School Suicide Prevention

Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento
brock@csus.edu
http://www.csus.edu/indiv/b/brocks/
916-278-5919

Santa Clara County Office of Education

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Workshop Outline

1. Introduction
   a) Suicide Statistics
2. Levels of Suicide Prevention
3. Primary Prevention
4. Secondary Prevention
5. Tertiary Prevention

National Youth Suicide Statistics

- Fourth leading cause of death among 10-14 year olds in 2006 (*N* = 216).*
- Third leading cause of death among 15 to 24 year olds in 2007 (*N* = 4030).**
- 2007 YRBS***
  - 14.5% of high school students reported having seriously considered suicide in the prior 12 months.
  - 11.3% reported having made a suicide plan in the prior 12 months.
  - 6.9% of high school students reported having attempted suicide.
  - 2.0% indicated that the attempt required medical attention.
- 100 to 200 attempts for each completed youth suicide (vs. 4:1 among the elderly).****

**National Center for Injury Prevention and Control*, 2009, http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
***National Vital Statistics Reports*, 2009, www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_01.pdf
****Youth Risk Behavior Surveillance*, 2008, www.cdc.gov/mmwr/PDF/ss/ss5704.pdf
*****Suicide Data Page*, 2009, www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-142.pd

Other Suicide Facts: All Age Groups

(2006 Final National Data)

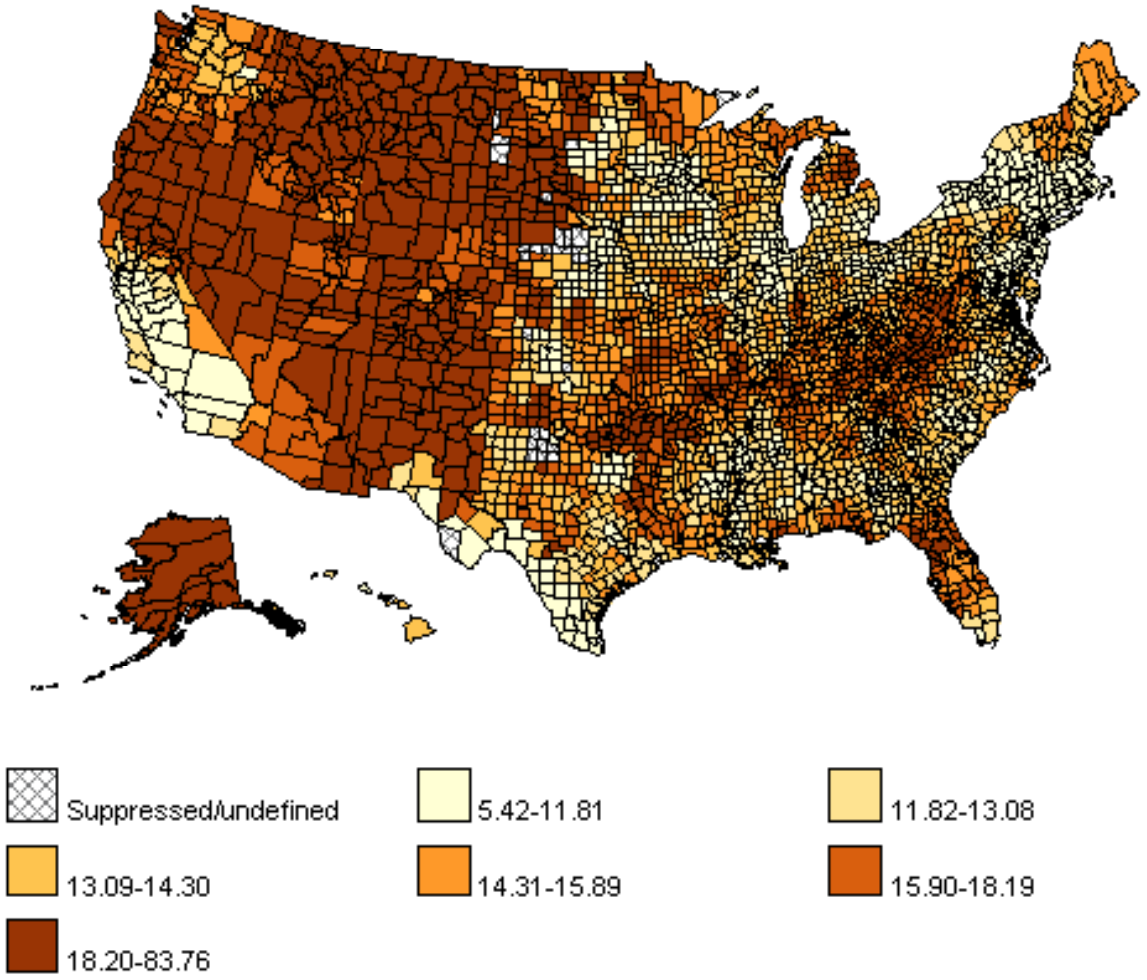
- Total number of deaths = 33,300[1]
  - 11th leading cause of death[2]
- More men die by suicide[1]
  - Gender ratio 3.8 male suicides (*N* = 26,308) for each females suicide (*N* = 6,992)
- Suicide Rate = 11.1/100,000 (males, 17.8; females, 4.6)[1]
- 50.7% of suicides were by firearms. [1,3]
  - Suicide by firearms rate = 5.60 (*N* = 16,883)
  - Suicide by firearms rate (15-19 yrs) = 3.30
  - Suicide by firearms rate (15-19 yrs male) = 5.87
  - Suicide by firearms rate (15-19 yrs female) = 0.60
- Highest suicide rate is among white men over 85 (43.44/100,000[3] vs 7.32/100,000 among 15-19 year olds[3]).
  - However the 6th highest rate is among American Indian/Alaskan Native 15-19 year old males[3].

[1] *Suicide Data Page*, 2009, www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-142.pdf

[2] *National Vital Statistics Reports*, 2009, www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_01.pdf

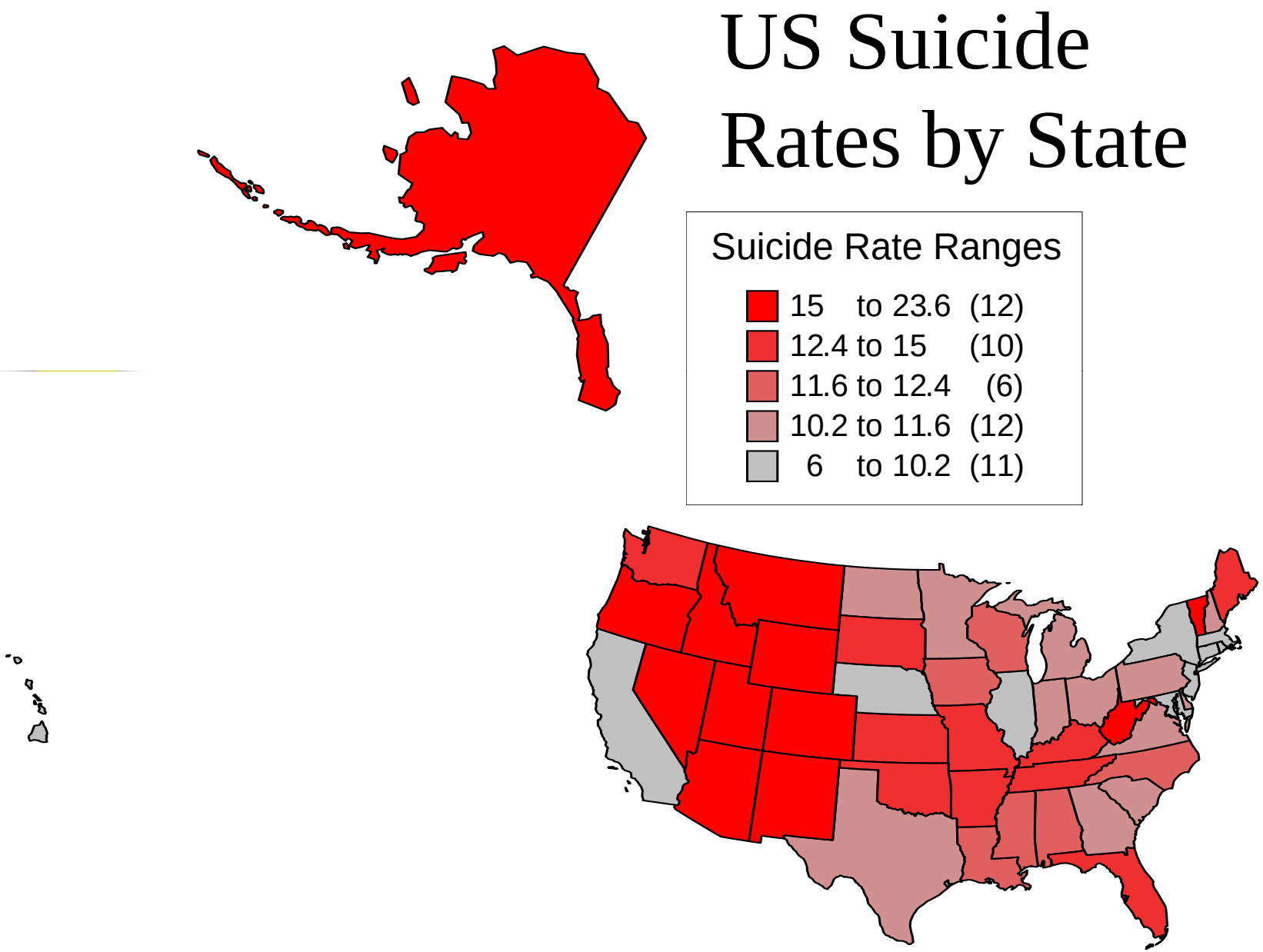
[3] *National Center for Injury Prevention and Control* (2009), http://webappa.cdc.gov/sasweb/ncipc/mortrate10_sy.html

Suicide Rates by County



Source: http://www.cdc.gov/violenceprevention/suicide/statistics/suicide_map.html

US Suicide Rates by State

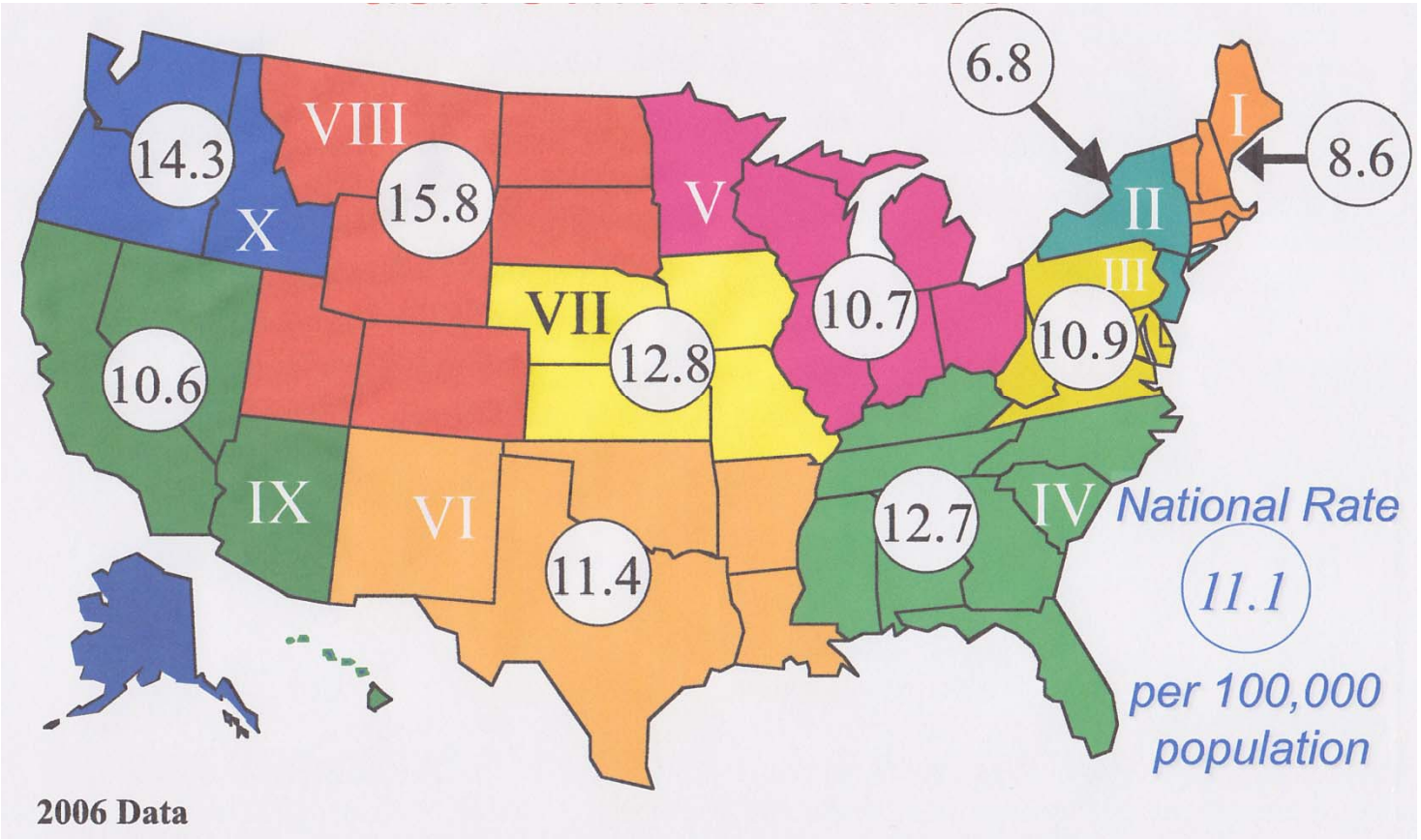


Suicide Rates by State (2006 Final Data)

Rank	State (2005 rank)	#	Rate
1	Wyoming (4T)	116	22.5
2	Alaska (3)	135	20.1
3	Montana (1)	189	20.0
4	Nevada (2)	486	19.5
5	New Mexico (4T)	352	18.0
6	South Dakota (9)	125	16.0
7	Arizona (8)	979	15.9
8	Oregon (10)	579	15.6
9	Colorado (6)	730	15.4
10	Idaho (7)	222	15.2
National Total		**32,637**	**11.0**
43	California (42)	3,334	9.1

Source: McIntosh (2008)

