Suicide Prevention and Intervention in Schools

Guide I-107

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"An educated school environment with an awareness of the signs of depression and suicide risk among students, teachers and others can create a safety net for recognition and referral."[2]

New Mexico youth are shooting, hanging and poisoning themselves or finding other ways to end their lives because life has become unbearably painful for them. Their deep psychological pain comes from intense feelings of depression, worthlessness, anger, anxiety and hopelessness–the hopelessness arising from a perception that there is "no way out" from their suffering. There is not only the tragic number of completed suicides, but also the large numbers of contemplated and attempted suicides.

2004 data from the New Mexico Office of the Medical Investigator show that there were 34 suicides in the state among youth, ages 15-19, which is a rate of about 23/100,000 (based on 2000 consensus). Also, regarding young people in New Mexico, ages 15-24, averaged data for the years 2000-2002 gives a suicide rate of 19.1/100,000.[3] Males had a higher rate than females: 32.2 vs. 5.5, respectively. Rates (again, per 100,000) within the following designated race/ethnicity categories were: (1) *Asian/Pacific Islander and Other*: 30.4; *American Indian*: 25.3; *White-Non-Hispanic*: 20.5; *White-Hispanic*: 16.7; *Black*: 8.3. Furthermore, the 2003 New Mexico Youth Resiliency & Risk Survey shows: 20 percent (1 out of 5) of high school students reported that they seriously considered attempting suicide in the previous 12 months; 14 percent (1 out of 7) reported that they had attempted suicide one or more times during the past 12 months (8 percent indicated that their attempt had to be treated by a doctor or nurse).

Putting aside, for a moment, the sheer *quantity* of young people in New Mexico who have seriously thought about, attempted, or committed suicide, *one* suicide is one too many. The impact of suicide in a family, school and community is enormous. There is the subsequent, painful awareness about the suffering that must have been endured by the person who committed suicide–until they could no longer endure that suffering–as well as the deep emotions felt by family, friends and community members afterward. Furthermore, research has shown that one suicide can lead to another among peers, family members or others in the community.

Suicide is a permanent, fatal act in response to an existential crisis of intolerable psychic pain that can be prevented through relieving the pain and remedying its causes. Schools have a unique opportunity to reduce the number of youth suicides occurring across New Mexico each year. They can provide an optimal environment for identifying suicidal youth and assisting them and their families in finding help. In order to create this environment, all school personnel should receive training on:

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[1] This publication has been reviewed by Assistant Professors Todd A. Savage, Ph.D., and Elsa Arroyos-Jurado, Ph.D., School Psychology Program, New Mexico State University.

[2] Dr. Cheryl Ann King, past president of the American Association of Suicidology. From *Suicide Prevention and Youth: Saving Lives: Hearing before the Subcommittee on Substance Abuse and Mental Health Services of the Committee on Health, Education, Labor, and Pensions-United States Senate-108th Congress.* U.S. Government Printing Office: Washington, D.C. (2004).

[3] New Mexico Department of Health (2004).

(1) suicide risk factors, protective factors and warning signs;

(2) how to respond to:
   (a) a student presenting with warning signs of suicide,
   (b) a suicide attempt,
   (c) a completed suicide.

Furthermore, schools should have:

(1) a means for detecting/identifying students at risk for suicide[4];

(2) protocols for responding to:
   (a) students presenting with warning signs of suicide,
   (b) a suicide attempt,
   (c) a suicide completion (postvention).

Detecting/Identifying Suicidal Student

Detecting suicidal students is fundamental to a youth suicide prevention program. Warning signs of suicide include:

- suicide threat and/or statements revealing a desire to die (e.g., "I want to die," "I'm going to kill myself," "I wish I could just go to sleep forever");
- having a suicide plan, method and means;
- preoccupation with death;
- depression and marked changes in behavior (e.g., feelings of hopelessness, helplessness, social isolation; sudden happiness when preceded by significant depression; lack of interest in previously important activities; increased alcohol and/or other drug use);
- making final arrangements (e.g., giving away prized possessions).

