

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and <u>underlined</u>.	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, " <i>I've thought about killing myself</i> " without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. " <i>I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.</i> " <u>Have you been thinking about how you might kill yourself?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to " <i>I have the thoughts but I definitely will not do anything about them.</i> " <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <u>If YES, ask: How long ago did you do any of these?</u> • Over a year ago? • Between three months and a year ago? • Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.

New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Since Last Visit	
Ask questions that are bold and <u>underlined</u>	YES	NO
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, " <i>I've thought about killing myself</i> " without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. " <i>I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it.</i> " <u>Have you been thinking about how you might kill yourself?</u>		
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Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
3. In the past week, have you been having thoughts about killing yourself? Yes No
4. Have you ever tried to kill yourself? Yes No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? Yes No

Next steps:

- If patient answers “No” to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers “Yes” to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - “Yes” to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation.
 - **Patient cannot leave until evaluated for safety.**
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient’s care.
 - “No” to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief** suicide safety assessment to determine if a **full** mental health evaluation is needed. **Patient cannot leave until evaluated for safety.**
 - Alert physician or clinician responsible for patient’s care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741



Suicide Prevention, Intervention and Postvention

Tools for Keeping Students Safe

Patti M. Clark, MBA, CPS



Why I'm Here



Cabinet for Health and Family Services



Suicide: Kentucky Facts & Figures

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Kentucky	776	17.06	16
Nationally	44,193	13.26	

Suicide is the **11th leading** cause of death overall in Kentucky.



On average, one person dies by suicide approximately **every 11 hours** in the state.



Based on most recent 2015 data from CDC



Suicide cost Kentucky a total of **\$746,659,000** of combined lifetime medical and work loss cost in 2010, or an average of **\$1,183,295** per suicide death.

IN KENTUCKY, SUICIDE IS THE...

2nd leading cause of death for ages 10-34

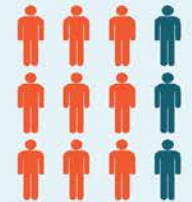
4th leading cause of death for ages 35-44

5th leading cause of death for ages 45-54

9th leading cause of death for ages 55-64

16th leading cause of death for ages 65 & older

More than three times as many people die by suicide in Kentucky annually than by homicide; the total deaths to suicide reflect a total of **15,292** years of potential life lost (YPLL) before age 65.



30 YEARS STRONG




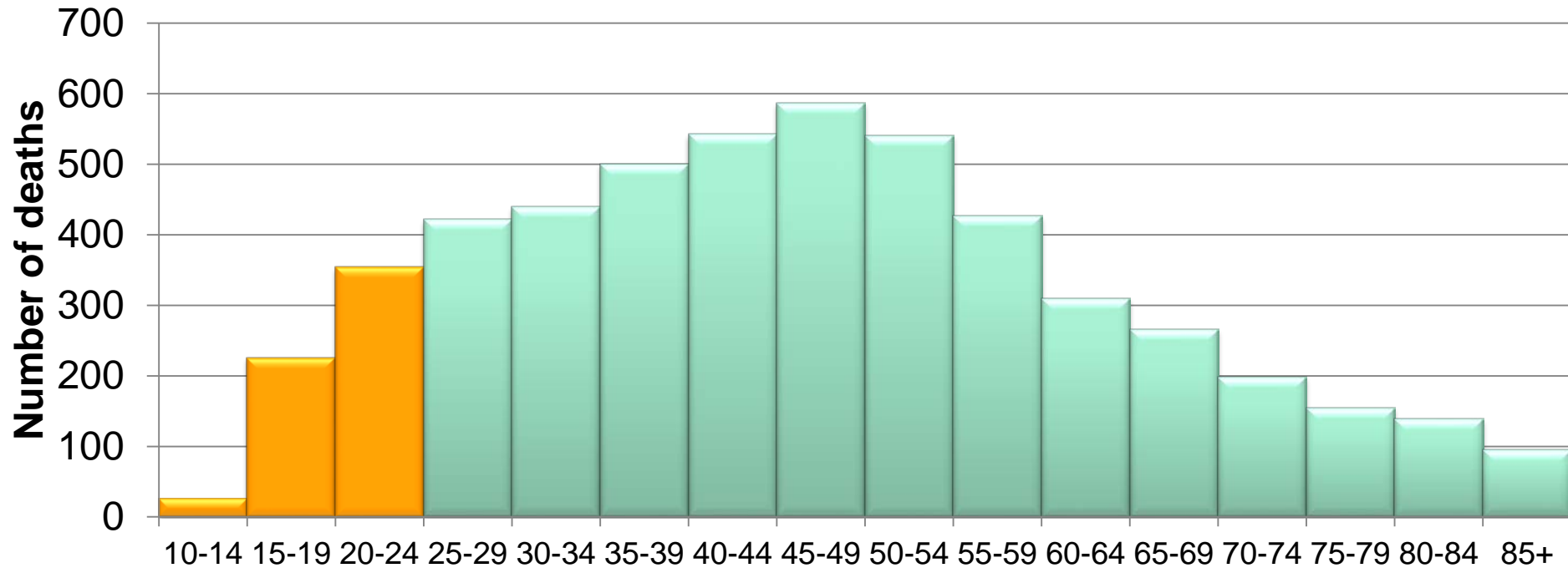
AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org

Cabinet for Health and Family Services

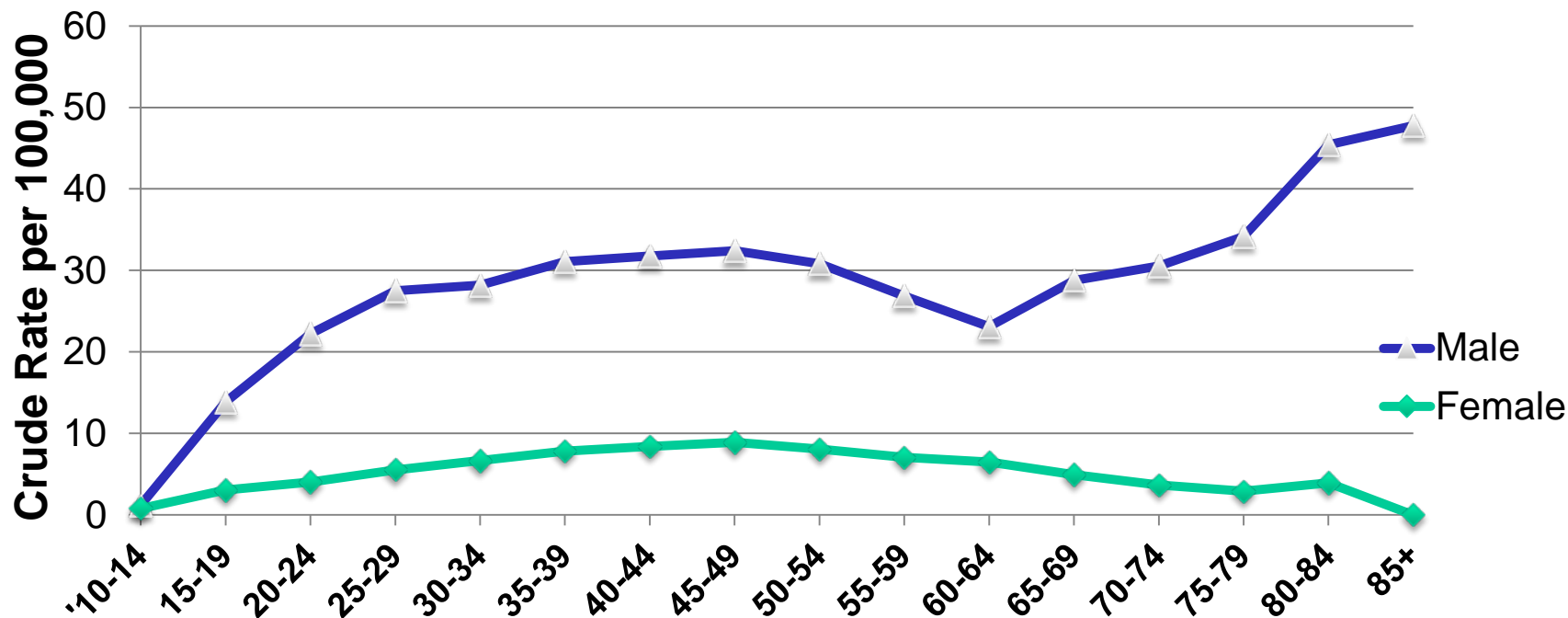


Suicide In Kentucky By Age Group



The majority of deaths by suicide in Kentucky occur in the middle-age population. There have been over 600 deaths among 10-24 year olds between 2005 and 2013.

Suicide Deaths by Sex Across the Lifetime

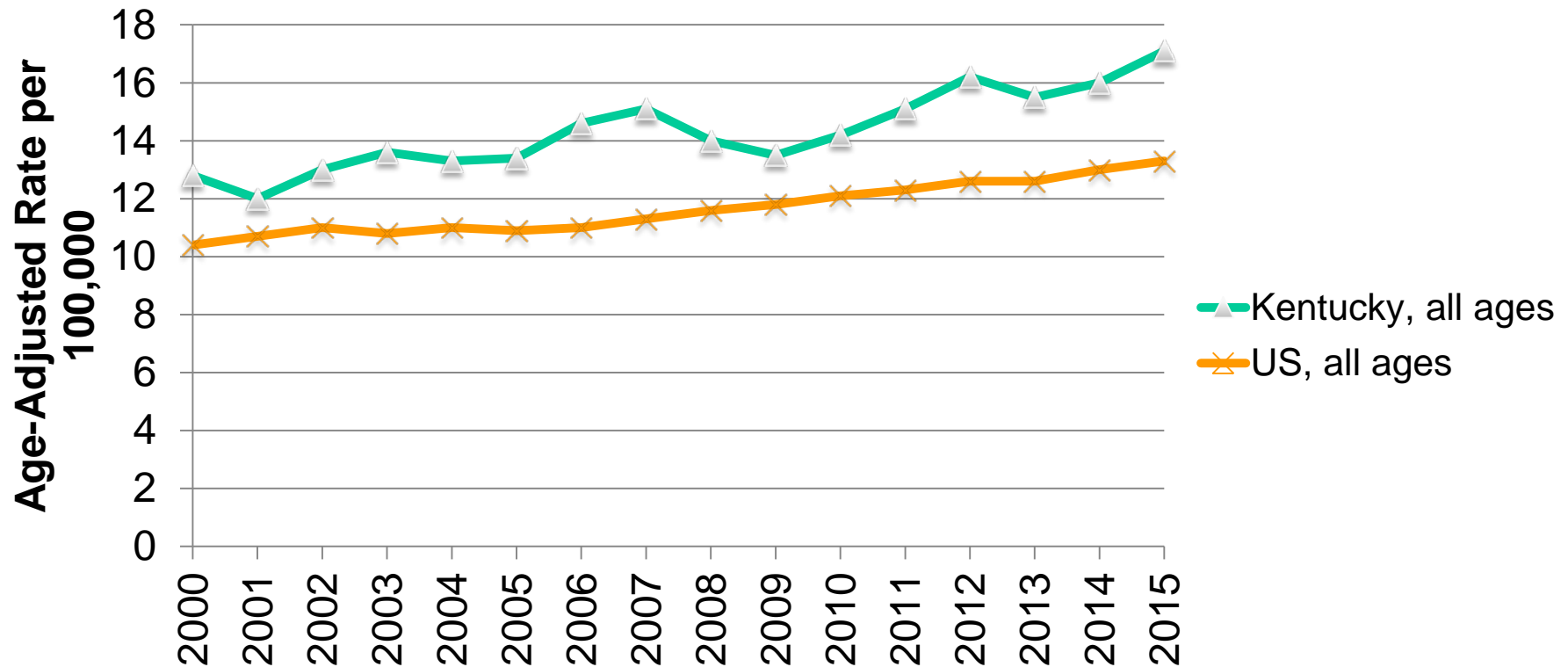


* Indicates unstable estimate due to small sample size

--* Indicates state-level count and rate based on fewer than 10 deaths have been suppressed to retain confidentiality.

Males are at a higher risk of suicide than females at all ages, and males' risk of suicide increases at the end of life, whereas females' risk of suicide decreases at the end of life.

KY vs. US Deaths, All Ages



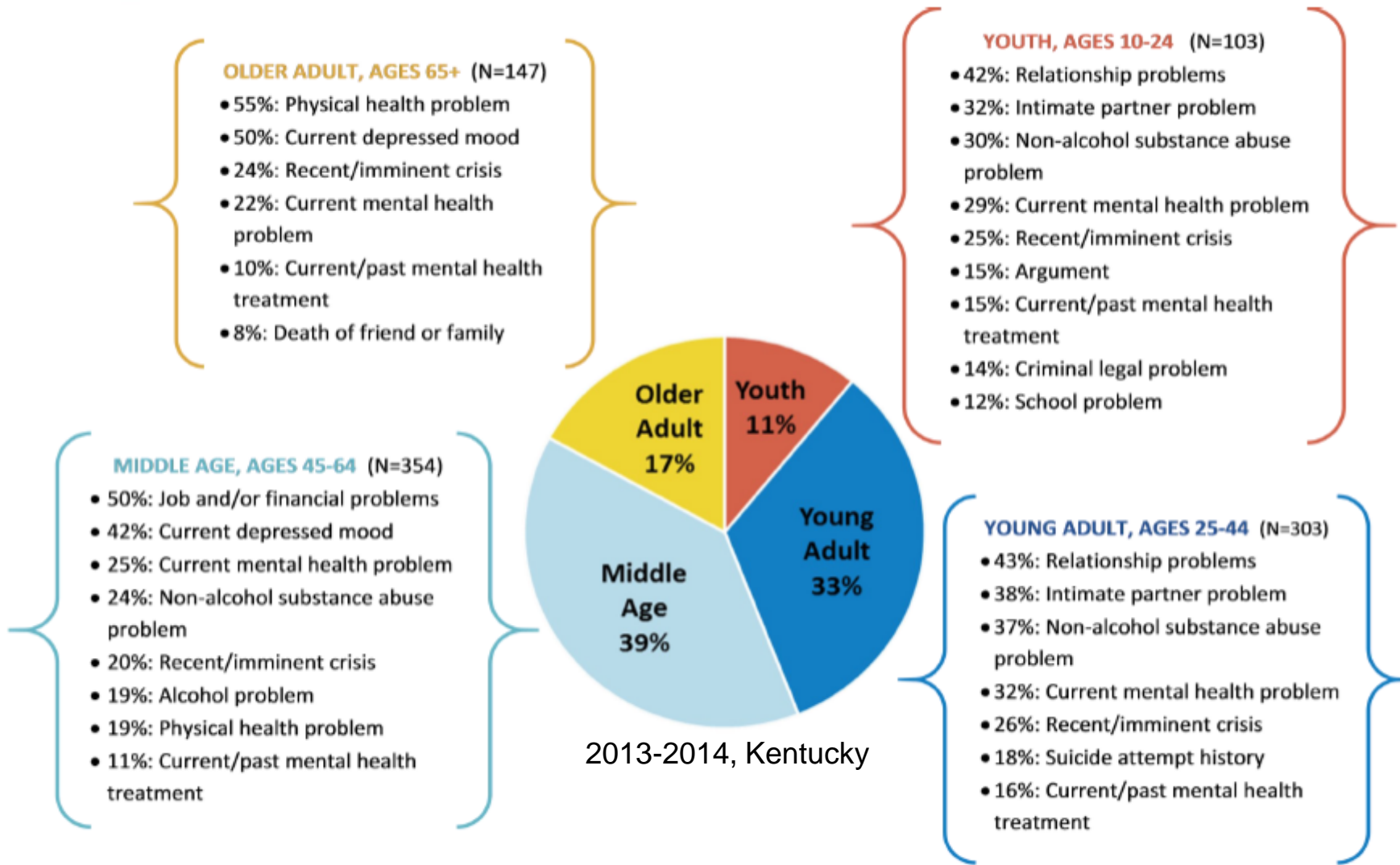
Kentucky has a higher suicide rate than the US, and both are on the rise.

