Addressing Students’ Mental Health Needs To Improve School Climate and Academic Performance
What We Will Cover

• Students’ mental health needs
  – Overview of students’ mental health needs (co-occurring disorders, trauma, and suicide)
  – Connection to school climate and educational achievement

• What can be done
  – Federal and State initiatives and resources related to prevention, intervention, and treatment

• Q&A

• Charge for the breakout session
Northwestern Juvenile Project: Detention and Beyond

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Faculty
Linda A. Teplin, PhD (PI)
Karen Abram, Ph.D.
Leah Welty, Ph.D.
Jessica Jakubowski, Ph.D.
1-Day Count of Juvenile Offenders in Custody, 1991-2013 (in 1,000s)
Percentage of Juvenile Court Cases that Involve Females, 1985-2013
Why Study Detained Youth?
Disproportionate Minority Confinement

% of African Americans in US population (13%)

- 39.7% of AA's, Youth in Corrections
- 34.8% of AA's, Adults in Prisons and Jails

Legend:
- % of AA's, Youth in Corrections
- % of AA's, Adults in Prisons and Jails
Methods

• Stratified random sample, N=1829

• Sampled from Cook County Detention Center, 1995-1998

• Re-interviewed in community or corrections

• Array of measures

• State of the art locating
<table>
<thead>
<tr>
<th>Wave</th>
<th>Original Sample</th>
<th>Interviews Completed*</th>
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<tbody>
<tr>
<td>3 year</td>
<td>1829</td>
<td>97.5%</td>
</tr>
<tr>
<td>3½ year</td>
<td>997</td>
<td>95.5%</td>
</tr>
<tr>
<td>4 year</td>
<td>997</td>
<td>93.1%</td>
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<tr>
<td>4½ year</td>
<td>1829</td>
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<tr>
<td>6 year</td>
<td>1829</td>
<td>84.2%</td>
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<tr>
<td>8 year</td>
<td>1829</td>
<td>82.3%</td>
</tr>
<tr>
<td>10 year</td>
<td>800</td>
<td>85.5%</td>
</tr>
<tr>
<td>11 year</td>
<td>800</td>
<td>87.4%</td>
</tr>
<tr>
<td>12 year</td>
<td>1829</td>
<td>87.8%</td>
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<tr>
<td>13 year</td>
<td>800</td>
<td>87.1%</td>
</tr>
<tr>
<td>14 year</td>
<td>1829</td>
<td>84.1%</td>
</tr>
<tr>
<td>15 year</td>
<td>1829</td>
<td>83.6%</td>
</tr>
<tr>
<td>16 year</td>
<td>1829</td>
<td>81.6%</td>
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</table>

*Of those still living at the time their follow-up was due
During Detention
Mood Disorders

Depression:
sadness, tearfulness, diminished capacity to enjoy pleasurable activities, irritability, feelings of worthlessness or guilt, and physical symptoms such as significant change in appetite or weight, sleep disturbances, fatigue

Symptoms present almost every day during the same 2 week period

Mania:
abnormally, persistently elevated, expansive or irritable mood; decreased need for sleep, increased energy, behaving strangely in the classroom, impulsivity, being more talkative, excessive involvement in pleasurable activities

Symptoms present for most of the day, nearly every day, for a period of at least 1 week
Anxiety Disorders

e.g., Panic, Generalized Anxiety, Separation-Anxiety, Obsessive-Compulsive, Posttraumatic Stress

- Feeling nervous or “on edge”
- Unfounded or unrealistic fears
- Trouble separating from parents
- Sleep disturbance
- Obsessive thoughts and/or compulsive behaviors
- Trembling, sweating, shortness of breath, stomachaches, headaches, muscle tension, and/or other physical symptoms

Anxiety is excessive or persists beyond developmentally appropriate periods

Symptoms are persistent for 6 months or more
Trauma

Acute traumatic events:

• Experiencing a serious injury or witnessing a serious injury to or the death of someone else; facing imminent threats of serious injury or death to oneself or others; experiencing a violation of personal physical integrity

• Typically evokes overwhelming feelings of terror, horror, or helplessness

Prolonged trauma exposure, e.g., ongoing abuse, domestic violence, war.

• Can lead to intense feelings of fear, loss of trust in others, decreased sense of personal safety, guilt, and shame.