A "gatekeeper" strategy has been successfully used for identifying youth at-risk in the school setting for suicide. "Gatekeepers" in the school environment are administrators, faculty, staff and students…anyone who can potentially come into contact with an at-risk student. The goal of this strategy is to increase gatekeepers' knowledge, skills and abilities to: (1) readily identify at-risk students (recognize warning signs of suicide), (2) provide an initial response, and (3) get help. Gatekeeper training is included in one objective of the Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Strategy for Suicide Prevention*.

There are various school suicide prevention programs utilizing this strategy. One such program, for example, is *Signs of Suicide* (SOS).[5] The SOS program is unique in that it combines both (a) education about suicide and its prevention and (b) a brief screening for depression (including questions regarding suicidal ideation and behavior). The SOS program has demonstrated a reduction in suicide attempts[6] and an increase in help-seeking behavior.[7] Screening for suicidal ideation and behavior has been found to be helpful, not harmful,[8] and is a major element of the nation's agenda for youth suicide prevention.[9] SOS is the only school-based suicide program selected by the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services to be included on its National Registry of Effective Programs. It is also endorsed by leading school-based professionals' organizations including the American School Counselor Association, National Association of School Nurses, National Association of School Psychologists, National Association of Secondary School Principals and others.

Protocols for Responding to Suicidal Behavior

As part of a comprehensive suicide prevention and intervention program, it is essential that schools have written protocols for responding to: (a) *students presenting with warning signs of suicide*, (b) *a suicide attempt*, and (c) *a suicide completion*. As an integral part of responding to any school crisis, it is suggested that schools have a crisis intervention

[4] If a program is to be implemented for detecting students at risk for suicide, it is imperative that there is an infrastructure in the school to respond and that community resources are available for referral.

[5] See *Screening for Mental Health* in the *Bibliography* section of this publication.

[6] Aseltine & DeMartino (2004)

[7] Aseltine (2003)

[8] Gould et al. (2005)

[9] New Freedom Commission on Mental Health (2003)

team.[10] An established crisis team enhances the infrastructure and process of response via collaborative action, collegial support and shared responsibility of decision making.

The protocols, for effective intervention and response will, at a minimum:

- designate specific individuals (including alternates) and their roles for responding to the situation;
- delineate specific actions to be taken as a response to the threat of student suicide, a suicide attempt or a suicide completion;
- identify pre-arranged partnerships and procedures with community resources (e.g., referral sources, crisis intervention specialists, first responders, media) so services are readily accessible when needed;
- establish documentation procedures and forms.[11]

PROTOCOL FOR STUDENTS PRESENTING WITH WARNING SIGNS OF SUICIDE

Once a student has been identified as presenting with warning signs of suicide, school personnel need to intervene with an immediate, appropriate and comprehensive response. The school's response should include, at a minimum:

- assessing the risk level of student suicidality;
- notifying a parent/guardian;
- contacting police/child protective services as applicable;
- providing supervision for the student;
- securing mental health services;
- providing follow-up.[12]

Assessing the Risk Level of Student Suicidality

Mental health or medical professionals in the school should assume the assessment role. Ideally, assessment for suicidal risk should be a collaborative process between more than one health professional in the school.

The initial assessment will be a matter of determining where the student is along the continuum of suicidal thought to suicidal action. In assessing risk, direct questions should be asked (for example):

- "Do you think about suicide?" or "Are you thinking about killing yourself?" (when? how often?)
- "Have you attempted suicide before?" or "Did you ever try to kill yourself?" (when? how/means?)
- "Do you have a plan to hurt yourself now?" (If so, explore how detailed the plan is by asking about time, place, means [access and lethality]; in general, the more concrete and detailed a plan is, the greater the risk.)
- "How likely is it you will try to kill yourself?"

If a student has suicidal thoughts *with* a detailed plan for committing suicide, she or he should be considered high risk. Having access to the means of suicide increases the risk. It's important to realize that someone seriously considering suicide may knowingly withhold their intentions.

Some level of suicidal thinking in adolescents is fairly common. Moreover, averaged national results from the Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) (1991-2003) show that, during the 12 months prior to being surveyed, approximately:

- 22 percent of the respondents seriously considered attempting suicide;
- 8 percent attempted suicide;
- 3 percent of the adolescents who attempted suicide needed medical attention.

