ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Zero Suicide:

A Comprehensive Approach to Suicide Prevention for Health Care Systems

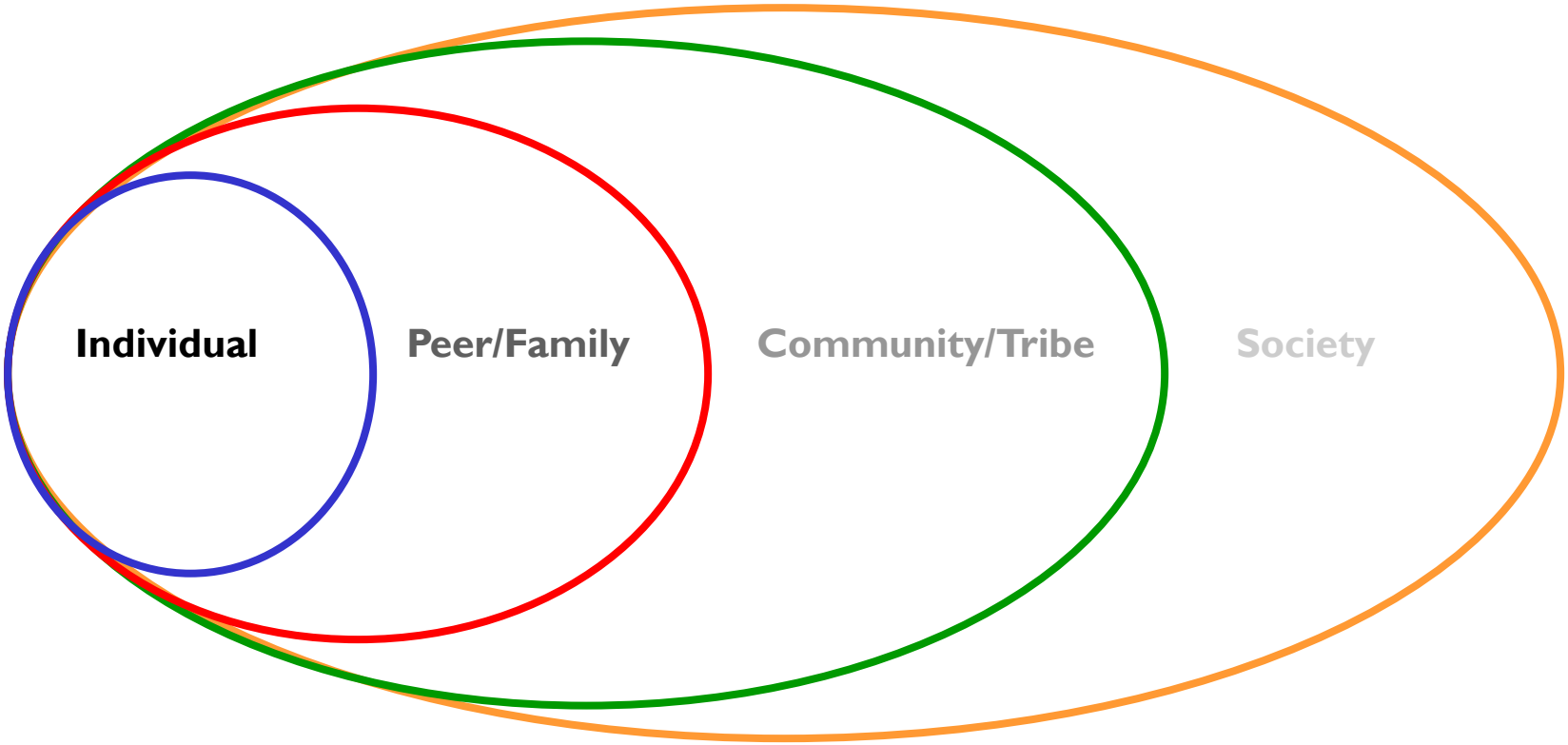
EDC Learning transforms lives.

