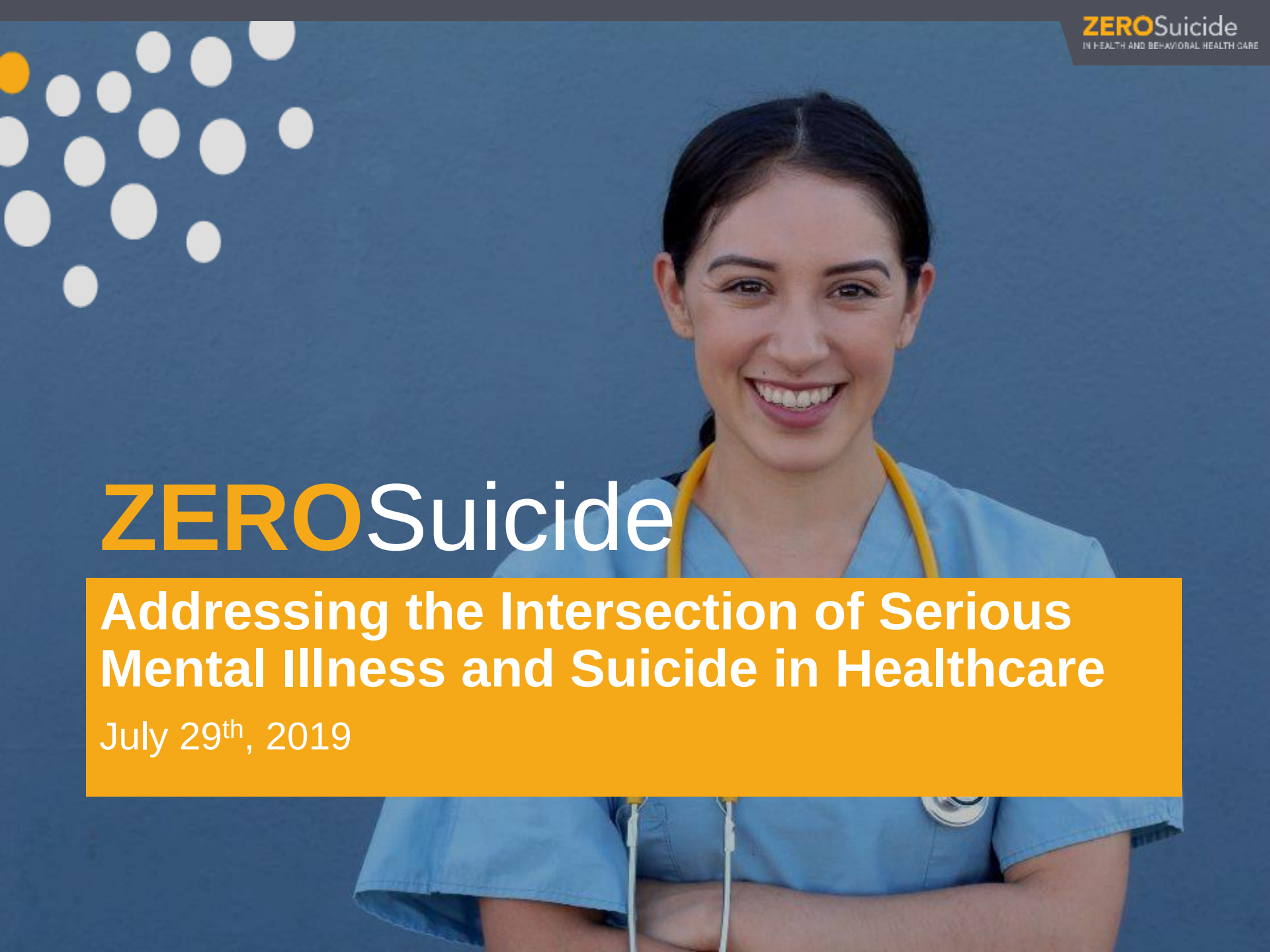


ZEROSuicide

Addressing the Intersection of Serious Mental Illness and Suicide in Healthcare

July 29th, 2019

Funding and Disclaimer

» The Suicide Prevention Resource Center at EDC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 5U79SM062297.

» The views, opinions, and content expressed in this product do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS.

Suicide Prevention Resource Center

ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

The national **Suicide Prevention Resource Center (SPRC)** is your one-stop source for suicide prevention. We help you develop, deliver, and evaluate evidence-informed suicide prevention programs.

What we offer

- Best practice models
- Toolkits
- Online trainings
- Research summaries and more!

Who we serve

- Organizations
- Communities
- Agencies
- Systems

CONNECT WITH US

www.sprc.org

@SuicidePrevention ResourceCenter

@SPRCTweets

Zero Suicide

- Started in behavioral health—that's the core
- Aims to keep people alive so they can experience recovery
- Focuses on error reduction and safety in health care
- A set of best practices and tools including www.zerosuicide.com

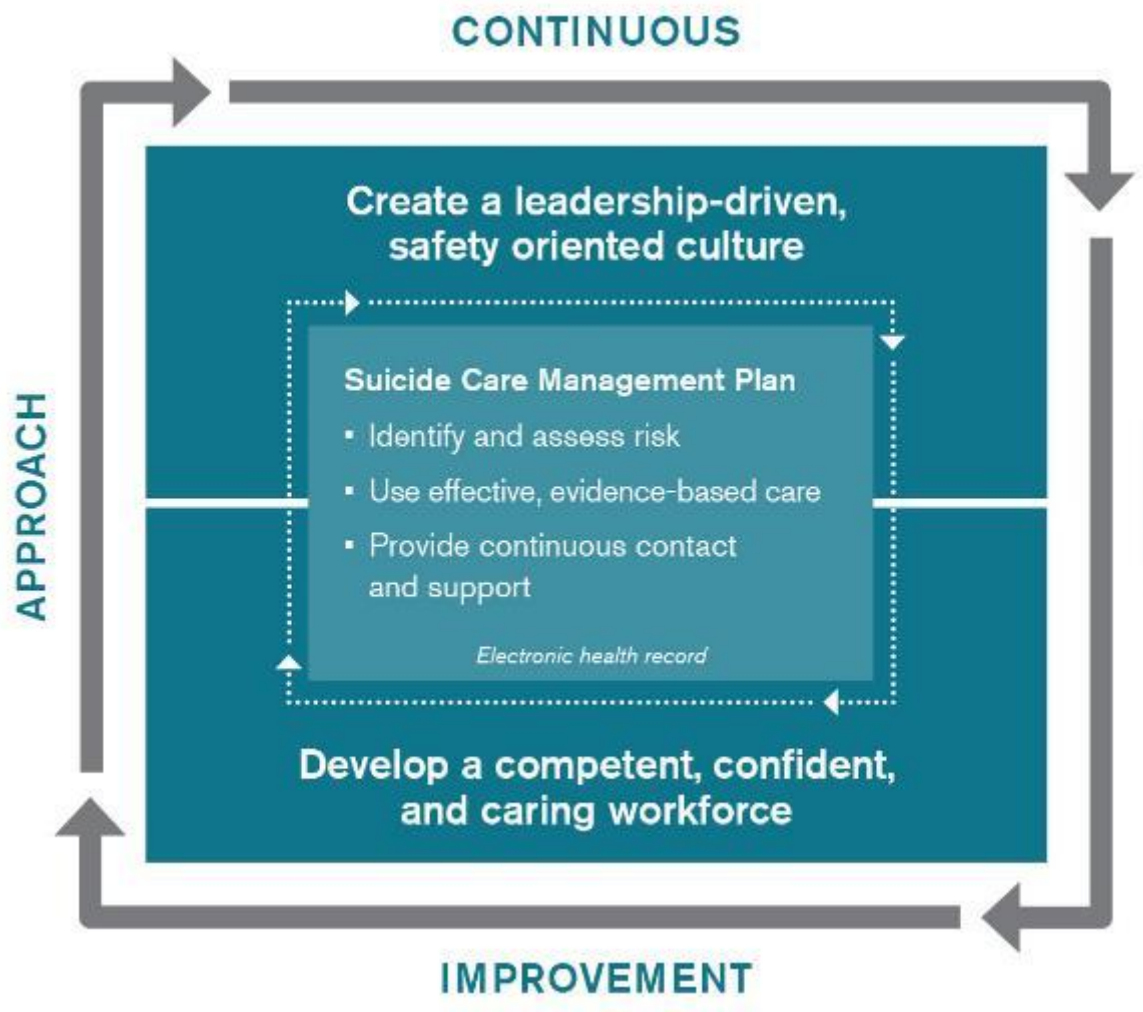
Seven Elements of Zero Suicide

www.zerosuicide.com

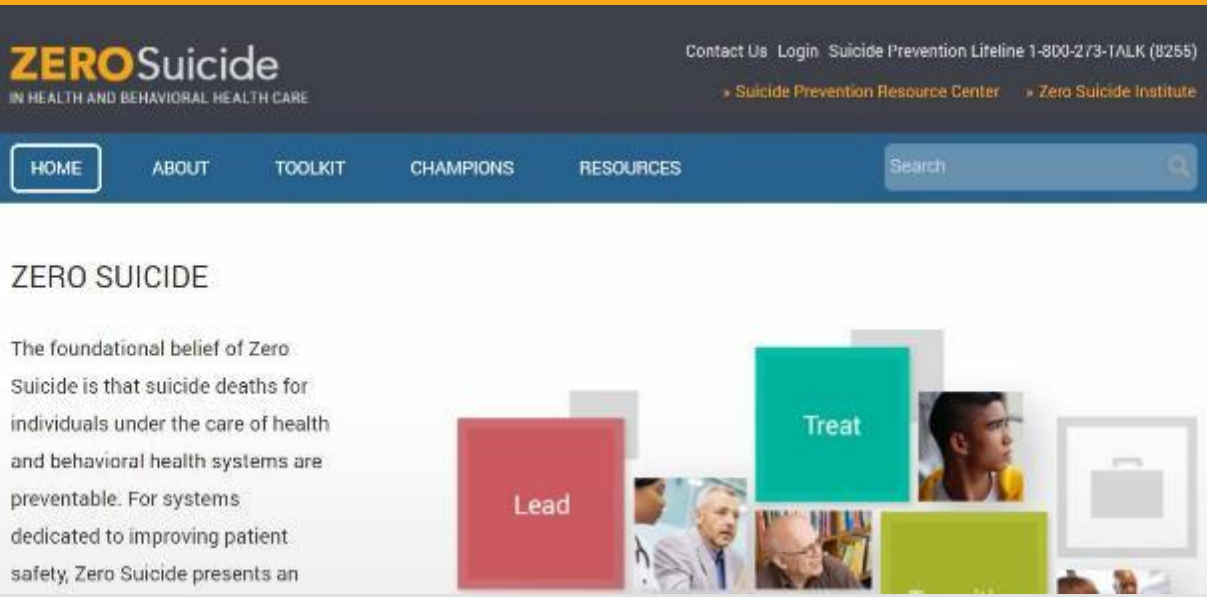
The National Action Alliance for Suicide Prevention outlined seven core components necessary to transform suicide prevention in health care systems:

LEAD	Lead system-wide culture change committed to reducing suicide.
TRAIN	Train a competent, confident, and caring workforce.
IDENTIFY	Identify individuals at-risk of suicide via comprehensive screening and assessment.
ENGAGE	Engage all individuals at-risk of suicide using a suicide care management plan.
TREAT	Treat suicidal thoughts and behaviors using evidence-based treatments.
TRANSITION	Transition individuals through care with warm hand-offs and supportive contacts.
IMPROVE	Improve policies and procedures through continuous quality improvement.

Continuous Quality Improvement



Zero Suicide Toolkit



www.zerosuicide.com

The online Zero Suicide Toolkit offers free and publically available tools, strategies, and resources, plus links and information to:

- Get key implementation steps and research information
- Explore tools, readings, webinars and other public resource
- Access templates from implementers across the country
- Connect with national implementers on the Zero Suicide email list

Learning Objectives

- Describe the importance of addressing suicide risk for those with SMI in HBH organizations.
- Identify resources that are available to support suicide prevention and care for individuals with SMI and how to access these resources.
- List the benefits of taking a patient-centered approach to treating suicide risk and SMI that includes community, peer, family, and other supports.

Presenters

David Covington
Recovery Innovations, Inc.

Shareh Ghani
Magellan Health

Teri Brister
National Alliance on Mental Illness (NAMI)

Presenter

David Covington, LPC, MBA
CEO & President
Recovery Innovations, Inc.

