Suicide Prevention and Assessment

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Model For Schools, Communities & Families

Prevention

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Intervention

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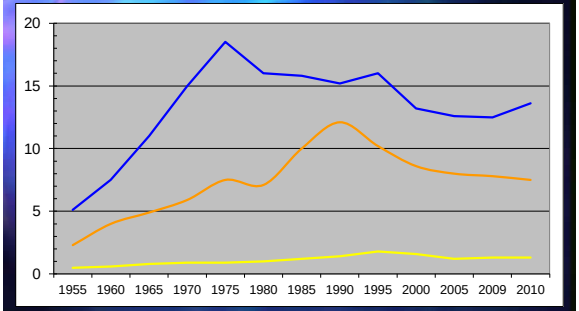
Postvention

U.S. Youth Suicide Rates



10 Leading Causes of Death by Age Group, United States – 2010

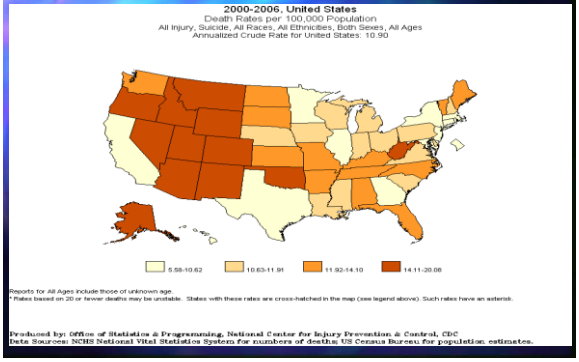
Rank	Age Groups										
	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Congenital Anomalies 5,107	Unintentional Injury 1,364	Unintentional Injury 716	Unintentional Injury 885	Unintentional Injury 12,241	Unintentional Injury 14,173	Unintentional Injury 14,792	Malignant Neoplasms 50,211	Malignant Neoplasms 109,501	Heart Disease 477,338	Heart Disease 597,689
2	Short Gestation 4,144	Congenital Anomalies 507	Malignant Neoplasms 439	Malignant Neoplasms 477	Homicide 4,678	Suicide 5,735	Malignant Neoplasms 11,809	Heart Disease 36,729	Heart Disease 68,077	Malignant Neoplasms 398,870	Malignant Neoplasms 574,743
3	SIDS 2,063	Homicide 385	Congenital Anomalies 163	Suicide 267	Suicide 4,600	Homicide 4,258	Heart Disease 10,594	Unintentional Injury 10,667	Chronic Low. Respiratory Disease 14,242	Chronic Low Respiratory Disease 118,011	Chronic Low. Respiratory Disease 138,080
4	Maternal Pregnancy Comp. 1,661	Malignant Neoplasms 346	Homicide 111	Homicide 150	Malignant Neoplasms 1,604	Malignant Neoplasms 3,619	Suicide 6,571	Suicide 8,799	Unintentional Injury 14,022	Cerebro-vascular 108,900	Cerebro-vascular 129,476
5	Unintentional Injury 1,110	Heart Disease 158	Heart Disease 68	Congenital Anomalies 136	Heart Disease 1,038	Heart Disease 3,222	Homicide 2,873	Liver Disease 8,651	Diabetes Mellitus 11,677	Alzheimer's Disease 82,816	Unintentional Injury 130,859
6	Placenta Cord. Membranes 1,030	Influenza & Pneumonia 91	Chronic Low Respiratory Disease 60	Heart Disease 117	Congenital Anomalies 412	HIV 741	Liver Disease 2,423	Cerebro-vascular 5,910	Cerebro-vascular 10,693	Diabetes Mellitus 49,191	Alzheimer's Disease 83,494
7	Bacterial Sepsis 583	Septicemia 82	Cerebro-vascular 47	Chronic Low Respiratory Disease 73	Cerebro-vascular 190	Diabetes Mellitus 606	Cerebro-vascular 1,904	Diabetes Mellitus 5,610	Liver Disease 9,764	Influenza & Pneumonia 42,846	Diabetes Mellitus 69,071
8	Respiratory Distress 514	Benign Neoplasms 50	Benign Neoplasms 37	Benign Neoplasms 43	Influenza & Pneumonia 181	Cerebro-vascular 517	HIV 1,898	Chronic Low. Respiratory Disease 4,452	Suicide 6,364	Nephritis 41,994	Nephritis 50,476
9	Circulatory System Disease 507	Perinatal Period 52	Influenza & Pneumonia 37	Cerebro-vascular 43	Diabetes Mellitus 165	Liver Disease 487	Diabetes Mellitus 1,789	HIV 3,223	Nephritis 5,082	Unintentional Injury 41,100	Influenza & Pneumonia 50,097
10	Necrotizing Enterocolitis 472	Chronic Low Respiratory Disease 51	Septicemia 32	Septicemia 35	Complicated Pregnancy 163	Congenital Anomalies 397	Influenza & Pneumonia 773	Viral Hepatitis 2,376	Septicemia 4,004	Septicemia 26,310	Suicide 34,364

Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC using WISQARS™.