Suicide: A Multi-factorial Event

Douglas Jackobs, 2003 R. Dale Walker, MD, 2005 One Sky Center

Social Ecological Model

Domains Influencing Suicidal Behavior: A Native Ecological Model



Interacting Spheres of Influence

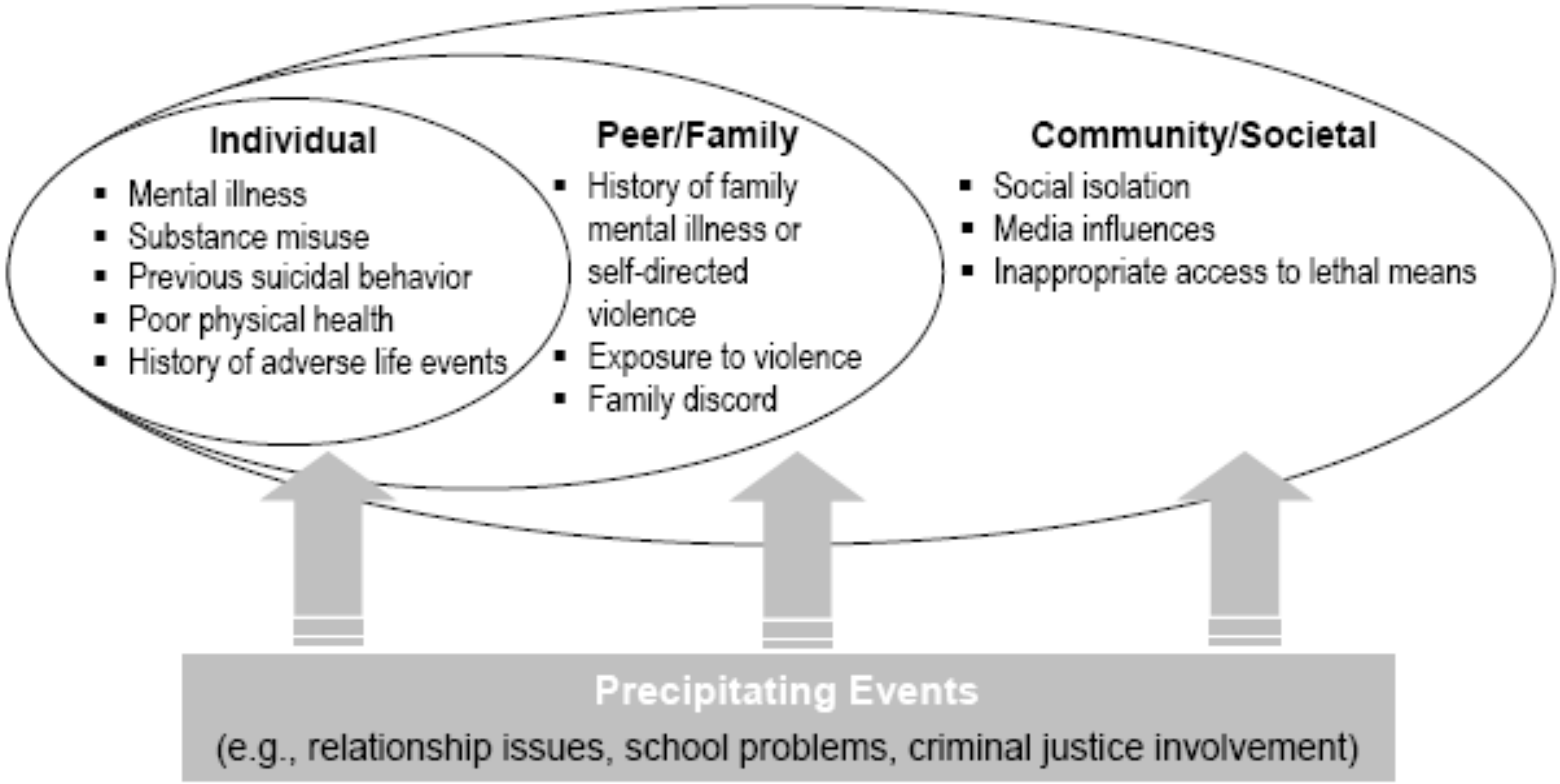


Figure 2. Interacting Spheres of Influence for Suicidal Behavior. Shown above are risk factors for suicidal behavior that span a range of individual, peer/familial, and community/societal factors.

Interacting Spheres of Influence

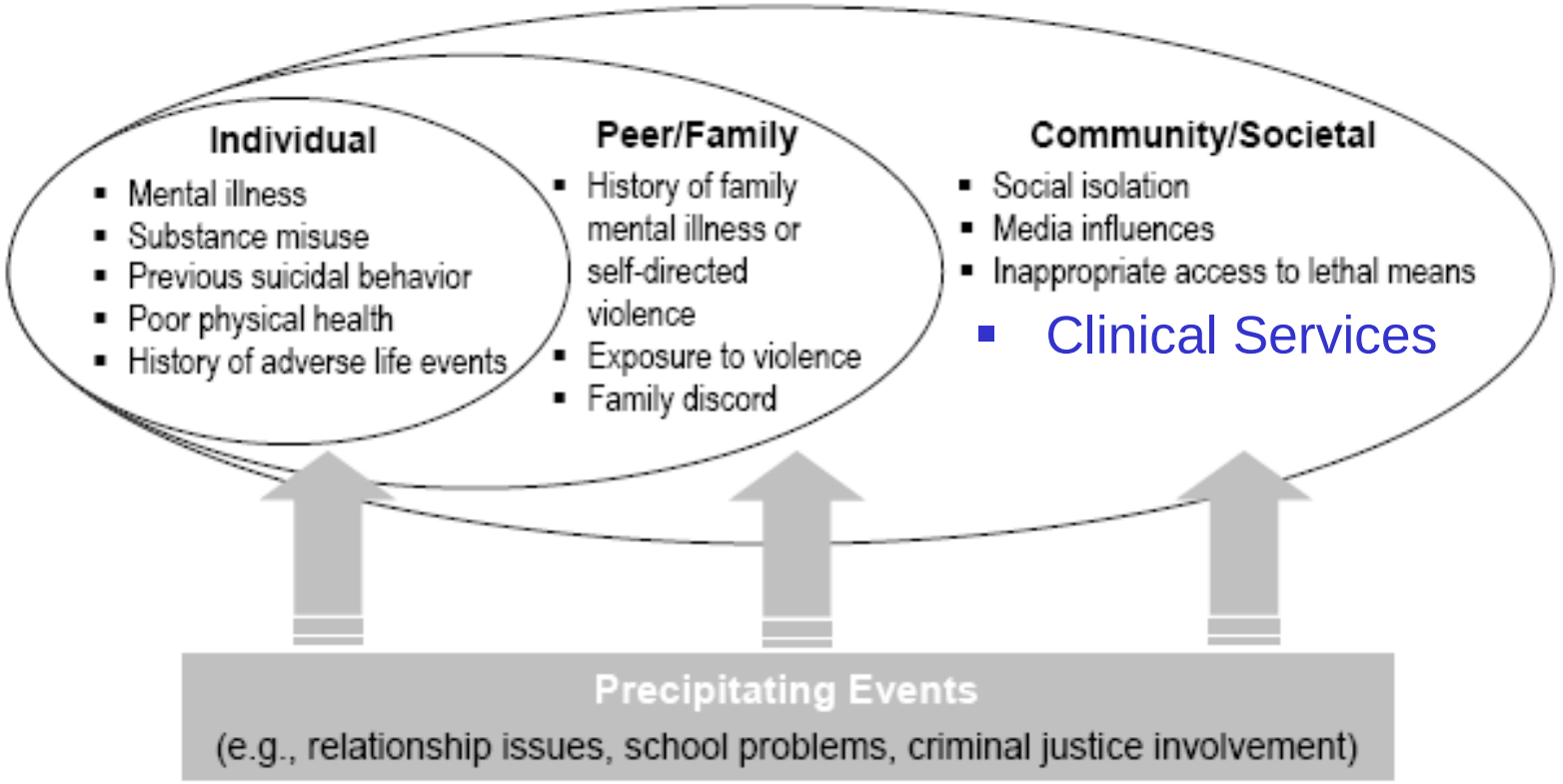


Figure 2. Interacting Spheres of Influence for Suicidal Behavior. Shown above are risk factors for suicidal behavior that span a range of individual, peer/familial, and community/societal factors.

WHY IS ZERO SUICIDE RELEVANT FOR AI/AN COMMUNITIES?

