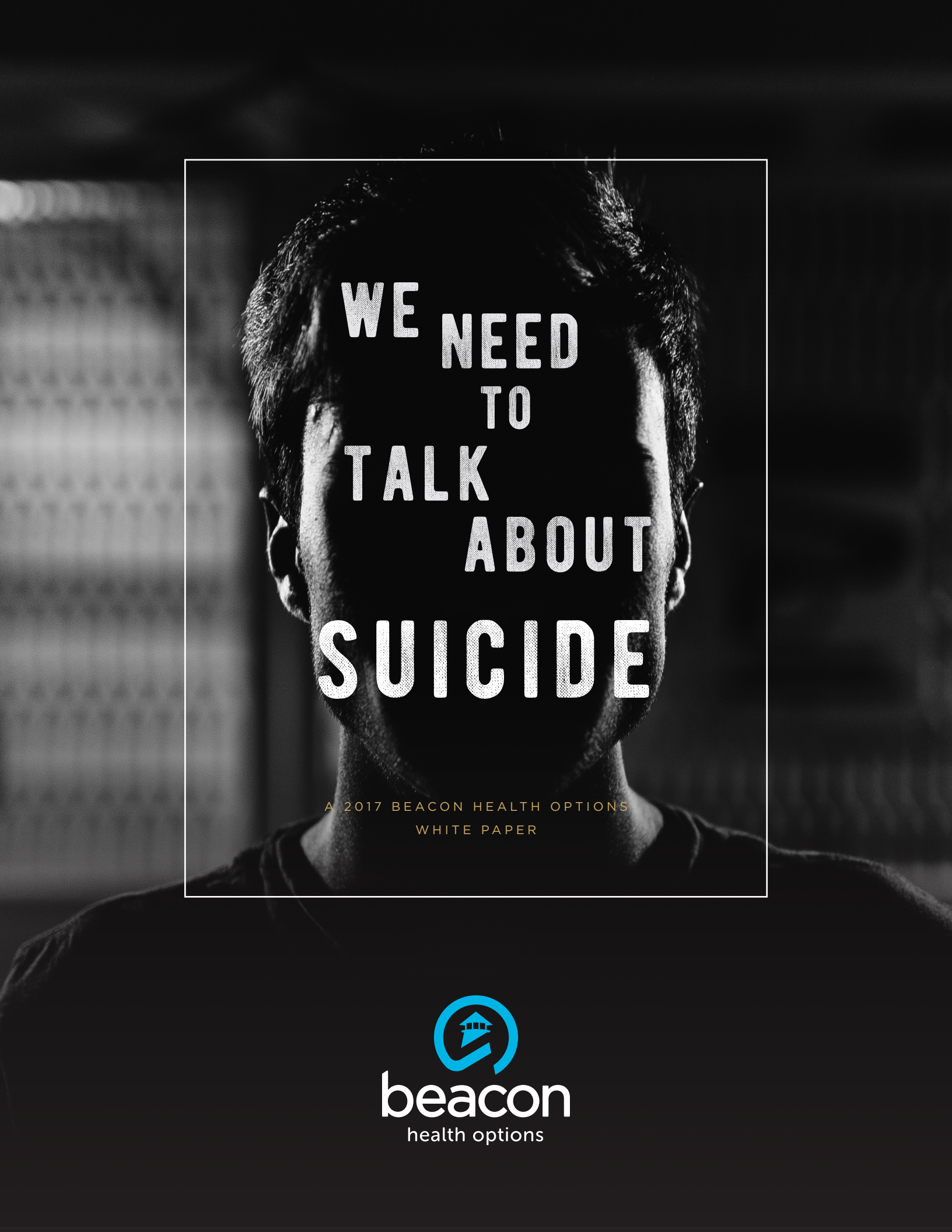

A 2017 BEACON HEALTH OPTIONS
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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the report's conclusions or recommendations, nor did they see the final draft of the report before its release.

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WE NEED TO TALK ABOUT SUICIDE

A 2017 BEACON HEALTH OPTIONS WHITE PAPER

A MESSAGE FROM OUR CEO

We at Beacon Health Options are making a commitment, marked through the publication of this White Paper, to improving care for our members who are struggling with suicidal behavior disorder. We know that the most vital difference we can make as a company, through our work with our provider partners, is to help people live their lives to their fullest potential. Consequently, we aspire to make suicide a "never event" whenever humanly possible. To some, this may sound audacious, but simply put: suicide extinguishes full human potential not only in the person taking his or her life, but also for his or her family and friends. This is antithetical to our company's mission, and thus we must strive to do better.

As we all know, the work of caring for individuals with suicidal behavior disorder is daunting, emotional and fraught with second-guessing by clinicians, family, friends and support networks. Beacon Health Options is committed to making sure that our internal team and those we work with in the community have access to best practices to reduce greatly, and hopefully, eliminate suicides. As we evolve, we will commit to the Zero Suicide approach to prevent and provide care to people with suicidal behavior disorder, a comprehensive approach developed by the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention. We believe this approach will improve the care and safety of our members. Through the publishing of this manuscript, this work starts today at Beacon Health Options.

In closing, similar to countless other people, my life was profoundly affected by a loved one's decision to take his life. With almost 20-years hindsight, I still grapple with decisions made and advice provided during the years leading up to the suicide. Candidly, I worked with no roadmap, except for trying almost anything that I thought would help. In retrospect, a disjointed health system, stigma and many other factors contributed to this terrible outcome. Today, I am more optimistic for those with suicidal thoughts and their support networks as we have better treatment practices and reduced stigma for those seeking care. I hope this manuscript helps and that you will join us in this important work. Suicide must not be an option for those who have entrusted us with their care.

Timothy Murphy

CEO, Beacon Health Options

ZEROSuicide IN HEALTH AND BEHAVIORAL HEALTH CARE | National Action Alliance for Suicide Prevention

FOREWORD

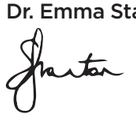
Over the past 10 years, deaths from people having heart attacks have decreased by 38 percent.[i] It turns out there is a lot we can learn that is relevant for suicide prevention and treatment from a strategy that has substantially reduced deaths from heart attacks over the last decade. This phenomenal improvement in outcomes from heart attacks has been achieved by focusing on a single metric: "door-to-balloon" time. This metric is the amount of time it takes from a person first presenting in the Emergency Room (ER) with chest pain to the time it takes to insert a catheter to the blocked artery, to inflate a balloon to unblock it and then insert a stent. The longer the time this takes, the more muscle that dies. In this way, time is muscle. In the old way of managing heart attacks, the most senior clinician – the interventional cardiologist – determined whether someone in the ER was having a heart attack and needed a stent, often taking several hours. Once the decision was made, different members of the heart attack team would be alerted to perform the procedure. This protocol took varying amounts of time, based on staff availability.

In the new order, ER physicians determine whether someone is experiencing a heart attack through reviewing the electrocardiogram (EKG), accelerating the initial assessment step. The entire heart attack team is simultaneously alerted when the patient is having a heart attack and called to the same room. If offsite and on-call, they are required to be within a set distance of the hospital. As these changes were first introduced, people felt they were losing control. Some even feared that patients would get a worse outcome. However, as "door-to-balloon" time was reduced, patients received treatment faster, and death rates reduced. Notably, this improvement in outcomes was achieved across all demographic groups and in different settings: from rural health care to academic health centers. It wasn't through reducing obesity, hypertension or any other investments in preventive health efforts but through a commitment to measurement-based care that led to improved outcomes for people with heart attacks.

This improvement in outcomes would not have been achieved if the focus had been on improving the whole of physical health care simultaneously. Although mental health treatment can be arguably more complicated than the singular intervention focus highlighted in the heart attack treatment example, the fundamental principles apply: we are unlikely to move the needle for suicide if we continue to spread our energy across a diffuse range of preventive efforts. As important as prevention efforts are, more than 50 years of research into suicide prevention have led to conflicting findings on what risk factors matter most.[ii] What will deliver most impact, and indeed save lives, is better identifying those who are experiencing suicidal behavior disorder today and ensuring access to evidence-based interventions for effective treatment. These evidence-based treatments are spelled out in this document.

