Providence
Behavioral Health Leadership Council

Pediatric Grand Rounds

Zero Suicide

Paul Giger, MD
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December 7, 2021

Conflict of Interest

Planning Committee & Faculty Disclosure: The Planning Committee and Faculty have no relevant financial relationships with commercial interests to disclose.

Learning Objectives

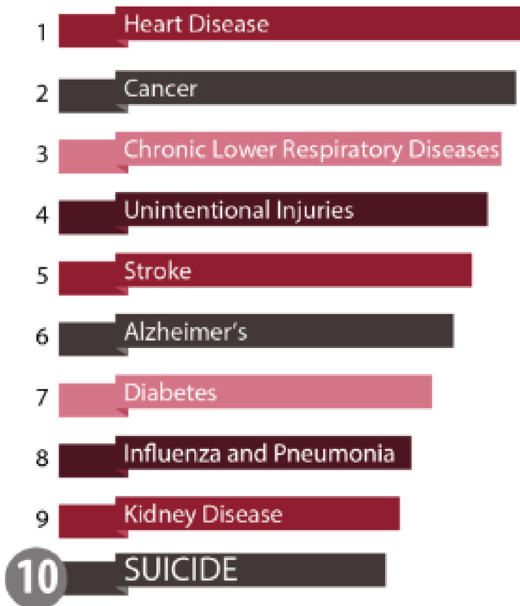
1. Develop an understanding of the Zero Suicide Pathway
2. Become familiar with the resources within the Zero Suicide Toolkit
3. Learn how to implement Zero Suicide in your clinic.

Why Zero Suicide?

SUICIDE in the United States

ALL FACTS PROVIDED BY THE CENTERS OF DISEASE CONTROL

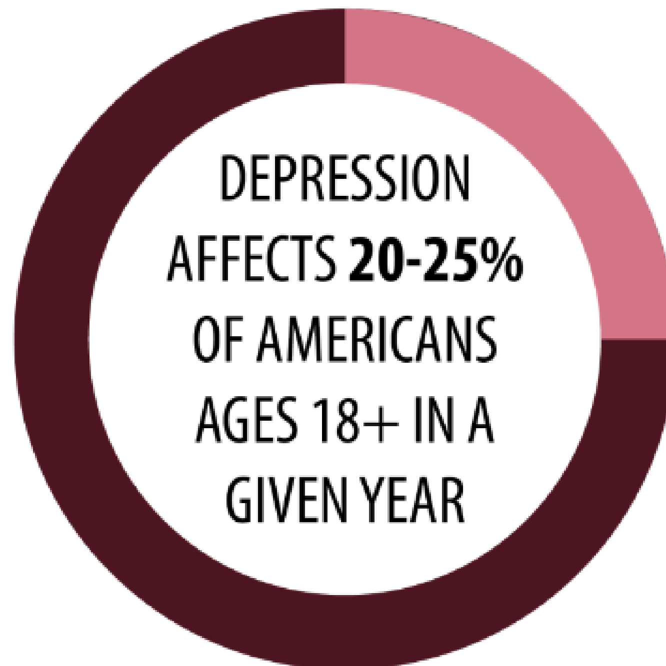
10th LEADING CAUSE OF DEATH IN THE UNITED STATES



