Suicide Prevention and Early Intervention Network

Garrett Lee Smith State and Tribal Suicide Prevention Grant Program

Year 1 Annual Report

Cohort 9

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Maryland Department of Health and Mental Hygiene

Behavioral Health Administration

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MD-SPIN Annual Report

General Overview:

Maryland's Suicide Prevention and Early Intervention Network (MD-SPIN) provides a continuum of suicide prevention training, resources, and technical assistance to advance the development of a comprehensive suicide prevention and early intervention service system for youth and young adults. MD-SPIN currently serves youth and young adults throughout the State of Maryland. Maryland ranks 19th in the nation in population, with 5.8 million residents, and is among the most diverse states, with minorities comprising 45.3% of the population versus 36.3% nationally. Sixty-four percent of its citizens are white, 27.9% black or African American, 4% Asian, and 0.4% Native American and Alaskan Native, with 4.3% indicating they were of Latino or Hispanic origin. Within Maryland households, 87.4% speak English only in the home, 4.7% speak Spanish, 2.7% speak Asian and Pacific Island languages, and 4.0% speak other Indo-European languages. Marylanders are 51.6% Female, 6.3% are under the age of five, 23.1% are under the age of 18, 51.8% are ages 18 to 64, and 12.5% are age 65 and older (U.S. Census Bureau). The socioeconomic and cultural status of the state is varied. For persons 25 years or older, 5.3% have an associate's degree, 18.0% have obtained a bachelor's, and 13.4% have earned a master's or professional degree, while 11% lack basic literacy skills. The median household income is $72, 419, with 9% of families falling below the poverty line. Two major populations of focus in the MD-SPIN grant are LGBTQ youth and veterans. While we do not have precise data on the LGBTQ, there are 476,202 veterans in Maryland. Fort Meade (located in Anne Arundel County) is one of the largest U.S. military bases, home to approximately 9,350 military personnel, representing all services, as well as 31,669 civilian employees. Maryland has 27,674 military-dependent students, placing it in the top ten military-impacted states.

The State of Maryland consists of many different geographical regions. There are large urban populations in Baltimore City/County, Anne Arundel County, Prince Georges County, and Montgomery County.

Programmatic Recap:

The goals for Year 1 of the MD-SPIN grant were as follows:

Training 1,574 (1,000 secondary school staff, 500 higher education staff, 24 primary care providers (PCPs), 10 ED and inpatient providers, 20 youth/young adult peers, and 20 family members) individuals in Year 1.

Kognito Training	Goal	Usage to Date

K-12	1,000	1,004
Higher Education	500	942

Kognito Gatekeeper Training Progress

K-12 Overview

Online gatekeeper training by Kognito's Training Games and Simulations for Health have been used to train educators, health, and behavioral health providers, youth peers, and families in suicide risk assessment in youth across settings. Kognito's online, self-paced, and narrative-driven simulations range from 30-60 minutes, provide organizations with high-quality, easy-access, and cost-effective solutions for training a broad and diverse audience in using engaging and effective learning tools that include practice and real-time, personalized feedback.

In January 2015, we began publicizing availability of the Kognito gatekeeper training programs. For K-12 school professionals we have the Kognito At-Risk Trainings for Elementary, Middle, and High School teachers. The Middle and High School training modules were available at the onset of the MD-SPIN program, which began September 30, 2014. The Elementary School module was uploaded to the Maryland Kognito portal March 1, 2015. The trainings are free to all Maryland teachers and other school staff such as social workers, school counselors, nurses, administrators, and volunteer staff. An internal implementation plan for the widespread dissemination plan for Kognito was created to systematically move the training throughout the State. We have partnered with the Maryland State Department of Education (MSDE) to disseminate information about the Kognito trainings to school staff in various jurisdictions. We used data from the state to target a few of the counties with higher suicide prevention rates among youth such as Montgomery County and Baltimore County. Presentations on the features and functionality of Kognito were given at professional development meetings and to student services leadership to market the program to supervisors and leaders within the local school systems. Continuing Education Units (CEUs) as well as Credits for Professional Development (CDPs) are available to any teachers, nurses, school counselors, therapists, or social workers who complete modules on the Maryland Kognito website. Additional marketing of the Kognito program took place at the Maryland 26th Annual Prevention Conference. One of the grant staff provided a workshop on Kognito and the features of the program to attendees. The conference averages around 400 attendees per year. The Kognito K-12 program is also promoted through the State's suicide prevention social media sites on Facebook and Twitter, as well as the Behavioral Health Administration's website.

