MIDD Briefing Paper

King County Zero Suicide Initiative
BP 26 Suicide Attempters Support Group and Post Discharge Follow Up
BP 140 Suicide Safe Emergency Departments
BP 78 Lethal Means Provider Training
BP 102 Transformation to a Zero Suicide Approach in KC Behavioral Health System

Existing MIDD Program/Strategy Review □ MIDD I Strategy Number _____ (Attach MIDD I pages)
New Concept □ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: The programmatic approach of Zero Suicide is based on the understanding that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary. The challenge and implementation of a Zero Suicide Initiative cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and to close the gaps.

The following seven elements of suicide care for health and behavioral systems would be adopted through training and technical assistance:

1. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
2. Train – Develop a competent, confident, and caring workforce. Train all staff commensurate with their potential role in suicide prevention.
3. Identify – Systematically identify and assess (screening and assessment) suicide risk among people receiving care.
4. Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet their needs. Include collaborative safety planning and restriction of lethal means.
5. Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
6. Transition – Provide continuous contact and support, especially after acute care. Utilize peers who are in behavioral health recovery who also experience suicidal behaviors to help support those who are at-risk.
7. Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Collaborators:

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Name	Role	Organization
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The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

This concept paper integrates several suggested new concepts involving suicide prevention.
Zero Suicide[1] is the foundational belief that suicide deaths for individuals receiving services in health and behavioral health systems are preventable, thus presenting a bold and aspirational challenge of no suicides. The Zero Suicide Initiative is a comprehensive suicide prevention strategy/plan for King County. It would be a new approach for suicide prevention for the region.

Suicide is a major public health problem. In Washington State, suicide is the 8th leading cause of death overall and the 2nd leading cause of death among young people ages 15-24. In King County, there are roughly 250 deaths by suicide every year. For every suicide, it is estimated that 25 attempts are made, some requiring expensive emergency room and hospital visits. For every suicide death, it is estimated that six friends and family members of the deceased will struggle with this particularly devastating form of grief for the rest of their lives. [2]

Despite the magnitude of this tragedy, the U.S. Surgeon General considers suicide to be one of the most preventable forms of death. To date, very little progress in reducing suicide rates has been made, in part due to the stigma that surrounds suicide, mental health and behavioral health disorders. Approaches to reducing suicide, in order to be effective, must change attitudes and behaviors in addition to systems.

Therefore, a multi-stage project where the primary care health and behavioral health care systems adopt and implement Zero Suicide through intensive training and technical support to adopt and to

[1] http://zerosuicide.sprc.org/about
[2] http://www.doh.wa.gov/Portals/1/Documents/5500/IV-SUI2013.pdf

sustain a Zero Suicide Initiative is proposed. Zero Suicide is also a specific set of strategies and tools. Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention[3].

The programmatic approach of Zero Suicide is based on the understanding that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary. The challenge and implementation of a Zero Suicide Initiative cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and to close the gaps.

The following seven elements of suicide care for health and behavioral systems would be adopted through training and technical assistance:

8. Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
9. Train – Develop a competent, confident, and caring workforce. Train all staff commensurate with their potential role in suicide prevention.
10. Identify – Systematically identify and assess (screening and assessment) suicide risk among people receiving care.
11. Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet their needs. Include collaborative safety planning and restriction of lethal means.
12. Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
13. Transition – Provide continuous contact and support, especially after acute care. Utilize peers who are in behavioral health recovery who also experience suicidal behaviors to help support those who are at-risk.
14. Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk. - See more at: http://zerosuicide.sprc.org/about#sthash.3qZWfYEm.dpuf

As contemplated in this concept paper, the Zero Suicide Initiative will be rolled out in three phases: Phase 1: King County behavioral health and health care system (DCHS and PH) and trainings/development; Phase 2: Hospital and Healthcare systems participating in SBIRT; Phase 3: Remaining Hospital, Behavioral Health and Healthcare systems.

Phase 1 (King County behavioral health and primary care health care system (DCHS and PH) includes the following: Lethal means restriction training (development and implementation); suicide attempt follow up care program when released from Emergency Department or inpatient; universal and proper implementation of suicide risk screening at Emergency Departments (coupled with brief interventions, discharge planning and follow up); and programming for families/friends who have lost someone to suicide (development and implementation). Each of these will be repeated for phase 2 and 3.

- Universal community-based suicide prevention gatekeeper trainings and suicide prevention intervention trainings, such as Applied Suicide Intervention Skills Training (ASIST[4]), Question

[3] http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf
[4] Applied Suicide Intervention Skills Training (ASIST) is for everyone 16 or older—regardless of prior experience—who wants to be able to provide suicide first aid. https://www.livingworks.net/programs/asist/

Persuade Refer (QPR[5]) and Assessing and Managing Suicide Risk (AMSR[6]) (develop training capacity within county and offer trainings on an ongoing basis quarterly)

- Develop lethal means restriction training, which will be required of all contracted primary care health and behavioral health contracted agencies. There is an opportunity to address both adult and youth suicides in King County by incorporating lethal means restriction counseling into the routine delivery of care. Lethal means restriction counseling is advising people at risk for suicide, and their friends and family, to keep firearms (and other lethal means) away from the at-risk person until the person recovers. Lethal means restriction training will be offered on an ongoing basis quarterly and developed into a train the trainer model.
- Universal screening, brief intervention and follow up for suicide risk will be implemented county-wide in Emergency Departments (ED).
- Suicide attempt survivors group and a post-discharge follow-up program will be developed for individuals after an ED or inpatient stay for a suicide attempt.
- Support services for families and friends who have lost someone to suicide will be developed and implemented. Information will be distributed through the medical examiner's office, local law enforcements and 211/crisis line, etc. The creation of a post-vention (post incident) response network and activities in the event of a suicide or other unexpected death will help respond to the immediate emotional needs of people affected by the crisis, as well as the long-term risk to vulnerable people (populations such as, schools, seniors, those in institutions) who have been exposed to the event directly or indirectly through news reports and conversations. Postvention includes providing grief counseling, working with the news media, and finding ways to memorialize those who have died by suicide without raising the risk of contagion (suicide risk associated with the knowledge of another person's suicidal behavior). Postvention is defined as: A **postvention** is an intervention conducted after a **suicide**, largely taking the form of support for the bereaved (family, friends, professionals and peers). Family and friends of the **suicide** victim may be at increased risk of **suicide** themselves.[7]

The following stages will be used within each phase:
Stage 1: Technical assistance would begin at the County level working with King County's Department of Community and Human Services and Public Health- Seattle King County to: 1) identify sources of data that can be improved and analyzed to assess, as fully as possible, the extent of suicidal behavior occurring within King County's public behavioral health care system and primary care system and, to put into place, a reporting system on suicidal behavior, and, 2) analyze provider contracts to recommend changes to incentivize Zero Suicide approaches within contracted agencies.

A summit of leaders in Health and Behavioral Healthcare in King County would be organized to present data on the County's findings, the rationale, and next steps to achieving a Zero Suicide approach. Contracted provider agencies would apply for two-year grants to assess their current readiness to implement a Zero Suicide Initiative. A first cohort of the provider agencies, who are determined to be ready based on a base-line assessment, would be recruited to begin work and would receive Zero Suicide grants.

[5] Question Persuade Refer (QPR) Three steps anyone can learn to help prevent suicide. https://www.qprinstitute.com/about-qpr
[6] Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals (competence in assessing and managing suicidal patients) http://www.sprc.org/training-institute/amsr
[7] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3315078/

Stage 2: The first cohort of contracted provider agencies will receive intensive training and technical assistance to implement a Zero Suicide Initiative. There will be a 2-day Zero Suicide learning collaborative comprised of implementation teams from each agency. During the two days, each team will develop a strategic plan for their work over the next two years and a cross-agency learning collaborative will be established. Technical assistance to each agency and many training opportunities for agency staff will be provided to the learning collaborative of participating contracted agencies over the two-year period. Each participating agency will repeat the assessment of where they stand relative to a Zero Suicide Initiative two additional times over the 2 years. There will be a graduation for agencies that are successful in shifting to a Zero Suicide Initiative.

Stage 3: A second cohort of contracted provider agencies will repeat the learning collaborative, training and technical assistance steps outlined above, Phase 2 will begin, repeating the stages in the following Phase 2 and 3 sites: hospital and healthcare systems participating in SBIRT and remaining hospital, behavioral health and healthcare systems.

Note: Four New Concepts were received related to suicide prevention, prompting the briefing paper to include a wider scope within King County for suicide prevention, incorporating the new concepts and the County Suicide Prevention Plan (2010 DRAFT) into this comprehensive approach for King County.

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

   ☒ **Crisis Diversion** ☒ **Prevention and Early Intervention**

   ☐ **Recovery and Re-entry** ☒ **System Improvements**

   Please describe the basis for the determination(s).

Crisis diversion and Prevention and Early Intervention: If more people receive education/training in suicide prevention and how to respond to suicidal individuals, that will increase the likelihood that people will receive care for suicide ideation and help sooner, therefore preventing suicide. Earlier intervention can also result in catching people in crisis before they become suicidal.

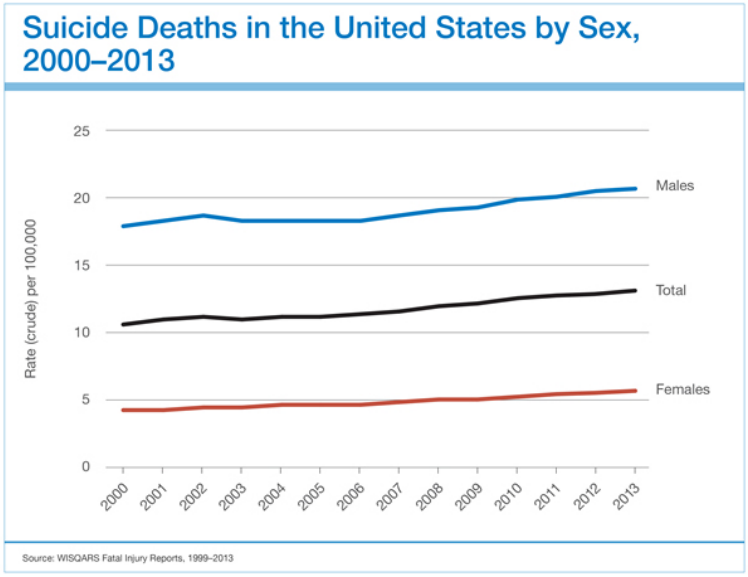
System Improvements: Providing more education to providers and community members about Zero Suicide and having a system-wide approach will help reduce stigma among those seeking behavioral health care, foster support for individuals in crisis, and bring more attention and resources to agencies that provide health and behavioral healthcare services.

