

April

Spring Can Be a High Risk Time for Students

Time is running out for catching up;
decisions are made about who passes and who fails;
&
parties and proms to celebrate the end of the year
can have some negative side effects.

Of special concern are youngsters who seem depressed.

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**It's time to prevent;
it's time to help;
and there's still time to enable many students to turn it all around.**

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KEEPING PROBLEMS IN PERSPECTIVE

In the Summer, 1999 and Fall, 2002 issues of the Center's newsletter, we discussed "Youth Suicide/Depression/Violence." We introduced the discussion as follows: Too many young people are not very happy. This is quite understandable among those living in economically impoverished neighborhoods where daily living and school conditions frequently are horrendous. But even youngsters with economic advantages too often report feeling alienated and lacking a sense of purpose.

Youngsters who are unhappy usually act on such feelings. Some "internalize;" some "act out;" and some respond in both ways at different times. The variations can make matters a bit confusing. Is the youngster just sad? Is s/he depressed? Is this a case of ADHD? Individuals may display the same behavior and yet the causes may be different and vice versa. And, matters are further muddled by the reality that the causes vary.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits to relatively minor group and individual vulnerabilities on to major biological disabilities (that affect only a relatively few individuals). It is the full range of causes that account for the large number of children and adolescents reported as having psychosocial, MH, or developmental problems.

Recent highly publicized events and related policy initiatives have focused renewed attention on youth suicide, depression, and violence. Unfortunately, such events and the initiatives that follow often narrow discussion of causes and how best to deal with problems.

The Classification of Child and Adolescent Mental Diagnoses in Primary Care (DSM-PC) developed by the American Academy of Pediatrics is a useful resource to help counter this tendency to overpathologize (see attached below).

ABOUT SEASONAL VARIATIONS

(From: "Temporal Variations in School-Associated Student Homicide and Suicide Events --- United States, 1992--1999" *Morbidity and Mortality Weekly Report*, 2001, August, 10:50(31):657-60.)

"... By describing temporal variations in school-associated student homicide and suicide events, this report provides information that can assist school administrators and faculty in planning the timing and focus of violence prevention programs. ... The findings on suicide are consistent with other studies that have shown increased suicide rates in the general population during the spring Programs designed to prevent suicide and suicidal behavior among students should recognize that the spring semester is the period of highest risk. The Surgeon General recommends training teachers to recognize students that show signs of risk for suicide and refer them to a mental health professional for assessment and treatment Prevention programs can be effective in preventing youth violence Effective programs often focus on both individual risk factors and environmental conditions that may predispose young persons toward violent behavior.

A Few Related References

- Chew KSY, McCleary R. The spring peak in suicides: a cross-national analysis. *Soc Sci Med* 1995;40:223--30.
- Dwyer K, Osher D. Safeguarding our children: an action guide. Washington, DC: US Departments of Education and Justice, American Institutes for Research, 2000.
- Kachur SP, Stennies GM, Powell KE, et al. School-associated violent deaths in the United States, 1992 to 1994. *JAMA* 1996;275:1729--33.
- Thornton TN, Craft CA, Dahlberg LL, et al. Best practices of youth violence prevention: a sourcebook for community action. Atlanta, Georgia: US Department of Health and Human Services, CDC, 2000.
- US Department of Health and Human Services. Youth violence: a report of the Surgeon General. Rockville, Maryland: US Department of Health and Human Services, CDC; Substance Abuse and Mental Health Services Administration, Center for Mental Health Services; and National Institutes of Health, National Institute of Mental Health, 2001.
- US Public Health Service. The Surgeon General's call to action to prevent suicide. Washington, DC: US Public Health Service, 1999.

