



2018 ZERO SUICIDE WORKFORCE SURVEY SUMMARY

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Zero Suicide Workforce Survey Introduction

This report presents results from the 2018 Utah Zero Suicide Workforce Survey that focused on assessing the status of Behavioral Health Workforce statewide. The purpose of the survey is to inform state leaders about how professional staff feel about their capacity to effectively respond to the needs of clients or patients who may be at risk of suicide. Specific topics in the survey include employee knowledge and skills related to suicide screening and risk assessment, patient care and service delivery, organizational supports, and priority training needs.

The online survey was emailed to the DOPL list of licensed health professionals. The survey was open for a 6-week period from April 17, 2018 to May 15, 2018. A total of 5,038 surveys were collected.

A previous Behavioral Health Workforce Suicide Prevention survey was conducted in 2013 which included a number of similar questions. Results from those survey findings are compared to the 2018 findings in vertical bar charts throughout this report for contextual comparison (direct comparison is not possible due to the minor differences in question wording between the two surveys).

Understanding the Format of the Charts

There are three types of charts used in this report. There are several graphical elements common to all the charts. Understanding the format of the charts and what these elements represent is essential in interpreting the results of the 2018 Utah Behavioral Health Workforce Suicide Prevention Survey.

Most of the questions on the survey were scored based on a 5-point Likert Scale with responses: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), and Strongly Agree (5). The horizontal bar charts represent the range of scores (percentage) by those who responded to a given statement or question. The bars represent the entire possible range of answers for each survey item. Each set of differently colored bars (tan-to-grey-to-blue/green) represent the cumulative responses to each of the 5-point ratings provided by survey respondents. Each bar chart displays the total percent responses with the left hand side (tan) representing the total percent of Strongly Disagree and Disagree and the right hand side (blue/green) representing the total percent of Agree and Disagree. The neutral response is also depicted in the center of the chart (in grey). The graphs with vertical bar charts are two-fold. The first, display only survey findings from 2013 and 2018 on specific questions or statements that could be compared. The second vertical charts represent “composite” questions or statements that are grouped, based on similar content. Many of the displays (both figures and tables) include response comparison by respondents working in Physical Health Care, Behavioral/Mental Health, or “Other” categories of health care.

Section 1. Respondent’s Work Environment. The first series of questions in the survey asked respondents to report on characteristics of their work environment and their role within that environment:

Question 1 - Assesses whether the respondent works in an inpatient setting, outpatient setting, or both settings. All survey respondents were asked this question.

Figure 1. Respondents by work setting type

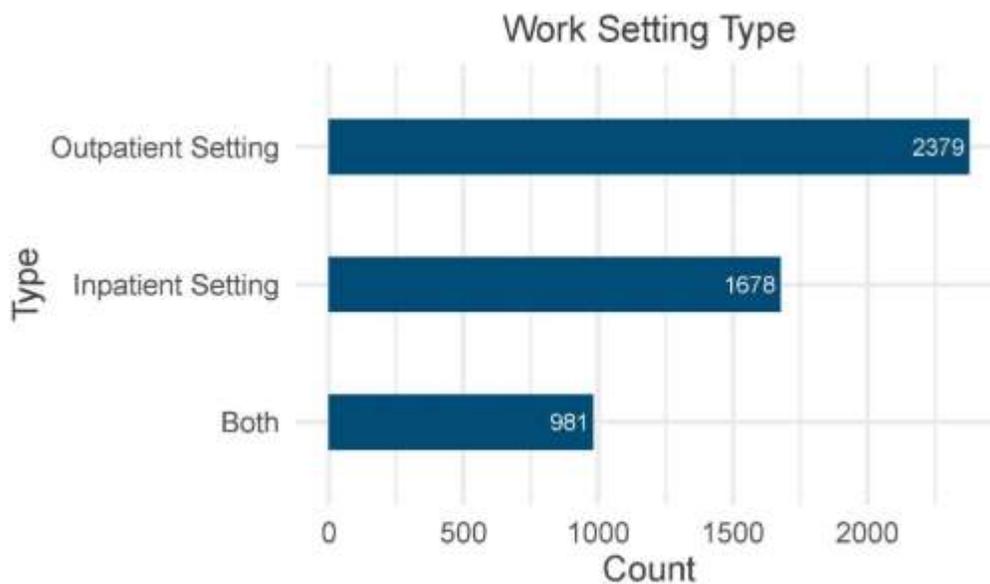
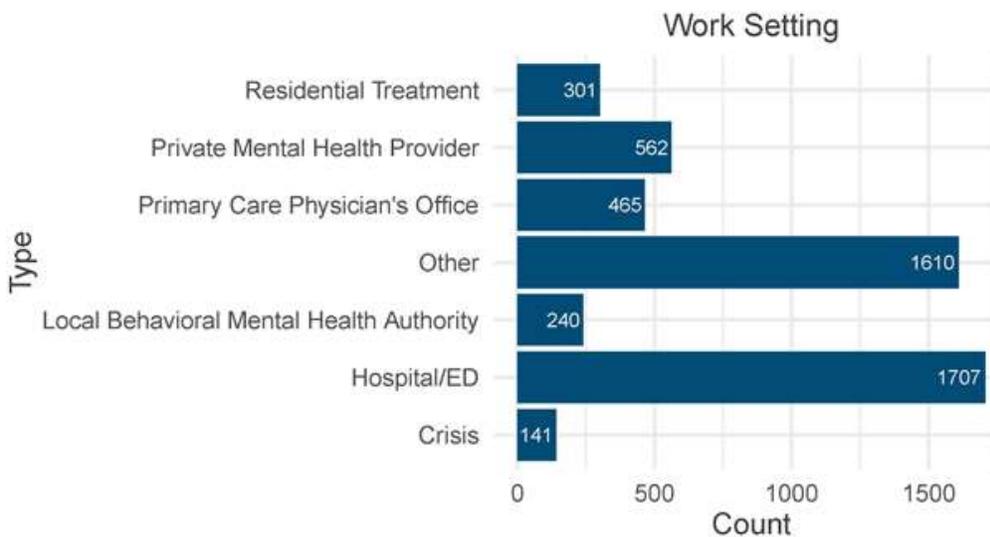


Figure 1 above indicates 47 percent of respondents selected “outpatient setting” as their type of work environment. Thirty-three percent identified “inpatient setting”, and 20 percent selected “both” setting types.

Figure 2. Respondents by specific work setting



In Figure 2 above, “Hospital/Emergency Department” (34%) and “Other” (32%) were selected by the majority of respondents as their specific work setting. Of the 1,610 who identified “Other” as their primary work setting, 1,055 (66%) were in outpatient settings, 247 (15%) were in inpatient settings, and 308 (19%) indicated they worked in both setting types.

Question 2 - Respondents were asked to identify their primary professional role according to a list of employment categories. All survey respondents were asked this question.

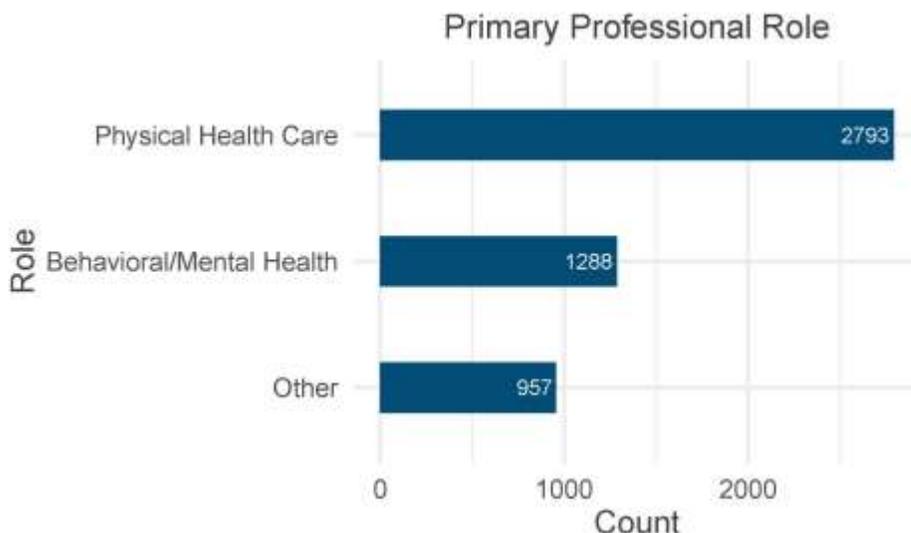
Table 1. Respondent’s primary professional role by employment category

Professional Role	N
Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)	49
Behavioral Health Clinician (Counselor, Psychologist, Social Worker, Substance Abuse Counselor, or Therapist)	1,180
Business, Administrative, and Clerical (Accounting, Reception, Human Resources, Billing, Records, Information Technology)	37
Case Management	238
Crisis Services	65
Facility Operations (Dietary, Housekeeping, Maintenance, Security, or Transportation)	2
Management (Administrators, Supervisors, Managers, or Coordinators)	410
Nurse	1,882
Patient Observer	10
Physical Health Care / Medication Management (Physician, Nurse Practitioner, or Physician’s Assistant)	911
Psychiatry (Psychiatrist, Psychiatric Nurse Practitioner)	91
Support and Outreach (Outreach, Faith, Family Support, Peer Support)	35
Technician (Mental Health Technician, Behavioral Technician, Patient Care Assistance, or Residential Technician)	17

In Table 1 above, the highest number of respondents identified their primary professional role as “Nurse” (37%), “Behavioral Health Clinician” (23%), “Physical Health Care/Medication Management” (18%), Management (8%), and “Case Management (5%).

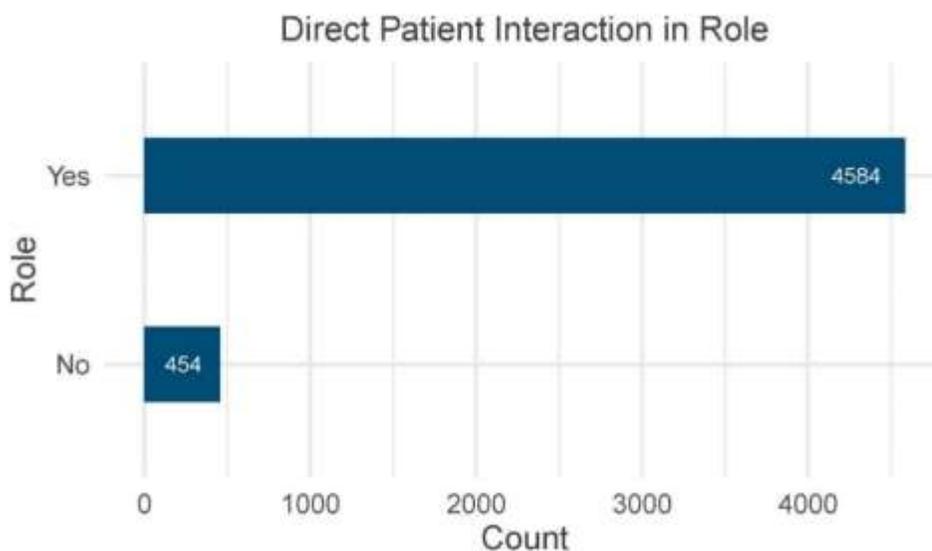
In Figure 3 below, “Physical Health Care” (55%), “Behavioral / Mental Health” (26%), and “Other” (19%) were selected by the respondents to describe type of health care setting where they were employed. Those in the “other” category include those in administration, business, clerical, case management, education, facilities, and outreach.

Figure 3. Respondent’s primary professional role by health care type



Question 3 - Respondents were asked if they directly interact with patients during their day-to-day duties. All survey respondents were asked this question. Figure 4 below shows that ninety-one percent (N=4,584) of respondents directly interacted with patients.

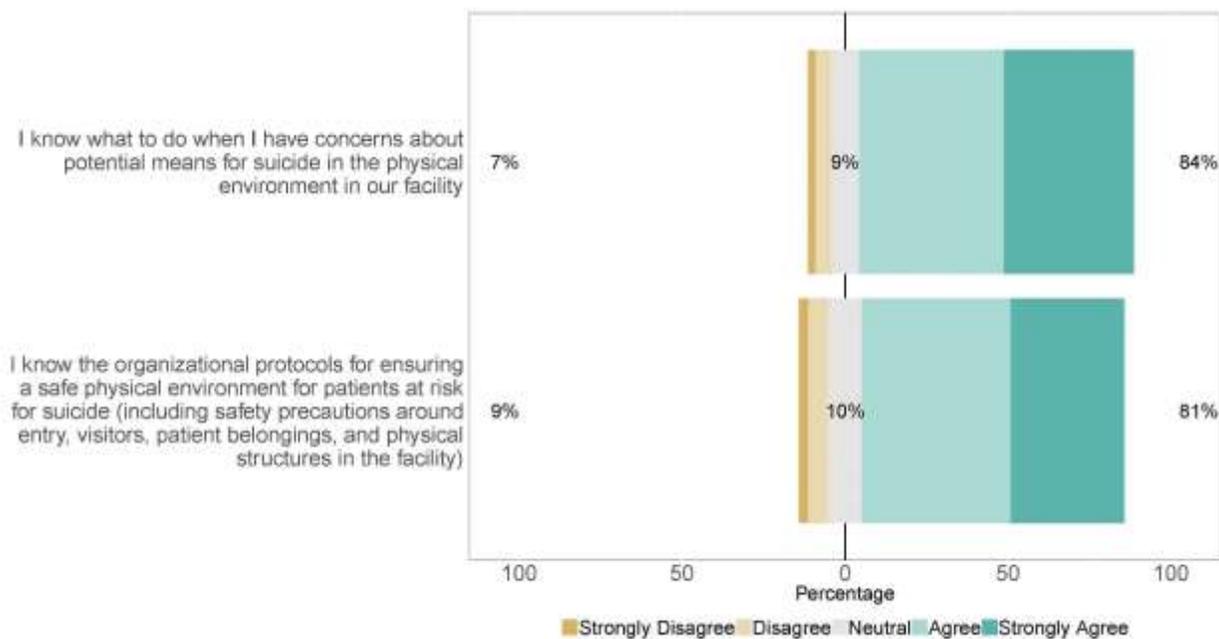
Figure 4. Respondents with a direct patient interaction



Question 4 - This was a two-part question examining perceived safety of the physical environment. Responses are only from those who reported they work in an inpatient setting (N=1,678).

