Evaluation of Zero Suicide Implementation in Community Mental Health Agencies

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Learning Objectives

Following this presentation, attendees will be able to:

- Describe the evaluation of the Zero Suicide approach being implemented in two Vermont community mental health agencies
- Discuss barriers and facilitators to Zero Suicide implementation that were articulated in an interview study
- Identify qualitative methods for assessing Zero Suicide implementation

Zero Suicide Pilot Project Evaluation

Overall Evaluation

- Interviews with key informants
- CAMS pre- and post-training assessments
- Zero Suicide Workforce Surveys (adapted for VT)
- Annual Zero Suicide Organizational Self-Assessments
- Six client-level measures collected across both agencies

Why do Interviews?

- Get the “story behind the numbers”
- Can probe in real time about issues that arise in responses
- Prompts can be used to improve questioning, like changing level of detail or rephrasing questions
- Learn personal experiences regarding Zero Suicide implementation
- Side benefits: Can help interviewee clarify their thinking and prompt action

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Zero Suicide Interview Topics/Goals

- Which aspects of Zero Suicide implementation are working well and which are not working well?
- Describe changes to care processes.
- Learn about communication within and between programs.
- What is the perceived effectiveness of the CAMS and CALM trainings in helping clinicians work with clients?
- What are the perceived impacts of Zero Suicide on clients?

Big Picture: Need this information in order to: 1) guide changes to current implementation, and 2) plan for statewide spread of Zero Suicide approach (assuming it's working well)

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Example Interview Questions

1.1 *Thinking back to* [start time], *what changes have been made in your program about how you provide care for people at risk for suicide?* [ask for specific examples] *What aspects of these changes have worked well? What are some ways these changes could have worked better?*

2.1 [provide overview of example ZS changes] *What are some examples of how you, or people you work with, have different relationships with other people and programs within your agency? What are some new partnerships or relationships that have been developed since* [start time] *that are related to caring for people at risk for suicide? Are these working well/not well? What are some ways that you think communication between colleagues or programs should be changed, but maybe the changes haven't happened yet?*

4.2 *A closely related topic to action planning is Quality Improvement (QI). QI can be thought of as conducting tests of a change or changes over time, where the results of the test then being used to implement new changes is needed. QI also implies monitoring process over time. What are some ways that you or your colleagues have been involved with QI aimed at changing care for clients at risk for suicide?*

Vermont Zero Suicide Interview Guide (September 2016 version)

Interviewer: Date:

Interviewee: Phone / In-Person

Role in Organization: Time in role:

1.1 *Thinking back to* [start time], *what changes have been made in your program about how you provide care for people at risk for suicide?* [ask for specific examples] *What aspects of these changes have worked well? What are some ways these changes could have worked better?*

Example Zero Suicide Change Areas

Training (CAMS, CALM, screenings, etc)	Lethal means reduction
Screening approaches	Evidence Based Practices (CAMS, CALM)
Risk assessments/formulation	Caring contacts after treatment
Suicide care management plans	Contacting clients who miss appointments
Safety planning	Supervision

Key Informant Interviews

- Aimed at identifying strengths, challenges and opportunities around implementation of Zero Suicide
- Semi-structured interview, pilot tested with colleagues knowledgeable about Zero Suicide
- Lasts about 45 minutes
- In person or by phone
- 12 participants from two VT Designated Agencies (6 from each)
- Different levels of work represented: front line clinicians, supervisors, program directors, executive leadership.
- Detailed notes taken, with quotes, and checking with interviewees for clarification when needed.

Key Informant Interviews

- Interviewees were identified jointly by the evaluator and staff/leaders from the agencies.
- All who were asked to participate by the evaluator did so.
- Interviews were confidential (tricky in the reporting!)
- $10.00 Amazon gift code as incentive.