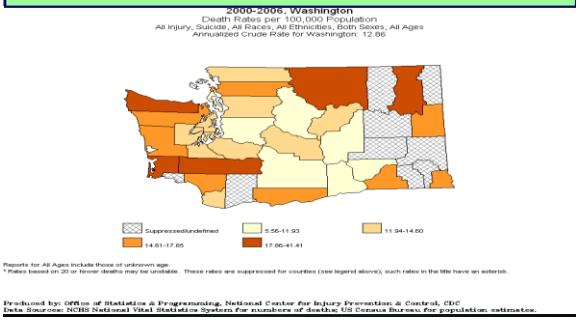
10 Leading Causes of Death, Washington 2013, All Races, Both Sexes

Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Congenital Anomalies 94	Unintentional Injury 20	Unintentional Injury 14	Malignant Neoplasms 13	Unintentional Injury 79	Unintentional Injury 141	Unintentional Injury 290	Unintentional Injury 292	Malignant Neoplasms 902	Malignant Neoplasms 2,308	Heart Disease 8,599	Malignant Neoplasms 11,928
2	Short Gestation 53	Congenital Anomalies 11	Malignant Neoplasms ---	Suicide 10	Suicide 57	Suicide 69	Suicide 173	Malignant Neoplasms 223	Heart Disease 485	Heart Disease 1,224	Malignant Neoplasms 8,362	Heart Disease 10,524
3	SIDS 47	Malignant Neoplasms ---	Congenital Anomalies ---	Unintentional Injury ---	Homicide 12	Homicide 39	Malignant Neoplasms 73	Heart Disease 146	Unintentional Injury 451	Unintentional Injury 373	Alzheimer's Disease 3,246	Alzheimer's Disease 3,277
4	Maternal Pregnancy Comp. 30	Homicide ---	Perinatal Period ---	Congenital Anomalies ---	Malignant Neoplasms ---	Malignant Neoplasms 23	Homicide 49	Suicide 142	Liver Disease 249	Liver Disease 326	Chronic Low. Respiratory Disease 2,516	Chronic Low. Respiratory Disease 2,933
5	Placenta Cord Membranes 23	Influenza & Pneumonia ---	Anemias ---	Cerebro-vascular ---	Heart Disease ---	Heart Disease ---	Heart Disease 48	Liver Disease 68	Suicide 190	Chronic Low. Respiratory Disease 322	Cerebro-vascular 2,308	Unintentional Injury ---
6	Unintentional Injury 20	Perinatal Period ---	Chronic Low. Respiratory Disease ---	---	Meningitis ---	Congenital Anomalies ---	Liver Disease 24	Diabetes Mellitus 43	Diabetes Mellitus 99	Diabetes Mellitus 282	Diabetes Mellitus 1,273	Cerebro-vascular 2,652
7	Necrotizing Enterocolitis ---	Heart Disease ---	Meningitis ---	---	Cerebro-vascular ---	Diabetes Mellitus ---	Diabetes Mellitus 13	Cerebro-vascular 25	Cerebro-vascular 92	Cerebro-vascular 214	Unintentional Injury 1,138	Diabetes Mellitus 1,616
8	Respiratory Distress ---	Acute Bronchitis ---	---	---	Congenital Anomalies ---	Cerebro-vascular ---	Congenital Anomalies ---	Homicide 25	Chronic Low. Respiratory Disease 72	Suicide 192	Influenza & Pneumonia 661	Suicide 1,027
9	Intrauterine Hypoxia ---	Chronic Low. Respiratory Disease ---	---	---	Influenza & Pneumonia ---	Chronic Low. Respiratory Disease ---	Four Tied ---	Chronic Low. Respiratory Disease 15	Viral Hepatitis 37	Viral Hepatitis 121	Parkinson's Disease 573	Liver Disease 966
10	Two Tied ---	Diseases Of Appendix ---	---	---	Pneumonitis ---	Three Tied ---	Four Tied ---	HIV 11	Septicemia 33	Two Tied 65	Hypertension 497	Influenza & Pneumonia 768

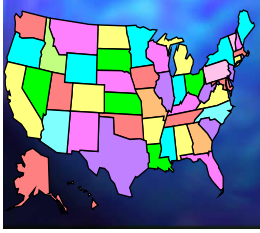
Death due to Suicide



Suicide Prevention and Assessment



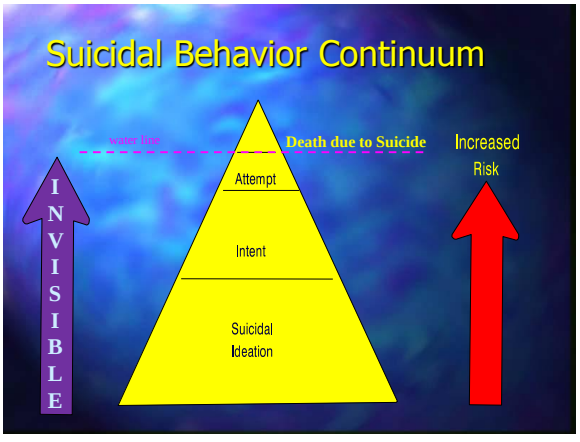
What is the ranking of deaths due to suicide by State for 15- 19 yr-olds in 2010?



Rank - State Rate Number (2010)

1 Alaska……..36.4
2 North Dakota……..31.5
3 South Dakota……..31.2
4 Montana……..19.6
5 New Mexico……18.0
U.S.A. TOTAL……..7.5
47 Maryland……4.9
48 New York……..4.7
49 Florida……..4.6
50 New Hampshire……1.1
51 Washington, DC……..0.5

27 Washington……8.2



Suicide Prevention and Assessment

Suicidal Ideation

- Morbid ideation, thoughts about death
- Wishes of never being born, better off dead
- Life's not worth living
- Suicide as retribution or punishment
- Thoughts of suicide (general & specific)

(CDC, 2012)

Suicide Prevention and Assessment

Suicidal Intent

Definition: There is past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. **Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.**

- Writing notes and/or will
- Giving away possessions or talking about it
- Collecting pills
- Buying a gun in preparation for suicide

(Gutierrez, 2011)