Rural vs. Urban Suicides

- From 1999-2015, suicide rates increased 14% among residents aged 10 or older
- During first half of time frame, increases greater in urban areas
- In second half, however, largest rate of increase was in areas with a population of 10,000 or less
- Less than 9% of communities in Kentucky have populations greater than 10,000

CDC, JAMA, 2017

Suicide Circumstance by Life Stage

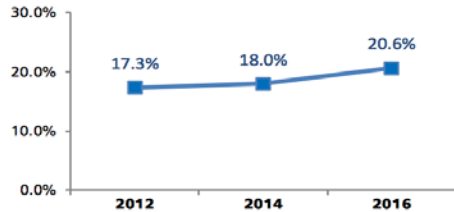


Youth Suicides in Kentucky



KIP 2016

30-Day Serious Psychological Distress 2012-2016 - KY State Trend for 10th graders*



*(% meeting the threshold for serious psychological distress)

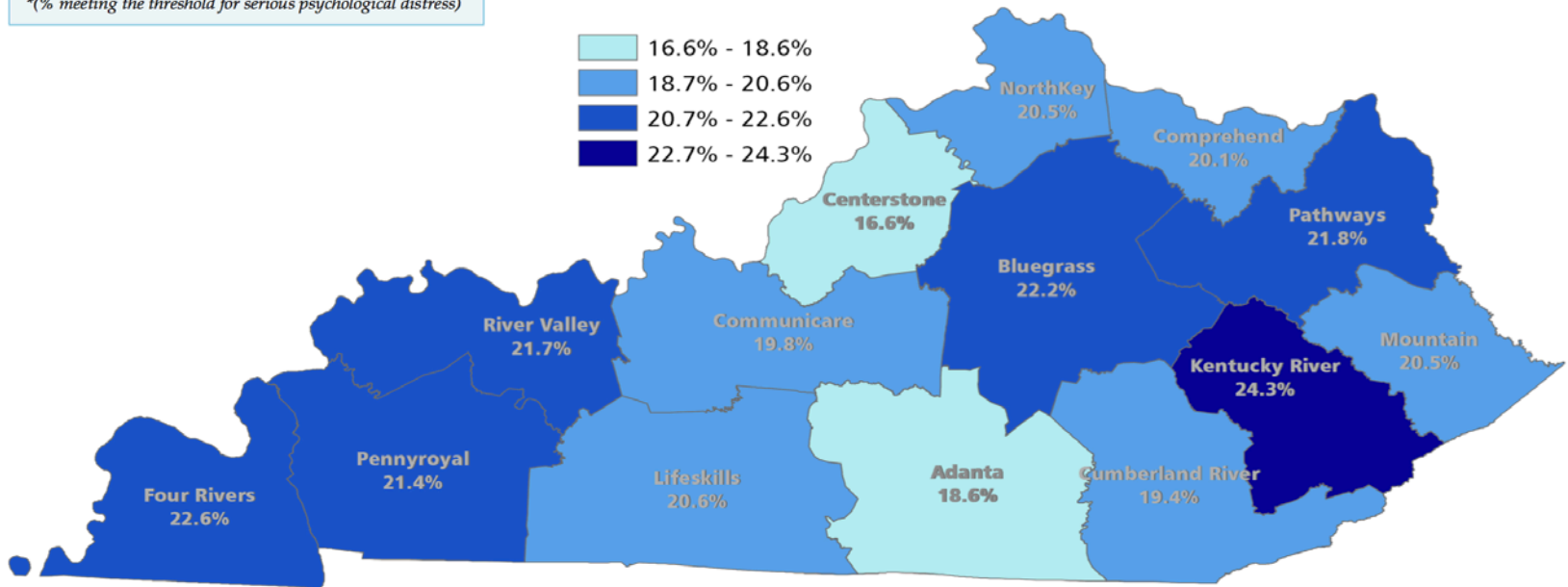
Grade 10 - Serious Psychological Distress,* 2016

**nervous, hopeless, restless or fidgety, so depressed nothing could cheer you up, everything was an effort, worthless*

(% meeting the threshold for serious psychological distress)

PERCENTAGE OF 10TH GRADERS, 2016

Min: 16.6% (CENTERSTONE); Max: 24.3% (KENTUCKY RIVER)



NON-PARTICIPATING DISTRICTS BY REGION: FOUR RIVERS (Calloway County, Murray Independent), PENNYROYAL (Dawson Springs Independent), LIFESKILLS (Bowling Green Independent, Warren County), COMMUNICARE (Meade County), CENTERSTONE (Anchorage Independent, Eminence Independent, Jefferson County), NORTHKEY (Beechwood Independent, Bellevue Independent, Kenton County, Southgate Independent,), PATHWAYS (Ashland Independent, Morgan County), MOUNTAIN (Martin County, Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent, Laurel County), BLUEGRASS (Fayette County)

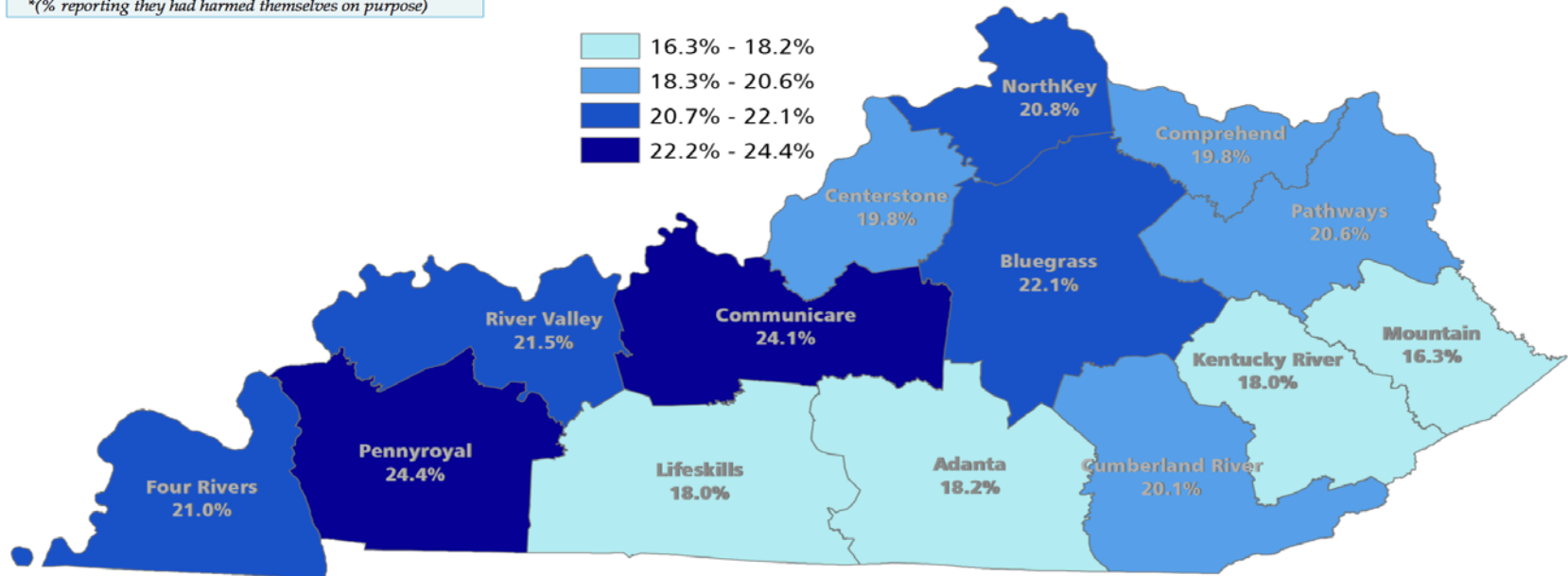
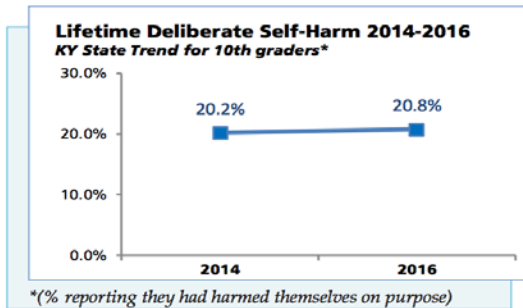
KIP 2016

Grade 10 - Self-Harm, 2016

(% responding that they had ever cut or harmed themselves on purpose)

PERCENTAGE OF 10TH GRADERS, 2016

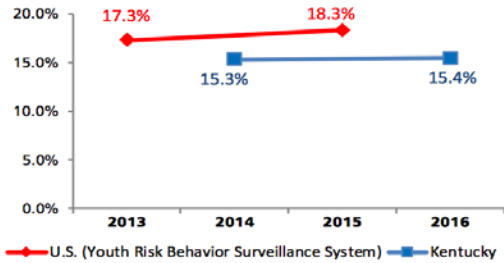
Min: 16.3% (MOUNTAIN); Max: 24.4% (PENNYROYAL)



NON-PARTICIPATING DISTRICTS BY REGION: FOUR RIVERS (Calloway County, Murray Independent), PENNYROYAL (Dawson Springs Independent), LIFESKILLS (Bowling Green Independent, Warren County), COMMUNICARE (Meade County), CENTERSTONE (Anchorage Independent, Eminence Independent, Jefferson County), NORTHKEY (Beechwood Independent, Bellevue Independent, Kenton County, Southgate Independent,), PATHWAYS (Ashland Independent, Morgan County), MOUNTAIN (Martin County, Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent, Laurel County), BLUEGRASS (Fayette County.)

KIP 2016

Past Year Suicidal Ideation 2013-2016
U.S. and KY State Trends for 10th graders*

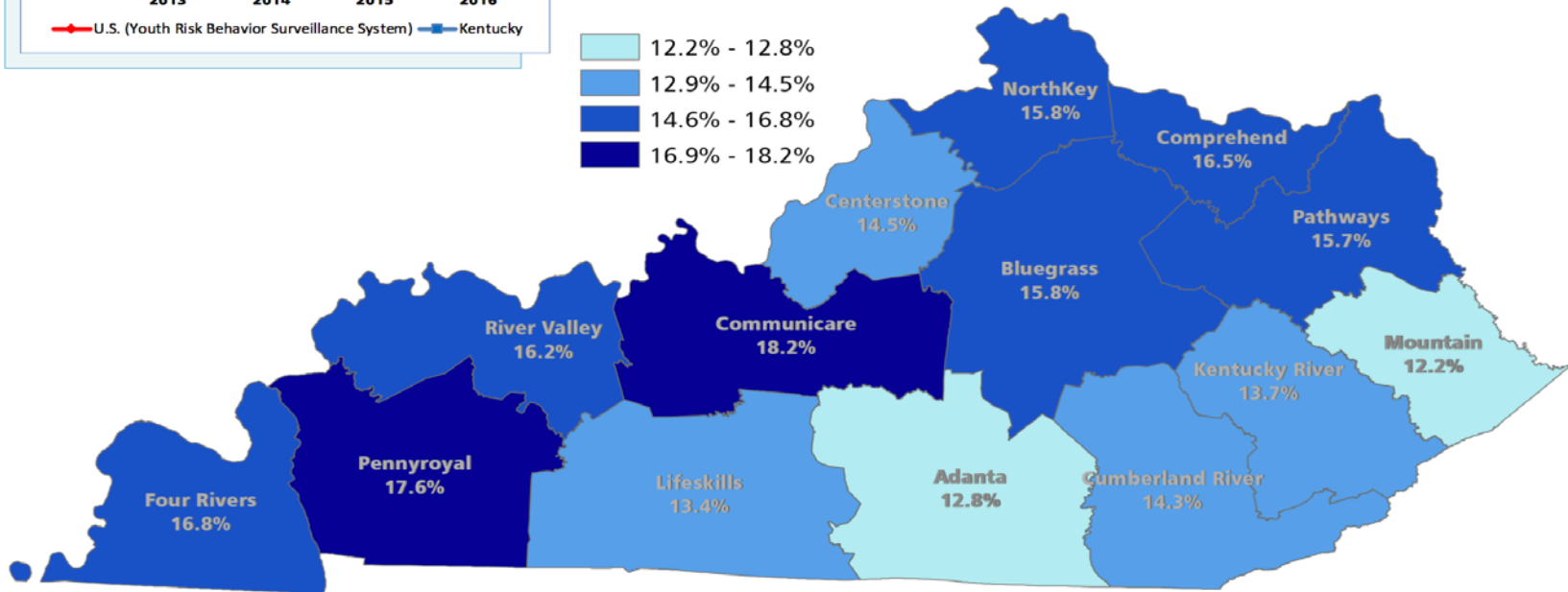


Grade 10 - Suicidal Ideation, 2016

(% responding that they had seriously considered attempting suicide within the past year)

PERCENTAGE OF 10TH GRADERS, 2016

Min: 12.2% (MOUNTAIN); Max: 18.2% (COMMUNICARE)



NON-PARTICIPATING DISTRICTS BY REGION: FOUR RIVERS (Calloway County, Murray Independent), PENNYROYAL (Dawson Springs Independent), LIFESKILLS (Bowling Green Independent, Warren County), COMMUNICARE (Meade County), CENTERSTONE (Anchorage Independent, Eminence Independent, Jefferson County), NORTHKEY (Beechwood Independent, Bellevue Independent, Kenton County, Southgate Independent.), PATHWAYS (Ashland Independent, Morgan County), MOUNTAIN (Martin County, Paintsville Independent), CUMBERLAND RIVER (East Bernstad Independent, Laurel County), BLUEGRASS (Fayette County.)

