

# Substance Use Disorders in the Zero Suicide Framework

July 10<sup>th</sup>, 2018

# Funding & Disclaimer

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# Moderator

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**Julie Goldstein Grumet, PhD**  
Director of Health and Behavioral Health Initiatives  
Suicide Prevention Resource Center



**The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.**

[www.sprc.org](http://www.sprc.org)



@SPRCTweets





**#ZeroSuicide**  
**@ZSinstitute**  
**@SPRCtweets**

# Zero Suicide is...

- » Embedded in the *National Strategy for Suicide Prevention* and *Joint Commission Sentinel Event Alert #56*
- » A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- » A set of best practices and tools including [www.zerosuicide.com](http://www.zerosuicide.com)

# Elements of Zero Suicide



# A Continuous Process





## WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems and is also a specific set of strategies and tools.

## ZERO SUICIDE TOOLKIT

VIEW TOOLKIT +

## FOR CHAMPIONS

Zero Suicide Champions believe that anything short of zero suicides in health care is unacceptable.

### MAKING HEALTH CARE SUICIDE SAFE

Mike Hogan describes why now is the time for Zero Suicide.

## HOW DO I GET STARTED?

Join the Zero Suicide community.



## NEWS AND EVENTS

Zero Suicide is an evolving initiative.



## ZERO SUICIDE ACADEMY™

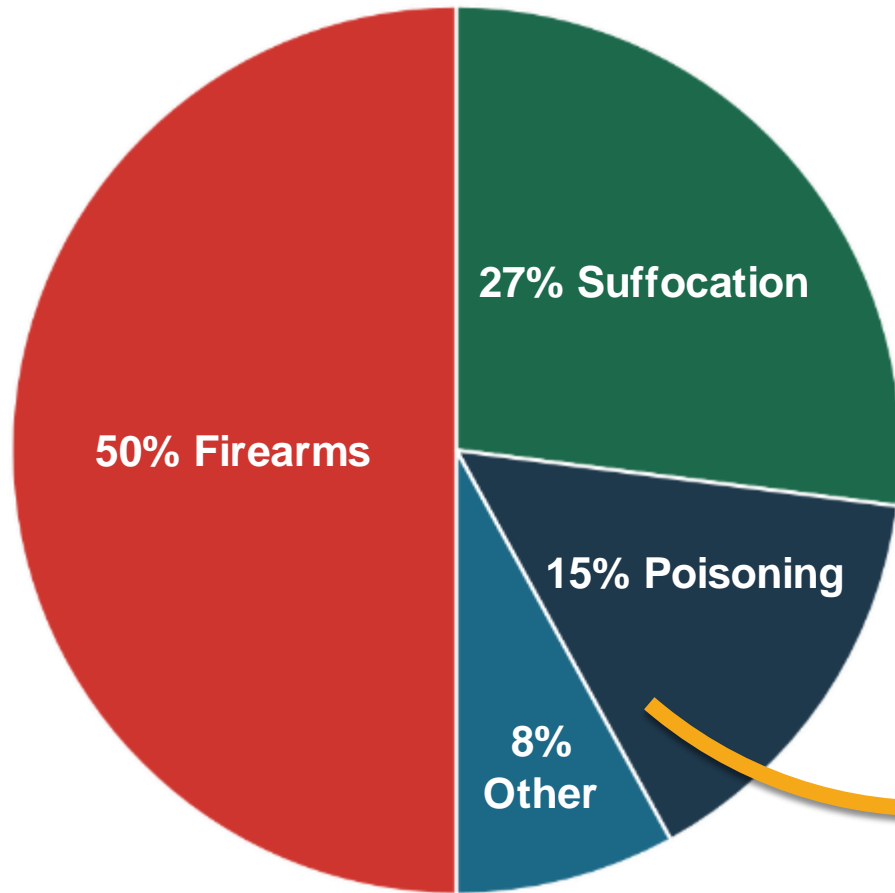
## GET TECHNICAL ASSISTANCE

Access the  
Zero Suicide Toolkit  
[www.zerosuicide.com](http://www.zerosuicide.com)

# Suicide and Substance Abuse

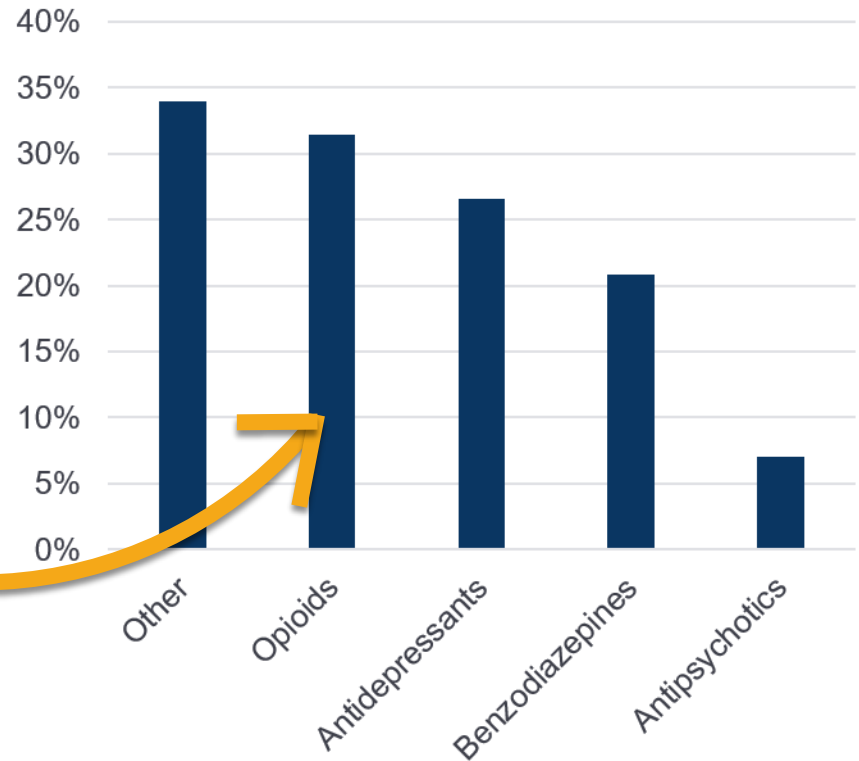
- » Suicide and drug overdose deaths in the United States increased since 2001 and the rate of drug overdose death surpassed that of suicide in 2015 (CDC WISQARS, 2018).
- » Adults who abused opioids at least weekly were more likely to engage in suicide planning and attempts (Ashrafioun, Bishop, Conner, & Pigeon, 2017)

# Suicide by Method (2015)



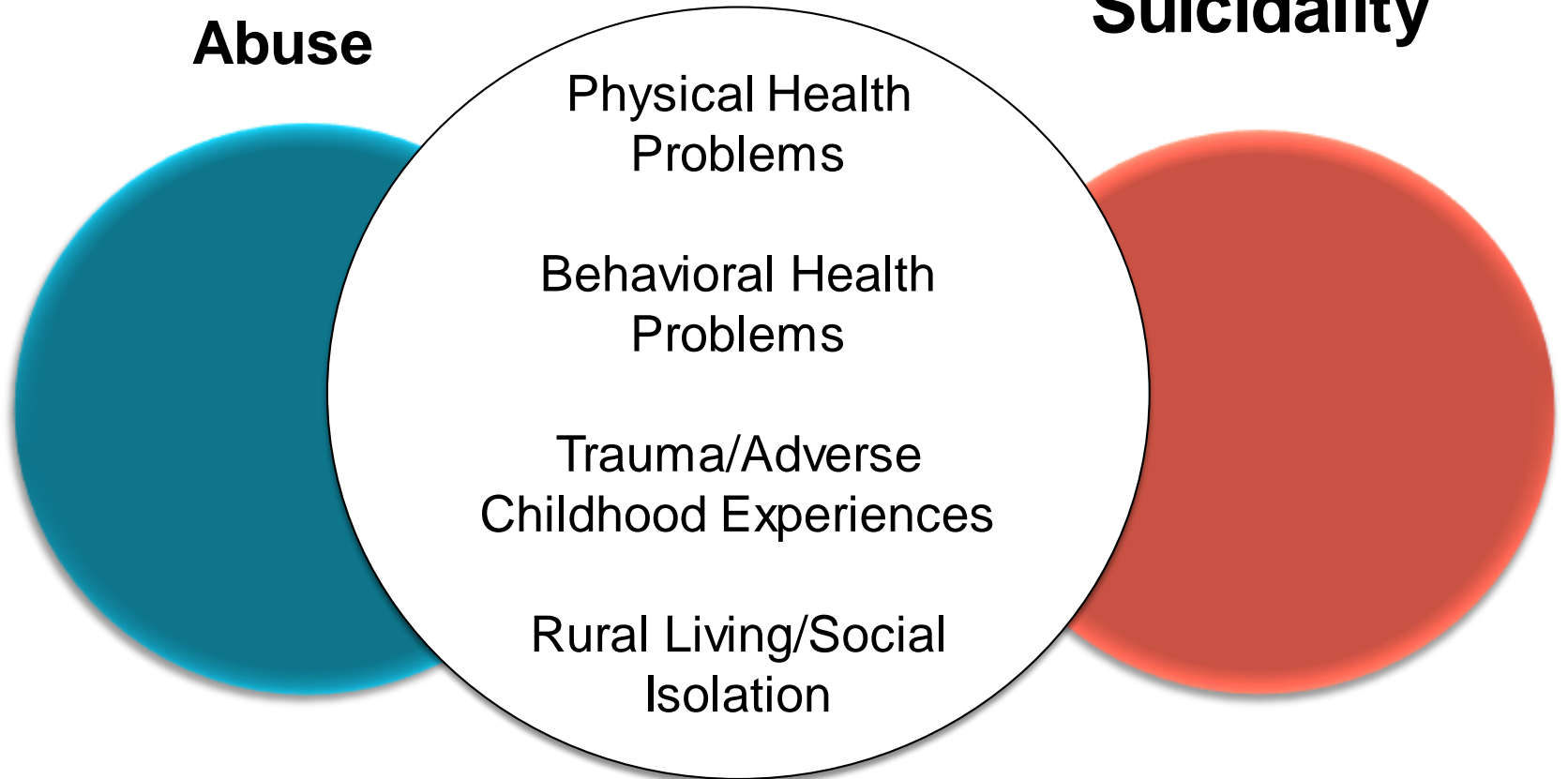
Means of Suicide, United States<sup>4</sup>

Poisoning suicides by substance – 27 states (2015)<sup>4</sup>




**Substance Abuse**

**Suicidality**




**Intersection**

# SPRC Resources



**Preventing Suicide among Men in the Middle Years: Recommendations for Suicide Prevention Programs**

SPRC | Suicide Prevention Resource Center



**Suicide Prevention Resource Center**  
About Suicide | Effective Prevention | Resources & Programs | Training & Events | News & Highlights | Organizations

**SUICIDE PREVENTION LIFELINE** 8 2 5 5  
1 (800) 273 TALK

### Speaker Information

## Men in the Middle Years

Speaker: Jeff Sung, MD

**"If we're going to reduce the overall number of suicide deaths in the United States, men in the middle years need our attention."**

Jeff Sung, MD

Dr. Jeff Sung is a psychiatrist who teaches workshops in suicide risk, assessment, management, and treatment. He has a private practice and also works at a clinic in Seattle, Washington, where he mainly sees patients who are men in the middle years.