The University of Maryland, School of Medicine has also received two grants that will implement Kognito; NIJ violence prevention grant, and SAMHSA Project AWARE grant are

incorporating Kognito into their implementation plans. Baltimore County (one of 24 jurisdictions in the state) is incorporating Kognito as an intervention in the NIJ violence prevention grant. Twenty schools (13 elementary schools, 5 middle schools and 2 high schools) began participating in November 2015 and during that month a total of 558 users completed training.

MD AWARE (Advancing Wellness and Resilience in Education), is also incorporating Kognito as one of many evidence-based interventions designed to enhance access to behavioral health in schools and the community, implement community and school-wide violence prevention programs, and build internal capacity for school staff to identify and address mental health issues. We are working with MD AWARE on implementation strategies for Kognito.

Higher Education Overview

Beginning April 2015, Kognito On-Campus, LGBTQ and Veteran modules were added to the Maryland Kognito portal for faculty and students. In year one, we have four colleges and universities partnering with us on the grant; Salisbury University, Coppin State University, University of Maryland Baltimore County (UMBC), and Howard Community College. Each of the institutions of higher education have marketed and promoted the Kognito gatekeeper trainings to their students, faculty, and staff. Our grant staff has worked with each institution and their counseling centers to create individualized strategies to increase the use of Kognito. The campuses have been connecting with various student and special interest groups on campus to promote the training to current students as well as incoming freshman. In year 2, we will be expanding our partnering campuses to eight including, Morgan State University, Johns Hopkins University, Towson University, and University of Maryland, Eastern Shore. Staff have been in contact with 18 additional colleges and universities to discuss Kognito implementation and will continue to follow up and provide technical assistance when appropriate.

Please note: Salisbury University usage data are not included in year one numbers as they are reporting through a Campus GLS grant.

Kognito Family of Heroes (FOH) Training

Family of Heroes is an online evidence-based resiliency & PTSD training simulation where family members learn essential skills to manage the challenges they may face in adjusting to post-deployment life. This includes managing expectations from their veteran's return, learning to identify post-deployment stress, and managing conversations with the goals of de-escalating arguments, negotiating family responsibilities, and, if needed, motivating the veteran to seek help for post-deployment stress, PTSD, or thoughts of suicide.

The MD-SPIN team have fostered relationships with other agencies working with veterans in the community to promote the *Family of Heroes* training. We have begun to collaborate with the Maryland Commitment to Veterans, which operates through the MD Department of Health and Mental Hygiene (DHMH). Regional resource coordinators provide assistance to veterans and their families to support a healthy transition to civilian life. With support from the DHMH’s Behavioral Health Administration, they provide a solid connection to wellness

services, with an emphasis on mental health and substance use disorder services. Maryland's Commitment to Veterans also has dedicated funds to provide for the coordination and facilitation of transportation for veterans to and from behavioral health appointments. We have partnered with the Director of the program and the program coordinators to assist MD-SPIN in promoting Kognito *Families of Heroes* to the various veteran groups they serve across Maryland. We have also established interest in Kognito from the Suicide Prevention Coordinator at Aberdeen Proving Grounds in Northern Maryland. We are hoping to build upon that interest in year 2 of the grant.

We have met with the Chief Psychologist at the Mental Health Clinical Center of the VA Maryland Health Care System and Director of Training to discuss implementation of the Family of Heroes module. They are considering how to implement *FOH* on Maryland military bases since there are issues with firewalls.