Suicide Prevention and Assessment

Suicide Attempt

- Suicidal Self-Directed Violence without injury
  - ✓ Taking 5 aspirin (cry for help)
- Suicidal Self-Directed Violence with injury
  - ✓ Cutting wrists (low lethality)
- Suicidal Self-Directed Violence without injury, interrupted by others
  - ✓ Gun to the head (high lethality)

(CDC, 2012)

Suicide Prevention and Assessment

Myths about Suicide

- Asking about Suicide may cause Suicidal Behavior
- Most suicidal behavior is impulsive without forethought
- Those who attempt Suicide get medical treatment
- Suicide attempters leave Suicide Notes
- Parents know if their Child is Suicidal

(Reynolds, 1988)

Suicide Prevention and Assessment

Risk Factors for Suicide

- Negative Personal History
- Psychopathology & Negative personality traits
- Social and interpersonal isolation & alienation
- Breakdown of defenses
- Self negative ideation
- Availability & Accessibility

Berman et al., 2006

Suicide Prevention and Assessment

Untalked About Risk Factor

- Social & Interpersonal Isolation & Alienation
  - **Sexual Orientation – Gay, Lesbian, & Bisexual Youth**
    - **Difficult population to study**
    - **Considerably higher suicidal attempt and ideation rates**
    - **Higher incidence of other risk factors – depression, victimization and abuse alcohol**
    - **Males – more likely to have a family history of suicide**
    - **Females – more likely to have peers who have attempted suicide**

Suicide Prevention and Assessment

Sexual Orientation

Research Study	Suicide attempt same-sex	Suicide attempt different sex	"X" times greater
Massachusetts Study (1995)	35.5%	9.1%	3.3-times
Seattle (1995)	20.6%	6.7%	3-times
National Longitudinal Study of Adolescent Health (2001)	15%	7%	2.2-times

Suicide Prevention and Assessment

Research results for males

Gender/Risk Factors	Suicidal Thoughts		Suicide Attempts	
	Model #1	Model #2	Model #1	Model #2
Males	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Same Sex Orientation	1.68*	1.31	2.45*	1.70*
Hopelessness		1.24*		1.11
Depression		1.15*		1.15*
Alcohol abuse		1.04*		1.06*
Suicide or attempt by family member		2.42*		2.22*
Suicide or attempt by peer		1.91*		2.09*
Victimization		1.58*		2.13*

(Russell & Joyner, 2001)

Suicide Prevention and Assessment

Research results for females

Gender/Risk Factors	Suicidal Thoughts		Suicide Attempts	
	Model #1	Model #2	Model #1	Model #2
Females	Odds Ratio	Odds Ratio	Odds Ratio	Odds Ratio
Same Sex Orientation	2.14*	1.66*	2.48*	1.79*
Hopelessness		1.27*		1.31*
Depression		1.14*		1.12*
Alcohol abuse		1.05*		1.07*
Suicide or attempt by family member		1.25*		1.65*
Suicide or attempt by peer		2.41*		2.25*
Victimization		1.57*		2.40*

(Russell & Joyner, 2001)

Suicide Prevention and Assessment

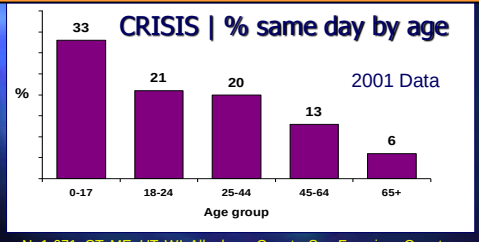
Suicides by Age Group: Household Gun Ownership (2000-2002)

	High-Gun States (Total Pop., 2000-2002: 115 Million) 15 Highest States (Mean)	Low-Gun States (Total Pop., 2000-2002: 118 Million) 6 Lowest States (Mean)	Mortality Rate Ratio (High Gun : Low Gun)
	47% of Households have firearms	**15% of Households have firearms**	
5-19 Year Olds			
Firearm Suicide	654	121	5.5
Non-Firearm Suicide	417	339	1.3
Total Suicide	1071	460	2.4
35-64 year olds			
Firearm Suicide	4674	1316	3.6
Non-Firearm Suicide	2775	2992	1.0
Total Suicide	7449	4308	1.8

Miller et al., 2006

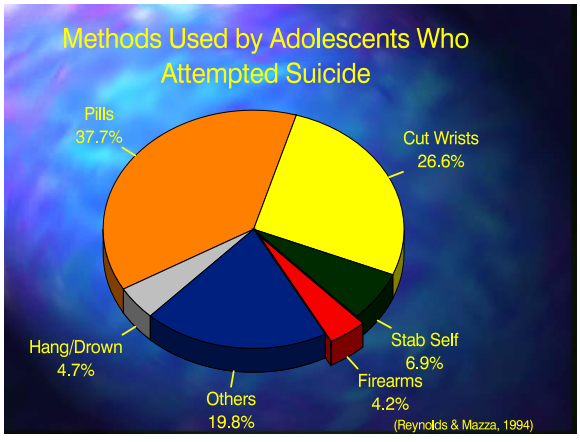
Suicide Prevention and Assessment

Suicidal Behavior in Youth vs. Adult

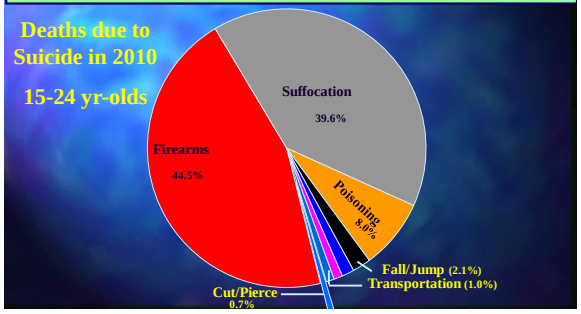


N=1,671 CT, ME, UT, WI, Allegheny County, San Francisco County

(Miller, 2006)