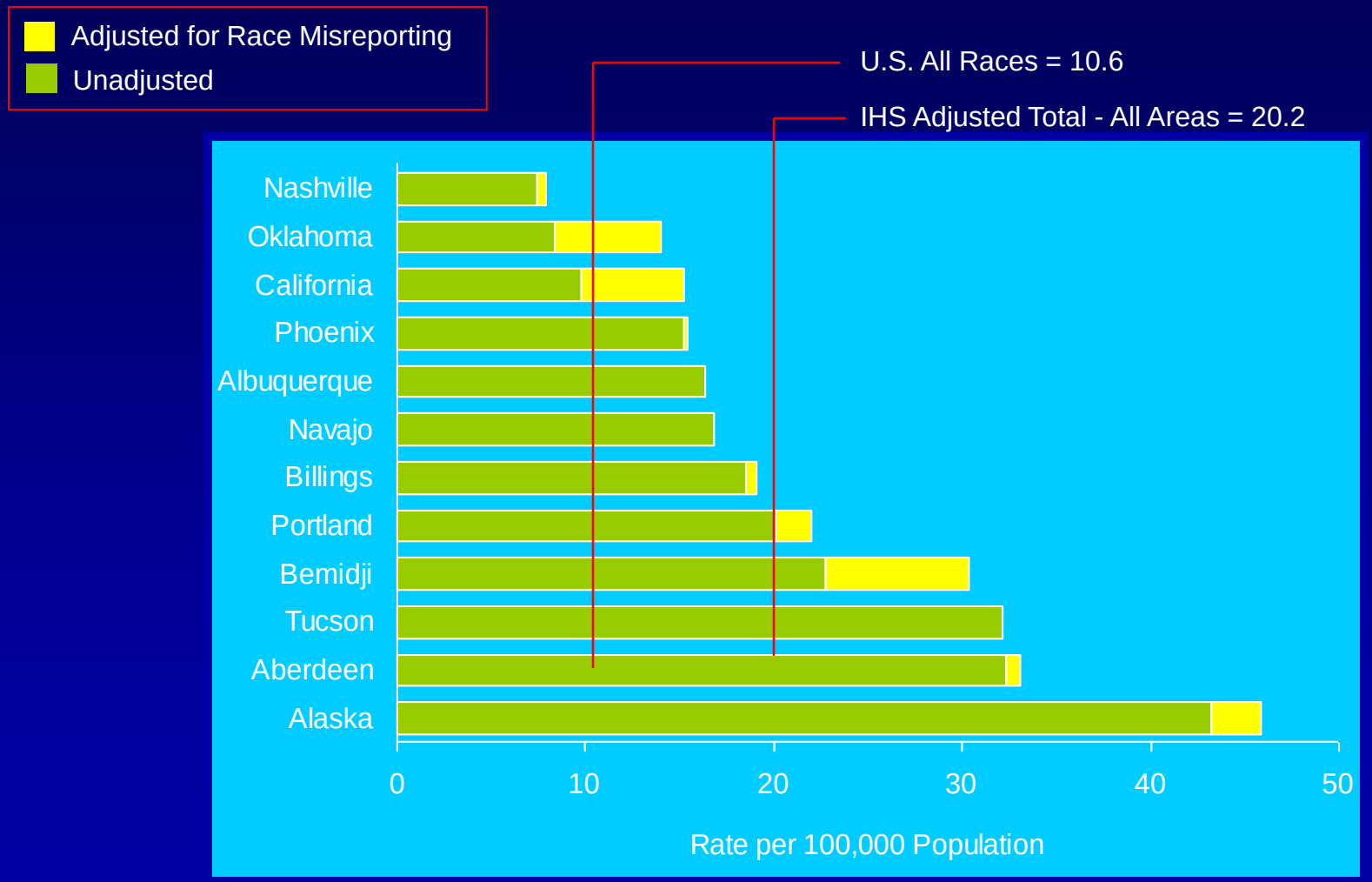
EDC Learning transforms lives.

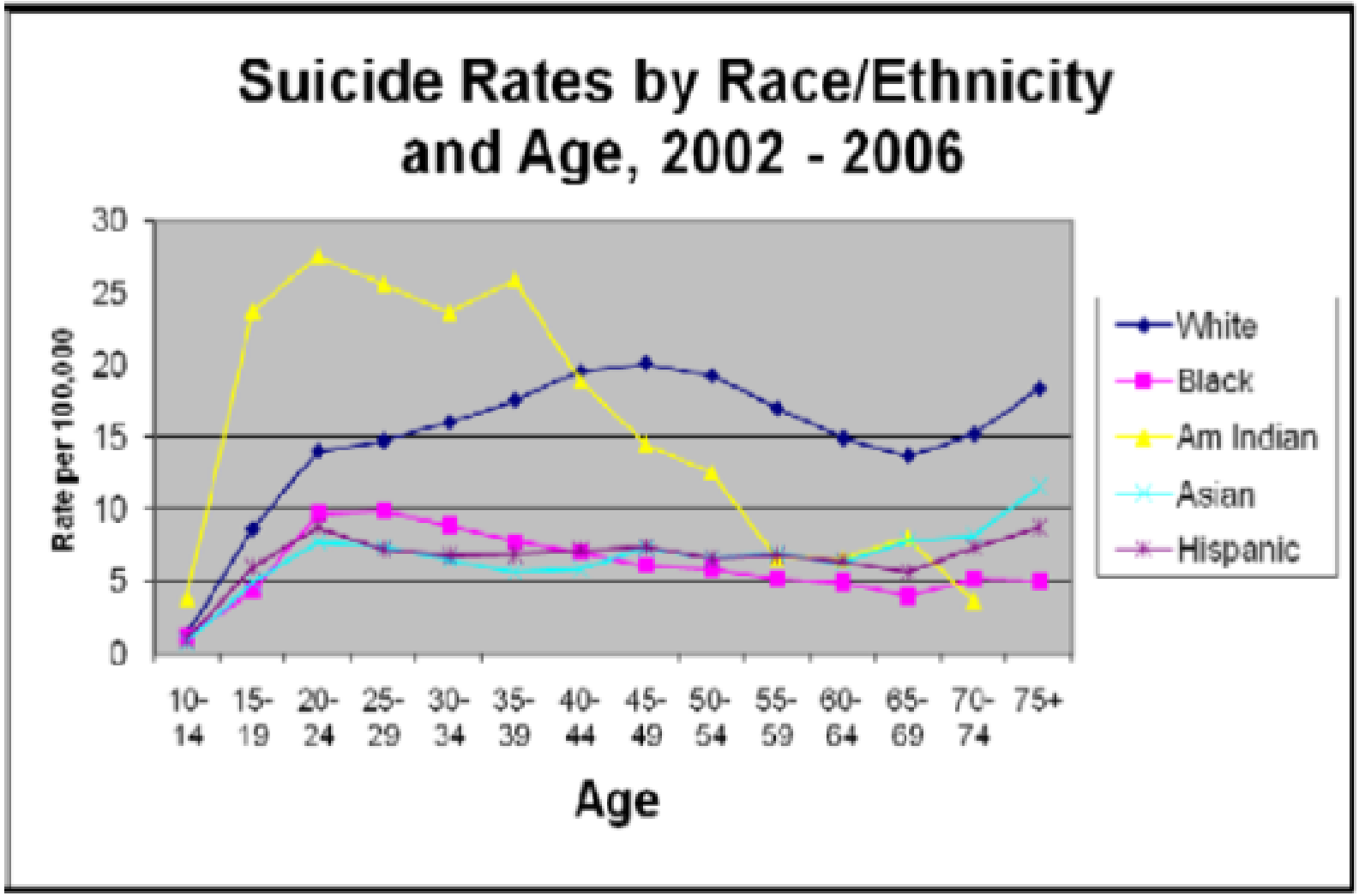
SUICIDE IN AI/AN COMMUNITIES

- Suicide rates for American Indians and Alaska Natives are 4x the national average.
- Among AI/AN aged 10-34 years, suicide is the second leading cause of death.
- The suicide rate among AI/AN adolescents and young adults is 1.5 times higher than the national average of the same age group.

AAS Fact Sheet, 2012.
New York State Office of Mental Health. (2013). Getting to the goal: Suicide as a never event in New York state.