Interview Analysis

Used a thematic content analysis approach[1,2]

- Responses transcribed into tables.
- Two coders identified emergent themes.
- Themes categorized as representing successes (or likely facilitators of success) in implementing the Zero Suicide approach or as challenges (or likely to be barriers) to implementation.
- Identified an additional category of needs/next steps.
- Themes aggregated across coders and discrepancies were resolved

1. Vaismoradi, Turunen, Bondas (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing and Health Sciences* 15, 398-405.
2. Sargeant J (2012). Qualitative research part II: participants, analysis, and quality assurance. J Grad Med Education 4, 1-3.

Interview Findings: Key successes and Facilitators of Implementation

1) Clinicians' increased comfort and competence in addressing suicidality and a corresponding change in the need to engage crisis teams "automatically" when suicidality is expressed

2) Increased focus on the drivers of suicidal thinking and more directly addressing these in work with clients

3) Focus on safe and timely client handoffs across different clinicians and programs. Facilitating factors for these successes (e.g., pre-existing focus on lethal means safety among crisis teams) were also identified.

4) Leadership focus on supporting the implementation of specific components of Zero Suicide

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Interview Findings: Challenges and Barriers to Implementation

1) Not always being able to make handoffs to clinicians and programs who were similarly trained (e.g., on CAMS)

2) Lack of consistent buy-in among community partners, specifically on their screening practices and policies

3) Lack of operationalization of systems changes that would support increased suicide-specific care (EHR, forms, policies)

4) Challenges of adapting Zero Suicide to certain care settings, such as co-located behavioral health and primary care offices

Interview Findings: Opportunities and Action Areas

- Have CAMS (and other EBPs) forms integrated into the EHR, as opposed to scanning in hard copy forms which is the current practice
  - ➢ Could be searchable / more easily reportable using EHR
- Expand CAMS trainings to additional programs within agencies and to partner agencies in the communities being served
- Need to adapt EHRs to line up with Zero Suicide changes that are in process, like for post transfer or discharge follow-up.
- Make CALM training truly universal for clinicians

Interview Conclusions

This study identified specific accomplishments related to adoption of the Zero Suicide approach in two community mental health agencies, as well as facilitating factors and barriers that may be relevant for spreading Zero Suicide.

