City of Philadelphia

DBHIDS

DEPARTMENT of BEHAVIORAL HEALTH and INTELLECTUAL disABILITY SERVICES

Suicide Prevention in Philadelphia
A Strategic Framework
2024

The mission of the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) is to educate, strengthen, and serve individuals and communities so that all Philadelphians can thrive.
We envision a Philadelphia where every individual can achieve health, well-being, and self-determination.

The principles on which the public health approach to suicide prevention is built, in alignment with the core values of DBHIDS, include:

- Aligned with the TEC lens and PACE Strategic Framework.
- Strength-based approaches that promote hope.
- Community inclusion, partnership, and collaboration.
- Person- and family-directed approaches.
- Family inclusion and leadership.
- Peer culture, support, and leadership.
- Person-first (culturally competent and linguistically inclusive) approaches.
- Trauma-informed and trauma-responsive approaches.
- Holistic approaches.
- Care for the needs and safety of children and adolescents.
- Partnership and transparency.

Read more about the Practice Guidelines for Resilience and Recovery Oriented Treatment

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Introduction

The National Institute of Health defines public health emergencies as "situations whose scale, timing, or unpredictability threatens to overwhelm routine capabilities."[1] In the United States, suicide meets the criteria for a public health emergency. Between 2000 and 2018, suicide rates increased by 30 percent. In 2020 there was 45,979 suicide deaths in the United States. In the same year, 12.2 million (nearly 5 percent) of the adult population seriously considered suicide.[2] This framework uses a socio-ecological model to better understand the complex intersection of suicide at the individual, interpersonal, community, and societal levels. The model allows us to understand the range of factors that put people at risk for suicide and prevent or protect individuals from experiencing suicidal thoughts, attempts, or deaths.

Suicide prevention is important to mitigate loss of life and improve quality of life and the ability of individuals to lead productive lives. Individuals struggling with suicidal ideation often experience ambivalence and the desire to be relieved from suffering but the innate instinct to continue living. Suicide prevention, intervention, and postvention act as protective factors for these individuals during these vulnerable periods to reduce personal and societal harm. In Philadelphia, age-standardized rates for suicide are lower than Pennsylvania and the United States for the past five years. For example, in 2020 age-standardized suicide rates were 13.5 for the nation, 12.6 for Pennsylvania, and 10.13 for Philadelphia.[3] Although Philadelphia has a lower mortality rate than the national rate, DBHIDS firmly believes that one suicide is one too many and embraces the Zero Suicide Model, a world without suicide. Suicide is a personal and social phenomenon that is reactive to current conditions of social determinants of health and contemporary political, social, and international events. The guiding belief that all suicides are preventable necessitates a paradigm of continued work and vigilance.

Between the rising rates of suicide nationally over the last two decades and the widespread impact of the COVID-19 pandemic, a resurgence of visibility for mental health and suicide prevention has taken

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2936581/
[2] https://www.cdc.gov/suicide/pdf/suicideTechnicalPackage.pdf
[3] https://www.cdc.gov/suicide/suicide-data-statistics.html

place. This increased attention to mental health at the federal, state, and local levels has led to additional funding and opportunities around behavioral health crisis system expansion. Philadelphia's Crisis 2.0 is the framework for expanding the infrastructure of the Philadelphia crisis continuum that includes Crisis Response Centers (CRCs), expanded mobile crisis team capacity, a Behavioral Health Urgent Care Center, Philadelphia Crisis Line, and necessary administrative staff. Suicide prevention and crisis services are inextricably linked, as crisis resources are the frontline of intervention when a mental health emergency occurs. The concept of crisis intervention must be embedded throughout prevention efforts, and, in turn, the concept of prevention must be embedded throughout intervention.

The purpose of this framework is to position DBHIDS to become a model of how a major city can address suicide prevention.

Alignment with TEC Lens

The TEC vision is, "addressing Trauma, achieving Equity, and Community." TEC layers on top of the DBHIDS PACE (Prioritizing to Address Our Changing Environment) Strategic Framework and provides a lens to prioritize and focus on transformation initiatives.

- **Addressing Trauma:** Trauma is defined as a single or collection of distressing experiences that result in challenges managing one's spiritual, mental, and emotional well-being. DBHIDS' goal to address trauma is to transform processes, practices, and systems to be trauma-informed, trauma-responsive, and trauma reducing.
- **Achieving Equity:** Equity is defined as creating opportunities and changes to a space or system, so marginalization doesn't unjustly predict one's success, ultimately improving outcomes for all. DBHIDS' goal to achieve equity is to transform systems to reduce behavioral health disparities and promote racial equity amongst Black, Indigenous, and people of color (BIPOC)
- **Engaging Community:** Community is defined as a "group of individuals with a shared feeling of fellowship because of shared common attitudes, interests, or goals. DBHIDS' goal to engage community is to increase community-based services and sustain programming through integrating initiatives more fully throughout Philadelphia.

Every component of the proposed Suicide Prevention Strategic Framework is guided by the TEC lens. Evidence-based suicide prevention interventions are inherently trauma-informed and trauma-responsive. The suicide prevention work of DBHIDS will be conducted with the TEC lens at the forefront of programming, policy, and innovation.

Alignment with PACE Strategic Framework

In 2018, DBHIDS introduced the PACE Strategic Plan. PACE stands for Prioritizing to Address Our Changing Environment. It is the blueprint for how DBHIDS divisions work together to align, coordinate, and integrate initiatives across the organization. The Suicide Prevention Strategic Framework was created in alignment with the PACE Strategic Plan to demonstrate continuity and congruency within and across City agencies and the provider network's delivery of services within the crisis continuum.

