ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

Preventing Suicide In ALL Healthcare Settings: Now We Know What Must Be Done.

Boise Idaho

June 2019

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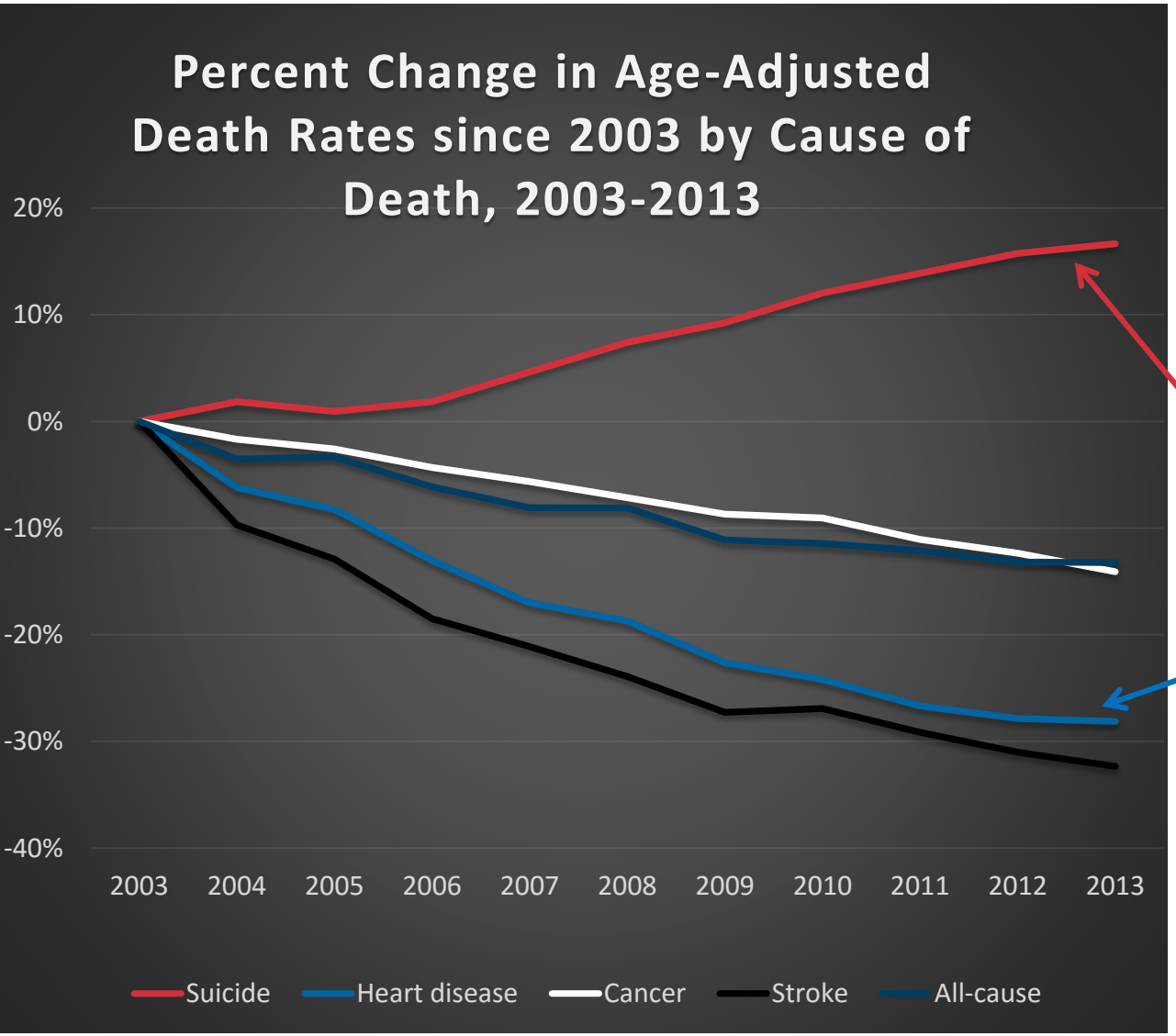
EDC Learning transforms lives.

