# Minority Fellowship Program Suicide Prevention Webinar

Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

**Minority Fellowship Program Training**
**Webinar • February 27, 2019**

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# Disclaimer

The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration (SAMHSA), or the U.S. Department of Health and Human Services.

# Suicide Prevention Snapshot

Brandon J. Johnson, M.H.S.
Public Health Advisor
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

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# The Expanding Problem

- In 2017, there were 47,173 deaths from suicide.
- From 1999 through 2017, the age-adjusted suicide rate increased 33%, from 10.5 to 14.0 per 100,000.
- Suicide rates were significantly higher in 2017 compared with 1999 among females in all age groups ranging from 10-74 years: for those aged 10–14 (1.7 in 2017 and 0.5 in 1999, respectively), 15–24 (5.8 and 3.0), 25–44 (7.8 and 5.5), 45–64 (9.7 and 6.0), and 65–74 (6.2 and 4.1).
- Suicide rates were significantly higher in 2017 compared with 1999 among males in all age groups ranging from 10-74 year: for those aged 10–14 (3.3 in 2017 and 1.9 in 1999, respectively), 15–24 (22.7 and 16.8), 25–44 (27.5 and 21.6), 45–64 (30.1 and 20.8) and 65–74 (26.2 and 24.7).

# 10 Leading Causes of Death

| Rank | Cause | Number of deaths |
|---|---|---|
| 1 | Heart Disease | 635,260 |
| 2 | Malignant Neoplasms | 598,038 |
| 3 | Unintentional Injuries | 161,374 |
| 4 | Chronic Lower Respiratory Disease | 154,596 |
| 5 | Cerebrovascular Disease | 142,142 |
| 6 | Alzheimer's Disease | 116,103 |
| 7 | Diabetes mellitus | 80,058 |
| 8 | Influenza and pneumonia | 51,537 |
| 9 | Nephritis | 50,046 |
| **10** | **Suicide** | **44,965** |

Source: CDC vital statistics



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# Suicide Ranks Among Age Groups

| Rank | 10-14 Yrs | 15-19 Yrs | 20-29 Yrs | 30-39 Yrs | 40-49 Yrs | 50-59 Yrs |
|---|---|---|---|---|---|---|
| 1 | Unintentional Injuries | Unintentional Injuries | Unintentional Injuries | Unintentional Injuries | Unintentional Injuries | Malignant Neoplasms |
| 2 | **Suicide** | **Suicide** | **Suicide** | **Suicide** | Malignant Neoplasms | Heart Disease |
| 3 | Malignant Neoplasms | Homicide | Homicide | Malignant Neoplasms | Heart Disease | Unintentional Injuries |
| 4 | Homicide | Malignant Neoplasms | Malignant Neoplasms | Heart Disease | **Suicide** | Liver Disease |
| 5 | Congenital Malformations | Heart Disease | Heart Disease | Homicide | Liver Disease | Chronic Lower Respiratory Disease |
| 6 | Heart Disease | Congenital Malformations | Diabetes Mellitus | Liver Disease | Diabetes Mellitus | Diabetes Mellitus |
| 7 | Chronic Lower Respiratory Disease | Chronic Lower Respiratory Disease | Congenital Malformations | Diabetes Mellitus | Cerebro-vascular | **Suicide** |
| 8 | Cerebro-vascular | Cerebro-vascular | | Cerebro-vascular | Homicide | Cerebro-vascular |

**Source: CDC vital statistics**



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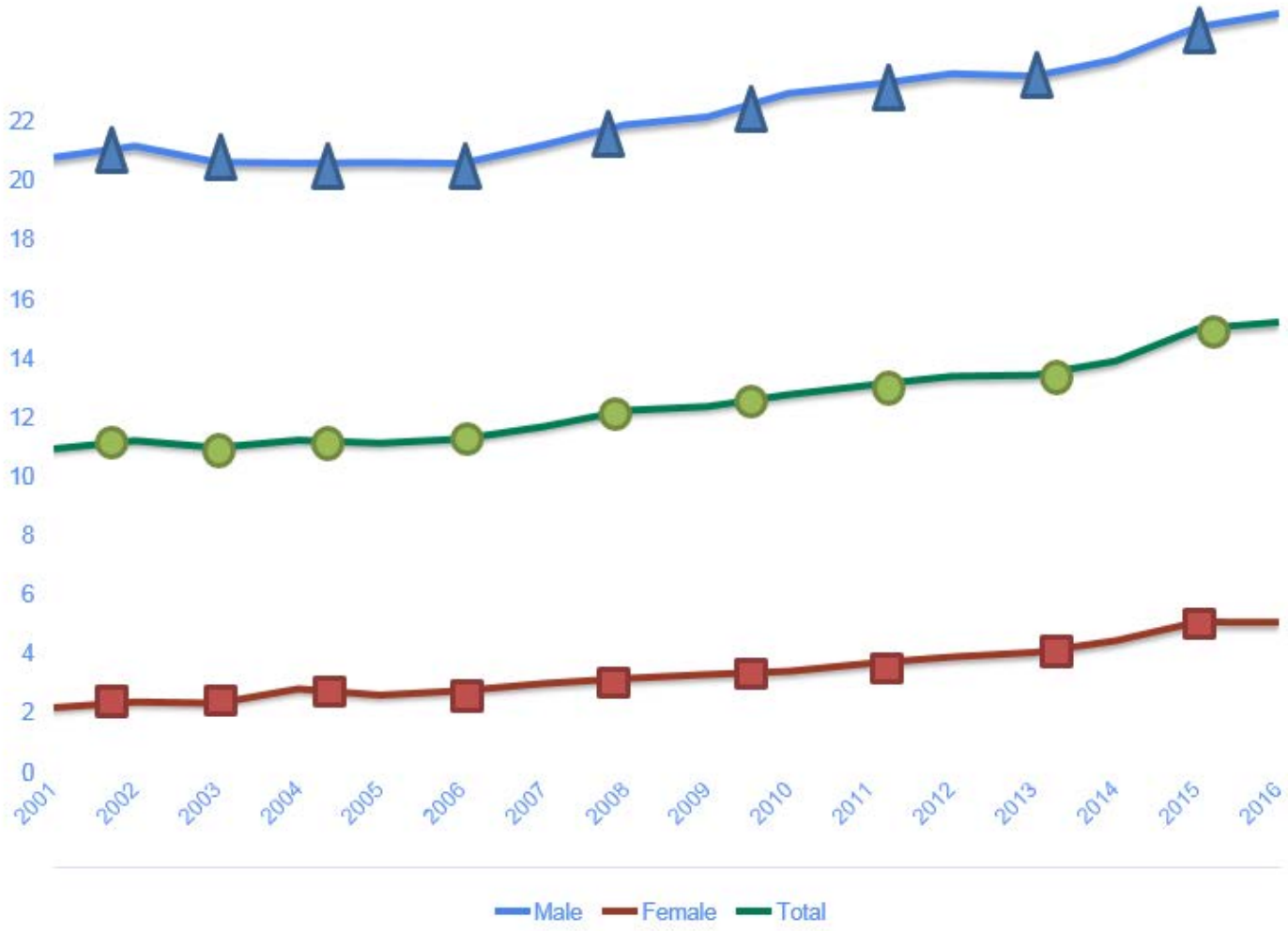
# Suicide rates among all persons by sex – United States, 2000-2016




