Exploring the Impact of Suicide Prevention Research in Health Care Settings

Moderator: Yeates Conwell, M.D.
Meeting Orientation

- Audio is streaming through your computer speakers. If you cannot listen through computer speakers, call 855-257-8350
- Type any technical questions or questions for the presenters into the Q&A box on the left.
- This meeting will be recorded and archived.
Suicide Prevention Research in Health Care Settings

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Henry Ford Health System

ICRC-S Webinar Series
“Exploring the Impact of Suicide Prevention Research in Multiple Settings”
February 11, 2015
Background / Significance

- Suicide is the 10th leading CoD in the US.
  - #1 cause of injury-related death.
  - >38,000 people die of suicide each year.

- US suicide rates have not improved over time.
  - Adult rates have risen ~30% since 1999.

- Healthcare systems may be key to identification, prevention, and intervention.
Proposed Overall Model

Need for care for suicide risk

Accurate assessment and identification

All care providers able to assess and manage suicidal patients or refer

Effective interventions with multiple access points to care:
in-person, telephonic, video, Interactive web

Entry into stepped care

Care management
Across all services settings:
Engagement strategies
Care coordination
Risk monitoring
Continued stepped care
Mental health services

Reduced suicide attempts/deaths

Ahmedani & Vannoy, 2014
Prevention Approaches

- Universal
  - Low-intensity approaches delivered broadly (e.g., screening in primary care).

- Selective
  - Moderate to High intensity approaches delivered to individuals at increased risk (e.g., individuals with mental health conditions, previous suicide attempts).
Assessment & Identification

- **Screening**
  - PHQ-9 depression/suicide screening.
    - Now implemented across many healthcare systems.
    - Response to item 9 predicts suicide attempts.
  - Other suicide screening measures (C-SSRS, SAFE-T, SBQ-R).
  - False positives; Burdensome for some providers.

- **Risk Factors / EMR algorithms**
  - Mental health/substance use diagnoses; Prior attempt.
  - What else????

- **Universal Outreach**
  - Could be expensive; Increased volume.
Risk of suicide attempt by response to PHQ item 9

Health Care Visits Prior to Suicide

Any Visit
Any MH
IP MH
IP CD
IP Other
ED MH
ED CD
ED Other
PC MH
PC CD
PC Other
OP MH
OP Other
OP CD

Ahmedani, et al, 2014
Health System Models

- Collaborative Depression Care (Bruce, et al, 2004).
  - PROSPECT Trial; screening/elderly care management.
  - Reduction in frequency and intensity of suicide ideation.

- Mandated Coordinated Care (Gunnel, et al, 2012).
  - Decrease in suicide attempts in the UK.

- Health System Enhancements (While et al, 2012).
  - Removal of ligature points, outreach, 24 hour crisis line, 7-day follow-up, training, improved policies.
  - Reduction in suicide deaths in the UK.

- Mental Health Parity (Lang, 2013)
  - Reduction in rates of suicide; increased access.
Health System Models


  - Behavioral health patients; Chronic care model, multi-level suicide risk assessment, department culture change, zero suicide goal; Reduction in suicide death rates; Basis for US and UK national zero suicide goals.
Future Health System Models?

Pragmatic trial of population-based programs to prevent suicide attempt.

- Mental Health Research Network (MHRN).
- PI: Simon; UH3AT007755.

Outpatients responding “more than half the days” or “nearly every day” to PHQ item 9

- Usual Care
- Emotion Regulation Skills Training
- Risk Assessment / Care Management
Future Emergency Department Models?

ED-SAFE Trial
- UMASS / Massachusetts General Hospital.
- Screening, Assessment, Telephone Follow-up.
- PI: Boudreaux; U01MH088278.

ED-STARS Trial
- PECARN Network.
- Screening and triage for suicide risk among youth.
- PI: King; U01MH104311.
Promising Intervention Models

  - Current Feasibility Study assessing barriers/facilitators of means restriction after ED discharge (R21MH105827; PI: Runyan).


Barriers

- People who need care, don’t always seek care.
  - Beliefs about medical care.
  - Stigma.
  - Limited resources / access.
  - Do not recognize problem.
  - Limited training/knowledge among providers.
  - False positive detection.
Limitations of Current Research

- Most studies do not target (or measure) suicide behavior outcomes.
- Most studies conducted outside of US – within different healthcare environments.
- Most studies have small sample sizes with limited diversity in sample characteristics.
## Future Research

**Table 1**: Breakthroughs needed to enhance suicide prevention by improving health services access and engagement

1. Prioritization of suicide across all levels of care
2. Effective identification and assessment strategies
3. Comprehensive surveillance systems and outcome tracking
4. Large registries linking risk across systems and providers
5. Enhanced electronic medical records with real-time notification of risk
6. Care coordination within and between providers, departments, and systems
7. Effective interventions using existing and alternative approaches to care
8. Informed care pathways
9. Stepped care treatment approaches
10. Treatment engagement
Short-Term Research

- Epidemiologic/Observational studies to understand risk factors, assessment, monitoring within current system in US.

