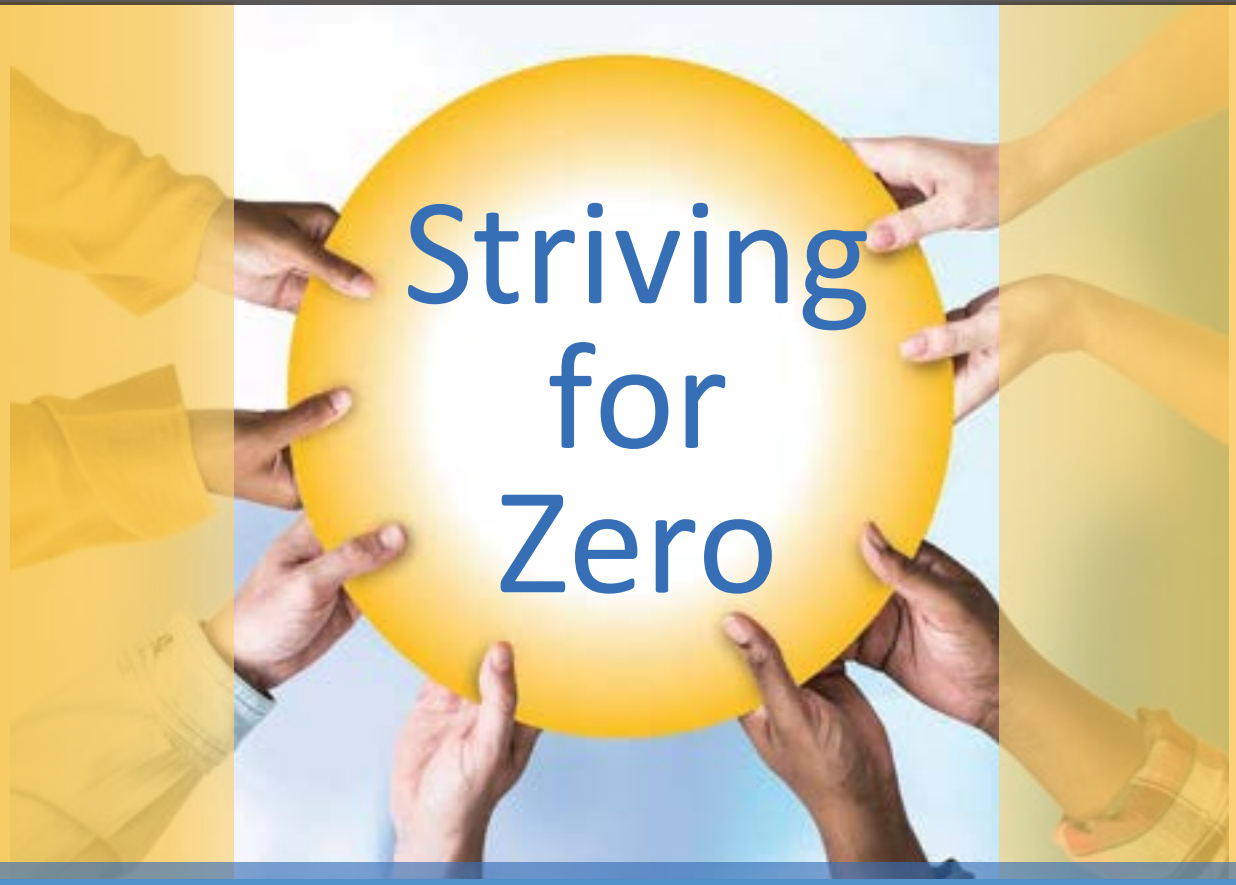


Striving for Zero Learning Collaborative

Module – Downstream Suicide Prevention– January 31, 2024

Support for people at risk for suicide or those supporting people at risk is available by calling the **Suicide and Crisis Lifeline:** Call or text 988

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** 988

Welcome!

Please add your county name to your display name and introduce yourself in the chat.

We will share the slides and recording with you.

Support for people at risk for suicide or those supporting people at risk is available by calling the **Suicide & Crisis Lifeline** - Call or text 988

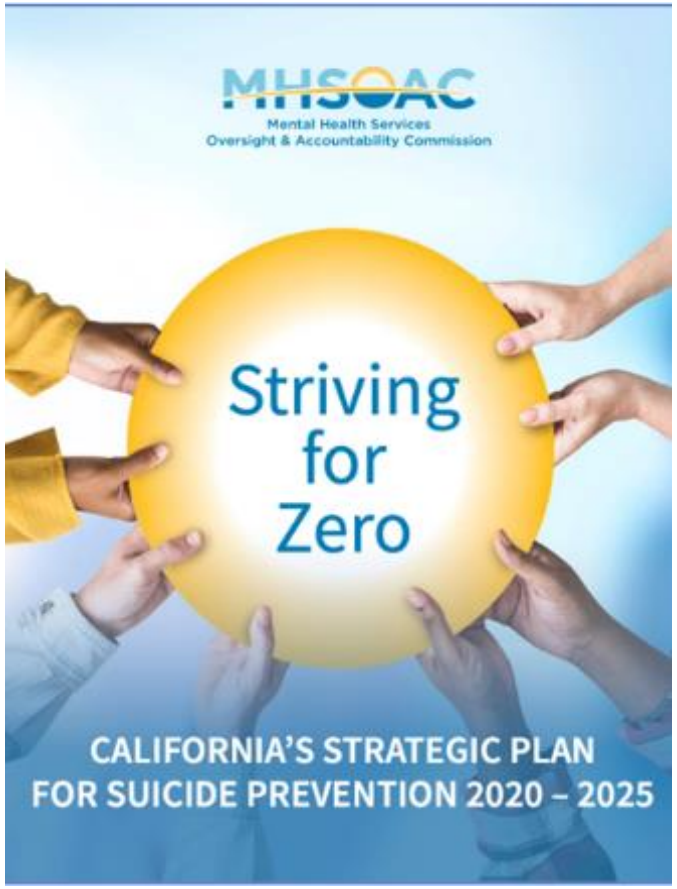
Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline 988**

Striving for Zero Learning Collaborative

Advance local strategic planning and implementation and alignment with strategic aims, goals and objectives set forth in California's Strategic Plan for Suicide Prevention

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Builds on a previous Learning Collaborative offered by the California Mental Health Services Authority



Find the Plan here: https://mhsoac.ca.gov/sites/default/files/Suicide%20Prevention%20Plan_Final.pdf

Upcoming Collaborative Module

Wednesday, April 17, 2024
10:00 AM – 12:00 PM, PT

Register in advance for this meeting:
https://us06web.zoom.us/webinar/register/WN_Zxq9fUQjR3-0cvdz-P4-jw

Striving for Zero Learning Collaborative Resource Page

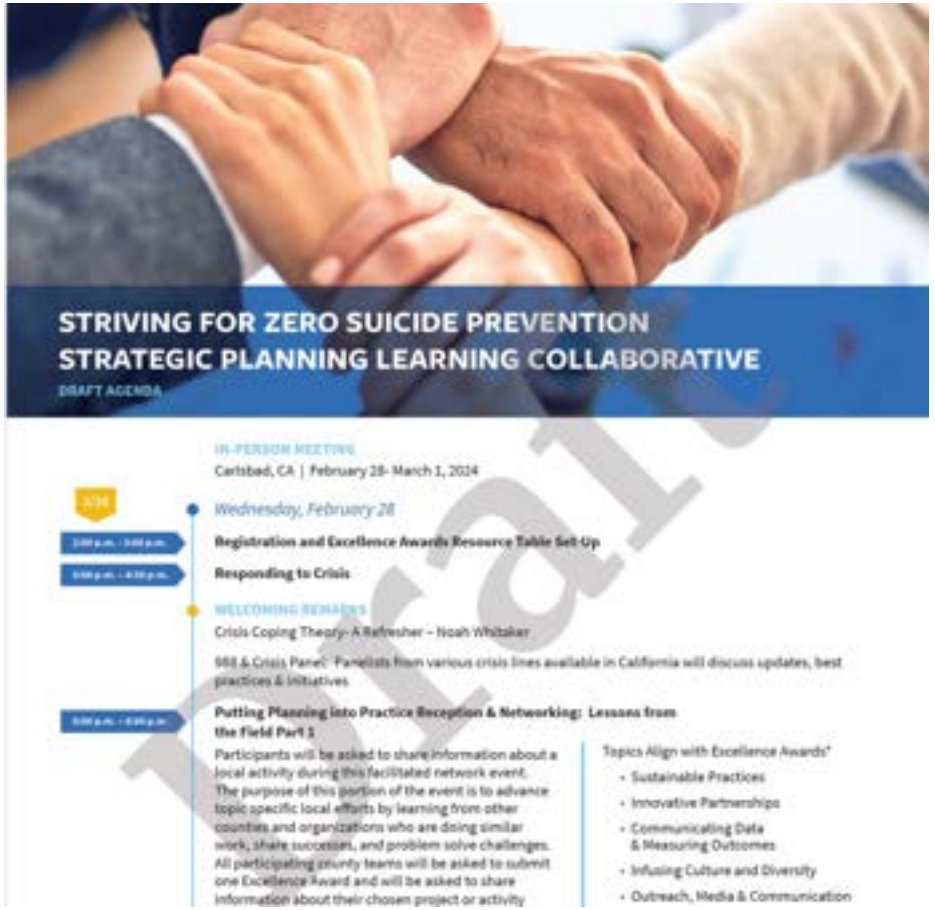
https://mhsoac.ca.gov/initiatives/suicide-prevention/collaborative/

Striving for Zero Learning Collaborative: In Person Convening

When: Wednesday, February 28 (2 PM) - Friday, March 1, 2024 (1 PM)

Location: Cape Rey Carlsbad Beach – Hilton | 1 Ponto Road, Carlsbad, CA 92011

Registration Ends :
https://docs.google.com/forms/d/e/1FAIpQLSeJJ1G-CSPo0Pb3fIEtFIifZDPXLDW8lNzVLI19iv6wgYExdA/viewform?pli=1



Striving for Zero Learning Collaborative: In Person Convening

What to Expect:

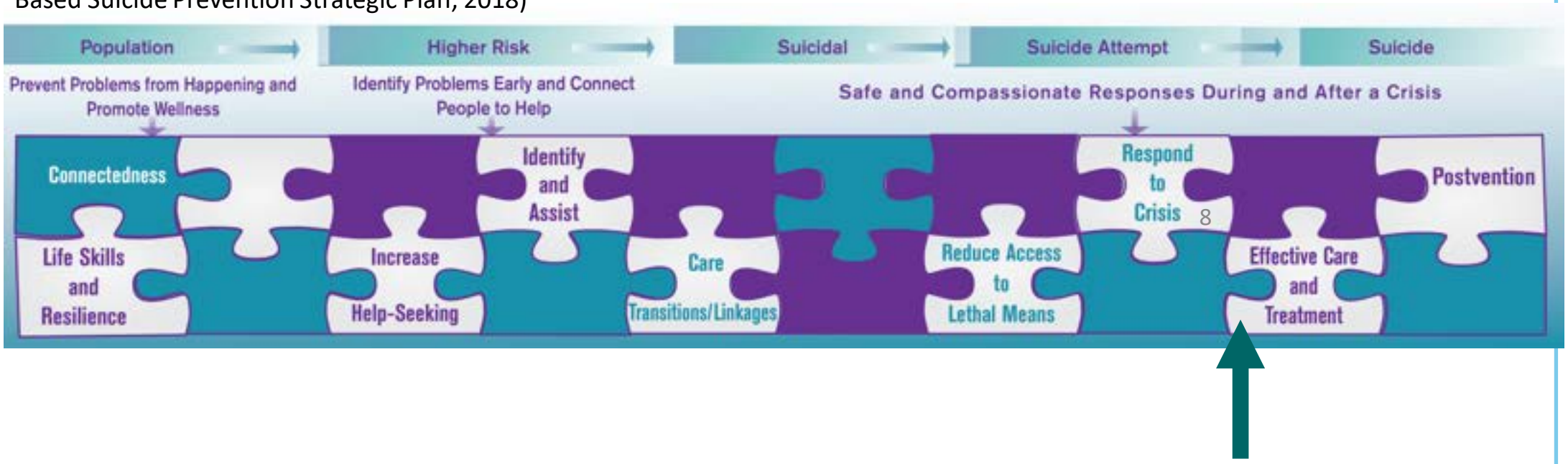
- 988 Updates & Crisis Panel
- Excellence Awards Reception and Networking Session
- Keynote speaker Marina Nitze: Hack Your Bureaucracy
- Update on National Strategy for Suicide Prevention – Jerry Reed, Ph.D., MSW
- Milestones from CA Statewide Strategic Plan and Striving for Zero Collaborative
- Interactive activity: Strengthening and Sustaining Partnerships
- Dedicated sessions on:
  - Putting Planning Into Practice: Lessons from the Field
  - Infusing Culture & Measuring Outcomes
  - A Deep Dive into Accessing and Communicating Data
  - Downstream Suicide Prevention: Culturally Responsive Suicide Clinical Care

Steps of Strategic Planning

Based on the Steps of Strategic Planning Framework from the Suicide Prevention Resource Center (SPRC)

Suicide Prevention Resource Center (SPRC)
Comprehensive Approach to Suicide Prevention

"The Suicidal Crisis Path is a model that intends to integrate multiple theoretical approaches and frameworks within the context of an individual's suicidal experience. In doing so, the purpose is to match intervention approaches with the timing, risk factors, and protective factors that would be the mechanisms to prevent a suicide from happening." (Lezine, D.A. & Whitaker, N.J., Fresno County Community-Based Suicide Prevention Strategic Plan, 2018)



Mego Lien, MPH, MIA
mego.lien@hhs.sccgov.org

Mego Lien is a public health professional with expertise in chronic disease and injury prevention. She created and oversees the Prevention Services Division at the County of Santa Clara's Behavioral Health Services Department (BHSD). Previously, she oversaw BHSD's Suicide Prevention Program and worked on Injury and Trauma Prevention at Prevention Institute, a national public health non-profit. Mego has ten years of prior global health experience in topics such as tobacco control, road safety, and violence prevention, working at institutions that include Vital Strategies, the Earth Institute, and the United Nations Development Programme.

Joyce Chu, PhD
joycepchu@gmail.com

Joyce Chu is a licensed Clinical Psychologist whose expertise lies in the areas of suicidology, diversity and culture, and community mental health. She is a Director of Community Connections Psychological Associates and holds a Professor position at Palo Alto University. Her work is focused around advancing the assessment and prevention of suicide for ethnic minority and LGBTQ populations, particularly in Asian Americans. She has published numerous works including a cultural theory and model of suicide and a tool that assists in accounting for cultural influences on suicide risk. She does work in program evaluation, suicide prevention organizational consultation, and training.

Christopher Weaver, PhD
chrisweaver.phd@gmail.com

Chris Weaver is a licensed Clinical Psychologist whose expertise lies in the areas of forensics, suicide, assessment, substance use, violence, and trauma. He is a Director of Community Connections Psychological Associates and holds a Professor position at Palo Alto University. His work is in the areas of psychopathy and violence and suicide risk assessment, and more recently in the areas of substance abuse and psychological trauma. He does work in program evaluation, suicide prevention organizational consultation, and training.

Please take of yourself

While we are all passionate about suicide prevention, please remember to take care of yourself or step away if you need to.

What are your struggles or questions about downstream suicide prevention work? Write anonymous questions/comments here: https://forms.gle/RwfAn45gRxmdFZ6s6

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline : Call or text** 988

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline 1-**888-682-9454 o 988

Downstream Suicide Prevention

Crisis response and clinical activities that intervenes and prevents suicide for individuals at risk. Examples: screening, assessment, safety planning, crisis response, mental health treatment/ intervention, and reducing access to lethal means. Some also include postvention as a downstream effort.

https://www.whitehouse.gov/wp-content/uploads/2023/04/PCAST_Public-Health-Report_May2023.pdf

Journeying Downstream in Suicide Prevention

MEGO LIEN, MPH, MIA

PREVENTION SERVICES DIVISION MANAGER

COUNTY OF SANTA CLARA
Behavioral Health Services

Santa Clara County

- Silicon Valley: Palo Alto to Gilroy
- Population 1.87 million (2022)
- Racial/ethnic diversity:
  - 41% Asian
  - 28% white
  - 25% Hispanic/Latinx
- 2009-10 community response to cluster of teenage suicides in City of Palo Alto

The Suicide Prevention Advisory Committee is proposing broad recommendations to:

One: *Implement and coordinate suicide intervention programs and services for targeted high risk populations*

Two: *Implement a community education and information campaign to increase public awareness of suicide and suicide prevention*

Three: *Develop local communication "best practices" to improve media coverage and public dialogue related to suicide*

Four: *Implement a policy and governance advocacy initiative to promote systems change in suicide awareness and prevention*

Five: *Establish a robust data collection and monitoring system to increase the scope and availability of suicide-related data and evaluate suicide prevention efforts*

Six: *Integrate culture and diversity throughout all suicide prevention programming, to serve the needs of the culturally diverse communities within Santa Clara County*

SANTA CLARA COUNTY SUICIDE PREVENTION PROGRAM

Goals

Reduce and prevent **suicide deaths** in Santa Clara County

Outcome Objectives

1. Strengthen suicide prevention and crisis response systems
2. Increase early identification and support for people in psychological distress
3. Increase help-seeking for mental health challenges and suicide
4. Reduce access to lethal means
5. Improve messaging in media about suicide
6. Create supportive community environments

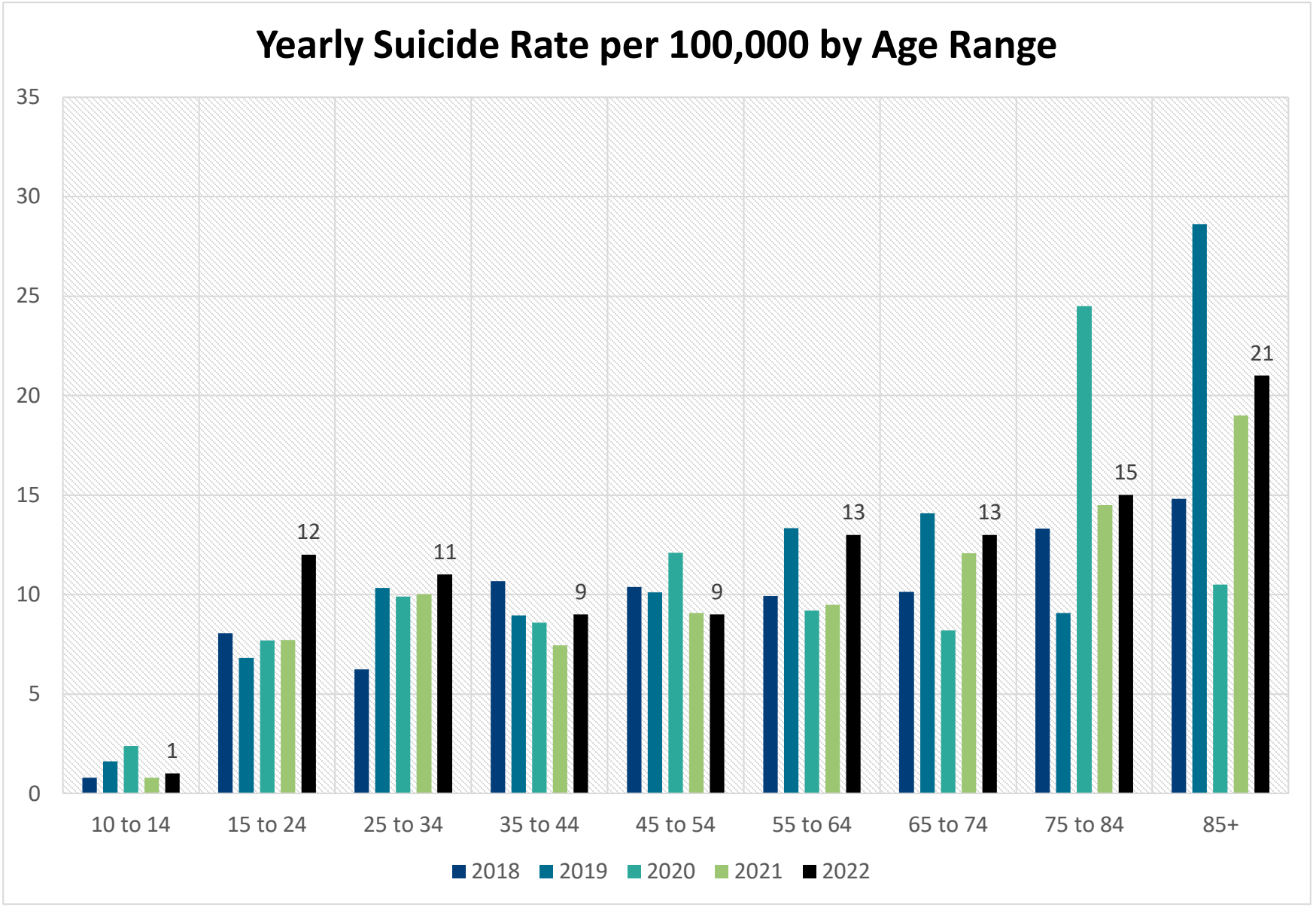
Cross-cutting

Data & evaluation

Policy implementation

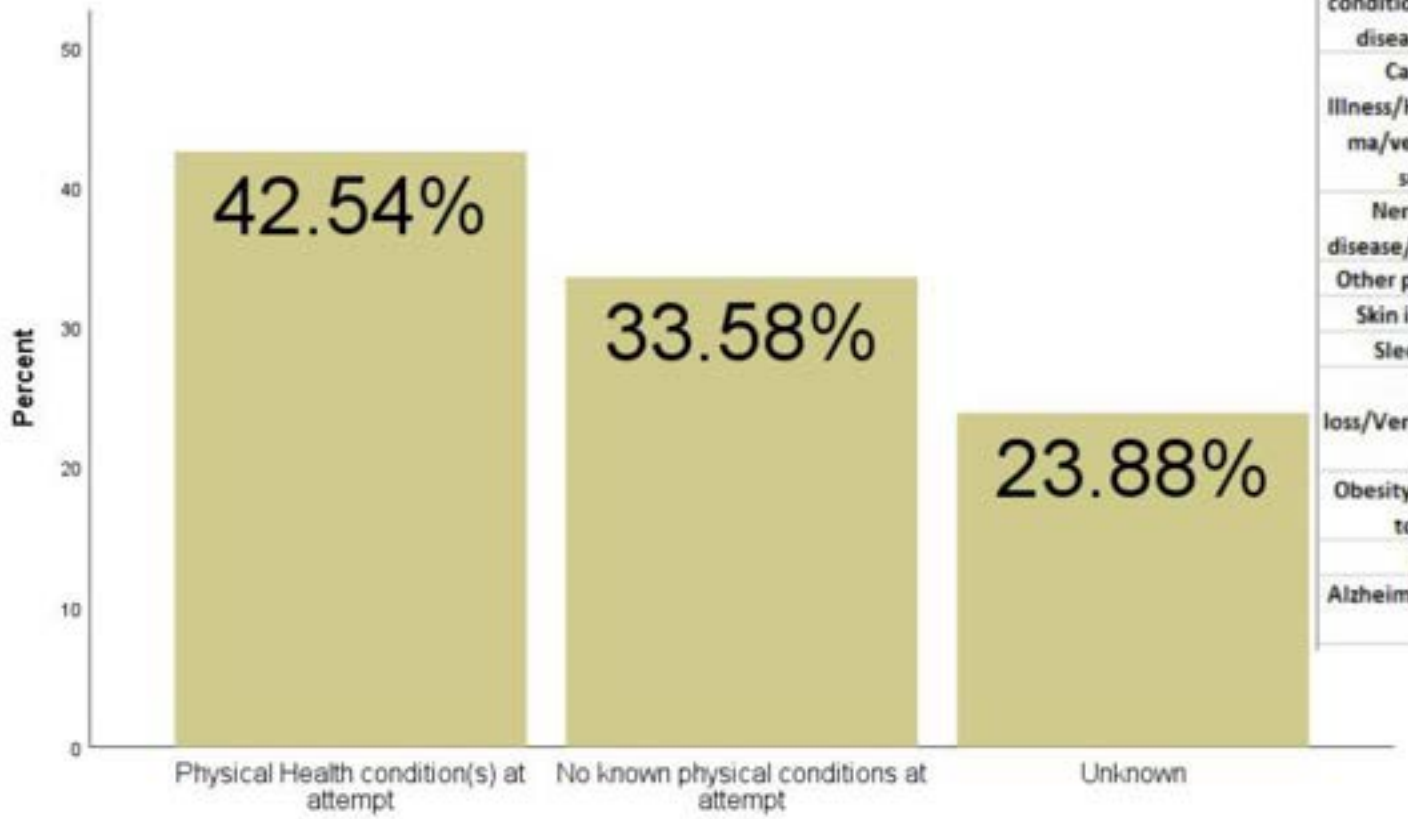
Cultural competency

COUNTY OF SANTA CLARA
Behavioral Health Services



COUNTY OF SANTA CLARA
Behavioral Health Services

Physical Health Issues (2016 data)



