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

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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

Disclaimer

- Dr. Bereiter and Laura Rombach have no financial relationship to this program

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

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 in the United States

- Nearly 40,000 people in the United States die from suicide annually
- 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 occurred by use of a firearm

Substance Abuse and Mental Health Services Administration 2014

Youth

New Mexico

- New Mexico has the 5th highest suicide rate in the United States
- The New Mexico suicide rate is more than 50% higher than the United States rate
- In 2014 - 450 New Mexicans died by suicide (21.1 deaths per 100,000 residents)
- Suicide is the 7th leading cause of death in New Mexico
- Suicide rates have been increasing in New Mexico and the United States since 2000
- Suicide is the 2nd leading cause of death among New Mexico residents 10 to 39 years old

From the NMDOH Health Fact Sheet September 2015

New Mexico

- Over the past 30 years, New Mexico has consistently had among the highest alcohol-related death rates, and the highest drug-induced death rate in the nation. (SAMHSA, 2013)
- New Mexico has the highest prescription drug overdose death rate in the nation.

Polling Question

- In 2013 _____% of **high school** students attempted suicide.

  a. 5%

  b. 9%

  c. 12%

  d. 20%

New Mexico Youth

- In 2013 - 7.8% of middle school students in New Mexico had attempted suicide
- In 2013 - 9.4% of high school students in New Mexico had attempted suicide
  - *This rate has decreased from 14.5% in 2003*
- In 2014 - 3,443 visits to emergency departments in New Mexico were due to self-injury

NMDOH Health Fact Sheet
September 2015

Most Vulnerable

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

- 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 a history of trauma
- American Indians and Alaska Natives
- People with mental and/or substance use disorders
- People who are lesbian, gay, bisexual, or transgender
- Members of the military and veterans

Polling Question

- How many people saw their primary care doctor in the month prior to death by suicide?

  a. 20%

  b. 30%

  c. 50%

  d. 75%

Rates of Suicide After Seeing a Provider

- 50% of people who die by suicide had contact with their primary care provider 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 two months before they died

SAMHSA Suicide Safe http://store.samhsa.gov/apps/suicidesafe/

What is Zero Suicide?

- Commitment to suicide prevention in health and behavioral health care systems
- Suicide deaths for people under care are preventable
- Set of specific goals and strategies
- Both a concept and a practice

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Mike Hogan, Ph.D.
Zero Suicide in Health Care

Video

- https://www.youtube.com/watch?v=6L3AeGnUbuQ

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 Different in Zero Suicide?

Shift in Perspective

From:	To:
Accepting suicide as inevitable	Every suicide in a system is preventable
Assigning blame	Nuanced understanding: ambivalence, resilience, recovery
Risk assessment and containment	Collaborative safety, treatment, recovery
Stand alone training and tools	Overall systems and culture changes
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?"

2010 National Action Alliance for Suicide Prevention

Lead

- Leadership supported
- Safety oriented culture
- Committed to reducing suicide among people under care
- Immediate access
- Seamless care
- Written polices 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 does staff address client’s suicide risk
- Identify training needs

Workforce Survey

- Examples of questions from the Zero Suicide Workforce Survey
  - ❖The rate of suicide in my state is lower than the national average.
  - ❖If you talk to someone about suicide, you may inadvertently give that person permission to seriously consider it.
  - ❖People have a right to suicide.
  - ❖I am comfortable asking direct and open questions about suicide.

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

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

LivingWorks

ASIST

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

QPR Institute

QPR Instructor Resources | QPR Gatekeeper Training Login | QPR Advanced Courses Login | Advanced Course Library

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 stepsanyone 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
Included in SAMHSA's National Registry of Evidence-based Programs and Practices

