Zero Suicide Utah: Can Suicide Be A Never Event?

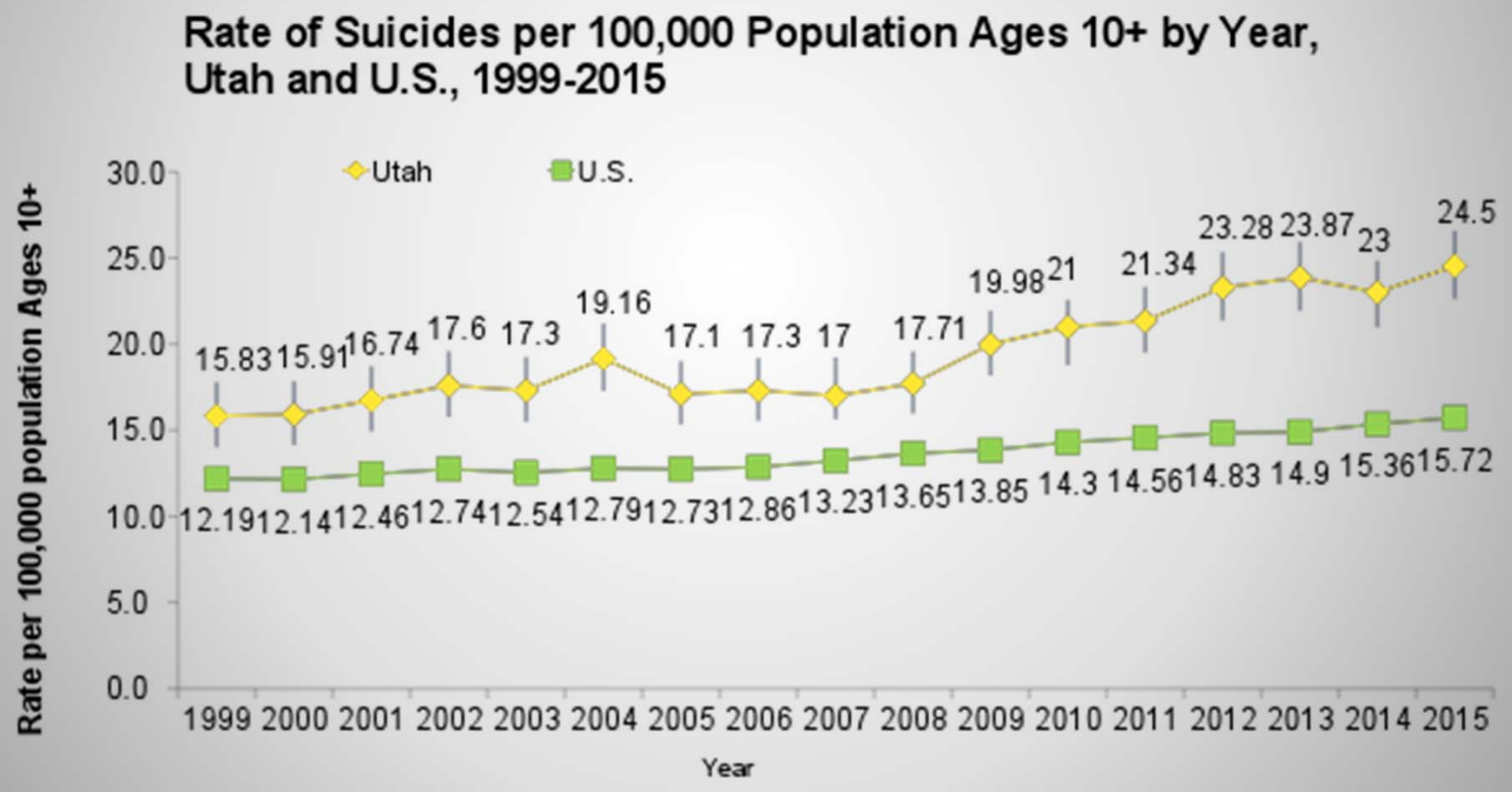
Kim Myers, MSW
Utah Suicide Prevention Coordinator

utah department of
human services
Division of Substance Abuse and Mental Health

AGENDA

- Introductions
- Intro to Zero Suicide Model
- Purpose/Benefit of Participating in the Collaborative
- Implementation Team- Lived Experience
- Introduction to implementing Zero Suicide & Developing a Work Plan using the Self-Assessment
- Communicating with staff about your Zero Suicide Initiative
- Workforce Survey- Andrea Hood
- Technical Assistance- Andrea Hood

Utah and U.S. Suicide Trend

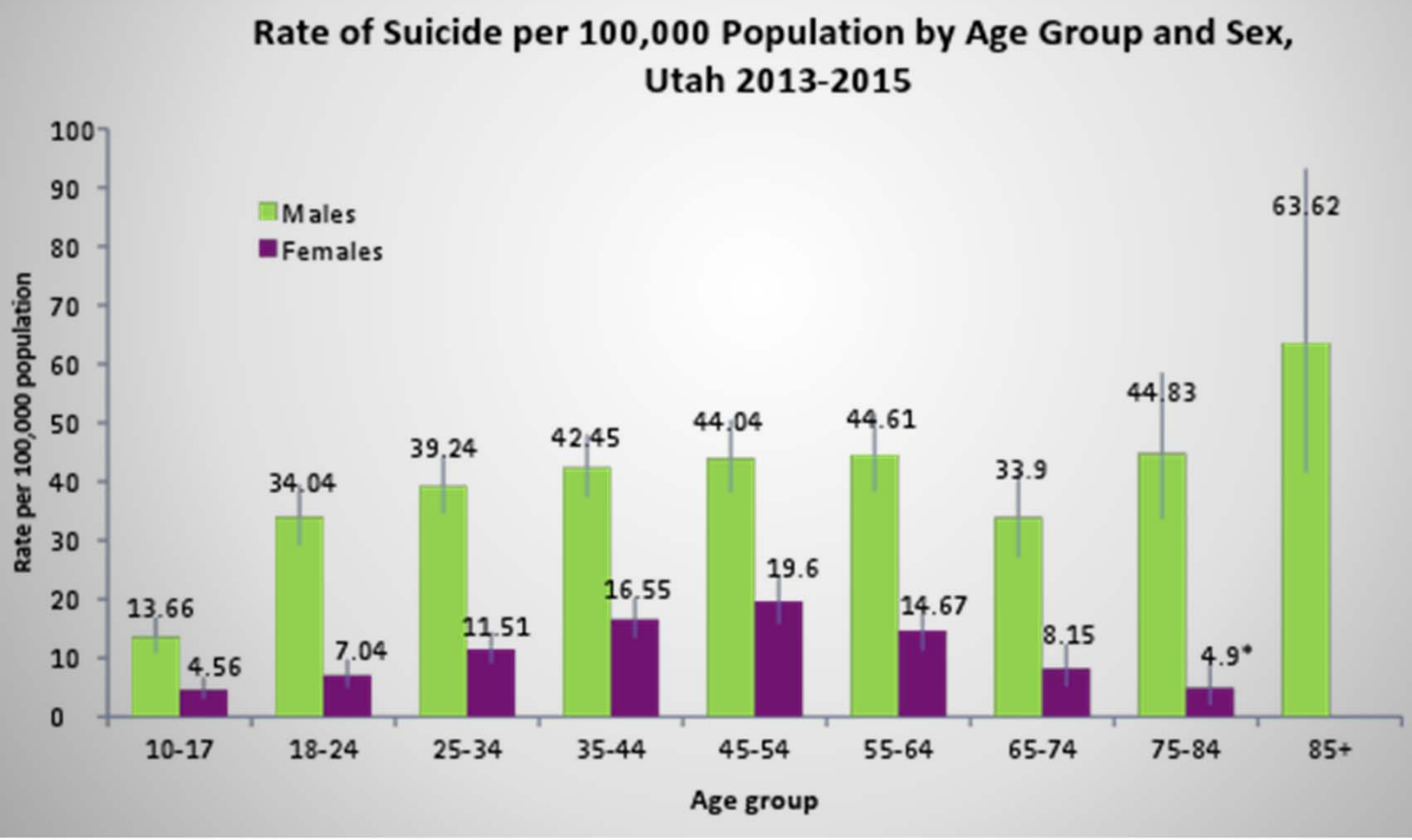


Data Source: Utah Death Certificate Database, U.S. Centers for Disease Control and Prevention

