

*Getting to the Goal*

# **Suicide as a Never Event in New York State**

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***New York State Office of Mental Health  
Division of Quality Management***

*The New York State Office of Mental Health Division of Quality Management wishes to extend its thanks to and acknowledge the contributions of the following individuals to this report:*

*Lynda Battaglia*

*Mary Jean Coleman, MSW*

*Melanie Puerto Conte*

*Laura Davis*

*Sheila Donahue*

*Susan Essock, PhD*

*Colleen Garrahan*

*Michael Hogan, PhD*

*Michael Holley*

*Steven Huz, PhD*

*Gregory Miller, MD*

*Thomas O'Clair*

*Betty Pease, RN*

*Lloyd Sederer, MD*

*Maxine Smalling, RN*

*Jack Smitka*

*Mark Stevens*

*Jayne Van Bramer*

## Getting to the Goal

# Suicide as a Never Event in New York State

Suicide and suicidal behaviors exact serious economic and human costs to individuals, families, communities and society worldwide.<sup>1</sup> In its recent report, *Suicide Care in a Systems Framework*,<sup>2</sup> the National Action Alliance for Suicide Prevention Clinical Care and Intervention Task Force completed an environmental scan of innovative national suicide prevention programs with demonstrated positive outcomes. Specifically, it examined the Air Force Suicide Prevention Program, Henry Ford Health System Perfect Depression Care program, National Suicide Prevention Lifeline Suicide Risk Assessment Standards, and the Central Arizona Programmatic Suicide Deterrent System Project.

Common to the four initiatives was dramatic success in reducing suicide attempts, reducing costs associated with unnecessary hospital and emergency department care, and, most important, saving lives. The review of these programs identified three distinct and critical attributes contributing to the success:

### ■ Core Values

A deep commitment to safety in health and behavioral healthcare, leading to reductions or even the elimination of suicide in a population under care through continuous quality improvement and improvements in access, risk assessment and treatment so that suicide for people under care can become “a never event”

### ■ Systems Management

Systematic steps taken in organizations and systems of care aimed at creating a safety culture that no longer finds suicide acceptable, while supporting the clinical personnel who do this difficult work; setting achievable goals to reduce and hopefully eliminate suicide attempts and deaths; and taking the steps to improve service delivery that can help achieve the goal

### ■ Evidence-Based and Clinical Best Practices

Using methods, interventions and practices that are research-validated and/or consistent with research evidence and based on expert judgment, delivered through a care system that emphasizes productive (healing) patient and staff interactions

#### Core Values: Beliefs & Attitudes

- Leadership leading to cultural transformation
- Continuity of care and service responsibility
- Immediate access to care for all persons in suicidal crisis
- Productive interactions between persons at risk and persons providing care
- Evaluation of performance and use for quality improvement



#### Systems Management: Implementation & Action

- Written policies and procedures
- Collaboration and communication
- Trained and skilled workforce

#### Evidenced-Based Clinical Care Practice

- Screening
- Assessment for suicide risk
- Engagement and empowerment of persons at risk
- Treatment responses
- Intervention
- Follow-up process

Within each of these domains, the Task Force identified elements it believes are essential for health and behavioral health organizations to adopt as well as adapt in implementing suicide prevention effectively; to manage successful service delivery; and to ensure culturally competent, recovery-oriented approaches to identifying and treating people with suicidal ideation and behaviors. The report of the Task Force was accepted by the Action Alliance, and a number of its key recommendations were included in the updated *National Strategy for Suicide Prevention* released on September 10, 2012, by United States (US) Surgeon General Dr. Regina Benjamin. For example, Objective 8.1 of the newly released *National Strategy* is to “Promote the adoption of ‘zero suicides’ as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.”<sup>3</sup>

Taking the Alliance’s “bold vision of our nation free from the tragedy of suicide”<sup>4</sup> to heart, the New York State (NYS) Office of Mental Health (OMH) is committed to this notable moment to look at patient care in our system, identify opportunities for substantial improvement and change, and demonstrate the leadership needed to advance the conviction that “suicide is everybody’s business” in the mental health system. OMH is reaffirming its commitment to reduce the number of suicides and suicide attempts and it is reinforcing this commitment by seeking to embrace suicide as “a never event” for people in our care. Importantly, with the release of the revised *National Strategy for Suicide Prevention*, OMH is also heeding the strategy’s call to action for guiding suicide prevention actions statewide and nationally over the next decade.

Toward these ends, OMH has undertaken a review of suicides occurring within the public mental health system over the past several years and is using the data, in addition to the latest evidence on suicide prevention and treatment, to develop an action plan for NYS. We intend to use recommendations from the Alliance’s Task Force report and the *National Strategy* as catalysts for change.

This briefing report and draft recommendations, thus, aim to stimulate dialogue and, beginning with the public mental health system, set the State on a path toward systematically preventing suicide for people in our care. What follows are details of the review, a summary of findings and a set of draft recommendations for discussion, collaboration, and thoughtful planning.

## **The Picture of Suicide and Suicidal Behaviors Nationally and in NYS**

### **National and NYS Suicide Rates**

According to a May 2, 2013, Centers for Disease Control and Prevention (CDC) press release, there were 38,364 reported deaths by suicide and 33,687 deaths from motor vehicle crashes in 2010. Suicide rates among middle-age Americans have risen substantially since 1999: Using data available from the CDC’s Web-based Injury Statistics Query and Reporting System (WISQARS), annual suicide rates for adults ages 35–64 increased 28% since 1999, with the greatest increases among white non-Hispanic and American Indian and Alaska Natives, ages 50–54 years. (Rates for ages 10 to 34 and 65 and older did not change significantly.)<sup>5</sup> Suicide rates increased 23% or more across all four major regions of the US. Moreover, results from the 2010 National Survey on Drug Use and Health<sup>6</sup> indicate that suicidal behaviors led to 572,000 hospitalizations, 752,000 attempts that required medical attention, and 1.1 million suicide attempts. Almost 9 million people seriously considered suicide.

The number of completed suicides in the US is equivalent to one death by suicide every 16 minutes. Suicide is the 11<sup>th</sup> leading cause of death for all ages and the second leading cause of death among 25–34 year olds. Suicide deaths are most associated with a history of one or more suicide attempts and current, persistent suicidal ideation. Suicides are frequently found in association with mental illness, particularly major depression, other mood disorders and substance abuse.<sup>7</sup>

The most recent data from the NYS Department of Health (DOH) indicate that the total number of annual deaths by suicide has risen from 2008 to 2010 with 1,392, 1,376 and 1,514 deaths reported, respectively. This represents an overall suicide death rate of 7.3/100,000 population for the period<sup>8</sup>. According to 2010 figures from the CDC, NYS has a suicide death rate of 8.0/100,000 population with only the District of Columbia reporting a lower rate.<sup>9</sup> The ratio of emergency department visits/hospitalizations for self-harm to deaths is about 7:1 and the emergency department/inpatient cost for treating consequences of self-harm is about \$200 million per year.<sup>10</sup>

While global data on suicide are also striking—and while OMH supports suicide prevention efforts for many populations and in many communities—our focus here is *on the people at highest risk in our State*. These are individuals with serious mental illness—especially when they also use drugs or alcohol—and people who have been seen or hospitalized following a prior suicide attempt.