Emergency Department Screening Assessment and Follow-up

To build upon initial efforts toward training Maryland's Emergency Department and Inpatient providers in suicide prevention, we have worked to augment the intervention approach by implementing evidence-based: 1) screening, 2) brief interventions, and 3) follow-up in the ED at Johns Hopkins Hospital, Bayview Medical Center, and University of Maryland Medical Center. The *Ask Suicide Screening Questions (ASQ)* is a recently developed, non-proprietary instrument to screen for suicide risk during the ED triage phase with patients ages 10-21 years (Horowitz, 2012). In the development study across three pediatric EDs, the ASQ demonstrated good sensitivity and specificity when compared to the Suicide Ideation Questionnaire (SIQ) (Reynolds, 1988) for ED patients with psychiatric and non-psychiatric concerns. MD-SPIN grant staff have worked to provide trainings to ED staff on the following interventions: 1) Safety Planning (Stanley & Brown, 2012), and 2) Emergency Department Means Restriction (*evidence-based program*) (McManus et al). Drs. Wilcox, Cwik and colleagues have analyzed JHU ED screening data from the ASQ which demonstrated feasibility for use in the pediatric emergency department. The Johns Hopkins Hospital has adopted the ASQ screening tool and is doing screening and assessment of youth who are brought into the ED with a chief complaint of psychological distress. The pediatric ED director at Johns Hopkins Hospital has agreed to make the ASQ a universal screening tool, with implementation of that effort taking place in year 2. University of Maryland Medical Center (UMD) has implemented the ASQ for patients with a chief psychological complaint as of July 2015. UMD ED staff has participated in means restriction and safety planning trainings provided my MD-SPIN staff. There have been discussions with another local hospital, Franklin Square, on using the ASQ screening tool at their hospital. An agreement to use the ASQ was not reached as of the end of Year 1.

Education and Training of Youth/Young Adult Peers and Family Members

Through the Maryland Coalition of Families (MCF), a peer and family support and advocacy organization, Peer Outreach staff who have lived mental health experience, outreach to caregivers and youth/young adult peers to promote education and training regarding suicide prevention. Family members participate in workshops on crisis response and suicide prevention, Youth Mental Health First Aid, and Yellow Ribbon Suicide Prevention trainings. A total of 35 family members received training through these efforts during Year 1.

In addition, staff conduct advocacy and outreach through various activities including exhibits at the Maryland Suicide Prevention Conference (400 attendees at the conference), Suicide Awareness Walk (42 team members in Harford County, the Eastern Shore and Washington County participated), and suicide awareness vigilas in 12 counties across the state.

MCF also distributes suicide prevention information and materials through the following events and mechanisms:

Event	Target Group	Type and Number of Materials Distributed
School Fairs and Community Events	Family Members	MD Crisis Hotline Materials 400 "After an Attempt" Brochures 150
	Cecil County (for new family members encountered)	Suicide Awareness packets 40
	Youth	National Youth Crisis Hotline Materials 300

Taking Flight website (http://www.taking-flight.org/ – *Taking Flight* is a council of young adult leaders (aged 16 to 26) working to empower young adults as they prepare for independent lives, facilitate system collboration, promote acceptance and education, and reduce stigma in areas including mental health, LGBTQ, and foster care.group for teens and young adults with lived mental health experience. During *Taking Flight's* statewide Leadership Retreat in June and events in May during the 2015 Children's Mental Health Awareness Week campaign, MCF'S Youth Engagement Supervisory shared his experiences with Kognito training and provided information about how to access Kognito training for those interested.

