Indian Health Service
2012 National Behavioral Health Conference

Welcome

Suicide Clusters in Schools:
Lessons learned from cycles of crisis and cycles of response

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University of Montana

Mobilizing Partnerships to Promote Wellness

House Keeping

- Please be sure to sign in and out on the Sign In Sheets located near the entrance to this room.
- Please complete the evaluation at the end of this presentation.
- For more information on Continuing Education Units (CEUs), please visit the Registration Desk

Comfort Room

- To promote wellness and self-care, a Comfort Room is available in Atrium Room 8 for your use.

- If you need further assistance, please visit the Indian Health Service Division of Behavioral Health booth.

Partnerships

- Meaningful, mutually respectful partnerships with tribes, schools, behavioral health agencies and community members is central to the work of the National Native Children's Trauma Center (NNCTC).

- NNCTC partnerships are rooted in the understanding that:

  - Tribes know the consequences of trauma in their community, therefore they are intensifying their commitment to community, family and individual wellness.
  - Many non-tribal mental health service providers and treatment model minimize the value of tribal holistic practices.
  - In the past, tribes have been exploited by universities and other institutional researchers.
  - Potential risk continues to exist amongst well-intentioned but culturally uninformed researchers and universities.
  - Tribes exist as sovereign nations therefore they carry the responsibility to determine the type of research that serves tribal members.
  - Any research products or outcomes (e.g., data, intellectual property) are *owned* by the tribe.
  - Trauma intervention is necessary for and effective with Native American children.

attribution: National Native Children's Trauma Center Position Paper, June 2008

National Native Children's Trauma Center

- **Established** in Fall 2007 to serve as a Treatment and Services Adaptation Center (Cat II) within the National Child Traumatic Stress Network (NCTSN)

- **Mission**: *In respectful partnerships with tribes, NNCTC will implement, adapt, evaluate and disseminate trauma interventions to decrease the social, emotional, spiritual and educational impact traumatic experiences have on American Indian and Alaska Native children.*

- Part of the Institute for Educational Research and Service – which also houses the **Montana Safe Schools Center**

A PARTNER IN NCTSN The National Child Traumatic Stress Network

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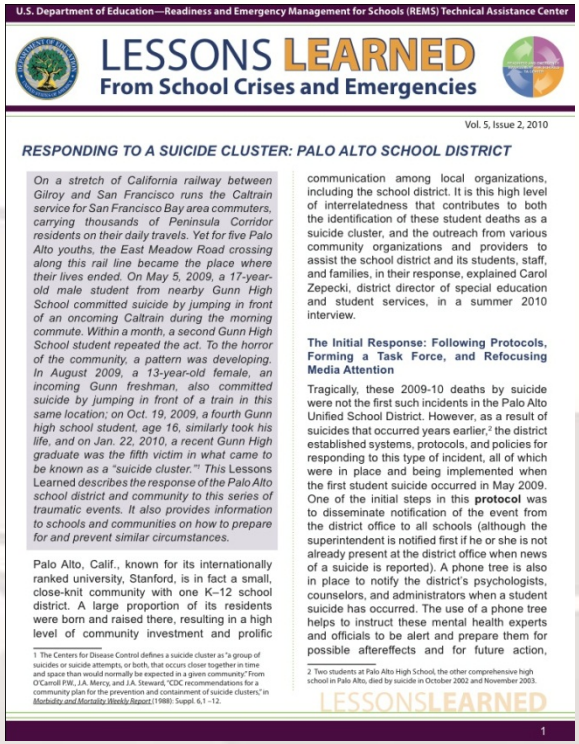
Suicide impacts all aspects of the emergency response cycle… and is preventable

Suicide impacts all school communities.

- 8.3 million adults / 3.7% had serious thoughts of suicide in the past year according to a 2009 SAMHSA report. 2.3 million actually made a plan.
- Young adults 18-25 were most at risk for contemplating. People with substance abuse disorders are 3x more likely to seriously consider attempting and 4x more likely to plan.
- Suicide & suicide clusters occur across the country, in Native and non-Native schools. They impact learning, attendance, behavioral issues and community confidence.
- See the U.S. Dept. ED's/OSDFS recent Lessons Learned publication from a suicide cluster in Palo Alta CA.