PACE is comprised of five key priority areas that include:

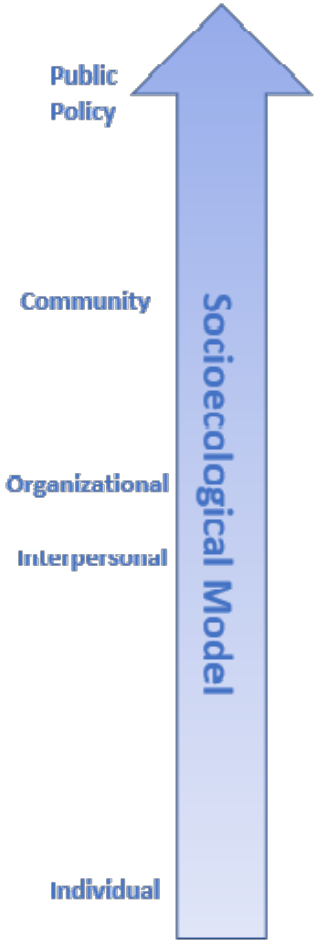
- Prevention and Early Intervention.
- Treatment and Services.
- Health Economics.
- Infrastructure and Intelligence.
- Innovation.

Each of these priority areas is accompanied by Department-wide strategic goals and key performance indicators that will enable us to assess our progress towards meeting our goals. Every component of the proposed Suicide Prevention Strategic Framework[4] is guided by the PACE strategy.

The Suicide Prevention Strategic Framework outlines strategic priorities for suicide prevention efforts along the socioecological continuum in alignment with the TEC lens and PACE strategic framework. Each priority may not fit perfectly into one TEC or PACE subsection (as shown below) but cut across multiple focus areas. Displayed below is a "best fit" distribution for priorities with understanding that many priorities overlap within a complex network of care.

[4] Learn more about the DBHIDS PACE Strategic Framework here.

Overview



	Prevention and Early Intervention	Treatment and Services	Health Economics	Infrastructure and Intelligence	Innovation	Addressing Trauma	Achieving Equity	Engaging Community
Policy Work	X		X	X	X	X	X	
Research and Evaluation	X	X		X	X	X	X	
Task Force	X			X	X	X	X	X
Peer Advocacy	X				X	X	X	X
Training and Education	X				X	X	X	X
Support Groups	X				X	X	X	X
Discharge Planning	X	X	X			X	X	
Crisis Care		X	X		X	X	X	X
Screening	X	X	X			X	X	X

Guiding Principles Across DBHIDS Suicide Prevention Efforts

The Zero Suicide Framework

The fundamental belief and core value of the Zero Suicide framework is that all suicide deaths are preventable. Although this is an aspirational goal, it is a critical driving force behind the concepts and practices of Zero Suicide initiatives. Zero Suicide models have had significant success in emergency departments[5], outpatient psychiatric settings[6], and psychiatric inpatient facilities[7]. Within the Suicide Prevention strategic framework, Zero Suicide is a lens through which initiatives can be organized and catered to maximize efficiency and effectiveness towards the goal of preventing all suicides. The Zero Suicide approach begins with self-study and assessment to determine areas of change, then guides an institution through seven pillars of focus and action. A future goal of this framework is to adapt portions of the Zero Suicide model for use outside of traditional health care settings to be applied in community settings. The basis of this model is contained within these seven pillars:

Lead - Leadership commits to systemwide, organizational change. The adoption of the cultural shift is supported downward through all stakeholders.
Train - An assessment is completed to determine the needs of all stakeholders to complete their role. Stakeholders receive training appropriate to their role in suicide prevention.
Identify - Comprehensive screening and assessment are the core tasks essential to identifying those at risk for suicide. Adapting screenings and assessments for various environments will be a necessary component of this framework.
Engage - A collaborative and engaging approach is essential to creating a supportive intersection of evidence-based practices and individual autonomy for those in need of suicide care and intervention.
Treat - Treatment should directly address suicidal ideation and behaviors alongside any diagnoses and should occur in the least restrictive setting possible.
Transition - Ensuring that individuals make and attend appointments is the responsibility of organizations providing care, not the individual. Transitions in care settings are high-risk periods for individuals, and an integrated approach with warm hand-offs is most supportive during this time.
Improve - Better outcomes can be achieved for those at risk for suicide when continuous quality improvement is centered around data-driven approaches. This philosophy also emphasizes a "just" and "blame free" culture of improvement.

Peer Inclusion

Inclusion of people with lived experience is essential in all suicide prevention efforts. Lived experience with suicide includes individuals who have lost a loved one to suicide, or survivors of suicide loss, and

