Ending Suicide in Healthcare Settings
How many deaths are acceptable?
What are our next steps to save lives?

Adapted by Jan Ulrich, KY Division of Behavioral Health

Originally Developed and Presented to AAS Conference by David Covington, LPC, MBA
National Action Alliance for Suicide Prevention
Clinical Care and Intervention Task Force

U.S. Suicide Deaths Vs. Motor Vehicle Fatalities

- **Suicide deaths now outnumber motor vehicle fatalities in the United States.**
  - **Motor Vehicle Fatalities: 35,498**
  - **Suicide Deaths: 38,364**

CDC WISQARS Fatal Injury Reports 2010

"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

"Suicide represents a worst case failure in mental health care. We must work to make it a 'never event' in our programs and systems of care."
- Dr. Mike Hogan
NY State Office of Mental Health (Ret.)

National Action Alliance for Suicide Prevention

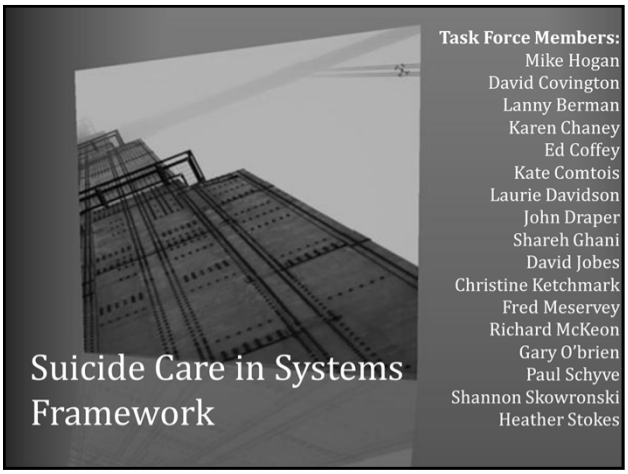
- Launched Sept. 10, 2010 (World Suicide Prevention Day)
  - Secretaries Sibelius and Gates, Pam Hyde
  - Co-chairs: Army Secretary John McHugh, Sen. Gordon Smith

National Action Alliance for Suicide Prevention

- **Vision**: A nation free of the tragic experience of suicide
- **Mission**: To advance the National Strategy for Suicide Prevention (NSSP) by:
  - Championing suicide prevention as a national priority;
  - Revising, and catalyzing efforts to implement high priority objectives of the NSSP;
  - Cultivating the resources needed to sustain progress.

Clinical Care & Intervention Task Force

- Mission
  - Improve suicide prevention and intervention practices in specialty behavioral health settings;
  - Articulate clinical care and intervention strategies for specialty and general health plans;
  - Propose standards and essential elements for suicide prevention that might be recommended to national accrediting bodies and for inclusion in state and federal guidelines.



What is a "System of Care"?

- System of care:
  - Any entity serving a defined population;
  - Has shared leadership, policy, or other structures that enable changes across subunits.
- What qualifies as a system? Examples:
  - Healthcare or behavioral health systems
  - Networks of providers
  - Military branches, schools, college campuses (though focus is healthcare)
  - Many lessons also apply to smaller units (e.g., EDs, multi-provider practices, etc.)

Case Examples

FOUR SYSTEMS

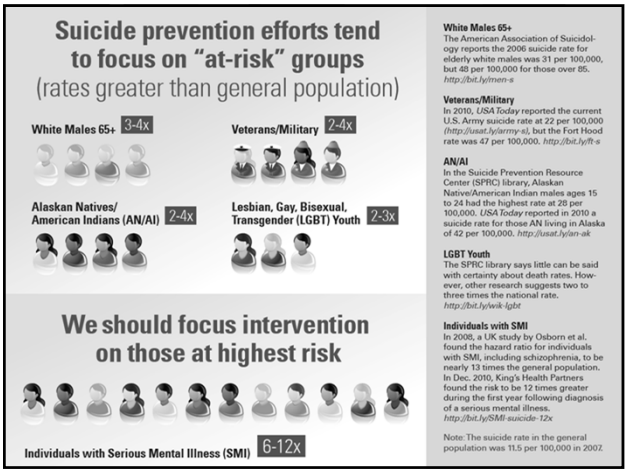
- U.S. Air Force
- Henry Ford Health Systems
- Magellan Maricopa Collaborative
- Veteran's Administration

