



## PREVENTING SUICIDE

### *A Preventable Public Health Issue*

#### **WHAT IS SUICIDE?**

Suicide occurs when a person ends their life. It is the 11th leading cause of death among Americans, but suicide deaths are only part of the problem. More people survive suicide attempts than actually die. They are often seriously injured and need medical care.

Suicide is recognized as a chronic epidemic. Despite the overwhelming numbers, the tragedy of suicide is hidden by stigma, myth and shame. The stigma surrounding suicide serves to restrict prevention and intervention.

Additionally, many people have the mistaken notion that talking about suicide causes it to happen. Today, experts agree that suicide is preventable.

#### **WHO IS AT RISK**

Suicide does not discriminate based on race, gender or age. However, there is a higher risk of suicide for those who have been diagnosed with a mental illness. In fact, the risk of suicide is increased by more than 50 percent in individuals affected by depression. Studies also show that roughly 90 percent of individuals who die by suicide have one or more mental disorders.

Also, some groups are at higher risk than others. Men are four times more likely than women to die from suicide. However, three times more women than men report attempting suicide. In addition,

suicide rates are higher among young people and those older than age 65.

#### **RISK FACTORS**

Risk factors are characteristics that make it more likely that an individual will consider, attempt, or die by suicide. It is important to note factors identified as increasing risk are not factors causing or predicting a suicide attempt. Risk factors for suicide can include:

- Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders and certain personality disorders
- Alcohol and other substance use disorders
- Hopelessness
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Major physical illnesses
- Previous suicide attempt
- Family history of suicide
- Job or financial loss
- Loss of relationship
- Easy access to lethal means
- Local clusters of suicide
- Lack of social support and sense of isolation
- Stigma associated with asking for help
- Lack of health care, especially mental health and substance abuse treatment
- Cultural and religious beliefs, such as the belief that suicide is a noble resolution of a personal dilemma
- Exposure to others who have died by suicide (in real life or via the media and Internet)

## PROTECTIVE FACTORS

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Protective factors are characteristics that make it less likely individuals will consider, attempt, or die by suicide. Examples of protective factors include:

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and handling problems in a non-violent way
- Cultural and religious beliefs that discourage suicide and support self-preservation

## WARNING SIGNS

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The following signs may mean someone is at risk for suicide. The risk of suicide is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change. If you or someone you know exhibits any of these signs, seek help as soon as possible by calling the National Suicide Prevention Lifeline at [1-800-273-TALK](tel:1-800-273-TALK) (8255).

- Talking about wanting to die or to kill themselves
- Looking for a way to kill themselves, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

## WARNING SIGNS FOR YOUTH

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Suicide may be imminent, particularly if behavior is new or increased and related to anticipated or actual painful event, loss or change. Warning signs include:

- Talking about or making plans for suicide
- Expressing hopelessness about the future
- Displaying severe emotional distress, sadness, or pain
- Showing worrisome behavioral clues or marked changes in behavior, especially:
  - Significant withdrawal from social connections/situations
  - Increased agitation or irritability
  - Anger or hostility that seems out of character or out of context
  - Changes in sleep (increased or decreased).

Individuals often do not seek help because of the stigma associated with asking for help, limited access to treatment, the shame they feel about having these thoughts or no one recognizes their call for help.

## LOOKING FOR HELP

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When a person encounters written, spoken, or other communication of suicide, they should take it seriously. They should be direct to the person in distress and ask questions such as “Are you thinking about killing yourself?” “Are you considering taking your own life?” and “Do you ever feel like things would be better if you were dead?” A person should not judge anyone they believe might be thinking of suicide and should avoid acting shocked if a youth says he or she is considering suicide. In these situations, one should not be sworn to secrecy or make promises that they won’t tell anyone.

Any suspicion that a youth is thinking about suicide should be communicated to a mental health professional or supervisor *immediately*. The person who communicates suspicion to a mental health professional should stay with the youth until assistance arrives. One should *not* leave a suicidal

youth alone while they seek assistance for the youth.

