PREVENTING SUICIDE THROUGH CONNECTION:
SYSTEMS CHANGE & COLLABORATIVE SAFETY PLANNING

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PROJECT 2025

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Suicide in the U.S.

Despite more research, education, and awareness to prevent suicide, the annual rate of suicide continues to rise in the U.S. Today, it is the 10th leading cause of death – and we lose more than 47,000 Americans each year.

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How Do We “Bend the Curve”?

By delivering effective, affordable, and evidence-informed approaches that identify those at risk for suicide and provide suicide prevention interventions, and by expanding the reach of these activities to save the most lives in the shortest amount of time.

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What is Project 2025?

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A nationwide initiative to reduce the annual rate of suicide in the U.S. 20 percent by 2025

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Together with its expert advisors, AFSP has examined:

- Who we are losing to suicide
- How we are losing them
- Where we are losing them
- What we can do to save lives in the shortest amount of time

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The Approach

- Identify evidence-informed strategies for preventing suicide in critical areas with the potential to save the most lives in the shortest amount of time
- Develop key partnerships and invested in the development of needed resources in these areas
- Accelerate and scale-up progress in the delivery of these resources and programs across the U.S.

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The Four Critical Areas

Firearms

Healthcare Systems

Emergency Departments

Corrections Systems

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Healthcare Systems

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Up to 45%

of people who die by suicide visit their primary care physician in the month prior to their death.

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Contact with Healthcare Providers

When suicide risk increases, many seek help

- 64% who attempt suicide visit a doctor in the month before their attempt, 38% in the week before
- 45% saw PC within month of suicide death
- 20% saw MHP within month of suicide death

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: review of the evidence. *Am J Psychiatry* 2002

Strategy

By working with healthcare systems and accrediting organizations, we can accelerate the acceptance and adoption of suicide prevention practices in various healthcare settings, including primary care.

Backdrop: The Joint Commission SEA 56

Detecting and caring for suicidal patients in all healthcare settings
February 28, 2016

“Many communities and HC orgs presently do not have adequate suicide prevention resources, leading to low detection and treatment of those at risk. As a result, providers who do identify patients at risk for suicide often must interrupt their work flow and disrupt their schedule for the day to find treatment and assure safety for these patients”

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RELEASED JULY 1, 2019
The Joint Commission National Patient Safety Goal 15.01.01

The new NPSG for suicide prevention includes:

- Clear steps for hospitals and BHOs to take
- Emphasis on organization's SP *program* rather than just screening or referral
- 7 elements of performance (EPs)

www.jointcommission.org/topics/suicide_prevention_portal.aspx

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TJC National Patient Safety Goal 15.01.01

Elements of Performance (EPs)

1. Environmental risk reduction
2. Screening for SI - all patients in BH settings and those w/ primary psychiatric conditions in general hospital or ED settings
3. SRA that goes beyond solely assessing SI
4. Counseling of Access of Lethal Means
5. Care plan and documentation
6. Counseling - as part of clinical care and discharge planning
7. Written policies for all of the above, as well as for reassessment, monitoring, staff training
8. A process for ensuring ongoing quality

Happening Now

AFSP is partnering with **The National Action Alliance for Suicide Prevention** and **The Zero Suicide Institute** to disseminate recommended minimum standards for suicide prevention in healthcare settings, as well as comprehensive systems-level improvement strategies.

