

Suicide Prevention in Schools

Best practices and questionable
practices

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Today we will. . .

- Review contemporary school-based prevention approaches, examine some key research findings, and analyze the controversy surrounding particular practices.

Why are we concerned?

- The school-based Youth Risk Behavior Survey conducted by the CDC in 2001 found that 8.8% of high school students had attempted at least once during the previous year. 2.6% of these students required medical attention. 19% reported having seriously considered a suicide attempt, with 14.8 % having made a specific plan (Grunbaum et al., 2002).
- Suicide remains the third leading case of death among 15-24 year-olds despite a slight drop from 11.1 per 100,000 in 1998 to 10.4 in 2000 (Minino et al., 2002)

Why are we confused?

- Communities put pressure on schools to do something, especially in the aftermath of a tragedy. Yet. . .
- The literature offers conflicting advice regarding school-based prevention programs, especially curricula.
- Some programs have met with wide acceptance among communities even though they have never formally been evaluated. Are they risky?

Differences in approaches

- Some approaches (Kalafat, Lazarus) seek to strengthen protective factors and support networks.
- Another group of approaches derives from *mental health research* on risk factors and precipitating events in suicide (AACAP, Shaffer, Gould).
- A third group of suicide prevention approaches derives from the direct personal experiences of those who have lost a loved one to suicide.

We are in search of a
comprehensive, research-based
model that specifically
addresses the school setting.

How would this model look?

Suicide prevention models should:

- Incorporate current research regarding how suicide happens
- Reflect best clinical practice in the assessment, treatment, and crisis management of suicidal individuals
- Should safeguard against increasing the risk for suicidal behaviors
- Be responsive to the local community and school culture without compromising integrity

Requirements for any successful school-based suicide prevention approach

1. Data collection
2. Staff development
3. Board policy and implementing central office and school procedures
4. Interagency collaboration/referral/treatment or intervention process
5. Student awareness/skills development/safeguards
6. Public awareness/dissemination/critical alliances
7. Postvention
8. Funding and resources

Let's examine these elements of
a comprehensive school-based
suicide prevention program.

1. Data Collection

- **ANSWER**, a Kansas City project funded by SAMHSA and the Robert Wood Johnson Foundation blends the “unique perspectives and ideas of community-based school officials and students, and other interested community members with the input of university-based researchers” (Geis and Edlavitch, 2003, p. 5)

Improving our practice:

- Seek funding to conduct school and community surveys.
- Be diligent about learning what others are doing and discovering.
- Question all practices, despite the rush to do something immediately.
- Use resources wisely.

2. Staff Development

Most schools rely on their own staff to identify and refer students at risk for suicide. Here are key questions to ask about our practice:

- What do school employees know?
- What do they perceive as their knowledge?
- In particular, what do teachers (who have the most frequent student contact) know?

How well informed are school gatekeepers?

- One report indicated that only 9% of US health teachers believed that they could recognize a student at risk for suicide (King, Price Telljohann, & Wahl, 1999).
- According to one study, high school teachers do not consider themselves knowledgeable about suicide (Schepp & Biocca, 1991).

Scouller and Smith (2002)

- Scouller and Smith (2002) conducted an Australian study to examine whether physicians and teachers were knowledgeable about suicide.
- Studied 481 secondary school teachers in Australia; stratified random sample of public, Catholic, and independent schools.

- Teachers were poorly informed about risk factors for adolescent suicide, yet 99% had interacted with one student they deemed at risk for suicide.
 - Fewer than half identified correctly that a suicide attempt of high lethality increases the risk for suicide.
 - Only 47% of teacher identified specific behavioral warning signs.
 - Only 11% understood the link between psychiatric disorders and suicide; 73% *discounted* this connection.
 - Only 20% were informed about the contribution of family history to increased suicide risk.

Improving our practice:

- Assess what school employees know.
- Correct misinformation. Provide the most current information on risk factors, warning signs, and school procedures.
- Alert employees to those at highest risk (males 16-19; teens with mental health or drug and alcohol problems; GLBT teens, those who have attempted, those with a pending disciplinary incident who have other risk factors).
- Include all employees with student contact in the training.
- Repeat this training (or make it available through technology) for new employees.

3. Board policy and central office and school procedures

Common pitfalls

- policy and procedures templates written from a singular perspective (e.g., crisis response or medical) and adopted without regard to the local school and community's culture and resources.
- failure to involve those who will implement the procedures and can troubleshoot implementation problems ahead of time [e.g., include secretaries and all teachers, not merely counselors].
- lack of training and practice on the procedures [written to sit on the shelf].

