Translating Suicide Research to Practice

April 27, 2018

Injury Control Research Center
for Suicide Prevention

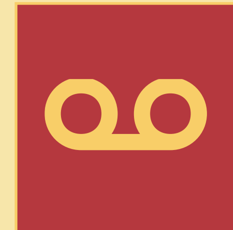
UNIVERSITY of ROCHESTER
MEDICAL CENTER

Technical Tips

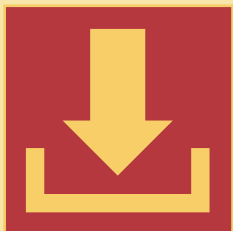
For audio, **(855) 257-8350**

Use the chat (bottom left) to ask questions at any time

Please mute yourself when you're not talking



This is being recorded



Download resources in the File Share pod (above the slides)

Brett Harris, NYS Office of Mental Health

Topic

- Substance use is the second most common risk factor for suicide and present at the time of a significant number of suicides

Audience

- Outpatient substance use disorder treatment providers

Process

- Conducted a learning collaborative with six substance use disorder treatment provider organizations in two counties in Western NY (June 2017-May 2017). One upper level administrator and one clinical supervisor per organization.

Brett Harris, NYS Office of Mental Health

Results/reaction

- Participants found the learning collaborative useful and made them more prepared to implement Zero Suicide. They gained knowledge in all seven domains of the model.

Challenge(s)

- Competing demands, changes in leadership and gaining leadership buy-in, no dedicated staff time for technical assistance.

Success(es)

- Participants believe they have the tools and knowledge to implement Zero Suicide. Are following up with them on experience.

Brett Harris, NYS Office of Mental Health

Lesson(s) Learned

- Participants are at various stages of readiness for implementation, substance use disorder treatment providers treat patients at risk for suicide and should be equipped to address suicidality. Opioid crisis and suicide are connected.

Recommendation(s)

- Use evidence to support the work you are conducting and collect data, even if it's just process data, to document your outcomes and obtain support for continued implementation moving forward.

Injury Prevention Center, Connecticut Children's Medical Center

Topic

- Evaluation of Lethal Means Restriction (LMR) in Emergency Department (ED)

Audience

•Patients ages 10 - 18 years and caregivers that have presented to ED with behavioral health concerns

Process

- Survey to see if restrictions have been made to access lethal means
- Asking high-risk youth about their current access to lethal means in order to improve LMR counseling

Injury Prevention Center, Connecticut Children's Medical Center

Results/reaction

- 78 patients and caregivers in the ED
- Phone interviews of 13 caregivers/adolescent patients
- Phone interviews confirmed low rates of effective counseling

Challenge

- Translational strategies are underdeveloped and have not been systematically evaluated
- Progress may depend less on generating new resources for translational efforts, and more on leveraging existing resources carefully
- To create LMR specific policy and procedures

Success

- New processes developed to ensure patient/caregiver connection is made after ED visit

Injury Prevention Center, Connecticut Children's Medical Center

Lesson(s) Learned

- Coordinating change efforts, targeting all behavioral health patients, experimenting with strategies, and focusing on greater use of multiple department communication
- New process development with Care Coordinators will follow up by phone after the ED visit offering a “warm hand off” with additional behavioral health services available to them

Recommendation(s)

- New translation strategies within organization may improve outcomes and prove sustainable without adding administrative costs

Tom Delaney, Vermont Zero Suicide Pilot Project

Topic

- A pilot project implementing Zero Suicide in community mental health provider settings offers the opportunity to learn how to better support other mental health agencies and care settings in adopting aspects of Zero Suicide, as well as to learn how to better use data to guide the implementation in the currently participating agencies.
- With regard to workforce training, the agencies are implementing CAMS, CALM and new screening approaches, and making related policy and systems changes.

Audience

- Researchers and others who want to study aspects of effectively implementing workforce training-related aspects of Zero Suicide.

Process

- As we collect data (workforce surveys, interviews, training effectiveness data and client outcomes) from agencies in the process of implementing Zero Suicide, we are trying to identify the lessons (successes and challenges) that may generalize to other provider organizations and settings.