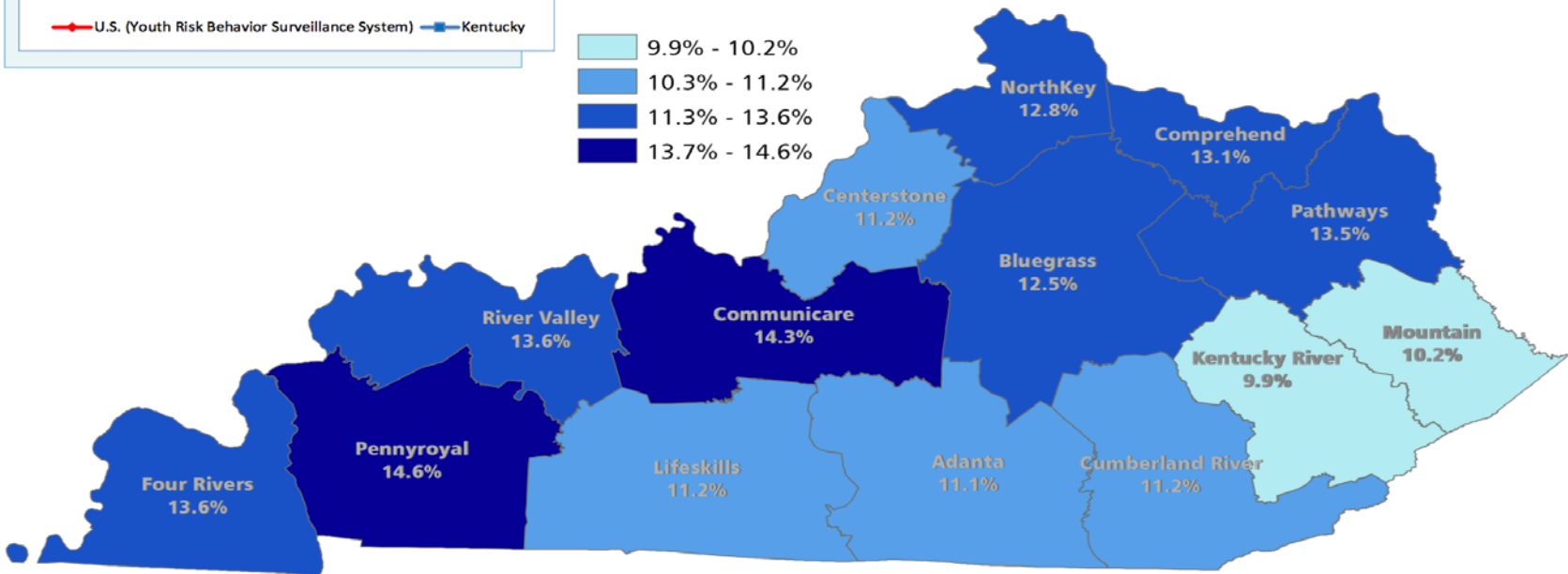
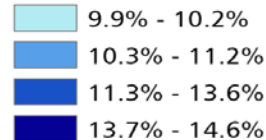
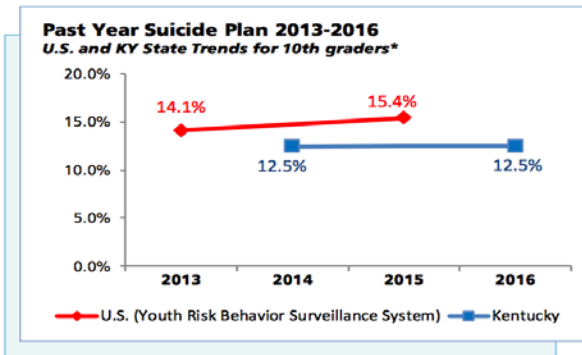
KIP 2016

Grade 10 - Suicide Plan, 2016

(% responding that they had made a plan about how they would attempt suicide within the past year)

PERCENTAGE OF 10TH GRADERS, 2016

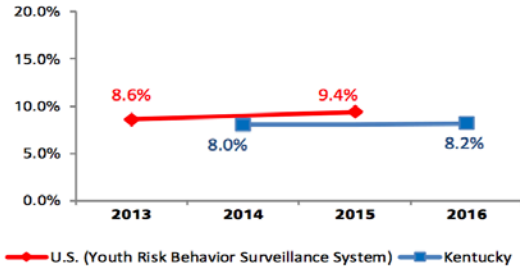
Min: 9.9% (KENTUCKY RIVER); Max: 14.6% (PENNYROYAL)



NON-PARTICIPATING DISTRICTS BY REGION: FOUR RIVERS (Calloway County, Murray Independent), PENNYROYAL (Dawson Springs Independent), LIFESKILLS (Bowling Green Independent, Warren County), COMMUNICARE (Meade County), CENTERSTONE (Anchorage Independent, Eminence Independent, Jefferson County), NORTHKEY (Beechwood Independent, Bellevue Independent, Kenton County, Southgate Independent.), PATHWAYS (Ashland Independent, Morgan County), MOUNTAIN (Martin County, Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent, Laurel County), BLUEGRASS (Fayette County.)

KIP 2016

Past Year Suicide Attempt 2013-2016
U.S. and KY State Trends for 10th graders*

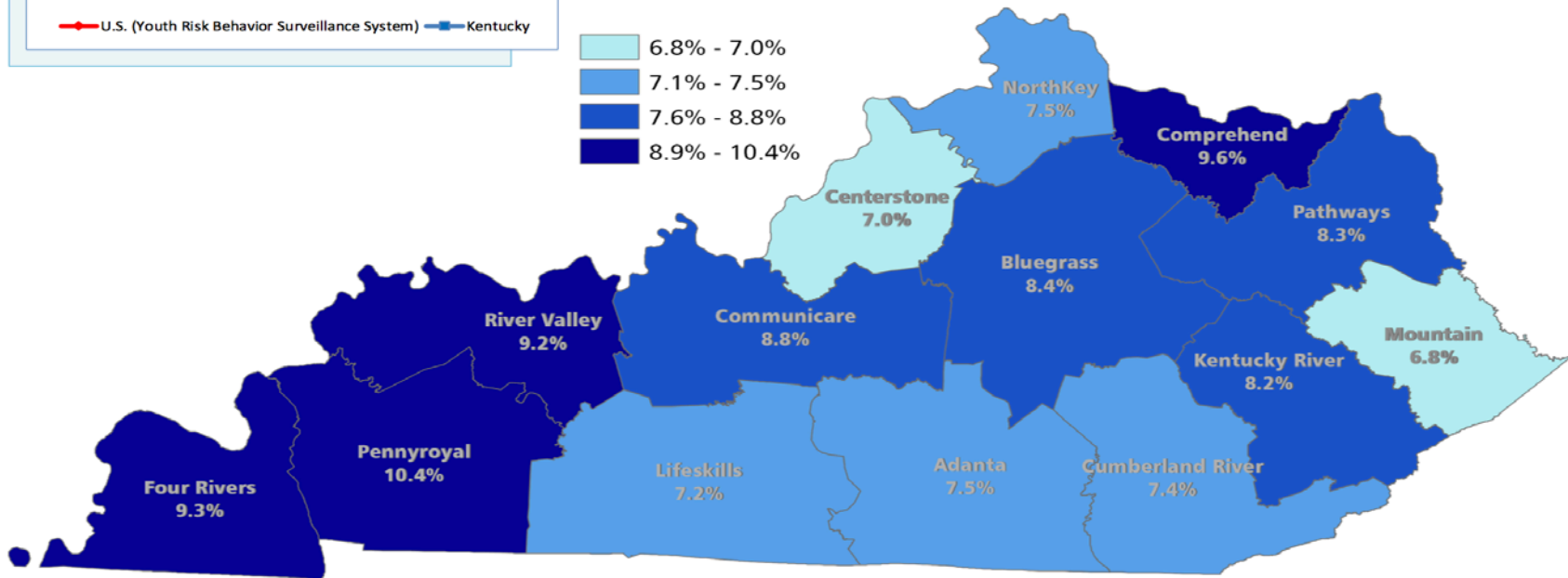


Grade 10 - Suicide Attempt, 2016

(% responding that they had actually attempted suicide at least one time within the past year)

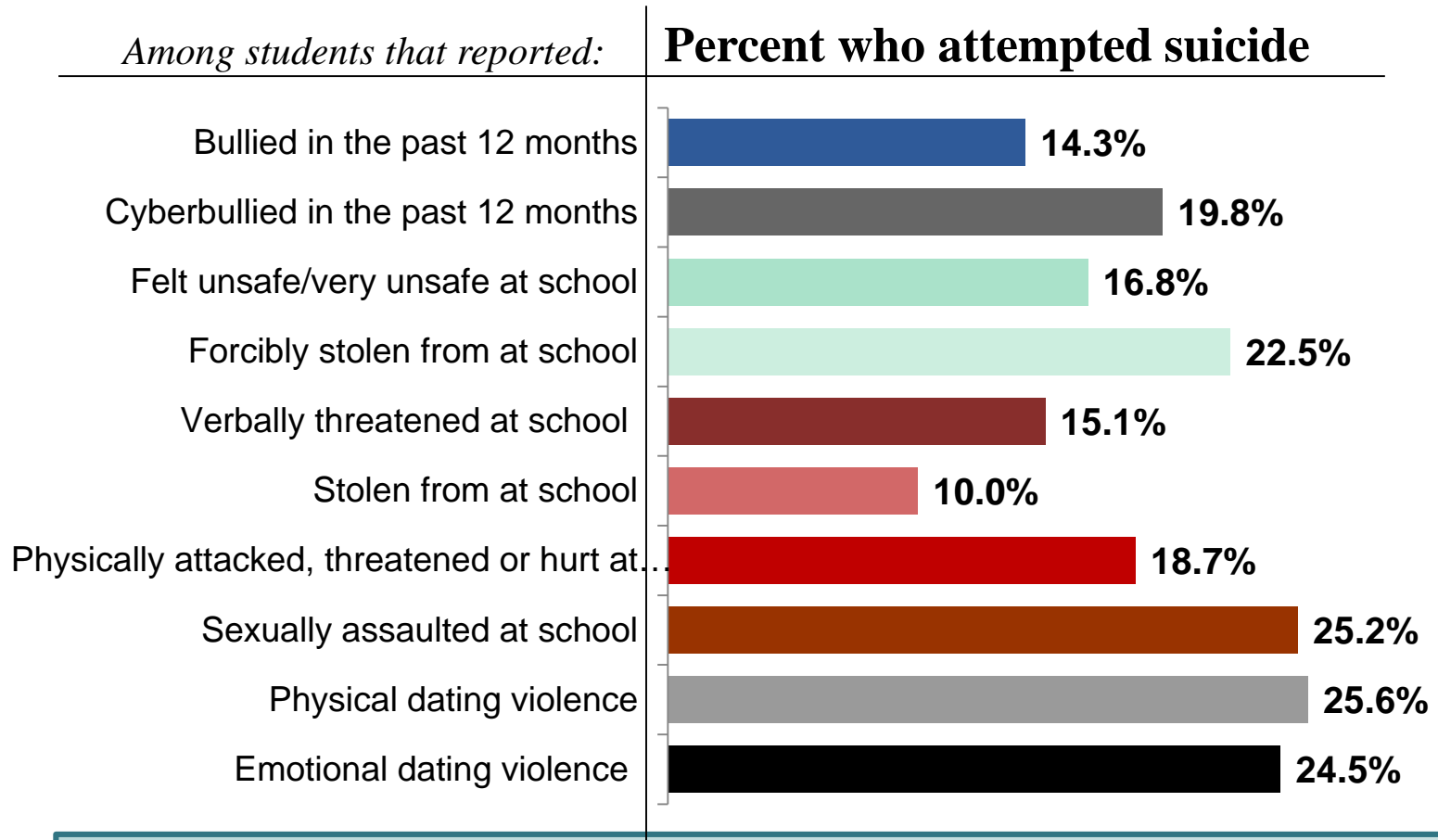
PERCENTAGE OF 10TH GRADERS, 2016

Min: 6.8% (MOUNTAIN); Max: 10.4% (PENNYROYAL)



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Risk factors: School & Social Relationships



All of the shown risk factors greatly increase one's risk of attempting suicide. Among these risk factors, students who experience dating violence (both physical and emotional), sexual assault at school, forcible theft at school, and cyberbullying have the highest rate of attempted suicide.