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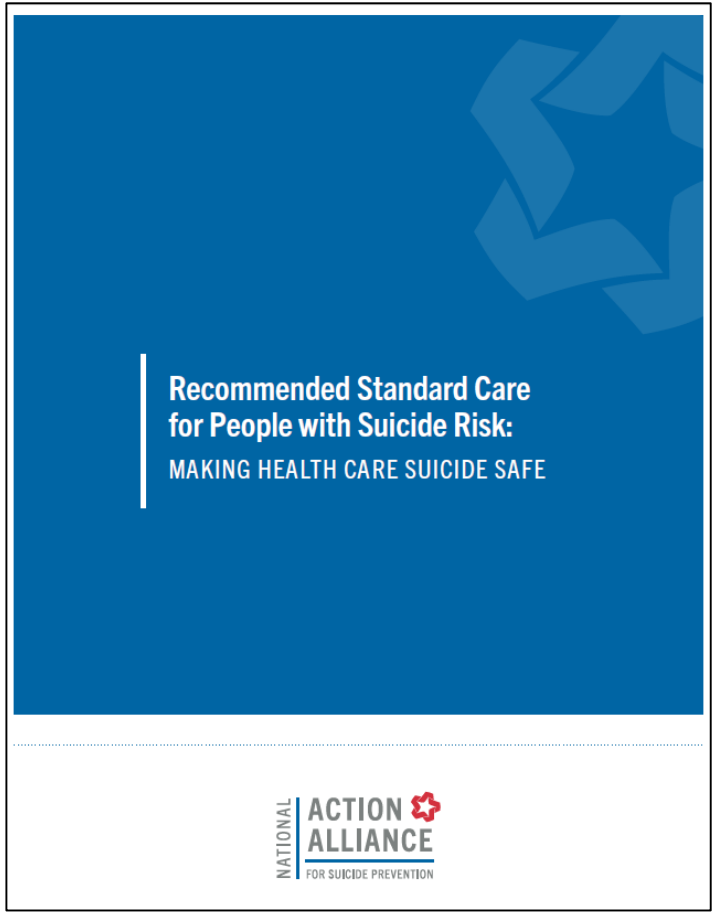

"We should treat suicide prevention in health care systems as we treat heart attack prevention."

http://actionallianceforsuicideprevention.org/

Recommended Standard Care

Primary Care Providers have a unique opportunity to help prevent suicide. Frequently, when someone dies by suicide, we hear that he or she fell through the cracks in healthcare. By some studies, over 80% of those who died by suicide had been seen by a healthcare professional in the year prior. Most did not have a mental health diagnosis.

Healthcare organizations have recommended standards to improve care to address other urgent medical conditions, such as heart attack, stroke, and serious injury. The same can be done for suicide prevention.

The American Foundation for Suicide Prevention, and the Action Alliance, have determined a research-tested, low-cost, high-value approach to preventing suicide within primary healthcare settings.

"We should treat suicide prevention in health care systems the same as we approach prevention of cardiovascular deaths."

Using the framework of "Lean Production" which is widely applied in healthcare, these recommendations help ensure that fewer people fall through the cracks, by:

- Proactively identifying intense suicide risk in the same way we screen for risk in other medical conditions
- Acting effectively for safety, through methods such as safety planning and means reduction
- Providing supportive contacts, in the same way brief follow-up is arranged after outpatient surgery

Each recommendation has been used successfully in ordinary healthcare settings. Suicide is a public health crisis, and currently the tenth leading cause of death in the United States. Action is overdue and urgently needed. It's time we address suicide prevention in health care systems in the same as we address heart attack prevention.

Continued >

Recommended Standard Care Elements for Primary Care

Identification and Assessment

Identify suicide risk in all patients with mental illness or substance disorders or treatment (e.g., psychiatric medications) using a standardized instrument. If risk is identified, proceed with an active referral for appropriate hospital or outpatient care.

Safety Planning

Complete the brief Safety Planning Intervention during the visit when risk is identified. With consent, discuss the safety plan with the family to gain support for the customized components of the patient's safety plan.

Lethal Means Counseling

As part of the safety plan, discuss any lethal means considered by and available to patient. Advise removal (even temporarily) of lethal means as feasible.

Caring Contacts

Make an appointment with a mental health professional. Complete one or more caring contacts (phone call or, if preferred by patient, text or email) within 48 hours or the next business day following the patient's visit.

National Action Alliance for Suicide Prevention

To find out more, read the full report *Recommended Standard Care for People with Suicide Risk* at ActionAllianceForSuicidePrevention.org.

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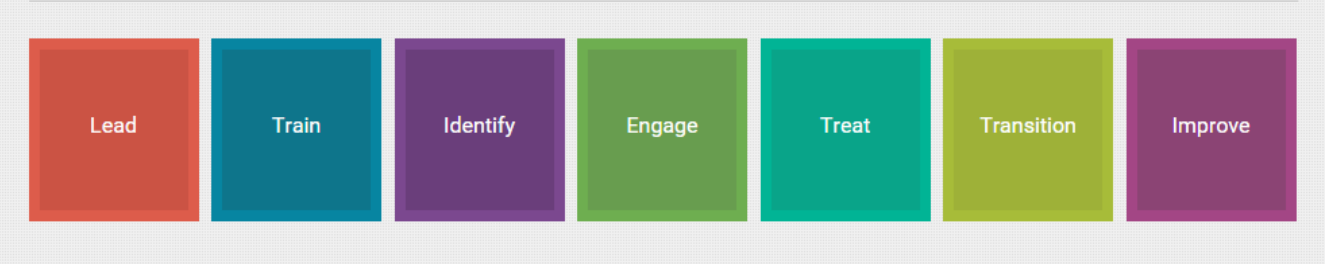
ZERO Suicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