Figure 5. Respondent's perceived safety of their physical environment

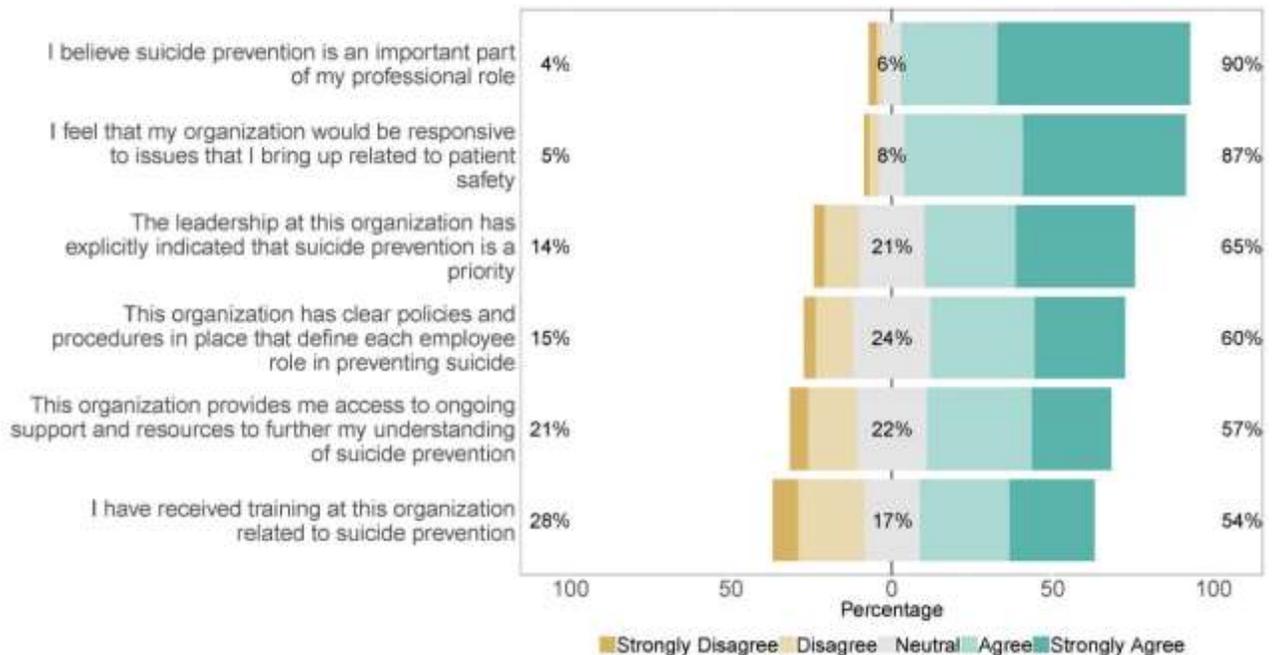
In Figure 5 below, eighty-four percent of respondents either “agree or strongly agree” that they know what to do when they have concerns about potential lethal means for suicide are present in the facility and a similarly high response (81%) report knowing the organizational protocols for ensuring a safe physical environment for patients.



Section 2. Suicide Prevention within the Work Environment. The questions in this section ask respondents to reflect on the status of suicide prevention within their work environment.

Question 5 - A series of questions focusing on suicide prevention within the organizational work environment. All survey respondents were asked these questions.

Figure 6. Suicidal prevention within the organizational work environment



In Figure 6 above a very high percent of respondents agree or strongly agree that “suicide prevention is an important part of their professional work” (90%), and 87% indicate their “organization would be responsive to issues . . . related to patient safety”. Given these strong endorsements, it is surprising that there is more than a 30% reduction in respondents indicating their organizations “provide support and resources” (57%) and “training” (54%) related to suicide prevention.

In figures 7 – 12 below, the questions in Figure 6 above are categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care. Clearly, it is worth noting the significant difference in responses between those employed in Physical Health Care compared to those employed in Behavioral/Mental Health Care in Figures 8 (Organizational priority of suicide prevention, **56% vs 84%**), 9 (Organization’s policies and procedures regarding employees role in suicide prevention, **54% vs 74%**), 10 (Respondent’s received training, **44% vs 72%**), and 11 (Respondent’s receiving ongoing support and resources, **49% vs. 73%**).

Figure 7. Respondent's belief about suicide prevention by category of health care

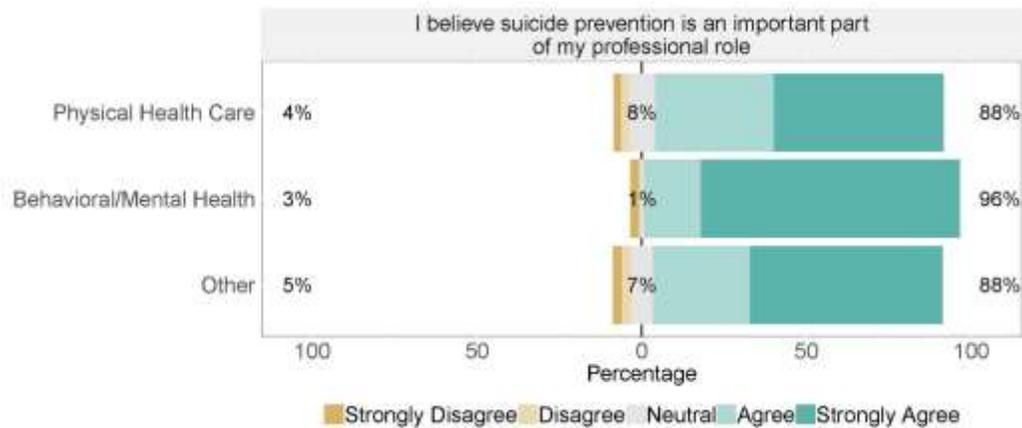


Figure 8. Respondent's belief about organizational priority of suicide prevention by category of health care

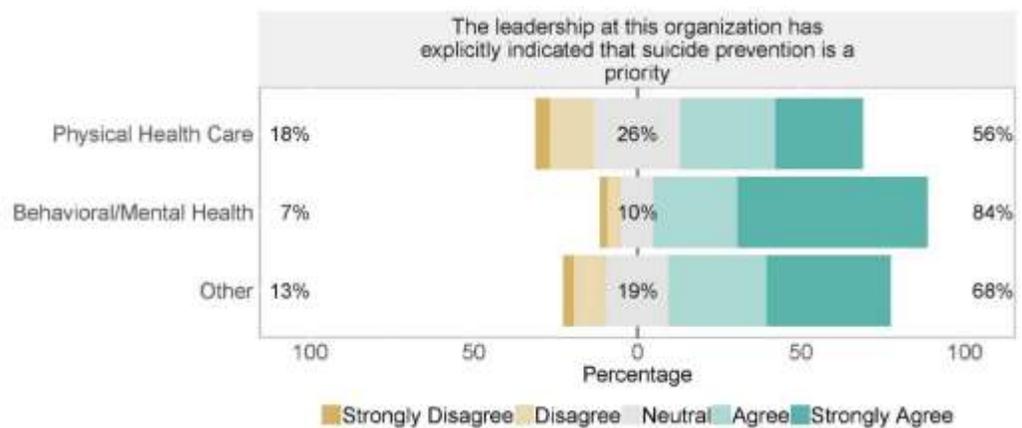


Figure 9. Respondent's belief about their organizations policies and procedures regarding employee's role in preventing suicide by category of health care

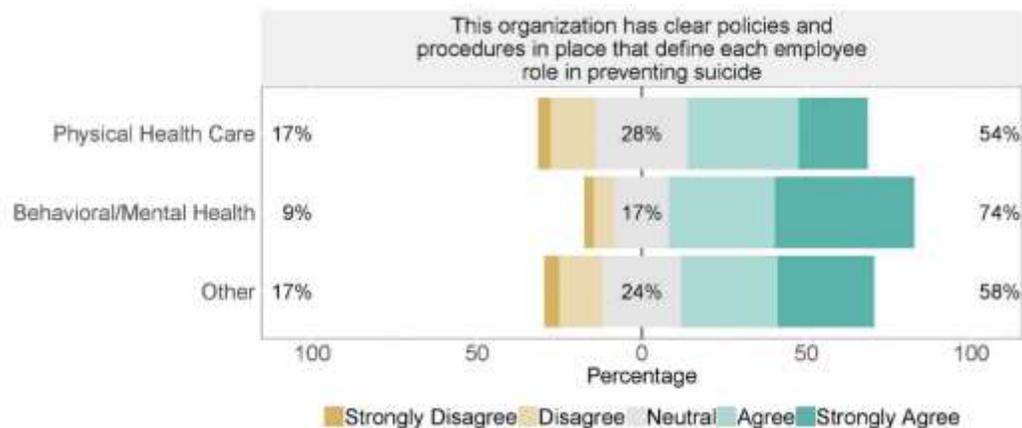


Figure 10. Respondent's received training related to suicide prevention by category of health care

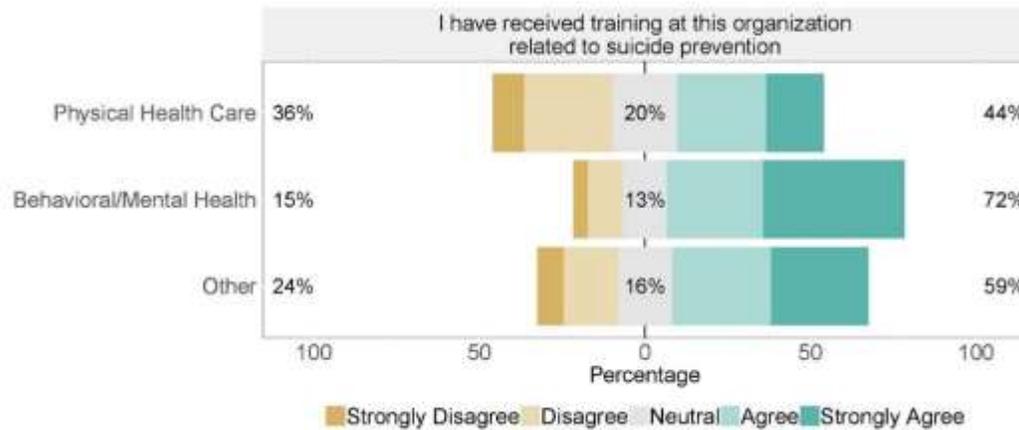


Figure 11. Respondents receive ongoing support and resources related to suicide prevention by category of health care

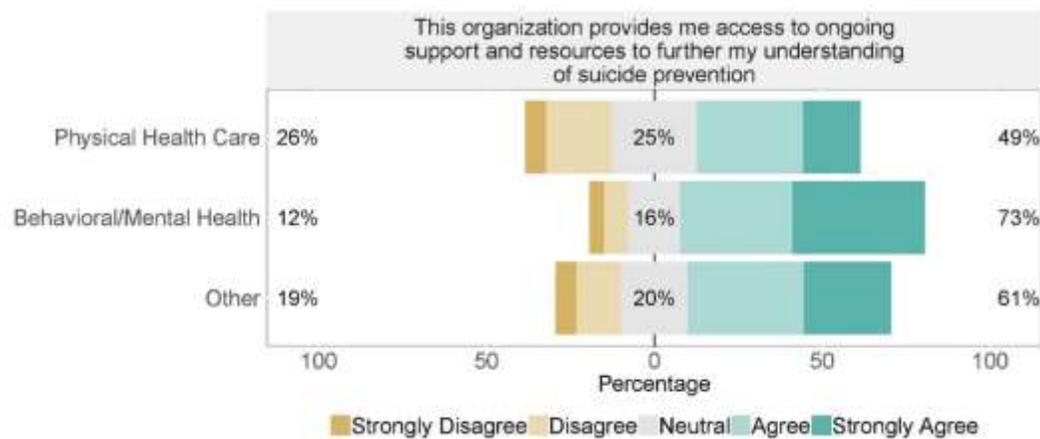


Figure 12. Respondent's feelings about organizational response to patient safety by category of health care

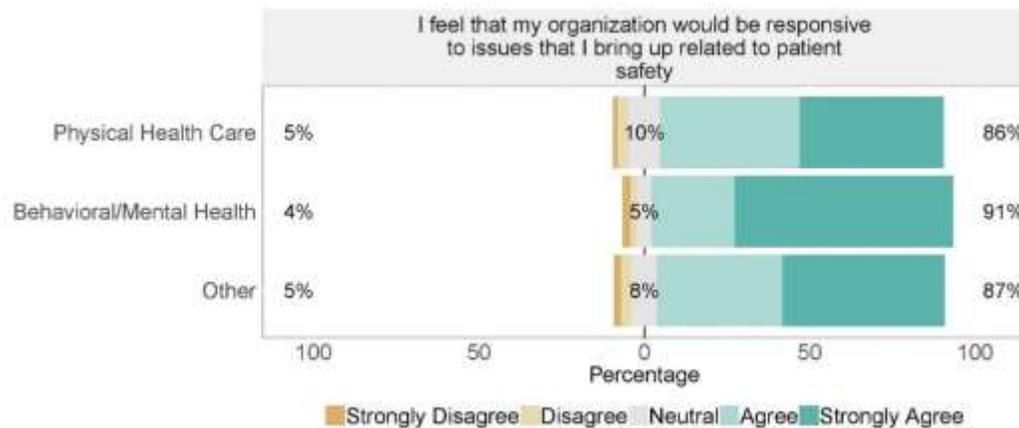


Figure 13. I have received training related to suicide prevention: 2013 vs. 2018

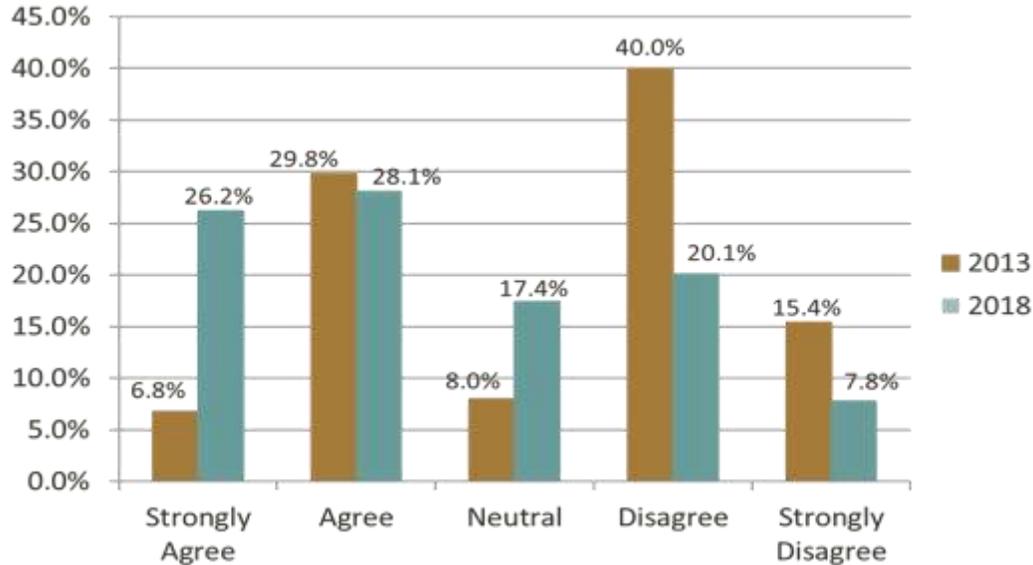


Figure 13 above provides a comparison between 2013 and 2018 for respondents indicating they worked in Physical Health Care, Behavioral/Mental Health, or Other categories of health care on whether they had “received training on suicide prevention”, with 54% in 2018 “agreeing or strongly agreeing” they had received training, while only 36% of 2013 respondents indicated they had received training. In figure 14 below, 57% of the 2018 respondents compared to 48% of the respondents “agreed or strongly agreed” that their organizations provided access to ongoing support and resources to further the respondents understanding of suicide prevention.

