Montana
Office of Public Instruction
Denise Juneau, State Superintendent

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Montana School-Based Crisis Intervention Project

In 2014, the Montana Office of Public Instruction (OPI) began the process of developing systematic, school-based crisis intervention policies and procedures across three demonstration sites (Bitterroot Valley Education Cooperative, Praireview Education Cooperative, Fort Peck Indian Reservation) with the intent to support local school districts (e.g., technical assistance, web-based resources) in their efforts to develop, scale up and sustain protocols of their own across Montana. The Project would not have been possible without the capable assistance and expertise of the following individuals and agencies.

Montana Office of Public Instruction Administrative Staff

Madalyn Quinlan – Chief of Staff
Deb Halliday – Policy Advisor
Erin Butts – School Mental Health Coordinator
Susan Bailey Anderson – Professional Development Unit Manager
Steve York – Assistant Superintendent
Frank Podobnik – Special Education Division Administrator
Tracy Moseman – Coordinated School Health
Karin Billings – Administrator, Health Enhancement & Safety Division
Mandy Smoker Broaddus – Director of Indian Education
Don Wetzel, Jr. – American Indian Youth Development Coordinator
Susan Court – Youth Risk Behavior Survey Profiles and Health Enhancement Programs

Fort Peck Indian Reservation

Stephanie Iron Shooter – Montana Office of Public Instruction
Karla Two Two – Montana Office of Public Instruction
Courage Crawford – Youth Probation
Dennis Four Bear – Fort Peck Tribal Health
Dale Four Bear – Spotted Bull Treatment Center
Roxanne Gourneau – Tribal Councilwomen
Dale DeCoteau – Health Promotion Disease Prevention (HPDP)
Ernie Bighorn – Fort Peck Site Coordinator, MT Rocky Mountain Tribal Leaders Council, Tribal Prevention Initiative

Bitterroot Valley Education Cooperative

Steven Zieglowsky – Implementation Coach
Tim Miller – Director
Chris Hughes – Assistant Director

Praireview Education Cooperative

Linda Farber – Implementation Coach
Debra Linn – Coordinator

Final Report: OPI School-Based Crisis Intervention Project

Kurt D. Michael, Ph.D., JP Jameson, Ph.D.

I. EXECUTIVE SUMMARY

The issue of youth suicide is a significant public health problem in the State of Montana. Recent estimates from the CDC suggest the prevalence of completed suicides in Montana is among the highest in the United States. The rates within Montana are even higher in the more remote and underserved areas of the State. There are also data to suggest that the problem begins early in life and is correlated with a number of risk variables including: undetected or untreated depression, family conflict, limited access to health care, substance abuse, and economic problems. In 2014, given the prevalence and significance of suicide and the associated risk variables, the Montana Office of Public Instruction (OPI) endeavored to address this public health problem in a context where many of these issues first become evident, in the Montana public schools. The primary aim of the Project is to begin the process of developing systematic crisis intervention policies and procedures across three demonstration sites (Bitterroot Valley Education Cooperative, Praireview Education Cooperative, Fort Peck Indian Reservation) with the potential of supporting school districts (e.g., technical assistance, web-based resources) in their efforts to develop, scale up and sustain protocols of their own across Montana. It is the hope of OPI administrators that by helping to demonstrate the value and feasibility of systematic crisis intervention protocols where the majority of youth and families interface with fellow citizens and community agencies on a daily basis, these strategies will reduce and/or prevent youth suicide through early identification and appropriate referrals for effective intervention. The results of this demonstration project, albeit preliminary, suggest that crisis intervention protocols can be implemented effectively into communities when local champions are identified to lead the effort, protocols are adapted to reflect the strengths and needs of the community, and adequate time and resources are dedicated to support ongoing implementation and sustainability.

II. BACKGROUND

Between 1986 and 2000, the overall suicide rate in the U.S. declined from 12.5 to 10.4 suicides per 100,000 persons in the population. Since then however, the rates have gradually climbed back up to 12.6 suicide deaths per 100,000 persons in 2013 (Xu, Murphy, & Kochanek, in press). This translates to one suicide every 13 minutes, 111 suicides per day, 3,429 per month, and a total of 41,149 completed suicides for the year. The suicide rates are almost twice as high in many rural regions in the U.S., especially in Alaska and the Rocky Mountain West (e.g., Montana, Utah, Wyoming, New Mexico, and Colorado). Moreover, the rural-urban discrepancies in suicide rates have worsened over time (Fontanella et al., 2015).

Specifically for rural youth, Singh, Azuine, Siahpush, and Kogan (2013) reported that youth in the most rural areas of the country exhibited suicide mortality rates 84% higher than youth in highly urban areas after controlling for socioeconomic factors. Similarly, Fontanella and colleagues (2015) analyzed the longitudinal trends of those aged 10-24 years who completed suicide between 1996 and 2010 and reported that the rates for those in rural settings were almost double the rate of individuals living in urbanized regions.

Despite the sobering evidence that suicide is a major public health problem without signs of abatement, especially in rural settings, efforts to stem the tide have been limited either in scope or effectiveness (Fontanella et al., 2015; Hirsch et al., 2006). These disappointing results are, in part, explained by a number of barriers that preclude treatment seeking in rural settings, including lack of access to qualified providers, economic and transportation limitations, and stigma (Hirsch & Cukrowicz, 2014). However, there have been several innovations in recent years that have been designed to provide better access to behavioral health care

in rural settings, such as integrated primary care (Evans, Polaha, Valleley, Jones-Hazeldine, & Foster, 2006) and school mental health (SMH; Michael, Renkert, Wandler, & Stamey, 2009). Consequently, these paradigms are well positioned to respond to this persisting public health crisis.

