Suicide and Self-Harm Prevention in Schools

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Learning objectives:

Gain an understanding of what self-harm and the spectrum of behaviors related to self-harm.

Learn about benefits and challenges of school-based prevention efforts for self-harm and suicide.

Learn about best practices from Multi-tiered System of Support and SAMHSA to support prevention of self-harm.
Suicide is a Public Health Problem

Suicide Rates from National Vital Statistics System, 1999-2014 (Curtin et al, 2016)

Figure 2. Suicide rates for females, by age: United States, 1999 and 2014

Figure 3. Suicide rates for males, by age: United States, 1999 and 2014

NOTES: For all age groups, the difference in rates between 1999 and 2014 is significant ($p < 0.05$). Suicides are identified with codes U03, X60–X64, and Y87.0 from the International Statistical Classification of Diseases and Related Health Problems, Tenth Revision. Access data for Figure 2 at: [http://www.cdc.gov/nchs/data/hestats/suicide_14/000014.pdf](http://www.cdc.gov/nchs/data/hestats/suicide_14/000014.pdf).

# Range of Suicide Risk Behaviors

|-------------------------|-------------------------------------|-----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Suicide Attempt         | 8.6%                                | A potentially self-injurious behavior associated with at least some non-zero intent to die.     | *strongest predictor; method critical to understanding risk  
                          |                                                    |                                                                                                         | * Multiple attempts  
<pre><code>                      |                                                    |                                                                                                         | * Moderate false positive rate |
</code></pre>
<p>| Interrupted Attempt     | ?                                   | Person begins to take steps toward making a suicide attempt but somebody else stops them prior to any self-injurious behavior. | Unknown predictive strength                                                                                          |
| Aborted Attempt         | ?                                   | Person begins to take steps toward making a suicide attempt but stops themself prior to any self-injurious behavior. | Unknown predictive strength                                                                                          |
| Non-Suicidal Self-Injury| 13-21% (Barrocas, 2012)             | Self-injurious act without any intent to die. Often associated with other goals, such as to relieve distress. | *Strong predictor, potentially equal to suicide attempt                                                            |
| Suicidal ideation       | 17.7%                               | Thinking about killing self; ranges from passive (wish to be dead) to active (thoughts about killing oneself). | * High false positive risk;                                                                                       |</p>
<table>
<thead>
<tr>
<th>Distal Risk Factor</th>
<th>Proximal Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior self-injury</td>
<td>Stressful Life Events- particularly those with high levels of shame/embarrassment</td>
</tr>
<tr>
<td>Psychopathology (Esp. Comorbid Depression, Panic, Substance Use, Conduct Disorder)</td>
<td>Accessible Means</td>
</tr>
<tr>
<td>Impulsive-Aggressive Traits</td>
<td>Intense Affective State+ Sleep Disturbance</td>
</tr>
<tr>
<td>Race/Ethnicity (likely related to social conditions including assimilation, disruption of social structure, minority stress)</td>
<td>Academic /Employment Difficulties</td>
</tr>
<tr>
<td>Disturbed Family Context/Family history of suicide /Early life adversity</td>
<td>Functional Impairment from Physical Disease/Injury</td>
</tr>
<tr>
<td>Male</td>
<td>Suicide in Social Milieu</td>
</tr>
<tr>
<td>Sexual Minority</td>
<td>Talking about suicide, burden to others, purposelessness</td>
</tr>
<tr>
<td>Abuse</td>
<td></td>
</tr>
</tbody>
</table>
Multiple Suicide Prevention Strategies Needed

Christensen (2016) JAMA viewpoint
Reducing Suicide Risk

Universal Strategies

Selective Strategies

Indicated Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Estimated % of Suicide Attempts Prevented</th>
<th>Estimated % of Suicides Prevented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Awareness</td>
<td>0.3</td>
<td>0</td>
</tr>
<tr>
<td>Media Guidelines</td>
<td>1.2</td>
<td>2</td>
</tr>
<tr>
<td>Means Restriction</td>
<td>0.5</td>
<td>4</td>
</tr>
<tr>
<td>School Based Programs</td>
<td>2.9</td>
<td>6</td>
</tr>
<tr>
<td>GP Training</td>
<td>6.3</td>
<td>8</td>
</tr>
<tr>
<td>Gatekeeper Training</td>
<td>4.9</td>
<td>10</td>
</tr>
<tr>
<td>Coordinated Aftercare</td>
<td>19.8</td>
<td>12</td>
</tr>
<tr>
<td>Psychosocial Treatment</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>
Mental health and academic problems commonly co-occur (DeSocio & Hootman, 2004; Roeser et al., 1999)

Schools = the most common site for the identification and treatment of youth mental health problems (Costello et al., 2014; Farmer et al., 2003; Lyon et al., 2013)
  - ~20% of all students receive SMH services annually (Foster et al., 2005)

Schools improve service access for traditionally underserved youth (Kataoka et al., 2007; Lyon et al., 2013)
Importance of the School Context

- Service use across sectors by race/ethnicity...

