School-Based Suicide

Risk Assessment, Prevention, & Postvention

“THE NEED TO BELONG & TO CONTRIBUTE IN SOME WAY TO SOCIETY SEEMS TO BE AN ESSENTIAL PART OF WHAT IT MEANS TO BE HUMAN.” THOMAS JOINER

Risk Factors & Warning Signs

**RISK FACTORS** (can be used for identification)
Combination of genetic, neurobiological, social, cultural, and psychological influences. They predispose an individual to suicidal behaviour and are more distant in time.

* Typically longstanding & unchangeable
* Presence of 1 or more mental health disorder
* Previous suicidal behaviour (especially attempts)
* Social isolation &/or bullying
* Limited access to mental health facilities
* Poor problem-solving & coping skills
* Low self-esteem
* Dysfunctional parenting or family environments or parental psychopathology
* Repeated engagement in or exposure to violence
* Access to lethal weapons
* Cultural or religious beliefs

**WARNING SIGNS**
May indicate the increased probability of suicidal behaviour. They are more immediate in time and are typically more dynamic.

* Hopelessness
* Rage, anger, seeking revenge
* Engaging in risky activities or acting recklessly
* Feeling trapped (feel there is no way out)
* Increasing alcohol or drug use
* Withdrawal from friends, family, or society
* Experiencing anxiety &/or agitation
* Being unable to sleep or sleeping excessively
* Dramatic mood changes
* Perceiving no reason for living

*SITUATIONAL CRISSES, STRESSFUL LIFE EVENTS MAY “TRIGGER” SUICIDAL BEHAVIOUR IN VULNERABLE INDIVIDUALS (increase risk)*

Interpersonal-Psychological Theory of Suicide Behaviour

A youth has both the **desire** as well as the **capacity** to die by suicide. Desire is developed by perceived **burdensomeness** and failed **belongingness**. The view that one’s existence burdens family, friends, and/or society, and that one is alienated from others and not an integral part of a family, circle of friends, or other valued groups are potentially fatal misperceptions. Capacity is developed through past pain and provocation that habituate an individual to the fear and pain of self-injury. In varying degrees any experience that produces substantial pain and/or fear may further this habituation process (injury, accidents, violence, “daredevil” behaviours).

**IMPLICATIONS:**
- Emphasis of interventions should be on interpersonal contact (target perceived burdensomeness & failed belonging which are more malleable).
- Combine symptom based screening with theory-based screening.
- Material on warning signs should be considered for prevention protocols
- Underscores importance of creative positive, genuine, & meaningful connections between students and school personnel

**DEMOGRAPHICS**
- Suicide is the 3rd leading cause of death among adolescents ages 15-19, and the 4th leading cause of death among youth ages 10-14.
- Caucasian youth have the highest numbers of suicide, but proportionally Native Americans are higher.
- **GIRLS ATTEMPT** 2/3 times more than boys, but **BOYS DIE** 4/5 times more than girls (consistent pattern across ethnicity & age)
- Suicide rate increases as youth get older.
- **SEXUAL MINORITIES** are at greater risk for ideation & attempts
- **RURAL areas & LOW SES** have higher rates of suicide behaviour.
- 90% of youth who have died by suicide would have qualified as having a mental illness.
Conducting Risk Assessments in Schools

**PRIMARY PURPOSES:**

1) To determine if a student is potentially suicidal (& if so to what extent)
2) Link assessment results with interventions that will best meet student’s needs.

**5 POSSIBLE RISK LEVELS**

1. **Minimal Risk** = no identifiable suicidal ideation.
2. **Mild Risk** = suicidal ideation (limited frequency, intensity, duration, & specificity).
3. **Moderate Risk** = frequent suicidal ideation with limited intensity/duration, some specificity in terms of plan, no associated intent.
4. **Severe risk** = frequent, intense, & enduring suicidal ideation, specific plan, objective markers of intent.
5. **Extreme risk** = frequent, intense, and enduring suicidal ideation, specific plans, clear intent.

**INDIVIDUAL STUDENT INTERVIEW**

- Be cognizant of developmental issues.
- May bring in another trusted adult (to make student comfortable).
- Be very specific in your language & approach
- Clearly inform student why interview is being conducted
- Record student responses verbatim

*Use the interview to determine which risk category to place the student & act accordingly.

*Make sure to document everything that was done after interview & that student is receiving appropriate intervention.