#### Related Files

- Transcript
- Key Points
- Resources

Men in the Middle Years

**Jeffrey Sung, MD**  
Psychiatrist

# SAMHSA Resources






## SUBSTANCE USE AND SUICIDE: A NEXUS REQUIRING A PUBLIC HEALTH APPROACH

Suicide is a serious and preventable public health problem in the United States. Collaboration among prevention professionals across behavioral health fields has the potential to reduce suicide rates. While multiple factors influence suicidal behaviors, substance use—especially alcohol use—is a significant factor that is linked to a substantial number of suicides and suicidal thoughts. This “nexus” between substance use and suicide provides an opportunity for behavioral health leaders to develop a cohesive strategy within a public health framework to reduce suicidal behaviors and suicide rates.


This strategy examines the relationship between substance use and suicide and provides information and prevention professionals with information on the scope of the problem, an understanding of traditional barriers to collaboration and current programming, and ways to work together on substance use and suicide prevention strategies.

### SCOPE OF THE PROBLEM




1 in 12 people in the U.S. have suicidal thoughts.

**41,000+** More than 11,000 deaths a year in the U.S. from suicide.



20% of suicides are related to substance use.

4x Higher risk of suicide for people with substance use disorders.





22% of people with substance use disorders have suicidal thoughts.

Behavioral Health Is Essential To Health • Prevention Works • Treatment Is Effective • People Recover

## Addressing Suicidal Thoughts And Behaviors in Substance Abuse Treatment



### A Treatment Improvement Protocol TIP 50

Substance Abuse and Mental Health Services Administration  
 www.samhsa.gov • 1-877-SAMHSA-7 (1-877-624-6747)

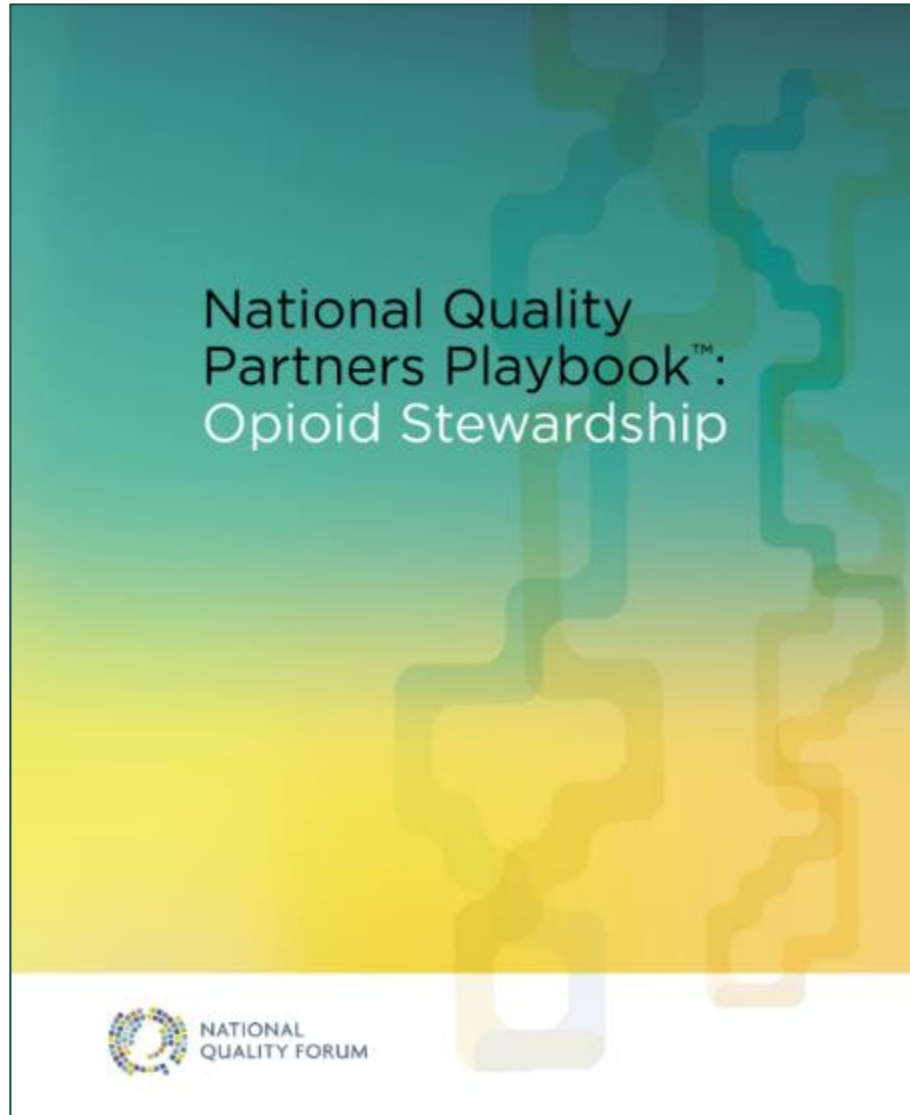
## SAMHSA Opioid Overdose Prevention TOOLKIT

- Opioid Use Disorder Facts
- Five Essential Steps for First Responders
- Information for Prescribers
- Safety Advice for Patients & Family Members
- Recovering From Opioid Overdose

Substance Abuse and Mental Health Services Administration

# National Quality Forum Resources



# Learning Objectives

By the end of this webinar, participants will be able to:

1. Identify ways to improve staff attitudes and confidence towards working with patients at risk for suicide and overdose deaths.
2. Share unique patient engagement and suicide care management plan considerations for this population.
3. Describe the benefits of a patient-centered perspective to treating suicide risk and overdose risk concurrently.



# Presenters

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**Rick Strait**  
Community Counseling  
Center



**Thomas  
McCarry**  
The Institute for  
Family Health



**Barbara Gay**  
Area Substance  
Abuse Council, Inc.

# Presenter

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**Rick Strait, MS, LPC, CRDAC, CCDP, CGDC**

Program Manager

Integrated Treatment for Co-occurring Disorders (ITCD)

Community Counseling Center

# Community Counseling Center

- » Launched Zero Suicide in 2016.
- » Suicide prevention is an organizational priority for all staff.
- » Adapt Zero Suicide to support staff in the delivery of Integrated Treatment for Co-occurring Disorders (ITCD).

# Screening and Assessment

- » PHQ-9 at individual sessions, if triggered then the C-SSRS
- » DBT diary check in cards for our groups

# Screening and Assessment

- » Prior to screening and assessment, we have a conversation:
  - » Normalize that while in treatment it is possible that suicidal thoughts may be present.
  - » If thoughts are present or become present, we have staff who are willing and comfortable talking about suicide who will help them through that crisis.

# Screening and Assessment

- » Explain that hospitalization is always our last resort, and that the majority of the time we are able to safety plan.
- » Even if there is no indicated risk we still complete a mini-safety plan (provide information and resources if things change).

# Safety Planning

- » Stanley & Brown
  - » Reviewed at each session
  - » Aware of additional lethal means (substances)
- » Included in safety plan
  - » Using
  - » Relapse
  - » High risk situations
- » Does safety planning work?

# Safety Planning

- » Currently working on a plan to train staff and consumers on how to use Naloxone (Narcan).
  - » Intentional overdose
  - » Accidental overdose



# Care Transitions

- » In addition to typical transitions identified by Zero Suicide, we are also aware of:
  - » Change in stage of treatment (stages of change)
  - » Relapse
  - » Starting or stopping MATs
  - » Support of family increasing or decreasing
  - » Pending legal charges/jail time

# Care Transitions

- » Aggressive outreach
- » Care cards
- » Other cards/notes
- » Warm hand-off
- » Visiting with consumer while in hospital/jail if possible
- » Provide information during group and individual therapy about potential for increased risk during transitions

# Key Takeaways

- » Normalize that it is possible that while in treatment suicidal thoughts may be present.
- » Recovery-specific safety plan components.
- » In substance abuse recovery, care transitions happen more frequently and in different ways, so being proactive is necessary.

# Audience:

Using the chat box, please share one key takeaway from Rick's presentation.



# Presenter

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## **Thomas McCarry, LMHC**

Director of Substance Abuse Prevention  
Program Director, Opioid Overdose Prevention Program  
The Institute for Family Health

# Case Study: Overdose Prevention

- » Ulster County Jail: Kingston, NY
  - » Improved discharge planning

# Case Study: Overdose Prevention

- » Ulster County Jail: Kingston, NY
  - » Improved discharge planning



- » Improved was not good enough!

# Needed Radical Change

- » Modeling existing workflows
- » How are suicide and overdose similar?
  - » Fatal and non-fatal
- » Zero Overdose Model



# Zero Overdose: LEAD/TRAIN

- » An explicit commitment to reduce overdose deaths requires leadership support.
- » Assess staff skills, confidence, attitudes in providing suicide prevention care with overdose prevention.
- » Train all staff to identify individuals at risk and respond effectively, commensurate with their roles.