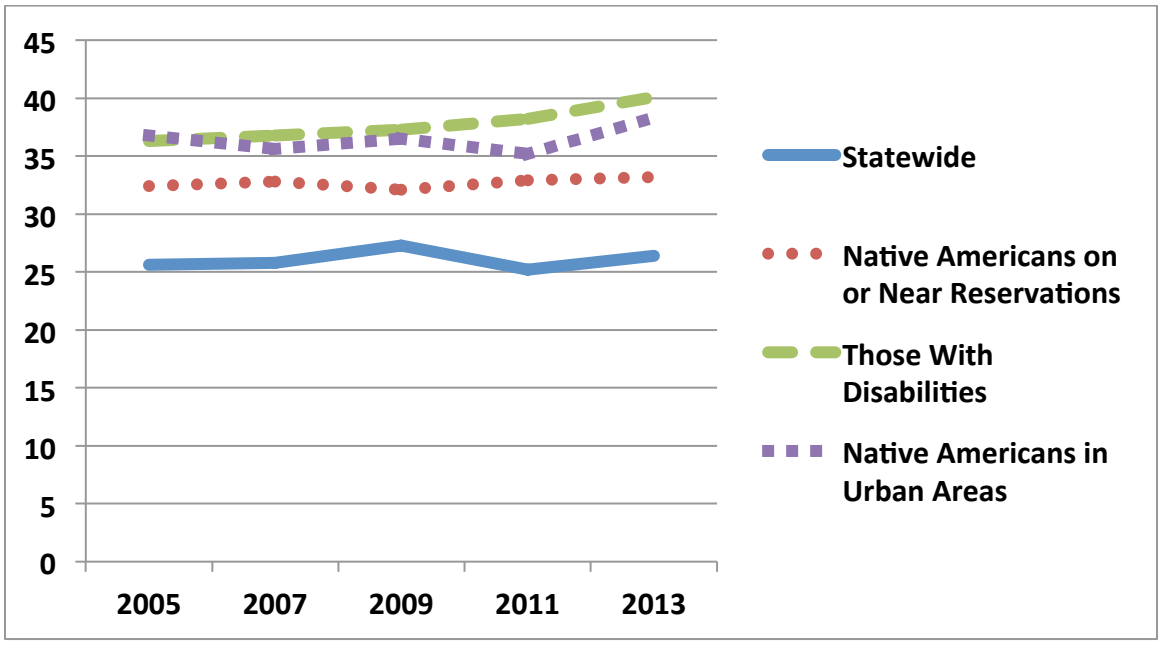
III. THE SUICIDE PROBLEM IN MONTANA

Based on the most recent data available from the Centers for Disease Control (CDC) on the problem of suicide in the United States during 2013 (Xu et al., in press), Montana had the dubious distinction of evidencing the highest suicide rate in the nation at 23.7 deaths by suicide per 100,000 population, almost double the national average. Although the rankings shift somewhat from year to year and Montana is not always the highest, the CDC has observed consistently high suicide rates for the last several years in Montana, a trend also commensurate with mainly rural and often frontier regions in the Rocky Mountain west (as described above). Based on 2013 numbers, suicide was the 6th leading cause of death in Montana overall, behind heart disease, cancer, accidents, chronic respiratory disease, and stroke.

According to 2013 CDC data, there were 243 deaths by suicide in Montana and certain groups were at a higher risk of suicide that others. For instance, although American Indians comprise 6% of the total population, they accounted for 9% of the deaths by suicide according to the most recent report from the Montana Suicide Review Team (MSRT; Montana Department of Public Health and Human Services, 2014). Further, 8 out of every 10 suicides were male and almost a quarter of the completed suicides were veterans.