The question arises: Who will ideate vs. who will act? A study,[13] asking exactly this question and utilizing the 1999 Youth Risk Behavior Survey, looked at the co-occurrence of health-threatening problem

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[10] For information on building school crisis response teams, refer to Brock, S. (2002). For an in-depth, how-to publication on responding to school crises, which includes building a school crises response team, see Center for Mental Health in Schools at UCLA (2004) in *Bibliography* section of this publication. (Also, be sure to check out their Web page for more resources for mental health in schools.)

[11] These are stated goals for a suicide intervention plan in Maine's *Youth Suicide Prevention, Intervention and Postvention Guidelines–A Resource for School Personnel* (see bibliography section of this publication) and should be incorporated by all schools developing suicide prevention/intervention/postvention protocols.

[12] Poland (1989); Lieberman and Davis (2002); Poland and Lieberman (2002)

[13] Miller, T. and Taylor, D. (2005)

behaviors as risk for suicide ideation and attempt. Problem behaviors included *violent behavior*, *binge drinking*, *disturbed eating behavior*, *regular tobacco smoking*, *illicit drug use,* and *high-risk sexual behavior*. The researchers found that:

- the move from ideation to attempt was highly concentrated in youth with multiple concurrent problems;
- 17 percent of youth reported four or more problem behaviors and accounted for 60 percent of medically treated suicide attempts;
- close to half (47 percent) of youth reporting all six problem behaviors had attempted suicide within the previous year;
- within each category of *ideation*, *attempt* and *treated attempt*, the odds of these out comes occurring increased with increased counts of problem behaviors.[14] Compared to youth reporting zero problem behaviors, the odds for:
  - *Ideation* were 2.2, 2.6, 3.8, 5.5, 7.4 and 13.4 times greater for youth with one to six problem behaviors, respectively;
  - *Attempt* were 3.6, 6.5, 8.4, 11.7, 24.0 and 60.2 times greater for youth with one to six problem behaviors, respectively;
  - *Medically Treated Attempt* were 2.3, 8.8, 18.3, 30.8, 50.0 and 227.3 times greater for youth with one to six problem behaviors, respectively.

- The mere count of co-occurring problem behaviors–regardless of the problem type–identifies suicide risk.

With its complex etiology stemming from an interactive mix of biological, psychological, social and cultural determinants, suicidal behavior cannot be predicted and prevented with certainty. Knowing warning signs,[15] risk factors and protective factors provides information for assessment and enhances opportunity for preventing suicides. Risk and protective factors include:

Risk Factors

- For completed suicide, being male[16]
- Feelings of worthlessness, anger, anxiety, hopelessness, helplessness
- Lack of coping and problem-solving skills
- Previous suicidal behavior/attempts
- Psychiatric/behavioral disorder:[17] major depression, anxiety, bipolar, substance abuse, disruptive behavior, impulse-control
- Low family and social support
- Stress related situational factors (e.g., unwanted pregnancy, interpersonal loss or conflict, rejection, family crisis, minority stress) coupled with other risk factors
- Family history of suicidal behavior
- Contagion: exposure to real or fictional accounts of suicide (e.g., via the media)
- Parental psychopathology
- Multiple, co-occurring health-threatening problem behaviors[18]
- Being gay, bisexual, lesbian and transgender (for ideation and attempts)
- Physical and sexual abuse
- Availability of means to commit suicide (e.g., firearm)
- Antidepressant use (for ideation and attempts).[19]

Protective Factors

- Resiliency
- Self-efficacy
- Problem-solving and coping skills
- A sense of purpose/hope/connectedness
- Family and other social support/connectedness

Figure 1 provides a conceptual framework for suicide regarding dynamics between psychic pain, risk factors, protective factors, and the ideation ⇔ action continuum.

There are adolescent suicide risk assessment instruments available that address a variety of risk

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[14] Because the YRBS is a cross-sectional study, it's unknown whether problem behaviors are antecedents or consequences of suicidal behavior or a mixture of both.

[15] See *Detecting/Identifying Suicidal Students* section

[16] While females attempt suicide at a higher rate than males, the rate of completed suicides is higher among males (vis a vis use of more lethal means).