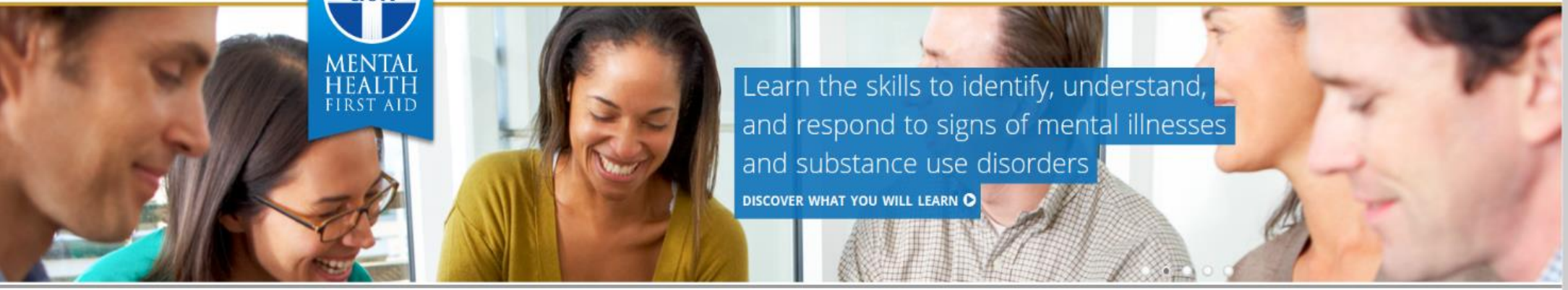
NREPP Program Adoption
Recommended Questions and Answers

RESOURCES	TRAINING PROGRAMS	Bookstore	QPR FOR ORGANIZATIONS
Instructor Resources	QPR Gatekeeper Training		Business
About QPR	QPR Suicide Triage Training	The Forever Decision (free book)	Community
QPR Mission Statement	QPRT Suicide Risk Assessment and Risk Management		Healthcare
QPR Theory	Online Counseling and Suicide Intervention Specialist Training	QPR Gatekeeper Training Certificate	Law Enforcement
QPR Faculty	QPR Courses for EMS/Firefighter		Mental Health
Evidence for QPR	Law Enforcement	QPR in the Classroom	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 is an in-person training that teaches you how to help people developing a mental illness or in a crisis.

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

Sign up for a Mental Health First Aid class near you

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.

Polling Question

- How does your organization screen for suicide risk?
  a. Standardized screening
  b. Staff ask question about self harm or suicidal thoughts.
  c. No screening is done for suicide risk

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

© 2013 Research Foundation for Mental Hygiene, Inc.

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	
Ask questions that are bold and underlined	**YES**	**NO**
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. **Have you wished you were dead or wished you could go to sleep and not wake up?**		
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."* **Have you actually had any thoughts of killing yourself?**		
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."* **Have you been thinking about how you might kill yourself?**		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* **Have you had these thoughts and had some intention of acting on them?**		
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. **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?**		

	Past 3 Months	
	YES	**NO**
6) Suicide Behavior **Have you done anything, started to do anything, or prepared to do anything to end your life?** 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

- Child and Adult 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

- People won’t always tell you, you need to ask.

Comorbidity

- More than 90% of people who die 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

Suicide Prevention Toolkit for Rural Primary Care 2015

Identify – Patients at Risk of Suicide

- Patient Health Questionnaire 9 (PHQ9)and PHQ3
  - PHQ- A for adolescents
    - Screens for depression
- AADIS – Adolescent Alcohol and Drug Involvement Scale
    - Screens for tobacco, alcohol and drug use

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	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
D	D	D	D

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

PHQ-9 Modified for Adolescents (PHQ-A)

Severity Measure for Depression—Child Age 11–17*

*PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: How often have you been bothered by each of the following symptoms during the past 7 days? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					
					Total/Partial Raw Score:	
					Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Adolescent Alcohol and Drug Involvement Scale - AADIS

- Screens for tobacco, alcohol and drug use
  - Drug use history includes frequency of use
  - Interview & self-report versions – 14 questions
- Score over 37 requires full assessment

Developed by D. Paul Moberg, Center for Health Policy and Program Evaluation, University of Wisconsin Medical School.