Source: CDC vital statistics

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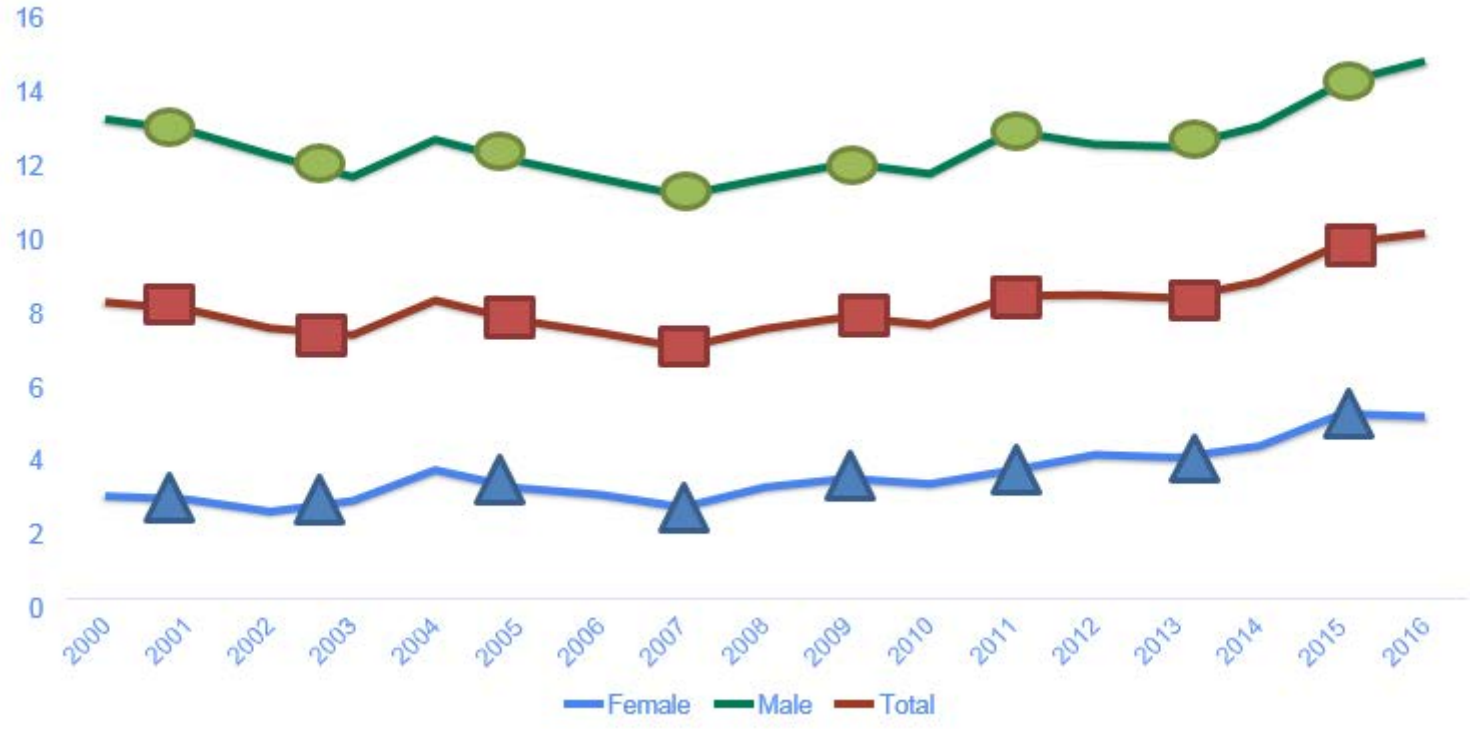
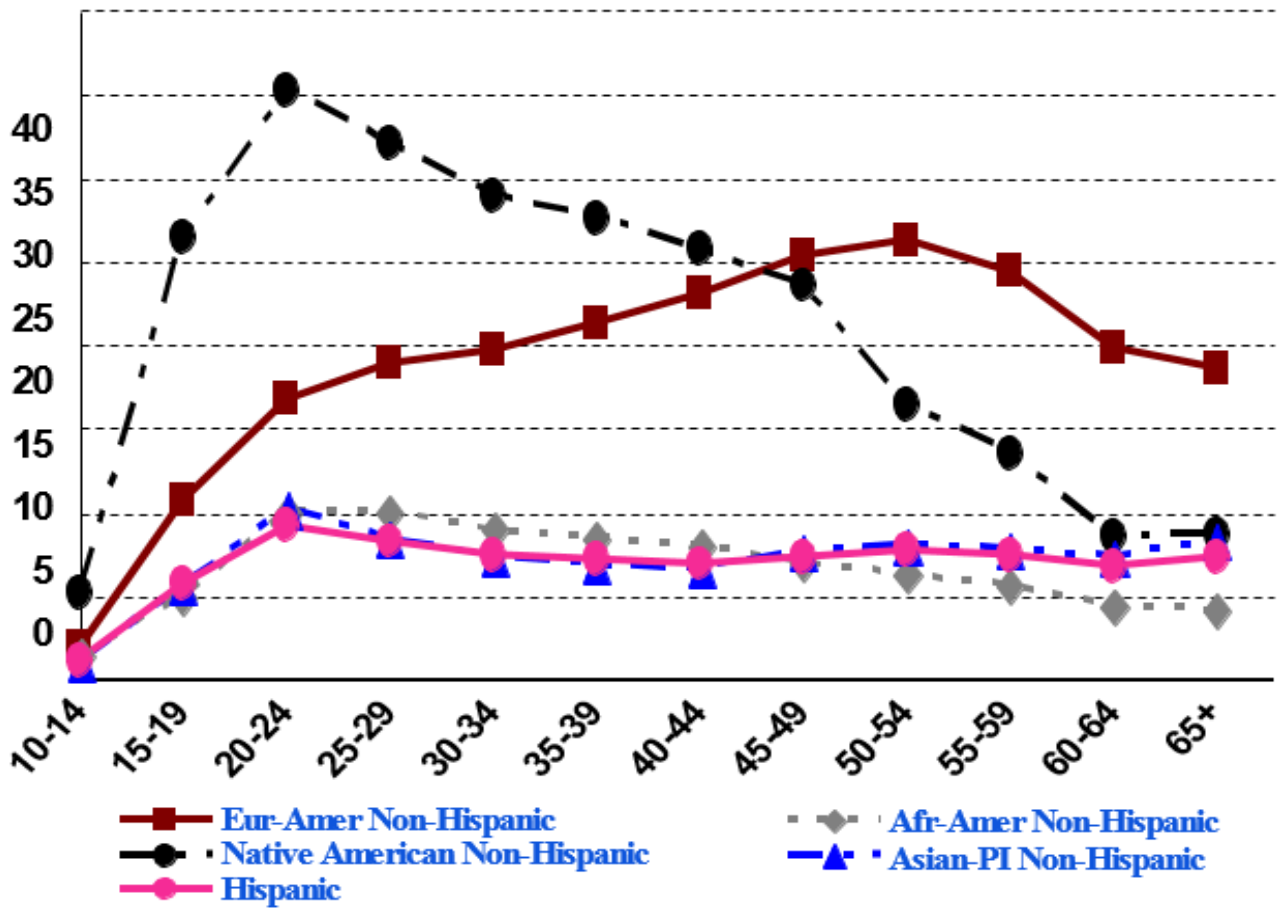
# Suicide rates among persons aged 15-19 years by sex– United States, 2000-2016