[5] Stapelberg, N., Sveticic, J., Hughes, I., Almeida-Crasto, A., Gaee-Atefi, T., Gill, N., . . . Turner, K. (2021). Efficacy of the Zero Suicide framework in reducing recurrent suicide attempts: Cross-sectional and time-to-recurrent-event analyses. *The British Journal of Psychiatry, 219*(2), 427-436. doi:10.1192/bjp.2020.190
[6] Layman, D. M., Kammer, J., Leckman-Westin, E., Hogan, M., Goldstein Grumet, J., Labouliere, C. D., Stanley, B., Carruthers, J., & Finnerty, M. (2021). The relationship between suicidal behaviors and zero suicide organizational best practices in Outpatient Mental Health Clinics. *Psychiatric Services*, *72*(10), 1118–1125. https://doi.org/10.1176/appi.ps.202000525
[7] https://zerosuicide.edc.org/sites/default/files/2022-01/Zero%20Suicide%20Outcomes%20%281%29.pdf

individuals who have survived a suicide attempt, called attempt survivors. People with lived experience can serve as models of hope for others at risk of suicide or those who have lost a loved one. Additionally, the unique perspective of survivors plays an invaluable role in prevention planning, treatment, education, awareness, improving care and service delivery, and programming to support other survivors. The involvement of people with lived experience is a core value of DBHIDS and applies across all suicide prevention work at the Department. To foster an inclusive, equitable culture that uplifts community voices, the suicide prevention work of DBHIDS will continually center survivors in all activities.

Individuals who offer lived experience for the improvement of suicide prevention efforts will be respected as equals with individuals with other credentials. DBHIDS staff work to foster an environment in which people with lived experience are empowered to speak out, feel included and respected, and are valued for their expertise. Whenever possible, individuals who offer lived expertise should be compensated for their time and dedication to the advancement of suicide prevention efforts.

Special Populations

Suicide can impact every member of society; however, it is important to recognize the distinct and individual needs of special populations. These groups are recognized as special populations due to greater vulnerability to suicide attempts and suicide deaths and/or an above average, negative impact on of suicide deaths on said population. In this regard, suicide prevention programming and policy must recognize the distinct need of these populations. Identified special populations in Philadelphia include but are not limited to:

1. Immigrants and refugees.
2. LGBTQ+ populations.
3. Transition-aged youth, especially of minority demographics.
4. Those with co-occurring behavioral health and intellectual disability diagnoses.
5. First responders: police, EMTs, paramedics, and fire fighters.
6. Faith-based communities.
7. Medical professionals.
8. Veterans/servicemembers.
9. The elderly.
10. New and emerging special populations at risk as identified via evolving, dynamic, data driven identification methods.

A focus on equity and cultural appropriateness will be applied as suicide prevention strategies and programming are developed and expanded. Assuring equity will involve the use of data to track the deployment of resources as well as outcomes of programs and interventions. DBHIDS recognizes that the onus for developing services for special populations lies in the County to respond appropriately to the specialized and unique needs of the community.

Addressing Social Determinants of Health as Suicide Prevention

Social determinants of health (SDOH) are defined as the “conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.” DBHIDS has taken a population health approach to address SDOH, noting that the various factors that impact an individual’s health are unique yet intersectional. SDOH contributes to health disparities among various populations based on gender, race, or socioeconomic

status. SDOH also contributes to the development of chronic diseases such as obesity, hypertension, diabetes, and depression.

Addressing SDOH is suicide prevention work. DBHIDS works to address SDOH through an intersectional, collaborative approach that can indirectly improve suicide outcomes for the City of Philadelphia. As outlined in Healthy People 2030, key SDOH areas that prevent suicide are economic stability, education, health and health care, neighborhood and the built environment, and social and community context. It is important that the suicide prevention work of DBHIDS incorporates the reduction of poverty, unemployment, homelessness, alcohol use, social isolation, and racism in all prevention strategies and policies. Conversely, mental health and suicide risk must be considered in all policy, programming, and decision-making processes.

Prevention and Early Intervention

Prevention and early intervention services and initiatives are the foundation of our population health approach, aiming to help individuals protect their health and sustain their wellness. At the community level, activities that support prevention and early intervention include those specifically focused on individual at-risk identification and support, as well as those focused on addressing trauma, social isolation, unemployment, homelessness, and other social determinants of health early on. All these factors can otherwise threaten health and well-being and contribute to health disparities. This should be done broadly across the city but with efforts targeted at indicated populations, many of which have experienced centuries of disinvestment. Community-level activities also involve infusing communities with a range of advocational, educational, and other supports that increase the number of allies and peer-supports beyond the formal system.

DBHIDS follows a three-tiered approach to prevention:

1. Developing prevention programming that is universal (for the public)
2. Selective (for individuals or subgroups of the population at risk due to biological, psychological, and/or social factors)
3. Targeted (high risk individuals with detectable symptoms of mental health disorders).

Key components of prevention and early intervention services should be peer-led/supported, using community engagement teams.

Screening

Behavioral health screenings play an important role in prevention and early intervention by identifying individuals at risk as early as possible. Early identification is a key concept as any screening or basic questioning on suicide thoughts/behaviors is very likely to divert a potential suicide attempt. A goal of successful behavioral health screenings will be to determine target populations and, therefore, locations of screenings to reach the most individuals possible. Screenings will need to be adapted for this purpose, not only for the participant taking the screening but for the individuals who may be administering screenings with or without extensive mental health experience. For example, in school settings teachers can be trained in administering a simple school-aged children screening such as ASQ (Ask Suicide Questions). Screenings are commonplace in some points of the care continuum such as inpatient psychiatric settings, outpatient psychiatric settings, and substance use treatment settings. Local data from Philadelphia shows that many individuals who die by suicide do not have contact with any behavioral health services in the year leading up to their death. The expansion of screenings to less

traditional mental health environments will allow for greater community engagement with mental health well-being, further de-stigmatization of suicide and mental health topics, and the ability to reach the most individuals possible. Given the increased vulnerability of the populations such as first responders (police, paramedics, EMTs, and firefighters) minoritized communities, and youth, a useful strategy would include universal screening for these populations. Instead of being limited to traditional clinical settings, such screenings can take place in schools (to include teachers and aides); faith-based settings (by clergy and leaders), and other community settings such as within recreational organizations and youth sports or adult intramural settings.