Utah Ranks 5th in the Nation

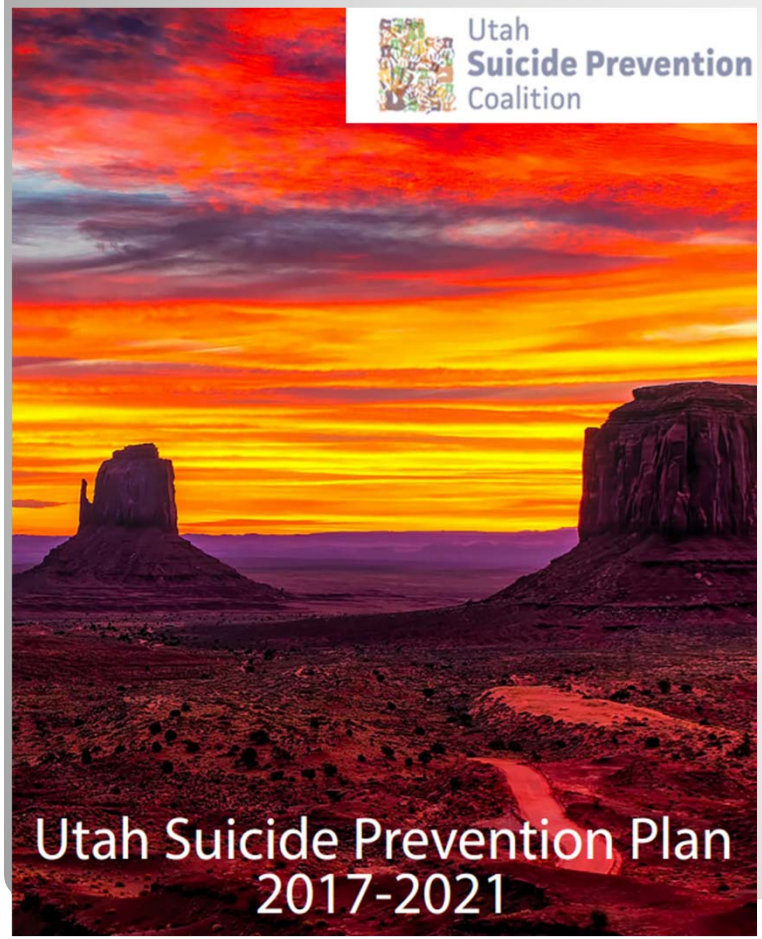
Data Source: WISQARS 2014 Suicide Fatality Rates ages 10+

Suicide Rate by Age Group and Sex Utah, 2013-2015



Data Source: Utah Death Certificate Database, Utah Department of Health

Utah Suicide Prevention Plan



People At Risk For Suicide Are Falling Through the Cracks in Our Health Care System

In the month before their death by suicide:

- Half saw a general practitioner
- 30% saw a mental health professional

In the 60 days before their death by suicide:

- 10% were seen in an emergency department

"Suicide represents a worst case failure in mental health care. We must work to make it a 'never event' in our programs and systems of care."

Dr. Mike Hogan
NY Office of Mental Health

Suicide Care in Behavioral Health Care Settings

- Suicide prevention is a core responsibility for behavioral health care systems

- Many licensed clinicians are not prepared
  - 39% report they don't have the skills to engage and assist those at risk for suicide
  - 44% report they don't have the training

  - In Utah- 61% of providers surveyed reporting not having the skills to engage those at risk and 58% report they don't have the training

"Over the decades, individual (mental health) clinicians have made heroic efforts to save lives… but systems of care have done very little."

Dr. Richard McKeon
SAMHSA

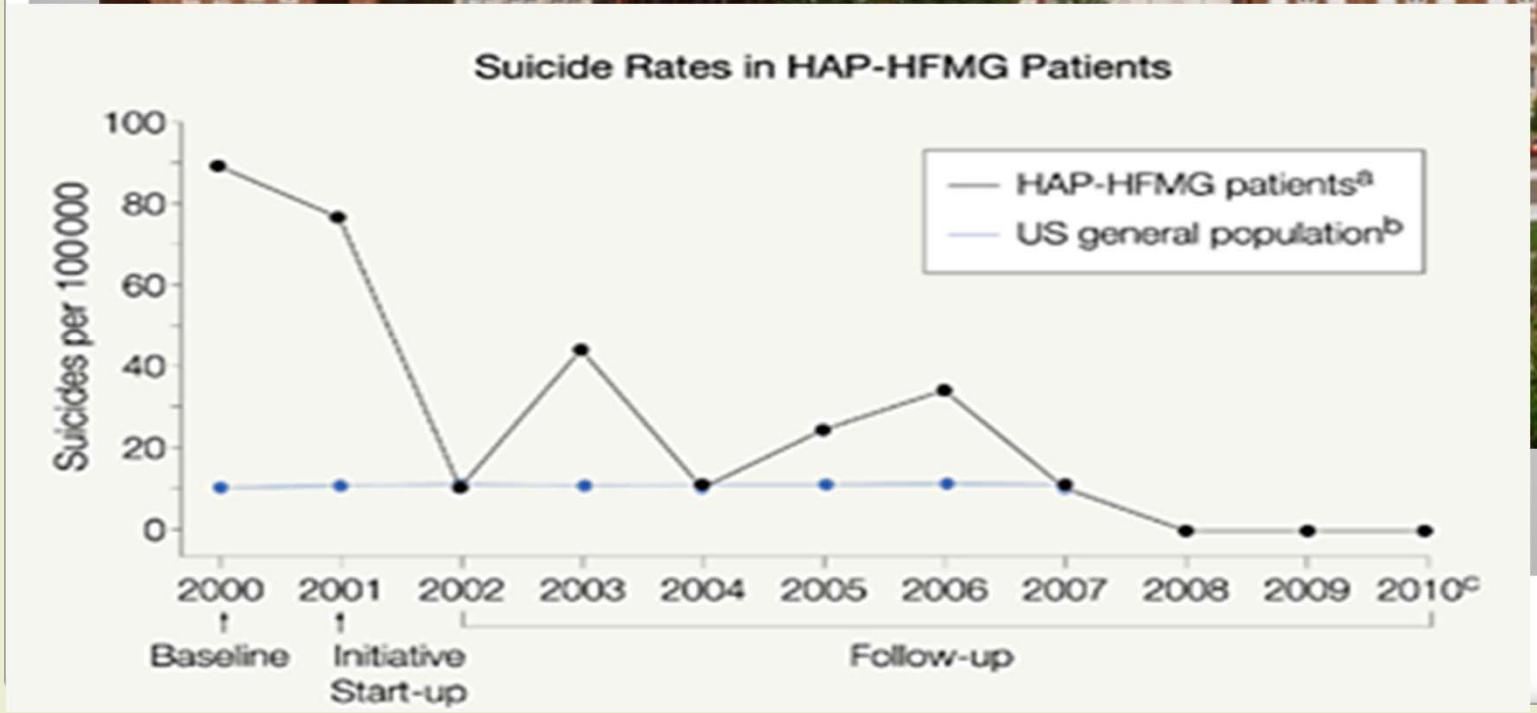
What is Zero Suicide?