Suicide Prevention and Assessment



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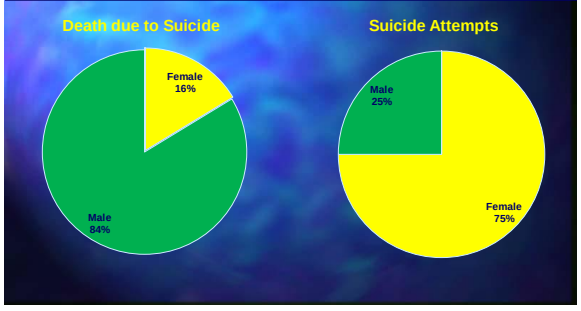
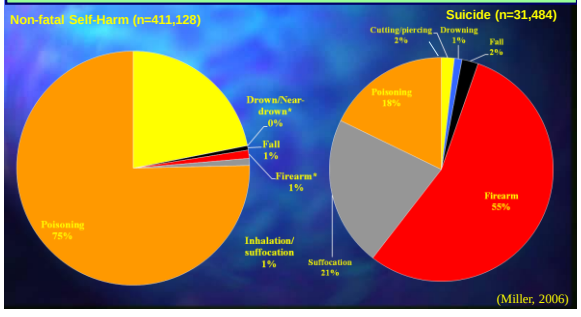


Suicide Prevention and Assessment

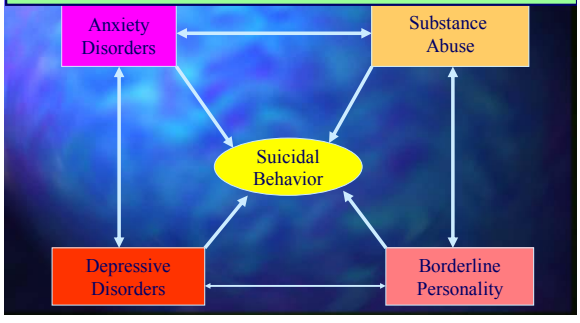


Suicide Prevention and Assessment

Warning Signs of Suicide

- I Ideation
- S Substance Abuse
- P Purposelessness
- A Anxiety
- T Trapped
- H Hopelessness
- W Withdrawal
- A Anger
- R Recklessness
- M Mood Change

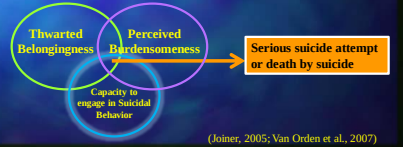
Suicide Prevention and Assessment



Suicide Prevention and Assessment

Current Theory of Suicide

I. **Interpersonal theory of Suicide**
   A. **Requires 3 components**
      1. **Thwarted Belongingness**
      2. **Perceived Burdensomeness (hopelessness about these states)**
      3. **Capacity to engage in suicidal behavior**



(Joiner, 2005; Van Orden et al., 2007)

Suicide Prevention and Assessment

3 Steps for Prevention

- Show you care
  - a. I'm concerned about you…. about how you feel
- Ask the question
  - a. Are you thinking about suicide?
  - b. What thoughts or plans do you have?
- Call for help
  - a. I know where we can get some help

Washington State Department of Health, 1997

Poster, Flyer & T-Shirt

Suicide Prevention and Assessment

I. Current Educational Model: Academics 1st

Education = Academics + Coping Strategies

School Structures: Assessment of Cognitive & Academic Abilities

Learning Disabilities → Special Education

High Stakes Testing → HSPE & EOC-HS Smarter B. - E&MS

Suicide Prevention and Assessment

I. Current Educational Model: Coping Strategies 1st

Education = Academics + Coping Strategies

School Structures: ???
*Youth Risk Behavior Survey

Emotional Behavioral Disabilities

Externalizing Behaviors → More frequent in Males

Internalizing Behaviors → More frequent in Females

Current State of Mental Health in Schools

Suicide Prevention and Assessment

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:

- Screening Programs
- School Gatekeeper Training
- Community Gatekeeper Training
- General Suicide Education
- Crisis Centers & Hotlines

(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:

- Screening Programs
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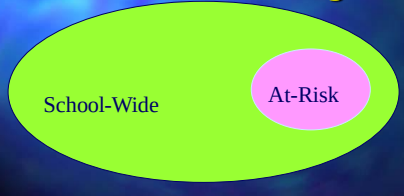
(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Identification of At-Risk Youth

- **School-Based Screening**



(Reynolds, Gutierrez & Mazza, 2007)

Suicide Prevention and Assessment

School-Based Screening

- Screening for adolescents who are at-risk for suicidal behaviors is a proactive approach
- The goal of screening is to identify and prevent suicidal behavior in adolescents.