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

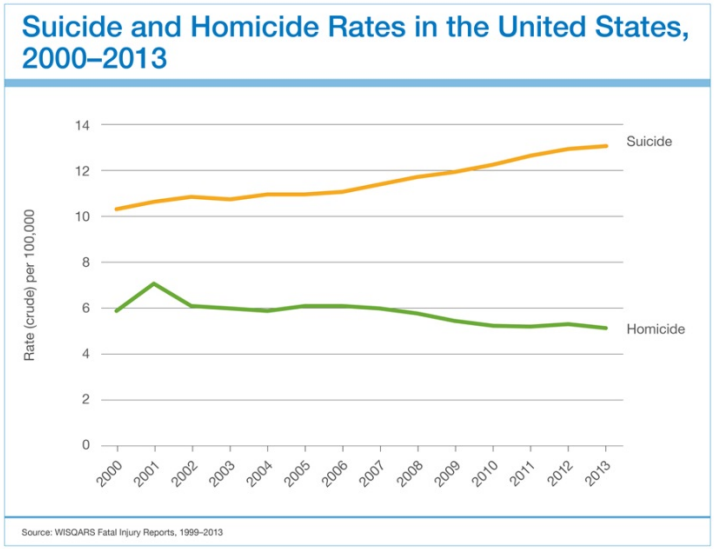
1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

In 2011 there were 3,604 hospitalizations in Washington State for non-fatal suicide attempts. The average length of a hospital stay in Washington State is 10.2 days at a cost of $30,178. That is a State

expenditure of $108,761,512 annually.[8] This cost does not include ED visits without hospital admission, which are an even greater cost, not just in dollars, but in resources and time. The suicide rate for Americans in 2009 was TWICE as high as the homicide rate, thereby causing an increase in the cost in medical, police, and civil intervention as well. Lastly, it is important to realize that the suicide rate in Washington State is 10 percent higher than the national average.



Between 2000 and 2013, the suicide rate in the United States rose from 10.43 (per 100,000) to 13.02. Over the same time period, the suicide rate for males went from 17.11 to 20.59. Among females, the rate rose from 4.00 to 5.67. Overall, men die by suicide at four times the rate of women.[9]



[8] Behavioral Risk Factor Surveillance System Washington State Department of Health
[9] http://www.sprc.org/basics/scope/us

Suicides consistently outnumber homicides. The suicide rate is trending up, while the homicide rate is trending down.[10]

King County: In 2010, there were 226 suicide deaths, approximately 25 percent more than in 2001. The most frequent suicide methods include[11]:

Firearms (38%)
Poisoning /Overdose (24%)
Suffocation (21%)
Cut/Pierce (4%)

Gun Suicides a Preventable Problem.
Between 2006-2010 in King County, the average number of firearm deaths was 130 per year and 68 percent of firearm deaths overall were suicides; in King County, nearly one-quarter of all households have at least one firearm. Among households with firearms, an estimated 22 percent (40,800 households) stored them loaded, and 17 percent (31,200 households) stored them loaded and unlocked, and nearly 12,000 public school kids in King County reported that it would be very or sort of easy to get a handgun. Most suicide attempts with guns were completed; only ~six percent of suicide attempts with guns were survived, demonstrating that gun attempts are usually lethal. While a higher percentage of suicides occurred in adults using guns, a significant percentage (~40 percent) of completed suicides in youth were found to have been from guns between 1999 and 2012. Ninety-five percent of gun suicides among youth (where gun ownership was known) were completed with guns either owned by the family or the child (teens can legally own shotguns and hunting rifles in WA). The risk of completed firearm suicides among King County children < 18 years is at least 9.2 times greater when firearms in or around the home are stored unlocked compared to when firearms are stored locked. [12]

Opportunity to Replicate and Further Refine What Works.
Reducing the availability of highly lethal and commonly used suicide methods [such as guns] has been associated with declines in suicide rates of as much as 30-50 percent in other countries. The lethality of the method readily available during a suicidal crisis plays an important role in whether the person survives an attempt. A survey of people who had seriously considered suicide in the past year found that for about 30 percent, the suicidal period lasted under an hour. Ninety percent of attempters who survive a nonfatal attempt will not go on to die by suicide thereafter[13].

There is evidence that training providers on lethal means counseling does result in increased firearm risk assessment and counseling[14]. And importantly, counseling does make a difference with families who seek treatment for an adolescent with major depression[15]. With training and support, primary care and mental health providers at the school-based health centers can provide this evidence-based suicide prevention counseling for youth and their families in King County.

[10] http://www.sprc.org/basics/scope/us
[11] Washington state Dept. of Health, Injury Data Tables, August 2012
[12] Gun Violence in King County, Assessment, Policy Development, and Evaluation, PHSKC; The Impact of Firearms on King County's Children: 1999 – 2012, Assessment, Policy Development, and Evaluation, PHSKC
[13] Barber and Miller, 2014
[14] Slovak and Brewer, 2010
[15] Brent et al, 2000

Emergency Departments. Behavioral health patients have longer stays in the ED than any other type of patient. Research indicates that the point of highest risk for suicide is in the days and weeks following discharge from an emergency department or inpatient psychiatric unit[16]. One in ten suicide deaths occur among people who have visited the ED in the prior 60 days[17]. Despite these statistics, follow-up care for suicidal patients presenting to EDs is sorely lacking. Up to 70 percent of patients treated in an ED for a suicide attempt do not attend their first outpatient appointment[18].

Research indicates that eight percent of patients presenting to the ED for a reason other than suicide risk have active suicidal ideation and two percent have a suicide plan[19]. One study found that half of patients and one-third of family members felt directly punished or stigmatized by ED staff when they/their family member presented to the ED for a suicide crisis[20]. ED staff attitudes affect whether or not patients attend follow-up care and whether or not they go on to die by suicide (Dr. Leslie Zun, Chair of Emergency Medicine, Mount Sinai Hospital). A survey of Colorado EDs found that 40 percent of hospitals rarely or never provide information on safe storage of firearms to adult patients admitted for a suicide attempt. There is no similar data available for Washington.

Based on significant anecdotal evidence from suicide prevention advocates, King County ED social workers have limited knowledge of available crisis resources and rarely engage suicidal patients in any of the recommended brief interventions, which include safety planning, patient/family education, and counseling on restricting access to lethal means. Many people in the general population are at-risk for suicide, which presents a challenge for prevention efforts. However, the people at most acute risk are concentrated in emergency departments. Therefore, EDs can significantly improve health outcomes for suicidal patients if afforded the requisite training and technical assistance. According to national studies, interventions in the ED could reduce suicide deaths by 20 percent annually[21]. Taiwan achieved a 63 percent reduction in suicide attempts among people who accepted their ED follow-up program.

Suicide attempts are far more common than most people realize. In a recent U.S. survey, one in 200 adults, or approximately 1.1 million adults, reported having attempted suicide in the past year. One in 500 adults reported that they stayed overnight or longer in a hospital as a result of a suicide attempt[22].

While most people who attempt suicide do not attempt again, data from one study show that 37 percent of survivors repeat attempts within five years. The risk that a person may reattempt suicide is highest immediately after discharge from an emergency department or inpatient psychiatric unit and remains high over the next one to five years. For some attempt survivors, this suicide risk remains high for an even longer time.

Studies show that 50 to 70 percent of people discharged from a hospital or emergency department following a suicide attempt do not keep their first scheduled outpatient appointment for on-going

[16] Goldbacre 1993, Paulson 1996
[17] Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department or Inpatient Psychiatric Unit, Suicide Prevention Resource Center, 2011
[18] Knesper, 2010
[19] Silverman, American Association of Suicidology, 2014
[20] Silverman, American Association of Suicidology, 2014
[21] National Action Alliance for Suicide Prevention: Research Prioritization Task Force, 2014
[22] Substance Abuse and Mental Health Services Administration, 2009

care[23]. This may result from a sense of shame or dissatisfaction following their initial treatment in the hospital. People who do receive therapy often drop out after a few sessions and do not complete therapy. Many people who go to the emergency department for suicidal crises are discharged without mental health assessments. Aside from attempt survivors who are seen in emergency departments, hospitals, or doctors' offices, a number of individuals who attempt suicide do not seek treatment and remain unknown to any health or mental health provider.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

The Zero Suicide Initiative addresses suicide prevention/high rates of suicide/suicide ideation through a multifaceted comprehensive approach of the following:

1. Zero Suicide would offer resources in the form of county-wide technical assistance trainings, small grants coupled with leadership training, strategic planning processes, training and technical assistance to enable systems transformation within these provider agencies and other partner behavioral and healthcare agencies. The Zero Suicide concept also ensures that the county's priorities are in alignment with a Zero Suicide Initiative for its contracted provider agencies.

2. Universal evidence-based community-based suicide prevention gatekeeper trainings, such as SafeTALK, ASIST and QPR (Gatekeeper trainings will be identified through the Suicide Prevention Resource Center Best Practices Registry, based on community needs/readiness). Through the Zero Suicide Initiative, the County will develop training capacity within county and community partners and offer no-cost trainings on a quarterly on-going basis. In order to ensure that agencies can send staff to participate in trainings, a backfill/overtime will be established and provided for staff.

3. Lethal means restriction training/counseling, which will be required of all contracted health and behavioral health contracted agencies and offered to all providers. There is an opportunity to address both adult and youth suicides in King County by incorporating lethal means restriction counseling into the routine delivery of care. Lethal means restriction counseling is advising people at risk for suicide, and their friends and family, to keep firearms (and other lethal means) away from the at-risk person until the person recovers. Lethal means restriction training will be offered on an on-going quarterly basis and developed into a train the trainer model. In order to ensure that agencies can send staff to participate in trainings, a backfill/overtime will be established and provided for staff.

4. Universal Screening, brief intervention and follow up for suicide risk will be implemented county-wide in Emergency Departments (ED).Universal screening for suicide risk is currently part of SBIRT (screening brief intervention referral to treatment). Evidence based universal suicide risk screening/SBIRT will be developed and implemented (including training and technical assistance).

5. A suicide attempt survivors group and post-discharge follow-up program will be developed and implemented for individuals after an ED or inpatient stay for a suicide attempt. There is a service gap for people recovering from a suicide attempt. While it is commonly agreed

[23] Knesper et al., 2010

that therapy and support services are vital after a suicide attempt, there are very few effective programs devoted specifically to this population. Many attempt survivors don't seek any mental health treatment after their attempt, often discouraged by previous experiences in therapy where they may not have benefited. Some look for services specifically for suicide attempt survivors and are disappointed to find few exist. Other attempt survivors may feel embarrassed that they let their therapist down by making a suicide attempt. Still other attempt survivors might be angry with the mental health system because when trying to talk about their suicidal thoughts and feelings, they were prematurely involuntarily hospitalized by the outpatient mental health provider, thereby precluding their ability to explore this issue in therapy on an outpatient, and ongoing, basis. For attempt survivors facing significant barriers to mental health services, support groups may provide an alternative option or a first step that leads to treatment and recovery. (Note: The Substance Abuse Mental Health Services Administration-SAMHSA model will be explored for feasibility and replication in King County.) In addition, the County will approach the three hospitals implementing SBIRT-Screening Brief Intervention Referral to Treatment (Harborview, Highline and St. Francis) first to partner on this project. The model will also incorporate internal healthcare system referrals into the model and where that is not available or the individual is not interested in staying with that healthcare system for behavioral health, a next day appointment will be offered and set up within the King County Behavioral Health System.

6. Support services for families and friends who have lost someone to suicide will be developed and implemented. Information will be distributed through the medical examiner's office, local law enforcement, and 211/crisis line, etc. There are many Postvention resources[24] that the County will draw on to develop a plan and activities on responding to a suicide, suicidal crisis or other unexpected death (which may increase suicide risk).

