School Suicide Prevention, Intervention, and Postvention

Stephen E. Brock, PhD, NCSP
Past-President, National Association of School Psychologists
California State University, Sacramento
School Psychology Program
brock@csus.edu
http://www.csus.edu/indiv/b/brocks/

Richard Lieberman, NCSP
Loyola Marymount University
rlieberm@lmu.edu

1

Workshop Goals

- When you leave this workshop we hope that you will have …
  1. a better understand the term "suicide" and be able to differentiate it from other forms of self-injury
  2. a better understanding suicide statistics and demographics, and appreciate how these data can inform risk assessments.
  3. considered a variety of primary prevention strategies.
  4. increased your knowledge of suicide risk assessment.
  5. increased your knowledge of how schools should intervene with the student at risk for suicidal behavior.
  6. increased your knowledge of how to respond to the aftermath of a completed suicide.

2

Workshop Outline

- Suicide
  1. Definitions
  2. Statistics and Demographics
  3. Prevention
  4. Risk Assessment
  5. Intervention
  6. Postvention

3

Part 1

What is "suicide"

GOAL:
Understand the term "suicide" and be able to differentiate it from other forms of self-injury

4

Definitions

- Self-Directed Violence (SDV)
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself."
    - Includes Non-Suicidal and Suicidal behaviors

5

Crosby, Ortega, & Melanson (2011, p. 21)

Definitions

- Non-Suicidal SDV(AKA self-mutilation, cutting, self-injury)
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent."
- Suicidal SDV
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent."

6

Crosby, Ortega, & Melanson (2011, p. 21)

Definitions

- Non-Suicidal and Suicidal SDV
  - Similarities
    - Coping behaviors
      1. Suicide aims at eliminating overwhelming and intolerable pain
      2. Non-Suicidal SDV aims at managing pain
  - Differences
    - Death orientation
      1. Suicide associated with conscious thoughts of death
      2. Non-suicidal SDV not associated with conscious thoughts of death

7

Definitions

- Undetermined SDV
  - "Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based on the available evidence."

Crosby, Ortega, & Melanson (2011, p. 21)

8

Part 2

Suicide Statistics and Demographics

GOAL:

Have a better understanding suicide statistics and demographics, and appreciate how these data can inform risk assessments

9

Statistics & Demographics

- Magnitude of the problem
  - Suicidal SDV
    - 10-14 yr olds = 2nd leading cause of death
      - *N* = 425
    - 15-19 yr olds = 2nd leading cause of death
      - *N* = 1,834
    - Across age groups = 10th leading cause of death
      - *N* = 42,773

CDC (2016)

10

Statistics & Demographics

- Magnitude of the problem
  - Suicidal SDV among high school students in 2013[1]
    - 17.0% seriously considered suicide
    - 13.6% made a suicide plan
    - 8.0% attempted suicide
    - 2.7% attempt required medical attention
  - 100 to 200 attempts for each completed suicide.[2]

[1]Kann et al. (2014); [2]Drapeau & McIntosh (2015)

11

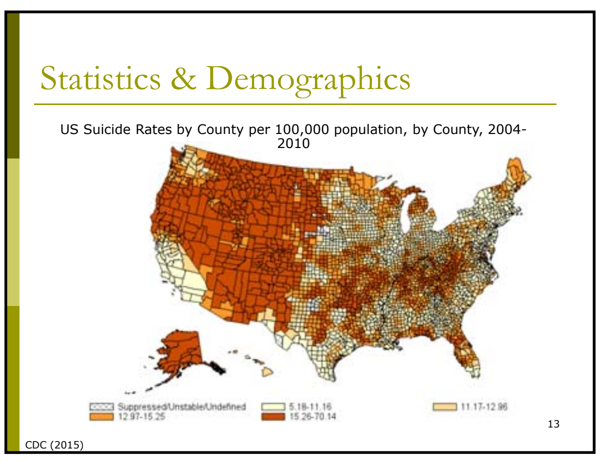
Statistics & Demographics (2014 National Data)

- More men die by suicide
  - Gender ratio 3.43 male suicides (*N* = 33,113) for each females suicide (*N* = 9,660)
- Suicide Rate = 13.41 per 100,000 (males, 20.65; females, 5.77)
- 51.4% of suicides were by firearms.
  - Suicide by firearms rate = 6.69
  - Suicide by firearms rate (14-18 yrs) = 3.04
  - Suicide by firearms rate (15-19 yrs male) = 5.29
  - Suicide by firearms rate (15-19 yrs female) = 0.69
- Highest suicide rate is among white men over 85 (39 per 100,000 vs. 8.71 per 100,000[1] among 15-19 year olds).

CDC, 2016

12

Statistics & Demographics



CDC (2015)

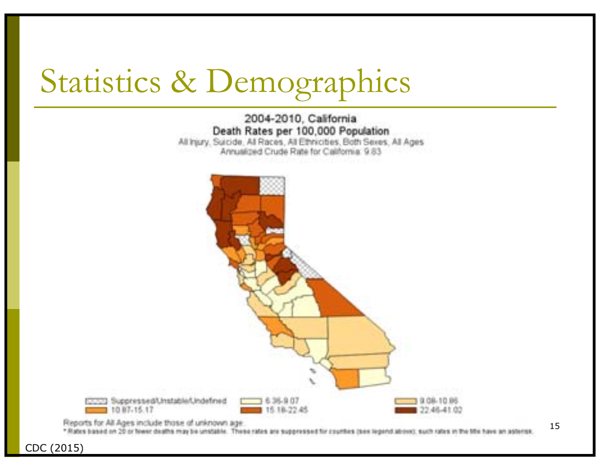
Statistics & Demographics (2014 rankings)

Rank	State (2013 rank)	N	Rate
1	Montana (1)	251	24.52
2	Alaska (2)	167	22.67
3	New Mexico (4)	449	21.53
4	Wyoming (3)	120	20.54
5	Colorado (7)	1083	20.22
6	Nevada (6)	573	20.18
7	Vermont (10)	124	19.79
8	Oregon (11)	782	19.7
9	Idaho (8)	320	19.58
10	West Virginia (15)	359	19.4
National Total		**41,149**	**13.14**
43	California (45)	4,214	10.86

14

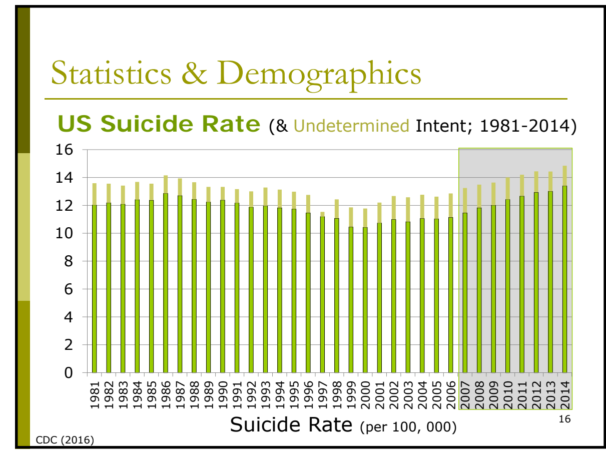
CDC (2016)

Statistics & Demographics



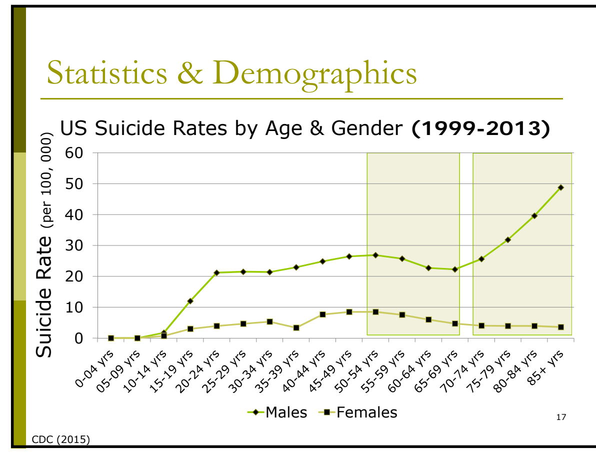
CDC (2015)

Statistics & Demographics



CDC (2016)

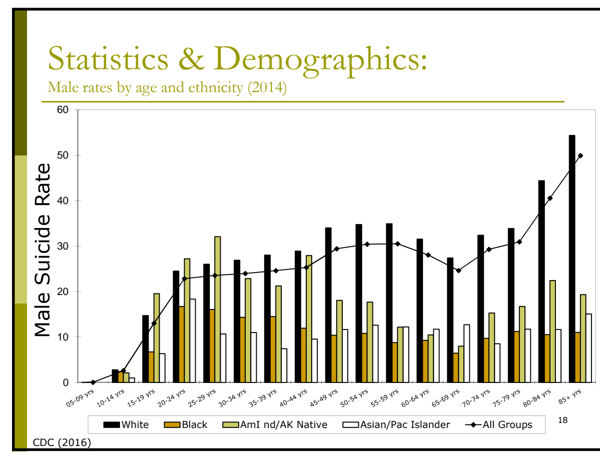
Statistics & Demographics



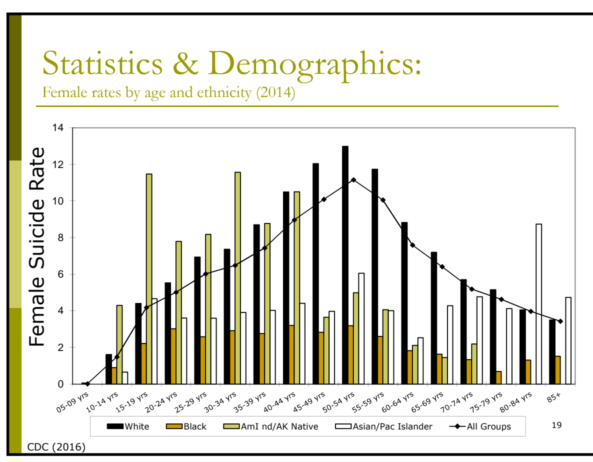
CDC (2015)