- *A priority* of the Utah Suicide Prevention Coalition
- *A priority* of the Utah Division of Substance Abuse and Mental Health
- *A priority* of the National Action Alliance for Suicide Prevention
- *A goal* of the National Strategy for Suicide Prevention
- A *project* of the Suicide Prevention Resource Center
- *A framework* for systematic, clinical suicide prevention in behavioral health and health care systems
- *A focus* on safety and error reduction in healthcare
- *A set of best practices* and tools for health systems and providers

"It is critically important to design for zero even when it may not be theoretically possible…It's about purposefully aiming for a higher level of performance."

Thomas Priselac
President and CEO of Cedars-Sinai Medical Center

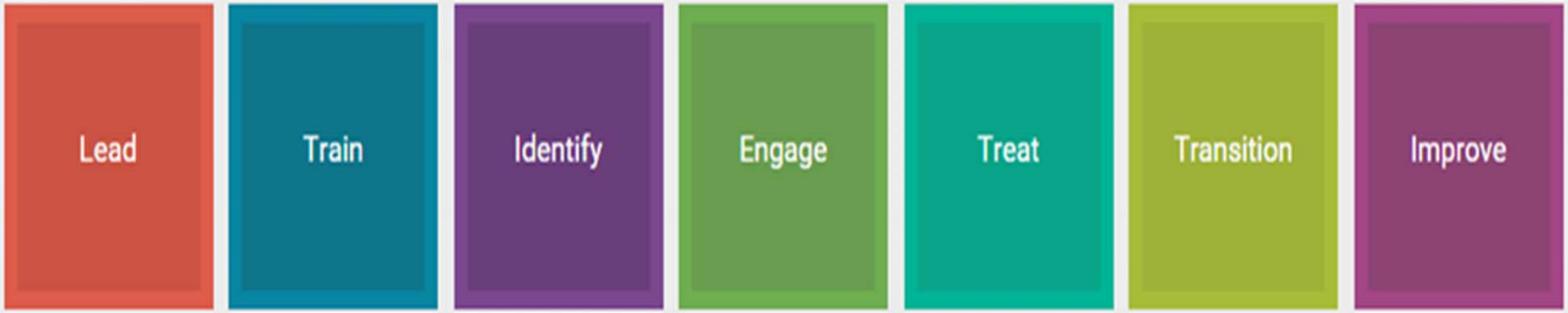
Henry Ford Health Center

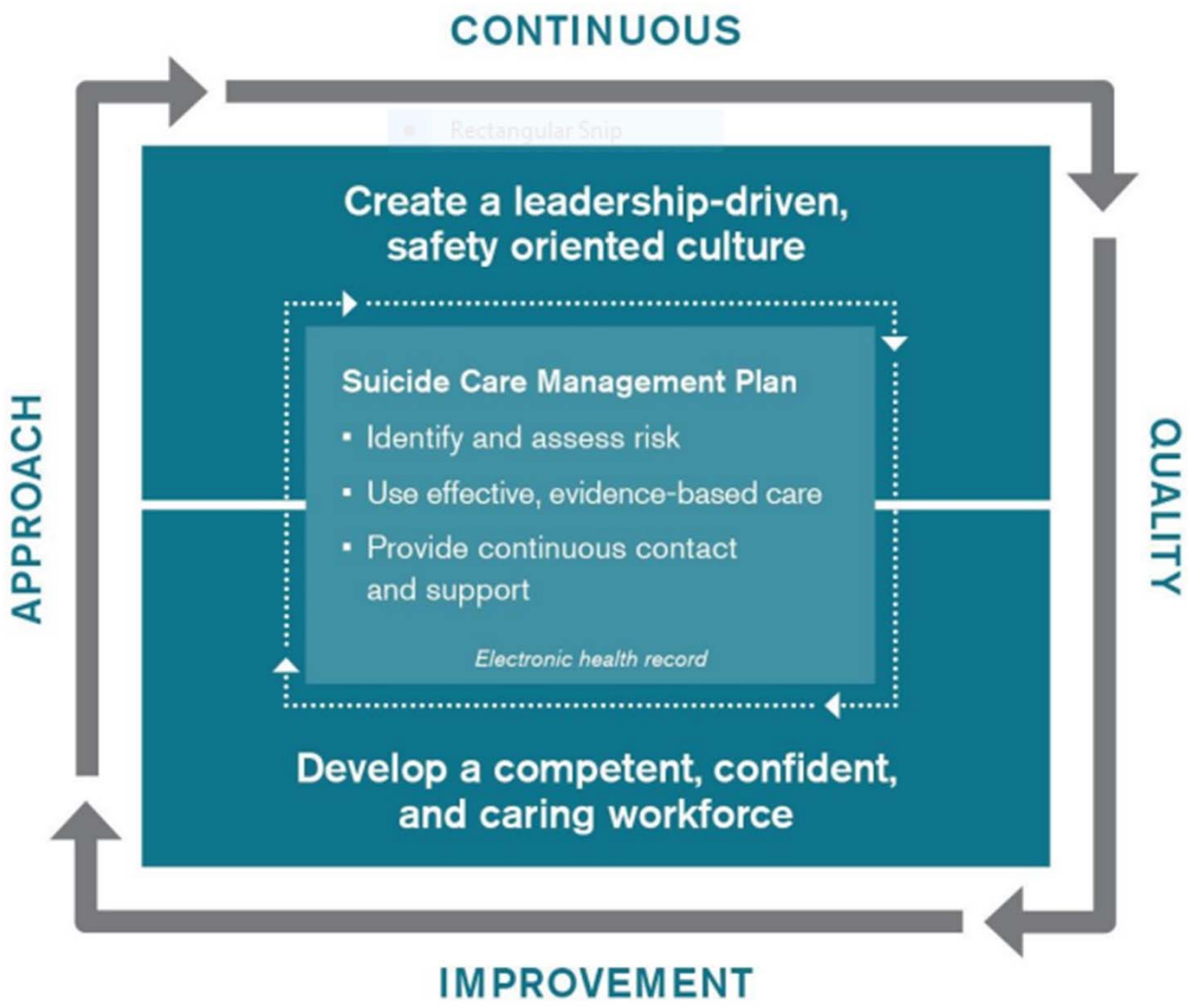


Suicide Care in System Framework

From:	To:
Training and tools	Systems & culture change
Individual provider actions; suicide care as "specialty"	Suicide prevention woven into all aspects of care; everyone's job
Episodes of crisis	Continuity of care

Better Approaches to Suicide Care Are Available, Effective, and Fill The Cracks in Our Health Care System




CONTINUOUS
Create a leadership-driven, safety oriented culture
Suicide Care Management Plan
Identify and assess risk
Use effective, evidence-based care
Provide continuous contact and support
Electronic health record
Develop a competent, confident, and caring workforce
APPROACH
QUALITY
IMPROVEMENT

LEADERSHIP

Make an explicit commitment to reduce suicide deaths.

