Suicide and Self-Harm Prevention in Schools

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Location of presentation

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Disclaimer Slide

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Goals for this presentation

Learning objectives:

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

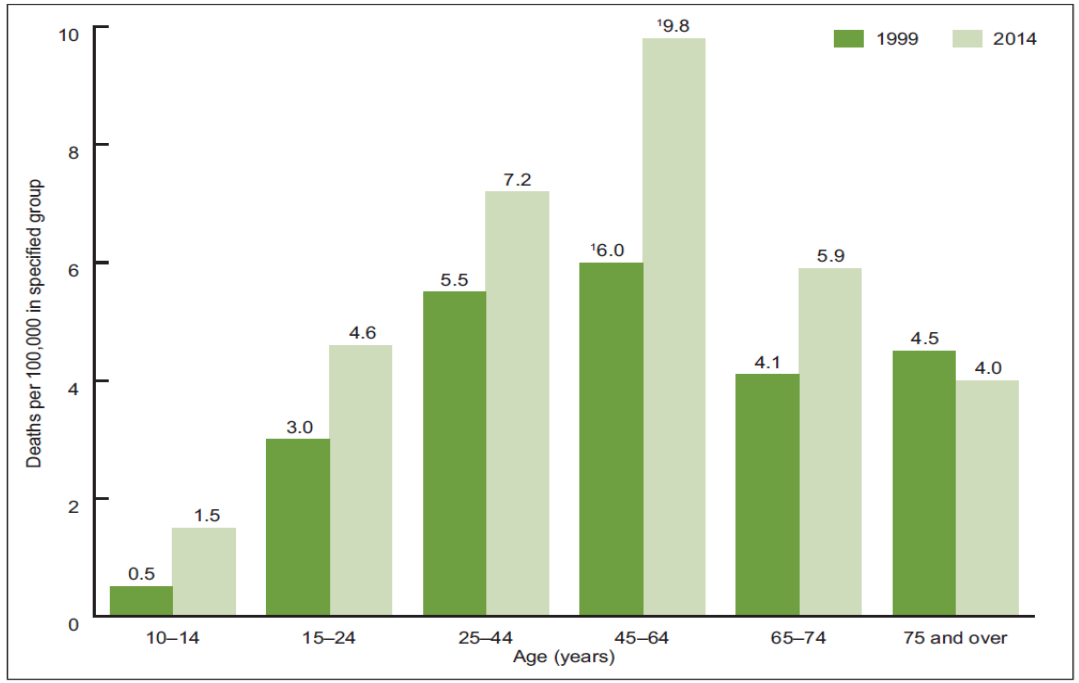
Learn about benefits and challenges of school-based prevention efforts for self-harm and suicide

Learn about best practices from Multi-tiered System of Support and SAMHSA to support prevention of self-harm.