Survivors of Suicide Loss Support Groups

Survivors of Suicide Loss support groups are offered by DBHIDS as a community-based prevention resource for individuals who have suffered the loss of someone to suicide. Suicide loss survivors are at a greater risk of developing complicated grief, which is correlated with poor mental health outcomes like major depression and suicidal ideations when compared to other types of loss[8]. Groups are held remotely or in-person, depending on risks and benefits in relation to current safety protocols. SoSL groups are peer-led support groups held in hour-long sessions that are open to the public to join without registration. SoSL information (Zoom links, dates, times, etc.) is available on the DBHIDS.org and on the Healthy Minds Philly website, along with other suicide loss support group listings (AFSP, Prevent Suicide PA).

Each group is run by two volunteer peer facilitators who are interviewed, selected, and trained by DBHIDS. Peer facilitators do their volunteer work under the supervision of the Suicide Prevention Coordinator. Counseling and quarterly check-ins are scheduled between the Suicide Prevention Coordinator and the peer facilitators to ensure their mental well-being is also a priority. Resources are provided to facilitators and group participants in the form of facilitator guides, self-check-in packets, and welcome packets that offer participants support/crisis resources and links.

Support groups provide spaces for sharing and healing that do not actively seek to solve problems but work to relieve suffering through the human capacity for compassion and connection. Individuals who have lost someone to suicide are more likely to suffer from poor mental health outcomes and more likely to have suicidal ideations and suicide attempts. SoSL support group facilitators are trained and given resources to help manage basic crisis situations and refer a participant towards intervention if needed. Future efforts will focus on increased visibility of SoSL support group offerings to increase participation and accessibility. Support group offerings will also expand to more specific needs such as: Suicide Loss for Parents, Suicide Loss for Partners and Spouses, Suicide Loss in the Black Community, Suicide Loss for Military and Service Families, etc.

Student Assistance Program (SAP)

Philadelphia Single County Authority partners with four local behavioral health providers to administer the Student Assistance Program, which provides screening and support services to elementary, middle, and high schools in Philadelphia. The goal of the SAP is to help identify and address social and behavioral barriers to students staying in and succeeding in school such as drug use and mental health issues. Participating schools have formed SAP in-house teams consisting of teachers, counselors, and social

[8] Tal Young, I., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. *Dialogues in clinical neuroscience*, *14*(2), 177–186. https://doi.org/10.31887/DCNS.2012.14.2/iyoung

workers who identify and refer students in need to the SAP. An SAP liaison will then perform a series of evidence-based screenings and assessments with the student depending on what barriers they are struggling with. If further services are needed to address the barrier for the student, the SAP liaison will assist in making community referrals.

Training and Education

Training and education play a critical role in suicide prevention and early intervention within the community. Education is needed for the community, providers, professionals, and all stakeholders. Opportunities for education should be readily available in every community engagement effort, particularly when those efforts include vulnerable/target populations. By reducing stigma around discussing mental health topics, DBHIDS and the crisis system at large are essential to breaking down barriers to prevention and early intervention within communities. It is important to recognize that education is an ongoing process involving changing approaches and knowledge, and initiatives around education need to be flexible to accommodate this.

Training initiatives are a natural step beyond education in that individuals commit to learning an approach or set of skills with a purpose. Through a partnership with Behavioral Health Training and Education Network, DBHIDS can provide a range of trainings to the public, City employees, and other stakeholders. Offerings include gatekeeper trainings, psycho-education sessions, social determinant deep dives, skills trainings for professionals, and more. Traditionally, all gatekeeper courses offered by BHTEN have been adult focused. A school-aged children gatekeeper training should be adopted and/or developed to cater to the specific needs of Philadelphia school districts, families, and caregivers. Courses can put useful skills and knowledge into the hands of community members, City employees, and local stakeholders to empower as many people as possible to play a role in suicide prevention and early intervention.

Community Conference

To give visibility to the issue of suicide prevention in Philadelphia, DBHIDS will coordinate an annual suicide prevention forum/conference to bring together local and national stakeholders to collaborate starting year two of the reinvestment plan. Sharing research, methods, data, and ideas are paramount when facing an issue that affects the entire population. The forum/conference offers a way for DBHIDS to show its commitment and dedication to suicide prevention while contributing to academic and practical discourse. Invitations should be sent to local, regional, and national organizations.

Gatekeeper Trainings (QPR, ASIST, SOS)

In partnership with BHTEN, DBHIDS offers two gatekeeper training courses: Question Persuade Refer and Applied Suicide Intervention Skills Training. Expansion of gatekeeper trainings will consist of the Suicide Prevention Coordinator becoming a trainer and holding regular trainings for community, providers, and internally for DBHIDS. Offerings will also be expanded to include school-aged children gatekeeper training such as Signs of Suicide. Gatekeeper trainings are a vital tool for empowering community members to help support those around them and take responsibility for suicide prevention and early intervention in their homes and communities.