	Frequency	Percentage
Hypertension	20	14.93
Pain/Arthritis	17	12.69
Diabetes	16	11.94
Gastric issues/Urinary issues	12	8.96
Cholesterol/Hyperlipidemia	11	8.21
Stroke/seizures/Parkinsons/ tremors	9	6.72
Heart condition/Heart/Liver/Lung disease/Asthma/COPD	8	5.97
Cancer/Terminal Illness/HIV/AIDS/Tumor/Coma/vegetative state/life support/other	8	5.97
Nerves/spine/brain disease/Hepatitis C/Anemic	7	5.22
Other physical health issue	4	2.99
Skin issues/ulcers/rash	3	2.24
Sleep issues/apnea	2	1.49
Vision loss/Vertigo/dizzyness/balance loss	2	1.49
Obesity/Emaciated/Failure to thrive/other	2	1.49
Hearing loss	2	1.49
Alzheimers/delirium/delusions	1	0.75

SANTA CLARA COUNTY
Behavioral Health Services

2018 Process Evaluation

- 27 stakeholders interviewed from current active SPOC members and original strategic planning committee
  - Semi-structured interview process addressing:
    - SPOC overall
    - Cultural competency
    - Specific workgroups
    - Improvements and suggestions

- Results
  - Overall strengths
  - #1: Increase staffing
  - #2: Expand and clarify SPOC membership
  - #3: Process improvements related to SPOC structure and communications
  - #4: Process improvements related to data and evaluation
  - #5: Improve coordination with other entities
  - #6: Programmatic improvements related to reaching specific cultural groups and regions
  - #7: Increase school-based support for youth
  - **#8: Expand efforts downstream**
  - #9: Strengths and recommendations for Suicide and Crisis Services

Downstream Policies

- **AB 89, AB 1436** (2018): Six hours of suicide assessment and intervention training for psychologists, LMFTs, LCSWs licensed by the Board of Behavioral Sciences
- **Joint Commission Revised National Patient Safety Goal** (NPSG 15.01.01) on Suicide Prevention in Healthcare Settings (2019)

Data from Zero Suicide Implementation

- **Pilot-testing, 2013-14**
  - Showed feasible implementation in ordinary care settings, i.e. built into the routine clinical workflow, carried out successfully by current staff, provided without additional funding, and measured successfully.
  - 200+ health care and behavioral health orgs implementing; some implemented at state level (as of 2016)
- **Centerstone, large behavioral health nonprofit, Tennessee**
  - 65% reduction in suicide rate two years into implementation
  - Suicide rate 31 people per 100,000 → 11 per 100,000 *(Hogan and Grumet, 2016)*
- **Henry Ford Health System, Michigan** (Perfect Depression Care program)
  - 80% reduction in suicide, statistically significant and maintained over 10 years
  - Suicide rate 110.3 per 100,000 → 36.21 per 100,000 *(Coffey and Coffey, 2016)*

NPSG Elements of Performance	Zero Suicide Elements
Environmental risk assessment and action to minimize suicide risk	**Lead** system-wide culture change committed to reducing suicides
Use of a validated screening tool to assess at-risk patients	**Train** a competent, confident, and caring workforce
Evidence-based process for conducting suicide risk assessments of patients screened positive for suicidal ideation	**Identify** individuals with suicide risk via comprehensive screening and assessment
Documentation of patients' risk and the plan to mitigate	**Engage** all individuals at-risk of suicide using a suicide care management plan
Written policies and procedures addressing care of at-risk patients and evidence staff are following them	**Treat** suicidal thoughts and behaviors using evidence-based treatments
Policies and procedures for counseling and follow-up care for at-risk patients at discharge	**Transition** individuals through care with warm hand-offs and supportive contacts
Monitoring of implementation and effectiveness, with action taken as needed to improve compliance	**Improve** policies and procedures through continuous quality improvement

Getting Started with Zero Suicide

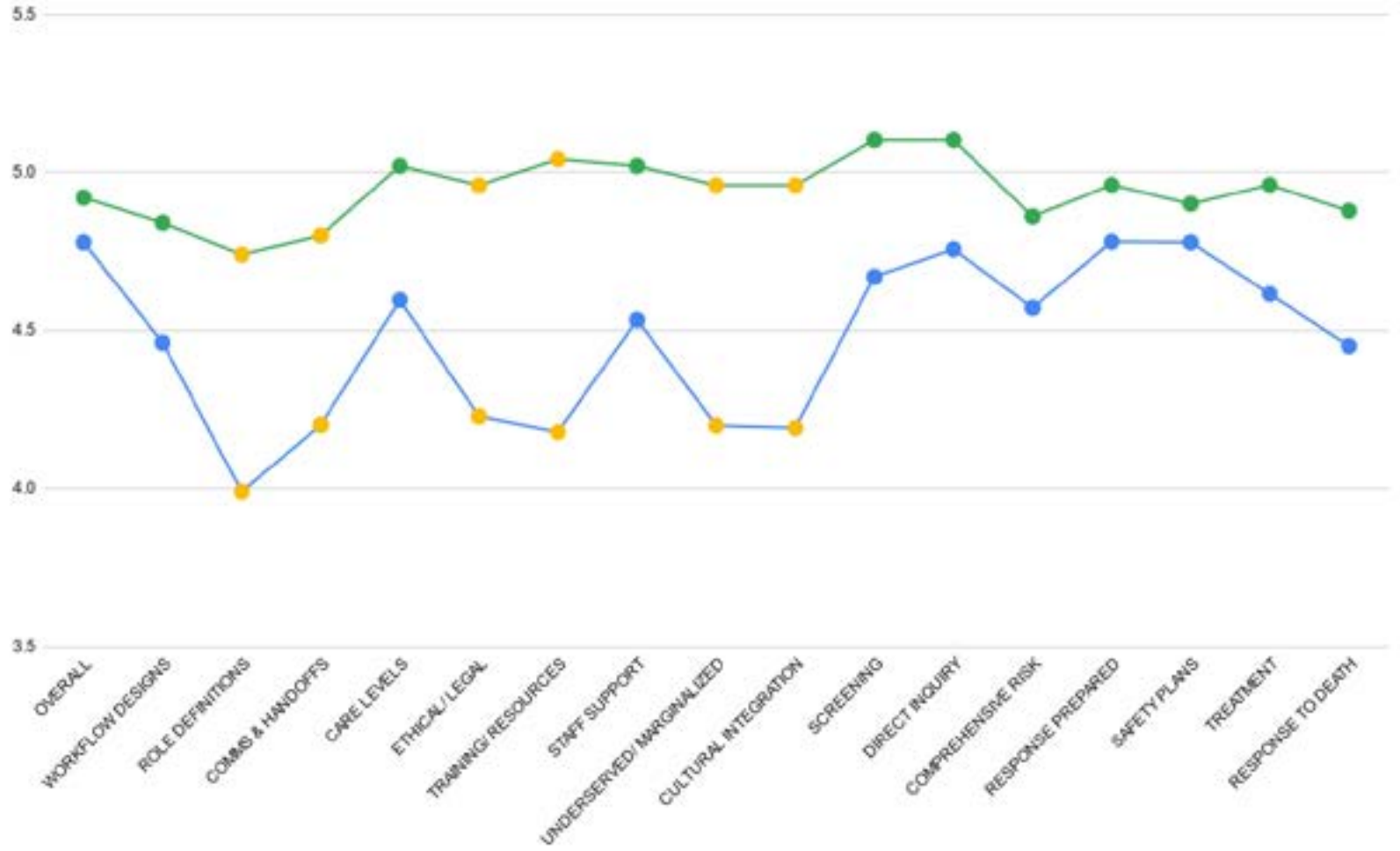
1. **Review Zero Suicide Toolkit and understand framework and resources**
2. **Garner buy-in from organizational leadership**
3. **Convene implementation team of 5-10 staff members willing to lead initiative**
4. **Complete Zero Suicide Organizational Self-Study as a team**
5. Learning about training and consultation available through Zero Suicide Institute
6. Formulate data, evaluation, and quality improvement plan
7. Announce to staff adaptation of an enhanced suicide care approach. Administer Zero Suicide Workforce Survey to all staff
8. Review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transitions. Examine use of health records to support processes.
9. Evaluate progress and measure results
10. Make use of Zero Suicide Email Discussion List

Barriers to Entry and What Helped

- Lack of authority (through position or clinical background)
- Don’t know what we don’t know
- “There’s no problem”
- Limited time and resources; work seems overwhelming

- Partnership with CCPA
- Clinical training meeting AB 89/AB 1436 req’s
- Needs assessment with clinical and non-clinical staff
- Partnership with CCPA; priority-setting; leveraging program trainings and materials; framing system improvements as win-wins (i.e. work more efficiently and effectively)

Figure 6. Pretest (blue) and Posttest (green) ratings of satisfaction with suicide prevention practice areas (higher is better). Yellow points indicate areas of focus.



Footnote of the Upstream Story

MEGO.LIEN@HHS.SCCGOV.ORG

WWW.SCCBHD.ORG/SUICIDEPREVENTION

COUNTY OF SANTA CLARA
Behavioral Health Services

Improving Clinical Systems of Care: A Focus on Downstream Suicide Prevention

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Professor, Palo Alto University

https://communityconnections.net/consultation/

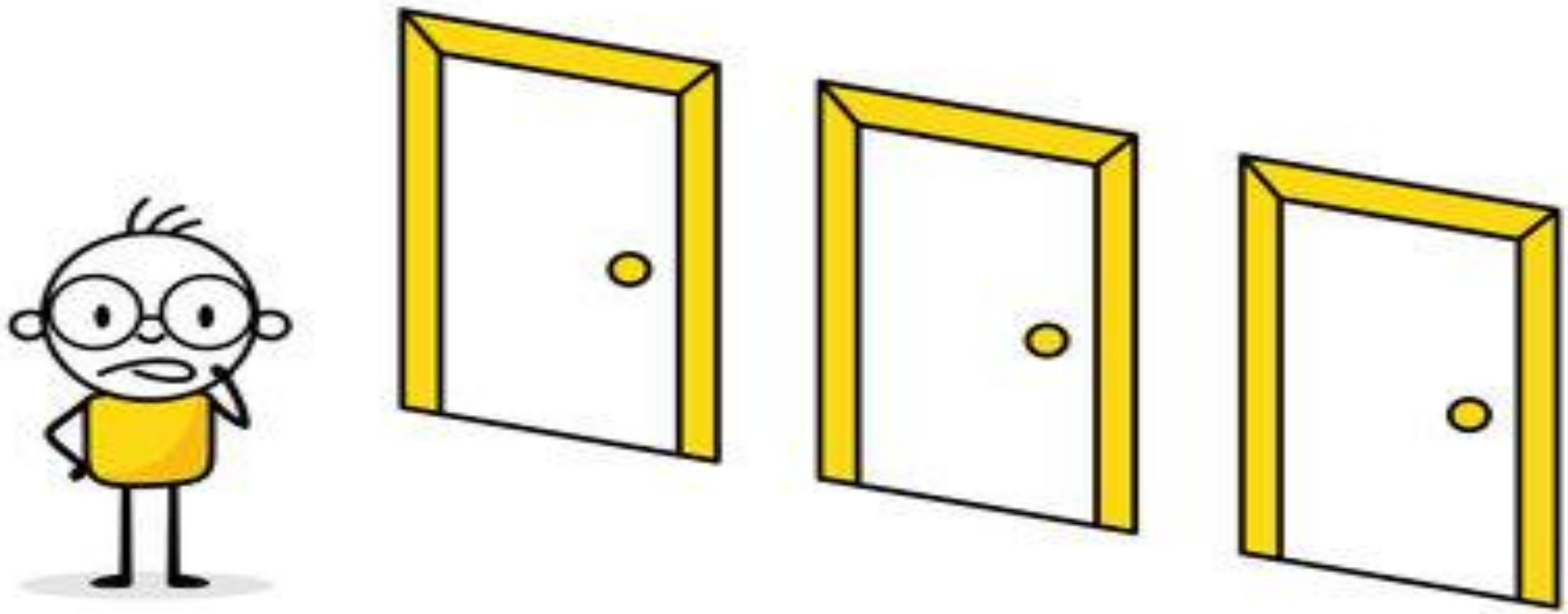
CommunityConnections
Psychological Associates, Inc.

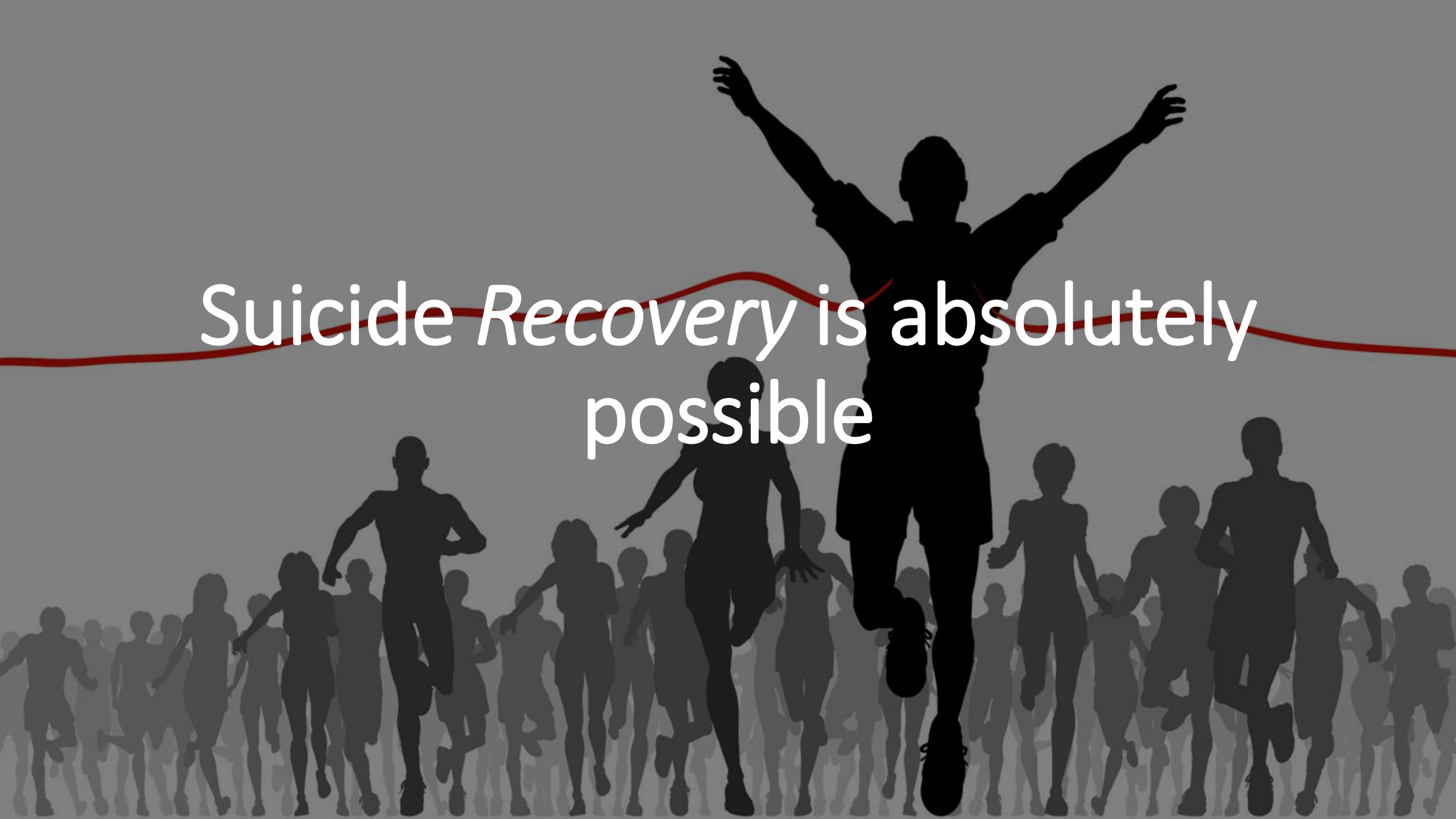
Why is Downstream Work Important?

Background Context

Why is Upstream Work Important?

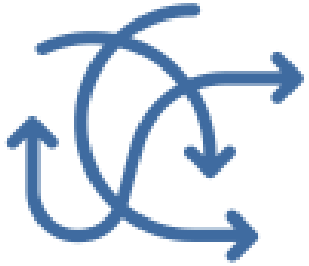
Support & Connection




Suicide *Recovery* is absolutely possible

Missed Opportunities for Downstream Suicide Prevention

Incomplete



Lost

Fires

Culture & Diversity

People with suicide risk reach out to health & mental health professionals…

…often within the weeks or months prior to a serious attempt or death

Suicide Prevention Opportunities Across the System

- **Primary Care:** 45% seen by a primary care provider (PCP) in the month, and 60% in the year, prior to dying by suicide (Ahmedani et al., 2014; Bongar & Sullivan, 2013; Walker et al., 2019).
- **Mental Health Providers:** 1/3 engage with mental health care providers in the year before a suicide death (Ahmendani, et al., 2019)
- **Emergency Departments and Hospitalizations:** Emergency Departments as critical points of contact (Roelands et al., 2017)
- **Post-discharge:** 1 week to 1 month after discharge from psychiatric hospitalization: Risk 100+ times elevated
  - Follow-up within 7 days related to significantly reduced risk (Fontanella et al., 2020)
  - Only half receive care within 1 week; 2/3 within 1 month (NCQA, 2020)
- **Inadequately prepared providers?** Many providers (medical providers, mental health professionals) rate their preparation to assess & manage suicide risk as inadequate (Boukouvalas et al., 2019; Schoen et al., 2019)

Why is Downstream Work Important?

Background Context

Poll

What is the downstream suicide prevention development stage of your county?

A. **Undeveloped:** We are just beginning to think about downstream suicide prevention

B. **Early stages of development**: We have some downstream efforts, but have not put it together with goals or a plan.

C. **Middle stages of development**: Downstream efforts are a core component of our plan, and we have begun implementation

D. **Advanced stages of development:** Downstream efforts are a core component of programming and current implementation.

What are some barriers to pursuing your downstream suicide prevention work? (choose all that apply)

A. I don't know where to start

B. We don't have the right stakeholders in our team/coalition to do the work

C. Not enough resources

D. It's not clear that we need downstream work to do good suicide prevention

E. Downstream suicide prevention isn't written into our SP coalition goals

A Role for Downstream System Consultation: Enhancing Culturally Responsive Clinical Suicide Practices

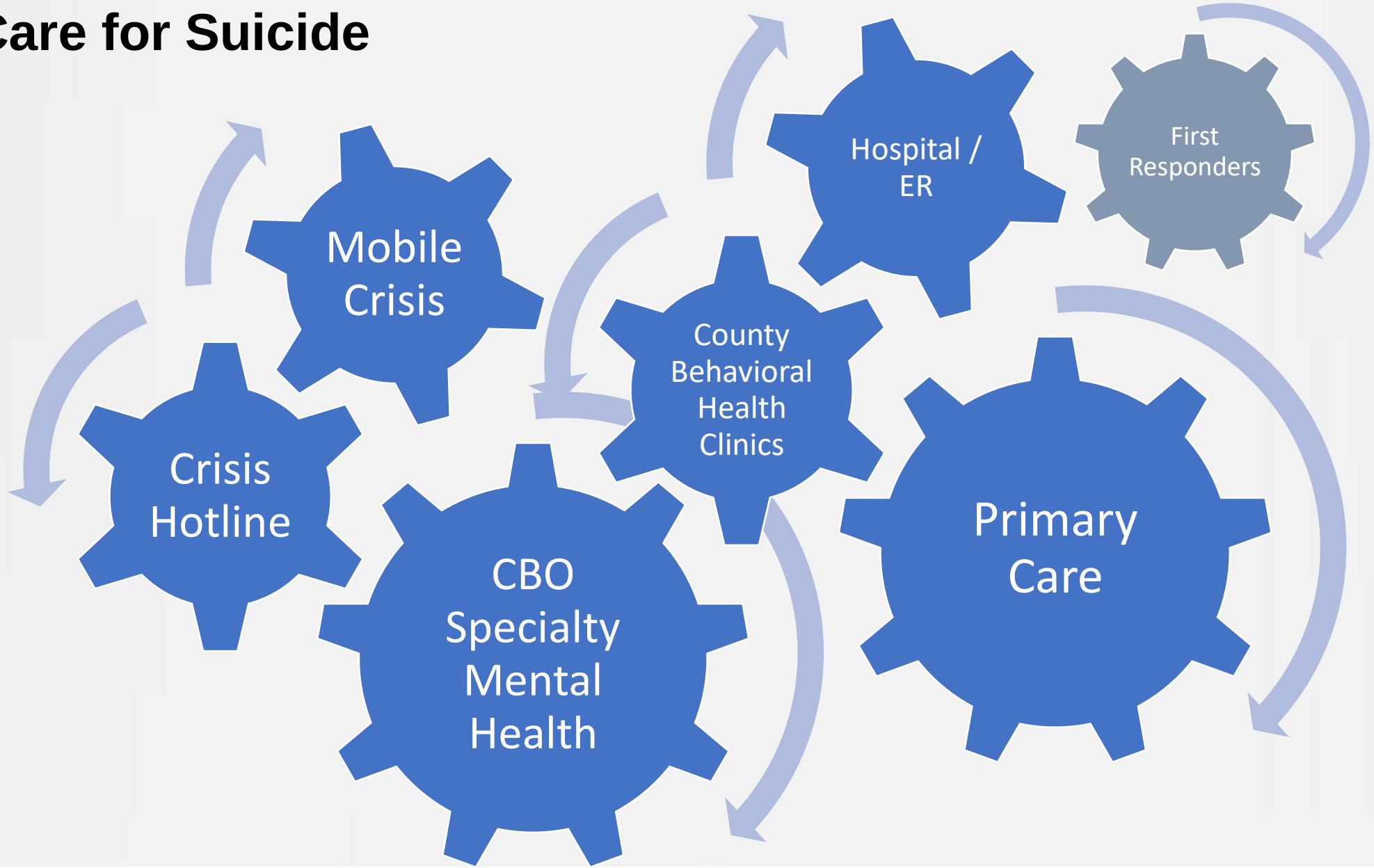
In the County of Santa Clara

SANTA CLARA COUNTY
Behavioral Health Services

CommunityConnections
Psychological Associates, Inc.

Mission: *To prevent suicide deaths by ensuring that the clinical services of the Santa Clara County have the resources and support needed to detect and facilitate recovery from suicidal crises for its diverse communities.*

A Coordinated and Culturally Responsive System of Clinical Care for Suicide



List of Organizational Consultation Functions / Services

Function / Service #	Description
1	Mobilize efforts (e.g., increase awareness, foster buy-in) to analyze and refine or improve downstream suicide assessment, stabilization, and recovery services.
2	Identify gaps, strengths, and priorities for organizational improvement through collection and analysis of qualitative and quantitative needs assessment data.
3	Conduct consultation meetings on system improvements as indicated
4	Identify and implement the need for program adaptations, changes, or additions in the areas of culture and diversity (i.e., to prevent suicide and promote recovery in the diverse populations of the County).
5	Assist in development of suicide-relevant policies and procedures
6	Determine needs for training of clinic staff, providers, or other relevant stakeholders
7	Provide ongoing consultation regarding initial and booster training, and education
8	Collaboratively customize screening and assessment tools. Streamline processes to balance effectiveness with feasibility.
9	Implement evidence-based practices to assure referral, safe discharge, continuity of care and recovery to meet and exceed legal, ethical, and clinical standards.
10	Assess and modify forms and clinical notes to optimize clinical care, minimize clinician burden, and address legal and ethical standards.
11	Track outcomes on system improvements through collection and analysis of evaluation data.
12	Consult on the setup of a program evaluation and data collection, monitoring, and analysis system.