Prolonged trauma exposure, e.g., ongoing abuse, domestic violence, war.

http://www.nctsn.org/content/defining-trauma-and-child-traumatic-stress
Symptoms of Child Traumatic Stress and PTSD

- **Intrusion**
  Recurrent, involuntary, intrusive memories; traumatic nightmares; flashbacks; intense or prolonged distress after exposure to traumatic reminders; marked physiologic reactivity (e.g., increased heart rate) after exposure to trauma-related stimuli

- **Avoidance**
  Persistent avoidance of distressing trauma-related stimuli after the event

- **Negative Alterations in Cognitions and Mood**
  Inability to recall key features of the traumatic event; persistent, negative beliefs and expectations about self and the world; persistent distorted blame of self or others; persistent negative trauma-related emotions; markedly diminished interest in activities; feeling alienated from others; inability to experience positive emotions; "time skew" (younger children); "omen formation“ (younger children); posttraumatic play (compulsively repeating some aspect of trauma and does not relieve anxiety)

- **Alterations in Arousal and Reactivity**
  Irritable or aggressive behavior; self-destructive or reckless behavior; hypervigilance; exaggerated startle response; problems in concentration; sleep disturbance
Disruptive Behavioral Disorders

• Conditions involving problems in the self-control of emotions and behaviors

• Behaviors that:
  – violate the rights of others
  – or get youth into trouble (e.g., aggression, destruction of property)

• At least 4 symptoms last at least 6 months
Prevalence of Psychiatric Disorders at the Baseline Interview
(N=1,829)

- Mood: Females 28, Males 19
- Anxiety: Females 31, Males 21
- Behavioral: Females 47, Males 41
- Substance Use: Females 51, Males 46
- Any Disorder: Females 74, Males 66

Teplin et al., 2002. JAMA Psychiatry
Prevalence of Psychiatric Disorders Among Males, Baseline

- Mood:
  - African American: 19
  - Hispanic: 22
  - non-Hispanic white: 14

- Anxiety:
  - African American: 21
  - Hispanic: 26
  - non-Hispanic white: 14

- Behavioral:
  - African American: 40
  - Hispanic: 43
  - non-Hispanic white: 60

- Substance Use:
  - African American: 49
  - Hispanic: 55
  - non-Hispanic white: 63

- Any Disorder:
  - African American: 65
  - Hispanic: 70
  - non-Hispanic white: 82

Teplin et al., 2002. JAMA Psychiatry
Prevalence of Psychiatric Disorders Among Females, Baseline

- Mood: 26 (African American), 29 (Hispanic), 23 (non-Hispanic white)
- Anxiety: 31 (African American), 33 (Hispanic), 30 (non-Hispanic white)
- Behavioral: 39 (African American), 57 (Hispanic), 62 (non-Hispanic white)
- Substance Use: 42 (African American), 52 (Hispanic), 62 (non-Hispanic white)
- Any Disorder: 71 (African American), 76 (Hispanic), 86 (non-Hispanic white)

Teplin et al., 2002. JAMA Psychiatry
Comorbid Types of Disorder Among Males

None of the Listed Disorders 34.8%

ADHD/ Behavioral 41.7%

Affective 17.9%

Anxiety 21.1%

Substance 49.8%

Abram et al., 2003. JAMA Psychiatry
Comorbid Types of Disorder Among Females

None of the Listed Disorders
27.2%

Substance 44.5%

ADHD/Behavioral 46.3%

Affective 26.4%

Anxiety 31.5%

Abram et al., 2003. JAMA Psychiatry
Suicidal Ideation and Behavior Among Females, Baseline

- Ever Felt Life Was Hopeless: 52 African American, 46 Hispanic, 41 non-Hispanic white
- Thought About Death (Past 2 Weeks): 26 African American, 13 Hispanic, 19 non-Hispanic white
- Thought About Suicide (Past 2 Weeks): 17 African American, 4 Hispanic, 7 non-Hispanic white
- Specific Suicide Plan: 15 African American, 9 Hispanic, 10 non-Hispanic white
- Ever Attempted Suicide: 32 African American, 43 Hispanic, 22 non-Hispanic white
- Attempted Suicide (Past 6 Months): 12 African American, 8 Hispanic, 8 non-Hispanic white

Abram et al., 2008, JAACAP
Suicidal Ideation and Behavior Among Males, Baseline

- Ever Felt Life Was Hopeless
  - African American: 38
  - Hispanic: 43
  - non-Hispanic white: 35

