Crisis and Suicide: Assessment, De-Escalation and Referral in Early Psychosis

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September 12, 2024

SAMHSA
Substance Abuse and Mental Health Services Administration

MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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At the time of this publication, Miriam E. Delphin-Rittmon, Ph.D., served as Assistant Secretary for Mental Health and Substance Use in the U.S. Department of Health and Human Services and the Administrator of the Substance Abuse and Mental Health Services Administration.

The opinions expressed herein are the views of the authors and do not reflect the official position of the Department of Health and Human Services (DHHS), SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this document is intended or should be inferred.

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Presented 2024

MHTTC

Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The purpose of the MHTTC Network is technology transfer - disseminating and implementing evidence-based practices for mental disorders into the field.

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), the MHTTC Network includes 10 Regional Centers and a Network Coordinating Office.

Our collaborative network supports resource development and dissemination, training and technical assistance, and workforce development for the mental health field. We work with systems, organizations, and treatment practitioners involved in the delivery of mental health services to strengthen their capacity to deliver effective evidence-based practices to individuals. Our services cover the full continuum spanning mental illness prevention, treatment, and recovery support.

SAMHSA

Substance Abuse and Mental Health Services Administration

MHTTC Mental Health Technology Transfer Center Network
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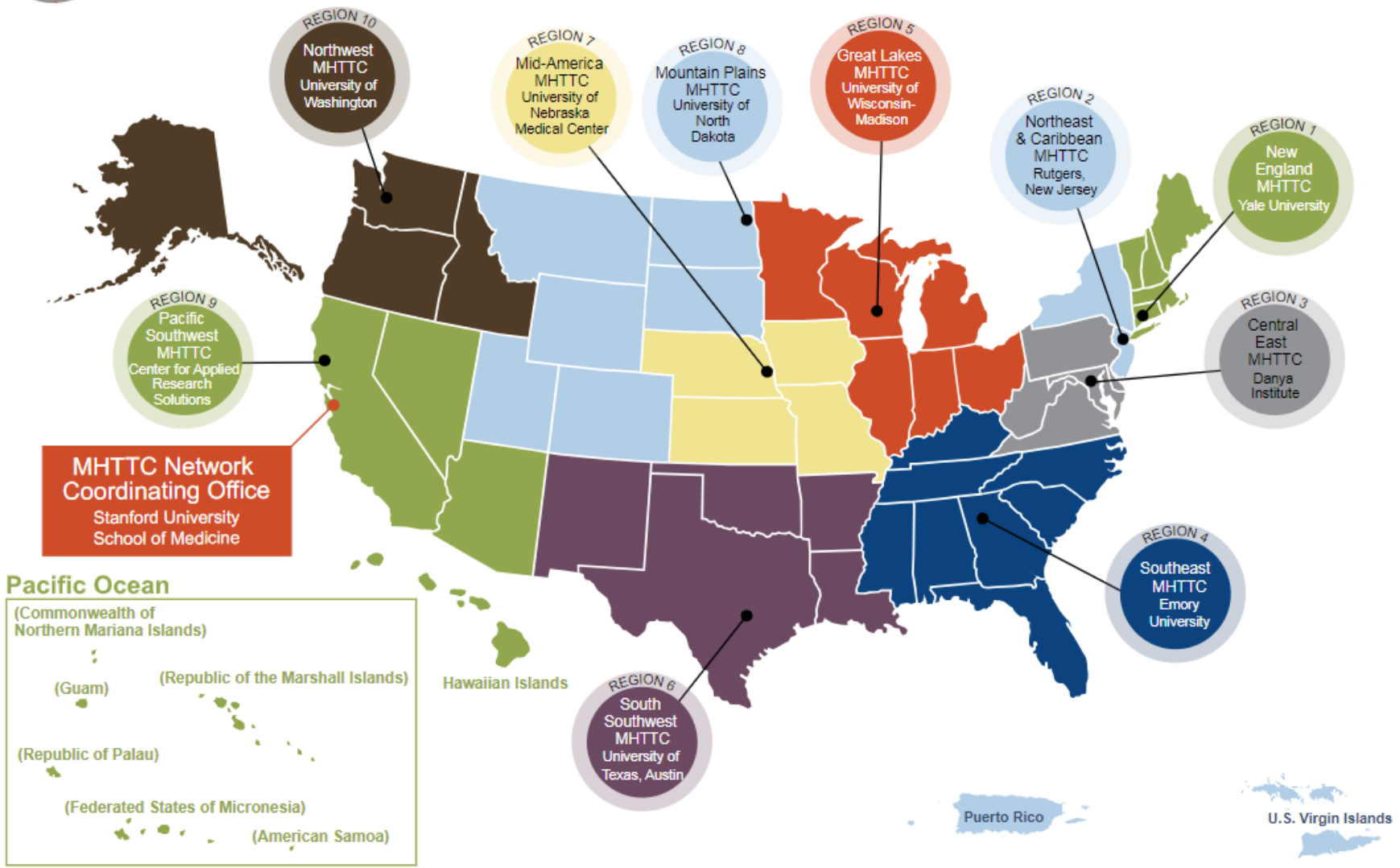
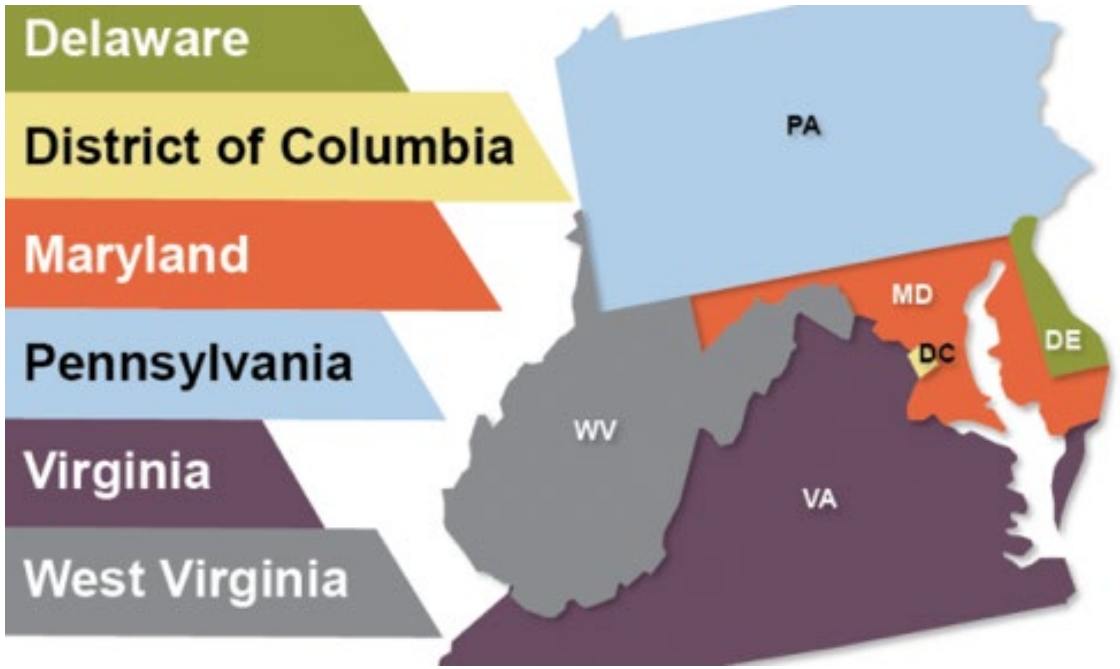
MHTTC Network



Central East Region 3



Central East (HHS Region 3)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

- Strengths-based and hopeful
- Inviting to individuals participating in their own journeys
- Person-first and free of labels
- Inclusive and accepting of diverse cultures, genders, perspectives, and experiences
- Non-judgmental and avoiding assumptions
- Respectful, clear and understandable
- Healing-centered and trauma-responsive
- Consistent with our actions, policies, and products

Adapted from: https://mhcc.org.au/wp-content/uploads/2019/08/Recovery-Oriented-Language-Guide_2019ed_v1_20190809-Web.pdf

HeadsUp

Central East (HHS Region 3) MHTTC Mental Health Technology Transfer Center Network Funded by Substance Abuse and Mental Health Services Administration

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MHTTC

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Perelman School of Medicine University of Pennsylvania