Suicide is a Public Health Problem

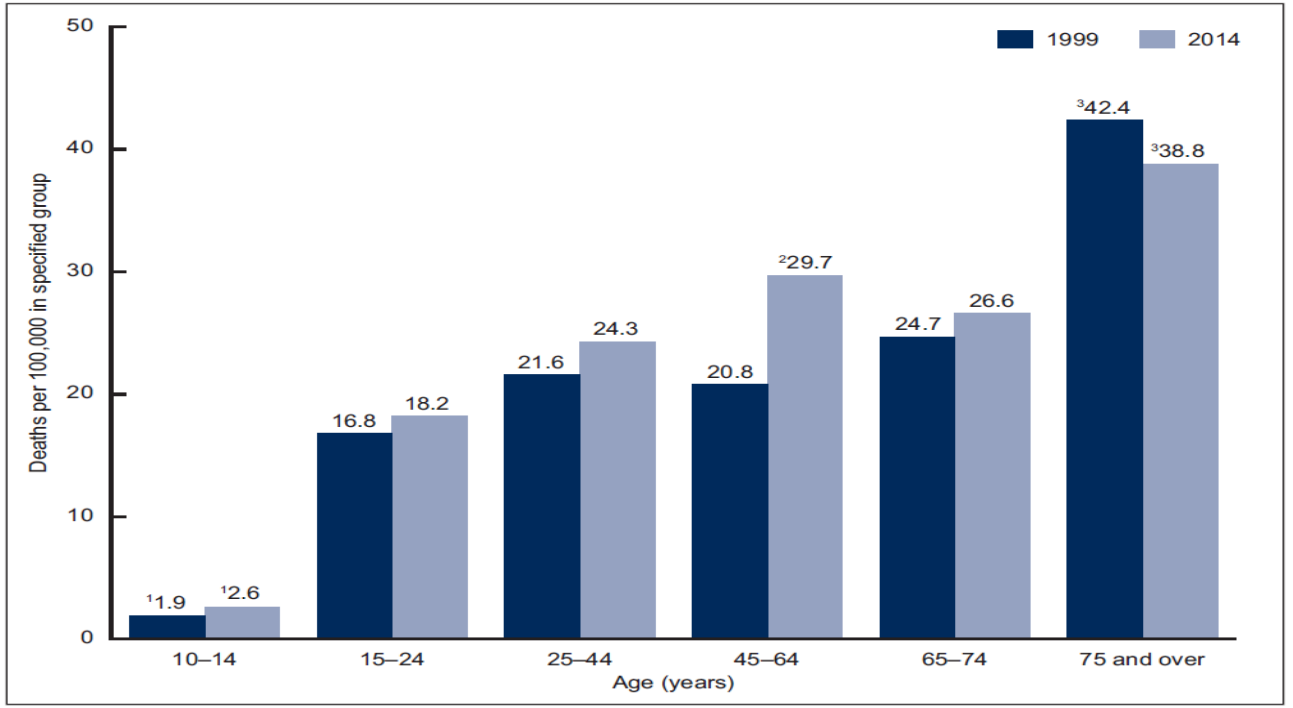
Suicide Rates from National Vital Statistics System, 1999-2014 (Curtin et al, 2016)

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



[1]Significantly higher than rates for all other age groups ($p < 0.05$).
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–X84, 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/databriefs/db241_table.pdf#2.
SOURCE: NCHS, National Vital Statistics System, Mortality.

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



[1]Significantly lower than rates for all other age groups ($p < 0.05$).
[2]Significantly higher than rates for all other age groups except 75 and over ($p < 0.05$).
[3]Significantly higher than rates for all other age groups ($p < 0.05$).
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–X84, and Y87.0 from the *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*. Access data for Figure 3 at:

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Range of Suicide Risk Behaviors

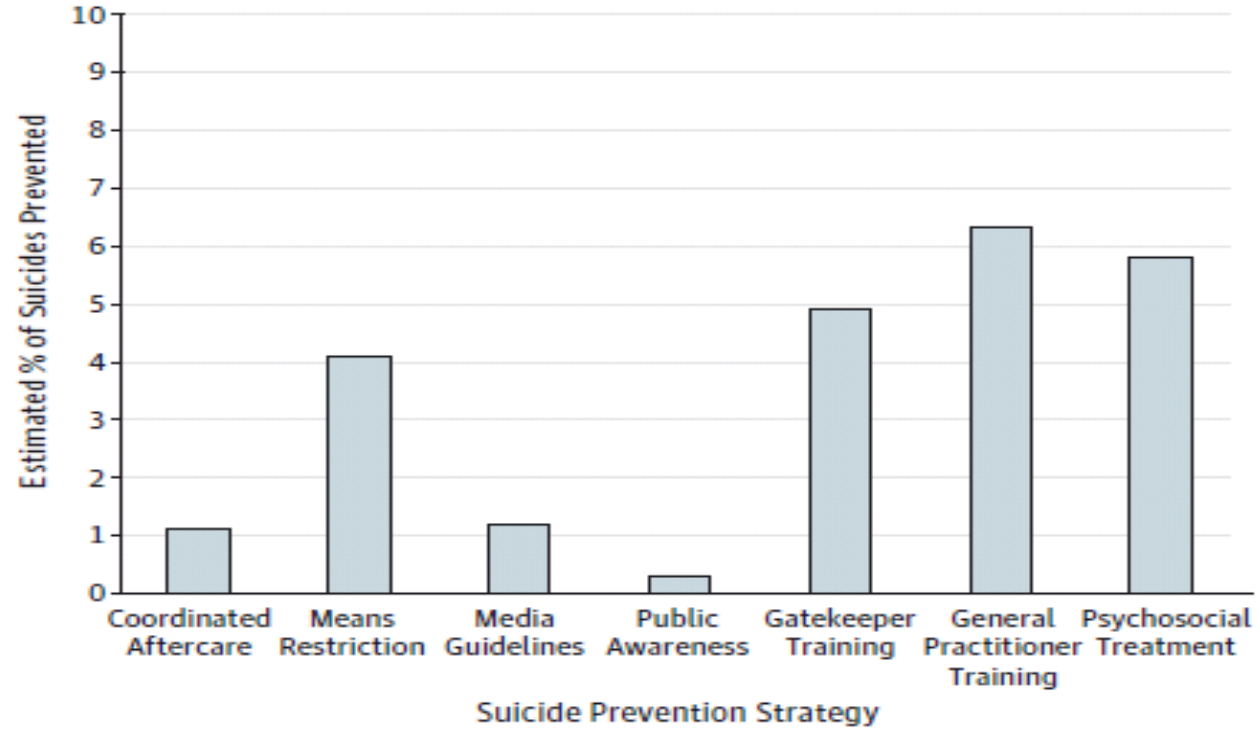
Behavior	High School Estimates (YRBS, 2015)	**Definition** (Posner et al., 2009)	**Risk/Relation to Suicide** (Fowler, 2012)
Suicide Attempt	8.6%	A potentially self-injurious behavior associated with at least some non-zero intent to die.	*strongest predictor; method critical to understanding risk * Multiple attempts * Moderate false positive rate
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;