### **Suicide in the NYS Public Mental Health System**

The NYS public mental health system is composed largely of agencies and organizations licensed, certified or funded by OMH and/or that receive Medicaid funding. For the most part, State psychiatric center inpatient and outpatient services, psychiatric departments of general hospitals, community mental health agencies, and services operated by counties comprise the public mental health system.

Across these settings, in 2011, the NYS public mental health system served an estimated 717,000 persons, with about an equal proportion of men and women receiving services. During 2011, service rates per the general population in NYS were highest among people who were Native Hawaiian/Pacific Islander (62.5/1,000 general population), multi-racial (51.8/1,000 general population), Hispanic (51.6/1,000 general population), and Black (51.4/1,000 general population) and lowest among people who were Asian (8.2/1,000 general population), Native American/Alaskan Native (22.0/1,000 general population) and White (26.7/1,000 general population).

Most people in the public mental health system receive services in outpatient programs. In 2011, approximately three quarters of children ages 0–17 (72%) served by the public mental health system received services in outpatient settings, while 62% of adults aged between 18 and 64 years of age received services in those settings. Many fewer people served by the public mental health system receive services in inpatient settings; in 2011, about 10% of children ages 0–17 served in the public mental health system received services in inpatient settings, while 13% of adults ages 18–64 in inpatient settings.<sup>11</sup>

OMH certifies more than 1,600 mental health programs including residential, inpatient, outpatient and emergency services. In addition, OMH currently operates 24 psychiatric hospitals that serve adults, children and people who have had contact with the criminal justice system.

Under NYS regulations, any program licensed or operated by OMH is required to file incident reports when adverse events happen.<sup>12</sup> On average, just over 10,000 incident reports were filed annually between 2009 and 2012. Completed suicides during those years represented approximately 2% of all incidents filed.

The remainder of this report section focuses on the population of individuals served in inpatient, outpatient and licensed residential programs and presents information for the period 2009–2012 on rates of completed suicide and suicide attempts by OMH region, gender, age, race/ethnicity and service type. Information regarding suicide activity is expressed in rates so that the reader is able to assess the relative risk a particular population cohort (e.g., female/male, individuals in various age groups) has for either completed suicide or suicide attempt. Additionally, this section summarizes other improvement opportunities identified through a review of incident reports and root cause analyses conducted by OMH.

Completed suicide and suicide attempt data are from the OMH NYS Incident Management and Reporting System. Data on the number of persons in treatment are from the 2009 and 2011 OMH Patient Characteristics Survey.

**Completed suicides and suicide attempts**

Between 2009 and 2012, the number of completed suicides among consumers of inpatient, outpatient and residential services rose from 180 to 226 per year. This represents an increase from 3.20 to 3.88/10,000 service consumers,<sup>13</sup> a rise of 21.3%.

During the same period, attempted suicides increased at a somewhat slower rate. Between 2009 and 2012, the rate of attempted suicides among service consumers rose from 27.5 attempts/10,000 service consumers to 32.1 attempts/10,000 service consumers, an increase of 16.6%.

Table 1 shows the number of completed suicides and suicide attempts and rates per OMH service population.

**Geographic distribution**

The statewide trend observed between 2009 and 2012 for both completed suicides and suicide attempts was, for the most part, seen at the OMH regional level as well. In all regions except New York City the rate of completed suicides rose. Variability in the rate of change between 2009 and 2012 and the magnitude of the completed suicide rate is evident among the regions. In the Long Island and the Hudson River regions, for example, the rates of completed suicide rose by 45.0% and 61.0%, respectively.

In 2012, the highest rates of completed suicides were seen in Long Island (6.95/10,000 consumers), Western New York (5.84/10,000 consumers) and the Central Region (5.68/10,000 consumers). In New York City, the rate of completed suicide decreased by 5.5% between 2009



OMH Regional Map

and 2012 and New York City had the lowest rate of completed suicide in 2012, with 2.20/10,000 consumers.

Four of the five OMH regions also mirrored the statewide trend in suicide attempts. The two highest rates of increase in suicide attempts were seen in New York City (40.7%) and the Hudson River regions (29.6%). In the Central Region the rate of suicide attempts declined by 15.2%.

In 2012, the highest rate of suicide attempt among mental health consumers was in the Western New York Region (46.84/10,000 consumers) while the lowest was observed in New York City (23.21/10,000 consumers).

*Table 2* displays the annual number and rates of completed suicide and suicide attempts for 2009–2012.

### **Gender**

From 2009 to 2012, men served by the public mental health system were at greater risk than women of completing a suicide attempt. During those years, the average annual rate of completed suicide for males (4.98/10,000 consumers) was more than twice that of females (2.16/10,000, consumers). However, conversely, over the same time period, female consumers were at greater risk of suicide attempt.

*Figure 1* shows that, between 2009 and 2012, females attempted suicide at an average annual rate of 32.89/10,000 consumers compared to males who attempted suicide at a rate of 25.5/10,000 consumers.

### **Age**

*Figure 2* displays average annual rates of completed suicide and suicide attempts among consumers of public mental services by age category. From 2009 until 2012, consumers between ages 30–44 years had the highest rate of completed suicides (4.64/10,000 consumers) when compared to consumers in other age categories. The next highest rates of completed suicide were found among consumers ages 45–59 (4.2/10,000 consumers), 15–29 (3.7/10,000 consumers) and 60–74 (3.6/10,000 consumers).

Consumers ages 15 to 29 were at highest risk of attempting suicide between 2009 and 2012, with a rate of 45.4 suicide attempts/10,000 consumers. Age groups with the next highest rate of suicide attempt were consumers between 30–44 years (37.6/10,000 consumers) and 45–59 years (26.8/ 10,000 consumers).

### **Race/ethnicity**

Between 2009 and 2012, among consumers for whom race/ethnicity was known, those who were White had the greatest risk of completed suicide with a rate of 5.1/10,000 consumers. The next highest rates were among Asian/Pacific Islanders (4.3/10,000 consumers) and Native American/ Alaskan (3.4/10,000 consumers), although the number of actual events for these groups was relatively small, 19 and 2 respectively.

Regarding suicide attempts, the highest rate was seen among consumers who were Native American/Alaskan (42.7/10,000 consumers), white (37.2/10,000 consumers) and Asian/Pacific Islanders (32.9/10,000 consumers).

*Figure 3* displays average annual rates of completed suicides and suicide attempts by race and ethnicity for 2009 through 2012.

