



Community Needs Assessment/Gap Analysis of Suicide Prevention Efforts Across Ohio

Submitted By

The Office Of Quality, Planning and Research

Prepared by: Christine L. Sielski, Helen Anne Sweeney, Jacob Pine, and Lucki Ratsavong

September, 2016

ACKNOWLEDGEMENTS

A special note of thanks to Mark Hurst, M.D. Office of Medical Director, Sanford Starr, Deputy Director of the Office of Quality, Planning, and Research, Angie Bergefurd, Deputy Director of the Office of Community Supports, Justin Trevino, M.D., Office of Medical Director, Kathleen Coate-Ortiz, Office of Medical Director, Molly Stone, Bureau of Prevention and Wellness, Valerie Connolly-Leach, Bureau of Prevention and Wellness, and Kraig Knudsen, Office of Quality, Planning, and Research, Precia Shenk Stuby, Executive Director of Hancock County Board of Alcohol Drug, and Mental Health Board, Douglas Smith, M.D., Medical Director, Summit County Board of Alcohol Drug, and Mental Health Board Services, and Delaney Smith, M.D., Medical Director of Alcohol Drug, and Mental Health Board of Franklin County.

Suicide was the 11th leading cause of death in Ohio between 2008 and 2014, with 10,051 Ohioans dying by suicide (Ohio Department of Health, 2008-2014). The Ohio Department of Mental Health and Addiction Services (OhioMHAS) and its partners, the Ohio Department of Medicaid and the Ohio Department of Health, have undertaken a public health initiative to reduce the overall suicide rate. In order to develop these strategies, OhioMHAS instructed the Office of Quality, Planning, and Research (QPR) staff to conduct a statewide, community based needs assessment to determine the availability and gaps in suicide prevention and treatment services.

A community needs assessment engages key community stakeholders in a collaborative process to identify the needs and gaps that exist regarding a specific problem (Fuchs, 2008). In this case, the problem is the rising number of suicides in Ohio. The overarching purpose of this community needs assessment is to identify the needs and gaps in suicide prevention, treatment, and postvention efforts with the goal of reducing suicide deaths. QPR staff used responses gathered from Alcohol, Drug, and Mental Health Boards (Boards), suicide prevention coalitions (Coalitions), community behavioral health organizations (BHOs), and Crisis Service Line Organizations to create a holistic picture of statewide suicide prevention efforts. The results will be used in a strategic planning process to determine whether services should be introduced and/or expanded to reduce Ohio's suicide rate. The results in this report are given in aggregate. Results are also organized according to the following four geographical Board classifications: Appalachia, Small Metropolitan, Large Metropolitan, and Rural Boards.

Theory

This community needs assessment/gap analysis utilizes two separate and yet complimentary theories to address suicide prevention efforts. The first theory is organizational readiness for change based on the concept that organizations are at various stages of readiness. The other theory provides researchers a framework to group public behavioral health systems by population, socio-economic factors, and access to resources.

According to organizational readiness for change theory, the organization's readiness to make changes is a critical precursor for adoption of enhancements and complex changes to be successful in healthcare (Weiner, 2009). This theory addresses three critical steps in how a needs assessment can assist a community in making the needed changes to enhance the service delivery mechanism. First, when applying this theory within a community needs assessment for suicide prevention and treatment efforts, organizational participants should think of needs as a gap between the current set of efforts and the preferred efforts (Pennington, 1980). In order to accomplish organizational change, organizations must then use a needs assessment to define what gaps should be addressed to bring about planned change. Next, organizational leadership must adjust the status quo needs and introduce necessary changes to bring about the desired efforts (Pennington, 1980). Building capacity within communities and organizations is a critical area for improving these efforts. Organizational change represents an area of action required to continue to build capacity and infrastructure to address suicide prevention and treatment effort challenges (Batras, Duff & Smith, 2014).

Classifying public health systems, include public behavioral health systems, based on population size, socio-economic factors, and access to resources is an evolving schema and has gained some traction. Both public

health and public behavioral health researchers have suggested that local public systems are unique to community norms and vary in the quality and type of available services. (Baxter and Mechanic, 1997; Jacobson, Dalton, Benson-Grad, & Wiseman, 2005). When studying variation in public health systems, Mays et al. (2006) proposed a different framework to compare variation among systems. They found that commonalities exist among systems with similar population sizes and classified systems into various geographical designations, such as large metropolitan and rural systems. According to their findings, large metropolitan communities, due to population size, are able to build the infrastructure to offer effective services since they benefit from a large tax base, a diversified set of providers, and economies of scale. In contrast, small metropolitan and rural systems, due to smaller population bases, are unable to build effective systems due to smaller tax bases and a lack of diversified partners offering a wide range of supported services. Also, rural areas are often confronted with transportation access. Sweeney and Knudsen (2014) extended Mays, et al. framework to study the Great Recession's effects on the public behavioral health system. According to Sweeney and Knudsen, a wide variation in service availability existed among providers located in large metropolitan areas compared to providers in small metropolitan and rural areas. Large metropolitan providers were able to access system resources, including partnerships with other organizations, to continue and expand services, while small metropolitan and rural providers either maintained or contracted services due to a lack of community level resources (Sweeney & Knudsen, 2014).

The system variation framework as introduced by Mays, et al. (2006) and applied by Sweeney and Knudsen (2014) will be used in this analysis to exam the differences in the quality and availability of available, community-based suicide prevention, treatment, and postvention services. The number of geographical classifications as found by Sweeney and Knudsen has been expanded to four groupings based on county- level suicide prevalence rates (Fontanella et al., 2015) and other socio-economic factors in federally designated Appalachian counties.

Table 1 and Table 2 provide the reader with socio-economic factors, and potential property tax revenue for behavioral health services by geographical classification of Boards. Property tax revenue displayed in Table 2 is the average amount of property tax revenue that each Board within the classification could potentially generate to fund behavioral health services from a local property levy of 0.5%. According to data shown in Table 1 and Table 2, Large Metropolitan Boards, on the one hand, have the highest poverty rates and the lowest property tax revenue per resident, while both Small Metropolitan and Rural Boards have lower poverty rates and higher property tax revenue per resident than the Large Metropolitan Boards. However, due to a large population and tax base, Large Metropolitan Boards can raise a higher amount of total property tax revenue and can achieve the economies of scale, as suggested by Mays et al. (2006) to develop infrastructures to deliver a diversified set of services, such as suicide prevention services. Appalachian Boards, as depicted in these two tables, are the most disadvantaged, due to the lowest amount of tax revenue that can be raised, highest rates of suicide, Medicaid coverage, and unemployment. As May et al. (2006) notes, public health systems, such as behavioral health systems served by Appalachian Boards, simply do not have local resources to develop prevention services and data surveillance

systems needed to prevent and treat suicide ideation. The lack of local resources is further compounded by high rates of Medicaid coverage since Medicaid does not reimburse local systems for prevention efforts.

Table 1
Socio-Economic Factors, By Board Type, Calendar Year, 2014

| Board Type | Suicide Rate Per 100,000 Residents | Poverty Rate | Unemployment Rate | % of Population Covered by Medicaid | Average Population Size |
|-----------------------|--|--------------|----------------------|---|-------------------------------|
| Statewide | 12.5 | 15.1% | 5.0% | 22.1% | 11,613,423 |
| Appalachia | 13.2 | 17.7% | 6.4% | 29.3% | 142,555 |
| Small Metropolitan | 12.0 | 11.9% | 4.5% | 19.0% | 213,046 |
| Large Metropolitan | 12.0 | 18.1% | 4.6% | 19.1% | 801,365 |
| Rural | 11.3 | 12.9% | 4.6% | 21.3% | 125,608 |

Sources: Suicide Rates: Ohio Department of Health Death Certificate File and Ohio Department of Development County Population Estimates, 2014.

Poverty Rate: Ohio Department of Development County Population Estimates, 2014

Unemployment Rate: Ohio Department of Job and Family Services, Labor Market Information, December, 2014

% of Population Covered by Medicaid: Ohio Department of Medicaid and Ohio Department of Development County Population Estimates

Average Population Size: Ohio Department of Development County Population Estimates, 2014

Table 2
Estimated Property Tax Raised, 0.5% Rate, By Board Type, CY 2014

| Board Type | Average Property Tax Revenue Per Board | Property Tax Revenue Per Person |
|--------------------|---|------------------------------------|
| Statewide | \$819,788 | \$3.54 |
| Appalachia | \$410,302 | \$3.92 |
| Small Metropolitan | \$854,207 | \$3.72 |
| Large Metropolitan | \$2,808,604 | \$3.50 |
| Rural | \$325,469 | \$4.32 |

Source: Ohio Department of Taxation Property Tax Tables, 2014

Methodology

Suicide Needs/Gap Survey Development and Administration

QPR staff developed three different surveys to gather information from Boards, Coalitions, BHOs, and Crisis Line Service Organizations. Questions were designed to solicit yes/no/don't know responses, Likert scale ratings, and comments to open ended questions. OhioMHAS policymakers reviewed and approved the survey instruments. When possible, instruments were pilot tested to discern ease of understanding, wording, and comprehension of the directions. After the surveys were finalized, QPR staff entered the instruments into Survey Monkey.

QPR staff disseminated the surveys to the appropriate organizations by email which contained the survey link and deadlines for completing the survey. The email had a statement to advise respondents that they

consented to participate by opening the survey. Both email and telephone reminders to complete the survey were used as ways to gain maximum response rates.

QPR staff administered the surveys at three different time points. Between March and April 2015, QPR disseminated the Board/Coalition survey to the executive directors of the 50 local Boards and the representatives of Coalitions, which operate in 85 of Ohio's 88 counties. QPR staff disseminated surveys to these two groups since Boards are empowered to plan, develop, fund, manage, and evaluate community-based behavioral health services. Coalitions offer support services and resources to individuals at risk of suicide and raise community awareness about suicide issues. The Ohio Suicide Prevention Foundation provided a list of Coalition contacts and their email addresses. The Board response rate was 100%, and Coalition rate was 48.8%

QPR staff disseminated a survey to BHO directors between June and July 2016. The universe of BHOs is a subset of approximately 650 organizations certified by the OhioMHAS Office of License and Certification to deliver community-based behavioral health services. BHOs selected for survey had to offer case management services, behavioral health counseling, and at least one other Medicaid-covered service, such as pharmacy management; 206 BHOs met this designation. Of the 206 organizations, 147 returned a survey for a response rate of 71.4%.

QPR staff disseminated the Crisis Line Service Organization survey between July and August 2016 to organizations offering either a crisis hotline and/or warm line service. Organizations offering crisis hot line services and participating in this survey are certified by OhioMHAS, Office of License and Certification; 46 met this designation. Ohio AIRS 2-1-1 Call Center Services provided a list of organizations operating warm lines. Of 52 organizations receiving a survey invitation, 30 returned the survey for a response rate of 57.7%.

QPR staff transferred the completed surveys into the Statistical Package for Social Sciences (SPSS). The data were cleaned; non-usable cases were deleted. Board and Coalition results were sorted by Boards, then by Coalitions to enhance analysis. QPR staff reported results in aggregate, then across geographical Board types and/or counties. It is important to report results by Board type due to the geographic influences that exist within Ohio. This analysis, in turn, gives a multifaceted perspective of current, statewide suicide prevention efforts and highlights differences in the availability and quality of suicide prevention, treatment, and postvention services.

Data Analysis

The suicide needs/gap survey instrument collected both quantitative and qualitative data. For the quantitative data, the team used descriptive statistics, such as means, medians, proportions, and frequency counts to analyze results. For the qualitative data, the team assigned themes to comments and grouped themes to determine the number of respondents who were associated with the themes.

Results were tabulated in the aggregate and when appropriate were also calculated by Board type. For the purposes of this analysis, Boards were classified into the following four groups: Appalachia, Small Metropolitan, Large Metropolitan, and Rural. Boards classified as Appalachia had at least one county in the Board service area that is a federally-designated Appalachian county. Large Metropolitan Board areas are located in a Standard Metropolitan Statistical Area (SMSA), and each Board has at least 300,000 residents in the service area.

Small Metropolitan Boards are also located in a SMSA, and the largest county within the Board area has less than 300,000 residents, while no county within the Board area is designated as an Appalachian county. Rural Boards, by contrast, have no counties that are located within a SMSA or that are federally designated as Appalachian. There are 16 Appalachian Boards; 6 Large Metropolitan Boards, 17 Small Metropolitan Boards, and 11 Rural Boards. (A listing of Boards by Group can be found in Appendix A).