Lethal Means

There is an opportunity to address both adult and youth suicides in King County by incorporating lethal means restriction counseling into the routine delivery of care. Lethal means restriction counseling is advising people at risk for suicide, and their friends and family, to keep firearms (and other lethal means) away from the at-risk person until the person recovers. MIDD's goals focus on improving treatment of those in mental health crisis; saving lives by restricting lethal means allows the mental health system to be successful in delivering care to these individuals, moving beyond the immediate crisis.

Counseling by health care providers can make a difference in school-based settings in King County. Brief counseling efforts by family physicians has been found to have a significant positive impact on the firearm storage habits of their patients. Safe storage practices have been found to result in significant reductions in the risk of unintentional and self-inflicted firearm injuries and deaths among adolescents and children.

Adult-Focused Expansion of "Lethal Means" Training to Community Health Center Primary Care Providers and other primary care settings- Suicide gun deaths among adults in King County outnumbers homicide gun deaths. Implementing lethal means training of primary care providers and others may also help to reduce suicide deaths by reducing access to lethal means when a person is in crisis. This

[24] http://www.sprc.org/library_resources/listing/search?tid_3=All&tid_2=229&tid_1=All&tid=All

approach would continue to improve provider competency and comfort with this screening technique, expand the evidence for what works, and potentially encourage diffusion into the broader health care systems in King County as we communicate results.

Emergency Department Project: ED teams will receive extensive training in the following areas: Screening: Options for screening in the ED, including utilizing technology for screening, will be presented to the ED teams. Tools such as the Columbia Short Screen and the PHQ 2 and PHQ 9 can help ED staff identify the eight percent of their patients who have active suicidal ideation, but are not presenting as such.

Assessment: For patients presenting to the ED with a primary complaint of a behavioral health condition, the Joint Commission's National Patient Safety Goal 15.01.01 calls for a comprehensive risk assessment that identifies patient and environmental characteristics that may increase or decrease his or her suicide risk. EDs will receive training on the Suicide Prevention Resource Center's Decision Support Tool and SAMHSA's Suicide Assessment Five-step Evaluation and Triage (SAFE-T) assessment tool.

Brief interventions: These include patient/family education, safety planning, lethal means counseling, rapid referral, and caring contacts. Patient/family education is crucial for breaking down stigma and engendering hope. Safety planning is an effective intervention to allow patients to return home safely. It helps patients identify distraction techniques and coping strategies that they can employ by themselves, natural supports they can call, as well as contacts for acute crisis. This is far different than a contract for safety. Lethal means counseling refers to working with a patient and his/her family to temporarily restrict access to lethal means that can be used in a suicide attempt such as firearms and prescription medications. Rapid referral relates to the ED setting up an outpatient appointment for a patient in one week or less. Caring contacts includes various forms of follow-up with patients presenting to the ED for suicide risk, including mailing postcards or personal or automated phone calls. One of the only RCTs ever to prove a reduction in suicide deaths involved a hospital simply sending a standard postcard with a caring message to individuals who had presented to the ED with a suicide crisis (G.L. Carter, 2013).

Discharge planning: At present, the responsibility of the ED ends when the patient leaves the hospital and the responsibility of the outpatient provider doesn't begin until the individual's first appointment, which can be weeks out. Those weeks constitute the period of greatest risk for suicide. It is essential that ED personnel provide "warm hand-offs" to crisis services or outpatient behavioral health care, as opposed to simply handing patients a list of phone numbers for agencies that may or may not have availability. There is a significant difference between a resource and a referral. This section will include in-depth information on the array of crisis and behavioral health services available in King County.

Empathy training: Driven by input from individuals with lived experience and UW behavioral health experts, Forefront would develop an empathy training that will be given to all staff at each participating ED. Empathy training would alleviate some of the stigma that behavioral health patients often describe feeling and facilitate staff forming a therapeutic alliance with patients.

Creating suicide safe emergency departments is identified as a critical strategy in both the National Strategy for Suicide Prevention and the Washington State Suicide Prevention Plan.

3. **What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.**

The following evidence exists:

- Zero Suicide Initiative is a key concept of the 2012 National Strategy for Suicide Prevention[25] , a priority of the National Action Alliance for Suicide Prevention[26], and a project of the Suicide Prevention Resource Center (SPRC)[27]. Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, including a specific set of tools and strategies. Zero Suicide is a concept and a practice, it relies on a system-wide approach to improve outcomes and close gaps, versus having all responsibility for suicide prevention lie solely on the individual practitioner. The Zero Suicide Initiative for King County is broad and includes engagement with the broader community, especially suicide attempt survivors, family members, policymakers, and researchers.

Within the Zero Suicide Initiative, evidence exists for each additional component:

- Universal evidence-based community-focused suicide prevention gatekeeper trainings will be selected from the Suicide Prevention Resource Center (SPRC) list[28] of Suicide Prevention Gatekeeper Training Programs, which are also on the Best Practices Registry of Evidence-Based Programs for Suicide Prevention[29].
- Lethal means restriction training/counseling. Means reduction (reducing suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. SPRC Best Practice registry will be reviewed for Lethal Means trainings/counseling options and options for what will work best for King County communities will be selected and may be adapted.
- Universal Screening, brief intervention and follow up for suicide risk will be implemented county-wide in Emergency Departments (ED).
  Using a Screening, Brief Intervention, Referral to Treatment (SBIRT) model for the universal screening model, SBIRT is a comprehensive, integrated public health model designed to provide universal screening, secondary prevention (detecting risky or hazardous substance use before the onset of abuse or dependence), early intervention, and timely referral and treatment for people who have SUDs[30]. One of the strengths of the SAMHSA SBIRT model is that it screens all patients regardless of an identified disorder, allowing healthcare professionals in a variety of settings to address the spectrum of such behavioral health problems even when the patient is not actively seeking an intervention or treatment for his or her problems.[31] [32] SBIRT is being

[25] http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf
[26] http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf
[27] http://www.sprc.org
[28] http://www.sprc.org/sites/sprc.org/files/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf
[29] http://www.sprc.org/bpr/section-i-evidence-based-programs
[30] Babor et al., 2007; Babor & Higgins-Biddle, 2001; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011
[31] http://www.uspreventiveservicestaskforce.org/Page/Document/ClinicalSummaryFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care

used successfully in King County to screen for SUDs and is currently used to screen for depression and suicide risk at sites who have opted in, the proposal for the Zero Suicide Initiative is to expand to universal implementation.

- A suicide attempt survivors group and post-discharge follow-up program will be developed and implemented for individuals after ED or inpatient stay for a suicide attempt. For attempt survivors facing significant barriers to mental health services, support groups may provide an alternative option or a first step that leads to treatment and recovery. In recent years, the Crisis Clinic has received many calls from suicide attempters looking to join the Survivors of Suicide support group and are disappointed to learn it is for the family and friends who lost a loved one to suicide.

  Research demonstrates that:

  1. Suicide is the tenth leading cause of death in the United States, with 41,149 suicides in 2013 in the United States – an average of 112 each day[33].
  2. Suicide results in an estimated $34.6 billion in combined medical and work loss costs[34].
  3. Recent studies show that there is a service gap for suicide attempt survivors after a visit to the emergency department or a hospital stay. In 2008, of 1.1 million adults that attempted suicide, only 678,000 (61 percent) reported receiving medical attention for their suicide attempt, and only 500,000 (45 percent) reported being hospitalized[35].
  4. The National Strategy for Suicide Prevention notes, "All too often the assumption is that individuals are no longer at risk for suicide once they are discharged from inpatient hospital or institutional settings." Yet, despite the fact that those who attempt suicide and others experiencing a suicidal crisis who are seen in the health care system are a high risk population going through a clear high risk period, there have been few systematic suicide prevention efforts in the United States that have focused on this population during this time period. Elevated post discharge rates of death by suicide, suicide attempts, and readmissions to acute care services have been repeatedly documented, but this has not been matched by proportionate prevention efforts.[36].

  According to data maintained by Crisis Clinic's Hospital Authorization Program during the 3rd quarter of 2015 there were 412 individuals voluntarily hospitalized due to the presence of suicide ideation, threat or attempt. Of these 412 individuals, 72 (17 percent) had an actual suicide attempt. Comparable information on those involuntarily committed is not currently available, but would be good for the County to investigate to get a fuller picture of potential candidates for this service. Also not included in this number are those who experienced a

[32] Babor, T. F., McRee, B. G., Kassebaum, P. A., Grimaldi, P., Ahmed, K., & Bray, J. (2007). Screening, brief intervention, and referral to treatment (SBIRT): Toward a public health approach to the management of substance abuse. In R. Saitz & M. Galanter (Eds.), *Alcohol/drug screening and brief intervention: Advances in evidence-based practice* (pp.7–30). Binghamton, NY: Haworth Medical Press.
Babor, T. F., & Higgins-Biddle, J. C. (2001). *Brief intervention for hazardous and harmful drinking: A manual for use in primary care*. Geneva, Switzerland: World Health Organization, Department of Mental Health and Substance Dependence.

[33] Centers for Disease Control, 2012

[34] Centers for Disease Control, 2012

[35] SAMSHA, 2009

[36] Continuity of Care for Suicide Prevention and Research 2011

suicide attempt, had an emergency department visit, but were not admitted. There are a significant number of people in this group that would benefit from this service.

- Support services for families and friends who have lost someone to suicide
  The impact on people who lose a friend or loved one to suicide can last for a lifetime. Clinicians, psychologists, social workers, and other providers of behavioral health care need to be prepared to work with survivors of suicide loss (sometimes called "suicide survivors" or "survivors"). The SPRC has a list of Suicide Prevention Resources for Survivors of Suicide Loss (found here[37]), in addition to a resource library[38] for clinicians and others working directly with those have lost someone to suicide.

- King County Suicide Prevention Strategic Plan – the 2010 plan is based on the local needs and the federal and state suicide prevention plan. While the Plan needs to be updated, many concepts will remain and implementation of the county-wide Plan, incorporating the Zero Suicide Initiative, will be an important part of the continuum of care.

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Evidence-Based Practice. Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

The Zero Suicide Initiative is a new concept for King County.

Suicide prevention is an important part of the continuum of publicly funded behavioral healthcare services; many components of a comprehensive Zero Suicide Initiative are evidence-based practice and play an important role in preventing suicides. The Suicide Prevention Resource Center (supported by SAMHSA) compiles the evidence-based practices in suicide prevention (called the Best Practices Registry[39]). Specifically, the concept of Zero Suicide is key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), and a project of the Suicide Prevention Resource Center (SPRC). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge and the evidence is based on the programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary. The seven essential elements of the Zero Suicide concept (p. 3) are research based approaches to suicide reduction[40].

