Tackling Adolescent Suicide with Zero Suicide

Nicole E. Gonzales

Follow this and additional works at: https://digitalrepository.unm.edu/hsc_advpracticenursing

Recommended Citation
https://digitalrepository.unm.edu/hsc_advpracticenursing/12

This Student Paper is brought to you for free and open access by the Health Sciences Center Student Scholarship at UNM Digital Repository. It has been accepted for inclusion in Theoretical Foundation in Advanced Practice Nursing by an authorized administrator of UNM Digital Repository. For more information, please contact amywinter@unm.edu, lsloane@salud.unm.edu, sarahrk@unm.edu.
Theory Application Paper: Tackling Adolescent Suicide with Zero Suicide

Nicole Eloyda Gonzales, BSN, RN-BC
Department of Nursing, University of New Mexico

NURS 501: Theoretical Foundations of Advanced Nursing

Heidi Honegger Rogers, DNP, FNP-C, APHN-BC

Melody Avila, DNP, RN, FNP-C
Critical Issue: Adolescent suicide

Working in an inpatient child and adolescent psychiatric hospital our number one worst outcome is patient suicide. The CDC reports that suicide is the “second leading cause of death for persons aged 10-19” (Curtin, 2019) Sentinel event prevention has made suicide very rare in the inpatient setting. Units are designed to prevent inpatient suicide, so as healthcare workers we can feel that our patients will be safe during their hospitalization. We know that once a patient is admitted into an acute care setting their risk of suicide after discharge is now much higher than the general populations risk (Qin & Nordentoft, 2005).

Preventing suicide in adolescents is something that should be started upon admission to a psychiatric hospital with the goal of recovery. Suicide prevention is a 2020 National Patient Safety Goal for behavioral health care by The Joint Commission (Joint Commission, n.d.). Planning with patient’s families on how they will make sure their home is safe is key to prevention. Suicide can be a very difficult topic for parents and is still taboo in many cultures. Many parents struggle with believing that their child is actually at risk for suicide and is not just making empty statements. The inpatient treatment team should be confronting the topic straight forward from admission, and provide follow-up care focused on prevention.

I’ve personally noticed that suicidal ideations are glossed over as simply another presentation. It doesn’t seem to be given the caution that it deserves. Because suicidal ideations are a common presentation in the inpatient population it becomes very common place; almost accepted. When patients come in with homicidal ideation this symptom is given much more respect and worry. I would argue that mental-health professionals need to respond equally to suicidal ideation as they do to homicidal ideations. We must give suicidal ideation the seriousness it deserves.

There seems to be an issue with attention seeking behaviors in many mental-health provider’s mindsets. We see these behaviors all the time, and deal with many adolescents who are not suicidal but cause self-harm. There is much complexity in self-harm and suicidal ideation and it is very easy to get muddled in the actual risks. Because of the complexity of unknowns into what
a patient may truly be seeking from their behaviors- I believe many mental-health providers do not want to address either of these issues. We need to provide more education to health care workers to understand both of these issues.

**Conceptual Framework Zero Suicide**

I found that Zero Suicide has had the most recent success in lowering suicide rates. The Zero Suicide model is a firm approach to tackling the issue of suicide with the literal intent to reach a zero-suicide rate. Zero suicide is a framework built around the unique structure of the healthcare system. So, upon a self-study of the organization they will collaborate to tackle what changes are needed to focus on to enact the Zero Suicide model. Because this framework is designed to be adjusted to various behavioral health settings I believe it would work well in any healthcare setting.

In 2001 the Henry Ford Behavioral Health Services (BHS) conceptualized the goal of Zero Suicide. They were literally able to achieve this for 18 months in 2009-2010, and since its start have seen a consistent 80% reduction in suicide (Henry Ford Behavioral Health, n.d.). The Henry Ford BHS results inspired a nationwide goal of zero suicide. The “National Action Alliance for Suicide Prevention, and a project of Education Development Center’s Suicide Prevention Resource Center (SPRC), supported by the Substance Abuse and Mental Health Services Administration (SAMHSA)” focused on Zero Suicide and created the website [https://zerosuicide.edc.org/](https://zerosuicide.edc.org/) to guide organizations on how to implement Zero Suicide (Zero Suicide - In Health and Behavioral Healthcare, n.d.).