The results are separated into the following sections: community-based suicide prevention efforts, crisis lines, treatment services, postvention services, staff training, and resource barriers. The organization of these sections follows a pattern similar to a client’s progression through the various types of services.

| PREVENTION AND POSTVENTION SERVICES | | | | | |
|--|------------------|--------------------|------------|---|---|
| <i>Respondent</i> | | | | <i>Problem</i> | <i>Gap</i> |
| <i>Board</i> | <i>Coalition</i> | <i>Crisis Line</i> | <i>BHO</i> | <i>Problem</i> | <i>Gap</i> |
| Suicide Prevention Coalitions | | | | | |
| X | X | | | <i>Formalized management practices and membership building for Coalitions</i> | All existing Coalitions need management practices and membership training and technical assistance in formalizing processes. |
| X | X | | | <i>Technical assistance to establish new Coalitions.</i> | Coalitions are not present in the following types of Board areas: Appalachian: 5 Small Metropolitan: 1 Large Metropolitan: 1 Rural: 1 |
| Suicide Prevention Education and Training | | | | | |
| X | | | | <i>College Student Prevention programs</i> | 23 Boards do not have College Student Prevention programs; 37 Boards do not target special populations. |
| X | | | | <i>Stigma Reduction Education</i> | 23 Boards do not have Stigma Reduction Education; 40 Boards do not target Stigma Reduction Education to special populations. |
| X | | | | <i>Youth Led Programs</i> | 29 Boards do not have Youth Led Programs. |
| X | | | | <i>Gatekeeper Training</i> | 30 Boards do not have Gatekeeper Trainings. |
| X | | | | <i>QPR Training</i> | 36 Boards do not have QPR training. |
| X | | | | <i>Signs of Suicide Training</i> | 19 Boards do not have Signs of Suicide training. |
| X | | | | <i>Kognito Training</i> | 35 Boards do not have Kognito Training. |
| X | | | | <i>CALM Training</i> | 42 Boards do not have CALM Training. |
| Suicide Prevention Promotional Materials | | | | | |
| X | | | | <i>Face Book</i> | 23 Boards do not use Face Book. |
| X | | | | <i>Billboards</i> | 35 Boards do not use billboards to promote suicide prevention in their communities. |
| X | | | | <i>Public Service Announcements (PSAs)</i> | 36 Boards do not use PSAs to promote suicide prevention in their communities. |

| PREVENTION AND POSTVENTION SERVICES | | | | | |
|-------------------------------------|-----------|-------------|-----|---|---|
| Respondent | | | | Problem | Gap |
| Board | Coalition | Crisis Line | BHO | Problem | Gap |
| Postvention Services | | | | | |
| X | X | | | <i>LOSS Teams</i> | The number of Boards by type that do not have LOSS Teams in their communities: Appalachia: 9 Boards Small Metropolitan: 12 Boards Large Metropolitan: 4 Boards Rural: 8 Boards |
| X | X | | | <i>Peer Support</i> | The number of Boards by type that do not have peer support for postvention services: Appalachia: 11 Boards Small Metropolitan: 8 Boards Large Metropolitan: 2 Boards Rural: 8 Boards. |
| X | X | | | <i>Referral and Navigation</i> | The number of Boards by type that do not offer postvention referral and navigation services to families and friends: Appalachia: 9 Boards Small Metropolitan: 6 Boards Large Metropolitan: 2 Boards Rural: 8 Boards |
| X | X | | | <i>Media Guidelines</i> | 42 Boards do not have media guidelines for reporting suicide deaths. |
| | | X | X | <i>Postvention Services for client's family/friends</i> | 32.0% of the BHOs and 53.3% of Crisis Services Organizations responding to the survey do not offer postvention follow-up services to the client's family and friends. |
| | | | X | <i>Postvention Services for BHO staff when client dies by suicide</i> | Less than 50.0% of the BHOs participating in the survey provide postvention services to staff when a client dies by suicide. |

Prevention and Postvention Results

Results include Board and Coalition responses to questions about prevention and postvention efforts and services offered in their communities. Results, when applicable, are reported by Board type. Results also include responses from BHOS and Crisis Line Service Organizations about postvention services offered to family members as well as staff members who have had a client die by suicide.

Community-Based Suicide Prevention Efforts

Community perceptions

Table 1

Degree of Concern Regarding Suicide in the Community

| Board Type | Degree of Concern | |
|--------------------|-------------------|--------|
| | Mean | Median |
| All Boards | 4.2 | 4.0 |
| Appalachian | 4.1 | 4.0 |
| Small Metropolitan | 4.3 | 4.0 |
| Large Metropolitan | 4.6 | 5.0 |
| Rural | 4.2 | 4.0 |

Ratings: "1"="Not a Concern;" "2"="Slight Concern;" "3"="Neutral;" "4"="Moderate Concern;" and "5"="Extreme Concern."

Board participants rated the degree to which suicide is a concern in their communities on a Likert scale of "1" to "5", where "1" equals "No Concern" and "5" equals "Extreme Concern." According to Table 1, the average rating was a "Moderate Concern" (mean, 4.2; median, 4.0). Only Large Metropolitan Boards had average ratings of "Extreme Concern" (mean=4.6, median=5.0).

Table 2

Degree to Which Boards Agree Suicide Prevention Efforts Are Present in the Community

| Board Type | Degree of Agreement | |
|--------------------|---------------------|--------|
| | Mean | Median |
| All Boards | 4.3 | 4.0 |
| Appalachian | 4.0 | 4.0 |
| Small Metropolitan | 4.3 | 4.0 |
| Large Metropolitan | 4.8 | 5.0 |
| Rural | 4.4 | 4.0 |

Ratings: "1"="Strongly Disagree;" "2"="Disagree;" "3"="Neither Disagree nor Agree;" "4"="Agree," and "5"="Strongly Agree."

Board respondents also rated their agreement as to whether suicide preventions efforts are present in their communities on a Likert scale of "1" to "5," where "1" is "Strongly Disagree" and "5" is "Strongly Agree." (Refer to Table 2). The average rating was "agree" (mean, 4.3; median, 4.0). By Board type, Large Metropolitan Board respondents tended to "strongly agree" with the statement (mean, 4.8; median, 5.0), compared to other Board type respondents who had average ratings of "agree."

**Prevention
Efforts and trainings.**

Table 3

Types of Community-Based Suicide Prevention Efforts Offered in Board Areas

| Type of Prevention Effort | % of Boards | | | Large Metropolitan | Rural | Targeted Population* |
|----------------------------------|---------------------|-------------|-----------------------|-----------------------|-------|-------------------------|
| | Offering Service | Appalachian | Small Metropolitan | | | |
| Suicide Coalitions | 84.0% | 75.0% | 94.1% | 66.6% | 90.9% | 44.0% |
| Awareness Campaigns | 70.0% | 56.3% | 17.6% | 66.6% | 81.8% | 36.6% |
| Middle/High School Prevention | 68.0% | 43.8% | 88.2% | 66.6% | 72.7% | 22.0% |
| College Student Prevention | 46.0% | 37.5% | 70.6% | 33.3% | 27.7% | 25.3% |
| Stigma Reduction Education | 46.0% | 50.0% | 52.9% | 16.6% | 45.6% | 19.3% |
| Youth Led Programs | 42.0% | 25.0% | 64.7% | 16.6% | 45.6% | 21.3% |

*Targeted populations include disabled, criminal justice involved, gender specific, immigrants/refugees, LGBTQ, and military/veterans.

When asked about the suicide prevention efforts offered in their communities, the majority of Board respondents indicated that they have suicide coalitions (84.0%), awareness campaigns (70.0%), and middle/high school prevention programs (68.0%). (Refer to Table 3). Efforts vary by Board types. For instance, only 17.6% of Small Metropolitan Boards have awareness campaigns, while 81.8% of the Rural Boards have campaigns.

Table 3 also shows the results by targeted populations. These populations include the disabled, criminal justice involved, gender specific, immigrants/refugees, LGBTQ, and military/veterans. Overall, communities do not aim their efforts to targeted populations. For instance, only 19.3% of the Boards' stigma reduction education efforts are for targeted populations.

Table 4
Gatekeeper Trainings Offered in Board Areas

| Type of Gatekeeper Training | Percent of Board Responses | Appalachian | Small Metropolitan | Large Metropolitan | Rural |
|--|----------------------------|-------------|--------------------|--------------------|-------|
| Mental Health First Aid | 76.0% | 75.0% | 76.5% | 66.6% | 81.8% |
| General Gatekeeper Training | 40.0% | 56.3% | 41.2% | 16.7% | 18.2% |
| Signs of Suicide | 38.0% | 18.7% | 64.7% | 0.0% | 45.5% |
| Question, Persuade, Refer (QPR) | 28.0% | 18.7% | 35.3% | 33.3% | 27.3% |
| Kognito At-Risk, High School Educators | 26.0% | 37.5% | 23.5% | 0.0% | 27.3% |
| CALM | 14.0% | 12.5% | 23.5% | 0.0% | 9.1% |

Table 4 displays results of Board participants’ responses about gatekeeper trainings offered in their areas. Mental Health First Aid is offered in 70.0% of the Board areas, while only 14.0% indicated that CALM training is provided in their areas. By Board type, Large Metropolitan Boards are least likely to have any of the gatekeeper training options listed in Table 4, with no Large Metropolitan Board having either Signs of Suicide, Kognito At-Risk, High School Educators, or CALM.

Prevention gaps.

In the open comments field, Board respondents offered suggestions on how to improve suicide prevention efforts. According to their comments, 19.6% of Boards want to expand Mental Health First Aid, while 17.0% want to expand awareness campaigns. Board respondents said that active Coalitions require additional technical assistance in how to expand their efforts, such as offering stigma trainings. Several Board respondents noted the need for technical assistance to set up Coalitions. However, establishing Coalitions was not a priority due to other more urgent issues requiring Board attention. According to Board participants, programs for targeted populations, such as Mental Health First Aid programs for males, should be expanded. QPR trainings should be increased, and Mental Health First Aid trainings should be offered in a single session rather than split across several sessions. Several Board respondents stated that suicide prevention funding should be increased.

Prevention information available in community.

Table 5

Methods Used to Disseminate Suicide Prevention Information in the Community, By Board Type

| Dissemination Method | All Boards | Appalachian | Small | Large | Rural |
|------------------------------|------------|-------------|--------------|--------------|-------|
| | | | Metropolitan | Metropolitan | |
| Billboards | 30.0% | 25.0% | 35.2% | 33.3% | 27.3% |
| Facebook | 56.0% | 56.3% | 58.8% | 50.0% | 54.5% |
| Newspaper, Radio, TV | 72.0% | 56.3% | 88.2% | 83.3% | 54.5% |
| Public Service Announcements | 28.0% | 25.0% | 29.4% | 33.3% | 27.3% |
| Pamphlets/Brochures | 80.0% | 56.3% | 82.4% | 66.6% | 72.7% |

As results shown in Table 5 indicate, Boards disseminate suicide prevention information in their communities in a variety of ways. The most frequently used methods are pamphlets/brochures (80.0%) and newspaper/radio/TV (72.0%). Only 28.0% of Board participants indicated that their Boards disseminate information through public service announcements. Dissemination methods vary by Board Types. For instance, both Small Metropolitan Boards (88.2%) and Large Metropolitan Boards (83.3%) are more likely to disseminate information by newspaper/radio/TV than the other two groups. Small Metropolitan Boards (82.4%) and Rural Boards (72.7%) are more apt to use pamphlets/brochures than the other two groups.

Postvention Services

Postvention refers to intervening services offered to assist bereaved individuals, or suicide “survivors,” in coping with a suicide attempt or death in a way that minimizes psychological distress. Survivors of suicide are at greater risk for mental health issues, such as depression, anxiety, and substance abuse. They may also experience specific social and financial difficulties as a result of suicide. (Andriessen & Krysinka, 2012). Postvention services anticipate these concerns and attempt to guide the adjustment process to diminish these difficulties.

Postvention programs and strategies include social supports (e.g., peer support services and suicide support groups) and offer survivors opportunities to share their experiences with other survivors and behavioral health professionals. Media guidelines are also a postvention tactic, which acknowledges the media’s ability to encourage or discourage future suicidal behavior. Local Outreach to Suicide Survivor (LOSS) teams provide an important postvention resource for victims of suicide. Survivors have been shown to benefit from interactions with LOSS Teams and experience satisfaction by participating in LOSS Teams as members (Campbell, Cataldie, McIntosh, & Millet, 2004; Cerel & Campbell, 2008). LOSS Teams ultimately empower survivors by showing them how personal struggles can be used to help others and can prevent survivors from dying by suicide.

Table 6

Types of Postvention Services Offered by Board Areas

| Postvention Service | All Boards | Appalachia | Small | Large | Rural |
|---------------------------|------------|------------|--------------|--------------|-------|
| | | | Metropolitan | Metropolitan | |
| Suicide Prevention Groups | 68.0% | 60.0% | 82.4% | 66.7% | 63.6% |
| Referral/Navigation | 60.0% | 50.0% | 76.7% | 36.4% | 45.5% |
| Peer Support Services | 42.0% | 46.7% | 47.1% | 66.7% | 18.2% |
| LOSS Teams | 28.0% | 33.4% | 29.4% | 33.4% | 9.1% |
| Media Guidelines | 16.0% | 13.3% | 35.3% | 16.4% | 0.0% |

When asked about postvention services offered in their communities, 68.0% of Board respondents reported that their Boards have suicide support groups, and 60.0% have referral/navigation services. (Refer to Table 6). Only 28.0% of the Board participants indicated that their Boards have LOSS Teams, and 16.0% have media guidelines. By Board type, Small Metropolitan Boards are most likely to have suicide prevention groups (82.4%) and referral/navigation services (76.7%) when compared to the other Board types. Rural Boards (9.1%) are the least likely to have LOSS Teams in comparison to other groups. Only one Large Metropolitan had media guidelines, and none of the Rural Boards have media guidelines.

Table 7

Types of Postvention Services Offered in Coalition Areas

| Postvention Service | Total | Appalachian | Small | Large | Rural |
|-------------------------|------------|-------------|--------------|--------------|-------|
| | Coalitions | | Metropolitan | Metropolitan | |
| Suicide Support Groups | 76.9% | 63.6% | 86.7% | 75.0% | 77.7% |
| Referral/Navigation | 52.0% | 18.8% | 70.6% | 0.0% | 66.7% |
| Peer Supported Services | 41.0% | 45.5% | 53.3% | 50.0% | 11.1% |
| LOSS Teams | 33.3% | 36.4% | 33.3% | 50.0% | 25.0% |
| Media Guidelines | 24.1% | 18.2% | 26.7% | 25.0% | 0.0% |

As Table 7 indicates, Coalition participants' answers were similar to Board participants' responses in regards to the type of postvention services offered in the communities. Like Board participants, the majority of Coalition respondents (76.9%) indicated that their communities have suicide support groups. Only 33.3% of the Coalition respondents reported that their communities have LOSS Teams, and 24.1% of their communities have media guidelines.

