Wayne State University
Suicide Prevention Initiative
Year One – Year Three
Quarter 1

The initiative seeks to eliminate deaths by suicide in the University community through the development of an infrastructure of education, training, & dissemination of information to all faculty, staff, students & their families.

October 2017 – December 2019

- **145** collaborations with campus & community organizations
- **147** outreach & awareness events
- **40** students on the Advisory Board
- **26,168** individuals reached for outreach & awareness
- **100** members in the student group

3 Kognito online training modules
on suicide prevention & mental health promotion

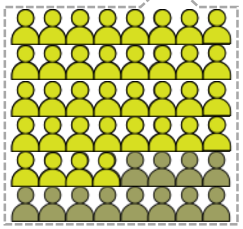
- **87** mental health/healthcare professionals & trainees trained
- **781** general campus community members trained

51 Suicide prevention presentations
for generalized & specialized audiences

- **2,092** campus community members trained
- **409,765** individuals reached with all suicide prevention messaging

46 Mental Health First Aid trainings

6312 in-person training hours with:



- **631** mental health/healthcare professionals & trainees
- **207** general campus community members

Participant scores **increased significantly** on:

- attitudes
- confidence
- knowledge

For more information & how to get involved, visit: suicideprevention.wayne.edu

Prepared by the Wayne State School of Social Work Center for Social Work Research 2020-02-13

PIHP Director Interviews
High Impact Program Components

PIHP directors for each of the ten Michigan PIHPs were interviewed by phone. The interviews took place between March 9 and March 30, 2020. Areas of inquiry included challenges of administering the STR grants and perceptions of areas of impact for both the PIHPs and their service providers. This report extracts key activities that PIHP directors identified as having a high impact in their communities.

Medication Assisted Treatment (MAT)

All ten of the PIHP directs mentioned the availability of MAT as having a high impact in their communities. Three PIHPs used funding to establish new MAT clinics and six indicated an expansion of access to MAT in other settings. Three of those talked specifically about partnerships with jails and expanding access to MAT in jails.

> *I think STR 5 especially helped us to expand provider programs around MAT. It helped with funding doctors, it helped with funding clinicians, and it helped with funding peer recovery coaches. They also got a lot of training because we were able to offer a lot of evidence-based practice training across the network.*

> *One of the things we used with the STR money was to help fund the opening of a methadone clinic … We did not have a methadone clinic and so, we were able to help the provider purchase a ton of equipment to get that up and running. They've been opened about a year now…*

Naloxone

Eight of the ten PIHP directors mentioned Naloxone has having the most impact in their communities. All eight indicated the funding for the drug was extremely helpful. Six of the PIHP directors specifically mentioned the training that was completed with community partners in when and how to use it was helpful. Many of these mentioned how the Naloxone availability and trainings also helped to build partnerships and reduce stigma.

> *…Having Naloxone in all counties and having staff that can spend some time doing trainings. We were able to also get Naloxone in every police department, so any person who works road patrol in our counties, if they didn't already have Naloxone, this grant paid for that*

> *I think with this naloxone distribution that was highly successful. It wasn't just the saving lives, which is why we do what we do. I mean that was number one with this. It truly did save lives, but it also was able to increase awareness of the issue, and what to do about it too. People didn't feel helpless with it, they were armed with something tangible that they could use if needed.*

Training

Eight of the ten PIHP directors mentioned staff training and building capacity at both the PIHP and provider levels. This included training on MAT and Naloxone, as well as on the evidence-based programs and practices, including Project Assert, Strengthening Families, and motivational interviewing.

> *…anytime you can enhance the capacity of your existing staff or help to identify needs as your moving forward that's a good thing.*

> *We are able to send providers staff for trainings and increase the trainings in the region in evidence-based practices which is what I am a big fan of. It's always fantastic to be able to do that.*

Transportation to Treatment

Six of the ten PIHP directors cited the importance of providing transportation to treatment. This included use of cab and Uber providers. One PIHP indicated that a new bus line has been established as was being maintained beyond grant funding for this purpose.

> *Transportation that got people to treatment. That's always our number one issue when we do client satisfaction surveys and that's transportation. So, to be able to offer that and get people there was fantastic.*

> *We now have some specific routes with local bussing companies that are routes that they're offering to an individual to basically be able to be taken to go get their daily, or sometimes weekly medication assisted treatment for those who are not in the jail system. So, for those who are having an opiate use disorder that need to get from one end of the county to the other end where their actual provider is, we are able to provide bussing now and there's actual routes dedicated to that*

Additional high impact practices

Project Assert was mentioned by four PIHP directors as being of impact in their community in providing a gateway to treatment.

> *Project ASSERT appears to have the most success out of the STR grant and thats due to the number of people served which are very large, but also the expansion of our peers within our community … the buy in and support of the local hospitals that let us partner with them in this because that was a huge change in culture to be willing and open to really address the needs of this population where it hadn't been before..*

Recovery coaches in general was mentioned by four PIHP directors as being of impact in their community.

> *… That really significantly increased our peer recovery coaches within our primary contracted program for that service because they did that. They also did another project that involved peers, so they really significantly increased our staff.*

Strengthening Families was mentioned by three PIHP directors as being a very useful prevention program that engaged the entire family.