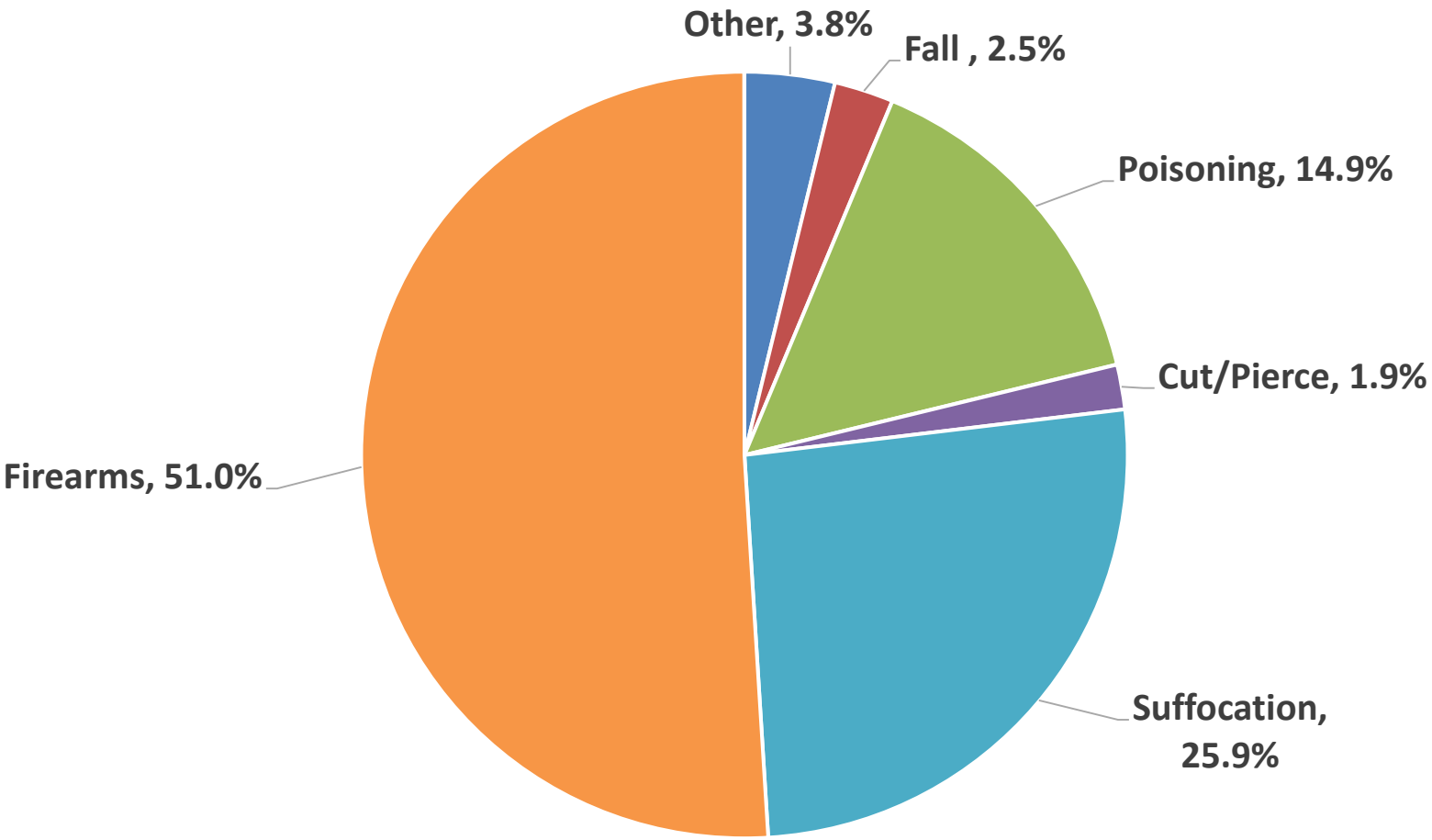

Source: CDC vital statistics

# Suicide rates by age group and race/ethnicity – United States, 2012-2016




Source: CDC vital statistics

# Suicide by Method – United States, 2016




Source: CDC vital statistics

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# Comprehensive Approach to Suicide Prevention


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# SAMHSA Suicide Prevention Efforts

- Garrett Lee Smith State and Tribal Suicide Prevention Grant Program
- Garrett Lee Smith Campus Suicide Prevention Grant Program
- National Strategy for Suicide Prevention
- National Suicide Prevention Lifeline
- Crisis Center Follow-up Grant Program
- Suicide Prevention Resource Center
- Native Connections
- Zero Suicide

State/Tribal Youth Suicide Prevention Program

Campus Suicide Prevention Program


NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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# Suicide Prevention Resource Center, Promoting a public health approach to suicide prevention


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

EDC Learning transforms lives.

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# SPRC Major Initiatives

- **Goal 1: Health and Behavioral Health Initiatives:** Increases capacity to embed quality, accessible suicide care in health and behavioral health systems. (Zero Suicide Institute)

- **Goal 2: Grantee and State Initiatives**: Builds SAMHSA grantee and state, territorial, and tribal capacity to implement effective suicide prevention programs

- **Goal 3: National Partner Initiatives**: Provides leadership and strategic guidance to national initiatives, including the National Action Alliance for Suicide Prevention

- **Goal 4: Communications and Resources:** Provides effective, appropriate resources to support suicide prevention efforts (e.g. Weekly SPARK!, SPRC Webinars)

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# Contact Information: Brandon Johnson

**Brandon J. Johnson, M.H.S.**

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Division of Prevention, Traumatic Stress, and Special Programs (DPTSSP)

Suicide Prevention Branch

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# Suicide Prevention in Healthcare Settings: The Suicide Prevention Resource Center and Zero Suicide Framework


Caitlin Peterson, M.S. MFT

Senior Project Associate for Health & Behavioral Health Initiatives, Suicide Prevention Resource Center

Education Development Center


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# Funding and Disclaimer



The Suicide Prevention Resource Center at EDC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 5U79SM062297.

