

ABSTRACT**The Massachusetts Youth Suicide Prevention Project (YSPP)**

The goals of the **MA Youth Suicide Prevention Project** are: to create Suicide-Safe Centers of Care to enhance effective treatment and care management of youth at-risk; to develop Suicide-Safe Communities in which prevention and early identification are priorities and treatment and support are available; and to ensure suicide prevention is integrated into state systems to create a Suicide-Safe Commonwealth.

The purpose of the **MA Youth Suicide Prevention Project** is to reduce the rate of suicide attempts and suicide completions among youth ages 10-24. Two regional hospitals will implement Zero Suicide standards of organizational and clinical practice. Training to enhance treatment skills of clinical and behavioral health providers in treating suicide risk in youth will result in more effective prevention, early intervention and follow-up care for youth and young adults. The high risk populations of focus in these two areas include: rural youth, youth with mental illness and substance abuse disorders, LGBT youth, young veterans, victimized youth and youth who have considered or attempted suicide. Activities in communities focus on strengthening capacities to provide prevention services and early identification, referral and treatment of youth at-risk for suicide through work with schools, colleges and community organizations. System change statewide will be effected by the creation of a Learning Collaborative with the Department of Mental Health and the Massachusetts Behavioral Health Partnership (the Medicaid payor for 1200 providers) for the implementation of Zero Suicide standards and by working with youth serving state agencies to integrate suicide prevention into their services and those of their providers.

Measurable impacts:

- Increase in identification, referral and treatment of at-risk youth
- Reduced rates of suicide
- Reduced rates of suicide attempts
- Youth voice in strategic planning

147,652 people will be served (29,531 annually) throughout the efforts of this grant.

Table of Contents

Abstract	1
Table of Contents	2
Project Narrative	
Section A: Population of Focus and Statement of Need	3
Section B: Proposed Evidence-Based Service/Practice	8
Section C: Proposed Implementation Approach	14
Section D: Staff and Organizational Experience	24
Section E: Data Collection and Performance Measurement	26
Budget Narrative File	36
Supporting Documentation	
Section F: Literature Citations	36
Section G: Lead Agency Description	39
Section H: Biographical Sketches and Job Descriptions	40
Section I: Confidentiality and SAMHSA Participant Protection/Human Subjects	68
Attachment 1:	
Licensed mental health/substance abuse treatment provider organization	74
List of all Direct Service Provider Organizations	74
Letters of Commitment	75
Statement of Assurance	90
Attachment 2: Data Collection Instruments/Interview Protocols	92
Attachment 3: Sample Consent Forms	119
Attachment 4: Massachusetts Strategic Plan for Suicide Prevention	123
Attachment 5: State Letter	127

Section A: Population of Focus and Statement of Need

A-1: Youth suicide is a serious and growing public health problem in Massachusetts (MA), with suicide rates among youth 10-24 years of age increasing 62% (N=52 to N=85) from 2009 through 2013. In 2004, 2007 and 2012, the Massachusetts Department of Public Health (MDPH) was awarded SAMHSA funding through the Garrett Lee Smith cooperative agreements. These funds provided MDPH with the opportunity to address the adolescent and young adult population, providing gatekeeper training in suicide prevention to schools, foster parents, juvenile justice, group home staff. MDPH also provided skills training to behavioral health clinicians, organized regional suicide prevention coalitions, and integrated suicide prevention in graduate schools of social work. The **Youth Suicide Prevention Project (YSPP)** will build upon these accomplishments by effecting system change in youth-serving state agencies, the private statewide behavioral health system and two rural healthcare systems.

The population of focus for Massachusetts' Youth Suicide Prevention Project is youth ages 10-24 years statewide. The focus of our system-based initiatives is youth ages 10-24 in predominantly rural sections of MA: the westernmost county, Berkshire County, site of Berkshire Medical Center, and the north central region of Massachusetts, the Heywood Healthcare catchment region. The high risk populations of focus within these geographic regions include rural youth, youth with mental illness and substance abuse; gay, lesbian, bisexual, and transgender youth (LGBT); young veterans; youth who have been victimized and youth who have considered or attempted suicide.

Statewide Demographics:

Massachusetts (MA) had an estimated 1,339,155 youth ages 10-24 years in 2013, representing 20% of the overall population.¹ Of these youth 69.9% are white, non-Hispanic (NH), 14.3% Hispanic, 8.8% black, NH, 6.8% Asian, NH, and 0.3% American Indian/Native American; 49.5% are female. According to the 2013 Massachusetts Youth Health Survey, 90% of the MA high school youth describe themselves as heterosexual, 1.8% gay or lesbian, 4.9% bisexual and 3.2% were unsure; 2.6% of MA high school youth identified themselves as transgender.² Sixteen percent of MA children live in families with incomes below the federal poverty level (FPL) and 8% in families below 50% of FPL.³ Nineteen percent of children in MA aged 2-17 years have been diagnosed by their doctor as having one or more emotional, developmental or behavioral problems.³ According to the 2012-2013 National Household Survey of Drug Use and Health (NSDUH) of MA youth 18-25 years of age, 4.5% experienced a serious mental illness in the previous year, and 21.7% reported having any mental illness.⁴

Fifteen percent of the overall population is foreign born; 21.9% of those 5 years and older speak a language other than English at home (and 8.9% speak English less than very well).⁵ MA five-year high school graduation rates were 87.7% in 2013.⁶ Veterans made up 7.4% of the population over age 18 years in 2013.⁵ The MA Department of Youth Services (juvenile justice) reports as of 4/1/15, the statewide committed caseload is 648, of whom 30% are black, 23% are white, and 38% are Hispanic.⁷

Berkshire County Demographics:

Berkshire County is Massachusetts' westernmost and most rural county. A recent study finds that suicide rates for adolescents and young adults are higher in rural than urban communities in the

U.S. and that these disparities have increased over time.⁸ In 2013, there were 24,153 residents 10-24 years of age, 18.6% of the County population as a whole. Of these youth, 85% are white, non-Hispanic, 6.3% Hispanic, 5.9% black, non-Hispanic, 0.2% American Indian/Native American, and 2.6% Asian, non-Hispanic; 49.7% are female.¹ Berkshire County is also Massachusetts' poorest county with 12.8% of individuals living below the poverty level. Median income is 23% below the state average. Veterans made up 9.8% of civilian population over age 18 years in 2013.⁵ Foreign born individuals make up 4.9% of the overall population; 7.5% speak a language other than English at home (and 2.4% speak English less than very well). Educationally, 90.6% of County residents ages 25 years and older attained a high school degree or higher.⁵

Heywood Healthcare Region Demographics:

Heywood Healthcare comprises two acute care hospitals, Heywood and Athol Hospitals, and a catchment area of fifteen contiguous towns in Massachusetts' north central region of the state. Heywood Hospital is a non-profit, 153 bed acute care hospital primarily serving six of these communities, with Gardner, MA being the largest. Sixty percent of the population live in towns designated as rural. The hospital has a network of primary care physicians and specialists, a rehabilitation center, two community health centers and a school-based health center. Athol Hospital is a Critical Access, non-profit acute care hospital serving nine communities; 100% of the service area (nine communities, the largest being Athol, MA) is designated rural.⁹

US Census data from 2010 indicates 16,636 youth ages 10-24 years live in the Heywood Healthcare catchment region. Of these youth, 91.5% are white, non-Hispanic, 1.5% are black, non-Hispanic, 5.3% are Hispanic, 1.5% are Asian, non-Hispanic, and 0.1% are American Indian/Native American; females make up 47.2%. Two of the largest communities served by this health system, Gardner and Athol, have substantially higher proportions (24.8% and 23.3%, respectively) of children living below 100% of the poverty level, compared with MA as a whole (14.9%) and higher proportions of adults aged 25 years and older with no high school diploma (18%, and 15.3%, respectively).⁹

A-2: The purpose of the proposed Massachusetts Youth Suicide Prevention Project is to:

- 1) Create two model Suicide-Safe Care Centers characterized by suicide prevention leadership and appropriate pathways to competent treatment and follow up.
- 2) Support development of Suicide-Safe Communities where prevention and early identification are priorities and those at-risk have access to support and treatment.
- 3) Support a Suicide-Safe Commonwealth through integration of suicide prevention as a core priority across statewide systems.

The high risk populations of focus who will benefit from these system changes are rural youth, youth with mental illness and substance abuse; lesbian, gay, bisexual, and transgender youth (LGBT); young veterans; youth who have been victimized and youth who have considered or attempted suicide.

According to the Massachusetts Youth Health Survey (MA-YHS), a biannual anonymous written survey of a sample of middle and high school youth and supported by the Massachusetts Department of Public Health, 16.1% of middle and 23.8% of high school students in 2013 reported that in the past 12 months they felt so sad or hopeless almost every day for 2 weeks in a row that they stopped usual activities, with females having a higher prevalence than males (20.9% vs. 11.4% for middle school, respectively, and 31.3% vs. 15.9% for high school students) and black, Hispanic and multiracial students having a higher prevalence than white students (29.5%, 35.6%, and 29.2%, vs. 20.5%, respectively for high school students).² Suicidal thoughts and attempts were also prevalent: 8.4% of middle school and 11.9% of high school students reported they seriously considered suicide in the past 12 months and 4.1% and 4.5%, respectively, reported that they attempted suicide, with gender and racial disparities similar to that seen for depression symptoms (higher in females compared with males and higher in blacks, Hispanics and multiracial students compared with whites).^{2,10} Middle and high school youth who reported emotional problems or learning disabilities also have significantly higher suicide attempts (17.0% combined middle and high school youth in 2011 and 2013).¹⁰ Further, the prevalence of depression and suicidal thoughts among MA youth is also higher than among MA adults.

MA youth with substance abuse issues are at higher risk of suicidal thoughts and behaviors: the 2013 YHS indicates that of the high school students reporting lifetime nonmedical prescription drug use, 26% seriously considered suicide in the preceding 12 months compared with 9.7% who did not.¹⁰ Victimization also greatly increases a youth's risk for suicide. 2011 and 2013 MA-YHS data reveal that of the middle and high school students (combined) who reported being victims of cyberbullying, 26.3% seriously considered suicide compared with 7.3% who were not, and 32.1% of those who reported being a victim of dating violence seriously considered suicide compared with 8.6% who were not. Of the middle school students who reported they were physically hurt by a family member, 25.8% reported they seriously considered suicide, compared with 5.4% of those who were not hurt.¹⁰ Cumulative victimizations (bullied in past 12 months, felt unsafe at school or on way to school in past 30 days, threatened with a weapon on school property in past 12 months, ever physically hurt by a date, ever had sexual contact against their will) exponentially increase one's risk for attempted suicide.

