Pre-teen Suicide Risk and the Need for Upstream Prevention

Texas Suicide Prevention Symposium

John Ackerman, PhD
Center for Suicide Prevention & Research
Nationwide Children's Hospital

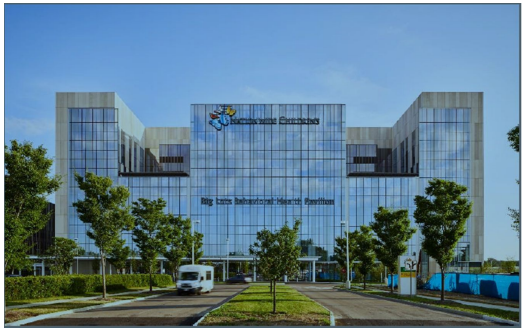
NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.

Presentation Objectives

1. Identify trends in pre-teen suicide including risk factors and ways that suicidal thoughts and behaviors are expressed in young children versus older teens.
2. Review emerging evidence for upstream suicide prevention highlighting barriers, opportunities, and key considerations when working with young children.
3. Discuss promising strategies to identify, treat, and prevent preteen suicidal thoughts and behaviors.

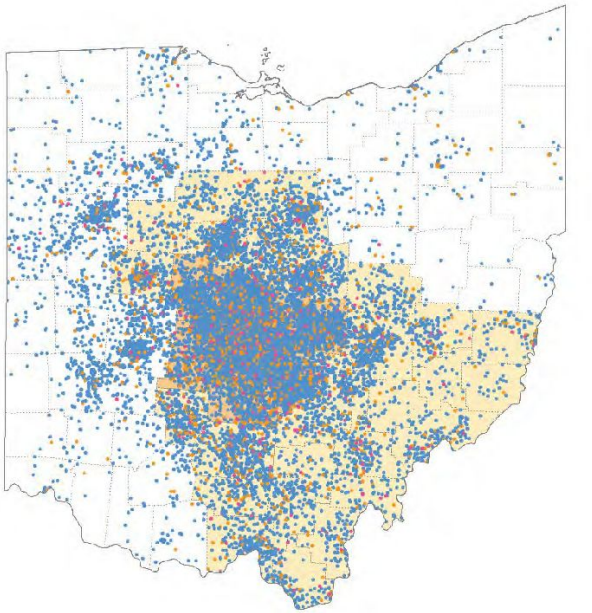
Nationwide Children's Hospital (Columbus, OH)

- Largest behavioral health department in a pediatric hospital setting in the US
- Broad continuum of outpatient, inpatient, & prevention services
- Increasing acuity (+466% in ED visits for BH problems since 2005)
- Nearly 40k patients in 2021
- >265k patient visits in 2021



NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.

Nationwide Children's Hospital



- Behavioral Health Services referrals draw from a large portions of central and southeastern Ohio
- Prevention services and hospital-community partnerships are critical
- This is true with youth suicide prevention as well

Center for Suicide Prevention & Research

- Provide consultation and training on suicide prevention, assessment, intervention & postvention
- Provide suicide prevention trainings and education to youth and the adults who support them
- Reduce stigma and build awareness of mental health issues
- Identify and cultivate natural supports and coping strategies of young people and their families
- ***"We engage each community member to understand their role in preventing suicide"***

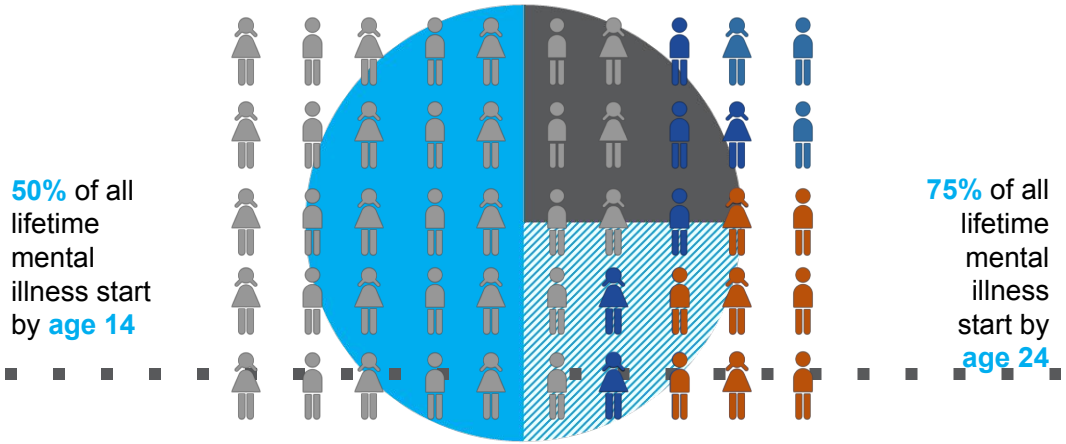
Setting the Stage

Burden of Mental Illness on Children

11% of children (ages 8 to 11) have or have had a mental illness with severe impairment

22% of teens (ages 13 to 18) have had a mental illness with severe impairment in their lifetime

Only 50% of youth with a mental health disorder receive any behavioral health treatment



Source: National Health & Nutrition Examination Survey , 2010; National Comorbidity Survey Replication-Adolescent Supplement, 2010; NIMH, Mental Illness Exacts Heavy Toll: Beginning in Youth, 2005

NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.

Surgeon General's Advisory: Protecting Youth Mental Health

"Mental health challenges in children, adolescents and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression and thoughts of suicide — and rates have increased over the past decade. The COVID-19 pandemic further altered their experiences at home, school and in the community, and the effect on their mental health has been devastating. The future well-being of our country depends on how we support and invest in the next generation."

— Vivek H. Murthy, MD, MBA, Surgeon General of the United States

Noted examples of collective stressors on children since March of 2020 include:

Pandemic-related social isolation

Difficulties with remote learning

Fears about the virus

Exposure to news coverage of racial injustice and a divided political landscape

Socioeconomic pressure on families

The Impact of COVID-19

- Symptoms of anxiety, depression, and other mental health concerns have increased
- Approx. 140,000 US children lost a parent or grandparent caregiver as of June 2021
- Increased risk for MH symptoms:
  - Youth with intellectual and developmental disabilities
  - Racial and ethnic minority youth
  - LGBTQ+ youth
  - Youth in rural communities
  - Youth in immigrant households
  - Youth involved with justice, foster care, and/or child welfare systems
  - Youth experiencing homelessness

Source: Protecting Youth Mental Health: The U.S. Surgeon General's Advisory, 2021. Retrieved 12/7/2021, from Youth Mental Health Reports and Publications | HHS.gov

RISK FACTORS CONTRIBUTING TO YOUTH MENTAL HEALTH SYMPTOMS DURING THE PANDEMIC *Note: Not a comprehensive list of risk factors*

Having **mental health challenges** before the pandemic[61, 64]

Living in an **urban area** or an **area with more severe COVID-19 outbreaks**[65]

Having parents or caregivers who were **frontline workers**[66]

Having parents or caregivers at elevated risk of **burnout** (for example, due to parenting demands)[67, 68]

Being **worried about COVID-19**[64]

Experiencing **disruptions in routine**, such as not seeing friends or going to school in person[69, 70, 71]

Experiencing more **adverse childhood experiences (ACEs)** such as abuse, neglect, community violence, and discrimination[72, 73, 74]

Experiencing more **financial instability, food shortages, or housing instability**[75, 76]

Experiencing **trauma**, such as losing a family member or caregiver to COVID-19[77]

Covid-19 impacted family systems

Six in 10

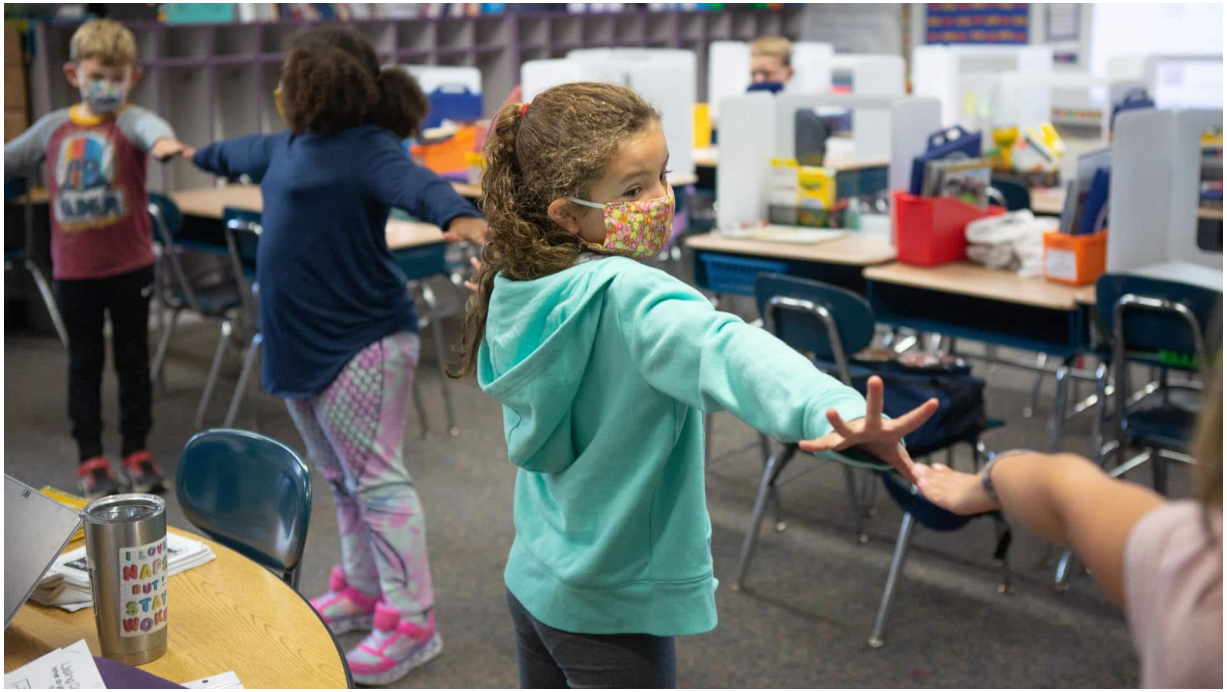
working parents reported being **"very" to "extremely" concerned about their child's emotional health and development or behavior in the past two years.**

The Great Collide: An *On Our Sleeves®* Study on the Impact of Children's Mental Health on America's Workforce

The Impact of COVID-19

- Increases in distress are common in disasters but most youth cope well and do not go on to develop mental health disorders
- Several measures of distress returned to pre-pandemic levels by mid-2020
- Some young people thrived during the pandemic
  - Increased sleep
  - More quality time with family
  - Less academic stress and bullying
  - Flexible schedules
  - Improved coping

Developmental Considerations



Cognitive and Behavioral Differences

- Differences in impulse control, emotion regulation, distress tolerance, perspective-taking, and other executive functions
- Less sophisticated language and self-talk
- Reduced understanding of abstract concepts (e.g., death)
  - term “killing oneself” is often understood; “suicide” less so
  - Many youth understand death is final but young children may believe dead people can still have experiences
- Increased suggestibility
- Difficulty understanding risk-related outcomes
- Less self-directed use of coping skills

