


Suicide Prevention: A Gatekeeper Training for School Personnel

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Mass Administrators for Special Education
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A SERVICE OF RIVERSIDE COMMUNITY CARE

But I'm a....

School Resource Officer	Coach	History Teacher	Administrator
English Teacher			Bus Driver
Guidance Counselor	Math Teacher	School Nurse	Parent Teacher Liaison

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A Major Public Health Issue Nationally

- In 2016: 44,965 suicide deaths
 - 123 people a day
 - 10th leading cause of death (www.cdc.gov)
- Leading cause of injury-related death (surpassing auto accidents since 2009). (www.cdc.gov/injury/wisqars/index.html)
- Over 90% of people who die by suicide suffer from a diagnosable mental illness – most often depression. (Jacobs, 1999)
- Suicide is “the most preventable form of death in the U.S. today.” (Former Surgeon General, David Satcher)

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A Major Public Health Issue for Young People

2017 Youth Risk Behavior Survey Quiz:

	U.S.	MA
What % of students felt so sad or hopeless for 2+ weeks that they stopped doing some usual activity?	31.5%	27.4%
What % of students seriously considered attempting Suicide?	17.2%	12.4%
What % of students made a suicide plan?	13.6%	10.9%
What % of students made a suicide attempt?	7.4%	5.4%
What % of students made a suicide attempt that required medical attention?	2.4%	1.9%

- Suicide ranks as the 2nd leading cause of death for young people (ages 10-24). (CDC, 2016)
- For every suicide death of a young person, it is estimated that 100 to 200 attempts are made. (Goldsmith et al., 2002)

www.cdc.gov/HealthyYouth/yrbs/index.htm Riverside Trauma Center

A Major Public Health Issue in Massachusetts

- 631 deaths ruled as suicides in 2016
- The number of suicides in 2015 was 4X higher than homicides.
- From 2005-2015:
 - More than 6,100 MA residents died by suicide.
 - Suicide rates increased an average of 2.6% per year, and 27.4% overall from 7.3 to 9.3
- 48th of the States in terms of suicide rate in 2016.
- MA Samaritans and the United Way of Tri-County's *Call2Talk Center* took 167,708 crisis calls in 2016.


Figure 3B: Suicide Rates by Sex and Age Group, MA 2015 (N=631)

Age Group	Male	Female
0-14	12.3	3.6
15-24	17.7	5.3
25-34	16.5	6.2
35-44	23.0	9.4
45-54	18.9	6.6
55-64	13.2	3.5
65-74	15.2	4.0
75-84	18.4	4.0

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Our "Definition" of Suicide

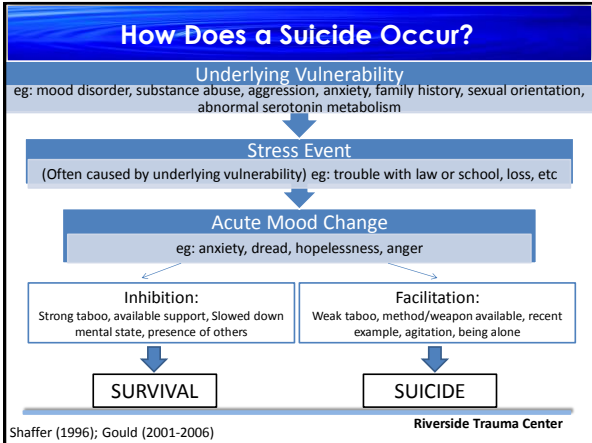
Suicide is an attempt to solve the problem of intense psychological pain.