- Research testing existing mental health/substance use approaches tailored to directly test suicide outcomes via trials or carefully planned quasi-experimental designs.
Long-Term Research

- Healthcare service redesign.
- Healthcare reimbursement redesign.
- Technology-based approaches.
  - EMR, social media.
Mental Health Research Network: Suicide Prevention SIG

MHRN Suicide Prevention Scientific Interest Group
- All investigators are welcome.
- Monthly conference calls to discuss research opportunities.
  - Contact Brian Ahmedani: bahmeda1@hfhs.org.
- Targets Health Care Settings.
  - Identify risk factors of suicide behavior.
  - Develop health care risk algorithms.
  - Develop and Implement standardized suicide risk assessment.
  - Develop and test individual-, provider-, and system-level interventions for prevention of suicide behavior.
  - Identify effective services that reduce suicide.
References


Hampton T. Depression care effort brings dramatic drop in large HMO population’s suicide rate. JAMA 2010;303(19):1903–5.


Ursula Whiteside, PhD
#ZeroSuicide
@UrsulaWhiteside
www.NowMattersNow.org
WHAT IS ZERO SUICIDE?
What is Zero Suicide?

“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 Office of Mental Health
Zero Suicide is...

• Embedded in National Strategy for Suicide Prevention

• Error reduction and patient safety in healthcare

• Framework for systematic, clinical suicide prevention in behavioral health and healthcare systems

• Set of best practices and tools [www.zerosuicide.com](http://www.zerosuicide.com)
Zero Suicide in Health and Behavioral Health Care

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and also a specific set of tools and strategies. It is both a concept and a practice. Its core proposition is that suicide deaths for people under care are preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept.

The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff who do the demanding work of treating and supporting suicidal patients. Read more...

Zero Suicide Toolkit

The Clinical Care and Intervention Task Force of the National Action Alliance for Suicide Prevention identified essential dimensions of suicide prevention for health care systems, including health care plans or care organizations serving a defined population of consumers, such as behavioral health programs, integrated delivery systems, and comprehensive primary care programs. These dimensions are described in the Zero Suicide Toolkit.

New eLearning workshops available!

- Safety Planning Intervention for Suicide Prevention
- Assessment of Suicidal Risk Using C-SSRS

Made possible by the NY State Office of Mental Health and Columbia University.

If you are a behavioral healthcare practitioner in New York State working in a not-for-profit setting and would like a certificate of completion, please complete the training through the Center for Practice Innovations (CPI) Learning Community and choose “suicide prevention” from the topics.

Recorded Webinars

- The Emerging Zero Suicide Paradigm
  Watch Recording | View PowerPoint Slides
- Screening and Assessment for Suicide in Health Care Settings: A Patient-Centered Approach
  Watch Recording | View PowerPoint Slides
- Safety Planning and Means Reduction in Large Health Care Organizations
  Watch Recording | View Powerpoint Slides

ICRC-S

Creating the Zero Suicide Culture
Ensuring Every Person Has a Pathway to Care
Developing a Competent Workforce
Identifying and Assessing Suicide Risk Level
Using Effective, Evidence-based Care
Continuing Contact After Care
The Dimensions of Zero Suicide

Create a leadership-driven, safety-oriented culture

Pathway to Care
- Identify and assess risk
- Use effective, evidence-based care
- Continue contact and support

Electronic Health Record

Develop a competent, confident, and caring workforce

Continuous

Approach

Quality

Improvement
A Learning Healthcare System

Each patient care experience naturally reflects the best available evidence, and, in turn, adds seamlessly to learning what works best in different circumstances.

IOM Roundtable on Evidence-Based Medicine, 2008
In a Learning Healthcare System...

• All experience contributes to evidence
• Evidence is truly based in experience
• Learning happens continuously, in real time
• Clinical data = research data
Proportion of primary care antidepressant treatment episodes with PHQ9 recorded in EMR

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Proportion of specialty mental health visits with assessment (PHQ9/GAD2/Audit-C) in EMR

Compliance Rate of PHQ9 Documentation by Quarter

Central

Eastside

Olympia

Peninsula

Snohomish

Spokane

Tacoma

Department

Target = 80%

* All visits, including group, count toward this measure.
* Patients >= 12 years old.

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Does Response on the PHQ-9 Depression Questionnaire Predict Subsequent Suicide Attempt or Suicide Death?

