Suicide Prevention and Intervention in Schools

Guide I-107
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Cooperative Extension Service • College of Agricultural, Consumer and Environmental Sciences

"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]

INTRODUCTION

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.

In New Mexico, suicide is the second leading cause of death for youths ages 15 to 24. Nationally, suicide is the third leading cause of death among those in this age group. In 2009, the suicide rate in the U.S. for ages 15 to 24 was 10.1 per 100,000, but in New Mexico the rate was 21.2 per 100,000—twice the national rate. Data from the New Mexico Office of the Medical Investigator (2010) show there were 26 suicides in the state among youths ages 15 to 19. In 2010, New Mexico ranked among the states with the highest suicide rates for young adults ages 15 to 24 (19.9 per 100,000). Suicide deaths in 2010 were more common among young males (69%) than females (31%).

Data from the years 2005 to 2009 showed the New Mexico suicide rate averaged the highest among American Indian youths ages 15 to 24 (29.7 per 100,000). Hispanics followed closely with a rate of 19.2 per 100,000.

The New Mexico Youth Resiliency & Risk Survey (2011) found that 8.6% of high school students reported they had seriously considered attempting suicide in the previous 12 months. The New Mexico rate of attempted suicide was higher than the U.S. rate (8.6% compared to 7.8%). Females (12.3%) had a higher rate of attempted suicide than males (5.0%).

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. 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. The impact of suicide on families, schools, and communities is enormous. There is the subsequent, painful awareness about the suffering that the person who committed suicide must have endured—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.

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 suicide risk factors, protective factors, and warning signs. Additionally, they should be trained in how to respond to a student presenting with warning signs of suicide, a suicide attempt, or a completed suicide.

Furthermore, schools should have a means for detecting/identifying students at risk for suicide[3] and protocols for responding to students presenting with warning signs of suicide, a suicide attempt, or a suicide completion (postvention).

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

DETECTING/IDENTIFYING SUICIDAL STUDENTS

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

- suicide threats 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 that includes 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); and
- making final arrangements (e.g., giving away prized possessions).

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

There are various school suicide prevention programs utilizing this strategy. One such program, for example, is Signs of Suicide (SOS).[4] The SOS programs are developed for high school and middle school students. They are unique in that they combine both (a) education about suicide and its prevention and (b) screening for depression (including questions regarding suicidal ideation and behavior). In a randomized control study, the SOS program showed a 40% reduction in self-reported suicide attempts (Aseltine et al., 2007). Screening for suicidal ideation and behavior has been found to be helpful, not harmful (Gould et al., 2005). The U.S. Preventive Services Task Force recommended routine depression screening for all teens ages 12 to 18 by their primary care providers (TeenScreen, 2009).

Web-based social media tools are also providing service to help prevent suicides (Facebook Safety, 2011). For example, Facebook users can use the Report Suicidal Content link or the report links found throughout the site to report a suicidal comment they see posted by a friend to Facebook. The person who posted the suicidal comment will immediately receive an email with prevention support contacts.

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 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 response team.[5] An established crisis response team enhances the infrastructure and process of responding via collaborative action, collegial support, and shared responsibility of decision-making.

At a minimum, the protocols for effective intervention and response will:

- 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 response specialists, first responders, media) so services are readily accessible when needed; and
- establish documentation procedures and forms (Maine, 2009).

PROTOCOLS 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. At a minimum, the school's response should include:

- 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, and

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[4] See Screening for Mental Health in the *References* section of this publication.

[5] For an in-depth, how-to publication on responding to school crises, which includes building a school crisis response team, see *Youth Risk Taking Behavior: The Role of Schools*, available at http://smhp.psych.ucla.edu/pdfdocs/policyissues/risktaking.pdf, as well as *A Model for School-based Crisis Preparedness and Response*, available at http://www.ojp.usdoj.gov/ovc/publications/bulletins/schoolcrisis/pg3.html.

- providing follow-up (Poland, 1989; Lieberman and Davis, 2002; Poland and Lieberman, 2002).

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/by what 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) (2011) show that, during the 12 months prior to being surveyed, approximately:

- 15.8% of the respondents seriously considered attempting suicide,
- 7.8% attempted suicide one or more times, and
- 2.4% of the adolescents who attempted suicide needed medical attention.

The question arises: Which students will ideate (contemplate or consider) suicide versus which students will act? A study by Miller and Taylor (2005) asking exactly this question and utilizing the 1999 Youth Risk Behavior Survey looked at the co-occurrence of health-threatening problem 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.
- Seventeen percent of youth reported four or more problem behaviors and accounted for 60% of medically treated suicide attempts.
- Close to half (47%) 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 outcomes occurring increased with increased counts of problem behaviors.[6] 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—identified suicide risk.

With its complex causes stemming from an interactive mix of biological, psychological, social, and cultural determinants, suicidal behavior cannot be predicted and prevented with certainty. Knowing warning signs[7], 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[8]
- Feelings of worthlessness, anger, anxiety, hopelessness, helplessness
- Lack of coping and problem-solving skills
- Previous suicidal behavior/attempts
- Psychiatric/behavioral disorder[9], such as major depression, anxiety, bipolar, substance abuse, disruptive behavior, impulse-control
- Low family and social support

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[6] 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.

[7] See *Detecting/Identifying Suicidal Students* section of this publication.

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

[9] 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.

