

State Suicide Prevention Plan Steering Committee
Meeting Notes
March 18, 2015
9 a.m.-noon



Agenda Item/Discussion	Actions/ Decisions
<p>1) Open and Introductions Therese Hansen</p> <p>2) Listening session debrief: Spokane session and upcoming sessions Karyn Brownson</p> <ul style="list-style-type: none"> • The Spokane listening session on March 9 had about 50 participants in person and by phone. • A very diverse and involved group of people attended and feedback was positive. We walked away with about 20 flipchart pages of notes. • The conversation focused on resource limitations in Eastern Washington, tribal suicide prevention programs, and rural-appropriate plan content. • Upcoming listening sessions: <ul style="list-style-type: none"> - April 16, Longview, cohosted by the Cowlitz Tribe - April 1, by phone with the Benton/Franklin Suicide Prevention Coalition and the Bridge Builders Task Force - More locations to be determined – time is a constraint. <p>3) Lead Report-Out</p> <p>a) Healthy and Empowered Individuals, Families and Communities (Jenn Stuber): Workgroup has already presented and would like guidance on its role as the project continues</p> <p>b) Clinical and Community Preventative Services (Scott Waller): The workgroup presented at the January meeting and hasn't met since.</p> <p>c) Surveillance, Research, and Evaluation (Ursula Whiteside): The workgroup is continuing to flesh out its goals. Its presentation to the larger group will be on April 6.</p>	

4) **Workgroup 3 presentation: Treatment and Support Services –**
Dan Clark, Andrea Valdez, and Julie Madsen

Introduction: This group’s content focuses on availability and quality of treatment for people at risk of suicide, continuity of care after hospitalization, and postvention support after a suicide loss.

See attached PowerPoint for more details.

Goal 1: Expand and equalize access to mental health care, substance abuse treatment, and crisis intervention services

Goal 1 comments and discussion:

- Question: Is the SBIRT (screening, brief intervention and referral to treatment) program inclusive of suicide or just focused on substance abuse? Answer: Focus is only on substance use. However, there is significant overlap between suicidal thinking, mental illness, and substance abuse so it may be a place to add this.
- Comment: The National Guard’s Transition Center is a good example of a care system totally infused with suicide prevention training. System is set up to support people during referral and transition. Small system but works very well.
- Another good applicable model is the colocation of school-based health centers with behavioral health providers.
- Comment: The connect-the-dots system of referrals is very difficult for people getting services from multiple systems – difficult even for providers.
- Comment: The navigator role is critical for helping people make their way through complex health care systems.

Goal 2: Promote continuity of care and the safety and well-being of individuals treated for suicide risk in emergency departments and inpatient units

Goal 2 comments and discussion:

- Chaplains should be included in the model of continuity of care – could also be peer supporters.
- Concern: Even in a well-functioning referral system, resources that lack cultural competency can do harm. Part of the problem there is burnout and compassion fatigue – empathy training and care for burnout may help.

Be sure to include in this section that these programs are cost-effective and can lead to big financial savings.

- Comment: Need to improve training and practices in the “warm handoff” when making referrals (guiding and supporting the person through the system instead of just giving a number)
- Comment: Screening for suicidality should happen at ER intake – many patients are thinking about suicide but it’s not the presenting problem.
- Comment: Importance of safety plans as part of continuity of care – there is a belief that safety plans have been proven ineffective but this isn’t actually the case as they have been improved.
- Challenge: Intoxicated people are not properly evaluated for suicidality – often will deny suicidal thoughts if given an opportunity to detox, but when intoxicated again the thoughts return.
- Resource: It’s possible to set up a somewhat formal support system through secret Facebook groups – members can pay attention to one another’s wellbeing and offer concrete supports (transportation, hospital visits, social support, etc.).

A good safety plan template is here:

<http://www.sprc.org/sites/sprc.org/files/SafetyPlanTemplate.pdf>

Goal 3: Identify and implement guidelines to effectively engage families and concerned other, when appropriate, throughout the entire episode of care for persons with suicide risk

Goal 3 comments and discussion:

- Comment: There is a lack of evidence base about what programs work
There is a need to learn about what family support programs work. What exists that’s good besides NAMI’s resources?
- Comment: Family is an essential support system for some people but disconnected or harmful for others. Need to assess family’s role instead of making assumptions. Use language such as “self-defined support network” instead until people say who their supports are.
- Comment: There are misconceptions about confidentiality from both providers and the community, and they impede communication.

This evidence base needs to be built – include in research recommendations

Goal 4: Identify and implement effective suicide postvention programs (postvention refers to family and community supports after a suicide)

Goal 4 comments and discussion:

- Postvention is an opportunity to improve prevention – people