Partnerships with State and local agencies

Collaboration with Core Service Agencies and Schools

Initial talks have begun between increased suicide prevention trainings and resources for the MD Core Service Agencies (CSAs), as well as the Local Addiction Authorities (LAAs). The CSAs in Maryland are the local Mental Health Authorities responsible for planning, managing, and

monitoring public mental health services at the county level. There is a Core Service Agency to be of assistance in every county in the state and in Baltimore City. Each of Maryland's twenty-four jurisdictions has a "Local addictions authority" which is the designated county or multicounty authority that is responsible for planning, managing, and monitoring publicly funded substance use disorder services. In year 2, the MD-SPIN team will meet with the Maryland Association of Core Service Agencies (MACSA) to integrate them into the suicide prevention efforts of the grant and to improve on suicide prevention strategies throughout Maryland. The goal of the meeting is to discuss ways in which the CSAs can create or provide schools with a referral network for their area. We will guide the CSAs in building a resource for schools to have to know information about services and locations of behavioral health providers in their local jurisdiction who provide services to youth.

MD-SPIN has partnered with Community Behavioral Health (CBH) Association of Maryland in this effort during year one. CBH helps to improve the health of youth and adults in Maryland by advocating for and providing technical assistance to community behavioral health service providers and their constituents. CBH is a statewide professional organization of community service programs and is dedicated to making high quality rehabilitation, vocational, residential, and treatment opportunities available to all with mental illnesses. CBH will help MD-SPIN with resource mapping of behavioral health services and will promote training of behavioral health staff, youth who identify as LGBTQ, and young veterans and military families. We have asked CBH to assists us in identifying providers in local communities to provide behavioral health care treatment services. The goal is to create this resource through collaboration between the CSAs, LLAs, and CBH and disseminate it to local school jurisdictions through our collaboration with MSDE.

Maryland Commission on Suicide Prevention

MD-SPIN has worked closely with the MD Governor's Commission on Suicide Prevention. On October 7, 2009, Executive Order 01.01.2009.13 was issued, establishing the Governor's Commission on Suicide Prevention which sets forth the suicide prevention strategies and initiatives adopted by the State Coordinator of Suicide Prevention and the MD Behavioral Health Administration. The Commission consists of 21 Commissioners, brought on board because of their professional expertise and personal experiences with suicide and its consequences. The work of the Commission is aligned with national suicide prevention efforts, especially in the State's historic and continuing emphasis on youth suicide prevention. The Commissioner's Plan initial plan was submitted to the Governor in 2012, with a new plan being submitted in 2016.

The goals of MD-SPIN have been placed in the new Commissioner's Plan as strategies to use to combat suicide throughout the State. The Commission is currently chaired by MD-SPIN's Principal Investigator. The goal is to combine the resources and statewide influence of the Commissioners to advance the efforts of MD-SPIN in order to see a reduction in suicide attempts and deaths in the state. MD-SPIN will be using data from a Commission-driven project to use data from the Maryland Violent Death Reporting System (MVDRS) as well as state Medicaid data to better understand the circumstances around suicide deaths. MD-SPIN plans to use the data to guide further implementation strategies throughout the life of the grant.

Challenges and Opportunities

During the implementation of the Kognito gatekeeper trainings, we have encountered a few challenges. As mentioned earlier, the Kognito gatekeeper training program is an avatar based program that allows the trainee to simulate a conversation with a peer or student who is exhibiting some type of psychological distress. There was some feedback regarding one of the modules in the Kognito At-Risk Training for High School module. A scenario features a young woman who is believed to be cutting herself. The cutting is never confirmed in the scenario, only hinted at by other students in her class. During the simulated conversation, the young woman says that she is stressed and feeling overwhelmed and the teacher asks her to see the school counselor the next day. This method of handling that situation seemed to be different from the protocol of a local school jurisdiction. The protocol for teachers was to immediately take the student to the school counselor because the self-harm was viewed as a potential suicidal behavior. The module received some negative feedback and conversation with the developers at Kognito and their expert consultants took place. The developers and subject matter experts at Kognito have agreed to have a discussion with us to talk about what could be done to improve or modify that simulation to address the concerns of the jurisdiction leaders.

