Zero Suicide 101

What is this and why are we doing it?
What is Zero Suicide?

Why is this important?

What does Zero Suicide look like in Colorado?

What are the existing resources?

How does this map on to HQIP?
Quick Caveat and Disclaimer.
This is just an overview.

This is not a Zero Suicide Academy.
What is Zero Suicide?
What is Zero Suicide?

- A priority of the National Action Alliance for Suicide Prevention
- A goal of the National Strategy for Suicide Prevention
- A project of the Suicide Prevention Resource Center
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- A focus on safety and error reduction in healthcare
- A set of best practices and tools for health systems and providers
WHAT ZERO SUICIDE IS NOT

NOT the only element in a comprehensive community-based initiative. Health Systems are only one piece of the puzzle, albeit an important one.

Separate initiatives within other sectors are ongoing and can align with Zero Suicide efforts.

Zero Suicide is a paradigm shift- this is not a one and done training!

Zero Suicide is not prescriptive

Zero Suicide is not a training solely for mental health providers- but rather the SYSTEM itself.
<table>
<thead>
<tr>
<th>ELEMENTS</th>
<th>1. Leadership commitment</th>
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<tbody>
<tr>
<td></td>
<td>2. Identification - Standardized screening and safety assessment</td>
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<td>3. Engage - Suicide care management plan</td>
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<td>4. Workforce development and training</td>
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<td>5. Effective, evidence-based treatment</td>
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<td>6. Follow-up during care transitions</td>
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<td>7. Ongoing quality improvement and data collection</td>
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ITEMS TO CONSIDER

- Buy-in from leadership
- Building an Implementation Team with authority and representation from across the system
- Honoring the leadership of Lived Experience
- Organizational Self-Study
- Communicating to staff
- Avoiding burnout
Example from MHCD

“The Mental Health Center of Denver is committed to the safety of the people we serve as well as the support and safety of our incredible staff. The Zero Suicide Initiative provides an important framework as we continue to strive towards the goal of zero suicides.”

- Dr. Carl Clark, CEO, April 2018
A complimentary publication of The Joint Commission
Issue 57, March 1, 2017

The essential role of leadership in developing a safety culture

In any health care organization, leadership’s first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors. Competent and thoughtful leaders contribute to improvements in safety and organizational culture. They understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes. James Reason compared these flaws – latent hazards and weaknesses – to holes in Swiss cheese. These latent hazards and weaknesses must be identified and solutions found to prevent errors from reaching the patient and causing harm. Examples of latent hazards and weaknesses include poor design, lack of supervision, and manufacturing or maintenance defects.

The Joint Commission’s Sentinel Event Database reveals that leadership’s failure to create an effective safety culture is a contributing factor to many types of adverse events – from wrong site surgery to delays in treatment.
Basic Suicide Prevention
Gatekeeper training

This empowers all staff from the organization with skills and knowledge to identify those that may be struggling, ask the hard question, and connect them with supportive resources.

- Can be done in person or virtually.
- Can range from 60 minutes to 2 full days.
- Good news! There are existing training resources you can leverage!

Clinical Staff

Specialized training relative to role.

Depending on how an organization is structured for workflow, different staff may need different skills. The trainings should be tailored to the specific tools used in your organization.

- Screening and Assessment
- Collaborative Safety Planning
- Lethal Means Counseling
- Good news! There are existing training resources here too!

Treatment providers

Evidence-based and suicide-specific treatment training.

For those clinicians in your agency serving clients with identified suicidality, there are key evidence-based suicide care trainings they should have.

- Specific to suicide care.
- Suited to those providing continuing care.
- Good news here too!
ITEMS TO CONSIDER

- Workforce Survey and how to respond
- Set training benchmarks using the Survey
- Avoid training burnout
- Bake in to onboarding
- Don’t reinvent the wheel!
All JCMH staff have been trained in QPR (1,341)

All new hires receive QPR during orientation

CAMS rollout began in Oct 2017, since then 278 clinical staff trained

Additionally- clinicians have completed the Zero Suicide Process training module
ITEMS TO CONSIDER

- When/How/Where to screen
- Documentation
- Workflows
- Training
- Comprehensive safety/risk formulation by trained clinician
ENGAGE
ITEMS TO CONSIDER

● Safety Planning
● Care Pathway:
  1. How to enter the Pathway- and how to exit
  2. How is this communicated to client
  3. Bake in to EHR

● Address the issue of suicide head on with referral for evidence-based care
● What additional training is needed to support staff
Safety Planning

All individuals identified as at risk of suicide should have a safety plan.

