Responding to Crisis

Mental Health Crisis Intervention

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Session Outline

- Incidence of Traumatic Stressors
- The PREPaRE Model
- Suicide Postvention

2

Responding to Crisis: Mental Health Crisis Intervention

INCIDENCE

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Incidence

- **Traumatic Stress**
  - By 16 years of age, 68% of youth report having experienced at least one traumatic stressor
    - 37% report two or more events
  - 90% of adolescent girls from urban settings have experienced at least one traumatic stressor
    - Witnessing of community violence the most frequent trauma reported

Nickerson et al. (2009); Lipschitz et al. (2000)

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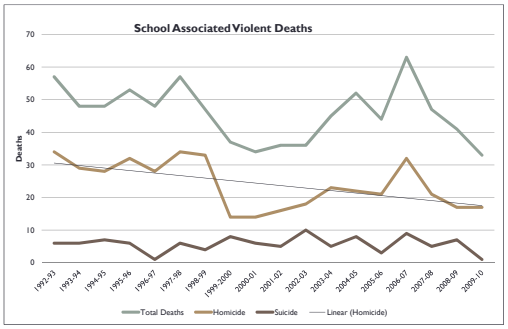
Incidence

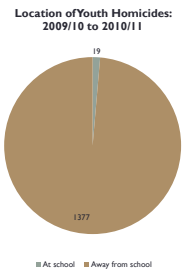


Robers, Zhang, & Truman (2012)

5

Incidence

- **Traumatic Stress**



Robers, Zhang, & Truman (2013)

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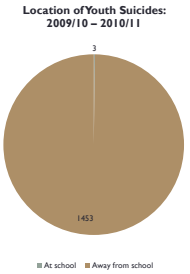
Incidence

- **Traumatic Stress**



Robers, Zhang, & Truman (2013)

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Incidence

Firearm Deaths in the United States (CDC, 2012)

- In 2010, there were 2,711 child/teen firearm deaths
  - Every day there were seven such fatalities
  - Every week there were 52 children and teens killed via firearms
- Between 1981 and 2010, 112,375 children and teens were killed by firearms
  - This is 25,000 more deaths than the number of solders killed in Vietnam, Korea, Afghanistan, and Iraq combined

CDC(2013); Children's Defense Fund (2013)

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Incidence

Firearm Deaths in the United States (CDC, 2012)

- Of the 1,982 youth murders in 2010 (age 10-19)
  - **84% were killed by a firearm**
- Of the 1,659 teen suicides in 2010 (age 15-19)
  - **40% were killed by a firearm.**
- Of the 1,323 teen male suicides in 2010 (age 15-19)
  - **45% were killed by a firearm**
- Of the 336 teen female suicides in 2010 (age 15-19)
  - **20% were killed by a firearm**
- In 2010, across all age groups, there 31,672 individuals killed by firearms
  - **61% were suicide**
  - **26% were homicide**

CDC (2013)

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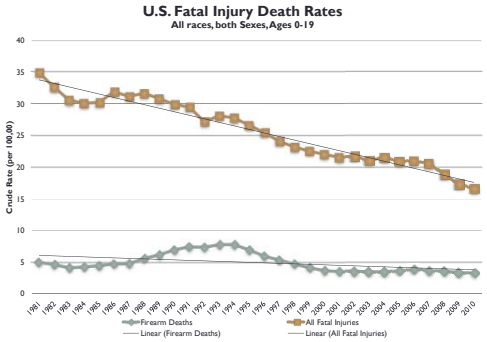
Incidence



CDC (2013)

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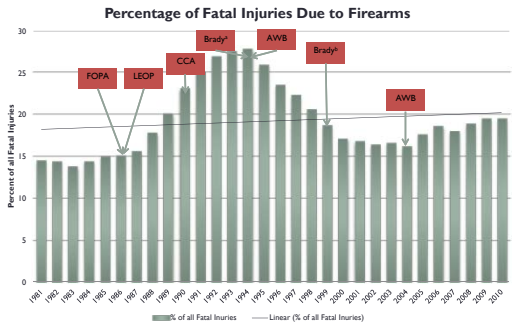
Incidence



CDC (2013)