Common Pitfalls



- outdated procedures [e.g., without obsolete contact information and phone numbers; disregard for current regulations]

Improving our practice:

- Offer suicide prevention training to board members every two years.
- Review all policies and procedures annually.
- Ensure that key employees know what to do in crisis situations.
- Re-engage community agencies in the review and implementation of these practices.

4. Interagency collaboration/referral/treatment process

- “Screening or suicide education programs for teens that do not include procedures to evaluate and refer identified ideators or attempters are not endorsed.” [AACAP]]

Direct case-finding

- These approaches derive from the belief that prevention of suicide relies on identifying and treating those at risk.
- Moreover, these programs hope to expand the safety net, given that only one third of suicide completers have been in contact with a mental health practitioner and only 7-8% of suicide victims are active treatment at the time of their deaths (Ashkenassy, Clark, Zinn, & Richtsmeiser, 1992; Pirkis & Burgess, 1998).

Screening approaches

- Specifically screens for suicide risk or related risk factors using individual instrument(s).
- Has appeal as large numbers of students can be screened in one location.
- Specific implementation guidelines may not always fit school setting or community.
- Requires parent consent in many situations.
- Labor-intensive; may require several steps to rule out false positives.
- Funding not always available for screening of risk factors, referral, and evaluation.
- Screening at one point in time may not identify problems that emerge later.

Screening cont'd

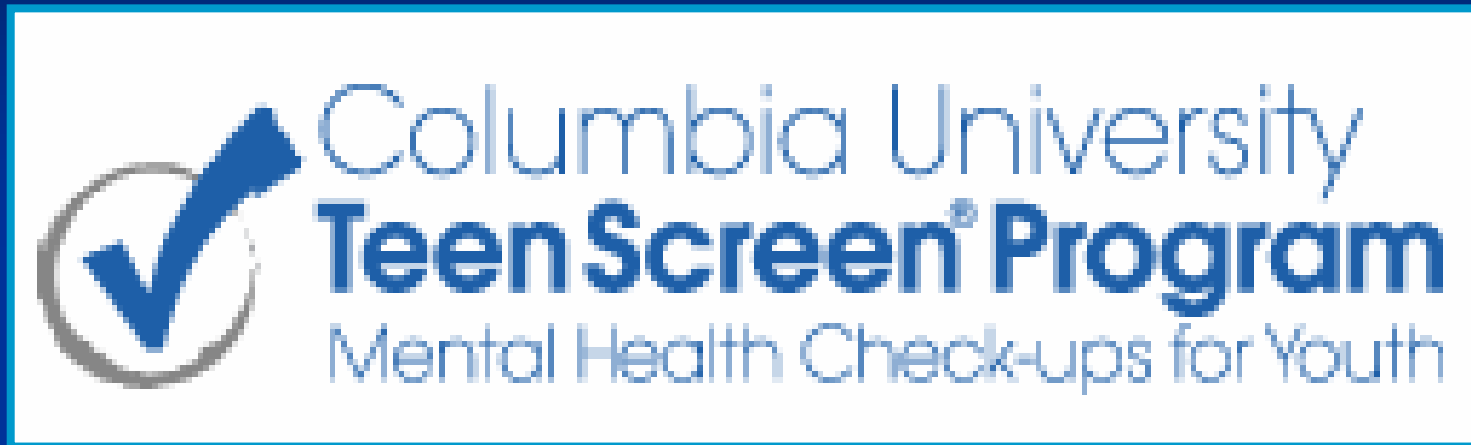
■ Pros:

- Studies have found very few false-negatives.

■ Cons:

- Studies have found many false-positives which demonstrates the need for second-stage assessment.
- Suicidal risk increases and diminishes over time suggesting the necessity for multiple screenings.
- School principals rate it as less acceptable than curriculum based and staff in-service programs.
- Success is dependent on the effectiveness of the referral (Gould, Greenber, Velting, & Shaffer, 2003).

An example



Columbia TeenScreen Program (CTSP)

www.teenscreen.org

or

Diagnostic Interview Schedule for Children (DISC)

www.c-disc.com/biblio.htm

Another example: Gutierrez et al (2004)

- Used the 30-item Suicidal Ideation Questionnaire for grades 10-12; 15-item versions for grade 9.
- Used the Reynolds Adolescent Depression Scale (30-item self-report measures symptoms associated with depression in 13-18 year-olds.
- Parental consent required.
- University staff implemented in collaboration with school staff.
- Individual risk assessment for those meeting criteria.
- Study took place throughout the school year.