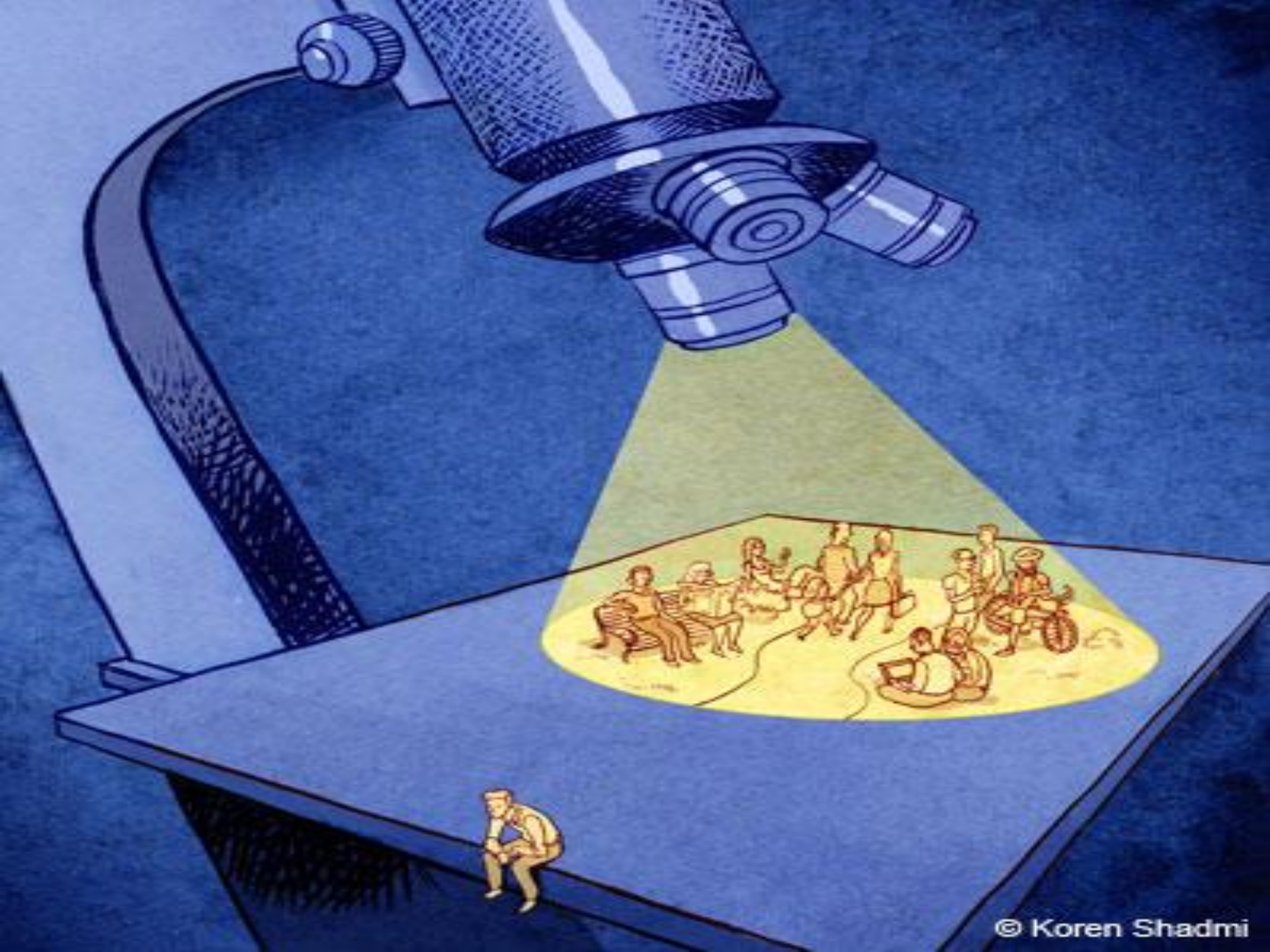
Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)

The Way Forward: Federal Action for a System That Works for All People Living with SMI and SED and Their Families and Caregivers

CRISIS: 4.2 Develop an integrated crisis response system to divert people with SMI and SED from the justice system *(also 2.1 Define and implement national standard for crisis care and 2.2 Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization)*

ZERO SUICIDE: 3.7 Advance the national adoption of effective suicide prevention strategies*. All federal departments, including VA and DoD, should adopt Zero Suicide as a model for suicide reduction, and agree to develop and implement strategic plans with achievable and transparent targets for progress. Consider ways to widely disseminate and universally apply these strategies in the public health system.*

PEER SUPPORTS: 2.8 Maximize capacity of BH workforce: Include coverage of peer and family support specialists in federal health benefit programs *(also 3.1 Comprehensive continuum of care, with team-based models that are interdisciplinary and incorporate peer and family support specialists, 4.2 Crisis response system should include warm lines staffed by certified peer specialists and 5.2 Adequately fund the full range of services, including family and peer support services*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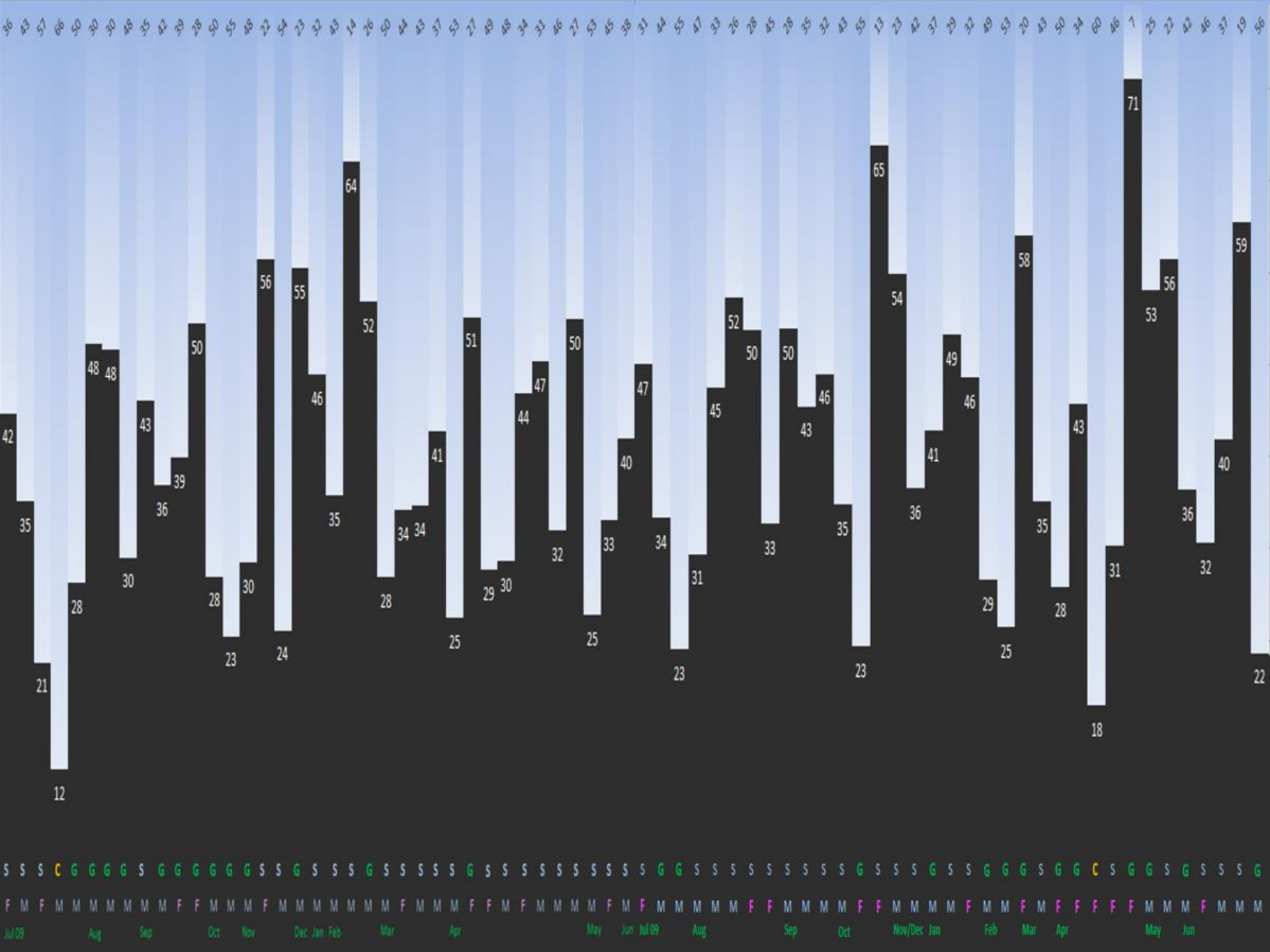
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Suicide prevention efforts tend to focus on "at-risk" groups

(rates greater than general population)

White Males 65+
The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85. *http://bit.ly/men-s*

Veterans/Military
In 2010, *USA Today* reported the current U.S. Army suicide rate at 22 per 100,000 *(http://usat.ly/army-s)*, but the Fort Hood rate was 47 per 100,000. *http://bit.ly/ft-s*

AN/AI
In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. *USA Today* reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. *http://usat.ly/an-ak*

LGBT Youth
The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate. *http://bit.ly/wik-lgbt*

Individuals with SMI
In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness. *http://bit.ly/SMI-suicide-12x*

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.


SUICIDAL?
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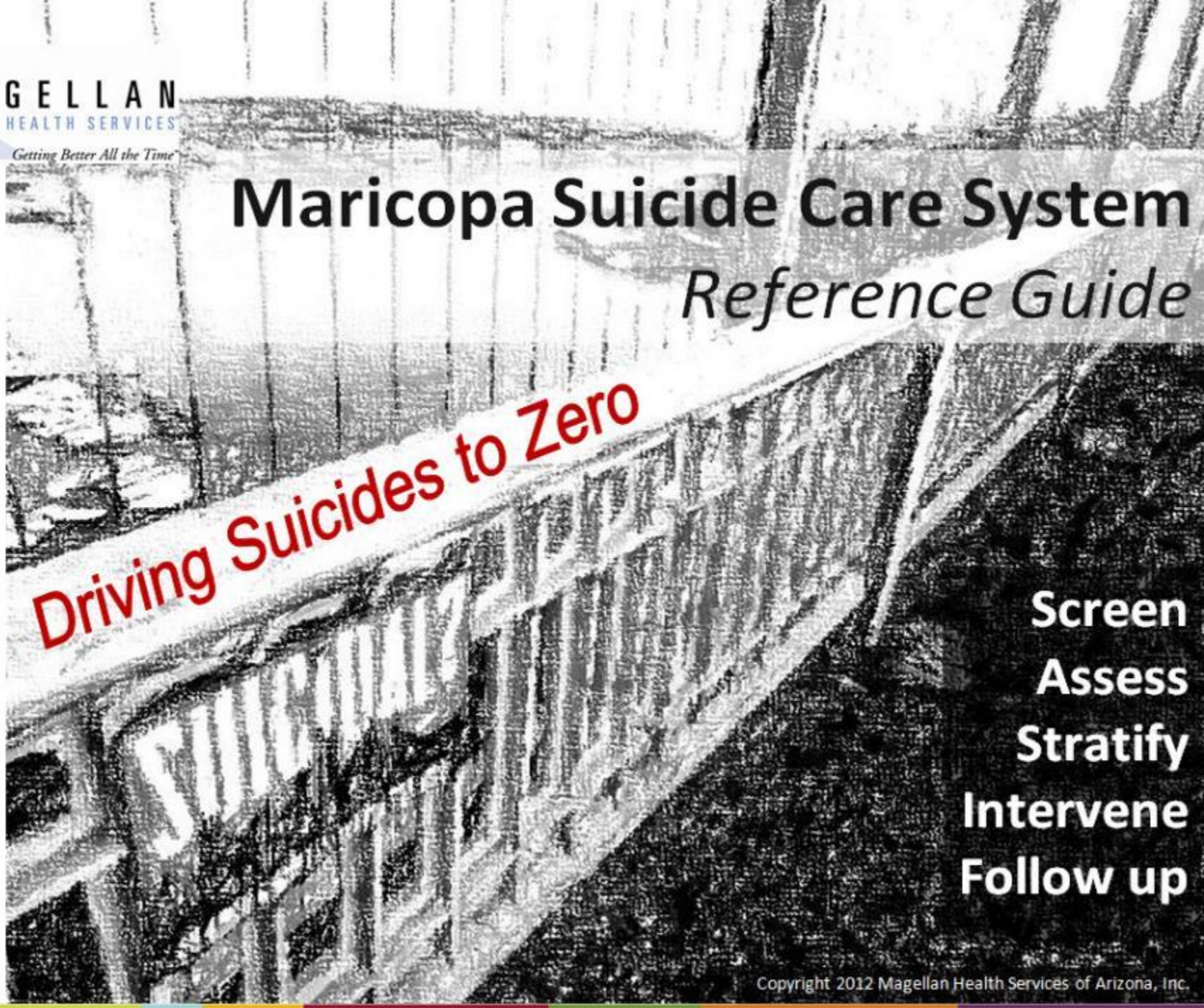
MAGELLAN HEALTH SERVICES

Getting Better All the Time

Maricopa Suicide Care System

Reference Guide




4TH INTERNATIONAL
ZERO SUICIDE SUMMIT
ROTTERDAM 2018
ZERO SUICIDE INTERNATIONAL
LEAD | TRAIN | IDENTIFY | ENGAGE | TREAT | TRANSITION | IMPROVE

Type in the chat box:

Share one key takeaway from David's presentation.