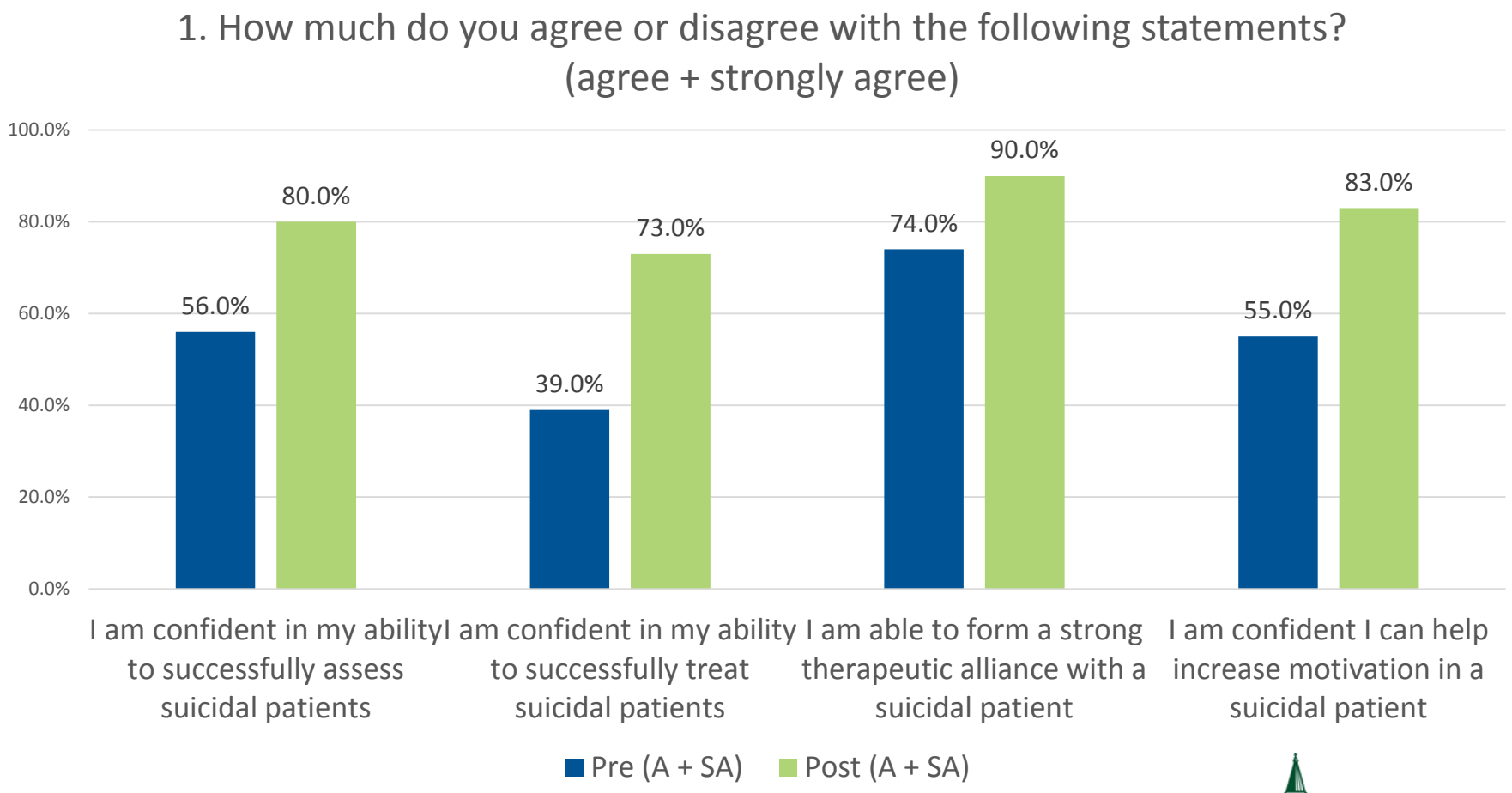
The identified themes generally cut across different participants' roles and programs, supporting reliability of the findings.

Interview findings will be combined with data from workforce surveys, organizational self-assessments, training assessments, administrative processes and client-level outcomes to understand how the DAs and their partners can incorporate Zero Suicide into their systems.

CAMS Findings

- Three waves of CAMS trainings to date (two included)
- Data summarized as pre- versus post-training changes
- For simplicity, “agree” and “strongly agree” are combined
- Height of the bars reflects the percent of trainees who indicated “agree” or “strongly agree” as their response
- Items with an asterisk are “flipped”, in that they were asked in a negative way, and were re-coded to reflect agree + strongly agree instead of disagree + strongly disagree