INSTITUTE



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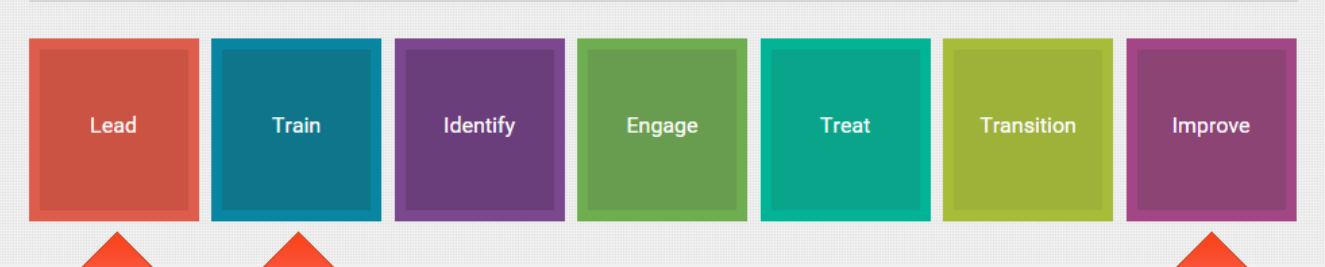
ZERO Suicide IN HEALTH AND BEHAVIORAL HEALTH CARE | INSTITUTE



Culture change / education

Training programs

Advocacy / Partnerships

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Happening Now

AFSP partnered with **SafeSide Prevention** to provide innovative and scalable, online and team-based suicide prevention education for primary care providers and their staff across 200 practices by 2022.

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Happening Now

SafeSide PREVENTION

Video-based Instruction and Demonstration

Anthony R. Pisani, Ph.D. and Kristina Mossgraber teach a systematic framework to care. Real clinicians model skills with patient actors.

Monthly Office Hours

Staff can ask questions and share experiences with Dr. Pisani and SafeSide subscribers from around the world in brief monthly Q&A webinars.

Updates and Refreshers

Your staff receive quick, entertaining videos 3 times a year to keep current with evolving best practices and research in Zero Suicide care.

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Emergency Departments

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39% of people

who die by suicide make an Emergency Department visit in the year prior to their death.

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Research

- Risk of a suicide attempt or death is highest within the first 30 days after discharge from an ED or inpatient psychiatric unit.
- Yet, up to 70 percent of patients who leave the ED after a suicide attempt never attend their first outpatient appointment.

Suicide Prevention Resource Center. (2015). Caring for adult patients with suicide risk: A consensus guide for emergency departments. Waltham, MA: *Education Development Center, Inc*.

Strategy

We can provide a safety net by educating and equipping emergency physicians and staff with the suicide prevention tools they need to screen and care for at-risk patients in emergency departments.

Happening Now

AFSP partnered with the **American College of Emergency Physicians (ACEP)** to develop and deliver a rapid, online suicide risk assessment and suicide prevention intervention tool (ICAR2E) for their more than 40,000 member emergency physicians.