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SOME CENTER RESOURCES TO GUIDE PREVENTION AND EARLY INTERVENTION

For specific intervention ideas, see the following Center Resources:

Quick Training Aids on:

- >***Suicide Prevention*** (materials for staff development including screening tools and descriptions of evidence based programs)
- >***Assessing & Screening***
- >***Case Management in the School Context***
- >***School Interventions to Prevent and Respond to Affect and Mood Problems***

Intro. Packet: *Affect and Mood Problems Related to School Aged Youth*

Resource Aid Packet: *Screening/Assessing Students: Indicators and Tools*

Technical Assistance Sampler: *School Interventions to Prevent Youth Suicide*

Quick Finds on: Suicide Prevention; Depression; related topics

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BELOW ARE SOME TOOLS FOR STAFF DEVELOPMENT

SOME PREVENTION GUIDELINES

In the Technical Assistance Sampler: *School Interventions to Prevent Youth Suicide*, you will find the following *Excerpts from... Guidelines for School Based Suicide Prevention Programs* circulated by the American Association of Suicidology, 1999, <http://www.suicidology.org>

Conceptual Basis for Prevention Approaches

A clear conceptual basis gives us the rationale for choosing a particular prevention strategy for a particular problem, with a particular population, in a particular setting. Part of the effort to build the conceptual base for prevention in general has resulted in typology intended to clarify prevention methodology (Institute of Medicine, 1994) which included:

- 1 *Universal* interventions, which are directed at an entire population rather than selected subpopulations or individuals.
- 2 *Selective* interventions, which are targeted to subpopulations that are characterized by shared exposure to some epidemiologically determined risk factor(s).
- 3 *Indicated* interventions are targeted to specific individuals who are already preclinical levels of a disorder and who have been identified through screening procedures.

Universal Approaches

The goal of universal approaches is *to raise the overall supportiveness and responsiveness of the at risk youths' environment*. The role of the school is seen as critical, but limited. All schools are not assumed to possess the resources to treat suicidal or emotionally disturbed students. They *can* enhance their capacity to identify and get help for these students as part of their mandate to socialize and protect their students.

The overall goals of the universal program are to increase the likelihood that school gatekeepers (administrators, faculty, and staff) and peers who come into contact with at-risk youth can more readily identify them, provide an appropriate initial response to them, will know how to obtain help for them, and are consistently inclined to take such action.

Protective Factors & Wellness Promotion

Some longitudinal research indicates that the presence of protective factors may have a stronger influence on the likelihood that risk behaviors will occur than the presence of risk factors. These protective factors include personal characteristics such as social problem solving competencies; and, environmental characteristics such as contact with a caring adult and a school climate that promotes students' involvement, contribution, and sense of connection with their school. One caveat concerning resilient youth is in order. Research indicates that youth who come from high risk environments and yet do well in school and peer relations still evidence a greater prevalence of anxiety and depression than peers who do not come from such environments. Anxiety and depression are significant risk factors for suicide, and these internalizing disorders are more likely to go undetected than the externalizing behaviors.

Selective Prevention Programs

While subgroups that are at greater risk for suicide will by definition be exposed to universal programs, these programs are aimed more at their peers and may not be of sufficient dosage or focus to affect specific vulnerable subpopulations such as disenfranchised or depressed students. Some of these students may become known to school officials, particularly if school personnel and parents are educated to identify troubled students before they make overt statements or attempts. Thus gatekeeper training is a common selective program that has shown promise for increasing identification and referral.

There is some evidence that students are more likely to use telephone crisis and referral services because they are anonymous, and don't require fees, transportation, or appointments. Publicizing these services (e.g. through wallet cards continuously available throughout the school) and linking them to established screening teams can facilitate contact with at risk youth. However, these services are still underutilized by males.

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(Prevention Guidelines – cont.)

Indicated Prevention Programs

The goal of indicated programs is to reduce the incidence of suicidal behaviors among students who already display risk factors or early warning signs associated with suicide such as frequent suicidal thoughts, previous attempts, depression, or substance abuse.