Suicide Rates by Region

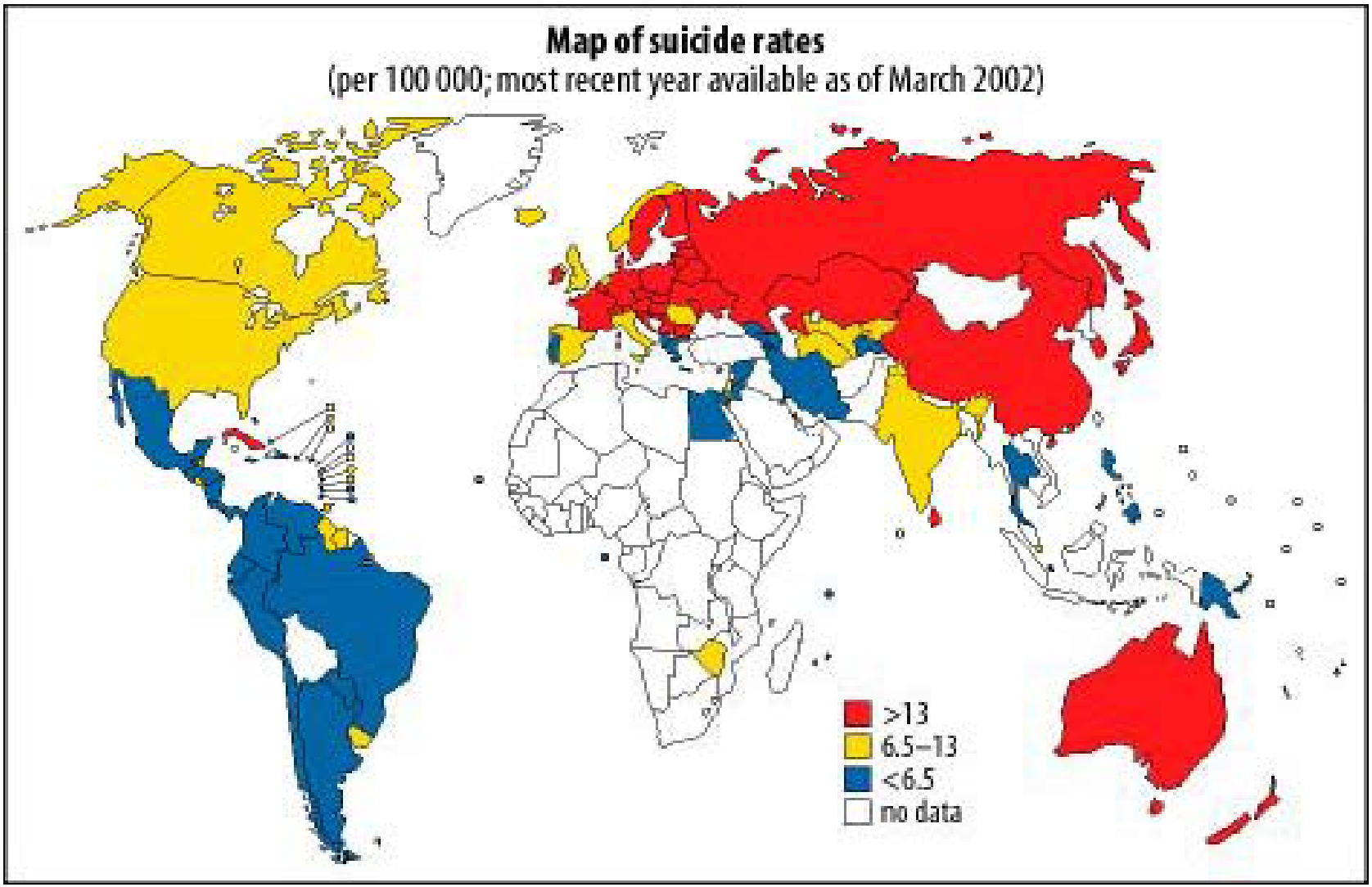


Source: www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-143.pdf

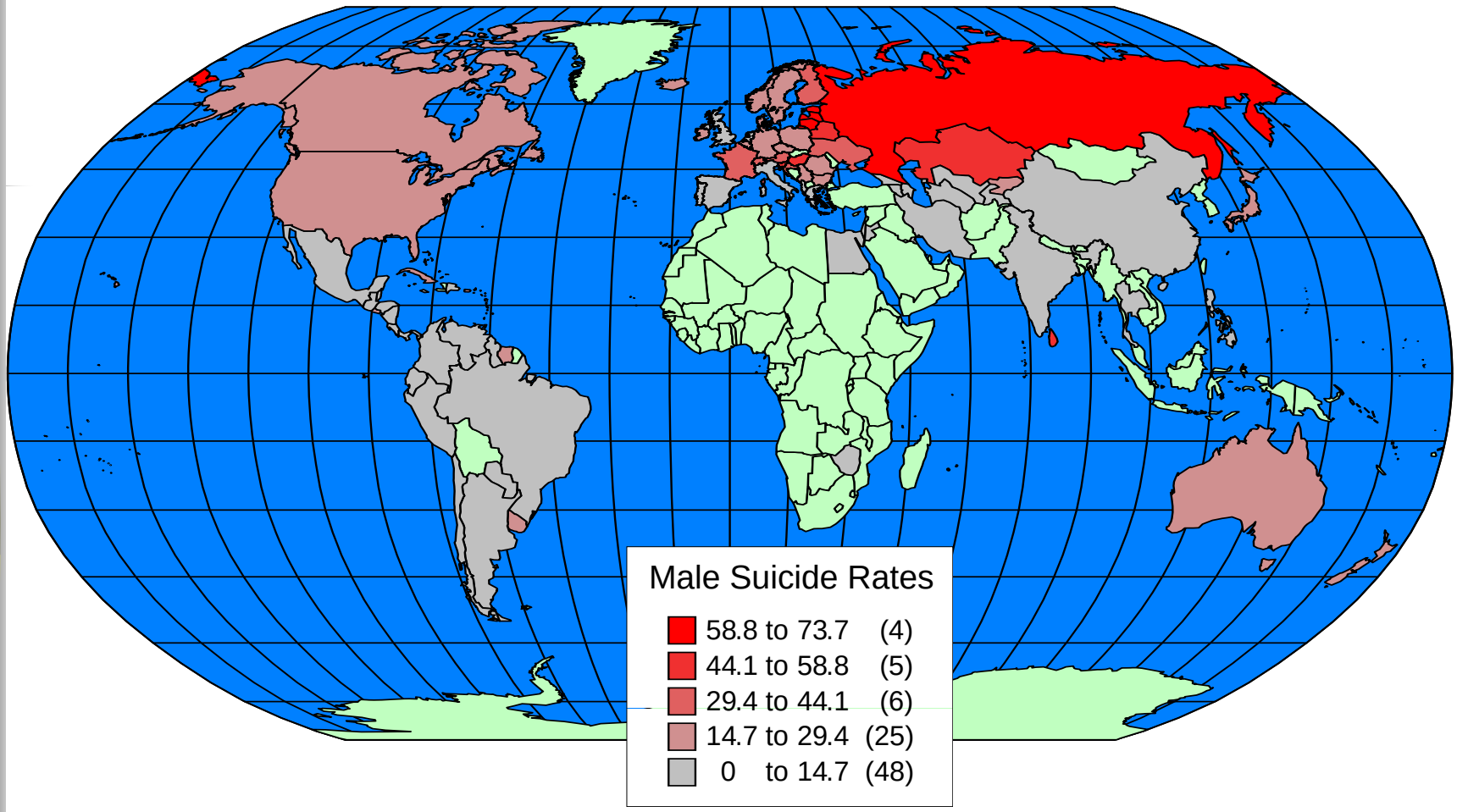
Suicide Rates by Country

- World Health Organization (most recent year available; as of 2009)
  - http://www.who.int/mental_health/prevention/suicide_rates/en/index.html

