BEST PRACTICES IN SUICIDE CARE FOR HEALTH CARE SYSTEMS AND PROVIDERS
PLANNING FOR THE DAY
INTRODUCTIONS
Today’s Faculty:

- **Diana Cortez**, Advocate and Lived Experience Consultant
- **John Draper**, Director, National Suicide Prevention Lifeline, MHA-NYC
- **Julie Goldstein Grumet**, Director of Health & Behavioral Health Initiatives, SPRC
- **Mike Hogan**, Consultant, Mike Hogan Health Solutions LLC
- **Virna Little**, Senior Vice President, Institute for Family Health
- **Richard McKeon**, Chief, SAMHSA Suicide Prevention
- **Becky Stoll**, Vice President of Crisis & Disaster Management, Centerstone
- **Ursula Whiteside**, CEO, [NowMattersNow.org](http://NowMattersNow.org)
Introductions

• Brief introduction
• Describe your reasons for wanting to attend this preconference
• One topic or question you hope will be answered in today’s workshop
Zero Suicide Website: ZeroSuicide.com
Suicide Prevention in the U.S. Health Care System

Richard McKeon Ph.D., MPH
Chief, Suicide Prevention
SAMHSA
Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover

#NATCON17  #BH365
Preventing suicide
A global imperative

World Health Organization
National Strategy for Suicide Prevention

2012 National Strategy for Suicide Prevention: Goals and Objectives for Action
In support of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention

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NSSP Goals 8 and 9

• Goal 8- Promote suicide prevention as a core component of health care services

• Goal 9- Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.
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.

Mental Health Research Network Report
(within 12 months of suicide death)

- Contact with Health Care: 17%
- No Contact with Health Care: 83%

Of those with contact with health care, 45% had a psychiatric diagnosis.

Suicide Decedents from NVDRS States

- In mental health treatment at time of death: 31%
- Not in mental health treatment at time of death: 69%


Improving Care Transitions

- There are lethal gaps in many systems.
- Period after IPU and ED discharge is one of high risk, particularly the first 30 days.
- Rates of follow up care are poor.
- Intervention during this time has been shown to save lives and reduce suicidal behavior.
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ED visits with suicidal ideation, N</strong></td>
<td>388,100</td>
<td>690,200</td>
<td>903,400</td>
<td>12.8</td>
</tr>
<tr>
<td>Transferred to other hospital or facility, N (%)</td>
<td>128,400 (33.1)</td>
<td>210,200 (30.5)</td>
<td>276,500 (30.6)</td>
<td>11.6 (-1.1)</td>
</tr>
<tr>
<td>Admitted to same hospital, N (%)</td>
<td>130,500 (33.6)</td>
<td>275,500 (39.9)</td>
<td>372,400 (41.2)</td>
<td>16.2 (3.0)</td>
</tr>
<tr>
<td>Average length of inpatient stay, days</td>
<td>5.1</td>
<td>5.8</td>
<td>5.6</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>ED and inpatient costs combined</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aggregate cost in millions, $</td>
<td>600</td>
<td>1,700</td>
<td>2,200</td>
<td>20.4</td>
</tr>
<tr>
<td>Average cost per stay, $</td>
<td>5,000</td>
<td>6,200</td>
<td>6,000</td>
<td>2.6</td>
</tr>
<tr>
<td>Average cost per day, $</td>
<td>1,200</td>
<td>1,300</td>
<td>1,200</td>
<td>0.0</td>
</tr>
<tr>
<td>Variable</td>
<td>Medicaid</td>
<td>Commercial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------</td>
<td>------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of individuals in dataset with an intent-to-harm-self ED visit</td>
<td>24,590</td>
<td>22,983</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with ≥1 antidepressant or anxiolytic prescription drug fill, %</td>
<td>43.5</td>
<td>45.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a primary care visit with a behavioral health diagnosis, %</td>
<td>13.9</td>
<td>18.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a primary care visit without a behavioral health diagnosis, %</td>
<td>21.0</td>
<td>26.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a specialty visit with a behavioral health diagnosis, %</td>
<td>7.2</td>
<td>17.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a non-intent-to-harm-self emergency department visit with a behavioral health diagnosis, %</td>
<td>23.8</td>
<td>11.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a non-intent-to-harm-self emergency department visit without a behavioral health diagnosis, %</td>
<td>20.8</td>
<td>12.1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Table 2. Health Care Utilization in the 90 days Following an ED Visit With an Intent-to-Harm-Self Code, 2014