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Incidence

Suicide

- **Fifth** leading cause of death among 5-14 year olds (*N* = **266**; 0.7:100,000)
  - **Third** leading cause in the 10-14 age group, *N* = **259; 1.3:100,000**)
- **Third** leading cause of death among 15-24 year olds (*N* = **4,600)**
  - 15-19 (*N* = 1659; 7.5:100,000
  - 20-24 (*N* = 2,941; 13.6:100,000)

Kochanek, K. D., et al. (2011, March)

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Incidence

Suicide: All Age Groups

- Total number of deaths 2010 (*N* = **38,364; 12.4**:100,000)
  - 10th leading cause of death
  - Highest rate in 22 years (1988 rate = 12.44).
- More men die by suicide
  - 3.72 male suicides (*N* = **30,277**) for each females suicide (*N* = **8,087**)
  - 3 female attempts for each male attempt

McIntosh & Drapeau (2012, September)

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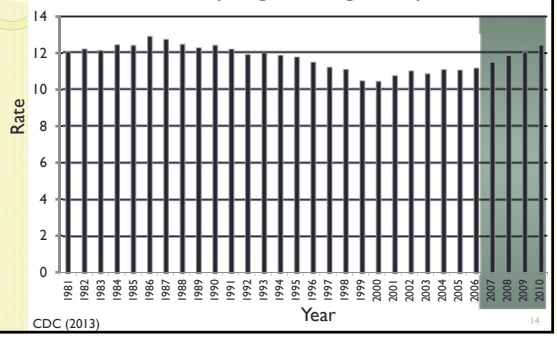
Incidence

Suicide (all ages, both genders)



CDC (2013)

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Incidence

Suicide

- 50.5% of suicides are by firearms.[1]
  - Suicide by firearms rate = 6.3:100,000
  - *N* = 19,392
- Highest suicide rate is among white men over 85
  - 48.8 : 100,000 vs. 11.8 : 100,000 among white male adolescent 15-19).[2]
  - However the 2nd highest rate is among American Indian/Alaskan Native 20-24 year-old males (38.9 : 100,000).

[1]McIntosh & Drapeau (2012, September); [2]National Center for Injury Prevention & Control. (2011, Dec.)

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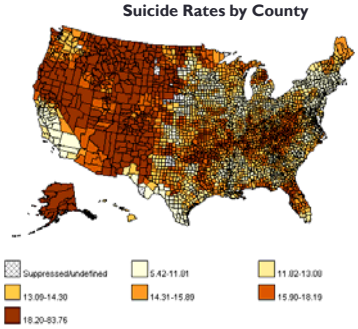
Incidence

Suicide Rates by County



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

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Incidence

Suicide Rates by State (2010 Final Data)

Rank	State (2009rank/Gun in home rank)	#	Rate
1.	Wyoming (4/1)***	131	23.2
2.	Alaska (1/3)*	164	23.1
3.	Montana (2/2)*	227	22.9
4.	Nevada (5/37)**	547	20.3
5.	New Mexico (3/28)***	413	20.1
6.	Idaho (11/8)*	290	18.5
7.	Oregon (9/49)***	685	17.9
8.	Colorado (6/35)***	865	17.2
8.	South Dakota (25/4)*	140	17.2
10.	Arizona (8/31)**	1,093	17.1
10.	Utah (15/16)*	473	17.1
National Total		**38,364**	**12.4**

Firearms Regulations: *Minimal, **Moderate, ***Maximum
(Sterzer, 2012); CDC (2013)

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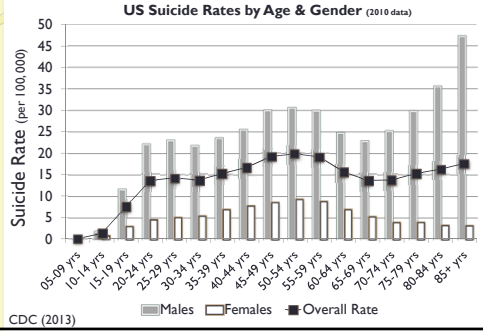
Incidence

US Suicide Rates by Age & Gender (2010 data)



CDC (2013)