Age-Adjusted Suicide Death Rates by IHS Area





Source: CDC, WISQARS, 2009

2012 National Strategy for Suicide Prevention:

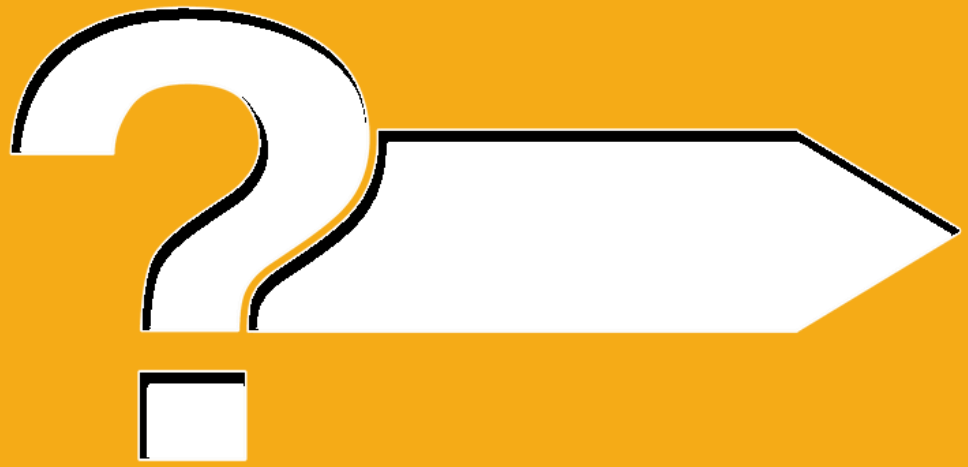
GOALS AND OBJECTIVES FOR ACTION

A report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention

GOAL 8: Promote suicide prevention as a core component of health care services.

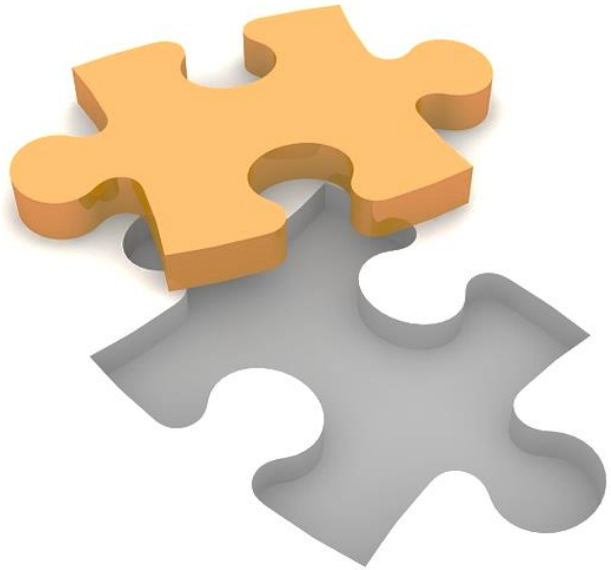
GOAL 9: Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors.

WHAT IS ZERO SUICIDE?



ZERO SUICIDE...

- Aspirational goal
- Focus on error reduction and safety in health care
- Fill the gaps that exist in suicide care
- Based on evidence based practices



JOINT COMMISSION SENTINEL EVENT ALERT 56:
DETECTING AND TREATING SUICIDE IDEATION IN ALL SETTINGS

Sentinel Event Alert

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. *Sentinel Event Alert* may be reproduced if credited to The Joint Commission. To receive by email, or to view past issues, visit www.jointcommission.org.

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the suicidal thoughts (also known as suicide ideation) of individuals (including children and adolescents) who eventually die by suicide, even though most of them receive health care services in the year prior to death,[5] usually for reasons unrelated to suicide or mental health.[6-7] Timely, supportive continuity of care for those identified as at risk for suicide is crucial, as well.[8]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[8] The risk of suicide is three times as likely (200 percent higher) t… first week after discharge from a psychiatric facility[9] and continues … especially within the first year[8,10] and through the first four ye… discharge.

This alert replaces two previous alerts on … suggested actions in this alert cover… screening, risk assessment, safety, treatment, discharge, and … of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

"The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care."

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WHAT'S DIFFERENT ABOUT ZERO SUICIDE?

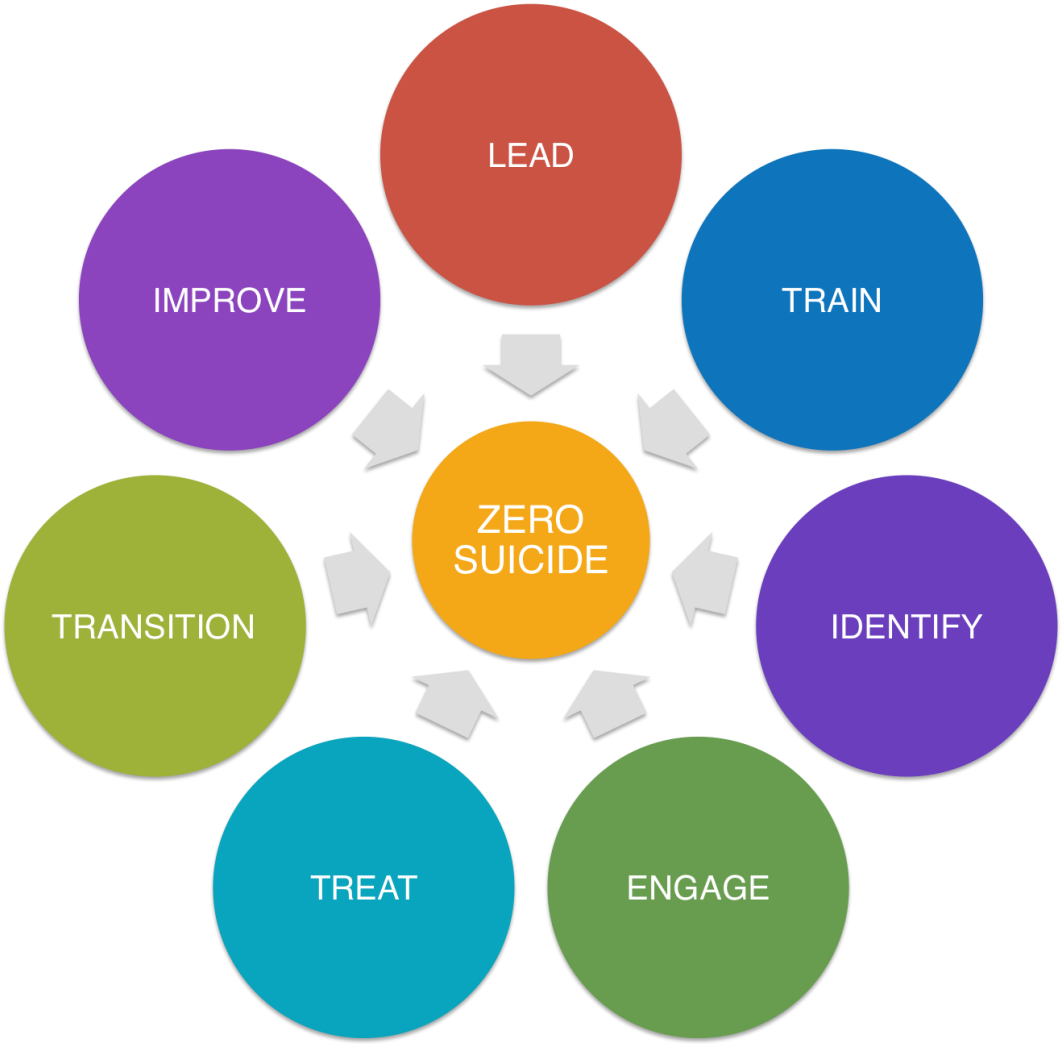
- Suicide prevention is accepted as a core responsibility of health care
- Patient deaths by suicides are not an inevitability
- Emphasizes data, best practices, and continuous quality improvement

WHY FOCUS ON HEALTH CARE SETTINGS

- 45% of people who died by suicide had contact with **primary care** providers in the month before death.
- 19% of people who died by suicide had contact with **mental health** services in the month before death.
- 10% of people who died by suicide were seen in an **emergency department** in the two months before death.

