CAN SUICIDE BE A NEVER EVENT?

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PEOPLE AT RISK FOR SUICIDE ARE FALLING THROUGH THE CRACKS IN OUR HEALTH CARE SYSTEM

In the month before their death by suicide:

Half saw a general practitioner (80% within one year)

20% saw a mental health professional within a month prior to their death

In the 60 days before their death by suicide:

10% were seen in an emergency room

"Suicide represents a worst-case failure in mental health and general health care. We must work to make it a '***never event***' in our programs and systems of care."

Dr. Mike Hogan
Chairperson President's New Freedom Commission on Mental Health

SUICIDE CARE IN BEHAVIORAL HEALTH CARE SETTINGS

Suicide prevention is a core responsibility for behavioral health care systems

Many licensed clinicians are not prepared

- 39% report they don't have the skills to engage and assist those at risk for suicide
- 44% report they don't have the training
  - (2017 study)

"Over the decades, individual (mental health) clinicians have made heroic efforts to save lives… but systems of care have done very little."

Dr. Richard McKeon
SAMHSA

"It is critically important to design for zero even when it may not be theoretically possible…It's about purposefully aiming for a higher level of performance."

Thomas Priselac

President and CEO of Cedars-Sinai Medical Center

WHAT IS ZERO SUICIDE?

A priority of the National Action Alliance for Suicide Prevention

A goal of the National Strategy for Suicide Prevention

A *project* of the Suicide Prevention Resource Center

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

A focus on safety and error reduction in healthcare

A set of best practices and tools for health systems and providers

IT TAKES A COMMUNITY

- Schools
- Police
- First responders
- Peers
- Human Service providers
- Faith Based
- Family members
- Hospitals
- Behavioral Health providers
- Survivors
- Health Care providers
- Private businesses

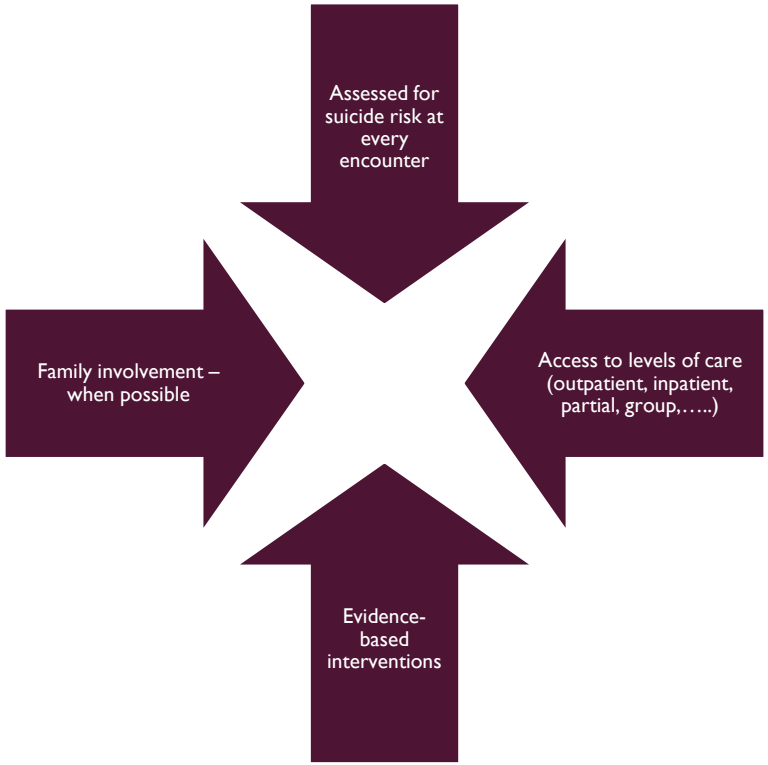
BIRTH OF ZERO SUICIDE

- Henry Ford Healthcare System – 2001
  - Care pathway to access and modify suicide risk
  - Led to Zero suicides for 18 months in 2009 – 2010 and relevant decrease in suicide rates within the Henry Ford Healthcare System
  - Started a worldwide Zero Suicide movement