According to the 2011, 2013 Youth Risk Behavior Survey (YRBS), the prevalence of suicide attempts increased from 2.9% high school youth with zero victimization to 49.5% among students reporting being affected by 4-5 types of victimization.¹¹ In 2008, two of the largest communities in Berkshire County (North Adams and Pittsfield) were ranked first and second in statewide reporting rates for child maltreatment (156.9 and 142.2 per 1000 children vs. 52.9 statewide).¹⁵ The city of Pittsfield, located in Berkshire County, is also one of six MA cities with the highest level of Department of Youth Services (DYS) involvement in the Commonwealth.¹⁶

According to the 2011, 2013 YRBS, sexual minority youth are also at higher risk of suicidal thoughts and behaviors and are much more likely to be victims of bullying than heterosexual students. Nearly one in three (30.9%) self-identified homosexual youth, 44.9% self-identified bisexual youth, and 22.6% of high school students who were "not sure" of their sexual orientation seriously considered suicide, compared with 9.1% of their heterosexual peers. Disparities in suicide attempts in this population is similarly striking: 21.2% of self-identified

homosexual, 26.3% of bisexual, and 7.0% of high school students who were “not sure” of their sexual orientation seriously considered suicide, compared with 3.2% of their heterosexual peers.¹⁰ (There is no question for transgender youth on the YRBS.)

A-3: Suicide and nonfatal self -injury data and service gaps

For the five year period 2009 through 2013, suicide rates among MA youth 10-24 years of age increased 62% from 3.9 to 6.3 per 100,000 persons (N=52 to N=85), mirroring a national trend.^{12,13} Youth suicides in MA have increased across all age subgroups (10-14, 15-19, 20-24 years), among both males and females, and among white, NH persons. In 2013 MA males aged 10-24 years had a suicide rate of 8.6 per 100,000 compared with 4.1 per 100,000 females. Five year (2009-2013) average annual rates among white-NH, black NH, Hispanics and Asian NH youth were 5.7, 6.4, 3.9, and 5.5 per 100,000 persons, respectively.¹² Acute care hospital rates for treatment associated with nonfatal self-inflicted injury (a summation of inpatient hospitalizations, emergency department visits and observation stays, all mutually exclusive databases for a single hospital event) of MA youth was 311.8 per 100,000 persons in 2012 (the latest calendar year for which nonfatal data is available).¹⁴ This exceeds the national rate of 270.3 per 100,000 persons in 2012.¹³

Berkshire Medical Center/Berkshire County

For the data years 2009-2013, the average annual suicide rate among residents 10-24 years of age living in Berkshire County was 4.8 per 100,000 youth (5 year N=6).¹² Although this is lower than the average annual national rate of 7.8 per 100,000 youth during the same time period, Berkshire County youth have the highest average annual rate of hospital events (inpatient + observation stays + emergency department visits) for nonfatal self-inflicted injury in the state, 517.5 per 100,000, higher than the state and 1.9 times the national rate.^{13,14}

Heywood Healthcare Region

For the data years 2009-2013, the average annual suicide rate among residents 10-24 years of age living in the Heywood Healthcare catchment region was 10.8 per 100,000 youth (5 year N=9), higher than the average annual national rate of 7.8 per 100,000 youth during the same time period.^{12,13} The average annual rate of hospital events (inpatient + observation stays + emergency department visits) for nonfatal self-inflicted injury among youth residing in this region was 390.7 per 100,000 for CY2011 and 2012 (2 year N=130), higher than the state and 1.4 times the national rate during this time period.¹⁴

Service gaps:

Despite the fact that over 96% of MA residents have health insurance, a May 2015 report from the Donahue Institute at the University of Massachusetts finds that residents are having particular problems accessing mental health services. The report notes that many mental health clinicians in Massachusetts are intentionally taking on more private pay clients and one in six do not accept insurance at all. The survey also found that 41% of clinicians, mostly mental health counselors, were finding difficulty in getting on an insurer’s panel, with 68% stating the main reason given that the insurer was not accepting new providers in their service area. This payment and access structure disproportionately affects individuals in poverty and those living in isolated and rural areas. Massachusetts individuals with severe mental illness are experiencing limitations in access to care and use of mental health services. A report from the Treatment Advocacy Center

(October 2013) indicates that over 37,000 MA individuals with schizophrenia and over 58,000 with bipolar disorder are untreated. The report also notes that the state ranks 31st nationwide in public psychiatric beds per 100,000 population and had a 31% reduction in the number of these beds from 2005-2010.

Access to mental health services for MA youth is even more of a challenge. According to a 2009 survey to assess the Massachusetts Child Psychiatry Access Project (MCPAP), a project that was developed to increase primary care clinicians' access to child psychiatry consultation and to support referrals to mental health specialists, only 34% of primary care providers participating in the project agreed or strongly agreed that there was adequate access to child psychiatry for their patients and 28.8% did not feel that they were able to meet the psychiatric needs of children with psychiatric problems with existing resources (The Massachusetts Child Psychiatry Access Project: Supporting Mental health Treatment in Primary Care, March 2010). The Children's Behavioral Health Initiative (CBHI), which requires that primary care providers offer standardized behavioral health screenings at well child visits, and which created a new system of mental health services and supports for children found to have significant mental health concerns, has substantially improved the status of mental health screening among Massachusetts youth. However, a recent report from the Children's Mental Health Campaign noted limited access to services across the Commonwealth, with significant variation in service access across different geographic regions.

According to focus groups conducted for a recent community health assessment, residents of the Heywood Healthcare region identified behavioral health problems (substance abuse and/or mental health problems), along with a lack of adequate behavioral health providers (only one child/adolescent psychiatrist in the whole area of service) and treatment resources (especially pediatric/adolescent mental health specialists and trauma counselors, and specialists to work with LGBTQ individuals) as one of the biggest health concerns.⁹ In Berkshire County, there are only two FTE child and adolescent psychiatrists. Youth under age 16 need to be sent out of the area if they need inpatient psychiatric care. Waiting times for an appointment with a child/adolescent psychiatrist in this county in an outpatient setting is two months. This compares with wait times of one week for individuals 18 years and older.

A-4: The Massachusetts Department of Public Health will not use grant funds for infrastructure changes.

A-5: MDPH is the public health authority for the Commonwealth of Massachusetts. MDPH provides programs to address specific diseases and conditions, offers services to address the needs of vulnerable populations and is the designated agency to address youth suicide. MDPH develops, implements, promotes, and enforces policies to assure that the conditions under which people live are most conducive to health and enable people to make healthy choices for themselves and their families. MA's Youth Suicide Prevention Project (YSPP) will create two model hospital suicide safe centers that will embrace the Zero Suicide system-wide approach to improve outcomes, close gaps in access to care, provide follow-up for youth after a suicide attempt and engage the surrounding communities in suicide prevention efforts. System change will occur as a result of efforts of the MA youth serving state agencies embedding suicide prevention into their activities and those of their provider organizations. The MA Behavioral

Health Partnership (MBPH) with a network of 1,200 providers across the state is committed to promoting and supporting Zero Suicide in their role as the exclusive contract administrator mandated to provide behavioral health services for youth and their families receiving Medicaid. YSPP will work with state-wide systems to increase identification, referral, and treatment, improve continuity of care, follow-up and accessibility for youth with suicidal ideation, suicide attempts and/or substance abuse disorders, including youth who identify as LGBT, youth who have suffered victimization from child maltreatment or bullying and youth with mental illnesses. YSPP Project will increase the competency of clinicians to assess and treat youth at-risk for suicide and will reduce the rates of youth suicides and suicide attempts in the state.

Section B: Proposed Evidence-Based Service/Practice

B-1: The YSPP has three broad goals that aim to affect meaningful systemic change at the institutional, community and state-wide levels with respect to addressing youth suicide and suicide risk.

Goal 1 aims to create system change within two local hospital systems (including affiliated providers) that will support development of leadership-driven, safety-oriented culture with an organizational commitment to reduce suicide deaths (Obj. 1.1). Achievement of this commitment will be evidenced by the development of sustainable pathways to care that incorporate universal screening and coordinated care management to ensure early identification, appropriate treatment and follow-up consistent with standards of the Zero Suicide framework. Quality follow-up care will be insured through services provided by Clinical Care Coordinators/ Navigators who will identify and coordinate resources needed to transition youth to less restrictive care as well as provide treatment support insuring adherence to treatment plans and identification of service gaps (Obj. 1.2). Lethal means assessment and restriction education will become standard practice for all emergency department admissions when risk of suicide is present (Obj. 1.3).

Goal 1: To create two model Suicide-Safe Care Centers characterized by suicide prevention leadership, appropriate pathways to competent treatment and follow-up	
<i>Obj. 1.1: Two regional hospital systems will adopt Zero Suicide as an aspirational goal by the end of GY1</i>	<p>Performance measures:</p> <ul style="list-style-type: none"> ● # of organizations collaborating/sharing resources; ● # of policy changes ● # of organizations that demonstrate improved readiness to change their systems ● # of organizations that enter into formal MOU’s/MOA’s ● # of organizations that obtain and analyze mental health related data ● # of individuals screened, referred and receiving mental health services after referral ● # of people in mental health (MH) related workforce trained in MH related practice ● # and % of advisory council members are consumer/family ● # of individuals & contacts made through outreach ● # of organizations that implement MH related practice as a result of /consistent with the goals of the grant ● # of organizations that regularly obtain/analyze and use MH data as a result of the grant
<i>Obj. 1.2: By the end of GY3, 75% of youth patients seen in ED departments and by hospital affiliated PCP’s will receive universal screening of suicide risk and substance abuse and will have access to coordinated care management and follow-up as needed when seen for treatment</i>	
<i>Obj. 1.3: 85% of ED at-risk youth admissions will be assessed for access to lethal means and will receive education on lethal means restriction by the end of GY2Q2</i>	

Goal 2 aims to create communities that are better equipped to recognize, reduce, and treat suicide risk. Work in targeted schools will be focused on advancing operational commitment to implementation of a comprehensive suicide prevention program, including screening and engaging students as suicide prevention peer leaders (Obj. 2.1). Meaningful enhancement of treatment efficacy within communities will be addressed by creating a pipeline for advanced clinical training in the CAMS (Collaborative Assessment and Management of Suicidality) framework, including ongoing supervision, for therapists who work with suicidal individuals (Obj. 2.2). The Youth Suicide Prevention Project will improve early identification and referral for particular at-risk populations, will address victimization, child maltreatment, and youth with serious mental illness (including early onset psychosis) served through the Department of Mental Health (DMH), and support youth with substance abuse histories served through the Bureau of Substance Abuse Services (BSAS), young veterans served through the MA National Guard and Department of Veterans’ Services (DVS), and transitional-age youth served through DMH, BSAS, DYS, and the Department of Children and Families (DCF) (Obj. 2.3). DMH programs targeted to be included in our proposal are:

- The Center for Early Detection and Response to Risk (CEDAR) which provides community education, outreach, early intervention and treatment to youth at-risk for psychosis.
- Prevention and Recovery in Early Psychosis (PREP), intensive outpatient treatment to young adults experiencing the recent onset of a psychotic illness and their families;
- STAY Together, a SAMHSA funded collaborative effort between DMH and Children’s Behavioral Health Initiative (CBHI) to enhance the capacity of community service agencies to more effectively engage and retain young adults with serious emotional disturbances.
- Two transitional age youth (TAY) programs serving youth who have experienced extensive out of home placements including inpatient psychiatric hospitalizations, residential programs, and involvement with the juvenile justice system.