Risk Factors

Distal Risk Factor	Proximal Risk Factor
Prior self-injury	Stressful Life Events- particularly those with high levels of shame/embarrassment
Psychopathology (Esp. Comorbid Depression, Panic, Substance Use, Conduct Disorder)	Accessible Means
Impulsive-Aggressive Traits	Intense Affective State+ Sleep Disturbance
Race/Ethnicity (likely related to social conditions including assimilation, disruption of social structure, minority stress)	Academic /Employment Difficulties
Disturbed Family Context/Family history of suicide /Early life adversity	Functional Impairment from Physical Disease/Injury
Male	Suicide in Social Milieu
Sexual Minority	Talking about suicide, burden to others, purposelessness
Abuse	

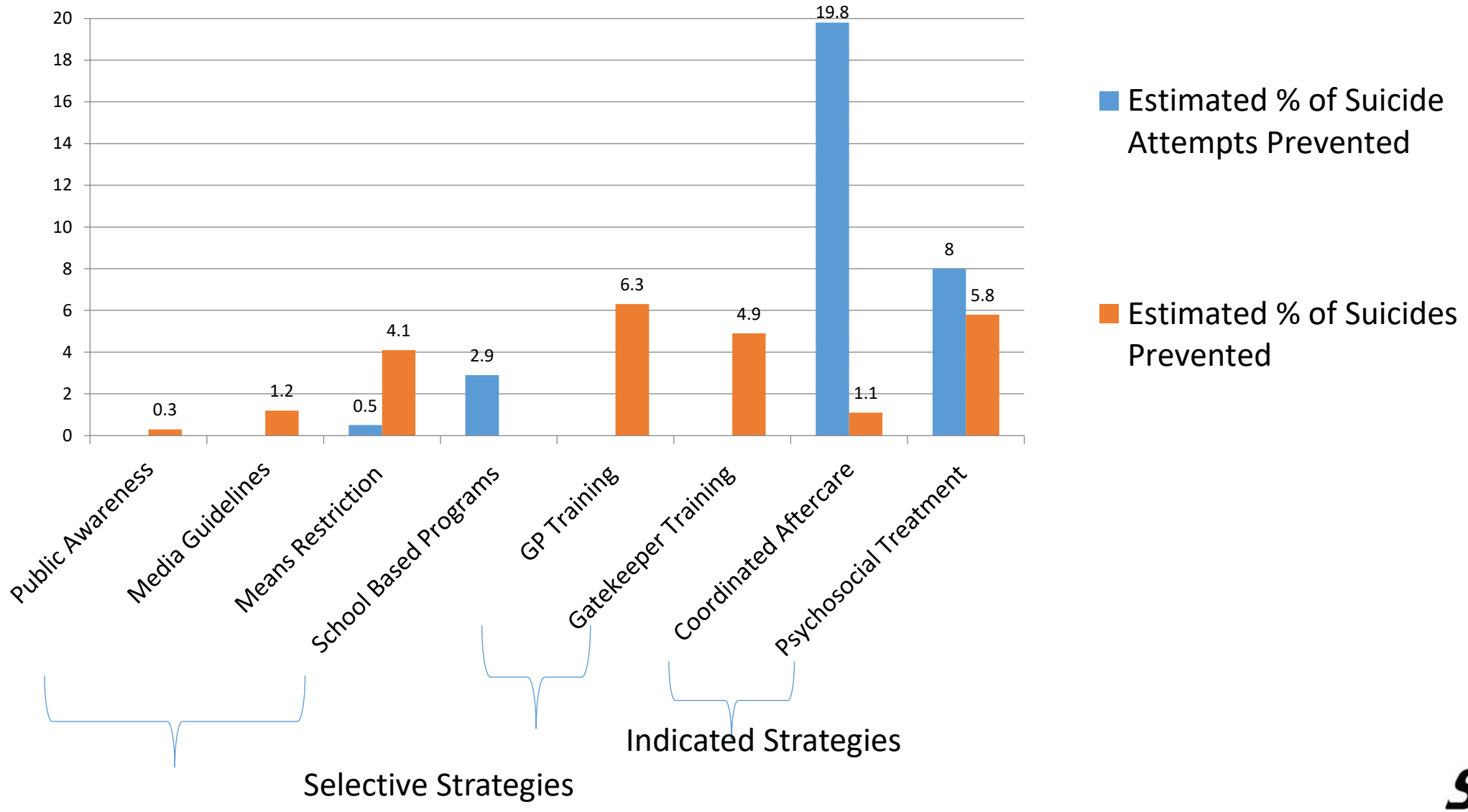
Multiple Suicide Prevention Strategies Needed

