

Connecticut's Networks of Care for Suicide Prevention

Evaluation Report
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Introduction

Connecticut's Networks of Care for Suicide Prevention (NCSP) project was designed to implement evidence-based suicide prevention, intervention and response strategies to reduce non-fatal suicide attempts and suicide deaths among youths and young adults, ages 10 to 24 years old in Connecticut. The NCSP took a two-level approach, implementing suicide prevention activities statewide and in a specific selected community, in an Intensive Community Based Effort (ICBE). At both the statewide and ICBE levels, the NCSP built suicide prevention infrastructure and increased access to trainings, resources, and other materials to build suicide prevention capacity; promoted suicide prevention in health care by encouraging healthcare organizations to adopt the Zero Suicide Framework; promoted identification, referral, and follow up for youths at risk for suicide; and fostered the enhancement of suicide prevention-related data collection systems. Some specific activities included establishing five Regional Networks of Care (RNC), to coordinate suicide-prevention services and deliver suicide prevention-related trainings statewide; establishing a Community Network of Care (CNC) in the selected ICBE community, Manchester; and encouraging the implementation of the Gizmo mental health curriculum in schools statewide. Connecticut's Department of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), and Department of Public Health (DPH) co-directed the NCSP. The co-directors partnered with United Way-CT to program manage the NCSP statewide initiatives, and with Community Health Resources (CHR) to program manage the NCSP ICBE in Manchester. DMHAS has contracted with UConn Health to conduct the local evaluation. The NCSP was funded, in part, by a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) - Center for Mental Health Services (CMHS) State Suicide Prevention Program, which awarded the Connecticut Department of DMHAS a five-year State/Tribal Youth Suicide Prevention Cooperative Agreement (SM-15-004) grant on August 1, 2015.

Background

Connecticut has been systematically collecting suicide-related data at the state level since the 19th century.¹ The modern approach taken by the state to prevent suicide began in the late 1980s. In 1989, the legislature mandated that public school curriculums include a component of "mental and emotional health, including youth suicide prevention." The same year, the legislature created a Youth Suicide Advisory Board (YSAB), and located it within the state department that is now the Department of Children and Families (DCF). The YSAB is tasked with serving as a "coordinating source for youth suicide prevention."² Connecticut's Department of Public Health (DPH) organized an informal group among the state agencies to discuss suicide-related issues following a conference on preventable injuries in June 2000. This group was called the Interagency Suicide Prevention Network (ISPN). Inspired in part by the promulgation of the National Strategy for Suicide Prevention in 2001 and by the

¹ Dewey, D. Statistics of Suicide in New England, Publications of the American Statistical Association, vol. 3, no. 18/19 (June - September 1892).

² CGS §17a-52.

recommendations of an earlier state Blue Ribbon Commission on Mental Health, the ISPN drafted Connecticut's first Comprehensive Suicide Prevention Plan in 2005. The plan took a lifespan approach to suicide prevention.

In January of 2012, the YSAB and the ISPN merged to form the Connecticut Suicide Advisory Board (CTSAB), which soon became a stakeholder group of individuals supporting suicide prevention across the age span. According to its website, the current (2020) mission and vision of the CTSAB are:

Mission: The CTSAB is a network of diverse advocates, educators and leaders concerned with addressing the problem of suicide with a focus on prevention, intervention, and health and wellness promotion.

Vision: The CTSAB seeks to eliminate suicide by instilling hope across the lifespan.³

The CTSAB meets monthly for programmatic and strategic planning to address issues related to suicide in Connecticut. As of 2020, it was led by a board of three chairs, including a representative from DMHAS, one from DCF, and one from the Connecticut Chapter of the American Foundation for Suicide Prevention.⁴ The CTSAB has developed and disseminated the Connecticut suicide prevention campaign, "*1 Word, 1 Voice, 1 Life: Be the 1 to start the conversation*" (1 Word), which promotes the National Suicide Prevention Lifeline. It released Connecticut's second comprehensive suicide prevention plan in December of 2014, "*State of Connecticut Suicide Prevention Plan 2020.*" At the time of this report (August 2020), the CTSAB is finalizing another update to the state plan, which is expected to be called "*State of Connecticut Suicide Prevention Plan 2025.*" The CTSAB also makes information and suicide prevention materials available through the public through its website [preventsuicidect.org](https://www.preventsuicidect.org).

Garrett Lee Smith Memorial Act

At the national level, the Garrett Lee Smith (GLS) Memorial Act was passed in 2004 to provide funds to states, Native American tribes, and institutions of higher education to develop suicide prevention and intervention programs. The GLS Program, pursuant to the statute, is administered by the federal Substance Abuse and Mental Health Services Administration (SAMHSA)/Center for Mental Health Services (CMHS), which is housed within the federal Department of Health and Human Services (HHS).

Connecticut Youth Suicide Prevention Initiative (CYSPI)

The State of Connecticut received a three-year grant through the GLS program in 2006. This grant was used to fund the Connecticut Youth Suicide Prevention Initiative (CYSPI), which was administered by DMHAS. The program included many components, touching upon

³ 1 Word 1 Voice 1 Life, be the 1 to start the conversation, "About Us" <https://www.preventsuicidect.org/about-us/> (accessed March 24, 2020).

⁴ Id.

several areas of youth and community suicide prevention services. The Center for Public Health and Health Policy (CPHHP) at UConn Health conducted a local evaluation that focused on four components of the CYSPI: Middle School, High School, College, and programs for high-risk youth.⁵

Connecticut Suicide Prevention Initiative

SAMHSA awarded Connecticut a second three-year grant from the Garrett Lee Smith Suicide Prevention Program on August 1, 2011. The state program funded by this grant was named the Connecticut Suicide Prevention Initiative (CSPI). The initial overall goal of the CSPI was to develop and enhance sustainable evidence-based, culturally competent suicide prevention and mental health promotion policies, practices, and programs at institutions of higher education to reduce suicide contemplation, attempts and deaths of students attending college in Connecticut, with a focus on students ages 18 to 24. DMHAS announced grant sub-recipients in March 2012, and awarded funds to four college campuses from across Connecticut. The participating colleges were Connecticut College, New London; Manchester Community College, Manchester; Norwalk Community College, Norwalk; and Sacred Heart University, Fairfield. It was later decided to expand efforts through the Regional Action Councils (RACs) and subsequently mini-grants were created to fund community groups that serve youths and young adults aged 10 to 24.

Networks of Care for Suicide Prevention

Connecticut began planning to create the Networks of Care for Suicide Prevention (NCSP) in 2015. Generally, the goal of the NCSP was to create regional versions of the CTSAB to facilitate communication between the CTSAB and local prevention efforts and to identify and discuss suicide related concerns specific to certain regions of the state. Connecticut received a third round of GLS funding on August 1, 2015 that enabled the creation of the NCSP. The main initiatives of the NCSP project were to create the infrastructure of the five regional networks of care; create one community network of care; encourage the adoption of the Zero Suicide Framework among healthcare providers; enhance data collection capacity regarding suicide prevention; and provide trainings and other resources.

The goals, objectives, and strategies of the NCSP grant, formally stated, are as follows:

Goal 1: Strengthen CT capacity and infrastructure in support of mental health promotion, suicide prevention, intervention and response with the use of evidence-based practices.

Objective 1: Integrate and coordinate suicide prevention, intervention and response activities across multiple sectors and settings through the enhancement and formalization of a sustainable Statewide Network of Care (SNC) for Suicide Prevention consisting of the CTSAB

⁵ Institute for Public Health Research, Center for Public Health and Health Policy (August, 2010). Connecticut Youth Suicide Prevention Initiative Local Evaluation: Final Report.

and five Regional Networks of Care (RNCs), and one Community Network of Care (CNC) in the town with the intensive effort to support prevention, intervention and response.

Strategies:

1. Identify state, regional and community needs and priorities.
2. Build capacity, readiness and support statewide for suicide prevention, intervention and response efforts.
3. Develop, enhance, implement, and monitor effective EBPs and strategies based on identified needs and priorities that promote wellness and prevent suicide and related behaviors, and address the unique needs of the priority population and sub-populations.
4. Promote suicide prevention as a core component of healthcare services, and engage at least one local behavioral health or healthcare provider per region to adopt the Zero Suicide approach.
5. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement.
6. Increase the acquisition, timeliness, and utility of data and surveillance systems statewide relevant to youth/young adult suicide prevention, and improve the capacity to collect, analyze, and use this information for action.

Goal 2: Develop, enhance, implement and sustain evidence-based, culturally competent suicide prevention, intervention and response practices through an intensive community-based effort for youth age 10-24 in the Town of Manchester, CT.

Objective 2: Integrate and coordinate suicide prevention, intervention and response activities across multiple sectors and settings through the development and formalization of a sustainable Community Network of Care (CNC) for suicide prevention, intervention and response linked to the RNC and SNC.

Strategies:

1. Identify community needs and priorities.
2. Build capacity, readiness and support statewide for suicide prevention, intervention and response efforts.
3. Develop, enhance, implement, and monitor effective EBPs and strategies based on identified needs and priorities that promote wellness and prevent suicide and related behaviors, and address the unique needs of the priority population and sub-populations.
4. Provide early identification/screening, assessment, referral and connection to treatment, recovery support services, and follow-up services for at risk youth and young adults.
5. Promote suicide prevention as a core component of healthcare services, and engage two local behavioral health and healthcare providers to adopt the Zero Suicide approach.

6. Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement with an emphasis on the two local providers.
7. Increase the acquisition, timeliness, and utility of local data and surveillance systems relevant to youth/young adult suicide prevention and improve community capacity to collect, analyze, and use this information for action.

I. Suicide Prevention Resources and Infrastructure in Connecticut

One aim of the NCSP was to build the capacity of communities throughout Connecticut to identify youths age 10 to 24 who are at risk for suicide and connect those youths to suicide prevention care.

A. Statewide (Goal 1, Strategies 1, 2, & 3)

Strategy 1: Identify state, regional and community needs and priorities

Strategy 2: Build capacity, readiness, and support the statewide plan for suicide prevention, intervention and response efforts

Strategy 3: Develop, enhance, implement, and monitor effective [evidence-based practices] and strategies based on identified needs and priorities that promote wellness and prevent suicide and related behaviors, and address the unique needs of the priority population and sub-populations

Connecticut's Networks of Care for Suicide Prevention project was designed to organize the many suicide prevention resources across the state and formalize communication between youth-serving organizations in order to make suicide prevention, intervention, and postvention services more comprehensive and responsive in communities statewide. To do this, the NCSP organized the various suicide prevention systems into one Statewide Network of Care for Suicide Prevention with three constituent levels of organization: a state level, a regional level, and a local level. The Connecticut Suicide Advisory Board (CTSAB), which was created in 2012, was identified to serve as the state level organization.

The NCSP team early in the project created the Connecticut Community Suicide Prevention Survey: Services for 10 to 24 Year-olds (*Services Survey*) to assess the suicide prevention, intervention, and postvention services offered by key stakeholders in communities throughout the state. The results were shared with the NCSP leadership and the CTSAB. The NCSP focused on building the infrastructure of Connecticut's suicide prevention system by further developing the CTSAB and by creating regional organizations dedicated to suicide prevention that could help organize suicide prevention initiatives in local communities. Initially, these regional groups were called the Regional Networks of Care (RNCs), but were later renamed the Regional Suicide Advisory Boards (RSABs). The NCSP facilitated the offering of SPRC-recognized trainings in communities throughout the state and created a resource and curriculum for children, Gizmo's Pawesome Guide to Mental Health, which at the time of this

report was being considered by the American Foundation for Suicide Prevention (AFSP) to be a third-party AFSP-approved program.

Identifying Needs and Priorities: The Services Survey

As an early step in implementing the strategies of the grant, the NCSP leadership determined to identify state, regional, and community needs by creating and administering a comprehensive survey of suicide prevention, intervention, and postvention services available at the community level throughout the state. This survey was named the Connecticut Community Suicide Prevention Survey: Services for 10 to 24 Year-olds (*Services Survey*).