Figure 14. Organization access, ongoing support, and resources to further my understanding of suicide prevention: 2013 vs. 2018

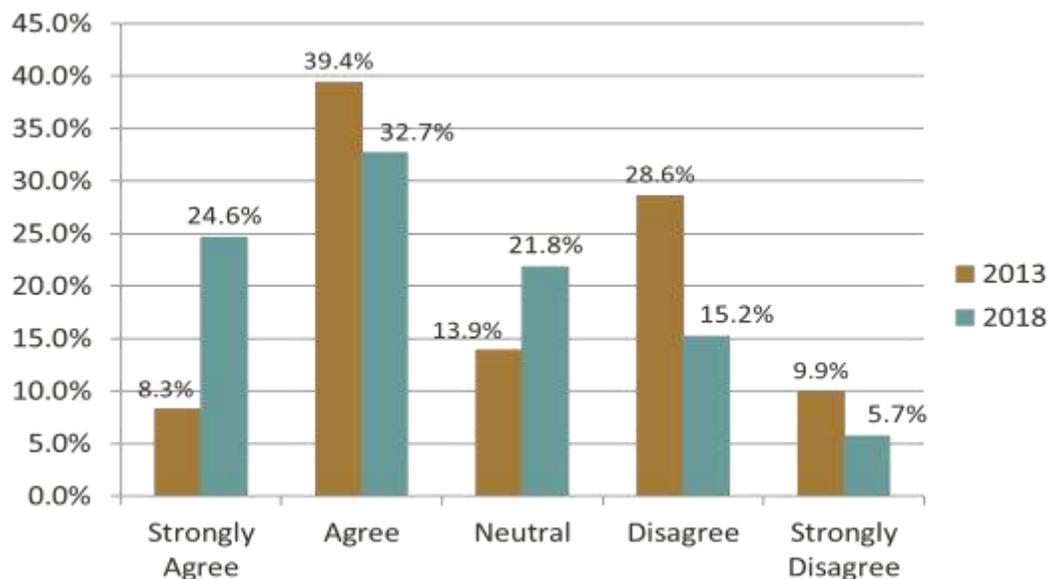


Figure 15. 2018 summary of organizational response to suicide prevention

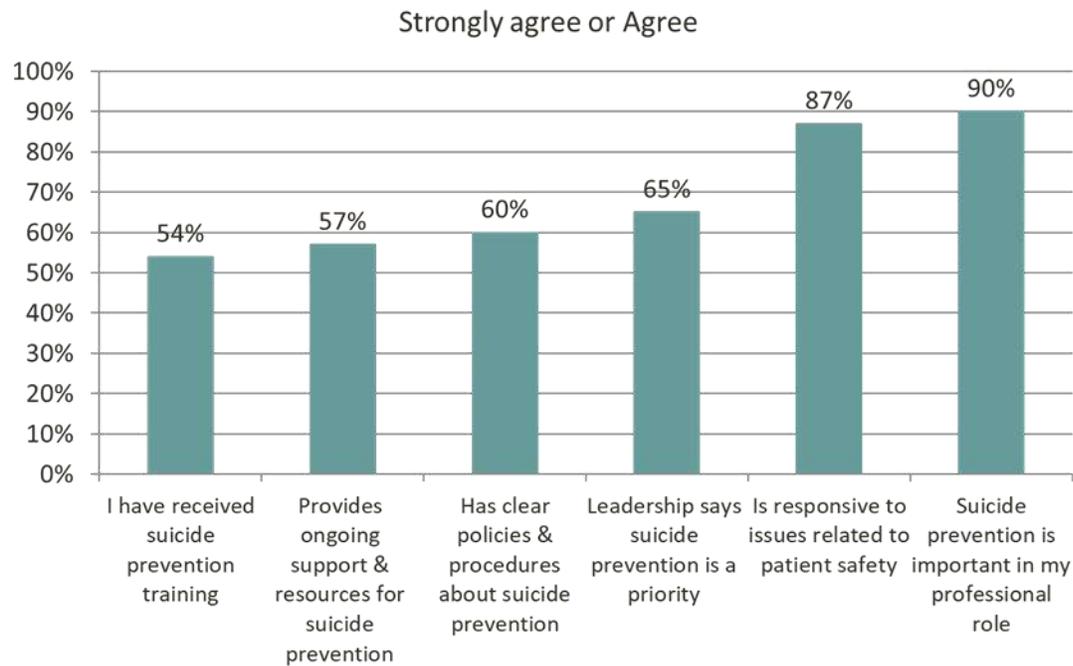


Figure is a composite summary of 2018 respondents “agreeing or strongly agreeing” to various questions associated with Section 2 questions which describe the components of suicide prevention within the organizational work environment (no 2013 data available for comparison).

Question 6 - Interaction with a Patient Who Ended his or her life.

Table 2. Respondents who have interacted with a patient who died by suicide

While working at this organization, I have directly or indirectly interacted with a patient who ended his or her life by suicide.	
I don't know	784 (15.56%)
No	2,468 (48.99%)
Yes, it has happened more than once	815 (16.18%)
Yes, it happened once	542 (10.76%)

Figure 16. I have interacted with a consumer who ended his/her life by suicide: 2013 vs. 2018

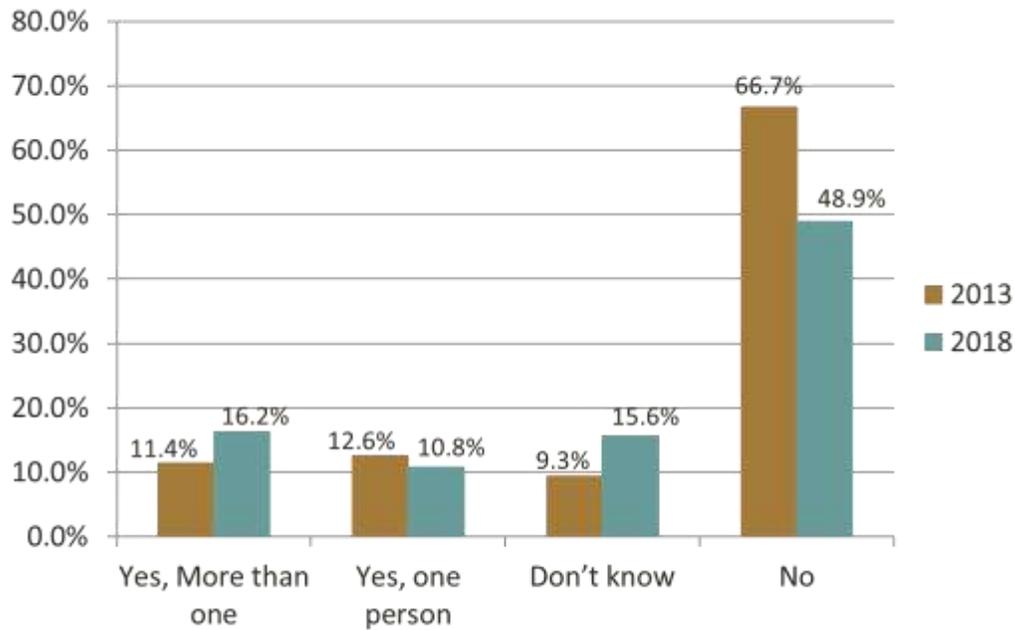
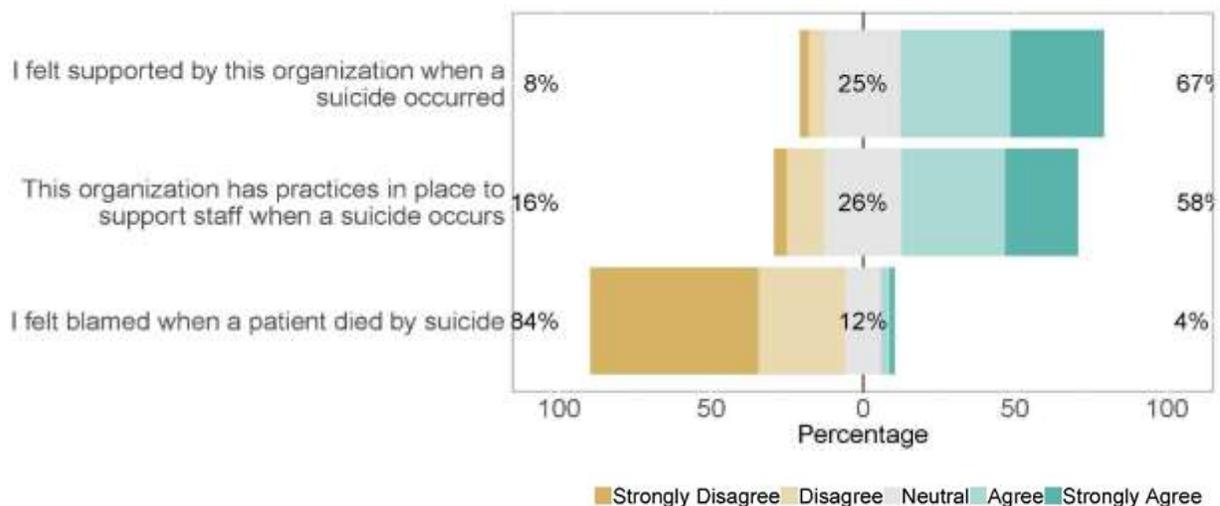


Figure 16 above summarizes the differences between 2013 and 2018 on whether respondents had interacted with a consumer who ended his or her life by suicide. A slightly higher number of respondents in 2018 (27%) than 2013 (25%) had interacted with one or more persons who died by suicide.

Question 7 - Organizational Supports Following Suicide: A three-part question about organizational supports following a suicide. Only survey respondents who reported that they interacted with a patient who ended his/her life by suicide responded to these questions.

Figure 17. Responses regarding organizational supports following a suicide



In figures 18-19 below, the questions in Figure 17 above are categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care.

Figure 18. Respondent's beliefs regarding organizational supports following a suicide by category of health care.

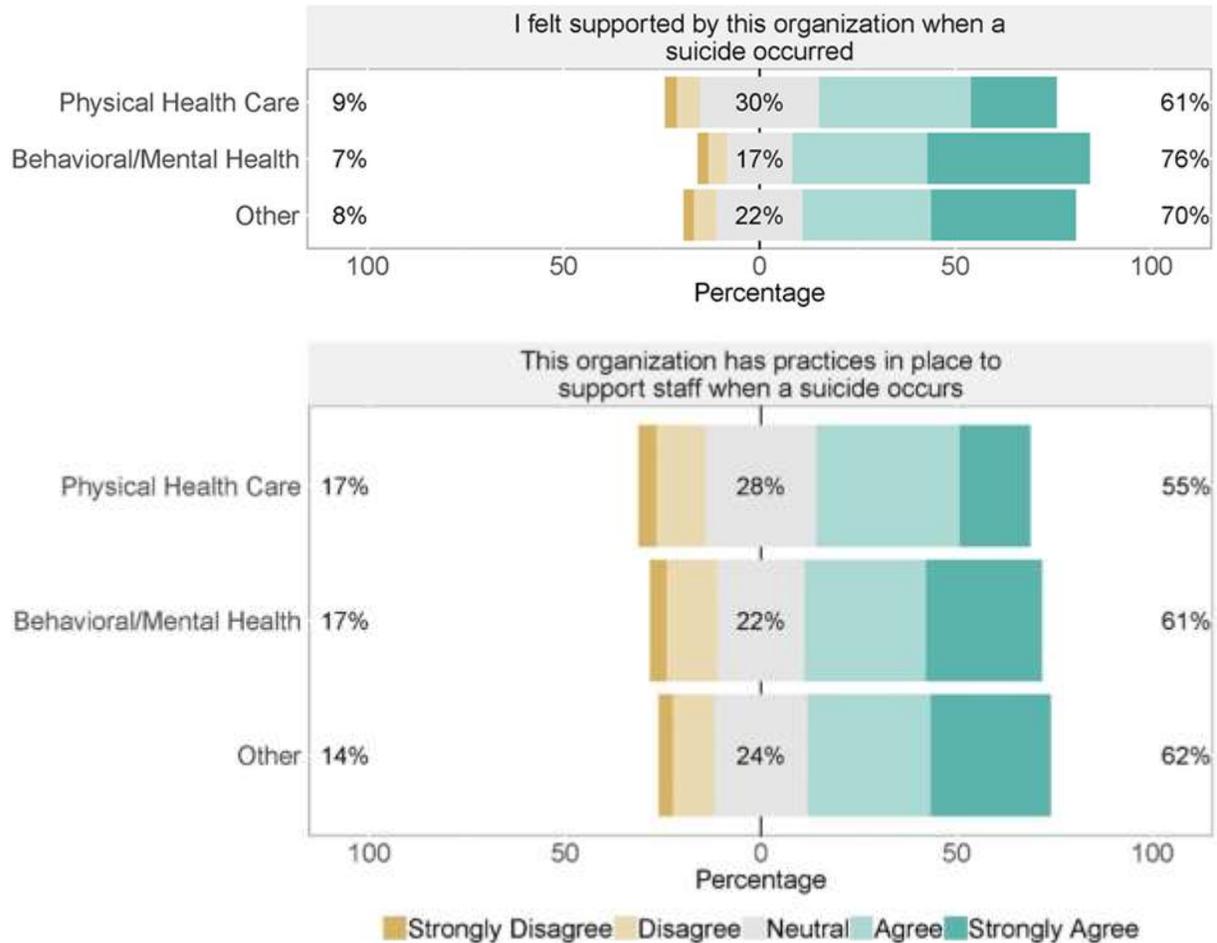


Figure 19. Respondent's beliefs regarding organizational supports following a suicide by category of health care