System change occurs with sustained and committed leaders who learn and improve practices following adverse events.

(1) utilizing lessons learned from high-reliability organizations,
(2) fostering a just culture,
(3) maintaining focus on a comprehensive approach to preventing suicide deaths in their systems, and
(4) focusing on continuous quality improvement and fidelity to the Zero Suicide model.

TRAIN

Develop a competent, confident, caring workforce.

Train all staff—clinical and non-clinical—to identify individuals at risk and respond effectively, commensurate with their roles.

Assess employees beliefs, training and skills

Develop a training play for all employees which should include at a minimum:

*Screening and Identification

*Internal policies and procedures

*Assessing, safety planning, continuity of care, referrals, and treatment for clinical staff

IDENTIFY

Identify every person at risk for suicide.

Screen and assess every new and existing patient for suicidal thoughts and behaviors in an ongoing and systematic way using standardized tools.

Evidence-based screening and assessment tools should be incorporated into clinical practice as the use of such tools coupled with clinical judgment has been found to be more accurate than clinician judgment alone.

Developing policies and procedures around identification of risk that leverage evidence-based tools is a crucial step toward safer suicide care

Commonly used tools include the PHQ-9 and the Columbia Suicide Severity Rating Scale coupled with narrative risk assessments

ENGAGE

Engage clients in a Suicide Care Management Plan.

Patients at risk for suicide agree to actively engage in a package of evidence-based practices that directly targets their suicidal thoughts and behaviors.

Suicide Care Management Plans may include:

- Ongoing screening using evidence based tools
- Same-day access to behavioral health professionals for those determined to be at immediate risk through use of a standard risk formulation framework
- Requirements and protocols for safety planning, crisis support planning, and lethal means reduction, including the frequency of visits and actions to be taken if a patient misses appointments or drops out of care
- Channels for communicating with a patient about diagnosis, treatment expectations, and what it means to have a suicide care management plan
- A referral process to suicide-specific, evidence-based treatment and requirements for continued contact, especially during transitions in care
- Criteria and protocols for closing out a patient's suicide care management plan
- Training for all staff at least annually in suicide care management plan policies and protocols and documentation requirements
- A schedule for regular team meetings and clinical case consultations to discuss patients at risk for suicide
- A schedule for management to regularly review charts to determine that policies and protocols are followed

TREAT

Treat Suicidal Thoughts and Behaviors Directly.

Utilize evidence-based treatments that focus explicitly on reducing suicide risk to keep patients safe and help them thrive.

Recent research strongly supports targeting and treating suicidal ideation and behaviors specifically and directly in the least restrictive environment

Effective, Evidence-Based Care:

- CBT-SP
- DBT
- CAMS
- Safety Planning/Crisis Response Planning
- Lethal Means Restriction

TRANSITION

Follow patients through every transition in care.

Put policies into action that ensure safe hand-offs between caregivers and upon discharge

Organizational policies provide guidance for successful care transitions and specify the contacts and support needed throughout the process to manage any care transition

- Follow-up and supportive contacts for individuals on a suicide care management plan, also called a pathway to care, are tracked and managed using an electronic health record or paper record

- Patients are engaged in an individualized, culturally sensitive manner that takes into account their needs and preferences

- Staff are trained how to provide supportive caring contacts and follow-up care using techniques such as motivational interviewing, safety planning, and lethal means assessment and counseling

IMPROVE

Apply data-driven quality improvement.

Use data to inform system changes that will lead to improved patient outcomes and better care for those at risk.

1) identify patient care outcomes demonstrating whether systems and policy changes are impacting practice;

1) assess care outcomes for all patients who have a suicide care management plan;

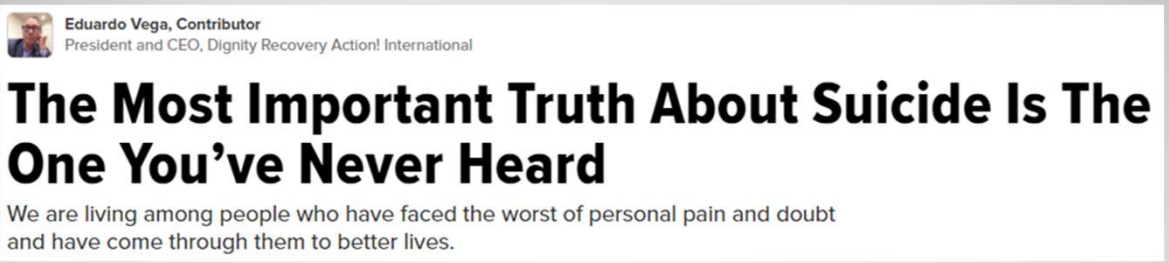
1) develop, review, and improve data collection on suicide attempts and deaths among those in care; and

1) assess the experience and satisfaction of patients who are or have been engaged in a suicide care management plan.

Recommended Measures:

	Measure	Numerator		Denominator		%
1	Screening	Number of clients who received a suicide screening during the reporting period		Number of clients enrolled during the reporting period		
2	Assessment	Number of clients who screened positive for suicide risk and had a comprehensive risk assessment (same day as screening) during the reporting period		Number of clients who screened positive for suicide risk during the reporting period		
3	Safety Plan Development	Number of clients with a safety plan developed (same day as screening) during the reporting period		Number of clients who screened and assessed positive for suicide risk during the reporting period		
4	Lethal Means Counseling	Number of clients who screened and assessed positive for suicide risk and were counseled about lethal means (same day as screening) during the reporting period		Number of clients who screened and assessed positive for suicide risk during the reporting period		
5	Missed Appointment Follow-up	Number of clients with a suicide care management plan who missed a face-to-face appointment and who received contact within 8 hours of the appointment during the reporting period		Number of clients with a suicide care management plan who missed a face-to-face appointment during the reporting period		
6	Acute Care Transition	Number of clients who had a hospitalization or emergency department visit who were contacted within 24 hours of discharge during the reporting period		Number of clients who had a hospitalization or emergency department visit during the reporting period		

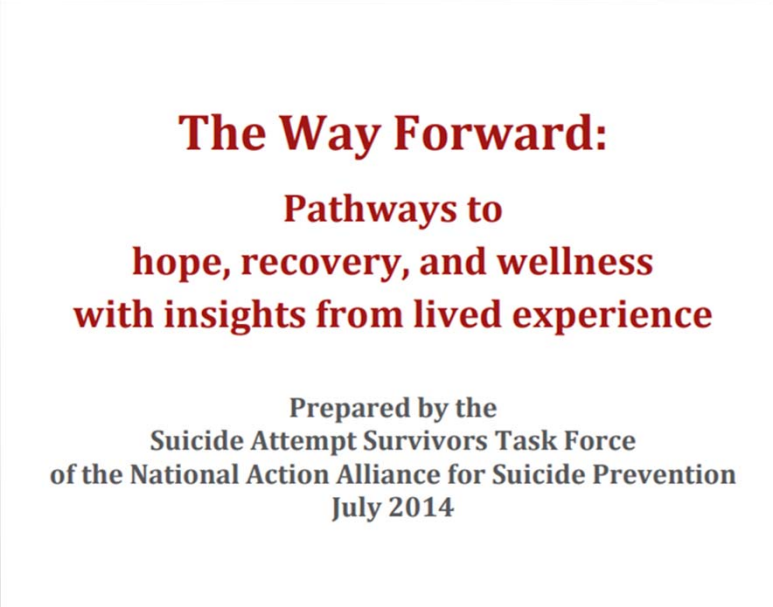
Involving those with lived experience


Eduardo Vega, Contributor
President and CEO, Dignity Recovery Action! International

The Most Important Truth About Suicide Is The One You've Never Heard

We are living among people who have faced the worst of personal pain and doubt and have come through them to better lives.