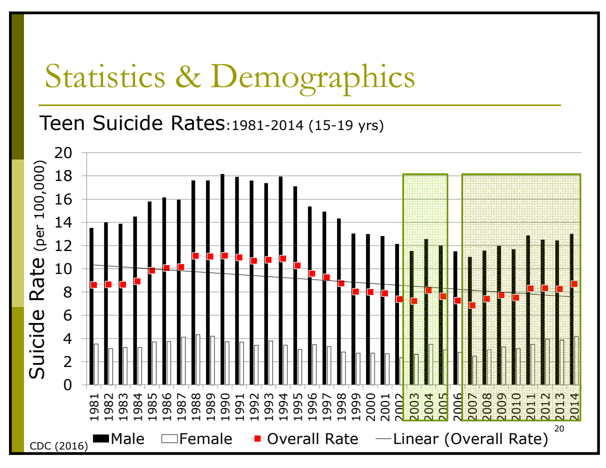
Statistics & Demographics:

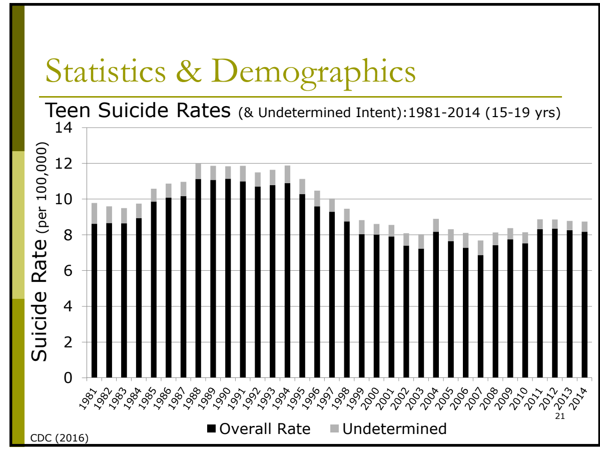
Male rates by age and ethnicity (2014)

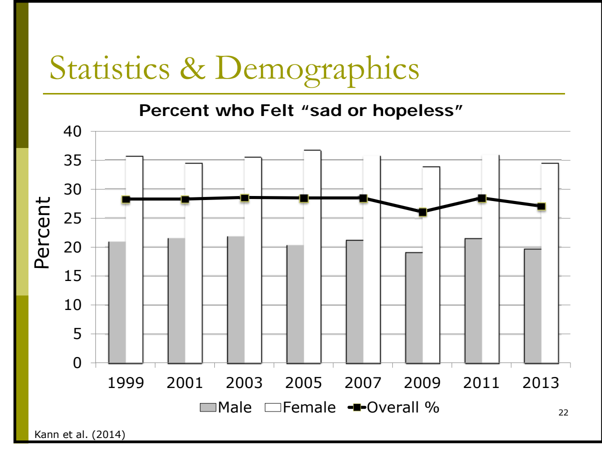


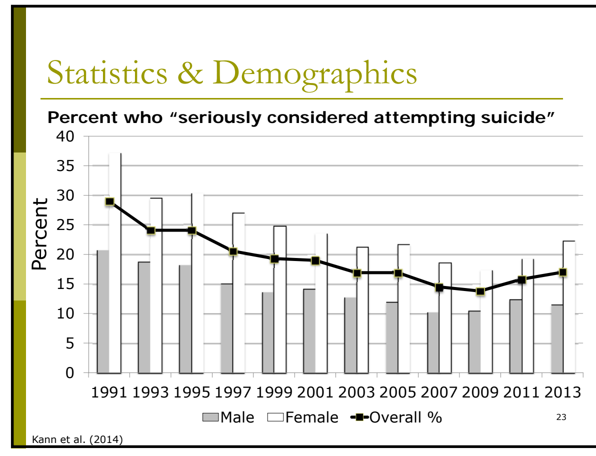
CDC (2016)

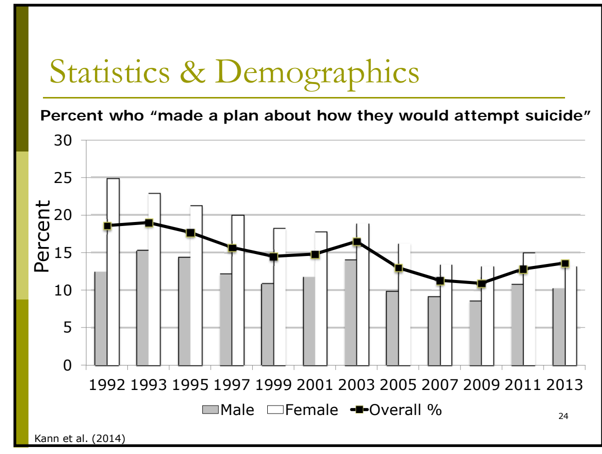

Statistics & Demographics:
Female rates by age and ethnicity (2014)
Female Suicide Rate
White
Black
AmI nd/AK Native
Asian/Pac Islander
All Groups
19
CDC (2016)

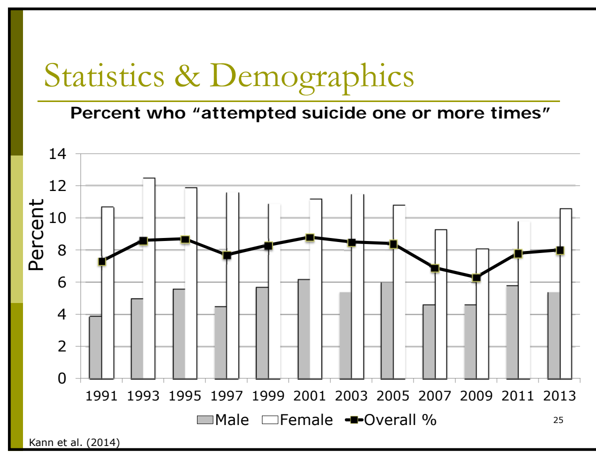

Statistics & Demographics
Teen Suicide Rates:1981-2014 (15-19 yrs)
Suicide Rate (per 100,000)
Male
Female
Overall Rate
Linear (Overall Rate)
20
CDC (2016)

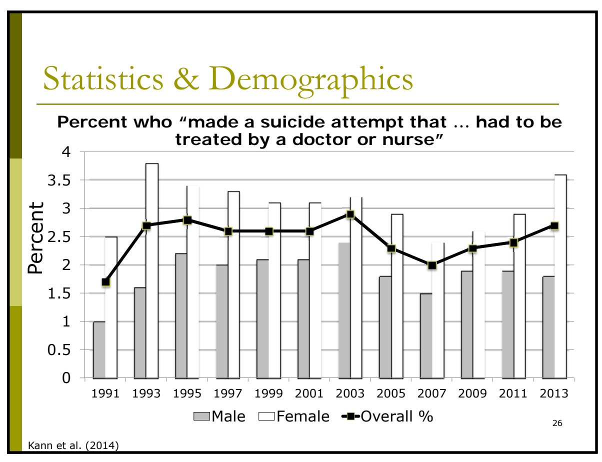

Statistics & Demographics
Teen Suicide Rates (& Undetermined Intent):1981-2014 (15-19 yrs)
Suicide Rate (per 100,000)
Overall Rate
Undetermined
21
CDC (2016)

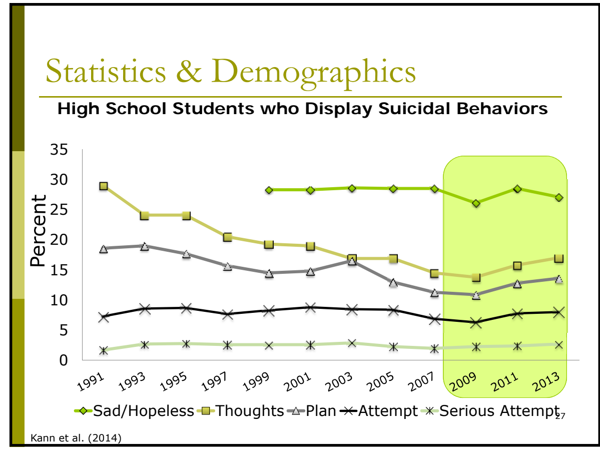

Statistics & Demographics
Percent who Felt "sad or hopeless"
Percent
Male
Female
Overall %
22
Kann et al. (2014)

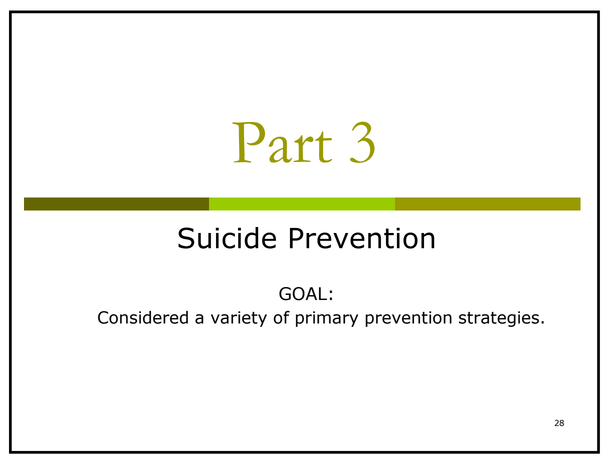

Statistics & Demographics
Percent who "seriously considered attempting suicide"
Percent
Male
Female
Overall %
23
Kann et al. (2014)


Statistics & Demographics
Percent who "made a plan about how they would attempt suicide"
Percent
Male
Female
Overall %
24
Kann et al. (2014)









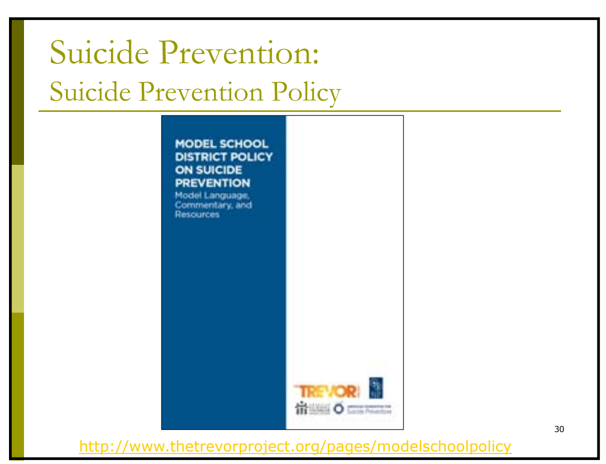
Suicide Prevention:

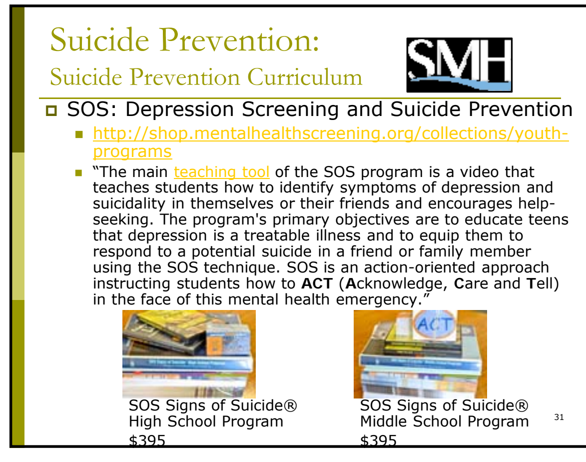
Suicide Prevention Policy

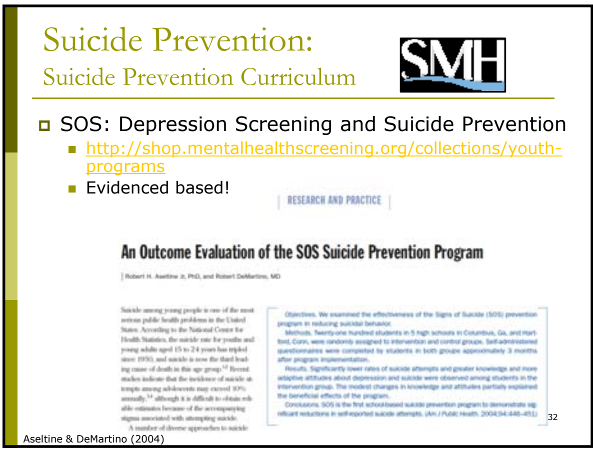
It is the policy of the Governing Board that all staff members learn how to recognize students at risk, to identify warning signs of suicide, to take preventive precautions, and to report suicide threats to the appropriate parental and professional authorities.

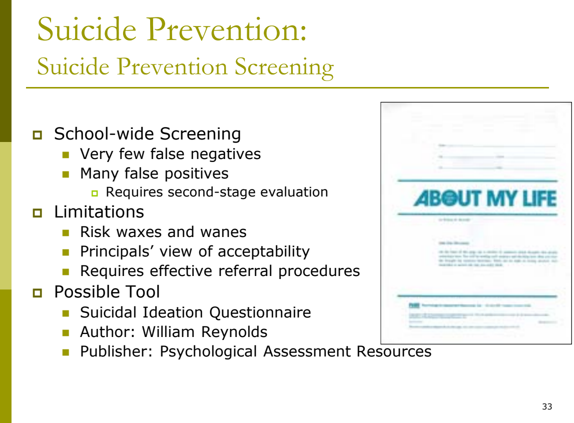
Administration shall ensure that all staff members have been issued a copy of the District's suicide prevention policy and procedures. All staff members are responsible for knowing and acting upon them.

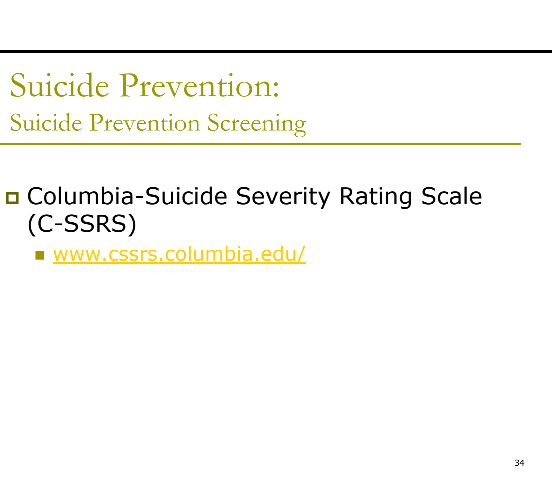
29











Suicide Prevention:
Suicide Prevention Screening

- **Columbia Suicide Severity Rating Scale**
  - **For information about the psychometric properties of the C- SSRS, please see:**
  - Posner, K., Brown, G.K., Stanley, B., Brent, D.A., Yershova, K.V., Oquendo, M.A., Currier, G.W., Melvin, G., Greenhill, L., Shen, S., & Mann, J.J. (2011). The Columbia-Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults. *American Journal of Psychiatry, 168*,1266-1277.

Suicide Prevention:
Suicide Prevention Screening

- **For information about the feasibility and validation of the eC-SSRS:**
  - Mundt, J.C., Greist, J.H., Gelenberg, A.J., Katzelnick, D.J., Jefferson, J.W. & Model, J.G. (2010). "Feasibility and Validation of a Computer-Automated Columbia-Suicide severity Rating Scale Using Interactive Voice Response Technology." Journal of Psychiatric Research, doi:10.1016/j.jpsychires.2010.04.025.
  - Mundt, J. C., Greist, J. H., Jefferson, J. W., Federico, M., Mann, J. J., & Posner, K. (2013). Prediction of suicidal behavior in clinical research by lifetime suicidal ideation and behavior ascertained by the electronic Columbia-Suicide Severity Rating Scale. *The Journal of clinical psychiatry, 74*(9), 887-893.

Suicide Prevention:
Suicide Prevention: Gatekeeper Training

- Training natural community caregivers
  - (e.g., Suicide Intervention Training)
- Advantages
  - Reduced risk of imitation
  - Expands community support systems
- Research is limited but promising
  - Durable changes in attitudes, knowledge, intervention skills

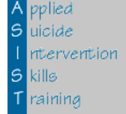
37

Gould & Kramer (2001)

Suicide Prevention:
Suicide Prevention: Gatekeeper Training

A Specific Training Program:

- Applied Suicide Intervention Skills Training
  - Author: Ramsay, Tanney, Tierney, & Lang
  - Publisher: LivingWorks Education, Inc
  - 1-403-209-0242
  - http://www.livingworks.net/



- The ASIST workshop (formerly the Suicide Intervention Workshop) is for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over 200,000 caregivers have participated in this two-day, highly interactive, practical, practice-oriented workshop.
- Training for Trainers is a (minimum) five-day course that prepares local resource persons to be trainers of the ASIST workshop. Around the world, there is a network of 1000 active, registered trainers.

38

Suicide Prevention:
Hotlines

- Rationale
  - Suicidal ideation is associated with crisis
  - Suicidal ideation is associated with ambivalence
  - Special training is requires to respond to "cries for help"
- Likely benefit those who use them
- Limitations
  - Limited research regarding effectiveness
  - Few youth use hotlines
  - Youth are less likely to be aware of hotlines
  - Highest risk youth are least likely to use

39

Gould & Kramer (2001)

Suicide Prevention:
Hotlines

Washington Unified School District
Suicide Help Card

- **Stay** with the person – you are their *lifeline!*
- **Listen**, *really listen.* Take them seriously!
- **Get**, or **call help** *immediately!*

24 Hour Crisis Hopeline
(530) 666-7778 (Woodland)
(530) 756-5000 (Davis)

NATIONAL SUICIDE PREVENTION LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

Suicide Help Card

If some one you know threatens suicide; talks about wanting to die, shows changes in behavior, appearance, or mood; abuses drugs or alcohol; deliberately injures themselves; appears depressed, sad, or withdrawn…
You can help by staying calm and listening, being accepting and not judging, asking if they have suicidal thoughts, taking threats seriously, and not swearing secrecy – **tell someone!**

Get help: You can't do it alone: Yolo County Mental Health Mobile Crisis Unite/Suicide Prevention Counseling
(916) 357-6350

40

Suicide Prevention:
Hotlines

- Texting is the preferred mode of communication for teens and young adults
  - Crisis Text Line
    - CTL is the first nationwide, free, 24/7 text hotline for teens in crisis. Text "FB" to 741741 to chat with a compassionate, trained counselor.
    - http://www.crisistextline.org/
  - Teen Line
    - Teens helping teens
    - https://teenlineonline.org/
  - REACHOUT.com
    - www.reachout.com

CRISIS TEXT LINE

TEEN LINE

41

Swearer et al. (2015)

Suicide Prevention:
Media Education

- *Reporting on Suicide: Recommendations for the Media*
  - www.sprc.org/library/sreporting.pdf

42

Suicide Prevention:
Public Awareness

- *Safe and Effective Messaging for Suicide Prevention*
  - http://www.sprc.org/sites/sprc.org/files/library/SafeMessagingrevised.pdf

43

Suicide Prevention:
Risk Factor Reduction

- Postvention
- Skills Training
- Restriction of Lethal Means
  - *r* = .61 (% of homes w/ firearms & suicide rate)
  - *r* = .85 (% of homes w/ firearms & firearm suicide rate)
    - States with a higher percentage of firearms in their homes tend to have higher suicide rates (especially suicide by firearm suicide rates).

44

Suicide Prevention:
Risk Factor Reduction

Number and Percent of Firearms Used in School-Associated Suicide, by Source of Firearm

Source of Firearm	Number	Percent
Home of Victim	26	76.5%
Friend/Relative of Victim	4	11.8%
Purchased	0	00.0%
Stolen	2	05.9%
Unknown	2	05.9%

45

Reza et al. (2003)

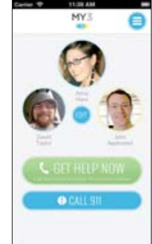
Other Suicide Prevention Resources

- **For Caregivers**
  - Suicide Assessment Five-Step Evaluation and Triage (SAFE-T): Pocket Card for Clinicians
    - http://store.samhsa.gov/product/Suicide-Assessment-Five-Step-Evaluation-and-Triage-SAFE-T-Pocket-Card-for-Clinicians/SMA09-4432

46

Other Suicide Prevention Resources

- **For Persons At-Risk**
  - Suicide Prevention App (MY3)
    - www.my3app.org/



47

Other Suicide Prevention Resources

- **General Prevention Information**
  - Suicide Prevention Resource Center
    - www.SPRC.org

48

Part 4

Suicide Risk Assessment

GOAL:
Increase your knowledge of suicide risk assessment.