### **Service type**

Table 3 displays trends in completed suicide and suicide attempts by inpatient, outpatient and residential program types between 2009 and 2012. In inpatient settings the rate of completed suicide dropped from 5.23 to 4.26/10,000 consumers, a decline of 18.6%. However, the rate of completed suicides among outpatients increased by 28.4 % from 2.61/10,000 consumers to 3.34/10,000 consumers. In residential settings, although the number of incidents were few, there was a greater than threefold increase in the rate of completed suicides from 1.67 to 7.27/10,000 consumers.

Between 2009 and 2012, rates of suicide attempts rose in all three service types. The largest increase was seen in residential programs where a 40.4 % increase was observed. The increase in inpatient and outpatient programs was 6.7% and 17.3%, respectively. In 2012, rates of suicide attempt per consumer in inpatient, outpatient and residential programs were 24.42, 29.32 and 66.63 per 10,000 consumers,, respectively.

An inpatient consumer of public mental health services is more likely to have a fatal suicide attempt when compared to consumers in outpatient and residential settings.

Figure 4 shows that, between 2009 and 2012, 17% of suicide attempts by inpatient consumers were fatal compared to 10% and 7% among consumers in outpatient and residential service settings.

A closer look at the pattern of completed suicides among consumers served by the public mental health system in inpatient settings shows that the risk of a completed suicide is substantially higher soon after discharge from the hospital than during hospitalization.

Figure 5 shows that, between 2009 and 2011 (these data were not available for 2012), the average rate of completed suicide while in the hospital was less than 1/10,000 inpatient consumers. The average rate, however, was twice as high for inpatient consumers within 72 hours of discharge and nearly four times as high for inpatient consumers between 72 hours and 30 days following discharge.

### **Qualitative review of root cause analyses**

Programs licensed and/or operated by OMH are required to perform a root cause analysis when an incident meets the Joint Commission (TJC) criteria for a Sentinel Event.<sup>14</sup>

A review of the incident reports and root cause analyses completed following suicide and attempted suicide events revealed a number of improvement opportunities that support the move toward a culture of suicide as a never event. These include:

- Systematic use of an evidence-based suicide assessment protocol such as the Columbia-Suicide Severity Rating Scale (C-SSRS) to identify suicidal ideation and risk
- Greater attention to discharge planning and facilitation of each client's engagement in post-hospital care and in community living by focusing on reducing the number of suicides occurring within 72 hours of and then during the first few months following discharge
- Improved communication and collaborative care between inpatient and outpatient settings for individuals at risk for suicidal behavior
- Fidelity to policies and practices aimed at reducing suicides and suicide attempts (e.g., strengthening staff communications during transitions in care)



- Clear protocols for identifying and intervening to reduce environmental hazards associated with suicidal behavior (e.g., loopable hazards in bathrooms)

## **We Can Do Better**

OMH believes that the mental health system—especially the clinicians who work in it—are already committed to and helping to keep people alive. In fact, considering the lethality associated with serious and acute mental illness, we could expect to see higher death rates. We believe that lives are already being saved by keeping people engaged in care and by helping them to manage their risks through supportive relationships. But, we also believe that we can do better. Importantly, we think that better tools are available today than in the recent past—tools for assessing risk, for treating suicidality as well as mental illness, for keeping people safer in the high risk period after hospital or emergency department treatment, and for systematically improving the quality and safety of mental health care. While NYS has one of the lowest suicide rates in the nation, former OMH Commissioner Michael Hogan asserted, “No one brave enough to seek care for a mental disorder should die from suicide. Yet many do, joining a stunning number of Americans who lose their lives every year. We are determined to do better.”<sup>15</sup>

## **Using Data to Help Guide Transformation**

Recent suicide and suicide attempt data from the State-operated and licensed programs provide a lens through which the OMH community can better understand trends and develop priorities for comprehensive planning to do even better at saving lives. The data serve as a starting point for a careful examination of facets of quality care for the various populations served in the public mental health system.

Although no definitive conclusions can be drawn, it is possible the variations in sentinel event numbers mirror the direction of the agency’s leadership at various points over the past decade. In June of 2009, the OMH Bureau of Quality Improvement released a report that highlighted the sentinel event suicides from 2002–2008.<sup>16</sup> With that came a targeted education campaign directed at improving safety on inpatient hospital units by identifying and correcting environmental safety hazards and follow-up by OMH certification staff on regular licensing visits.

Furthermore, data from OMH confirm scientific findings, which we used for planning, implementation and evaluation. For example, the finding that the rate of suicide for people discharged within 72 hours and between 3 days and 30 days of discharge is much greater than prior to discharge within NYS is consistent with the literature, indicating that the rate of suicide is highest in the first few days after discharge from hospital, when people leave structured, staffed environments.<sup>17</sup>

In many cases, the mental status of people near discharge or recently discharged is improved, which can reduce risk. On the other hand, explicit efforts to directly reduce suicidality remain rare,<sup>18</sup> so people may be discharged in a healthier but still vulnerable state. Just as critically, follow-up (especially for people at the highest risk) is not uniformly achieved in a timely manner. Linking risk assessments to immediacy of follow-up contacts, including contact with crisis line staff, can help us keep people safer after discharge.

## Relying upon Scientific Evidence to Drive Improvements in Care

### Chain of Survival

The 2011 report by Knesper and colleagues focuses on continuity of care and suicide prevention. It stresses the potential for saving many lives by targeting high-risk individuals who attempt suicide and helping them receive evidence-based treatments. To be beneficial, however, any strategy crucially depends upon assuring that patients discharged from emergency departments and psychiatry inpatient units obtain the follow-up recommended to and developed with them.

The nucleus of this strategy is clinically attuned, continuity of care that links people in need of care with their care providers, in a timely manner. What is needed is to provide all the necessary clinical information to make the transition *safe, smooth and uninterrupted*. This sequence can be seen as a “chain of survival,” and offers a foundation for a transformed system that provides quality mental health care in America.<sup>19</sup>

More research continues to emerge about the most effective approaches for preventing, assessing, treating, and evaluating care for people with suicidal ideation and behaviors. In addition to the four programs studied by the Alliance Task Force, the scientific literature provides a great deal more evidence to inform our care. Programs listed on the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-based Programs and Practices point to the continuing growth of knowledge in the field of suicide prevention and intervention.<sup>20</sup> Additionally, other recent knowledge pertinent to evidence-based care includes:

#### ***Inpatient psychiatric treatment***

Inpatient psychiatric treatment is the current standard of care for people with suicidal ideation and intent. However, reviews of its efficacy are mixed—particularly because inpatient care has generally been oriented toward insuring immediate safety rather than providing direct interventions for the suicidality that may have precipitated hospitalization. As a result, this leaves a person at risk upon discharge.

Our perspective is that inpatient care is a needed, safe and effective intervention for many people with acute states of mental illness.<sup>21</sup> If suicidality is a precipitating reason for hospitalization, we need to address it during the episode of hospitalization, taking all needed steps to keep people safe, while addressing their risks upon discharge.