U.S. Department of Education—Readiness and Emergency Management for Schools (REMS) Technical Assistance Center

LESSONS LEARNED
From School Crises and Emergencies

Vol. 5, Issue 2, 2010

RESPONDING TO A SUICIDE CLUSTER: PALO ALTO SCHOOL DISTRICT

On a stretch of California railway between Gilroy and San Francisco runs the Caltrain service for San Francisco Bay area commuters, carrying thousands of Peninsula Corridor residents on their daily travels. Yet for five Palo Alto youths, the East Meadow Road crossing along this rail line became the place where their lives ended. On May 5, 2009, a 17-year-old male student from nearby Gunn High School committed suicide by jumping in front of an oncoming Caltrain during the morning commute. Within a month, a second Gunn High School student repeated the act. To the horror of the community, a pattern was developing. In August 2009, a 13-year-old female, an incoming Gunn freshman, also committed suicide by jumping in front of a train in this same location; on Oct. 19, 2009, a fourth Gunn high school student, age 16, similarly took his life, and on Jan. 22, 2010, a recent Gunn High graduate was the fifth victim in what came to be known as a "suicide cluster."[1] This Lessons Learned *describes the response of the Palo Alto school district and community to this series of traumatic events. It also provides information to schools and communities on how to prepare for and prevent similar circumstances.*

Palo Alto, Calif., known for its internationally ranked university, Stanford, is in fact a small, close-knit community with one K–12 school district. A large proportion of its residents were born and raised there, resulting in a high level of community investment and prolific communication among local organizations, including the school district. It is this high level of interrelatedness that contributes to both the identification of these student deaths as a suicide cluster, and the outreach from various community organizations and providers to assist the school district and its students, staff, and families, in their response, explained Carol Zepecki, district director of special education and student services, in a summer 2010 interview.

The Initial Response: Following Protocols, Forming a Task Force, and Refocusing Media Attention

Tragically, these 2009-10 deaths by suicide were not the first such incidents in the Palo Alto Unified School District. However, as a result of suicides that occurred years earlier,[2] the district established systems, protocols, and policies for responding to this type of incident, all of which were in place and being implemented when the first student suicide occurred in May 2009. One of the initial steps in this **protocol** was to disseminate notification of the event from the district office to all schools (although the superintendent is notified first if he or she is not already present at the district office when news of a suicide is reported). A phone tree is also in place to notify the district's psychologists, counselors, and administrators when a student suicide has occurred. The use of a phone tree helps to instruct these mental health experts and officials to be alert and prepare them for possible aftereffects and for future action,

1 The Centers for Disease Control defines a suicide cluster as "a group of suicides or suicide attempts, or both, that occurs closer together in time and space than would normally be expected in a given community." From O'Carroll P.W., J.A. Mercy, and J.A. Steward, "CDC recommendations for a community plan for the prevention and containment of suicide clusters," in *Morbidity and Mortality Weekly Report* (1988): Suppl. 6,1 –12.

2 Two students at Palo Alto High School, the other comprehensive high school in Palo Alto, died by suicide in October 2002 and November 2003.

