Applying Patient Safety to Suicide Prevention: Lessons from Systems Work

Melissa Young, PsyD · Brian Kurtz, MD
Cincinnati Children's · Children's Hospital Association · 2026

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LEARNING OBJECTIVES

What You'll Take Away

01 | Apply patient-safety science to suicide-risk assessment and clinical response.

02 | Describe system-level strategies for suicide-safer care across settings and roles.

03 | Explain population-level prevention — lethal-means safety and the 988 Lifeline.

04 | Recognize patients and families as co-producers of prevention.

Scope of the Problem

Suicide is a Wicked Problem

Coined in 1973 by design theorists Horst Rittel and Melvin Webber.

High level of complexity

Biological, psychological, social, cultural, and economic factors interact. No single root cause to target.

Notoriously difficult to solve

No algorithm reliably predicts or prevents it — despite 50 years and thousands of studies.

No Definitive Solution

Strategies must be adaptive, multifaceted, and continuously evaluated. The response itself must learn.

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National and State Policy Drivers

Critical Care Gaps

Without policy-driven training requirements, clinicians remain ill-equipped to recognize and manage suicide risk.

Outcomes Unmeasured

The lack of requirements for measuring outcomes limits opportunities for system-wide improvement.

Quantity Not Quality

Youth at highest risk often receive care from those with the least suicide-specific training.

Escalation by Design

Systems are structured to move youth into higher levels of care, often bypassing outpatient evidence-based suicide-focused treatments.

Medicalizing Social Drivers

When social drivers like poverty, trauma, and housing instability go unaddressed by policy, youth are often shifted into the mental health system.

Funding VS. Evidence

Reimbursement incentivizes higher levels of care ≠ evidence-based suicide-focused treatments delivered in outpatient settings.

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Youth Suicide and Healthcare Contacts

YEAR BEFORE DEATH

88%

One or more healthcare visits the year before death.

MONTH BEFORE DEATH

42%

Healthcare visit within 30 days of death.

MENTAL HEALTH DX

60%

No documented mental health concerns.

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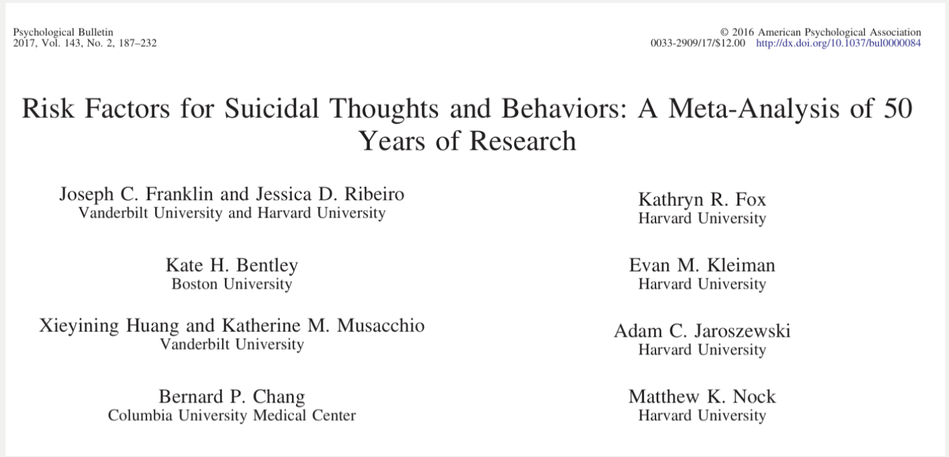
After 50 years, we still cannot reliably predict suicide…

So, prevention can't depend on prediction — it must be built into the system.



Psychological Bulletin
2017, Vol. 143, No. 2, 187–232

0033-2909/17/$12.00 http://dx.doi.org/10.1037/bul0000084

Risk Factors for Suicidal Thoughts and Behaviors: A Meta-Analysis of 50 Years of Research

Joseph C. Franklin and Jessica D. Ribeiro
Vanderbilt University and Harvard University

Kathryn R. Fox
Harvard University

Kate H. Bentley
Boston University

Evan M. Kleiman
Harvard University

Xieyining Huang and Katherine M. Musacchio
Vanderbilt University

Adam C. Jaroszewski
Harvard University

Bernard P. Chang
Columbia University Medical Center

Matthew K. Nock
Harvard University

365

Studies reviewed — spanning 50 years

3,400+

Individual risk factors examined

55–60%

Predictive accuracy — barely better than chance

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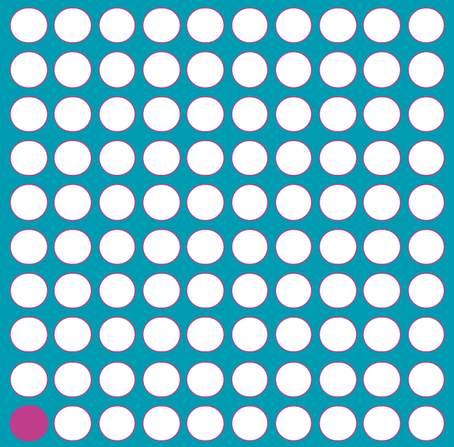
Franklin JC, et al. *Psychol Bull.* 2017;143(2):187-232.

Fallacy of Risk Prediction

High Rate of False Positives

Most people identified as "high risk" **will not** die by suicide, even with the most optimistic estimates.



Low Predictive Value

Suicide is a rare event, so even good sensitivity and specificity result in very poor predictive value.

Because suicide is rare, even the best tools produce more false alarms than true cases. This is a mathematical reality, not a failure of research or clinical tools.

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NICE Clinical Practice Guidelines for Suicide Risk

Common practice	✓ NICE recommends instead
Rely on risk scoring tools Checklists and tools used to generate a risk score or predict suicide.	**Do not rely on predictive tools.** Risk checklists do not reliably identify who will die by suicide. Using them creates false confidence.
Assign a risk category Classify patients as low, medium, or high risk to guide resource allocation and escalation.	**Avoid global risk stratification.** "Low / medium / high" implies precision the evidence does not support and drives risk-averse over person-centered decisions.
Protocol-driven response Care determined by risk category rather than individual need.	**Use formulation to guide care.** Understand the individual — their history, circumstances, and needs. Build care around the person, not a score.

National Institute for Health and Care Excellence — The United Kingdom's independent body for evidence-based clinical guidelines, used internationally as a benchmark for best practice. *NICE CG133. 2011.*

[Link to guidelines]

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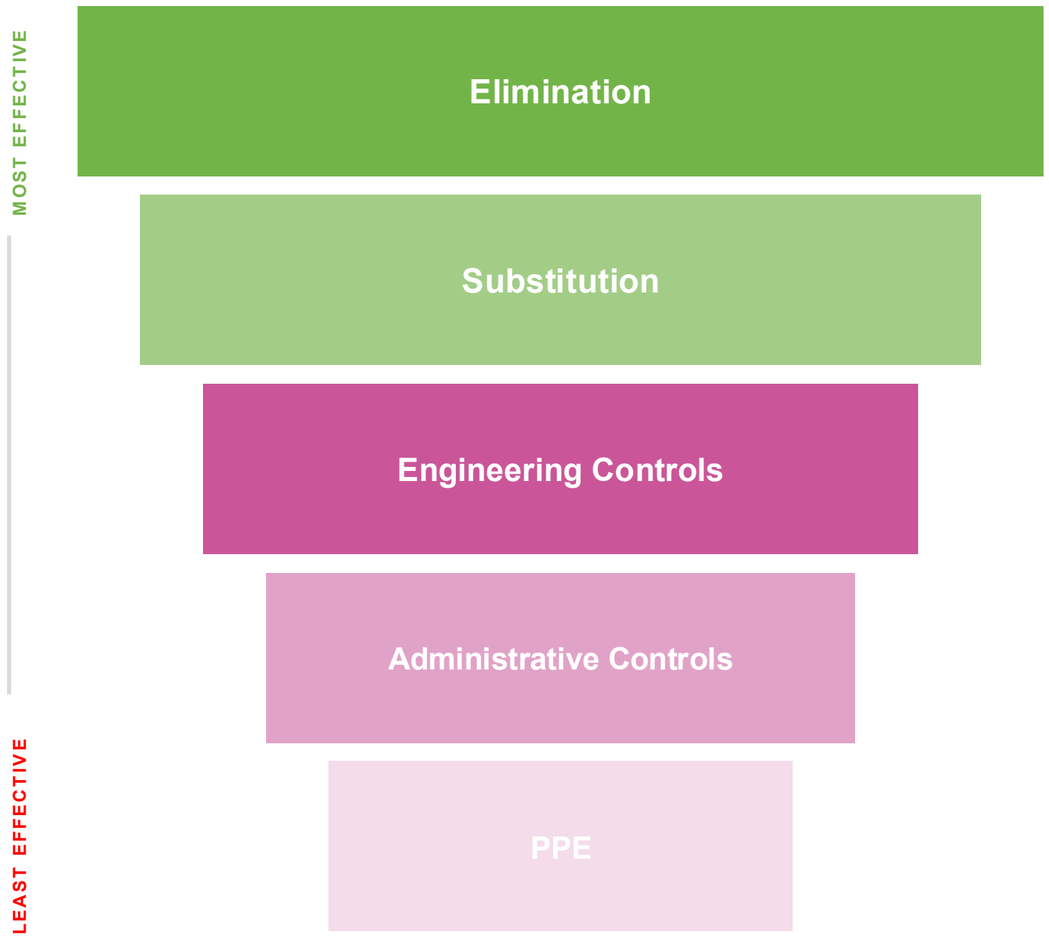
Suicide Prevention by Design

The Hierarchy of Controls



→ **Elimination**
Remove the hazard entirely.

→ **Substitution**
Replace it with a safer alternative.

→ **Engineering Controls**
Physically separate people from the hazard.

→ **Administrative Controls**
Change how people work — policies, procedures, and training.

→ **Personal Protective Equipment**
Protect the individual at the point of exposure.

NIOSH. Hierarchy of Controls. Centers for Disease Control and Prevention; 2023.

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Military Suicide Prevention

57% reduction in deaths by suicide

1,171,357 soldiers | 2006–2012 | Multi-component systems approach

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The Challenge

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Original article

An effective suicide prevention program in the Israeli Defense Forces: A cohort study

L. Shelef[a,b,*], L. Tatsa-Laur[b], E. Derazne[c], J.J. Mann[d], E. Fruchter[b]

[a] Psychology Branch, Israel Air Force, Ramat Gan, Israel
[b] Mental Health Department, Israel Defense Force Medical Corps, Ramat Gan, Israel
[c] Statistican, Medical Corps, Israel Defense Force, Ramat Gan, Israel
[d] Division of Molecular Imaging and Neuropathology, Department of Psychiatry, Columbia University and New York State Psychiatric Institute, New York City, USA

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

Original article

The effect of the Suicide Prevention Program (SPP) on the characteristics of Israeli soldiers who died by suicide after its implementation

Leah Shelef[a,d], Ishai Nir[a,d,*], Lucian Tatsa-Laur[a,d], Ron Kedem[b,d], Niv Gold[a,d], Tarif Bader[c,d], Ariel Ben Yehuda[a,d]

[a] Mental Health Department, Israel Defense Force Medical Corps, Ramat Gan, Israel
[b] Statistican, Medical Corps- Israel Defense Forces, Ramat Gan, Israel
[c] Surgeon General's Headquarters, Israel Defense Force, Ramat Gan, Israel
[d] Department of Military Medicine, Hebrew University, Jerusalem, Israel

Before Program (1992–2005)

23 per 100,000 person-years

344 suicides over 14 years

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Interventions

01 Means Restriction →	Soldiers kept firearms at base during weekends and leave, removing access to the most lethal method.
02 Psychoeducation & Stigma Reduction →	Integrated Mental Health Officers into units. Education on recognizing warning signs and normalizing help-seeking.
03 Gate-Keeper Training →	Every soldier and commander trained as a gate-keeper — responsible for identifying and referring distressed peers.
04 Service Timeline Monitoring →	Targeted high-risk periods: boot camp, first year of service, unit transitions, and the six months before discharge.
05 Suicide Review Process →	Systematic post-incident psychological autopsy. External civilian expert team provided quality assurance.

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Shelef L, et al. European Psychiatry. 2016;31:37–43.

What Changed

↓ 57%

Hazard Ratio 0.44 (95% CI 0.34–0.56, p < .001)

Before Program (1992–2005)

23 per 100,000 person-years

344 suicides over 14 years

After Program (2006–2012)

11 per 100,000 person-years

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Shelef L, et al. European Psychiatry. 2016;31:37–43.

Pesticides and Sri Lanka

1990’s

World’s highest suicide rate; ~80% from ingestion of pesticides.

1995–2011

Phased out highly toxic pesticides in a landmark public health move.

1996–2005

Suicides dropped 50% following pesticide bans.

~ 2015

Suicides fell ~70% from peak—among the world’s most successful prevention efforts.

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Pesticides and Sri Lanka

20,000

Lives Saved

From 1996-2005

93,000

Lives Saved

By 2015

When deaths by suicide from pesticides dropped, other methods didn't rise—refuting the substitution myth while demonstrating that means restriction saves lives.

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HEALTH

A Killer Within Easy Reach

Pesticides are a leading means of suicide. The tiny nation of Suriname is working to restrict access to one of the most common and dangerous ones.

By Ted Alcorn and Alessandro Falco

PRINT EDITION
June 10, 2025, Page D1

New York Times [June 2025]

Paraquat is a pesticide that is quickly absorbed by the body and has no antidote. Even a small dose causes multi-organ failure, though death may take hours or days.

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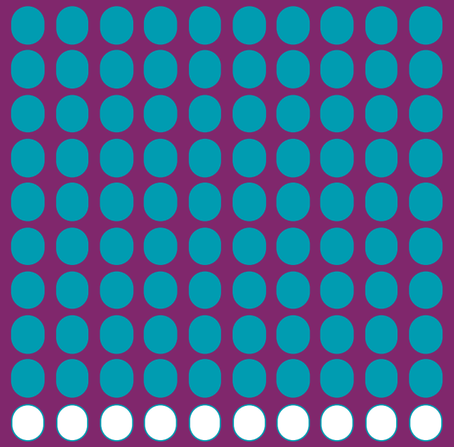
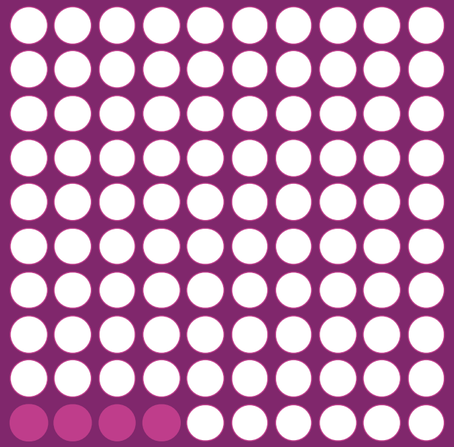
Method vs. Intent



>90% Fatal by Firearm

When a firearm is used in a suicide attempt, it is almost always fatal — leaving little to no chance for intervention or help.