- Thought About Death (Past 2 Weeks)
  - African American: 22
  - Hispanic: 16
  - non-Hispanic white: 20

- Thought About Suicide (Past 2 Weeks)
  - African American: 5
  - Hispanic: 9
  - non-Hispanic white: 3

- Specific Suicide Plan
  - African American: 7
  - Hispanic: 7
  - non-Hispanic white: 5

- Ever Attempted Suicide
  - African American: 9
  - Hispanic: 18
  - non-Hispanic white: 9

- Attempted Suicide (Past 6 Months)
  - African American: 5
  - Hispanic: 6
  - non-Hispanic white: 2

Abram et al., 2008, JAACAP
What % of males and females received needed mental health treatment?

- 41% Female
- 13% Male

Teplin et al., 2005; American Journal of Public Health
Prevalence of Childhood Maltreatment Among Juvenile Detainees

King et al., 2011; Psychiatric Services
Prevalence of Childhood Maltreatment: Self-Report vs. Record

King et al., 2011; Psychiatric Services
Prevalence of Traumatic Experiences among Detained Youth

- **Sexual Assault**: 30 females, 2 males
- **Bad Accident**: 22 females, 34 males
- **Attacked/Severely Beaten**: 31 females, 36 males
- **Thought Would Die**: 49 females, 54 males
- **Threatened with Weapon**: 47 females, 59 males
- **Witnessed Severe Violence**: 64 females, 75 males
- **Ever Traumatized**: 84 females, 93 males

Abram et al., 2004, AGP
Proportion of Sample by IQ (KBIT)

IQ Category

- Above Average
- Average
- Below Average
- Well Below Average
- Lower Extreme

Lansing et al. 2014; J. of Cor. Hlth Care
After Detention
Prevalence of Any Juvenile or Adult Incarceration After Baseline*

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td></td>
<td></td>
<td>94%</td>
<td>74%</td>
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<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Total</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American</td>
<td>98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>95%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>83%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>79%</td>
<td></td>
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</tr>
<tr>
<td>Hispanic</td>
<td>72%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>56%</td>
<td></td>
<td></td>
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</tbody>
</table>

* Until October 2013; includes juvenile detention, juvenile prison, adult jail, and adult prison.

Preliminary Data; please do not cite without permission
Prevalence of Any Adult Incarceration After Baseline*

* Until October 2013; includes adult jail and adult prison.

Preliminary Data; please do not cite without permission
Delinquents: Cause of Death, Ages 15-29 by Gender

Delinquent Males

- Homicide: Firearm, 86%
- Homicide: Other, 5%

Delinquent Females

- Motor Vehicle, 1%
- Drug Overdose, 1%
- Suicide, 2%
- Other, 5%

Teplin at al., 2014, Pediatrics
Cause of Death: Males Ages 15-29*

- **Homicide: Firearm**
  - Delinquent Males: 85%
  - General Population Males: 49%

- **Other**
  - Delinquent Males: 5%
  - General Population Males: 25%

- **Motor Vehicle**
  - Delinquent Males: 1%
  - General Population Males: 13%

- **Drug Overdose**
  - Delinquent Males: 1%
  - General Population Males: 5%

- **Suicide**
  - Delinquent Males: 2%
  - General Population Males: 4%

- **Homicide: Other**
  - Delinquent Males: 5%
  - General Population Males: 4%

*Teplin et al., 2014, Pediatrics*
Lifetime Prevalence
Substance Use Disorder

By 12 years after baseline:

- **90%** had had any substance use disorder
  - **77%** had had an alcohol use disorder
  - **83%** had had a marijuana use disorder
  - **22%** had had an other drug use disorder
Size of Social Support Network
8 Years after Detention

Preliminary Data; please do not cite without permission
Positive Outcome Domains

• Educational Attainment
• Gainful Activity
• Interpersonal Functioning
• Parenting Responsibility
• Residential Independence
• Mental Health
• Abstaining from Substance Abuse
• Desistance from Criminal Activity
Figure 1. Prevalence of Total Counts of Positive Outcomes: Sex Differences

5 years after detention

- Males:
  - Mean (95% CI) = 2.8 (2.6, 3.0)

- Females:
  - Mean (95% CI) = 4.4 (4.2, 4.5)

