

Editorial

Zero Suicide – What About “Treat”?

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The Challenge

In the United States annually there are 42,000 breast cancer deaths and 52,000 colorectal cancer deaths. Importantly, these leading killers have seen notable mortality declines over several decades largely due to robust screening, early detection, and use of proven clinical interventions (Caswell-Jin et al., 2024; Siegel et al., 2023). It is unimaginable that healthcare providers would disregard the use of evidence-based clinical practices for identifying and treating individuals for leading causes of death. To do otherwise would be utterly unacceptable within contemporary healthcare delivery. Yet evidence-based treatment approaches to suicidal thoughts and behaviors are routinely underutilized by providers.

Suicide is a global issue, taking more than 700,000 lives annually (<https://www.who.int/news-room/fact-sheets/detail/suicide>). Provisional data in the US for 2022 indicate that there were 49,449 suicides in the country—the highest suicide death count in recorded history (www.cdc.gov/nchs). Moreover, 2,553,000 American adults and teens reported attempting suicide that year and a whopping 16,600,000 Americans reported *serious thoughts of suicide* (Substance Abuse and Mental Health Services Administration, 2023). For individuals (and families) facing a suicide crisis, finding effective care can be fraught with challenges including timely access to care, insurance barriers, stigma, and the taboo to openly discuss it. While not all will access health-care providers for support or treatment, for those who do have the courage to ask for help, they should expect nothing less than compassion, clinical skill, and a reliance on proven treatments.

Zero Suicide

Zero Suicide is a quality improvement framework that transforms system-wide suicide care, establishing suicide

prevention as a core health-care responsibility in the US and abroad (National Action Alliance for Suicide Prevention, Clinical Care & Intervention Task Force, 2012). Seven core elements comprise the model: “lead,” “train,” and “improve” are the structural components embedded throughout the system and necessary for change success, fidelity, and continuous quality improvement. “Identify,” “engage,” “treat,” and “transition” are clinical components of the model and define the care patients should receive.

Despite evidence supporting each component, use of the full model within systems of care varies. Many Zero Suicide implementation efforts focus on identification followed by brief interventions to reduce acute suicide risk. Central to Zero Suicide care management is a standardized suicide prevention pathway (SPP) that typically includes screening and assessment leading to a collaborative safety plan, reducing access to lethal means, and caring contacts/warm hand-offs. Although “treat” is integral to the model, it is often addressed after adopting other components of the model first, and the SPPs of some organizations fail to explicitly incorporate clinical treatments of suicidal thoughts and behaviors altogether.

The Zero Suicide approach has demonstrated notable reductions in suicide and suicide behaviors. For example, a study in Australia of Zero Suicide within a health-care system of over 600,000 people found that individuals who were on the SPP experienced significantly lower risk of repeated suicide attempts within 90 days of the first attempt. Further, there was approximately a 23.3% reduction in suicide deaths (Turner et al., 2021). In the US, Centerstone – a large behavioral health nonprofit and early adopter of Zero Suicide – saw a 64% reduction in suicides 2 years after implementation (Hogan & Goldstein Grumet, 2016). Zero Suicide case studies reveal readmission rates were reduced by 17%–21%; rehospitalization among patients with suicidal ideation decreased by 45%; care transition teams reduced emergency department visits by

70% and hospital bed days by 90%; and mobile crisis teams diverted 94% of patients away from emergency departments (Department of Health and Human Services, 2023). Finally, another study found that greater fidelity to Zero Suicide practices was associated with lower risk for suicide-related behaviors within outpatient care (Layman et al., 2021).

