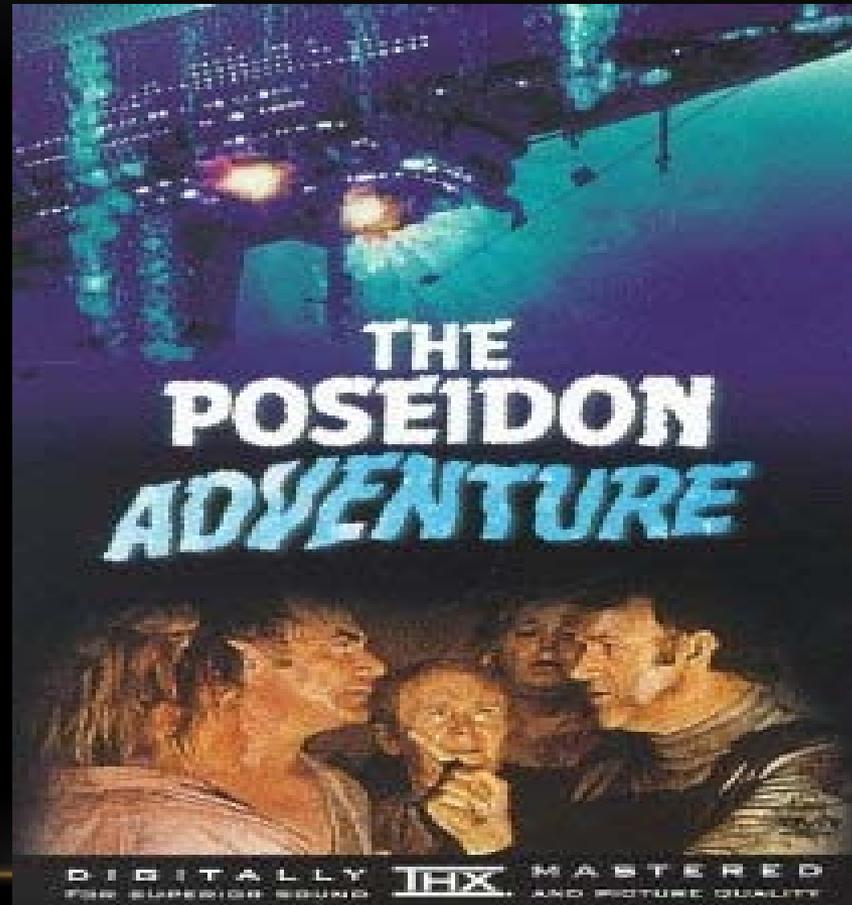


IMPLEMENTING A STATEWIDE SUICIDE RISK REDUCTION PROGRAM WITHOUT NEW FUNDING

ESSENTIAL ELEMENTS



WHOSE RESPONSIBILITY IS IT TO DEVELOP A PLAN?



CONTACT INFORMATION

- Mark Besen, Ph.D
- Area Director Onslow Carteret Behavioral Healthcare Services
- Phone 910-219-8000; 856-701-1228
- Mark_Besen@ocbhs.org; whaler88@msn.com

ESSENTIAL ELEMENTS

- Administrative will to reinforce process
 - Consensus about model – Shared Understanding of Suicide Risk and How to Reduce
 - Consistent expectations/ Written Protocols
 - Appropriate network of Services
 - Method of monitoring with consequences
 - Methods of funding
 - Methods of Measuring Results
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ADMINISTRATIVE WILL

- Requires high energy, positive marketing
 - Training is NOT Development
 - Person accountable for long term support of process
 - Liaisons to organizations implementing change
 - Development of Contract Deliverables (unfunded mandates)
 - Development of supportive legislation
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MODELS

- www.sprc.org/bpr - American Foundation for Suicide Prevention/Suicide Prevention Resource Center Best Practice Registry: 3 levels, majority in section III (expert consensus)
- www.nrepp.samhsa.gov – SAMHSA National Registry of Evidence Based Programs and Practices: Meet research standards (12 suicide programs, most related to school based)

EXAMPLES OF EVIDENCE BASED AND BEST PRACTICE MODELS

Examples NREPP

- SOS (Signs of Suicide) – Adolescent Program
- DBT (Dialectical Behavioral Therapy)
- MST (Multisystemic Therapy)