Collaborative safety planning is becoming standard practice. A safety plan should:

• Be brief, in the patient’s own words, and easy to read
• Involve family members as full partners
• Include a plan to restrict access to lethal means
• Be updated whenever warranted
• Be in the patient’s possession

Free training available online!
Why Means Matter

• Many suicide attempts occur with little planning during a short-term crisis.

• Intent isn’t all that determines whether someone lives or dies; means also matter.

• 90% of those who survive an attempt do NOT go on to die by suicide later.

• Access to firearms is a risk factor for suicide.

• Firearms used in youth suicide usually belong to a parent.

• Reducing access to lethal means saves lives.
**Firearm Deaths in Colorado**

For every 1 unintentional firearm death,

there were 18 homicides

and 78 firearm suicides.

Source: Violent Death Reporting System, Colorado Department of Public Health and Environment
What these conversations are **NOT**

- **Not** engaging in polarizing political debate
- **Not** about the 2\(^{nd}\) Amendment
- **Not** restriction on firearm ownership

✔ This is about safety: No one matter your political stance, we can all agree that no one wants their firearm used in a suicide.

✔ This is temporary.
Lethal Means Safety

- Free online training available
- Free patient resources available
- Online decision aid for physicians and family members

Check out: cdphe.colorado.gov/suicide-prevention/gun-safety-and-suicide
ITEMS TO CONSIDER

- Evidence-based care focusing directly on the issue of suicide: CBT-SP, DBT, CAMS
- In house or referral
- Local priority around CAMS and current resources available
- Collaborative, patient-centered
TRANSITION
ITEMS TO CONSIDER

- Caring Contacts
- Follow up for missed appointments
- Keeping clients informed
- Revising safety plan
Patients discharged from an emergency department after an evaluation for suicidal thoughts or behaviors are at highest risk for up to one month post-discharge.
As many as 70% do not access behavioral healthcare services after discharge.

National Data indicate 25% of individuals who die by suicide have recently visited an ED prior to their death.
Research indicates that follow-up with recently-discharged patients has positive effects for both patients and providers

- Cost effective
- Protective for reattempts/suicide deaths
- Improves patient motivation, reduces barriers to care
- Improves in-person follow-up with helping resources
ITEMS TO CONSIDER

- Data data data - process and outcome
- Culture free of blame
- Measuring fidelity to policies and opportunities for system improvement
# ZERO Suicide Data Elements Worksheet

**Description and Instructions**

This worksheet is intended to assist health and behavioral health care organizations in developing a data-driven, quality improvement approach to suicide care. The worksheet:

- Reflects the top areas of measurement that behavioral health care organizations should strive for to maintain fidelity to a comprehensive suicide care model.
- Includes a list of supplemental measures that organizations may want to consider. These measures are clinically significant but may be much harder to measure.

The Data Elements Worksheet should be completed every three months, and an evaluation team should use the findings to determine areas for improvement. The data elements included on the worksheet can be captured in an electronic health record to allow data to be tracked and compared over time.

**Please note:** The Zero Suicide Initiative is an evolving model. While many of the measures described in this document may help to reduce the risk of suicide, data collection and improvement are areas that need to be continuously maintained.

**Use note:** The Zero Suicide Data Elements Worksheet is in conjunction with the Zero Suicide 3.1 and 3.2 improvements can be made in care, training, and policies. We recommend your organization complete a comprehensive evaluation of your system.

**Terminology**

Case sheet: Cases are considered closed when a person has not had a recent event or count suicide deaths for those enrolled in care. We suggest to close a case if it occurred more than 30 days after a case was considered open and no events occurred within 180 days since the last event.

Enrolled in care: A patient enrolled in care is anyone with an open case file.

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**Recommended Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
<th>%</th>
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</thead>
<tbody>
<tr>
<td>1. Screening</td>
<td>Number of clients who received a suicide screening during the reporting period</td>
<td>Number of clients screened during the reporting period</td>
<td></td>
</tr>
<tr>
<td>2. Assessment</td>
<td>Number of clients who screened positive for suicide risk and had a comprehensive risk assessment (same day as screening) during the reporting period</td>
<td>Number of clients screened during the reporting period</td>
<td></td>
</tr>
<tr>
<td>3. Safety Plan Development</td>
<td>Number of clients with a safety plan developed (same day as screening) during the reporting period</td>
<td>Number of clients screened during the reporting period</td>
<td></td>
</tr>
<tr>
<td>4. Lethal Means Counseling</td>
<td>Number of clients who screened and assessed positive for suicide risk and were counseled about lethal means (same day as screening) during the reporting period</td>
<td>Number of clients screened during the reporting period</td>
<td></td>
</tr>
<tr>
<td>5. Missed Appointment Follow-up</td>
<td>Number of clients with a suicide care management plan who missed a face-to-face appointment and who received contact within 5 hours of the appointment during the reporting period</td>
<td>Number of clients with a suicide care management plan who missed a face-to-face appointment during the reporting period</td>
<td></td>
</tr>
<tr>
<td>6. Acute Care Transition</td>
<td>Number of clients who had a hospitalization or emergency department visit who were contacted within 24 hours of discharge during the reporting period</td>
<td>Number of clients who had a hospitalization or emergency department visit during the reporting period</td>
<td></td>
</tr>
<tr>
<td>7. Rate of Deaths by Suicide Among ALL Clients</td>
<td>Number of clients who died by suicide during the reporting period</td>
<td>Number of clients enrolled for services during the reporting period (e.g., open case file) regardless of when they were last seen</td>
<td>(Numerator / Denominator) x 10,000 Per 10,000 population</td>
</tr>
<tr>
<td>8. Rate of Suicide Deaths Among Those with Identified Suicide Risk</td>
<td>Number of clients with a suicide care management plan who died by suicide during the reporting period</td>
<td>Number of clients with a suicide care management plan during the reporting period</td>
<td>(Numerator / Denominator) x 10,000 Per 10,000 population</td>
</tr>
</tbody>
</table>
Why is this important?
The Health Care System Plays an Important Role.