LESSONSLEARNED

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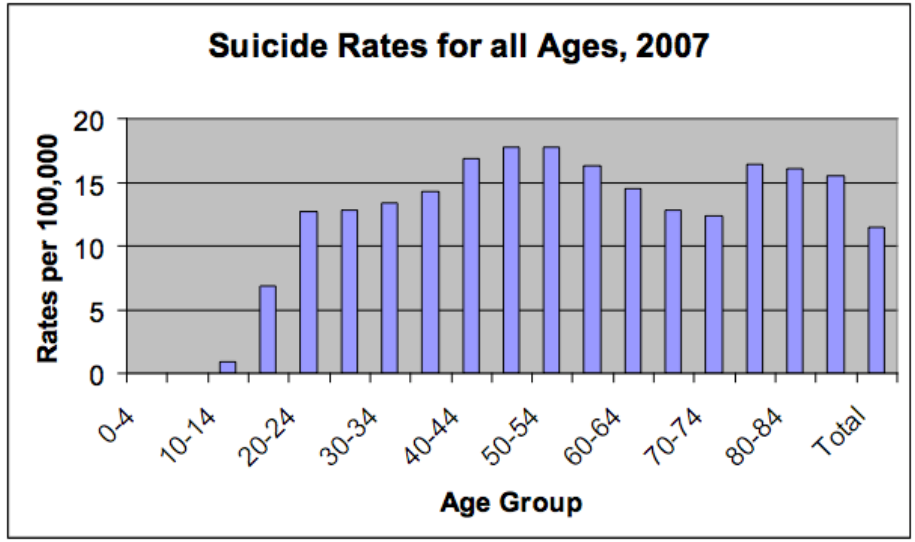
The issue more broadly…

- Females attempt 3x more than males; but males *complete* 3.6x times more than females.
- It is the 11th leading cause of death across all age groups; but 3rd for ages 15-24 (behind accidents and homicides, CDC) and 2nd for ages 25-34.
- Completion rates between ages of 15-24 increased 200% from the 1950s - 70s, leveled until the 90's, decreased slightly until 2007, then rose again.
- There were just over 35,500 completions in 2007 - or 1 every 15 minutes.
- The Intermountain West is consistently the most deadly region with 6 of the top 10 states.

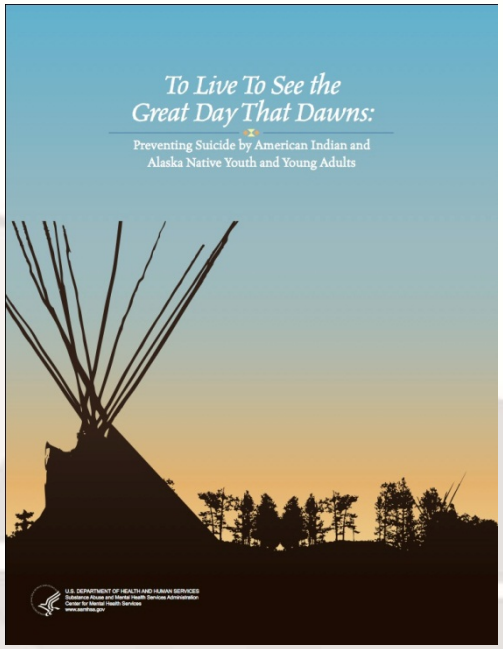


American Association of Suicidology 2010 factsheet: http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-244.pdf

What is a suicide cluster?

A suicide cluster is defined in the U.S. Substance Abuse and Mental Health Service Administration's 2010 report on American Indian/Alaska Native suicide prevention entitled ***To Live To See The Great Day That Dawns*** (pg 37), as:

"when a group of suicides or suicide attempts occur closer together in time and space than would be normally expected in a given community."



Suicide in Indian Country

- Suicide is epidemic in Indian Country, with American Indian and Alaska Native (AI/AN) youth *more at risk than any other cultural or ethnic group*.
- Suicide is often associated with poverty, and many American Indian communities have the some of the highest poverty rates of any ethnic group in the Nation. 50-80% on many Plains Reservations….
- Native populations are disproportionately young compared to the rest of the nation. 38% are under the age of 19 and another 23% are between the ages of 20 and 34.
- Intergenerational trauma, decreased access to health care, a host of socioeconomic risk factors and extended families = greater chance of Native youth to experience familial loss, grief and traumatic stress.