The Garrett Lee Smith grant's National Outcome Evaluation's Prevention Strategies Inventory drove the organization of the survey, and the strategies investigated. This was supplemented by the Suicide Prevention Resource Center's Comprehensive Approach to Suicide Prevention, the JED model, and local suicide prevention needs.

The survey touched upon eight suicide prevention services areas: outreach and awareness; gatekeeper training; workforce development; life skills and wellness development; screening programs; reducing access to lethal means and increasing safe storage; suicide related policies, protocols, and infrastructure; and direct services and traditional healing. The survey also elicited information on suicide prevention coalitions with which the respondents' organizations engaged. It provided respondents an opportunity to rate the capacity of their organizations and rate their organizations' levels of need for assistance to further develop 14 suicide prevention-related capacities. Respondents could also provide additional information in an open comment section.

Approximately 800 individuals representing as many organizations were invited to complete the *Services Survey*. The respondent organizations included private and public mental health providers, police departments, public schools, towns and cities and other key community level organizations. The survey was administered from June to November 2017.

One hundred and fifteen individuals responded to the survey for an estimated overall response rate of 14 percent. The majority of respondents reported that their organizations serve youths ages 0 to 25+ with the largest percentage serving 15 to 19 year olds. Over half (50.4%) of the respondents were affiliated with organizations that provide mental health services. The majority thought their organization was somewhat adequate or adequate at providing suicide prevention (69.2%), intervention (57.4%), and response services (60.9%). Over half of the respondents reported that their organization had medium to high need to improve identifying 10 to 24 year olds who may be at risk for suicide (59.1%), using data to inform system change to improve care for those at risk (57.4%), developing written policies and/or protocols (55.7%), and providing postvention response (51.3%).

The responses to the *Services Survey* served as one source to inform NCSP decisions regarding training and other resource needs across the state. In addition to the survey results, the NCSP

reviewed suicide death and suicide attempt data. The RNCs/RSABs, once established, provided a continual source of information about the needs of communities statewide.

Connecticut Suicide Advisory Board

The CTSAB was identified to serve as the state-level network of care for suicide prevention. It was formed in 2012 from two earlier groups that had focused on suicide prevention. Membership is open to anyone with an interest in preventing suicide. The CTSAB listserv is used to estimate “membership”, since there are no formal membership requirements to join or continue to be part of the CTSAB. In 2014, before the commencement of the NCSP project, there were 204 members of the CTSAB. In the first state fiscal year of the NCSP (July 1, 2015 to June 30, 2016), there were eleven regular meetings of the CTSAB and a symposium in September. On average, 37 members participated in each meeting. The most highly attended meeting that year, in October, attracted 50 attendees. The most lightly attended meeting occurred in April and had 25 members present. One hundred twenty-nine individuals attended at least one CTSAB meeting that year, 61 of whom only attended once. Four members attended 10 of the possible 11 meetings. On average, each member who attended at least one meeting, attended three meetings each. In October 2015, the first month of the current GLS grant, the CTSAB had four active committees: Zero Suicide, Intervention-Postvention, Student Wellbeing, and Armed Forces. The last two committees were styled as a workgroup and advisory panel, respectively.

By the end of the current GLS grant, membership in the CTSAB had grown more numerous, and members tackled an increased number of specific suicide prevention, intervention, and postvention topics. By August 2020, the CTSAB had 790 members. It continued to have eleven regular meetings per year, with an annual symposium in September. In state fiscal year (SFY) 2020 (July 1, 2019 through June 30, 2020), the last full SFY of the current CT GLS grant, there was an average of 44 members present at each meeting, with a high of 64, in April, and a low of 30, in March. Each member who attended at least one CTSAB meeting, attended, on average, three meetings. Fifty-nine attended only one meeting during the year, and one member attended all eleven.

Because of the COVID-19 pandemic, the CTSAB had to switch to an online only format in the spring of 2020. Previously, all CTSAB meetings had been in person, though call-in and other tele-meeting options were often available if requested. One effect of the new format may have been to increase attendance, at least in the short term. The average attendance between July 2019 and February 2020 was 40 and the average between April and June was 57 members. (Other factors, such as the anticipated increase in need for suicide prevention and other behavioral health services that might result from the pandemic, may have encouraged this increase in attendance.)

By June 2020, the CTSAB had eight committees that regularly met: Data and Surveillance (see Section IV.A), Intervention-Postvention, Lethal Means, Attempt Survivors/Lived Experience, Zero Suicide Learning Community (ZSLC) (see Section II.A), Advocacy, and Armed Forces. In

addition, the ZSLC had developed a clinical workgroup to focus specifically on the clinical needs of implementing the Zero Suicide Framework. Each committee regularly reports updates to the full CTSAB (depending on the frequency with which the committee meets). Starting in November 2017, the CTSAB also began receiving periodic reports from the suicide prevention groups created in each of the DMHAS regions. Information from these groups assisted the CTSAB determine statewide priorities.

Regional Networks of Care / Regional Suicide Advisory Boards

One of the key initiatives of the NCSP was to create suicide prevention organizations in each of the five DHMAS regions across the state. The primary intended functions of these regional organizations were to assist organize and direct local suicide prevention efforts, and inform the CTSAB of suicide prevention-related information from communities across the state.

The NCSP began planning for the creation of these organizations almost immediately after notification of the grant award. The initial versions of these organizations were referred to as the Regional Networks of Care for Suicide Prevention (RNC). The RNCs were created, in part, with support from the CT GLS grant, and were organized by NCSP staff, with the NCSP statewide program manager responsible for the details of facilitating the RNC meetings. Each RNC consisted of key suicide prevention stakeholders in the respective regions, and the expectation was that each region would meet in a community forum multiple times throughout the year.

In August 2017, in preparation of the first RNC community forums, the NCSP hosted a 45-minute introductory webinar. For the convenience of the RNC participants, the webinar was offered at three different times (Table 1). The webinar introduced the goals of the NCSP and provided an overview of the planned activities. The webinar also informed the attendees of the initial RNC community forum meetings and described the expectations of those meetings.

Table 1
RNC Webinar Dates

August 17 th from 12:00 p.m. to 12:45 p.m.
August 17 th from 3:00 p.m. to 3:45 p.m.
August 18 th from 9:00 a.m. to 9:45 a.m.

The RNCs commenced their first series of meetings in the autumn of 2017. Representatives from key suicide prevention organizations in each region and NCSP staff attended. The NCSP project co-director from DMHAS and the NCSP statewide program manager facilitated the forums, and provided introductions and an overview of suicide prevention in Connecticut.

The first of the community forums was held in Windsor, in Region 4, on October 11, 2017. Each of the RNCs met three times to discuss community needs related to suicide prevention in their regions during FFY 2018. The types of organizations represented at these RNC meetings included: adult and child mobile crisis, school systems, Local Prevention Councils, town governments, child guidance clinics, behavioral health organizations, and institutions of higher education.

Table 2 displays the dates of the community forums and the number of members in attendance during FFY 2018. Most of the meetings were held in person at locations within a given region. One community forum was conducted via a Zoom online conference. Phone conference lines were made available on several occasions although no participant utilized this option.

Table 2
RNC Meetings, FFY 2018

Region	Kickoff/Launch Meeting	Meeting 2	Meeting 3
Southwestern (Region 1, Norwalk, CT)	October 24, 2017	March 23, 2018	July 20, 2018
Number attended	16	17	7
South Central (Region 2, Branford, CT)	October 18, 2017	March 28, 2018	June 7, 2018
Number attended	20	20	9
Eastern (Region 3, Norwich, CT)	November 1, 2017	April 23, 2018	July 25, 2018
Number attended	11	17	15
Northcentral (Region 4, Windsor, CT)	October 11, 2017	April 27, 2018	July 24, 2018
Number attended	24	16	5
Northwestern (Region 5, Newton, CT)	October 26, 2018	March 16, 2018	June 15, 2018
Number attended	19	16	9

The agenda items for each of the three meetings were uniform across the RNCs. Each meeting began with a welcome and introductions. The content of the Kickoff Meetings focused on an overview of suicide prevention in Connecticut, regional and state-level suicide death and hospitalization data, the CTSAB State Plan and Goals, and a description of the state Network of Care for Suicide Prevention initiative. In Meeting 2, the NCSP statewide program manager reviewed the NCSP initiative's purpose, objectives, timeline, and opportunities for involvement with the RNC. The community forum for Meeting 3 focused on the formalization of the coalition. During the course of these meetings, the RNCs were provided region-specific results of the *Services Survey*, and region-specific suicide ideation, attempt, and death data as estimated by data from the YRBS survey, HIDD, and the CTVDRS.

Each RNC hosted four quarterly meetings in FFY 2019 (Table 3). The meetings continued to be facilitated by the NCSP statewide program manager and had fairly uniform meeting dates and agenda items across the regions.

Table 3

RNC Meetings, FFY 2019

Region	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Southwestern (Region 1)	October 10, 2018 Online meeting	January 9, 2019 Wilton	April 10, 2019 Wilton	July 10, 2019 Norwalk
South Central (Region 2)	October 9, 2018 North Haven	January 8, 2019 North Haven	April 9, 2019 North Haven	July 9, 2019 North Haven
Eastern (Region 3)	October 23, 2018 Norwich	January 22, 2019 Norwich	April 23, 2019 Norwich	July 23, 2019 Norwich
North Central (Region 4)	October 16, 2018 Rocky Hill	January 15, 2019 East Hartford	April 16, 2019 Manchester	July 16, 2019 East Hartford
Northwestern (Region 5)	October 25, 2018 Newtown	January 24, 2019 Newtown	May 1, 2019 Waterbury	July 10, 2019 Norwalk

Each of the RNC meeting agendas included the topics of data sharing and identification of other community representatives to invite to join the RNC. The RNC meeting agendas also introduced a new topic at each of the quarterly meetings. At the first quarterly meetings in FFY 2019, held in October of 2018, the RNCs discussed potential suicide prevention-related areas of focus for the communities within their regions. They identified regional training needs at the second quarterly meetings and identified training opportunities at their third quarterly meetings. At the fourth quarterly meetings, held in July 2019, the RNCs focused on determining how to sustain themselves after the close of the current GLS grant in September 2020.

During FFY 2019, the three Co-Directors of the NCSP and the NCSP statewide program manager at United Way formed the RNC Advisory Group. The initial purpose of the advisory group was to assist the RNCs identify a means to continue beyond the close of the current GLS grant in September 2020. It also identified cross-region issues, and helped the RNCs select resources relevant to their regions. The RNC Advisory Group first met on November 6, 2018. Twenty-two individuals joined the first meeting.

The RNC Advisory Group met seven times in FFY 2019. Eleven entities were regularly represented at these meetings. These included the home agencies of the three project directors: DMHAS, DPH, and DCF; each of the five RNCs; a non-profit entity, FAVOR; and Beacon Health. In addition, a representative from Communities 4 Action joined the first RNC Advisory Group meeting on November 6, 2018.

Themes that were introduced at the first meeting and continued throughout the fiscal year included sustaining the RNCs within the existing DMHAS and DCF systems after the conclusion of the current GLS grant in 2020; helping RNCs involve physical health providers in suicide prevention initiatives; collecting and sharing region-relevant data; and identifying resources for the RNCs.

The advisory group determined that the RNCs should transition into the newly created Regional Behavioral Health Action Organizations (RBHAOs). The RBHAOs were organized in February 2018, to consolidate and continue the work of Connecticut's former Regional Mental Health Boards (RMHBs) and Regional Action Councils (RACs).

Over the course of the year, the RNC Advisory Group made connections with local health departments, which culminated in a presentation to Local Health District members in June; empaneled a data workgroup to examine region-specific data needs and resources; and helped conceptually organize the discussions at the RNC meetings.

The RNC Advisory Group continued to meet during FFY 2020, the final year of the GLS grant. The organizations represented at the RNC Advisory Group meetings continued from the previous year.