DATA SOURCE: KIP, 2014²

KIP 2016

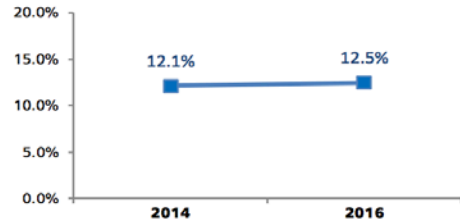
Grade 10 - Emotional Dating Violence, 2016

(% responding that they had been emotionally hurt on purpose by a boyfriend or girlfriend within the past year, including threats, threatening phone calls/texts, name-calling, online harassment)

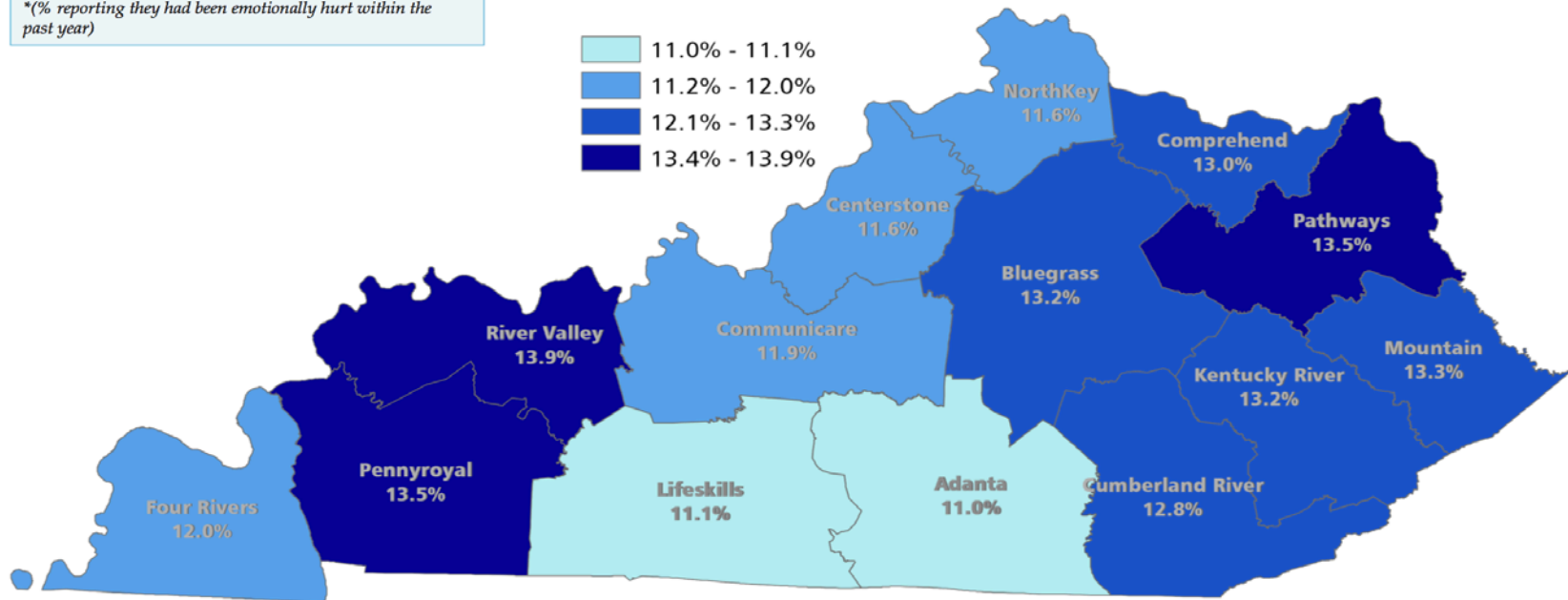
PERCENTAGE OF 10TH GRADERS, 2016

Min: 11.0% (ADANTA); Max: 13.9% (RIVER VALLEY)

Past Year Emotional Dating Violence 2014-2016
KY State Trend for 10th graders*



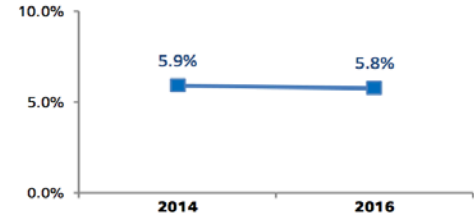
*(% reporting they had been emotionally hurt within the past year)



NON-PARTICIPATING DISTRICTS BY REGION: FOUR RIVERS (Calloway County, Murray Independent), PENNYROYAL (Dawson Springs Independent), LIFESKILLS (Bowling Green Independent, Warren County), COMMUNICARE (Meade County), CENTERSTONE (Anchorage Independent, Eminence Independent, Jefferson County), NORTHKEY (Beechwood Independent, Bellevue Independent, Kenton County, Southgate Independent,), PATHWAYS (Ashland Independent, Morgan County), MOUNTAIN (Martin County, Paintsville Independent), CUMBERLAND RIVER (East Bernstadt Independent, Laurel County), BLUEGRASS (Fayette County).

KIP 2016

Past Year Physical Dating Violence 2014-2016
 KY State Trend for 10th graders*



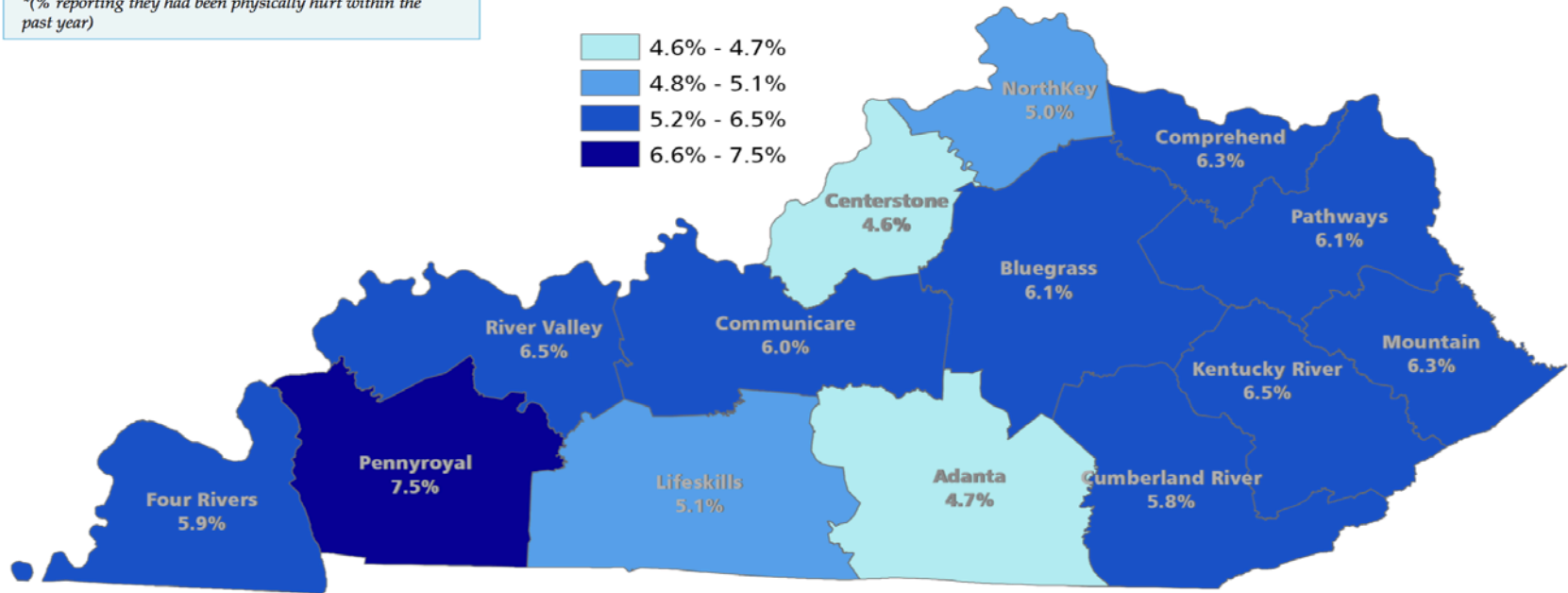
*(% reporting they had been physically hurt within the past year)

Grade 10 - Physical Dating Violence, 2016

(% responding that they had been physically hurt on purpose by a boyfriend or girlfriend within the past year, including being hit, pushed, or hair pulled)

PERCENTAGE OF 10TH GRADERS, 2016

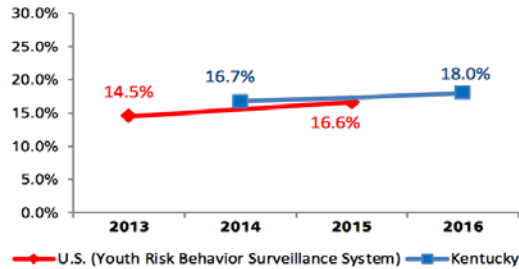
Min: 4.6% (CENTERSTONE); Max: 7.5% (PENNYROYAL)



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KIP 2016

Past Year Cyberbullying at School 2013-2016
U.S. and KY State Trends for 10th graders*



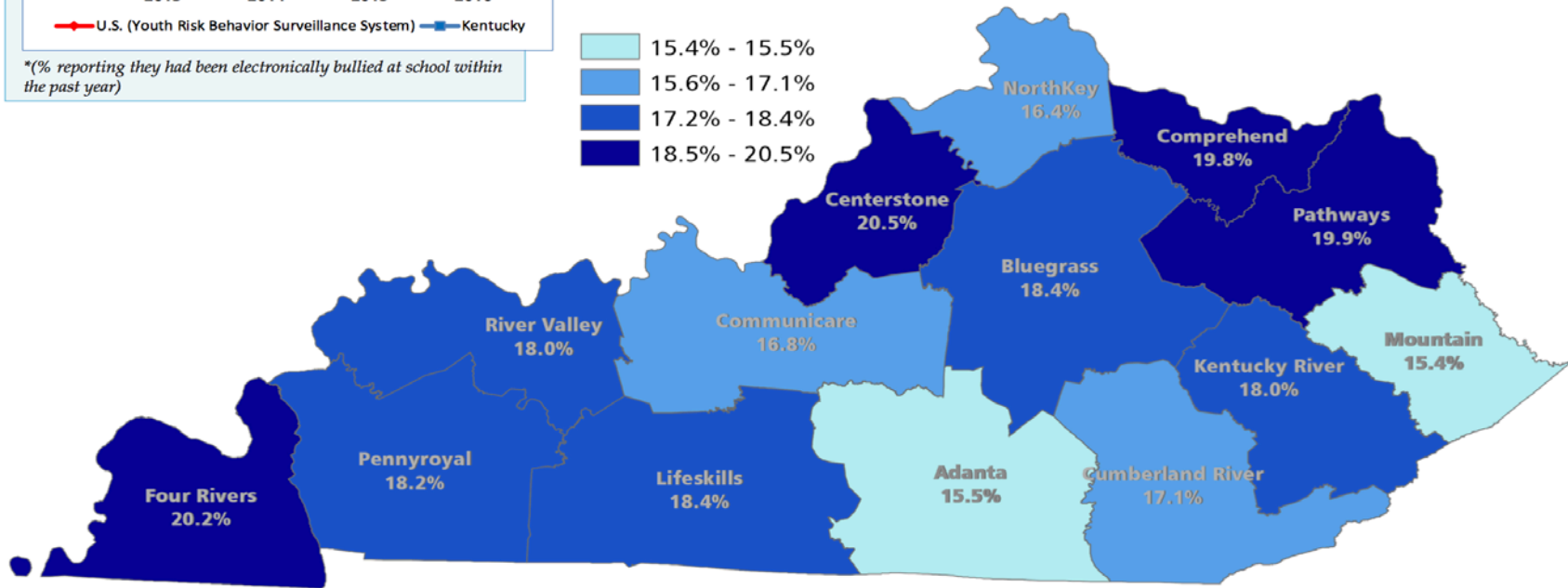
*(% reporting they had been electronically bullied at school within the past year)

Grade 10 - Cyberbullying, 2016

(% responding that they had been electronically bullied within the past year, including bullying through email, chat rooms, instant messaging, websites, social networks, or texting)

PERCENTAGE OF 10TH GRADERS, 2016

Min: 15.4% (MOUNTAIN); Max: 20.5% (CENTERSTONE)

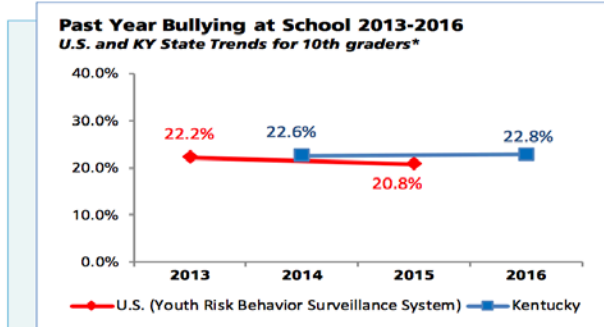


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KIP 2016

Grade 10 - Bullying at School, 2016

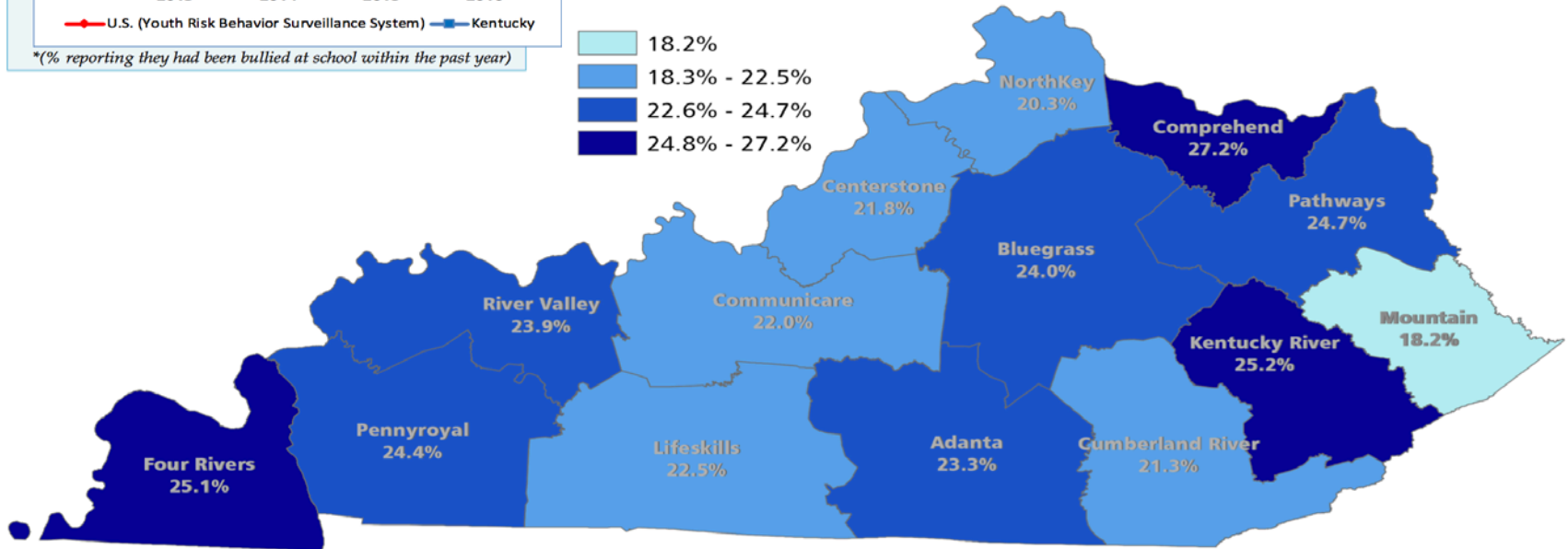
(% responding that they had been bullied on school property within the past year)



*(% reporting they had been bullied at school within the past year)