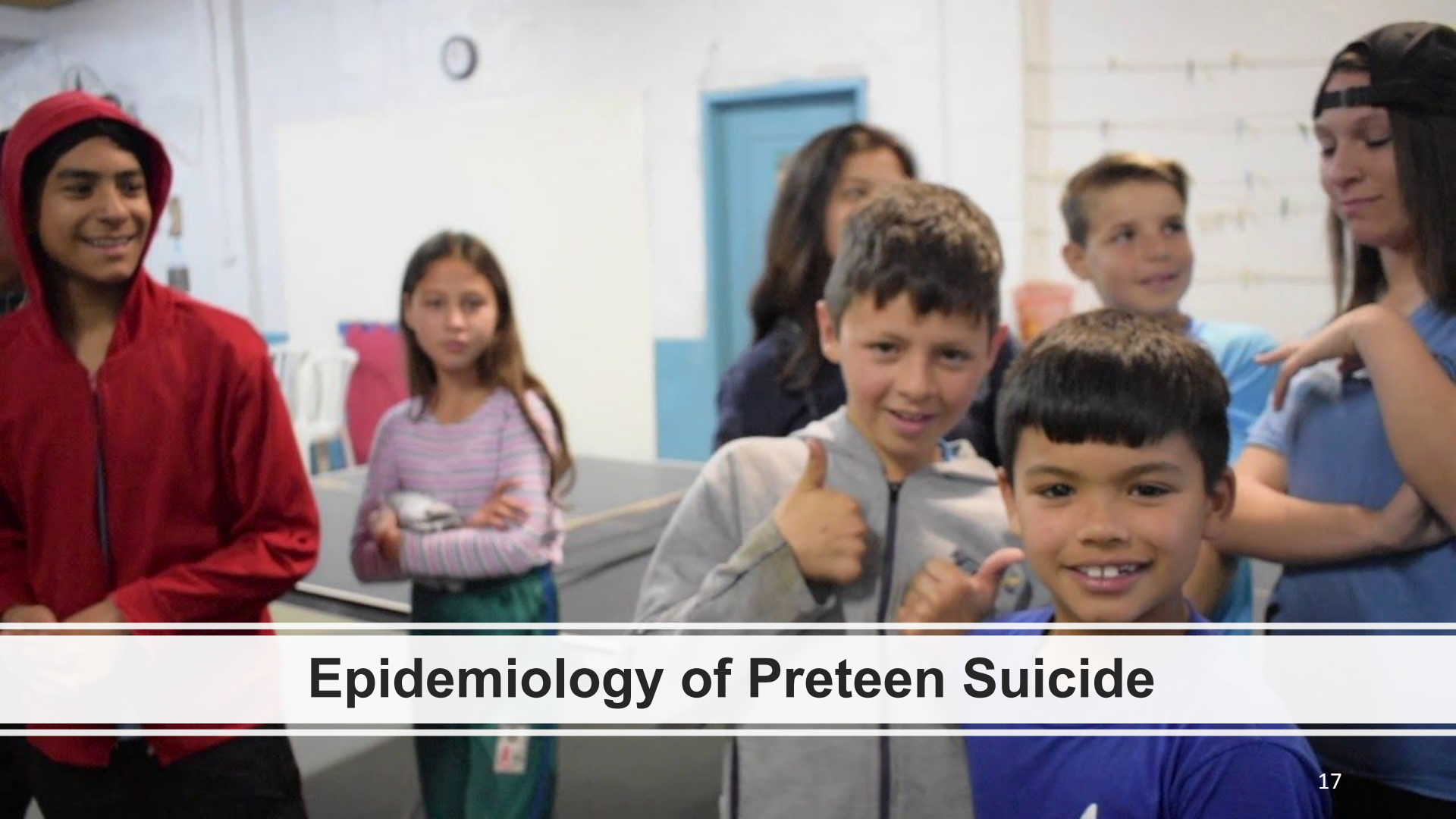
Family/Home Context

- Younger children are more influenced by relationships in the immediate family which has **+/-** implications
  - Perceived parental support and monitoring
  - Family conflict and exposure to violence
  - Early adverse experiences (e.g., sexual abuse, physical abuse)
  - Family psychiatric history and family history of suicide

- Accessibility of lethal means & acquired capacity to harm self

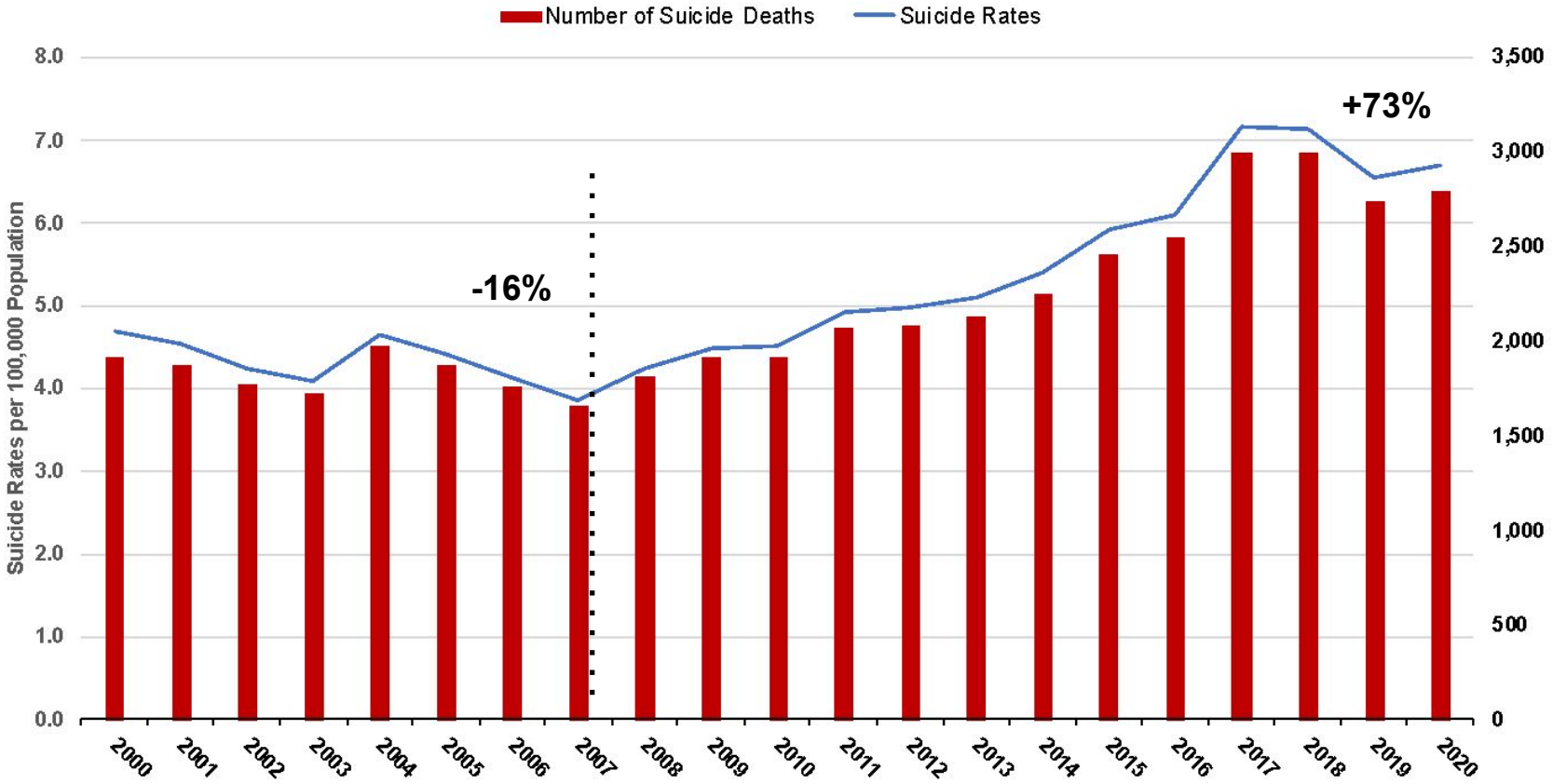
Peer Influences

- Relationships become more youth driven over time
- Social norms shift
- Social status and comparison
- Social media availability
- Bullying and cyberbullying
- Co-rumination and behavior modeling increase
- Contagion

