

# Transforming Youth Suicide Prevention in Michigan: *Collaboration with Child Welfare*

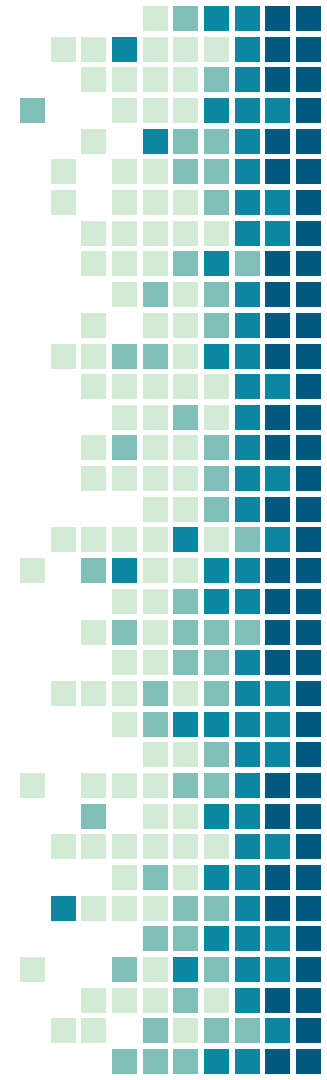
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Pat Smith, MA

Michigan Suicide Prevention



# Disclaimer

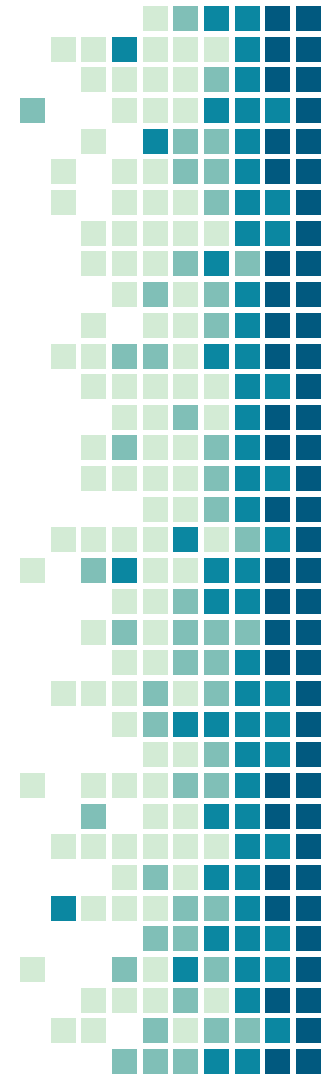
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# GLS Grant Core Components



- **Create state-level systems change in support of youth suicide prevention**
- **Partner with youth serving agencies to make suicide prevention a core priority**



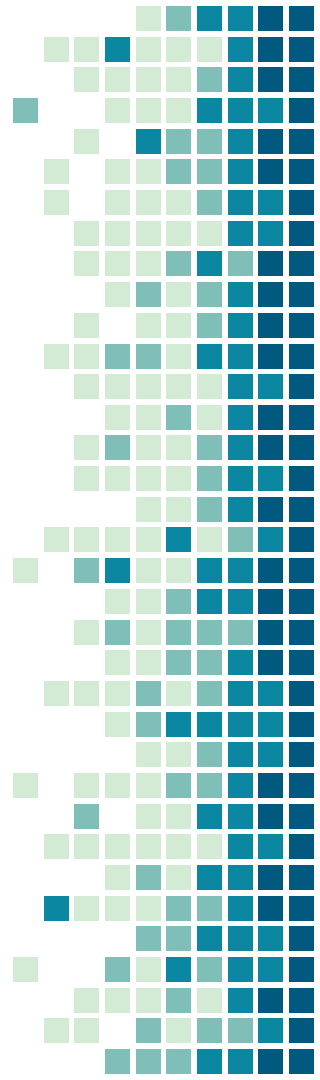
# Link between interpersonal trauma & suicide

10-fold increase for suicide among youth exposed to interpersonal violence<sup>1</sup>

ACES study: for every additional ACE, suicide risk increases by 60%<sup>2</sup>

Chronicity of victimization is associated with risk over and above other factors<sup>3</sup>

1. Castellví et al., 2017
2. Dube, Anda, Felitti, Chapman, Williamson, & Gilles, 2001
3. Geoffroy et al., 2016



# 90,152 reports

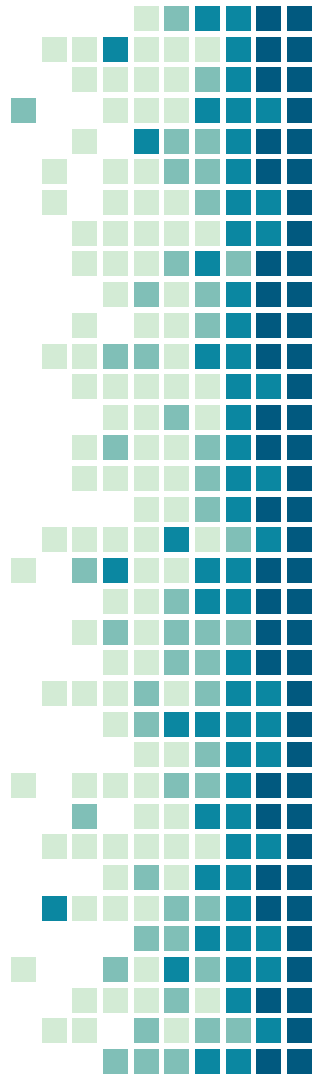
Of child abuse/neglect investigated in MI in 2017