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# Agenda

- Introduction to the Suicide Prevention Resource Center
- Overview of the Zero Suicide framework and components of care
- Zero Suicide alignment with current standards of care
- Evidence of early outcomes
- Toolkit and resources

# About SPRC

- Funded since 2002 by SAMHSA, housed at EDC
- Consultation and support for suicide prevention grantees and state leadership
- Support for health and behavioral health care organizations
- The Weekly Spark newsletter with the latest news and research
- Guidance for your effective prevention approach

# The Zero Suicide Framework - Background

- Started in behavioral health – that's the core
- Aims to keep people alive so they can experience recovery
- Focused on error reduction and safety in health care

# The Zero Suicide Framework – Background (con't)

- Embedded in the National Strategy for Suicide Prevention and Joint Commission Sentinel Event Alert #56
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- A set of best practices and tools including www.zerosuicide.com

# What's Different About Zero Suicide?

- Suicide prevention is accepted as a core responsibility of health care
- Continually applying new knowledge about suicide and treating it directly
- A systematic clinical approach in health systems, not 'the heroic efforts of crisis staff and individual clinicians.'

# What's Different About Zero Suicide? (con't)

- Is not focused on just one intervention, but rather a bundle of interventions that fill in the gaps in care that can be dangerous for people at risk of suicide
- Goes beyond clinical interventions and applies a systemic organizational approach
- Focuses on culture change and continuous quality improvement

# The Zero Suicide Framework




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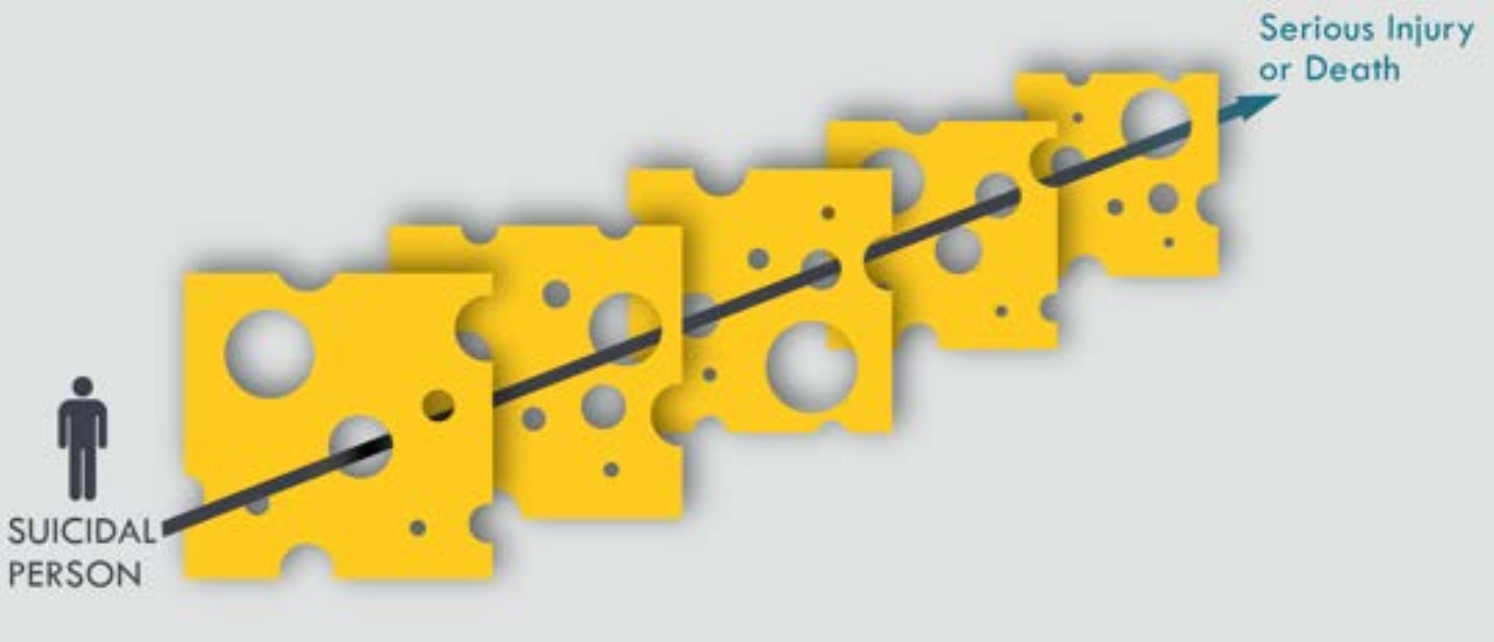
# The Zero Suicide Framework (2)

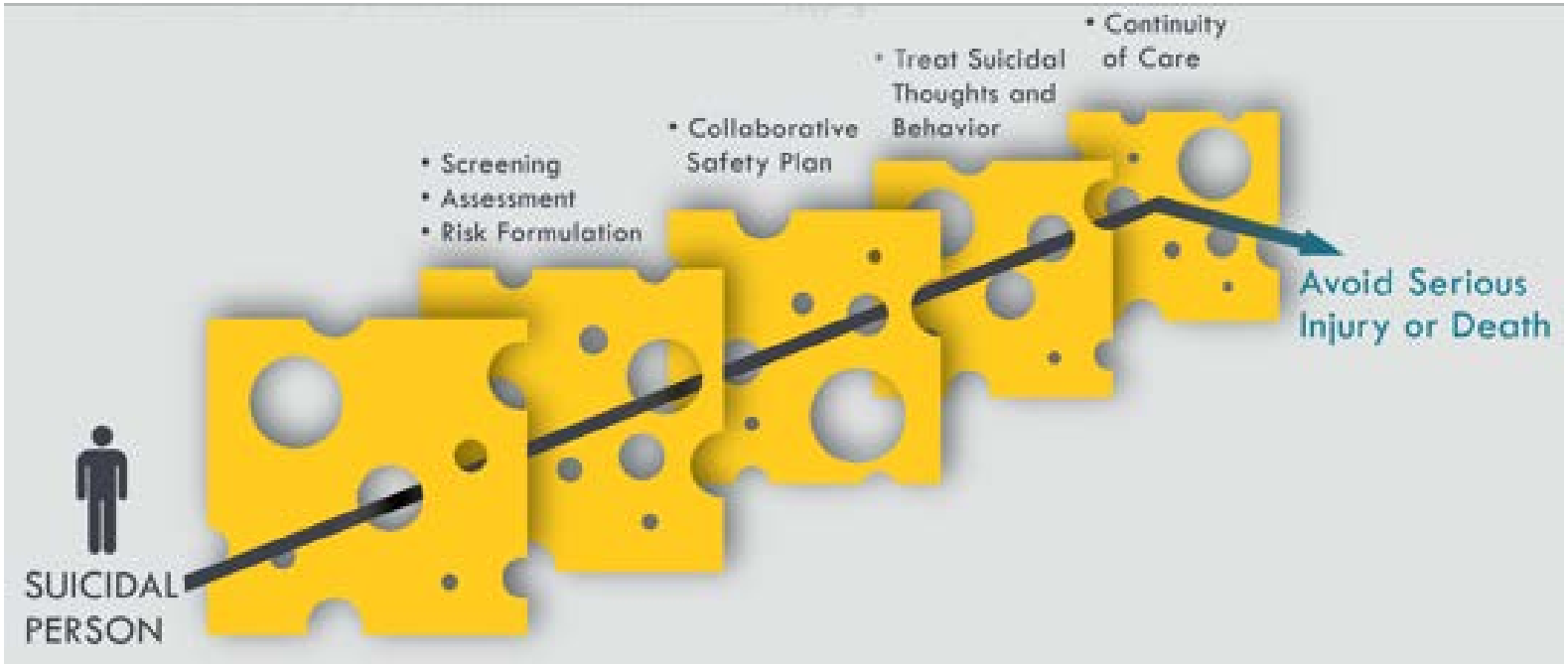
Without improved suicide care, people slip through gaps