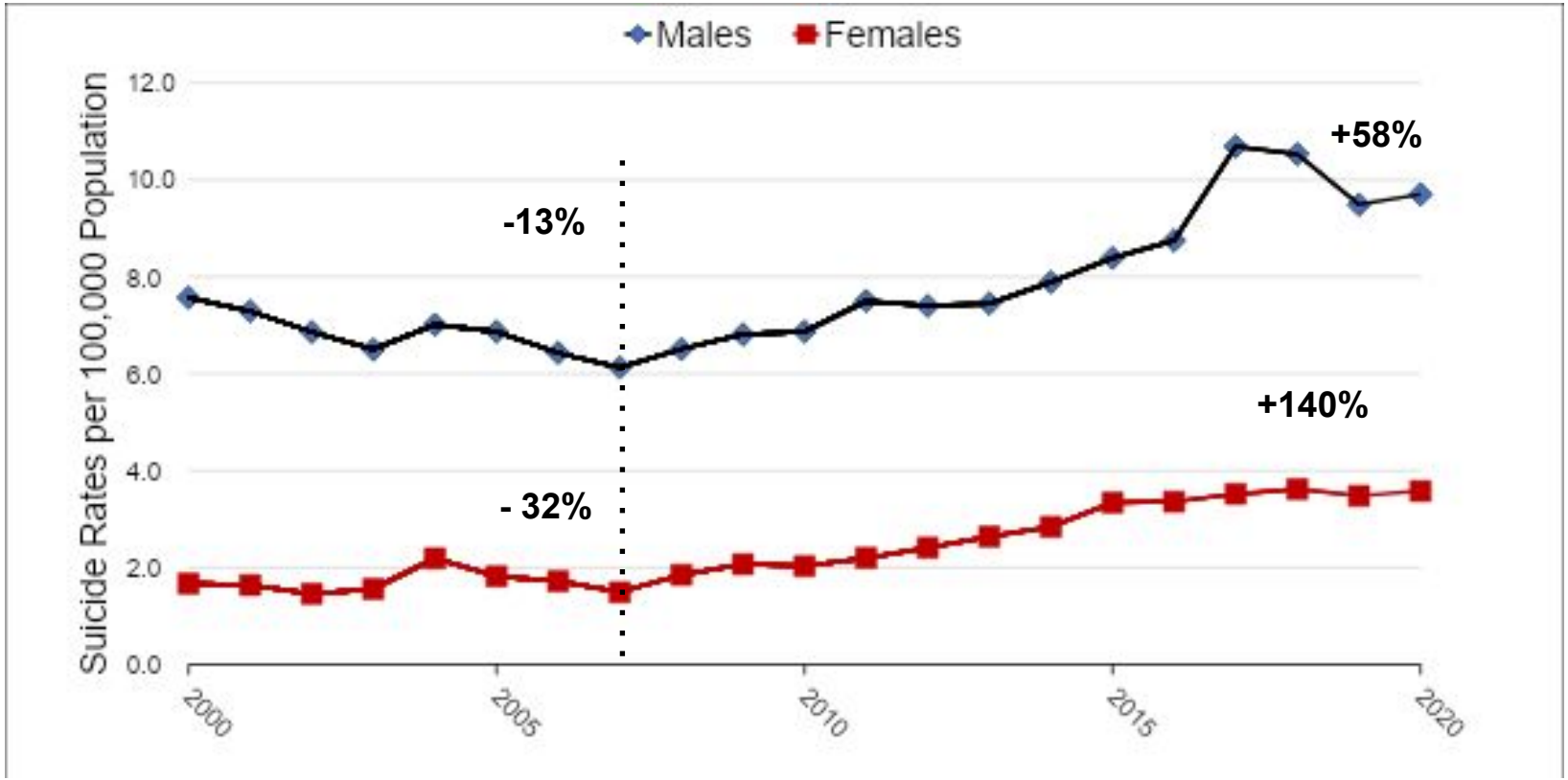


Epidemiology of Preteen Suicide

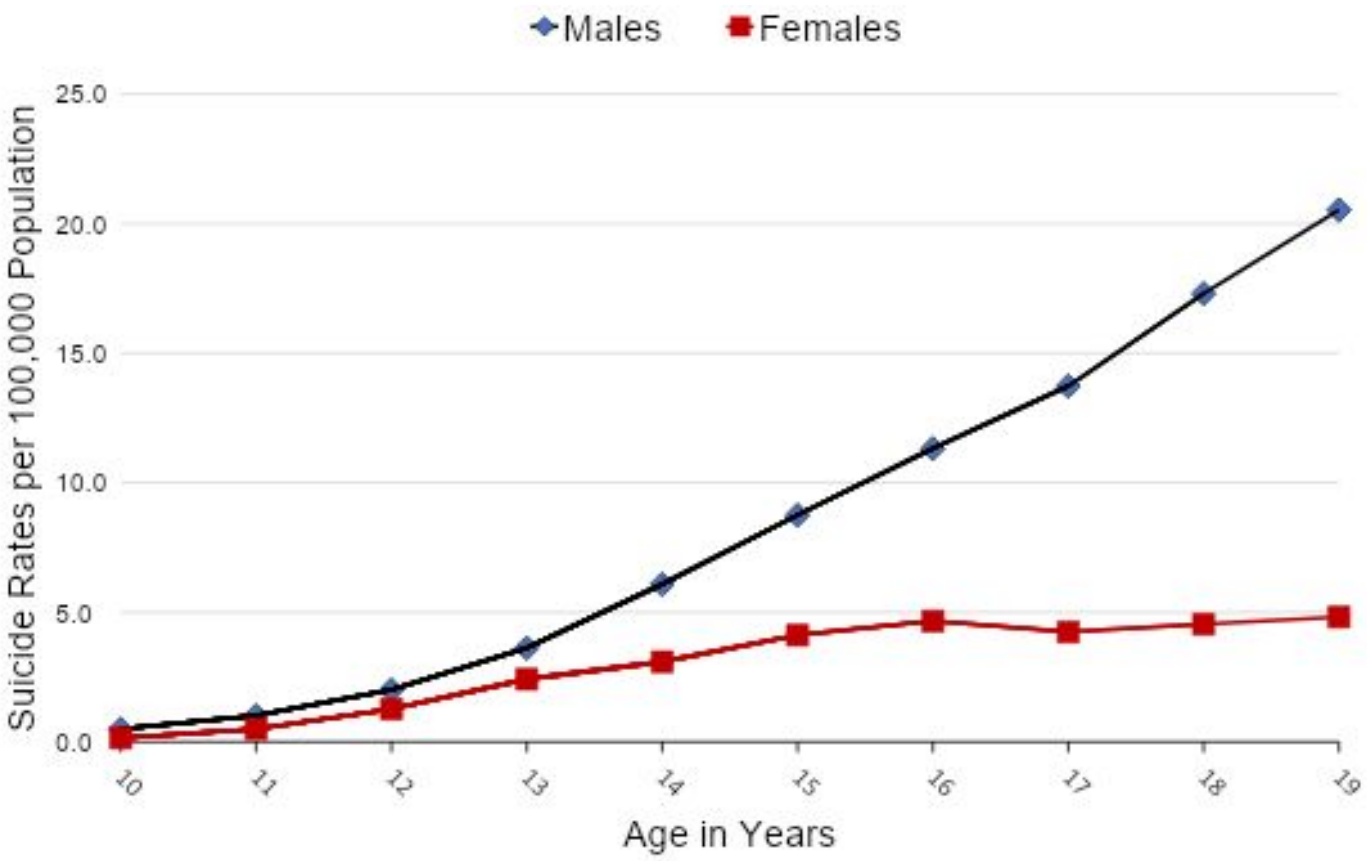
U.S. Youth Suicide Rate: Ages 10-19 Years, 2000 to 2020



U.S. Youth Suicide Rate: Ages 10-19 Years, 2000 to 2020



U.S. Youth Suicide Rate: Ages 10-19 Years, 2000 to 2020



Leading Causes of Death, Age 5-12 years

2009

Rank	Age Groups 5-12
1	Unintentional Injury 1,253
2	Malignant Neoplasms 713
3	Congenital Anomalies 285
4	Homicide 197
5	Influenza & Pneumonia 172
6	Heart Disease 152
7	Chronic Low. Respiratory Disease
8	Suicide 82
9	Neoplasms 69
10	Septicemia 60

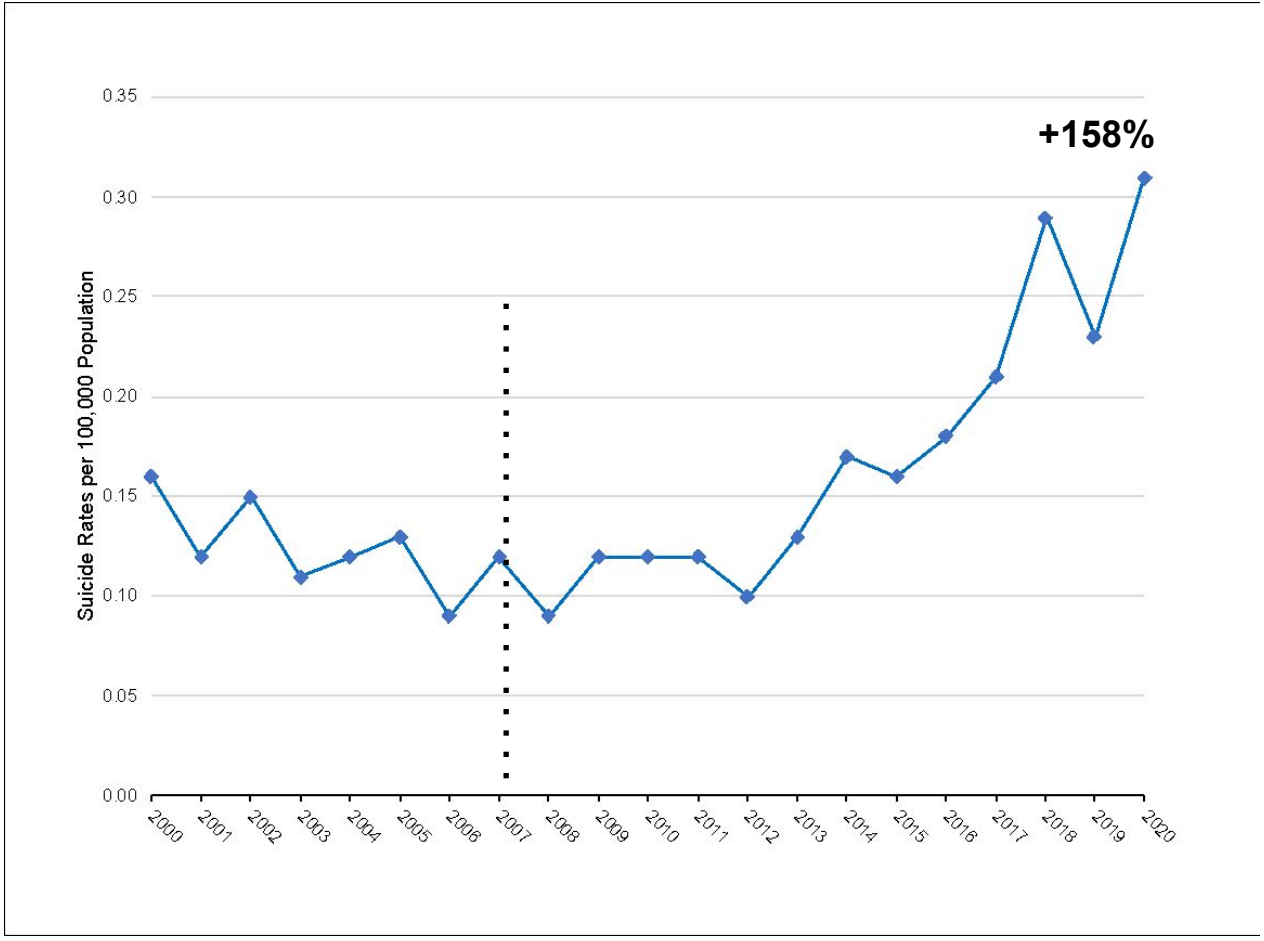
2014

Rank	Age Groups 5-12
1	Unintentional Injury 1,099
2	Malignant Neoplasms 662
3	Congenital Anomalies 286
4	Homicide 185
5	Heart Disease
6	Suicide 117
7	Respiratory Disease 113
8	Influenza & Pneumonia 78
9	Cerebro-vascular 66
10	Benign Neoplasms 58