At Beacon Health Options (Beacon), we stand for the evidence base around what works for people with mental health problems and substance use disorders. This white paper topic, written from the perspective of a payer and our role in supporting providers, is of particular importance to us because we know that we play an important role, along with our partners, to improve access to evidence-based treatments for our members, our colleagues, our family and friends.

Dr. Emma Stanton



Primary author and Associate Chief Medical Officer, Beacon Health Options

EXECUTIVE SUMMARY

Suicide is preventable. Yet in the United States, more than 1 million people attempt suicide and more than 40,000 people die by suicide annually. Significantly, deaths by suicide have increased 24 percent over the past 15 years, keeping suicidal behavior disorder a leading cause of death even as overall mortality rates decline.

However, the probability of any individual committing suicide remains very low, making suicide a highly complicated phenomenon. Indeed, a recently published meta-analysis reveals that, despite extensive research over decades, we still can't conclusively predict who is at most risk of suicide.[iii] Therefore, the intent of this manuscript is not to point to a simplistic or reductionist approach.

The core message of this paper is that suicidal behavior disorder is a treatable condition in its own right, rather than being a side effect of depression or any other underlying mental health problem. By defining suicidal behavior as a diagnosis distinct from co-occurring conditions, approaches to its identification can be better integrated into clinical practice. However, a significant barrier to overcome is that many mental health clinicians practicing today have been trained to identify and treat underlying conditions only. This White Paper aims to dispel that point of view by explaining why suicidal behavior disorder should be treated like any other behavioral or physical health condition.

This paper's proposed solution is based on the 'Zero Suicide' model, a comprehensive approach developed by the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention, the nation's public-private partnership for suicide prevention. Their efforts emerged from a 1999 Surgeon General call to action to prevent suicide[v] and the landmark 2001 Institute of Medicine report, *Crossing the Quality Chasm*.[vi] The seven-pronged model, shown below, is anchored in the foundational belief that "suicide deaths for individuals under care within health and behavioral health systems are preventable." Critics of this model claim that such a "zero suicide" goal is aspirational and not readily attainable, particularly for individuals with serious mental illness. However, organizations such as the Henry Ford Health System and others that have adopted and implemented this framework demonstrate otherwise.

> **"Establishing suicide prevention as a priority will require significant changes by health systems and mental health programs in terms of policies, protocols, and staff training."**
>
> – Michael F. Hogan, Pioneer of Zero Suicide, 2016

1. Lead: *Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.*

Any action plan for Zero Suicide starts with a commitment from leadership to change organizational culture. Practical ways to achieve this include: 1) conducting an internal assessment of current levels of knowledge around suicidal behavior disorder and the resources allocated to suicidal behavior disorder care; 2) prioritizing systemwide access initiatives, such as 24/7 crisis services; 3) promoting a non-punitive environment for anyone to express quality-of-care concerns around suicidal behavior disorder; 4) reviewing and promoting suicide-related data to assess progress; and 5) supporting frontline staff who do this important and difficult work.

2. Train: *Develop a competent and caring workforce*

All health care organizations have mandatory annual employee trainings. Specific training for suicidal behavior disorder can easily be incorporated into curricula through one of many free training modules available on evidence-based clinical practices. Such training may also include screening, risk assessment, and appropriate care pathways for people with suicidal behavior disorder.

3. Identify: *Systematically identify and assess suicide risk among people receiving care*

Payer and provider organizations can be more proactive in identifying at-risk individuals by: 1) developing policies and protocols requiring the assessment of suicidal risk, i.e., asking individuals whether they have suicidal thoughts; 2) enforcing screening of individuals at potentially higher risk, e.g., those with mental health or substance use disorder diagnoses and/or recent inpatient admissions; and 3) incentivizing coding for suicidal behavior disorder as part of a broader reimbursement strategy for screening.

4. Engage: *Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.*

The following are basic steps to ensure that people receive the care they need during a crisis:

- Develop safety plans in advance that indicate what an individual should do during a crisis
- Facilitate access to services via 24-hour support to help reduce suicides and provide alternatives to emergency services
- Involve peers to promote engagement
- Work with patients and their families to identify and reduce access to means of self-harm

5. Treat: *Use effective evidence-based treatments that directly target suicidal thoughts and behaviors*

To treat suicidal behavior disorder directly, the following are evidence-based best clinical practices: 1) brief educational interventions, such as a one-hour, individual informational session; 2) non-demand caring contacts, i.e., check-in phone calls or text messages; 3) Collaborative Assessment and Management of Suicidality (CAMS), to empower suicidal patients in an outpatient setting as a partner in designing their own care plan; 4) psychotherapy, including such well-known interventions as Dialectical Behavior Therapy (DBT) and Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) and less well-known interventions, Mentalization-Based Treatment (MBT) and Transference-Focused Psychotherapy (TFP); and 5) pharmacotherapy.

6. Transition: *Provide continuous contact and support, especially after acute care*

Suicide risk is highest immediately following discharge from acute care. When suicidal individuals know they have easy access to services and supports, they have better outcomes, even if not using more services. Therefore, some kind of follow-up contact within 24 hours after discharge from a higher level of care to a lower level of care is essential.

7. Improve: *Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk*

Driving positive organizational change requires a leadership-driven culture supported by ongoing quality improvement activities. Organizations must continuously assess their aftercare services to ensure that at-risk individuals have access to the care they need following an inpatient admission. However, critical to continuous quality improvement efforts is the ongoing surveillance of suicidal behavior disorder throughout the care continuum, not just during and following inpatient levels of care.

In summary, this White Paper provides action-oriented recommendations for implementing each of the seven tenets of the Zero Suicide framework and shows how multiple stakeholders – providers, payers, policymakers and employers – have a role to play in supporting the infrastructure to drive this transformative vision to both identify and treat suicidal behavior disorder.

SCOPE OF PROBLEM

INTRODUCTION

In a 2010 *Forbes Magazine* article, Harvard Medical School psychiatrist Ross Baldessarini called suicide a "neglected disease" and "one of the most under-researched areas in all of psychiatry"[vii]. Some of that failure can be explained by cultural bias. As a society, we struggle with the sacredness of human life and the meaning of death invoked by sociocultural and religious beliefs. Our language perpetuates the idea of suicide as a punishable offense: to attempt or "commit" suicide as one would attempt or commit a crime. As this paper is written from a health care perspective, we refer to "suicidal behavior disorder". However, this is not an attempt to medicalize all the accountability and risk factors surrounding suicidality, as broader societal responsibility is required to address the complex web of issues surrounding increased rates of suicide.

> "I feel that suicide is the 'dirty little secret' of behavioral health and that we don't like to talk about it or focus on it. This is a mistake."
>
> – Surveyed Beacon employee

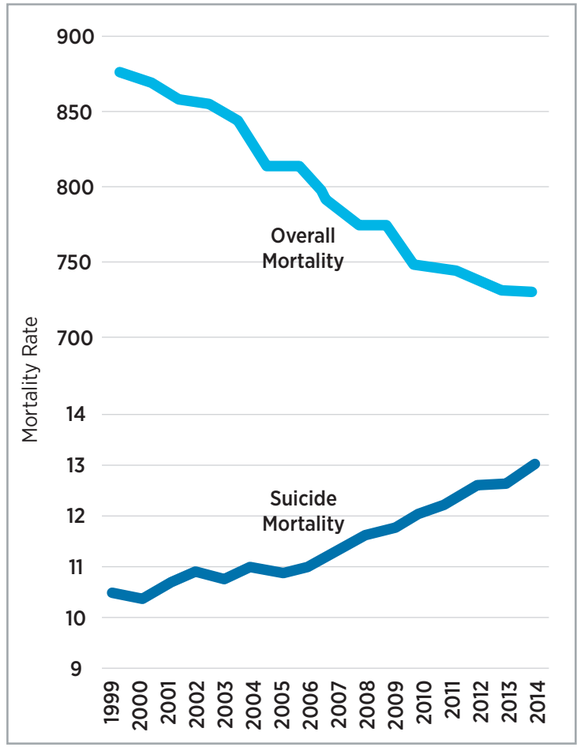
Similar to the analogy of treating heart attacks to reduce mortality, this paper outlines an evidence-based framework for identifying and treating suicidal behavior disorder. However, first we want to acknowledge upfront that this is also an incredibly emotive topic, one that leads to devastation for families and friends who have lost loved ones. This is what drives our mission.