[17] While 95% of those with mental disorders do not complete suicide, over 90% of completed suicides in the U.S. are associated with mental illness and/or alcohol and substance abuse.

[18] See specifically Miller & Taylor (2005).

[19] See specifically U.S. Food and Drug Administration (2004).

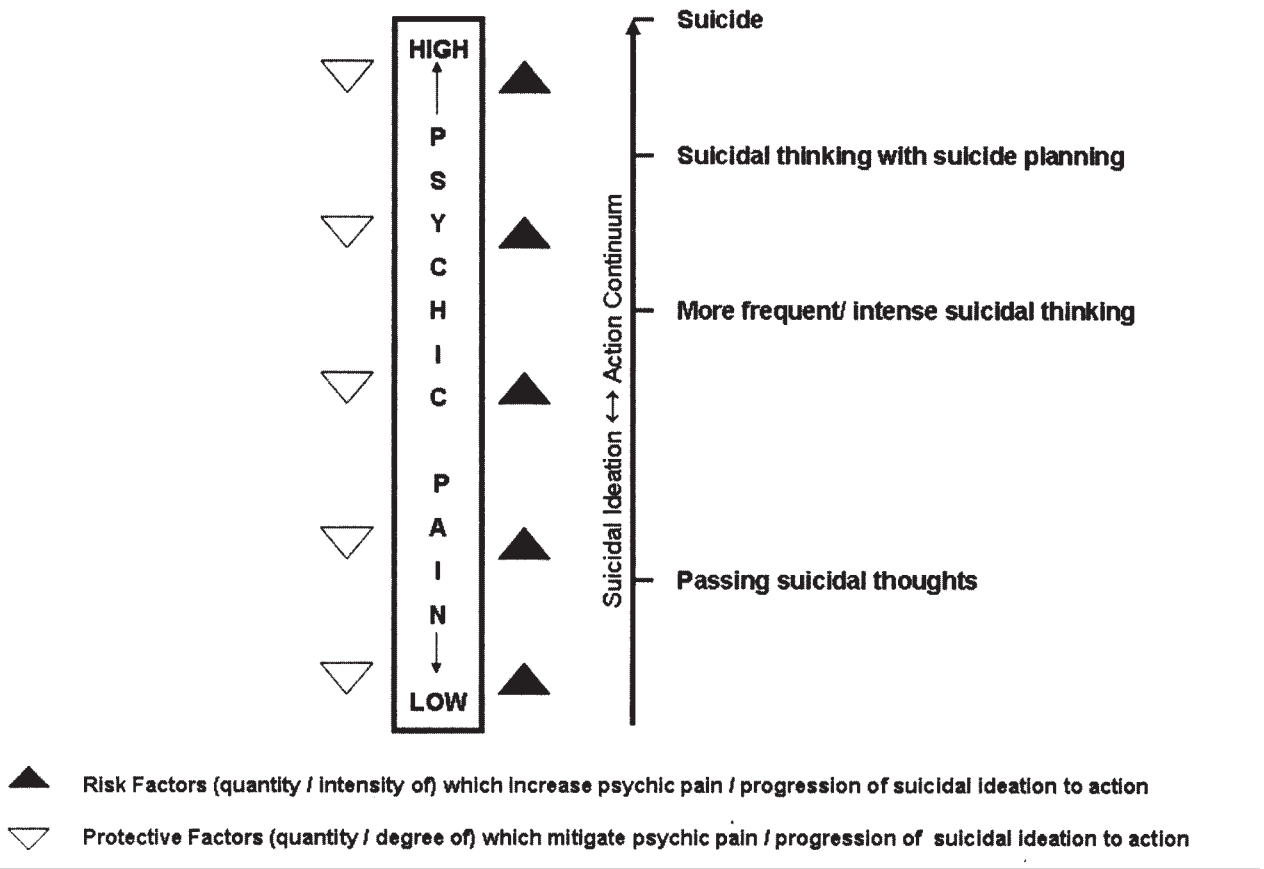

Figure 1. Conceptual framework for suicide regarding dynamics between psychic pain, risk factors, protective factors and ideation ↔ action continuum.