Some behaviors may indicate that a person is at immediate risk for suicide. The following three behaviors are a prompt to immediately call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or a mental health professional, as well as stay with the person while they wait for assistance, upon hearing or seeing a person that is:

- Talking about wanting to hurt or kill themselves
- Looking for ways to kill themselves (such as searching online or seeking access to pills, weapons, or other means)
- Talking about feeling hopeless or having no reason to live

Other behaviors may also indicate a serious risk – especially if the behavior is new, has increased, and/or seems related to a painful event, loss or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

## **RESOURCES**

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Information about suicide can be obtained from the following organizations:

- **National Action Alliance for Suicide Prevention** - <http://actionallianceforsuicideprevention.org>
- **Suicide Prevention Resource Center**- <http://www.sprc.org>
- **National Suicide Prevention Lifeline** - <http://www.suicidepreventionlifeline.org>; (800) 273-TALK (8255)

- **National Center for Injury Prevention and Control**  
<http://www.cdc.gov/ViolencePrevention/suicide>
- **It Only Takes One** – public awareness campaign for Illinois – [www.itonlytakesone.org](http://www.itonlytakesone.org)

*Information compiled from the following sources:*

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- U.S. Centers for Disease Control and Prevention
- Illinois Department of Public Health
- Illinois Suicide Prevention Strategic Plan
- National Suicide Prevention Lifeline
- Youth consensus meeting on warning signs

# INJURY PREVENTION

## *illinois*

### **SEXUAL ORIENTATION, GENDER IDENTITY AND YOUTH SUICIDE**

#### **\* WHAT IS SEXUAL ORIENTATION**

Sexual orientation refers to whom a person is attracted to emotionally, physically and intellectually. Gender identity is a person's sense or experience of belonging to a particular gender category as a man or a woman and where a person feels they fit in society's man/woman structure. Both the concepts of sexual orientation and gender identity are included in the acronym LGBT (lesbian, gay, bisexual and transgender).

Lesbian, gay and bisexual refer to types of sexual orientation lesbians are women attracted to some other women, gay men are attracted to some other men and bisexual people are those for whom gender is not the first criteria in determining attraction.

Transgender is an umbrella term for people whose gender identity or expression does not match the cultural "norm" for their biological sex. This umbrella term includes identities such as transsexual, genderqueer and cross-dresser. Sometimes, a 'Q' is added on to the 'LGBT' acronym and stands for questioning. Questioning often occurs during adolescence, the development stage when many young people struggle with issues of sexuality, gender and identity. This struggle can be especially difficult and prolonged for people exploring LGBT sexual orientations and gender identities.

#### **\* WHY ARE THEY AT RISK**

Lesbian, gay and bisexual youth were identified by the National Strategy for Suicide Prevention as populations at risk of suicide.

Data from the U.S. Centers for Disease Control and Prevention's Youth Risk Behavior Survey (YRBS) administered in Illinois in 2009 found when LGB youth are compared to their non-gay peers they are more than three times more likely to report considering suicide in the past 12 months and to have made a suicide plan in the past 12 months. Additionally, they were almost five times more likely to have attempted suicide in the past 12 months.

#### **Suicide Ideation**

- A 2002 study of gay males ages 15-25 revealed 20 percent had contemplated suicide within the past month and 6 percent reported they still would "like to kill themselves."

#### **Suicide attempts**

- Studies exploring the relationship between suicidality and sexual orientation have found consistently high rates of suicide attempts, ranging from 20 percent to 42 percent among LGBT youth.
- A statewide survey of junior and senior high school students found that suicide attempts were reported by 28 percent of LGBT males and 21 percent of LGBT females, compared to 15 percent of heterosexual females and 4 percent of heterosexual males.
- The study also revealed of gay males ages 15-25, one-third had attempted suicide in the past with 5 percent having attempted in the past year.

- The incidence and prevalence of suicide attempts were, respectively, two and five times higher.

These numbers are startling when compared with the general population.

#### Data limitations

- Since sexual orientation is not uniformly recorded on death certificates, suicide completion rates for the LGBT community are not readily available.
- Collecting data on suicidality among LGBT youth has many challenges. Since many researchers perceive sexual orientation in youth as a sensitive topic, most surveys do not collect sexual identity data and thus can yield no information about the suicide risk of LGBT youth.
- Less research is available on the suicide attempt and completion rates of transgender individuals. However, a 1981 study surveying transsexuals reported 53 percent of those in the study had attempted to suicide.

