ZERO SUICIDE

in Health and Behavioral Health Care
PLANNING & IMPLEMENTATION

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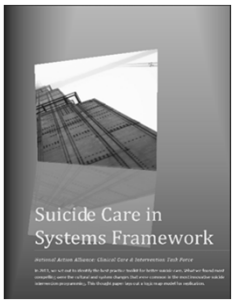
OVERVIEW OF PRESENTATION

- Zero Suicide history and overview
- 3 critical factors for success
- 7 essential dimensions of Zero Suicide
- National collaborative(s)
- Zero Suicide Missouri initiatives

A CULTURE OF SAFETY

- Crossing the Quality Chasm
- Patient safety laws & organizations
- Applying patient safety to behavioral health

CLINICAL CARE & INTERVENTION TASK FORCE



SUCCESSFUL OUTCOMES

- Air Force Suicide Prevention Program (report 2001)
- Henry Ford Health System "Perfect Depression Care" (2001-present)
- National Suicide Prevention Lifeline "Suicide Risk Assessment Standards" (2007-present)
- Central Arizona Programmatic Suicide Deterrent System Project (2009-present)

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

CRITICAL FACTORS

- Core Values
  - Beliefs and Attitudes – The foundation for eliminating suicide deaths and attempts
- Systems Management
  - Implementation and action for care excellence
- Evidence-Based Clinical Care Practice
  - Comprehensive quality care to save lives

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

WHAT IS ZERO SUICIDE?

- A framework for systematic, clinical suicide prevention in behavioral health and healthcare systems.
  - Leadership driven
  - Culture of safety
- A set of best practices and tools including: www.zerosuicide.com.

National Action Alliance for Suicide Prevention

A SHIFT IN PERSPECTIVE

FROM	TO
Accepting suicide as inevitable	Every suicide in a system is preventable
Assigning blame	Nuanced understanding: ambivalence, resilience, recovery
Risk assessment and containment	Collaborative safety, treatment and recovery
Stand-alone training and tools	Overall systems and culture changes
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 lives are acceptable?"
Zero Suicide Academy, 2014	

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION: Goals & Objectives

- A priority of the National Action Alliance for Suicide Prevention.
  - Embedded in the *National Strategy for Suicide Prevention.*
    - *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.*

National Action Alliance for Suicide Prevention. (2010). *National Strategy for Suicide Prevention.*.

THE JOINT COMMISSION BEHAVIORAL HEALTH CARE: 2015 Natl. Patient Safety Goals

- NPSG.15: Identify patients at risk for suicide.

The Joint Commission (2015). *Behavioral health care: 2015 national patient safety goals*. Retrieved from http://www.jointcommission.org/assets/1/6/2015_BHC_NPSG_ER.pdf

CRITICAL FACTORS

- Core Values
- Systems Management
- Evidence-Based Clinical Care Practice

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

CORE VALUES
Beliefs & Attitudes

- 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

National Action Alliance : Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

CORE VALUES: Leadership Leading to Cultural Transformation

- Leadership commits to suicide safe care
- Staff informed
- Processes embedded in other initiatives

National Action Alliance : Clinical Care & Intervention Task Force . (2011). *Suicide Care in Systems Framework.*

CORE VALUES: Continuity of Care & Shared Service Responsibility

- Address suicide risk directly (not just as a symptom)
- Requires team approach and crosses treatment environments
- Levels of care link to others (i.e., hospital discharge plans
- Everyone accepts service responsibility

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

CORE VALUES: Immediate Access to Care for All Persons in Suicidal Crisis

- Pathways to care
  - Community vs. hospitalization
  - Collaborative safety planning

National Action Alliance: Clinical Care & Intervention Task Force . (2011). *Suicide Care in Systems Framework.*

CORE VALUES: Productive Interactions

- Caring, competent staff
- No niche staff
- Collaboration
- Connectedness

National Action Alliance : Clinical Care & Intervention Task Force . (2011). *Suicide Care in Systems Framework.*