4 Cases

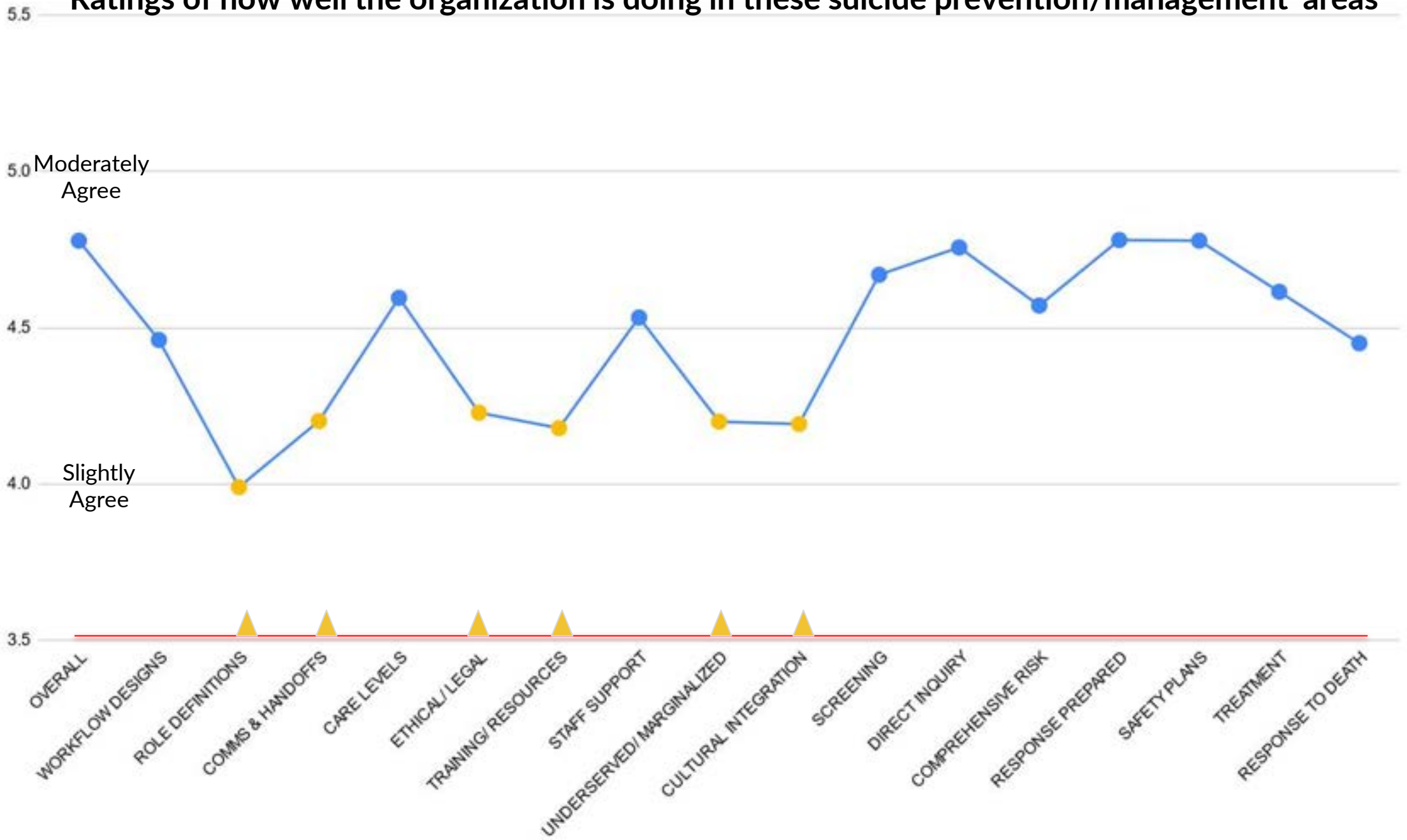
- **Case A:** Medical / Primary Integrated Care
- **Case B:** Community-based mental health clinic (ethnic-focused)
- **Case C:** Community-based mental health clinic
- **Case D:** Different County Centralized System

Case C

The following questions are designed to understand suicide prevention within your organization. Please indicate how much you agree or disagree with the following statements.

		Strongly Disagree	Moderately Disagree	Slightly Disagree	Slightly Agree	Moderately Agree	Strongly Agree
1.	Overall, our organization and staff are effective in their assessment and management of suicidal patients.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
2.	Our organization's clinical workflows are well-designed for effective assessment and management of suicide	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
3.	Our organization's policies and procedures appropriately and effectively define each employee's role and responsibilities in preventing suicide.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
4.	Our organizational culture and procedures facilitate effective communication and hand-offs of suicidal patients between staff / providers within our clinic.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
5.	Our organization's clinical workflows determine appropriate levels of care and referrals for patients at risk for suicide.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
6.	Our organizational procedures effectively address ethical and legal considerations related to the management of suicide risk.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
7.	Our organization offers training and resources related to suicide prevention and management.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
8.	Staff are adequately supported by our organization and leadership when they have a suicidal patient, or have concerns related to suicide management.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6
	Our organization is equipped to manage suicide risk in patients from						

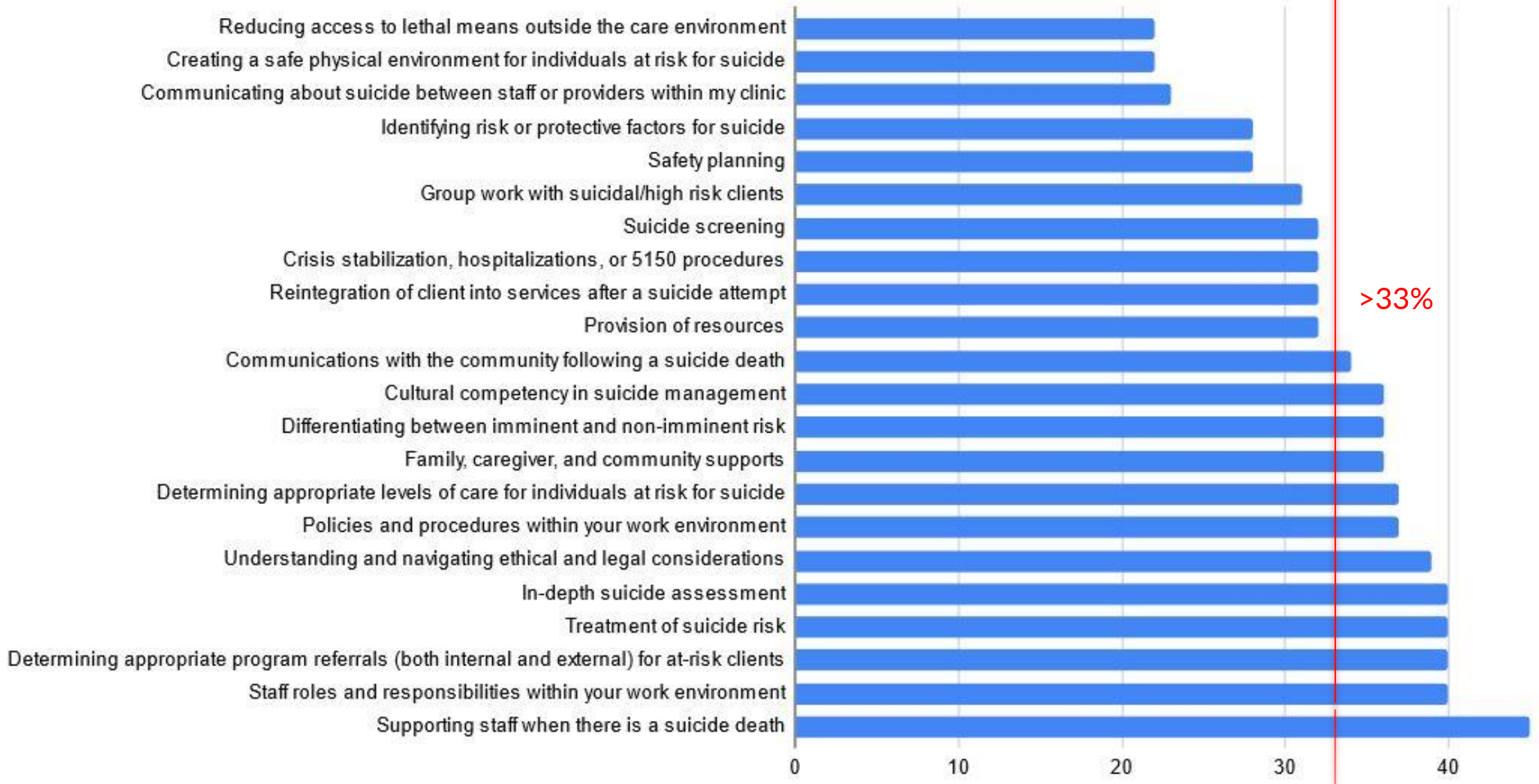
Ratings of how well the organization is doing in these suicide prevention/management areas



What areas of suicide prevention and management have you felt you need more training or support? (select all that apply)

- ☐ Cultural competency in suicide management
- ☐ Suicide screening
- ☐ In-depth suicide assessment
- ☐ Identifying risk or protective factors for suicide
- ☐ Differentiating between imminent and non-imminent risk
- ☐ Determining appropriate levels of care for individuals at risk for suicide
- ☐ Safety planning
- ☐ Crisis stabilization, hospitalizations, or 5150 procedures
- ☐ Understanding and navigating ethical and legal considerations
- ☐ Treatment of suicide risk
- ☐ Group work with suicidal / high risk clients
- ☐ Reducing access to lethal means outside the care environment

PRE: Percent Respondents Indicating Need for Training or Support (N = 107)



What are some challenges or areas of improvement? (79 out of 110 provided qualitative comments)

Notable context (N=7): The need for support related to recent increases in attempts, stresses, or deaths for both clients and staff.

Most frequently mentioned issues

1. Training (N=22)
2. Workflow/Roles/Team Coordination (N=14)
3. Treatment & Monitoring (N=11)
4. Suicide Assessment (N=10)
5. Paperwork, Policies, Procedures (N=10)
6. Handling crises and 5150 situations (N=8)
7. Insufficient staff/workload concerns (N=8)
8. Organizational / leadership support & communication (N=7)

Category	Examples
1. Training (N=22)	• Continuous trainings (maybe one a year) would be really helpful. • We need to have regular training from top experts in this area.
2. Workflow/Roles/Team Coordination (N=14)	• Having so many phone number is confusing and need to be set up a specific outreach number and referral process need to be simpler. • I'm also unclear on the exact protocol required of me as a case manager, i.e., aside from documenting what I know about the client in my progress notes… • Monitoring clients more carefully with high risk clients and working better as a team. • Protocol(s) are not made clear to new staff as to who to contact in case of client (on site or over the phone)is actively suicidal. Not clear who provides Risk/safety assessments, nor is it made clear who can perform 5150 holds • Centralized policies and procedures for crises situations. If program manager or clinicians are unavailable, staff feel at a loss as how to proceed • Collaboration with law enforcement and working as a team.

Case D

Example conclusions & recommendations from a downstream organizational needs assessment

OVERALL EXECUTIVE SUMMARY OF RECOMMENDATIONS

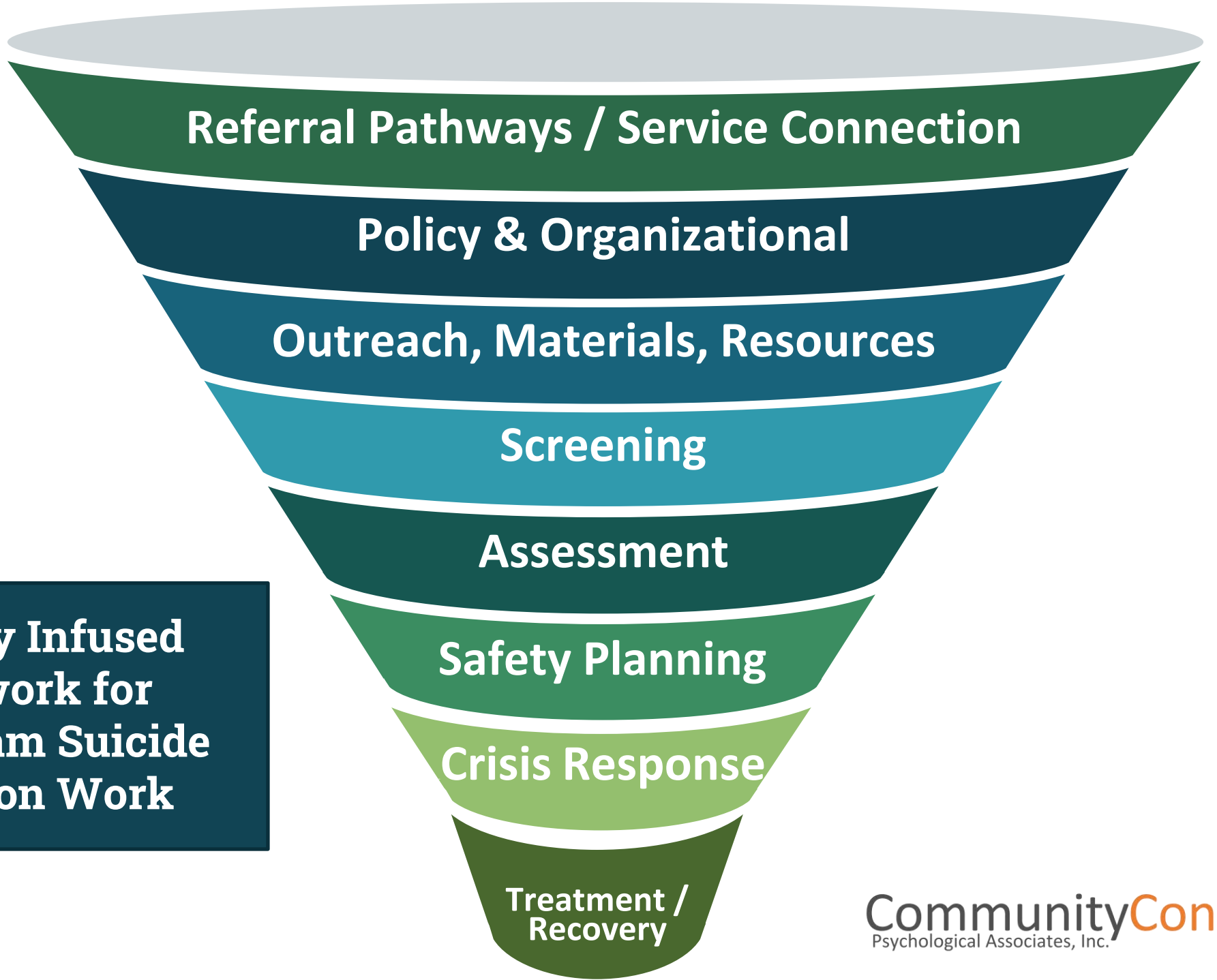
This executive summary details the data-driven recommendations of Case D's Suicide Prevention workgroup's suicide needs assessment . After analyzing the mixed-method qualitative and quantitative data, the Community Connections Psychological Associates (CCPA) team synthesized data findings into the following set of recommendations for consideration by Case D stakeholders. A more detailed discussion of key takeaways and recommendations are located at the end of this report.

	Suicide Prevention & Management Recommendations for Case D
Culture and Diversity in Suicide-related Efforts	1. **Increase cultural integration into suicide risk and management conceptualization and intervention.** 2. Pay specific attention to management of suicide risk among **underserved/ marginalized individuals** (e.g. ethnic minority, non-English speaking, veterans, LGBTQ+ etc.)
Centralized System for Suicide-related Trainings	3. **Develop & Implement a Centralized System for Suicide-related Trainings.** Ensure that trainings are accessible, sustainable, offered to staff in multiple roles, comprehensive in coverage of specific suicide-related skills, and culturally responsive. 4. **Draw from strengths in existing resources and trainings for the centralized training system** (i.e., Relias, Suicide Prevention 201).
Staffing and Policies, & Procedures	5. **Support workforce recruitment & retention.** Support efforts to support and retain the strong existing Case D workforce. In addition, addressing gaps in recruitment and retention of core Case D staff is an essential component of ensuring accessible, high quality, suicide prevention and management client and crisis care. 6. **Develop and/or refine Case D suicide prevention & management policies and workflow**. Clarify policies that outline workflows and the definition and integration of various roles within the Case D system of care.
Centralized System for Screening / Assessment Tools and Documentation	7. **Identify suicide screening and assessment tools and associate documentation templates.** Identify a centralized set of screening and assessment tools should fit the various levels of care and clinical and cultural needs of the Case D stakeholders. 8. **Create a system for screening and assessment tools / documentation templates to be accessed and used by Case D staff.** Consistent use of screening tools require easy access by all staff, along with potential integration into Case D's electronic health record system. 9. **Integrate culture and diversity into screening options.** 10. **Develop a policy around screening and assessment** that includes operationalization of various levels of risk.
Suicide Loss Support for CASE D Staff	11. **Develop a system of support for staff following a suicide death or loss.** 12. **Develop specific guidance about communicating about suicide deaths**, both internally and externally.
Clinical Service Options and Referrals	13. **Explore additional clinical service options and referrals to support longer-term care and recovery.** Explore the option of providing additional clinical service options, particularly for outpatient care, high acuity care, longer-term treatment following elevated suicide risk, or referral options/continuity of care.

10 Steps to Take as You Get Ready to Retire

10 questions to ask a CCRC

Culturally Infused Framework for Downstream Suicide Prevention Work

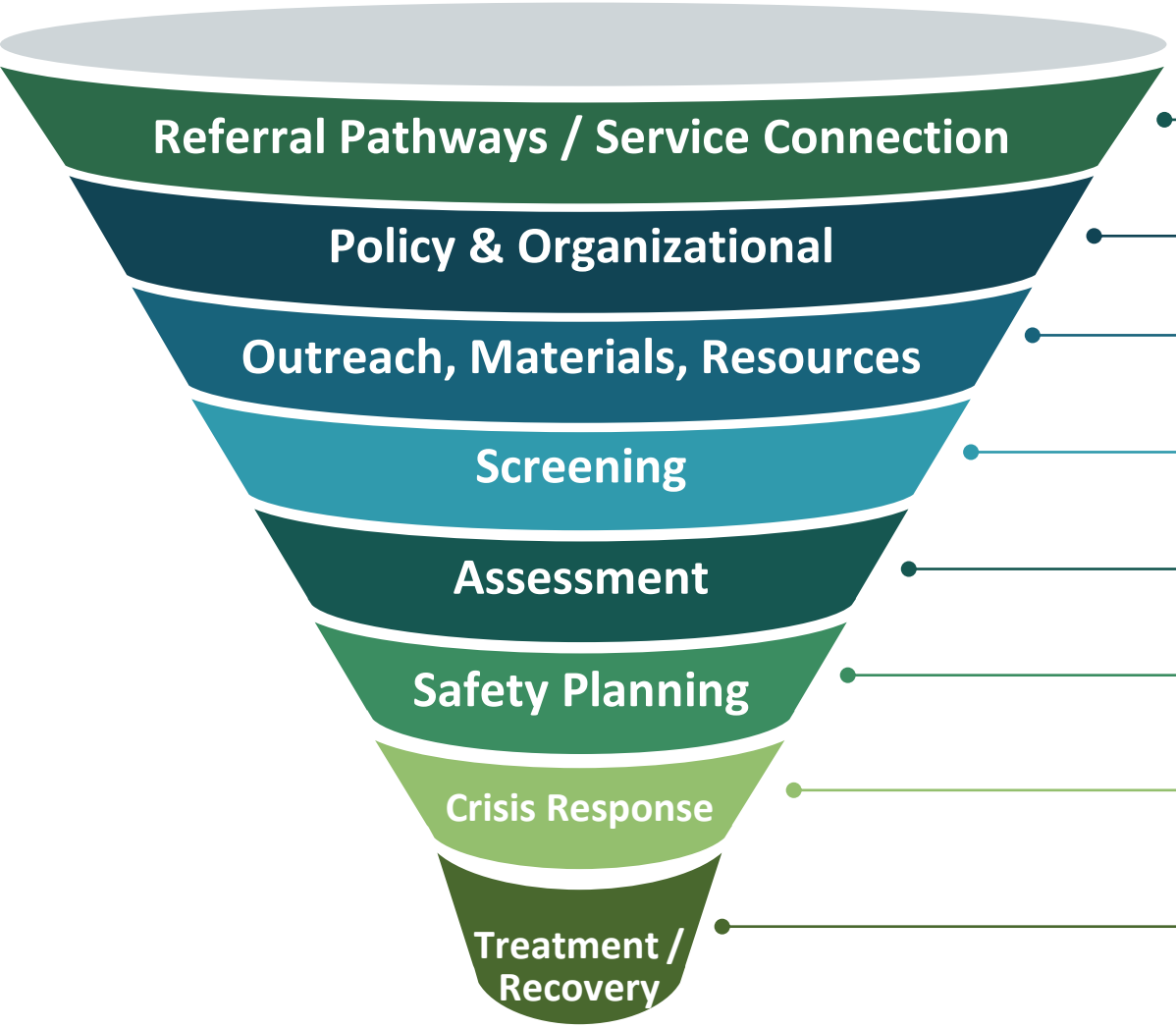


CommunityConnections
Psychological Associates, Inc.

Brainstorm

What is one way that culture and diversity should be integrated into suicide prevention?

Culturally Infused Framework for Downstream Suicide Prevention Work



- Attuned to help preferences, communication styles, stigma, language needs
- DEI Suicide Prevention policies and statements – DEI leadership
- Compendium of Cultural Materials for clinicians and community
- Cultural idioms of distress in screening tools
- Culturally attuned static/dynamic approach/paperwork
- Cultural Model factors
- Attention to cultural bias and traumatization
- Cultural Model factors in case conceptualizations & treatment planning

CommunityConnections
Psychological Associates, Inc.