ONE NETWORK

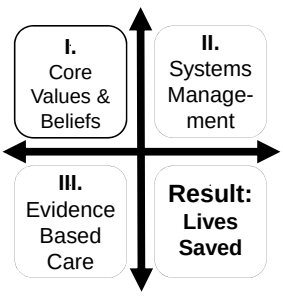
- National Suicide Prevention Lifeline

Lessons Learned

Shift in Perspective from:	To:
Accepting suicide as inevitable	Every suicide is preventable
Stand alone training and tools	Overall systems and culture change
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification and interventions
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care
"If we can save one life…"	"How many deaths are acceptable?"

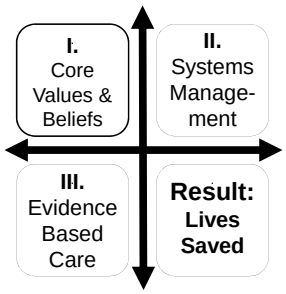


Systems of Care Framework



- High Reliability – Aviation goal zero commercial crashes
  - Don't train only the pilots; instead, all procedures & systems target success
- Health Systems – Eliminate:
  - Wrong-site, patient surgery
  - Inpatient falls
  - Medication errors
- Crossing the Quality Chasm

I. Core Values & Beliefs



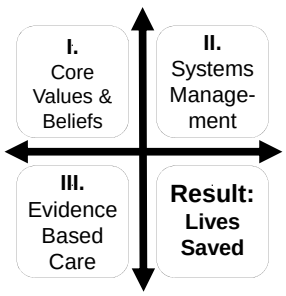
- Current science: Suicide is preventable
  - Those who die by suicide have intense ambivalence
  - Caring saves lives
- Last decade:
  - Increased research on effective interventions
  - Development of standardized risk assessments & standards
  - Systems successes

Core Values

BELIEFS AND ATTITUDES – FOUNDATION FOR ELIMINATING SUICIDE DEATHS AND ATTEMPTS

- Leadership leading to cultural transformation
- Continuity of care and shared service responsibility
- Immediate access to care for all persons in suicidal crisis
- Productive interactions between persons at risk and persons providing care
- Evaluate performance and use for quality improvement

II. Systems Management



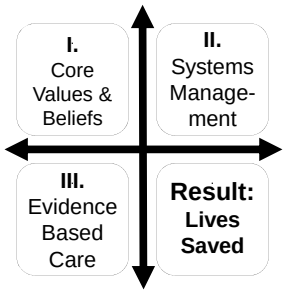
- Robust Performance Improvement
  - Workforce Development
  - Standardized Clinical Care
    - ✓ Screening & Assessment
    - ✓ Stratification of Risk
    - ✓ Regimen of Key Interventions
      - o Access to Care
      - o Means Restriction
      - o Follow-up
  - Transparent Reporting & Feedback Loops, Commitment to Improvement

Systems Management

IMPLEMENTATION AND ACTION FOR CARE EXCELLENCE

- Specific written policies and procedures; all staff trained on how to employ with scheduled refreshers
- Collaboration and communication; direct and open communications with persons at risk; timely and effective communication with all personnel collaborating in person's care
- Trained and skilled work force; public and behavioral health orgs should assure all staff working with persons at risk are appropriately trained/skilled

III. Evidence Based Clinical Care



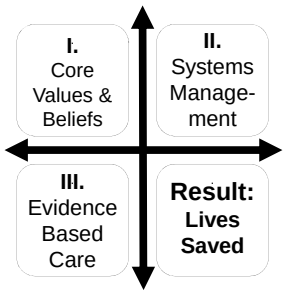
- "Productive Interactions" – Therapeutic relationships based on engagement and collaboration
- Treat suicide risk directly (not just underlying diagnosis)
- Evidence based care
- Involuntary hospitalization is minimized, considered a safety measure and possible sign of community care defects

