The Zero Suicide Initiative in Health Care

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U.S. Department of Health and Human Services

SAMHSA
Substance Abuse and Mental Health Services Administration

Disclaimer

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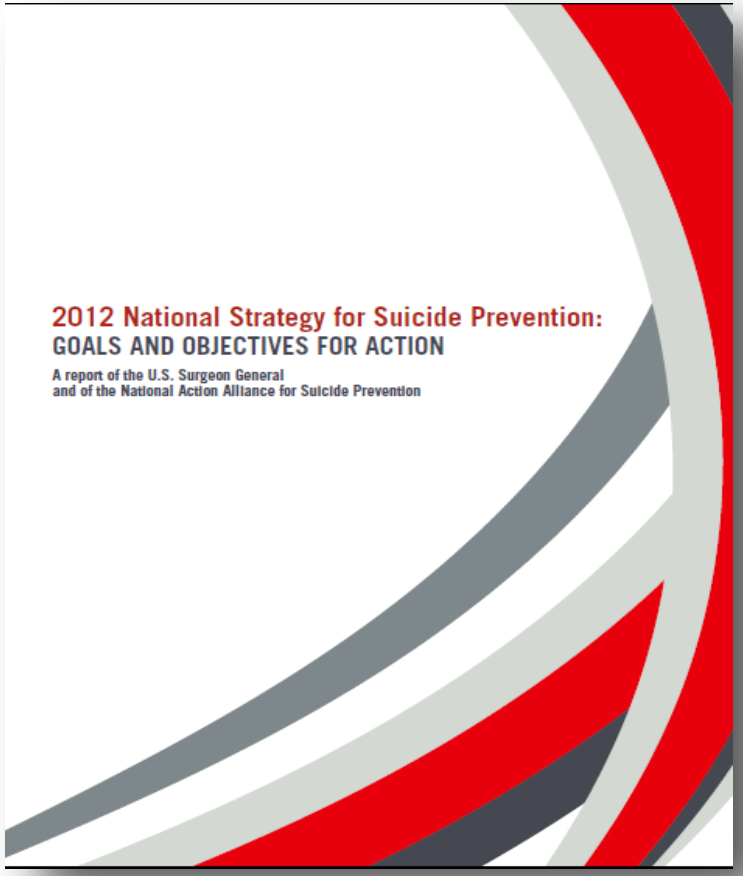
Preventing suicide
A global imperative
World Health Organization

National Strategy for Suicide Prevention



SAMHSA
Substance Abuse and Mental Health Services Administration

NSSP Goals 8 and 9

- Goal 8- Promote suicide prevention as a core component of health care services
- Goal 9- Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

The Zero Suicide Movement

SPRC

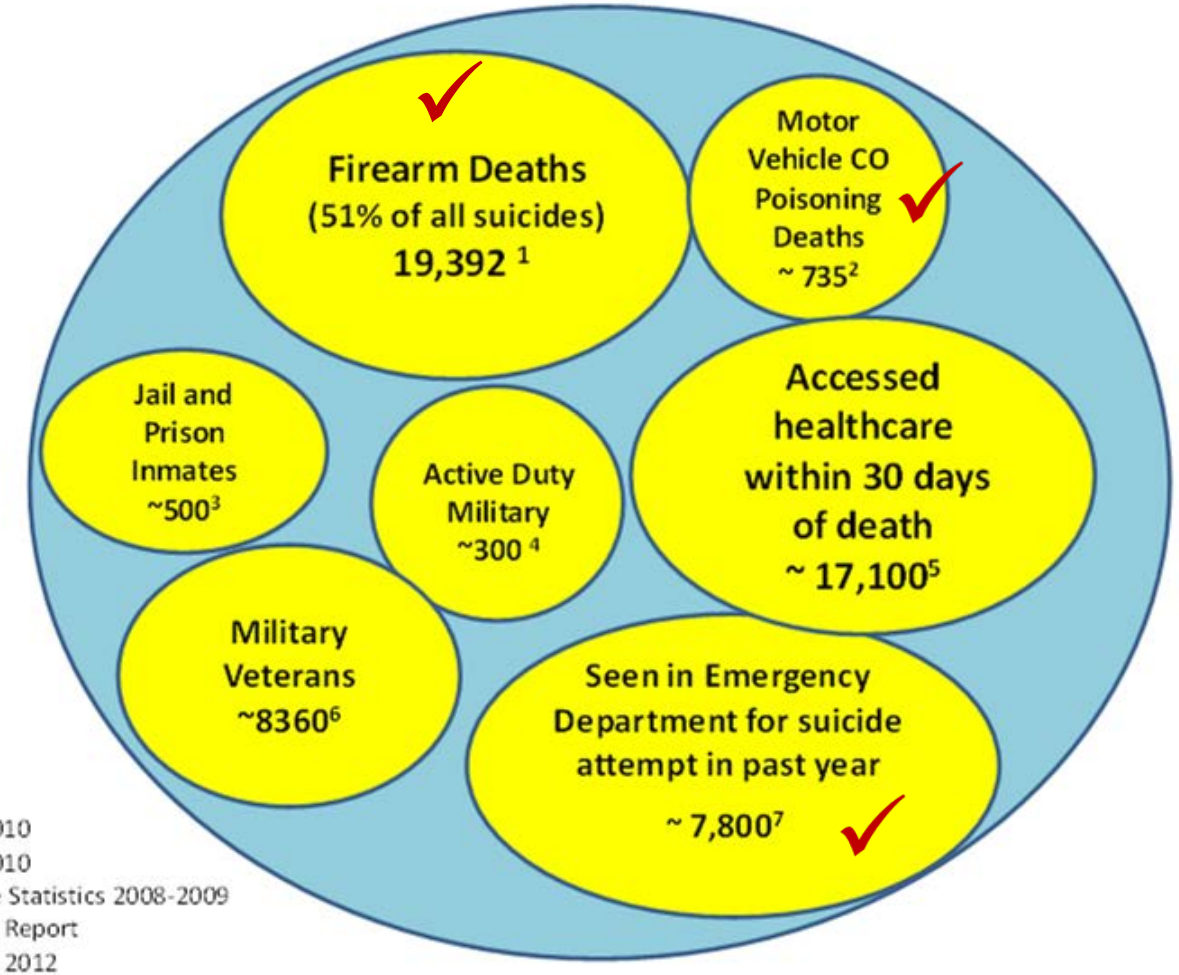
National Action Alliance for Suicide Prevention

Zero Suicide…

- Makes suicide prevention a core responsibility of health care.
- Applies new knowledge and proven tools for suicide care.
- Supports efforts to humanize crisis and acute care.
- Is a systematic approach in health systems, not “the heroic efforts of crisis staff and individual clinicians.”
- Is embedded in the Joint Commission Sentinel Event Alert and the National Strategy for Suicide Prevention (NSSP).

Deconstructing Suicide Deaths in the U.S.

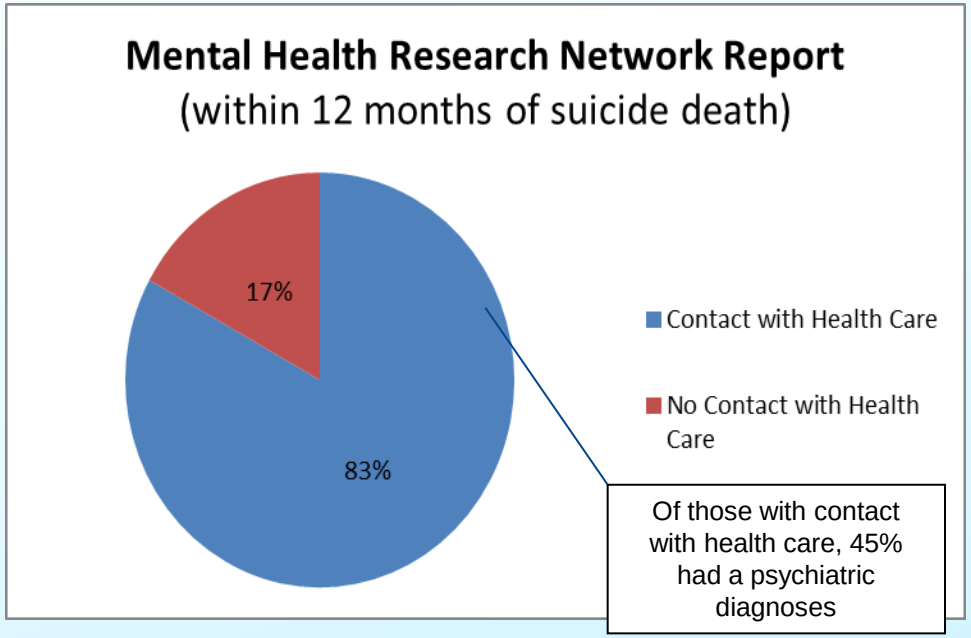
✓ = Already Modeled

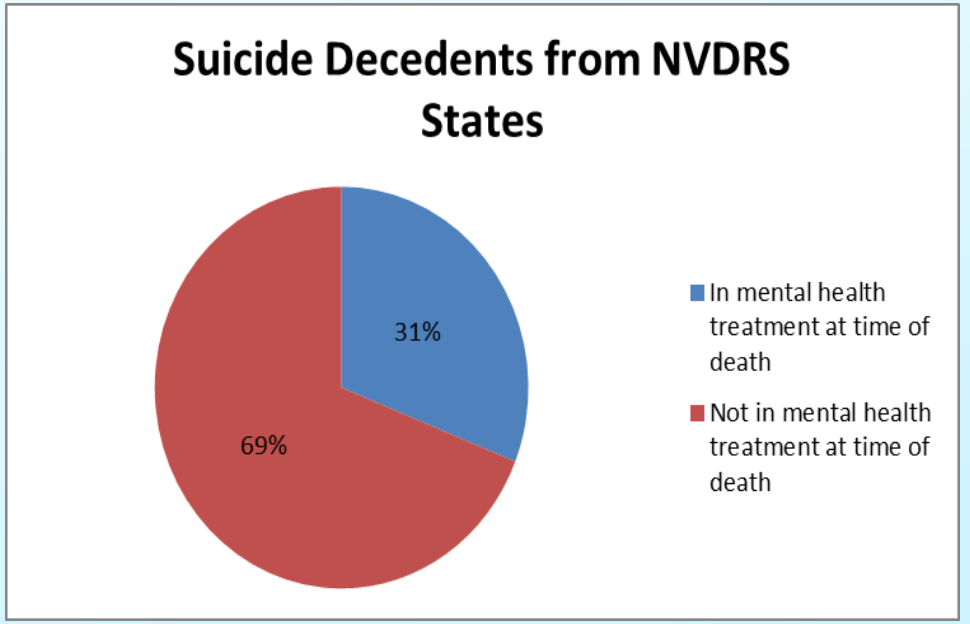


Data Sources:
1. CDC WISQARS 2010
2. CDC WONDER 2010
3. Bureau of Justice Statistics 2008-2009
4. DoDSER CY 2011 Report
5. Trofimovich et al 2012
6. Department of Veterans Affairs 2012
7. CDC WISQARS 2010 & Owens et al, 2002

You can't fix what you can't measure….

Perhaps a third of all suicide decedents accessed care prior to death, but few U.S. health care systems track suicide outcomes.





Ahmedani BK et al (2014). Health care contacts in the year before suicide death. Journal of General Internal Medicine, online Feb 25. DOI: 10.1007/s11606-014-2767-3.

Karch, DL, Logan, J, McDaniel, D, Parks, S, Patel, N, & Centers for Disease Control and Prevention (CDC). (2012). Surveillance for violent deaths—national violent death reporting system, 16 states, 2009. Morbidity and Mortality Weekly Report. Surveillance Summaries (Washington, DC: 2002), 61(6), 1-43.

Defining the Problem: Health Care Needs to Improve Suicide Safety

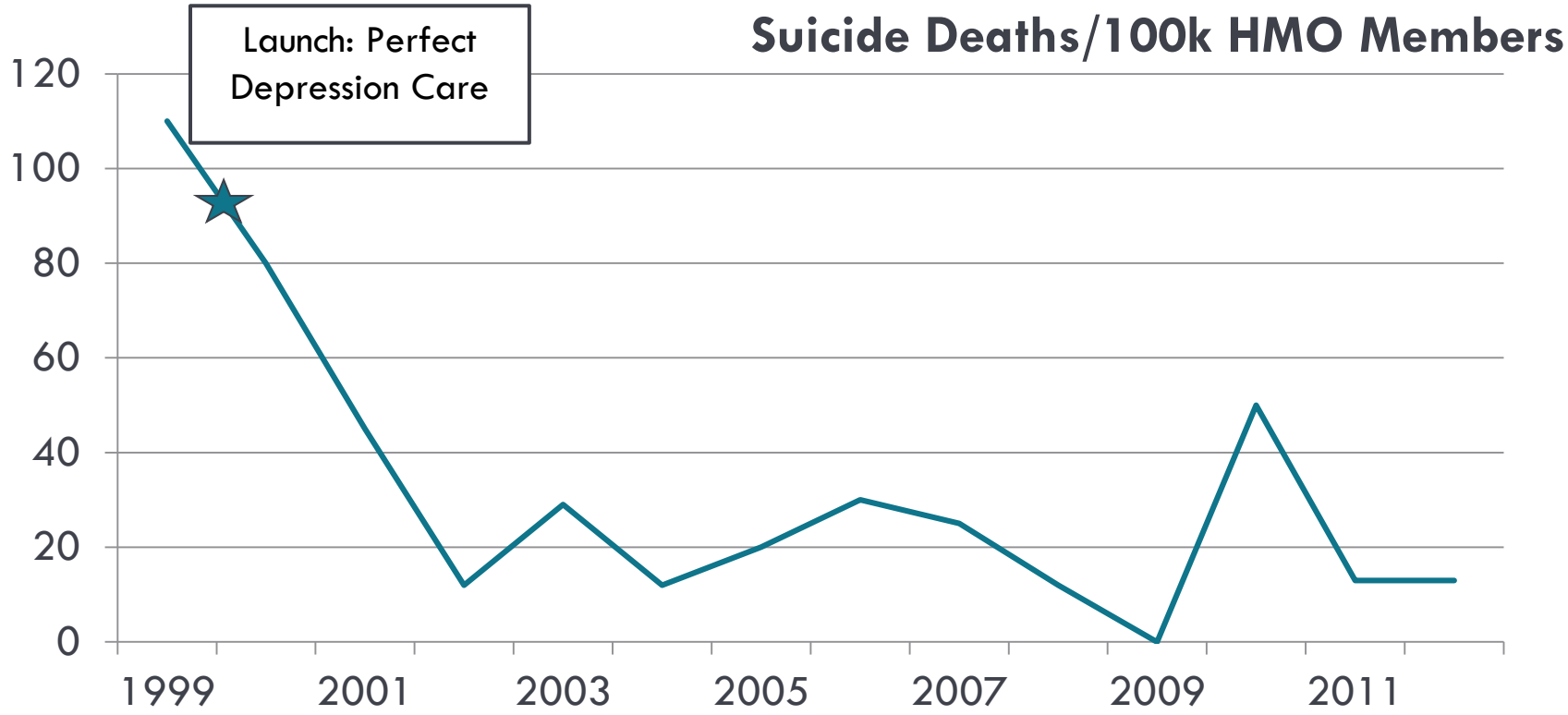
- 45% of people who died by suicide had contact with **primary care** providers in the month before death. Among older adults, it's 78%.
- 25% of men and 50% of women who die by suicide had recent mental health contact (NVDRS)
- South Carolina: 10% of people who died by suicide were seen in an **emergency department** in the two months before death.