New Efforts, But We Are Not Winning Yet

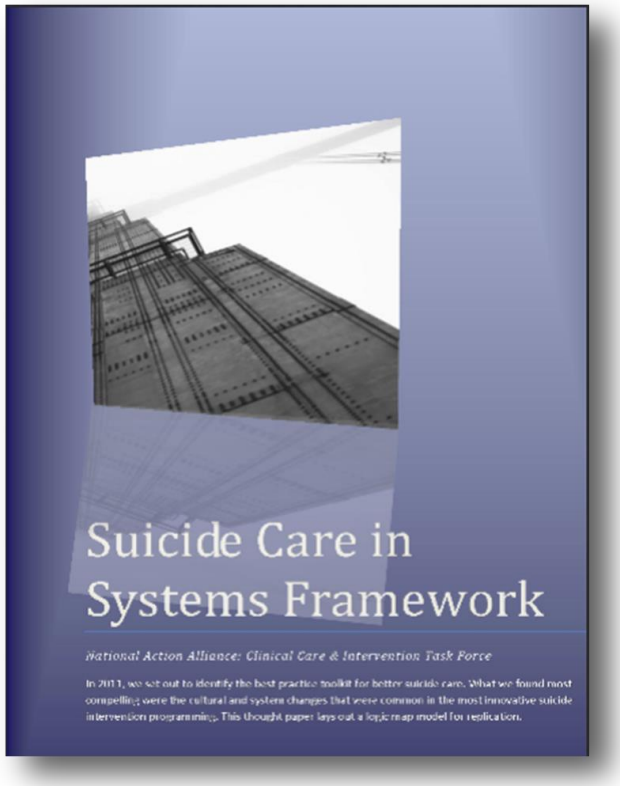


Could we make suicide care more like heart care?

Recent Advances in Suicide Prevention

- Suicide prevention in 2000 (NSSP I):
  - Public Health model. USAF viewed as gold standard…but rates keep rising. Public Health approaches underpowered
- New knowledge: Joiner (Interpersonal Theory of Suicide) Klonsky (Three Stages) Millner et al. (Pathways to Suicide)
  - Vulnerability + Loss → Many have ideation
  - Many people have suicidal thoughts, few progress to attempts
  - Isolation is like poison for those with ideation; Developing "capability" to kill oneself is the dangerous step
  - The time between initial thoughts of suicide and serious attempts is often long…***this gives us time to help, but only if we know***

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



- Suicide in healthcare is a problem: awareness, ownership lacking
- We have promising new interventions
- Systematic approaches emphasizing culture change, "productive relationships" are needed
- Next: build and test "Zero Suicide"

