Zero Suicide/Suicide Safe Care:

Making Suicide Prevention a Core Responsibility of Health Care

Mike Hogan--National Action Alliance on Suicide Prevention
Spokane WA. March 2015
How Did We Get Here?
National Action Alliance for Suicide Prevention
Why an Action Alliance for Suicide Prevention?

- WHO guidance: need National Strategy, and national guidance and leadership group
  - Annual deaths increased 28% by 2012
- Need to update the NSSP:
  - New tools and evidence...largely unused
  - Health care as a focus
New Knowledge: Better Treatment Saves Lives

Figure 3. Survival analysis for time to first suicide attempt. The treatment
Case Study
Organized Health Care Delivery System • August 2009

Henry Ford Health System: A Framework for System Integration, Coordination, Collaboration, and Innovation

DOUGLAS MCCARTHY, KIMBERLY MUELLER, AND JENNIFER WRENN
ISSUES RESEARCH, INC.

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ABSTRACT: Henry Ford Health System is a vertically integrated health care system in southeastern Michigan whose leadership is committed to systemic integration, clinical excellence, and customer value through the core competencies of collaboration, care coordination, and innovation and learning. Henry Ford’s care innovation initiatives are multidisciplinary, team-led projects that target improvements in quality measures and evidence-based standards through problem-solving and the identification of common metrics to build consensus. The collaborative approach, fostered by shared vision and values, facilitates transformation throughout the system. Moreover, Henry Ford’s integration of care delivery and coverage facilitates quality monitoring, measurement, and improvement activities.
Clinical Care Task Force Members

- Ed Coffey, MD, HFHS
- Lanny Berman, AAS
- Christian Comeau, Empact SPC
- Kate Comtois, UW
- Laurie Davidson, SPRC
- Holly Dixon, Crisis Response Network
- John Draper, Natl SP Lifeline
- David Jobes, Catholic U
- Richard McKeon, SAMHSA
- Meredith Mechenbier, Com. Bridges
- Jill Robinson, SE Network
- Paul Schyve, MD, TJC
- Shannon Skowronski, US Admin. Aging

- Co-Chairs: David Covington, Mike Hogan
- Magelllan Team:
  - Shareh Ghani MD, Chris Damle, Gabriella Guerra, Christine Ketchmark, Roni Siebels, Gaye Tolman, Jose Abreu, Liz Smithhart, Cindy Wilkins
- SPCNY:
  - Fred Meservey (lead author), Pat Breaux, Gary O’Brien, Cassandra Kahl
Clinical Care and Intervention Task Force

- Zero Suicide concept and model: Clinical Care Task Force, 2011
- Advocates, survivors, clinicians, researchers
- Key concepts:
  - Suicide takes place among people in health care and can be prevented there
  - Much has been learned about suicide care since 2000, but most of it is not used
  - Let’s apply what we know to make health care suicide-safe
  - Let’s test its feasibility in health and behavioral health
Suicide Among Health Care Patients Is A Problem

- Half of the people who die by suicide were in GP's care, seen in prior year, 25% seen by GP in previous month
- South Carolina: 10% of all suicide deaths were people seen in ED in previous month
- People receiving care in mental health system:
  - Risk among people with depression and other mental health problems up to 20x general population
  - Kentucky: 25%+ of all suicides among people with MH care
  - Vermont: 24% of all suicides among people with MH care
  - NYS: 226 reported suicides in public MH system in 2012 (13% of estimated 1700 deaths in NYS)
Health Care is Not Suicide-Safe

Continue of Caring, or
Refer and Hope

Suicidal Person

Screen, Assess for Suicidality… Or “Don’t Ask, Don’t Tell’

Take Concrete Steps for Safety, or… Send them home

Treat Suicidality, or Commit to Hospital Care and Hope for the Best

Serious Injury or Death
Treat Suicidality: Suicide-Informed CBT, Groups, DBT, CAMS

Excellent Access, and Follow-up Contact after ED, Inpatient

Screen, Assess for Suicidality

Collaborative Safety Plan with Lethal Means Restriction

Suicidal Person

Death or Serious Injury Avoided
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 at risk for suicidal behaviors.
What is Different in Zero Suicide?