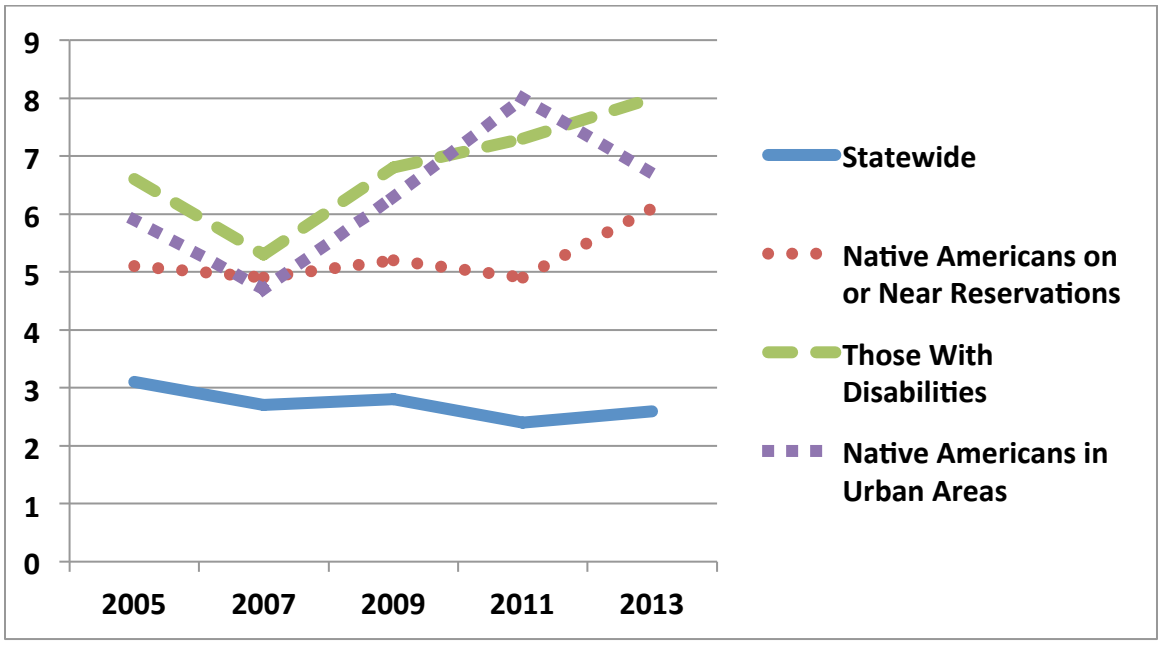
The data regarding youth suicide and suicidal behavior is equally disturbing. Since 1993, the Montana Office of Public Instruction has partnered with the CDC to regularly collect, analyze, and report Youth Risk Behavior Survey (YRBS) data from Montana youth. The data on depression, suicidal thinking, planning a suicide attempt, and self-reported suicide attempts meet and regularly exceed the national base rates for these behaviors over the last several years. Whereas the rates of reporting significant depression (i.e., feeling sad or hopeless for two weeks or more in a row) among high school students during the past year is approximately 16% nationally (United States Department of Health and Human Services [USDHHS], 2014), the state average for Montana youth is roughly 26% and it has remained at or above that level for over a decade (Montana Office of Public Instruction, 2013). The 2013 rates for "feeling sad or hopeless" were even higher among youth who had been identified as receiving special education services (40.1%) and American Indian teens (approximately 35%) in Montana. Although the national average for reporting a suicide attempt that resulted in "injury requiring treatment" within the past 12 months was 2.4% (USDHHS, 2014) and the Montana rates for this behavior were only slightly higher overall (2.6%) in 2013, membership in a particular group was associated with a substantially higher risk for a suicide attempt. For example, in 2013, approximately 8% of Montana students "with a disability" reported attempting suicide during the previous 12 months that required medical treatment, which was over 3 times the national average. Similarly, there were disproportionately higher rates of this behavior among Native Americans who lived in urban areas (6.7%) and those that lived on or near a reservation (6.1%). See Figures 1 and 2.

Figure 1. Reported Feeling Sad or Hopeless During the Past 12 Months on the 2013 Montana YRBS



Based on separate analyses conducted for the purpose of this report by the primary authors, other adolescent risk behaviors appear to interact significantly with suicide rates in Montana, particularly among Native American youth. For example, Among Montana youth that endorsed a past suicide attempt, American Indian/Alaskan Native teens were significantly more likely to endorse combined binge drinking and marijuana use than other ethnic groups, $OR = 1.57$, $p = .001$. Furthermore, American Indian/Alaskan Native youth living in urban areas were more likely to report a suicide attempt than those living off reservations, $OR = 1.32$, $p = .05$. Interestingly, although female adolescents tend to be more at risk for a suicide attempt than their male counterparts nationally, the odds of a past suicide attempt as reported on the YRBS were not significantly different between males and females ($p = .06$). Thus, these data suggest a much closer examination of the associated factors (e.g., substance abuse, gender) that might complicate or exacerbate risk of a suicide attempt. Indeed, based on the 2014 Report compiled by the MSRT, the interaction of substance use and completed suicide is significant; approximately half of those who died by suicide in Montana during 2014 tested positive for alcohol.

Figure 2. Reported a Suicide Attempt that Required Medical Treatment During the Past 12 Months on the 2013 Montana YRBS



Taken together, these findings suggest that planning and developing suicide prevention and intervention strategies in Montana demand careful consideration of multiple variables simultaneously in context. Although a suicide attempt or a completed suicide is considered the worst-case scenario, the signs of trouble (e.g., feeling depressed, socially isolated) and heightened risk (e.g., substance abuse, lack of support) are often evident well in advance of a catastrophic event. Thus, any strategy designed to prevent or reduce the chances of a suicide must account for the behavioral and contextual conditions that surround these youth. The citizens of Montana have long known that specific features in particular communities often act as barriers to effective prevention and intervention, including the circumstances in the aftermath of an unsuccessful attempt, such as untreated substance abuse in the family, chronic economic despair, unemployment, unfettered access to lethal means, and a pervasive lack of hope in the future. One of the findings that will be highlighted later in the report is the fact that the majority of Montana youth surveyed as part of this project were amenable to mental health interventions in schools. However, a common barrier to youth receiving adequate mental health care, even for those who find it acceptable, is whether such care is actually accessible (e.g., qualified providers in rural settings; possessing adequate insurance). It is also important to consider the full impact of suicide, both in scope and economic terms.

Based 2013 CDC data, the approximate number of annual hospital visits to emergency departments for intentional self-harm in the United States is 500,000. Thus, based on the total number of completed suicides in 2013, it would suggest that for every completed suicide, there are approximately twelve attempts that do not result in a fatality. However, many intentional acts of self-harm go unreported and some estimates indicate that there are well over one million acts of intentional self-harm each year in the United States (American Suicidology Association, 2003). Based on the data from the 2014 MSRT Report of completed suicides of those between 5 and 24 years old ($N = 37$), this would indicate that somewhere between 500 and

