

It Takes a Community to Prevent Suicide: What is Zero Suicide Concept and Practice?

Presented by Laura Rombach m.a.
University of New Mexico
Department of Psychiatry and Behavioral Sciences
Division of Community Behavioral Health

It Takes a Community to Prevent Suicide: What is Zero Suicide Concept and Practice?

The Suicide Prevention Training is presented through the National Strategy of Suicide Prevention in New Mexico

In collaboration with the University of New Mexico and the State of New Mexico, Human Services Department, Behavioral Health Services Division

Learning Objectives

- Recognize the components for the pathways to care
- Identify steps in adopting a Zero Suicide approach in health care organizations
- Describe the advantages of suicide prevention as a core component for health care

Rates of Suicide in the United States

- Nearly 40,000 people in the United States die from suicide annually
- The suicide rate has been rising over the past decade
- Much of the increase is due to suicides in mid-life
- The highest number of suicides among both men and women occurred among those aged 45 to 54
- There are 3.6 male suicides for every female suicide
- From 1999 to 2010, the age-adjusted suicide rate for adults aged 35 to 64 in the United States increased significantly (28.4%). Half of these deaths occur by use of a firearm
- The highest rates of suicides (suicides per 100,000) occurred among men aged 75 and up and among women aged 45 to 54

Substance Abuse and Mental Health Services

Administration 2014

New Mexico

- Over the past 30 years, NM has consistently had among the highest alcohol-related death rates, and the highest drug-induced death rate in the nation (SAMHSA, 2013).
- NM also has the highest prescription drug overdose death rate in the nation.
- Mental illness increases the risk for both attempted suicide and suicide completion
- Approximately 90% of suicide victims in NM had a diagnosable behavioral health condition, most commonly a mood or substance use disorder (IBIS, 2012).

Most vulnerable

The following groups have demonstrated a higher risk for suicide or suicide attempts than the general population:

- American Indians and Alaska Natives
- People bereaved by suicide
- People in justice and child welfare settings
- People who intentionally hurt themselves (non-suicidal self-injury)
- People who have previously attempted suicide
- People with medical conditions
- People with mental and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans
- Men in midlife and older men

Suicide Prevention

- 2012 National Strategy for Suicide Prevention
Report of the U.S. Surgeon General and the National Action Alliance for Suicide Prevention
 8. Promote suicide prevention as a core component of health care services
 9. Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors

Rates of Suicide After Seeing a Provider

- 50% of people who die by suicide had contact with their primary care providers in the month prior to their suicide
- 80% of people who die by suicide had contact with their primary care provider in the year prior to their death
- 20% of people who die by suicide saw a behavioral health provider within the month before they died
- 10% of people who die by suicide visited the Emergency Department within 2 months before they died

What is Zero Suicide?

- Commitment to suicide prevention in health and behavioral health care systems
- Set of specific goals and strategies
- Both a concept and a practice

What is Zero Suicide

“IF WE WERE PROVIDING PERFECT DEPRESSION CARE MAYBE
OUR PATIENTS WOULDN’T KILL THEMSELVES”

Ed Coffey, CEO Behavioral Health System

- <https://www.youtube.com/watch?v=7teSz9YqOrY>

Zero Suicide

- Providing good depression care
- Audacious goal
- Create a just culture that is supportive and not punitive if the goal is not reached
- Reducing rate of suicides

What is a Zero Suicide Culture

- Proposes that suicide deaths are preventable for people under care
- Commitment to patient safety
- Relies on a system wide approach

What is Different in Zero Suicide?

Shift in Perspective

From:

Accepting suicide as inevitable
Assigning blame
Risk assessment and containment
Stand alone training and tools
Specialty referral to niche staff
Individual clinician judgment & actions

Hospitalization during episodes of crisis
“If we can save one life...”

To:

Every suicide in a system is preventable
Nuanced understanding: ambivalence, resilience, recovery
Collaborative safety, treatment, recovery
Overall systems and culture changes
Part of everyone’s job
Standardized screening, assessment, risk stratification, and interventions
Productive interactions throughout ongoing continuity of care
“How many deaths are acceptable?”