LOSS Teams.

According to Board and Coalition participants' responses, with the exception of media guidelines, LOSS Teams are the least available postvention service in Board areas. In the Comments section about postvention services, both Board and Coalition participants indicated that their communities need LOSS Teams. Also, Board respondents stated that law enforcement should use LOSS Teams and that teams should be deployed at the scene of suicide deaths. Some Board participants mentioned LOSS Teams are only deployed upon request.

Peer support postvention services.

Table 8

Ways that BHOS Connect Clients to Peer Support Services as a Postvention Strategy

| Connecting Method | % of BHOs Using Method |
|-----------------------|------------------------|
| Support Groups | 46.2% |
| Family Outreach | 34.6% |
| Connect | 30.7% |
| LOSS Teams | 26.9% |
| Peer Support Services | 23.0% |
| Other | 21.2% |

When asked if their organization offers postvention peer support to clients at-risk of suicide, 52 or 35.4% of the BHO participants indicated that their organization does. As Table 8 shows, BHO organizations, according to participants, connect individuals in a variety of ways. BHOs were most likely to use support groups (46.2%) as the connecting method and least likely to use peer support services (23.0%).

Other postvention service gaps.

In addition to comments about LOSS Teams, both Board and Coalition respondents voiced concerns about the gaps in other postvention services. Board respondents mentioned that crisis stabilization services, which provide families with coping mechanisms for psychological distress, are needed. Board participants noted that clinicians should be assessed for emotional turmoil after a client dies by suicide and given appropriate supports to recover from the distress. Also, Board respondents stated that both suicide survivor groups and outreach by social workers should be expanded.

Coalition participants had additional suggestions on what postvention services needed to be expanded. Suggestions included having Coalition members receive additional training on how and undertake in administrative activities to expand community-based coalition efforts, peer support services, and awareness campaigns. One coalition member commented that there is a need for “community education to let people know that mental illness is a disease and people should not be made fun of.” Additional needs encompassed sufficient, stable funding for activities, use of media guidelines, community gatekeeper trainings, and the development of LOSS Teams.

Postvention services for staff.

Table 9

Postvention Methods for Crisis Service Organization Staff

| Postvention Method | % of Crisis Service Organizations Using Method |
|---|--|
| Supervision Support | 46.7% |
| Compassion Fatigue Self-Test | 3.3% |
| Compassion Satisfaction/Fatigue Self-Test for Helpers | 3.3% |
| Professional Quality of Life (ProQoL) Self-Test | 3.3% |
| Other | 13.3% |

Note: “Other” includes referral for assessment, crisis response team, or debriefing.

Table 10
Postvention Methods for BHO Staff

| Postvention Method | % of BHOs Using Method |
|---|------------------------|
| Supervision Support | 33.3% |
| Compassion Fatigue Self-Test | 10.9% |
| Professional Quality of Life (ProQoL) Self-Test | 5.4% |
| Life Stress Self-Test | 3.4% |
| Other | 2.0% |

Note: “Other” includes Critical Incident Stress Management, Critical Incident Stress Debriefing, Employee Assistance Program and Trauma Event Crisis Intervention Plans.

Both BHO and Crisis Line Service Organization respondents were asked about postvention protocols for staff members in the event that a client dies by suicide. According to results, some Crisis Line Service Organizations (46.7%) and the majority of BHOs (68.0%) provide postvention protocols for staff in the event of a client suicide. According to respondents’ answers, less than 50.0% of either Crisis Line Service Organizations or BHOs offered any of the postvention methods to support staff after the death of a suicide. (Refer to Tables 9 and 10). Supervision support is most commonly used postvention method for each of the two organizational types, with 46.7% of the Crisis Line Service Organizations and 33.3% of the BHOs using this method.

Discussion

This section summarizes prevention and postvention results for the Suicide Prevention Needs Assessment and Gap Analysis. Findings have policy and practice implications. These implications create a framework for improving and informing the way that the state and local communities deliver prevention and postvention in Ohio.

Perceptions

Board respondents were asked the degree to which suicide was a concern in their communities and the degree of which suicide prevention efforts were present in their communities. On average, Board respondents indicated that suicide was “a moderate concern.” Ratings varied by Board type. For instance, Large Metropolitan Boards’ average scores were “extreme concern,” with individual Large Metropolitan scores ranging from “a moderate concern” to “an extreme concern.” On the other hand, Appalachian Boards had an average score of “moderate concern,” and individual Appalachian Board scores ranged from “a slight concern” to a “moderate concern.” Board ratings for whether suicide prevention efforts are present in the community exhibit similar patterns. Overall, Boards, on average, “agreed” that suicide prevention efforts are present in their communities. Large Metropolitan Board average ratings were higher than the overall average, while Appalachian Board average ratings were lower than the overall rating.

The variation in perceptions by Board type may be related to the availability of system-wide resources. As Mays et al. (2006) noted, Large Metropolitan Boards have a bevy of resources with the ability to allocate resources to prevention services. On the other hand, systems in smaller communities do not have a broad selection of providers, thus limiting the availability of different types of services. Poor rural systems, such as those found in

Appalachia, are further hampered in developing prevention services since these systems lack funding for basic treatment services. Thus, Appalachian Board respondents' perceptions are probably related to a lack of resources in offering prevention and treatment services, rather than an indifference to individuals at risk of suicide.

Prevention Efforts

The results concerning gaps in suicide prevention services are in some ways contradictory to the overall disparities present among the four Board types. Results indicate that availability and capacity, or lack of, tends to be consistent across all Board types. Given that the lack of services appears to be statewide, OhioMHAS and Suicide Prevention Foundation (SPF) may not have the necessary resources to develop and expand suicide prevention services if the two organizations approach this problem in a traditional manner. Thus, OhioMHAS and SPF are faced with a conundrum of how to offer technical assistance and training efficiently and simultaneously to a variety of projects. Results concerning technical assistance for Coalitions, the lack of Youth-Led programs/targeted populations, and the deficiency in available Gatekeeper training in communities illustrate the need for OhioMHAS and SPF to rely on alternative strategies.

While 84.0% of Boards have Coalitions, both Boards and Coalitions reported the need for technical assistance to establish new Coalitions and to sustain existing ones. About 52.0% of the Boards do not offer Youth-Led programs, and 78.0% of Boards do not target programs to special populations, such as the disabled, LGBTQ, immigrants and refugees, and the military/Veterans. About 60.0% of the Boards do not have General Gatekeeper trainings. Only 26.0% of the Boards have "Kognito At-Risk for High School Educators, and 14.0% of the Boards have Counseling on Access to Lethal Means (CALM). While 76.0% of Boards offer Mental First Aid, Boards expressed the need to expand local community training options and to offer different types of Mental Health First Aid, such as Mental Health First Aid for Youth.

In order to provide technical assistance and trainings simultaneously and efficiently, OhioMHAS and SPF may want to consider offering virtual trainings about methods to create new Coalitions and sustain existing ones. Another strategy is to identify various online gatekeeper trainings. OhioMHAS and SPF will want to explore marketing strategies to increase community usage of Kognito trainings available on SPF's website. When developing these strategies, both OhioMHAS and SPF should solicit the input of Board and Coalition representatives to ensure that technical assistance and training options meet community norms. Also, evaluation strategies through a three-year cycle is critical in making necessary adjustments in a real-time manner, thus ensuring that community participants can benefit from the new and expanded services.

Results indicate that Boards and Coalitions use similar tactics to disseminate suicide prevention information within their communities. For instance, about 80.0% use pamphlets/brochures, and 56.0% have Facebook pages dedicated to suicide prevention. OhioMHAS and SPF may want to consider statewide strategies to increase the audience of people who receive information about suicide prevention information by forming partnerships with other state agencies and businesses. For instance, OhioMHAS and SPF could work with the Bureau of Motor Vehicles to distribute inserts in license renewal mailings and the Department of Natural

Resources to hang posters in state parks. Also, OhioMHAS and SPF could work with Board/Coalition representatives to develop a virtual training about creating and maintaining Facebook pages.

Postvention

Like Prevention efforts, the lack of postvention services is consistent across Board types. For instance, only 28.0% of Boards report having LOSS Teams, and 42.0% have postvention peer support services. As suggested for prevention section, OhioMHAS and SPF may need to rely on alternative ways of virtual trainings and online trainings to provide technical assistance to communities to create new and expand existing postvention services. OhioMHAS and SPF should also explore options to include local peer support/consumer operated service organizations in developing postvention service strategies. Many postvention strategies rely on peer support, such as referral and navigation services, survivor groups, and LOSS Teams. Both peer support and consumer operated services organization are natural conduits for recruiting volunteers and raising awareness about these services.

Crisis Line Service Organization and BHO staff often experience trauma after a client dies by suicide. According to results, 46.7% of Crisis Line Service Organizations and 68.0% of BHOs provide postvention services to staff in the event that a client dies by suicide. Respondents reported that if their organizations offer postvention services to staff, the service is usually supervision. Only 3.3% of the organizations administer the Compassion Fatigue Self-Test, Compassion Satisfaction/Fatigue Self-Test for Helpers, and the Professional Quality of Life Self-Test. Again, OhioMHAS and SPF may want to consider offering online courses for supervisors who provide postvention services to staff and online courses for staff who have a client die by suicide.

CRISIS SERVICES

| Suicide Prevention Needs/Gap Analysis | | | | | |
|--|-----------|-------------|-----|--|--|
| Crisis Services | | | | | |
| Respondent | | | | Problem | Gap |
| Board | Coalition | Crisis Line | BHO | | |
| Crisis Services Availability | | | | | |
| X | | | | Peer Support Services | 21 Boards do not have peer support services for people who access crisis services. |
| X | | | | Warm Lines | Warm Lines are not available in the following Board service areas: Appalachian: 13 Boards Small Metro: 8 Boards Large Metro: 4 Boards Rural: 6 Boards. |
| Crisis Line Certification and Credentials | | | | | |
| | | X | | Accreditation | 31.0% of the Crisis Service Organization respondents stated that their organization does not have accreditation. |
| | | X | | Standardization | There is a lack of consistency or standardization of Crisis Line Services credentials across organizations. |
| Crisis Services | | | | | |
| | | X | | Assessment Tools | Crisis Line Services assessment tools vary by organizations. According to Crisis Service Organization respondents, organizations use: <ul style="list-style-type: none"> • Suicide Assessment Checklist (33.3%) • Suicide Risk Assessment Profile (16.7%) • Scale for Suicide Ideation (6.7%). |
| | | X | | Follow-Up Services | Crisis Service Organizations lack follow-up services. According to Crisis Services Organization respondents, 42.4% of the organizations do not: <ul style="list-style-type: none"> • Measure telephone call outcome • Conduct follow up telephone interviews • Analyze surveillance data. |
| Crisis Services Trainings | | | | | |
| | | X | | Crisis Line Worker Orientation training offered in the community | According to Crisis Service Organization respondents, between 40.0% and 50.0% of the organizations do not offer orientation training about call documentation, call protocol, data entry, mental health/substance abuse, child abuse, sexual abuse, community resources information, and lethality assessments. Also, 60.0% of the organizations do not have basic counseling skills training. |
| | | X | | Crisis Line Worker On-going Training offered in the community | According to Crisis Service Organization respondents, organizations do not offer: <ul style="list-style-type: none"> • Documentation update training (50.0%) • Crisis Line skills training (43.7%) • Assessment training (56.7%) • Role playing (70.0%). |
| | | X | | Ways to Help Training | According to Crisis Service Organization respondents, about 40.0% of the organizations do not have Ways to Help Training. |

**Suicide Prevention Needs/Gap Analysis
Crisis Services**

| Respondent | | | | Problem | Gap |
|------------|-----------|-------------|-----|---------------------|--|
| Board | Coalition | Crisis Line | BHO | | |
| | | X | | Supervisor Training | <p>According to Crisis Service Organization respondents, organizations do not:</p> <ul style="list-style-type: none"> • Monitor documentation skills of probationary staff (50.0%) • Provide verbal feedback or do not give written feedback (53.3%) • Monitor telephone calls (56.7%) • Monitor productivity (73.3%) • Monitor counseling skills (76.7%) |

Crisis Line Services Results

Crisis Line Services encapsulate a variety of telephone-based and text interventions that allow mentally or emotionally distressed individuals access to trained behavioral health staff and/or peer supporters. Research shows that attempters contact crisis lines within 10 minutes or less of deciding to die. (Williams, Davidson, & Montgomery, 1980; Simon et al., 2001; Deisenhammer, Ing, Strauss, Kemmler, Hinterhuber, & Weiss, 2009). These statistics suggest that crisis line services offer a crucial advantage as a readily available form of suicide intervention. Crisis line services include hotlines, warm lines, text lines, and 211 Helpline services. Crisis lines have varying purposes. Hotline services deescalate potentially life-threatening crisis situations, and staff are trained to apply emergency service interventions when necessary. Warm line services offer callers the opportunity to speak with a peer support specialist who has experienced similar episodes of psychological distress. Crisis text lines connect callers to behavioral healthcare when speaking may be unsuitable.

Results for crisis line services are divided into two main sections. The first section displays results about crisis services, including crisis line services, offered in the Board areas. The second section is concerned with responses from Crisis Line Service Organizations about service offerings, use of assessment tools, staffing, training, follow-up services, and funding.