SUICIDAL BEHAVIOR DISORDER IN THE UNITED STATES

Overall Prevalence

Suicide rates are on the rise in the United States – increasing by 24 percent from 1999 to 2014 based on suicides per 100,000 individuals with a net change to more than 40,000 suicide deaths annually. This increase is higher in the latter half of this time period, jumping from 1 percent to 2 percent annually (Figure 1). Strikingly, this contrasts with a prior decline in suicide mortality from 1986 to 1999 and a decline in overall mortality[viii]. For example, cancer deaths declined by 25 percent during the same time period.[ix]

Figure 1. National age-adjusted mortality rate per 100,000



Data Source: Centers for Disease Control and Prevention

There are many special populations at increased risk of suicidal behavior disorder as discussed under 'Social Determinants' starting at the bottom of this page. Veterans are just one example. In July 2016, the Department of Veterans Affairs released statistics on veteran suicide rates, revealing that the risk for suicide among veterans was 21 percent higher when compared to US civilian adults. Further, since 2001, the age-adjusted rate of suicide among veterans has increased by more than 32 percent.[x]

Scientists are still investigating why suicide rates have increased in the last 15 years. Today, it is the 10th leading cause of death, outpacing homicides, car accidents, and HIV/AIDS.

For adolescents, whose deaths by suicide have now caught up to deaths by traffic accidents – specifically for the group aged 10 to 14 – there is speculation that technological advances could be increasing media exposure leading to copycat suicides[xi] and cyberbullying incidents that increase suicide risk for victims and perpetrators[xii].

It is widely recognized that deaths from suicide are significantly under-reported, with an estimate of between 10 and 30 percent of accidental deaths as actually due to suicide.[xiii] Unlike the heart attack example in the Foreword, our efforts at suicide prevention to date have not (yet) turned the tide.

CAUSES OF SUICIDE

Individual Risk Factors

While genetics certainly play a role in suicide risk, and a family history of suicide does increase risk, so far no biomarker for suicidal behavior disorder has emerged. Factors such as hopelessness, social isolation, impulsiveness, and a pattern of aggressive or antisocial behavior also increase suicide risk. Indeed, some suicides are impulsive decisions made within 5 to 10 minutes during short-term crises[xiv]. In one study, the degree of hopelessness accurately predicted 91 percent of participants who died by suicide over the following 10 years[xv].

> "There are no words to describe the tremendous impact a completed suicide has on a family."
>
> – Surveyed Beacon employee

Five *relatively* strong risk factors[xvi,xvii] deserve particular consideration in health care settings: prior suicide attempts, inpatient psychiatric care, mental illness, substance use and access to lethal means.

However, these factors alone cannot predict suicide risk. Protective factors predict suicidal behavior better than exposure to stressful life events. Examples of protective factors include effective clinical care, improved access to care, family support and limited access to lethal means of suicide. They help reduce the likelihood of suicidal behavior, which might include an individual's genetic or neurobiological makeup, attitudinal and behavioral characteristics, and environmental attributes. As protective factors fluctuate, there is a need for frequent reassessment.

Social Determinants

Sociologist Emile Durkheim, an early pioneer in suicidal behavior disorder research, first proposed that societal structures affect suicide rates. Scientific evidence now confirms the effects of social influences, such as a history of trauma or loss, involvement in justice and child welfare settings, adverse child events, and serious medical conditions or physical impairments[xviii]. Such effects are especially potent in the presence of other psychiatric symptoms. Six core social determinants are highlighted in further detail in Table 1.

Table 1. Key Social Determinants of Suicidal Behavior Disorder

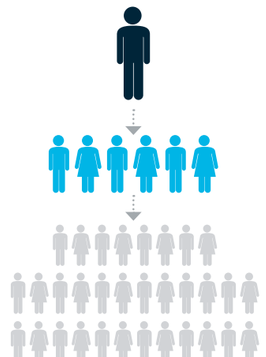
Gender	Women are at greater risk for suicidal thoughts and attempts; men are at more than three times greater risk of dying by suicide (77.9 percent of completed suicides).
Age	Middle-aged adults (age 45 to 64) have the highest total number of suicides (56 percent), while older adults (over age 75) have the highest proportion of suicides. Adolescents have lower rates but are high-risk as suicide is the second leading cause of death for this group. Among older adults, physical illness co-occurs in up to 80 percent of cases. Functional impairment is also common[xix].
Race and ethnicity	In the United States, American Indians (AI) and Alaska Natives (AN) have the highest suicide rate. Next are non-Hispanic White Americans, who are the largest segment of the population. There are not significant differences for other racial and ethnic groups. For AI/AN, potential explanations include higher rates of substance use, anxiety, and depression as well as history of trauma, childhood adversity, unemployment, and incomplete schooling[xx].
Gender orientation and sexual orientation	Lesbian, gay, bisexual, and transgender (LGBT) individuals are at greater risk for suicide. LGBT youth are twice as likely to think about it. Hypotheses for why include prejudice and discrimination, stress in interpersonal relationships, limited sources of support, greater alcohol and substance use, and higher rates of HIV[xxi].
Socioeconomic status	Poverty is linked to worse mental health[xxii] which, in turn, increases suicide risk. Economic recessions and high unemployment also increase suicide risk.
Geographic place of residence	People living in rural areas are at greater risk for suicide, with higher rates compared to people living in other regions. The U.S. "Suicide Belt" of Western states is a prime example. Hypotheses for why include greater social isolation, less access to health services, and lower levels of education, among others.

Primary Data Source: Centers for Disease Control and Prevention

CONSEQUENCES OF SUICIDAL BEHAVIOR DISORDER

Societal Impact

Each suicide touches six to 32 loved ones, who then become at increased risk for suicide themselves.[xxiii] Based on the number of hospital visits due to self-harm, approximately 12 people harm themselves for every reported death by suicide, according to the American Foundation for Suicide Prevention.[xxiv] Many survivors experience a range of complex grief reactions (guilt, anger, abandonment, denial, helplessness, shock), some of whom would benefit from professional support themselves, thereby increasing demands on the behavioral health care system. Survivors of suicide are likely to miss work and/or to work less effectively when caring for a suicidal loved one or grieving after a loss. Employers can help and support their workers through these difficult times through such services as Employee Assistance Programs.



Each suicide touches six to 32 loved ones

Economic Burden

From an economic impact perspective, on average, each suicide cost society more than $1 million in 2010. Overall, completed suicides cost approximately $51 billion in 2015, $167 million in medical expenses and the remaining $50.8 billion in lost productivity[xxvi]. Non-fatal, self-inflicted injuries cost another $10.4 billion in medical expenses and lost productivity. These estimates do not include the costs to the public (e.g., law enforcement, prosecution, corrections) or family (e.g., funeral), among others. Suicide attempts also contribute to escalating health care costs due to emergency department visits, inpatient hospitalizations and subsequent psychiatric care.

> **"The ethical standpoint is to assume that enough money is allocated to the prevention of suicide, regardless of cost-effectiveness. Unfortunately, this is not the case."**
>
> – Knorring et al., 2000[xxv]

SUICIDAL BEHAVIOR DISORDER IN HEALTH CARE

Current State

Official Mandate

For a long time, health care abdicated responsibility for suicidal patients outside of inpatient settings. In 2007, the Joint Commission first established a National Patient Safety Goal to identify patients at risk of suicidal behavior disorder in hospital and health care facilities. In 2016, this guidance was expanded across all health care settings to include detection, screening, risk assessment, safety, treatment, discharge and follow-up care. The role of primary care has since expanded as well.