#### \* **RISK FACTORS**

LGBT youth have more risk factors, more severe risk factors and fewer protective factors for suicide than non-LGB youth. LGBT youth are at higher risk if the following pertains

- homelessness
- the youth has run away
- live in foster care
- involved in juvenile justice or corrections
- youth who have disclosed sexual preference at an earlier age

Suicide attempts among LGBT youth are associated with gender non-conformity, early awareness of the feeling of being different, stress, being the victim of violence, lack of support, dropping out of school, family problems, suicide attempts and completions by friends, homelessness, substance abuse and emotional problems. School enrollment is a protective factor for suicide attempt;

youths who are no longer in school are more likely to attempt suicide than those in school. Because studies are often school-based, the suicide risk for LGBT dropouts, who also have a significant rate of homelessness, have not been able to be explored and are predicted to be much higher than is realized.

#### \* **PROTECTIVE FACTORS**

Protective factors for all youth include ability to adapt, belief that someone has the ability to manage their feelings and behaviors, internal locus of control, high self esteem, good problem solving skills, social support, one emotionally close family member, positive school experience and spiritual faith.

Protective factors for LGBT youth build on the ones listed above to also include positive role models, high self esteem, parental support of sexuality and gender, family connectedness, safe schools, caring adult, supportive peers and sense of community.

#### \* **PREVENTION/INTERVENTION STRATEGIES FOR THE HOME**

Lack of support and family problems have both been cited as risk factors for LGBT youth suicide and suicide attempts. Parents and families need to be aware of the issues and facts surrounding LGBT youth. Parents and families also need to be aware of the warning signs of suicidal ideation. In addition to knowing the warning signs, it is important for parents and other influential adults to learn the ability to connect with and support LGBT youth.

Because many parents and families respond to LGBT youth in negative ways, from isolation to complete abandonment, changing the dominating cultural views of LGBT people in general also is a good prevention strategy, though quite difficult to accomplish.

**\* PREVENTION/INTERVENTION STRATEGIES FOR THE COMMUNITY**

There are many settings appropriate for community prevention interventions for LGBT youth suicide. Three venues that are crucial in influencing safety and inclusion for LGBT youth are school, mental health, and social services and health care.

Schools are an important setting for most youth and can utilize curricula that teach students coping skills and enhance self-esteem. Further, curricula can be introduced in many subjects that incorporate LGBT history and role models so students can begin seeing a future for themselves as LGBT people. Teachers and all school personnel can be routinely trained in LGBT issues and can learn how to stop homophobic bullying and harassment, as well as anti-gay violence. In addition, school staff can ensure safe and inclusive referrals for LGBT students to services.

Anyone who works with youth should be trained on how to effectively serve LGBT youth, including recognizing and responding to warning signs, risk factors and protective factors for suicide.

Include information regarding LGBT suicide in health promotion materials. Make accurate information about LGBT issues and resources easily available.

Build partnerships between youth-serving, suicide prevention and LGBT youth agencies. In addition, develop peer-based support groups.

**\* PREVENTION/INTERVENTION STRATEGIES**

Eliminate the pervasive homophobia and heterosexism that exists through education, awareness and promotion of equal rights.

Implement non-discrimination policies that are inclusive of sexual orientation and gender identity to assure LGBT people equal rights.

Institute protocols and practices on how to respond if a youth is at risk of self-harm, has made a suicide attempt or died by suicide.

Collaborate with schools and government to develop administrative procedures to handle complaints and resolve situations in which the non-discrimination policy has been breached.

Train all personnel on the existence of the policy and know how to make complaints or direct others to make complaints if necessary.

Advocate for training of all school personnel and faculty in LGBT issues and combating anti-gay bullying, harassment and violence.

Ensure collection of data through the YRBS and other routine adolescent health surveys on sexual orientation and gender identity as it pertains to youth. It also is necessary to ensure death certificates begin to collect demographic information on sexual orientation and gender identity in order to fully track suicide completion.

Request funds be available to address LGBT youth homelessness, lack of access to supportive mental health care and LGBT youth truancy and absenteeism.