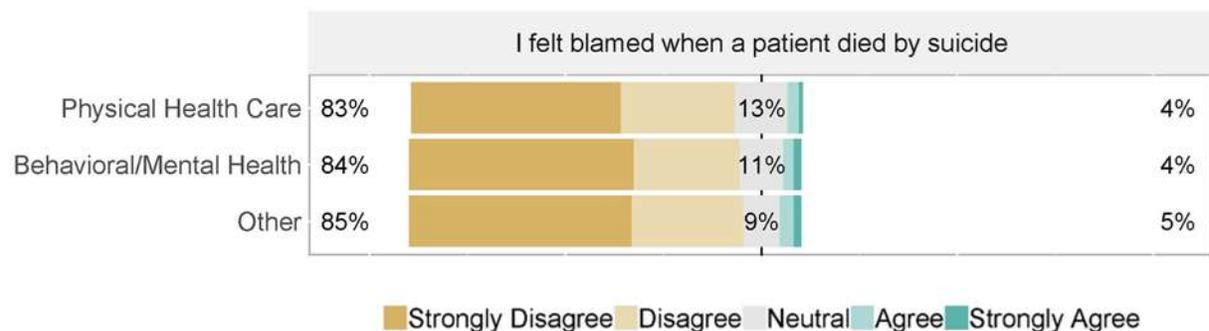


Figure 20. Organizational supports following a suicide: 2018

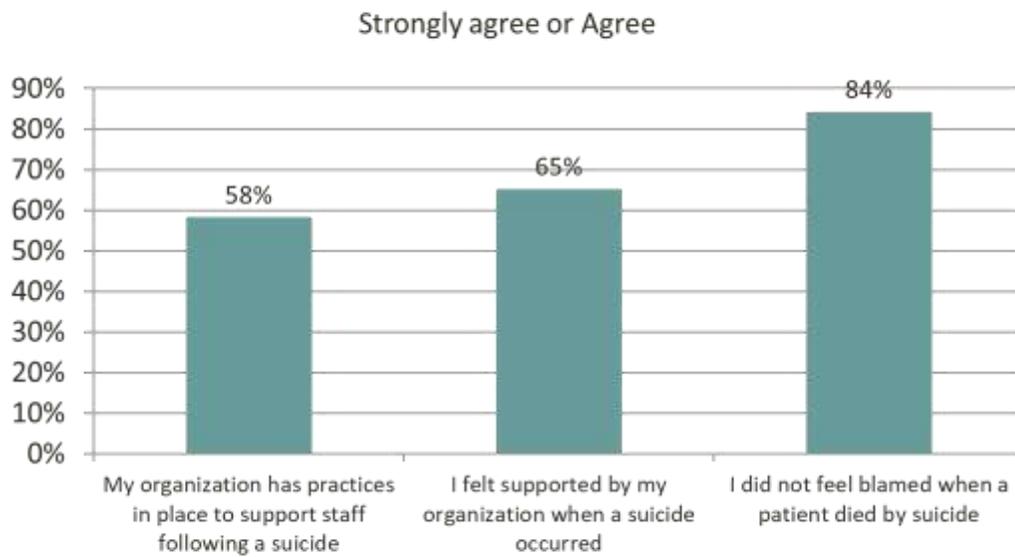


Figure 20 above is a composite summary of 2018 respondents “agreeing or strongly agreeing” to various questions related to the perception of the availability of organizational supports following a suicide (no 2013 data available for comparison).

Section 3. Recognizing When Patients May Be at Elevated Risk for Suicide. These questions examine respondent knowledge and comfort related to recognizing when a patient may be at elevated risk for suicide.

Question 8 - A four-part question about recognition and response when a patient may be at elevated risk for suicide. All survey respondents were asked these questions.

Figure 21. Respondent’s knowledge, comfort, and confidence in their ability to recognize and respond to patient’s who may be at elevated risk for suicide.

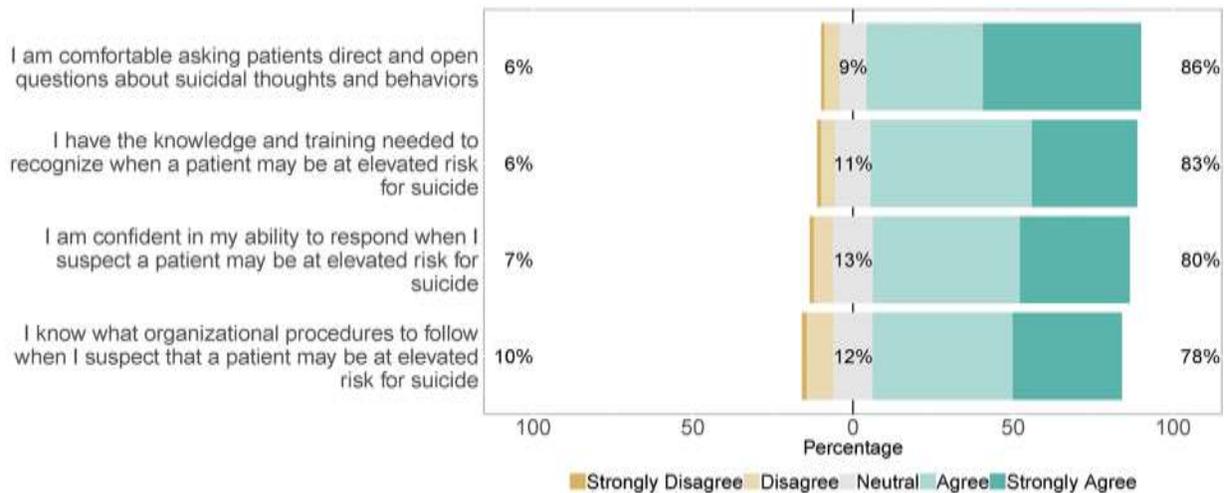


Figure 22. I am comfortable asking direct and open questions about suicidal thoughts and behaviors: 2013 vs. 2018

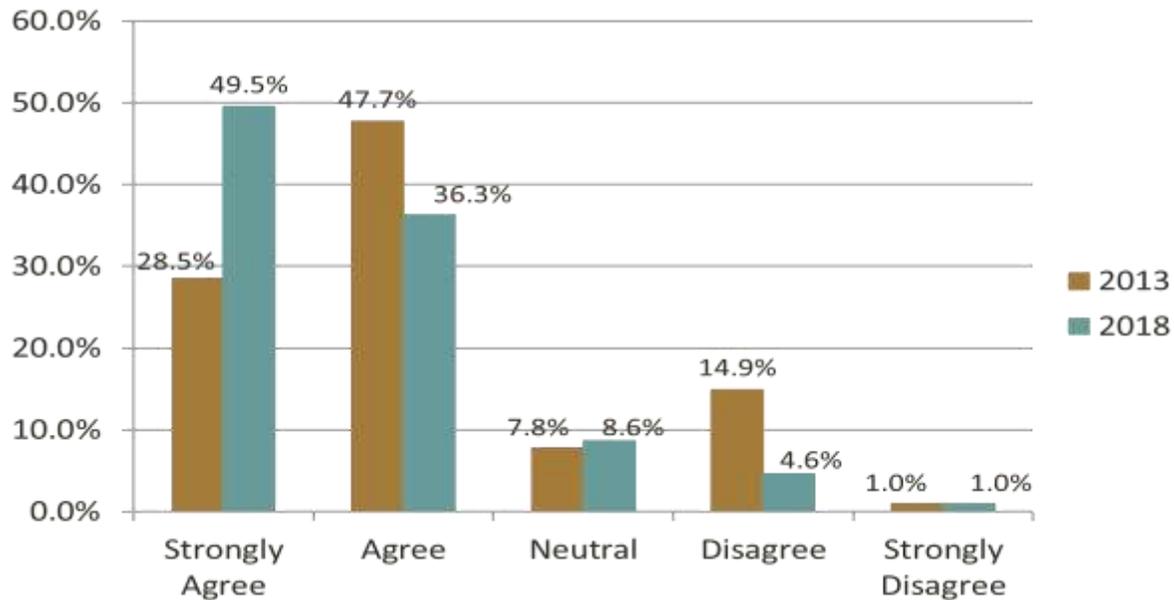


Figure 22 above summarizes the differences between 2013 and 2018 on respondents reported level of “comfort asking direct and open questions about patient suicidal thoughts and behaviors”. In 2018 (86%) the agreed or strongly agreed that they were comfortable asking those questions, while (76%) reported they were comfortable doing so in 2013.

Question 9 - Training on Recognizing Warning Signs: A single item about receipt of training on recognizing warning signs of elevated risk. All survey respondents were asked this question.

Table 3. Respondents reporting having received training on how to recognize the warning signs of suicide by employment category

Have you ever received training on how to recognize the warning signs that a patient may be at elevated risk for suicide?			
	NO	YES	N
Other	17.3%	82.7%	825
Behavioral / Mental Health	4.8%	95.2%	1,178
Physical Health	25.8%	74.2%	2,428

Question 10 - Training at Current Organization: A single item asking whether training on recognizing elevated risk was provided by the respondent's current organization. Only survey respondents who reported in Question 9 that they have received training in the past responded to this question.

Table 4. Respondents reporting they have received training on recognizing the warning signs of suicide at their current organization by employment category

Has your current organization provided you with training on how to recognize the warning signs that a patient may be at elevated risk for suicide?			
	NO	YES	N
Other	31.2%	68.8%	676
Behavioral / Mental Health	30.8%	69.2%	1,101
Physical Health	42.4%	57.6%	1,772

Figure 23. Recognizing patients at elevated risk for suicide: 2018

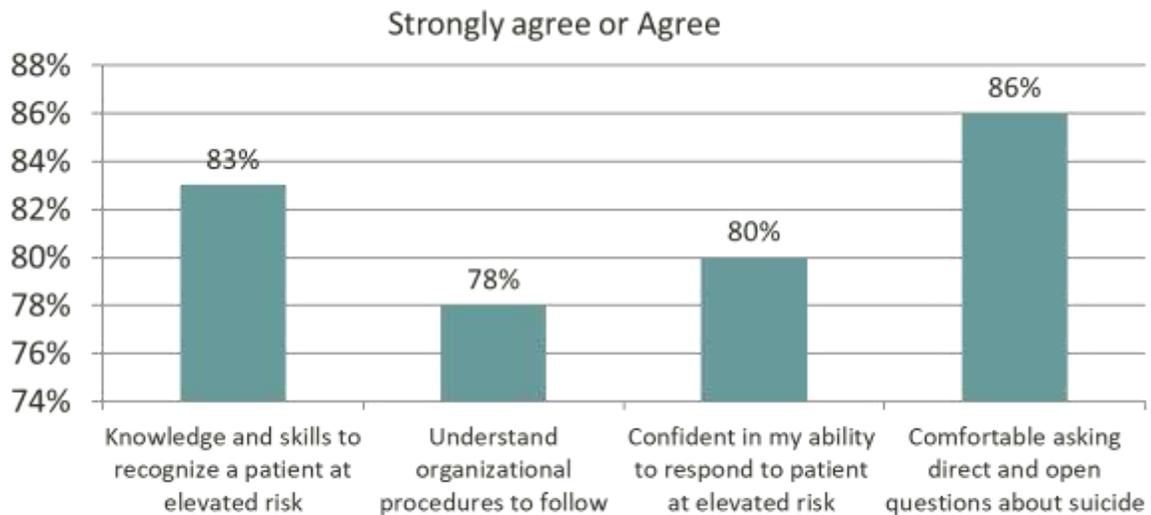


Figure 23 above is a composite summary of 2018 respondents “agreeing or strongly agreeing” to various questions related to having the knowledge, skills, and confidence, and organizational procedures to support working directly with patients as elevated risk for suicide (no 2013 data available for comparison).

Section 4. Screening and Assessing Patients for Suicide Risk. These survey questions address those who have a role of screening patients who may be at elevated risk for suicide. Respondents who reported in Question 4 that they directly interact with patients either in person or from a distance during their day-to-day duties within the organization (including things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services) were asked all the questions in this section.

Question 11 - Primary Patient Population: A single item asking which primary patient population the respondent works with.

