PREVENTING SUICIDE IN ALL HEALTHCARE SETTINGS: WHAT WE ARE LEARNING.

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SE MHTTC
New Efforts, But We Are Not Winning Yet

Percent Change in Age-Adjusted Death Rates since 2003 by Cause of Death, 2003-2013

Could we make suicide care more like heart care?
What’s Working?

Upstream Prevention

CVD

Preventive Interventions

Cholesterol → Statins
BP → ACE Inhibitors

Intense Treatment

Angioplasty, Stents, Bypass surgery, Valve Replacement

Impact?

Smoking Cessation
Diet, Exercise

(30%) (50%+)

(15%)

Are these patterns relevant to preventing suicide?
Where are we in Suicide Prevention?
Better Concepts, Not Enough Action--Yet

- Suicide prevention in 2000:
  - Public Health model. USAF viewed as gold standard...but rates keep rising. To date, Public Health approaches are underpowered

- New knowledge: Joiner (Interpersonal Theory of Suicide) Klonsky (Three Stages) Millner et al. (Pathways to Suicide)
  - Many have thoughts of suicide (“ideation”)
  - But few progress to attempts
    - Isolation is poisonous
    - Developing “capability” to kill oneself is dangerous
  - The time between initial thoughts of suicide and serious attempts is often long...this gives us time to help, but only if we know

- Developments in suicide care
Action Alliance Clinical Care and Intervention Task Force Report--2011

Access at: www.zerosuicide.com
Suicide and Health Care Settings: It’s A Problem, and a Place to Intervene

- Over 80% of people dying by suicide (>90% with attempts) had health care visits in the prior 12 months
  - 45% of people who died by suicide had a primary care visit in the month before death.
  - 19% of people who died by suicide had contact with mental health services in the month before death.
  - 37% had an emergency department visit in the prior year
  - The risk of suicide death following inpatient psychiatric discharge is 44x the population rate
Suicide and Health Care Settings: A Problem, and Places to Intervene

- Over 80% of people dying by suicide (>90% with attempts) had recent health care visits
- So, we have ample time to intervene
- Are there effective, evidence-based, feasible tools that could allow us to mirror CVD intervention successes?
Evidence for Suicide Care—
Screening to Identify People at Elevated Risk

• Simon et al. study (2015):
  • Examined subsequent history of 75k+ who completed PHQ-9
  • 80% of those who subsequently died by suicide had indicated elevated thoughts on q9
  • Old thinking: we can’t predict who’ll die, when…so screening is ineffective
  • Do cardiologists worry about this? We have very good predictors of who needs help
  • *Defining need for suicide intervention at least as good as for CVD intervention*
Do We have Evidence About Helping People Be Safe?

- Hospitalization?
  - Might be necessary. Might not be helpful
    - For inpatient care to be helpful:
      - Is suicidality directly treated in hospital?
      - Do people receive post-hospital support AND transition to community care?

- Can we help people be safe in their communities?
Evidence: ”Crisis Response Plan” (CRP)

RCT* of Soldiers receiving CRP vs. safety contract, at follow-up the CRP showed:

• Significantly fewer attempts (75%)
  • Strengthening patient’s “reasons for living” explained the difference in attempts at follow-up (greater ambivalence)
• Significantly faster reduction in SI
• Significant reductions in inpatient stay

The Enhanced CRP added Reasons for Living discussion
• Made clinicians 86% less likely to hospitalize patients, even though risk profile was the same

Better than statins *Bryan et al, 2017
Evidence: Safety Planning plus Follow-Up

- Safety Planning “makes sense”, is feasible, is widely used, but until recently not well tested
- ED based matched cohort comparison--1640 pts with suicide related visit, 1186 in intervention group
- Tested brief Safety Planning Intervention (SPI) plus telephonic follow up
- Results
  - SPI+ pts had 45% fewer subsequent suicide behaviors (p<.03)
  - SPI+ pts were twice as likely to participate in follow up care (p<.01)
- Better than effectiveness of statins to prevent MI

Stanley et al., JAMA Psychiatry 2018
Evidence for Suicide Care: Means Restriction

- Evidence and experience in population level means restriction…it works
- How about we do it for people at risk?
  - Impact at Henry Ford, Centerstone
  - Emerging evidence

Better than statins...
Evidence: Caring Contacts

• Caring contacts (phone calls, letters, texts, postcards, visits) are effective
  • Motto study established this…and was ignored
• Schoenbaum et al. study (2017)
  • Caring letters work better than usual care and cost less
  • Phone calls work even better
  • Cognitive Behavioral Therapy also effective

About as good as treating hypertension. But cheaper…
Evidence: Directly Treating Suicidality

- Evidence for effectiveness of suicide-focused therapies in RCT’s over usual care
  - Dialectical Behavior Therapy
  - Cognitive Therapy for Suicide Prevention
  - Collaborative Assessment and Management of Suicide (CAMS)
  - (Denmark) post-attempt counseling
  - (Switzerland) ( Attempted Suicide Short Intervention Program—ASSIP)
- As effective as acute care interventions for CVD
These are the Zero Suicide tools

Leadership and Support Elements

Clinical Elements

Create a leadership-driven, safety oriented culture

Suicide Care Management Plan
- Identify and assess risk
- Use effective, evidence-based care
- Provide continuous contact and support

Electronic health record

Develop a competent, confident, and caring workforce
Systematic Approaches Work: HFHS

Suicide Deaths/100k HMO Members

Launch: Perfect Depression Care

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# What Would Work?

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Emerging Evidence: Suicide Safe Care/ZS

- All the elements have compelling evidence *individually*
- No RCT’s yet of ZS, NIMH studies underway. But we know:
  - Rates in usual care are very high
  - All reports where ZS has been well implemented are positive
- Henry Ford: 75% reduction in suicide in psychiatric care population—to general level
- Centerstone TN: 65% reduction over 3-4 years in CMH population to general pop level of 15/100T
- Institute for Family Health (NY): 65% reduction in integrated primary care over 3-4 years to about 2/100T
- MO: CMHC’s implementing ZS see 30% reduction while overall state rate increases
- NY Medicaid QI project, 180 MH clinics do self assessment.
  - Suicide rates in clinics with higher self assessment scores had lower rates of suicide death in prior 6 months than those with lower scores (p< .05)
Are We Making Healthcare Suicide Safe?

- Early, incomplete progress on orienting healthcare to suicide prevention
  - Joint Commission, NSSP, CARF, COA
Joint Commission: From Sentinel Event Alert to National Patient Safety Goal/Survey Standards

**Sentinel Event Alert**

Published for Joint Commission-accredited organizations and interested health care professionals. Sentinel Event Alert provides information on specific types of sentinel and adverse events and high-risk conditions, describes relevant processes and practices, and offers recommendations to improve patient safety. Please visit www.jointcommission.org for more information.

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**National Patient Safety Goal for suicide prevention**

Published for Joint Commission-accredited organizations and interested health care professionals, R³ Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, R³ Report goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. R³ Report may be reproduced if credited to The Joint Commission. Sign up for email delivery.

**ZERO Suicide**

IN HEALTH AND BEHAVIORAL HEALTH CARE

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Resources

• zerosuicide.com
  • Comprehensive resource. "How-to" resources e.g.:
    • Streaming video courses
    • Self-assessment tool to assess your organization’s status
    • Survey to assess staff training needs

• zerosuicideinstitute.com
  • For technical assistance and information

• dr.m.hogan@gmail.com
  • Follow-up questions on this webinar
A Movement and a Mission