Zero Suicide Element: Transition

Provide continuous contact and support, especially after acute care.

Zero Suicide Element: Transition

- Suicidal individuals often fall through multiple cracks in a fragmented and sometimes distracted health care system so a systematic approach to quality improvement is necessary.

- Care transitions are high-risk times for patients
  - Have comprehensive policies for safe care transitions that create bridges
  - Remove barriers to scheduling a patient's follow-up appointments.
  - Address suicide risk at every visit within an organization, from behavioral health clinician to another or between primary care and behavioral health staff in integrated care setting.

- Organizational policies provide guidance for successful care transitions
- Ensure continuity of care

Zero Suicide Element: Transition

- Provide brief patient education that promotes understanding of their condition and what treatment options exist to facilitate patient and family follow-through
- Assist the individual in understanding and navigating the system of potential supports, preferably from a peer
- Utilize Crisis Services to supplement care

Zero Suicide Element: Transition

- Caring Contact examples on the Zero Suicide website

Zero Suicide Element: Transition

- The County's role in emergency detentions or working with emergency departments
- Liability issues that may arise

Zero Suicide Element: Transition

- Utilize community organizations and programming in the least restrictive environments
  - Peer run respite
  - Warmline
  - Educational groups
  - Support groups

New Hampshire Hospital Aftercare Program

Creating Community Connections to Prevent Youth Suicide

Presented by:
Elaine de Mello, LCSW
Shannon Murano, MS

New Hampshire Hospital (NHH)

- NHH provides impatient psychiatric tx to patients admitted on an involuntary basis by an Emergency Admissions Process (IEA)
- 168 beds including 24 children's beds
- Approx 600 staff including: board certified psychiatrists, general medical services, specialized nursing, allied clinical, administrative and support personnel

https://www.dhhs.nh.gov/dcbcs/nhh/

Project Red

- Educate pt about Dx, tests, assessment
- Set up post discharge appts and services
- Review medication plan
- Reconcile d/c plan with national guidelines
- Review plan and contingencies
- Expedite exchange of clinical information to providers
- Follow up call to assure linkage, problem solve barriers

Overview of NHH Aftercare Program

- The NHH A/C program was designed to expand, develop, and direct New Hampshire's youth suicide prevention and early intervention strategy, targeting high risk youth.

- Over the 3-year grant period, the project served youth ages 10-24, specifically those who demonstrate factors placing them at higher risk for suicide, such as: substance abuse, military experience, minority and refugee populations, LGBTQ populations, young adults not enrolled in college, and justice-involved young people.

New Hampshire Hospital

New Hampshire Hospital's goal:

- To reduce suicide incidents by increasing access to essential care and supports through a systematic approach to identified high-risk youth

Why New Hampshire Hospital?

- NHH is the last resort for highest risk individuals
- The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an inpatient psychiatric hospital
- The number of post-hospitalization suicides peaks within a week after discharge
- Over 70% of suicide attempters (of all ages) do not attend their first outpatient appointment

(Luxton, June, and Comtois, 2012)

Referrals

- Meet with NHH Treatment team regularly to identify cases to be assigned by the following criteria:

  - Between the ages of 10 and 24
  - Have made an attempt and/or at risk for suicide/readmission
  - In need of and ready/willing to engage in follow-up support
  - Priority sub-populations
  - Returning to priority areas

Program Overview

- Following youth and their families for up to 90 days subsequent to discharge from N.H.H.
- Providing enhanced follow-up services including care coordination and support in order to reduce risk of suicide, improve engagement in recovery activities, and avoid readmission
- Follow-up services include both face-to-face and telephonic interventions; the frequency varies and is determined on a case-by-case basis

Program Components

- Education to youth and support system about warning signs, risk and protective factors, and means restriction
- Identification of social supports and personal resources
- Interface with professional agencies, other statewide organizations, programs, and resources
- Safety Planning
- On going Assessment

Program Components

- Education and Assessment:
  - Ongoing review, education and evaluation with youth and support system of personal risk and protective factors, warning signs and triggers related to the youth and their environment
  - Means restriction education to ensure that caregivers are aware of the potentially dangerous items in their home; assistance is offered in developing a plan to remove those items

Program Components

- Identification of Social Supports:
  - Identification of trusted adult(s) that the youth is willing to talk to when they are having thoughts of suicide
  - Open communication is key in assisting youth and caregivers in identifying potential triggers leading to suicidal thoughts/behaviors

Program Components

- Interfacing with other professionals, agencies, organization to ensure continuity of care:

  - NHH treatment teams
  - Community Mental Health Centers (CMHCs)
  - Regional Public Health Networks (RPHNs)
  - National Alliance on Mental Illness (NAMI)
  - Peer Support Services
  - Schools
  - Community Services
  - Natural Supports

Community Connections

The Civil Air Patrol Cadet Program

5K JUMPSTART5K

Civil Air Patrol's Cadet Program is a non-profit, year-round youth leadership and aerospace education organization for students ages 12 to 20. Chartered by U.S. Congress and tasked with creating tomorrow's leaders, Civil Air Patrol has been mentoring teens and helping them succeed since 1941. Cadets progress through our self-paced education and military-style-advancement structure and wear Air Force-style uniforms but are not obligated to join the Armed Forces; this is not a recruiting program.

Appalachian Mountain Teen Project

AMTP fosters resilience, enriches opportunities, and develops stable, secure relationships in the lives of young people who face difficult life circumstances.

Therapeutic Horsemanship

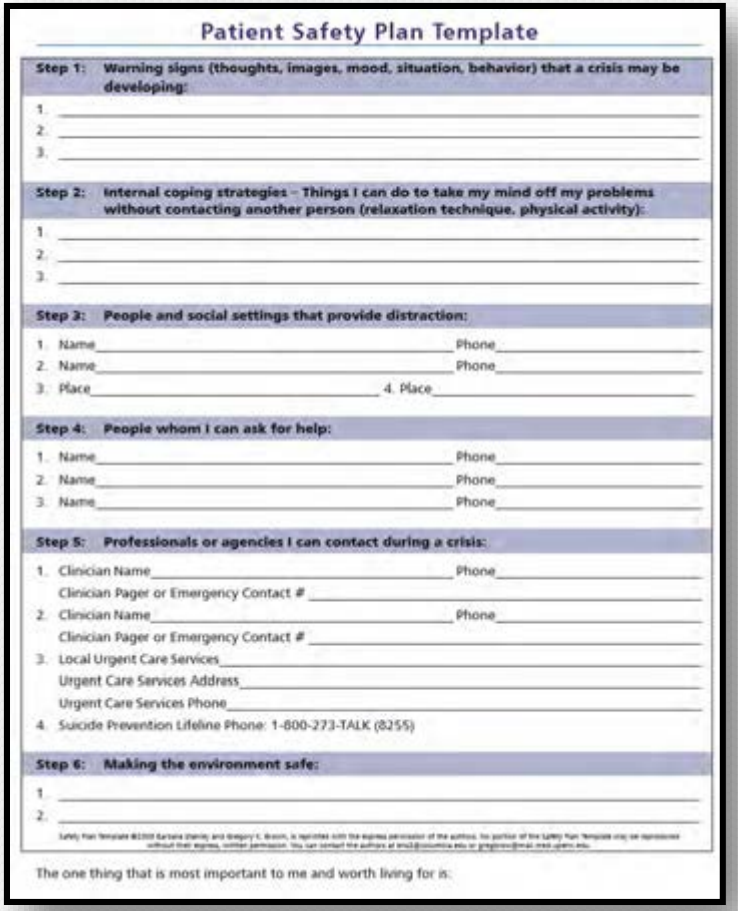
Therapeutic horsemanship includes Equine Assisted Activities (EAA) organized and taught by an instructor trained to work with people with varied disabilities and diverse needs.

Girls on the Run

Girls on the Run is a life-changing, non-profit program for girls in the 3rd through 8th grade. Their mission is to inspire girls to be joyful, healthy and confident using a fun, experience-based curriculum which creatively integrates running.

Program Components

- Safety Planning:
  - Prioritized list of coping strategies and sources of support to use during a crisis



Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

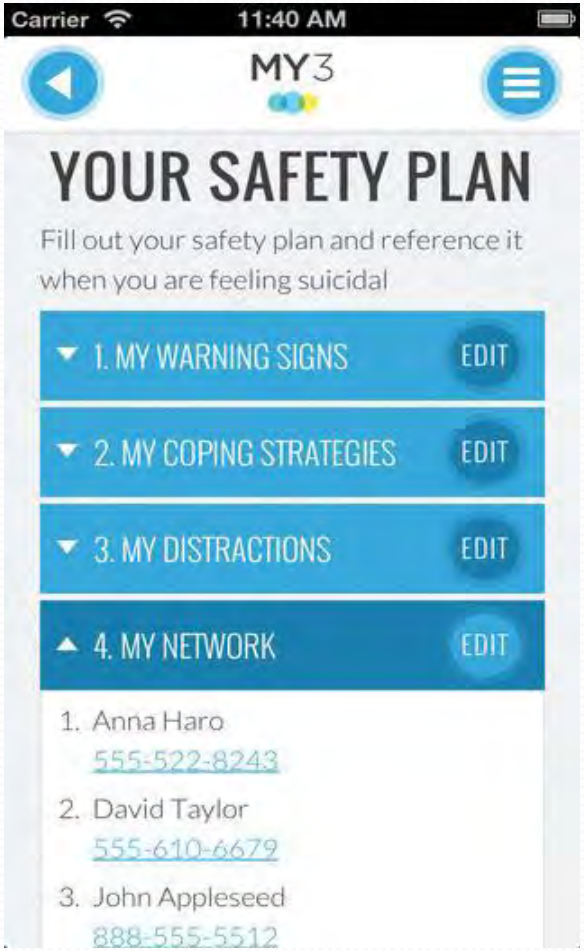
1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

Suicide Prevention Resources



Available on the App Store

Get it on Google play

http://www.my3app.org/

Resources

- Dialectical Behavioral Therapy (DBT) and Illness Management and Recovery (IMR) focused groups
- Suicide prevention education for parents
- Mayo-clinic video for parents/family/caregivers
- My3 Safety Planning application introduced prior to discharge
- Families connected with NAMI NH prior to discharge

Assessment

Preparedness Assessment Tool:

- Measures:
  - a. Hope
  - b. Connections/Support
  - c. Self-Management

- Suicide Risk Scale:
  - a. 1=No/Low Need
  - b. 2=Moderate Need
  - c. 3=High Need

HOPE			
1=No/Low Hope	**2 = Moderate Hope**	**3= High Hope**	
Patient *cannot identify* any spiritual, educational, familial, or personal resources Patient cannot identify any goals or something to look forward to Patient has made hopeless comments	Patient can identify *one or two* spiritual, educational, familial, or personal resources Patient can identify something to look forward to upon leaving the hospital OR can identify a personal goal Patient has made ambivalent comments about hope	Patient can identify *more than two* spiritual, educational, familial, or personal resources Patient expresses enthusiasm for some event in the future and can identify any short or long-term goal Patient has made hopeful comments	**Hope=**

SUPPORT			
1=No/low Support	**2=Moderate Support**	**3=High Support**	
Pervasive interpersonal problems, family dysfunction, no close friends or meaningful relationships, problems at school and with peers, tendency to withdraw and/or become isolated, reported stigmatization and inability to identify any sources of support.	Multiple problem areas and few connections/support	One or two problem areas and strong connections/support. Patient's family is engaged and participates in treatment plan. The patient has one or two friends regarded as close and is engaged in activities.	**Support=**

SELF MANAGEMENT			
1=No/Low Self Manage	**2= Moderate Self Manage**	**3= High Self Manage**	
Patient and family does not know the patient's diagnosis, symptoms, and medications Patient and family cannot identify early warning signs and triggers or describe crisis plan Patient and family are not confident in their ability to manage at home	Patient and family's understanding is minimal Patient and family are somewhat confident in their ability to manage at home	Patient and family knows the patient's diagnosis, symptoms, and medications Patient and family can identify early warning signs and triggers, and describe crisis plan Patient and family are confident in their ability to manage at home	**Self Manage=**

Total Preparedness Score (Hope+Support+ Self Management)/3=

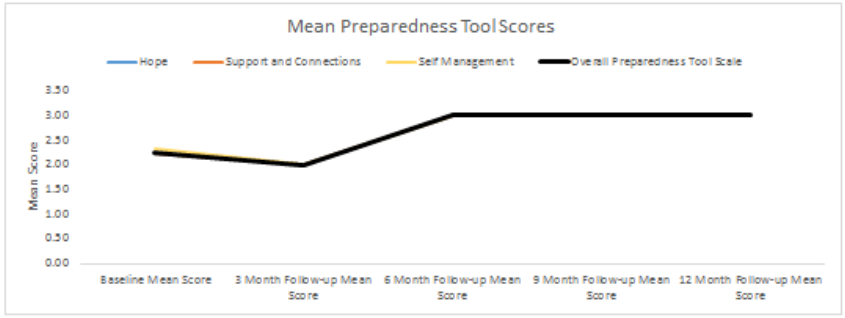
Data Dashboard: Demographics

Case ID	Current Status	Date of Referral to GLS Liaison	Date of NHH Intake	Referring Team/Clinical Staff Person	Patient Age	Previously Worked With GLS Coordinator	Number of Prior Admissions	Priority Region