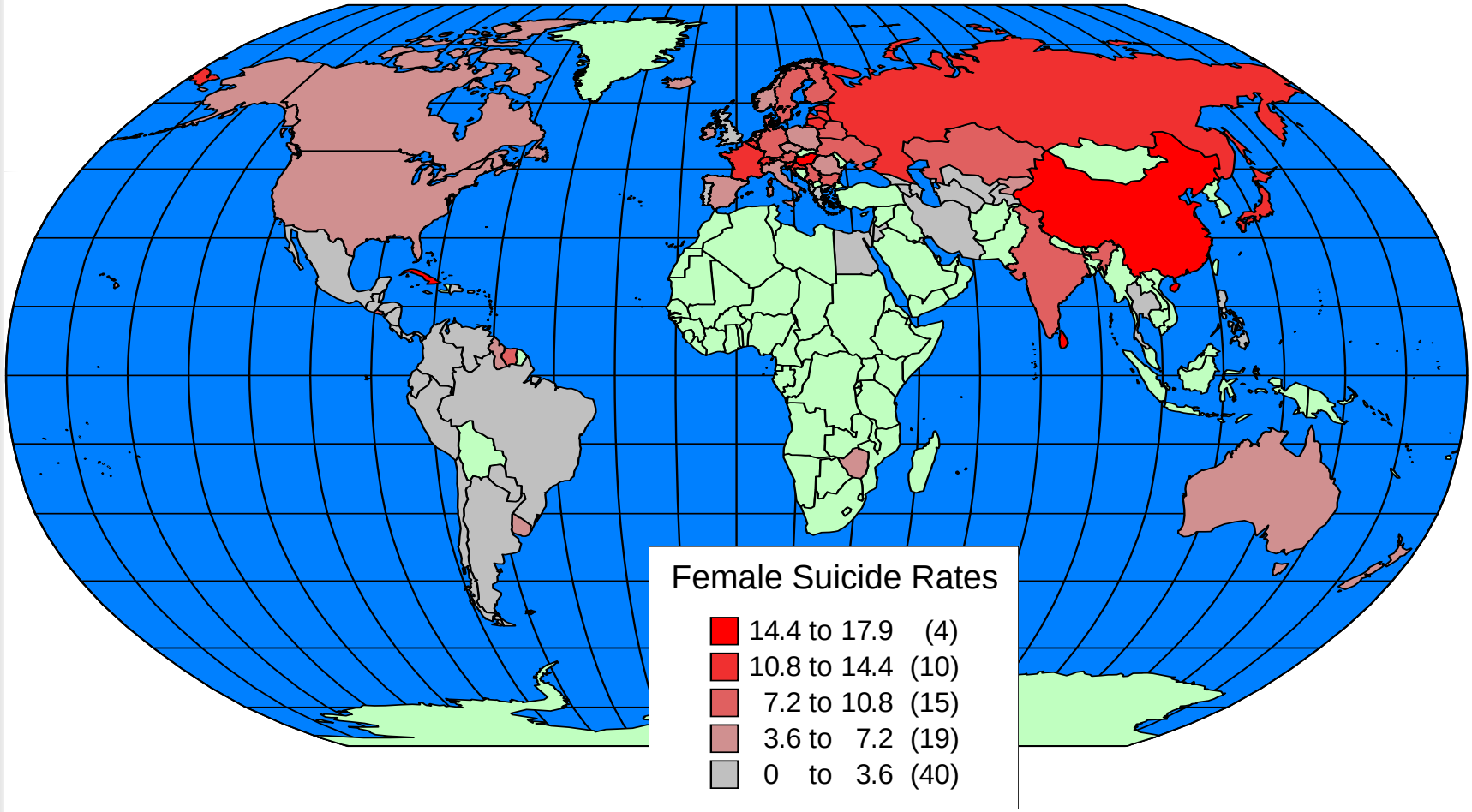
World Wide Suicide Rates



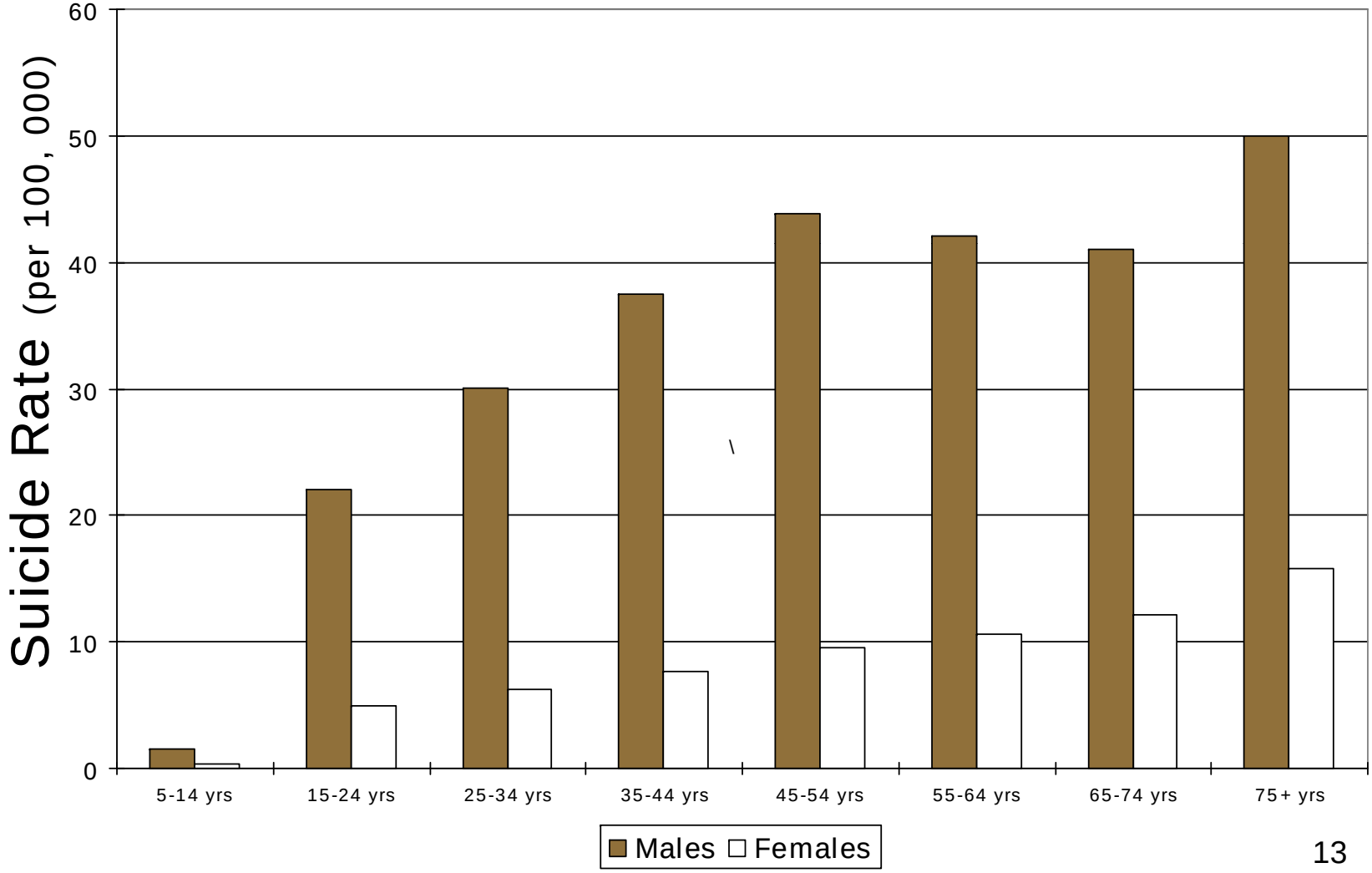
Male Suicide Rates by Country



Female Suicide Rates by Country



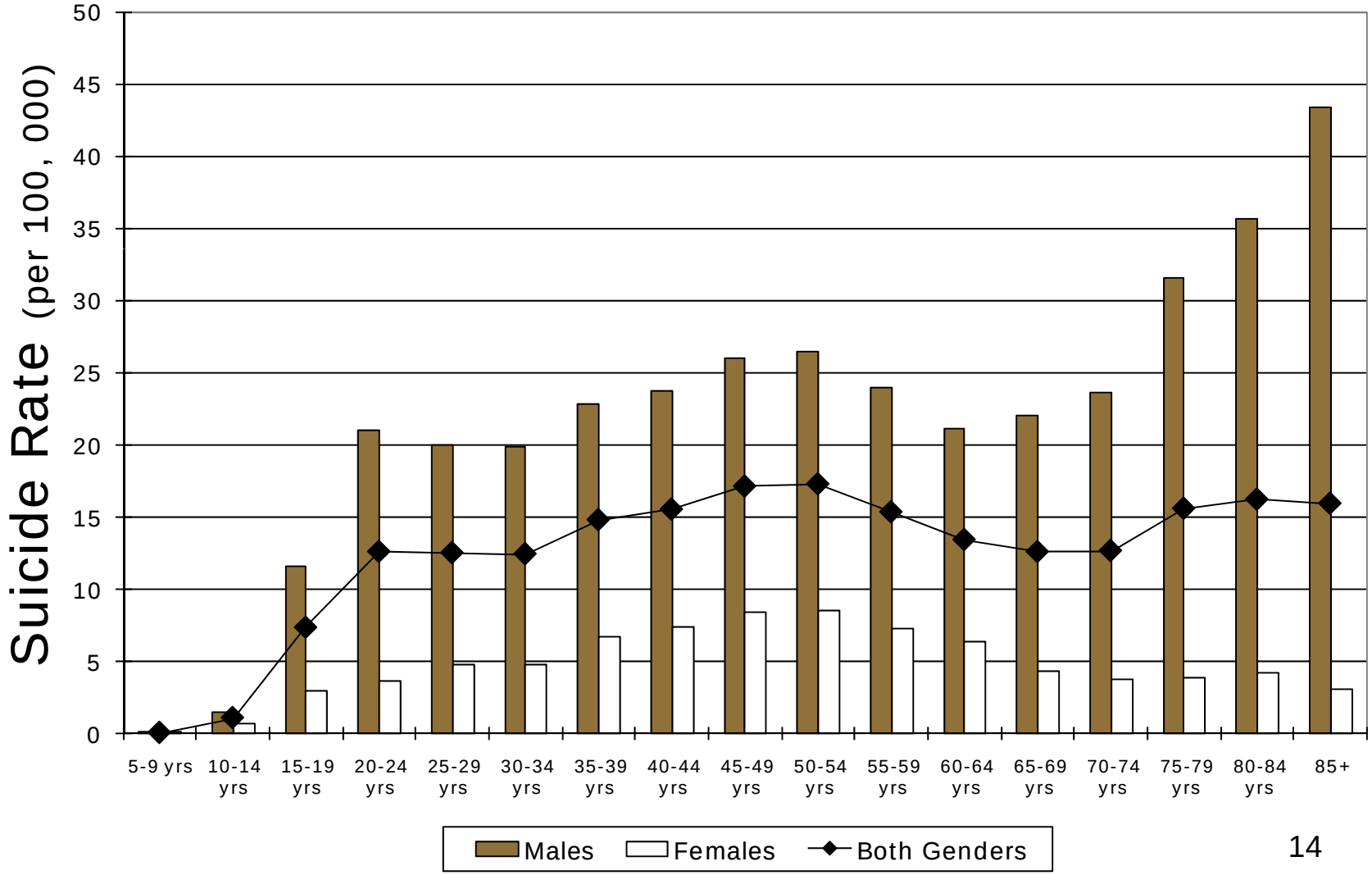
World Suicide Rates by Age & Gender (2000 data)



Source: WHO (2002)

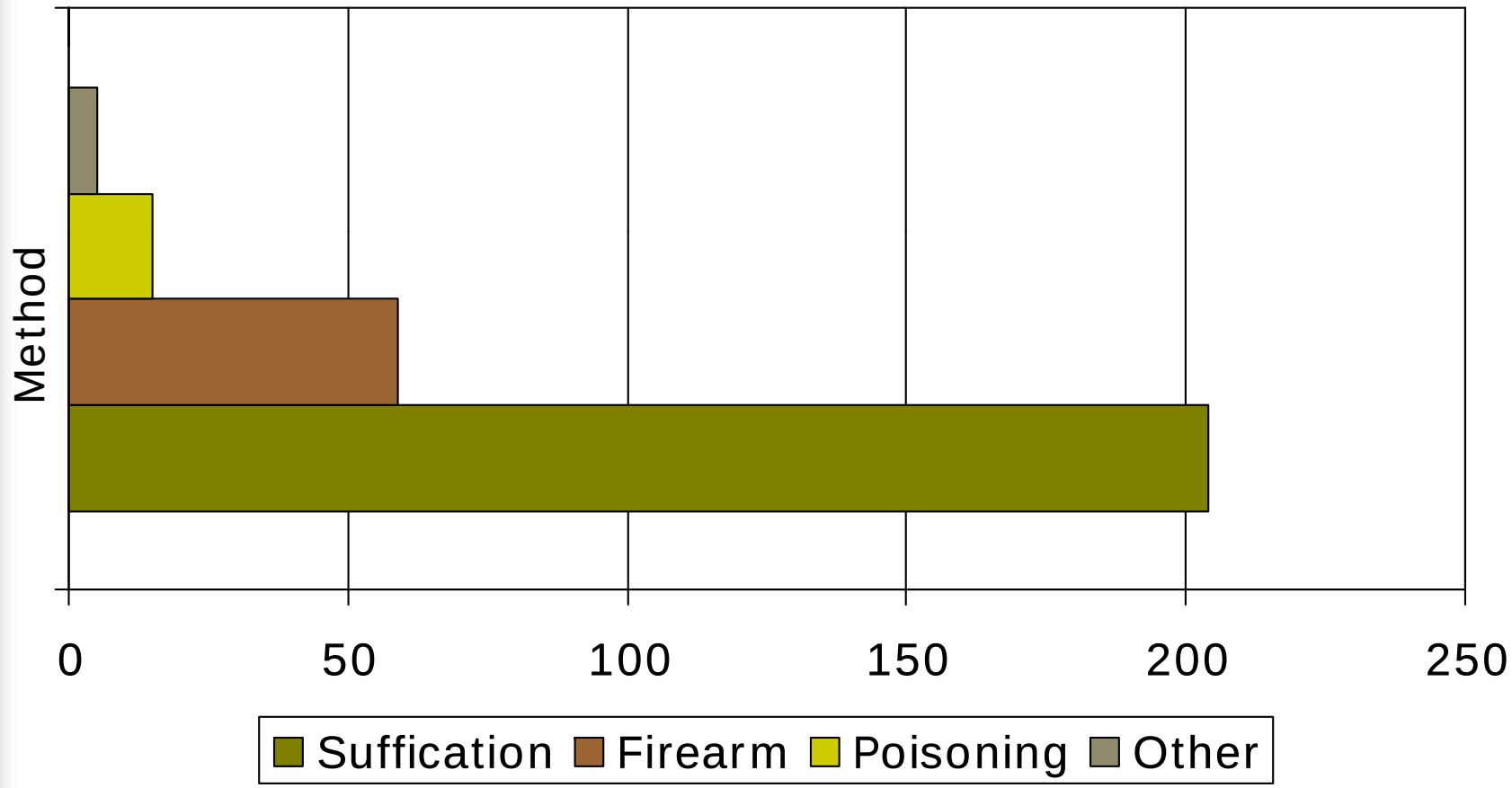
US Suicide Rates by Age & Gender

(2006 data)



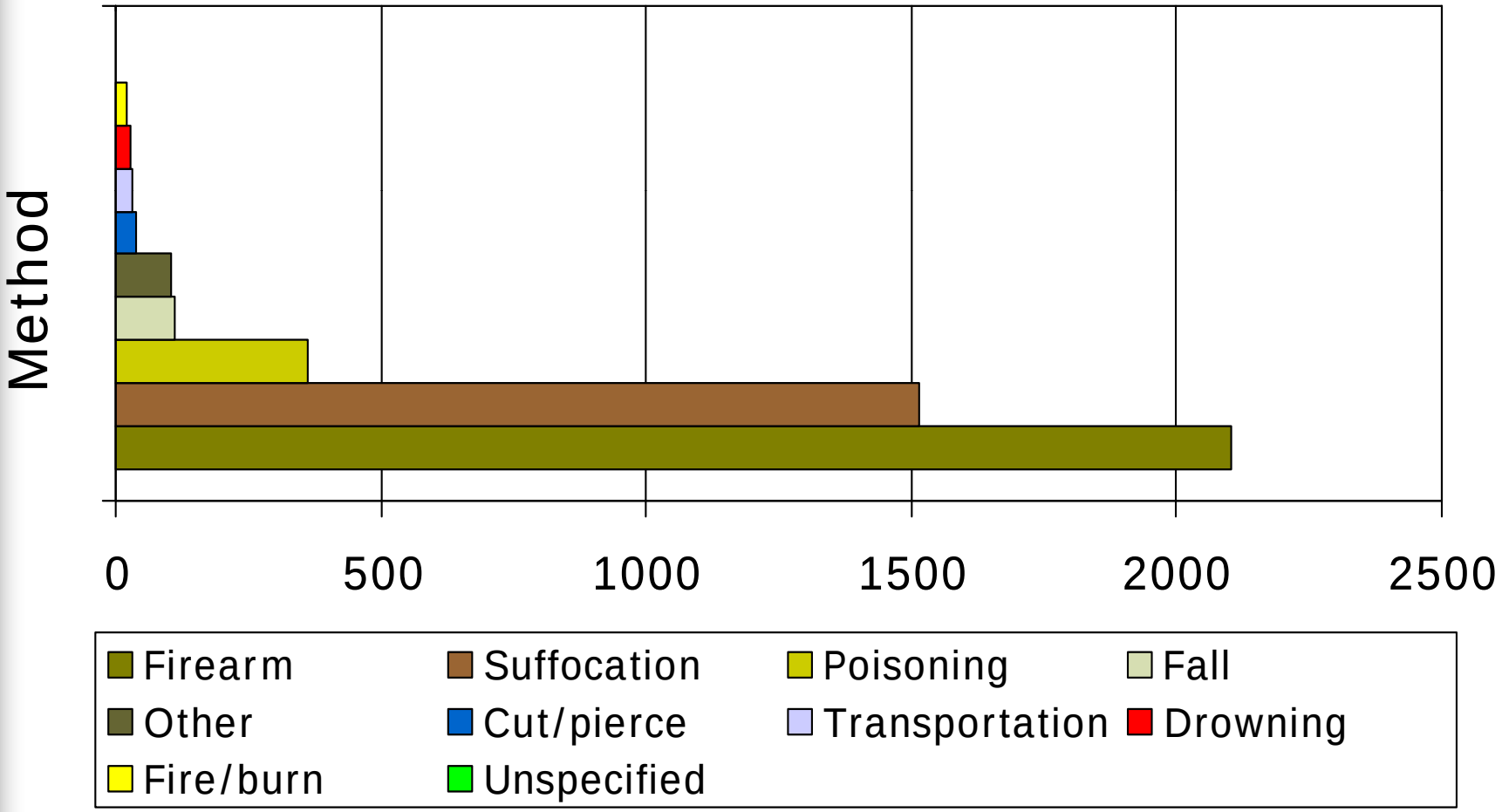
Source: NCIPC (2009)

Suicide Methods: 10-14 Year Olds (2004 data)



Source: NCIPC (2007)

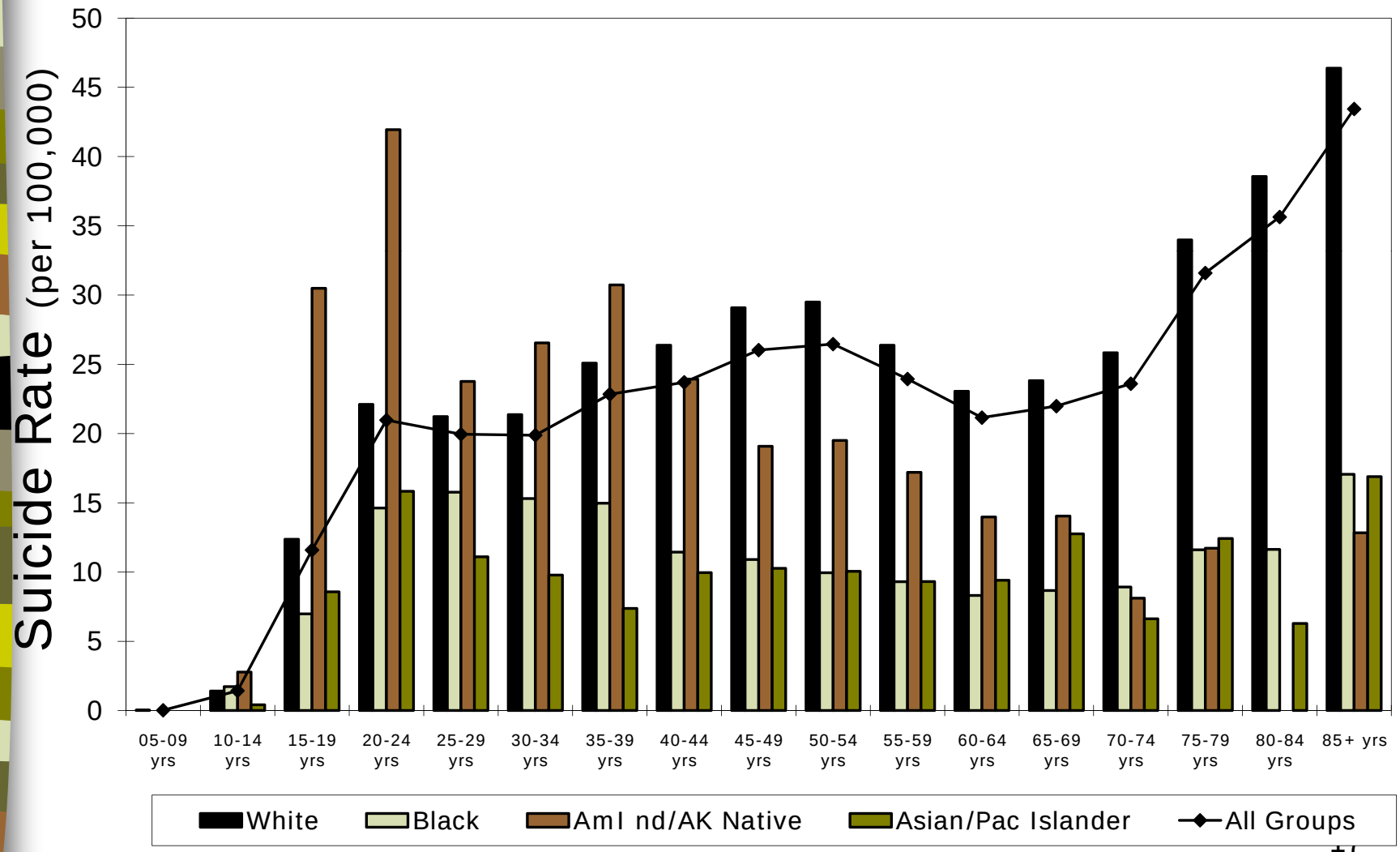
Suicide Methods: 15-24 Year Olds (2004 data)