#### ***Columbia -Suicide Severity Rating Scale (C-SSRS)***

In November 2011, a landmark study was released by Posner and colleagues at Columbia University and the NYS Psychiatric Institute, that found the C-SSRS valuable in assessing suicidal behavior and in predicting attempts. The scale can, with high sensitivity, identify people thought to be at risk who actually are not at imminent risk, as well as be effective in identifying patients who could benefit from treatments for their suicidal intent.<sup>22</sup>

#### ***Safety planning***

One of the most comprehensive discharge planning guidance documents for high-risk inpatients comes out of the US Department of Veterans Affairs. Originally developed for use with veterans but now available widely, Dr. Barbara Stanley and Dr. Gregory Brown have developed a *Safety Plan Treatment Manual to Reduce Suicide Risk*.<sup>23</sup> The intervention provides a clear,

straightforward approach that is superior to the widespread use of (ineffective) “no harm/no-suicide contracts.”

### ***Cognitive behavioral therapy and dialectical behavioral therapy***

There are two studies that demonstrate the efficacy of cognitive behavioral therapy (CBT) in reducing suicide attempts. There are also another 11 randomized controlled trials that support the view that dialectical behavioral therapy reduces suicidal behavior and time spent in the hospital for patients with histories of chronic suicidal behaviors.<sup>24</sup>

### ***Intensive follow-up and case management***

A randomized clinical trial using a “caring letter,” which is an intervention with patients who are suicidal and reject further treatment on discharge, demonstrates promise for the individuals receiving it. Essentially, the subjects in this experimental group received a simple letter every four months over a five-year period, expressing concern and support, contrasting with the control group that received no letter. The results show that those people who received the letter have significantly fewer deaths by suicide in comparison to the individuals in the control group. Other types of follow-up case management and supportive non-demand outreach have demonstrated similar reductions in suicidal behavior.<sup>25</sup>

### ***Collaborative assessment and management of suicidality***

This novel collaborative clinician–client approach emphasizes assessment, crisis response planning, and problem-focused interventions designed to identify and treat the causes of suicidal risk. While several studies are under way, there is recent evidence from a randomized clinical trial that this approach is effective in treating suicidal ideation, overall symptom distress, and hopelessness as well as in enhancing reasons for living at 12-month follow-up, in comparison to enhanced usual care.<sup>26</sup>

## **Creating a Culture of Safety**

The data on completed suicides and suicide attempts, as well as qualitative data from root cause analyses and incident reports in the State public mental health system, are cause for us to seek significant improvements in care for individuals at high risk for suicide and suicidal behaviors. In setting priorities for this change, OMH is guided by the *National Strategy* and by the work of the Clinical Care Task Force. Much has been learned about suicide prevention in the last decade. We have better approaches for risk assessment, better interventions for people at the highest risk, and improved knowledge about caring for people in transition.

The most powerful finding from the Alliance Clinical Care Task Force, however, is the realization that improvements in clinical practice, alone, are *insufficient*. Care systems that approach suicide reduction systematically on behalf of all the people under care can achieve better results. Indeed, research in the United Kingdom reinforces this view: it showed empirically that health districts implementing mental health improvements more comprehensively had significantly reduced suicide rates compared with those only having achieved partial implementation.<sup>27</sup> Further, in reviewing these systematic efforts, we find that leadership and culture change are the initial and ongoing essential ingredients required.

The time is right to do even better, and, as such, OMH has embarked on a multi-faceted approach, following the guidelines set forth in the *Suicide Care in Systems Framework* report of the National Action Alliance Clinical Care and Intervention Task Force as well as goals and

actions outlined in the revised *National Strategy for Suicide Prevention*. OMH will work toward suicide as a never event for people in our care. We will also leverage OMH's safety and performance improvement culture toward this end; orient and train the workforce in proven suicide intervention and care methods; and ensure adoption of evidence-based suicide prevention practices across the system of mental health and health care.<sup>28</sup> As we do this, we must also work to create a just culture that recognizes the complexity of suicide and self-harm and that supports survivors of suicide, families, and caregivers.

Below is Part 1 of a plan to change the culture within OMH. The information is meant to stimulate dialogue and to represent our commitment to excellence in suicide care at all levels of leadership and throughout the OMH workforce, within the hospitals and outpatient programs we operate, as well as in those we license. We urge you to consider the outline and recommendations contained below, and to take needed actions.

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## **GETTING TO ZERO: PART 1**

### **Leadership and Culture Change**

#### ***Articulating the vision***

As evidenced by the successful initiatives of the Air Force, Henry Ford Health Service, Lifeline and Central Arizona, leadership is essential for cultural transformation and change. Leadership must start by confronting pessimism regarding the possibility of dramatically reducing or eliminating suicide. This pessimism may have grown from the experience of losing people we cared for, and doubts as to whether we “could have done more.” It may be reinforced by the fact that much of what we now know was not available 10 years ago, and that limited knowledge likely affected existing culture and attitudes (e.g., we now know that no-harm contracts are ineffectual, that collaboratively developed safety plans are superior, that new treatments show the promise of directly treating suicidality).

As our root cause analyses have demonstrated over the years, the belief that suicide can't be either predicted or prevented is pervasive. On the other hand, the successful projects mentioned above underscore that when leadership mobilizes staff to see and believe that suicide can be prevented *and provides tangible supports in a safe and blame-free environment*, dramatic reductions in suicide deaths can be achieved. A major challenge for organizations to effectively eliminate suicide requires them to assess workforce knowledge and beliefs, provide training and supports, move toward collaborative commitments to reduce or even eliminate suicide for people under care, and systemically manage service delivery around that core belief.<sup>29</sup>

#### ***Identifying leaders and implementing learning collaboratives***

Throughout the years, several individuals and organizations have stepped forward to successfully reduce the number of suicides in their organizations. These individuals will form the core group of a facilitated learning collaborative, under the direction of OMH Medical Director Lloyd Sederer, MD, and Statewide Suicide Prevention Director Melanie Puerto Conte to achieve culture change in provider organizations throughout the State. Organization leaders who have had success in reducing the number of deaths by suicide

will work with leaders in other organizations still striving to bring about this change for people they serve. A recent example of strong leadership is the community-based Federation Employment and Guidance Services (FEGS) health and human services agency in New York City, which launched a comprehensive suicide prevention effort agency-wide in August 2012.<sup>30</sup> Another example is described below under “Collaborating with behavioral health organizations.”

### **Achieving Systemic Change**

While targeting individual organizations to achieve culture change through collaboration, OMH will simultaneously work to achieve a transformation to save lives throughout the public mental health system.

#### ***Raising the bar for suicide care for providers licensed by OMH***

As an agency that licenses more than 1,600 inpatient and outpatient mental health providers, OMH has a significant opportunity to interact with a large and diverse population of mental health providers. To address its commitment to get to zero suicides, OMH has developed a suicide care standard as a component of licensing. This protocol promotes use of evidence-based practices for screening, assessment and treatment for suicidality, and a collaborative review of clinician competencies to assess the training and supports needed for effective suicide care.