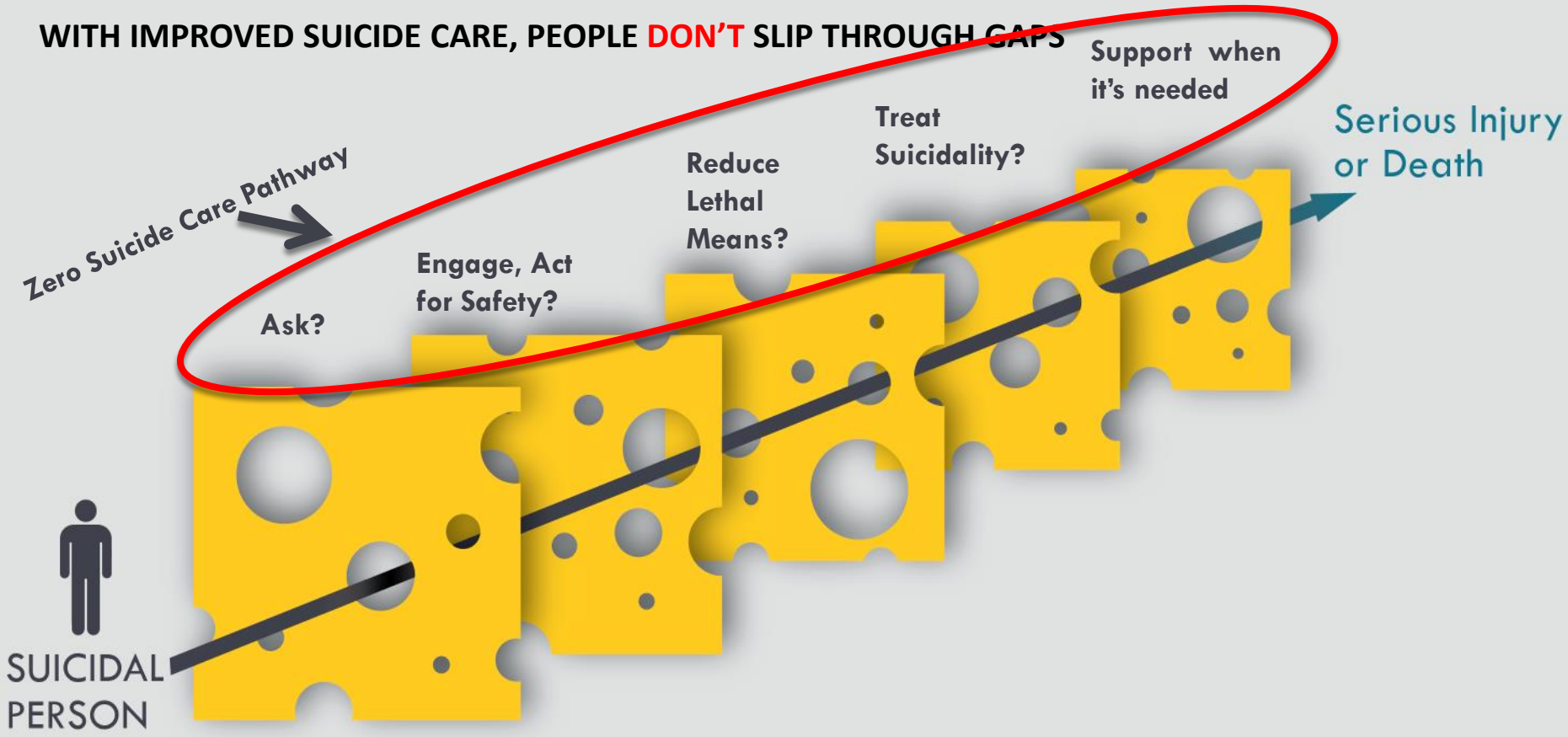
Access at: www.zerosuicide.com

Suicide and Healthcare 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.
  - A disproportionate number of suicide decedents were receiving mental health care.
  - 37% had an emergency department visit in the past year
  - The risk of suicide death following inpatient psychiatric discharge is 44x the population rate
- *We have ample time to intervene—do we?*

ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION



Adapted from James Reason's "Swiss Cheese" Model Of Accidents

Suicide and Healthcare Settings: A Problem, and Places to Intervene

- Over 80% of people dying by suicide (>90% with attempts) had recent healthcare visits
- *So, we have ample time to intervene*
- *Are there effective, evidence-based, feasible tools?*

Evidence for Suicide Care--Screening

- 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
    - Is suicidality directly treated in hospital?
    - Do people transition to community care afterwards?
    - Rates after discharge are extreme
- An alternative: Can we intervene to help most 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

At least as effective as managing BP

*Bryan et al, 2017

Evidence: Safety Planning With 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 ($p<.01$)
- Effectiveness is better than that for 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
  - Coal gas
  - Fertilizer
  - Bridge enclosures
  - Firearms safe storage
- How about we do it for people at risk?