12 years after detention

- Males:
  - Mean (95% CI) = 3.2 (3.0, 3.3)

- Females:
  - Mean (95% CI) = 4.6 (4.5, 4.8)

Preliminary Data; please do not cite without permission
Positive Outcomes, 12 Years After Baseline: Gender Differences

- **Educational Attainment**
  - Females: 54%
  - Males: 52%

- **Gainful Activity**
  - Females: 39%
  - Males: 20%

- **Criminal Desistance**
  - Females: 68%
  - Males: 27%

- **Residential Independence**
  - Females: 67%
  - Males: 38%

- **Interpersonal Functioning**
  - Females: 36%
  - Males: 37%

- **Parenting Responsibility**
  - Females: 84%
  - Males: 24%

- **Mental Health**
  - Females: 61%
  - Males: 52%

- **Abstaining from Substance Abuse**
  - Females: 54%
  - Males: 53%

* indicates statistical significance.
Positive Outcomes, 12 Years After Baseline: Racial/Ethnic Differences Among Males

- Educational Attainment: W > AA, H
- Gainful Activity: W > H > AA
- Criminal Desistance: W > AA, H
- Residential Independence: W > AA
- Interpersonal Functioning: W > AA, H
- Parenting Responsibility: W > AA
- Mental Health: AA, H > W
- Abstaining from Substance Abuse: W > AA, H

Preliminary Data; please do not cite without permission
Positive Outcomes, 12 Years After Baseline: Racial/Ethnic Differences Among Females

- **Educational Attainment**
  - Non-Hispanic White: 68%
  - Hispanic: 56%
  - African American: 52%
  - Non-Hispanic White > African American

- **Gainful Activity**
  - Non-Hispanic White: 37%
  - Hispanic: 42%
  - African American: 38%
  - Hispanic > African American

- **Criminal Desistance**
  - Non-Hispanic White: 62%
  - Hispanic: 67%
  - African American: 62%
  - Hispanic > African American

- **Residential Independence**
  - Non-Hispanic White: 68%
  - Hispanic: 69%
  - African American: 66%
  - Non-Hispanic White > African American

- **Interpersonal Functioning**
  - Non-Hispanic White: 59%
  - Hispanic: 38%
  - African American: 33%
  - Non-Hispanic White > African American, Hispanic

- **Parenting Responsibility**
  - Non-Hispanic White: 82%
  - Hispanic: 35%
  - African American: 80%
  - Non-Hispanic White > African American

- **Mental Health**
  - Non-Hispanic White: 48%
  - Hispanic: 61%
  - African American: 61%
  - Non-Hispanic White > African American

- **Abstaining from Substance Abuse**
  - Non-Hispanic White: 52%
  - Hispanic: 53%
  - African American: 61%
  - African American > Non-Hispanic White
Highest Level of Educational Attainment, 12 Years After Detention: Gender Differences

- **Less than high school/GED**
  - Females: 48%
  - Males: 48%
  - Gender Difference: No significant difference

- **GED**
  - Females: 19%
  - Males: 31%
  - Gender Difference: Males have higher attainment

- **High school**
  - Females: 21%
  - Males: 12%
  - Gender Difference: Females have higher attainment

- **Vocational/technical**
  - Females: 7
  - Males: 5
  - Gender Difference: Females have higher attainment

- **Postsecondary**
  - Females: 5
  - Males: 4
  - Gender Difference: Females have higher attainment

*Preliminary Data; please do not cite without permission*
Highest Level of Educational Attainment, 12 Years After Detention: Racial/Ethnic Differences Among Females

- **Postsecondary**:
  - non-Hispanic white: 6%
  - Hispanic: 7%
  - African American: 6%

- **Vocational/technical**:
  - non-Hispanic white: 6%
  - Hispanic: 7%
  - African American: 7%

- **High school**:
  - non-Hispanic white: 19%
  - Hispanic: 21%
  - African American: 24%

- **GED**:
  - non-Hispanic white: 32%
  - Hispanic: 24%
  - African American: 18%

- **Less than high school/GED**:
  - non-Hispanic white: 44%
  - Hispanic: 48%
  - African American: 48%

*Preliminary Data; please do not cite without permission*
Highest Level of Educational Attainment, 12 Years After Detention: Racial/Ethnic Differences Among Males