Gregory E. Simon, M.D., M.P.H.
Carolyn M. Rutter, Ph.D.
Do Peterson, M.S.
Malia Oliver, B.A.
Ursula Whiteside, Ph.D.
Belinda Operskalski, M.P.H.
Evette J. Ludman, Ph.D.

Does Response on the PHQ-9 Depression Questionnaire predict subsequent suicide attempt or suicide death? *Psychiatric Services*, 64, 1195-1202. PMID: 24036589 (2013)
Data drive integration of research and practice

Response to PHQ item 9 predicts suicide risk

Change in practice
• Standard risk assessment and follow-up tools

Continuous improvement
• Monitoring adherence to standard work

Population-based research
• Risk prediction
• Population-based prevention
Practice support: Standard tools and processes for risk assessment and follow-up care

Structured assessment required if PHQ item 9 score <=2

Risk-specific follow-up protocol:

- Low: Routine follow-up
- Moderate: Create crisis plan
- High: Create crisis plan, refer to acute-care coordination path
- Severe: Consider hospitalization
# Quality improvement: Monitoring and feedback regarding adherence to standard work

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Use of PHQ9 across four health systems

- Group Health
- HealthPartners
- KP Colorado
- KP So Cal

Data for years 2007 to 2012.
Intervention Research: Pragmatic trial of population-based selective prevention programs (Greg Simon Uh3 funded by NIH Collaboratory)

Outpatients responding “more than half the days” or “nearly every day” to PHQ item 9

- Usual Care
- Emotion Regulation Skills Training (NowMattersNow.org is DBT Skills)
- Risk Assessment / Care Management
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

join us
mindfulness

opposite action

suicidal thoughts
Now Matters Now
Team Now
Matters Now
Designing Messaging to Engage Patients in an Online Suicide Prevention Intervention: Survey Results From Patients With Current Suicidal Ideation

Ursula Whiteside, PhD; Anita Lungu, PhD; Julie Richards, MPH; Gregory E Simon, MD, MPH; Sarah Clingan, BA; Jaeden Siler, AA; Lorilei Snyder; Evette Ludman, PhD

Group Health Research Institute, Seattle, WA, United States

Designing Messaging to Engage Patients in an Online Suicide Prevention Intervention: Survey Results from Patients with Current Suicidal Ideation. Journal of Medical Internet Research, 6(2):e42. doi:10.2196/jmir.3173 (2014)
Pragmatic Interventions

We need interventions that can augment existing care and are financially feasible

• Emotion Regulation Skills Training
  (NowMattersNow.org is DBT Skills)
• Online Cognitive Behavior Therapy
Just beginning to scratch the surface

- Most of our research is focused on those already known to be at risk
- Most of those who die are not known to be suicidal or at risk for suicide…
Zero Suicides in Health Care: Targeting Pathways to Suicide and Suicide Attempt

Dr. Ursula Whiteside

HealthCare System Population

Enrolled Consumers

Not Enrolled

Seeing PC and/or BHS Provider

Not Seeing PCP

Receiving PHQ

Not Receiving PHQ

Reporting Ideation

Not Reporting Ideation

Medically Treated Self-Injury Coded as a Suicide Attempt or Suicide Death
Zero Suicides in Health Care
Targeting Pathways to Suicide and Suicide Attempt
Dr. Ursula Whiteside

HealthCare System Population

50% of suicide attempts

Enrolled Consumers

Not Enrolled

Seeing PC and/or BHS Provider

Receiving PHQ

Not Seeing PCP

Not Receiving PHQ

25% of suicide attempts

Reporting Ideation

25% of suicide attempts

Not Reporting Ideation

Medically Treated Self-Injury Coded as a Suicide Attempt or Suicide Death
Zero Suicides in Health Care:
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Dr. Ursula Whiteside

HealthCare System Population

Not Enrolled

Insurance enrollment includes automatic registration for secure messaging with providers using medical record

Not Receiving PHQ

Not Seeing PC

Not Enrolled

Medically Treated Self-Injury Coded as a Suicide Attempt or Suicide Death

Seeing PC and/or BHS Provider

Receiving PHQ

Depression Screening and Lethal Means Removal Protocol for those with Depression

Online CBT offered

Health Profile (including depression screening) sent annually via secure messaging

Online CBT offered

Attempt to schedule PCP visit

Simon Suicide Risk Identification Method
Columbia Suicide Severity Rating Scale
Crisis Planning
Lethal Means Removal Protocol

Reporting Ideation

Not Reporting Ideation

Unexpected Attempt Qualitative Interviews

Medically Treated Self-Injury Coded as a Suicide Attempt or Suicide Death
Questions?

Next webinar:
Evidence and Impact in the Workplace
Tuesday, March 24, 3:00-4:00 pm EST
http://edc.adobeconnect.com/e6vu338d599/event/registration.html

Please complete this brief evaluation:
https://www.surveymonkey.com/r/XXC277R