<4% Fatal by Other Means

The vast majority of individuals who attempt suicide by other methods survive.

The method of attempt is the strongest predictor of outcome. Firearms are uniquely lethal — leaving virtually no chance for rescue or second thoughts. Means restriction saves lives.

Anglemyer A, et al. Ann Intern Med. 2014;160(2):101–110.

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What about youth in the U.S.?

Firearms

Leading cause of death by suicide among youth since.

73–85%

Lower risk of firearm injury when guns are locked and stored separately from ammunition [2,3]

251

Young lives estimated saved in a single year if half of unsecured home guns were locked [3]

13–15%

Fewer youth firearm deaths in states with safe storage laws [4]

4.6M

Youth in the US living with at least one loaded, unlocked gun at home (2021) [7]

Medications

Most common way youth attempt suicide; less often fatal than firearms.

2×

Youth self-poisoning by medication doubled from 2000 to 2018 — from 40,000 to 80,000 cases per year [5]

73%

Rise in medication self-poisoning among youth ages 10–12 from 2019 to 2021 [5]

43%

Drop in overdose deaths after the UK limited the number of pills sold in a single package [6]

Doubles safe storage

A single counseling conversation roughly doubles the likelihood of safe gun and medication storage [7]

1. Goldstick JE, et al. *N Engl J Med.* 2022;386(20):1955-1956. 2. Grossman DC, et al. *JAMA*. 2005;293(6):707-714. 3. Monuteaux MC, et al. *JAMA Pediatr.* 2019;173(7):657-662. 4. Azad HA, et al. *JAMA Pediatr.* 2020;174(5):463-469. 5. Spiller HA, et al. *J Pediatr.* 2019;210:201-208. 6. Hawton K, et al. *BMJ.* 2013;346:f403. 7. Miller M, Azrael D. *JAMA Netw Open*. 2022;5(2):e2148823.

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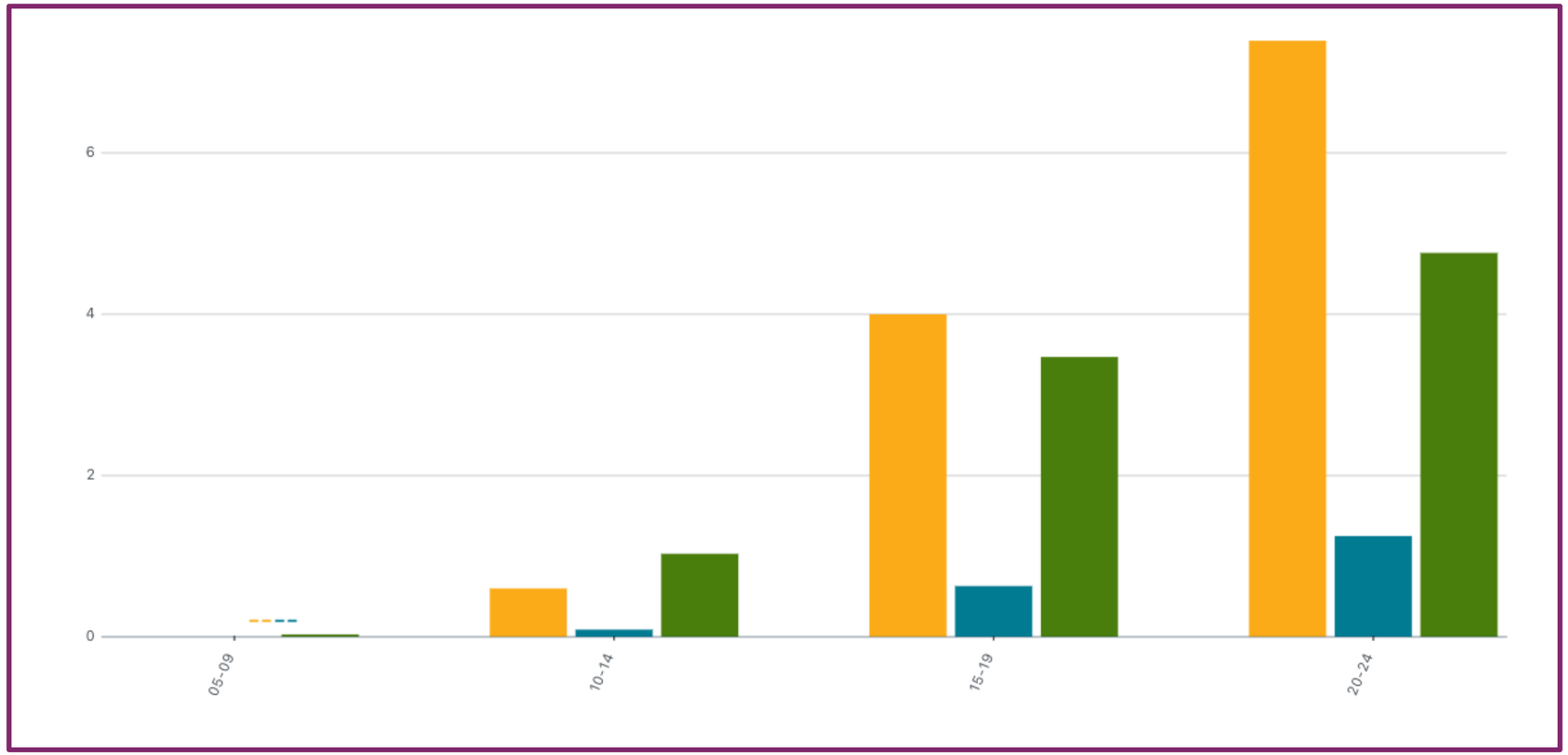
Leading Suicide Methods by Age Group



Applied Filters

Causes: Suicide Firearm
Suicide Poisoning
Suicide Suffocation
Years: 2001 to 2023
Age: 5 to 9 through 20 to 24
Race: All Races
Metro: None Selected
Race Year: 2001 - 2023 with No Race

Geography: United States
Sex: All Sexes
Ethnicity: All Ethnicities
YPLL: 65

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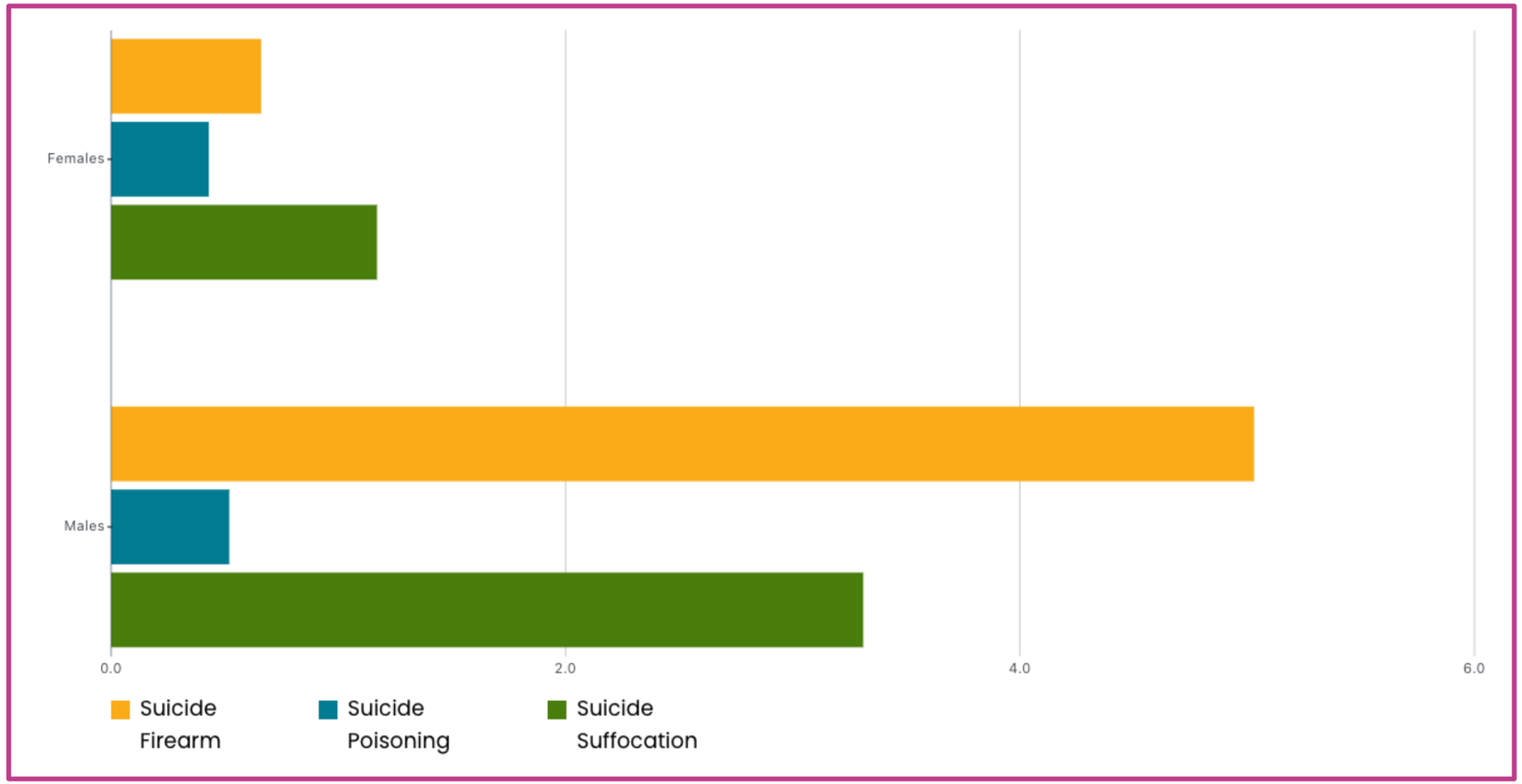
Leading Suicide Methods by Sex



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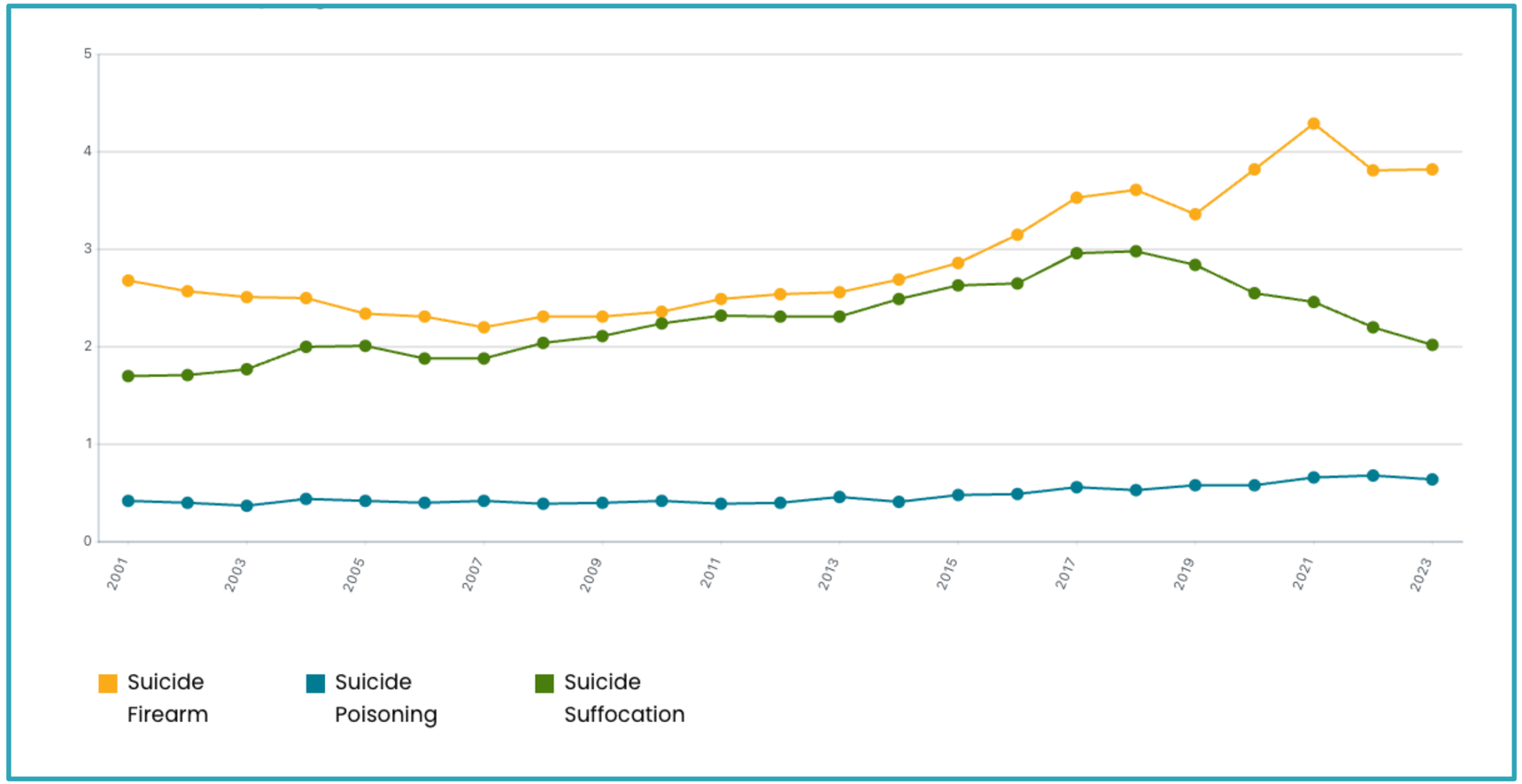
Leading Suicide Methods by Year



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Sex: All Sexes
Ethnicity: All Ethnicities
YPLL: 65