Table 5. Respondents indicating what patient age group they work with

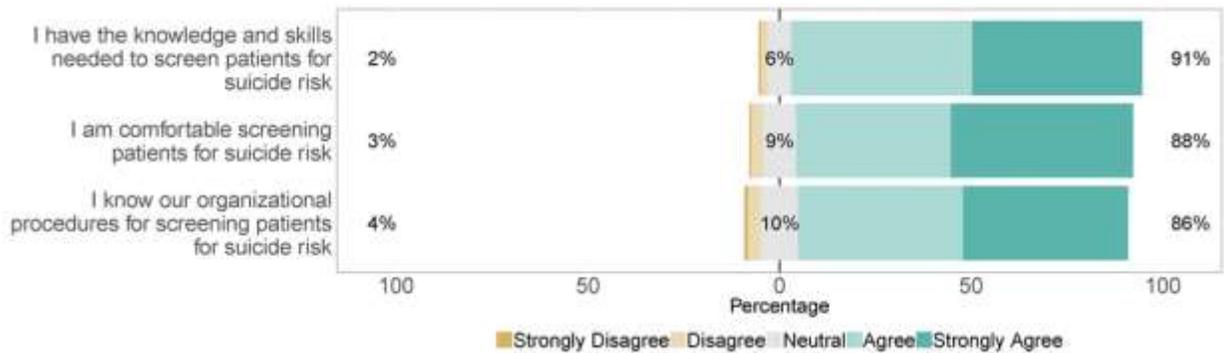
Which of the following groups do you primarily work with?		
	%	N
Adolescents	12.01%	479
Adults	68.35%	2725
Children	11.19%	446
Elderly	8.45%	337

Question 12 - Responsibility for Conducting Screening: A single item asking if the respondent is responsible for conducting screenings for suicide risk.

Table 6. Respondents indicating they have a primary professional role to screen patients for suicide risk by category of health care

Do you have a responsibility for conducting <i>suicide screenings</i> for suicide risk?			
	NO	YES	N
Other	17.3%	82.7%	825
Behavioral / Mental Health	4.8%	95.2%	1,178
Physical Health	25.8%	74.2%	2,428

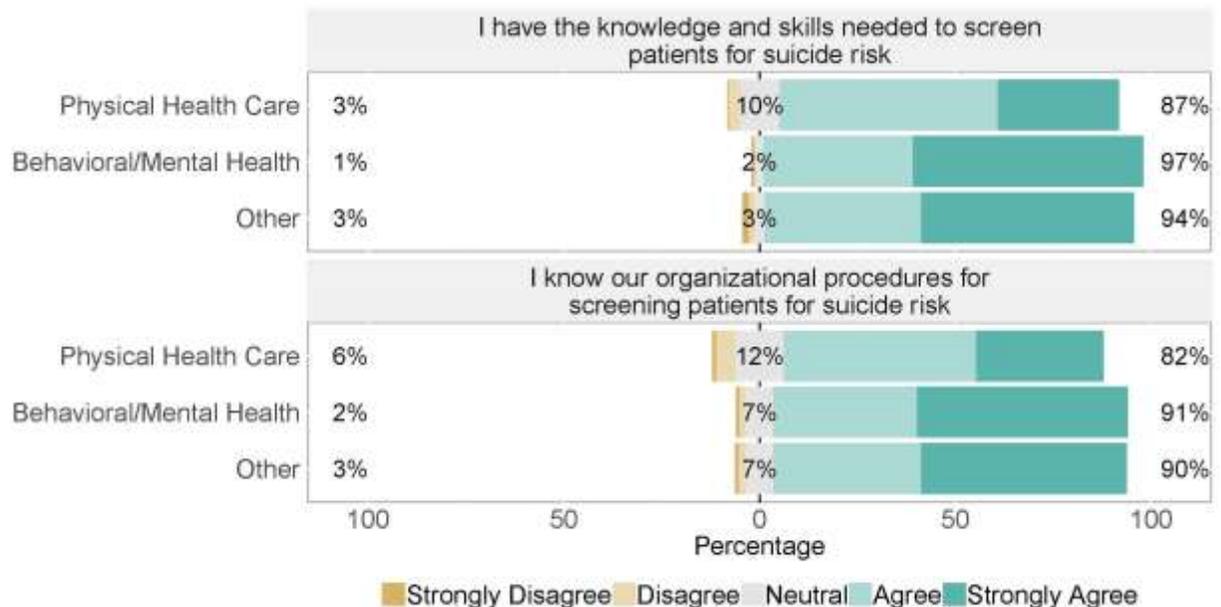
Figure 24. Respondent's beliefs about their knowledge, comfort, and organizational procedures for conducting suicide screening



In figures 25-26 below the questions in Figure 24 above is categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care.

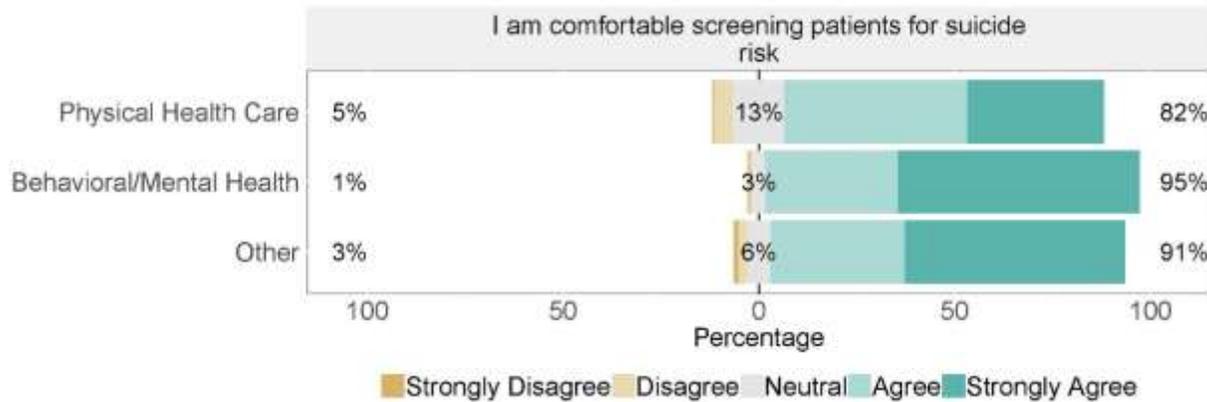
In figures 25 -26 below, there is a similar difference observed in responses between those employed in Physical Health Care compared to those employed in Behavioral/Mental Health Care, with those in Behavioral/Mental Health reporting they “agree or strongly agree” about 10% higher on each item than those in Physical Health Care. For example on “knowledge and skills needed to screen patients for suicide risk”, 97% of Behavioral/Mental Health respondents indicated they did, while 87% of Physical Health Care respondents did so. With regard to “knowing organizational procedures for screening patients for suicide risk”, 91% of Behavioral/Mental Health respondents agreed or strongly agreed, while 82% of those in Physical Health Care did.

Figure 25. Respondent's beliefs regarding their knowledge and organizational supports for conducting suicide screenings by category of health care



Similarly on respondents reported “comfort conducting suicide screenings”, 95% of Behavioral/Mental Health respondents indicated they did, while 82% of Physical Health Care respondents did so.

Figure 26. Respondent’s beliefs about their comfort conducting suicide screenings by category of health care

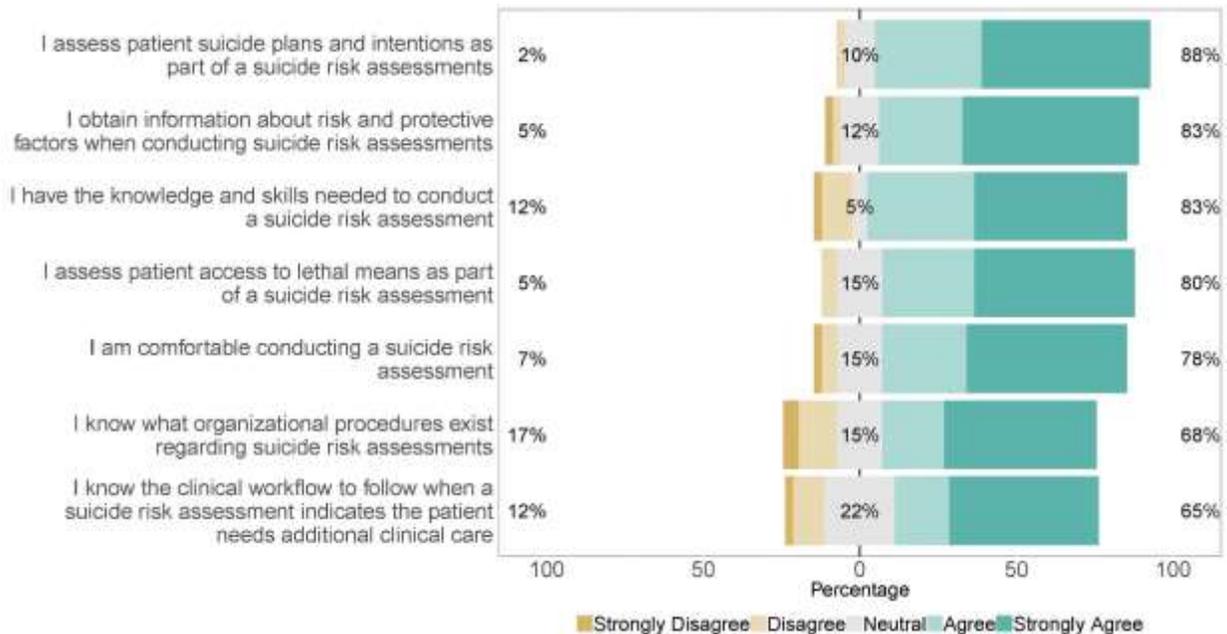


Question 13 - Conducting Suicide Risk Assessments: A multi-part item asking about conducting suicide risk assessments. Only survey respondents who reported in Question 12 that they are responsible for conducting *screenings* for suicide risk.

Table 6. Respondents indicating they have a responsibility to conduct suicide risk assessments by category of health care

Do you have a responsibility for conducting <i>suicide risk assessments</i> ?			
	NO	YES	N
Other	67.5%	32.5%	619
Behavioral / Mental Health	22.2%	77.8%	1,107
Physical Health	65.3%	34.7%	2,234

Figure 27. Respondent's beliefs about various aspects of conducting suicide risk assessments



In figures 28-31 below, the questions in Figure 27 above are categorized by those employed in Physical Health Care, Behavioral/Mental Health, or Other categories of health care. In each of these questions there are significantly higher responses by those employed in Behavioral / Mental Health than those in Physical Health Care. Specifically, in Figure 28 regarding “knowledge and skills to conduct suicide risk assessments”, **86%** of Behavioral/Mental Health respondents agreed or strongly agreed that they did, while **73%** of Physical Health Care respondents did. In the following question on “obtaining information about risk and protective factors during suicide risk assessments” **100%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while only **67%** of Physical Health Care respondents did. Then in Figure 29 in responding to “assess patient access to lethal means during assessment”, **93%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while **73%** of Physical Health Care respondents did. In the next item those who “assess patient suicide plans and intentions during assessment” **93%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while **80%** of Physical Health Care respondents did. In Figure 30 responding to their level of “comfort in conducting suicide risk assessments”, **86%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while only **60%** of Physical Health Care respondents did. Next to the question of “knowledge of organizational procedures regarding suicide risk assessments”, **93%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while only **33%** of Physical Health Care respondents did. And finally in Figure 31 to the issue of “knowledge of clinical workflows when a suicidal patient needs additional care”, **69%** of Behavioral/Mental Health respondents agreed or strongly agreed they did, while **47%** of Physical Health Care respondents did.

Figure 28. Respondent's beliefs about various aspects of conducting suicide screenings by category of health care

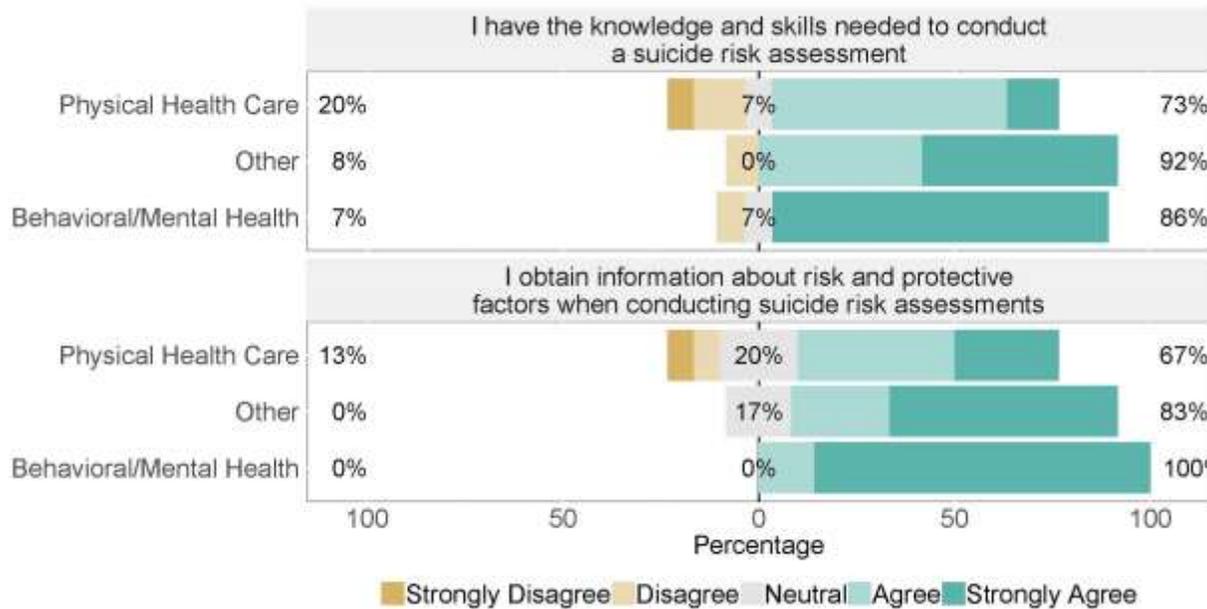


Figure 29. Respondent's beliefs about various aspects of conducting suicide screenings by category of health care