We have also been assisting our higher education partners increase their Kognito usage for faculty.

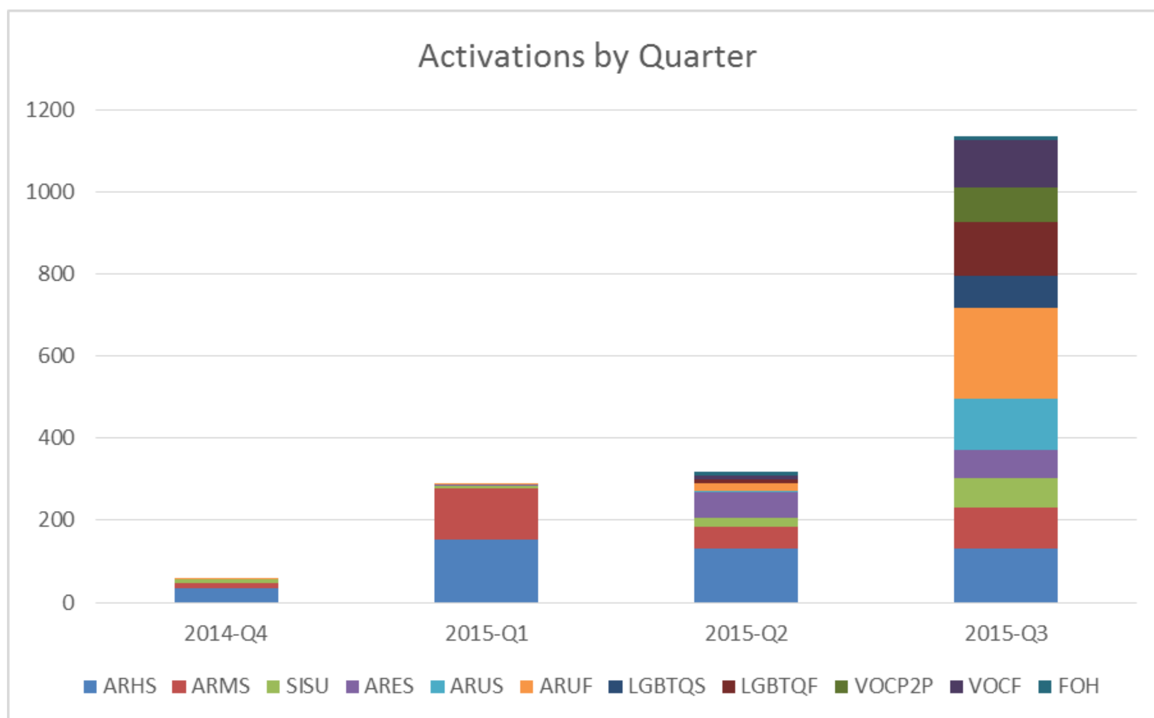
Accomplishments and Lessons Learned

Kognito Gatekeeper Training

From September 30, 2014 through September 29, 2015, there were 301 institutions that accessed the simulations and trained a total of 1,803 users. Higher Ed launched in June and had 800 learners through the end of this reporting period. The majority of this usage came during the 2015 back to school time. The faculty versions of the 3 higher education courses all received more activations than the student versions. Survey results were overwhelmingly positive with 94.91% of overall users stating that they would recommend the courses to their peers.

Course	Activated	Completed	Completion %
At-Risk for High School Educators (ARHS)	451	310	68.74%
At-Risk for Middle School Educators (ARMS)	290	243	83.79%
Step In, Speak Up! (SISU)	112	103	91.96%
At-Risk for Elementary School Educators (ARES)	133	96	72.18%
At-Risk for Students (ARUS)	128	93	72.66%
At-Risk for Faculty & Staff (ARUF)	241	188	78.01%