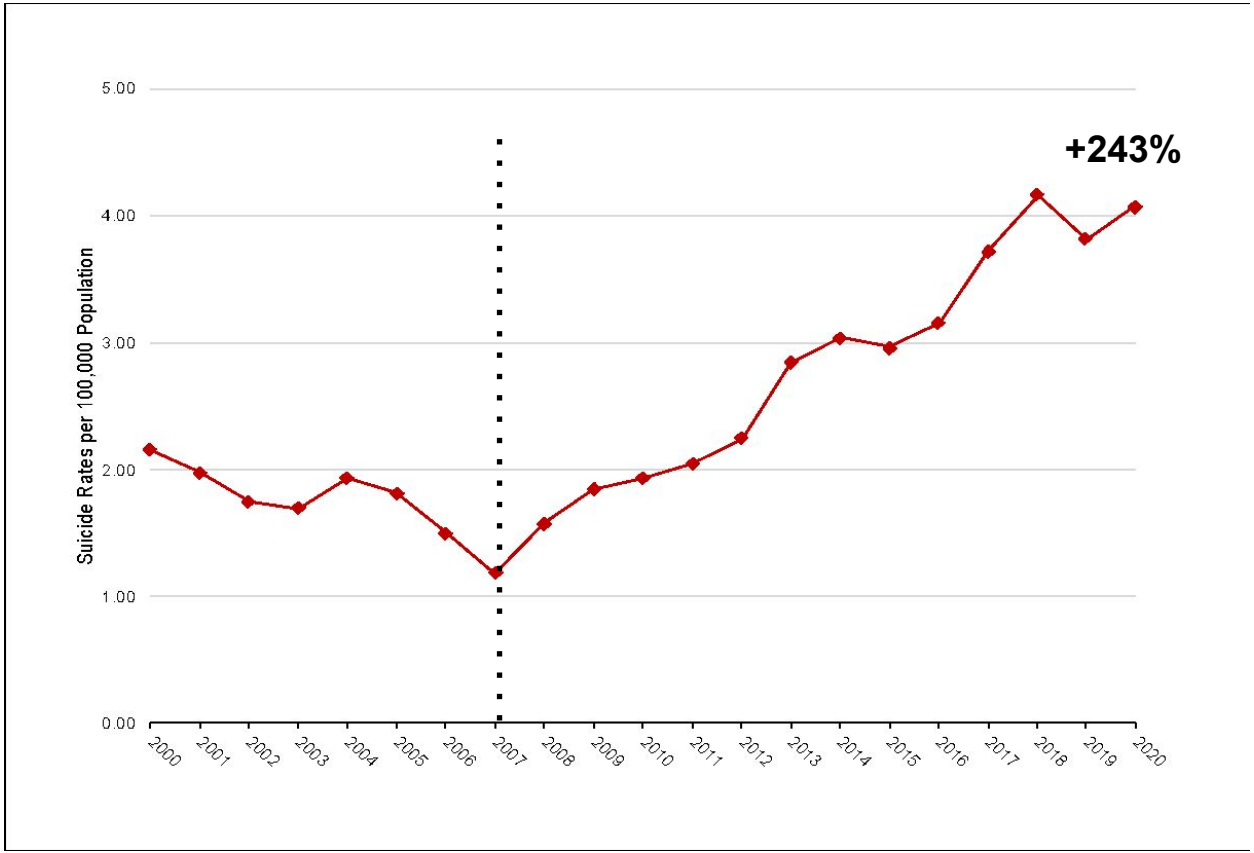
2019

Rank	Age Groups 5-12
1	Unintentional Injury 1,113
2	Malignant Neoplasms 611
3	Congenital Anomalies 309
4	Homicide
5	Suicide 164
6	Disease 135
7	Chronic Low. Respiratory Disease 122
8	Influenza & Pneumonia 96
9	Cerebro-vascular 62
10	Benign Neoplasms 52

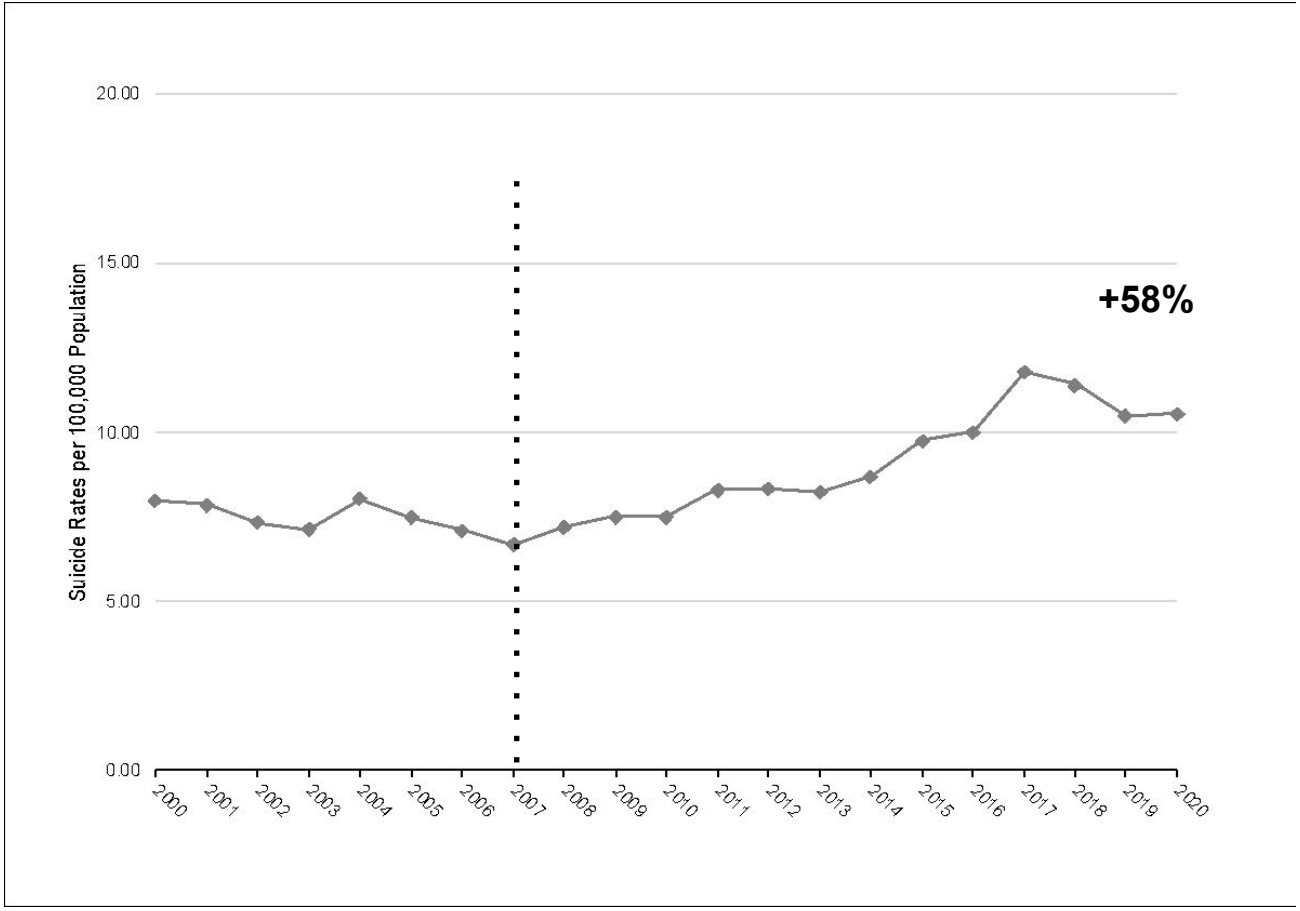
U.S. Youth Suicide Rate: Ages 5-11 Years, 2000 to 2020



U.S. Youth Suicide Rate: Ages 12-14 Years, 2000 to 2020



U.S. Youth Suicide Rate: Ages 15-19 Years, 2000 to 2020

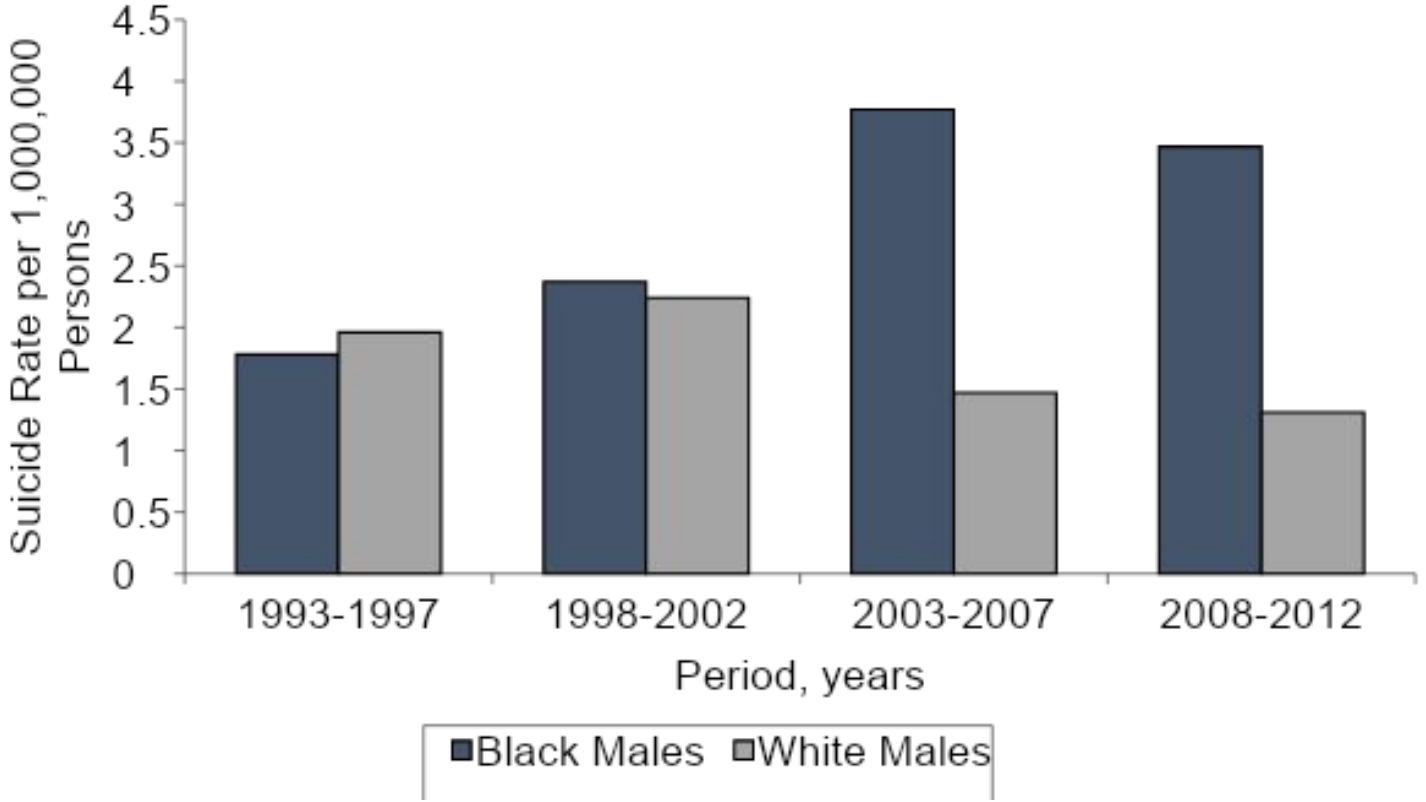


Suicide Trends in Elementary School-Aged Children, 5-11 yrs, in the US, 1993 to 2012

Bridge et al., JAMA Pediatrics, 2015

- 657 children died by suicide
  - ~33 deaths per year
  - 11th leading cause of death in 2012
- 553 (84% boys)
- 558 (85% aged 10-11 years)
- 514 (78%) hanging/suffocation
- 441 (67% White Non-Hispanic);177 (27% Black)

Suicide Rates Among White and Black Males Aged 5-11 Years in the US: 1993-1997 to 2008-2012



Bridge et al., 2015

Follow-up Study of Suicide in Elementary School-Aged Children and Early Adolescents (Sheftall et al., 2016)

Suicide in Elementary School-Aged Children and Early Adolescents

Arielle H. Sheftall, PhD,[a] Lindsey Asti, MPH,[b] Lisa M. Horowitz, PhD, MPH,[c] Adrienne Felts, MA, PCC,[a] Cynthia A. Fontanella, PhD,[d] John V. Campo, MD,[d] Jeffrey A. Bridge, PhD[a,e]

abstract

BACKGROUND AND OBJECTIVES: Suicide in elementary school–aged children is not well studied, despite a recent increase in the suicide rate among US black children. The objectives of this study were to describe characteristics and precipitating circumstances of suicide in elementary school–aged children relative to early adolescent decedents and identify potential within-group racial differences.

