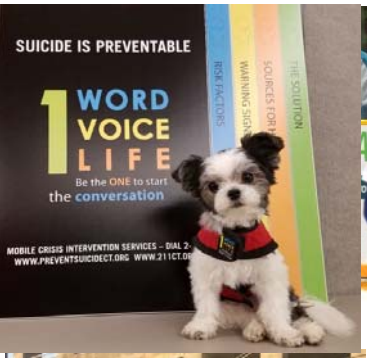
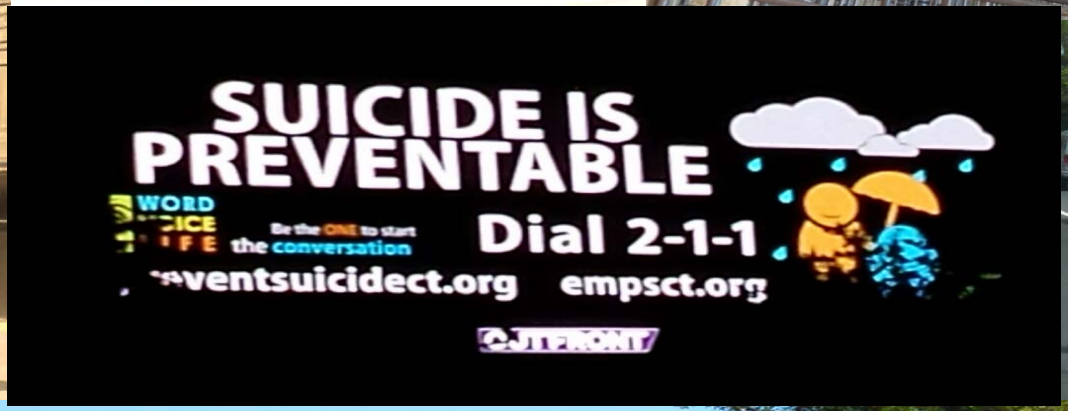

SUICIDE IS PREVENTABLE
1 WORD VOICE LIFE
Be the ONE to start the conversation
MOBILE CRISIS INTERVENTION SERVICES – DIAL 2-1-1
WWW.PREVENTSUICIDECT.ORG WWW.211CT.ORG


1 WORD VOICE LIFE
Be the ONE to start the conversation
SUICIDE IS PREVENTABLE
Dial 2-1-1
www.preventsuicidect.org
www.empsct.org


SUICIDE IS PREVENTABLE.
FOR HELP
DIAL 2-1-1
AND PRESS 1
Outside CT Dial
800.273.8255
PREVENTSUICIDECT.ORG
CONNECTICUT


1 WORD VOICE LIFE
SUICIDE IS PREVENTABLE
EMPS
Crisis Intervention Services
Dial 2-1-1


SUICIDE IS PREVENTABLE
Dial 2-1-1
TRASH
BOTTLES & CANS
NEWSPAPER
NEWSPAPER


SUICIDE IS PREVENTABLE
WORD VOICE LIFE
Be the ONE to start the conversation
Dial 2-1-1
ventsuicidect.org
empsct.org


2214
1 WORD VOICE LIFE
Mobil
Mart
ATM


1 WORD VOICE LIFE
Be the 1 to start the conversation
www.preventsuicidect.org

Welcome

Andrea Iger Duarte – CT Department of Mental Health and Addiction Services

Scott Newgass – CT State Department of Education

Connecticut Suicide Advisory Board

Andrea Iger Duarte, MSW, MPH, LCSW
CT Department of Mental Health and Addiction Services
CT Suicide Advisory Board

Scott Newgass, MSW, LCSW
CT State Department of Education
CT Suicide Advisory Board

Back to School Symposium on Mental Health Promotion & Suicide Prevention for K-12

Middletown, CT - September 14, 2017

Suicide Prevention in CT

1989 –DCF *Youth Suicide Advisory Board* (YSAB). Legislatively mandated to date.

2000 – *DPH Interagency Suicide Prevention Network* (ISPN).

2005 – ISPN releases 1st state plan: *CT Comprehensive Suicide Prevention Plan* was published.

2006- Present – State has received 3 SAMHSA *Garrett Lee Smith (GLS) Youth Suicide Prevention State Grants*, managed by DMHAS with state board as advisory to the grants (2006-10, 2011-14, 2015-20)

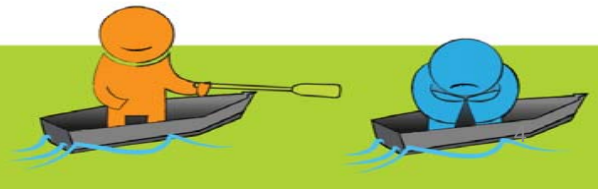
January 2012- YSAB and ISPN merged to create the *CT Suicide Advisory Board* (CTSAB) co-chaired by DCF and DMHAS. Mission, vision and priorities identified.

September 2012 – CTSAB released the "*1 WORD, 1 VOICE, 1 LIFE…Be the 1 to start the conversation"* Initiative and Prevent Suicide CT website.

Spring 2013-Present – DCF, DMHAS, DPH *coordinate and braid federal block grant dollars* to support suicide prevention.

Spring 2015- CTSAB released 2nd state plan: *CT Suicide Prevention Plan 2020.* Mission, vision, and priorities revised and aligned with new plan.

October 2015- CTSAB joins the national Zero Suicide effort.



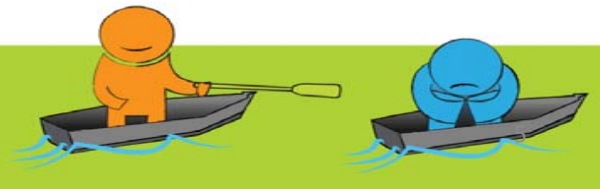
CT Suicide Advisory Board

The state-level suicide advisory board that addresses suicide prevention and response across the lifespan.

Mission: The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, response.

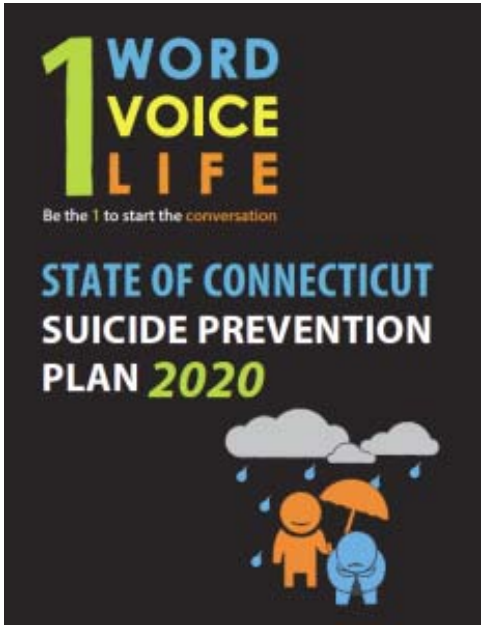
Vision: The CTSAB seeks to eliminate suicide by instilling hope across the lifespan and through the use of culturally competent advocacy, policy, education, collaboration and networking.

CONNECTICUT Suicide Advisory Board

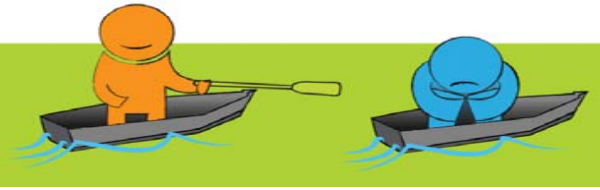


CT State Suicide Prevention Plan 2020

- **GOAL 1**: Integrate and coordinate suicide prevention activities across multiple sectors and settings.
- **GOAL 2**: Develop, implement and monitor effective programs that promote wellness and prevent suicide and related behaviors.
- **GOAL 3**. Promote suicide prevention as a core component of health care services. Adopt *Zero Suicides* as an aspirational goal.
- **GOAL 4**: Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.
- **GOAL 5**: Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.



CONNECTICUT Suicide Advisory Board



Introduction

Heather Spada – United Way of CT

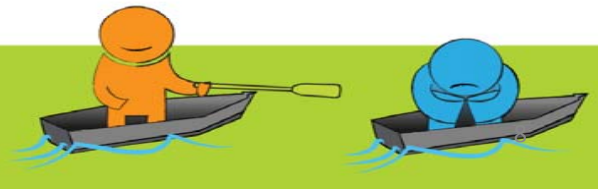
CT Networks of Care for Suicide Prevention Initiative 2015-2020

Overall purpose: Reduce non-fatal suicide attempts and suicide deaths among at risk youth and young adults age 10-24 in CT.

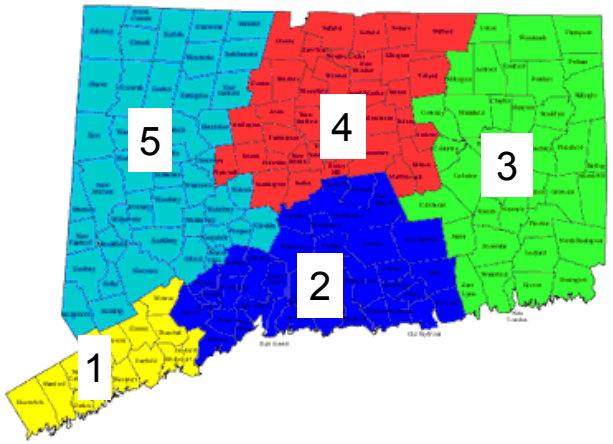
Goal 1: Strengthen CT capacity and infrastructure in support of mental health promotion, suicide prevention, intervention and response with the use of evidence-based practices.

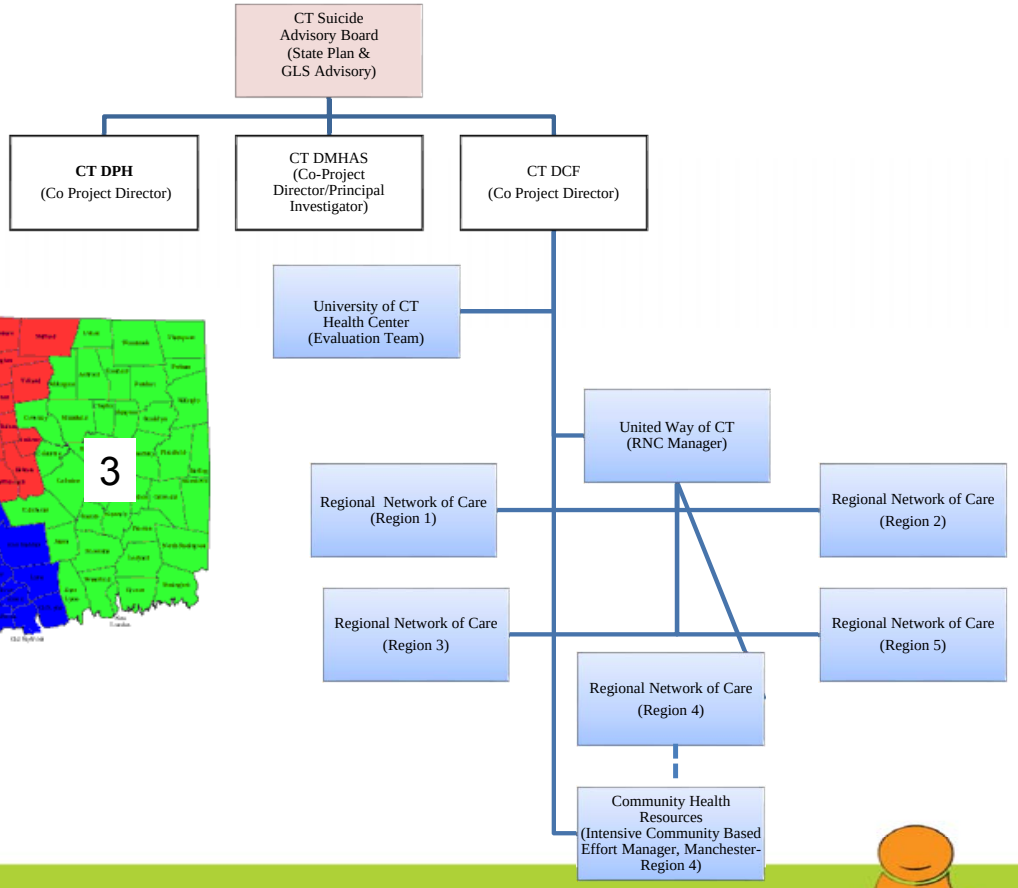
Primary Objective: Integrate and coordinate suicide prevention, intervention and response activities across multiple sectors and settings through the enhancement and formalization of a sustainable Statewide Network of Care (SNC) for Suicide Prevention consisting of the CTSAB and *five Regional Networks of Care (RNCs)*, and *one Community Network of Care (CNC)* in the town with the intensive effort to support prevention, intervention and response.

CONNECTICUT Suicide Advisory Board

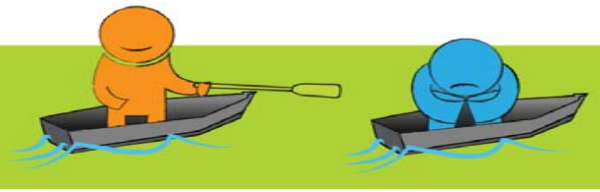


CT Networks of Care for Suicide Prevention Initiative 2015-2020
Organizational Chart





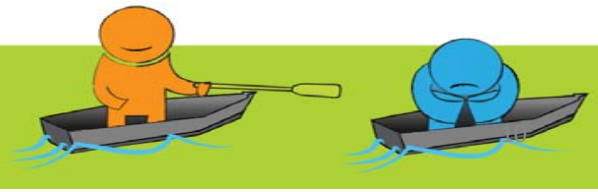
CONNECTICUT Suicide Advisory Board



RNC Goal

- Overarching goal: to enhance suicide prevention, intervention, and response services for youth and young adults ages 10-24 at-risk for suicide.
- Primary features:
  - Statewide implementation
  - Region-specific planning
  - Funding to support planning implementation
  - RNCs link with existing state network (CTSAB)

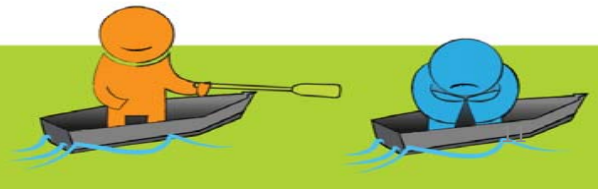
CONNECTICUT Suicide Advisory Board



RNC Highlights

- Quarterly meetings
  - Address selected areas of need with evidence-based strategies
  - Guide and facilitate implementation of these strategies
- Forming of own RNC leadership and plan
- Evidence-based practice implementation in communities
- Formalize existing networks for prevention, intervention and response.

CONNECTICUT Suicide Advisory Board



The Scope of the Problem

Faith Vos Winkel – Office of the Child Advocate

Robert H. Aseltine, Jr. – UCONN Health

OFFICE OF THE CHILD ADVOCATE

AN OVERVIEW OF YOUTH SUICIDE

Faith Vos Winkel, MSW
Assistant Child Advocate
Child Fatality Coordinator
Office of the Child Advocate
faith.voswinkel@ct.gov
www.ct.gov/oca

OFFICE OF THE CHILD ADVOCATE & THE CHILD FATALITY REVIEW PANEL

The Office of the Child Advocate (OCA) was created in 1995 after the death of an infant in state care. The General Assembly sought to create an agency that would advocate for the well-being of children by holding other stakeholders accountable. Since 1995, OCA has conducted in-depth fatality investigations, facility investigations, developed general reports on issues related to the well-being of children, and routinely engages in legislative and public policy advocacy. OCA produces an annual report on the activities of the office.