AACAP Practice Parameter

“ Clearly, screening programs need to go beyond identifying a teenager with a high-risk profile. Youth identified in this way should be referred to evaluation and, if necessary, treatment.” (p. 44s)

Screening or suicide education programs for teenagers that do not include procedures to evaluate and refer identified ideators or attempters are not endorsed.” (p. 28s)

A note on suicide scales

The AACAP Parameter advises that:

“Self-administered suicide scales are useful for screening normal, high-risk, and patient populations, They cannot substitute for a clinical assessment, and their tendency is to be oversensitive and underspecific. At this point, suicide scales alone do not have a predictive value. A child or adolescent who is positive on a suicide scale should always be assessed clinically.”

(p. 38s)

A note on no-suicide contracts for suicidal youth

- “No-suicide contracts are of unclear value and should be used only in conjunction with a comprehensive suicide risk prevention plan .”(AACAP, 2001)
- Lazarus and Kalafat seem to support no suicide contracts. “Poland reported that in one district thousands of students . . have signed no suicide contracts over the past ten years yet non have committed suicide while enrolled in school.” (2001, pp. 29-30)

Improving our practice

- Discourage support staff from relying on no-suicide contracts. Do not encourage these through community campaigns.
- Seek funding and resources to offer comprehensive screening for risk (mental health problems, drug and alcohol, suicide) for students in grades 6-12. This screening does not have to be school-based but could be done in collaboration with primary practitioners, local hospitals and clinics.
- Consider the ongoing collaboration models (ANSWER, Gutierrez et al.).

5. Student instruction

- To promote resilience and increase protective factors, coping skills, and support networks.
- To promote an understanding of suicide and its associated risks and behaviors.

Suicide Awareness Curriculum

- Developers' rationale: Teenagers turn to peers rather than adults for support.
- Include presentations, statistics, and videotapes demonstrating the consequences of failing to help peers.
- May or may not include a screening component.

Suicide Awareness Curriculum

- Pros:
 - Modest increase in knowledge, attitude & help-seeking behavior
 - Cost-effective
- Cons:
 - Some programs might motivate imitation.
 - Changes in knowledge and attitude don't necessarily correlate with behavioral changes.
 - Since peer networks of suicidal teens are not as supportive as non-suicidal teens, it may not be aimed toward high-risk youth (Gould, Greenber, Velting, & Shaffer, 2003).

An example of a Suicide Awareness and Help-Seeking Program

- National Depression Screening Day's SOS program
www.mentalhealthscreening.org/depression.htm
- Teaches youth to question and to report the behavior of others.

20th Annual
SOS High School Suicide Prevention Program

A Tested Program That Increases Help-Seeking By Teens
Endorsed by Leading School Professional Organizations

What is the program?
The SOS High School Suicide Prevention Program is a national program implemented by school health professionals. It is currently being implemented in 100 schools across the United States and is designed to reduce the risk of suicide by providing a supportive and caring environment for students. The program is designed to reduce the risk of suicide by providing a supportive and caring environment for students. The program is designed to reduce the risk of suicide by providing a supportive and caring environment for students.

How is it implemented?
The program is implemented through a series of steps that include: 1. Assessment of the school's current suicide prevention efforts. 2. Development of a school suicide prevention plan. 3. Implementation of the plan. 4. Evaluation of the program's effectiveness.

SOS Schools Report Increases in Help-Seeking
Approximately 1,000 high schools nationwide reported to increase SOS Program enrollment by the 20th annual year — a 40% increase in participation from the first to second year of the program.

Indicators of Efficacy and Safety
• 80% of schools reported an increase in help-seeking behavior.
• The number of students seeking help for depression and anxiety disorders increased by 10% after implementing the program, increasing from 15 to 17 students per school.

Highlights in the Program and Educational Materials
• 80% of schools reported an increase in help-seeking behavior.
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Endorsed in part by the
National Depression Screening Day Committee
National Suicide Prevention Hotline
National Alliance on Mental Illness
National Association of State Public Health Officials
National Association of State Health Officers
National Association of State Health Departments
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Effectiveness of the SOS Program

- In a study of 2100 randomly assigned youth in two urban districts, AseLINE and DeMartino (2004) reported a significant decrease in self-reported suicide attempts three months after the implementation of the SOS program.
- No significant effects were observed for suicidal ideation and help-seeking behaviors.

Suicide awareness education
has been debated.

Let's examine what the experts
say.

AACAP Parameter

“Controlled studies (Shaffer et al., 1991); Spirito et al., 1988a; Vieland et al., 1991) have failed to show that classes for high school students about suicide increase students’ help-seeking behavior when they are troubled or depressed. On the other hand, there is evidence that previously suicidal adolescents are perturbed by exposure to such classes (Shaffer et al, 1990). Such educational programs seem, therefore, to be both an ineffective mode of case-finding and to carry with them an unjustified risk of activating suicidal thoughts.”