Having facilitated the transition of the work of the RNCs into the RBHAOs, the RNC Advisory Group turned its attention to the details of reorganizing the regional networks. The group developed templates of organizing documents for the RNCs, now named the Regional Suicide Advisory Boards (RSABs), including a template for by-laws, coalition agreements and a TA document. The group also developed a plan to advertise the newly reformed RSABs within the Connecticut suicide prevention community and worked with the CTSAB to establish an area on the preventsuicidetct.org website for RSAB materials. This was accomplished and the RSABs posted their FFY 2020 meeting minutes to the designated webpage.

The RNC Advisory Group determined that a common theme across the regions was a desire for more postvention resources. The group focused on identifying postvention resources for the RSABs until the SARS-CoV-2 virus was detected in the state in early spring. The first COVID-19 case was diagnosed on March 8, 2020 and Connecticut's governor declared a public health emergency on March 10, 2020. The next meeting of the RNC Advisory Group following the declaration of a public health emergency occurred on June 9, 2020. At this meeting the group switched focus to the newly emerging needs caused by the pandemic, with particular attention given to identifying resources for schools in anticipation of their re-opening in late summer. At this meeting, it was also determined that the work of the RNC Advisory Group would be aided by the creation of a subcommittee that focuses on resources for specific populations that are currently underrepresented.

The final meetings of the RNCs, as originally organized, occurred in July of 2019 for all of the regions. During the summer and fall, the new RBHAOs were formed and the RNCs were reorganized and renamed the Regional Suicide Advisory Boards (RSABs), which became constituent parts of the RBHAOs. The first newly reconstituted RSAB meeting occurred on September 13, 2019. This was the Southwest RSAB. The NCSP statewide program manager from United Way continued to be involved in the RSABs, but organizational leadership was transitioned to the respective RBHAOs.

Table 4

RSAB Meetings, September 2019 to June 2020

Region	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Southwestern (Region 1)*	September 13, 2019 Norwalk	December 13, 2019 Norwalk	May 15, 2020 Online	
South Central (Region 2)				
Eastern (Region 3)	October 3, 2019 SERAC November 7, 2019 SERAC			
North Central (Region 4)		January 15, 2020 East Hartford	April 30, 2020 Online	
Northwestern (Region 5)*	September 25, 2019	December 18, 2019	May 14, 2020 Online	June 24, 2020 Online

* As the Region 1 and Region 5 RNCs became the Region 1 and Region 5 RSABs, the meeting patterns of these two regions shifted to a month earlier than previously. While September 2019 was technically in the fourth quarter of FFY 2019, the September meetings for these regions were treated by the participants as the first meeting of the “year,” and so marked accordingly on this table.

Most of the RSABs continued to meet during FFY 2020. By August, the Northwestern Region had reported meeting each quarter. The Southwestern Region reported meeting three times, and the Eastern Region and the North Central Region both reported meeting twice. In the fall, the focus of the meetings across the reporting RSABs was the development of postvention resources in their respective communities. The April, May and June meetings however, all of which were conducted online, quickly shifted to address the needs arising as a result of the pandemic. With the shift in leadership from the NCSP to the RBHAOs, there was less uniformity at the meetings across the regions than previously. For example, two of the regions shifted their first meetings of the year back a month from October to September (presumably to more closely track the school year). The subsequent meetings in these two regions similarly occurred a month earlier than in prior years.

NCSP Gatekeeper and Other Trainings

NCSP staff, working with the RNCs/RSABs, have offered training for suicide prevention in all five DMHAS regions in Connecticut. Data on these trainings were collected using the Training Activity Summary Page (TASP). These data were collected by the project manager for the ICBE component at CHR and by the project manager for the statewide component of the NCSP at United Way until April 30, 2019. Although suicide prevention trainings continued in

Connecticut after that date, statewide training-related information was unavailable to the evaluators for trainings that occurred after April 30, 2019.⁶

During this period, NCSP staff offered 164 training sessions to an aggregate total of 7,644 attendees in the five DMHAS regions (individuals may have attended more than one training in one or more DMHAS regions). Region 5, Northwestern, had the most training sessions (n= 59). As was true for the state overall, most of the trainings in Region 5 were for the gatekeeper training “Question, Persuade, Refer” (QPR), with 41 sessions. The region also hosted 18 sessions of Signs of Suicide (SOS) in middle schools and high schools. Region 4, North Central, which is home to Manchester and the NCSP’s ICBE, reported training the highest aggregate number of attendees: 4,294.

Of the 164 training sessions delivered during the period, there were 132 QPR sessions; one QPR-T training; one QPR for Physicians, Physician Assistants, Nurse Practitioners, and others; 24 sessions of SOS; one CALM training; two CSSR-S trainings, and three Mental Health First Aid trainings (Table 5). Most of the trainees (5,896) were connected to K-12 educational institutions, including teachers, staff, and students. There were also 566 mental health providers trained during the period (Table 6). For the vast majority of trainings, the primary intended purpose was to help participants have conversations about suicide and suicide prevention with youths and others (136, or 83% of FFY 2019 training sessions). Fifteen of the trainings had the primary purpose of training staff or community members in suicide prevention, five trainings focused on identifying youths who might be at risk for suicide prevention and one training primarily intended to convey information on making mental health services referrals (Table 7). Other trainings focused on screening youths for suicide behaviors (2); working with adult at-risk populations (2), and enhancing life skills and coping mechanisms (2).

⁶ The Manchester CNC continued to provide limited training data specific to Manchester for the local evaluation covering trainings provided through it in the final year of the grant. Those results are reported in Section I.B.

Table 5

NCSP-sponsored Suicide Prevention Trainings, September 7, 2016 to April 30, 2019

DMHAS Region	Name of Training	Number of Trainings	Number of Training Attendees*
1. Southwest	Total	4	40
	QPR	4	40
2. South Central	Total	26	1,043
	QPR	25	904
	SOS	1	139
3. Eastern	Total	22	726
	QPR	20	576
	SOS	2	150
4. North Central	Total	53	4,294
	QPR	43	2,360
	QPR-T	1	11
	SOS	3	854
	CALM	1	570
	CSSRS	2	455
	Mental Health First Aid	3	44
5. Northwest	Total	59	1,541
	QPR	40	1,089
	QPR for Phys., PAs, NPs, etc.	1	17
	SOS	18	435
Total QPR		132	4,969
Total QPR-T		1	11
Total QPR for Physicians, PAs, NPs, and others		1	17
Total SOS		24	1,578
Total CALM		1	570
Total CSSRS		2	455
Total Mental Health First Aid		3	44
Total		164	7,644

Table 6
Suicide Prevention Training Attendees, by Primary Role in the Community

	Number of Trainees	Percent of Trainees by Primary Role
K-12	5,896	84.3
Higher Education	99	1.4
Substance Abuse	54	0.8
Juvenile Justice/Probation	32	0.5
Emergency Response	54	0.8
Tribal Services/Tribal Government	0	0.0
Child Welfare	31	0.4
Mental Health	566	8.1
Primary Healthcare	60	0.9
Other	201	2.9
Total	6,993*	100.0

* Data on the primary role of a total 81 attendees, at five trainings, were missing.

Table 7
Primary Intended Outcomes for Training Participants, FFY 2019

	Number of Trainings	Number of Trainees
Screen youths for suicide behaviors (using a screening tool)	2	221
Have conversations about suicide and suicide prevention with youths and others	136	5,468
Identify youths who might be at risk for suicide	5	1,082
Provide direct services to youths at risk for suicide and/or their families	0	0
Train other staff or community members	15	225
Make referrals to mental health services for at-risk youths	1	14
Work with adult at-risk populations	2	586
Enhance life skills and coping mechanisms	2	42
None listed	1	6
Total	164	7,644

Gizmo's Pawesome Guide to Mental Health

Gizmo's Pawesome Guide to Mental Health is a picture book with an associated curriculum that introduces mental health and wellness knowledge and skills to youth with the hope that they might apply what they learn to stay healthy and safe. Development of the guidebook began in the spring of 2017. The book incorporates Connecticut's suicide prevention mascot, Gizmo the therapy dog, who is depicted as the narrator of the book. Gizmo and his friends introduce youth to the concept of mental health, teach coping strategies, and guide relationship building with trusted adults. The organization and content of the book was influenced by Brown and Stanley's Safety Plan. The program is designed for youth in grades K-5 but is recommended for students in second to fifth grade.

Gizmo's Pawesome Guide to Mental Health was officially released at Connecticut's suicide prevention symposium on September 14, 2017. By November of that year, 4,000 copies of the guide had been distributed. Most copies of the book were distributed in Connecticut, but there was interest from other states and other countries, too. In September 2018, a distribution system was established that enabled the Gizmo book to be distributed out of state.

By December 2017, NCSP staff and others began developing a curriculum to introduce the Gizmo book in schools. The curriculum was informed, in part, by feedback from educators who had acquired the book and incorporated it into their classrooms. The initial version of the Gizmo curriculum was completed by May 2018. During this period, a website for the book and curriculum was also developed, www.gizmo4mentalhealth.org.

A feasibility study was conducted with six voluntary public elementary schools with 150 students in grades first through fifth during the 2018 spring semester. The data collection tools for the feasibility phase of the Gizmo evaluation were developed and administered by DMHAS. Results from the feasibility study were used to modify the curriculum for use in the subsequent phases of the evaluation.

A Request for Proposals, entitled the CT Networks of Care for School Systems Suicide Prevention and Mental Health Promotion (Networks of Care for School Systems), was disseminated by United Way in May 2018 to CTSAB members through the listserv, public school superintendents in Connecticut, and the five Regional Networks of Care.

Twenty-one entities submitted applications (although one later withdrew). Twenty applications were funded: eleven school systems and nine towns that collaborated with a school system. The RFP required that the funded school systems involve an elementary school, middle school and high school. For their participation in the entire project, the grantees received a total of \$20,000 over two years (\$10,000 per year).

The grantees committed to participating in two years of the curriculum evaluation. The Pilot Year (Year 1, spring semester 2019) focused on better understanding of the Gizmo curriculum, activities and implementation process including areas of strength and suggestions for

improvement. This information contributed to updating the curriculum and corresponding activities. The links to the surveys were active until July 2019. Site coordinators were required to submit annual reports to United Way of Connecticut by July 15, 2019. The Implementation Year (Year 2, academic year 2019-2020) focused on identifying which of the required and optional activities were implemented, identifying areas of strength and suggestions for improving the activities (e.g., time requirements, supplies needed, etc.), determining the degree of adoption and utilization of the Mental Health Plan (e.g., do students and/or adults understand the purpose of the Mental Health Plan, are students and/or adults using the Mental Health Plan), determining the degree of adoption and utilization of the Trusted Adult materials (e.g., Valentines, pins, stickers).

There were two sets of surveys used for this evaluation: one for the Pilot Year and one for the Implementation Year. For the Pilot Year, data collection surveys were created using SurveyGizmo, an online survey tool. There were eight different surveys sent to sites participating in the pilot program. These surveys included a demographic form, a survey for each of the five segments of the curriculum, a Six Week Check-up survey, and an Overall Curriculum Survey. In November 2019, the evaluation team revised the pilot surveys and created new surveys using SurveyMonkey, an online survey software. Based on the results from the pilot, the surveys were consolidated into two components: the Gizmo Guide Evaluation Survey that collected demographics and feedback about the five segments of the curriculum; and the Gizmo Six-Week Check-up and Overall Evaluation Survey. For the Pilot Year, the survey links opened during spring semester 2019 and closed July 2019. For the Implementation Year, the survey links were active from November 2019 to July 2020. Descriptive analyses of the implementation survey data were conducted in FFY 2020. Item numbers and percentages were calculated in SPSS Version 25. Results of the Gizmo evaluation are provided in a separate report.

