ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

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

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SE MHTTC

EDC Learning transforms lives.

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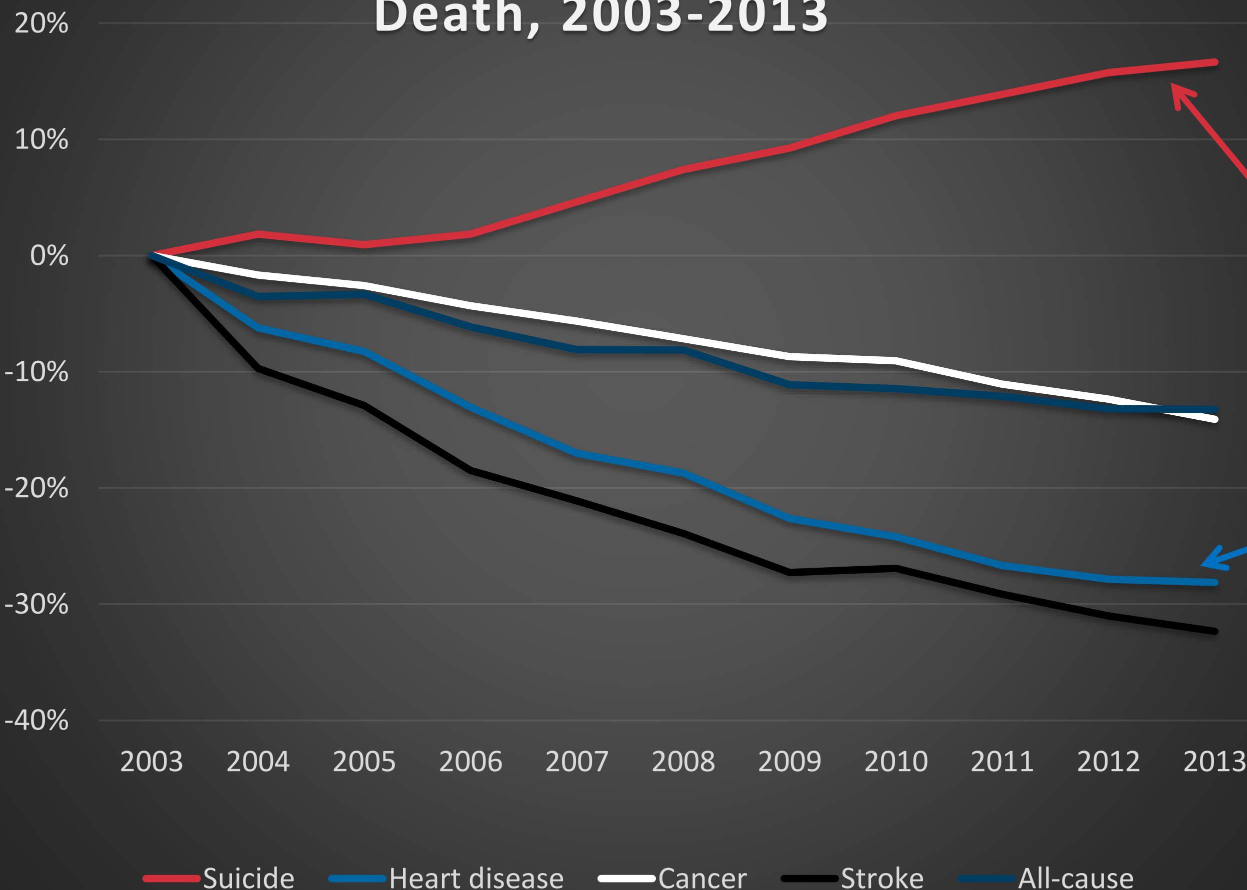
New Efforts, But We Are Not Winning Yet



Could we make suicide care more like heart care?

What's Working?

Upstream Prevention	Preventive Interventions	Intense Treatment
CVD		
Smoking Cessation Diet, Exercise	Cholesterol-→ Statins BP-→ ACE Inhibitors	Angioplasty, Stents, Bypass surgery, Valve Replacement
Impact? (30%)	(50%+)	(15%)

Are these patterns relevant to preventing suicide?

