



How We Dramatically Reduced Suicide

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In 2001, the Behavioral Health Services division of Henry Ford Health System set out to radically transform its mental health care delivery system by participating in the Robert Wood Johnson Foundation’s “Pursuing Perfection National Collaborative.” Our “Perfect Depression Care” (PDC) initiative leveraged the power of an audacious goal — eliminating suicide — to achieve dramatic and sustained reductions in patient suicide, as well as improved performance of our entire delivery system. The goal of zero suicides has since become an international movement.

KEY TAKEAWAYS

- 1 Pursuing perfection is a viable model for health care system transformation.
- 2 Pursuing perfection is most successful within a just culture.
- 3 Zero suicides is a social transformation, not a bundle of specific interventions.
- 4 Suicide is preventable.

The Challenge: Suicide rates over the last several decades have remained unchanged. Despite tremendous advances in clinical neuroscience, physicians and mental health care workers can't reliably predict whether or when a patient will commit suicide. Preventive strategies have the potential to lower the risk of these tragedies, but widespread implementation requires traditional mental health care systems to undergo radical redesign. The Institute of Medicine's *Crossing the Quality Chasm* report (2001) called for sweeping reform of the American health care system, and the Robert Wood Johnson Foundation and the Institute for Healthcare Improvement responded with a \$26 million national demonstration project — *Pursuing Perfection* — that challenged health care systems to dramatically improve patient outcomes by redesigning all major care processes in order to deliver perfect care. Our participation in the first phase of Pursuing Perfection (we were not ultimately awarded an implementation grant) challenged us to create a workplace culture in which the performance goal was *perfection*, not just incremental improvement.

In spite of its radicalism — indeed because of it — the goal of zero suicides became the galvanizing force behind an effort that achieved one of the most dramatic and sustained reductions in suicide in the clinical literature.”

The Goal: We selected depression care as the target for transformation for our department, but struggled initially to articulate a vision of what “perfect care” would look like. Finally one of our staff suggested that if depression care was truly perfect, no patient would die from suicide. That stunning idea set in motion a debate that continues even today.

The notion of eliminating suicide is radical and antithetical to traditional teaching in psychiatry, where suicide has historically been understood as the unfortunate but inevitable outcome in some patients with mental illness. Our team challenged this assumption and asked, If zero is not the right goal for suicide occurrence, then what number is? Two? Twelve? Which twelve? In spite of its radicalism — indeed

because of it — the goal of *zero suicides* became the galvanizing force behind an effort that achieved one of the most dramatic and sustained reductions in suicide in the clinical literature.

The Execution: The audacious goal of zero suicides was part of the Behavioral Health Services division's larger goal to develop a system of perfect care for depression. Our roadmap for transformation was the *Quality Chasm* report, which defined six dimensions of perfect care: safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness. We set perfection goals and metrics for each dimension, with zero suicides being the perfection goal for effectiveness. Very quickly, however, our team seized on zero suicides as the overarching goal for our entire transformation.

We used three key strategies to achieve this goal. The first two — improving access to care and restricting access to lethal means of suicide — are evidence-based interventions to reduce suicide risk. While we had pursued these strategies in the past, setting the target at zero suicides injected our team with gumption. To improve access to care, we developed, implemented, and tested new models of care, such as drop in group visits, same-day evaluations by a psychiatrist, and department-wide certification in cognitive behavior therapy. This work, once messy and arduous for the PDC team, became creative, fun, and focused. To reduce access to lethal means of suicide, we partnered with patients and families to develop new protocols for weapons removal. We also redesigned the structure and content of patient encounters to reflect the assumption that every patient with a mental illness, even if that illness is in remission, is at increased risk of suicide. Therefore, we eliminated suicide screens and risk stratification tools that yielded non-actionable results, freeing up valuable time. Eventually, each of these approaches was incorporated into the electronic health record as decision support.



When we achieved the goal of “zero suicides,” the success was self-evident. In turn, the initiative gained even more traction as a transformational force”

Notwithstanding this system redesign, the pursuit of perfection was not possible without a *just culture* for our internal team. Ultimately, we found this the most important strategy in achieving zero suicides. Since our goal was to achieve radical transformation, not just to tweak the margins, PDC staff couldn't justly be punished if they came up short on these lofty goals. We adopted a root cause analysis process that treated suicide events equally as tragedies and learning opportunities. Participating in this process left staff feeling not only supported but also empowered to be agents of improvement. The key to establishing a just culture was to hold people accountable for learning and improving.