Adolescent Alcohol and Drug Involvement Scale: AADIS

A. DRUG USE HISTORY

For each drug I name, please tell me if you have ever tried it. Then, if you have tried it, tell me how often you typically use it [*before* you were taken into custody or enter treatment]. Consider only drugs taken without prescription from your doctor; for alcohol, don't count just a few sips from someone else's drink.

	Never Used	Tried But Quit	Several Times a Year	Several Times a Month	Week-Ends Only	Several Times a Week	Daily	Several Times a Day
Smoking Tobacco (Cigarettes, cigars)	0	1	2	3	4	5	6	7
Alcohol (Beer, Wine, Liquor)	0	1	2	3	4	5	6	7
Marijuana or Hashish (Weed, grass)	0	1	2	3	4	5	6	7
LSD, MDA, Mushrooms Peyote, other hallucinogens (ACID, shrooms)	0	1	2	3	4	5	6	7
Amphetamines (Speed, Ritalin, Ectasy, Crystal)	0	1	2	3	4	5	6	7
Powder Cocaine (Coke, Blow)	0	1	2	3	4	5	6	7
Rock Cocaine (Crack, rock, freebase)	0	1	2	3	4	5	6	7
Barbiturates, (Quaaludes, downers, ludes, blues)	0	1	2	3	4	5	6	7
PCP (angel dust)	0	1	2	3	4	5	6	7
Heroin, other opiates (smack, horse, opium, morphine)	0	1	2	3	4	5	6	7
Inhalants (Glue, gasoline, spray cans, whiteout, rush, etc.)	0	1	2	3	4	5	6	7
Valium, Prozac, other tranquilizers (without Rx)	0	1	2	3	4	5	6	7
OTHER DRUG_____	0	1	2	3	4	5	6	7

B. AADIS

These questions refer to your use of alcohol and other drugs (like marijuana/weed or cocaine/rock). Please answer regarding the time you were living in the community *before* you were taken into custody or entered treatment. Please tell me which of the answers best describe your use of alcohol and/or other drug(s). Even if none of the answers seem exactly right, please pick the ones that come closest to being true. If a question doesn't apply to you, tell me and we will leave it blank.

1. How often do [did] you use alcohol or other drugs (such as weed or rock) [before you were taken into custody/entered treatment]?

   a. *[0]* never
   b. *[2]* once or twice a year
   c. *[3]* once or twice a month
   d. *[4]* every weekend
   e. *[5]* several times a week
   f. *[6]* every day
   g. *[7]* several times a day

2. When did you last use alcohol or drugs? *[Before you entered treatment or were taken into custody]*

   a. *[0]* never used alcohol or drugs
   b. *[2]* not for over a year
   c. *[3]* between 6 months and 1 year [before]
   d. *[4]* several weeks ago [before]
   e. *[5]* last week [the week before]
   f. *[6]* yesterday [the day before]
   g. *[7]* today [the same day I was taken into custody]

3. I usually start to drink or use drugs because: (**TELL ME ALL THAT ARE TRUE OF YOU**)

   a. *[1]* I like the feeling
   b. *[2]* to be like my friends
   c. *[3]* I am bored; or just to have fun ("kickin' it")
   d. *[4]* I feel stressed, nervous, tense, full of worries or problems
   e. *[5]* I feel sad, lonely, sorry for myself

4. What do you drink, when you drink alcohol? (**CIRCLE ALL MENTIONS**)

   a. *[1]* wine
   b. *[2]* beer
   c. *[3]* mixed drinks
   d. *[4]* hard liquor (vodka, whisky, etc.)
   e. *[5]* a substitute for alcohol

5. How do you get your alcohol or drugs? (**CIRCLE ALL THAT YOU DO**)

   a. *[1]* Supervised by parents or relatives
   b. *[2]* from brothers or sisters
   c. *[3]* from home without parents' knowledge
   d. *[4]* get from friends
   e. *[5]* buy my own (on the street or with false ID)

6. When did you first use drugs or take your first drink? (**CIRCLE ONE**)

   a. *[0]* never
   b. *[2]* after age 15
   c. *[3]* at ages 14 or 15
   d. *[4]* at ages 12 or 13
   e. *[5]* at ages 10 or 11
   f. *[6]* before age 10