1000 young people in Montana attempted to kill themselves during 2014. These numbers are even more sobering when the economic impact of suicide is taken into account. It has been estimated that the economic cost (i.e., medical, legal, pain and suffering, lost productivity) of a single suicide is approximately two million dollars (McDaid et al., 2010). On the other hand, investing in suicide prevention and intervention can lead to significant cost savings for individuals, communities, and societies. McDaid, Park, & Bonin (2011) conducted a study in the UK and projected that a relatively modest investment (total public services equaling £19 million over 10 years) in a population-level suicide awareness training and intervention (Applied Suicide Intervention Skills Training; ASIST) and delivered through general practitioners would result in a net cost savings of over £1.27 billion dollars in the same 10 year span. Thus, the cost offset of providing effective prevention and intervention in the model is over £66 for every dollar spent. These projections are consistent with the findings that suggest providing cognitive-behavioral therapy (CBT) to patients who attempted suicide were 50% less likely to re-attempt in the 18 months after the intervention than the patients who received usual community care (Brown, Ten Have, Henriques, Xie, Hollander, & Beck, 2005). In summary, despite the persisting nature, scope and adverse implications of the problem of suicide in Montana, there is hope. Suicide prevention and intervention strategies (e.g., ASIST, CBT) have been shown to be effective, but creating and sustaining the capacity to address this major public health problem among Montana's youth on a consistent basis over time remains a significant challenge.

IV. INCREASING CAPACITY TO RESPOND VIA SCHOOL MENTAL HEALTH PARADIGMS

Providing mental health services within the school context is a sensible method of addressing some of the most pressing public health problems (e.g., suicide) in Montana. School mental health paradigms have also shown promise in reducing barriers to treatment seeking among youth, especially in rural areas (Owens, Murphy, Richerson, Girio, & Himawan, 2008; Owens, Watabe, & Michael, 2013). Advocacy organizations such as the North Carolina Youth Suicide Prevention Task Force, a group supported by the North Carolina Institute of Medicine (NCIOM), have recommended that school mental health (SMH) programs lead some of the broad-based suicide prevention efforts (NCIOM, 2012). However, most of the prevention programs are educational in nature (i.e., *universal*) and are not equipped to provide *selected* or *indicated* interventions to students who have been identified as exhibiting a risk of suicide (see Cooper, Clements, & Holt, 2011 for a review). Prevention programs such as gatekeeper training have been shown to improve knowledge, attitudes, and skills, but effects on suicide rates are largely unknown (Isaac et al., 2009; Katz et al. 2013). Further, existing practice parameters for responding to suicide threat (e.g., American Academy of Child and Adolescent Psychiatry, 2001) do not include specific recommendations for implementing crisis response protocols in school settings, and few studies have examined interventions that consider suicidal intent (de Silva, Parker, Purcell, Callahan, Liu, & Hetrick, 2013). Based on a systematic review of programs aimed at responding to suicidal youth, Robinson and colleagues (2013) reported that the evidence for indicated interventions is limited and cautioned against using such approaches in non-clinical settings. However, in light of the fact that many SMH paradigms effectively function as clinical settings within the context of schools, they are amenable to the inclusion of indicated interventions as part of a comprehensive suicide prevention strategy.

One such example of a clinical model in schools is the Assessment, Support, & Counseling (ASC) Center, a comprehensive SMH program operated through a university-community partnership in rural western North Carolina. The original program was developed in one local school district approximately 10 years ago by licensed clinicians employed by a local university in conjunction with professional school staff (e.g., administrators, professional school counselors, teachers) to provide mental health services in the place where adolescents can most easily access them. Since the initial partnership, ASC Centers have been implemented in two additional districts. Each ASC Center site has been tailored to address the specific needs of the

community where it exists, but the menu of services is broad and includes assessment, individual and group therapy, behavioral consultation, professional development/training, outreach, risk behavior surveillance, mental health education for students, and crisis intervention. The ASC Model operates across primary, secondary, and tertiary levels of prevention, intervention, and postvention. In the school setting, this tiered model is often referred to as Multi-Tiered Systems of Support (MTSS) and has been found to be a feasible model to implement in the context of public schools (Sulkowski & Michael, 2014). The MTSS model affords opportunities for prevention and intervention across the spectrum of needs that often emerge in rural districts. For instance, ASC staff members have gone into all classrooms shortly after a student death to not only to offer crisis intervention and support, but also to provide up-to-date and tangible methods for students to get involved with helping to support each other and to prevent future events, including the potential for contagion (e.g., entering crisis hotline number directly into phones, increased surveillance for those at risk, increasing mental health literacy, breaking down the code of silence). In addition, a crisis intervention website was established to support the youth living in rural western North Carolina (www.highcountryhelp.com).

Referrals to the ASC Center are made predominantly by professional school counselors and administrators when it has been determined that the mental health needs of the student exceed the school's capacity to address them adequately in the context of staff's existing professional roles. Over the last several years, well over half of the referrals to the ASC Center have been related to internalizing problems (i.e., depression, anxiety, non-suicidal self-injury, suicidal ideation, and suicidal intent). The benefits of the ASC Center have been documented in the literature, both in terms of significant reductions in psychological distress after a course of cognitive-behavioral therapy (Albright, et al., 2013) and a modest impact on academic outcomes (Michael et al., 2013).