OCA is an independent state agency with multidisciplinary staff who possess backgrounds in law, social work, nursing, human development & family studies, education, and public health.

The Child Fatality Review Panel (CT-CFRP) operates under the OCA and its governing statutes. The CT-CFRP is also multidisciplinary team that is charged with reviewing the "unexpected or unexplained" deaths in order to improve prevention efforts and to better identify trends across the state (Conn. Gen. Stat. § 46a-13). The panel may request that the OCA to conduct an independent fatality investigations for certain cases or the Child Advocate may do so independently of any formal request.

STATUTORY AUTHORITY

Connecticut General Statutes **Sec. 46a-13*l***

"The panel shall review the circumstances of the death of a child placed in out-of-home care or whose death was due to unexpected or unexplained causes to facilitate development of prevention strategies to address identified trends and patterns of risk and to improve coordination of services for children and families in the state."

State Agencies

The Office Child Advocate (OCA), Department of Public Health (DPH), Department of Emergency Services and Public Protection (DESPS), Office of the Chief Medical Examiner (OCME), Department of Children and Families (DCF), and the Office of the Chief State's Attorney (CSA)

Legislative Appointments

A pediatrician, appointed by the Governor; a representative of law enforcement, appointed by the president pro tempore of the Senate; an attorney, appointed by the majority leader of the Senate; a social work professional, appointed by the minority leader of the Senate; a representative of a community service group appointed by the speaker of the House of Representatives; a psychologist, appointed by the majority leader of the House of Representatives; and an injury prevention representative, appointed by the minority leader of the House of Representatives." The panel also may choose no more than three (3) additional members with expertise to serve on the panel.

INTENTIONAL SUICIDE DEATHS

1 WORD VOICE LIFE
Be the 1 to start the conversation
www.preventsuicidect.org
CALL 2-1-1

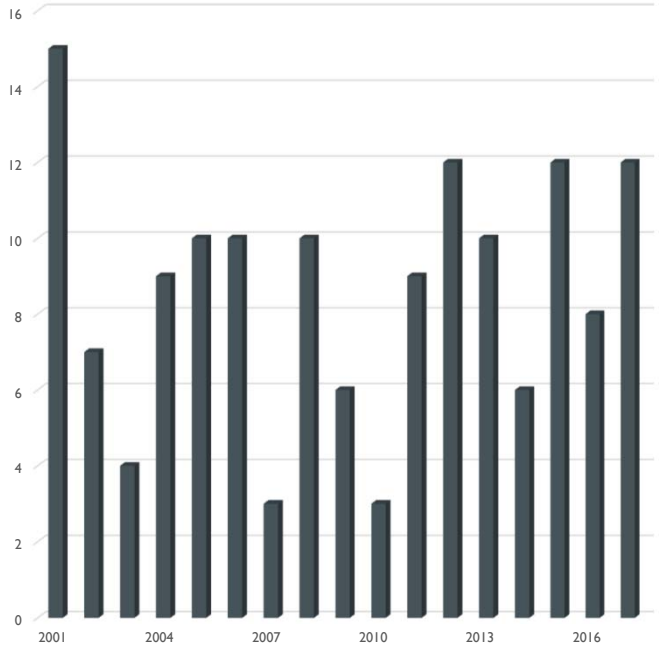
January 1, 2001 to September 1, 2017

Gender
- 90 Boys
- 56 Girls

Race
- 114 White
- 18 Black
- 10 Hispanic/White
- 4 Asian/Other

Method
- 106 died by hanging
- 23 from gunshot would
- 7 drug overdose
- 4 other asphyxia
- 6 other trauma

Ages
- 2-- 10 years-old
- 2-- 11 years-old
- 4-- 12 years-old
- 12--13 years-old
- 18--14 years-old
- 23--15 years-old
- 46--16 years-old
- 39--17 years-old



TRENDS, CONCERNS, LIMITATIONS

- Over the past 6 years, 30 girls died by suicide, this accounted for nearly half of the suicides of girls over the past 16 years.
- Nearly three-quarters of Connecticut youth died by hanging. While restricting lethal means and access to weapons is one key component to suicide prevention, lethal means also includes securing objects that can be used in strangulation.
- This data is inclusive of youth ages 10 through 17. It does not include any 18 year old youth (even though they may have been in high school).
- We know that suicide attempts in the LGBTQ community can be higher. While it is difficult to know how many of these youth suicides may have been a consequence of gender preference or gender identity, we do know that for some youth this was a factor.

WHAT CAN WE DO

- It is imperative that all involved are knowledgeable of the warning signs, risk, and behavior associated with suicide. This can help further prevent suicide amongst youth.
- In addition, in order to further prevent suicide in the state of Connecticut, the 5-year report outlines key recommendations such as:
  - Increase access to mental health supports by implementing recommendations from the Governor's Sandy Hook Commission Report as well as the OCA report on Sandy Hook;
  - Increase screening for depression and mandate the use of a common suicidality screening tool;
  - Increase public awareness about protective factors in youth – such as family and community connections and building skills in problem solving;
  - Increase training opportunities for both school and community personnel to help identify at-risk students, to help deal with a student in crisis, and to help cope with the suicide of a student.

Using Suicide Attempt Data to Inform Prevention Efforts in Connecticut

Rob Aseltine, PhD
UConn Health
September 14, 2017

Resources for Preventing Suicide Scarce

- Suicide prevention not a federal priority
  - NIH spending in FY 2014 = $22 million
    - 195th out of 244 disease areas in funding[3]
  - SAMHSA spending in FY 2015 = $60 million
    - = 1.7% of the agency's budget.[4,5]
- Challenge is to get actionable information on who is at risk/where the risk is

Suicide Deaths vs. Attempts

- Deaths ultimate target for prevention, but ….
  - Relatively rare ~ 10/100,000
    - ~360 per year in CT, 60-75 among adolescents
- Medical claims for suicide attempts
  - Capture serious attempts
  - Numerous (10*x* more frequent than deaths)
  - Demographic detail (esp. geography)
  - Available (47 states report into HCUP)

Twice as many ED non-admits

Connecticut Data on Medically Serious Suicide Attempts

CT Hospital Inpatient Discharge Database (DPH)

- Contains claims data from all 30 acute care facilities in state
- Suicide attempts identified using diagnosis codes
- Analyzed 5 years of data (2008-2012) on 15-19 year olds (2.2 million claims)
- Combined with mortality data from OCME

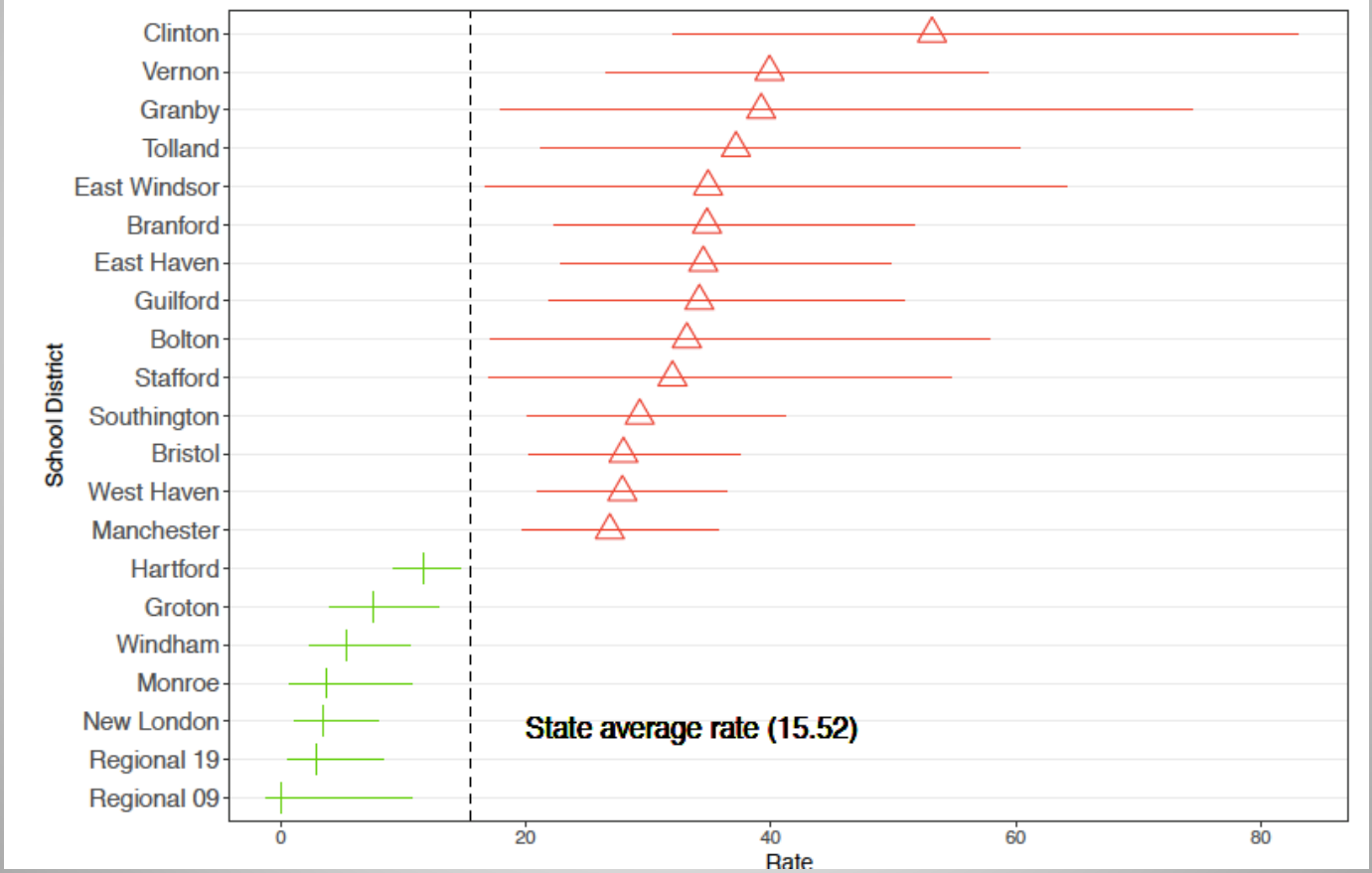
Overview of Analysis

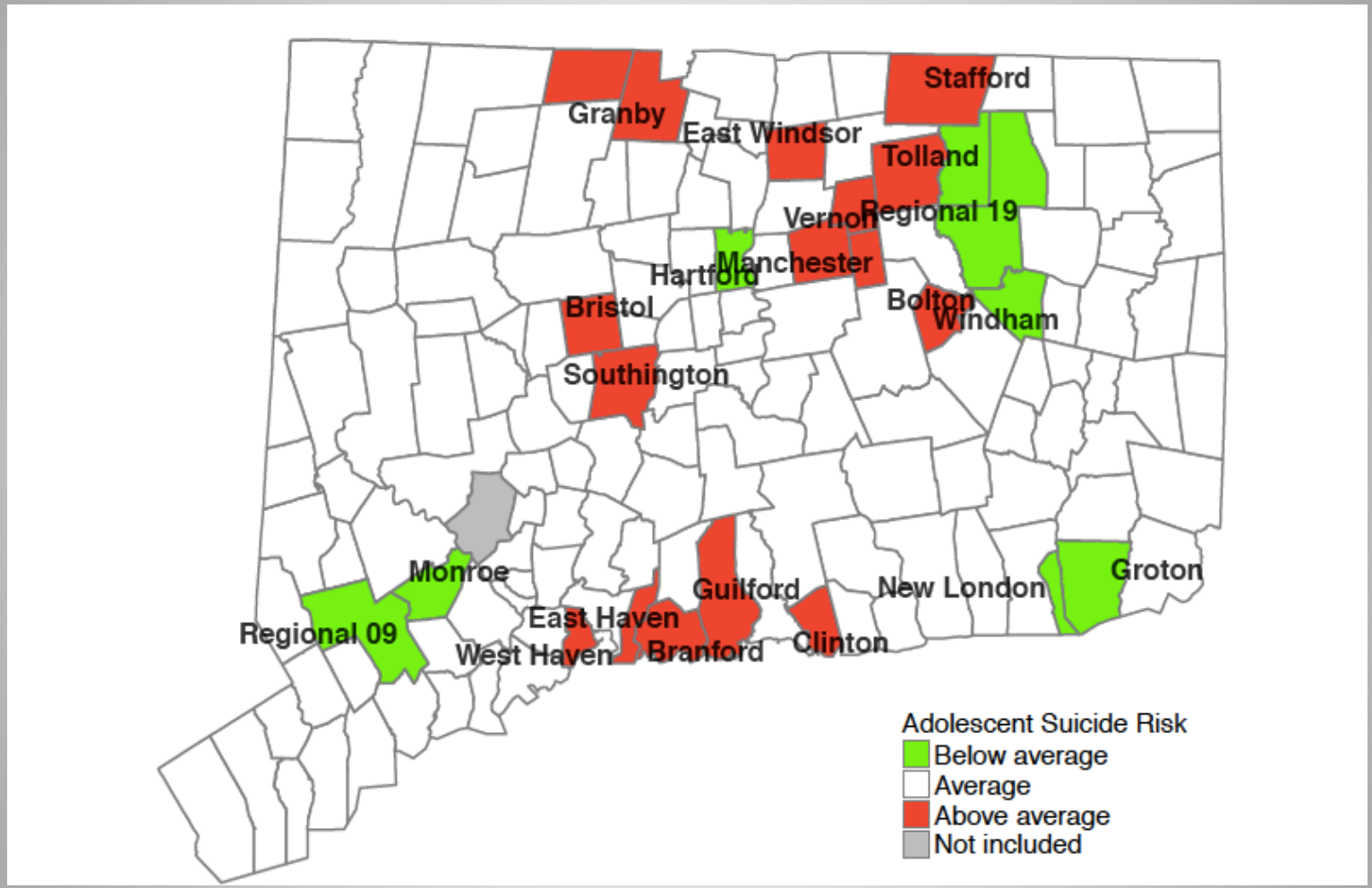
Use morbidity data (claims), mortality data (death), and community demographics to:

- Identify high & low risk school districts in CT
- Control for community level advantages/disadvantages
- Identify districts better/worse ***than expected*** based on underlying characteristics

High and Low Risk Districts: Unadjusted

Rates of Suicide/Suicide Attempt per 10,000: 2010-2014




Granby
East Windsor
Stafford
Tolland
Regional 19
Vernon
Manchester
Hartford
Bristol
Bolton
Windham
Southington
Monroe
Regional 09
East Haven
West Haven
Branford
Guilford
Clinton
New London
Groton
Adolescent Suicide Risk
Below average
Average
Above average
Not included

