Zero Suicide in Texas

January 2016

Crisis Services

A new resource provided by the Substance Abuse and Mental Health Services Administration summarizes current practices in crisis care. The resource documents the research evidence supporting a variety of crisis services, including crisis residential programs, mobile crisis services, crisis respite, crisis hotlines, and peer crisis services.

In addition to these traditional crisis services, the resource also discusses the use of warm lines and psychiatric advance directives. Warm lines are run by trained mental health peers and allow individuals in distress to receive support and compassion, in an attempt to prevent possible escalation of the situation and prevent the need of more intensive services. A survey of callers suggested they experienced reduced feelings of isolation and a decrease in the use of crisis services.

Advanced directive statements allow a person to document their treatment preference if they become unable to make treatment decisions. Although limited, research suggests these directives may reduce compulsory admissions, but only when developed in collaboration with a mental health treatment team.

The report also summarized different mechanisms used by states to fund crisis services and emphasized the importance of coordinated funding from multiple sources to ensure access to a continuum of care.

Read SAMHA's report here for more information in crisis services.

Lessons Identified by States

- Medicaid waivers, such as 1115 and 1915b, can be helpful in providing flexibility for building and sustaining crisis services.
- Data collection on the quality of crisis services, such as response time to crisis calls or the percent of individuals diverted from inpatient hospitalization, have helped states improve services.

SPSM Chat

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The Suicide Prevention Social Media (SPSM) Chat is an innovative way to address suicide prevention and incorporate technology and innovation. This chat, which uses Twitter to generate, curate, and share the best information and innovations in the field of suicide prevention, presents on a variety of topics and brings in guest experts from the field.

Last November Jerry Reed, the Director of the Suicide Prevention Resource Center, was brought on the show to discuss the past, present, and future of suicide prevention at the national level.

You can learn more about SPSM Chat here, and watch Jerry's interview here.

Upcoming Events

49th Annual American Association of Suicidology Conference
Tuesday, March 29 – Saturday, April 2
The Palmer House, Chicago, Illinois
The AAS Annual Conference begins on Tuesday, March 29th with two pre-conference workshops and continues on Wednesday, March 30th with full and half-day offerings. The conference continues with a combination of plenary and break-out sessions on Thursday, Friday, and Saturday. Please visit http://www.suicidology.org/annual-conference/49th-annual-conference for additional information and registration.

ASIST Train the Trainers
Spring-Summer 2016
Please email Erica Shapiro at erica.shapiro@austin.utexas.edu to request a number of spots for your organization. The cost of the training, morning and afternoon meals, as well as a small (~$100) travel stipend, will be provided. More information will be shared about the location and date in the near future.

What the data tells us

Based on community centers participating in the most recent Zero Suicide Workforce Survey, individuals who receive some training in suicide safer care feel more capable, confident, and supported in their work with individuals who are at heightened risk for suicide. However, 48% of the sample have not received any training and many of those who have received training feel that they could still benefit from additional training.

Question	Some Training	No Training
I have received the training I need to engage and assist those with suicidal desire and/or intent.	64.4 %	15.3%
I have the skills to screen and assess a patient/client's suicide risk.	54.6%	16.7%
I have the support/supervision I need to engage and assist people with suicidal desire and/or intent.	54.6%	16.7%
I am confident in my ability to assess a patient/client's suicide risk.	65.2%	29.6%
I am confident in my ability to manage a patient/client's suicidal thoughts and behavior.	56.2%	20.8%
I am confident in my ability to treat a patient/client's suicidal thoughts and behavior using an evidence-based approach such as DBT or CBT	53.3%	13.7%