<table>
<thead>
<tr>
<th>Variable</th>
<th>Dataset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals with ≥1 antidepressant or anxiolytic prescription drug fill,</td>
<td>Medicaid: 55.3</td>
</tr>
<tr>
<td>Sociodemographic Factors</td>
<td>Unadjusted Suicide Case Fatality Rate (Standard Error)</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Overall</td>
<td>3.2 (0.14)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>1.1 (0.04)</td>
</tr>
<tr>
<td>26-44</td>
<td>3.2 (0.24)</td>
</tr>
<tr>
<td>&gt;45</td>
<td>5.3 (0.53)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5.7 (0.36)</td>
</tr>
<tr>
<td>Female</td>
<td>1.2 (0.07)</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>4.4 (0.25)</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>1.0 (0.11)</td>
</tr>
<tr>
<td>Non-Hispanic other</td>
<td>1.5 (0.14)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.4 (0.25)</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>&lt;high school education</td>
<td>8.8 (0.66)</td>
</tr>
<tr>
<td>High school education</td>
<td>1.3 (0.09)</td>
</tr>
<tr>
<td>Some college</td>
<td>0.8 (0.07)</td>
</tr>
<tr>
<td>College graduates or beyond</td>
<td>1.5 (0.24)</td>
</tr>
</tbody>
</table>
Table 2. Unadjusted 12-month suicide case fatality rates among adult cases (fatal cases plus nonfatal cases) in the U.S. by sociodemographic factors (n=149,400\(^1\))

<table>
<thead>
<tr>
<th>Sociodemographic Factors</th>
<th>Unadjusted Suicide Case Fatality Rate (Standard Error)</th>
<th>Unadjusted Suicide Case Fatality Rate Ratio (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>3.2 (0.14)</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>4.2 (0.40)</td>
<td>2.0 (1.65-2.50)</td>
</tr>
<tr>
<td>Widowed</td>
<td>6.5 (1.76)</td>
<td>3.1 (1.85-5.35)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>3.4 (0.37)</td>
<td>1.6 (1.29-2.05)</td>
</tr>
<tr>
<td>Never married</td>
<td>2.1 (0.10)</td>
<td>1.0</td>
</tr>
<tr>
<td>Region</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northeast</td>
<td>2.5 (0.27)</td>
<td>1.0</td>
</tr>
<tr>
<td>Midwest</td>
<td>2.8 (0.22)</td>
<td>1.1 (0.86-1.43)</td>
</tr>
<tr>
<td>South</td>
<td>3.7 (0.25)</td>
<td>1.4 (1.13-1.85)</td>
</tr>
<tr>
<td>West</td>
<td>3.3 (0.33)</td>
<td>1.3 (0.97-1.73)</td>
</tr>
<tr>
<td>Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>3.1 (0.24)</td>
<td>1.00</td>
</tr>
<tr>
<td>2009</td>
<td>3.2 (0.24)</td>
<td>1.0 (0.85-1.24)</td>
</tr>
<tr>
<td>2010</td>
<td>3.2 (0.26)</td>
<td>1.0 (0.81-1.27)</td>
</tr>
<tr>
<td>2011</td>
<td>3.1 (0.21)</td>
<td>1.0 (0.81-1.23)</td>
</tr>
</tbody>
</table>

Notes: \(^1\)SAMHSA requires that any description of overall sample sizes based on the restricted-use data files has to be rounded to the nearest 100, which intends to minimize potential disclosure risk. Significant associations are in bold.
Mortality After Recent Suicide Attempts

- SAMHSA NSDUH data
- Significant post non-fatal attempt suicide mortality - 3.2%
- Higher among men then women
- 45 and older with less then a high school education - 16%
- 40.6% had any outpatient mental health treatment, 15.8% had 1-4 visits,
Suicide Safe: Suicide Prevention App for Health Care Providers

Suicide Safe Helps Providers:

- Integrate suicide prevention strategies into practice and address suicide risk
- Learn how to use the SAFE-T approach
- Explore interactive sample case studies
- Quickly access and share information and resources
- Browse conversation starters
- Locate treatment options

Learn more at bit.ly/suicide_safe.
Richard McKeon, Ph.D., M.P.H.
Branch Chief, Suicide Prevention, SAMHSA
240-276-1873
Richard.mckeen@samhsa.hhs.gov
WHAT IS ZERO SUICIDE?