ZERO SUICIDE CORE COMPONENTS

- Leadership commitment
- Workforce development and training
- Standardized screening and risk assessment
- Suicide care management plan
- Effective, evidence-based treatment
- Follow-up during care transitions
- Ongoing quality improvement and data collection

SUICIDE RISK ASSESSMENT



- Reducing access to means
- Self-management – coping strategies
- Comfort/caring cards – 7-30 day post discharge and following outpatient appointments

STANDARDIZED SCREENING TOOLS

- Depression screening tools
- Suicide assessment tools

Which do you use?

SCREENING TOOLS

- **PHQ9**
  - Patient Health Questionnaire 9
  - Screens for depression
- **AADIS**
  - Adolescent Alcohol and Drug Involvement Scale – screens for tobacco, alcohol and drug use
- **Columbia Suicide Severity Rating Scale**
  - Screener Version – gatekeepers, EMS
  - Full Version – clinicians
  - Flexible format
  - Integrates information given by collateral sources

PHQ-9 Modified for Adolescents PHQ-A

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screening Version - Recent

	Past Month	
Ask questions that are bold and underlined	**YES**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan." **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) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*" **Have you been thinking about how you might kill yourself?**		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" **Have you had these thoughts and had some intention of acting on them?**		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. **Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?**		

	Past 3 Months	
	YES	**NO**
6) Suicide Behavior **Have you done anything, started to do anything, or prepared to do anything to end your life?** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

Adolescent Alcohol and Drug Involvement Scale: AADIS

A. DRUG USE HISTORY

For each drug I name, please tell me if you have ever tried it. Then, if you have tried it, tell me how often you typically use it [*before* you were taken into custody or enter treatment]. Consider only drugs taken without prescription from your doctor; for alcohol, don't count just a few sips from someone else's drink.

	Never Used	Tried But Quit	Several Times a Year	Several Times a Month	Week-Ends Only	Several Times a Week	Daily	Several Times a Day
Smoking Tobacco (Cigarettes, cigars)	0	1	2	3	4	5	6	7
Alcohol (Beer, Wine, Liquor)	0	1	2	3	4	5	6	7
Marijuana or Hashish (Weed, grass)	0	1	2	3	4	5	6	7
LSD, MDA, Mushrooms Peyote, other hallucinogens (ACID, shrooms)	0	1	2	3	4	5	6	7
Amphetamines (Speed, Ritalin, Ectasy, Crystal)	0	1	2	3	4	5	6	7
Powder Cocaine (Coke, Blow)	0	1	2	3	4	5	6	7
Rock Cocaine (Crack, rock, freebase)	0	1	2	3	4	5	6	7
Barbiturates, (Quaaludes, downers, ludes, blues)	0	1	2	3	4	5	6	7
PCP (angel dust)	0	1	2	3	4	5	6	7
Heroin, other opiates (smack, horse, opium, morphine)	0	1	2	3	4	5	6	7
Inhalants (Glue, gasoline, spray cans, whiteout, rush, etc.)	0	1	2	3	4	5	6	7
Valium, Prozac, other tranquilizers (without Rx)	0	1	2	3	4	5	6	7
OTHER DRUG_____	0	1	2	3	4	5	6	7

ZERO SUICIDE IS FEASIBLE

- Health and behavioral health care organizations have found:
  - It's feasible with buy in at all levels
  - It's working—lives are being saved.
- For resources and additional information:
- www.ZeroSuicide.com

What is Different in Zero Suicide?