(Reynolds, Gutierrez & Mazza, 2007)

Suicide Prevention and Assessment

Issues Surrounding Screening

I. A closer look at some of the pertinent issues

B. Resources and money

1. Once students are identified as "at-risk"

a) Need follow-up assessment to determine current risk status

1. Trained interviewers for follow-up assessment
2. Academic counselors have been reportedly used to conduct follow-up assessments rather than mental health professionals (Pena & Cane, 2006)

Suicide Prevention and Assessment

I. A closer look at some of the pertinent issues

B. Resources and money (continued)

2. Budgetary concerns
   a) The number of false positives
   b) Resource needs to follow-up with false positives
3. Staff frustration
   a) Using the Suicide Risk Screen (Eggert et a., 1994) identified 29% as needing follow-up (Hallfors et al., 2006)
      1. As a result school staff chose to discontinue the screening after 2 semester
      2. Staff hesitant to be trained for follow-up interviews

Suicide Prevention and Assessment

Issues Surrounding Screening

I. A closer look at some of the pertinent issues

C. Principal's view on Screening Programs (Miller et al., 1999)

1. Compared 3 different programs
   a) School-wide screening program
   b) Staff in-service program
   c) Curriculum based program

Suicide Prevention and Assessment

Secondary Principals (n=185) (Miller et al., 1999)

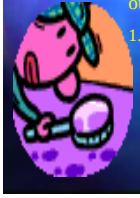
Program Type	Acceptability Rating (range 1 to 72)	Statistical Results
a. School-wide screening program	39.5	b, c > a
b. Staff in-service program	46.7	b > a, p < .001
c. Curriculum-Based program	44.9	c > a, p < .02

Suicide Prevention and Assessment

Issues Surrounding Screening

I. A closer look at some of the pertinent issues

C. Need for further education – not throwing the baby out with the bathwater



1. School psychologists (Eckert et al., 2003)
   a) Compared 3 different programs
      1. School-wide screening program
      2. Staff in-service program
      3. Curriculum based program

Suicide Prevention and Assessment

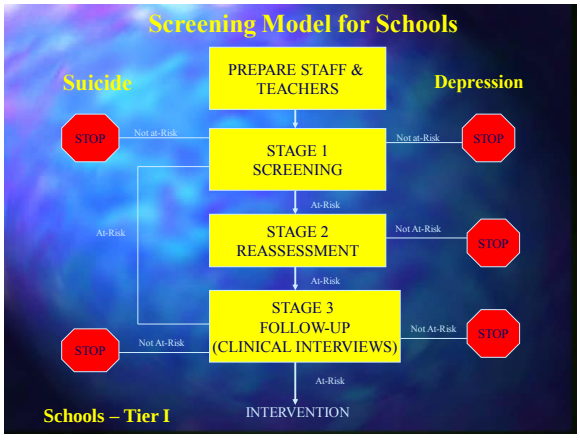
School Psychologists (n=242) (Eckert et al., 2003)

Program Type	Intrusive factor scores	Acceptability factor score	Statistical Results
a. School-wide screening	16.96	30.27	a > b, c b, c > a
b. Staff in-service program	14.33	38.11	b < a, b > a, p < .001
c. Curriculum-Based program	13.87	37.69	c < a, c > a, p < .001

Suicide Prevention and Assessment

- The Take Home Messages
  - Screening instruments do work and are very effectively in identifying at-risk students
    - ✓ Valid
    - ✓ Proactive approach
  - Resources are needed:
    - ✓ training staff and mental health professionals
    - ✓ dollars for screening program and follow-up assessments
  - Don't throw the baby out with the bathwater
    - ✓ Need to educate mental health professionals, staff and principals regarding the strengths of screening programs

Screening Model for Schools



Screening Measure: The SIQ-JR

This thought was in my mind:	Almost every day.	Couple of times a week.	About once a week.	Couple of times a month.	About once a month.	I had this thought before but not in the past month.	I never had this thought.
1. I thought it would be better if I was not alive	○	○	○	○	○	○	○
2. I thought about killing myself	○	○	○	○	○	○	○
3. I thought about how I would kill myself	○	○	○	○	○	○	○
4. I thought about when I would kill myself	○	○	○	○	○	○	○
5. I thought about people dying	○	○	○	○	○	○	○
6. I thought about death	○	○	○	○	○	○	○
7. I thought about what to write in a suicide note	○	○	○	○	○	○	○
8. I thought about writing a will	○	○	○	○	○	○	○
9. I thought about telling people I plan to kill myself	○	○	○	○	○	○	○
10. I thought about how people would feel if I killed myself	○	○	○	○	○	○	○
11. I wished I were dead	○	○	○	○	○	○	○
12. I thought that killing myself would solve my problems	○	○	○	○	○	○	○
13. I thought that others would be happier if I was dead	○	○	○	○	○	○	○
14. I wished that I had never been born	○	○	○	○	○	○	○
15. I thought that no one cared if I lived or died	○	○	○	○	○	○	○

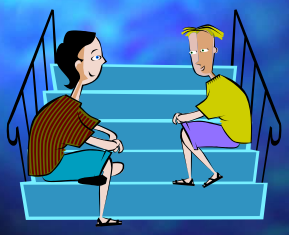
Suicide Prevention and Assessment

I. Why use the SIQ
- A. Assesses current suicidal ideation
  1. Not diagnostic
  2. Not used to predict future behavior
- B. Good psychometric properties
  1. Large normative sample
  2. Test-rest reliability (1 month) - .72
  3. Internal consistency - .94 & .97
  4. Excellent construct validity
- C. Gold standard measure for youth - ⇩ 5th

