Suicide Prevention and Assessment

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Model For Schools, Communities & Families
Prevention

Intervention

Postvention

U.S. Youth Suicide Rates

Annual Rate per 100,000
National Center for Health Statistics (2015)
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
17 Maryland .................. 4.9
18 New York .................. 4.7
19 Florida .................... 4.6
20 New Hampshire ........... 1.1
31 Washington, DC .......... 0.5
27 Washington ................ 8.2

Suicidal Behavior Continuum
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)

**Suicidal Intent**

**Definition:** There is past or present evidence (explicit or implicit) 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 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)
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)

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

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

#### Research Study

<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Suicide Attempt</th>
<th>Suicide Attempt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same-sex</td>
<td>35.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Different sex</td>
<td>3.3-times</td>
<td>3-times</td>
</tr>
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</table>


<table>
<thead>
<tr>
<th>Sexual Orientation</th>
<th>Odds Ratio</th>
<th>Odds Ratio</th>
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<tbody>
<tr>
<td>Same Sex Orientation</td>
<td>3.3</td>
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<tr>
<td>Hopelessness</td>
<td>1.34*</td>
<td>1.31*</td>
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<td>Depression</td>
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<td>1.15*</td>
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<td>2.42*</td>
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<tr>
<td>Suicide or attempt by non</td>
<td>1.91*</td>
<td>2.09*</td>
</tr>
<tr>
<td>Victimization</td>
<td>1.58*</td>
<td>2.13*</td>
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#### Seattle (1995)

<table>
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#### National Longitudinal Study of Adolescent Health (2001)

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### Research results for males

<table>
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<tr>
<th>Gender/Risk Factors</th>
<th>Suicidal Thoughts</th>
<th>Suicide Attempts</th>
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<td>Model #2</td>
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<td>Males</td>
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<tr>
<td>Victimization</td>
<td>1.55*</td>
<td>2.40*</td>
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Suicide Prevention and Assessment


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<tbody>
<tr>
<td>5-19 Year Olds</td>
<td>47% of Households have firearms</td>
<td>15% of Households have firearms</td>
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<tr>
<td>Firearm Suicide</td>
<td>654</td>
<td>121</td>
<td>5.5</td>
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<tr>
<td>Non-Firearm Suicide</td>
<td>417</td>
<td>339</td>
<td>1.3</td>
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<tr>
<td>Total Suicide</td>
<td>1071</td>
<td>460</td>
<td>2.4</td>
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<tr>
<td>25-64 year olds</td>
<td>47% of Households have firearms</td>
<td>15% of Households have firearms</td>
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<tr>
<td>Firearm Suicide</td>
<td>4674</td>
<td>1316</td>
<td>3.6</td>
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<tr>
<td>Non-Firearm Suicide</td>
<td>2775</td>
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<tr>
<td>Total Suicide</td>
<td>7449</td>
<td>4308</td>
<td>1.8</td>
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</table>

Miller et al., 2006

Suicide Prevention and Assessment

Suicidal Behavior in Youth vs. Adult

<table>
<thead>
<tr>
<th>Age group</th>
<th>CRISIS</th>
<th>% same day by age</th>
<th>2001 Data</th>
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<tbody>
<tr>
<td>5-17</td>
<td>33</td>
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<td>18-24</td>
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<td></td>
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<td>25-44</td>
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<td>45-64</td>
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<tr>
<td>65+</td>
<td>6</td>
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</table>

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

Suicide Prevention and Assessment

Methods Used by Adolescents Who Attempted Suicide

- Pits: 37.7%
- Cut Wrists: 26.6%
- Hang/Drown: 9.7%
- Others: 19.8%
- Slab Self: 6.9%
- Firearms: 4.2%

Reynolds & Maua, 1994
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

Anxiety Disorders → Substance Abuse → Suicidal Behavior → Depressive Disorders → Borderline Personality

Suicide Prevention and Assessment

Current Theory of Suicide

1. 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
  - 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
I. Current Educational Model: Coping Strategies 1st

Education = Academics + Coping Strategies

School Structures: ???
*Youth Risk Behavior Survey

Externalizing Behaviors

Emotional Behavioral Disabilities

Internalizing Behaviors

More frequent in Males

More frequent in Females

Current State of Mental Health in Schools

Suicide Prevention and Assessment

Schools

The safety triangle for our Children and Adolescents

Parents/Family Community
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:
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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

School-Wide At-Risk

(Reynolds, Gutierrez & Mazza, 2007)
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)

   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 al., 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
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)

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Acceptability Rating (range 1 to 72)</th>
<th>Statistical Results</th>
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</thead>
<tbody>
<tr>
<td>a. School-wide screening program</td>
<td>39.5</td>
<td>b, c &gt; a</td>
</tr>
<tr>
<td>b. Staff in-service program</td>
<td>46.7</td>
<td>b &gt; a, p &lt; .001</td>
</tr>
<tr>
<td>c. Curriculum-Based program</td>
<td>44.9</td>
<td>c &gt; a, p &lt; .02</td>
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</tbody>
</table>