METHODS: We analyzed National Violent Death Reporting System (NVDRS) surveillance data capturing suicide deaths from 2003 to 2012 for 17 US states. Participants included all suicide decedents aged 5 to 14 years ($N = 693$). Age group comparisons (5–11 years and 12–14 years) were conducted by using the χ^2 test or Fisher's exact test, as appropriate.

National Violent Death Reporting System (NVDRS)

- State-based surveillance system collects data on all violent deaths
- **Uses multiple sources** (e.g., medical examiners, coroners, law enforcement)
- Expanded to 50 states in 2018; data online in only 34 states
- **Information collected** includes circumstances related to suicide (e.g., depression, relationship or school problems)

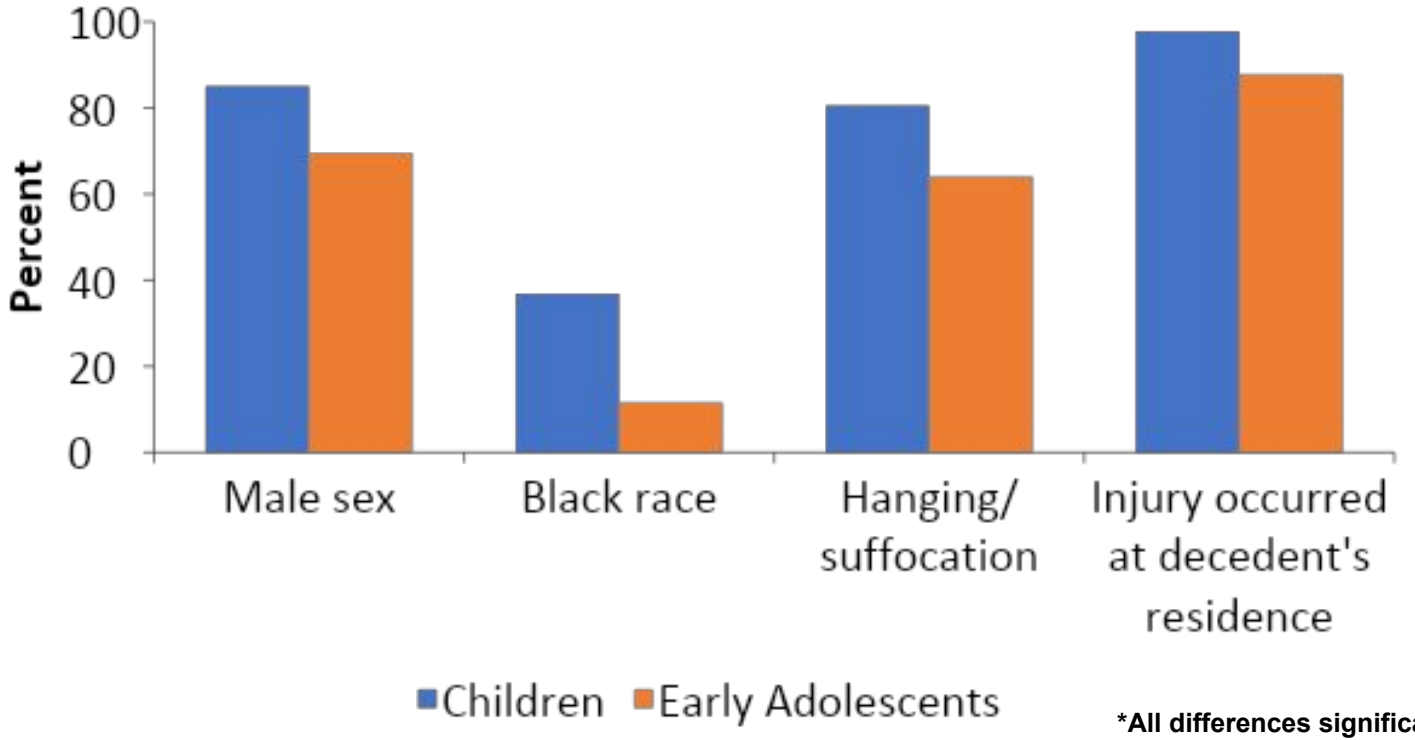
Available at: http://www.cdc.gov/violenceprevention/nvdrs/

Precipitating Circumstances of Suicide in Children and Early Adolescents

- 2003-2012 data on suicide decedents aged **5 to 14 years**
- Restricted-use data available for **17 states**
- **Precipitating circumstances** included: mental health history/treatment, substance use, physical health history, stressful life events, & suicide-related circumstances
- Comparisons were made based on:
  - **Age group** (5-11 vs. 12-14 years)
  - **Race** (black vs. non-black)

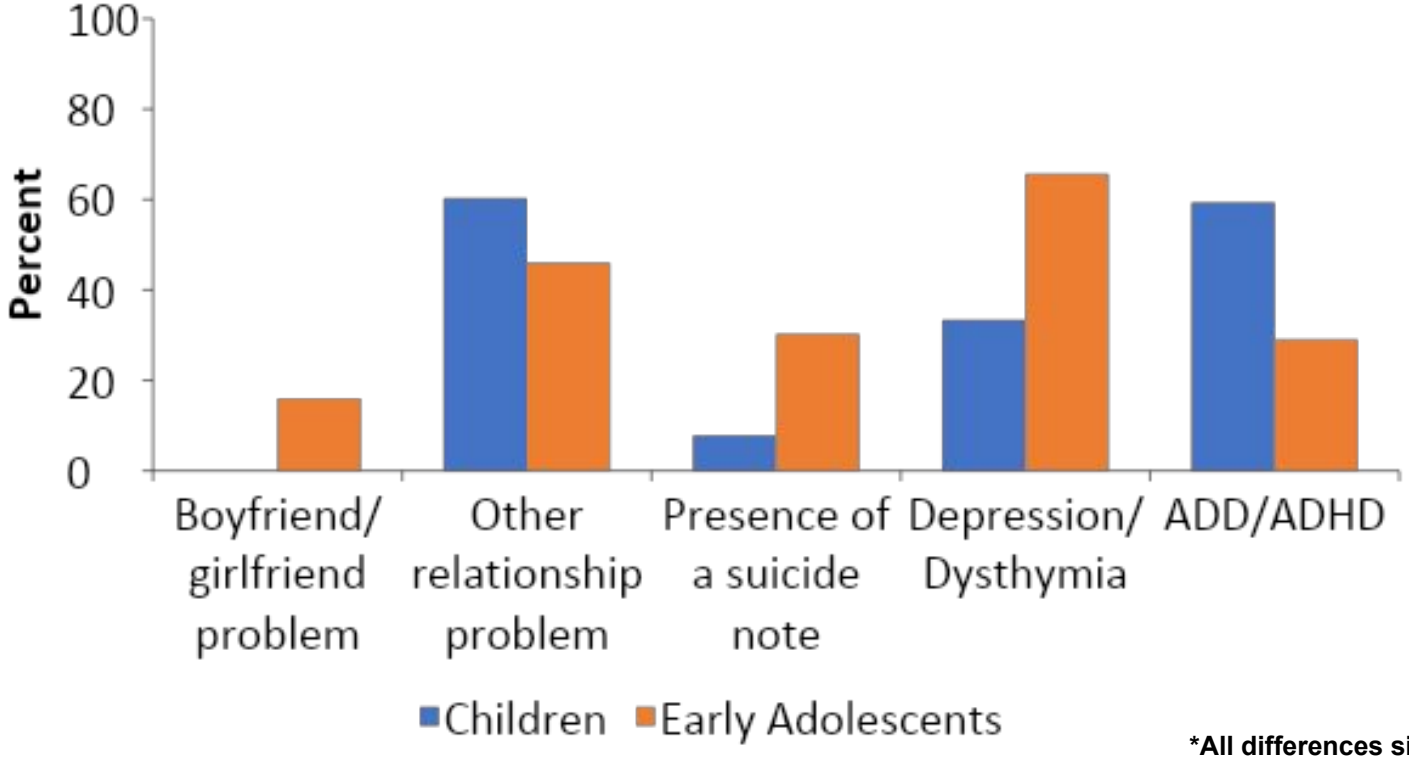
Sheftall et al., Pediatrics, 2016

Differences Between Child (N=87) and Early Adolescent (N=606) Suicide Decedents*



*All differences significant at $P < 0.05$; Sheftall et al., *Pediatrics 2016*

Differences Between Child (N=87) and Early Adolescent (N=606) Suicide Decedents*



*All differences significant at $P < 0.05$; Sheftall et al., Pediatrics, 2016

Non-significant Differences Between Child and Early Adolescent Suicide Decedents

- In public custody at time of death
- Legal problems
- Physical health problems
- School problems (incl. bullying)
- Death of a friend or family member
- History of suicide attempt
- Recent suicide of family member or friend

- **Suicide intent disclosed (29.5% child vs. 28.9% early adolescen**t)
- Recent crisis
- Current mental health concern
- History of mental health treatment
- Problems with alcohol or drugs
- Presence of alcohol or drugs at time of death (toxicology reports)

Sheftall et al., *Pediatrics*, 2016

JAMA Network™

From: **Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015**
JAMA Pediatr. 2018;172(7):697-699. doi:10.1001/jamapediatrics.2018.0399

- Bridge et al. 2018 examined age-related racial disparities in youth suicide in the US from 2001-2015
- Identified 1,661 suicide deaths among black youths and 13,341 suicide deaths among white youths
- Found white youths 42% more likely to die by suicide for ages 5-17, but finding was strongly moderated by age
- Black youths ages 5-12 had higher suicide rates that white youths with differences even greater in males

Table. Comparison of Suicide Rates Between US Black and White Youths by Age and Sex, 2001-2015

	Youth Suicides, No. (Rate per 1 Million Persons)		
Age, y	Black	White	IRR (95% CI)[a]
All			
5-9	26 (0.53)	45 (0.19)	2.73 (1.69-4.43)
10	47 (4.68)	79 (1.68)	2.79 (1.95-4.00)
11	101 (9.93)	190 (4.00)	2.48 (1.95-3.16)
12	129 (12.57)	471 (9.86)	1.28 (1.05-1.55)
13	167 (16.16)	979 (20.37)	0.79 (0.67-0.93)
14	194 (18.69)	1625 (33.65)	0.56 (0.48-0.64)
15	252 (24.25)	2496 (51.48)	0.47 (0.41-0.54)
16	317 (30.49)	3372 (69.20)	0.44 (0.39-0.49)
17	428 (41.13)	4084 (83.39)	0.49 (0.45-0.54)
Boys			
5-9	22 (0.88)	40 (0.34)	2.62 (1.56-4.41)
10	42 (8.24)	67 (2.78)	2.97 (2.02-4.36)
11	70 (13.55)	154 (6.33)	2.14 (1.62-2.84)
12	91 (17.45)	336 (13.72)	1.27 (1.01-1.60)
13	122 (23.24)	649 (26.34)	0.88 (0.73-1.07)
14	129 (24.47)	1117 (45.09)	0.54 (0.45-0.65)
15	164 (31.07)	1760 (70.71)	0.44 (0.37-0.52)
16	238 (45.07)	2512 (100.33)	0.45 (0.39-0.51)
17	347 (65.62)	3281 (130.17)	0.50 (0.45-0.56)
Girls			
5-11[b]	40 (1.17)	53 (0.33)	3.53 (2.34-5.32)
12	38 (7.53)	135 (5.80)	1.30 (0.91-1.86)
13	45 (8.85)	330 (14.10)	0.63 (0.46-0.86)
14	65 (12.73)	508 (21.60)	0.59 (0.46-0.76)
15	88 (17.20)	736 (31.19)	0.55 (0.44-0.69)
16	79 (15.44)	860 (36.30)	0.43 (0.34-0.54)
17	81 (15.83)	803 (33.78)	0.47 (0.37-0.59)

Abbreviation: IRR, incidence rate ratio.