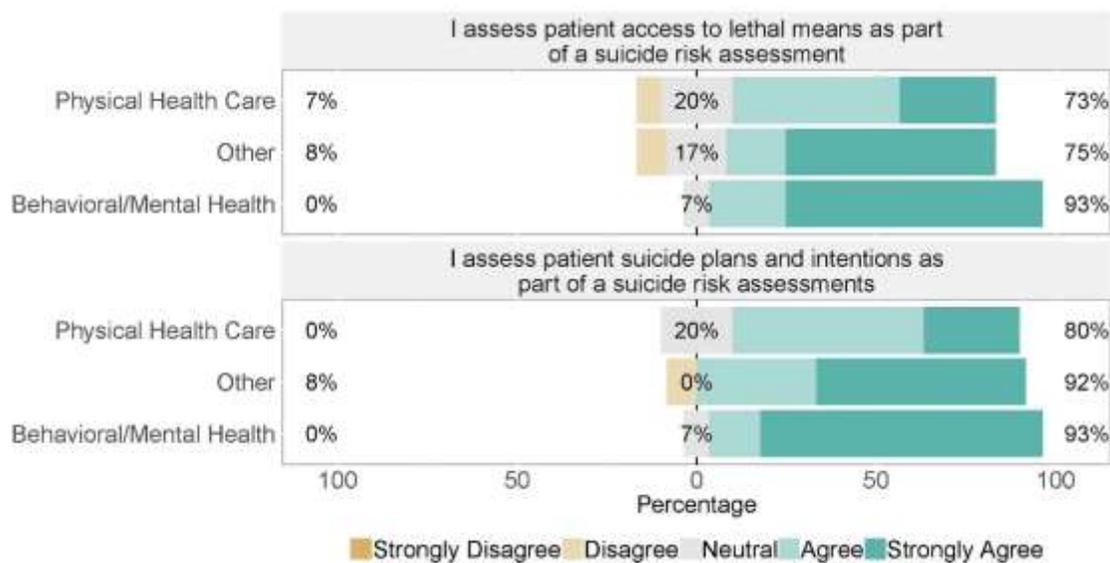


Figure 30. Respondent's beliefs about various aspects of conducting suicide screenings by category of health care

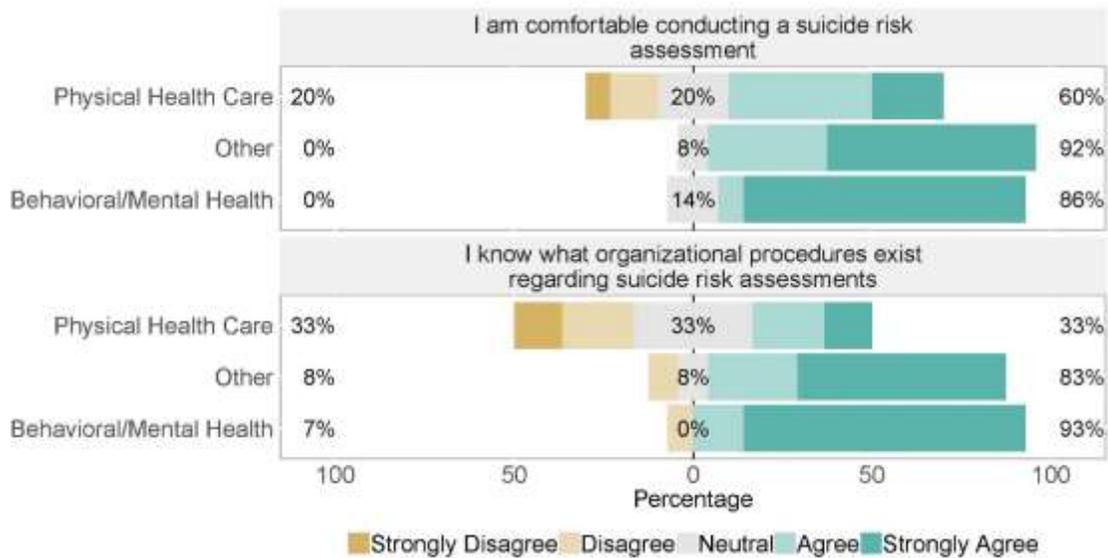


Figure 31. Respondent's beliefs about various aspects of conducting suicide screenings by category of health care

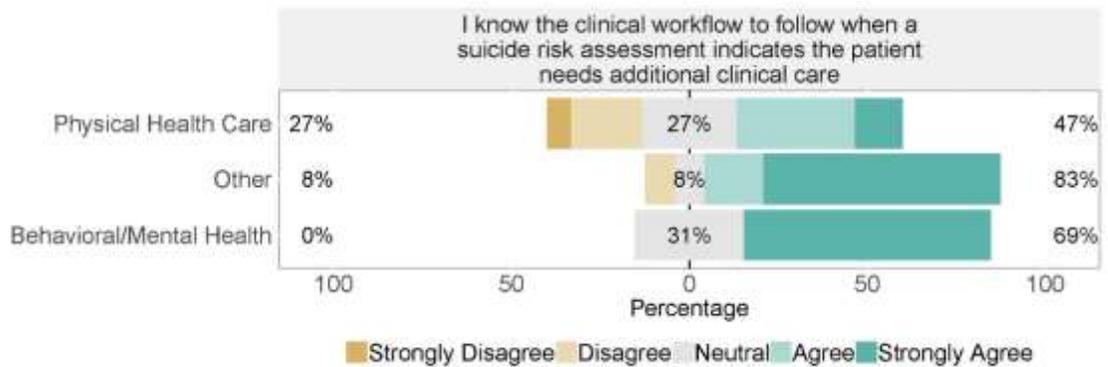


Figure 32. Screening patients for suicide risk: 2018

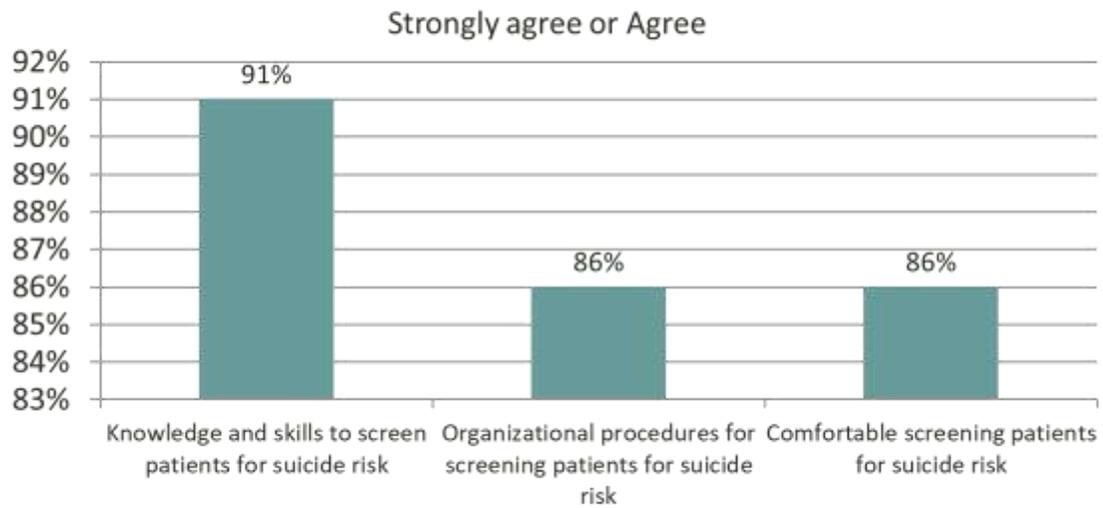


Figure 32 above is a composite summary of 2018 respondents “agreeing or strongly agreeing” to questions related to screening patients for suicide risk (no 2013 data available for comparison).

Section 5. Training on Screening and Risk Assessment. The questions in this section are aimed at identifying any training the respondent may have received on screening and suicide risk assessment (even if it is not part of their current professional duties). Respondents who reported previously that they directly interact with patients either in person or from a distance during their day-to-day duties within the organization (including things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services) were all asked the questions in this section.

Question 14- Ever Trained on Screening or Risk Assessment: A single item asking whether the respondent has ever received training on conducting suicide screenings or suicide risk assessments. All survey respondents who directly interact with patients.

Table 7. Respondents indicating they have received training on conducting suicide risk assessments by category of health care

Have you ever received training on <i>conducting suicide screenings or suicide risk assessments</i> ?			
	NO	YES	N
Other	33.8%	66.2%	610
Behavioral / Mental Health	11.5%	88.5%	1,088
Physical Health	45.3%	54.7%	2,198

Question 15 - Training at Current Organization: A single item asking if the respondent received training on conducting suicide screenings or suicide risk assessments at their current organization. Only survey respondents who reported in Question 16 that they have received training

Table 8. Respondents indicating their current organization has provided training on conducting suicide risk assessments by category of health care

Has your current organization provided training on <i>conducting suicide screenings or risk assessments</i> ?			
	NO	YES	N
Other	33.2%	66.8%	400
Behavioral / Mental Health	36.1%	63.9%	945
Physical Health	48.0%	52.0%	1,186

Question 16 - Trainings Taken on Screening or Risk Assessment: A multi-part question that asked respondents which training(s) they have taken on screening or suicide risk assessment. Only survey respondents who reported in Question 16 that they have received training.

Table 9. Types of trainings completed on screening or suicide risk assessment by survey respondents

Training	N
A different training on screening or suicide risk assessment	579
AMSR (Assessing and Managing Suicide Risk)	206
An in-service or webinar training at a former organization	900
An in-service or webinar training at my organization	870
CASE Approach (Chronological Assessment of Suicide Events)	118
Columbia Suicide Severity Rating Scale (C-SSRS)	1,054
Commitment to Living	68
QPRT (Suicide Risk Assessment and Management Training (not basic QPR training))	166
RRSR (Recognizing and Responding to Suicide Risk)	97
Suicide Care	26

In Table 9 above, the highest reported trainings completed were “Columbia Suicide Severity Rating Scale”, “a training at a former organization”, or “a training at the current employer”.

Question 17 - Standard Tools, Instruments, or Rubrics: A single item asking if the respondent uses a standard tool, assessment instrument, or rubric for suicide screening or risk assessment. All survey respondents who directly interact with patients.

Table 10. Respondents indicating they use a standard tool, assessment instrument, or rubric in conducting suicide screening or risk assessment by category of health care

Do you use a standard tool, assessment instrument, or rubric for suicide screening or risk assessment?			
	NO	YES	N
Other	49.9%	50.1%	603
Behavioral / Mental Health	43.8%	56.2%	1,075
Physical Health	49.0%	51.0%	2,179

Question 18 - Standard Tools, Instruments, or Rubrics Used: A multi-part question that asked respondents which standard tools, instruments, or rubrics they currently use for suicide screening or risk assessment. Only survey respondents who reported in Question 19 that they used standard tools, instruments, or rubrics.

Table 11. Types of standard tool, assessment instrument, or rubric used in conducting suicide screening or risk assessment by survey respondents

Tool, instrument, or rubric	N
A different tool, instrument, or rubric	214
A tool, instrument, or rubric developed by my organization	354
Asking Suicide-Screening Questions (ASQ)	273
Beck's Suicide Intent Scale (SIS)	132
Columbia Suicide Severity Rating Scale (C-SSRS)	974
National Suicide Lifeline Risk Assessment Standards	38
PHQ-2	253
PHQ-9	551
Risk Assessment Matrix (RAM)	36
Risk of Suicide Questionnaire (RSQ)	97
SAFE-T	46
Suicide Ideation Questionnaire (SIQ or SIQ-JR)	58
Suicide Care	13

In Table 11 above, the highest reported types of standard tools or assessments used were "Columbia Suicide Severity Rating Scale", "PHQ-9", "a tool developed by my organization", or "Asking Suicide-Screening Questions".

Section 6. Providing Care to Patients at Risk. These questions are only for staff responsible for providing care to patients determined to be at elevated risk for suicide.

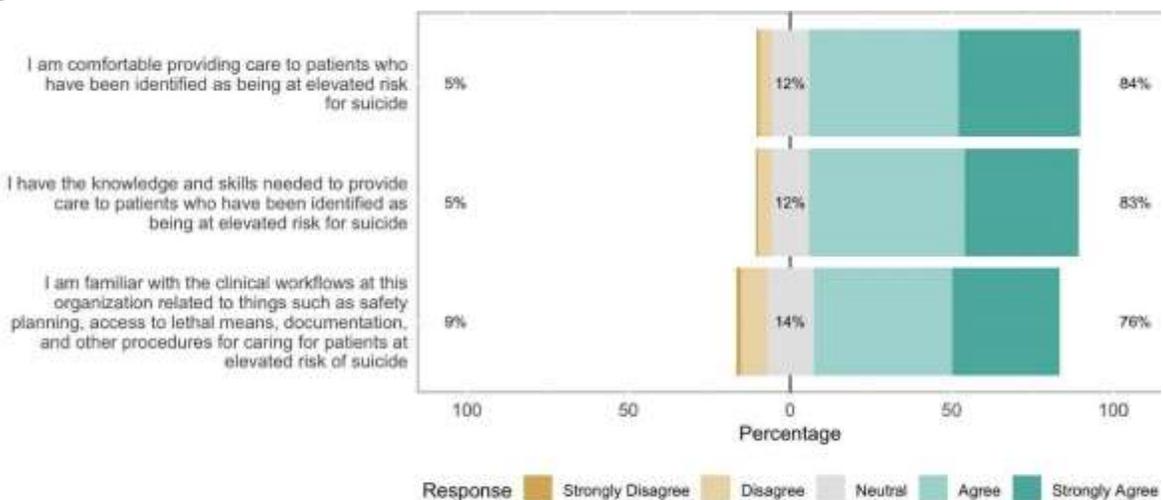
Question 19 - Responsibility for Providing Care: A single item asks whether the respondent provides direct care to patients who have been identified as being at elevated risk for suicide based on their risk assessment. All survey respondents who directly interact with patients.

Table 12. Respondents providing direct care to patients identified as being at risk for suicide by category of health care

Do you provide direct care to patients who have been identified as being at elevated risk for suicide based on their risk assessment?			
	NO	YES	N
Other	55.1%	44.9%	599
Behavioral / Mental Health	21.5%	78.5%	1,067
Physical Health	41.0%	59.0%	2,160

Question 20 - Providing Care to Patients at Elevated Risk: A three-part item asking about providing care to patients at elevated risk for suicide. Only survey respondents who reported in Question 21 that they provide direct care to patients who have been identified as being at elevated risk for suicide based on their risk assessment.