Source: NCIPC (2007)

Male Suicide Rates by Age & Ethnicity

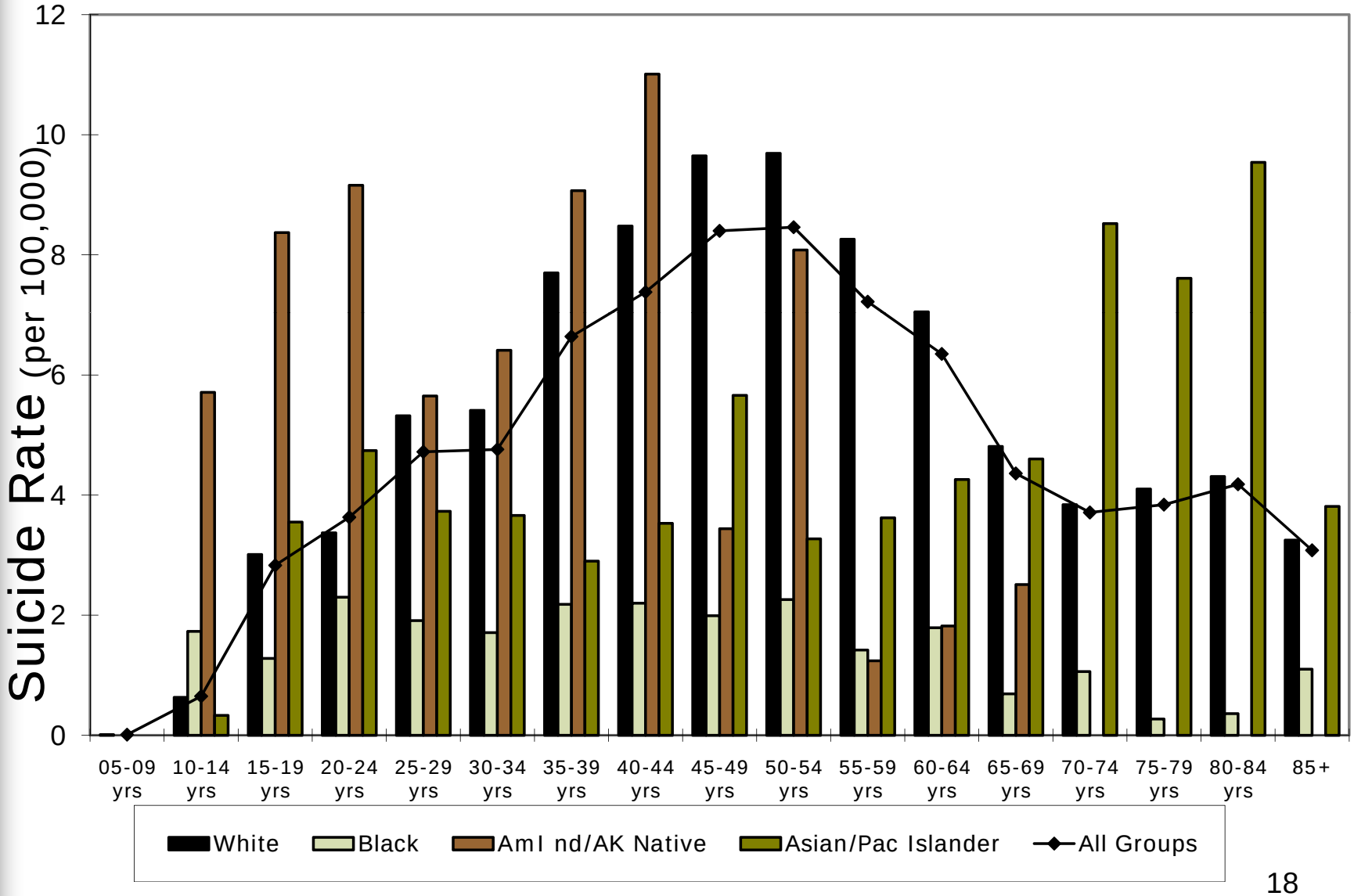
(2006 data)



Source: NCIPC (2009)

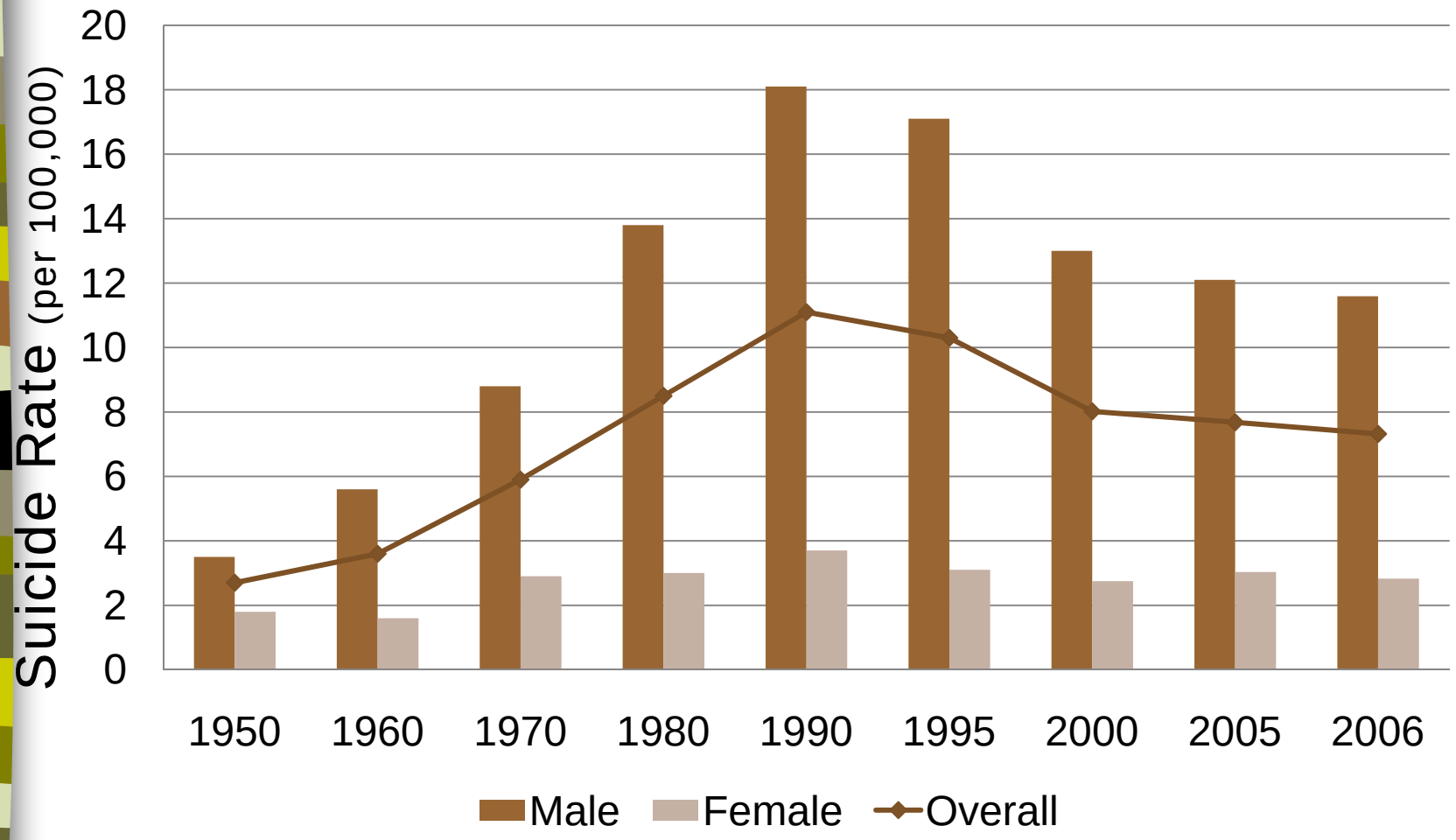
Female Suicide Rates by Age & Ethnicity

(2006 data)



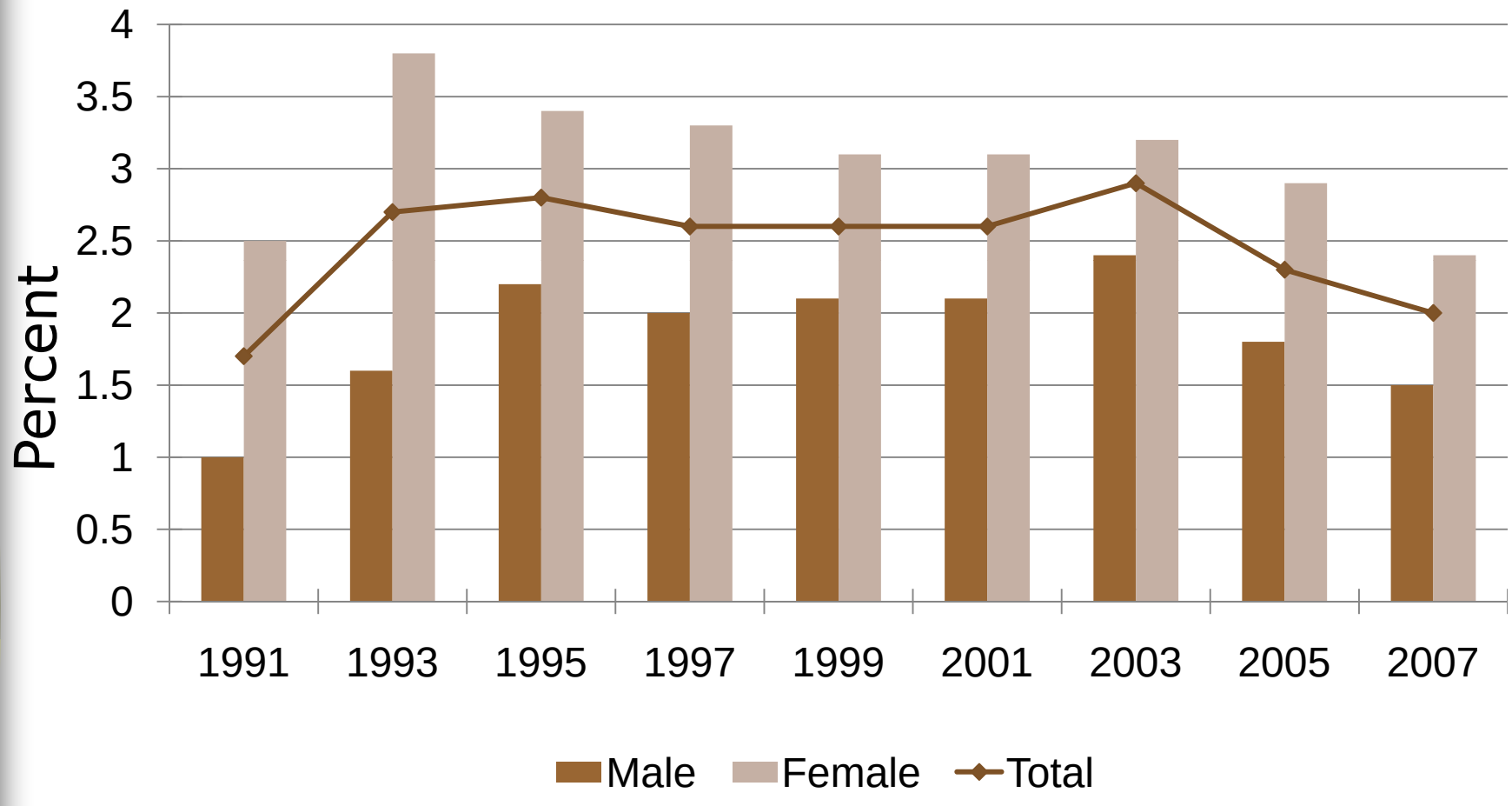
Source: NCIPC (2009)

15-19 Year Old Suicide Rates Over Time



Source: NCIPC (2009)

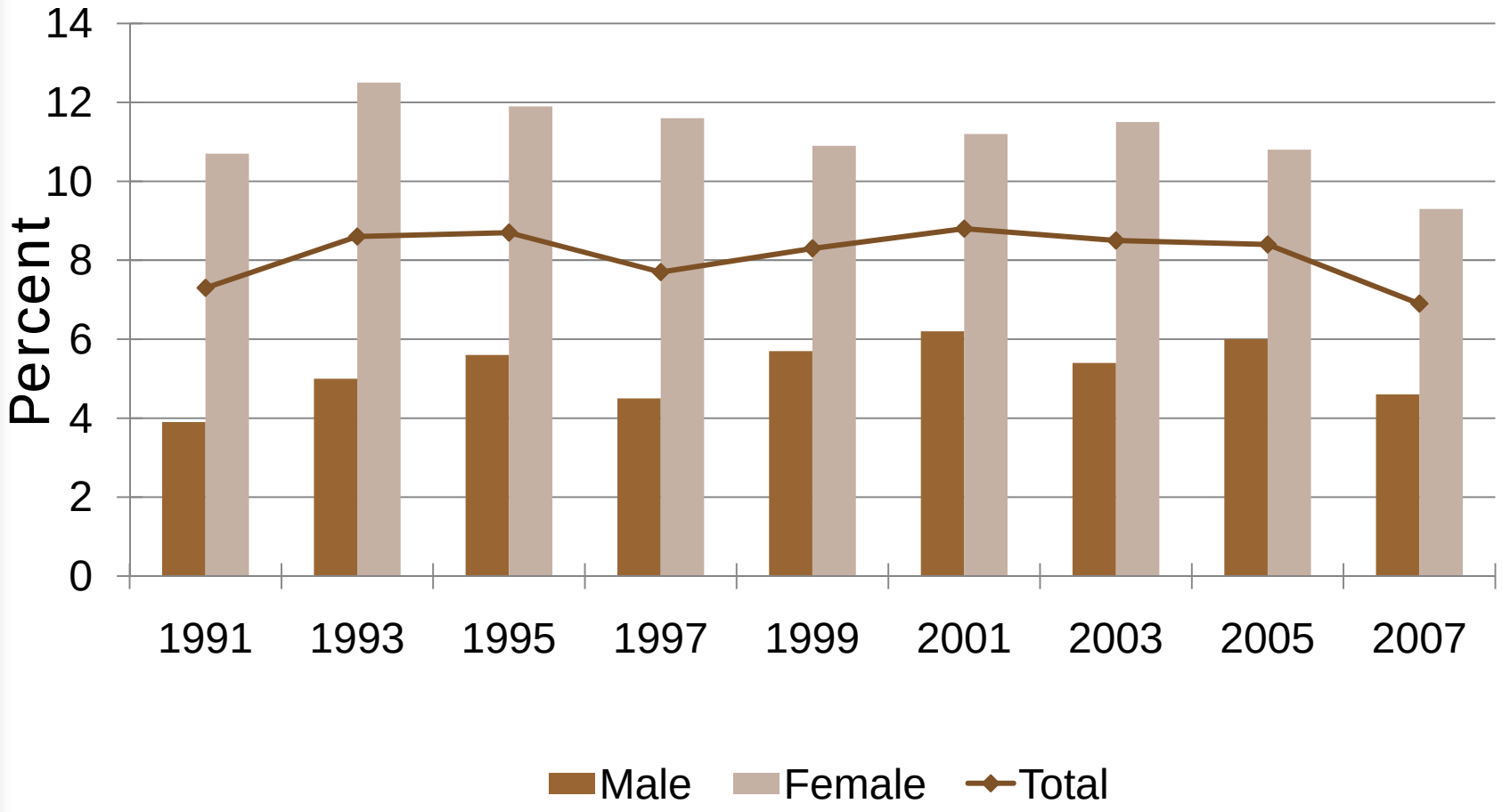
Percent[1] of 9-12 Grade Students with an Injurious Suicide[2] Attempt (YRBS)