Journal of the American Academy of Child & Adolescent Psychiatry
Available online 9 September 2021
In Press, Uncorrected Proof What are Uncorrected Proof articles?

New research

Black Youth Suicide: Investigation of Current Trends and Precipitating Circumstances

Author links open overlay panel

Arielle H. Sheftall PhD[ab] FatimaVakil BS[a] Donna A. Ruch PhD[a] Rhonda C. Boyd Ph D[cd] Michael A. Lindsey PhD[ef] Jeffrey A. Bridge PhD[ab]

https://doi.org/10.1016/j.jaac.2021.08.021Get rights and content

Objective

Suicide among Black youth is a significant public health concern, yet research investigating the epidemiology of suicide in this population is limited. This study examines current trends and precipitating circumstances of suicide by sex and age group in Black youths 5 to 17 years of age, using 2 national databases.

Conclusion

Increases in Black youth suicide call for the prioritization of research aimed at identifying specific risk and protective factors as well as developmental mechanisms associated with Black youth suicidal behavior. To implement effective suicide prevention programming, understanding targets for intervention is necessary.


RING THE ALARM
THE CRISIS OF BLACK YOUTH SUICIDE IN AMERICA
Report Released December 2019
A REPORT TO CONGRESS FROM THE CONGRESSIONAL BLACK CAUCUS
EMERGENCY TASKFORCE ON BLACK YOUTH SUICIDE AND MENTAL HEALTH
REPRESENTATIVE BONNIE WATSON COLEMAN, TASK FORCE CHAIR

JAMA Network | Open

Original Investigation | Psychiatry

Prevalence and Family-Related Factors Associated With Suicidal Ideation, Suicide Attempts, and Self-injury in Children Aged 9 to 10 Years

Danielle C. DeVille, MA; Diana Whalen, PhD; Florence J. Breslin, MS; Amanda S. Morris, PhD; Sahib S. Khalsa, MD, PhD; Martin P. Paulus, MD; Deanna M. Barch, PhD

- Nationally representative 23-site longitudinal study (ABCD; n=11,814 children aged 9-10)
- **6.4% for lifetime history of passive suicidal ideation; 4.4% for nonspecific active suicidal ideation; 2.4% for active ideation with method, intent, or plan**
- **1.3% for suicide attempts**
- **9.1% for non-suicidal self-injury (NSSI)**
- Suicidal ideation associated with high family conflict, low parental monitoring and NSSI
- Very low parent-child concordance overall (88% of parents of youth reporting a suicide attempt were unaware of the attempt; 77% of parents of youth w/ ideation were unaware)

Received: 7 April 2020 | Revised: 16 July 2020 | Accepted: 29 July 2020

DOI: 10.1002/da.23087

RESEARCH ARTICLE

ADAA ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA WILEY

Suicidal thoughts and behaviors in preadolescents: Findings and replication in two population-based samples

Rachel F. L. Walsh[1] | Ana E. Sheehan[2] | Richard T. Liu[3,4]

- Authors examined suicidal ideation and attempts among 11- and 12-year-olds in Minnesota using anonymous student surveys
- Survey data from 2007 & 2010 (n=42,149 and n=40,359 respectively)
- Found that approximately 9% of participants reported suicidal ideation
- Nearly 2% in each cohort reported a past year suicide attempt
- Parental support, physical and sexual abuse, and perceived safety at school were associated with suicidal ideation and attempts

Original Investigation | Psychiatry

May 17, 2019

Trends in Suicide Among Youth Aged 10 to 19 Years in the United States, 1975 to 2016

Donna A. Ruch, PhD[1]; Arielle H. Sheftall, PhD[1,2]; Paige Schlagbaum, BS[1]; et al

» Author Affiliations | Article Information

JAMA Netw Open. 2019;2(5):e193886. doi:10.1001/jamanetworkopen.2019.3886

- Boys die by suicide more often than girls
- Ratio of male to female suicides decreased significantly over time
- Among 10-14 year-olds the ratio of male to female suicides declined at the highest rate (3.14 [95% CI, 2.74-3.61] to 1.80 [95% CI, 1.53-2.12])
- Females > attempts over time using increasingly lethal means such as hanging/suffocation

JAMA Network **Open**
Original Investigation
Psychiatry
July 27, 2021

Characteristics and Precipitating Circumstances of Suicide Among Children Aged 5 to 11 Years in the United States, 2013-2017

Donna A. Ruch, PhD[1]; Kendra M. Heck, MPH[1]; Arielle H. Sheftall, PhD[1,2]; et alCynthia A. Fontanella, PhD[3]; Jack Stevens, PhD[1,2]; Motao Zhu, PhD[1,2]; Lisa M. Horowitz, PhD[4]; John V. Campo, MD[5]; Jeffrey A. Bridge, PhD[1,2]
JAMA Netw Open. 2021;4(7):e2115683. doi:10.1001/jamanetworkopen.2021.15683

Key Points:

Question What characteristics and precipitating circumstances are associated with childhood suicide?

Findings In this multistate population-based qualitative study, childhood suicide was associated with multiple risk factors including mental health, prior suicidal behavior, trauma, and family or peer relation issues, with most suicides occurring by hanging or suffocation in the decedent's bedroom. Firearms were the second most prevalent suicide method, and among cases with detailed information, all children obtained guns stored unsafely in the home.

Meaning The findings underscore the importance of early suicide prevention efforts that include improvements in suicide risk assessment, family relations, and lethal means restriction, particularly safe firearm storage.

What Kinds of Psychological Treatments are Effective?

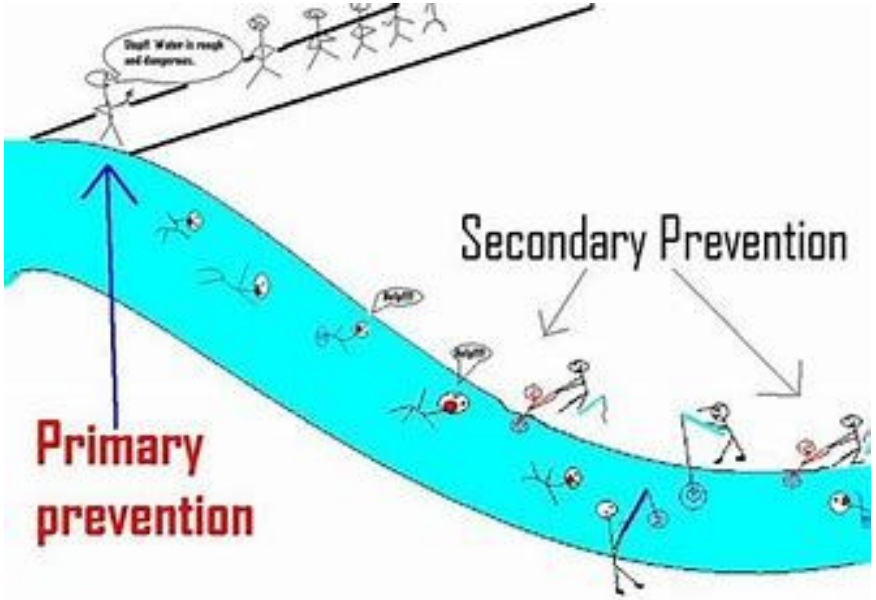
Suicide-Specific Interventions

- No well-established interventions for preteens
- Glenn et al (2019) provided a review of evidence-based interventions for suicidal behaviors and self-harm in youth
- For teens, Dialectical Behavior Therapy (DBT-A) was the only well-established intervention from 26 randomized controlled trials (RCTs)
- Common elements of effective suicide-specific care:
  - Family-centered
  - Skills-based included emotion regulation, distress tolerance, mindfulness, interpersonal effectiveness, and problem-solving
  - Meaningful dose of personalized treatment to build relationship, trust, and capacity to navigate crisis

Suicide-Specific Interventions

- Although there is a lack of strong preteen treatment outcome research to guide clinician decisions, the following elements should be considered by clinicians:
  - Routine screening, assessment, and safety planning with the youth
  - A family component to maximize parent support and supervision as well as strategies to reduce family conflict or the potential for maltreatment
  - Engage family members and trusted adults in lethal means safety efforts
  - Highlight community-level protective factors and ways to build self-worth and connectedness
  - Build youth coping skills and reinforce use frequently in and out of session
  - Help youth understand drivers of a suicidal crisis and how to stay safe
  - Potential candidates: DBT-C, SAFETY, ABFT, CAMS, CBT, FFT, MST, IPT

What if We Don’t Want to Wait for a Crisis to Emerge?