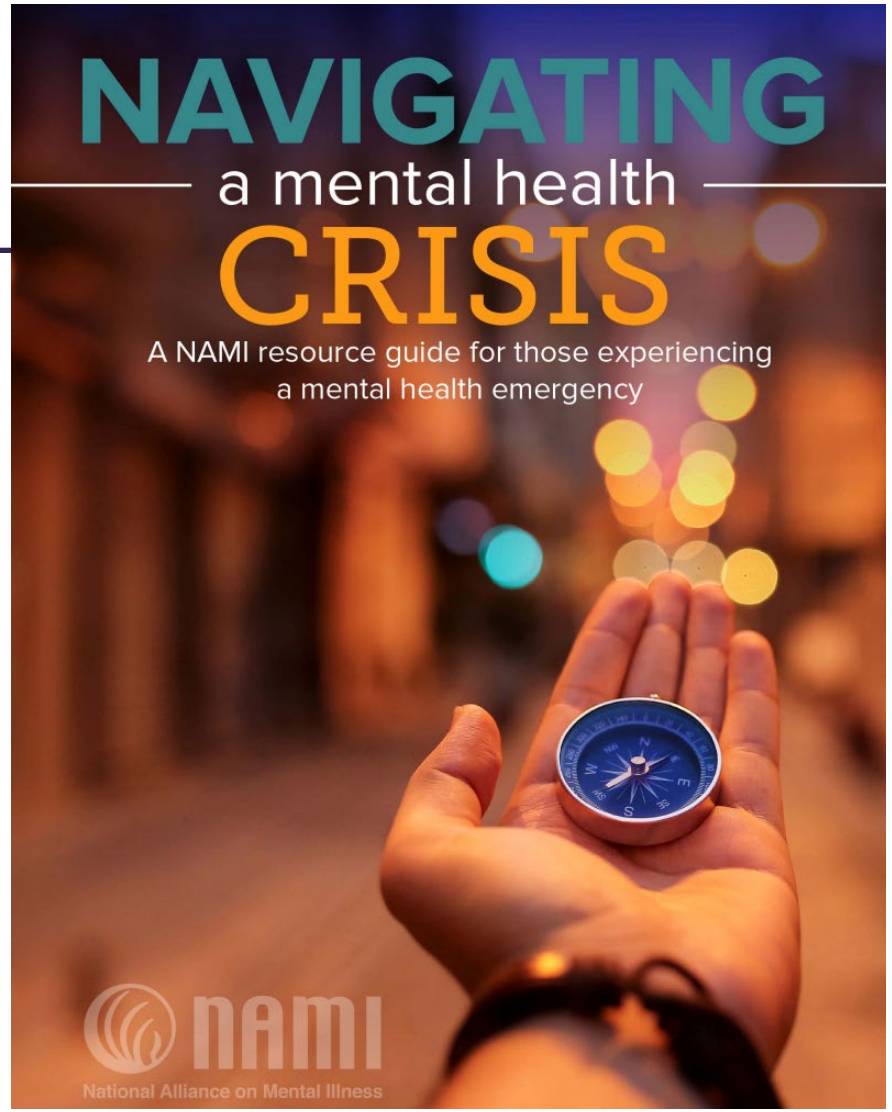
pennsylvania DEPARTMENT OF HUMAN SERVICES OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Objectives

- Understand the difference between suicide assessment and screening
- Identify crisis de-escalation techniques
- Name current treatment recommendations for suicide including identification of resources for individuals, support systems, and professionals

What is a Crisis?

- **“A mental health crisis is any situation in which a person’s behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community. Many things can lead to a mental health crisis.”**
  - **Navigating a Mental Health Crisis Resource Guide**



HeadsUp

What does crisis look like in first episode psychosis?

ⓘ Start presenting to display the poll results on this slide.

Crisis Response Services

- **Based on level of care (LOC) needed**
  - Peer-based crisis services
  - Text-based crisis services
    - Text HOME to 741741
  - Phone-based crisis services
    - Local phone crisis links
    - National Suicide Prevention Lifeline 800-273-8255
    - 988
  - Mobile crisis teams
  - Walk-in crisis clinics/urgent care clinics
  - Hospital-based psychiatric emergency services

988- Call or Text

“

You have reached the 988 Suicide & Crisis Lifeline, also serving the Veteran Crisis Line. Para Español oprima el número dos. If you are in emotional distress or suicidal crisis, or are concerned about someone who might be, we are here to help.

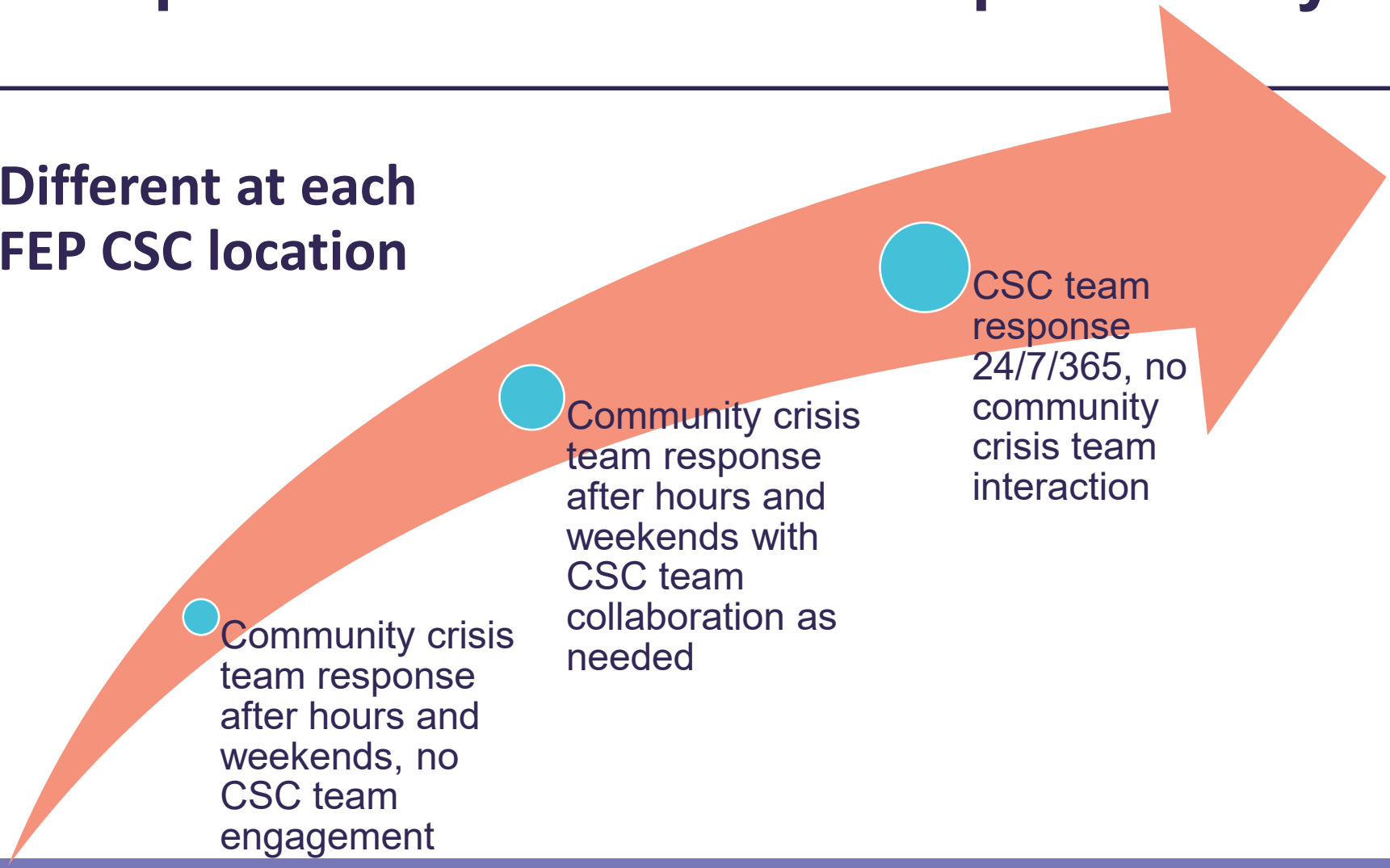
If you are a US military veteran or current service member, or calling about one, please press 1 now. Otherwise, please hold while we route your call to the nearest crisis center in our network.