Goal 2: Support development of Suicide Safe Communities in which prevention and early identification are priorities and those at risk have access to support and treatment	
<i>Obj. 2.1: 53 schools that are currently trained in LIFELINES will demonstrate implementation of a comprehensive approach to addressing suicide risk in their school community, including SOS screening and student awareness training by GY2Q4</i>	Performance measures: <ul style="list-style-type: none"> • # of organizations that demonstrate improved readiness to change their systems in order to implement practices consistent with the goals of the grant • # of people in mental health (MH) related workforce trained in MH related practice • # of individuals screened, referred and receiving mental health services after referral • # of organizations collaborating/sharing resources; • # of individuals trained in prevention or mental health promotion • # of policy changes completed as a
<i>Obj. 2.2: Two cohorts of 100 (total) clinical staff affiliated with hospital based care centers, community, DVS and DMH affiliated providers treating youth and veterans will develop and practice advanced clinical competence in treating suicide risk in those populations by the end of GY3</i>	
<i>Obj. 2.3: Increase early identification and referral of transitional age youth, youth with serious emotional disturbances, and youth who abuse substances, engaged in DMH and BSAS and DCF services by training staff, adult supports and youth consumers</i>	
<i>Obj. 2.4: 30 colleges across the commonwealth will improve support for students at risk, including veterans, LGBT students and students at risk of or in recovery from mental illness through campus wide initiatives implemented based on campus needs assessment beginning GY1Q4</i>	

<p><i>Obj. 2.5: Train 80 Suicide Intervention Officers annually (total 400) in postvention and suicide intervention to further MA National Guard suicide prevention efforts starting GY1-GY5</i></p>	<p>result of the grant</p> <ul style="list-style-type: none"> • # of individuals & contacts made through outreach • # of organizations that implement MH related practice as a result of /consistent with the goals of the grant • # of organizations that regularly obtain/analyze and use MH data as a result of the grant
<p><i>Obj. 2.6: Reach an average of 4,000 at-risk young people annually through innovative technology (texting) that expands access to suicide prevention helplines and resources</i></p>	
<p><i>Obj. 2.7: Provide support services to 40 suicide attempt survivors by the end of the grant</i></p>	

Through targeted technical assistance YSPP will enhance the capacity of 30 colleges across the commonwealth to improve student support and treatment for those at risk of suicide, with a special emphasis on addressing the needs of students who are veterans, LGBT or who have, or at risk for, mental illness (Obj. 2.4). In partnership with the MA National Guard, YSPP will train specially assigned service personnel serving as Suicide Intervention Officers in early intervention and postvention services to improve outcomes for young people serving in the military (Obj. 2.5). Capitalizing on the preferred communication medium of youth, YSPP will expand the use of crisis lines through the use of innovative crisis text line technology, with estimated demand to exceed 2,000 texts per month (Obj. 2.6). Building on very successful efforts in working with suicide attempt survivors supported by our Cohort VII GLS grant (note: www.avoicetothetable.org/) YSPP will continue to provide support to suicide attempt survivors based on regional needs assessments.

Goal 3 aims to promote sustainable system wide change across the Commonwealth through engagement of pillars of the Commonwealth’s youth serving infrastructure, and is our most ambitious goal for sustained impact. In preparation for this proposal MDPH has secured a commitment from the MA Behavioral Health Partnership (MBHP), which is the exclusive administrator of over 54 behavioral health services for the MA Medicaid program, to encourage and support the adoption and implementation of Zero Suicide standards among their 1,200 contracted providers (Obj. 3.1). MDPH also proposes to expand commitment to integration of suicide prevention programming into operational practice in a wide range of youth serving agencies through an interagency workgroup aimed at understanding and addressing organizational and programmatic barriers (Obj 3.2). Towards the aim of creating a suicide prevention leadership pipeline, the YSPP proposes developing youth as suicide prevention leaders at the regional and statewide level (Obj. 3.3). These efforts will support individuals across the entire commonwealth and last well beyond grant funding.

<p>Goal 3: Support a Suicide Safe Commonwealth through integration of suicide prevention as a core priority across state-wide systems</p>	
<p><i>Obj. 3.1: By grant end, 55% of behavioral health systems receiving payment from the MBHP (Medicaid) program will have entered into MOA’s to adopt Zero Suicide standards as an aspirational goal</i></p>	<p>Performance measures:</p> <ul style="list-style-type: none"> • # of organizations that demonstrate improved readiness to change their systems in order to implement practices consistent with the goals of the grant • # of organizations collaborating/sharing resources • # of organizations entered into formal MOU’s/MOA’s • # of policy changes completed as a result of the grant • # of organizations that implement MH related practice
<p><i>Obj. 3.2: Six youth serving state agencies and 75 funded organizations will commit to suicide prevention planning and programming as standard operational priority and practice by GY4Q2</i></p>	

<p><i>Obj. 3.3: Support 100 youth to become suicide prevention leaders with demonstrated participation in advancing the commonwealth's goal of reducing youth suicide</i></p>	<p>as a result of /consistent with the goals of the grant</p> <ul style="list-style-type: none"> • # of organizations that regularly obtain/analyze and use MH data as a result of the grant • # and % of advisory council members are consumer/family
---	--

B-2: The proposed services implemented through the project will be drawn from evidence-based resources and recommendations from SAMHSA. The sections below are organized by youth sub-populations. All programs listed in this section have been approved in SAMHSA’s National Registry of Effective Programs and Practices (NREPP) as an Evidence-Based Practice and the Suicide Prevention Resource Center’s (SPRC) Best Practices Registry (BPR) for suicide prevention. These programs were selected based on a comprehensive review of the literature on effective approaches to youth suicide prevention.

Youth At-Risk: To increase clinicians’ ability to effectively treat youth identified as at-risk for suicide, clinicians identified by the hospitals and the Department of Mental Health and others will be trained in one or more of the following evidence-based trainings:

- 1) *Collaborative Assessment and Management of Suicidality CAMS* - a therapeutic framework for suicide-specific assessment and treatment of a patient’s suicidal risk. All assessment work in CAMS is collaborative, and the patient is said to be a co-author of their own treatment plan, which is in line with DMH’s philosophy of promoting self-determination. Evaluation results of CAMS have shown statistically and clinically significant reductions in depression, hopelessness, suicide cognitions, and suicidal ideation, as well as improvement on factors considered “drivers” of suicidality, particularly in the inpatient setting.¹⁷
- 2) *Suicide Risk Assessment and Management Training Program QPRT* is designed to reduce mental health consumer morbidity and mortality by standardizing the detection, assessment, and management of patients at elevated risk for suicidal behaviors in all settings and across the age span. This universal program is well suited to the clinical setting where high-risk youth who have made a suicide attempt, will be seen. QPRT was developed in response to the lack of standardized suicide risk assessment that may have contributed to preventable patient deaths, and will therefore help fill this gap.¹⁸
- 3) *Best Practices in Suicide Assessment and Intervention:* Comprehensive, full day training designed to increase knowledge and improve the skills and confidence of clinicians and others who find themselves identifying high risk youth and adults, and planning for their care. Participants learn about the scope of the problem of suicide in the US and Massachusetts, review current information on suicide risk factors, and examine personal reactions to dealing with suicidal behaviors. Best practices in risk assessment are reviewed and attendees learn techniques for eliciting suicidal ideation. Liability management and planning for intervention are among the many topics covered. This training has been recently accepted into the SPRC Best Practice Registry.
- 4) *AMSR (Assessing and Management Suicide Risk):* A one-day workshop for mental health professionals that will help them better assess suicide risk, plan treatment, and manage the ongoing care of clients at-risk for suicide. AMSR has been widely used to train hundreds of clinicians throughout Massachusetts. AMSR was selected because of its universality to assess and manage suicidal patients of all ages and demographic backgrounds, and because of its

positive history in MA. Evaluations consistently show participants reporting increased confidence and competence in assessing and managing suicidal patients.²⁸

- 5) *CALM (Counseling on Access to Lethal Means)*: This workshop is designed to help providers implement counseling strategies to help clients at risk for suicide and their families reduce access to lethal means, particularly but not exclusively, firearms.

General Population: Trainings on Youth Mental Health First Aid (YMHFA) and QPR will be provided to community members, state agencies, schools and institutes of higher learning. This will ensure continuity of services and learning across all areas of those who support youth especially those struggling with mental health disorders, suicidal ideation, and those under protective services including foster care and juvenile probation. Additionally, there will be a train the trainers for YMHFA and/or QPR for select agencies to increase their internal suicide prevention capacity. This will support the agencies in sustaining their training goals after the grant ends.

- 1) *Youth Mental Health First Aid (YMHFA)* is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge or is in crisis. YMHFA is primarily designed for adults who regularly interact with young people. Topics covered include anxiety, depression, substance use, disorders in which psychosis may occur, disruptive behavior disorders (including AD/HD), and eating disorders. YMHFA also addresses the needs of transition age youth as they prepare to leave home to be on their own, making this an appropriate training for our partners within the institutes of higher learning.¹⁹
- 2) *QPR* has been shown to increase levels of knowledge about suicide, gatekeeper self-efficacy and skills, and knowledge of suicide prevention resources.²⁰ QPR has been rigorously evaluated among a diverse group of young adult populations, including college students, all genders, racial/ethnic groups, all socioeconomic levels, and all geographic locations. (<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=299>).

Lesbian, Gay, Bisexual and Transgender (LGBT) Youth: Due to the high rate of suicides, suicidal ideation, and suicide attempts among the LGBT youth population, YSPP proposes to provide the following evidenced-based training:

- 1) *Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth*²² will be implemented at college campuses by identifying the LGBT center staff and/or other culturally competent champions on campus to be trained in this curriculum. Creating a welcoming, inclusive campus is key promoting mental health and decreasing suicide risk for LGBT students. One component is training staff and students on LGBT issues, another trains staff on how to be more supportive to LGBT students.