[1]Response is for the 12 months preceding the survey
[2]A suicide attempt that required medical attention

Youth Risk Behavior Survey (2008)

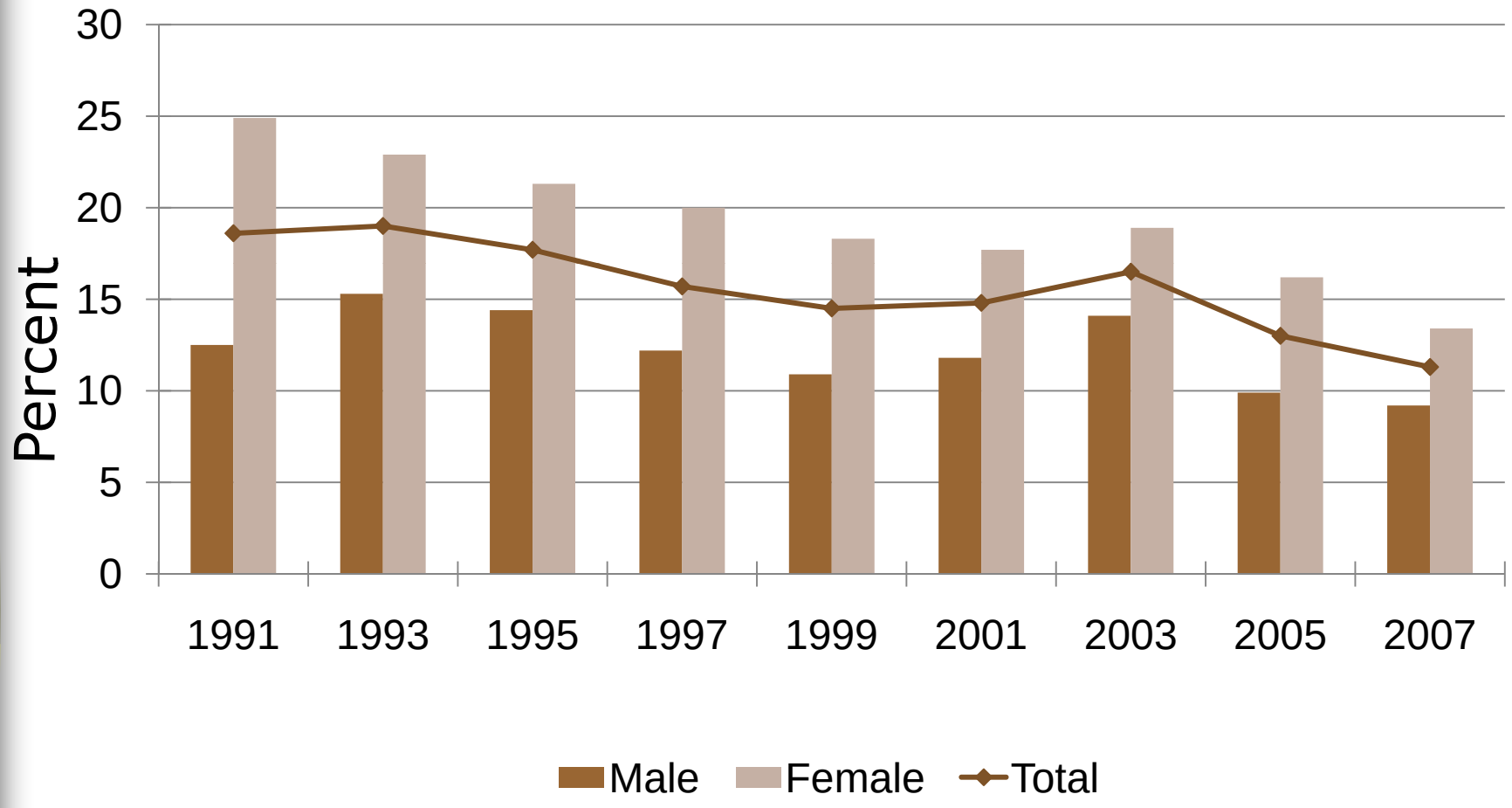
Percent[1] of 9-12 Grade Students with a Suicide Attempt[2] (YRBS)



[1]Response is for the 12 months preceding the survey
[2]A suicide attempt that did not necessarily require medical attention

Youth Risk Behavior Survey (2008)

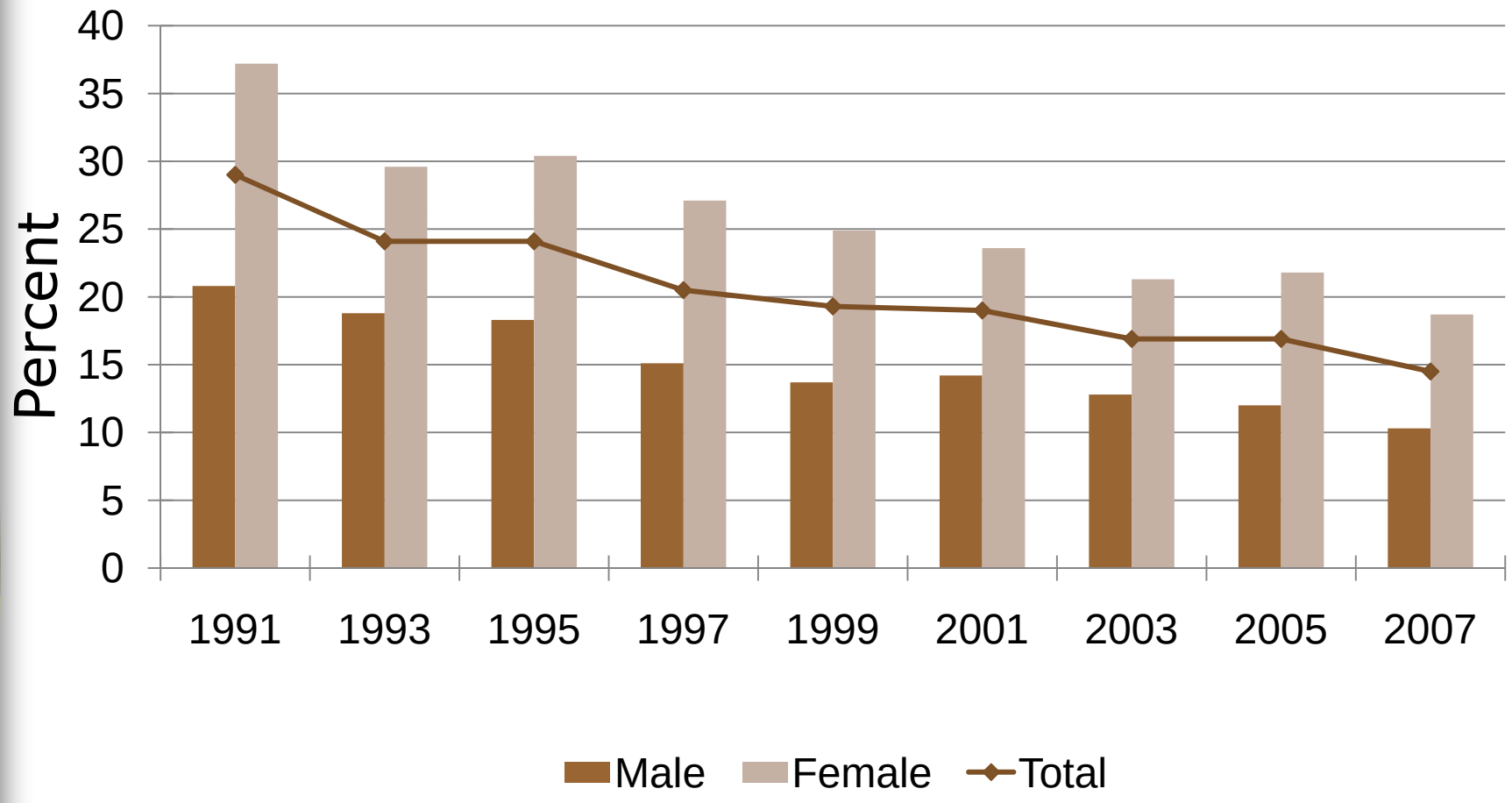
Percent[1] of 9-12 Grade Students with a Suicide Plan[2] (YRBS)



[1]Response is for the 12 months preceding the survey
[2]Thought about how they would attempt suicide

Youth Risk Behavior Survey (2008)

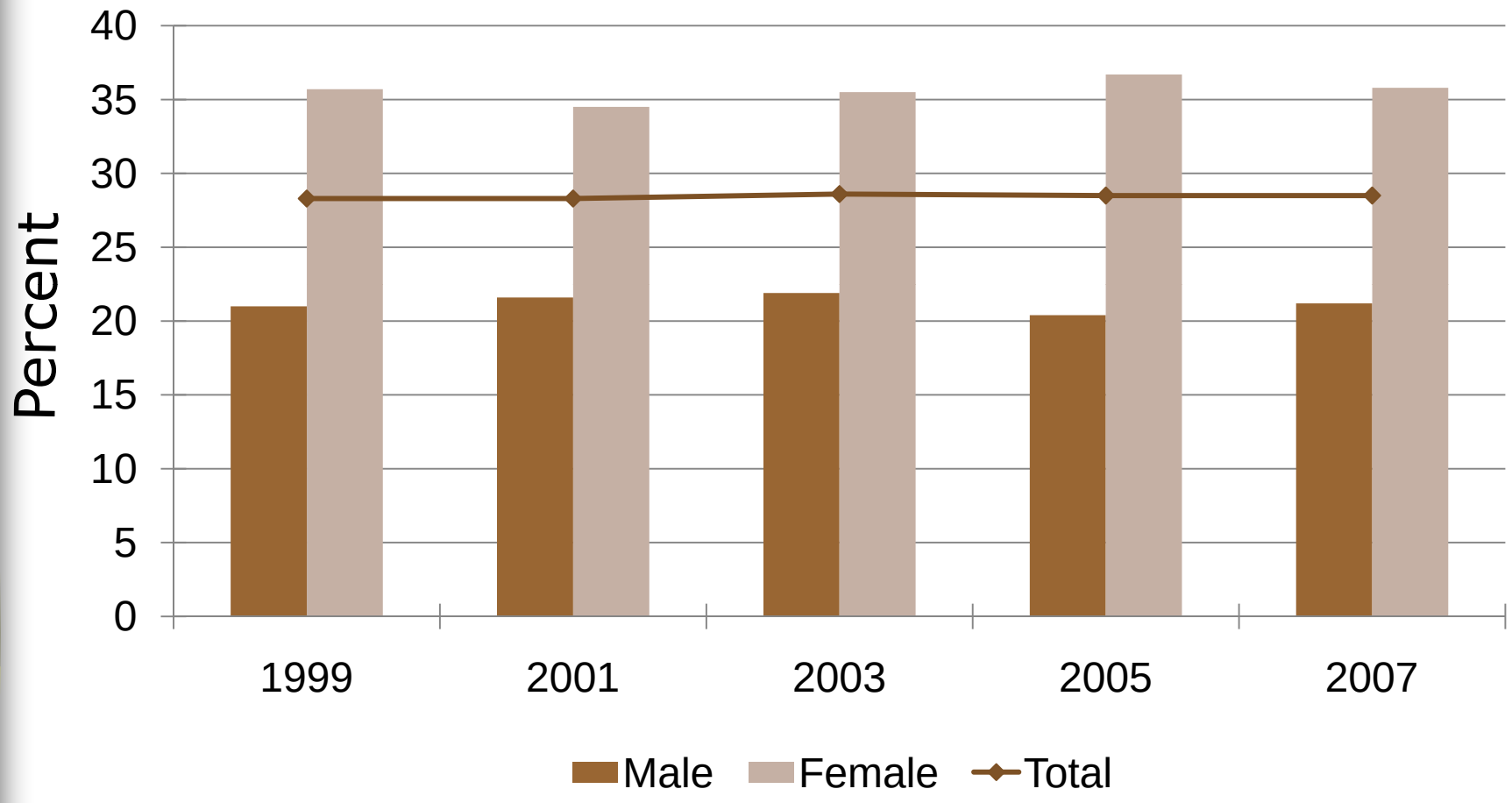
Percent[1] of 9-12 Grade Students who Seriously Considered Suicide (YRBS)



[1]Response is for the 12 months preceding the survey

Youth Risk Behavior Survey (2008)