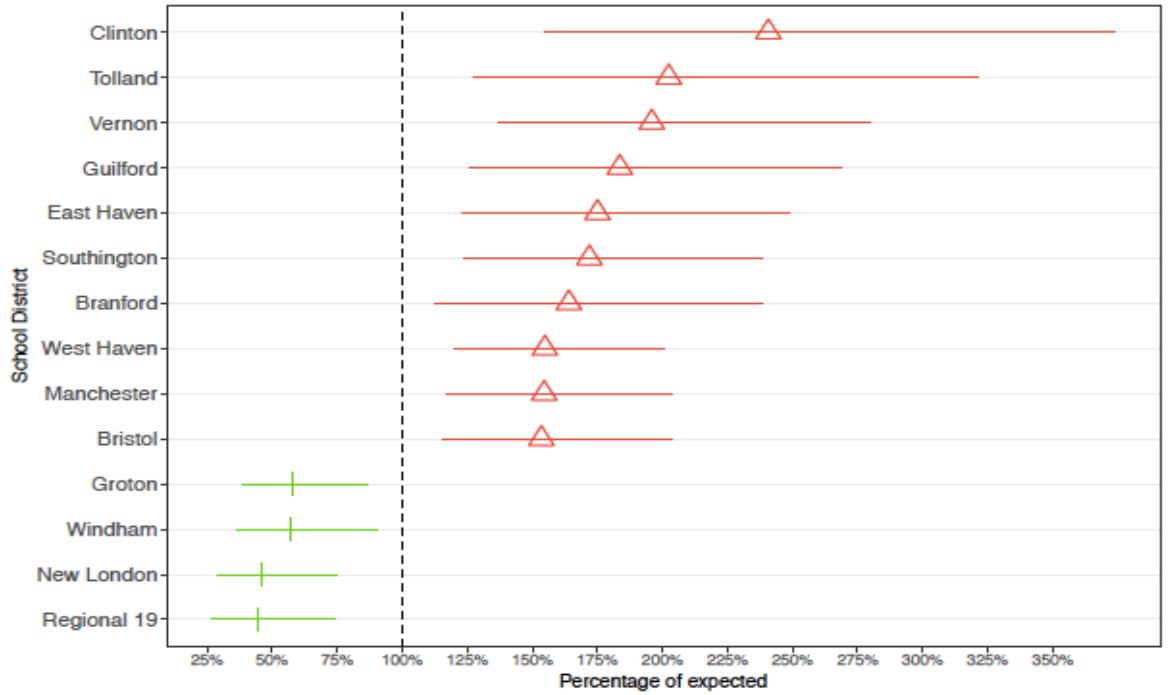
Adjusting for Community Level Advantages & Disadvantages

- **Socioeconomic characteristics:**
  - % Population with male in household
  - Household size
  - % Population under 18
  - % Population White
  - Median income

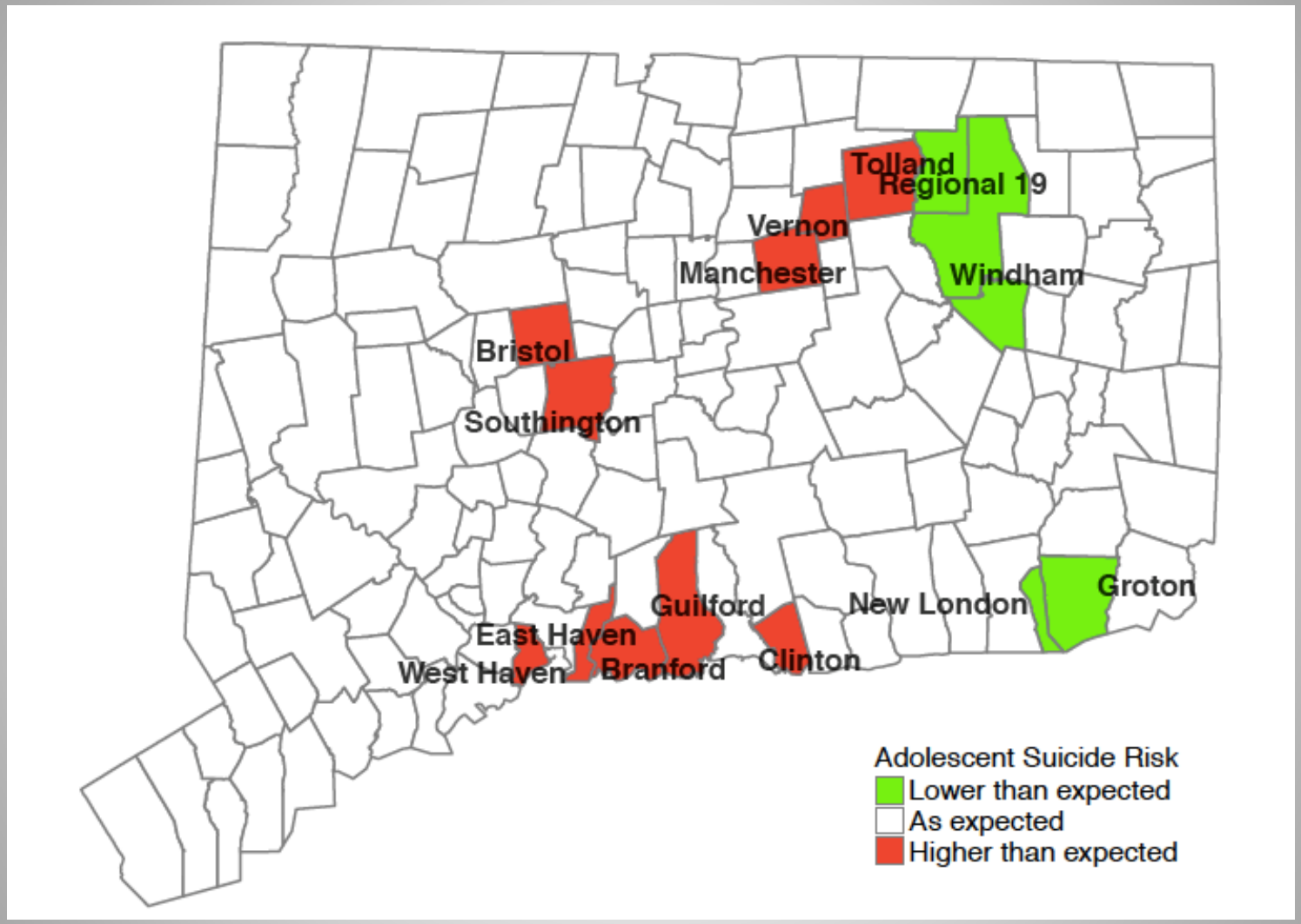
- **Academic characteristics:**
  - CAPT scores
  - Graduation rate
  - Dropout rate
  - Serious incident rate
  - Attendance rate

High and Low Risk Districts: Adjusted

Rates of Suicide/Suicide Attempt per 10,000: 2010-2014



- 7 "better" districts reduce to 4.
- 14 "worse" districts reduce to 10.


Tolland
Regional 19
Vernon
Manchester
Windham
Bristol
Southington
Guilford
New London
Groton
East Haven
West Haven
Branford
Clinton
Adolescent Suicide Risk
Lower than expected
As expected
Higher than expected

Summary

- Suicide attempt data provide an untapped resource in identifying areas at risk
  - Critical when prevention delivered geographically
- Question: What is it that low risk districts are doing that is effective?
  - Limits to medical data – no insight into best practices

Questions?

References

1. National Institutes of Health. Available at: http://report.nih.gov/categorical_spending.aspx. Accessed March 2015.

2. Substance Abuse and Mental Health Services. Available at: http://www.samhsa.gov/suicide-prevention/samhsas-efforts. Accessed March 2015.

3. US Department of Health and Human Services. Budget in Brief. Available at: http://www.hhs.gov/budget/fy2016-hhs-budget-in-brief/hhs-fy2016budget-in-brief-samhsa.html#SAMHSA%20Programs%20and%20Services. Accessed March 2015.

Keynote

Dennis D. Embry – PAXIS Institute/PAX Good Behavior Games

pax | Good Behavior Game

13 Reasons for PAX GBG

Dennis D. Embry, Ph.D. president senior scientist, PAXIS Institute.
co-investigator, Johns Hopkins Center for Prevention & Early Intervention;
co-investigator, Manitoba Centre for Health Policy

1st Reason

Every student has authentic voice for what they want to have more of and less of in their classrooms and schools.

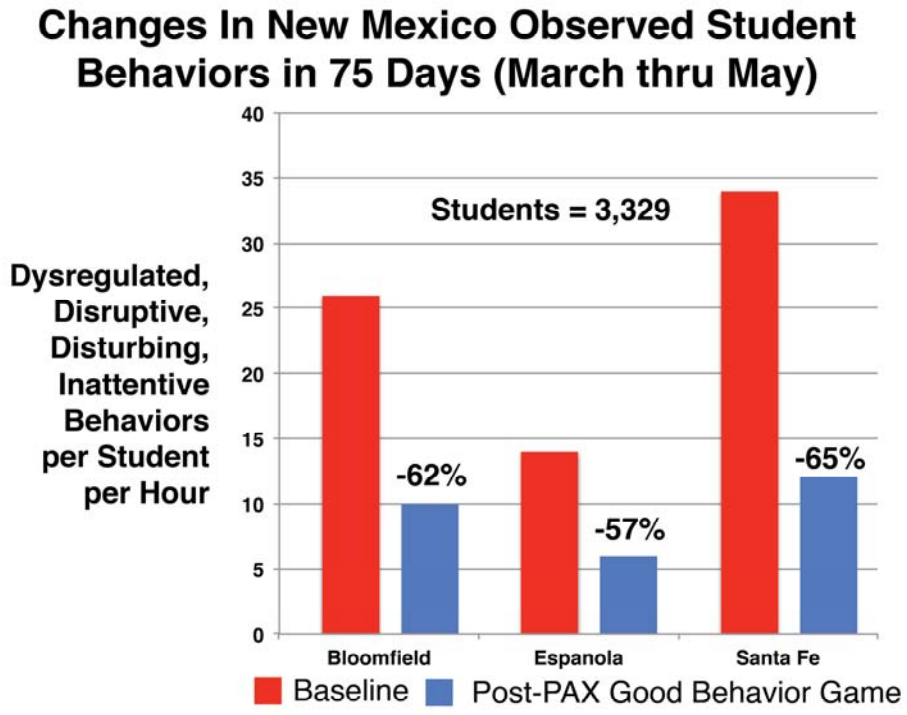
That creates hope.

2nd Reason: students better their world

2nd Reason

PAX GBG enables children to develop powerful self-regulation that reduces risk of suicide.

3rd Grader in the a Title I school in epicenter of the Ohio Opiate Epidemic speaks about PAX.



3rd Reason

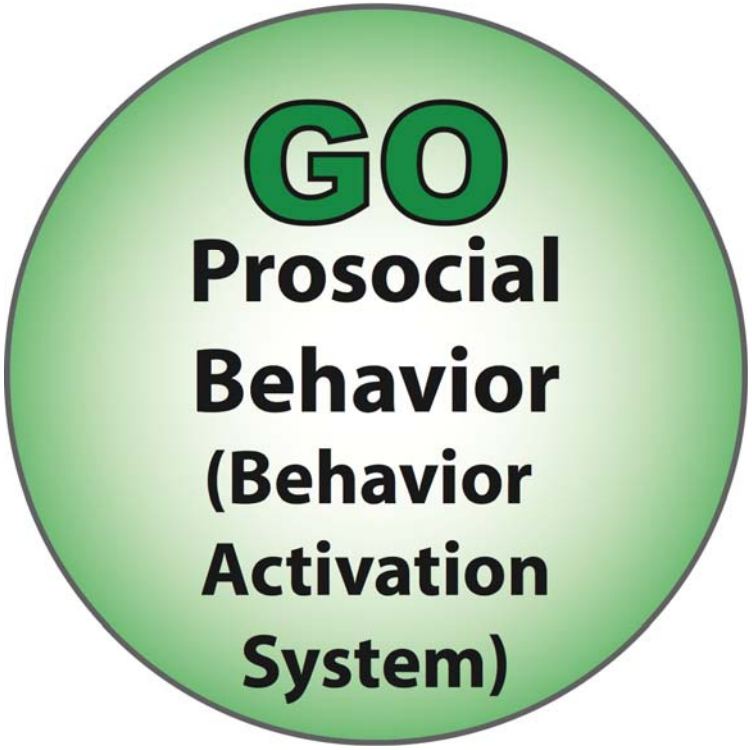
PAX rapidly reduces disturbing, disruptive, aggressive behavior in schools. This benefit is widely replicated around the world.

Such classroom behaviors are an ecological predictor of suicide risk as well as multiple adverse lifetime outcomes.

4th Reason

Teachers are better able to teach, and less likely to use coercive methods on students. Both child & adult mental health improves.

This shift protects teacher mental health, with a recent study showing that PAX reduces teacher stress by 60% in five months.



5th Reason

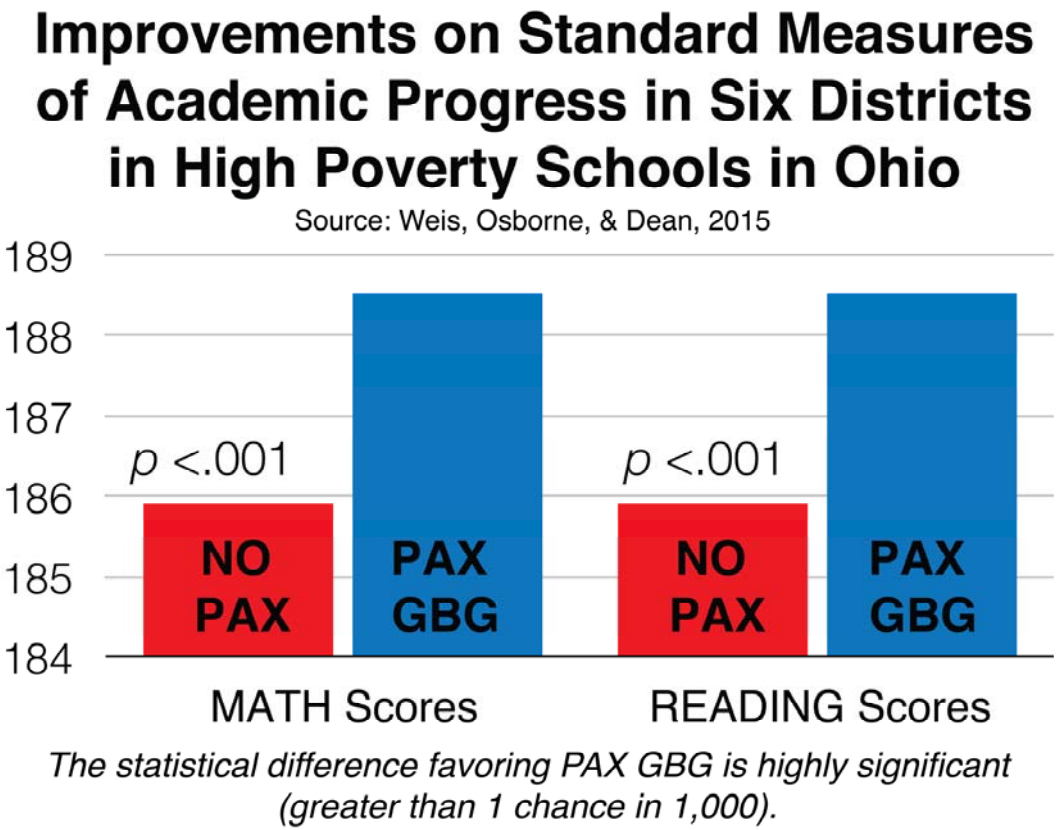
PAX GBG dramatically improves easily measured prosocial behavior among peers, the mediator of reduced lifetime suicide risk.

Newcomer, A. R., Roth, K. B., Kellam, S. G., Wang, W., Ialongo, N. S., Hart, S. R., . . . Wilcox, H. C. (2016). Higher Childhood Peer Reports of Social Preference Mediates the Impact of the Good Behavior Game on Suicide Attempt. Prev Sci, 17(2), 145-156. doi:10.1007/s11121-015-0593-4

Here are the prosocial behaviors that predict lifetime positive outcomes…

1. Function well even with distractions.
2. Can accept things not going his/her way.
3. Copes well with failure.
4. Is a self-starter
5. Works/plays well without adult support.
6. Accepts legitimate imposed limits.
7. Expresses needs and feelings appropriately.
8. Thinks before acting.
9. Resolves peer problems on his/her own.
10. Stays on task.
11. Can calm down when excited or all wound up.
12. Can wait in line patiently when necessary.
13. Very good at understanding other people's feelings.
14. Is aware of the effect of his/her behavior on others.
15. Works well in a group.
16. Plays by the rules of the game.
17. Pays attention.
18. Controls temper when there is a disagreement.
19. Shares materials with others.
20. Cooperates with peers without prompting.
21. Follows teacher's verbal directions.
22. Is helpful to others.
23. Listens to others' point of view.
24. Can give suggestions and opinions without being bossy.
25. Acts friendly toward others.