Example SPRC

- ASIST (Applied Suicide Intervention Skills Training)
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QPR/QPRT – EXAMPLE OF MODEL

WWW.QPRINSTITUTE.COM

QPR – Question, Persuade, Refer (gatekeeper training) – NREPP (pending), SPRC Best Practice (expert consensus)

QPRT – Question, Persuade, Refer, Treat (clinical training) – SPRC Best Practice (expert consensus), TIP
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QPR/T DIFFERENT FLAVORS

- 1-2 hour gatekeeper training for public (teachers, family, clerical/administrative, etc.)
 - Full day train the trainer model for new trainers.
 - Full day triage training for health care professionals (physicians, nurses), emergency responders (police), public health professionals.
 - Full day treatment training for mental health professionals (psychiatrists, psychologists, counselors).
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QPR/T ACCREDITATIONS/ENDORSEMENTS

- QPR programs are officially endorsed and used by the health and mental health leadership in the following states: Virginia, Tennessee, Kentucky, Montana, Georgia, Oklahoma, Oregon, South Carolina, Colorado, Wisconsin, Alaska, Florida, Missouri, Illinois and others.
- QPR is currently taught on more than 207 college and university campuses in US and Canada
- Official gatekeeper program for US Army... elements of Air Force, Marines, and Navy
- Veterans Administration Hospitals using system - 22

QPR STATS CONTINUED

- Certified QPR Instructors – 8,500
 - Gatekeepers Trained to date – 1.2 Million
 - Advanced QPRT Clinical Trainers – 150
 - Over 500,000 licensed assessments completed in practice.
 - Professionals Trained in Risk Assessment (as of 2008)– 17,900
 - Adopted in Canada, Korea, Cuba, Italy, New Zealand, Puerto Rico, Qatar, Singapore. Israel, Bhutanese Refugees.
 - Available on-line training, subscription service, essential learning.
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CONTENT OF QPR AND QPRT TRAINING

(QPR ONLY HIGHLIGHTED IN RED)

- Identification of Suicide as Solution to Perceived Insoluble Problem and relationship of suicide risk to untreated psychiatric illness.
 - Increased awareness of risk factors associated specific psychiatric illnesses.
 - Increased awareness of risk factors associated with environmental events.
 - Identification of protective factors.
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CONTENT OF QPR AND QPRT TRAINING

(QPR ONLY HIGHLIGHTED IN RED)

- Practice Risk Ratings Exercises using risk factor vs. protective factor model.
- Specific instruction of how to talk with people who may be at risk of suicide and link with resources.
- Specific questions/content areas to include in suicide risk assessment including practice role plays.
- Review of organizational protocols/policies and how to implement in organizations.

VALUE OF ADOPTING A MODEL

- Establish shared understanding of why person is contemplating suicide and how to intervene.
 - Establishes common language in identifying and discussing risk within and across organizations and with person/family members at risk.
 - Establishes written expectations of how to assess for risk.
 - Establishes written expectations of when to assess, how to document, how to monitor throughout care process and how to link with very specific resources that will decrease risk.
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SAMPLE ELEMENTS OF WRITTEN CLINICAL PROTOCOL

- Minimum requirements for staff training and continuing refresher training.
 - Minimum documentation expectations and components of standard assessment.
 - Specific times when suicide risk must be assessed.
 - How risk will be included in plan of care and how will be monitored throughout care.
 - How risk will be communicated within and between agency.
 - How risk will be addressed for persons with persistent suicidal ideation.
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ESSENTIAL SERVICES IN NETWORK TO REDUCE RISK

- Crisis Response Model Focused on Problem Solving Support outside of Emergency Department
 - Accessible care including medications/ Follow up with care coordination.
 - Evidence based treatment protocols for:
 - Integrated treatment for co-occurring substance use disorders and other psychiatric illness (IDDT).
 - Personality Disorders (DBT; Schema Focused Cognitive Therapy for PD; Trauma Focused Therapy)
 - Psychotic Disorders (WMR/IMR, ACTT)
 - Affective Disorders (CBT)
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A NOTE ON CRISIS RESPONSE MODELS

- Recommend community based 24 hour community based centers providing intensive non residential (less than 24 hour), support. Not same as mobile crisis.
- Spokane Mental Health in Washington State:
- Over 3 years of data demonstrates:
- Average length of stay – approximately 17 hours.
- Average hospitalization rate post intervention – 3%
- Average recidivism rate as determined by hospitalization within 30 days post discharge – 3%
- Average ED hospitalization rate in NC approximately 35%.
- Average ED hospitalization rate in Onslow and Carteret Counties 45% (70% is add crisis residential).