- **Postsecondary**
  - non-Hispanic white: 6%
  - Hispanic: 3%
  - African American: 4%

- **Vocational/technical**
  - non-Hispanic white: 7%
  - Hispanic: 5%
  - African American: 5%

- **High school**
  - non-Hispanic white: 14%
  - Hispanic: 20%
  - African American: 11%

- **GED**
  - non-Hispanic white: 39%
  - Hispanic: 29%
  - African American: 31%

- **Less than high school/GED**
  - non-Hispanic white: 49%
  - Hispanic: 49%
  - African American: 6%

*Preliminary Data; please do not cite without permission*
Employment Status, 12 Years After Detention: Gender Differences

- Not employed: 61% females, 71% males
- Employed part-time: 10% females, 9% males
- Employed full-time: 28% females, 20% males

Preliminary Data; please do not cite without permission
Employment Status, 12 Years After Detention: Racial/Ethnic Differences Among Females

Preliminary Data; please do not cite without permission
Employment Status, 12 Years After Detention: Racial/Ethnic Differences Among Males

Preliminary Data; please do not cite without permission
Funding Agencies

National Institute on Drug Abuse
Office of Juvenile Justice and Delinquency Prevention
Office of Behavioral and Social Sciences Research
Centers for Disease Control and Prevention
National Institute on Alcohol Abuse and Alcoholism
NIH Center on Minority Health and Health Disparities National Institute of Mental Health
Center for Substance Abuse Prevention (SAMSHA)
Center for Mental Health Services (SAMSHA)
Center for Substance Abuse Treatment (SAMSHA)
NIH Office of Research on Women’s Health
NIH Office of Rare Diseases
Department of Labor
Department of Housing and Urban Development
Robert Wood Johnson Foundation
William T. Grant Foundation
Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
SAMHSA’s Approach to Serving At-Risk Youth

Ingrid Donato, Chief
Mental Health Promotion Branch
Center for Mental Health Services
SAMHSA’s Trauma and Justice Strategic Initiative

- Integrating a trauma-informed approach throughout health, behavioral health, and related systems in order to reduce the harmful effects of trauma and violence on children, adults, families, and communities.

- Utilizing innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.
Prevalence of BH and JJ-involved Youth

- Up to **93% of youth** in the criminal justice system have experienced some form of trauma;
- An estimated **15.5 million children** live in families in which physical violence between parents occurred in the past year; seven million of those children were living in a home in which severe violence occurred between parents; and
- Research shows that children exposed to trauma and violence are more likely to **struggle in school, act up, feel depressed, and get into trouble with the law**.
Prevalence of BH and JJ-involved Youth

Young people in the juvenile justice sector are about three times more likely to have a mental health diagnosis than their peers, with girls in the juvenile justice sector being even more likely than boys to have mental health diagnoses.

(Anoshiravani et al., 2015).
Impact of Trauma Over the Life Span

Effects of childhood adverse experiences:

- Neurological
- Biological
- Psychological
- Social

(Felitti et al., 1998)
Demographics of the Justice-Involved Population

SAMHSA Programs

• FY 14 Juvenile Justice Drug Courts
• Children’s Mental Health Initiative
• Adolescent Substance Abuse Treatment grants: SAT-ED/SYT
• National Child Traumatic Stress Initiative
Upstream Approaches

- Project LAUNCH
  - Center of Excellence for Infant and Early Childhood MH Consultation
- Safe Schools/ Healthy Students State Cooperative Agreements
- Project AWARE – Advancing Wellness and Resilience In Education
  - Project AWARE- SEA
  - Project AWARE – LEA
  - Project AWARE- Community
- ReCAST – supporting high risk youth and their families due to effects of civil unrest.
Cross-Federal Collaborations

• Defending Childhood Initiative
• Disproportionate Minority Contact
• The Supportive School Discipline Initiative
• National Forum on Youth Violence Prevention
State Juvenile Justice Policy Academies

Policy development for diversion of youth with mental health and/or substance use issues into services and not into the justice systems.

*Included focus on: trauma, screening, treatment, court personnel training, probation, disproportionate minority contact with the JJ system.*

- 2014 Tribes: Cheyenne River Sioux, Lower Brule Sioux, Red Lake Band of Chippewa, and Ute Mountain Ute
- 2014 States: Georgia, Indiana, Massachusetts, and Tennessee
- 2013 States: Arkansas, Kentucky, Michigan, Minnesota, Mississippi, New York, South Carolina, and Virginia
Policy Academy (June 28-29, DC)

Financing Effective, Community-Based Behavioral Healthcare Services and Supports for Youth Diverted from the Juvenile Justice System.