The SIQ

This thought was in my mind:	Almost every day	Couple of times a week	About once a week	Couple of times a month	About once a month	I had this thought before but not in the past month	I never had this thought
1. I thought it would be better if I was not alive	○	○	○	○	○	○	○
2. I thought about killing myself	○	○	○	○	○	○	○
3. I thought about how I would kill myself	○	○	○	○	○	○	○
4. I thought about when I would kill myself	○	○	○	○	○	○	○
5. I thought about people dying	○	○	○	○	○	○	○
6. I thought about death	○	○	○	○	○	○	○
7. I thought about what to write in a suicide note	○	○	○	○	○	○	○
8. I thought about writing a will	○	○	○	○	○	○	○
9. I thought about telling people I plan to kill myself	○	○	○	○	○	○	○
10. I thought that people would be happier if I were not around	○	○	○	○	○	○	○
11. I thought about how people would feel if I killed myself	○	○	○	○	○	○	○
12. I wished I were dead	○	○	○	○	○	○	○
13. I thought about how easy it would be to end it all	○	○	○	○	○	○	○
14. I thought that killing myself would solve my problems	○	○	○	○	○	○	○
15. I thought others would be better off if I was dead	○	○	○	○	○	○	○
16. I wished I had the nerve to kill myself	○	○	○	○	○	○	○
17. I wished that I had never been born	○	○	○	○	○	○	○
18. I thought if I had the chance I would kill myself	○	○	○	○	○	○	○
19. I thought about ways people kill themselves	○	○	○	○	○	○	○
20. I thought about killing myself, but would not do it	○	○	○	○	○	○	○
21. I thought about having a bad accident	○	○	○	○	○	○	○
22. I thought that life was not worth living	○	○	○	○	○	○	○
23. I thought that my life was too rotten to continue	○	○	○	○	○	○	○
24. I thought that the only way to be noticed is to kill myself	○	○	○	○	○	○	○
25. I thought that if I killed myself people would realize I was worth caring about	○	○	○	○	○	○	○
26. I thought that no one cared if I lived or died	○	○	○	○	○	○	○
27. I thought about hurting myself but not really killing myself	○	○	○	○	○	○	○
28. I wondered if I had the nerve to kill myself	○	○	○	○	○	○	○
29. I thought that if things did not get better I would kill myself	○	○	○	○	○	○	○
30. I wished that I had the right to kill myself	○	○	○	○	○	○	○

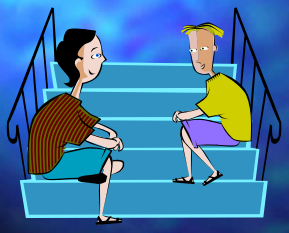
Suicide Prevention and Assessment



*Need to assess the risk and severity of the behaviors

*Determine next steps for intervention

Stage 2 Follow-up Clinical Interviews



Suicidal Behavior Interview (SBI)

(Reynolds, 1991)

Stage 2 Follow-up Clinical Interviews

I. Characteristics of the SBI

A. Practical features

- Semi-structured clinical interview
  - 20 items - 18 are scored
- Continuous scale – ½ points used
- 3 factor structure
  - Global psychological distress
  - Suicidal thoughts & preparation behavior
  - Past suicide attempt
- Training required

Stage 2
Follow-up Clinical Interviews

Sample Item on the SBI

1. In general, how have you been feeling these days? Do you feel….
   a. Anxious or Nervous?
   b. Depressed?
   c. Do things seem out of control?
   d. How does the future look to you? Do things seem hopeless?

Global rating of psychological distress

0	1	2	3	4
Absent	Minimal	Mild	Moderate	Severe

Stage 2
Follow-up Clinical Interviews

Sample Items on the SBI

7. Did you think of how you were going to kill yourself? (recent episode)

0	1	2	3	4
Absent	Vague Plan	Thought of couple ways	Thought of how (no details)	Detailed plan

9. Did you think of when?

0	1	2
Absent	Vague	Definite

10. Did you think of where?

0	1	2
Absent	Vague	Definite

Stage 2
Follow-up Clinical Interviews

Sample Items on the SBI

11. Did you write a note or plan to write one?

0	1	2
Absent	Planned	Wrote

14. Did you ever do something really bad to yourself, like try to hurt yourself but not really kill yourself?

0	1	2	3	4
Absent	Minor hurt	Major hurt	Minor injury	Major injury

Stage 2
Follow-up Clinical Interviews

Sample Items on the SBI

15. Did you ever try to kill yourself? When? (if no go to item #20)

0	1	2	3	4
Absent	> 1 year	7-12 mo.	3-6 mo.	< 3 mo. ago

17. How did you try to kill yourself? (assess lethality & rescue probability)

0	1	2	3	4
Absent	Minor no injury	Mild injury	Significant injury	Severe hospitalized

20. At the present time, do you feel like hurting or killing yourself?

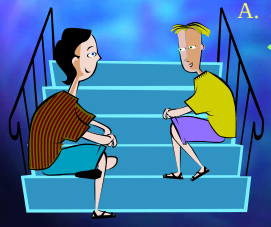
0	1	2	3	4
Absent	Mild thoughts	Specific thoughts	Intent	Very serious

Stage 2
Follow-up Clinical Interviews

I. Characteristics of the SBI

A. 3 factors

- ❖ psychological distress
  - ➢ 5 items
    - ✓ depress/hopelessness
    - ✓ hassles
    - ✓ social support
    - ✓ major life events

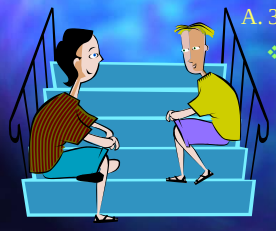


Stage 2
Follow-up Clinical Interviews

I. Characteristics of the SBI

A. 3 factors (cont.)

- ❖ covert & overt suicidal features
  - ➢ 10 items – largest
    - ✓ planning
    - ✓ method
    - ✓ warning signs



Stage 2
Follow-up Clinical Interviews

I. Characteristics of the SBI

A. 3 factors (cont.)

- ❖ past suicide attempt
  - ➢ 3 items
    - ✓ recency
    - ✓ seriousness
    - ✓ lethality