7. What time of day do you use alcohol or drugs? (**CIRCLE ALL THAT APPLY TO YOU**)

   a. *[1]* at night
   b. *[2]* afternoons/after school
   c. *[3]* before or during school or work
   d. *[4]* in the morning or when I first awaken
   e. *[5]* I often get up during my sleep to use alcohol or drugs

8. Why did you take your first drink or first use drugs? (**CIRCLE ALL THAT APPLY**)

   a. *[1]* curiosity
   b. *[2]* parents or relatives offered
   c. *[3]* friends encouraged me; to have fun
   d. *[4]* to get away from my problems
   e. *[5]* to get high or drunk

9. When you drink alcohol, how much do you usually drink?

a. *[1]* 1 drink
b. *[2]* 2 drinks
c. *[3]* 3-4 drinks
d. *[4]* 5 -9 drinks
e. *[5]* 10 or more drinks

10. Whom do you drink or use drugs with? (**CIRCLE ALL THAT ARE TRUE OF YOU**)

a. *[1]* parents or adult relatives
b. *[2]* with brothers or sisters
c. *[3]* with friends or relatives own age
d. *[4]* with older friends
e. *[5]* alone

11. What effects have you had from drinking or drugs? (**CIRCLE ALL THAT APPLY TO YOU**)

a. *[1]* loose, easy feeling
b. *[2]* got moderately high
c. *[3]* got drunk or wasted
d. *[4]* became ill
e. *[5]* passed out or overdosed
f. *[6]* used a lot and next day didn't remember what happened

12. What effects has using alcohol or drugs had on your life? (**CIRCLE ALL THAT APPLY**)

a. *[0]* none
b. *[2]* has interfered with talking to someone
c. *[3]* has prevented me from having a good time
d. *[4]* has interfered with my school work
e. *[5]* have lost friends because of use
f. *[6]* has gotten me into trouble at home
g. *[7]* was in a fight or destroyed property
h. *[8]* has resulted in an accident, an injury, arrest, or being punished at school for using alcohol or drugs

13. How do you feel about your use of alcohol or drugs? (**CIRCLE ALL THAT APPLY**)

a. *[0]* no problem at all
b. *[1]* I can control it and set limits on myself
c. *[3]* I can control myself, but my friends easily influence me
d. *[4]* I often feel bad about my use
e. *[5]* I need help to control myself
f. *[6]* I have had professional help to control my drinking or drug use.

14. How do others see you in relation to your alcohol or drug use? (**CIRCLE ALL THAT APPLY**)

a. *[0]* can't say or normal for my age
b. *[2]* when I use I tend to neglect my family or friends
c. *[3]* my family or friends advise me to control or cut down on my use
d. *[4]* my family or friends tell me to get help for my alcohol or drug use
e. *[5]* my family or friends have already gone for help about my use

Developed by D. Paul Moberg, Center for Health Policy and Program Evaluation, University of Wisconsin Medical School. Adapted with permission from Mayer and Filstead's "Adolescent Alcohol Involvement Scale" (Journal of Studies on Alcohol 40: 291-300, 1979) and Moberg and Hahn's "Adolescent Drug Involvement Scale" (Journal of Adolescent Chemical Dependency, 2: 75-88, 1991).

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

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
- Not the same as a “no suicide contract”

Why It's Important to Reduce Access to Lethal Means

- Many suicide attempts occur during a short-term crisis
- Many suicide attempts are impulsive
  - Studies show many people report less than 5-10 minutes between decision to commit suicide and attempt
- 90% of attempters who survive do NOT go on to die by suicide later (Owens D, Horrocks J, House A. 2002. Fatal and non-fatal repetition of self-harm. Systematic review.)
  - 7% reattempted and died by suicide
  - 23% reattempted nonfatally
  - 70% made no further attempts

    (*Br. J. Psychiatry* 181:193–99)

