Wisconsin Public Psychiatry Network Teleconference (WPPNT)

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WPPNT Reminders

• Call 877-820-7831 before 11:00 a.m.

• Enter passcode 107633#, when prompted.

• Questions may be asked, if time allows.

• To ask a question, press *6 on your phone to un-mute yourself. *6 to re-mute.
The Power of Zero
A Systems Approach to Suicide Prevention
March 1, 2018
Presenters

Karissa Vogel, MSW, LCSW
Associate Director

Shel Gross, MPA
Director of Public Policy

Mental Health America of WI
What is Zero Suicide?

Culture Shift

The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable.

Suicide should be a “never event”.
What is Zero Suicide?

- Program
- Screening
- Continuity of Care
- Workforce Training
- Engagement

Set of Practices for HC settings
What is Zero Suicide

Over the decades, there have been many instances where individual mental health clinicians have made heroic efforts to save lives, but systems of care have done very little.

Dr. Richard McKeon
Suicide Prevention Branch Chief
SAMHSA
Why Zero Suicide?

Average WI Suicides:

2005-2007: 677
2008-2011: 747
2012-2015: 804
Why Zero Suicide?

Wisconsin Violent Death Reporting System

Of those who died by suicide:

- 51% had mental health issues
- 43% were under care
- 26% had alcohol issues
- 13% had substance abuse issues
Why Zero Suicide?

• In the month before their death:
  – Half saw a general practitioner
  – 30% saw a mental health professional

• In the 60 days before their death:
  – 10% were seen in an emergency department.
Why Zero Suicide?

Many licensed mental health clinicians are not prepared to respond to suicidality:

- 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
Why Zero Suicide?

 Joint Commission Sentinel Event Alert

• Issued in Feb. 2016
• “Suggested” actions to incorporate many of the practices of Zero Suicide.

Zero Suicide is now the standard of care for health care settings.
Zero Suicide Works

Henry Ford Health System

Perfect Depression Care Project:
Challenged to set a bold goal

If we’re providing perfect depression care
no one will complete suicide.
Zero Suicide Works

A System-Wide Approach for Health Care: Henry Ford Health System

Launch: Perfect Depression Care

Suicide Deaths/100k HMO Members

1999 2001 2003 2005 2007 2009 2011

ZEROSuicide
Zero Suicide Works

Air Force Suicide Prevention Initiative
• Suicides dropped by 1/3 over six years.

Maricopa Suicide Deterrent System Project
• 38% reduction among SMI

All three programs demonstrate the ability to dramatically reduce suicide in a “boundaried” population.
# Zero Suicide Works

## North Central Health Care Deaths by Suicide

<table>
<thead>
<tr>
<th>Year</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>2012</td>
<td>7</td>
</tr>
<tr>
<td>2013</td>
<td>6</td>
</tr>
<tr>
<td>2014</td>
<td>3</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
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</table>
Elements of Zero Suicide

Lead-Train-Identify-Engage
Treat-Transition-Improve

Toolkit: http://zerosuicide.sprc.org/toolkit
– Narrative
– Readings
– Tools
• Make an explicit, top down commitment to reduce suicide deaths

• Organizational Self-Assessment

• Develop a communications plan/obtain buy-in.
Train

Develop a confident, competent and caring workforce.

- Workforce survey; for all staff (not just clinicians)

- Trainings; for all staff (not just clinicians)
  - Table of trainings

- Treating the suicidality vs. treating the mental illness
Identify

• Screen EVERY person; no one in BH setting is at 0 risk for suicide.
• Incorporate into EMR if possible
• Popular tools:
  – C-SSRS – free online training, reduces false positives
  – PHQ-9 – screening in physicians’ offices
  – PSC – for youth
Engage clients in a suicide care management plan

• Assessment should be collaborative
• Develop a safety plan
• Utilize motivational interviewing to determine readiness for change
• Utilize those with lived experience
Treat suicidal thoughts and behaviors directly

- Multisystemic Therapy (MST)
- Collaborative Assessment and Management of Suicidality (CAMS)
- Dialectical Behavior Therapy (DBT)
- Cognitive Behavioral Therapy (CBT)
- Trauma-informed Care (TIC)
Transition