Evidence Based Clinical Care

COMPREHENSIVE QUALITY CARE TO SAVE LIVES

- Screening and suicide risk assessments; universal screening for risk should be routine in healthcare settings
- Intervening to increase coping to ensure safety
- Treating and caring for persons at-risk of suicide
- Follow Up; persons with suicidal risk leaving intervention and care settings should receive follow-up contact from provider or caregiver

Accountability for Results: Lives Saved



- Timely public reporting of suicide deaths
  - Measure & Report
  - Feedback Loop

Air Force 1996 - 2002

- "When the Air Force launched its first suicide-prevention program, there was a lot of debate about whether or not it was even possible to reduce suicide through this type of an effort. A lot of people, including mental health practitioners, were skeptical. But over a six-year period, the suicide rate dropped by one-third."

  David Litts, Retired Air Force Colonel
  Suicide Prevention Resource Center

Air Force 1996 - 2002

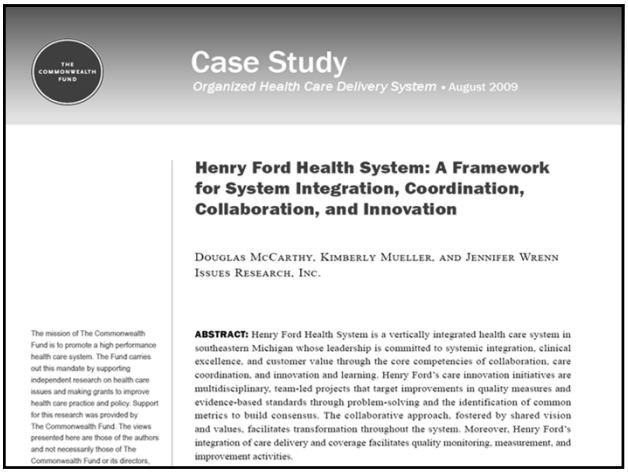
CULTURE CHANGE FOCUS

- Strong commitment from top leadership demonstrated through consistent and effective communication;
- Skills and information training on suicide intervention for all Air Force members, varying in intensity based upon rank and level of responsibility;

Air Force 1996 - 2002

CULTURE CHANGE FOCUS

- Creating the first privileged communication for suicidal personnel who are under investigation; and
- Encouraging the responsibility of all Air Force members to care for one another — "buddy care."



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.

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors,

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.

Henry Ford Health System

HFHS BEHAVIORAL HEALTH SERVICES HMO
POSITIVE OUTCOMES

- Suicide rate decreased by 75% in four years.
- Not a single reported suicide death among enrolled for 10 consecutive quarters

EB Clinical Care Practice: Case Examples

- *Henry Ford Health System*
  - Improved access to immediate care
    - Drop-in group medication appointments
    - Advanced same-day access to care
    - Email "visits"
  - Planned care model
    - Risk stratification into 3 levels with associated interventions: emphasis on means
    - Established and maintained clinician competency in Cognitive Behavioral Therapy (CBT)

Henry Ford Health System

KEYS TO PROGRAM SUCCESS

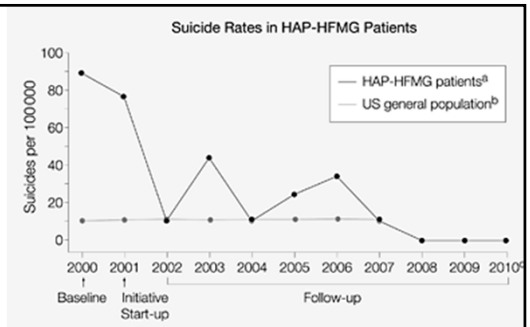
- Partnership with patients through advisory council for design of the program and increased partnership throughout treatment planning and care process;
- Planned care model, including stratification of risk into three levels with accompanying interventions, including emphasis on means restriction;