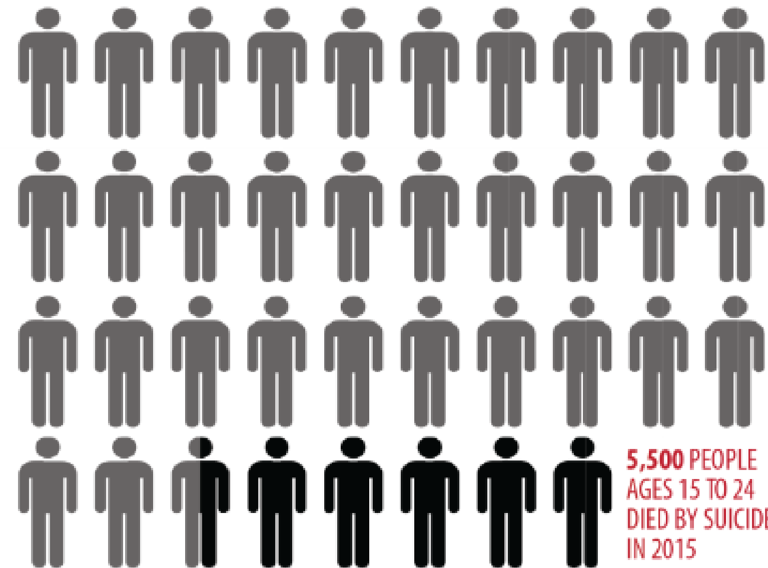
2nd LEADING CAUSE OF DEATH IN THE UNITED STATES AMONG 15-TO-24-YEAR-OLDS

There is one death by suicide in the US every **12** minutes

Every day, approximately **105** Americans die by suicide

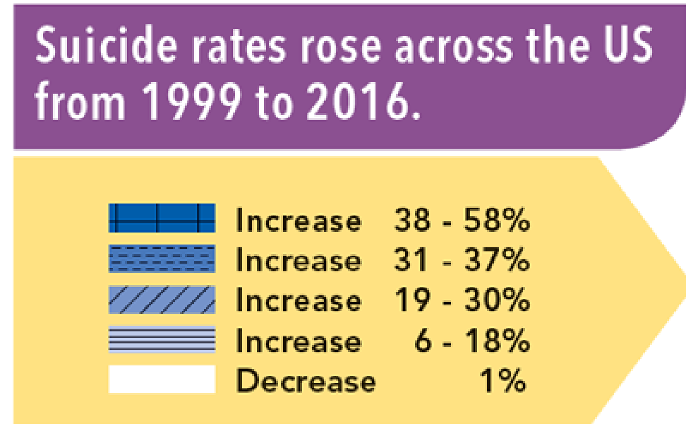


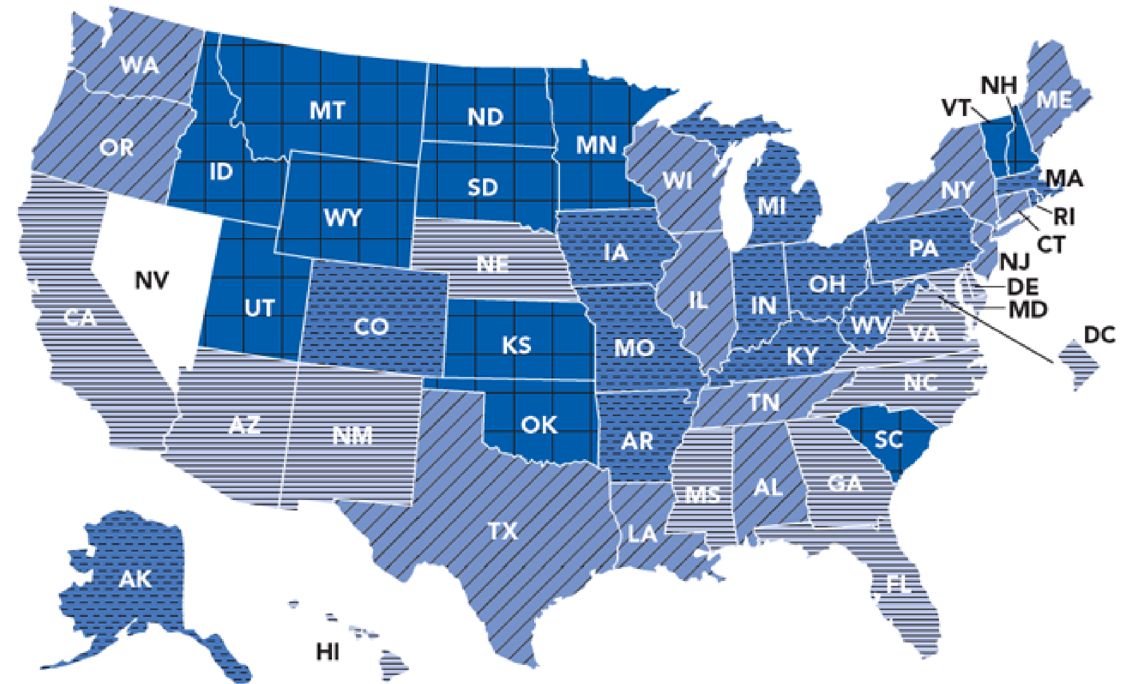
SUICIDE TAKES THE LIVES OF OVER **38,000** AMERICANS EVERY YEAR



Suicide rising across the US

More than a mental health concern





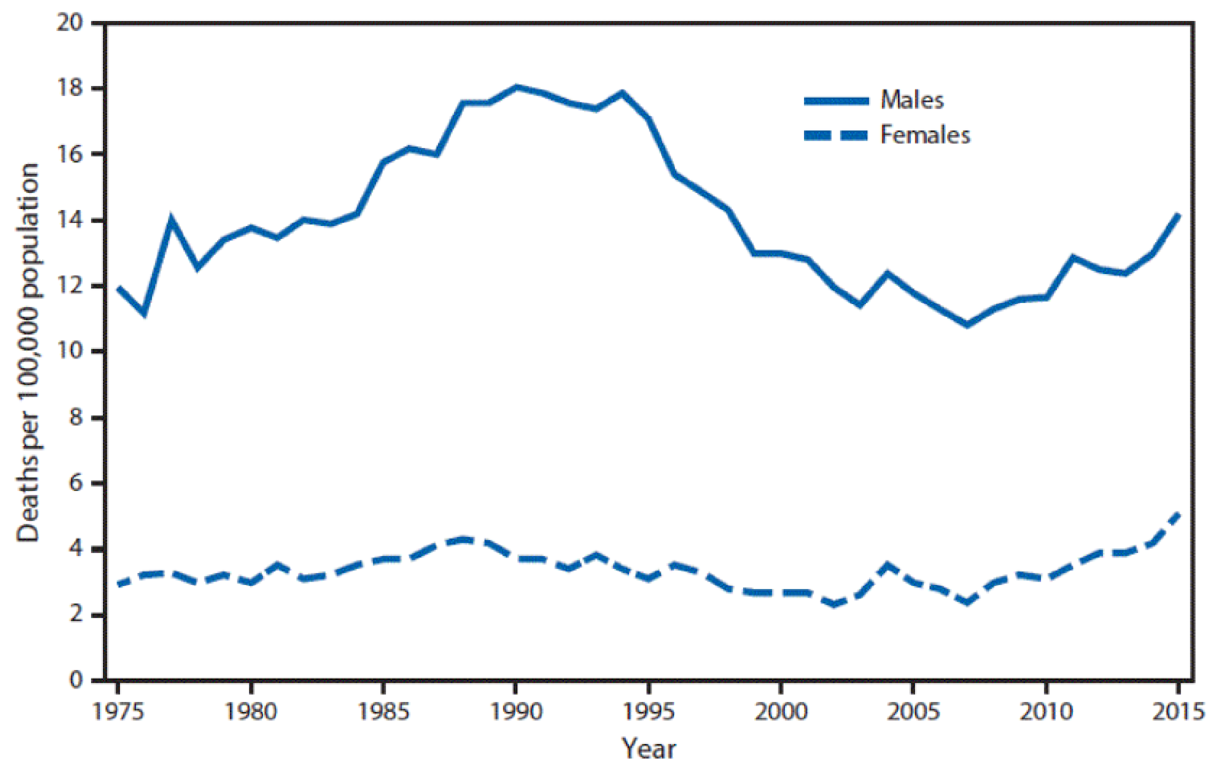
Suicide rates rose across the US from 1999 to 2016.