Licensing visits and training sessions provide OMH with opportunities to help link clinicians to appropriate ongoing educational opportunities regarding current evidence-based practices for suicide care. Additionally, closed case reviews during licensing visits now include a tracer for completed suicide, while open case reviews will include a tracer for suicide attempts. Basically, during this process, the OMH compliance analyst will review each case with program staff to identify opportunities for improved care and treatment. The licensing protocol is attached as Appendix 1.

#### ***Collaborating with behavioral health organizations***

Starting in January 2013, OMH began work with the Office of Alcoholism and Substance Abuse Services (OASAS), and Magellan, a managed behavioral health organization with experience and expertise managing behavioral health services for individuals with substance use and mental illnesses. In two counties—Broome and St. Lawrence— regional approaches to reducing suicides and attempts for people receiving community care in Central New York are being developed. The effort is titled “Zero Suicide Care System Transformation Project” and covers all mental health inpatient and outpatient as well as substance abuse providers in the two counties.

Drawing on its experience with suicide care in its Central Arizona Programmatic Suicide Deterrent System Project,<sup>31</sup> Magellan is assisting providers licensed by both OMH and OASAS in these two counties to achieve systemic change in to reduce suicide rates. The project stresses the importance of transitions (e.g., inpatient and crisis to out-patient and aftercare), measuring success by reductions in suicide attempts and deaths, recognizing efforts made and outcomes achieved.

#### ***Improving suicide care in State-operated psychiatric centers***

OMH currently operates 24 inpatient hospitals and over 80 clinics affiliated with these hospitals. The programs serve approximately 3,000 inpatients and 19,700 outpatients.

Working with volunteer programs in the OMH system (Greater Binghamton Health Center, South Beach, Buffalo and St. Lawrence psychiatric centers), OMH is implementing a suicide prevention project that will work toward reducing and eliminating suicide for people in our care.

Leadership is guiding a culture change, including revised policies and procedures to reflect evidence-based treatment and responses for persons presenting with suicide risk. Moreover, the project is raising the bar on the quality of clinical care by increasing the core competencies of OMH staff. Extensive training is being provided staff in the C-SSRS as well as the importance of “warm hand-off” approaches during high risk periods for suicide, especially the first three days and the first 30 days post discharge.

A very important ingredient has been the use of “bridger” staff. These peer specialists meet either face to face or by phone with individuals prior to discharge from inpatient units. They also accompany people for their first outpatient treatment appointment, ensure that additional appointments are made and educate about support services. Called the “Hope Initiative,” this effort helps with making connections to a supportive community and an include introduction to self -help and spiritual groups, as well as other local organizations and community activities with the goal to reduce the isolation associated with greater suicide risk.

### ***NYS Suicide Prevention Initiative***

OMH has been committed to the goal of suicide prevention for the past decade and annually funds the Suicide Prevention Center. The Center aims to advance and support State and local actions to reduce suicide attempts and suicides in NYS and to promote the recovery of persons affected by suicide. Center staff members provide information and training on the current evidence-based practices on suicide care, offer Applied Suicide Intervention Skills Training (ASIST), support community coalitions, help schools to design suicide intervention plans, and provide access to resource materials.

OMH also received a SAMSHA-funded Garrett Lee Smith Youth Suicide Prevention Grant in 2011 to build youth suicide prevention capacity through regional training centers at four major child serving agencies throughout the State (Hillside Family Centers, Parsons Child and Family Center, NY Foundling, Communilife Latina/Latino Adolescent Youth Services Program). These organizations will become youth suicide prevention training centers, beginning with their own programs and settings and expanding to sister providers within each catchment area. The project is further extending the knowledge of evidence- based practices in suicide care, improving suicide risk assessment, raising core competencies of staff and providing resiliency training in 18 counties and their systems across NYS to build competent and caring suicide prevention systems within these counties.

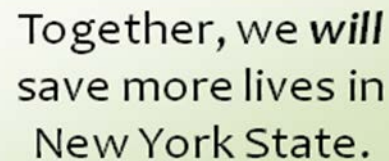
### **Raising the Standard of Clinical Practice for Suicide Care**

Embedding education about evidence-based practices into each of the systemic approaches outlined above and monitoring through the licensing process to determine if the practices have taken hold are expected to significantly advance the shared sense of responsibility throughout NYS for reducing suicides. Other plans to raise the standard of clinical practice for suicide care include the following:

### ***Strengthening core competencies to save lives***

Through the NYS OMH Suicide Prevention Initiative and affiliations with suicide prevention coalitions throughout the State, OMH has provided training in evidence-based practices on suicide prevention. In spite of these efforts, OMH continues to see evidence for the need for systemic change. Opportunities for improvement, as noted previously, continue to present themselves, from regular screening for suicide risk to improving the hand-offs in care between discharge and return to the community and home.

Recognizing the need for continued growth, OMH is collaborating with the Center for Practice Innovations (CPI) at Columbia Psychiatry/NYS Psychiatric Institute to develop online distance learning modules for screening and suicide risk assessment, including using the C-SSRS; intervening to increase safety; and embedding effective transitions between levels of care. The first two modules have been completed. The third is in process. All three will be available free and nationally through the OMH Suicide Prevention Initiative.



Together, we *will*  
save more lives in  
New York State.

### ***Standards of suicide care***

Like the standards of clinical care developed in 2008 for clinic providers, also under the direction of Dr. Sederer, OMH is developing guidance for what can be exemplary suicide care to guide providers in treating people at risk. We will recommend in these standards attention to screening and risk assessment processes, care pathways based on risk levels, evidence-based treatments, and intensive follow-up for people at elevated risk for suicides upon discharge from acute care and emergency settings. These standards will be distributed in late 2013.

### ***A focus on self-harm and suicide attempts***

The scientific literature is replete with studies that demonstrate the connection between deliberate self-harm (which may or may not involve suicidal intent) and greater risk for suicide. A single visit to the emergency department for deliberate self-harm is associated with a six-fold increase in the risk of suicide. The period immediately after an episode of deliberate self-harm poses the greatest risk of completed suicide or a repeated episode of deliberate self-harm.<sup>32</sup>

Given this link between prior attempts and later suicide, OMH is committed to increasing its clinical monitoring activities. Currently, OMH requires providers to complete root cause analyses of suicides, in keeping with the sentinel event definition of the Joint Commission. OMH will further work with organizations that have embraced suicide as a never event to complete root cause analyses of suicides that have been completed within 30 days of discharge (thereby exceeding the 72 hour standard) and for suicide attempt incidents submitted in OMH's incident management system.

These collaborative reviews will be crucial in identifying trends, patterns and possible areas for technical assistance, to assist in pursuing the goal of suicide as a never event.

## **Holding Ourselves Accountable**

### ***Tracking and reporting data on suicides and suicide rates annually***

This report is the second effort in 10 years to present information on suicides and of the attempts in the public mental health system to promote improved care. This report, however, goes beyond the past efforts and seeks to establish a transformed system of care in which we make suicide as a never event goal in the public mental health system, as well as in the broader mental health system in NYS.