The establishment of a new school partnership in the region in 2012 raised unique challenges to the ASC Center model because of the high volume of crisis incidents encountered by the local school staff. Moreover, the results from Youth Risk Behavior Survey (YRBS) of the high school student body that found self-report rates of suicide attempts to be significantly higher than state and national averages (Kirk et al., 2014). Out of necessity to respond to this community public health problem, ASC Center clinicians and school staff collaborated to develop a systematic and repeatable set of procedures to respond appropriately and expeditiously to a high number of youth who present with a risk of violence to self or others. Thus, during the 2012-13 academic year, the Prevention of Escalating Adolescent Crisis Events (PEACE) protocol was developed and first implemented (Sale, Michael, Egan, Stevens, & Massey, 2014). The purpose of the PEACE protocol was to ensure thorough and systematic evaluation of risk for suicide, homicide, or non-suicidal self-injury for self-referred, peer-referred, or school personnel-referred students. It was developed to guide decision making for treatment, safety planning, and referral based upon level of risk. The PEACE protocol facilitated this process by providing ASC Center staff and school personnel with clear roles, a systematic set of response procedures, and a common language (i.e., color coded levels of risk) to assess and intervene with at-risk youth. During the first year of implementation, PEACE was utilized 33 separate times across 20 individuals (2% base rate for the school population). Each instance resulted in a successful de-escalation of the crisis and often a referral to a higher level of care (e.g., hospitalization), outpatient treatment, or an increased dosage or revision to the current psychotherapeutic treatment (Sale et al., 2014). In addition to this published study, on-going evaluations of the PEACE protocol from subsequent years have been published in peer-reviewed scientific journals (2013-14; Michael, Jameson et al., 2015) or are in preparation (2014-15; Michael, Jameson et al.). The results reported in these studies are roughly commensurate with the results from Sale et al., 2014 even though the number of students assessed with the PEACE Protocol has varied over time (4% base rate in 2013-14; 3% base rate in 2014-15).

V. GOALS OF THE OPI CRISIS INTERVENTION PROJECT

As described above, the primary aim of the OPI Crisis Intervention Project was to begin the process of developing systematic crisis intervention policies and procedures across three demonstration sites including: 1) the Bitterroot Valley Education Cooperative; 2) the Praireview Education Cooperative and 3) the Fort Peck Indian Reservation. The PEACE protocol was conceptualized as only one example of how schools might consider adapting systems, procedures, and policies to best fit the needs of the local culture and the resources that already existed within the aforementioned communities and districts. The main expenditures for the Project were the hiring of an external consultant, recruiting and hiring three site-based implementation coaches (1.6 FTE's across 3 sites), and the utilization of a current OPI professional's time and expertise in school mental health. The following four specific goals were established:

1. Educate OPI professionals and stakeholders across three identified demonstration sites in Montana on existing protocols for identifying and intervening with youth at risk for suicide;

2. Help OPI professionals assess readiness for potential adoption of modified protocols across the three identified demonstration sites;

3. Assist OPI and demonstration site professionals prepare and potentially implement the salient elements of the modified protocols, depending existing community infrastructure and sufficient buy-in from local opinion leaders and champions in support of implementation; and

4. Depending on the extent of successful implementation of salient elements, help OPI professionals set up appropriate evaluation protocols and opportunities for broader dissemination and sustainability across the State of Montana.

VI. ASSESSMENT OF PROGRESS TOWARDS GOALS

The initial accomplishment of the Project was the identification of three demonstration sites willing to engage the difficult issue of youth suicide in Montana, followed by the hiring of qualified implementation coaches in the Bitterroot Valley and Praireview Education Cooperatives. These accomplishments were not minor and required the on-going support and vision of skilled administrators across sites. Although the Fort Peck Indian Reservation was not successful in hiring an implementation coach during the grant period, several important meetings with key existing stakeholders (including members of the Tribal Executive Board and professionals from OPI) took place over the course of the project and ultimately culminated with the creation of the Fort Peck Tribal Crisis Protocol (an adapted version of the PEACE protocol; see Appendices). Several exemplars of broad outcomes related to goals 1-4 across sites are outlined below.

Goal 1: *Educate OPI professionals and stakeholders across three identified demonstration sites in Montana on existing protocols for identifying and intervening with youth at risk for suicide.*

- Community stakeholders, school district personnel, implementation coaches, and administrators convened multiple times, in multiple configurations, across sites to highlight community assets, share local data, and to identify gaps in service in order to address the problem of youth suicide in Montana.

- Using information gleaned from these meetings, action plans were developed and executed by implementation coaches and key constituents to strengthen existing linkages between schools and communities, administrators and mental health providers, professionals, families, consumers, and systems of care.

Goal 2: *Help OPI professionals assess readiness for potential adoption of modified protocols across the three identified demonstration sites.*

- It was determined by OPI staff that tremendous variability in readiness for potential adoption of modified crisis protocols existed across sites and that no single crisis intervention protocol was sufficient to accommodate the diversity of cultures or existing resources. Consequently, the development plan for each demonstration site was revised in accordance with the existing assets and challenges of each location.

- There were examples across the sites where the mental health resources were so scarce and underdeveloped, that any discussion of a specific crisis intervention protocol in schools was entirely premature. As a result, efforts in these sites were re-directed to raising community awareness, developing initial relationships to foster evolving school mental health partnerships.

- Moreover, implementation coaches were successful in administering youth perception surveys. In two of the demonstration sites, student surveys revealed that the vast majority (>85%) of youth perceived that receiving mental health services was "acceptable," a finding that contradicts previous assumptions suggesting that most young people would not be amenable to mental health intervention due to stigma or other perceptual barriers.

- Equally important findings from the perceptual surveys included 1) a student preference to reach out to peers or family for support versus professionals as an initial step in help-seeking; 2) a majority belief that the community had <u>inadequate</u> mental health resources; and 3) a common perception that it was <u>not okay</u> to keep a secret about a peer's potential suicide threat.