QuickStats: Suicide Rates*,† for Teens Aged 15–19 Years, by Sex — United States, 1975–2015

Weekly / August 4, 2017 / 66(30);816

English (US)

View suggested citation



Article Metrics

Altmetric:

Metric Details

* Rates are per 100,000 population.

Zero Suicide Framework

•Inspired by health care systems that had seen dramatic reductions in patient suicide, Zero Suicide began as a key concept of the 2012 National Strategy for Suicide Prevention, and quickly became a priority of the:

- •National Action Alliance for Suicide Prevention (Action Alliance)
- •Education Development Center's Suicide Prevention Resource Center (SPRC)
- •Substance Abuse and Mental Health Services Administration (SAMHSA).

frontiers in Psychiatry

PERSPECTIVE
published: 23 February 2018
doi: 10.3389/fpsyt.2018.00033

The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care

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Suicide is reaching epidemic proportions, with over 44,000 deaths by suicide in the US, and 800,000 worldwide in 2015. This, despite research and development of evidence-based interventions that target suicidal behavior directly. Suicide prevention efforts need a comprehensive approach, and research must lead to effective implementation across public and mental health systems. A 10-year systematic review of evidence-based findings in suicide prevention summarized the areas necessary for translating research into practice. These include risk assessment, means restriction, evidence-based treatments, population screening combined with chain of care, monitoring, and follow-up. In this article, we review how suicide prevention research informs implementation in clinical settings where those most at risk present for care. Evidence-based and best practices address the fluctuating nature of suicide risk, which requires ongoing risk assessment, direct intervention and monitoring. In the US, the National Action Alliance for Suicide Prevention has put forth the Zero Suicide (ZS) Model, a framework to coordinate a multilevel approach to implementing evidence-based practices. We present the Assess, Intervene and Monitor for Suicide Prevention model (AIM-SP) as a guide for implementation of ZS evidence-based and best practices in clinical settings. Ten basic steps for clinical management model will be described and illustrated through case vignette. These steps are designed to be easily incorporated into standard clinical practice to enhance suicide risk assessment, brief interventions to increase safety and teach coping strategies and to improve ongoing contact and monitoring of high-risk individuals during transitions in care and high risk periods.

OPEN ACCESS

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Specialty section:
This article was submitted to Psychopathology, a section of the journal Frontiers in Psychiatry

Received: 11 December 2017
Accepted: 29 January 2018
Published: 23 February 2018

Citation:
Brodsky BS, Spruch-Feiner A and Stanley B (2018) The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. Front. Psychiatry 9:33. doi: 10.3389/fpsyt.2018.00033

Keywords: suicide, prevention, evidence-based, psychology, interventions

Suicide is a public health crisis reaching epidemic proportions and has claimed the lives of over 44,000 individuals in the US in 2015 (1) and 800,000 people worldwide in the past year. These figures reflect an increase in death by suicide by over 25% in the US (2), and 4% internationally in the last decade (3), despite increases in multitiered suicide prevention strategies and research. A 10-year systematic review of nearly 1,800 studies (4) highlighted the importance of increasing and coordinating the application of evidence-based suicide prevention strategies and concluded that research needs to lead to implementation across public health and clinical mental health systems.

In the US, the National Action Alliance for Suicide Prevention has put forth the Zero Suicide (ZS) Model, a framework and resources to coordinate a multilevel approach to implementing evidence-based practices for suicide prevention. Founded on the principle that death by suicide is preventable for patients in behavioral health systems, the ZS model offers an integrated, system-wide strategy

THE POWER OF ZERO:
STEPS TOWARD HIGH RELIABILITY HEALTHCARE

- Industries such as aviation and nuclear power succeed in preventing harm by implementing systems that not only enact the concept of collective mindfulness but that also pursue a **zero-defect environment**
- Although no healthcare organization can yet call itself an HRO, an increasing number of hospitals and health systems are making that achievement their end game—and leadership has a responsibility to make high reliability a priority
- **Success is not based on the heroics of individual clinicians but a care team approach**

"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

"We have very intentionally incorporated high reliability into everything we do. It's not just a 'strategy'—it is the prevailing, defining attitude in our organization."

LISA K. JONES, DSc, FACHE
Owensboro Medical Health System

"As they strive for high reliability, organizations shift away from having outside bodies solely determine their quality agenda to developing an agenda that incorporates the organization's most important goals."

MARK R. CHASSIN, MD, FACP
The Joint Commission and Joint Commission Center for Transforming Healthcare

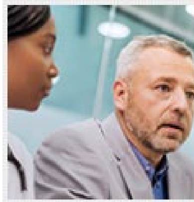
This is what it means to

#FINISHCANCER

Pioneering immunotherapy research. Developing breakthrough treatments. Delivering hope.

Zero Suicide Framework

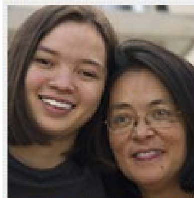
- After researching successful approaches to suicide reduction, the Action Alliance's Clinical Care and Intervention Task Force identified seven essential elements of suicide care for health and behavioral health care systems to adopt.
- Zero Suicide operationalizes the core components necessary for health care systems to transform suicide care into seven elements.