PERCENTAGE OF 10TH GRADERS, 2016

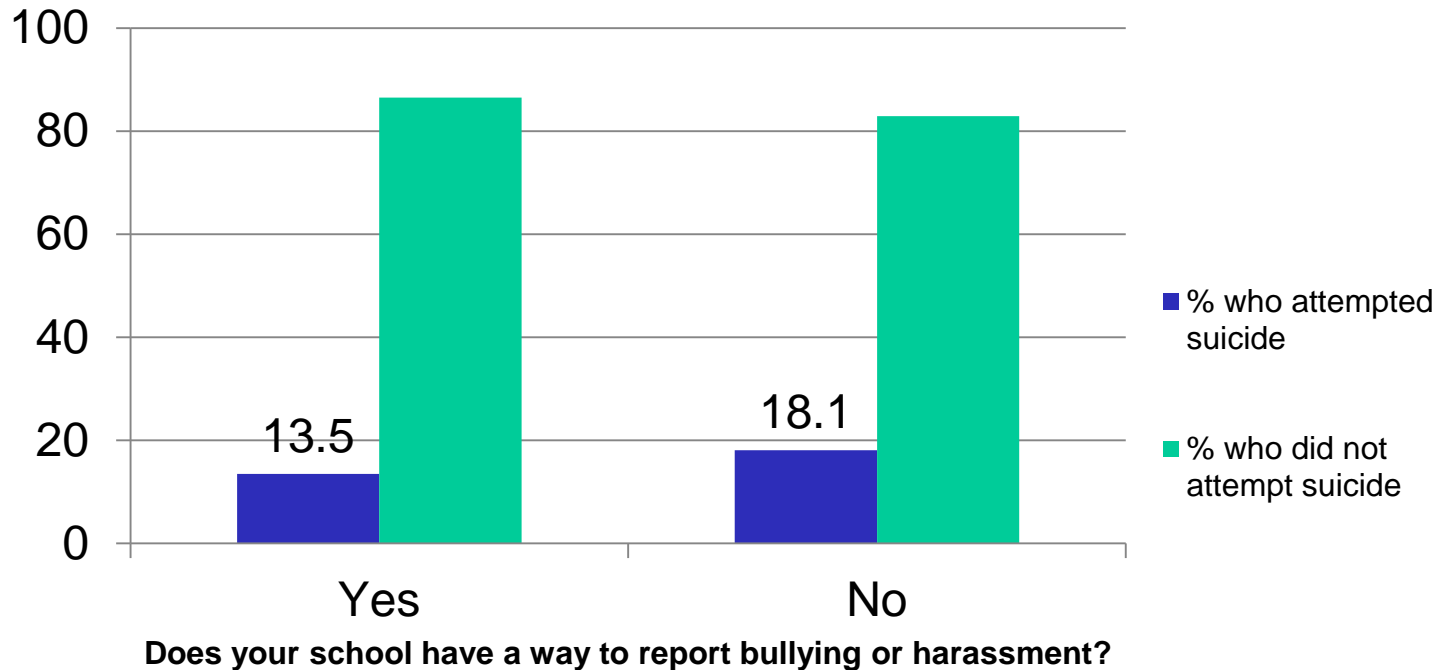
Min: 18.2% (MOUNTAIN); Max: 27.2% (COMPREHEND)



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School Bullying Policies & Suicide

Among students who were bullied...

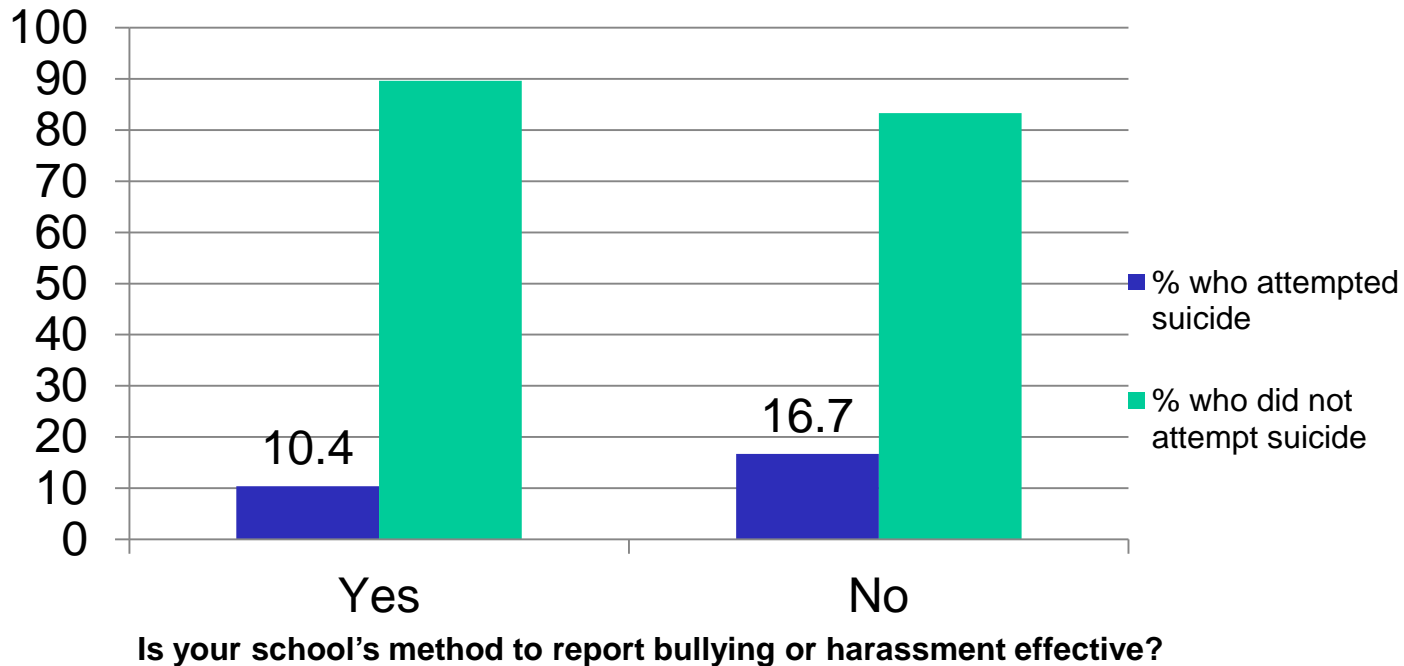


Students who were bullied and did not know of a way to report bullying or harassment at their school were significantly more likely to attempt suicide than students who were bullied and did know of a way to report bullying or harassment.

DATA SOURCE: KIP, 2014²

Bullying Policy Effectiveness & Suicide

Among students who were bullied...



Students who were bullied and felt their school's way to report bullying was ineffective were significantly more likely to attempt suicide than students who were bullied and felt their school's way to report bullying was effective.

KIP 2016

Safe at School 2004-2016
KY State Trend for 10th graders*



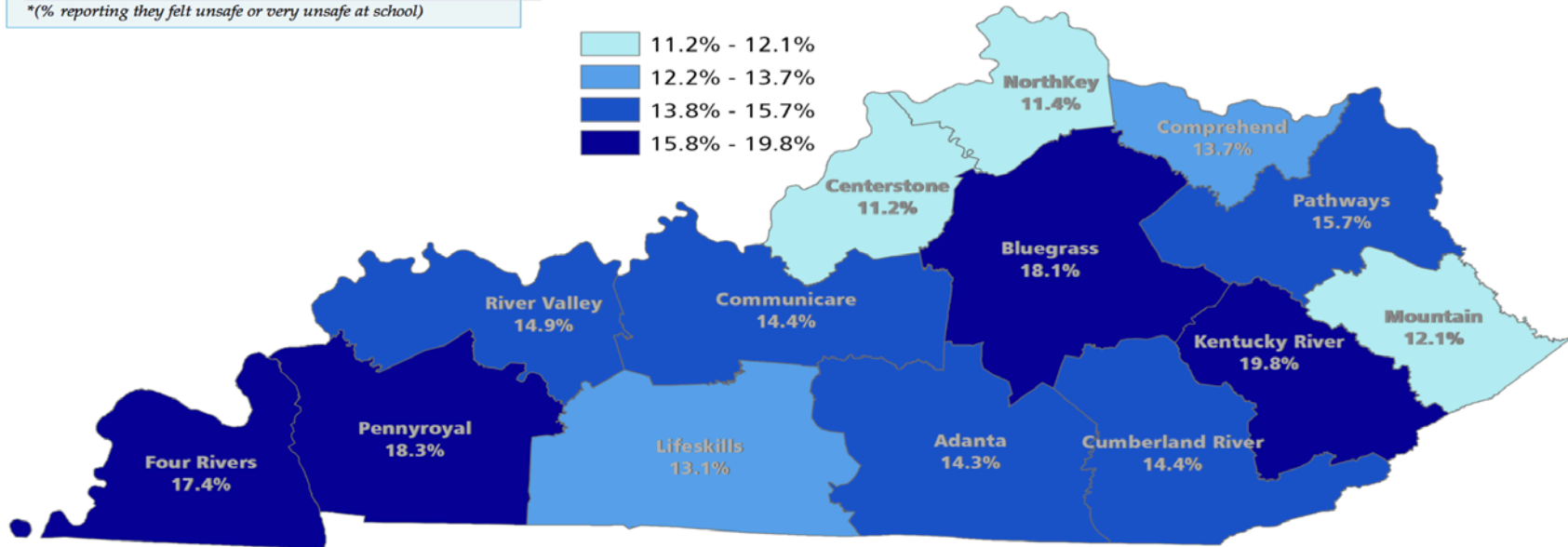
*(% reporting they felt unsafe or very unsafe at school)

Grade 10 - Safe at School, 2016

(% responding that they felt unsafe or very unsafe at school)

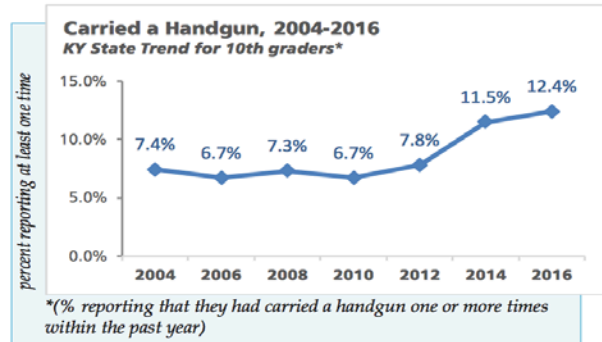
PERCENTAGE OF 10TH GRADERS, 2016

Min: 11.2% (CENTERSTONE); Max: 19.8% (KENTUCKY RIVER)



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KIP 2016

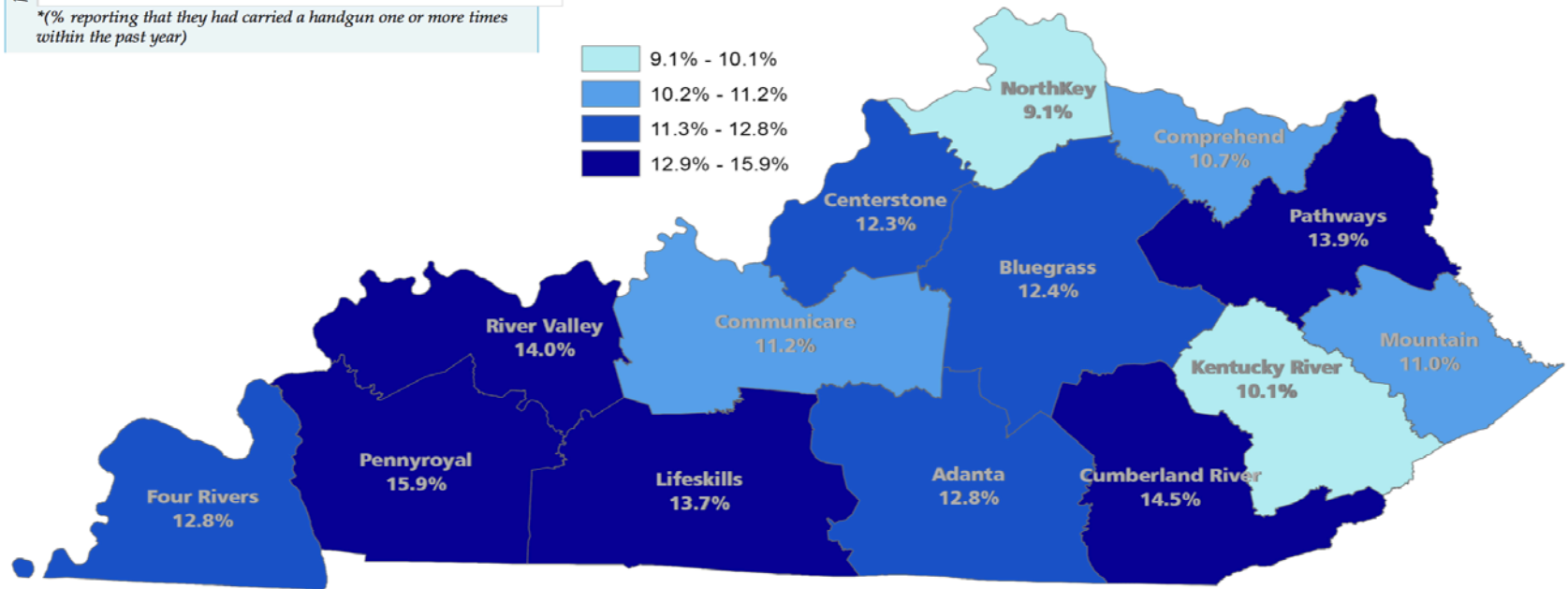


Grade 10 - Carried a Handgun, 2016

(% responding that they had carried a handgun at least one time within the past year)

