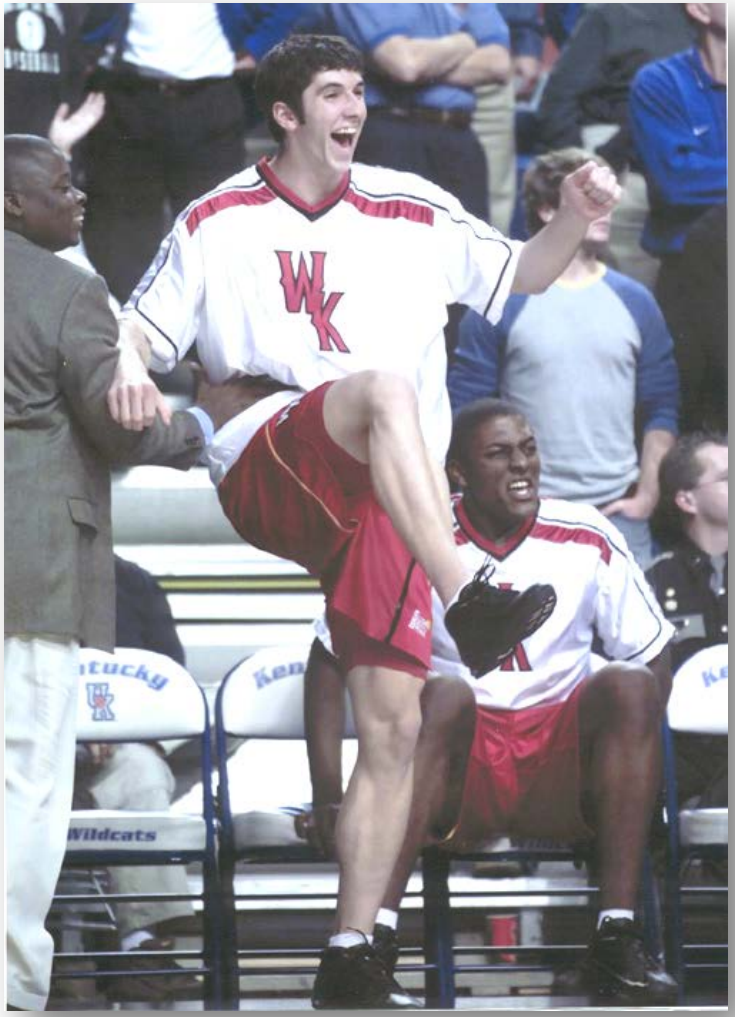
Launching A Statewide Zero Suicide in Systems of Care Initiative

in Kentucky

Jan Ulrich
Kentucky Suicide Prevention Coordinator
Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities

- **Who am I?**

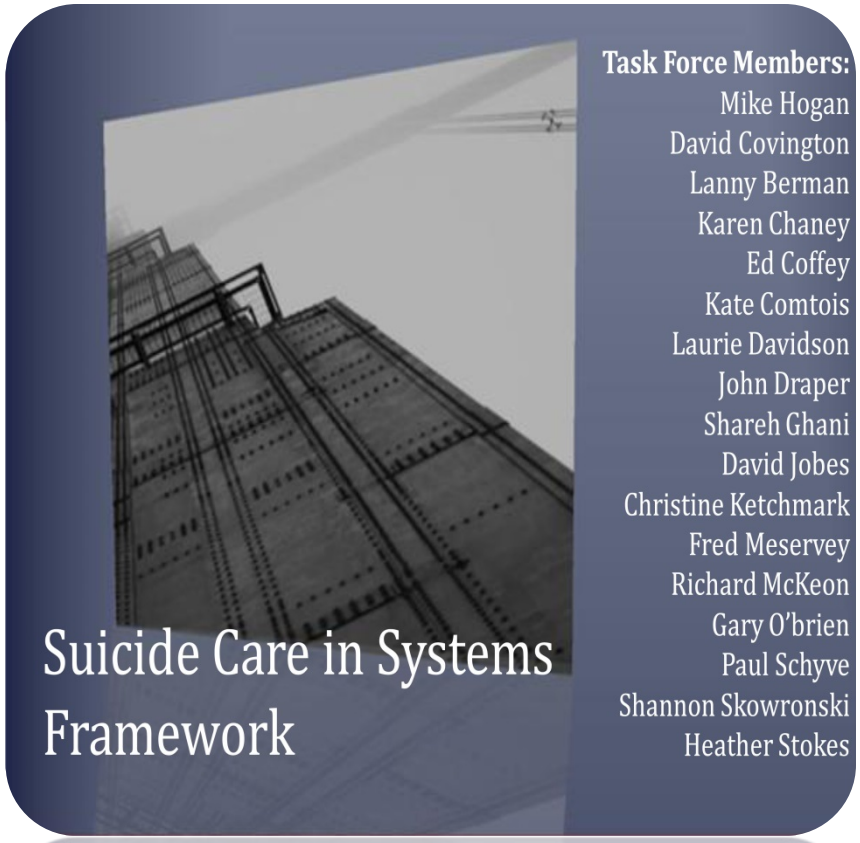


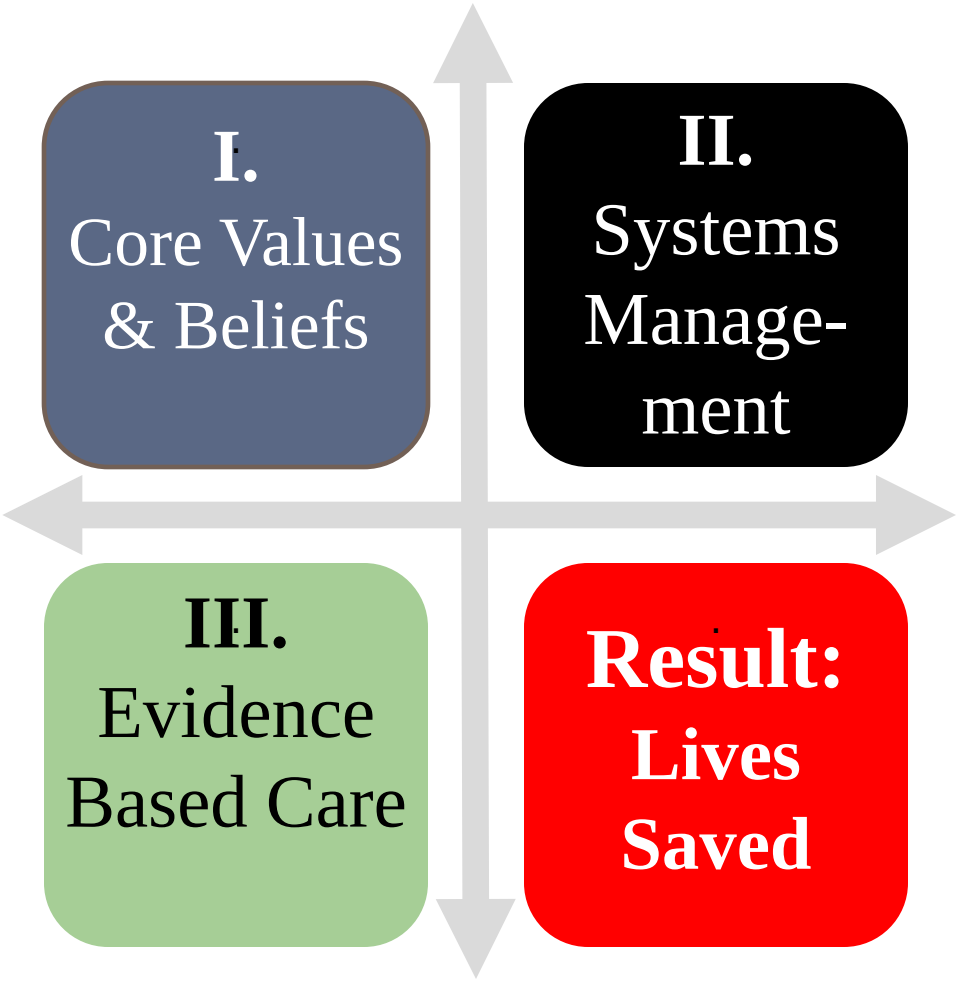
U.S. Suicide Deaths Vs. Motor Vehicle Fatalities

- **Suicide deaths now outnumber motor vehicle fatalities in the United States.**
  - **Motor Vehicle Fatalities: 35,498**
  - **Suicide Deaths: 38,364**

CDC WISQARS Fatal Injury Reports 2010

• Suicide Care in Systems Framework Report





National Action Alliance for Suicide Prevention

- **Vision**: A nation free of the tragic experience of suicide
- **Mission**: To advance the National Strategy for Suicide Prevention (NSSP) by:
  - Championing suicide prevention as a national priority;
  - Revising, and catalyzing efforts to implement high priority objectives of the NSSP;
  - Cultivating the resources needed to sustain progress.

