Suicide Prevention Best Practices

Authority: The 2021-2023 Florida Suicide Prevention Interagency Action Plan; 14.20195, F.S.

Requirement: Contract

Frequency: Ongoing

Description: **Below**

LSF Health Systems is committed, with the Department of Children and Families as well as other state agencies working together, to reduce deaths by suicide in Florida. The prevention of suicide, specifically the reduction in number of individuals completing suicide while receiving state-funded behavioral health services, is a priority goal of the Department's Office of Substance Abuse and Mental Health (SAMH) Statewide Office for Suicide Prevention (SOSP). The Managing Entity (LSF Health Systems) collaborates with the SOSP by contributing to the Suicide Prevention Coordinating Council (SPCC) to prepare an annual report documenting suicide prevention activities, trainings and efforts throughout its 23-county catchment area.

LSF Health Systems will ensure that its suicide prevention goals are aligned with the SOSP and the statewide Suicide Prevention Interagency Action Plan. LSFHS provides training, education and oversight of suicide prevention practices throughout its provider network and their communities. The Managing Entity will monitor Network Service Providers, as appropriate to their program services, to ensure that enrolled individuals receive best practice screening, risk assessment, safety planning and lethal means reduction counseling in addition to post-crisis care transition protocols. The Managing Entity, using Zero Suicide as a best practice approach with recommended instruments, shall:

- Increase public knowledge of the factors that offer protection from suicidal behaviors and promote wellness and recovery.
- Implement and monitor effective evidence-based programs to promote wellness and prevent suicide-related behaviors.
- Provide training on the prevention of suicide and related behaviors to community and network service providers.
- Promote suicide prevention as a core component of healthcare services.
- Promote and implement effective clinical and professional best practices for screening, assessing and treating those identified as being at-risk for suicidal behaviors.

Background Data:

Suicide is a public health issue and a leading cause of death nationally. It significantly impacts family members, coworkers, schools, communities, service members and veterans. In 2018, **3,552** lives were lost to suicide in Florida.

Based on Florida Health Charts 2018 data, 19 of the 23 counties in the LSFHS catchment area have suicide rates that are higher than the state average (16.9%). See chart below:

Suicide Age-Adjusted Death Rate, Single Year Per 100,000, 2018		
County	**Count**	**Rate**
Florida	**3552**	**15.3**
Lafayette	0	0
Hamilton	1	6.1
Dixie	3	9.7
Sumter	21	11.1
Bradford	5	16
Alachua	42	16.5
Duval	164	16.9
Hernando	33	17.4
Clay	39	18
Baker	5	18.4
Suwannee	9	19.3
Volusia	125	19.4
Union	3	20
Gilchrist	5	20.2
Lake	77	21.3
Nassau	18	21.7
St. Johns	56	22
Columbia	18	23.1
Flagler	29	24.8
Levy	11	24.9
Marion	91	25
Putnam	24	29.6
Citrus	51	30.9

Suicide was the eighth leading cause of death in Florida in 2018. The suicide rate per 100,000 population was 16.9%, an increase from 15.5% in 2017. *For a breakdown in suicides across the nation and Florida by age, method, race and gender, please refer to*: https://www.myflfamilies.com/service-programs/samh/publications/docs/2019%20Annual%20Report%20Suicide%20Prevention%20Coordinating%20Council%20FINAL.pdf

More than half of the Floridians who died by suicide in 2018 used a firearm. Less than a quarter died by hanging, strangling, or suffocation. LSF Health Systems recognizes that educating on lethal means reduction and raising awareness on ways to enhance safety is key to method reduction and will be included in best practice oversight.

The Network Service Provider and any applicable subcontractor shall:

- Provide care to those at risk for suicide. The NSP will have a policy and procedure to provide guidance for care management for individuals at different risk levels, including frequency of contact, care planning, and safety planning.
- Use an evidence-based screener at intake for all individuals receiving either behavioral health or primary medical care and reassess at every visit for those at risk. Examples are the Patient Health Questionnaire-9, Columbia-Suicide Severity Rating Scale screener.

- Conduct a suicide risk assessment using a validated instrument and/or established protocol that includes assessment of both risk and protective factors and risk formulation. Risk is reassessed and integrated into treatment sessions.
- Develop safety plans for all individuals at elevated risk (low, moderate and high). No risk is not the same as low risk. All safety plans must include risks and triggers and concrete coping strategies. The safety plan is shared with the individual's partner or family members (with consent). All staff use the same safety plan template. It is recommended that staff receive training in how to create a collaborative safety plan.
- Include lethal means restriction on all safety plans; families are included in means restriction planning. The NSP will provide training on counseling on access to lethal means (Florida Certification Board online course available). The provider will set policies regarding the minimum actions for restriction of access to means.
- Provide clients identified at risk with evidence-based treatment specifically for suicide (CAMS, CT-SP, CBT-SP and DBT), or make referrals to same. The NSP will provide staff with access to competency-based training in empirically supported treatments targeting suicidal thoughts.
- Establish protocols for follow-up for individuals with suicide risk soon after they discharge from crisis stabilization care. Care protocols will be created for suicide risk individuals who don't show for appointments. This may include active outreach, such as phone calls to the individual or his or her family members, until contact is made and the individual's safety is ascertained; it can include home visits and/or virtual home check-ins. It is recommended that NSP provide regular training for staff supports to improve engagement efforts.
- Conduct root cause analysis and/or mortality death review on all suicide deaths of people in care as well as for those up to 30 days past case closed. Policies and trainings are updated as a result.

Zero Suicide is aspirational. If followed, a suicide care pathway will be observed for individuals with elevated risk. It is recommended that suicide care become entirely embedded in an NSP's Electronic Health Record, with a flagging system developed. Data from EHR or chart reviews are routinely examined (at least every two months) by a designated team to determine that staff are adhering to suicide care policies and to assess for reductions in suicide.

More information on Suicide Prevention Training and Best Practices can be found at:

- http://zerosuicide.edc.org/
- http://www.sprc.org/
- https://www.myflfamilies.com/service-programs/samh/prevention/suicide-prevention/
- https://qprinstitute.com/become-an-instructor
- https://courses.qprinstitute.com/index.php?option=com_zoo&task=item&item_id=5&Itemid=739
- https://training.sprc.org/enrol/index.php?id=20