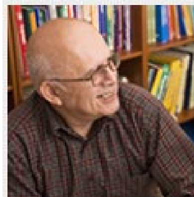
LEAD
system-wide culture change committed to reducing suicides

TRAIN
a competent, confident, and caring workforce

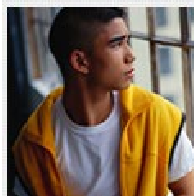
IDENTIFY
patients with suicide risk via comprehensive screenings



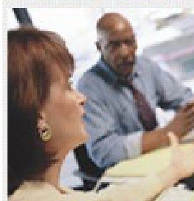
ENGAGE
all individuals at-risk of suicide using a suicide care management plan



TREAT
suicidal thoughts and behaviors using evidence-based treatments



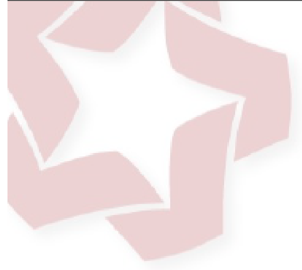
TRANSITION
individuals through care with warm hand-offs and supportive contacts



IMPROVE
policies and procedures through continuous quality improvement

Zero Suicide: Changing Perspective

From:	To:
Accepting suicide as inevitable	Every suicide in a system is preventable
Assigning blame	Nuanced understanding
Risk assessment and containment	Collaborative safety, treatment, 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 on-going continuity of care
“If we can save one life…..”	“How many deaths are acceptable?”



Systematic Suicide Care Plugs the Holes in Health Care

- Systematic Suicide Care

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Henry Ford Health System

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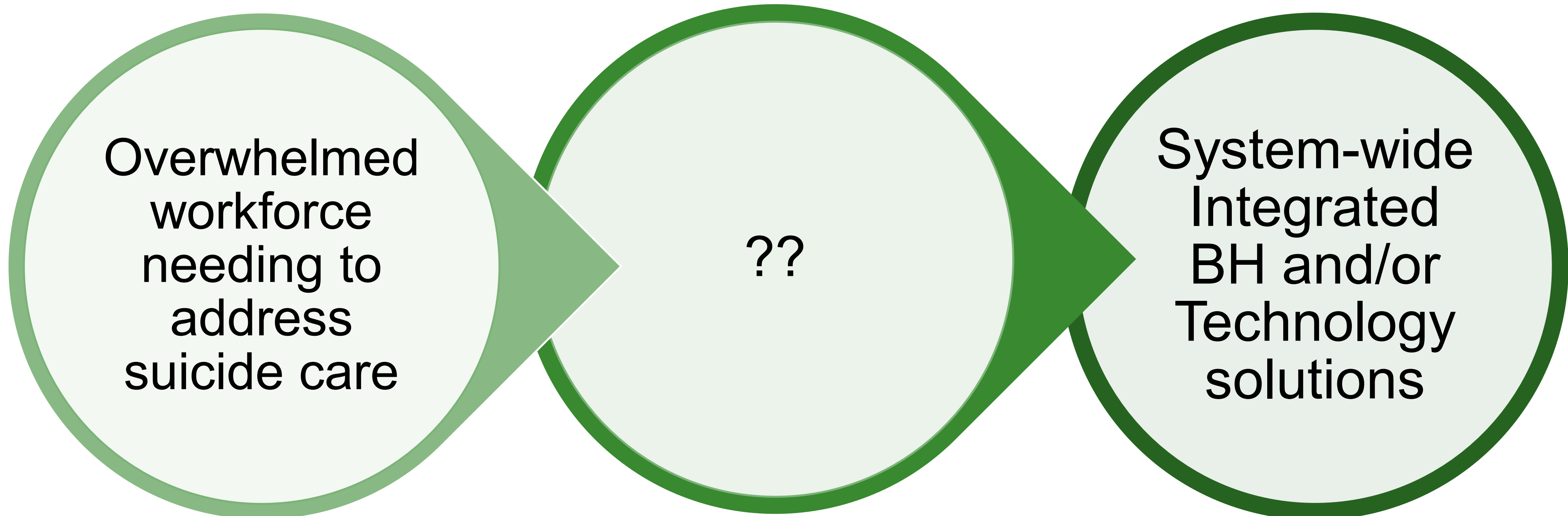
The Work of the Zero Suicide Focus Group

CURRENT STATE

FUTURE IDEAL STATE



1. Increasing incidence of SI nationwide
2. Priority for Providence to address Mental Health and SI care
3. COVID-19

What can we do now?

Zero Suicide Clinical Focus Group

Goals:

- Create clinical standards, education, and tools that are evidence based to address suicide care to ease the way of teams and prepare our caregivers to be confident to care for our patients

Zero Suicide Toolkit: Three-Pronged Approach

Just-in-time set of simple tools and guidance to assist caregiver be confident in providing care

Clinical Guidance

System standardization of SI care delivery for Primary Care, ED, and Inpatient care settings

Standard workflow:

Columbia Screening

Stanley Brown Safety Planning

Tools

Epic: Optimization and SmartPhrases

Recommended Digital Tools

Training

Providence developed training

Suicidal Organization resources

Just in time, brief/focused videos

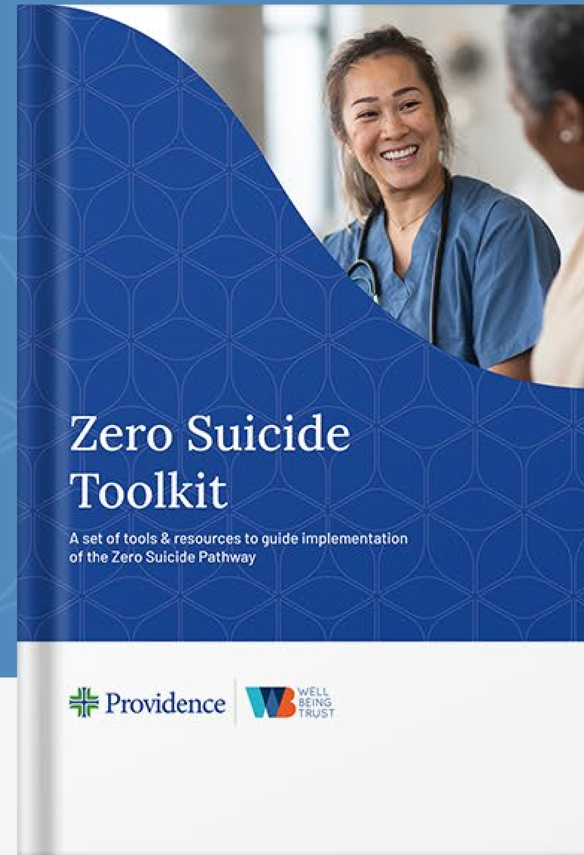
Training guidance materials/resources and regional SME contacts