What appears to truly have had an impact is that there is the goal of perfection- zero. So, when you have all of an organization’s healthcare workers striving to obtain zero they really develop the best strategies for prevention. This is a clear focus on the concept of mental health recovery- finding how we can assist in the recovery of suicidal patients. This model also has used the concept of literary synthesis by using guidelines we know work from evidence-based research, such as safety plans (Zero Suicide - In Health and Behavioral Healthcare, n.d.).
Zero Suicide breaks down the steps into 7 essential elements of suicidal care (see figure 1). Starting with 1. Lead, which is a system-wide culture change committing to reducing suicides (Zero Suicide - In Health and Behavioral Healthcare, n.d.). This was a big issue I noted with my topic- I feel as though suicidal ideation has not been taken seriously. I imagine this is an issue at most behavioral health hospitals; suicide becomes an everyday topic.

The second element is train- “train a competent, confident, and caring workforce.” (Zero Suicide - In Health and Behavioral Healthcare, n.d.) This is making sure all the healthcare workers who interact with these patients will possess the tools to prevent suicide and know the appropriate language to address patients in their current suicidal thought process. The third element is identify- “Identify individuals with suicide risk via comprehensive screening assessment” (Zero Suicide - In Health and Behavioral Healthcare, n.d.), and this is one that most behavioral hospitals are well equipped with addressing. Screening is a routine and mandatory process, that is addressed every shift in inpatient psychiatric hospitals. Nurses, therapists, psychiatrists, and
even mental health technicians all must ask patients if they are currently having any suicidal thoughts; and if so they will be further evaluated.

The fourth element is to engage- “engage all individuals at-risk of suicide using a suicide care management plan” (Zero Suicide - In Health and Behavioral Healthcare, n.d.). This step is another that I feel is really lacking in inpatient mental health. Engagement is really done only by the therapist who meets with the patient every 1-2 days. So, if a patient reports suicidal ideation at around 1600 it is sometimes not addressed until the next day that they will sit down with the therapist to update a safety plan. I feel that this is inadequate, and when you have many well qualified mental health technicians and nurses available 24/7 it is not something that should be left for the next day. Zero Suicide would be able to make sure all staff are equipped to engage with patients.

The 5th element is to treat- “treat suicidal thoughts and behaviors using evidence”-based treatments (Zero Suicide - In Health and Behavioral Healthcare, n.d.). This is something that I do not believe is practiced. Zero Suicide states “The research evidence strongly supports targeting and treating suicidal ideation and behaviors specifically and directly, independent of diagnosis, as well as any diagnosed mental health or substance abuse problem.” (Zero Suicide - In Health and Behavioral Healthcare, n.d.) Unfortunately, even some of the most therapeutic therapists struggle with discussing suicidality. Zero Suicide also encourages treating suicide in the least restrictive care. This is something that is so challenging in health care because of the liability. When family members, or guardians, express that they feel unsafe taking the patient home doctors will have to admit the patient. It is very challenging because research proves that admission to an inpatient psychiatric hospital increases the risk of suicide (Chung et al., 2017). So, there needs to be a systemwide change that addresses intense outpatient care for persons at risk of suicide.

“Transition individuals though care with warm hand-offs and supportive contacts” (Zero Suicide - In Health and Behavioral Healthcare, n.d.) is the 6th element. This is something that would be very beneficial for discharging patients. It’s also something that is more difficult when working with children because much of the discharge planning is done with the patient’s guardian.
However, having a person, like a liaison or a case manager to guide the family in the switch from inpatient to outpatient would be very beneficial.

The final element is “improve policies and procedures through continuous quality improvement” (Zero Suicide - In Health and Behavioral Healthcare, n.d.). This is necessary to continue to make Zero Suicide effective. Overall, Zero Suicide is a framework that must be adopted specifically for an organization and is not a one-size fits all approach. This approach makes it appropriate for many types of behavioral health settings.