- Florida
- Illinois
- Maryland
- South Dakota
The Trauma-Informed Juvenile Justice System Resource Site

With leadership from the Justice Consortium and the Juvenile Justice and Treatment Subcommittee the National Child Traumatic Stress Network has maintained creating trauma-informed juvenile justice systems as an important goal since its inception in 2001. This site highlights resources from multiple levels of the juvenile justice system that are important in creating a trauma-informed system including trauma-informed juvenile courts, trauma-informed detention and residential settings, trauma-informed interventions for juvenile justice settings, special topics, and additional resources.

- Trauma-Informed Juvenile Justice Courts
- Trauma-Informed Detention and Residential Settings
- Trauma-Informed Screening and Assessment for Juvenile Justice Settings
- Trauma-Informed Interventions for Juvenile Justice Settings
- Special Topics
- Collaborative Partnerships

Trauma-Informed Juvenile Courts
SS/HS Framework

1. Provide early childhood social and emotional learning programs
2. Promoting mental, emotional, and behavioral health
3. Connecting families, schools and communities
4. Preventing behavioral health problems
5. Creating safe and violence-free schools

• Collaboration & Partnership
• Technology
• Policy Change & Development
• Capacity Building
• Systemic Change & Integration

• Cultural & Linguistic Competency
• Serving Vulnerable & at-risk Populations
• Developmentally Appropriate
• Resource Leveraging
• Sustainability
• Youth Guided & Family Driven
• Evidence-Based Interventions
Project AWARE - Alaska

- **Partners:** ED, BH, JJ, Association of School Boards, Youth and Family Networks, Medicaid, Public Health, MH Board, University of Alaska
- **Populations of focus:** students in secondary alternative school settings
- Supports access to **school-based MH services** for alternative school sites
- Nine of the 13 alternative education sites staff a **dedicated MH provider** and offer a full scope of EBPS to build resilience and promote wellness for student success
- Focus on **reducing stigma** related to alternative schools
- Utilizes **trauma-informed** approaches
- Integrating with other federal and state funding sources, like GLS
Thank you!

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Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover
Federal Suicide Prevention Initiatives

James Wright, LCPC
Public Health Advisor
Suicide Prevention Branch
Utah Youth Suicide Study

- Utah has consistently had a higher youth suicide rate compared to the U.S. for more than a decade, prompting the development of the Utah Youth Suicide Study. Death certificates provided by the Office of the Medical Examiner and additional data from multiple government agencies were collected on 151 youth suicides. Results:
  - 89% were male.
  - 63% had contact with the juvenile courts.
  - 54% of the decedents who had contact with juvenile court had a referral(s) for substance possession, use, or abuse and 32% had one felony referral.
  - 35% had either a suspension or expulsion from school.
  - 27% referred to MH treatment, 14% ever completed course of treatment, and only 1% of the suicide decedents were in public mental health treatment at the time of death.
National Action Alliance for Suicide Prevention

EXECUTIVE COMMITTEE

PRIVATE SECTOR CO-CHAIR
PUBLIC SECTOR CO-CHAIR

SECRETARIAT

NOMINATING COMMITTEE:
Nominating new Executive Committee members

SUSTAINABILITY COMMITTEE:
Working to ensure long-term viability of the Action Alliance

TASK FORCES:
Time limited work groups advancing the National Strategy for Suicide Prevention

ADVISORY GROUPS

NATIONAL COUNCIL FOR SUICIDE PREVENTION
FEDERAL WORKING GROUP ON SUICIDE PREVENTION
IMPACT GROUP
NSSP IMPLEMENTATION ASSESSMENT ADVISORY GROUP
ZERO SUICIDE ADVISORY GROUP
AD HOC ADVISORY GROUPS
Juvenile Justice Task Force

- Established in June 2011; completed its work in 2013 by focusing attention on the needs of youth in the juvenile justice system, particularly in the areas of suicide-related awareness and education, suicide research, suicide prevention programming and training, and collaboration between the juvenile justice and mental health systems. (http://actionallianceforsuicideprevention.org/youth-contact-juvenile-justice-system)