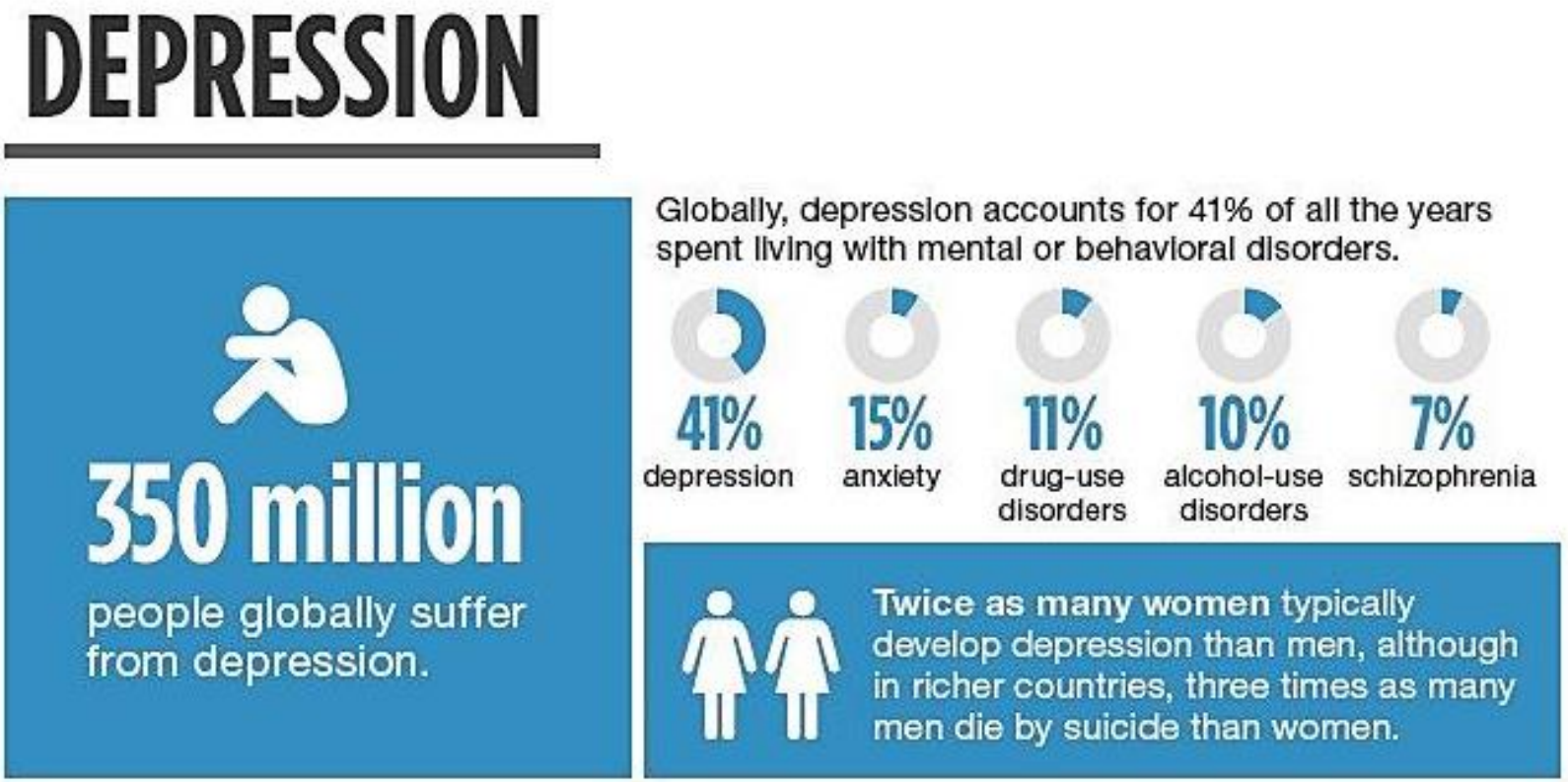
Presenter

Shareh Ghani, MD
Vice President Medical Director
Magellan Health

Overview

- Enhanced Treatment Record Review (TRR) Tool
- Changes to Peer Review Committee processes
- Updates to the health plan's provider handbook

Prevalence of Mental Illness



SOURCES: Global Burden of Diseases, Injuries, and Risk Factors Study 2013; World Health Organization

Mental Illness and Suicide

- Of those who die from suicide, more than 90% have a diagnosable mental disorder.
- People who die by suicide are frequently experiencing undiagnosed, undertreated, or untreated depression.
- An estimated 2-15% of persons who have been diagnosed with major depression die by suicide.
- Suicide risk is highest for:
  - Depressed and/or hopeless individuals
  - Recent Hospital Discharge
  - Family history of suicide
  - Past suicide attempt

Source: http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp

Mental Illness and Suicide

- An estimated 3-20% of persons who have been diagnosed with bipolar disorder die by suicide.
  - Hopelessness, recent hospital discharge, family history, and prior suicide attempts all raise the risk of suicide in these individuals.
- An estimated 6-15% of persons diagnosed with schizophrenia die by suicide.
  - Suicide is the leading cause of premature death in those diagnosed with schizophrenia.
  - Between 75 - 95% of these individuals are male.
- Also at high risk are individuals who suffer from depression at the same time as another mental illness. Specifically, the presence of substance abuse, anxiety disorders, schizophrenia and bipolar disorder put those with depression at greater risk for suicide.

Source: http://mentalhealth.samhsa.gov/suicideprevention/suicidefacts.asp

Background

- Risk factors for suicide have been clearly described in the literature. Previous suicide attempts, family history of suicide, presence of a mental illness, substance abuse or increase in substance use all lend themselves to greater risk of suicide completions.

- Risk factors are determined to be equal in all populations, yet we also know that in the Seriously Mentally Ill population (SMI), suicide completions are 6-12 times greater than in the general population.

Purpose

We reviewed suicides from 2009 until 2012 in Maricopa County (Phoenix), Arizona in the Medicaid population to determine if there were any differences in the risk factors or protective factors for individuals diagnosed with a mental illness and who were receiving treatment, as compared to other studies with similar cohorts.

Methods

- The authors completed an extensive review of medical records for 100 consecutive completed suicides during the period from 2009-2012.

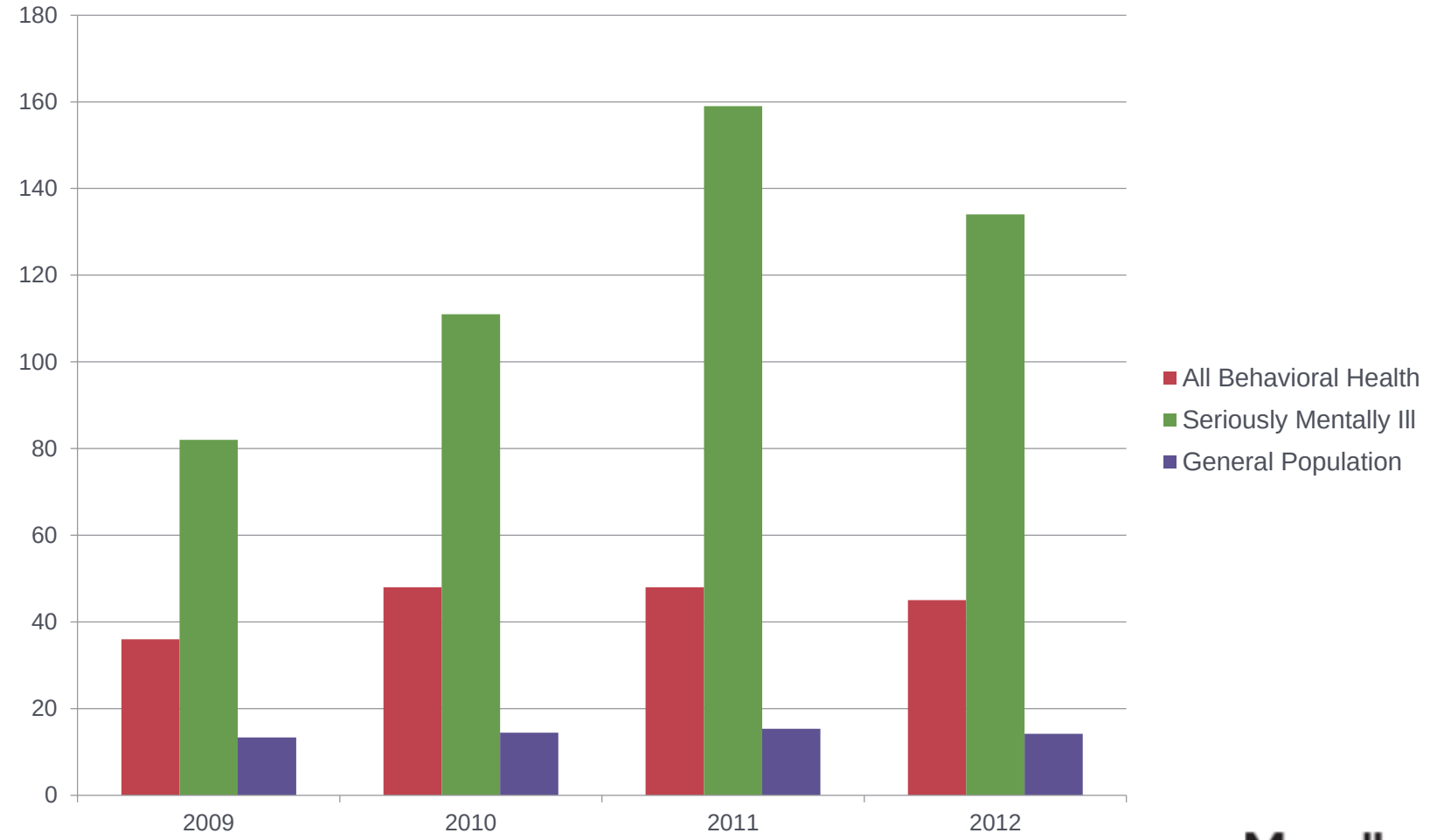
- These cases were identified when autopsy reports noted manner of death as suicide.

- Diagnoses as well as other pertinent information (risk and protective factors) were gathered from a review of the clinical records. Diagnoses were based on criteria from the DSM-IV.

Methods

- We examined risk factors such as:
  - Means of suicide
  - Number of prior suicide attempts
  - Differences in suicide rates by age bands
  - Identification of any precipitating events leading up to suicide
- Additionally, we examined:
  - Support systems in place for the individuals
  - Adherence to treatment
  - Last behavioral health or other medical provider visit
  - Recent hospitalizations or crisis interventions

Suicide Rates: Population Distribution



*Rate per 100,000

Source: Arizona Department of Health Services. Arizona Health Status and Vital Statistics. Injury mortality: Intentional self-harm (suicide), Arizona 2002-2012.

Magellan HEALTHCARE

Findings

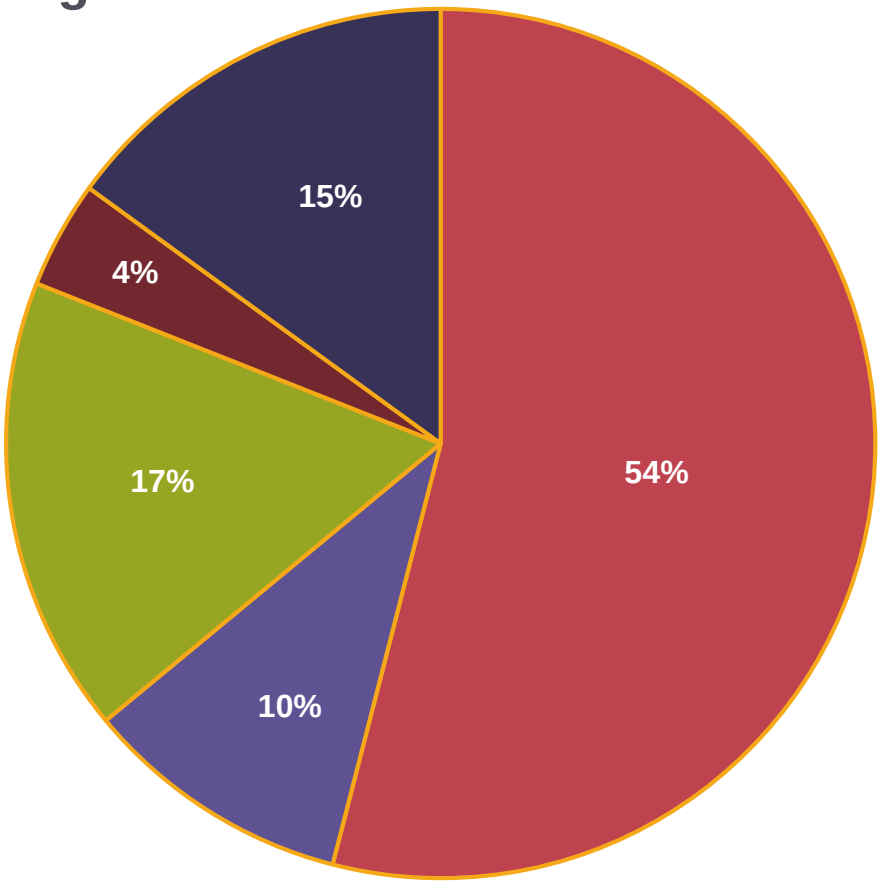
Age Stratification, Gender Distribution and Demographics

	Age 18-34 39%	35-65 59%	65+ 2%
Male: 59%	•Caucasian-70% •Latino-19%	•Caucasian-73% •Latino-16%	•Caucasian-100%
Female: 41%	•Caucasian-90% •Latino-5%	•Caucasian-91% •Latino-5%	•Caucasian-100%

- The age groupings were guided, in part, by the Centers for Disease Control and Prevention (CDC) analysis of suicides in the United States from 1999-2010.
- They found a significant increase in suicides for the middle age group (35-64), thus leading our team to analyze similar age groups.
- However, unlike the CDC analysis, our most significant findings were not among the middle age group.