Suicide prevention efforts tend to focus on "at-risk" groups

(rates greater than general population)

White Males 65+ 3-4x

Veterans/Military 2-4x

Alaskan Natives/ American Indians (AN/AI) 2-4x

Lesbian, Gay, Bisexual, Transgender (LGBT) Youth 2-3x

We should focus intervention on those at highest risk

Individuals with Serious Mental Illness (SMI) 6-12x

White Males 65+
The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85. *http://bit.ly/men-s*

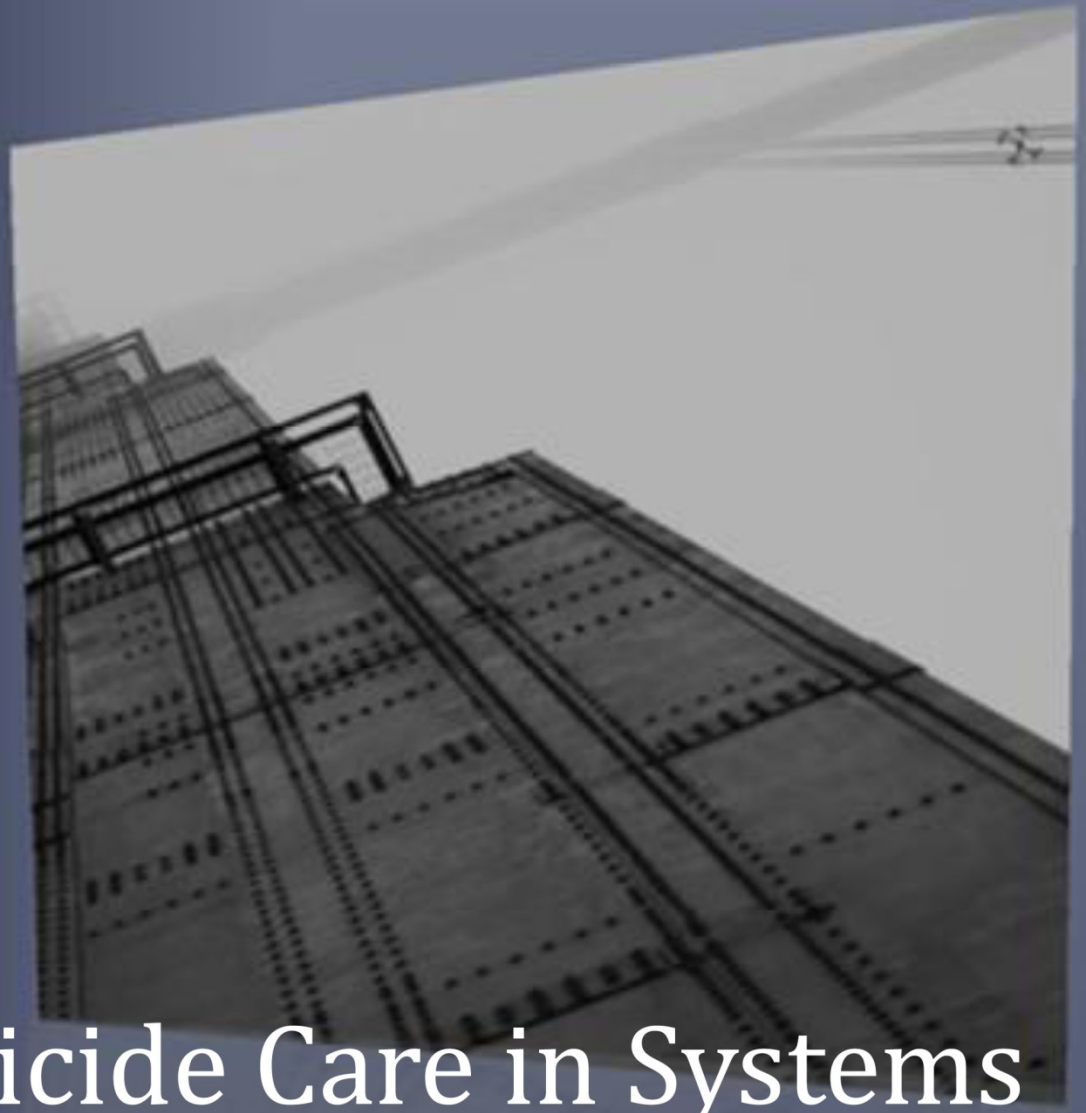
Veterans/Military
In 2010, *USA Today* reported the current U.S. Army suicide rate at 22 per 100,000 *(http://usat.ly/army-s)*, but the Fort Hood rate was 47 per 100,000. *http://bit.ly/ft-s*

AN/AI
In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. *USA Today* reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. *http://usat.ly/an-ak*

LGBT Youth
The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate. *http://bit.ly/wik-lgbt*

Individuals with SMI
In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness. *http://bit.ly/SMI-suicide-12x*

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.



Suicide Care in Systems Framework

Task Force Members:

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“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

“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
New York State Office of Mental Health

- System of care:
  - Any entity serving a defined population;
  - Has shared leadership, policy, or other structures that enable changes across subunits.
- What qualifies as a system? Examples:
  - Healthcare or behavioral health systems
  - Networks of providers
  - Military branches, college campuses (though our focus is healthcare)
  - Many lessons also apply to smaller units (e.g., EDs, multi-provider practices, etc.)

What is a “System of Care”?

Case Examples

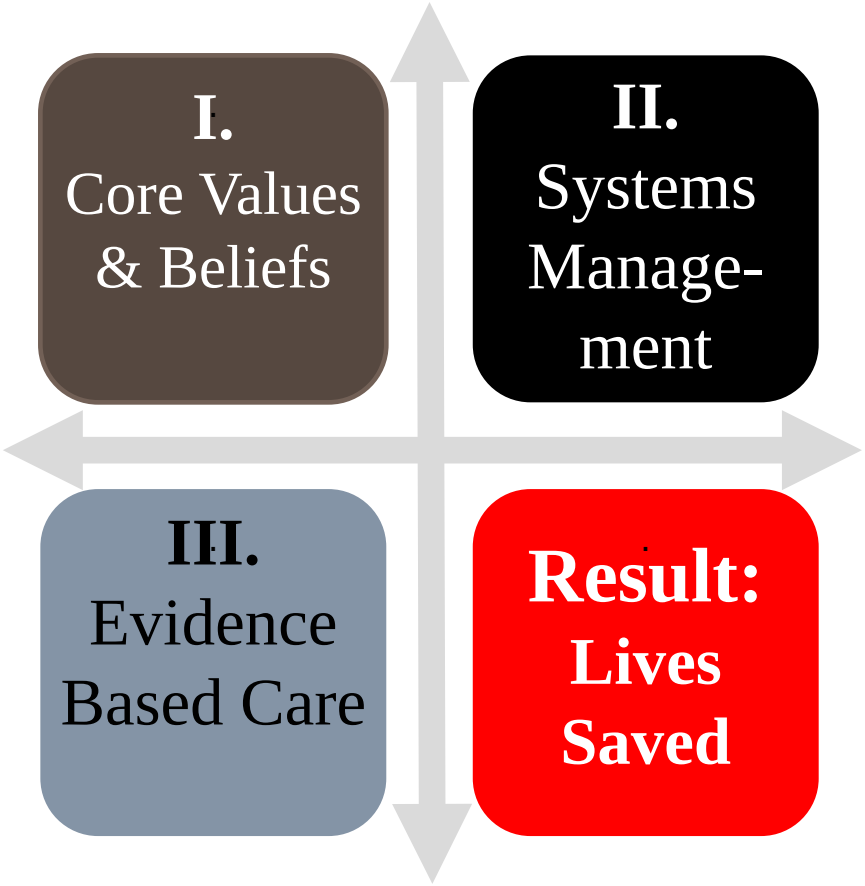
FOUR SYSTEMS

- U.S. Air Force
- Henry Ford Health Systems
- Magellan Maricopa Collaborative
- Veteran's Administration

ONE NETWORK

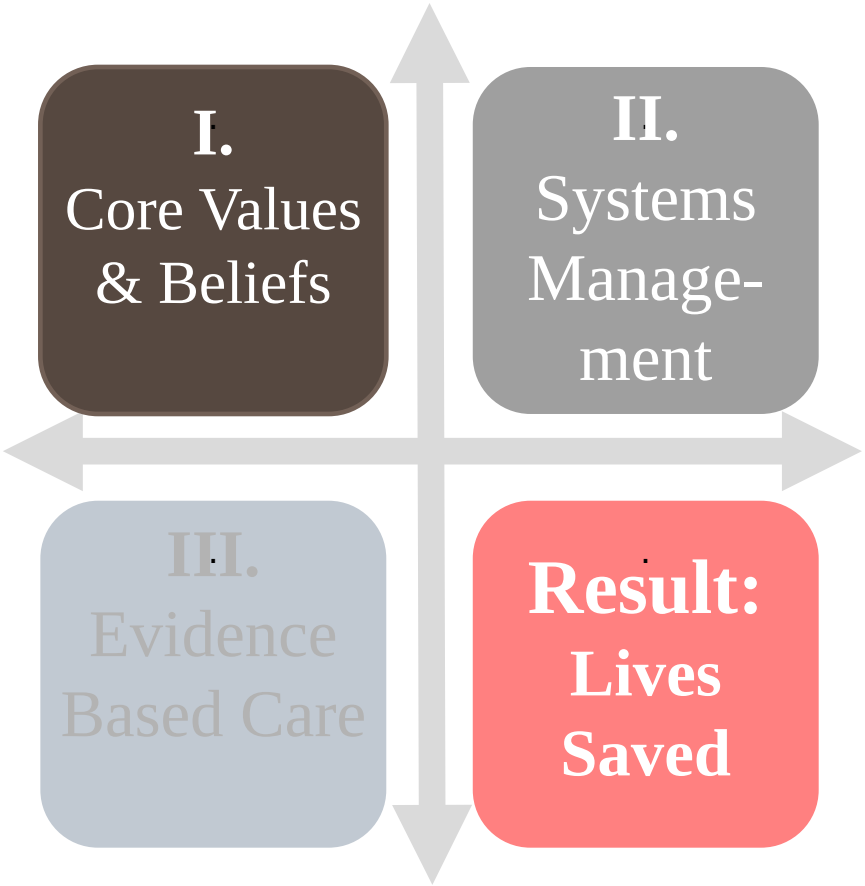
- National Suicide Prevention Lifeline

Shift in Perspective from:	To:
Accepting suicide as inevitable	Every suicide is preventable
Stand alone training and tools	Overall systems and culture change
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification and interventions
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care
"If we can save one life…"	"How many deaths are acceptable?"