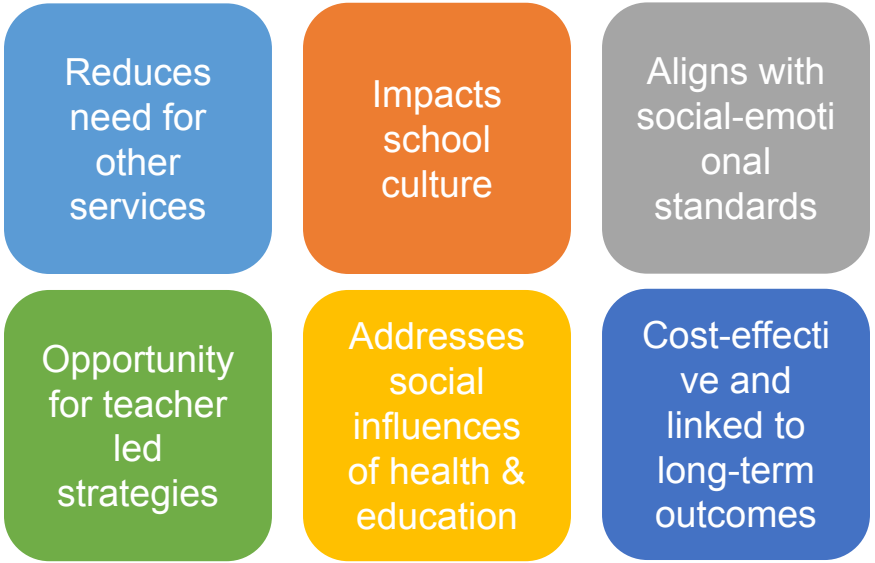
Upstream and Integrated Prevention

- We can't treat ourselves out of this public health crisis
- Trauma-informed, cost-effective, & compassionate
- Addresses a range of barriers
  - Gaps in access and utilization (George, Zaheer & Kern, 2017)
  - Shortage of providers & barriers to treatment (Owens et al., 2002)
  - Capacity
    - Training, supervision, consultation (Tapia et al., 2017)
  - Limitations in providing evidence-based care
    - EBTs reached 1-3% of children in multi-state study (Bruns et al., 2015)

Why Prevention in Schools?

- Evidence suggests universal prevention works *(Domitrovich et al., 2010; Sanchez et al., 2018; Tanner-Smith, Durlak & Marx, 2018)*
- Mitigates equity issues and reduces barriers to treatment (e.g., insurance, transportation, etc.)
- Teacher led interventions equally effective and embed into natural role *(Sanchez et al., 2018)*
- Fidelity and consistent implementation inform outcomes *(Rones & Hoagwood, 2000)*

Benefits:



Trauma-Informed Schools

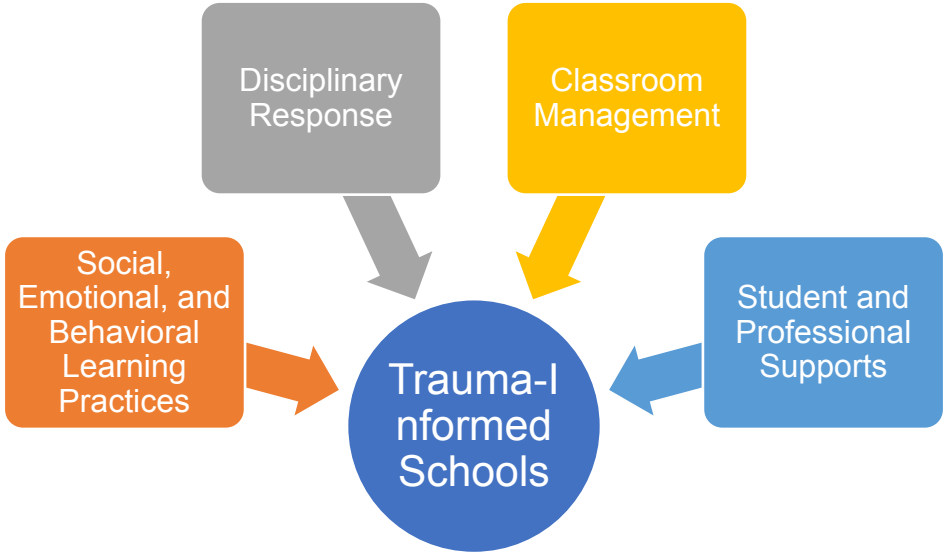
A trauma-informed school nurtures the relationship between mental health and academic achievement, while maintaining it's focus on educational outcomes.

REALIZES the prevalence and impact of trauma

RECOGNIZES signs of trauma and the need for learning supports

RESPONDS to trauma with developmentally appropriate support

RESISTS re-traumatization by integrating principles of trauma-informed care into classroom practices



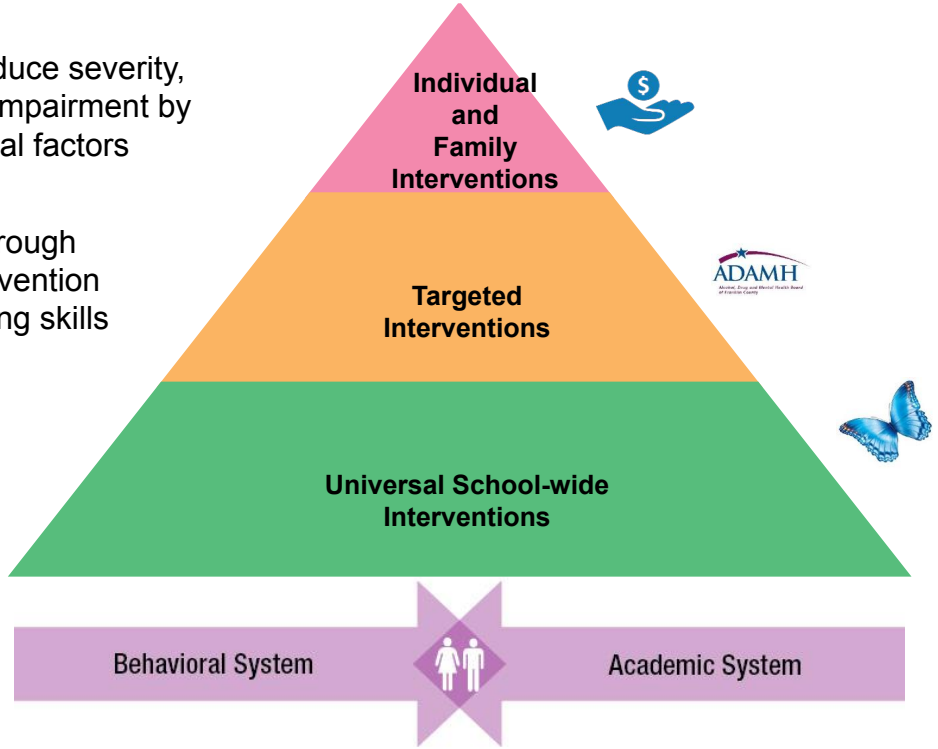
Source: National Child Traumatic Stress Network, Schools Committee. (2017). Creating, supporting, and sustaining trauma-informed schools: A system framework. Los Angeles, CA, and Durham, NC: National Center for Child Traumatic Stress.

School-Based Behavioral Health Model

Tier 3 – **1-5%** of students; Reduce severity, intensity of symptoms driving impairment by addressing family and individual factors

Tier 2 – **15-20%** of students; Reduce risk through consultation, individual skill building and prevention groups to strengthen social emotional learning skills

Tier 1 – **80-85%** of students; Promote a positive school climate though wellness promotion and implementation of prevention programs that provide consistent and structured responses to behavioral and emotional concerns through by educating teachers, families and students



NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

Universal School-wide Interventions

Goal: Promote a positive school climate through wellness promotion and implementation of prevention programs that provide consistent and structured responses to behavioral and emotional concerns

Strategies: Teacher, family and student education

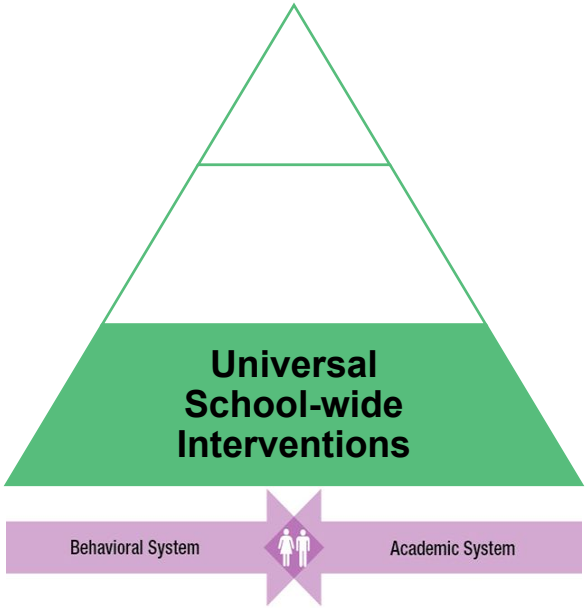
Programs:

- Elementary – PAX Good Behavior Game; Triple P / IY
- Middle – Signs of Suicide (SOS)

Additional School-wide Supports:

- Needs and readiness assessment
- Staff training
- Student SEL programming

Outcomes: Improved school climate and staff competence, enhanced social-emotional learning, reduced disruptive behaviors, improved academic performance, reduced suicidal behavior



NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.

PAX Good Behavior Game

PAX Good Behavior Game is an evidence-based prevention program teacher driven as a part of their daily maintenance of their classroom. The program is rooted in social and emotional learning and adheres to the PBIS framework. The goal is to build self-regulation by reinforcing desirable prosocial behaviors and inhibiting unwanted problematic behaviors, incorporating the principals of trauma-informed care.

pax Good Behavior Game

- PAX GBG is an evidence-based Tier 1 universal prevention model applied by teachers in the classroom
- Provides Tier 1 mechanisms and strategies for teachers, administrators, and school personnel to effectively implement PBIS Tier 1
- Research based strategies that teach self regulation and behavior as a skill set

Why PAX Good Behavior Game?

A set of behavioral principles implemented by the teacher throughout the school day to teach self-regulation which results in:

- More nurturing classroom environments
- Increased academic performance
- Improved long-term outcomes

PAX classrooms typically report:

- 45 to 60 additional minutes of instruction
- Up to 75% reduction in disturbing or disruptive behavior
- Up to 60% decrease in discipline referrals
- Up to 20 to 30% decrease in special education referrals
- Sig increases in Math and Reading scores

Long-term outcomes include:

- Up to 50% reduction in suicidal ideation
- 68% reduction in tobacco use
- 35% reduction in alcohol dependence
- 50% reduction in other substance use
- 23% reduction in violent & criminal behaviors

(e.g.,Bradshaw et al., 2009; Wilcox et al., 2008)

Signs of Suicide (SOS)

Signs of Suicide is an evidence-based program designed to reach the entire population, without regard to individual risk factors and are intended to reach a very large audience.

- Full model involves gatekeeper training (staff and parent education), student awareness training, peer-to-peer support, screening & risk assessment
  - Train all adults to identify depression symptoms and warning signs for suicide
  - Teach action steps to students and adults when encountering suicidal behavior
  - Increase student awareness and help-seeking

Acronym (ACT)

- ✔ **A**cknowledge
- ✔ **C**are - Show that you care
- ✔ **T**ell a trusted adult

Signs of Suicide (SOS)

Evidence-based universal suicide prevention

- Three RCTs show 40-64% reduction in self-reported suicide attempts at 3-month follow-up
  - (Aseltine & DeMartino, 2004; Aseltine, 2007; Schilling et al., 2016)
- Significantly greater pre-post knowledge and attitudes about depression
- Increase in help-seeking behaviors not significant
  - (Aseltine, 2007)

Advantages

- Incorporates best practice elements
- Implemented by school staff
- Engages existing supports including school staff, parents, peers, community
- Increases dialogue around mental health, reducing stigma
- Sustainable

School-Based Depression & Suicide Screening

- Universal suicide screening of 5th & 6th graders is feasible and acceptable as part of enhanced Signs of Suicide(SOS) implementation
- Screening occurs after staff training, caregiver education, counselor training, student SOS curriculum, and protocols for positive screens including triage, risk assessment, safety planning, and disposition/referral

CSPR Preteen Student Screening Data

- 5^{th}-6^{th} graders = 4,734
- 7-12^{th} graders = 43,861
- 5^{th} - 6^{th} graders had more positive screens (17%) than 7^{th}-12^{th} graders (15%)
- Higher outpatient referral rates (7.7% vs 5.0%)
- Slightly higher rate of crisis referral (0.76% vs 0.57%)
- Preteen youth had more requests to speak to an adult about concerns generally (21% vs 9%)


WHAT'S
NEXT?