Stage 2
Follow-up Clinical Interviews

II. Factors to consider when implementing Stage 2

A. Prepare local community mental health organizations that you may need their services

- ❖ list of different community resources available
  - ➢ referral cards & fee schedules

Stage 2
Follow-up Clinical Interviews

II. Factors to consider when implementing Stage 2

B. Notify school psychologists, counselors, teachers & principal regarding identifying at-risk students

- ❖ counselors should prioritize at-risk students
- ❖ teachers need to let these students out of their classrooms
- ❖ principal may need to be available for emergency meetings

Stage 2
Follow-up Clinical Interviews

II. Factors to consider when implementing Stage 2

C. Private rooms for interviewing

- ❖ less distractions
- ❖ promotes caring setting
- ❖ confidentiality

Stage 2
Follow-up Clinical Interviews

II. Factors to consider when implementing Stage 2

D. need all students schedules

- ❖ interview those most at-risk during Stage 1 first
  - ➢ very important to do all follow-ups
- ❖ hall passes & teacher communication

Stage 2
Follow-up Clinical Interviews

III. Summary

A. Use a proactive approach

- ❖ **2 stage model very effective**
- ❖ **Ask direct questions**

B. Organization is extremely important

- ❖ **follow-up with high at-risk students first**
- ❖ **utilize all your resources**
  - ➢ **local community mental health agencies**
  - ➢ **school personnel and facilities**

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:

- Screening Programs
- School Gatekeeper Training
- Community Gatekeeper Training
- General Suicide Education
- Crisis Centers & Hotlines

(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Schools – Tier II

- Gatekeeper training

1. Increase awareness to peers and adults within the school
2. Provide training to peer helpers and caring adults

A. SOS – Sources of Strength
   1. Peers and adults working as a team
   2. http://sourcesofstrength.org/

B. SOS - Signs of Suicide
   1. Peers and adults
   2. Utilizes ACT (Acknowledge, Care, Tell)
   3. http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/

Suicide Prevention and Assessment

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- Crisis Centers & Hotlines

(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Community

- ❖ What can the community do?

1. Increase community awareness
2. Increase community training of available resources – Community Gatekeeper training

A. ASIST (LivingWorks) – Applied Suicide Intervention Skills Training
   1. 2 full day training
   2. Booster sessions available
   3. SafeTALK (3 hours)

B. QPR (Quinnett) for Communities – Question, Persuade, & Refer
   1. Work with community agencies

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:

- Screening Programs
- School Gatekeeper Training
- Community Gatekeeper Training
- General Suicide Education
- Crisis Centers & Hotlines

(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Parents/Family

- ❖ What can Parents/Family?

1. Increase awareness of mental health issues
2. Increase awareness of suicidal behavior
3. Increase effectiveness in listening and talking to their son/daughter

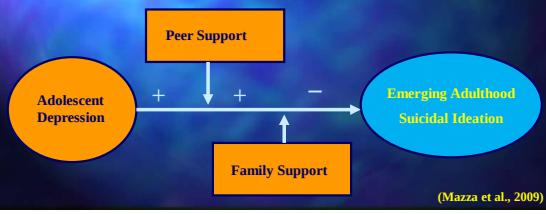
A. FRIENDS for Life
   1. http://www.mcf.gov.bc.ca/mental_health/friends.htm
B. Attending workshops on adolescent mental health and signs and symptoms
C. Provide son/daughter with emergency contact numbers and resources communication skills

Suicide Prevention and Assessment

DO PARENTS STILL MATTER DURING ADOLESCENCE?

v. YES, Parents still matter

A. Longitudinal study in emerging adulthood



(Mazza et al., 2009)

Suicide Prevention and Assessment

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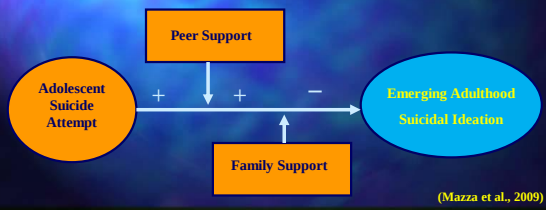

(Mazza et al., 2009)

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:

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- Crisis Centers & Hotlines

(CDC, *Youth Suicide Prevention Programs: A Resource Guide*, 2007)

Suicide Prevention and Assessment

Community – Crisis Lines

- Do they work?

1. Recent data suggests mixed results
   a. A mixed approach of worked best
      1. Empathy and a dash of problem-solving
      2. 723 out of 1431 failed to ask the caller if they were suicidal
      3. 43% of follow-up caller had thoughts about suicide after the initial call
      4. 12% reported the call kept them from harming themselves
   b. Results suggest that regular re-training on empathy and problem-solving is warranted

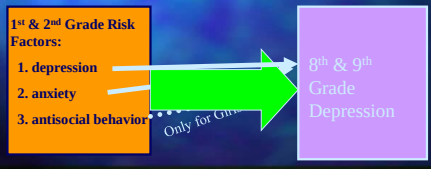
Suicide Prevention and Assessment

WHEN SHOULD WE INTERVENE?

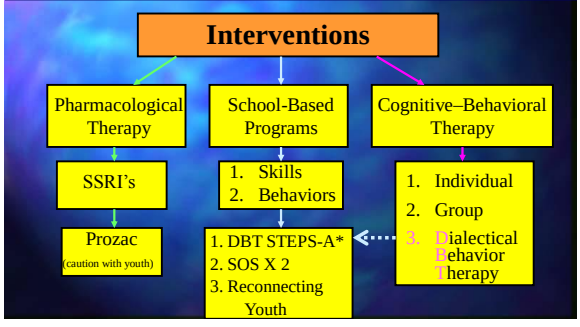
A. Simple answer is: the earlier the better, but how early?

