Best Practices in Suicide Prevention and Intervention

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OVERVIEW

In 2010, 38,364 Americans died by suicide, accounting for 1.6% of deaths in the United States (Centers for Disease Control and Prevention [CDC], 2011). In that same year, Americans 10–24 years old completed 4,867 (12.6%) of those deaths by suicide (CDC, 2011). The CDC (2012) Youth Risk Behavioral Surveillance Survey reported that while rates of students who have seriously contemplated suicide decreased between 1991 and 2009 from 29.0 to 13.8%, these rates have increased from 2009 to 2011 from 13.8 to 15.8%. Similar trends occurred among the same age group for making a suicide plan attempting suicide, having declined between 2001 and 2009 and then increasing between 2009 and 2011. Furthermore, 7.8% of high school students had attempted suicide in the previous 12 months. It is important to note that the number of reported suicides may be an underestimation of the actual number of deaths by suicide. Whereas the facts illustrate the dire need to focus on youth suicidal behavior, legislation pertaining to suicide prevention programs in schools serving K–12 has only been passed and enforced in few states (LaFleur & Poland, 2012). Thus, it is essential that schools become a skilled setting that enhances knowledge and methods for assessing for suicidal risk, seeking appropriate support/care, and intervening with at-risk youth.

School psychologists play a critical role as a consultant and trainer to other school personnel to ensure proper suicide prevention measures are taken. This translates to the school psychologist taking an active role in training the school staff on suicide screening, as well as in advocating for (and aiding in) the implementation of suicide prevention and intervention programs. The objective of this chapter is to provide the information, skills, model practices, and strategies that are critical to the services highlighted in the Preventive and Responsive Services domain of the National Association of School Psychologists (NASP) Model for Comprehensive and Integrated School Psychological Services (NASP, 2010).

Gender and Developmental Factors

Research illustrates that death by suicide is the third leading cause of death after accidents and homicides for males and females between the ages of 10 and 24 across all ethnicities (CDC, 2012). Whereas males accounted for 84% of completed suicide in this age range in 2010, their same-age female peers are more likely to seriously contemplate suicide (females: 19.3%, males: 12.5%), make a suicide plan (females: 15%, males: 10.8%), and attempt suicide (females: 9.8%, males: 5.3%; CDC, 2012). In other words, although females might contemplate, plan for, and attempt suicide at a rate two to three times higher than males, the rate that males tend to complete suicide is about five times higher than the rate of female completed suicide within the same age group. Males are less likely to seek support when in need and are more likely to use more lethal means than their same-age female peers.

Research continuously indicates that 100–200 suicide attempts are made for every young person who dies by
suicide (CDC, 2012). Given these statistics, it is estimated that there are just about 1 million suicide attempts annually by young people. Given the aforementioned statistics, it is apparent that suicide prevention programs are necessary to reduce suicidal ideation, risk, and attempts among young people in addition to helping to increase knowledge and awareness about prevention.

Because this chapter examines suicide prevention and intervention in schools, it is also crucial to look at differential suicide rates across the differing ages of students attending school. It appears as though the risk in suicide increases with age (higher for 15 year olds than for those 10–14). While the rate of suicide among youth 10–14 years old has steadily declined over the past few years, the overall rate of suicide in this population is still higher than it has been in previous decades and continues to be of concern (Miller, 2011). Because the suicide rate among the population of 10–24 year olds is quite alarming, it is important to employ appropriate suicide prevention and intervention programs that target this age group.

Ethnicity and Cultural Factors

The prevalence of suicidal ideation and attempts also varies among individuals from different racial and ethnic backgrounds. American Indian and Alaska Natives have the highest rates of suicidal ideation, attempts, and planning among individuals between the ages of 15 and 19, followed by Hispanic, Caucasian, and African American individuals, respectively (CDC, 2012). In fact, while the prevalence of those seriously contemplating suicide among Hispanic individuals ages 15–19 was found to be at 16.7%, the prevalence rates for the same aged Caucasian and non-Hispanic Black populations were found to be 15.5% and 13.2%, respectively (CDC, 2012). However, the rates of completed suicide differ from the aforementioned statistics. The highest rate of completed suicide among youth is also within the American Indian and Alaska Natives; however, Caucasian youth, non-Hispanic Black youth, Asian/Pacific Islander youth, and Hispanic youth follow behind, respectively. The prevalence rates of American Indians and Alaskan Natives, the leading population of 10–24 year olds who are completing suicide, are doing so at rates of 31.27 per 100,000 among males and 10.16 per 100,000 among females. Additionally, it appears as though there has been an increase in suicide among the male population of African Americans over the past few decades that should be further addressed.

Sexual Orientation and Bullying

There has been a dramatic increase of media attention recently on the subject of the relationship between adolescents’ sexual orientation and risk for suicidal behaviors (Hatzenbuehler, 2011). Though a question of mediating factors such as depression, hopelessness, and the social environment remains, gay, bisexual, and transgender (LGBT) children and adolescents are at a higher risk for suicidal ideation and attempts than their heterosexual peers (Hatzenbuehler, 2011). On average, Latino, immigrant, religious, and low-socioeconomic status families tend to have a lower acceptance of their child’s sexual identity (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Whereas 38.3% of LGBT children and adolescents with low family acceptance of their sexual orientation reported suicidal thoughts over the previous 6 months, only 18.5% of youth experiencing high family acceptance reported the same thoughts (Ryan et al., 2011). Reported lifetime suicide attempts reduced from 56.8 to 30.9% when a family engaged in high acceptance behaviors/attitudes versus those families demonstrating low acceptance. Furthermore, suicide risk declines (as psychological well-being increases) in LGBT children and adolescents who experience family connectedness, school safety, strong and positive associations to the LGBT community, and perceived caring from other adults (Eisenberg & Resnick, 2006).