**AREAS TO ASSESS**

- How student currently feels
  - Past/current levels of:
    - Depression
    - Hopelessness
    - Suicidal ideation
  - Perceptions of burdensomeness & belongingness
  - History of drug use/abuse
  - Current problems/stressors at home, school
  - History of and previous suicide attempt(s)
- Methods used in any previous attempts
- Presence or absence of suicidal plan
- Specificity & lethality of method in suicide plan
- Availability of lethal means
- Possibility of rescue
- Current support systems
- Reasons to live

**UNIVERSAL PROGRAMS**

**PRINCIPLES OF EFFECTIVE PROGRAMS**

- Reinforce protective factors while reducing risk factors
- Provides students with accurate information
- Teaches problem-solving & coping skills
- There are reliable and valid screening & assessment measures available (SIQ)
- Theory-driven & evidence-based
- Emphasize behaviour change as well as promote personal/social competencies
- Recognize importance of multiple environmental influences
- Foster connections to adults & prosocial peers
- Permits flexible approaches to fit the needs, preferences, & values of population
- Evaluate & modified as needed
- Implemented properly & effectively
- Teaches students how and where to get help
- Improve school climate, school satisfaction, & school connectedness

**COMMON MYTHS About Youth Suicide**

- Most youths leave a note: Most don’t!
- Suicidal youth are crazy or impulsive: They have cognitive distortions
- December has higher rates of suicide: December has LESS
- Parents know of their child’s suicidal behaviour: They DON’T
- Suicide is a result of stress: it’s the combination of stress plus vulnerabilities
- If you talk about suicide or question youth about it you will “put ideas into their head”: This belief impedes prevention & progress
- If someone wants to die by suicide there is little anyone can do to stop it: it actually INCREASES knowledge & referrals, & CHANGES ATTITUDES

“Talking about suicide does not cause someone to become suicidal—but it may prevent it.”

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Dianne Ballance

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Selected Interventions

―The only good assessment is one that results in an effective intervention.―
Frank Gresham

AT-RISK STUDENTS

INCREASE CONNECTEDNESS
* Check & Connect Program
* Structured extracurricular activities
* Increase positive interactions between staff & students

FOR DEPRESSION & HOPELESSNESS
* Penn Resiliency Program
* Cognitive Behavioural Strategies
  - cognitive restructuring
  - disputing irrational thoughts
  - attribution retraining
  - self-monitoring & self-control training
  - increasing engagement in pleasant activities

HIGH RISK STUDENTS

- Remove access to all lethal means
- Keep student safe
- Break confidentiality
- Use commitment to treatment statements
- Notify parents/guardians
- Notify police & other community supports
- Documentation
- Prepare for the student’s return to school
- Increasing contact

RECOMMENDED RESOURCES
American Association of Suicidology www.suicidology.org
Sources of Strength Program www.sourcesofstrength.org
SOS Signs of Suicide Screening www.mentalhealthscreening.org
Suicide Prevention Resource Center (SPRC) www.sprc.org
Crisis Centre BC www.crisiscentre.bc.ca
Canadian Association for Suicide Prevention www.suicideprevention.ca
River of Life Program www.riveroflifeprogram.ca
Applied Suicide Intervention Skills Training (ASIST) www.livingworks.net

POSTVENTION GUIDELINES

- Plan in advance of any crisis; review guidelines from professional organizations (such as NASP, CPA, BCASP).
- Have the school crisis team meet or communicate as soon as possible following a suicide to make plans & assign duties.
- Verify and confirm that a suicide occurred. Communicate with medical examiner, coroner, or family of the deceased.
- Do not dismiss school or encourage funeral attendance during school hours, BUT let students know they can attend funeral with parental approval.
- DO ensure that school staff members attend the funeral to support the affected students as well as the family of the suicide victim.
- Dedicate a “living” memorial rather than a physical one.
- Contact the family and offer condolences and support. Appraise the family of how the school is responding.
- Disseminate information about the suicide to students in classrooms or in small groups.
- Be truthful but avoid unnecessary explicit details or focusing on why the suicide happened.
- Recognize that different students will react in different ways (e.g., shock, depression, anger).
- Try to focus students on general factors in suicide prevention, focusing on coping skills, and let students know about community supports.
- Monitor close friends & classmates of the suicide victim, meet with them individually.
- Arrange for makeshift counseling rooms available so that mental health professionals can meet privately with students and school personnel.
- Collaborate with media, law enforcement, & community agencies (emphasize help is available & no one thing is to blame.
- Provide follow-up services to those most affected & be aware of anniversary dates (birthday, death).
- Evaluate the postvention response

REFERENCES