Providence Zero Suicide Toolkit

Providencebhguides.com

Zero Suicide Toolkit

Tools and resources to guide implementation of the Zero Suicide Pathway, an evidence-based, suicide care pathway for patients experiencing suicidal thoughts in any care setting.



DOWNLOAD PLAYBOOK ↓

Why It's Needed

Suicide is one of the leading causes of death and a worldwide public health crisis. Health care systems need an efficient, effective, and evidence-based approach for patients experiencing suicidal thoughts. By taking a focused approach across the healthcare system, patient safety can be improved and stress among care teams reduced.

Goals

- Support clinical teams in all settings in implementing highly reliable care to patients who are experiencing suicidal ideation.

Goal: Toolkit to drive clinical care/safety, efficiency, top of license practice, and performance goals through:

1. Establishing Standard of Clinical Care
2. Epic builds to support recommendations
3. Clinical staff workflows
4. Education (min specifications, videos, training guides, etc)
5. Technology (Patient facing digital solutions)
6. Reporting (Metrics and data)

Selected Resources

Dive directly into the playbook for specific guidance on the following areas:

Page 6: Providence Minimum Specifications & Best Practices

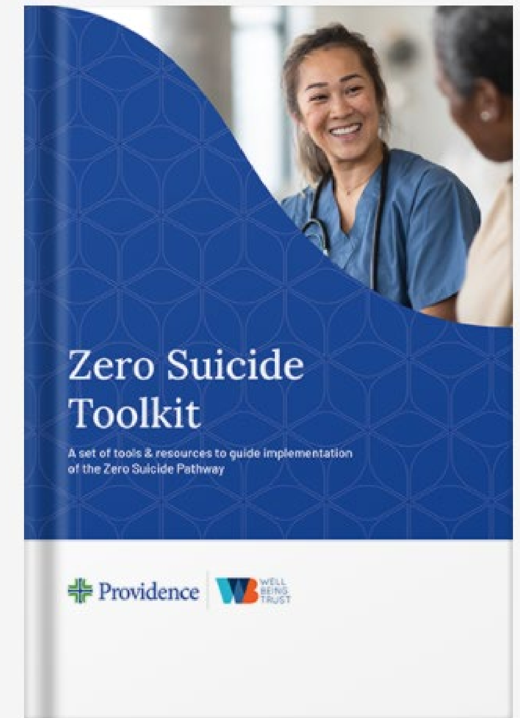
Page 10: Implementation Tools & Resources

Page 12: Measurement & Evaluation

Page 17: Screening & Safety Planning: FAQ

Page 21: Organizational Self-Study

Page 53: Suicide Safety Plan Smart Phrase



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Clinical Guidance

	Columbia Suicide Severity Rating Scale (C-SSRS)	Stanley Brown Safety Plan
Purpose	The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk and gauge the level of support the person needs. **The C-SSRS offers the following:** **Simple.** Ask all the questions in a few moments—with no mental health training required. **Efficient.** Use of the protocol redirects resources to where they're needed most. It reduces unnecessary referrals and interventions by more accurately identifying who needs help — and it makes it easier to correctly identify the level of support a person needs, such as patient safety monitoring procedures, counseling or emergency room care. **Effective.** Real-world experience and data show the protocol has helped prevent suicide. **Evidence-supported.** An unprecedented amount of research has validated the relevance and effectiveness of the questions used in the Columbia Protocol to assess suicide risk, making it the most evidence-based tool of its kind. **Universal.** The Columbia Protocol is suitable for all ages and special populations in different settings and is available in more than 140 country-specific languages. **Free.** The protocol and the training on how to use it are available free of charge for use in community and healthcare settings, as well as in federally funded or nonprofit research.	The Stanley Brown Safety Plan is a proven, evidence-based approach to suicide safety planning. It has been adopted by state health organizations, major health systems including the VA, as well as suicide prevention organizations. Many Providence regions have effectively adopted the Stanley Brown Safety Plan in various clinical areas with great success, patient care efficiency and safety. The use of the Stanley Brown tool meets regulatory and accreditation requirements and is already being utilized in some regions with some Epic functionality to support. **The Stanley Brown Safety Plan offers the following:** A written list of coping strategies and resources to help patients in their times of crisis. Includes elements such as means reduction, problem solving and coping skills, enhancing social support and identifying emergency contacts. A standardized and tangible set of questions to document an agreed upon plan in the event a patient has thoughts of harming themselves. A brief, easy to read format that uses the individual's own words. Can be used as a single session intervention or incorporated into ongoing treatment.

