Zero Suicide in Indian Country

May 2, 2016
SAMHSA Annual GLS Grantee Meeting
Suicide Prevention Resource Center
Promoting a public health approach to suicide prevention

The nation’s only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention.

www.sprc.org
National Action Alliance for Suicide Prevention

VISION
The Action Alliance envisions a nation free from the tragic experience of suicide.

MISSION
To advance the NSSP by:
- Championing suicide prevention as a national priority
- Catalyzing efforts to implement high priority objectives of the NSSP
- Cultivating the resources needed to sustain progress

GOAL
To save 20,000 lives in five years

ZERO Suicide
In Health and Behavioral Health Care
Defining the Problem: Health Care is Not Suicide Safe

- 45% of people who died by suicide had contact with primary care providers in the month before death. Among older adults, it’s 78%.

- 19% of people who died by suicide had contact with mental health services in the month before death.

- South Carolina: 10% of people who died by suicide were seen in an emergency department in the two months before death.
Suicide in AI/AN Health Care Settings

- **White Mountain Apache:** 82% (n=59) of people who attempted suicide visited an emergency department in the year prior to the attempt. 26% (n=19) visited an emergency department for a psychiatric reason, including suicidal thoughts or self-harm.
Zero Suicide...

- Makes suicide prevention a core responsibility of health care
- Applies new knowledge and proven tools for suicide care
- Supports efforts to humanize crisis and acute care
- Is a systematic approach in health systems, not “the heroic efforts of crisis staff and individual clinicians.”
- Is the health care component of a comprehensive approach to suicide prevention.
- Is embedded in the National Strategy for Suicide Prevention (NSSP).
Elements of Zero Suicide

- **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**

**Continuous**

**Approach**

**Quality**

**Improvement**
A System-Wide Approach Saved Lives: Henry Ford Health System

Launch: Perfect Depression Care

Suicide Deaths/100k HMO Members

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“Upon suffering beyond suffering: the Red Nation shall rise again and it shall be a blessing for a sick world. A world filled with broken promises, selfishness, and separations. A world longing for light again. I see a time of Seven Generations when all the colors of mankind will gather under the Sacred Tree of Life and the whole Earth will become one circle again. In that day, there will be those among the Lakota who will carry knowledge and understanding of unity among all living things and the young white ones will come to those of my people and ask for this wisdom. I salute the light within your eyes where the whole Universe dwells. For when you are at that center within you and I am in that place within me, we shall be one.”

-Crazy Horse, Oglala Lakota Chief
Leadership Commitment and Culture Change

- Leadership makes an explicit commitment to reducing suicide deaths among people under care and orients staff to this commitment.

- Persons with lived experience are supported, and participate in program design and delivery.

- Organizational culture focuses on safety of staff as well as persons served; opportunities for dialogue and improvement without blame; and deference to expertise instead of rank.
Native Americans for Community Action

Leadership

- Compliance
- Quality Assurance
- Sustainable
ACCOMPLISHMENTS

Development of Policy and Protocols – HR 419 Early Identification, Assessment and Management of Suicide Risk

- Screen all consumers using our primary health clinic; each visit
- Training the workforce
- Sustainable protocols
Pathway to Care
- Screening and Assessment:
  - PHQ-9, C-SSRS, AMSR
- CAMS, CAST, Diversion Activities
- Client/Patient Follow-up, EIRF, NYSL, UNITY,
- Electronic Health Record

ASIST and safeTALK

Integration Zero Suicide Sub-Committee
Policy and Protocol development

Continuous

NACA QI Team

Quality

Improvement

Original design from Education Development Center, Inc.
Screening and Risk Assessment

- Screen specifically for suicide risk, using a standardized screening tool, in any health care population with elevated risk.

- Screening concerns lead to immediate clinical assessment by an appropriately credentialed, “suicidality savvy” clinician.
Unique Leadership Considerations

- Sustain leadership throughout implementation.
- Codify leadership responsibilities in policies and procedures so work continues if turnover occurs.
Employee Assessment and Training

• Employees are assessed for the beliefs, training, and skills needed to care for persons at risk of suicide.