Treatment and Services

Comprehensive crisis response and stabilization services are a crucial element of behavioral health systems. Comprehensive crisis services can improve outcomes for individuals, reduce inpatient hospital stays and costs, reduce over-reliance on law enforcement interventions, and facilitate access to other

necessary behavioral health services and supports. Crisis response services also perform important public health, public safety, and community well-being functions.
Treatment and services are the central portion of the intervention aspect of suicide prevention and, as such, suicide prevention and crisis services are inextricably linked. This idea should be made explicit to highlight the continuum aspect of crisis care from prevention to intervention to postvention. As an important contact point in the continuum, treatment and services need to also interweave education on prevention and wellness, mentoring on resource availability and access, and the inclusion of peer supports/peer advocacy.

Evidence-based Practice Implementation

Over the past several decades, researchers have identified a growing number of practices that are effective in supporting people with behavioral health challenges. These evidence-based and innovative practices are important components of a resilience and recovery-oriented behavioral health system. DBHIDS has partnered with researchers, treatment experts and providers to promote the delivery of behavioral health evidence-based practices throughout Philadelphia by creating the Evidence-based Practice and Innovation Center. The use of appropriate evidence-based practices (like the Zero Suicide framework, screening with C-SSRS or ASQ, postvention through WHO's BIC Program, and Safety Planning, etc.) should be the foundation of suicide prevention, early intervention, and risk reduction. Promoting the use of EBPs will be a key component of educating and supporting providers and organizations to respond to the needs of individuals with an appropriate response and intervention. Preparation and analysis of areas of improvement can be completed via the Workforce Readiness survey within the Zero Suicide toolkit.

Clinical Practice Guidelines

In collaboration with partners at the DBHIDS Division of Community Behavioral Health, DBHIDS will develop and publish Clinical Practice Guidelines for Safer Suicide Care. This will be used to inform the behavioral health provider network on standards of care and best practices for suicide prevention in treatment settings. The Clinical Practice Guidelines will promote suicide prevention through universal screening strategies as well as discharge planning and postvention efforts. Development of the Clinical Practice Guidelines will create a foundation on which to build more direct suicide care into the public behavioral health system through our relationships with provider agencies.

Crisis Response Centers

In July 2022, DBHIDS helped roll out the national launch of 988 services to better respond to the community mental health crisis. This service contributes to the work done by regional Crisis Response Centers (CRCs). CRCs offer the community no-wrong-door access to mental health and substance use challenges by accepting all walk-ins as well as ambulance, fire, and police drop-offs. CRCs specialize in varying populations by providing referral and assessment services. An optimal treatment package combined with efficient throughput will be the focus of the service, resulting in a connection to providers in the crisis and behavioral health treatment continuums aimed at stabilizing the individual outside of an inpatient level of care.

Those seeking relief at CRCs will receive individualized care aimed at preventing, resolving, or ameliorating a behavioral health crisis, reducing acute symptoms of mental illness, addressing social needs related to the behavioral health crisis, and preventing escalation of a crisis. To achieve these goals, CRCs will employ brief therapeutic observation and appropriate crisis management techniques which may support resolution of crisis without need for inpatient stay. Peer-support specialists may be

utilized in establishing rapport, sharing experiences, and strengthening engagement with individuals in crisis. Standardized lethality screenings, comprehensive risk assessments including CSSR, and discharge planning EBPs will be used across all CRCs, with this information incorporated into a pathway of care that offers structured follow-up and connections to services. CRCs fulfill a public-facing role in suicide prevention.

Philadelphia Crisis Line/988

The Philadelphia Crisis Line (PCL) is a nationally accredited 24/7 clinically staffed call center that provides crisis intervention capabilities for those in emotional distress.
The PCL is part of the National Suicide Prevention Lifeline network and adheres to its crisis intervention standards including screening, risk assessment, crisis intervention, safety planning, and follow-up practices. A comprehensive and integrated crisis network supported by advanced technology is essential to efficiently operating a crisis call hub, which in turn supports preventing tragedies of public and individual safety, civil rights, and extraordinary and unacceptable loss of lives while improving efficiency of resource allocation.

In 2022, PCL transitioned from the ten-digit National Suicide Prevention Lifeline number to three simple digits, 988. This transition is part of a nationwide system overhaul that mirrors that of the 911 emergency call system decades ago. Alongside this standardization, increased focus on mental health during the COVID pandemic starting in 2020 has led to additional federal funding for crisis expansion. Named “Crisis 2.0”, the expansion of the Philadelphia Behavioral Health Crisis System includes a new CRC, a Behavioral Health Urgent Care Center, and significantly more mobile teams. The process of expansion will continue through 2024.

Mobile Crisis/Crisis 2.0

Mobile crisis response teams are a critical component of a crisis system. Mobile crisis response teams provide community-based services that deliver resolution-focused and recovery-oriented behavioral health assessments and stabilization where the individual is experiencing the crisis and where the individual feels the most comfortable. The teams provide immediate crisis stabilization, de-escalation, behavioral health assessment, and crisis resolution to individuals within their homes, workplaces, or in the community. Mobile crisis response teams also work to reduce law enforcement intervention with individuals experiencing behavioral health crises to support a true justice system diversion. The teams can connect individuals to facility-based care as needed through warm hand-offs. The Philadelphia model is designed to deflect 911 calls out of the police response setting and into the Behavioral Health setting via the Philadelphia Crisis Line using a triage script and embedded behavioral health professionals within the 911 response center. The teams coordinate transport as needed, schedules follow-up appointments with preferred providers, and monitor the individual until the appointment takes place.