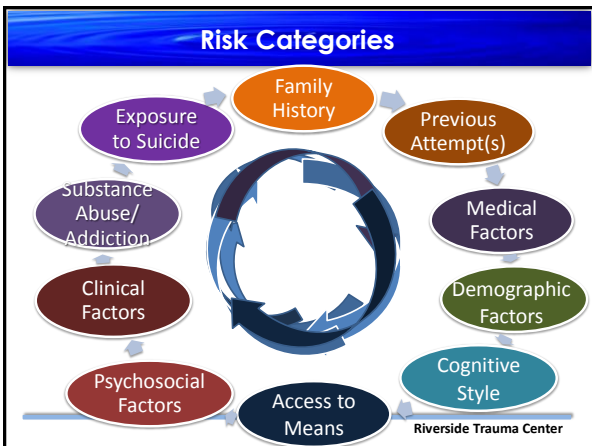


Empty Row Boat Stories – B Matros

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Adapted from Schneidman (1985)





Groups of Students at Higher Risk

- Students with mental illness;
- Students who have previously attempted suicide or who know someone who died by suicide;
- Victims or perpetrators of abuse or bullying;
- Students who are gay, lesbian, bisexual, transgender, or questioning their sexuality (especially if their families or community are rejecting of their sexuality);
- Perfectionists and high-achievers;
- American Indian students and white, male students;
- Students at risk for dropping out;

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Adapted from dpi.wi.gov & 2012 National Strategy for Suicide Prevention

Groups of Students at Higher Risk (cont)

- Students who are highly aggressive or impulsive;
- Students who abuse alcohol or other drugs.
- Students recently discharged from an Inpatient Psychiatric Hospitalization;
- Students involved with the Justice and/or Child Welfare Systems;
- Students Who Engage in Nonsuicidal Self-Injury;
- Students With (certain) Medical Conditions;
 - Cancers, CNS Disorders/Injuries, HIV/AIDS, Chronic Kidney Disease, Arthritis, Asthma

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Adapted from dpi.wi.gov & 2012 National Strategy for Suicide Prevention

Adverse Childhood Experiences (ACEs) Study

ACE Category	Women (N = 9,367)	Men (N = 7,970)	Total (N = 17,337)
<u>Abuse</u>			
Emotional Abuse	13.1	7.6	10.6
Physical Abuse	27.0	29.9	28.3
<u>Neglect</u>			
Sexual Abuse	24.7	16.0	20.7
<u>Household Dysfunction</u>			
Emotional Neglect	16.7	12.4	14.8
Physical Neglect	9.2	10.7	9.9
Mother Treated Violently	13.7	11.5	12.7
Household Substance Abuse	29.5	23.8	26.9
Household Mental Illness	23.3	14.8	19.4
Parental Separation or Divorce	24.5	21.8	23.3
Incarcerated Household Member	5.2	4.1	4.7

CDC

ACE Score and Suicide Attempts

- The relationship between suicide and adverse childhood experiences is **“of an order of magnitude that is rarely observed in epidemiology and public health data.”**
- 80% of suicide attempts during childhood/adolescence were attributable to ACEs.
- Childhood and adolescent suicide attempts increased 51-fold, or 5,100% with an ACE score of 7 or more.

ACE Score	% Attempting Suicide
0	0
1	1
2	2
3	3
4+	4

Dube et al. (2001) Riverside Trauma Center

Impulsivity

Crisis On Same Day as Death

Age	Percentage
0-17	33%
18-24	21%
25-44	20%
45-64	13%
65+	6%

N=1671

Miller (2001); www.hsph.harvard.edu/means-matter/ Riverside Trauma Center

Non Suicidal Self-injury (NSSI) in Youth


- Non suicidal self-injury is defined as “the deliberate, direct, and self-inflicted destruction of body tissue resulting in immediate tissue damage, for purposes not socially sanctioned and without suicidal intent.”
- Self-injury is a maladaptive coping skill employed by youth experiencing painful emotions.
- Is generally NOT an attempt to die by suicide.
- Death can occur, even if unintentionally.
- While suicidal behaviors and NSSI are distinct behaviors both may occur in the same person.
- NSSI is a significant risk factor for suicide.