Lethality of Methods of Suicide

- Intent isn’t all that determines whether an attempter lives or dies
- Lethality of methods differs:
  - Guns are the most lethal means 84% fatal
  - Suffocation/Hanging is the next most lethal 69% fatal
  - Falls 31% fatal
  - Poisoning/overdose 2% Fatal
  - Cutting 1% Fatal

Case fatality ratio by method of self-harm, USA 2001

Reducing Access to Guns

- Guns were used in 51% of completed suicides in 2013
- In children under 15, the suicide rate in the US is 2x that of other industrialized countries (largely due to firearm suicide rate)
- Firearms used in youth suicide usually belong to a parent
- Reducing access to firearms is the most modifiable risk factor for suicide we have

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

Polling Question

- What are some of the ways that your agency follows up with patients?

  a. Phone calls

  b. Text messages

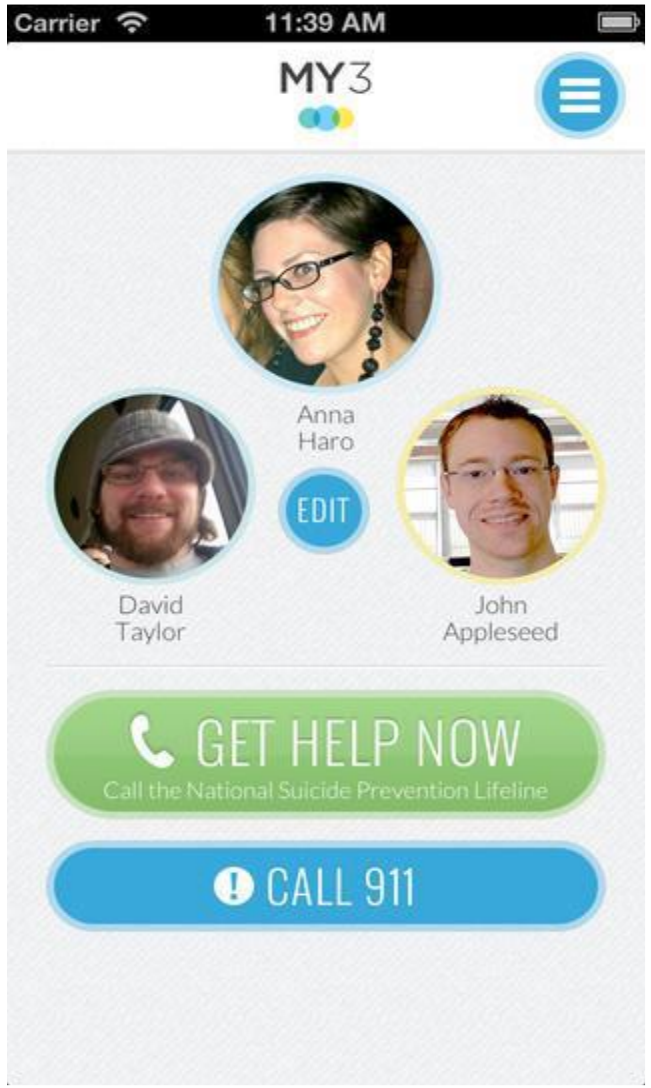
  c. Mailing cards or letters