Board Responses

Table 1

Crisis Services Available, By Board Type

| Crisis Service | All Board Areas | Appalachian | Small | Large | Rural |
|-------------------|-----------------|-------------|--------------|--------------|--------|
| | | | Metropolitan | Metropolitan | |
| Crisis Hotline | 94.0% | 93.7% | 94.1% | 83.3% | 100.0% |
| Peer Support | 56.0% | 50.0% | 58.8% | 55.7% | 54.5% |
| Crisis Warm Lines | 36.0% | 18.7% | 52.9% | 36.4% | 36.3% |
| Respite Care | 30.0% | 18.7% | 52.9% | 0.0% | 27.2% |

When asked about availability of various crisis services, 94.0% of Board respondents reported having crisis hotlines in their areas. (Refer to Table 1). By Board type, all Rural Boards indicated having crisis hotline services.

Crisis Line Service Organizations' Responses

Table 2

Crisis Lines Services Offered by Crisis Line Service Organizations

| Service | % Offering This Service | Mean Length of Time | Median Length of Time | Mean Number of Calls | Median Number of Calls | Lowest Number of Calls | Highest Number of Calls |
|---------------|-------------------------|---------------------|-----------------------|----------------------|------------------------|------------------------|-------------------------|
| Hotlines | 70.0% | 2.9 | 3.0 | 3,627 | 1,000 | 15 | 14,000 |
| Warm Lines | 20.0% | 3.0 | 3.0 | 100 | 100 | 100 | 250 |
| Other Sources | 46.7% | 3.0 | 3.0 | 566 | 500 | 10 | 1,840 |

Options for Length of Time: "1"="less than one year," "2"= "one to three years," and "3" equals "more than three years."

Of the 30 Crisis Line Service Organizations that participated in the survey, 70.0% have hotlines, and 20.0% operate warm lines. (Refer to Table 2; organizations could offer more than one crisis line service). Respondents were asked to indicate the number of years that their organization has delivered crisis line services, where "1" equals "less than one year," "2" equals "one to three years," and "3" equals "more than three years". On average, organizations have offered crisis text lines "one to three years." Organizations have offered all other services listed in Table 2 "more than three years."

Table 2 also displays the average number of telephone calls fielded by Crisis Line Service Organizations on a monthly basis. Hotline services have the highest average monthly number of calls of 3,627 (median=1,000). Hotline telephone calls per organization range from 15 to 14,000 monthly calls.

Table 3

Crisis Line Service Organization Credentials

| Credential | % of Organizations with Credential |
|--|------------------------------------|
| Behavioral Health Hotline Service/OhioMHAS | 20.7% |
| AIRS | 13.8% |
| CARF | 13.8% |
| American Association of Suicidology | 6.9% |
| Crisis Center Accreditation | 6.9% |
| Did Not Specify | 31.0% |

According to results, 69.0% of Crisis Line Service Organization respondents reported that their organizations have crisis services credentials, while 31.0% did not indicate as to whether their organization has credentials. Table 3 lists the types of crisis line service credentials that participating organizations reported having. Of the credentials listed, the largest percentage of respondents indicated that their organizations has Behavioral Health Hotline Service (20.7%). (Note: Organizations could select more than one type of credential).

Table 4
Average Peak Hours for the Crisis Lines by Day

| Day of Week | Morning 6:00 a.m. – 11:59 a.m. | Afternoon Noon – 5:59 p.m. | Evening 6:00 p.m. – 11:59 p.m. | Night Midnight – 5:59 a.m. |
|-------------|-----------------------------------|-------------------------------|-----------------------------------|-------------------------------|
| Sunday | 6.6% | 23.3% | 20.0% | 6.7% |
| Monday | 33.3% | 26.7% | 30.0% | 6.7% |
| Tuesday | 20.0% | 26.7% | 30.0% | 3.3% |
| Wednesday | 20.0% | 26.7% | 33.3% | 3.3% |
| Thursday | 20.0% | 26.7% | 26.7% | 3.3% |
| Friday | 13.3% | 26.7% | 26.7% | 3.3% |
| Saturday | 13.3% | 33.3% | 20.0% | 6.7% |

Crisis Line Service Organization participants were asked about peak hours when crisis line services are delivered. Table 4 displays the results by day of week for the following four time increments: morning hours of 6:00 a.m. to 11:59 a.m., afternoon hours of noon to 5:59 p.m., evening hours of 6:00 p.m. to 11:59 p.m., and night hours of midnight to 5:59 a.m. The largest percent of respondents (33.3%) indicated that their organization’s average peak hours occur either on Monday morning, Saturday afternoon, or Wednesday evening. The lowest percentage of respondents reported that peak hours occurred on Sunday morning (6.7%) and for night hours on a daily basis (3.3% to 6.7%).

Table 5
Suicidality Level for Individuals Accessing Crisis Line Services

| Suicidality Level | % of Organizations With Callers at This Stage |
|---|--|
| Do not have a suicide plan | 53.3% |
| Are in the process of developing a suicide plan | 50.0% |
| Are calling on behalf of an at-risk individual | 50.0% |
| Have a suicide plan | 43.3% |
| Are actively attempting suicide | 33.3% |
| Other | 23.3% |

Note: “Other” includes general requests for local resources, referrals, and loss of loved one.

When asked about the suicidality level of calls the organization receives, according to Crisis Line Service Organization participants, about 53.3% of organizations receive telephone calls from individuals who do not have a suicide plan, while 50.0% of organizations field telephone calls from individuals who are in the process of developing a suicide plan and/or from individuals who are calling on behalf of an at-risk individual. (Refer to Table 5). According to respondents, 43.3% of the organizations receive telephone calls from individuals who have a suicide plan, and 33.3% of the organizations handle telephone calls from individuals who are actively attempting suicide.

Table 6

Instruments Used with Crisis Line Callers

| Instrument | % of Organizations Using This Instrument |
|---------------------------------|--|
| Suicide Assessment Checklist | 33.3% |
| Suicide Risk Assessment Profile | 16.7% |
| Scale for Suicide Ideation | 6.7% |
| Other | 20.0% |

Note: “Other” includes Basic Lethality Assessment and Lifeline Suicide Risk Model.

Crisis Line Services Organization participants provided information about whether their organization uses various instruments during crisis line telephone calls as listed in Table 6. According to participants, 33.3% of the organizations use the suicide assessment checklist, compared to 16.7% of the organizations that use the suicide risk assessment profile.

Table 7

At-Risk Client Problems Handled by Crisis Services Organizations

| At-Risk Problem | % of Organizations Handling Problem |
|--|-------------------------------------|
| Mental Health Crisis | 56.7% |
| Suicide Crisis | 56.7% |
| Domestic Abuse | 53.3% |
| Youth/Young Adult Issue | 53.3% |
| General Information Seeking | 50.0% |
| Addiction Crisis | 46.7% |
| Basic Needs (food, housing and transportation) | 46.7% |
| Parent/Adult Issues | 46.7% |
| Health Crisis | 43.3% |
| Trauma Crisis | 43.3% |
| Bullying | 40.0% |
| Employment and Education Crisis | 40.0% |
| Pregnancy/Sexuality | 40.0% |
| Victim of Crime | 36.7% |
| Gender Conflict/Discrimination Issues | 33.3% |

According to Crisis Line Service Organization respondents, organizations receive telephone calls about a variety of problems, as shown in Table 7. Over half of the organizations handle telephone calls about mental health crisis, suicide crisis, domestic abuse, and youth/young adult issues. Organizations were least likely to field telephone calls about victims of crime (36.7%) and gender conflict/discrimination issues (33.3%).

Table 8

Ways that Crisis Line Staff Are Able to Help Callers

| Type of Help | % of Crisis Line Staff Offering Help | Frequency of Type of Help | |
|---|---|---------------------------|--------|
| | | Mean | Median |
| Help callers develop coping skills/ deal with distress | 56.6% | 4.4 | 4.5 |
| Determine if caller is at eminent risk | 56.7% | 4.8 | 5.0 |
| Use active engagement beyond active listening | 56.7% | 4.5 | 5.0 |
| Use the least invasive intervention with the caller | 56.7% | 4.6 | 5.0 |
| Maintain caller ID | 56.7% | 4.3 | 4.0 |
| Confirm that emergency services have made contact | 56.7% | 4.4 | 5.0 |
| Utilize supervisory staff for consultation | 56.7% | 4.7 | 5.0 |
| Review safety with individual | 56.7% | 4.4 | 5.0 |
| Practice active engagement with someone who is calling on behalf of someone else | 56.6% | 4.8 | 5.0 |
| Initiate lifesaving services or active rescue | 54.9% | 4.6 | 5.0 |
| Provide local resource information | 53.4% | 4.9 | 5.0 |
| Provide follow-up service information | 53.3% | 4.3 | 5.0 |

Ratings: "1" equals "Never," "2" equals "Rarely," "3" equals "Sometimes," "4" equals "Often," and "5" equals "Always"

As Crisis Line Service Organization respondents reported, more than half of the organizations help clients in a variety of ways. (Refer to Table 8). These methods represent skills, such as active listening and supervision, that crisis line service staff should possess when handling crisis telephone calls. If the organization is engaged in one of the methods, they tend to use the method either "often" or "always."

Table 9

Other Services Offered By Crisis Line Service Organizations

| Type of Service | % of Organization Offering Service |
|---|------------------------------------|
| Referral | 63.3% |
| Follow-Up Services | 50.0% |
| Community Training | 43.3% |
| Mental Health Information | 43.3% |
| Community Outreach | 40.0% |
| Behavioral Health Counseling and Therapy | 30.0% |
| Crisis Intervention Mental Health | 30.0% |
| Community Psychiatric Supported Treatment | 26.7% |
| Mental Health Assessment | 26.7% |
| Survivor Support | 26.7% |
| Pharmacological Management | 23.3% |
| Specialty Lines | 23.3% |
| Other | 100.0% |

Crisis Line Service Organization participants were asked about other related services offered by their organizations. Of the services listed in Table 9, 63.0% of the organizations provide referrals, and 50.0% of the organizations have follow-up services. Examples of “other” services include homeless hotline services, Ohio Long Term Benefits Care line for supported employment program, homeless outreach, Victims of Crime hotline services, rape crisis line, depression support groups, and Medication Assisted Treatment. Also, (not reported in Table 9), Crisis Line Service Organization participants indicated as to whether their organization’s staff know the medical coverage status of clients served by the organization. According to respondents, 58.8% of the organizations do not know the individual’s medical coverage.

Table 10

Frequency Crisis Line Services Organizations Engage In Follow-Up

| Follow-Up Service | % of Organizations | Frequency Engaged in Follow-Up | |
|-----------------------------------|--------------------|-----------------------------------|--------|
| | | Mean | Median |
| Measure Caller Outcomes Post Call | 56.7% | 3.0 | 3.0 |
| Examine Surveillance Data | 56.7% | 2.6 | 3.0 |
| Conduct Follow-Up Phone Interview | 56.7% | 3.0 | 3.0 |
| Conduct Follow-Up Assessment | 29.9% | 3.0 | 3.0 |

Ratings: “1”=“Never”, “2”=“Sometimes”, and “3”=“Always”

Table 10 provides a list of follow-up services and frequency of follow-up that participating Crisis Line Service Organizations offer the services. Participants indicated that less than 60.0% of the organizations measure caller outcomes after the call, conduct a follow-up phone interview, and/or examine surveillance data. Less than 30.0% of the organizations conduct a follow-up assessment. Also, according to participants, if the organization has the follow-up service, the organization tends to “always” have the follow-up services listed in Table 10.

Staffing.

Table 11
Employees Pay/Full-Time Status Answering the Crisis Lines

| Paid/Full-Time Status | Number of Employees Having Status | % of Organizations Employees with Status |
|---------------------------|-----------------------------------|--|
| Full-Time Paid Staff | 64 | 63.1% |
| Full-Time Supervisors | 24 | 59.9% |
| On-Call Paid Staff | 25 | 46.6% |
| Part- Time Paid Staff | 58 | 46.6% |
| Full-Time Volunteer Staff | 25 | 76.7% |
| Part-Time Volunteer Staff | 9 | 16.6% |
| On-Call Volunteer Staff | 4 | 6.7% |

Crisis Line Service Organization respondents were asked questions about whether their organizations have paid staff to deliver crisis line services, which was not reported in Table 11. According to respondents, 73.3% of the Crisis Line Service Organization respondents reported that their organization has paid staff; 40.0% have non-student volunteer staff, and 26.7% have student volunteer staff.

Another way to examine staffing patterns, as presented in Table 11, is to determine the number of employees based on full-time/part-time status and paid/volunteer basis. According to Table 11, 76.7% of Crisis Line Service Organization respondents indicated that their organizations have full-time volunteer staff. In contrast, the percentage of organizations with full-time staff is 63.1%. Organizations tend to have 64 full-time, paid staff members compared to an average of 25 full-time volunteers. Less than 60.0% of the participants reported that their organizations have full-time supervisors, and 46.6% of participants indicated that their organization employs, on average, 25 on-call paid employees.

Table 12
Crisis Line Service Organization Staff Qualifications

| Qualification | % of Organization Having Qualification |
|--|--|
| Bachelor's Degree | 30.0% |
| Masters of Social Work/Master of Counseling Degree | 23.3% |
| Crisis Worker Certification | 16.7% |
| Other | 36.7% |

Note: "Other" refers to: High School Diploma, QMHS, Associates Degree in social service related field, HHCC training certification, CIRS, Suicide Prevention Center's six- week of training, successfully complete 80 hours of agency Helpline Training.