49

Myths and Facts Quiz (True or False)

1. If you talk to someone about their suicidal feelings you will cause them to commit suicide.
2. When a person talks about killing himself, he's just looking for attention. Ignoring him is the best thing to do.
3. People who talk about killing themselves rarely commit suicide.
4. All suicidal people want to die and there is nothing that can be done about it.
5. If someone attempts suicide he will always entertain thoughts of suicide.
6. Once a person tries to kill himself and fails, the pain and humiliation will keep him from trying again.

50

Griffen & Felsenthal (1983)

Suicide Risk Assessment

- Variables suggesting the need for a risk assessment
  - Risk Factors
  - Warning Signs

51

Suicide Risk Assessment

- Risk Factors
  - Far from perfect predictors
  - Suicide is very idiosyncratic
    - There are likely as many paths to suicide as there are suicide victims

52

Suicide Risk Assessment

- Risk Factors
  - Mental disorders
    - 90+% of suicide victims have a mental disorder
  - Exacerbating factors
    - A small minority of the mentally ill commit suicide
  - Social stressors
    - The "straw that breaks the camel's back"
  - Personal vulnerability
    - Isolation and aloneness

53

Klott (2012)

See Handout 1

Suicide Risk Assessment

Variables That Enhance Risk

- Adolescence and late life
- Bisexual or homosexual gender identity
- Criminal behavior
- Cultural sanctions for suicide
- Delusions
- Disposition of personal property
- Divorced, separated, or single marital status
- Early loss or separation from parents
- Family history of suicide
- Hallucinations
- Homicide
- Hopelessness
- Hypochondriasis

54

Suicide Risk Assessment

- Warning Signs
  - Variables that signal the possible presence of suicidal thinking.
    - Especially when combined with risk factors, warning signs indicate the need for a suicide risk assessment

55

Suicide Risk Assessment

- Warning Signs
  - Non-Suicidal Self-Directed Violence
  - Helplessness, fatalistic despair
    - *The problem cannot be solved*
  - Hopelessness, severe devaluation/self-hate
    - *I can't solve the problem*

56

Suicide Risk Assessment

- Warning Signs
  - Direct threats
    - "I have a plan to kill myself"

57

Suicide Risk Assessment

- Warning Signs
  - Indirect threats
    - "I wish I could fall asleep and never wake up"
    - "Everybody would be better off if I just weren't around"
    - "I'm not going to bug you much longer"
    - "I hate my life. I hate everyone and everything"
    - "I'm the cause of all of my family's/friend's troubles"
    - "I wish I would just go to sleep and never wake up"
    - "I've tried everything but nothing seems to help"
    - "Nobody can help me"
    - "I want to kill myself but I don't have the guts"
    - "I'm no good to anyone"
    - "If my (mom, dad, teacher) doesn't leave me alone I'll kill myself"
    - "Don't buy me anything. I won't be needing any (clothes, books)"

58

Suicide Risk Assessment

- Warning Signs
  - Behavioral indicators
    - Writing of suicidal notes
    - Making final arrangements
    - Giving away prized possessions
    - Talking about death
    - Reading, writing, and/or art about death
    - Hopelessness or helplessness
    - Social Withdrawal and isolation
    - Lost involvement in interests & activities
    - Increased risk-taking
    - Heavy use of alcohol or drugs

59

Suicide Risk Assessment

- Asking the "S" Question
  - The presence of suicide warning signs, especially when combined with suicide risk factors generates the need to conduct a suicide risk assessment.
  - A risk assessment begins with asking if the student is having thoughts of suicide.

60

Suicide Risk Assessment

- Be direct when asking the "S" question.
  - **BAD**
    - *You're not thinking of hurting yourself, are you?*
  - **Better**
    - *Are you thinking of harming yourself?*
  - **BEST**
    - *Sometimes when people have had your experiences and feelings they have thoughts of suicide. Is this something that you're thinking about?*

61

Suicide Risk Assessment

- Predicting Suicidal Behavior (CPR++)
  - Current plan (greater planning = greater risk).
    - How (method of attempt)?
    - How soon (timing of attempt)?
    - How prepared (access to means of attempt)?
  - Pain (unbearable pain = greater risk)
    - How desperate to ease the pain?
      - Person-at-risk's perceptions are key
  - Resources (more alone = greater risk)
    - Reasons for living/dying?
      - Can be very idiosyncratic
      - Person-at-risk's perceptions are key

62

Ramsay, Tanney, Lang, & Kinzel (2004)

Suicide Risk Assessment

- Predicting Suicidal Behavior (CPR++)[1]
  - (+) Prior Suicidal Behavior?
    - of self (40 times greater risk)
    - of significant others
    - An estimated 26-33% of adolescent suicide victims have made a previous attempt[2]
  - (+) Mental Health Status?
    - history mental illness (especially mood disorders)
    - linkage to mental health care provider

63

[1]Ramsay, Tanney, Lang, & Kinzel (2004); [2]American Foundation for Suicide Prevention (1996)

Suicide Risk Assessment Summary Sheet

Instructions: When a student acknowledges having suicidal thoughts, use as a checklist to assess suicide risk. Items are listed in order of importance to the Risk assessment.

		Risk present, but lower	*Medium Risk*	*Higher Risk*
1.	Current Suicide Plan A. Details	____Vague.	____Some specifics.	____Well thought out.
	B. How prepared	____Means not available.	____Has means close by.	____Has means in hand.
	C. How soon	____No specific time.	____Within a few days or hours.	____Immediately.
	D. How (Lethality of method)	____Pills, slash wrists.	____Drugs/alcohol, car wreck.	____Gun, hanging, jumping.
	E. Chance of intervention	____Others present most of the time.	____Others available if called upon.	____No one nearby; isolated.
2.	Pain	____Pain is bearable. ____Wants pain to stop, but not desperate. ____Identifies ways to stop the pain.	____Pain is almost unbearable. ____Becoming desperate for relief. ____Limited ways to cope with pain.	____Pain is unbearable. ____Desperate for relief from pain. ____Will do anything to stop the pain.
3.	Resources	____Help available; student acknowledges that significant others are concerned and available to help.	____Family and friends available, but are not perceived by the student to be willing to help.	____Family and friends are not available and/or are hostile, injurious, exhausted
4.	Prior Suicidal Behavior of… A. Self	____No prior suicidal behavior.	____One previous low lethality attempt; history of threats.	____One of high lethality, or multiple attempts of moderate lethality.
	B. Significant Others	____No significant others have engaged in suicidal behavior.	____Significant others have recently attempted suicidal behavior.	____Significant others have recently committed suicide
5.	Mental Health	____History of mental illness, but not currently considered mentally ill.	____Mentally ill, but currently receiving treatment.	____Mentally ill and not currently receiving treatment.
	A. Coping behaviors	____Daily activities continue as usual with little change.	____Some daily activities disrupted, disturbance in eating, sleeping, and schoolwork.	____Gross disturbances in daily functioning.
	B. Depression	____Mild, feels slightly down.	____Moderate; some moodiness, sadness, irritability, loneliness, and decrease of energy.	____Overwhelmed with hopelessness, sadness, and feelings of helplessness.
	C. Medical status	____No significant medical problems.	____Acute, but short-term, or psychosomatic illness.	____Chronic debilitating, or acute catastrophic, illness.
	D. Other Psychopathology	____Stable relationships, personality, and school performance.	____Recent acting-out behavior and substance abuse; acute suicidal behavior in stable personality.	____Suicidal behavior in unstable personality; emotional disturbance; repeated difficulty with peers, family, and teacher.
6.	Stress	____No significant stress.	____Moderate reaction to loss and environmental changes.	____Severe reaction to loss or environmental changes.
Total Checks				

See Handout 2

Risk Assessment

- Suicide intervention script and role play observation form

65

See Handout 3

Risk Assessment

- Questions to ask in the evaluation of suicidal risk in **children**
  1. *Suicidal fantasies or actions*:
     Have you ever thought of hurting yourself?
     Have you ever threatened or attempted to hurt yourself?
     Have you ever wished or tried to kill yourself?
     Have you ever wanted to or threatened to commit suicide?
  2. *Concepts of what would happen*:
     What did you think would happen if you tried to hurt or kill yourself?
     What did you want to have happen?
     Did you think you would die?
     Did you think you would have severe injuries?

66

Part 5

School-Based Suicide Intervention

GOAL:
Increase your knowledge of how schools should intervene with the student at risk for suicidal behavior.

67

School-Based Suicide Intervention

- General Staff Procedures for Responding to a Suicide Threat
  - The actions all school staff members are responsible for knowing and taking whenever suicide warning signs are displayed.
- Mental Health Professional Risk Assessment and Referral Procedures
  - The actions taken by school staff members trained in suicide risk assessment and intervention.

68

School-Based Suicide Intervention

- General Staff Procedures for Responding to a Suicide Threat
  - **A student who has threatened suicide must be carefully observed at all times** until a qualified staff member can conduct a risk assessment. The following procedures are to be followed whenever a student threatens to commit suicide.

69

School-Based Suicide Intervention

- General Staff Procedures for Responding to a Suicide Threat
  1. Stay with the student or designate another staff member to supervise the youth constantly and without exception until help arrives.
  2. Under no circumstances should you allow the student to leave the school.
  3. Do not agree to keep a student's suicidal intentions a secret.
  4. If the student has the means to carry out the threatened suicide on his or her person, determine if he or she will voluntarily relinquish it. **Do not force the student to do so. Do not place yourself in danger.**

70

School-Based Suicide Intervention

- General Staff Procedures for Responding to a Suicide Threat (continued)
  5. Take the suicidal student to the prearranged room.
  6. Notify the Crisis Intervention Coordinator immediately.
  7. Notify the Crisis Response Coordinator immediately.
  8. Inform the suicidal youth that outside help has been called and describe what the next steps will be.

71

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  - Whenever a student judged to have some risk of engaging in self-directed violence or suicide, a school-based mental health professional should conduct a risk assessment and make the appropriate referrals.

Identify → Assess → Consult → Refer

72

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  1. Identify Suicidal Thinking
  2. From Risk Assessment Data, Make Appropriate Referrals
  3. Risk Assessment Protocol
     - a) Conduct a Risk Assessment.
     - b) Consult with fellow school staff members regarding the Risk Assessment.
     - c) Consult with County Mental Health.

73

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  4. Use risk assessment information and consultation guidance to develop an action plan. Action plan options are as follows:
     - A. **Extreme Risk**
     - B. **Crisis Intervention Referral**
     - C. **Mental Health Referral**

74

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  - A. **Extreme Risk:** If the student has the means of his or her threatened suicide at hand, and refuses to relinquish such then follow the Extreme Risk Procedures.
    - i. Call the police.
    - ii. Calm the student by talking and reassuring until the police arrive.
    - iii. Continue to request that the student relinquish the means of the threatened suicide and try to prevent the student from harming him-or herself.
    - iv. Call the parents and inform them of the actions taken.

75

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  - B. **Crisis Intervention Referral:** If the student's risk of harming him or herself is judged to be moderate to high then follow the Crisis Intervention Referral Procedures.
    - i. Determine if the student's distress is the result of parent or caretaker abuse, neglect, or exploitation.
    - ii. Meet with the student's parents.
    - iii. Determine what to do if the parents are unable or unwilling to assist with the suicidal crisis.
    - iv. Make appropriate referrals.

76

School-Based Suicide Intervention

- Mental Health Professional Risk Assessment and Referral Procedures
  - C. **Mental Health Referral:** If the student's risk of harming him or herself is judged to be low then follow the Mental Health Referral Procedures.
    - i. Determine if the student's distress is the result of parent or caretaker abuse, neglect, or exploitation.
    - ii. Meet with the student's parents.
    - iii. Make appropriate referrals.
  - Protect the privacy of the student and family.
  - Follow up with the hospital or clinic.

77

School-Based Suicide Intervention

A Risk Assessment and Referral Resource

Substance Abuse and Mental Health Services Administration. (2012). *Preventing suicide: A toolkit for high schools*. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Author. Retrieved from http://store.samhsa.gov/shin/content//SMA12-4669/SMA12-4669.pdf

78

Part 6

School-Based Suicide Postvention

GOAL:
Increase your knowledge of how to respond to the aftermath of a completed suicide.

79

School-Based Suicide Postvention

- "… the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress on the survivors whose lives are forever altered."

E.S. Shneidman
Forward to Survivors of Suicide
Edited by A. C. Cain
Published by Thomas, 1972

80

School-Based Suicide Postvention

Prevention and Preparedness

- Develop a district/school suicide prevention task force
- Develop policies and procedures
- Crisis team mandates provide foundation
- Components of a suicide prevention program include prevention (gatekeeper training; depression screening), intervention and postvention guidelines.
- Cultural responsiveness includes materials in native languages, interpreters, and understanding the rituals, customs and traditions of diverse populations.

81

Lieberman, Poland & Kornfeld (2014); Brock & Lieberman (2008)

School-Based Suicide Postvention

Why postvention in schools?

- Schools are often unsure about how to respond after a suicide and there has been debate as to best practice response.
- Certain practices may put some students at greater risk.
- An effective response can reduce the risk of suicide contagion and restore a safe, healthy learning environment.

82

School-Based Suicide Postvention

- Key Terms and Statistics
  - Suicide postvention
    - … is the provision of crisis intervention, support and assistance for those affected by a completed suicide.
    - Affected individuals includes both "survivors" and other persons who were "exposed" to the death.

83

Andriessen & Krysinska (2012)

School-Based Suicide Postvention

- Key Terms and Statistics
  - Survivors of suicide
    - "the family members and friends who experience the suicide of a loved one" (McIntosh, 1993, p. 146).
    - "a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss" (Andriessen, 2009, p. 43).
    - "… someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (Jordan & McIntosh, 2011, p. 7).

84

School-Based Suicide Postvention

- Key Terms and Statistics
  - There is a distinction between "suicide survivorship" and "exposure to suicide."
    - Survivor applies to bereaved persons who had a personal/close relationship with the deceased.
    - Exposure applies to persons who did not know the deceased personally, but who know about the death through reports of others or media reports or who has personally witnessed the death of a stranger.

Andriessen & Krysinska (2012)

85

School-Based Suicide Postvention

- Key Terms and Statistics
  - Both survivors and exposed persons need support.
    - Survivors need…
      - support groups.
      - support from outside of the family.
      - to be educated about the complicated dynamics of grieving.
      - to be contacted in person (instead of by letter or phone).

Grad et al. (2004)

86

School-Based Suicide Postvention

How many survivors of suicide are there?

- Estimates vary greatly
  - Shneidman (1969) = 6 per suicide
  - Wrobleski (2002) = 10 per suicide
  - Berman (2011) = 45-80 per suicide

_______ X 41,149 = _______

N of Survivors per suicide; Completed Suicides (U.S. 2013); Suicide Survivors

_______ X 517,859 = _______

N of Survivors per suicide; Completed Suicides (US 1999-2013); Suicide Survivors

87

School-Based Suicide Postvention

- Special factors that make the postvention response a special and unique form of crisis intervention.
  1. Suicide contagion & clusters
  2. A special form of bereavement
  3. Social stigma
  4. Developmental differences
  5. Cultural differences

88

School-Based Suicide Postvention

1. Suicide contagion
   - "…a process by which exposure to the suicide or suicidal behavior of one or more persons influences others to commit or attempt suicide."
   - Contagion is rare, but…
     - "The effect of clusters appears to be strongest among adolescents."
     - A death by suicide or suicidal behavior in youth may increase the likelihood of suicidal ideation or attempts in other youth.
     - Contagion can lead to a cluster

O'Carroll & Potter (1994, April 22)

89

School-Based Suicide Postvention

1. Suicide Clusters
   - Multiple suicides within a defined geographical area within an accelerated time frame.
   - 1-5% of teenage deaths by suicide occur in a cluster (100-200 deaths annually).
   - Can occur in institutional settings such as psychiatric settings, schools, prisons, military.
   - Gould has identified 53 suicide clusters (defined as 3 to 11 victims, ranging in age from 11 to 20 years, within a year).
   - Victims appear to be influenced by earlier deaths, but do not necessarily "know" previous victims.

90

School-Based Suicide Postvention

1. Suicide contagion
   - Sonneck et al. (1994).
     - "Surveyed all suicide cases in Vienna, Austria that were reported in major daily newspapers and analyzed them in connection with subway suicide. …. The number of subway suicides in Vienna increased dramatically between 1984 and mid-1987. Based on the hypothesis that there was a connection between the dramatic way in which these suicides were reported and an increase in suicides and suicide attempts, the Austrian Association for Suicide Prevention developed media guidelines and initiated discussions with the media that culminated with an agreement to abstain from reporting on cases of suicide. Following the implementation of these guidelines in mid-1987, there was a 75% decrease in subway suicides that has been sustained for 5 yrs."

Sonneck et al. (1994, p. 453)

91

School-Based Suicide Postvention

1. Suicide contagion
   - Suicide rates increase when …
     - The number of stories about individual suicides increases
     - A particular death is reported at length or in many stories
     - The story of an individual death by suicide is placed on the front page or at the beginning of a broadcast
     - The headlines about specific suicide deaths are dramatic

Daily Mail
THE INTERNET SUICIDE CULT?
DAILY EXPRESS
ANOTHER GIRL HANGS HERSELF IN DEATH TOWN

American Foundation for Suicide Prevention (2001)

92

School-Based Suicide Postvention

1. Suicide contagion
   - Suicide rates increase when …
     - There has been unsafe messaging such as simplifying the causes of suicide
     - The death has been glorified
     - The death has been presented as a means for achieving a certain end (a tool to obtain a goal).

American Foundation for Suicide Prevention (2001)

93

School-Based Suicide Postvention

1. Suicide contagion
   - As a consequence of "contagion" suicide clusters have been reported.
     - A suicide cluster is "… a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community."
     - How do you determine if you have a cluster?
       - Establish a baseline rate or percentage.

$$\frac{\text{Number of Suicides}}{\text{Population}} \times \text{selected proportion of population} = \text{Rate}$$

CDC (1998, August 19)

94

$$\frac{\text{Number of Suicides}}{\text{Population}} \times \text{selected proportion of population} = \text{Rate}$$

School-Based Suicide Postvention

Suicide rates and identifying clusters
- **19,180 US youth committed have suicide (1999-2013; ages 14-18 years)**
  - A nation-wide 14 year average of 1,370 suicides per year
    - Among 14-18 year olds, a nation-wide average annual rate of 6.04 per 100,000 individuals.
      $$\frac{19,180}{317,333,193} \times 100,000 = 6.04$$
    - A 1,000 student high school can expect a completed suicide about **once every 16 years** (.06 x 16 ≈ 1).
      $$\frac{19,180}{317,333,193} \times 1,000 = 0.06$$
    - A 2,500 student high school can expect a completed suicide about **once every 6.5 years** (.15 x 6.5 ≈ 1).
      $$\frac{19,180}{317,333,193} \times 2,500 = 0.15$$

CDC (2015)

95

School-Based Suicide Postvention

1. Suicide contagion
   - Percent of US high school students with a self-reported attempt (in the 12 months prior to survey) that required medical attention

4
3
2
1
0
1991 1993 1995 1997 1999 2001 2003 2005 2007 2009 2011 2013
Male Female Overall %

- Annual overall average (2001-2013) = 2.5%

CDC (2014)

96

School-Based Suicide Postvention

- Centers for Disease Control Recommendations
  - Convene planning committee that involves all sectors of school and community.
  - Deliver a public response that minimizes sensationalism and avoids glorification.
  - Evaluate and counsel the close friends of the suicide victim and those previously know to be suicidal
  - Community resources must include: hospital and emergency personnel, community mental health, local and state agencies, clergy, school leaders, parent groups, survivor groups, police, media and crisis hotline personnel.

CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters. (1988). *MMWR, 37*(S-6),1-12.

97

School-Based Suicide Postvention

Mass clusters

- Mass clusters are media related and grouped more in time than space and are in response to the media coverage of actual or fictional suicides.
- Research shows stronger effect for actual versus fictional media coverage and the term "Werther effect" has been around for nearly a century.

98

School-Based Suicide Postvention

Point Clusters

- Occur locally and victims are contiguous in space and time
- Social connections through internet etc. greater than ever before and vulnerable individuals are likely to form relationships with each other
- Research has found 75% of point cluster victims to have had a major psychiatric disorder

99

School-Based Suicide Postvention

- Factors that make the postvention response a special and unique form of crisis intervention.
  1. Suicide contagion & clusters
  2. A special form of bereavement
  3. Social stigma
  4. Developmental differences
  5. Cultural differences

100

School-Based Suicide Postvention

2. A special form of bereavement
   - Survivors report …
     - Guilt and shame
     - More depression and complicated grief
       - Less vitality and more pain
     - Social stigma, isolation, and loneliness
     - Poorer social functioning, and physical/mental health
     - Searching for the meaning of the death
     - Being concerned about their own increase suicide risk

Cain (1972); De Groot et al. (2006)

101

School-Based Suicide Postvention

2. A special form of bereavement
   - Multiple levels of grief reactions
     a) Common grief reactions
        e.g., sorrow, yearning to be reunited
     b) Unexpected death reactions
        e.g., shock, sense of unreality
     c) Violent death reactions
        e.g., traumatic stress
     d) Unique suicide reactions
        e.g., anger at deceased, feelings of abandonment

Jordan & McIntosh (2011)

102

School-Based Suicide Postvention

- Factors that make the postvention response a special and unique form of crisis intervention.
  1. Suicide contagion & clusters
  2. A special form of bereavement
  3. Social stigma
  4. Developmental differences
  5. Cultural differences

103

School-Based Suicide Postvention

3. Social Stigma
   - Both students and staff members may be uncomfortable talking about the death.
   - Survivors may receive (and/or perceive) much less social support for their loss.
     - Viewed more negatively by others as well as themselves.
   - There may exist a reluctance to provide postvention services.

Jordan (2001); Roberts et al. (1998)

104

School-Based Suicide Postvention

3. Social Stigma
   - Suicide postvention is a unique crisis situation that must be prepared to operate in an environment that is not only suffering from a sudden and unexpected loss, but one that is also anxious talking openly about the death.

105

School-Based Suicide Postvention

- Factors that make the postvention response a special and unique form of crisis intervention.
  1. Suicide contagion & clusters
  2. A special form of bereavement
  3. Social stigma
  4. Developmental differences
  5. Cultural differences

106

School-Based Suicide Postvention

4. Developmental Differences
   - Understanding of suicide and suicidal behaviors increases with age.
     - Primary grade children appear to understand the concept of "killing oneself," they typically do not recognize the term "suicide" and generally do not understand the dynamics that lead to this behavior.
     - Around fifth grade that students have a clear understanding of what the term "suicide" means and are aware that it is a psychosocial dynamic that leads to suicidal behavior.
   - The risk of suicidal ideation and behaviors increases as youth progress through the school years.

Mishara (1999)

107

School-Based Suicide Postvention

- Factors that make the postvention response a special and unique form of crisis intervention.
  1. Suicide contagion & clusters
  2. A special form of bereavement
  3. Social stigma
  4. Developmental differences
  5. Cultural differences

108

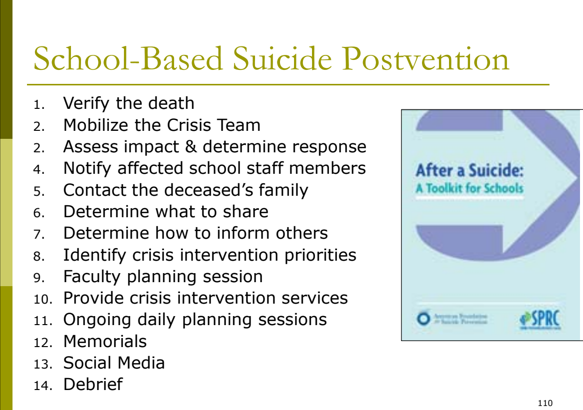
School-Based Suicide Postvention

5. Cultural Differences
   - Attitudes toward suicidal behavior vary considerably from culture to culture.
   - While some cultures may view suicide as appropriate under certain circumstances, other have strong sanctions against all such behavior.
   - These cultural attitudes have important implications for both the bereavement process and suicide contagion.

109

Ramsay et al. (1999)

School-Based Suicide Postvention



1. Verify the death
2. Mobilize the Crisis Team
2. Assess impact & determine response
4. Notify affected school staff members
5. Contact the deceased's family
6. Determine what to share
7. Determine how to inform others
8. Identify crisis intervention priorities
9. Faculty planning session
10. Provide crisis intervention services
11. Ongoing daily planning sessions
12. Memorials
13. Social Media
14. Debrief

110

American Foundation for Suicide Prevention et al. (2011)

School-Based Suicide Postvention

Goals

- Assist survivors in the grief process.
- Identify and refer individuals who may be at risk following the suicide.
- Provide accurate information while minimizing the risk of suicide contagion.
- Implement ongoing prevention efforts.

111

School-Based Suicide Postvention

Practical Suggestions

- Intervene only when indicated.
- Do not inform staff or students by intercom.
- Triage staff and make appropriate notification in person (not by memo or e mail).
- Have substitutes to relieve staff during the day.
- Facilitate social support systems for HS/Secondary students.

112

School-Based Suicide Postvention

1. Verify that a death has occurred
   - Confirm the cause of death
     - Confirmed suicide
     - Unconfirmed cause of death

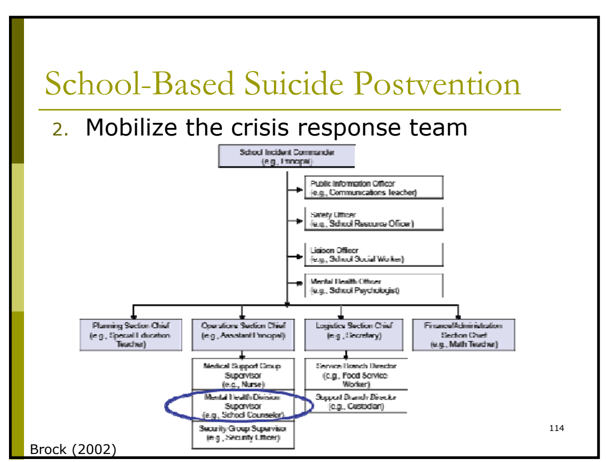
OFFICE OF THE CHIEF MEDICAL EXAMINER

113

Brock (2002)

School-Based Suicide Postvention

2. Mobilize the crisis response team



114

Brock (2002)

School-Based Suicide Postvention

3. Assess the suicide's impact on the school and estimate the level of response required.
   - The importance of accurate estimates.
     - Make sure a postvention is truly needed before initiating this intervention.
   - Temporal proximity to other traumatic events (especially suicides).
   - Timing of the suicide.
   - Physical and/or emotional proximity to the suicide.

Brock (2002)

115

School-Based Suicide Postvention

4. Notify other involved school staff members.
   - Deceased student's teachers (current an former)
   - Any other staff members who had a relationship with the deceased
   - Teachers and staff who work with suicide survivors.

Brock (2002)

116

School-Based Suicide Postvention

5. Contact the family of the suicide victim within 24 hours of the death.
   - Purposes include…
     - Express sympathy.
     - Offer support.
     - Identify the victim' s friends who may need assistance.
     - Discuss the school' s postvention response.
     - Identify details about the death that could be shared with outsiders.
     - Discuss funeral arrangements and whether the family wants school personnel and/or students to attend.

Brock (2002); American Foundation for Suicide Prevention et al. (2011)

117

School-Based Suicide Postvention

6. Determine **what** information to share about the death
   - Several different communications may be necessary
     - When the death has been ruled a suicide
     - When the cause of death is unconfirmed
     - When the family has requested that the cause of death not be disclosed
     - Templates provided in *After a Suicide: A Toolkit for Schools*

Sample Death Notification Statement for Students

Brock (2002); American Foundation for Suicide Prevention et al. (2011)

118

School-Based Suicide Postvention

6. Determine **what** information to share about the death
   - Avoid detailed descriptions of the suicide including specific method and location.
   - Avoid over simplifying the causes of suicide and presenting them as inexplicable or unavoidable.
   - Avoid using the words "committed suicide" or "failed suicide."
   - Always include a referral phone number and information about local crisis intervention services
   - Emphasize recent treatment advances for depression and other mental illness.

Brock (2002); American Foundation for Suicide Prevention et al. (2011)

119

School-Based Suicide Postvention

7. Determine **how** to share information about the death.
   - Reporting the death to students...
     - Avoid tributes by friends, school wide assemblies, sharing information over PA systems that may romanticize the death
       - Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
       - Provide information in small groups (e.g., classrooms).

Brock, 2002

120

School-Based Suicide Postvention

7. Determine **how** to share information about the death.
   - Reporting the death to the media...
     - It is essential that the media not romanticize the death.
     - The media should be encouraged to acknowledge the pathological aspects of suicide.
     - Photos of the suicide victim should not be used.
     - "Suicide" should not be placed in the caption .
     - Include information about the community resources.
     - Sample media statement provided in *After a Suicide: A Toolkit for Schools*

121

Brock, 2002; American Foundation for Suicide Prevention et al. (2011)

School-Based Suicide Postvention

7. Determine **how** to share information about the death.
   - Reporting the death to the media: Guidelines from the World Health Organization
     1. Suicide is never the result of a single incident
     2. Avoid providing details of the method or the location a suicide victim uses that can be copied
     3. Provide the appropriate vital statistics (i.e., as indicated provide information about the mental health challenges typically associated with suicide).
     4. Provide information about resources that can help to address suicidal ideation.

122

Brock (2002); World Health Organization (2000)

School-Based Suicide Postvention

8. Identify students significantly affected by the suicide and initiate referral procedures.
   - Risk Factors for Imitative Behavior
     - ***Physically*** proximal to suicide
     - ***Emotionally*** proximal to victim
     - ***Psychologically vulnerable*** due to history of depression; previous suicidal behavior; suicide in family; history of trauma or loss.