Follow patients through every transition in care

• Use of common screening tool across settings is helpful.
• Warm hand-offs
• Follow-up calls/cards
Improve

Apply data-driven quality improvement

- No-blame approach/Just Culture
- Death review teams
- Utilize root cause analysis to identify if/where system failed.
Upcoming Training

June 21-22
Wisconsin Dells
Teams of 4-6 people
$100/person

http://www.preventsuicidewi.org/zero-suicide
Upcoming Training

Prevent Suicide Wisconsin
Annual Conference

http://www.preventsuicidewi.org/conference.aspx
Contact

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Implementing Zero Suicide

Reflections on Our First Two Years

ROCK COUNTY HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
MARCH 2018
<table>
<thead>
<tr>
<th>Shift in Perspective From:</th>
<th>To:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepting suicide as inevitable</td>
<td>Every suicide is preventable</td>
</tr>
<tr>
<td>Stand-alone training and tools</td>
<td>Overall systems and culture change</td>
</tr>
<tr>
<td>Specialty referral to niche staff</td>
<td>Part of everyone’s job</td>
</tr>
<tr>
<td>Individual clinician judgment &amp; actions</td>
<td>Standardized screening, assessment, risk stratification and interventions</td>
</tr>
<tr>
<td>Hospitalization during episodes of crisis</td>
<td>Productive interactions throughout ongoing continuity of care</td>
</tr>
<tr>
<td>“If we can save one life...”</td>
<td>“How many deaths are acceptable?”</td>
</tr>
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</table>
Rock County Human Services
Behavioral Health Division

• Five Program Areas
  • Crisis Intervention and Stabilization
  • Community Support Programs (CPS)
  • Comprehensive Community Services (CCS)
  • Outpatient Services – Behavioral Health clinic services
  • Children’s Long Term Support (CLTS)
• 140 staff – licensed therapists, prescribers, nurses, case managers, crisis workers, peer specialists, paraprofessionals
March 2016 – Applied to attend the Zero Suicide Academy

- Team met to complete application and self-study
- Divided up sections to work on
- Reconvened to review as a whole
- Self-study asked for specific data which helped us realize how segmented our programs were
- Application included detail about suicide care within agency
- Letters of recommendations
June 2016 – Four people went to the two-day Academy

- Behavioral Health Division Manager, Outpatient Program Manager, Crisis Program Manager, Consumer with Lived Experience
- Outstanding training – included overview of Zero Suicide, lots of practical experience presented, and developed preliminary implementation plan
Summer 2016 – Share with stakeholders

- Human Services Board members
- Key Community Partners
  - Behavioral Health Steering Committee
  - Police
  - Health Care organizations/EDs
- HSD Staff
- Laid the foundation for success and successful partnerships
August 2016 – selected screening and assessment tool, Safety Plan

- Columbia Suicide Severity Rating Scale (C-SSRS)
  - Screen
  - Assessment
- Adaptation of Brown Stanley Safety Plan
- Screen was built into medical record immediately
- All other forms still on paper
- Selection was straightforward based on ease of use and our client population
September 2016 – Completed workforce survey to measure staff views – confidence, competence, experience

- Used Survey Monkey to develop survey
- Emailed to staff and reinforced need to complete
- 63% of staff completed
- Results indicated that staff are talking with clients about suicide with various levels of comfort and perceived self-confidence
- Helped us design our training approach
October 2016 – Launched community collaborative in Rock County

- Invited partners to collaborate on status and what’s working
- Focused on using similar tools and language
- Has included Health Systems, Police, Behavioral Health agencies, NAMI, Prevention agencies, Schools
October 2016 – Launched screening pilot in Crisis programs

- Trained Crisis staff
- Focused on new clients, jail clients, and safety plans
- As staff gained experience, expanded to all Crisis clients
- Learned how to coordinate with other internal programs
- Addressed staff concerns with frequent callers
- Crisis staff were critical to helping us understand how to implement and supporting other programs to implement
December 2016 – Began planning training and implementation