CORE VALUES: Evaluate Performance and Use for Quality Improvement

- Root Cause Analysis
- Mortality Review
- Psychological Autopsy

National Action Alliance: Clinical Care & Intervention Task Force.(2011). *Suicide Care in Systems Framework.*

SYSTEMS MANAGEMENT Implementation & Action for Care Excellence

- Policies and procedures
- Collaboration and communication
- Trained and skilled work force

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

SYSTEMS MANAGEMENT: Policies And Procedures

- Embed in P&P's
  - Focus on detection of suicide risk
  - Focus on response
  - Inform staff

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

SYSTEMS MANAGEMENT: Collaboration & Communication

- Persons at risk
- Involved staff

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

SYSTEMS MANAGEMENT: Trained & Skilled Work Force

- Workforce survey
- Training

WORKFORCE SURVEY

- Administer to all staff
- Use in planning
  - Staff training
  - Policies & procedures

Zero Suicide Academy, 2014

SUICIDE FACTS

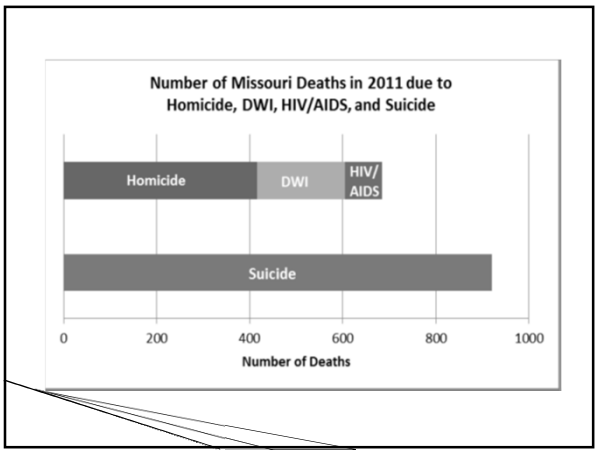
- National
  - 10th leading cause of death in the U.S.
  - Twice as many suicides per year than homicide
  - Between 2001 – 2009, someone died from suicide every 15 minutes (33,000 per year)
  - In 2011
    - 8 million adults thought about suicide
    - 2.5 million had a plan
    - 1.1 million had an attempt

2012 National Strategy for Suicide Prevention

SUICIDE FACTS IN MISSOURI

- Missouri
  - In 2011, there were twice as many suicides per year than homicide (921 v. 416)
  - Suicide was the 3rd leading cause of death for ages 15-24
  - More Missourians died from suicide than DUI accidents, homicide and AIDS combined
  - Ranks 22nd (2010) – rate of 14.29 per 100,000

Missouri Institute of Mental Health (MIMH)

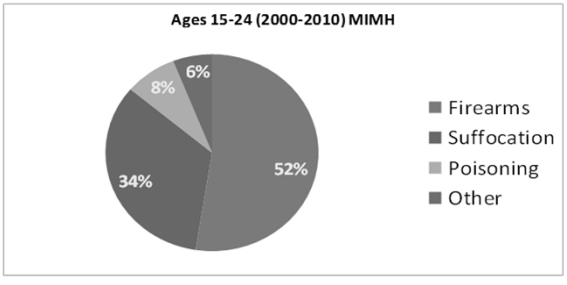


LETHAL MEANS

- Firearms is primary in MO
  - Adults – poisoning
  - Ages 15-24 - suffocation
- Other methods
  - Suffocation
  - Poisoning
  - Other

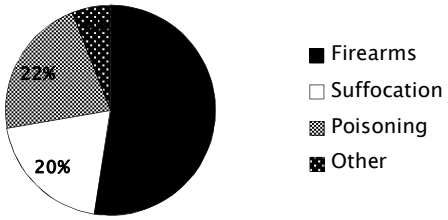
Missouri Institute of Mental Health (MIMH)

MO Lethal Means MIMH



MO Lethal Means (MIMH)

Ages 25-64 (2000-2010) MIMH



MO Lethal Means (MIMH)

- Firearms
  - Pistols, rifles and shotguns
- Suffocation
  - Hanging and asphyxiation
- Poisoning
  - Drug overdose
- Other
  - Jumping, cutting, drowning and unspecified

Missouri Institute of Mental Health (MIMH)

EVIDENCE-BASED CLINICAL CARE PRACTICE
Comprehensive Quality Care to Save Lives

- Screening and suicide risk assessment
- Intervening to increase coping to ensure safety
- Treating and caring for persons at-risk of suicide
- Follow Up

National Action Alliance: Clinical Care & Intervention Task Force. (2011). Suicide Care in Systems Framework.