”

988
SUICIDE
& CRISIS
LIFELINE

Crisis Response Services in First Episode Psychosis

- **Different at each FEP CSC location**



Suicide Definitions

- **Suicide** - death caused by self-directed injurious behavior *with intent to die* as a result of the behavior

- **Suicide Attempt** - non-fatal, self-directed, potentially injurious behavior *with intent to die* as a result of the behavior
  - might not result in injury

- **Suicidal Ideation** - thinking about, considering, or planning suicide

- **Non-Suicidal Self-Injury** - self-harm that involves causing pain or damage to your body without the intention of suicide

Suicide Statistics

- Rates of completed suicide increased by 36% since 2000, claiming the lives of 49,479 people in 2022
- Second leading cause of death among individuals between the ages of 10-14 and 20-34 in 2022
- Average 1 death by suicide every 11 minutes
- Estimated 1.6 million suicide attempts in 2022

Centers for Disease Control and Prevention (CDC)

Over

49,000

people died by suicide in 2022

1 death every

11 minutes

Many adults think about suicide or attempt suicide

13.2 million
Seriously thought about suicide

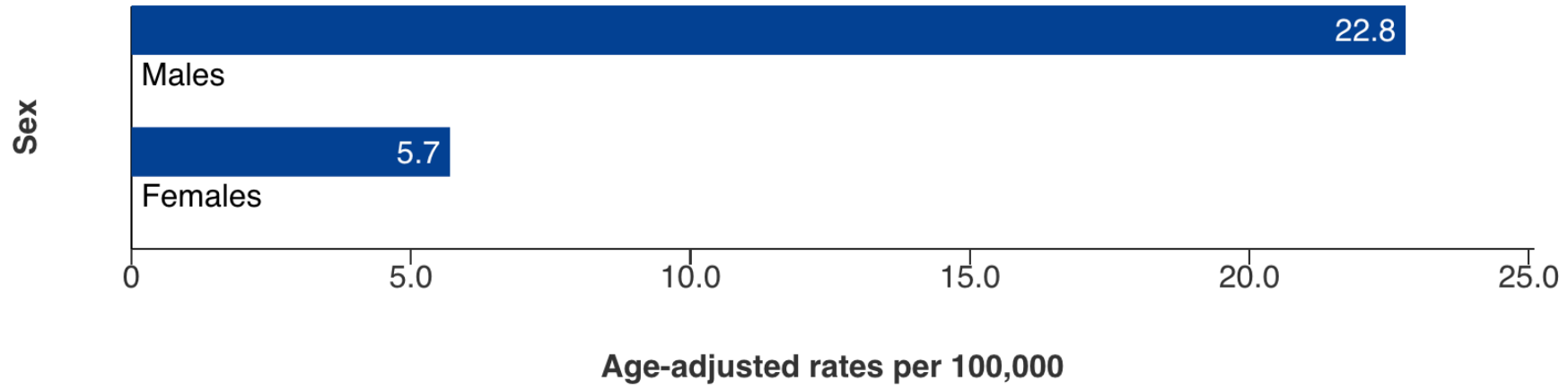
3.8 million
Made a plan for suicide

1.6 million
Attempted suicide

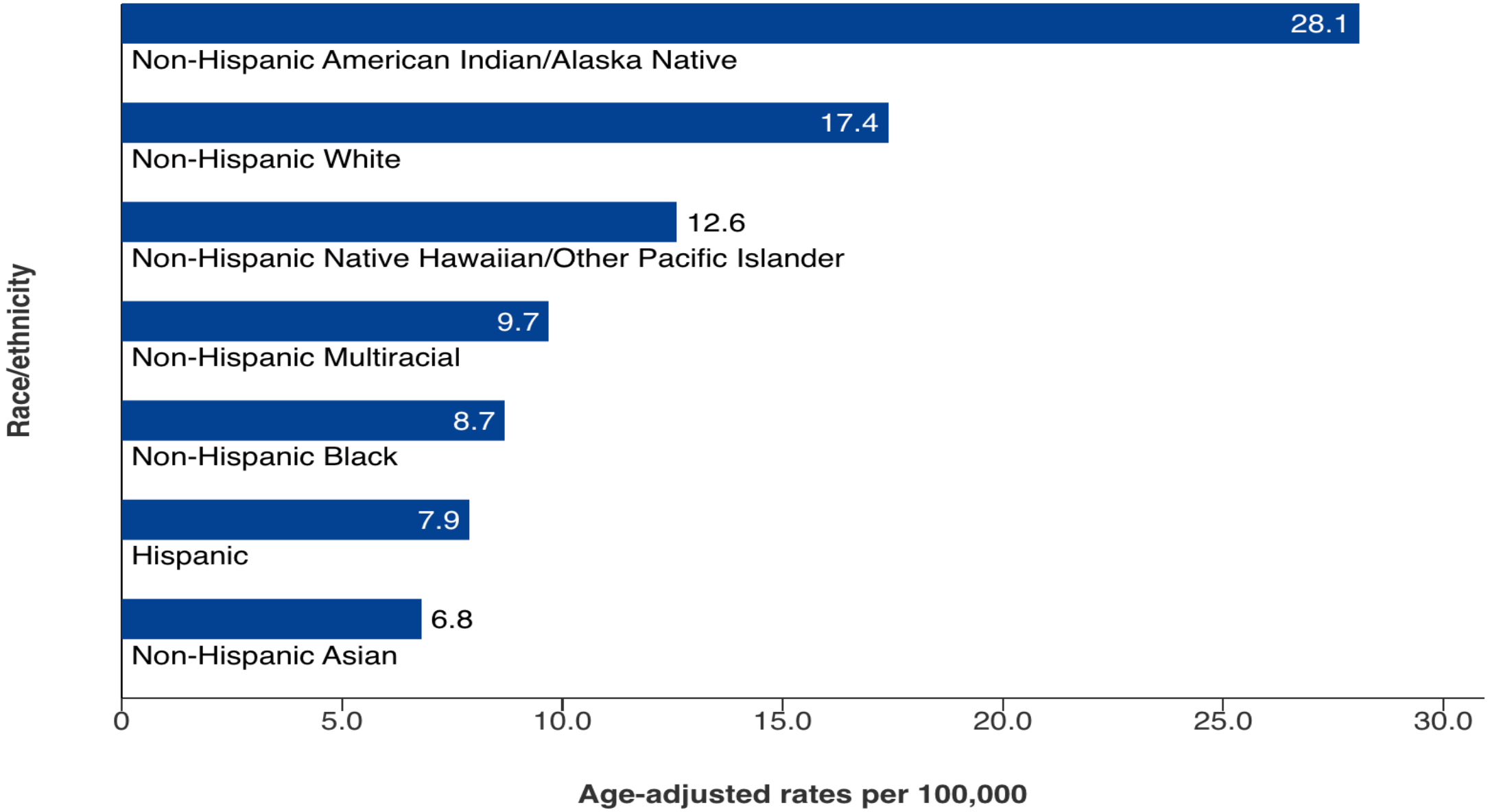
Graphic from CDC

Suicide Statistics

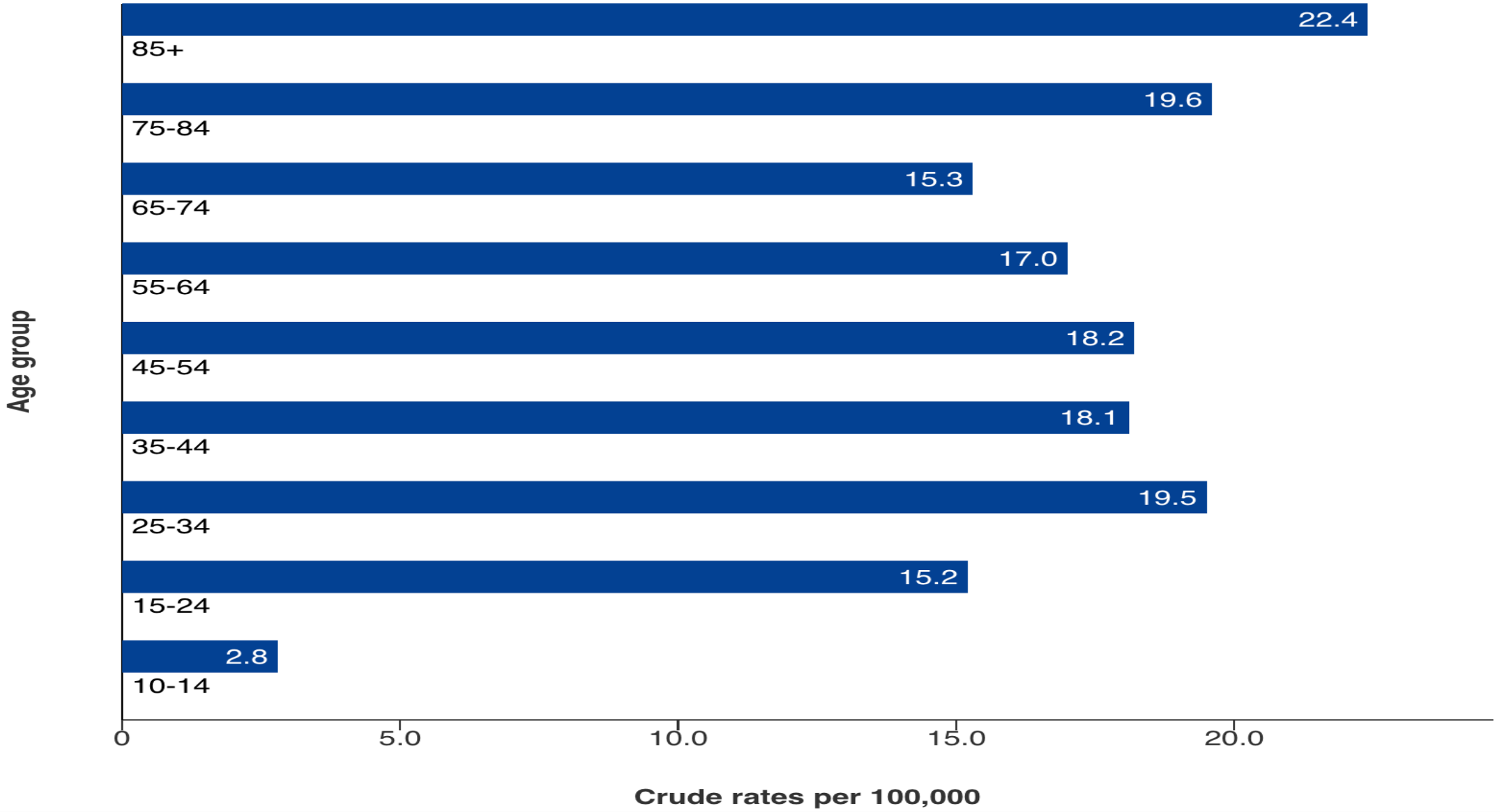
- Among racial/ethnic groups, American Indian/Alaska Native people and non-Hispanic Caucasian Americans have the highest rates
- The rate of completed suicide is nearly 4x higher in men compared to women