Figure. Estimated Percentages of Suicides Prevented by Use of Different Suicide Prevention Strategies



Christensen (2016) JAMA viewpoint

Reducing Suicide Risk



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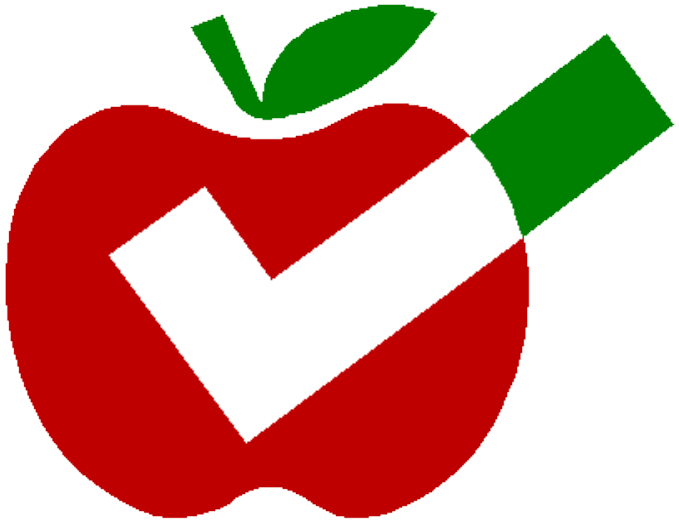
Schools are an Important Context for Self-Harm Prevention

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)