Mobile crisis response teams are a community branch of intervention and suicide prevention with direct ties and interactions with the community at-large and on a one-to-one basis. Ensuring a therapeutic response to behavioral health crises is a primary goal in removing trauma from behavioral health crisis response systems to engage communities and promote equity. Ongoing collaboration between DBHIDS and mobile team providers regarding risk assessments and safety planning through established evidence-based practice ensures alignment.

Discharge Planning

Discharge planning is a critical component of postvention and future prevention. This is accomplished by working with the individual from time of admission to develop a safe and successful transition plan that recognizes the importance of engaging the individual's family and support system and their preferred providers in the discharge process. The goal of discharge planning is to ensure the individual can maintain stability within the community and is connected to appropriate family, community, and behavioral health supports.

For discharge planning to be successful, it must incorporate safety. It must also include outpatient appointments that are logistically feasible and reasonably timed. Safety planning implementation should be tailored to each individual through collaboration and evidence-based practices. A discharge plan that does not incorporate safety planning and/or reasonable outpatient appointments is more likely to increase distress and lead to higher rates of readmission.

Conversation About Access to Lethal Means

Conversations about access to lethal means is a relevant practice for many socio-ecological levels. These include conversations about access to guns in the home, use of locked cabinets, and separation of ammunition from guns. Historically, these conversations occur between an outpatient provider and a client or during the discharge planning process. These conversations have been a valuable part of safety planning to create collaboration amongst the individual at risk, their family, and other accountable parties to share the responsibility of identifying and neutralizing potential lethal means in a person's living environment.

This approach can be tailored to a much wider audience to increase societal collaboration on lethal means safety. DBHIDS has data on lethal means and demographic data that can be analyzed to identify trends. These analyses can lead public and community messaging to maximize safety. We support the use of best practices in the conversations about lethal means between community members, clinicians and patients, and family members.

Transitions in Care

Transitions in care occur at many points of the crisis continuum and include aspects of suicide prevention, intervention, and postvention. It's important to consider escalating crisis response from an outpatient to inpatient setting and stepping down from inpatient to outpatient setting as transitions. Transitional periods for individuals in the crisis continuum can be the most vulnerable period for suicide attempts and increases in suicidal ideation.

DBHIDS promotes comprehensive discharge planning and evidence-based safety planning in various settings, but that can still leave an individual alone dealing with their stressors and attempting to navigate the behavioral health system. Applying approaches that involve warm handoffs between levels of care, creating a robust postvention system, and using data to drive the identification of gaps in transitions will reduce the likelihood of suicide attempts and ideation during this period.

Postvention

Postvention is a type of intervention that occurs after a crisis system interaction. This could be after an inpatient stay, after a particularly difficult outpatient session, or after a CRC/mobile crisis whether it led to hospitalization. Calling, texting, or emailing an individual after a crisis can display care for their well-

being and significantly reduce the risk of another crisis. It also offers an opportunity for further intervention, reinforcement of discharge/safety planning, help with logistics like medication or outpatient appointment management, and collection of feedback/data.

DBHIDS has created a Postvention Specialist position that will work on postvention efforts as a collaboration between crisis services and suicide prevention. This position will be trained via Philadelphia Crisis Line protocols and available gatekeeper trainings. Criteria will be set as to which individuals receive postvention efforts, and data will be collected on the effectiveness and efficiency of the process. Iteration of the process and analysis of the criteria will be needed to ensure the greatest impact of this new position. Data can be incorporated into Crisis 2.0 processes and existing suicide surveillance studies.

Health Economics

Attention to health economics means making smart investments that achieve greater value in service delivery, such as upstreaming services and interventions that reduce or avoid more restrictive, higher cost services downstream. Examples could include developing a strong network of community- and family-based supports such as peer-run or peer-led crisis respite/crisis residential facilities as an alternative to CRC visits and acute inpatient stays. Or ambulatory sobering units as an alternative to inpatient withdrawal management and law enforcement transport. Expanding the role of peers in crisis service delivery represents an opportunity to create efficiency in the crisis system. Leveraging the skills and experience of peers within community and clinical settings frees up licensed professionals and clinicians to focus on delivering more complex care. Investing in services that engage flexibly with participants over a longer duration (such as the Children's Mobile Intervention Service) may lead to avoiding readmissions and future attempts. Building all this on a foundation of paying for value (i.e., payment tied to specific, measurable outcomes) aligns incentives for providers to exercise fiscal responsibility while ensuring early identification and intervention of behavioral health crises.

The Economic Burden of Suicide

Suicide losses affect the emotional well-being of those left behind and have medical and productivity costs to society. Estimates from SAMHSA and the U.S. Department of Health and Human Services put the yearly cost of suicide between $70 billion and $93 billion. This includes medical intervention in response to individual suicides as well as estimates of lost productivity due to premature death. These estimates do not include the economic impact of those devastated by the suicide of a loved one, which can also include medical costs and lost productivity. This burden can be mitigated with improvements to continuity of care shown by a 2015 study that estimated a six-to-one cost-benefit ratio with increases to medical, counseling, and linkage services.[9]

Cost-savings Mechanisms

Cost-saving mechanisms can be incorporated along the continuum of DBHIDS suicide prevention efforts. Overarching the entire suicide prevention system is the cost savings related to lost productivity and medical intervention realized when suicide prevention efforts successfully divert an attempt. The overall