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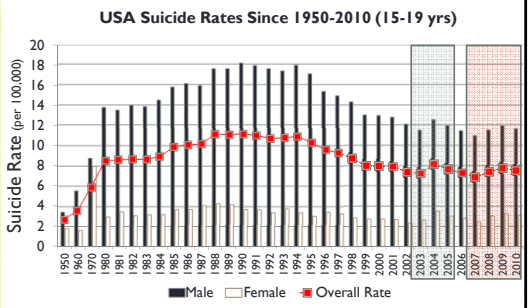
Incidence



CDC (2013)

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Responding to Crisis: Mental Health Crisis Intervention

PREPaRE

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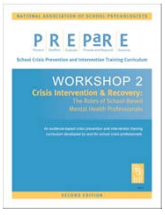
P R E PaR E

Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

- Crisis Intervention and Recovery
  - The Roles of School-Based Mental Health Professionals



Brock (2011)

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P R E PaR E

Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

P	**Prevent** and **Prepare** for psychological trauma
R	**Reaffirm** physical health and perceptions of security and safety
E	**Evaluate** psychological trauma risk
P a R	**Provide** interventions and **Respond** to psychological needs
E	Examine the effectiveness of crisis prevention and intervention

Brock (2011)

P R E PaR E

Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Crises:
Ensure physical safety

a. Crime prevention through environmental design
   i. Natural surveillance
   ii. Natural access control
   iii. Territoriality
b. Vulnerability assessment

Reeves, Nickerson, & Jimerson (2006)

P R E PaR E

Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Crises:
Ensure psychological safety

a. School-wide positive behavioral supports
b. Universal, targeted, and intensive academic and social–emotional interventions and supports
c. Identification and monitoring of self- and other-directed violence threats
d. Student guidance services

Reeves et al. (2006)

P R E PaR E
Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Traumatization:
Foster Internal Student Resiliency

- Promote active (or approach-oriented) coping styles.
- Promote student mental health.
- Teach students how to better regulate their emotions.
- Develop problem-solving skills.
- Promote self-confidence and self-esteem.
- Promote internal locus of control.
- Validate the importance of faith and belief systems.
- Nurture positive emotions.
- Foster academic self-determination and feelings of competence.

Brock (2011) 25

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Traumatization:
Foster External Student Resiliency

- Support families.
- Facilitate peer relationships.
- Provide access to positive adult role models.
- Ensure connections with prosocial institutions.
- Provide a caring, supportive learning environment.
- Encourage volunteerism.
- Teach peace-building skills.

Brock (2011) 26

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Trauma Exposure:
Keep Students Safe

- Remove students from dangerous or harmful situations
- Implement crisis response procedures (e.g., evacuations, lockdowns)
  - "The immediate response following a crisis is to ensure safety by removing children and families from continued threat of danger." (Joshi & Lewin, 2004, p. 715)
  - "To begin the healing process, discontinuation of existing stressors is of immediate importance." (Barenbaum et al., 2004, p. 48)

Brock (2011) 27

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prevent Trauma Exposure:
Avoid Crisis Scenes and Images

- Direct ambulatory students away from the crisis site
  - Do not allow students to view medical triage
- Restrict and/or monitor media exposure
  - Avoid excessive viewing of crisis images on television or Internet

Brock (2011) 28

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Prepare for Crisis Intervention

- Develop immediate crisis intervention resources
- Identify longer-term psychotherapeutic resources

Brock et al. (2009) 29

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Reaffirm <u>Physical</u> Health & Safety

1. General and special needs students
2. Responding to acute needs
3. Ensuring physical comfort
4. Providing accurate reassurances

Brock (2011)

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Reaffirm Psychological Health & Safety

1. Recognizing the importance of adult reactions and behaviors
2. Minimizing crisis exposure
3. Reuniting/locating caregivers and significant others
4. Providing facts and adaptive interpretations
5. Returning students to a safe school environment
6. Providing opportunities to take action

Brock (2011)