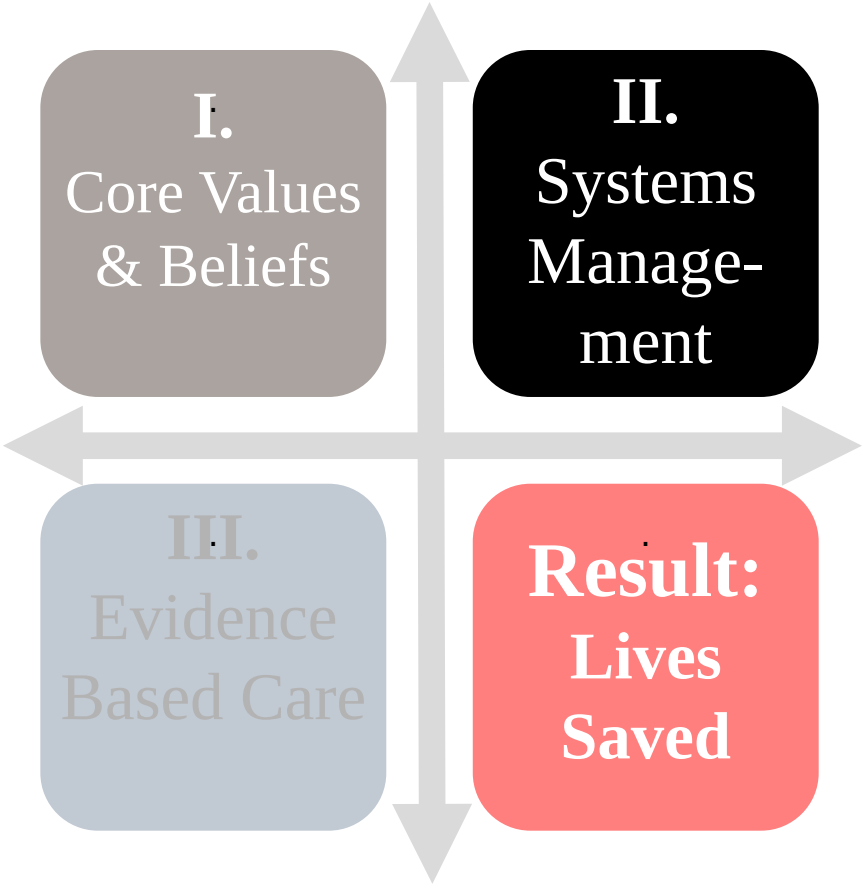
- High Reliability – Aviation goal zero commercial crashes
  - Don't train only the pilots; instead, all procedures & systems target success
- Health Systems – Eliminate:
  - Wrong-site, patient surgery
  - Inpatient falls
  - Medication errors
- Crossing the Quality Chasm

Systems of Care Framework



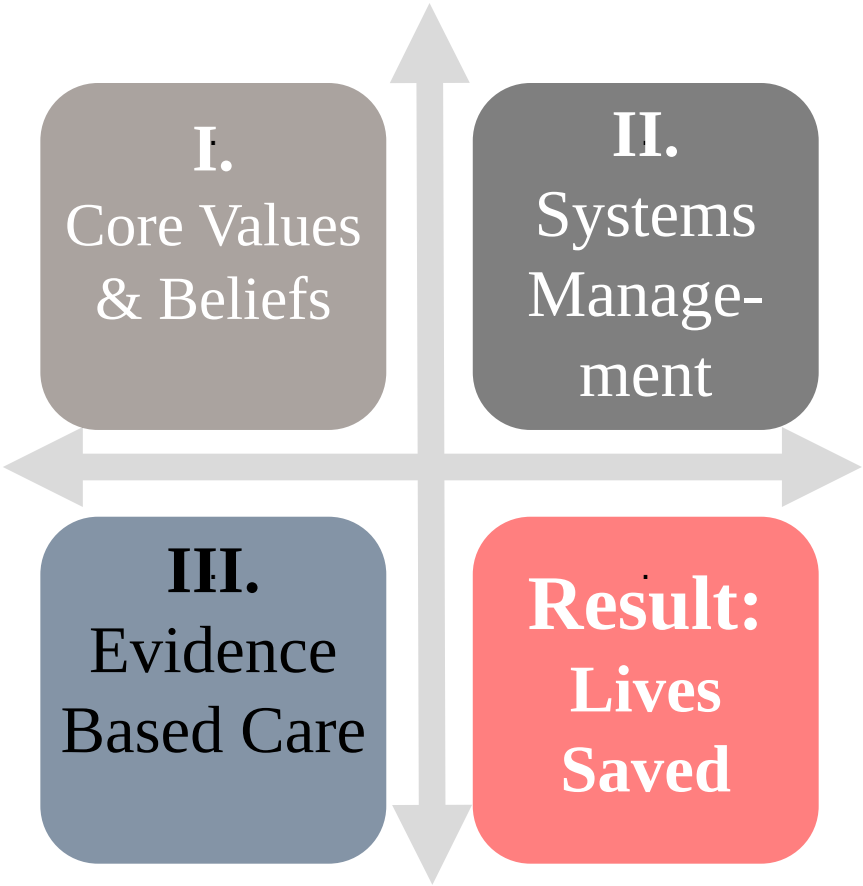
- Current science: Suicide is preventable
  - Those who die by suicide have intense ambivalence
  - Caring saves lives
- Last decade:
  - Increased research on effective interventions
  - Development of standardized risk assessments & standards
  - Systems successes

I. Core Values & Beliefs



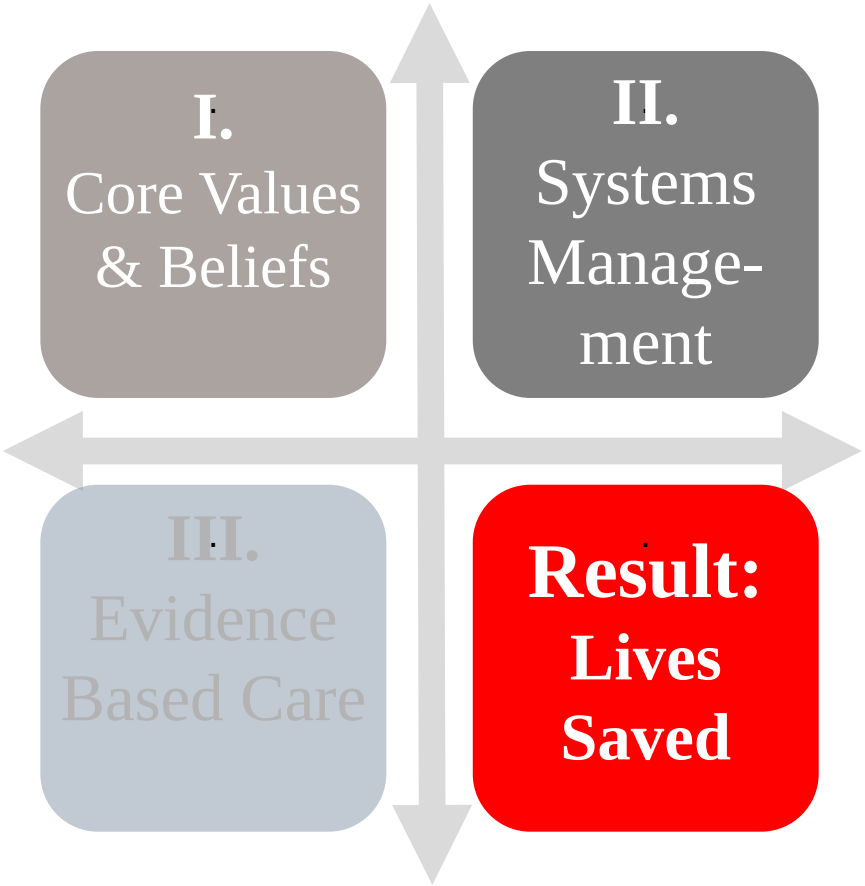
- Robust Performance Improvement
  - Workforce Development
  - Standardized Clinical Care
    - ✓ Screening & Assessment
    - ✓ Stratification of Risk
    - ✓ Regimen of Key Interventions
      - Access to Care
      - Means Restriction
      - Follow-up
  - Transparent Reporting & Feedback Loops, Commitment to Improvement

II. Systems Management



- "Productive Interactions" – Therapeutic relationships based on engagement and collaboration
- Treat suicide risk directly (not just underlying diagnosis)
- Evidence based care
  - Involuntary hospitalization is minimized, considered a safety measure and possible sign of community care defects

III. Evidence Based Clinical Care



- Timely public reporting of suicide deaths
  - Measure & Report
  - Feedback Loop

Accountability for Results: Lives Saved

THE COMMONWEALTH FUND

Case Study

Organized Health Care Delivery System • August 2009

Henry Ford Health System: A Framework for System Integration, Coordination, Collaboration, and Innovation

Douglas McCarthy, Kimberly Mueller, and Jennifer Wrenn
Issues Research, Inc.