Figure 33. Respondent’s beliefs about providing care to patients identified as being at risk of suicide



In figure 34 below, the questions in Figure 33 above are categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care. In each of these questions there are significantly higher responses by those employed in Behavioral / Mental Health than those in Physical Health Care. Specifically, in the questions in Figure 34 respondents' comfort in providing care to patients with elevated risk for suicide, **92% vs 78%**; familiarity with clinical workflows related to safety planning, access to lethal means, documentation and other patient care procedures, **90% vs. 66%**; and knowledge and skills to provide care to patients at elevated risk for suicide, **93% vs 76%**.

Figure 34. Respondent's beliefs about various aspects of providing patient care to patients identified as being at risk of suicide by category of health care

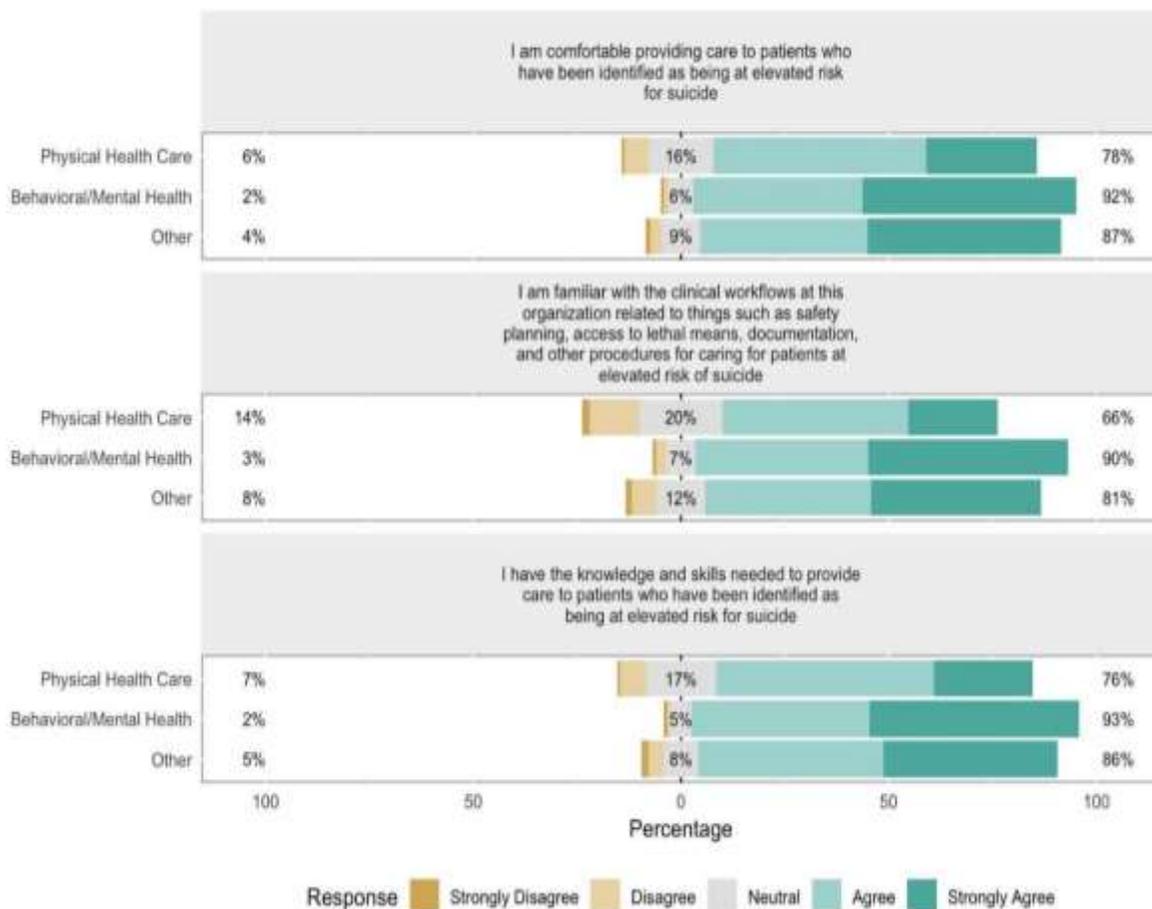


Figure 35. I have the knowledge and skills needed to provide care to patients who have been identified as being at elevated risk for suicide: 2013 vs 2018

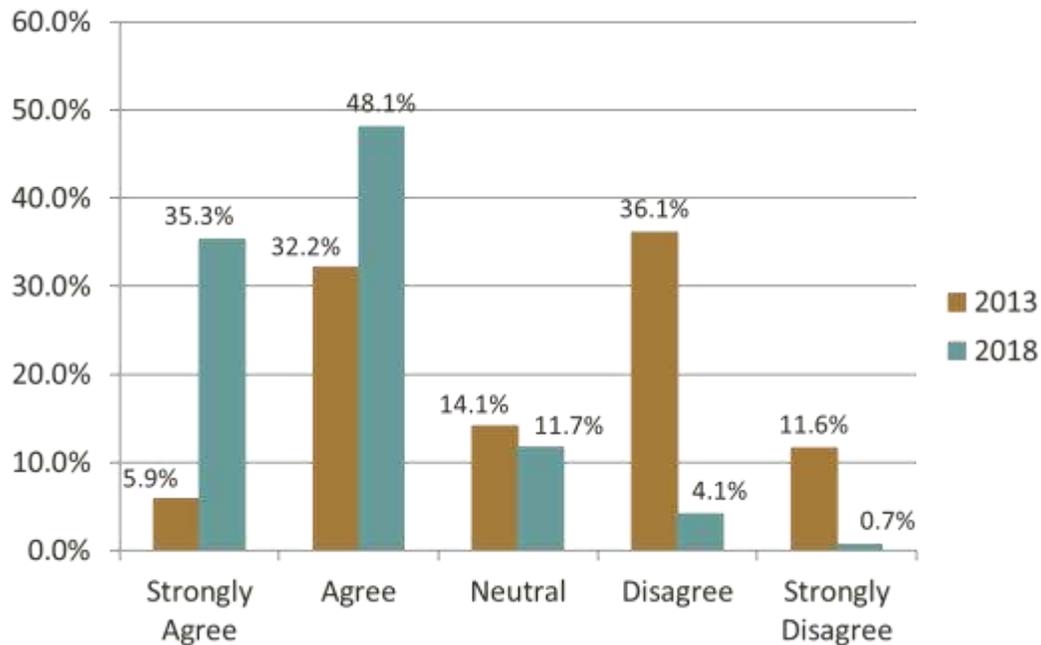


Figure 35 above summarizes the differences between 2013 and 2018 on respondents reporting they “have the knowledge and skills needed to provide care to patients with an elevated risk for suicide”. In 2018 (83%) the agreed or strongly agreed that they were able to provide this type of care, while (38%) reported they were able to do so in 2013.

Question 21 - Access to Lethal Means: A single item asking whether the respondent has taken the Counseling on Access to Lethal Means (CALM) course either online or in person. All survey respondents who directly interact with patients.

Table 13. Respondents reporting they have taken the Counseling on Access to Lethal Means (CALM) course

Have you taken the Counseling on Access to Lethal Means (CALM) course either online or in person?

	NO	YES	N
Inpatient	33.4%	27.2%	1,249
Outpatient	48.2%	48.5%	1,816
Both	18.4%	23.3%	697

Table 14 below categorizes the primary professional role of those completing a CALM course.

Table 14. Respondent’s primary professional role by employment category

Professional role	N
Management (Administrators, Supervisors, Managers, Coordinators)	5
Business, administrative, clerical (Accounting, HR, Billing, Records, IT)	9
Facility Operations (Dietary, Housekeeping, Maintenance, Security, Transportation)	22
Behavioral Health Clinician (Counselor, Social Worker, Therapist, Psychologist)	25
Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)	6
Case Management	10
Crisis Services	26

Figure 36. Conducting suicide risk assessments: 2018

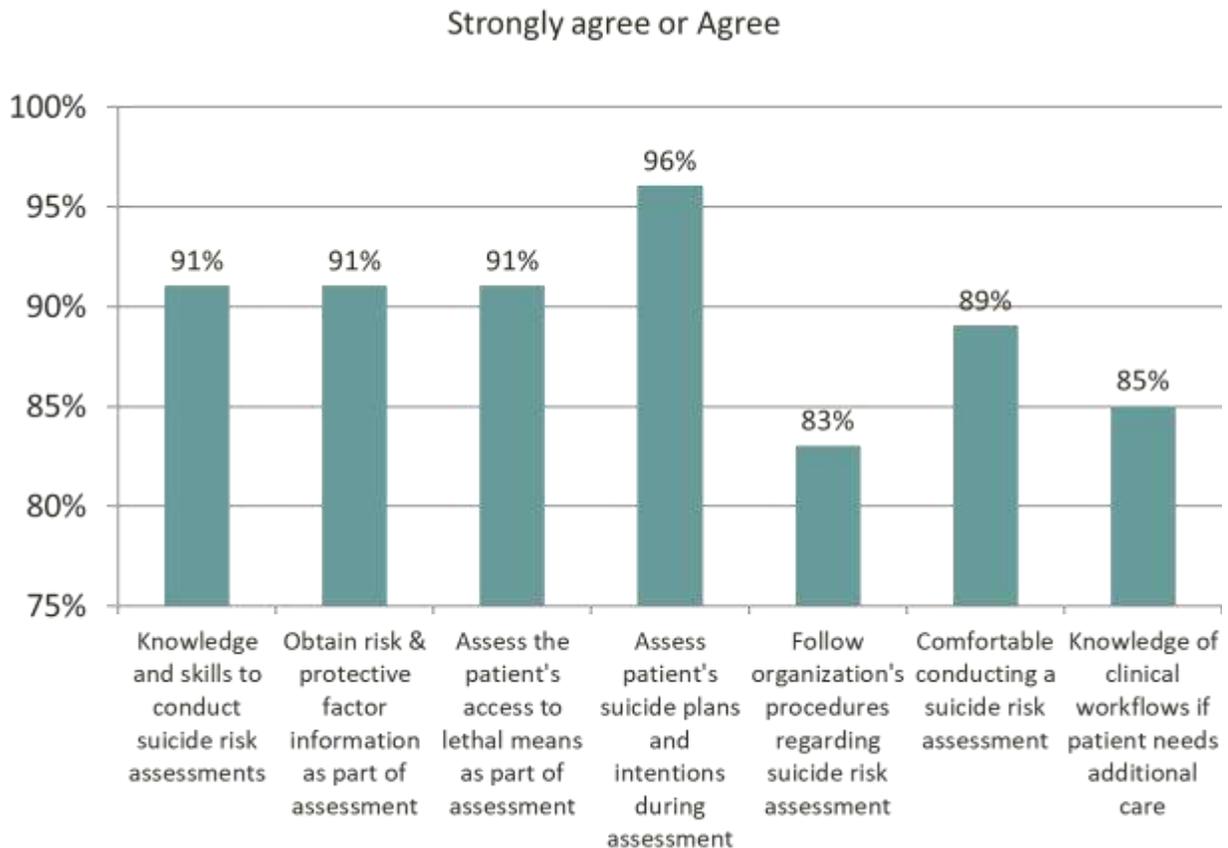


Figure 36 above is a composite summary of 2018 respondents indicating they “agreeing or strongly agreeing” they can conduct suicide risk assessments with regard to multiple related components (no 2013 data available for comparison) .

Section 7. Use of Evidence-Based Treatments That Directly Target Suicide. Questions in this section focus on individuals who deliver clinical treatment (e.g. CAMS, CBT-SP, DBT) to patients identified as being at elevated risk for suicide.

Question 22 - Clinical Treatment: A single item asking whether the respondent provides clinical treatment to patients who have been identified as being at elevated risk for suicide. All survey respondents who directly interact with patients.

Table 15. Respondents reporting they deliver clinical treatments to patients identified as being at elevated risk for suicide

Do you deliver clinical treatment (e.g. CAMS, CBT-SP, or DBT) to patients who have been identified as being at elevated risk for suicide?

	NO	YES	N
Inpatient	35.4%	26.3%	1,257
Outpatient	45.3%	58.0%	1,820
Both	19.3%	15.7%	698

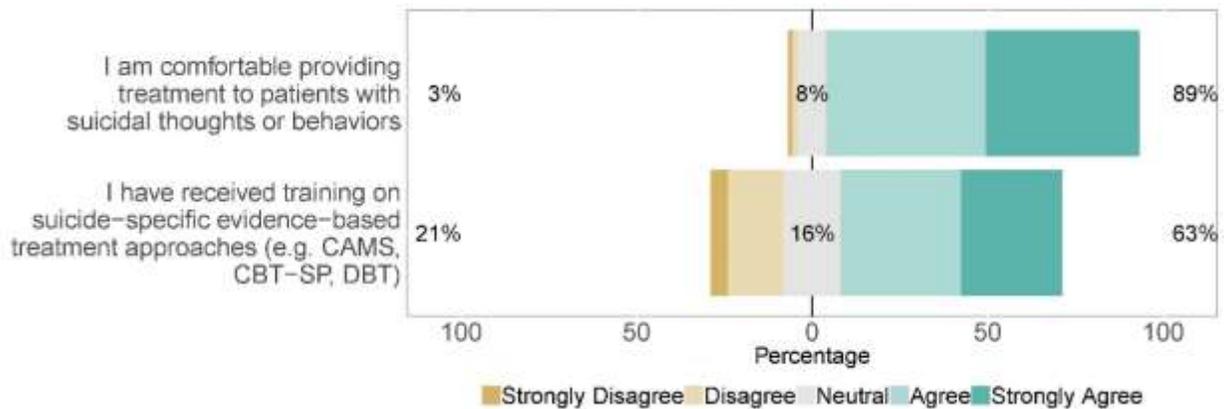
Table 16 below categorizes the primary professional role of those who deliver clinical treatment services.