Current Gaps in Preteen Suicide Prevention

- Identification and prediction of preteen suicide risk is poor
- When youth are identified, access to care is limited
- Few research studies explore specific risk/protective factors
- Few well-supported intervention or prevention approaches in this age group
- School and community organizations are under-prepared to address preteen suicide risk
- Insufficient funding

Opportunities

- Preteens experience suicidal thoughts & behaviors, share their distress with peers, & display actionable warning signs
- Preteens are often willing to discuss difficult emotional topics with trusted adults when given a safe platform to do so
- Screening identifies youth early (upstream)
- Pathways to support youth in crisis exist
- Pair with SEL programming and/or MTSS

Where to go from here?

- Commit to upstream suicide prevention with meaningful family and community input
- Build from an SEL framework
- Consider identification tools that are clear, concrete, and validated with young children (e.g., ASQ)
- Develop and test suicide intervention and prevention models with attention to developmental considerations
- Focus on staff skills training and sustainable implementation
- Track outcomes and effectiveness over time

Program Elements of Effective Preteen Suicide Prevention

- Engage at the level of the learner with lots of reinforcement
- Account for developmental differences in cognition, language, and social development
- Make programs universal but culturally relevant/dynamic
- Ensure staff and peers can support risk identification and have a clear pathway for engaging community BH partners
- Impact school culture by reducing stigma and increasing connectedness
- Reduce interpersonal threats and systemic factors that lead to invalidation based on identity

Legislative Efforts to Reduce Youth Suicide in Texas

- The 86th Texas Legislature passed several bills in 2019:
  - **HB 906** created the Collaborative Task Force on Public School Mental Health Services to study the suicide rate of school employees, students, and family/guardians receiving state-funded mental health services
  - **SB 11** added suicide prevention and mental health instruction to public school health curricula, and provided districts with annual funding allotments to support student mental health and suicide prevention strategies
  - **HB 18** established strategies to help school districts support the mental health needs and development of their students, including comprehensive suicide prevention

Texas Child Mental Health Care Consortium

- The Texas Child Mental Health Care Consortium (TCMHCC), created by the **86th Texas Legislature in Senate Bill 11 (SB 11)** to address gaps in mental health care for children and adolescents in Texas, is responsible for implementing the following initiatives:

  - Child Psychiatry Access Network (CPAN) : A network of child psychiatry access centers based at the HRIs to provide telemedicine-based consultation and training to PCPs to assist them with identifying and treating mental health issues in patients

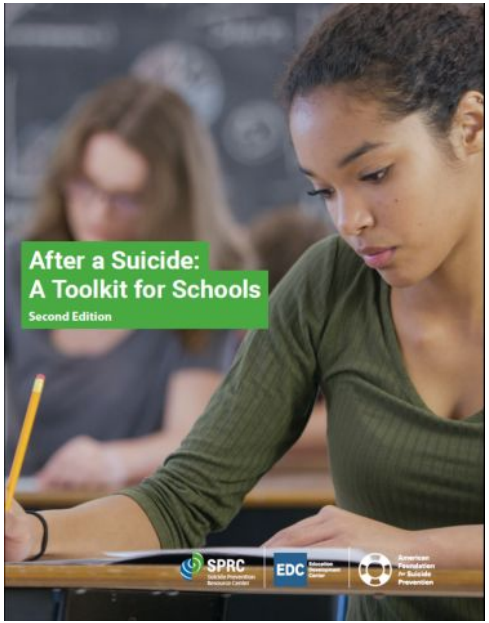
  - Texas Child Health Access Through Telemedicine (TCHATT): Telemedicine or telehealth programs using HRIs to assist local school districts (ISDs) with direct tele-psychiatric care for students, including assessments, brief intervention, referrals and training

  - Community Psychiatry Workforce Expansion (CPWE): Full-time academic psychiatrists are funded to serve as academic medical directors at facilities operated by community mental health providers and new psychiatric resident rotation positions are established

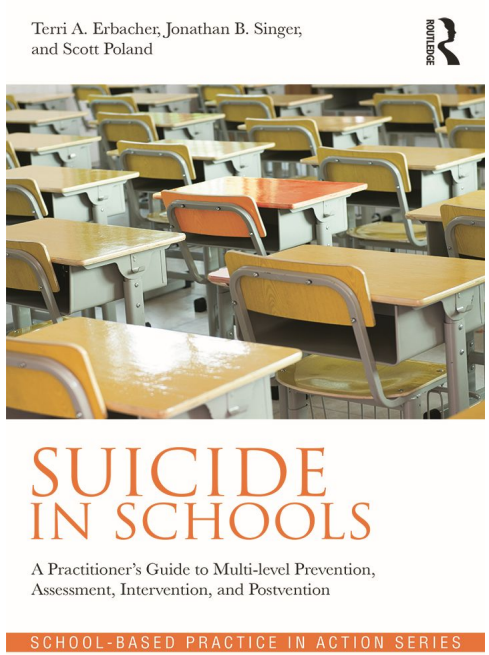
  - Child and Adolescent Psychiatry Fellowships (CAP Fellowships): This program expands both the number of child and adolescent psychiatry fellowship positions in Texas and the number of these training programs at Texas HRIs

  - ***Research: Coordinate mental health research across state university systems in accordance with the statewide behavioral health strategic plan developed by the Texas Health and Human Services Commission (HHSC)***

Comprehensive resources



American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.) Waltham, MA: EDC.

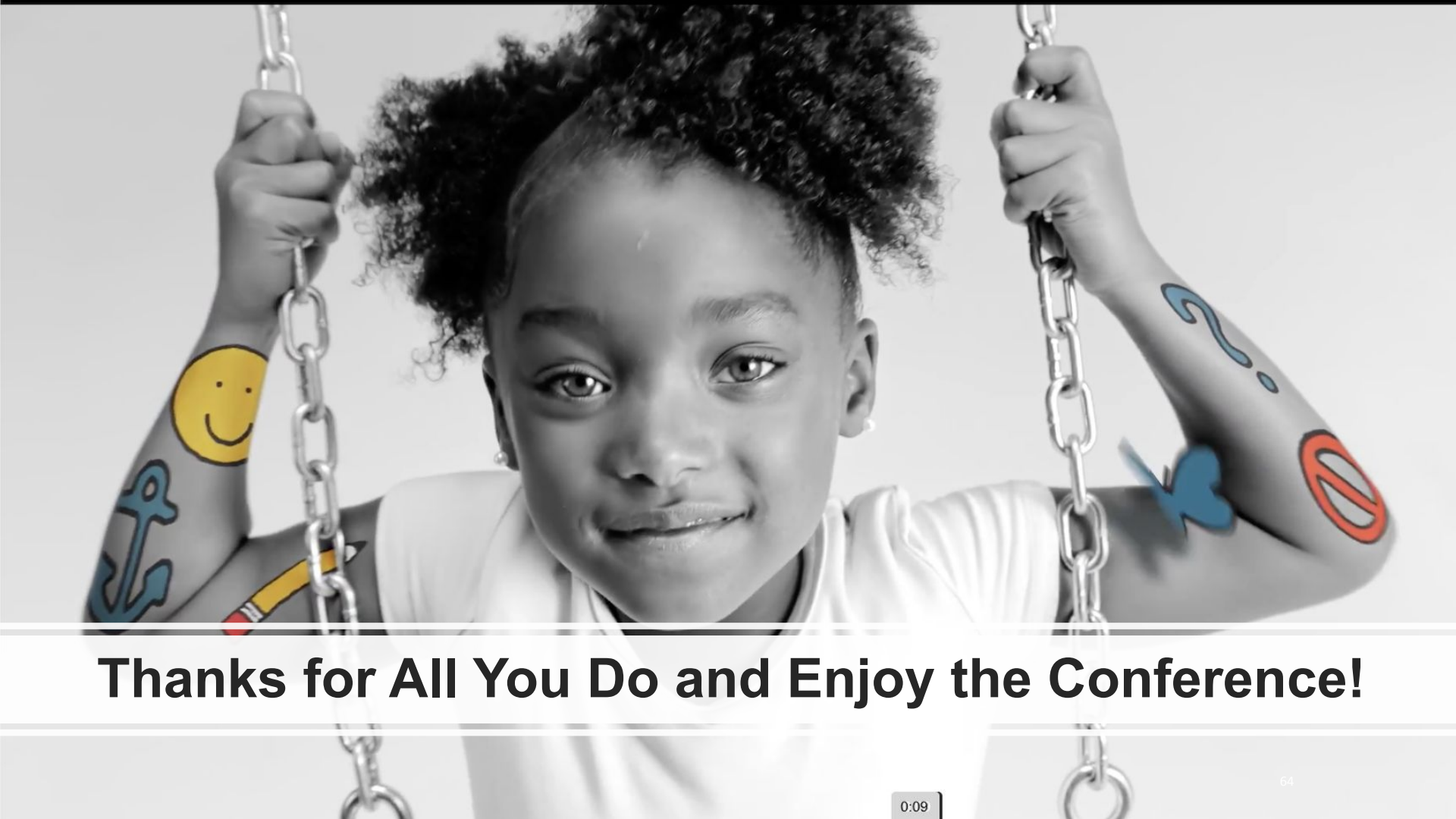


Erbacher, T. A., Singer, J. B., & Poland, S. (2015). *Suicide in schools: A practitioner's guide to multi-level prevention, assessment, intervention, and postvention*. New York: Routledge.

Thanks to my CSPR colleagues!

- Amberle Prater, PhD, LPCC-S
- Elizabeth Cannon, LPCC-S
- Melanie Fluellen, LPCC-S
- Laurel Biever, LPC
- Stephanie Castine, LISW-S
- Rachel Jones, LPCC-S
- Fatimah Masood, MPH
- Elena Camacho, BA
- Jeff Bridge, PhD
- Arielle Sheftall, PhD
- Donna Ruch, PhD
- Jaclyn Tissue, LPCC
- Kendra Heck, MPH
- Glenn Thomas, PhD
- Meredith Chapman, MD
- Jennifer Hughes, PhD

NATIONWIDE CHILDREN'S®
When your child needs a hospital, everything matters.



Thanks for All You Do and Enjoy the Conference!

0:09