Table 12 displays the various qualifications that Crisis Line Service Organization staff members have. According to respondents' answers, 30.0% of organizations have crisis line staff with a bachelor degree, and 23.3% of the organizations have staff with either a master's of social work or a master's of counseling degree. Examples of "other" qualifications include high school diploma and certifications for crisis line service workers.

Table 13
Supervisor Qualifications

| Qualification | % of Organizations with Supervisors Having Qualification |
|---|--|
| <i>Certifications</i> | |
| Licensed Social Workers | 43.3% |
| Licensed Counselors | 6.7% |
| Other (e.g., Bachelor’s Degree, Certified Resource Specialist) | 23.3% |
| <i>Other Qualifications:</i> | |
| Ability to supervise, work with, and mentor staff/volunteers | 50.0% |
| Ability to multi-task in a fast paced environment | 46.7% |
| Crisis and suicide intervention experience | 46.7% |
| Ability to provide on the job training for crisis line staff | 46.7% |
| Ability to review call reports generated by line staff for quality assurance | 46.7% |
| Experience with data base documentation systems | 43.3% |
| Ability to ensure that crisis line room atmosphere is consistent with the delivery of respectful, professional and compassionate services | 43.3% |
| Ability to train non-crisis line supervisors and staff | 36.7% |
| Completion of a 2-day Applied Suicide Intervention Skill Training (ASIST) | 20.0% |
| Other (e.g., working across the organization and other agencies to ensure effective care and training on using technology) | 20.0% |

According to responses about supervisory qualifications, Crisis Line Services organizations supervisors have a variety of different qualifications that include degrees and certifications and types of experiences. (Refer to Table 13). According to respondents, 43.3% of the organizations require the supervisor to be a licensed social worker. Also, 50.0% of the organizations require a supervisor to be able to supervise, work with, and mentor staff/volunteers.

Orientation training.

Table 14
Number of Hours of Orientation Training Crisis Line Staff Receive

| Training | % Offering | | | |
|---|------------|---------------|----------------|--------------------|
| | Training | 1 to 10 Hours | 11 to 20 Hours | More than 20 Hours |
| Training by Observation | 56.7% | 16.7% | 16.7% | 23.3% |
| Training by Instruction | 56.6% | 23.3% | 13.3% | 20.0% |
| Independently Answering Calls Under Supervision | 46.7% | 20.0% | 10.0% | 16.7% |

Note: Other orientation training consists of 26 hours of supervised role-playing of actual past calls or online AIRS courses.

Crisis Line Services Organization participants were asked about the types and duration of orientation training provided to new staff. The number of weeks of orientation varies among the organizations ranging from 35.3% of organizations providing 9 to 12 weeks of training to 11.8% providing one to four weeks of training. According to results displayed in Table 14, 56.7% of the organizations offer both training by observation and

training by instruction. Less than a quarter of the organizations offer more than 20 hours for the three types of training listed in Table 14.

Table 15
Crisis Line Services Orientation Training Components

| Orientation Training Component | % of Organization Using Orientation Training Component |
|--|--|
| Call Documentation | 56.7% |
| Call Protocol | 56.7% |
| Data Entry | 56.7% |
| Mental Health/Substance Abuse/ Child Abuse/ Sexual Abuse | 56.7% |
| Community Resources Information | 53.3% |
| Lethality Assessment | 50.0% |
| Basic Counseling Skills | 40.0% |
| Other | 56.7% |

Note: “Other” includes Crisis Intervention 6-Step Model, ABC’s of I & R Training Manual, active engagement skills, imminent risk protocols, Listening and Communication Skills, and de-escalation training.

According to Crisis Line Service Organization participants, when asked if different orientation training elements are offered to staff, less than 60.0% of the organizations provide any of the listed elements in Table 15. Only 40.0% of the organizations have basic counseling skills training.

Table 16
Supervision Provided to Staff during Probation

| Supervision | % of Organizations Providing Supervision |
|------------------------------|--|
| Monitor Documentation Skills | 50.0% |
| Give Verbal Feedback | 46.7% |
| Monitor Calls | 43.3% |
| Give Written Feedback | 36.7% |
| Monitor Productivity | 26.7% |
| Monitor Counseling Skills | 23.3% |
| Other | 10.0% |

Note: “Other” includes additional training about procedures after agency hours and active rescue and monitoring attendance.

Crisis Line Service Organization participants were asked about the types of supervision provided to probationary staff. According to Crisis Line Service Organization respondents, 50.0% of the organizations have supervisors monitor the staff’s documentation skills during probation. (Refer to Table 16). In contrast, 26.7% of organizations have supervisors monitor productivity, and 23.3% of the organizations have supervisors monitor counseling skills during the probationary period.

Ongoing training.

Table 17
Ongoing Training Offered Annually to Crisis Line Staff

| Training | % Organizations Offering Training |
|----------------------|-----------------------------------|
| Documentation Update | 50.0% |
| Crisis Line Skills | 46.3% |
| Assessment | 43.3% |
| Workshop | 36.7% |
| Role Play | 30.0% |

Note: 80% of the Crisis Line Services Organizations select “Other.” Other responses included all CEU options for license renewal, informal feedback, Six Step Crisis Model, annual peer review, trauma-informed care, and in-services.

Table 17 presents results about ongoing training offered annually to Crisis Line Service Organization staff. According to respondents, 50.0% of the organizations provide documentation update training annually. However, less than half of the organizations offer any of the other trainings displayed in Table 17. Organizations (30.0%) are least likely to offer role play.

Table 18
Data Collected by Crisis Services Organizations

| Data Collected | % of Organizations Collecting Data | Frequency of Data Collection | |
|--|------------------------------------|------------------------------|--------|
| | | Mean | Median |
| Tracks call volume | 56.7% | 3.0 | 3.0 |
| Use a standardized crisis line call record keeping process | 53.3% | 2.7 | 3.0 |
| Use a standardized evaluation process of crisis line calls | 53.3% | 2.4 | 3.0 |
| Uses a crisis line call quality assessment process | 50.0% | 2.6 | 3.0 |
| Makes use of internal call monitoring | 50.0% | 2.1 | 2.0 |

Ratings: “1”=“Never”; “2”=“Sometimes”, and “3”=“Always”

Crisis Line Service Organization participants were asked about data collected to monitor service quality and rated the frequency to which data are collected, with “1”=“Never” and “3”=“Always.” Between 50.0% and 60.0% of organizations are apt to use one of the five options listed in Table 18 with the highest percentage of organizations tracking telephone call volume (56.7%). Frequency ratings ranged from “sometimes” for “makes use of internal call monitoring” (mean=2.1, median=2.0) and “uses a standardized evaluation process of crisis line calls” (mean=2.4, median=3.0) to always for the other three options. The option with the highest ratings was “tracks call volume” (mean=3.0; median=3.0).

Table 19

Promotional Methods Used by Crisis Line Organizations

| Method | % of Organizations Using Promotional Method |
|---|---|
| Promotional materials (Pamphlets or flyers) | 53.3% |
| Website | 53.3% |
| Social media | 46.7% |
| Billboard(s) | 16.7% |
| Other | 23.3% |

Note: "Other" includes movie theatre ads, ads on local transit buses, permanent 2-1-1 signs on buildings, TV ads, public service announcements, health fairs, community programs, workshops and business cards.

When asked about the methods used to promote their crisis line services, 53.3% of the participants reported that their organizations either use websites or promotional materials, such as pamphlets or flyers. (Refer to Table 19). Only 16.7% of the organizations utilize billboards.

Funding.

Table 20

Funding Sources Identified By Crisis Line Services Organizations

| Source | % of Organizations with Funding Source |
|-------------|--|
| Boards | 43.3% |
| Donations | 23.3% |
| United Way | 23.3% |
| Foundations | 10.0% |
| Other | 23.3% |

Note: Other includes local library levy funds and Attorney General Victims of Crime Act grants.

Crisis Line Service Organization respondents provided information about their organizations' funding sources for crisis line services. As shown in Table 20, 43.3% of the organizations receive funding from Boards. An equal percentage of organizations (23.3%) also identified donations and United Way as funding sources.

General comments.

In the comments section, Crisis Line Service Organization participants identified many gaps and ways to improve services. Gaps include training, equipment, performance monitoring, staffing, and funding needs.

In regards to training, participants mentioned that their organizations need resources to hire a full-time trainer and to provide off-site training to staff on a variety of topics. Training topics included statistics, performance monitoring, and appropriate ways for volunteers to respond to callers. One participant mentioned that ASSIST training was unavailable in the community. Also, free and low cost training options should be expanded. One organization is meeting bi-monthly to review incidents, issues, and trends that might identify organizational and community needs regarding training topics.

Many Crisis Line Service Organization participants cited the need for new equipment and upgrades. Upgrades include on-line chat and text capacity. Telephone systems are old and should be replaced. One organization is procuring a cloud-based telephone system to allow for a broad range of monitoring tools, including telephone call recording.

Staff issues, in addition to training, include paying employees and offering pay raises in order to recruit and retain qualified staff. Participants mentioned the need for more experienced and older volunteers to handle calls. Some organizations would also like to recruit military veterans to answer telephone calls. Organizations lack staff capacity to cover overnight shifts, to monitor calls consistently and frequently for quality assurance, to update websites, and to analyze performance data. When organizations do not have adequate staffing for evening and night shifts, they routinely switch their calls through contractual agreements to other organizations that may or may not be familiar with their communities. These arrangements may negate the ability to monitor the flow of crisis calls.

Discussion

This section summarizes the Crisis Line Service Organization results for the Suicide Prevention Needs Assessment and Gap Analysis. Findings have policy and practice implications. These implications create a framework for improving and informing the way that crisis line services are delivered in Ohio.

Availability of Services

Although 94.0% of Board respondents report having crisis hotlines, Boards lag behind in offering other crisis services, such as crisis warm lines, peer support, and respite care. This gap in services exists in communities where individuals are already exposed to known suicide risk factors, such as higher poverty and unemployment rates.

Staff Qualifications/Credentials

Equally important is the wide variation in the type of staff qualifications required by Crisis Line Service Organizations. The variation may be attributable to a variety of factors. Some variation may be attributable to how survey respondents counted volunteers who work the crisis lines since student volunteers enrolled in college may have been considered as only having a high school diploma. Another factor influencing the variation is the amount of required training that organizations require staff to undertake. Even though most organizations require some form of in-house training or formal training/certification, organizations differ on the level and type of training required for staff to work the crisis lines independently. Also, another factor influencing variation is type of credentials that organizations require a supervisor to have. Results show that only 50.0% of supervisors are licensed social workers and/or licensed counselors. Supervisors play an important and pivotal role in the daily operation of crisis lines. Supervisors are expected to train new employees and make life-saving decisions in addition to other duties. This variation in type of qualifications for both employee/volunteers and supervisors demonstrates a need for formal credential requirements for crisis line workers.

Organization Credentials

According to results, accreditation and certification differ among the participating Crisis Line Service Organizations. Although the various accrediting bodies may have similar requirements, a disparity exists between holding an accreditation and holding a certification. Of the 30 organizations participating in the survey, seven different certifications/accreditations were mentioned with the top the Behavioral Health Hotline Service (20.7%). This variation creates a lack of uniformity in the formalizing process for crisis service organizations.

Orientation Training

Another organizational level issue is the orientation training used to prepare employees and/or volunteers staffing Crisis Line Service Organization. Crisis Line Service Organizations employ a variety of individuals with differing pay statuses ranging from full- time paid staff to part-time volunteers. However, results indicate that only 23.3% of organizations require 20 or more hours of observation training; 23.3% of the organizations require one to 10 hours of instruction, and 20.0% of the organizations require one to 10 hours of independently answered telephone calls under supervision. In addition, the number of weeks that orientation is offered differs among organizations, ranging from 35.3% of organizations providing 9 to 12 weeks of training to 11.8% providing 1 to 4 weeks of training. Although new staff members have various levels of experience and education, these statistics indicate a lack of uniformity in the orientation requirements for new staff. Orientation should function as an educational process and bring all employees/volunteers to a similar level of ability to handle crisis lines. According to respondents, other orientation training components include supervision of call documentation, instruction in call protocol, data entry, and resources for mental health, substance abuse, child and sexual abuse, lethality assessment and basic counseling skills. Although organizations offer ongoing training, results indicate only 23.3% of organizations offer it annually. This gap in ongoing training presents an opportunity to provide crisis line workshops and trainings.

Other Training

The issue of training is further highlighted by the types of telephone calls that crisis line staff members handle. Most crisis line callers, according to respondents, contact a crisis line in regards to either a mental health issue or a suicide crisis. However, crisis line staff members field other types of telephone calls involving such issues as domestic violence, trauma, and addiction. In addition to different types of telephone calls, staff members determine if a client is at eminent risk, assist individuals with coping skills, and deliver a wide range of services, such as referrals. The variety in telephone calls, services, and assistance validates the need for adequate training and orientation. However, when asked about training staff in ways to help callers, 56.0% or less of the survey respondents indicated that their organization offered this type of training to crisis line staff. These results reiterate the need for stronger orientation and ongoing training.

Calls and Staffing Rotation

Crisis Line Service Organization respondents were asked to indicate what their peak hours are for crisis telephone line calls. Peak hours were defined as hours when Crisis Line Service Organizations receive the highest telephone call volume. Monday morning (6:00 a.m. to 11:59 p.m.), Saturday afternoon (noon to 5:59 p.m.), and Wednesday evening (6:00 p.m. to 11:59 p.m.) were the peak times. Peak call times have staffing and funding implications for crisis line service organizations. Some respondents mentioned that when the organization is closed or too busy, calls are redirected to another external entity. If multiple organizations use the same external entity, the transfer of telephone calls may be creating a possible burden on the external entity receiving the telephone calls. Further investigation is needed to determine if telephone calls are unanswered or do not go through due to high call volume when telephone calls are transferred. Importantly, results show that 50.0% of callers are in the process of developing a suicide plan. If their telephone calls are redirected and/or not answered, the outcome of re-contacting the crisis line may be affected.

