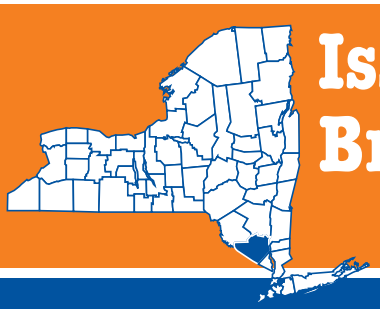
Intervention Strategies



Issue Brief 6a

ORANGE COUNTY • NEW YORK

Establishing a Community Response

Too often the burden of responsibility falls solely upon the shoulders of the school when responding to a suicide crisis situation. While it is critical for the school to have procedures in place for responding to a crisis and for educating staff on how to respond effectively to a suicidal crisis, schools may find it extremely helpful and more effective to share the responsibility for successful and comprehensive intervention with the community (5, 6, 7, 8). The organized efforts of a community are the foundation of a public health approach. Schools are an integral partner in a public health approach for any area focused on children and youth.

The public health model, a multi-pronged, population-oriented model built on known best practices, is widely regarded as the approach that is most likely to produce significant and sustained reductions in suicide. Applying the public health approach to suicide prevention requires five steps:

1. **Define the problem** – collecting information about the rates of suicide or cost of injuries helps to define the extent to which suicide is a burden to the community.
2. **Identify causes** – identifying and understanding the relationship between risk and protective factors and how some protective factors can mitigate against risk factors for suicide helps to design effective programs.
3. **Develop and test interventions** – rigorous scientific testing prior to large scale implementation, is important to ensure that interventions are safe, ethical and feasible.
4. **Implement interventions** – by selecting a broad mix of interventions, analyzing cost and effectiveness, and considering ways to integrate interventions into existing programs, more comprehensive programs can be developed.
5. **Evaluate effectiveness** – evaluation can help a community determine the best strategy for a specific population and if necessary, how it can be modified (18, 31).

A growing body of evidence supports the effectiveness of a public health approach to suicide prevention (17, 19, 23, 24, 25, 29). In addition, research indicates that effective suicide prevention programs may reduce the severity and/or frequency of specific risk factors for suicidal behavior and other mental health issues (3). Perhaps one of the best-known population-oriented approaches to reducing risk of suicide is the US Air Force Suicide Prevention Program. A key finding was that personnel exposed to the program experienced a 33% reduction of risk of dying by suicide compared with personnel prior to implementation. Knox et al. (2010) suggested that the "*enduring*

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public health message from 12 years of this program [US Air Force Suicide Prevention Program] is that suicide rates can be reduced, and that program success requires interventions to be consistently supported, maintained, and monitored for compliance" (p. 2462) (19).

In a study of the efficacy of 15 years of a public health oriented suicide prevention program (i.e., the Western Athabaskan Tribal Nation's Adolescent Suicide Prevention Program) findings indicated that while suicide deaths neither declined significantly nor increased, there was a 73% decrease in self-destructive acts (17).

An example of how one community came together in response to the tragedy of teen suicide and incorporated best practices into a comprehensive program is Project Safety Net (PSN), in Palo Alto, California (22). The PSN report provides a comprehensive plan that includes 22 best-known practices for community-based mental health and suicide prevention. In addition, PSN uses the Questions, Persuade, Refer (QPR) gatekeeper training (26) and endorses the 40 Developmental Assets model identifying external assets (such as family support, community values, and activities) and internal supports (such as social competency and positive identity) as integral to the healthy development of young people (27).

A comprehensive school-based suicide prevention program cannot function properly without outside support from the community and this is especially true when addressing intervention (9). Research has suggested that one of the most essential components, if not the central component, for responding to a student potentially at risk for suicide is to have established relations and links to agencies within the community, such as mental health agencies, crisis centers, law enforcement agencies, youth health service agencies, psychiatric facilities, primary care physicians, the clergy, or the community health department (1, 2, 4-8, 10-12). Relationships with organizations such those above, have the potential to lead to changes in behaviors that impact rates of suicide. For example, research indicates that restricted access to lethal means is associated with decline in suicide with that specific method, and in many cases also with overall suicide mortality (16, 32). In addition, studies tend to indicate that 1) many persons seem to have a preference for a given means which would limit the possibility for substitution towards another method, and 2) that a suicide crisis is very often short-lived which would limit the possibility of the individual putting off plans to later (30).

