Comprehensive Suicide Prevention and Intervention for LEPs

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Training Objectives

- Pupil Suicide Prevention Legislation
- District and Private Practice Approaches
- Prevention
- Intervention
- Postvention
Suicide Prevention Legislation

- AB 2246 Pupil Suicide Prevention Policy (2016)
- AB 89 Psychologists: suicide prevention training for licensees, 6 hours (2017)
- AB 2639: Requires that school suicide prevention policies be updated, at a minimum, every five years (2018)
- AB 1808: Funding for online suicide prevention training for staff and students (2018)
- SB 972: Crisis resources on student ID cards (2019)
Workshop Components:

- Common myths about suicide
- Protective factors
- Risk factors & warning signs of youth suicide
- Appropriate ways to interact with at risk youth
- Procedures for responding to suicide risk
- Procedures for responding in aftermath of suicide
- Resources
- Emphasis on immediate referrals & supervision
PREVENTION
Student Prevention Resources:

Education, Access, Stigma

- Curriculum (SEL, Health, Adv Psyc, Reconnecting Youth)
- Student ID cards with crisis and text hotlines numbers
- Parent Education
- NAMI On Campus High School Club (NCHS) are student-led clubs that raise mental health awareness and reduce stigma on campus through peer led activities and education. Student Leaders attend training to learn about mental health and being advocates on campus. The Club is open to all students - those with mental health conditions, those with family members with a condition, or students who are interested in the field or in advocacy.
- State and Nationwide NAMIWalks
- Youth Mental Health First Aid (YMHFA)
- Each Mind Matters (EMM) SanaMente
  - Directing Change Videos
  - Know The Signs
  - Walk In Our Shoes

*CA Health Education Framework and Curriculum update!
Directing Change Video: “If We All Speak Loud Enough”
NAMI On Campus Clubs

- Partnership between CalMHSA, California Department of Education, and the National Alliance of Mental Illness.
- NAMI High School Club Mission Statement (created by student members):
  - “To raise mental health awareness, provide a safe student environment for all students, prevent student suicide, and reduce stigma and discrimination against mental illness, and promote student mental health on campus through peer advocate led activities and education”
  - https://www.youtube.com/watch?v=82E3gnDnELY
Safe Messaging

- Unsafe messaging can lead to contagion
- Media: “Committed suicide”/“Died by suicide”
- Suicide is preventable
- There are evidenced based treatments for all the risk factors of youth suicide
- Everyone plays a role in suicide prevention
- Resilience and recovery are possible

Suicide and the grief that follows a death by suicide are very complex and no one person, no one thing is ever to blame.
Toolkit for Mental Health Promotion and Suicide Prevention

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K-12
Myth or Fact?

- Talking about suicide increases risk.
- All depressed youth are suicidal and all suicidal youth are depressed.
- Suicide occurs out of the blue. Young people do not show warning signs.
- Suicide among 5-11 does not exist and elementary school children are too young to be suicidal.
- Once a youth is suicidal, nothing can stop them from attempting.
Suicide is the second leading cause of death for 10-24 year olds in the US (CDC, 2017).

Almost one in ten youth deaths by suicide in the US occur in California.

More teenagers and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease, COMBINED.

Each day in our nation, there are an average of over 5,240 attempts by young people grades 7-12.

Four out of Five teens who attempt suicide have given clear warning signs
# 10 Leading Causes of Death by Age Group, United States - 2017

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<th>Age Groups</th>
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Data Source: National Vital Statistics System, National Center for Health Statistics, CDC. 
Produced by: National Center for Injury Prevention and Control, CDC using WISQARS™.
Youth suicide in CA: 2017

- 2nd leading cause of death for 10-24 year olds
- Over twice as many people die by suicide than by homicide in CA
- Rate all ages 10.9 #46 in US
- Rate 10-24 10.5 #45 in US
- Steady increases since 2007
- Roughly one in ten suicides in the US occur in CA
- Most common method: strangulation
- Highest risk youth: Hispanic & White; LGBTQ+
What protects youth from suicide?

- Good relationships with other youth
- Seeks adult help when needed
- Lack of access to suicidal means
- Access to mental health care
- Spirituality and religious involvement
- Positive school environment that encourages help seeking, promotes health, and provides resources
Protective factors

- Family cohesion and stability
- Strong cultural values/identity
- Coping and problem solving skills
- Resiliency and
- Positive self worth and impulse control
- School connectedness and extracurricular participation
- Academic success
Suicide

- A complex public health challenge involving many biological, psychological, social, and cultural determinants.

- Interpersonal Theory for Suicide
  - 3 components must align to predict risk for suicide or a serious suicide attempt:
    - “thwarted belongingness”
    - “perceived burdensomeness” and
    - acquired capability for lethal self-injury.
  - Lethality of means (suffocation vs drug overdose vs weapon access) increases with age and escalates with the number of suicide attempts.

Risk factors

- There is no single predictor of youth suicide
- Risk factors come together in a perfect storm
  - Alcohol & substance abuse*
  - Accessibility to means (firearms)*
  - Depression/Co-morbidity*
  - Previous suicidal behaviors
  - History of trauma or exposure to suicide*
  - Hopelessness, expressing no reason to live
  - Impulsivity, engaging in risky activities
  - Insomnia and disturbed sleeping patterns
  - Non-Suicidal Self-Injury (NSSI)
Risk factors of youth suicide

- Situational crises: Precipitating events
  - Loss (Death, divorce, transience, romance, dignity)
  - Victimization/exposure to violence
  - School crisis (disciplinary, academic)
  - Family crisis (abuse, domestic violence, running away, argument with parents)
  - Exposure to suicide
Risk Factors for College Students

- Academic and social stressors
- New and unfamiliar school environment
- Difficulties adapting to new demands and workloads
- Feelings of failure or decreased academic performance
- Family history of mental illness
- Feelings of alienation
- Lack of coping skills
- Depression, sadness, hopelessness

American College Health Association, 2000
Continuum of Self-destructive Behavior

**Stressors: Chronic**
Mental Illness/Co-morbidity

**Warning signs**

**Stressors: Acute**
Precipitating Event

**Thoughts**

**Behaviors:**
- Suicide attempts
- Self-injury
- Alcohol/substance abuse
30.5% felt sad or hopeless
13.1% seriously considered suicide
11.4% made a plan
8.4% made one or more attempts
2.8% actually got to medical help

CA | US
---|---
32.1 | 31.5
17.0 | 17.2
14.1 | 13.6
9.4 | 7.4
3.1 | 2.4

www.cdc.gov (9-12th grade students)
High School Students who Display Suicidal Behaviors

Statistics & Demographics

Kann et al. (2016)
Youth Suicide Rate: 2013-2015

Definition: Number of suicides per 100,000 youth ages 15-24 (e.g., in 2013-2015, there were 7.9 suicides per 100,000 California youth ages 15-24).

High risk youth: Cultural issues

- **Hispanic youth**
  - Latina
  - Highest in reporting of suicidal thoughts and behaviors

- **Asian American youth**
  - Highest in adolescent females associated with acculturation and family expectations.

- **African American youth**
  - The suicide rate among children ages 5 to 11 doubled 1993-2013.

- **Native American/Alaskan Native youth**
  - Although suicide rates vary widely among individual tribes, it is estimated that 14 to 27 percent of AI/AN adolescents have attempted suicide.
High risk youth

- Exposed to suicide
- Bullies and victims
- Lesbian, gay, bisexual, or transgender
- Depressed
- Non-Suicidal Self-Injury (NSSI)
- Traumatized
- Alcohol/substance abuse
- Homeless/Runaway/Foster children
High risk youth: Those exposed to suicide

- Research based estimate suggests that for each death by suicide 135 people are exposed (6.3 million annually), and among those, 1/3 experience a major life disruption (Cerel et al, 2018)

- A loss by suicide can be a traumatic loss
High risk youth: Bullies & Victims

- Children who have been bullied have reported a variety of behavioral, emotional and social problems.
- Highest risk has been both bully/victim
- Key factor is pre-existing psychopathology
- Some gender differences in response to bullying
- High risk groups include: LGBT, Disabled, Race & Religion
High risk youth: LGBTQ+

- Higher rates of family rejection & peer victimization
  - 3X more likely to report suicidal ideation
  - 8X more likely to have attempted suicide
  - 6X more likely to have higher levels of depression
- Compared to non-LGBT youth, LGBT youth suicide attempts *may* be more serious
High risk youth:
Depressed youth

- 32% youth in the US report feeling so sad or hopeless over the past year that they affected their daily activities.
- The majority do not receive services
- Co-occurring disorders
- Ignited by precipitating events
- Effective treatments include talk therapy and medications
High risk youth: Disabilities

- Relates to the physical, sensory, cognitive, and/or mental disorders that substantially limit one or more major life activities.
- Social isolation, misunderstanding, and bullying.
- Psychiatric comorbidities increases the risk for suicide.
- Multiple sclerosis and spinal cord injury (chronic illnesses).
High risk youth: Non-Suicidal Self Injury

- Maladaptive coping strategy
- Generally assess at low risk for suicide
- Episodic associated with emotional regulation
- Repetitive NSSI associated with history of trauma, ACEs
- Suicidal risk increases with number of years engaging in self injurious behaviors and number of methods
High risk youth: Trauma and ACEs

Adverse Childhood Experiences (ACEs) is the term given to describe all types of abuse, neglect, and other traumatic experiences that occur to individuals under the age of 18.

The landmark Kaiser ACE Study examined the relationships between these 10 experiences during childhood and reduced health and well-being later in life.

<table>
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<tr>
<th>Abuse</th>
<th>Neglect</th>
<th>Family Challenges</th>
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<tr>
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<td>Divorce</td>
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</table>
ACEs and Suicide Attempts

Number of Adverse Childhood Experiences

Percent Attempting Suicide

none 1 2 3 4+

ACEs and Suicide Attempts
High Risk Adolescent and Adult Populations

- Females make more suicide attempts than males
- Males complete more suicides than females
- Higher risk of suicide for widowed, single or divorced people
- Higher risk for married adolescents
High Risk Adolescent and Adult Populations

- Suicide is the 2\textsuperscript{nd} leading cause of death in college students 20-24 years old
- 1 in 12 college students have made a plan for suicide
- Higher risk for students who have a pre-existing mental health condition, or those who develop a mental health condition while in college

American College Health Association, 2000
Consensus warning signs of youth suicide

- Talking about or making plans for suicide.
- Expressing hopelessness about the future.
- Displaying severe/overwhelming emotional pain or distress.
- Sudden marked changes in behavior, personality, friends, dress/hygiene

Suicide Awareness Voices of Education

http://www.save.org/
Consensus warning signs of youth suicide

- Showing worrisome behavioral cues
  Specifically, this includes significant:
  - Withdrawal from or changing in social connections/situations
  - Changes in sleep (increased or decreased)
  - Anger or hostility that seems out of character or out of context
  - Recent increased agitation or irritability
INTERVENTION
Guidelines for
School Staff
and
Private Practitioners
Suicide Intervention in the Schools

- No absolute predictors of youth suicide so we must be vigilant even with low risk
- Kids are not suicidal 24/7 and levels of risk can change within hours
- Youth population is vulnerable to contagion
- Try to create a circle of care between child, parent, school, community agencies
- Brief suicide assessment in the schools
- Collaborating with district crisis response teams
Suicide intervention in schools

- Collaboration & supervision
- Assessing suicide risk
- Notifying parents or protective services
- Interventions for low, moderate-high risk
- Action plans for in/out school suicide attempts
- Local resources & Law enforcement
- Re-entry planning
- Safety planning
District Crisis Response Team (CRT)

- Maintain supervision of student
- Contact a CRT Member:
  - Administrator
  - School psychologist
  - School counselor
  - School nurse
- Community collaborations:
  - Law enforcement, Dept of Mental Health, Emergency Services
Procedures

- Supervision
- Assessment of risk
- Duty to notify
- Duty to refer/provide resources
- Documentation

Collaboration is your liability insurance
Columbia Suicide Severity Rating Scale (C-SSRS) Triage Version

- Researched and increasingly used by hospitals/schools/law enforcement
- Brief assessment C-SSRS has 2-5 direct questions on suicide thoughts, method, and intent
- Appropriate for all ages and its free with translation for over 100 languages
- Training Video available at https://www.youtube.com/watch?v=Ted_gl-UXi8

www.cssrs.columbia.edu
C-SSRS Triage: Questions

1. Have you wished to be dead?
2. Have you actually thought of killing yourself?
   - If No go to directly to question 6.
   - If Yes ask questions 3, 4 and 5.

   **Subcategory questions of Question 2**
   
   3. Have you been thinking of how to do this?
   4. Have you had thoughts and some intention to act on them?
   5. Do you have a plan to kill yourself?

6. Have you ever done or prepared to do anything to harm yourself?
   - If Yes ask in the last 3 months?

Suicidal ideation questions

Behavioral intent question

Handout: C-SSRS Triage Version
SAFE-T from SAMHSA

- Suicide Assessment Five-step Evaluation and Triage
  1. **Identify risk factors** especially those that can be reduced
  2. **Identify protective factors** that can be modified
  3. Conduct suicide inquiry
  4. Determine risk level
  5. Document assessment, intervention and follow up

Download the APP!
#1 Suicide Attempt? Yes or No

Young girl wanted to escape from her mother’s home. She researched lethal doses of ibuprofen. She took 6 ibuprofen pills and said she felt certain from her research that this amount was not enough to kill her. She stated she did not want to die, only escape from her mother’s home. She was taken to the emergency room where her stomach was pumped and she was admitted to a psychiatric ward.

1. Yes
2. No
3. Not enough information
Teen girl, following a fight with her boyfriend, felt like she wanted to die, impulsively took a kitchen knife and made a superficial scratch to her wrist; before she actually punctured the skin or bled, however, she changed her mind and stopped.

1. Yes
2. No
3. Not enough information
Young boy was feeling ignored. He went into the family kitchen where mother and sister were talking. He took a knife out of the drawer and made a cut on his arm. He denied that he wanted to die at all ("not even a little"), but just wanted them to pay attention to him.

1. Yes
2. No
3. Not enough information
#4 Suicide Attempt? Yes or No

Young woman made cuts on her arm after an argument with her boyfriend.

1. Yes
2. No
3. Not enough information
Young man is distraught about his recent breakup of a long term personal/intimate relationship. His grades have fallen from A’s and B’s to F’s. His usual happy and upbeat behavior has changed to being withdrawn and looking disheveled. He has told his friends he just wants to die, no one loves him, and has shared he has access to a weapon. He also reveals that he has placed the loaded weapon to his head on a few occasions, but his young siblings walked into the room before he could finish his intent so he stopped.

1. Yes
2. No
3. Not enough information
Suicide Inquiry

- Ideation
  - Frequency, intensity, duration (48 hrs; past month)
- Plan
  - Lethality, availability of means; preparatory acts
- Behaviors
  - Past attempts; rehearsals
- Intent
  - Explore ambivalence; reasons to die vs. reasons to live
- Parent/teacher feedback (i.e. previous attempts, changes in behaviors)
Notifying Parents

- Involve student
- Obtain relevant mental health history
- Insurance information
- History of traumatic losses; victimization
- Obtain signed release of information
- Assess family support
- Assess protective factors
Safety Planning

- Utilize safety planning
  - Therapy appointments
  - Medication management
  - Identify circle of care of adults/peers
  - Promote help-seeking behaviors
  - Promote communication skill building
  - Provide relevant hotlines/websites/resources
Safety Planning: App Resources

A Friend Asks App
www.jasonfoundation.com

Virtual Hope Box

MY3 App
www.my3app.org
Re-Entry Meetings

- Maintain contact with parent and set up re-entry meeting.
- Have parent escort student back to school first morning following exit from hospitalization and conduct a re-entry meeting.
- Obtain any records from hospital and have parent sign a release of information form.
- Discuss confidentiality.
- Debate about notifying student’s teachers
Re-Entry Guidelines

- Provide interventions:
  - Modify academic programming as appropriate
  - Identify on-going counseling resources at school or in the community
  - Medication follow up plan with parent permission

- Monitor student to make certain no bullying takes place in the classroom as many students may know the student was hospitalized and word spread through social networking.

- Check in frequently during the first week the student returns to school.
Documentation

- Document all actions of crisis response
- Keep in a confidential file (not in student cumulative folder)
- HIPAA and FERPA considerations
Assess and document any predisposing suicide factors:

- Demographics/Populations
- Psychosocial Stressors
- Environmental Factors
- Family history of mental illness
- Medical factors
Suicide Assessment in Private Practice

- Assess and document any potential suicide factors
  - Assess for psychotic, depressive, bipolar and anxiety disorders
  - Assess for comorbid conditions
  - Assess for personality disorders and antisocial personality disorders
- Mental Status Exam
Suicide Assessment in Private Practice

- Is client’s suicidality chronic or acute?
  - Is the client actively suicidal?
- Evaluate competence, impulsivity and acting out behavior
- Ideology, plan, access, means
- Plan the type and frequency for reassessing suicidal risk
- Assess the need to break confidentiality, based on severity and imminence
- Assess support networks
Examples of Suicide Specific Interview Questions

☐ Is the client sufficiently competent to participate in treatment?

☐ Is the client capable of developing a therapeutic alliance or relationship?

☐ Are suicidal ideations present?
  ▪ If so, ask the client to describe these suicidal thoughts or feelings.
Examples of Suicide Specific Interview Questions

- Has the client proceeded in any way in the planning process for suicide?
  - For example, has the client bought a gun or started to collect prescription medications or drugs for possible use in a suicide plan?

- What meaning or purpose does suicide have to the client?
  - For instance, is it intended to end physical suffering, depressive symptoms, or extreme anxiety?
Examples of Suicide Specific Interview Questions

- Does the client perceive to have lost the will to live?
  - Is this type of loss anticipated in the near future?

- Does the client perceive to have lost a significant or essential relationship?
  - Is this type of loss anticipated in the near future?

- Are there any previous suicide attempts?
Examples of Suicide Specific Interview Questions

- Does the client’s mental status increase the risk for suicide?
  - For instance, is the client extremely agitated, anxious, manic, etc.?

- Is the client experiencing depression accompanied by despair and hopelessness?

- Is the client susceptible to emotional states like self-hatred, homicidal rage, and extreme shame or panic?
Examples of Suicide Specific Interview Questions

- Does the client’s physiological state increase the risk of suicide?
  - For example, is the client intoxicated? In pain? Have a physical illness? Experiencing delirium? Have an organic impairment?
- Is the client experiencing any recent stressors?
- What is the client’s capacity for self-containment and emotional regulation?
- What are the client’s coping mechanisms currently?
Guidelines for Confidentiality

☐ Discuss limits of confidentiality with clients prior to beginning services.

☐ Enlist client’s permission to discuss suicidal ideology with family and/or network of support (release of information)
  ☐ This would include collaborating with school personnel if the client is under 18 and in K-12.

☐ Clients under age 18, mandated to inform if self-harm is deemed possible
Guidelines for Confidentiality

- Clients over 18, mandated reporting becomes more complicated. There is a judgment call involved based on your assessment, but you could be held liable if client self-harms and you do not report.
  - Most clients who report suicide ideology are seeking help
  - Chronic clients who have a long history of suicidal thoughts become savvy to the process and can “fake good” in order to avoid the reporting
    - Clients may indicate they are feeling suicidal, then take that statement back if you attempt to report
    - Seek consultation with colleagues, err on the side of safety and keep detailed records of your assessment, interventions and session notes
Interventions for Adult Clients

- Attempt to gain permission to involve family/social supports
  - Release of information

- Contract for Safety/Self-Care Plans
  - Can be verbal or written
    - Written and signed by all parties involved creates accountability
    - Purpose is to create dialogue, not necessarily to use as an actual contract
      - Client is asking for help
Interventions for Adult Clients

- Community Services
  - Psychiatric eval if not already under the care of a psychiatrist
  - Refer out if suicide prevention is not part of your training/skill set
- Support groups
- Community mental health agencies
- Day Treatment programs
- State and National Organizations/Hotlines
Interventions for Adult Clients

- Hospitalization
  - Voluntary
    - Call ahead to make sure there is a bed
    - ER
  - Involuntary
    - Psychiatric Mobile Response Team
      - They can assess and write holds
      - They will call an ambulance or other means of transport
    - 911/Sherriff/Police
      - They can write 5150 and transport
        - Never transport a client yourself, you will incur liability
POSTVENTION
After a Suicide: A Toolkit for Schools
Second Edition 2018

Suicide Prevention Resource Center
American Foundation for Suicide Prevention
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.
Suicide Contagion

- Contagion is rare, but adolescents and young adults are more susceptible than other age groups.

- 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”
  - 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).
Suicide Cluster
Contributing Factors

- Social media
- Media coverage
  - Number/placement of stories
  - DETAILS
  - Sensational/glamorous/romanticized coverage
- Unsafe messaging such as simplifying the causes of suicide
- Glorifying suicide or those that die by suicide
- Presenting suicide as a tool for achieving certain goals
Practical Suggestions

- Intervene only when indicated.
- Time is valuable! The more time you give staff to process, at home or in private, the better. Some staff may choose to call in ill.
- **Do not inform staff or students by intercom.**
- Triage staff and make appropriate notification in person (not by memo or email). Phone trees!
- Have substitutes to relieve staff during the day. Plan with Human Resources, employee assistance services, and local DMH if needed.
- Facilitate social support systems for HS/Secondary students.
Suicide Postvention Checklist

1. Verify that a death has occurred and confirm cause.
2. Mobilize the District/Site Crisis Response Team and identify procedures.
3. Assess the suicide’s impact on the school and estimate the level of postvention response.
4. Notify other involved school personnel or sites.
5. Contact the family of the suicide victim (1 contact person).
6. Determine what information to share about the death.
7. Determine how to share information about the death (Superintendent and public relations)
Suicide Postvention Checklist

8. Identify students significantly affected by the suicide and initiate a referral mechanism
9. Conduct a faculty planning session
10. Initiate crisis intervention services
11. Conduct daily planning sessions
12. Memorials
13. Social Media
14. Prevention messaging
15. Debrief the postvention response
Contact the Family of the Suicide Victim

Contact should be made in person within 24 hours of the death. Purposes include...

- Express sympathy.
- Offer support (local resources)
- Identify the victim’s siblings, friends who may need assistance
- Share 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.
Family Privacy and Staff Communications

- Consult *After a Suicide Toolkit: 3 Sample letters for parents & students*

- Three scenarios:
  - Death has been ruled a suicide
  - Cause is unconfirmed (ask that rumors not be spread)
  - Family has requested cause of death not be disclosed (rumors of suicide and since that subject has been raised it’s complex but mental illnesses such as depression are usually the cause)
Identify Significantly Affected Students

- Risk Factors for Imitative Behavior
  - Backed out of pact
  - Had a negative interaction with victim
  - **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.
Conduct a Staff Planning Session

- Replacing rumors with facts and honoring the family's request for privacy
- Encouraging the ventilation of feelings
- Stressing the normality of grief and wide array of stress reactions children demonstrate
- Discouraging attempts to romanticize the suicide
- Identifying students at risk for an imitative response
- Making the appropriate referrals
- Address staff reactions and student perceptions
- Prevention messaging
Memorials

- Strive to treat all student deaths the same way
- Encourage and allow students, with parental permission and support, 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
  - American Foundation for Suicide Prevention Memorial Funds & Support Groups
Social Media

- Appoint a Social Media Manager to assist PIO
- 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
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.
Postvention for Adult Clients

- Clinical work should start with survivors as soon as possible
  - Within 72 hours, especially with children, colleagues and other social network groups
  - Can be complicated by grieving family resistance
- Seek permission from family to provide services
- Facilitate communication between family members, especially between bereaved parents and surviving siblings
Postvention for Adult Clients

- Explore ambivalence, anger and other negative emotions toward the deceased
- Support survivors in dealing with denial
- Refer to other professional and community supports
  - School
  - Community mental health
  - Support groups
- Seek support for yourself from trusted colleagues
  - Put yourself into therapy
Impact of Client Suicide on the Practitioner

About 1 in 6 people who complete a suicide were under some form of mental health treatment.

- 25% of therapists and interns, and 50% of psychiatrists will lose at least one client to suicide during their career.

The clinician is often deeply impacted by the suicide of a client, but they are not part of the bereavement circle or network of social support.
Impact of Client Suicide on the Practitioner

- Clinicians care for their clients and the initial reaction is similar to the loss of a loved one.
  - Can result in a conflict between personal and professional responses.
- Clinicians may be judged or blamed by others and their grief may interfere with occupational and social roles, leaving the clinician feeling alienated from family, friends and colleagues.
Impact of Client Suicide on the Practitioner

- Can be the most difficult challenge in a clinician’s professional career
  - Experience feelings of guilt, self-blame, self-doubt, incompetence, isolation

- Clinicians can lose confidence in their professional competence and role performance, fear repercussions from the family and colleagues, and worry about legal action.
Impact of Suicide on the Practitioner

- Clinicians need to explore their own grief, fears, questions, self-doubts and beliefs of responsibility in the event with;
  - Trusted colleagues
  - Supervisors
  - Therapists
  - Support Groups
Impact of Suicide on the Practitioner

- Clinicians need to prepare for suicidal clients by having
  - Malpractice insurance
  - A plan to deal with suicidal clients
  - Self-Care Plans
  - American Association for Suicidology (suicidology.org)
    - Clinician Survivor Task Force
Suicide: National Resources

- The Trevor Project
  www.thetrevorproject.org
- National Suicide Prevention Lifeline
  www.suicidepreventionlifeline.org
- Suicide Prevention Resource Center
  www.sprc.org
- Centers for Disease Control
  www.cdc.gov
Suicide: National Resources

- American Association of Suicidology
  http://suicidology.org
- American Foundation for Suicide Prevention
  http://afsp.org
- National Association of School Psychologists
  http://nasponline.org
Safe Messaging

- National Action Alliance for Suicide Prevention Framework for Successful Messaging
  http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/

- Toolkit: Making Headlines: A Guide to Engaging the Media in Suicide Prevention
  http://resource-center.yourvoicecounts.org/content/making-headlines-guide-engaging-media-suicide-prevention-california-0

- How to Use Social Media for Suicide Prevention
  http://resource-center.yourvoicecounts.org/content/how-use-social-media