CAMS Findings



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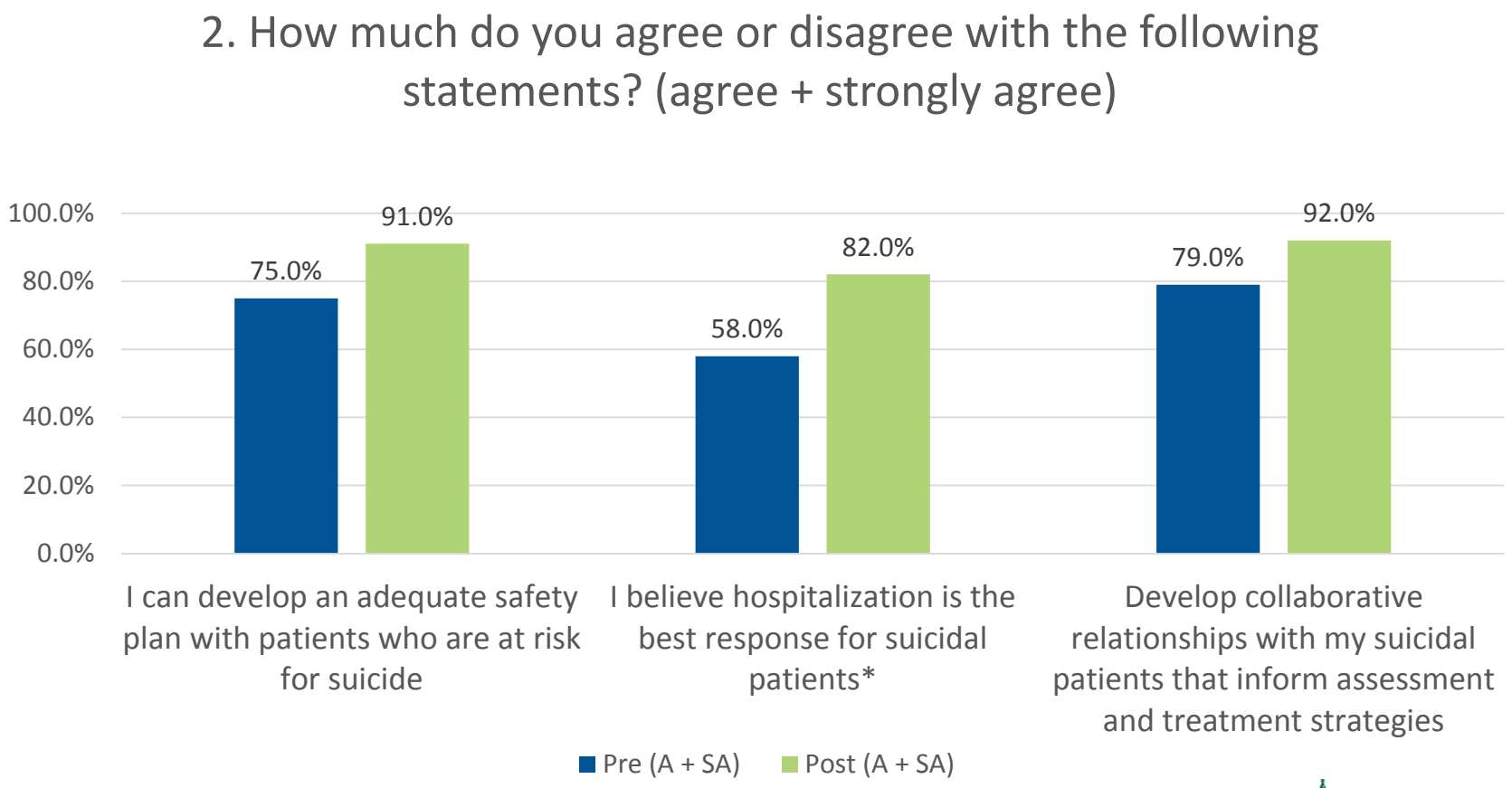
CAMS Findings