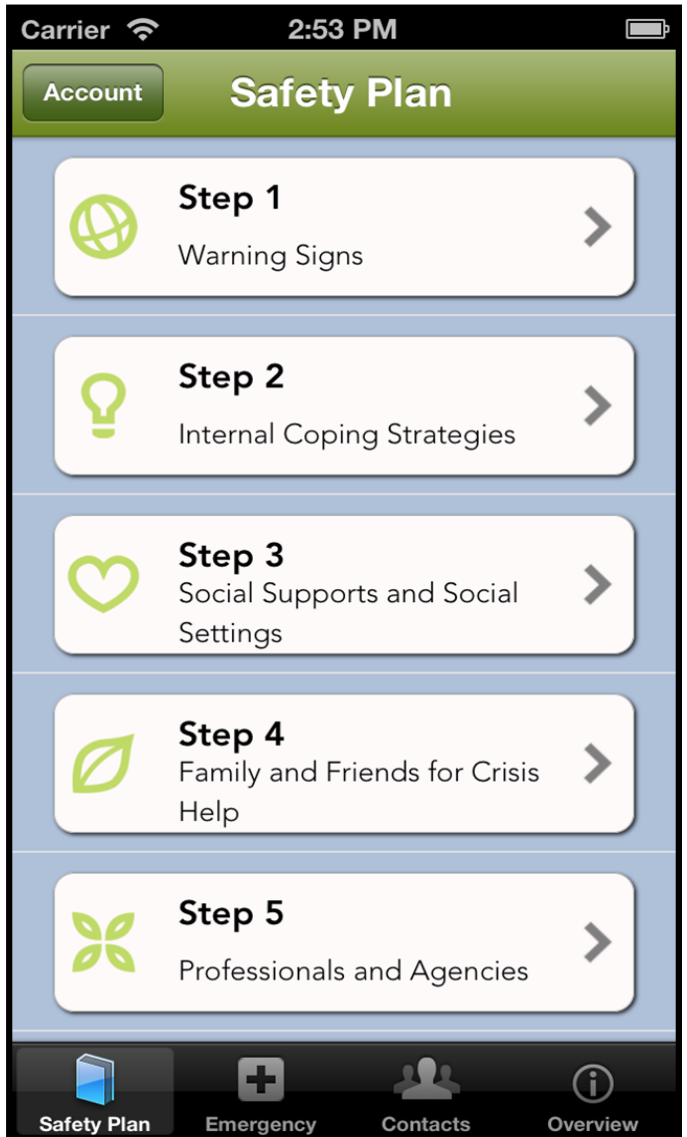
  d. None

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

My3 and Safety Plan Apps





Suicide Safe: The Suicide Prevention App for Health Care Providers Free from SAMHSA

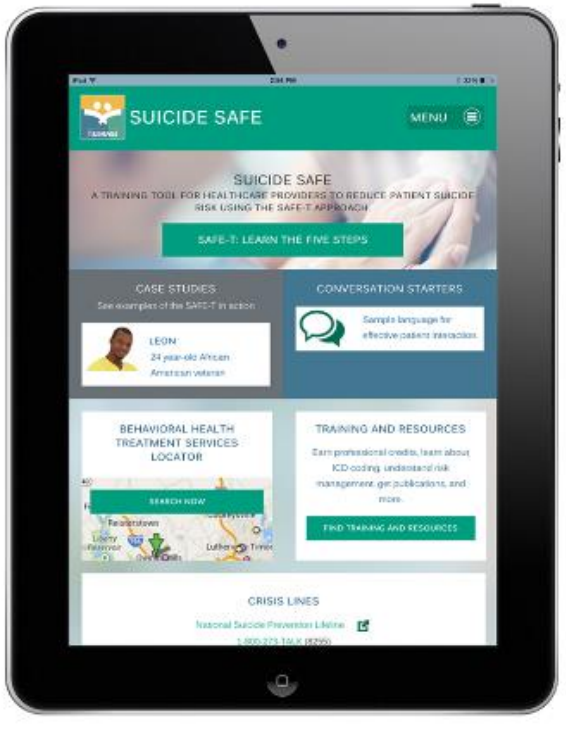
For individuals at risk of suicide, behavioral health and primary care settings provide unique opportunities to connect with the health care system and access effective treatment. Almost half (45%) of individuals who die by suicide have visited a primary care provider in the month prior to their death, and 20% have had contact with mental health services.[1]

Suicide Safe, SAMHSA's new suicide prevention app for mobile devices and optimized for tablets, helps providers integrate suicide prevention strategies into their practice and address suicide risk among their patients. Suicide Safe is a free app based on SAMHSA's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) card.