Findings

Psychiatric Diagnoses



Magellan HEALTHCARE

Findings

Previous Suicide Attempts

Diagnosis	Percent with Single Attempt	Percent with Multiple Attempts	Percent with No Prior Attempts
Bipolar Disorders	28	39	33
Major Depressive Disorder	10	30	60
Schizophrenia and Schizoaffective Disorders	41	41	18
Anxiety Disorders	50	50	0
Psychosis NOS, substance use, gender identity, and unknown	13	40	47

- In this cohort of 100 suicides, men and women had similar histories of prior suicide attempts.
- Among the younger age group (18-34), 28% had one attempt, while 50% had multiple attempts in the past. The middle age group (35-64) demonstrated a rate of 27% among the females who had multiple attempts.
- Among the males in the younger group (18-34), there was a 42% rate for multiple attempts and 24% for those who attempted once.

Findings

Prevalence of Substance Use

Distribution by Co-morbid Substance Use and Psychiatric Diagnosis:

Diagnosis	Comorbid Substance Use Disorder
Bipolar Disorders	32%
Major Depressive Disorder	10%
Schizophrenia and Schizoaffective Disorders	24%
Anxiety Disorders	25%
Psychosis NOS, gender identity, unknown	unknown
Total	30% of the total

- Comparison of males and females in the younger age group demonstrated 10% higher active substance abuse for males.
- In the middle age group (35-64), substance abuse rates were similar among males and females.
- Males were higher at 76% in the younger age group, while males in the middle age group were at 54% for an active substance abuse diagnosis.

Findings

Precipitating Events Within 30 Days of Suicide

A qualitative review of the medical records demonstrated precipitating events in 82% of the sample within 30 days of the suicide. Individuals had one or more of the following precipitating events occur.

Category	Description	Percent
Change in Living situation	Homeless/moved, jail, job-precipitated	16%
Change in Care	Medication change, facility change, Medical condition change	14%
Family Loss	Death, illness, custody	14%
Substance Abuse	Increase in use	14%
Relationship Changes	Breakup, divorce, family conflict	10%
Recent Hospitalization	Inpatient hospitalization	7%
Decompensation	Decompensation in illness	5%

Findings

Medical Provider Visits, Psychiatric Hospitalizations, and/or Psychiatric Crisis Visits within 30 Days Prior to Suicide

- Of the females within the younger age group, 72% visited either a psychiatric emergency room (ER) or had an admission to a psychiatric hospital within 30 days of completing suicide.
- In contrast, only 38% of males in this age group were seen in the psychiatric ER or admitted to a psychiatric hospital during this timeframe.
- This finding confirms the previously drawn conclusions that women are more likely to seek care (both psychiatric and non-psychiatric) prior to completing suicide.
- 70% saw a medical provider (Primary Care Provider [PCP] or Behavioral Health Medical Provider [BHMP]) within 30 days of their completed suicide.

We recommend improved management using suicide prevention strategies in the ER setting for those with mental health issues who frequent the ER's. Additionally, rates of seeking medical care during the year prior to suicide have been documented to be as high as 83%, ***suggesting the necessity of education and assessment of suicide risk factors in all medical and primary care settings.***

Magellan HEALTHCARE

Findings

Medication/Treatment Adherence, Compliance

Based on clinical review of notes by the medical provider, nurse or case manager:

- 43% of middle age males and 33% of younger males were determined to be non-adherent to medication and/or treatment recommendations.
- Among females, 55% in both the younger and middle age groups were described in the medical record by staff as being non-adherent to treatment and/or medications.
- Medication and/or treatment adherence, based on chart review, totaled 49.5%.

In comparing adherence by psychiatric diagnosis:

- 70% of those diagnosed with Major Depressive Disorders were treatment adherent, while only 40.7% of those with Bipolar Disorders were adherent.
- Those with Schizophrenia Spectrum Disorders were adherent at a rate of 41.2%.

Findings

Natural Supports and Social Connectedness

- Since natural supports of any sort are considered preventive to suicide, review of the 100 records noted that 80.4% of these individuals had family support; however, only 18.9% of our sample population allowed family to be involved in treatment planning.

- Social support or social connectedness, defined as meaningful activities with others outside the person's home, was noted in 62.5% of those reviewed.

- Remarkably, outreach by case management occurred in 78% of the cases to ensure engagement.

Although connectedness and natural supports are considered preventive for suicide, we do not know the frequency of connectedness, or the quality of the supports; thus more research is warranted to understand this data.

Comparative Analysis

Manner of Death

Manner of Death in 100 Suicides:

Method	Percent
Hanging	25.7 %
Overdose	35.7%
Firearm	33.7%
Weapon (other than firearm)	3.0%

Distribution of Suicide Method by Gender:

Method	Female	Male
Hanging	14.6 %	33.8 %
Firearm	21.9	42.4
Overdose	60.9	18.6
Weapon (other than firearm)	2.4	3.4

- **Younger males (18-34 yrs.) tended to complete suicide by firearm 62% of the time, as compared to 32% in the middle age group (35-65 yrs).**
- **Younger females were also more likely to use a firearm (33%) for completing suicide than the middle age group counterparts (14%).**

Comparative Analysis

Manner of Death

Distribution of Suicide Method by Gender and Age:

Method	Younger Females (16-34)	Younger Males (16-34)	Middle Age Females (35-64)	Middle Age Males (35-64)
Hanging	16.7%	33.3%	13.6%	35.1%
Firearm	33.3	61.9	13.6	32.4
Overdose	44.4	0	72.7	27.0
Weapon (other than gun)	5.6	4.8	0	2.7

- Please note that the Older Age Group (65+) is not included in these statistics.
- Given the small sample size of that age group (1 male, 1 female, both died by overdose), the focus is on the younger and middle age groups.
- Please note that suicide by traffic accident is not included in these statistics due to the small incidence (1.0%).

Conclusions and Implications

- While not surprising, our data confirms the considerable rate of seeking medical/psychiatric care prior to suicide.
- Causal risk factors for Medicaid beneficiaries, such as involuntary psychiatric examination/hospitalization, occurring within 30 days of suicide, suggest that suicide treatment/intervention was not being utilized at the time of the involuntary hospitalization.

Conclusions and Implications

- That those diagnosed with Bipolar Disorders were five times more likely to die by suicide than those diagnosed with Major Depressive Disorder contrasted with prior studies, which documented the opposite.
- Implications are clear in terms of the need to develop strategies to treat/intervene within this high-risk group of those psychiatrically diagnosed.

Conclusions and Implications

- The most striking finding was the number of younger women who used means of suicide with a high lethality, including gunshot and hanging.
- These more violent methods are typically more expected of men, while women are generally expected to use the less lethal means of overdosing and wrist cutting.
- While this was true for the middle age female group, their younger counterparts (age 16-34) chose the most lethal of suicide methods at a higher rate than was expected.

Type in the chat box:

Share one key takeaway from Shareh's presentation.

Presenter

Teri Brister, PhD
Director of Information & Support
National Alliance on Mental Illness (NAMI)

WE ARE NAMI

National Alliance on Mental Illness

an association of hundreds of local affiliates, state organizations and volunteers who work in communities across the country. We are the nation's largest grassroots mental health organization providing advocacy, education, support and public awareness so that individuals and families affected by mental illness can build better lives.

OUR WORK

SUPPORT

EDUCATION

AWARENESS

ADVOCACY

NAMI

Collaborative Care

NAMI offers 3 types of programs

NAMI Family-to-Family

National Alliance on Mental Illness

NAMI Provider
National Alliance on Mental Illness

NAMI Basics
National Alliance on Mental Illness

NAMI Homefront
National Alliance on Mental Illness

NAMI Peer-to-Peer
National Alliance on Mental Illness

NAMI Connection
National Alliance on Mental Illness RECOVERY SUPPORT GROUP

NAMI Family Support Group
National Alliance on Mental Illness

NAMI Family & Friends

NAMI Ending the Silence
National Alliance on Mental Illness

NAMI In Our Own Voice
National Alliance on Mental Illness

www.NAMI.org

7 Million

total website users annually*

The NAMI Helpline

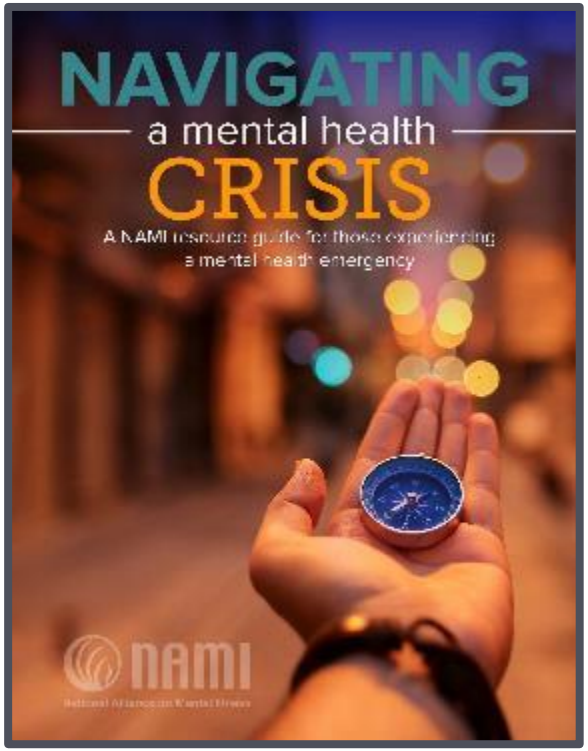
800-950-NAMI

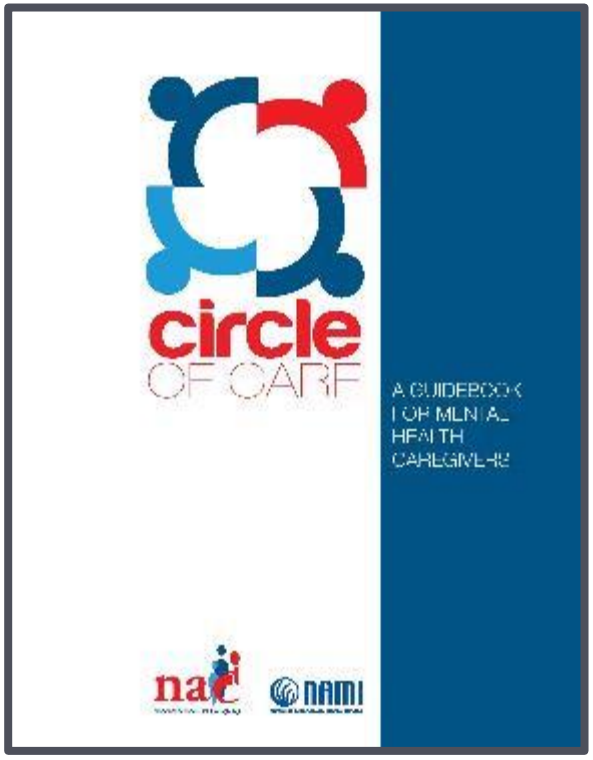
125,000

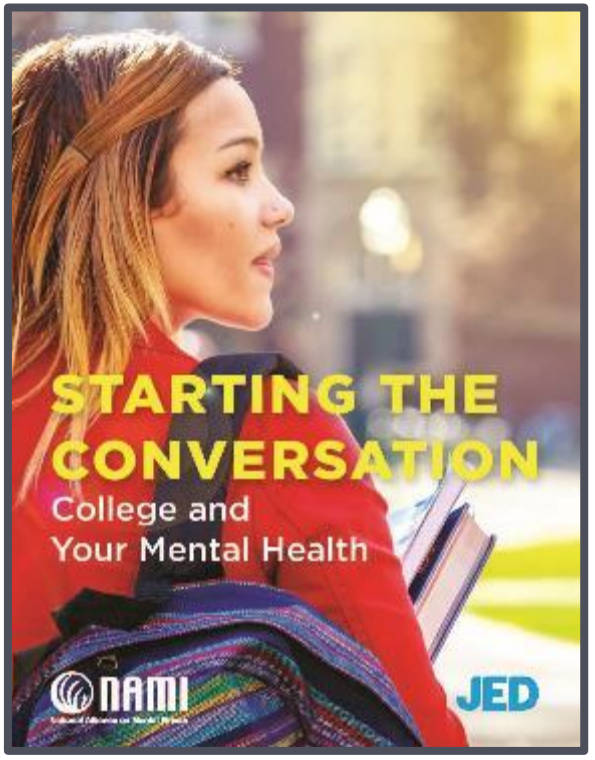
inquires annually

Source: Google Analytics from July 13, 2017 - July 13, 2018*

NAMI
National Alliance on Mental Illness







New collaboration with the American Psychiatric Association

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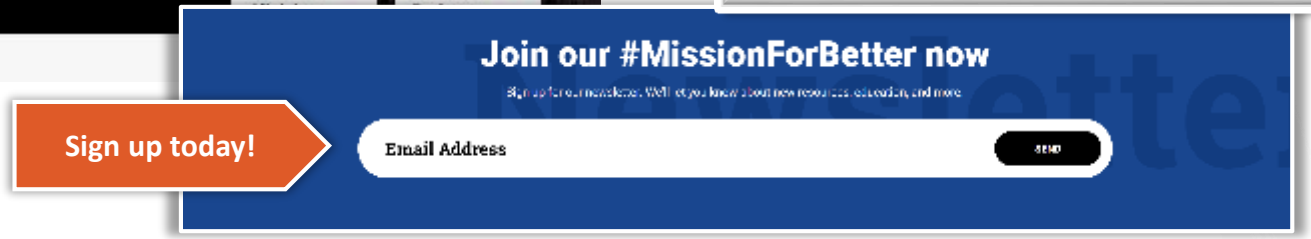
Visit www.SMIadviser.org to join our #MissionForBetter now!