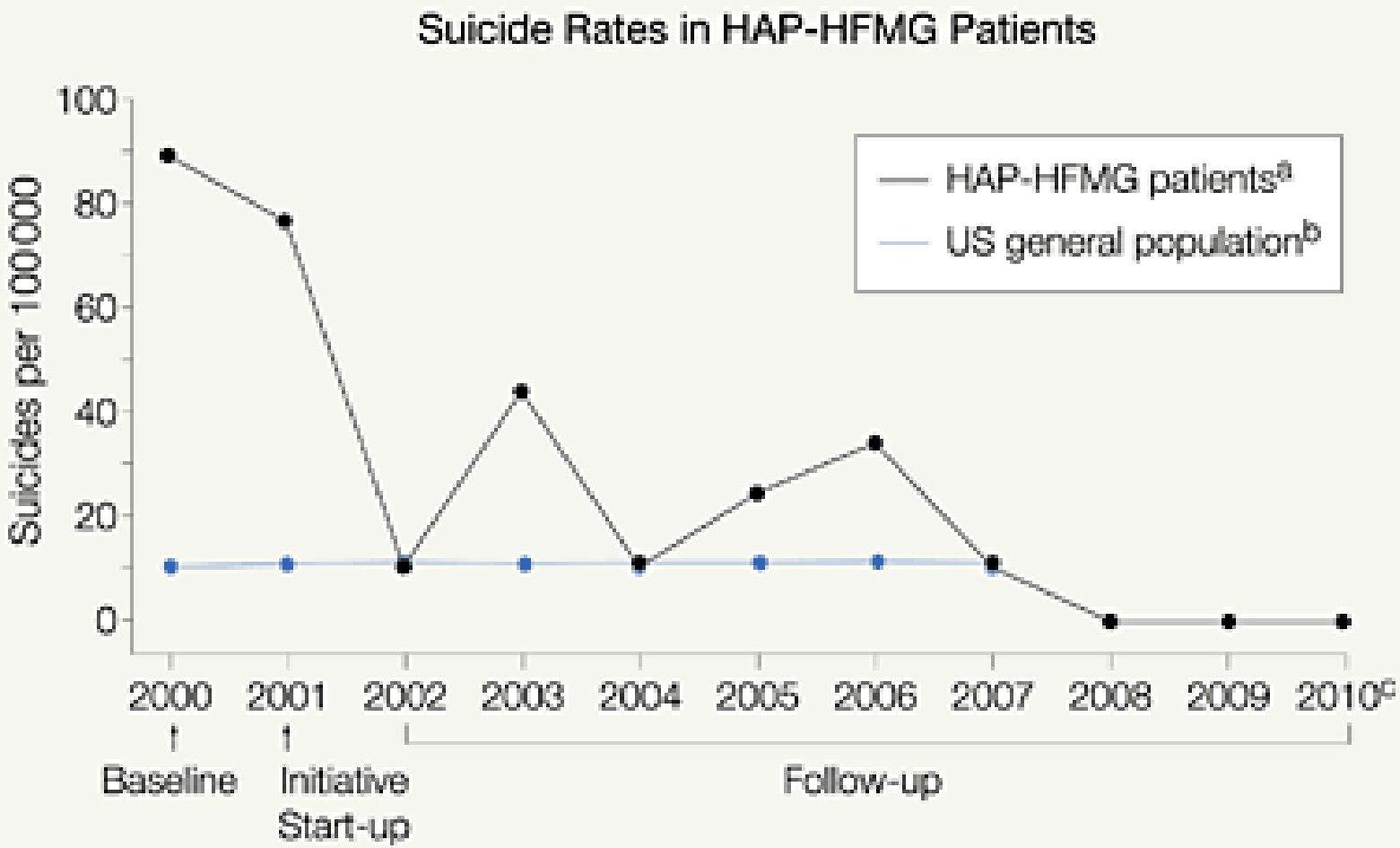
The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors,

ABSTRACT: Henry Ford Health System is a vertically integrated health care system in southeastern Michigan whose leadership is committed to systemic integration, clinical excellence, and customer value through the core competencies of collaboration, care coordination, and innovation and learning. Henry Ford's care innovation initiatives are multidisciplinary, team-led projects that target improvements in quality measures and evidence-based standards through problem-solving and the identification of common metrics to build consensus. The collaborative approach, fostered by shared vision and values, facilitates transformation throughout the system. Moreover, Henry Ford's integration of care delivery and coverage facilitates quality monitoring, measurement, and improvement activities.

- *Henry Ford Health System*
  - Improved access to immediate care
    - Drop-in group medication appointments
    - Advanced same-day access to care
    - Email “visits”
  - Planned care model
    - Risk stratification into 3 levels with associated interventions: emphasis on means
    - Established and maintained clinician competency in Cognitive Behavioral Therapy (CBT)

EB Clinical Care Practice: Case Examples

Henry Ford Health System



[a]Health Alliance Plan (HAP) health maintenance organization members receiving care from the Henry Ford Medical Group (HFMG). Data source: C. Edward Coffey, MD/Henry Ford Health System.

[b]Data sources: Heron MP et al. Deaths: final data for 2006. *Natl Vital Stat Rep.* 2009;57(14):30. Xu J et al. Preliminary data for 2007. *Natl Vital Stat Rep.* 2009;58(1):20.

[c]Includes first quarter of 2010.

MAGELLAN
HEALTH SERVICES
Getting Better All the Time

Maricopa Suicide Care System

Reference Guide

Driving Suicides to Zero

Screen
Assess
Stratify
Intervene
Follow up

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ASIST

Evidence based program

More than 2,400 staff trained

Continued training of new staff at all sites

Clinical Care & Intervention

Best practice review: HFHS, Harvard & Suicide Care in Systems Framework

Screening tools developed – adult, adolescent & child

Assessment categories -high, medium and low risk

Detailed interventions and support strategies

Survivor Support Group

Competitive RFP, selection process, awards, implementation

Working with peer run organizations to increase participation.

Participation, venue, frequency

Family Engagement

Developed a family engagement training with NAMI

Incorporated into new employee orientation

Finalizing Family Welcome Packet with Community Resources

Suicide Prevention and Intervention Model Validation

Case Analysis of 100 suicide cases (2009-2011)

Working collaboratively with providers and stakeholders to identify potential risk factors & predictive characteristics

Examples
- Social Support History
- Family Supports
- Suicide History
- Length of Care
- Family History of Suicide

- Substance Use
- Willing to Accept Help
- Medication/TX Adherence
- Hospitalization/Crisis Use
- Co-morbid conditions
- Recent Stressors

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ASIST suicide intervention training is changing the culture of community behavioral healthcare

Learn advanced suicide intervention and first aid skills

ASIST

Applied Suicide Intervention Skills Training

A 2-day workshop at either Southwest Network or Choices

Many who consider suicide would prefer to find a way to live.

The innovative ASIST workshop is designed to help caregivers feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over 750,000 caregivers have participated in this two-day, highly interactive, and practice-oriented workshop.

As an ASIST-trained first aid intervention caregiver, you will be better able to:

- Identify people who have thoughts of suicide
- Understand how your beliefs and attitudes can affect suicide interventions
- Understand the reasons for thoughts of suicide and the reasons for living
- Review current risks and develop a plan to increase safety from suicidal behavior
- Follow up on all safety commitments,

2010 WORKSHOP SCHEDULE

You may attend classes at either location. Class sizes are limited—register now to get the dates and location of your choice.

Jan. 12-13 ..... SWN
Jan. 27-28 ..... CHOICES
Feb. 9-10 ..... SWN
Feb. 24-25 ..... CHOICES
Mar. 9-10 ..... SWN
Mar. 24-25 ..... CHOICES
Apr. 13-14 ..... SWN
Apr. 28-29 ..... CHOICES
May 11-12 ..... SWN
May 26-27 ..... CHOICES
June 8-9 ..... SWN
June 24-25 ..... CHOICES
July 13-14 ..... SWN
July 28-29 ..... CHOICES
Aug. 10-11 ..... SWN
Aug. 25-26 ..... CHOICES
Sep. 15-16 ..... SWN
Sep. 22-23 ..... CHOICES
Oct. 12-13 ..... SWN
Oct. 27-28 ..... CHOICES
Nov. 9-10 ..... SWN
Nov. 17-18 ..... CHOICES
Dec. 14-15 ..... SWN

Southwest Network

CHOICES Network of Arizona

38% of the Maricopa behavioral health workforce reports someone in their care has died by suicide (19% more than once)

Staff who have completed the ASIST training "completely agree" that they have the training, skills and supports to engage and support those at risk of suicide at significantly higher rates.