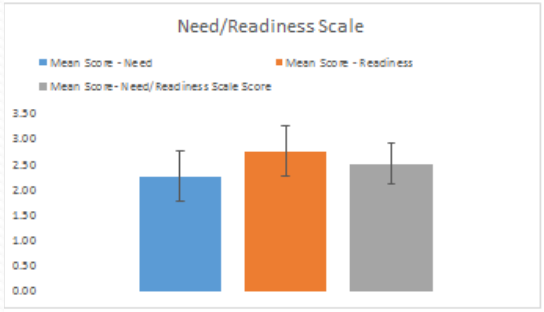
Data Dashboard: Assessment

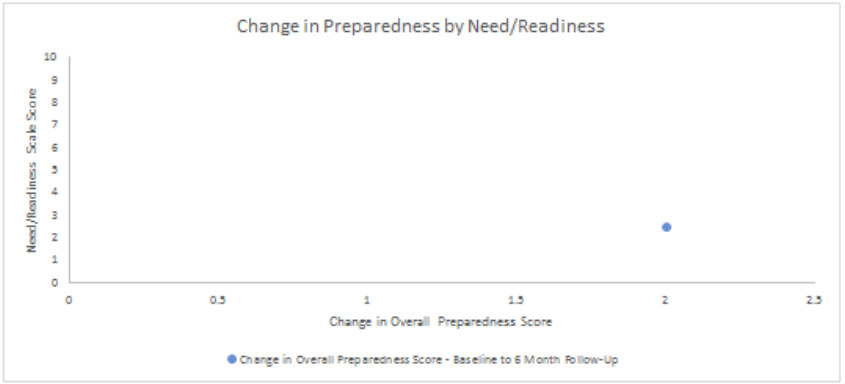
	General		Prior Admissions				Prioity Region				Priority Population						
	Total number of Referred	Total number of active	Minimum Number	Maximum Number	Mean	Mode	Not From Priority	Capital Regio	oakes Regio	anchester Regio	LGBT	Minority	Refugee	Substance Abuse	Military Experience	College Age and Not Enrolled in	Justice Involv
Number of Cases	5	1	1	8	4.14	4	0	0	0	0	0	0	0	0	0	0	0

	Hope	Support and Connection	Self Management	Overall Preparedness
Baseline Mean Score	2.22	2.22	2.33	2.26
3 Month Follow-up Mean Score	2.00	2.00	2.00	2.00
6 Month Follow-up Mean Score	3.00	3.00	3.00	3.00
9 Month Follow-up Mean Score	3.00	3.00	3.00	3.00
12 Month Follow-up	3.00	3.00	3.00	3.00