Adapted from James Reason's "Swiss Cheese" Model of Accidents

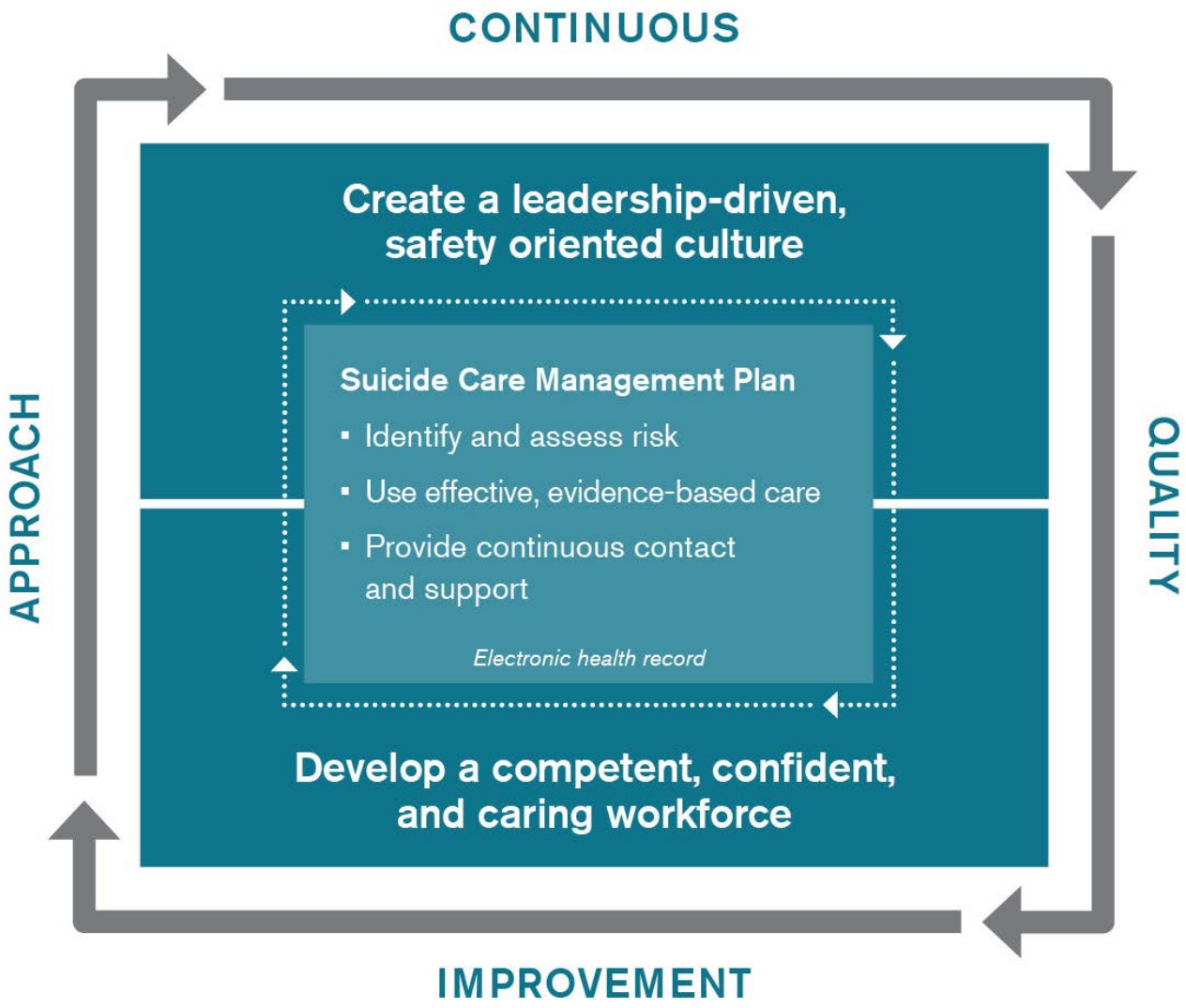
# The Zero Suicide Framework (3)

The tools of Zero Suicide fill in the gaps




Adapted from James Reason's "Swiss Cheese" Model of Accidents

# The Zero Suicide Framework (4)



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# Momentum – Joint Commission Sentinel Event

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


Sentinel Event Alert

"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."

https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf



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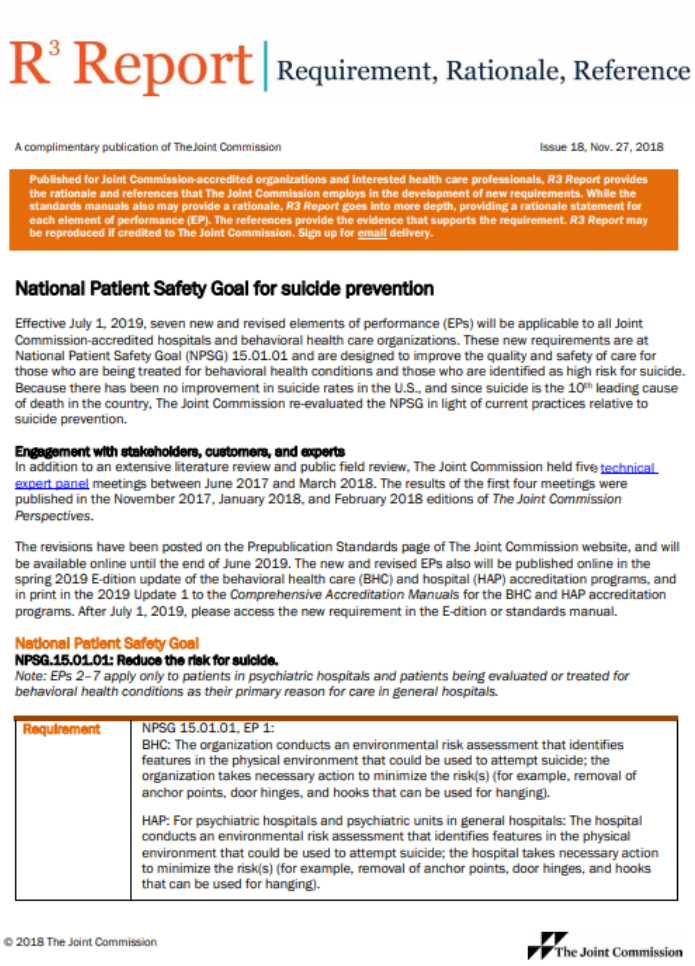
# Momentum – National Patient Safety Goal Revisions



R³ Report | Requirement, Rationale, Reference

A complimentary publication of The Joint Commission — Issue 18, Nov. 27, 2018

**Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.**

## National Patient Safety Goal for suicide prevention

Effective July 1, 2019, seven new and revised elements of performance (EPs) will be applicable to all Joint Commission-accredited hospitals and behavioral health care organizations. These new requirements are at National Patient Safety Goal (NPSG) 15.01.01 and are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide. Because there has been no improvement in suicide rates in the U.S., and since suicide is the 10th leading cause of death in the country, The Joint Commission re-evaluated the NPSG in light of current practices relative to suicide prevention.