**Application: Zero Suicide in the Least Restrictive Setting**

Suicide has shown to be best treated in an outpatient setting. The Zero Suicide model clearly describes the importance of treatment in the least restrictive setting (Zero Suicide - In Health and Behavioral Healthcare, n.d.). Like I have previously discussed, inpatient hospitalization may prevent suicide while the patient is in the hospital, however there are not suicide-specific techniques taught for once the patient is discharged. Furthermore, studies have shown that suicide risk is particularly high after discharge (Chung et al., 2017). So, I decided to focus my application on the pediatric outpatient behavioral health setting- a setting that I hope to work in as a Psychiatric Mental Health Nurse Practitioner.

In chapter 5 of *Theoretical Basis for Nursing* the authors discuss the various way to analyze and evaluate theories (McEwen & Wills, 2019). The Hardy theory of evaluation mentions logical adequacy which is a strength of Zero Suicide. Zero Suicide’s framework is simple and clear with simple guidelines. Testability is another standard of Hardy. Zero Suicide is difficult in this area without looking at the hard data of patient death from suicide. It is difficult to test Zero Suicide without fully implementing its framework into a setting. The Henry Ford (BHS) was able to see the quantitative data by their consistent 80% reduction in suicide (Zero Suicide - In Health and Behavioral Healthcare, n.d.).

The Zero Suicide model starts with Lead. In an outpatient behavioral health center this means a systemwide cultural shift will need to happen from the front desk staff and to all the clinicians
involved in patient care. Calls from distressed parents regarding high suicidal patients will need to be immediately forwarded to a clinician to provide safety planning. An on-call after hours clinician will be required for emergent safety planning. The goal will be to prevent the need for these patients to show up to the ER for treatment; and to prevent suicide. All members of the healthcare team will understand the goal of attaining zero suicide.

**Train** is the second element and will require Zero Suicide training of all members involved in patient care. Training nurses to call patients over the phone in between appointments would provide more frequent monitoring and support to families. Training will equip all team members with ability to deescalate a patient in the event of immediate harm to themselves. Training should also include caregivers of high-risk patients- as these will be the people who spend the most time with the patient and will likely be the first resource in preventing suicide.

The third element **screening** will take place at the minimum during every appointment, with high risk patients having more frequent appointments or phone call check ins. Nurses should also screen over the phone when checking in with patients. Screening will also include direct conversations about safety measures in the home. Because suicide requires a means to lethal objects home safety screens will be of utmost importance. One of the limitations of Zero Suicide is it does not specify a specific suicidal risk assessment tool. This would need to be further evaluated using evidence-based research to decide which assessment tool would be used.

The fourth element **engage** is engagement with suicide care management plans. The therapist will plan with the patient and the family on a suicide care management plan at every appointment and over the phone as needed. This form will be available electronically to all the staff to use should the patient or a family member call in distress. This will be useful for all team members to understand what resources and coping skills the patient may have available. This is something not specifically made clear by Zero Suicide, however facilitators of the framework may provide more answers on how to specifically engage when enrolled in the program of study.
The fifth element is *Treat*. Treat using evidence-based care so that patients or family members calling in distress, or reporting increased suicide risk will be immediately treated. The model calls for direct targeting of suicidal ideations. Knowing that inpatient hospitalizations will only temporarily protect the patient, yet the goal of preventing suicide is long-term. The clinicians will understand the importance of immediate intervention in high-risk situations instead of providing referral to psychiatric emergency services. This is why having an on-call therapist will be of great importance. Treat is one of the areas of Zero Suicide that is only as good as the amount of available therapist and practitioners available. So, although in a perfect world this would be possible—zero suicide does not and cannot address the shortage of mental health providers.

The 6th element *Transition* refers to the need for greater collaboration between healthcare workers. For these patients in the event of a change in provider the previous clinician and the new clinician should meet with the patient and the family to provide a warm hand-off. This also should apply in the event of a patient requiring hospitalization. Should hospitalization occur the clinician should attempt to visit the patient and family while inpatient, and reestablish care before discharge. This could also be done by a case worker who is familiar with the patient and family. Also, transition should include a collaborative effort with a local hospital to continue the goal of Zero Suicide for admitted patients.

The 7th element *improve* will be the continual evaluation of this plan, and modification. Because Zero Suicide is not a one-size fits all approach, the particular outpatient center will need to continually make the framework more appropriate. All healthcare team members should be involved in the evaluation, and so should patients. Patients and family’s continual input should be sought to understand which interventions have been most beneficial. Perhaps after performing a survey a patient might report that there was no benefit from the nurse screenings between visits, then this could be modified or discontinued.