Goal 3: *Assist OPI and demonstration site professionals prepare and potentially implement the salient elements of the modified protocols, depending existing community infrastructure and sufficient buy-in from local opinion leaders and champions in support of implementation*

- Across all three sites, community champions were identified and each had some amount of protected time to further raise community awareness, develop linkages, create user-friend mental health resources for community consumption, and otherwise increase the capacity of the Montana public schools to address the problem of youth suicide. For example, some of the work products produced by the implementation coach in the Bitterroot Valley Education Cooperative included several excellent web-based resources for community constituents, including families, schools, and local mental health providers (http://www.bvec-mt.org/).

- Other accomplishments were less obvious at first blush, but certainly no less significant. For example, in the Praireview Education Cooperative, there were successes in helping to develop buy-in and awareness about the value and impact of conducting broad surveillance and providing mental health intervention with the context of rural schools. Consequently, these early efforts led to some implementation successes (i.e., delivery of direct services) in select schools with plans to continue the following school year. In addition, the schools in the Praireview Education Cooperative were amenable to reviewing district policies and procedures at the beginning of the 2015-16 year.

Goal 4: *Depending on the extent of successful implementation of salient elements, help OPI professionals set up appropriate evaluation protocols and opportunities for broader dissemination and sustainability across the State of Montana.*

- Given the existing assets and infrastructure across sites, several tangible products were developed. In two of the sites, modified PEACE protocols were created. In the Bitterroot Valley Education Cooperative, a 3-level assessment algorithm was created to promote a consistent and repeatable set of procedures across people and sites. It resembled PEACE, but was adapted to fit within the available resources in the Bitterroot Valley.

- Equally impressive, in collaboration with OPI staff, the Fort Peck Tribal Executive Board developed the *Assiniboine and Sioux Tribes Crisis Response Protocol*. This contribution was the result of many meetings with community members who possessed a broad range of skills and who had the local knowledge and culturally specific expertise to tailor the existing protocol into a product reflective of community strengths and needs. Refer to Appendices.

- At the conclusion of the Project, a series of interviews were conducted with key stakeholders across sites to evaluate the results and to assess the potential for further development and sustainability of the Project's aims. After a careful analysis of the findings, there were a number of *lessons learned* over the course of the Project as it pertains to development, scaling up, sustainability, and broader dissemination. The *lessons learned* are outlined below.

VII. LESSONS LEARNED

1. Capacity to develop crisis intervention protocols in Montana schools.

    a. Initiatives gained traction where local program champions were identified. At each site, one or more identified leaders championed suicide crisis response as a critical issue and facilitated communication among local stakeholders. Equally important, the champions had protected time within their job role to function as a champion.

        i. Capacity building should include local champions.
        ii. Local champions may be drawn from local school districts, community mental health agencies, and/or tribal organizations.

    b. Activities varied by district depending on perceptions of local strengths and local needs, and effective crisis response protocols should be developed to reflect these community strengths and needs.

        i. The definition of crisis itself varied by district.

            1. Direct threat of suicidal harm vs. very high risk for harm of various types (e.g., domestic violence, dangerous substance use).
            2. Definitional differences were driven by discussions between local champions and stakeholders and consideration of community risk factors.

        ii. Local champions should inform need.

            1. Local champions are well positioned to identify and mobilize existing resources.
            2. Local champions are typically aware of existing service gaps that may be addressed with additional crisis response resources.

    c. Implementation of crisis protocols was most successful when local stakeholders had dedicated time to invest in the development and implementation of crisis protocols.

        i. Building relationships with other stakeholders, developing policies and procedures that fit both the needs and resources of the community, training staff to utilize protocols.

2. Considerations for the dissemination & sustainability of crisis intervention protocols.

        i. Stakeholders reported three barriers to sustainability:

            1. Without adequate funding, including frontloaded investment in time, permanent lines (FTEs), money, and collateral resources, any initiative no matter how compelling, will not succeed.
            2. Implementation coaches would be given additional responsibilities that would compete with time necessary to train additional staff to implement the protocol.
            3. School staff would no longer utilize the protocol without ongoing local leadership.

VIII. FINAL RECOMMENDATIONS

1. Conceptualize the OPI Crisis Intervention Project as a solid beginning and foundation for future endeavors in addressing youth suicide in Montana.

2. Infuse the project with additional funds and human resources.

3. Emphasize the identification of local community champions.

4. Emphasize the value of youth perception and youth voice into crisis intervention programming.

5. Include youth in all aspects of prevention, intervention, and postvention, including increased surveillance, instruction on tangible methods of providing peer support and referral, and the prevention of potential contagion effects.

6. Devote assets to further develop and promote tangible resources across the state (e.g., Bitterroot website).

7. Promote the *Assiniboine and Sioux Tribes Crisis Response Protocol* as the model for other sites as the initial step towards scaling up.

8. Explore additional partnerships for remote sites with limited resources (e.g., more direct service, Tele-Mental Health).

9. Explore methods of integrating services for known factors that worsen suicide risk (e.g., substance abuse, social isolation, economic hardship).