**Engagement with stakeholders, customers, and experts**

In addition to an extensive literature review and public field review, The Joint Commission held five technical expert panel meetings between June 2017 and March 2018. The results of the first four meetings were published in the November 2017, January 2018, and February 2018 editions of *The Joint Commission Perspectives*.

The revisions have been posted on the Prepublication Standards page of The Joint Commission website, and will be available online until the end of June 2019. The new and revised EPs also will be published online in the spring 2019 E-dition update of the behavioral health care (BHC) and hospital (HAP) accreditation programs, and in print in the 2019 Update 1 to the *Comprehensive Accreditation Manuals* for the BHC and HAP accreditation programs. After July 1, 2019, please access the new requirement in the E-dition or standards manual.

**National Patient Safety Goal**

**NPSG.15.01.01: Reduce the risk for suicide.**

*Note: EPs 2–7 apply only to patients in psychiatric hospitals and patients being evaluated or treated for behavioral health conditions as their primary reason for care in general hospitals.*

| Requirement | NPSG 15.01.01, EP 1:<br>BHC: The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the organization takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).<br><br>HAP: For psychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). |
|---|---|



The Joint Commission

https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_12_7_18_Rev_FINAL.pdf



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# Resources – Zero Suicide Toolkit


http://zerosuicide.sprc.org/toolkit



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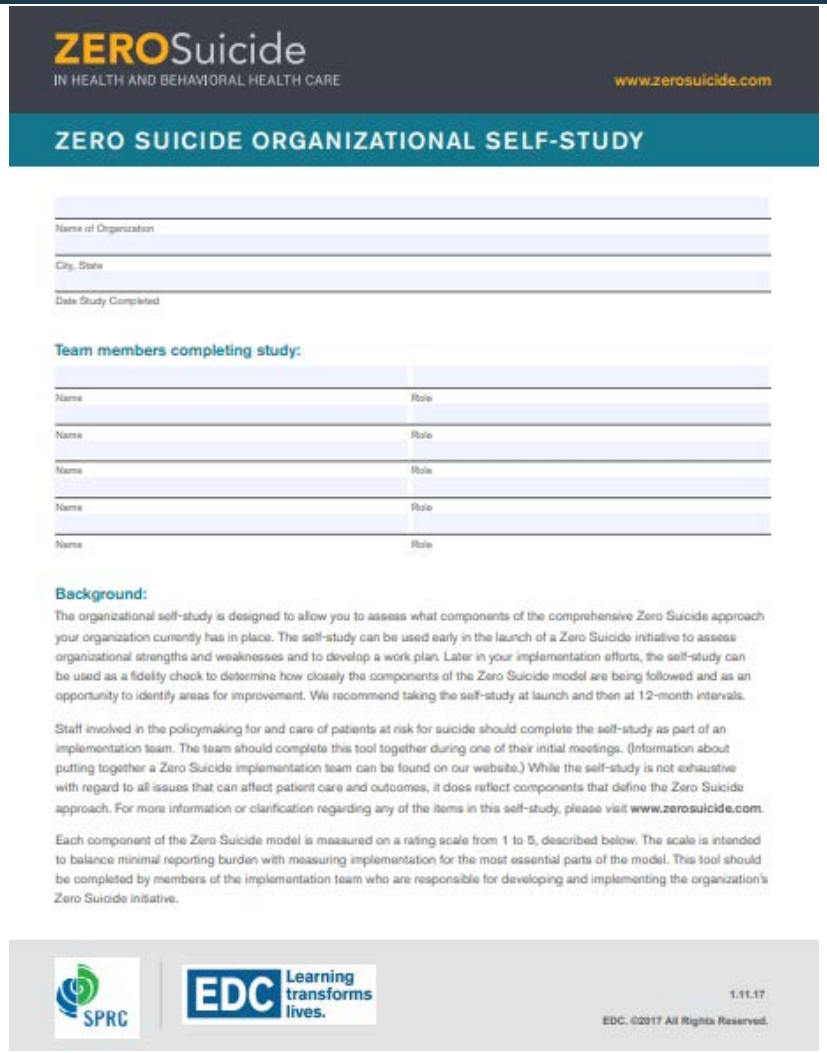
# Resources – Organizational Self-Study



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www.zerosuicide.com

ZERO SUICIDE ORGANIZATIONAL SELF-STUDY

Name of Organization

City, State

Date Study Completed

**Team members completing study:**

| Name | Role |
|---|---|
| Name | Role |
| Name | Role |
| Name | Role |
| Name | Role |

**Background:**

The organizational self-study is designed to allow you to assess what components of the comprehensive Zero Suicide approach your organization currently has in place. The self-study can be used early in the launch of a Zero Suicide initiative to assess organizational strengths and weaknesses and to develop a work plan. Later in your implementation efforts, the self-study can be used as a fidelity check to determine how closely the components of the Zero Suicide model are being followed and as an opportunity to identify areas for improvement. We recommend taking the self-study at launch and then at 12-month intervals.

Staff involved in the policymaking for and care of patients at risk for suicide should complete the self-study as part of an implementation team. The team should complete this tool together during one of their initial meetings. (Information about putting together a Zero Suicide implementation team can be found on our website.) While the self-study is not exhaustive with regard to all issues that can affect patient care and outcomes, it does reflect components that define the Zero Suicide approach. For more information or clarification regarding any of the items in this self-study, please visit **www.zerosuicide.com**.

Each component of the Zero Suicide model is measured on a rating scale from 1 to 5, described below. The scale is intended to balance minimal reporting burden with measuring implementation for the most essential parts of the model. This tool should be completed by members of the implementation team who are responsible for developing and implementing the organization's Zero Suicide initiative.