- Scheduled training for May 2017
- Identified basic documentation needs – electronic vs paper
- Incorporated feedback from early users
- Considered what should training include
- Started data collection
Spring 2017 – Created draft policies for screening, assessment, safety planning, lethal means restriction

- Policy categories:
  - Suicide Screening and Assessment
  - Safety Planning
  - Lethal Means Counseling
  - Firearms Protocol for Safety Planning
- Required multiple reviews with representation across Division
May 2017—Trained all staff across Division and got feedback about policies

- 140 staff in 16 different programs across the Division
- Focused on general training on C-SSRS screen and assessment, safety planning, lethal means restriction
- Used online training videos with entire group
- Distributed draft policies and requested feedback from each program area
July/August 2017 - “Finalized” policies, then got more feedback

- Following training and feedback, we finalized policies
- Identified implementation date
- Implementation was mixed due to multiple perspectives on how to implement
- Staff and program feedback about implementation
Fall/Winter 2017-2018

- Developed Death Response policy
- Revised Suicide Screening and Assessment policy
- Planning for CAMS training
- Completed QPR training for support staff
- Updating Safety Planning policy
- Working on firearm storage process
Data Collection – through 2/16/18

- Total screens completed
- Positive screens
- By staff and program area
- During several months:
  - 5,808 screens with 20 - 25% screening in
  - 2,047 unique clients
  - 108 staff completed at least one screen
Lessons Learned

◦ It’s a journey that requires persistence and flexibility
◦ Expect and respect that this is a significant change process and people will ask lots of questions
◦ There are moments of great accomplishment and moments of desperation
◦ And it’s totally worth it
Closing Comments
Zero Suicide: Workforce Development

Jim Salasek, Ph.D.
Licensed Psychologist
Zero Suicide: Workforce Development

Agnesian HealthCare’s evolution & journey in suicide prevention
- Identifying the rationale
- Identifying the barriers
- Identifying key partners within the system for collaboration
- Identifying resources
- Present the case
- Implementation
- Build on success
Zero Suicide: Workforce Development

Just some of the requirement:

- **National Patient Safety Goals (NPSG) NPSG.15.01.01, Element of Performance (EP) 1:** Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide. EP 2: Address the patient’s immediate safety needs and most appropriate setting for treatment. EP 3: When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

- **BEHAVIORAL HEALTH Care, Treatment, and Services (CTS) CTS.02.01.01:** The organization has a screening procedure for the early detection of risk of imminent harm to self or others.

- **Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings**
  
  [https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf](https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf)

- **Evaluating and Responding to Suicide Risk - Tools and Practices for Consideration**
  
  Webinar Replay
  
  [https://www.jointcommission.org/webinar_replay_evaluating_responding_to_suicide_risk_tools_practices](https://www.jointcommission.org/webinar_replay_evaluating_responding_to_suicide_risk_tools_practices)

- **Sentinel Event Alert 57: The essential role of leadership in developing a safety culture**

- **DHS 35 - (2)** The clinic shall include, in its written policies, the procedures for identifying risk of attempted suicide or risk of harm to self or others.

- **DHS 75: (6)** TRAINING STAFF IN ASSESSMENT AND MANAGEMENT OF SUICIDAL INDIVIDUALS.

  INDIVIDUALS, (a) Each service shall have a written policy requiring each new staff person who may have responsibility for assessing or treating patients who present significant risks for suicide to do one of the following:

  1. Receive documented training in assessment and management of suicidal individuals within two months after being hired by the service.

  2. Provide written documentation of past training or supervised experience in assessment and management of suicidal individuals.
Zero Suicide: Workforce Development

Requires effective leadership that is committed to:

- firmly believing that reducing suicide for those at-risk is possible
- promote changes in policies and procedures
- convince staff/others to see and believe that suicide can be prevented
- provide tangible supports in a safe, stigma and blame-free environment
- providing regular input and advice
Zero Suicide: Workforce Development

**Train - an element of Zero Suicide**

• Complete the Organizational Self Study to understand the process/policies and procedures you have and where they need improved.