Graphic from CDC

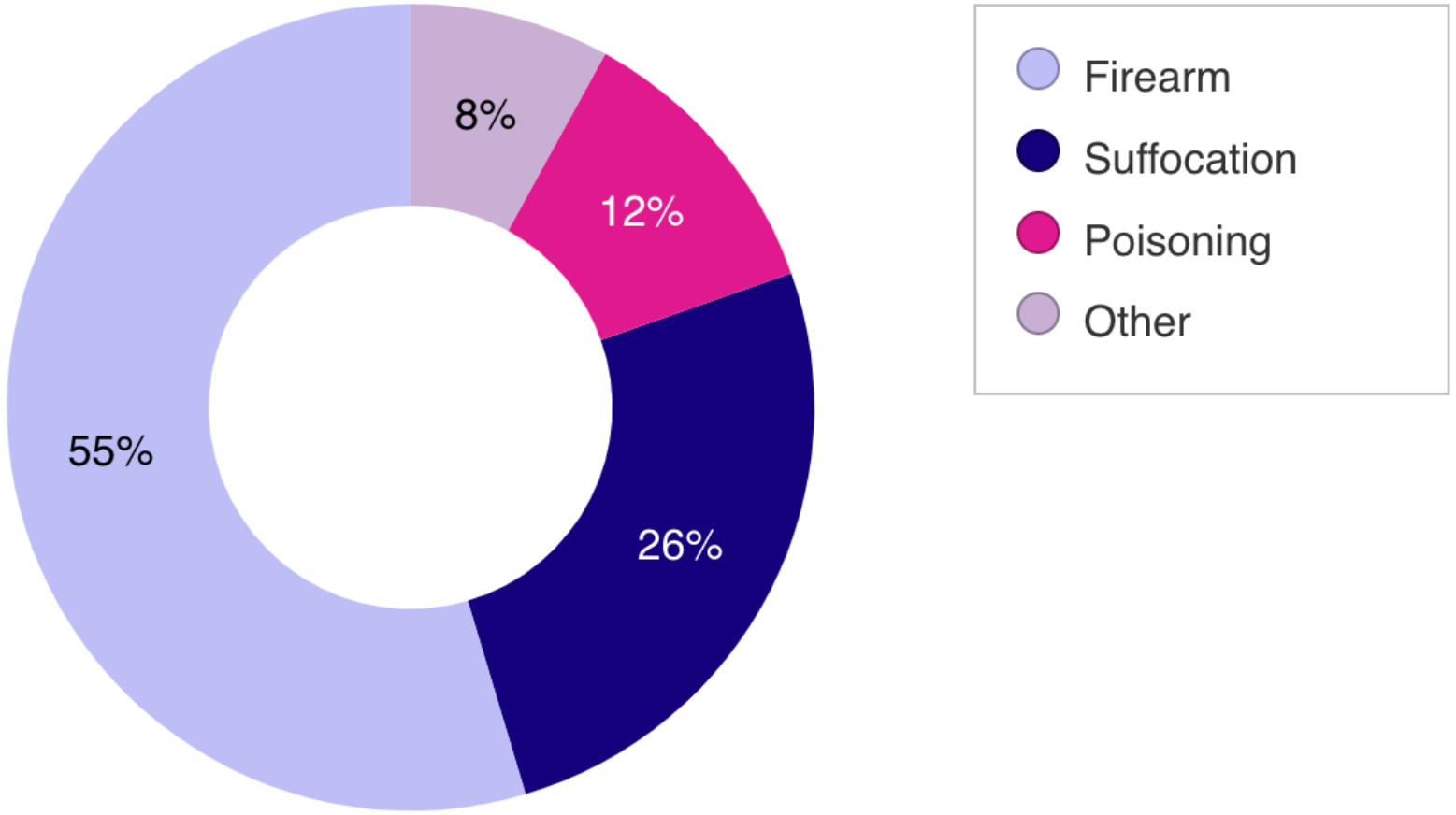


Graphic from CDC



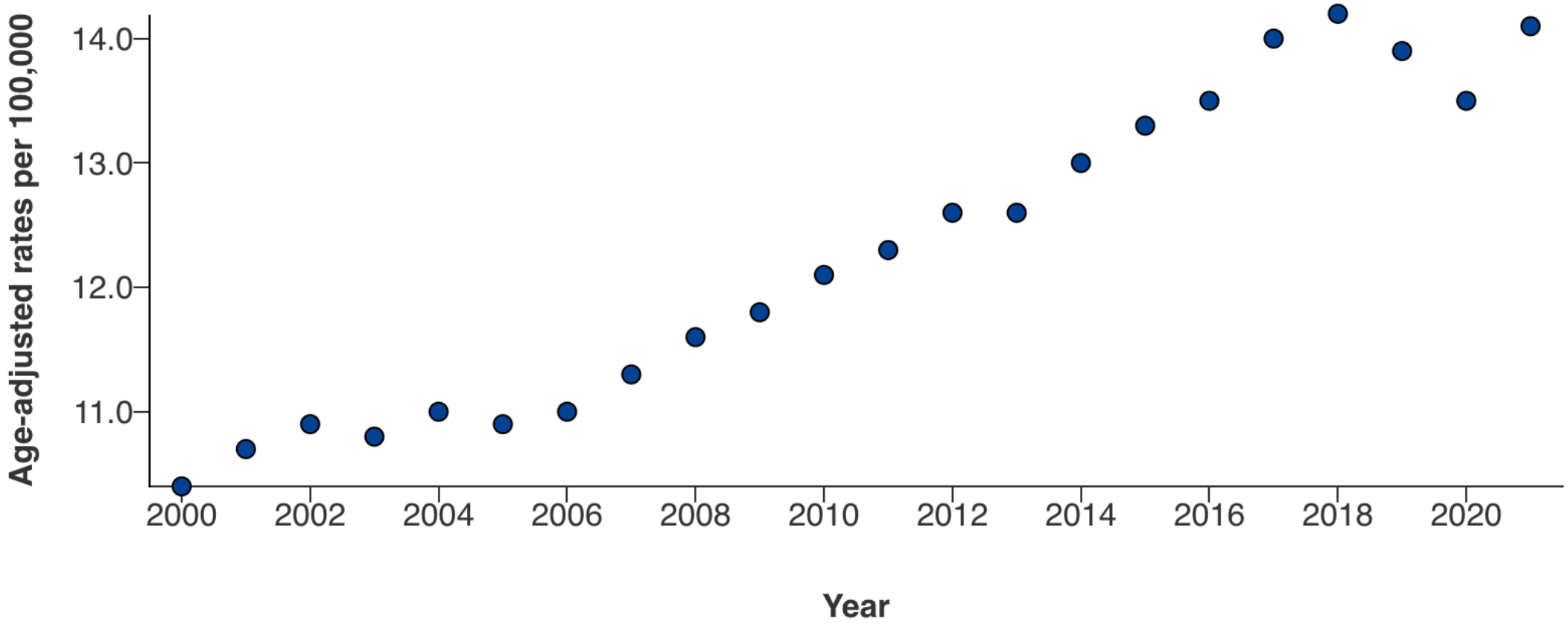
Graphic from CDC

Firearms are the most common method used in suicides.
Firearms are used in more than 50% of suicides.



Graphic from CDC

Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. However, rates nearly returned to their peak in 2021.



Graphic from CDC

Suicide within our patient population

- Suicide risk is 2-3 times higher in the year following first psychiatric hospitalization compared to other stages of the illness

- In first episode psychosis, rates of suicide attempt range from 5-12% and death by suicide between 1-4%

Verbal/Expression Warning Signs

Talking about

- feeling great guilt or shame
- wanting to die or wanting to kill themselves
- feeling empty or hopeless or having no reason to live
- feeling trapped or feeling that there are no solutions
- being a burden to others
- saying goodbye to friends and family
- or thinking about death often
- unbearable emotional or physical pain

Observable/Behavioral Warning Signs

- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Withdrawing from family and friends
- Giving away important possessions
- Putting affairs in order, such as making a will
- Using alcohol or drugs more often
- Acting anxious or agitated
- Showing rage or talking about seeking revenge
- Changing eating or sleeping habits
- Looking for ways to kill themselves, such as searching for lethal methods online, stockpiling pills, or buying a gun
- Taking great risks that could lead to death, such as driving extremely fast

Risk Factors for Suicide

Suicidal behavior is complex, and there is no single cause. The main risk factors for suicide are:

- Depression, other mental health disorders
- Substance use disorders
- Chronic pain
- A history of suicide attempts
- Family history of a mental disorder or substance use
- Family history of suicide
- Exposure to family violence, including physical or sexual abuse
- Presence of guns or other firearms in the home
- Having recently been released from prison or jail
- Exposure, either directly or indirectly, to others' suicidal behavior, such as that of family members, peers, or celebrities

Consider the impact of stressful life events in conjunction with risk factors.

Most people who have risk factors will NOT attempt suicide.

Are there risk factors unique to FEP? Examining evidence from an FEP program in Montreal

- Living alone was the strongest demographic risk factor for SI, increasing odds of ideation almost fourfold; only demographic factor associated with attempt
- Higher levels of depressive and positive symptoms were associated with higher risk of suicide attempt
- Previous suicide attempt was the strongest risk factor for further attempts

HeadsUp

Is insight a protective factor or a risk factor for individuals early on in psychosis?

ⓘ Start presenting to display the poll results on this slide.

Suicide Protective Factors

- Coping and problem-solving skills
- Cultural and religious beliefs that discourage suicide
- Connections to friends, family, and community support
- Supportive relationships with care providers
- Availability of physical and mental health care
- Lack of substance use/abuse
- Limited access to lethal means among people at risk

Suicide Assessment

Screening vs. Assessment – What's the difference?

- **Screening** - ***brief, intended to identify need for in depth assessment***
  - **Ask Suicide Screening Questions (ASQ)**
  - **Zero Suicide Patient Health Questionnaire (PHQ-9)**
    - **Last question assesses passive SI**
  - **Columbia-Suicide Severity Rating Scale (C-SSRS)**

- **Assessment** – ***comprehensive evaluation done by a clinician to confirm suspected suicide risk, estimate the immediate danger to the individual, and determine a course of treatment to ensure safety***