The additional phases of the Zero Suicide Initiative will use evidence-based programs from the SPRC Best Practices Registry (BPR), which is consistent with the National Strategy for Suicide Prevention and aligns with the County Zero Suicide Initiative. The BPR is a source of information about evidence-based programs; expert and consensus statements; and programs, practices, and policies whose content has been reviewed according to specific standards. Its purpose is to identify, review, and disseminate

[37] http://www.sprc.org/sites/sprc.org/files/Survivors.pdf
[38] http://www.sprc.org/library_resources/listing/search?tid_3=All&tid_2=All&tid_1=All&tid=254
[39] http://www.sprc.org/bpr
[40] http://zerosuicide.sprc.org/about

information about best practices that address specific objectives of the *National Strategy for Suicide Prevention*.[41]

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

Zero Suicide system outcomes:
• Improved system level outcomes for healthcare policies and procedures for individuals at risk of suicide in health care systems
• Increase in leadership driven, safety-oriented culture that commits to reducing suicide
• Increase in universal screening and systematically identifying and assessing suicide risk levels
• Increase in access to timely care to meet health care needs
• Increase in workforce development activities to develop a competent, confident and caring workforce to identify and treat suicidality
• # of effective, evidence-based care interventions for suicide prevention, safety planning, restriction of lethal means and treatment of suicidality
• # of continuity of contact, care and acute after care following suicidality
• Increase in data-driven quality improvement approach for system changes for improved patient outcomes and better care for those at risk

Zero Suicide provider initial outcomes:
The results of successful implementation would be: 1) reduced suicide rates among clients served within King County's behavioral health system; 2) increased numbers of clinical and support staff who are trained in how to prevent suicide commensurate with their role in the agency; 3) measureable systems-based improvements in suicide care; and 4) fewer emergency room visits and inpatient stays in psychiatric hospitals for clients in publically funded behavioral healthcare systems.

Lethal means training outcomes:
providers who receive lethal means training (data will be collected at trainings)
providers with increased knowledge and improved attitude towards lethal means reduction (pre/post survey with providers)
adults and children who die by suicide by firearms annually reduced (data produced by MEO/APDE)

ED screening outcomes:
Increased # of ED providers trained; increased awareness of crisis resources among ED providers; increased empathy for behavioral health patients among ED staff; increased use of brief interventions for suicide risk
1) Decrease in suicide deaths following a visit to the ED, 2) decrease in suicide attempts following a visit to the ED, 3) decrease in repeat visits to the ED among behavioral health patients

Survivor attempt curriculum/group outcomes:
Short-term goals of the Suicide attempt survivor curriculum include:
• Maintain participants' safety and manage risk
• Reduce internalized/ perceived stigma
• Increase comfort with, and ability to speak about the thoughts and feelings that led to their suicide

[41] http://www.sprc.org/faq/best-practices-registry-1#t188n1557

attempt, and to learn how to recognize and cope with these feelings if they return in order to decrease the likelihood of reattempts
• Increase coping skills as they relate to suicidal thoughts
• Increase knowledge about, and the likelihood of using, safety planning tools
• Increase connectedness, including access to peers who can support each other in times of crisis
• Creating a "built-in" safety net where members are comfortable sharing thoughts/risk for suicide without fear of how others will react
• Manage and reduce lethal means
• Increase hopefulness

Longer-term goals of the Suicide attempt survivor group can be met as participants return for future cycles or as the group process starts to move in a forward direction with greater gains made over time. The seeds may be planted for growth and progress on a slower timeline than the initial eight weeks. Long-term goals include:
• Reduce suicidal desire
• Reduce suicidal intent
• Increase protective factors
• Prevent future attempts
• Create a peer support network
• Increase in individual's ability to plan for the future
NOTE: Because there are very few groups for suicide attempt survivors and even fewer evaluations of their effectiveness, it is important to establish a plan to measure the effectiveness of this group in meeting objectives. Didi Hirsch Suicide Prevention Center established pre- and post- surveys to collect both qualitative and quantitative information. Using measures that are already established by a best practice model allows for a consist delivery of service and measure of effectiveness on a larger scale. Feedback obtained from participants can also be used to make changes to improve the group from cycle to cycle.

Support services for families and friends who have lost someone to suicide (Postvention) outcomes:
1 .# of support sessions for normal grief process and minimize complicated grief and guilt reactions
2. Reduce the risk of further suicidal behavior
3. # of connections made for family and friends to health and mental health providers and to other community resources
4. Increase in education and information about steps family and friends can take to help prevent suicide clusters and contagion in the immediate aftermath of a suicide.

C. Populations, Geography, and Collaborations & Partnerships

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

- ☐ **All children/youth 18 or under**
- ☐ **Children 0-5**
- ☐ **Children 6-12**
- ☐ **Teens 13-18**
- ☐ **Transition age youth 18-25**
- ☐ **Adults**
- ☐ **Older Adults**
- ☐ **Racial-Ethnic minority (any)**
- ☐ **Black/African-American**
- ☐ **Hispanic/Latino**
- ☐ **Asian/Pacific Islander**
- ☐ **First Nations/American Indian/Native American**
- ☐ **Immigrant/Refugee**
- ☐ **Veteran/US Military**

- ☐ **Families**
- ☒ **Anyone**
- ☐ **Offenders/Ex-offenders/Justice-involved**
- ☐ **Other – Please Specify:**
- ☐ **Homeless**
- ☐ **GLBT**
- ☐ **Women**

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

The King County Zero Suicide Initiative a new concept for a comprehensive county-wide plan for the prevention of deaths due to suicide, it corporates the development and implementation of a Zero Suicide Initiative for the county; universal community-based suicide prevention gatekeeper trainings; lethal means restriction training developmental and implementation; universal screening for suicide risk; suicide survivor support group/follow up; and support services for individuals impacted by a suicide loss.

The King County Zero Suicide Initiative is designed to be county-wide because suicide impacts everyone and prevention, knowledge and early intervention are the key to preventing suicides.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

In order to implement a system-wide Zero Suicide initiative, collaborations and partnerships are needed and include the following: Behavioral health providers, primary care providers, hospitals, Public Health Seattle-King County, Schools, Medical Examiner, law enforcement, Child Death Review Board, etc. In addition, the Suicide Prevention Resource Center and the National Action Alliance for Suicide Prevention[42] are available to provide technical assistance.

Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**

The services provided through the Zero Suicide Initiative are an initial step in the continuum of care, intended to provide prevention and early intervention services and to promote access to care. In addition, there is a longer term goal of connection to and ongoing maintenance of services, regardless of

[42] http://actionallianceforsuicideprevention.org/

whether the individual's needs are related to mental health, substance use or co-occurring disorders, and fits well with the integration of behavioral health care.

There have been changes in state law, requiring all clinicians to be trained in suicide prevention, the Zero Suicide Initiative impacts this by providing an avenue for agencies to support staff in working toward within a zero suicide framework.
From the University of Washington, Forefront-innovations in suicide prevention website[43]:
Washington State is now considered one of the most proactive states in the nation with regard to the prevention of suicide. A first in the nation, Washington requires that its licensed mental health (Bill number 2366) and health care professionals (Bill number 2315) have training in how to assess, manage and treat individuals who are at risk for suicide. K-12 public schools are becoming more fully prepared to prevent suicide (1336).
House Bill 2315: Concerning training health care professionals in suicide assessment, management and treatment.
Summary: In 2012, a law was passed that requires mental health professionals to have training in the assessment, management and treatment of suicide as a condition of having a license to practice. HB 2315 extends the training requirement to health care professionals. This law is critical because more than half of all individuals who die by suicide visit their primary care physicians less than a month before taking their own lives. HB 2315 also tasks Washington's Department of Health to develop a state plan to reduce lives lost to suicide across age groups. Washington has a youth suicide prevention plan that is not sufficient, since it does not address the fact that middle-aged men, American Indian/Alaska Native residents, and veterans of the US armed forces die by suicide at the highest rates and in the largest numbers.

House Bill 2366: Concerning training mental health professionals in suicide assessment, management and treatment
Summary: Washington State passed ESHB 2366, otherwise known as the Matt Adler Suicide Assessment, Treatment, and Management Act of 2012. ESHB 2366 is a significant legislative achievement as it is the first law in the country to require certain health professionals to obtain continuing education in the assessment, treatment, and management of suicide risk as a requirement to obtain and maintain licensure.
House Bill 1336: Increasing the capacity of school districts to recognize and respond to youth at-risk for suicide
Summary: This law increases the capacity of schools to recognize and respond to troubled youth and to build awareness for students who may be struggling with mental health issues that may lead to attempted suicide. The law requires:

- New certification training requirements for school counselors, social workers and psychologists to provide suicide screening and referral
- Training teachers to recognize and respond emotional or behavioral distress in students,
- Schools to have a model plan for recognition, initial screening, and response to emotional or behavioral distress in students, including but not limited to indicators of substance abuse, violence, and youth suicide.
- School districts to form partnerships with qualified health, mental health and social services agencies – four meetings
- Training 32 trainers on the principles of Mental Health First Aid.

[43] http://www.intheforefront.org/policy

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**

Barriers to implementation include stigma towards behavioral health services and especially to suicide prevention and individuals who attempt suicide and die from suicide. The societal belief that this is an individual flaw needs to be changed; suicide risk needs to be treated like diabetes, very proactivity and preventatively.

Providers, media and elected officials all have roles to play in overcoming the stigma associated with suicide.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**

It could have potential impacts to the outpatient system due to an increase in referrals. Wait times for resources and services could increase if the outpatient system is unable to accommodate increasing numbers of referrals from providers due to additional suicide screenings.

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**

Individuals at risk for suicide will continue to utilize costly resources such as EDs, inpatient hospitals and sometimes jails. Hospitals, law enforcement and other first responders would have limited access to resources to assist in the field and would rely on jail and hospital settings to address the needs of this population. There is a focus every day in local and national news on the number of individuals in jails and prisons with mental health and/or substance use disorders, as well as on how law enforcement responds to these individuals. Without resources that provide the community with alternative options for addressing these needs appropriately, there will be an over-reliance on jails and hospitals to manage this population.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

There are no known systemic, alternative approaches to providing suicide prevention. Providing a prevention program before a suicide crisis compared to crisis and treatment services following a suicide attempt is always more desirable and less costly. There are alternatives to this comprehensive approach. Independent piecemeal trainings could be provided. This would likely lead to very uneven results; it would be difficult to assure inclusion of evidence-based practices and the County would be forfeiting a leadership role in bending the curve on suicide. However, an uncoordinated, non-standardized approach will not lead to system improvement and is not likely to have the same effectiveness.

It is unlikely that this New Concept can be merged with another concept since this is an overarching initiative for Zero Suicide, however, the Mental Health First Aid training New Concept can be

incorporated into the Zero Suicide Initiative. The benefit of including Mental Health First Aid training as part of the Zero Suicide Initiative is that the training helps a person assist someone learn about mental health. Just as CPR training helps a person with no clinical training assist an individual following a heart attack, Mental Health First Aid training helps a person assist someone experiencing a mental health crisis, such as contemplating suicide. In both situations, the goal is to help support an individual *until appropriate professional* help arrives.

In addition, the Collaborative School Based Behavioral Health briefing paper includes a component on School Based Suicide Prevention (training for kids and teachers), an existing MIDD strategy (MIDD 4d School Based Suicide Prevention). School based suicide prevention could be merged with the Zero Suicide Initiative or remain as part of the Collaborative School Based Behavioral Health concept; both are feasible options. School Based Suicide Prevention is an important component of a comprehensive Suicide Prevention strategy and is not included in this New Concept because it is included in another briefing paper.

D. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

The Zero Suicide Initiative is a multi-prong approach: a primary prevention effort that will divert people from the behavioral health system entirely; an early intervention/ secondary prevention effort that will intervene during a crisis and also help people engage in services sooner and avoid more costly and intrusive interventions; and after care/ recovery support care.