Diagnostic Criteria

Historically, an individual's choice of suicide was informally considered a matter of personal liberty and, consequently, was excluded from prior versions of the diagnostic manual as a standalone mental health condition. The current version, *DSM-5, (Diagnostic and Statistical Manual of Mental Disorders-5)* proposes the inclusion of suicidal behavior disorder for the first time as a diagnosable condition, defined as a suicide attempt within the prior two years. The vigorous debate around labeling a behavior as a 'disorder' reflects our evolving understanding of suicide. Yet from a health care perspective, Beacon Health Options finds it helpful to use the term "suicidal behavior disorder" as it reinforces the treatability of the condition in its own right.

Treatment Practices

Too often today, suicidal patients continue to be hospitalized, despite limited evidence of benefit. This statement excludes those individuals with severe mental illness who may require the more intensive services of an inpatient setting.

While short admissions of less than a week can increase suicide risk, staying in higher levels of care for longer than necessary because of fear or lack of knowledge around suicide prevention can also increase suicide risk.[xxvii] Fear of this type of automatic involuntary inpatient treatment also poses a major barrier to accurate diagnosis, as patients may be unwilling to disclose suicidal thoughts and behaviors. More about patients' reluctance to discuss suicidal thoughts can be found under "Identify" in the Core Recommendations section.

Clinicians and Suicidal Behavior Disorder

Contact with Clinicians

In the month prior to a completed suicide, almost half (45 percent) of people who died visited their PCP. Only a fifth (19 percent) visited mental health services.[xxviii]

Unfortunately, higher rates of contact in primary care have not translated into higher rates of effective care for individuals with suicidal behavior disorder. Studies show that for patients with undisclosed suicidal thoughts, physicians discussed suicide in only 11 percent of encounters. For patients who requested antidepressants or presented with major depression or adjustment disorder, only 36 percent of physicians discussed suicide[xxix]. Although US Preventive Services Task Force guidelines recommend depression screening, PCPs are reluctant to identify patients at high risk of suicidal behavior disorder when they believe that they have limited options to address the issue. For example, some practitioners even omit the question on suicide on the Patient Health Questionnaire, PHQ-9. This builds the case for the more systematic integration of behavioral health expertise into primary care settings.

Training alone is insufficient to solve the problem. Access is also an issue. Despite more than 90 percent of people who complete suicide having a mental illness, only half (53 percent) will receive any mental health treatment in their lifetime.[xxx]

Clinician Preparedness

Lack of Training

Most behavioral health clinicians have never received formal training on treating suicidality. Indeed, a survey across seven states revealed that 64.1 percent of behavioral health staff never received specific training for treating suicidal behavior disorder. Such staff members reported less knowledge about suicidal behavior disorder and less confidence in their skills relative to their trained colleagues[xxxi]. Half of psychology interns and three-quarters of psychiatry interns still do not receive suicidal behavior disorder training[xxxii], even though three-quarters of graduate program directors would like to offer more[xxxiii].

Ineffective or Harmful Practices

Ineffective or harmful practices that can increase suicide risk are rooted in persistent myths and old habits, such as the frequent practice of involuntary inpatient hospitalization or the use of "no suicide" contracts. Not only is this practice ineffective, it also does nothing to mitigate legal consequences for failing to safeguard patients at risk of suicide.[xxxiv] Other moments of potential harm include failing to reexamine a patient carefully (especially before discharge); overlooking suicidal shifts in recovering patients; reluctance to prescribe electroconvulsive treatment (more rapid responses can have effects prior to discharge); and changing clinicians (discontinuity of care)[xxxv].

CORE RECOMMENDATIONS: IMPLEMENTATION ACTION ITEMS

As in the case of the heart attack analogy, identification of the disorder – in this case suicidal behavior disorder – and then treating that disorder should be the focus of an improved system of suicide care. All other systemic elements must support those two activities. The Zero Suicide model includes seven essential elements of care, two of which are "Identify" and "Treat". Beacon views the remaining five pillars – Lead, Train, Engage, Transition and Improve – as the structural and organizational requirements needed to support diagnosis (identify) and treatment. This framework substantively reduces suicide by striving to deliver "perfect care" for mental health conditions[xxxvi]. The U.S. Surgeon General endorsed Zero Suicide in 2012; the U.K. prime minister did so in 2015. See Box 1 showing Beacon's own recent efforts in Colorado.

BOX 1: COLORADO - THE POWER OF ZERO

During a two-week period in May 2016 at a local high school in Colorado Springs, four students took their lives. A subsequent report from the Colorado Department of Public Health and Environment asserted that one suicide intimately affects 25 people, translating to more than 27,000 people affected by the number of suicides in 2015 occurring in Colorado alone.

This tragedy rocked the local community and prompted Beacon's Colorado office to rethink its approach to identifying and treating people with suicidal behavior disorder. With total support from leadership, four employees from that office attended a Zero Suicide Academy held June 2016 in Colorado as a first step in implementing best practice around suicidal behavior disorder treatment and prevention.

Within three months, the office had a Zero Suicide strategy implementation team with representation from the IT, Quality, Administration, and Clinical departments, which meets biweekly. Since then, they have:

- Created a weekly discharge report per mental health center (MHC) with member information, suicide rating scale at time of admit, and member contact information. The goal is for MHCs to reach out to members who have been recently discharged from inpatient care with a non-demand caring contact.
- Created a quarterly meeting with MHCs to align Zero Suicide efforts
- Taught Mental Health First Aid to community and internal staff members
- Developed a standardized screening tool for internal staff
- Implemented Lunch-and-Learns to train staff on what to do if someone answers YES to questions about feeling suicidal and to refocus thinking towards greater resiliency and coping skills
- Circulated weekly research articles to internal staff members
- Created a Zero Suicide Office365 shared workspace to house all minutes, research articles, etc.

> **"Managed care accepted two sometimes conflicting missions: to control costs and to improve the outcome of treatment. … Yet the managed care revolution holds a potential for good that is equally revolutionary: insurers can promulgate evaluation standards and treatment procedures that incorporate emerging scientific advances, and providers can respond by more effectively evaluating patients, formulating behavioral treatments, and speeding transitions to lower levels of care."**
>
> – Alan Lipschitz, M.D., *Treatment of Suicidal Patients in Managed Care* (2001)

The role of managed behavioral health care brings the potential to coalesce a system that has so far been broken regarding suicide; providers certainly cannot shoulder the burden alone to transform the system. "Systemwide" means multiple players, including employers; providers; payers; policymakers; government and social agencies; and individuals themselves. All need to work together to achieve transformative change.

The following section sets out action-oriented recommendations for each of the seven Zero Suicide elements.

1. Lead: *Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.*

Implementing a Zero Suicide strategy must start with commitment at the top. This means that leadership teams in provider and payer organizations across the health care system need to internalize the belief in Zero Suicide, set the vision, and commit to a systemwide approach through engaging in the following activities to support identification and treatment of suicidal behavior disorder. This cultural change benefits from the inclusion of peers who have struggled with suicidal thoughts or attempted suicide in the past, or family members who have dealt with the aftermath of suicide.

a. Conduct an internal assessment of the organizational capability

A helpful place to start is to conduct an internal assessment of current levels of knowledge and comfort around suicidal behavior disorder and the resources allocated to suicidal behavior disorder care. At Beacon, we recently undertook a companywide online survey to discover our own employees' strengths and weaknesses applying best-practice principles.

Even as a leading behavioral health specialty company, we discovered pockets of knowledge gaps regarding industry best practice – as shown in Box 2 on the next page.

BOX 2: **BEACON EMPLOYEE SURVEY ON SUICIDAL BEHAVIOR DISORDER (2016)**

As a preliminary step towards implementing Zero Suicide, Beacon recently surveyed its employees about both their professional and personal experience with suicidal behavior disorder to understand better the needs of our workforce in this area. The overarching message is that most people have been affected in some way by suicide.