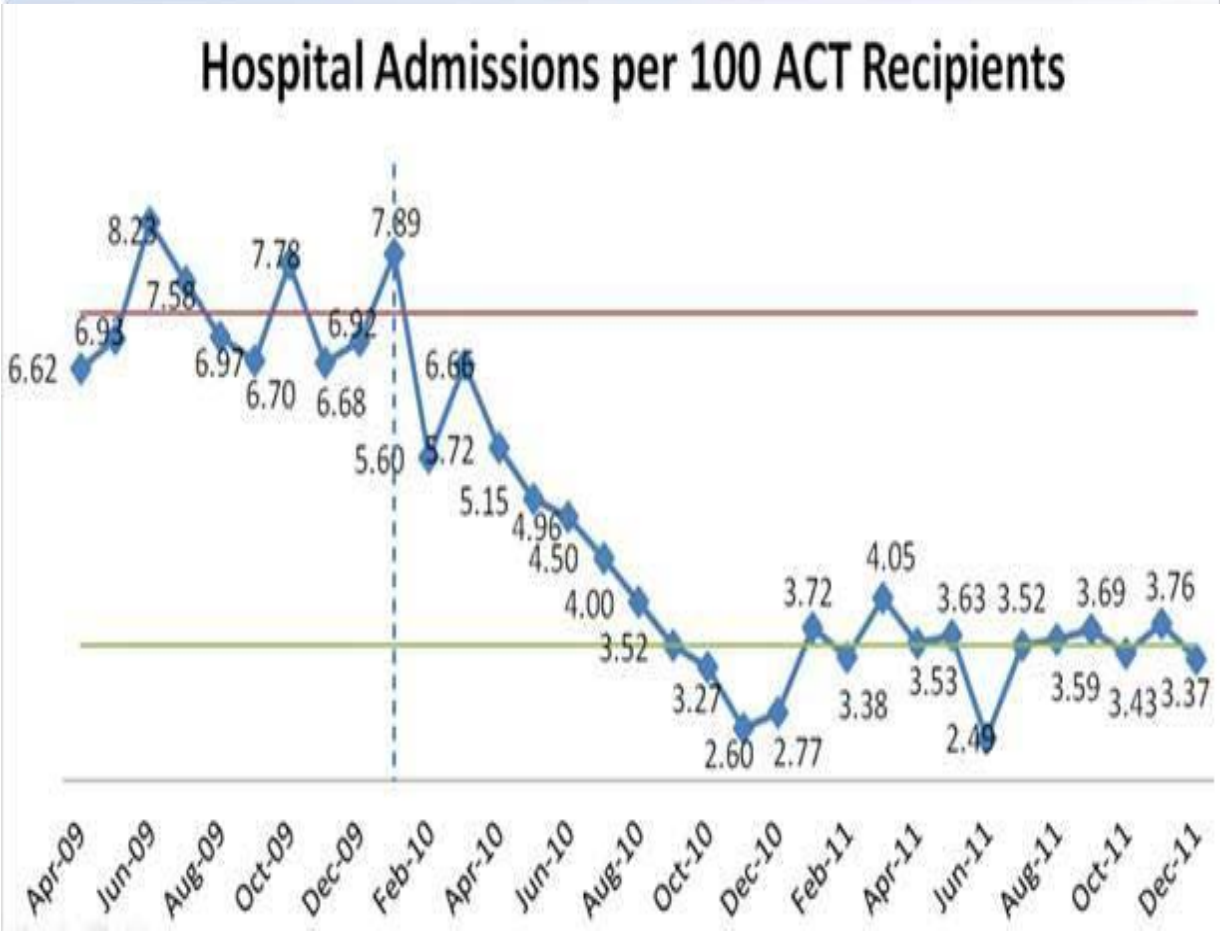
Workforce Survey	2009 AZ	2010 GA	2010 AZ	'10 vs. '09 Δ	'10 vs. GA Δ
Sample	1,630	1,550	665		
Training	14%	10%	41%	↑ 187%	↑ 289%
Skills	15%	10%	34%	↑ 131%	↑ 247%
Supports	18%	14%	35%	↑ 97%	↑ 151%

Above: Comparison of the 2009 Maricopa County and 2010 Georgia statewide with the 2010 Maricopa County ASIST trained respondents shows significant increases in "completely agree" responses.

Saving Lives Saves Money: Case Examples

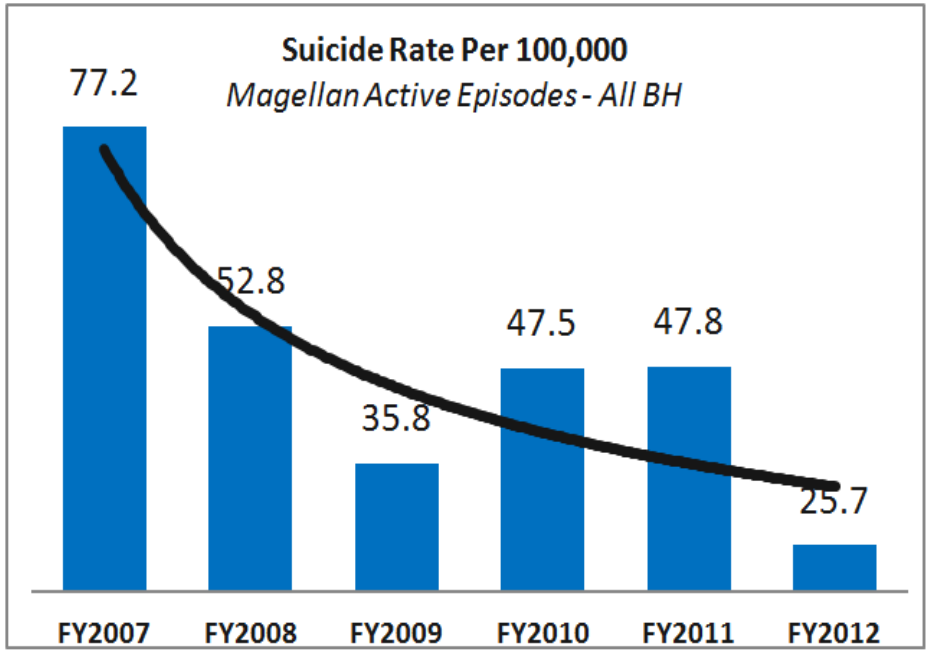
Clinical Excellence Logic Map

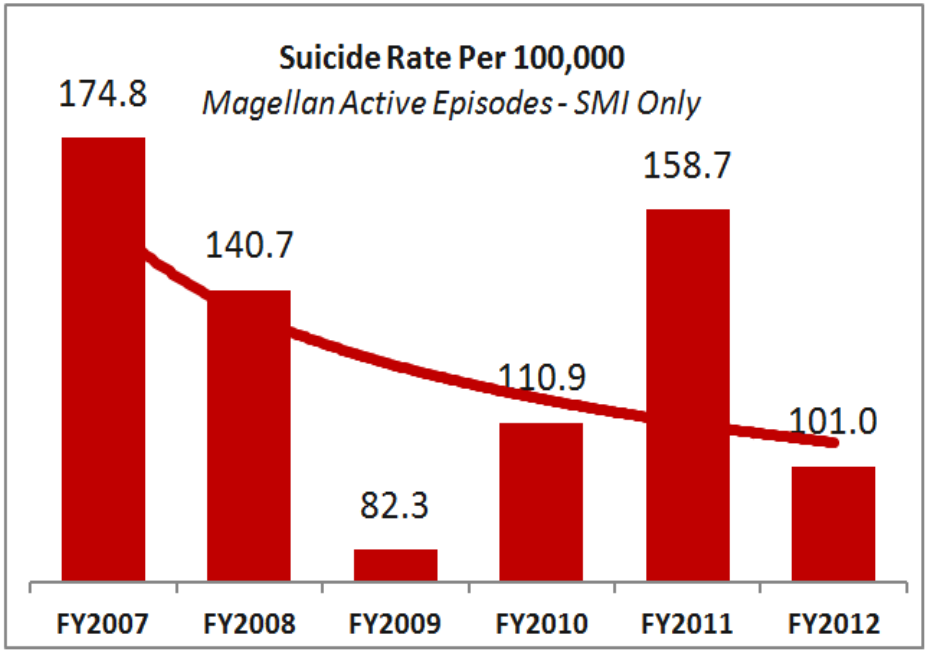
In the December 2010 "Policy for Helping Callers at Imminent Risk," SAMHSA emphasizes the need to reduce unnecessary hospitalizations and "active rescues" through stronger engagement, collaboration and follow-up.



Reduction in Suicide Rates

	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	Reduction
SMI	*174.8*	*140.7*	*82.3*	*110.9*	*158.7*	*101.0*	*42%*
Child	*5.4*	*10.6*	*0.0*	*4.3*	*6.1*	*0.0*	*100%*
GMH/SA	*58.1*	*25.0*	*32.4*	*37.8*	*30.8*	*12.7*	*78%*
Total BH	***77.2***	***52.8***	***35.8***	***47.5***	***47.8***	***25.7***	***67%***





• Making the Case for a State-directed Zero Suicide in Healthcare Initiative

Summary of Deaths by Suicide For State Fiscal Years 2007-2013
For Clients Who Were Served by Kentucky
Community Mental Health Centers (CMHCs)

RESULT 1: Of all CMHC clients served over the last seven years, an average of 156 (.08%) per year died of suicide in the year of or the year following their CMHC services.

SUMMARY BY STATE FISCAL YEAR Of all CMHC Clients Served:	State Fiscal Year (SFY)							Average per SFY	N
	2007	2008	2009	2010	2011	2012	2013 ^		
Total number of CMHC clients who died of suicide during the year or the year after they received CMHC services	169	183	162	187	132	172	88	**156**	**1,093**
Percentage of CMHC clients served who died of suicide during the year or the year after they received CMHC services	0.09%	0.09%	0.08%	0.09%	0.06%	0.08%	0.04%	**0.08%**	

^ 2013 includes partial year vital statistics data at the printing of this report.