Luoma, J.B., Martin, C.E., & Pearson, J.L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, 159(6), 909-916..

SEVEN ELEMENTS OF ZERO SUICIDE



ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Make an explicit commitment to reduce suicide deaths.

LEAD

Leadership Commitment and Culture Change

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

- 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.

Unique Leadership Considerations

- Sustain leadership throughout implementation.

- Document leadership responsibilities in policies and procedures so work continues if turnover occurs.

Develop a confident, competent, and caring workforce.

TRAIN

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.

Zero Suicide Workforce Survey

Section 4. Training and Skills

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Don't Know
22. I have received the training I need to engage and assist those with suicidal desire and/or intent.	○	○	○	○	○	○
23. I have the skills to screen and assess a patient/client's suicide risk.	○	○	○	○	○	○
24. I have the skills I need to treat people with suicidal desire and/or intent.	○	○	○	○	○	○
25. I have support/supervision I need to engage and assist people with suicidal desire and/or intent.	○	○	○	○	○	○
26. I am confident in my ability to assess a paitent/client's suicide risk.	○	○	○	○	○	○
27. I am confident in my ability to manage a patient/client's suicidal thoughts and behavior.	○	○	○	○	○	○
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.	○	○	○	○	○	○

Resource: Suicide Care Training Options

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

www.zerosuicide.com

SUICIDE CARE TRAINING OPTIONS

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

TRAINING NAME (Organization) Website	LENGTH & FORMAT	PROGRAM HIGHLIGHTS
Applied Suicide Intervention Skills Training (ASIST) (LivingWorks) www.livingworks.net/programs/asist	2 days (14 hours) In person	• Workshop emphasizes teaching suicide first aid to help a person at risk stay safe and seek further help as needed • Standardized, customizable, and delivered by two trainers
Assessment of Suicidal Risk Using the Columbia Suicide Severity Rating Scale (C-SSRS) (NY State Office of Mental Health and Columbia University) http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/cssrs_web/course.htm	30 minutes Online, self-paced	• Teaches how the C-SSRS is structured and how to administer the brief screening and full versions • Videos show how to use the scale's Suicidal Ideation and Suicidal Behavior sections in client interviews

SPRC | Action Alliance for Suicide Prevention

Unique Training Considerations

- Create resolutions and policies to ensure all staff are trained despite turnover.

- Respectfully address community-specific beliefs, perspectives, and possible misconceptions.

- Coordinate with Meth and Suicide Prevention Initiative.

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.

Identify every person at risk for suicide.

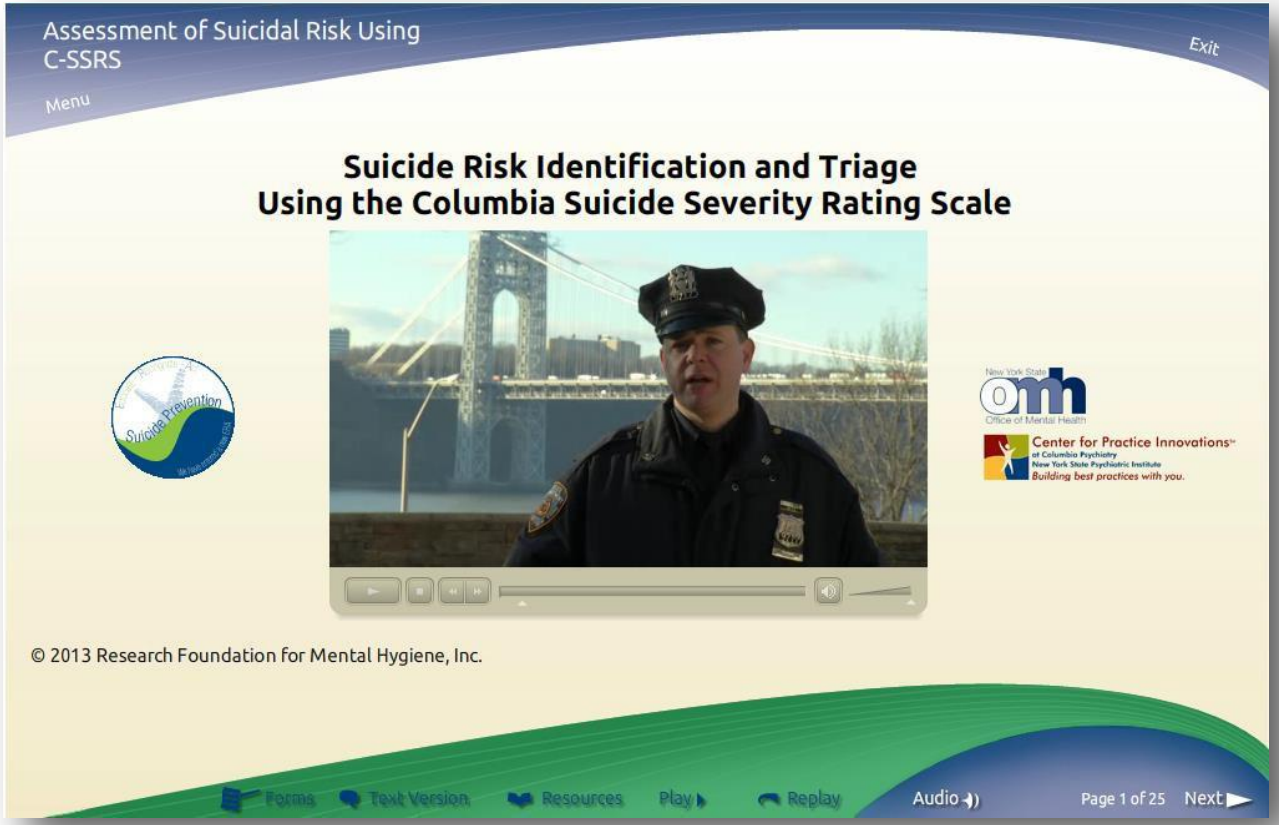
IDENTIFY

Screening and 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 (champion).

Resource: Using the C-SSRS



Access at: www.zerosuicide.com

ZERO Suicide IN HEALTH AND BEHAVIORAL HEALTH CARE

Engage clients in a Suicide Care Management Plan.

ENGAGE

Safety Planning and Means Restriction

- All persons with suicide risk have a ***safety plan*** in hand when they leave care.

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

Suicide Care Management Plan

- Design and use a ***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 cultural 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.

Treat suicidal thoughts and behaviors directly.

TREAT

Effective, Evidence-Based Treatment

- Care directly targets and treats suicidality *and* behavioral health disorders using effective, ***evidence-based treatments***.