Eighty-five percent of Beacon clinicians surveyed stated they have the training to assist those with suicidal desire or intent, and 80 percent say they have the skills. However, only 58 percent agree that they are confident in treating a suicidal individual using such evidence-based approaches as DBT or CBT-SP, which suggests a disconnect between perception of abilities and actual abilities in addressing suicidal individuals and thus facilitating our provider partners to treat this group. This important information will help Beacon with its training efforts to bridge any gap between practice and the evidence base.

Additionally, many employees shared their own personal experiences with suicidal behavior disorder: *"I am a survivor of suicide, and I appreciate this survey."* Another wrote: *"Having been suicidal myself, more needs to be done."*

b. Access

Leaders also need to advocate for timely and consistent follow-up, particularly after inpatient psychiatric admissions. Systemwide improvement initiatives for access include: 24/7 crisis services, technology solutions, and same-day access for behavioral health services to be integrated into primary care settings. For more information on the evidence base for the effective integration of behavioral health services into primary care, please see Beacon's 2016 White Paper, "Integration".

c. Promote a climate of continuous improvement

Following lessons learned from the patient safety movement, it is critical for leadership teams to promote an open, safe and non-punitive environment for anyone to express quality-of-care concerns related to suicidal behavior disorder. Doing so means creating a culture striving for perfection yet not penalizing providers or systems of care for failing to meet this standard. Overcoming resistance and skepticism to the notion that the "zero suicide" goal is achievable can be a major barrier and so education is critical to gaining buy-in.

2. **Train:** *Develop a competent and caring workforce*

Developing a "competent and caring workforce" necessitates training on both the payer and provider sides. Requiring 100 percent completion of annual suicidal behavior disorder training is an effective path to ensuring this competency is developed. It can occur via access to one of many training modules available on suicidal behavior disorder and evidence-based clinical practices for treatment of suicidality.

Identifying and naming internal Zero Suicide champions is also a successful way for organizations to drive change at scale as such champions can be responsible – and catalytic – for specific actions as follows:

- **Invest in soft-touch opportunities with different stakeholders** (e.g., community kickoff event, "Lunch & Learn" events, expert panel dinners, provider appreciation breakfasts, quarterly provider forums) to share the vision for, and obtain commitments to, Zero Suicide and Mental Health First Aid initiatives
- **Offer access to a suicide prevention training module,** with incentives for completion by providers and staff
- **Offer convenient opportunities to learn about evidence-based treatments for suicidal behavior disorder** (e.g., webinars with continuing medical education/continuing education units)
- **Provide ready-to-go templates** for universal screening, risk assessment, safety planning, and follow-up care
- **Capture suicide-related data** to provide real-time feedback on relevant metrics of effective care and target outcomes
- **Offer practical courses** to identify mental health issues, including "Mental Health First Aid". Such courses empower individuals, as well as professionals, on how to administer "first aid" to those in crisis.
- **Offer training that requires role-playing** in asking about suicidal thoughts. One excellent course can be accessed at QPR Institute.

A crucial part of developing a caring workforce is not just how we act or treat, but how we think. Evidence shows that when experts talk about epidemics, suicide rates increase.[xxxvii] For example, when the Centers for Disease Control and Prevention reported that the suicide rate in this country was increasing, the rate increased even more. The more we talk about it rising, the more it increases.

The media, therefore, also has a vital role to play in changing the conversation about suicidal behavior disorder. Health care champions also need to get that word across through promoting the following messages to both the media and communities at large:

- For every one person who dies by suicide, there are 278 people who move past serious thoughts about killing themselves.[xxxviii]
- Studies have found that the reporting of individual suicidal ideation followed by recovery was associated with a *decrease* in suicide rates.

There is an association between telling positive recovery stories and a decrease in suicides. These published accounts of hope suggest that prevention of suicidal behavior by media reports is possible.[xxxix]

3. **Identify:** *Systematically identify and assess suicide risk among people receiving care*

Suicidal behavior disorder remains difficult to identify, predict, and treat but – as for heart attacks – it's no longer impossible.

a. Development of policies

Policies need to reflect that protocols require the assessment of suicidal behavior disorder risk, regardless of the presence or absence of a mental health diagnosis. Just as in the example of changing how we treat heart attacks in the ER, those guidelines should clarify the core elements of good suicidal behavior disorder care, at minimum, as follows:

- Risk assessment, including universal screenings across all services and enumeration of care pathways by level of risk for crisis, behavioral health (clinical practice guidelines), and primary care services (electronic health record automation with tools such as safety plans and resources such as decision-support)
- The development of care plans using templates that emphasize evidence-based treatments, safety planning and follow-up care
- The requirement of a centralized resource, such as an intranet site with clinical guidelines and electronic tools to improve quality and efficiency of care

Additionally, specific policies for people with comorbid substance and/or alcohol use disorders have proven to be effective at reducing suicides. Such policies need to include a reassessment of post-discharge processes, specifically around improving better contact rates and quality of follow-up care. Further, policies should address medication-assisted treatment as an evidence-based option for people with substance use disorders (SUD) and increased access to SUD services in general. These SUD policies should also address the inclusion of peer support.

b. Assessment and universal screening

Despite our best efforts, the truth is that physicians, and other behavioral health providers, are notoriously poor at predicting who is at highest risk of attempting suicide. In fact, a recent meta-analysis examining 50 years of suicide research revealed that researchers still can't predict who is most at risk of suicidal thoughts and behaviors.[xl] However, we are developing better diagnostics, much like the improved assessment techniques in the "door-to-balloon" time heart attack analogy. One such innovation is the Interpersonal Theory of Suicide, which asserts that an individual will not die by suicide unless he/she has both the desire and the ability to do so. The desire is driven by two simultaneously held psychological states – "perceived burdensomeness" and "social alienation". If clinicians are more aware of assessing these specific psychological states, they will be better placed to evaluate suicidal behavior disorder risk and provide care faster.[xli]

Reinforcing this point, staff at Beacon's offices in Colorado conducted a study in 2012 to interview members who were suicidal. When questioned why they did not tell anyone (including therapists) that they were suicidal, the number one response was *"because no one ever asked"*. In fact, we now know that the most evidence-based way to predict risk is to ask people. A 2014 study by Simon et al. examined patterns of suicide for more than 75,000 people who had completed the nine-item Patient Health Questionnaire (PHQ-9), which includes a question about thoughts of self-harm. About 80 percent of those who died by suicide in the follow-up period had indicated they had suicidal thoughts. The risk of dying by suicide was 10 times higher for those who indicated they had suicidal thoughts every day.[xlii]

Such evidence dispels the myth that asking about suicidal thoughts may inadvertently prompt suicidal behavior. In fact, a literature review on this topic showed no statistically significant increase in suicidal ideation among participants when asked about suicidal thoughts. Indeed, asking about suicide may actually reduce its potential as well as improve mental health treatment.[xliii]

However, we cannot rely on self-reports alone. Screening is an important tool in behavioral health practice, but its efficacy for assessing suicidal behavior disorder potential is debated. Indeed, best practice would include use of a screening tool combined with clinician judgment as current assessment methods rely mostly on self-report, which is problematic for several reasons. For example, many people are motivated to hide suicidal thoughts, which are also often transient in nature. Approximately 80 percent of people who die by suicide while in the hospital denied suicidal thoughts or intent.[xliv]

Most screening tools for suicidal behavior disorder are already familiar to behavioral health professionals, such as the PHQ-9 mentioned above, which is a strong predictor of suicide attempts and a moderate predictor of suicide death[xlv]. Use of the Columbia-Suicide Severity Rating Scale is endorsed by Beacon as it helps to reduce clinician burden; encourages self-disclosure; and facilitates clinical follow-up.[xlvi] The fundamentals of screening are to ask early; ask often; and to be clear about the care pathway in the event of a crisis, just as the emergency treatment of heart attacks requires quick assessment and clear protocols. The Joint Commission *Sentinel Alert* recommends that suicide screening be conducted at every mental health admission (inpatient or outpatient) and reviewed with the patient at discharge or after an appointment. Both of these screening tools are shown in the Appendix.