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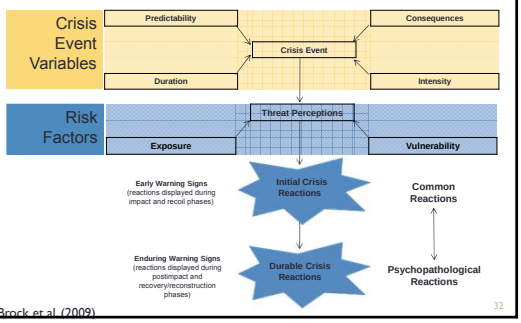
Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Evaluate Psychological Trauma



Brock et al. (2009)

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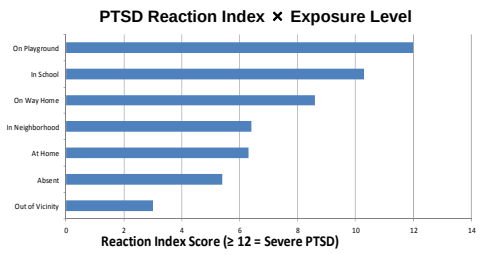
Evaluate Psychological Trauma: Crisis Exposure Physical Proximity Risk Factor



Pynoos et al. (1987)

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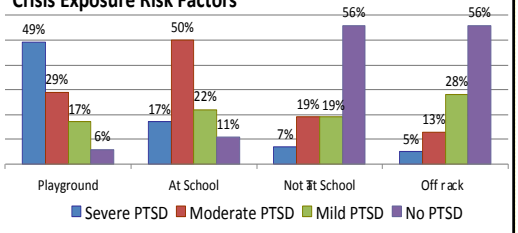
Prevent Reaffirm Evaluate Provide and Respond Examine

Evaluate Psychological Trauma:
Crisis Exposure Risk Factors



Off track refers to students who were on vacation from school.
Pynoos et al. (1987)

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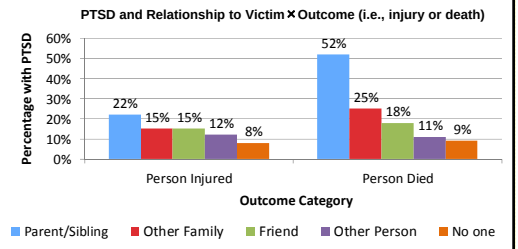
Evaluate Psychological Trauma:
Crisis Exposure Emotional Proximity Risk Factor



Applied Research and Consulting et al. (2002, p. 34)

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P R E PaR E
Prevent Reaffirm Evaluate Provide and Respond Examine

Evaluating Psychological Trauma:
Internal Vulnerability Risk Factors

i. Avoidance coping style
ii. Pre-crisis psychiatric challenges
iii. Poor ability to regulate emotions
iv. Low developmental level and poor problem solving
v. History of prior psychological trauma

Brock et al. (2009)

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Evaluating Psychological Trauma: External Vulnerability Risk Factors

i. Family resources
   1. Not living with a nuclear family member
   2. Family dysfunction (e.g., alcoholism, violence, child maltreatment, mental illness)
   3. Parental PTSD/maladaptive coping with the stressor
   4. Ineffective and uncaring parenting
   5. Poverty or financial stress

ii. Extra-familial social resources
   1. Social isolation
   2. Lack of perceived social support

Brock et al. (2009)

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Evaluating Psychological Trauma: Threat Perception Risk Factor*

a. Subjective impressions can be more important than actual crisis exposure.
b. Adult reactions are important influences on student threat perceptions.

*Risk factors increase the probability of psychological trauma and, as such, should result in increased vigilance for symptoms of traumatic stress (or warning signs).

Brock et al. (2009)

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Evaluating Psychological Trauma: Crisis Reaction Warning Signs*

a. Early warning signs
b. Enduring warning signs
c. Developmental variations
d. Cultural variations

*Warning signs are symptoms of traumatic stress.

Brock et al. (2009)

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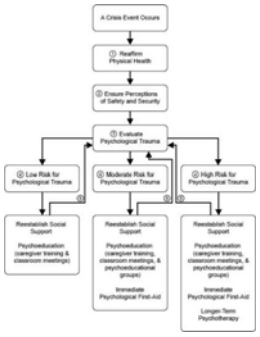
Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

1. Reaffirm physical health.
2. Ensure perceptions of safety.
3. Evaluate psychological trauma.
4. Make initial crisis intervention treatment decisions.
5. Reevaluate degree of psychological injury and make more informed crisis intervention treatment decisions.