Youth in Substance Abuse Treatment: To reduce the rate of suicide and self-inflicted injury among youth with substance abuse disorders, YSPP will provide:

- 1) *QPR certification training* for substance abuse counselors- See description under Youth at-Risk.
- 2) *SAMHSA's "Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50."* This evidenced-based intervention was chosen as the best way to provide comprehensive education and skills-based training to substance abuse staff who work with youth at high risk of suicide and self-injury.²³
- 3) *Youth Mental Health First Aid* - see General Population.

School Aged Youth: Schools in the two catchment areas and schools that have received the Lifelines training will be assisted in expanding and enhancing their suicide prevention programs. Schools will be given the option to choose one of the curricula listed below. Prior to any screening, schools will obtain active parental permission and will have protocols in place to refer students who are found to be at risk for suicide especially those suffering from child maltreatment and victimization including bullying.

- 1) *SOS Signs of Suicide Program*, developed by Screening for Mental Health, is a three lesson curriculum that encourages student help-seeking by instructing students how to ACT® (Acknowledge, Care and Tell) in the face of a mental health emergency. The program includes an optional student screening that assesses depression and suicide risk, and awareness and training information for teachers and parents. SOS was studied with diverse populations of youth and found to be effective in decreasing self-reports of suicide attempts, and increasing knowledge and more desirable attitudes about depression and suicide.²⁴ The screening tool is available in Spanish.
- 2) *Break Free From Depression (BFFD)* developed by Dr. Nadja Reilly at Swensrud Depression Prevention Initiative, in the Department of Psychiatry at Children's Hospital in Boston.²⁵ After program implementation, participating students will have increased knowledge about depression and suicide, greater confidence to identify signs of depression and suicide in themselves and their peers, and improved ability to find help for themselves and their peers. BFFD and HNTKAS both recommend using a suicide screening tool like SOS.
- 3) *How Not to Keep a Secret (HNTKAS)*²⁶ is a peer leader training program developed by Dr. Barbara Green at South Shore Hospital, Weymouth, MA. It is designed to provide education to teens about depression and suicide, increase help-seeking behaviors, and decrease stigma associated with mental illness. The day-long HNTKAS training includes a clinical presentation, the documentary *Breaking Free From Depression (see 2 above)*, and interactive activities.
- 4) *More Than Sad: Teen Depression*²⁷ is a high school curriculum developed by the American Foundation for Suicide Prevention (AFSP) featuring a 26-minute film and discussion guide that includes positive vignettes of four teens with depression who seek help in different ways. The program includes an optional student screening that assesses for depression and suicide risk, and awareness and training information for teachers and parents.

College-Aged Youth: Suicide is the second leading cause of death for collage aged youth. Boston University will distribute a needs assessment survey to all 80 Massachusetts public and private two and four year colleges and universities. Data will be analyzed by geographical region, degree of readiness and need. This data will be used to prioritize those schools that have a certain level of readiness and need to develop or expand a suicide prevention program on campus.

- 1) *JED Foundation's Campus Mental Health Action Plan (JED MHAP)* was developed to help college and university professionals develop a comprehensive plan to promote the mental health of their campus communities and support students who are struggling emotionally.
- 2) Other potential programs to be offered that have been listed previously include: *Youth Mental Health First Aid*; *Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth*; and *QPR*.

MA National Guard: Building on work from MDPH's current grant, Suicide Intervention Officers (SIO's) will be trained in Best Practices in Suicide Assessment and Intervention (described above).

Veterans: Since 2008, the MDPH Suicide Prevention Program has provided funding for the Statewide Advocacy for Veterans' Empowerment (SAVE) Program at the MA Department of Veterans' Services (DVS). The program's primary mission is the prevention suicide and mental health distress through the identification of issues veterans face when they return from service, and proactively provide them with access to benefits and services that may address these issues and result in positive transitions back to civilian life. SAVE personnel are former military women and men who understand these challenges and act as a liaison between veterans and their families and various state and federal agencies.

1) "*Battlemind*"²¹ (A presentation developed by the US Department of Defense) examines the skill set that helps soldiers survive in combat and how those skills can cause problems for them when they return home if they are unable to adapt their behaviors in civilian life. It will be provided for college staff by SAVE personnel who are experienced in giving this presentation.

B-3: Not applicable.

B-4: Berkshire Medical Center and Heywood Hospital will provide follow-up care for youth ages 10-24 after discharge from their emergency departments or inpatient hospitalization after a non-fatal attempt. This will include direct services, strength-based safety planning, lethal means education to patient and family, warm hand off and coaching to support engagement in outpatient treatment. When indicated they will provide a higher level of support and case management as well as assist in discharge planning and reintegration to support the transition back to family and school following a hospitalization and/or suicide attempt. Follow-up contact and support will be provided to assure the youth are receiving the services recommended in the discharge plan.

Section C: Proposed Implementation Approach

C-1: As referenced in Section B, MDPH will work with a wide range of community organizations and state agencies to increase successful early identification and competent treatment of youth at risk for suicide. The three broad goals aim to institutionalize Zero Suicide standards in two hospital systems, creating Suicide Safe Care Centers; create communities that are better equipped to adopt suicide prevention as a priority and support those at highest risk; and to create a safer Commonwealth by supporting statewide systems change and developing suicide prevention leadership across the state.

Goal 1: In order to achieve Goal 1, YSPP will partner with two hospital systems that have a proven track record of commitment to suicide prevention across the lifespan. Both have leadership committed to implementing a Zero Suicide organizational strategy and are very actively engaged with the suicide prevention coalitions within their catchment areas. The hospital partners will assign coordinators to oversee hiring of project staff and direct project funded activities that support our proposed objectives, as outlined in the table below. Electronic medical records maintained by the hospitals will allow tracking of program outcomes, which will be coordinated locally by the hospital coordinators. The project evaluators will provide technical

assistance in reporting of de-identified patient related data and tracking of process outcomes. Hospitals are prepared to begin project implementation within the first quarter of grant funding and have committed to prioritizing development of a data driven approach to quality improvement. While activities under Objective 1.1 focus on organizational change, activities under Objectives 1.2 and 1.3 focus on direct service, the bedrock of which is early identification in healthcare settings, and care coordination and follow-up. Institutionalized universal screening in hospitals and primary care settings aims to maximize early identification of youth at risk. Increased use of psychiatric consultation services (MCPAP) will allow PCP’s to provide higher quality care for at-risk youth. Staff hired to coordinate ongoing care utilization will improve treatment adherence and ultimate outcomes; lethal means restriction education aims to reduce preventable deaths. These efforts will be coordinated locally at each hospital.

<p>Goal 1: To create two model Suicide-Safe Care Centers characterized by suicide prevention leadership, appropriate pathways to competent treatment and follow-up</p>
<p>Objective 1.1: <i>Two local hospital systems will institute system changes necessary to adopt Zero Suicide as an aspirational goal by the end of GY1</i></p>
<ul style="list-style-type: none"> • Activity 1.1.1: Each hospital will develop a Zero Suicide Organizational Work Plan and identify gaps that need to be addressed in organizational procedures related to suicide prevention and treatment • Activity 1.1.2: Institute Zero Suicide Task Force consisting of hospital and community leaders, behavioral health and medical staff, suicide attempt and loss survivors and veteran/military family representatives, to provide organizational and community leadership in meeting the needs of those at-risk of suicide • Activity 1.1.3: Create a multidisciplinary team tasked with developing and applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at-risk
<p>Objective 1.2: <i>By the end of GY3, 75% of youth patients seen in ED departments and by hospital affiliated PCP’s will receive universal screening of suicide risk and substance abuse and access to coordinated care management as needed</i></p>
<ul style="list-style-type: none"> • Activity 1.2.1: Develop and implement procedures and protocols for introduction of universal suicide risk and substance abuse screening, follow-up and data reporting in ED’s and 10 hospital affiliated PCP practices • Activity 1.2.2: Annual training in utilization of universal screening protocols for suicide (e.g. C-SSRS) and substance abuse risk (SBIRT) in primary care and ED settings • Activity 1.2.3: Provide PCP’s with annual training in the effective use of MCPAP psychiatric consultation service • Activity 1.2.4: Institute availability of Coordinated Care Coordinators/ Navigators to assist youth identified through screening or ED admission transition to less restrictive care; Youth Community Health Workers to assist in identification and utilization of care resources and support services • Activity 1.2.5: Develop systems of data surveillance and reporting to insure that all youth seen in ED and inpatient settings receive follow-up within 72 hours of discharge
<p>Objective 1.3: <i>85% of ED at-risk youth admissions will be assessed for access to lethal means and will receive education on lethal means restriction by the end of GY2Q2</i></p>
<ul style="list-style-type: none"> • Activity 1.3.1: Provide all ED & hospital affiliated PCP staff Counseling on Access to Lethal Means (CALM) training in lethal means assessment and education

Goal 2: For implementation of the activities under Goal 2 YSPP will engage schools that have demonstrated momentum in beginning implementation of coordinated suicide prevention initiatives, providing technical assistance to further develop and embed this programming in the school culture. Hospital partners, DMH, DVS and others will identify clinicians who are committed to working with youth at risk of suicide for advanced training and supervision in use of the CAMS framework of clinical care. The Project Coordinator will work with DMH to implement training for youth, staff and parents of consumers of the youth programs referenced in Activities 2.3.1-2.3.3. Strong partnerships between MDPH, BSAS and DCF will facilitate delivery of QPR and YMHA train the trainer opportunities to program staff, supporting sustainability of gatekeeper training for two agencies that have high staff turnover. To support colleges YSPP will partner with Boston University (BU) to engage two and four year colleges across the state in assessment of readiness to institutionalize suicide prevention efforts on their campuses. BU will also provide ongoing technical assistance to 30 campuses (10 per year starting GY2-GY4) in program implementation (such as starting Active Minds Chapters) based on the outcome of their needs assessment. These efforts will supported by three regional college mental health conferences (one per year starting GY2-GY4) that will focus on understanding and addressing the needs of high risk groups on campus including young veterans involved youth, LGBT students and those at-risk of, or experiencing mental illness. Colleges will also be supported through training college mental health clinicians in suicide risk assessment and intervention.

Our working partnership with MA National Guard in developing suicide prevention leadership within the Guard provides us a valuable opportunity to impact the lives of young military service people. By training Suicide Intervention Officers, YSPP has the opportunity to minimize adverse outcomes for this population. Because texting is the preferred method of communication of young people YSPP propose expanding access to crisis support services by introducing Helpline texting services. Samaritans, Inc. has administered the MA toll-free helpline for 40 years. It is one of two crisis centers in the country working with Crisis Text Line, a division of *dosomething.org*. Grant funding will provide resources for training of additional volunteers so that the program can be offered across the state by grant-end. Expanding on work that was begun in GLS Cohort 7 to advance the presence of suicide attempt survivors in suicide prevention leadership (see <http://avoicethetable.org/>), YSPP will engage regional coalitions to conduct local needs assessment of suicide attempt survivors and plan for support services accordingly. YSPP are committed to increasing the voice of attempt survivors in regional and statewide suicide prevention planning.