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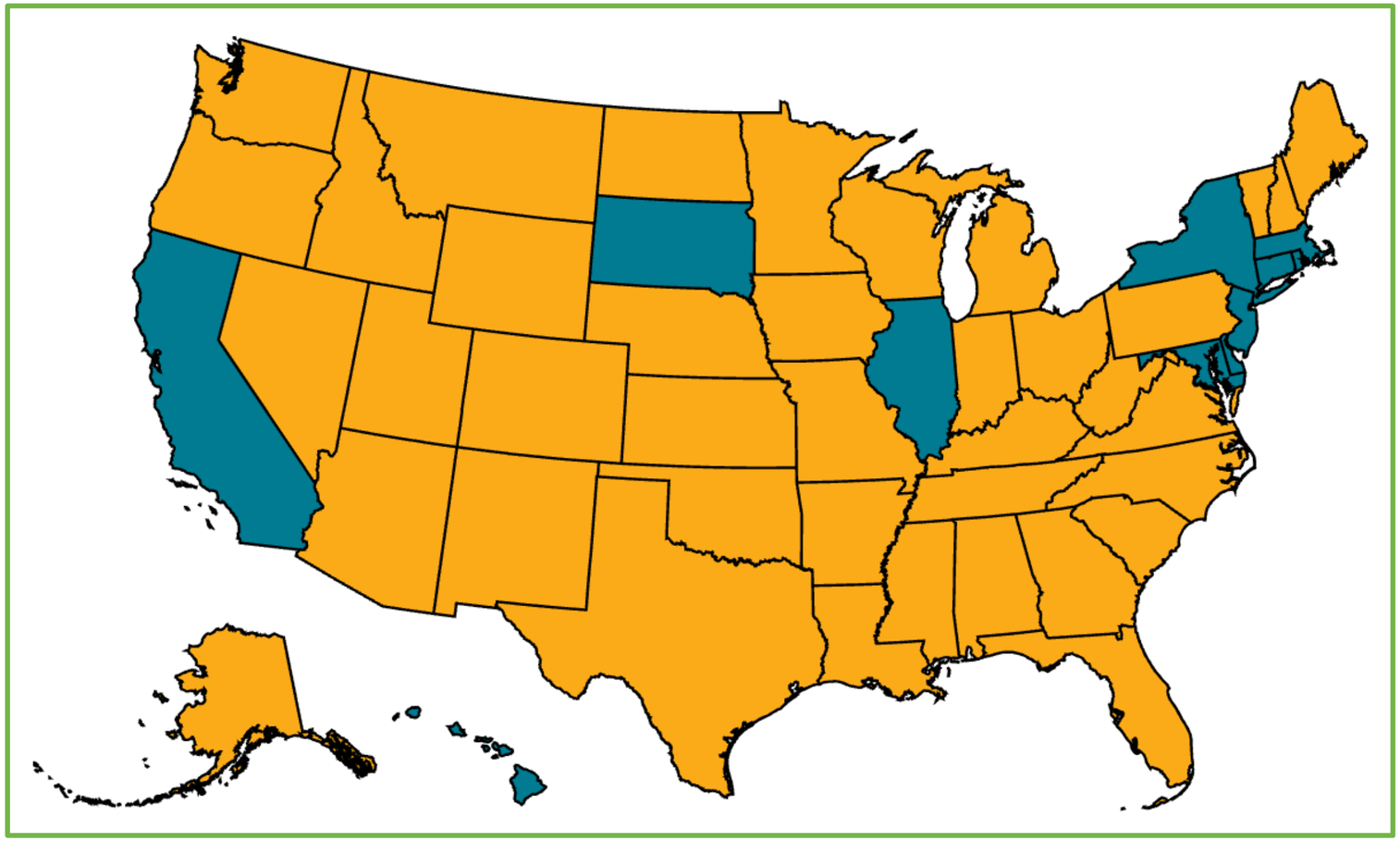
Leading Suicide Methods by State



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Firearm

Suffocation

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Lessons from Injury Prevention

The Haddon Framework for Injury Prevention

Injuries are **non-random and preventable** through structural change — not individual behavior. Public health redesigns the surrounding environment.

THE COUNTERMEASURE MATRIX — WHEN TO INTERVENE

Host	Agent	Environment
The person — age, immunity, behavior	Source of harm — energy, force, pathogen	Physical & social context shaping risk
PRE-EVENT Reduce vulnerability	**PRE-EVENT** Limit hazard exposure	**PRE-EVENT** Redesign the setting
EVENT Protect during impact	**EVENT** Contain the energy	**EVENT** Engineered safeguards
POST-EVENT Rapid rescue & recovery	**POST-EVENT** Suppress ongoing harm	**POST-EVENT** Trauma systems & access

Haddon W Jr. *Public Health Rep.* 1980;95(5):411-421.

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Policy Cannot Do it Alone: Essential Role of Marketing and Communications

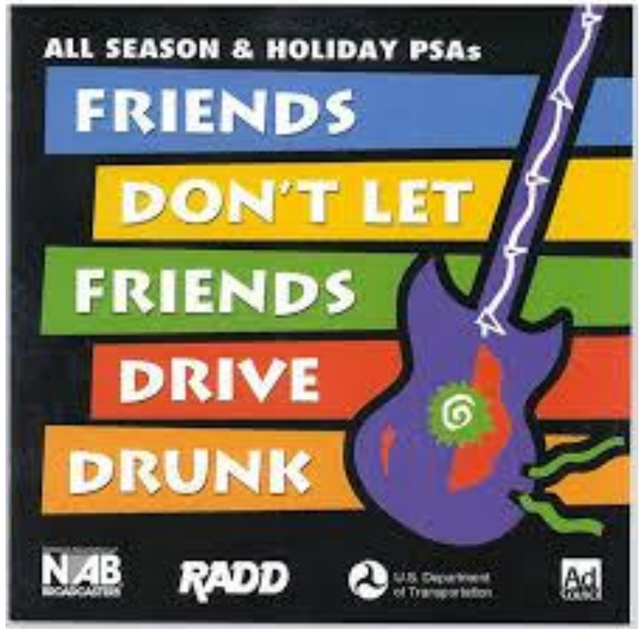
Memorable campaigns using sticky messages…

Structures & Policies

- Taxation & pricing (tobacco)
- Smoke-free air laws; FDA authority
- Seat-belt & primary enforcement laws
- Vehicle & road engineering; graduated licensing

Marketing & Communications Strategies

- truth® — empowerment, not fear (≈22% of the youth-smoking decline; Farrelly, AJPH 2005)
- “Click It or Ticket” — high-visibility enforcement
- “Friends Don’t Let Friends Drive Drunk” — bystander norms
- Branded, repeated, norm-shifting messaging



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Safety Science

Suicide Prevention is Patient Safety

TRADITIONAL VIEW		THE REFRAME
A behavioral-health problem	→	A patient-safety problem
A risk-prediction problem	→	A systems problem
The individual clinician's responsibility	→	An organizational responsibility

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Individual vs. System

THE PERSON APPROACH
“Who made the mistake?”

- ✕ Focuses on individual carelessness or competence.
- ✕ Responds with blame, naming, and retraining.
- ✕ Drives reporting underground — the same failures recur.

VS

THE SYSTEM APPROACH
“What let this happen?”

- ☑ Assumes capable people in flawed conditions.
- ☑ Emphasizes learning and healing simultaneously.
- ☑ Surfaces failures so the system can learn and improve.

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Foundations of Patient Safety

01

Humans are fallible.

Error is a normal feature of human performance — not a moral failing. The system must account for this, not punish it.

02

Systems shape outcomes.

The design of the system makes errors more or less likely. The same person performs differently in different systems.

03

Harm is multifactorial.

Adverse events arise from many aligned conditions — rarely a single cause or a single person's failure.

Learning improves safety.

Systems that study their own failures get safer over time. Silence about errors is the greatest threat to safety.

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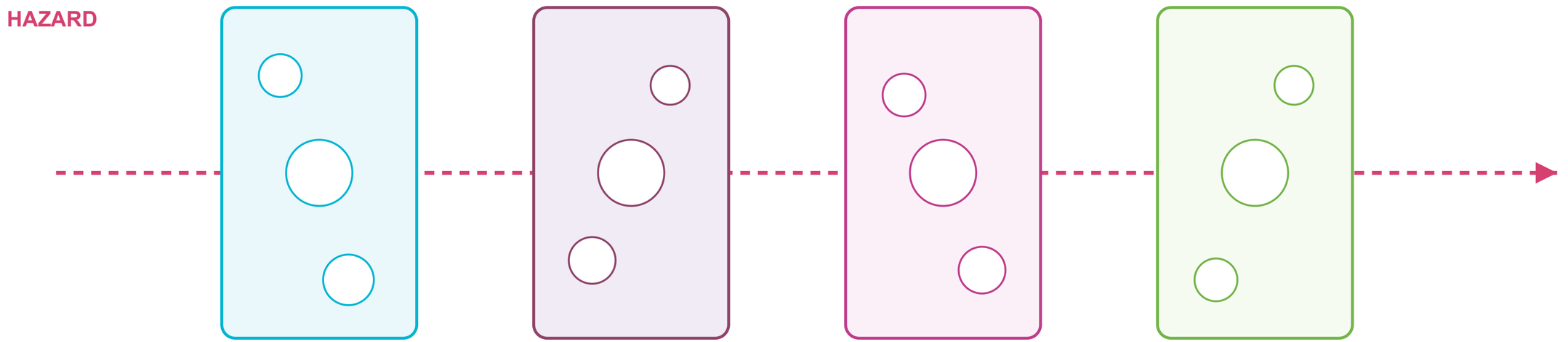
Harm Passes Through Many Failures — Not One

Layered defenses protect patients. Each has gaps. Harm reaches the patient only when the holes momentarily align.



When a defense layer fails, the question is what to change in the system — not who to blame.

Link to publication

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Psychological Safety

AE

Amy C. Edmondson

Harvard Business School · coined the term, 1999

“Psychological safety is not about being nice. It's about giving candid feedback, openly admitting mistakes, and learning from each other.”

— AMY C. EDMONDSON

Edmondson AC. *Adm Sci Q.* 1999;44(2):350-383.

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The Learning Zone: Edmondson's Framework

Safety alone is just comfort. Pair it with high standards, and teams learn.

PSYCHOLOGICAL SAFETY ↑

Comfort Zone

Plenty of candor, little drive. People speak freely, but the bar is low — the team coasts on consensus.

Learning & High Performance

Candor meets ambition. People raise hard questions, surface errors, and test new ideas — and the team delivers.

Apathy Zone

People show up, hold back, and disengage. No risk-taking, no learning, no real performance.

Anxiety Zone

Pressure to perform, no room to speak. Problems get hidden, mistakes repeat, and burnout climbs.

ACCOUNTABILITY & STANDARDS →

Edmondson AC. *The Fearless Organization.* Hoboken, NJ: Wiley; 2019.

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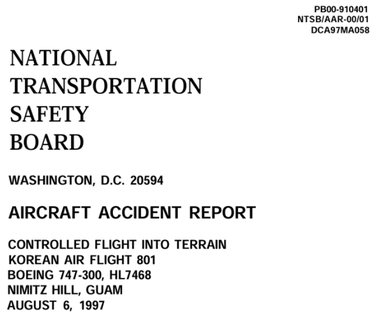
Korean Air Flight 801

August 6, 1997 · Nimitz Hill, Guam



PB00-910401
NTSB/AAR-00/01
DCA97MA058

NATIONAL
TRANSPORTATION
SAFETY
BOARD

WASHINGTON, D.C. 20594

AIRCRAFT ACCIDENT REPORT

CONTROLLED FLIGHT INTO TERRAIN
KOREAN AIR FLIGHT 801
BOEING 747-300, HL7468
NIMITZ HILL, GUAM
AUGUST 6, 1997

228

of 254

lives lost

The crew saw the danger. No one spoke.

Junior crew members were expected to defer completely to the captain. Questioning him was seen as disrespectful — even as the aircraft descended toward a hillside.

Psychological safety determines whether knowledge becomes action.

Can team members raise concerns, flag errors, and stop unsafe actions — without fear of humiliation or retribution?

Culture change works. Zero fatal crashes since 2000.

Korean Air rebuilt its culture so any crew member can stop the flight. The same principle governs every safe care team.

AFTER THE CULTURE REBUILD

Zero fatal crashes since 2000.

Korean Air rebuilt its culture so that any crew member can stop the flight. The same principle governs every safe care team.

Link to report

Helmreich RL. *BMJ*. 2000;320(7237):781-785.

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PROJECT ARISTOTLE · GOOGLE PEOPLE ANALYTICS

What actually makes a team effective?

2012–16	180	250+
Study period	Teams studied	Attributes measured

Frazier ML, et al. Pers Psychol. 2017;70(1):113-165

#1

SINGLE STRONGEST PREDICTOR OF TEAM EFFECTIVENESS

Psychological safety.

"Can we take risks on this team without being embarrassed, rejected, or punished for speaking up, asking questions, admitting mistakes, or taking risks?" — the question that predicted everything else.

Psychological safety

Foundation. The base all other dynamics rest on.

Dependability

Can we count on each other to do high-quality work on time?

Structure & clarity

Are goals, roles, and execution plans clear to everyone?

Meaning

Is the work personally important to each of us?

Impact

Do we believe our work matters and makes a difference?

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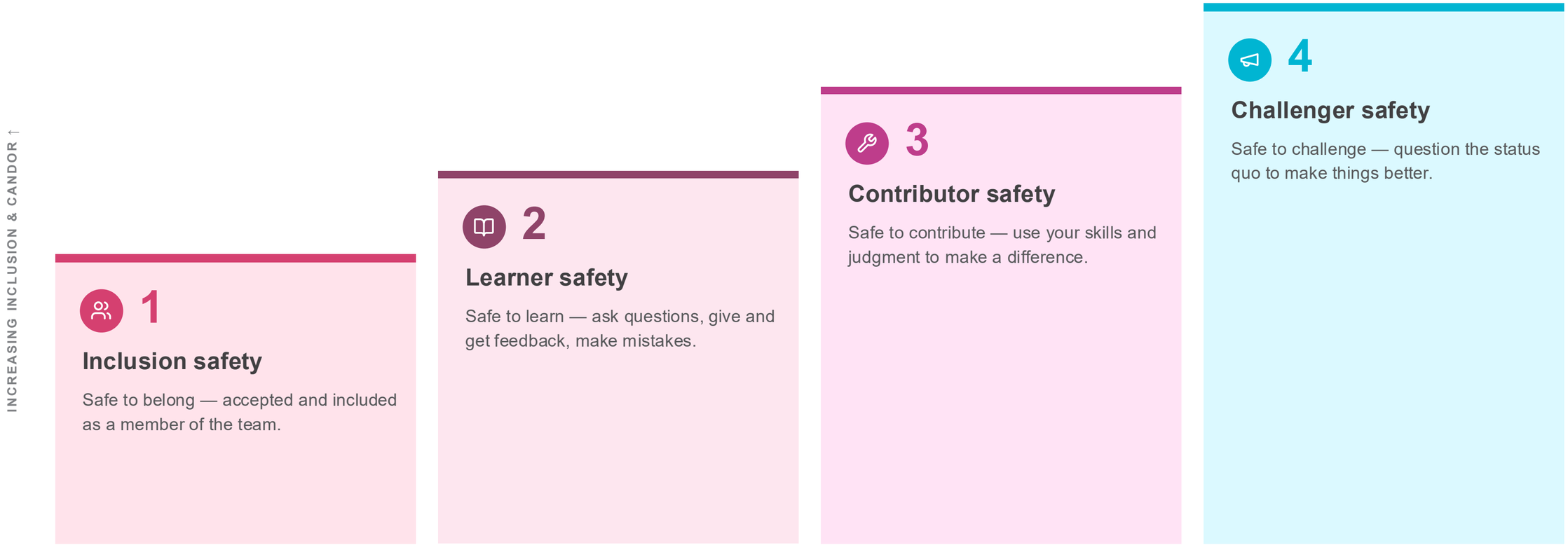
Timothy Clark's Four Stages of Psychological Safety



Clark TR. *The 4 Stages of Psychological Safety.* Oakland, CA: Berrett-Koehler; 2020.