# 37,986 victims

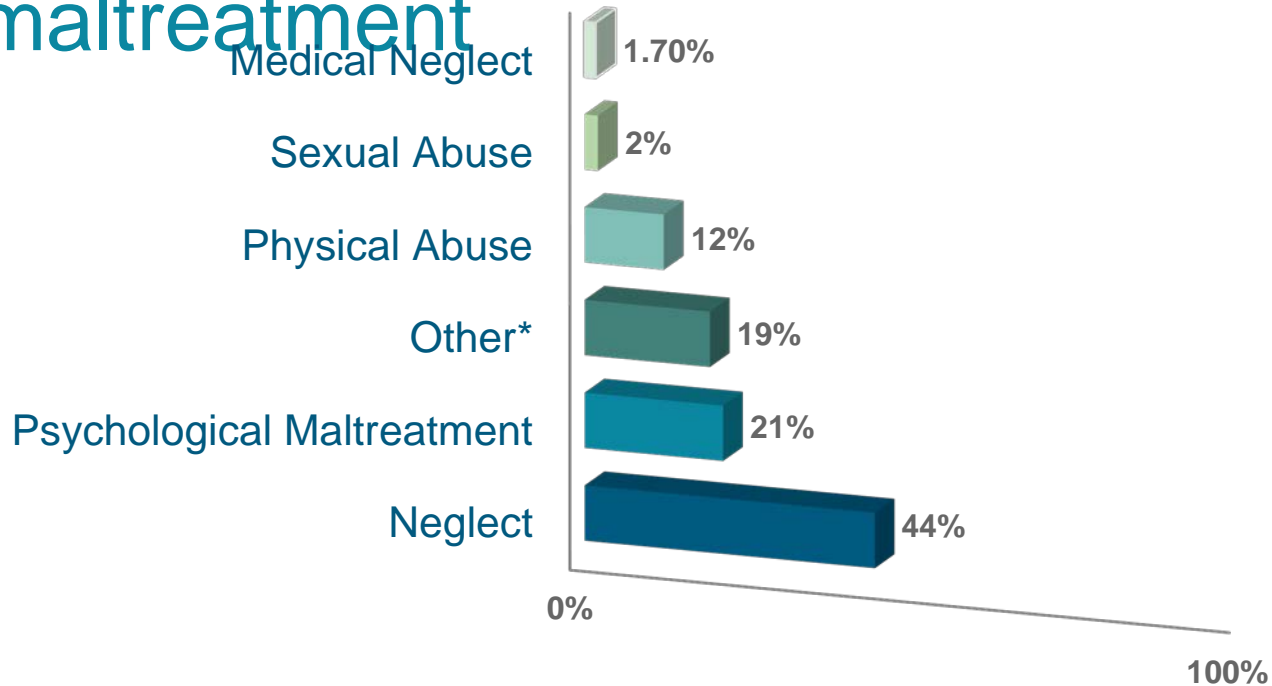
Of child abuse/neglect in MI in 2017

# 7429 children

Were separated from a parent in MI in 2017

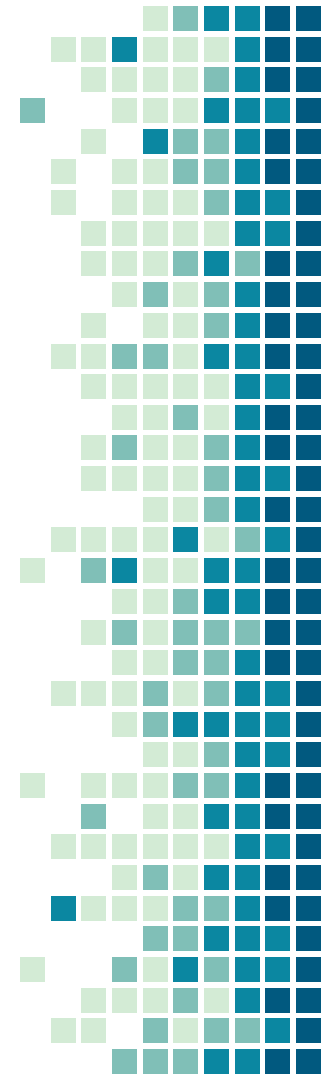


# Victimized children are likely to experience more than one type of maltreatment



# Michigan Youth in Foster Care

- 4,995 youth ages 10-23 in foster care (April, 2014)
- 53% female, 47% male
- 10 deaths of MI foster care youth since 2008
  - 9/10 deaths were males
- No state surveillance on suicide-related risk factors (e.g., mental health dx, sexual identity, substance use) despite national data suggesting elevated prevalence in foster care youth.



# TWO PROJECTS



1. Child Welfare Workforce Evaluation
2. Screening for Risk in Child Welfare Involved Youth



# Rationale for Workforce Initiative

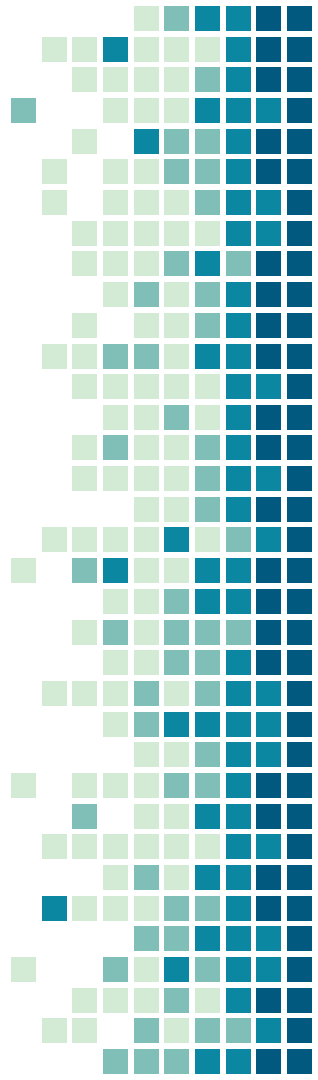
## 1. Close contact

Child welfare staff are in close contact with youth with multiple risk factors for suicide

- 5,000 staff
- 7,200 licensed foster care parents

## 2. Limited training

Suicide prevention training offered to workers and foster care parents was previously very limited- but all have CEU requirements.



2<sup>nd</sup> Annual  
SUICIDE PREVENTION  
CONFERENCE  
“Know The Signs”



Michigan Department of Health & Human Services

# One day, one conference, 14 safeTALKs!

Thursday, December 15, 2016 | *LivingWorks Education*

When the Michigan Department of Health and Human Services hosted a one-day youth suicide prevention conference for employees and local foster parents, they wanted all participants to be trained in safeTALK. With over 260 attendees, that meant a lot of safeTALK sessions... 14, to be exact! Needless to say, no single trainer could present 14 safeTALKs in one day, but a team of dedicated, coordinated trainers could—and that's exactly what happened.