The American Foundation for Suicide Prevention (AFSP) began discussing the possibility of recognizing the Gizmo book and accompanying curriculum as a third-party AFSP-approved program in March of 2019. Discussions continued throughout the remainder of the year. A multi-state pilot of the program was to be implemented in the spring of 2020, but, due to the COVID-19 pandemic, the pilot was postponed.

B. Intensive Community Based Effort (Goal 2, Strategy 1, 2, & 3)

Strategy 1: Identify community needs and priorities

Strategy 2: Build capacity, readiness, and support [communitywide] for suicide prevention, intervention and response efforts

Strategy 3: Develop, enhance, implement, and monitor effective [evidence-based practices] and strategies based on identified needs and priorities that promote wellness and prevent suicide and related behaviors, and address the unique needs of the priority population and sub-populations.

A primary initiative of the Intensive Community Based Effort (ICBE) was to create a Community Network of Care (CNC). CNCs are intended to provide a network for key organizations that either provide suicide care in the community or regularly encounter youths and young adults aged 10 to 24 years old. These providers and potential gatekeepers are intended to gather information about community needs; collaborate on issues related to coordinating care, identifying those at risk, providing resources to avert a suicide crisis, and ensuring appropriate follow-up care; and help identify useful trainings and other resources. They are also expected to communicate with (and have members that participate in) the RNC/RSABs. Manchester was selected as the location for the ICBE, and, consequently, hosted the first CNC. The NCSP funded a program manager to oversee the ICBE; this program manager was situated at CHR, which acts as DMHAS's Local Mental Health Authority in the town of Manchester. In addition to forming the local component of the statewide network of care, the NCSP ICBE component sponsored several suicide prevention trainings during the grant period.

Manchester Community Network of Care

The original members of the Manchester CNC were: CHR; Eastern Connecticut Health Network (ECHN), which is the parent organization of Manchester Memorial Hospital; Manchester Community College (MCC); the Manchester Police Department (MPD); and Manchester Public Schools (MPS). Connecticut Children's Medical Center (CCMC) indicated interest in the NCSP during the grant period and began regularly attending CNC meetings during the final year of the NCSP project. CCMC does not have a campus in Manchester, but it does regularly serve youths and young adults from the town.

The initial meeting of the Manchester CNC was on February 27, 2017. The CNC met a total of five times in its first year, FFY 2017. Additionally, many regular attendees of the CNC meetings gathered as part of SAMHSA's Connecticut site visit in September 2017. The dates, locations, and organizational representation of the CNC meetings are displayed in Table 8. In addition to the community partners, NCSP staff, including the NCSP statewide program manager, regularly attended CNC meetings.

Table 8

Manchester CNC Meetings, FFY 2017

Date	Location	CNC partners in attendance
February 27, 2017	Manchester Community College	CHR, MPS, ECHN, MCC
March 27, 2017	Manchester Police Department	CHR, ECHN, MCC, MPS, MPD
April 24, 2017	Manchester Memorial Hospital	CHR, ECHN, MCC, MPS
May 22, 2017	Manchester Memorial Hospital	CHR, ECHN, MCC, MPD
July 31, 2017	CHR	CHR MCC, MPS, MPD

The Manchester CNC also formally met five times during FFY 2018 (Table 9). In addition, NCSP staff met individually with CNC partners, and the partners themselves communicated frequently via email with each other and jointly organized events outside of the formal CNC meetings. All of the CNC partners from FFY 2017 continued into FFY 2018.

Table 9
Manchester CNC Meetings, FFY 2018

Date	Location	CNC partners in attendance
October 23, 2017	CHR	CHR, MCC, MPS
December 11, 2017	Manchester Board of Education	CHR, ECHN, MCC, MPS
February 26, 2018	Manchester Police Department	^a
July 6, 2018	CHR	CHR, MCC, MPS
September 17, 2018	Manchester Memorial Hospital	CHR, ECHN, MCC, MPD, MPS

^a The minutes from this meeting were unavailable at the time of this report; it is unclear which CNC partners attended.

In FFY 2018, the Manchester CNC engaged in several coordinating activities and served as a means for the CNC partners to advertise suicide prevention programs, events, and related information from across Manchester. The CNC partners also developed work plans that provided for both coordinated CNC activity, and suicide prevention activities of individual CNC partners outside the formal structure of the CNC.

The Manchester CNC was invited to present at the Connecticut Suicide Prevention Conference in May 2018. The presentation was entitled “Collaborating across Community Sectors and Settings to Prevent Suicide.” The CNC also organized GLS-sponsored gatekeeper trainings, suicide-prevention awareness events, and a radio advertisement that aired on a local radio station that year. The CNC partners helped to organize a group that addresses the specific concerns of first responders in the Manchester area. The initial First Responders meeting was held on June 22, 2018.

In addition, the Manchester CNC, or individual partners working jointly with other CNC partners, organized several events in FFY 2018. MCC regularly hosted QPR trainings, most of which were open to the public. On December 28, 2017, MCC and CHR organized a QPR training specifically for EMPS professionals at CHR. MCC hosted a National Depression Screening Day on October 5, 2017, at which CHR clinicians screened nearly 70 students for depression. CHR hosted a Community Health Fair the following day, to which MPD sent staff. MPS organized a pilot program to implement the “Jordan Porco Fund’s 4 What’s Next” program in the 2017-18 school year, with assistance from CHR and other CNC partners; and MCC hosted its first Fresh Check Day on September 26, 2018, with assistance of the CNC. This last event was attended by nearly 250 students.

At the end of FFY 2018, Connecticut Children’s Medical Center (CCMC), which serves patients throughout the state, indicated an interest in joining the CNC and coordinating with CHR to implement Zero Suicide in its Emergency Department.

The Manchester CNC formally met at least five times during FFY 2019 (Table 10). All of the original CNC partners continued to participate in FFY 2019.

Table 10
Manchester CNC Meetings, FFY 2019

Date*	Location	CNC partners in attendance
November 19, 2018	CHR	CHR, MPS, MPD, ECHN
December 19, 2018**	CHR	CHR, MCC, MPS, ECHN
January 28, 2019**	CHR	CHR, MPD, ECHN
March 25, 2019	CHR	CHR, MCC, MPS, ECHN
August 26, 2019	CHR	CHR, MPS

* There may also have been a meeting held on May 20, 2019, but, if so, no information about it was made available for the local evaluation.

** Minutes were available for the December 2018 and January 2019 meetings.

The partners determined, at the December 19, 2018 meeting, to build upon the work plans they developed the previous year and create 90-day action plans. Whether this was done, however, is not reflected in the CNC meeting minutes provided for the local evaluation. In March 2019, the CNC hosted a guest speaker, Ann I. Dagle of the Brian T. Dagle Memorial Foundation. The June meeting was canceled; the August meeting was quickly adjourned due to low attendance; and the September meeting was cancelled.

As part of its awareness campaign, the Manchester CNC facilitated the placement of a banner across Main Street in Manchester during the month of October 2018. This banner notified the community of the Connecticut Suicide Prevention Campaign - *1 Word, 1 Voice 1 Life...Be the 1 to start the conversation!*

Negotiations to create a Memorandum of Agreement (MOA) between CHR and CCMC began in early FFY 2019. In June, CHR announced that it and CCMC had signed an MOA. Among other things, CCMC indicated an intent to work with the CNC clinical partners to implement Zero Suicide and share identification, referral, and follow-up data for the Manchester youths entering its emergency department that it identifies as at risk for suicide.

CNC partners, either alone or in coordination with other CNC partners, sponsored several events in FFY 2019. CHR hosted its second Wellness Fair on October 5, 2018. This event was open to the public. The CNC had a table at the fair with suicide prevention related

information. MCC, with the assistance of CHR, sponsored a National Depression Screening Day, during which more than 65 students were screened for depression. A second depression-screening event in May 2019 screened 80 students, faculty, and staff. MCC and CHR spent time in FFY 2019 planning for a National Fresh Check Day to be held on the MCC campus in early FFY 2020.

The Manchester CNC formally met three times in FFY 2020. Minutes were taken at two of those meetings. All of the original members of the CNC continued to be active in FFY 2020. In addition, CCMC formally joined the CNC and began attending meetings in January 2020. Returning to its previous practice, the CNC meetings were hosted by different CNC partners each month and, consequently, were held in three different locations around town.

Table 11
Manchester CNC Meetings, FFY 2020

Date	Location	CNC partners in attendance
November 19, 2019	CHR	CHR, ECHN
January 29, 2020*	Manchester Police Department	CHR, MPD, MCC, CCMC
February 24, 2020*	Manchester Community College	CHR, MPD, MCC, MPS, ECHN, CCMC

* Minutes were available for the January and February meetings.

As in previous years, the CNC meetings provided the partners an opportunity to inform other members in the group of their individual suicide prevention activities, share ideas related to those activities, identify and coordinate the implementation of appropriate trainings and determine activities to engage in as a group. At the January 2020 meeting, CCMC provided a general overview of its newly begun suicide screening program and provided some summary data on Manchester youths and young adults screened by that program. As part of the CNC’s awareness campaign, CNC members provided interviews on two occasions in the spring of 2020. Staff from CHR and MCC were interviewed by a local CBS affiliate through a Facebook Live event, and staff from CHR provided an interview with local radio station The River, 105.9 (this interview has been archived by the internet radio service iHeartRadio). Manchester CNC members also discussed means of identifying funding for CNC activities after the conclusion of the current GLS grant. At the February 2020 meeting, the members decided to formalize a bi-monthly meeting schedule moving forward. The arrival SARS-CoV-2 to Connecticut and the ensuing pandemic, however, disrupted meeting plans. At the time of this report, no formal meetings occurred after February. The various Manchester CNC partners continued to communicate informally with each other, however, through email, telephone and video conference meetings. A postvention training organized in conjunction with NAMI NH, originally scheduled for March, was held as a virtual training on July 15, 2020.

Other activities organized by one or more CNC partners in FFY 2020 included the annual Fresh Check Day on October 3, 2019, hosted by MCC and organized in conjunction with CHR.

MCC reported that 150 surveys were collected. CHR and MCC soon thereafter began organizing the next Fresh Check Day, to be held in the fall of 2020. CHR held its third annual Wellness Fair on October 4, 2019. CHR and MPD continued to meet to discuss the CIT program, and invited other members to join.

NCSP ICBE Suicide Prevention Trainings

The NCSP ICBE sponsored 30 suicide prevention and related trainings between January 17, 2017 and July 15, 2020. An aggregate total of 2,365 individuals were reported to have attended these trainings (some individuals may have attended more than one training). The following trainings were offered during this period: QPR, SOS, CALM, and Mental Health First Aid, and training to use CSSR-S (Table 12). CHR initially collected data regarding these trainings using the NOE instrument the Training Activity Summary Page (TASP). CHR discontinued this on April 30, 2019, but continued to collect limited data regarding the trainings through the duration of the grant.

Table 12

NCSP ICBE-Sponsored Suicide Prevention Trainings, January 27, 2017 to July 15, 2020

Type	Number of sessions	Number of attendees
QPR	30	290
QPR for Physicians, etc.	2	11
SOS	4	854
CALM	8	664
Mental Health First Aid	4	53
CSSRS	4	493
Total	52	2,365*

* Two trainings are missing attendee counts.

Each of the original CNC partners hosted at least one training session at their respective facilities. (CCMC, which joined the Manchester CNC later, also offered suicide prevention-related trainings, but these were not funded by the NCSP project and so are not included in these tables.) MCC hosted the most CNC trainings, 29 out of the 52. Most of these trainings were QPR trainings. After SARS-CoV-2 was discovered in the state in the spring of 2020, several of the planned trainings were adopted for on-line presentation. In total, 11 NCSP ICBE-sponsored trainings were provided online. MCC hosted QPR trainings via the internet video service Zoom. A two-day postvention training was made accessible through Zoom and GoToWebinar.

Table 13

Location of NCSP ICBE-Sponsored Trainings, January 27, 2017 to July 15, 2020

Location	Number of trainings	Number of attendees
MCC	29	276
CHR	5	861
MPD	3	35
MPS	2	822
ECHN	1	216
Virtual	11	146
Location missing	1	9
Total	52	2,365

*Two trainings are missing attendee counts.