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Appendices

Figure Caption: Assiniboine & Sioux Tribes Crisis Protocol Cover Page

Assiniboine & Sioux Tribes Crisis Response Protocol

Figure Caption: Yellow Level of Risk and the Associated Features and Action Steps

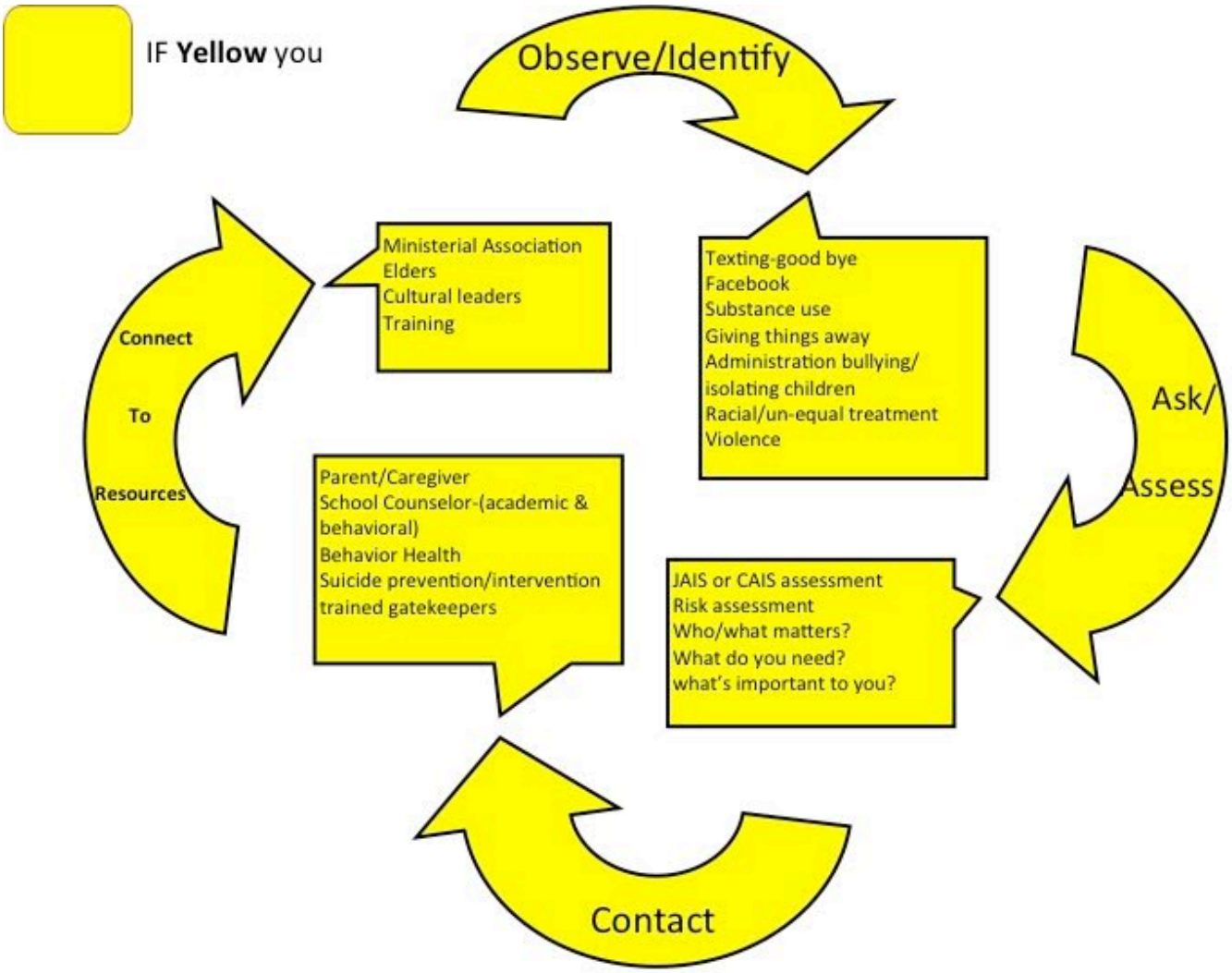

Figure Caption: Orange Level of Risk and the Associated Features and Action Steps