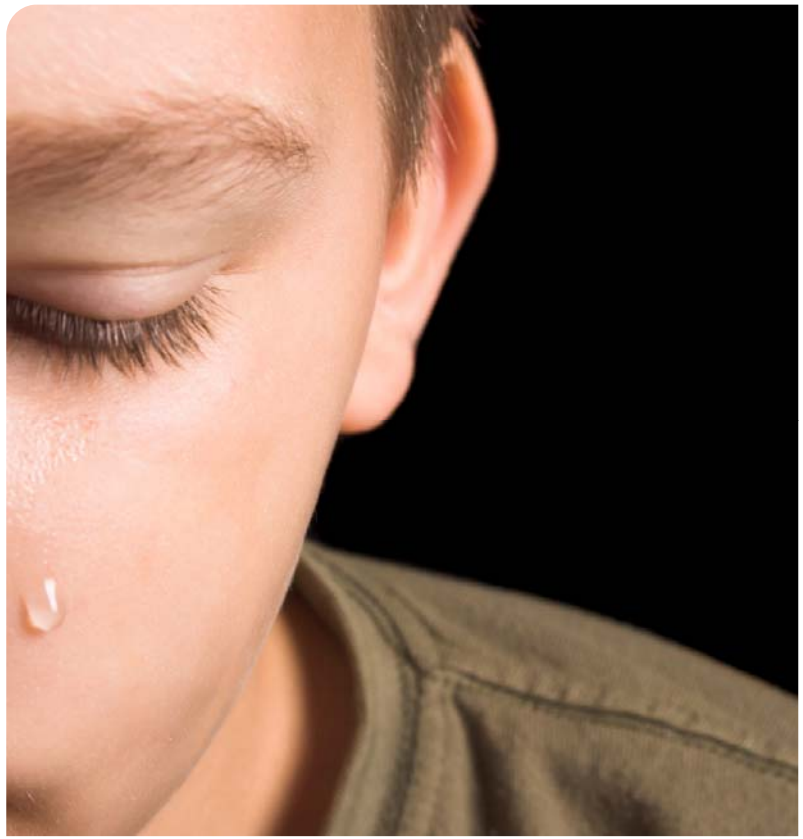
Jones, D. E., Greenberg, M., & Crowley, M. (2015). Early Social-Emotional Functioning and Public Health: The Relationship Between Kindergarten Social Competence and Future Wellness. *Am J Public Health, 105*(11), 2283-2290. doi:10.2105/ajph.2015.302630



6th Reason

Standardized measures of academics improve in the poorest of schools with PAX

Weis, R., Osborne, K. J., & Dean, E. L. (2015). Effectiveness of a universal, interdependent group contingency program on children's academic achievement: A countywide evaluation. *Journal of Applied School Psychology, 31*(3), 199-218. doi:10.1080/15377903.2015.1025322



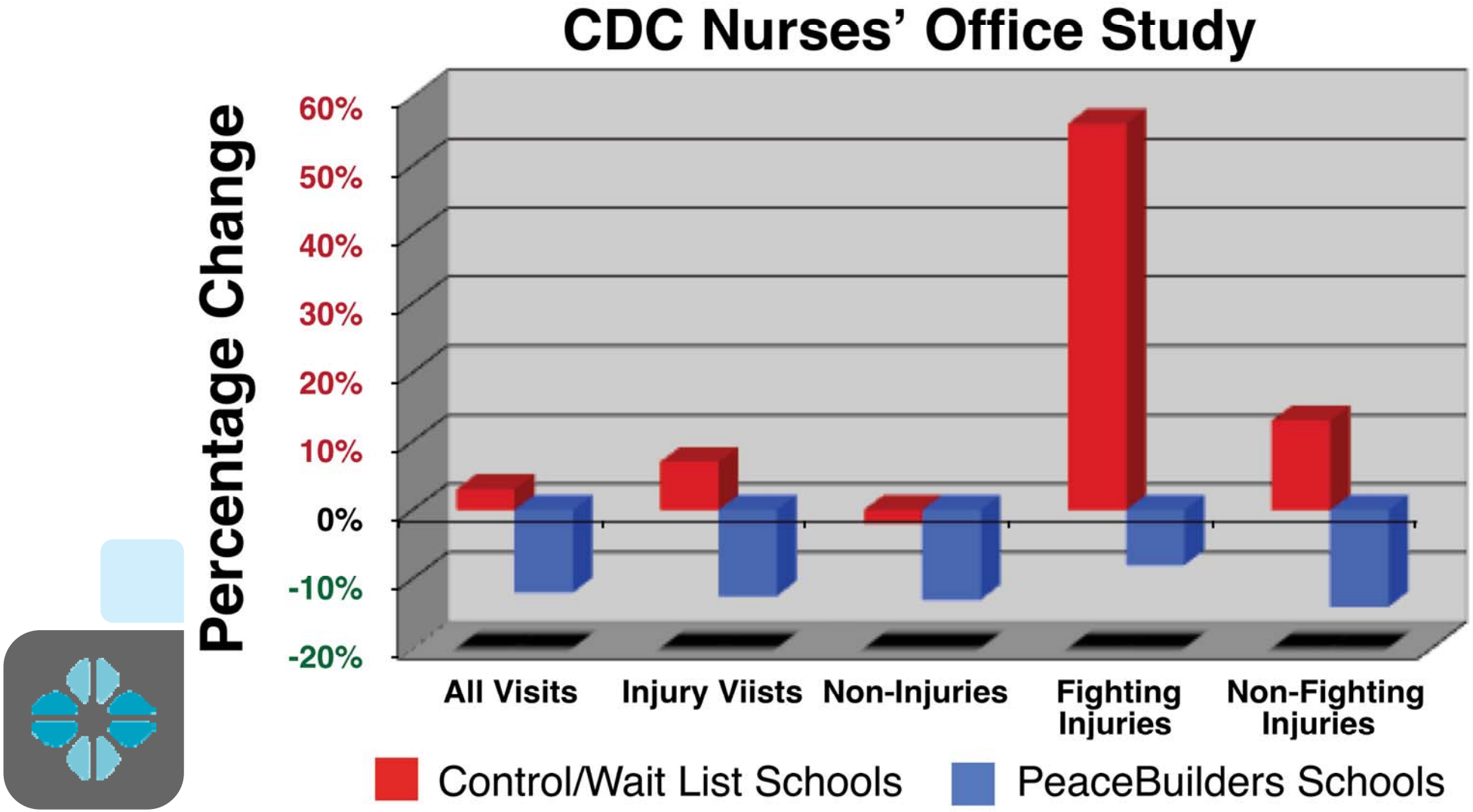
7th Reason

PAX GBG was the U.S. first randomized comparative effectiveness study to show reductions in bullying, and takes no time from curriculum.

8th Reason

An earlier study of the "PAX" part of PAX GBG improved every health indicator of students in a CDC EPI-team study an outbreak of peace & health.

Krug, E. G., Brener, N. D., Dahlberg, L. L., Ryan, G. W., & Powell, K. E. (1997). The impact of an elementary school-based violence prevention program on visits to the school nurse. American Journal of Preventive Medicine, 13(6), 459-463.


CDC Nurses' Office Study
Percentage Change
60%
50%
40%
30%
20%
10%
0%
-10%
-20%
All Visits
Injury Viists
Non-Injuries
Fighting Injuries
Non-Fighting Injuries
Control/Wait List Schools
PeaceBuilders Schools

Why PAX?

The Alignment of PBIS and the PAX Good Behavior Game

Rob Horner and Dennis Embry

Positive Behavioral Interventions and Supports (PBIS) and the PAX Good Behavior Game (PAX GBG) are sympathetic companions. The best way to see this linkage is through review of what has been identified as the "kernels" of each approach (the active ingredients). While PBIS emphasizes the whole school and PAX GBG focuses on classroom practices they share these kernels:

a) ***Prevention***: Both PBIS and PAX GBG are focused on building learning environments that prevent the emergence of problem behavior. While clear consequences for problem behavior are necessary, the emphasis on prevention dominates both PBIS and PAX GBG.

b) ***Teach what you want:*** Both PBIS and PAX GBG build formal strategies for teaching pro-social behavior. This commitment to actively teaching social behavior is of special importance for those students who enter school without clear foundations in positive behavior.

c) ***Acknowledge what you want***: Both PBIS and PAX GBG define multiple, formal ways for adults (and peers) to acknowledge appropriate behavior. Acknowledgement strategies both reinforce appropriate behavior, and help teach what is desirable.

d) ***Establish community***: Effective schools are learning communities. Students who participate in PBIS and GBG schools learn together, not just in isolation. In effective classrooms students learn from each other as well as from the teacher.

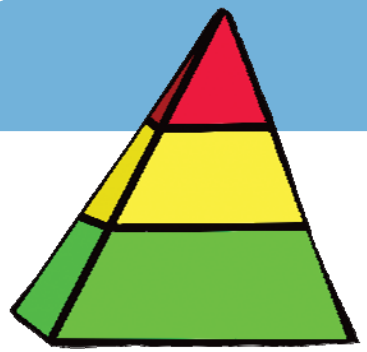
e) ***Use of data***: Both PBIS and PAX GBG emphasize the collection and use of data… data to document what is being done, and data to document what is and is not working. Only those who believe they always get it "right" can educate without on-going data. For the rest of us, the goal is on-going use of data to get "better." PBIS and PAX GBG are constantly working to get better.

f) ***Adaptation to local culture***: Both PBIS and PAX GBG offer specific examples of classroom practice, but both also allow variations by local educators to match the social and community culture. Building a predictable, consistent, positive and safe classroom can happen in many ways.

While PBIS emphasizes the whole school and GBG focuses on classroom practices, the shared commitment to active ingredients makes the two approaches highly compatible. By implementing both compatible whole school and classroom strategies, both science and common sense suggest that outcomes for students, schools, and communities will be better.

9th Reason

PAX GBG provides teachers powerful tools to make PBIS real in the classroom as a Tier 1, 2 & 3 suite of strategies.



10th Reason

Students want PAX because they directly experience reduced stress, increased wellbeing and feel safer.

O'Donnell, M., Morgan, M., Embry, D. D., O'Kelly, N., & Owens, C. (2016). Supporting the development of pupils' self-regulation skills: Evaluation of the PAX GBG Programme in Ireland. *Irish Teachers' Journal, 4* (1), 9-29.

This is the last snip of raw united footage shown at a town event about PAX GBG, where a whole school district has embraced PAX Pre-K thru 12th grade.

11th Reason

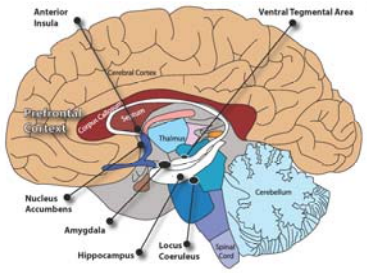
PAX causes positive gene expression in genes sensitive to ACEs.

Musci, R. J., Bradshaw, C. P., Maher, B., Uhl, G. R., Kellam, S. G., & Ialongo, N. S. (2013). Reducing aggression and impulsivity through school-based prevention programs: A gene by intervention interaction. Prevention Science, No Pagination Specified. doi:10.1007/s11121-013-0441-3

These are pages from the teachers' manual related to neuroscience at Hopkins on GBG

	GO Prosocial Behavior (Behavior Activation System)	STOP Inhibition Behavior (Behavior Inhibition System)
Serotonin	Greater perceived safety increases serotonin. Increased serotonergic function improves friend making. Increased serotonergic function reduces depression and anxiety.	Perceived danger or threat decreases serotonergic function. Lower serotonin increases mental and behavioral impulsivity. Decreased serotonergic function increases aggression and self-harm.
Dopamine	Perceived safety and trust allow delayed gratification. Perceived safety and trust enable long-term goal seeking. Rich reinforcement for prosocial behavior increases happiness.	Low perceived trust and safety lead to immediate reward seeking. Low perceived trust and safety increase drug-seeking actions. Low dopamine increases impulsive risk-taking.
Adrenaline (Epinephrine)	Moderate stress sharpens attention. Too little increases apathy.	High levels cause freezing and/or impulsivity. High levels increase pain and sickness. High levels increase burnout.