PERCENTAGE OF 10TH GRADERS, 2016

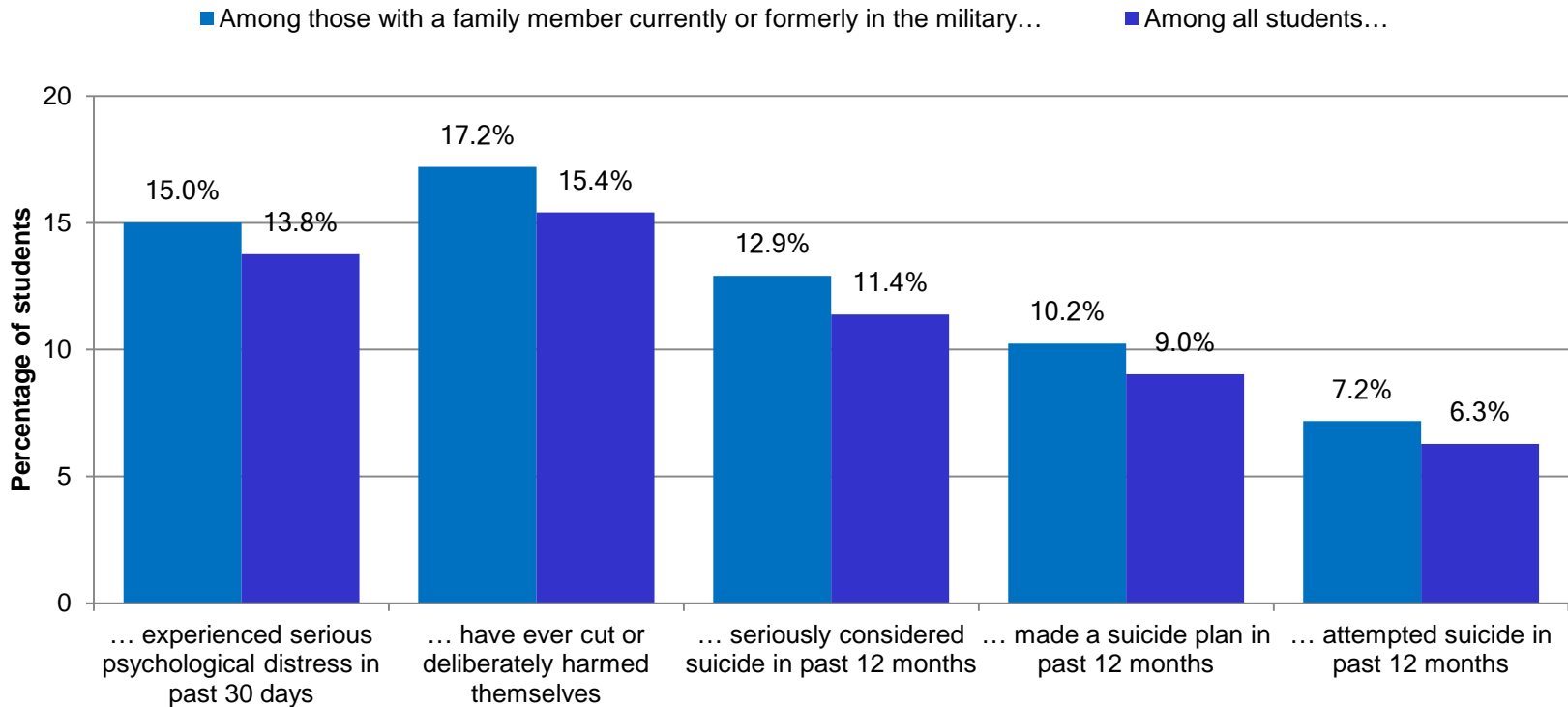
Min: 9.1% (NORTHKEY); Max: 15.9% (PENNYROYAL)



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Military families & mental health/suicidality

Serious psychological distress and suicidal behaviors among students with one or more family members/people close to them currently or formerly in the military

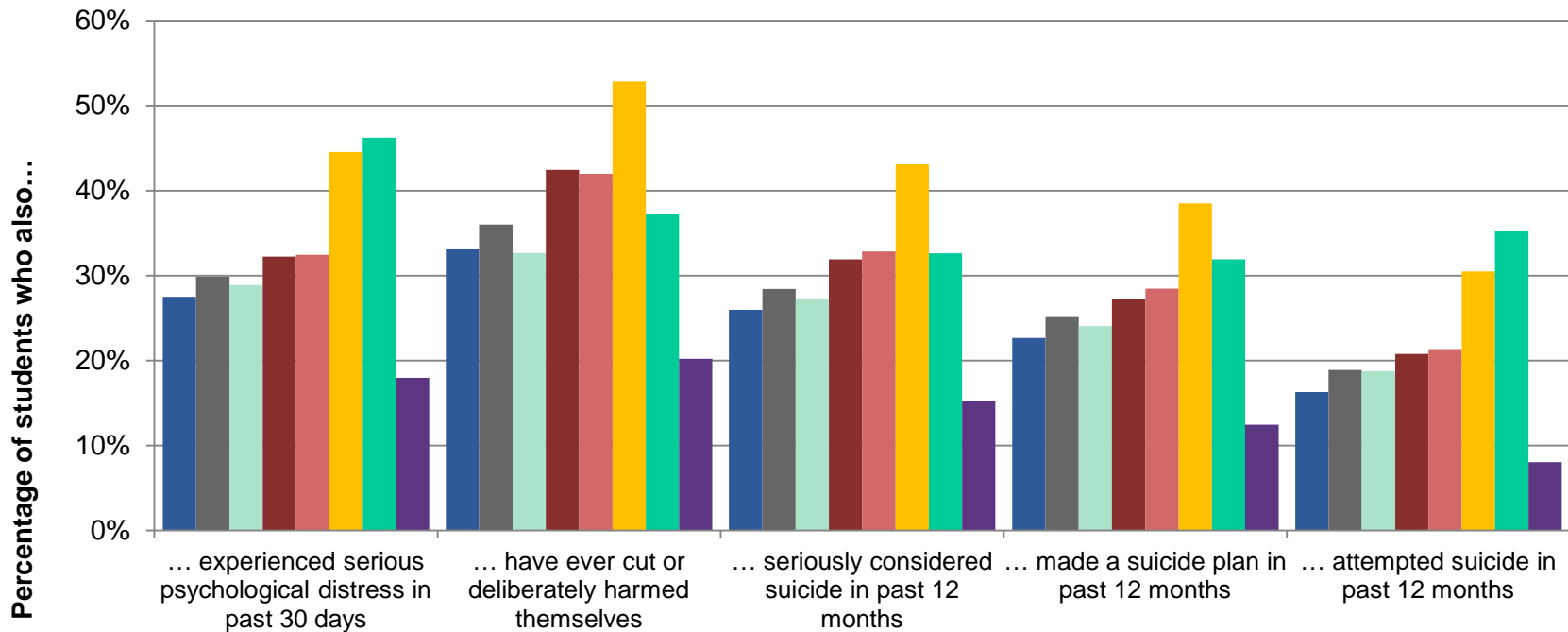


Students who have one or more family members or people close to them who have served in the military were significantly more likely to experience serious psychological distress and suicidal behaviors than students who do not have a family member or someone close to them who has served in the military.

Mental Health/Suicidality Among Students who Reported Substance Abuse

Among 10th grade students who


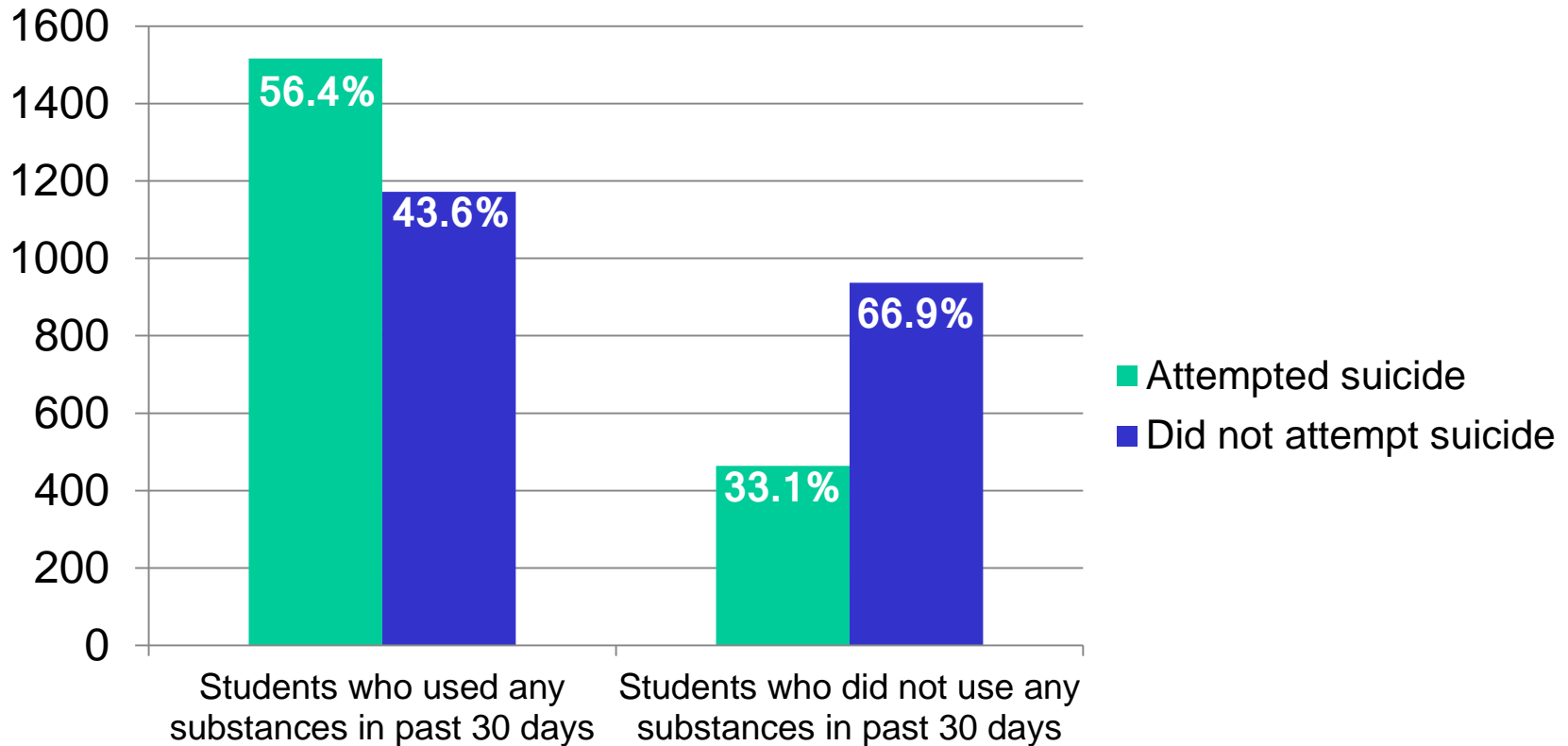
- Drinking alcohol in past 30 days
- Alcohol intoxication in past 30 days
- Binge drinking in past 30 days
- Smoking cigarettes in past 30 days
- Using marijuana in past 30 days
- Using prescription drugs without a doctor's prescription in past 30 days
- Using heroin in past 30 days
- AMONG ALL STUDENTS



Students who reported using any substance in the past 30 days were significantly more likely to experience serious psychological distress and report suicidal thoughts or behaviors than students who did not use substances. Students who used prescription drugs and heroin had the highest rates of serious psychological distress and suicidal thoughts and behaviors.

Mental Health/Suicidality Among Students who Reported Substance Abuse

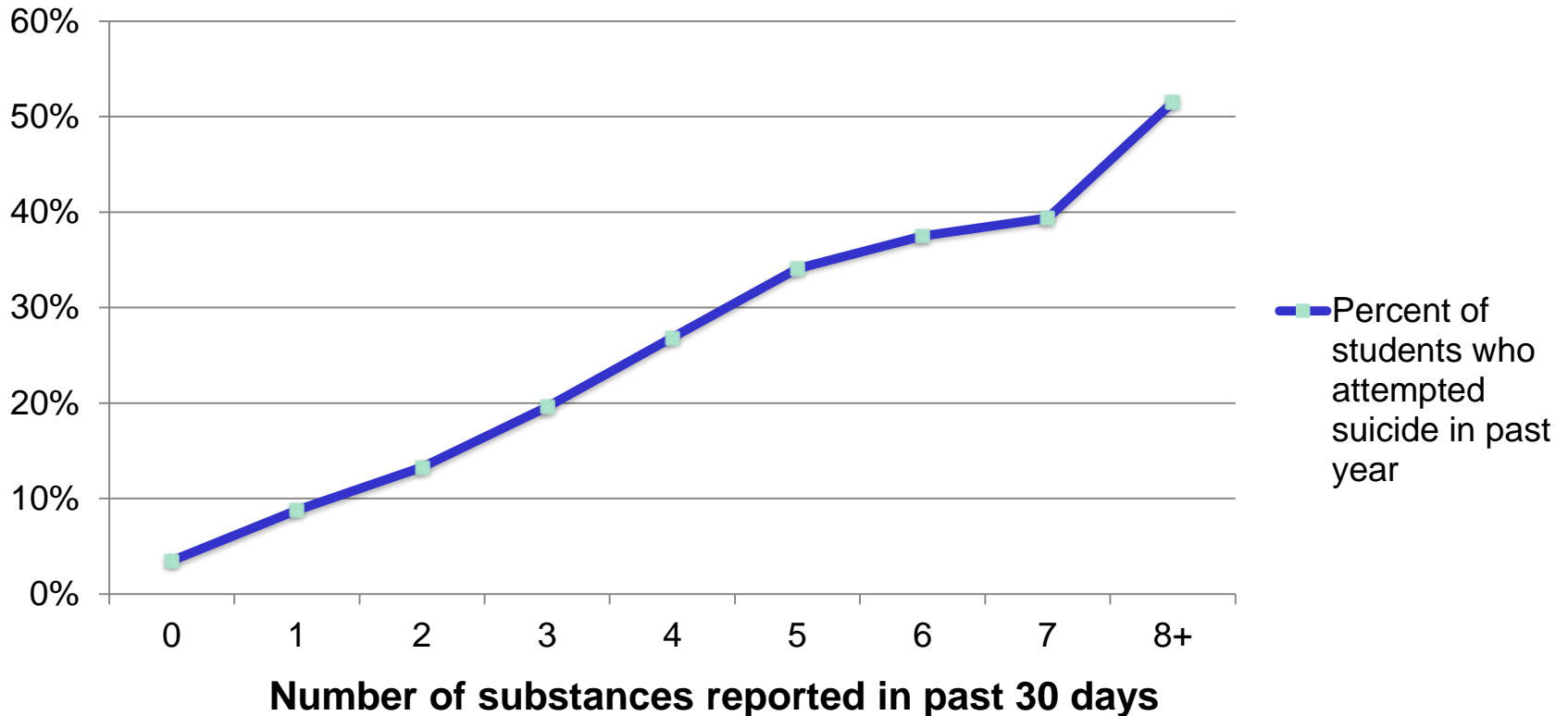
Among 10th graders who seriously considered suicide in the past year...



Students who seriously considered suicide in the past year were significantly more likely to have attempted suicide in the past year if they reported using any substance in the past 30 days.