(p. 44s)

AACAP Parameter

“Because curriculum-based suicide awareness programs disturb some high-risk students, a safer approach might be to focus on the clinical characteristics of depression or other mental illnesses that predispose to suicidality, In the absence of evidence to the contrary, talks and lectures about suicide to groups of children and adolescents drawn from regular classes should be discouraged [Not endorsed]. This is because of their propensity to activate suicidal ideation in disturbed adolescents whose identify is not usually known to the instructor.” (pp. 27-28s)

A different point of view. . .

- First generation programs addressed a variety of topics and lacked focus. Evaluation results were mixed.
- Many second generation programs were more focused and showed increases in knowledge, decreases in suicidal feelings. [LIFELINE suicide awareness curriculum]
- “. . .the promulgation of the myth that school-based suicide prevention programs are harmful because talking about suicide with students will promote suicide is irresponsible and harmful to prevention efforts” (Kalafat, p. 219).

A better approach: use data

- “In all the surveying we did, only 15 students responded that they would turn to a peer-helper for help, even as a second or third option. Also, students’ reported inclination to seek help from an adult in the school ranged from 6% to 11%, depending on the school setting. . . This surveying, combined with teacher and student feedback, caused us to shift to an intervention model that emphasized training all students, community members and school personnel—and not a model that utilized peer-helpers.” (Geis and Edlavitch, 2003, p. 12)

Student education: Skills Training Programs

- Education emphasizing the development of problem solving, coping, and cognitive skills, along with social support perspectives
- Some target specific populations of students.

Skills Training, cont'd

■ Pros:

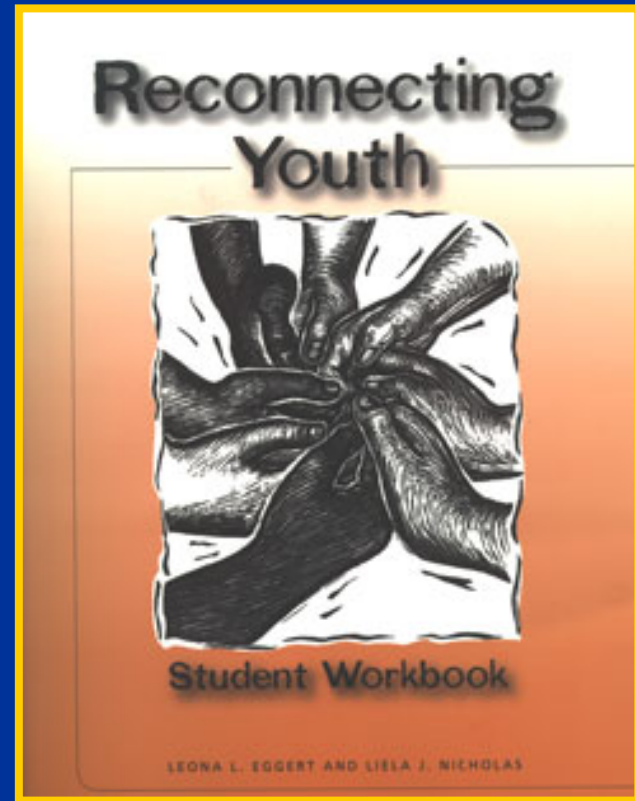
- Focus is not directly on suicide which reduces the risk of contagion.
- Studies have demonstrated reductions in suicidal tendencies and hopelessness, and an increase in knowledge and ability to cope with problems.
- Cost-effective

■ Cons:

- The specific aspects of the programs that have yielded risk reduction are still unclear (Gould, Greenber, Velting, & Shaffer, 2003).

Example: Reconnecting Youth Program

- “Reconnecting Youth (RY) is a school-based prevention program for youth in grades nine through twelve (14 to 18 years old) who are at risk for school dropout. Reconnecting Youth uses a partnership model involving peers, school personnel, and parents to deliver interventions that address the three central program goals.”
(www.modelprograms.samhsa.gov)



Improving our practice:

- Don't guess. Systematically conduct local studies to determine needs, then adopt current research-proven approaches.
- Identify and enroll youth at risk in specialized programs to improve their resilience, support networks, and school performance (Reconnecting Youth).
- Adopt bullying and harassment prevention programs K-12, using only models with proven results. Consider the special vulnerability of GLBT students in these efforts.