How Some Key Brain Chemicals Modulate Behavior in Your Classroom

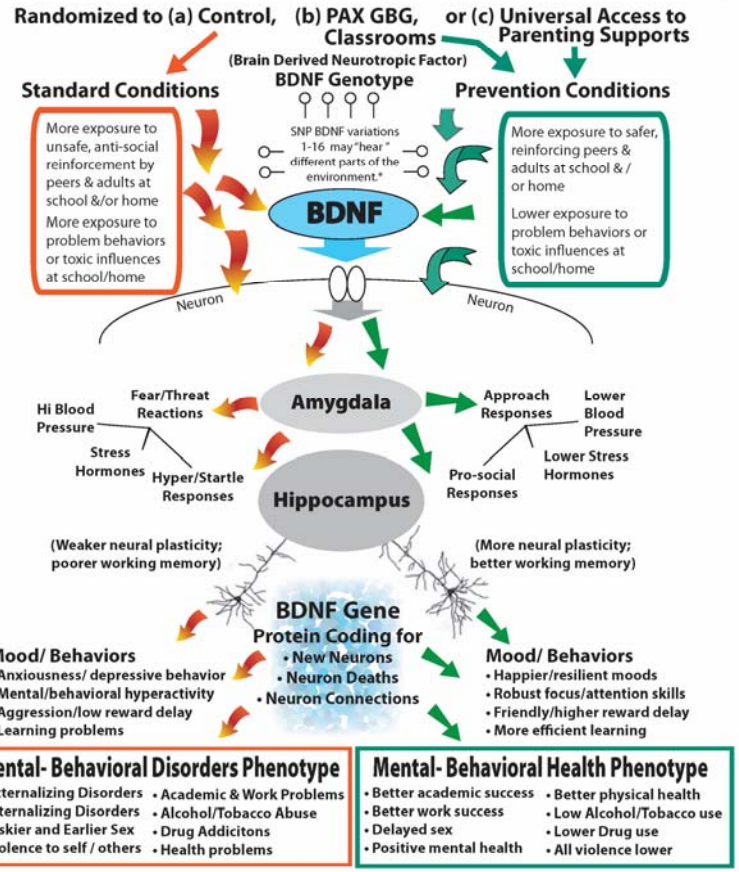


A PAX Classroom Environment Is a Good Brain Chemical Factory

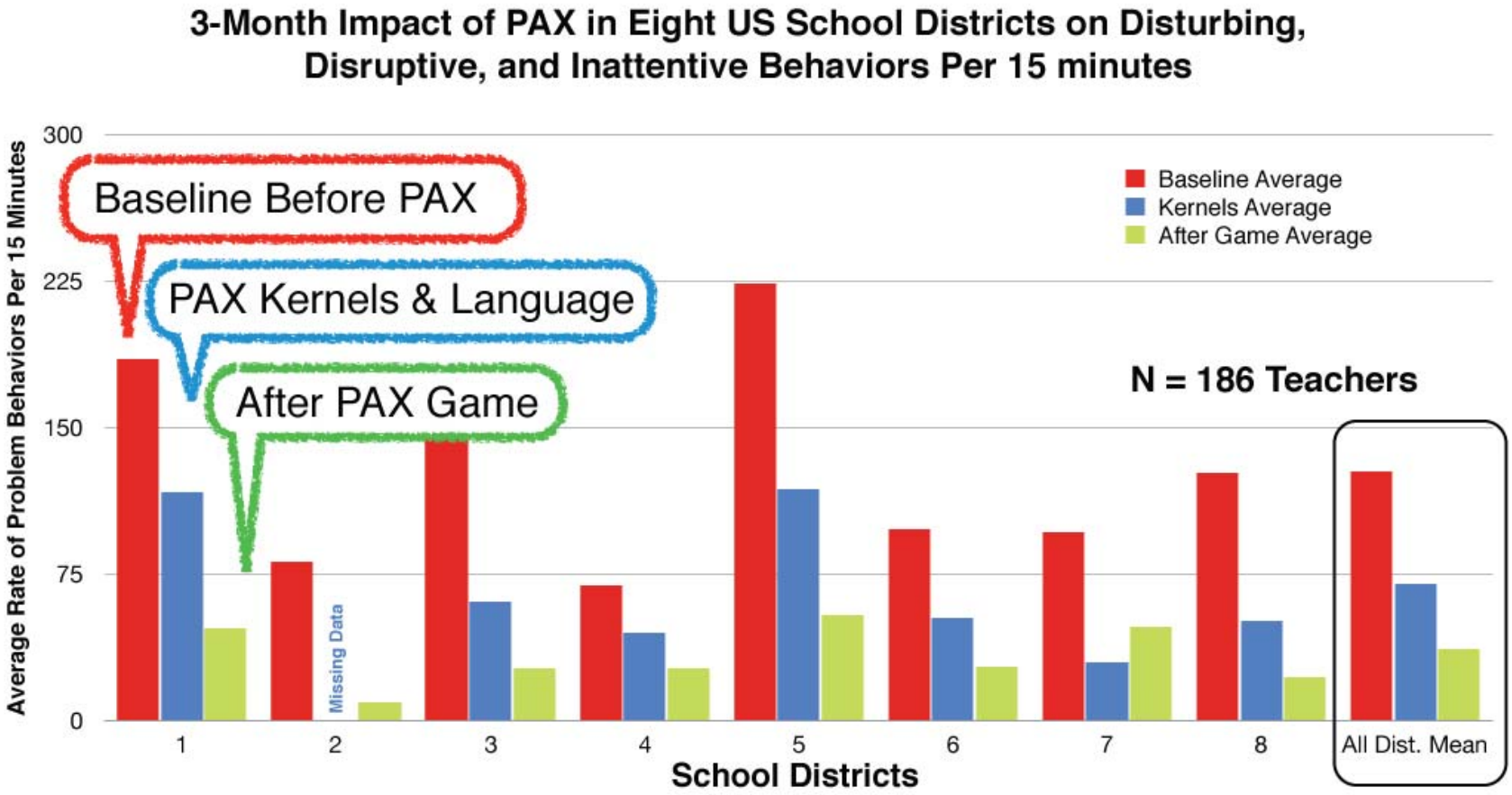
As you use the PAX Good Behavior Game and Granny's Wacky Prizes, you assist the Ventral Tegmental Area (VTA) to do its job synthesizing dopamine, which is the "hydraulic fluid" of the brain's self-control and self-regulation circuits to help achieve your valued goals in life you checked. As you use the PAX Cues skillfully, you disarm or dampen the danger alarm circuits in the Locus Coeruleus and other areas of the brain that signal threats and human predators to children's brains.

When you, other adults, and children use the language of belonging and safety (PAX OK and Spleems Not OK) of the PAX Good Be-

How the Social Environment Affects Expression of Genes Associated with Mental and Behavioral Disorders from Recent Experimental Results Following Children for Two Decades*



*Graphic visualizatiion ofthe findings from: Musci, R. J., Bradshaw, C. P., Maher, B., Uhl, G. R., Kellam, S. G., & Ialongo, N. S. (2013). Reducing aggression and impulsivity through school-based prevention programs: A gene by intervention interaction. Prevention Science, No Pagination Specified. doi: 10.1007/s11121-013-0441-3.
Note: The beneficial effects were twice for the classroom strategy compared to the parenting supports.



12th Reason: PAX works fast everywhere

Wilson, D. S., Hayes, S. C., Biglan, A., & Embry, D. D. (2014). Evolving the Future: Toward a Science of Intentional Change. Brain and Behavioral Sciences, 37(4), 395-416.

Washington State Institute for Public Policy

13th Reason

PAX GBG changes lifetime outcomes with an economic rate of return of 60-to-1 to 90-to-1.

OUTCOMES	STUDENT GROUPS	GBG CLASSROOM	STANDARD CLASSROOM
Drug abuse and dependence disorders	All males	19 percent	38 percent
	Highly aggressive males	29 percent	83 percent
Regular smoking	All males	6 percent	19 percent
	Highly aggressive males	0 percent	40 percent
Alcohol abuse and dependence disorders	All males and females	13 percent	20 percent
Antisocial personality disorder (ASPD)	Highly aggressive males	40 percent	100 percent
Violent and criminal behavior (and ASPD)	Highly agressive males	34 percent	50 percent
Service use for problems with behavior, emotions, drugs, or alcohol	All males	25 percent	42 percent
Suicidal thoughts	All females	9 percent	19 percent
	All males	11 percent	24 percent

Kellam, S. G., Mackenzie, A. C., Brown, C. H., Poduska, J. M., Wang, W., Petras, H., & Wilcox, H. C. (2011). The good behavior game and the future of prevention and treatment. Addict Sci Clin Pract, 6(1), 73-84.

What are the good reasons why we can’t do PAX in Connecticut?

BREAK – 15 minutes

Gizmo says, “Take 15 and we’ll start up at 11:00”

Signs of Suicide (SOS)

Meghan Diamon – Screening for Mental Health, Inc.

SOS Signs of Suicide® Prevention Program

For middle and high school students

SMH

Screening for Mental Health and SOS

Screening for Mental Health is a national non-profit organization whose mission is to provide innovative mental health and substance abuse resources, linking those in need to quality treatment options.

The SOS Signs of Suicide® Prevention Program is a universal, evidence-based educational curriculum and screening tool used in middle and high schools across the country.

Universal Prevention Goals

- **Decrease** suicide and attempts by **increasing** knowledge and adaptive attitudes about depression.
- **Encourage** individual help-seeking and help-seeking on behalf of a friend.
- **Reduce** stigma: mental illness, like physical illness, requires treatment.
- **Engage** parents and school staff as partners in prevention through education.
- **Encourage** schools to develop community-based partnerships.

SOS Key Program Components

Peer-to-Peer Student Curriculum: student video and guided discussion

Depression Screening: validated, seven-item Brief Screen for Adolescent Depression (BSAD) designed to identify at-risk students for further evaluation

Help-Seeking: ACT message (Acknowledge, Care, Tell) and response cards encouraging students to reach out

Education for Faculty and Parents: In-person and online

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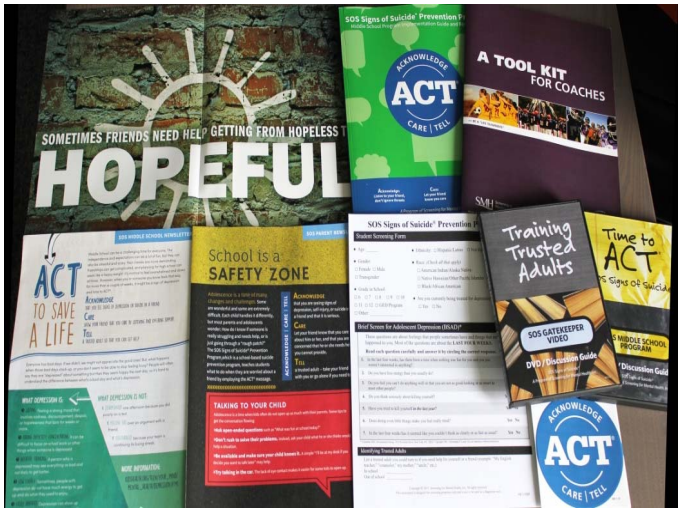
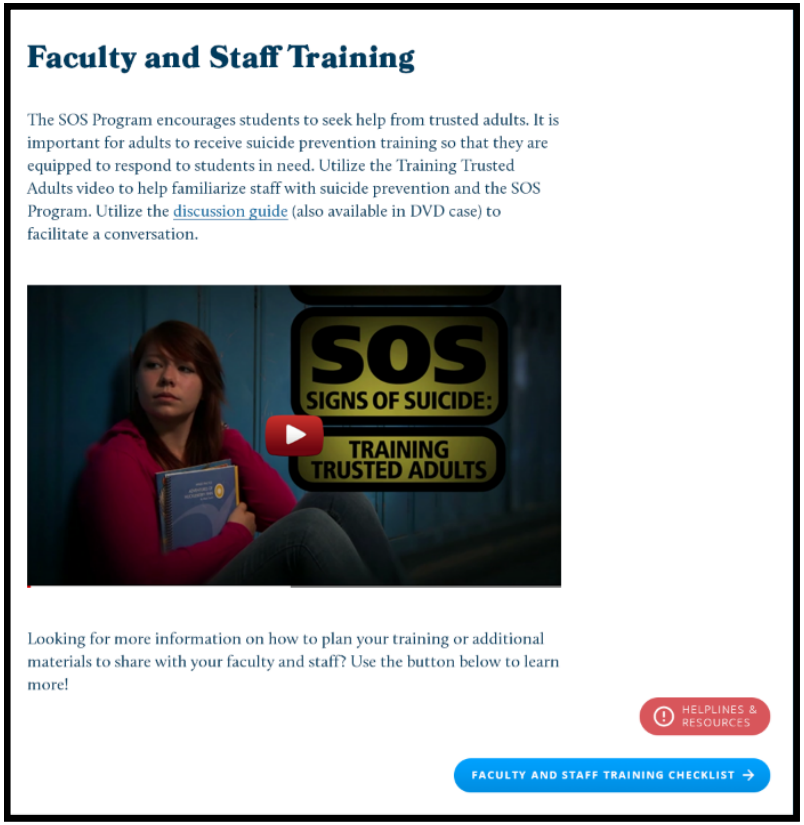
SOS Program Materials





Engaging Parents

Watch the Video

Learn about youth suicide prevention and the program your child is receiving in school. This video provides an overview of the SOS Program and contains clips from the high school student video.

Contact your school with any questions about how the program will be implemented in your community.

Concerned about your child?

Mental health is a key part of your child's overall health. This depression screening is the quickest way to determine if your child should connect with a mental health professional. The program is completely anonymous and confidential. Immediately following the brief questionnaire, you will receive results, recommendations, and key resources from your child's school or community.

TAKE A SCREENING

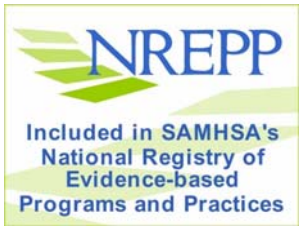
Evaluation of the SOS Program

SOS is the only universal school-based suicide prevention program for which a reduction in self-reported suicide attempts has been documented.

In randomized controlled studies, the SOS Program has shown a reduction in self-reported suicide attempts by 40-64%.

A new replication study published in the Prevention Science Journal (2016) found SOS to be associated with:

- greater knowledge and more adaptive attitudes about depression and suicide
- 64% fewer suicide attempts among intervention youths relative to untreated controls
- decrease in suicide planning for "high risk participants" (those who reported a lifetime history of suicide attempt) (Schilling et. al, 2016)



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Step 1: Video and Discussion

Step 2: Identifying Students In Need

Students are identified 3 ways:

- Screening
- Student response card
- Help-seeking: students ACT and tell a trusted adult (teachers, coaches, parents)

BASED ON THE VIDEO AND/OR SCREENING, I FEEL THAT:

□ I need to talk to someone …

□ I do not need to talk to someone …

ABOUT MYSELF OR A FRIEND.

NAME(PRINT):_____

HOMEROOM SECTION:_____

TEACHER:_____

IF YOU WISH TO SPEAK WITH SOMEONE, YOU WILL BE CONTACTED WITHIN 24 HOURS. IF YOU WISH TO SPEAK WITH SOMEONE SOONER, PLEASE APPROACH STAFF IMMEDIATELY.

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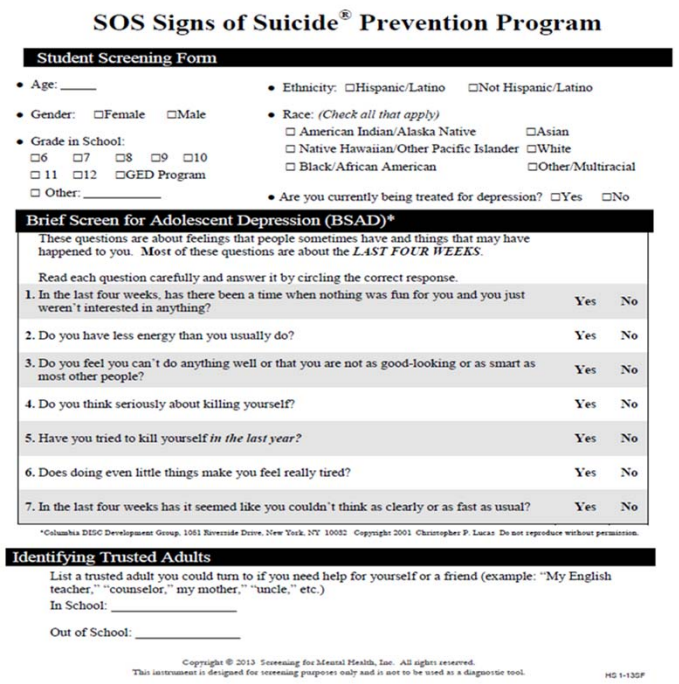
Brief Screen for Adolescent Depression (BSAD)



SOS Signs of Suicide® Prevention Program

Student Screening Form

- Age: _____
- Gender: ☐Female ☐Male
- Grade in School:
  ☐6 ☐7 ☐8 ☐9 ☐10
  ☐ 11 ☐12 ☐GED Program
  ☐ Other: _____
- Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino
- Race: *(Check all that apply)*
  ☐ American Indian/Alaska Native ☐Asian
  ☐ Native Hawaiian/Other Pacific Islander ☐White
  ☐ Black/African American ☐Other/Multiracial
- Are you currently being treated for depression? ☐Yes ☐No

Brief Screen for Adolescent Depression (BSAD)*

These questions are about feelings that people sometimes have and things that may have happened to you. **Most** of these questions are about the ***LAST FOUR WEEKS***.

Read each question carefully and answer it by circling the correct response.

1. In the last four weeks, has there been a time when nothing was fun for you and you just weren't interested in anything?	Yes	No
2. Do you have less energy than you usually do?	Yes	No
3. Do you feel you can't do anything well or that you are not as good-looking or as smart as most other people?	Yes	No
4. Do you think seriously about killing yourself?	Yes	No
5. Have you tried to kill yourself *in the last year?*	Yes	No
6. Does doing even little things make you feel really tired?	Yes	No
7. In the last four weeks has it seemed like you couldn't think as clearly or as fast as usual?	Yes	No

*Columbia DISC Development Group, 1051 Riverside Drive, New York, NY 10032 Copyright 2001 Christopher P. Lucas Do not reproduce without permission.