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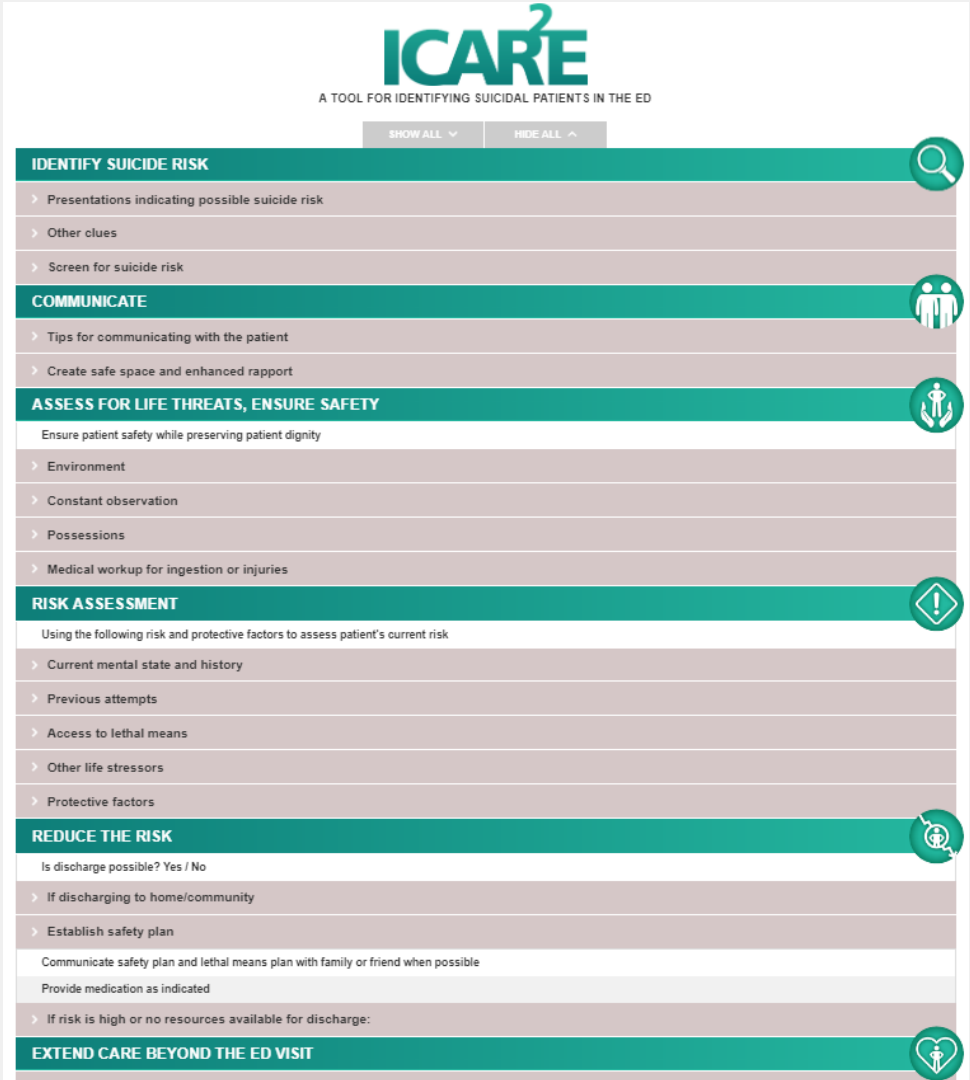

EMERGENCY DEPARTMENTS

ACEP/AFSP ICAR2E

Systematic review of ED interventions

Meta analysis of effectiveness

Tool algorithm

Expert panel report

Website and app development

Tool launched at ACEP conference in October 2018

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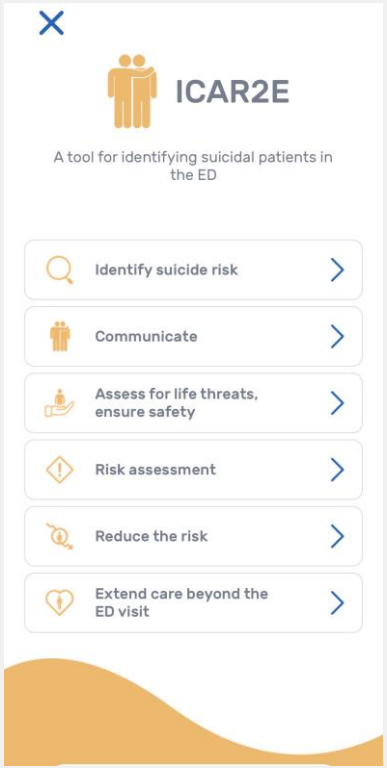
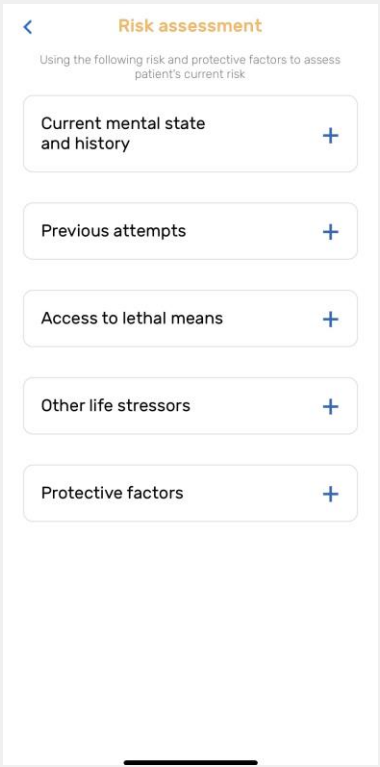
ACEP EMPoC App