To monitor progress toward systematic change and excellence in the care of persons with suicidal behaviors, OMH will monitor and track clinical service performance on a regular basis to ensure that the efforts under way are having their intended impact. Toward this end, OMH will make data on these efforts available on the Suicide Prevention and Quality Management pages of the OMH web site. We will work closely with and collaborate with shareholders in the State's system of care to achieve reductions in suicide and suicide attempts—in our collective move toward suicide as a never event.

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*For more information or to offer comments,  
please contact [Marcia Fazio, Deputy Commissioner](#)*



# Tables and Figures

**Table 1**  
**Completed Suicides and Suicide Attempts**  
**among Consumers of Public Mental Health Services\***  
**2009-2012**

	Number of Completed Suicides	Completed Suicides (per 10,000 Service Consumers*)	Number of Suicide Attempts	Suicide Attempts (per 10,000 Service Consumers*)
2009	180	3.20	1548	27.52
2010	183	3.25	1615	28.71
2011	191	3.28	1644	28.22
2012	226	3.88	1870	32.10

\* "Consumers of public mental health services" refers to consumers in inpatient, outpatient and licensed residential programs

Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

**Table 2**  
**Number and Rates\* of Completed Suicides and Suicide Attempts**  
**among Consumers of Public Mental Health Services\*\* by Region – 2009–2012**

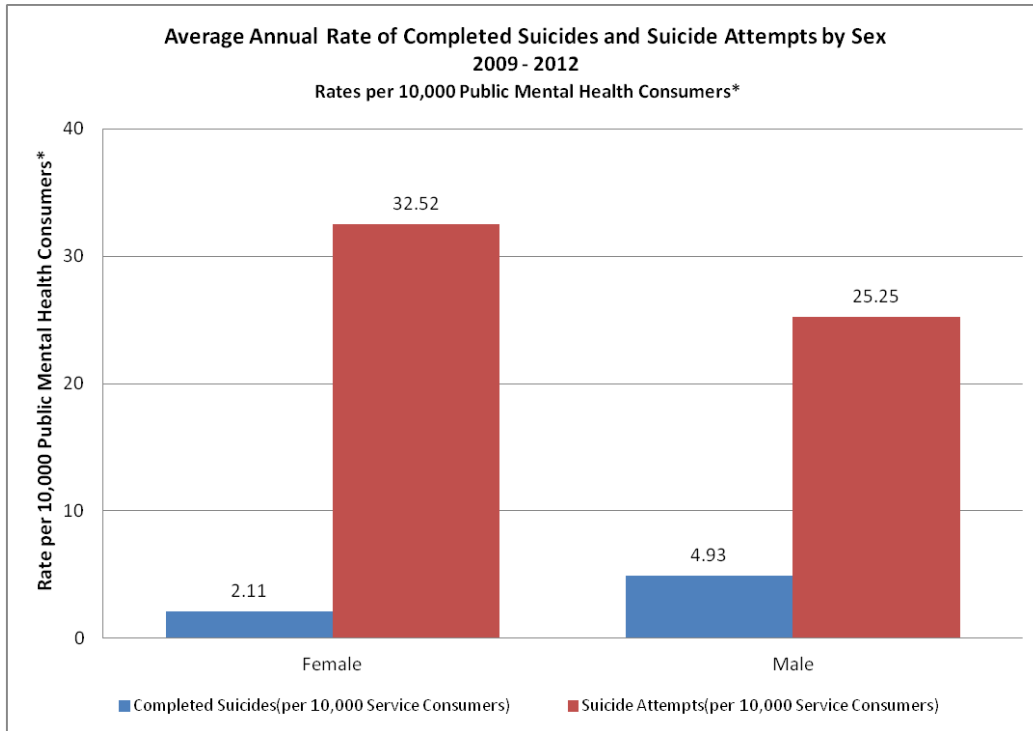
<b>Completed Suicides by Region</b>												
	Central New York		Hudson River		Long Island		New York City		Western New York		All Regions	
	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>
2009	28	4.82	22	2.27	24	4.79	62	2.32	44	4.50	180	3.20
2010	25	4.30	33	3.41	19	3.80	52	1.95	54	5.52	183	3.25
2011	34	5.22	34	3.46	15	3.07	53	1.94	55	5.45	191	3.28
2012	37	5.68	36	3.66	34	6.95	60	2.20	59	5.84	226	3.88
<b>% Change between 2009 and 2012</b>												
		17.9%		61.0%		45.0%		-5.5%		29.9%		21.2%
<b>Suicide Attempts by Region</b>												
	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>
2009	243	41.83	284	29.34	160	31.96	440	16.49	421	43.04	1548	27.52
2010	242	41.66	346	35.74	154	30.77	459	17.21	414	42.32	1615	28.71
2011	211	32.40	309	31.40	195	39.87	487	17.83	442	43.76	1644	28.22
2012	231	35.47	374	38.01	168	34.35	634	23.21	463	45.84	1870	32.10
<b>% Change between 2009 and 2012</b>												
		15.2%		29.6%		7.5%		40.7%		6.5%		16.6%

\* Rate per 10,000 service consumers

\*\* "Consumers of public mental health services" refers to consumers in inpatient, outpatient and licensed residential programs

Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

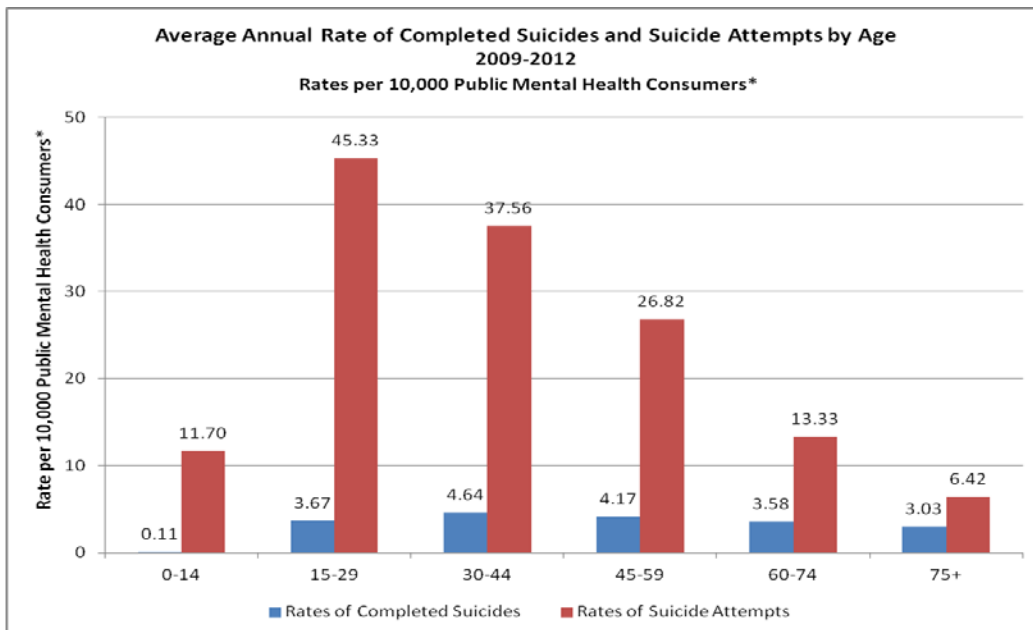
**Figure 1**



\*"Public mental health consumers" refers to consumers in inpatient, outpatient and licensed residential programs.

Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

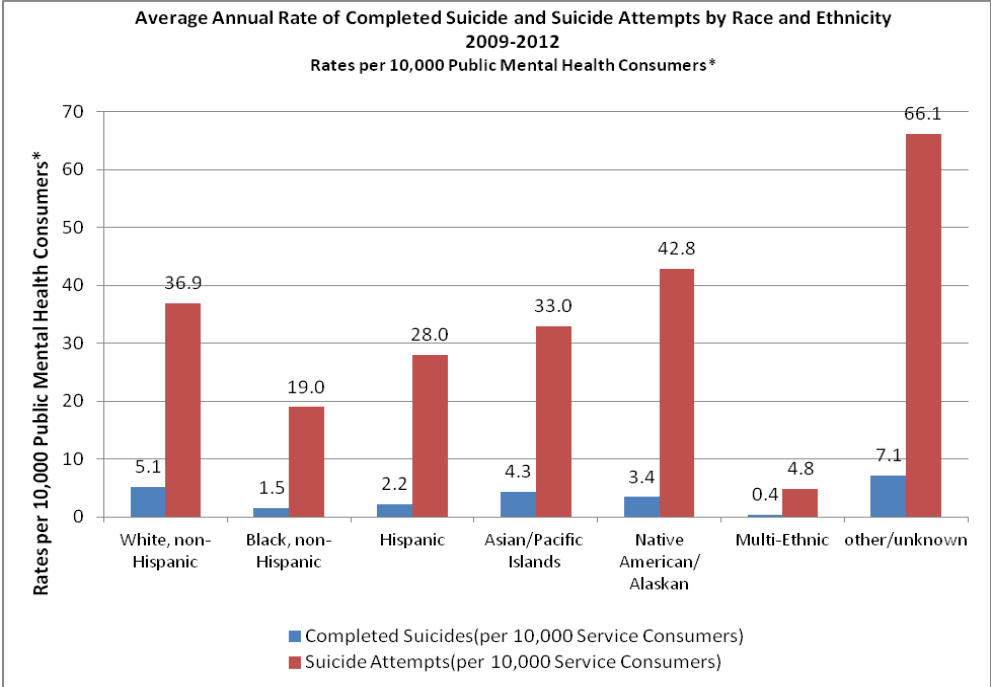
**Figure 2**



\*\*"Public mental health consumers" refers to consumers in inpatient, outpatient and licensed residential programs.

Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

**Figure 3**



\*\*"Public mental health consumers" refers to consumers in inpatient, outpatient and licensed residential programs.

Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

**Table 3**  
**Number and Rates\*of Completed Suicides and Suicide Attempts among Consumers of Public Mental Health Services\*\***  
**by Service Type**  
**2009–2012**

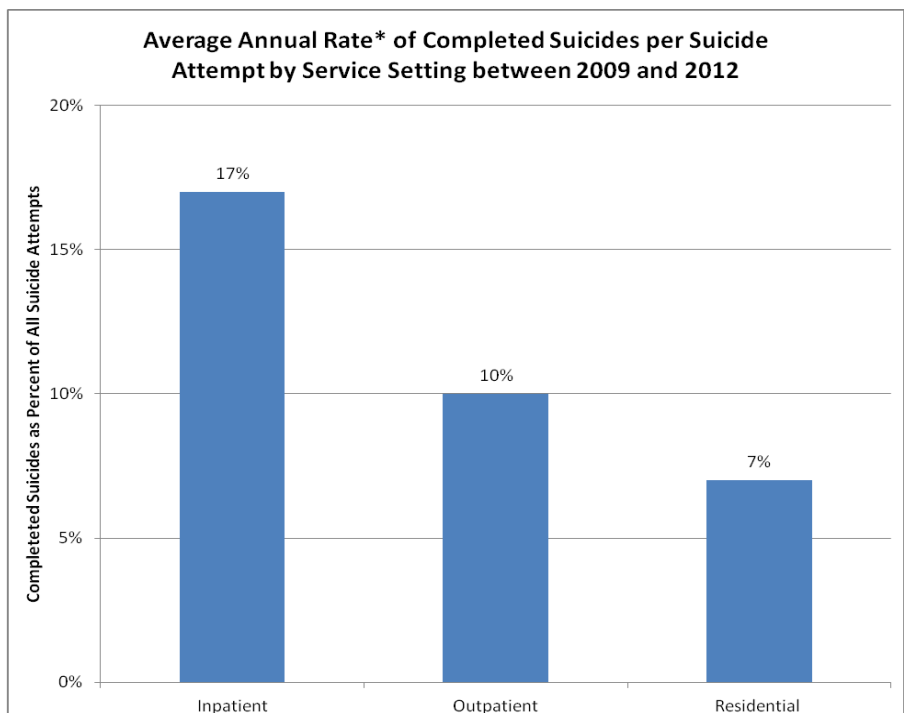
<b>Completed Suicides By Service</b>						
	Inpatient		Outpatient		Residential	
	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>
2009	45	5.23	132	2.61	3	1.67
2010	36	4.19	139	2.74	8	4.47
2011	43	4.82	144	2.74	4	2.42
2012	38	4.26	176	3.34	12	7.27
<b>% Change between 2009 and 2012</b>						
		-18.6%		28.4%		334.0%
<b>Suicide Attempts by Service</b>						
	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>	<i>Number</i>	<i>Rate</i>
2009	197	22.90	1266	24.99	85	47.46
2010	200	23.25	1324	26.14	91	50.81
2011	200	22.41	1339	25.45	105	63.60
2012	218	24.42	1542	29.31	110	66.63
<b>% Change between 2009 and 2012</b>						
		6.7%		17.3%		40.4%

\* Rate per 10,000 service consumers

\*\* Consumers of public mental health services refers to consumers in inpatient, outpatient and licensed residential programs