Indicated programs require the presence in schools of individuals who are trained to screen students and to provide the indicated programs. School faculty or special services staff such as guidance counselors can be trained to provide the programs, but professionals such as psychologists or social workers would have to conduct the screening. There are a growing number of school-linked services (community gatekeepers who provide assessment and counseling services on site) and school based service centers or clinics that can house indicated interventions.

The overall goals of indicated programs are to identify at risk students, preferably through existing school procedures, and provide them with accessible, brief interventions that include support, skill training, and opportunities to bond with the school and maintain contact with a caring adult.

Requirements for Effective Prevention Programs

- C Conceptually & empirically grounded goals and objectives.
- C Clearly articulated and packaged components (lesson outlines and plans, detailed instructor guidelines that include typical student responses and how to respond to these, all handouts, and references for additional materials).
- C Comprehensive: address all levels of targeted organization.
- C Ecological: address the multiple contexts in which participants interact.
- C Conform to the context/culture/values of the target population and organization.

Comprehensive School Based Prevention Programs

... Comprehensive programs are multilevel, multicomponent interventions that include the following components, usually implemented in this order:

1. *Administrative consultation* to ensure that policies and procedures for responding to at risk students, attempts, and completions are in place; and to ensure that community linkages exist for close coordination of referrals to, and return of students from, community gatekeepers.
2. *School gatekeeper training* for all faculty and staff (including such staff as bus drivers and cafeteria workers) on the identification of, initial response to, and effective referral of troubled and at risk students. This sometimes includes the establishment of in school crisis response teams made up of faculty, staff, and administrators.
3. *Parent training* covering similar material as the school gatekeeper training, as well as means restriction strategies.
4. *Community gatekeeper training* that incorporates policies and procedures for effective response and coordination with schools and families. This sometimes includes training in the treatment of depressed and suicidal adolescents. Community crisis teams and media campaigns have also been implemented.
5. *Student classes* usually consist of 4 to 5 class periods included in the health curriculum. Classes include a variety of media, and involve students in discussions and roleplays to prepare them to recognize and respond to troubled peers, and to destigmatize seeking adult help.
6. *Postvention interventions* that are provided by external consultants to schools and communities in which a suicide completion or serious attempt has occurred. These interventions consist of standard steps designed to process faculty, student, and community reactions to the event; facilitate grief work; and, prevent imitative acts among identified vulnerable peers.

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The following screening tools are from our Center's Technical Assistance Sampler on *School Interventions to Prevent Youth Suicide*.

Suicidal Assessment - Checklist *

Student's Name: _____ Date: _____ Interviewer: _____

(Suggested points to cover with student/parent)

(1) PAST ATTEMPTS, CURRENT PLANS, AND VIEW OF DEATH

<i>Does the individual have frequent suicidal thoughts?</i>	<i>Y</i>	<i>N</i>
<i>Have there been suicide attempts by the student or significant others in his or her life?</i>	<i>Y</i>	<i>N</i>
<i>Does the student have a detailed, feasible plan?</i>	<i>Y</i>	<i>N</i>
<i>Has s/he made special arrangements as giving away prized possessions?</i>	<i>Y</i>	<i>N</i>
<i>Does the student fantasize about suicide as a way to make others feel guilty or as a way to get to a happier afterlife?</i>	<i>Y</i>	<i>N</i>

(2) REACTIONS TO PRECIPITATING EVENTS

<i>Is the student experiencing severe psychological distress?</i>	<i>Y</i>	<i>N</i>
<i>Have there been major changes in recent behavior along with negative feelings and thoughts?</i>	<i>Y</i>	<i>N</i>

(Such changes often are related to recent loss or threat of loss of significant others or of positive status and opportunity. They also may stem from sexual, physical, or substance abuse. Negative feelings and thoughts often are expressions of a sense of extreme loss, abandonment, failure, sadness, hopelessness, guilt, and sometimes inwardly directed anger.)