Better than statins…

Evidence: Caring Contacts

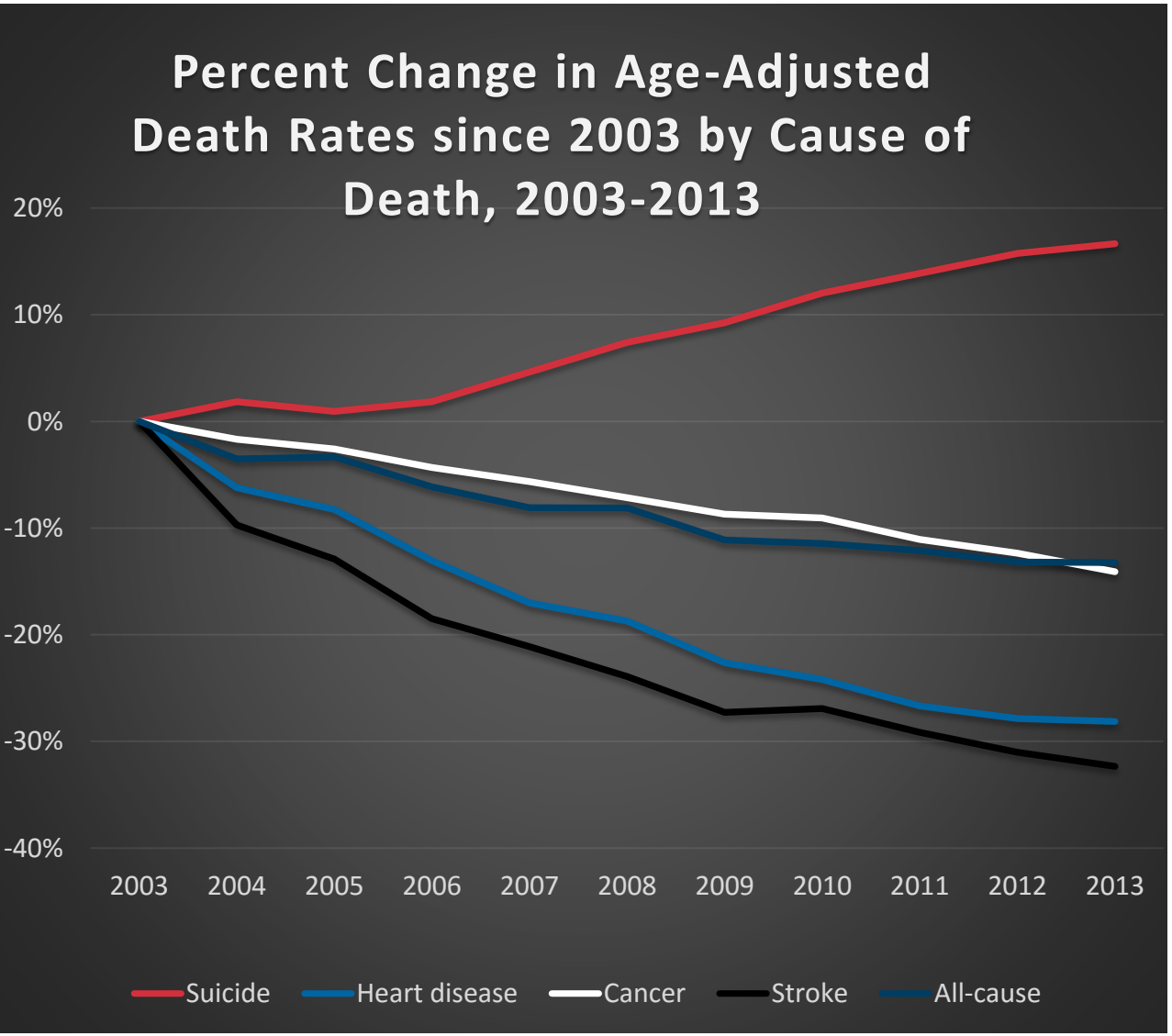
- Caring contacts (phone calls, letters, texts, postcards, visits) are effective
- Schoenbaum et al. study (2017)
  - Caring letters work better than usual care and cost *less*
  - Phone calls work even better
  - Cognitive Behavioral Therapy also effective