Children and adolescents who are questioning their sexual orientation are also more likely to be bullied than their heterosexual counterparts, and bullied children and adolescents are more likely to contemplate and to attempt suicide (Hatzenbuehler, 2011). Social environment, such as the experience of verbal, physical, social, and cyberbullying, plays a considerable role in the association between LGBT children and adolescents and suicide. The likelihood that a child or adolescent with a minority sexual orientation has attempted suicide in the previous 12 months compared to his or her heterosexual peer is 21.5% to 4.2%, respectively. Further, a more supportive social environment significantly reduced the probability of a suicide attempt, especially those children and adolescents among the LGBT population, in comparison to a more negative environment (Hatzenbuehler, 2011).

BASIC CONSIDERATIONS

In order to adequately determine suicide risk, the school psychologist must carefully assess both risk and protective factors. Research that examines intrapersonal factors
has found greater resilience among individuals with higher self-esteem (Sharaf, Thompson, & Walsh, 2009). In addition to this intrapersonal characteristic of resilience, interpersonal factors are also examined. When the availability of peer and family support is present, suicide risk decreases as self-esteem increases (Eisenberg & Resnick, 2006; Sharaf et al., 2009). Knowing that resilience can be defined as “the process of overcoming the negative effects of risk exposure, coping successfully with traumatic experiences, and avoiding the negative trajectories associated with risk” (Sharaf et al., 2009, pp. 160–161) increasing such protective factors (self-esteem and social support through peers and family) among youth in the United States may be a helpful tactic in suicide prevention programs.

Additionally, those students who feel as though they know adults who are trustworthy and capable of helping them with suicidal concerns maintain a positive attitude toward seeking help from school staff, are actively engaged in school and school activities, and are willing to potentially break promises of secrecy to talk with adults about suicidal ideation/behavior are major predictors of help-seeking behaviors for suicide (Eisenberg & Resnick, 2012; Pisani et al., 2012). As a result, designing suicide prevention strategies with the intent of strengthening self-esteem and social supports among students, as well as increasing their trust in school staff, may be effective in decreasing suicide risk among children and adolescents.

**Risk Factors**

There are numerous risk factors and trends for suicide among adolescents in the United States. These include but are not limited to gender; ethnicity; involvement in bullying; previous suicide attempts; a psychological disorder such as major depressive disorder or a substance abuse disorder; family history of suicide; family violence; sexual orientation minority/same-sex attraction; situational factors; and exposures to suicidal behavior of others, such as family members, peers, or the media (Miller, 2011). Furthermore, students who feel socially isolated, or a lack of connectedness to their peers or school, are also at risk for suicidal ideation and behaviors (Miller, 2011).

**Psychopathological Disorders**

A major risk factor for suicide among adolescents is the presence of a psychiatric disorder. There is an increased risk for suicide in adolescents with a mood disorder, most notably major depressive disorder (Miller, 2011). While there is a high comorbidity rate with suicide in females with depression and alcohol/substance abuse, the highest comorbidity for males and suicide is with depression and conduct disorder. Further, since 3–5% of the adolescent population experiences a depressive disorder, it is important to be aware of this adverse and potentially fatal effect depression has. Hopelessness, or feeling as though life will never get better in the future, is a factor that significantly influences suicidal ideation and behaviors (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

The presence of impulsivity is another significant factor that influences suicidal ideation and attempts among children and adolescents according to research (Goldsmith et al., 2002). Higher scores in assessments measuring impulsivity, sensation-seeking attitudes, and aggressiveness are found to be significant risk factors for suicide, and male children and adolescents tend to rank higher on such scales. An impulsive adolescent may not exhibit signs of depression, hopelessness, or suicidal ideation prior to a suicidal attempt. Rather, the adolescent may just act on impulse in a crisis situation. Whether or not an adolescent is using and abusing substances as a means to numb himself or herself or escape from psychological distress, adolescents who use alcohol and/or drugs are at an increased risk for suicide than their non-substance-using peers (Miller, 2011). Further, adolescents with a depressed affect who use and abuse substances tend to be more impulsive, and are also at a greater risk for suicidal behaviors. Mental illness, which affects up to 20% of the teen population, is a significant risk factor for suicide among teenagers, with a strong emphasis on depressive disorders, the presence of impulsivity, and substance use disorders.

**Familial and Biological Factors**

Four of the major problem areas of childhood adversity factors that are associated with elevated risk for suicidal behavior are (a) childhood maltreatment or victimization, (b) problematic parenting or family environment, (c) socioeconomic hardships, and (d) childhood adversities such as difficult peer relationships, legal problems, loss of a parent or caregiver, and a history of mental disorder or suicide attempts in the child and/or family members (Hardt, Johnson, Courtney, & Sareen, 2006). It is unclear whether a family history of suicidal behaviors is linked to a genetic predisposition, to contagion, to gaining increased attention for such behaviors, or, more likely, to some combination.

Not only might there be a genetic factor increasing a risk of engaging in suicidal behaviors or a contagion
effect, but there are also other aspects of family life that may contribute to an increased risk of suicide attempts among children and adolescents. As discussed previously, having family acceptance of their sexual identity was found to be a strong protective factor for an LGBT child or adolescent’s mental and physical health. Parental acceptance of their child’s sexual orientation, when he or she identifies as LGBT, also plays a significant role in their child’s overall suicide risk by reducing overall suicidal ideation and risk three-fold (Ryan et al., 2010).

In 2003, the U.S. Food and Drug Administration (FDA) proposed a new warning pertaining to the association between the administration of antidepressants among children and adolescents with depression (ages 5–17) and increased risk of suicidal ideation/behaviors. Further, the FDA (2004) then mandated that the manufacturers of 10 antidepressants drugs add such a warning to the label. While antidepressant medication has proven to be successful at helping to treat depression in children and adolescents, this black box label created an adverse effect on the prescription of these drugs. Because of these labels, there became hesitancy on the part of psychiatrists and physicians to prescribe antidepressant medication to children or adolescents suffering from major depression and suicidal ideation. While a principal goal of the proposal of the warning was for clinicians to more closely monitor children or adolescents on antidepressants, it actually created an overall doubt and a reduction in the prescription.