Mental Health/Suicidality Among Students who Reported Substance Abuse

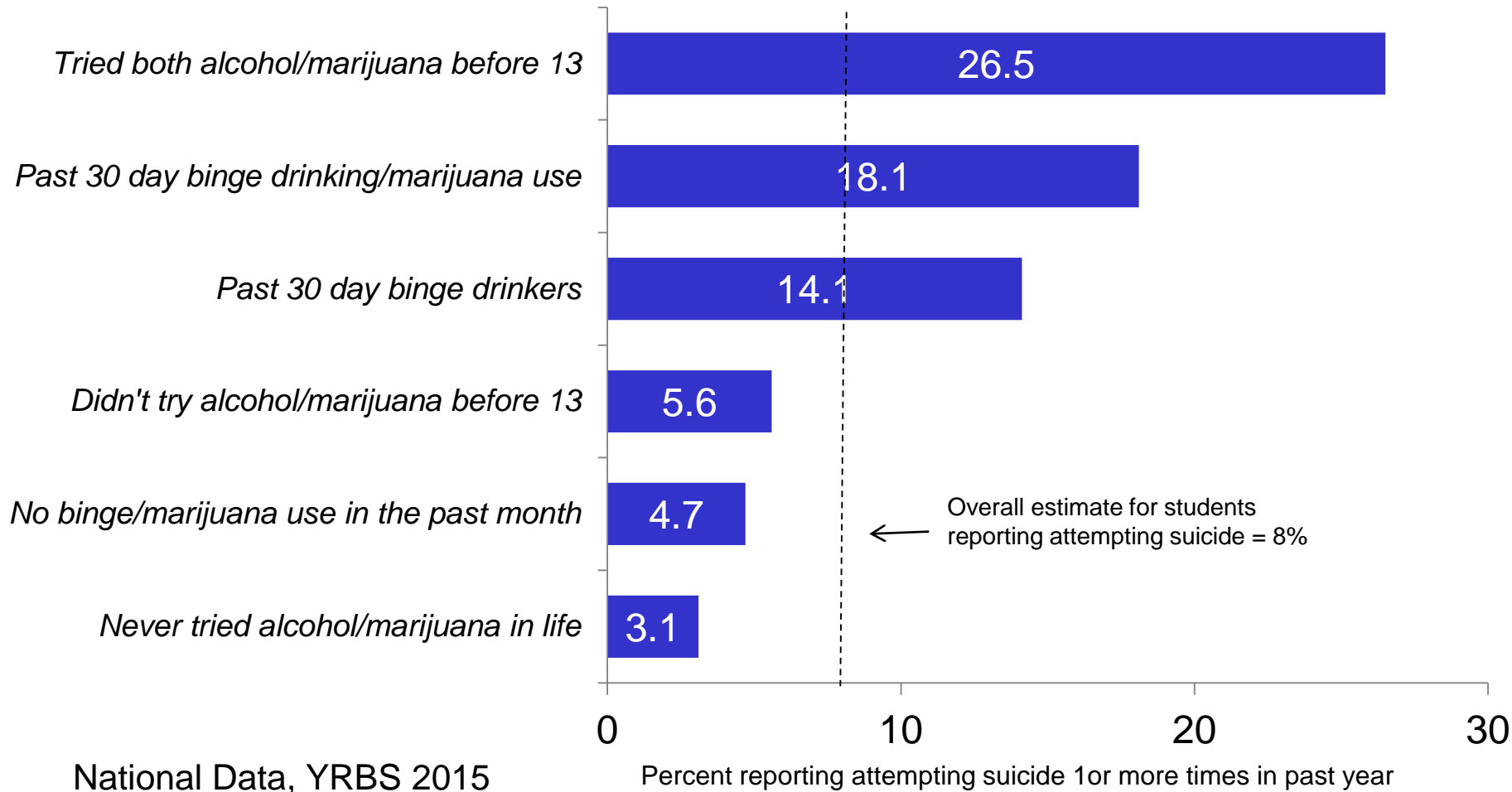
Among 10th graders...



Students who used more substances in the past 30 days were more likely to have attempted suicide in the past year than students who used no or fewer substances.

DATA SOURCE: KIP, 2014²

Past Year Suicide Attempts among High-School Students by Substance Use Patterns



Suicide Prevention



State Laws

***Suicide Prevention Education for Middle and High School Staff
Signed by Governor April 13, 2010***

<http://www.lrc.ky.gov/record/10RS/SB65.htm>

Amends KRS 158.070 to require all high school and middle school principals, guidance counselors and teachers to complete a minimum of two hours of self-study review of suicide prevention materials each school year. Also amends KRS 161.011 to permit suicide prevention training for classified employees.

** Note: although it does not designate a yearly date of completion for the mandatory training, the Kentucky Department of Education and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities recommend that staff training be completed prior to dissemination of suicide prevention materials to students.*

State Laws

***Suicide Prevention Information for Middle and High School Students
Signed by Governor March 4, 2010***

<http://www.lrc.ky.gov/record/10RS/HB51.htm>

Amends KRS 156.095 to require the Cabinet for Health and Family Services to post suicide prevention awareness and training information on its Web page by Aug. 1, 2010;

Require every public middle and high school administrator to disseminate suicide prevention awareness information to all middle and high school students by Sept. 1, 2010, and Sept. 1 of each year thereafter.

State Laws

Training requirements for social workers, marriage and family therapists, professional counselors, fee-based pastoral counselors, alcohol and drug counselors, psychologists, and occupational therapists in suicide assessment, treatment, and management.

Signed by Governor March 19, 2013.

<http://legiscan.com/KY/bill/SB72/2013>

Requires six hours of training every six years. Required training by July 1, 2016. Respective boards determine what successfully meets the training requirements.

Warning Signs of Suicide

- Talking about suicide
- Making statements about feeling hopeless, helpless, or worthless
- A deepening depression
- History of mental illness
- Preoccupation with death
- Taking unnecessary risk or exhibiting self-destructive behavior
- Engaging in non-suicidal self injury
- Being victimized by bullying
- Being a bully
- Out of character behavior, dramatic changes in behavior
- Loss of interest in the things one cares about
- Visiting or calling people in a way that hints at going away
- Making arrangements, setting one's affairs in order
- Giving prized possessions away
- Exposure to suicide

Risk Factors Specific To School-Aged Youth

- Depressed: experiences overwhelming hopelessness, irritability and sadness, even when things are going well
- Substance Use: self-medicates with substances, or engages in increasingly risky behavior while under the influence
- Borderline or schizotypal: has difficulties maintain healthy interpersonal relationships and expressing emotions in health ways

Risk Factors Specific To School-Aged Youth

- Antisocial, acting out, or conduct-disordered adolescent: rejects social sanctioned notions of health, well-being and pro-social activities
- Marginal, isolated loner: disconnected from peers, parents or associates mostly with other marginalized youth
- Rigid perfectionist; experiences any type of failure whether it is defined by self or others

Risk Factors Specific To School-Aged Youth

- Psychotic: experiences delusions or hallucinations, or lives in fear of decompensation
- In-crisis: lives in a state of perpetual stress-related overwhelm; responds in impulsive and irrational ways; unable to engage in creative productive problem solving

Additional Populations At Risk & Risk Factors

- LGBTQ – 2-3 times higher than heterosexual peers
- Learning disabilities
- Sleep deprivation – found as issue in suicide contagion areas
- Non Suicidal Self Injury – strong predictor
- Depression
- Precipitating event (romantic breakup, argument with friends)
- History of trauma and abuse

Kentucky's Unique Cultural Context



7th highest
in the nation for
**DRUG OVERDOSE
DEATHS AMONG
12-TO 25-YEAR
OLDS**



3rd highest
in the nation for
**SMOKING RATE
AMONG HIGH
SCHOOL
STUDENTS**



27th lowest
in the nation for
EDUCATION



4th highest
in the nation for
**DISABILITY
AMONG 15-20 YEAR
OLDS**



2nd highest
in the nation for
**CHILDREN IN
POVERTY**



35th lowest
in the nation for
**OVERALL CHILD
WELL-BEING**



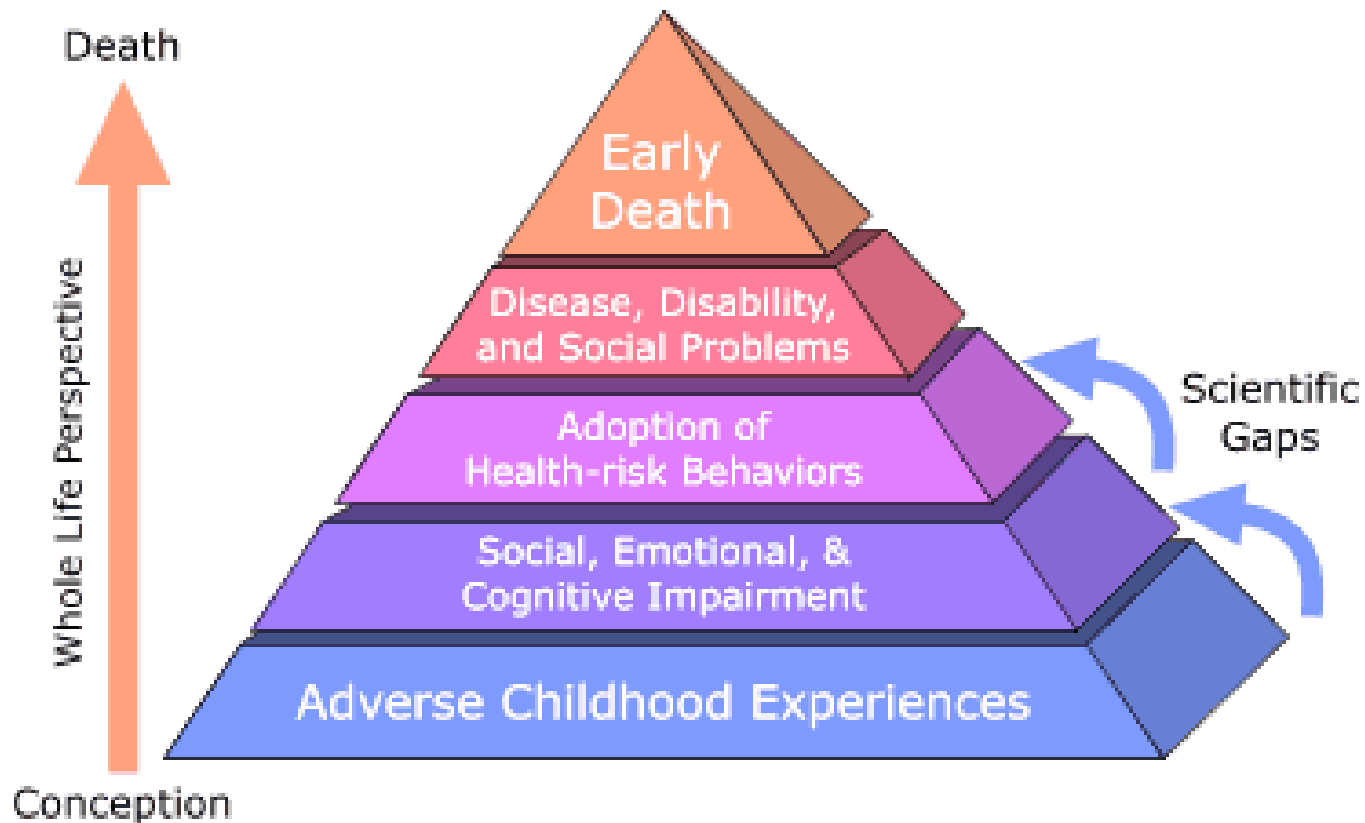
38th lowest
in the nation for
**ECONOMIC
WELL-BEING**



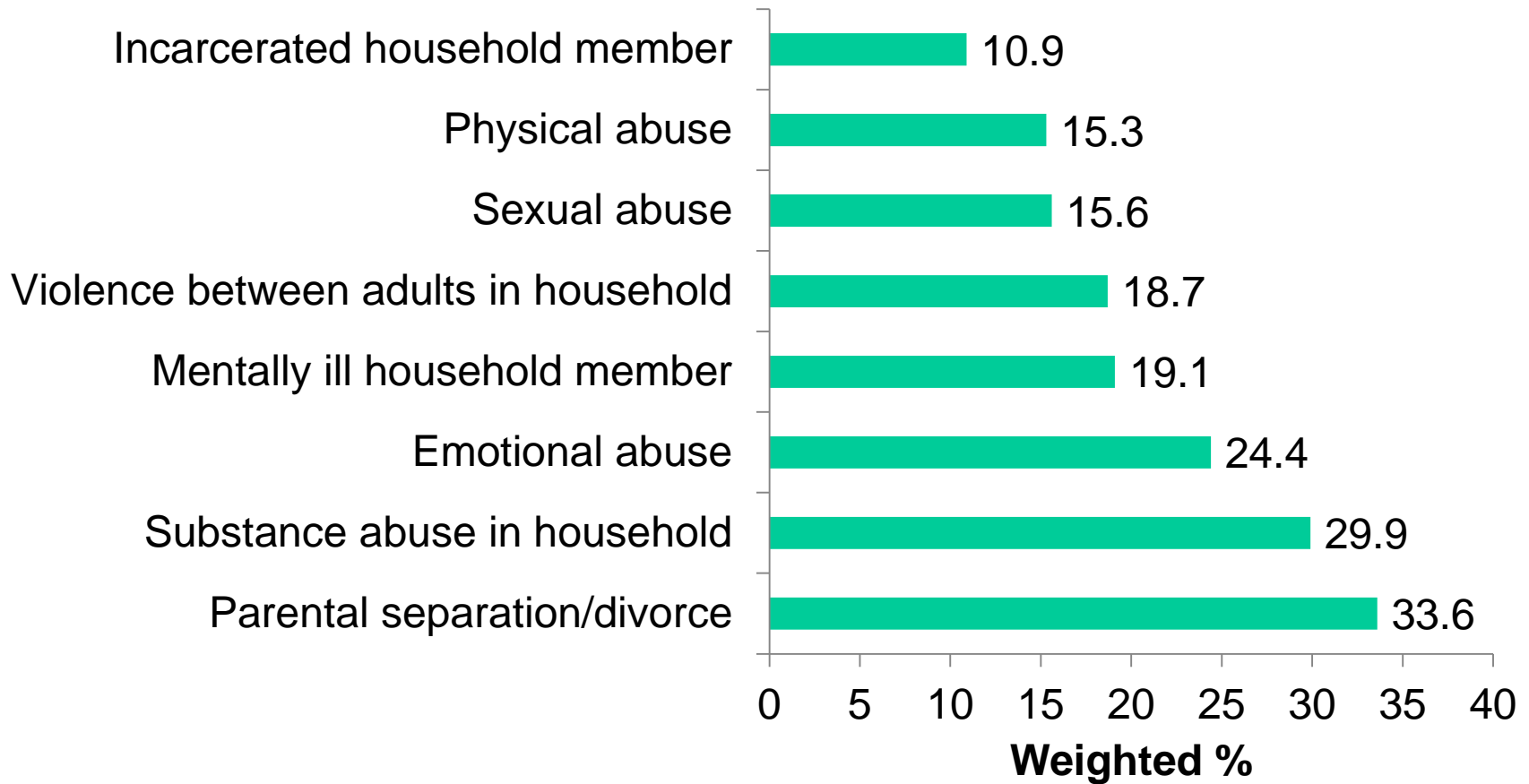
37th lowest
in the nation for
**FAMILY AND
COMMUNITY**