  - **Typically developed/ adapted by your organization**
  - **Some organizations commonly use longer screening tool (e.g., C-SSRS, Beck Scale for SI, etc.)**

Assessing past suicidal behavior

- **Actual attempt:** a potentially self-injurious act committed with at least some intent to die as a result of the act
- **Interrupted attempt:** when outside circumstances stop the individual from starting the self-injurious act
- **Aborted attempt/self-interrupted attempt:** when the individual begins to take steps toward attempting suicide but then stops themselves before engaging in the self-destructive behavior
- **Preparatory acts or behavior:** anything action beyond a verbalization or thought

Source: Columbia-Suicide Severity Rating Scale

How I ask about potential suicidality

Wish to be dead

Active thoughts of suicide

Thoughts of method

Intent to act

Specific plan

Acts of furtherance

Suicide Assessment

Suicide Assessment Five-Step Evaluation and Triage for Clinicians (SAFE-T)

Suicide Assessment

1. Identify risk factors
2. Identify protective factors
3. Conduct suicide inquiry
4. Determine risk level and intervention
5. Document!

Columbia Suicide Severity Rating Scale (CSSRS)

"The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk screening through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, determine the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people:

- Whether and when they have thought about suicide (ideation)
- What actions they have taken — and when — to prepare for suicide
- Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition"

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

988 SUICIDE & CRISIS LIFELINE

If YES to 2 or 3, seek behavioral healthcare for further evaluation.
If the answer to 4, 5 or 6 is YES, get immediate help: Call or text 988, call 911 or go to the emergency room.
STAY WITH THEM until they can be evaluated.

Download Columbia Protocol app

https://cssrs.columbia.edu

Columbia Suicide Severity Rating Scale (CSSRS)

ASKING QUESTIONS

"Protocol administrators ask a series of questions about suicidal thoughts and behaviors. The number and choice of questions they ask depend on each person's answers. The questioner marks "yes" or "no," as well as how recently the thought or behavior occurred and a scoring of its severity. The shortest screeners are condensed to a minimum of two and a maximum of six questions, depending on the answers, to most quickly and simply identify whether a person is at risk and needs assistance. For a more thorough risk screening, Columbia Protocol askers should use the standard scale.

The Columbia Protocol questions use plain and direct language, which is most effective in eliciting honest and clear responses. For example, the questioner may ask:

- "Have you wished you were dead or wished you could go to sleep and not wake up?"
- "Have you been thinking about how you might kill yourself?"
- "Have you taken any steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)?"

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Columbia Suicide Severity Rating Scale (CSSRS)

DETERMINING NEXT STEPS

"To use the Columbia Protocol most effectively and efficiently, an organization can establish criteria or thresholds that determine what to do next for each person screened. Decisions about hospitalization, counseling, referrals, and other actions are informed by the "yes" or "no" answers and other factors, such as the recency of suicidal thoughts and behaviors.

The Columbia Lighthouse Project provides many examples of triage documents that Columbia Protocol users in hospitals, primary care practices, behavioral health care facilities, military services, prisons, and other settings employ to make these decisions. The Project also provides assistance to any organization that is thinking through its policy and establishing a care plan."