**Bullying**

Olweus (1993), creator of the Olweus Bullying Prevention Program, defines bullying as occurring when a person who has difficulty defending himself or herself, “is exposed repeatedly and over time, to negative actions on the part of one or more students” (p. 9). While 15–25% of students are being bullied, only one third of those students are reporting these incidents to the proper supports at school or home, such as teachers or caregivers. A child or adolescent’s connectedness to his or her peers can play a significant role in his or her risk for suicide, and a higher feeling of victimization or isolation may lead to a higher risk for suicidal ideation and behaviors. Children or adolescents involved in bullying, as a victim or bully, were at a significantly higher risk for depression and suicide. According to Lieberman and Cowan (2011), “adolescents frequently cite interpersonal problems as a precipitant of suicidal behavior and, relevant to the issue of loss as a trigger, bullying causes a substantial loss of dignity and humanity” (p. 13). Furthermore, the more frequently an adolescent was involved in bullying, the more likely that he or she was depressed, had feelings of hopelessness, had serious suicidal ideation, or had attempted suicide (Gould & Kramer, 2011).

Adolescents who are physically threatened or injured by peers report a higher frequency of suicidal thoughts and attempts than adolescents who were not victimized in such a manner, illustrating a significant connection between peer victimization and suicidal ideation/attempts (Kaminski & Fang, 2009). This may contribute to the victimized student feeling a low sense of connectedness to his or her peers and school, further increasing his or her risk for suicide. Students experiencing bullying in conjunction with higher social isolation, depressed feelings, and/or suicidal ideation are at higher risk for subsequent suicidal ideation 4 years later than students who experience one of the factors exclusively (i.e., bullying without feelings of depression/suicidality or feelings of depression/suicidality in the absence of bullying; Klomek et al., 2011).

As a dependence on technology is growing within the U.S. culture, there is a significant need to look at the impact that technology, particularly cyberbullying, has on suicide risk among children, adolescents, and young adults. Cyberbullying can be viewed as any act of bullying (i.e., mean or hurtful comments, spreading rumors, physical threats, pretending to be someone else, and mean or hurtful pictures) through a cell phone text, e-mail, or any social media outlet or online source (Hinduja & Patchin, 2012). About 20.8% of individuals ages 10–18 report having been victims of cyberbullying in their lifetimes and 19.4% report having cyberbullied others (Hinduja & Patchin, 2012). Low self-esteem, family issues, academic difficulties, school violence, delinquent behaviors, and suicidal ideation are all correlated with being a victim of cyberbullying (Hinduja & Patchin, 2012). As discussed previously, depressive symptoms and psychopathology have a grave impact on an individual’s suicidal risk.

**Self-Injury**

While self-injurious behavior in itself may not necessarily be indicative of suicidal intention, an individual engaging in such behaviors is at greater risk for suicide because of it. Many children and adolescents typically engage in nonsuicidal self-injury, most commonly the cutting of the skin, as a means to release their emotional suffering and dissociate from psychological distress without the intention of dying (Lieberman & Poland, 2006). On the other hand, suicidal behavior is intended
to end one’s life under the belief that death is the only option. Self-harming is a chronic and repetitive risky behavior that many engage in at a high frequency.

Self-injury is, in fact, a risk factor for suicide and can lead to an individual being three times more prone to attempt or consider suicide at least once, if not multiple times in his or her life (Whitlock et al., 2012). If a child or adolescent who engages in nonsuicidal self-injury becomes suicidal, it is likely to be much easier for that individual to carry out the actions needed to cause lethal damage to himself or herself through possible desensitization (Whitlock et al., 2012). Furthermore, it is important to note that two factors that seem to lower suicidal risk among children and adolescents who have a history of engaging in nonsuicidal self-injury are (a) discussing their distress with their parents and (b) perceiving a meaning in life (Whitlock et al., 2012).

**Situational Factors**

Firearms were reported to be the leading cause of death by suicide among individuals between the ages of 10 and 24, followed by suffocation (CDC, 2011). The rates of the various methods for suicide among this population in the United States have changed over the past 2 decades. When broken down into specified ages and genders, the rates differ. For instance, whereas firearms are most often used for completed suicides among males ages 10–24 (49.7%), females within the same age range are more likely to commit suicide by suffocation. Suicide by firearms and poisoning has actually decreased significantly for females between the ages of 10 and 24 since 1990 (Berman et al., 2009). In 2004, hanging/suffocation became the leading cause of death by suicide for females (Berman et al., 2009). The rate of females utilizing suffocation as a means of suicide increased 233% between 1991 and 2009 and the rate of female usage of firearms has dramatically decreased since 1993 (Berman et al., 2009). While this may be the case for females between the ages of 10 and 24, male suicides among the same age group are still more often completed by firearm (Berman et al., 2009).

Whether or not a child or adolescent has an identifiable mental health disorder or other suicide risk factors, the presence of a firearm in a home, especially a loaded gun, is highly associated with an increased risk for youth suicide (American Foundation for Suicide Prevention, 2006). Further, 83% of gun-related deaths in homes containing firearms are the result of a suicide, and findings illustrate that someone other than the actual gun owner is often the individual completing suicide in these cases (American Foundation for Suicide Prevention, 2006).

Another situational risk factor associated with child and adolescent suicidal behavior comes from social learning theory and is known as a contagion effect. Adolescents may learn that suicide is the only permanent solution to their problems by observing suicidal behaviors among celebrities, peers, or even family members.

Situational crises are also situational factors that can dramatically increase suicide risk, as these crises can be precipitating incidents for suicidal behaviors among children or adolescents. While these acute incidents are not the actual cause of a suicide attempt or completed suicide, they can lead to suicidal behaviors when in conjunction with other risk factors such as access to lethal means, substance use and abuse, depression, and/ or past suicide attempts (Miller, 2011; Poland & Lieberman, 2002). Some specific examples of what constitutes a situational crisis are provided in Table 19.1.