Henry Ford Health System

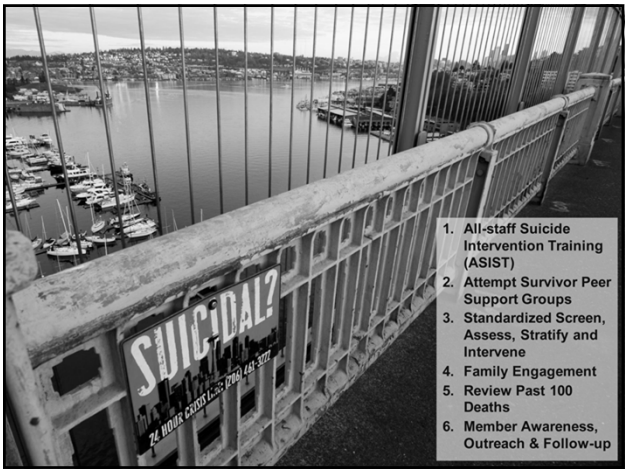
KEYS TO PROGRAM SUCCESS

- Established and maintained all clinician competency and training in Cognitive Behavioral Therapy (CBT);
- Robust performance improvement techniques; and
- Improved access to immediate care for patients, including drop-in group medication appointments, advanced same day access to care and e-mail "visits."

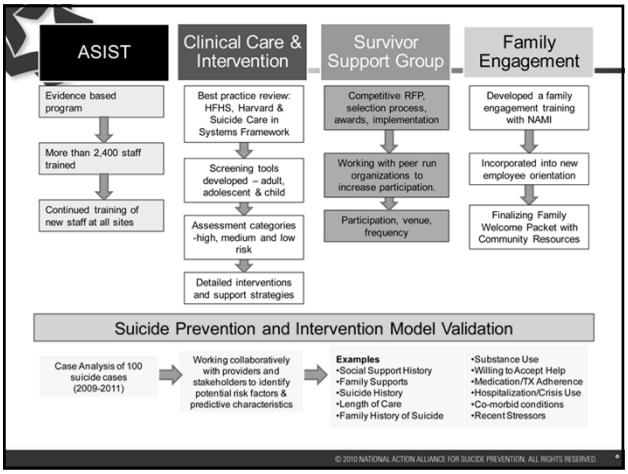
Henry Ford Health System



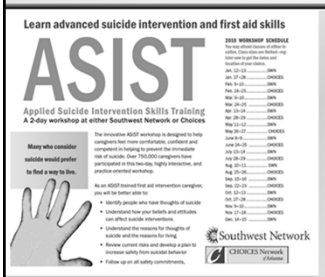
[a]Health Alliance Plan (HAP) health maintenance organization members receiving care from the Henry Ford Medical Group (HFMG). Data source: C. Edward Coffey, MD/Henry Ford Health System.
[b]Data sources: Heron MP et al. Deaths: final data for 2006. *Natl Vital Stat Rep*. 2009;57(14):30 Xu J et al. Preliminary data for 2007. *Natl Vital Stat Rep*. 2009;58(1):20.
[c]Includes first quarter of 2010.



1. **All-staff Suicide Intervention Training (ASIST)**
2. **Attempt Survivor Peer Support Groups**
3. **Standardized Screen, Assess, Stratify and Intervene**
4. **Family Engagement**
5. **Review Past 100 Deaths**
6. **Member Awareness, Outreach & Follow-up**



ASIST suicide intervention training is changing the culture of community behavioral healthcare



Staff who have completed the ASIST training "completely agree" that they have the training, skills and supports to engage and support those at risk of suicide at significantly higher rates.

Workforce Survey	2009 AZ	2010 GA	2010 AZ	'10 vs. '09 Δ	'10 vs. GA Δ
Sample	1,630	1,550	665		
Training	14%	10%	41%	↑ 187%	↑ 289%
Skills	15%	10%	34%	↑ 131%	↑ 247%
Supports	18%	14%	35%	↑ 97%	↑ 151%

Above: Comparison of the 2009 Maricopa County and 2010 Georgia statewide with the 2010 Maricopa County ASIST trained respondents shows significant increases in "completely agree" responses.