> *The Strengthening Families model, I think that's something that brought families closer because families weren't sitting down as a family to sit down and eat. With Strengthening Families, they're not only doing the curriculum with that individual, they're doing it with the entire family, and they're providing them with a well-balanced meal as they go along with that. So, it gave them what it's like to sit down as a family and talk about these things.*

Exploration of Staff Perceptions at the Children's Center

Executive Summary

The Children's Center (TCC) values the critical role of professional staff in meeting its mission and achieving successful treatment outcomes for children and their families. In the continuing collaboration with Wayne State University School of Social Work (WSU/SSW), the two organizations jointly created an assessment process to provide information on clinical competencies, training needs, and challenges related to making clinical diagnoses and clinical progress. Two strategies were used to gather the data. First, a web-based survey was sent to all Children's Center clinicians. Approximately half (51%) of the clinicians responded. Second, three focus groups were conducted with clinicians, including clinical coordinators. Protocols, including consent forms, were approved by the WSU Institutional Review Board and Detroit Wayne County Community Mental Health Research Advisory Committee.

The major findings from the survey established that clinicians reported the highest level of competency in skills related to establishing clinical relationships (e.g., building rapport, empathy in interviewing) and adhering to laws and public policies related to children. Participants report their lowest competencies in administering/interpreting standardized assessment and diagnostic tools and in using group interventions with children and families. These results are consistent with the needs they identified for training. In addition, clinicians report needing more assistance in implementing new therapies with children and recommended employing onsite experts and additional hands-on training with intervention implementation.

Clinicians are aware of their responsibility for continuous learning; they rely most frequently on individual supervision, co-workers, the internet and case conferencing with the psychiatrist. They believe training/conferences are good sources for information on new treatment techniques. Almost all report that they implement new information gained from trainings attended and believe that it's easy to apply new clinical training to TCC clients.

Three main themes emerged from the focus groups when clinicians discussed barriers to good clinical diagnosis. Clinicians acknowledge that parents are overwhelmed with multiple problems, children, expectations and pressures. Consequently the first theme is that parents minimize or dramatize symptoms. Time was the second major thematic barrier. Diagnosis is hampered by the clinician's access to key information to complete a thorough assessment, meet with coordinators, coordinate with other helping professionals and complete paperwork. Good rapport was identified as an essential element for making a clinical diagnosis; however this, too, was diminished by lack of time with families and the amount of time between sessions. Finally, while action has been taken by TCC to address case staffing, clinicians felt that better education on DSM diagnosis for children, and more time with supervisors and applied training on common childhood diagnosis would be useful.

Barriers to clinical progress overlapped with the barriers to clinical diagnosis. Due to budget constraints in Michigan caseloads have grown in recent years. But despite the fact that TCC has made concerted effort to keep their caseloads from expanding at the rate of their peer institutions, TCC clinicians are hindered by caseload size and paperwork. Parents, as a group, were again singled out as a barrier to making progress with children. No-shows, parent's mental health affecting follow-through with therapeutic interventions, and insufficient parenting skills impede

clinical progress. In addition, home environments with problems like domestic violence producing trauma that maintain symptoms for the child despite therapeutic interventions were also indentified as a barrier. A final barrier was that clinical supervision over emphasized administrative timelines and goals. Variability was noted among clinicians, some receive supervision more frequently and supervisory techniques were not consistent.

Recommendations

The Children's Center has made several strides to address the gap between the reality and ideal conditions for effective diagnosis and treatment of children. Fortunately, the commitment of the administrative staff , competencies of the clinicians, and their joint willingness to facilitate and engage in professional development point to several strategies that can be employed to help eliminate barriers to good clinical diagnosis and progress. What is evident is that the spectrum of goals and strategies for TCC range from organizational processes and practices, training and technical assistance for clinicians and coordinators, to implementing communication tactics for staff and expanding new service options for families.

The following suggestions represent a menu of opportunities to be discussed further and expanded upon.

Goals/Strategies	**Recommended Action**
Organizational Processes/Practices	1) Develop flow chart for making internal and external referrals (e.g., for parents with childcare and/or mental health service needs) 2) Review clinical supervision for quality (reflective), approach (group and/or individual) and focus (clinical emphasis over administrative) 3) Examine ways to expedite case termination process (e.g., review no-show policy) 4) Ensure regularly scheduled clinical case staffing 5) Provide access to recent research published in journals and offer brown bag presentations for discussion 6) Promote organizational culture of clinical competence, parents as partners and professional performance 7) Facilitate peer mentoring for new staff in use of termination strategies
Staffing	8) Employ more case managers (e.g., to assist with collecting documentation from other organizations, completing paperwork)
Training/Technical Assistance	9) Group intervention techniques for children and their families 10) Administering/interpreting standardized assessment and diagnostic tools 11) Evidence-based interventions for children using hands-on training 12) Facilitate/promote clinical supervision certificate 13) Enhance understanding of working with children and families experiencing poverty
Communication	14) Develop orientation/information sheet on diagnosis and therapeutic processes for distribution at intake 15) Develop FAQ webpage for clinicians and families
Service Options	16) Offer parenting skills, support groups, psycho-education groups for parents