**BEST PRACTICES IN SUICIDE PREVENTION AND INTERVENTION**

It is not only necessary for research to focus on a range of interventions for those at risk for suicide, but it is also important for school psychologists to understand the
benefits of various prevention strategies. The numerous secondary intervention and postvention programs (i.e., those that play a significant role in aiding individuals who have been emotionally affected by a suicide) will, it is hoped, in turn, help thwart subsequent suicide attempts.

However, a principal focus on primary prevention is essential for school psychologists. The theme of Gene Cash’s 2008–2009 NASP presidency was preventing youth suicide, affirming that suicidal behavior among youth is an urgent national public health concern that needs to be addressed. The conceptualization of youth suicide as a public health problem has allowed for the nation to adopt a public health model of its prevention.

The public-health approach focuses on identifying patterns of suicide and suicidal behaviors in a group or population. It aims at changing the environment to protect people against diseases and changing the behaviors that put people at risk of getting them. (Yip, 2011, p. 118)

Although suicide is not a disease in the usual sense, it is a massive public health concern. Therefore, school psychologists must understand the importance of facilitating the development and adoption of suicide prevention programs through a public health lens in schools in order to reduce suicide risk and suicide rates among students.

Under Cash’s NASP presidency, a call to action regarding youth suicide prevention, further advocates for a three-tiered public health model of prevention, intervention, and postvention that is explicated in his call to action (Lazarus, 2009). This multitiered model is based upon the severity and features of the suicidal risk, as well as the need for intervention. Each tier can each be thought of as (a) low risk: ideation; (b) moderate risk: current ideation and previous attempts or behaviors; and (c) high risk: current plan and intent with access to means (Lieberman, Poland, & Cassel, 2008).

There are two major goals of suicide prevention programs (CDC, 1994). The first goal is to look at individuals who are already at risk in order to make appropriate referrals and to provide effective treatment. The second goal is to reduce risk factors in general.

The American Foundation for Suicide Prevention maps out four evidence-based frameworks for ensuring success of suicide prevention strategies that incorporate these two goals. The first, gatekeeper training, involving educating individuals in the respective contexts (school staff and community members such as clergy, recreational staff, clinical providers of healthcare to adolescents) to identify adolescents at risk for suicide. Approaches using this framework also teach the staff how to respond to suicidal individuals or other crises in their respective environments (American Foundation for Suicide Prevention, 2011).

The second recommended framework is general suicide psychoeducation, (i.e., teaching students about suicide, warning signs, and how to seek help for self or others). These strategies also often incorporate activities helping to boost the self-esteem of the adolescents involved. This framework can also be seen as one aspect of gatekeeper training, as the specified school staff members would be educated by a trained professional prior to educating the students on suicide.

The third recommended framework is the restriction of access to lethal means such as handguns and illicit substances to limit the accessibility of potential methods of self-harm. This is because ease of access to such measures increases the chance for a death by suicide to occur.

The fourth recommended framework is providing mental health treatment to individuals with depression and/or anxiety disorders, or those who are at-risk for such disorders. Screening programs are instruments or questionnaires that can be interpreted in order to identify high-risk individuals, as well as to provide further assessment and treatment. The Substance Abuse and Mental Health Services Administration, has provided Preventing Suicide: A Toolkit for High Schools (based on the Maine Youth Suicide Prevention Program; DiCara, O’Halloran, Williams, & Canty-Brooks, 2009) that recommends schools have screening programs in place as well as a plan to educate school staff, students, and parents on youth suicide/suicidal behaviors (Substance Abuse and Mental Health Services Administration, 2012). These are highly regarded methods for helping to uncover those adolescents who are possibly at risk for suicide, which will then lead to the utilization of appropriate protocols. Further, evidence-based suicide prevention programs are identified within the toolkit that can (and should) be implemented in schools in order to reduce student suicide. The two Tier 1 prevention approaches that most directly apply to schools are gatekeeper training and screening programs.

**Gatekeeper Training and Screening Programs**

Prevention programs have been proven to be successful Tier 1 strategies that properly train and educate school
The Signs of Suicide plan incorporates two frameworks: (a) increasing awareness through educating both students and school staff about recognizing the warning signs of depression and suicide and ways to intervene and (b) a screening that provides students with a short questionnaire to assess depression and suicide risk. This tool is used among eighth-grade and older students, and there is a distinct kit to use within each age group. While no formal training is necessary, the school psychologist is the appropriate staff member to serve as a key advocate and consultant for its implementation.

The Signs of Suicide kit includes teaching materials (a video and discussion guide) and a brief screening instrument for students (previously the Columbia Depression Scale and currently the Brief Screen for Adolescent Depression). The video, entitled Friends for Life, helps to teach students signs of suicidal ideation/behaviors within themselves and others, to teach students that suicide is not the normal response to stressors, and to educate students about the specific actions to take in order to help someone in need. Additionally, the video focuses on current issues and risk factors among suicidal students, such as self-injurious behavior as it includes dramatizations of three adolescents who struggle with mental health issues. A peer-to-peer intervention strategy is suggested in the video in which students are taught to acknowledge a peer’s suicidal ideation/behaviors, to care about the student in need through showing empathy and support, and to tell a responsible adult who will be able to help the depressed or suicidal student (Aseline et al., 2007).

The video also encourages students to have open discussions about such issues with their parents in order to keep lines of communication open and honest, as well as to reduce the frequency and severity of such thoughts and feelings. Through these steps, this video increases awareness among students who may otherwise be ignorant of warning signs and actions to take. Children and adolescents are more apt to confide in peers than adults regarding depressive and suicidal thought. This video, along with the subsequent discussion, empowers its student audience and teaches them how to intervene appropriately when a friend approaches them about such thoughts and emotions (Aseline et al., 2007).