(3) PSYCHOSOCIAL SUPPORT

<i>Is there a lack of a significant other to help the student survive?</i>	<i>Y</i>	<i>N</i>
<i>Does the student feel alienated?</i>	<i>Y</i>	<i>N</i>

(4) HISTORY OF RISK-TAKING BEHAVIOR

<i>Does the student take life-threatening risks or display poor impulse control?</i>	<i>Y</i>	<i>N</i>
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*Use this checklist as an exploratory guide with students about whom you are concerned. Each yes raises the level of risk, but there is no single score indicating high risk. A history of suicide attempts, of course, is a sufficient reason for action. High risk also is associated with very detailed plans (when, where, how) that specify a lethal and readily available method, a specific time, and a location where it is unlikely the act would be disrupted. Further high risk indicators include the student having made final arrangements and information about a critical, recent loss. Because of the informal nature of this type assessment, it should not be filed as part of a student's regular school records.

Follow-Through Steps After Assessing Suicidal Risk -- Checklist

___(1) As part of the process of assessment, efforts will have been made to discuss the problem openly and nonjudgmentally with the student. (Keep in mind how seriously devalued a suicidal student feels. Thus, avoid saying anything demeaning or devaluing, while conveying empathy, warmth, and respect.) If the student has resisted talking about the matter, it is worth a further effort because the more the student shares, the better off one is in trying to engage the student in problem solving.

___(2) Explain to the student the importance of and your responsibility for breaking confidentiality in the case of suicidal risk. Explore whether the student would prefer taking the lead or at least be present during the process of informing parents and other concerned parties.

___(3) If not, be certain the student is in a supportive and understanding environment (not left alone/isolated) while you set about informing others and arranging for help.

___(4) Try to contact parents by phone to

- a) inform about concern
- b) gather additional information to assess risk
- c) provide information about problem and available resources
- d) offer help in connecting with appropriate resources

Note: if parents are uncooperative, it may be necessary to report child endangerment after taking the following steps.

___(5) If a student is considered to be in danger, only release her/him to the parent or someone who is equipped to provide help. In high risk cases, if parents are unavailable (or uncooperative) and no one else is available to help, it becomes necessary to contact local public agencies (e.g., children's services, services for emergency hospitalization, local law enforcement).

Agencies will want the following information:

- *student's name/address/birthdate/social security number
- *data indicating student is a danger to self (see Suicide Assessment -- Checklist)
- *stage of parent notification
- *language spoken by parent/student
- *health coverage plan if there is one
- *where student is to be found

___(6) Follow-up with student and parents to determine what steps have been taken to minimize risk.

___(7) Document all steps taken and outcomes. Plan for aftermath intervention and support.

___(8) Report child endangerment if necessary.

Table #1:

Developmental Variations: Behaviors within the Range of Expectation for Age Group*

DEVELOPMENTAL VARIATIONS	COMMON DEVELOPMENTAL PRESENTATIONS
<p><i>Sadness Variation</i> Transient depressive responses or mood changes to stress are normal in otherwise healthy populations.</p> <p><i>Bereavement</i> Sadness related to a major loss that typically persists for less than 2 months after the loss...</p>	<p><i>Early Childhood</i> The child may have transient withdrawal and sad affect that may occur over losses and usually experiences bereavement due to the death of a parent or the loss of a pet or treasured object.</p> <p><i>Middle Childhood</i> The child feels transient loss of self-esteem after experiencing failure and feels sadness with losses as in early childhood.</p> <p><i>Adolescence</i> The adolescent's developmental presentations are similar to those of middle childhood but may also include fleeting thoughts of death. Bereavement includes loss of a boyfriend or girlfriend, friend, or best friend.</p>
<p><i>Thoughts of Death Variation</i> Anxiety about death in early childhood.</p> <p>Focus on death in middle childhood or adolescence.</p>	<p><i>Early Childhood</i> In early childhood anxiety about dying may be present</p> <p><i>Middle Childhood</i> Anxiety about dying may occur in mid childhood, especially after death in family.</p> <p><i>Adolescence</i> Some interest with death and morbid ideation may be manifest by a preference for black clothing and an interest in the occult. If this becomes increased to a point of preoccupation, a problem or a serious ideation should be considered.</p>
<p><i>Thoughts of Death Problem</i> The child has thoughts of or a preoccupation with his or her own death.</p> <p>If the child has thoughts of suicide, consider suicidal ideation and attempts (...).</p>	<p><i>Early and Middle Childhood</i> The child may express a wish to die through discussion or play. This often follows significant punishment or disappointment.</p> <p><i>Adolescence</i> The adolescent may express nonspecific ideation related to suicide.</p>