Primary Care Suicide Screening & Safety Plan Recommendation

Clinical Guidance

<table>
<tr><th>Step</th><th>Min Spec</th><th>Best Practice</th></tr>
<tr><td>Screening</td><td>• PHQ Screening collected for the following patients:
  • Age 12+ during annual visit,
  • New patients,
  • Presenting with mood disorder complaint, or
  • Have history of depression
• All patients with a non-zero answer to PHQ item 9 or who endorse suicidal ideation receive CSSRS screener
• CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project</td><td>• PHQ Screening collected for patients in accordanace with Depression Care Pathway recommendations (LINK)
  • (Specify inclusion criteria)</td></tr>
<tr><td>Risk Assessment</td><td colspan="2">• All patients screening positive undergo suicide risk assessment, including risk & protective factors, severity of suicidality, and providing recommendations for potential interventions</td></tr>
<tr><td>Safety Planning</td><td>• All patients with a positive (any yes answers) CSSRS screener will develop a safety plan during visit, and receive information for local & national crisis lines</td><td>• All patients with a positive PHQ-9 item 9 will develop a safety plan during visit, and receive information for local & national crisis lines
• Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning, next level of care planning, following guidelines based on assessed risk level, which may include involving other individuals and/or health professionals
• Annual training, including CALM training provided for caregivers</td></tr>
</table>

ED Suicide Screening & Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	• All patients with a primary BH dx will receive a CSSRS screener • CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project	
Risk Assessment	• All patients screening positive undergo suicide risk assessment process	
Safety Planning	• All patients with a positive (any yes answers) CSSRS will receive a safety plan prior to discharge (whether during ED stay or inpatient admission)	• Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning, next level of care planning • Annual training, including CALM training provided for caregivers

Clinical Guidance

Inpatient Acute Screening/Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	• All patients with a primary BH dx will receive a CSSRS screener (apart from PHQ-4 result) • CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project, and provides guidance on 1:1 observation	• All patients with a BH dx receive a CSSRS screener
Risk Assessment	• All patients who screen positive undergo suicide risk assessment process (performed by psychiatrist, BH clinician or nurse depending on resource availability	
Safety Planning	• All patients with a positive (any yes answers) CSSRS will receive a safety plan prior to discharge • Documentation on screening, risk assessment & safety plan captured in assessment plan	• Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning & next level of care planning • Annual training, including CALM training provided for caregivers

Tools

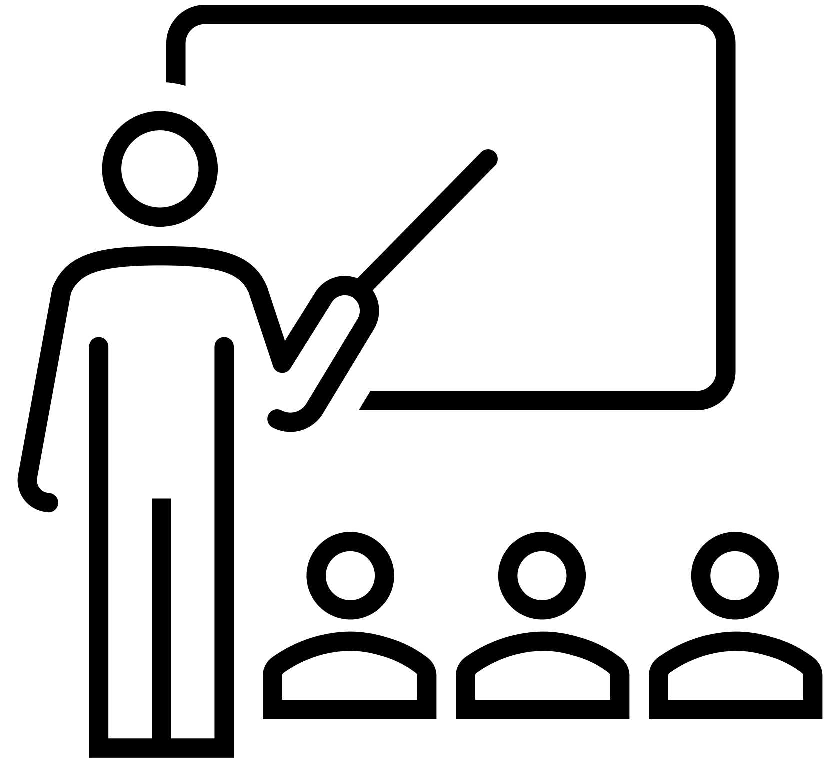
Digital Tools

- 3 apps identified as potentially useful resources for patients experiencing suicidal ideation
- Currently unable to integrate data in Epic, but short term option
- Long-term plan to test a comprehensive tool mediates full care pathway, (e.g., Jaspr) as a system solution

App	Description	Scope
MY3	Designed for **suicide prevention** – designate your network, enter your safety plan, and find resources.	Widely relevant and includes resources for many populations.
Virtual Hope Box	Designed for **general mental health** – choose pictures/videos that give you hope or choose activities to distract/cope/relax while you're struggling.	Designed for veterans, so resources will not apply to many. No general crisis information.
CalmHarm	Designed to **avoid self-harm** – choose short or long activities to avoid urges to self-harm, journal about your activities.	Designed for self-harm but not specific to suicide.

Toolkit Training Resources

- Combining internally developed videos/webinars with externally available resources
- **Internal materials:**
  - Short & focused videos & informational content (~5 minutes)
  - Walk through work flow, with narrative & video for each segment
  - Scripting for interactions
- **External**
  - Free, self-guided webinars & training modules – screening, risk assessment & safety planning, CALM
  - Virtual care guidance
  - Recommendations for specific populations