Funding

Lack of funds is a factor in staffing, training, and handling telephone calls. Survey respondents mentioned that their organizations lack the financial resources to pay staff, to recruit staff, and to update equipment to handle large telephone call volume and new technologies, such as texting. Also, several respondents noted funding is required to offer new and expand existing training options within the community. The lack of training options within the community made it necessary for some organizations to expend time and money to travel to other venues for free or reduced cost training.

Presently, as indicated by respondents, Crisis Line Service Organizations receive the majority of their funding (43.3%) from Boards. Other funding sources include the United Way Foundation, local library levies, and the Ohio Attorney General Victims of Crime Act grants. Results further show a high dependency on donations (23.3%), fundraising (10.0%), and other outside source (26.7%). This multifaceted financial system contains unstable monetary sources, such as fundraising and donations, and highlights the need for Crisis Line Service Organizations to function without dependence on non-renewable economic sources.

TREATMENT SERVICES

| Suicide Prevention Needs/Gap Analysis | | | | | |
|---------------------------------------|-----------|-------------|-----|--|--|
| Treatment Services | | | | | |
| Respondent | | | | | |
| Board | Coalition | Crisis Line | BHO | Problem | Gap |
| Screenings | | | | | |
| | | | X | Screening tool use | 27.0% of the BHO respondents said that their organizations do not use a screening tool to detect suicide ideation. |
| | | | X | Screening tool variance | There is a lack of consistency and standardization in the screening tools that BHOs use. |
| | | | X | Screening Tool Training | <p>According to BHO respondents, 60.0% of the organizations do not train case managers and intake workers on how to administer a screen; 32.0% do not train clinicians on how to a screen.</p> <p>BHO respondents were asked to rate their confidence on administering various types of screening tools, with the rating scale ranging from “Not Confident” to “Highly Confident.” Screening tools included, but were not limited to, the Columbia Scale, the Depression screening, and the PHQ-9. No respondent assigned a rating “Highly Confident” when administering any of the screening tools.</p> |
| Assessments | | | | | |
| | | | X | Administration of a comprehensive assessment | Approximately 40.0% of BHO respondents said that their organizations do not administer comprehensive risk assessments at intake to detect suicidality among their clients |
| Safety Planning | | | | | |
| | | | X | Safety Plan Template | About 65.0% of the BHO respondents said that their organizations do not use a safety plan template. |
| Evidence-Based Treatments | | | | | |
| | | | X | Availability of EBT treatments | According to BHO respondents, about 75.0% of BHOs offer CBT or CBT-related treatments; only 40.0% offer DBT. |
| Follow-Up Services | | | | | |
| | | | X | Availability of follow services | <p>According to BHO respondents, organizations do not offer:</p> <ul style="list-style-type: none"> Peer Support Services (90.5%) Support Groups (81.0%) Family Outreach (72.8%) Follow-up Telephone Calls (45.6%) |

Treatment Services Results

The survey queried BHO respondents about client referrals, assessment, safety plans, treatment, and follow-up services. The ensuing analysis of results is divided among these topics.

Client referrals

Table 1

Client Referral Source

| Referral Source | % of BHOs with Referral Source |
|---|--------------------------------|
| Primary Care Provider | 79.6% |
| Crisis Services | 66.6% |
| Private Psychiatric Hospital/Inpatient Unit | 66.6% |
| Emergency Departments | 62.6% |
| State Behavioral Health Hospital | 52.4% |
| Other | 42.9% |

Table 1 provides information about external sources which refer clients at-risk of suicide to the BHO. (Note: BHOs can receive a referral from any of the listed sources in Table 1). According to respondents, 79.6% of BHOs receive referrals from primary care providers. Over 60.0% of BHOs receive referrals from crisis services, private psychiatric hospital/inpatient units, and emergency departments. “Other” referral sources include the criminal justice system, County Departments of Job and Family Services, insurance companies, social service agencies, client himself/herself, other clients, and family/friends.

Table 2

At-Risk Client’s Wait Time for First Appointment after Referral

| Average Wait Time | % of BHOs Indicating Wait Time |
|-----------------------|--------------------------------|
| Seven Days or less | 74.3% |
| Eight Days to 30 Days | 25.0% |
| More than 30 Days | 7.0% |

When asked about average wait times for a referred client to be seen for a first appointment, 75.0% of BHO respondents reported that wait times are seven days or less. (Refer to Table 2). Only 7.0% of respondents reported that average wait times exceed 30 days. According to comments, BHO participants noted that the completion of release forms is important. This form allows communications and collaboration between the BHO and referring organizations to ensure transition of care continuity and the ability to monitor the level of risk for each client on a continuous basis. Also, participants stated that BHO staff use telephone calls and satisfaction surveys to monitor follow-up services for an individual after receiving a referral from another organization.

Screening

When asked if the BHO screened at-risk clients for suicide ideation, 108 or 73.5% of the respondents indicated that their organization screens at-risk clients for suicide ideation, while 26.5% do not. Analysis of BHO responses pertaining to screening will only include answers from BHOs that screen clients for suicide ideation. (The denominator is based on 108 respondents who indicated that their organization screens at-risk clients for suicide ideation).

Table 3
Suicide Screens Used by BHOs

| Screens | % of BHOs Using Screens |
|--|-------------------------|
| Depression Screening | 35.4% |
| Patient Health Questionnaire-9 | 23.8% |
| Beck Scale of Suicidal Ideation (BSSI) | 20.4% |
| Columbia-Suicide Severity Rating Scale | 5.4% |
| Child Suicide Assessment (CSA) | 4.8% |
| Measurement of Adolescent Potential for Suicide (MAPS) | 4.1% |
| Safe-T | 3.4% |
| Suicide Behavior Questionnaire (SBQ-R) | 2.7% |
| Suicide Probability Scale (SPS) | 2.7% |
| Suicide Risk Assessment Pocket Card | 2.7% |
| Self-Harm Behavioral Questionnaire (SHBQ) | 1.4% |
| Other | 38.1% |

Table 3 displays the various screens that BHO organizations administer to at-risk clients (Note: A BHO can use more than one screening). According to respondents, BHOs are most likely to administer the Depression Screening (35.4%). For "Other," BHO respondents frequently mentioned that staff use the Solutions for Ohio's Quality Improvement and Compliance (SOQIC) Lethality Assessment.

Table 4
BHO Staffs' Confidence Level in Using Screens to Identify At-Risk Clients

| Screens | Degree of Confidence | |
|--|----------------------|--------|
| | Mean | Median |
| Beck Scale for Suicidal Ideation (BSSI) | 1.7 | 2.0 |
| Columbia-Suicide Severity Rating Scale | 1.6 | 1.0 |
| Child Suicide Assessment (CSA) | 1.4 | 1.0 |
| Depression Screening | 2.2 | 2.0 |
| Measurement of Adolescent Potential for Suicide (MAPS) | 1.4 | 1.0 |
| Patient Health Questionnaire-9 (PHQ-9) | 2.1 | 2.0 |
| Reasons for Living Inventory | 1.4 | 1.0 |
| Safe-T | 1.4 | 1.0 |
| Suicide Behaviors Questionnaire Revised (SBQ-R) | 1.3 | 1.0 |
| Self-Harm Behavior Questionnaire (SHBQ) | 1.3 | 1.0 |
| Suicide Risk Assessment Pocket Card | 1.6 | 1.0 |

Ratings: "1"="No Confidence"; "2"="Confident;" and "3"="Highly Confident."

BHO respondents rated their degree of confidence in administering various screening tools on a Likert Scale, where “1” equals “No Confidence” and “3” equals “Highly Confident.” As Table 4 shows, average scores tended to range from “Not Confident” to “Confident.” Depression Screening received the highest average rating of “2.2,” and both the Suicide Behaviors Questionnaire Revised (SBQ-R) and the Self-Harm Behavior Questionnaire (SHBQ) had the lowest ratings of “1.3.”

Table 5

BHOs’ Use of Screenings

| Screen’s Use | % of BHOs Using Screening | Degree of Frequency | |
|-------------------------------------|---------------------------|---------------------|--------|
| | | Mean | Median |
| Document in Client’s Record | 68.0% | 4.8 | 5.0 |
| Use to Develop Safety Plan | 67.3% | 4.7 | 5.0 |
| Identify Clients At-Risk of Suicide | 64.3% | 4.0 | 4.0 |
| Make Staff Members Aware of Results | 64.3% | 4.6 | 5.0 |
| Incorporate into Treatment Plan | 63.9% | 4.3 | 5.0 |
| Administer at Intake | 62.2% | 4.1 | 5.0 |
| Administer to All Clients | 53.1% | 3.8 | 5.0 |

Ratings: “1”=“Never,” “2”=“Rarely,” “3”=“Sometimes,” “4”=“Often”, and “5”=“Always.”

BHO representatives provided information about ways their organization uses screening results. Respondents also rated the degree of frequency with which the results are used on a Likert Scale where “1” equals “Never” and “5” equals “Always.” (Refer to Table 5). According to respondents, over 60.0% of BHOs document results in client’s record (68.0%), use results to develop safety plan (67.3%), identify clients at-risk of suicide (64.3%), make staff members aware of results (64.3%), incorporate results into the treatment plan (63.9%), and administer the screen at intake (62.2%). About 50.0% of BHOs administer screens to all clients. BHOs ratings tended to range from an average score of “3.8” for administering the scree to all clients to “4.8” for documenting the results in the client’s records.

Table 6

BHO Staff Roles Trained in Administering Screenings in Last 12 Months

| Staff Roles | % of BHOs with Staff Trained to Screen | % of BHOs with Staff Trained in Last 12 Months |
|-----------------|--|--|
| Clinicians | 68.0% | 61.2% |
| Intake Workers | 41.5% | 32.7% |
| Case Managers | 40.1% | 35.4% |
| Administrators | 15.6% | 13.6% |
| Peer Supporters | 6.1% | 5.4% |
| Other | 8.2% | 7.5% |
| None | 0.0% | 4.1% |

Table 6 shows BHO participants’ answers about which staff roles receive trainings to administer screens and whether staff received this training in the last 12 months. According to results, 68.0% of BHOs provided training about screens to clinicians and 61.2% trained clinicians in the last 12 months. A lower percentage of BHOs,

however, offer training regarding screens to other staff roles. For instance, about 40.0% of BHOs offered trainings to case managers and intake staff.

Assessment

BHO respondents provided information about whether their organizations develop comprehensive risk assessments for clients with suicide ideation, the various ways that an assessment is used, and the degree of frequency to which the assessment is used. Of the BHOs responding to the survey, 107 or 72.8% indicated that their organization develops comprehensive assessments for suicide ideation while 27.8% do not. Analysis of BHO responses will only include answers from BHOs that develop assessments for clients at risk of suicide. (The denominator equals the 107 respondents which indicated that their BHO develops comprehensive assessments for suicide ideation).

Table 7
BHO Use of Comprehensive Risk Assessments

| Use of Risk Assessments | % of BHOs Using Risk Assessments | Degree of Frequency | |
|--------------------------------------|----------------------------------|---------------------|--------|
| | | Mean | Median |
| File Assessment in Client Record | 98.0% | 4.8 | 5.0 |
| Ensure Appointment Adherence | 98.0% | 4.7 | 5.0 |
| Provide Staff Access to Assessment | 97.1% | 4.7 | 5.0 |
| Use to Generate Safety Plan | 93.9% | 4.2 | 4.0 |
| Update Assessment Frequently | 91.4% | 3.9 | 4.0 |
| Administer Risk Assessment at Intake | 83.0% | 3.9 | 4.0 |

Ratings: "1"="Never," "2"="Rarely," "3"="Sometimes", "4"="Often", and "5"="Always."

The survey queried BHO participants about ways that their organizations use assessments. The survey also asked respondents to rate the degree of frequency with which the assessment results are used for a particular purpose on a Likert Scale of "1" to "5," where "1" equals "Never" and "5" equals "Always." As shown in Table 7, over 90.0% of BHO participants reported that the staff typically files the assessment in the client record (98.0%), uses the results to ensure appointment adherence (98.0%), has access to assessments (97.1%), uses results to generate safety plans (93.9%), and frequently updates the assessment (91.4%). A lower percentage of BHO participants (83.0%) indicated that their organization administers the risk assessment at intake. On average, the BHOs "often" or "always" use the assessment for each of the options listed in Table 7.

Safety Plans

When asked if clients receive a copy of their safety plan, all of the respondents said that the clients do. BHO respondents were also asked if their organization uses a safety plan template. According to BHO respondents, 96 or 65.3% of the BHO organizations use a safety plan template. Analysis of BHO responses will only include answers from BHOs that have a safety plan template.

Table 8

Client Safety Plan Template Components Used by BHOs

| Client Safety Plan Template Components | % of BHOs Using Components |
|---|----------------------------|
| List of Supportive People That Can Help The Client | 95.8% |
| List of Professionals That Can Assist The Client | 93.7% |
| Internal Coping Strategies | 82.2% |
| List of Warning Signs That A Crisis May Be Developing | 81.2% |
| Ways to Make the Environment Safe | 71.8% |
| Reduction in Access to Lethal Means | 65.6% |
| Harm Reduction | 63.5% |
| Setting that Provide a Distraction | 51.0% |
| One Thing that is Important And Worth Living For | 46.8% |
| People that Provide Distraction | 45.8% |

Respondents were asked to indicate if their organization’s safety plan template had any of the components listed in Table 8. As shown in Table 8, the three most common elements in safety plan templates are: a list of supportive people that can help the client (95.8%), a list of professionals that can assist the client (93.7%), and internal coping strategies (82.2%). Only 46.8% of the BHO respondents reported that the safety plan template includes a component about “one thing that is important and worth living for.”