38% of the Maricopa behavioral health workforce reports someone in their care has died by suicide (19% more than once)

Outcomes: Recipients, Workforce & Public Stewards

In 2011, Magellan is launching suicide attempt survivor peer supports groups

In an early Maricopa suicide task force meeting, Katie Ayotte revealed that she had recently made a suicide attempt. The group was riveted as Katie explained how her peers, clinical team, family and community engaged her on a deep personal level around this attempt. Over the past 18 months, Katie has translated this experience into becoming a national leader in stigma reduction and peer empowerment. She strongly believes in repealing the "don't ask, don't tell" shadows and darkness that surround the subject of suicide. She has told her story publically with the same frank and open manner that one would talk about diabetes or heart disease. Katie will be part of the implementation of Attempt Survivor Support groups in 2011.

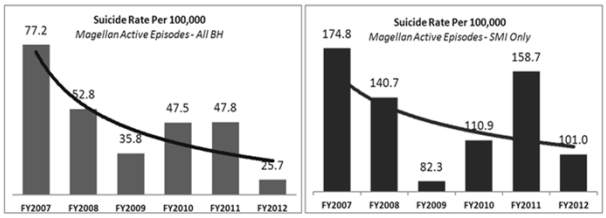
- **Peer Designed**
- **Peer Facilitated**
- **Peer Directed**

"The only documented effective intervention for suicide prevention is caring."

Dr. Thomas Joiner
Why People Die by Suicide

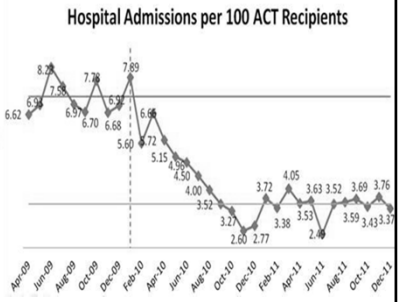
Reduction in Suicide Rates

	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	Reduction
SMI	174.8	140.7	82.3	110.9	158.7	101.0	42%
Child	5.4	10.6	0.0	4.3	6.1	0.0	100%
GMH/SA	58.1	25.0	32.4	37.8	30.8	12.7	78%
Total BH	77.2	52.8	35.8	47.5	47.8	25.7	67%



Saving Lives Saves Money: Case Examples

In the December 2010 "Policy for Helping Callers at Imminent Risk," SAMHSA emphasizes the need to reduce unnecessary hospitalizations and "active rescues" through stronger engagement, collaboration and follow-up.



VISN 7 Suicide Risk Reduction Process Improvement Project

EVIDENCE-BASED SUICIDE TREATMENTS/INTERVENTION

- Limited evidence of the overall efficaciousness of pharmacotherapy-only treatment for suicidal risk;
- Limited evidence to support the widespread use of inpatient psychiatric hospitalization for suicidal patients;
- Follow-up interventions and case management treatment have demonstrated a significant impact on reducing suicide behaviors including deaths;

VISN 7 Suicide Risk Reduction Process Improvement Project

EVIDENCE-BASED SUICIDE TREATMENTS/INTERVENTION

- To date, certain coping oriented psychotherapies have the most research support for effectively treating suicidal risk. In particular, the research supports highly-structured, problem solving approaches.