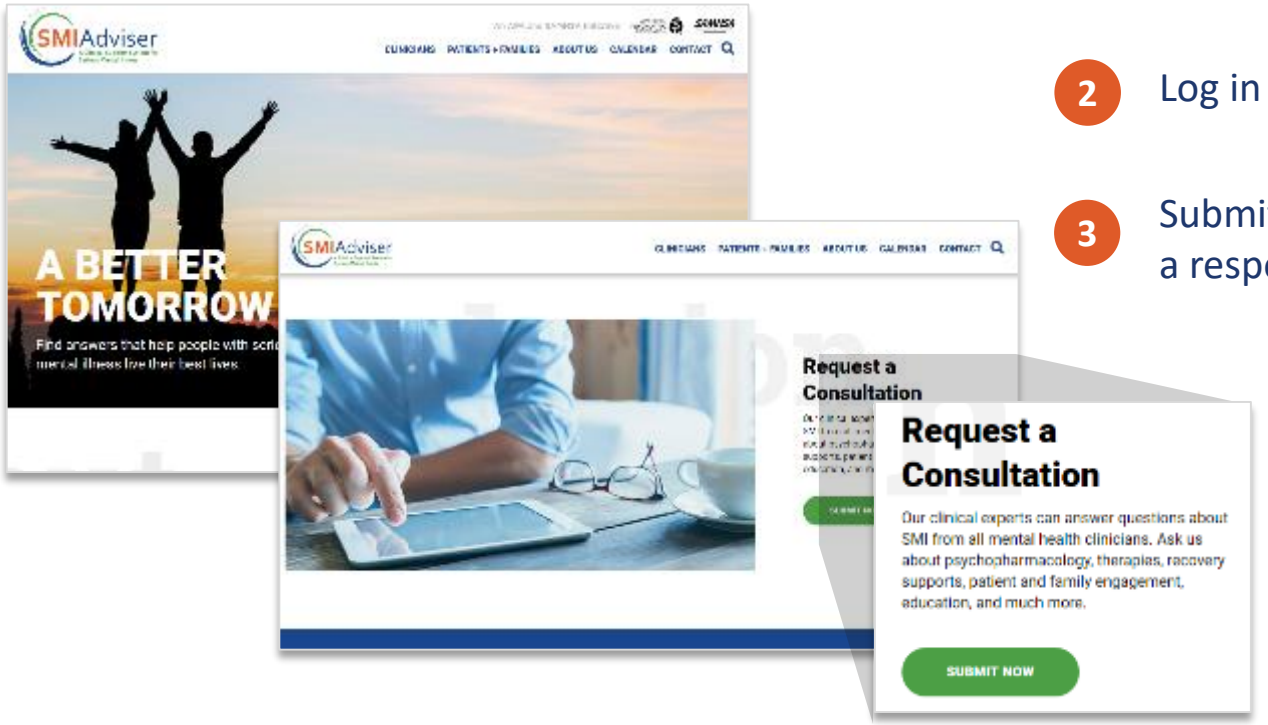


An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA Substance Abuse and Mental Health Services Administration

REQUEST A CONSULTATION RIGHT NOW



1. Go to SMIadviser.com/submit-consult
2. Log in or create an account
3. Submit any question and receive a response from an SMI expert

Ask us about psychopharmacology, therapies, recovery supports, patient and family engagement, education, and more.

An APA and SAMHSA Initiative

AMERICAN PSYCHIATRIC ASSOCIATION

SAMHSA Substance Abuse and Mental Health Services Administration

Type in the chat box:

Share one key takeaway from Teri's presentation.

Type in the Q&A box:

What questions do you have for our presenters?

ZEROSuicide

Thank you for joining systems nationwide striving for zero suicide among patients in care.

www.zerosuicide.com

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>> Okay. We are opening doors.

>> JULIE GOLDSTEIN GRUMET: Good afternoon. Welcome to today as webinar addressing the intersection of serious mental illness and suicide in health care. Type your name in to the chat box. We want to see your name, your organization, city and state where you are from.

So please take a moment. Tell us where you are calling in from. We love to see the broad reach of these webinars. I'm Julie Goldstein Grumet. I will be moderating today's webinar and we will get started in a minute or two. While you are waiting type your name in the chat as we as the organization, city and state where you are calling from.

We'll give people a couple of minutes and get themselves settled. We will be getting started in a moment or two. You are in the webinar addressing the intersection of serious mental illness and suicide in health care. Thank you for joining today and we will be getting started in another minute or two.

We will give everyone a moment. I'm Julie. And looking really forward to joining you today.

I hope everyone has had a great day. It is already 4:30 in afternoon on the East Coast. I hope that everyone else is prepared for the end of day webinar and it is a great topic and we have some great speakers joining us today. We will give people one more minute before we get started.

Okay. I'm going to turn us over to getting started since we see the time is about 4:31. Looking forward to joining us today's webinar. It is Zero Suicide webinar addressing the intersection of serious mental illness and suicide in health care. I am your moderator and I am going to turn it over to our tech team for a few tips.

>> Thank you Julie. Thank you everyone for joining us today. If you have any technical questions or problems, please put them in to the chat box or in to the Q and A box that you will see later on the left-hand side of your screen and we will work with you. Anyone who has called in today will be muted throughout the duration of this call and we will also have the computer speakers open so you can listen over your computer speakers. At any point you can make the slide deck larger by clicking on the four arrows pointing outwards located at the upper right-hand side of your slide deck on. Click on it again to make it go back to the regular size. We will be recording this event and it will be located on the Zero Suicide website about a week after. Thank you. I can pass it back to you.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you so much. So we will go ahead and get started.

I can see a lot of great typing in already. I see people from Texas, Indiana, Virginia, many people we have already worked with. Looking for my country, where the country, different from the U.S. I'm going to keep looking for it until I find it because we do know that Zero Suicide is international now. I am thrilled that we have people joining us from all different types of settings, from schools to outpatient mental health, Salvation Army, just appreciate the diversity in today's webinar and hope that you also find it interesting. We have a great group lined up. So I'm sure that it will be another exceptional webinar.

So I'm going go ahead and get started. Again today's webinar is Zero Suicide addressing the intersection of serious mental illness and suicide in health care. This is one of suite webinars we have done. You can find them on our website, zerosuicide.com. We try to tackle topics that people are struggling with or have some additional and we try to bring in presenters that have tackled some of these delicate issues. There are webinars on legal and trauma informed care, on coping

after suicide. And this is just our next webinar on serious mental illness. So as we said you will find it archived in about a week on website and I encourage you to listen to this. Share it with others on your team who might not have been able to join you today. And listen to some of our other previous webinars.

So this is our standard disclaimer. I am Julie Goldstein Grumet. I am the director of health and behavioral health care at the suicide prevention resource center. SPRC is supported by a grant from SAMSHA. This is our disclaimer that the views, opinions and content expressed in this webinar don't necessarily reflect SAMSHA's opinions.

So for those of you who may not be familiar with the SPRC, SPRC was established in 2002 and federally funded through SAMSHA administration. SPRC provides prevention support and it serves as a restore destain nation for anyone who interested in learning more about suicide prevention whether on the community side or clinical side or any health care system, setting, age group. We are the clearinghouse for all of these resources. We provide assistance to populations from campuses and local communities, statewide agencies, tribes, health care systems as well as compliance. SPRC has developed free and updated online counseling on access to lethal means that many health care systems have their staff take to learn about how to have a meaningful conversation about access to lethal means. It is a great educational course to give you a chance to better understand those skills. SPRC is also home to the Zero Suicide initiative and it provides all oversight to operationalize this model and developed many of the resources for adopting this model.

So I am not going to go in-depth. Just to give very brief overview, there is many additional materials on our SPRC website. SPRC.org about suicide care, across various population but I want to let you know a little about what Zero Suicide is and why it began and then some of our presenters are talk about the challenges and successes of improving health care can. So we though that 84% of those who have died by suicide have been seen by a health Kay provider in the year before their death. So how is it that people are seen -- and disclose these spots, we don't ask directly. People at risk are often not -- if they are, we are not doing enough to educate them and their families or engaging them in meaningful and effective care. We have to change the health care culture to ensure that all systems are prepared but the confident, competent, well trained staff who believe that suicide is preventible and that better care is possible. Zero Suicide is aspirational goal. May of you not even know yet whether you like the title Zero Suicide and we

hope to change your mind today. Is there a better number. Anything else we strive for. For so long we have set goals to reduce suicide deaths. And that is great work and it is no bell and really hard but is it sufficient? What are we really aiming for if we are only aiming for reductions of 10 or 20 or 50%. What if that was your mother? Or your son or your wife. The airline industry and nuclear power plants aim for zero disasters. We expect that of them. They maintain the safety by consistently applying effective to fix the problems that exist and maintaining the belief that failure is unacceptable. The same has to be true for people coming to us when having thoughts of suicide. Health care has to be safe and we have to be committed resolute and steadfast if we want to see thee types of powerful changes for people who are having thoughts of suicide and for their families and for our loved ones.

There are several components that make up the framework. Each of these have been shown individually to show a reduction. Each of the tools that comprises these seven components is evidence-based but the research is relatively new. It is come out in a lot of cases in the last ten years or so. And many providers were never trained during graduate school or via CEUs to use these tools and practices and they don't know that they exist. Emerging evidence suggests that significant reductions in suicide in health care systems can be achieved if they bundle these core components. Singular interventions won't have the this type of effectiveness that using this entire bundle will. While making a great first step are not really adopting the entire Zero Suicide framework. So as you start your journey, you really need to think about how you are going to adopt all sefrn components and yet we know that you never adopt all of them at once. That would be a really difficult thing for any organization but you have to begin somewhere.

Settings that have a high density of at risk individuals so behavioral health or primary care, emergency departments, inpatient psyche hospitals. And they should have the means to identify and care for those patients using best practices. Any health care door through which a suicide patient enters has to be a safe open caring door through which that they can be identified, they can get effective treatment for themselves, where their family is educated and where it leads to quality and timely and effective care and that's what Zero Suicide is. It is both a goal as well a set of practices to achieve that goal.

So what is Zero Suicide entail? It highlights pieces that need to be in place. Leadership committed to safety, accountability and transparency as well as well trained prepared workforce that's beyond the clinical team. It has to be the entire staff. The inside box or the components of care that we

know that work and the evidence and research supports using these practices saves lives. So is that includes systematically identifying and assessing for suicide risk, providing care that directly targets and treats suicidality, cognitive behaviors that are for suicide prevention, BVT, CAMS as well as using contact and for support. Warm handoffs as people are leaving acute care settings, ensuring that gaps are shored up and that people are transferred to appropriate meaningful care where the burden is on the health care system to ensure that people are accessing and remaining in care. Also should be a care pathway. So this is essentially the protocols and practices that -- and this must be taught to all clinicians and ideally baked no, the electronic health record. Today's webinar will discuss this effective care that I was just speaking about and how a care pathway should be modified to care for people with serious mental illness. The foundational principles and critical pieces of care that are essential and necessary parts of the Zero Suicide model don't change but the model can be adapted or modified to be culturally respectful or to be adapted in various settings. We won't look exactly the same and in an emergency department if it does in inpatient psyche unit. It needs to be adapted but these core principles need to remain in place. And as you see from the hours around the model the model relies on data to maintain quality and compliance with these best practices and also to uncover areas for improvement. Know if you are consistently doing what you are doing.

This is the Zero Suicide toolkit. It is free. And publically available. You can find it at zerosuicide.com. A lot of information. Our archived past webinars are there. A lot of videos with faculty talking about best practices. You can access outcome stories. We have interviewed several sites that have had successful outcomes and began to write up how did they get there. So you can look for yourself and see how did they do -- how did they gather their data and where am I similar. There a lot of research that we have supported on website that you can access as well but really this is an implementation toolkit to walk you through your journey. It is also a place where you can get involved. We have a very robust online listserv. There is well over 2,000 people on the listserv, people with lived experience and running health care systems and people are very generous and gracious in sharing their tools. Does anyone have a policy about clients who want to give up their access to highway leave that will means or anybody adapted this for working with youth. I have a few questions and people are wonderful about sharing their resources. If you are not already signed up for the Zero Suicide listserv please feel free to sign up after today at

zerosuicide.com and we would love to learn from you and hear from you.

So on to today's webinar. We have three learning objectives. First is to describe the importance of addressing suicide risk for those with serious mental illness. To identify the resources that are available to support suicide prevention and care for individuals are serious mental illness and how to access these resources. And who to list the benefits of taking a patient- centered approach to treating suicide risk, includes community, peer, family and other supports. We have three wonderful presenters that are really thrilled were able to join us. I have had the privilege of working with several of them in the past. They each bring a unique perspective to help you think about thou do the work in the setting in which you live and we will have time for questions and answers at the end of today's webinar.

So our first speaker is David Covington. He is the CEO and president of Recovery Innovations. He is a behavioral health innovator, entrepreneur and story teller and also a partner in behavioral health and founder of international initiative in Hope Inc. and he will talk a little bit about Zero Suicide and serves as member of the Department of Health and Human Services interdepartmental serious mental illness committee established in 2017 in accordance with the 21st Century to report to Congress on advances in behavioral. David served on national action lines for suicide action committee and is really heavily influenced a lot of direction action alliance has taken. He is chair of the national suicide prevention lifeline and SAMSHA's steering committee and he cochairs the action lines task force that launched and catapulted Zero Suicide. Just a true leader in Zero Suicide. So I'm thrilled that he is here to join us today and I will turn it over to you David.