factors and warning signs that have been tested for validity and reliability.[20] For the most part, these tools are not readily available and accessible (e.g., are not downloadable from the Internet, cost money and are copyrighted). One exception to these barriers is the *Suicide Behaviors Questionnaire*-14 (SBQ-14).[21]

Notifying a Parent/Guardian

Parents need to be notified if there is any indication that their child is suicidal for any level of risk. Notifying parents that their child is presenting with warning signs of suicide serves at least three purposes: (1) it can initiate the family help and support needed for psycho-emotional healing and the prevention of an adolescent taking his or her life, (2) parental information can be valuable for assessing the student's risk for suicide and (3) it can prevent lawsuits in the event of a student suicide.[22] If calling a parent would endanger the child (abuse/neglect by the parent is suspected), then child protective services should be notified.

School personnel must realize that the duty to notify a parent trumps student confidentiality. School staff should not promise a student that his or her communication–whether verbal or written–will be confidential. This includes communication in academic assignments, such as journal writing for an English class or drawing for an art class, in which a student reveals suicidal ideation or behavior.

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[20] For a listing and description, see, for example, Range (2005) and Goldston, D. (2000).

[21] The SBQ-14 was developed by Dr. Marsha M. Linehan and colleagues. While copyrighted, with permission, the SBQ can be downloaded for use from the Internet at http://www.brtc.psych.washington.edu/pubs/SBQ.pdf. (Accessed 9/05.) Most questions on the SBQ-14 address suicidal ideation/behavior/threat/attempt and cover frequency, intensity, probability, means and lethality.

[22] Following a student suicide, schools have been found liable for failing to notify parents when the student was known to be suicidal.

Contacting Police, EMS, and/or Child Protective Services as Needed

Optimizing supervision of the student and preventing harm is the key here. If a parent is unavailable and the student is in immediate need of mental health services (she or he is at high risk for suicide), school personnel should contact a first responder (e.g., police or EMS). A school's emergency plan could include provisions for obtaining parental consent for transporting students in need of immediate treatment. Police should be called if the student has in possession a lethal means of harming self or others, and as needed if the student becomes combative.

Child Protective Services needs to be called if:

- child abuse/neglect is suspected;
- parents do not take appropriate action to get a high-risk child the mental health services she or he needs, thus endangering the life of the child.

Providing Supervision for the Student

Parents need to be contacted if there is any degree of suicidal risk. It's critical to stay with the student if risk of imminent danger exists. Student safety and support is paramount.[23] Until the school hands the student over to another authority (e.g., parent, police, EMS), it is the school's responsibility to appropriately supervise the student. While a low-risk student may not need an immediate "safety watch," a support system should be mobilized and subsequently the child should be monitored for an increased level of risk. Collaboration should occur among appropriate personnel to supervise, support and monitor at-risk students.

Securing Mental Health Services

Referrals will be based on student need and level of risk. The referral is a major element of an intervention. Schools should have a prearranged, collaborative infrastructure in place with community mental health resources for addressing student mental health needs. This infrastructure should include referral policies, designated provider agencies based on type and severity of need/risk, specific contact numbers, student information exchange logistics, follow-up agreements and documentation procedures.

In the referral process, it's important to:

- provide basic information about all relevant sources of support;
- help the student/family appreciate the need for and value of the referral;
- account for access barriers such as cost, location, cultural issues;
- to optimize their decision making process, assist student/families in understanding their support options;
- facilitate the student/family in connecting to the referral resource;
- follow-up with the student/family and referral resource to determine if referral decisions were appropriate[24] (and to determine follow-through by involved parties).

Providing Follow-Up

Providing follow-up is a matter of continuing to support the child and his or her family. This will include directing the student and family to further resources as needed, following up with referrals as discussed in the above section, utilizing general school-based care management and working with teachers to develop plans to help the student keep up with academics as needed (for example, if school attendance is hindered due to the student's participation in a therapy program or need for family support, schools can modify study workloads and provide "take-home" assignments[25]).