HOW TO MONITOR?

(IF YOU MEASURE IT, IT WILL HAPPEN)

- Require elements to be reported in dashboards for MCO's and Providers
 - Require elements to be incorporated in QM plans
 - Require staff training for qualifications for services
 - Require fidelity scales for EBP's as part of contract monitoring
 - Joint Commission requires suicide policies and procedures
 - Require continuing education for license renewal (including other professionals outside of behavioral health)
 - Required continuing education for teacher recertification
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HOW TO IMPLEMENT WITHOUT NEW FUNDING?

- Assign responsibility within Division to take accountability for implementing project. Provide ongoing technical assistance to MCO's and providers over years.
 - Pass responsibility to LME/MCO's – LME's can fund train the trainer sessions for provider network. Can use existing model (cost for proprietary materials) or develop own based on content (careful about intellectual property copyright infringement).
 - Pass responsibility to CABHA's and other providers – Providers can be required through contracts to include certain elements in care delivery.
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IMPLEMENTATION CONTINUED

- Promote and require use of appropriate evidence based practices to support effective care for persons at risk of suicide.
- Implement gatekeeper training throughout state – very inexpensive if community groups take on. For example, train the trainer sessions for QPR cost \$500/trainer (already have robust number of trainers in state) and \$1.75 for each community participant trained afterwards. Can get free training scholarships for community members as well.
- Lobby for legislative reform such as that achieved in New Jersey and Washington State.
- Implement suicide specific training in residency programs, medical schools, nursing programs, and allied behavioral health programs.

HOW EXPENSIVE IS THIS?

EXAMPLE OF IMPLEMENTATION FOR ORGANIZATION OF 200 CLINICIANS USING QPRT

- Cost for train the trainer \$500 (start up only)
- Cost for each staff member initial training $\$25 \times 200 = \5000 (start up only) est. annual cost at 20% turnover = \$1000
- Cost for licensure for using proprietary assessments in organization providing full continuum of services (estimated at 10,000 assessments / year) \$3500
- Start up total = \$9000; Annual = \$4500; Annual without using proprietary assessment = \$1000
- Cost of one inpatient hospitalization at \$500/day for 7 days = \$3500.

HOW TO KNOW IF IMPLEMENTATION SUCCESSFUL?

- Pre-post content knowledge from training.
- Fidelity of service delivery models to state of art content – measured through contract review/dashboards.
- Number of reported deaths by suicide in communities and by state in terms of number of deaths / 100K
- Volume at emergency departments.
- Number/percent of gatekeepers trained per high risk community/population.
- Review outcomes measures from associated research.

PUBLIC HEALTH GOAL FOR 2020

- Current North Carolina Suicide Rate = 12.4/100K
- National Average Suicide Rate = 11/100K
- Lowest Suicide Rate in US = 6/100K
- Projected North Carolina Suicide Rate = 8/100K

SUMMARY OF IDEAS

- State to identify point person for gatekeeper initiative and a point person for clinical initiative.
- Set up steering committees for each with state, NC Council, LME, provider, service recipient, family, and other stakeholders as appropriate. Make small enough to be productive.
- Identify specific desired content for gatekeeper and clinical trainings. Identify acceptable models.
- Build training requirements into contracts with LME's and providers (or pilot in selected areas). Allow to choose from models or participate in state developed training
- Build standard elements of suicide risk management into LME and provider contracts (or pilot in selected areas).
- Include these elements in monitoring of new MCO's performance.
- Lobby for legislative reform for licensed professions including teachers for continuing education requirements for recertification/ licensure.