The trainers—Lisa Clavier, Anne Kramer, Erin MacLeod-Smith, Karen Marshall, Stephanie Salazar, Barb Smith, and Kathryn Szewczuk—didn't work for the same organization, but came together at the request of conference organizers to provide seven safeTALKs in the morning and another seven in the afternoon. They coordinated to ensure a consistent experience for all participants. "We had some

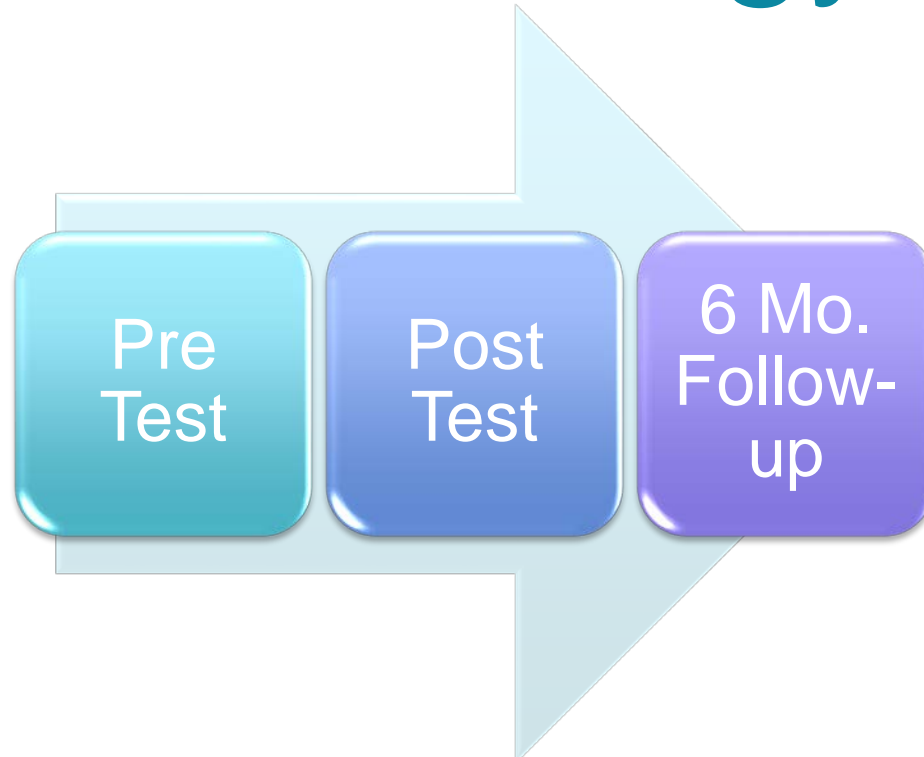


safeTALK®

*suicide alertness for everyone*



# Methodology



Ewell Foster, C. J., Burnside, A. N., Smith, P. K., Kramer, A. C., Wills, A., & King, C. A. (2017). Identification, Response, and Referral of Suicidal Youth Following Applied Suicide Intervention Skills Training. *Suicide and Life-Threatening Behavior*, 47(3): 297-308.

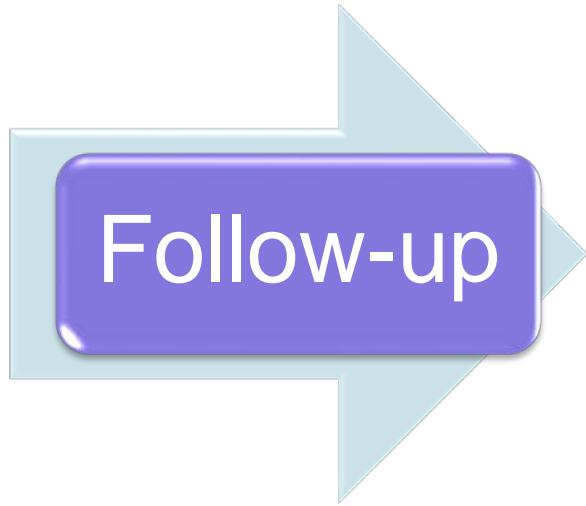
# Pre Test

- I. Previous Training/Agency Policies
- II. Gatekeeper Efficacy, Reluctance, & Preparedness Attitudes<sup>1</sup>
- III. Practice Patterns (Identification, Response, Referral)
- IV. Suicide Knowledge
- V. Your Ideas (open-ended questions)

# Post Test

- I. Gatekeeper Efficacy, Reluctance, & Preparedness attitudes<sup>1</sup>
- II. Suicide Knowledge

# Qualtrics survey emailed to participants 6 months later...



Practice Patterns:  
Identification, Response, Referral





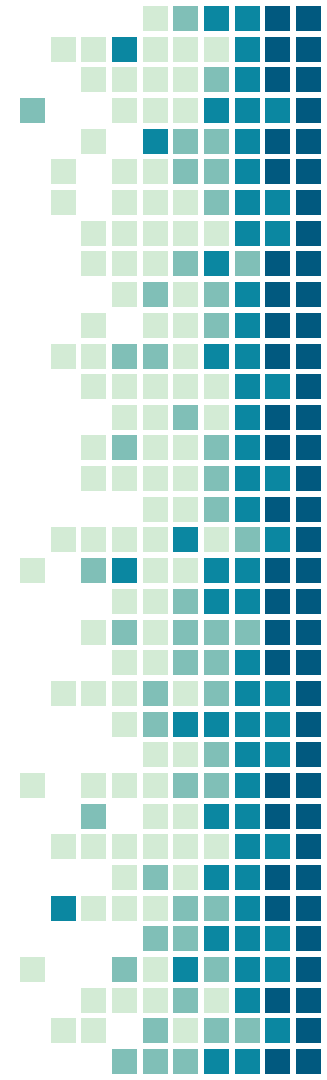
CHILD WELFARE WORKFORCE  
**QUANTITATIVE EVALUATION**

Quantitative Report on Michigan's Child Welfare Workforce Evaluation  
January 11, 2017

# Baseline Data Report

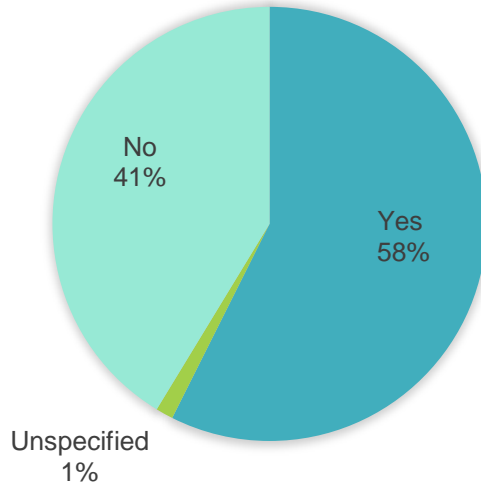
Documenting participants':