Download on the App Store

GET IT ON Google Play





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COLLABORATIVE SAFETY PLANNING

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Safety Planning

- Using safety planning engages life protectors
- We incite hope to help the person save themselves
- Happens after identifying someone is at risk of suicide

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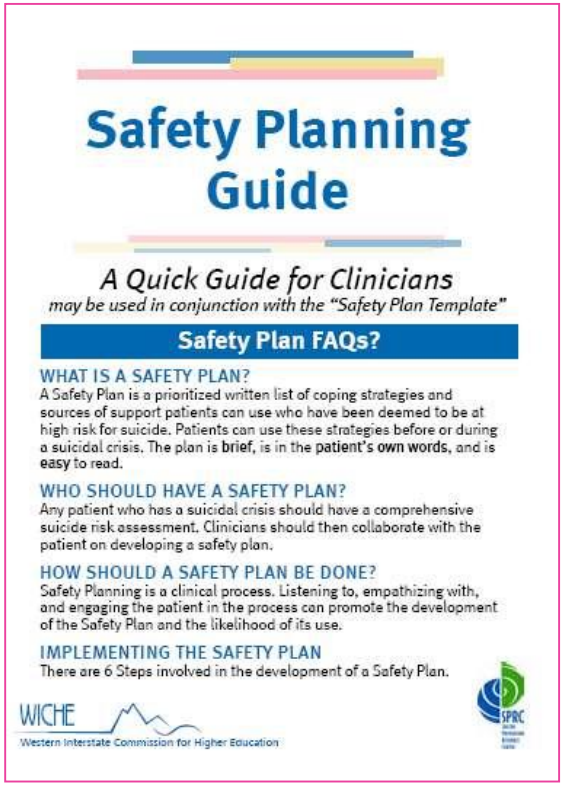
Safety Planning



Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the "Safety Plan Template"

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

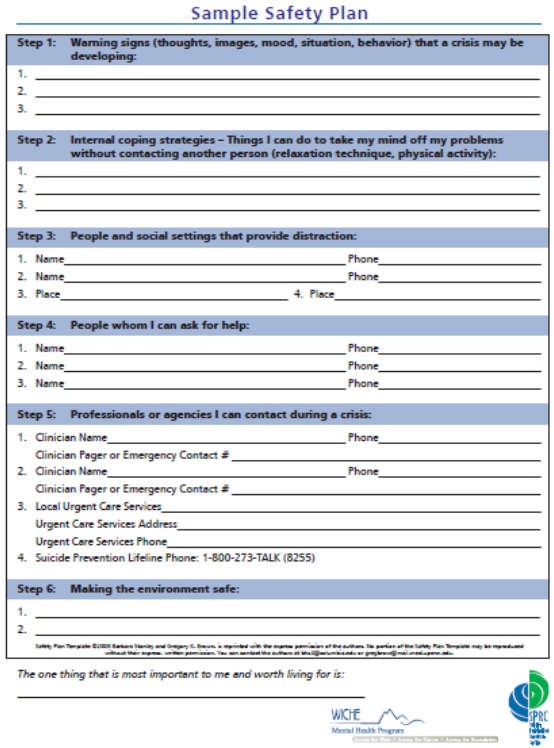
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

WICHE Western Interstate Commission for Higher Education

URL: http://www.sprc.org/library/SafetyPlanningGuide.pdf



Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

WICHE Mental Health Program

http://www.sprc.org/library/SafetyPlanTemplate.pdf

Recognizing warning signs

STEP 1: How will you know when the safety plan should be used?

Thoughts: "*I am a failure.*" "*I don't make a difference.*"

Images: *"Flashbacks."*

Thinking Processes: *"Having racing thoughts."*

Mood: *"Feeling irritable."* *"Feeling down."* *"Worrying a lot."*

Behavior: *"Spending a lot time by myself."* *"Avoiding other people."*

Employing internal coping strategies

STEP 2: What can you do on your own if you become suicidal again, to help yourself not to act on your thoughts or urges?