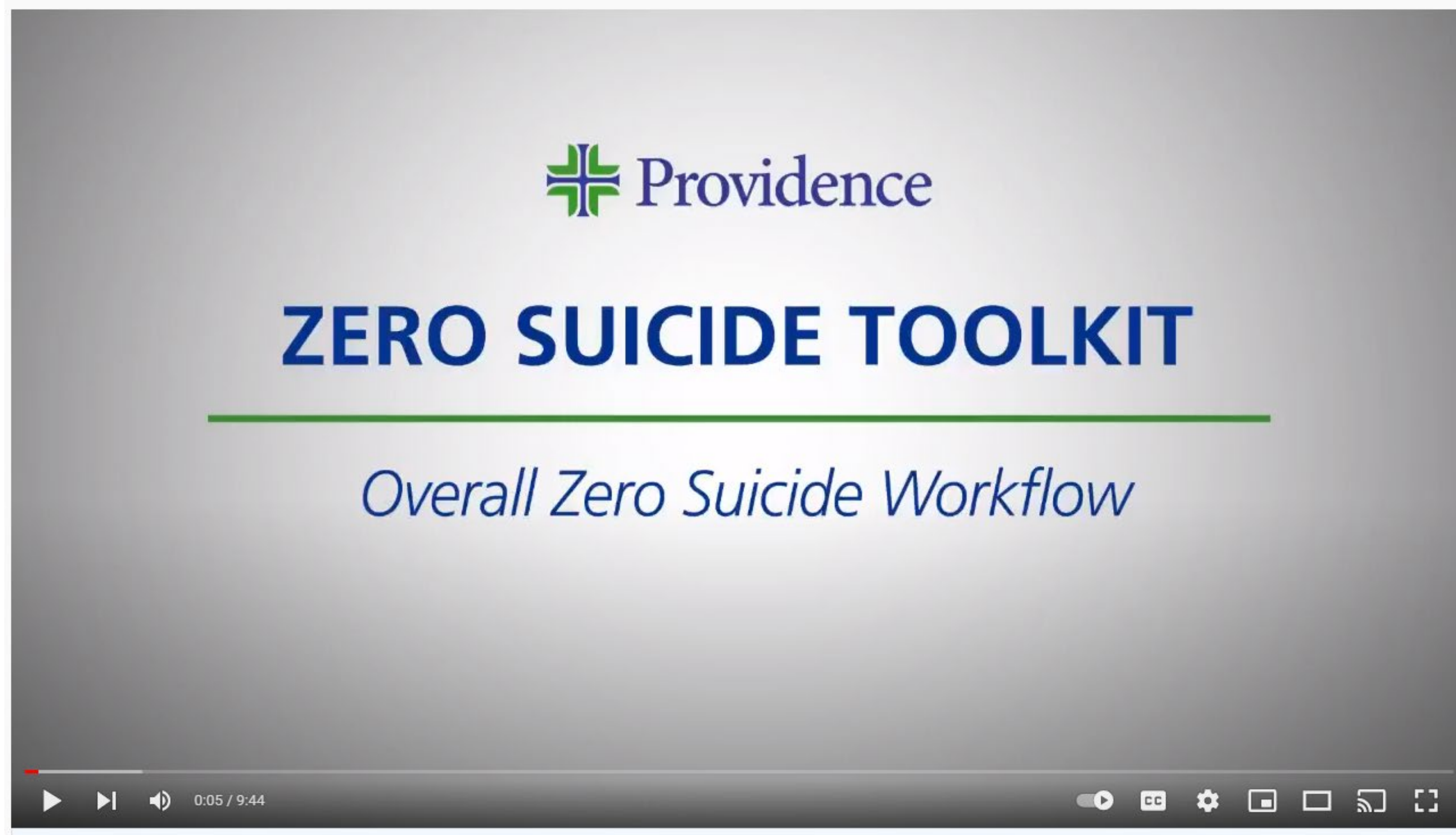
Training

Zero Suicide Toolkit Training Videos

VIDEO TITLE	PRESENTERS	GOAL OF SEGMENT
Importance of Zero Suicide	Howard Mun, PharmD Paul Giger, MD	Intro to Zero Suicide Framework
Overall Zero Suicide Workflow	Manvi Smith, PsyD Howard Mun, PharmD	High level overview of Zero Suicide protocol steps, Role Play
PC Environment	Manvi Smith, PsyD Michael Lynam, MD	Primary care workflow, PCP attestation
ED Environment	Margaret Skoog, MSN, ARNP, AGCNS-BC, CEN Stacia Fisher, LICSW	ED workflow, ED RN & SW attestation
Med/Surg Environment	Gale Springer, RN, MSN, ARPN, PMHCNS-BC Nicole Searl, BSN, RN, AMB-BC	Acute care workflow, Acute care RN attestation

Training

Sample Video: Zero Suicide Toolkit: Overall Zero Suicide Workflow - YouTube



Questions?

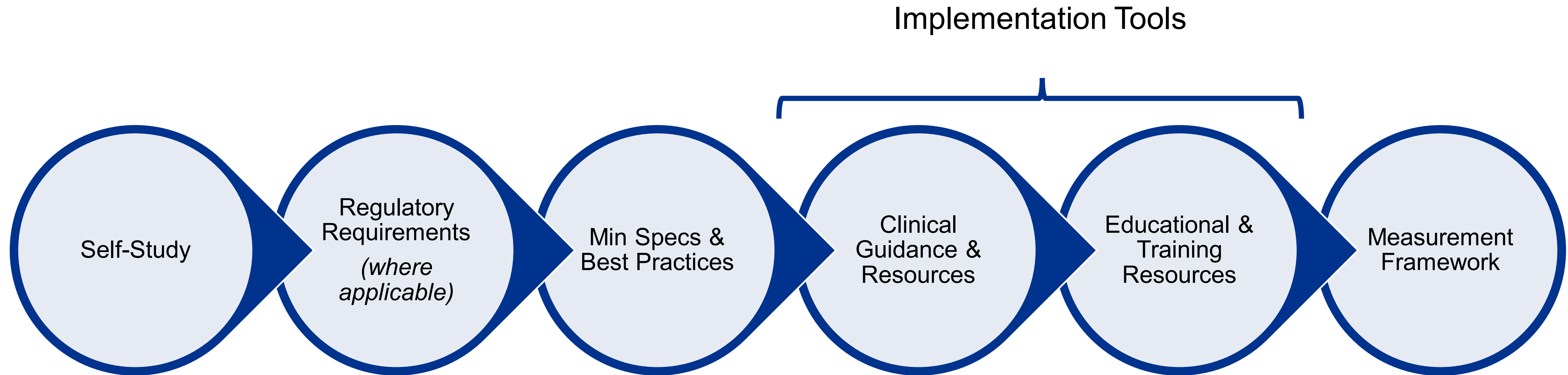
- Paul Giger, MD paul.giger1@providence.org
- Howard Mun, PharmD howard.mun@providence.org

Interested in joining the Zero Suicide Focus Group?