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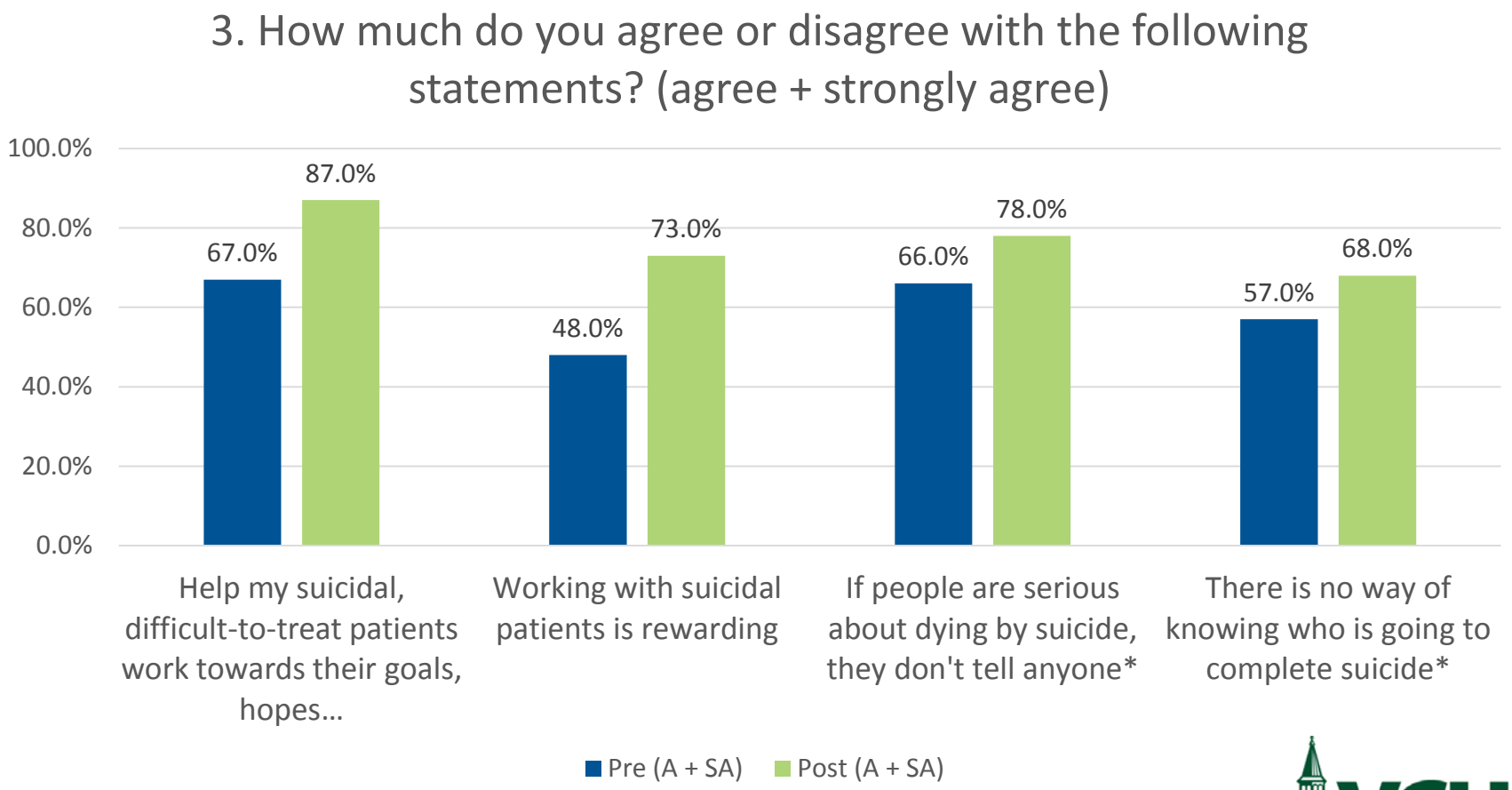
CAMS Findings