The apparent success of Zero Suicide over the past decade has been compelling; however, “treat” tends to be underemphasized within Zero Suicide based clinical care. “Treat” is defined as: “Treat suicidal thoughts and behaviors using evidence-based treatments.” Notably, proven clinical treatments for suicide risk are rarely described in published papers of Zero Suicide implementation. Emblematic of this concern is an excellent application of Zero Suicide in New York (Labouliere et al., 2018) with a publicly available SPP for those at risk for suicide. Within this example there is an emphasis on increasing clinical contact, treatment plans focused on reducing risk factors and increasing protective factors, and providing long-term interventions to address mental health symptoms, including providing suicide-specific treatments “if available” (i.e., if clinicians have training in these practices). This example is not unique and highlights an inherent challenge; the lack of suicide-specific treatment emphasis within Zero Suicide is common.

We are encouraged that current Zero Suicide strategies appear to be working, and yet, it is discouraging that once a person has been stabilized and is out of acute crisis, the treatment of what makes them suicidal is too often missing to ensure a lasting recovery. While saving lives is vital, reducing ongoing suicide despair for millions should be a priority (Jobes & Joiner, 2019).

Clinician Training

There is an online evolving toolkit available at www.ZeroSuicide.EDC.org supporting the adoption of the Zero Suicide model that includes tools, research behind the interventions, and resources, including the Zero Suicide Workforce Survey, developed to measure health-care staff’s self-perception of their comfort, confidence, and skill in delivering suicide-specific interventions. Over 700 health-care organizations, representing both the US and abroad, have used this survey; and among 20,000+ respondents who are responsible for delivering treatment, fewer than half report receiving training on suicide-specific evidence-based treatment approaches. Moreover, only 32.8% strongly agree that they are confident in their ability to provide treatment to individuals with suicidal thoughts or behaviors and only 35.3% report comfort-providing treatment (Goldstein Grumet et al., 2023).

These results are unacceptable if we truly aspire to save lives and decrease suffering.

The clinical science of treating suicidality has evolved such that we now have several proven suicide-specific treatments with additional promising treatments in development (Jobes, 2023; Jobes & Barnett, in press). However, graduate programs, professional certification, and continuing education rarely focus on suicide-specific treatments as a competency for graduation or licensure. This may help explain why so many surveyed providers (many in practice for 20+ years) have limited experience in training and comfort using these interventions clinically.

Admittedly, challenges to using evidence-based practices (EBPs) do exist. Reasons health-care systems and providers share for not using evidence-based suicide-specific clinical interventions include the costs associated with obtaining training, lack of time needed to deliver interventions, high patient demands, inconsistent patient attendance, lack of management support or supervision of EBPs for suicide care, and high staff turnover. Randomized controlled trials (RCTs) too often under-represent minority populations or patients with comorbid conditions and therefore may not be as generalizable to real-world settings (Cook et al., 2017). Further, mental health providers routinely default to long-established familiar interventions or treatment modalities that have no, mixed, or limited evidence of being effective for suicide care. These include brief inpatient admissions that, for some, can actually be iatrogenic (Czyz et al., 2016; Large et al., 2014; Ward-Ciesielski & Rizvi, 2021), involuntary hospitalizations that may in fact do more harm than good (Borecky et al., 2019; Stefan, 2016), and an over-reliance on medications that have little to no impact on suicidality (with exceptions, e.g., Ballard et al., 2014) and may even *increase* suicidal risk (Li et al., 2022). Finally, US clinicians are often plagued by the prospect of malpractice tort litigation for “wrongful death” if a suicide outcome occurs. The fear of litigation can drive “better safe than sorry” clinical practices that may not be in the patient’s best interest (Jobes, 2017). In truth, the best clinical risk management strategy is to use EBPs proven to effectively treat suicidality and to document that work well (Jobes & Barnett, in press).

Clinical Treatments for Suicidal Risk

The empirically supported treatments for suicide behaviors that have emerged over the past 30 years are primarily used on an *outpatient* basis and focus on the underlying causes of longer-term distress with the goal of reducing suicide attempts and ideation. What follows is a brief review of suicide treatments well supported by RCTs – the

gold standard methodology for establishing the highest level of *causal* impact of an intervention. These treatments have replicated (and independent) RCT support (i.e., similar RCT findings by investigators who did not develop the treatment being studied).

