

# Lone Star State Engages the Public in Suicide Prevention

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Based on an interview with Heather Cobb for National Council Magazine

As the legislatively mandated state suicide prevention coordination within the Texas Department of State Health Services, I oversee the work of the local mental health authorities, including the 39 local community behavioral health centers across the state, providing policy oversight, programmatic support, and financial support. Each of these centers employs a suicide prevention gatekeeper who is key to ensuring the centers have suicide prevention policies and postvention protocols.

We have and continue to do a great deal of population-based outreach. We have a website hosted through [TexasSuicidePrevention.org](http://TexasSuicidePrevention.org); we publish English and Spanish suicide prevention and mental health awareness brochures; we have developed a free suicide prevention training akin to QPR; and we developed the first app to go with that training – the first Smartphone app in the world on suicide prevention.

We also developed the online training for high school teachers using gaming technology – it's a one-hour course where they log on at their convenience and go at their own pace through a guided session in which three students have mental health issues, one of which is suicidal thinking, to learn how to discuss suicide and mental health issues. This is the first training using online gaming technology for U.S. high school teachers related to suicide, and we are nearly prepared to release a middle school version, an anticipated resource since there are so few resources and trainings for middle school teachers on suicide prevention.

We are also developing an app for students, called the Virtual Hope Box, where kids can store things that make them feel hopeful and good, like poetry or music. When they start feeling down, they can access it all in one place, at any time.

In addition to our population-based outreach, we are also engaged in systems change – especially since the National Action Alliance for Suicide Prevention's Clinical Care Task Force's groundbreaking report came out last fall. The report points out that people with serious mental illness are 6-12 times likely to die of suicide. Of the people that are dying

by suicide, the research now shows that 90% have an underlying mental health or substance abuse issue, either treated or undertreated. That is a nail that we could hang our hats on. These are the people we need to focus on.

The Clinical Care and Interventions Task Force outlined the kinds of changes we need in our health-care system to eliminate suicides. Our population-based work is impactful, but this report gives us a chance to promulgate these strategies and initiatives through the entire behavioral health system. The Zero Suicide philosophy has become our goal for the entire Texas system.

With this report as our beacon, we are creating transformational change through changing or reinforcing positive cooperation around suicide care. We have the leadership buy-in we need, which is a real paradigm shift.

Our healthcare system by and large has failed the suicidal person. We traditionally assume someone who is suicidal needs to be hospitalized. Research now shows that a person who has made suicide attempts is most at risk of dying by suicide in the immediate days following discharge from the emergency department. The Clinical Care Taskforce Report outlined strategies to address this.

Staff needs to be filled and trained, they need to be confident to intervene once someone is suicidal, and they need to have a sustainable best practice or evidence-based training program in place to ensure all staff speak the same language. We much create an environment that accepts that suicide is everyone's business, everyone's problem. It's an issue for the entire agency – everybody from the van driver to the receptionist, to the clinical team. With the training, the models, the tools, and the agency's support, staff can better meet the needs of individuals at risk of suicide.

We are operationalizing evidence-based trainings and procedures. We follow the person through the evidence-based clinical services they receive. When a person is discharged from a hospital, we focus on proper follow-up. The research shows that people feel safer when receive follow up through texts,

phone calls, or postcards – when they know the clinician and the agency cares.

With prior permission, We are creating guidelines for a designation that will become a gold standard in Texas, calling certain centers Suicide Safe Care Centers. They will be able to apply and receive this designation next to their name, like a badge of honor showing that they went through all the trainings and changes to meet the guidelines. This will require some time and financial commitment by the centers, but their suicide attempt rate and complete rates will go down and hospital emergency department and admission utilization will go down. Not only would you be recognized as a suicide safe care site, but ultimately there's a cost savings – better skilled staff, and less staff burnout.

Following what the Clinical Care Taskforce uses to measure the workforce's skills, we have begun pre- and post-testing to ensure staff is confident in intervening with suicidal patients. The tests asks questions to assess knowledge, as well as value-based questions about comfort in openly discussing suicide with patients and whether they believe suicides can be prevented. It only takes participants about 5 minutes to answer. It serves as a needs assessment and is important to any large-scale change. Soon, we hope to have a baseline; we already have received 4,000 surveys back, which is significant.

To have a well thought out system strategy, to implement it and support it, we do national speaking engagements through webinars and conferences, share multimedia information, resources, and tools through [www.texasuicideprevention.org](http://www.texasuicideprevention.org), and we talk with centers and stakeholders on the local level to ensure proper implementation and engagement.

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