1. Previous training in suicide prevention, knowledge and perceptions of preparedness to engage in suicide prevention practices with youth
2. Awareness of their agencies' suicide prevention policies, procedures, and resources
3. Practice patterns regarding suicide prevention prior to safeTALK training

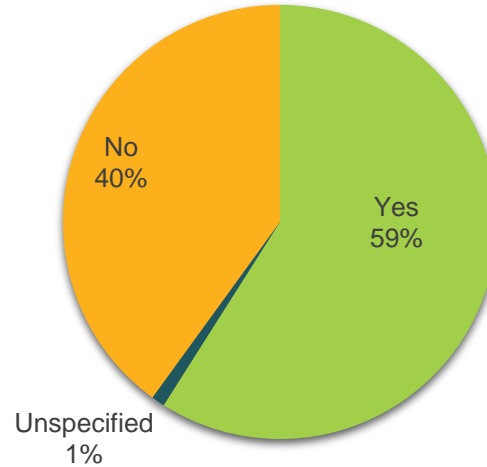


# Findings: Previous Training in Suicide Prevention

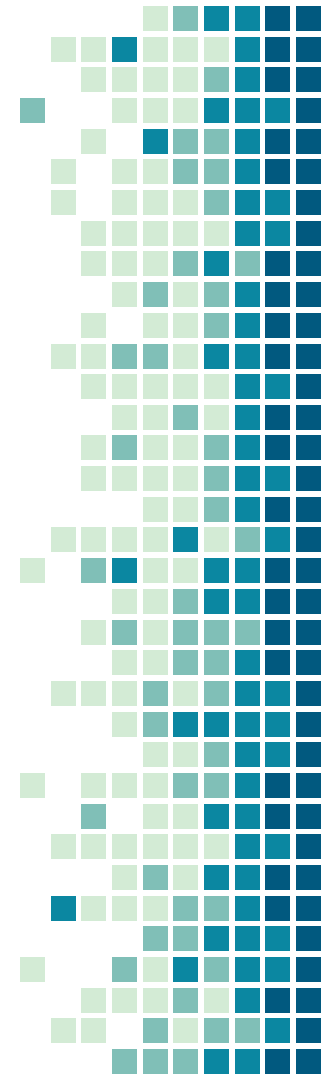
Personal Experience with Suicide



Professional Experience with Suicide



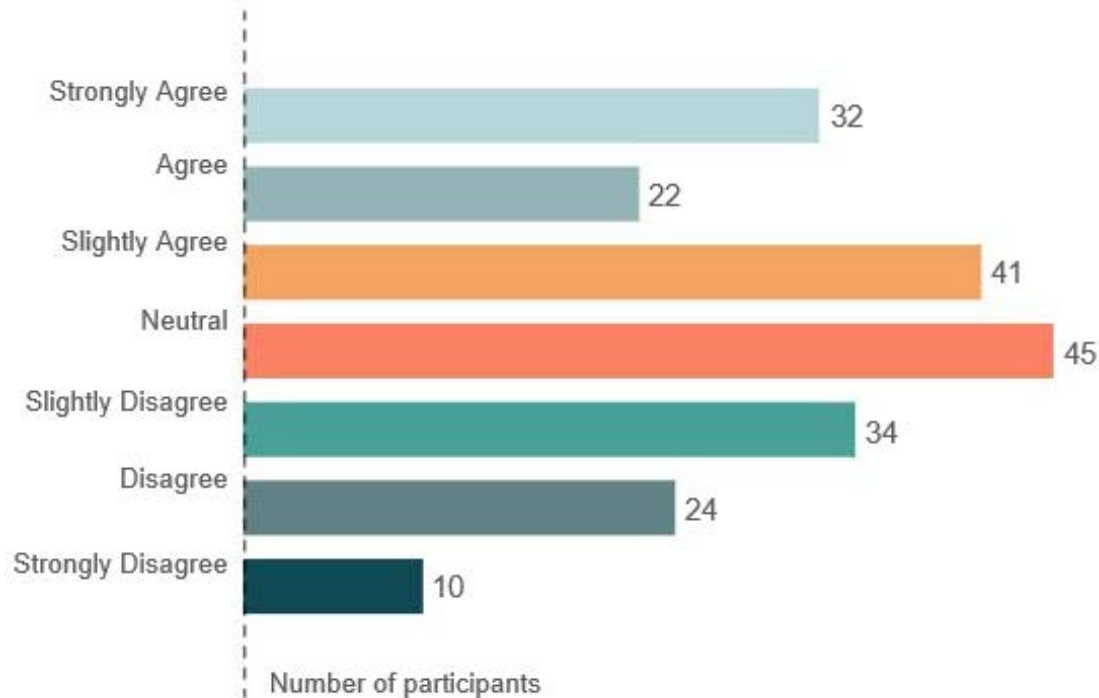
Although 82.6% of respondents endorsed having a direct experience with suicide, **over a quarter** of respondents indicated that they had no previous suicide prevention



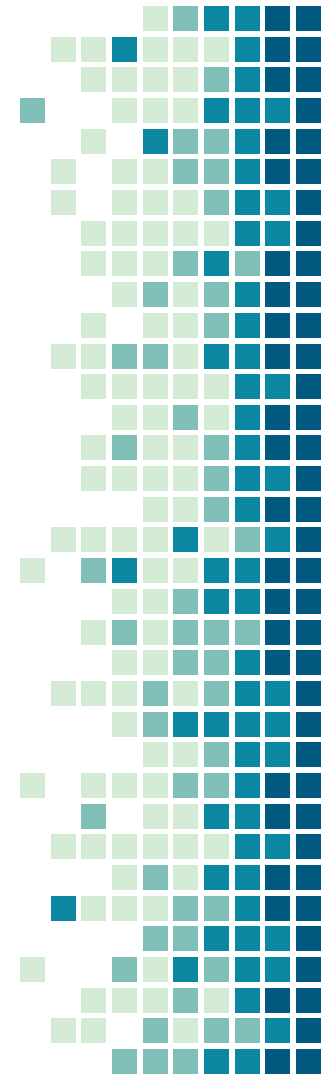


# Findings: Awareness of Agency Policies, Procedures, & Resources

“My workplace encourages me to ask youth about thoughts of suicide.”