Lyon et al. (2013)
High schools provide an accessible setting for identifying youth at-risk (Farmer et al., 2003)

School-based screening/assessment methods could be substantially improved (Romer & McIntosh, 2005)

- Practical/staffing concerns
- Only 2% of schools carry out routine universal emotional health screening
Multi-Tiered System of Support (MTSS) Provides a Framework for Organizing School Interventions

- **Universal** (All Students)
- **Selected** (SOME At-risk Students)
- **Targeted/Intensive** (FEW High-risk students)

Screening → Progress monitoring →
Components of SAMSHA Framework:

- Protocol for responding to death
- Protocol to address students at risk
- Screening
- Education for parents
- Education for students
- Education for staff

SAMSHA Preventing suicide: Toolkit for schools
### Tier 1: Education for Staff, Parents and Students

<table>
<thead>
<tr>
<th>Students</th>
<th>Parents</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Specific Information (Signs of Suicide, Sources of Strength)</td>
<td>Information about programming for youth</td>
<td>Education Programs like QPR, Asist,</td>
</tr>
<tr>
<td>Universal Screening</td>
<td>Information about warning signs</td>
<td>Education regarding crisis response procedures</td>
</tr>
<tr>
<td>Integrated SEL Curricula</td>
<td></td>
<td></td>
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</tbody>
</table>
Parent and Staff Education:
• Garrett Lee Smith legislation: gatekeeper training can be effective in reducing suicide attempts and death by suicide
• Training efforts must be ongoing to yield reductions in suicide-related outcomes (Garraza et al., 2015)

Student Education:
• Studies suggest that interventions designed to enhance students’ skills may be particularly important for school-based suicide prevention efforts (Singer et al., 2015 for review).
Universal Screening

- Effective Identification is Essential for Suicide Prevention
- Screening for suicide risk is challenging
- Assessment places significant resource demands on the gatekeepers and clinicians
- Feasibility is a concern
- Effects of emotional health screening leads to improved detection, but connection to indicated supports demonstrates mixed results
<table>
<thead>
<tr>
<th>Students</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment following screening</td>
<td>Training related to key duties in a crisis</td>
</tr>
<tr>
<td>Supports for Indicated Populations</td>
<td>Identification of students</td>
</tr>
<tr>
<td></td>
<td>Provision of appropriate assessment and supports</td>
</tr>
</tbody>
</table>
## Tier 3: Indicated Interventions

<table>
<thead>
<tr>
<th>Students</th>
<th>Parents</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual intervention</td>
<td></td>
<td>Responding to non-lethal suicidal behavior</td>
</tr>
<tr>
<td>school-based, safety planning, referrals</td>
<td></td>
<td>Responding to death by suicide</td>
</tr>
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<td></td>
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</tbody>
</table>
Benefits of decades of research to routine service have been negligible.

It takes 17 years for just 14% of original research to benefit practice (Balas & Boren, 2000).
Implementation Gap

I'M BACK FROM TRAINING.

I GOT A BIG BINDER.

THE TRAINING IS ALREADY FORGOTTEN, BUT THE BINDER WILL LAST FOREVER.

A LIVING MONUMENT TO TEMPORARY KNOWLEDGE!
Implementation Determinants

• Factors that obstruct or enable changes in professional behaviors or service delivery processes (i.e., barriers and facilitators) (Krause et al., 2014)

• Helpful determinant resources
  • Conceptual frameworks (e.g., CFIR, TDF, etc.)
  • Taxonomy of determinants (Flottorp et al., 2013)
  • Specific measures – e.g., ILS (Aarons et al., 2014), ICS (Ehrhart et al., 2013), OSC (Glisson et al., 2008), etc.
• Methods or techniques used to enhance the adoption, implementation, & sustainment of practices (Powell et al., 2012; Proctor et al., 2013)
Implementation Outcomes

- Effects of deliberate actions to implement new practices (Proctor et al., 2011)

**Implementation outcomes**
- Acceptability
- Adoption
- Appropriateness
- Costs
- Feasibility
- Fidelity
- Penetration
- Sustainment

**Service outcomes**
- Efficiency
- Safety
- Effectiveness
- Equity
- Student-centeredness
- Timeliness

**Student outcomes**
- Satisfaction
- Functioning
- Symptoms

(Proctor et al., 2011)
Your role in helping youth

Unique position to intervene!