Also, BHO Respondents were asked to rate the degree to which their organization has the capacity to monitor clients to ensure they keep appointments and treatment adherence on a Likert Scale where “1”=“Never” and “5”= “Always”. According to results, BHO respondents indicated that, on average, the organization “often” (mean=4.2) has the capacity to monitor clients to ensure appointment compliance and treatment adherence.

Table 9

Types of Follow-Up Care Available for BHO Clients

| Type of Follow-Up Care | % of BHO Responses Using Follow-Up Care |
|--|---|
| Organization Follow-Up Telephone Contact | 54.4% |
| Family Outreach | 27.2% |
| Other | 19.7% |
| Support Groups | 19.0% |
| Peer Support Services | 9.5% |

BHO respondents were asked if their organizations had any of the follow-up services listed in Table 9. According to results, BHOs that offer follow-up services are most likely to use telephone contact (54.4%) and least likely to offer peer support services (9.5%).

Treatment Services

Table 10

Behavioral Health Organization (BHOs) Use and Perception of Effectiveness for Evidence Based Practices for Treating Suicide Ideation

| Treatment | % of BHOs Using Treatment | Effectiveness | |
|------------------------------------|---------------------------|---------------|--------|
| | | Mean | Median |
| Cognitive Behavioral Therapy (CBT) | 72.1% | 2.4 | 2.0 |
| Trauma-Focused CBT | 68.7% | 2.2 | 2.0 |
| Talk Therapy (Psychotherapy) | 64.6% | 2.2 | 2.0 |
| Dialectical Behavior Therapy (DBT) | 44.2% | 2.4 | 2.0 |
| Multi Systemic Therapy (MST) | 6.8% | 2.6 | 3.0 |

Ratings: "1"="Not Effective," "2"="Effective," and "3"="Highly Effective."

When asked whether their organization offers evidence-based practices (EBPs) for treating clients with suicide ideation, all BHO respondents reported that their organizations do. BHOs are most likely to deliver Cognitive and/or Behavioral Therapies (CBTs) when treating at-risk clients with 72.1% offering CBT, 68.7% of organizations offer trauma-focused CBT, and 64.6% of the organizations provide talk therapy (Refer to Table 10). The survey prompted BHO participants to rate the effectiveness of the EBPs used to treat at risk-clients on a Likert scale of "1" to "3," where "1" equals "Not Effective" and "3" equals "Highly Effective." While less than 7.0% of BHOs offer MST, respondents rated MST, on average, as "highly effective" in treating suicide ideation (mean=2.6, median=3.0). Respondents, on average, scored all the other EBPs as "effective."

Also, 95.2% of respondents rated whether the current and future level of EBPs used in treating individuals with suicide ideation meets demand, on a Likert scale, where "1" equals "Somewhat" and "3" equals "Will Meet Future Demand." On average, respondents rated the current and future levels as "will meet future demand" (mean equals 2.8, median=3.0). (Results are not displayed in a table).

Table 11

Suicide Prevention Treatment Trainings Behavioral Health Organizations (BHOs) Plan to Offer in the Next Year

| Suicide Prevention Training | % of BHOs Planning to Offer Training |
|------------------------------------|--------------------------------------|
| Cognitive Behavioral Therapy (CBT) | 66.6% |
| Trauma Focused CBT | 65.3% |
| Talk Therapy | 55.1% |
| Dialectical Behavior Therapy (DBT) | 40.8% |
| Multi-Systematic Therapy (MST) | 7.5% |
| Other | 27.8% |

The survey queried BHO respondents as to the likelihood of whether staff would receive specific EBP trainings (Refer to Table 11). According to BHO participants, about two-thirds of the organizations plan to offer CBT and/or Trauma Focused CBT, and 55.1% plan to offer Talk Therapy. Examples of "Other" include Attachment Based Family Therapy and Counseling on Access to Lethal Means.

Table 12

Peer Supporters' Role in a BHO

| Peer Supporter Role | % BHOs | Mean | Median |
|--|--------|------|--------|
| Are treatment team members | 86.3% | 3.9 | 4.0 |
| Coordinate services with peer support organizations | 65.0% | 3.0 | 3.0 |
| Are assigned to clients at-risk of suicide | 62.1% | 2.9 | 3.0 |
| Coordinate follow-up services for clients at-risk of suicide | 61.5% | 2.8 | 3.0 |
| Have access to client records | 71.5% | 3.6 | 5.0 |

Rating: 1="Never," 2="Rarely," 3="Sometimes," 4="Often," and 5="Always"

When asked if their organization offers peer support to clients at-risk of suicide, 52 or 35.4% of BHO participants indicated that their organization does. Table 12 displays the various peer support functions and/or responsibilities and the frequency with which peer supporters have this function/responsibility. (Analysis of results only includes those participants indicating that their organization has peer support services). According to results, 86.3% of BHOs consider peer supporters to be treatment team members, and 71.5% of respondents reported that peer supporters have access to client records. BHO respondents indicated that their organization "sometimes" coordinate peer services with peer support/consumer-operated organizations (mean=3.0, median=3.0), assign peer supporters to clients at-risk of suicide (mean=2.9, median=3.0), and "often" provide peer supporters with access to client records (mean=3.6, median=5.0).

Discussion

Client Referrals

BHOs receive referrals to treat clients at-risk of suicide from a variety of sources. The majority of BHOs (74.3%) reported that the average wait time for an appointment for a referred client is less than seven days. In order to coordinate referrals more efficiently and effectively, BHOs may want to encourage their referral partners to download the Suicide Safe application to their mobile telephone or tablet. This application customizes the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) process for non-behavioral health organizations and provides information about behavioral health treatment site locations and other resources to coordinate referrals.

Screening

According to respondents, about 28.0% of the BHOs do not screen clients for suicide risk at any point during the course of treatment, and 38.0% of the BHOs do not administer a suicide screen at intake. Results did not reveal a commonly used screening tool used across BHOs. The majority of respondents (35.4%) indicated that their organizations administer the Depression Scales. When asked to rate their confidence in using various screening tools, respondent's ratings ranged from "somewhat confident" to "confident." They did not assign a rating of "highly confident" to any instrument. Also, about 40.0% of the organizations do not offer suicide screening training to clinicians, and 60.0% of organizations do not train case managers or intake workers in the administration of suicide screens.

These results suggest that policymakers need to develop interlocking strategies to increase the use of suicide screens. As a first step, OhioMHAS and the Ohio Department of Medicaid may want to design a benefits package that allows BHOs to be reimbursed to administer suicide screens frequently to clients at risk of suicide. A change in Medicaid's reimbursement policy for suicide screenings may be an impetus for policymakers and the BHOs to adopt a standard set of screening tools and to train BHO workers on how to administer screens. BHOs may want to encourage staff to download the SAFE-T application. This application is a reference tool with information to evaluate a client's risk of suicide and could be adopted as one of the screens used by non-clinicians to flag clients that need a more comprehensive assessment.

BHO respondents' ratings of their confidence in administering various screens raise two juxtaposing issues. On the one hand, the degree of confidence may be related to a worker not knowing how to administer the screen and interpret results. On the other hand, workers may view the screens as not accurately identifying the client's risk of suicide. In either scenario, training and the common usage of a set of instruments may raise worker's confidence as they would have a better understanding of how to administer the tool and may perceive that they are using a more reliable and valid instrument.

Assessments/Safety Plans

Other identified treatment service gaps include the BHO's use of assessment plans, development of a comprehensive assessment at intake, use of safety plan templates, and the variation in safety plans components across BHOs. According to BHO responses, 27.8% of BHOs do not administer assessments, and 39.5% of BHOs do not administer a comprehensive assessment at in-take. About 35.0% of BHOs use a safety plan template. In regards to safety plan variation, over 90.0% of the BHOs include lists of supportive people and professionals that assist the client, while 71.8% of the BHOs include a component about "ways that the client can make the environment safe."

These results suggest that BHO staff administer a comprehensive assessment at intake. To assist BHOs in building this capacity, OhioMHAS staff may consider the possibility of offering the Assessing and Managing Suicide Risk (AMSR) training courses. These results also suggest that OhioMHAS and BHOs should explore ways to create a standardized safety plan template that uses a set of common elements. As part of developing a standardized safety plan, OhioMHAS and BHO representative should identify steps to disseminate information to BHOs about the availability of a standardized template and the ways to use the template.

Follow-Up

Follow-up service helps clients and/or survivors maintain a non-distressed state of being by allowing the clients to continue their therapeutic relationships, share experiences with peers, and connect to other services. As results indicate, a limited number BHOs deliver follow-up services. Only 54.4% of BHOs make follow-up calls while 27.2% offer family outreach, 19.0% have support groups, and 9.5% deliver peer support services.

BHOs should consider developing a strategy to hire peer supporters for follow-up services and/or contracting with the local peer support/consumer-operated organizations. To assist BHOs, OhioMHAS should

consider the possibility of developing and launching a virtual training application to provide information about how peer supporters can deliver follow-up services. Also, OhioMHAS may want to launch various pilot projects which make use of text messaging and postcards. Note: The state of Washington uses a registry of active clients at-risk of suicide (SPRC, 2016). While this registry is in the embryonic phase of development, OhioMHAS may want to consider a pilot project with BHOs to create and test how a registry could be used to track at-risk clients.

Treatment Services

According to results, all BHOs deliver EBPs to clients with suicide ideation. When asked about the various EBPs offered, 72.1% of respondents reported that their organizations deliver CBT, and 43.0% offer DBT. In comments addressing gaps in treatment services, respondents mentioned that staff members need refresher courses and new training for all EBPs, including CBT. BHO respondents rated DBT as being “effective” in treating clients with chronic suicide ideation and frequently mentioned the need for DBT training. Policymakers may want to target CBT and DBT trainings to communities with the highest suicide rates and/or the high numbers of individuals dying by suicide.

Peer Support

According to respondents, only 35.4% of BHOs offer peer support services. The National Strategy for Suicide Prevention (SPRC, 2016) considers peer support services to be an integral component in treating and supporting individuals at risk of suicide. Of those BHOs offering peer support services, the majority of BHOs consider peer supporters to be treatment team members. Peer supporters coordinate services with peer support organizations, are routinely assigned to clients at-risk of suicide, and coordinate follow-up services.

OhioMHAS and SPF may want to collaborate with Boards, BHOs, and peer support organizations to develop a plan on how to integrate peer support services across the spectrum of treatment services, such as coordinating referrals and follow up services and conducting support groups. The plan should include virtual trainings about integrating peer support services into treatment plans of clients with suicide ideation. OhioMHAS and SPF may also want to recruit BHOs that offer peer support services to share how these BHOs established peer support services.

References

- American Foundation for Suicide Prevention. (2016). *About Suicide*. Retrieved August 02, 2016, from asfp.org/about-suicide/suicide-statistics.
- Andriessen, K., & Krysiniska, K. (2011). Essential questions on suicide bereavement and postvention. *International Journal of Environmental Research and Public Health*, 9(1), 24-32.
- Batras, D., Duff, C., & Smith, J. (2014). Organizational change theory: Implications for health promotion. *Health Promotion International*, 31(1), 231-141.
- Baxter, R. J., & Mechanic, R.E. (1997). The status of local health care safety nets. *Health Affairs*, 16(4), 7-23.
- Campbell, F.R. (1997). Changing the legacy of suicide. *Suicide and Life-Threatening Behaviour*, 27, 329-338.
- Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis*, 25(1), 30-32.
- Cerel, J. & Campbell, F. R. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. *Suicide & Life Threatening Behaviors* (38(1), 30-40.
- Deisenhammer, E. A., Ing, C. M., Strauss, R., Kemmler, G., Hinterhuber, H., & Weiss, E. M. (2008). The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt?. *The Journal of clinical psychiatry*, 70(1), 19-24.
- Fontanella, C.A., Hiance-Steelesmith, D.L., Phillips, G.S., Bridge, J.A., Lester, N., Sweeney, H.A., & Campo, J.V. (2015). Widening rural-urban disparities in youth suicides, United States, 1996 to 2010. *JAMA Pediatrics*, 169(5,466-573.0)
- Fuchs, D.M. (2008). *Assessment of communities*. In *Comprehensive handbook of social work and social welfare*. In Social work practice. W. Rowe and L. A Rapp-Paglicci (Eds.). (pp. 488-504). Hoboken, NJ: Wiley.
- Jacobson, P.D., Dalton, V.K., Benson-Grad, J., Weisman, C.S. (2005). Survival strategies for Michigan's health care safety net provider. *Health Services Research*, 40(3), 923-940.
- Mays, G. P., McHugh, M. C., Kyumin, S., Perry, N., Lenaway, D., Halverson, P. K. & Moonesinghe, R. (2006). Institutional and economic determinants of public health system performance. *American Journal of Public Health*, 96, 523-531.
- Ohio Department of Development. (2015). Population estimates. Retrieved June 6th, 2016 from https://development.ohio.gov/reports/reports_pop_est.htm.
- Ohio Department of Health. (2014). Death certificate File. Retrieved on June 4th from the Vital Statistics data transfer file.
- Ohio Department of Job and Family Services. (2016). Unemployment data. Retrieved on June 12th from <http://ohiolmi.com/ces/lmr.htm>.
- Ohio Department of Medicaid. (2015). Retrieved on June 10th from <http://medicaid.ohio.gov/RESOURCES/ReportsandResearch/MedicaidEligiblesandExpendituresReports.aspx>.