Dialectical Behavior Therapy

The most proven treatment with a well-established impact on suicide attempts and self-harm behaviors is dialectical behavior therapy (DBT; Linehan, 1993) with *dozens* of supportive and independent RCTs. In short, DBT is an intensive team treatment that emphasizes (1) skills group, (2) individual therapy (supporting DBT-based skills), (3) phone-coaching to practice skills, and (4) consultation support of the treatment team (Linehan, 1993). DeCou et al.'s (2019) meta-analysis of 18 DBT RCTs showed that DBT reduces suicidal and self-harm behaviors.

Suicide-Focused Cognitive Behavioral Therapy

There are two similar cognitive behavioral therapy (CBT)-oriented treatments with RCTs demonstrating impressive outcomes. The first is cognitive therapy for suicide prevention (CT-SP) developed by Brown et al. (2005). CT-SP was shown to effectively reduce suicide attempts by 50% after 10 sessions when comparing treatment with usual care (Brown et al., 2005).

The second CBT-oriented treatment is brief cognitive behavioral therapy for suicide prevention (BCBT-SP; Rudd et al., 2015). BCBT-SP is a phasic treatment that centers on the suicidal mode concept and incorporates a relapse prevention protocol (Bryan & Rudd, 2018). In their RCT with high-risk US Army soldiers, BCBT-SP reduced suicide attempts by 60% when compared with usual treatment control care at the 18-months follow-up. Similar to CT-SP, BCBT-SP did not necessarily reduce suicidal ideation. Importantly, having general CBT training does not mean one can deliver CT-SP or BCBT-SP with fidelity.

Collaborative Assessment and Management of Suicidality

Developed by Jobes (2000, 2023), the collaborative assessment and management of suicidality (CAMS) is a suicide-focused therapeutic framework. CAMS employs a multi-purpose assessment, stabilization, treatment planning, tracking, and clinical outcome tool called the "Suicide Status Form" (SSF) that targets patient-identified "drivers" of their suicidality (i.e., problems that cause them to consider suicide). There are eleven correlational clinical trials, seven published RCTs, and two published meta-analyses providing ample support for CAMS (Jobes, 2023). CAMS reliably reduces suicidal ideation, symptom distress, and hopelessness (while increasing hope) in comparison with control care (Swift et al., 2021). CAMS can significantly reduce suicide attempts

(Santel et al., 2023), is cost-effective (McCutchan et al., 2022), and telehealth-CAMS is effective (O'Neill et al., 2023).

Emerging Suicide Treatments

Clinical suicidology is now a vibrant focus of research with several other excellent suicide treatments in need of RCT replication and/or independent replication. These include attachment-based family therapy, mentalization-based therapy, the Attempted Suicide Short Intervention Program, problem solving therapy, and the Coping with Long-Term Active Suicide Program.

Addressing the Challenge of "Treat"

Health-care systems and dedicated providers can undoubtedly decrease suicidal suffering and save lives. If suicide-specific effective treatments are reliably provided within a Zero Suicide framework, we contend that the best possible approach to care will have been rendered, which should meaningfully reduce suicidal suffering and ultimately help save lives. To help realize the promise of this vision, we propose the following broad recommendations:

Research Addressing Obstacles to Using EBPs

While we have presented many potential reasons why health-care systems and providers are reluctant to utilize EBPs, additional research on barriers and solutions is needed to better inform our treatment efforts.

Structural Changes to Suicide-Focused Care

There is a need to fundamentally move away from the routine use of the familiar and comfortable. For example, emergency department (ED) care can be meaningfully transformed by offering care that is more healing for people who are suicidal. There is support for EmPATH units that offer an alternative model to ED care emphasizing peer support and more nurturing environments (<https://www.vituity.com/healthcare-services/psychiatry/empath-units/>). Technology can be used to create a suicide-focused therapeutic ED experience (e.g., <https://jasprhealth.com/>). Use of evidence-based suicide-focused treatment could significantly improve the psychiatric inpatient experience (e.g., Bohus et al., 2004; Santel et al., 2023).

