Recognition of the critical role that primary care and mental health providers can play in addressing suicide risk among patients has received national focus. The “Zero Suicide” framework aims to eliminate suicides among all patients. This session will focus on the Identify and Transition steps of the model. The speakers will provide a selection of screening/assessment tools that can be used in the school setting and discuss considerations for transitioning students back into the school environment after treatment for a suicide related event.
# Learning Objectives

1. Identify the key concepts of Zero Suicide and the role of primary care: Brief list of content topics: Research of patients health care visit trends, effectiveness of institutions that use Zero Suicide, the 7 step Zero Suicide framework.

2. Select a suicide screening/assessment tool that is appropriate for your setting examples include Patient Health Questionnaire (PHQ-9), MAYSJ, Columbia Suicide Severity Rating Scale, Beck Depression Inventory, Massachusetts Youth Screening Instrument and examples of other tools. Planning and selecting the best tool for your setting.

3. Formulate a transition plan for returning students: Brief list of content topics: Identification of partners, engaging the family and student, establishing a personalized crisis plan, using newly developed apps to connect and engage students.

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# Youth Suicide in North Carolina

[Logo: North Carolina Injury & Violence Prevention Branch]
Data Sources: Suicide and Self-Inflicted Injury

- North Carolina Violent Death Reporting System (NC-VDRS)
  - Death Certificate
  - Law Enforcement Incident Reports
  - Medical Examiner Reports

- Hospital Discharge

- Emergency Department Admissions
  - NC-DETECT

- N.C. Youth Risk Behavior Survey (YRBS)-Department of Public Instruction

Suicide Methods: N.C. Residents ages 10-24, 2009-2011
**Suicide Circumstances: N.C. Residents ages 10-24, 2009-2011**

### Mental Health Circumstances

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current depressed mood</td>
<td>31.8%</td>
<td>32.4%</td>
</tr>
<tr>
<td>Current mental health problem</td>
<td>27.8%</td>
<td>42.4%</td>
</tr>
<tr>
<td>Current treatment for mental illness</td>
<td>24.2%</td>
<td>48.5%</td>
</tr>
<tr>
<td>Ever treated for mental illness</td>
<td>28.1%</td>
<td>50.0%</td>
</tr>
</tbody>
</table>

### Interpersonal Circumstances

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intimate partner problem</td>
<td>36.4%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Other relationship problem</td>
<td>15.1%</td>
<td>17.6%</td>
</tr>
</tbody>
</table>
Suicide Circumstances: N.C. Residents ages 10-24, 2009-2011

Suicide Event Circumstances

- Left a suicide note: Female 26.4%, Male 26.5%
- Disclosed intent to complete suicide: Female 26.6%, Male 26.5%
- History of suicide attempts: Female 18.7%, Male 15.6%

Source: NC-VDRS, 2009-2011; Analysis by Injury Epidemiology and Surveillance Unit

Comparing Youth Suicide and Suicide Attempt Injury in North Carolina

Suicidal Behavior: N.C. High School Students, 2015
Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center’s Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.

- The programmatic approach of Zero Suicide is based on the realization that suicidal individuals often fall through cracks in a fragmented, and sometimes distracted, health care system. A systematic approach to quality improvement in these settings is both available and necessary.
- The challenge and implementation of a Zero Suicide approach cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.
- [https://www.youtube.com/watch?v=bFKAvYUh6es](https://www.youtube.com/watch?v=bFKAvYUh6es)
Henry Ford Health System (Michigan)  

Zero Suicide idea came from a NURSE

Implemented the Perfect Depression Care initiative

- Assessing patients for risk of suicide
- Implementing measures to reduce that risk

Results

Baseline in behavioral health services department was 89 suicides per 100,000

Within first four years of program suicides dropped by 75%

In 2009, there were no suicides.

For past few years, average 20 suicides per 100,000 which is still 80% below baseline.

In the system’s general population, average 5 suicides per 100,000 (below national and state average)

Zero Suicide: Steps

LEAD  TRAIN  IDENTIFY  ENGAGE  TREAT  TRANSITION  IMPROVE
**Health Care Settings**

- Primary care is the setting in which Americans receive most of their health and behavioral health care. Frequent contacts and long-standing relationships between primary care providers (PCPs) and their patients make primary care an ideal setting for suicide prevention.

- People who die by suicide are more likely to have seen a PCP in the previous month before their death than any other health care provider.

- Only 1 in 2 suicidal patients visiting the emergency departments (EDs) asked if they have access to lethal weapons.
Screening and Early Intervention – what is the role of the School Nurse?