Defining the Problem: Behavioral Health Care Needs to Improve Suicide Safety

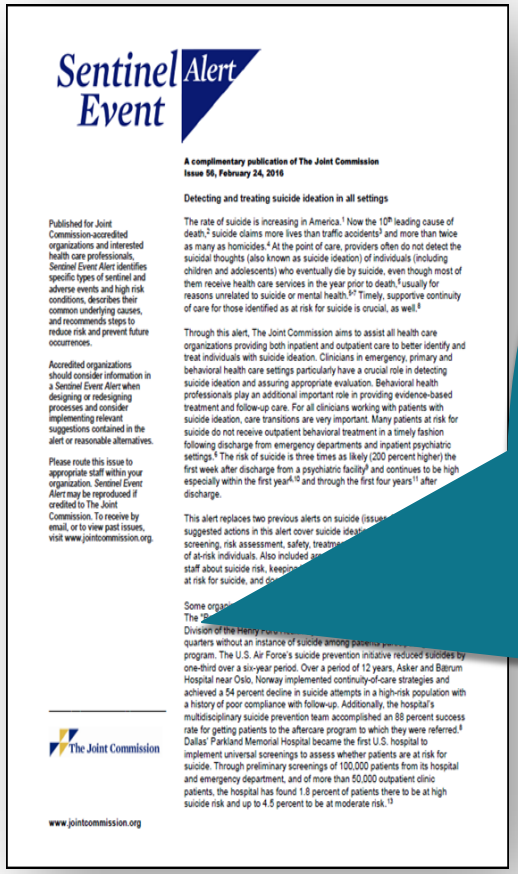
- **Ohio:** Between 2007-2011, 20.2% of people who died from suicide were seen in the public behavioral health system within 2 years of death.
- **New York:** In 2012 there were 226 suicide deaths among consumers of public mental health services, accounting for 13% of all suicide deaths in the state.
- **Vermont:** In 2013, 20.4% of the people who died from suicide had at least one service from state-funded mental health or substance abuse treatment agencies within 1 year of death.

The Elements of Zero Suicide in a Health Care Organization

A System-Wide Approach Saved Lives: Henry Ford Health System



Joint Commission Sentinel Event Alert 56: *Detecting and Treating Suicide Ideation in All Settings*



Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6,7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[9] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[9,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues

suggested actions in this alert cover suicide ideat

screening, risk assessment, safety, treatm

of at-risk individuals. Also included ar

staff about suicide risk, keeping

at risk for suicide, and d

Some organi

The "B

Division of the Henry

quarters without an instance of suicide among patients

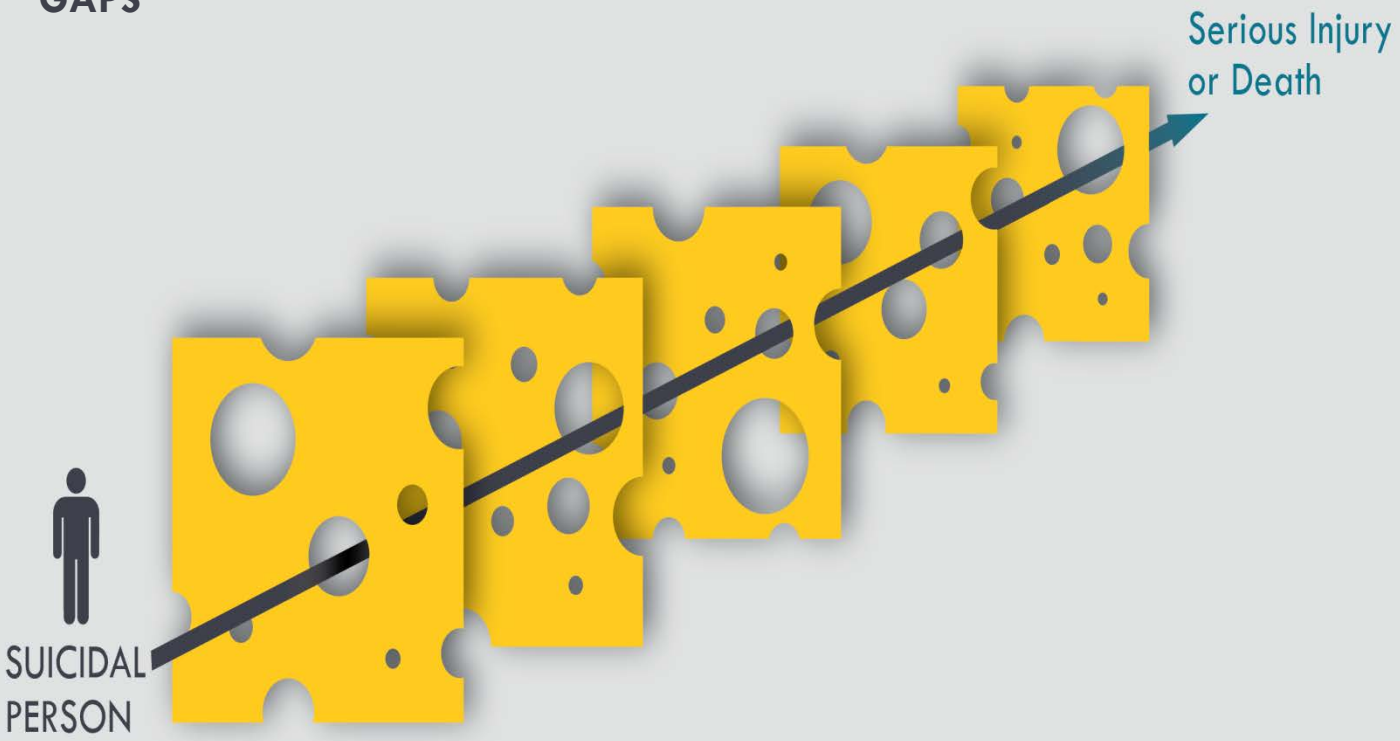
program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

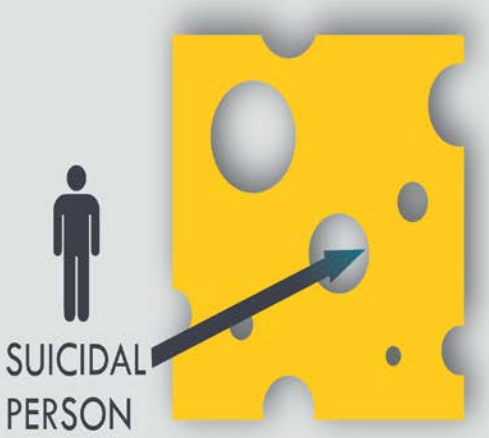
"The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care."

WITHOUT IMPROVED SUICIDE CARE, PEOPLE SLIP THROUGH GAPS



Adapted from James Reason's "Swiss Cheese" Model Of Accidents

THE TOOLS OF ZERO SUICIDE FILL THE GAPS



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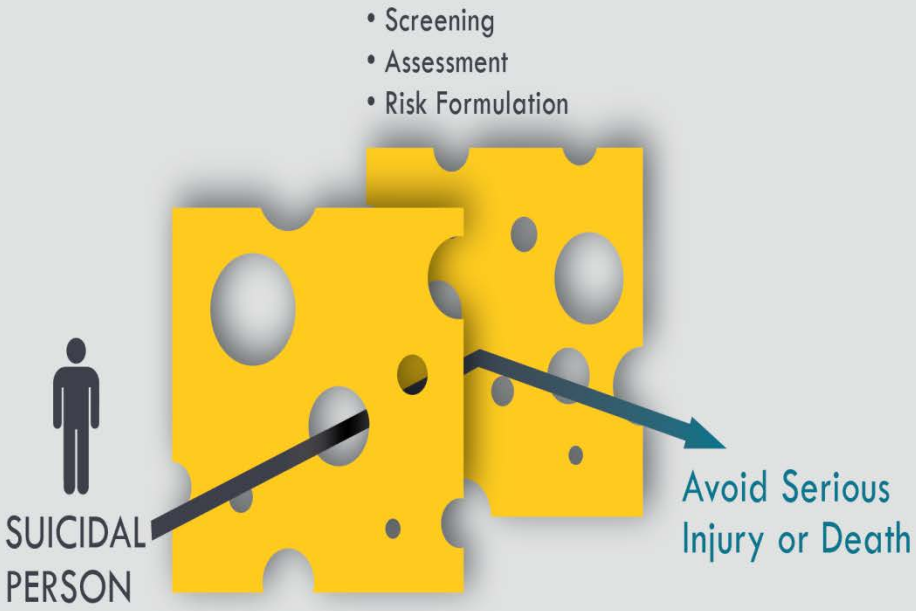

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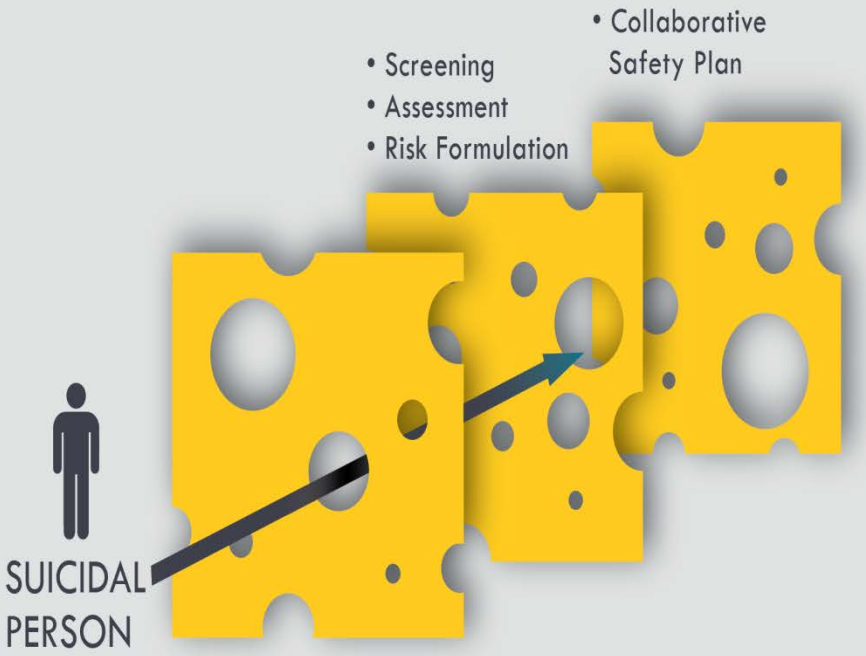

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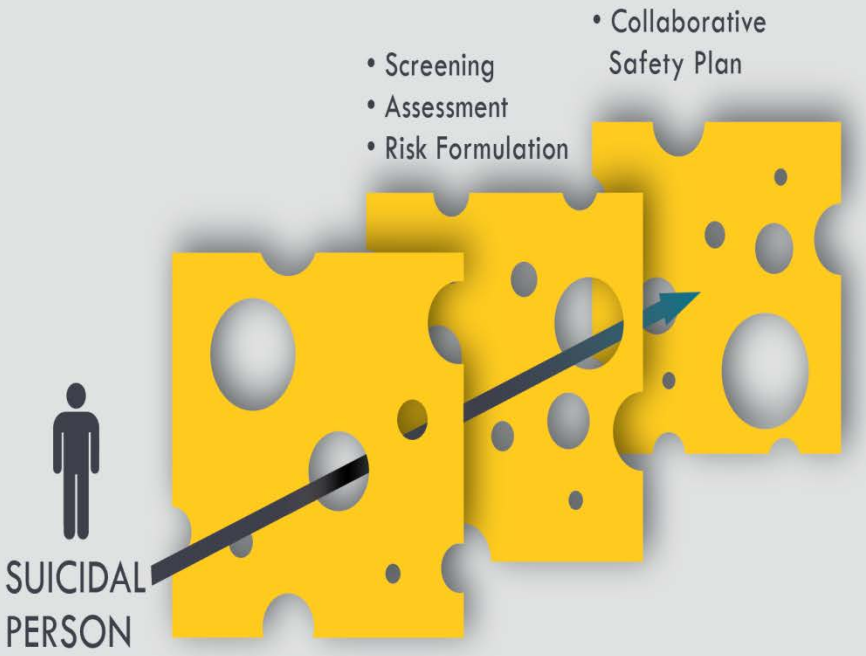