• All employees, clinical and non-clinical, receive suicide prevention training appropriate to their role.
MISSION:
To assist Northwest tribes to improve the health status and quality of life of member tribes and Indian people in their delivery of culturally appropriate and holistic health care.
Workforce Survey

- Administering the Survey
  - Paper vs. electronic
  - Outreach: Team meetings, Follow-up
  - Analysis: Options
  - Finalized Report
Section 1. Understanding the prevalence of suicide

1. The rate of suicide in my state is lower than the national average.
   - True 7.8% (8)
   - False 62% (52)
   - Don’t Know 30.2% (25)
   - Missing 0.0% (0)

Section 2.2 Beliefs about suicide

<table>
<thead>
<tr>
<th>By Trainee Professional Role¹</th>
<th>Percentage who &quot;Agree&quot; or &quot;Strongly Agree&quot; By Trainee Professional Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Staff</td>
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<tr>
<td>4. If a person is serious about suicide, there is little that can be done to prevent it.</td>
<td>8%</td>
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<tr>
<td>5. Suicidal people want to die.</td>
<td>0%</td>
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<tr>
<td>6. Suicide is always unpredictable.</td>
<td>14%</td>
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<tr>
<td>7. If you talk to someone about suicide, you may inadvertently give that person permission to seriously consider it.</td>
<td>9%</td>
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<tr>
<td>8. Depression indicates a suicide risk.</td>
<td>57%</td>
</tr>
<tr>
<td>9. Individuals with Borderline Personality Disorder frequently discuss or gesture suicide but do not really intent to kill themselves; instead they intend to provoke or manipulate others.</td>
<td>42%</td>
</tr>
<tr>
<td>10. People have a right to suicide.</td>
<td>13%</td>
</tr>
<tr>
<td>11. Few people want to kill themselves.</td>
<td>63%</td>
</tr>
</tbody>
</table>
Workforce Survey

- Created a Review Guide to:
  - Synthesize the results.
    - make the results less daunting and easier to interpret
  - Guide the site coordinators & teams to:
    - Select priorities and
    - Identify next steps
  - It helped streamline conversations...
Reviewing the Spring 2015 Workforce Survey Results

(Tribal Logo)

August 2015

This document should help guide you through your year 1 Zero Suicide workforce survey results. Please discuss the questions and statements below along side your results with your implementation team members. As part of your partnership with THRIVE’s Garrett Lee Smith youth suicide prevention grant Zero Suicide. Follow-up workforce surveys to show change will be administered in Sept./Oct. 2016 and again in Sept./Oct. 2018.

2. In section 3, what stood out to your team the most?
   (As a team, discuss the following questions and feel free to jot down some important points)
   a. Are you surprised by the number of staff that do/don’t bring up the topic of suicide with clients?
   b. Do you feel that the number of staff who are “neutral” or do not feel comfortable giving resources to a suicidal person to be acceptable?
   c. Do you feel the number of people who talk to suicidal person but do not discuss removal of lethal means is acceptable?
   d. What strategies, events, trainings could be used to remedy any topics within section 3 that your team feels are lacking?
3. In section 4, what stood out to your team the most?
   (As a team, discuss the following questions and feel free to jot down some important points)
   a. Are you surprised by the number of staff that do not feel comfortable talking about suicide?
   b. Do you feel that the number of staff who do not feel they have the necessary skills to help a suicidal person is acceptable?
   c. Do you feel the number of staff who answered “disagree” or “strongly disagree” to the question about having the support/ supervision needed to engage and assist people with suicidal desire and/or intent is acceptable?
      a. How does your team feel about this question, do they feel the “disagree” or “strongly disagree” answers are accurate?
   d. Does your team feel that additional skill building workshops and/or trainings around suicide prevention and how to talk with a suicidal person are necessary?
      a. If yes, what strategies, events, trainings could be used to increase the number of people comfortable talking about suicide with others and to increase the number of suicide prevention trained individuals at your site?
   e. Based on section 4, is there a group of staff you would like to target for suicide prevention?
      (Please provide inline notes and related questions to guide discussion.)
Workforce Survey Results

- Everyone’s results will vary
- Many sites choose to start with “quick wins”
- Trained specific departments in a sequence
Unique Training Considerations

- Adapt standardized training programs to fit cultural needs and values.

- Establish method to orient locum providers.

- Emphasize trauma-informed care. Recognize staff may have lived experience of suicide or have vicarious traumatization.
## Section 4. Training and Skills

<table>
<thead>
<tr>
<th>Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>22. I have received the training I need to engage and assist those with suicidal desire and/or intent.</td>
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<td>23. I have the skills to screen and assess a patient/client's suicide risk.</td>
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<td>24. I have the skills I need to treat people with suicidal desire and/or intent</td>
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<tr>
<td>25. I have support/supervision I need to engage and assist people with suicidal desire and/or intent</td>
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<td>26. I am confident in my ability to assess a patient/client's suicide risk.</td>
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<td>27. I am confident in my ability to manage a patient/client's suicidal thoughts and behavior.</td>
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<tr>
<td>28. I am confident in my ability to treat a patient/client's suicidal thoughts and behavior using an evidence-based approach such as DBT or CBT.</td>
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## Suicide Care Training Options