"How likely do you think you would be able to do this step during a time of crisis?"

"What might prevent you from thinking of these activities or doing these activities even after you think of them?"

Socializing with others as a way of distraction

STEP 3: Use step 3 if step 2 does not resolve the crisis or lower risk

"Who helps you feel good when you socialize with them?"

"Who helps you take your mind off your problems at least for a little while? You don't have to tell them about your suicidal feelings."

"Where can you go where you'll have the opportunity to be around people in a safe environment?"

Contacting family members or friends to help resolve crisis

STEP 4: Use step 4 if step 3 does not resolve the crisis or lower risk

“Among your family or friends, who do you think you could contact for help during a crisis?”

“Who is supportive of you and who do you feel that you can talk with when you’re under stress?”

Contacting mental health professionals/agencies

STEP 5: Use step 5 if step 4 does not resolve the crisis or lower risk

“Who are the mental health professionals that we should identify to be on your safety plan?” “Are there other health care providers?”

List names, numbers and/or locations of clinicals, local urgent care services

Reducing potential for use of lethal means

STEP 6: **Should ask which means the person considers during a suicidal crisis and collaboratively identify ways to secure or limit access to these means.**

“What means do you have access to and are likely to use to make a suicide attempt or to kill yourself?”

“How can we go about developing a plan to limit your access to these means?”

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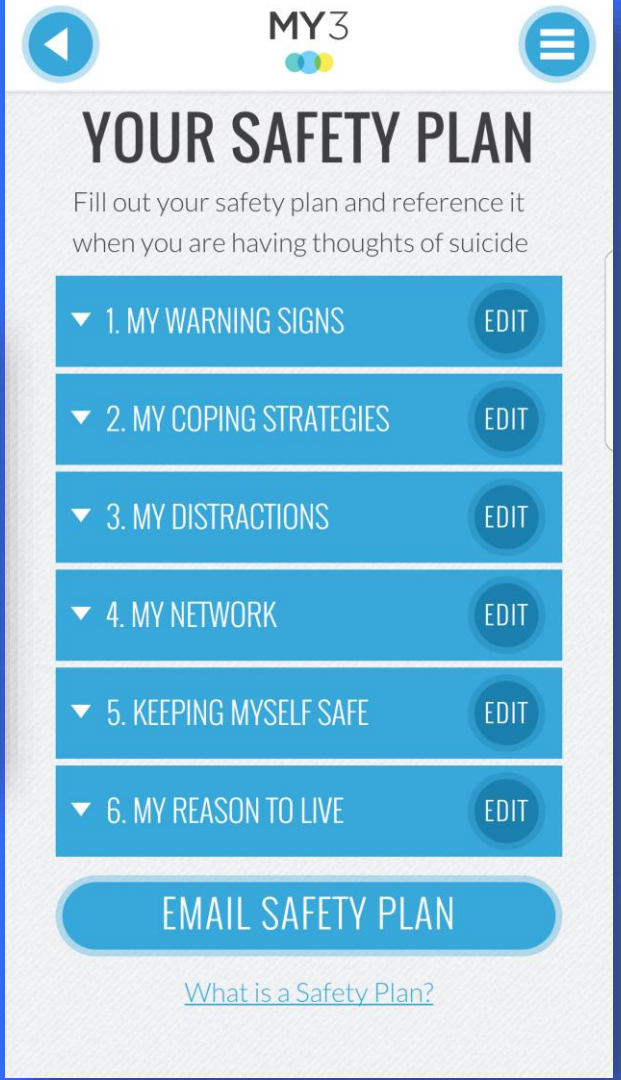

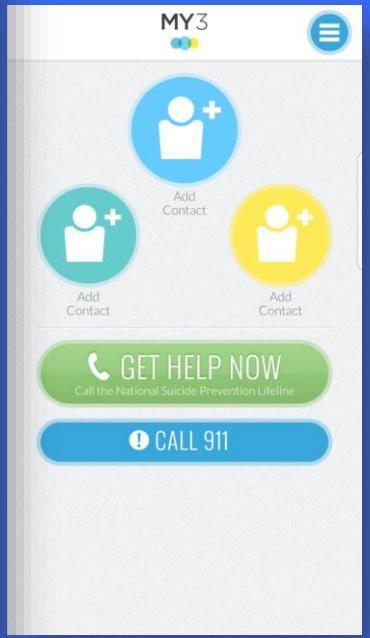

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Steps for Healthcare Organizations