It's important to note that screening should occur in primary care settings as well as specialty care. To promote that practice, state mental health authorities can require screening for suicide risk at all primary care appointments for individuals with depression and/or substance use disorder conditions.[xlvii]

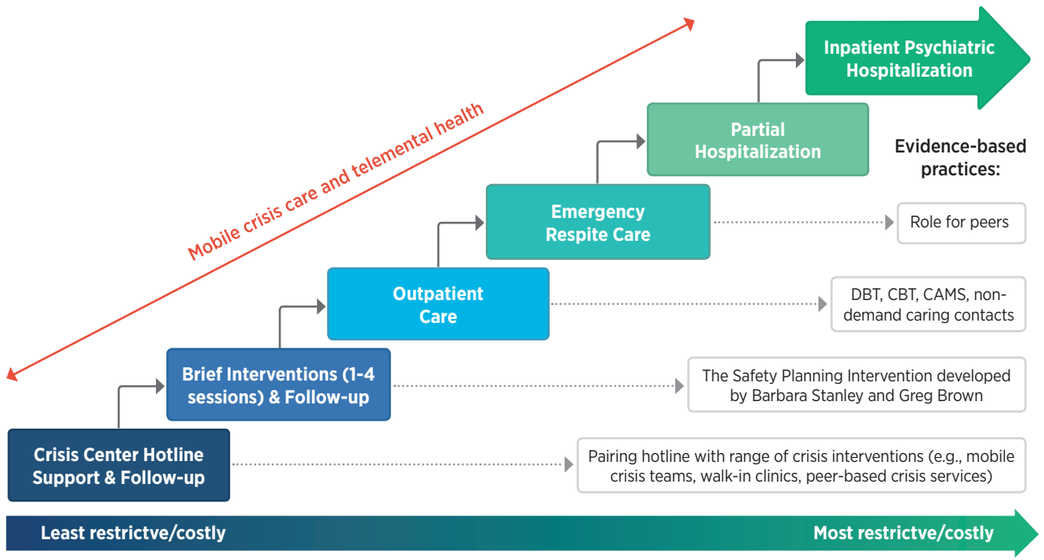
c. Coding to support screening for better identification

Enforcement of coding for suicidal behavior disorder as part of a reimbursement strategy for screening matters as this influences how money flows in the health system. Prospectively, we need to better align with best practices to treat suicidal behavior disorder as a disorder in its own right. Indeed, the ICD-10 codes that became effective in October 2015 include R45.851, to specify a diagnosis of suicidal ideations and T14.91, for a suicide attempt. Even though these codes are not commonly used as primary diagnoses, it is important to include them when appropriate so that more information regarding the incidence of suicidal ideas and behaviors is available.

In addition to standardizing suicide-related billing and coding, the application of machine learning and natural language processing provides promising opportunities to better identify suicide risk from the free text captured in clinical notes. For example, a new study from the Cincinnati Children's Hospital Medical Center reveals that machine learning is 93 percent accurate in classifying a suicidal person and 85 percent accurate in identifying someone at risk of suicide; someone who has a mental illness but not at risk of suicide; or neither.[xlviii]

4. Engage: *Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.*

Figure 2: Stepped care model for treatment of suicidal behavior disorder



Source: Adapted from the Zero Suicide website, http://zerosuicide.sprc.org/toolkit/treat/providing-least-restrictive-care

a. Safety planning intervention

Safety plans, developed with the patient, indicate what an individual should do during a crisis. Also known as "wellness plans," they include: 1) techniques to manage suicidal thoughts and experiences of intolerable distress or pain; 2) specific next steps if the patient feels unable to manage those thoughts; and 3) voluntary plans to restrict access to lethal means (e.g., temporary removal from home). They can also be used to obtain advance consent to coordinate with family and friends, alleviating concerns of confidentiality and privacy.

The next level of safety plan is what is known as a WRAP (Wellness and Recovery Action Plan). More than a crisis plan, it helps people to recognize their triggers and what to do to handle those triggers. It includes a description of what he/she looks like when well, a list of personal strategies, and resources that he/she finds helpful.[xlix] It is important to note that safety and wellness planning is undertaken before the member is in crisis, and it is distinct from discharge planning. Additionally, for those individuals at elevated risk, it is recommended that these plans are updated at every visit.

Note: Suicide contracts: Asking patients to sign a contract where they promise never to harm themselves is no longer recommended. Safety plans focus on what the patient can do, instead of dictating what they should not do.[l]

b. 24/7 crisis services

> **"At night, it would have been nice if there had been someone, a contact, someone I'm familiar with, to say this is how I'm feeling, not necessarily someone who was going to talk to me long-term, just somebody to check in with."**
>
> – Interviewed Beacon member

Improved access to services via 24-hour support has led to a reduction in suicides and provided alternatives to emergency services, including virtual or remote access (e.g., hotlines, SMS/texting). For example, a 2012 United Kingdom study revealed that the implementation of best-practice recommendations reduced suicide rates, with 24-hour crisis care correlated with the biggest reduction.[li] An estimated 200 to 300 fewer suicides a year are linked to these best-practice recommendations. The National Suicide Prevention Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, seven days a week. In a series of interviews with callers who had used the lifeline, approximately 80 percent felt the lifeline played a role in keeping them alive, with about 12 percent of suicidal callers noting that talking to someone prevented them from harming or killing themselves. Easy access – even without being used – carries a preventive effect with demonstrated fewer attempts and overall reduced service use. To that end, public mental health systems should collaborate with hotlines to ensure that at-risk individuals get the help they need, 24/7.[lii]

BOX 3: FOLLOW-UP CALLS MAKE NYC CRISIS PROGRAM A STAND-OUT

Beacon, in partnership with the Mental Health Association of New York City, is part of a new initiative in New York City: NYC Well, launched at the end of 2016. This system directly connects individuals to counseling, crisis intervention, peer support and referrals to ongoing treatment services. Mental health professionals are available 24/7/365 to help those with suicidal thoughts, mental health problems, and substance use disorders. Accessible in more than 200 languages, free and confidential, individuals can contact NYC Well via phone, text and chat. Crucially, the system makes follow-up calls or texts to individuals who have reached out to NYC Well until they are fully connected with needed services. Additionally, NYC Well offers callers a chance to speak with individuals who have experienced similar behavioral health challenges through a peer support line. The service has been highly successful. In the period from October 24 to January 31, 2017, NYC Well received 59,728 contacts, and within that same period, Beacon made 7,180 follow-up non-crisis contacts for 3,175 callers assigned to the Beacon team.

c. Restricting lethal means

There is a demonstrated association between nations and U.S. states that have enacted legislation to limit access to common means of suicides and those with relatively lower suicide rates.[liii] Therefore, health care organizations, payers and employers can influence policy through taking a stand on restricting the availability of lethal means to help prevent suicide through educating policymakers about the causal link. State mental health authorities can further support those efforts by developing and implementing strategies to do so.[liv] Further detail on this can be found at CALM: Counseling on Access to Lethal Means at the Suicide Prevention Resource Center (SPRC).

d. Involvement of individuals with lived experience

As noted on page 12, peers have an important role to play in suicide prevention. In fact, peer involvement appears to have more effect on engagement than any other area – particularly when peer specialists act as expert storytellers.

5. Treat: *Use effective evidence-based treatments that directly target suicidal thoughts and behaviors*

Treat suicidality directly. As previously noted, suicidal behavior disorder needs to be treated directly as a condition in its own right and not only as a symptom of an underlying cause, which requires promoting the evidence base to those providers trained to practice it.