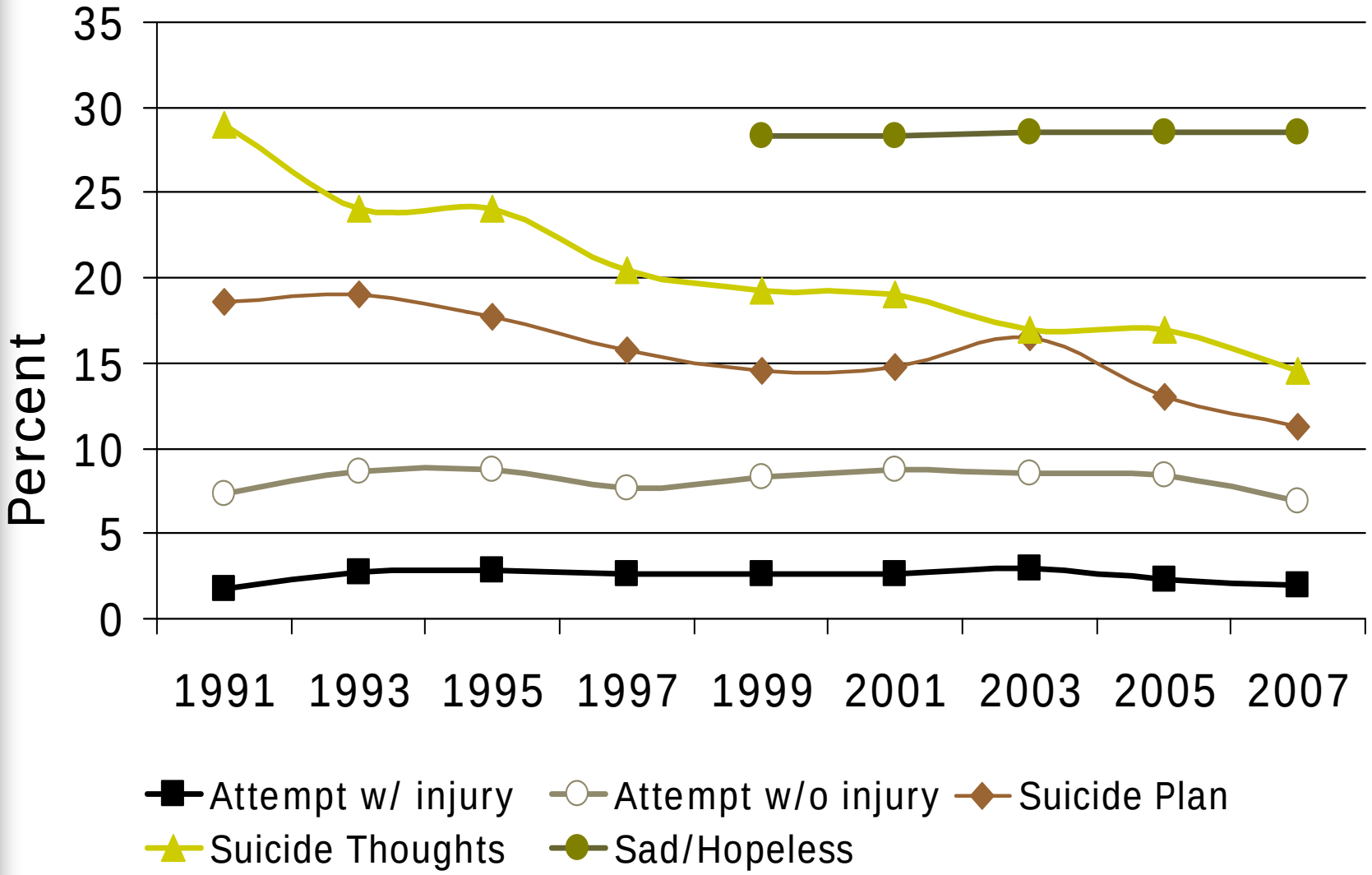
Percent[1] of 9-12 Grade Students who felt "sad or hopless"[2] (YRBS)



[1]Response is for the 12 months preceding the survey
[2]Almost every day for two weeks or more in a row and as a result stopped doing some usual activities

Youth Risk Behavior Survey (2008)

Percent[1] of 9-12 Grade Students who display suicide related behaviors[2] (YRBS)



[1]Response is for the 12 months preceding the survey
[2]Both genders

Youth Risk Behavior Survey (2008)

Workshop Outline

1. Introduction

2. Levels of Suicide Prevention
   a) Primary
   b) Secondary
   c) Tertiary

3. Primary Prevention

4. Secondary Prevention

5. Tertiary Prevention

Levels of Prevention

- Primary (Suicide Prevention)
  - District and/or School Policy
  - School Suicide Awareness Curricula
  - School-Wide Screening
  - Gatekeeper Training
  - Crisis Centers and Hotlines
  - Risk Factor Reduction
    - Restriction of Lethal Means
    - Media Education
    - Postvention
    - Skills Training

Levels of Prevention

- Secondary (Suicide Intervention)
  - Risk Factor Identification
  - General Staff Procedures
  - Risk Assessment and Referral Procedures

Levels of Prevention

- Tertiary (Suicide Postvention)
  - Definitions
  - Special Suicide Postvention Issues
  - Suicide Postvention Protocol

Workshop Outline

1. Introduction
2. Levels of Suicide Prevention
3. Primary Prevention
   a) Prevention Policy
   b) Curriculum
   c) Screening
   d) Gatekeeper training
   e) Hotlines
   f) Risk Factor Reduction
4. Secondary Prevention
5. Tertiary Prevention

Primary 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.

Primary Prevention:
Suicide Prevention Curricula

- Nationally, 15.9% of schools offer a classroom curriculum-based program.
- An almost universal component of these programs is the targeting of all adolescents regardless of their suicide risk.
- Programs on the average lasted almost 4 hours.

Primary Prevention:[1]

Suicide Prevention Curricula Goals

- Increased awareness of the problem of youth suicide.
- Facilitating both peer and self identification and referral.
- Improve coping skills.

NOTE:

Most curricula employ a stress model of suicide vs. a mental illness model

[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

Primary Prevention:[1]

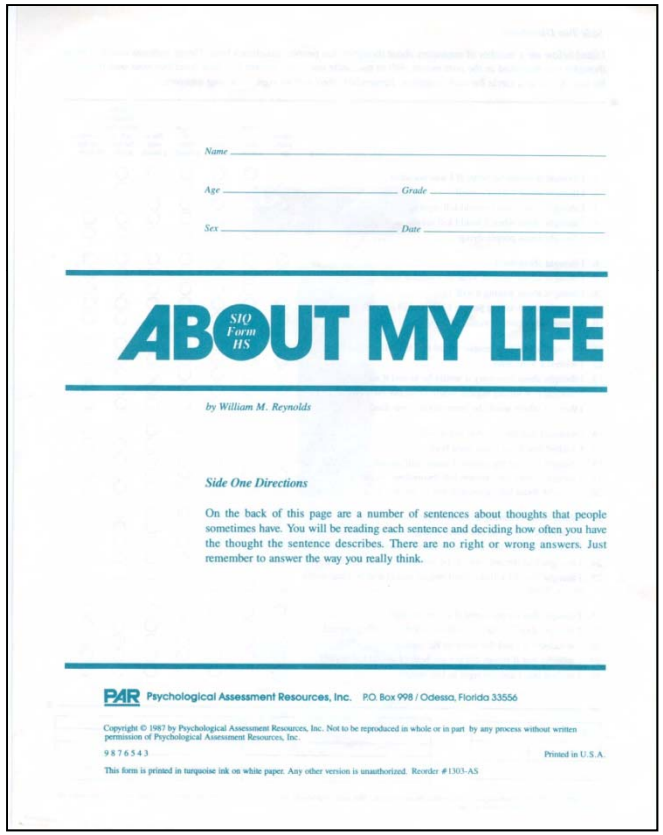
Suicide Prevention Curricula Criticisms

- Few Suicidal Students Are Reached.
- Uncertain Effects on the Suicidal Student.
  - Some research indicates slight positive effects (attitudes & knowledge).
  - Some research indicates no effect.
  - Some research indicates negative effects.
    - Reduced likelihood of referral
    - Negative reactions among at-risk students
      - Not recommending the program
      - Feeling more suicidal/anxious
- Tendency to Normalize Suicidal Behavior.

[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

Primary Prevention:[1]
Suicide Prevention Screening

- School-wide Screening
  - Very few false negatives
  - Many false positives
    - Requires second-stage evaluation
- Limitations
  - Risk waxes and wanes
  - Principals' view of acceptability
  - Requires effective referral procedures
- Possible Tool
  - Suicidal Ideation Questionnaire
  - Author: William Reynolds
  - Publisher: Psychological Assessment Resources


Name _____

Age _____ Grade _____

Sex _____ Date _____

ABOUT MY LIFE

SIQ Form HS

by William M. Reynolds

Side One Directions

On the back of this page are a number of sentences about thoughts that people sometimes have. You will be reading each sentence and deciding how often you have the thought the sentence describes. There are no right or wrong answers. Just remember to answer the way you really think.

PAR Psychological Assessment Resources, Inc. P.O. Box 998 / Odessa, Florida 33556

9 8 7 6 5 4 3 Printed in U.S.A.

This form is printed in turquoise ink on white paper. Any other version is unauthorized. Reorder #1303-AS

[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

SCREENING FOR MENTAL HEALTH

Primary Prevention:
Suicide Prevention Curriculum

- SOS: Depression Screening and Suicide Prevention
  - http://www.mentalhealthscreening.org/highschool/
  - “The main teaching tool of the SOS program is a video that teaches students how to identify symptoms of depression and suicidality in themselves or their friends and encourages help-seeking. The program's primary objectives are to educate teens that depression is a treatable illness and to equip them to respond to a potential suicide in a friend or family member using the SOS technique. SOS is an action-oriented approach instructing students how to **ACT** (**A**cknowledge, **C**are and **T**ell) in the face of this mental health emergency.”
  - Evidenced based!
  - SOS PowerPoint

Primary Prevention:
Suicide Prevention Screening

- SOS: Depression Screening and Suicide Prevention
  - The *Brief Screen for Adolescent Depression* (BSAD) is a 7-question screening tool that reinforces the information students receive regarding depression through the video and educational materials. Screenings can be administered anonymously. Forms are available in English and Spanish.
  - Following the video and/or screening, schools should provide an opportunity for students to talk further with a school professional.

Primary Prevention:[1]

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

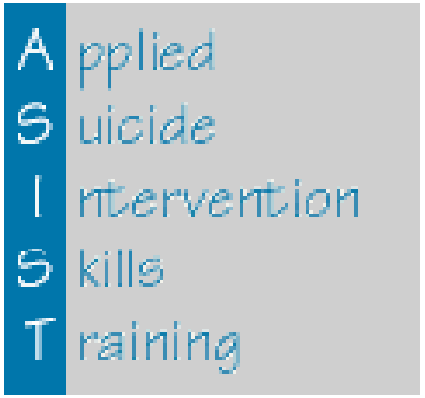
[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

Primary 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.

Primary Prevention:[1]

Suicide Prevention & Crisis 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

[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

Primary Prevention:
Suicide Prevention & Crisis 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)

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

Primary Prevention:[1] Risk Factor Reduction

- Restriction of Lethal Means
- Media Education
- Postvention
- Skills Training

[1]Acknowledgement/Reference: Gould, M. S., & Kramer, R. A. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31* (sup.), 6-31.

Primary Prevention:[1] Risk Factor Reduction

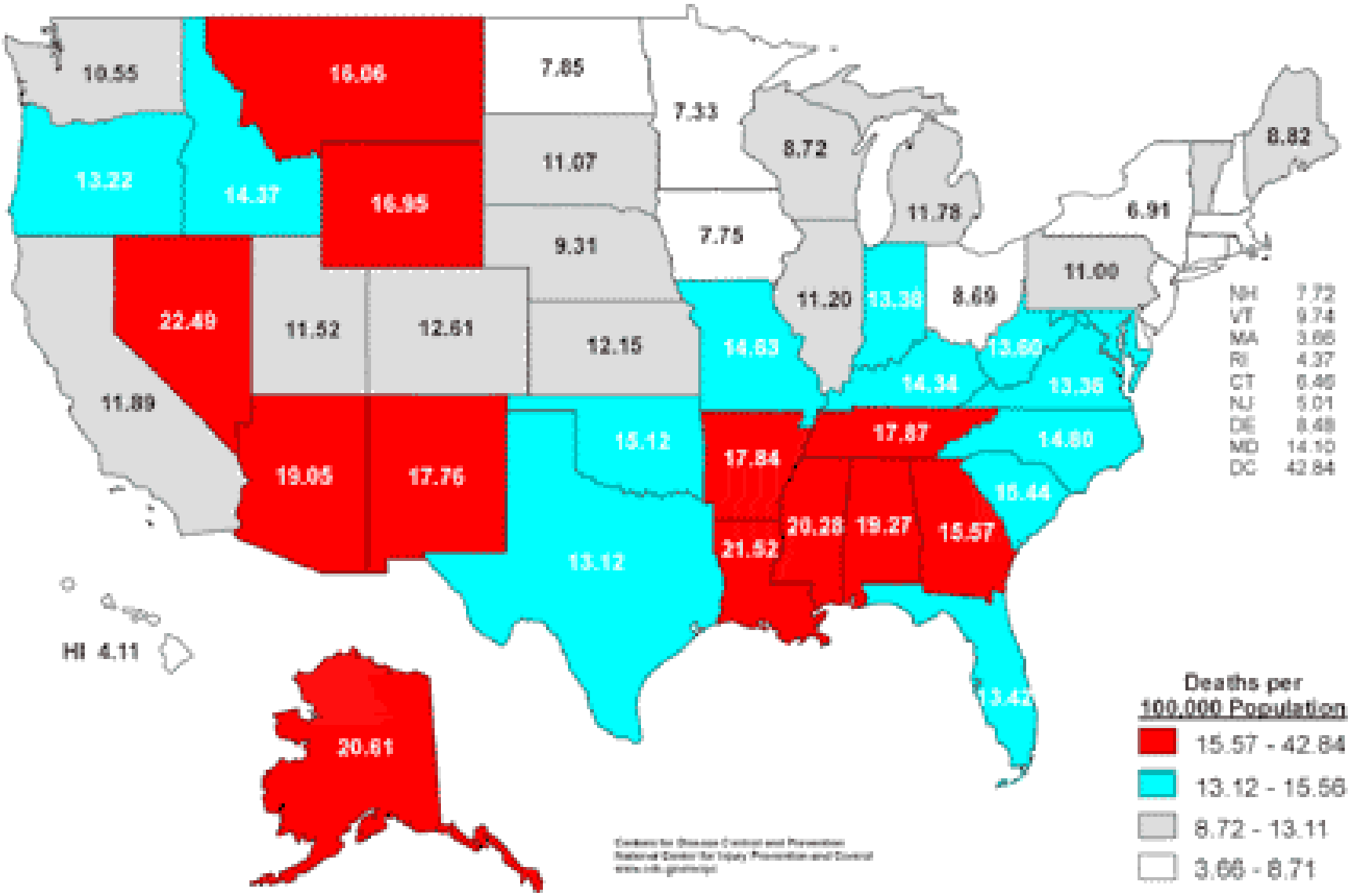
- Restriction of Lethal Means
  - http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5209a1.htm

TABLE 1. Number and percentage of firearms used by student perpetrators in all school-associated, firearm-related events and firearm-related suicide and homicide events, by source of firearm — United States, 1992–1999*

Source	Firearms used in suicide events		Firearms used in homicide events		Total	
	No.	(%)	No.	(%)	No.	(%)
Home of perpetrator	26	(76.5)	22	(23.4)	**48**	**(37.5)**
Friend/relative of perpetrator	4	(11.8)	26	(27.6)	**30**	**(23.4)**
Purchased	0	(0.0)	9	(9.6)	**9**	**(7.0)**
Stolen	2	(5.9)	5	(5.3)	**7**	**(5.5)**
Victim	—	—	2	(2.1)	**2**	**(1.6)**
Other	0	(0.0)	3	(3.2)	**3**	**(2.3)**
Unknown	2	(5.9)	27	(28.7)	**29**	**(22.7)**
Total	**34**		**94**		**128**	

* Firearms used by perpetrators who committed a homicide and then killed themselves as part of a homicide-suicide event were included in analyses of firearms used by homicide perpetrators.