Brock (2011)

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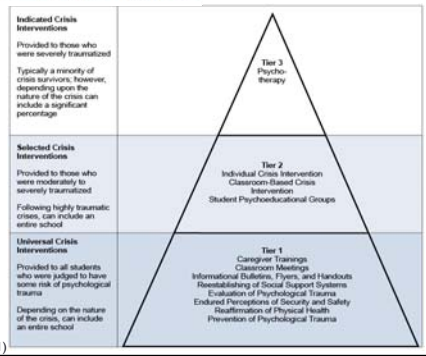

Brock (2011)

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Reestablish Social Support Systems

1. Reunite students with primary caregivers.
2. Reunite students with peers and teachers.
3. Return students to familiar environments and routines.
4. Facilitate community connections.
5. Empower caregivers with crisis recovery information.

Brock &Jimerson (2004)

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Limitations of Social Support

1. Caregivers can be significantly affected by the crisis.
2. Not sufficient following extremely violent and life-threatening crises (e.g., mass violence), chronic crisis exposure, or when psychopathology is present.
3. Support is sometimes not perceived as helpful.

Brock &Jimerson (2004)

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Psychoeduction Strategies

1. Informational documents
2. Caregiver trainings
3. Classroom meetings
4. Student psychoeducational groups

Brock et al. (2009); Reeves, Kanan, & Plog (2010)

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Psychoeducation:
Caregiver Training Elements

1. **Introduce** caregivers to the training (5 min)
2. **Provide** crisis facts (10 min)
3. **Prepare** caregivers for the reactions that may follow crisis exposure (15 min)
4. **Review** techniques for responding to children's crisis reactions (15 min)

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Psychoeducation:
Classroom Meeting Elements

1. **Introduce** the meeting (5 min).
2. **Provide** crisis facts (5 min).
3. **Answer** student questions (5 min).
4. **Refer** to techniques for responding to children's crisis reactions.

Adapted from Reeves et al. (2010)

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Psychoeducation:
Student Psychoeducational Group Elements

1. **Introduce** students to the lesson (5 min)
2. **Answer** questions and dispel rumors (20 min)
3. **Prepare** students for the reactions that may follow crisis exposure (15 min)
4. **Teach** students how to manage crisis reactions (15 min)
5. **Close** the lesson by making sure students have a crisis reaction management plan (5 min)

Brock et al. (2009)

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Limitations of Psychoeducation

1. Not sufficient for the more severely traumatized
2. Must be paired with other psychological interventions and professional mental health treatment
3. Limited research

Amstadter, McCart, & Ruggiero (2007); Howard & Goelitz (2004); Lukens & McFarlane (2004); Oflaz, Hatipoğlu, & Aydin (2008)

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Psychological Intervention Strategies

1. Immediate classroom-based (or group) crisis intervention
2. Immediate individual crisis intervention
3. Long-term psychotherapeutic treatment interventions

Brock et al. (2009) 49

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Psychological Interventions:
Classroom-Based Crisis Intervention

1. **Introduce** session (10–15 min)
2. **Provide** crisis facts and dispel rumors (30 min)
3. **Share** crisis stories (30–60 min)
4. **Identify** crisis reactions (30 min)
5. **Empower** students (60 min)
6. **Close** (30 min)

Brock et al. (2009) 50

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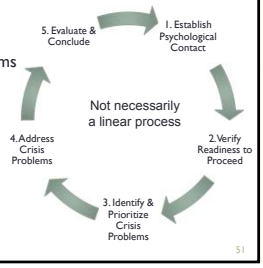
Psychological Interventions:
Individual Crisis Intervention Elements

1. Establish contact
2. Verify readiness
3. Identify and prioritize problems
4. Address crisis problems
5. Evaluate and conclude



Brock et al. (2009) 51

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Psychological Interventions:
Psychotherapeutic Treatments
Trauma-Focused Therapies

Trauma-focused psychotherapies should be considered first-line treatments for children and adolescents with PTSD. These therapies should

1. Directly address children's traumatic experiences
2. Include parents in treatment in some manner as important agents of change
3. Focus not only on symptoms improvement but also on enhancing functioning, resiliency, and/or developmental trajectory.