EVIDENCE-BASED CLINICAL CARE PRACTICE: Screening for Suicide Risk

- Universal risk screen
  - Intake
  - Transitions
  - Discharge
  - Crisis

Zero Suicide Academy Manual Section 4

EVIDENCE-BASED CLINICAL CARE PRACTICE: Suicide Risk Assessment

- Suicidal desire
- Suicidal capability
- Suicidal intent
- Buffers/connectedness

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

SUICIDE RISK SCREENING & ASSESSMENT: Examples

- Patient Health Questionnaire 9 (PHQ-9)
- Patient Health Questionnaire 2 (PHQ-2)
- Question, Persuade, Refer and Treat (QPR-T)
- Columbia Suicide Severity Rating Scale (C-SSRS)
- Beck Scale for Suicide (BSS)
- National Suicide Prevention Lifeline Risk Assessment Standards

National Action Alliance: Clinical Care & Intervention Task Force. (2011). Suicide Care in Systems Framework.

EVIDENCE-BASED CLINICAL CARE PRACTICE: Intervening to Increase Coping to Ensure Safety

- Collaborative safety planning
- Restriction of lethal means
- Effective treatment of suicidality

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

COLLABORATIVE SAFETY PLANNING

- Not a No-Suicide Contract
- Safety Planning Intervention (SPI)
  - Recognize warning signs
  - Predetermined coping strategies
  - Social contacts as distractions
  - Contact family or friends
  - Contact Behavioral Health professionals
  - Reduce access to lethal means

Suicide Care in Systems Framework: National Action Alliance Clinical Care and Intervention Task Force

RESTRICTION OF LETHAL MEANS

- Collaborate with individual
- Engage family for assistance

Zero Suicide Academy Manual Section 7

EFFECTIVE TREATMENT OF SUICIDALITY

- Cognitive-Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Collaborative Assessment and Management of Suicidality (CAMS)

http://zerosuicide.actionallianceforsuicideprevention.org/using-effective-evidence-based-care

EVIDENCE-BASED CLINICAL CARE PRACTICE: Treating & Caring for Persons at-risk Of Suicide

- Increase coping to reduce risk
  - Safety planning
  - Problem solving
  - Collaborative treatment
  - Interventions outside or after the clinical visit

http://zerosuicide.actionallianceforsuicideprevention.org/using-effective-evidence-based-care

EVIDENCE-BASED CLINICAL CARE PRACTICE: Follow Up

- After a visit to a behavioral health outpatient setting or primary care, for anyone at risk
- Between services for those with scheduled care and to engage those not actively engaged in care
- After discharge from acute care settings

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

ZERO SUICIDE MODEL

http://zerosuicide.sprc.org/

ESSENTIAL DIMENSIONS

- Creating a leadership, safety oriented culture that commits to dramatically reducing suicide among people under care and includes suicide attempt and loss survivors in leadership and planning roles.
- Systematically identifying and assessing suicide risk levels among people at risk.
- Ensuring every person has a pathway to care that is both timely and adequate to meet their needs.
- Developing a competent, confident, and caring workforce.

http://zerosuicide.sprc.org/

ESSENTIAL DIMENSIONS

- Using effective, evidence-based care, including collaborative safety planning, restriction of lethal means, and effective treatment of suicidality.
- Continuing contact and support, especially after acute care.
- Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

http://zerosuicide.sprc.org/

WHAT IS ZERO SUICIDE IN MO?