Mike Hogan, Zero Suicide Faculty
Action Alliance Clinical Care and Intervention Task Force Report

Access at: www.zerosuicide.com
A CEO's Perspective

Ed Coffey
A System-Wide Approach for Health Care: Henry Ford Health System

Suicide Deaths/100k HMO Members

Launch: Perfect Depression Care

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Zero Suicide is...

• Embedded in the *National Strategy for Suicide Prevention* and Joint Commission Sentinel Event Alert #56.

• A focus on error reduction and safety in health care.

• A framework for systematic, clinical suicide prevention in behavioral health and health care systems.

• A set of best practices and tools including [www.zerosuicide.com](http://www.zerosuicide.com).
Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

“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.”
Suicide and Health Care Settings

- 45% of people who died by suicide had contact with primary care providers in the month before death.

- 19% of people who died by suicide had contact with mental health services in the month before death.

- South Carolina: 10% of people who died by suicide were seen in an emergency department in the two months before death.
Ohio: Between 2007-2011, 20.2% of people who died from suicide were seen in the public behavioral health system within 2 years of death.

New York: In 2012 there were 226 suicide deaths among consumers of public mental health services, accounting for 13% of all suicide deaths in the state.

Vermont: In 2013, 20.4% of the people who died from suicide had at least one service from state-funded mental health or substance abuse treatment agencies within 1 year of death.
Leadership Commitment and Culture Change

– Leadership makes an explicit commitment to reducing suicide deaths among people under care and orients staff to this commitment.

– Organizational culture focuses on safety of staff as well as persons served; opportunities for dialogue and improvement without blame; and deference to expertise instead of rank.

– Attempt and loss survivors are active participants in the guidance of suicide care.
WITHOUT IMPROVED SUICIDE CARE, PEOPLE SLIP THROUGH GAPS

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
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Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
The tools of Zero Suicide fill the gaps

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior

Avoid Serious Injury or Death

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

SUICIDAL PERSON

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION

THE TOOLS OF ZERO SUICIDE FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Avoid Serious Injury or Death

SUICIDAL PERSON

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
What is Different in Zero Suicide?

• Suicide prevention is a core responsibility of health care

• Applying new knowledge about suicide and treating it directly

• A systematic clinical approach in health systems, not "the heroic efforts of crisis staff and individual clinicians."
Elements of Zero Suicide

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

Develop a competent, confident, and caring workforce

CONTINUOUS

APPROACH

QUALITY

IMPROVEMENT
Quality Improvement and Evaluation

• Suicide deaths for the population under care are measured and reported on.

• Continuous quality improvement is rooted in a just safety culture.

• Fidelity to the Zero Suicide model is examined at regular intervals.
Zero Suicide at Centerstone: Results

Annual Suicides per 10,000 Clients Seen (Rolling 12 months)
A Movement and a Mission
Discussion at Tables

• How will you launch Zero Suicide and maintain communication with staff, management, leadership, and your Board about this new initiative and its results?
• How can you maintain Zero Suicide as a core priority of your organization?
• How can you develop a “just culture”?
• Why is it important to incorporate the voices of lived experience into planning, resource development, evaluation, and care?
Suicide Care Management Plan

Design and use a Suicide Care Management Plan, or pathway to care, that defines care expectations for all persons with suicide risk, to include:

- Identifying and assessing risk
- Using effective, evidence-based care
- Safety planning
- Continuing contact, engagement, and support
Electronic Health Records (EHRs)

- Screening, assessment, the suicide care management plan, treatment, safety planning, and continuing contact and engagement are embedded in the electronic health record and clinical workflow.
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

Develop a competent, confident, and caring workforce

Electronic health record

CONTINUOUS

APPROACH

QUALITY

IMPROVEMENT
Screening and Assessment

- Screen specifically for suicide risk, using a standardized screening tool, in any health care population with elevated risk.

- Screening concerns lead to immediate clinical assessment by an appropriately trained provider.
## PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
9. Over the last two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

– Not at all
– Several days
– More than half the days
– Nearly every day
PHQ Item 9 Predicts Suicide Attempt

“Thoughts you would be better of dead or thoughts of hurting yourself in some way”

- Nearly every
- More than half
- Several days
- Not at all

Days Since PHQ

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PHQ Item 9 Predicts Suicide Death

“Thoughts you would be better off dead or thoughts of hurting yourself in some way”

- Nearly every
- More than half
- Several days
- Not at all
In the past month

1. Have you wished you were dead or wished you could go to sleep and not wake up?

2. Have you actually had any thoughts of killing yourself?

   If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.