Data is available on the primary community role of the trainees and the types of resources provided to trainees for the 30 trainings that occurred between January 27, 2017 and April 30, 2019, only. Among the attendees, the highest proportion were connected with the provision of mental health services (47.1%). This was followed closely by members of K-12 educational institutions (teachers, staff, and students), who comprised 40.6 percent of the trainees. Attendees with other roles in the community included higher education, primary health care and other community settings (Table 14).

Table 14

Primary Role of Trainees in CNC-sponsored Suicide Prevention Trainings January 17, 2017 to April 30, 2019

	Number of Trainees	Percent of Trainees by Primary Role
K-12	860	40.6
Higher Education	99	4.7
Substance Abuse	6	0.3
Juvenile Justice/Probation	1	0.0
Emergency Response	22	1.0
Tribal Services/Tribal Government	0	0.0
Child Welfare	14	0.7
Mental Health	998	47.1
Primary Healthcare	45	2.1
Other Community Settings	75	3.5
Total	2,120*	100

*The primary role is unknown for 6 trainees. These 6 attended a training on 12/6/2018 for QPR.

Several resources were made available to attendees during the training sessions, in addition to the training itself. Attendees were provided with local crisis center information, mobile or online tools for suicide prevention and fact sheets at most of the trainings. Attendees at half of the trainings were also provided with wallet cards with suicide prevention information (Table 15).

Table 15

Resources Offered at CNC-sponsored Gatekeeper Trainings, January 17, 2017 to April 30, 2019

Type of resource	Number of trainings offering resource	Percent
Local crisis center information	26	86.7
Mobile or online tools or applications for suicide prevention	21	70.0
Fact/Resource sheets	20	66.7
Wallet card information	15	50.0
None	4	10.0

II. Promote Suicide Prevention as a Core Component of Healthcare Services

A second aim of the NCSP was to ensure that healthcare providers throughout the state are equipped to provide adequate suicide prevention care.

A. Statewide (Goal 1, Strategy 4 & 5)

Strategy 4: Promote suicide prevention as a core component of healthcare services, and engage at least one local behavioral health or healthcare provider per region to adopt the Zero Suicide approach

Strategy 5: Promote and implement effective clinical and professional practice for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement

Connecticut's Zero Suicide Learning Community (ZSLC) was created as a committee of the CTSAB in the fall of 2015, in conjunction with the start of the NCSP project. The kickoff meeting was held on October 8, 2015. Twelve organizations from across the state involved with healthcare services attended, including healthcare providers, behavioral health providers, and state agencies. Following the kickoff meeting, the ZSLC has met regularly, first monthly then bimonthly, for the duration of the NCSP and plans to continue to meet after the close of the current GLS grant in September 2020. Meetings of the ZSLC were planned to coincide with the larger monthly CTSAB meetings, and the work of the ZSLC was closely coordinated with the work of the larger group.

The ZSLC helped organize a Zero Suicide Academy in Connecticut, held on May 2 & 3, 2018. Eleven Connecticut systems attended (Beacon Health Options, Bristol Hospital, Community Health Resources, CT Children’s Medical Center, CT Department of Correction, CT Valley Hospital, ECHN, Hartford Healthcare-Natchaug and Rushford, Perceptions Programs, and Veterans Affairs Healthcare System). Group facilitators were from Beacon Health Options, DMHAS, CHR, Judicial/Court Support Services Division, UConn Health, and the Institute of Living.

At the beginning of FFY 2019, 119 individuals representing 30 healthcare systems had joined the ZSLC; approximately 17 individuals, on average, attended each monthly meeting. In October 2018, Hartford Healthcare announced its plans to implement Zero Suicide in all of its healthcare sites. Early in FFY 2019, the ZSLC invited Dr. Sara Wakai to present research findings related to implementation of Zero Suicide to inform their work. The presentation focused on the role of suicide prevention training and evidence for its effectiveness and limitations. During the course of the year, the ZSLC primarily focused on creating a core training curriculum for all Connecticut healthcare systems, and incorporating the principles of Zero Suicide into the revised version of Connecticut’s State Suicide Prevention Plan.

The ZSLC introduced a few changes in the fifth year of the grant. Committee members decided to meet every other month, but double the length of the meeting. They moved the location of their meeting to a Connecticut Hospital Association site, in order to encourage healthcare providers to attend, and they developed a survey to encourage the members to provide feedback to guide future ZSLC meetings. The arrival of the SARS-CoV-2 to Connecticut in the spring of 2020 necessitated another structural change in the Zero Suicide meetings. Starting in March, the committee transitioned over to an online and teleconference only format. Meetings were continuing in this manner at the time of this report. Starting at the May meeting, committee members began reviewing how healthcare organizations have responded to COVID-19, and discussing risks of suicide to healthcare workers during and after crises.

By August 2020, the ZSLC’s listserv included 127 individuals, representing 55 organizations and organizational units (e.g., healthcare provider sites that are part of a healthcare system). There is at least one site in every DMHAS region that is currently adopting the Zero Suicide approach (Table 16). In order for a site to be considered to have “adopted” the approach, it has to have a Leadership Team, and to have performed an organizational self-assessment, using the Zero Suicide toolkit. There were 18 sites across the state and one site in Rhode Island (whose service area includes eastern Connecticut) that were actively implementing Zero Suicide by the end of the grant. These sites were part of approximately 11 health systems.

Several of these sites provide services to patients in multiple regions, or statewide. There are three sites implementing Zero Suicide that serve patients statewide, for which site location is not available. Many other sites, though they have not adopted the full Zero Suicide Framework, are implementing evidence-based practices that are aligned with the Zero Suicide approach.

Table 16
Zero Suicide Adoption by DHMAS Region

DHMAS Region	Number of systems adopting Zero Suicide
Region 1	1
Region 2	4
Region 3	2
Region 4	6
Region 5	1

In Year 4, a subset of the members of the ZSLC formed a clinical work group to focus specifically on the clinical needs for implementing Zero Suicide. The group released its curriculum for core competency training on September 6, 2019. The subsequent webinar was created so that the training might be taken online.

At the end of Year 4 and through the first half of Year 5 of the NCSP, the ZSLC members closely worked with the full CTSAB to revise Connecticut’s Suicide Prevention plan. The committee focused on Goal #3, “promote suicide prevention as a core component of healthcare services.”

One of the topics discussed at the Zero Suicide Academy in 2018 was the importance of caring follow up with a patient who has attempted suicide after discharge from a hospital, and the difficulty of incorporating such follow up into clinical care. In part motivated by a desire to address this, members of the ZSLC partnered with a private firm, Angel Breeze Scents, to develop a line of cards to send to patients after discharge. The cards are scented and contain hand written messages. DMHAS funded a pilot project using these cards that, at the time of this report, is being implemented by the Institute of Living (IOL) (a part of Hartford Healthcare).

The ZSLC survey was initially planned to be sent out in March, but was suspended due to COVID-19. The survey opened in late July 2020 and was intended, at that time, to close on July 30. Due to technical issues, the open date was extended to August 7. The survey was administered at the system level (not the site level). Seven of the 11 health systems with at least one site implementing Zero Suicide responded to the survey by August 5, 2020, and three other types of organizations also responded.

The NCSP also offered trainings for healthcare professionals and others. From September 7, 2016 to April 30, 2019, 1,335 healthcare services professionals attended NCSP-sponsored trainings (Table 17). For the purposes of this analysis, healthcare services professionals were defined as those with a primary role in substance abuse, emergency response, child welfare, mental health, and primary healthcare. As noted in Section I.A, data on these trainings were collected using the TASP. Statewide, 17.5 percent of all training attendees had a healthcare-related role. Region 3 had the highest number of trainees that fit this description, at 657. No trainees from Region 1 identified themselves as having one of the included roles.

Table 17
Primary Role of Trainees

	Number of Trainees	Percent of Trainees by Primary Role
Substance Abuse	54	0.7
Emergency Response	54	0.7
Child Welfare	31	0.4
Mental Health	1,136	14.9
Primary Healthcare	60	0.8
<i>Subtotal</i>	1,335	17.5
All Others	6,309	
Total	7,644	100

Table 18
Healthcare Training Attendees by Region

Region	Healthcare attendees
Southwestern (Region 1)	0
South Central (Region 2)	511
Eastern (Region 3)	657
North Central (Region 4)	33
Northwestern (Region 5)	134
Total	1,335

B. Intensive Community Based Effort (Goal 2, Strategy 5, Strategy 6)

Strategy 5: Promote suicide prevention as a core component of healthcare services, and engage two local behavioral health and healthcare providers to adopt the Zero Suicide approach

Strategy 6: Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors through outreach and engagement with an emphasis on the two local providers

A second aim of the ICBE was to assist two healthcare organizations adopt the Zero Suicide Framework.

By the final year of the grant, two health systems in Manchester had adopted Zero Suicide, as envisioned in the NCSP plan. These two were CHR and ECHN. In addition, a third health system that provides services to children in Manchester, CCMC, had adopted Zero Suicide.

CHR, which manages the Manchester CNC, has provided additional details on its process of implementing the Zero Suicide Framework.

In October and November, 2017, CHR's Zero Suicide committee began reviewing the Zero Suicide organizational self-study that it had conducted previously in order to prepare for a Zero Suicide Academy planned for the following May. In the months leading up to the Zero Suicide Academy, CHR reviewed its suicide related policies and formed a Zero Suicide workgroup for its Adult Division. CHR submitted its application for the Zero Suicide Academy in February and sent five staff members to attend the Academy in May. While at the Academy, CHR staff created a 90-day work plan to focus on implementing activities under the Zero Suicide Framework. In the months following the Zero Suicide Academy, CHR created an entity-wide suicide prevention campaign, provided QPR and other training for staff, and reviewed the quality of screening, safety planning and use of a safety protocol for all clients who are determined to be at risk for suicide.

CHR's Zero Suicide committee continued to meet monthly during FFY 2019. Among other things, the committee oversaw the third implementation of the Zero Suicide Organization Self-Study and decided to conduct the self-assessment annually. The committee also fostered the revision of CHR's policy on Workforce Traumatic Events Postvention, to make clear that an employee may report concerns about their personal safety or request assistance following a traumatic event without the fear of retaliation from CHR. It organized a postvention subcommittee to investigate postvention services more generally in the summer of FFY 2019. CHR reviewed and updated its Front Desk Protocol for adult walk-ins and investigated ways to make CSSRS results easier to report and interpret. CHR also implemented a training in CALM, and made it mandatory for 571 staff members.

CHR reported that its staff and ECHN staff met periodically through FFY 2019 to discuss ways that ECHN might incorporate the Zero Suicide Framework. At the close of FFY 2019, CHR reported that it was working with ECHN to complete a Zero Suicide Organizational Self-Study.

In alignment with RSAB Region 4, and the rest of the RSABs, CHR began FFY 2020 focusing on its postvention protocol and practices. To facilitate this, CHR created a postvention subcommittee to evaluate its then current protocol and practices and make recommendations. This subcommittee continued to meet through the end of the grant. This process started in September with an examination of the individuals who initiate postvention follow-up calls with patients. Members of committee attended a 2-day postvention training in the town of Enfield.

The Zero Suicide committee also continued to examine the use and expansion of the Columbia Suicide Severity Rating Scale (CSSRS), and the way in which CSSRS results are added to the EHR and, ultimately, used in care. Further, the committee investigated the extent to which clinicians were using the various versions of the CSSRS. During the winter and early spring,

CHR began participating in the Caring Cards project adopted by the CTSAB as part of its postvention services expansion. Staff on the Zero Suicide committee reviewed designs and developed a proposal for the project.

In the winter of 2020, the Zero Suicide committee drafted a marketing plan to communicate the Zero Suicide goals and principles and the particular activities in which CHR was engaging to attain those goals to the full CHR staff.