# Zero Overdose: IDENTIFY

- » Universal and ongoing screenings
- » Using standardized tools:
  - » NIDA-modified ASSIST
  - » AUDIT, DAST 10
- » Guidelines for Assessing Appropriateness for Office Based Buprenorphine Treatment  
G-FAAFOBBT

# Zero Overdose: ENGAGE

- » Overdose Care Pathway
  - » Integrated care approach
  - » Formalized policy
  - » Internal and external referrals
- » Substance Use Safety Plans
  - » Harm Reduction Safety Plan
  - » Recovery Safety Plan

# Recovery Safety Plan

## **My Personal Recovery Safety Plan**

**Congratulations on your efforts to maintain sobriety!**

**Let's work together to develop and write down a plan which will help support you and prepare for tough times should you hit bumps.**

- » Individualized: Triggers, coping skills, and resources
- » Guided discussion on increased risk of overdose

# Harm Reduction Safety Plan

- » Reinforcing commitment to patient
- » Based in Motivational Interviewing
- » Overdose risks, harm reduction tips
- » Stages of Change model

# Zero Overdose: TREAT

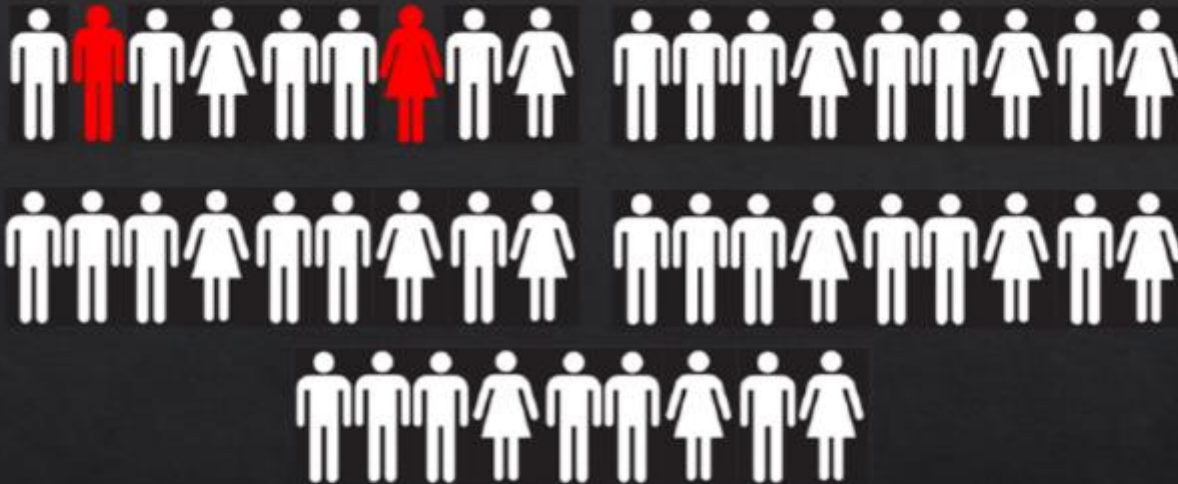
- » Individualized and evidence-based
- » Stepped Care Approach
- » Safety First: Naloxone
- » Medication Assisted Treatment
  - » Buprenorphine, Methadone, Naltrexone

# Zero Overdose: TRANSITION

- » Transitions are high-risk periods
  - » Bridging works
  
- » Reduced tolerance contributes to overdose

# Zero Overdose: IMPROVE

Since Enhanced Transitional Care



There have been Zero Overdose deaths of patients being referred from the jail.



# Audience:

Using the chat box, please share one key takeaway from Tom's presentation.



# Presenter

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**Barbara Gay, MA**

Executive Director  
Area Substance Abuse Council, Inc. (ASAC)

# Overview of ASAC



# Overview of ASAC

## Mission

ASAC provides accessible, comprehensive substance abuse services delivered with dignity, respect and professionalism to reduce the impact of substance use disorders.

## Values

- » Adaptability to meet patient needs and to changing environments
- » Support patients, families, and communities with integrity and understanding
- » Accommodate individuals of all cultures and backgrounds
- » Compassion in the delivery of effective prevention, treatment and recovery services

# Overview of ASAC



## Prevention

- » Educational Services
- » Environmental Strategies
- » Community Coalitions
- » Workplace Services

## Treatment

- » Outpatient
- » Residential

## Recovery

- » Short-term transitional housing
- » Long-term transitional housing
- » Recovery supports

# Integrated Care from the Substance Abuse Provider – Why?

**Opportunity:** Patients come to ASAC often because there is an external motivator; they are not in the habit of seeking out care

# Integrated Care from the Substance Abuse Provider – Why?

**Experience:** Many ASAC patients report having felt “disrespected”, “worthless” or “unreliable” by other providers; their reporting of other conditions was either dismissed or ignored because of their substance abuse/misuse.

# Integrated Care from the Substance Abuse Provider – Why?

**Linkages:** Strong connections with other providers often help get ASAC patients into additional services quickly; often avoiding having to seek a provider and be on a wait list.



# How We Began to Integrate

- » Reviewed our patient data to identify areas of need.
- » Determined metrics that fit for our patients.
- » Moved from using PHQ-9 and making a referral to developing a system of real-time care.
- » Bring contracted services on-site.



# Treatment as an Opportunity for Connections to Additional Care

## » **Benefit for the Provider**

- » Comprehensive care keeps patients connected to your services.
- » Acceptance of people as they are, meeting them where they are, allows them to achieve their goals with the support of your services.
- » Linkages to other services can improve engagement.

## » **Benefit for the Patient**

- » Coordinated care means less repetition.
- » Reduction in real and perceived stigma which can increase care seeking.
- » Opportunity for having mental health care be treated as important as their physical health care.

# Audience:

Using the chat box, please share one key takeaway from Barb's presentation.



# Audience:

Type in the Q&A box:

What questions do you have for our presenters?



**THANK YOU FOR  
JOINING US!**

# Contact Information

**Zero Suicide**

**Suicide Prevention Resource Center**

**EDC**

[zerosuicide@edc.org](mailto:zerosuicide@edc.org)

**Title**

**Speakers: Julie Goldstein Grumet, PhD, Rick Strait, Thomas  
McCarry, Barbara Gay**

**Transcription provided by:**

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>> JULIE GOLDSTEIN GRUMET: Today is the Substance Use Disorders in the Zero Suicide Framework. We do many public webinars. And as Chelsea said, they are all archived on [zerosuicide.com](http://zerosuicide.com).

Before we get started, this is just a reminder that SPRC is funded by SAMHSA, the Substance Abuse Mental Health Services Administration, and that the opinions and content shared here are our own and don't reflect those of SAMHSA or the Department of Health and Human Services.

Me, I'm Julie Goldstein Grumet. I direct the Health Care Initiative Team with the Suicide Prevention Resource Center and I lead our Zero Suicide work.

The Suicide Prevention Resource Center, we call it SPRC, is the nation's only federally supported resource center devoted to advancing the national strategy for suicide prevention. SPRC is funded by the U.S. Department of Health and Human Services, by SAMHSA, and SPRC provides training, support, and materials to increase the knowledge and expertise of suicide prevention practitioners and other professionals serving people at risk for suicide. We cross the entire range of ages, settings. We put out a lot of resources, whitepapers, training, online training, and are constantly evolving in terms of what's next in the suicide prevention field. We're also home to all of the resources that are available to support the adoption of the Zero Suicide Initiative.

This is our hashtag. We use that today as well as for all of our events, so please go along and follow today's webinar or feel free to post comments and thoughts with this hashtag.

I'll start by giving you a brief introduction to what Zero Suicide is in case you're not already familiar with it. Zero

Suicide is an aspirational goal. And I ran a suicide prevention program before I came to SPRC, so I understand that for so long we set the goals to reduce suicide death by 10% or 20% or even 50%. And that's great. And it's noble. And it's really difficult work. But is it sufficient? What are we really aiming for if we're accepting anything less than zero? We have to aim for zero.

The revised 2012 National Strategy for Suicide Prevention includes goals eight and nine now which are specific to health care. And health care as the focus of suicide prevention was left out of the first National Strategy, which really kind of sounds remarkable if you think about it, that the assumption was that health care already was doing well in suicide prevention, so much so that we didn't even need to include it in the nation's strategy. However, it is clear that health care had to be included in order to save lives. What is necessary is that we must have a better trained, better prepared clinical workforce. People often don't get this training in graduate school. It's not required of CEUs. And we have to have health care systems that believe suicide is a necessary and core responsibility of their work. That's kind of the essence of the Zero Suicide Framework.

Zero Suicide focuses on error reduction and patient care through a robust, comprehensive, system-wide, bundled approach to suicide care in health and behavioral health systems, and that includes substance abuse serving systems. We have to apply new knowledge about suicide and we have to apply continuous evaluation and quality improvement efforts in order to know if we're doing what we say we're doing, how well we're doing, and where we can do better. Those systems who have done this approach with fidelity have seen reductions in suicide and suicide behaviors for their patients. We have many tools and resources available to help you do this work at [zerosuicide.com](http://zerosuicide.com).

These are the elements of Zero Suicide. Seven components make up the model, each of which has been shown individually to support a reduction in suicide deaths and behaviors. Each tool is evidence-based, but the research is relatively new. And as I said, many providers were not trained to use these tools and best practices and often don't even know that they exist. Zero Suicide fills these gaps in care and even in providers' education that can happen routinely in health care by using this set of evidence-based tools, by using consistent practices, training for the workforce in how to use these tools or how to apply these interventions, and the workflows are embedded in



electronic medical records to ensure that we have sustainability and that we can assess the data as to how well we're doing. Data is routinely gathered and routinely assessed. Zero Suicide is not a program, it's not a curriculum, it's not a marketing slogan; it's a culture shift. It transforms the culture through ongoing leadership and attention to using these elements, and it's how health care systems view and manage patient safety so that they can routinely deliver quality and effective suicide care.

The core of Zero Suicide is the Suicide Care Management Plan. Suicide care can and should be systematized and routinely delivered just like standard care management that would happen for those diagnosed with diabetes or asthma or heart disease. We know evidence-based practices exist for those diseases and we know that there are evidence-based practices that exist that can be applied to suicide prevention that work and we have to use them. Some of the mechanics of the Suicide Care Management Plan would include screening. We have to screen all patients regardless of the setting or the reason for their visit when they enter the health care system.