Zero Suicide is aligned with physical and behavioral health integration, as people with behavioral health conditions may seek services through primary care first. There should be no "wrong door" for people who want help.

Zero Suicide is also relevant for Best Starts for Kids. If families and school staff can recognize symptoms of suicide and behavioral health disorders, they can intervene sooner and help prevent further difficulties in the future. Youth who learn about behavioral health conditions can also learn about their own mental health and learn skills to use and available resources when they themselves are in distress. Zero Suicide is also aligned with the Veterans and Human Services Levy (VHSL), the County currently funds hundreds of agencies with VHSL money, but they remain sort of unconnected in their service delivery to any other part of the system. When you look at the VHSL target populations and investment strategies (see directly below) -- you see that they want to serve veterans with mental health and primary health problems and those with instability due to various causes and then to invest in helping them have stable lives and to improve their health. Yet, suicide is at epidemic proportions for the veteran population. It is one of the highest risk populations, with a rate of 22 veterans dying by suicide each day[44]. Incorporating the Zero Suicide Initiative is needed within this population.

Veterans and Human Services Levy – Populations and Strategies

[44] www.va.gov

1. Veterans, military personnel and their families who are struggling with mental and physical health problems, unstable housing or homelessness, or unemployment and in need of supports that will help them build on their strengths and respond to the unique challenges they face.
2. Residents who experience instability in their lives resulting in involvement in the homelessness, criminal justice, or emergency medical systems.
3. Families and individuals for whom prevention and early interventions will help lay the foundation for a successful future and prevent involvement in crisis systems.

Investment Strategy Areas

1. Supporting veterans and their families to build stable lives and strong relationships
2. Ending homelessness through outreach, prevention, permanent supportive housing and employment
3. Improving health through the integration of medical and behavioral health services
4. Strengthening families at risk

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

The Zero Suicide Initiative components are informed by principles of recovery, resiliency, and trauma-informed care.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

One of the goals of the Zero Suicide Initiative aims to reduce stigma, which aligns with Equity and Social Justice. People experiencing behavioral health symptoms and suicide ideation are people, and should be able to access and receive services, and experience the same dignity as others.

Suicide prevention is an equity and social justice issue and deserves a comprehensive public health approach to prevention, such as, Zero Suicide. In order to take a more upstream approach suicide needs to be viewed through the lens of the many systems that are involved in creating change for Zero Suicide (e.g., schools, workplaces, healthcare systems, behavioral health care systems, justice, faith communities and many more). Everyone has a role in suicide prevention and in using a Zero Suicide lens; Equity and social justice is served when there is a focus on increasing protective factors, such as social and community connectedness and resiliency along with equal and adequate access to treatment.

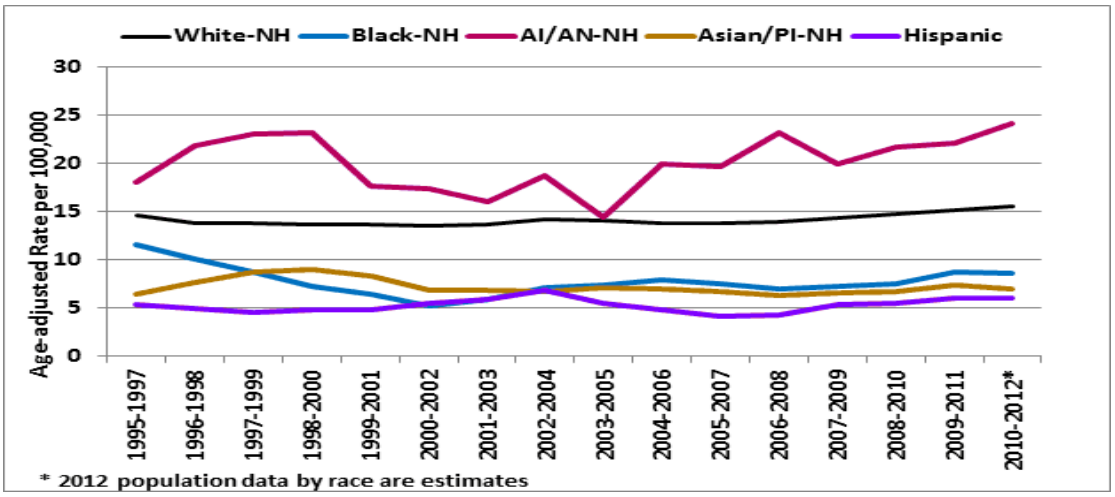
Data from the Washington State Injury and Violence Prevention Guide, 2013 shows that American Indian and Alaskan Natives have the highest rates of suicides in Washington State, elderly males (age 85+) have the highest rate and generally, the older one is, the higher the risk for suicide. In addition, a gap in the data was noticed in that, no data is available for the Lesbian, Gay, Bi-Sexual, Transgender, Queer (LGBTQ) populations, and there is not consistent suicide attempt data available. Lastly, Veterans are the highest risk group in Washington State, with 23 percent of all suicide deaths in Washington being among Veterans, which is alarming considering that Veterans only make up 8.3 percent of the population.[45]

[45] http://www.intheforefront.org/media/stats

Given this, Zero Suicide prevention activities will address inequities and use universal prevention approaches and seek to develop indicated approaches for high risk populations.

Suicide Race and Ethnicity 2010-2012

In Washington State, American Indian and Alaskan Natives have the highest rates of suicide, while whites make up the largest number of deaths.



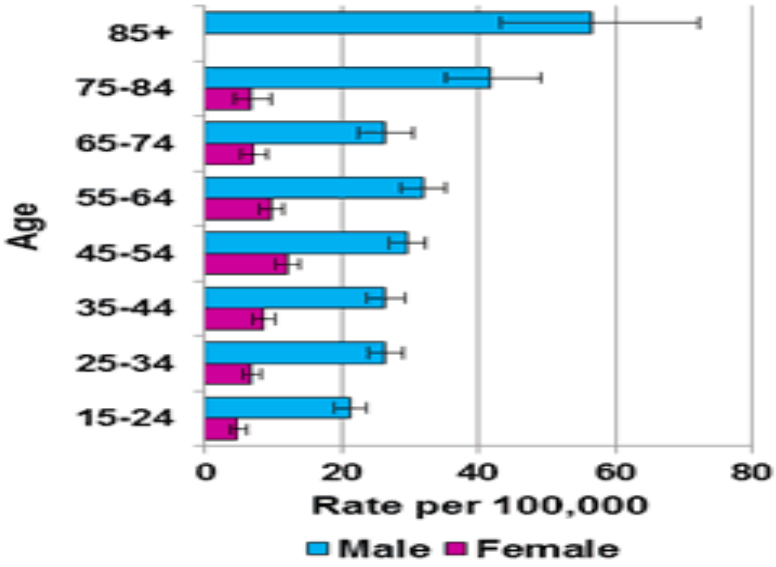
Suicide and Veterans

Twenty three percent of all deaths by suicide in Washington between the years of 2010-2012 were by members of the U.S. Armed Forces however, veterans only make up 8.5% of the general population.

	U.S. Armed Forces Participation			
Age Group (years)	Yes		No	
	# of suicides	% of suicides	# of suicides	% of suicides
10–24	26	7	363	93
25–44	134	14	812	86
45–64	243	22	882	78
65+	265	56	211	44
Total	668	23	2268	77

Suicide Age and Gender, 2010-2012

Elderly males have the highest suicide rate in Washington; generally the older the male, the higher the rate of suicide. Men ages 45–64 had the highest number of suicides. Female suicide rates are highest in the 45-54 age groups.



E. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**

Staff, trained facilitators, program management support (marketing, recruitment, contracting, etc.), physical space, training materials, program/training development and evaluation.

The County currently has no contractual requirements and no required training or other required parts of the zero suicide package linked to or required by contracted providers (across the multiple initiatives- Best Start for Kids, MIDD, Veterans and Human Services Levy, etc.); it is recommended that this be changed and contracted agencies across all initiatives participate in the training components of the Zero Suicide Initiative.

2. **Estimated ANNUAL COST. $1,500,001-$2.5 million Provide unit or other specific costs if known.**

The Zero Suicide Initiative briefing paper incorporates four new concepts and has six components to create an overarching initiative for suicide prevention for King County. The budget is as follows:

Zero Suicide and King County Suicide Prevention Plan:	$375,000
Universal Gatekeeper Training:	$350,000
Lethal Means Restriction Training:	$100,000
Universal SBIRT Emergency Departments:	$250,000
Suicide attempt survivors group and post-discharge follow-up program	$250,000
Support services for families	$250,000
Zero Suicide Program Management/Evaluation (DCHS & PH)	$225,000
Zero Suicide Initiative Total:	$1,800,000

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**

There are no known other revenue sources that could or currently fund this work.

4. **TIME to implementation: Less than 6 months from award**
    a. **What are the factors in the time to implementation assessment?**

Many agencies in King County, such as UW Forefront, Crisis Clinic, Youth Suicide Prevention Program, Seattle-King County Public Health and DCHS have current efforts underway related to suicide prevention. Organizing the current Zero Suicide Initiative will occur as part of the King County Suicide Prevention Coalition and can occur quickly.

    b. **What are the steps needed for implementation?**

The first step is to discern what resources are needed for each phase/stage (funds, trainers, contracting, etc.). Work will be necessary to determine where and when the courses should occur, what staffing is needed, what administrative support is available, how to reach populations that may benefit and initial work plan.

    c. **Does this need an RFP?**

Yes, either an RFP or letter of interest/intent will be needed.

F. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

On January 6, 2016, Governor Inslee signed an Executive Order launching a statewide public health initiative to reduce and prevent gun-related fatalities and injuries. "Between 2012 and 2014, an annual average of 665 people died in Washington state from firearm injuries per year, compared to 497 deaths from automobile accidents per year, according to the Department of Health Department of Vital Statistics. Approximately 80 percent of the firearm deaths were suicides."[46] Part of the state initiative is the implementation of the statewide suicide prevention plan, the King County Zero Suicide Initiative will fold in nicely with the statewide suicide prevention plan and address this serious preventable public health problem.

Subject matter experts and collaborators are excited to partner with the County on this initiative.

The following New Concepts are attached:
26: Suicide Attempters Support Group and Post-Discharge Follow up Program
78: "Lethal Means" Provider Training
102: Transformation to a Zero Suicide Approach in King County's Public Behavioral Health System
140: Suicide Safe Emergency Departments

[46] http://www.governor.wa.gov/news-media/inslee-announces-public-health-initiative-curb-gun-crime-and-suicide

New Concept Submission Form

Please review the preceding pages before completing this form.

Please be specific. Be sure to describe how the concept addresses mental health or substance abuse needs in King County. All programs funded by MIDD II must be implemented in King County.

26

Working Title of Concept: Suicide Attempters Support Group and Post-Discharge Follow up Program

Name of Person Submitting Concept: Kathleen Southwick
Organization(s), if any: Crisis Clinic
Phone: 206-436-2980
Email: ksouthwick@crisisclinic.org
Mailing Address: 9725 3rd Avenue NE #300 Seattle, WA 98115

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

There is a need for a Suicide Attempt Survivors Support Group and Post-Discharge Follow-Up Program that can be offered to individuals being released from a hospital emergency department or discharged after an inpatient stay for a suicide attempt. This would be a new service because there is currently a gap in the continuum of care for this population. This program would offer immediate telephone support from a peer with a lived experience of a suicide attempt and an eight week closed support group co-facilitated by a Mental Health Professional and a Peer Counselor.