VISN 7 Suicide Risk Reduction Process Improvement Project

EVIDENCE-BASED SUICIDE TREATMENTS/INTERVENTION

- Dialectical Behavior Therapy – most thoroughly studied and efficacious psychotherapy for suicidal behavior
- Cognitive Therapy – the next most studied and supported suicide-relevant psychotherapy
- Other Promising Interventions – The authors cited two other interventions that exhibit strong correlational support and are now being studied in randomized clinical trials – Safety Planning Intervention and Collaborative Assessment and Management of Suicidality (CAMS)

VISN 7 Suicide Risk Reduction Process Improvement Project

EVIDENCE-BASED SUICIDE TREATMENTS/INTERVENTION

- Dialectical Behavior Therapy – most thoroughly studied and efficacious psychotherapy for suicidal behavior
- Cognitive Therapy – the next most studied and supported suicide-relevant psychotherapy
- Other Promising Interventions – The authors cited two other interventions that exhibit strong correlational support and are now being studied in randomized clinical trials – Safety Planning Intervention and Collaborative Assessment and Management of Suicidality (CAMS)

National Suicide Prevention Lifeline
Veterans Crisis Line

National Suicide Prevention Lifeline
2005 - present

PROMISING PARTNERS IN CRISIS CARE

- Prior to 2000, many in the suicide prevention field doubted effectiveness of crisis call centers; little research or data to evidence positive outcomes and few national standards of practice.
- In 2004, SAMHSA awarded the Mental Health Association of New York City (through a subsidiary Link2Health) the contract to manage the National Suicide Prevention Lifeline, a network of over 150 crisis agencies across the country.

National Suicide Prevention Lifeline
2005 - present

PROMISING PARTNERS IN CRISIS CARE

- In 2005, SAMHSA released a series of findings from independent evaluators of Lifeline member crisis centers, demonstrating that these crisis centers were effective in reducing emotional distress among crisis callers and significantly reducing suicidality among suicidal callers.
- In past 6 years, dramatic increase in capacity and calls to 1-800-273-TALK
- Implemented a Veteran's hotline through a partnership with the VA, and added chat technology to augment the telephonic interface.
- Introduced best practice standards utilized across the network:
  - 2007 publication of the SAMHSA Suicide Risk Assessment Standards;
  - 2011 publication of the SAMHSA Policies and Guidelines for Helping Callers at Imminent Risk of Suicide

National Suicide Prevention Lifeline
2005 - present

GUIDELINES FOR HELPING CALLERS AT IMMINENT RISK OF SUICIDE

- Active Engagement
- Least Invasive Intervention
- Initiation of Life-Saving Services for Attempts in Progress
- Active Rescue
- Third Party Callers
- Supervisory Consultation
- Caller I.D
- Confirmation of Emergency Services Contact
- Procedures for Follow-Up when Emergency Services Contact is Unsuccessful

International Support for a Systems Approach

THE LANCET

Implementation of 9 mental health service recommendations in England and Wales and suicide rates, 1997—2006: a cross-sectional and before-and-after observational study.
While et al (February 2, 2012)

www.lancet.com

1. **Inpatient psych unit safety**
2. **Assertive outreach team**
3. **24/7 crisis team**
4. **7 day follow-up**
5. **Written policy on non-adherence**
6. **Dual diagnosis treatment**
7. **Criminal justice sharing**
8. **Debriefing and family contact after suicide.**
9. **Front-line clinical staff trained in management of suicide risk at least every 3 years.**

International Support for a Systems Approach

- ***"Services that had implemented seven to nine recommendations had a significantly lower suicide rate than those implementing fewer"***
- Powerful impact of a comprehensive approach
  - P< .005
  - Suicide death rate 17% lower under comprehensive approaches (in U.S. equates to 6,000 lives)
- Some recommendations appear most significant: having a 24 hour crisis team, having a dual diagnosis policy, and post suicide multidisciplinary review

Why Strive for Suicide as a "Never Event" in KY?

- KY fell from 10th highest suicide rate in the nation in 2007 to 23rd highest in 2009, but stays consistently in top 25%
- 25 to 30% of Kentuckians who die by suicide were clients of our CMHCs within year of their deaths

SUMMARY BY STATE FISCAL YEAR Of all CMHC Clients Served:	State Fiscal Year (SFY)					Average per SFY	N
	2007	2008	2009	2010	2011 ^		
Total number of CMHC clients who died of suicide during the year or the year after they received CMHC services	169	183	162	187	132	**167**	**833**
Percentage of CMHC clients served who died of suicide during the year or the year after they received CMHC services	0.09%	0.09%	0.08%	0.09%	0.06%	**0.08%**	

- Suicides determined by linking CMHC clients to Ky. mortality data obtained from Vital Statistics.
- 2011 includes partial year (~10 months) at the printing of this report.