FROM

-ACCEPTING SUICIDE AS INEVITABLE
-ASSIGNING BLAME
-RISK ASSESSMENT AND CONTAINMENT
-STAND ALONE TRAINING TOOLS
-SPECIALTY REFERRAL TO NICHE STAFF
-INDIVIDUAL CLINICIAN JUDGMENT & ACTIONS

HOSPITALIZATIONS DURING EPISODES – "IF WE CAN SAVE ONE LIVE"

TO

-EVERY SUICIDE IN A SYSTEM IS PREVENTABLE

-NUANCED UNDERSTANDING: AMBIVALENCE, RESILIENCE, RECOVERY

-COLLABORATIVE SAFETY, TREATMENT, RECOVERY

-OVERALL SYSTEMS AND CULTURE CHANGES

-PART OF EVERYONE'S JOB

-SCREENING, ASSESSMENT, INTERVENTIONS

-PRODUCTIVE INTERACTIONS THROUGHOUT CARE – "NO DEATH IS ACCEPTABLE"

TREATING THE WHOLE PERSON

- More than 90% of people who die by suicide have a mental health condition or substance abuse disorder or both
- More thank 50% are associated with major depressive disorder
- 50% of people who die by suicide had contact with their primary care provider in the month prior to their suicide (80% within the year of their death)
- 20% saw a behavioral health provider within the month before they died
- 10% visited the Emergency Department within two months before they died

REDUCING ACCESS TO MEANS

Most suicide attempts occur during a short-term crisis

Impulsive

90% of attempters who survive do not go onto reattempt.

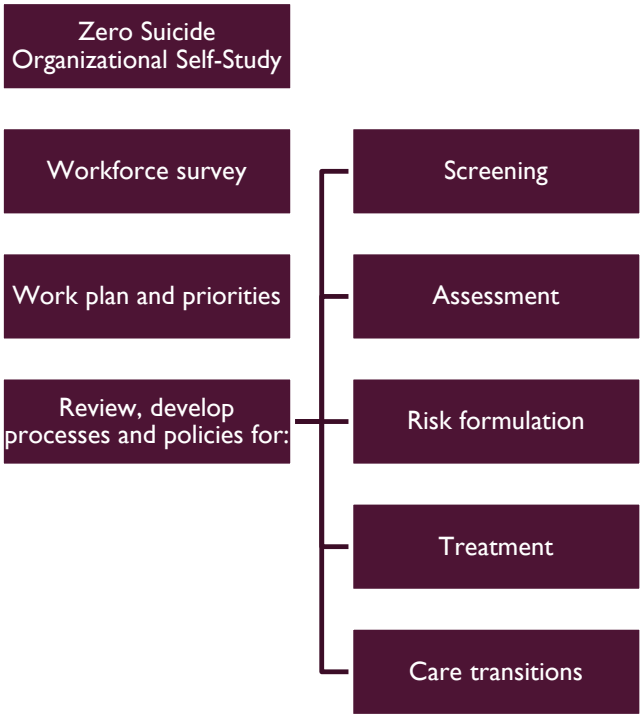
- Lethality methods
  - Firearms
  - Suffocation
  - Falls
  - Poisoning
  - Cutting

ENGAGE

- Engagement of the person in best-practice interventions geared to risk level
  - Every person has a pathway to care that is timely
    - Warm hand off
    - Phone call follow up between appointments
    - Postcard or letters
    - Home visits
    - Safety planning

- What are ways in which you follow-up with people after they receive care?
- Suicide Prevention Resource Center – Best Practices Registry