LGBTQ on Campus for Students (LGBTQS)	79	69	87.34%
LGBTQ on Campus for Faculty & Staff (LGBTQF)	139	123	88.49%
Veterans on Campus: Peer to Peer (VOCP2P)	84	67	79.76%
Veterans on Campus for Faculty & Staff (VOCF)	129	116	89.92%
Family of Heroes (FOH)	17	NA	NA
Total	**1803**	**1408**	**78.83%***



The college and university partners have been quite successful in their strategies to promote Kognito throughout their respective campuses. In our first year, we have learned about the differences in campus structure and how that plays a role in access to students, methods in which students receive information, and strategies to reach specific populations. There should be strategic differences in ways target audiences are approached on campuses where there is a high student resident population as opposed to a school where most of the student body commutes to the campus. We have worked closely with college and university staff in creating plans for dissemination depending on the make-up of the campus and student body.

Strategizing with K-12 teachers and staff have recently been quite successful towards the end of year 1. The partnership between BHA and MSDE has proven to be beneficial to encouraging K-12 staff to take the Kognito training. MD-SPIN staff have been given many opportunities to share information on Kognito at events, professional development meetings, and school activities. This partnership has increased access of school districts to BHA to promote Kognito.

Emergency Department Screening, Assessment, and Follow-Up

The receptiveness of the ASQ screening tool and the ease of adapting it in the system of Hopkins and UMD EHRs has been promising. The inclusion of the ASQ screening tool has been fairly seamless and has worked well thus far. The Johns Hopkins Pediatric Emergency Department has been discussing possibly going to a universal screen with all youth, regardless of the chief complaint. This would be a major step in increasing identification of youth who need referrals for suicidal ideation. There have been other emergency departments who have expressed interest in adding the ASQ to their screening tools. The goal moving forward is to keep track and monitor the progress made by Hopkins and UMD. The lessons learned from their adoption of ASQ will be used to build the screen into the EHR of other pediatric emergency departments across Maryland. Johns Hopkins University has hired a research assistant to work with hospital pediatric emergency departments to help create follow-up protocols for youth who are referred to services.

Reports from Kognito on Evaluation

We are gathering reports from Kognito on questions asked at the time of training on confidence to recognize signs of psychological distress, likelihood of making a referral to health services for students, and likelihood of recommending Kognito gatekeeper training program to someone else. Below are the results gathered for Year 1.

The following questions are *At-Risk for High School Educators* and *At-Risk for Middle School Educators*:

Would you recommend this course to your colleagues (or friends and peers)?	**ARHS**	**ARMS**

Yes	95.29%		96.84%	
How would you rate your ability to recognize when a student's behavior is a sign of psychological distress?	Pre	Post	Pre	Post
High or Very High	62.42%	88.24%	58.07%	93.68%
How likely are you to recommend mental health support services?	Pre	Post	Pre	Post
Likely or Very Likely	96.52%	97.65%	97.67%	98.95%

The following questions are *Step In, Speak Up* only:

Would you recommend this course to your colleagues (or friends and peers)?	**SISU**	
Yes	94.94%	
How would you rate your preparedness to use gender-neutral language in class?	**Pre**	**Post**
High or Very High	45.45%	87.35%
How would you rate your preparedness to discuss with a student your concern about their being teased, harassed, or bullied?	**Pre**	**Post**
High or Very High	55.68%	87.35%

The following data is pulled from the *At-Risk for Elementary School Educators* pre- and post-course surveys:

Would you recommend this course to your colleagues?	**ARES**	
Yes	98.75%	
How would you rate your preparedness to recognize when a student's behavior is a sign of psychological distress?	**Pre**	**Post**
High or Very High	47.61%	95.00%

How would you rate your preparedness to motivate a parent whose child is exhibiting signs of psychological distress to seek help?	**Pre**	**Post**
High or Very High	34.92%	88.75%
How likely are you to try helping parents be informed about mental health support services available to a student exhibiting signs of psychological distress?	**Pre**	**Post**
Likely or Very Likely	87.10%	96.25%

The following questions are *At-Risk for Students* and *At-Risk for Faculty and Staff*:

Would you recommend this course to your colleagues (or friends and peers)?	**ARUS**		**ARUF**	
Yes	92.54%		98.68%	
How would you rate your ability to recognize when a student's behavior is a sign of psychological distress?	Pre	Post	Pre	Post
High or Very High	50.88%	86.56%	40.79%	79.47%
How likely are you to recommend mental health support services?	Pre	Post	Pre	Post
Likely or Very Likely	53.39%	94.03%	84.58%	96.58%

The following questions are *LGBTQ on Campus for Students* and *LGBTQ on Campus for Faculty and Staff*:

Would you recommend this course to your colleagues (or friends and peers)?	**LGBTQS**	**LGBTQF**
Yes	81.40%	100%

How would you rate your preparedness to use gender-neutral language in class (or when appropriate)?	Pre	Post	Pre	Post
High or Very High	57.35%	83.73%	42.60%	81.33%
How likely are you to recommend mental health support services?	Pre	Post	Pre	Post
Likely or Very Likely	85.30%	95.35%	89.72%	100%

The following questions are *Veterans on Campus: Peer to Peer* and *Veterans on Campus for Faculty and Staff*:

Would you recommend this course to your colleagues (or friends and fellow veterans)?	VOCS		VOCF	
Yes	92.00%		98.68%	
How would you rate your ability to recognize when a student veteran's behavior is a sign of psychological distress?	Pre	Post	Pre	Post
High or Very High	27.94%	86.00%	31.13%	75.00%
How likely are you to recommend mental health support services?	Pre	Post	Pre	Post
Likely or Very Likely	76.92%	92.00%	76.92%	96.05%

The initial data shows that Kognito seems to be most effective in increasing people's ability to recognize signs of psychological distress in students. We are looking forward to seeing an increase in students that are referred to services because of early identification and intervention at the first signs of distress. We imagine that the overall consumer satisfaction of the program will result in more Maryland residents being aware of the program and taking it based on a colleague's recommendation.

Brief Story

We have been pleased with the feedback received about the impact of the Kognito trainings. These are a few quotes from people who have taken the training:

Here are some representative comments from the surveys in response to "What did you like best about the course?"

- It helped me to have a better understanding of the LBGTQ lifestyle and some insight as to what some of the transgender population maybe going through.
- I loved how interactive it was and how realistic the students' responses and tone were. It showed how important it is to be able to roll with resistance and not get caught in arguments.
- I like that the course was fluid and changed based on the choices I made about how to have the conversation with the student
- Additional knowledge. It's important, especially now, to be able to recognize or get others involved when you think there is a problem with a student.
- Now I think I understand how to talk to a friend in stress without offending them in any way. It gave me tools and advice to make my conversation more effective and helpful.

Final Thoughts

The collaborative work of all of the partners and agencies involved have contributed greatly to the success of MD-SPIN. We have met our year 1 goals for training and are continuing to build relationships in local jurisdictions to expand training and by-in for year 2. We are excited to further promote the new Family of Heroes module and the Kognito module for Primary Care Physicians. We will also be releasing a peer-to-peer module for high school students called Friend 2 Friend. We plan to begin to promote this module to youth across the state once it becomes available. We are also excited about the year 1 progress made in the screening, assessment, and follow-up component of the grant. Johns Hopkins Hospital has taken the lead in the ASQ screening and has given us tours to watch the process of the screening. We are anticipating using the lessons learned and shared from Hopkins to expand it to the more suburban and rural hospitals in the state, which may require a more hands-on approach because of the difference in infrastructure, capacity, and location. The news of Hopkins considering making the ASQ a universal screen is one that is quite exciting to the MD-SPIN team. We are excited to be working with the CSAs and LAAs in year 2, including them in the suicide prevention work that the state is looking to build upon. They will be an integral partner in improving the suicide prevention work in the community. We look forward to continuing our work in year 2 and further improving on the year 1 progress.