<p>Goal 2: Support development of Suicide Safe Communities in which prevention and early identification are priorities and those at risk have access to support and treatment</p>
<p>Objective 2.1: <i>53 schools that are currently implementing LIFELINES will demonstrate implementation of a comprehensive approach to addressing suicide risk in their school community, including SOS screening and student awareness training by GY2Q4</i></p>
<ul style="list-style-type: none"> • Activity 2.1.1: Provide technical assistance for development of school-wide screening protocols, procedures and data management • Activity 2.1.2: Train peer leaders in How Not to Keep A Secret
<p>Objective 2.2: <i>A total of 100 clinical staff affiliated with hospital based care centers, community DMH and DVS affiliated providers treating youth and veterans will develop and practice advanced clinical competence in treating suicide risk in those populations by the end of GY3</i></p>

<ul style="list-style-type: none"> • Activity 2.2.1: Provide CAMS 4hr online training to 2 cohorts of a total of 150 clinicians from hospital care centers, community, DMH and DVS • Activity 2.2.2: Two cohorts of a total of 100 clinicians (a subset of those trained in the online training) will participate in 1.5 day in person training and clinical consultation
<p><i>Objective 2.3: Increase early identification and referral of transitional age youth, youth with serious emotional disturbances, and youth who abuse substances by training staff, adult supports and youth themselves, engaged in DMH and BSAS and DCF services</i></p>
<ul style="list-style-type: none"> • Activity 2.3.1: Train 15 staff and 10 youth annually in CEDAR, PREP and TAY programs in suicide risk assessment and intervention • Activity 2.3.2: Train 100 Peer Mentors within the STAY program and youth who are members of the DMH Youth Advisory Council in How Not to Keep a Secret and/or YMHFA • Activity 2.3.3: Train 100 CBHI Parent Navigators in Break Free from Depression, QPR and/or YMHFA • Activity 2.3.4: Train 20 BSAS and DCF program staff to be trainers of QPR and/or YMHFA
<p><i>Objective 2.4: 30 colleges across the state will improve support for students at risk, including veterans, LGBT students and students at risk of, or in recovery from, mental illness through campus wide initiatives implemented based on campus needs assessment</i></p>
<ul style="list-style-type: none"> • Activity 2.4.1: Conduct state-wide assessment of campus readiness to engage in suicide prevention programming • Activity 2.4.2: Three regional conferences on building campus culture that supports mental wellness and suicide prevention programming • Activity 2.4.3: Targeted technical assistance to 30 schools over the course of the grant in implementing student supports services for students that are veterans, LGBT, or at risk of, or in recovery from, mental illness (e.g provide Battleminds presentation, implement Active Minds chapters) • Activity 2.4.4: Annual training for college counseling staff in suicide risk assessment and intervention
<p><i>Objective 2.5: Train 400 National Guard Suicide Intervention Officers (SIO) in postvention and suicide intervention to further National Guard suicide prevention efforts</i></p>
<ul style="list-style-type: none"> • Activity 2.5.1: Annual training in Best Practices in Suicide Assessment and Intervention
<p><i>Objective 2.6: Reach an average of 4,000 at-risk young people annually through innovative technology (texting) that expands access to suicide prevention helplines and resources</i></p>
<ul style="list-style-type: none"> • Activity 2.6.1: Expand Samaritans’ hotline crisis text line service across the commonwealth • Activity 2.6.2: Implement awareness campaign regarding text line spearheaded by local coalitions • Activity 2.6.3: Suicide prevention youth subcommittees of regional coalitions (see obj. 3.3) will be supported in exploring and developing youth friendly suicide prevention and resilience resources
<p><i>Objective 2.7: Provide support services to 40 suicide attempt survivors over the course of the grant period</i></p>
<ul style="list-style-type: none"> • Activity 2.7.1: Engage/Support the Zero Suicide Advisory board and local coalition leadership to assess needs of attempt survivors • Activity 2.7.2: Provide technical assistance for the formation of at least two attempt survivor groups for youth ages 18-24

Goal 3: Goal 3 is YSPP’s most ambitious goal, aiming to create lasting systemic change. The most ambitious objective involves partnerships with DMH and MBHP to support adoption of Zero Suicide standards across their 1,200 contracted providers. This will be accomplished through the development of a Suicide Prevention Learning Collaborative through which

participants can learn and share strategies, successes and barriers to implementation of suicide prevention related policies and protocols in their organizations. YSPP will increase the inclusion of suicide prevention as a standardized operational priority in program development across youth serving state agencies. This will be accomplished by the inclusion of suicide prevention planning in relevant state agencies RFR’s. Lastly YSPP’s ongoing commitment to advancing suicide prevention as a priority for the state requires development of a leadership pipeline, which will be supported by engaging youth in developing leadership skills and experience.

Goal 3: Support a Suicide Safe Commonwealth through integration of suicide prevention as a core priority across state-wide systems
Objective 3.1: <i>By grant end, 55% of behavioral health systems receiving payment from the MBHP (Medicaid) program will have entered into MOA’s to adopt Zero Suicide standards as an aspirational goal</i>
<ul style="list-style-type: none"> • Activity 1.1: MDPH, DMH and MBHP co-chair Suicide Prevention Learning Collaborative aimed at sharing and developing strategies for adoption of the Zero Suicide goal across behavioral health systems in the commonwealth
Objective 3.2: <i>Six youth serving state agencies and 75 funded organizations will incorporate suicide prevention planning and programming as operational priority and practice by GY4Q2.</i>
<ul style="list-style-type: none"> • Activity 3.2.1: MDPH, DMH, and other state youth serving agencies will work to initiate the requirement for inclusion of suicide prevention planning in relevant RFR’s • Activity 3.2.2: MDPH, DMH, BSAS, DYS, DCF, DVS and Juvenile Probation will participate in an interagency task force aimed at exploring and sharing strategies for integrating suicide prevention into organizational practice
Objective 3.3: <i>Support 100 youth to become suicide prevention leaders with demonstrated participation in advancing the commonwealth’s goal of reducing youth suicide</i>
<ul style="list-style-type: none"> • Activity 3.3.1: Development of suicide prevention subcommittees of youth in 9 regional coalitions • Activity 3.3.2: Development of a Suicide Prevention Youth Leadership summit annually GY3-GY5

Key milestones, timeline and responsible staff for the five year grant period are below:

Key Milestones	Time Frame*	Responsible Staff**
Project staff hired/assigned (all)	GY1Q1	PD/HC
Subcontracts in place (all)	GY1Q1	PD
Review of Zero Suicide Organizational Work Plans (1.1)	GY1Q1-ongoing	HC
Formation of Zero Suicide Task Forces and 1 st meeting (1.1)	GY1Q1-ongoing	HC
Suicide Prevention Learning Collaborative promoting Zero Suicide Convenes (3.1)	GY1Q1-ongoing	PD
Interagency work group expanding suicide prevention programming convenes (3.2)	GY1Q1-ongoing	PC
National Guard SIO training (2.5)	GY1Q1-GY4Q4	PC
Initiate crisis text line service and promotional campaign (2.6)	GY1Q2-ongoing	PC
TA to schools (2.1)	GY1Q2-ongoing	PC
Lethal means training delivered to ED staff /PCP’s (1.2)	GY1Q2/GY1Q4	PD/HC
QPR & YMHA train the trainer trainings (2.3)	GY1Q2-GY3Q4	PC
Suicide prevention youth subcommittees roll-out in 2 coalitions, expand annually (3.3)	GY1Q2-GY4Q4	PD/HC

Key Milestones	Time Frame*	Responsible Staff**
Screening protocol and referral resource development (1.2)	GY1Q3	HC
Training in screening protocols (1.2)	GY1Q3-yearly	HC
Data-driven quality improvement work team and plan developed, including: Assessment of workforce skill & satisfaction; Patient satisfaction; review of adverse outcomes related to suicide (1.1)	GY1Q4	HC/EV
Data surveillance systems developed to track follow-up care (1.2)	GY1Q4	HC/EV
College assessments completed (2.4)	GY1Q4	BUC
Implementation universal screening in ED and (1.2)	GY1Q4-ongoing	PC/HC
Training for DMH program consumers and adult supports (2.3)	GY1Q4-ongoing	PC
RFR's require inclusion suicide prevention initiatives (3.2)	GY1Q4-ongoing	PD
CAMS online training -Cohort 1/ Cohort 2 (2.2)	GY2Q1/GY2Q4	PC/HC
DMH Staff trained in Best Practices in Suicide Assessment & Intervention (2.3)	GY2Q1-GY4Q4	PC
Attempt Survivor needs assessment completed (2.7)	GY2Q2	PC/EV
CAMS role play training & supervision -Cohort 1/Cohort 2 (2.2)	GY2Q2/GY3Q1	PC
College counseling staff trained (2.4)	GY2Q2-GY4Q2	PD
Annual Conference on College Mental Health (2.4)	GY2Q3-GY4Q4	BUC
Attempt survivor group for 18-24 y.o. begins (2.7)	GY2Q4-ongoing	PD
1 st of 3 regional Suicide Prevention Youth Leadership summits (3.3)	GY3Q1-GY5Q2	PD
Statewide Suicide Prevention Youth Leadership summits (3.3)	GY5Q3	PD
* GY=GrantYear; Q=Quarter ** PC=Project Coordinator; PD=Project Director; HC=Hospital coordinators; EV=Evaluators; BUC Boston University College Coordinator		

C-2: Berkshire Medical Center (BMC) and Heywood Hospital provide emergency department care, psychiatric hospitalization of youth (BMC ages 17-22, Heywood age 16+) care navigation for youth identified in the ED, psychiatric unit and referred by community agencies for assessment, treatment, continuity of care, and follow-up. They will work toward becoming Zero Suicide organizations, expand their task force/coalition to include state agencies serving youth, work with MDPH to provide training for clinical staff, area clinicians, school personnel and other suicide prevention activities in their catchment areas. **Samaritans, Inc.** will expand their texting services to Massachusetts youth adding this function to the Samaritans state-wide helpline number. **The Department of Youth Services, Department of Children and Families, Department of Elementary and Secondary Education (DESE), the Department of Mental Health, Department of Veterans Services (DVS) and the Juvenile Probation Department** will participate in a suicide prevention task force and learning collaborative to integrate or expand suicide prevention activities in their organizations. There will be training for staff in these agencies and DESE will continue to work with MDPH to support the schools that have received Lifelines training. **The Department of Mental Health** is committed to supporting Zero Suicide in their role as licensing agency, payer and provider. DMH will co-chair with MDPH and MBHP a Suicide Prevention Learning Collaborative to promote and support Zero Suicide implementation in programs and facilities across the state. DMH will assist youth (many of whom are attempt and loss survivors) in joining youth sub-committees of the state and regional Suicide Prevention Coalitions, identify a cohort of DMH clinicians to receive advanced training and supervision in the CAMS framework for treating suicide. **The Massachusetts Behavioral Health Partnership (MBHP)** is committed to promoting and supporting Zero Suicide in their role as the exclusive payer and contract administrator for more than 54 services available to Medicaid (MassHealth) enrollees and includes a state-wide network of 24 hour psychiatric emergency services teams and a network of 32 community agencies (1,200 providers) across the

state mandated to provide access to behavioral health services and care coordination for youth with serious emotional disturbances and their families (Children's Behavioral Health Initiative). MBHP also operates the Massachusetts Child Psychiatry Access Program (MCPAP), a free state-wide psychiatry consultation service for primary care practitioners. **The Massachusetts Coalition for Suicide Prevention** will continue its partnership with MDPH and will work with the regional coalitions to establish sub-committees of youth and support youth leadership development. **Boston University**, College of Health and Rehabilitation Services: Sargent College Center for Psychiatric Rehabilitation will conduct a state-wide assessment of campus readiness to engage in suicide prevention programming, sponsor three regional conferences on building campus culture that supports mental wellness and suicide prevention, and provide technical assistance to schools in implementing student supports for students who are veterans, LGBT, or at risk for, or recovering from mental illness.