▪ Making suicide prevention (keeping our patients alive) a core responsibility of health care
▪ Systematic "Suicide Safe Care"...not a single, underpowered approach (e.g. a training session)
▪ Applying our new knowledge:
  ▪ Asking about suicidality among people with risk (screening) is a must
  ▪ Personal safety plans work. “No-harm contracts” do not
  ▪ Personal lethal means restriction is effective.
  ▪ Treatment and support for suicidal feelings is effective
  ▪ Supportive contacts help keep people alive
### The Clinical Dimensions of Zero Suicide

#### CLINICAL ELEMENTS
- **ASK** (Screen, assess)

#### EXAMPLES, EVIDENCE, AND OPTIONS
- Mental Health Research Network report (Greg Simon et al.)—responses on Question 9 of PHQ-9 *DO* predict suicide
- Reliability and feasibility established for Columbia Suicide Severity Rating Scale (C-SSRS)
- Assessment: more than screening. To find ways to manage risk, not just classify it
The Dimensions of Zero Suicide

- **CLINICAL ELEMENTS**
  - Collaborative Safety Plan

Sample Safety Plan

<table>
<thead>
<tr>
<th>Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:</th>
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<tbody>
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<tr>
<th>Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):</th>
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<th>Step 3: People and social settings that provide distraction:</th>
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<tbody>
<tr>
<td>1. Name Phone</td>
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<td>2. Name Phone</td>
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<tr>
<td>3. Place 4. Place</td>
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<th>Step 4: People whom I can ask for help:</th>
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<tr>
<td>1. Name Phone</td>
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<td>2. Name Phone</td>
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<td>3. Name Phone</td>
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<tr>
<th>Step 5: Professionals or agencies I can contact during a crisis</th>
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<tr>
<td>1. Clinician Name Phone Clinician Pager or Emergency Contact #</td>
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<tr>
<td>2. Clinician Name Phone Clinician Pager or Emergency Contact #</td>
</tr>
<tr>
<td>3. Local Urgent Care Services Phone Urgent Care Services Address</td>
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<tr>
<td>4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)</td>
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<th>Step 6: Making the environment safe:</th>
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The one thing that is most important to me and worth living for is:

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The Dimensions of Zero Suicide

- CLINICAL ELEMENTS
  - Remove Lethal Means
The Clinical Dimensions of Zero Suicide

- Evidence-based treatment and support for managing suicidal feeling as well as mental illness/substance use:
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Competent clinical staff trained in Assessing and Managing Suicide Risk (AMSR)
  - Dialectical Behavior Therapy
  - Suicidality-informed Cognitive Behavioral Therapy
  - Plus…Peer support

- Sustained engagement of people with significant suicidality during treatment, and during periods of risk/transition
Experience and Learnings: Zero Suicide

- It *can be done*. Successful implementation in behavioral health and integrated primary care
- Implementation is hard work
  - The tools are available; putting them in place takes work
  - Different challenges and opportunities at different stages
  - It takes a team, leadership, a planned approach, CQI
- We have evidence, not proof:
  - Not acting is unacceptable: People are dying in usual care
  - There is good evidence behind all the clinical elements of ZS: Screening, Safety Planning, Means Restriction, Targeted Treatment, Supportive Contacts
  - Early adopters are approaching Henry Ford results
Experience and Learnings: Zero Suicide

- Early adopters are approaching Henry Ford results: Centerstone
Resources at: www.zerosuicide.com
Welcome to the Zero Suicide Toolkit

Information, resources, and tools for systematic suicide prevention in behavioral health and health care.

Learn more about the fundamentals of providing suicide safer care and create a Zero Suicide work plan for each of seven key elements.

Lead  Train  Identify  Engage  Treat  Transition  Improve
Thank You!