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Depression & Suicide Risk Factors

Depression is a primary risk factor for suicide and is also linked to other risk factors including:

- Use/abuse of alcohol and other drugs
- Nonsuicidal Self-Injury (NSSI)
- Social isolation
- Bullying (Both victim and perpetrator)
- Physical pain/poor health outcomes



Dependence - B. Matros
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What Does Depression Look Like?

- Frequent sadness, tearfulness, crying
- Expressed hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Frequent complaints of physical illnesses such as headaches and stomachaches

American Academy of Child & Adolescent Psychiatry
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What Does Depression Look Like? (cont)

- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of, or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

American Academy of Child & Adolescent Psychiatry
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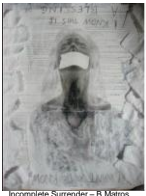
Characteristics of Pediatric Depression

Despite some similarities, pediatric depression differs in important ways from adult depression. Associated anxiety symptoms, such as fears of separation or reluctance to meet people, and somatic symptoms, such as general aches and pains, stomach aches, and headaches, are more common in depressed children and adolescents than in adults with depression.

Substance Abuse and Mental Health Services Administration

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Several Studies have indicated that 50-70% of people communicate intent prior to making a suicide attempt or dying by suicide



In most cases these communications are behavioral or coded rather than direct threats.

Robins et al. (1959); Coombs, et al. (1992)

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- What are some of the ways teens might communicate their wish to die?
- What about younger children? What might we see or hear?



Dad's Tree - B Matros

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Warning Signs

A Young Person may be at Critical Risk of Suicide if He or She:

- Threatens to hurt or kill him or herself; or talks of wanting to hurt or kill him or herself;
- Looks for ways to kill him or herself by seeking access to firearms, pills, or other means;
- Talks or writes about death, dying or suicide, when these actions are out of the ordinary.

AAS (n.d.) Riverside Trauma Center

Warning Signs of Suicidal Youth

If a youth shows or expresses any of the following behaviors or symptoms, they may signal a suicidal crisis.

- Feelings of **Hopelessness**
- **Anxiety**, agitation, trouble sleeping or sleeping all of the time
- Expressions of having no reason for living; no sense of **purpose** in life
- Feelings of being **trapped** - like there's no way out
- Increase **alcohol and/or drug use**
- **Withdrawal** from friends, family, and community
- Rage, uncontrolled **anger**, expressions of wanting or seeking revenge
- **Reckless** behavior or more risky activities, seemingly without thinking
- Dramatic **mood changes**
- **Giving away** prized possessions

AAS (n.d.) Riverside Trauma Center

Teen Suicide Prevention Video for School Personnel

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“If you think something’s wrong, the only way to find out is to ask.”

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How to Ask the Question

Indirect:

- “Do you wish you would go to sleep and not wake up?”
- “Do you wish you were dead?”

Direct:

- “Have you thought about killing yourself?”
- “Have you had thoughts about suicide?”

Shea (2002)

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How Not to Ask the Question:

“You’re not thinking about suicide, are you?”

Quinnett (2000)

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Why Not?

“Are you thinking about hurting yourself?”

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How Would You Ask?

- I’m concerned....
- I’ve noticed that you seem really quiet lately, like something might be bothering you...
- You know, you’ve been saying some things that make me wonder....
- Sometimes when kids are feeling as upset as you’re telling me you feel, they say they might have thought life wasn’t worth living or they wish they were dead. I’m wondering if you’ve ever thought that?

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How Would You Ask? - ACT

Acknowledge that you are seeing signs of depression or suicide in a student and that it is serious

Care: Let the student know you **care** about them and you can help

Tell: Follow your school protocol and **tell** your mental health contact

It’s also what we teach the students

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What is the school's/district's protocol for handling students at risk of suicide?

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Next Steps

- What is your school protocol?
 - Does it include:
 - A designated point of contact in the building?
Student support team? Risk team?
 - Notification of parents?
 - Referral to local Emergency Services Team?
 - Independent evaluation?
 - Re-entry plan and follow-up plan?
- How do you access community resources?