3. Have you been thinking about how you might kill yourself?

4. Have you had these thoughts and had some intention of acting on them?

5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life?
Resource: Using the C-SSRS

Access at: www.zerosuicide.com
QUESTIONS AND DISCUSSION
Discussion at Tables

• Why is it important that all staff use the same screening and assessment tools?
• How do you know you’re not missing someone in your screening protocol?
• How do you ensure care is timely and coordinated and discussed by all providers for high risk patients?
• How do you ensure patients are educated about their suicide care management plan and care considerations?
Safety Planning and Means Restriction

• All persons with suicide risk have a safety plan in hand when they leave care that day.

• Safety planning is collaborative and includes:
  – aggressive means restriction
  – communication with family members and other caregivers
  – regular review and revision of the plan
Safety Planning Intervention
(Stanley & Brown)

1) Warning signs
2) Internal distraction
3) External distraction
4) Social support
5) Professional support
6) Means reduction

SAFETY PLAN

Step 1: Warning signs:
1. 
2. 
3. 

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:
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 ______
2. Clinician Name ______ Phone ______
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255) ______
4. Local Emergency Service ______
   Emergency Services Address ______
   Emergency Services Phone ______

Making the environment safe:
1. 
2. 


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Resource: Safety Planning Intervention

Access at: www.zerosuicide.com
"Crisis Response Plan": Research

Bryan et al, 2017: RCT of 97 Army soldiers in emergency behav. health setting

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, which

• Made clinicians 86% less likely to hospitalize patients, even though risk profile was the same (clinician thought they would be less likely to attempt in the future)
Lethal Means Restriction

- Means restriction included on all safety plans
- Contacting family to confirm removal of lethal means is required, standard practice
- Training provided to staff
- Means restriction recommendations reviewed regularly
Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com
QUESTIONS AND DISCUSSION
Review - Language Matters

Died of Suicide vs Committed Suicide
Suicide Death vs Successful Attempt
Suicide Attempt vs Unsuccessful Attempt
Suicide vs Completed Suicide
Describe the Behavior vs Manipulative
Working with vs Dealing with Suicidal Patients
Care directly targets and treats suicidality and behavioral health disorders using effective, evidence-based treatments.
Treating Suicidal Thoughts and Behaviors Directly

Evidence-based models of care for suicidal patients.

Treating Suicidal Risk Directly

David Jobes

Proven models of care.
Evidence-Based Treatments for Suicidality

- With 50+ studies there are few evidence-based treatments
- There is little to no support for medication-only
- RCTs and replications support:
  - Dialectical Behavior Therapy (DBT)*
  - 2 similar types of Cognitive Behavior Therapy:
    - Cognitive Therapy for Suicide Prevention (CT-SP)*
    - Brief Cognitive Behavioral Therapy (B-CBT)
  - Collaborative Assessment and Management of Suicidality (CAMS)*
  - Non-demand follow-up contact (caring contacts)
  - Adaptations for inpatient settings
- *SAMHSA’s National Registry of Evidence-based Programs and Practices
Medications for Suicidal Risk

- Mann et al (2005): Treating mood and the underlying psychiatric disorder is “...a central component of suicide prevention.”
- There is RCT evidence for lithium (Tondo et al., 2001) and clozapine (Meltzer et al., 2003—only FDA approved Rx).
- RCT’s not finding a SSRI effect on suicide ideation/behavior:
  - Gunnell et al (2005)
  - Ferusson et al (2005)
- RCT’s that did find a SSRI effect on suicide ideation/behavior:
  - Zisook et al (2011)
  - Gibbons et al (2012)

Ketamine?

Slide courtesy of David Jobes
Dialectical Behavior Therapy (DBT)

DBT's Impact on Suicide Attempt Behavior

Figure 3: Survival analysis for time to first suicide attempt. The treatment period ended at 595 days, and the follow-up period ended at 733 days. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

DBT's Impact on Non-Suicidal Self-Injury Behavior

Figure 4: Mean ordinal non-suicidal self-injury during the 2-year study. The treatment period ended at 12 months, and the follow-up period ended at 24 months. The 5-level ordinal categories per assessment period were 0, 0.01 to 1, 1.01 to 2, 2.01 to 4, and 4.01 and higher. CTBE indicates community treatment by experts; DBT, dialectical behavior therapy.