C-3:

Direct Healthcare Service: Approximately **2,923 total patients** (585 annually) will be served through two model hospital systems. The hospitals will provide direct services, strength-based safety planning, lethal means education to patient and family and warm hand off and coaching to support engagement in outpatient treatment. Follow-up contact will be provided to assure the youth are receiving the services recommended in the discharge plan. The US Census data from 2010 estimates that of youth ages 10-19 years living within the two hospital catchment areas, 2613 (89.4%) are white, non-Hispanic, 162 (5.5%) Hispanic, 92 (3.1%) black, non-Hispanic, 53 (1.8%) Asian, non-Hispanic, 4 (0.1%) American Indian/Native American; 1,403 students are expected to be female.²⁹ Using data from the MA Youth Risk Behavior Surveys, 2011-2013 it is estimated that 2,815 patients will be heterosexual, 35 gay/lesbian and 94 bisexual.³⁰

Samaritans: It is projected that a total of **20,000 youth** (4,000 annually) will be served through the hotline and texting services. This number was derived from the current work (2,000 text conversations per month) that the Samaritans receive. Due to the structure and confidentiality of the Samaritans program we are unable to provide any demographic information on the clients who use the crisis services.

Schools: Massachusetts will work with approximately 53 middle and high schools. The expected reach is **29,250 students**, (5,850 annually) of which it is estimated that 26,149 (89.4%) will be white, non-Hispanic, 1,618 (5.5%) Hispanic, 916 (3.1%) black, non-Hispanic, 531 (1.8%) Asian, non-Hispanic, 35 (0.1%) American Indian/Native American; 14,040 students are expected to be female. Using data from the YRBS, 2011-2013 it is estimated that 27,378 students (93.6%) will be heterosexual, 351 gay/lesbian (1.2%) and 936 students (3.2%) bisexual.³⁰

Colleges: Massachusetts will also work with approximately 30 colleges across the state. The expected reach is **93,229 students**, (18,646) of which it is estimated that 70,740 (75.9%) will be white, non-Hispanic, 9,655 (10.4%) Hispanic, 7,157 (7.7%) black, non-Hispanic, 5,398 (5.8%) Asian, non-Hispanic and 278 (0.3%) American Indian and Alaska Native; females will make up roughly 50.5%.^{31,32} Using data from the Behavioral Risk Factor Surveillance Survey of 2012 it is estimated that among 86,983 (93.3%) students will be heterosexual, 1,585 (1.7%) gay/lesbian and 3,077 (3.3%) bisexual.³³

Training: The grant will support trainings for gatekeepers, clinicians, substance abuse counselors, teachers, parents, community leaders, youth serving state agencies staff, physicians, and youth leaders. We estimate that there will be **2,250 people** (450 annually) trained at 40 trainings. No calculation of demographics for people who will attend the various trainings is given since the participants are not expected to reflect the proportion of race, ethnicity, gender and sexual orientation of the general population.

C-4: The number of people served over the 5-year span of the MA Youth Suicide Prevention Project is projected to be 147,652. The total amount of the grant is \$3,680,000. Less 20% for data and performance assessment leaves \$2,944,000. The per person cost for the program is estimated to be **\$19.94** (\$2,944,000/147,652).

High quality services will be maintained through the application of quality improvement principles, the selection of evidence-based practices, regular feedback from provider partners and their consumers of service, the voices of youth, regular internal staff reviews of objective achievements, the local evaluation process, quarterly reports to SAMHSA and monthly meetings with our Government Project Officer.

C-5: The two hospitals serving as model suicide-care centers for this grant are planning to sustain the positions funded by the grant by the transformation of reimbursement mechanisms from fee-for-service to population/global payments for care. If the payment system has not changed to population health based reimbursement by the end of the grant, then the salary for the positions at BMC will come from directly billable fee-for-service encounters. The positions at Heywood Hospital will be sustained by exploring and identifying assets, expansion of partnerships, and sustainability will be part of the agenda for the hospital Advisory Committee during the grant period. The Interagency Suicide Prevention Task Force work to embed suicide prevention as a core priority in state agencies that serve youth ensures that identifying and addressing suicide risk will be institutionalized. Training trainers in these agencies will provide a means of sustaining grant activities after grant funding. The Suicide Prevention Learning Collaborative will be sustained through the continued efforts of MDPH, DMH and MBHP staff. The MA Suicide Prevention Coalition will continue to support the youth sub-committees and youth development initiatives that are started with this grant. Advanced clinical training using the CAMS framework will be supported after grant funding through supervisory collaboratives that will be nurtured throughout the grant period. Such collaboratives are an aim of the training objective, creating a group of skilled and dedicated clinicians who received advanced training and supervision so that they will be available to serve as mentors to clinicians in need of clinical support in treating suicidal individuals. In working with colleges in Massachusetts, Boston University will start with the JED Campus MHAP Framework which focuses on sustainability from the beginning. The colleges engaged in the grant activities will be schools that demonstrate the greatest readiness to expand their efforts to address suicide risk on campus and their activities will largely be student led which maximizes the likelihood that lasting change will occur on these campuses. Program continuity will be maintained if there is a change in the operational environment. Each segment of the YSPP has a number of people involved, most of whom have been working in their positions for a considerable length of time. Suicide Prevention is their

expertise, so if there is a change of staff or change in project leadership. other key staff have the requisite experience to keep YSPP moving forward and on track.

C-6: Berkshire Medical Center has a local crisis team (ESP) and three emergency departments. Youth identified as at risk will be triaged to an appropriate level of care using the close relationship the BMC has with community agencies. The Care Navigator working in consultation with the child/adolescent psychiatrist will help with the triage and track the process assuring that the youth have been connected with appropriate treatment. Tracking youth screened outside of the ED would be achieved through existing systems/processes of communication between BMC's Dept. of Psychiatry and the Brien Center ESP team which would be configured to ensure a tight linkage with a specific plan for tracking each youth who is evaluated off-site. BMC will provide direct services, strength-based safety planning, lethal means education to patient and family and coaching to support engagement in outpatient treatment. The coordinator will also track referrals and ensure warm hand-offs to outpatient providers for youth at risk identified in emergency and acute hospital settings and/or following a suicide attempt with or without hospitalization. Telepsychiatry will be utilized from a central hub in Pittsfield for the three emergency departments and primary care practices in other regions of this large, geographically dispersed rural county. Follow-up contact will be provided to assure that youth are receiving the services recommended in the discharge plan.

The **Heywood Healthcare** area has two emergency departments and an area emergency services team responds to crisis calls. The Emergency Departments use a Behavioral Health Care Coordination Model that includes behavioral health navigation, case management and therapeutic services in the ED. The hospital is a member of the Regional Behavioral Health Collaborative that consists of emergency department directors and staff, emergency service providers, school personnel and community health workers, as well as hospital administrators to facilitate improved information sharing (universal consent), system-wide response and protocol development. A Clinical Care Coordinator/Navigator (CCC/N) will be hired to support referrals from organizations trained to identify and refer youth at risk for suicide including: primary care practices, schools, colleges/universities, foster care programs, and juvenile justice programs. The CCC/N will be well-versed on the resources and protocols to assist in connecting youth referred for services to timely, appropriate care. The CCC/N will also triage youth referred for services to identify those who may need a higher level of support and case management as well as to assist in discharge planning and reintegration to support the transition from hospitalization back to family and school. Follow-up supportive services will be provided to youth needing case-management support in home and community settings. BMC and Heywood will promote the use of the Massachusetts Child Psychiatry Access Project (MCPAP), a free pediatric behavioral health consultation service to primary care practitioners operated by the MBHP.

C-7: The table below demonstrates the linkages between project activities, project outcomes and overall impact. The activities of this project support system changes including development of a trained workforce, in order to provide continuity of care between healthcare and behavioral health care systems. Activities also focus on strengthening communities' capacities to provide prevention services and early identification, referral and treatment of youth at risk for suicide through work with schools, colleges, and community organizations. Finally, project activities focus on strengthening statewide systems of care.

Activities	Outcomes	Impacts
<ul style="list-style-type: none"> • Identify gaps/develop policies/procedures to identify and refer youth aged 10- 24 in two healthcare systems (Emergency staff/PCPs) • Institute Zero Suicide Task Force • Training in utilization of suicide and substance abuse screening in primary care and ED settings for 10-24 yo • Lethal means training to ED staff and PCPs • Technical assistance to schools in screening and referral protocols and procedures • Train peer leaders (schools) and peer mentors (DMH) in <i>How Not to Keep a Secret</i> • Provide advanced CAMS training to clinicians affiliated with hospital care centers, community DMH and Veterans services • Train DMH staff in CEDAR, PREP & TAY programs in suicide risk assessment and intervention • Train SIOs (National Guard) in evidence based suicide assessment and intervention • Train BSAS and DCF program staff to be trainers of QPR and/or YMhFA • Statewide campaign to increase youth access to Samaritans text line • Provide support services to suicide attempt survivors • State agencies and Juvenile Probation interagency work group aimed at integrating suicide prevention into organizational practice • MDPH, DMH and MBHP support for Suicide Prevention Learning Collaborative aimed adoption of the Zero Suicide goal across behavioral health systems in the Commonwealth • Support for youth leadership development in suicide prevention • SP youth leadership education conferences 	<p>A multifaceted state-wide youth suicide prevention program resulting in:</p> <p>Increased number of persons in multiple settings that are trained to identify and refer youth at risk for suicide, including LGBT, veterans and those at risk of serious mental illness, victimized youth</p> <p>Increased number of clinicians trained to assess, manage and treat youth at risk for suicide</p> <p>Increased identification of risk, referral and utilization of behavioral health services</p> <p>Improved continuity of care, follow-up and accountability for youth seen in and discharged from partner hospitals for suicidal ideation, substance abuse disorders and/or depression</p> <p>Increased promotion and utilization of Samaritans Hotline and texting</p> <p>Increased support for attempt survivors</p> <p>Increase collaboration across Massachusetts State Agencies</p> <p>Robust youth leadership in suicide prevention</p>	<p>Increase in identification, referral and treatment of at-risk youth aged 10-24</p> <p>Reduced rates of suicide</p> <p>Reduced rates of suicide attempts</p> <p>Youth voice in strategic planning</p>

Impact will be assessed by examining project evaluation data (see section E) in relation to changes in surveillance data from the following data sources: Massachusetts Violent Death Reporting System (MAVDRS); MA Inpatient Hospital Discharge Database, MA Center for Health Information and Analysis; MA Emergency Department Discharge Database and Samaritans, Inc. Suicide Crisis texting data. These findings will be reported to SAMHSA in our annual progress reports.