- Suicide prevention and behavioral health care organizations can engage, hire, and/or collaborate with peer support professionals. They should also include attempt survivors as key partners in suicide prevention efforts.
- Providers of crisis or emergency services can develop formal partnerships with organizations that offer peer support services and especially organizations that are operated or driven by people with lived experience.
- Suicide prevention and behavioral health groups can engage attempt survivors as partners in developing, implementing, and evaluating efforts.
- All types of providers can use a certified peer specialist on care coordination teams. This involvement can have direct benefits for a person receiving care, including role modeling and improved problem-solving.


The Way Forward:

Pathways to hope, recovery, and wellness with insights from lived experience

Prepared by the
Suicide Attempt Survivors Task Force
of the National Action Alliance for Suicide Prevention
July 2014

Purpose of the Collaborative

TRAIN on components of Zero Suicide

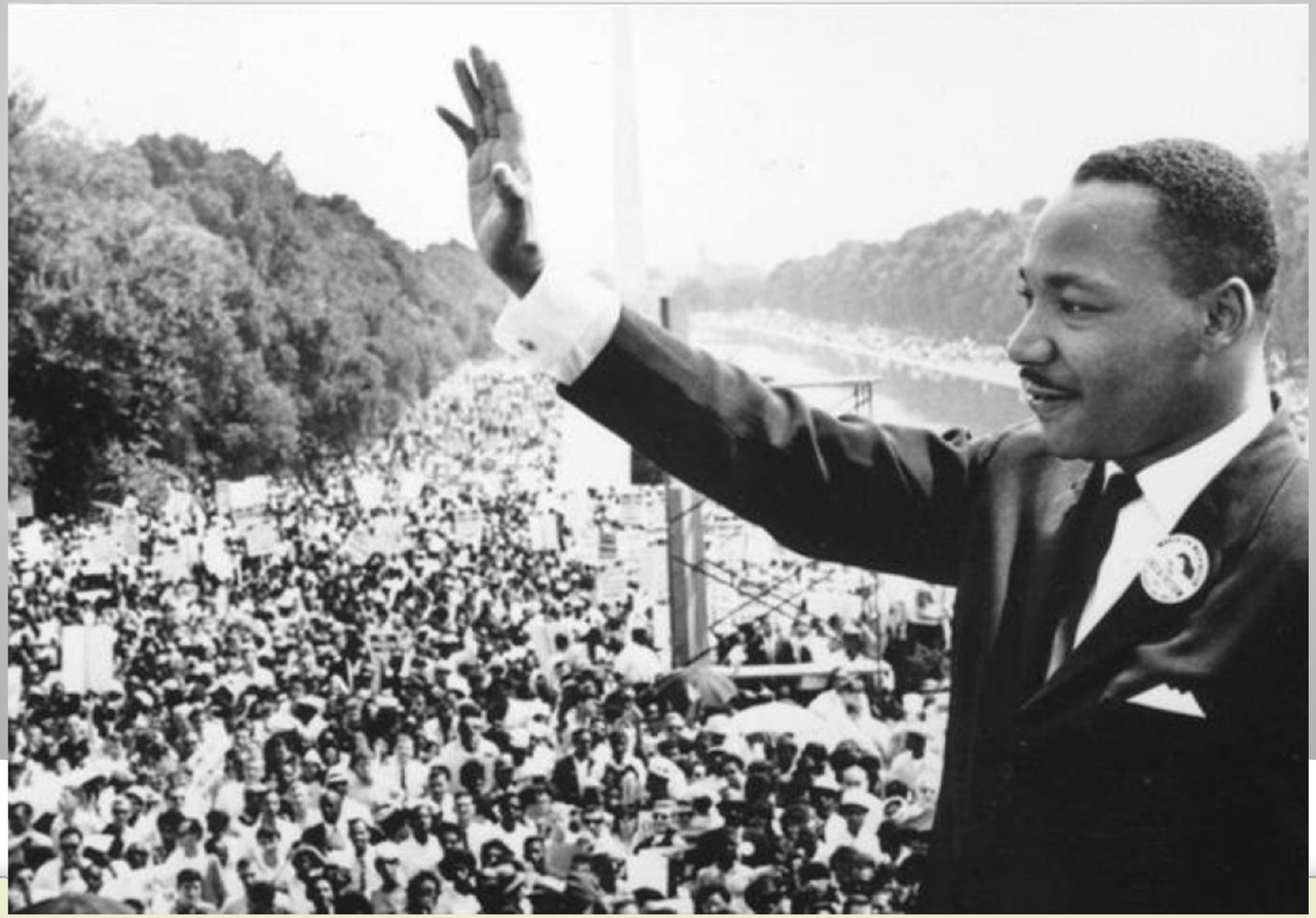
CONNECT you to local and national subject experts

PROBLEM SOLVE as a group to overcome barriers and discover practical applications

EMPOWER - Gain priority in DSAMH-sponsored training opportunities and other resources

Purpose of the Collaborative

Leading Zero Suicide Efforts



Getting Buy In From the Top Down

Create **urgency** that preventable deaths by suicide are unacceptable from moral, legal, and business viewpoints.

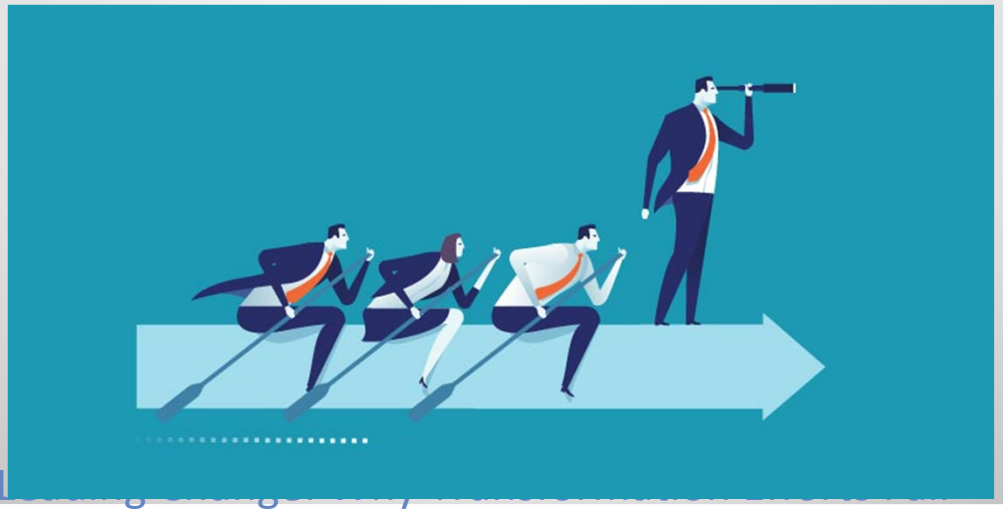
Use data and stories to show that **suicide is preventable**

Like Martin Luther King Jr and civil rights activists, have both a **dream** and a **plan**.