Sources:
Suicide Prevention Resource Center, *Suicide Among American Indian/Alaska Native Youth Fact Sheet.* Retrieved from: http://www.sprc.org/library/ai.an.facts.pdf
National Congress of American Indians. Retrieved from http://www.ncai.org/Economic-Development.45.0.html
U.S. Department of Health and Human Services. (2010). To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults. DHHS Publication SMA (10)-4480,CMHS-NSPL-0196

A recent suicide cluster on the Fort Peck Reservation in Montana…also in SD and NM

- Five adolescents from the Poplar community killed themselves in separate events over the 2009/2010 year.
- Twenty more students in Poplar Schools also attempted suicide that same year.
- By mid-summer, two adults also killed themselves.
- According to an Indian Health Service report, during spring 2010, the suicide rate on the Fort Peck reservation was three times the Montana average (already one of the highest in the nation) and more than six times U.S. rates.

Protective Factors

- **Effective clinical care** for mental, physical, and substance use disorders
- Easy **access** to a variety of clinical interventions and support for help-seeking
- **Decreased access to** highly lethal **means** of suicide
- **Strong connections** to family and community support
- Support through **ongoing** medical and mental health care relationships
- Problem solving, conflict resolution, and **nonviolent handling** of disputes
- Cultural and religious **beliefs** that discourage suicide and support resilience
- Connections to the land
- Safe, supportive **school environments**
- **Trusting,** positive, role models and mentors.
- Healthy and safe peer **activities**

Lessons Learned and re-Learned

- We must take great care our response efforts never stigmatizes the victims or their families. If we don't,..
  - We risk offense to the survivors.
  - We risk further alienating other students who may be on the verge of reaching out for help.

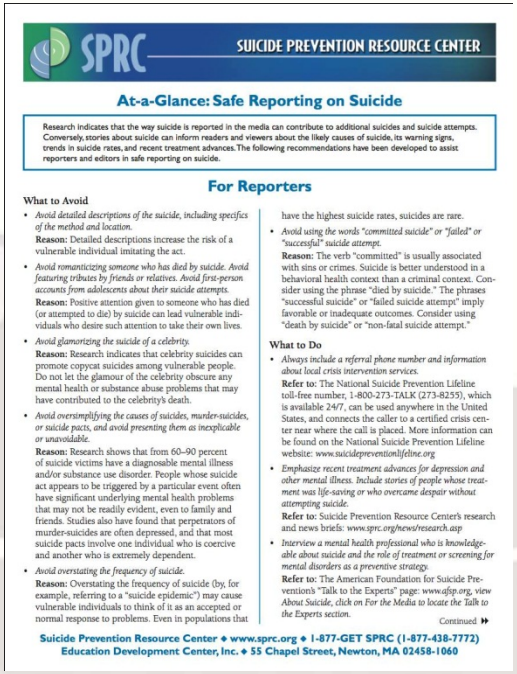
- Keep a close eye on your school's drug and alcohol data. Especially YRBS binge drinking info.

  - Intoxication lessens inhibitions and increases impulsivity. Suicide is often impulsive.

- The way you and the media report on suicide can have a big impact.

- How you speak to someone at risk matters:

  - "A long term solution to a short term problem" (you are judging their perception)
  - "You're not thinking about suicide are you?" (you are telling them you want to hear "no")
  - Asking directly does **not** increase the risk - but may be just what they need to open up.



SPRC SUICIDE PREVENTION RESOURCE CENTER

At-a-Glance: Safe Reporting on Suicide

Research indicates that the way suicide is reported in the media can contribute to additional suicides and suicide attempts. Conversely, stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. The following recommendations have been developed to assist reporters and editors in safe reporting on suicide.