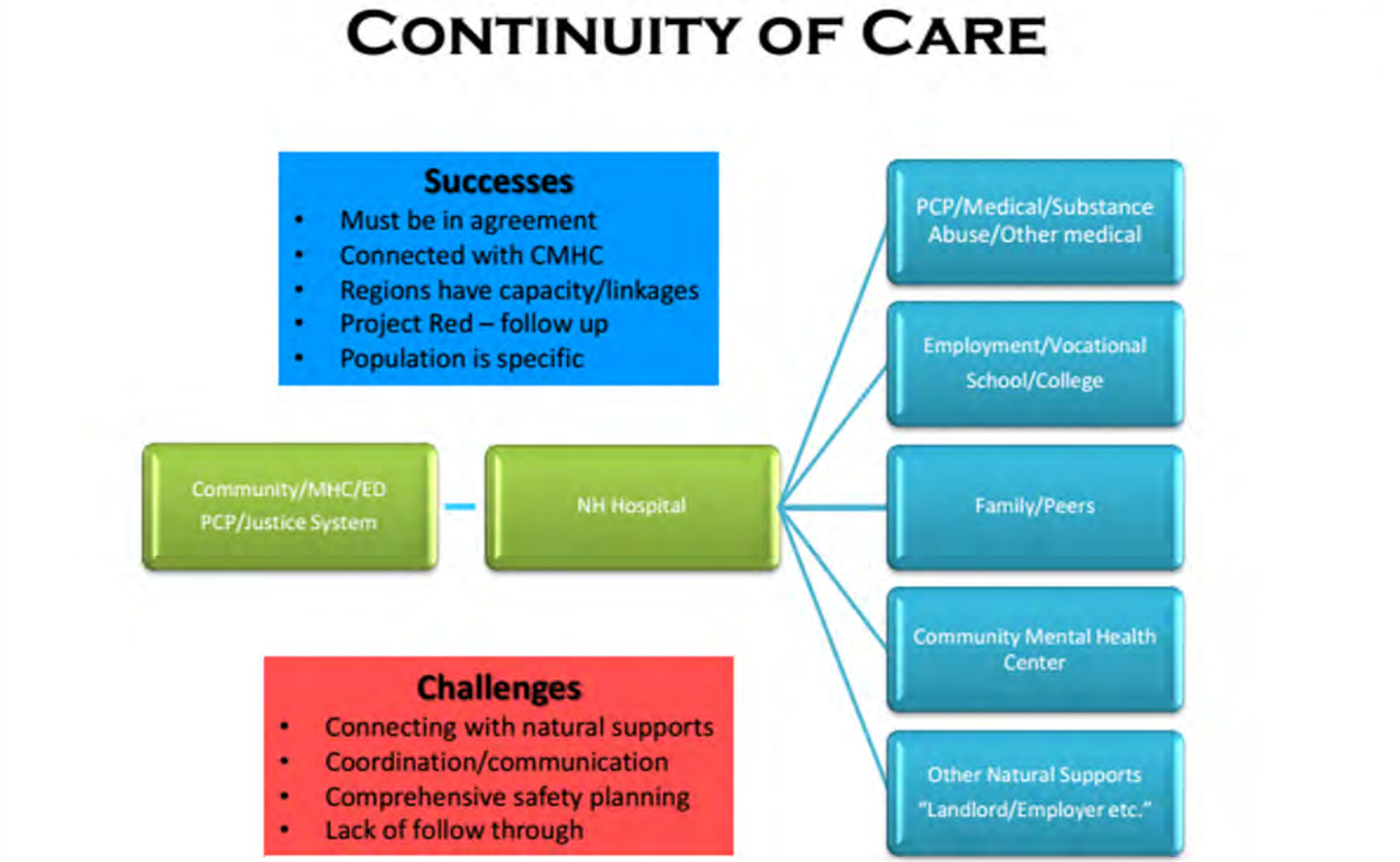
	Need	Readiness	Need/Readiness Scale Score
Mean Score	2.25	2.75	2.50
Standard	0.50	0.50	0.41





Community Linkages

Continuity of Care



Strategies for Continuity of Care

- MHC release form signed prior to discharge-ensures immediate communication & eliminate gaps in contact
- Safety plan to involve and educate natural supports as selected by the youth and family member
- MHC provides reminders for visits (personal calls) at several intervals prior to appointment
- MHC does immediate follow-up if youth does not show
- MHC alerts After Care Liaison of certain adverse events: no-show; attempt or other crisis
- MHC advises AC liaison if someone is admitted, esp with hx of non-compliance to generate early engagement prior to discharge

Instituting Best Practices

- Conducting Safety Plans with all patients prior to discharge
- All patients get NSPL and NAMI NH info on discharge
- Better linkages and reducing gaps in care: releases for providers & supports signed prior to discharge; safety plans shared
- Families and patients educated on lethal means
- All Mental Health Workers receive Connect suicide prevention training as part of orientation
- Suicide Prevention Task Force established in 2015
- NHH has 4 Connect Train the Trainers

Life Saving Interventions

Challenges & Lessons Learned

Challenges:

- Patient/family willingness to involve others varies
- Communication with key supports/schools
- No consistent or integrated EHR
- Research and evaluation

Lessons Learned

- Public/private partnership
- Engaging key personnel from beginning
- Establish protocols, relationships and ROI process early
- Embed position at the hospital
- Hire the right person as Liaison
- Champions to move the pace and the needle
- Persistence

Successes

- Best practices and Zero Suicide being implemented
- All patients & supports involved in safety planning and lethal means counseling prior to discharge
- All patients & family members get NSPL and NAMI NH info
- Records and communication exchange across MH System greatly enhanced
- All MHW and SW staff trained in Connect
- Position sustained

For More Information:

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Thank you, Elaine & Shannon!

Questions???

Implementation Planning: Transition

- How does your organization keep in touch with clients during times of transition or discharge?
- Are you aware of any “cracks” in the system that contribute to individuals not receiving adequate follow-up services? What will it take to improve this?
- Are there policies and procedures in place to coordinate, track and monitor individuals who are at-risk?
- What can be done to improve the system-wide approach to coordinating care between agencies for those at-risk?