At a system level, to spread the application of evidence-based clinical practices, we need to identify those providers in each region who are specifically trained and experienced in delivering evidence-based treatments for suicidal behavior disorder. That way, afflicted members can be signposted accordingly, while improving the confidence and competence of the entire clinical workforce. Similar to heart attack care, evidence-based treatments for suicidal behavior disorder call for interventions provided by trained clinicians in interdisciplinary teams. The following are evidence-based clinical practices specifically to treat suicidality:

a. Brief educational interventions

A one-hour, individual informational session combined with regular, long-term follow-up (via phone or in-person contacts by a clinician over 18 months) reduced suicide death compared to treatment as usual among patients with prior suicide attempts[lv]. Although such interventions are popular because they are low-cost and require minimal training, it is important to note they have not been tested alone for suicidal behavior disorder.

b. Non-demand caring contacts

Following up periodically in a low-impact way without needing anything from the patient (e.g., just to check in and not remind about an appointment or ask about their health) has been shown to reduce suicide rates.[lvi] This approach is a non-clinical intervention and an important role that peers can play, particularly when supporting patients' transition from the hospital to outpatient services. Multiple formats such as check-in phone calls or mailed letters/postcards have also worked. Text messages may also be a feasible and effective lower-cost alternative.

c. Collaborative Assessment and Management of Suicidality (CAMS)

CAMS is a therapeutic framework for how to partner with suicidal individuals to engage them in designing their own care plan. A core element is creating a collaborative safety plan (i.e., Plan for Life), which can be done more effectively sitting side-by-side with the patient to foster a sense of equality. Additionally, the plan should be written by hand so the individual feels it has been individualized to his/her needs. It is important to specify the duration of the commitment and to have a fixed end date. Sometimes, a signature by a witness can be used to involve and endorse the important role of social supports.

d. Psychotherapy

There are several evidence-based psychotherapies for treating suicidal behavior disorder, examples provided below.

These therapies commonly include a treatment framework; a strategy for managing suicidal crises; a focus on affect; a participatory therapist style; and exploratory and change-oriented interventions.[lvii]

- **Dialectical Behavior Therapy (DBT).** Considered the most effective psychotherapy for suicidal behavior, DBT was originally designed for suicidality in borderline personality disorder (BPD) and is now recommended more generally. Compared to other non-behavioral psychotherapies, DBT is uniquely effective at reducing suicide attempts and increasing engagement with services.[lviii]
- **Cognitive Behavior Therapy for Suicide Prevention (CBT-SP).** This therapy is a tailored version of CBT, specifically for individuals with suicidal thoughts and behaviors. Among people who had recently tried to take their own lives, those receiving CBT-SP were 50 percent less likely to try again within 18 months relative to those in usual care.[lix]
- **Mentalization-Based Treatment (MBT).** A type of psychotherapy typically used with individuals with BPD, this therapy focuses on helping people to understand, acknowledge and predict thoughts and feelings. Studies show that MBT decreases the frequency of suicide attempts as well as the number of individuals engaging in suicide attempts.[lx] While this therapy is less commonly used for individuals with suicidal behavior disorder, we include it here to be more complete as the evidence suggests its positive effect on treating individuals with this disorder.
- **Transference-Focused Psychotherapy (TFP).** Also commonly used to treat individuals with BPD and again less commonly for individuals with suicidal behavior disorder, TFP helps the individual to understand his/her psychological state through his/her relationship with the therapist, known as "transference". TFP helps to reduce parasuicidality more than "supportive" therapy techniques.[lxi]

e. Pharmacotherapy

When treating underlying conditions, lithium for bipolar disorder, clozapine for schizophrenia, and some antidepressants have been shown to reduce suicide risk.[lxii] However, limited data exist for pharmacotherapy-only treatment for suicidal behavior disorder, as many drug trials explicitly exclude suicidal patients.

The neurotransmitter serotonin has been linked with suicidal behavior disorder, and the selective serotonin reuptake inhibitor (SSRI) paroxetine has decreased suicidal behavior in participants with prior suicide attempts and no history of depression. Importantly, discontinuation of antidepressants leads to a period of increased risk immediately after. More specifically, antidepressants might increase suicidal thoughts and behaviors for adolescents[lxiii]. In 2004, the Food and Drug Administration (FDA) issued a black box warning indicating that adolescents taking antidepressants were at an increased risk of suicidal thinking and behavior. Studies suggest that the FDA warning affected diagnostic practices for this age group; a review of claims data has revealed that antidepressant use among adolescents reduced significantly within the two years after the FDA advisory.[lxiv] However, ultimately most adolescents who have suicidal behavior disorder are not receiving treatment.[lxv]

While medication treatment alone is inadequate treatment for suicidal behavior disorder, prescribing clinicians should be aware of the evidence supporting the use of such medications for patients with diagnoses linked to suicidal behavior disorder, especially during transitions in care and following acute care stays.

6. **Transition:** *Provide continuous contact and support, especially after acute care*

Continuity of care is essential to treatment. Its absence increases suicide risk and its presence decreases risk.[lxvi] Suicidal individuals have better outcomes knowing they have easy access to services, even if not using them.

a. Primary care

As discussed in Beacon's 2016 White Paper, the integration of behavioral health care into primary care settings based on the collaborative care model is fundamental to providing the most effective and affordable health care.[lxvii] To be effective, primary care physicians need to know where and how to access additional support for people with suicidal behavior disorder. Sadly, in most parts of the country, the specialty mental health care system is underequipped to treat the vast number of people with mental health and substance use disorders. More than three-quarters of U.S. counties have a serious shortage of mental health professionals, a problem particularly acute in rural and low-income areas.[lxviii] One path to address this is to harness new technologies, including telehealth, as a means of integrating behavioral health in to primary care settings without requiring additional onsite staff. For example, American Well – a leading telehealth provider – frequently assesses and safely treats people with suicidal behavior disorder remotely.

b. Transitions in care

Suicide risk is highest immediately following discharge from inpatient care – even for patients who did not report suicidal thoughts prior to or during hospitalization – and yet rates of engagement in follow-up care are troublingly low (e.g., only about half complete a follow-up visit within a week). Studies from the United Kingdom reveal that 37 percent of all post-discharge deaths were in the first three weeks following an inpatient admission[lxix]. This elevated level of risk may persist for months following an inpatient admission.

Follow-up between transitions of levels of care is particularly important following discharge from an acute-care setting (e.g., inpatient care, emergency department), where any individual considered at high risk for suicide should be contacted by a provider or caregiver within 24 hours. State mental health authorities can strengthen such continuity-of-care activities for these high-risk individuals by initiating policies and best practices to do so.[lxx] Additionally, managed behavioral health organizations have an important follow-up role to play through promoting telephonic care management, intensive case management and home-based therapy. The only two randomized controlled trials in the suicide prevention literature that have shown a reduction in the number of deaths by suicide have both involved following up with high-risk populations after discharge from acute-care services.[lxxi]

Examples of good transitional care protocol include designating a specific person for proactive follow-up and including family members as necessary, through non-demand caring contacts as discussed under "Treat". Similarly, this person can be available for unscheduled support (same-day access, drop-in groups, email "visits"). Additionally, patient depression websites, drop-in groups and apps for safety planning have all shown to be effective.

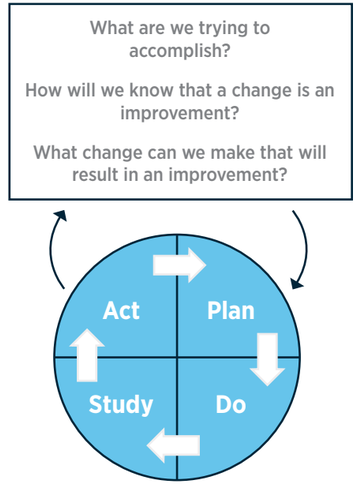
7. **Improve:** *Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk*

The international declaration on Zero Suicide states: "Targeting zero is neither innovative nor controversial, but simply a technique other industries use daily."