Referral Pathways / Service Connection

Common Struggles

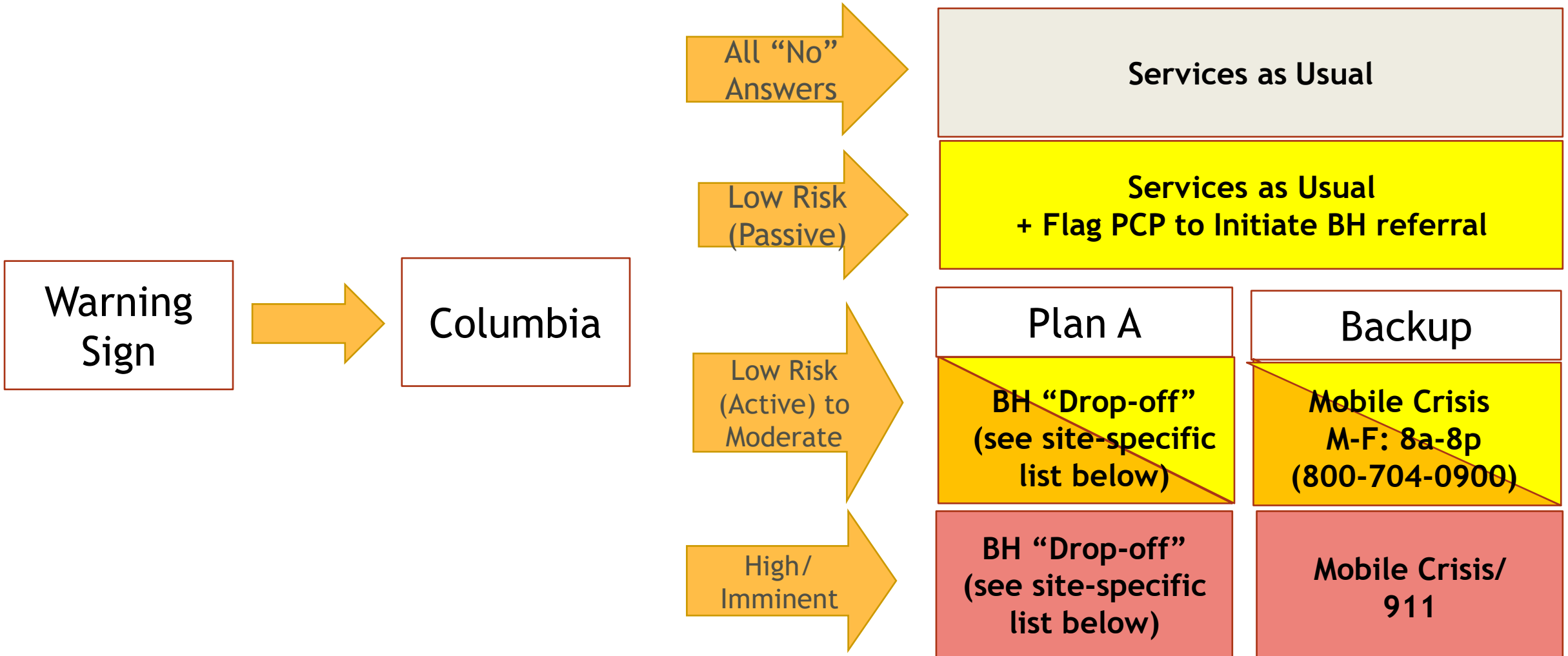
- Unclear Communication pathways
- Lack of coordination between service entities
- Wait times for service connection / provider back line
- Not enough available services
- Referral pathways don't fit cultural needs

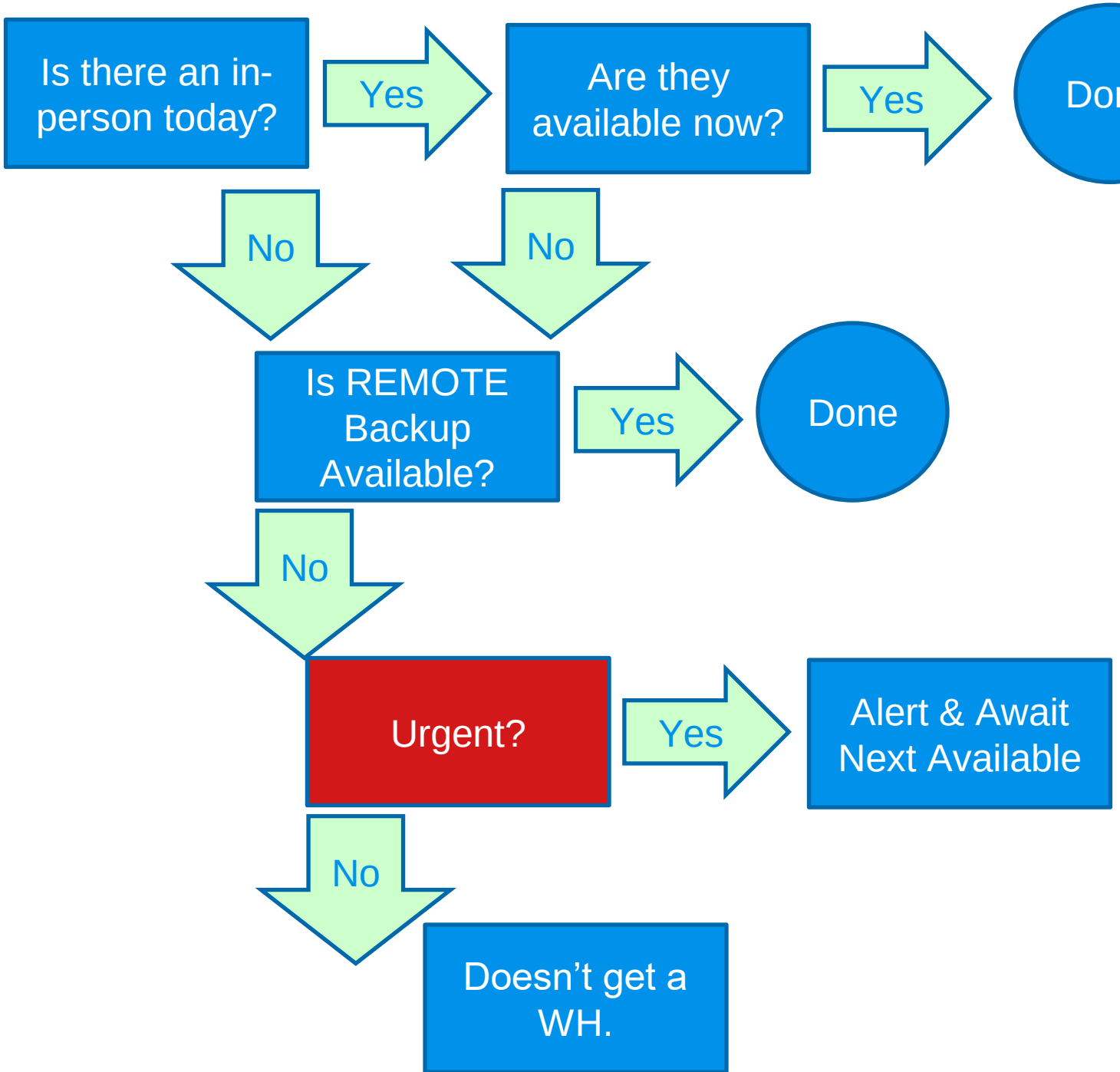
Critical Components

- Communication channels
- Warm handoff systems
- Follow-up care coordination procedures
- Complete workflow (within and outside of each service entity)
- Sufficiently resourced mental health services
- Service connection pathways that are culturally attuned (to cultural help preferences, stigma, communication styles, language needs)

Case A

Referral workflow




Is there an in-person today?
Yes
Are they available now?
Yes
Done
No
No
Is REMOTE Backup Available?
Yes
Done
No
Urgent?
Yes
Alert & Await Next Available
No
Doesn't get a WH.

Option 1: Prioritizing Clinician Equality – 7 rotations – DAY 1

Clinic 1	Clinic 2	Clinic 3	Clinic 4	Clinic 5	Clinic 6	Clinic 7	Clinic 7
	P-iatrist	P-ologist	PSW-II	PSW-II	P-iatrist	PSW-II	PSW-II
	P-ologist		PSW-II	LPT	Psych NP	PSW-II	LPT
	PSW-II				P-ologist	PSW-II	LPT
	PSW-II				P-ologist	PSW-II	
					PSW-II		
					PSW-II		

COMBO

ONLINE

Pending

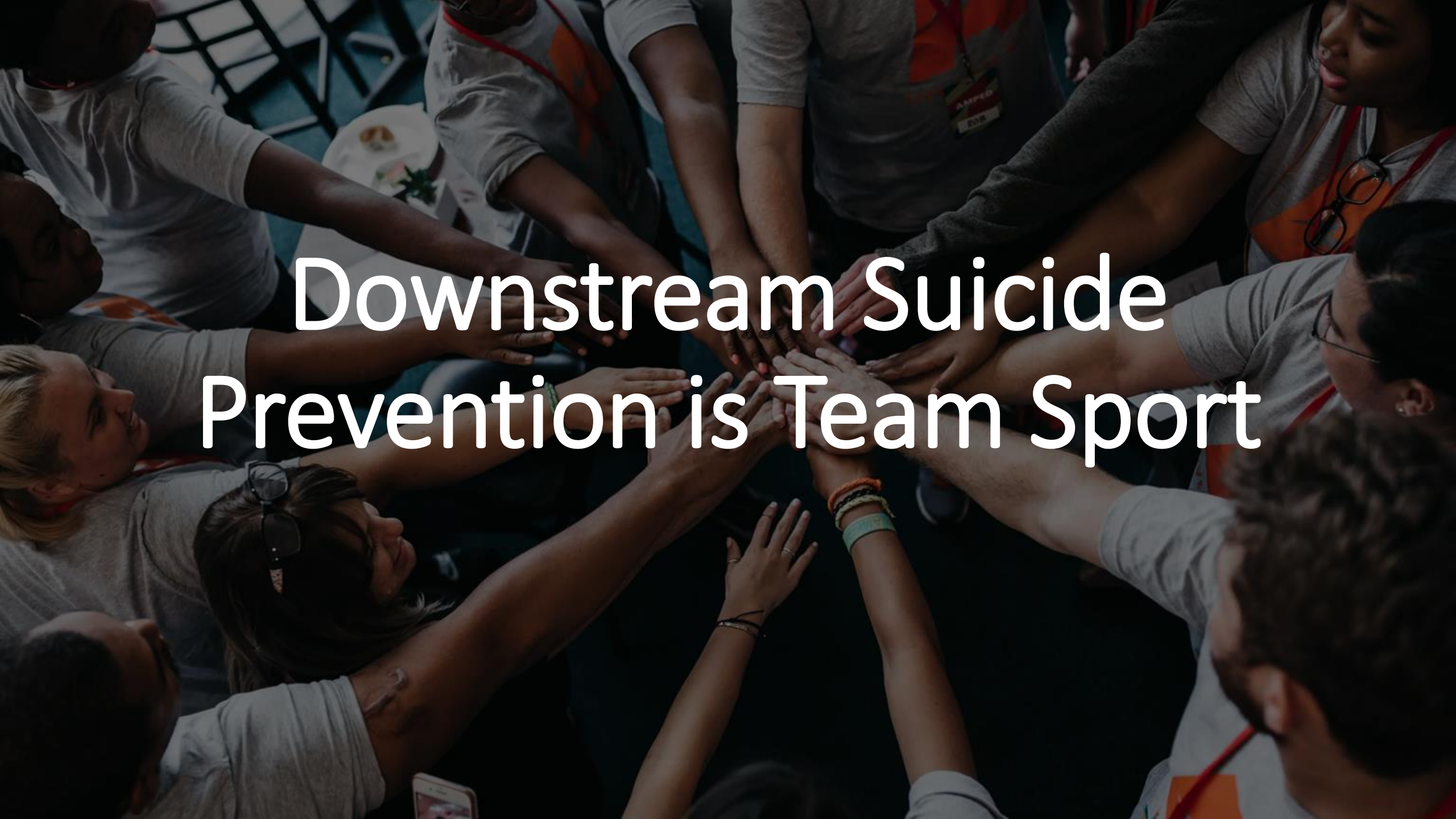
Dedicated

PSW-II

PSW-II


Referral Pathways / Service Connection
Policy & Organizational


YOU'RE ONLY AS GOOD AS YOUR
TEAM


Downstream Suicide
Prevention is Team Sport

Policy & Organizational

Common Struggles

- Insufficient training system
- Staffing / Personnel

Critical Components

- Training (at onboarding, always accessible, comprehensive in staff role and content, culturally infused)
- Staffing / Personnel (SP coordinator, security, on-call, all staff trained)

A *System* of Downstream TRAINING

- A *System* of training is needed – not just one-off trainings
- Cover content *and* policies/ procedures
- Availability is key (onboarding, and at all times “PRN”)
- Practice (with cases after; integrate into supervision / consultation groups)
- Infuse using cultural frameworks
- Train everyone (in the service provision system)

Case C:
A Training System

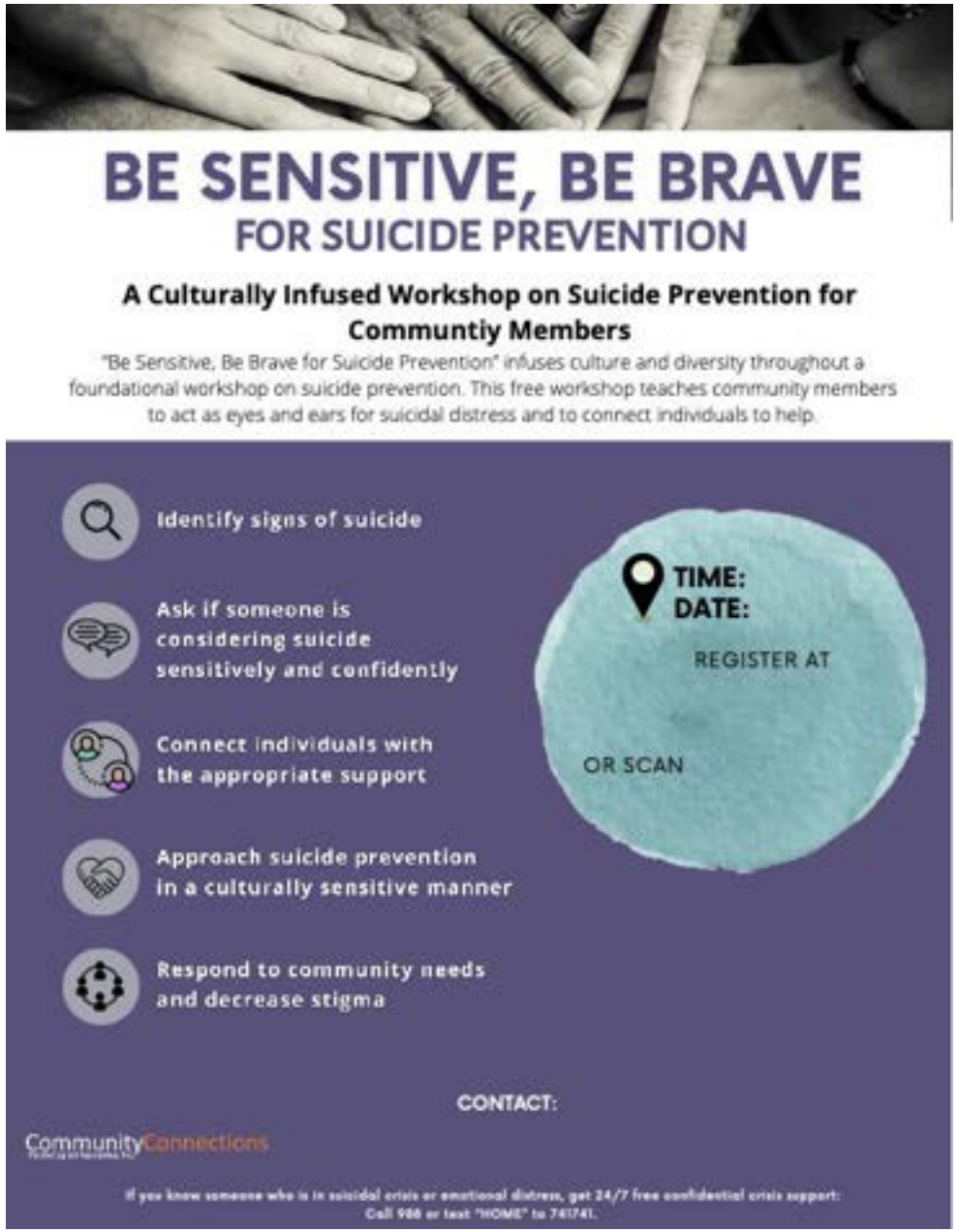
2021 Suicide Prevention Month

A six-month series of suicide enhancements and strengths

OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY
Culture & Underserved Populations	Assessment and Documentation	Community Support Following A Suicide Loss	Safety Planning and Treatment	Crises and 5150s: Practical Policies and Procedures

Supported by (Case C) *stand-out strengths in: Team-supportive Environments, Strong Therapeutic Relationships, and Safety Planning Know-How. Bolstered by: Trainings, Stakeholder-driven input & Organizational leadership, support & communications.*

http://www.besensitivebebrave.com



Suicide Prevention 201:

Advancing Suicide Prevention & Management for Diverse Clientele

Joyce Chu, PhD
Clinical Psychologist

Christopher Weaver, PhD
Clinical Psychologist

6 CE credits

Target audience: Post-licensure instruction

Beginning, intermediate, or advanced levels Board of Behavioral Sciences or Board of Psychology

CE Course Overview: This workshop will provide instruction and a forum for clinical discussion and case practice, on the current standards of practice for suicide prevention and management. A useable framework and accessible guidelines will ensure that workshop participants are able to competently manage suicide risk, incorporating the latest standards in suicide science and practice.

Throughout its content, this workshop address the management of suicide in diverse populations. Attendees will learn state-of-science theoretical, measurement, and applied research as practical approaches to assist clinicians in accounting for cultural influences on suicide risk among diverse populations. Aims are to provide guidance to advance culturally competent suicide research and practice.

Contact: community.connections.psych@gmail.com

Learning Objectives

- Identify 6 key steps of assessing & managing suicide risk
- Apply standard approaches to suicide risk assessment & inquiry
- Identify major components of safety planning, suicide risk case conceptualization, and treatment planning while accounting for important clinical documentation & legal considerations
- Discuss the latest research on cultural differences in suicide, & culturally competent assessment & prevention of suicide among ethnic minority & LGBTQ populations
- Apply a guiding framework & assessment tools/approaches that advance culturally competent suicide practice w/ diverse clients

APA APPROVED SPONSOR

Community Connections Psychological Associates, Inc. is approved by the American Psychological Association to sponsor continuing education for psychologists. Community Connections Psychological Associates, Inc maintains responsibility for this program and its content. There is no known commercial support for this program.
Note: APA CE credits are accepted by the CA Board of Behavioral Sciences and the Board of Psychology. Check your licensing body for confirmation

OCTOBER, PART 1

Culture and Suicide Prevention 101: Be Sensitive, Be Brave for Suicide Prevention

Evelyn Quintanilla and Jay Donoghue, MPH

This workshop is ideal for any client-facing, administrative, or support staff who would like to learn to recognize warning signs of suicide and get someone connected with help. "Culture and Suicide Prevention 101: Be Sensitive, Be Brave for Suicide Prevention" is foundational workshop in suicide prevention that teaches community members to act as eyes and ears for suicidal distress and to help connect individuals with appropriate services. Workshop participants will learn to recognize suicide risk, how to ask individuals if they are thinking about suicide, and connect them with help. This workshop will discuss navigating conversations about suicide across diverse populations, with the aim of equipping community members to be culturally responsive within their communities.

OCTOBER, PART 2

Culture and Suicide Prevention 201: Cultural Issues in Suicide Prevention for Diverse and Underserved Clients

Joyce Chu, Ph.D.

This workshop is ideal for any client-facing staff who may be responsible for screening, assessing, managing, or treating clients in suicidal distress. In October, Case C's 6-month suicide prevention initiative will focus on culture and underserved populations in suicide prevention. Dr. Joyce Chu, national expert on culture/diversity and suicide, will give a workshop addressing the management of suicide in culturally diverse clients. We invite all clinical staff to come learn state-of-science theoretical, measurement, and practice approaches to assist clinicians in accounting for cultural influences on suicide risk. Aims are to provide guidance to advance culturally responsive suicide prevention services.

NOVEMBER

Suicide Risk Assessment and Documentation

Christopher M. Weaver, Ph.D.

In November, Case C's 6-month suicide prevention initiative will focus on assessment and documentation in suicide prevention. Dr. Christopher Weaver, a national expert on law and mental health, forensic psychology, and suicide assessment, will give a workshop addressing comprehensive assessment and streamlined documentation of suicide risk in culturally diverse clients. We invite all clinical staff to come learn a usable, evidence-based approach to improving your clinical decision-making process in suicide assessment, along with tools that will help you with documentation and paperwork. Aims are to provide guidance to advance culturally responsive suicide prevention services.

DECEMBER

Case C Community Support Following a Loss

Speaker Name 1

This course is the fourth in a series on suicide prevention and is intended to discuss various aspects of Vicarious Trauma and community supports available to Case C employees. Vicarious trauma will shed a lens on the experience of innately stressful aspects of the service delivery and resources for employees to access.

JANUARY

Treatment of suicide risk with Dialectical Behavioral Therapy

Janice Kuo, Ph.D.

This presentation will offer a primer on the key theoretical underpinnings of dialectical behavior therapy (DBT) and how it relates to the conceptualization and treatment of disorders characterized by emotion dysregulation (e.g., borderline personality disorder) and suicidal behaviors. Participants will learn how to implement a chain analysis to assess the occurrence of suicidal behaviors, and apply suicide risk management and crisis strategies to target suicidal behaviors.

FEBRUARY

5150: Practical Policies and Procedures, A Panel Discussion

Speaker Names 2-5

Case C's Suicide Prevention series will conclude with a panel and didactic event titled "Crisis and 5150s: Practical Policies and Procedures." Participants will learn from a panel of Case C staff in different programs and roles who have experience with 5150 holds, The panel will discuss challenges and solutions related to 5150 crisis situations, and will be opened with a brief didactic about the mechanics of placing 5150 holds at Case C by speaker 2.

Integration into daily team meetings & supervision

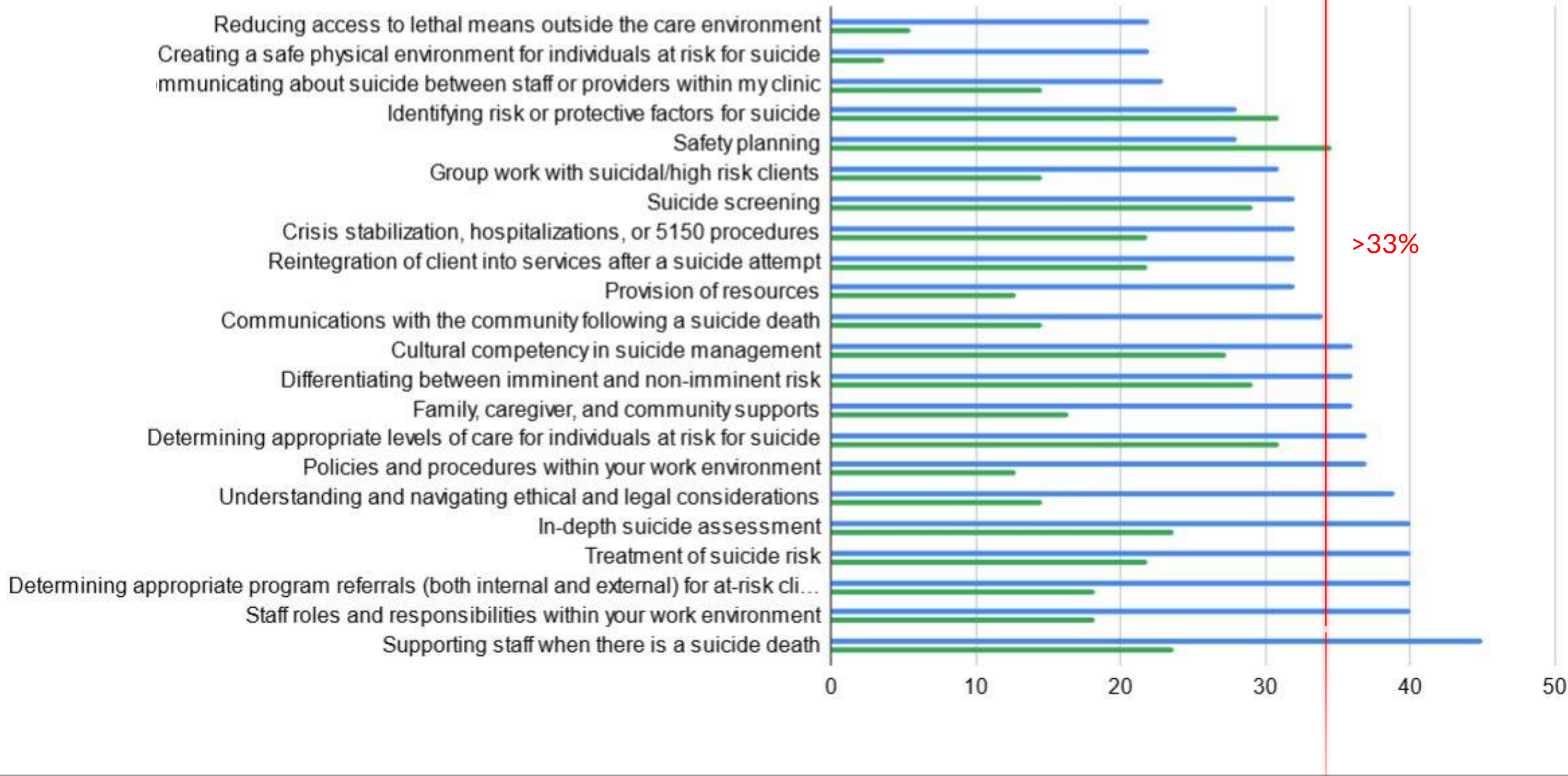
Facilitator's Guide
Culture & Suicide Prevention Discussion Groups
Joyce Chu, Ph.D. (joycepchu@gmail.com)