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[23] Other students must also be kept safe and away from a potentially harmful situation, and supported psychologically and emotionally in regard to their exposure to the situation. These guidelines are listed in Center for Mental Health UCLA (2003).

[24] These guidelines are listed in Center for Mental Health UCLA (2003).

[25] Some in-patient, youth mental health facilities provide schooling within the facility so that students can keep up with their academics while in treatment.

PROTOCOL FOR A SUICIDE ATTEMPT

If a suicide attempt results in a life-threatening or potentially life-threatening situation, immediate first aid needs to be provided (e.g., CPR, stopping bleeding) and 911 mobilized. The student should be comforted and kept safe. Other persons, not needed for help, should be kept clear of the area. The appropriate school personnel need to be notified of the situation (ideally, the school has an established crisis response team).

For both life-threatening and non-life threatening suicide attempt situations, the guidelines for the *Protocol for Students Presenting with Warning Signs of Suicide* regarding notifying a parent/guardian, mobilizing community resources, student supervision and follow-up should be adhered to. It's also important to support other students affected by the suicide attempt, including referral to community resources as needed.

A school can play an important role in monitoring and supporting the student who returns to school after having attempted suicide. Persons who have attempted suicide are at increased risk for completed suicide. Monitoring and support includes watching for warning signs of suicide and ensuring an appropriate level of care management applicable to the school setting.

POSTVENTION REGARDING A COMPLETED SUICIDE

Sometimes the psychic pain of sorrow and suffering leads to a suicide. A suicide prevention program in the school is, of course, intended to lessen the probability of this sad and tragic event. A suicide leaves in its wake a spectrum of thoughts and deeply felt emotions experienced by family, friends, peers, teachers and the community as a whole. Many persons will be in need of psychological and emotional support. Additionally, one suicide can lead to another suicide among peers, surviving family members or others in the community. The purpose of postvention in the school following a completed suicide is to bring support and assistance to those affected, to return the school environment to its normal routine, and to reduce the risk of another student "copying" the suicide (thus postvention is a means of prevention). A publication entitled *Suicide Postvention Guidelines: Suggestions for Dealing with the Aftermath of Suicide in Schools* can be obtained directly from the American Association of Suicidology (see Bibliography).

SUMMARY

Suicide is an incredibly tragic occurrence that is preceded by an existential state of intolerable psychic pain, followed by a range of deeply felt emotions experienced by those left in its wake. Many times, co-occurring with the psychological and emotional turmoil of the suicidal individual, are behavioral warning signs of suicidal intent. Many of our youth are considering killing themselves but have not taken that final step and are at risk for doing so. Schools have a vital opportunity to implement suicide prevention programs for: (1) detecting suicidal students, and (2) mobilizing intervention efforts for preventing suicides. It's important for schools to have an appropriate infrastructure in place to optimize their prevention and intervention efforts, e.g., gatekeeper training on suicide prevention; a school/community crisis response team; protocols for responding to suicidal behavior; and an overall climate of concern, care and action when it comes to youth suicide prevention. This publication addresses the problem of youth suicide and provides some suggested guidelines schools can use for developing and implementing a suicide prevention program.

A Note about the Use of No-Suicide Contracts

No-suicide contracts are sometimes used by mental health professionals as part of a suicide prevention strategy. This verbal or written agreement asks an individual not to harm him or herself and to seek help if they have ideas or the desire to do so. There are differing perspectives on whether no-suicide contracts have value. Some things to consider:

- Currently, there's a lack of scientific evidence to support their efficacy in preventing suicides.
- The "contract" has no legal grounds and does not provide protection against law suits.
- Use may enhance the therapeutic alliance if the at-risk individual perceives care and commitment on the part of the health professional.
- Use may hurt the therapeutic alliance if the at-risk individual perceives the health professional's motivation for use is to reduce liability or involvement in treatment.
- Usefulness may depend on the strength of the therapeutic/support relationship.
- Use may falsely reassure the health professional that the at-risk individual will not attempt suicide.
- Reasons an at-risk individual agrees or doesn't agree to the no-suicide contract may be multifaceted; thus, motivation and risk level may be difficult to discern.
- If used, it should be only used as a part of a comprehensive assessment and therapeutic process, not in isolation.

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