Another study examining method specific fatality rates for suicide among persons 15 years and older found that poisoning with drugs accounted for 74% acts of suicide but only 14% of fatalities, whereas firearms and hanging accounted for only 10 percent of acts but 67% of fatalities. Firearms were the most lethal means (91% resulted in death) (20). One component of a community response to findings such as these may include working with local law enforcement to implement Project ChildSafe, a nationwide program implemented in 2003, whose purpose is to promote safe firearms handling and storage practices among firearms owners through the distribution of key safety educational messages and free gun locking devices through local participating law enforcement agencies. Project ChildSafe is an expansion of National Shooting Sports Foundation's (NSSF) Project HomeSafe program that was created in 1999 to educate gun owners about their responsibilities to safely handle and properly store firearms in the home with the goal of preventing tragic accidents among children (21). A public health approach would include examining relevant data used in developing intervention strategies that address current trends. For example, in a CDC analysis of trends in suicide methods among 10 – 19 year old youth in the United States from 1992 - 2001, results indicated a substantial decline in suicides by firearm and an increase in suicides by suffocation (28).

As with all school initiatives, establishing relationships with local family and youth organizations should be a major component of the suicide prevention program. Family organizations can provide peer-to-peer support to other family members and youth and help to ensure that families and youth know about and have access to needed relevant services (15). In addition to helping create awareness about the national hotline number 1-800-273-TALK and national public awareness resources, family organizations can help to encourage survivors of suicide to participate in prevention task forces, coalitions, focus groups, peer programs, and special community events. It is also important to be aware of other local and national resources that might be helpful to youth who are struggling but not yet at imminent risk. For example, the Trevor Project is the leading national

organization that provides crisis and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. The Trevor Project (866-488-7386/866-4-U-TREVOR) website at http//www.thetrevorproject.org includes a search engine to help youth, families, organizations, schools, and communities find local, regional and national resources.

Because many educators are not adequately trained, (nor do they have the time), to counsel students longer than would be necessary for an immediate crisis response, only by establishing positive relationships with community agencies in advance will schools be able to effectively respond to a student's suicide attempt or threat (13). Utilizing community agencies increases the people-power necessary to effectively respond to the immediate crisis as well as its long-term consequences (5). Once these critical links have been established, it is necessary that schools inform staff, as well as students, about the services that these community links provide. This will ensure that should a student experience suicidal thoughts, or should an educator come in contact with (or experience suicidal thoughts themselves) a potentially suicidal adolescent, each will have contact information that could provide critical intervention and potentially prevent a suicidal event from occurring. It is essential that educators in particular understand the importance of knowing local and national resources and making an appropriate and effective referral.

When Making a Student Referral for Services

Kalafat and Underwood (14) provide some suggestions when making a student referral for services. The Guide has summarized these suggestions.

1. **Make sure that you know what problems the student may be having.** Although counseling may certainly be appropriate, if one of the student's problems is that he/she was abused by a therapist in the past, the referral to a counseling center should be carefully chosen. Inappropriate or poor referrals will waste time, resources, and may annoy the student so much that he/she refuses to cooperate further.
2. **Give the student the opportunity to talk about any reluctance or apprehension he/she may have about accepting the referral.** This can usually provide a good opportunity for you to access how compliant the student will be with regards to treatment.
3. **Involve the parents in the referral.** This will help you make an appropriate referral. If the counseling center for instance, is forty minutes away, and the family lacks transportation, this referral may not be the best. Also, use a referral that matches the family's and student's background (e.g., religious affiliation, cultural background, payment system). It may not be the best idea to refer a low-income family to an expensive, specialized psychiatrist with stringent, expensive services.
4. **Limit the number of referrals to one or possibly two.** You do not want to overwhelm an already overwhelmed adolescent or his/her family.
5. **Provide the family with as much information about the referral as possible.** Contact name and number, address, directions, information about cost or insurance coverage. The more information you provide and the easier you make it, the more likely the family is to actually get necessary help.
6. **Follow up with both the referral agency and the family.** Often times, because of rules of confidentiality, a service provider cannot deny or confirm anything about anyone, unless the student or his/her parents sign a release of information form. This signed form will allow you to check on the progress and compliance of the student.

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Establishing a Community Response

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Establishing a Community Response

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