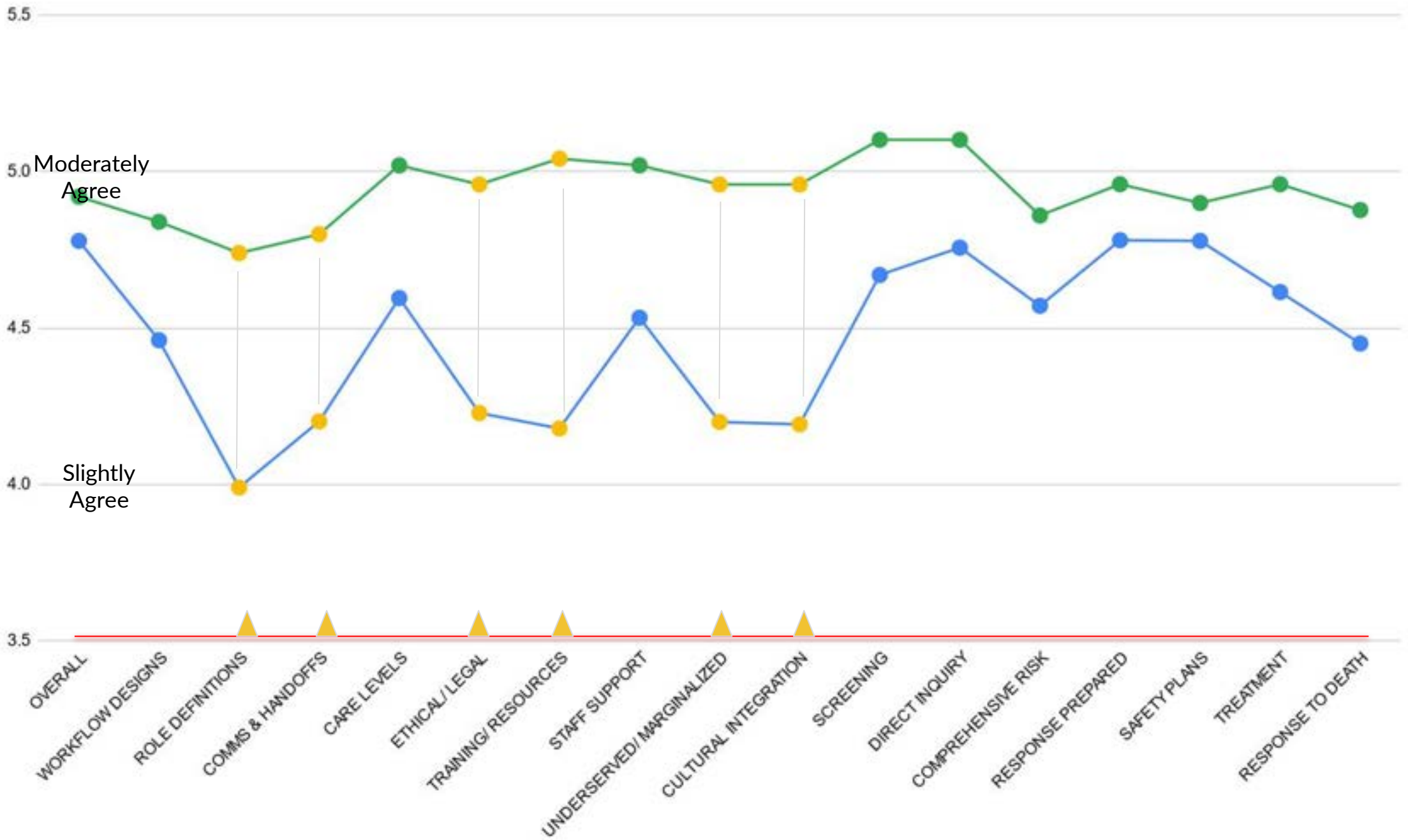
Discussion Questions

1. Do you have any cases where cultural idioms of distress or cultural warning signs may be at play?
    - For example, any cases where you think suicidal distress may being missed?
    - Any alternative screeners or suicide questions you should consider?
    - Any ways that your client prefers to be supported by you because of communication/interpersonal style?

2. Any cases where the cultural suicide factors of MISC would change your assessment of suicide risk level or suicide management plan

Percent Respondents Indicating Need for Training or Support (N = 107)




5.5
5.0
4.5
4.0
3.5
Moderately Agree
Slightly Agree
OVERALL
WORKFLOW DESIGNS
ROLE DEFINITIONS
COMMS & HANDOFFS
CARE LEVELS
ETHICAL/ LEGAL
TRAINING/ RESOURCES
STAFF SUPPORT
UNDERSERVED/ MARGINALIZED
CULTURAL INTEGRATION
SCREENING
DIRECT INQUIRY
COMPREHENSIVE RISK
RESPONSE PREPARED
SAFETY PLANS
TREATMENT
RESPONSE TO DEATH

2023 Re-Launch With an Eye on Sustainability

Policy & Organizational

Common Struggles

- Insufficient training system
- Staffing / Personnel
- Policies: Non-existent, uncoordinated, or mixed with clinical guidelines

Critical Components

- Training (at onboarding, always accessible, comprehensive in staff role and content, culturally infused)
- Staffing / Personnel (SP coordinator, security, on-call, all staff trained)
- DEI-infused SP Policy & Procedures across all clinics

Case B

Suicide Prevention Policy & Procedures

BEHAVIORAL HEALTH POLICIES & PROCEDURES	Case B Suicide Prevention Policy & Procedures DRAFT Version: _____	
Policy ID:	Approved by:	Effective Date:
HIPAA Section:	Policy Custodian:	Last Updated:

Applies to:	Peer Specialist	LPHA	Interns / Practicums	Volunteers
	Family Partner	Clinician	Program Specialist	MD

PURPOSE & GOALS

The purpose of this policy is to set in place procedures and expectations for CASE B to take proactive steps to prevent, manage, and respond to client suicide attempts and deaths by suicide. This policy seeks to:

- State and define CASE B's intention to meet and exceed minimum standards of care in suicide risk screening, assessment, and intervention
- Set minimum boundaries for the use of evidence-based assessment techniques, including minimum cultural sophistication of evaluation processes.
- Empower clinicians to be able to make adjustments as needed for cultural fit or to keep abreast of moving science.
- Formally link assessment outcomes to minimum expected interventions.

RELATIONSHIP BETWEEN THIS POLICY AND CLINICAL GUIDELINES:

To facilitate the above purpose and goals, this policy is written to work in concert with separate, more specific, Suicide Prevention Clinical Guidelines. Those guidelines are expected to be fluid in nature, reflecting the changing nature of resources (internal and external) and evolutions in culturally-informed suicide prevention science and policy. CASE B staff are encouraged to

SP Clinical Guidelines

The following clinical guidelines do not represent a comprehensive guide for suicide practice, but instead supplement and augment the content specified in its companion suicide prevention policy.

Screening

- When using a questionnaire or measure in screening procedures, staff may choose from a list of evidence-based suicide screeners. Recommended instruments are listed below; upon staff discretion, other evidence-based tools may also be used.

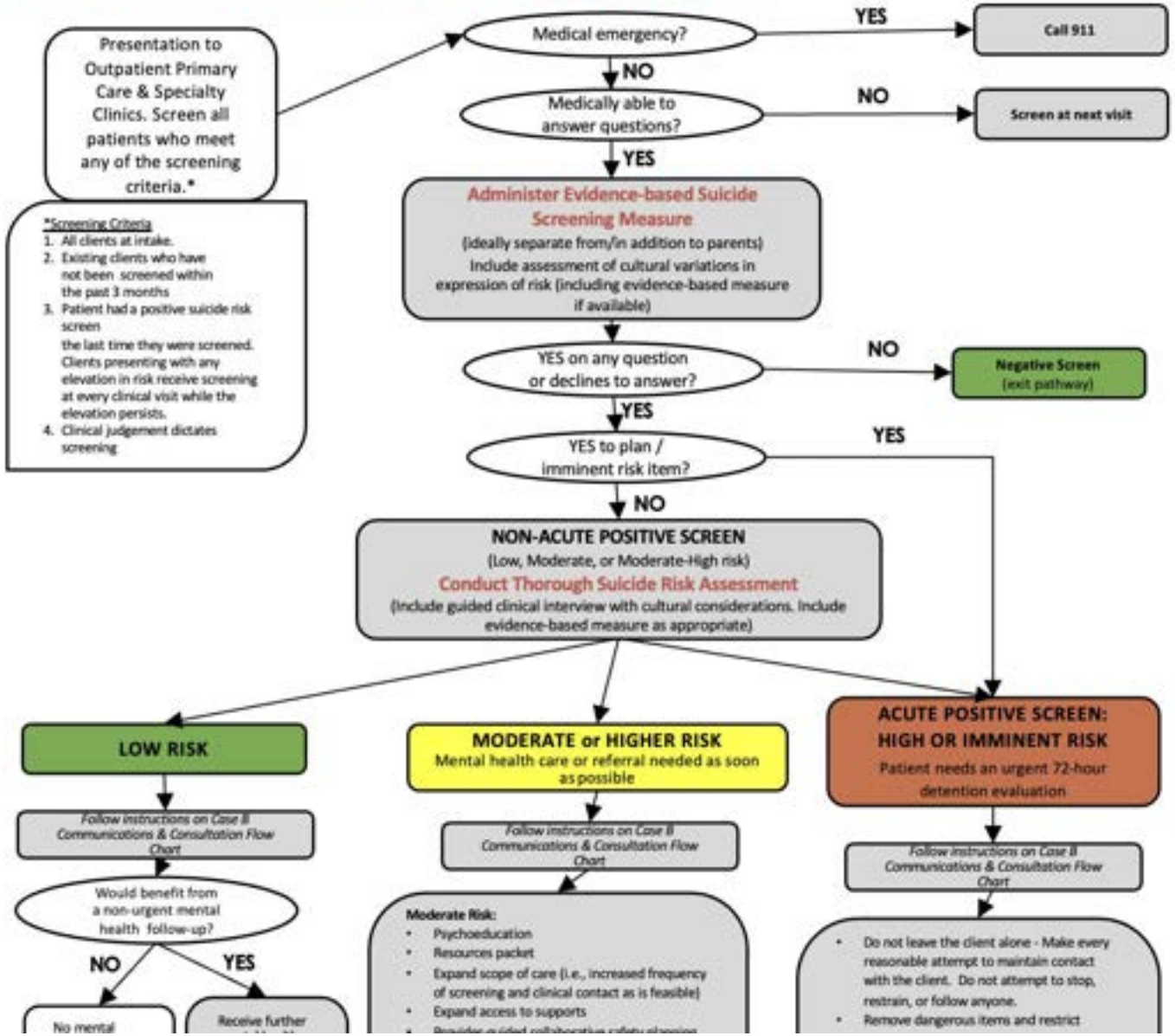
Assessment

- Assessing staff will include differentiation of static versus dynamic risk factors where appropriate.
- Interpret discrepancies between multiple sources of risk in favor of the highest indication of risk until that indication can be reasonably proven to be invalid.

Culturally responsive practices

- Suicide screening, assessment, prevention, and management efforts should be culturally attuned and responsive to the cultural needs of clients whenever possible. These efforts may include but are not limited to: provision of culturally-responsive resources and

Case B Suicide Risk Screening & Management Pathway



Policy & Organizational

Common Struggles

- Insufficient training system
- Staffing / Personnel
- Policies: Non-existent, uncoordinated, or mixed with clinical guidelines
- Scattered SP resources

Critical Components

- Training (at onboarding, always accessible, comprehensive in staff role and content, culturally infused)
- Staffing / Personnel (SP coordinator, security, on-call, all staff trained)
- DEI-infused SP Policy & Procedures across all clinics
- Internal resource infrastructure (internal website, easily accessible, repository for SP documents)

Case C

Internal Resource Infrastructure

Poll

Which of the following organizational structures does your county system have? (choose all that apply)

A. A system for suicide prevention training
B. A clear suicide policy and procedures document
C. A place where clinicians can access internal suicide prevention resources
D. Suicide documentation built into the electronic health record
E. Culture & diversity infused in all of the above
F. I don’t know

Suicide Prevention and Management Resource Library

Resources to Help People

Whether for yourself, a family member, a colleague or a client, find national and local resources to help people struggling with suicide risk.

Resources for Staff

Momentum has support services for staff to help with all manner of challenges, including stressors coming from managing suicide risk.

Tools for Clinicians

Find assessment and training resources to help you provide clinical care to diverse Momentum consumers.

COUNTY OF SANTA CLARA SUICIDE PREVENTION

For those who may prefer resources outside of those offered by Momentum, the County of Santa Clara's Suicide Prevention Program provides a suite of services to address community and individual needs following a suicide. Program offerings are no-cost and include the following:

Trainings and Consultation on Safety Messaging and Reporting on Suicides

These trainings are designed for youth, media professionals, and general audiences.

Suicide Prevention Trainings

- Foundational workshops for community members to recognize cultural suicide and mental health warning signs and connect people to help
- Clinical culturally-infused suicide assessment and treatment workshops for mental health professionals

For more information visit:

Suicide Prevention & Crisis

Crisis and Suicide Prevention Lifeline 24/7: Dial 9-8-8

CRISIS TEXT LINE 24/7: Text *RENEW* to 741741

CRISIS TEXT LINE en español 24/7: Envía un mensaje de texto con la palabra COMUNIDAD al 741741

Critical Incident Stress Management and Response Support

- CISM is a highly structured intervention for traumatic incident first responders.
- CISR professionals respond to a scene following a traumatic accident. The Bill Wilson CISR team collaborates with local agencies to ensure comprehensive critical incident response plans.

Student and School Community Support

- *The HEARD Alliance* is a collection of health care professionals helping Bay Area communities promote well-being and prevent suicide in adolescents and young adults. Offerings include:
  - K-12 mental health/suicide prevention kits, including a *postvention kit*.
  - School-based support, including assistance with *Kognito online health simulations for educators*.
  - Postvention protocol review and development assistance.

Policy & Organizational

Common Struggles

- Insufficient training system
- Staffing / Personnel
- Policies: Non-existent, uncoordinated, or mixed with clinical guidelines
- Scattered SP resources
- Insufficient technology and documentation assistance

Critical Components

- Training (at onboarding, always accessible, comprehensive in staff role and content, culturally infused)
- Staffing / Personnel (SP coordinator, security, on-call, all staff trained)
- DEI-infused SP Policy & Procedures across all clinics
- Internal resource infrastructure (internal website, easily accessible, repository for SP documents)
- Technology & Documentation (electronic health records, culturally infused documentation templates, panic buttons)

Case B

Technology & Documentation Infrastructure

Suicide Assessment Note

Patient Name:
Patient Age:
Gender Identity
Race or Ethnicity:
Sexual Orientation:
Other Cultural Identities:
Translator Used: Yes/No?
Preferred Language:

Sociocultural History:

Patient's Current Location:
-Asked patient to verify location and address in case of emergency *[if it's a telehealth visit]*

Permissions / Release of Information:
Obtained the following permissions /ROI forms to communicate with collateral contacts in case of increased suicide risk: *[list names/numbers]*

Obtained verbal consent to call pt's emergency contact as listed below in case of an emergency.

Suicide Screening
Suicide screening was completed using the [*Specific name of the measure/version – e.g., COLUMBIA PROTOCOL*], an evidence-based tool for determining level of risk and initial corresponding level of referral. This screening procedure determined that this patient's level of risk to be (yellow = low; orange = moderate; red = high).

Columbia Protocol
[Author: Distribute all 6 items among the 3 categories below]
1. "Have you wished you were dead or wished you could go to sleep and not wake up?"
2. "Have you actually had any thoughts about killing yourself?"
3. "Have you thought about how you might do this?"
4. "Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the

Risk Level determination process

For the Columbia Protocol, risk is determined by the category of the most concerning item that is endorsed. In this case, the highest category item endorsed was:

[Author: choose 1 of the following]

1. "wished you were dead", which is in the yellow tier indicating low risk.
2. "thoughts about killing yourself", which is in the yellow tier, indicating low risk with a need for behavioral health referral."
3. "how you might do this", which is in the orange tier, indicating moderate risk with a need for immediate behavioral health referral."

As the clinician, I agreed with this determination of [*LOW, LOW TO MODERATE, MODERATE, MODERATE TO HIGH, HIGH, IMMINENT*] risk.

Other Cultural Idioms of Suicidal Distress

[insert other expressions / symptoms – (e.g., headaches, fatigue, shame, emotions, behaviors, physical, etc.) – that may represent the diverse ways that suicidal ideation/intent/plan/means is showing up]

Comprehensive Suicide Assessment

The individual listed above was assessed for risk of danger to self by the assessing clinician using a

Assessing Clinician:

The individual listed above was assessed for risk of danger to self by the assessing clinician using a interview and conceptualization method that has been empirically demonstrated to improve consideration and communication of key risk factors.

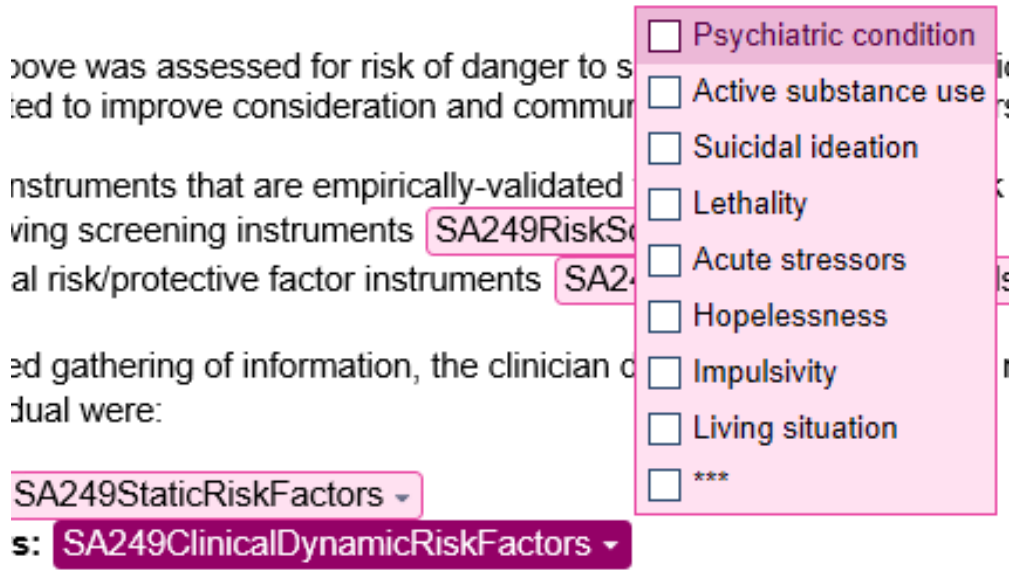
Formal psychometric instruments that are empirically-validated to screen for suicide risk or assess for risk and protective factors also exists. The individual was

-
-
-

Static Risk Factors: SA249StaticRiskFactors
Dynamic Risk Factors: SA249ClinicalDynamicRiskFactors

Risk factors denied by the individual were SA249APARiskFactors
Risk factors that were not yet assessed were SA249APARiskFactors

-
-
-



Case C Risk Dashboard

Patient Name: Chris Weaver ID: 1234567

SUMMARY AT-A-GLANCE

Most recent risk determination: Moderate on 1/15/22 Most recent hospitalization: N/A

Known long-term risk factors: Impulsivity, Substance Abuse Hx, Unstable Housing

Known fluctuating risk factors: Family Discord, Active Substance, Work Stressors

Tracking Aggression Risk

Multiple instances of being physically hostile with staff when emotional/upset

Known Coping/Safety Recommendations

[Auto-fill items from safety planning sections. Add the word "Contact:" in front of items from the "People I Can Ask for Help" or "Professionals I Can Contact During a Crisis" sections]

Reasons for Living

[Auto-fill items from "Reasons for Living Card" safety planning section]

DETAILED SUICIDE RISK TRACKING

Tracking Ideation, Intent, Plans, Means

Most Recent Columbia: Moderate (needs referral to BH assessment) on 1/15/22

Administer New | See Full History

Tracking Detailed Static Risk Factors

FACTOR	MOST RECENT SCORE					
Impulsivity	○ Unknown	○ No	○ Maybe	◉ Yes	Add Comments	See Full History
Substance Abuse Hx	○ Unknown	○ No	○ Maybe	◉ Yes	Add Comments	See Full History
Minority Stressors	○ Unknown	◉ No	○ Maybe	○ Yes	Add Comments	See Full History
…						
Overall Static Risk	○ Unknown	○ Low	◉ Moderate	○ High	Add Comments	See Full History

Tracking Aggression Risk Add Comments | See Full History

Safety Planning Components *(note: continued below)*

Policy & Organizational

Common Struggles

- Insufficient training system
- Staffing / Personnel
- Policies: Non-existent, uncoordinated, or mixed with clinical guidelines
- Scattered SP resources
- Insufficient technology and documentation assistance

Critical Components

- Training (at onboarding, always accessible, comprehensive in staff role and content, culturally infused)
- Staffing / Personnel (SP coordinator, security, on-call, all staff trained)
- DEI-infused SP Policy & Procedures across all clinics
- Internal resource infrastructure (internal website, easily accessible, repository for SP documents)
- Technology & Documentation (electronic health records, culturally infused documentation templates, panic buttons)
- DEI-commitment by leadership

Poll

Which of the following organizational structures does your county system have?

A. A SYSTEM for suicide prevention training
B. A clear suicide policy and procedures document
C. A place where clinicians can access internal suicide prevention resources
D. Culture & diversity infused in the above
E. Suicide documentation built into the electronic health record
F. I don’t know


Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources

Outreach, Materials, Resources

Common Struggles

- Having things without people knowing about them
- Materials/services not culturally infused or available in multiple languages
- Lack of resources for families (how to navigate / support client in crisis)

Critical Components

- Culturally-infused outreach materials in all languages, and cultural resources (LGBTQ+, ethnic minority, disability, religion / spritual)
- Training on how to use resources & pamphlets as part of the crisis response and recovery plan

Case C

Assessment Tools

Access our ever-growing Library of Suicide Risk Assessment and Management Tools, including the Cultural Assessment for Risk of Suicide (CARS), and Columbia Suicide Screening measures translated into multiple languages

CLINICAL TOOLS FOR SUICIDE

QUICK ACCESS TOOLS:

CARS

COLUMBIA

Training Resources

Access asynchronous clinician-level trainings on topics related to suicide risk management, or check out our ongoing list of live trainings offered in the community or at Momentum.

Training Now:

Suicide Prevention & Assessment Trainings on Relias

Momentum 5150 & Crises Talk March 2022

Previous Momentum Training Materials

Upcoming Live Training:

SCC Be Sensitive. Be Brave. Training Series

5150 Training - Behavioral Health Services - County of Santa Clara -...

Name

- LGBTQ Resource Flyer_Vietnamese.pdf
- LGBTQ Resource Flyer_English.pdf
- LGBTQ Resource Flyer_Chinese.pdf
- LGBTQ Resource Flyer_Spanish.pdf

Name

- MH Guide for Immigrants_Spanish.pdf
- MH Guide for Immigrants_English.pdf
- MH Guide for Immigrants_Chinese.pdf
- MH Guide for Immigrants_Vietnamese.pdf
- MH Guide for Immigrants_Tagalog.pdf

Name

- PHQ9_Arabic-for-Israel.pdf
- PHQ9-Spanish.pdf
- PHQ-9-German.pdf
- PHQ-9-Portuguese.pdf
- PHQ9_Arabic-for-Tunisia.pdf
- PHQ-9-Vietnamese.pdf
- PHQ-9-Italian.pdf
- PHQ9_Dutch-for-Belgium.pdf
- PHQ-9-Russian.pdf
- PHQ9_Africaans-for-South-Africa.pdf
- PHQ9_Traditional-Chinese-for-Hong-Kon...

