Comprehensive Suicide Prevention and Intervention for the LEP

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Inspired to lead

CASP Convention 2023

Suicide Prevention for the LEP: Agenda

- Suicide prevention in the schools
  - Contemporary issues
  - Comprehensive programs
    - Prevention strategies
    - Intervention policies
    - Postvention procedures
- Suicide prevention for the clinician

Suicide Prevention for the LEP: Agenda

- Understanding Suicide Assessment in Private Practice
- The Use of Telehealth in Suicide Assessment
- Intervention in Private Practice
- Postvention in Private Practice

International Symposium on Youth Suicide

- Alarming increases but statistics are questioned
- Media sensationalism of suicide
- Clusters of suicides occur
- Schools are the best place to intervene
- Students are under extreme pressure
- Guns are too available
-

Suicide Prevention in Schools: Contemporary Issues

- AB 2246/1767, AB 58 Comprehensive Programs
  - Components
  - High risk groups
- Trends: Youth Suicide
  - Developmental: Suicide prevention in TK-5
  - Cultural: Risk factors
  - COVID and disproportional impact on Black & Brown communities
- Best practices & Resources
  - Prevention
  - Intervention
  - Postvention

Suicide Prevention in Schools: Comprehensive Programs

AB 2246: Pupil Suicide Prevention Policies

- Mandates that the Governing Board of any local educational agency (LEA) that serves pupils in grades 7th-12th, inclusive, ***SHALL adopt a comprehensive policy*** of pupil suicide prevention, intervention, and postvention.
- The policy shall specifically address the needs of ***high-risk groups.***
- Include annual suicide prevention ***training for teachers.***

AB 2246: Pupil Suicide Prevention Policies

- This training shall be offered under the direction of school employed mental health professional.
- Ensure that a school employee acts within the authorization and scope of the employee's credential or license.
- Guidance provided by:
- ***CDE Model Pupil Suicide Prevention Policy***
- ***AFSP/Trevor Project Model School District Policy on Suicide Prevention.***

AB 1767 Pupil Suicide Prevention Policies

- **AB 1767** is an extension to AB 2246 to add age groups from kindergarten through the 6th grade.
- This effectively ***mandates*** that all local education agencies serving students from kindergarten through the 12th grade adopt a policy on suicide prevention, also specifically addressing the needs of ***high-risk groups.***

AB 58 Pupil Health, Suicide Prevention Policies and Training

- AB 58 Extends provisions to AB2246 and 1767 requiring that LEAs update their suicide prevention policies and revise training materials to reflect CDE model policies by January 1, 2025
- AB58 "encourages" LEAs to provide training to teachers of pupils of all ages
- AB58 requires the CDE to provide guidance and resources to LEAs for offering trainings remotely.

High-Risk Youth

- Exposed to suicide
- Depressed; Mental Illness
- Alcohol/Substance Abuse
- Bullies and Victims
  - Youth with Disabilities
  - Lesbian, Gay, Bisexual, Transgender or Questioning Youth
- Engaged in Non-Suicidal Self-Injury (NSSI)
- Traumatized
- Youth Experiencing Homelessness or Youth in Foster Care

High-Risk Adolescents/ 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

High-Risk Adolescents and Adult Populations

- Females make more suicide attempts than males
- Males die by suicide more often than females
- Higher risk of suicide for widowed, single or divorced people
- Higher risk for married adolescents

High-Risk Adolescents and Adult Populations

- Suicide is the 2nd 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

COVID Impact

- Over one million Americans died from COVID and every child has a story to tell.
- The pandemic intensified pre-existing mental health issues.
- Children were not only isolated from connections of school, but they had greater difficulty accessing mental health services.
- Many families experienced financial hardship.
- The isolation was especially difficult for adolescents and few students did well with only virtual learning.
- The impact to children continues

Trends: Developmental

- Suicide has been a leading cause of death for teens and young adults for decades in the US and in the most recent year of data, 2020, it was #2 for MS and HS aged kids.
- 8 out of 10 deaths by suicide in this age group are boys yet ¾ attempts are by girls and during the pandemic, ER visits increased significantly.
- Of particular concern are the rates of MS aged youth have more than doubled in the past decade.
- **The contemporary issue is now SP in TK-5.**

Issue: Suicide Prevention in TK-5

- Policies & Procedures
- Dispelling myths
- Training ALL staff
- Involving parents
- Upstream Suicide Prevention

Issue: Firearms

- Across all ages firearms are the most common method of suicide. involved a firearm.
- Those who attempt suicide with a firearm rarely survive.
- Males are more likely to use a firearm than females.
- Increasing numbers of adolescent females are using a firearm.
- It is not a question of an adults' right to own a gun but a question of their responsibility to secure guns from children.
- School personnel who know a student is at-risk for suicide must have direct conversations with caregivers about secured storage of firearms.

Trends: Cultural

- Highest numbers: Whites (Impacts what we know about risk factors)
- Contemporary issue: More research needed on risk factors for diverse populations.
- COVID has had such disproportionate impact on black and brown communities.
- Highest rate: American Indian/Alaskan Native (Depression/serotonin)
- Highest increases: African American (MS girls; EL boys)
- Latinos: Highest reports of suicidal thoughts and behaviors
- Highest rates of depression: Asian American
- In addition to COVID, racism and victimization; historical trauma, stigma, access to firearms and obstacles to mental health services are all factors that exacerbate risk in these diverse groups.

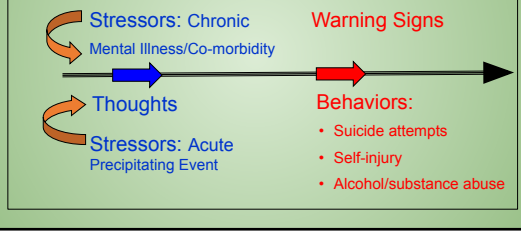
High-Risk Youth

- Exposed to suicide
- Depressed; Mental Illness
- Alcohol/Substance Abuse
- Bullies and Victims
  - Youth with Disabilities
  - Lesbian, Gay, Bisexual, Transgender or Questioning Youth
- Engaged in Non-Suicidal Self-Injury (NSSI)
- Traumatized
- Homeless & Youth in Foster Care

What protects youth?

- Family cohesion and stability
- Good relations with peers*
- Having a go-to trusted adult at school*
- Positive connections to school and extracurricular participation *
- Coping and problem-solving skills*
- Access to mental health services*
- Knowing when to seek adult help
- Religious involvement
- Lack of access to lethal weapons

Continuum of Self-Destructive Behavior



Risk factors: Chronic

- There is no single predictor of youth suicide
- Risk factors come together in a perfect storm.
  - Alcohol & substance abuse
  - Accessibility to means (firearms)
  - Depression/Comorbidity
  - Previous suicidal behaviors
  - History of trauma, adverse childhood experiences (ACES)
  - Hopelessness
  - Impulsivity
  - History of non-suicidal self injury

Risk factors Acute/ Situational Crises

- Loss (Death, divorce, transience, romance, dignity)
- Victimization/traumatic exposure to violence
- School crisis (disciplinary, academic)
- Family crisis (abuse, domestic violence, running away, argument with parents)
- Exposure to suicide

Warning Signs

- Suicidal notes/texts/social media posts
- Threats
  - Direct: “I want to die” “I am going to kill myself”
  - Indirect: “No one will miss me” “The world will be better without me”
- Depression/Hopelessness
  - Loss of energy/lack of enthusiasm for life
  - Risk-taking behaviors such as drinking and driving, gun play, alcohol and substance abuse
- Plan/method/access
- Giving away prized possessions/making final arrangements

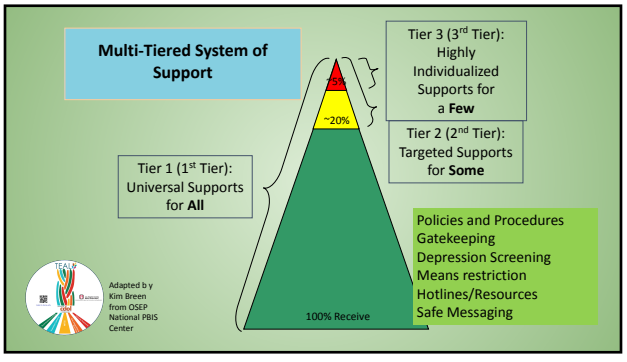
Warning Signs

- Intense feelings of being a burden
- Isolation and a lack of belonging/connections
- Sudden changes in behaviors, personality, friends
  - Changes to eating or sleeping habits
- Death and suicidal themes in writings, readings, websites
- Elementary school age children may:
  - Threaten to run into traffic
  - Jumping from high places
  - Cutting/scratching or marking the body
-

Notifying Parents

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

SUICIDE PREVENTION IN SCHOOLS



Suicide Prevention: Universal Strategies in the Schools

- Policies and procedures
- Dispelling myths
- Gatekeeper programs for staff, students and parents
- Depression screening
- Means restriction: Firearms & Suicide
- Access to hotlines/resources
- Safe messaging

Dispelling Myths

- 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.

Staff/Parent Training: Core 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

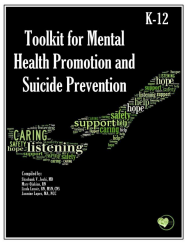
Issue: Safe Messaging

- Unsafe messaging can lead to contagion
- Media: “Committed suicide”/”Died by suicide”
- Many suicides can be 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

Issue:
Safe
Messaging

Suicide and the grief that follows a death by suicide, are complex and no one person, no one thing, is ever to blame.

Toolkits for Mental Health Promotion and Suicide Prevention



SPORT

Local Resources

SPORT
SUICIDE PREVENTION ONGOING RESILIENCY TRAINING

preventsuicide.lacoe.edu

Los Angeles County Office of Education
Serving Students • Supporting Communities • Leading Educators

cdol
Center for Distance & Online Learning

Questions? Please contact your county liaison

SUICIDE INTERVENTION IN SCHOOLS AND PRIVATE PRACTICE

Suicide Intervention in Schools-Part I

- 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 School Site Crisis Teams

Suicide Intervention in Schools-Part II

- Maintain supervision throughout the process of determining risk
- Collaboration is your liability insurance
  - School employed mental health professional
  - Administrator
  - Support personnel
- Assessing suicide risk
- Collaborate with law enforcement if appropriate
- Notifying parents or protective services

Suicide Intervention in Schools-Part III

- Interventions for low, moderate-high risk
- Action plans for in/out school suicide attempts
- Collaborating with local resources & law enforcement
- Safety planning
- Re-entry planning
- Documentation

Columbia Suicide Severity Rating Scale (C-SSRS)

- Researched and increasingly used by hospitals/schools/law enforcement
- Brief assessment C-SSRS has 3-6 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

Brief Suicide Assessment

1. Have you ever thought about suicide? (Present thoughts)

LOW

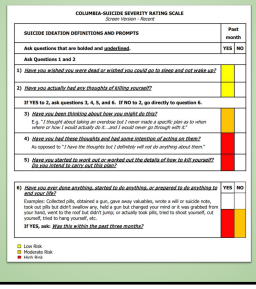
2. Have you ever tried to kill yourself before? (Previous behaviors)

MODERATE

3. Do you have a plan to kill yourself today

HIGH

Screening vs Risk Assessment



COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g."I thought about taking an overdose but I don't know exactly a specific plan as to when where or how I would actually do it...and I would never go through with it"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	**YES**	**NO**
If YES, ask: *Was this within the past three months?*		

Low Risk
Moderate Risk
Hight Risk

Suicide Assessment in Private Practice

- 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 the 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?