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De-Escalation – Psychosis and Trauma Considerations

- How does psychosis impact de-escalation?
  - Fear/ paranoia
  - Disconnect from reality
  - Decreased support systems
  - Community supports not trained on proper response
- How does trauma impact de-escalation?
  - Brain operates between alert and alarmed state
    - Alarmed state: fight/ flight response easily triggered and abstract thinking response is limited based on level of arousal
    - Goal is to return to alert state

De-Escalation Tips with the Individual

- Work as a team
- Control the environment
  - If possible, redirect to safe, quiet space away from others
- Project calmness
- Speak in short, concise sentences
- Express empathy but be authentic
- Offer realistic options, never promise secrets or things you can not deliver
- Be mindful of body language
  - Including where and how you are standing
    - Never block the exit but make sure you have an easy and quick exit yourself

De-Escalation Tips for the Team

- *Know your and your team's triggers and strengths*
- Conduct on-going internal assessments of stress to identify who and how each team member takes an active role in de-escalation
  - Like CPR, sometimes we need to switch the responder so we do not get burned out
- Build a relationship with local emergency response personnel who are trained in Mental Health Crisis response
  - If none, help them to get trained
    - CIT training for police or ambulance personnel
    - Mental Health First Aid for Law Enforcement and First Responders
- Have calm, quiet, safe spaces in the office to redirect individuals in crisis to

Factors to consider in responding to a crisis

- Can the individual be safely examined in the office?
- Is the person on board with an evaluation at the crisis center and potential hospitalization? Or is an involuntary commitment needed? If so, who should petition?
- Do Police need to be involved? Does this create any additional risks?

Treatment – CSC Teams

- **Safety Planning**
  - **It is recommended that *ALL* participants have a safety plan that is updated regularly**
    - **Ways to limit access to lethal means**
    - **Coping strategies**
    - **Support persons**
    - **Crisis resources**
  - **Follow-up phone calls**

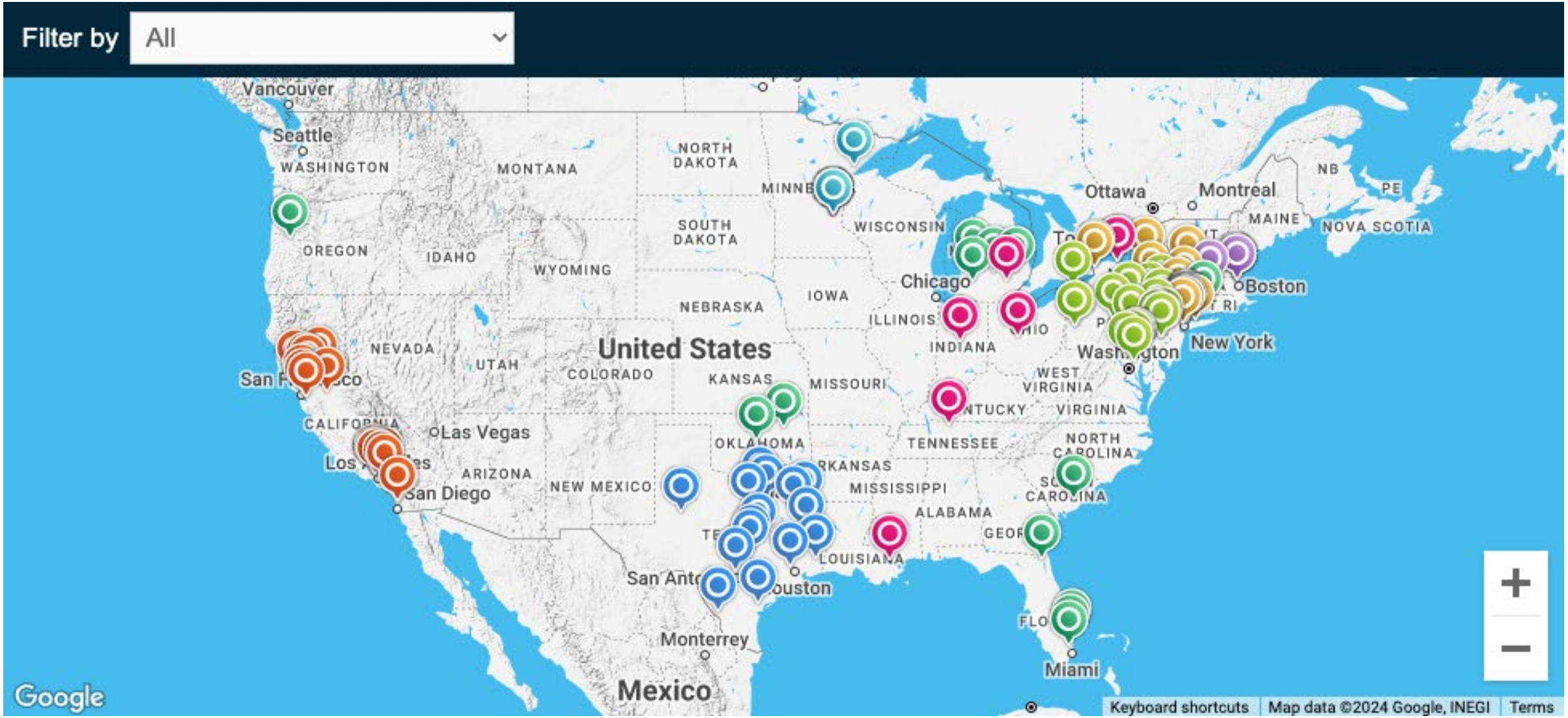
- **Collaborative Care**
  - **CSC team and family/ supports**
  - **Physical health care professionals included**

Treatment – CSC Teams (cont.d)

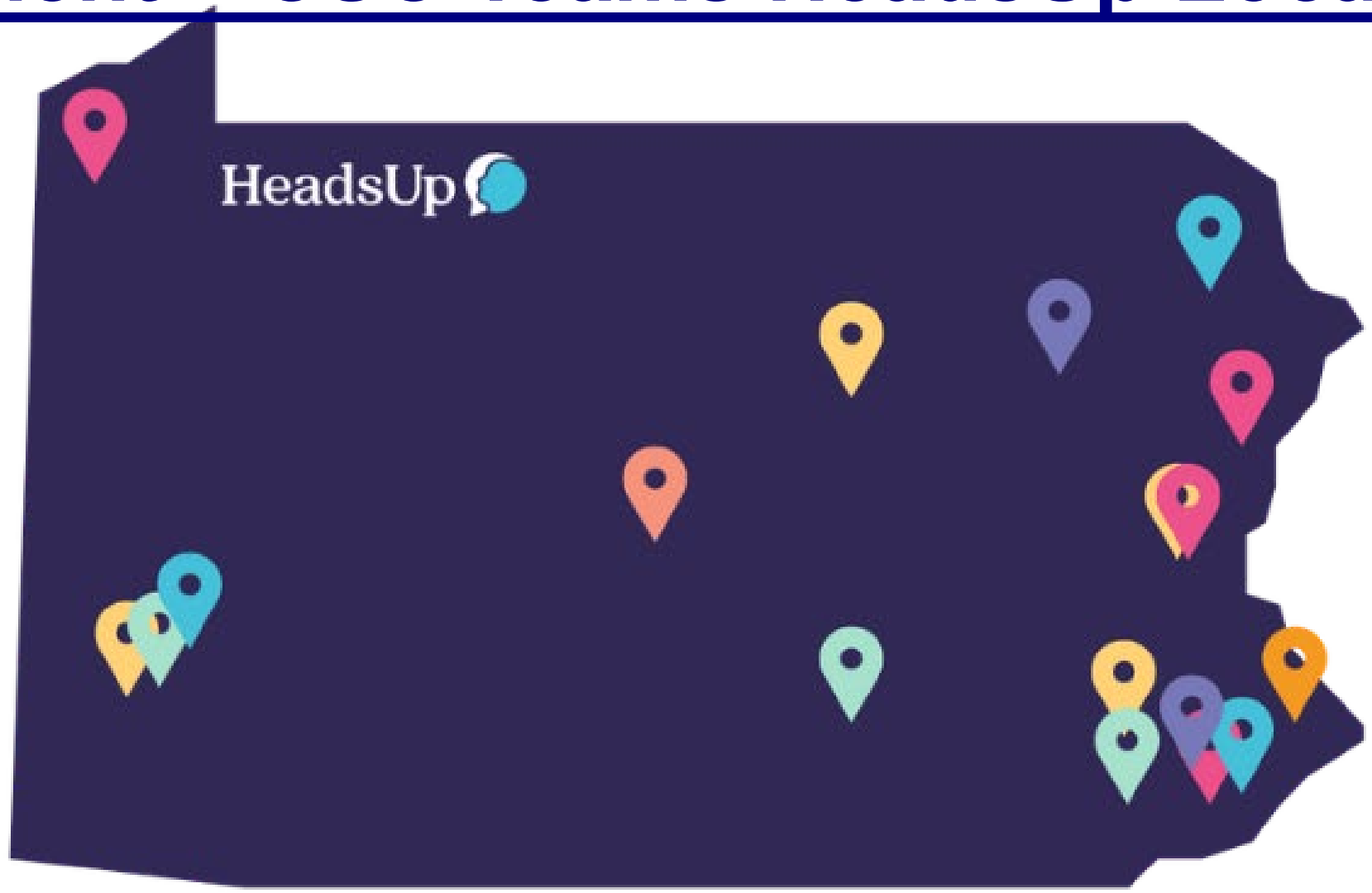
- **Psychotherapy**
  - **DBT** has been shown to reduce suicidal behaviors
  - **CBT** helps individuals recognize their thought patterns and redirect their thinking