123

Brock (2002); Brock & Sandoval (1996)

School-Based Suicide Postvention

8. Identify students significantly affected by the suicide and initiate referral procedures.
   - Risk Factors for Imitative Behavior
     - Facilitated the suicide.
     - Failed to recognize the suicidal intent.
     - Believe they may have caused the suicide.
     - Had a relationship with the suicide victim.
     - Identify with the suicide victim.
     - Have a history of prior suicidal behavior.
     - Have a history of psychopathology.
     - Shows symptoms of helplessness and/or hopelessness.
     - Have suffered significant life stressors or losses.
     - Lack internal and external resources

124

Brock (2002); Brock & Sandoval (1996)

School-Based Suicide Postvention

Re-entry guidelines for students identified at risk for suicide.

- Have parent escort student back to school first morning following hospitalization and conduct re-entry meeting.
- Collaborate with members of crisis team.
- Obtain any records from hospital and have parent sign a release of information form.
- Provide interventions:
  - Modify academic programming as appropriate.
  - Identify on-going counseling resources at school or in the community.
  - Discover if student is on medications and monitor with parent consent.
  - Notify student's teachers as appropriate.

125

School-Based Suicide Postvention

Re-entry guidelines for students identified at risk for suicide.

- Monitor student to make certain no bullying takes place in the classroom as many students may know the student was hospitalized
  - Such news often spread through social networking.
- Monitor social networking sites with cooperation of the parent.
- Check in frequently during the first week the student returns to school.

126

School-Based Suicide Postvention

Re-entry guidelines for students identified at risk for suicide.

- Safety planning
  - Follow up counseling plan.
  - Identify resources at school and in community.
  - Identify circle of adults at scho... ...me.
  - Identify peer supports.
  - Keep track of medications.
  - http://www.my3app.org/

127

School-Based Suicide Postvention

9. Conduct a faculty planning session.
   - Share information about the death.
   - Allow staff to express their reactions and grief..
   - Provide a scripted death notification statement for students.
   - Prepare for student reactions and questions
   - Explain plans for the day.
   - Remind all staff of the role they play in identifying changes in behavior and discuss plan for handling students who are having difficulty.
   - Brief staff about identifying and referring at-risk students as well as the need to keep records of those efforts.
   - Apprise staff of any outside crisis responders or others who will be assisting.
   - Remind staff of student dismissal protocol for funeral.
   - Identify which Crisis Response Team member has been designated as the media spokesperson and instruct staff to refer all media inquiries to him or her.

128

Brock (2002); American Foundation for Suicide Prevention et al. (2011)

School-Based Suicide Postvention

10. Initiate crisis intervention services
    a) Initial intervention options…
       - Individual psychological first aid.
       - Group psychological first aid.
       - Classroom activities and/or presentations.
       - Parent meetings.
       - Staff meetings.
    b) Walk through the suicide victim’s class schedule.
    c) Meet separately with individuals who were proximal to the suicide.
    d) Identify severely traumatized and make appropriate referrals.
    e) Facilitate dis-identification with the suicide victim…
       - Do not romanticize or glorify the victim's behavior or circumstances.
       - Point out how students are different from the victim.
    f) Parental contact.
    g) Psychotherapy Referrals.

129

Brock (2002)

School-Based Suicide Postvention

12. Consider memorials
    - “A delicate balance must be struck that creates opportunities for students to grieve but that does not increase suicide risk for other school students by glorifying, romanticizing or sensationalizing suicide.”

Center for Suicide Prevention (2004)

School-Based Suicide Postvention

12. Consider memorials
    - Strive to treat all student deaths the same way.
    - Encourage and allow students, with parental permission, to attend the funeral.
    - Reach out to the family of the victim.
    - Contribute to a suicide prevention effort in the community.
    - Develop living memorials, such as student assistance programs, that address risk factors in local youth.
    - Address spontaneous memorials on school grounds.

131

School-Based Suicide Postvention

12. Consider memorials
    - Prohibiting all memorials is problematic.
    - Recognize the challenge to strike a balance between needs of distraught students and fulfilling the primary purpose of education.
    - Meet with students and be creative and compassionate.
    - Spontaneous memorials should be left in place until after the funeral.
    - Avoid holding services on school grounds.

132

School-Based Suicide Postvention

12. Consider memorials
- Schools may hold supervised gatherings such as candlelight memorials.
- Monitor off campus gatherings.
- Student newspaper coverage should follow media reporting guidelines.
- Yearbook and graduation dedication or tributes should all be treated the same.
- Grieving friends and family should be discouraged from dedicating a school event and guided towards promoting suicide prevention.
- Permanent memorials on campus are discouraged.

133

School-Based Suicide Postvention

12. Consider memorials
- Do **NOT** . . .
  - send all students from school to funerals, or stop classes for a funeral.
  - have memorial or funeral services at school.
  - establish permanent memorials such as plaques or dedicating yearbooks to the memory of suicide victims.
  - dedicate songs or sporting events to the suicide victims.
  - fly the flag at half staff.
  - have assemblies focusing on the suicide victim, or have a moment of silence in all-school assemblies.

Brock & Sandoval (2006)

134

School-Based Suicide Postvention

12. Consider memorials
- **DO** . . .
  - something to prevent other suicides (e.g., encourage crisis hotline volunteerism).
  - develop living memorials, such as student assistance programs, that will help others cope with feelings and problems.
  - allow students, with parental permission, to attend the funeral.
  - Donate/Collect funds to help suicide prevention programs and/or to help families with funeral expenses
  - encourage affected students, with parental permission, to attend the funeral.
  - mention to families and ministers the need to distance the person who committed suicide from survivors and to avoid glorifying the suicidal act.

Brock & Sandoval (2006)

135

School-Based Suicide Postvention

13. Social Media
- Create a Social Media Manager to assist the Public Information Officer.
- Utilize students as "cultural brokers" to help faculty and staff understand their use of social media.
- Train students in gatekeeper role, and specifically identify what suicide risk looks like when communicated via social media.
- Have staff monitor social networks and provide safe messaging when important (this will require that districts not completely block these networks).
- Have parents get involved in their child's social media.

136

School-Based Suicide Postvention

13. Social Media
- Monitor for high risk students.
- Psycho-education: Make use of social media to post prevention messages, hotlines and community mental health resources.
- Give students specific helpful language to include when making use of social media.
- Work with YouTube and Facebook to take down messages, disturbing images or language.
- Utilize the Facebook application for concerns or issues with content.

137

School-Based Suicide Postvention

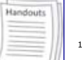
14. Debrief the postvention response.
- Goals for debriefing will include…
  - Review and evaluation of all crisis intervention activities.
  - Making of plans for follow-up actions.
  - Providing an opportunity to help interveners cope.

Brock (2002)

138

School-Based Suicide Postvention

14. Debrief the postvention response.
    - Prevention messaging for staff:Answering the difficult questions
      - Why did he/she do it?
      - What method did they use?
      - Why didn't God stop them?
      - Is someone or something to blame?
      - How do we prevent further suicides?
      - How should I feel towards suicide victim?



139

School-Based Suicide Postvention

Prevention Messaging for Administrators

- While suicide is widely known as preventable, sadly, some suicides cannot be prevented.
- The goal now is to reach out to everyone in the school community who might be in need of support and to identify those in need of referrals and local mental health resources.
- We want our students to know that under no circumstances is suicide an option. Help is available. If they are concerned about a friend they should never hold such information confidential and they should tell a trusted adult.

140

School-Based Suicide Postvention

Prevention Messaging for Administrators

- The legacy of survivors includes many questions that cannot be answered but a key to healing for many has been to become an advocate for suicide prevention efforts in the community they live in.
- There are very clear risk factors for suicide and they include a history of depression, alcohol and substance abuse, and recent losses. There are evidenced based treatments for all the risk factors of youth suicide.
- Children and teens are resilient and capable of recovery.

141

School-Based Suicide Postvention

- "… the person who commits suicide puts his psychological skeleton in the survivor's emotional closet; he sentences the survivor to deal with many negative feelings and more, to become obsessed with thoughts regarding the survivor's own actual or possible role in having precipitated the suicidal act or having failed to stop it. It can be a heavy load" (p. x).

Shneidman (1972)

142

Handout 1

Risk Factors for Suicidal Self-Directed Violence

(Adapted from Klott, 2012)

Mental Disorders

- ✓ Children
  - o PTSD associated w/ guilt/shame (feel guilty and/or blame self for traumatic stressor)
- ✓ Adolescents
  - o Generalized Anxiety Disorder (persistent disabling fear of failure in academics/athletics that is uncalled for)
- ✓ Adults
  - o Major Depressive Disorder (with psychotic features)
  - o Bipolar Disorder (Type II more likely to commit suicide)

Exacerbating Factors

- ✓ Persistent Depressive Disorder *w/alcohol use or hopelessness*
- ✓ Bipolar II *as they leave depressive episode*
- ✓ Generalized Anxiety Disorder:*w/cannabis use to self-medicate (among adults)*
- ✓ PTSD
  - *a) 12+months undetected/untreated*
  - *b) Child abuse/trauma exposure during childhood*
  - *c) Depressed (disabling depression among females; irritability, anger, rage among males)*
  - *d) Self-medicating [alcohol or cannabis most common] (among adolescents and adults).*
- ✓ Neurodevelopmental disorders (e.g., Autism, ID, ADHD)
  - *a) Talk about a sense of being different*
  - *b) No social cohesion (no friends)*
  - *c) Victimized by bullying*
- ✓ Gender Dysphoria *w/rejection of primary support systems*
- ✓ Substance Related Disorder *when such is to self-medicate another mental disorder*
- ✓ Psychotic Disorders *w/in 4 months of initial diagnosis (associated with hopelessness)*

Personal Vulnerabilities

- ✓ Internal
  - a. Performance Anxiety
    - *i. I am only loved for what I do*
  - b. Emotional Constriction
    - *i. I can't feel anything*
  - c. Defenseless Personality
    - *i. I am worthless*
- ✓ External
  - a. Lack of resources

Social Stressors

- ✓ Adults
  - a) Overwhelming and intolerable loss
    - i. Financial security
    - ii. Relationships (suicide survivor)
    - iii. Social and occupational definition
    - iv. Self esteem
    - v. Autonomy/independence
- ✓ Adolescents
    - vi. Developing a mental disorder and self-medicating
    - vii. Perceived isolation and aloneness
    - viii. Actual isolation and aloneness (Rejection, bullying, caregiver dysfunction)
    - ix. Disciplinary crisis (Young male incarcerated for the first time)
    - x. Academic performance anxiety
    - xi. Family discord
  - a) Impulsivity (The impulsive suicide is the most common suicide observed among adolescents without a mental health history). Interacts with firearm access
    - i. Suicide survivorship

Suicide Risk Assessment Summary Sheet

Instructions: When a student acknowledges having suicidal thoughts, use as a checklist to assess suicide risk. Items are listed in order of importance to the Risk assessment.