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Barriers and Facilitators by Stage

	✓ FACILITATORS	✕ BARRIERS
1 **Inclusion safety** SAFE TO BELONG	Inclusive onboarding; value differences; learn names.	Bias, cliques, and in-group / out-group lines.
2 **Learner safety** SAFE TO LEARN	Reward curiosity; treat errors as data; leaders admit gaps.	Blame for mistakes; ridiculing questions; perfectionism.
3 **Contributor safety** SAFE TO CONTRIBUTE	Grant autonomy; clarify roles; recognize good work.	Micromanagement; gatekeeping; taking credit.
4 **Challenger safety** SAFE TO CHALLENGE	Invite dissent; separate idea from identity; model fallibility.	Fear of retaliation; defensiveness; punishing dissent.

Clark TR. *The 4 Stages of Psychological Safety.* Oakland, CA: Berrett-Koehler; 2020.

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Examples of Barriers and Facilitators by Stage

	✓ WHEN IT WORKS	✕ WHEN IT BREAKS
1 **Inclusion safety** SAFE TO BELONG	Every meeting and training opens with first names only — no titles. When someone says "Dr." the team notices and redirects. In other words, a lived experience team member and family partner is referred to the same way as the medical director.	The clinical faculty arrive together, sit together, and debrief together after the suicide meeting. The care coordinators are in every meeting. They are never invited into the conversation.
2 **Learner safety** SAFE TO LEARN	Before leading a lethal means training, a subject matter expert discloses they have cared for a patient who died by suicide. The disclosure comes before the first slide. The room — and the training — shifts because of it.	A resident says in a case debrief "I wasn't sure how to counsel this family on limiting access to lethal means." The attending says, ”You should know that. It was in the training." The resident doesn't ask for help again.
3 **Contributor safety** SAFE TO CONTRIBUTE	A quality improvement specialist is assigned to lead a test of change— across the medical center and regionally. They design the materials, set the timeline, and present to leadership. When the campaign launches, the division director names them as the lead.	A fellow asks whether anyone has talked to patients about whether they'd actually call 988. The senior leader says, "that's not what we're here to measure." The fellow doesn't raise another idea for the rest of the project.
4 **Challenger safety** SAFE TO CHALLENGE	Psychologist tells the department chair "the denominator changed — the readmission rate isn't actually improving." Department chair asks them to walk through it. Slide deck is corrected before it goes to leadership.	A junior faculty member points out in grand rounds that the suicide risk screening tool consistently misses a key demographic in the data. The senior faculty presenter says, "this tool has been validated, and it’s required by the joint commission, and shakes their head."

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Clark TR. *The 4 Stages of Psychological Safety.* Oakland, CA: Berrett-Koehler; 2020. · Edmondson AC. *Adm Sci Q.* 1999;44(2):350-383.

Impact on Patient Safety

01

Reporting dries up

Near-misses never surface. Safety data understates the real danger. The system becomes blind to its own risks.

→

02

Learning stops

The same failures repeat. You can't fix what no one will name. The organization learns nothing from its own experience.

→

03

People disengage

Burnout and turnover rise. The staff who spot risk most clearly are the ones who leave first.

→

04

Patients are harmed

Preventable events reach the bedside. Family trust erodes. The organization reacts instead of learns.

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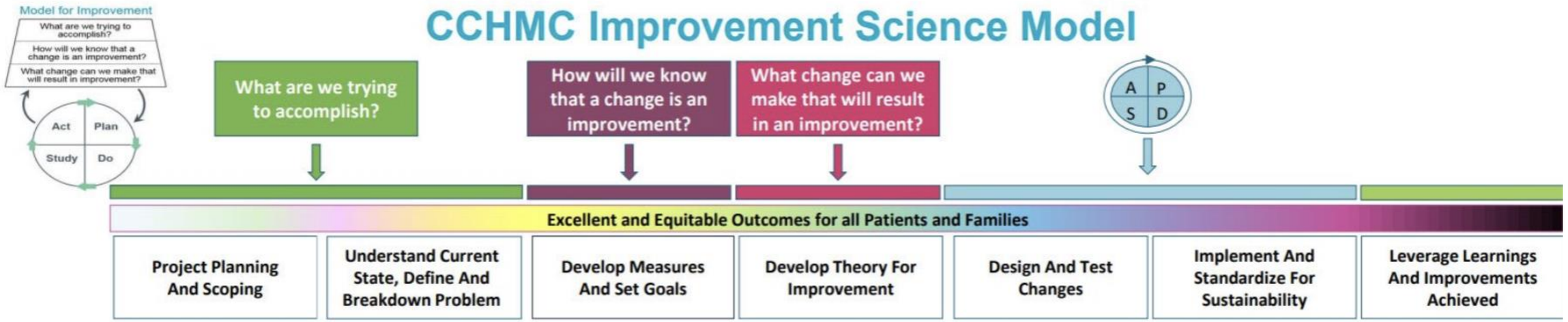
Professional Experiences with Suicide

Sponsored Safety Event

Cincinnati Children's Model for Improvement



Timeline

July 17, 2025

FMEA Planning Session

Systemwide suicide case review (*n* = 9) establishes foundation for comprehensive response

Sep 9–23, 2025

Leadership Preparation

Quality improvement prep aligns stakeholders across divisions

Sep 29, 2025

FMEA #1 Kickoff

Collaborative analysis launched across quality improvement teams

Oct 16, 2025

FMEA #2

System vulnerabilities prioritized; opportunities identified for action

Oct 29, 2025

Transition to Action Plans

Three focused workgroups mobilized from FMEA findings

Feb–Aug 2026

Implementation

Three action plans launched in parallel across settings

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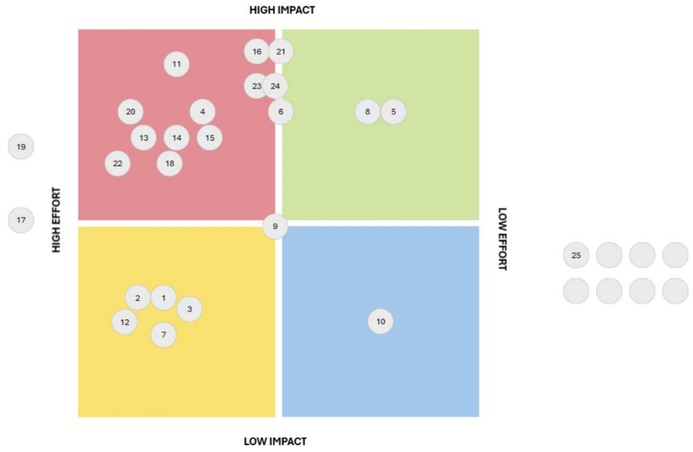
Intervention Generation

150+

intervention ideas generated by the team



Impact × Feasibility

Ideas were plotted by impact and feasibility, then synthesized and prioritized through leadership review into three coordinated action items — approved by executive sponsors and team leads.

Zero Suicide: Systemwide Suicide Risk Response Enhancement Project Key Driver Diagram (KDD)

Revision Date: *05/01/2026 (v2)*
Project Leader(s): Melissa Young, Brian Kurtz, & Sarah Weller
Executive Sponsors: Laurel Leslie & Eileen Murtagh Kurowski

Legend	
Active Intervention	Adopted Intervention
Potential Intervention	Abandoned Intervention

Global Aim

Eliminate suicide among youth and young adults in the greater Cincinnati region.

Smart Aim

Eliminate suicide deaths among youth and young adults within 30 days of a CCHMC encounter by January 1, 2030.

Population

All patients, ages 5–25, who received ambulatory, emergency, or inpatient care at all Cincinnati Children's locations

Key Drivers

Decreased Access to Lethal Means

Reducing youth access to lethal means through clinical practice, systems change, and policy advocacy.

Integrated Reliability in Epic for Suicide Prevention

Alignment of Epic workflows and documentation with evidence-based, suicide-focused practices (e.g., workflows, alerts, suicide prevention navigator, etc.)

Dynamic Formulation-Based Suicide Risk Assessments

A consistent, suicide-focused risk formulation approach that informs safety planning, follow-up intensity, transitions of care, and intervention selection across settings.

Equitable Access to Evidence-Based Suicide-Focused Treatments

Deliver and continuously improve youth-centered, evidence-based interventions and practices that directly target suicidal thoughts and behaviors.

Sustained Visibility of Lifesaving Messages

Embed repeated exposure to two core messages — secure storage saves lives and 988 is available 24/7.

Enthusiastic Collaboration with Lived Experience & Co-Production Partners

Partner with youth, families, and communities with lived experience to co-design, deliver, and evaluate suicide prevention strategies.

Interventions (LOR #)

- Stock and replenish lethal-means safety devices (e.g., gun locks, medication lock boxes) with a defined distribution process for low-frequency sites (LOR 2)
- Develop Knowing Notes for firearm safety, firearm storage options, and reducing access to lethal means (LOR 1)
- Introduce the rebuilt Stanley Brown Safety Plan with CALM Content in Epic workflows (LOR 2)
- Integrate EpiCenter suicide attempt surveillance into monitoring and reporting workflows (LOR 3)
- Test the BSSA (in lieu of C-SSRS) in ambulatory, emergency, and inpatient settings (LOR 1)
- Implement CALM training at scale across MBHI & Social Services (LOR 3)
- Deliver SafeSide training to support suicide prevention practice alignment (LOR 1)
- Pilot Caring Contacts program at Hopple Street & BMCP General Mental Health (LOR 1)
- Disseminate a best-practice toolkit outlining role-based workflows, documentation standards, and communication scripts, with planned refresh cycles (LOR 1)
- Standardize suicide-focused messaging through universal out-of-office replies (LOR 1)
- Launch 988 and MRSS signage planning in partnership with General Pediatrics (LOR 1)
- Expand transportation and resource navigation support by partnering with Medicaid transport, rideshare programs, and resource navigators (LOR 2)

Enablers	Institute Commitment to Youth Suicide Prevention I Robust Data Systems I County Public Health & Coroner Partnerships I Philanthropic Support
Shared Values	We Continuously Strive for Zero I We focus on the HOW then the WHY I We Co-Produce with our Patient's Caregivers and Families

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ACTION PLAN 1

FOCUS

Suicide Risk Identification & Clinical Response

WORKGROUP LEADERS

Brian Kurtz

Sarah Weller

Christine McClurg

KEY ACTIVITIES

- Brief Suicide Safety Assessment (BSSA) pilot & spread
- Formulation-based clinical response training
- Safety planning quality improvement

ACTION PLAN 2

FOCUS

Lethal Means Safety & 988 Awareness Campaign

WORKGROUP LEADERS

Melissa Young

Kelly Kaiser

Maria Geiser

KEY ACTIVITIES

- Firearm & medication safe storage counseling (CALM)
- 988 Lifeline awareness across clinical settings
- Campaign rollout: internal + community partners

ACTION PLAN 3

FOCUS

Co-Production with Patients, Caregivers & Families

WORKGROUP LEADERS

Teresa Pestian

Anna Bass

Steph Weber

KEY ACTIVITIES

- Lived-experience partnership in design & oversight
- Caregiver and family experience research integration
- Safety partnership model across acute & outpatient

Action Plan Team #1

- Stephanie Collins – Clinical Manager Social Services
- Jessie Schoff – PIRC Clinician
- Aubrey Coates – Psychologist (BMCP)
- Stephen Porter – Physician (ED)
- Rachel Snedecor – Physician (AYAM)
- Alex Nyquist – Psychologist (BMCP)
- Ryan Bartels – Sr. EMR Analyst
- Joe Coz – Sr. Clinical Informatics Specialist
- Rachel Mathews – Psychologist (BMCP)
- Vivek Ashok – Physician (PCP)
- John Strader – Physician (PIRC)
- Emily Meyer – School-based Clinical Manager

Action Plan Team #2

- Samantha Joiner - HealthVine
- Sky Strange – Sr. Clinical Research Coordinator
- Nancy Miller – 1N5 Founder & Executive Director
- Grant Mussman – Health Commissioner of Cincinnati
- Maryse Amin – Assistant Health Commissioner of Cincinnati
- Emmanuel Chandler – AYAM Division Director
- Molly Haycraft – NICU Clinical Manager
- Stephanie Lyons – Firearm Injury Prevention Program Manager
- Michelle Price – Sr L&D Specialist
- Kate Junger – Director of Systems Integration
- Lisa Belle – Clinical Manager of Social Services
- Thomas Elliott – Physician (Gen Peds)
- Stephanie Vogel – NKY Health Department)
- Morgan Calahan – Clermont County Public Health

Action Plan Team #3

- Karen Vonderhaar – EBDM Consultant
- Christine Whelan – Lived Experience
- Karisa Moore – Lived Experience
- Keturah Kirk – Lived Experience
- Bryan Wright – Grief & Spiritual Care
- Steph Weber – Psychologist (DDBP)
- Lisa Clifford – Psychologist (BMCP)
- Meghan Fanta – Physician (Hospital Medicine)
- Jennifer Spitznagel - Clinical Director of PIRC
- Scott Hale – Clinical Manager Social Services
- Susan Shelton – MindPeace Executive Director

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Evidence-Based Decision-Making (EBDM) Literature Review

EBDM-1 · Experience

Moderate / Moderate

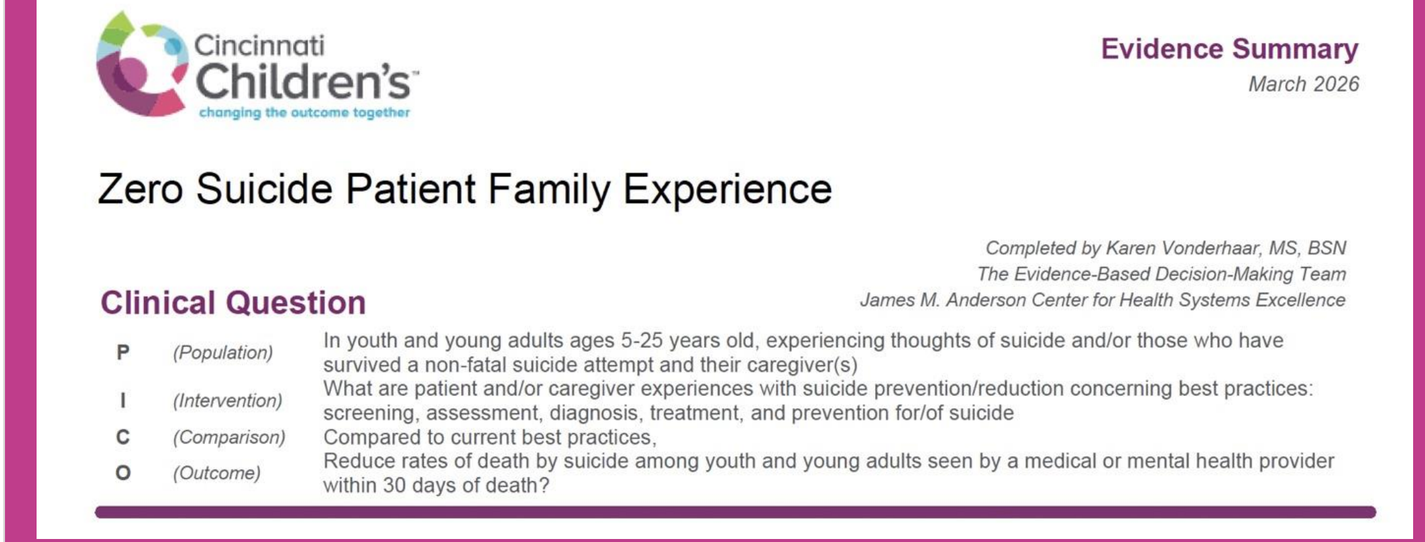
What families experience

Across prevention, screening, assessment, treatment, and care delivery.