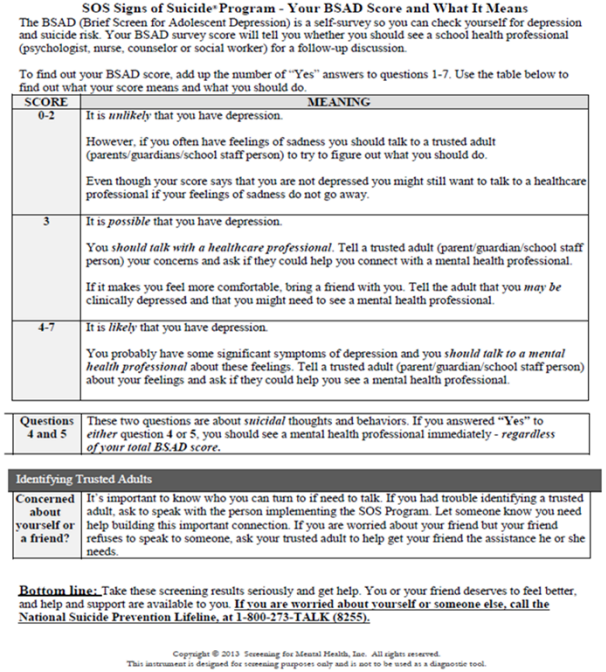
Identifying Trusted Adults

List a trusted adult you could turn to if you need help for yourself or a friend (example: "My English teacher," "counselor," my mother," "uncle," etc.)

In School: _____

Out of School: _____

HS 1-13SF



SOS Signs of Suicide® Program - Your BSAD Score and What It Means

The BSAD (Brief Screen for Adolescent Depression) is a self-survey so you can check yourself for depression and suicide risk. Your BSAD survey score will tell you whether you should see a school health professional (psychologist, nurse, counselor or social worker) for a follow-up discussion.

To find out your BSAD score, add up the number of "Yes" answers to questions 1-7. Use the table below to find out what your score means and what you should do.

SCORE	MEANING
0-2	It is ***unlikely*** that you have depression. However, if you often have feelings of sadness you should talk to a trusted adult (parents/guardians/school staff person) to try to figure out what you should do. Even though your score says that you are not depressed you might still want to talk to a healthcare professional if your feelings of sadness do not go away.
3	It is *possible* that you have depression. You ***should talk with a healthcare professional***. Tell a trusted adult (parent/guardian/school staff person) your concerns and ask if they could help you connect with a mental health professional. If it makes you feel more comfortable, bring a friend with you. Tell the adult that you *may be* clinically depressed and that you might need to see a mental health professional.
4-7	It is *likely* that you have depression. You probably have some significant symptoms of depression and you ***should talk to a mental health professional*** about these feelings. Tell a trusted adult (parent/guardian/school staff person) about your feelings and ask if they could help you see a mental health professional.

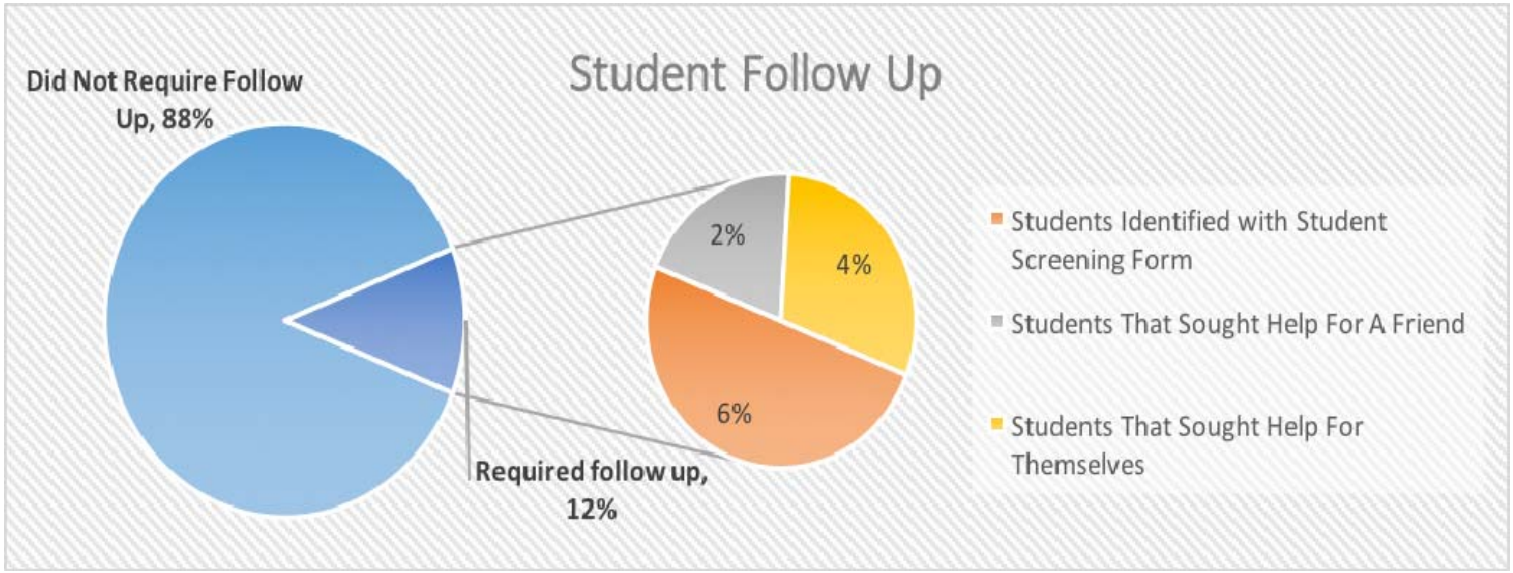
Questions 4 and 5	These two questions are about *suicidal* thoughts and behaviors. If you answered **"Yes"** to *either* question 4 or 5, you should see a mental health professional immediately - ***regardless of your total BSAD score.***

Identifying Trusted Adults

Concerned about yourself or a friend?	It's important to know who you can turn to if need to talk. If you had trouble identifying a trusted adult, ask to speak with the person implementing the SOS Program. Let someone know you need help building this important connection. If you are worried about your friend but your friend refuses to speak to someone, ask your trusted adult to help get your friend the assistance he or she needs.

Bottom line: Take these screening results seriously and get help. You or your friend deserves to feel better, and help and support are available to you. **If you are worried about yourself or someone else, call the National Suicide Prevention Lifeline, at 1-800-273-TALK (8255).**

How Many Students Will Need Follow-up?



Step 3: Student Follow-Up

- Mental health screenings are for educational purposes and ***not diagnostic***
- Contact parents, refer for further assessment, as needed
- Prior to the program, work with community partners to gather referral resources
- Document all suicide prevention/intervention activities (student follow-up form provided)

Planning to Implement SOS for Students

- Selecting pilot group
- Lessons take one class period per group of students
- Designed to be implemented by existing school staff
- Training available:
  - Teaching suicide prevention for 6-12th graders
  - Preparing faculty and parents
  - Depression screening best practices
  - Updating suicide prevention and intervention policies

For More Information Contact:

Meghan Diamon, LCSW
Senior Manager of Suicide Prevention Programs
mdiamon@mentalhealthscreening.org

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK (8255)
suicidepreventionlifeline.org

SMH

4 What’s Next

Marisa Giarnella-Porco and Elizabeth McOsker – Jordan Porco Foundation

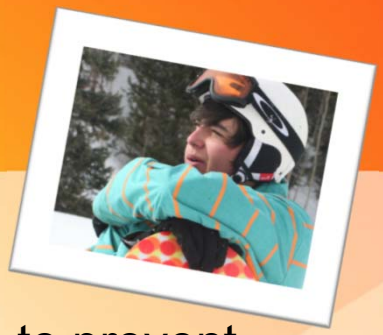
4 WHAT'S NEXT

Because change happens.

A program of
JORDAN PORCO
— FOUNDATION —

About Us

JORDAN PORCO FOUNDATION



- Established 2011
- The mission of the Jordan Porco Foundation is to prevent suicide, promote mental health, and create a message of hope for young adults.
- To accomplish this, we
  - **H**elp challenge stigma by talking openly about mental health issues
  - **O**ffer engaging and uplifting programming, emphasizing peer-to-peer messaging
  - **P**romote help seeking behavior, self-care, and coping skills
  - **E**ducate about the risk factors and warning signs of suicide and other related mental health concerns

WHAT'S NEXT

College Success

freshcheckday

Fresh Check Day: a mental health promotion and suicide prevention fair

- Includes peer-run interactive booths, free food, music, and exciting prizes and giveaways
- Encourages open dialogue about mental health and to build connections
- Growth: 150+ events at 100+ schools in 30+ states in just over 5 years
- Results: Our survey data show that after attending Fresh Check Day in 2016,
  - 86.8% of student respondents are more likely to seek help when in distress
  - 90.3% are more aware of available resources
  - 87.6% are more prepared to help a friend

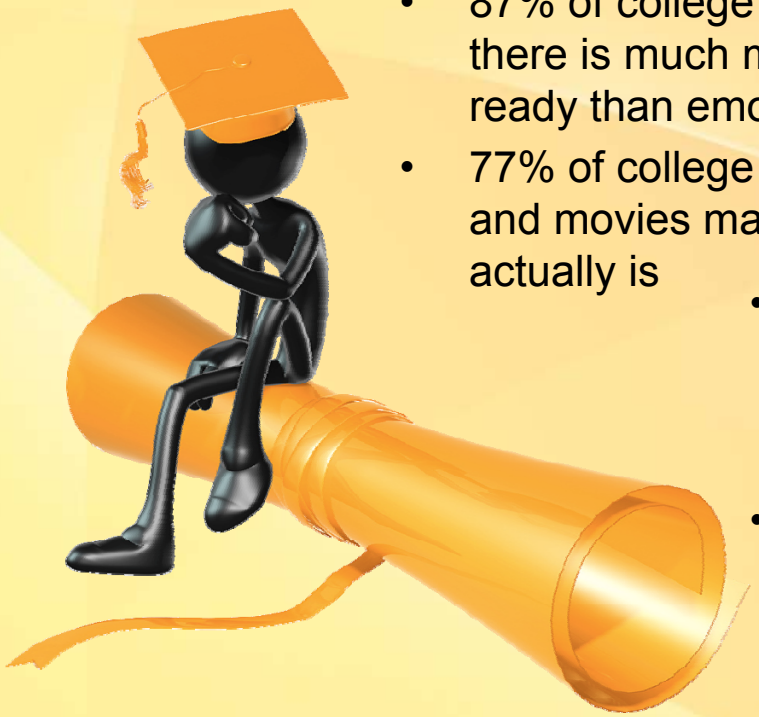
4 WHAT'S NEXT

Why High School?

- Initial partnership with Jed Foundation and Yale Center for Emotional Intelligence to address a lack of social and emotional preparedness for college
- Background research: Harris Poll conducted with the Jed Foundation and the Partnership for Drug-Free Kids
  - 1500 college freshmen nationwide surveyed
  - Questions about their social, emotional, and academic preparation, as well as their experiences in college
  - Visit settogo.org/research to learn more

WHAT'S NEXT

Key Results from Harris Poll



- 87% of college freshmen said that in high school, there is much more focus on being academically ready than emotionally ready
- 77% of college freshmen said that social media, tv, and movies make college seem a lot more fun than it actually is
  - 51% of college freshmen said that at times they found it difficult to get emotional support when they needed it at college
  - Students who said they felt less emotionally prepared for college than their peers were more likely to have a lower grade point average (on average, 3.1 vs 3.4)

4 WHAT'S NEXT

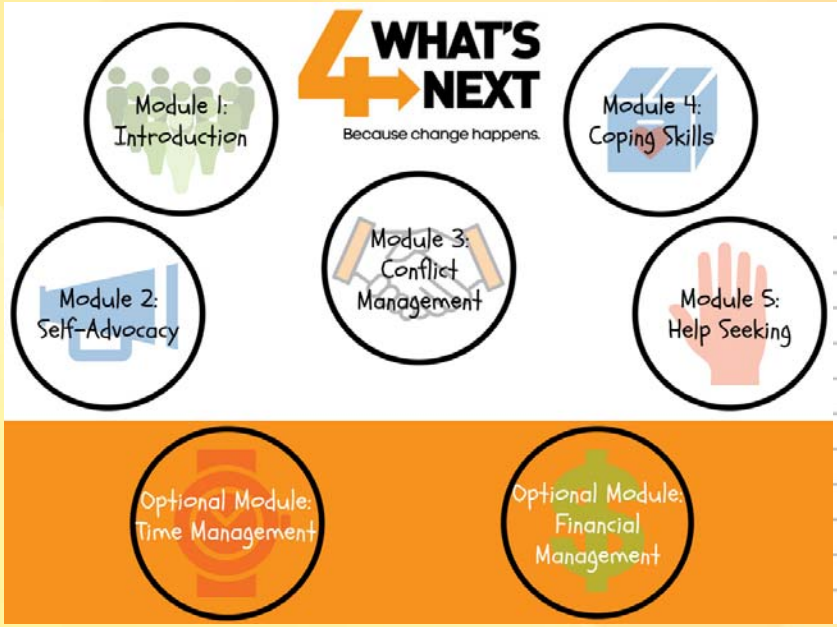
4 What's Next: Background

- Program conceptualization began in 2012
- Consultations with a variety of stakeholders throughout CT and even nationwide
- Focus Groups:
  - Adults (teachers, administrators, school social workers, mental health professionals, and parents of high school students) to study options for implementation
  - High school students to test curriculum
- Literature Review and research into similar programs conducted by Ph.D. students at Carlos Albizu University in Miami
- Pilots of early concepts and program components at several schools, including East Catholic, Windham High, Walnut Hill School

What is 4 What's Next?

- 4 What's Next is a student-driven primary prevention program to help high school students develop positive coping skills and enhance protective factors in preparation for life beyond high school
- Program Goals: Students will be able to
  - Develop protective factors and social and emotional skills
  - Build openness, connectedness, and empathy
  - Create and communicate individual awareness, knowledge, and skills as a culmination of learning
  - Identify future challenges and have the knowledge and skills to approach them with confidence

How does it all work?



4 WHAT'S NEXT

Early Feedback

"It was important to be a part of something that was meant to help my peers with issues they may have in their lives"

"Talking about the transition into college helped make me feel less overwhelmed about it"

4 WHAT'S NEXT

Future Plans

- Full program piloting at 5-10 schools in the 2017-18 school year
- Partnership with the Injury Prevention Center at Connecticut Children's Medical Center to conduct a formal program evaluation
- Continued quality improvement and feedback cycles to ensure this becomes a best practice program

Why 4 What's Next?

- Because change happens…and we want your students to be ready for it
- A chance for your students to have meaningful conversations about REAL issues
- Build connectedness and improve school climate
- Be on the forefront of mental health programming in high schools
- Prepare your students for ALL aspects of life, not just academics
- Have input into developing a program that will be in schools all over the country within a few years

4 WHAT'S NEXT

Questions?

Marisa Giarnella-Porco, LCSW, President and CEO
mgiarnella-porco@jordanporcofoundation.org

Elizabeth McOsker, MPH, Senior Program Coordinator and Data Analyst
emcosker@jordanporcofoundation.org

Jordan Porco Foundation
225 Asylum St., 12th Floor
Hartford CT 06103
(860) 904-6041

Question, Persuade, Refer (QPR)

Tom Steen – Capital Area Substance Abuse Council (CASAC)

School Symposium: Mental Health and Suicide Prevention
September 2017

Presented by:

Thomas J. Steen

Executive Director

Capital Area Substance Abuse Council (CASAC)

Windsor, CT

QPR Master Trainer/Gatekeeper Instructor

CONNECT Prevention/Postvention Trainer

Survivor Voices Trainer

"More Than Sad" Trainer

QPR

In School Settings

Ask A Question, Save A Life

QPR

In School Settings

Question, Persuade, Refer

Why QPR in a school setting?

Youth Suicide Prevention is all about..