Firearm-Related Death Rates
United States, 1996-1998



Primary Prevention

Based on the available empirical data, ruling out any prevention strategy is probably premature; however, there is sufficient evidence to suggest that we should proceed cautiously with school-based suicide awareness curriculum programs (Gould & Kramer, 2001, p. 21).

Workshop Outline

1. Introduction
2. Levels of Suicide Prevention
3. Primary Prevention
4. Secondary Prevention
   a) Risk Factor Identification
   b) General Staff Procedures
   c) Risk Assessment and Referral Procedures
5. Tertiary Prevention

Suicide Intervention Risk Factors

- Psychopathology
  - Associated with 90% of suicides
  - Prior suicidal behavior the best predictor
  - Substance abuse increases vulnerability and can also act as a trigger
- Familial
  - History
  - Stressor
  - Functioning

Suicide Intervention Risk Factors

- Biological
  - Reduced serotongenic activity
- Situational
  - 40% have identifiable precipitants
  - A firearm in the home
  - By themselves are insufficient
  - Disciplinary crisis most common

Suicide Intervention Warning Signs

- Suicide notes
- Direct & indirect suicide threats
- 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

Suicide Intervention Warning Signs

- Abrupt changes in appearance
- Sudden weight or appetite change
- Sudden changes in personality or attitude
- Inability to concentrate/think rationally
- Sudden unexpected happiness
- Sleeplessness or sleepiness
- Increased irritability or crying easily
- Low self esteem

Suicide Intervention Warning Signs

- Dwindling academic performance
- Abrupt changes in attendance
- Failure to complete assignments
- Lack of interest and withdrawal
- Changed relationships
- Despairing attitude

Suicide Intervention General Staff Procedures

- 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 recommended whenever a student threatens to commit suicide.

Suicide Intervention General Staff Procedures

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.**

Suicide Intervention General Staff Procedures

5. Take the suicidal student to the prearranged room.
6. Notify the Student Care Coordinator immediately.
7. Notify the Incident Commander immediately.
8. Inform the suicidal youth that outside help has been called and describe what the next steps will be.

Risk Assessment and Referral

- Identify Suicidal Thinking
- Conduct a Risk Assessment
- Make Appropriate Referrals

Risk Assessment and Referral

- **Identification of suicidal intent**
  - 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?*

Risk Assessment and Referral

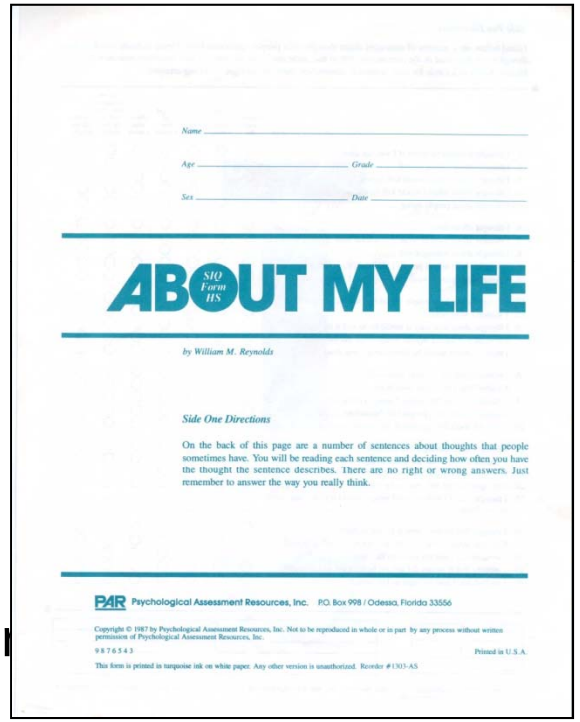
- **Ramsay, Tanney, Lang, & Kinzel, 2004 (CPR++)**
  - **C**urrent plan (greater planning = greater risk).
    - How (method of attempt)?
    - How soon (timing of attempt)?
    - How prepared (access to means of attempt)?
  - **P**ain (unbearable pain = greater risk)
    - How desperate to ease the pain?
      - Person-at-risk's perceptions are key
  - **R**esources (more alone = greater risk)
    - Reasons for living/dying?
      - Can be very idiosyncratic
      - Person-at-risk's perceptions are key

Risk Assessment and Referral

- **Ramsay, Tanney, Lang, & Kinzel, 2004 (CPR++)**
  - (+) Prior Suicidal Behavior?
    - of self
      - 40 X greater risk
    - of significant others
      - breaks down protective taboos
  - (+) Mental Health Status?
    - history mental illness
      - especially mood disorders & particularly bipolar disorder increases risk
    - linkage to mental health care provider
      - may decrease risk

Risk Assessment and Referral

- Suicide Screening
  - Very few false negatives
  - Many false positives
    - Requires second-stage evaluation
- Limitations
  - Risk waxes and wanes
  - Principals' view of acceptability
  - Requires effective referral procedur
- Possible Tool
  - Suicidal Ideation Questionnaire
  - Author: William Reynolds
  - Publisher: Psychological Assessment Resources


Name _____

Age _____ Grade _____

Sex _____ Date _____

ABOUT MY LIFE

SIQ Form HS

by William M. Reynolds

Side One Directions

On the back of this page are a number of sentences about thoughts that people sometimes have. You will be reading each sentence and deciding how often you have the thought the sentence describes. There are no right or wrong answers. Just remember to answer the way you really think.

PAR Psychological Assessment Resources, Inc. P.O. Box 998 / Odessa, Florida 33556

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This form is printed in turquoise ink on white paper. Any other version is unauthorized. Reorder #1303-AS

Risk Assessment and Referral

- Suicide Risk Assessment Summary

Risk Assessment and Referral

- Referral
  - Contracting to reduce risk.
    - Facilitative (when risk is low)
    - Directive (when risk is high)
      - Help the person to identify reasons for living (resources)
        - » Objective knowledge of resources becomes important
      - Surface ambivalence
  - Implementing the contract.

Risk Assessment and Referral

- Suicide intervention script

Risk Assessment and Referral

- Risk Assessment Protocol
  1. Conduct a Risk Assessment.
  2. Consult with fellow school staff members regarding the Risk Assessment.
  3. Consult with County Mental Health.

Risk Assessment and Referral

4. Use risk assessment information and consultation guidance to develop an action plan. Action plan options are as follows:

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.

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.

C. Contracting

- If the student's risk of harming him or herself is judged to be low then follow the Contracting Procedures.

Risk Assessment and Referral

- **A. Extreme Risk**
  - 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.

Risk Assessment and Referral

B. Crisis Intervention Referral

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.

Risk Assessment and Referral

C. Contracting

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.
iv. Write a no-suicide contract.

- 5. Protect the privacy of the student and family.
- 6. Follow up with the hospital or clinic.

Workshop Outline

1. Introduction
2. Levels of Suicide Prevention
3. Primary Prevention
4. Secondary Prevention
5. Tertiary Prevention
   a) Definitions
   b) Special Suicide Postvention Issues
   c) Suicide Postvention Protocol

Suicide Postvention Case Study

James was a well-liked high school junior. Active in after school sports, he was considered by many to be a "popular" student. However, over the course of the past year, James had developed a serious alcohol problem. In fact, his drinking at weekend parties had become something of a local legend. Friday after school, James' girlfriend broke up with him claiming that she could no longer tolerate his drinking. Distraught, James went home, got drunk, found his father's rifle and shot himself. Quickly discovered by a classmate, who had stopped by for a visit, James was rushed to the hospital.

Suicide Postvention Case Study

Tragically, however, he was declared dead upon arrival. In a suicide note, James declared that if he could not be with his girlfriend he did not want to live. By the start of school on the following Monday, this death had been classified a suicide by the coroner's office. Reacting to the social stigma surrounding suicide and fearing other such deaths, the school principal suggested that staff not talk "to much" about this tragedy. The stunned staff, anxious talking about suicide in the first place, took this as cue to try to deny the magnitude of this tragedy. Very little classroom discussion occurred.

Suicide Postvention Case Study

Small Group Discussion:

1. What suicide postvention issues are illustrated within this case study?
2. What crisis intervention strategies would you recommend?

Be prepared to share the results of your small group discussion with the larger group.

Definitions

Suicide “Postvention”...

- *Postvention is the provision of crisis intervention, support and assistance for those affected by a completed suicide.*

“Affected” individuals...

- *“Affected” individuals may include classmates, friends, teachers, coworkers, and family members.*

“Survivors” of Suicide...

- *Affected individuals are often referred to as “survivors” of suicide.*

Special Issues

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.

Special Issues

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."
- "The effect of clusters appears to be strongest among adolescents."

O'Carroll & Potter (1994, p. 9)

Special Issues

Suicide Contagion

- "…between 1984 and 1987, journalists in Vienna covered the deaths of individuals who jumped in front of trains in the subway system. The coverage was extensive and dramatic. In 1987, a campaign alerted reporters to the possible negative effects of such reporting, and suggested alternate strategies for coverage. In the first six months after the campaign began, subway suicides and non-fatal attempts dropped by more than 80 percent. The total number of suicides in Vienna declined as well."

American Foundation for Suicide Prevention (2001, p. 1)

Special Issues

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

American Foundation for Suicide Prevention (2001, p. 1)

Special Issues

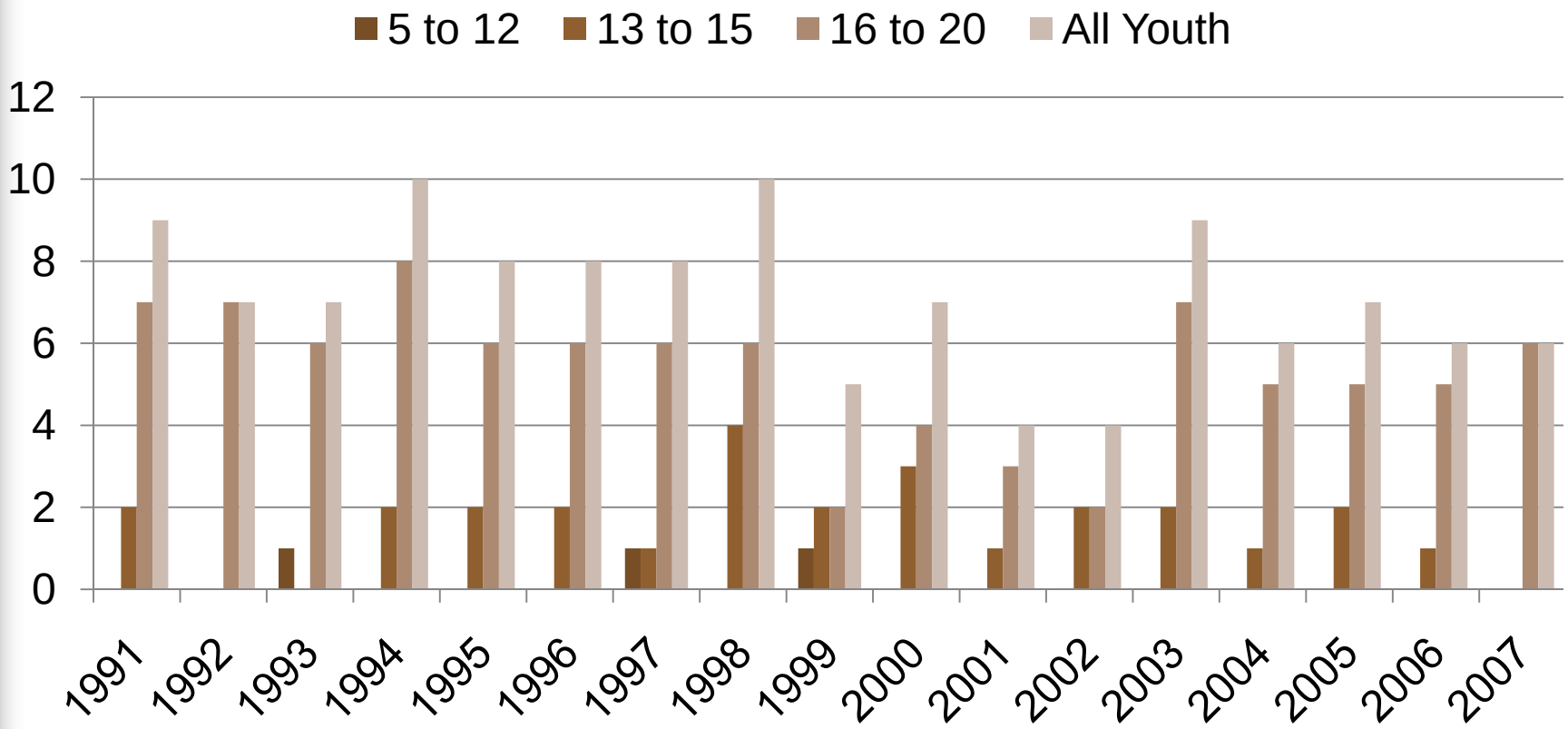
- Suicide Contagion
  - How do we determine if there is a suicide cluster?

www.applications.dhs.ca.gov/epicdata/content/ST_suicide.htm

EPICenter
California Injury Data Online

Special Issues

- Suicide Contagion
  - How do we determine if there is a suicide cluster?



Special Issues

Emotional Reactions

- Traumatic stress.
- Grief.
- Guilt.
- Anger.
- Rejection/Abandonment.
- Shame/Isolation.

Special Issues

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.

Special Issues

Developmental Considerations

- 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.

Special Issues

Cultural Considerations

- 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.

Special Issues

Given these special issues the goals of suicide postvention are to:

1. prevent other suicides.
2. reduce the onset and degree of debilitation by psychiatric disorders (e.g., PTSD).
3. reduce feelings of isolation among suicide survivors.