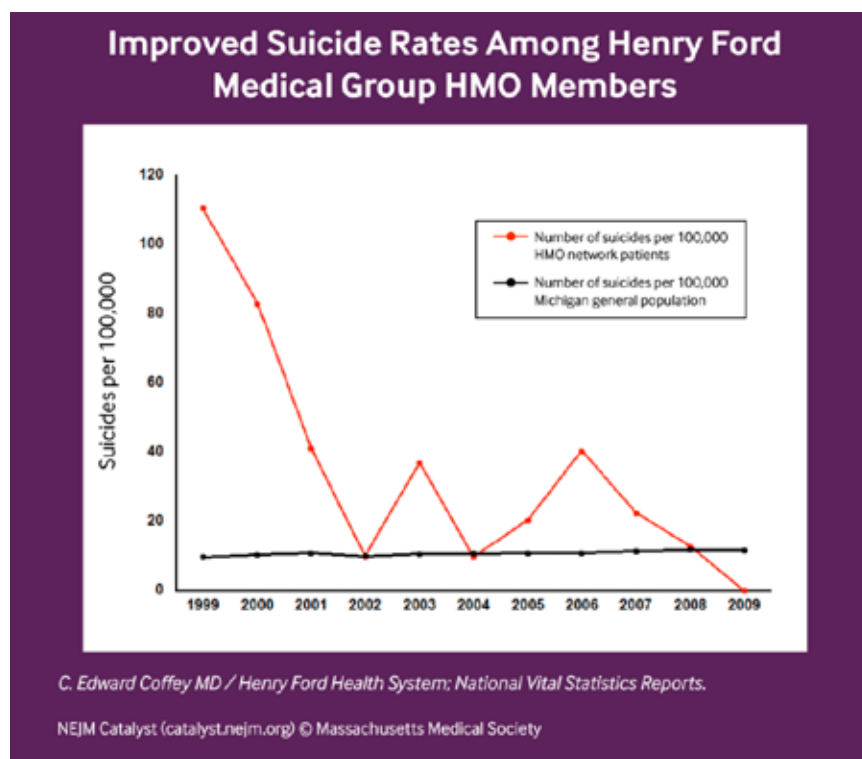
The early success of PDC created momentum that facilitated its spread. The U.S. Surgeon General and the Substance Abuse and Mental Health Services Administration endorsed the goal of zero suicides and invited one of the authors (CEC) to help develop the [2012 National Strategy for Suicide Prevention](#). In addition, the clinical leaders of Henry Ford Health System charged one of the authors (MJC) to spread PDC into [primary care and the general hospital setting](#).

The Team

Dubbed the “Blues Busters,” the PDC team was led by the Department of Psychiatry Chair (CEC) and included all clinical and administrative leaders within the department.

The Metrics

The overall result of this transformation was a dramatic and statistically significant 80% reduction in suicide that has been maintained for over a decade, including one year (2009) when we actually achieved the perfection goal of zero suicides (see the figure below). During the PDC initiative, the annual HMO network membership ranged from 182,183 to 293,228, of which approximately 60% received care through Behavioral Health Services. From 1999 to 2010, there were 160 suicides among HMO members. In 1999, as we launched PDC, the mean annual suicide rate for these mental health patients was 110.3 per 100,000. During the 11 years of the initiative, the mean annual suicide rate dropped to 36.21 per 100,000. This decrease is statistically significant and, moreover, took place while the suicide rate actually increased among non-mental health patients and among the general population of the state of Michigan.



Care teams don't often know the suicide rate in their patient population, and initially we were no different. We learned very quickly that official government mortality records were of little use in managing real-time improvement, because there was a delay of two years before they became available. So we implemented a real-time suicide surveillance system and, retrospectively, reconciled data obtained from it with government data once they became available.

Communicating effectively about the metrics was crucial. Statistically speaking, suicide is a rare event. But while metrics like “rate per 100,000 population” or “time between events” were informative, they did not stir people to action. On the other hand, when we achieved the goal of “zero suicides,” the success was self-evident. In turn, the initiative gained even more traction as a transformational force.

Of note, Perfect Depression Care had no negative impact on our division’s financial health, which remained strong throughout the Initiative.

Hurdles

The most unexpected hurdles were skepticism that perfection goals like zero suicides were reasonable or feasible (some objected that it was “setting us up for failure”), and disbelief in the dramatic improvements obtained (we heard comments like “results from quality improvement projects aren’t scientifically rigorous”). We addressed these concerns by ensuring the transparency of our results and lessons, by collaborating with others to continually improve our methodological issues, and by supporting teams across the world who wish to pursue similar initiatives.

Where to Start

Begin by making a commitment to radical quality. Commit to the goal of zero suicides — or whatever perfection goal most inspires your team. Determine the baseline rate of defects, then engage all team members in devising creative ways to drive that rate to zero. Leaders must ensure a just culture that nurtures this pursuit of perfection.



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