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Upstream Prevention

Suicide Rate by Age (1999-2009)

Age	Rate per 100,000
6	0.1
7	0.1
8	0.1
9	0.1
10	0.2
11	0.3
12	0.5
13	1.0
14	2.0
15	3.5
16	5.5
17	7.5
18	9.5
19	11.5
20	12.0
21	13.5
22	13.0
23	13.5
24	13.5

Be prevented here?

Can a suicide that occurs here

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CDC Centers for Disease Control and Prevention Adapted by Rogers (2013)

Key Goals for Prevention and Protection

+ PROSOCIALITY

- Supportive social networks
- Empathy and concern about the welfare and rights of others

- TOXIC INFLUENCES

- Biological, Psychological, Social, Environmental, Cultural

+ PSYCHOLOGICAL FLEXIBILITY

- Understanding and acting in service of one's values
- Adapting to changing circumstances
- Problem solving, response inhibition, & other executive functions


Adapted from Biglan, et al. (2012) Riverside Trauma Center

Protective Factors

- Availability of Physical and mental health care
- Restrictions on lethal means of suicide
- Safe and supportive school and community environments
- Sources of continued care after psychiatric hospitalization
- Moral objections to suicide
- Connectedness to individuals, family, community, and social institutions
- Supportive relationships with health care providers
- Coping and problem solving skills
- Reasons for living (e.g. pets, connection to family, future goals, etc.)

2012 National Strategy for Suicide Prevention Riverside Trauma Center

Enhancing Protective Factors & Capacity for Resilience



- Positive emotions - optimism and humor
- Emotion regulation - fear, anger, etc
- Coping style - active/approach vs passive/avoidant
- Social support
- Cognitive flexibility - positive explanatory style, positive reappraisal, and acceptance
- Spirituality
- Moral code - including altruism
- Resilient role models
- Purpose and meaning - mission, patriotism, colleagues
- Training - physical, psychological and spiritual

Southwick & Charney (2012) Riverside Trauma Center

The Role of Schools in Prevention & Identification

- How/where do we spot youth with emotional challenges?
- How/where in our curriculum can we address these concerns?
- Do we have procedures/policies for what to do when we're concerned?
- **How do we promote strength and resilience in our students?**

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To Be or Not to Be, That is NOT the Only Question

Examples of Ways to Include Suicide Prevention and Healthy Coping Messaging Into Existing School Curriculum:

- Reframe the narrative: *"The real tragedy here is..."*
- Downplay the romanticism of suicide and mental illness
- Mention that suicide is complex and avoid simplistic explanations for suicide
- Talk about other choice points/problem solving option for the characters
- Embed information into regular conversations and interactions about: Trauma, Coping skills, Self-regulation, Prosociality, & Problem solving
- Offer hope and assert that there is always help

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"Take Home" Message

- Everyone is a "gatekeeper"
- Always take a suicidal communication seriously!
- Don't be afraid to ask directly about suicide.
- Holding the hope for a suicidal student
- Clear school protocols that everyone knows

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Gratitude Letter

Dear Ms. Daniels,

I'm not sure if you remember me, but I was in your 10th grade English class in 2005-2006. You may not have realized it, but I had a raging eating disorder throughout my high school years. I was very wounded, desperate, and alone. One day after class you asked me to stay, and I did. You asked me if I was OK and if I need to talk. I told you no, but I think we both knew that I did. I didn't talk to you then or ever, but I remember you and your compassion.

I'm in treatment now for my eating disorder. I want you to know that in all of my years of high school, you are the only person who ever expressed concern for me. I will never forget it. I was too sick to appreciate it at the time or to take advantage of your help, but I never forgot it. Thank you for taking the time to care about me and all of your students.

Sincerely,
Susan S.

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Siegfried (2012)

QUESTIONS?



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