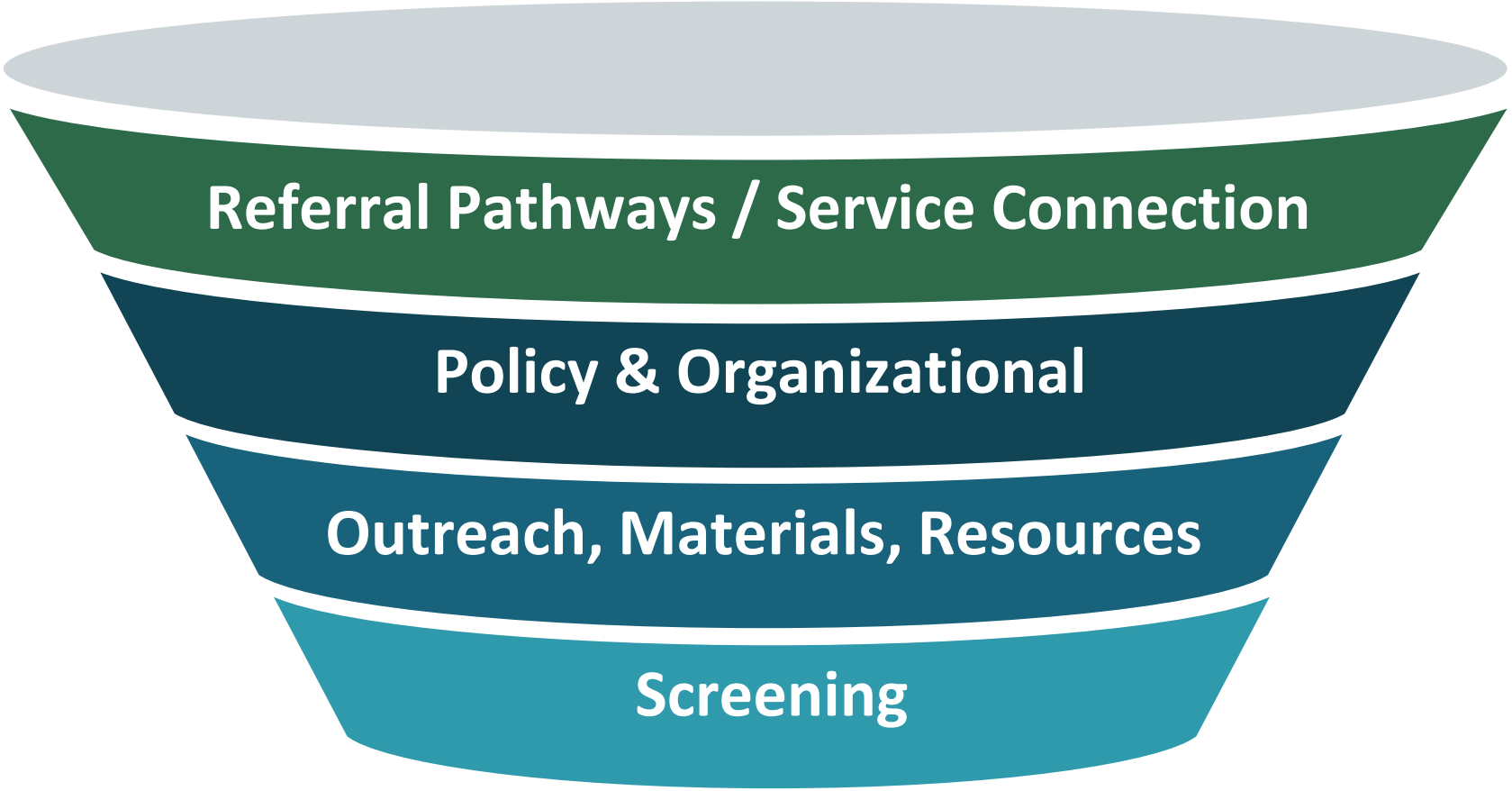
Outreach, Materials, Resources

Common Struggles

- Having things without people knowing about them
- Materials/services not culturally infused or available in multiple languages
- Lack of resources for families (how to navigate / support client in crisis)
- Providers & community members not knowing about how and when to use inpatient and crisis services

Critical Components

- Culturally-infused outreach materials in all languages, and cultural resources (LGBTQ+, ethnic minority, disability, religion / spritual)
- Training on how to use resources & pamphlets as part of the crisis response and recovery plan
- Marketing & outreach plan


Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources
Screening

Screening

Common Struggles

- Carving 1 screener tool into stone as policy
- Missing cultural idioms of distress

Critical Components

- Choice of evidence-based screeners
- A screener that attends to cultural needs
- Screeners built into electronic health record systems
- Screeners in different languages

Cultural Variations in how to ask about suicide

Have you ever wanted to give your life away?

Have you ever felt your loved ones would be better off without you?

Have you ever felt no one would care if you weren't around anymore?

Have you ever felt you don't deserve to be alive?

Have you felt so ashamed that you wanted to disappear?

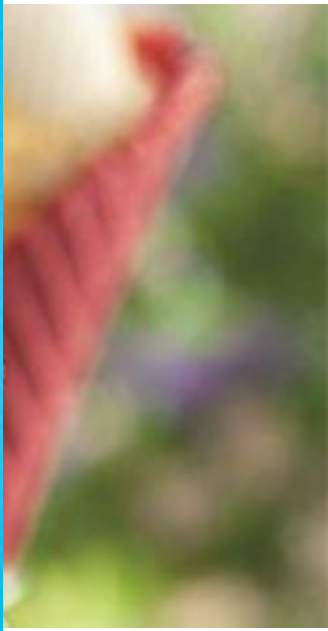
Have you ever felt your time on this earth is done?

Have you felt this world has rejected you and it's time to leave?

Have you ever wished someone else would just end your life?

TOP TEN ICE CREAM FLAVORS THAT

MAKE PEOPLE HAPPY



Screening

Common Struggles

- Carving 1 screener tool into stone as policy
- Missing cultural idioms of distress

Critical Components

- Choice of evidence-based screeners
- A screener that attends to cultural needs
- Screeners built into electronic health record systems
- Screeners in different languages

Screening

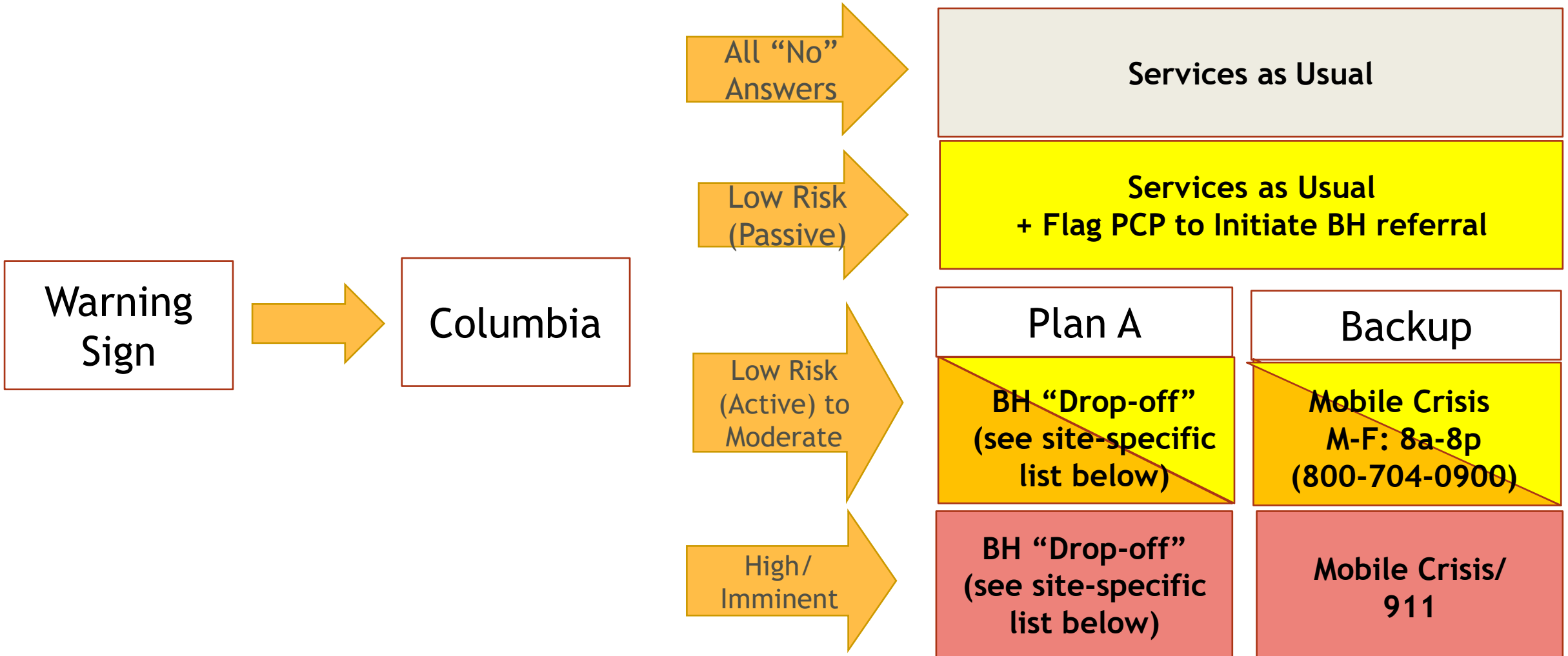
Common Struggles

- Carving 1 screener tool into stone as policy
- Missing cultural idioms of distress
- Fear of screening because of lack of backup ("What you don't know can't hurt you")

Critical Components

- Choice of evidence-based screeners
- A screener that attends to cultural needs
- Screeners built into electronic health record systems
- Screeners in different languages
- Screeners clearly linked to crisis response (including an on-call system) and treatment actions
- Screening built into workflows, including non-mental health providers (PCP, medical room staff, peer specialists)

Referral workflow



Screening

Common Struggles

- Carving 1 screener tool into stone as policy
- Missing cultural idioms of distress
- Fear of screening because of lack of backup ("What you don't know can't hurt you")
- Confusing screening for assessment
- Ignoring your middle group (moderate risk)
- Using depression as a screener for suicide

Critical Components

- Choice of evidence-based screeners
- A screener that attends to cultural needs
- Screeners built into electronic health record systems
- Screeners in different languages
- Screeners clearly linked to crisis response (including an on-call system) and treatment actions
- Screening built into workflows, including non-mental health providers (PCP, medical room staff, peer specialists)
- Differentiation of screening from assessment

PHQ-2 Screening Instrument for Depression

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Scoring: A score of 3 or more is considered a positive result. The PHQ-9 (Table 3) or a clinical interview should be completed for patients who screen positive.

PHQ = Patient Health Questionnaire.

Adapted from Patient Health Questionnaire (PHQ) screeners. http://www.phqscreeners.com. Accessed February 8, 2018.

Screening

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- Differentiation of screening from assessment

Case D

Centralized System for Screening / Assessment Tools and Documentation	7. **Identify suicide screening and assessment tools and associate documentation templates.** Identify a centralized set of screening and assessment tools should fit the various levels of care and clinical and cultural needs of the Case D stakeholders. 8. **Create a system for screening and assessment tools / documentation templates to be accessed and used by Case D staff.** Consistent use of screening tools require easy access by all staff, along with potential integration into Case D's electronic health record system. 9. **Integrate culture and diversity into screening options.** 10. **Develop a policy around screening and assessment** that includes operationalization of various levels of risk.

Suicide Prevention and Management Policy for Outpatient Services

SCREENING

As a minimum baseline, all clients will receive routine screening at initial intake and annually thereafter. Clients presenting with any elevation in risk receive screening at every clinical visit while the elevation persists. Clinical staff are encouraged to re-screen clients with relevant presenting issues, including but not limited to, stressors related to their cultural identities…

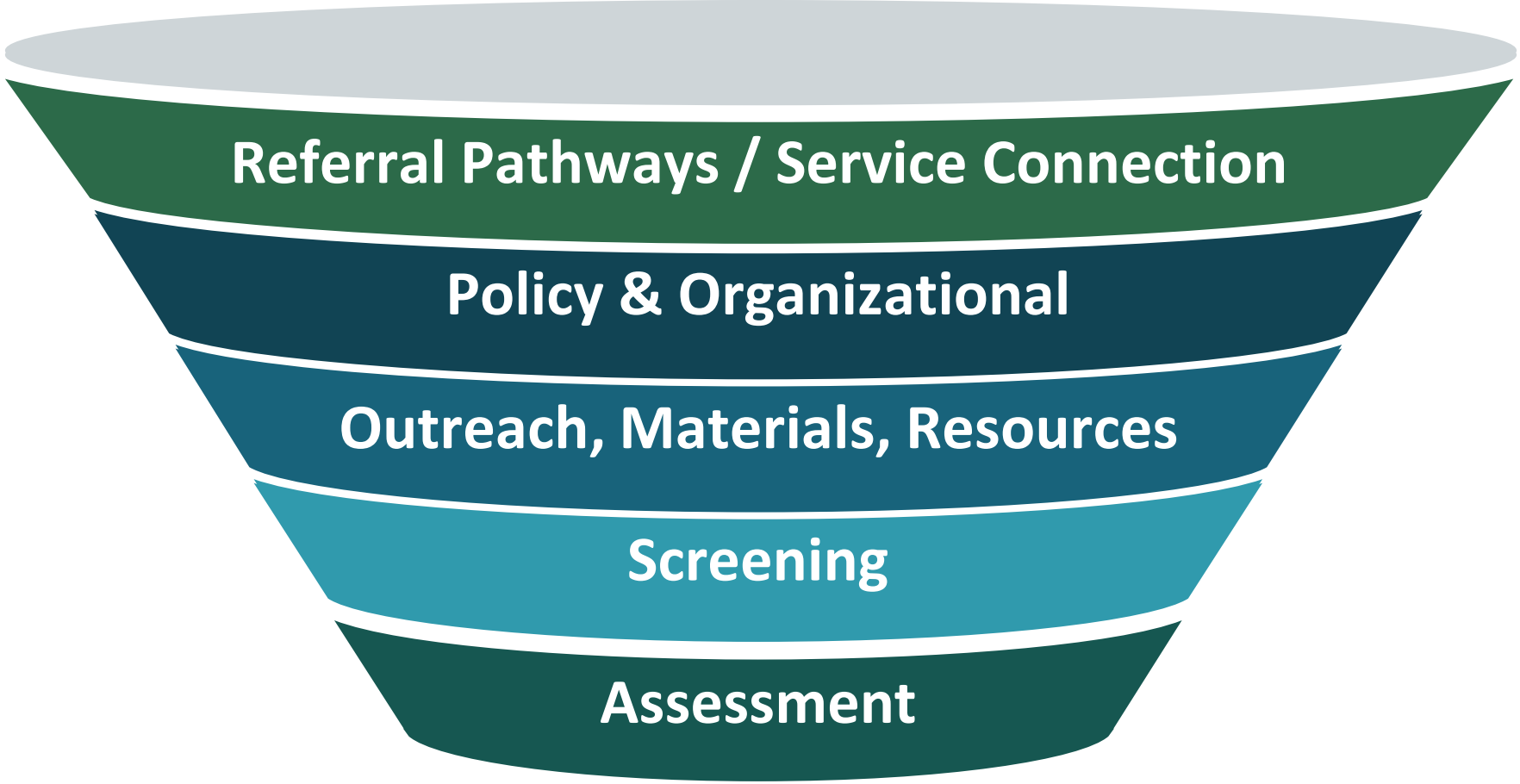
…Screening procedures will include the use of at least one evidence-based brief screener. If there is any indication of risk and the client identifies as part of a marginalized community, the screening will also include assessment of cultural variations in expression of risk (including…

SP Clinical Guidelines

The following clinical guidelines do not represent a comprehensive guide for suicide practice, but instead supplement and augment the content specified in its companion suicide prevention policy.

Screening

- When using a questionnaire or measure in screening procedures, staff may choose from a list of evidence-based suicide screeners. Recommended instruments are listed below; upon staff discretion, other evidence-based tools may also be used…


Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources
Screening
Assessment


I'M GONNA NEED MORE SPECIFIC FEEDBACK ON MY FORMATIVE ASSESSMENTS.
BAD DOG

Assessment

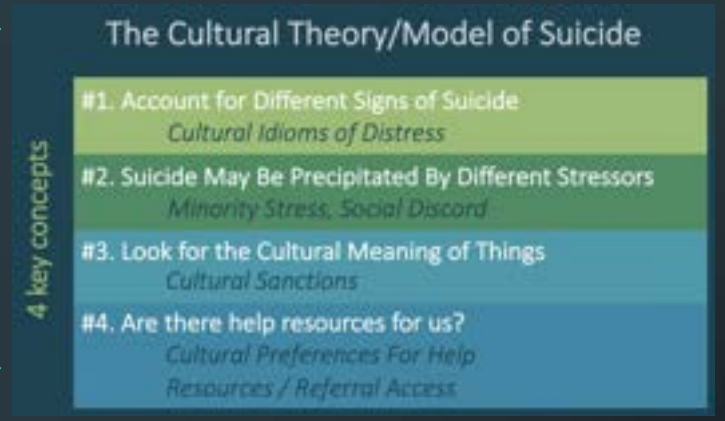
Common Struggles

- The wild west of thorough assessment
- Not fully documenting one's rationale for the assessment
- Neglecting to account for cultural meanings & risk & protective factors

Critical Components

- Attention to static & dynamic (clinical & risk management) factors, including cultural factors
- Options for evidence-based measures
- Documentation templates (culturally infused, & includes prompts for what was/wasn't there & what wasn't assessed)

SP201 CE COURSE: THE FRAMEWORK



Suicide Risk

Static

- Historical
  - Long-term risk
  - Lower Tx Focus
  - Makes others more concerning

Dynamic

- Clinical
  - Changing but not quickly
  - Highest Tx Focus
- Risk Management
  - Rapid Fluctuation
  - If/then statements
  - Tx Planning
  - Imminence

Suicide Prevention 201:

Advancing Suicide Prevention & Management for Diverse Clientele

CommunityConnections
Psychological Associates, Inc.

Comprehensive Suicide Assessment
The individual listed above was assessed for risk of danger to self by the assessing clinician using a conceptualization method that has been empirically demonstrated to improve consideration and communication of key risk factors.

Formal psychometric instruments that are empirically-validated to screen for suicide risk or assess for risk and protective factors also exist. The individual was administered the following screening instrument(s) _____, and the following formal risk/protective factor instruments: CARS. Formal assessments indicated: [summarize CARS here]

Following this structured gathering of information, the clinician determined this person's overall risk to be **MODERATE to HIGH**. Risk factors endorsed or possibly endorsed by the individual were…

STATIC RISK FACTORS:
[Psychiatric History, Previous Attempts, Possible Substance Abuse History, Minority stress]

DYNAMIC RISK FACTORS:
[Current Psychiatric Issues, Potential Current Substance Use, Current Suicidal Ideation, Lethality of Method, Acute Stressors, Hopelessness, Impulsivity, Possible Poor Reasons for Living, Lack of Personal Support, Minority stress, Ongoing Stress (academic)]


Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources
Screening
Assessment
Safety Planning

Safety Planning

Common Struggles

- Wild west of safety planning (different training, no evidence of what is done, whether evidence-based standards are used)
- Lack of inclusion of cultural considerations
- Many lack training in means restriction counseling

Critical Components

- Safety plan template and training
- Youth version
- Cultural infusion
- EHR integration
- Safety plan apps as resources (posted to the internal resources site)

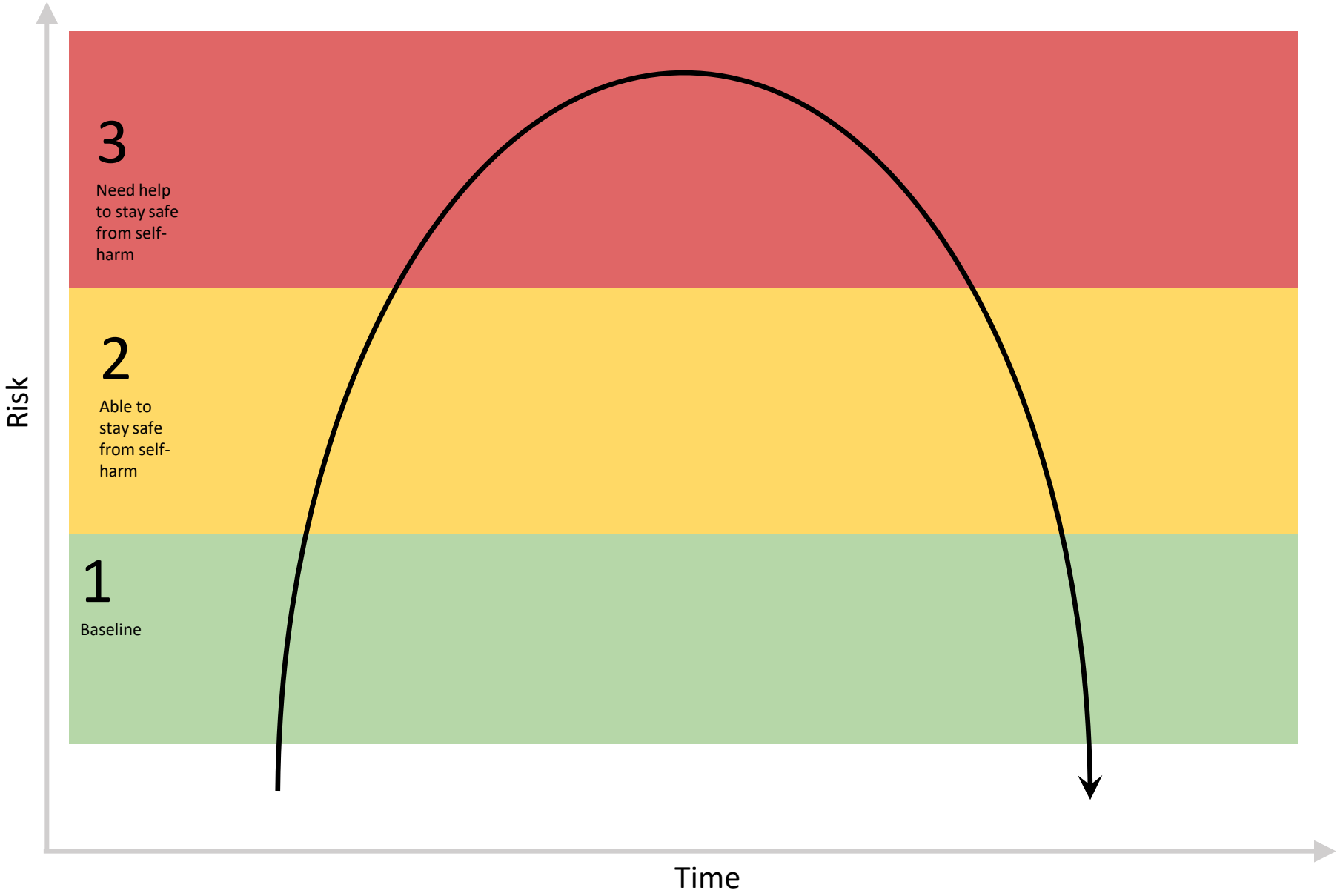
SAFETY PLAN

(Borges et al., 2010; Bryan et al., 2017; Stanley & Brown, 2009; Miller et al., 2017)

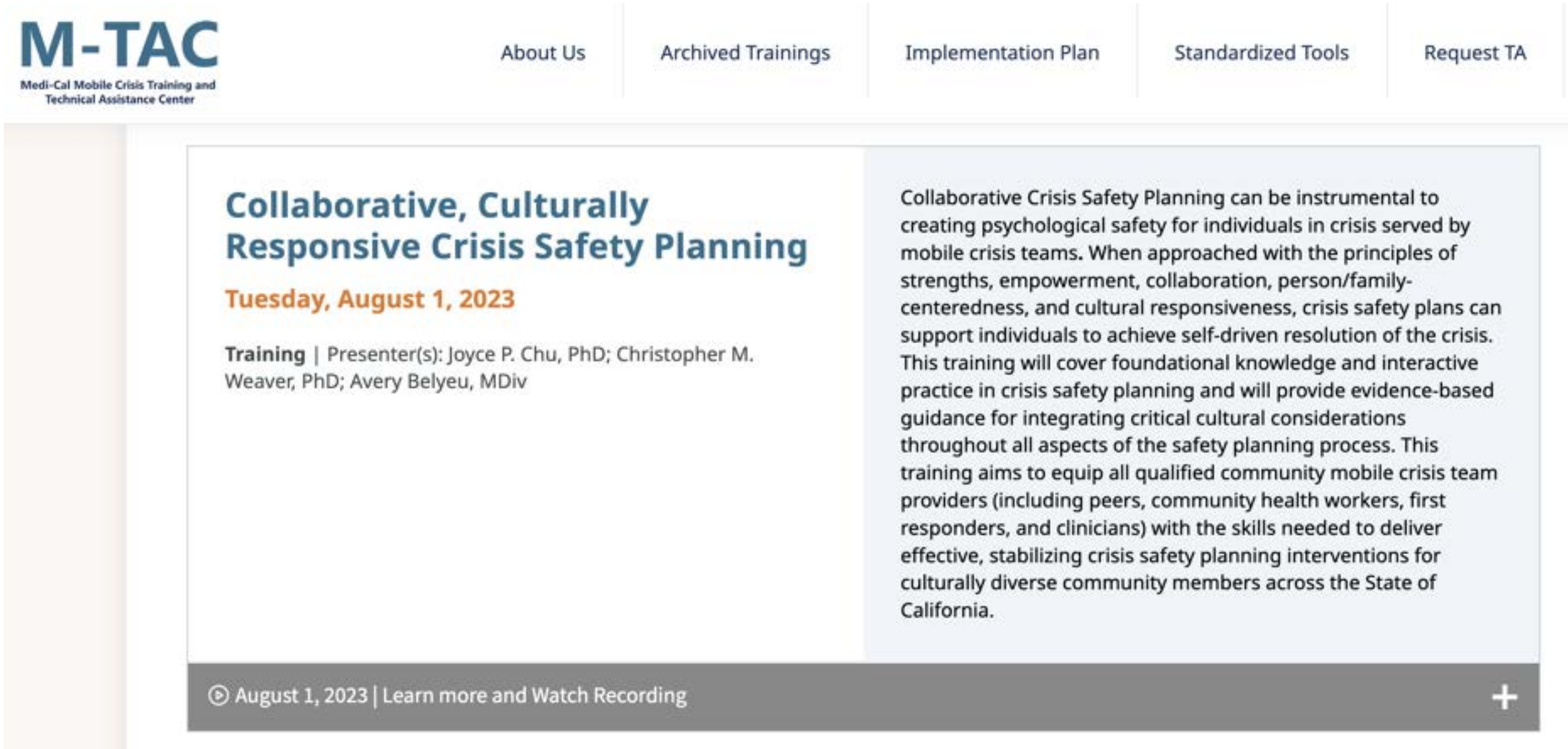
Warning Signs (Minority Stress, Idioms of Distress, Social Discord, Cultural Sanctions)	**Coping Strategies** (Idioms of Distress – Culturally congruent ways of expressing & coping)
Social Contacts & Settings That Provide Distraction (Idioms of Distress, Culturally responsive sources of help)	**People I Can Ask For Help** (Idioms of Distress, Culturally responsive sources of help)
Professionals I Can Contact During a Crisis (Culturally responsive sources of help)	**Making the Environment Safe (including Reducing Access to Lethal Means)** (Idioms of Distress-culturally preferred suicide means)
Reasons for Living (Cultural Sanctions-Cultural meaning of life events, etc.)	