Once someone enters care:

- Identifying those who may be struggling.
- Assessing needs and potential risk.
- Collaborative Safety Planning and Lethal Means Counseling.
- Responsive care specific to suicide.
- Follow Up and Care Coordination.
- Tracking outcomes, continuing quality improvement.

All of these require that systems are empowering staff with the tools, training, and resources to accomplish these.
People At Risk For Suicide Are Falling Through the Cracks in Our Health Care System

In the month before their death by suicide:
- Half saw a general practitioner
- 30% saw a mental health professional

In the 60 days before their death by suicide:
- 10% were seen in an emergency department
Large Healthcare Systems spanning both primary and behavioral care are a critical setting where coordinated suicide prevention strategies can have a dramatic impact on lives saved.

Strategy
Project 2025 is collaborating with the country’s largest healthcare systems and accrediting organizations to accelerate the acceptance and adoption of risk identification and suicide prevention strategies we know work.

Projection
By identifying one out of every five at-risk people in large healthcare systems – such as during primary care and behavioral health visits – and providing them with short-term intervention and better follow-up care, we can expect an estimated 9,200 lives saved through 2025.

Tools
2021 Illinois Suicide Prevention Summit

Up to 45% of people who die by suicide visit their primary care physician in the month prior to their death.
THE COLORADO PLAN
Colorado’s Action Template for Reducing Suicide

VISION FOR COLORADO
We envision a Colorado where every individual has access to and is able to afford high-quality healthcare, including mental health services; where every individual has the social support to lead meaningful and satisfying lives; where every individual is connected to their community; and where any individual who has thoughts of suicide, has attempted suicide, and/or has experienced suicide loss is supported across the continuum; and where no individual dies by suicide.

OVERARCHING PRIORITIES
- Implement a Shared Protective Factor Approach
- Zero Suicide in Health Care
- Lethal Means Safety
- Safe Reporting and Messaging
- Evaluation, Data Collection and Analysis

DEMOGRAPHIC-BASED PRIORITIES
In addition to the overarching system strategies, Colorado must also devote resources to demographic category strategies to reach and support Coloradans in specific ways. The following priorities are data-driven based on relative proportion of suicide fatalities. In order to achieve a 20 percent reduction in the suicide rate, Colorado must prioritize strategies that are designed to have the biggest impact among populations disparately affected by suicide and suicide risk.

- Adults (Ages 25-64)
- Older Adults 65+
- Transition Age Adults 19-24
- Youth 0-18
- LGBTQ+ Community
- Veterans

Colorado aims to reduce the suicide rate by 20% by 2024
This is not just about mental health...

More than half of people who died by suicide did not have a known mental health condition.

54%

Many factors contribute to suicide among those with and without known mental health conditions.

Relationship problem (42%)

Problematic substance use (28%)

Job/Financial problem (16%)

Loss of housing (4%)

Crisis in the past or upcoming two weeks (29%)

Physical health problem (22%)

Criminal legal problem (9%)

Note: Persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

What does Zero Suicide look like in Colorado?
Zero Suicide in Colorado

Recommendation of the Colorado Suicide Prevention Commission
Supportive legislation 2016
3 Academies since 2016
All Community Mental Health Centers trained
11 currently funded partners (5 CMHCs, 5 hospital systems, 1 FQHC)
Follow-Up after ED discharge*
Collaborative Assessment and Management of Suicidality training
Counseling on Access to Lethal Means, Safety Planning
Gatekeeper training for staff
EHR improvements
Monthly Learning Collaboratives
2 Upcoming Academies (July and August)