Tom Delaney, Vermont Zero Suicide Pilot Project

Results/reaction

- Our provider agencies are being encouraged to adjust their implementation of Zero Suicide based on the findings of the evaluation being conducted.
- Findings are seen as valuable for support the spread of Zero Suicide to other community mental health agencies throughout Vermont.

Challenge(s)

- We have struggled with establishing systems that allow for reporting on client outcome measures associated with the implementation of Zero Suicide activities in the participating agencies.
- Participation in the Zero Suicide Workforce Surveys has been inconsistent across different agencies and at different points in time.

Success(es)

- High degree of “buy-in” by leaders and clinicians around the need to collect data in the context of the pilot implementation of Zero Suicide.
- Have identified areas where we need to ask (and answer) more specific questions in order to better support implementation.

Tom Delaney, Vermont Zero Suicide Pilot Project

Lesson(s) Learned

- Training on suicide prevention with the community mental health agency workforce cannot be treated as "one and done", and this is particularly true in the context of high turnover
- Implementing very broad-based workforce training on basic suicide-prevention skills can be challenging, even in smaller organizations; while some training can be truly universal (e.g., gatekeeper) there is a need for good "fit" between the training content and the learner's role in the organizations.

Recommendation(s)

- Regarding our effort to translate practice into new research, we recommend using an Implementation Science lens to address emerging questions/topics around Zero Suicide implementation in new settings such as community mental health agencies. Example important areas for study include 1) how to better support the improvement of workforce training, development and retention, 2) identifying strategies for improving team and inter-agency functioning around providing effective suicide care, and 3) identifying and reducing barriers to engaging family members and others in supporting clients' safety and recovery.

Rhode Island Department of Health

Youth Suicide Prevention Initiative (SPI)

- SPI is an innovative and coordinated youth suicide prevention referral system that links public elementary, middle and high schools with mental health services. The program diverts at-risk students who express suicidal ideation and/or non-suicidal self-harm from unnecessary Emergency Department (ED) visits by connecting the student to local mental health services with follow-up support.

Audience

- Program specific training for school crisis team members to utilize the CSSRS tool in consultation with the Kids'Link Hotline to direct assessments in community mental health centers, when ED use is not required.

Process

- School staff receive training in QPR. School Crisis Team members receive training in CSSRS screening, consult with Kids'Link staff for access to same day/next day assessments for students at risk, but not needing medical clearance from and ED. Follow up consultation at 2 week, one month, and one year by Kids'Link staff, and referral information back to school with parental permission.

Rhode Island Department of Health

Results/reaction

- Over three years, 328 students from elementary, middle and high schools participating in SPI were identified as needing mental health services by a School Support Team member. The referral process to Kids' Link was completed on behalf of 258 students for a 78.7% referral rate

Challenge(s)

- SPI is a response to the challenges that exist in connecting children and adolescents who have behavioral and mental health problems to mental health services beyond those available in the school. Evaluations of suicide prevention screening programs that include referral of at-risk students to mental health services with follow-up are limited, and have not been done on a national scale. School Crisis Team members in four SPI school districts shared that many parents who were receptive to having their child referred for a mental health evaluation were less open to "check-in" telephone support over one year.

Success(es)

- The Providence School District has formally adopted the SPI protocol as a stand-alone section in the district's School Emergency Preparedness Plan for the district's 39 schools and nearly 24,000 students. The district has also been able to embed 15 school based clinicians from local CMHC's that can now provide the assessments in the school, including follow up appointments.

Rhode Island Department of Health

Lesson(s) Learned

- Administrative "buy-in" is essential. If the school administration does not publicly get behind the staff in this process, they will be hesitant to engage in a new process due to perceive personal liability concerns. Don't get too big too fast. RI proposed 42 schools in 5 years and started with 41 schools in the first month. Build capacity and engage key partners to maintain sustainability.

Recommendation(s)

- Be thoughtful, and continuously engage your stakeholders, provide feedback, and be willing to change course if necessary.
- You must be a constant ambassador for your work, and when some partners are funded and some are not, be ready to explain the benefit for all.