Slide courtesy of David Jobes
Cognitive Therapy for Suicide Prevention (CT-SP)

Survival Functions for Repeat Suicide Attempt by Study Condition


Slide courtesy of David Jobes
Collaborative Assessment and Management of Suicidality (CAMS)

CAMS RCT (Comtois et al., 2011)

Significantly higher patient satisfaction ratings and better clinical retention
Collaborative Assessment and Management of Suicidality (CAMS)

First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation

CAMS Interim Tracking Sessions

CAMS Outcome/Disposition Session

Slide courtesy of David Jobes
Use of a one-time psychological intervention on medical-surgical units with inpatient suicide attempters...
Motivational Interviewing

Peter Britton, Ph.D.

1-2 sessions of Motivational Interviewing with veterans following a suicide attempt...

An Open Trial of Motivational Interviewing to Address Suicidal Ideation With Hospitalized Veterans

Peter C. Britton,1 Kenneth R. Conner,1 and Stephen A. Maisto2

1 VA Center of Excellence for Suicide Prevention
2 Syracuse University

Objective: The purpose of this open trial was to test the acceptability of motivational interviewing to address suicidal ideation (MI-SI) for psychiatrically hospitalized veterans with suicidal ideation, estimate its pre-post effect size on the severity of suicidal ideation, and examine the rate of treatment engagement after discharge. Methods: Participants received a screening assessment, baseline assessment, one or two MI-SI sessions, posttreatment assessment, and 60-day follow-up assessment. Thirteen veterans were enrolled, 9 (70%) completed both MI-SI sessions and the posttreatment assessment, and 11 (85%) completed the follow-up assessment. Results: Participants found MI-SI to be acceptable. They experienced large reductions in the severity of suicidal ideation at posttreatment and follow-up. In the 2 months following discharge, 73% of participants completed two or more mental health or substance abuse treatment sessions each month. Conclusions: These preliminary findings suggest that MI-SI has potential to reduce risk for suicide in psychiatrically hospitalized veterans and that a more rigorous trial is needed. © 2012 Wiley Periodicals, Inc. J. Clin. Psychol. 68:961–971, 2012.

Slide courtesy of David Jobes
Attempted Suicide Short Intervention Program

80% between-group reduction in suicide attempts at 2 year follow-up...
Peer Taught
Dialectical Behavior Therapy (DBT) Skills

Have you had suicidal thoughts?
Problems that felt unsolvable?
You are in excellent company – we’ve been there.
Here we offer strategies to survive and build more manageable and meaningful lives.
Now Matters Now hacks suffering
Peer Taught Dialectical Behavior Therapy (DBT) Skills

suicidal thoughts

opposite action

mindfulness of current emotions

Suicide becomes an option when we are barely living - opposite action is practice living all the way.

#DBT_OA

watch videos
Dear Stephanie,

It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you.

Sincerely,
Dr. Smith

- Caring letters
- Caring postcards
- Caring phone calls
- Caring emails
- Caring texts
- ED follow-up calls
- Inpatient follow-up calls
- Post D/C home visits
A Stepped Care Model for Suicide Care

Suicide-specific Care at Each Step
From Least to Most Restrictive Intervention

- Crisis Center Hotline Support + Follow-up
- Brief Intervention + Follow-up
- Emergency Respite Care
- Partial Hospitalization
- Inpatient Psychiatric Hospitalization

Adapted from Jobes, D. (2014)
QUESTIONS AND DISCUSSION
Discussion at Tables

- What is the general approach to providing evidence-based treatment for suicide in your organization?
- What type of training does staff receive on how to develop a collaborative safety plan?
- What type of training does clinical staff receive on means restriction?
- Where do you see room for improvement in your training practices?
Break
Follow-up and Engagement

- Persons with suicide risk get timely and assured transitions in care. Providers ensure the transition is completed.

- Persons with suicide risk get personal contact during care and care transitions, with method and timing appropriate to their risk, needs, and preferences.
Improving Care Transitions for People with Behavioral Health Disorders

Richard McKeon, Ph.D., MPH
Chief, Suicide Prevention Branch
Preventing Deaths, Injuries, and Readmissions

• The period after inpatient discharge is the time of highest risk for death by suicide by those receiving mental health care.