Improving our practice:

- Monitor the research and consider the adoption of suicide prevention curricula, only after a comprehensive plan for screening, referral, treatment, and follow-through is established.
- Discourage any curricula that adopt a “stress” model of adolescent suicide---a model found in some suicide awareness programs.
- Ensure that curricula do not inadvertently promote discrimination or bias; curricula should promote tolerance and acceptance of diversity.

6. Public awareness/critical alliances

- Many of the community-based approaches are appealing to lay people because they do not require high levels of expertise.
 - They often convey a personal connection through a survivor of suicide; they are compelling and engaging.
 - Grass-roots efforts tend to be low-cost and lend themselves to trainer of trainers and other rapid dissemination.
 - Their evaluation is limited.
- Others are highly developed gatekeeper training programs for specific groups (e.g, first responders).

Example: Gatekeeper Training

- Education and training of adults who come in contact with suicidal youth
 - School personnel (teachers, counselors, & coaches)
 - Community leaders (clergy, police, pediatricians, etc.)
- Stresses taking suicidal threats seriously, accepting the need to breach confidentiality, and recognizing the importance of obtaining help from mental health professionals.

Example: Yellow Ribbon

- school and community-based
- promotes help-seeking behavior.
 - (1) increasing public awareness of suicide prevention,
 - (2) training gatekeepers
 - (3) facilitating help-seeking by distributing “Ask for Help” cards

Yellow Ribbon



- Planning sessions with school and community leaders.
- Training for staff and youth leaders, followed by school-wide assemblies.
- Booster training and training for new staff members and students.
- Establishment of community task forces to ensure on-going resource connections, awareness reminders, event coordination, and expanded gate-keeper training.
- Program has not been rated by SAMHSA.

Gatekeeper Training

■ Pros:

- Doesn't carry the risk of imitation
- Increases school personnel's intervention skills, preparations for a crisis, & referral practices
- In-service programs are more accepted by principals

■ Cons:

- There is limited research on the effectiveness.



Example: Gatekeeper Program



- LivingWorks, based in Canada with programs around the world, offers workshops entitled ASIST “to train community-based caregivers. . . to be effective in achieving an immediate reduction of self-harm and suicide.” www.livingworks.net
- Program has not been rated by SAMHSA.

Improving our practice: community efforts

- Seek funding to develop systematic data-driven community-wide prevention.
- Establish school-based health clinics to reduce the stigma of help-seeking and to improve access.
- Support gatekeeper training, if it is based on programs that have shown their effectiveness.
- Support community efforts to limit access to lethal means (including firearms, drugs and alcohol.)
- Encourage the establishment of asset-building in the community to support youth (SEARCH Institute).



Improving our practice:

- Discourage any presentations that depict suicide through a videotape or personal message that has not been well-reviewed and endorsed by experts in suicide treatment and prevention.
- Avoid large student assembly formats.
- Avoid placing responsibility on peers to “save their friends.”
- Discourage any campaigns that adopt a “stress” model of adolescent suicide.
- Discourage campaigns that inadvertently promote discrimination or bias; promote tolerance and acceptance of diversity.

7. Postvention

■ Pros:

- Meets the immediate needs of schools and communities in crisis after a death.
- Allows face-to-face screening of those at risk
- Can be an opportunity to improve the school's prevention approaches

■ Cons:

- Can be quite variable from one provider to another.
- Very limited research and evaluation on this approach.

Postvention

- Timely responses to survivors is likely to reduce the harmful effects in the aftermath of a suicide
- Designed to assist survivors with the grieving process and to limit the risk of suicide contagion.

Improving our practice:

- Use postvention approaches that are conceptually grounded and comprehensive.
- Be diligent about monitoring students over time.
- Participate in evaluations of postvention efforts.

8. Funding and resources

- <http://www.mentalhealth.samhsa.gov/suicideprevention/funding.asp>
- <http://www.irisfund.org/grants/grants.html>
- Garrett Lee Smith Memorial Act, request for proposals to be released in April, 2005, through SAMHSA.

Recommended Reading

Many of the findings reported here are summarized in:

- Gould, M. , Greenber, T., Velting, D., Shaffer, D. (2003) *Youth Suicide Risk and Preventive Interventions: A Review of the Past 10 Years*. Journal of the American Academy of Child and Adolescent Psychiatry, 42: 4, 386-405

We are indebted to Dr. Gould and her colleagues for their work and urge all of the participants to read this paper.

For more information go to:



- **STAR-Center at University of Pittsburgh.** Web site for the STAR-Center, a youth suicide treatment, research, and education center at the University of Pittsburgh.
www.wpic.pitt.edu/research/star/

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