When the Henry Ford Health System first tried to envision what "Perfect Depression Care" would look like as a quality improvement goal, they ended up with the answer of zero suicide (i.e., suicide as a 'never event'). As with other organizations considering this initiative, their internal debate struggled with the perceived impossibility of the goal, but also the equally impossible task of identifying any number other than zero that could be considered acceptable. As it turns out, their performance improvement approach reduced suicide rates by 75 percent, from approximately 89 per 100,000 at baseline (2000) to approximately 22 per 100,000 for the four-year follow-up interval (the average rate for 2002-2005),[lxxii] leading to 10 consecutive quarters without a suicide.[lxxiii]

As illustrated in our earlier reference to a reduction of deaths by heart attack in a hospital setting, measurement of data is key. Payer and provider organizations have a role to play in establishing protocols to collect and review suicide-related data, to use in assessing progress on quality improvement and to rapidly inform systemic changes. Doing this in a "Plan Do Study Act" (PDSA) cycle, as shown in Figure 3, will accelerate improvement efforts.

Figure 3: Model for Improvement



Source: Langley GL, Moen R, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

Therefore, a leadership-driven culture coupled with a quality improvement framework will be the most successful approach to embed many of the elements described in this paper, including mandatory staff training; optimizing continuity of care; and adoption of evidence-based clinical practices.

An excellent example of a leadership-driven initiative is NAMI Mass's CEOs Against Stigma pledge, a statewide campaign in Massachusetts to reduce the negative impact of mental-illness stigma in the workplace by facing and talking about the reality of mental illness. Additional examples include Secular Organizations for Sobriety and I Will Listen, an anti-stigma initiative of NAMI's New York Metro chapter.

a. Conduct ongoing surveillance of suicide throughout the care continuum

Many health care organizations, including ours, struggle to reliably keep track of and share the baseline number of people in their care who attempt and complete suicide in any given year. In part, this is because coding means that suicidal behavior disorder is often hidden under "depression" categorization or as other disorders. Achieving such a baseline is crucial to know whether efforts at raising awareness and preventing suicide are making a difference, which will likely require investment in data collection and evaluation to provide direct feedback to improve processes. However, the mission for achieving more accurate reporting and reliable data may take years and, as such, need not delay the implementation of evidence-based treatments as described earlier.

b. Reassess post-discharge aftercare requirements

Aftercare services address barriers to successful ambulatory treatment after discharge from an inpatient setting. One example of aftercare activities is Beacon's Home-Based Therapy Program, which provides therapy services in individuals' homes, medication management, and care coordination services for those people unable to access outpatient services or unable to keep follow-up appointments after a psychiatric hospitalization. Whatever the type of service, post-discharge processes constantly need re-evaluating to ensure they are occurring and working effectively to make continuous improvements as indicated. This includes reviewing the care and safety plan assessment templates as well as ensuring the information obtained is kept up-to-date for each individual.

CONCLUSION

While we can continue to debate and research the risk factors contributing to suicidal behavior disorder, and indeed this is important work to continue, the framework for Zero Suicide exists and works today.

We cannot wait any longer to act. Given that suicide rates continue to rise even as overall mortality rates plummet and that most people who die by suicide also have a mental illness, the time is now for us to take a stand.

To date, the Zero Suicide movement has largely been led by forward-thinking providers and policymakers, but there are roles for all stakeholders in joining this important initiative. Together, we can eliminate needless deaths from suicide. We reduced mortality for people experiencing heart attacks by identifying the condition faster and then treating it. We can do the same for people with suicidal behavior disorder.

All stakeholders have a role to play in challenging and changing the stigma around suicidal behavior disorder that persists. Let's aim to shift the suicide conversation from the negative focus on the numbers of completed suicides to the more hopeful message of recovery and the majority of people who go on to live their lives to their fullest potential.

The time to act is now. One suicide is one too many. Together, we can achieve zero suicide.

APPENDICES

PHQ-9

As shown below, the PHQ-9 scale assists with the identification of depression and monitoring progress through asking nine questions, including thoughts about suicide. It is easy to use, can be completed over the phone, via SMS texting, online or on paper, and is available in multiple languages.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or staying a	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	For Office Coding __0___ + _____ + _____ + _____ =Total Score: _____			

Source: www.phqscreeners.com

The Columbia-Suicide Severity Rating Scale (C-SSRS)

The C-SSRS is a series of questions that anyone can ask anywhere and has multiple adaptations depending upon setting and population.

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*) Recent - ***Most Severe Ideation:*** _____ (*Type # (1-5)*) _____ (*Description of Ideation*)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	

Version 1/14/09

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**	**Past 3 months**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you_____ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from_____?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) If yes, describe:	**Yes** ☐ **No** ☐ Total # of Attempts _____	**Yes** ☐ **No** ☐ Total # of Attempts _____
Has subject engaged in Non-Suicidal Self-Injurious Behavior?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of interrupted _____	**Yes** ☐ **No** ☐ Total # of interrupted _____
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____	**Yes** ☐ **No** ☐ Total # of aborted or self-interrupted _____
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
Suicidal Behavior: Suicidal behavior was present during the assessment period?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

	Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code* _____	*Enter Code* _____	*Enter Code* _____

Source: http://cssrs.columbia.edu

RESOURCES

Below is a subset of key references that contributed significantly to the shaping of this paper.

» National Center for Health Statistics: Increase in Suicide in the United States, 1999-2014 *(Centers for Disease Control and Prevention, 2016)*

» Zero Suicide: An International Declaration for Better Healthcare *(Australia, Canada, China, Denmark, French Polynesia, Hong Kong, Japan, Malaysia, Netherlands, New Zealand, Taiwan, United Kingdom, United States, 2016)*

» Suicide Care in Systems Framework *(National Action Alliance: Clinical Care & Intervention Task Force, 2014)*

» National Strategy for Suicide Prevention: Goals and Objectives for Action *(U.S. Surgeon General and the National Action Alliance for Suicide Prevention, 2012)*

» Detecting and Treating Suicide Ideation in All Settings *(Sentinel Alert Event, Joint Commission, 2016)*

» Treatment of Suicidal Patients in Managed Care *(James M. Ellison, American Psychiatric Association, 2001)*

» Night Falls Fast: Understanding Suicide *(Kay Redfield Jamison)*

» Zero Suicide Website: http://zerosuicide.sprc.org/

» SAMHSA Website: http://www.samhsa.gov/tribal-ttac/resources/suicide-prevention

» *CALM: Counseling on Access to Lethal Means:* Suicide Prevention Resource Center website: http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

NYC Well: 1-888-NYC-9355

ABOUT BEACON HEALTH OPTIONS

Beacon Health Options (Beacon) is a managed behavioral health care organization that specializes in the management of mental illness and substance use benefits on a fully integrated basis. The company's foundational principle is focused on a single but important premise: Treat the whole person to address mental health and substance use disorders. Since its inception, Beacon has maintained that overriding, whole-person principle while meeting the evolving health care market's needs through the enrollment of medically complex populations, mental health parity, nationwide autism mandates, escalating costs and the ACA.

Experience has led Beacon to focus our expertise on specialty populations, including the seriously mentally ill, dually eligible individuals and those with co-morbid conditions. We have been able to leverage that expertise with specialty populations to further focus and fine-tune our services for commercial populations. Our clients include regional and specialty health plans; employers and labor organizations; and federal, state and local governments.

Accredited by both URAC and NCQA, Beacon manages services for more than 50 million members representing commercial, FEP, Medicaid, Medicare and Exchange populations, with more than 100 health plans in all 50 states.

In this capacity, Beacon offers:

- management of core behavioral health services;
- care coordination for members with co-morbid conditions;
- evidence-based autism treatment;
- care management for medically complex members;
- employee assistance program;
- substance use disorder management;
- aftercare services; and
- informatic products to improve psychotropic drug prescribing practices.

To download additional copies of this white paper, please go to: www.beaconhealthoptions.com.

For more information about this white paper, please contact Dale Seamans, Executive Editor, at dale.seamans@beaconhealthoptions.com.

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