SPECIAL INFORMATION

Between 12% and 25% of primary school and high school children have some form of suicidal ideation. Those with a specific plan or specific risk factors should be considered at most risk.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics. Notes: Dots (...) indicate that the original text has a reference to another section.

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(cont.) Table #2: Problems -- Behaviors Serious Enough to Disrupt Functioning with Peers,
at School, at Home, but Not Severe Enough to Meet Criteria of a Mental Disorder*

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS
<p><i>Sadness Problem</i> Sadness or irritability that begins to include some symptoms of major depressive disorders in mild form.</p> <ul style="list-style-type: none">• depressed/irritable mood• diminished interest or pleasure• weight loss/gain, or failure to make expected weight gains• insomnia/hypersomnia• psychomotor agitation/retardation• fatigue or energy loss• feelings of worthlessness or excessive or inappropriate guilt• diminished ability to think/concentrate <p>However, the behaviors are not sufficiently intense to qualify for a depressive disorder.</p> <p>These symptoms should be more than transient and have a mild impact on the child's functioning. Bereavement that continues beyond 2 months may also be a problem.</p>	<p><i>Early Childhood</i> The child may experience similar symptoms as in infancy, but sad affect may be more apparent. In addition, temper tantrums may increase in number and severity, and physical symptoms such as constipation, secondary enuresis (...), encopresis (...), and nightmares may be present.</p> <p><i>Middle Childhood</i> The child may experience some sadness that results in brief suicidal ideation with no clear plan of suicide, some apathy, boredom, low self-esteem, and unexplained physical symptoms such as headaches and abdominal pain (...).</p> <p><i>Adolescence</i> Some disinterest in school work, decrease in motivation, and day-dreaming in class may begin to lead to deterioration of school work. Hesitancy in attending school, apathy, and boredom may occur.</p> <p>SPECIAL INFORMATION Sadness is experienced by some children beyond the level of a normal developmental variation when the emotional or physiologic symptoms begin to interfere with effective social interactions, family functioning, or school performance. These periods of sadness may be brief or prolonged depending on the precipitating event and temperament of the child. Reassurance and monitoring is often needed at this level. If the sad behaviors are more severe, consider major depressive disorders.</p>
<p>*Adapted from <i>The Classification of Child and Adolescent Mental Diagnoses in Primary Care</i>. (1996) American Academy of Pediatrics. Notes: Dots (...) indicate that the original text has a reference to another section.</p>	<p>The potential for suicide in grieving children is higher. Evaluation of suicidal risk should be part of a grief workup for all patients expressing profound sadness or confusion or demonstrating destructive behaviors toward themselves or others.</p> <p>Behavioral symptoms resulting from bereavement that persist beyond 2 months after the loss require evaluation and intervention. Depressed parents or a strong family history of depression or alcoholism (...) puts youth at very high risk for depressive problems and disorders. Family and marital discord, ... exacerbates risk. Suicidal ideation should be assessed (see Suicidal Thoughts or Behaviors cluster).</p> <p>Lying, stealing, suicidal thoughts (see Suicidal Thoughts or Behaviors cluster), and promiscuity may be present. Physical symptoms may include recurrent headaches, chronic fatigue, and abdominal pain (...).</p>

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In working on this important problem during a time when the dangers are increased, those working to support students in schools will find their skills in working with staff, administrators, families, and community resources are especially important.

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