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1.11.17



Source: [Zero Suicide Organizational Self-Study]



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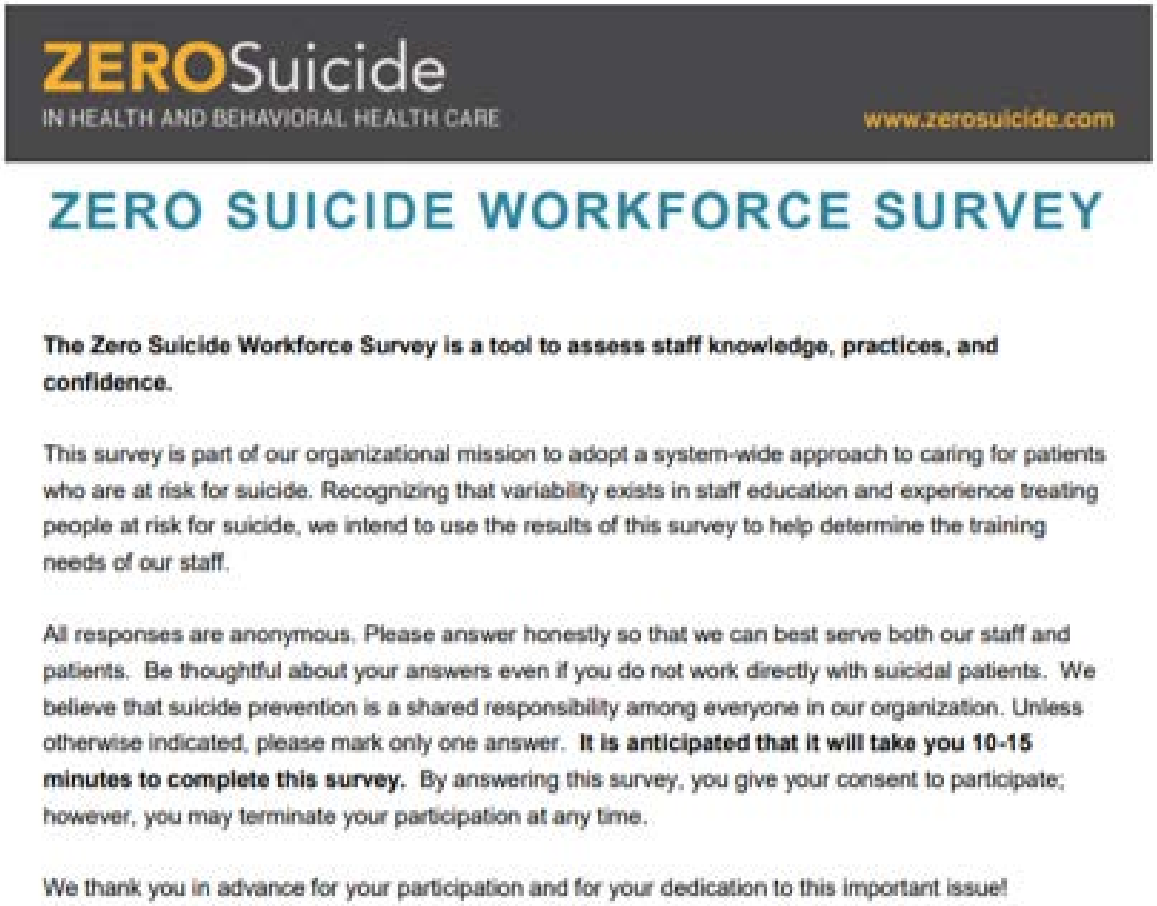
# Resources – Workforce Survey



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www.zerosuicide.com

## ZERO SUICIDE WORKFORCE SURVEY

**The Zero Suicide Workforce Survey is a tool to assess staff knowledge, practices, and confidence.**

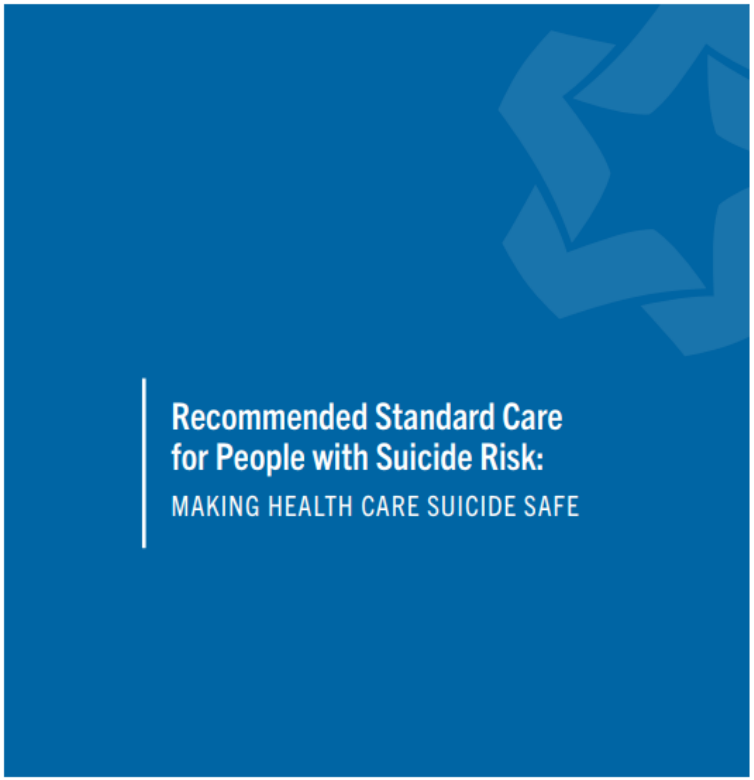
This survey is part of our organizational mission to adopt a system-wide approach to caring for patients who are at risk for suicide. Recognizing that variability exists in staff education and experience treating people at risk for suicide, we intend to use the results of this survey to help determine the training needs of our staff.

All responses are anonymous. Please answer honestly so that we can best serve both our staff and patients. Be thoughtful about your answers even if you do not work directly with suicidal patients. We believe that suicide prevention is a shared responsibility among everyone in our organization. Unless otherwise indicated, please mark only one answer. **It is anticipated that it will take you 10-15 minutes to complete this survey.** By answering this survey, you give your consent to participate; however, you may terminate your participation at any time.

We thank you in advance for your participation and for your dedication to this important issue!

Source: Zero Suicide Workforce Survey Resources

# Resources – Recommended Standard Care




NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf



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# Resources – A Lived Experience Story


A Lived Experience Story About What Makes a Difference

*Diana Cortez Yanez*



How positive interactions with staff promote recovery.