- **Medication**
  - **Clozapine** is only antipsychotic medication with FDA specific indication for reducing the risk of recurrent suicidal behavior in persons with schizophrenia
  - **Lithium** has been shown to be protective against suicide and may be beneficial in individuals with a mood component to their illness

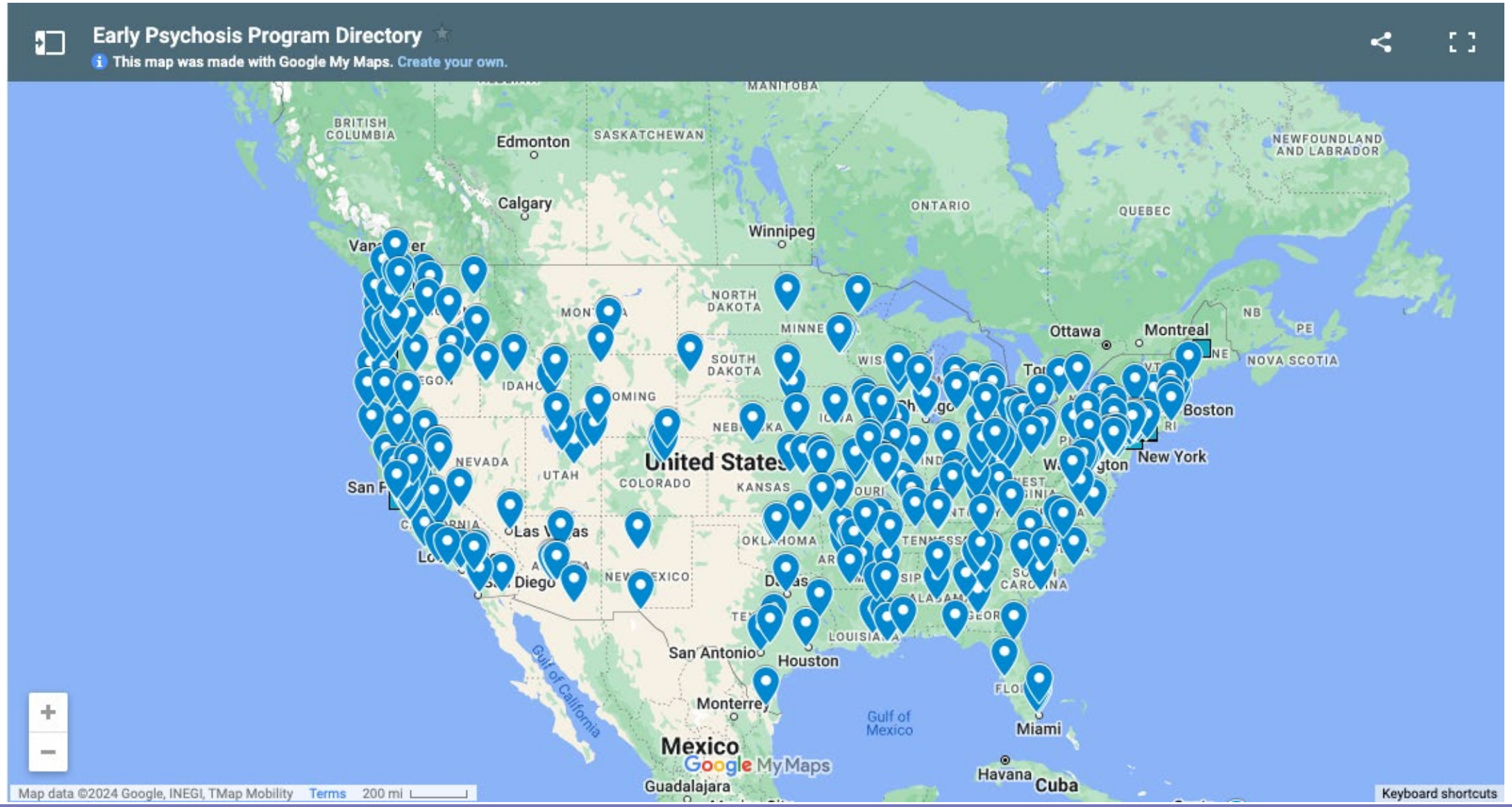
Treatment – CSC Teams EPINET Locator



Treatment – CSC Teams HeadsUp Locator



Treatment – CSC Teams PEPNET Locator



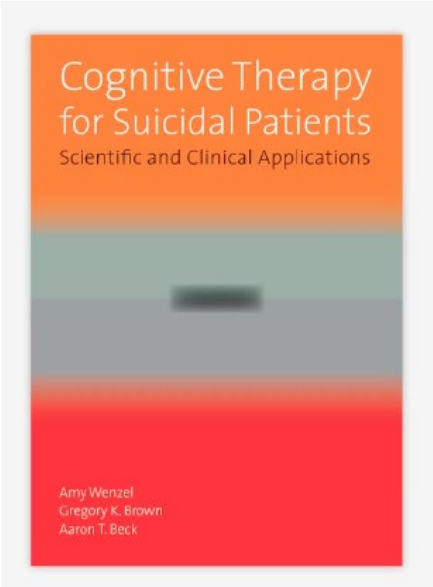
Treatment – Caring Contact

- Outreach to person after attempt has been shown to change completion behaviors
  - Contact can be letter, post card, phone call, visit, etc.
- Most data on impact of attempted and completed suicides
- Study Results:
  - Patients in the contact group had a lower suicide rate in all five years of the study
  - Formal survival analyses revealed a significantly lower rate in the contact group (p=.04) for the first two years

Motto, J. A. & Bostrom, A. G. (2001). A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services.*
Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis: The Journal of Crisis Intervention and Suicide Prevention.*

Treatment – Cognitive Therapy for Suicidal Patients (Beck Institute)

Study Results: 10 session intervention led to 50% reduction in repeat attempt behavior



Book:

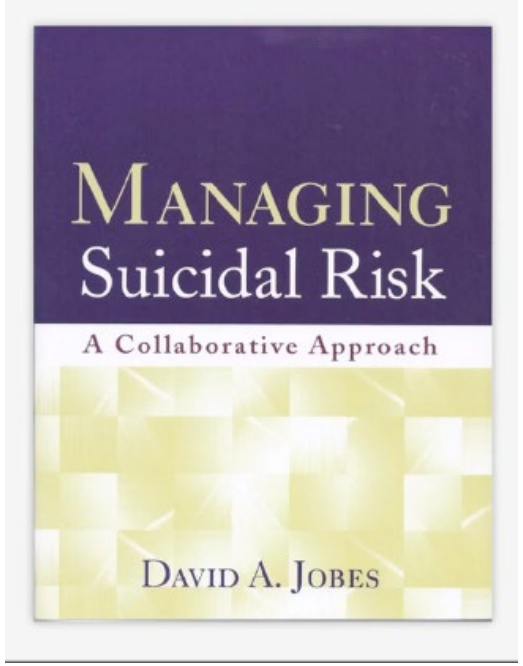
- Crystallizes more than 3 decades of basic, clinical, and therapeutic research, providing a comprehensive review of the psychological factors associated with suicidal behavior
- The authors describe their cognitive model of suicidality, the instruments they developed to classify and assess suicidal behavior, and effective cognitive intervention techniques for suicidal individuals
- The book includes a step-by-step protocol for cognitive therapy that is vividly illustrated in an extended case study
- Individual chapters are dedicated to applying the protocol with special populations and overcoming challenges when working with suicidal patients

Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications.* American Psychological Association. https://doi.org/10.1037/11862-000

Treatment – Collaborative Assessment & Management of Suicidal Risk (CAMS)

- Power trial at the Army in Fort Stewart, GA
  - Rapidly decreases ideation
    - Significant within 3 months of treatment

- A Randomized Controlled Trial of the Collaborative Assessment and Management of Suicidality versus Enhanced Care as Usual With Suicidal Soldiers



Postvention - There is Hope!