The other aspect of Signs of Suicide the Brief Screen for Adolescent Depression, is a self-screening tool that assesses depressive symptoms and suicidal ideation among eighth grade and older students. These students are asked to score the screenings themselves, and depending on the student’s score on this screening, appropriate recommendations are made. A score of four or higher is considered to be an indicator of clinical depression, and students who receive such scores are encouraged to seek help immediately (Aseline et al., 2007). Rather than limiting this referral solely to mental health professionals, the student may also be prompted to discuss personal issues and feelings with a trusted loved one or a trained school professional, such as a teacher or school psychologist.

Signs of Suicide has been found to be a straightforward and effective tool in reducing suicidal ideation and behavior among adolescents. The idea of a peer-to-peer intervention strategy is developmentally appropriate, as social interaction with peers and friends is the primary source of support among the majority of teenagers. Second, the implementation of this tool is relatively uncomplicated. It has been shown to be an effective method of preventing suicidal ideation and behaviors in adolescents. It is important to note that school staff members who carry out Signs of Suicide must be prepared properly in these areas through participating in the first of the previously mentioned methods of Tier I suicide prevention, gatekeeper training, and psychoeducation. By participating in effective training, faculty and staff will be able to assess properly for suicidal ideation and other mental health issues in adolescents.

Further, faculty and staff will be able to educate at-risk students and their peers suitably so that those students at risk are apt to seek out or to be referred to the appropriate mental health services. While teachers are trained to teach specific academic courses, the school psychologists (who are not necessarily in such close contact with numerous students on a daily basis) are experts in behavioral, emotional, and cognitive change. These school psychologists should utilize their knowledge in order to train the faculty and staff to be prepared to handle depressed or potentially suicidal students.

**Identifying Suicidal Youth**

It is imperative that schools put forth effort in identifying adolescents who are at risk for suicide. While many of
such adolescents go unknown, the majority of them display warning signs and clues in some fashion that they are contemplating suicide. Because children and adolescents do not often refer themselves to treatment, a school psychologist’s or other gatekeeper’s effort to identify at-risk youth is vital. As previously discussed, gatekeeper training is an essential aspect of suicide prevention, and a strong effort should be made to ensure that these school staff members are properly trained and taught the various warning signs of suicide among youth. Warning signs can be understood as an acute risk factor such as a trait, attribute, or characteristic that has been found to be associated with suicidal ideation/behavior. There are various warning signs of youth suicide (Poland & Lieberman, 2002; Rudd et al., 2006; Substance Abuse and Mental Health Services Administration, 2012):

- **Threats:** Can be either passive (e.g., “No one understands. What’s the use?”) or direct (e.g., “I wish I were dead”). Children and adolescents may utilize artistic outlets, such as creative writing or visual art pieces, to express thoughts of suicide. These threats may be made through cyber methods such as social media outlets or text messages. Whether direct or indirect communication, an individual who hears or reads such threats has the duty to take it seriously.

- **Plan/method/access:** The more specific the plan might be, the greater the probability for self-harming. Someone who has easier access to and is actively searching for access to means to hurt himself or herself with firearms, sharp objects, pills, drugs, and alcohol may be providing warning signs.

- **Final arrangements:** Someone who has a sense of purposelessness may begin to give away possessions and begin to write goodbye notes.

- **Sudden changes:** Dramatic changes in mood, behavior, friends, or personality should be looked at as a potential warning side of suicidal ideation/behaviors. While it is common for adolescents to go through mood changes, a dramatic shift that continues for days may be an indication of possible suicidal ideation. Withdrawal from friends, family, and society may also be a warning side of suicide.

There are various methods of Tier 2 and Tier 3 interventions that schools can utilize for suicidal youth, and it is important that each school plan in advance the steps to take with a potentially suicidal student. The Substance Abuse and Mental Health Services Administration (2012) toolkit strongly advocates for the placement of protocols at each school in order to specify which staff will handle each of the tasks in the event of a suicide risk, suicide attempt, or completed suicide. Two crucial components that should be in place in every school, even if the school does not provide further suicide prevention strategies, are “protocols for helping students at possible risk of suicide” and “protocols for responding to a suicide death (and thus preventing additional suicides)” (Substance Abuse and Mental Health Services Administration, 2012, p. 17).

The school psychologist can take the lead role of developing a protocol to include necessary handouts and essential forms for documentation, risk assessment, notifying parents, providing referrals, and follow-up support. Some sample protocols for helping those students at risk that are provided within the toolkit include forms for parents and staff regarding at-risk adolescents; resources on properly assessing risk; information sheets for staff, students, and parents on various risk factors for youth suicide; suitable documentation examples; and methods for notifying parents of their child’s suicide risk.

The school should have at least one appointed staff member who is properly trained at assessing a student’s risk, such as the school psychologist. However, if the school did not designate someone, the school should contact a local mental health provider or National Suicide Prevention Lifeline (http://www.suicidepreventionlifeline.org) to identify a trained, local provider. Because school psychologists are trained in diagnostic assessment and interpretation of specific scales and instruments, the school psychologist may also be involved in risk assessment and may be best trained in using self-report questionnaires or screen scales referenced in Table 19.2. Through the utilization of such measures, school psychologists are more effective at screening for suicide potential, in addition to the presence of suicide risk factors, among students. These measures also aid in beginning to assess if a student’s risk is at Tier 1, 2, or 3 for the school psychologist to act accordingly. Further, school psychologists may be trained in assessing student’s suicide risk with many of the leading questions outlined in Table 19.3. The following general intervention for school-based crisis teams is recommended in order to assess for safety, identify the problem at hand, address the student’s feelings and emotions, and ensure the student receives appropriate care (Lieberman et al., 2008; Miller, 2011; Substance Abuse and Mental Health Services Administration, 2012):
Keep the student safe: A thorough assessment for safety and lethality is extremely important and so it is essential for a school to adequately supervise a student who is suspected to be at risk to himself or herself. As previously stated, a trained gatekeeper is a critical aspect of ensuring that the student is properly assessed for risk and brought into the school psychologist. In such a situation, it is important for the school staff to work together to best care for the student in need. No student at risk for suicide ought to be allowed to leave school unattended or to be left alone, even if just going to the restroom. This should begin with teachers and school staff not allowing at-risk students to even walk down the hall to the school psychologist unescorted by an adult.