C-8: Specific dimensions of the Zero Suicide model are addressed at all levels of this proposal and are detailed by objective in Section B-1. The core priorities from the Zero Suicide models will be implemented in the two hospital systems. They have made a commitment to work on the seven essential dimensions identified for health care systems. Some of these are already part of

their practices and others will be implemented or expanded as part of their partnership on this grant. MDPH will be working with other state agencies to embed suicide prevention as a core priority. An initial project will involve incorporating suicide prevention planning into relevant MDPH Requests for Response (RFR) starting at the Bureau level, expanding throughout appropriate MDPH programs and those of other state agencies. The RFR is a procurement process and an opportunity to influence contractor performance by adding additional contract requirements.

The Department of Mental Health is committed to supporting Zero Suicide in their role as licensing agency, payer and provider. The Massachusetts Behavioral Health Partnership is committed to encouraging and supporting the adoption and implementation of Zero Suicide among their contractors. MDPH, DMH and MBHP will co-chair a Suicide Prevention Learning Collaborative to promote and support Zero Suicide implementation in behavioral health programs and facilities across the state. In promoting and supporting Zero Suicide these organizations are implementing Goal 8, “Promote suicide prevention as a core component of health care services” and Goal 9 “Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors” of the 2012 National Strategy for Suicide Prevention.

SECTION D: STAFF AND ORGANIZATIONAL EXPERIENCE

D-1: *The Youth Suicide Prevention Project (YSPP)* will be administered by the **MDPH Suicide Prevention Program (SPP)**. The SPP has received funding since 2004 from the state legislature. The SPP has administered three Garrett Lee Smith SAMHSA grants which were funded in 2004, 2007 and 2012. This grant application is characterized largely as an agent for system change – incorporating suicide prevention into two selected healthcare systems, communities, state agencies and the private behavioral health care provider system, the population of focus remains the same as in previous grants. The high risk populations of focus who will benefit from these system changes are: rural youth, youth with mental illness and substance abuse; lesbian, gay, bisexual, and transgender youth (LGBT); young veterans; youth who have been victimized and youth who have considered or attempted suicide.

Massachusetts boasts a very active suicide prevention coalition which was developed by SPP. The Massachusetts Coalition for Suicide Prevention (MCSP) receives support from the MDPH and the Director of the Suicide Prevention Program serves on the Executive Committee. Nine Regional Coalitions, positioned throughout the state, provide networking, training, support and treatment for local residents. Many of the partners listed in this application are active members of their regional coalitions including: Berkshire Medical Center, Heywood Hospital, and Samaritans, Inc.

D-2: Staff Role and Responsibilities:

Principal Investigator: *Alan Holmlund, Director MDPH Suicide Prevention Program (0.10 FTE in-kind)*: Works with the Massachusetts Coalition for Suicide Prevention and the regional coalitions; coordinates other divisions of MDPH and other agencies of state government; reports project results; ensures project goals and objectives are met. **Alan Holmlund**, Principal Investigator, has been the Director of the MA Department of Public Health Suicide Prevention Program since 2004. He was the Principal Investigator for the last three SAMHSA GLS grants. Formerly, he was the Executive Director of a Samaritans agency in Framingham MA, which

operated a 24-hour suicide hotline staffed totally by volunteers. Mr. Holmlund has a Master of Social Work degree from Boston College and was President and CEO of a multi-service human service agency in southeastern Massachusetts for nine years.

Project Director: Kelley Cunningham, Assistant Director, MDPH Suicide Prevention Program (0.20 FTE in-kind): Supervises the Project Coordinator and ensures project goals and objectives are met. **Kelley Cunningham** is the Assistant Director of the MDPH Suicide Prevention Program. Ms. Cunningham started at the MDPH in December of 2014. Previously, she worked for seven years as the Director of Community Education and Outreach at Samaritans, Inc. in Boston. Her primary responsibility was to ensure suicide prevention services were delivered throughout their region in schools, educating students in grades 7-12, teachers, administrators and parents on effective suicide prevention strategies. She is a registered ASIST (Applied Suicide Intervention Skills Training) trainer and is certified through AAS's School Suicide Prevention Accreditation Program. She has a BS in Psychology from Boston College and a MS in Training & Development from Lesley University.

Project Coordinator: TBH (1.0 FTE): Implements project day-to-day activities, maintains collaborations with the regional partners, provides technical assistance to achieve project objectives, administers all aspects of the federal grant requirements and collects project results. *This position will be filled upon grant award.* Candidates will have appropriate skills and experience to fulfill the duties and responsibilities of the position.

In-Kind contributions: Core Staff: Massachusetts Suicide Prevention Director/Principal Investigator (0.10 FTE), Project Director (0.20 FTE). **Other staff:** This project will draw on in-kind contribution of staff time from a number of MDPH personnel including the Program Assistant of the Suicide Prevention Program, Accounting Officer, Director of Administration & Finance, Budget Officer and Data Analysts as needed.

D-3: Demonstrated Experience:

For the last 10 years, the Suicide Prevention Program has received funding through our state legislature to provide suicide prevention support throughout the state. The well qualified staff of the Suicide Prevention Program demonstrates the dedication to this important program as well as the level of expertise to address the needs of those at risk of suicide, attempt survivors and suicide loss survivors. The Suicide Prevention Program is currently completing their third round of SAMHSA Youth Suicide Prevention grants, implementing sustainable programs, services, and resources. MDPH is well positioned to take on this grant opportunity, which will allow the Program to enhance youth and young adult suicide prevention efforts.

D-4: The Program has, from its inception, benefited from the voice of those with lived experience, suicide attempt and loss survivors. The Program's initial funding was the result of a state senator's plea to provide services in the wake of the loss of his brother to suicide. The statewide and regional suicide prevention coalitions all have members with lived experience, attempt survivors and loss survivors. There is a designated seat on the executive committee of the statewide coalition for a suicide attempt and loss survivor. There are 15 survivors of suicide loss support groups throughout the state and five attempt survivor support groups funded by the Program. Under the current SAMHSA Youth Suicide Prevention grant, one of our coordinators

produced and directed “A Voice at the Table” a documentary of suicide attempt survivors and those with lived experiences. The two healthcare systems adopting Zero Suicide are committed to the inclusion suicide loss and attempt survivors on their suicide prevention Advisory Committee.

D-5: The Suicide Prevention Program is viewed as a leader in the suicide prevention field across the state. As a result, state agencies and the managing contractor for Medicaid behavioral health services have already agreed to work toward a Zero Suicide goal. Commitments have been received from various state agencies who work with at-risk youth population to incorporate suicide prevention within their organizations. The acute care hospital partners are dedicated to providing support and services to those patients who exhibit high risk of suicide and substance abuse related issues. They have committed themselves to working toward a zero suicide organization and supporting the communities surrounding their hospitals. Both hospitals currently provide multiple services for the communities and schools. This grant will allow them to provide a more comprehensive follow-up process and a continuity of care for those youth and young adults who have been treated on their in-patient or emergency departments for suicidal attempts, ideation, and substance abuse issues.

Section E: Data Collection and Performance Measurement

E-1: The ultimate intended outcome of this project is to reduce youth suicide attempts and completions. Toward that end the three goals are to create Suicide-Safe Centers of Care to enhance effective treatment and care management of youth at-risk of suicide, to develop Suicide-Safe Communities in which prevention and early identification are priorities and treatment and support are available, and to ensure suicide prevention is integrated into state systems to create a Suicide-Safe Commonwealth.

Goal 1: Evidence continues to suggest that individuals under care within healthcare systems may fall through the cracks due to fragmented systems. People are at the highest risk for suicide following discharge from an ED or inpatient unit for a suicide attempt or crisis. Up to 25% of suicide attempters seen in ED will re-attempt (Beautrais, 2004)³⁴ and 5-10% will eventually complete suicide (Owens, Horrocks, & House, 2002)³⁵. Adoption of Zero Suicide as aspirational goals in two hospital systems will set the stage for addressing some of these care system gaps that can cost lives. Through screening and lethal means training, PCP’s and ED staff will be better able to identify suicide risk and minimize adverse outcomes upon discharge. Care coordinators will arrange for, and support adherence to treatment post discharge, providing support for successful recovery. In short, if Goal 1 is achieved, those who are at-risk will be effectively identified, and those who are identified will get the treatment they need.

Goal 2: Outside the hospital system, communities must have increased awareness of those at risk, as well as the resources and qualified personnel to support resilience and provide competent intervention when needed. Toward this end we have planned efforts to engage schools, clinicians, those who work with vulnerable youth populations (such as LGBT, youth in rural areas and victimized youth) and youth themselves. Training those who have the most contact with youth to recognize warning signs of distress and take appropriate action has the potential to increase early intervention to address risk. MDPH already has a working relationship with 53 schools across the state at the beginning stages of implementation of the evidenced based

LIFELINES program. Grant funding will allow seamless continuation of this support to implement comprehensive suicide prevention policies, protocols, and programming leading to earlier intervention and improved outcomes for school-age youth. The expectation is that vulnerable youth involved with DMH, DCF and BSAS will experience improved outcomes if the adults that work with them and the peers that live with them are more educated and capable of recognizing early signs of risk. If this is achieved it is expected that youth will receive services at lesser stages of acuity, resulting in less disruption and better treatment outcomes. MDPH has a robust and active collaborative relationship with DMH, which has agreed to partner in working toward statewide changes across youth serving agencies to better serve those at risk. The Bureau of Substance Abuse Services (BSAS), a division of MDPH, is already engaged in an interagency collaborative examining issues related to substance abuse. Additionally, the likelihood that a youth will reach out for help on their own in a crisis situation is increased by expanding a technology platform (texting) that is highly utilized by this age group. To carry this out, YSPP has partnered with Samaritans Inc., which operates the statewide crisis hotline. Early usage data suggests that crisis textline contacts will reach an average of 4,000 youth annually across the state. The confidence we have in Samaritans ability to successfully expand access and achieve successful outcomes using this technology is based on Samaritans 40 year history as a crisis line center, having trained over 4,500 volunteers and provided support for over 2.5 million calls through their statewide hotline.

