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John P. Ackerman, PhD

Suicide Prevention Coordinator

Nationwide Children's Hospital

Testimony for HB 123

Chairwoman Lehner, Vice-chairman Brenner and Ranking Member Fedor, and members of the Senate Education Committee, thank you for allowing me to provide testimony for HB 123. My name is John Ackerman and I direct the suicide prevention efforts of the Center for Suicide Prevention and Research at Nationwide Children’s Hospital. We provide evidence-based suicide prevention using the Signs of Suicide Program (Aseltine et al., 2004, Aseltine et al., 2007, Schilling et al., 2016) in schools across 34 counties in central and Southeast Ohio at no cost.

Suicide rates among youth continue to rise nationally and in Ohio (<https://afsp.org/about-suicide/state-fact-sheets/#Ohio>). Suicide is the second leading cause of death among school-aged youth aged 10-19. The sharpest increase in number of suicides occurs between early adolescence and young adulthood (Nock et al., 2008; WHO, 2017). The majority of those who have ever considered or attempted suicide first did so during their youth (Kessler et al., 1999). Teens who experience suicidal thoughts are approximately 12 times more likely to have attempted suicide by age 30 (Reinherz et al., 2006) and over one third of teens who experience suicidal thoughts later attempt suicide (Nock et al., 2013). Without the implementation of effective universal prevention strategies, this concerning trajectory will likely persist. Use of evidence-based practices for suicide prevention reduces suicidal behavior among students and improves school staff confidence and competence in identifying and supporting students at risk for suicide. However, faced with limited resources, competing priorities, and limited research, schools often use a piecemeal approach to suicide prevention, which reduces effectiveness.

It is challenging to sustain such programs over time. Recent data from federally funded Garrett Lee Smith (GLS) Memorial Act suicide prevention programs tell us that unless programs are delivered consistently in schools or in the community, positive effects quickly fade away (Garraza et al., 2015) and have minimal impact after two years if not sustained (Garraza et al., 2019). Consistent exposure to quality programs over time is associated with increased size and duration of positive effects. Of course, many schools are hesitant to initiate suicide prevention programs due to anxiety about their ability to manage students who are identified as needing support for suicidal thoughts or behavior.  Time and staff resources dedicated to training, planning, and supporting youth who screen positive for elevated risk of depression and/or suicide constitute a significant investment. Thus, it is critical that such an investment will lead to meaningful results.

The best way for a school to ensure meaningful results is by using what are called evidence-based practices (EBPs). EBPs involve the integration of external scientific evidence, expert opinion and experience, and student/educator/caregiver perspectives. When these components are considered together, schools are able to make informed decisions and provide high-quality prevention services that will reduce the risk of suicide. The strongest evidence comes from randomized control trials, meta-analyses, and designs with strong statistical controls.

While there is still much to learn, there is growing evidence about what elements are important for school-based suicide prevention. We can draw from models that have shown positive outcomes using a rigorous approach to program evaluation (e.g., Signs of Suicide, Sources of Strength, Youth Aware of Mental Health Programme, PAX Good Behavior Game). Based on several randomized clinical trials (Aseltine et al., 2004, Aseltine et al., 2007, Schilling et al., 2016; Wasserman et al., 2015; Wyman et al., 2010), we know that the most effective school-based suicide prevention programs use multiple approaches including education of school staff and youth caregivers/parents, screening for suicide risk, and peer outreach and support. Upstream suicide prevention also has benefits. The PAX Good Behavior Game, a universal prevention program delivered in elementary schools, teaches children self-management skills in a prosocial and nurturing classroom environment. The Good Behavior Game has been shown in randomized control trials to reduce suicidal ideation and attempts over time, even though it does not specifically address suicide in the classroom (Wilcox, 2008).

We now recognize that gatekeeper trainings for adults or student awareness programs alone are generally insufficient to create lasting change. Furthermore, we need to be aware that failing to use EBPs runs the risk of using programs that may actually contribute to increased student risk. There are studies suggesting that youth can increase harmful behavior when provided with unproven interventions, even when interventions intuitively seem to have the potential to deliver positive results (see Dishion et al., 1999).

In summary, while the field is continuing to learn more about suicide prevention, with some newer interventions that are being rigorously evaluated showing significant promise, there is scientific evidence as to which programs actually work and work well when implemented with fidelity. HB 123 provides the opportunity for schools to prioritize evidence-based suicide prevention programs that can be sustainable and will have a demonstrated impact in reducing suicide risk. Providing our children with interventions that have been the subject of rigorous scientific evaluation is the best way to provide optimal care for this vulnerable population.

On behalf of Nationwide Children's Hospital, thank you for allowing me to testify on HB 123.