• In a study of almost 900,000 veterans treated for depression, Valenstein et al (2009) found that while all transitions were associated with increased risk, the highest risk was in the 12 weeks following discharge.
Preventing Deaths, Injuries, and Readmissions

• “Our data suggest that health systems might have the most impact on suicide if they first allocated resources for prevention efforts for depressed patients recently discharged from inpatient psychiatric settings.”
England

- 519 (24%) suicides occurred within three months of hospital discharge, the highest number occurring in the first week after discharge (National Confidential Inquiry into Suicide and Homicide; Appleby et al).
Why are ED’s critical to U.S. suicide prevention efforts?

- Many people at high risk are seen in Emergency Departments and many suicide deaths and attempts occur after discharge.
- Post discharge follow up and care transitions are often problematic.
- There is strong evidence that intervention at this time can be life saving.
EMERGENCY DEPARTMENT F/U

• Fleischmann et al (2008)
  – Randomized controlled trial; 1867 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

Results at 18 Month F/U

Percent of Patients

<table>
<thead>
<tr>
<th>Died of Any Cause</th>
<th>Died by Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual Care</td>
<td>Brief Intervention</td>
</tr>
</tbody>
</table>

NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
NATCON CONFERENCE

#NATCON17  #BH365
Major International Efforts Have Reduced Suicides

• Taiwan-nationwide effort to intervene with those who have attempted suicide, 50,000+
• 63.5% reduction in suicide attempts among those who accepted the program. Those who refused but then persuaded 22% reduction.
• Denmark-referral from EDs of those who attempted suicide led to reductions in suicide deaths
What if we targeted these groups for suicide prevention programs?

<table>
<thead>
<tr>
<th></th>
<th>Estimated Number in Population (Number in Thousands)</th>
<th>Past year Suicidal Ideation (Number in Thousands)</th>
<th>Past Year Suicide Attempt (Number in Thousands)</th>
<th>Past year SMI and suicidal ideation (Number in Thousands)</th>
<th>Past year SMI and Suicide attempt (Number in Thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full time Employed (18+)</td>
<td>118,225</td>
<td>3,678</td>
<td>351</td>
<td>1,213</td>
<td>149</td>
</tr>
<tr>
<td>Treated in ER for any reason in past year (18+)</td>
<td>57,977</td>
<td>3,839</td>
<td>686</td>
<td>1,686</td>
<td>403</td>
</tr>
<tr>
<td>Military Veterans (18+)</td>
<td>24,356</td>
<td>804</td>
<td>74</td>
<td>276</td>
<td>44</td>
</tr>
<tr>
<td>Adults (18 +) on Medicaid/CHIP</td>
<td>18,629</td>
<td>1,383</td>
<td>270</td>
<td>644</td>
<td>164</td>
</tr>
<tr>
<td>Full time College Students (18+)</td>
<td>14,612</td>
<td>785</td>
<td>108</td>
<td>312</td>
<td>64</td>
</tr>
<tr>
<td>Adults (18+) on Probation or Parole</td>
<td>5,581</td>
<td>585</td>
<td>161</td>
<td>285</td>
<td>106</td>
</tr>
<tr>
<td>Adults in Substance Use Treatment</td>
<td>2,292</td>
<td>395</td>
<td>106</td>
<td>238</td>
<td>80</td>
</tr>
</tbody>
</table>

Data Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug use And Health (NSDUH), 2008-2013.
Prevent Readmissions

- Top Ten Most Common Medicaid 30-Day Readmissions (with Total Cost) 2011-18-65
- 1. Mood disorders — 41,600 total readmissions ($286 million)
- 2. Schizophrenia and other psychotic disorders — 35,800 total readmissions ($302 million)
- 3. Diabetes mellitus with complications — 23,700 total readmissions ($251 million)
- 4. Other complications of pregnancy — 21,500 total readmissions ($122 million)
- 5. Alcohol-related disorders — 20,500 total readmissions ($141 million)
- 6. Early or threatened labor — 19,000 total readmissions ($86 million)
- 7. Congestive heart failure (non-hypertensive) — 18,800 total readmissions ($273 million)
- 8. Septicemia (except in labor) — 17,600 total readmissions ($319 million)
- 9. Chronic obstructive pulmonary disease and bronchiectasis — 16,400 total readmissions ($178 million)
- 10. Substance-related disorders — 15,200 total readmissions ($103 million)
Objective 8.4