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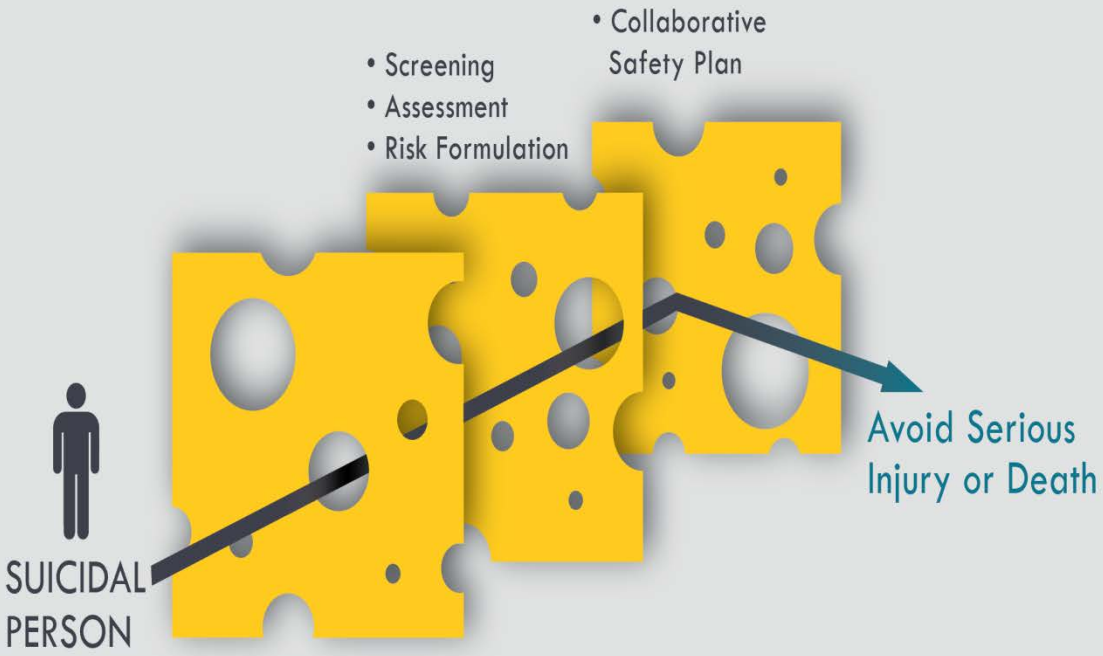

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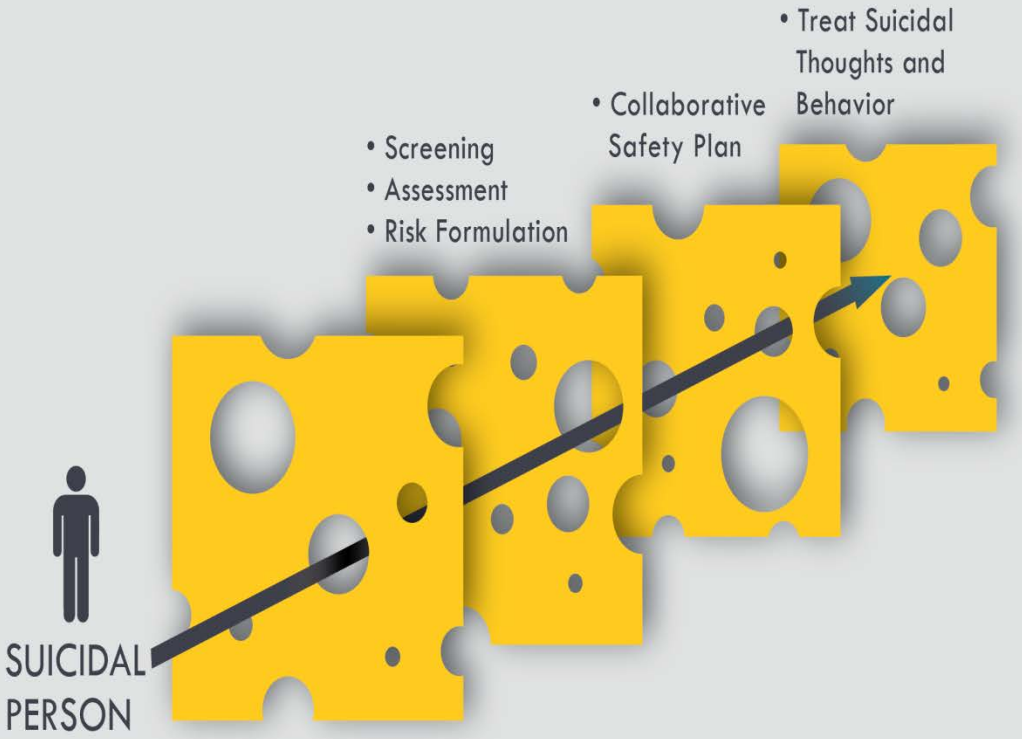

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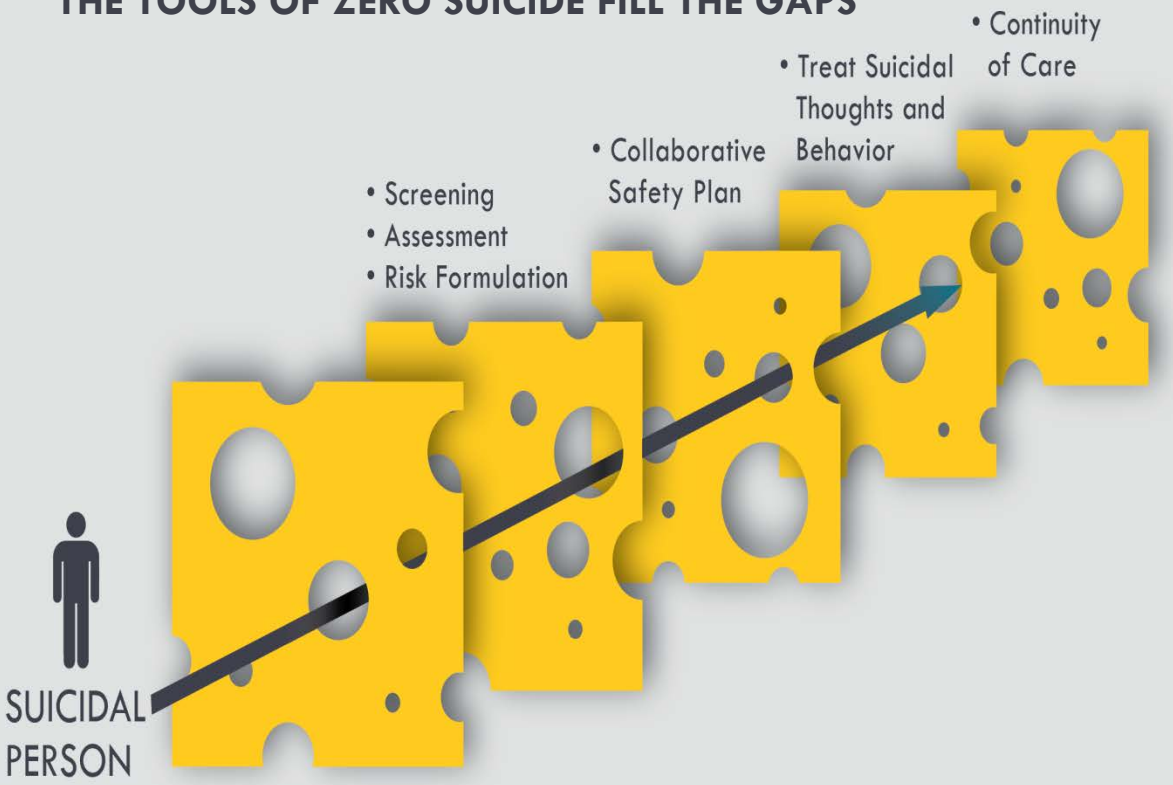

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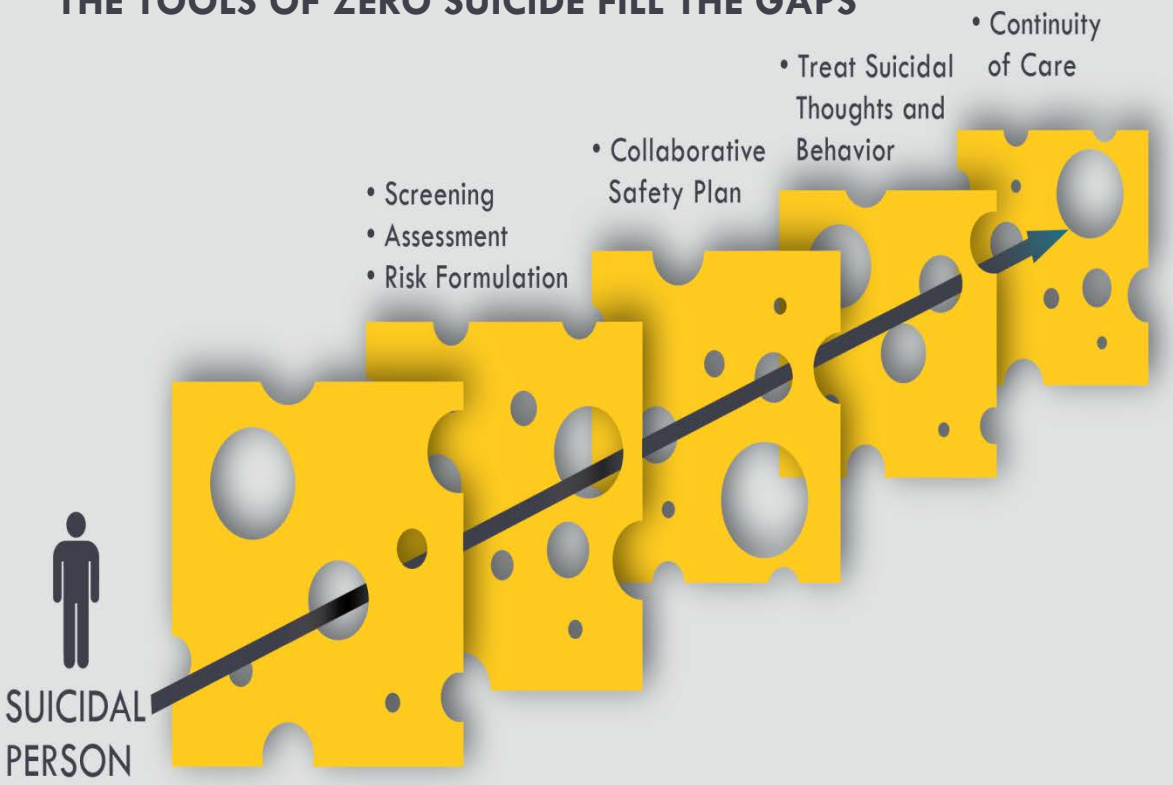

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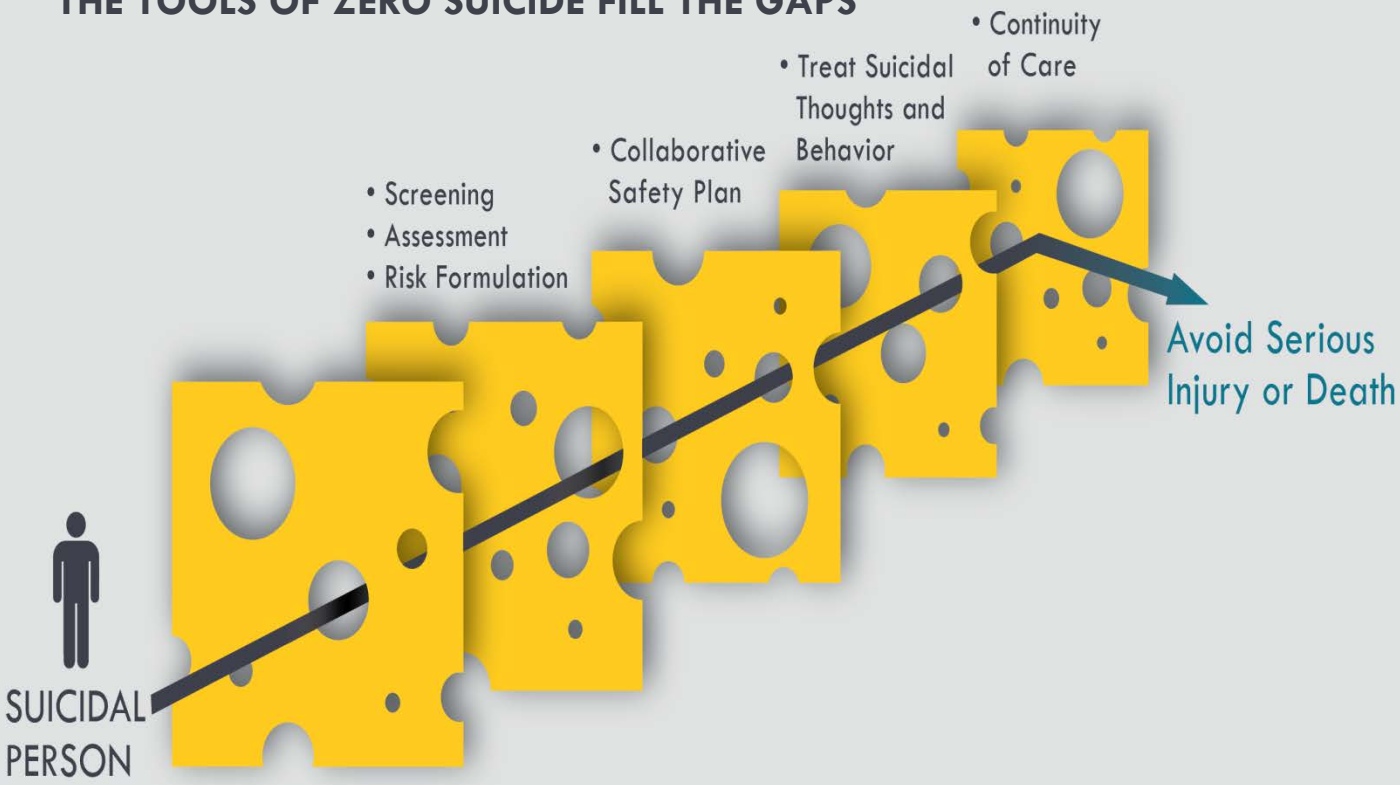
A FOCUS ON PATIENT SAFETY AND ERROR REDUCTION