For those who screen positive, they should be assessed for their suicide using a robust risk assessment tool. For those at risk, they need to be placed on a pathway and receive care that focuses specifically on their heightened risk. And there needs to be a plan or a policy both for putting people onto this high-risk pathway as well as how to take people off this high-risk pathway. Care should include the development of a collaborative patient-centered safety plan. All safety plans have to include a discussion of how to reduce access to lethal means, and clearly this would include removing or reducing access to drugs and alcohol that could contribute to suicide. One of our speakers today will talk about how to ensure that the safety plan includes content specifically for those with substance abuse disorders.

Clinicians do report a lack of comfort and skill and preparedness to treat people at risk for suicide, even licensed professionals. But there are treatments that are available that directly target suicide thoughts and behaviors, things like dialectical behavior therapy, cognitive therapy for suicide prevention, collaborative assessment and management of suicide that clinicians can be trained in, and we have to apply these types of evidence-based treatments if we want to see people's reduction in their thoughts and suicide behaviors.

The last piece of the Suicide Care Management Plan has to do with care transitions because care transitions are an extremely high-risk time for patients. Many suicide deaths occur in between providers and systems as people are discharged from in-patient settings or discharged from emergency departments. Care providers and clinicians must bridge patient transitions from in-patient or ED or even primary care to outpatient behavioral health by ensuring that the plans are carefully reviewed with the patient, that they understand what their treatment plan is, who the provider is, how to get there, the purpose of that care and treatment, what to expect, and then the burden is on the health care system to follow up that this linkage was made. It's no longer acceptable to just hand somebody a piece of paper with a name, address, and phone number and say you should really call this system to make an appointment. We have to close the loop if we want to help reduce suicide.

I've talked a lot about data, so I think you can see how important it is in this system, but it has to be a priority. You have to know what your data looks like at the start of your initiative so you can know where to best focus your efforts and also to gauge how well you're doing.

I mentioned our website. This is [zerosuicide.com](http://zerosuicide.com). This includes an implementation toolkit with many of the resources for getting started and sustaining your efforts. That's the button at the top right that says toolkit in green. We provide the rationale and information for each of the components of Zero Suicide. So if you're looking for some of the evidence behind those components, information can be found there. We also have a very active ListServ that any of you can join. You click on the box on the left, how do I get started, that's in turquoise, and sign up. It's a wonderful community. People are incredibly gracious and generous with sharing their resources, their tools, their experiences. We'll get to as many questions as we can during today's webinar at the end when we do Q&A. But for anything that we're unable to get to today, please continue that conversation on the ListServ. It's really an incredible resource of people with lived experience, researchers, people implementing Zero Suicide in all different types of settings.

Zero Suicide is certainly a framework relevant for many types of health care systems. It's used already today in primary care, in integrated delivery networks, in outpatient behavioral health, in in-patient psychiatric hospitals, and I think it can very successfully also be used in agencies working with individuals with substance use disorders. I already described

that Zero Suicide is a robust framework, but it's not a manualized approach. You don't click and download a manual. Each system needs to create a team that focuses on system-wide culture change as it applies to suicide prevention and then tailor it and adopt each of the elements to create the policies and the training that works to best fit the population or setting or needs of the community in which you work.

Today's webinar will focus on suicide and substance abuse. Why are we choosing to do a webinar on that topic? I think it's no surprise that deaths by overdose have risen dramatically and actually surpassed suicide deaths in the United States in 2015. I'd love to see more agencies that serve people struggling with substance abuse disorders really think about how they focus on suicide prevention. And I think hopefully after today, the Zero Suicide Framework will help to provide a foundation for changes you might make, either improving the wonderful care that you already provide or thinking about tools in different ways than you'd thought of previously. It's critical because we know that people with substance abuse issues are at higher risk for suicide. Studies have shown that those abusing opioids in particular were more likely to exhibit suicide behaviors. It's clear that agencies need to be well prepared and to strategize around preventing suicide for those with substance use disorders, and hopefully today and in our ongoing conversation on the ListServ you will get a lot of new ideas.

In suicide deaths that occurred as a result of poisoning, and poisoning really includes forms of intentional overdose, one-third of those overdoses were due to opioids. There is clearly an avenue to prevention here that we'll discuss today. You can see some of the other substances that people died of with regard to suicide. And I think this is an underreporting. We know that coroners struggle with was it intentional, was it unintentional. I think health care systems certainly reflect that when we look at numbers of suicide deaths in agencies, was it accidental or not. I think any of the numbers that we see published probably are a dramatic underreporting. We can catch more people as we really kind of think about how we're going to embed these practices.

Understandably and I'm sure again this is no surprise to all of you who work in these systems, there is a set of risk factors common to both substance abuse and to suicide, some of those are included in the circle in the middle. Orienting and adapting suicide care so that it can be responsive to individuals with this diverse and complex set of needs is essential.

I want to share just a few resources that you might not be familiar with. These are both available on SPRC's website, [sprc.org](http://sprc.org). We know the suicide rate for men in the middle years is more than double the national average. Thinking about how to reach men without necessarily using conventional mental health channels is necessary, certainly in suicide prevention and also in substance use prevention. We want to make appropriate treatment that's relevant and accessible. A lot of that is covered in the Preventing Suicide among Men in the Middle Years report. There are some great recommendations. On the right is what we call our Spark talks. We have a series of wonderful talks. Barb Gay, one of our speakers today, is also highlighted in one of those Spark talks, but this one highlights Dr. Jeff Sung who is a psychiatrist at the University of Washington. He actually gave our last webinar on working with the homeless population. He's been a tremendous friend and asset to the SPRC. But his Spark talk kind of helps to highlight what is it about men in the middle years and what do we have to do to think differently with regard to suicide prevention.

These are some resources available on the SAMHSA website, [samhsa.gov](http://samhsa.gov). SAMHSA offers a number of programs and initiatives and resources to help people recognize mental and/or substance use disorders and to get help. You can access all of those on the SAMHSA website.

Finally, this was a recently released resource from the National Quality Forum, the National Quality Partners Playbook: Opioid Stewardship, and it provides essential guidance for health care organizations and for clinicians across a diversity of care settings committed to appropriate pain management strategies and opioid stewardship. If you take a look at it, you'll see a lot of the principles kind of line up with how we think about suicide prevention. I think this is a natural partnership. It's one that makes sense. And I think we'll see more and more efforts begin to align in the coming years.

Moving on to today's webinar. Today's learning objectives are identify ways to improve staff attitudes and confidence towards working with people at risk for suicide and overdose deaths, share unique patient engagement and suicide care management plan considerations for this population, so that model that I showed you a little while ago, how do we tweak that to work with people who also have substance use disorders, and describe the benefits of a patient-centered perspective to treating suicide risk and overdose risk concurrently.

We have a great lineup of speakers. They are very good friends to the SPRC and to suicide prevention generally. They're each going to tell you about some of the innovative ways in which they have really thought about the intersection of suicide and substance use. And I really appreciate their joining us today and for all of you who have made time in your day to join us in today's webinar.

I'm going to go ahead and get started with Rick. He's a licensed professional counselor and certified substance abuse counselor at Community Counseling Center of Missouri. Rick is also a suicide attempt survivor. He's worked with the co-occurring population for 18 years. He's a board member of the Eastern Chapter of Missouri's American Foundation for Suicide Prevention and serves as the education chair as well as an advocacy ambassador. Rick has an incredible and unique ability to really bridge his knowledge with his lived experience that helps to provide him with a depth of understanding and practical application that has really served the consumers with whom he works and the program in which he works well. And he's a valued member of our Zero Suicide faculty.

I'm going to turn it over to you, Rick.

>> RICK STRAIT: Thank you, Julie.

The Community Counseling Center, we launched our Zero Suicide initiative in 2016. Suicide prevention is an organizational priority for all of our staff. But in the course then came how do we adapt the Zero Suicide model to support staffs for delivery our co-occurring treatments. I've been working in this field for 18 years, as Julie mentioned. In that time, I've lost some consumers to suicide, some to substance use, and a lot that we didn't know. Working to find a way to increase safety anyway was in our bull's eye and I was already in love with the framework for Zero Suicide, so we kind of met as a team and we started discussing it. Our agency is a community mental health agency that services five counties in southeast Missouri. The program I manage is called ITCD, which stands for Integrated Treatment for Co-occurring Disorders. In order to qualify to be in our program, an individual must have a chronic mental health disorder and on some level a substance use disorder.

When our team first started discussing, okay, so how do we apply this? What is different in our program than maybe what Zero Suicide was already looking at? Do we need to change

anything? Do we not? How do we know if it's something that's a suicidal risk, a substance use risk, or both, or does it really matter? Is it just a risk and we need to address it? These are the conversations that we started with that helped us kind of develop our current program.

The type or amount of services our consumers receive varies for each consumer. It's kind of based on their stage treatment which comes from the stage of change they're in, what they want to do, and the needs they're having. There are individual sessions. We do the PHQ-9. If that's triggered, do the Columbia. At that time, individual session, we can start to review or change the safety plan as needed. During our groups, we use DBT style diary cards for check-in. Most of our consumers are encouraged to attend one to two groups a week, but a lot of our consumers are actually attending groups four to five times a week, so they're checking in with those cards multiple times. What we do is we kind of look at how is their baseline. We might have somebody who almost every time says their suicidal thoughts are a four and we still touch base with them to see and make sure they're okay, make sure they have a safety plan, and if anything else is going on. But if you have somebody who usually says they're a one and they check in with a two, we're going to pull them aside between breaks or after group and see what's going on and possibly start a safety plan at that time.

Prior to screening and assessment, we have a conversation. This is one of the favorite things we do in our program that I really enjoy and I think is one of the things we're doing that has one of the biggest impacts. We recognize when they're coming to see us they're starting a new program. We recognize they might be very nervous about that. They may have never been in substance use treatment before and they may not know what to expect. Or they may have been in treatment before and not had a positive experience. Before we rush into asking more questions and starting treatment, we just talk. We explain our program, how it may be different than some past treatment programs, what we want to try to help them with, and see what they need. We talk about their life, what they want, any concerns they have, and what they would want from treatment.