Since 2007, suicide prevention clinics have existed across Denmark for individuals with suicidality where their distress can be managed quickly through counseling, therapy, and practical support. This has been associated with a reduction in long-term fatal (29%) and nonfatal (18%) suicidal acts (Healthcare Denmark, 2023). The Hope Institute in the US is another example of an outpatient clinic model for suicide care that averts ED visits

and inpatient admissions (Jobes, 2023). Launching new models for rapid suicide-focused treatment should become a mental health priority.

Increased Awareness and Training

There is a need for more and better training in suicide-specific EBPs both while in professional training programs and throughout careers. We must convince providers that treating suicide risk with proven clinical care is available and crucial. Identifying and promoting common elements of effective care that cut across different treatment settings and disciplines and are integrated into routine clinical practice could offer a better overall patient experience (Rudd et al., 2022).

Malpractice and Root Cause Analysis Reform

A restorative just culture is an underlying and necessary principle in Zero Suicide (Turner et al., 2020) whereby system learning and improvement is the focus when errors or adverse events occur, rather than on placing blame. While the US is particularly plagued by a litigious culture related to malpractice liability, there are approaches to tort reform and proactive use of informed consent that could help providers feel less paralyzed by the threat of litigation (Stefan, 2016). Even in less overtly litigious countries, there are still coroner's inquests and "root cause analyses" that can become focused on *blaming* providers or systems of care. Sometimes, even optimal evidence-based care, be it for suicidality, stroke, cancer, or childbirth, still results in an adverse and tragic outcome, yet is a legally defensible outcome as a provider.

Reimbursement for Suicide-Specific EBPs

Mental health treatment and care has long suffered in terms of parity to medical care. Within medicine, new technologies and surgical procedures are constantly advancing and providers routinely receive training to ensure they are ready to deliver optimal care. Cost for training remains one prohibitive reason for the lack of use of treatment-focused EBPs related to suicide as the margins for reimbursement are lower for mental health and there are additional costs incurred when providers are not delivering direct care. Therefore, we propose that insurers establish CPT codes for suicide-focused interventions known to be effective, thereby defraying the cost of training to the health-care system and provider. While this reference to CPT codes is specific to the US, other countries face similar challenges. Further, we suggest that value-based and/or payment bundles for effective suicide care be made available and propose a pilot program of this approach.

Accountability, Accreditation, and Licensing

The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF) in the US have updated their suicide care standards. These were strong and aggressive notices that the evidence was available that more could and should be done in health care to address suicide risk. However, longer-term treatment with EBPs that reduce suicide distress, once the acute risk has been reduced, are not yet incorporated into accreditation requirements at this time. We contend that TJC and CARF – and similar organizations in other countries – should *require* demonstration that treatment-specific EBPs be offered as part of the suicide care management plan in outpatient settings. In the US, there are currently 11 states requiring suicide prevention training for licensed providers in order to maintain their license. We propose that governing bodies consider adopting some minimal hours specific to suicide treatment and care as part of continuing education and licensure.

Conclusion

We have noted meaningful gains in systems-level suicide prevention efforts and believe that the international embrace of the Zero Suicide framework has in part contributed to these encouraging gains. And yet, there has been a general hesitancy to fully embrace the "treat" element of Zero Suicide despite evidence of its value. When comparing treatments and adoption of available EBPs for other leading causes of death, the apparent evidence-to-practice gap in suicide care is hard to understand or justify. Accordingly, Jobes and Barnett (in press) have argued that using evidence-based clinical care for suicidal risk has become an *ethical and professional imperative* within contemporary mental health care. Although notable challenges to such care exist, the good news is that treatment works, offering an opportunity to ameliorate the suffering of millions with serious suicidal thoughts and saving lives too often lost to suicide.

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