Reducing risk factors and increasing protective factors

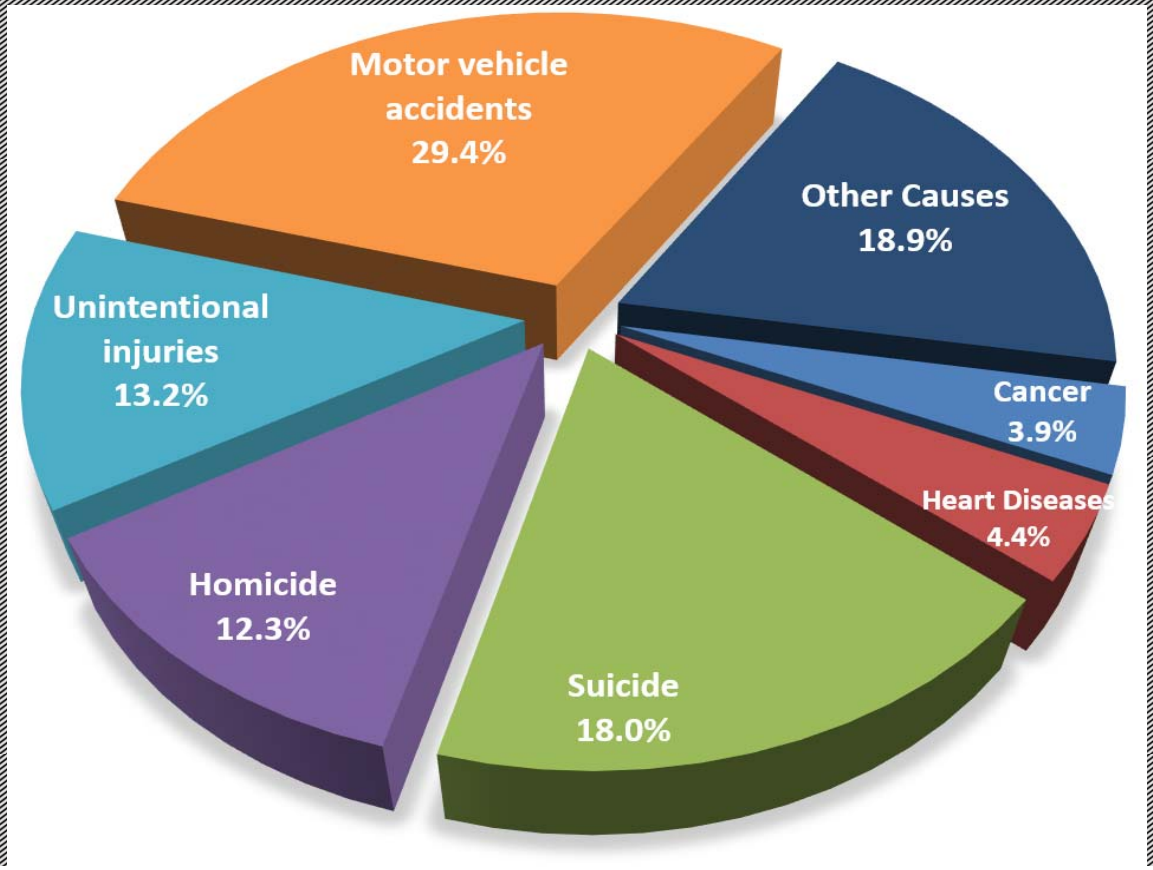
Connecticut School Health Survey

Youth Risk Behavior Component

2015 Results

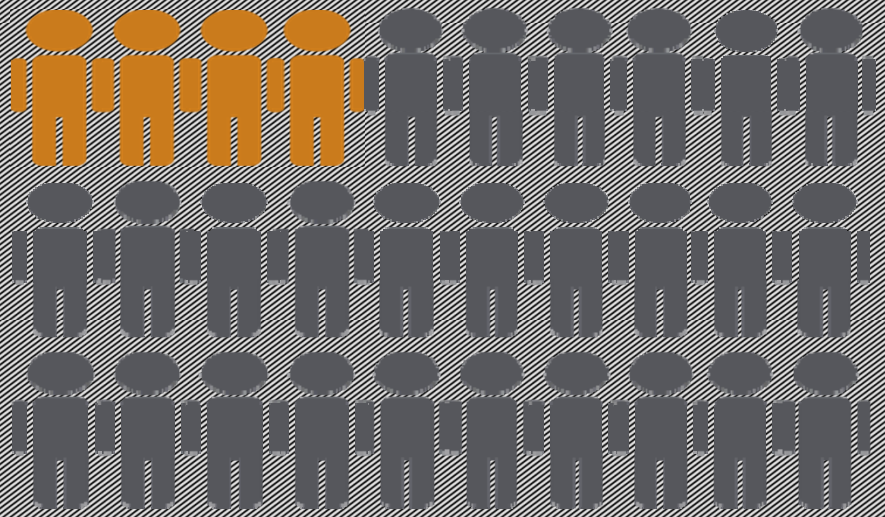
Celeste Jorge, MPH
Epidemiologist
YRBS Coordinator
CT Department of Public Health

Why ask about these behaviors?

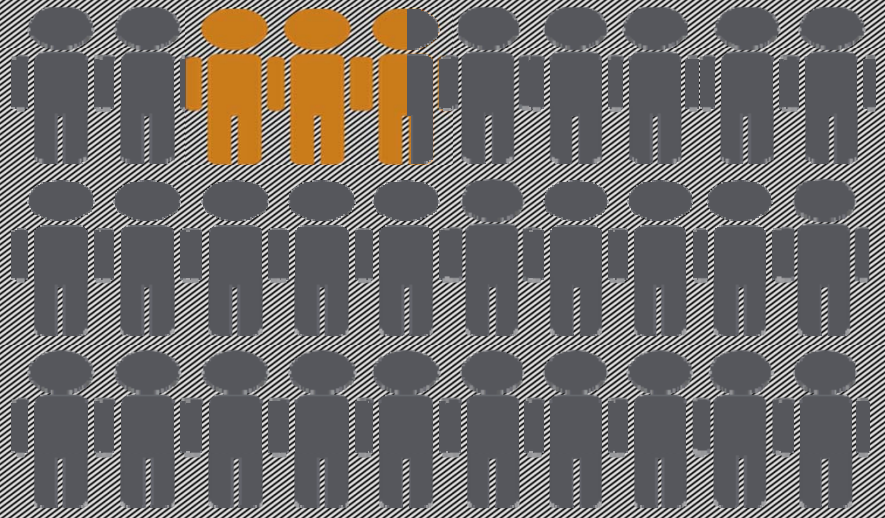


Leading Causes of Death in CT Youth Ages 15-19 years, 2011–2013 Source: CT Dept of Public Health

In a classroom of 30 high school students,
about 4 students said they seriously considered attempting suicide one or more times during the past 12 months



In a classroom of 30 high school students,
about 2 or 3 students said they actually attempted
suicide one or more times during the past 12 months



Connecticut School Health Survey
Youth Risk Behavior

Publications, survey information, and program information are available on the following web pages

www.ct.gov/dph/CSHS

www.cdc.gov/YRBSS

Or contact:

Celeste Jorge, MPH
Epidemiologist
CT Department of Public Health
Celeste.Jorge@ct.gov

About QPR

- QPR is on the Suicide Prevention Resource Center's Best Practice Registry (SPRC BPR) and the National Registry of Evidence-based Programs and Practices (NREPP)
- Goals of QPR:
  - Raise awareness
  - Dispel myths and misconceptions
  - Teach warning signs and what to do

Key QPR Training Concepts

- QPR has 21 core slides and a QPR booklet that must be used in the training
- QPR is not a form of treatment or counseling
- QPR educates people on the warning signs of suicide and gives people a way to respond appropriately

5 QPR Training Objectives

QPR Training Increases:

1. Knowledge about suicide
2. Gatekeeper self-efficacy
3. Knowledge of suicide prevention resources
4. Gatekeeper skills
5. Diffusion of gatekeeper training information

*As measured by numerous independent university researchers

Key QPR Training Concepts: Time

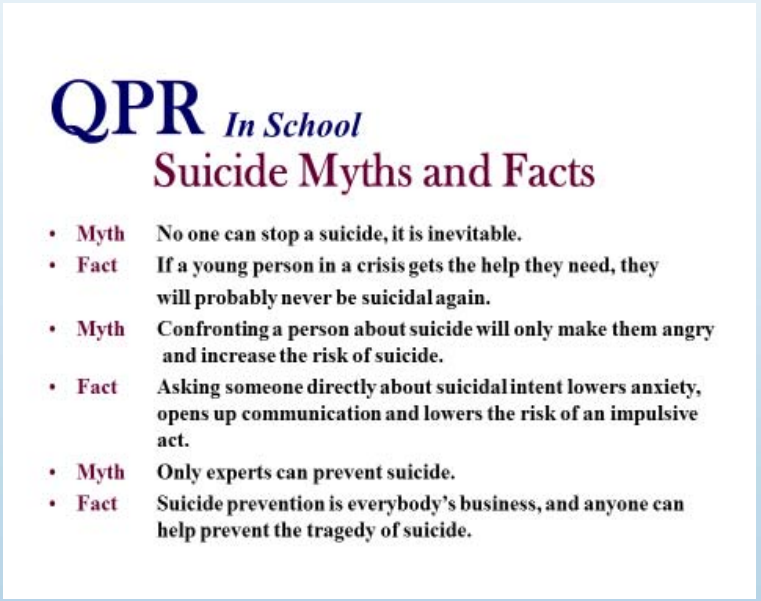
- Length of QPR trainings:
  - Minimum: 1 hour plus time for Q & A
  - Suggested: 90 minutes
  - QPR can be done during a staff meeting

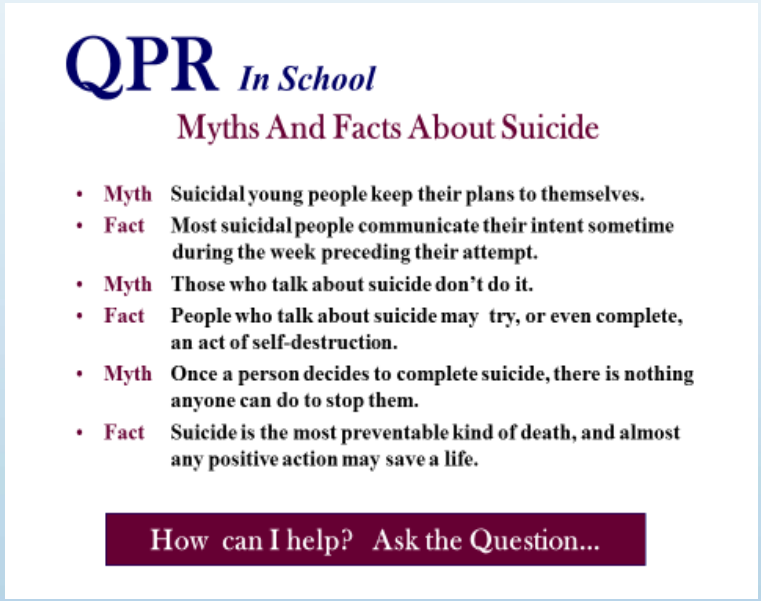
- A QPR training should not be conducted within six months following a suicide death

QPR Core Slides

- Myth and Facts about Suicide
- Suicide Clues and Warning Signs
- How to Ask the Question
- How to Persuade
- How to Refer
- Effective QPR Strategies

Myths and Facts about Suicide





Suicide Clues

QPR *In School*

Verbal Clues:

- "I've decided to kill myself."
- "I wish I were dead."
- "I'm going to commit suicide."
- "I'm going to end it all."
- "If (such and such) doesn't happen, I'll kill myself."

QPR *In School*

Indirect or "Coded" Verbal Clues:

- "I'm tired of life, I just can't go on."
- "My family would be better off without me."
- "Who cares if I'm dead anyway."
- "I just want out."
- "I won't be around much longer."
- "Pretty soon you won't have to worry about me."

Warning Signs

QPR *In School*

Behavioral Clues:

- Past suicide attempt
- Getting a gun or stockpiling pills
- Giving away prized possessions
- Impulsivity/increased risk taking
- Unexplained anger, aggression, irritability
- Self-destructive acts (i.e., cutting)
- Chronic truancy, running away
- Perfectionism

QPR *In School*

Situational Clues:

- Being expelled from school/fired from job
- Family problems/alienation
- Loss of any major relationship
- Death of a friend or family member, especially if by suicide
- Diagnosis of a serious or terminal illness
- Financial problems (either their own or within the family)
- Sudden loss of freedom/fear of punishment
- Feeling embarrassed or humiliated in front of peers
- Victim of assault or bullying

How to Ask the Question

Q

QUESTION

HOW TO ASK THE SUICIDE QUESTION

Less Direct Approach:

- "Have you been unhappy lately?" "Have you been very unhappy lately?" "Have you been so unhappy lately that you've been thinking about ending your life?"
- Do you ever wish you could go to sleep and never wake up?"

Q

QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you can not ask the question, find someone who can.

How to Persuade

P

PERSUADE
FOR QPR IN SCHOOL SETTINGS

- Listen to the problem and give them your full attention
- Remember, suicide is the solution to a perceived insoluble problem. Suicide is not the problem.
- Do not rush to judgment
- Offer hope in any form

P

PERSUADE CONT.

THEN ASK:

- "Will you go with me to talk with your school counselor?"
- Would you like me to tell your school counselor that you would like to talk to him or her?"

How to Refer

R

REFER FOR QPR IN SCHOOL SETTINGS

- Suicidal young people often believe they cannot be helped, so you may have to do more.
- The best "referral" involves taking the person directly to see the school counselor.
- The next best "referral" is when the student wants you to talk to the counselor first, or when they agree to talk to the counselor on their own within the immediate future. (The young person should be monitored closely in the interim.)
- The third best option is to make sure the student is safe, is under observation by an adult, and then you tell the school counselor the warning signs you have observed.

Effective QPR Strategies

For Effective QPR In School Settings

- Say: "I want you to live," or "I'm on your side and we'll get through this."
- Communicate with the school counselor and administration.
- Get Others Involved. Ask the person who else might help. Family? Friends? Teachers? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

For Effective QPR Cont.

- Join the Team. Offer to work with other school personnel and concerned members of the community members to help reduce youth suicide.
- Follow up with a visit, a phone call, a card, or in whatever way feels comfortable to you, to let the young person know you care about what happens to them. Caring may save a life.

INTERVENTION PROCEDURE

- DO YOU KNOW YOUR SCHOOLS PROCEDURE, PROTOCAL OR POLICY?

- **EXAMPLE**: IF ANY AGENCY EMPLOYEE RECOGNIZES OR SUSPECTS THAT A CLIENT MAY BE SUICIDAL, HE/SHE MUST NOTIFY THE ADMINISTRATOR OR DESIGNEE IMMEDIATELY

AFSP programs

Suicide is a health issue.