THE TOOLS OF ZERO SUICIDE FILL THE GAPS



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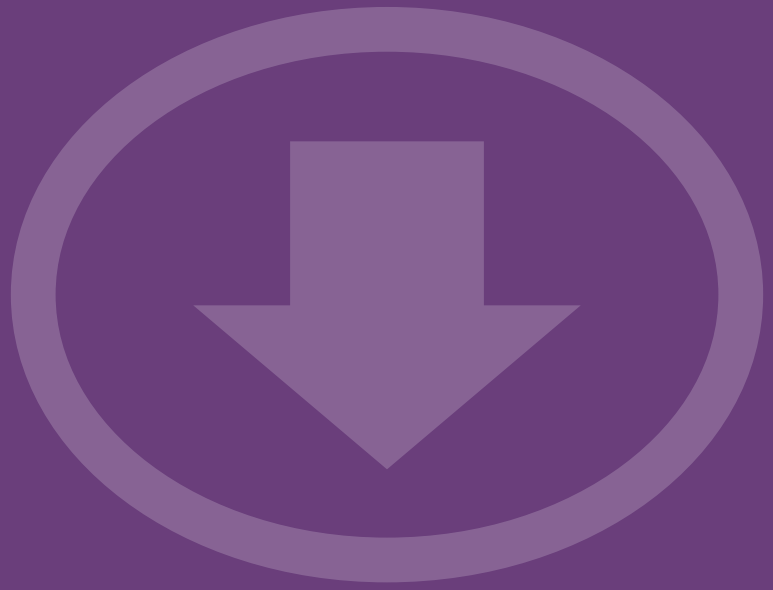
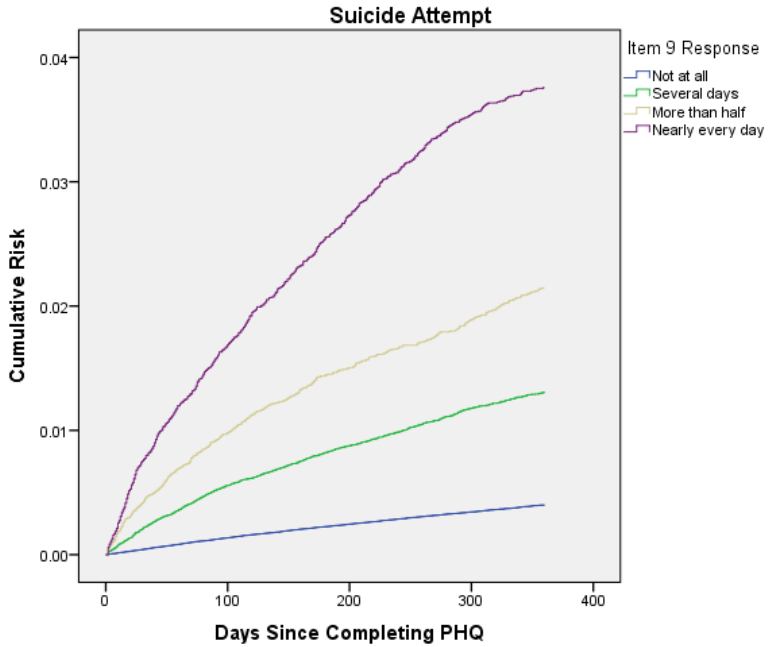
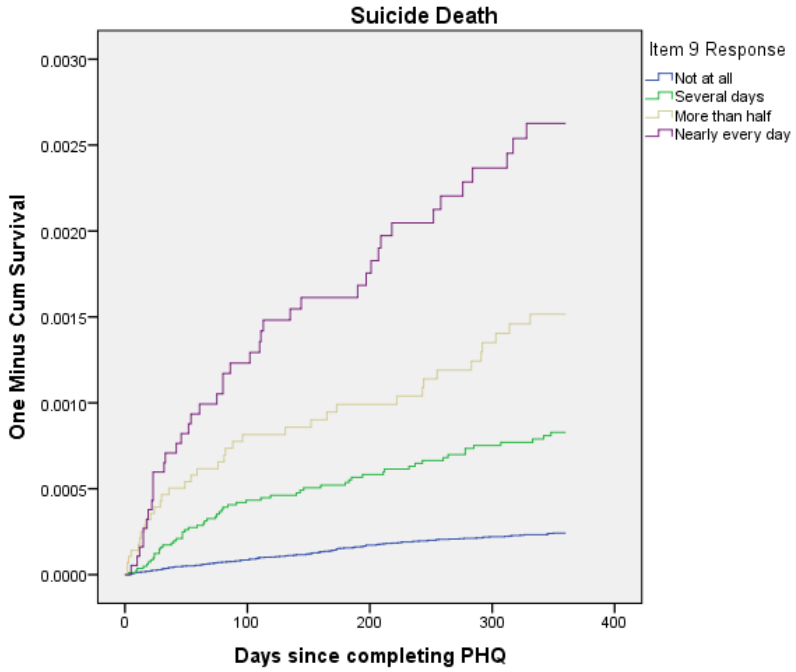


IDENTIFY

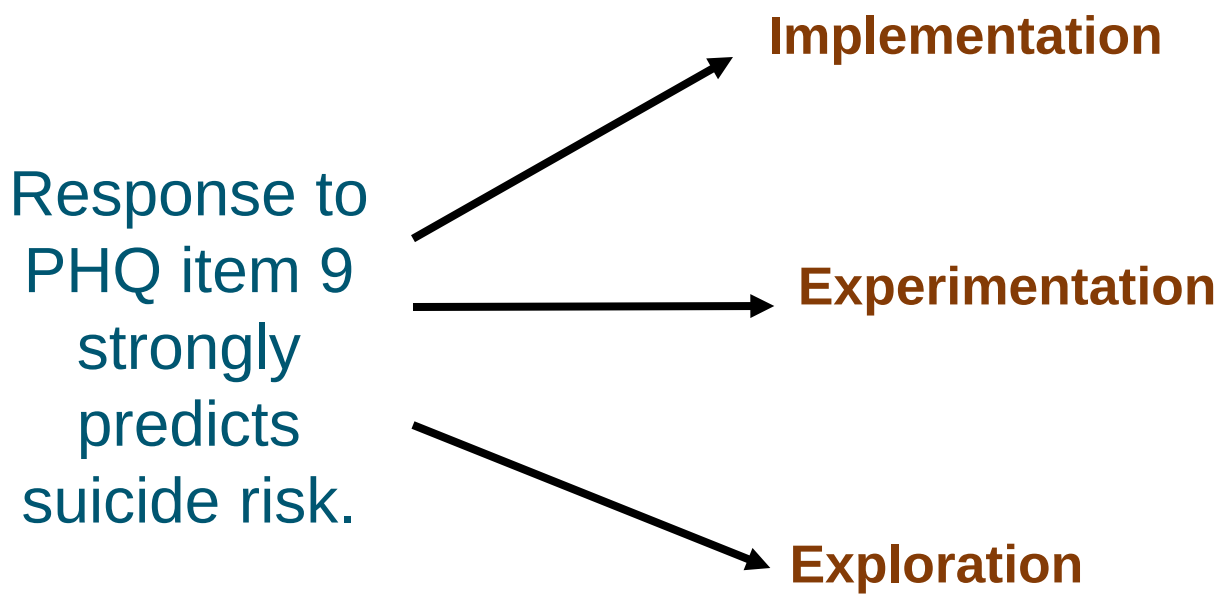
Risk following completion of PHQ9 (sample size = 1.2 million)

GroupHealth RESEARCH INSTITUTE





And that answer leads to…

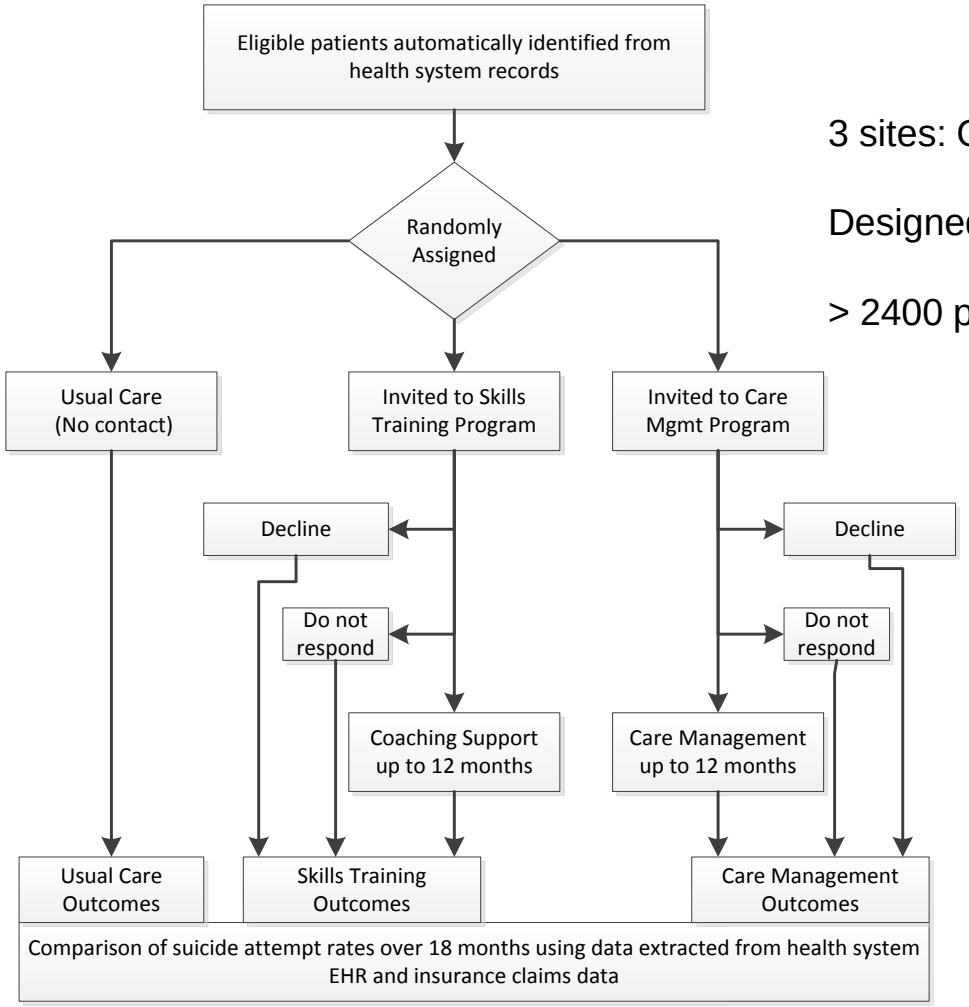


Implementation:
Standard work for suicide risk assessment and safety planning in mental health clinics

GroupHealth RESEARCH INSTITUTE

- Abbreviated version of Columbia Suicide Severity Rating Scale
- Training for all mental health clinicians
- EHR prompts for standard work
- Defined care pathway for high risk patients
  - Safety plan recorded in EHR and noted on problem list
  - Acute care pathway
- Continuous monitoring of:
  - Adherence to standard work
  - Suicide attempt and suicide death rates

Experimentation:
Pragmatic trial of population-based outreach programs



3 sites: Group Health, HealthPartners, KP Colorado

Designed in collaboration with delivery system leaders

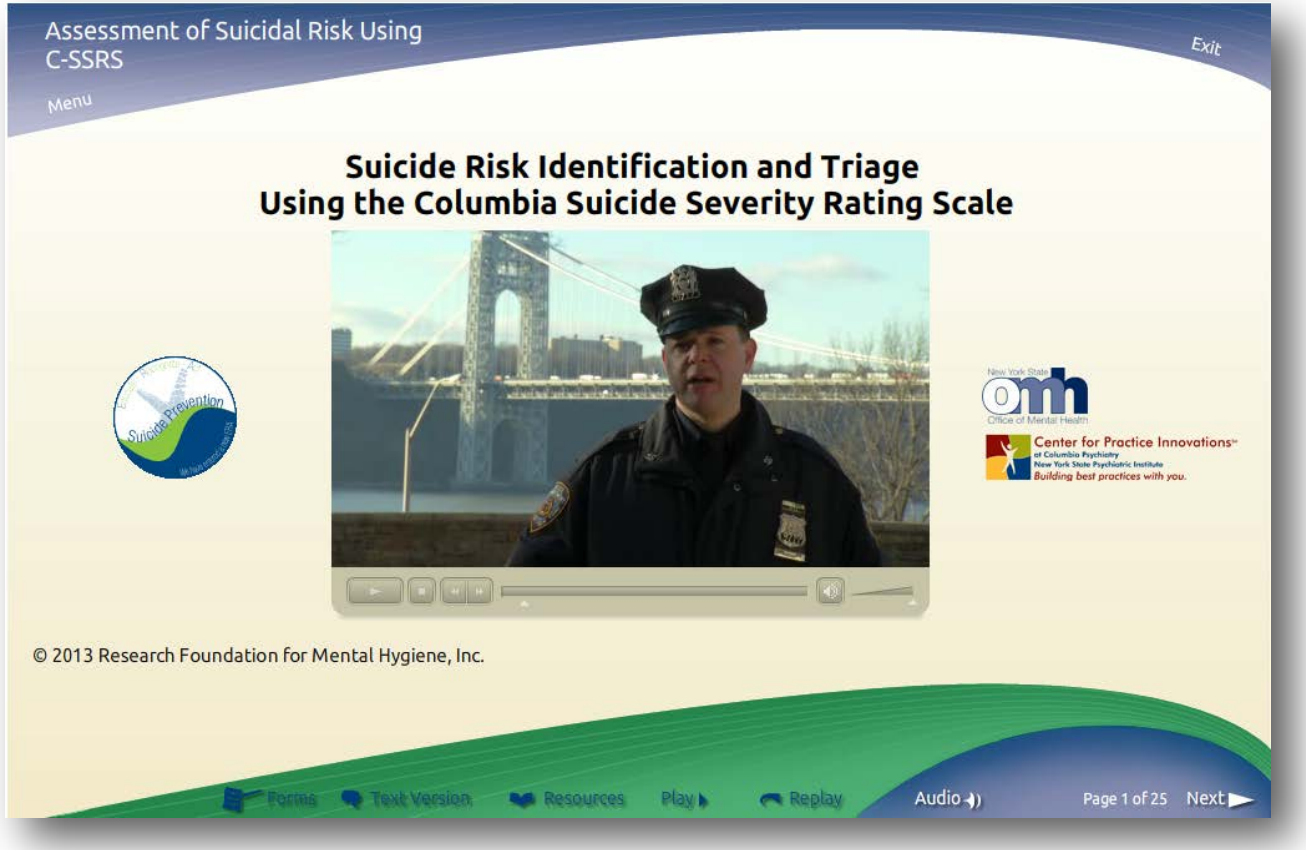
> 2400 participants enrolled (approx. 100/week)

Exploration:
Suicide attempt following negative response to PHQ item 9

GroupHealth RESEARCH INSTITUTE

- Of people who attempt suicide within 30 days of completing PHQ, 25% respond “Not at all” to item 9.
- Two very different explanations:
  - Sudden onset of suicidal ideation – “It just came over me.”
  - Concealed suicidal ideation – “I didn’t want you to stop me.”
- Exploration at 2 levels:
  - Large-scale data mining to identify hidden signals in health records
  - Small-scale interviews of people who survive unexpected attempts

Resource: Using the C-SSRS

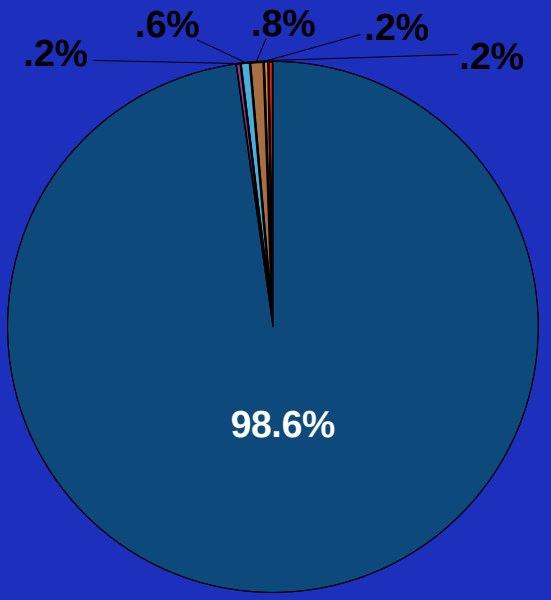


Access at: www.zerosuicide.com

ALL Behaviors Are Prevalent and Predictive

Each behavior is EQUALLY PREDICTIVE to an attempt

- No Behavior: 28,303
- **Actual Attempt: 70**
- Interrupted Attempt: 178
- Aborted Attempt: 223
- Preparatory Behavior: 71



Multiple behaviors = greater risk

***Only 1.7% had any worrisome answer**
***Only .9% with ~50,000 administrations**

472 Interrupted, Aborted and Preparatory (87%)
vs. 70 Actual Attempts (13%)

Mundt et al., 2011

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Reducing Suicide

Utah:

- Reversed an alarming increasing trend
- Part of Medicaid Improvement Plan
- In their legislative suicide prevention report they state "we are committed to becoming a Zero Suicide System of Care"

utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

State Suicide Prevention Programs
FY 2015 Report

Centerstone:

- Nation's largest provider of community-based behavioral healthcare
- Tennessee saw a 64% reduction in suicides in the first 10 months of using the C-SSRS.