As with much of the healthcare provider community, CHR altered its Zero Suicide implementation to accommodate the demands of addressing the COVID-19 pandemic. Many staff, including those actively participating with the NCSP, transitioned to telework as much as possible. The postvention training was first postponed from March to July, and then converted into an on-line only training and offered in July. CHR clinicians transitioned into offering telehealth services where feasible, and in the spring CHR created a hotline dedicated specifically for frontline medical providers.

III. Identification, Referral, and Follow-up in the Intensive Community Based Effort (Goal 2, Strategy 4)

The NCSP ICBE aimed to ensure that youths identified as at risk by Manchester CNC partners were connected with appropriate suicide prevention resources.

Strategy 4: Provide early identification / screening, assessment, referral and connection to treatment, recovery support services, and follow-up services for at-risk youth and young adults

The major purpose of the Manchester CNC was to identify youths age 10-24 in the community who are at risk for suicide and ensure that those youths have access to appropriate care. To support this, the Manchester CNC created the Manchester CNC identification, referral, and follow-up tracking system (tracking system). The purpose of the tracking system was to facilitate data sharing about at-risk youths among the CNC partners and to provide data for the GLS national evaluation and NCSP local evaluation. This section presents the results of the identification, referral, and follow-up activities of the Manchester CNC during the project period, as captured by data submitted to the tracking system. (More information on the creation of the system appears in Section IV.B.)

Youths were tracked in the system for three months following identification for being at risk for suicide, to determine whether they received follow-up care within that time period. The length of the follow-up period was set by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), through its then national evaluation contractor ICF, International, for the national evaluation. The local evaluators adopted the three-month follow-up period for the local evaluation.

This section includes data on youths who were identified as at risk for suicide by the CNC partners between October 1, 2016 and February 28, 2020.⁷ The beginning date was set by CHR's establishment of the tracking system, the end date was chosen to provide a sufficient time before the end of the project to collect three months' worth of follow-up data and to clean and analyze the data collected. The tracking system is physically housed at CHR. It includes identifiable, patient-level data. Only authorized CHR staff may access the system. Other CNC partners, however, have been encouraged to contribute data to the system by submitting data to CHR.

Unless stated otherwise, data is reported by "case." Several youths were identified as being at risk of suicide more than once during the project period and received multiple episodes of care. Thus, a single youth may constitute one or more cases. Dates associated with the cases are the dates of identification.

Overall, the Manchester CNC partners made 500 identifications of youths at risk for suicide in Manchester during the project period, as recorded in the tracking system. Of these 500 cases, 496 were referred to follow-up care (Table 19). The data show that 336 of these cases (two-thirds) are known to have received follow-up care within three months of identification, and 30 cases (about 6.5%) did not. Follow-up data is missing, however, for more than a quarter of all cases (130).

Because some youths were identified more than once as being at risk for suicide during the course of the reporting period, the 500 cases involved 423 individual youths in Manchester between the ages of 10 and 24 years. Four hundred nineteen of the individual youths were referred for follow-up care and approximately 64.7 percent of these individual youths are known to have received follow-up care at some point after they were identified.

⁷ CCMC joined the Manchester CNC in January 2020, but, at the time of this report, it had not joined the tracking system.

Table 19

Total Identifications, Referrals, and Follow-up Within Three Months

	# Identified	# Referred	Number of youth referred who received follow-up within three months					
			Yes		No		Don't Know	
			n	%	n	%	n	%
All Cases	500	496	336	67.7	30	6.0	130	26.2
CHR	314	311	261	83.9	27	8.7	23	7.4
MPD	165	165	57	34.5	2	1.2	106	64.2
MPS	11	10	9	90.0	0.0	0.0	1	10.0
MCC	0	--	--	--	--	--	--	--
ECHN	6	6	6	100.0	0.0	0.0	0.0	0.0
Unknown	4	4	3	75.0	1	25.0	0.0	0.0
Individual youths	423	419	271	64.7	30	7.2	118	28.2

*Identification*⁸

The first step in linking a youth at risk for suicide with appropriate follow-up care and support is identifying the youth as being at risk. Youths are identified either through CHR's suicide prevention screening program or by staff members of one of the CNC partners, many of whom received gatekeeper training during one of the NCSP-sponsored training sessions. Only youths with Manchester addresses are included.

The CNC partners collectively made 500 identifications during the data collection period. These identifications involved 423 individual youths between the ages of 10 and 24 living in the town of Manchester. Some youths were identified as being at risk more than once during project period.⁹

Specifically, 370 youths (87.5%) were identified by the CNC partners as being at risk for suicide once during the project period and 53 youths were identified more than once as being at risk for suicide (Table 20). Among this latter group, 37 youths were identified twice, 9 were identified three times, and 6 youths identified four times within the project period. One youth was identified five times during the 41 months of the project.

⁸ The Connecticut Children's Medical Center (CCMC) joined the CNC in the last year of the NCSP project. It does not participate in the Manchester CNC data tracking system at the time of this report. It has, however, begun its own suicide prevention screening program in its emergency department. CCMC reports that between August 2019 and June 2020 it screened 636 youths from Manchester and that 87 of them screened positive. It is unclear whether any of these youths are the same individuals as youths identified by the other CNC partners.

⁹ Youths who were reassessed and determined to be at risk for suicide within three months of a prior identification are not counted as a separate identification.

During the reported period, more youths were identified as being at risk for suicide in some months than others. Table 21 displays the number of youths identified each month over a three-year period (March 2017 to February 2020). The column “Identifications over three year period” aggregates the three years’ worth of data. Overall, September had the highest number of identifications, with 11.8 percent of all identifications occurring during that month. Other months with unusually high numbers of identifications were November and February. April and July had the lowest number of youths identified for being at risk for suicide. Although September has a higher than average number of identifications each year, and July a lower than average number of identifications each year, there is some variation from year to year, as displayed in the right three columns of Table 21.

Table 20
Number of Episodes of Care

Number of episodes	Individual youths
One episode	370
Two episodes	37
Three episodes	9
Four episodes	6
Five episodes	1
Total	423

Table 21
All Identifications (March 2017 to February 2020)

Month of Identification	Total No. IDs		Mar 2017- Feb 2018	Mar 2018- Feb 2019	Mar 2019- Feb 2020
	Mar 2017 - Feb 2020	Percent			
March	47	10.1	11	21	15
April	27	5.8	6	13	8
May	40	8.6	9	20	11
June	38	8.2	10	21	7
July	23	4.9	9	10	4
August	31	6.7	6	13	12
September	52	11.2	19	20	13
October	36	7.7	11	6	19
November	47	10.1	16	22	9
December	37	7.9	15	15	7
January	37	7.9	15	9	13
February	51	10.9	26	10	15
Total	466	100.0	153	180	133

*Identifications between October 2016 and February 2017 were excluded from this table, so that each month estimate would include exactly three years of data.

The majority of identifications for suicide risk (60.8%) were made in a mental health setting (e.g., CHR) during the project period. The second most frequent place for making an identification was the youth’s home (28.0%). A small proportion of youths were identified as being at risk for suicide in other places around the town of Manchester.

Table 22
Setting of Identification (October 2016 to February 2020)

Setting of identification	Count	Percent
Emergency response unit or emergency department	4	0.8
Home	140	28.0
Juvenile justice agency	2	0.4
Law enforcement agency	7	1.4
Mental health service provider (not school-based)	1	0.2
Mental health setting	304	60.8
Physical health agency	3	0.6
School based health center	34	6.8
Social service agency	2	0.4
Other	1	0.2
Don't know	2	0.4
Total	500	

A slight majority of the youths identified as at risk for suicide during the project period were female. Overall, 54.6 percent of identifications were female, 42.8 percent were male, and for the remaining 2.6 percent, the youths either identified as a gender other than male or female, or the information was missing.

Table 23
At-risk Identifications by Gender (October 2016 to February 2020)

Number of identified suicide episodes	Males		Females		Other/information missing		
	n	%	n	%	n	%	
Total	500	214	42.8	273	54.6	13	2.6

The ages of focus for the NCSP project included youths and young adults 10 to 24 years old. This age group spans two different systems of service in the state of Connecticut: suicide prevention services for children, largely organized by DCF, and services for adults, largely organized by DMHAS. Part of the aim of the NCSP was to create a seamless system of suicide prevention services for all individuals within the age group, regardless of whether they are youths or young adults. During the reported period, 56.4 percent of the individuals identified as at risk for suicide were 10 to 18, and 43.6 percent were 19 to 24 years old (Table 24).

Referral

The next step after identifying a youth as being at risk for suicide is to determine whether the youth would benefit from suicide prevention-related

Table 24
Identifications by Age Group (October 2016 to February 2020)

Age	10 to 18	19 to 24
Number	282	218
Percentage	56.4	43.6

services and then refer the youth to such services. For the purposes of the NCSP project, an expansive definition of referral was adopted: any time an identifying CNC partner directed a youth to follow-up care. Further, “care” encompassed both professional mental health services as well as community-based and family-based support.

All but four of the youths identified as at risk for suicide were referred for suicide prevention-related follow-up services during the project period (Table 25).

There are several mental health and non-mental health resources in and around Manchester to which a youth at risk for suicide might be referred. During the project period, most youths who were identified as at risk for suicide (60.7%) were referred to a public mental health provider, such as CHR (Table 26). A large minority of the youths were referred to an emergency department for further care. Typically, these cases involved youths identified by the MPD as needing immediate suicide-related care who are taken into police custody and transferred to an emergency department using the PEER process. A smaller proportion of identified youths were referred to other mental health services, such as a private mental health provider (9.3%), a school counselor (2.6%), or substance abuse treatment (0.6%).

Table 25

Youths Identified as At-risk for Suicide Who Were Referred to Services (October 2016 to February 2020)

Received referral for suicide preventions services?	n	Percent
Yes	496	99.2
No	4	0.8

Table 26

Referrals to Specified Mental Health Services (October 2016 to February 2020), n=496

	Count	Percentage
Public mental health provider	301	60.7
Private mental health provider	46	9.3
Psychiatric hospital	2	0.4
Emergency department	171	34.5
Substance abuse treatment center	3	0.6
School counselor	13	2.6
Mobile crisis unit	39	7.9
School-based health clinic	0	0
Tribal/cultural service	0	0
Other	6	1.2
Any service	496	100

More than half of the youths identified as being at risk for suicide (50.6%) were reported to have been referred to one or more of several non-mental health sources of support after being

identified (Table 27). Most of these youths, however, were referred to their own families for support. Only 23.8 percent of cases were referred to community supports outside of the family. The most frequently referred support was the crisis hotline number, which was provided in 11.7 percent of cases.

Table 27

Referrals to Specified Non-Mental Health Services (October 2016 to February 2020) n=496

	Count	Percentage
School organization	26	5.2
Family	203	40.9
Community based organization	4	0.8
Physical health provider	28	5.6
Law enforcement	16	3.2
Social service agency	7	1.4
Crisis hotline	58	11.7
Other	18	3.6
Any service	251	50.6

Follow-up

Youths referred to appropriate suicide-prevention supports and services would ideally be able to access (and actually receive) those supports and services. To determine the frequency with which this occurs, the tracking system included data on mental health services the identified youths received following identification. The tracking system recorded whether the youths attended up to two follow-up appointments within a three-month period following an identification. Both the number of months and the number of appointments tracked were set by SAMHSA for the NOE through its then national evaluation contractor ICF, International, and incorporated into the local evaluation so that the reporting for the two evaluations would be aligned.

a. Youths who received follow-up services

One of the key outcomes tracked by the CNC tracking system is whether youths referred to mental health services actually attended their appointments and received follow-up services within three months of identification for being at risk for suicide. For a quarter of the youths identified (130 cases), this cannot be answered with the data available. These youths were referred to some organization that did not contribute data to the CNC tracking system. For the remainder of the identified youths, those for whom there is data, 336 attended (or are

presumed to have attended¹⁰) a follow-up appointment and 281 youths attended a second follow-up appointment (Table 28). As a proportion, among the youths for whom there is data, 91.8% received follow-up care and 83.6% of youths who attended a first appointment received additional follow-up care at a second appointment.