• Complete a Workforce survey for staff – determine the needs of individuals at each level of the system

• Who should have what training and how will it be delivered

• Identify any relevant policies and procedures to assess what the needs are if someone is identified as “at-risk” and where changes may be needed

• Community level training and support based upon a common language and philosophy
Zero Suicide: Workforce Development

Train  Ensure that training contains the following elements:

• The fundamentals of the organization’s (Zero Suicide) philosophy
• Policies and protocols relevant to the staff member’s role and responsibilities
• Basic, research-informed training on suicide identification for all staff
• Additional training to all clinical staff to ensure a basic level of skill in assessing, managing, and treatment planning for patients at risk of suicide, including safety planning and reduction of access to lethal means
• Advanced training to deepen skills and increase confidence and effectiveness
• Annually review policies, procedures and training
Zero Suicide: Workforce Development

**Train**

There are a wide variety of **FREE** training webinars available across the spectrum of elements we are introducing you to here today. Some can be found on the Zero Suicide website, others on YouTube or TedTalks. It is important for you to complete a Workforce Assessment and an Organizational Self-Assessment to identify where your gaps are. Then you need to create the time to do the work that needs to get done.

Go to the Zero Suicide Toolkit (http://zerosuicide.sprc.org/toolkit) and access each element for specific training to assist in implementing strategies designed to achieve better outcomes.
Annual computer based training – 60 minutes and required to score at least 85%

Suicide: Assessment and Intervention

Furthering our commitment to excellence

- Statistics
- High Risk Populations
- SUICIDE as a Multi-factorial event
- Look for Acute Waming Signs
- Look for Other Warning Signs
- Assess for Risk Factors - Individual
- Assess for Risk Factors - Social/Environment
- Assess for Risk Factors - Societal
- Assess Suicidality - Thinking
- Assess Suicidality - Planning
- Assess Suicidality - Intent
- Assess for Protective Factors
- Determine Risk Level
- Implement Intervention
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<th>The Plan</th>
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<tr>
<td>1</td>
<td>August</td>
<td>The Emerging Zero Suicide Paradigm  <a href="https://edc.adobeconnect.com/_a1002235226/p1krurs0t71">https://edc.adobeconnect.com/_a1002235226/p1krurs0t71</a></td>
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<td>Screening and Assessment for Suicide in Health Care Settings  <a href="http://edc.adobeconnect.com/p2e71j71ahw/#sthash.MQaPv60Ij2YMx74G.dpuf">http://edc.adobeconnect.com/p2e71j71ahw/#sthash.MQaPv60Ij2YMx74G.dpuf</a>  <a href="http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf">http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf</a></td>
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<tr>
<td>4</td>
<td>December</td>
<td>Counseling on Access to Lethal Means -  <a href="http://training.sprc.org">http://training.sprc.org</a></td>
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<tr>
<td>5</td>
<td>January</td>
<td>What are the most effective services to treat and prevent suicidal behavior?  <a href="http://actionallianceforsuicideprevention.org">http://actionallianceforsuicideprevention.org</a></td>
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<tr>
<td>7</td>
<td>March</td>
<td>What interventions prevent suicidal behavior?  <a href="http://actionallianceforsuicideprevention.org">http://actionallianceforsuicideprevention.org</a></td>
</tr>
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<td>8</td>
<td>April</td>
<td>Principles of Effective Suicide Care  <a href="http://edc.adobeconnect.com/p3b5v78vwue">http://edc.adobeconnect.com/p3b5v78vwue</a>  See more at: <a href="http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf">http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf</a></td>
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<td>9</td>
<td>May</td>
<td>The Role of Peer Support Services slides 6-2-15  <a href="http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf">http://zerosuicide.sprc.org/resources?type_1%5B%5D=webinar#sthash.MQaPv60I.dpuf</a></td>
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<tr>
<td>10</td>
<td>By the end of December all nursing and clinical staff must complete</td>
<td>The research evidence for suicide as a preventable public health issue (this is a self-guided 12 hour course)  <a href="http://training.sprc.org">http://training.sprc.org</a></td>
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