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Steps organizations can take

- Put ‘Caring Contacts’ in place systematically
- Provide education to staff; Lethal Means Counseling
- Ask for consent to involve fam at the start of Tx
- Routine screening/assessment
- Document actions taken
    - Referral to BH, communication w family
    - Safety Plan completed, provided Lifeline
    - Counseled on lethal means removal

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Clinical Pearls

- Slow down the pace to get the narrative
    - The patient's "logic" is important
- Suicide Risk Assessment goes further than SI/plan
    - Consider other factors
- Follow up closely
- Caring contact matters
- Consider suicide specific therapy referral
- Consider medications to reduce suicide risk

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We are not expected to be able to predict suicide; we are expected to take reasonable steps toward prevention when suicide is a foreseeable outcome for a patient.

Translating evidence into practice saves lives and improves many more.

When We Reach Our Goal

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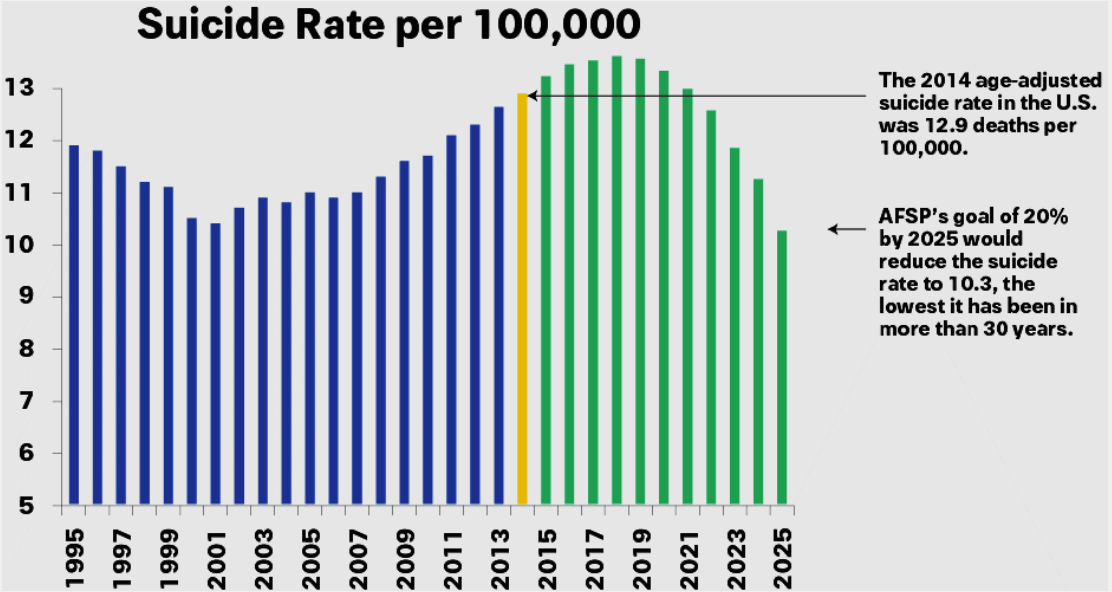
By 2025

The U.S. suicide rate will have dropped to its lowest in **30 YEARS**

More than **20,000 lives** will have been saved



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The researchers found that the probability of suicide in the first year after discharge from an emergency department was highest — almost 57 times that of demographically similar Californians overall — for people who had presented with deliberate self-harm. For those who presented with suicidal ideation, the suicide rate was approximately 31 times higher than among Californians overall. The suicide rate for the reference patients was the lowest amongst the studied groups, but still double the suicide rate among Californians overall.

The risk for death via unintentional injury (i.e., accidents) was also markedly elevated — 16 times higher for the deliberate self-harm group and 13 times higher for the ideation group than for demographically similar Californians. Most deaths due to unintentional injury were found to be due to overdose — 72% in the self-harm group and 61% in the ideation group — underscoring the overlap between suicide and overdose risk.

Goldman-Mellor, S., Olfson, M., Lidon-Moyano, C., & Schoenbaum, M. (2019). Association of suicide and other mortality with emergency department presentation. JAMA Network Open.

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