[9] Shepard DS, Gurewich D, Lwin AK, Reed GA Jr, Silverman MM. Suicide and Suicidal Attempts in the United States: Costs and Policy Implications. Suicide Life Threat Behav. 2016 Jun;46(3):352-62. doi: 10.1111/sltb.12225. Epub 2015 Oct 29. PMID: 26511788; PMCID: PMC5061092.

effectiveness in reducing frequency of attempts, lethality of attempts, and overall suicide deaths will lead to the single greatest cost-saving measure. Smaller-scale savings exist in the form of value-based payments, implementation of evidence-based practices, and incorporation of peer specialists. Value-based payments will tighten the criteria for reimbursement for providers and, in turn, reward the quality of care over the quantity of care. Implementation of evidence-based practices, such as approved screenings and assessments, can reduce areas where individuals would potentially "fall through the cracks" of the system and add to the economic burden of an attempt or suicide loss. Incorporating certified peer specialists into work areas can increase patient engagement with resulting improvements in treatment, retention, and treatment adherence. Peer specialists also enhance the quality of services because they have been shown to be effective in peer advocacy.

Infrastructure and Intelligence

Infrastructure and intelligence refer to bolstering the infrastructure of DBHIDS by utilizing data in a more efficient manner to drive decision making and strategy development. The use of qualitative and quantitative data across suicide prevention efforts is essential in building a public health approach. Suicide prevention data will facilitate transparency and accountability in operationalizing the suicide prevention framework. Up-to-date, relevant business intelligence will facilitate a transition from reacting to deaths by suicide to proactively preventing suicide death.

Research and Evaluation

Syndromic Surveillance

Public health surveillance is defined by the Centers for Disease Control and Prevention as, "the ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice."[10] While this is a cornerstone of public health practice, the approach is relatively new to suicide prevention. Suicide can be treated similarly to infectious and chronic disease in that it can be monitored from a systemic lens to identify trends and develop appropriate prevention interventions.

DBHIDS has developed a novel syndromic surveillance system in partnership with Philadelphia's Medical Examiner's Office and the Philadelphia Department of Public Health to monitor suicide deaths and attempts in Philadelphia. Data included in syndromic surveillance efforts includes deaths by suicide, suicide-related emergency department visits to all Philadelphia hospitals, and encounter data among the Medicaid populations of behavioral health services with suicidal thoughts, ideations, or attempts identified in the diagnosis. DBHIDS has also developed a new data management system and dashboard, QLIK. Syndromic surveillance data is initially added to a storage warehouse, prepared for use, and uploaded into the QLIK application database for visual data representations, manipulation, and review. A team of public health professionals review syndromic surveillance quarterly and make recommendations as appropriate.

New data can and should be considered to bolster syndromic surveillance efforts to measure suicide attempts and ideation. As DBHIDS works to expand and enhance Philadelphia's crisis system, special consideration to suicide-related data collection should be considered and included in syndromic surveillance efforts.

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https://www.cdc.gov/training/publichealth101/surveillance.html

Research Projects

DBHIDS has participated in innovative research opportunities with academic partners. Our work includes a longitudinal, retrospective analysis of 15 years of suicide deaths and the decedents' interactions with the public behavioral health system, prison system, and homeless/shelter system. This research aims to identify risk factors for suicide among vulnerable populations. The findings of this research are delivered to the Philadelphia Suicide Prevention Task Force and DBHIDS leadership to inform suicide prevention programming and policy.

DBHIDS will continue to partner with academia to advance the research efforts in suicide prevention. Future research projects can include a focus on special populations, including individuals with a history of incarceration and veterans. Additionally, the research will continue to consider the intersections of various systems and the impact these systems have on the outcome of suicide for individuals with multiple system interactions.

Fatality Review

Fatality review is a public health practice designed to identify and understand risk factors for death. It is a collaborative process that requires cross-system participation with the intention of identifying patterns, trends, and factors that contribute to mortality. The Philadelphia Medical Examiner's Office hosts several fatality review programs, including child non-homicide fatality review, in which children who die by suicide in Philadelphia are reviewed. There is no fatality review program for adults who die by suicide in Philadelphia.

DBHIDS and Community Behavioral Health have established an internal process to review deaths by suicide of individuals who had received behavioral health service within 90 days of the date of death in the Medicaid behavioral health system. This review process is required of the Managed Care Organization under the HealthChoices contract with the Commonwealth. The purpose of this review is to identify trends across suicide deaths and gaps in the treatment system that can be improved upon. Over time, the adult suicide fatality review hosted jointly by CBH and DBHIDS will expand to include more City departments to access more information on individuals who die by suicide in Philadelphia. Participating departments shall be informed by the suicide prevention research study as it works to identify risk factors and may include the Department of Humans Services, the Department of Prisons, and the Office of Homeless Services.

The qualitative data collected through fatality review will be used to inform suicide prevention efforts and develop a culture of cross-system collaboration, working as one city in the fight against suicide.

Suicide Prevention Annual Report

DBHIDS will publish an annual report on suicide-related data and statistics for Philadelphia County. This report will provide transparency and highlight the work of DBHIDS relating to suicide prevention. Critical issues and special populations will be highlighted through the innovative use of data in the report. Disseminating knowledge is a key part of the public health approach to suicide prevention. External stakeholders will be able to refer to the report for their own presentations or efforts to prevent suicide in their respective fields. The report will position DBHIDS as a leading voice in suicide prevention for the City of Philadelphia.