Early detection and recognition of suicide risk is only half of the equation. In order to improve outcomes for those at risk in our communities, we must assure access to competent and flexible behavioral health treatment. CAMS provides an evidence based framework that maximizes patient engagement and likelihood of adherence to treatment. By providing extensive training and support to clinicians we expect that they will attain the mastery of clinical competencies necessary to successfully treat individuals in serious, high-risk distress, improving outcomes through treatment in the least restrictive settings possible and ultimately reducing suicide mortality. In short, if Goal 2 is reached, communities (both targeted regions and across the commonwealth) will be better prepared to identify and provide life-saving intervention for at risk youth.

Goal 3: While Goals 1 and 2 take a bottom-up approach to suicide prevention, starting with the individuals in need and working to meet those needs in various ways, Goal 3 takes a more top down approach, meaning whole systems have to adapt, to make suicide prevention a statewide priority and goal. The first two objectives under Goal 3 involve state agencies that serve at risk youth. Meeting these objectives will result in youth suicide prevention becoming a core component of their work. Strong working relationships and resource sharing between these agencies and service providers suggest a high likelihood of success. All of this hard work would be for naught, however, if future generations do not maintain the same level of commitment. That is why it is important to develop a pipeline of young leaders in suicide prevention. With a network of regional suicide prevention coalitions across the state that have solid community support and involvement, we are confident that we will be able to recruit and engage a pool of talented and committed youth to develop into future leaders. If Goal 3 is reached the Commonwealth will have improved systems to support continued reductions in suicide mortality.

E-2: The evaluators for YSPP have an extended history working with the Garrett Lee Smith Grants which has afforded us the opportunity to refine data collection, management and reporting protocols. They will work with the Zero Suicide Task Forces at each hospital to design data driven quality improvement practices that align with collection of evaluation and performance measures to minimize data collection and reporting burden. They have been engaged with ICF Macro and the Suicide Prevention Data Center for the past eight years. Based on this experience they developed a data organization and reporting tool to meet the reporting requirements of the more labor intensive data tracking activities. Over the past year they developed an innovative approach to data collection and reporting for a particular cross-site measure—Early Identification and Referral (EIRF) measure—that has been considered for nationwide dissemination by the cross-site evaluators. They have been working with the federal platform for reporting of GPRA measures since its inception. Protocols for organizing and reporting many of the GPRA data elements have been developed and in place for the past seven years. They are available for implementation on the first day of grant funding if the grant is awarded. The evaluators will use their extensive data collection experience and resources to expand these data collection and reporting protocols to include newly required performance measures. Massachusetts commits to continued involvement with the national evaluation. The evaluators will work closely with local coordinators to insure that they have a clear understanding of data collection and reporting responsibilities, protocols and tools available to them. Training and screening data will be collected on a rolling basis. Other program activities will be reported monthly. All data once collected locally, will be managed centrally by our evaluators who will maintain full responsibility for data maintenance, security and reporting.

The Massachusetts Youth Suicide Prevention Project surveillance system will include population-based and project-specific data. Hospital Discharge Data, Emergency Department (ED) Data and Vital Record Death Certificate data are analyzed to monitor prevalence and trends in non-fatal youth suicide attempts and youth suicide deaths. The evaluators will also use program-specific training outcome evaluation instruments to assess knowledge gains post-training and at follow-up intervals. Key informant interview protocols to be developed will be used to inform a qualitative understanding of program outcomes de-identified project-specific data collected and maintained by the evaluators.

E-3: All of the Massachusetts population-based and program-specific data will have fields for gender, race/ethnicity, and age, which allow analysis by demographic characteristics. EHR systems used by our two hospital partners will be used to provide data on subpopulations served. MDPH has access to surveillance data from several sources. Data is routinely tracked from MA Inpatient Hospital, Observation Stay and Emergency Department Discharge Databases. These databases contain statewide administrative (ICD-9-CM coded) data submitted according to regulatory requirements, including external cause of injury codes (E codes), self-injury and related risk factors (depression, substance abuse), from all acute care hospitals in Massachusetts. These data will inform the need for modifications to program implementation when necessary. The Massachusetts Youth Health Survey (MA-YHS), administered biannually by the Massachusetts Department of Public Health, can be used to monitor statewide youth data as it includes suicide-specific questions (ideation, attempts) and questions on factors that may influence the risk of suicide (recent depression, alcohol and substance use, unwanted sexual intercourse, bullying). These data can track risk rates by youth demographics (gender,

race/ethnicity, sexual orientation, and age). All evaluation materials for the process evaluation will track participant demographics (gender, race/ethnicity, age, and sexual orientation) and analysis of these data will allow for tracking of participation in grant activities, (including training, screening, and referral) by race/ethnicity, gender and sexual orientation. Data from all of these sources will be used to inform the program and allow for quality improvement in reducing disparities in access and outcomes. The evaluation will rely upon a participatory framework to engage all project partners in a continuous feedback loop that provides them with the knowledge needed for implementation and positive student outcomes. The implementation will be modified in response to any weakness or concerns identified by project staff and community partners. The evaluation team, Project Director, and Principal Investigator will remain in regular contact so that barriers to implementation can be addressed. They will also create quarterly reports and meet to discuss for grant performance feedback.

E-4: Over the five-year grant period, MA will produce a strategic evaluation plan as well as individual evaluation plans specific to each of the project goals. The evaluation will utilize a mixed method design with both quantitative and qualitative methods to fully capture the complexity of the planned project. Both process and outcome evaluation questions will be used for overall assessment of the project's impact. Specific evaluation measures we plan to use are presented in the chart at the end of this section. Data monitoring plans will center on the following:

Process Evaluation

The following questions will guide the process evaluation:

1. Are activities being implemented as intended? If not, why? (barriers/facilitators)
2. Were activities changed to address disparities in access, use and continuity of care for mental health/behavioral health services?
3. What number of organizations in the two catchment areas are collaborating, coordinating and sharing resources?
4. What number of agencies are linked in order to share service population and service delivery?
5. What number of individuals are reached by project activities?
6. What number of community-level and/or policy changes occur as a result of project activities?

The process evaluation will include measures and strategies for assessing implementation Zero Suicide standards in the Suicide Safe Care Centers, trainings, screenings, and referral of high-risk youth. The participatory nature of the evaluation will allow project staff to identify success based on data. The evaluation will document elements of a successful program or identify possible flaws in an unsuccessful program. The outcome evaluation will use objective and subjective performance measures to determine the effectiveness of the project.

Outcome Evaluation

The following questions will guide the outcome evaluation:

1. To what extent were project goals achieved?
2. To what extent did trainings increase:
 - Clinical competence in screening or treatment

- Ability to identify suicide risk
 - Efficacy and self-confidence in responding to a youth at risk for suicide or a suicide event?
3. Did the project increase the number of at-risk youth ages 10-24 identified, screened, and referred to mental health/behavioral services?
 4. Did the project increase the number of at-risk youth ages 10-24 accepting and receiving treatment and followed at 3- and 12 months to ensure continuity of care?
 5. Did the project decrease unnecessary ED visits for mental health/behavioral health services for at-risk youth ages 10-24?
 6. Are results of analyses being used for program improvement & sustainability?

The outcome evaluation will document both proximal and long term outcomes of related activities. Proximal outcomes include post-training data, workforce development improvements, policy and procedural changes, early identification, referral, and treatment of youth. Long term outcomes include reduction in suicides and suicide attempts. Multiple data sources will be used to gather these data to inform grant progress. Examining outcome data in relation to changes in suicide and self-injury data available through the following sources will be used to demonstrate linkages between activities and improved outcomes: Massachusetts Violent Death Reporting System (MAVDRS); MA Inpatient Hospital Discharge Database, MA Center for Health Information and Analysis; MA Emergency Department Discharge Database and Samaritans, Inc. Suicide Crisis hotline data. These findings will be reported to SAMHSA in our annual progress reports.

Goal 1: To create two model Suicide-Safe Care Centers characterized by suicide prevention leadership, appropriate pathways to competent treatment and follow-up	
Process Evaluation measures: <ul style="list-style-type: none"> • Number of trainings • Patient satisfaction survey • Other... 	Intended Outcomes: <ul style="list-style-type: none"> • Development of leadership support for implementation of Zero Suicide organization-wide standards • Screening protocols institutionalized • Successful transition for youth from more to less restrictive levels of care
Outcome Evaluation Measures <ul style="list-style-type: none"> • # and type of Policies/protocols in place related to Zero Suicide standards • Annual survey/interview of Task Force members • Patient outcomes • Assess training efficacy through pre-post training surveys • Workforce skill assessment • Data extraction from EHR • MCPAP consultations/outcomes • Annual Zero Suicide organizational self -assessment 	
Goal 2: Support development of Suicide Safe Communities in which prevention and early identification are priorities and those at risk have access to support and treatment	
Process Evaluation measures: <ul style="list-style-type: none"> • Person-hours of supervision • Admission records and data related to length of stay • Documentation & assessment of programs implemented • Documentation of TA provided • # individuals and populations engaged 	Intended Outcomes: <ul style="list-style-type: none"> • Improved clinical competence • Decreased length of hospital stays for youth admitted for suicidal ideation/attempts • Development of suicide prevention campus infrastructure

<p>Outcome Evaluation Measures</p> <ul style="list-style-type: none"> • Pre-post training assessment • Assessment of clinical competency • Jed Campus MHAP assessment and follow-up • # of textline contacts • Early Identification, Referral and follow up data across populations served • Surveillance data 	<ul style="list-style-type: none"> • Improved capacity to identify and refer individuals at risk in multiple settings • Increased resilience and improved outcomes for veterans • Availability of youth-centric means for accessing crisis help • Increased support for suicide attempt survivors
<p>Goal 3: Support a Suicide Safe Commonwealth through integration of suicide prevention as a core priority across commonwealth-wide systems</p>	
<p>Evaluation measures:</p> <ul style="list-style-type: none"> • Documented policy changes/commitment to Zero Suicide • Service contracts RFR’s that include requirements to include suicide prevention awareness/services • # of organizations expanding suicide prevention efforts 	<p>Intended Outcomes:</p> <ul style="list-style-type: none"> • Adoption of Zero Suicide framework across state agencies that serve youth • Increased focus on suicide prevention as a priority across the commonwealth • Developed pipeline of youth leadership focused on suicide prevention