**SUICIDE CARE TRAINING OPTIONS**

**TRAINING FOR THE NON-ClinICAL WORKFORCE (PAGE 1 OF 2)**

<table>
<thead>
<tr>
<th>Training Name (Organization) Website</th>
<th>Length &amp; Format</th>
<th>Program Highlights</th>
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<tbody>
<tr>
<td>Applied Suicide Intervention Skills Training (ASIST) (LivingWorks) <a href="http://www.livingworks.net/programs/assist">www.livingworks.net/programs/assist</a></td>
<td>2 days (14 hours) in person</td>
<td><em>Workshop emphasizes teaching suicide first aid to help a person at risk stay safe and seek further help as needed</em>&lt;br&gt; <em>Standardized, customizable, and delivered by two trainers</em></td>
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<tr>
<td>Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS) (NY State Office of Mental Health and Columbia University) <a href="http://zerosuicide.org/zh/en/zerosuicide.aspx?link=fr/index.aspx">http://zerosuicide.org/zh/en/zerosuicide.aspx?link=fr/index.aspx</a></td>
<td>30 minutes Online, self-paced</td>
<td><em>Teaches how the C-SSRS is structured and how to administer the brief screening and full versions</em>&lt;br&gt; <em>Videos show how to use the scale’s Suicidal Ideation and Suicidal Behavior sections in incident interviews</em></td>
</tr>
</tbody>
</table>

Access at: [www.zerosuicide.com](http://www.zerosuicide.com)
Safety Planning and Means Restriction

- All persons with suicide risk have a safety plan in hand when they leave care on the same day as the assessment.

- Safety planning is collaborative and includes: communication with family members and other caregivers, and regular review and revision of the plan.

- Means restriction is comprehensive, includes family, and confirmation that access to means has been removed.
Resource: Safety Planning Intervention

Access at: www.zerosuicide.com
Resource: Counseling on Access to Lethal Means

Access at: www.zerosuicide.com
Suicide Care Management Plan

- Design and use a care Suicide Care Management Plan, or pathway to care, that defines care expectations for all persons with suicide risk, to include:
  - Identifying and assessing risk
  - Using effective, evidence-based care
  - Safety planning
  - Continuing contact, engagement, and support
Unique Engagement Considerations

- Open dialogue to understand cultural considerations.
- Call the Safety Plan a Wellness Plan instead.
- Include traditional and religious beliefs and customs in Wellness Plan.
- Provide education about Wellness Plan to family members and other caregivers.
Unique Engagement Considerations

• Remember, lethal means doesn’t just mean firearms.
  1) What methods are used in your community?
  2) How will you address those?

• Utilize community partners to assist with follow-up and engagement.
Care directly targets and treats suicidality and behavioral health disorders using effective, evidence-based treatments.
Unique Treatment Considerations

- Consider telehealth.
- Provide updated training on a regular basis to address turnover.
- Utilize culturally-based clinical approaches (e.g. Holistic Systems of Care for Native Americans, traditional healers).
- Incorporate Motivational Interviewing for Native Americans.
Unique Treatment Considerations

- Implement culturally competent evidence-based practices.

- Provide training on stigma, confidentiality, and other logistical barriers to accessing care.

- Train public health nurses, community health representatives, and family physicians in suicide treatment.
Follow-up and Engagement

- Persons with suicide risk get timely and assured transitions in care. Providers ensure the transition is completed.

- Persons with suicide risk get personal contact during care and care transitions, with method and timing appropriate to their risk, needs, and preferences.
Resource: Structured Follow-up and Monitoring

Welcome to Structured Follow-Up and Monitoring for Suicidal Individuals

Access at: www.zerosuicide.com
Unique Transition Considerations

- Identify practices for limited resource areas (e.g. telehealth, coordinate with mobile programs).
- Utilize natural helpers, community health representatives, paraprofessionals, and certified peer support workers.
- Provide follow-up in the local language and coordinate with local resources (e.g. IHS, primary care, substance abuse).
Unique Transition Considerations

- Utilize crisis centers, if available, for follow-up; provide their staff with cultural training.

- Communicate about Zero Suicide across tribal departments.

- Coordinate care with Medicaid and health information exchanges.
Quality Improvement and Evaluation

- Suicide deaths for the population under care are measured and reported on.

- Continuous quality improvement is rooted in a Just Safety Culture.
Resources and Tools

www.ZeroSuicide.com
Questions and Comments

Please Use the Mic to Ask Your Question
"Let us put our minds together and see what life we can make for our children."

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