n = 208



# Findings: Awareness of Agency Policies, Procedures, & Resources

36.5%

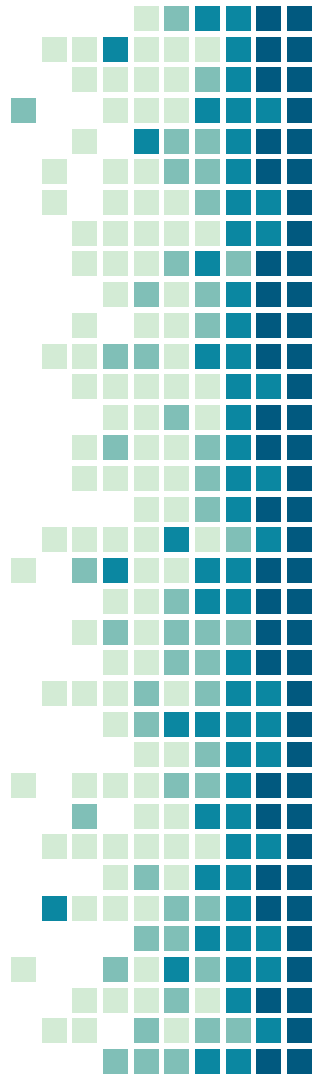
Were unsure if their agency has suicide prevention youth education or resource materials

80%

Indicated that their agency provided resources to youth

40%

Reported that their referral network was adequate in terms of linking youth to needed care



# Conclusions & Next Steps



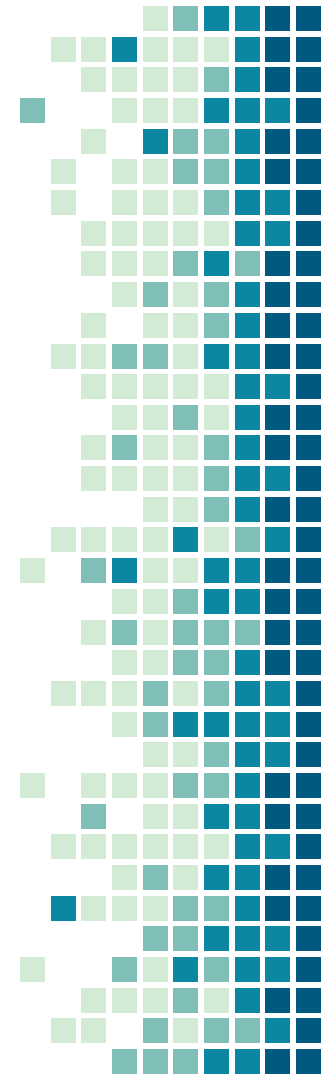
Strong need for additional suicide prevention training



Improve the development & dissemination of suicide prevention policies



Need for additional referral resources at child welfare agencies for youth contemplating suicide



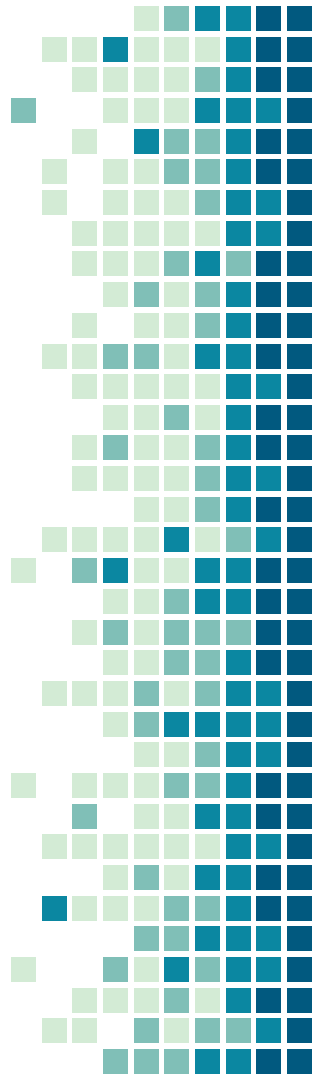
# How do you sustain hope for the children and families you work with?



- *Meet them where they are at, listen.*
- *Be open and honest. Don't leave them in the dark. Communicate with them.*
- *I assure them that we are a team and are in it together.*
- *Showing them they have strengths and a future.*

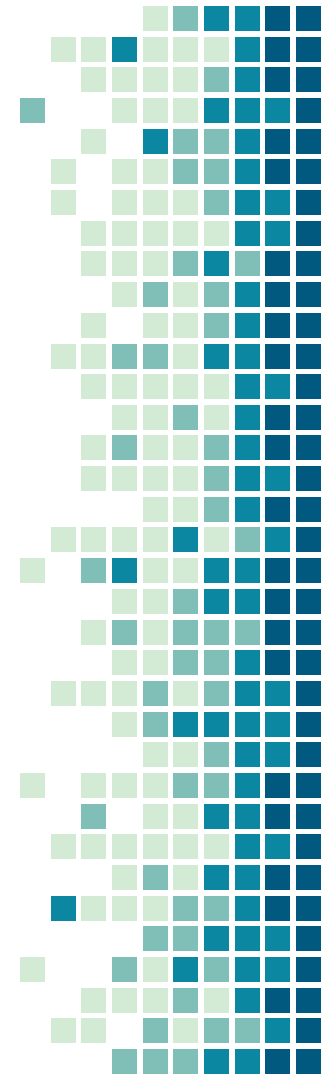
# 6 Month Follow-up Data

- Baseline N= 230; 44% Participation at F-up (limitation)
- Identification:
  - Non-significant change from pre to post
- Referral:
  - Significant increase in referral rates at follow-up
  - $t(100) = -2.80, p = 0.006$
  - 1.56 (SD = 1.66) youth referred at baseline
  - 2.08 (SD = 1.45) youth referred at follow-up
- Analyses are ongoing



# Systems Changes/Lessons Learned

- Importance of having a CW staff member provide training
- 9 Health Liason Officers Trained in ASIST & safeTALK T4T in 2017; 10 more planned
- Offering safeTALK in county offices across MI
- Challenges of fast-paced, unpredictable schedules interfering with attendance