During that initial conversation, we also talk about suicide and risk of suicide. We work to normalize that it's common for someone to have suicidal thoughts and it can change in their lives, such as treatment could increase those thoughts. We let them know that we are counseling staff talking about suicidal thoughts and they don't need to rush - we don't have to rush

into crisis. We're not going to rush them to the hospital. We want to help them through that. We ultimately want to keep them safe. What's really neat is we watch that. When we do that, you can almost watch some of the tension melt away in some of the consumers when they hear that we're comfortable talking about it and that's the approach we're going to use.

Even if they have no indicated risk, we still complete what I call a mini safety plan which is pretty much just providing some basic information, some resources, and the crisis numbers if they were to be needed. We explain that, again, that during treatment suicidal thoughts are common, and so we are going to ask about suicidal thoughts at most every session if not at every session. We kind of make the correlation of this it's like if you go to the doctor and you go to the doctor three times in one week. Each time you go to the doctor, they're going to take your vitals. We kind of look at it the same way. We're just going to continually monitor your mental health so we can provide you with the best safety we can.

Again, the mini safety plan is very simple. Most of the time, it's a verbal thing. We discuss, we give them those crisis numbers, and we give them a card that has our local crisis number on it, the National Suicide Prevention crisis line, and the text crisis. Before we wrap up that first conversation, we try to ensure that they know that we want to help them. We do have some resources if they need them, and we provide them again those crisis numbers. Then the last question I always try to ask them: If something changed and you did start to have those thoughts, who would you contact? We want them to have those thoughts in their mind when they leave our office in case those thoughts do come or if they're having those thoughts and they just weren't ready to be open about it.

The safety plan we're currently using is Stanley & Brown. If you have a safety plan, it's reviewed at each session. Working with our population, we are also aware of additional lethal means, the substances they maybe are using, and then we include that in their safety plan. Right now, we don't have a specialized form for that; we're just adding it to the Stanley & Brown safety plan, writing it on there. I see them several different times. We had a gentleman who was actively using heroine who was clear he was not ready to stop using. What he expected was we were going to take him out of treatment and all that, which we did not. What we did was say, okay, let's include that in your safety plan. During that process, we did not condone the substance use but we also did not condemn it or

criticize it. We just helped him develop a plan that said if you are going to continue to use, what can you do to help keep you safe? What can you do to help prevent an overdose?

Currently we are also working to train our staff and consumers on how to use Narcan, work on our plan to do this, whether it be an intentional overdose or an accidental overdose. Bottom line, we're just focusing on safety. We can't do our treatment if they're not here for us to treat.

In care transitions, this is one area that we decided the risk was extremely high. It may look a little different than what may be addressed in the standard Zero Suicide model. We added some other additional areas to be aware of. In addition to the things already covered in the Zero Suicide model, we look at changes in their stage of treatment, which is stage of change, a relapse, starting or stopping medication-assisted treatment, change in their family support, whether it's increasing or decreasing, pending legal charges, pending things with Social Services, anything that could have an impact or increase risk. At those times, we're trying to be aware and re-evaluate and maybe change or modify the safety plan.

One of the things we do in the care transitions is we have what I like to call aggressive outreach. We explain that to the consumers when they start a program that if you don't show up for an appointment, we're going to mail you a care card. If you're high-risk or we're concerned about you, or we think there is a reason to be high-risk or concerned, we're going to come knock on your door. We're going to come check on you. Now if you just don't want to come to treatment today, that's okay. That's your right. You don't have to. You can just give us a call and say, hey, I'm not coming today, I don't feel like it, and we're not going to come knock on your door, but we are going to make sure you're okay. I do believe that the aggressive outreach approach has saved at least three lives, two from potential overdoses and one from a suicide attempt that was interrupted. That's one of the things that we get to do.

Care cards I already kind of mentioned. Those are really nice post cards we send that are shiny, they're colorful with positive messages. We also do some other cards and notes. For instance, we had a consumer, she was a new mother, had her first Mother's Day, she had zero support system outside of her treatment, everyone else in her life was either actively using, trying to take advantage of her, or some other negative thing in her life. So on Mother's Day, her specialist got her a Mother's



Day card and her whole treatment team signed it with positive comments and how happy we were for her and the qualities of good motherhood that she was showing and things like that. She got that card and carried that card and talked about how much that meant to her.

We definitely try to do warm hand-off, whether it's picking somebody up and they're coming to start our program or going someplace else. We know that in that transition sometimes people may not ever start that next level, so we want to make sure we can help eliminate that barrier when possible.

Visiting a consumer while in the hospital or jail. Now that's not a billable service. We understand that. But we do know that a short visit while they're there has really good and lasting positive effects on our consumers. We had a consumer that had overdosed and was in ICU. He was in ICU for almost a week. When he came back to treatment, he came in my office and let me know how much he appreciated his counselor. He said when I woke up, I found out that my counselor had been by to check on me twice when I was not awake. And he said that meant a lot to him. He stayed in treatment. He had a history of not being very compliant - for lack of a better word - in treatment in the past and I think that was one of the kind of turning points.

If I were to say what would be some key takeaways from what we have learned and what we're still learning is I think it's important to normalize that it's possible that while in treatment suicidal thoughts may be present. I think it's also important that we include recovery-specific safety plan components. And then in substance use recovery, care transitions happen more frequently and in different ways, so being proactive is very necessary. We decided as a team that applying the Zero Suicide model to co-occurring treatment was not only possible, it was needed.

We are still trying to work on a way to try to track some of those outcomes and get the data that's needed to show that this is working. Right now we have consumers that talk about it. We had one the other day that told me that the way we do treatment helps convey that we see them as individuals. Another lady stopped by my office and told me I can tell that I can share whatever is going on, my thoughts and my fears, without judgment. I have not thought that in the past. It's a positive side for our staff. It helps keep us aware of where they are in their recovery.

Thank you and back to you, Julie.

>> JULIE GOLDSTEIN GRUMET: Thank you so much, Rick. I love all the examples about how this actually works in your system and how it's been effective.

We're going to open up the chat box and ask that you share one key takeaway from Rick's presentation. What is something that you're going to take back to your team and kind of chew on a little bit more that Rick shared? He shared some really tangible ideas about things that you might begin to do. What are things you're going to tell your colleagues who missed today's webinar? What is the key takeaway, something that you've been doing but now you might be able to kind of craft slightly differently? I know for me, I really think that the idea of how well Rick's agency prepares the consumer, there's such transparency about what is the safety plan, how do you use it. If you don't come to your treatment, we're going to find you. It's our responsibility. Rick said you can't treat them if they're not there to treat, and that's true.

I see a lot of comments happening. People say you're normalizing the suicide thoughts in treatment; you're not trying to avoid them. Several people wrote that. I see that again and again. Checking in on people more, making it the burden of the health care system to check in and ensure that people are safe. A couple people commenting on the idea of the care cards. And it looks like people counting substances as lethal means is another thing that people are perhaps thinking differently about. Addressing substance abuse on the safety plan coming up a few times. I think it's critical. If you know that that's a possible lethal means or something that could get in the way of how somebody is able to apply their safety plan, most definitely the clinician has to address it, has to think about it.

A lot of people talking about outreach, the important of following up, doing what you say you're going to do, checking on your clients when they don't come. We want them to come back. We want to treat them like human beings. We want them to know that we care. Many people are commenting Rick on how clear it is that your agency treats people with dignity and respect, honesty. It's very clear what a caring community you've created in your system. A couple people are asking about some of the resources for these caring cards. Rick has talked about them in the past on one of our previous webinars, so, certainly, I would encourage you to check out some of our previous webinars. We have examples of the text that could be included in some caring

contacts on zerosuicide.com, so please take a look there. I'm sure others would be happy to share on the Zero Suicide ListServ.

I'm going to move on. What I'll do while I'm introducing Tom is give you a chance to kind of type in the chat a little bit more if any questions are beginning to occur to you or any additional comments. Thank you, Rick. We'll be sure to have time for Q&A at the end.

I'm going to move on to our second speaker who is Tom McCarry. He's the Director of Substance Abuse Prevention at the Institute for Family Health. Tom is responsible for the development and implementation of integrated substance abuse prevention and treatment services. He leads the initiative that utilizes the Zero Suicide Framework to reduce overdose deaths and they've dubbed that Zero Overdose. They've really done a great job of thinking through what does Zero Suicide and suicide prevention look like in the substance use agency, so I love the idea of Zero Overdose. He oversaw the creation and implementation of overdose prevention safety plans, including workflows to enhance engagement through transitions of care and various workforce surveys to ensure that the staff is well trained and prepared to do this work, and also coordinated the availability of free naloxone kits across all their institute sites. He's been very busy, very creative. And I'm going to turn it over to Tom.

>> THOMAS MCCURRY: Thank you so much, Julie. And thank you, Rick, for your presentation as well. I'm absolutely thrilled to be a part of this panel and touched by the sheer volume and breadth of those tuning in today. I do hope that you find this presentation helpful and useful and have some takeaway tools that you can think about implementing within your program. I would like to start with a case example that helps to highlight what led us to more formally look at the framework used for suicide prevention as it relates to overdose.

I work with the Institute for Family Health. We are a federally qualified health center, a network of federally qualified health centers throughout New York City and up into the Hudson Valley. Ulster County is in the mid-Hudson Valley of New York. It is also one of the counties which has one of the higher overdose rates in the state. We were approached by the Ulster County Office of Mental Health in the fall of 2016 to help improve the Ulster County Jail discharge planning. The Ulster County Jail does a very good job of working with

patients' mental health needs while they are incarcerated, including providing their psychiatric services. Upon release from the jail, the patients are provided five days' worth of medication. It's not a lot and virtually impossible to obtain a psychiatric appointment within five days in our community and I think most.