- National collaborative
  - Zero Suicide Academy
  - Breakthrough Series
    - Pilot in SW MO
- Planning & Implementation Team
  - Advance in Community Behavioral Health organizations, Primary Care and Emergency Departments
  - State operated psychiatric facilities

ZERO SUICIDE NATIONAL COLLABORATIVE

The purpose of the Zero Suicide National Collaborative is to advance the 2012 National Strategy for Suicide Prevention: Goals and Objectives; 8 & 9, through the implementation of the Zero Suicide approach.

ZERO SUICIDE ACADEMY

ZERO SUICIDE BREAKTHROUGH SERIES

- Purpose
  - Advance implementation of Zero Suicide approach & facilitate successful improvements in suicide care (SW MO Pilot)
    - Learn what state-level actions support implementation; and
    - What provider-level actions

STAKEHOLDER PLANNING & IMPLEMENTATION TEAM

- The purpose of the Stakeholder team is to implement the Zero Suicide approach in state operated facilities (DMH); and
- To engage community contracted providers in the Zero Suicide approach.

GETTING STARTED: Creating a Zero Suicide Culture

- Bring together leaders and champions to plan an approach to Zero Suicide for your organization
- Conduct an Organizational Assessment to determine the organization's level of readiness
- Implement a Root Cause Analysis for all suicide deaths and attempts for the past year and going forward

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

GETTING STARTED: Ensure Every Person Has a Pathway to Care

- Research protocols and pathways to care for patients who might be thinking about suicide
  - Starting with Magellan's Clinical Decision Support Tools
- Develop your organization's Pathways to Care, and train all staff to follow the protocol

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

GETTING STARTED: Developing a Competent Workforce

- Conduct a survey to determine staff's knowledge, ability, and confidence to work effectively with suicidal patients
- Use survey results, engage clinical and/or training director in plans for training both clinical and non-clinical staff

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

GETTING STARTED: Identifying and Assessing Suicide Risk Level

- Develop protocols for screening and assessment and pilot test them
- Ensure that training for clinical staff includes content in risk formulation
- Continue Root Cause Analysis for all suicide deaths and attempts

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

GETTING STARTED: Using Effective, Evidence-based Care

- Start a conversation with clinical staff leaders and champions about hospitalization as a last resort for patients with suicidal thoughts
- Train staff in problem-solving therapies and techniques that engage the patient in collaborative treatment

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

GETTING STARTED: Continuing Contact After Care

- Ensure follow-up contact after a patient is discharged, even from outpatient care
- Start a peer support group for those who have attempted suicide
- Engage local crisis centers, especially centers affiliated with the National Suicide Prevention Lifeline, in making follow-up contact

http://zerosuicide.actionallianceforsuicideprevention.org/creating-zero-suicide-culture

THE POWER OF ZERO

"When you design for zero, you surface different ideas and approaches that if you're only designing for 90 percent, may not materialize. It's about purposefully aiming for a higher level of performance."

-Thomas M. Priselac
-Cedars-Sinai Medical Center

RESOURCES

- Suicide Prevention Resource Center
http://www.sprc.org/
http://zerosuicide.sprc.org/

- Zero Suicide
http://zerosuicide.org/

RECOMMENDED READING

National Action Alliance: Clinical Care & Intervention Task Force. (2011). *Suicide Care in Systems Framework.*

Jobes, D.A., Rudd, M.D., Overholser, J.C. & Joiner, T.E. (2008). *Ethical and competent care of suicidal patients: Contemporary challenges, new developments, and considerations for clinical practice*. Professional Psychology: Research and Practice, 39(4) pp. 405-413.

Joiner, T., et.al. *Establishing Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline*. Suicide and Life Threatening Behavior: 37 (3). June 2007.

Stanley, B. & Brown, G.K. (2012). *Safety planning intervention: A brief intervention to mitigate suicide risk*. Cognitive and Behavioral Practice: 19, pp. 256-264.

RECOMMENDED READING

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Jobes, D.A. (2012). *The collaborative assessment and management of suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk*. Suicide and Life Threatening Behavior. 42(6), pp. 640-653.

Luxton, D.D., June, J.D., Comtois, K.A. (2013). *Can post discharge follow-up contacts prevent suicide and suicidal behavior?* Crisis. 34(1), pp. 32-41