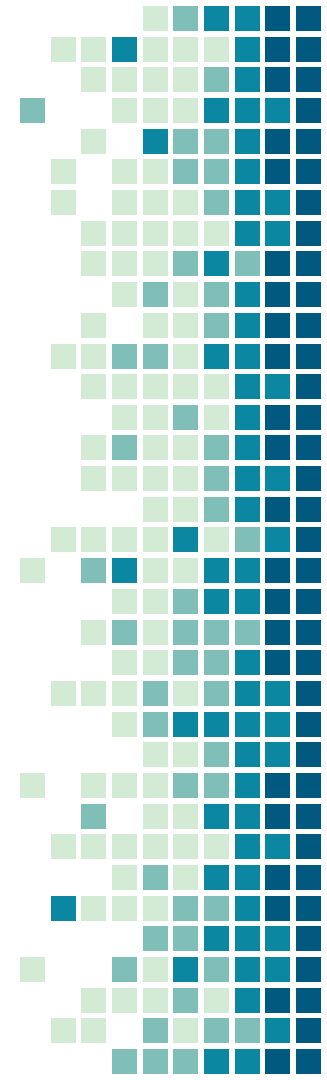


# Foster Care Screening Project



# Rationale For Screening

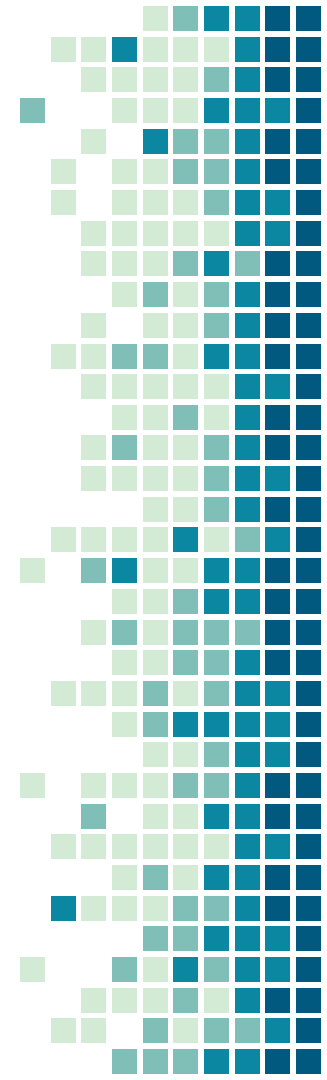
- Evidence suggests suicide risk in foster care youth is 3-5X higher than general population
- Ten deaths in MI since 2008
- Number of attempts unknown
- OFA investigating deaths & wondering how they could have been prevented
- Current standard for mental health assessment





# Screening Beyond Ideation

- Pro-active suicide risk screening is a recommended practice
- Suicidal ideation (SI) is only a modest predictor of suicide attempts within clinical samples of adolescents<sup>1</sup>
- SI failed to predict attempts among high risk males<sup>2</sup>:
- Tri Risk Screen: SI, Depression, and Alcohol/Substance Abuse<sup>3</sup>



# ED-STARS: King, Grupp-Phelan, & Rudd

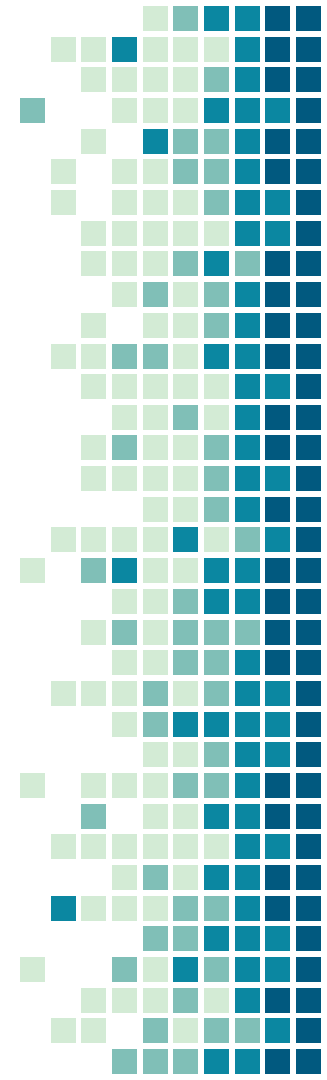
- Large-scale NIMH-funded collaborative project with PECARN and the Whiteriver PHS Indian Hospital
- Designed to develop & validate a computerized adaptive screen (CAS) for adolescent suicide risk
- Brief, tailored, & adaptive

The logo for ED-STARS is displayed within a light blue rectangular box with a dark blue border. The text "ED-STARS" is written in a bold, dark blue, sans-serif font. The letter "S" is replaced by a five-pointed star symbol. The background of the slide features a decorative pattern of small squares in various shades of blue and green, arranged in a grid-like fashion that tapers off to the right.

**ED-STARS**

# Constructs Measured on ED- STARS Youth Assessment

- Demographics
- Tri-risk Screen (PHQ-9, AUDIT, ASQ)
- CSSRS
- Pubertal Development
- Connectedness (Parents, Friends, School)
- Stressful Life Events
- Sleep Quality
- Non-Suicidal Self Injury
- Peer Victimization
- Homicidal Ideation
- PANAS (Positive & Negative Affect Scale)
- YRBS (fights, sexual intercourse, restrictive eating)
- Drug Use
- Agitation
- Anxiety
- Trauma Screen
- Sexual Identity
- Binge Eating
- Coping Style



# Specific Aims

1. Test the acceptability and feasibility of a screening protocol for use by foster care workers with youth in state custody.