CENTERSTONE

The Marines:

- Helped lead to a 22% reduction in suicides in 2014
- Top-down rollout at 14 Marine Bases and training for all support staff
- Lowest suicide rate of any branch of the armed forces

Marine Corps Times
A GANNETT COMPANY

THE COLUMBIA LIGHTHOUSE PROJECT
IDENTIFY RISK. PREVENT SUICIDE.

Decreased Unnecessary Intervention & Getting Care to Those Who Need It

SUICIDE SCREENING *in a General Hospital Setting: Initial Results*

Presented by: Debra Haas Stawarski, RN, MS; Director, Nursing Research • The Reading Hospital and Medical Center, West Reading, Pennsylvania

PURPOSE

A major barrier to effective suicide screening in the acute care hospital setting has been lack of a brief, valid, reliable, and universally acceptable tool that addresses ideation and behavior, and provides clear operational definitions of both. An abbreviated version of the Columbia-Suicide Severity Rating Scale (C-SSRS) screen was developed as part of a hospital suicide screening protocol. This study evaluated the psychometric properties of the abbreviated C-SSRS screen, protocol performance, and impact on selected outcome indicators.

THEORETICAL FRAMEWORK

The Johnson Behavioral Systems Model was used as the framework for the study. Johnson's model addresses the integration of patient behavior for prevention of illness and injury, as well as influences on behavior of both patient and caregiver.

RESEARCH TEAM

- Debra Stawarski, RN, MS: Director of Nursing Research, The Reading Hospital and Medical Center
- Udonna Millsaps, MEd: Research and Continuing Education Coordinator, Department of Psychiatry, The Reading Hospital and Medical Center
- Andres J. Pumariega, MD: Chair of Psychiatry, Cooper University Hospital, Camden, N.J.
- Kelly Posner, PhD: Associate Professor of Psychiatry and Director, Center for Suicide Risk Assessment, Columbia University Medical Center, New York, N.Y.
- Barbara Romig, RN, MSN: Director of Education/Professional Development, The Reading Hospital and Medical Center
- Robert Rice, BSN, RN-BC: Clinical Practice Educator, Inpatient Psychiatry, The Reading Hospital and Medical Center
- Heather Close, BS: Former Research Assistant, The Reading Hospital and Medical Center
- Mary Jo Castellucci, BS: Systems Analyst, The Reading Hospital and Medical Center

METHODS

Descriptive Study Design
- Instrument ratings
- Inter-rater reliability

Naturalistic Setting
- >500-bed community hospital
- Eastern Pennsylvania

Convenience Sample: Adult Inpatients
- Admitted January – June 2010

INSTRUMENT: ABBREVIATED C-SSRS

- C-SSRS: gold standard for suicide assessment
- Brief, valid, reliable tool desired for routine screening
- Abbreviated C-SSRS (2009)
- Triage algorithm for The Reading Hospital and Medical Center response to C-SSRS levels developed by Posner, Pumariega, Millsaps (2009)

CAREGIVER EDUCATION

- DVD Training on C-SSRS Tool
- Introduction to abbreviated C-SSRS Tool
- Caregiver reflection on attitudes toward suicide assessment
- Vignette training

CLINICAL SUICIDE SCREENING PROTOCOL

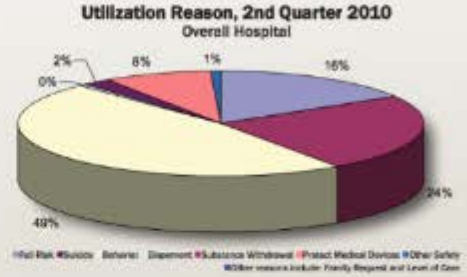
- Screening C-SSRS incorporated into admission assessment for all medical-surgical patients
- Automated risk stratification
- Prevention protocol triggered for identified risk
- Safety interventions implemented specific for risk levels 1 - 5

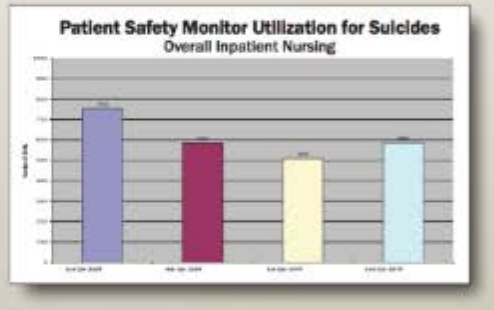
NURSE INTER-RATER RELIABILITY

Intra-rater Reliability Broken Down by Experience
Two-Way Random Intra-Rater Reliability

	No. Raters	Agreement: Single Measure	Agreement: Average Measure	Consistency: Single Measure	Consistency: Average Measure	Cronbach's Alpha
Experience Unknown	19	0.943	0.980	0.959	0.989	0.989
Experience 0 to 10 years	406	0.930	0.995	0.957	0.995	0.995
Experience 11 years and above	213	0.919	0.990	0.957	0.994	0.994
Experience 0 to 20 years	602	0.925	0.993	0.958	0.994	0.994
Experience 21 years and above	216	0.943	0.990	0.963	0.987	0.988

PATIENT SAFETY MONITOR UTILIZATION





IMPLICATIONS FOR PRACTICE

The abbreviated C-SSRS has been successfully incorporated into a clinical suicide screening protocol that is a component of assessment for all patients admitted to the acute care hospital setting, regardless of psychiatric history. This practice, implemented in early 2010, complies with Joint Commission recommendations published in a November 2010 Sentinel Event Alert.

The Reading Hospital and Medical Center
www.readinghospital.org

COLUMBIA LIGHTHOUSE PROJECT
IFY RISK. PREVENT SUICIDE.

Suicide Assessment Five-step Evaluation Triage

RESOURCES

- Download this card and additional resources at www.sprc.org or at www.stopasuicide.org
- Resource for implementing The Joint Commission 2007 Patient Safety Goals on Suicide www.sprc.org/library/jcsafetygoals.pdf
- SAFE–T drew upon the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors www.psych.org/psych_pract/treatg/pg/SuicidalBehavior_05–15–06.pdf

ACKNOWLEDGEMENTS

- Originally conceived by Douglas Jacobs, MD, and developed as a collaboration between Screening for Mental Health, Inc. and the Suicide Prevention Resource Center.
- This material is based upon work supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) under Grant No. 1U79SM57392. Any opinions/findings/conclusions/recommendations expressed in this material are those of the author and do not necessarily reflect the views of SAMHSA.

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

www.sprc.org

www.mentalhealthscreening.org

SAFE–T

Suicide Assessment Five–step Evaluation and Triage

1
IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2
IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced

3
CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4
DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5
DOCUMENT
Assessment of risk, rationale, intervention and follow–up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

SAMHSA
Substance Abuse and Mental Health Services Administration

Suicide Assessment Five-step Evaluation Triage

Suicide assessments should be conducted at first contact, with any subsequent suicidal behavior, increased ideation, or pertinent clinical change; for inpatients, prior to increasing privileges and at discharge.

1. RISK FACTORS

- ✓ **Current/past psychiatric diagnoses:** especially mood disorders, psychotic disorders, alcohol/substance abuse, Cluster B personality disorders. Co-morbidity and recent onset of illness increase risk
- ✓ **Key symptoms:** anhedonia, impulsivity, hopelessness, anxiety/panic, global insomnia, command hallucinations
- ✓ **Suicidal behavior:** history of prior suicide attempts, aborted suicide attempts or self-injurious behavior
- ✓ **Family history:** of suicide, attempts or Axis 1 psychiatric diagnoses requiring hospitalization
- ✓ **Precipitants/stressors:** triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial or health status—real or anticipated). Ongoing medical illness (esp. CNS disorders, pain). History of abuse or neglect. Intoxication
- ✓ Access to firearms

2. PROTECTIVE FACTORS *Protective factors, even if present, may not counteract significant acute risk*

- ✓ **Internal:** ability to cope with stress, religious beliefs, frustration tolerance, absence of psychosis
- ✓ **External:** responsibility to children or beloved pets, positive therapeutic relationships, social supports

3. SUICIDE INQUIRY *Specific questioning about thoughts, plans, behaviors, intent*

- ✓ **Ideation:** frequency, intensity, duration--in last 48 hours, past month and worst ever
- ✓ **Plan:** timing, location, lethality, availability, preparatory acts
- ✓ **Behaviors:** past attempts, aborted attempts, rehearsals (tying noose, loading gun), vs. non-suicidal self injurious actions
- ✓ **Intent:** extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; Explore ambivalence: reasons to die vs. reasons to live

* ***Homicide Inquiry:*** *when indicated, esp. postpartum, and in character disordered or paranoid males dealing with loss or humiliation. Inquire in four areas listed above.*

4. RISK LEVEL/INTERVENTION

- ✓ Assessment of risk level is based on clinical judgment, after completing steps 1-3
- ✓ Reassess as patient or environmental circumstances change

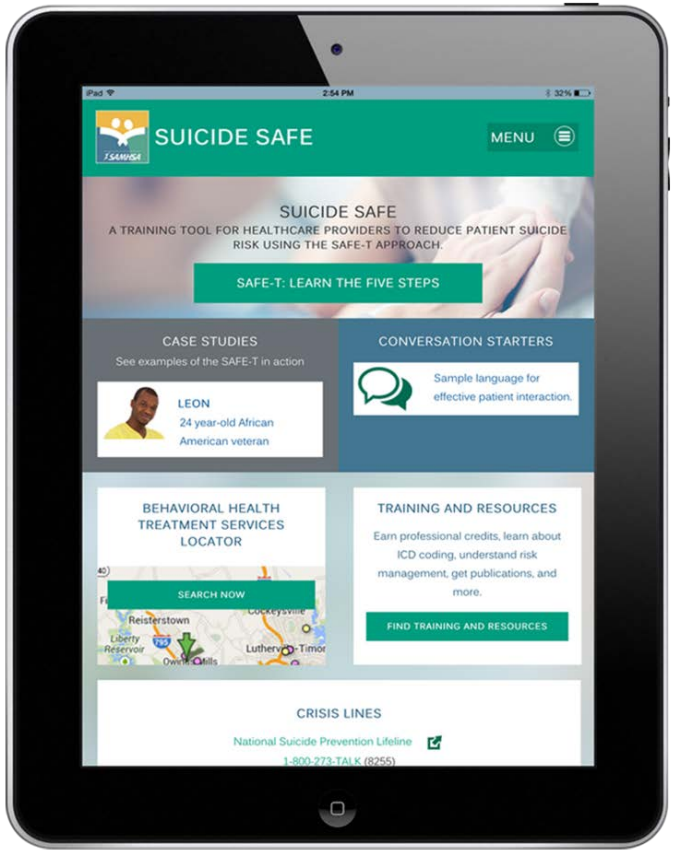
RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY	POSSIBLE INTERVENTIONS
High	Psychiatric diagnoses with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior	Outpatient referral, symptom reduction. Give emergency/crisis numbers

(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)

5. DOCUMENT: Risk level and rationale; treatment plan to address/reduce current risk (i.e., medication, setting, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan

SAMHSA
Substance Abuse and Mental Health Services Administration

Suicide Prevention App for Health Care Providers



Free for Apple® and Android™ mobile devices

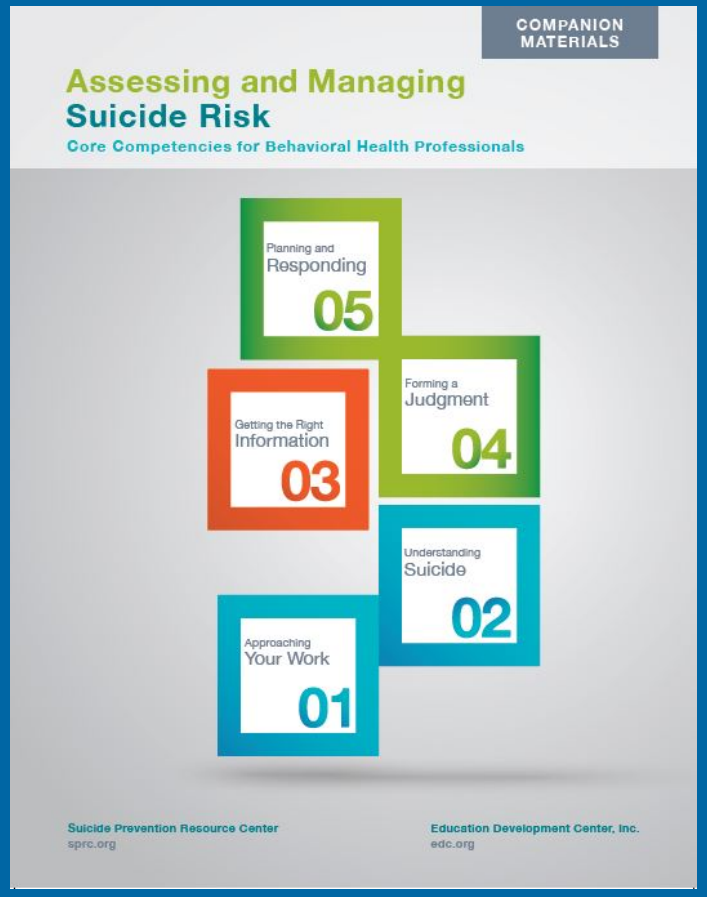
Suicide Safe Helps Providers:

- Integrate suicide prevention strategies into practice and address suicide risk
- Learn how to use the SAFE-T approach
- Explore interactive sample case studies
- Quickly access and share information and resources
- Browse conversation starters
- Locate treatment options

Learn more at **bit.ly/suicide_safe.**

SAMHSA
Substance Abuse and Mental Health Services Administration

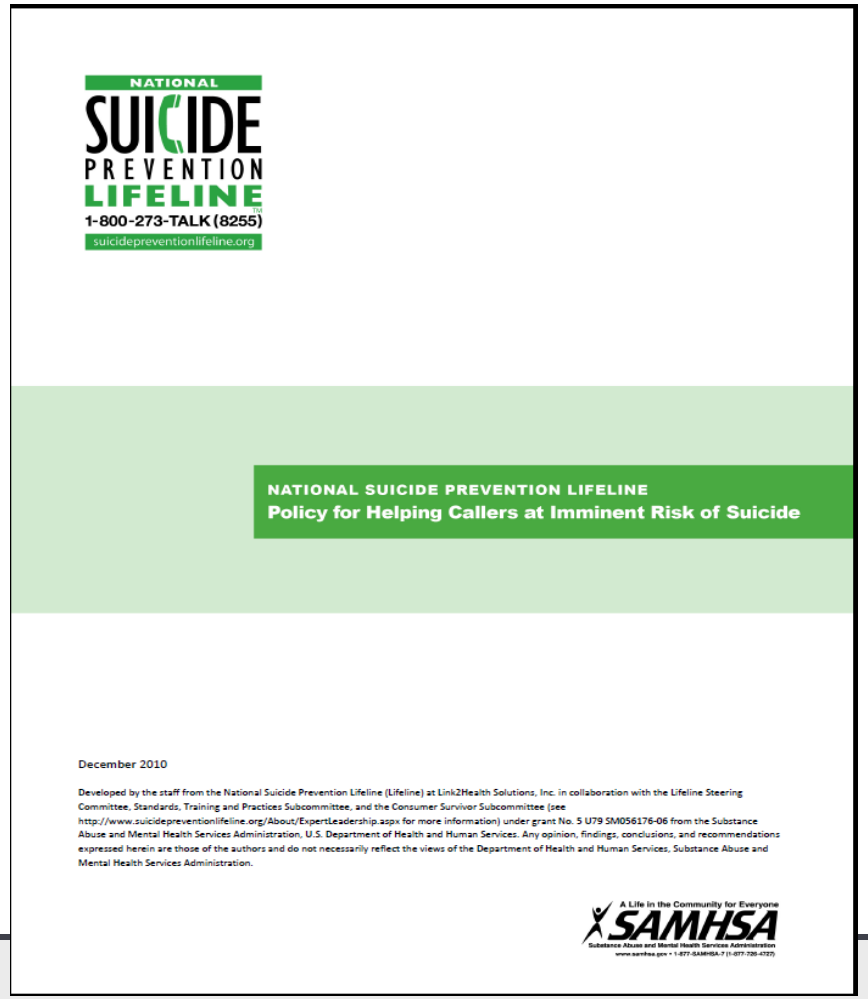
Assessing and Managing Suicide Risk



http://www.sprc.org/training-events/amsr

SPRC

Lifeline's Imminent Risk Policy (2011)

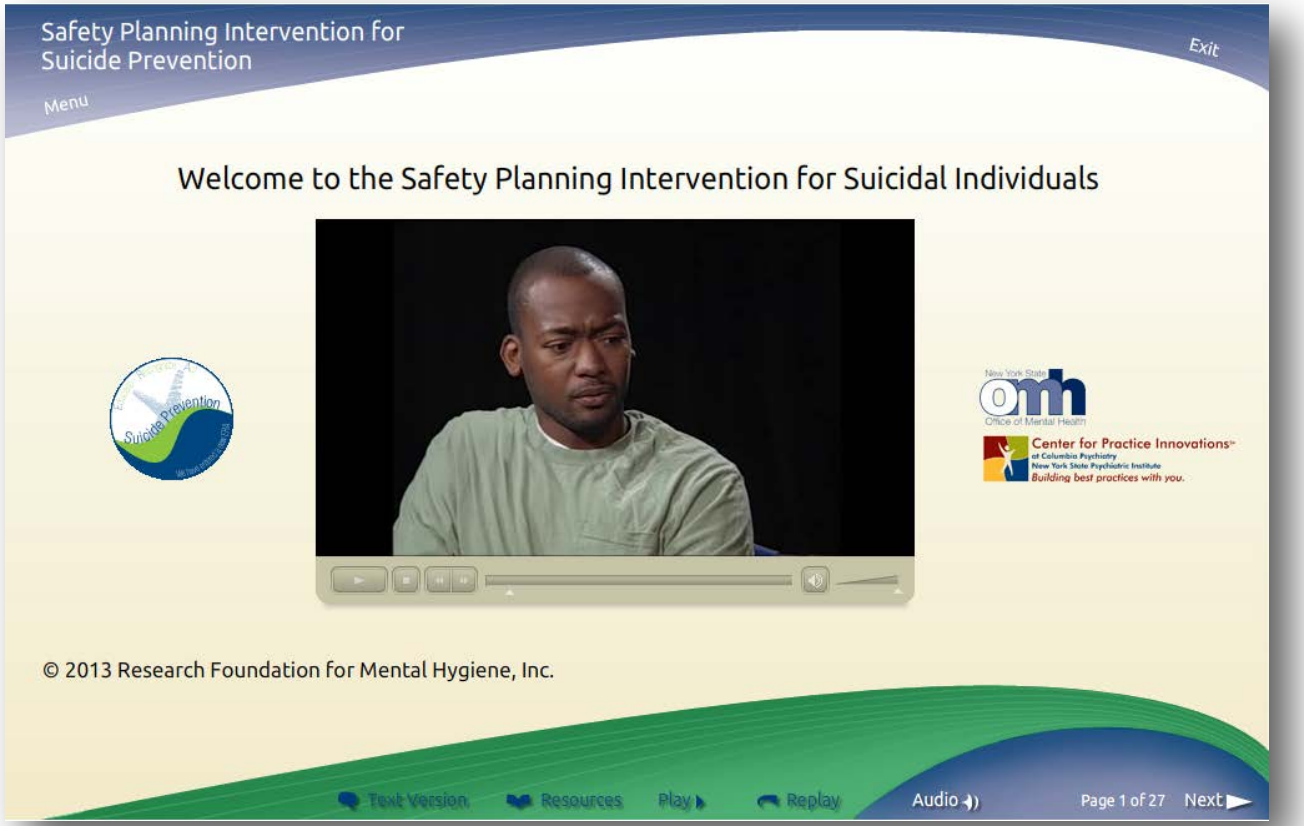


Helper Interventions with Imminent Risk Callers (N= 491)

TYPE OF INTERVENTION	SPECIFIC INTERVENTION	N	%
Active Engagement (Collaborative)	**Person at Imminent Risk Agreed to…..**		
Less Invasive	Take action on his/her own behalf to immediately reduce risk (e.g., collaborate on safety plan; not incl. self-transport)	214	43.6%
	Receive follow-up from center	142	28.9%
	Involve a 3rd party to keep him/her safe (not for transport)	125	25.5%
	Get rid of means	65	13.2%
	Be evaluated by a mobile crisis/outreach team	22	4.5%
	Transport him/herself to a hospital or walk-in clinic	21	4.3%
	Have center contact the VA	20	4.1%
	Be transported to the hospital by a 3rd party	15	3.1%
	Any less invasive Active Engagement	334	68.0%
More Invasive	Have center send emergency services (police, sheriff, EMS)	94	19.1%
	Any Active Engagement	375	**76.4%**
Active Rescue (Non-collaborative)	**Without Consent of Person at Imminent Risk, Helper…..**		
Less Invasive	Involved a 3rd party (not for transport)	8	1.6%
	Sent a mobile crisis/outreach team	5	1.0%
	Contacted the VA	4	0.8%
	Involved a 3rd party for transport to hospital	1	0.2%
	Any less invasive Active Rescue	18	3.7%
More Invasive	Sent emergency services (police, sheriff, EMS)	121	24.6%
	Any Active Rescue	136	**27.7%**
Imminent Risk Reduced Enough so Rescue was Not Needed		192	**39.1%**

ENGAGE

Resource: Safety Planning Intervention



Access at: www.zerosuicide.com

Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com

Engage Families and those with Lived Experience

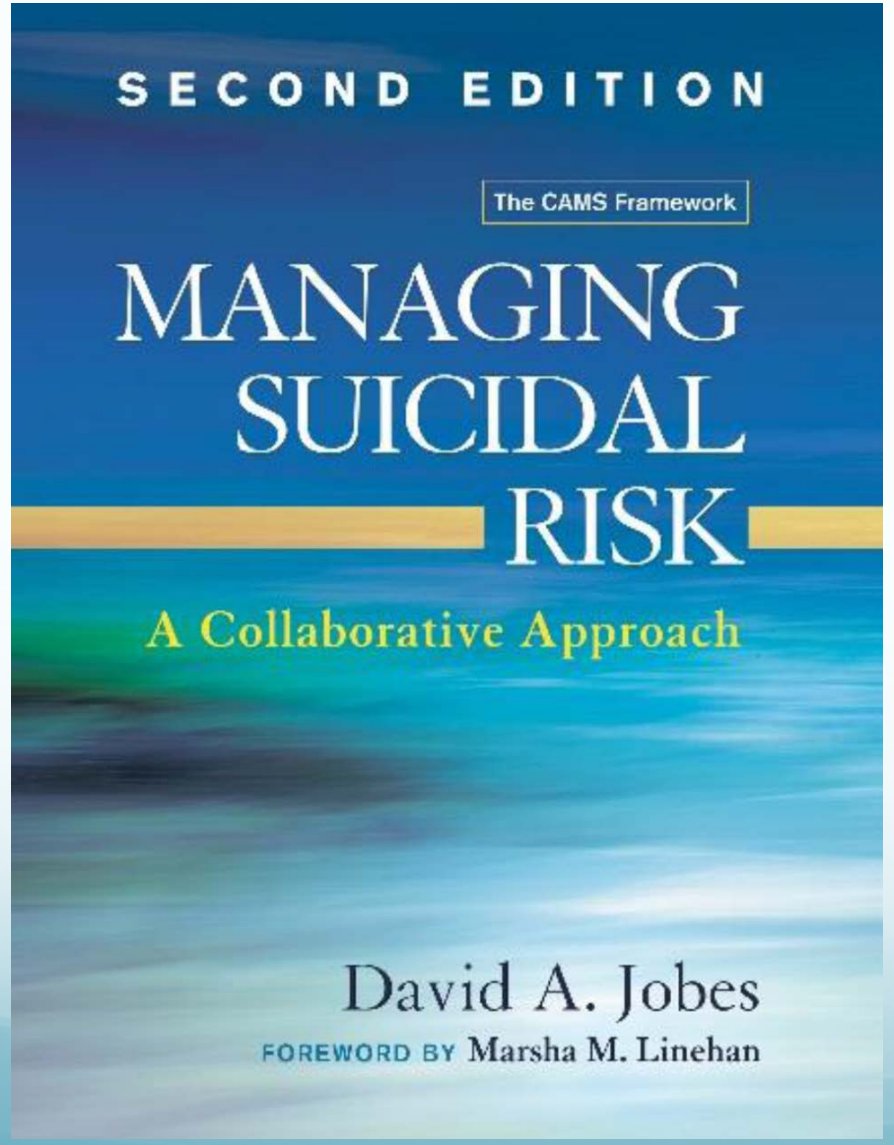
- Those with lived experience with suicidal crises need to have a voice in the system of care and in their treatment.
- Peer workforce
- Family members need support .
- Involving family in review of suicide deaths.

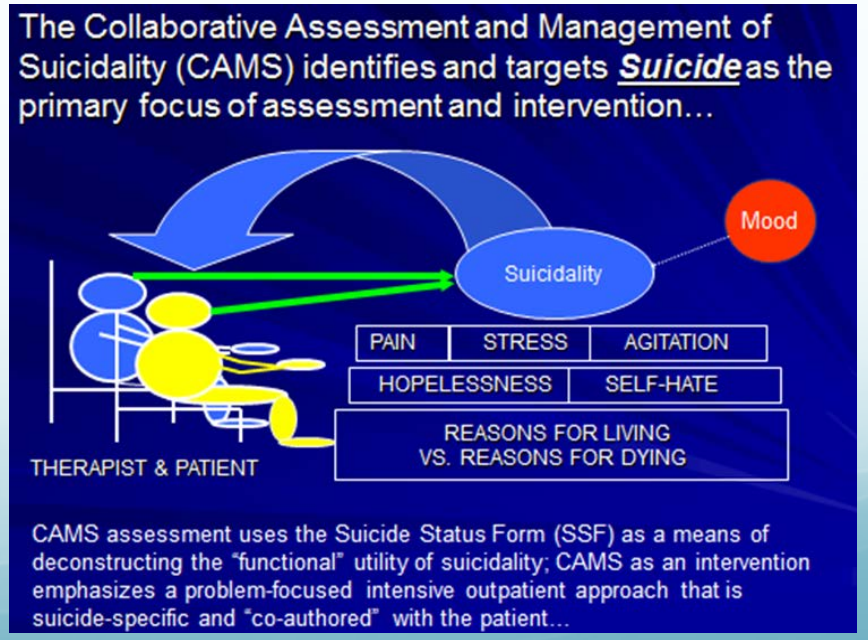
TREAT

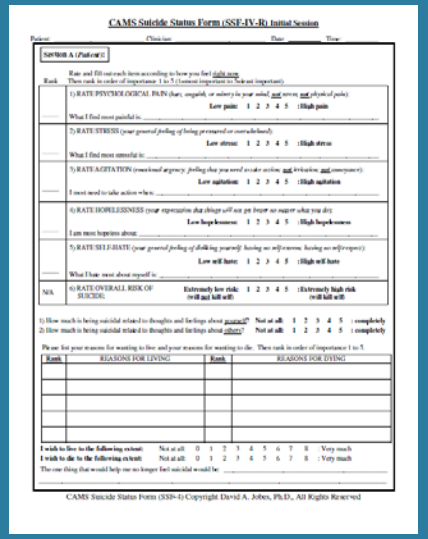
Treat Suicidality Directly

- Both treating suicidality directly as well as treating underlying conditions is crucial.
- There are now multiple RCT's showing reductions in suicidal behavior . All focus directly on suicidality.
- DBT, CBT (civilian and military), CAMS,ASSIP
- CBT for insomnia can reduce suicidal ideation

Collaborative Assessment and Management of Suicidality (CAMS)







CAMS Suicide Status Form (SSF-IV-R) Initial Session

Section A (Patient):

Rate and fill out each item according to how you feel right now.