The Ulster County Jail had been making referrals to a program which provided intake appointments within five days but this did not correlate to how quickly they were seen by a psychiatrist. My organization said this is not a problem. We can set up intake appointments. They'll have a psychosocial appointment as well as see the psychiatrist on the same day within the first five days of their release from jail. We left that meeting so happy, felling like, wow, we've really got something in place that's going to make a big difference. This was an easy fix and we can't wait to get it started. Well, sure enough, the first referral came shortly after that and I rolled out the red carpet. I said make sure you schedule this patient with me. I want to work with him. And we rolled out the red carpet. They were a little actually taken aback by how enthusiastic I was to meet them in the waiting room. Because, to them, this was just care as it should be, right? They were given five days' worth of medication and they're having an appointment within these first five days. However, to us and the community at large, this was pretty revolutionary.

Well, that day went very well. Unfortunately, the next patient didn't arrive. I come to find out this individual had died by overdose on the day that they were released from jail. I called up the jail and they found out, actually, for this individual, substance use wasn't part of their problem list, it wasn't part of their treatment plan, it wasn't an identified issue for this patient. Okay. It was pretty shocking. The jail wasn't so shocked that somebody had died. But I was. It doesn't happen very often with the people I'm working with. This kind of went on. We continued to have - the first couple referrals were trickling in. The seventh patient, similar experience. They also died by overdose before their first appointment. I went back to the jail and I said this is - we're not hitting this. This is not acceptable. What can we do more? And so we started to look at - what we realized was that although this was a huge improvement from what was going on before, it was not an improvement enough. We needed to really look for ways of radically changing the model not only for these referrals from the jail but as an organization overall that's working with risk of overdose.

We started looking at our existing workflows. And being a Zero Suicide organization, we have implemented a very formalized structure to address suicide risks throughout the program and the culture of the organization. We thought to - this really started kind of formalizing something that we had kind of been thinking about and saying what's keeping us from really tackling the risk of overdose. And that improvement is not enough. We should be striving for zero overdoses, just like the Zero Suicide Model is striving for zero overdose within health and behavioral health care settings. We thought why should this be different? We have the opportunity to work with individuals. And if not in health and behavioral health care settings, where would this be possible? This is what we are striving for. We started to look at ways in which we could implement the different elements of the Zero Suicide model to address risk of overdose.

The first element of Zero Suicide is lead. We started to look at this as a translation, so making an explicit commitment to reduce the deaths requires leadership support. No organizational change is going to be sustainable unless it has commitments from executive leadership and a true commitment to supporting this idea. And assessing for staff skills, confidence, and attitudes in providing suicide prevention care with overdose prevention. And so we did a staff assessment and found some interesting things. I oftentimes say I wasn't very pleased when I saw this, but that's the idea of doing an assessment is that you don't look at sort of what your perception is; you get the actual opportunity to have data and to know what is really happening.

What we found was that staff - and we gave the survey to all staff from medical providers to the front desk staff, administrators, as well as mental health clinicians and social workers, all the same questions. What we found was that pretty universally the attitude was that substance use should be treated similar to other chronic illness, and so that was very reinforcing. However, there was a general attitude that addressing substance use was not a part of their role. This was a big discrepancy for me and also highlighting areas in which we can train, being able to provide site- and role-specific trainings and providing tools which can help support the work that needs to be done. This is again commensurate with their role. Somebody who is answering the phone needs different training than mental health clinicians, than the primary care staff, nursing, social workers. So identifying the needs within each role and having them aware within their scope on how to

assess for and how that is integrated into the overall care of those individuals.

Looking on ways to identify persons at risk of overdose we are addressing is similar, this idea that there needs to be universal and ongoing screenings. Now, unfortunately, at this time, there is not a screening that helps to stratify the risk of overdose. We have evidence-based screenings for substance use and substance dependence, however not necessarily ones which specifically look at risk of overdose. We have sort of overlaid different ways of assessing for risk, including substance use but also prescriptions which have an associated risk of overdose. Another screening which I like to highlight is the Guidelines for Assessing Appropriateness of Office-based Buprenorphine Treatment, which I jokingly gave the abbreviation for simplicity as the G-FAAFOBBT. It's not much easier to say. However, what this is very useful in doing is helping to stratify the complexity of an individual's needs to help assess for the appropriateness of what level of care is needed and helping to ensure that they are being referred to and treated at an appropriate level of care. I'm going to come back to this idea as well. These are ways of identifying those who are at risk.

Similar to the Zero Suicide elements for engage, we are looking at overdose care pathways and the use of safety planning. The care pathways is the ability to have a formalized policy in how staff are to integrate this into their care and including how to assess for and provide internal and external referrals. Again, making sure people are at the correct level of care and providing the support and framework around identifying that. I love talking about our substance use safety plans. We developed two different substance use safety plans, a harm reduction safety plan and a recovery safety plan. It's kind of identifying that there is not necessarily one pathway to accidental overdose, that people are at increased risk in early recovery and they are at different risks when continuing to use or not yet in recovery.

Here is an excerpt from the recovery safety plan. Coming back to the idea that many staff do not necessarily feel like they have the needed skills and abilities to necessarily address risk of overdose, this intentionally was written in a conversational tone to act as much as a tool for the staff as it is for the patients receiving and collaboratively developing the plan. Congratulations on your efforts to maintain sobriety. Let's work together to develop and write down a plan which will help

support you and prepare you for tough times should you hit bumps. Right? These ideas that a staff, regardless of their expertise, will have the language and script almost to have an informed discussion about the risks of overdose and ways to help keep people safe.

They are individualized and help to identify the triggers, coping skills, local resources, and it also includes a guided discussion on the increased risk of overdose. This is critically important and oftentimes not an easy conversation to have with somebody in early recovery. It can be taken personally that the provider does not have belief in the individual's ability to maintain their sobriety. Having it written down in the treatment plan - sorry, in the safety plan, it has an increased likelihood of sort of depersonalizing this. It's not an attitude about an individual. I've found that the response to that is very different. People have, oh, this is so important, I'm really glad that this is on the safety plan, as opposed to them feeling hurt by my bringing up the conversation.

The harm reduction safety plan provides a reinforcement of commitment to the patient, that we are going to meet you where you're at, and talking about your substance use is something that you should be able to do with your primary care and behavioral health and social work providers, that is based in motivational interviewing and it also provides concrete harm reduction tips as well as information to reduce risk of overdose. Planned together acknowledged the stages of change, right? The early recovery safety plan also talks about slips and relapse. The harm reduction safety plan helps somebody where they're at but also gives a promise that recovery is possible, and if they're looking for treatment, that we can help make sure that they're getting the care that they need. The two together acknowledge the sort of circular stages of change model.

Treatment. Treatment is effective, right? We hear this. Developing individualized and evidence-based treatment utilizing the stepped care approach - so in Zero Suicide, they talk about providing care in the least restrictive environment appropriate, right? The same in substance use is more commonly referred to as stepped care, so providing care at the appropriate level. This comes back to policies and procedures to ensure that there are guidelines on how to get people referred to and connected with specific substance use treatment, outpatient/inpatient, when needed. A safety first model. This in a way relates parallel to the means restriction, building into all of this along with the safety plan is helping get naloxone and overdose prevention kits

out to our patients, out to their collaterals, their partners, their friends, anyone who has an interest in obtaining an overdose prevention kit. In New York State, we are very lucky to have a lot of access to overdose prevention kits. Right now the gold standard for treatment is medication-assisted treatment, buprenorphine, Suboxone, methadone, and naltrexone. I like to highlight that this is medication-assisted treatment. The medication itself is not the treatment, is not the full treatment. These medications, similar to for depression and anxiety, medication by itself is not necessarily effective, and that's certainly the case for opioid use and substance use.

Transitions. The vignette that I was talking about in the beginning, it has a positive ending. It is that we dramatically changed how we are working with the jail. We now have staff who are trained as volunteers and can go into the jail. We have started to build the culture around the appointments; if a patient does not come to their appointment, that we are treating these just as we would referrals from inpatient psychiatric hospitals. Kind of like working within the culture and what we are used to is providing this enhanced transition of care. That is specific with the jail. But also this theme - except we don't necessarily have the capability to go into other programs - but this idea that transitions are high-risk periods of time and particularly to overdose because most of these transitions include a reduced tolerance, so that tolerance to opiates decreases relatively quickly after stopping use. This can also include times as short as 48 hours that somebody might be spending in the emergency room that counts as a high-risk transition. If somebody has stopped using their substances for any period of time, whether it be in the emergency room due to other psychosocial things like a pregnancy or environmentally like an incarceration, but also bridging from higher levels of care like outpatient substance use treatment, inpatient substance use treatment, so providing extra support around these transitions of care.

I am very happy to present that since enhancing our transitions of care with the Ulster County Jail, there have been zero overdose deaths as part of this referral program. There have been zero overdose deaths related from the referrals from this jail. There have been over 60 referrals now since the fall of 2016. Another thing I'd like to highlight at this time is that originally there was some pushback. Do we really have to go out of our way to be working with the jail? We have enough patients, Tom. Why are we doing this? And there was not explicitly but a little bit implicitly why are we working with



those people, right? What I love, data is essential, right? This is like with Zero Suicide is around improvement. Data is essential.

What we have learned through this transition of care and referral program is that about over 75% of the referrals from our local jail are existing patients. Oh, I was so happy to be able to have that data and to really show that these are not different people. These are not those people. These are our patients that we previously had not been providing good care to. This is one example of both how transitions of care are important but also data is essential. What areas do we look at in the continuous quality improvement? What metrics are we looking for? Obviously we are looking to reduce overdose deaths, and that is a challenging thing to track, right? And this is not unique within my program. But identifying a baseline for overdose deaths is challenging. We heard a little bit about that in this overlap between suicide deaths and overdose deaths for both populations is very difficult to oftentimes identify what was the intention of the death. Oftentimes, both are underreported. Identifying what a baseline is is a challenging first start as you are looking to implement different methods of improving your overdose care from the very beginning thinking about ways of establishing a baseline.

Another baseline that I talked about was the attitudes and practices that we originally assessed with our staff. I very much hope that after our trainings and our site- and role-specific trainings related to substance use integration into primary and behavioral health care that when we reassess the attitudes and practices, I will have some data to share with you again about how we at the Institute for Family Health have been improving our overdose prevention care in the same model as Zero Suicide.

Thank you so much for tuning in. I do hope that you have questions and that I look forward to hearing from you as well. Back to you, Julie.