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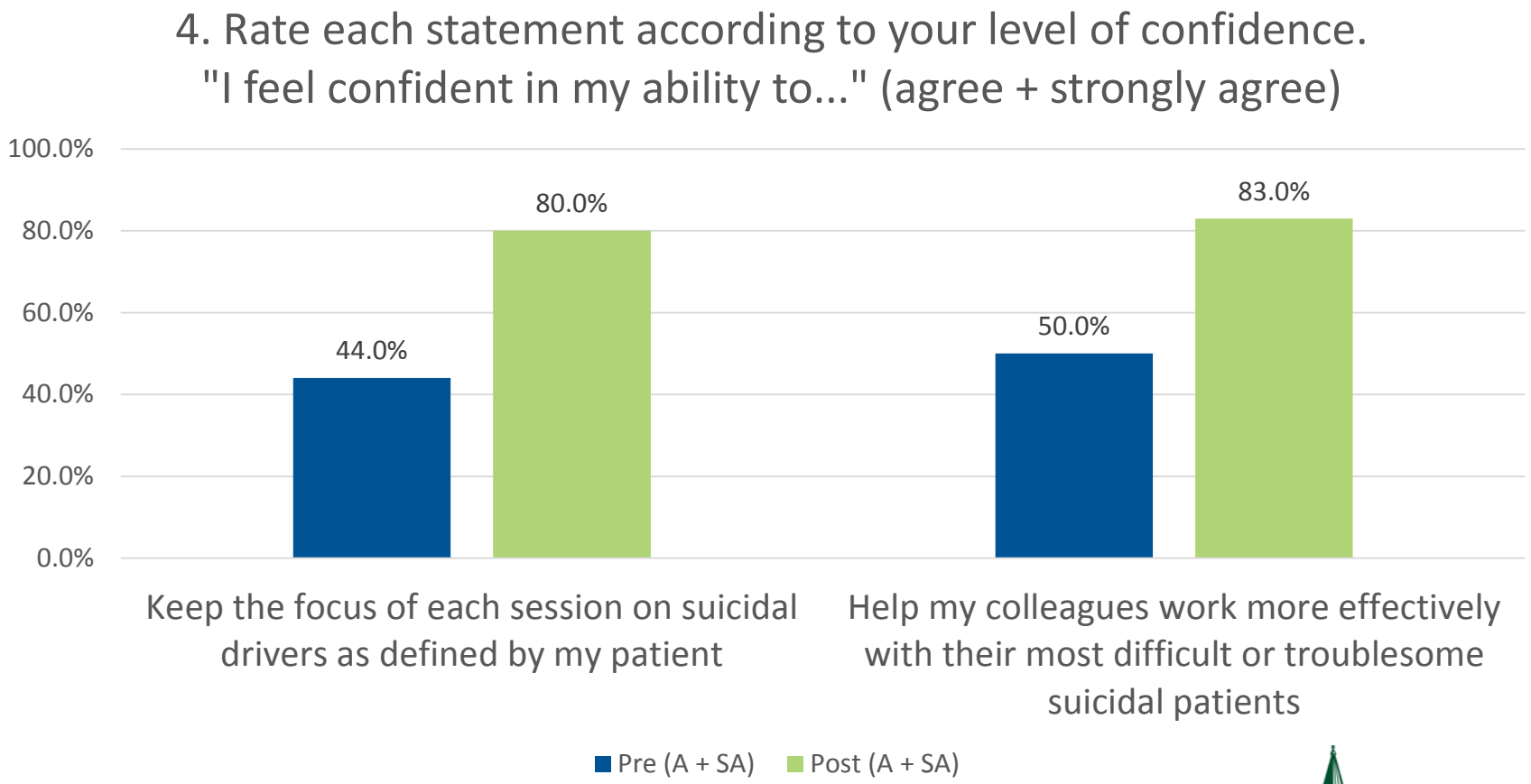
CAMS Findings



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CAMS Conclusions

- Overall substantial increases in knowledge and confidence related to implementing CAMS with clients
  - Seven additional items showed less than 10% increase
  - Five other items showed no or small increase BUT pre- and post-training scores were already in the 90% range.

Limitations

- Descriptive research
- Not (yet) able to relate evaluation findings to client-level data (outcomes)
- Possible selection bias
- Possible Hawthorne effect
- Possible interviewer/coder bias
- Used notes versus recordings
- Interviewees may have viewed the interviewer as “part of” Zero Suicide efforts

Overall Findings

- Clinicians, managers and other leaders identified strengths, challenges and important next steps for Zero Suicide implementation.
  - Likely would not have been captured using a more passive survey approach
  - Possible that the interviews functioned as an “intervention” to drive thinking and discussion around implementation

- CAMS trainings are associated with strong increases (and no decreases) in participants’ knowledge and confidence related to the CAMS EBP model.

- Evaluation of a systems change model like Zero Suicide requires multiple, complimentary approaches to evaluation; evaluation has to occur at different levels of the implementation.

THANK YOU!!!

Questions/Comments: Tom Delaney

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