Note: Noted in red are potential categories of culture & diversity factors (e.g., from the Cultural Theory and Model of Suicide or others) that may affect the relevant safety plan components. The lists provided may not exhaustive or all-inclusive.

Communication about safety



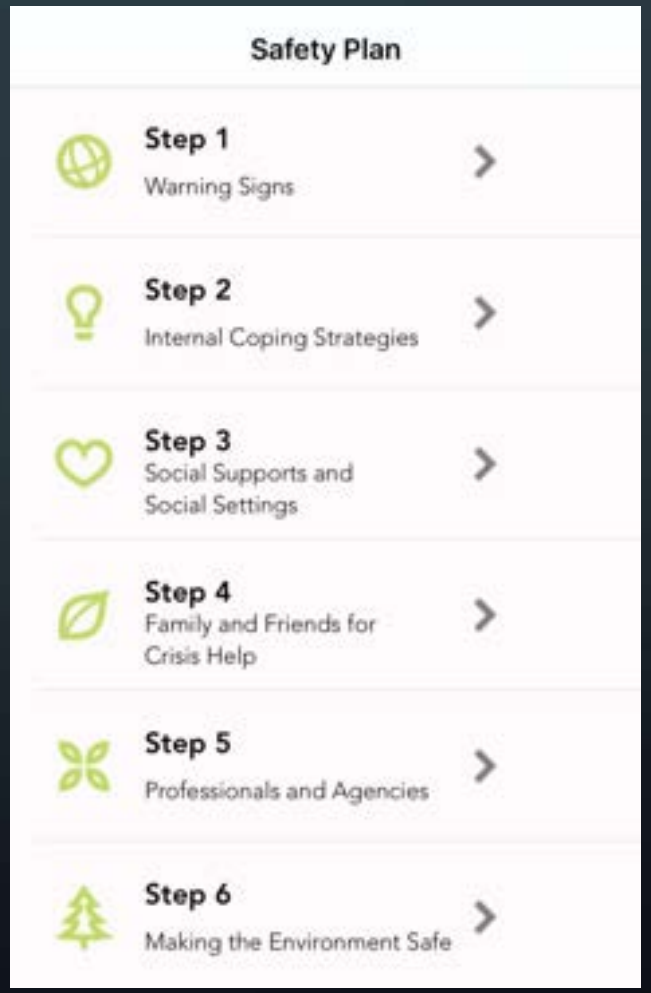
https://camobilecrisis.org/archived-required-trainings/



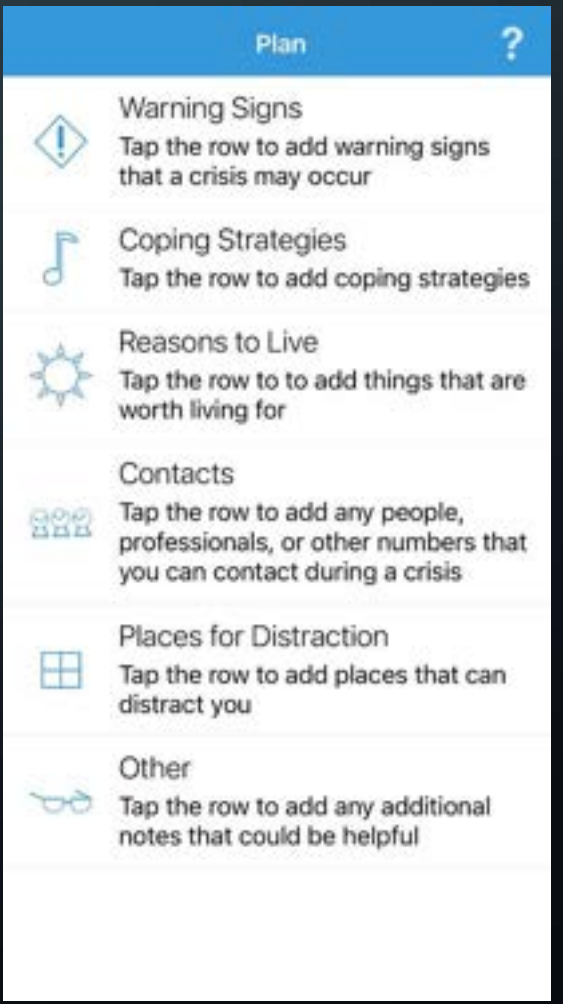
The Safety Plan: *Technological Tools*

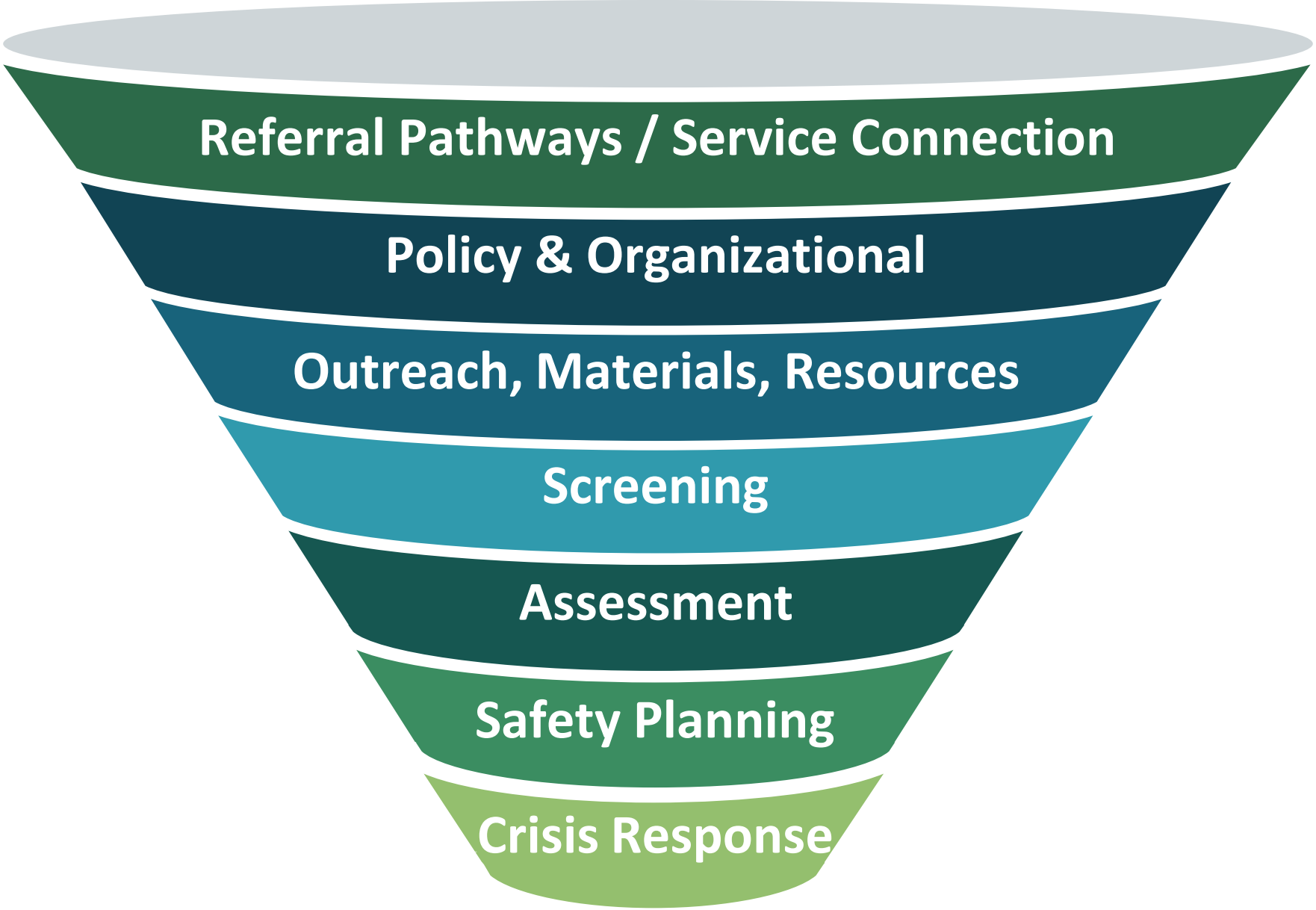
Be Safe

The Stanley-Brown Safety Plan



Safety Plan




Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources
Screening
Assessment
Safety Planning
Crisis Response

Crisis Response

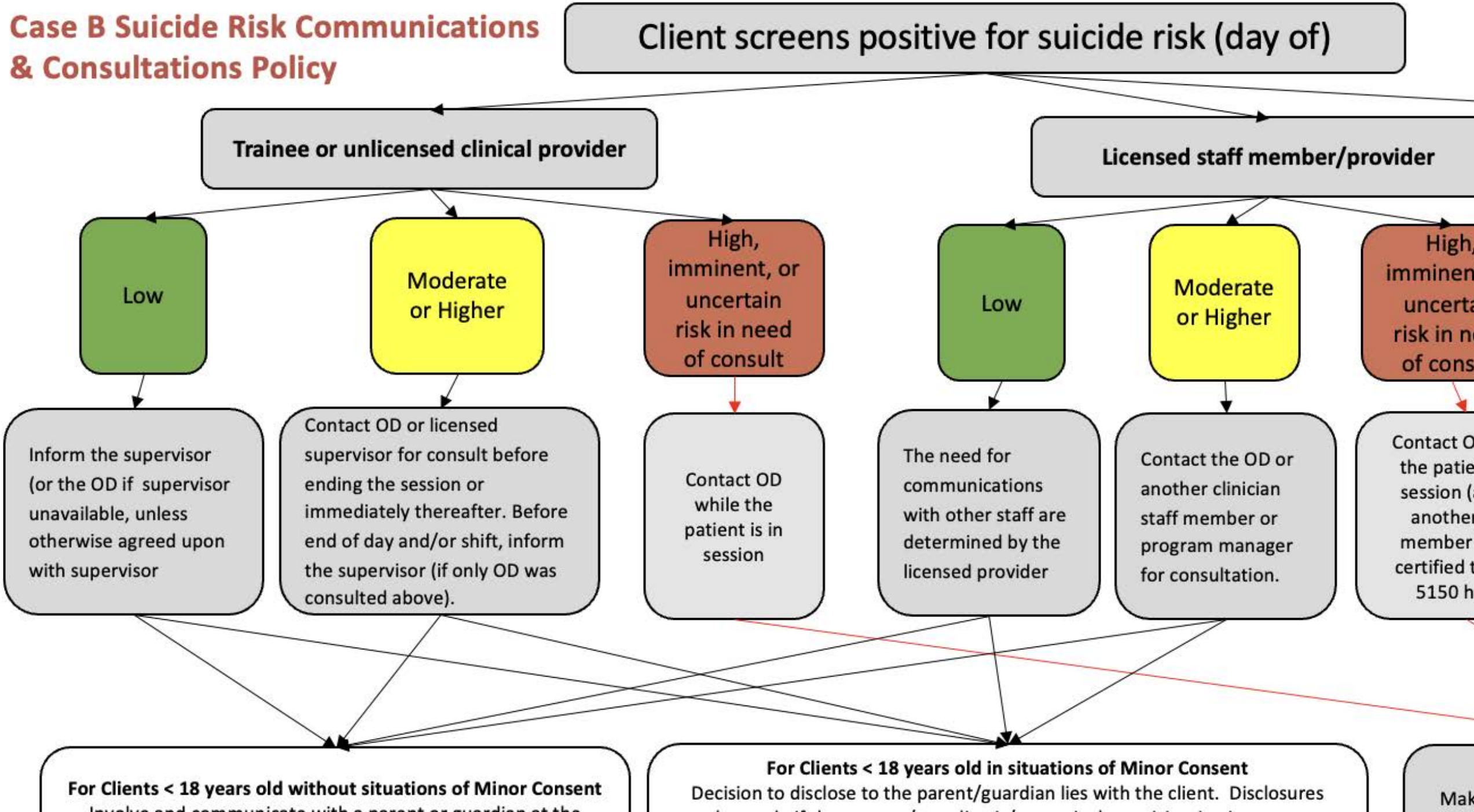
Common Struggles

- Unresponsive, unclear, or complicated on-call system

Critical Components

- Workflow for 72 hour holds
- System for 5150 certification for providers & staff
- On-call system

Case B Suicide Risk Communications & Consultations Policy



Crisis Response

Common Struggles

- Unresponsive, unclear, or complicated on-call system
- Safety concerns by staff

Critical Components

- Workflow for 72 hour holds
- System for 5150 certification for providers & staff
- On-call system
- Security officers or system
- Transportation system

Different options for on-call and safety from Cases A-D

Safety

- Panic button at front desk
- Security officer available on-call
- Policy to have two people waiting in 5150 / 5585 situations at all times
- 911 (CIT) as backup

On-call

- Rotating On-Duty Officer
- Inpatient providers and psychiatrist as on-call
- Chain of command (i.e., Psychiatrist → Supervising behavioral health clinician → Supervising senior manager → Admin on-call)
- Combination of virtual & in-person across clinics to cover a multi-clinic system
- 988 and 911 as back-up

Note: Differentiate processes for licensed vs. unlicensed; 5150-certified vs. not certified

Crisis Response

Common Struggles

- Unresponsive, unclear, or complicated on-call system
- Safety concerns by staff
- Growing pains around mobile crisis & law enforcement
- Concerns about cultural bias & traumatization of cultural groups

Critical Components

- Workflow for 72 hour holds
- System for 5150 certification for providers & staff
- On-call system
- Security officers or system
- Transportation system
- Clarity around procedures between mobile crisis & law enforcement
- DEI training and procedures during crisis response

Crisis Response

Common Struggles

- Unresponsive, unclear, or complicated on-call system
- Safety concerns by staff
- Growing pains around mobile crisis & law enforcement
- Concerns about cultural bias & traumatization of cultural groups
- Organization's response & support for staff after a suicide loss

Critical Components

- Workflow for 72 hour holds
- System for 5150 certification for providers & staff
- On-call system
- Security officers or system
- Transportation system
- Clarity around procedures between mobile crisis & law enforcement
- DEI training and procedures during crisis response
- SOPs for organization's postvention response

Case C

Standard Operating Procedures & Resources for Postvention

CRITICAL INCIDENT

RESPONSE AND DEBRIEFING

Critical incidents can happen anywhere at any time.They are often unplanned, sudden and can be traumatic. They can lead to immediate and ongoing stress. People like us that work in the community health field are particularly susceptible to exposure to such events in the course of our work. Some common examples of such critical incidents

- The death of a client or coworker, including by suicide
- Encounters with clients in crisis at program sites or in the community
- Witnessing or being the victim of violence, verbal threats, or aggressive behavior
- Participating in a difficult 5150 hospitalization
- Witnessing law enforcement forcibly restraining a client
- Speaking with angry family members

For more information about Critical Incident Stress, including common causes, signs, and tips for managing - click below to access the CISM Brochure

Critical Incident Stress Management Brochure

ABOUT OUR SERVICES

Your Options

Your Manager/Director

Contact your manager or director with the expectation that they will support you immediately to the best of their ability and assist you to connect to additional resources.

Critical Incident Stress Management Team (CISMT)

CISMT is made up of [redacted] employees trained in Critical Incident Support and Debriefing.

- Call Quality Improvement at [redacted]
- Email Quality Improvement at [redacted]@ntummh.org

Concern EAP

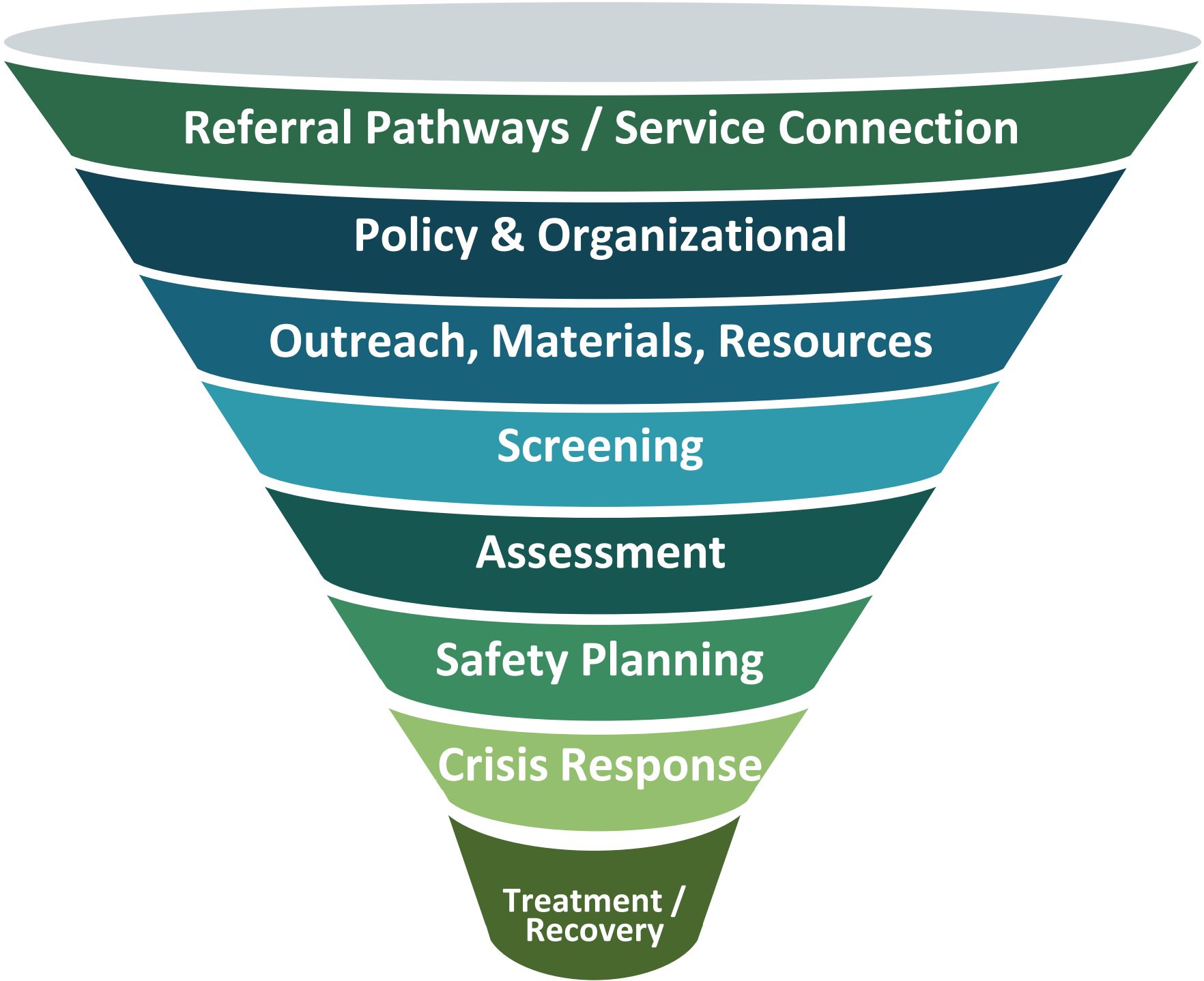
You can call our free Employee Assistance Program at (800)344-4222.