2. Develop sustainable policies and protocols to support the pilot screening program.

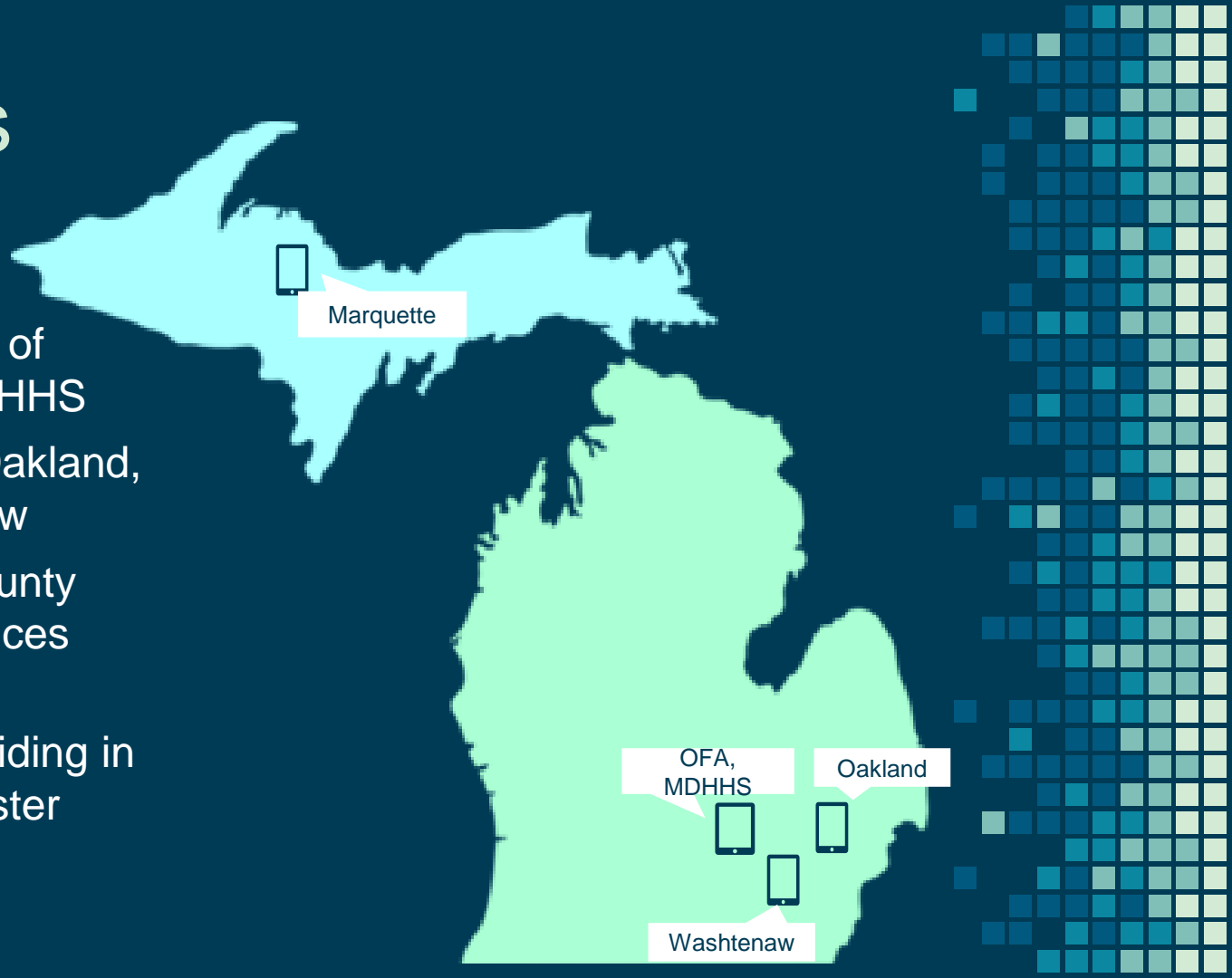
3. Evaluate impact of screening on case identification, referral, and prevention of adverse events for youth at risk for suicide who are in foster care placement.

4. Document the extent of risk factors that characterize foster care youth in our partner counties and the capacity for surveillance provided by this screening tool.

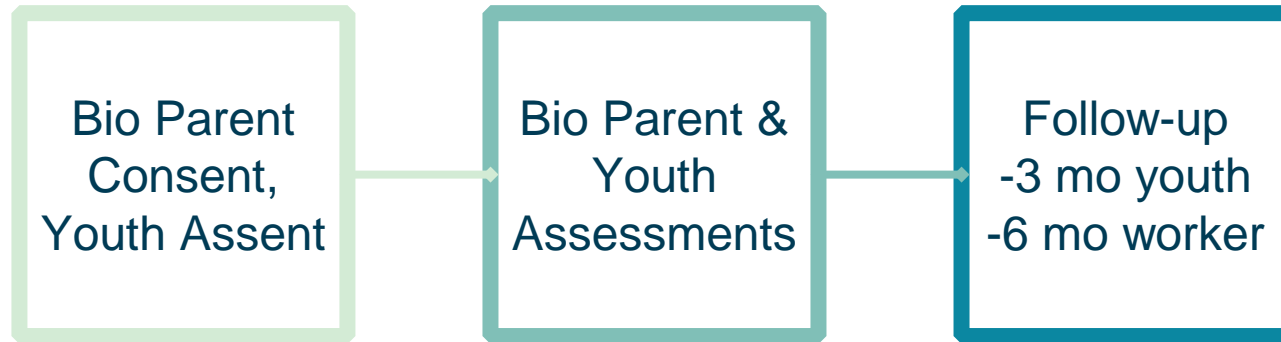


# Our Partners

- State partner = Office of Family Advocate, MDHHS
- 3 Partner Counties: Oakland, Marquette, Washtenaw
- Collaboration with County CMHs to access services post screen
- Youth ages 10-17 residing in county with county foster parents
- Bio parent consent



# DESIGN/PROCEDURE



# Youth Assessment

1. Youth completes tri-risk screen on iPad
2. Screen is scored → results sent to worker's email
3. Youth completes full assessment

**REDCap™**  
Research Electronic Data Capture

Survey Launch Page

1) Please select the type of survey you are administrating:  
\* must provide value

2) Caseworker's Email Address:  
\* must provide value

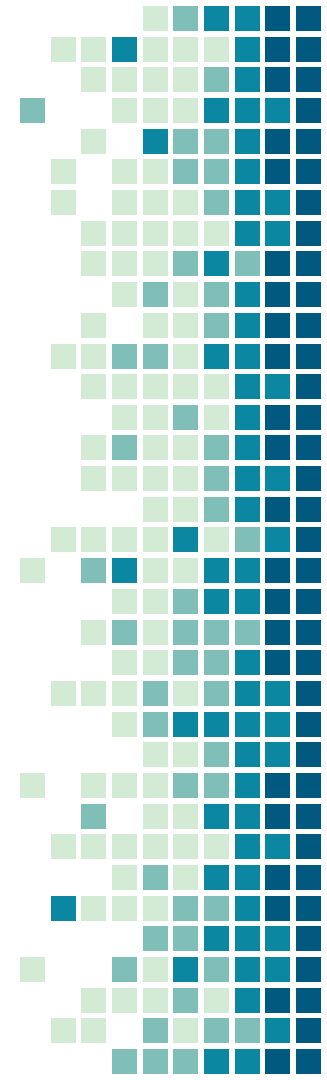
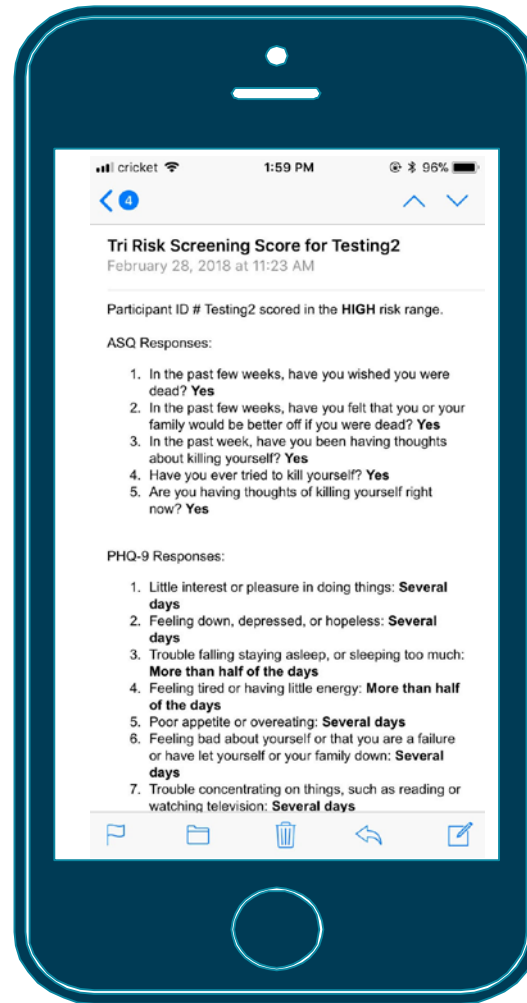
3) Participant ID:  
\* must provide value