For Reporters

What to Avoid

- *Avoid detailed descriptions of the suicide, including specifics of the method and location.*
  Reason: Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- *Avoid romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts.*
  Reason: Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
- *Avoid glamorizing the suicide of a celebrity.*
  Reason: Research indicates that celebrity suicides can promote copycat suicides among vulnerable people. Do not let the glamour of the celebrity obscure any mental health or substance abuse problems that may have contributed to the celebrity's death.
- *Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.*
  Reason: Research shows that from 60–90 percent of suicide victims have a diagnosable mental illness and/or substance use disorder. People whose suicide act appears to be triggered by a particular event often have significant underlying mental health problems that may not be readily evident, even to family and friends. Studies also have found that perpetrators of murder-suicides are often depressed, and that most suicide pacts involve one individual who is coercive and another who is extremely dependent.
- *Avoid overstating the frequency of suicide.*
  Reason: Overstating the frequency of suicide (by, for example, referring to a "suicide epidemic") may cause vulnerable individuals to think of it as an accepted or normal response to problems. Even in populations that have the highest suicide rates, suicides are rare.
- *Avoid using the words "committed suicide" or "failed" or "successful" suicide attempt.*
  Reason: The verb "committed" is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context. Consider using the phrase "died by suicide." The phrases "successful suicide" or "failed suicide attempt" imply favorable or inadequate outcomes. Consider using "death by suicide" or "non-fatal suicide attempt."

What to Do

- *Always include a referral phone number and information about local crisis intervention services.*
  Refer to: The National Suicide Prevention Lifeline toll-free number, 1-800-273-TALK (273-8255), which is available 24/7, can be used anywhere in the United States, and connects the caller to a certified crisis center near where the call is placed. More information can be found on the National Suicide Prevention Lifeline website: *www.suicidepreventionlifelne.org*
- *Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.*
  Refer to: Suicide Prevention Resource Center's research and news briefs: *www.sprc.org/news/research.asp*
- *Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.*
  Refer to: The American Foundation for Suicide Prevention's "Talk to the Experts" page: *www.afsp.org*, view *About Suicide, click on For the Media to locate the Talk to the Experts section.*

Continued ▸▸

Suicide Prevention Resource Center ♦ www.sprc.org ♦ 1-877-GET SPRC (1-877-438-7772)
Education Development Center, Inc. ♦ 55 Chapel Street, Newton, MA 02458-1060

Examples of School Suicide Response Strategies in Indian Country

- Lifeline (crisis call centers) & ASIST/QPR/Native HOPE (trainings)
- Community outreach (including community dinners)
- Parental outreach/consent
- Triage/nomination process
- 1:1 information gathering/assessments
- Mentoring nominations/check-in
- Self Care plans
- Cognitive Behavioral classroom/group work (ongoing)
- Healing Circles (future)
- Traditional Ceremonies
- School-wide interventions
- After-school/summer programs
- Community Centers
- Safe houses - with safe transportation

Excellent resources & references for schools:

- U.S. Department of Education REMS Technical Assistance Center
  - Lessons Learned Publications (www.rems.edu.gov)

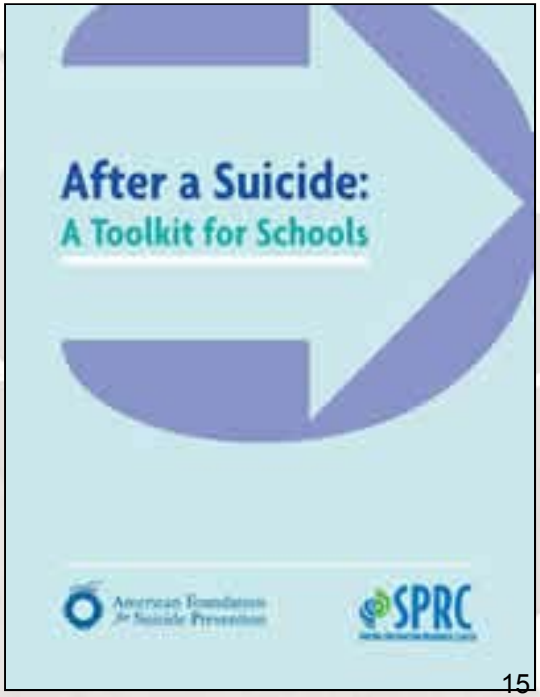
  When Grief Visits Schools. By: Dr. John Dudley (2003, 2nd edition)