846 articles screened

48 in synthesis

including 10 systematic reviews



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Evidence Summary

March 2026

Zero Suicide Patient Family Experience

Completed by Karen Vonderhaar, MS, BSN
The Evidence-Based Decision-Making Team
James M. Anderson Center for Health Systems Excellence

Clinical Question

P	*(Population)*	In youth and young adults ages 5-25 years old, experiencing thoughts of suicide and/or those who have survived a non-fatal suicide attempt and their caregiver(s)
I	*(Intervention)*	What are patient and/or caregiver experiences with suicide prevention/reduction concerning best practices: screening, assessment, diagnosis, treatment, and prevention for/of suicide
C	*(Comparison)*	Compared to current best practices,
O	*(Outcome)*	Reduce rates of death by suicide among youth and young adults seen by a medical or mental health provider within 30 days of death?

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Cincinnati Children's, James M. Anderson Center. Internal evidence-based decision-making reviews; 2026.

Evidence-Based Decision-Making (EBDM) Literature Review

EBDM-2 · Effectiveness

High / Large

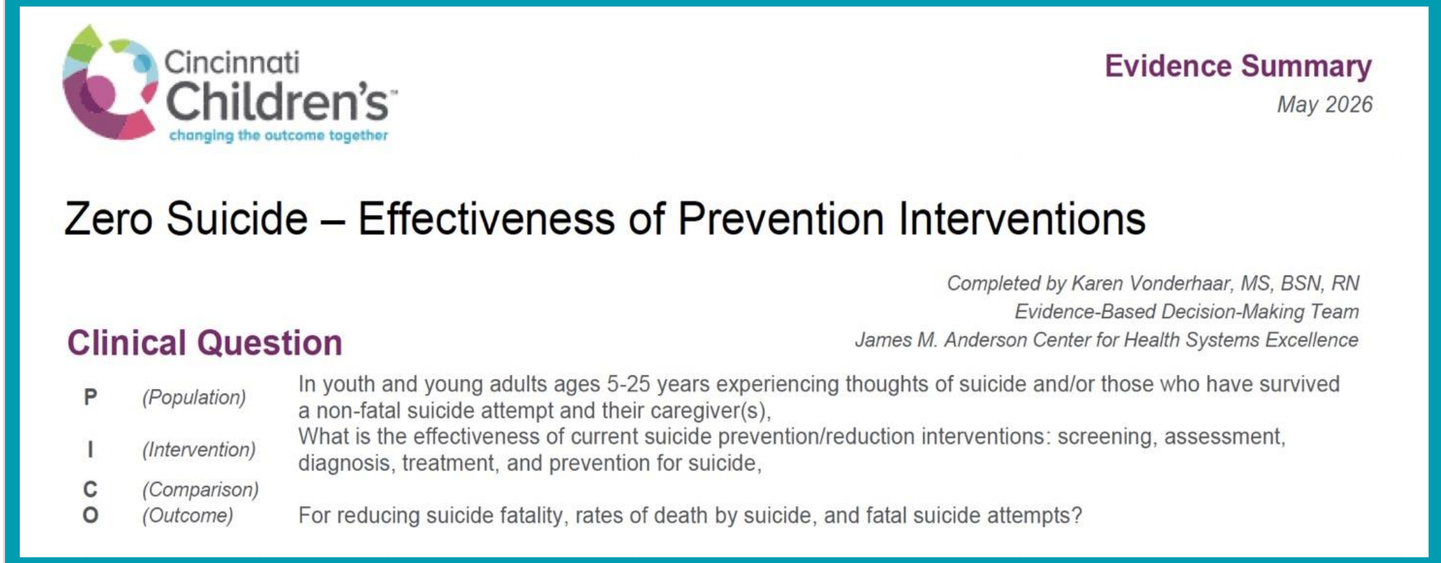
What interventions work

Screening, assessment, treatment, and lethal-means safety for youth 5–25.

596 articles screened

46 in synthesis

including 29 systematic reviews & meta-analyses



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Evidence Summary
May 2026

Zero Suicide – Effectiveness of Prevention Interventions

Completed by Karen Vonderhaar, MS, BSN, RN
Evidence-Based Decision-Making Team
James M. Anderson Center for Health Systems Excellence

Clinical Question

P	*(Population)*	In youth and young adults ages 5-25 years experiencing thoughts of suicide and/or those who have survived a non-fatal suicide attempt and their caregiver(s),
I	*(Intervention)*	What is the effectiveness of current suicide prevention/reduction interventions: screening, assessment, diagnosis, treatment, and prevention for suicide,
C	*(Comparison)*	
O	*(Outcome)*	For reducing suicide fatality, rates of death by suicide, and fatal suicide attempts?

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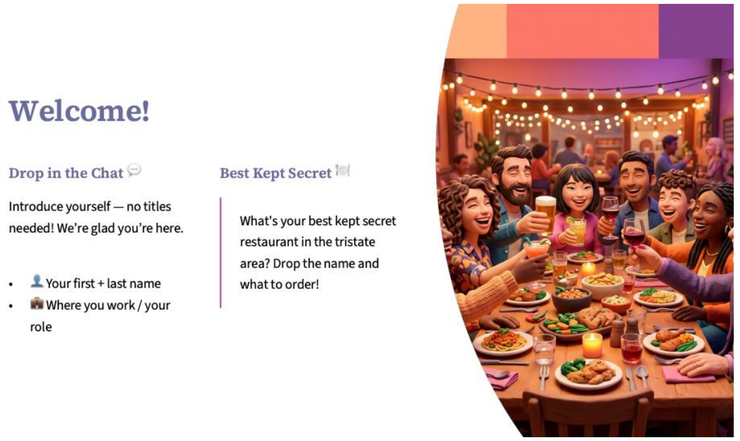
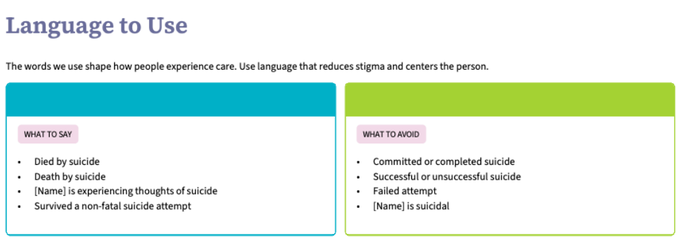
Cincinnati Children's, James M. Anderson Center. Internal evidence-based decision-making reviews; 2026.

Building Psychological Safety

- Our Mission
  - Eliminate suicide among youth and young adults in the Greater Cincinnati region
  - Agenda Setting
  - Welcome & Icebreaker
  - Language to Use
  - Psychological Safety Recap





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Action Plan 1

From Prediction to Prevention

1 Risk Status

ENDURING · HISTORICAL

How does this patient's risk compare to others in a reference group? Psychiatric history, prior attempts, family history.

2 Risk State

DYNAMIC · CURRENT

How does this moment compare to the patient's baseline? Recent stressors, events, and acute symptoms elevating risk now.

3 Available Resources

PROTECTIVE

What can the patient draw on if risk escalates? What could prevent them from accessing those resources in a crisis?

4 Foreseeable Changes

ANTICIPATED

What upcoming events, losses, or stressors could rapidly shift the patient's risk state — for better or worse?

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Brief Suicide Safety Assessment (BSSA)

FEASIBILITY

Cycles 1–2 · Feb 10–19

Prove BSSA fits the clinical workflow

An n-of-1 ED test scaled to 7 clinicians across BMCP and ED with no major friction — the tool worked in real flow.

REACH

1 → 7 clinicians

ADAPTATION

Cycles 3–5 · Feb 20–Mar 12

Refine the tool with a wider clinician mix

Used alongside C-SSRS in clinical flow; testing invovled non-MH staff added across three departments.

REACH

3 departments

MULTI-SITE TESTING

Cycles 6–8 · Mar 13–Apr

Test across Primary Care and school-based settings

Primary Care → whole-team → school-based testing. Surfaced the CALM-vs-BSSA tension; staged the testing across settings.

REACH

PC → school-based

ONGOING

Ongoing · from Apr 2

Gather feedback and evaluate next steps before any wider spread.

Led by Emily Meyer. Provider meetings and site check-ins continue; school-based findings pending.

REACH

Still in pilot

Brief Suicide Safety Assessment (BSSA)

Plan-Do-Study-Act (PDSA) Ramp · 8 Cycles · Feb–May 2025

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CYCLE	P PLAN	D DO	S STUDY	A ACT
1 CYCLE 1 **2/10–2/11** 1 clinician (Jessie) ED	Single-clinician BSSA feasibility test in ED workflow (n-of-1)	Tested with 10-year-old with ASD; wording well-received; one question flagged for impulsivity	Tool rated extremely helpful for new clinical staff; made assessments more concise	Adapt → expand to BMCP + 2 social workers
2 CYCLE 2 **2/12–2/19** 7 clinicians BMCP / ED	Multi-clinician BSSA testing across BMCP and ED	BSSA used by 7 clinicians across BMCP and ED; broader workflow integration tested	No major friction identified; tool scaled without disrupting workflow	Adapt → add new BMCP clinician and 2 different social workers
3 CYCLE 3 **2/20–2/26** 6 + Diabetes SW BMCP / ED / Endocrinology	Suicide-method question wording tested across 3 sites	Clinician discomfort with hypothetical wording; clarified that a plan is not a method	Reframed toward lethal-means counseling; gentler phrasing adopted across sites	Adapt → revise question wording; expand to new population and testers
4 CYCLE 4 **2/27–3/5** 8 clinicians BMCP / ED	BSSA testing with broader clinician mix including non-MH staff	BSSA outperformed C-SSRS in clinical flow; non-MH testers struggled; written guidance unclear	Ease of use varied by clinical background; written guidance requires revision	Adapt → continue testing across new clinical populations
5 CYCLE 5 **3/6–3/12** 6 clinicians Endocrinology / PC / BMCP	Cross-site review of BSSA content and workflow fit	Reviewed cross-site feedback; discussed caregiver-youth interviews and method phrasing	Team confirmed readiness to spread beyond core testers	Adapt → prepare PC as first spread site
↓ SPREAD — CYCLES 6–8	Broader rollout beyond initial testing group			
6 CYCLE 6 **3/13–3/19** 3 clinicians PC / BMCP	First spread to PC sites; weekly social work huddles	Tension between CALM and BSSA identified: ask less vs. document more	School-based sites and BMCP require a staged, incremental spread approach	Adapt → begin partial spread; training materials refined
7 CYCLE 7 **3/20–4/1** Team-wide PC / Endocrinology	Whole-team rollout at PC sites; training to Endocrinology social workers	CALM-vs-BSSA tension resurfaced in huddles across both sites	Whole-team onboarding feasible; larger teams require staged rollout	Adapt → advance partial spread to school-based sites and BMCP
8 CYCLE 8 ONGOING **4/2–present** Lead: Emily Meyer School-based / BMCP	Partial spread to school-based sites and BMCP	Check-ins held 4/15 (PC/Endocrinology); provider meetings scheduled 4/16 and 5/19	Feedback collection in progress; findings pending	Adapt → decision pending feedback from school-based sites

BSSA= Brief Suicide Safety Assessment · **ED**= Emergency Department · **BMCP**= Behavioral Medicine & Clinical Psychology · **PC**= Primary Care · **C-SSRS**= Columbia Suicide Severity Rating Scale · **CALM**= Collaborative Assessment & Management of Suicidality

BSSA Pilot Feedback — Theme × Respondent Matrix

Adoption was easy (12/15) and the tool reliably surfaced non-routinely-assessed content (9/15); the "feels diagnostic" tension clusters in outpatient settings.

