestly so that we can best serve both our staff and our clients. Unless otherwise indicated, please mark only one answer. It is anticipated that this survey will take you between 10-15 minutes to complete.

We thank you in advance for taking this survey and for your dedication to this very important issue!

Understanding the prevalence of suicide.

1. The rate of suicide varies significantly from state to state, with rates in the mountain states nearly double that of those in the northeastern states.
   - True
   - False
   - Don't know

2. Youth ages 10-to 24 have a significantly greater risk of suicide than individuals ages 65 or older.
   - True
   - False
   - Don't know

3. The rate of suicide among those with severe mental illness is how many times that of the general population?
   - 1x
   - 2x
   - 3x
   - 4x
   - 6 to 12x

Resources: Learning Collaborative

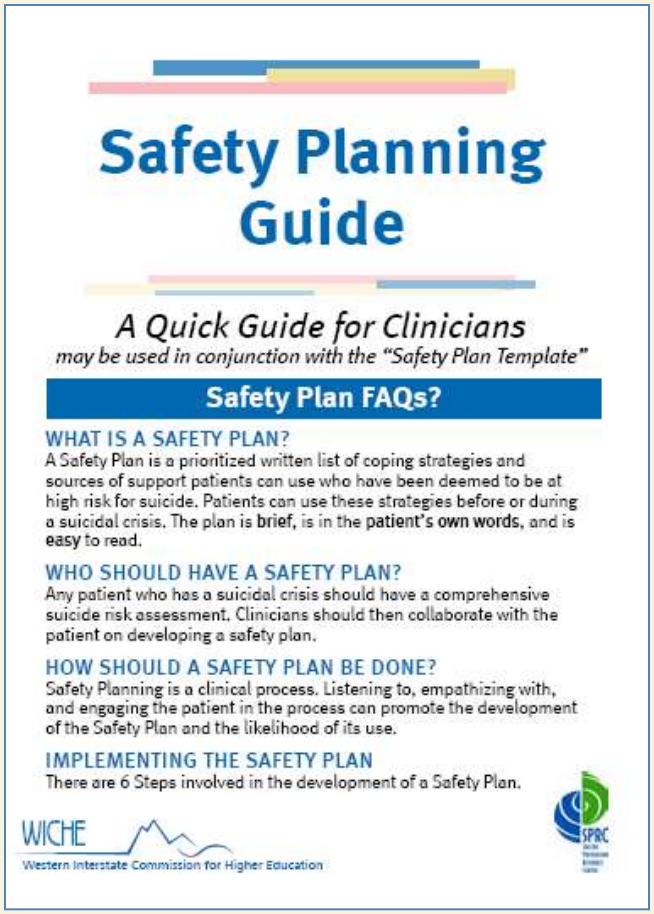
- Moderated conference call
- Typically the first Wednesday of every month
- Organizations actively implementing Zero Suicide share tools and approaches
- Zero Suicide Academy
- SPRC Supplement
- GLS and NSSP grants
- Join at www.zerosuicide.com

Zero Suicide Academy

- June 26-27, 2014 in Washington, DC
- For health or behavioral health care organizations providing community-based clinical services
- Applying in teams
- Organizations to develop action plans for implementation