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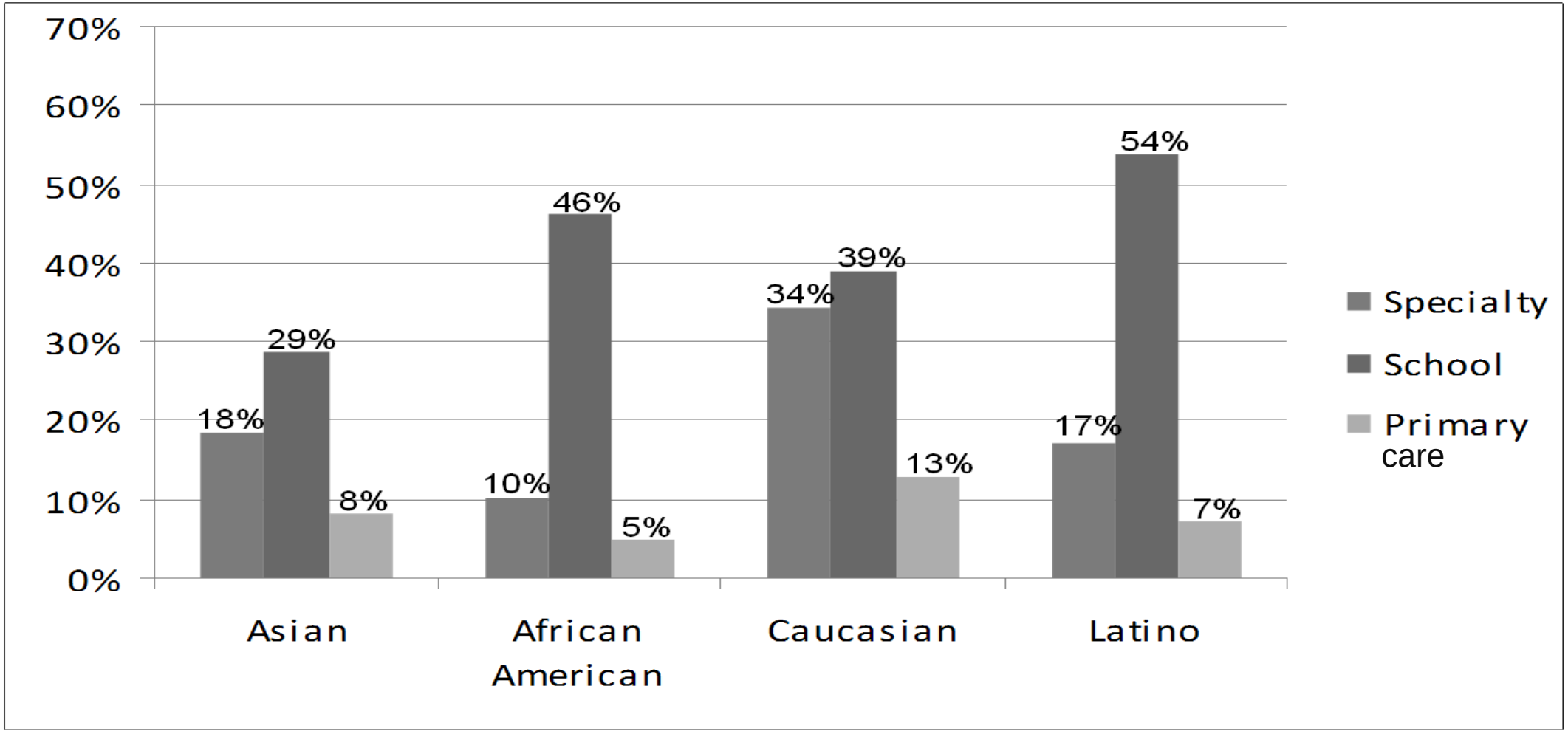
Importance of the School Context

- Service use across sectors by race/ethnicity…



Lyon et al. (2013)