Lead

- Leadership supported
- Safety oriented culture
- Committed to reducing suicide among people under care
- Immediate access
- Seamless care
- Written policies and procedure
- Organizational self study – Zero Suicide

Lead

- **It takes a community to prevent suicide**
- Schools
- Police
- First responders
- Peers
- Family members
- Hospitals
- Behavioral health providers
- Survivors
- Health care providers

Train

Begin with a Competent Workforce

“Just as “CPR” skills make physical first aid possible, training in suicide intervention develops the skills used in suicide first aid.”

Train - Work Force Survey

- Survey of all staff
- Responses are anonymous
- Used to learn about staff's beliefs about suicide prevalence and risk
- How staff address suicide risk is addressed
- Identify training needs

Train

Training for providers

- Standardized screening and assessment for:
 - Depression and other mental health problems
 - Substance abuse
 - Suicidality
- Engaging persons at risk
- Collaborative safety plan – means restriction, communicating with family members.
- Intervention and treatment using evidenced based practices
- Follow up process

Train

- **Community and Staff**
 - safe TALK
 - ASIST
 - QPR Gatekeeper Training
 - Mental Health First Aid

safeTALK half-day workshop

Most people with thoughts of suicide don't truly want to die, but are struggling with the pain in their lives.

safeTALK is a half-day alertness workshop that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. Most people with thoughts of suicide don't truly want to die, but are struggling with the pain in their lives. Through their words and actions, they invite help to stay alive. safeTALK-trained helpers can recognize these invitations and take action by connecting them with life-saving intervention resources, such as caregivers trained in ASIST.

Since its development in 2006, safeTALK has been used in over 20 countries around the world, and more than 200 selectable video vignettes have been produced to tailor the program's audio-visual component for diverse audiences. safeTALK-trained helpers are an important part of suicide-safer communities, working alongside intervention resources to identify and avert suicide risks.

+ Who should attend a safeTALK workshop?

+ Who provides safeTALK workshops?

+ What can I expect at a safeTALK workshop?

+ Does safeTALK provide CEU credits?

+ How does safeTALK integrate with ASIST?

+ How much does it cost to attend?

safe TALK

- For anyone over the age of 15
 - Used by students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and professional athletes, among many others
- Become a suicide-alert helper and connect people to lifesaving resources
- Half day training alertness workshop
- Hands-on skills practice and development
- TALK steps: Tell, Ask, Listen, and Keep Safe

ASIST

Applied Suicide Intervention Skills Training (ASIST) is for everyone 16 or older—regardless of prior experience—who wants to be able to provide suicide first aid. Shown by major studies to significantly reduce suicidality, the ASIST model teaches effective intervention skills while helping to build suicide prevention networks in the community.

Virtually anyone age 16 or older, regardless of prior experience or training, can become an ASIST-trained caregiver. Developed in 1983 and regularly updated to reflect improvements in knowledge and practice, ASIST is the world's leading suicide intervention workshop. During the two-day interactive session, participants learn to intervene and help prevent the immediate risk of suicide. Over 1,000,000 people have taken the workshop, and studies have proven that the ASIST method helps reduce suicidal feelings for those at risk.

Workshop features:

- Presentations and guidance from two LivingWorks registered trainers
- A scientifically proven intervention model
- Powerful audiovisual learning aids
- Group discussions
- Skills practice and development
- A balance of challenge and safety

+ [Who should attend an ASIST workshop?](#)

+ [Who provides ASIST workshops?](#)

+ [What are the core features of an ASIST workshop?](#)

+ [What is the structure of an ASIST workshop?](#)

+ [Does ASIST provide CEU credits?](#)

+ [How much does it cost to attend?](#)

+ [What is ASIST 11?](#)

+ [What is the Suicide Intervention Handbook?](#)