- Continued follow-up and return to routine screening
- Step down to lower levels of care
- Update safety plan to address current state
  - What worked?
  - What didn’t work?
  - Who helped?
  - Who didn’t help?
  - Medications?
- Advanced directives

HeadsUp

How else can a crisis look in early psychosis?

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Suicide Resources - General

- Suicide Prevention Resource Center (SPRC) is the only federally supported resource center devoted to advancing the implementation of the National Strategy for Suicide Prevention
- National Action Alliance for Suicide Prevention is a public-private partnership working to advance the National Strategy for Suicide Prevention
- National Suicide Prevention Lifeline: The Lifeline provides 24-hour, toll-free, and confidential support to anyone in suicidal crisis or emotional distress. Call 1-800-273-TALK (8255) to connect with a skilled, trained counselor at a crisis center in your area. Support is available in English and Spanish and via live chat.
- Veterans Crisis Line: This helpline is a free, confidential resource for Veterans of all ages and circumstances. Call 1-800-273-8255, press "1"; text 838255; or chat online to connect with 24/7 support.
- Crisis Text Line: Text HELLO to 741741 for free and confidential support 24 hours a day throughout the U.S.
- Trevor Lifeline is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) young people under 25. The TrevorLifeline is a crisis intervention and suicide prevention phone service available 24/7 at 1-866-488-7386. TrevorText is available by texting “START” to 678678.
  - TrevorSpace is an online international peer-to-peer community for LGBTQ young people and their friends.
- Trans Lifeline is a national trans-led 501(c)(3) organization dedicated to improving the quality of trans lives by responding to the critical needs of our community with direct service, material support, advocacy, and education. The line is available daily from 10 a.m.–4 a.m. EST. Volunteers may be available during off hours. Call 877-565-8860 to speak to someone now.

Suicide Resources – For Participants

- **SAMHSA's Suicide Prevention Resource Center**
  SAMHSA's SPRC provides accurate data, up-to-date research, and knowledge of effective strategies and interventions that are essential to our ability to prevent suicide. Find programs, toolkits, fact sheets, and other resources to help you take effective action.
- **Zero Suicide**
  The foundational belief of Zero Suicide is that suicide deaths for individuals under the care of health and behavioral health systems are preventable. For systems dedicated to improving patient safety, Zero Suicide presents an aspirational challenge and practical framework for system-wide transformation toward safer suicide care.
- **#BeThe1To**
  #BeThe1To is the National Suicide Prevention Lifeline's message for National Suicide Prevention Month and beyond, spreading the word about actions we can all take to prevent suicide. The Lifeline network and its partners are working to change the conversation from suicide to suicide prevention, to actions that can promote healing, help and give hope. Together, we can prevent suicide by learning to help ourselves, help others, seek consultation from trained providers (hotlines and clinicians) and to seek hospital care when necessary.
- **National Action Alliance for Suicide Prevention**
  The National Action Alliance for Suicide Prevention (Action Alliance) is the nation's public-private partnership for suicide prevention. The Action Alliance works with more than 250 national partners to advance the National Strategy for Suicide Prevention. Current priority areas include: transforming health systems, transforming communities, and changing the conversation.
- **Comprehensive Approach to Suicide Prevention**
  This model shows nine strategies that form a comprehensive approach to suicide prevention and mental health promotion. Each strategy is a broad goal that can be advanced through an array of possible activities (i.e., programs, policies, practices, and services).
- **SPRC's Effective Suicide Prevention Model**
  This four-minute video provides a brief overview of SPRC's Effective Suicide Prevention Model, which can help you carry out suicide prevention efforts that are most likely to be effective. It will guide you through the three elements of the model—Strategic Planning, Keys to Success, and the Comprehensive Approach.
- **Strategic Planning Approach to Suicide Prevention**
  Suicide prevention activities, programs, and other efforts are most effective when they are guided by a strategic planning process. The strategic approach can be applied to any aspect of your work—whether you are starting a new program or assessing your progress midway through a project.

Suicide Resources – For Youth and Families

- **#Chatsafe: A Young Person's Guide for Communicating Safely Online About Suicide (PDF | 6.7 MB)**
  The #chatsafe guidelines have been developed in partnership with young people to provide support to those who might be responding to suicide-related content posted by others or for those who might want to share their own feelings and experiences with suicidal thoughts, feelings, or behaviors.
- **Help a Friend in Need: A Facebook and Instagram Guide (PDF | 524 KB)**
  Facebook and Instagram are proud to work with The Jed Foundation and The Clinton Foundation, nonprofits that work to promote emotional well-being and to share potential warning signs that a friend might be in emotional distress and need your help.
- **Seize the Awkward**
  Nobody likes an awkward silence. But when it comes to mental health, awkward silences don't have to be a bad thing. This campaign encourages teens and young adults to embrace the awkwardness and use this moment as an opportunity to reach out to a friend. The campaign focuses on that moment to break through the awkward silence to start a conversation about how they're feeling.
- **What to Do if You're Concerned About Your Teen's Mental Health: A Conversation Guide (PDF | 617 KB)**
  This guide is meant to help parents and families who are concerned about their teen's mental health and emotional well -being have important conversations with their child. Although parents often pick up on concerning signs that their teen is struggling, not everyone feels well-equipped to approach their child to have a conversation about how they are feeling.
- **Youth Mental Health First Aid**
  Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health and human services workers, and other caring citizens how to help an adolescent (age 12–18) who is experiencing a mental health or addiction challenge or is in crisis.

Suicide Resources – For Professionals

- **2012 National Strategy for Suicide Prevention: Goals and Objectives for Action (PDF | 5.1 MB)**
  The National Strategy is a call to action that is intended to guide suicide prevention actions in the United States over the next decade. It outlines four strategic directions with 13 goals and 60 objectives that are meant to work together in a synergistic way to prevent suicide in the nation.
- **AAP Suicide Prevention Resource Library for Pediatric Health Care Providers**
  Pediatricians and pediatric heath care providers have a role to play in reducing the risk of suicide among adolescents and young adults.
- **SPRC's Resources and Programs Repository**
  This searchable repository provides information on several types of suicide prevention programs, such as education/training, screening, treatment, and environmental change.
- **Sources of Strength**
  Sources of Strength is a strength-based comprehensive wellness program that focuses on suicide prevention but impacts other issues such as substance abuse and violence. The program is based on a relational connections model that uses teams of peer leaders mentored by adult advisors to change peer social norms about help seeking and encourages students to individually assess and develop strengths in their life.
- **The Relationship Between Bullying and Suicide: What We Know and What It Means (PDF | 4.9 MB)**
  The purpose of this document is to provide concrete, action-oriented information based on the latest science to help you improve your schools' understanding of and ability to prevent and respond to the problem of bullying and suicide-related behavior.
- **Think, Act, Grow in Action Webinar: Sources of Strength (40 minutes)**
  In this episode of the HHS Office of Adolescent Health's Successful Strategies for Improving Adolescent Health webinar series, Emily Novick discusses the application of the Sources of Strength program.

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HeadsUp

Q&A

Open Discussion

Perelman School of Medicine University of Pennsylvania

Central East (HHS Region 3) MHTTC Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

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DEPARTMENT OF HUMAN SERVICES
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Appreciation

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Let's connect: