



# CALIFORNIA ASSOCIATION OF SCHOOL PSYCHOLOGISTS RESOURCE PAPER

## SUICIDE PREVENTION

*If you are currently dealing with a suicidal child or adolescent, consider contacting the National Suicide Prevention Lifeline at 1-800-273-TALK or the Crisis Text Line, which can be accessed by texting "HOME" to 741741. If you think a student is at immediate risk of suicide, call 911 for immediate assistance.*

According to the Centers for Disease Control and Prevention (CDC, 2019), suicide among school age youth 10 years of age and older ranks as a leading cause of death. While student suicide is statistically rare (4.03 deaths for every 100,000 5-to-18-year-olds in the U.S.), suicidal thinking and non-fatal suicidal behavior is relatively common. Specifically, Kann et al. (2018) estimated that in 2017, among 9<sup>th</sup> to 12<sup>th</sup> grade U.S. students, 17% seriously considered suicide, 14% made a suicide plan, 7% attempted suicide, and just over 2% made a suicide attempt severe enough to require treatment from a doctor or nurse. Further, between 2007 and 2015 emergency room visits for suicidal ideation and behaviors more than doubled (Burstein, Agostino, & Greenfield, 2019).

Given these data and consistent with AB 2246 (CA. 2016), which requires school districts (serving students in grades 8 to 12) to have suicide prevention policies, the California Association of School Psychologists advocates for a comprehensive approach to school suicide prevention. Specifically, CASP asserts that California schools, supported by their school psychologists and other school-employed mental health professionals, should first engage in activities designed to prevent suicidal thinking. However, recognizing that even the best of primary prevention efforts will not prevent all students from becoming suicidal, schools must also be prepared to engage in immediate suicide intervention, the goal of which is to promptly identify suicidal thinking and to prevent suicidal behavior. Finally, although suicide deaths are rare, schools must have protocols and procedures in place for responding to the aftermath of a suicide death, the dual goals of which are to help students cope with a traumatic loss and to prevent additional suicidal behavior.

### **Primary Suicide Prevention**

The primary prevention of suicide begins at the individual level, followed by relationship, community, and societal levels (Stone et al., 2017). At the individual level suicide prevention involves identifying and addressing health challenges, monitoring students with a history of self-injury, and supporting those with a history of violence and victimization. Health problems, especially certain mental illnesses, are associated with suicide (Brådvik, 2018). Thus, efforts to promote mental wellness and treat those with illnesses such as depression (especially when it is associated with feelings of hopelessness) and universal screenings for mental illness are essential (Doll & Cummings, 2008). A prior history of suicide attempts is a powerful predictor of future suicide (Borowsky, Ireland, & Resnick, 2001), and non-suicidal self-injury is a risk factor for suicidal thinking and increases risk for a suicidal behavior (Taliaferro & Muehlenkamp, 2014). Thus, schools should monitor these students. Finally, a history of violence and victimization (e.g., having been bullied or being a bully, or having PTSD) increases the risk for suicide (Borowsky et al., 2001; Yen, Liu, Yang, & Hu, 2015), and again, special attention should

be directed to these students. Obviously, this level of suicide prevention requires adequate numbers of school employed mental health professionals.

At the relationship level suicide prevention involves facilitating connectedness to others, working to minimize relational conflict and violence, and monitoring those who have lost a family member or loved one to suicide (Stone et al., 2017). Isolation or aloneness is a powerful suicide risk factor (Calati et al., 2019), and interpersonal conflict is the most frequent precipitating event for suicide (Burón et al., 2016). Further, the quality of the student's relationship with their primary caregivers predicts suicidal behavior, with connectedness to a parent being a protective factor (du Roscoät et al., 2016). Thus, efforts to promote positive interpersonal relationships and parent-child connectedness are important prevention strategies. In addition, a history of a family member or loved one having died by suicide is a suicide risk factor (Pitman, Osborn, Rantell, & King, 2016). Monitoring those who have suffered such losses and as indicated providing suicide postvention (to be discussed later) are also important suicide prevention strategies.

At the community level suicide prevention involves facilitating connectedness to the broader community and ensuring access to health care providers and treatment (Stone et al., 2017). As has already been mentioned, isolation and aloneness are suicide risk factors, making connectedness to prosocial institutions an important suicide prevention strategy. In addition, to the extent possible the school should promote access to health care, and in particular mental health care. Here it is relevant to note that when services are provided at school treatment compliance increases 21 times (Juszczak, Melinkovich, & Kaplan, 2003). Finally, gatekeeper trainings such as the *Applied Suicide Intervention Skills Program* (<https://www.livingworks.net/programs/asist/>; Shannonhouse, Lin, Shaw, & Porter, 2017); *Question, Persuade, Refer* (<https://qprinstitute.com>; Litteken & Sale, 2017), and *Signs of Suicide* (<http://mentalhealthscreening.org/programs/youth>; Aseltine & DeMartino, 2004) can be important to the identification of suicidal youth and the prevention of suicidal behavior.

Finally, at the societal level suicide prevention involves reducing access to the means of suicide, working toward safe media portrayals of suicide, and reducing the stigma associated with mental illness and treatment (Stone et al., 2017). Relevant to the need to restrict access to lethal suicide means, it has been reported that when a person uses firearms in an attempt to die by suicide, death is the result 85% of the time. This stands in marked contrast to the 3% of fatalities that follow a drug overdose (Drexler, 2017). The American Foundation for Suicide Prevention offers guidance regarding safe media portrayals of suicide (<https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf>; <https://afsp.org/about-suicide/for-journalists/>) and Reporting on Suicide.org (<http://reportingonsuicide.org/recommendations/>). The National Association of School Psychologists (2017) provides an example of how a professional association can advocate for safe media suicide messaging. Finally, the assertive and universal promotion of mental wellness can be a powerful way to reduce the stigma of mental illness. For most school psychologists and other school employed mental health professionals, this level of prevention can include supporting the advocacy efforts of professional associations such as the California Association of School Psychologists. In addition, being an active participant in the democratic process and supporting these societal level efforts will help to prevent suicide deaths.

### **Suicide Intervention**

Schools must also support the timely identification of suicidal ideation and the ability to conduct suicide risk screenings. The ultimate goal of these activities is to keep suicidal thoughts from becoming suicidal behaviors. Hotlines, universal suicide risk screening, and development

of the school suicide intervention protocols are important to what can be considered secondary suicide prevention or suicide intervention. Hotlines include the resources mentioned at the beginning of this paper. Suicide risk screening tools include the Columbia Suicide Severity Rating Scale (Posner et al., 2011). A structure for school suicide intervention procedures can be found in the Screening for Mental Health and Suicide Prevention Resource Center's (2009) *Suicide Assessment Five-Step Evaluation and Triage* (SAFE-T). It is important to note that school resources are not always accessible (i.e., during non-school hours) and suicide is an around the clock concern (Brock & Reeves, 2018). Consequently, any school-based suicide intervention protocol must necessarily involve non-school resources (e.g., primary caregivers, community mental health agencies) that are accessible around the clock.

### **Suicide Postvention**

Finally, although suicide deaths are rare, schools must have procedures in place for responding to the aftermath of a suicide death, the goals of which are to help students cope with a traumatic loss and to prevent additional suicidal behaviors. Having a relative, friend, or other close associate die by suicide is highly traumatic (Mitchell & Terhorst, 2017) and is also associated with complicated grief reactions (Tal et al., 2017). These suicide survivors often receive less social support than do persons who have experience other types of loss (Cvinar, 2006). In addition, especially among adolescents and young adults, one suicide can lead to another (a phenomena known as suicide contagion; Yildiz, Orak, Walker, & Solakoglu, 2018). Given these factors, the response to a suicide must identify those persons significantly affected by the death, assertively provide them mental health crisis intervention assistance, and strive to minimize the risk of contagion. *After a Suicide: A Toolkit for Schools* (American Foundation for Suicide Prevention et al., 2018) is an important resource for what can be considered tertiary suicide prevention or suicide postvention.

### **Concluding Comments**

Comprehensive suicide prevention policies in California's eighth to twelfth grade public schools are mandated by AB2246. With this resource paper the California Association of School Psychologists has strived to provide basic guidance on this important topic. For additional information and resources, readers are encouraged to contact CASP's Crisis Intervention Specialist as well as the National Association of School Psychologists School Safety and Crisis Response Committee.

### **References and Resources**

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Written by Dr. Stephen E. Brock on behalf of the California Association of School Psychologists. May 2019.