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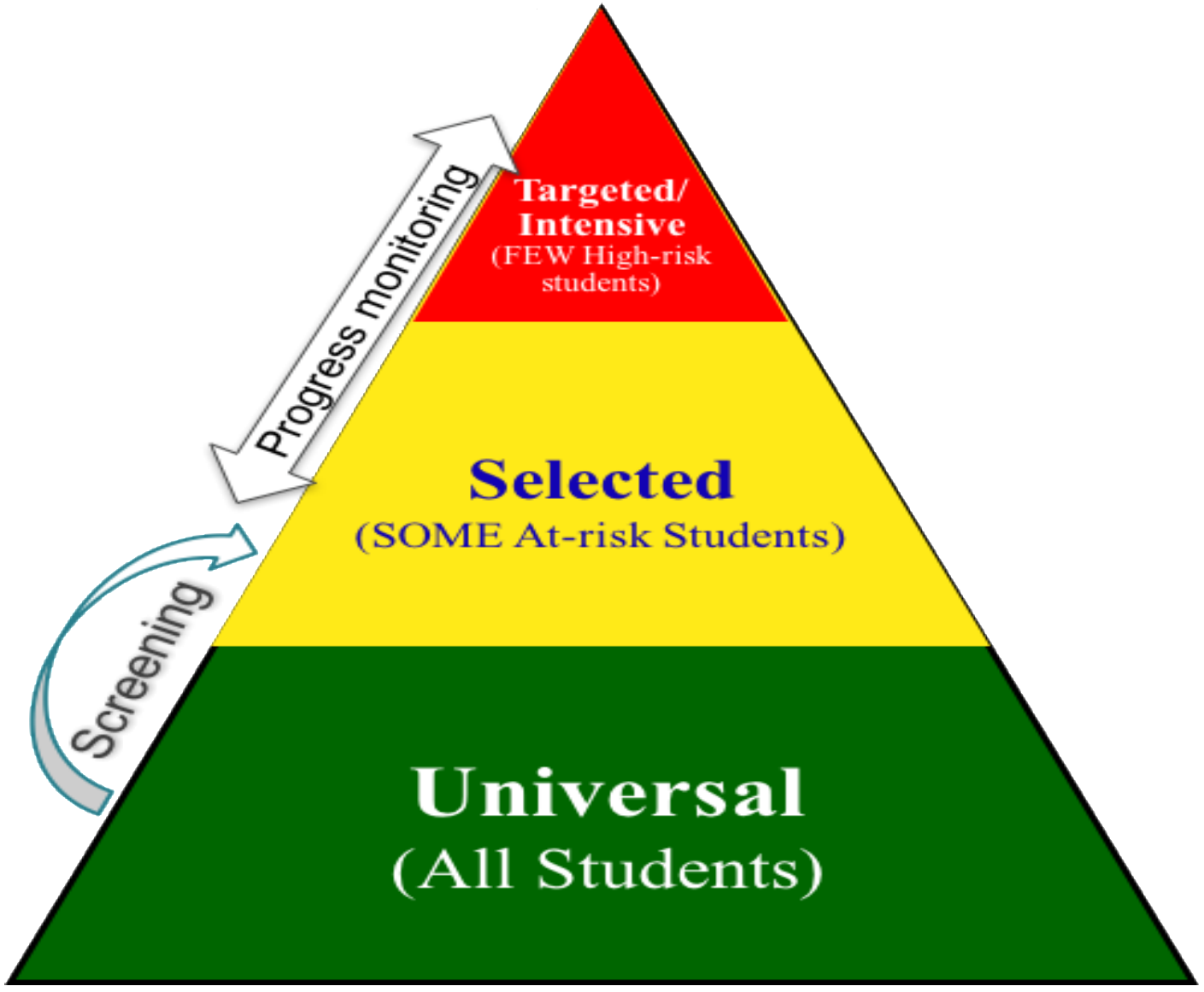
Importance of the School Context

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



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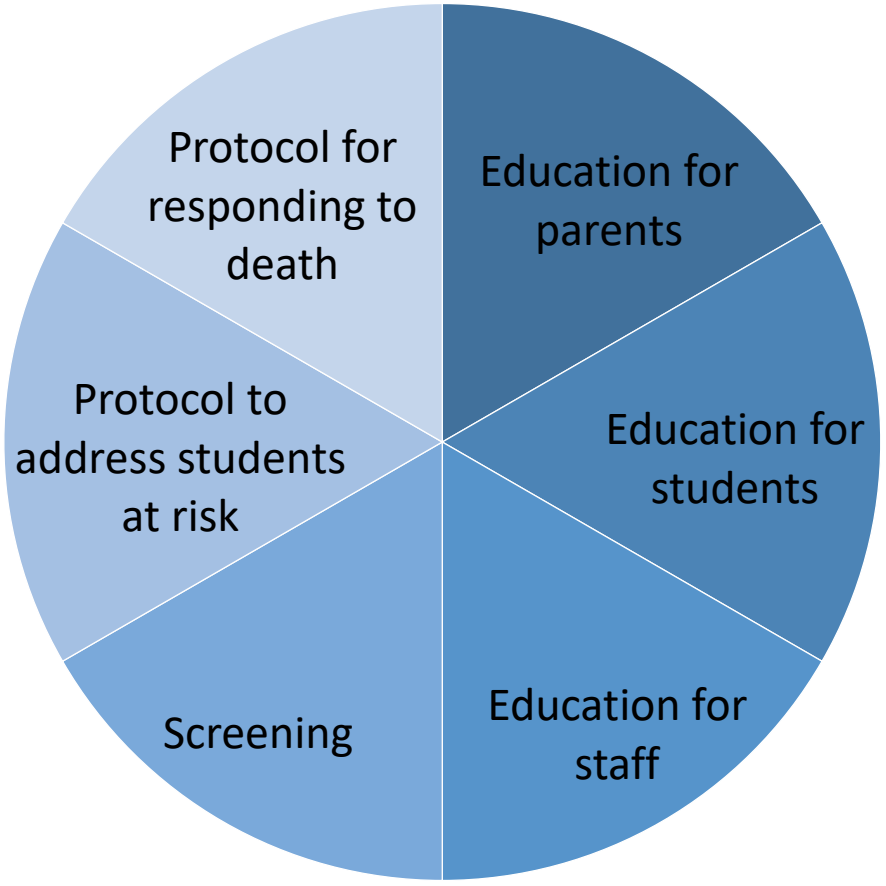
Components of SAMSHA Framework