Research shows that the first thirty days after a hospital discharge for someone who has attempted suicide is a high risk time for another attempt. By incorporating this service into the discharge plan, those being released from an emergency department or inpatient stay could be given the reassurance of immediate follow-up as they arrange in-person follow up care with their mental health or health care provider, which often takes many days to schedule. Regular telephone support immediately after discharge can help an individual remain safe by offering reassurance, encouragement in following up on discharge plans, providing emotional support, and using principles of active engagement.

Individuals would also be offered enrollment in an 8 week closed Suicide Attempters Support Group of six to eight adults. These groups would be offered on a frequent and continuous basis so participation can be soon after discharge. The groups offer a an effective means of connecting with others who have a similar experience of suicide and would be co-facilitated by a Mental Health Professional and Peer Counselor who has a lived experience of suicide.

2. What community <u>need, problem, or opportunity</u> does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Suicide prevention efforts must address the needs of attempt survivors. Individuals who have attempted suicide form a significant high-risk group for both repeat attempts and death by suicide. Interventions can reduce this risk and keep attempt survivors from reattempting or dying by suicide. Yet, services for attempt survivors are limited and often ineffective.

Suicide attempts are far more common than most people realize. In a recent U.S. survey, one in 200 adults, or approximately 1.1 million adults, reported having attempted suicide in the past year. One in 500 adults reported that they stayed overnight or longer in a hospital as a result of a suicide attempt (Substance Abuse and Mental Health Services Administration, 2009).

While most people who attempt suicide do not attempt again, data from one study show that 37% of survivors repeat attempts within five years. The risk that a person may reattempt suicide is highest immediately after discharge from an emergency department or inpatient psychiatric unit and remains high over the next one to five years. For some attempt survivors, this suicide risk remains high for even a longer time.

Studies show that 50 to 70% of people discharged from a hospital or emergency department following a suicide attempt do not keep their first scheduled outpatient appointment for ongoing care (Knesper et al., 2010). This may result from a sense of shame or dissatisfaction following their initial treatment in the hospital. People who do receive therapy often drop out after a few sessions and do not complete therapy. Many people who go to the emergency department for suicidal crises are discharged without mental health assessments. Aside from attempt survivors who are seen in emergency departments, hospitals, or doctors' offices, a number of individuals who attempt suicide do not seek treatment and remain unknown to any health or mental health provider.

There is a gap of services for people recovering from a suicide attempt. While it is commonly agreed that therapy and support services are vital after a suicide attempt, there are very few effective programs devoted specifically to this population. Many attempt survivors don't seek any mental health treatment after their attempt, often discouraged by previous experiences in therapy where they may not have benefited. Some look for services specifically for suicide attempt survivors and are disappointed to find few exist. Other attempt survivors may feel embarrassed that they let their therapist down by making a suicide attempt. Still other attempt survivors might be angry with the mental health system because when trying to talk about their suicidal thoughts and feelings, they were prematurely involuntarily hospitalized by the outpatient mental health provider, thereby precluding their ability to explore this issue in therapy on an outpatient, and ongoing, basis. For attempt survivors facing significant barriers to mental health services, support groups may provide an alternative option or a first step that leads to treatment and recovery. In recent years, Crisis Clinic has received many calls from suicide attempters looking to join our Survivors of Suicide support group and are disappointed to learn it is for the family and friends who lost a loved one to suicide.

We know that:

1. Suicide is the tenth leading cause of death in the United States, with 41,149 suicides in 2013 in the United States – an average of 112 each day (CDC 2012).
2. Suicide results in an estimated $34.6 billion in combined medical and work loss costs (CDC 2012).

3. Recent studies show that there is a gap in services for suicide attempt survivors after a visit to the emergency department or hospital stay. In 2008, of 1.1 million adults that attempted suicide, only 678,000 (61%) reported receiving medical attention for their suicide attempt, and only 500,000 (45%) reported being hospitalized. (SAMSHA, 2009).
4. It is noted in the National Strategy for Suicide Prevention, "All too often the assumption is that individuals are no longer at risk for suicide once they are discharged from inpatient hospital or institutional settings." Yet, despite the fact that those who attempt suicide and others experiencing a suicidal crisis who are seen in the health care system are a high risk population going through a clear high risk period, there have been few systematic suicide prevention efforts in the United States that have focused on this population during this time period. Elevated post discharge rates of death by suicide, suicide attempts, and readmissions to acute care services have been repeatedly documented, but this has not been matched by proportionate prevention efforts. (Continuity of Care for Suicide Prevention and Research 2011).

According to data maintained by Crisis Clinic's Hospital Authorization Program during Q3 of 2015 there were 412 individuals voluntarily hospitalized due to the presence of suicide ideation, threat or attempt. Of these 412 individuals, 72 (17%) had an actual suicide attempt. We do not have comparable information on those involuntarily committed, but would be good for the County to investigate to get a fuller picture of potential candidates for this service. Also not included in this number are those who experienced a suicide attempt, had an emergency department visit, but were not admitted. We believe there is a significant number of people in this group that would benefit from this service.

3. How would your concept address the need?
Please be specific.

In order to address this need, it would be imperative to establish a system of follow up calls to persons being released from emergency departments or discharged from an inpatient admission following a suicide attempt. These calls need to occur immediately and regularly in order to support the safety of the individual who remains at high risk for suicide. It would also be important to establish group support that operates from a peer model of recovery. A tool to be adopted for this purpose would be a curriculum developed by Didi Hirsch Suicide Prevention Center in Los Angeles, CA. Didi Hirsch has been providing Suicide Attempt Survivors support since 2011. They have evolved their curriculum into a best practice model that is now listed on the best practice registry of the Suicide Prevention Resources Center. This curriculum outlines the 8 week Suicide Attempt Survivors Group as follows:

Week One: Group Overview/ Introductions
Facilitators and participants introduce themselves and share their experiences with suicidal thoughts and attempts. Goals and guidelines for the group are reviewed. Participants complete initial group paperwork, including outcome surveys. Informed consent is discussed in detail.

Week Two: Talking About Suicide
Facilitators and participants view a video of others who have survived suicide attempts, reinforcing the safety of discussing their experience in the group setting as well as giving examples of hope.

Week Three: Giving and Receiving Support
Facilitators and participants discuss the benefits and challenges of using other support group participants for support. Using the crisis line as support is also discussed.

Week Four: What Causes My Thoughts?
Facilitators and participants discuss causes for suicidal thoughts and automatic thinking.

Week Five: How Can I Cope With The Thoughts?
Participants begin completing their safety plans and complete a survey on the impact of safety planning.

Week Six: Resources
Facilitators and participants discuss resources for suicide attempt survivors such as websites, professional therapy, books recommended for suicide attempt survivors, and community resources. These resources can be used to complete remaining steps of their safety plans.

Week Seven: Hope
Facilitators and participants discuss reasons for living and how they brought hope into participants' lives. Participants share a personal item that represents something hopeful in their life. Hope Box activity is completed.

Week Eight: Where Do We Go From Here?
Facilitators and participants discuss closure and ways for participants to stay connected, and fill out paperwork evaluating the group process and post-group measures.

4. Who would benefit? Please describe potential program participants.

Program participants would be any adult who is a King County resident and is being released from an emergency department or discharged from a hospital following a suicide attempt. This would be a voluntary program. It could be built into the hospital's discharge plan with the patient's consent for the provider to contact them to discuss the program. This program would also be a benefit to the discharge planner since often times there is not a lot of immediate support available for the individual being released or discharged. A primary focus of this program would be rapid engagement upon discharge.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The Suicide Attempt Survivor curriculum developed by Didi Hirsch Suicide Prevention Center outlines goals of the attempt survivor support group:
Short-term goals of the group include:
• Maintain participants' safety and manage risk
• Reduce internalized/ perceived stigma
• Increase comfort with, and ability to speak about the thoughts and feelings that led to their suicide attempt, and to learn how to recognize and cope with these feelings if they return in order to decrease the likelihood of reattempts
• Increase coping skills as they relate to suicidal thoughts
• Increase knowledge about, and the likelihood of using, safety planning tools
• Increase connectedness, including access to peers who can support each other in times of crisis
• Creating a "built-in" safety net where members are comfortable sharing thoughts/risk for suicide without fear of how others will react
• Manage and reduce lethal means
• Increase hopefulness
Longer-term goals can be met as participants return for future cycles or as the group process starts to move in a forward direction with greater gains made over time. The seeds may be planted for growth

and progress on a slower timeline than the initial eight weeks.
Long-term goals include:
• Reduce suicidal desire
• Reduce suicidal intent
• Increase protective factors
• Prevent future attempts
• Create a peer support network
• Increase in individual's ability to plan for the future
Because there are very few groups for suicide attempt survivors and even fewer evaluations of their effectiveness, it is important to establish a plan to measure the effectiveness of this group in meeting objectives. Didi Hirsch Suicide Prevention Center established pre- and post- surveys to collect both qualitative and quantitative information. Using measures that are already established by a best practice model allows for a consist delivery of service and measure of effectiveness on a larger scale. Feedback obtained from participants can also be used to make changes to improve the group from cycle to cycle.

Outcome measures already being used in this model include:
• Self-rated measures of suicidal desire, intent, and buffers at intake, at first group meeting and last group meeting
• Beck Scale for Suicide Ideation at first and last group meetings
• Pre- and post- survey that asks about participants' use of mental health supports, medication usage, suicide attempts, hospitalizations, and demographic information, as well as qualitative information regarding participant expectations and reactions
• A pre- and post- survey to measure the impact of safety planning, which measures the participants' knowledge and likelihood of using a safety plan
• A focus group where participants were asked about the positive and negative aspects of the group

Additionally, the National Suicide Prevention Lifeline (NSPL) suicide risk assessment standards can also be used as outcome measures to help assess the effectiveness of the support group. NSPL best practice standards on suicide risk assessment include assessment in four areas: Suicidal Desire, Suicidal Capability, Suicidal Intent, and Buffers/Connectedness.

The current model indicates that during the intake interview, all participants are asked to self-rate their feelings in regards to suicidal desire, intent, and buffers/connectedness using the questions below. Suicidal capability was excluded because many of the subcomponents of this principle are fixed and won't change over time (i.e., history of a suicide attempt or exposure to a suicide) or are more difficult for a participant to self-rate (i.e. increased symptoms of mental illness or extreme agitation). Participants are asked the questions from the intake interview again at the first meeting of the eight-week group cycle and again at the last meeting to identify changes from the intake baseline measures.
Suicidal Desire:
On a scale of 1-5 how much do you want to die? (1= low – 5= high)
Suicidal Intent:
On a scale of 1-5 how likely are you to kill yourself? (1= very unlikely – 5= very likely)
Buffers/Connectedness:
On a scale from 1-5, how connected to others/how supported do you feel?
(1= very unconnected/supported – 5 =very connected/supported)

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☒ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

This concept fits well with the MIDDII objective since the primary focus of the concept proposed is to increase the safety of individuals at risk of suicide, thereby, improving the health of persons living with mental health disorders. The concept of the Post-Discharge Follow-Up Program and Survivor Attempt Support Group focuses on empowering individuals to make positive life changes during a critical time. A support group of this nature would allow for creating a community of peer support, enabling persons who may be at risk of suicide to increase their personal coping strategies and resources. This allows individuals to live healthier lives after their crisis.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

The provider would need the cooperation of local hospitals that see people in their emergency departments following a suicide attempt, as well as those admitting individuals for psychiatric treatment after a suicide attempt. This collaboration would focus on the Post-Discharge Follow-Up Program and Survivor Attempt Support Group being part of the patients discharge plan, pending voluntary involvement and consent. This program would be valued resources for discharge planners who often need immediate services to refer individuals to for ongoing support and safety regarding suicide risk. The County would need to be an active champion of this program, encouraging hospitals to participate.