- 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 or exposure to real or fictional accounts of suicide (e.g., via the media)
- Parental psychopathology
- Multiple, co-occurring health-threatening problem behaviors (see specifically Miller and Taylor [2005])
- Being gay, bisexual, lesbian, or transgender (for ideation and attempts)
- Physical and sexual abuse
- Availability of means to commit suicide (e.g., firearm)
- Antidepressant use (for ideation and attempts; see specifically U.S. Food and Drug Administration [2004])

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 the 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 factors and warning signs that have been tested for validity and reliability. For the most part, these tools are not readily available and accessible (e.g., are not downloadable from the Internet, cost money, are copyrighted). Exceptions to these barriers include the Suicide Behaviors Questionnaire-14 (SBQ-14)[10]; the Tool for Assessment of Suicide Risk for Adolescents (TASR-A)[11]; Suicide Behaviors Questionnaire-Revised (SBQ-R), which includes scoring guidelines[12]; and a series of tools available from Teen Mental Health.[13]

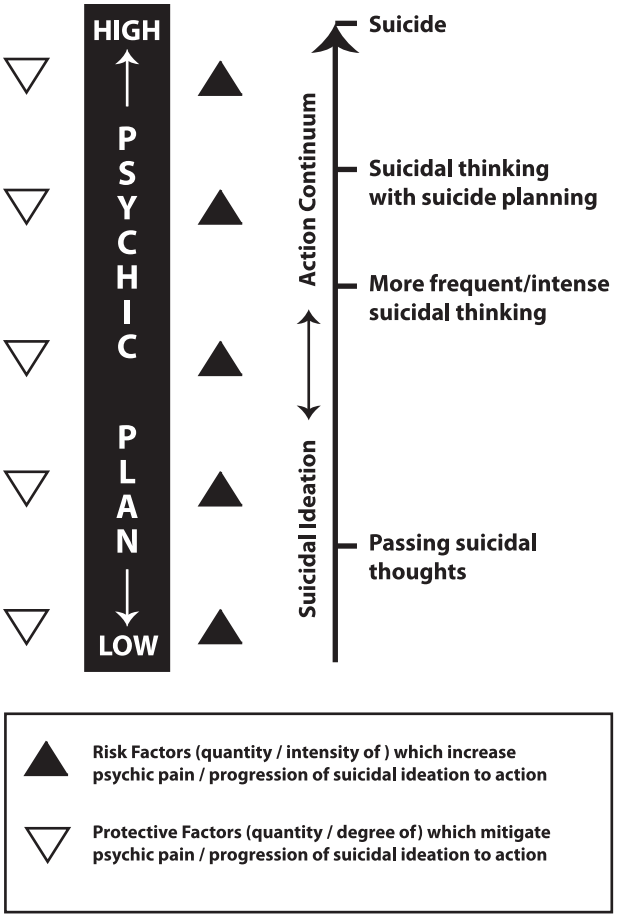

Figure 1. **Conceptual framework for suicide regarding the dynamics between psychic pain, risk factors, protective factors, and the ideation ↔ action continuum.**

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.[14] 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.

[10]Available at http://www.glaje.com/Scales/Suicidal_Beh_Quest_pre_assessment.pdf
[11]Available at http://www.teenmentalhealth.org/images/resources/TASR-A_Package.pdf
[12]Available at http://www.integration.samhsa.gov/images/res/SBQ.pdf
[13]Available at http://teenmentalhealth.org/for-health-professionals/clinical-tools/
[14]Following a student suicide, schools have been found liable for failing to notify parents when the student was known to be suicidal.

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 himself 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 is a lack of scientific evidence to support their efficacy in preventing suicides.
- The "contract" has no legal grounds and does not provide protection against lawsuits.
- 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 that 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 only be used as a part of a comprehensive assessment and therapeutic process, not in isolation.

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 possesses lethal means of harming herself or himself or others, and as needed if the student becomes combative.

Child Protective Services needs to be called if:

- child abuse/neglect is suspected or
- 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 are paramount.[15] 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 the child should subsequently 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, and cultural issues;
- optimize the student/family decision-making process and assist them in understanding their support options;
- facilitate the student/family in connecting to the referral resource; and
- follow-up with the student/family and referral resource to determine if referral decisions were appropriate[16] (and to determine follow-through by involved parties).

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[15] 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 in Schools at UCLA (2007b).

[16] These guidelines are listed in Center for Mental Health in Schools at UCLA (2007b).

Providing Follow-Up

Providing follow-up is a matter of continuing to support the child and the family. This will include directing the student and family to further resources as needed, following up with referrals as discussed in the previous section, utilizing general school-based care management, and working with teachers to develop plans to help the student keep up with academics as needed (e.g., 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[17]).

PROTOCOL FOR A SUICIDE ATTEMPT

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

For both life-threatening and non-life-threatening suicide attempts, the guidelines regarding notifying a parent/guardian, mobilizing community resources, supervising the student, and following up should be adhered to (in the *Protocols for Students Presenting with Warning Signs of Suicide* section of this publication). 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. People who have attempted suicide are at increased risk for completed suicide. Monitoring and support include watching for warning signs of suicide and ensuring there is an appropriate level of care management available that is applicable to the school setting.

POSTVENTION REGARDING A COMPLETED SUICIDE

Sometimes the psychic pain of sorrow and suffering leads to a suicide. A school suicide prevention program is, of course, intended to lessen the probability of this 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 people 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 *School Suicide Postvention Guidelines* can be obtained directly from the American Association of Suicidology (see *References*).

SUMMARY

Suicide is an incredibly tragic event 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, concurrent with the psychological and emotional turmoil of the suicidal individual, behavioral warning signs of suicidal intent can be seen. 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 response efforts for preventing suicides. It's important for schools to have an appropriate infrastructure in place to optimize their prevention and response 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.

ADDITIONAL RESOURCES

The National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org/) or a toll-free suicide prevention hotline network comprising 152 local crisis centers, 1-800-273-TALK (8255).

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

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