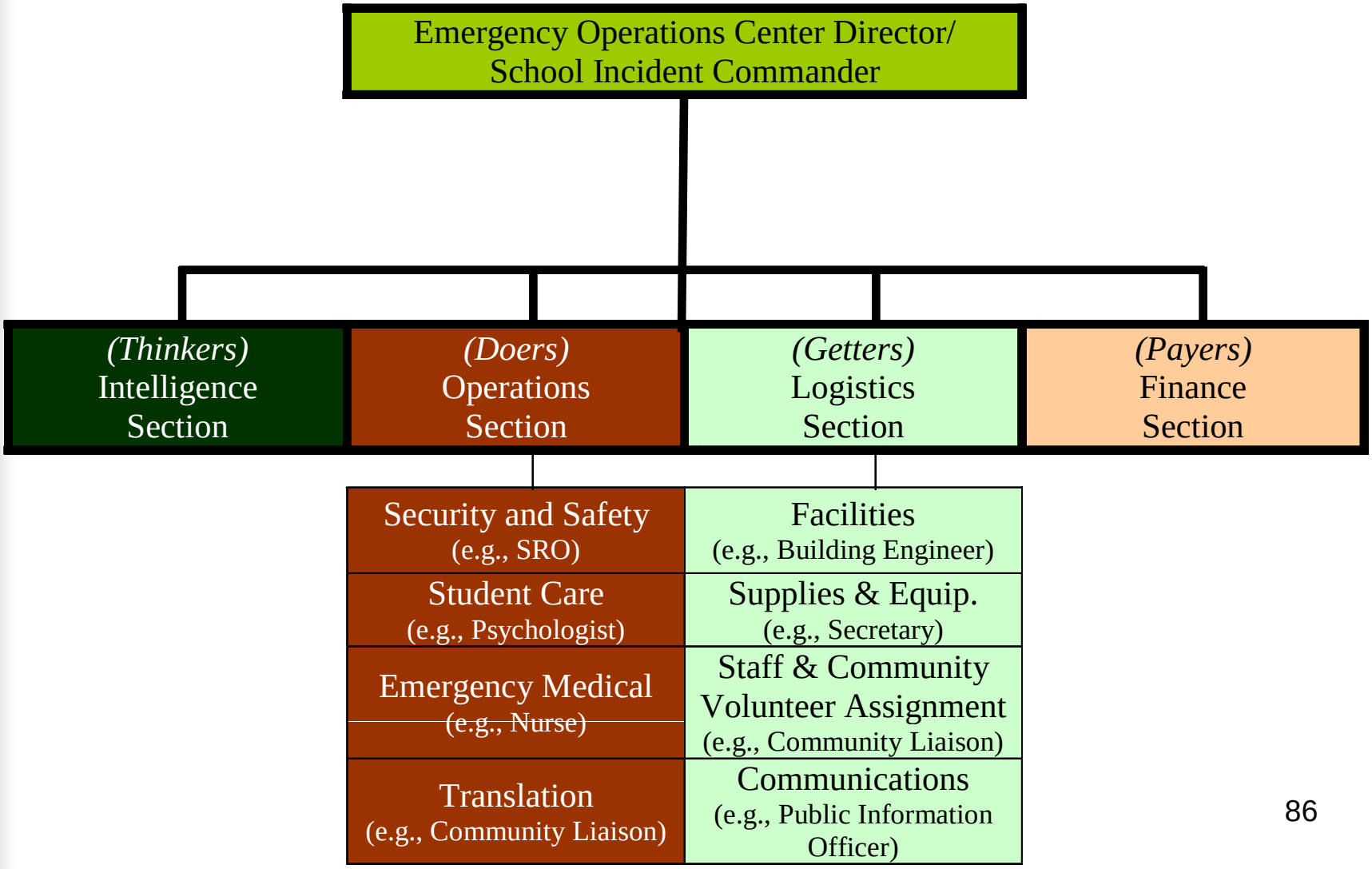
Suicide Postvention Protocol

- Preparedness is an essential component of effective postvention.
- Make sure that a postvention is needed before initiating this intervention.

Suicide Postvention Checklist

1. Verify that a death has occurred.
2. Mobilize the Crisis Response Team.
3. Assess the suicide's impact on the school and estimate the level of postvention response.
4. Notify other involved school personnel.
5. Contact the family of the suicide victim.
6. Determine what information to share about the death.
7. Determine how to share information about the death.
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. Debrief the postvention response.

Item 2:
Mobilize the Crisis Response Team (ICS)



Item 2:

Mobilize the Crisis Response Team

Incident Commander

- Verifies that at death has occurred.
- Mobilizes the crisis response team.
- Oversees all postvention interventions.

Student Care Coordinator and Crisis Intervention Specialist

- Identifies individuals in need of postvention assistance.
- Plans and implements interventions.
- Coordinates crisis intervention workers.

Item 2:
Mobilize the Crisis Response Team

Public Information Officer

- Provides access to information.
- Controls rumors.
- Deals with the media.

Emergency Medical Coordinator

- Keeps the crisis response team informed of victim's medical status.

Security and Safety Coordinator

- Responsible for crowd control.
- Monitors common areas.
- Communicates with law enforcement.

Item 3:

Assess the Suicide's Impact on the School and Estimate the Level of Postvention Response

- The importance of accurate estimates.
- Temporal proximity to other traumatic events (especially suicides).
- Timing of the suicide.
- Physical and/or emotional proximity to the suicide.

Item 5:

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.
  - Identify the victim's friends/siblings who may need assistance.
  - Discuss the school's postvention response.
  - Identify details about the death could be shared with outsiders.

  Family members can be told that school staff will not discuss or speculate on family problems or other reasons why the individual committed suicide. However, even if a family requests it, it is typically not possible to keep the basic fact that the death was a suicide a secret and in most jurisdictions "cause of death" is a matter of public record.

Item 6:

Determine What Information to Share About the Death

- The longer the delay in sharing facts, the greater the likelihood of harmful rumors.
- Several different communications will likely need to be offered.
  - Before a death is certified as a suicide.
  - After a death is certified as a suicide.
  - Provide facts and dispel rumors.
  - Do not provide suicide method details.

Item 7:

Determine How to Share Information About the Death

Reporting the death to students...

- Avoid detailed descriptions of the suicide including specific method and location.
  - Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- Avoid romanticizing someone who has died by suicide (e.g., tributes by friends, school wide assemblies, sharing information over PA systems).
  - 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).

Suicide Prevention Research Center (2005)

Item 7:

Determine How to Share Information About the Death

Reporting the death to students...

- Avoid over simplifying the causes of suicide and presenting them as inexplicable or unavoidable.
  - Doing so may cause vulnerable individuals to think of it as a common response. Research shows that more that 90% of suicide victims have a mental illness. Present it as a poor choice that was preventable.
- Avoid using the words “committed suicide” or “failed suicide.”
  - The verb “committed” is usually associated with sins or crimes. Suicide is better understood in a behavioral health context. Consider the phrase “died by suicide” or “non-fatal suicide attempt.”

Suicide Prevention Research Center (2005)

Item 7:

Determine How to Share Information About the Death

Reporting the death to students...

- Always include a referral phone number and information about local crisis intervention services
  - The National Suicide Prevention Lifeline toll-free number, 1-8000-273-TALK, is available 24/7. It connects the caller to a certified crisis center near where the call is placed.
- Emphasize recent treatment advances for depression and other mental illness.
  - This is likely associated with decreasing trends in suicide since 1990.

Suicide Prevention Research Center (2005)

Item 7:

Determine How to Share Information About the Death

Reporting the death to parents...

- Written memos.
- Personal or phone contacts.

Item 7:

Determine How to Share Information About the Death

Working with the media...

- The Media Liaison should work with the press to down play the incident.
- 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.

Suicide Prevention Research Center (2005)

Item 7:

Determine How to Share Information About the Death

Working with the media...(continued)

- 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.
     - http://cebmh.warne.ox.ac.uk/csr/images/WHO%20media%20guidelines.pdf

Item 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.

Note. Adapted from information provided by American Association of Suicidology (1998); Brent et al. (1989); Davidson (1989); Davidson, Rosenberg, Mercy, Franklin, & Simmons (1989); Gould (1992); O'Carroll et al. (1988); Ruof and Harris (1988); and Sandoval & Brock (1996).

Item 9:
Conduct a Staff Planning Session

1. Staff should be provided...
   - current information regarding the death.
   - an opportunity to ask questions and express feelings
   - if available, news articles about the death.
   - information about suicide contagion.
   - suicide risk factors.
   - an updated list of referral resources
   - direction regarding how to interact with the media
     - typically involves referral to the media liaison
   - plans for the provision of crisis intervention services.

Item 9:
Conduct a Staff Planning Session

2. Specific activities/responsibilities for teachers include...
   - replacing rumors with facts.
   - encouraging the ventilation of feelings.
   - stressing the normality of grief and stress reactions.
   - discouraging attempts to romanticize the suicide.
   - identifying students at risk for an imitative response.
   - knowing how to make the appropriate referrals.
3. Address staff reactions.
4. Staff members should be given permission to feel uncomfortable.

Item 10:
Initiate Crisis Intervention Services

1. Initial intervention options...
   - Individual psychological first aid.
   - Group psychological first aid.
   - Classroom activities and/or presentations.
   - Parent meetings.
   - Staff meetings.
2. Walk through the suicide victim's class schedule.
3. Meet separately with individuals who were proximal to the suicide.

Item 10:

Initiate Crisis Intervention Services

4. Identify severely traumatized and make appropriate referrals.
5. 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.
6. Parental contact.
7. Psychotherapy Referrals.

Crisis Intervention Procedures Following a Suicide

1. Without going into excessive detail, provide students with the facts about the suicide.
2. State that the only one ultimately responsible for the suicide is the victim.
3. Acknowledge that the suicide was an avoidable and poor choice. Portray the act as a permanent solution to temporary problems.
4. Discuss how the survivors are different from the suicide victim. Portray the suicide victim as very upset, disturbed, and as someone who had not found an effective way to work out problems. Help survivors to dis-identify with the suicide victim (without abusing the victim's character).
5. Facilitate the expression of feelings about the suicide.

Note. Adapted from information provided by American Association of Suicidology (1998); Berman & Jobes (1991); Davis & Sandoval (1991); O'Carroll et al. (1988); Poland & McCormick (1999); and Ruof and Harris (1988).

Crisis Intervention Procedures Following a Suicide

6. State that there is no “right way” to feel after a suicide.
7. Point out that painful reactions to the suicide will be alleviated with time and talk.
8. Acknowledge that people may have suicidal thoughts following the suicide of a significant other.
9. Provide information about the warning signs of suicidal behavior and available mental health resources.
10. If appropriate, prepare students for the funeral.

Note. Adapted from information provided by American Association of Suicidology (1998); Berman & Jobes (1991); Davis & Sandoval (1991); O’Carroll et al. (1988); Poland & McCormick (1999); and Ruof and Harris (1988).

Item 11:
Conduct Daily Planning Sessions

Goals of the planning sessions:

1. Plans should be made for the day.

2. Ongoing evaluation of the progress of the postvention.

3. Evaluate and address staff reactions/needs.

Item 12:
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)

Note. From "School Memorials After Suicide: Helpful or Harmful" by the Centre for Suicide Prevention (2004, May). Retrieved January 2006 from www.suicideinfo.ca

Item 12:
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.

Note. From "Suicidal Ideation and Behaviors," by S. E. Brock & J. Sandoval. In C. G. Bear, K. M. Minke, & A. Thomas, *Children's Needs II: Development, Problems, and Alternatives*, 2006, Bethesda, MD: National Association of School Psychologists.

Item 12:
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.

Note. From "Suicidal Ideation and Behaviors," by S. E. Brock & J. Sandoval. In C. G. Bear, K. M. Minke, & A. Thomas, *Children's Needs II: Development, Problems, and Alternatives*, 2006, Bethesda, MD: National Association of School Psychologists.

Item 13:
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 intervenors cope.

Responding to the Aftermath of a Death by Suicide

- Situation #1: You are the school principal and one of your teachers reports to you that a 15-year-old freshman has committed suicide by shooting himself in the head. This youth was part of a small peer group that was not considered to be especially popular at your school.

Responding to the Aftermath of a Death by Suicide

- Situation #2: Your are the school counselor. It is summer vacation and a parent calls asking for you to intervene with a group of distress teens after their friend was hit and killed by a car on a local highway. You are told that the deceased was out drinking with her boy friend, came home and got into a fight with her mother, and then ran out of the house onto the highway. The deceased was bright, attractive, and very popular. The start of school is three weeks away.

Responding to the Aftermath of a Death by Suicide

- Situation #3: The death of a 17-year-old senior has just been ruled a suicide by the coroner's office. The suicide victim was distraught after having had to leave his old high school in another state.

Responding to the Aftermath of a Death by Suicide

- Situation #4: A 12-year-old, seventh grade male, has just shot himself during his fourth period English class. Earlier he had been accused of sealing money from the purse of one of his teachers. He had just been told by the vice principal that he was in trouble with the law.

Responding to the Aftermath of a Death by Suicide

For the specified situation, discuss in a small group the following questions. Be prepared to share your responses to the large group at the conclusion of your discussion.

1. What do you estimate will be the suicide's impact on the school? What level of crisis intervention response do you think might be required (no response, school response, district response, regional response) *(Explain your reasoning.)*
2. Which student survivors do you think will be most affected by the suicide? *(Justify your selections.)*
3. What crisis intervention interventions would you consider? *(Be as specific as time permits.)*
4. Are there any special crisis intervention issues presented by the postvention situation?

Resources

American Foundation for Suicide Prevention et al. (2001) Reporting on Suicide: Recommendations for the Media. Retrived January 17,2010, from www.afsp.org/index.cfm?page_id=0523D365-A314-431E-A925C03E13E762B1

Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.

Brock, S. E. (2002). School suicide postvention. In S. E. Brock, P. J. Lazarus, & S. R. Jimerson (Eds.), *Best practices in school crisis prevention and intervention* (pp. 553-575). Bethesda, MD: National Association of School Psychologists.

Brock, S. E. (2003, May). *Suicide postvention.* Paper presented at the DODEA Safe Schools Seminar. Retrieved March 10, 2006, from www.dodea.edu/dodsafeschools/members/seminar/SuicidePrevention/generalreading.html#2

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. 187-197). Bethesda, MD: National Association of School Psychologists

Resources

Center for Suicide Prevention. (2004, May). *School memorials after suicide: Helpful or harmful?* Retrieved January 15, 2006 from www.suicideinfo.ca

Davis, J. M., & Brock, S. E. (2002). Suicide. In J. Sandoval (Ed.), *Handbook of crisis counseling, intervention and prevention in the schools* (2nd ed., pp. 273-299). Hillsdale, NJ: Lawrence Erlbaum Associates.

Doan, J., Roggenbaum, S., & Lazear, K. (2003). *Youth suicide prevention school-based guide – Issue brief 7a: Preparing for and responding to a death by suicide: Steps for responding to a suicide crisis.* Tampa, FL: University of South Florida.

O'Carroll, P. W., & Potter, L. B. (1994). Suicide contagion and the reporting of suicide: Recommendations from a national workshop. *MMWR, 43*(RR-6) 9-18.

Suicide Prevention Resource Center. (2005) At-a-glance: Safe reporting on suicide. Retrieved January 17, 2010, from http://www.sprc.org/library/at_a_glance.pdf

U.S. Department of Homeland Security. (2004, March). *National incident management system.* Retrieved on September 9, 2005, from www.fema.gov/pdf/nims/nims_doc_full.pdf

School Suicide Prevention

Stephen E. Brock, Ph.D., NCSP
California State University, Sacramento
brock@csus.edu
http://www.csus.edu/indiv/b/brocks/
916-278-5919

SACRAMENTO STATE

Santa Clara County Office of Education

January 21, 2010

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