9. If you are able to provide estimate(s), <u>how much funding per year</u> do you think would be necessary to implement this concept, and <u>how many people would be served</u>?

Pilot/Small-Scale Implementation: **$ 150,000 per year, serving 150 people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *<u>MIDDConcept@kingcounty.gov</u>*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *<u>MIDDConcept@kingcounty.gov</u>*.

New Concept Submission Form

78

Working Title of Concept: "Lethal Means" Provider Training

Name of Person Submitting Concept: Jennifer DeYoung
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Public Health is proposing to pilot and evaluate a short 'lethal means' training with our school-based health center providers, along with those serving our adult populations at Downtown, Eastgate and NAVOS (integrated behavioral health). This aligns with MIDD Strategy areas of Prevention and Early Intervention.
Because we know that a significant percentage of deaths by guns in King County are from suicide by gun, the purpose of the training, and the resultant 'lethal means counseling' is to assure that at-risk individuals cannot access unsecured firearms during an impulsive period. This project will result in at-risk individuals being seen in our public health clinics receiving this lethal means counseling.
Ultimately, prevention of suicide in a mental health crisis is a critical component of assuring that the individual has a chance at recovery. This intervention is a direct and appropriate way to support King County residents. If successful, the training could be diffused across the health care system more broadly in King County.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Gun Suicides a Preventable Problem. Between 2006-2010 in King County, the average number of firearm deaths was 130 per year and 68% of firearm deaths overall were suicides; in King County, nearly one-quarter of all households have at least one firearm. Among households with firearms, an estimated 22% (40,800 households) stored them loaded, and 17% (31,200 households) stored them loaded and unlocked, and nearly 12,000 public school kids in King County reported that it would be very or sort of easy to get a handgun. Most suicide attempts with guns were completed; only ~6% of suicide attempts with guns were survived, demonstrating that gun attempts are usually lethal. While a higher percentage of suicides occurred in adults using guns, a significant percentage (~40%) of completed suicides in youth were found to have been from guns between 1999 and 2012. 95% of gun suicides among youth (where gun ownership was known) were completed with guns either owned by the family or the child (teens can legally own shotguns and hunting rifles in WA). The risk of completed firearm suicides among King County children < 18 years is at least 9.2 times greater when firearms in or around the home are stored unlocked compared to when firearms are stored locked. (Data Source: Gun Violence in King County, Assessment, Policy Development, and Evaluation, PHSKC; The Impact of Firearms on King County's Children: 1999 – 2012, Assessment, Policy Development, and Evaluation, PHSKC).

Opportunity to Replicate and Further Refine What Works. Reducing the availability of highly lethal and commonly used suicide methods [such as guns] has been associated with declines in suicide rates of as much as 30-50% in other countries. The lethality of the method readily available during a suicidal crisis plays an important role in whether the person survives an attempt . . . a survey of people who had seriously considered suicide in the past

year found that for about 30%, the suicidal period lasted under an hour. 90% of attempters who survive a nonfatal attempt will not go on to die by suicide thereafter. (Barber and Miller, 2014)

There is evidence that training providers on lethal means counseling does result in increased firearm risk assessment and counseling (Slovak and Brewer, 2010). And importantly, counseling does make a difference with families who seek treatment for an adolescent with major depression (Brent et al, 2000). With training and support, primary care and mental health providers at the school-based health centers can provide this evidenced-based suicide prevention counseling for youth and their families in King County.

3. How would your concept address the need?
Please be specific.

There is an opportunity to address both adult and youth suicides in King County by incorporating lethal means restriction counseling into the routine delivery of care. Lethal means restriction counseling is advising people at risk for suicide, and their friends and family, to keep firearms away from the at-risk person until the person recovers. We propose a two-part project focused on both youth, and adults. MIDD's goals focus on improving treatment of those in mental health crisis; saving lives by restricting lethal means allows the mental health system to be successful in delivering care to these individuals, moving beyond the immediate crisis.

- Youth-Focused Expansion of "Lethal Means" School-Based Health Care Provider Training

Counseling by health care providers can make a difference at school-based health centers in King County. Brief counseling efforts by family physicians has been found to have a significant positive impact on the firearm storage habits of their patients. Safe storage practices have been found to result in significant reductions in the risk of unintentional and self-inflicted firearm injuries and deaths among adolescents and children.

There are three (3) school-based health centers that are staffed and administered by PHSKC. They are located at Cleveland High School, Ingraham High School and Rainier Beach High School. A pilot project of training providers on lethal means counseling as part of a continuum of screening for depression and other risks, suicide ideation and when indicated lethal means restriction at these three sites is feasible and practical. PHSKC Violence & Injury Prevention staff members have developed a lethal means restriction training for healthcare providers and have experience delivering it to mental health and youth service providers. The training is ready to be adapted for providers at school-based health centers, which will contribute to the local and national evidence base. Initial conversations with health center administrators are very positive. Dedicated staff time will be necessary to adapt and provide the training for providers and provide support and follow-up for them as they learn to incorporate the assessment and counselling into their practices.

- Adult-Focused Expansion of "Lethal Means" Training to Community Health Center Primary Care Providers

Suicide gun deaths among adults in King County outnumber homicide gun deaths. Piloting the lethal means training of primary care providers or other specialists in partner CHCs may also help to reduce suicide deaths by reducing access to lethal means when a person is in crisis. This approach would continue to improve provider competency and comfort with this screening technique, expand the evidence for what works, and potentially encourage diffusion into the broader health care systems in King County as we communicate results.

4. Who would benefit? Please describe potential program participants.

Youth and adults in King County who are at risk of completing suicide with a gun, as a lethal means, who are seen at public health clinics or in other settings (3 school-based clinics; 3 clinics with adult populations; in-home or other services provided by public health staff). Family members of these individuals, who can help see them through the immediate crisis, also benefit. These individuals can themselves then benefit from other mental health services; without interrupting lethal means, they are lost to us as a community; strengthening our system response to these individuals is ultimately required for additional mental health and supportive services to work – many providers, along with family and community suffer the loss and sense of system failure when we lose an individual

to lethal means.
In addition, the provider community would benefit by being able to help avoid suicides in our community.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

providers who receive lethal means training (data will be collected at trainings)
providers with increased knowledge and attitude towards lethal means reduction (pre/post survey with providers)
adults and children who commit suicide by firearm annually (data produced by MEO/APDE)

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☐ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Suicide not only affects the individual, but has significant impacts on families, communities, and society in general. The long-term goal of a population health approach to reducing people's risk for suicidal behavior is to address factors at multiple levels: individual (e.g. substance abuse or mental health conditions), family (e.g. familial violence); community (e.g. social isolation); and societal levels (e.g. discrimination and inequities in access to opportunities and services).

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

- School-based public health clinics - school nurses, mental health professionals
- Community Health Centers – doctors, physicians assistants, nurses, mental health professionals
- Other community partners to support the research approach, disseminate results, and leverage MIDD dollars by diffusing the intervention into other health systems.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: **$ 50,000 per year, serving** # of people here **people per year**
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

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 # 102
Working Title of Concept: Transformation to a Zero Suicide Approach in King County's Public Behavioral Health System

Submitted by: Jennifer Stuber, Ph.D. Associate Professor, University of Washington, School of Social Work/ Faculty Director, Forefront: Innovations in Suicide Prevention

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1. Describe the Concept

Suicide is a major public health problem. In WA, suicide is the 8th leading cause of death overall and the 2nd leading cause of death among young people ages 15-24.
In King County, there are roughly 250 deaths by suicide every year. For every suicide, it is estimated that 25 attempts are made some requiring expensive emergency room and hospital visits. For every suicide death, it is estimated that six friends and family members of the deceased will struggle with this particularly devastating form of grief for the rest of their lives.

Despite the magnitude of this tragedy, the U.S. Surgeon General considers suicide to be one of the most preventable forms of death. To date, very little progress in reducing suicide rates has been made in part due to the stigma that surrounds suicide, mental health and behavioral health disorders. Approaches to reducing suicide, in order to be effective, much change attitudes and behaviors in addition to systems.

Therefore, a multi-stage project where the Division and its contracted provider agencies will receive intensive training and technical support to adopt and to sustain a Zero Suicide Approach is proposed.

Zero Suicide is a foundational belief that suicide deaths for individuals within health and behavioral health systems are preventable. It is also a specific set of strategies and tools. Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf, a priority of the National Action Alliance for Suicide Prevention http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf, an a project of the Suicide Prevention Resource Center (SPRC) (zerosuicide.sprc.org). The challenge and implementation of a Zero Suicide approach requires a system-wide approach

to improve outcomes and to close gaps. The core elements of this system's base approach include:

- Leadership that conveys a patient safety-oriented culture that is committed to dramatically reducing suicide among people in care;
- Training all staff in the agency commensurate with their potential role in suicide prevention;
- Screening and assessing suicide risk among people receiving care;
- Ensuring every individual has a pathway to care that is both time and adequate to meet their needs;
- Involving family and significant others in safety planning and restriction of lethal means;
- Using evidence-based treatments that directly address suicidal thoughts and behaviors;
- Providing continuous contact and support for individuals at-risk for suicide including utilization of peers who are in recovery from behavioral health disorders who also experienced suicidal behaviors to help support those who are at-risk;
- Applying a data-driven quality improvement approach to inform systems changes that will lead to improved patient outcomes and better care for those at-risk.

This project would roll out in three phases:

Stage 1/Year 1: Technical assistance would begin at the County level working with King County's Mental Health and Chemical Abuse and Dependency Division to: 1) identify sources of data that can be improved and analyzed to assess, as fully as possible, the extent of suicidal behavior occurs within King County's public behavioral health care system and, to put into place, a reporting system on suicidal behavior, and, 2) analyze provider contracts to recommend changes to incentive Zero Suicide approaches within contracted behavioral healthcare agencies.

A summit of leaders in Behavioral Healthcare in King County would be organized to present data on the County's findings, the rational and next steps to achieving a Zero Suicide approach. Contracted provider agencies would apply for two-year grants to assess their current readiness to implement a Zero Suicide approach. A first cohort of the provider agencies, who are determined to be ready based on a bench-line assessment, would be recruited to begin work and would receive Zero Suicide grants.