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
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

Suicide Prevention and Assessment

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Intrusive factor scores</th>
<th>Acceptability factor score</th>
<th>Statistical Results</th>
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</thead>
<tbody>
<tr>
<td>a. School-wide screening</td>
<td>16.96</td>
<td>30.27</td>
<td>a &gt; b, c</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>b, c &gt; a</td>
</tr>
<tr>
<td>b. Staff in-service program</td>
<td>14.33</td>
<td>38.11</td>
<td>b &lt; a, b &gt; a</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>p &lt; .001</td>
</tr>
<tr>
<td>c. Curriculum-Based program</td>
<td>13.87</td>
<td>37.69</td>
<td>c &lt; a, c &gt; a</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>p &lt; .001</td>
</tr>
</tbody>
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Screening Model for Schools

Suicide

PREPARE STAFF & TEACHERS

STAGE 1 SCREENING

STAGE 2 REASSESSMENT

STAGE 3 FOLLOW-UP (CLINICAL INTERVIEWS)

Depression

Not at Risk

STOP

At Risk

STOP

STOP

STOP

Schools – Tier 1

INTERVENTION
Screening Measure: The SIQ-JR

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

The SIQ
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)

I. Characteristics of the SBI
   A. Practical features
      1. Semi-structured clinical interview
      2. 20 items, 18 are scored
      3. Continuous scale - 1/2 points used
      4. 3 factor structure
         a. Global psychological distress
         b. Suicidal thoughts & preparation behavior
         c. Past suicide attempt
      5. Training required

Stage 2 Follow-up Clinical Interviews

Suicidal Behavior Interview (SBI) (Reynolds, 1991)
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

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<thead>
<tr>
<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Absent</td>
<td>Minimal</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
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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)

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<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Absent</td>
<td>Vague Plan</td>
<td>Thought of couple ways</td>
<td>Thought of how (no details)</td>
<td>Detailed plan</td>
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9. Did you think of when?

<table>
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<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
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<tbody>
<tr>
<td>Absent</td>
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<td>Definite</td>
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10. Did you think of where?

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Stage 2
Follow-up Clinical Interviews

Sample Items on the SBI
11. Did you write a note or plan to write one?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absent</td>
<td>Planned</td>
<td>Wrote</td>
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</tbody>
</table>

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

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<thead>
<tr>
<th></th>
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<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Absent</td>
<td>Minor hurt</td>
<td>Major hurt</td>
<td>Minor injury</td>
<td>Major injury</td>
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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 A B C D
   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 A B C D
   Absent Minor no injury Mild injury Significant injury Severe hospitalized

20. At the present time, do you feel like hurting or killing yourself?
   0 A B C D
   Absent Mild thoughts Specific Intent Very serious

I. Characteristics of the SBI
   A. 3 factors
      • psychological distress
         5 items
         • depress/hopelessness
         • hassles
         • social support
         • major life events

   A. 3 factors (cont.)
      • covert & overt suicidal features
         10 items – largest
         • planning
         • method
         • warning signs
I. Characteristics of the SBI
   A. 3 factors (cont.)
      - past suicide attempt
        - 3 items
          - recency
          - seriousness
          - lethality

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

   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
II. Factors to consider when implementing Stage 2

C. Private rooms for interviewing
   - less distractions
   - promotes caring setting
   - confidentiality

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

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
B. SOS – Signs of Suicide
   1. Peers and adults
   2. Utilizes ACT (Acknowledge, Care, Tell)

Suicide Prevention and Assessment

Global Approaches to Suicide Prevention:
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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

Schools
The safety triangle for our Children and Adolescents

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 do?
  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
  B. Attending workshops on adolescent mental health and signs and symptoms
  C. Provide son/daughter with emergency contact numbers and resources communication skills
DO PARENTS STILL MATTER DURING ADOLESCENCE?
V. YES, Parents still matter
A. Longitudinal study in emerging adulthood

(Mazza et al., 2009)

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

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

1st & 2nd Grade Risk Factors:
1. depression
2. anxiety
3. antisocial behavior

8th & 9th Grade Depression

Interventions

Pharmacological Therapy
- SSRI's
- Prozac

School-Based Programs
1. Skills
2. Behaviors
   1. DBT STEPS-A®
   2. SOS X 2
   3. Reconnecting Youth

Cognitive–Behavioral Therapy
1. Individual
2. Group
   1. Dialectical behavior therapy

Interventions

Schools

The safety triangle for our Children and Adolescents
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!!
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

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.
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;
(d) Continuing and professional certificates for school counselors.

(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.

Section 44 (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.
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 developed and posted 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.

https://www.k12.wa.us/safetycenter/YouthSuicide/SuicidePrevention.aspx

TIER 3 SUPPORTS AND BEYOND
Facilitator of the new laws
School Psychologists

1. 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

1. 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!!!