Table 16. Respondent's primary professional role by employment category

Professional role	N
Management (Administrators, Supervisors, Managers, Coordinators)	40
Business, administrative, clerical (Accounting, HR, Billing, Records, IT)	91
Facility Operations (Dietary, Housekeeping, Maintenance, Security, Transportation)	283
Behavioral Health Clinician (Counselor, Social Worker, Therapist, Psychologist)	174
Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)	41
Case Management	113
Crisis Services	129

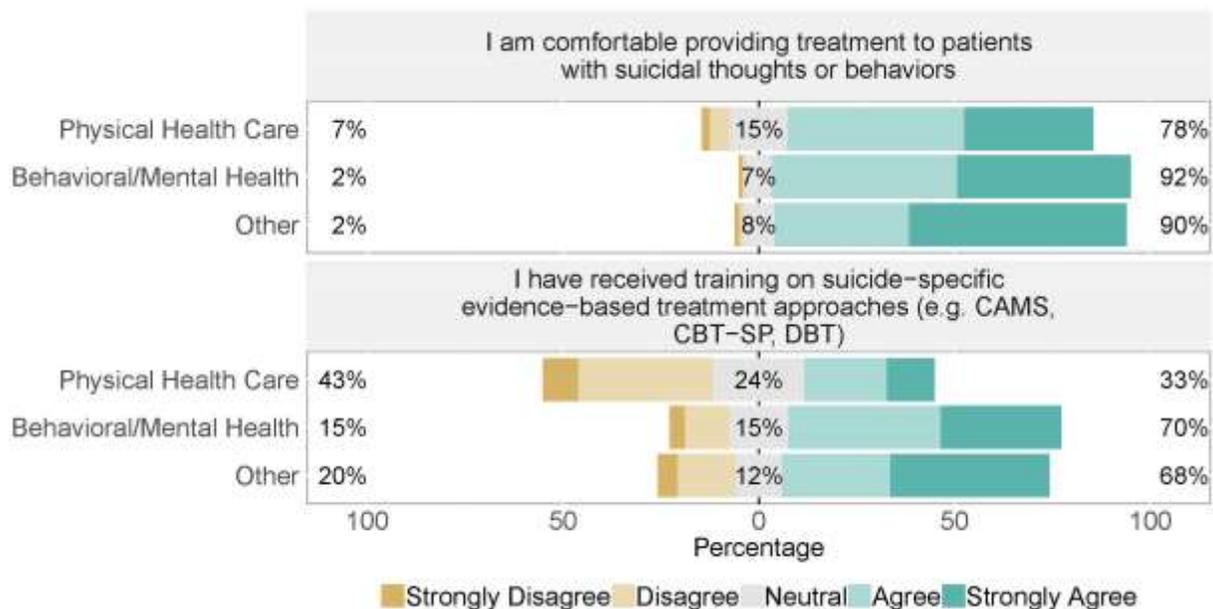
Question 23 - Evidence-Based Treatment: A three-part item asking about evidence-based treatments that directly target suicide. Only survey respondents who reported in Question 25 that they provide clinical treatment to patients who have been identified as being at elevated risk for suicide.

Figure 37. Respondent’s beliefs about providing clinical treatment to patients identified as being at risk of suicide



In figure 38 below, the questions in Figure 37 above are categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care. In each of these comparison questions there are significantly higher responses by those employed in Behavioral / Mental Health than those employed in Physical Health Care. Specifically, in the questions in Figure 38 respondents’ comfort in providing treatment to patients with suicidal thoughts or behaviors, **92% vs 78%** and received training on suicide-specific evidence-based treatment approaches, **70% vs 33%**.

Figure 38. Respondent’s beliefs about providing clinical treatment to patients identified as being at risk of suicide by type of health care



Question 24 - Evidence-Based Treatment Approaches: A multi-part item asking about which suicide specific evidence-based treatment approaches, if any, the respondent has been trained to use. Only survey respondents who reported in Question 25 that they provide clinical treatment to patients who have been identified as being at elevated risk for suicide.

Table 17. Respondents reporting which specific evidence-based treatment they have been trained to use

Training	N
CAMS (Collaborative Assessment and Management of Suicide)	97
CBT-SP (Cognitive Behavioral Therapy for Suicide Prevention)	250
DBT (Dialectical Behavior Therapy)	472
Another training	114

Section 8. Care Transitions. Questions from this section of the survey focus on individuals responsible for ensuring that patients identified as being at elevated risk for suicide are supported during transitions in care. Safe care transitions can be viewed as uninterrupted transitions in care, from one setting to another, through support and outreach/contact from the behavioral health provider, physical health provider or any other designated staff. Care transition approaches include warm hand-offs, rapid referrals, and/or caring contacts.

Respondents who reported in Question 4 that they directly interact with patients either in person or from a distance during their day-to-day duties within the organization (including things such as answering phones, scheduling appointments, conducting check-ins, and providing caregiving and/or clinical services) were all asked the questions in this section.

Question 25 - Responsible for Providing Safe Care Transitions: A single item asking whether the respondent is responsible for ensuring safe care transitions for patients who have been identified as being at elevated risk for suicide. All survey respondents who directly interact with patients.

Table 18. Respondents reporting they have a responsibility for ensuring safe care transitions for patients identified as being at elevated risk for suicide

Are you responsible for ensuring safe care transitions for patients who have been identified as being at elevated risk for suicide?

	NO	YES	N
Inpatient	31.1%	36.4%	1,254
Outpatient	51.5%	43.7%	1,810
Both	17.4%	20.0%	695

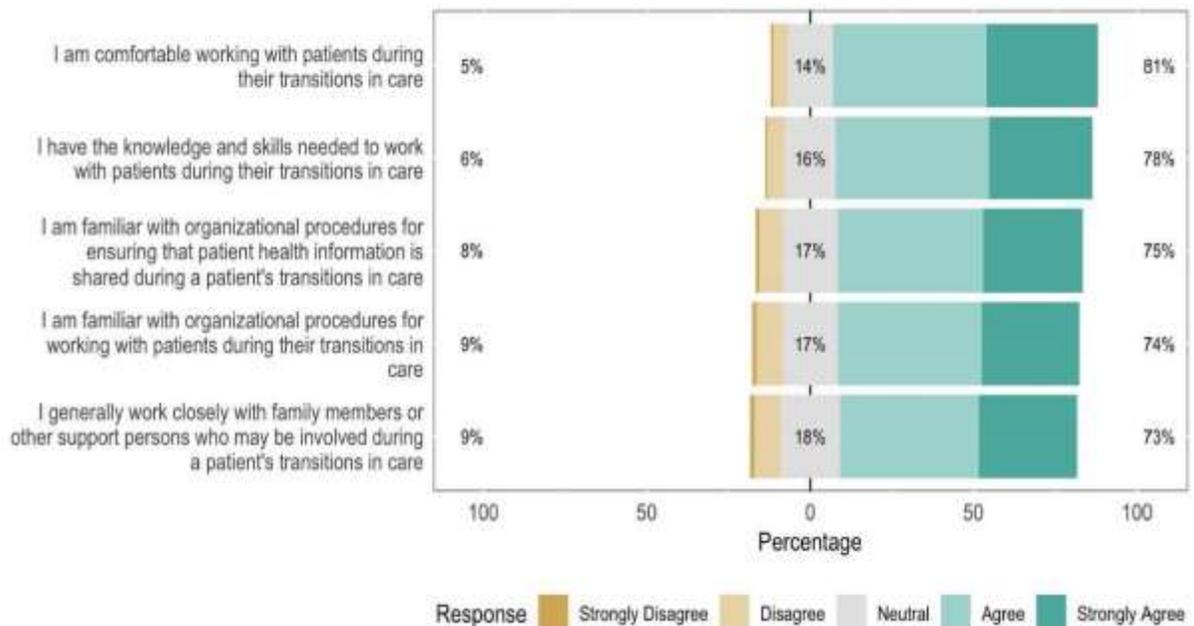
Table 19 below categorizes the primary professional role of those who deliver clinical treatment services.

Table 19. Respondent’s primary professional role by employment category

Professional role	N
Management (Administrators, Supervisors, Managers, Coordinators)	67
Business, administrative, clerical (Accounting, HR, Billing, Records, IT)	95
Facility Operations (Dietary, Housekeeping, Maintenance, Security, Transportation)	210
Behavioral Health Clinician (Counselor, Social Worker, Therapist, Psychologist)	625
Adjunct Therapist (Activity, Occupational, Physical, Rehabilitation)	177
Case Management	125
Crisis Services	308

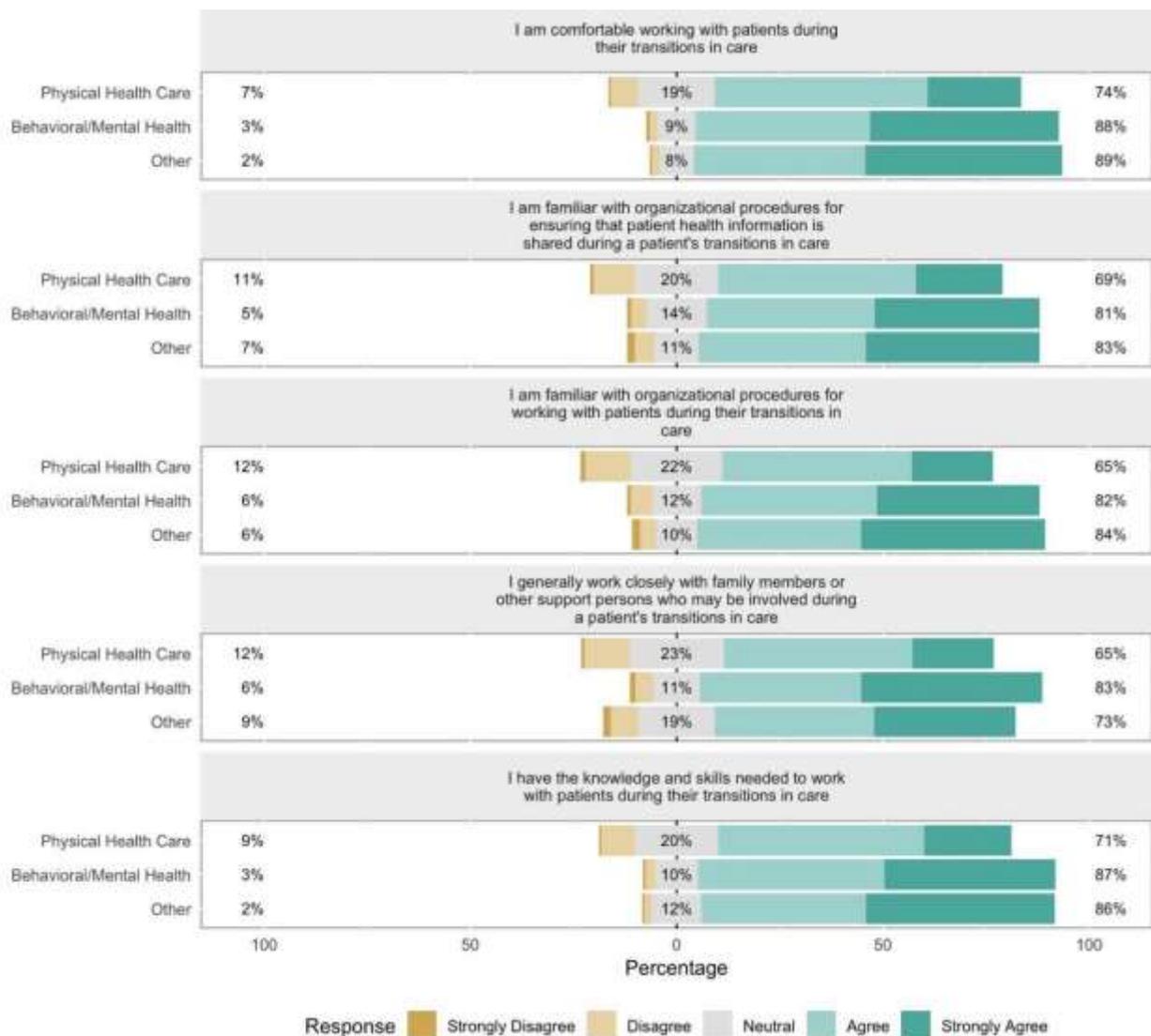
Question 26 - Safe Care Transitions: A five-part item asking about care transitions. Only survey respondents who reported in Question 28 that they are responsible for ensuring safe care transitions for patients who have been identified as being at elevated risk for suicide.

Figure 39. Respondent’s beliefs about working with patients during transitions in care



In figure 40 below, the questions in Figure 39 above are categorized by respondents working in Physical Health Care, Behavioral/Mental Health, or Other categories of health care. In each of these comparison questions there are significantly higher responses by those employed in Behavioral / Mental Health than those employed in Physical Health Care. Specifically, in the questions in Figure 40 comfort in working with patients during transitions in care, **88% vs 74%** familiar with organization procedures ensuring patient health information is shared during transitions, **81% vs. 69%** familiar with organization procedures working with patients during transitions, **82% vs. 65%** work closely with family members or others to support patient during transitions, **83% vs. 65%** and knowledge and skills to work with patients during transitions in care, **87% vs. 71%**.

Figure 40. Respondent's beliefs about working with patients during transitions in care by type of health care



Section 9. Training and Resource Needs. These questions identify whether staff members have the necessary skills, appropriate to their role, to provide care and feel confident in their ability to provide caring and effective assistance to patients with suicide risk.

Question 27 - Training and Resource Needs: A multi-part item asking about 20 areas in which respondents may like more training, resources, or support. All survey respondents.

Table 20. Respondents identifying areas they want additional training, resources, or support

In which of the following areas, if any, would you like more training, resources, or	N
Aftercare and follow- up	1,266
Collaborative safety planning for suicide	1,220
Communicating with patients about suicide	1,833 (1)
Creating a safe physical environment for patients at risk for suicide	1,363
Crisis response procedures and de-escalation techniques	1,798 (3)
Determining appropriate levels of care for patients at risk for suicide	1,619
Epidemiology and the latest research findings related to suicide	1,413
Family, caregiver, and community supports	1,804 (2)
Identifying risk factors for suicide	1,414
Identifying warning signs for suicide	1,751 (4)
Managing suicidal patients	1,441
Policies and procedures within your work environment	1,124
Procedures for communicating about potentially suicidal patients	1,068
Reducing access to lethal means outside the care environment	1,057
Suicide prevention and awareness	1,714
Suicide risk assessment practices	1,611
Suicide screening practices	1,739 (5)
Suicide-specific treatment approaches	1,316
Understanding and navigating ethical and legal considerations	1,540

***Five highest areas reported in bold and ranked order**