Evidence-Based Treatments for Suicidality

- With 50+ studies there are few evidence-based treatments…
- There is little to no support for medication-only or hospitalization
- RCT's and *replications* support:
  - Dialectical Behavior Therapy (DBT)
  - Cognitive Therapy for Suicide Prevention (CBT-SP)
  - Collaborative Assessment and Management of Suicidality (CAMS)
  - Non-demand follow-up contact (caring contacts)

IN HEALTH AND BEHAVIORAL HEALTH CARE

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 AI/ANs, traditional healers).
- Incorporate ***Motivational Interviewing*** for Native Americans.

Unique Treatment Considerations

- Develop and implement culturally relevant, 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 patients through every transition in care.

TRANSITION

LEAD TRAIN IDENTIFY ENGAGE TREAT TRANSITION IMPROVE

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.

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 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.

Apply data-driven quality improvement.

IMPROVE

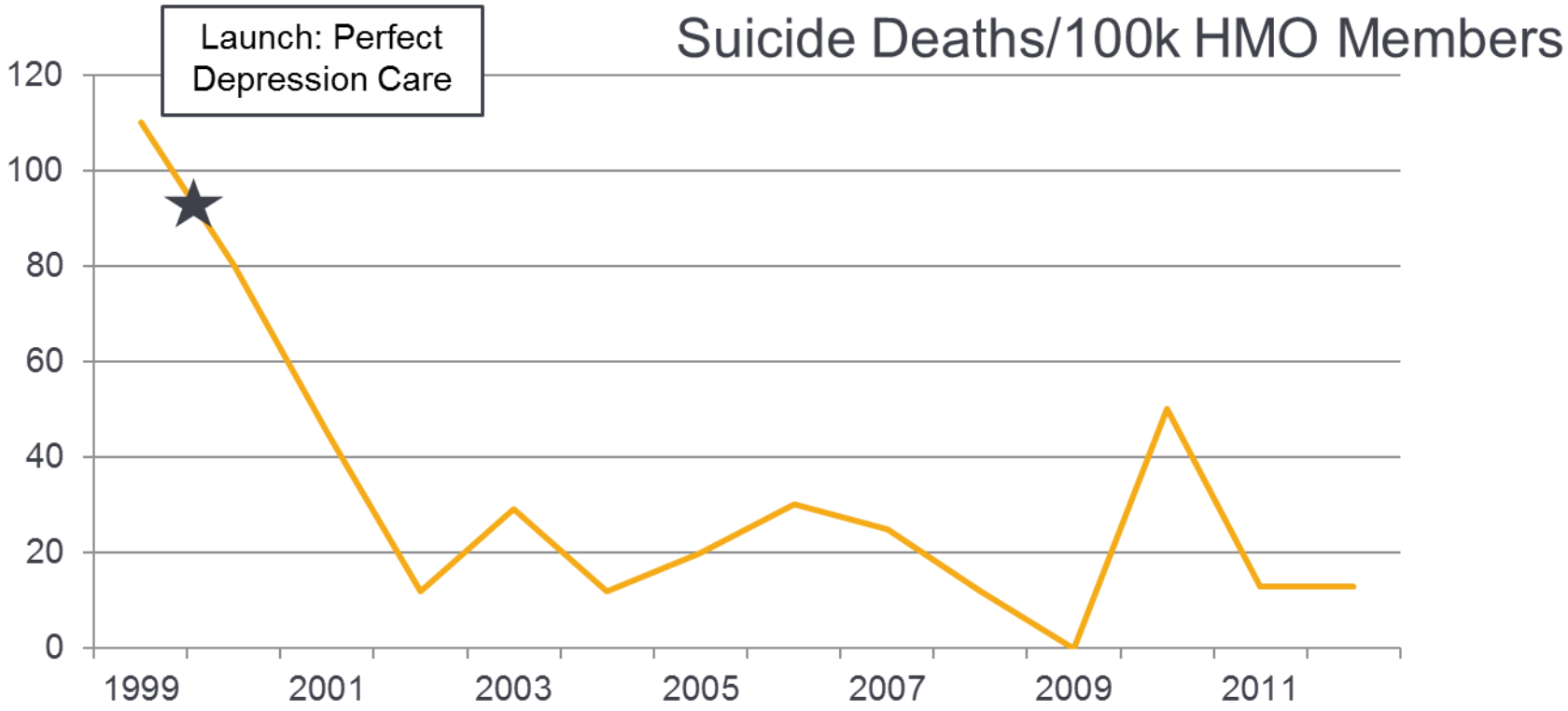
Quality Improvement and Evaluation

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

- Continuous quality improvement is rooted in a just safety culture.

- Fidelity to the Zero Suicide model is examined at regular intervals.

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



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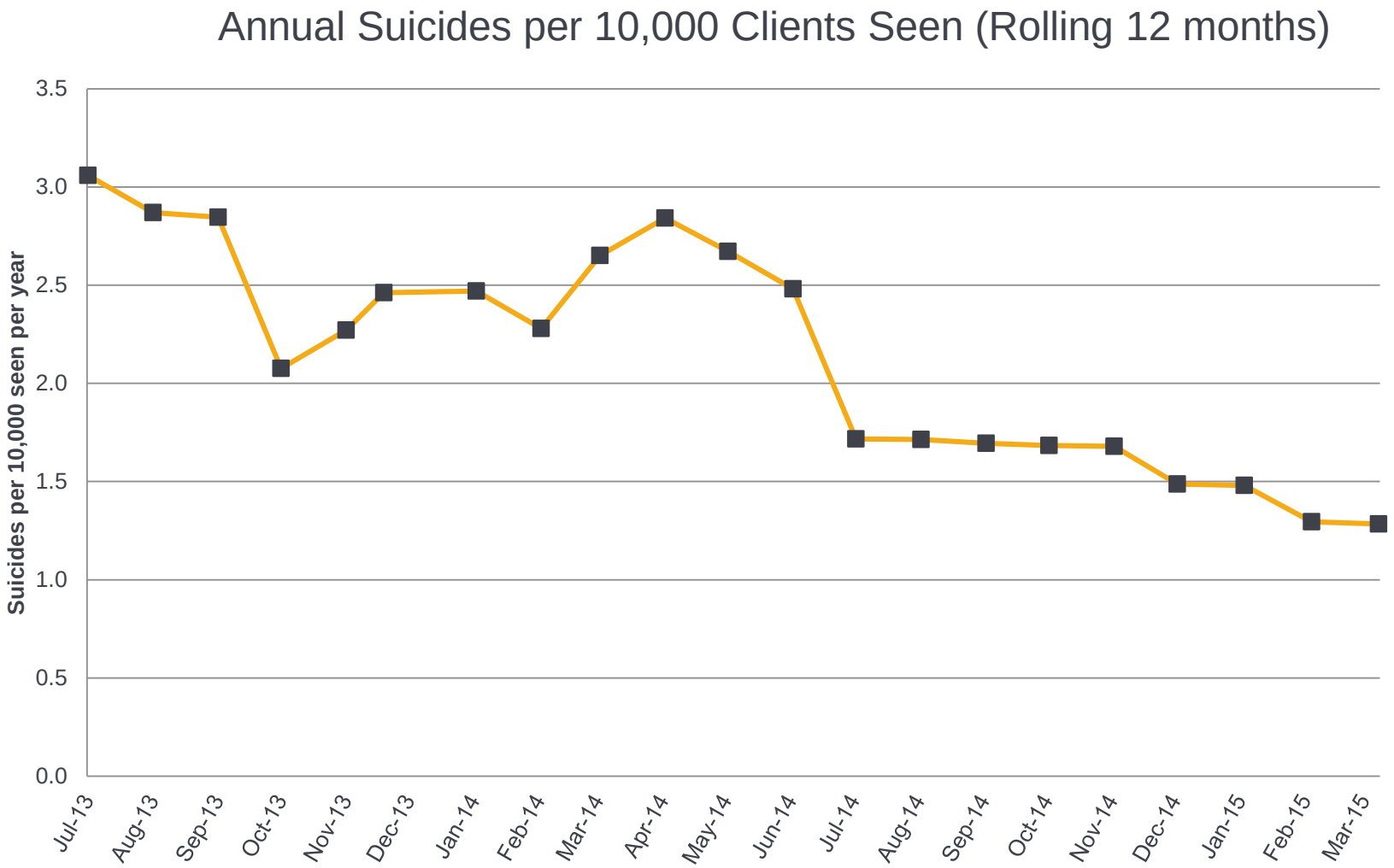
Zero Suicide at Centerstone: Results