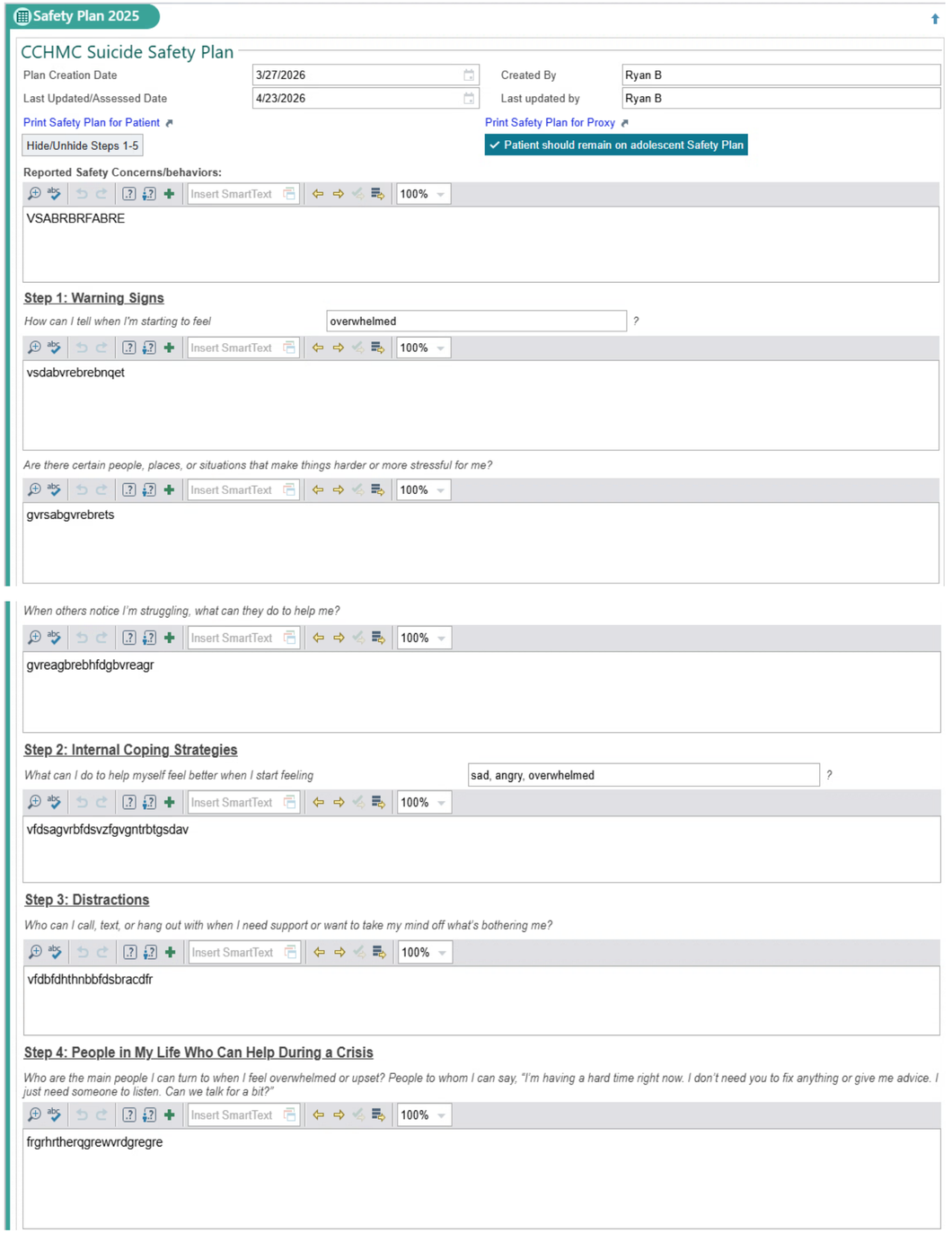
Theme	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	R12	R13	R14	R15	4/1	4/9	n
	PC	Endo	ED	BMed	ED	PC	ED	Endo	ED	Endo	PC	BMed	BMed	PC	ED	site	site	
1. Conversational flow / structure (+)				●			●	●	●			●	●					6
2. Surfaced non-routine content (contagion, etc.)	●	●	●	●							●	●	●	●	●			9
3. Method specificity & intent depth			●				●	●	●									4
4. Low workflow disruption	●	●	●	●	●		●		●	●	●	●		●	●			12
5. "How would you do it?" wording objection					●				●									2
6. Symptom breadth feels diagnostic		●				●				●					●			4
7. CALM / joint-interview friction						●										●	●	1
8. Overlap with C-SSRS (transitional)					●					●	●			●			●	4
9. EPIC / EHR integration ask								●	●					●	●			4
10. Needs time / practice										●	●		●					3
Themes per respondent →	2	3	3	3	3	2	3	3	5	4	4	3	3	4	4	1	2	49

● = theme expressed by that respondent. Professions: SW Social Worker · CC Clinical Counselor · Psy Psychologist · MD Psychiatrist. Settings: PC Primary Care · Endo Endocrinology · ED Emergency Dept · BMed Behavioral Medicine.
Row tint: green strengths · amber tensions · blue operational. "n" counts the 15 clinician reports only; Site (Hopple 4/1, 4/9) columns are aggregate site-level feedback and are excluded. Theme 8: the BSSA and C-SSRS were administered together as a transitional accommodation, not the intended end state.

Safety Plan

Link to Job Aid

Safety Plan



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Name	Relationship	Phone Number
fvrwgrgrwgrwegwer	rwgregregrgregre	fwergregergregregvre

Step 5: Professional and Emergency Supports

Our goal is to help the patient get the right care, at the right time, at the right place.

The steps below explain who to call and when, so you can get guidance and support during a mental health crisis.

1. Call or text 988, the Suicide & Crisis Lifeline

This service is free, private, and available 24/7.

When to call or text 988:

Patient is feeling very upset, overwhelmed, or unsafe.

Patient is having thoughts of suicide or self-harm.

Patient needs mental health support right away.

What to expect:

A person who cares, will listen, and provide support.

They can send mobile crisis support to your home or community, if needed.

2. Call the Psychiatric Intake Response Center (PIRC)

You can call PIRC at 513-636-4124, which is available 24 hours a day, 7 days a week, before going to the emergency department.

When to call PIRC:

You need help figuring out the best type of care.

You need help setting up an urgent mental health appointment.

What to expect:

A mental health professional will answer your call.

They will ask questions about what is happening and how patient is doing.

They will help you decide the safest and best next step.

They can set up an urgent appointment or guide you on other care options.

☐ Interpreter Needed?

3. Medical Emergencies During a Mental Health or Behavioral Health Crisis

Some mental health crises involve medical emergencies. The steps below explain when to go to the emergency department and when to call Poison Control.

If patient has a life-threatening medical emergency, call 911 or go to the nearest emergency department immediately.

If patient has attempted suicide or intentionally overdosed by taking too much or too little medication or another substance within the past 7 days, call the Psychiatric Intake Response Center (PIRC) at 513-636-4124.

Outpatient Team/Relationship	Name	Agency	Phone	E-mail	Appointment Dates/Times
RN/SW Care Manager	fcdsvgrgbrevre	vrsgvrgrgr	fwgvrgregre	fsgvfrgrger	fsfrewgregver
Case Manager (CPST)	cvdsagvgbrf	vfdasbfds	vdsafvf	vfdv fd	vdsav dsa

Additional Resouces & Supports

211 – Community Help Line	MRSS State Call Center	SAMHSA – Treatment Referral Hotline
National Human Trafficking Hotline	National Domestic Violence Hotline	National Runaway Safeline
Never Use Alone (US National Overdose Prevention Line)	Childhelp – National Child Abuse Hotline	Love is Respect (Teen Dating & Relationship Support)
Trevor Project LGBTQ		

Community Help Line (211)

Call:	211
When I Should Call:	If I need help finding resources for basic needs like food, housing, utilities, or health care.
What Will Happen:	Someone trained to help will ask what I need and connect me to local services.
Interpreter access:	I can say my language or ask for an interpreter at the start of the call.

Mobile Response and Stabilization Services (MRSS)

Call or Text:	988
When I Should Call:	If I feel very upset, have thoughts of suicide, or am having a mental health crisis.
What Will Happen:	I will talk to someone trained to help who will listen and support me; they can send a mobile team to come help me where I am, like at home, school, or in the community, and support me and my family.

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SAMHSA National Helpline

Call:	1-800-662-HELP (4357)
When I Should Call:	If I or a family member needs help with mental health or substance use.
When I Should Call:	Someone trained to help will give me free, private information and referrals to treatment programs, support groups, and community services.

National Human Trafficking Hotline

Call or Text:	1-888-373-7888
Text:	HELP to 233733
Website:	https://humantraffickinghotline.org
When I Should Call:	If I or someone I know is being forced to work or do things we do not want to do, including sexual things when we do not want to.
What Will Happen:	I will talk to someone trained to help who will support me, help me stay safe, and connect me to local services; it is private and available 24/7.

National Domestic Violence Hotline

Call:	1-800-799-SAFE (7233)
Text:	START to 88788
Website:	https://www.thehotline.org
When I Should Call:	If I am being hurt, abused, or treated in a way that makes me feel unsafe in a relationship.
What Will Happen:	I will talk to someone trained to help who offers private support, crisis help, and safety planning.

National Runaway Safeline

Call:	1-800-RUNAWAY (1-800-786-2929)
Text:	SAFE to 66008
Website:	https://www.1800runaway.org
When I Should Call:	If I have run away, am thinking about it, or need help while away from home.
What Will Happen:	I will talk to someone trained to help and get private support, crisis help, and help finding safe options and resources.

Never Use Alone, Inc. – Overdose Prevention Line

Call:	800-484-3731
Website:	https://neverusealone.com
When I Should Call:	If I am using drugs alone and want someone to help watch my safety.
What Will Happen:	Someone trained to help will stay on the phone and call for help if I stop responding.

Childhelp – National Child Abuse Hotline

Call or Text:	1-800-4-A-CHILD (1-800-422-4453)
Website:	https://www.childhelphotline.org
When I Should Call:	If I think a child is being abused or neglected, or if this is happening to me.
What Will Happen:	I will talk to someone trained to help who will support me and help me figure out next steps.

Love is Respect (Teen Dating & Relationship Support)

Call:	1-866-331-9474
Text:	LOVEIS to 22522
Website:	https://www.loveisrespect.org
When I Should Call:	If I have concerns about dating abuse or want to understand healthy relationships.
What Will Happen:	I will talk to someone trained to help who gives support, information, and help with safety planning.

Trevor Project LGBTQ

Call:	1-866-488-7386
Text:	START to 678678
Website:	https://www.thetrevorproject.org/get-help-now/
When I Should Call:	If I am LGBTQ+ and in crisis or need support.
What Will Happen:	I will talk to someone trained to help who gives private crisis support and suicide prevention help.

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Safety Plan

THE FOLLOWING IS FOR CAREGIVERS ONLY

Step 6: Limiting Access to Lethal Means

Most suicide attempts occur at home, are an impulsive response to emotional distress, and involve readily available lethal means.

Situations That Can Increase the Risk of Suicide among Youth

- Following a breakup, fight with a friend, bullying, or social rejection.
- During disciplinary action, school suspension, legal trouble, or loss of privileges.
- After the loss of a loved one, pet, or peer—especially due to suicide or overdose.
- During transition to a new school, foster care placement, or return from residential or inpatient treatment.
- When experiencing academic failure, rejection from a program, or college-related stress.
- After discharge from the emergency department or psychiatric hospitalization for suicidal ideation or a suicide attempt, as the risk for death by suicide is highest within the first 7–30 days post-discharge.
- Following a recent suicide attempt, self-injurious behavior, or other suicide-related event.

Firearms

Unlike most other methods used in suicide attempts, firearms rarely allow for a change of mind or the possibility of rescue once the trigger is pulled. Therefore, creating time and distance between a person experiencing suicidal thoughts and a firearm can save a life.

Plan for Limiting patient's Access to Firearms:

To ensure patient does not have access to firearms,

Mother	Father	Parents	Patient
Guardian	Grandmother	GrandFather	Primary Caregiver
Aunt	Uncle	Sister	Brother
Foster Parent	Other		

has agreed to implement the following secure storage measures (select all that apply).

- ✓ Store all firearms away from home (e.g., with a family member qualified to possess firearms, at a gun shop, pawn shop, shooting range, self-storage rental, or a police department)
- ☐ Locked in a tamper-proof safe or secure storage device (combination and/or biometric storage devices are preferred) that the participant cannot unlock (change the combination or where the key is kept regularly, ideally store the key outside of the home)
- ☐ Store ammunition locked up and separate from firearms
- ✓ Remove a key part of all firearms (bolt, slide, firing pin)
- ☐ Use cable lock or other external locks while stored in the secure device for added protection
- ☐ Not applicable—no firearms at home
- ☐ Other (add comments)

**Combination and/or biometric storage devices are preferred for enhanced security. Regularly change the combination or the location of the key and ideally store the key outside of the home. If the storage device requires a combination, ensure it is not an easily guessable date, such as a birthday or anniversary, and instead choose a combination that is difficult to remember. If the secure storage device uses a key, make sure the key is also secured in another secure storage device or a similarly secure location.*

Does this plan apply to all firearms?	Yes	No	Other
Will a self-defense or duty firearms be stored differently?	Yes	No	Other

Medications

Plan for reducing patient's access to medications including those that you can buy without a prescription:

- ✓ Discard any expired or unused prescription medications, especially for pain (e.g., opioids), sleep, or anxiety
- ☐ Reduce the accessible quantities of over-the-counter pain relievers and sleeping medications. Dispose of or lock up the rest
- ✓ Request that prescriptions be written or filled in quantities that would not cause serious harm even if taken all at once (e.g., weekly, or monthly prescriptions instead of a 90-day supply)
- ☐ Adults will administer medications as prescribed and then return them to the secured location that patient cannot access
- ☐ Ensure insulin or other refrigerated medications are secured in a device that is fridge safe
- ☐ Consult with a doctor or pharmacist

*Nearby locations to dispose of medications can be located here: https://safe.pharmacy/drug-disposal/

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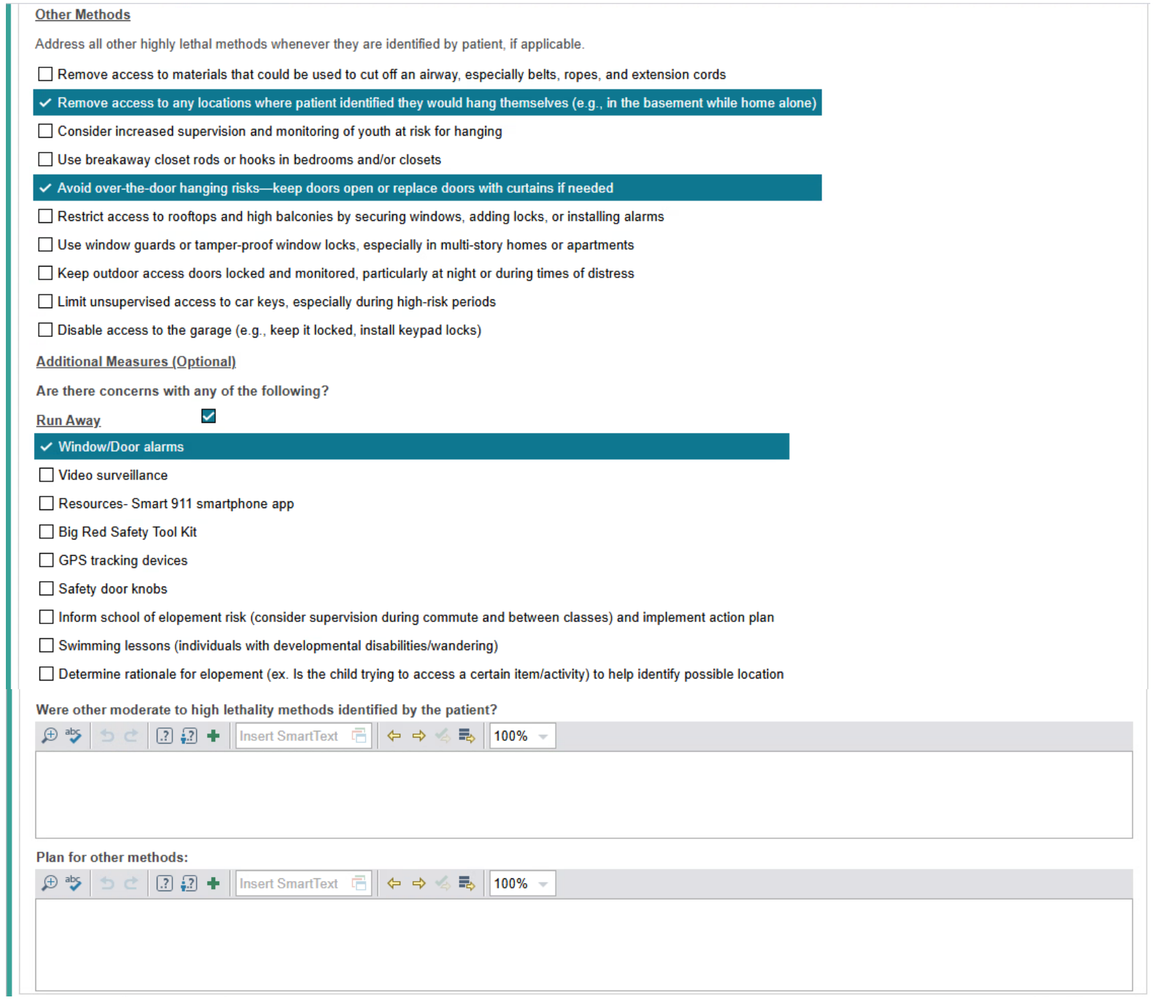
Safety Plan



Other Methods

Address all other highly lethal methods whenever they are identified by patient, if applicable.