Telehealth and Suicide Assessment

- Establish the location of your client
  - Are they in a safe place?
  - Do they have access to items that could be used for a suicide attempt?
- Have a way to contact your client should you lose the connection
  - Cell phone, landline

Telehealth and Suicide Assessment

- Establish an alternate contact person
  - You will need to have your client sign a release of information
- Have contact information for local law enforcement
- Have contact information for local community mental health agencies and/or Psychiatric Evaluation Team

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

NASP CHECKLISTS

Preparing for Suicide Intervention	Conducting Suicide Intervention


Preparing for School Suicide Interventions in a Time of Distance Learning: A Preparation Checklist


Conducting School Suicide Interventions in a Time of Distance Learning: An Intervention Checklist

Brock, S. E., Lieberman, R., Cruz, M. A., & Coad, R. (2021). Conducting school suicide risk assessment in distance learning environments. *Contemporary School Psychology*

Lieberman, R., Cruz, M. A., Coad, R., & Brock, S. E. (2020). Comprehensive school suicide prevention in a time of distance learning (Handouts/Checklists). National Association of School Psychologists.

SAFE-T from SAMHSA

Suicide Assessment Five-step Evaluation and Triage

- Identify risk factors especially those that can be reduced
- Identify protective factors that can be modified
- Conduct suicide inquiry
- Determine risk level
- Document assessment, intervention and follow up

https://store.samhsa.gov/product/suicide-safe

Interventions for Moderate or High-Risk

- Maintain supervision
- Handoff ONLY to:
  - Parent/Guardian
  - Law Enforcement
  - Psychiatric Mobile Response Team (PMRT)
  - Never transport a suicidal student alone
- Re-entry and safety planning upon return to school

Interventions for Private Practice Clients

- Attempt to gain permission to involve family/social supports
  - –Release of information
- 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 Private Practice 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 Private Practice 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/Sheriff/Police
    - –They can write 5150 and transport
      - •Never transport a client yourself, you will incur liability

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

A Friend Asks App
www.jasonfoundation.com

MY3 App
www.my3app.org

Virtual Hope Box

Re-Entry Guidelines

- 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.
  - Medication follow up plan with parent permission.

Re-Entry Guidelines

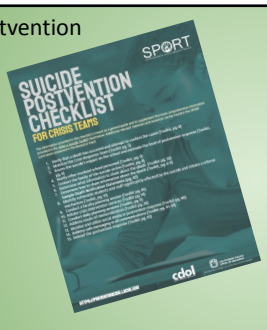
- Debate about notifying student's teachers.
- Monitor student to make certain no bullying takes place in the classroom as many students may know the student was hospitalized and word spread through social networking.
- Monitor social networking sites with cooperation of the parent.
- Identify circle of adults at school and at home.
- Check in frequently during the first week the student returns to school.

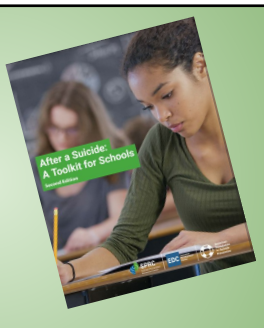
Documentation

- Establish documentation procedures.
  - Risk Assessment Referral Document
- Document all actions of crisis team response.
- NO Immediate Timelines! (Fill out later!)
- Keep in a confidential file (not CUME folder).
- Documentation never leaves district.
- Coordination when student transfers or graduates to other schools within district.

SUICIDE POSTVENTION IN SCHOOLS AND PRIVATE PRACTICE

Postvention





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.