North Carolina Annual School Health Services Report
2014-2015

<table>
<thead>
<tr>
<th>Mental Health Issue Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other MH Issues</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Suicide Ideation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students and Suicide</th>
<th>Elementary</th>
<th>Middle School</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide attempt</td>
<td>38</td>
<td>196</td>
<td>516</td>
</tr>
<tr>
<td>Death from suicide</td>
<td>0</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Suicide occurred at school</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
What do we know?

- Mental health problems can affect school performance and academic achievement. When mental health problems are not recognized, students may be unable to reach their academic potential, Paskar, K.R, Bernardo L.M. (2007).
- School nurses are in a key position to provide interventions to address mental health and academic achievement. School nurses are uniquely positioned between policymakers and the student body as caregiver, advocate, and expert (Cooper et al., 2012). This vantage point affords the school nurse the ability to identify and intervene with at risk adolescents as well as lead in developing prevention policy (Cooper et al., 2012).
- School nurses are the gatekeepers as gatekeepers to plan, prepare, and prevent child and youth suicide, (Zupp, 2013).

Why are schools reluctant to screen for mental health concerns?

- Concerns that mass screenings will over-diagnose students and stigmatize them with a life-long label
- Worry that screenings will uncover mental health problems that schools lack resources to treat
- Systems should be in place to ensure accurate diagnosis, psychotherapy and follow-up
- “Once we screen and assess and discover the need, I think it’s our responsibility to have the resources in place to service every one of those needs that are uncovered.”

So what can we do? We have choices! We can put a bucket over our head and ignore the situation or we can carry the bucket, fill it with ideas, carry it to our community, enhance our student’s resilience and build healthy schools.
So how do where do we start?

What are schools currently using?

• Screenings rates vary widely from state to state and even within each school district (No consistency on whether the schools screen, what ages they screen and what they screen for).
• Some types of screening tools can be used for the whole student population and others would be directed to a high risk group.

• Screening tools can vary in size, length, content, medium and need to be selected carefully with a full assessment of the target group that they are being designed for to maximize effectiveness.
• Policy and procedure in relation to carrying out a screening on an individual student or a group – who gives permission/ confidentiality/access to results.

We can brainstorm together
Getting started - An example from one school district.

https://www.youtube.com/watch?v=OgQx57os0UE

Talks about comprehensive screening:
https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/engaging-adolescents-just-ask/

Issue of referrals for MH
https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/engaging-adolescents-all-systems-go/

Scenario of teen with stress issues and physician interview technique
https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/engaging-adolescents-you-can-help/

Engaging adolescents: encouraging primary care to be more attentive to mental health issues including comprehensive screening
https://www.communitycarenc.org/population-management/pediatrics/engaging-adolescents/engaging-adolescents-we-care/

Importance of primary care.
http://www.sprc.org/video/zero-suicide
Examples of STUDENT MENTAL HEALTH SCREENING TOOLS
(Examples from practice will be discussed here).

• Eyberg Child Behavior Inventory (P/T): 2-16 years – 15 mins
• Child Symptom Inventory (P/T/Y): 3 – 18 years - 15 mins
• Massachusetts Youth Screening Instrument (Y): 12-17 years - 10 mins
• Pediatric Symptom Checklist (p): 4-16 years – 10 mins
• Problem-Oriented Screening Instrument for Teenagers (Y): 12-19 yrs–25 mins
• Strengths and Difficulties Questionnaire (P/T/Y): 3 – 16 years - 10 mins
• STARS (Screening the At-Risk Student) – Implemented by nurses in middle schools. And offer suicides and depression screenings and referrals for further psychological assessments as needed.
• MAYS12
• Columbia Suicide Severity Rating Scale
• Depression screening tools - to be discussed.

One more thing to consider -Returning Students following a crisis- Creating a smooth transition back to school

• Options for return.
• Liaison with family/ carers and professionals involved during the time away from the student’s traditional school setting.
• Creating safe connections for the returning student so that they have trusted adults to turn to if they become overwhelmed or just need to ask questions.
• Consider a peer support group/ buddy system.
• Maintaining a safe environment for the returning student
• Confidentiality – how much information should be shared and to whom.

Other possibilities –
504 plan: under Section 504 of the Rehabilitation Act (Pub L No. 93-112, 1973) and the Americans with Disabilities Act (Pub L No. 101-336, 1990), provides for a student who is not eligible for special education under an IEP but who requires accommodations in regular education on the basis of bona fide medical need, as documented by a physician and validation by the educational home.
Individualized health care plan: a written document created by a school nurse on the basis of information provided by the student’s pediatrician to document specific health care needs in the school setting with a plan for addressing each documented need.
Think Whole School!

Think out of the box!

Information on back of name badges, guest speakers, videos, games…

http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-/SMA09-4432

http://store.samhsa.gov/apps/suicidesafe/index.html

References


http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/36/Mental-Health-of-Students-Revised-June-2013


Any questions?

Thank you! School Nurses Rock!