Table 28

Number of Referred Youths Who Attended Follow-up Appointments Within Three Months After Identification (n=496)

January 2017 to May 2020 Attended...	Yes		No		Don't know	
	n	%	n	%	n	%
First follow-up appointment?	336*	67.7	30	6.0	130	26.2
Second follow-up appointment?	281	56.7	30	6.0	22	4.4

*Youths are presumed to have attended their first appointment, and to have been referred to a second, when there is data that the youth attended a subsequent appointment, even if the data regarding the first appointment is missing from the tracking system.

b. Time between identification and first follow-up appointment

Of the 496 referrals included in this report, there is data for identification and first follow-up appointment for 326 cases. Of those 326 cases, 296 attended an appointment for suicide-related follow-up services, and 295 cases have complete dates for both identification and first follow-up appointment. For these youths, there was an average of 12.7 days between initial identification and receipt of care at a follow-up appointment. The shortest time during this period was the same day as identification, and the longest was 91 days (Table 29). Fewer than half of the youths (47.6%) identified for being at risk for suicide received follow-up care in the first week of being identified. Nearly three quarters (74.3%), however, received follow-up care within the first two weeks following initial identification (Table 30).

Table 29

Days from Identification to First Follow-up Appointment Among Youths With Non-Missing Data for First Appointment

	Mean (SD)	Minimum	Maximum
January 2017 to May 2020 (n=295)	12.7 (14.3)	0	91

¹⁰ For forty cases, a youth was initially referred to an entity that did not provide data to the CNC tracking system, but subsequently received care by an entity that did, and, therefore, there is data in the system regarding the second but not the first appointment. The most frequent example of this is when a member of the MPD referred a youth to an emergency department (which did not report data into the system) and the youth subsequently received care at CHR (which did). Although technically there is no data in the CNC tracking system regarding whether these youths actually received care at the first appointment, because there is data that the identifier referred them to care and data that the youths attended a subsequent appointment, it is presumed that these youth also attended the first appointment. No assumptions are made, however, regarding the type of care that the youths may have received, or the time of its receipt.

Table 30

Time to First Follow-up Appointment Among Youths With Non-Missing Data for First Appointment

January 2017 to May 2020 (n=295)	Within 3 days	Within one week	Within two weeks	Within three months
Count	56	141	220	295
Percentage	18.9	47.8	74.6	100

c. Types of services the youths received

Three quarters of the youths who received suicide prevention services received mental health counseling at the first appointment (Table 31). In addition, all youths who are screened for suicide through CHR's suicide screening program are administered a substance use assessment and a mental health assessment as part of CHR's standard intake protocol (not shown).

Table 31

Types of Services Youths Received at Their First Follow-up Appointment January 2017 to May 2020 (n=296)

	Count	Percentage: Overall (Monthly low, Monthly high)
Mental health assessment	127	42.9 (0, 100)
Substance use assessment	108	36.5 (0, 100)
Mental health counseling	222	75.0 (0, 100)
Substance abuse counseling	31	10.5 (0, 50.0)
Inpatient services	6	2.0 (0, 75.0)
Medication therapy	15	5.1 (0, 21.4)
Suicide risk assessment	175	59.1 (0, 100)
Case management	53	17.9 (0, 50.0)

Table 32 displays the types of services youths received at their first follow-up appointment, organized by time of identification. In some months, most youths received mental health counseling, but in other months only a small percentage of youths were reported to have counseling.

Table 32

Percentage of Youths Receiving Specified Services at First Follow-up, By Month of Identification

MHA = mental health assessment SA = substance use assessment MHC = mental health counseling			SAC = substance abuse counseling Inp = inpatient treatment Med = medication therapy				SRA = suicide risk assessment Case = case management			
Month of identification	Year	Total # of cases	MHA %	SA %	MHC %	SAC %	Inp %	Med %	SRA %	Case %
January	2017	5	80.0	80.0	40.0	0.0	0.0	0.0	80.0	0.0
February	2017	5	0.0	0.0	40.0	0.0	0.0	0.0	0.0	40.0
March	2017	3	0.0	33.3	100.0	0.0	100.0	0.0	0.0	66.7
April	2017	5	0.0	0.0	60.0	0.0	20.0	0.0	0.0	20.0
May	2017	16	0.0	0.0	68.8	0.0	6.3	0.0	0.0	12.5
June	2017	11	0.0	0.0	36.4	0.0	9.1	0.0	0.0	27.3
July	2017	6	0.0	0.0	50.0	0.0	0.0	0.0	0.0	0.0
August	2017	9	11.1	11.1	66.7	0.0	0.0	0.0	11.1	0.0
September	2017	10	10.0	10.0	80.0	10.0	0.0	0.0	20.0	20.0
October	2017	11	0.0	0.0	63.6	0.0	0.0	0.0	0.0	9.1
November	2017	6	0.0	0.0	50.0	0.0	0.0	0.0	0.0	0.0
December	2017	20	0.0	0.0	70.0	0.0	0.0	0.0	0.0	5.0
January	2018	14	0.0	0.0	64.3	0.0	0.0	0.0	0.0	0.0
February	2018	12	0.0	0.0	100.0	41.7	0.0	33.3	91.7	25.0
March	2018	13	0.0	0.0	84.6	38.5	0.0	0.0	53.8	15.4
April	2018	15	6.7	6.7	73.3	26.7	0.0	6.7	66.7	26.7
May	2018	26	11.5	11.5	69.2	15.4	0.0	15.4	61.5	11.5
June	2018	20	10.0	10.0	45.0	0.0	0.0	10.0	50.0	10.0
July	2018	14	50.0	42.9	50.0	14.3	0.0	0.0	35.7	0.0
August	2018	20	35.0	30.0	20.0	0.0	0.0	5.0	35.0	0.0
September	2018	21	57.1	57.1	9.5	0.0	0.0	0.0	57.1	4.8
October	2018	10	90.0	90.0	0.0	0.0	0.0	10.0	90.0	20.0
November	2018	13	46.2	46.2	7.7	0.0	0.0	0.0	46.2	7.7
December	2018	20	70.0	65.0	30.0	0.0	0.0	0.0	70.0	10.0
January	2019	6	66.7	66.7	33.3	0.0	0.0	0.0	66.7	0.0
February	2019	22	40.9	40.9	27.3	0.0	0.0	0.0	40.9	4.5
March	2019	15	46.7	46.7	46.7	0.0	0.0	6.7	46.7	0.0
April	2019	9	77.8	77.8	55.6	0.0	0.0	0.0	77.8	0.0
May	2019	10	20.0	20.0	20.0	0.0	0.0	0.0	20.0	10.0
June	2019	15	26.7	20.0	60.0	20.0	0.0	6.7	46.7	33.3
July	2019	8	25.0	12.5	37.5	0.0	0.0	0.0	25.0	25.0
August	2019	11	0.0	0.0	27.3	9.1	0.0	0.0	9.1	9.1
September	2019	7	0.0	0.0	42.9	14.3	0.0	0.0	28.6	0.0

Table 32

Percentage of Youths Receiving Specified Services at First Follow-up, By Month of Identification

MHA = mental health assessment SA = substance use assessment MHC = mental health counseling			SAC = substance abuse counseling Inp = inpatient treatment Med = medication therapy				SRA = suicide risk assessment Case = case management			
Month of identification	Year	Total # of cases	MHA %	SA %	MHC %	SAC %	Inp %	Med %	SRA %	Case %
October	2019	4	50.0	50.0	50.0	25.0	0.0	0.0	50.0	0.0
November	2019	12	33.3	0.0	41.7	0.0	0.0	0.0	25.0	0.0
December	2019	13	23.1	15.4	15.4	7.7	0.0	0.0	15.4	15.4
January	2020	19	15.8	5.3	21.1	0.0	0.0	0.0	15.8	10.5
February	2020	9	33.3	22.2	33.3	0.0	0.0	0.0	33.3	11.1
March	2020	7	42.9	0.0	57.1	0.0	0.0	0.0	28.6	28.6
April	2020	10	50.0	20.0	60.0	20.0	0.0	0.0	40.0	20.0
May	2020	18	11.1	5.6	11.1	5.6	0.0	0.0	5.6	0.0

d. Youths who did not receive follow-up services and unknown

A few youths identified as at risk for suicide during the project period did not receive follow-up suicide-related services within three months following identification as being at-risk. For most of these cases, either an appointment was made but the youth did not attend the appointment or no appointment was made because the youth or parent refused to schedule an appointment (Table 33). For 130 youths, it is unknown whether they received suicide-related care following the identification. The reason for the vast majority of these cases is that there was no data tracking system in place between the care provider and the CNC tracking system (Table 33).

Table 33

Reasons Why Youths Did Not Receive Services, or Why Their Status Is Unknown

	1st appointment		2nd appointment	
	n	Percent	n	Percent
Reasons why youths did not receive a follow-up appointment				
• Made an appointment but youth did not attend the appointment	18	56.3	21	70
• Youth was wait-listed for more than 3 months	0	0	1	3.3
• Parent or youth refused service for personal reasons	9	28.1	5	16.7
• Other	5	15.6	3	10.0
Reasons why it is unknown to NCSP whether youths received a follow-up appointment				
• No tracking system in place	141	95.9	18	81.1
• Tracking system requires an agreement to share data but the agreement is not in place	0	0	1	4.5
• Parent or youth could not be contacted	0	0	1	4.5
• Don't know	6	4.1	2	9.1

Overall, the data show that most of the youths identified for being at risk for suicide in the town of Manchester during the NCSP project received follow-up services designed to address that risk, at least among those cases for which there is data. For a sizeable minority of youths, however, there is no data in the tracking system to determine whether they received care or not following an identification for being at risk for suicide. This is true for nearly all youths who were referred for mental health care to somewhere other than CHR, including the vast majority of youths who were sent to an emergency department for care. Only a small proportion of youths appear to have been connected with non-mental health supports in the community.

A large majority of youths who received an episode of care do not appear to have needed a subsequent episode of care (or, at least, they were not brought to the attention of the CNC partners). For 53 youths (or about 12.5 percent of all youths identified), however, multiple episodes of care were required during the project period.

IV. Data and Surveillance Systems

Finally, the NCSP aimed to increase the accessibility and use of suicide-related data to stakeholders involved in suicide prevention.

A. Statewide (Goal 2, Strategy 6)

Strategy 6: Increase the acquisition, timeliness, and utility of data and surveillance systems statewide relevant to youth/ young adult suicide prevention and improve community capacity to use this information for action

The NCSP worked with the CTSAB to create a Data and Surveillance Committee to focus on identifying existing data sources and data needs related to suicide prevention, intervention, and postvention in Connecticut. The committee first met in July 2016 and was guided by the NCSP Strategy 1.6 and the related Connecticut state suicide prevention plan's Goal Number 5, "Increase the timeliness and usefulness of state and national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action."

The Data and Surveillance committee reviewed many different data sources in Connecticut during the GLS grant period, including the Youth Risk Behavior Surveillance System (YRBS) / Connecticut School Health Survey results, local Connecticut Community Readiness Survey, the Connecticut Violent Death Reporting System (CTVDRS), results from the Connecticut Data Haven's Community Wellbeing Survey, hospital discharge data, and other sources. The committee communicates its findings related to this data to the full CTSAB and helps facilitate the creation of region-specific subsets of these data for the use of the RSABs.

A representative from DPH, which houses the state's Syndromic Surveillance System, joined the Data and Surveillance Committee at the end of FFY 2018 to discuss the possibility of expanding the system to include suicide, suicide attempts, and drug overdose data. Twenty-nine hospital emergency departments from across the state regularly contribute data to this data collection system. The Data and Surveillance Committee investigated this possibility during the first half of FFY 2019. In January 2019, the committee reviewed work being done in Rhode Island to incorporate suicide attempt-related data into their system. In February, members of the committee invited local health districts to send feedback on data needs related to potential Syndromic Surveillance System expansion.