http://zerosuicide.sprc.org/toolkit/lead#quicktabs-lead=2



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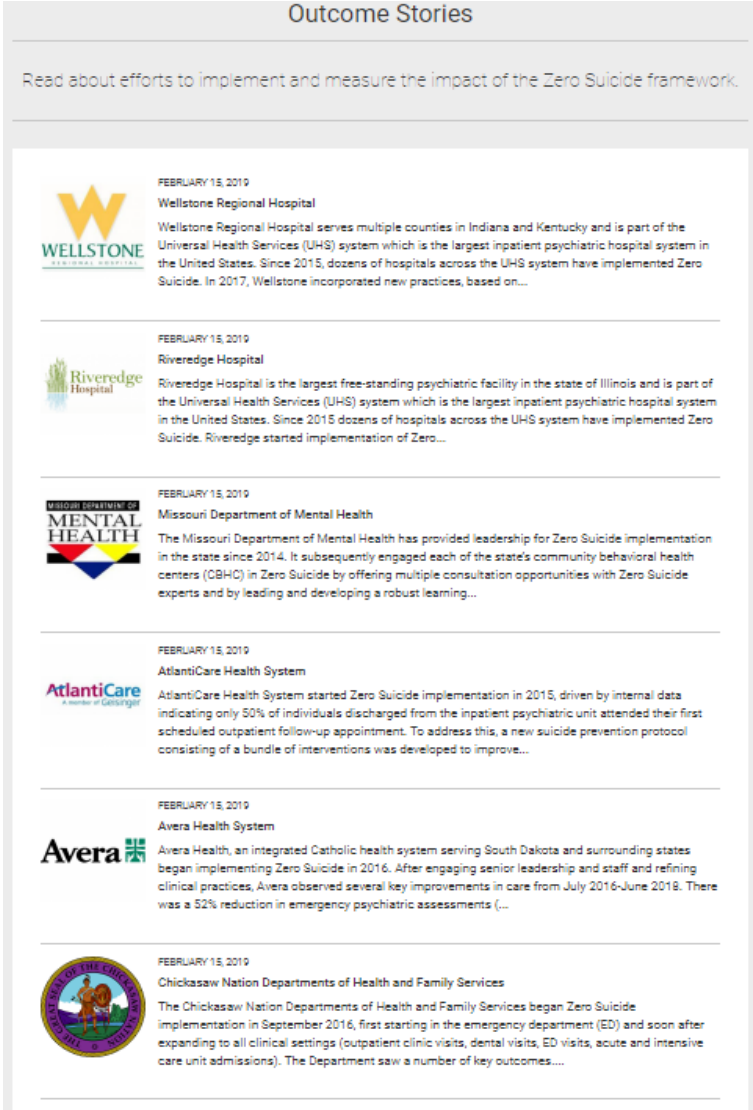
# Resources – Outcomes Stories

- SPRC worked with various organizations who had adopted the Zero Suicide framework to develop outcomes stories
- Outcomes that go beyond processes
- Useful as examples of what is possible across different types of organizations, serving different populations, in a variety of settings

Link: [Research Articles]



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# Contact Information: Caitlin Peterson

Caitlin Peterson, Senior Project Associate for Health & Behavioral Health Initiatives

Suicide Prevention Resource Center, Education Development Center

chpeterson@edc.org

# Panel Discussion, Meet the Panelists: Dr. Carolina Hausmann-Stabile

**Carolina Hausmann-Stabile, Ph.D.**
Assistant Professor
Bryn Mawr College

Dr. Hausmann-Stabile (PhD, 2013, WUSTL) has more than a decade of experience working to improve Latino health and mental health across the United States and Latin America, with a focus on reducing suicidal behaviors among Latinos. Her work has contributed research and conceptual developments to the study of Latina girls who attempt suicide, including identifying universal and group-specific issues that explain the suicidal behaviors of Latina teens; understanding the family dynamics relevant to suicidal behaviors among adolescents; explaining the role of acculturation and developmental issues in pediatric suicidal behaviors; and developing culturally competent services for Latina teens.



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# Panel Discussion, Meet the Panelists: Dr. Gail Mattox

**Dr. Gail Mattox, M.D.**
Child, Adolescent and Adult Psychiatry, Morehouse School of Medicine

Dr. Mattox currently serves as Professor and Chair of the Department of Psychiatry and Behavioral Sciences at Morehouse School of Medicine (MSM). She is a Diplomate of the American Board of Psychiatry and Neurology with board certification in psychiatry and sub-specialty board certification in child and adolescent psychiatry. She is a graduate of Meharry Medical College and completed general psychiatry training and child and adolescent psychiatry fellowship at Northwestern University Feinberg School of Medicine. Dr. Mattox is a Distinguished Life Fellow of the American Psychiatric Association and a Distinguished Life Fellow of the American Academy of Child and Adolescent Psychiatry. Dr. Mattox is also a member of Alpha Omega Alpha Honor Medical Society and the Arnold P. Gold Humanism in Medicine Honor Society. In addition to over thirty years of patient care, teaching and service, Dr. Mattox served as Project Director for the first SAMHSA funded HBCU Center for Excellence in Behavioral Health from 2011-2018 located at Morehouse School of Medicine in the Department of Psychiatry and Behavioral Sciences/Cork Institute.



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# Panel Discussion, Meet the Panelists: Jennifer Nanez

**Jennifer Nanez, MSW, LMSW**
(Pueblo of Acoma)
Acting Behavioral Health Consultant, MSPI/DVPI Project Officer
Indian Health Service/ Albuquerque Area Office

Jennifer S. Nanez, MSW, LMSW, currently serves as a Health System Specialist and Acting Behavioral Health Consultant with the Indian Health Service, Albuquerque Area Office. Ms. Nanez is an enrolled tribal member of the Pueblo of Acoma, New Mexico. Ms. Nanez has been in the social work and education fields for over 20 years with an emphasis in serving the American Indian population, and promoting effective engagement and clinical work in the American Indian community. Prior to coming on board the Indian Health Service, Ms. Nanez served as Senior Program Therapist and TeleBehavioral Health Program Manger with the University of New Mexico, Division of Community Behavioral Health and worked in her home community as Clinical Director for the Pueblo of Acoma Behavioral Health program.



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# Panel Discussion, Meet the Panelists: Gayle Zepeda

**Gayle Zepeda**
Independent Consultant
Master Facilitator,
Gathering of Native
Americans curriculum
Certified Trainer, safeTALK
and Mental Health First Aid

Gayle Zepeda (Redwood Valley Band of Pomo Indians) has over 30 years of experience working in tribal communities. Her educational background is in psychology and community development. As an independent consultant, she extensive experience working with tribes, community groups and Boards in the areas of group facilitation, culture competency, conflict resolution, suicide prevention, substance abuse prevention and native wellness. Gayle is a Master Facilitator/trainer of the Gathering of Native Americans curriculum. She is a certified trainer of both safeTALK and Mental Health First Aid (youth and adult curriculums). Gayle is also a certified trainer in the Community Resiliency Model, which provides trauma-informed self-help skills that are biologically based to help individuals and communities get back to balance in body, mind and spirit. She is an adjunct professor at Mendocino College where she has taught motivational interviewing and other human services courses for over 5 years. She resides on the Redwood Valley Reservation in Mendocino County where she is the proud mother of two grown sons, Eagle and Mikela Jones and grandmother to six beautiful grandchildren.



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# Panel Discussion

**Carolina Hausmann-Stabile, Ph.D.**
Assistant Professor
Bryn Mawr College

**Dr. Gail Mattox, M.D.**
Child, Adolescent and Adult Psychiatry, Morehouse School of Medicine

**Jennifer Nanez, MSW, LMSW**
(Pueblo of Acoma)
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**Gayle Zepeda**
Independent Consultant
Master Facilitator, Gathering of Native Americans curriculum
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# Thank You

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

www.samhsa.gov

1-877-SAMHSA-7 (1-877-726-4727)

1-800-487-4889 (TDD)



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