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Zero Suicide Implementation in AI/AN Communities

- IHS contracted with the Zero Suicide Institute of the Education Development Center to develop a tailored, culturally-specific Zero Suicide Implementation Program for AI/AN Healthcare Systems
- Completed program with Cohort 1 Sites in August 2017
- Launched program with Cohort 2 Sites in September 2017

AI/AN Zero Suicide Initiative Components

- **AI/AN Zero Suicide Academy™**

- **Community of Learning (CoL)** – An 8-session interactive collaborative that offers shared learning around implementation challenges and helpful tools/resources.

- **Tailored Technical Assistance** – Site-specific consultations, site visits, and/or other technical guidance for sites to support their unique challenges in implementing the Zero Suicide model.

Cohort 1 Sites (2015-2017)

- Alaska Area: Alaska Native Tribal Health Consortium
- Albuquerque Area: Pueblo San Felipe
- Great Plains Area: Pine Ridge Service Unit
- Navajo Area: Native Americans for Community Action
- Oklahoma City Area: Choctaw Nation
- Phoenix Area: Colorado River Service Unit
- Portland Area: Puyallup Tribal Health Authority
- Portland Area: Shoshone-Bannock Tribe
- Portland Area: Yakama Nation Behavioral Health
- Tucson Area: Tohono O'odham

Cohort 2 Sites (2017-2018)

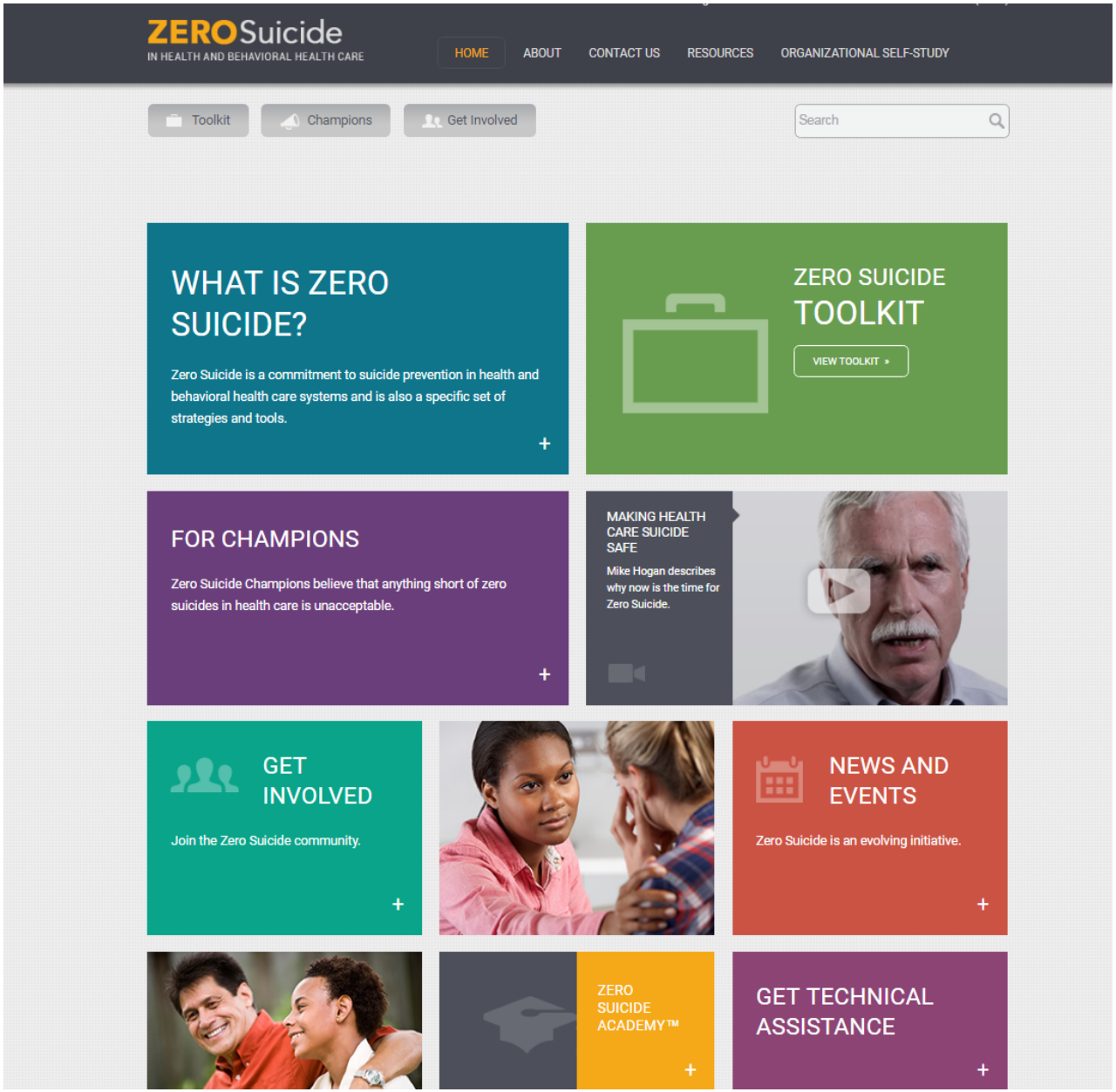
- Alaska Area: Fairbanks Native Association
- Bemidji Area: Oneida Nation- Behavioral Health Services
- California Area: United Indian Health Services, Inc
- Great Plains Area: Elbowoods Memorial Health Center
- Great Plains Area: Fort Thompson Indian Health Service
- Nashville Area: Mississippi Band of Choctaw Indians
- Nashville Area: Seneca Nation Health System
- Navajo Area: Chinle Comprehensive Healthcare Facility
- Oklahoma City Area: Muscogee (Creek) Nation
- Phoenix Area: Gila River Health Care

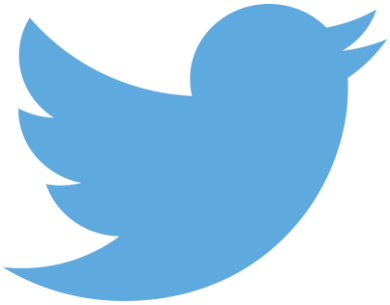
Lessons Learned *(so far)*

1. Leadership commitment must be strong.
2. Language agreement is an initial, vital step.
3. Community involvement/support a larger issue to address within AI/AN communities.
4. Leveraging strengths from related programs and/or initiatives is vital.
5. Marathon, not a sprint.
6. Important to build evidence for the model within Indian Country to support healthcare reimbursement process.