ACEs in Kentucky

- % of Adults with at least 1 ACE = 59%
- % of adults with 4 or more ACEs = 17%



ACEs Among Kentucky Adults



2015 KyBRFS

ACEs and KY Kids

- 30% of KY children with ACE \geq 2 (22.6% nationally)
- 1:5 KY children experience \geq 2 ACES by age 5 (1:8 nationally)
- KY children with ACE scores \geq 3, one of the highest rates in the country



2014 Kids Count

ACE's and Impact on Education

	Academic Failure	Severe Attendance Problems	Severe School Behavior Concerns	Frequent Reported Poor Health
Three of more ACEs N=248	3	5	6	4
Two ACEs N=213	2.5	2.5	4	2.5
One ACE N=476	1.5	2	2.5	2.0
No Known ACEs N=1,164	1	1	1	1

Higher ACE Scores in Youth =

- Early initiation of smoking cigarettes
- Alcohol use and abuse
- Use of illicit drugs
- Intercourse by 15
- Teen pregnancy
- Teen paternity
- Impaired performance
- Increased suicide risk

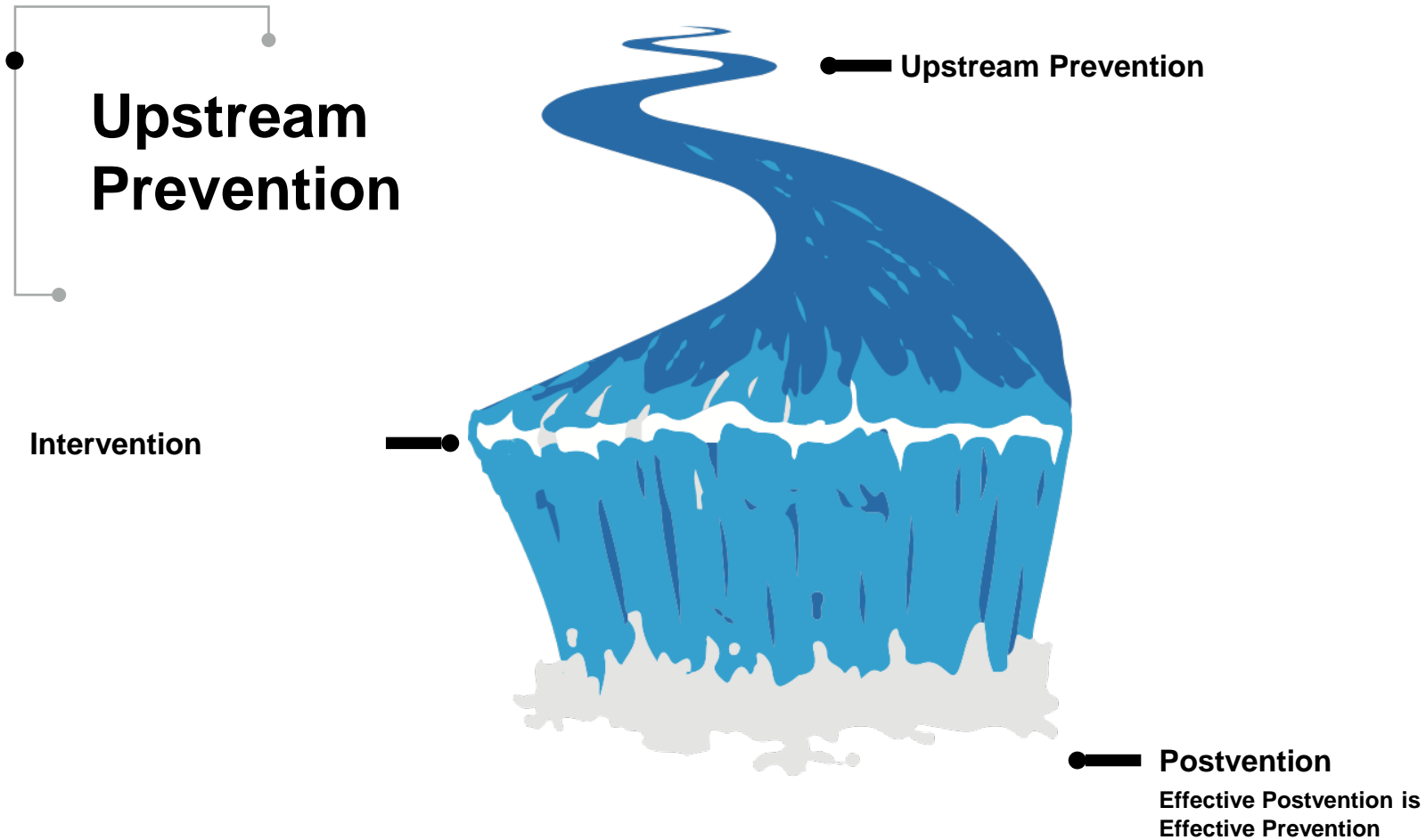
So Why is That Important?

- **Exposure to violence/trauma is the single most prevalent risk factor for children today.**
- Adversity is necessary for life and learning; toxic stress disrupts life and learning.
- **Relationships are necessary for resilience.**
- The lifelong toll of unaddressed Adverse Childhood Experiences is a [perhaps THE] major cause of death and disability in adults.
- **Knowing what we know, we can do better in preventing, mitigating, and treating toxic stress.**

Protective Factors for Suicide Prevention

- Family cohesion and stability
- Coping and problem solving skills
- Positive self-worth and impulse control
- Positive connections to school and extracurricular participation
- Successful academically
- Good relationships with other youth
- Seeks adult help when needed
- Lack of access to suicidal means
- Access to mental health care
- Religiosity
- School environment that supports help seeking and promotes health
- Early detection and intervention

Prevention/Intervention/Postvention



Prevention Best Practices

- All staff trained to identify students at risk
- All staff understand policies and procedures to refer a student to care
- All students participate in an evidence-based suicide prevention program (Sources of Strength, Lifelines, Signs of Suicide) implemented with fidelity
- Screening process established
- Intervention plan is in place before it is needed

Intervention Best Practices

- Assessment of students screened and identified to be at risk
- Evaluation by trained behavioral health clinicians
- Parental contact
- Referral
- Follow

EIRF

- **E**arly **I**dentification – don't wait to identify those kids at risk. The earlier you get them help, the better
- **R**eferral – know the process and resources with whom you will connect students before you need them. Put agreements in place for data sharing
- **F**ollow up – research shows that following up on an at-risk student when they return to school reduces risk by 50%

Early Identification...

- Helps maintain a safe and secure school environment
- Promotes the behavioral health of students, enhancing academic performance
- Helps schools avoid liability related to suicide attempts by students

2-8

Early Identification, Referral, & Follow-Up Form (EIRF)

Name of person completing form: _____
School/Agency: _____
Title: _____
Phone: _____ Email: _____

Referral Information

Date of Identification: □□ - □□ - □□□□

Youth ID: (Non-Identifying, Coded Student Number) 410-□□□□□□
First Initial, Last 3 of Student #, Last Initial

Source of information (Check ALL that apply): (Note: This is generally the person filling out form).
 Case record or data system review
 Directly from a provider (i.e., case manager, clinician, mental health professional, etc...)
 Directly from a gatekeeper (i.e., not a mental health provider) (*Use for Guidance Counselors)
 Other (Please describe): _____

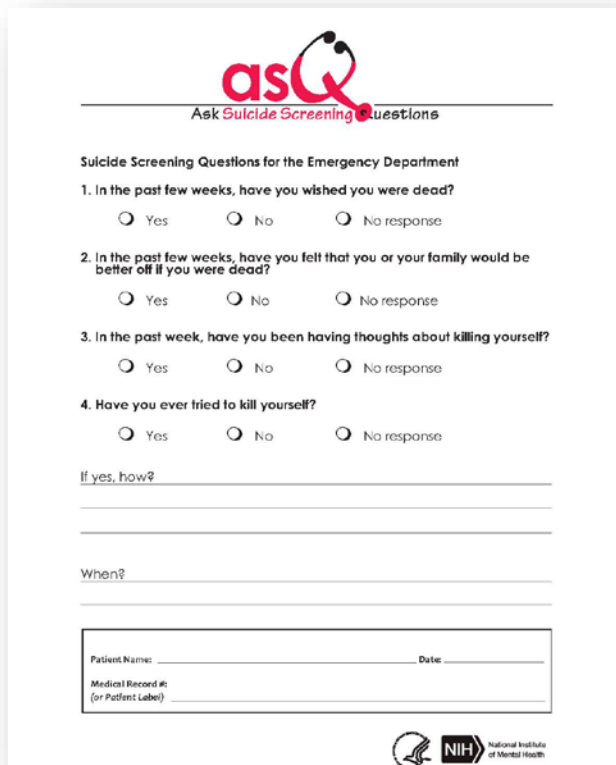
Where was youth identified as at risk (Check ONE):
 School
 Child Welfare
 Community-based organization, recreation, or after school activity
 Mental Health Agency
 Emergency Room
 Juvenile Justice
 Law Enforcement
 Physical Health
 Home
 Other (Please describe): _____

How was youth identified as at risk (Check ONE):
 Screening (no matter who conducted the screening and only youth at risk at the conclusion of the entire screening process)
 Parent/Foster Parent/Caregiver
 Community Based Organization, recreation, or after school activity
 Probation officer or other Juvenile Justice staff
 Emergency Room Staff
 Peer
 Mental Health Service Provider
 Teacher or other school staff
 Child welfare staff
 Primary Care provider (i.e., pediatrician)
 Police Officer or other law enforcement staff
 Other (Please describe): _____

Please Continue to Part I

Screening Tools

- ASQ – 4 questions, takes about 2 minutes



asq
Ask Suicide Screening Questions


Suicide Screening Questions for the Emergency Department

- In the past few weeks, have you wished you were dead?
 Yes No No response
- In the past few weeks, have you felt that you or your family would be better off if you were dead?
 Yes No No response
- In the past week, have you been having thoughts about killing yourself?
 Yes No No response
- Have you ever tried to kill yourself?
 Yes No No response

If yes, how?

When?

Patient Name: _____ Date: _____
 Medical Record #: _____
 (or Patient Label)



- CSSR-S – 6 questions

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
	YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it." <u>Have you been thinking about how you might do this?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <u>If YES, ask: Were any of these in the past 3 months?</u>		

Low Risk
 Moderate Risk
 High Risk

Postvention Best Practices

- Develop school protocols to deal with student or staff death (suicide or other)
- Access community resources
- Know your school's planned response – before you need to use it; make sure your staff do too
- Know who you will tell, when you will tell them and how you will tell them

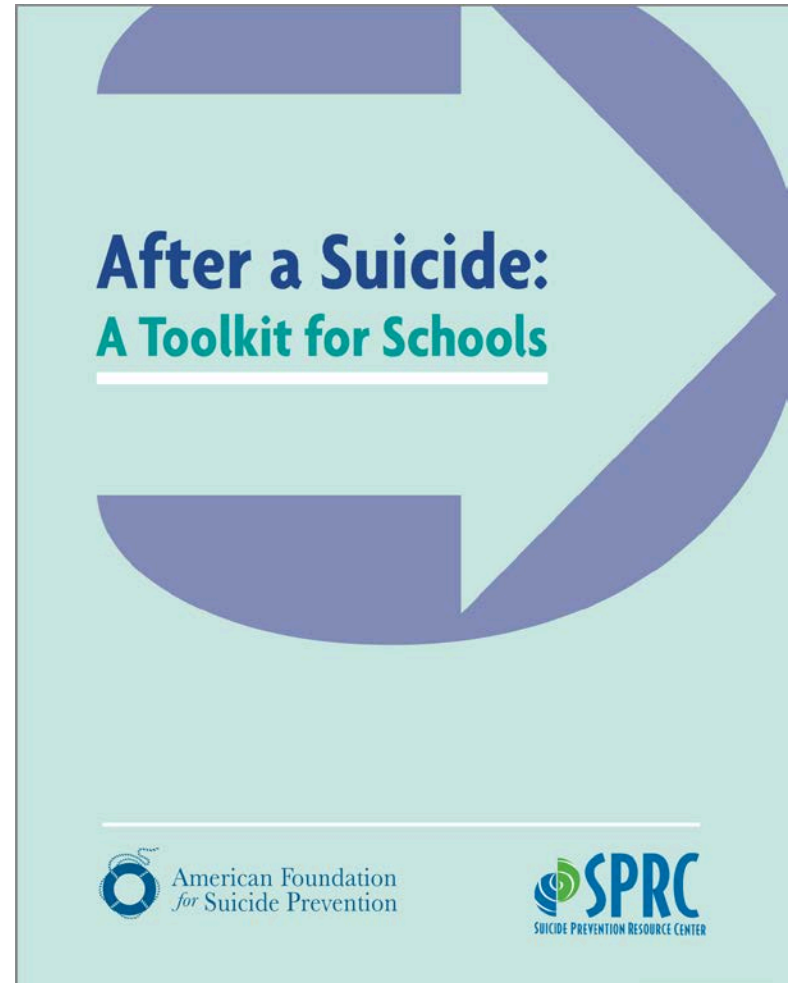
Postvention Best Practices

- Don't talk about specifics, especially with youth
- Identify vulnerable students and connect them to resources immediately
- All connections matter
- The crisis isn't over after the funeral – consider long-term response (no memorials, dealing with anniversaries, etc.)

Postvention Best Practices

- Review and update protocols on a yearly basis
- Update staff on protocols on a yearly basis

<http://www.sprc.org/sites/default/files/migrate/library/AfteraSuicideToolkitforSchools.pdf>



Put This Number in Your Cell

NATIONAL

SUICIDE

PREVENTION

LIFELINE

1-800-273-TALK (8255)

suicidepreventionlifeline.org

Contact Info

Patti M. Clark

Program Administrator

Kentucky Department for Behavioral Health Development
and Intellectual Disabilities

Patti.clark@ky.gov