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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*

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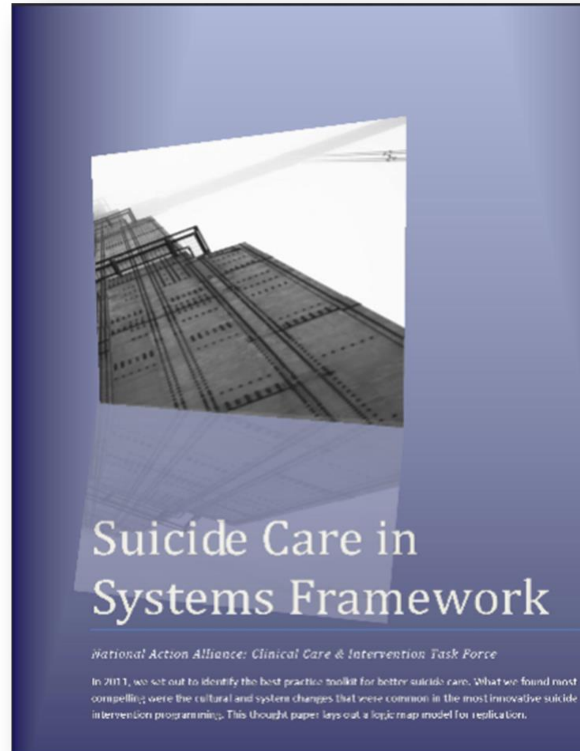
Action Alliance Clinical Care and Intervention Task Force Report--2011



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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

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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?*

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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*

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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?

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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

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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

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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…

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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…

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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

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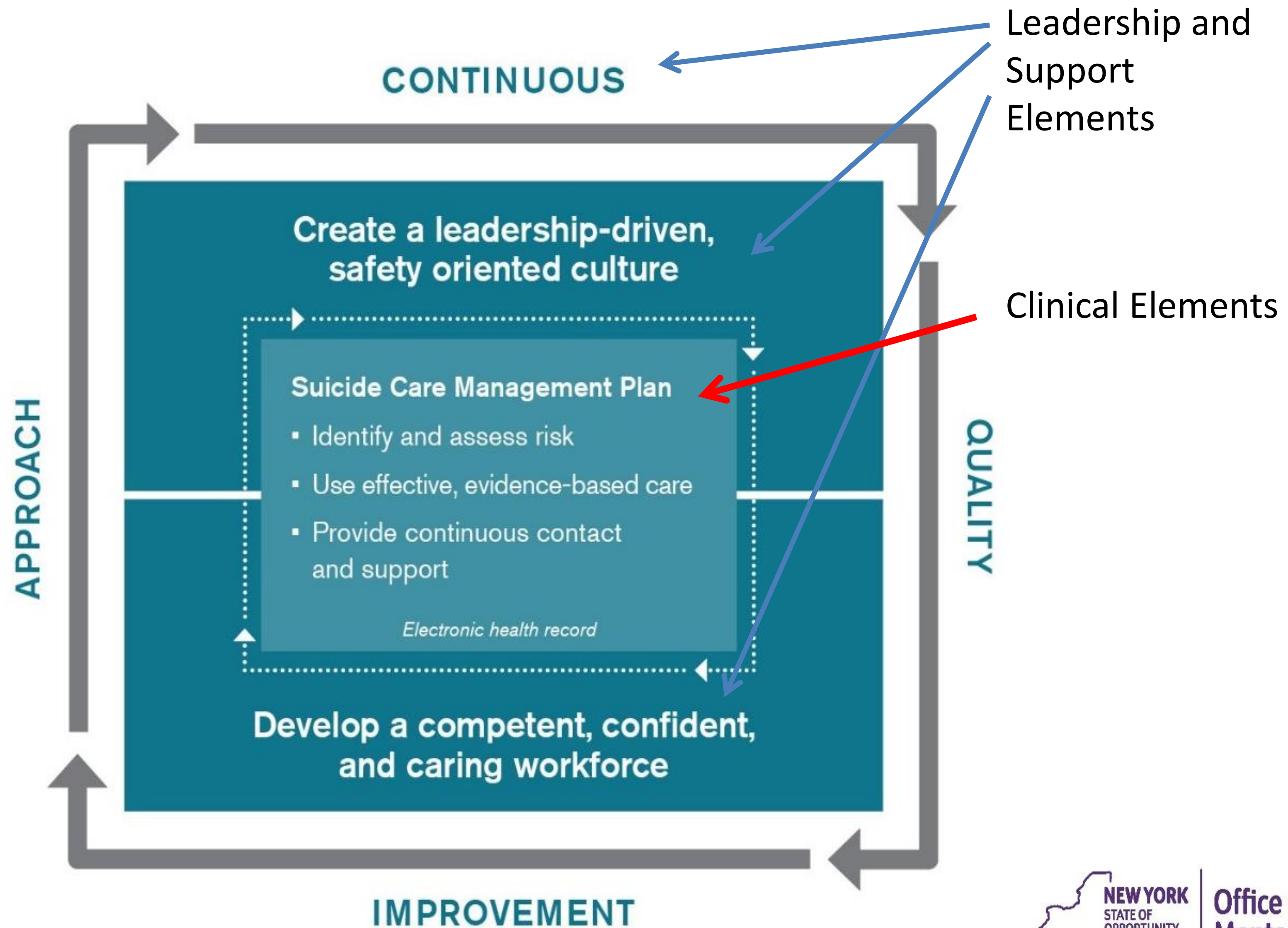
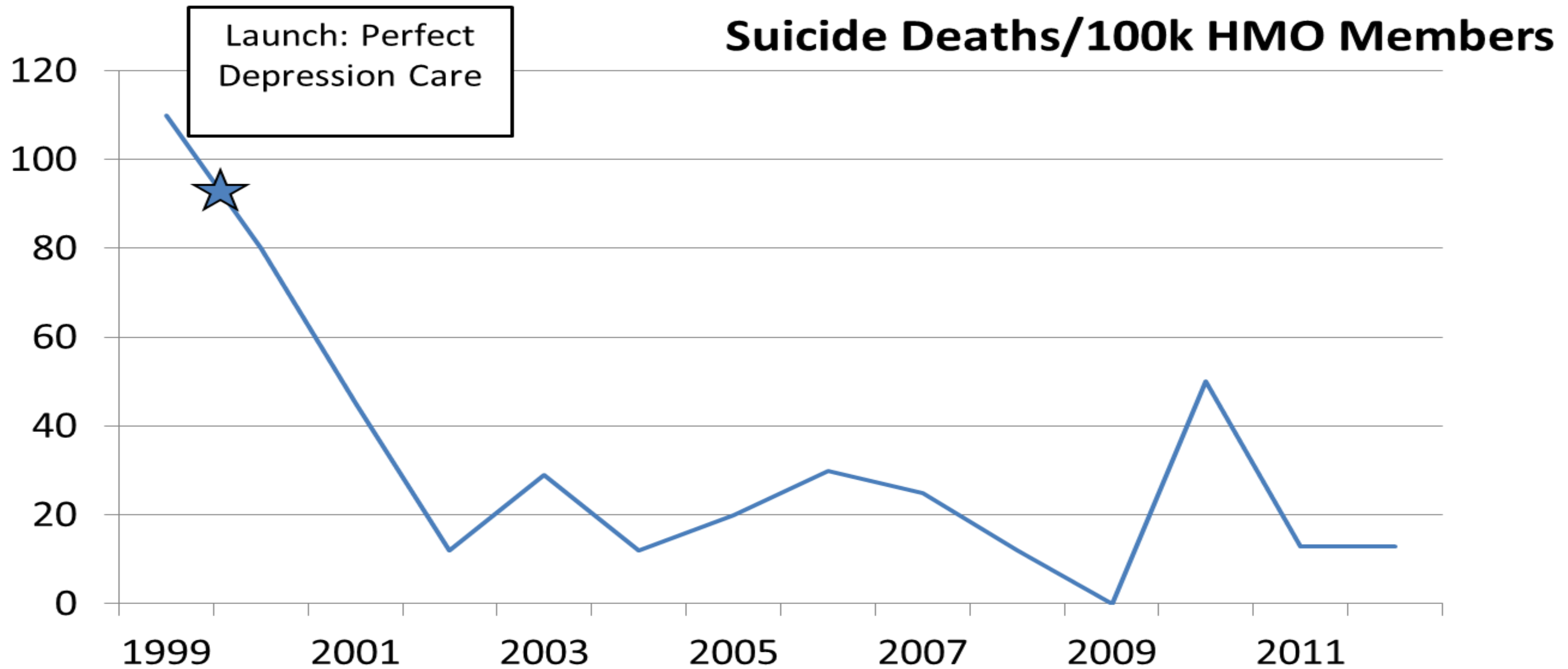
These are the Zero Suicide tools



Systematic Approaches Work: HFHS



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What Would Work?

Upstream Prevention	Preventive Interventions	Intensive Treatment

CVD

Upstream Prevention	Preventive Interventions	Intensive Treatment
Smoking Cessation Diet, Exercise	Cholesterol-→ Statins BP-→ ACE Inhibitors	Angioplasty, Stents, Bypass surgery, Valve Replacement

Suicide Care?

Prevent/Resolve Childhood trauma

Safety Planning

Lethal Means Reduction

Caring Contacts

Collaborative Assessment and Management of Suicidality

Dialectical Behavior Therapy

Cognitive Therapy for Suicide Prevention

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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 ($p < .05$)

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Are We Making Healthcare Suicide Safe?

- Early, incomplete progress on orienting healthcare to suicide prevention
  - Joint Commission, NSSP, CARF, COA

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Joint Commission: From Sentinel Event Alert to National Patient Safety Goal/Survey Standards

Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

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Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[5-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[6] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

R3 Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission

Issue 18, Nov. 27, 2018
UPDATED May 6, 2019

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.

National Patient Safety Goal for suicide prevention

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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

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A Movement and a Mission

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