- From Utah Study: Research indicates at least one in five youth under age 18 who have been arrested have serious mental health problems. However, mental health services for youth in juvenile offender facilities are insufficient. Even fewer resources are available for juvenile offenders involved with probation officers outside juvenile facilities in Utah. Early mental health interventions through the juvenile court system can be a cost-effective way for reaching teens at risk for suicide. Treatment should include both psychiatric care and in-home behavioral intervention.
SAMHSA’s Major Suicide Prevention Components

- Garrett Lee Smith (GLS) State and Tribal Suicide Prevention Grant Program
- GLS Campus Suicide Prevention Grant Program
- National Suicide Prevention Lifeline
  – Crisis Center Follow-up Grant Program
- Suicide Prevention Resource Center
- *National Strategy for Suicide Prevention*
- Tribal Grants
GLS

• **Purpose:** Support States and tribes in developing and implementing statewide and/or tribal youth (10-24) suicide prevention and early intervention strategies, grounded in public/private collaboration. Such efforts must involve public/private collaboration among youth-serving institutions and agencies and should include schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth supporting organizations.

• **Activities:** Include coalition and task force building, outreach and awareness campaigns, gatekeeper trainings and screening programs, and direct services. Grantees must use programming from the NREPP or BPR registries and can create specific training and screening for target populations (e.g. youth involved in the JJ system). Most states focus on middle/high school training.

• **Funding:** States currently receive $3.7M over 5 years. **All States have received GLS funding.**
Telephone network comprised of 165 independent crisis centers across the country dedicated to preventing suicide. By dialing 1-800-273-TALK (8255), people in emotional distress or suicidal crisis have 24/7 access to trained workers who can offer support, empathy and refer callers to additional crisis services, if needed. Using innovative technology, callers are routed to their nearest crisis center, ensuring that they receive culturally-relevant support and information about local community services.

Since its launch in 2005, the Lifeline has seen a steady increase in call volume and as of Jan 2016, has answered more than 120,000 calls per month and has taken more than six MILLION calls to date.
National Suicide Prevention Lifeline
1-800-273-TALK (8255)

• 165 local crisis centers
• Regional back-up capacity
• Collaborates with Veterans Administration for Press 1 option
• Answered 1.5 million calls in 2015
• In response to Lifeline evaluation findings, created the Crisis Center Follow-up Grants (30 crisis center grantees to-date funded)
• Chat services added 24/7 Feb 2014

- Follow-up grants, risk assessment standards, and imminent risk guidelines were all a result of the Lifeline evaluation findings (research-to-practice in action).
Suicide Prevention Resource Center

The Nation’s first and only Federally funded suicide prevention resource center

- SAMHSA-funded resource center devoted to advancing the National Strategy for Suicide Prevention
- Information on suicide prevention activities in every state (state plans, coordinators)
- Everyone has a role in preventing suicide: Information sheets for parents, teachers, co-workers, faith leaders, correctional officers, juvenile justice agency staff, foster care providers, and others
- Trainings: Clinical training for mental health professionals; Suicide Prevention for Juvenile Correctional Facilities; free online trainings
- Best Practices Registry for Suicide Prevention
- Secretariat for the National Action Alliance for Suicide Prevention
- Weekly SPARK e-newsletter (sign up!!)
- www.sprc.org
Other Responses to Suicide

- CDC and SAMHSA Epi Aid investigations
  - Public health authorities must invite CDC to assist in an epidemiologic investigation within their jurisdictions. SAMHSA and CDC have responded to several suicide cluster events for evaluation and recommendations.

http://www.cdc.gov/eis/epiaids.html
• Project School Emergency Response to Violence (SERV)
  – This program funds short-term and long-term education-related services for local educational agencies (LEAs) and institutions of higher education (IHEs) to help them recover from a violent or traumatic event in which the learning environment has been disrupted.

• Has been utilized in response to deaths by suicide

What You Can Do

• What you can do:
  – Identify your state resources (state coordinator, plans, current suicide prevention funding)
  – Know your local or statewide crisis center and promote the Lifeline
  – Identify appropriate trainings
  – Have a plan before a crisis or suicide occurs
James Wright, LCPC
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Q&A
Breakout Sessions

**Group A**: Salmon Community (200 A/B)

**Group B**: Gold Community (4117/4118)

**Group C**: Teal Community (200 C)