CAMs Trainings for mental/behavioral health providers

Follow Up Project for emergency departments

Monthly Learning Collaborative for interested systems

Peer Support Trainings (IPS, A2S)

Primary Care Practice Toolkit (Hard Copy and Electronic)

**COMING SOON! CALM training tracking**
What are the existing resources?
DATA SOURCES

Data Dashboard- www.coosp.org

Colorado Violent Death Reporting System (COVDRS) and Colorado Health Information Dataset

Colorado Child Fatality Review System

Behavioral Risk Factor Surveillance System

Healthy Kids Colorado Survey

Syndromic Surveillance

And more!
Training Resources for Clinical Staff

Screening and Assessment: The Columbia Suicide Severity Rating Scale has free training resources online. Ask Suicide Screening Questions Toolkit (ASQ)

Collaborative Safety Planning: Stanley and Brown have a Safety Plan template that is available online. More information here.

There is also excellent evidence behind the Crisis Response Plan learn more here.

Lethal Means Counseling: Talking about firearms can be touchy, leading folks to avoid it. But when someone is struggling, you cannot avoid the topic. Luckily there are some free trainings out there Counseling on Access to Lethal Means (CALM) online training

Free Pediatric Colorado Version of CALM! To access the free online training, please visit www.train.org/colorado and search for course 1076412 “Lethal Means Counseling: A Role for Colorado Emergency Departments to Reduce Youth Suicide.”

Recommended Standard of Care for People with Suicide Risk
Training Resources for Treatment Providers

Collaborative Assessment and Management of Suicidality (CAMS)- The Office has prioritized funding for this training modality as it is client-centered, can be done in numerous settings, and by clinicians across disciplines and theoretical orientations. Plus we now have a virtual option!

Click Here to get added to the interest list.

Other treatment modalities which have evidence specific for suicide include:
Cognitive Behavioral Therapy for Suicide Prevention - CBT-S
Dialectical Behavioral Therapy - DBT
There are many, these are just a few

- Applied Suicide Intervention Skills Training (ASIST) - 2 full days
- SafeTALK - half day
- Question Persuade Refer (QPR) - 60-90 minutes
- LivingWorks Start- online 60-90 minutes
- Mental Health First Aid (also a youth version) - 8 hours
Resources for Gatekeeper Training in Colorado

Question, Persuade, Refer (QPR)-designed to be done in 60 minutes, now has virtual option.

How to access: The Colorado Office of Suicide Prevention funds local community trainers in some areas of the state. The Office also has hard copy booklets we can provide to support organizations that have access to a trainer already.

LivingWorks Start Virtual Training Platform- online platform providing interactive gatekeeper training and role play.

How to access: If you are interested in a demo for this training platform, we have some Colorado licenses we can share for a trial run.

VA-funded SAVE training- focused on gatekeeper training with a lens of military/veteran experience. Virtual at this point. We can connect you if you are interested.

To find another gatekeeper training that would better serve your organization, check out the SPRC guide [here](#).
Other Colorado resources for your radar

Our office: [www.coosp.org](http://www.coosp.org)  
CDPHE_SuicidePrevention@state.co.us

- Connect with training events,
- Connect to local coalitions in your community,
- Access/analyze local/regional data,
- Get T/A from national experts,
- State and national resources
- Receive any hardcopy materials that might be useful to you,
- Learning Collaborative of health systems
- Join our newsletter to stay up to date.

Suicide Prevention Coalition of Colorado-[www.suicidepreventioncolorado.org](http://www.suicidepreventioncolorado.org)

American Foundation for Suicide Prevention-Colorado Chapter- [afsp.org/chapter/colorado](http://afsp.org/chapter/colorado)

Colorado Crisis System-[coloradocrisisservices.org](http://coloradocrisisservices.org)
National resources

Zero Suicide - www.zerosuicide.edc.org
Now Matters Now - www.nowmattersnow.org
American Foundation for Suicide Prevention - www.AFSP.org
Lock to Live - www.lock2live.org
Means Matter - www.hsph.harvard.edu/means-matter
Trevor Project - www.thetrevorproject.org
Trans Lifeline - www.translifeline.org

Link: Race, Racism, and Mental Health Resources
How does this map on to HQIP?
I. **Lead**
   - Buy in
   - Team
   - Survey
   - Plan

II. **Train**
   - Survey
   - Plan

III. **Identify and Engage**
   - Screening
   - Assessment
   - Safety Planning

IV. **Transition**
   - Follow up
   - Caring contacts

IV. **Improve**
   - Data
   - Quality Improvement
What would be helpful?
What do you need?
Thank you!

Next Meeting:
April 25, 2021- 10 – 11 am

Email topic suggestions, questions, needs to
Sarah.Brummett@state.co.us