A quality improvement approach is both necessary and available.

When is the buy in and urgency high enough?

When 75% of a company's management is honestly convinced that business-as-usual is totally unacceptable.



John P. Kotter "L

Deaths by Suicide are Unnacceptable

- Suicide Risk as a Vital Sign: Mike Hogan

Suicide Screening vs. Cholesterol Screening and Heart Disease

- Standards of Care- Skip Simpson

Suicide is foreseeable; prediction is not the standard of care." Foreseeable" means to anticipate something bad is going to happen if proper intervention is not taken to prevent that "bad thing." Proper suicide screening and then a systematic suicide assessment will tell us who is at risk for an attempted suicide in the near term—hours, days, or weeks.

- Institute Of Medicine Report:

Reducing Suicide: A National Imperative: "Knowing is not enough; we must apply. Willing is not enough; we must do."

Suicide is Preventable

Most people who think about suicide or attempt suicide, do NOT go on to die by suicide.

People with suicidal thoughts are often deeply ambivalent. Part of them is uncertain, connected to life, or hopeful for a better future.

People with suicidal thoughts do not actually want to die. They want to end overwhelming pain or find a solution to an overwhelming problem.

Suicide is Preventable

Suicide crises are often brief. If we keep the person safe and support them through the crisis, they are likely to survive.

There are effective treatments and brief interventions for reducing suicidality, that can empower a person to manage suicidal thoughts, reduce their distress, and live a long and meaningful life.

Henry Ford Health System created an 80% reduction in suicide deaths by implementing the strategies captured in the Zero Suicide Framework.

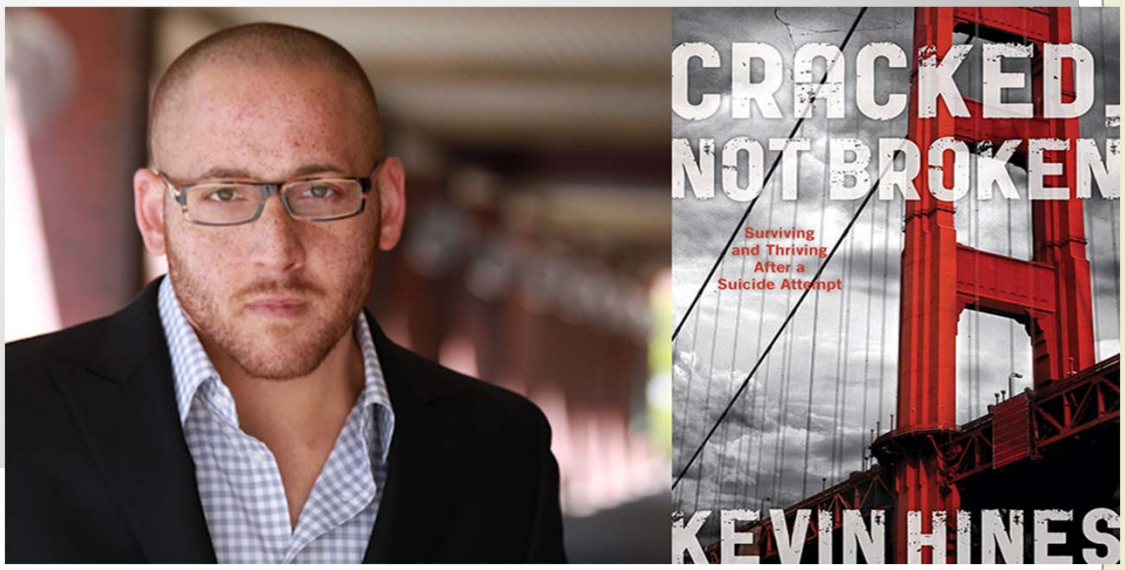
Suicide is Preventable

https://www.huffingtonpost.com/entry/the-most-important-truth-about-suicide-is-the-one-youve_us_594aebc2e4b062254f3a5b4b

https://sethadamsmith.com/category/life-is-worth-living/page/5/

http://www.kevinhinesstory.com/

http://livethroughthis.org/



Effective ZS Leadership

One of the most common errors made in Transformation Efforts is Undercommunicating the Vision by a Factor of Ten.

Use all existing communication channels to broadcast the vision.

Incorporate the vision into hour by hour activities such as routine problem solving meetings, performance appraisals, documentation, etc.

Executives learn to “walk the talk” and become a living symbol of the new culture.

John P. Kotter

“Leading Change: Why Transformation Efforts Fail

Effective ZS Leadership

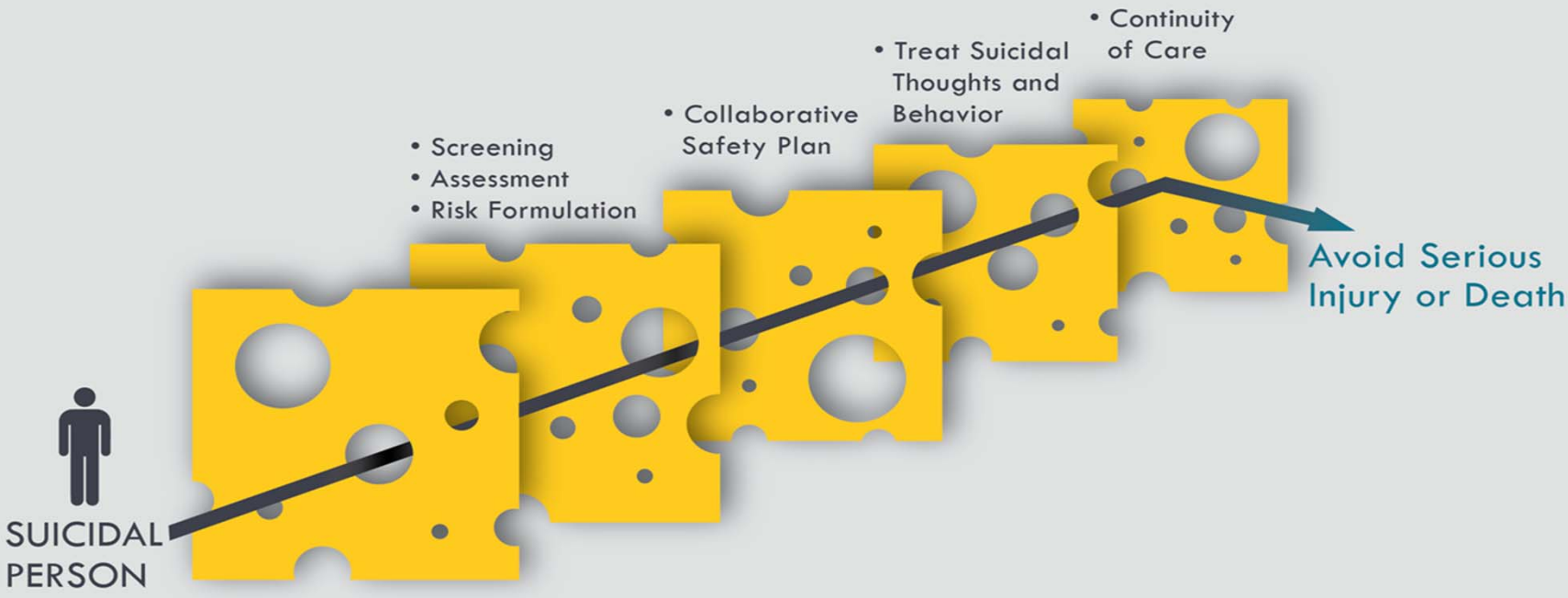
- "Baked In" to every level of organizational culture- reflected as a priority in budgets, staff meetings, training, documentation, etc.
- Must include written policy change WITH monitoring and support from mid-level management to carry out those policies
- Use stories and data to motivate and track success

Effective ZS Leadership

How do we have a culture of Zero Suicides and believe that suicide is truly preventable without staff feeling blamed when a client does take their life?