Care Transitions - Resources

Safety Planning



Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

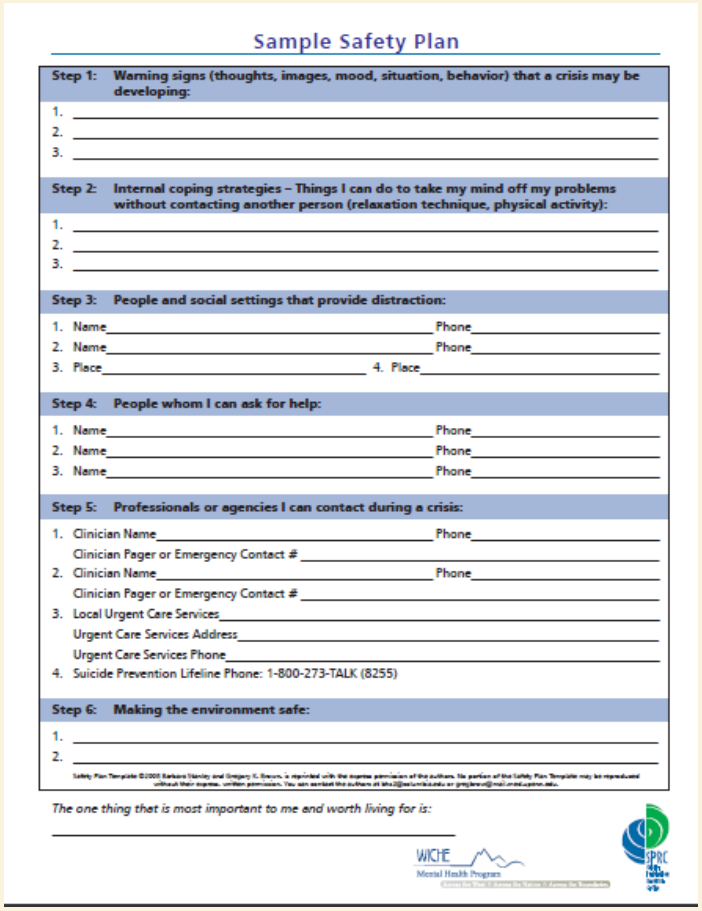
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE Western Interstate Commission for Higher Education

URL: http://www.sprc.org/library/SafetyPlanningGuide.pdf



Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

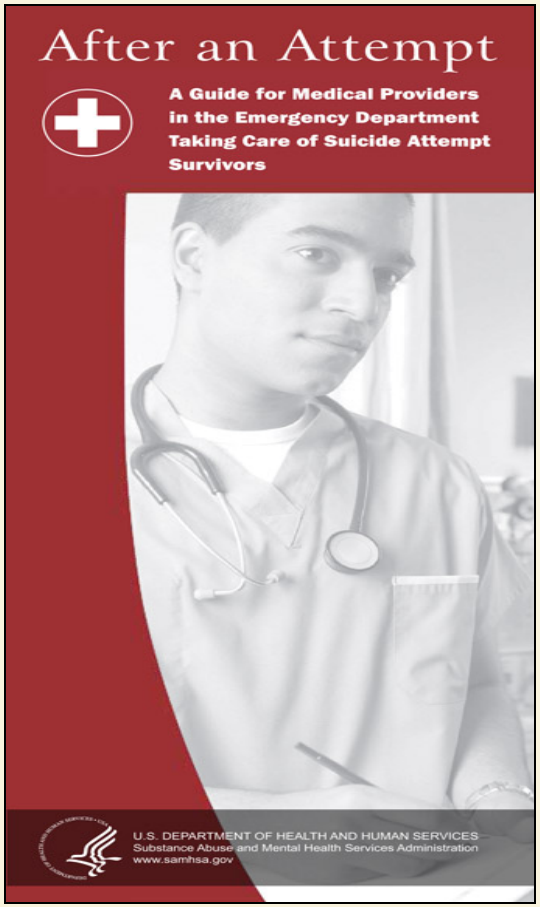
WICHE Mental Health Program

http://www.sprc.org/library/SafetyPlanTemplate.pdf

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

Care Transitions - Resources

- Gives professional care providers tips to enhance emergency department treatment for people who have attempted suicide
- Discusses the assessment, communicating with family and with other treatment providers, and HIPAA
- Versions available for medical providers, patients, and family members



http://store.samhsa.gov/product/SMA08-4359

Substance Abuse and Mental Health Services Administration
SAMHSA
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Is Suicide Safe Care Necessary? Can We Make Health Care Safe?

"There are those who say that the human body is much more complicated than our airplanes. There are those that counsel patience and say that these patient safety issues are complicated and they simply take time to fix.

But I take a different approach. I wish we were less patient. Every day, when each of us goes to work…we are choosing individually and collectively how many lives are going to be lost…

And the harm is so great, the numbers are so huge, that I don't think we should wait 20 more years until there are 4 million more preventable medical deaths. We should change the way we do business now. It's not going to be easy, but it is possible."

Chesley "Sully" Sullenberger Healthcare Financial Management, 2013

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