- [ ] Remove access to materials that could be used to cut off an airway, especially belts, ropes, and extension cords
- [x] Remove access to any locations where patient identified they would hang themselves (e.g., in the basement while home alone)
- [ ] Consider increased supervision and monitoring of youth at risk for hanging
- [ ] Use breakaway closet rods or hooks in bedrooms and/or closets
- [x] Avoid over-the-door hanging risks—keep doors open or replace doors with curtains if needed
- [ ] Restrict access to rooftops and high balconies by securing windows, adding locks, or installing alarms
- [ ] Use window guards or tamper-proof window locks, especially in multi-story homes or apartments
- [ ] Keep outdoor access doors locked and monitored, particularly at night or during times of distress
- [ ] Limit unsupervised access to car keys, especially during high-risk periods
- [ ] Disable access to the garage (e.g., keep it locked, install keypad locks)

Additional Measures (Optional)

Are there concerns with any of the following?

Run Away ☑

- [x] Window/Door alarms
- [ ] Video surveillance
- [ ] Resources- Smart 911 smartphone app
- [ ] Big Red Safety Tool Kit
- [ ] GPS tracking devices
- [ ] Safety door knobs
- [ ] Inform school of elopement risk (consider supervision during commute and between classes) and implement action plan
- [ ] Swimming lessons (individuals with developmental disabilities/wandering)
- [ ] Determine rationale for elopement (ex. Is the child trying to access a certain item/activity) to help identify possible location

Were other moderate to high lethality methods identified by the patient?

Insert SmartText 100%

Plan for other methods:

Insert SmartText 100%

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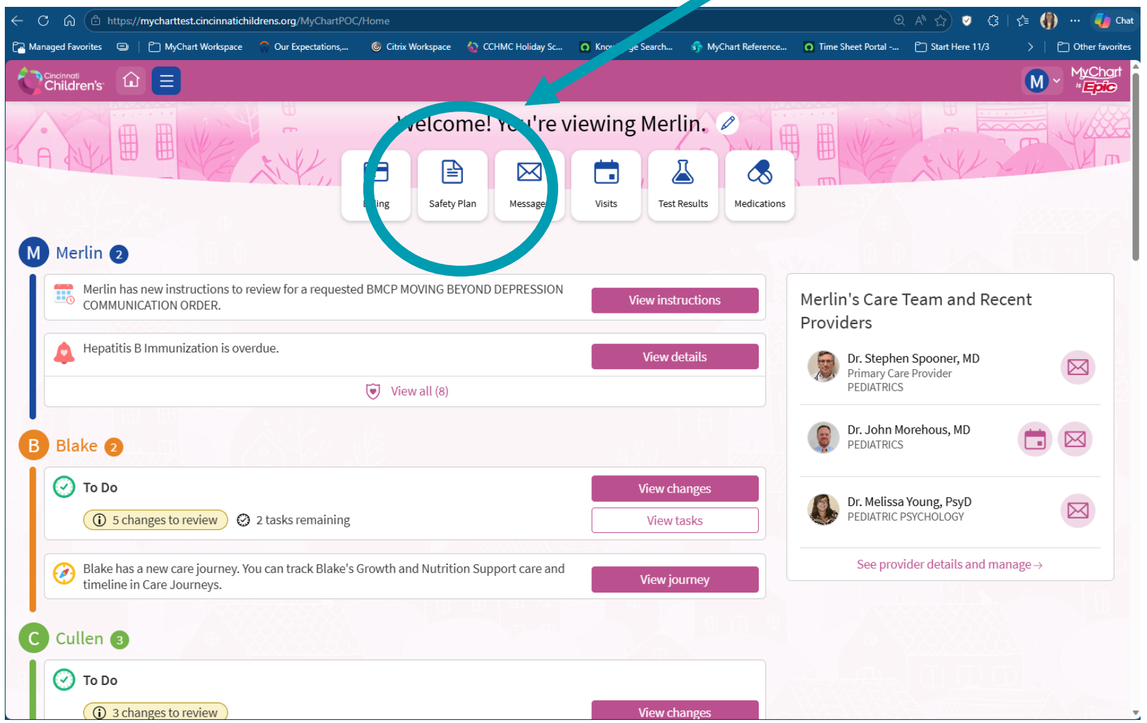
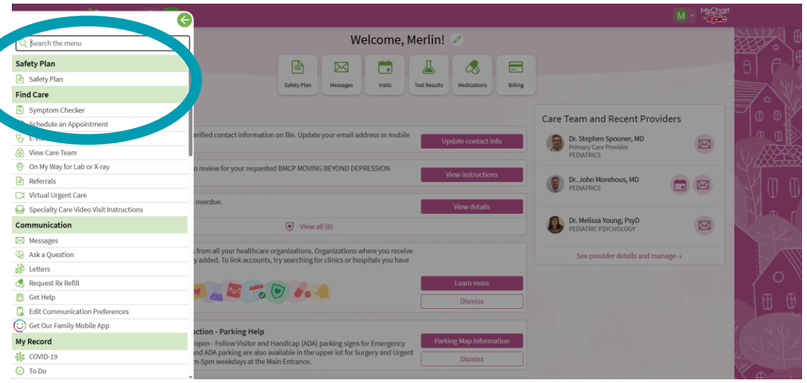
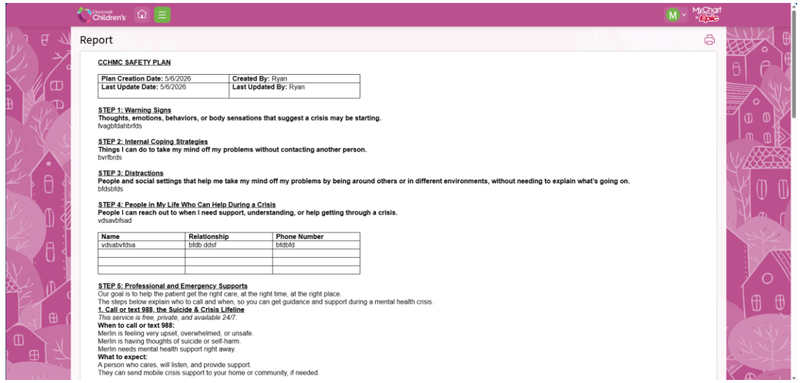
MyChart

Logged in as Proxy (Caregiver) – Viewing Patient's Account







MyChart Mobile

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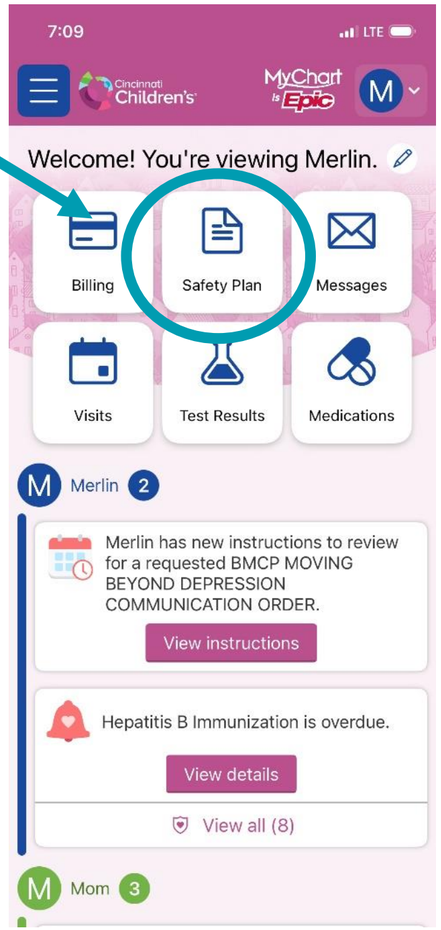

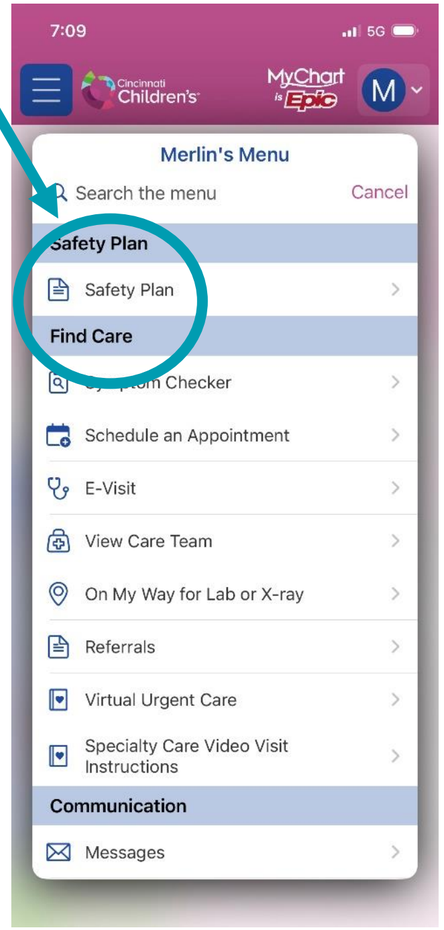

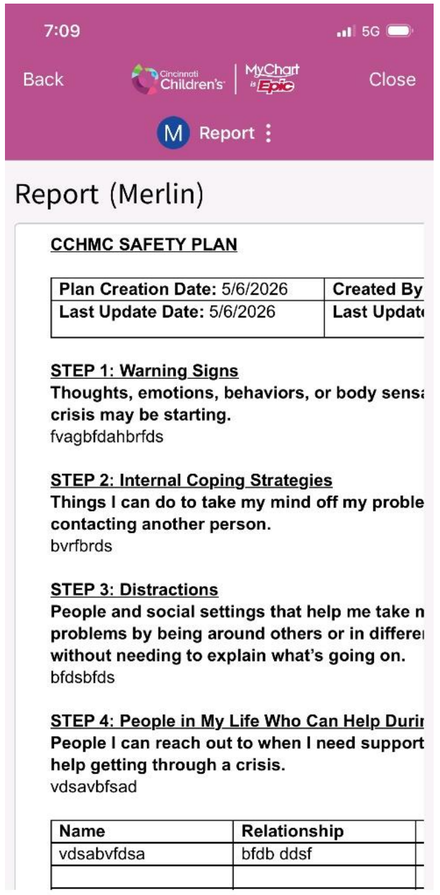

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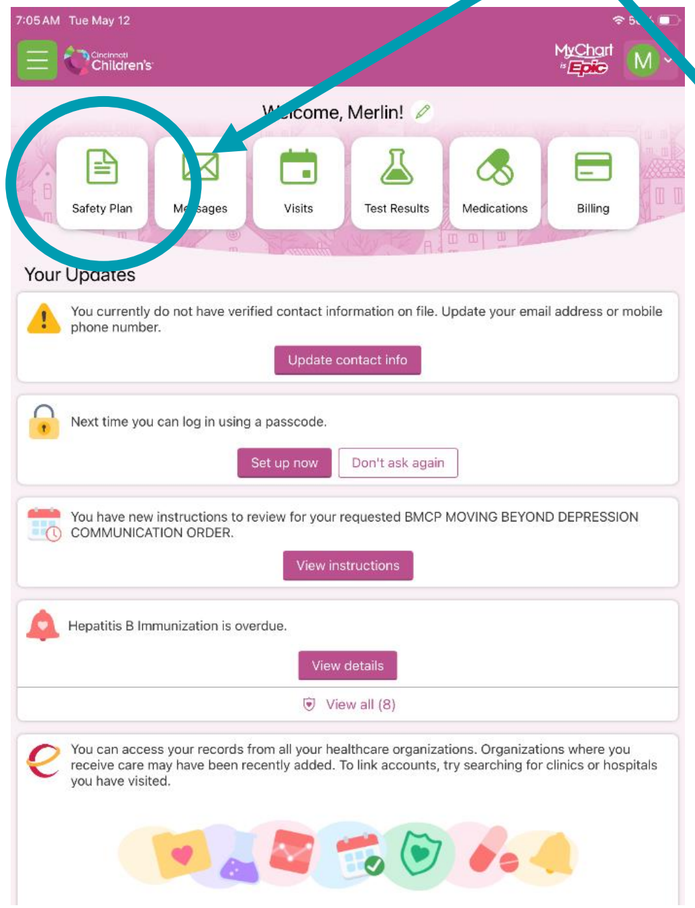