Click the buttons below for additional resources and support:

Concern EAP Brochure

Managing After a Traumatic Event

Dealing with Grief, Loss, Trauma & Change


Referral Pathways / Service Connection
Policy & Organizational
Outreach, Materials, Resources
Screening
Assessment
Safety Planning
Crisis Response
Treatment / Recovery

Common Struggles

- Few providers trained to offer evidence-based treatments
- Lack of attention to cultural factors in treatment planning and intervention

Critical Components

- Training in culturally-infused evidence-based treatments for suicide
- Providers trained to provide treatment, adapted for the complex context of public behavioral health
- Supervision and/or consultation groups

Common Struggles

- Few providers trained to offer evidence-based treatments
- Lack of attention to cultural factors in treatment planning and intervention
- Lack of resources to actually offer treatments and therapy

Critical Components

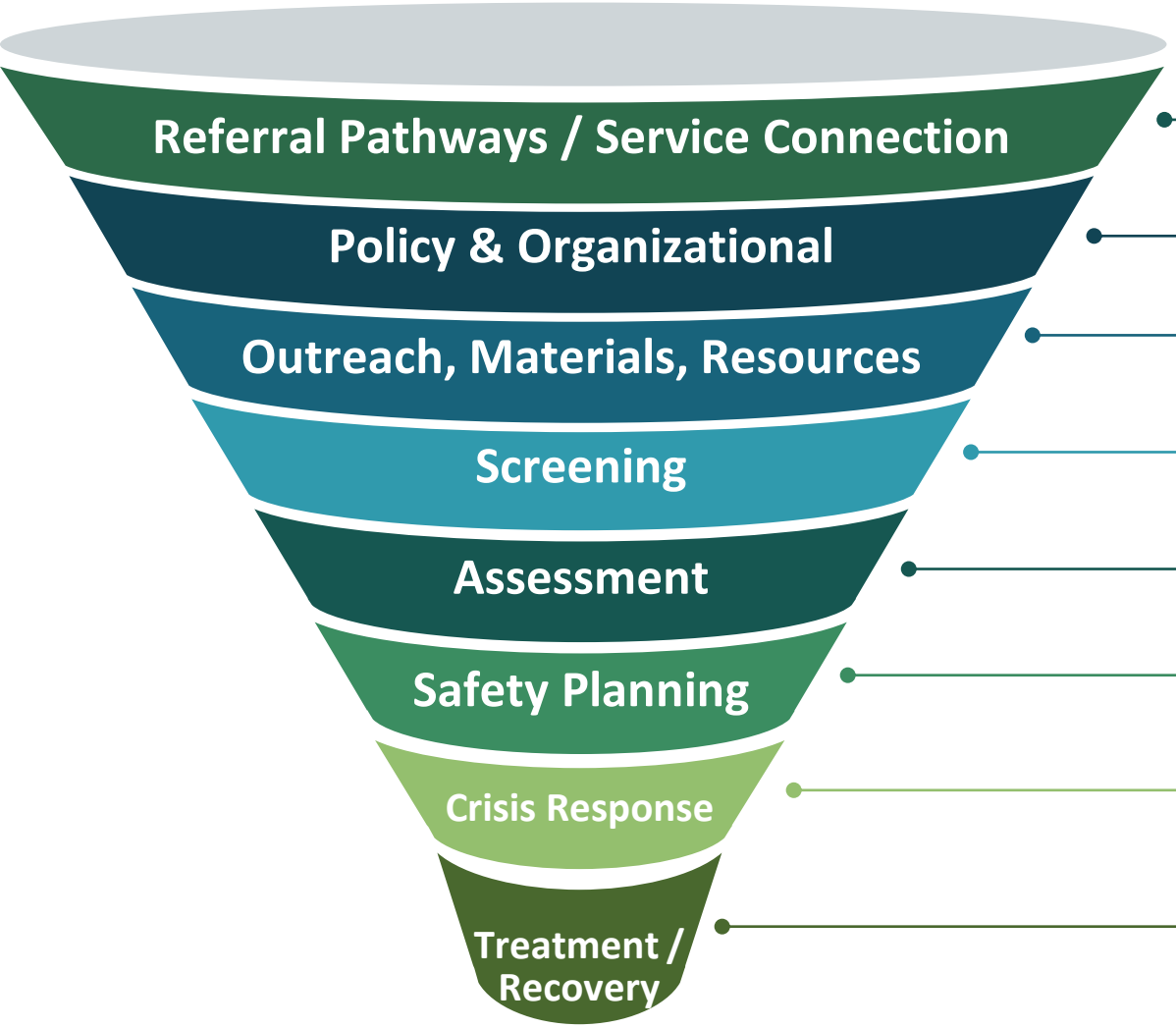
- Training in culturally-infused evidence-based treatments for suicide
- Providers trained to provide treatment, adapted for the complex context of public behavioral health
- Supervision and/or consultation groups
- Time and resources to deliver longer term treatment

Evidence-Based Interventions

- **Attempted Suicide Short Intervention Program (ASSIP):** For people who had an attempt (e.g., in the hospital post-attempt, 4-7 days of a stay) *(Gysin-Maillart, Schwab, Soravia, Megert, & Michel, 2016)*
- **The Collaborative Assessment and Management of Suicidality (CAMS)** *(Jobes, http://cms-care.com)*
- **The Zero Suicide Model** *(Brodsky, Spruch-Feiner, & Stanley, 2018)*
- **CBT for Suicide** *(Brown & Jager-Hyman, 2014; Beck as well)*

- **Other Treatments:** Dialectical Behavior Therapy (DBT), Voice Therapy for self destructive behavior, CBT and hot cognitions, Emotion-focused therapy, Self-compassion

Culturally Infused Framework for Downstream Suicide Prevention Work



- Attuned to help preferences, communication styles, stigma, language needs
- DEI Suicide Prevention policies and statements – DEI leadership
- Compendium of Cultural Materials for clinicians and community
- Cultural idioms of distress in screening tools
- Culturally attuned static/dynamic approach/paperwork
- Cultural Model factors
- Attention to cultural bias and traumatization
- Cultural Model factors in case conceptualizations & treatment planning

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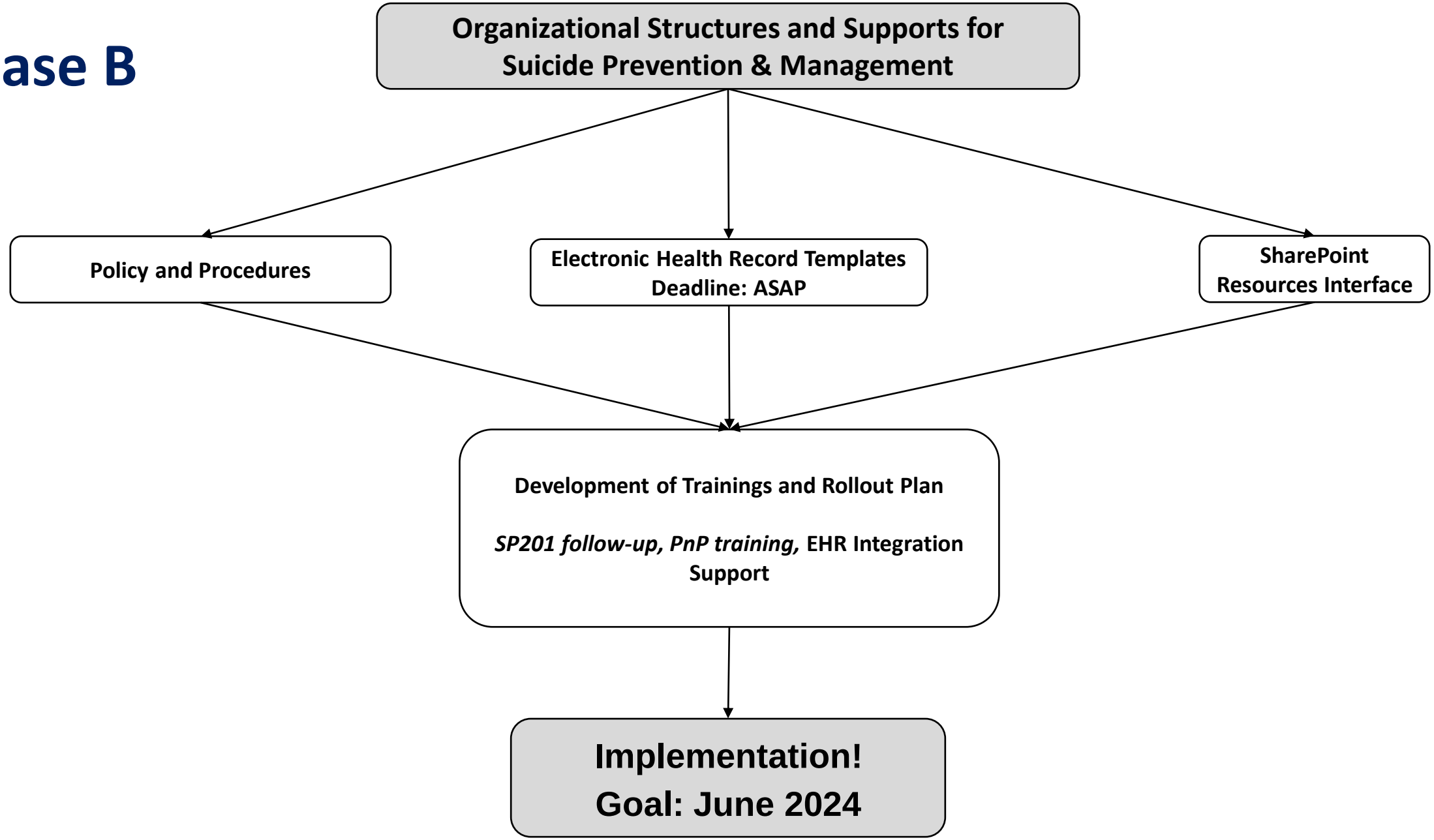
Planning for Change

“Without leaps of imagination or dreaming, we lose the excitement of possibilities. Dreaming, after all is a form of planning.” – Gloria Steinem

Case B


Organizational Structures and Supports for Suicide Prevention & Management
Policy and Procedures
Electronic Health Record Templates
Deadline: ASAP
SharePoint Resources Interface
Development of Trainings and Rollout Plan
SP201 follow-up, PnP training, EHR Integration Support
Implementation!
Goal: June 2024

Developmental vs. Transitional vs. Transformational change

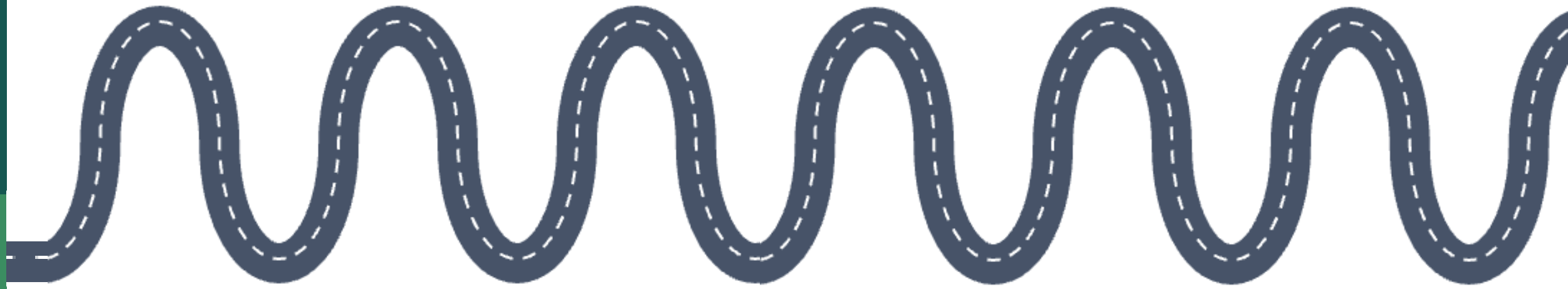
Developmental vs. Transitional vs. Transformational change

Piecemeal vs. Holistic Approach to Change Management

Kotter's Process for Developmental Change

https://www.kotterinc.com/methodology/8-steps/

Change Steps / Process



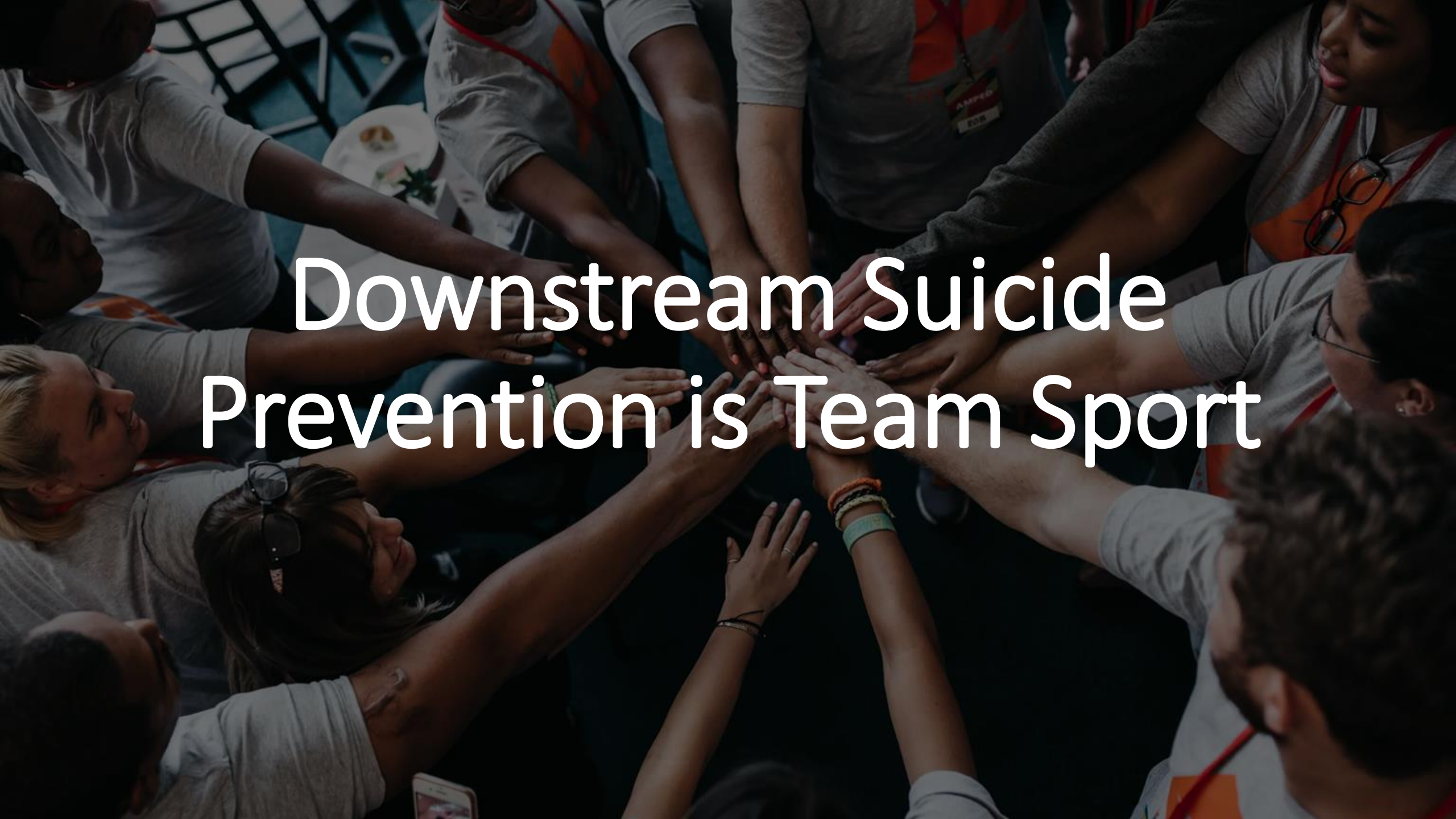
1. Downstream mapping of clinical systems & workflows
2. Structural supports (funding, strategic plan)
3. Identify change agent
4. Build downstream workgroup or coalition
5. Identify cultural framework, diversity strengths / gaps
6. Needs assessment (identify gaps & strengths)
7. Develop critical components
8. Data & Evaluation
9. Develop training system for critical components
10. Pilot test
11. Implement, iterate, & communicate

Change agent leader(s)

Potential options

- External consultant
- Internal Leadership
- Designated SP coordinator / change leader

Along with a downstream SP workgroup or coalition


Downstream Suicide
Prevention is Team Sport

Suicide Prevention's Planning Work
Questions to Workshop Your Programs

Downstream mapping of clinical systems & workflows

- What are major components of your downstream system? Follow the pathway of multiple client case studies – what systems of care would they encounter?

Structural supports (funding, strategic plan)

- Structural supports: Is downstream suicide prevention work a core part of your strategic plan?
- What funding streams might be able to support this work?

Identify change agent

- Who is your best change agent leader and coalition/workgroup?
- Does your system already have a downstream suicide prevention coordinator? (perhaps in QI/QA?)

Build downstream workgroup or coalition

- Do you have clinical system stakeholders in your suicide prevention coalition?
- Who could be members of your downstream workgroup or coalition?
- Who might represent the needs of your culturally diverse stakeholders?

The Downstream SP Coalition / Workgroup's Work
Questions to Workshop Your Programs (Part 1)

Identify cultural framework, diversity strengths / gaps

- Do you have a cultural framework and relevant stakeholders to guide infusion of culture and diversity in your downstream work and training?
- Which downstream efforts are already culturally infused? Where are the gaps?

Needs assessment (identify gaps & strengths)

- What workflows, policies/procedures, and resources are already available? Where are there gaps?

Develop critical components

- What is the best plan to address your downstream gaps while leveraging the system's strengths? Will you take a developmental vs. transitional (or even transformational) approach? Holistic or piecemeal? Are there any low-hanging fruit to encourage buy-in and improve the system in the short-term?

The Downstream SP Coalition / Workgroup's Work
Questions to Workshop Your Programs (Part 2)

Data & Evaluation

- Do you have a needs assessment / evaluation plan to inform downstream efforts, and to measure change over time?

Develop training system for newly developed critical components

- What resources do you have to implement a sustainable training plan?
- Are there internal or external experts that you can call upon to develop a training system?

Pilot test

Implement, iterate, and communicate

Discussion and Q/A

- One thing you learned
- Next steps for you, or your group or organization?
- Remaining questions

Improving Clinical Systems of Care: A Focus on Downstream Suicide Prevention

If you'd like to meet with Drs. Chu and Weaver for a (free) consultation meeting about downstream suicide prevention in your system, enter your name here (or just email them at community.connections.psych@gmail.com): https://forms.gle/JWppGjofe32FwRM96

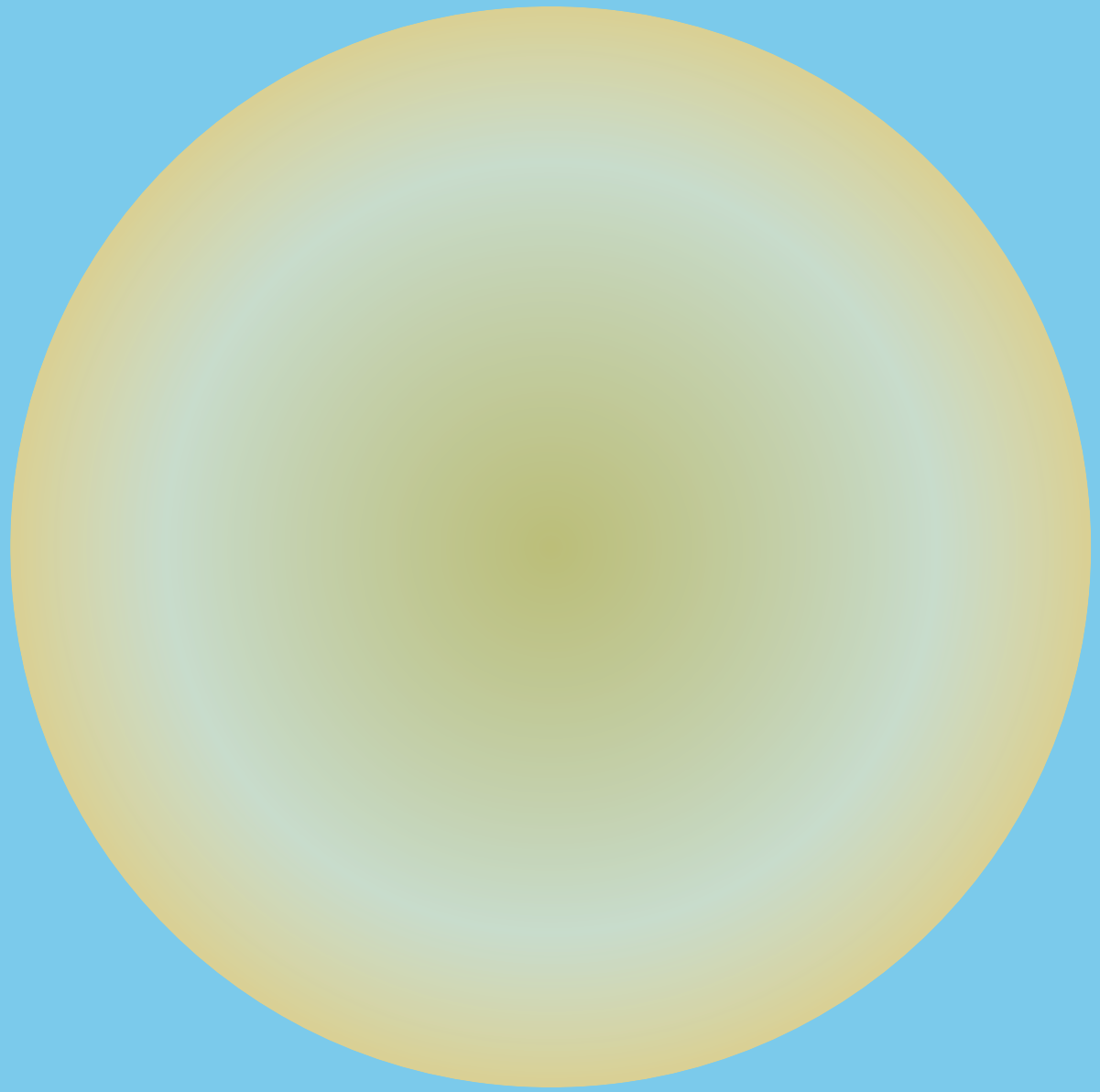
Joyce P. Chu, Ph.D.
joycepchu@gmail.com
Clinical Psychologist, PSY 23059
Director, CCPA
Professor, Palo Alto University

Christopher M. Weaver, Ph.D.
chrisweaver.phd@gmail.com
Clinical Psychologist, PSY 24133
Director, CCPA
Professor, Palo Alto University

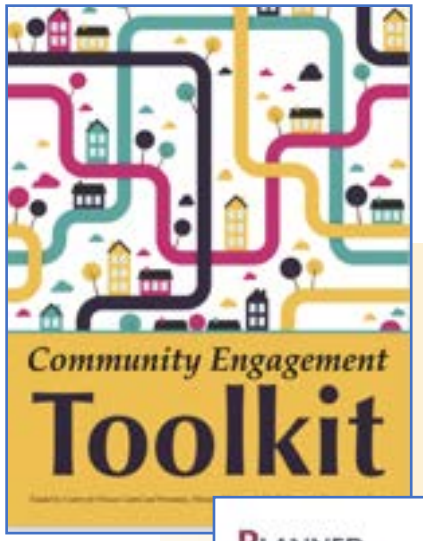
https://communityconnections.net/consultation/

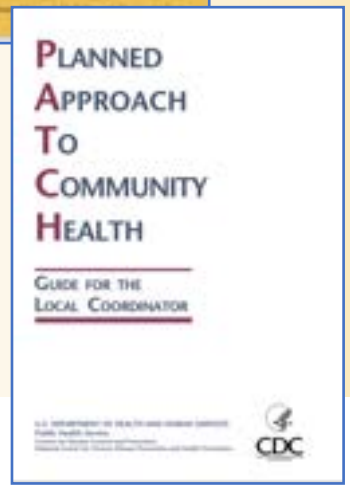
CommunityConnections
Psychological Associates, Inc.

Q&A

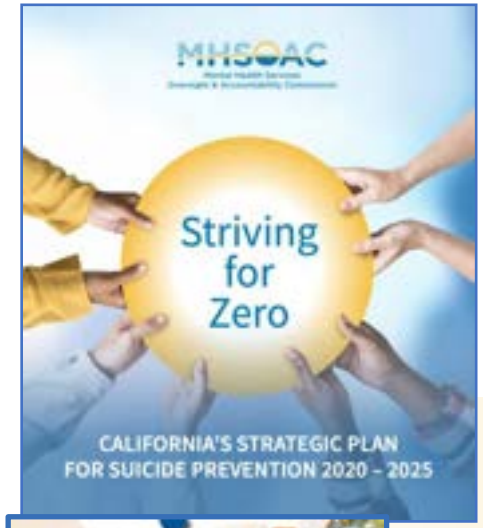


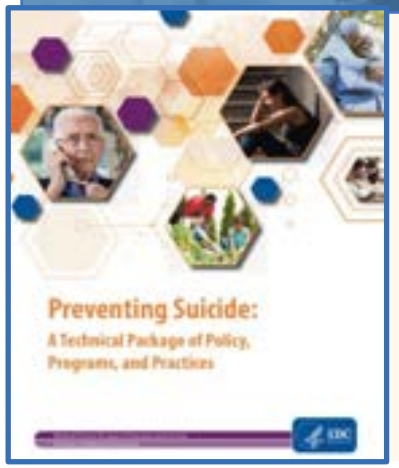
Guiding Resources

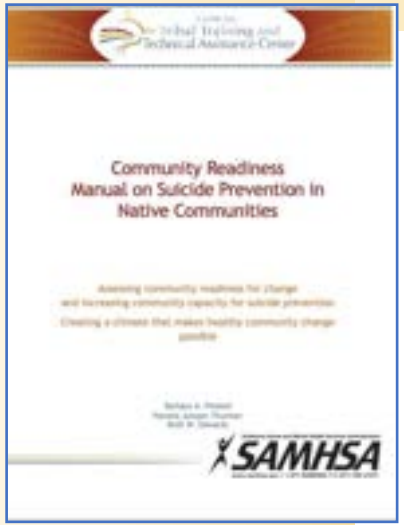




Community-Led Suicide Prevention







Upcoming Collaborative Module

Wednesday, April 17, 2024
10:00 AM – 12:00 PM, PT

Register in advance for this meeting:
https://us06web.zoom.us/webinar/register/WN_Zxq9fUQjR3-0cvdz-P4-jw

Striving for Zero Learning Collaborative Resource Page

https://mhsoac.ca.gov/initiatives/suicide-prevention/collaborative/

Thank you for your time

For more information please contact: jana@yoursocialmarketer.com

Support for people at risk for suicide or those supporting people at risk is available by calling the **National Suicide Prevention Lifeline** 1-800-273-TALK (8255) or 988

Apoyo y ayuda para personas a riesgo de suicidarse o para las personas que los apoyan está disponible llamando al **National Suicide Prevention Lifeline** **1-**888-682-9454 o 988