As I have mentioned Zero Suicide is specifically designed for each particular setting. This development means that any feature that does not work should be adjusted. Like all models there are shortcoming, yet its strength is its framework that is completely adaptable and moldable.
Working inpatient psychiatry, I’ve seen the failures of this system, and I’ve also seen the failures of outpatient psychiatry in the number of admissions we accept directly from our outpatient center. Unfortunately, there are many factors that lead to hospitalization in adolescent suicidal ideation. lack of outpatient providers, and liability from family stating that they feel ill equipped with keeping their child safe are all major factors. It will take a trained competent workforce with willingness to act emergently to fix these problems. Although there have been some institutions who have implemented Zero Suicide there have not been published data to show the progress allowing critical analysis.

Researchers are currently working on a large-scale implementation of Zero Suicide in outpatient behavioral health in New York State. 177 outpatient mental health clinics are participating in this implementation. This will provide quantitative and qualitative data to show how effective Zero Suicide is at preventing suicide. The researchers have so far published their framework for implementation in their paper titled “Zero Suicide”—A model for reducing suicide in United States behavioral healthcare (Labouliere et al., 2018). Their implementation phase began in October 2017 and results are not yet available. I am hopeful that this data will show how transformative Zero Suicide will be in the outpatient behavioral health setting. This research will also show how to best implement the theory, and hopefully guide further research to move into other settings.

Summary

The problem I found stemmed from my work in inpatient adolescent and child psychiatry and my dissatisfaction with the current treatment of suicidal ideation. I often feel that suicidal ideation is not directly addressed, and instead depression and psychiatric disorders are addressed. Diagnoses are treated with medications, and the patient is discharged to attend outpatient medication management and therapy. Throughout the patient’s admission the issue of suicide is not addressed. The actual reason for admission of a suicide attempt or ideations is rarely mentioned or discussed. I work with many skilled clinicians with years of experience, however I still see that the directness that suicide treatment requires is avoided. This avoidance of directness almost seems to minimize the issue.
Zero Suicide clearly articulates a framework on how to directly address suicidal ideation in any setting. I learned that inpatient hospitalization should be avoided since it does little to tackle this major issue. Instead outpatient settings in behavioral health or primary care should be transformed to provide holistic care to the patient and the family. Our patient’s whole world is outside the hospital. Their strongest allies are in their family members and friends, yet communication with these people is either decreased or completely halted during psychiatric hospital admissions.

Wanting to work in an outpatient pediatric behavioral health center I decided this would be the best area to focus on implementing Zero Suicide. I would love to one day work in a setting that uses the Zero Suicide framework in its management of suicide. Suicide is a tragic end to many mental health diagnoses and should be prevented at all costs. I have learned the power in community support, and realize that our greatest support for our patients will be to train their own family members in suicide prevention while collaborating with the outpatient healthcare team.

Zero Suicide needs to go beyond one outpatient clinic. It needs to be implemented in an entire health system or an entire community. There needs to be consistency from the outpatient therapist, the outpatient psychiatrist, and caseworker all the way to the inpatient hospital team. There needs to be standards in care on how to treat these patients. Much in the same way a cancer patient receiving outpatient chemotherapy would be admitted to the hospital for neutropenia- the hospital team would still continue with chemotherapy treatment. Our suicidal patients deserve this same continuity of care. We need to start with implementing Zero Suicide in the outpatient setting and move to the inpatient setting.

Zero Suicide will not provide an unlimited resource of trained providers and suddenly fix the healthcare shortage. It will however be able to tackle the issue of long-term suicidal ideation that currently burdens our healthcare system. There also needs to be more research to show how to implement it for best results, and to evaluate its effectiveness. If we do not work to stop suicide it will continue to cost not only our healthcare system, but the wellbeing of our community. We
know that not only does suicide effect the person’s family, it also effects the whole community. Many studies have shown that suicide appears in clusters (Haw et al., 2013). A person having a relative, or close association die by suicide increases the risk that they too will die by suicide (Haw et al., 2013). So, it is in all of our best interest to aim for the goal of zero-suicide, with the hope that one day suicide will no longer be the number two reason for death in adolescents.
References