Submit

REDCap 8.1.4 - © 2018 Vanderbilt University

# Risk Email

- Email sent to worker's email with tri-risk screen results and instructions about next steps
- Acute risk management as needed following the county's risk procedures



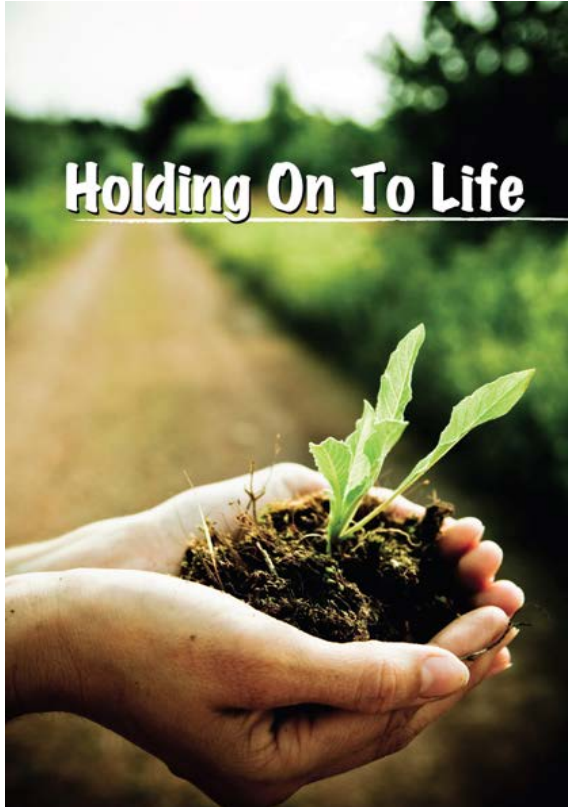


## Washtenaw County Foster Care Screening Risk Procedures

After the youth completes the Demographics questionnaire and the Tri-Risk Screen (i.e., PHQ-9, ASQ, AUDIT), an email will be sent directly to the foster care worker informing them of the youth's risk for suicide. Risk is defined as IMMEDIATE, HIGH, MODERATE, or LOW.

- A. IMMEDIATE = "YES" to #5 on ASQ
  - a. Stop everything and call the crisis team immediately: (734) 544 - 3050
    - i. "I'm a foster care worker with a youth who's [just transitioned into/in foster care] and completed a suicide risk screen. They scored in the immediate risk range, and I am VERY concerned about their health and safety. I'd like to speak to a crisis team clinician now."
    - ii. Do not leave the home until you speak to a crisis team clinician
    - iii. Follow the recommendations of the crisis team clinician
  - b. Speak with the foster parent about next steps (provided by CMH crisis clinician) and provide HOTL toolkit to foster parent.
  - c. After the youth completes the full assessment, speak with the youth about next steps
- B. HIGH = clinical range on 2/3 questionnaires –OR– "YES" to #3, #4 on ASQ –OR– endorsed #9 on PHQ-9
  - a. Stop everything and call the crisis team immediately: (734) 544 - 3050
    - i. "I'm a foster care worker with a youth who's [just transitioned into/in foster care] and completed a suicide risk screen. They scored in the high risk range, and I am VERY concerned about their health and safety. I'd like to speak to a crisis team clinician now."
    - ii. Do not leave the home until you speak to a crisis team clinician
    - iii. Follow the recommendations of the crisis team clinician
  - b. Speak with the foster parent about next steps (provided by CMH crisis clinician) and provide HOTL toolkit to foster parent.
  - c. After the youth completes the full assessment, speak with the youth about next steps
- C. MODERATE = clinical range on 1/3 questionnaires –OR– 1, 2 on ASQ –OR– endorsed #9 on PHQ-9
  - a. Finish what you planned to accomplish during the visit
  - b. Call the crisis team before you leave the home: (734) 544 - 3050
    - i. "I'm a foster care worker with a youth who's [just transitioned into/in foster care] and completed a suicide risk screen. They scored in the moderately elevated range, and I am concerned about their health and safety. I'd like to speak with a crisis team clinician."
    - ii. Do not leave the home until you speak to a crisis team clinician
    - iii. Follow the recommendations of the crisis team clinician
  - c. Speak with the foster parent about next steps (as provided by CMH clinician) and provide HOTL toolkit to foster parent.
  - d. After the youth completes the full assessment, speak with the youth about next steps
- D. LOW = 0 questionnaires are in the clinical range
  - a. Finish your work
  - b. Call the Access team before you leave the home: (734) 544 - 3050
    - i. "I'm a foster care worker with a youth who's [just transitioned into/in foster care] and completed a suicide risk screen. I would like to schedule an intake eligibility assessment to determine if the youth needs follow-up care."
  - c. Speak with the foster parent about next steps (provided by CMH clinician) and provide HOTL toolkit
  - d. After they youth completes the full assessment, speak with the youth about next steps

# Individualized Interventions



Foster Care Providers:  
Helping Youth at Risk for Suicide



# TYSP –MI Team

- *Thank you! Any questions?*



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