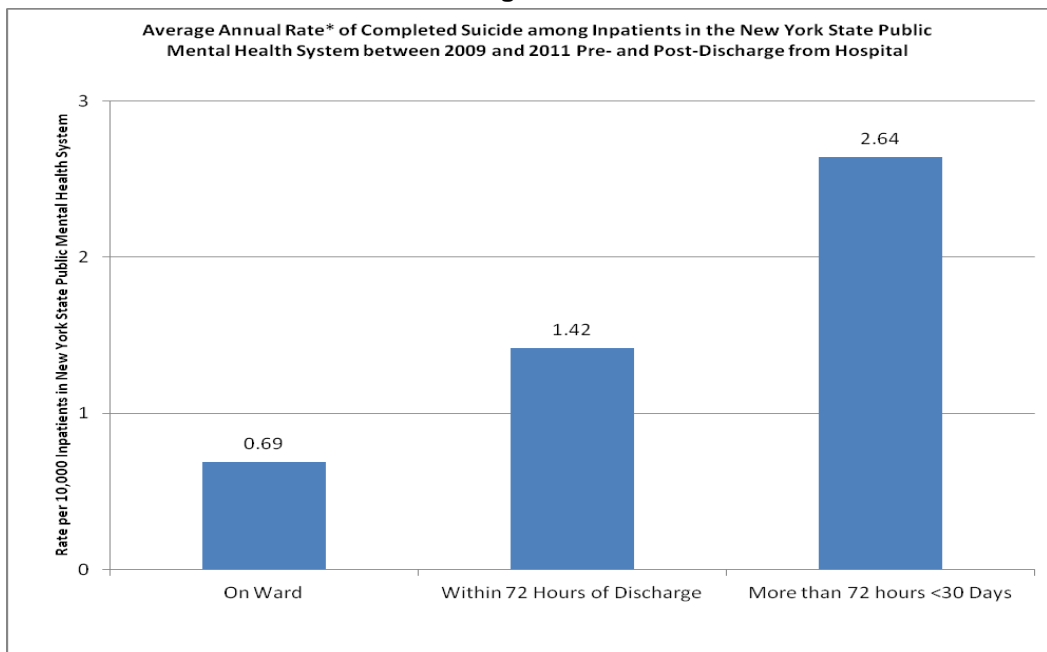
Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

**Figure 4**



\*Rate is calculated as the number of completed suicides each year between 2009 and 2012 divided by the number of suicide attempts each year between 2009 and 2012. Data Source: OMH NYS Incident Management and Reporting System.

**Figure 5**



\* Rate per 10,000 inpatient service consumers  
Data Source: OMH NYS Incident Management and Reporting System and 2009 and 2011 OMH Patient Characteristics Surveys

## Appendix 1

### New York State Office of Mental Health

# Licensing Protocol – Suicide Prevention

## Intent

The New York State (NYS) Office of Mental Health (OMH) Division of Quality Management (DQM) promotes screening and assessment for suicidality—including level of suicidality—as a component of every encounter between a clinician and an individual. Because mental health clinicians are recognized as gatekeepers, all clinicians should be educated in the management and use of evidenced- based practices to prevent suicides.

## Standards

The following standards pertain to all programs, as applicable:

1. Evidence that the program has identified and implemented the use of evidenced-based screening and assessment tool(s) into practice, i.e., Columbia-Suicide Severity Rating Scale (C-SSRS) or Dr. Shawn Christopher Shea’s Chronological Assessment of Suicide Events (CASE) approach to determine risk of suicide
2. Evidence of documentation that the staff members are trained and competent in the use of the selected evidenced-based risk assessment tool(s), including linguistically and culturally appropriate uses
3. Evidence that the screening and assessment tools are used and kept updated
4. Evidence that **all** staff have the opportunity for training in the management of suicide prevention, i.e., *Applied Suicide Intervention Skills Training (ASIST)*, the Safe Tell, Ask, Listen and Keep Safe (SafeTALK) program and the Focus on Integrated Treatment (FIT) modules on suicide prevention
5. Evidence that the program identifies and addresses the impact of co-occurring substance use on suicide risk
6. Evidence that clinicians have enhanced skills in Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT) and use these modalities to treat individuals with elevated risk and past suicide events
7. Evidence upon admission, during the course of treatment, and as part of discharge planning that a Safety Plan is completed with each individual and addresses means restriction and coping strategies
8. Evidence of effective transitions between levels of care, i.e., the use of a “Warm hand off.” Discharge is based upon a continuous communication, team-based, shared responsibility approach for the individual’s safety. This can include direct clinician-to-clinician contact, provider check-in phone calls to bridge the gap between discharge and follow up appointments, and a documented offer to establish Mobile Crisis Care follow up in those communities in which this service is available
9. Evidence that at discharge, each person is provided with local crisis phone numbers and contact information for the National Suicide Prevention Lifeline (See <http://www.omh.ny.gov/omhweb/speak/speakcrisisnumbers.htm>.)

## Intra-Divisional Efforts






During licensing recertification for all program types, the DQM Suicide Prevention Resource List is made available to the program at the time of the visit, along with reference to the DQM web pages.

1. During Tracer Visits, OMH Field Office staff work in consultation with the Bureau of Quality Improvement Clinical Risk Managers and use NYS Incident Management and Reporting System (NIMRS) summary reports to identify clients for trace.
  - a) Every attempt will be made to identify an active client with a suicide attempt.
  - b) Every attempt will be made to identify a client who has attempted suicide or a closed record of a client who completed suicide.

# Endnotes

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- <sup>3</sup> Office of the Surgeon General. (2012, September). 2012 National strategy for suicide prevention: Goals and objectives for action, *A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention*. Available online at <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>
- <sup>4</sup> National Action Alliance for Suicide Prevention Executive Committee, *Suicide care in a systems framework* (page 1).
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- <sup>10</sup> Bauer, Michael, NYS Department of Health Injury Prevention Program (personal communication, January 2012)
- <sup>11</sup> New York State Office of Mental Health. (2013). *Patient Characteristics Survey (PCS) portal*. Albany, NY: Author. Available online at <http://bi.omh.ny.gov/pcs/index>
- <sup>12</sup> New York State. (2012, June). Official compilation of codes, rules and regulations of the state of New York, Title 14. Department of Mental Hygiene, Chapter XIII. Office of Mental Health, Part 524. Incident management. Available online at [http://www.omh.ny.gov/omhweb/policy\\_and\\_regulations/emergency/Part\\_501\\_524\\_550\\_20130628.pdf](http://www.omh.ny.gov/omhweb/policy_and_regulations/emergency/Part_501_524_550_20130628.pdf)
- <sup>13</sup> “Consumers” refers to individuals served in inpatient, outpatient and licensed residential programs.
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- <sup>24</sup> Knesper D J, American Association of Suicidology and Suicide Prevention Resource Center. *Continuity of care for suicide prevention and research*.
- <sup>25</sup> Knesper D J, American Association of Suicidology and Suicide Prevention Resource Center. *Continuity of care for suicide prevention and research*.
- <sup>26</sup> Knesper D J, American Association of Suicidology and Suicide Prevention Resource Center. *Continuity of care for suicide prevention and research*.
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- <sup>28</sup> Covington D & Hogan M. (2012). Not another life to lose: The bridge to zero. *National Council Magazine*, 2, 8–10. Available online at <http://old.thenationalcouncil.org/galleries/NCMagazine-gallery/NC%20Mag%20Web%20Revised.pdf> 
- <sup>29</sup> National Action Alliance for Suicide Prevention Executive Committee, *Suicide care in a systems framework*.
- <sup>30</sup> New York Nonprofit Press. *FEGS launches suicide prevention initiative*.
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