HOW TO GET STARTED WITH A ZERO SUICIDE PLAN

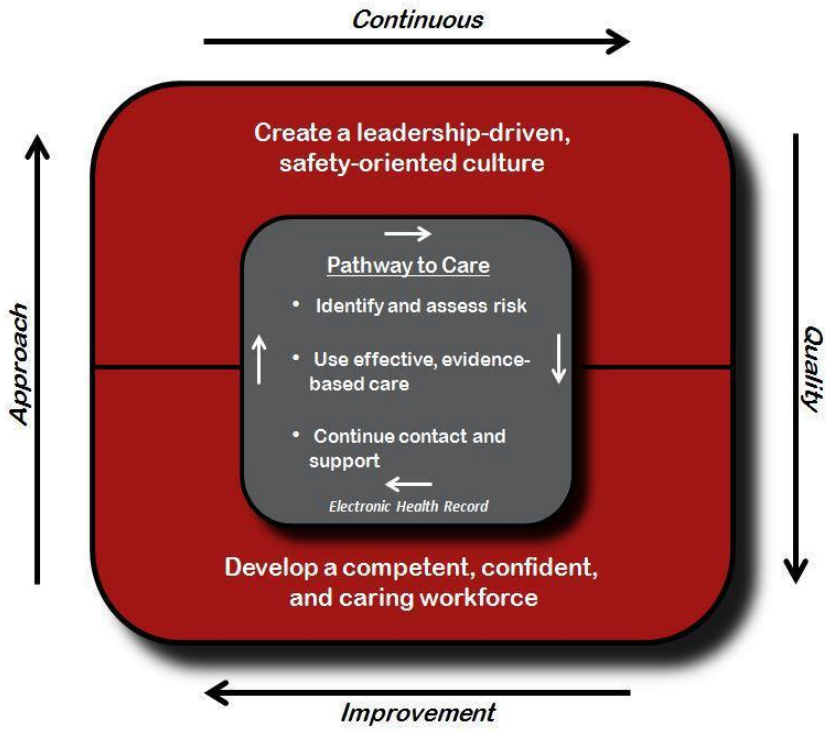


- Formulate a plan to collect data
- Evaluate progress
- Measure results

WHERE ARE THE GAPS?

- Who does the screening for depression, substance use, suicidality?
- Who needs to know the results of the screening?
- Who does further screening?
- How is the management plan communicated?
- Who provides services for people at risk?
  - Do they have a zero-suicide plan?

- DIMENSIONS of ZERO SUICIDE



ESSENTIAL ELEMENTS OF SUICIDE CARE

Lead system-wide culture change committed to reducing suicides

Train a competent, confident, and caring workforce

Identify individuals with suicide risk via comprehensive screening and assessment

Engage all individuals at-risk of suicide using a suicide care management plan

Treat suicidal thoughts and behaviors using evidence-based treatments

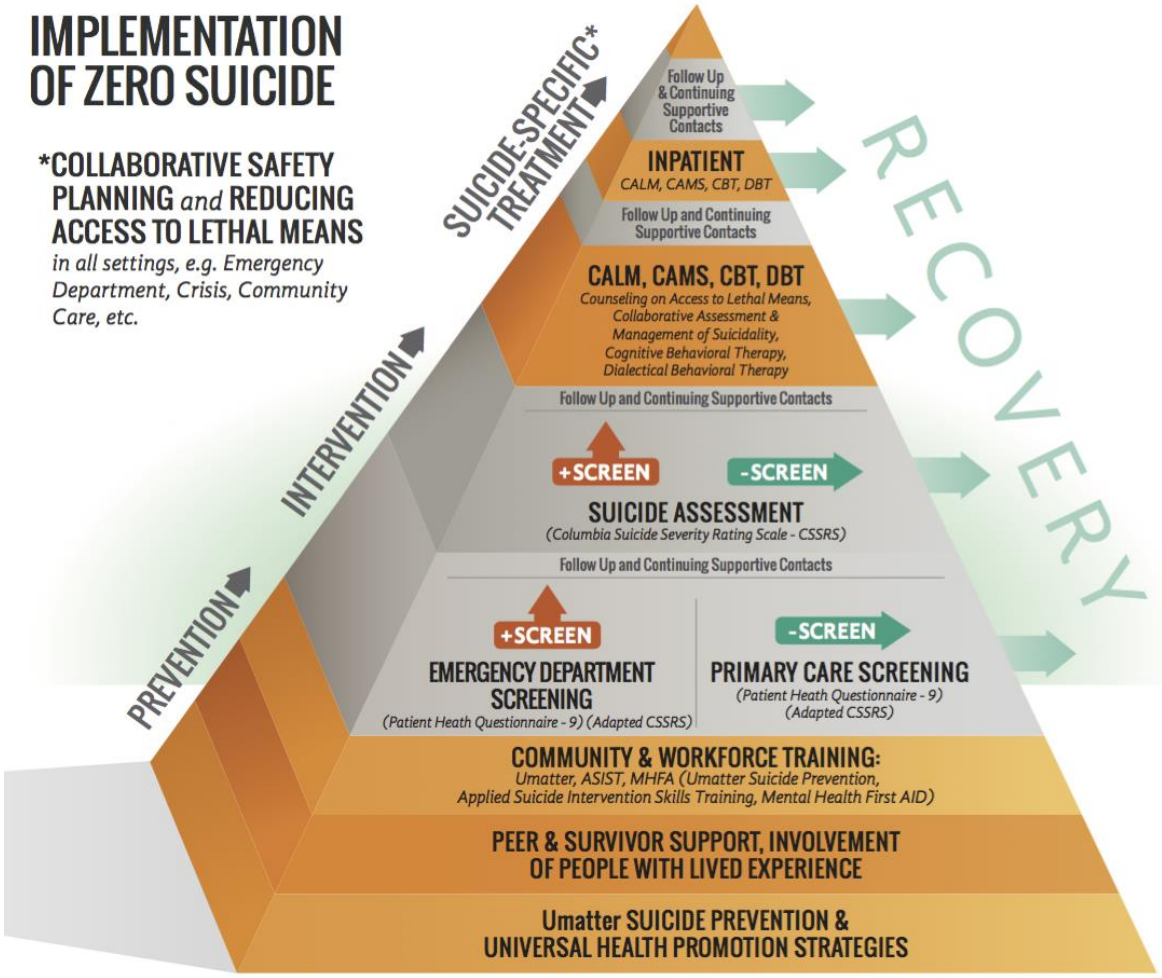
Transition individuals through care with warm hand-offs and supportive contacts