Better than statins…

Evidence: Directly Treating Suicidality

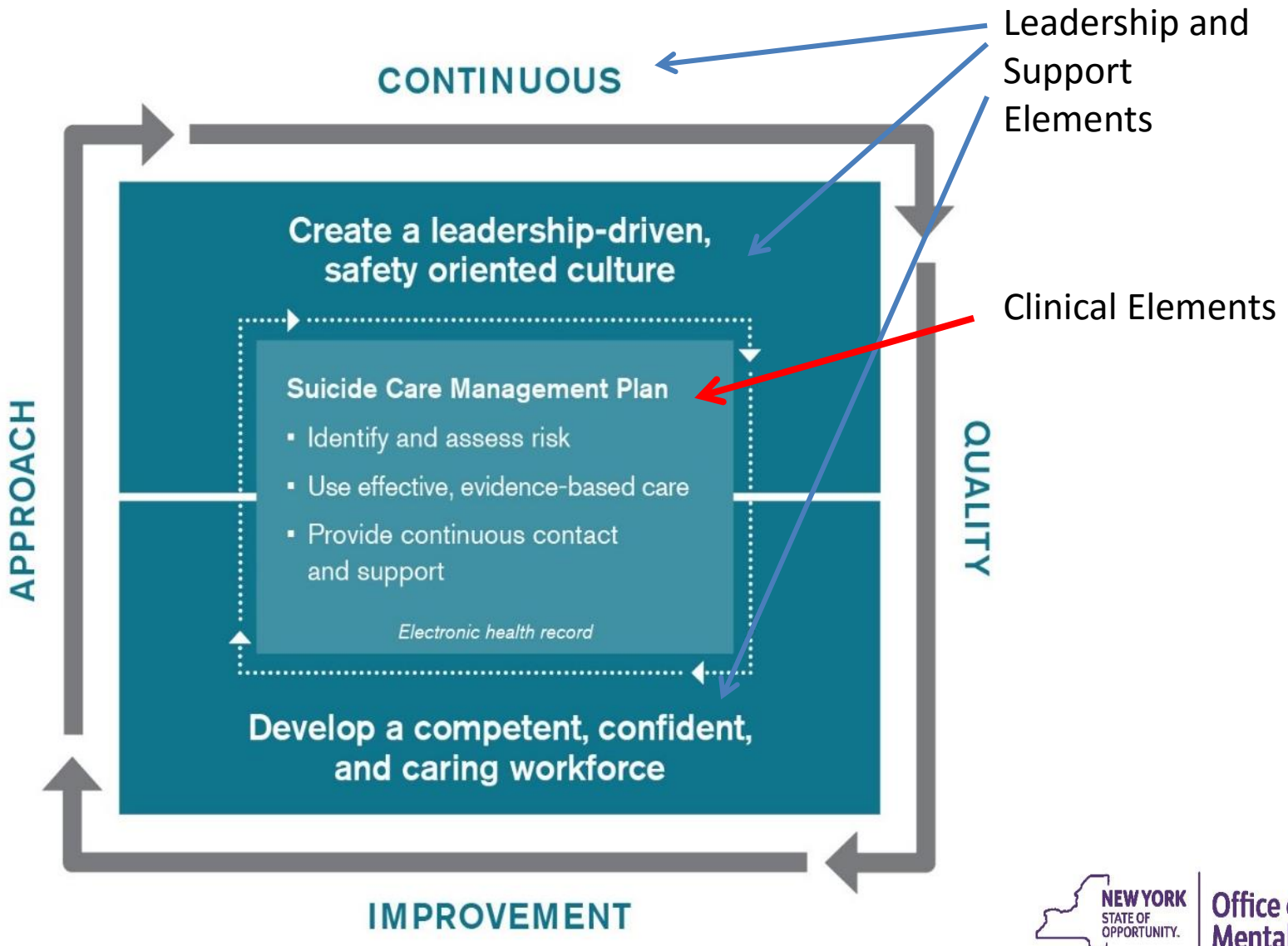
- Evidence for effectiveness of suicide-focused therapies in RCT's over usual care
  - Dialectical Behavior Therapy
  - Cognitive Therapy for Suicide Prevention
  - Collaborative Assessment and Management of Suicide (CAMS)
  - (Denmark) post-attempt counseling
  - (Switzerland) (Attempted Suicide Short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

