To reduce suicide incidents by increasing access to essential care and supports through a systematic approach to identified high-risk youth.
A Public/Private Partnership
The New Hampshire Nexus Project (NHNP)  
NHH Program Overview

- Following youth and their families for up to 90 days subsequent to discharge from N.H.H.
- Providing enhanced follow-up services including care coordination and support in order to reduce risk of suicide, improve engagement in recovery activities, and avoid readmission
- Follow-up services include both face-to-face and telephonic interventions; the frequency varies and is determined on a case-by-case basis
Program Components

- Education to youth and support system about warning signs, risk and protective factors, and means restriction
- Identification of social supports & strengths
- Interface with professional agencies, other statewide organizations, programs, and resources
- Safety Planning
- Initial and on going assessment
Assessment

Preparedness Assessment Tool:

- Measures:
  a. Hope
  b. Connections/Support
  c. Self-Management

- Suicide Risk Scale:
  a. 1=No/Low Need
  b. 2=Moderate Need
  c. 3=High Need
<table>
<thead>
<tr>
<th>HOPE</th>
<th>2 = Moderate Hope</th>
<th>3 = High Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient cannot</td>
<td></td>
<td></td>
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<tr>
<td>identify any spiritual,</td>
<td></td>
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<tr>
<td>educational, familial, or personal resources</td>
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<tr>
<td>Patient cannot identify any goals or something to look forward to</td>
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<tr>
<td>Patient has made hopeless comments</td>
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<tr>
<td>Patient can identify one or two spiritual, educational, familial, or personal resources</td>
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<tr>
<td>Patient can identify something to look forward to upon leaving the hospital OR can identify a personal goal</td>
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<tr>
<td>Patient has made ambivalent comments about hope</td>
<td></td>
<td>Patient has made hopeful comments</td>
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</tbody>
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<table>
<thead>
<tr>
<th>SUPPORT</th>
<th>2 = Moderate Support</th>
<th>3 = High Support</th>
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</thead>
<tbody>
<tr>
<td>Pervasive interpersonal problems, family dysfunction, no close friends or meaningful relationships, problems at school and with peers, tendency to withdraw and/or become isolated, reported stigmatization and inability to identify any sources of support.</td>
<td>Multiple problem areas and few connections/support</td>
<td>One or two problem areas and strong connections/support. Patient’s family is engaged and participates in treatment plan. The patient has one or two friends regarded as close and is engaged in activities.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>SELF MANAGEMENT</th>
<th>2 = Moderate Self Manage</th>
<th>3 = High Self Manage</th>
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<tbody>
<tr>
<td>Patient and family does not know the patient’s diagnosis, symptoms, and medications</td>
<td>Patient and family’s understanding is minimal</td>
<td>Patient and family knows the patient’s diagnosis, symptoms, and medications</td>
</tr>
<tr>
<td>Patient and family cannot identify early warning signs and triggers or describe crisis plan</td>
<td>Patient and family are somewhat confident in their ability to manage at home</td>
<td>Patient and family can identify early warning signs and triggers, and describe crisis plan</td>
</tr>
<tr>
<td>Patient and family are not confident in their ability to manage at home</td>
<td></td>
<td>Patient and family are confident in their ability to manage at home</td>
</tr>
</tbody>
</table>

Total Preparedness Score (Hope+Support+ Self Management)/3=
Data Spreadsheet

<table>
<thead>
<tr>
<th>Case ID</th>
<th>Current Status</th>
<th>Date of Referral to GLS Liaison</th>
<th>Date of NHH Intake</th>
<th>Referring Team/Clinical Staff Person</th>
<th>Patient Age</th>
<th>Previously Worked With GLS Coordinator</th>
<th>Number of Prior Admissions</th>
<th>Priority Region</th>
</tr>
</thead>
</table>
Education & Resources

- Suicide Prevention group on inpatient for teens
- Suicide Prevention education for parents
  - Mayo Clinic video for parents
  - Suicide prevention materials distributed to everyone
- My3 app introduced prior to discharge
- Families connected with NAMI NH prior to discharge
Data Dashboard
Strategies for Continuity of Care

- Mental Health Center release form signed prior to discharge
- Safety plan to involve and educate natural supports as selected by the youth and family member
- Connections made with key collateral identified by the youth: coaches, teachers, employers
Strategies for Continuity of Care

Mental Health Center:

- Provides reminders for visits (personal calls) at several intervals
- Does immediate follow-up if youth does not show
- Alerts After Care Liaison of certain adverse events:
  - no-show; attempt or other crisis
- Advises AC liaison if someone is admitted
Community Linkages
Challenges

- State moves at a different pace; but deliberate!
- Patient/family willingness to involve others varies
- Communication with key supports/schools
- Creative thinking with ROIs
Lessons Learned

- Trust, relationships and compassion are key
- Engage & collaborate with key personnel on protocols & community linkages from beginning
- Education, support and stigma reduction
- Embed the position vs. grant funded
- Lessons to be learned: Comparison study underway
Successes

Community System:
- MHCs, PHNs & families report improved communication & working relationships with NHH
- Documentation arriving before the first appointment

Hospital System:
- Almost all patients now have safety plans developed
- Connect training as part of orientation for new NHH staff
- NHH SP Task Force now led by COO
- Using Zero Suicide model to implement best practices throughout the hospital
- AfterCare Liaison position will be sustained

Individuals:
- More families educated, supported and connected with NAMI
- Awareness and communication led to interventions that averted crisis
- “L Is For Life”