Rank — Then rank in order of importance 1 to 5 (1=most important to 5=least important).

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not nerves, not physical pain):
Low pain: 1 2 3 4 5 :High pain

What I find most painful is: _____

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress: 1 2 3 4 5 :High stress

What I find most stressful is: _____

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
Low agitation: 1 2 3 4 5 :High agitation

I most need to take action when: _____

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
Low hopelessness: 1 2 3 4 5 :High hopelessness

I am most hopeless about: _____

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
Low self-hate: 1 2 3 4 5 :High self-hate

What I hate most about myself is: _____

N/A — 6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

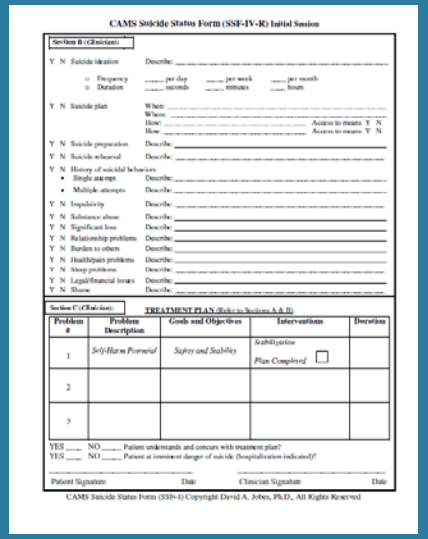
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
2) How much is being suicidal related to thoughts and feelings about others? Not at all: 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all 0 1 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all 0 1 2 3 4 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: _____



CAMS Suicide Status Form (SSF-IV-R) Initial Session

Section B (Clinician):

Y N Suicide ideation — Describe: _____
- Frequency _____ per day _____ per week _____ per month
- Duration _____ seconds _____ minutes _____ hours

Y N Suicide plan — When: _____ Where: _____ How: _____ Access to means Y N

Y N Suicide preparation — Describe: _____

Y N Suicide rehearsal — Describe: _____

Y N History of suicidal behaviors
- Single attempt — Describe: _____
- Multiple attempts — Describe: _____

Y N Impulsivity — Describe: _____

Y N Substance abuse — Describe: _____

Y N Significant loss — Describe: _____

Y N Relationship problems — Describe: _____

Y N Burden to others — Describe: _____

Y N Health/pain problems — Describe: _____

Y N Sleep problems — Describe: _____

Y N Legal/financial issues — Describe: _____

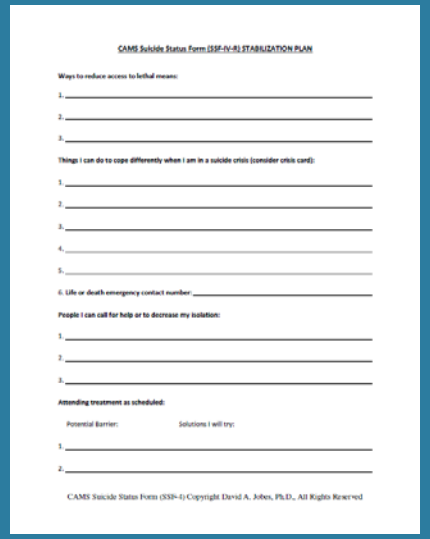
Y N Shame — Describe: _____

Section C (Clinician): TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				
3				

YES ____ NO ____ Patient understands and concurs with treatment plan?
YES ____ NO ____ Patient at imminent danger of suicide (hospitalization indicated)?

Patient Signature Date Clinician Signature Date



CAMS Suicide Status Form (SSF-IV-R) STABILIZATION PLAN

Ways to reduce access to lethal means:

1. _____
2. _____
3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. _____
2. _____
3. _____
4. _____
5. _____
6. Life or death emergency contact number: _____

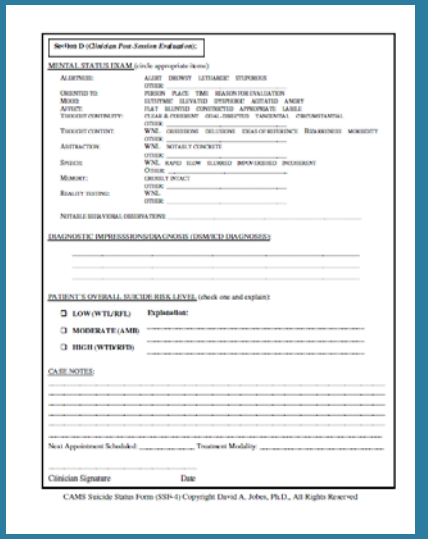
People I can call for help or to decrease my isolation:

1. _____
2. _____
3. _____

Attending treatment as scheduled:

Potential Barrier: Solutions I will try:

1. _____
2. _____



Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: _____

MEMORY: GROSSLY INTACT OTHER: _____

REALITY TESTING: WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ LOW (WTL/RFL) Explanation: _____

☐ MODERATE (AMB) _____

☐ HIGH (WTD/RFD) _____

CASE NOTES:

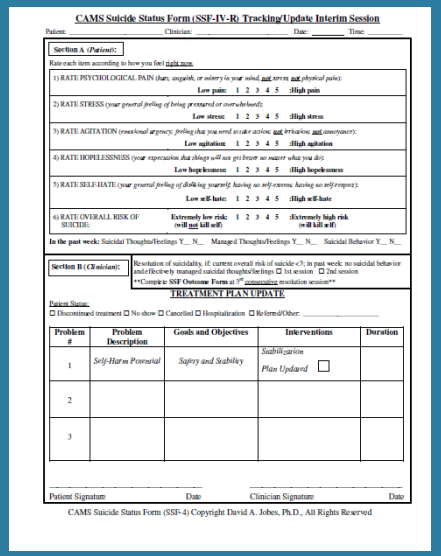
_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____

Clinician Signature Date

First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation



CAMS Suicide Status Form (SSF-IV-R) Tracking/Update Interim Session

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not nerves, not physical pain):
Low pain: 1 2 3 4 5 :High pain

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress: 1 2 3 4 5 :High stress

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
Low agitation: 1 2 3 4 5 :High agitation

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
Low hopelessness: 1 2 3 4 5 :High hopelessness

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
Low self-hate: 1 2 3 4 5 :High self-hate

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

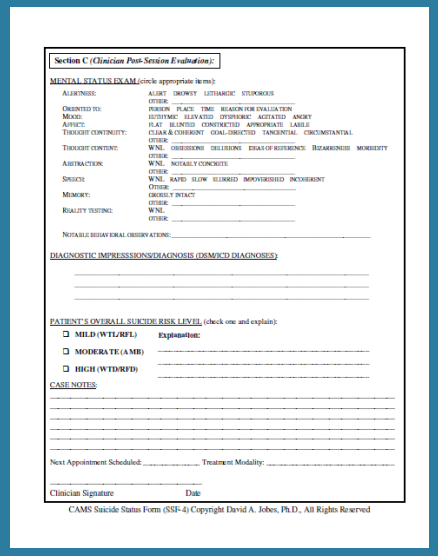
Section B (Clinician): Resolution of suicidality, if current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session
Complete SSF Outcome Form at 3rd consecutive resolution session

TREATMENT PLAN UPDATE

Patient Status:
☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Updated* ☐	
2				
3				

Patient Signature Date Clinician Signature Date



Section C (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: _____

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: _____

ABSTRACTION: WNL NOTABLY CONCRETE OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: _____

MEMORY: GROSSLY INTACT OTHER: _____

REALITY TESTING: WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ MILD (WTL/RFL) Explanation: _____

☐ MODERATE (AMB) _____

☐ HIGH (WTD/RFD) _____

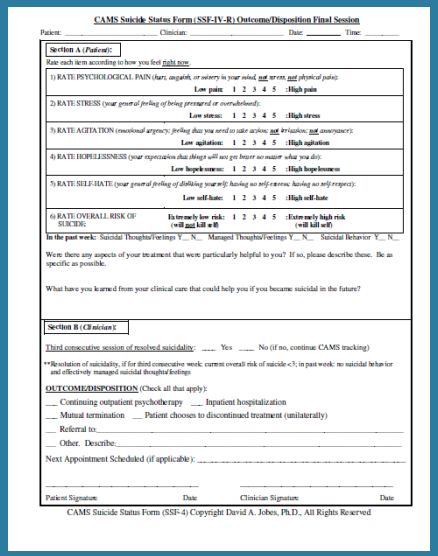
CASE NOTES:

_____

Next Appointment Scheduled: _____ Treatment Modality: _____

_____

Clinician Signature Date



CAMS Suicide Status Form (SSF-IV-R) Outcome/Disposition Final Session

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not nerves, not physical pain):
Low pain: 1 2 3 4 5 :High pain

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
Low stress: 1 2 3 4 5 :High stress

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):
Low agitation: 1 2 3 4 5 :High agitation

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
Low hopelessness: 1 2 3 4 5 :High hopelessness

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
Low self-hate: 1 2 3 4 5 :High self-hate

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Feelings Y__ N__ Managed Thoughts/Feelings Y__ N__ Suicidal Behavior Y__ N__

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?

Section B (Clinician):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if no, continue CAMS tracking)

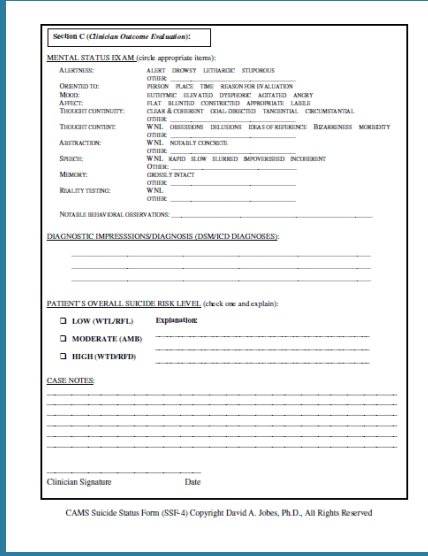
**Resolution of suicidality, if for third consecutive week: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization
___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)
___ Referral to: _____
___ Other. Describe: _____

Next Appointment Scheduled (if applicable): _____

Patient Signature Date Clinician Signature Date



Section C (Clinician Outcome Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

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MEMORY: GROSSLY INTACT OTHER: _____

REALITY TESTING: WNL OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

☐ LOW (WTL/RFL) Explanation: _____

☐ MODERATE (AMB) _____

☐ HIGH (WTD/RFD) _____

CASE NOTES:

_____

Clinician Signature Date

CAMS Interim Tracking Sessions

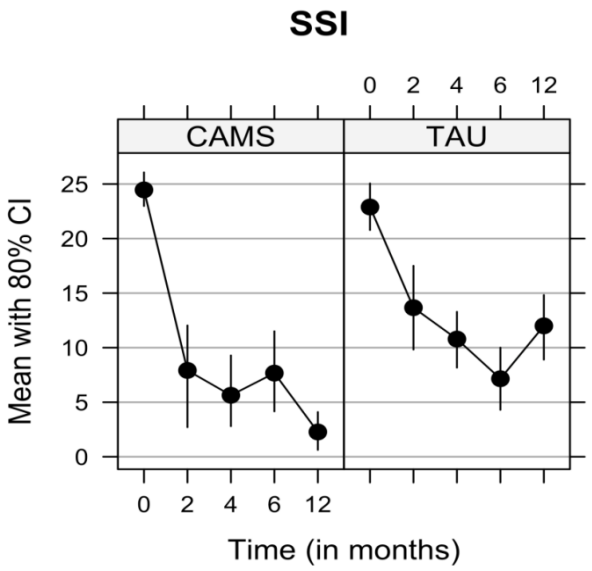
CAMS Outcome/Disposition Session

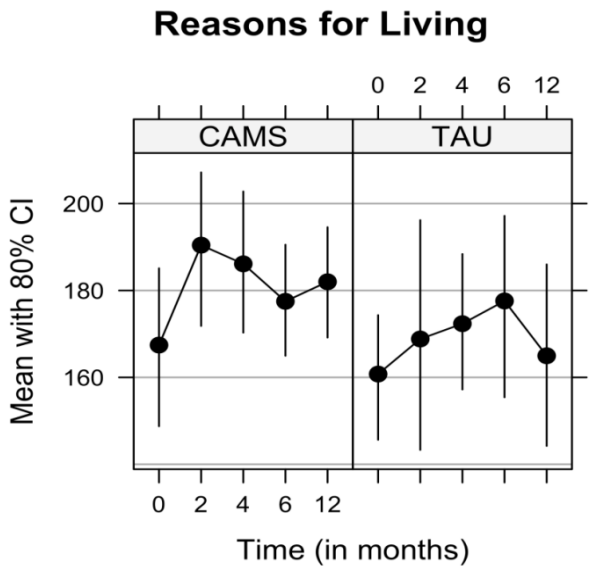
Randomized Controlled Trials of CAMS

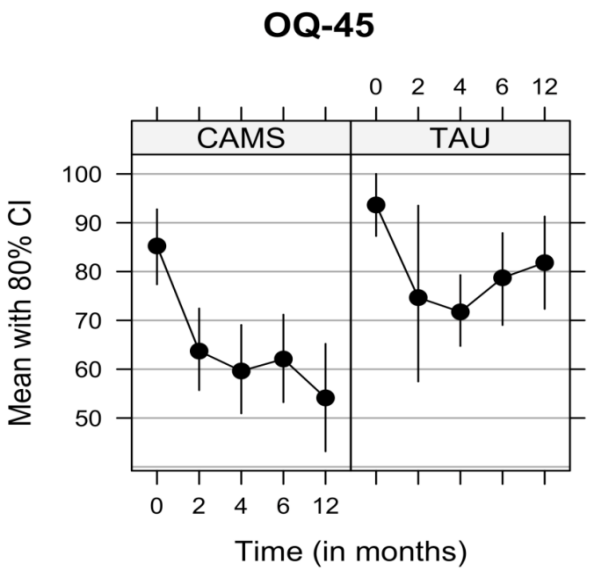
Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH patients	CAMS vs. TAU Next-day appts.	32	2011 published article
Andreasson (Nordentoft)	Danish Centers CMH patients	DBT vs. CAMS superiority trial	108	2016 published article
Jobes (Comtois et al)	Ft. Stewart, GA US Army Soldiers	CAMS vs. E-CAU	148	Manuscripts in preparation
Fosse	Norwegian Centers CMH patients	CAMS vs. TAU	100	ITT underway on-going
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design TAU/CAMS/DBT	60	Data analyses underway
Comtois (Jobes)	Harborview/Seattle CMH Patients	CAMS vs. TAU Post-Hospital D/C	200	Pilot phase underway