>> JULIE GOLDSTEIN GRUMET: Great. Thank you so much, Tom. Really impressive results. Certainly we are aiming for zero. One of the things as you're beginning to type in the chat box about some key takeaways, we're very familiar with the Institute for Family Health. They're one of the early adopters of the Zero Suicide Framework, a federally qualified health center with strong behavioral health presence. They really massaged a lot of the Zero Suicide components. It's a language and a culture

change that the system is already very familiar with. So kind of adopting it for substance abuse, I think, is a natural next step with strong support from behavioral health and the idea that staff are already familiar with these concepts. But I love that we can think about how to adapt in these settings as well.

People talking about the importance of care transitions and harm reduction. I heard somebody - somebody even said they wanted to see the program in a video. I see a YouTube video in your future, Tom. I think the idea, you know, we saw this with both Tom and with Rick and that transitions and safety plans have to be in a conversational language, meaningful to the patient, patient-centered, educated about the patients, and their families have to be educated about this. I've been in many systems where it's something that you check off on a box. Yes, we must do a safety plan. Check it off the list that we did it. If the safety plan is not meaningful to the patient, then there is no point in doing it.

If you do a chart audit and you pull out all your safety plans, they should not say the same thing. Not everybody should have call a friend, do some yoga, journal, take a bath, go for a run, right? That is not applicable to everybody, everywhere, of all ages. It should be very meaningful. And it should change. A safety plan has to change. If my husband is on my safety plan as the person that I will go to in distress and we separate, perhaps he should not be still on my safety plan. It should change over time. We have to update them. That's kind of what Zero Suicide and thinking about it in substance use settings is for is using the tools that are effective and meaningful and using them specifically for those with whom we work. I see a few other comments about training of all staff. Again, I think both Rick and Tom talked a lot about that. I know I talk a lot about that in Zero Suicide. You can't give people tools without telling them how to use them and their purpose.

While you can begin to kind of post some questions, even though we might not see them on the screen, we're gathering them as we gear up for our Q&A at the end of our webinar. But in the meantime, I'm going to turn to our final speaker, Barb Gay. Barb is the Executive Director of the Area Substance Abuse Council, ASAC, which is a comprehensive substance abuse treatment and prevention nonprofit. She's used her personal experiences to guide programs to improve resources and supports and to offer her voice as a suicide attempt survivor to really help advance the field of suicide prevention. She's a member of the Suicide Prevention Lifeline Consumer Survivor Committee which is also

funded by SAMHSA, and she's a certified prevention specialist. Barb has been doing suicide prevention for many years, is a great friend to SPRC, and really just contributes to all of our knowledge every time we hear her speak. I'm grateful that she joined us today.

And I'm going to turn it over to you, Barb.

>> BARBARA GAY: Thanks, Julie. I appreciate that introduction. Very kind words.

I am pleased to be here today and joining Tom and Rick and everyone else that's joining in because I think the shared learning is really what this is all about and how we share our experiences, what's been successful, what the challenges have been, and learn from others about how we can continue to improve care for those in substance abuse settings and those that are addressing suicide risk. My thanks to SPRC and the staff for putting on the webinar. As they know, it's been a passion of mine to integrate substance abuse care and suicide prevention, so I'm thrilled that this is the topic for today.

Just a little bit about our agency to give you some background. What we do here at ASAC in Cedar Rapids, Iowa, we serve the central-eastern part of the state. We serve about 3,000 patients a year and we have 180 staff. We've been in existence and doing substance use care for 40 years. Our general population that we serve, we serve kids, we serve adults, we also serve moms with kids because they can move into our residential treatment program with their children. But we do have a slightly higher male population in our patient mix than we do females. Our median age for our patient is right around 30 to 31.

And 2015 is really when our work began to take a look at what we were doing and we really took an overarching look as an agency as to what words are we using, how are we providing care, what does it look like to the patient, what's the patient experience. A phrase that we've used in our history is to say we have a whole person approach, and that became one of our key elements that we wanted to do more evaluation with as a staff. Our leadership staff took that upon themselves to say what does that mean if we do whole person care? As we began to delve into that, it really was talking about mental health care primarily, some about physical care, and a little bit about suicide care. With our leadership staff, we said we want a different experience for our patients and we changed our frame to say we

want to provide integrated care. And for us, that really focused on the suicide assessment, suicide risk, safety planning, as well as providing mental health care and primary physical care in a way that was different than we had in the past.

Prior, we would use a system where we would do assessment and do screening and identify issues for our patients that could be related to their substance use disorder or could be needed to be treated in a different care setting and then we would make a referral. We would suggest that they go find another provider. Sometimes we would do a little bit more, but that's really where it stopped for us is to say here is a great provider, we think that you would get good service, we hope that you're able to get connected with them. What we decided is that we wanted to do integrated care that meant we actually would know what happened with the patient. If we identified based on their PHQ-9 that they needed to have a comprehensive suicide assessment, we wanted to know what the outcome was of that, and so we took it upon ourselves as a leadership staff to start redefining how we provide services and in the way that we help those to do that.

Part of that meant changing our language internally of our staff. We had prior been talking about our services as far as prevention and treatment and we decided to break out recovery services. Recovery services we always understood to be something that started in the treatment process for our patients. But if we wanted to be seen as a partner to our patients' wellbeing and long-term recovery, we felt we needed to really identify exactly our role in how we would support them in their recovery process. This was really key for us as we communicated external but we first communicated internal to our staff in changing our language and our intentions.

Because we had had the phrase where we were treating the whole person before, it was an education piece that we had to take on. We created a branding and communications guideline for our staff. Some of the things were fairly simple, although it took many of us, including myself, quite a while to get used to it. But we decided to change from using the term client to using the term patient to refer to those who chose to seek care with us. That was important to us because we wanted to address the issue of substance use disorder as a medical condition. Back to that issue of making a referral, once we made an identification of a need that a patient had, we changed our term to be linkage because we wanted to know did they actually make the connection that we suggested for them based on their assessment. And if they made that linkage, how was it going for them? Were they

satisfied with the care they were getting? If they didn't make the connection, then could we help them find another connection, another provider that would be a better fit? And then we use those resources and integrate it into their substance abuse treatment plan.

When we started going down this path, we did look at our data and asked why as a substance abuse provider is it important for us to do the integrated care? When we look at our population - and Julie referenced this early on - but those that are in our care are often at high risk for suicide. As I mentioned, we have a high male population, so the men in middle years was a population that we knew we had an opportunity to do an early intervention with. Many of our patients are justice-involved that are referred to our agency. Many of our patients had not been involved in care with any other provider on a regular basis. We knew we had an opportunity to do an early intervention with those patients who chose to seek us as their care provider because we could build a relationship with them.

When they were here for their substance abuse assessment, oftentimes it was something that was required, we could ask them what else they wanted out of the experience and we could do the other screening tool so we could help them identify other areas that they may want to consider seeking care. This is a really important personal piece for me. I'm sure as many of you do; I bring my personal experiences to my work every day. As a young adult who did have several suicide attempts, I also was engaged in substance abuse care and mental health care, and all three of those things were very siloed for me. From a personal experience, I could see that we were doing the same thing today in many of our care situations where we were addressing the individual substance use, we were addressing their mental health needs, but we were doing these in individual settings and that's requiring a lot of extrawork for the patient and it certainly doesn't help them to feel the integration of their wellbeing as the provider experience.

When we asked our patients and started talking about how this would feel for them if we were talking with them about their mental health care and their suicide care, what we saw was many of them felt that they had been disrespected by other systems or sort of dismissed because of their substance use. It was something that, whether it was explicit or implied, they felt that they were patients that other care providers did not want to see. We oftentimes would hear this from community providers that we work in partnership with was really are these

individuals at high risk or are they just people that are coming in because they can get some meals and a place to sleep tonight? While some of it may have been perceived, some of it was actually real. From our perspective, with our experience with substance use disorder treatment is that substance use disorder patients are complex cases and they take a lot of time and oftentimes providers in other settings don't have that ability to spend the time and give that care that we think that all patients deserve.

Because we had had a prior approach to treating the whole person, we had many linkages in the community, many partnerships with other agencies. We often found advantage if we were helping patients with getting connected for suicide care that they could use the linkages that we already had with other agencies and providers. We did formalize those in creating memorandums of understanding or memorandums of agreement. There is no payment exchange between our agencies, but certainly they were willing to put our patients as a priority. We do this in a couple of different ways. Realizing that our expertise was in treating substance use disorder, we did not feel that we could take all of this on in an effective way to treat our patients, and so we used a number of agencies that come into our facilities and provide care, and then we also use our crisis center to do immediate care for suicide risk.

When we're doing a substance abuse assessment for a patient who has come in with their PHQ-9, we take a look at that right away, and depending upon the score, we may just pause the substance abuse assessment and provide that real-time linkage to our crisis center where they'll do the comprehensive suicide assessment. They can do that on their own or in some cases they can use their mobile crisis outreach and come on-site for us. Once that's created with the patient and once they've completed the assessment and they've completed a safety plan, then that information comes back from the crisis center to our agency where it's incorporated into the substance abuse treatment plan for the patient.

We knew early on that these beneficial partnerships would work out for our patients because oftentimes - and I'm sure in your communities as well, as Tom spoke to - there's a long waitlist to get into care and we felt we needed to be quick. If a patient was willing to share with us where they were at today and what struggles they were having, we wanted to be able to get them into care. It takes a very brave step to reach out for care and to ask for help, and so we never wanted to lose that

opportunity with any of our patients. We realized one other thing that happened from our partnerships is that when we introduced our patients to other care providers, they were able then to take advantage of other services. For example, with our local crisis center, we had a patient who was connected for the suicide care and stayed connected, and through their work with the crisis center became aware of the other services that they offered as an agency, including a youth shelter, and so they were able to take advantage of some services for their family as well as for themselves.

When we began to integrate care in this way, we focused tremendously, as Tom had mentioned, on staff training. I will tell you that was an area where we learned a lot, however, because simply providing training and giving the information was clearly not enough for our staff. We did our initial staff training and then we rolled out our procedures and we monitored how we were doing with our linkages and how our patient treatment plans were changing and we weren't getting to the goals that we had set for ourselves.