>> DAVID COVINGTON: Wow. Thanks. Just a gracious kind introduction and I really appreciate your friendship and your leadership in the field. So Julie referenced the ISMC but I want to give a little bit of context for how we got to a place where we could have these kinds of resources. Dr. Jerry Reed, Julie's colleague is in the webinar with us and back in 1998 Jerry and a very few others were working diligently in the space but there was little to no national recognition or investment in the effort. But I conference in Reno and a discussion with the surgeon general that led to surgeon general at the time making a statement about suicide being a serious public health problem in 1999 which led to a National Strategy for Suicide Prevention in 2001 which propagated to the states and in 2010 we launched a public private joint venture that Julie referenced has been influential in bringing together leaders from government and the

private sector to really begin to focus on suicide care and a host of at risk groups including people with serious mental illness. In 2017 the ISMC began to put together a sear ri of recommendations to give an honest assessment of where we stood in mental health and a series of recommendations about what would improve care and we borrowed heavily from the work that the national action alliance had done. The area of crisis we have a separate initiative that's closely related to called Crisis Now that was catalyzed again by the action alliance and there are number of recommendations in the ISMC report to Congress that calls for a stronger crisis response system, a crisis continuum of care and standards for crisis. The ISMC recommendation also specifically reference Zero Suicide reference. It says advance the national adoption of effective suicide prevention strategies. All federal departments including the VA and DOD should adopt Zero Suicide as a model for suicide redux and implement strategic plans. So I think what we have seen over the course of time is suicide prevention go from not being on the national radar to being a public health and then mental health initiative and then with the launch of the national action alliance we begin to see all sectors from business to veterans affairs to education to our correction systems begin to be more engaged and you see that effort with the ISMC report and I will call out one more of the significant recommendations in the report about maximizing a peer workforce and integrating peer supports in to the work.

A couple of interesting things, I think about the ISMC there have been national groups taking on mental health before under both Carter and Bush, Dr. Hogan who Julie referenced that was my cochair with that original Zero Suicide task force was LED was chair of freedom commission report for mental health. Both of those prior efforts were within largely within the substance abuse and mental health service administration, within that mental health silo and for the first time the ISMC that first word interdepartmental I mean so real thing. You have got multiple levels of government and secretaries from various departments who are coming in to that group in that original meeting which kicked off this effort at the time Ben Carson, and the secretary of Health and Human Services. There were a number of top level secretaries who came to that table to begin to focus on this effort and to bring all of government in to the discussion and, of course, the SAMSHA administrator was elevated to assistant secretary within the hierarchy of government no longer relegated down the chain. More of a key part of the administrative team. The other element that was key with the ISMC is a little bit of a political focus, if you will, under current that there was some concern that our public mental

health safety net was veering towards a focus on call it the worried well or people with general mental health and substance abuse issues, important effort to be engaged in but some concern that it was veering away from historic responsibility towards those most in need, those people with serious mental illness and kids with serious emotional disturbances. It is right in the name. And this issue of more serious mental illness has come up routinely as we talk about suicide prevention. Dr. Reed and I have had the opportunity, we pulled together the first group of Zero Suicide pioneers from multiple countries coming together in Oxford in 2014 and I have chance to attend many international summits. It is frequent that one of the discussion points in these international conversations is dispute over how -- what percentage of people who die actually have a mental health condition. And in certain Asian countries it certainly popular to say that it is much less than we say in the U.S. and, of course, in the U.S. we have some researchers who will go even higher than the 90% figure that sometimes is mentioned and say that many or all. So it is a little bit of a dispute over what percentage of people who die of suicide have some kind of mental health issue but what is clearly not of dispute and I'm so glad to see this webinar put some focus on it today, is the risk for people are serious mental illness. So let's talk about that a little bit. That same year that the national action alliance was launched there was an article in Forbes magazine the forgotten patients and it said that the mental health system and they were talking not about the public safety net but the entire industry. All of it. That if you have addiction or anxiety challenge or a depression or a past trauma or host of other issues there is a warm and loving light of care and concern and evidence-based practice and sets of protocols that are shown on those individuals. But if someone mentions the word suicide, that article suggests that they are pushed not out the system or services but far to the periphery as possible. And this same time that it article was coming out our second presenter Dr. Shareh Ghani and I are working together in Phoenix, Arizona and there we were responsible for the Reba contract. That's regional behavioral health authority. Magellan to administer the entirety of mental health service system and addiction system for the 4.2 million people living in Maricopa County. Virtue of having a serious mental illness and it meant that about 120,000 a year were actively receiving care from the network with whom we contracted. And we were responsible for those services. One of the things that we identified pretty quickly as we got in to the first couple of years and you are looking at two years of data on this screen was the number of individuals under our care who were tragically dying of suicide.

What you have on this particular graph are the first two years that Dr. Shareh Ghani and I were there together of individuals who died of suicide. The black columns represents the years of their life on the far left you see an individual who was a female who had a serious mental illness who died in July of 2009 at the age of 42 years old. At the bottom of the page you will see the gender and year and whether they were -- they were considered SMI in our system or they were part of our general mental health system or they were a child and adolescent. And we have very rigorous system of identifying an individual with serious mental illness which had to be independently verified by two psychologists. In Arizona SMI means something very precise and it is very significant and we know who those individuals are. What we had at the top of the page is a normal lifespan of 78 years. So what you are real ly looking at in the blue white is the potential years lost to suicide. You see a 71-year-old and on the far left you see a 12-year-old. So a couple of things to just note as we are looking at this data, while you see just slightly more Ss than Gs for general mental health, the number of people with serious mental illness is about 21,000. Whereas over 50,000 with general mental health and about 22,000 children and adolescents. So the rates are by far and away the highest in this group for people with serious mental illness. You also see that while there are more males than females there are many females in this list. It is a little disproportionate from what we normally see in the general population. I won't get in to the details of these but Shareh will speak more to that. We were very concerned for many of these individuals we did know they were suicidal. There was active care going on. And yet you had the worst possible outcomes occur for these individuals. So this is about 70, a little over 75 individuals who died during that two year time frame that were enrolled in our services and for whom we were responsible.

So we began to get very focused on the issue of serious mental illness and suicide. And at the time I wasn't even clear on what's the general rate for those individuals. It was very common at that time, still is for us to talk about "high risk groups", older white males, veterans in the military. And you can certainly find data out there that would suggest those groups of two, three, even at times four times, Ft. Hood when that was being reported on commonly several years ago, the rate was four times of that a general population. At the first, Dr. Shareh Ghani and I began talking about this, they weren't sure. One top researcher told it might be as much as six times. Even though we saw dramatic reductions we never had a suicide rate in our ESMA population as low as six times of that the general population. Subsequent to that we did find research

studies and began to continue to look at that data ourselves and I think very conservatively the rate is somewhere between 6 and 12 times as high and there is have been studies out there suggested it is 12 or 13 times. You have to stack not quite almost stack the relative hazard ratio of those typical high risk groups in order to achieve the risk for individuals are schizophrenia, bipolar disorder, major depression, eating disorders and individuals with border line personality disorder.

So we got very focus on how we could make a difference and we were consumed with some of these efforts to save lives on bridges. It became a metaphor for us and the Golden Gate Bridge with its efforts at that time to began planning a safety note and the Aurora bridge which started their effort after the Golden Gate Bridge. This was one of the most frequent places of suicide death after the Golden Gate Bridge and they effectively drove the suicide rate to zero on this bridge. We began to talk about could we put an equivalent barrier programmatic barrier, if you will, in to the service system. And we initially were thinking about how we could support our critical staff. We did surveys of our clinical workforce. We had several thousand in the behavioral workforce respond to an online survey that we asked about their skills, their training, their support. And then we began to look at how we could augment that with more significant support from family members, we even began suicide attempts survivor support groups. There were many loss survive support groups across the country but only a handful of groups nationally were doing anything where individuals were supporting each other. At least in a direct way.

So we began to take that effort and then as we met the folks from the Henry Ford health system and task force with actual alliance we began to implement a more rigorous assessment and intervention and follow-up and we saw some significant reductions offer the next several years in those individuals. And then most recently we had our fourth international summit of pioneers in this space. We are almost a decade later from those original efforts and over a hundred individuals from 19 countries put together an international Declaration for Zero Suicide that I think there is a link on these zerosuicide.com website that Julie referenced but I will drop a link in to the window for us to begin to lay out the case for safer care around the world and we are starting to see pioneers implementing these programs in Australia and the Netherlands. And that's where I will leave it. Thank you.

>> JULIE GOLDSTEIN GRUMET: David thank you so much. It is so clear -- I mean this has been really an initiative that's been really taking, you know, rapid pace, rapid hold in this country where health care systems are thinking more and more how

they can improve suicide care. These advancements are really incredible and David is at the helm of much of this work. So just thrilled to have them here and we want to see what did you learn. Give us one key take away from David's presentation today. We will take questions at the end but please go ahead and type in to the chat box what is one key take away from David's presentation to help the team around you, maybe begin to observe.

I also notice in case you didn't notice that the chat box is a little bit delayed. So for any of you who are looking for the chat box and noticing it is not there it is just a little bit delayed. So apologize for that. We have a large turnout today or there is a storm somewhere.

My key take away from David's presentation is really, you know, it is really the effectiveness. David talked about putting up the bridge barrier and once they put that barrier up suicide is reduced to zero. If you take laser beam focus to use the data, they knew that was one location where people died by suicide and they used effective interventions to reduce suicide there. Similar to what David talked about in Maricopa that Dr. Shareh Ghani is going to talk about momentarily. When you use laser beam focus to really -- to use your data, to inform how you can do your work better, how it is influencing people around you, David showed that chart of the 75 individuals who have died in the last couple of years and -- and the vast majority of people who or the large number of people with serious mental illness compared to other high risk groups and the need to say we have to do something sue nek to focus on this group of individuals or we are going to keep having suicide deaths for people under our care and when they shifted to that they were able to reduce suicide in their population. How are you going to use your data to look for suicides in your organization better understand that population at risk and how you can make changes using evidence-based practices that are sustained and train people to do and that you are constant reexamining the data.

I see somebody else mentioned peer and family supports. And what an incredible need there is to educate peers and family about the role that they play. I think it is really critical that we educate those around the people who are struggling to understand how do they help them and ensure they get to appointments and how can peers help people feel for confident when entering the health care system. One of the areas not how we identify people but how do we keep them in care. How do we assure them that their care that they receive is going to improve their outcomes. So more on that. But I do want to turn next to hear from our next presenter who is Dr. Shareh Ghani who

again has really done exceptional work in this area. Dr. Shareh Ghani is diplomat of the American board of psychology and vice-president medical officer for Magellan health care in California. His focus is on improving member engagement and the use of innovative technologies, especially for those with serious mental illness. He is part of Magellan's driving suicides to zero and serves on several national commit ties. His I think he will learn a lot about his passion through his speaking and how so much things can be improved by using data and a committed caring staff. It is really my pleasure to have Dr. Shareh Ghani join us today. I will turn it over to you.

>> SHAREH GHANI: Thank you Julie. Good afternoon everyone. It is a pleasure to be here and to be working with the folks the presenters on the panel today. And I have had the pleasure of working with David Covington in Arizona and since then.

Julie in addition to what you shared I'm also part of the National Action Alliance and primarily I am a psychiatrist. A clinician by training. So today I'm going to talk about the work David Covington was addressing back in Maricopa County in Phoenix, Arizona. We launched a driving Zero Suicide initiative. Which had the attempt survivor support groups and driving suicides to Zero program and analysis of completed suicides. So as we saw this, you know, one completed suicide is too many. And we decided to look at consecutive suicides coming out of Maricopa and we took 100 consecutive suicides and analyzed the data and information we had for them and I want to share with you our findings from that. It has been a few years but we continue to look at that data, to analyze it and see what we can find in there.

So off the bat I can tell you that the information that came out of this analysis that I am about to share has an impact on our processes. We -- as in all of the health plans have a treatment record review tool by which we measure the gaps or the quality of care that are provided by physicians, clinicians in the community. So this -- the tool -- this research has an impact on our treatment record review tool and it enhanced the information that we were looking for. It enhanced the reflection of the findings from the study had an impact on the tool. Any other health plans in the United States we have a peer review Committee process where we look at completed suicides and we look at -- we do like a retrograde or a root cause analysis and look at what broke down. What could have been done differently to avoid this unfortunate outcome and it changed the way we reviewed cases and we started looking in greater detail at the signs that point to risk or completion of suicide and it impacted the provider handbook. The providers

that participate in different networks have access to the provider handbook and where the health plan that is Magellan shares our expectation that is to be provided. So this research that I am about to share with you had the -- have those impacts. So really quick looking at the background, I'm sharing some demographic or information with you, depression, globally accounts for 41% of all the years spent living with mental or behavioral disorders. And followed by anxiety drug use disorders alcohol, specifically and then schizophrenia.

Of those who die in suicide more than 90% have a diagnosable mental disorder or mental illness. And people who die by suicide are frequently experiencing undiagnosed undertreated or untreated depression. If you combine those two bullets or those two points, it points to the need for improved screening, for individuals. Who may be seeking care for something else. But may have underlying depressive disorder.