Cohen et al. (2010, pp. 421–422)

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Psychological Interventions:
Psychotherapeutic Treatments
Cognitive–Behavioral Therapies

1. Imaginal and in vivo exposure
2. Eye-movement desensitization and reprocessing (EMDR)
3. Anxiety management training
4. Cognitive–behavioral intervention for trauma in schools (CBITS; group delivered)
5. Parent training

Brock et al. (2009); Cohen et al. (2010)

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Psychological Interventions:
Psychotherapeutic Treatment Interventions

"Overall, there is growing evidence that a variety of CBT programs are effective in treating youth with PTSD . . . Practically, this suggests that psychologists treating children with PTSD can use cognitive–behavioral interventions and be on solid ground in using these approaches."

"In sum, cognitive behavioral approaches to the treatment of PTSD, anxiety, depression, and other trauma-related symptoms have been quite efficacious with children exposed to various forms of trauma."

Feeny et al. (2004, p. 473); Brown & Bobrow (2004, p. 216)

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P R E PaR E
Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Examine

1. Needs assessment
2. Process analysis
3. Outcome evaluation

Brock et al. (2009)

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Caring for the Caregiver

1. Limit shifts.
2. Rotate responders.
3. Monitor responders who meet high-risk criteria:
   a. Survivor of crisis or disaster
   b. Those having regular exposure to severely affected individuals
   c. Those with preexisting conditions
   d. Those who have responded to many crises

Brymer et al. (2006); Figley (2002)

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Prevent | Reaffirm | Evaluate | Provide and Respond | Examine

Personal Self-Care Practice: Physical

1. Get adequate sleep and avoid extended periods of work
2. Ensure proper nutrition
3. Exercise regularly
4. Regularly use stress management techniques

Psychological

1. Self-monitor
2. Seek professional assistance if secondary traumatic stress lasts longer than 2–3 weeks
3. Seek help with own trauma history
4. Develop assertiveness, time management, cognitive reframing, and interpersonal communication skills

Brymer et al. (2006); Figley (2002)

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Personal Self-Care Practice
Social and Interpersonal

1. Plan for family and home safety
2. Identify social supports
3. Engage in social activism and advocacy
4. Practice your religious faith and spirituality
5. Use creative self-expression
6. Use humor

Brymer et al. (2006), Figley (2002)

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Responding to Crisis: Mental Health Crisis Intervention

SUICIDE POSTVENTION

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Suicide Postvention

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

E.S. Shneidman
Forward to *Survivors of Suicide*

Edited by A. C. Cain
Published by Thomas, 1972

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Suicide Postvention

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

Andriessen & Krysinska (2012)

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Suicide Postvention

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

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Suicide Postvention

- Key Terms and Statistics
  - How many survivors of suicide are there?
    - Estimates vary greatly
      - Shneidman (1969) = 6 per suicide
      - Wrobleski (2002) = 10 per suicide
      - Berman (2011) = 80-45 per suicide

_____	X	38,364	=	_____
N of Survivors per suicide		Completed Suicides		Suicide Survivors
_____	X	_____	=	_____
N of Survivors per suicide		Completed Suicides		Suicide Survivors

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Suicide Postvention

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

Andriessen & Krysinska (2012)

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Suicide Postvention

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

Grad et al. (2004)

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Suicide Postvention

Special Issues

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

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Suicide Postvention

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

American Foundation for Suicide Prevention (2001)

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Suicide Postvention

1. Suicide contagion
   - As a consequence of "contagion" suicide clusters have been reported.
     - A suicide cluster is "… a group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community."
       - Account for approx. 1-5% of adolescent/young adult suicides.
     - How do you determine if you have a cluster?
       - Establish a baseline rate or percentage.