- Leadership honesty and transparency
- Support for the clinician as a loss survivor
- Embed ZS in a "Just Culture" where accountability is shared and system improvement is promoted over individual punishment

Zero Suicide Organizational Self-Study



Adapted from James Reason's "Swiss Cheese" Model Of Accidents

Rating	Description
1	Routine care or care as usual for this item. The organization has not yet focused specifically on developing or embedding a suicide care approach for this activity.
2	Initial actions toward improvement taken for this item. The organization has taken some preliminary or early steps to focus on improving suicide care.
3	Several steps towards improvement made for this item. The organization has made several steps towards advancing an improved suicide approach.
4	Near comprehensive practices in place for this item. The organization has significantly advanced its suicide care approach.
5	Comprehensive practices in place for this item. The organization has embedded suicide care in its approach and now relies on monitoring and maintenance to ensure sustainability and continuous quality improvement.

Question Example

12. Systematically identify and assess suicide risk:

What are the organization's policies for **screening** for suicide risk?

» **Please select the number where your organization falls on a scale of 1–5.**

○	**1**	There is no systematic screening for suicide risk.
○	**2**	Individuals in designated higher-risk programs or categories (e.g., crisis calls) are screened.
○	**3**	Suicide risk is screened at intake for all individuals receiving behavioral health care.
○	**4**	Suicide risk is screened at intake for all individuals receiving either health or behavioral health care and is reassessed at every visit for those at risk.
○	**5**	Suicide risk is screened at intake for all individuals receiving health or behavioral health care and is reassessed at every visit for those at risk. Suicide risk is also screened when a patient has a change in status: transition in care level, change in setting, change to new provider, or potential new risk factors (e.g., change in life circumstances, such as divorce, unemployment, or a diagnosed illness).

- In your work plan, plan for short term wins that are fairly easy to attain and will increase momentum and excitement for Zero Suicide.
- Connect these changes to stories and evidence of lives saved and improved.

SOUTHWEST BEHAVIORAL HEALTH CENTER

Zero Suicide Initiative

ZEROSuicide

IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

» LEAD

» TRAIN

» IDENTIFY

» ENGAGE

» TREAT

» TRANSITION

» IMPROVE

Its core propositions are that suicide deaths for people under care are preventable, and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The Zero Suicide approach aims to improve care and outcomes for individuals at risk of suicide in health care systems. It represents a commitment to patient safety—the most fundamental responsibility of health care—and also to the safety and support of clinical staff, who do the demanding work of treating and supporting suicidal patients.

The challenge of Zero Suicide is not one to be borne solely by those providing clinical care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners. This initiative in health care systems also requires the engagement of the broader community, especially suicide attempt survivors, family members, policymakers, and researchers. Thus, Zero Suicide is a call to relentlessly pursue a reduction in suicide for those who come to us for care.

The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted

1. **LEAD** » Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.
2. **TRAIN** » Develop a competent, confident, and caring workforce.
3. **IDENTIFY** » Systematically identify and assess suicide risk among people receiving care.
4. **ENGAGE** » Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
5. **TREAT** » Use effective, evidence-based treatments that directly target suicidality.
6. **TRANSITION** » Provide continuous contact and support, especially after acute care.
7. **IMPROVE** » Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

to address each of the elements listed above. SPRC also provides technical assistance for organizations actively implementing this approach.

Learn more at www.zerosuicide.com.

FOR MORE INFORMATION, PLEASE CONTACT:

Julie Goldstein Grumet, PhD

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

ZERO SUICIDE WORK PLAN TEMPLATE

This template should be used by an implementation team after completing the Zero Suicide Organizational Self-Study. It is organized by element of the Zero Suicide model and does not have to be completed all at once. To go directly to a particular element, click the link in the table of contents below.

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TRANSITION	10
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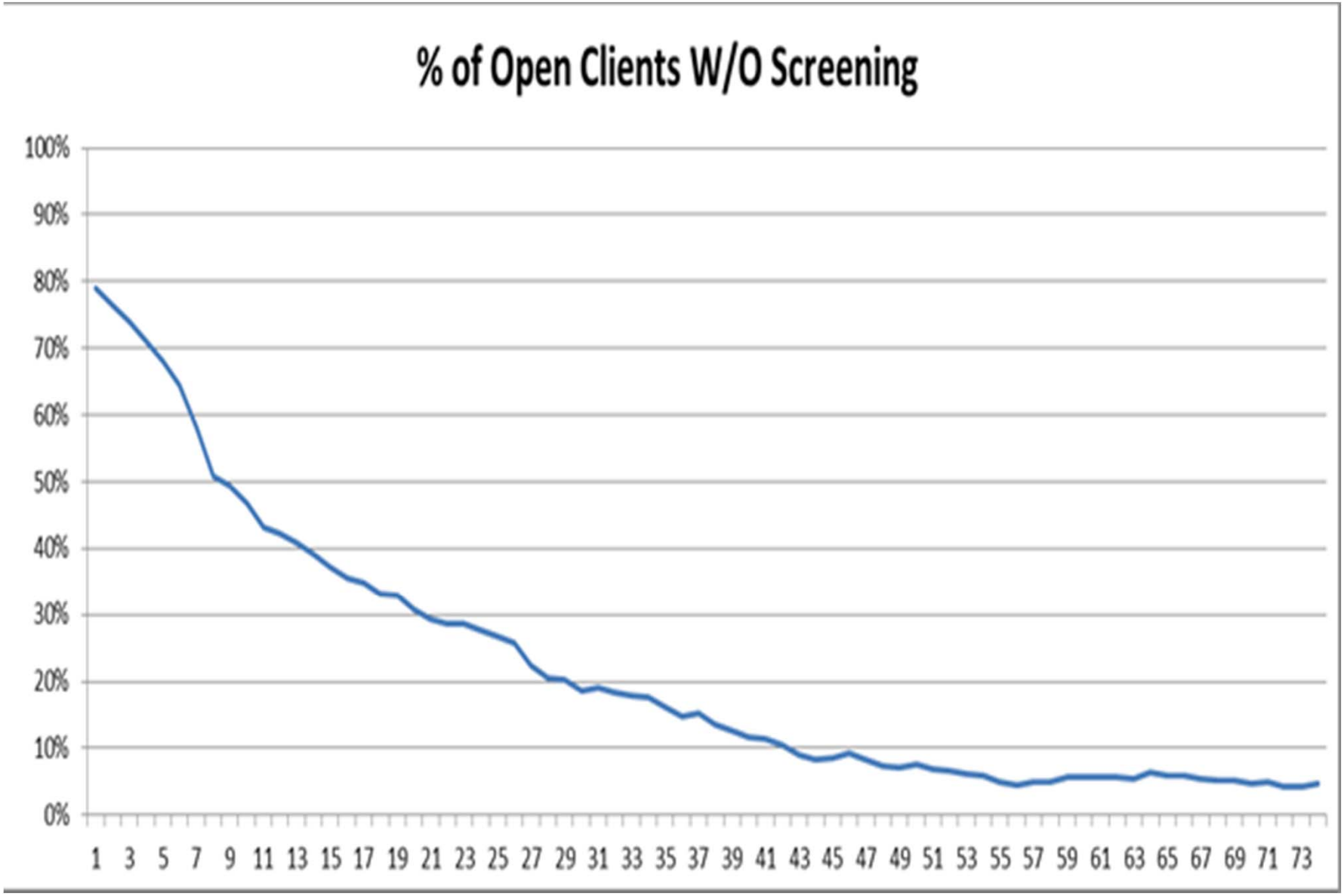
LEAD>> Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.					
	Timeline				
	Q1	Q2	Q3	Q4	Staff Responsible
Establish an implementation team. Clearly define tasks and roles of team members.					
Announce Zero Suicide philosophy to staff and establish ongoing communication about initiative.					
Consider ways to link Zero Suicide to other initiatives (e.g., trauma-informed care, substance abuse).					
Train management on new initiative (e.g., develop PowerPoint presentation for staff trainings).					
Present Zero Suicide to the board, where applicable.					
Establish budget to implement Zero Suicide (e.g., to purchase screeners, conduct training).					
Review agency policies to determine what new policies need to be developed.					
Ensure policies and procedures include review of adverse outcomes related to suicide.					
Ensure policies and procedures include support for staff who have experienced the suicide death of a patient.					