Suicide Cluster

- Multiple suicides within a defined geographical area within an accelerated time frame.
- 1-5% of teenage deaths by suicide occur in a cluster (150-300 deaths annually)
- Victims appear to be influenced by earlier deaths but do not have to know previous victims
- Mass vs Point clusters

Suicide Cluster: Contributing Factors

- 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

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
- Robin Williams, Kate Spade, Anthony Bourdain
- Kurt Cobain, Chris Cornell & Chester Bennington
- 13 Reasons Why!
- Magnified exponentially by social media
- COVID-19 & a vulnerable population

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
- CDC Epi Aid studies have found 75% of point cluster victims to have had a major psychiatric disorder*

CDC Epi-Aid investigations

.Risk factors:

- Males
- Untreated or undertreated depression/mental health issues
- History of suicidal ideation/attempt
- History of non-suicidal self-injury
- Alcohol & substance abuse

CDC Epi-Aid investigations

Risk factors:

- 92% had a recent crisis
- Relationship problems, intimate partner violence
- Sleep deprivation
- Sexual orientation
- Academic pressures/crisis/stress

Suicide Postvention in Schools

"Research suggests that coordinated postvention/crisis intervention efforts following a death by suicide *may* ***minimize*** *and* ***contain*** *the effects of* ***suicide contagion*** *and* ***restore a safe, healthy learning environment****."*

Madelyn Gould (2013)

Suicide Postvention in Schools

After a Suicide: Toolkit for Schools

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

Practical Suggestions

- A student suicide creates a ripple effect.
- 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 high school/secondary students.

Practical Suggestions

- Intervene with students in small groups, never in assemblies
- Share facts; dispel rumors; allow students to ventilate then validate the wide range of emotional reactions.
- Identify school & community supports and resources
- Have a memorial policy in place
- Review student role in suicide prevention

Suicide Postvention Checklist

- Verify that a death has occurred and confirm cause
- Mobilize the Crisis Response Team
- Assess the suicide's impact on the school and estimate the level of postvention response
- Notify other involved school personnel
- Contact the family of the suicide victim
- Determine what information to share about the death
- Determine how to share information about the death

Suicide Postvention Checklist

- Identify students significantly affected by the suicide and initiate a referral mechanism
- Conduct a faculty planning session
- Initiate crisis intervention services
- Conduct daily planning sessions
- Memorials
- Social media
- Prevention messaging
- Debrief the postvention response

PREPaRE: Top 10 Lessons Learned

1. Most people get better on their own, when left to their own natural support systems.
2. Interventions should be voluntary.
3. How the adults respond has significant impact on traumatization.
4. Triage is critical and must include not only those physically and emotionally proximal, but vulnerable youth as well.
5. People tolerate natural disasters better than sudden, violent events that result in fatalities.

PREPaRE: Top 10 Lessons Learned

6. Information helps: Psychological Education
7. Students need wide range of crisis reactions normalized: S&S/V&V/P&P
8. Always view crisis through two lenses: developmental & cultural
9. Violent images harm kids
10. CARE FOR THE CAREGIVER IS ESSENTIAL.

Postvention for Private Practice 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 Private Practice 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

Postvention and Telehealth

- Assess the effectiveness of postvention services delivered via telehealth
  - Are all members involved able to access services?
  - Would in person services be a better means of supporting those involved?
  - If telehealth would not be effective, you should refer to a local mental health professional and support the transition

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 Client 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 Client Suicide on the Practitioner

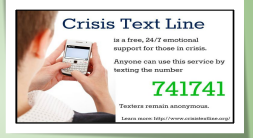
- Clinicians need to prepare for suicidal clients by having
  - –Malpractice insurance
  - –A plan to deal with suicidal clients
  - –Self-Care Plans
    - –American Association for Suicidology (https://suicidology.org/)
      - •Clinician Survivor Task Force

SPORT

HOTLINE RESOURCES

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

988 SUICIDE & CRISIS LIFELINE



SPORT

Local Resources

American Foundation for Suicide Prevention

SPRC

teen line
a program of Didi Hirsch Mental Health Services

KNOW THE SIGNS

SEIZE THE AWKWARD

SPORT

HOTLINE RESOURCES

THE TREVOR PROJECT
saving young lives

NAMI
National Alliance on Mental Illness
Find Help. Find Hope.

SAMHSA
Substance Abuse and Mental Health Services Administration