So we did a look again at our staff training and redevise what we were going to do. We focused on our administrative staff and the staff that provide direct care to our patients and supervision 24 hours a day and we focused on providing mental health, first aid, trauma-informed care, as well as adverse childhood experiences training. Realizing that for our front desk folks, those who answer the phone, they were really critical to patient success and we needed to give them the training to support their role.

For our clinical staff training, we went back and started doing role plays as our training. Rather than just sharing factual information and talking about the procedure, we actually asked the crisis center staff to come over and they went through role playing scenarios with our staff. That gave the opportunity for both our agency as well as the crisis center to learn more in-depth as to what our experience was and how we wanted the experience to go for the patient, but it also answered a lot of questions for our staff to be able to ask directly to the crisis center staff about talking about suicide, how to do the risk assessment, how to encourage the linkage when we have a patient who is hesitant.

Once we did that second round of training where we focused on our administrative staff and then did the role playing with our crisis center, we saw the number of linkages and the number of

treatment plans getting the other care plans incorporated just skyrocket. It, for us, became really key to making sure that when we do training, we provide that actual experience for our staff and time for them to express their concerns and ask their questions and understand the process.

We realized that as we've implemented this, we still have a ways to go. So we don't think that we're anywhere near done, but we keep evaluating our outcomes and keep monitoring for ourselves as an agency but also for our patient what's the benefit in us doing this work. Things that we've heard back from our patients have been that they feel that they've been heard, that someone cares for them, and oftentimes we hear I don't have to repeat my story, so they don't have to go to different care providers and share what's been going in their life but they can do that once with us and then we can help make the care connections for them based on what their needs are.

When we implemented this new approach and started doing integrated care, we also then redefined what does success look like for our patients? We, as many substance abuse treatment programs do, we monitored things like abstinence rate and were our patients staying abstinent after our follow - after services? We do a three-month and a six-month follow-up call. Were they remaining abstinent? Had they had any hospitalizations? But now we also monitor things like are they employed, are they getting back in to improve their education, what's their relationship like with their family and friends, do they feel that they have social connectedness. I will tell you that our staff initially when we stopped making the focus on abstinence, we had some members of our staff who were very concerned that we would be in a sense encouraging those to go ahead and continue to use while they were in substance abuse care. I am happy to report that our abstinent rate has stayed very consistent since we've integrated care and then we've seen these other outcomes improve for our patients. Redefining success for our patients really helped us redefine success as an agency as well.

We have found that the other important piece for us in doing this work with our patients has been with other care providers. As we have integrated our care, we're finding that they're interested in doing the same thing and integrating substance abuse care into their settings. It's been a great community collaborative in many ways for us.



Thank you, everyone, for the time today. Julie, I'll turn it back over to you.

>> JULIE GOLDSTEIN GRUMET: Thank you so much, Barb, for such great information.

As we kind of move into giving you a chance to think about what the key takeaways were or things you want to share from today, I'm very aware that continuous quality improvement is thoroughly embedded in the work that you do and it so epitomizes what is Zero Suicide. You changed things like calling people patients rather than clients and then educated staff that this is - what does that really mean? You changed things - it's not a follow-up appointment but it's a linkage. What does that really mean? You did such great training. You can't just create policies if you don't train your staff on what those policies are and then really thought about including the front desk staff as integral members of your team. And everything that you did, you constantly said are we doing it in the way that we set out to do it and how can we improve it. I think it's such a tremendous example of CQI and just really want to acknowledge that.

As people are beginning to type some key takeaways or thoughts, I'm also going to begin to invite people to type any questions they may have as we open up the end of the webinar for some Q&A. I see somebody, big letters, words matter. The idea of being very clear about your mission clearly comes through. People talk about real-time care; again, the idea that you can't give people long waiting lists. It took them courage to share these thoughts and we need to open up opportunities to see patients in real time, and that might involve a system-wide change. Again, that's what this is about. We can't use sort of old practices and expect to see new results. I see a couple people talking about the real-time care and the opportunities for training and role playing. People seem to really like the idea that front staff is trained. Again, I think that should be critical for all systems. They often interact more with patients. They're the ones who call for follow-up appointments or call when appointments are made and we want them to understand that they play a really powerful part in people's care and treatment. Many people talking about meeting people and accepting people for who they are.

While people are continuing to comment in the very active chat box, I love to see that, I hope that today's webinar stays with you, such that you continue to think about what would these

concepts look like in your own system and what are you going to take back to your staff and say, oh my gosh, I heard this great thing in a webinar, I can't wait to think about how we can do that. While we're doing that, I'm going to move on to some Q&A.

One question that came through was about rural settings specifically. Clearly a challenge. Rick and Barb, you both work in rural settings. So, first Rick. Any thoughts about things that you've had to do differently in your system to provide care to people in rural settings? Rick, you might be on mute. While you're thinking about that, what about you, Barb? Anything in particular that you've been able to do for accessing care for people in rural settings?

>> BARBARA GAY: It really is still a challenge, even in our more urban area. But we try to use technology more and more. One of the products that we use in our offices is Zoom allowing patients to get connected. If they're in our office, in a rural office, but have a treatment need that matches them better with a group that's larger in a different office, then we can use our Zoom connection and allow them to participate in treatment in that way. We still do a lot of travel. Our staff travel out into the areas, and so it's very staff-heavy on time and very mileage expensive, but that face-to-face care is still what we have found to be very best care for us.

But I would also say, Julie, the partnerships that we have. We share office space with other providers.

>> FEMALE SPEAKER: So that we may better assist you. Please choose from the following options.

>> JULIE GOLDSTEIN GRUMET: Thank you. Sorry about that for a sec. I'm sorry, Barb. Go ahead.

>> BARBARA GAY: Just saying we share - for example, we share offices with other providers that are also serving those rural areas and share office hours and partner together to provide the services the best we can.

>> JULIE GOLDSTEIN GRUMET: That's great. I hear - I think clearly we're at a point where tele mental health we have to think about. We have to think creatively about who are the partners on the ground that might be able to do this work. A lot of the things that I think Tom especially was talking about we can certainly teach some of those to para-professionals. I do think there is a big movement underway in suicide prevention as

well. We already talked about the lack of training. I think we can clearly train para-professionals to think about safety planning and follow-up and reducing access to lethal means, people with lived experience. I do think these may not completely cure us of these issues but I think that we need to think differently about how to use some of these available tools.

Barb, I know that your system, you talked about trauma-informed care already and a couple of questions came through about what role trauma plays in suicide care. Clearly we know that a lot of clinicians are not well trained in trauma. Like suicide, it's a topic people get very nervous about and often try not to ask about, and yet we know that that's absolutely not how care should be. How does your system do this work in a trauma-informed way?

>> BARBARA GAY: And, you know, it's a great question and it's challenging because it's an approach that we have to apply to all of our offices. So talking about being rural, we mentioned our spread here, we have 14 different offices. One of the things that we began as a conversation, Julie, was looking in a way to explain trauma-informed care using the ACE, the Adverse Childhood Experiences Language, because we find that to be a very universal language that people can relate to and understand, and shifting our question from what's wrong with you to what happened to you was a great starting point for us. We still have work to go. We still continue to seek a way to provide trauma-informed care consistently across our agency. We use supervisory groups as well as a way to share what our staff are learning and experiencing and a way to carry the training and the knowledge forward into our practice as well.

>> JULIE GOLDSTEIN GRUMET: I think that's great. I think, again, all three presenters today really emphasized the role of training. We cannot introduce something without giving the clinicians and the staff opportunities to practice, to ask questions, and be trained. One of the essential components to Zero Suicide is adjust culture. We can't blame people for not knowing what they were never trained in or not being well prepared if we didn't provide them with the proper preparation and training. I really applaud that you're giving such attention to that.

Tom, a couple people were asking about some of the research for Zero Overdose. I know that it lines up very well with the Zero Suicide approach. What are you finding in terms of some

logic models you might have created or one or two things about the research that really helps you to feel confident that your framework will continue to save lives? It looks like we're having a little bit of an audio issue with Tom being muted.

One of the things that I'm certainly aware of is we know that there is evidence for each of these components in the Zero Suicide Framework and I think thinking about how to apply them for substance abuse settings is important. Again, I think it's critical to have a well-trained staff in suicide prevention as well. And what I think we see coming through loud and clear in both of these examples is the idea of system-wide culture change, that we can do better, we will do better, and we have to apply evidence-based tools. There is information available on the Zero Suicide website about each of the components and the evidence for it in Zero Suicide.

Tom, is there any other additional evidence you want to share about the efficacy of sort of thinking about the way you've embedded these components into your Zero Overdose model?

>> THOMAS MCCARRY: Sure. I've done a lot of combing through as much research in the area of overdose prevention as I can find and one of the sort of overarching themes is that more research needs to take place. Some areas that do have a lot more research is through the Veterans Health Administration. It is a great resource of research through Dr. Amy Bohnert. A lot of their work, though, is with patients who are - and the vast majority of research that is out there at this time is within the population of patients who are receiving pain management. That is not all-encompassing of the pathways for overdose. I look forward to finding more data and being able to share more about our use of safety plans. In a safety first sort of approach, I really wanted to get these safety plans out there and being used and figure out how we can research it second. There are a lot of areas. I also referenced the SAMHSA Overdose Prevention Toolkit which is a really great resource and has been recently revised to include more on the influx of fentanyl into the overdose risks.

>> JULIE GOLDSTEIN GRUMET: Thanks, Tom. You've got some great resources. The SPRC continues to have information available about the intersection of substance use and suicide. We will continue to share as we learn on zerosuicide.com. And I certainly encourage people to continue this conversation on the Zero Suicide ListServ if we didn't get to your question today. Please make sure you continue this conversation on the ListServ.

It's a great resource and hopefully this is just the beginning of learning more about this. Thank you all for joining us. Thank you so much to our tremendous speakers for the passion that they've shared with us, the creativity, innovation, and the willingness to kind of stretch the imagination about how to do this work. This webinar will be archived. It was recorded. It will be archived. It will be available on zerosuicide.com within the next week or two. We let people know whenever it is archived on zerosuicide.com via the ListServ. If you're a member, you'll know when it's archived. Otherwise, check back in about two weeks. Stay tuned for the next webinar that will be in the next few months. Thank you again so much for joining us. I hope you all have a wonderful day. Thank you.