2	Legend	Blackened cells indicate the strategy does not apply to that component of implementation								
3		Cells shaded in red include the dates the strategy was completed. (Each date results in a point in the scoring column)								
4		Cells shaded in green include the name(s) of those accountable for completion of the strategy								
5	**Zero Suicide**		**Policy**	**Embed in EHR**	**Trained / Completed**	**1st Measure**	**Target Completion**	**Score**	**Out of**	**% Complete**	**Status/Comments**
6	**Domain**	**1. LEADERSHIP AND GENERAL TRAINING**									
7	**Goal**	**a. Create safety-oriented culture committed to the goal of zero suicide for people under care by development of a competent, confident, and caring workforce**									
8	**Strategies**	Create implementation team with clearly defined mission, tasks and	5/27/2015		5/27/2015			2	2	100%	
9		roles. Include suicide attempt and loss survivors	Michael		Michael						
10		Present Zero Suicide initiative to the board	12/7/2015					1	2	50%	
11			Michael		Michael						
12		Train CLT on Zero Suicide initiative	12/7/2015		5/3/2016			2	2	100%	
13			Michael		Michael						
14		Establish budget to implement Zero Suicide			6/14/2016			1	1	100%	
15					Mike						
16		General (anonymous) assessment of workforce for skills and	12/7/2015		5/27/2015	5/27/2015		3	3	100%	
17		confidence in providing suicide care	Michael		OS I-Team	OS I-Team					
18		Targeted (staff specific and non-anonymous) assessment of	12/7/2015					1	3	33%	
19		workforce for skills in providing suicide care	Michael								
20		Review last two years of client suicide deaths for opportunities of			2/2/2016			1	2	50%	Have each team engage in a conversation -
21		systemic change			OS I-Team	OS I-Team					facilitated by program managers This will probably take more than 1 meeting
22		Suicide prevention workflow model developed prior to training	12/7/2015	7/12/2016	7/12/2016			3	3	100%	Model can be attached to Home page of
23			OS I-Team	OS I-Team	OS I-Team						Credible
24		Develop training plan for all staff, based on assessments. Use	12/7/2015		2/2/2016			2	3	67%	Use Credible to monitor staff participation in
25		supervision, coaching and consultation mechanism	OS I-Team		OS I-Team	OS I-Team					training
26		Train staff on Zero Suicide philosophy and organization's program and	12/7/2015	7/12/2016	7/12/2016			3	4	75%	Use Credible to monitor staff participation in
27		expectations	OS I-Team	OS I-Team	OS I-Team	OS I-Team					training
28							SUB-TOTAL	19	25	76%	
29	**Domain**	**2. IDENTIFYING AND ASSESSING SUICIDE RISK**									
30	**Goal**	**a. Systematically and Universally Screen for suicide risk.**									
31	6	Universal application of C-SSRS and screening process - all new clients, every visit for those in OP, every week for those in IOP and Residential	12/7/2015	4/24/2015	8/2/2016	7/12/2016		4	4	100%	
32		All licensed staff trained	Michael	Michael	Michael	David					
33		All unlicensed staff complete QPR training	12/7/2015	7/13/2016	12/31/2016	7/13/2016					

May 2015 Narrative | MATRIX | Team


% of Open Clients W/O Screening
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
1 3 5 7 9 11 13 15 17 19 21 23 25 27 29 31 33 35 37 39 41 43 45 47 49 51 53 55 57 59 61 63 65 67 69 71 73

ZS Implementation Team

- Meets regularly to formulate, implement, and evaluate the work plan.
- Representation from different departments and levels of the organizational hierarchy.
- Authority for changing policies and procedures- must include several members with power to make changes
- Determine a role and goals in the work plan for all levels of staff.
- Responsible for measuring progress as well as suicide deaths within the agency and reporting outcomes back to agency at large.
- Helpful to have one point person on the team to be the face of the effort

ZS Implementation Team

- Includes those with lived experience and the suicide bereaved
  - Include people with lived experience in developing, implementing, and evaluating efforts
  - Include peer supports professionals on care coordination teams
- Taryn Hiatt from American Foundation for Suicide Prevention

Workforce Survey

2012 DSAMH Workforce Survey

I have received the TRAINING I need to engage and assist those with suicidal desire and/or intent:

36.6% Completely Agree or Agree

63.4% Completely Disagree, Disagree or Don't Know

I have the SKILLS I need to engage those with suicidal desire and/or intent:

38.1% Completely Agree or Agree

61.8% Completely Disagree, Disagree or Don't Know

I have the SUPPORT/SUPERVISION I need to engage and assist those with suicidal desire and/or intent:

47.7% Completely Agree or Agree

52.3% Completely Disagree, Disagree or Don't Know

Workforce Survey

DSAMH has already built out and paid for your staff to complete the new version of the survey in Qualtrics, just ask me for a link designated to your agency a few weeks before you would like to administer the survey. See the questions here http://zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/Zero%20Suicide%20Workforce%20Survey%20Questions.pdf

We will get the anonymous results back to you for your agency.

You can re-administer the survey and compare results in one to two years.

Technical Assistance & Training

Kim Myers and Andrea Hood available to provide one-on-one technical assistance and connect you to a national network of experts

Gatekeeper training (non-clinical introduction to suicide prevention) is available throughout the state for low or sometimes no cost

For information regarding clinical training opportunities and recommendations, see the handout.

Staff training should be recurring, built into comprehensive suicide prevention policy, and supported by supervision and consultation.