Core tasks are to:

• Ask the question!
• Understand patient’s self-harm
• Assess severity of behavior
• Present options for alternatives
• Monitoring the status, ensuring continuity of care, and reconnect with behavioral health as needed
Ask the question

• Common myth that asking teens about self-harm may be iatrogenic
• There is NO data to support this myth
• Ask the question and practice asking
  • “Have you thought about harming yourself?”
  • “Have you harmed yourself?”
Ask questions needed to assess the behavior can also generate change (e.g., Motivational interviewing)

Facilitate discussion

Prompt patient to think about change

Example questions:

1. This behavior must be serving a function for you. Are there disadvantages to continuing?

2. Is there anything that’s motivating you to stop hurting yourself?

3. There are a lot of options for getting help for this problem. What do you think you would need to stop?
Use a matter of fact, curious yet dispassionate communication style

Validation – a communication strategy that communicates understanding and their actions make sense given their current context

Validate the valid: find the kernel of truth

• It has been really stressful and you are not sure how to handle the stress.
• It’s hard to think of other solutions in the moment of stress because cutting has been immediately effective in the short term, though it has problems in the long term.
# Core Assessment Questions: STOPS FIRE
(Kerr et al., 2010)

<table>
<thead>
<tr>
<th>What to Assess</th>
<th>How to Assess</th>
<th>Indication of High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suicidal Ideation</strong></td>
<td>Do you have thoughts of killing yourself? Does this occur when you are engaging in [bx] or other times?</td>
<td>Intense thoughts of suicide while NSSI ; Thoughts of suicide before/ after NSSI</td>
</tr>
<tr>
<td><strong>Types</strong></td>
<td>What have you used? What ways do you injure yourself?</td>
<td>&gt;3 methods</td>
</tr>
<tr>
<td><strong>Onset</strong></td>
<td>When did you first begin X?</td>
<td>Early onset; &gt; 6 mo</td>
</tr>
<tr>
<td><strong>Place/Location</strong></td>
<td>What parts of your body have you X?</td>
<td>Genitals; face</td>
</tr>
<tr>
<td><strong>Severity</strong></td>
<td>Has X ever caused bleedings/ scarring? Have you ever gone to the ED due to X?</td>
<td>Hospitalization, reopening of wounds</td>
</tr>
<tr>
<td><strong>Function</strong></td>
<td>What does X do for you? How do you feel before? After?</td>
<td>Any relationship to suicide</td>
</tr>
<tr>
<td><strong>Intensity</strong></td>
<td>How strongly would you rate your urge to X on a typical day (0-100)?</td>
<td>70 or above</td>
</tr>
<tr>
<td><strong>Repetition</strong></td>
<td>How many times have you done this?</td>
<td>&gt; 10</td>
</tr>
<tr>
<td><strong>Episodic frequency</strong></td>
<td>How often do you do this in a typical week?</td>
<td>Multiple times per week; Multiple times per episode</td>
</tr>
</tbody>
</table>
Management and Treatment

• No FDA medications for treatment of self-harm
• Several promising psychotherapy practices (Ougrin et al., 2015)
  • Collaborative Assessment and Management of Suicidality
  • Dialectical Behavior Therapy
  • Mentalization
  • Problem solving therapies
• Common focus on observing and describing thoughts and emotions; more accurately interpret one’s own/others behavior
• Skills related to mindfulness, emotion regulation and interpersonal effectiveness
Conclusions

• Clinicians working in high schools are likely to encounter teens who self-harm

• Clinicians can be prepared to encounter this behavior by:
  • Aligning their MTSS and SAMSHA frameworks to support students
  • Exploring and understanding their own reactions
  • Understanding the function and course of self-harm
  • Be prepared to address the problem with validation and motivational interviewing strategies
  • Refer when teens are willing, harm is dangerous or repetitive, or indicates high risk