ZERO SUICIDE WEBSITE

Access at:
www.zerosuicide.com





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- For questions, please contact:
- ZeroSuicide@edc.org

- For in-person training and support, please visit:
- ZeroSuicideInstitute.com

INDIAN HEALTH SERVICE

DBH
DIVISION OF BEHAVIORAL HEALTH

Zero Suicide Initiative NOFO Overview

Background

- The Zero Suicide Initiative is a nationally-coordinated program that promotes the development of a system of care for those at risk for suicide through the implementation of a comprehensive, culturally informed approach to suicide prevention in Indian health systems.

ZSI Program Framework

The Zero Suicide Initiative cooperative agreement program is part of IHS's strategic focus suicide prevention and care in AI/AN health systems. Implementation of this program:

- Supports the IHS mission to raise the physical l, mental, social and spiritual health of American Indian and Alaska Native to the highest level;
- Consistent with the tenets of the National Strategy for Suicide Prevention (NSSP)
- Focuses on priorities of the National Action Alliance for Suicide Prevention (*Action Alliance*).

Eligibility

- A Federally recognized Indian Tribe as defined by 25 U.S.C. 1603(14).
- A Tribal organization as defined by 25 U.S.C. 1603(26).
- An urban Indian organization as defined by 25 U.S.C. 1603(29); operating an Indian health program operated pursuant to as contract, grant, cooperative agreement, or compact with the IHS pursuant to the ISDEAA, (25 U.S.C. 5301 *et seq.*). Applicants must provide proof of non-profit status with the application, *e.g.,* 501(c)(3).

Funding Amounts & Estimated Awards

- A total of $3.2 million available for funding
  - $2,000,000 for Tribes, Tribal organizations, and UIOs
  - $1,200,000 for and IHS Federal facilities.
- Approximately 8 awards will be issued under this notice of funding opportunity.

ZSI Federal Program Award Opportunity Announcement

- Posted at: https://www.ihs.gov/suicideprevention/zerosuicide/fundingannouncement/ on **August 21, 2017**

- Federal DVPI New Applicants: access the funding announcement.

Key Dates

Key Information	Date
Application Deadline	October 12, 2017
Objective Review Committee	October 16-20, 2017
Earliest Anticipated Start Date	November 1, 2017
Singed Tribal Resolution	October 12, 2017
Proof of Non-Profit Status	October 12, 2017

NOTE: IHS Federal facilities are not required to submit Tribal resolutions or proof of non-profit status.

Requirements for the Project Proposal

All applicants must include the following required application components:

- Cover Letter.
- Table of Contents
- Abstract
- Project Narrative (must be single-spaced and not exceed 20 pages total)

Selection Criteria

- All applicants will submit the same application and undergo the same eligibility and selection criteria.

- Points are assigned to each evaluation criteria adding up to a total of 100 points. A minimum score of 70 points is required for funding.

Population Focus/Statement of Need	20
Organizational Infrastructure/Capacity	25
Implementation Approach/Plan	30
Data/Performance/assessment/Evaluation	20
Categorical Budget/Budget Narrative	5
Total	100

Population Focus/Statement of Need (20 points)

- A clear description of the proposed catchment area and demographic information on the population(s) to receive services
- Presentation of the prevalence of suicidal behavior (*i.e.,* ideation, attempts, and deaths) within the population(s) of focus, including any current limitations of data collection in the health system.
- Culture of the community, communities, and mission.
- Tribal government or board of directors are in support of the project.
- Describe behavioral health service system, gaps, barriers, and challenges.
- Describe potential partners, community resources, communities being served.

Organizational Infrastructure/Capacity (25 points)

- Describe experience (successes and/or challenges) with the Zero Suicide model (*e.g.,* attended a Zero Suicide Academy, etc.) or similar collaborative efforts
- Discussion of the applicant Tribe or Tribal organization experience with and capacity
- Identification of how all departments/units/divisions will be involved in administering this project
- Describe the resources available for the proposed project

Implementation Approach/Plan (30 points)

- A viable plan to address each of the 7 Elements and 6 Objectives in a systematic, measureable, and interrelated manner.
- A clear description of strategies to engage the highest levels of leadership and a broad cross section of the hospital system in order to develop organizational commitment, participation and sustainability
- A contingency plan that addresses short-term maintenance and long-term sustainability.
- Project Timeline
  - The project time line should not exceed 1-page;
  - Should also give a broad overview of major project activities

Data Collection, Performance Assessment & Evaluation (20 points)

- Ability to collect and report on the required performance measures specified in the Data Collection and Performance Management section.
- A clear, specific plan for data collection, management, analysis, and reporting.
- Description of your plan for conducting the local performance assessment as specified above and evidence of your ability to conduct the assessment.
- Description of the quality improvement process that will be used to track progress towards your performance measures and objectives,

Categorical Budget and Budget Justification (5 points)

- Evidence of reasonable, allowable costs necessary to achieve the objective outlined in the project narrative.
- Description of how the budget aligns with the overall scope of work.
- Please use Budget/Budget Narrative Template Worksheet to support your responses in this section.

Resources

- As you prepare your application, please visit the ZSI webpage for the most current, up-to-date information.
- Applicants are encouraged to visit: *https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf* to access a copy of the 2012 National Strategy
- Applicants are encouraged to visit *http://zerosuicide.sprc.org* to review the Zero Suicide strategies and tools required for this grant program.
- Applicants are encouraged to visit : *https://www.jointcommission.org/sea_issue_56/*).

Agency Contacts: Grant Submission

Questions on grants management and fiscal matters may be directed to:

Andrew Diggs, Grants Management Specialist
5600 Fishers Lane, Mail Stop: 09E70
Rockville, MD 20857
Phone: (301) 443-2241
Fax: (301) 594-0899 E-mail: Andrew.diggs@ihs.gov

Questions on systems matters may be directed to:

Paul Gettys, Grant Systems Coordinator
5600 Fishers Lane, Mail Stop: 09E70
Rockville, MD 20857
Phone: (301) 443-2114; or the DGM main line (301) 443-5204
Fax: (301) 594-0899 E-Mail: Paul.Gettys@ihs.gov

Questions/Contacts

- **Questions on:**
  - programmatic issues;
  - how to apply;
  - application submission;
  - fiscal matters; and
  - Federal application process for IHS Federal facilities may be directed to:

Sean Bennett, Pubic Health Advisor
National Lead, Zero Suicide Initiative
Direct #: 301-443-0102
e-mail: sean.bennett@ihs.gov