- Ohio Department of Mental Health and Addiction Services. (2016). *Ohio's Suicide Prevention Plan SFY 2016-2017*. Retrieved August 17, 2016, from <http://mha.ohio.gov/Default.aspx?tabid=111>.
- Ohio Department of Taxation. (2015). Retrieved on June 02, 2016 from http://www.tax.ohio.gov/tax_analysis/tax_data_series/publications_tds_property.aspx#Realestateandpublicutilitypropertytaxes.
- Pennington, F. (1980). Needs assessment: Concepts, models and characteristics. *New Directions for Continuing Education*, 7, 1-14.
- Suicide Prevention Resource Center. (2014). *Suicide Screening and Assessment*. Retrieved August 17, 2016, from http://www.sprc.org/sites/default/files/migrate/library/RS_suicide%20screening_91814%20final.pdf.
- Sweeney, H. A., & Knudsen, K. (2014). The impact of the great recession on community-based mental health organizations: An analysis of top managers' perceptions of the economic downturn's effects and adaptive strategies used to manage the consequences in Ohio. *Community Mental Health Journal*, 50, 258-269.
- Tummey, R. (2001). A collaborative approach to urgent mental health referrals. *Nursing Standard*, 15(52), 39-42.
- Weiner, B. (2009). A theory of organizational readiness for change. *Implementation Science*, 4(1), 4-67.
- Williams, C. L., Davidson, J. A., & Montgomery, I. (1980). Impulsive suicidal behavior. *Journal of Clinical Psychology*, 36(1), 90-94.

Appendix A. Boards Listed by Classifications

Appalachian

- Adams, Lawrence, Scioto
- Ashtabula
- Athens, Hocking, Vinton
- Belmont, Harrison, Monroe
- Brown
- Carroll, Tuscarawas
- Clermont
- Columbiana
- Coshocton, Guernsey, Morgan, Muskingum, Noble, Perry
- Fayette, Highland, Pickaway, Pike, Ross
- Gallia, Jackson, Meigs
- Holmes, Wayne
- Jefferson
- Mahoning
- Trumbull
- Washington

Small Metro

- Allen, Auglaize, Hardin
- Butler
- Clark, Greene, Madison
- Lorain
- Richland
- Stark
- Clinton, Warren
- Darke, Miami, Shelby
- Delaware, Morrow
- Fairfield
- Geauga
- Lake
- Licking, Knox
- Portage
- Medina
- Union
- Wood

Large Metro

- Cuyahoga
- Franklin
- Hamilton
- Lucas
- Montgomery
- Summit

Rural

- Ashland
- Champaign, Logan
- Crawford, Marion
- Defiance, Fulton, Henry, Williams
- Erie, Ottawa
- Hancock
- Huron
- Mercer, Paulding, Van Wert
- Preble
- Putnam
- Sandusky, Seneca, Wyandot

Appendix B. Terms and Definitions

TERMS AND DEFINITIONS

This section contains terms and definitions for suicide prevention efforts contained in the surveys. Many of the terms and definitions are followed by the web site where you can read more information.

Attached Based Family Therapy (ABFT) Treatment for adolescents ages 12-18 that is designed to treat clinically diagnosed major depressive disorder, address suicidal ideation, and reduce dispositional anxiety.

<http://www.sprc.org/bpr/section-l/attachment-based-family-therapy-abft>

ACE (Ask, Care, Escort) Soldier-specific suicide intervention skills training support package for Army-wide distribution. A four-hour training that provides soldiers with the awareness, knowledge, and skills to intervene with individuals at risk for suicide. www.army.mil

AMSR (Assessing and Managing Suicide Risk) A one-day workshop for health professionals to help them assess suicide risk, plan treatment, and manage the care of at-risk clients. <http://www.intheforefront.org/event/amsr-training-nasw>

Awareness Campaign Comprehensive effort that includes multiple components (messaging, grassroots outreach, media relations, government affairs, budget, etc.) to help reach a specific goal.

CALM (Counseling on Access to Lethal Means) A course that offers information to counselors about assessing the probability of whether individuals at risk of suicide has access to a firearm or other lethal means and working with the individuals at risk of suicide and their families and support systems to limit their access until suicide feelings abate. (Harvard) <https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/>

CAMS (Collaborative Assessment and Management of Suicidality) A therapeutic framework for suicide-specific assessment and treatment of a patient's suicidal risk.

www.dcoe.mil/.../Navigation/Documents/SPC2012/2012SPC-Jobes-CAMS.pdf

CARE (Care, Assess, Respond, Empower) Therapy sessions that combine a computer assisted risk assessment with motivational counseling and connects the individual at risk of suicide with a case manager.

www.caresprevention.org

CAST (Coping and Support Training) School-based small group counseling program for at-risk youth that has demonstrated decreased suicide risk factors among other positive outcomes in adolescents.

www.sprc.org/bpr/section-l/cast-coping-and-support-training

CBT (Cognitive Behavior Therapy) Psychotherapeutic treatment that helps individuals at risk of suicide to understand their thoughts and feelings that influence suicide behaviors.

<http://psychology.about.com/od/psychotherapy/a/cbt.htm> and www.nimh.nih.gov

Columbia-Suicide Severity Rating Scale (C-SSRS) Assessment tool that identifies an individual's risk of suicide; was developed by Dr. Kelly Posner for the Federal Drug Administration and is available in 114 country-specific languages. <http://cssrs.columbia.edu/>

Community Capacity "Combined influence of a community's commitment, resources, and skills that can be deployed to build on community strengths and address community problems" (Mayer, 1995).

Community Needs Assessment Examination of services, policies, and systems within a given area to observe the effectiveness of current plans and pinpoint areas of improvement (CDC, 2013).

Connect Program Curriculum that includes ways to identify suicide warning signs and intervene with a person at risk with focuses on the community as a whole and ways to work across systems to build a safety net.
www.theconnectprogram.org

Crisis Hot Line Crisis lines that often serve as the first point of contact for individuals seeking help, support, and information with staff and volunteers typically available 24 hours a day, seven days a week.
<http://www.crisiscallcenter.org/>

Crisis Text Line Crisis intervention through the use of short messaging services
<http://www.crisistextline.org/textline/>

Crisis Warm Line Telephone services staffed by people with psychiatric disabilities offering support to peers. These lines are not crisis lines and the hours of operation may vary.
<http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335188>

DBT (Dialectical Behavior Therapy) Cognitive behavioral treatment originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder. mindfulnesstherapy.org/dbt

Efforts: Any programs, activities, or services in the community that address suicide and suicide prevention.

Evidence Based Programs: (EBP) Principles applied to decision making concerning interventions intended to improve or ameliorate the social or clinical problems of affected individuals (Prendergast, 2011).
www.sprc.org/bpr/section-i-evidence-based-programs

Gatekeeper Training Commonly used suicide prevention training targeted to individuals that are in a position to recognize a crisis and the warning signs that someone may be contemplating suicide.
<http://www.sprc.org/programmatic-issues/prevention-strategies/gatekeeper-training>

Kognito At-Risk for College Students Peer support suicide prevention online training simulation for being used by colleges to identify students who are at risk for suicide, motivate distressed students to seek help, and put students in touch with support services. <https://www.kognito.com/products/highered>

Kognito At-Risk for High School Educators One-hour evidence-based, online, interactive professional development program that uses role-play to help high school faculty, staff, and administrators learn common signs of psychological distress and suicidal ideation. <http://store.kognito.com/products/at-risk-for-high-school-educators>

Kognito Family of Heroes Post Traumatic Stress Disorder & resiliency training simulation for military families developed in collaboration with the Veteran Affairs of NY/NJ <https://www.kognito.com/news/?tag=family-of-heroes>

LEADS Program (Linking Education and Awareness of Depression and Suicide) Opportunities for students in grades 9-12 to have conversations within the classroom around suicide and depression and the stigma surrounding suicide. www.save.org/index.cfm?fuseaction=home.viewPage&page_id=45DFBB66-7

LOSS Teams provide immediate support and resources, as well as an installation of hope, to survivors as close to the time of their loss as possible.
http://www.mhatc.org/index.php?option=com_content&view=article&id=48&Itemid=48

Man Therapy Web-based tool to help men with their mental health issues mantherapy.org

Mental Health First Aid Public education program to help the public identify, understand, and respond to signs of mental illnesses and substance use disorders. The program includes a 5 step action plan.
www.mentalhealthfirstaid.org/cs/category/suicide-prevention

MST (Multisystemic Therapy) Intensive family- and community-based treatment program that focuses on addressing all environmental systems that affect chronic and violent juvenile offenders, their homes and families, schools and teachers, neighborhoods. <http://mstservices.com/>

Peer Support Services System of giving and receiving help founded on principles of respect, shared responsibility, and mutual agreement of what is helpful by focusing on another's situation through the shared experience of emotional and psychological pain. (SPRC) www.sprc.org/directorsblog/advancing-peer-support-suicide-prevention
www.intentionalpeersupport.org

Post Cards List of warning signs for suicide risk and statement that urges individuals who exhibit any sign of suicide risk to contact a behavioral health professional or call the suicide prevention hotline.
store.samhsa.gov/product/National-Suicide-Prevention-Lifeline

Postvention Provision of systematic crisis intervention, support, and assistance for those affected by a completed suicide and to minimize contagion. <http://www.sprc.org>

Principles of Effective Suicide Care Expectations of individuals at risk for suicide who seek help from a behavioral health professional to receive care that is research informed, collaborative, and focused explicitly on suicide risk.
safesupportivelearning.ed.gov/events/webinar/principles-effective.

QPR (Question, Persuade, Refer) Trained to teach people ways to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. www.qprinstitute.com

RRSR-PC (Recognizing and Responding to Suicide Risk) One-hour training program providing physicians, nurses/nurse practitioners, and physicians assistants with knowledge to integrate suicide risk assessments into routine office visits and work collaboratively with patients to create treatment plans. www.sprc.org/bpr/section-III/recognizing-and-responding-suicide

Respite Care Provision of a short-term accommodation outside of the home.

Substance Abuse and Mental Health Services Administration (SAMHSA) Suicide Mobile APP Suicide prevention application for mobile devices to help providers integrate suicide prevention strategies into practice and address client suicide risk. <http://store.samhsa.gov/apps/suicidesafe/>

SBQ-R (Suicide Behavior Questionnaire Revised) Psychological self-report questionnaire designed to identify risk factors for suicide in children and adolescents between ages 13 and 18.
www.integration.samhsa.gov/images/res/SBQ.pdf

Safe-T Training (Suicide Assessment Five-step Evaluation and Triage) pocket card for mental health and health care professionals, provides protocols used for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, and developing treatment plans. www.sprc.org/bpr/section-III/suicide-assessment-five-step.

SOS (Signs of Suicide) School-based curriculum and screening program that has demonstrated decreased suicide attempts, among other positive outcomes, in adolescents. www.sprc.org/bpr/section-I/sos-signs-suicide

Sources of Strength Youth suicide prevention project designed to harnesses the power of peer social networks to change unhealthy norms and culture, ultimately preventing suicide, bullying, and substance abuse and to promote help seeking. <https://sourcesofstrength.org>

SPARK Talks (Short, Provocative, Action-oriented, Realistic, and Knowledgeable) Videos of leaders who are in the suicide prevention movement and who each describe a new development or direction in the field.
<https://sparkstalk.com>

Stigma Negative stereotype or discrimination due to a distinguishing characteristic or personal trait that is considered to be, or actually is, a disadvantage . <http://www.mayoclinic.org/>

Stigma Reduction Activities designed to support those who plan to mount a statewide, regional, or local effort to address and counter stigma and discrimination.

http://www.sprc.org/library_resources/items/developing-stigma-reduction-initiative

Suicide Assessment Comprehensive examination given to assess the risk of suicide, determine level of lethality, and compose a treatment plan for a patient (Suicide Prevention Resource Center, 2014).

Suicide Coalition Allied group to pursuing coordinated strategies to educate and increase public awareness that suicide is a public health problem and to reduce stigma. www.ohiospf.org

Suicide Prevention Collective efforts of local citizen organizations, behavioral health organization, and related professionals to reduce the incidence of suicide and include awareness campaigns, suicide prevention programs, crisis services, screening, assessments, safety planning to reduce lethal harm, treatment services, follow up services, and postvention services.

Suicide Prevention in Juvenile Correctional Facilities A two-part webinar series sponsored by the Suicide Prevention Resource Center and the Council of Juvenile Correctional Administrators about youth with contact to the juvenile justice system.

Suicide Screening Tools used to provide a preliminary assessment of an individual's risk of suicide (Suicide Prevention Resource Center, 2014).

Suicide Support Group Support groups that offer structured ongoing series of meetings among people who share common problems and who give advice, encouragement, information, and emotional substance. (The Social Work Dictionary, 2003).

United States Air Force Suicide Prevention Program Military program designed to help prevent and reduce suicides for active duty Air Force members. www.af.mil/SuicidePrevention.aspx

Zero Suicide Academy™ Two-day training for senior leaders of health and behavioral health care organizations seeking to dramatically reduce suicides among patients. Participants learn how to incorporate best and promising practices into their organizations and processes to improve care and safety for individuals at risk. (Zero Suicide Academy™) <http://zerosuicide.sprc.org/zero-suicide-academy#sthash.d8YQLSSq.dpuf>