ASIST

- For anyone age 16 or older, regardless of prior experience or training
 - Used by students, teachers, community volunteers, first responders, military personnel, police, public and private employees, and professional athletes, among many others
- Two-day interactive session
- Participants learn to intervene and help prevent the immediate risk of suicide
- Presentations and guidance from two LivingWorks registered trainers



Latest news

Follow Dr. Quinnett's new blog: [On Suicide](#)



QPR and our Veterans - view video



QPR for Schools - Executive Summary

What they are saying about QPR

QPR Gatekeeper Training for Suicide Prevention

QPR stands for **Question, Persuade and Refer**, three steps anyone can learn to help prevent suicide. Just like CPR, QPR is an emergency response to someone in crisis and can save lives.

Individuals Online QPR Gatekeeper Training

[Enroll Now](#)



Organizations Bring QPR Online Gatekeeper Training to your organization, school or college..

[Information](#)

Become a Certified QPR Gatekeeper Instructor Learn to teach three simple steps everyone needs to know to help prevent suicide. For any person or organization interested in preventing suicide in their community. [Information](#)

QPR Suicide Prevention Courses for the Professional

HB2366: Approved training required for Washington state healthcare providers

Licensed healthcare provider impacted by new laws requiring training in suicide risk assessment, treatment, and management? Answers to 20 questions about our training program.

The QPR Institute provides CE-approved advanced online evidence-based and peer-reviewed training programs for a wide range of students and professionals including: mental health professionals, school counselors, crisis line workers, substance abuse professionals, EMS/firefighters, law enforcement, physicians, nurses and correctional workers. All courses may be completed from any high-speed internet connection, including from your mobile device. These courses are listed in the SPRC Best Practice Registry [here](#).

The QPR Institute's Suicide Risk Reduction Program [Please visit our library of advanced online courses](#)

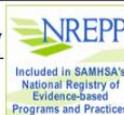
Complete List of QPR Gatekeeper Instructors



QPR Instructors per state

Free e Book *Suicide: The Forever Decision* Available in French, Serbian and Spanish [Read Now!](#)

QPR Gatekeeper Training for Suicide Prevention Listed in the National Registry of Evidence-based Practices and Policies - [Information](#)



[NREPP Program Adoption Recommended Questions and Answers](#)

RESOURCES

[Instructor Resources](#)
[About QPR](#)
[QPR Mission Statement](#)
[QPR Theory](#)
[QPR Faculty](#)
[Evidence for QPR](#)

TRAINING PROGRAMS

[QPR Gatekeeper Training](#)
[QPR Suicide Triage Training](#)
[QPR Suicide Risk Assessment and Risk Management](#)
[Online Counseling and Suicide Intervention Specialist Training](#)
[QPR Courses for EMS/Firefighter](#)
[Law Enforcement](#)

Bookstore

[The Forever Decision \(free book\)](#)
[QPR Gatekeeper Training Certificate](#)
[QPR in the Classroom](#)

QPR FOR ORGANIZATIONS

[Business](#)
[Community](#)
[Healthcare](#)
[Law Enforcement](#)
[Mental Health](#)
[Schools](#)

QPR

- QPR gatekeeper training
 - For an emergency response to someone in crisis
 - Online one hour training or in person training
- QPR suicide prevention course
 - For mental health professionals, school counselors, crisis line workers, substance abuse professionals, EMS/firefighters, law enforcement, physicians, nurses and correctional workers.



MENTAL HEALTH FIRST AID



INSTRUCTOR LOGIN

TAKE A COURSE BECOME AN INSTRUCTOR ABOUT NEWS & UPDATES



Learn the skills to identify, understand, and respond to signs of mental illnesses and substance use disorders

DISCOVER WHAT YOU WILL LEARN

Mental Health First Aid is an in-person training that teaches you how to help people developing a mental illness or in a crisis.

Sign up for a Mental Health First Aid class near you

Mental Health First Aid teaches you:



Signs of addictions and mental illnesses



5-step action plan to assess a situation and help



Impact of mental and substance use disorders



Local resources and where to turn for help

LEARN MORE

FIND A COURSE



Ready to become a Mental Health First Aid instructor?