SAMSHA Preventing suicide: Toolkit for schools

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Tier 1: Education for Staff, Parents and Students

Students	Parents	Staff
Suicide Specific Information (Signs of Suicide, Sources of Strength)	Information about programming for youth	Education Programs like QPR, Asist,
Universal Screening	Information about warning signs	Education regarding crisis response procedures
Integrated SEL Curricula		

Effects of Education Programs

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

Tier 2: Selected Interventions

Students	Staff
Assessment following screening	Training related to key duties in a crisis
Supports for Indicated Populations	Identification of students
	Provision of appropriate assessment and supports

Tier 3 : Indicated Interventions

Students	Parents	Staff
Individual intervention-school-based, safety planning, referrals		Responding to non-lethal suicidal behavior
		Responding to death by suicide

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Contemporary Research-to-Practice Gaps

- **Benefits of decades of research to routine service have been <u>negligible</u>**
- It takes **<u>17 years</u>** for just 14% of original research to benefit practice (Balas & Boren, 2000)

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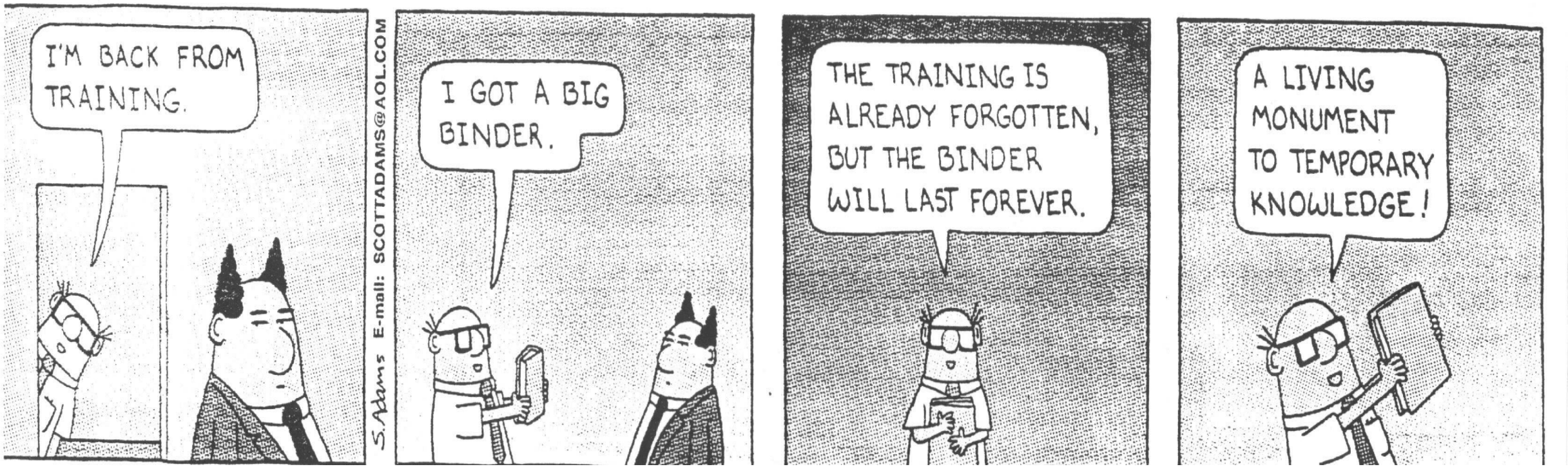
Implementation Gap