	Risk present, but lower	***Medium Risk***	***Higher Risk***
1. Current Suicide Plan			
A. Details	____Vague.	_____Some specifics.	____Well thought out.
B. How prepared	____Means not available.	_____Has means close by.	____Has means in hand.
C. How soon	____No specific time.	_____Within a few days or hours.	____Immediately.
D. How (Lethality of method)	____Pills, slash wrists.	_____Drugs/alcohol, car wreck	____Gun, hanging, jumping.
E. Chance of intervention	____Others present most of the time.	_____Others available if called upon.	____No one nearby; isolated.
2. Pain	_____Pain is bearable. _____Wants pain to stop, but not desperate. _____Identifies ways to stop the pain.	_____Pain is almost unbearable. _____Becoming desperate for relief. _____Limited ways to cope with pain.	_____Pain is unbearable. _____Desperate for relief from pain. _____Will do anything to stop the pain.
3. Resources	_____Help available; student acknowledges that significant others are concerned and available to help.	_____Family and friends available, but are not perceived by the student to be willing to help.	____Family and friends are not available and/or are hostile, injurious, exhausted
4. Prior Suicidal Behavior of…			
A. Self	____No prior suicidal behavior.	_____One previous low lethality attempt; history of threats.	____One of high lethality, or multiple attempts of moderate lethality.
B. Significant Others	____No significant others have engaged in suicidal behavior.	_____Significant others have recently attempted suicidal behavior.	____Significant others have recently committed suicide.
5. Mental Health	_____History of mental illness, but not currently considered mentally ill.	_____Mentally ill, but currently receiving treatment.	____Mentally ill and not currently receiving treatment.
A. Coping behaviors	_____Daily activities continue as usual with little change.	_____Some daily activities disrupted; disturbance in eating, sleeping, and schoolwork.	____Gross disturbances in daily functioning.
B. Depression	____Mild; feels slightly down.	_____Moderate; some moodiness, sadness, irritability, loneliness, and decrease of energy.	____Overwhelmed with hopelessness, sadness, and feelings of helplessness.
C. Medical status	____No significant medical problems.	_____Acute, but short-term, or psychosomatic illness.	____Chronic debilitating, or acute catastrophic, illness.
D. Other Psychopathology	_____Stable relationships, personality, and school performance.	_____Recent acting-out behavior and substance abuse; acute suicidal behavior in stable personality.	____Suicidal behavior in unstable personality; emotional disturbance; repeated difficulty with peers, family, and teacher.
6. Stress	____No significant stress.	_____Moderate reaction to loss and environmental changes.	____Severe reaction to loss or environmental changes.
Total Checks			

Adapted from Brock, S. E., Sandoval, J., & Hart, S. R. (2006). Suicidal ideation and behaviors. In G. Bear & K. Minke (Eds.), *Children's needs III: Understanding and addressing the developmental needs of children* (pp. 225-238). Bethesda, MD: National Association of School Psychologists & Miller, D. N. & Brock, S. E. (2010). *Identifying, assessing, and treating self-injury at school.* New York: Springer.

Handout 3: Suicide Intervention Script & Observation Form

I am counseling a 16-year-old boy, Chris, whose girlfriend killed herself after they broke-up. Chris cut school yesterday, and I know that he has been drinking heavily since his girlfriend's funeral. This morning he is at school and is sober. I have called Chris into my office.

Engage with the Person At-Risk of Suicide

Psychologist: Hello Chris. I want you to know how sorry I am for your loss. How are you doing?

Chris: OK, I guess. I just can't seem to stop thinking about Susan killing herself.

Psychologist: I understand it must be real painful to lose someone you care about. Can you tell me some more about your feelings?

Chris: I just can't help thinking that if it wasn't for me, Susan will still be alive right now. I just can't live with the guilt.

Psychologist: So not only are you dealing with the sudden death of Susan, but you are also feeling real guilty? Chris: Yes (Chris begins to cry).

Identify Suicidal Ideation

Psychologist: You know Chris, sometimes when people have experienced a sudden lose and feel as you do, they think of suicide. Is this something you have thought about?

Chris: (Chris stops crying, pauses, and tentatively says). Yes.

Inquire About the Reasons for Suicidal Thinking

Psychologist: I think I understand, but can you tell me some more about what it is that has lead you to think about suicide?

Chris: I just can't live with this guilt. Everyone is looking at me. They know that I had broken up with

Susan. No one, except you, will talk to me. I'm sure everyone hates me and wishes I were dead. I might as well do them a favor.

Psychologist: So then you are really feeling alone right now. You are thinking that you are being blamed for Susan's death.

Chris: You got that right (Chris' tears have now turned to some anger). I'll show them.

Psychologist: What do you mean "I'll show them"?

Chris: If I kill myself they will not have me to kick around anymore!

[I have identified that Chris is feeling very guilty about Susan's death, and feels isolated and alone. He is also feeling that everyone is blaming him for Susan's death (which may or may not be true). I know that he has thoughts of suicide, but need to assess his risk of engaging in such behavior.]

Assess the Degree of Suicide Risk

Psychologist: Chris, you mentioned that you think suicide is a way to cope with the feelings and problem generated by Susan's death. Do you have a plan? How would you go about killing yourself?

Chris: Yes, I could do it with my car

Psychologist: Have you thought about when you would do it?

Chris: Yes, I was planning to get drunk and drive off the bridge tonight.

Psychologist: So the pain feels so intense you are thinking of crashing your car off the bridge

tonight.

Chris: Yes.

Psychologist: Have you ever tried to talk to anyone about this pain before?

Chris: I was thinking about going to my old therapist, but I don't even know if she is still around. It has been over a year since I last saw her.

Psychologist: What were you seeing the therapist for?

Chris: Depression.

Psychologist: Chris, have you ever tried anything like this before?

Chris: No

Psychologist: Is their any one you can talk to about this. Anyone who you think could help you solve these problems.

Chris: No (Chris slums into his chair, the anger has dissolved, and he again begins to sob).

[Chris has a plan, he has the means to carry it out, and he has a pretty immediate time frame for engaging in suicidal behavior. He is in intense emotional pain and feeling extreme guilt. While he has no prior suicidal behavior himself, the fact that Susan has modeled such as a problem solving strategy places him at increased risk. Finally, I have learned Chris is unable to identify any resources that can move him from a suicide orientation and that he has a history of depression. I determine his risk for suicide is High.]

Take Action to Reduce the Suicide Risk

Psychologist: Chris, I know it hurts a lot right now and it seems like there is no way out, but I believe that I can help you, if you let me.

Chris: What can you do (a hint of anger returns to Chris' voice)? I'm ready to leave now.

[Chris gets up and leaves the office. After giving the secretary a signal that I need assistance, I follow Chris to the parking lot.]

Psychologist: Chris, we need to get some help right now. How would you like to proceed?

Chris: I'm done with all of this?

Psychologist: OK, Chris I understand. You see no hope. But I do. You need to come with me right now (my voice is compassionate, but firm).

[This intervention will need to be very directive. The secretary has alerted the principal of my need for assistance. He is standing by on the edge of the parking lot. If need be he could immediately contact the police for assistance. As it turned out Chris responded to my very direct and firm approach. He cooperated with me and his parents who took him to the crisis intervention clinic at the local mental health facility].

Suicide Intervention Observation Form

Role Players: ______________________________ ***Observer:*** ______________________________

Crisis Situation: ______________________________

____

Engage with the Person At-Risk of Suicide

1. *Establish psychological contact.*
   a. Introduction: ______________________________
      i. Identify self: ______________________________
   b. Empathy: ______________________________
      i. State known stressors and symptoms: ______________________________
   c. Respect: ______________________________
      i. Pause to listen: ______________________________
      ii. Do not dominate the conversation: ______________________________
      iii. Do not try to smooth things over: ______________________________
   d. Warmth: ______________________________
      i. Verbal communication is congruent with nonverbal: ______________________________
      ii. Use of and provide physical contact, as indicated: ______________________________

Identify Suicidal Ideation

2. *Ask the "S" question.*

[**Poor**: "You are not thinking of suicide are you?" **Better**: "Are you thinking of hurting yourself?" **Best**: Identify stressors + Identify symptoms + Directly ask: "Are you thinking of suicide (or killing yourself)?"]

____

____

Inquire About the Reasons for Suicidal Thinking

3. *Understanding reasons for suicidal ideation.*
   a. Stressors: ______________________________
   b. Symptoms: ______________________________

Assess the Degree of Suicide Risk (CPR++)

4. ***C****urrent Plan:*
   a. How? ______________________________
   b. How prepared? ______________________________
   c. How soon? ______________________________
5. ***P****ain:*
   a. Unbearable? ______________________________
6. ***R****esources:*
   a. Degree of "aloneness"? Reasons for living? ______________________________
7. *+Prior Behavior:*
   a. Prior suicidal behavior of self or significant other? ______________________________
8. *+Mental Health History*
   a. History of mental illness? Receiving therapy? ______________________________

Take Action to Reduce the Suicide Risk

9. *Suicide risk level*: Low Moderate High ______________________________

____

____

10. *Action Plan:* Facilitative Directive ______________________________

____

____

____