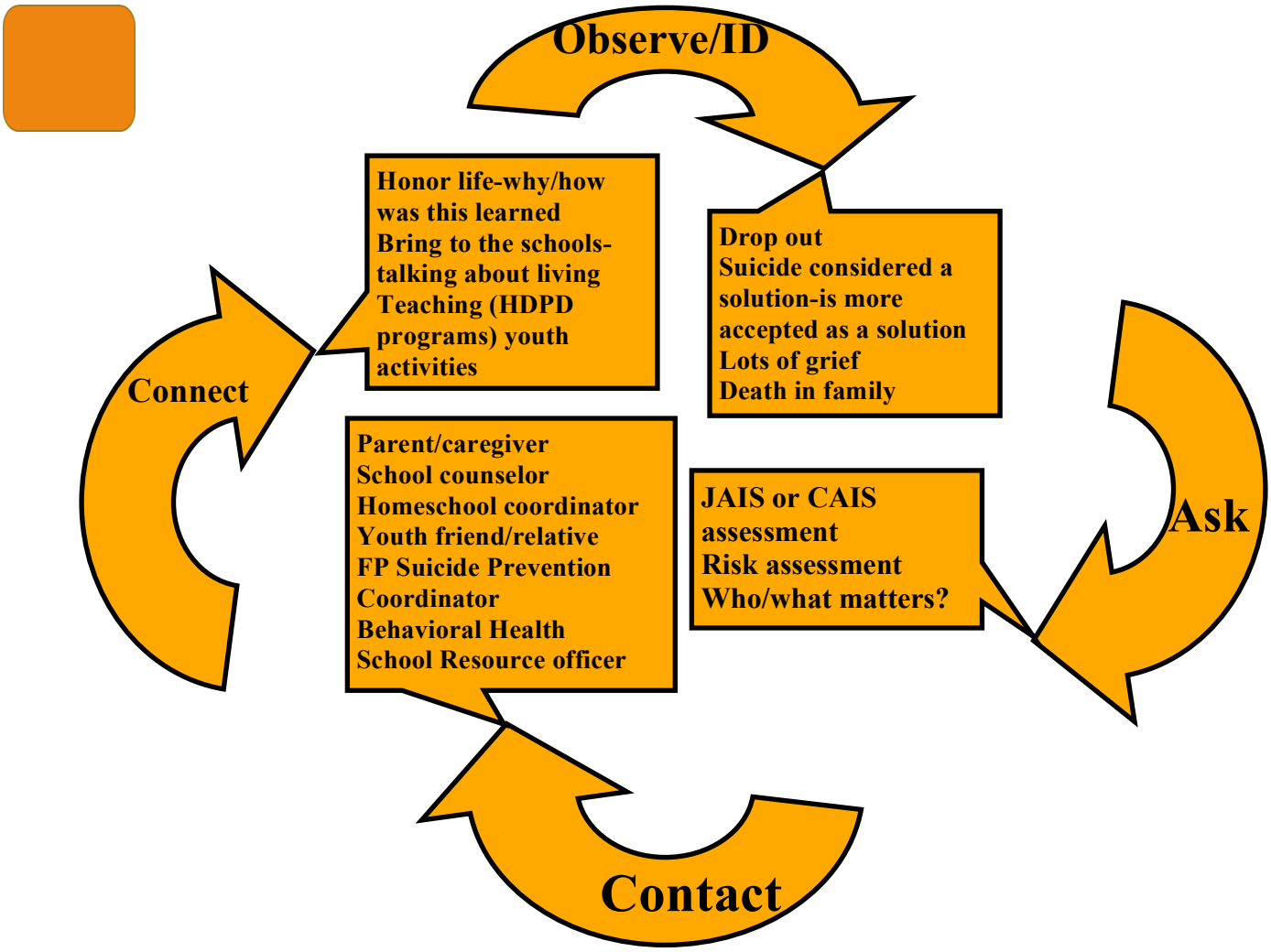

Figure Caption: Wraparound Concept as Fundamental to the Operation of Crisis Response System

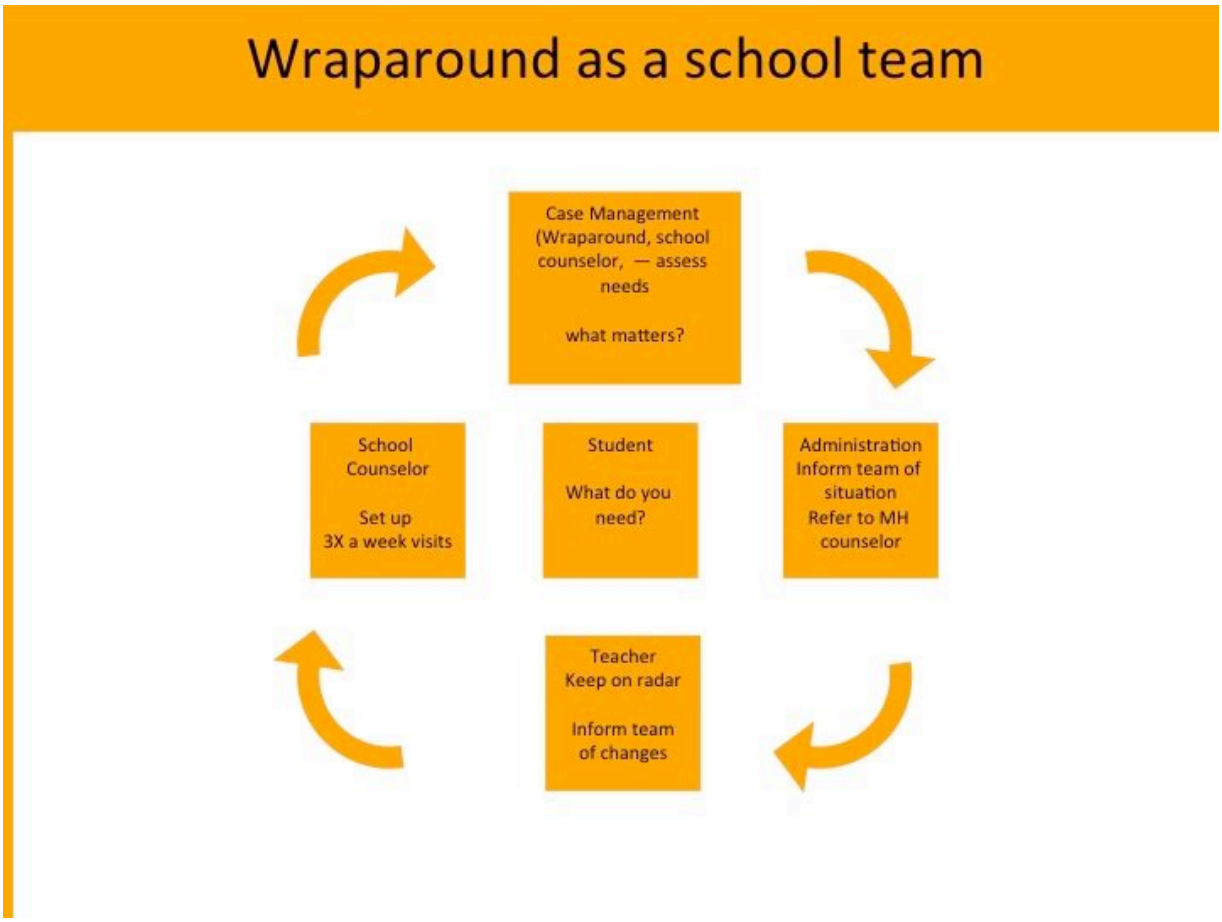

Figure Caption: Tangible Action Steps When a Youth has Been Assessed at the Orange Level of Risk