Creating Suicide Safer Care in Texas

Texas Suicide Prevention Symposium 2016
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Texas Suicide Safe Care Model

State:
- Coordinated state leadership
- Guiding state strategic plan
- Statewide public awareness
- Statewide technical assistance

Community:
- Local coalitions
- Regional summits
- Gatekeeper training
- Coordinated care and referral

Behavioral Health System:
- Zero Suicide leadership/culture
- Evidence-based screening and assessment
- Pathways to care
- Competent workforce
- Effective interventions
- Supportive policies
LEAD

Create Culture Change

SUICIDE IS PREVENTABLE

Core belief
Texas Leadership Statement

Zero Suicides in Texas is a commitment among Texas’ primary public health agencies to thoughtfully and systematically change the way we think about suicide prevention. The Texas Department of State Health Services and the Texas Health and Human Services Commission have undertaken the goal of advancing and actualizing patient safety for individuals receiving care through its public mental health system. **No longer will we thinking of prevention as fewer deaths, but rather no deaths.**
Leadership – Pilot Site

• Executive Management (including CEO)
  – trained first
  – understood importance of training, encouraged staff attendance.

• 100% participation in workforce survey

• 100% of staff trained in ASIST.
114,328 Total People Trained by Grant

All Staff LMHA
- ASIST
- SafeTALK
- ASIST about Suicide

Direct Providers
- C-SSRS
- Safety Planning
- CALM

Specialty Providers
- CAMS
- CBT-SP

Community
- ASK Gatekeeper
- CALM First Responders
- ASK Training of Trainers
- ASIST
- ASIST Train Trainer

School Staff K-12
- At Risk for Teachers K-12
- ASK

ZERO SUICIDE IN TEXAS
I have the TRAINING I need to assist those with suicidal desire and/or intent.

I have the SKILLS I need to engage those with suicidal desire or intent.

I have the SUPPORT / supervision I need to engage and assist people with suicidal desire and/or intent.
I always ask about suicide with new clients. I address access to lethal methods with all clients who report thoughts of suicide. I develop a collaborative safety plan with all suicidal clients.

All significant at \( p < .0001 \)
Staff Confidence

- **I am confident in my ability to assess a client's suicide risk.**  
  - 6 month Cohort: 38.9% Agreeing  
  - 18 month Cohort: 61.1% Agreeing

- **I am confident in my ability to manage a client's suicidal thoughts and behavior.**  
  - 6 month Cohort: 38.8% Agreeing  
  - 18 month Cohort: 61.2% Agreeing

- **I am confident in my ability to treat a client's suicidal thoughts and behavior using an evidence-based approach.**  
  - 6 month Cohort: 37.9% Agreeing  
  - 18 month Cohort: 62.1% Agreeing

All significant at \( p < .0001 \)
• How does my agency do this?
• Are we using a best practice tool?
• Is there a policy and training for everyone about this?
• Who do we screen?

• Identify – Screen – Assess – Triage into Path for Care
Identification = Embedding the C-SSRS

- Screening for all clients
- Evidence-based assessments
- Triage rules

<table>
<thead>
<tr>
<th>SUICIDAL IDEATION</th>
<th>Lifetime/Time He/She Felt Most Suicidal</th>
<th>Post 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1. Wish to be Dead</td>
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<tr>
<td>Subject endures thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. How long did you want to be dead or wish you could go to sleep and not wake up? If yes, describe:</td>
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<tr>
<td>2. Non-Specific Active Suicidal Thoughts</td>
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<tr>
<td>General non-specific thoughts of wanting to end one's life (commit suicide) (e.g., I've thought about killing myself) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. Have you actually had any thoughts of killing yourself?</td>
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<tr>
<td>If yes, describe:</td>
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<tr>
<td>3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act</td>
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<tr>
<td>Subject endures thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes persons who would say, 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 do this?</td>
<td></td>
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<tr>
<td>If yes, describe:</td>
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<tr>
<td>4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan</td>
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<tr>
<td>Active suicidal thoughts of killing oneself and subject 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?</td>
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<tr>
<td>If yes, describe:</td>
<td></td>
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<tr>
<td>5. Active Suicidal Ideation with Specific Plan and Intent</td>
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<tr>
<td>Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
<td></td>
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<tr>
<td>If yes, describe:</td>
<td></td>
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</tbody>
</table>
Identify – Pilot Site

- C-SSRS Provided a common language
  - Suicide Gesture?
  - Aborted attempt/interrupted attempt

- Made identifying high risk individuals easier
Engage

Engage People & those they love actively in their own treatment

- Safety Planning
- Counsel on Lethal Means
- Pathways to Care
Engage – Pilot site

JOHN’S STORY
Transition

happiness is a warm hand-off.
Transition – Pilot Site

• Transitions from ED to outpatient
  • Mobile Crisis reports to ED to complete risk of harm assessments.

• Transitions from inpatient to outpatient
  • Inpatient facilities direct drop clients to our facility for immediate aftercare

• Transitions out of services
  • Caring letters sent to all clients 60 days after discharge.
Treat

• Treat Suicidality Directly
  – Dialectical Behavior Therapy
  – Cognitive Behavior Therapy for Suicide Prevention
  – Collaborative Assessment and Management of Suicidality
Treat
Partners across Texas

Cohort 1
- Austin Travis County Integral Care
- Bluebonnet Trails Community Center
- Border Region MHMR
- Coastal Plains MHMR
- Denton County MHMR
- Hill Country Community Center
- MHMRA of Harris County
- MHMR of Tarrant County
- Spindletop Center
- Tri-County Services
- Tropical Texas Behavioral Health

Cohort 2
- Andrews Center
- Behavioral Health Center of Nueces
- Betty Hardwick Center
- MHMR Authority of Brazos Valley
- Center for Life Resources
- Gulf Bend Center
- Heart of Texas Region MHMR
- Helen Farabee Center
- Texas Panhandle Centers
- Pecan Valley Centers
- StarCare Lubbock
- Texana Center

Cohort 3
- ACCESS
- Camino Real Community Center
- Community Healthcore
- Gulf Coast Center
- LifePath Systems
- North Texas Behavioral Health Authority
- Permian Basin Community Centers
- West Texas Centers
Connect with Us! www.TexasSuicidePrevention.org

- Texas Toolkit: https://sites.utexas.edu/zest
- National Toolkit: www.zerosuicide.com
- Twitter: @StopTXSuicides

Be a Hero for Zero!