An estimated 2 to 15% of people die by suicide. Highest suicide is for individuals who are exhibiting depressions r hopelessness or have a family history of suicide and have a history of past suicide attempt. If you have one take away and you are a clinician in the field, these were flags that really seem to recur in different studies and findings. Now going more towards bipolar disorder, 3 to 20 wide range of folks that are diagnosed with bipolar disorder die by suicide and you see the risk factors in there. It is the leading cause of premature death in those diagnosed with schizophrenia.

Individuals that have dealt with depression at the same time as other mental illness are at high risk for suicide. Comorbidity or combination of depression with substance abuse and anxiety disorders, schizophrenia and bipolar disorder put those at greater risk for suicide. Take in to account the six times or higher increased risk of suicide or individuals with serious mental illness and within that hoe cohort, more than one type of mental illness in to addition to depression the risk is far greater.

Again repeat about risk factors, previous to suicide attempts family history, presence of mental illness, substance abuse disorders, increase in recent substance abuse lend to greater risk in suicide completion. And again the 6 to 12 times greater risk for suicide in an individual with serious mental illness. Now getting to the study, so this is consecutive suicides between the years of 2009 and 2012 in Maricopa County. And it was up to approximately a million people in Maricopa County that were included in the cohort.

And we looked at -- we looked at risks and we looked at the risk as well as protective factors for these individuals. And compared them to other studies in other cohorts.

The authors including David and myself completed an extensive review of records from 100 consecutive suicides. We looked at the diagnoses and all pertinent clinical information from the clinical records. And the diagnoses at that time were based on DSM-IV criteria. We looked at the means of suicide, number of private attempts, differences in suicide rates by age. So we divided the population in to different age bands and then identification of reciprocating events leading up to suicide. We looked at support system and adherence to treatment, last behavioral health or other medical provider visits or recent hospital or crisis intervention of any kind.

You are looking at the distribution of the suicide rate compared to the all individuals who are in behavioral health treatment in green are those with serious mental illness and then the general population. So these are rates per 100,000 individuals and you can compare the rates of individuals with mild to moderate mental illness or what is referred to as general mental health in Arizona and then the individuals with serious mental illness, like David Covington said earlier. There was a very defined tell for Arizona and then the general population. You can see how the individuals with serious mental illness stick out.

So the first group of or breakdown of 100 suicides you can call it 59% and 41% but it was 59 males and 41 females in the group. You see the age bands across the rows. So the age bands we use are 18 to 34. 35 to 55 and then 55 plus. Very few individuals in the group. We found the 20% Latinos or Hispanic origin. Similarly for 35 to 65 age band similar percentages. Then we came to females it was 90% Caucasian or white and then 5% Hispanic or Latino and then similar distribution across the board.

We used the Center for Disease Control and prevention guidance as part of their analysis of suicide they had used similar age bands. They found a significant increase in suicides. Middle age group that's leaving -- similar age groups but for us there was no difference within the age groups. Next we will look at the diagnostic mix. Major depressive disorder is the lighter red followed by schizophrenia and anxiety disorders and then a combination of psychotic disorder, substance abuse disorder and gender identity disorders.

Next we looked at the individuals with diagnosis and previous suicide attempts. They were broken up in to one attempt individuals with multiple attempts and then individuals of percent of the cohort with no prior attempt. And you can see across the board. Men and women have similar histories of prior suicide attempts. We found that amongst the younger group 28 percent had one attempt while 50% had multiple attempts in the

past. The middle aged group, middle -- the age group in the middle I should say 35 to 64 demonstrated a rate of 27% among the females who have multiple attempts. Amongst the males in the younger group interest was 42% group of, 42 had multiple attempts while 24% who attempted once.

Next we look at the prevalence of substance abuse compared to the psychiatric official on the left side. Comparing males to females we found a 10% higher active substance abuse for males. Males were higher at 76% in the younger age group. While those in the middle were at 54% for active substance abuse disorder.

Next we looked at the presence or absence of precipitating event within 30 days of suicide. You can see the categories of change and life -- living situation, changes in care levels, a loss of a family member, incidents, not prevalence, but just substance abuse, relationship changes, breakups divorced, family conflict, recent hospitalization and/or decompensation. And you can see the percentages on the right. So I mean we combined all these from a point of view of a substantial change. We found that 82% of the sample as hundred individuals in study, 82% have had a precipitating event from one of the categories below within 30 days of said suicide and then their individuals who are more than one precipitating events occur within 30 days of suicide.

So medical provider visits, and psychiatric hospitalizations or a visit to psychiatric emergency room within 30 days prior to suicide. The females that completed suicide, that's those 41 women, 72% had visited either a psychiatric emergency room or had an admission to psychiatric hospital within the last 30 days of completing suicide. In contrast only 38% of the males were seen. I carefully venture to say this confirms or shows corroborates that women are more likely to seek care prior to completing suicide.

And of the hundred now males and females combined 70% saw a medical provider, either a primary care physician or a psychiatrist. The term behavioral medical provider is an Arizona term for encompassing psychiatric practitioner within positive days of their completed suicide. So this was an opportunity to have a one-on-one session with a trained professional within 30 days of suicide and obviously we recommend from that study improved management using suicide prevention strategies in the emergency room settings for those with mental health conditions or presentations. Rates of seeking medication in the year as high as 83%. And suggesting necessity of education and assessment of the suicide risk factors in all medical and primary care settings. And let me correct that to the last 30 days, sorry not last year. It is a

typo on there.

Now medical treatment and adherence, this -- this starting to get in to the slightly -- I mean it is still objective. It is a physician or psychiatric nurse practitioner. Based on clinical review of notes of medical provider or nurse or case manager we have access to all three. We found that 43% of that males in the middle group, middle age group and 33% of the younger males were determined to be nonadherent. To so there was a comment of either noncompliance from nonadherence in the medical records when withe reviewed for them as documented by a case manager, a nurse or a doctor.

And it could be to medications or treatment recommendations. Amongst the females -- remember we have a very, very small number of people in the high in age group. This is pretty much 98% of the sample. Medication and/or treatment adherence. So half of the folks were identified as not being adherent. Now when we looked at -- we combined adherence with psychiatric diagnosis and wean found that 70% of those diagnosed with MDB were treatment adherence while only 40% of those with bipolar disorder were adherent. Those group of disorders adherence rate was 41%. All right. So natural supports and social connectedness, natural supports of any sort of considered preventive, the view of the hundred records noted that 80% of these individuals had family supports. However, only 18.9% of our sample population allowed families to be involved in treatment planning. What that means is the individual in treatment has to sign a consent form or an authorization form to allow family members to be contacted, to be involved in treatment. So I think that points to a significant issue that clinicians would probably be nodding on this call saying yes, we have seen some of this. Social support or social connectedness defined as meaning activities of others outside the person's home was noted in 62% of these reviewed. The number was higher than I expected. Outreach for case management occurred in 78% of cases to ensure engagement. So there was a lot of outreach and then -- in this -- Arizona has a really robust case management and support system. There is a lot of outreach noted in the documentation.

Moving quickly to our matter of death, younger males tend to complete suicide by firearm 62% of the time. Deferred method of choice by younger male was more definitive or more immediately lethal means. Younger females are more likely to use a firearm. 33% preferred a firearm for completing suicide compared to the -- to their middle age counterparts where overdosing was preferred.

In a comparative analysis, of the two, I am just going to let you guys take this in. Looking at hanging across younger

females, younger males and then middle aged group females and middle age group males and you can see that overdose in females is a preference as we get in to the younger females at 44% and then the middle age group females were at 72%. Firearms you can see is preferred by the younger females and specifically weapons and others by gun was a much smaller number.

So conclusions, our data confirms or showed that the considerable rate of seeking medical psychiatric care prior to suicide is there. The involuntary psychiatric examination suggests that suicidal treatment or interventions will not being fully utilized at the time of the involuntary hospitalization possibly. I add things like considerably, possibly because I want to leave it open to interpretation. And next those diagnosed by bipolar are five more times to die by suicide contrasted with prior studies which document the opposite. Implications clearly is the need to develop strategies to treat and intervene within the high risk groups of those that are diagnosed psychiatrically as well as the main finding was the -- that we found that stood out to us was younger women using means of suicide like gunshots and hanging. And we expect more of these in men and maybe it is reflection of the changing roles in society. While women are generally expected to use the less lethal means. This was true for the middle age but the younger counterparts used the more lethal method.

>> JULIE GOLDSTEIN GRUMET: Thank you so much. I think has been such a wonderful presentation about the need to collect data in your system and then use data to inform a lot of your decisions about clinical care, training for your staff, and the interventions that you need to use. So I really appreciate you taking the time to teach us all about what SMI looked like in the population you were working with. We have seen a few questions, and people asking for an elaboration about how your system used this data. We are going to get to that in the Q and A. But I am going to turn it over to our next speaker and that's Teri Brister. So we will have a chance to come back to you Shareh. Thank you so much for that presentation. Next up we have Teri Brister. And she serves as the director of information and support at NAMI, the national alliance for mentally ill. She is responsibility for ensuring that all content created and disseminated by NAMI. Teri is the author of NAMI basics and coauthor of the NAMI home front program. Prior to joining in 2005 Teri worked for 20 years in the community health mental health system in Mississippi, including assistant director in two different centers and is a licensed professional counselor in Mississippi and we are thrilled to have you here today.

>> TERI BRISTER: Thank you so much and listening to

David's presentation and Dr. Shareh Ghani's drilldown of what a very real specific population looked like in Arizona really underscores the need for this webinar. So I very much being appreciate being invited to be part of it. And to be able to talk to everyone on the call about what NAMI has available for individuals and for families with serious mental illness and with other mental health conditions and specifically in the area of suicide ideation. So let me talk to you a little bit about NAMI to begin with. The National Alliance on Mental Illness. It is the nation's largest grassroots mental health organization and we provide advocacy, education, support, and public awareness and our vision really is to make this information available so that all individuals and families affected by mental health conditions can have better lives. NAMI is the foundation of state organizations. We have a state organization in all 50 states and we have 700 plus affiliates or chapters across the country.

And these are made up of thousands of leaders who volunteer in their local communities and across the country to raise awareness around mental health conditions and serious mental illness and we celebrating our 40th anniversary this year. It was founded in 1979 literally by a small group of parents of adults with schizophrenia who were not getting what they felt like they needed from the treatment system and the awareness, the information they needed to be able to help care for their loved ones.

So we provide if you look at this slide in front of you, we really do however you want to look at this, four buckets or four legs of the stool but we provide four primary areas of support to the community at large and to individuals who are affected by mental illness, education, we offer classes. Presentations, and we do have an annual convention as well as hosting webinars, ask the expert webinars that we host on a quarterly basis. Advocacy, we advocate at the state and federal level on legislative and policy issues. And our state organizations actually can provide individual advocacy for people with health care systems in their areas. And support which is really a big part of what I want to talk to you specifically about related to the topic of suicide with people with mental illness, is we offer a help line at the national office. Many of our state organizations and affiliates offer local help lines and warm lines and we also offer support groups across the country that are done or operated on a similar model to alcoholics anonymous where we have a support group model and we train the trainer and have a truck structured model that all the support groups are based on and for the individuals these are called NAMI connection. And you know that if you attend a NAMI connection

support group in one part of the country it is going to be just like a NAMI support connection support group offered in other places.

And we also have support groups for families. And these groups are offered on either a weekly basis or a monthly basis. It varies from community to community. And then finally our last bucket or our last leg of the stool is just general awareness. We are constantly addressing the stigma and discrimination associated with mental illness through individual advocacy and community events like mental illness awareness week, our NAMI walks campaigns, activities that are related to mental health awareness month which just happened in May. And suicide prevention month that's going to be happening in September. We also have quarterly magazine called the NAMI advocate that goes out on a twice annual basis of. So that's a general overview of NAMI and who we are and what we do but what does that really look like and how does that impact this particular topic that we are talking about today and many of those of you who were on the phone listening in to webinar. And we really do promote a model of collaborative care and if you look at the diagram that's on the screen in front of you we really do feel like it -- we believe that it takes all of us. If you were listening to Dr. Shareh Ghani's presentation and also in David's presentation you heard both of them say in different ways that it really is about more than just identifying risk factors. It is about more than just noticing what's going on. We need better screening tools. They each talked about that. But it is really more about noticing. It is really more than just screening. It is about engaging with people. It is about you heard Dr. Shareh Ghani specifically talk about the higher percentages of people with mental illness who had died by suicide who were nonadherent to their treatment plan. One of the things that stood out to me in the presentation that Dr. Shareh Ghani made was that 80% of the individuals in population they studied had family members. They had a support system but only 19% of them had given permission for them -- for the family to be involved in the treatment process. And that's really what this VIN diagram is getting at here. It is very much about the mental health provider. It is about the individual, the person in recovery. It is about the family, whatever the definition of family is by the person. It doesn't necessarily mean biology or a legal relationship. The person of support to the individual might be someone who lives in the apartment next door. Whoever that person is that the individual has identified. And then you see that intersection there in the middle. Who is the advocate for this individual. We very much believe this is the gold standard of care. It is