- National Center for School Crisis and Bereavement website
  - http://www.cincinnatichildrens.org/svc/alpha/s/school-crisis/guidelines-bereavement.htm

- National Association of School Psychologists' website
  - *School Crisis Prevention & Intervention*, Brock et al, 2009 (PREPaRE)
  - After a Suicide: Answering Questions from Students by Dr. Scott Poland
  - http://www.nasponline.org/resources/principals/aftersuicide.aspx

- *After a Suicide: A toolkit for Schools*
  - (Harpel, West, Jaffe & Amundson, 2011)
  - *Published by the Suicide Prevention Resource Center and American Foundation for Suicide Prevention*
  - http://www.sprc.org/afterasuicideforschools.asp

- National Child Traumatic Stress Network
  - Trauma Toolkit for Educators
  - http://www.nctsn.org/resources/audiences/school-personnel/trauma-toolkit



Crisis Hotline Numbers

Suicide Prevention Lifeline Number:

- 1-800-273-TALK (8255)

National Domestic Violence Hotline:

- 1-800-799-SAFE (7233) or TTY 1-800-787-3224

National Child Abuse Hotline:

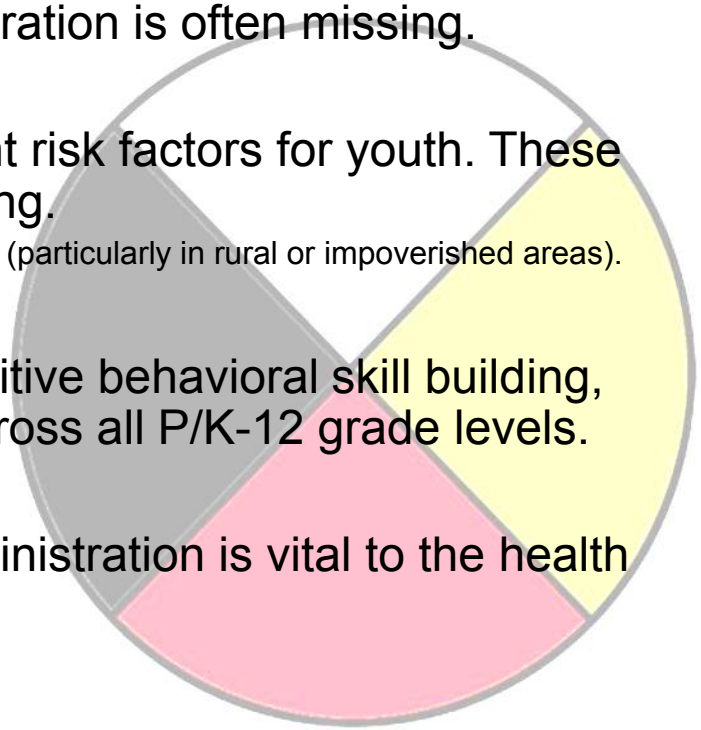
- 1-800-4-A-CHILD

Sexual Assault Hotline:

- 1-800-262-9800

Conclusions

- Resources are out there.
  - Tribal Elders and the youth themselves
  - SAMHSA's Lifeline Program & The Suicide Prevention Resource Center's Best Practices Registry
  - OSDFS School Emergency Response to Violence (SERV) & the REMS TA Center
  - National Center for School Crisis and Bereavement, National Child Traumatic Stress Network, Indian Health Service Youth Suicide
- Youth suicide is a community problem, not simply a school problem. Response efforts should reflect this.
- Schools must have policies and procedures to be prepared. These need to integrate with community efforts. Yet such integration is often missing.
- Trauma and exposure to violence are significant risk factors for youth. These must be addressed because they impact learning.
  - Schools are the de-facto mental health provider for most children (particularly in rural or impoverished areas). Policy, programming and funding should reflect this reality.
- Behavioral health issues - with a focus on cognitive behavioral skill building, resiliency and wellness - must be integrated across all P/K-12 grade levels.
- Structured self-care for teachers, staff and administration is vital to the health of the school and community.



Thank You!

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