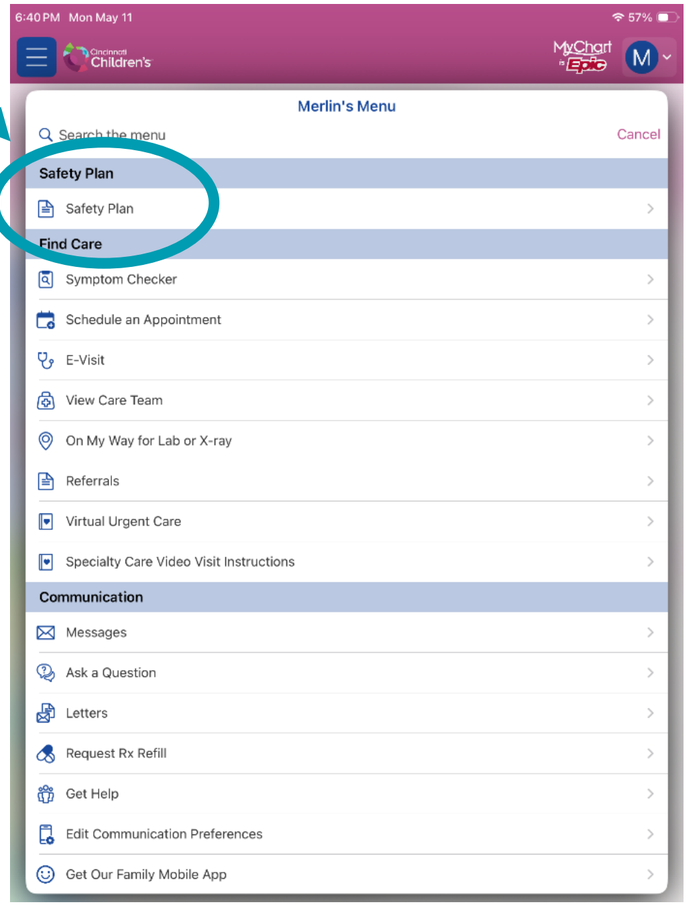

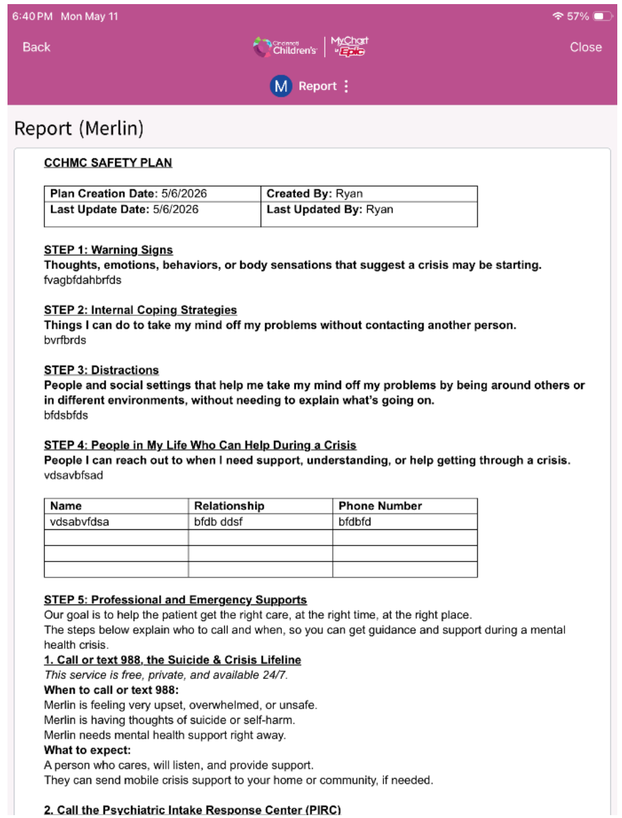

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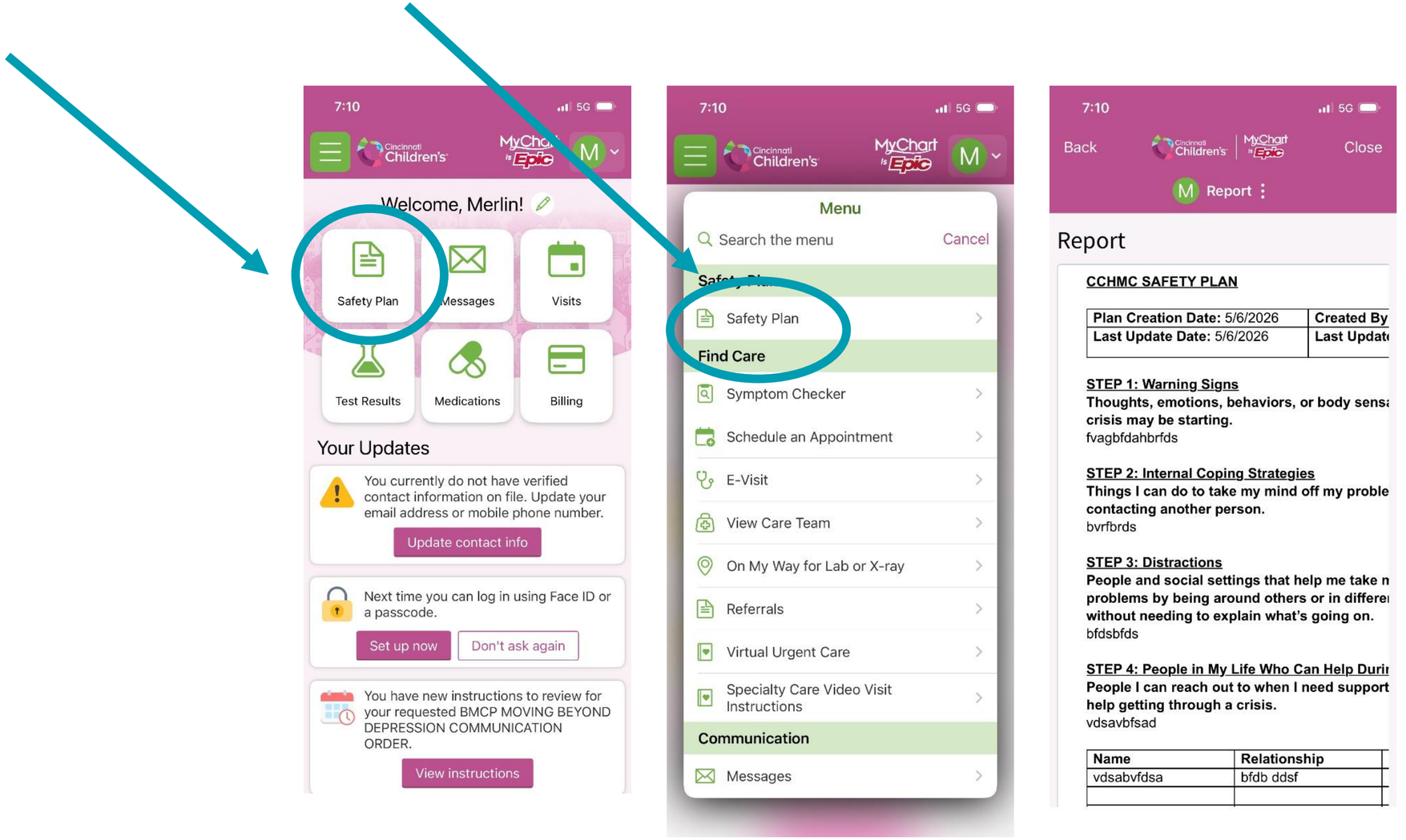
MyChart Mobile

Logged in as Patient



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Action Plan 2

988

FEWER DEATHS · JULY 2022 – DEC 2024

4,372

Fewer deaths than expected among young people ages 15–34 in the 30 months following 988's launch.

BELOW PROJECTED MORTALITY

–11%

Suicide mortality fell 11% below the projected rate. Sharpest reductions among ages 15–23 — those who used 988 most.

HIGH-UPTAKE VS. LOW-UPTAKE STATES

18%

Reduction in high-uptake states vs. 10.6% in states with lower 988 call volumes — a clear dose-response relationship.

INCREASE IN LIFELINE CONTACTS SINCE 2022

2×

Contacts doubled since launch. Driven disproportionately by adolescents and young adults — the highest-risk group.

Research Letter

Suicide Mortality Among Adolescents and Young Adults After Launch of a Suicide and Crisis Lifeline

Vishal R. Patel, MD, MPH[1,2]; Michael Liu, MD, MPhil[1,2]; Anupam B. Jena, MD, PhD[1,3,4]

Author Affiliations

RELATED ARTICLES

Suicide remains a leading cause of death among adolescents and young adults in the US.[1,2] In July 2022, the US launched the 988 Suicide and Crisis Lifeline, replacing the 10-digit 1-800-273-TALK number with a 3-digit number and investing more than $1.5 billion to expand crisis center capacity and workforce nationwide.[3] In the subsequent 3 years, contacts to the lifeline more than doubled,[4] with disproportionately higher use among adolescents and young adults.[5] Whether population-level suicide mortality in this group changed after launch of the 988 Lifeline is unknown.

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Lethal Means Safety & 988 Awareness Campaign

LETHAL MEANS SAFETY

Limiting access to lethal means saves lives.

Secure storage of firearms and medications puts **time and space** between someone at risk for suicide and lethal means, which could save their life.

SUICIDE & CRISIS LIFELINE

988

Call or Text — Help Is Available 24/7

If you, your child or teen, or someone you know is experiencing a mental health crisis or thinking about suicide, call or text 988 to reach the Suicide & Crisis Lifeline. Help is available 24/7.

Means Matter

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What We're Testing: Three PDSA's

Sites can participate in one or more of the PDSAs.

Firearm Safety

- ✓ Secure storage device distribution
- ✓ Accompanying educational materials

Medication Safety

- ✓ Deterra medication disposal bag distribution
- ✓ Accompanying educational materials

988 Awareness

- ✓ Testing awareness materials
- ✓ Increasing visibility and recall
- ✓ Identifying high-impact placements

Sites were invited to participate in one or multiple PDSAs based on interest and capacity.

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Tear-Off Pads with QR Code

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Testing Timeline

Day 1 — Launch

Materials placed, site contact informed, testing begins

Week 2 — Check-In

Brief mid-test touchpoint to troubleshoot and make any adjustments

Week 4 — End of Test

Feedback collected; team reviews results and plans the next iteration

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Project Team & Site Roles

What Our Team Provides

- All awareness and safety materials, along with implementation guidance to get your site started.
- Ongoing support throughout the test period, including check-in calls at weeks 2 and 4.
- Feedback questionnaires to capture perspectives from families and staff.

What Pilot Sites Provide

- Designate 1–2 site leads to champion and coordinate the initiative locally.
- Agree on placement locations for awareness and safety materials within your site.
- Share feedback at the 2-week check-in and end of the 4-week test period.

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Lethal Means & 988 Awareness Campaign

Target Completion: August 1, 2027

SITE / PROGRAM	PLAN-DO-STUDY-ACT FOCUS	STATUS	TEST START	2-WEEK	4-WEEK
Eating Disorders Behavioral Medicine & Clinical Psychology	Firearm Safety; Medication Safety; 988 Awareness	PENDING	—	—	—
General Mental Health Behavioral Medicine & Clinical Psychology	Firearm Safety; Medication Safety; 988 Awareness	PENDING	—	—	—
Enhanced Outpatient Program Behavioral Medicine & Clinical Psychology	Firearm Safety; Medication Safety; 988 Awareness	PENDING	—	—	—
Foster Care Clinic	Firearm Safety; Medication Safety; 988 Awareness	CONFIRMED	6/30/26	7/14/26	7/28/26
Neurodevelopmental & Behavioral Psychology	Firearm Safety; Medication Safety; 988 Awareness	CONFIRMED	6/29/26	7/13/26	7/27/26
Accountable Care Organization	Medication Safety; 988 Awareness	CONFIRMED	6/25/26 6/29/26	7/9/26 7/13/26	7/23/26 7/27/26
Pediatric Primary Care	988 Awareness	CONFIRMED	7/6/26	7/20/26	8/3/26
EXTERNAL COMMUNITY PARTNERS					
County Government Entity Site A	Firearm Safety; Medication Safety	PENDING	—	—	—
County Government Entity Site B	Medication Safety; 988 Awareness	PENDING	—	—	—
Northern Kentucky Health NKY Region	Firearm Safety; Medication Safety; 988 Awareness	PENDING	—	—	—

= External Community Partner CONFIRMED Test dates confirmed PENDING Start date TBD Feedback method for all sites: Providers/staff complete a Microsoft Form at 2- and 4-week timepoints

A crisis doesn't have to mean the emergency department...

988 anchors a continuum of crisis care — someone to call, someone to respond, and a safe place to go — keeping many crises out of the ED entirely.

SOMEONE TO CALL

988 Lifeline

24/7 phone and text with trained counselors.

→

SOMEONE TO RESPOND

MRSS

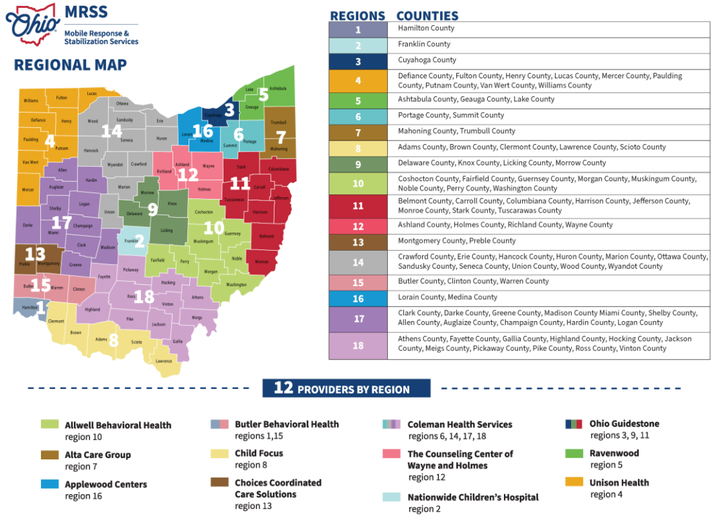
Mobile Response & Stabilization — crisis help that comes to the family.

→

A SAFE PLACE TO GO

Stabilization

Crisis stabilization as an alternative to the emergency department.



Link to Data

MRSS

Mobile Response & Stabilization Services

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Action Plan 3

Co-Production with Caregivers

While our group was originally scoped to evaluate resources, our focus groups revealed a deeper challenge:

*"Because caregivers feel **extremely** overwhelmed trying to get their child/teen the help they need, they struggle to process the usefulness of **any** resources they are given in the moment."*

We heard this from two focus groups we conducted:

Focus Group 1

Patient Safety Advisory Council

Parents and caregivers who serve on the advisory council

Focus Group 2

MBHI Family Navigators

Families navigating behavioral health services

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Commonalities Across Focus Groups

Co-produced with the Patient Safety Advisory Council and MBHI Family Navigators, informed by an EBDM literature review.

Caregiver Well-Being

Caregiver well-being is inseparable from child and adolescent safety. Caregiver distress directly affects their ability to support safety planning.

System Navigation

Families are often expected to navigate complex mental health systems independently, without adequate guidance or support.

Care Pathways

Lack of clear, suicide-specific care pathways creates uncertainty and distress for families during already difficult moments.

Resource Overload

Existing suicide prevention resources are often overwhelming in volume and format, reducing their practical usefulness.

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Cincinnati Children's is committed to improving the lives of the patients and families we serve. Our team is committed to working tirelessly to eliminate youth and young adult suicide in the Greater Cincinnati area.

Stay connected!

Cincinnati Children's®

CCHMC.ORG

Zero.Suicide@cchmc.org

THANK YOU

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