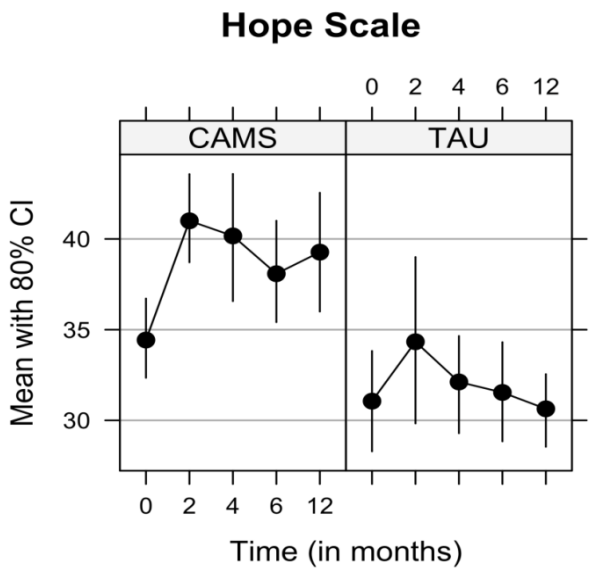
Note: There are seven published correlational and open trials supporting CAMS

CAMS RCT (Comtois et al., 2011)









CAMS had significantly higher patient satisfaction ratings and better clinical retention…

DEPRESSION AND ANXIETY 28:963–972 (2011)

Research Article

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY (CAMS): FEASIBILITY TRIAL FOR NEXT-DAY APPOINTMENT SERVICES

Katherine Anne Comtois, Ph.D. M.P.H.,[1]* David A. Jobes, Ph.D.,[2] Stephen S. O'Connor, Ph.D.,[1] David C. Atkins, Ph.D.,[1] Karin Janis, B.A.,[1] Chloe E. Chessen, B.A.,[1] Sara J. Landes, Ph.D.,[1,3] Anna Holen, M.D.,[1] and Christine Yuodelis-Flores, M.D.[1]

Background: *Despite the ubiquity of suicidality in behavioral health settings, empirically supported interventions for suicidality are surprisingly rare. Given the importance of resolving suicidality and therapists' anxieties about treating suicidal patients, there is a clear need for innovative services and clinical approaches. The purpose of the current study was an attempt to address some of these needs by examining the feasibility and use of a new intervention called the "Collaborative Assessment and Management of Suicidality" (CAMS) within a "Next-Day Appointment" (NDA) outpatient treatment setting.* Methods: *As part of a larger feasibility study, n = 32 suicidal patients were randomly assigned to CAMS care versus Enhanced Care as Usual (E-CAU) in an outpatient crisis intervention setting attached to a safety net hospital. Intent to treat suicidal patients were seen and assessed before, during, and after treatment (with follow-up assessments conducted at 2, 4, 6, and 12 months).* Results: *The feasibility of using CAMS in the NDA setting was clear; both groups appeared to initially benefit from their respective treatments in terms of decreased suicidal ideation and overall symptom distress. Although patients rated both treatments favorably, the CAMS group had significantly higher satisfaction and better treatment retention than E-CAU. At 12 months post-treatment, CAMS patients showed significantly better and sustained reductions in suicidal ideation, overall symptom distress, and increased hope in comparison to E-CAU patients.* Conclusions: *CAMS was both feasible in this NDA setting and effective in treating suicidal ideation, distress, and hopelessness (particularly at 12 months follow-up). Depression and Anxiety 28:963–972, 2011.* © 2011 Wiley Periodicals, Inc.

Key words: *suicide; attempted suicide; psychotherapy; risk assessment; crisis intervention; feasibility studies; clinical trial*

INTRODUCTION

More than 33,000 suicides occurred in the United States in 2006—91 suicides per day or one suicide every 16 min.[1,2] Death by suicide is part of a much larger problem; millions of Americans have suicidal thoughts and hundreds of thousands make suicide attempts each year.[3] In 2008, 2.3 million people made

[1]University of Washington, Seattle, Washington
[2]The Catholic University of America, Washington, District of Columbia
[3]National Center for PTSD, VA Palo Alto Health Care System, Palo Alto, CA

The authors disclose the following financial relationships within the past 3 years: Contract grant sponsor: American Foundation for Suicide Prevention.

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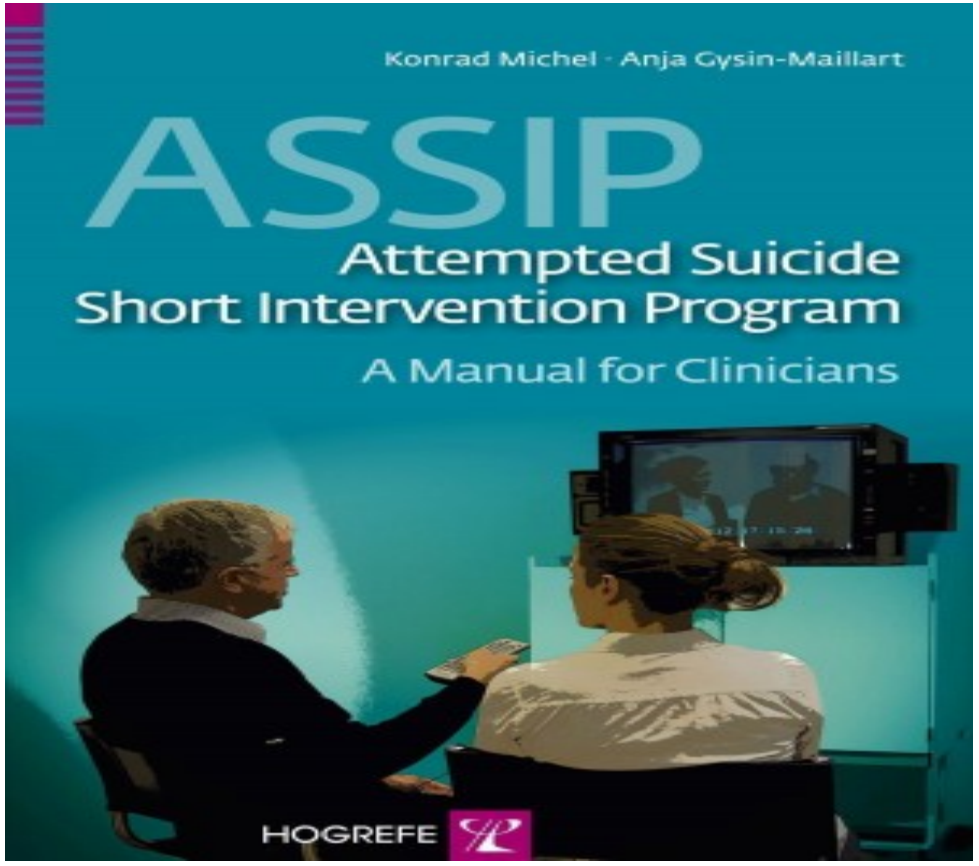
Study conducted at Harborview Medical Center, 325 9th Avenue, Seattle, WA 98104.

Received for publication 20 May 2011; Revised 25 July 2011; Accepted 26 July 2011

DOI 10.1002/da.20895

Published online 21 September 2011 in Wiley Online Library (wileyonlinelibrary.com).

Attempted Suicide Short Intervention Program



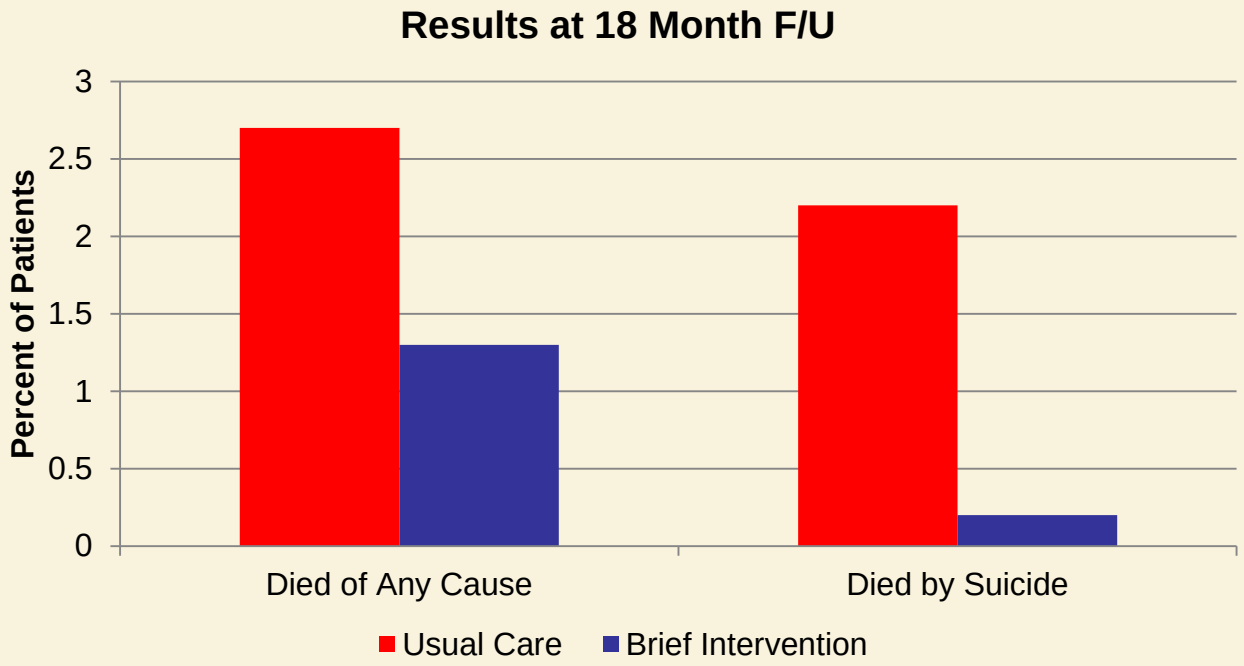
TRANSITION

Improving Care Transitions

- There are lethal gaps in many systems.
- Period after IPU and ED discharge is one of high risk, particularly the first 30 days.
- Rates of follow up care are poor.
- Intervention during this time has been shown to save lives and reduce suicidal behavior.

EMERGENCY DEPARTMENT F/U

- **Fleischmann et al (2008)**
  - *Randomized controlled trial; 1867 Suicide attempt survivors from five countries (all outside US)*
  - *Brief (1 hour) intervention as close to attempt as possible*
  - *9 F/u contacts (phone calls or visits) over 18 months*



Resource: Structured Follow-up and Monitoring

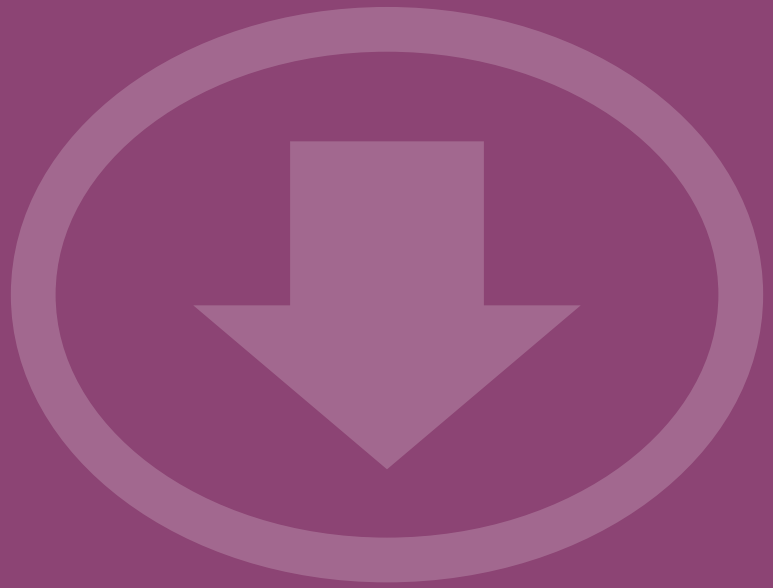
Access at: www.zerosuicide.com

Clients' Perceptions of Care: Cohort II (preliminary)

"To what extent did the follow-up call(s) stop you from killing yourself?"

	Callers (n= 283)	Hosp. Clients (n= 70)	Total (n= 353)
• A lot	60.8%	51.4%	58.9 %
• A little	22.6%	14.3%	21.0 %
• Not at all	16.6%	32.9%	19.8 %
• It made things	0.0%	1.4%	0.3

(17 callers, 2 hosp. clients had missing data)



IMPROVE

Mortality After Recent Suicide Attempts

- SAMHSA NSDUH data
- Significant post non-fatal attempt suicide mortality-3.2 %
- Higher among men then women
- 45 and older with less then a high school education - 16%
- 40.6% had any outpatient mental health treatment, 15.8% had 1-4 visits,

National Suicide Prevention Lifeline

- Joint Commission recommends giving those with suicidal ideation the Lifeline number -1-800-273-TALK (8255)
- Link to Veterans Crisis Line
- 160+ local crisis centers
- Local Lifeline crisis centers are a vital partner for suicide prevention-talk to them, support them, partner with them

Thank you.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

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