Breaking confidentiality: When a student expresses suicidal risk, attention of the student’s thoughts/behaviors should be immediately brought to the designated reporter (preferably a school psychologist) at the school. This reporter should be an individual who is properly trained to conduct risk assessments and make appropriate referrals. While some students at risk for suicide might ask to keep their suicidal ideation confidential, it is imperative that the designated reporter clearly make known that information regarding suicidal plan, ideation, or behavior must be disclosed to a third party, such as the student’s parents. The student should be told that disclosing such information to the people who care most about him or her is extremely important. Keeping students informed of what actions are to be taken is a way to empower them and help them to feel as though their concerns will be both heard and understood.

Collaborate with administration or crisis team personnel: It is common for a school psychologist to need support from other staff. Difficult decisions made in such situations will be best made when discussed with and supported by other staff members, such as a nurse or psychologist, a school administrator, and other members of a school’s crisis team.

### Table 19.2. Standardized Self-Report and Screening Scales for Assessment of Suicide

- The Columbia Suicide Severity Rating Scale (Posner et al., 2011)
- Beck Scale for Suicidal Ideation (Beck, 1991)
- The Suicidal Ideation Questionnaire (Reynolds, 1988; appropriate for students in grades 7–12)
- The Hopelessness Scale for Children (Kazdin, Rodgers, & Colbus, 1986)
- Signs of Suicide (http://www.mentalhealthscreening.org)
- Brief Suicide Risk Assessment Questionnaire (Miller & McConaughy, 2005)
- The Reynolds Adolescent Depression Scale-Second Edition (Osman, Gutierrez, Bagge, Fang, & Emmerich, 2010)
- MAPS: Measure for Adolescent Potential for Suicide (Eggert, Thompson, & Herting, 1994)

*Note.* Based on information from Lieberman et al. (2008), Miller and McConaughy (2005), and Substance Abuse and Mental Health Services Administration (2012).

### Table 19.3. Areas to Address When Assessing a Student’s Suicide Risk

- What are the current feelings of the student?
- What were the warning signs that initiated the referral?
- What is the student’s current and past level of depression?
- What is the student’s current and past level of hopelessness?
- Has the student currently, or in the past, thought about suicide (either directly or passively)?
- What is the method of any previous suicide attempt (any previous suicide attempts or prior self-injury may indicate higher risk)?
- Does the student have a current suicide plan or plan to harm himself or herself (the more specific the plan, if applicable, the higher the risk)?
- What method does the student plan to use and does the student have access to the means (higher risk when either or both of those are affirmed)?
- What are the student’s perceptions on burdensomeness and belongingness?
- Is there history of alcohol or drug use?
- What are the student’s current problems and stressors at home and at school?
- Has the student demonstrated any abrupt changes in behaviors?
- What is the student’s current support system (higher isolation might indicate higher risk)?
- What is the student’s current mental health status? Is there a history of mental illness?
- Is there a history of bullying, victimization, loss, or trauma (any affirmative response might indicate a higher risk)?
- What are the student’s reasons to live (healthy answers to this question might indicate lower risk)?

*Note.* Based on information from Lieberman et al. (2008) and Miller (2011).
Suicide proof the environment and safety planning: When a student is suspected to be suicidal, it is a primary responsibility of the surrounding adults to remove access to lethal means. In addition to ridding the environment of access to weapons or anything that has potential to cause physical pain/death, it can be beneficial to prompt the suicidal student to commit to treatment. While no-suicide contracts are sometimes utilized, research illustrates that the utilization of written, signed safety contracts give mental health professionals and school psychologists a false sense of security and, further, a reduction of clinical caution with the student (Miller, 2011). In lieu of a contract, a safety plan can be made in collaboration with the school psychologist and student to ensure the student remains safe when he or she is feeling suicidal. This safety plan is to be used as a method of expressing direct, concrete, and nonsuicidal action. Stanley and Brown’s Safety Planning Guide provides a six-step process for safety planning with suicidal students and can be utilized as a quick guide for school psychologists to refer to for such procedures (Stanley and Brown, 2008).

Utilize law enforcement and community supports when appropriate: It may be necessary to involve law enforcement in the process of taking care of the suicidal student depending on the severity of the suicidal risk, resistance/combativeness of the student, the student’s attempt to flee the situation, and possible transportation needs. It is important for school psychologists to know the proper procedures in their state for involuntary hospitalization. When informing third parties, the gravity of the situation must be disclosed, making known that it involves a suicidal student.

Prepare a plan for reentry to the school: It is necessary for the facilitation of a student’s reentry to school to be done in a careful, precise manner. A multidisciplinary approach is recommended that involves collaboration between the school psychologist, school personnel, the student, the student’s parents or guardians, and professionals who have worked with the student in other fields, such as medical staff, hospital staff, and mental health professionals. While some might fight to hold the student from returning to school or find themselves anxious for a student’s return, it has been found that a depressed person is much safer and better off in school than not. Additionally, school psychologists should check with their district’s policies and guidelines.

Documentation

Documenting every step of this process is a crucial aspect for clinical, legal, and ethical reasons. When possible, the documentation should be done on the day of the assessment or incident and important information collected through interviews and assessments should be written down verbatim. These documents are an essential step of Tier 3 support when a referral of a suicidal student is made and a crisis team is utilized. There should be specified forms available within each school district in order to ensure proper records are kept of their responses, actions taken, recommendations, and referrals made to a suicidal student and/or the student’s parents (Lieberman et al., 2008).