We Have to Use the Excellent Tools We Have



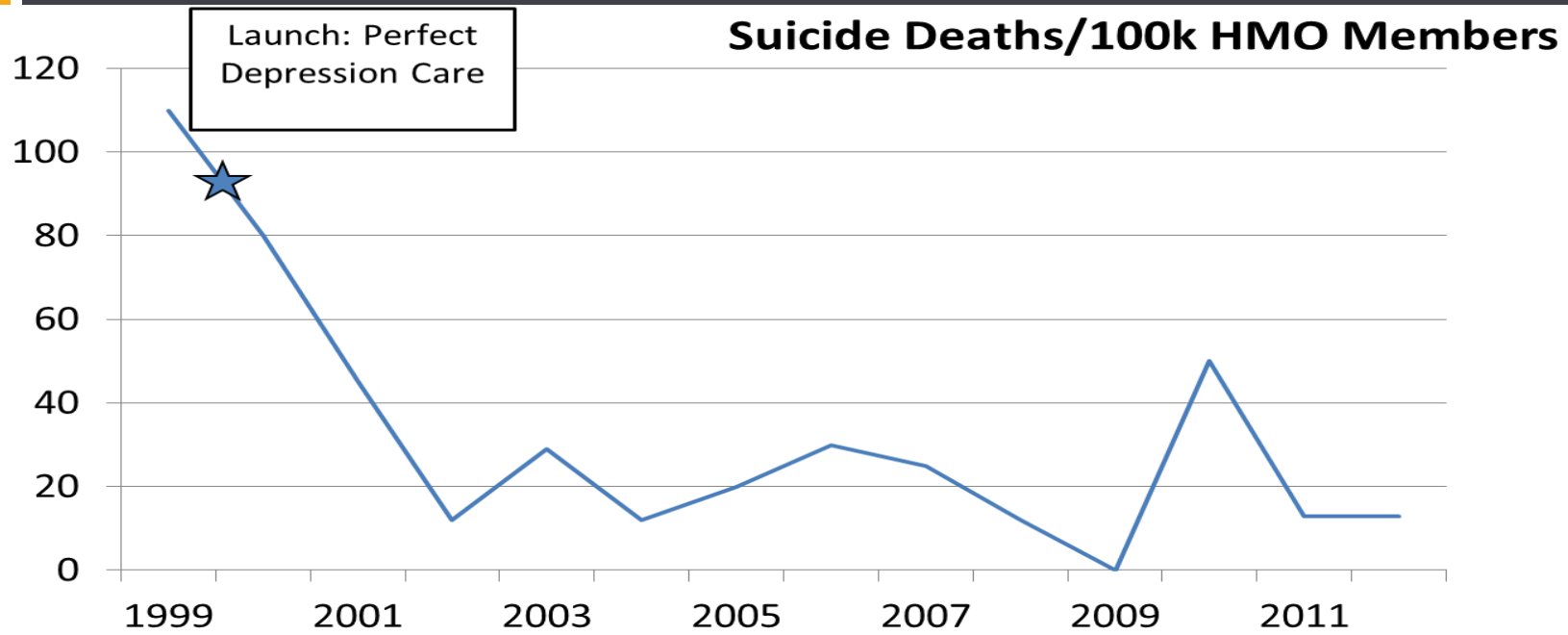
We CAN make suicide care more like heart care