NSSP Objective 8.4

Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

NSSP Objective 8.8

Develop collaborations between Emergency Departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow up after discharge.
Joint Commission Sentinel Event Alert 56: Detecting and Treating Suicide Ideation in All Settings

“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.”
Action Alliance Care Transition

- Care Transition recommendations
- Collaborative discharge and safety planning on IPU/ED
- Post Discharge Follow Up Phone Call
- Appointment Within One Week
SAMHSA Care Transition Resources

- Crisis Center Follow Up grants
- White Paper on Care Transitions in Behavioral Health
- Financing of Behavioral Health Care Transitions
- Return on Investment Study
Return on Investment
Post-Discharge Follow-up Calls

Savings

• Baseline hospital M/SUD readmission rate within 30 days of discharge
  – Hospital
    • Commercial Insurance – 9.1 percent
    • Medicaid – 10.4 percent
  – ED
    • Commercial Insurance – 9.0 percent
    • Medicaid – 7.4 percent
Return on Investment Post-Discharge Follow-up Calls

- The estimated Return on Investment (ROI) for hospital discharges
  - Commercial Insurance – $1.76
  - Medicaid – $2.43
- Estimated ROI for ED discharges
  - Commercial Insurance – $1.70
  - Medicaid – $2.05
Other Major Federal and Private Initiatives

- NIMH ED SAFE
- CMS Community Care Transition grants-reducing readmissions
- Excellence in Mental Health Act/Section 223
- Action Alliance Transforming Health Care Systems Priority
- Joint Commission Sentinel Event Alert
- GLS/Lifeline
“Many a suicide might be averted if the person contemplating it could find the proper assistance when such a crisis impends.”

- Clifford Beers, 1908

*A Mind That Found Itself*

Founder of America’s Mental Hygiene (Reform) Movement
Roles of Crisis Centers: CCBHCs

Centers can play one of the following roles:

- Integrated part of system—”baked in” (eg., Air Traffic Control model)
- “Designated Collaborating Organization”—”bolted on”
- Consulting/training role
CBHC Systems: Partnering with Crisis Centers

• Staff training
  – Risk Assessment
  – Suicide Prevention/Intervention

• Access & Availability
  – Outreach & engagement
  – Telephone/text, online-chat, telecounseling, etc.
  – 24/7 access to evaluation & crisis care

• Follow-up/Care Coordination
  – Relations with EDs/Hospitals, providers
  – Safety planning, peer supports
Find Your Local Lifeline Crisis Center

Lifeline Web Site’s crisis center locator

Info on Lifeline center Partnerships: Carole Ludwig, Director Member Services cludwig@mhaofnyc.org

suicidepreventionlifeline.org/our-network/
Resource: Structured Follow-up and Monitoring

Access at: www.zerosuicide.com
QUESTIONS AND DISCUSSION
Discussion at Tables

• How do you know if clients go to the provider to whom they were referred?
• What type of relationships do you have with other local providers such as emergency departments, crisis lines, psychiatric emergency departments, inpatient psychiatric hospitals, or other providers (e.g. substance abuse)? How might you engage with one another to promote continuity of care?
• How can you partner with local crisis centers to engage patients in their discharge plans?
Next Steps
Create an Implementation Team

Membership suggestions:
• Representative from executive leadership
• Well-regarded clinical leader(s)
• Attempt and loss survivors
• Performance improvement expertise
• I.T. staff
Implementation Team Functions

• Maintain organizational enthusiasm and commitment
• Orient all staff
• Draft and implement work plan
• Determine how to address gaps
• Evaluate initiative
With Your Implementation Team…

• Take *Zero Suicide Organizational Self-Assessment*

• Determine how to educate all staff about adoption of Zero Suicide approach

• Administer *Zero Suicide Work Force Survey*
Resources and Support

- Listserv: [http://zerosuicide.sprc.org/get-involved](http://zerosuicide.sprc.org/get-involved)
- Implementation Toolkit: ZeroSuicide.com
- Organizational Self-Study:
- nowmattersnow.org
- Contact us at: zerosuicide@edc.org
Zero Suicide Website
Closing and Evaluation