Stage 2/ Years 2 and 3: The first cohort of contracted provider agencies will receive intensive training and technical assistance to implement a Zero Suicide approach. There will be a 2-day Zero Suicide learning collaborative comprised of implementation teams from each agency. During the 2 days, each team will develop a strategic plan for their work over the next two years and a cross-agency learning collaborative will be established. Technical assistance to each agency and many training opportunities for agency staff will be provided to the learning collaborative of participating contracted agencies over the two-year period. Each participating agency will repeat the assessment of where they stand relative to a Zero Suicide approach two additional times over the 2 years. There will be a graduation for agencies that are successful in shifting to a Zero Suicide approach.

Stage 3/ Years 4 and 5: A second cohort of contracted provider agencies will repeat the learning collaborative, training and technical assistance steps outlined above.

At the end of the 5-year period, King County's public behavioral healthcare system will have made major progress in transitioning to a Zero Suicide approach saving many lives lost to suicide.

2. What community need, problem or opportunity does your concept address?

Suicide prevention should be a major priority for King County's Mental Health and Chemical Abuse and Dependency Division and for MIDD funding because behavioral health disorders are the leading risk factors for suicide. Of those who die by suicide over 90% have a diagnosable mental health disorder. Suicide is the number one cause of premature death among people living with serious mental illnesses who are served within the public behavioral healthcare system. Among people with schizophrenia, an estimated 5 percent end their lives. Suicide is even more pervasive in individuals with bipolar disorder, with 10 percent to 15 percent of these individuals dying by suicide. For clients who struggle with suicidal thoughts and behaviors that are not adequately addressed while in treatment – opportunities for recovery are diminished and utilization of crisis and expensive inpatient services are common. In short, suicide is the worst possible outcome of a behavioral health disorder. Yet, health and behavioral health care systems are often not equipped to address suicide.

3. How would your concept address the need?

Behavioral healthcare agencies often do not have adequate resources to undertake transformative initiatives such as the Zero Suicide concept described here. This concept would offer resources in the form of small grants coupled with leadership training, strategic planning processes, training and technical assistance to enable systems transformation within these provider agencies. The concept also ensures that the county's priorities are in alignment with a Zero Suicide approach for its contracted provider agencies.

Forefront: Innovations in Suicide Prevention would partner with these agencies to help support their transformation to a Zero Suicide approach. Forefront, an organization based out of the University of WA, has a proven track record in supporting systems-based approaches to improved suicide care within schools and Institutions of Higher Education. Because of Forefront's affiliation with the UW, it is easy to partner with the leading suicidologists and depression care experts in the region. Forefront offers evidence-based training to lay people and to health care providers in suicide prevention throughout WA. We are currently partnering with the Linehan Institute to offer training in Dialectical Behavior Therapy (DBT), one of the few know evidence-based practices that exists to treat individuals who are chronically struggling with suicidal behavior.

This concept, through intensive leadership training, strategic planning, on-site technical assistance, the development of a learning collaborative and training opportunities for staff working in behavioral health agencies, would improve the capacity and effectiveness of these agencies to ensure a greater emphasis and commitment to suicide prevention.

4. Who would benefit?

Clients served within King County's behavioral healthcare system who are at-risk for suicide. The provider agencies selected to participate in the Zero Suicide learning collaborative.

5. What would be the results of a successful implementation of the program?

The results of successful implementation would be: 1) reduced suicide rates among clients served within King County's behavioral health system; 2) increased numbers of clinical and support staff who are trained in how to prevent suicide commensurate with their role in the agency; 3) measureable systems-based improvements in suicide care; and 4) fewer emergency room visits and inpatient stays in psychiatric hospitals for clients in publically funded behavioral healthcare systems.

6. Which of the MIDD II Framework's four strategy areas best fit your concepts?

X Crisis diversion
X Systems improvements

7. How does your concept fit within the MIDD II Objectives- to improve health, social, and justice outcome for people living with, or at risk of, mental illness and substance abuse disorders?

See responses to questions 1 and 2.

8. What types of organizations and/ or partnerships are necessary for this concept to be successful?

* Partnerships with behavioral health agencies, mental health and substance abuse providers
* Partnerships with organizations who provide evidence-based training in suicide prevention, depression care and treatment for chronic suicidality
* Partnerships with King County's Mental Health and Chemical Abuse and Dependency Division
* Partnerships with the WA Community Mental Health Council who can work towards implementation of Zero Suicide approaches in provider agencies serving clients with mental health and behavioral health disorders outside of King County

9. How much funding per year do you think would be necessary to implement this concept and how many people would be served?
Year 1: 150,000 to bring King County into alignment with a Zero Suicide approach, to recruit agencies and to develop the assessment tools and training materials
Year 2: $250,000 cohort 1: 6-8 provider agencies served
Year 3: $250,000 cohort 1: 6-8 provider agencies served
Year 4: $250,000 cohort 2: 6-8 provider agencies served
Year 5: $250,000 cohort 2: 6-8 provider agencies served

New Concept Submission Form

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Working Title of Concept: Suicide Safe Emergency Departments

Name of Person Submitting Concept: Lauren Davis
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Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
*Concepts must be submitted via email to MIDDconcept@kingcounty.gov by **October 31, 2015**.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Forefront proposes to implement a suicide safe program for emergency departments (EDs) in King County. This would include training for EDs on proper suicide screening, assessment for suicide risk, brief patient interventions, appropriate discharge planning, and empathy training.

Forefront would provide a two-year long program of technical assistance in suicide prevention best practices to teams from King County EDs, which would consist of administrators, physicians, nurses, and social workers. This would include monthly visits from Forefront staff to assess progress, address challenges, review case examples, and conduct sustainability planning. Forefront would also conduct trainings in specific areas, such as using screening tools and counseling on access to lethal means, throughout the course of the two years.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

Behavioral health patients have longer stays in the ED than any other type of patient. Research indicates that the point of highest risk for suicide is in the days and weeks following discharge from an emergency department or inpatient psychiatric unit (Goldbacre 1993, Paulson 1996). One in ten suicide deaths occur among people who have visited the ED in the prior 60 days (Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department or Inpatient Psychiatric Unit, Suicide Prevention Resource Center, 2011). Despite these statistics, follow-up care for suicidal patients presenting to EDs is sorely lacking. Up to 70 percent of patients treated in an ED for a suicide attempt do not attend their first outpatient appointment (Knesper, 2010).

Research indicates that 8 percent of patients presenting to the ED for a reason other than suicide risk have active suicidal ideation and 2 percent have a suicide plan (Silverman, American Association of Suicidology, 2014).

One study found that half of patients and one-third of family members felt directly punished or stigmatized by ED staff when they/their family member presented to the ED for a suicide crisis (Silverman, American Association of Suicidology, 2014). ED staff attitudes affect whether or not patients attend follow-up care and whether or not they go on to die by suicide (Dr. Leslie Zun, Chair of Emergency Medicine, Mount Sinai Hospital).

A survey of Colorado EDs found that 40 percent of hospitals rarely or never provide information on safe storage of firearms to adult patients admitted for a suicide attempt. There is no similar data available for Washington.

Based on significant anecdotal evidence from suicide prevention advocates, King County ED social workers have limited knowledge of available crisis resources and rarely engage suicidal patients in any of the recommended brief interventions, which include safety planning, patient/family education, and counseling on restricting access to lethal means.

Many people in the general population are at-risk for suicide, which presents a challenge for prevention efforts. However, the people at most acute risk are concentrated in emergency departments. Therefore, EDs can significantly improve health outcomes for suicidal patients if afforded the requisite training and technical assistance. According to national studies, interventions in the ED could reduce suicide deaths by 20 percent annually (National Action Alliance for Suicide Prevention: Research Prioritization Task Force, 2014). Taiwan achieved a 63% reduction in suicide attempts among people who accepted their ED follow-up program.

3. How would your concept address the need?
Please be specific.

ED teams will receive extensive training in the following areas:

Screening: Options for screening in the ED, including utilizing technology for screening, will be presented to the ED teams. Tools such as the Columbia Short Screen and the PHQ 2 and PHQ 9 can help them identify the 8 percent of their patients who have active suicidal ideation, but are not presenting as such.

Assessment: For patients presenting to the ED with a primary complaint of a behavioral health condition, the Joint Commission's National Patient Safety Goal 15.01.01 calls for a comprehensive risk assessment that identifies patient and environmental characteristics that may increase or decrease his or her suicide risk. EDs will receive training on the Suicide Prevention Resource Center's Decision Support Tool and SAMHSA's Suicide Assessment Five-step Evaluation and Triage (SAFE-T) assessment tool.

Brief interventions: These include patient/family education, safety planning, lethal means counseling, rapid referral, and caring contacts. Patient/family education is crucial for breaking down stigma and engendering hope. Safety planning is an effective intervention to allow patients to return home safely. It helps patients identify distraction techniques and coping strategies that they can employ by themselves, natural supports they can call, as well as contacts for acute crisis. This is far different than a contract for safety. Lethal means counseling refers to working with a patient and his/her family to temporarily restrict access to lethal means that can be used in a suicide attempt such as firearms and prescription medications. Rapid referral relates to the ED setting up an outpatient appointment for a patient in one week or less. Caring contacts includes various forms of follow-up with patients presenting to the ED for suicide risk, including mailing postcards or personal or automated phone calls. One of the only RCTs ever to prove a reduction in suicide deaths involved a hospital simply sending a standard postcard with a caring message

to individuals who had presented to the ED with a suicide crisis (G.L. Carter, 2013).

Discharge planning: At present, the responsibility of the ED ends when the patient leaves the hospital and the responsibility of the outpatient provider doesn't begin until their first appointment, which can be weeks out. Those weeks constitute the period of greatest risk for suicide. It is essential that ED personnel provide "warm hand-offs" to crisis services or outpatient behavioral health care, as opposed to simply handing patients a list of phone numbers for agencies that may or may not have availability. There is a significant difference between a resource and a referral. This section will include in-depth information on the array of crisis and behavioral health services available in King County.

Empathy training: Driven by input from individuals with lived experience and UW behavioral health experts, Forefront would develop an empathy training that will be given to all staff at each participating ED. Empathy training would alleviate some of the stigma that behavioral health patients often describe feeling and facilitate staff forming a therapeutic alliance with patients.

Creating suicide safe emergency departments is identified as a critical strategy in both the National Strategy for Suicide Prevention and the Washington State Suicide Prevention Plan.

4. Who would benefit? Please describe potential program participants.

This program would benefit patients in EDs who present for any reason, but especially those presenting with a behavioral health crisis.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

First order outcomes: increased training of ED providers trained, increased awareness of crisis resources among ED providers, increased empathy for behavioral health patients among ED staff, increased use of brief interventions for suicide risk

Second order outcomes: (1) Decrease in suicide deaths following a visit to the ED, (2) decrease in suicide attempts following a visit to the ED, (3) decrease in repeat visits to the ED among behavioral health patients

We are not aware of this data being collected currently.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☐ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.
☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.
☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.
☐ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

The number one risk factor for suicide is mental illness and the number two risk factor is substance use disorder. The vast majority of suicides are preventable. Ninety percent of people who die by suicide have a treatable behavioral health condition. People recover from suicidal crises and go on to live healthy, productive lives.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

Individual hospitals, Washington State Hospital Association, American College of Emergency Physicians (WA state chapter)

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation: $ 250,000 per year, serving 4 emergency departments per year people per year
Partial Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**
Full Implementation: **$** # of dollars here **per year, serving** # of people here **people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.

If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.