Collaborating with Industry Leaders

Page: Training, Skills & Support

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

Around 48% didn't know or disagreed that they had received the training they needed to engage and assist those with suicidal desire and/or intent.

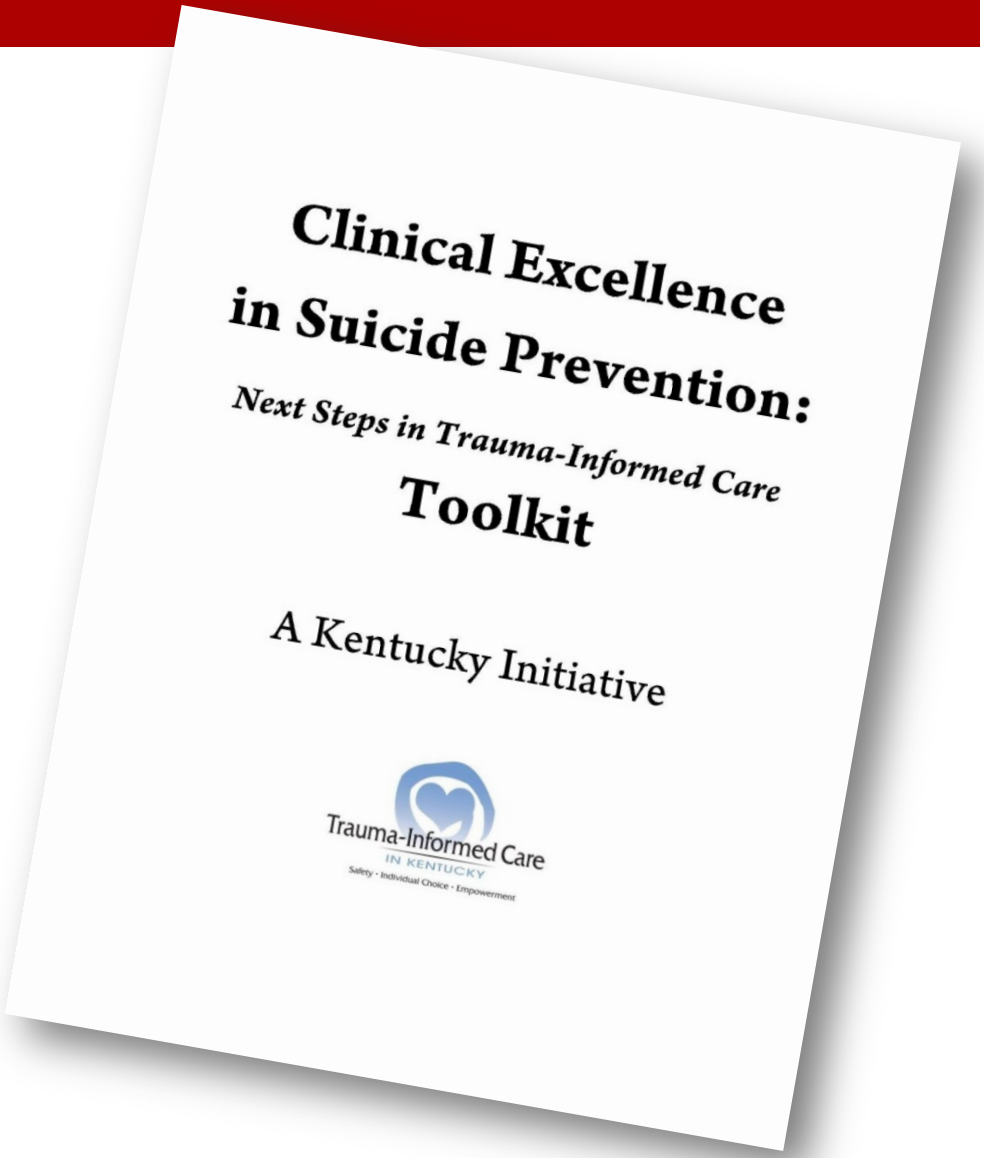
answered question	**2,672**
skipped question	**70**

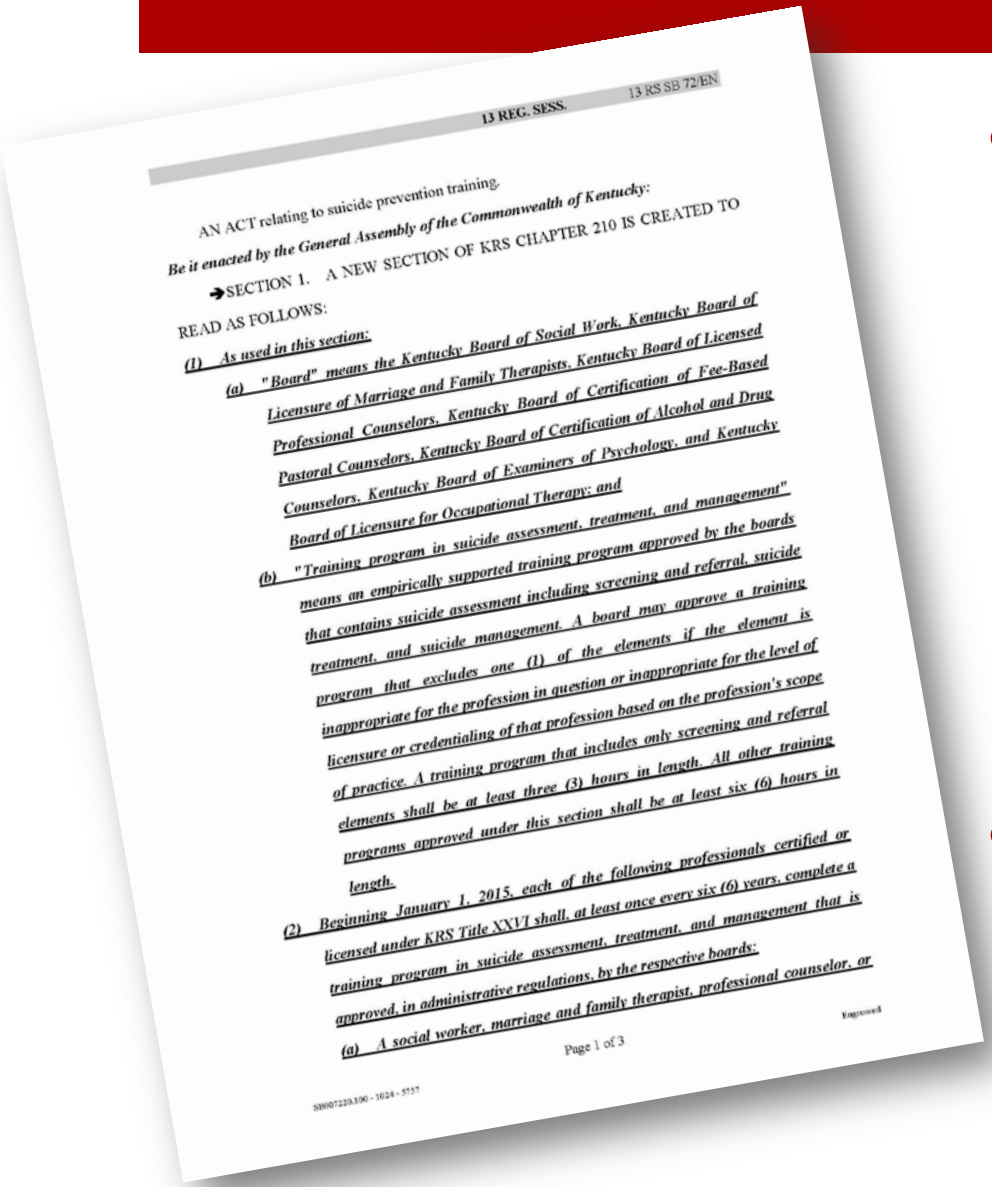
	Response Percent	Response Count
Completely agree	11.8%	314
Agree	**41.0%**	**1,095**
Don't know	8.5%	228
Disagree	31.0%	829
Completely disagree	7.7%	206

NOT ANOTHER LIFE TO LOSE:

Behavioral Healthcare Workforce Suicide Prevention Survey

- **Creating Conversion Experiences for Kentucky Leaders in Behavioral Health**





13 REG. SESS. 13 RS SB 72/EN

AN ACT relating to suicide prevention training.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS CHAPTER 210 IS CREATED TO READ AS FOLLOWS:

(1) As used in this section:

(a) "Board" means the Kentucky Board of Social Work, Kentucky Board of Licensure of Marriage and Family Therapists, Kentucky Board of Licensed Professional Counselors, Kentucky Board of Certification of Fee-Based Pastoral Counselors, Kentucky Board of Certification of Alcohol and Drug Counselors, Kentucky Board of Examiners of Psychology, and Kentucky Board of Licensure for Occupational Therapy; and

(b) "Training program in suicide assessment, treatment, and management" means an empirically supported training program approved by the boards that contains suicide assessment including screening and referral, suicide treatment, and suicide management. A board may approve a training program that excludes one (1) of the elements if the element is inappropriate for the profession in question or inappropriate for the level of licensure or credentialing of that profession based on the profession's scope of practice. A training program that includes only screening and referral elements shall be at least three (3) hours in length. All other training programs approved under this section shall be at least six (6) hours in length.