Improve policies and procedures through continuous quality improvement

DOES ZERO SUICIDE WORK?

- Henry Ford – 80% reduction in suicides – 18 months zero suicides
- Centerstone – Nashville, TN – 64% reduction in suicide deaths within their behavioral health system
- Gold Coast Health – Queensland – implemented toolkit, immediate reduction in suicides within their health system
- 5 year study underway in 5 states (Oregon, California, Washington, Michigan, Colorado – 10 million lives to reduce suicides within healthcare)

ZERO SUICIDE RELIES ON A SYSTEM-WIDE APPROACH TO IMPROVE OUTCOMES AND CLOSE GAPS RATHER THAN ON THE HEROIC EFFORTS OF INDIVIDUAL PRACTITIONERS.


IMPLEMENTATION OF ZERO SUICIDE
*COLLABORATIVE SAFETY PLANNING and REDUCING ACCESS TO LETHAL MEANS
in all settings, e.g. Emergency Department, Crisis, Community Care, etc.
PREVENTION
INTERVENTION
SUICIDE-SPECIFIC* TREATMENT
RECOVERY
Follow Up & Continuing Supportive Contacts
INPATIENT
CALM, CAMS, CBT, DBT
Follow Up and Continuing Supportive Contacts
CALM, CAMS, CBT, DBT
Counseling on Access to Lethal Means, Collaborative Assessment & Management of Suicidality, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy
Follow Up and Continuing Supportive Contacts
+SCREEN
-SCREEN
SUICIDE ASSESSMENT
(Columbia Suicide Severity Rating Scale - CSSRS)
Follow Up and Continuing Supportive Contacts
+SCREEN
EMERGENCY DEPARTMENT SCREENING
(Patient Heath Questionnaire - 9) (Adapted CSSRS)
-SCREEN
PRIMARY CARE SCREENING
(Patient Heath Questionnaire - 9)
(Adapted CSSRS)
COMMUNITY & WORKFORCE TRAINING:
Umatter, ASIST, MHFA (Umatter Suicide Prevention, Applied Suicide Intervention Skills Training, Mental Health First AID)
PEER & SURVIVOR SUPPORT, INVOLVEMENT OF PEOPLE WITH LIVED EXPERIENCE
Umatter SUICIDE PREVENTION & UNIVERSAL HEALTH PROMOTION STRATEGIES

THANK YOU!

QUESTIONS?