B. Longitudinal Study (Mazza et al., 2009)

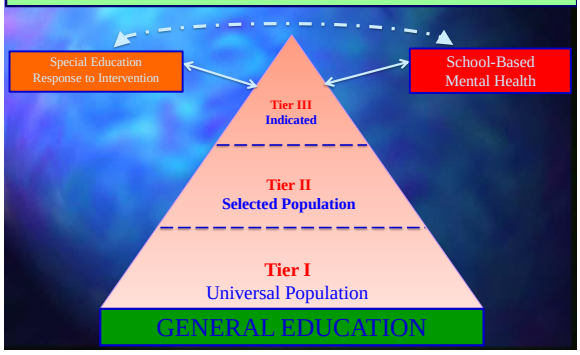
Results from 938 students in WA



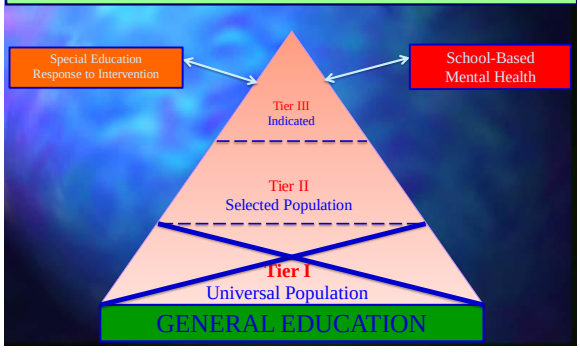
Suicide Prevention and Assessment



Suicide Prevention and Assessment



Suicide Prevention and Assessment



Suicide Prevention and Assessment

Summary

- Adolescent suicidal behavior is complex
- Examining protective and risk factors is important for youth mental health
- Address multiple co-occurring behaviors for prevention and intervention programs
- 3 steps to prevention - Ask the question
- Talking about suicide with youth is OKAY!!

Suicide Prevention and Assessment

Where do we go from here?

- Curriculum integration of decision-making and coping strategies for all youth, i.e., DBT STEPS-A, SOS (2) & RY
- Active role for family & community involvement is important to help change the stigma associated with suicide
- Identify youth who are at-risk for suicidal behavior
- Educating the public that it's okay to get professional help for themselves and their children
- Talking about suicide with youth is OKAY!!

Suicide Prevention and Assessment

Business Card

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Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

K-12 Troubled Youth Law: HB – 1336

Section 2 (School psychologists, counselors, social workers, nurses)

(1) As provided under subsections (2) and (3) of this section, individuals certified by the professional educator standards board as a school nurse, school social worker, school psychologist, or school counselor must complete a training program on youth suicide screening and referral as a condition of certification. The training program must be at least three hours in length. The professional educator standards board must adopt standards for the minimum content of the training in consultation with the office of the superintendent of public instruction and the department of health. In developing the standards, the board must consider training programs listed on the best practices registry of the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center.

Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

K-12 Troubled Youth Law: HB – 1336

Section 2

(2) This section applies to the following certificates if the certificate is first issued or is renewed on or after July 1, 2015:
(a) Continuing certificates for school nurses;
(b) Continuing certificates for school social workers;
(c) Continuing and professional certificates for school psychologists; and
(d) Continuing and professional certificates for school counselors.

Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

K-12 Troubled Youth Law: HB – 1336

Section 2

(3) A school counselor who holds or submits a school counseling certificate from the national board for professional teaching standards or a school psychologist who holds or submits a school psychologist certificate from the national association of school psychologists in lieu of a professional certificate must complete the training program under subsection (1) of this section by July 1, 2015, or within the five-year period before the certificate is first submitted to the professional educator standards board, whichever is later, and at least once every five years thereafter in order to be considered certified by the professional educator standards board.

Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

K-12 Troubled Youth Law: HB – 1336

Section #4 (School District)

(1) Beginning in the 2014-15 school year, each school district must adopt a plan for recognition, initial screening, and response to emotional or behavioral distress in students, including but not limited to indicators of possible substance abuse, violence, and youth suicide. The school district must annually provide the plan to all district staff.

Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

Section #5 (OSPI)

The office of the superintendent of public instruction and the school safety advisory committee shall develop a model school district plan for recognition, initial screening, and response to emotional or behavioral distress in students, including but not limited to indicators of possible substance abuse, violence, and youth suicide. The model plan must incorporate research-based best practices,
including practices and protocols used in schools and school districts in other states. The model plan must be posted by February 1, 2014, on the school safety center web site, along with relevant resources and information to support school districts in developing and implementing the plan required under section 4 of this act.

THIS HAS BEEN COMPLETED:
http://www.k12.wa.us/safetycenter/YouthSuicide/SuicidePrevention.aspx

TIER 3 SUPPORTS AND BEYOND

Facilitator of the new laws
School Psychologists

I. As the School Psych – you are the most likely to be the facilitator of this process for the whole school

   A. It could be at the district level – but given your training at UW – you may be the district facilitator

   B. What do you need to know?

      1. Programs & Strategies at all levels – DFT!!!

Troubled Youth Law – HB 1336

Application of 1336 affecting Schools

I. TAKE HOME MESSAGE
   A. Keep in mind that 1336 is for school personnel

      1. Most likely facilitators
         a. School counselors
         b. School nurses
         c. School social workers
         d. School psychologists

      2. Missing in this law:
         a. THE KIDS!!
            1. This law indirectly impacts the students

         b. Evidence-based programs to identify and screen for kids who are at high risk is not a part of this law

      3. Programs & Strategies at all levels – DFT!!!