These are the Zero Suicide tools



NEW YORK STATE OF OPPORTUNITY. Office of Mental Health

Systematic Approaches Work: HFHS



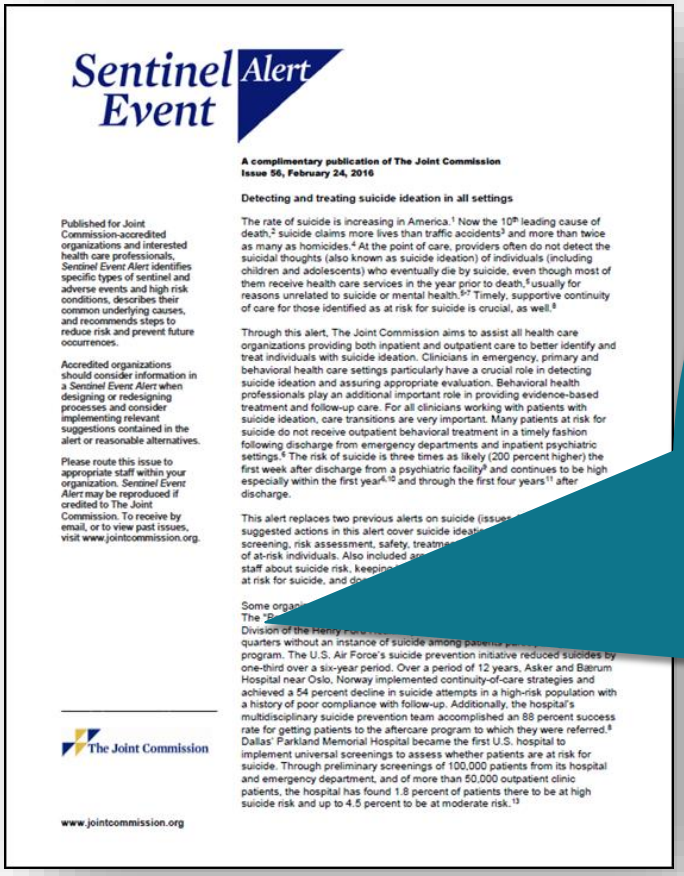
Emerging Evidence: Suicide Safe Care/ZS

- No RCT's yet, NIMH studies underway. But we know:
  - Rates in usual care are very high
  - All reports where ZS has been implemented thoughtfully 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 ($p < .05$)
  - Fidelity to reducing lethal means for those with risk is very effective ($p < .01$)

Are We Making Healthcare Suicide Safe?

- Early, incomplete progress on orienting healthcare to suicide prevention
  - A new (!) priority for the suicide prevention field
  - An accreditation focus: Joint Commission, CARF, COA

Joint Commission Sentinel Event Alert 56: *Detecting and Treating Suicide Ideation in All Settings (2016)*



Sentinel Event Alert

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

Detecting and treating suicide ideation in all settings

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.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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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.[6-7] 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.[9] 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[9,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues
suggested actions in this alert cover suicide ideati
screening, risk assessment, safety, treatm
of at-risk individuals. Also included ar
staff about suicide risk, keeping
at risk for suicide, and do

Some organ
The "B
Division of the Henry Ford
quarters without an instance of suicide among patients
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]

The Joint Commission

www.jointcommission.org

"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."

Are We Making Healthcare Suicide Safe?

- Spread of Zero Suicide:
  - SAMHSA grant focus in GLS, NSSP
  - IHS efforts—National, States, Nations
  - Adult suicide program authorized in 21st Century Cures Act. SAMHSA emphasis: ZS
  - Utah, NYS statewide Medicaid QI efforts
  - Adoption by large, leading health systems: Kaiser Permanente, Intermountain
- AFSP/Action Alliance "20 by 25" effort

Remarkable baby steps on making healthcare "suicide safe"..
The time is right to respond

A Movement and a Mission

Contact: dr.m.hogan@gmail.com