Available Now

GET IT ON Google play

Download on the App Store



Treat - Evidenced Based Practices

- “Evidenced based practices are interventions that have undergone rigorous evaluation and demonstrated positive outcomes”

  Suicide Prevention Resource Center

- Suicide Prevention Resource Center
  - Best practices registry

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
- Follow up especially after acute 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

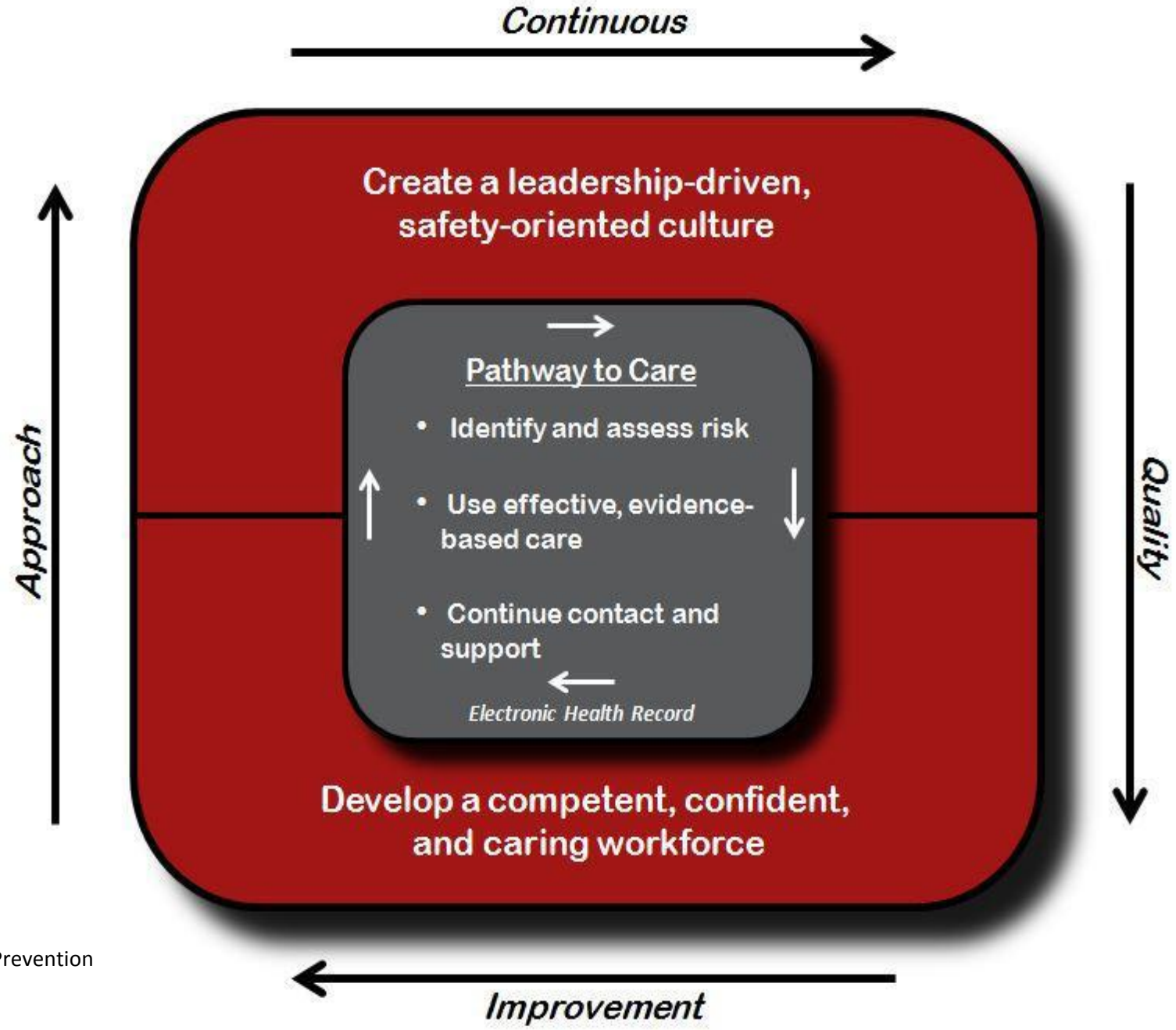
Improve

- **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



2010 National Action Alliance for Suicide Prevention

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.

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/