What Actions To Achieve The Vision in Kentucky?

- System of Care – partnering with secondary schools
- Mandatory training of school staff, students (2010)
- Promotion of evidence-based student programs, policies and procedures
- Increased post-secondary efforts
- Kentucky's youth and young adult suicide rate dropped from 15th highest (above the national average) in the nation to 37th in 2010, significantly below national average.

What Actions To Achieve The Vision in Kentucky?

- Behavioral Workforce Survey participation
- Follow recommendations of Action Alliance Clinical Care and Intervention Task Force
  - Promote "Suicide Care in Systems Framework" Report and Recommendations
  - Find Innovator/Early Adopter Systems and Leaders who will Implement a Systems Approach and Commit to Working Toward Zero Suicide for Their Members

NOT ANOTHER LIFE TO LOSE:
Behavioral Healthcare Workforce Suicide Prevention Survey

Page: Training, Skills & Support

1. I have received the TRAINING I need to engage and assist those with suicidal desire and/or intent.

answered question	2,672
skipped question	70

Around 48% didn't know or disagreed that they had received the training they needed to engage and assist those with suicidal desire and/or intent.

	Response Percent	Response Count
Completely agree	11.8%	314
Agree	**41.0%**	**1,095**
Don't know	8.5%	228
Disagree	31.0%	829
Completely disagree	7.7%	206

Self-assessment

NOT ANOTHER LIFE TO LOSE:
Behavioral Healthcare Workforce Suicide Prevention Survey

2. I have the SKILLS I need to engage those with suicidal desire and/or intent.

answered question	2,675
skipped question	67

Around 43% didn't know or disagreed that they had the skills they needed to engage those with suicidal desire and/or intent.

	Response Percent	Response Count
Completely agree	11.8%	315
Agree	**45.6%**	**1,219**
Don't know	11.9%	318
Disagree	25.3%	678
Completely disagree	5.4%	145

Self-assessment

NOT ANOTHER LIFE TO LOSE:
Behavioral Healthcare Workforce Suicide Prevention Survey

3. I have the SUPPORT/SUPERVISION I need to engage and assist those with suicidal desire and/or intent.

answered question	2,674
skipped question	68

Nearly 31% didn't know or disagreed that they had the SUPPORT/SUPERVISION THEY needed to engage and assist those with suicidal desire and/or intent.

	Response Percent	Response Count
Completely agree	16.9%	452
Agree	**52.4%**	**1,401**
Don't know	9.8%	262
Disagree	16.6%	443
Completely disagree	4.3%	116

Self-assessment

Excellence in Suicide Prevention: "Suicide Care in Systems Framework" Administrative Readiness Assessment

Frequently Asked Questions

How Will We Know that We Have Achieved Clinical Excellence in Suicide Prevention?

Group Activity

Break into small groups with various systems of care being represented in each group. Each group will use the SWOT format to address different aspects of the Suicide Care in Systems Framework model . For each of the following tenets, small groups will review related assessment questions, and determine strengths, weaknesses, opportunities and threats. Small groups will present their SWOT analysis for each tenet to the entire group.

- ***Core Values***
- ***Systems Management***
- ***Evidence-based Clinical Care***

Who Else Needs to Be at the Table?

Next Steps

Jan Ulrich
State Suicide Prevention Coordinator
Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities
Phone (502) 564-4456
jan.ulrich@ky.gov

"Suicide in Systems Care Framework Report"
www.actionallianceforsuicideprevention.org/sitesactionallianceforsuicideprevention.org/files/taskforces/ClinicalCareInterventionReport.pdf

Healthcare provider resources: www.sprc.org/for-providers/