[Apply for Instructor Training](#)

DONATE NOW



“I've taken regular first aid, and I've used both, but certainly the opportunities to use Mental Health First Aid are much more abundant.”

-Nathan Krause, Pastor, Olney Seventh-day Adventist Church, Maryland

READ SUCCESS STORIES

SUBMIT YOUR STORY

Mental Health First Aid

- In-person training that teaches how to help people who are experiencing a mental health problem or crisis.
 - Youth Mental Health First Aid
 - For parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions
 - Adult Mental Health First Aid
 - For anyone 18 years and older who wants to learn how to help a person who may be experiencing a mental health related crisis or problem

Identify

Standardized suicide screening of all members enrolled in active behavioral healthcare services.

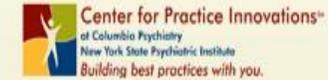
Including Emergency Rooms and Primary Care

- Why is this important?

Common Concerns: Asking About or Assessing Suicide Risk

- Will asking about it upset someone, or put those thoughts in their mind?
- What about cultures in which suicide is never discussed—is it culturally appropriate to ask?
- We don't have enough behavioral health services available for the patients we already know about—what will we do with the new patients we find?
- I don't have enough time as it is to get through all I have to do with patients. I don't have time to ask about suicide.
- I'm not sure what to say/what to do/how to follow up.

Suicide Risk Identification and Triage Using the Columbia Suicide Severity Rating Scale



Identify – Using Standardized Screening Tools

Columbia Suicide Severity Rating Scale

- Screener version appropriate for First Responders, gatekeepers, peer counselors
- Full version appropriate for behavioral health clinicians
- Versions for children, intellectually disabled
- Available in 100+ languages
- Versions to assess lifetime/recent/since last visit
- Flexible format, don't need to ask all the questions if not necessary
- Integrate information given by collateral sources family, caregivers

If 1 and 2 are no, ideation section is done.

Columbia Suicide Severity Rating Scale Screening Version

Minimum of 3 Questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE Screening Version - Recent

	Past Month	
	YES	NO
Ask questions that are bold and underlined		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan." <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." <u>Have you been thinking about how you might kill yourself?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?</u>		
	Past 3 Months	
	YES	NO
6) Suicide Behavior <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		

CSSRS– Full Version

- It is a clinical interview using a written instrument
- For clinicians- provides information to aid decision making
 - 6-16 questions
 - Ideation severity
 - Ideation intensity
 - Behaviors
 - Lethality of attempts

Identify - Why Is It Important to Screen for Suicidality?

- “Suicidality is a co-occurring disorder.”

Mike Hogan, PhD

Comorbidity

- More than 90% of people who dies by suicide have a mental health disorder or substance abuse disorder or both
- More than 50% of suicides are associated with a major depressive disorder
- Approximately 25% of suicides are associated with a substance abuse disorder
- Ten percent of suicides are associated with psychotic disorders

Identify – Patients at Risk of Suicide

- Patient Health Questionnaire 9 (PHQ9) and PHQ3
 - Screens for depression
- DAST 10
 - Screens for substance use
- AUDIT C
 - Screens for alcohol use

PHQ2 and PHQ9

- PHQ-9 is a 9 question screen for depression
 - the 9th question is about suicidality
- Validated for use in primary care and other busy clinical settings
- IHS recommends for use in Native American populations (IHS 2011)
- PHQ-2 is a briefer (2 question) screen which can be followed up by PHQ-9
- To better assess suicidality PHQ-2 plus 9th question can be used = PHQ-3

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all D	Somewhat difficult D	Very difficult D	Extremely difficult D
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Engage

Engagement of the patient or client in best-practice interventions geared to risk level.