(2) Beginning January 1, 2015, each of the following professionals certified or licensed under KRS Title XXVI shall, at least once every six (6) years, complete a training program in suicide assessment, treatment, and management that is approved, in administrative regulations, by the respective boards:

(a) A social worker, marriage and family therapist, professional counselor, or

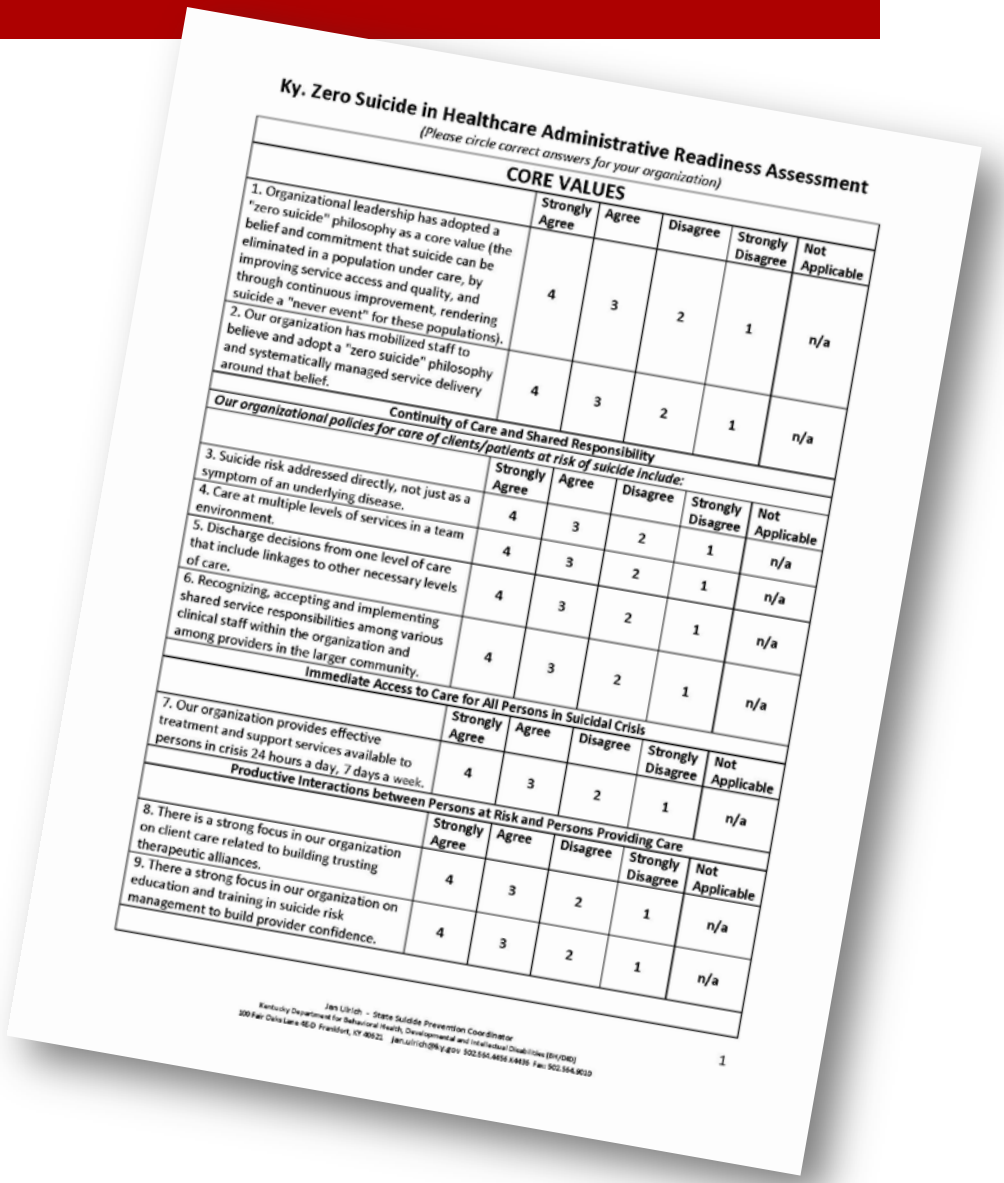
Engrossed

Page 1 of 3

SB007220.100 - 1024 - 5757

- **Legislating Change: Requiring Behavioral Health Professional Training in Suicide Risk Assessment, Treatment and Management**
- **Meeting the Need with Training of Trainers (AMSR and CAMS)**

- **Organizational Readiness Assessment and Improvement Planning in Community Mental Health Center Contracts**



Ky. Zero Suicide in Healthcare Administrative Readiness Assessment

(Please circle correct answers for your organization)

CORE VALUES	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
1. Organizational leadership has adopted a "zero suicide" philosophy as a core value (the belief and commitment that suicide can be eliminated in a population under care, by improving service access and quality, and through continuous improvement, rendering suicide a "never event" for these populations).	4	3	2	1	n/a
2. Our organization has mobilized staff to believe and adopt a "zero suicide" philosophy and systematically managed service delivery around that belief.	4	3	2	1	n/a
Our organizational policies for care of clients/patients at risk of suicide include:					
Continuity of Care and Shared Responsibility	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
3. Suicide risk addressed directly, not just as a symptom of an underlying disease.	4	3	2	1	n/a
4. Care at multiple levels of services in a team environment.	4	3	2	1	n/a
5. Discharge decisions from one level of care that include linkages to other necessary levels of care.	4	3	2	1	n/a
6. Recognizing, accepting and implementing shared service responsibilities among various clinical staff within the organization and among providers in the larger community.	4	3	2	1	n/a
Immediate Access to Care for All Persons in Suicidal Crisis	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
7. Our organization provides effective treatment and support services available to persons in crisis 24 hours a day, 7 days a week.	4	3	2	1	n/a
Productive Interactions between Persons at Risk and Persons Providing Care	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Applicable
8. There is a strong focus in our organization on client care related to building trusting therapeutic alliances.	4	3	2	1	n/a
9. There a strong focus in our organization on education and training in suicide risk management to build provider confidence.	4	3	2	1	n/a

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Launching A Statewide Zero Suicide in Healthcare Initiative in Kentucky

Suicide as a Never Event:

Setting the Stage for Change in Public & Behavioral Health Care Environments

DID YOU KNOW???

- Up to 88% of people who die by suicide had contact with their primary care provider (PCP) in the year prior to their death.
- Up to 66% had contact with their PCP in the month prior to their suicide.
- These same individuals were more than twice as likely to have seen their PCP as a mental health professional in the year and month prior to their suicide.

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence.

Primary Care Physicians

DID YOU KNOW???

- According to the Continuity of Care for Suicide Prevention and Research, a 2011 report regarding suicide attempts and suicide deaths subsequent to discharge from an emergency department or an inpatient psychiatry unit, "as many as 1 in 10 suicides are by people seen in the emergency department within two months of dying. *Many were never assessed for suicide risk."*

http://www.sprc.org/library/continuityofcare.pdf

Emergency Departments

- Most youth who die by suicide have a mental disorder, such as depression, or a substance use disorder.
- Youth in foster care are more likely to have a mental disorder or substance use disorder than those who were never in foster care (Pilowsky & Wu, 2006; Pecora et al., 2009).
- They are also 2 ½ x more likely to have seriously considered suicide and 4x more likely to have attempted suicide than other youth (Pilowsky & Wu, 2006).

Suicidal Behavior and Youth in Foster Care

- Many youth are placed in foster care because they have experienced trauma, abuse, and/or neglect by
- their families. According to one study, 54 percent of foster children had been sexually abused before placed with foster families, while another 28 percent had been physically abused or neglected (Pecora et al., 2005). Their families may have been affected by violence, mental disorders, and/or substance abuse. Another study found that having adverse childhood experiences, including emotional, physical, or sexual abuse, increased the risk of suicide attempts by 2-5x (Dube et al., 2001).

Suicidal Behavior and Youth in Foster Care

- 70% of juveniles who died by suicide while in confinement had history of suicidal behavior
- Self harm (including suicidal “gestures”) 24%
- Previously reported suicidal behavior 31%
- Suicide Prevention in Juvenile Detention and Correctional Facilities Webinar Series and Resources http://www.sprc.org/training-institute/juvenile-correctional-curriculum