Suicide Intervention Model

Understanding how to properly conduct a risk assessment and knowing how to appropriately respond based on the student’s level of risk are both significant factors in suicide prevention and intervention. Because early detection is extremely important, suicide risk assessment must be done carefully and accurately. Effective guidelines, as provided by Poland (1995) for the school psychologist to follow while assessing a student’s suicide risk are (a) connect with student through providing empathy, support, and trust; (b) reflect feelings, remain nonjudgmental, and do not minimize the problems; (c) respect the student’s developmental, cultural, and sexuality issues while collecting necessary information considering appropriate community referrals; (d) utilize an assessment worksheet; (e) be direct in questioning the student, staff member, and parents when collecting information; (f) never promise confidentiality; and (g) ensure that the school psychologist is maintaining the chain of supervision at all times.

Asking a student if he or she is thinking or has ever thought of suicide is vital, as it may lead to disclosure of risk that might otherwise have remained hidden. A multistage model can aid in early detection through the utilization of screenings and clinical interviews (Reynolds, 1991). While screenings should be brief, well validated, and reliable, the follow-up clinical interview with the student and the student’s support system should be thorough in assessing ideation, plan, intent, risk factors, warning signs, and protective factors. Questions, indicators levels of risk, and general interventions are summarized in Table 19.4.

Notifying Parents

The failure of the school psychologist to notify parents or guardians when there is reason to suspect that the student is suicidal is quite a common source for lawsuits. The school psychologist has an obligation to report any
Student who is suspected to be at risk for suicide based on foreseeability. In other words, even if a student denies suicidal ideation/intent, it is the duty of the school to notify the parents if the information available infers that the student is likely suicidal and would, furthermore, be considered negligence for school personnel to refrain from doing so (Eisel v. Board of Education of Montgomery County, 1991).

The importance of informing the parents of a possible suicidal child is not just to prevent a potential lawsuit. It is critical for parents or guardians to be notified in order to best care for their child’s safety (one caveat being if there are grounds to infer that the child would be abused or worsened by being in his or her home environment). Once the appropriate school staff member is with the student, preferably the school psychologist, it is vital to have that staff member get in touch with the parents or guardians. It is then essential to gain any further information from the parents or guardians that might contribute to the assessment of the student’s risk if they are available and cooperative (Poland et al., 2008). The Substance Abuse and Mental Health Services Administration toolkit contains guidelines for notifying parents and for suicide prevention in high schools. It also provides a list of helpful steps for helping to engage parents and support them through this process (Table 19.5).

In addition to providing the information in Table 19.5, three essential aspects of involving the parents with their child who is possibly suicidal in order to ensure safety are stressed (DiCara et al., 2009). First, a school staff member, such as the school psychologist, should explicitly inform the parents or guardians that their child is at risk for suicide and explain the reasons as to why this is believed to be true. The school staff member(s) on this case should then explain the importance of removing access in the home to any lethal means.

It is crucial to educate the parents or guardians on how to properly rid access to lethal means and ways in which to keep the child safe at home for the time being. Appropriate referrals, with the level of care based on the severity of the case, should also be given to the child’s parents or guardians at this time. In order for schools to provide the best practice for suicide prevention, policies for parental notification should be in place for students who are suspected to be suicidal, even if the student denies suicidal intent.

When it comes time to warn parents that their child might be suicidal, some issues may arise. First, if the team collaboratively decides that it is more of a risk to inform the student’s parents based on potential neglect or abuse in the home, the school staff may skip to directly calling the state’s child protective services.
instead. Second, some parents are uncooperative and may refuse to come to the school to talk and/or personally pick up their children to bring them home safely.

We strongly advise against allowing students to walk or take the bus home alone, no matter what the parents suggest. If a parent or guardian refuses to ensure the safety of their child, refuses to seek out additional mental health services for their child, or does not take the suicide risk seriously, it is recommended that the school psychologist, or other school personnel, calls the state’s respective child protective services.

**Providing Referrals**

School psychologists should keep a list of up-to-date community mental health resources to use as referrals for students who are possibly at risk for suicide in anticipation of suicidal crises. Once an action plan is in place for the student and his or her parent makes an appointment, it is recommended that the designated reporter or school psychologist contact the agency or mental health professional in order to ensure no relevant information be left out. Furthermore, various factors such as developmental, cultural, socioeconomic (potential need for provider who offers sliding scale rates), and sexuality issues should be considered when making such referrals (Lieberman, Poland, & Cowan, 2006).

**Following Up and Providing Support**

Whether or not the parents follow through with the school’s referrals, it is important that there be follow-up services offered for the student and his or her family. A school should monitor the student’s progress and make any modifications to the student’s plan when necessary to meet the primary goal of ensuring the student’s future safety. Additionally, the school’s effort to provide continuous support and resources is necessary in order to create a positive atmosphere for enhancing the student’s success (Lieberman et al., 2008).

**Postvention**

The term *postvention* refers to events and activities that are planned for schools to put into action following a suicide as a means to assess the overall impact, identify at-risk students, prevent a contagion effect from occurring, and support survivors who are emotionally affected by the death to cope effectively. While schools are often unprepared to handle the aftermath of a suicide, what is implemented following a suicide is just as essential as the prevention efforts.

The American Foundation for Suicide Prevention and Suicide Prevention Resource Center (2011) created the *After a Suicide: A Toolkit for Schools*, which provides schools with appropriate postvention considerations and guidelines for addressing a suicide among the community. A strong collaboration between the school, parents, media, and community must exist in order to appropriately handle the situation at hand and minimize further suicide risk for others. Following a suicide, a collaborative effort is needed in order to provide the proper support to those survivors and to prevent contagion. Survivors of the suicide include friends, family, previously attempted survivors, classmates, and the school psychologist who might have worked with the student. Discussions and counseling for these survivors throughout the day following a suicide, as well as mental health referrals, are methods in which schools can support staff and students. In order to provide the best care to the school/community, this toolkit outlines very specific courses of action to take, and not to take, following a suicide. A summary of such guidelines can be found in Table 19.6.