Every person has a pathway to care that is timely

- Warm hand off
- Phone call follow up between appointments
- Postcards or letters
- Home visits

– Follow up

Engage - Safety Planning

- Collaborative approach
- Means restriction
 - Guns, pills, alcohol and drugs - CALM
- Teach people brief problem solving & coping skills
- Increase social support and identify emergency contacts
- Motivational enhancement for further treatment

Engage - Reasons for Safety Planning

- Suicide risk fluctuates over time
- Problem solving capacity is lower during times of crisis so it helps to plan ahead
- Cognitive behavioral approaches reduce impulsive behaviors
- Learning to cope with suicidal crises without hospitalization helps increase a person's self-efficacy and self confidence
- Safety planning helps to instill hope!

Engage - Who Is Appropriate for Safety Planning & What Does it Do?

- Patients at increased risk for suicide who do not require immediate hospitalization
- Fills the gap between hospital or ED discharge and follow-up
- Provides an alternative for those who don't want or don't receive outpatient care

Safety Planning Apps

- Safety Plan by Two Penguins Studios LLC
- My3
- Both available in apple app store and Google Play
- SAMHSA Suicide Safe app – for clinicians suicide assessment

Treat- Evidence Based Therapy

- **Cognitive Behavioral Therapy - Suicide Prevention**
 - Case conceptualization
 - Precipitating factors, vulnerabilities, thoughts and feelings
 - Safety Planning
 - Skill building and problem solving
 - Manage emotional arousal
 - Relapse Prevention

Treat- Evidence Based Therapy

- **Dialectical Behavior Therapy**
 - Mindfulness
 - Interpersonal Skills
 - Emotional Regulation Skills
 - Distress Tolerance

Transition

- Provides a “continuity of caring”
- Keeps patients from falling through the cracks
- Plugs the holes in care

Transition - Contact Between Care and After Care

- Phone call follow up
- Text messaging
- Postcards or letters
- Home visits
- Groups for people with lived experience
- Suicide Prevention aps

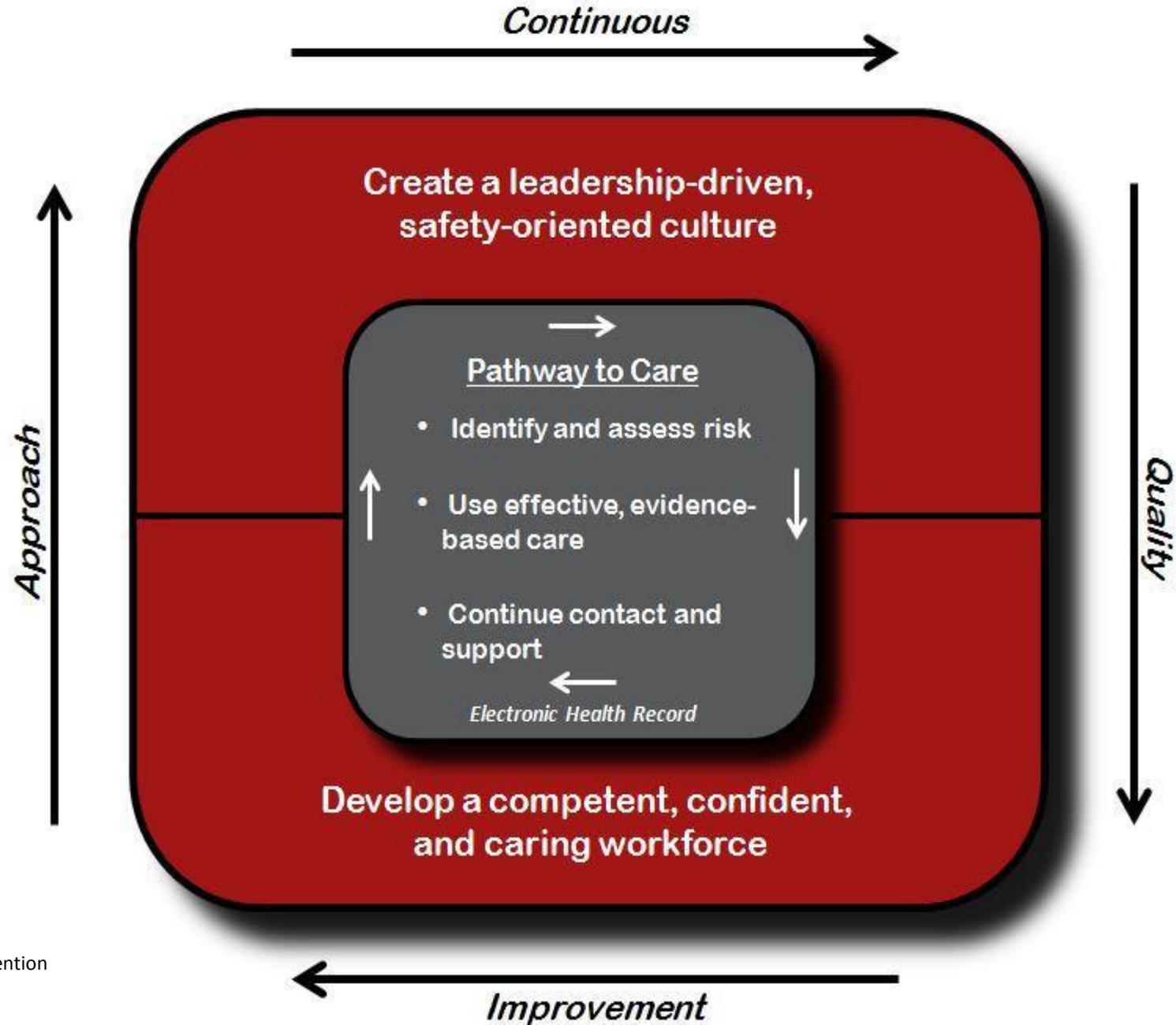
Improve

- **Applying a data driven quality improvement approach**
 - Build flow of assessments and screens and care into electronic health record
 - Data Informs system changes
 - Improves care

Improve - Where are the Gaps?

- Who does the screening for depression, substance use, suicidality?
- Who needs to know the results of the screening?
- Who does further screening?
- Where are the screening instruments kept?
- How is the management plan communicated?
- Who in your community provide services for people at risk?

The Dimensions of Zero Suicide



How to Get Started with Zero Suicide

- Zero Suicide Toolkit
- Encourage your organization to adopt a comprehensive approach to suicide care
- Develop a Zero Suicide implementation team
 - Community members
 - Family members and people with lived experiences
 - Providers

How to Get Started with Zero Suicide-Next Steps

- Zero Suicide Organizational Self-Study
- Workforce Survey
- Create a work plan and set priorities
- Review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transitions.
- Formulate a plan to collect data and evaluate progress and measure results.

 Toolkit

 Champions

 Get Involved

Search



WHAT IS ZERO SUICIDE?

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



ZERO SUICIDE TOOLKIT



[VIEW TOOLKIT »](#)

FOR CHAMPIONS

Zero Suicide Champions believe that anything short of zero

MAKING HEALTH CARE SUICIDE SAFE

Mike Hogan describes



Resources

- Action Alliance for Suicide Prevention-
<http://zerosuicide.actionallianceforsuicideprevention.org/>
- Suicide Prevention Resource Center - <http://www.sprc.org/>
 - American Indian and Alaska Native Suicide Prevention Programs
 - Garrett Lee Smith State/Tribal Suicide Prevention Program
- Suicide Prevention Life Line 1-800-273-TALK (8255)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- Military One Source <http://www.militaryonesource.mil/>
- Columbia-Suicide Severity Rating Scale Training <http://www.cssrs.columbia.edu/>

Resources

- Mental Health First Aid <http://www.mentalhealthfirstaid.org/cs/>
- ASIST – Applied Suicide Intervention Skills - <https://www.livingworks.net/programs/asist/>
- QPR – Question, Persuade and Refer - <https://www.qprinstitute.com/gatekeeper.html>
- CALM-Counseling on Access to Lethal Means http://www.sprc.org/library_resources/items/calm-counseling-access-lethal-means
- safe TALK <https://www.livingworks.net/programs/safetalk/>