In March 2019, the main focus of the Data and Surveillance Committee turned to reviewing the State Suicide Plan in order to make recommendations for its revision. Specifically, the Data and Surveillance Committee reviewed Goal 5. This review continued through the end of FFY 2019 and into FFY 2020.

B. Intensive Community Based Effort (Goal 2, Strategy 7)

Strategy 7: Increase the acquisition, timeliness, and utility of local data and surveillance systems relevant to youth/young adult suicide prevention and improve community capacity to collect, analyze and use this information for action

The ICBE data and surveillance system initiative consisted of two components: facilitating data sharing between CNC partners and preparing de-identified datasets for the local and national GLS evaluations. Both components were addressed by the creation of the Manchester CNC identification, referral, and follow-up tracking system (tracking system), housed at CHR.

Data Sharing between CNC partners

As originally conceived, the tracking system would enable the NCSP and the Manchester CNC to follow, with data, the care path of youths that are identified as at risk for suicide by the CNC partners. The aim of this was to facilitate a coordinated approach among the partners to ensure that the youths identified are connected to appropriate resources and services.

CHR houses the Manchester CNC identification, referral, and follow-up tracking system. As a practical matter, sharing data with the tracking system largely means sharing it with CHR. CHR itself makes data related to the youths it identifies as at risk available to that system. It reported that it established data sharing agreements with all of the CNC partners at the end of FFY 2017, and that it subsequently attempted to establish a data sharing system with the CNC partners so that the partners might submit data regarding the youths they identify as at risk for suicide. The tracking system contains identifiable, patient-level data and so only authorized CHR staff can access the data directly.

To assist the CNC partners, other than CHR, gather data on the youths they identify, CHR staff and the NCSP evaluators created the Manchester CNC Youth and Young Adult

Identification Form. The evaluators’ role was to ensure the form collected sufficient information for the NCSP evaluations. The evaluation team was not involved with either the data collection or the transfer of the data to CHR. NCSP staff at CHR reported providing one-on-one training with the CNC partners in use of the instrument once they begin collecting data.

Starting with an identification made on January 18, 2019, MPD regularly shared data for the youths it identified through the Police Emergency Examination Request (PEER) system through the duration of the NCSP project. The PEER, system which is governed by general statutes §17a-503, authorizes police officers to take individuals into custody, bring them to a general hospital and request an emergency examination under circumstances described in the statute.¹¹ At the January 2019, CNC meeting, the MPD discussed other youths that its officers encounter who may be at risk for suicide, or who might benefit from other behavioral health treatment, but who are outside of the PEER system. Discussions have been ongoing. At the time of this report, however, data on these other youths have not been incorporated into the tracking system.

The other CNC partners have submitted data on very few identifications. The extent to which this is because the other partners do not identify many youths at risk for suicide, or that they face barriers submitting data has not been reported.

Table 34
Identification Data Reported to the Manchester CNC Identification, Referral, and Follow-up Tracking System

	Cases submitted	Proportion of all cases submitted
All Cases	500	100%
CHR	314	62.8%
MPD	165	33.0%
MPS	11	2.2%
MCC	0	0.0%
ECHN	6	1.2%
Unknown	4	0.8%

By the end of the NCSP project, gaps in the CNC data tracking system remained. As displayed in Table 35 for more than a third of youths identified by CNC partners as being at risk for suicide and referred to care (34.4%), there is no data on whether they were connected to that care. This means that it is unclear whether a third of youths identified by CNC partners received any suicide prevention services at all. All youths identified by MPD that are currently reported to the CNC are taken to an emergency department or other hospital setting. For the vast majority of cases no follow-up data are provided because there is no data sharing system between the hospital to which the MPD has taken the youth and the CNC tracking system.

A small proportion of youths are “lost” to the tracking system between their first and subsequent follow-up services. For more than seven percent of youths who attend a first appointment and are determined to need a subsequent appointment, there is no data in the

¹¹ Department of Mental Health & Addiction Services, *Police Emergency Examination Request*, available at: <https://www.ct.gov/dmhas/cwp/view.asp?a=2913&q=607120> (accessed October 28, 2019).

tracking system demonstrating whether they received additional services or not. The overwhelming majority of follow-up data in the tracking system has been provided by CHR. The proportion of cases for which there is data about follow-up care, therefore, mostly reflects the proportion of youths who receive follow-up care from CHR rather than from another provider.

Table 35
Manchester CNC Tracking System and Data Gaps

For youths identified... (N=500)		For youths referred to a follow-up appointment... (N=496)		For youths referred to a second follow-up appointment... (N=332*)	
Is there data on whether the youth was referred to a follow-up appointment?		Is there data on whether the youth attended a recommended first follow-up appointment?		Is there data on whether the youth attended a recommended second follow- up appointment?	
Yes, there is data	No, the data is missing	Yes, there is data	No, the data is missing	Yes, there is data	No, the data is missing
500 (100.0%)	0 (0.0%)	326 (65.7%)	170 (34.4%)	308 (92.8%)	24 (7.2%)

* For ten cases included in this count, the youth is presumed to have been recommended for a second appointment because there is data of a subsequent appointment, even though data for the first appointment is missing. For four cases, the youths received a first follow-up appointment and were deemed not to need a second follow-up appointment; these four cases are not included in this count.

Data reporting for the national and local evaluations

The second, closely related, major data and surveillance initiative of the ICBE was the creation of datasets capturing identification, referral, and follow-up data for youths identified as at risk for suicide by the CNC partners, which were used in the National Outcomes Evaluation (NOE) and the local NCSP evaluation (local evaluation).

During the project period, CHR sent two datasets to UConn Health monthly. UConn Health submitted data on GLS-sponsored identifications to the Suicide Prevention Data Center (SPDC) for the NOE until that system closed on May 31, 2019. UConn Health also created a local evaluation dataset, which includes all reported CNC identifications, regardless of whether GLS funds were directly involved in the identification. Data collection for the local evaluation continued until June 2020. (The results are displayed in Section III.)

SAMHSA required data to be submitted for the NOE using two forms, the Early Identification, Referral, and Follow-up Individual Form (EIRF-I), and the Early Identification, Referral, and Follow-up Screening Form (EIRF-S). The EIRF-I collects individual-level data on all youths who are identified as needing suicide related services. It collects such things as demographic data; information on the first identifier and place where the first identification was made;

mental health and other supports to which the youth was referred; and whether the youth received those services. The form collects information on the first two services after the initial identification or services provided within the first three months after initial identification, whichever comes first. The EIRF-S form collects aggregate data on all youths and young adults who are screened for suicide by the NCSP suicide screening program at CHR. Data collected includes, among other things, number of individuals who receive screening, demographic information of those individuals, and number who screen positive (i.e., individuals determined to need suicide prevention-related services).

The local evaluation largely incorporated the federal forms, adding a few extra variables to account for the fact that the NCSP local evaluation tracked all identifications, regardless of whether they were the direct result of GLS funding.

CHR collected data, assigned identification numbers, and sent de-identified data to UConn Health for the NOE and local evaluations. CHR had to make substantial changes to its EHR and its data collection systems to acquire the necessary data for the local evaluation and the NOE and to create limited datasets that it could send to UConn Health for these purposes.

The evaluators worked closely with CHR as it developed its EHR to accommodate the data collection needs of the NCSP evaluations. The evaluators reviewed the NOE data collection requirements with CHR and provided a list of variables needed to satisfy the NOE and local evaluation data requirements. There were several in-person meetings regarding the data in FFY 2017.

The evaluation team and CHR staff had two in-person and two telephone meetings during FFY 2018 to discuss data. These meetings were held on December 21, 2017, February 5, 2018, March 26, 2018, and July 16, 2018. In addition, staff at UConn Health and NCSP staff at CHR corresponded by email regularly, often exchanging several emails per week.

The evaluation team and CHR staff participated in two in-person meetings in FFY 2019. One was on January 28, 2019 when the evaluation team joined the CNC meeting at CHR. The other was on July 18, 2019, when CHR data staff met at UConn Health in Farmington. In addition, there were six telephone meetings during the fiscal year. Four of these were organized to discuss the possibility of CCMC joining the CNC and sharing data with the CNC surveillance system. Two of these telephone meetings were attended by staff from CCMC. UConn Health and CHR staff also continued to communicate frequently by email during FFY 2019. Among other things, UConn Health sent detailed data quality reports to CHR every month throughout FFY 2019, continuing a practice begun during FFY 2018.

CHR began submitting data to UConn Health for the evaluations in October 2016. At that time, CHR was in the process of changing its IT system and building a data-entry protocol system that would yield data to satisfy the two evaluations. While submitting datasets at this early stage enabled the evaluation team to give frequent feedback to CHR as it developed its

systems, it resulted in the creation of several datasets that were too unreliable or incomplete to analyze for the local evaluation or to submit to the SPDC for the NOE. The first month of data adequate to submit to the SPDC was for youths identified in July 2017. These data were uploaded to the SPDC on January 29, 2018. Soon thereafter, February 9, 2018, the CNC data coordinator at CHR departed.

The departure of the CNC data coordinator and ongoing issues related to the quality of the data that persisted throughout FFY 2018 led to a backlog of data to be cleaned. A new data coordinator was not installed until approximately June 25, 2018. At that time, three months of data had been submitted to the SPDC, covering identifications made in July through September 2017; there was a 14-month backlog of cases in total, 5 months following the September identifications, and 9 months of older cases. Soon after the arrival of the new data coordinator, she and the evaluation team established a review and documentation system to review new data as it was generated, and clear the backlog of data that accrued earlier in FFY 2018. This system was intended to be a temporary expedient, used while CHR was building its capacity to error check its own data and submit clean, accurate data for the evaluations.

By January 2019, the backlog was cleared, except for the older data of youths identified between July 2016 and June 2017. On January 16, 2019, UConn Health staff wrote to staff at CHR to discuss ways of reviewing the data of youths identified as at risk during this earlier period. By March 1, 2019, CHR and the evaluation team agreed to review each month of this older data individually, starting with identifications from June 2017 and working backwards. UConn Health began this review by requesting that the data coordinator at CHR verify the number of June 2017 identifications and the date of identification. Several dates that were previously submitted were found to be incorrect (due to a technical error, which had since been fixed) and previously unreported data of a youth who screened positive for being at risk for suicide during this period was discovered.

The data coordinator at CHR, the second to hold that position during the grant, ceased full time employment with CHR on April 12, 2019. This, and the extra work caused by the closing of the SPDC on May 31, 2019, led to delays in reviewing the data of the June 2017 identifications. Nevertheless, that month's worth of data was cleaned by May 31, 2019 and submitted to the SPDC before it closed. The data coordinator at CHR also began reviewing the data of identifications made during the months of April and May 2017, but did not have time to complete that review before her departure from CHR and the NCSP.

CHR hired a new data coordinator, the third person to hold that position fulltime, on or about May 24, 2019. The previous data coordinator agreed to work limited hours on the NCSP project until her replacement was situated. This arrangement continued until June 2019. Among other things, the second data coordinator was able to provide a series of training sessions to her successor. The overlap in personnel resulted in a much smoother transition between the second and third data coordinators in FFY 2019 than had been the case for the transition between the first and second data coordinators in FFY 2018. Continuing data

quality and consistency issues, however, necessitated the continuance of the time-intensive monthly data review and documentation process created earlier.

On September 25, 2019, the UConn evaluation team sent feedback to the new CNC data coordinator at CHR for data on youths identified in May 2017, thus re-initiating the process of reviewing data for youths identified between July 2016 and May 2017. Shortly thereafter, CHR suspended all activities related to reviewing this early program data. CHR resumed activities checking the old data on or about January 7, 2020. Because of this delay, data collection related to individual cases ended a month early, in May 2020, rather than the anticipated June 2020, to review and process all of the data. CHR submitted its final month of data to UConn Health for the local evaluation on July 12, 2020.