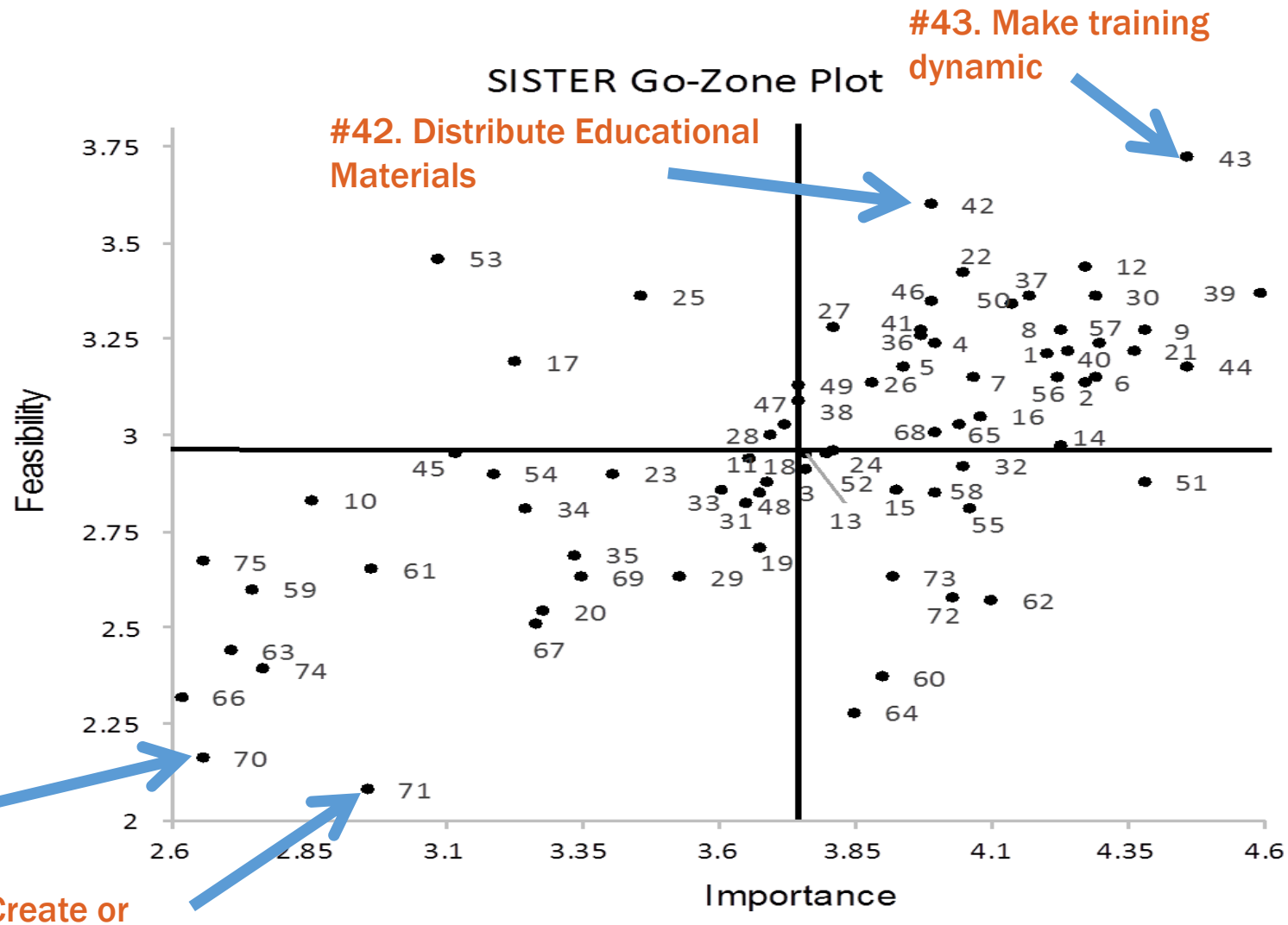
Implementation Determinants

- 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.

Implementation Strategies

- Methods or techniques used to enhance the adoption, implementation, & sustainment of practices (Powell et al., 2012; Proctor et al,. 2013)



Lyon et al. (under review)

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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)

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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 alteratives
- Monitoring the status, ensuring continuity of care, and reconnect with behavioral health as needed

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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?”

Understanding Self-Harm: Communication

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?

Understanding Self-Harm (continued)

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)

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

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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 behaviors by:
  - Aligning their MTSS and SAMSHA frameworks to support students
  - Exploring and understanding their own reactions
  - Understand 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