Innovation

The Suicide Prevention Strategic Framework sets forth innovative solutions to reduce suicide at the systemic, community, and individual levels. Innovative use of data and infrastructure allows for real-time response to a complex public health problem. The proposed initiatives will utilize innovative public health approaches to crisis treatment to transform the city's approach to suicide, from clinical care to policy-level interventions.

Suicide Prevention Task Force

The Philadelphia Suicide Prevention Task Force is a diverse group of researchers, clinicians, behavioral health providers, community members, and individuals with lived experience. The task force acts as an advisory group that guides suicide prevention efforts through a collaborative, cross-systems approach. The goal of the task force is to drive suicide prevention strategy across Philadelphia, share relevant updates and information, and elevate the importance of suicide prevention through advocacy and awareness.

Future directions for the task force include:

- Targeted outreach to groups not represented on the task force, including the faith-based community, LGBTQ+ community, and first responders, along with an increased presence of people with lived experience.
- Establish working subcommittees focused on achieving small, manageable tasks.
- Increasing engagement and visibility within community.
- Develop and disseminate resources and materials, including Clinical Practice Guidelines, Safe Reporting Guidelines, etc.

Peer Inclusion/Advocacy

The suicide prevention work will include peer inclusion and advocacy at every level of intervention. A key partnership in elevating survivor voices is with American Foundation for Suicide Prevention and the annual Out of the Darkness Walk. The annual event is a time to highlight the work of DBHIDS publicly and to uplift the voices of survivors in the fight against suicide. It is important that survivors feel seen and heard, and events such as the Out of the Darkness Walk function to increase the visibility of a group that is often stigmatized and in the shadows.

DBHIDS will work towards increased inclusion of lived experience on the Suicide Prevention Task Force, specifically in leadership positions to advance the mission and vision of the Task Force. Through participation, individuals with lived experience will create opportunities for peer advocacy to promote inclusion in programming and policymaking.

Examples of key roles for the inclusion of survivors include:

- Leadership roles on the Suicide Prevention Task Force.
- Survivors of Suicide Loss Support Groups – facilitated by survivors of suicide loss.
- Advocacy and storytelling for educational and awareness purposes.
- Postvention and assisting people in navigating resources and supports after a loss.
- Communications and messaging tailored to survivors of loss or attempt survivors.
- Peer support programming for people experiencing suicidal thoughts or attempts.

One area critical for peer inclusion is to advocate for increased peer specialist programming within the behavioral health crisis system. Peer support in behavioral health care is correlated with reduced rates

of suicide death and attempt.[11] People with lived experience can advocate for peer support programming throughout the behavioral health system to support individuals with suicidal ideation at any access point.

Suicide Prevention Policy

Lethal Means Restriction

Around half of the deaths by suicide in Philadelphia County involve a firearm. The suicide prevention work of the Department will take an active role in restricting access to firearms for the safety and security of individuals who experience suicidal ideation. This work includes collaboration with the Philadelphia Department of Public Health's Injury and Violence Prevention Unit, CeaseFire PA, and other organizations working towards common sense gun reform in the Commonwealth. Examples of policies that support lethal means restriction are Extreme Risk Protection Orders, background checks, encouraging safe storage in the home, or updated legislation regarding untraceable "ghost" guns. Suicide prevention efforts will use geographic data from the Medical Examiner's Office to determine "hot spots" of deaths by suicide and work to address the specific needs of that community at a policy level. Examples of addressing hot spots may include netting on bridges or safety turnstiles at specific train stations. DBHIDS may partner with SEPTA to work towards Zero Suicide deaths in the county's transit system.

Safe Reporting Guidelines

Reporting on suicide in the media can have a contagion effect, especially among youth, and must be done responsibly. DBHIDS will serve as a leader in suicide prevention language and talking points for local media sources to speak on suicide. This will include issuing a safe reporting guidelines toolkit for public use, as well as acting as a consultant on ad hoc requests that arise when a prominent figure dies by suicide in the county. Additionally, the Suicide Prevention Coordinator will support the work of the DBHIDS Network of Neighbors Trauma Response Network to encourage safe communications around death by suicide in the community, including in schools or other settings.

Value-based Payments

Value-based payments will change the way CBH reimburses its providers and change the way providers render their services to patients. At the core of value-based payments are best practices and key metrics to create maximum quality in the services rendered to the patient while efficiently managing resources to care for the community. Key metrics and best practices are determined by CBH through a process of service valuation driven by data. DBHIDS' data and subsequent analyses can be used to inform and help guide the key metrics established by CBH by determining, for example, the best level of care needed for individuals at risk, which in turn is matched with the best therapeutical approach to respond to the care needs.

[11] Bowersox, N. W., Jagusch, J., Garlick, J., Chen, J. I., & Pfeiffer, P. N. (2021). Peer-based interventions targeting suicide prevention: A scoping review. *American journal of community psychology*, *68*(1-2), 232-248.

What's Next

DBHIDS is seeking to expand and improve programming and policy related to suicide prevention across the socioecological continuum. Through discussions with stakeholders, including academicians, researchers, clinicians, and individuals with lived experiences, DBHIDS is soliciting information and ideas to re-imagine suicide prevention citywide.

DBHIDS serves the city's most vulnerable individuals, families, and communities as evidenced by our longstanding commitment to recovery, resilience, and self-determination. As the leader of Philadelphia's public behavioral health system, DBHIDS is uniquely positioned to approach suicide prevention from a public health angle, treating individuals and communities so that all Philadelphians can thrive.

Please see Appendix A for key deliverables and a Gannt chart that outlines next steps in the suicide prevention framework.