Suicidal Behavior and Juvenile Justice

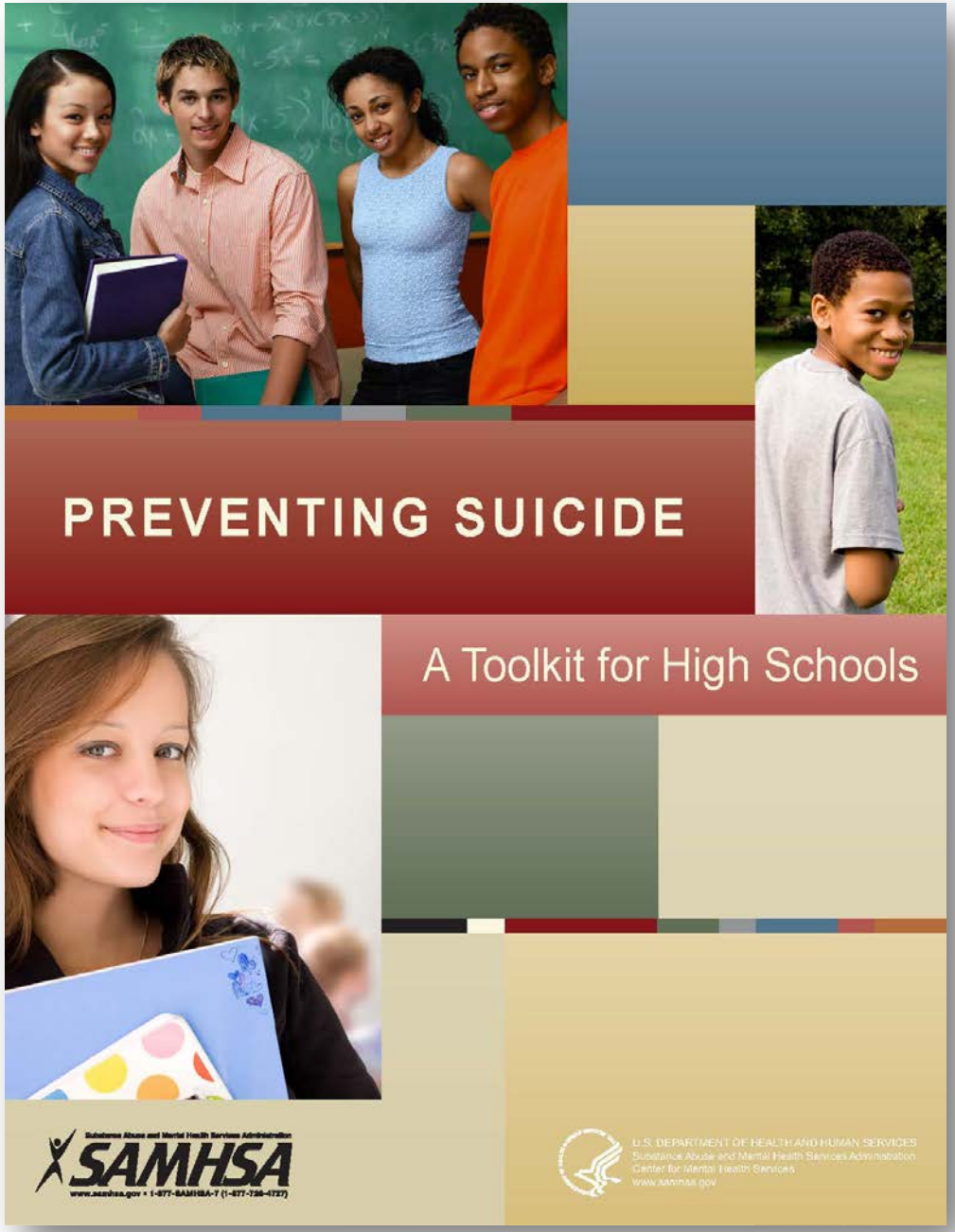
What is the School's Role?

- Create a comprehensive school crisis plan.
- Implement gatekeeping programs for staff, families and communities.
- Implement an evidence-based suicide prevention program for students.
- Be prepared to engage in "postvention".

Secondary Schools

Secondary Schools

http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf



Secondary Schools Checklist

Tool 1.I: Checklist of Suicide Prevention Activities

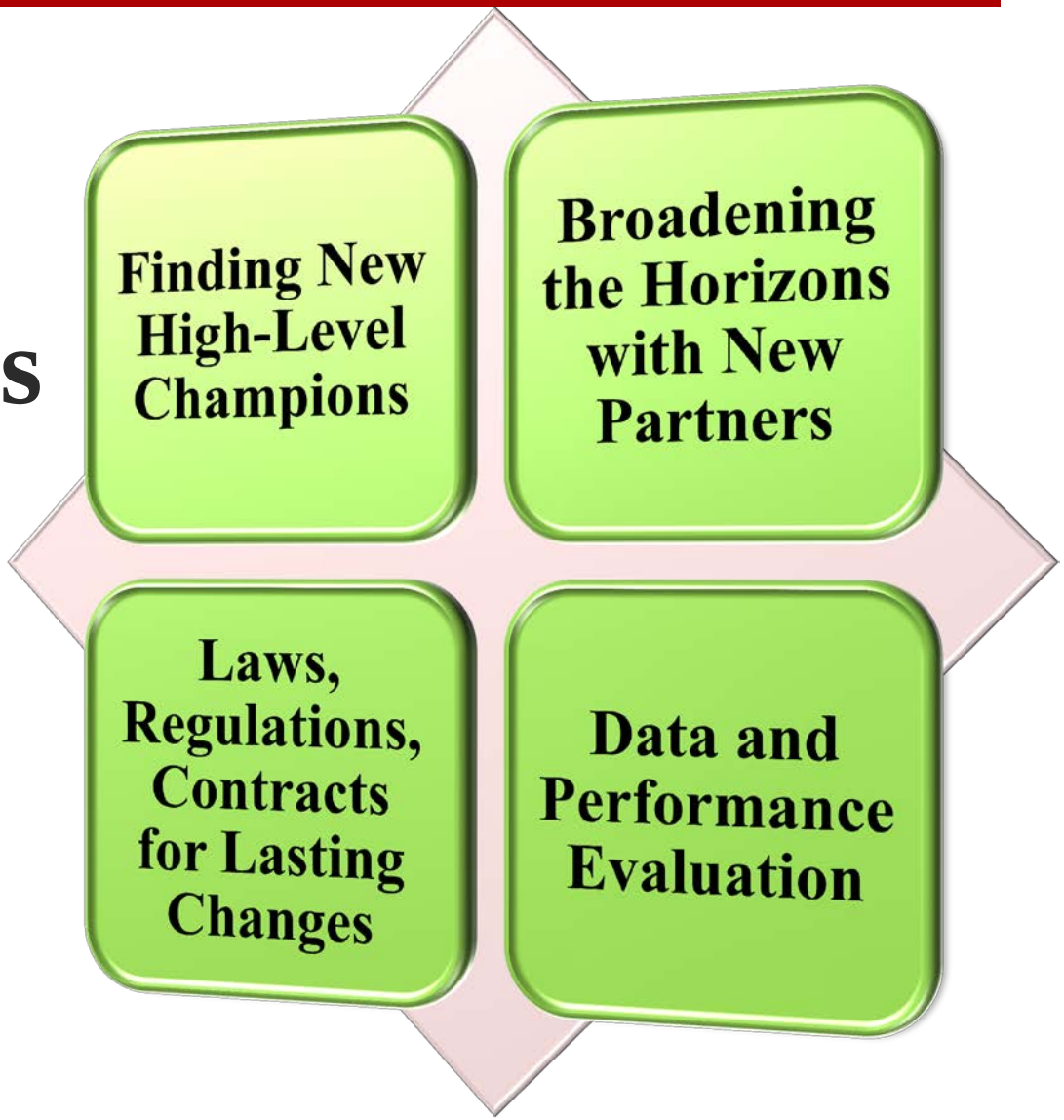
Suicide Prevention Activities	Yes	No	Not Sure	If no or not sure
Protocols for helping students at risk of suicide				
We have a written protocol for helping students who may be at risk of suicide that is consistent with the guidelines in Chapter 2 of this toolkit.	☐	☐	☐	Review and implement steps in Chapter 2
We have a written protocol for responding to students who attempt suicide at school that is consistent with the guidelines in Chapter 2 of this toolkit.	☐	☐	☐	Review and implement steps in Chapter 2
We have established agreements with outside providers to provide effective and timely mental health services to our students.	☐	☐	☐	Review and implement steps in Chapter 2
Protocols for after a suicide				
We have a written protocol for responding to the suicide of a student or other member of the school community that is consistent with the guidelines in Chapter 3 of this toolkit.	☐	☐	☐	Review and implement steps in Chapter 3
Staff who will implement the suicide response protocol are familiar with this protocol and the tools that will help them fulfill their responsibilities.	☐	☐	☐	Review and implement steps in Chapter 3
We have identified community partners to help us in the event of a suicide.	☐	☐	☐	Review and implement steps in Chapter 3
Staff education and training				
All professional and support staff have received information about the importance of school-based suicide prevention efforts, as described in Chapter 4 of this toolkit.	☐	☐	☐	Review and implement steps in Chapter 4
All professional and support staff have been trained to recognize and respond appropriately to students who may be at risk of suicide, as described in Chapter 4 of this toolkit.	☐	☐	☐	Review and consider implementing steps in Chapter 4
Our school has staff who have been trained to assess, refer, and follow up with students identified as at risk of suicide, as described in Chapter 4 of this toolkit.	☐	☐	☐	Review and consider implementing steps in Chapter 4
Parent/guardian education and outreach				
We educate the parents of our students about suicide and related mental health issues, as described in Chapter 5 of this toolkit.	☐	☐	☐	Review and consider implementing steps in Chapter 5

Suicide Prevention Activities	Yes	No	Not Sure	If no or not sure
We have a sufficient level of participation in our programs to educate parents about suicide.	☐	☐	☐	Review and consider implementing steps in Chapter 5
Student education				
We have implemented at least one type of program to engage students in suicide prevention.	☐	☐	☐	Review and consider implementing steps in Chapter 6
Suicide prevention is integrated into other student health/mental health courses and initiatives.	☐	☐	☐	Review and consider implementing steps in Chapter 6
Screening				
We have implemented a suicide screening program, as described in Chapter 7 of this toolkit.	☐	☐	☐	Review and consider implementing steps in Chapter 7
We have the support of parents, school staff, and community mental health providers for our suicide screening program.	☐	☐	☐	Review and consider implementing steps in Chapter 7

http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf

- **Challenges and Barriers**

- **Opportunities for Success**



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Zero Suicide Resources:

Zerosuicide.com

actionallianceforsuicideprevention.org

SPRC.org