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Table 19.5. Helpful Steps for a School Psychologist in Engaging and Supporting Parents of a Suicidal Student

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>State what you have noticed in their child’s behavior (not just results of your assessment) and ask how that fits with what they have seen in their child.</td>
</tr>
<tr>
<td>2.</td>
<td>Advise parents to remove lethal means from the home while the child is possibly suicidal. You can equate this to how you would advise taking car keys from their child who had been drinking.</td>
</tr>
<tr>
<td>3.</td>
<td>Provide empathy for this situation and comment on its scary nature.</td>
</tr>
<tr>
<td>4.</td>
<td>Acknowledge the emotional state of the parents.</td>
</tr>
<tr>
<td>5.</td>
<td>Acknowledge that it is essential for individuals to collaborate to help the child, as no one can do this alone.</td>
</tr>
<tr>
<td>6.</td>
<td>If the parent appears to be uncooperative or unwilling to take certain actions, find out the parent’s beliefs about youth suicide risk/behavior and see if there are myths the parent believe are blocking the parent from taking proper action.</td>
</tr>
<tr>
<td>7.</td>
<td>Acknowledge and explore any cultural or religious concerns, or any other concerns, with accepting a referral to a mental health provider. Allow time to explain what it is the parent can expect.</td>
</tr>
<tr>
<td>8.</td>
<td>When possible, align yourself with the parent. It is important for the parent to understand where their child has gotten this idea without minimizing behaviors.</td>
</tr>
</tbody>
</table>

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The postvention process can also be viewed as a prevention method or a Tier 1 level of support, as it is an important step in limiting imitative behaviors following a suicide. It is important for the community to highlight the positive contributions and aspects of the deceased’s life rather than glorifying the cause of death. A school should attempt to limit the amount and type of information used by the media when discussing the student’s suicide.

This process should be one that is empathizing and psychoeducational in nature, discussing ways in which to identify and find help for potentially suicidal individuals and those suffering from mental illness. Resources such as the After a Suicide toolkit and American Foundation for Suicide Prevention and Suicide Prevention Resource Center (2011).

### Table 19.6. Suicide Postvention Guidelines

It is important to confirm suicide as cause of death with the coroner, medical examiner’s office, and local law enforcement. The designated crisis team response leader should immediately meet with the team and assign duties.

**Safety**
- Keep standard school hours on the days following death.
- Discourage students from congregating in the hallway or bathroom and encourage the students to seek out appropriate counseling and help.
- Call on school resource officers to assist with keeping media off the grounds and assisting parents or others who might show up at the school.

**Operations**
- Contact the family, inform the family of the school’s intervention efforts, offer support, and assist with funeral arrangements.
- Do not release information in a large assembly or over the intercom. Disseminate information to the faculty, students, and parents in small groups, up to the size of a small classroom. Be truthful, but avoid explicit details of the method and why the suicide happened. Instead, maintain focus on the general factors in suicide prevention and emphasize coping skills for survivors.
- Monitor activities throughout the school.
- Arrange for crisis counseling rooms for survivors and those affected by the death.
- Provide counseling and discussion opportunities for the faculty.
- Arrange for teachers and staff from local schools to assist if necessary.
- Identify and provide extra support to those who may be having a more difficult time.
- Provide tissues and water, and arrange for food to be available to staff and crisis workers on site.
- Track and respond to requests for memorialization by students and family members. It is important to balance between appropriate grieving and inappropriately glamourizing the death as a means to prevent contagion.

**Community liaisons**
- Provide primary contacts for working with the coroner or medical examiner, law enforcement to ensure safety, local government to facilitate a community-wide response to the suicide, mental health communities and grief organizations, and outside trauma/crisis responders to brief them as they arrive at the school.
- Contribute to a suicide prevention effort on behalf of the schools or community.

**Funeral**
- Encourage the family to hold funeral service off of school grounds and outside of school hours if possible.
- Contact the funeral director. Discuss the need to have crisis counselors at the service.
- Ensure that some school faculty is present at the funeral as a means to show support to affected students and survivors.
- Discuss with the family the importance of the funeral conductor/clergy placing emphasis on the connection between suicide and mental health issues (i.e., depression). It is important to refrain from romanticizing the death, contributing to contagion.
- Based on the family’s wishes, assist in the distribution of information regarding the funeral to students, parents, and school staff.

**Media relations**
- Prepare a media statement including information on local support being provided, a list of possible suicide warning signs, as well as local and national mental health and suicide prevention resources.

**Social media**
- Consider bringing together a small group of friends of the deceased to work with school faculty and administration to monitor social networking sites and social media.
- Watch over the school’s use of social media as an aspect of the crisis response.

*Note.* Based on information from American Foundation for Suicide Prevention and Suicide Prevention Resource Center (2011).
Association of Suicidology (http://www.suicidology.org/home) provide letter templates and guidelines for the media and community in order to attempt to ensure that the suicide is handled properly to limit a contagion effect.

**National Legislation and Initiatives**

Because youth suicide is a national public health concern, an influx of initiatives and bills have been brought into recent action to address it. The 2004 Garrett Lee Smith Memorial Act was the first bill signed into law pertaining to youth suicide prevention, affirming that suicide is a national public health problem. The Act is an effort to provide funding to states, tribes, campuses, and behavioral mental health services for grants that support prevention and intervention efforts. A report from the U.S. Surgeon General describes an explicit strategy for taking action against suicide with a majority of the objectives pertaining to the implementation of suicide prevention protocols, in some fashion, within a school setting (U.S. Department of Health and Human Services Office of the Surgeon General & National Action Alliance for Suicide Prevention, 2012). This call to action places a strong emphasis on making suicide prevention a priority in the United States, and is a significant document for working toward the prevention of youth suicide.

**SUMMARY**

Suicide is now the third leading cause of death in the United States for 10–24 year olds. Many theories have been proposed to explain this increase: from the little black box on antidepressant medications to the explosion of social media, from economic strife to the trauma of military service, from the stigma surrounding trauma of military service, from the stigma surrounding mental health partners and law enforcement.

**REFERENCES**