the undercurrent in all of our education and support programs. But there are a lot of barriers that get in the way of this actually happening in the real world. There is resistance to change among some treatment systems and some treatment providers. Some individuals aren't necessarily trained in a collaborative model of care. You heard Julie in my introduction talk about the number of years I have worked in mental health system. This is not a model we were trained in. So with something that relatively new for some specialty areas and some system structures need to change as well, to recognize the involvement of the family. There is a need for education and guidance on how to involve family members. How do you engage the family. How do you engage or invite the person with mental illness to include their family or their person of support. The majority I would suspect, I don't have hard data in front of me to quote to you but I would suspect that many people especially when they are in crisis aren't really willing, aren't really excited about bringing their family or their support system in to the treatment process. So it is critical for clinicians to continue to ask, to ask repeatedly. Don't give up. Keep talking to them. Caseloads are another huge barrier that when you are -- when you heard Dr. Shareh Ghani describing the case management, the extensive case management and proactive it sounds like in a lot of the cases, system that was in place and still it -- it was not always -- there were still people who died by suicide. What NAMI offers, we had one of our -- three different categories, classes presentations and support groups, three different types of programs that are complimentary for what's going on in the clinical world. These are not replacements for clinical treatment. These are above and beyond the clinical treatment that's taking place additional support services, if you will, that are an available. These are available in most communities. And again these are all free of charge for individuals. They are all peer led. So in education program taught at NAMI, not -- I will talk about some of the specific ones in a minute, or a support group that's a NAMI support group are all led by peers. If it is for the person with a mental illness it is led by people in recovery. We have support groups even for youth and young adults with mental illness. You have who leads a NAMI program has been credentialed. There is an extensive rigorous weekend training that these individuals go through where they are trained in a model. They their Fidelity assessment. It is not that people go out and become support group leaders. The education classes are -- happen across multiple offerings. The shortest education program we have is five weeks. The longest one is 12 weeks. NAMI family to family program. All of our education programs

are manualized curriculums. They are made up of a combination of reck lectures, discussion periods, row plays and other interactive exercises. So again it is more than just someone coming and watching a powerpoint presentation. So wanted you to have kind of an idea of what I'm talking about. And what we know is that with family members as well as with the individuals with mental illness one of the things they need above and being -- above and beyond being involved in a treatment process is understanding about what it is they are going through. They need information about what they are experiencing, about how it compares to what others have experienced similar situations are like, and how others have coped with it. How others have dealt with it. So that's what I talk about lived experience, that's really the unique piece, the niche, if you will, with the NAMI programs. This slide gives you an idea of the different programs that NAMI offers. Some of them you ma may have heard of. NAMI family to family is our oldest program. It is evidence-based and there have been multiple control group studies done validating that people who take this course participate in this 12 session course. It is a psycho education model that's taught by family members and what we know is that people who have taken the class report feeling more empowered to make decisions and to help their loved one navigate the system of care and take care of themselves. They are better at problem solving. They are better at self-care for themselves. That's another Big Ten ant of the programs we offer, if you are not taking care of yourself you can't take care of anyone else. The NAMI basics program is for parents or other family caregivers of children and adolescents. Home front is our program for family members of service members and adults and then peer to peer is the program for individuals with mental illness themselves. And very much like the family programs we are teaching them about the different conditions. About what we know about the etiology of mental illness, about the different trajectories. It is about -- this is not your fault. That's one of the tenants that we have some basic beliefs some core principles in each of these education programs and one of them is that mental illnesses are no one's fault. You can't know everything and you can't know what no one has told you. When you break your leg, we use this analogy a lot in the NAMI programs. If you break your leg and go to an emergency room pretty much anywhere in the country there is a standard of care that you are going to get. The bone is going to be set and you will get instructions on how to take care of the cast and how long you will wear the cast and get a prognosis but with mental illnesses if you go to an emergency department and a psychiatric emergency, you may end up being taken to a correctional facility. Our programs teach families

what to expect and even the difference in to being admitted to an inefficient unit how that being different than being admitted in to a general hospital bed. We teach people all those so they know what to expect to know about the emergencies when they do happen. We let people there are so universal characteristics that all mental hel conditions share and that mental health conditions at their root are biological. There may be a variety of things going on but that it is nobody's fault. We provide current information and offer people a variety of solutions not that we have, you know, a cookbook of here's what you do and everything will be better. But here are some different skills that you and your family or if you are the family member that you and your loved one with a mental illness can learn and use to help better navigate the conditions that you are dealing with. We provide people with information about resources that are available in the communities. If you think about what Dr. Shareh Ghani and David were sharing in terms of noticing and being aware of the signs or symptoms that someone may be considering hurts themselves or considering suicide attempt, what do you do? As family member what do you do if you notice those things? Who do you call? When do you reach out for help? The other programs that are on the right side, the family support group and NAMI connection group these are like AA. Family and friends ending the silence our presentation programs that are made to the general public. Ending the silence is focused on school age youth, middle schools and high schools. Family and friends is a four-hour kind of like a mental health 101 and then NAMI in our own voice is individuals adults with serious mental illness who are in recovery who share their story. We get about 125,000 calls annually. Some of those come in through e-mails. Some of them are actually telephone calls where we direct people out to resources in their own individual communities. And we get about 7 million different users annually on our website much of our information is available via the web. This slide has three tools that we have specifically developed that I thought might be helpful for the group on the call today. The one at the top navigating a mental health crisis and it is actual guide of what to expect. It was developed for -- it is something I wanted back in my mental health center days for when family members or individuals were in a crisis a psychiatric emergency and didn't know where to start. What do I expect when I call. It is a navigating a crisis 101. Circle of care is a guide that we developed in collaboration with the national alliance on caregiving, specifically for family members of adults with mental illness and what caregivers need to know. We developed in collaboration with the JED foundation and it is for young adults. We know so

many times the symptoms either begin to exhibit themselves or exacerbate at that college age. What to expect and what to say to each other, suggestions on how to talk to each other and these are be all be downloaded and this is our newest collaboration that I wanted to mention to everyone on the call NAMI is a partner with the American Psychiatric Association. Called SMI advisor. And in is clinical support system for people with serious mental illness. It is a five year technical assistance center that is funded by SAMSHA and NAMI is one of the six content experts on this project. But the idea was to for APA and SAMSHA to team up to create this. Again it is a five year, 14 million dollars initiative focused on the most common conditions bipolar disorder, major depress and schizophrenia and SMI provider provides innovate education, resources and answers about these conditions for all providers on the mental health care team including the family members. And the individuals. It is includes an interactive chat bot feature you can submit case consult questions if you have questions about something you are dealing with with someone you are caring for. Or if you are the individual or the family member and you have specific questions, you can find resources for yourself as clinicians or for yourself as a family member or as a person with a mental illness on not just crisis situations but on different types of treatment, the whole premise was to create a one-stop shop of evidence-based practices for people with serious mental illness. And the vision is to transform care for people with SMI so they can lead their best lives and you can again go to smiadvisor.org and you see the link right there. You can sign up for a newsletter that comes out err two weeks and you will get notifications about webinars that are available. They offer CMEs through nursing, through psychologists through psychiatrists, through counselors and through the psychological association. Extensive resource library there. But this is -- it fits so well with NAMI because we really do promote the collaborative model of care. The individual, the person, the family, and the health care system and again it really is all about engagement. This slide talks about being able to submit for a case consultation. Again if you are a clinician and we will soon be able to if you are a family member or an individual submit for a case consult and someone on the clinical expert team will respond to that. Just want to close my portion of this by saying that NAMI is here to provide information support and advocacy to individuals and the families free of charge. And SMI is here to provide that same type of support to the clinicians as well as to the individuals and the families. So an excellent source of resources for all of you there and that concludes my portion.

>> JULIE GOLDSTEIN GRUMET: Thank you so much. What an incredible amount of resources that exist a that I am not sure all of our participants knew about. This work is really hard but the resources are being built and I hope that people are taking advantage of it. I think your VIN diagram of importance of family hits home and that work is hard and I think one of the first questions I have while people are typing in to the Q and A box any questions they have, one of the first questions is how do you get family involved when the patient may be unwilling? What have you found to be successful?

>> TERI BRISTER: What we have found is for the family, it is one of the ways that NAMI is can be helpful for the families to engage with other families and learn what they can do for themselves even if the patient is not willing for them to talk with their specific provider. There are things the family can do just to terms of how they interact. There are things they can do to keep in escalating the situation. Things that they can do to be supportive. We let families know that they can share information with the provider even if the provider isn't able to share information with them or even confirm that the individual is their patient. But they can express those concerns to the provider. So we try and help families learn what they can do for themselves and what they can do at home or in the particular environment. Hopefully while the individual gradually changes their name and their mind and wants them to be more actively engaged.

>> JULIE GOLDSTEIN GRUMET: Thank you. I had a question that came in for you which was how did the staff with whom you worked or leadership change their clinical approach based on the wonderful data you shared with us today? How did they use that to inform come of the work they were doing with patients?

>> SHAREH GHANI: That's a fantastic question because that was our biggest burden. I would even invite David to opine on that. We Julie, we took this very seriously in terms of workforce improvement and having tools available to them. So we connected with Living Works. Outstanding training program and opportunity and we trained our staff each and every one of them on not only recognition but how to problem solve and how to -- that hospitalization was not the only answer but before hospitalization, after we -- so living works training, face talk and then we also formed a governing board or body that was comprised of community-based providers thought leaders and we took guidance from Henry Ford health system and how they went about changing the mindset of not accepting suicide as an eventuality that is part of mental illness. So we have to get in to the mindset of Zero Suicide to be able to apply the learnings from these studies, from this study and others because

that's -- that was our biggest challenge was getting our staff in all of the same page.

>> JULIE GOLDSTEIN GRUMET: So it sounds like you used training to try to help reinforce that suicide could be reduced or preventible to kind of change the culture there, to help staff understand leadership is behind them, there was no blame. You were bringing in a lot of training to kind of help reorient them to things maybe they hadn't learned in grad school.

>> SHAREH GHANI: Including MDs, psychologists, case managers. Everyone has to have a pivot in their thought process and electronic health medical records appeal -- attempts to support survivors. There was a significant culture change that led to us -- we had successes in impacting suicide rates in Maricopa but it took a village.

>> JULIE GOLDSTEIN GRUMET: Thanks. David, what about you, do you have any additional thoughts? Teri mentioned some barriers for caring for people at risk and some ways that NAMI has developed to educate both patients and families and providers. Do you have any other thoughts about caring for people with SMI and barriers that exist and ways to overcome those barriers?

>> DAVID COVINGTON: I will mention one that Shareh is leaning in to a little bit. But in addition to the clinical pathway that was generated looking at what Henry Ford had done around risk identification, direct treatment and follow-up we did certainly some of that work. We worked on how we could shift the perspective from one that seems to be pretty common in the men tal health system in the United States. The therapists will include the family if the individual and care really twists their arm to do so. We decided we need to switch that up and have it be the opposite. We were going to include the family unless the individual twisted our arm not to. Those were some of the things that we did and it was -- it wasn't our workforce. It was a net work of service providers. We have about -- we had about 50 large organizations that had a workforce of 7 to 10,000 that we were engaged with. So working with that leadership as Shareh talked about the village. One of the efforts that we decided is important even the family and clinicians if they did all of that work to the precision that we hoped for, we didn't know if that got us where we wanted to go and they would have to be more care and support and we started looking at this concept of suicide attempts survivor support groups, additional adjunct to the care. And we face very significant barriers with getting those up and going. There were -- there was a lot of controversy within our steering committee about moving those forward and when we began to really discuss it we had one faction who felt like unless that was under very tight clinical

medical supervision and driven by the clinicians they wouldn't be appropriate. Another group who felt like we already had that level of service in place what we needed were caring support groups similar to that A model that Teri was mentioning as inspired NAMI and Stephanie Webber a national leader who done some work in this area had a hybrid approach. We finally got agreement to at least address this issue and we ended up bringing in a couple of national experts. To talk about this and I had carefully crafted out a set of talking points with Thomas. He didn't say any of that. He was supposed there a survivor groups going on every day in the country. We don't call them. They are the therapy groups. You can look at many peer run organizations where they have groups and this is a common discussion but what he said instead was there is actually only one documented research-based intervention for saving lives of suicide and that's -- he said that's caring and what better opportunity to do that than individuals supporting one another. But what we found even in getting those up and running that initially we had those embedded within clinical organizations and they tended stifle the referrals in to them and we moved those groups to peer run organizations. So I mention that one example. It was one of nine major things we were doing but it points to how hard these practices are to shift because of historic precedence around our beliefs around suicide prevention and concerns about medical liability and risk and for us to do something really different it does take a different approach. We use different language. We use the top leadership from those organizations as opposed to top clinical leaders in order to start that. And we did begin to shift that community practice over the course of the five years that we are were engaged in it.

>> JULIE GOLDSTEIN GRUMET: So inspirational and I think the idea of turning kind of conventional care on its is such an important take home point that you can't keep doing what you have been doing for the last 20 years and think that everything is going to change. Use the leadership and the passion around as David because talking about and it results in outcomes. So really want to thank all of our presenters for joining us and sharing their thoughts, leaderships, the path these have already taken and that helps many of you in today's call to adopt some of those practices. All of this information, many of these resources are available on zerosuicide.com. There is a survivor support group that DeDe Hersh in Los Angeles created. Their manual is on suicide.com. It is a manualized curriculum for that group. If we didn't get to your questions, we tried to get as many as we could but if we didn't please post them on the Zero Suicide listserv. These conversations generally continue

with an incredible amount of capacity and generosity on the part of that community as well. I hope you will join us in the future for other webinars, check out our website. I want to thank our team for putting on these webinars takes a lot of work but we love it and we hope that it was helpful to you all and want to wish everyone a good day and a good night. So thank you again for joining us. Take care.

>> Thank you.

>> Thanks all.

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