Talk Saves Lives

ASIST

More Than Sad

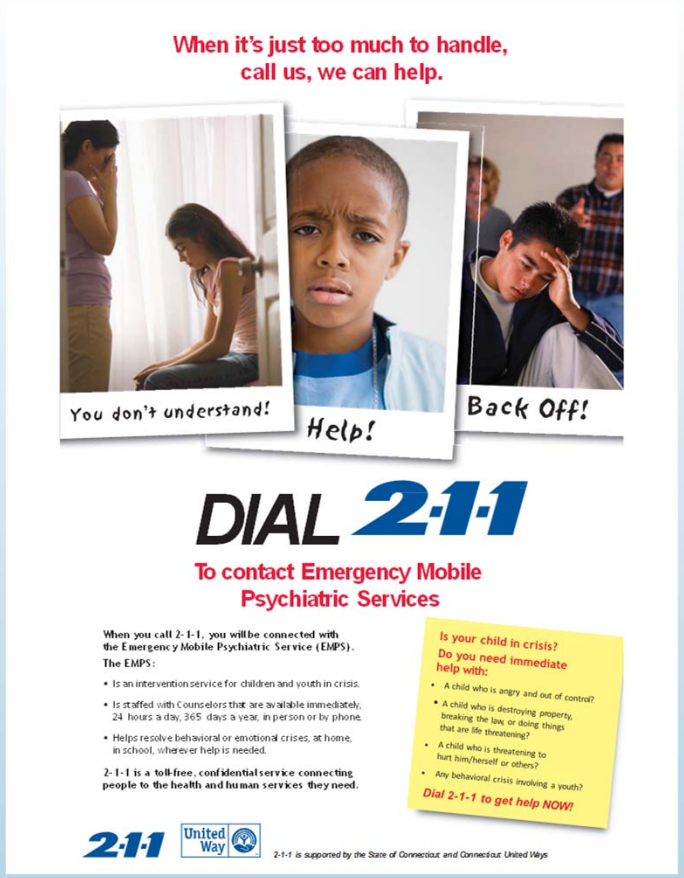
Safe Talk

1 WORD VOICE LIFE

Be the 1 to start the conversation

SUICIDE IS PREVENTABLE

www.preventsuicidect.org

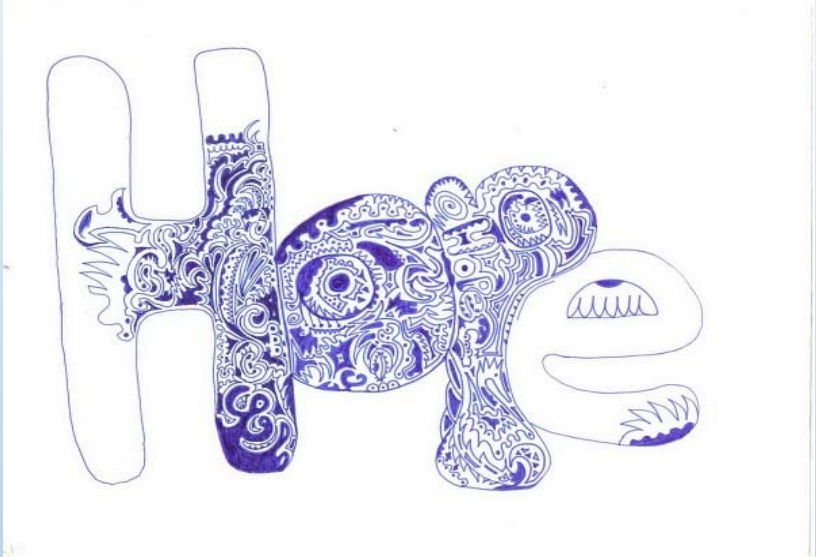


NATIONAL SUICIDE PREVENTION LIFELINE

1-800-273-TALK

www.suicidepreventionlifeline.org

AMERICAN FOUNDATION FOR Suicide Prevention



Tyler Steen- "Focus on your Dreams"

Questions?

My Contact info:
Email: tsteen@casac.org
Phone: 860-286-9333

Thank You!

Youth Mental Health First Aid

Sheryl Sprague – Hartford HealthCare Behavioral Health Network

Mental Health First Aid: Overview

Sheryl Sprague, CPS
Mental Health First Aid Trainer
Hartford HealthCare BHN
Sheryl.sprague@hhchealth.org
203-630-5357

MARYLAND

MISSOURI DEPARTMENT OF MENTAL HEALTH

NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

USA MENTAL HEALTH FIRST AID

THE MENTAL HEALTH FIRST AID ACTION PLAN

- **A**ssess for risk of suicide or harm
- **L**isten nonjudgmentally
- **G**ive reassurance and information
- **E**ncourage appropriate professional help
- **E**ncourage self-help and other support strategies

What Is Mental Health First Aid?

- *Help offered to a person developing a mental health problem or experiencing a mental health crisis*
- *Given until appropriate treatment and support are received or until the crisis resolves*
- *Not a substitute for counseling, medical care, peer support or treatment*

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Why Mental Health First Aid?

- Mental health problems are common
- Stigma/Discrimination is associated with mental health problems
- Professional help is not always on hand
- Individuals with mental health problems often do not seek help
- Many people…
  - are not well informed about mental health problems
  - do not know how to respond

THE MENTAL HEALTH FIRST AID ACTION PLAN

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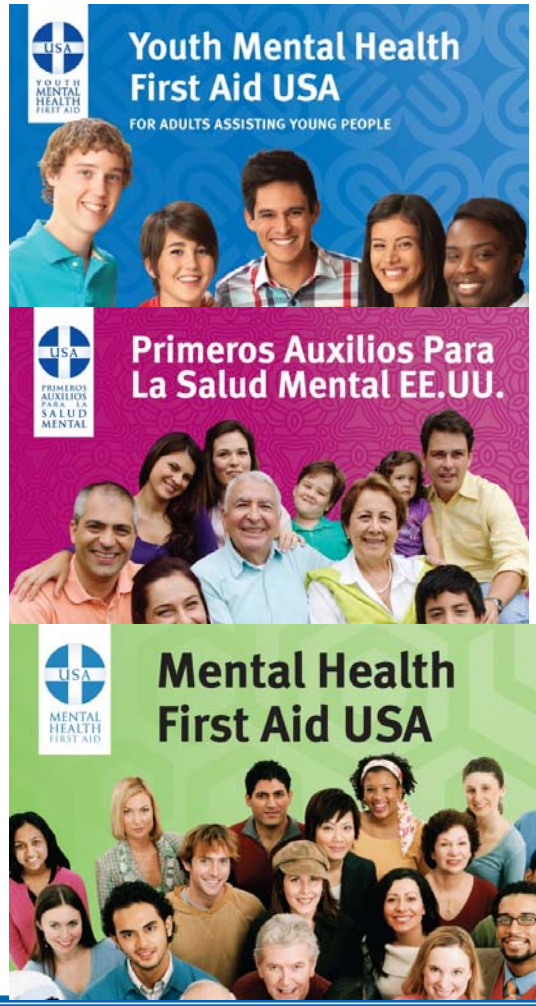
MENTAL HEALTH FIRST AID USA



- More than 1,000,000 trained
- 4,000+ instructors
- National policy and media attention

NREPP

Included in SAMHSA's National Registry of Evidence-based Programs and Practices

MENTAL HEALTH FIRST AID USA

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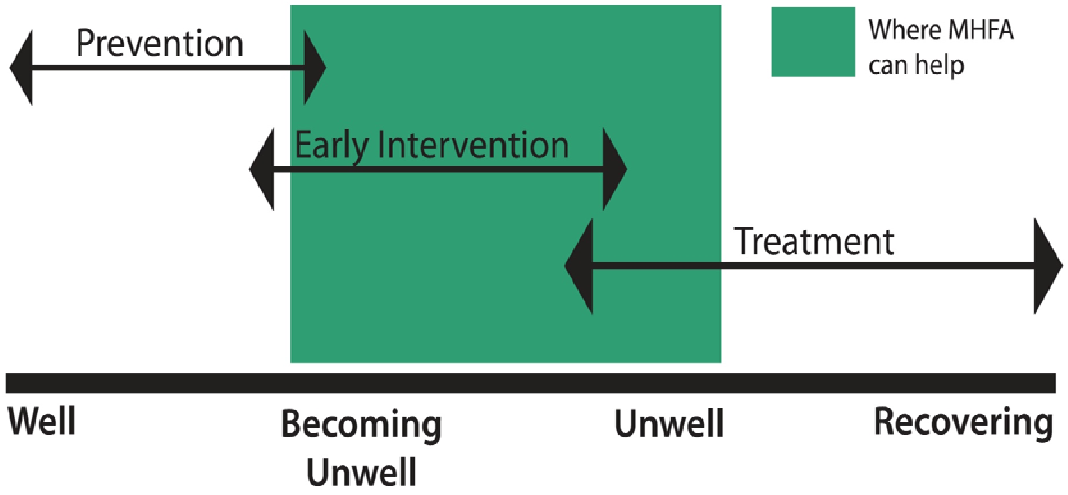
Spectrum of Mental Health Interventions



Spectrum of mental health interventions from wellness to mental disorders and through to recovery, showing the contribution of MHFA

MENTAL HEALTH FIRST AID

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What Is a Mental Disorder?

A **mental disorder** or **mental illness** is a diagnosable illness that:

- Affects a person's thinking, emotional state, and behavior
- Disrupts the person's ability to
  - Work or attend school
  - Carry out daily activities
  - Engage in satisfying relationships

THE MENTAL HEALTH FIRST AID ACTION PLAN

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U.S. Adults with a Mental Disorder in Any One Year

Type of Mental Disorder	% Adults
Anxiety disorder	19.1
Major depressive disorder	6.8
Substance use disorder	8.0
Bipolar disorder	2.8
Eating disorders	2.1
Schizophrenia	0.45
Any mental disorder	**19.6**

Only 41% of people with a mental illness use mental health services in any given year

MENTAL HEALTH FIRST AID

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U.S. Youth with a Mental Disorder during Adolescence (Age 13-18)

	Prevalence (%)	With severe impact (%)
Anxiety disorders	31.9	8.3
Behavior disorders	19.1	9.6
Mood disorders	14.3	11.2
Substance use disorders	11.4	11.4
Overall prevalence (with severe impact)		**27.6**

Behavior Disorders can be ADD, ADHD, Oppositional Defiance Disorder, Conduct Disorder (aggressive behaviors)

MENTAL HEALTH FIRST AID

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The Impact of Mental Illness

- Mental illnesses can be more disabling than many chronic physical illnesses.

- *"Disability"* refers to the amount of disruption a health problem causes to a person's ability to:
  - Work
  - Carry out daily activities
  - Engage in satisfying relationships

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USA
YOUTH MENTAL HEALTH FIRST AID
Youth Mental Health First Aid USA
FOR ADULTS ASSISTING YOUNG PEOPLE
MARYLAND
NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE
MENTAL HEALTH

What is Your Role?

- Parent/Guardian/Grandparent
- Clergy
- Friend or Neighbor
- Peer
- Professional: *"In the place of the parent"*

  Be aware of:
  - Mandatory reporting laws
  - Privacy rights of young people
  - When to communicate with parents and other care-givers

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What are Some of the Disorders we Might Hear About?

- ADD/ADHD/ODD
- Anxiety Disorders
- Bipolar Disorder
- Depression
- Eating Disorders
- Psychosis
- Substance Use Disorders

THE MENTAL HEALTH FIRST AID ACTION PLAN

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Typical Adolescent Development

- Physical Changes
  - Changes in hormones
  - Increases in height and weight
  - Becoming more focused on physical concerns
- Mental Changes
  - Developing more abstract thinking skills
  - Using logic and reason more in decision making
  - Developing own beliefs
  - Beginning to question authority

Typical Adolescent Development

- Emotional Changes
  - Can be quick to change
  - Feel more intensely
  - Can lead to risk taking and impulsive behavior
- Social Changes
  - May experiment with different levels of social and cultural identity
  - Peer influence increases
  - Notice sexual identity
  - Learn to manage relationships, including romantic relationships

THE MENTAL HEALTH FIRST AID ACTION PLAN

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Resiliency

- Most youth pass through adolescence with relatively little difficulty despite all of these challenges.
- When difficulties are encountered, youth tend to be quite resilient:
  - Thrive
  - Mature
  - Increase their competence

THE MENTAL HEALTH FIRST AID ACTION PLAN

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WHAT YOU MIGHT DO?

THE MENTAL HEALTH FIRST AID ACTION PLAN

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MHFA ACTION PLAN

Mental Health First Aid teaches a **five-step** action plan, ALGEE, for individuals to provide help to someone who may be in crisis.

- **A – Assess for risk of suicide or harm**
- **L - Listen non-judgmentally**
- **G - Give reassurance and information**
- **E – Encourage appropriate professional help**
- **E - Encourage self-help & other support strategies**

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How to Help:
The Mental Health First Aid Action Plan

Assess for Risk of Suicide or Harm

When helping a person going through a mental health crisis, it is important look for signs of suicidal thoughts and behaviors and/or non-suicidal self-injury.**

Some Warning Signs of Suicide Include:

- •Threatening to hurt or kill oneself
- •Seeking access to means to hurt or kill oneself
- •Talking or writing about death, dying or suicide
- •Feeling Hopeless
- •Acting Recklessly or engaging in risky activities
- •Increased use of alcohol or drugs
- •Withdrawing from family, friends, or society
- •Appearing agitated or angry
- •Having a dramatic change in mood

***Always seek emergency medical help if the person's life is in immediate danger. If you have reason to believe someone may be actively suicidal, call the National Suicide Prevention Lifeline: 1-800-273-TALK (8255).*

MENTAL HEALTH FIRST AID

THE MENTAL HEALTH FIRST AID ACTION PLAN

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Listen nonjudgmentally

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Listening Nonjudgmentally

- It may seem simple, but the ability to listen and have a meaningful conversation with an individual requires skill and patience
- It is important to make an individual feel respected, accepted, and understood
- Mental Health First Aid teaches individuals to use a set of verbal and nonverbal skills to engage in appropriate conversation – such as open body posture, comfortable eye contact and other listening strategies

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Give Reassurance and Information

- Mental illnesses are real, treatable illnesses from which people can and do recover
- When having a conversation with someone whom you believe may be experiencing symptoms of a mental illness, it is important to approach the conversation with respect and dignity for that individual and to not blame the individual for his or her symptoms.
- Mental Health First Aid teaches you helpful information and resources you can offer to someone to provide consistent emotional support and practical help

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Encourage Appropriate Professional Help

- There are a variety of mental health and substance use professionals who can offer help when someone is in crisis or may be experiencing the signs of symptoms of a mental illness.
- Types of Professionals
  - Doctors (primary care physicians or psychiatrists)
  - Social workers, counselors, and other mental health professionals
  - Certified peer specialists
- Types of Professional Help
  - "Talk" therapies
  - Medication
  - Other professional supports
- The Mental Health First Aid course will provide you with a variety of local and national resources to connect individuals to care, if needed.

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Encourage Self-Help and Other Support Strategies

- There are many ways individuals who may be experiencing symptoms of a mental illness can contribute to their own recovery and wellness.
- These strategies may include:
- Exercise
- Relaxation and Meditation
- Participating in peer support groups
- Self-help books based on Cognitive Behavioral Therapy (CBT)
- Engaging with family, friends, faith, and other social networks

Signs and Symptoms of Depression

Behaviors

- Crying spells, withdrawal from others, neglect of responsibilities, loss of interest in personal appearance, loss of motivation, slow movement, use of drugs and alcohol

Physical

- Fatigue, lack of energy, sleeping too much or too little, overeating or loss of appetite, constipation, weight loss or gain, headaches, irregular menstrual cycle, loss of sexual desire, unexplained aches and pains

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Signs and Symptoms of Depression

Psychological

- Sadness, anxiety, guilt, anger, mood swings, lack of emotional responsiveness, feelings of helplessness, hopelessness, irritability
- Frequent self-criticism, self-blame, pessimism, impaired memory and concentration, indecisiveness and confusion, tendency to believe others see one in a negative light, thoughts of death and suicide

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Vision

By 2020, Mental Health First Aid in the USA will be as common as CPR and First Aid.

MENTAL HEALTH FIRST AID

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Wrap up

Discussion / Questions

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Mental Health First Aid USA

- Custom Training Solutions for organizations available
- Visit www.MentalHealthFirstAid.org for further information the course and to find an instructor near you.
- Become a fan of Mental Health First Aid USA on Facebook get updates and information on a variety of mental health topics.
- For any further questions, contact Patricia Graham, MHFA Coordinator for HHC BHN at PatriciaC.Graham@hhchealth.org

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In Conclusion…

Heather Spada – United Way of CT