Reach out to mandi.ucab@providence.org for an invitation

Appendix

Toolkit Contents & Approach



Safety Plan Screen Shot- Pt.1 .suicideprevconcise

Suicide risk assessment and plan

(Pathway: Flowsheets --> PHQ9 --> mark item 9 --> click pop-up for C-SSRS --> answer all items in C-SSRS flowsheet)

Patient endorsed **item 9** on the PHQ-9 depression scale, "Thoughts that you would be better off dead, or of hurting yourself in some way?"

C-SSRS Columbia Suicide Severity Rating Scale:

1. In the past month, have you wished you were dead or wished you could go to sleep and not wake up? : **(!) Yes**
2. In the past month, have you actually had any thoughts of killing yourself? : **(!) Yes**
3. Have you been thinking about how you might kill yourself? : No
4. Have you had these thoughts and had some intention of acting on them? : No
5. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? : No
6. Have you EVER done anything, started to do anything, or prepared to do anything to end your life?: No

Assessment with C-SSRS indicates the patient is considered {Desc; low/moderate/high:110033} risk for suicide.

Low risk: Item 1: Suicidal ideation, no intent, no plan, no suicidal behavior
Moderate risk: Item 2 or 3: Suicidal ideation without specific plan, intent nor behavior
High risk: Item 4 or 5: intent or intent with plan or item 6: suicidal behavior in past 3 months

Based on the patient's assessed suicide risk, the following steps were taken:

Access to behavioral health (BH) services: {bhserviceask:"57702"}
If patient has BH provider: {consentBH:"57515"}

Interventions:

Safety Plan Screen Shot- pt.2 .suicideprevconcise

My Personal Safety Plan

Means safety
I will make my home safer by {pillsstatement:"57701"}
I will make my home safer by {firearmstatement:"57564"}

Warning signs
My triggers or warning signs for crisis: {suicide warning signs :"64453"}

Healthy actions
Healthy actions I can take to make myself feel better: {healthy actions:"64455"}

Purpose/reason for living
What is most important in my life: {reasons for living:"64456"}

Social support
I can talk to the following people that will make me feel better: Name(s): ***

Crisis phone numbers
I have {crisisphone:"57565"}

- *National: 24-hour, toll-free National Suicide Prevention Lifeline* 1-800-273-TALK
- *National: 24-hour, En Español:* 1-888-628-9454
- *National Suicide Prevention Lifeline (Deaf & Hard of Hearing Options)* 1-800-799-4889
- *Crisis Text Line 24-hour* Text HOME to 741741 anywhere in the US, anytime
- *Teen Text 866-833-6546, evenings 6:00 pm -10:00 pm*
- *My3 App*
- *Online crisis chat: imhurting.org*

Providence

Recommendations for Primary Care Clinics without BH Integration

Primary Care Suicide Screening & Safety Plan Recommendation

Step	Min Spec	Best Practice
Screening	• PHQ-9 Screening collected for the following patients: o Age 12+ during annual visit, o New patients, o Presenting with mood disorder complaint, or o Have history of depression • All patients with a non-zero answer to PHQ item 9 or who endorse suicidal ideation receive CSSRS screener • CSSRS screener automatically calculates initial risk level based on Columbia Lighthouse Project • PHQ Screening collected for patients in accordance with Depression Care Pathway recommendations (LINK)	
Risk Assessment	• All patients screening positive undergo suicide risk assessment, including risk & protective factors, severity of suicidality, and providing recommendations for potential interventions	
Safety Planning	• All patients with a positive (any yes answers) CSSRS screener will develop a safety plan during visit, and receive information for local & national crisis lines	• All patients with a positive PHQ-9 item 9 will develop a safety plan during visit, and receive information for local & national crisis lines • Safety planning is an engaging process between caregiver & patient, involving means safety, disposition planning, next level of care planning, following guidelines based on assessed risk level, which may include involving other individuals and/or health professionals • Annual training, including CALM training provided for caregivers

8

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External Training Resources

Topic	Item	Link	Description
Virtual Care	COVID Guidance – screening during Telehealth visits	covid-suicidescreentelehealth_3.pdf (theactionalliance.org)	2-pager from National Action Alliance for Suicide Prevention
	SPRC Resources for Treating suicidal patients during COVID	Treating Suicidal Patients during COVID-19 | Suicide Prevention Resource Center (sprc.org)	Landing page with various resources providing guidance during COVID-19
Additional Considerations	Understanding Lived Experience	https://www.sprc.org/micro-learning/lived-experience-story-about-what-makes-difference-0	2-min video, lived experience story
	Competencies for Faith Leaders	fhl_competencies_v8_interactive.pdf (sprc.org)	21-page document with suicide prevention competencies for faith leaders
	Stand Together: Talking about Teens, Technology & Suicide	Stand Together: Talking About Teens, Technology and Suicide	61-min video, interviews with experts
Regulatory Guidance	Joint Commission	Suicide Prevention Recommendations; R3 Report	
	DNV	DNV Regulations	Pages 127-129