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

CDC (1998, August 19)

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Suicide Postvention

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

1. **Suicide contagion**
   - 1999-2010, 554 NY youth committed suicide (ages 14-18)
     - A state-wide average of 50suicides per year
     - Among 14-18 year olds, a state-wide average annual rate of 3.46 per 100,000 individuals.

$$\frac{554}{15{,}995{,}846} \times 100{,}000 = 3.46$$

     - A 2,000 student high school can expect a completed suicide about **once every 14 years** (14 x .07 = 1).

$$\frac{554}{15{,}995{,}846} \times 2{,}000 = 0.07$$

     - A 4,000 student high school can expect a completed suicide about **once every 7 years** (7 x .14 = 1).

$$\frac{554}{15{,}995{,}846} \times 4{,}000 = 0.14$$

CDC (2013)

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Suicide Postvention

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

1. **Suicide contagion**
   - 1999-2010, 1,252 CA youth committed suicide (ages 14-18)
     - A state-wide average of 114 suicides per year
     - Among 14-18 year olds, a state-wide average annual rate of 3.93 per 100,000 individuals.

$$\frac{1,252}{31,881,494} \times 100,000 = 3.93$$

     - A 2,000 student high school can expect a completed suicide about **once every 12.25 years** (12 x .08 = 1).

$$\frac{1,252}{31,881,494} \times 2,000 = 0.08$$

     - A 4,000 student high school can expect a completed suicide about **once every 6.25 years** (6.25 x .18 = 1).

$$\frac{1,252}{31,881,494} \times 4,000 = 0.16$$

CDC (2013)

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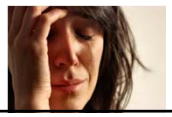
Suicide Postvention

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



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

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Suicide Postvention

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

Jordan & McIntosh (2011)

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Suicide Postvention

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

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

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Suicide Postvention

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

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Suicide Postvention

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

Mishara (1999)

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Suicide Postvention

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

Ramsay et al. (1996)

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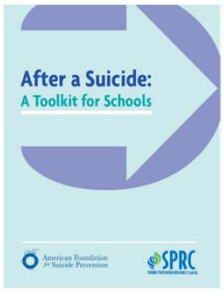
Suicide Postvention Protocol

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



American Foundation for Suicide Prevention et al. (2011)

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Suicide Postvention Protocol

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

Brock (2002)

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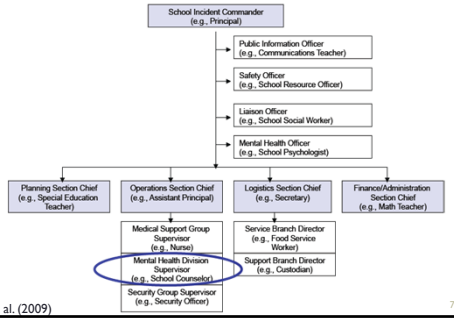
Suicide Postvention Protocol

2. Mobilize the crisis response team



Brock et al. (2009)

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Suicide Postvention Protocol

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

Brock (2002)

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Suicide Postvention Protocol

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

Brock (2002)

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Suicide Postvention Protocol

5. Contact the family of the suicide victim.
   - Purposes include...
     - Express sympathy and offer support.
     - Identify the victim's friends/siblings who may need assistance.
     - Discuss the school's response to the death.
     - Identify details about the death could be shared with outsiders.

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

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Suicide Postvention Protocol

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

Sample Death Notification Statement for Students

Option 1 - When the death has been ruled a suicide

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

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Suicide Postvention Protocol

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

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

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Suicide Postvention Protocol

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

Brock, 2002

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Suicide Postvention Protocol

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

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

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Suicide Postvention Protocol

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

Brock (2002); World Health Organization (2000)

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Suicide Postvention Protocol

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

Brock (2002); Brock, Sandoval, & Hart (2006)

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Suicide Postvention Protocol

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

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

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Suicide Postvention Protocol

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

Brock (2002)

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Suicide Postvention Protocol

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

Center for Suicide Prevention (2004)

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Suicide Postvention Protocol

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

Brock, Sandoval, & Hart (2006)

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Suicide Postvention Protocol

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

Brock, Sandoval, & Hart (2006)

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Suicide Postvention Protocol

12. 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.

Brock (2002)

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Books by Stephen E. Brock

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STUDENT SUCCESS
MENTAL HEALTH MATTERS

Responding to Crisis

Mental Health Crisis Intervention

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