**\* LOOKING FOR HELP**

Call 9-1-1 or seek immediate help from a mental health provider when you hear or see someone that is:

- threatening to hurt or kill themselves
- looking for ways to kill themselves (e.g., seeking access to pills, weapons or other means)
- talking or writing about death, dying or suicide

Contact a mental health professional or call the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255) for a referral should you witness, hear or see anyone with one or more of these behaviors:

- hopelessness
- rage, anger, seeking revenge



- acting reckless or engaging in risky activities, seemingly without thinking
- feeling trapped—like there's no way out
- increasing alcohol or drug use
- withdrawing from friends, family or society
- anxiety, agitation, unable to sleep or sleeping all the time
- dramatic mood changes
- no reason for living; no sense of purpose in life

## \* RESOURCES

More information about suicide can be obtained from the following organizations:

- **National Center for Injury Prevention and Control** [www.cdc.gov/ncipc](http://www.cdc.gov/ncipc)
- **National Strategy for Suicide Prevention** <http://mentalhealth.samhsa.gov/suicideprevention/>
- **Suicide Prevention Resource Center** [www.sprc.org](http://www.sprc.org)
- **The Trevor Project** [www.thetrevorproject.org](http://www.thetrevorproject.org)
- **Illinois Safe Schools Alliance** [www.illinoissafeschools.org](http://www.illinoissafeschools.org)
- **It Only Takes One** – public awareness campaign for Illinois – [www.itonlytakesone.org](http://www.itonlytakesone.org)

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# Suicide Prevention



## SUICIDE *and* COLLEGE STUDENTS

For students, the college or university is their community for a significant portion of the year. Colleges are a diverse group, including traditional, commuter, older, international and veterans. With more than 180 two- and four-year colleges and universities in the state, a significant segment of the Illinois population falls into the category of student (Degree-granting, 2012).

### WHY THEY ARE AT RISK

Suicide is a leading cause of death among college-aged students in the United States. It is estimated a campus of 10,000 students will see a student suicide every 2-3 years. Data from five years of suicide deaths on 645 campuses as reported by the National Survey of Counseling Center Directors indicates a rate of seven deaths by suicide per 100,000 students in the population. Data also indicates the suicide rate for female students (2.0/100,000) is slightly less than that of males (7.1/100,000) (Schwartz, 2011), yet it is important to recognize women attempt suicide more than men.

The American College Health Association's National College Health Assessment (2012) indicates in 2011 more than 6 percent of students admit to seriously thinking about suicide with another 1.1 percent having made an attempt. Of the students surveyed, more than 60 percent reported feeling very sad, 45 percent reported feeling hopeless and 50 percent felt overwhelming anxiety.

### RISK FACTORS

Presence of a diagnosable mental illness, often major depression, has been consistently identified as a major risk factor for suicide in all segments of the population. Many depressed individuals are

never diagnosed or adequately treated. The American College Health Association's National College Health Assessment (2012) found 30 percent of college students reported feeling so depressed they were unable to function at least once within a one-year period, yet only 6.7 percent of male and 13.1 percent of female students had been formally diagnosed or treated for depression within the year 2011. A National Survey on Drug Use and Health report published by the Substance Abuse and Mental Health Administration (SAMHSA) Center for Behavioral Health Statistics and Quality (2012) found 4.5 percent of men and 12 percent of women experienced at least one major depressive episode in the years 2008 through 2010. Of those students, less than 40 percent had received mental health counseling and less than 30 percent had received prescription medication in the previous year.

Based on the National Survey of College Counseling Centers 2013, college and university counseling center directors in the United States reported 69 student deaths by suicide in the past year.

- 21 percent were current or former center clients, 71 percent were males, 76 percent were undergraduates and 33 percent of the deaths by suicide occurred on or near campus.
- 77 percent were Caucasian, 11 percent were Latino, 9 percent were African American and 2 percent were Asian or Pacific Islanders.
- To the extent that it was known, 48 percent of the students were depressed, 27 percent had relationship problems, 16 percent had academic problems and 6 percent had financial problems. These numbers may appear low, as directors



reported only on the primary factor rather than a combination of factors.

- 17 percent were on psychiatric medication and 9 percent were known to have had previous psychiatric hospitalizations.

Students identified at greatest risk of suicide ideation and attempts are those with an existing mental health problem when they start school and those who develop mental health problems while enrolled.

- Students (under 21 years of age), males, Asian and Latino, and those currently in treatment are at greater risk of suicide-related behaviors.
- A variety of factors have been determined to contribute to suicidal ideation and attempts in college students, including loneliness, helplessness, academic problems, relationship problems, difficulties with parents and financial concerns.

Transitioning into college life can be challenging. Students are introduced to new freedoms, new responsibilities, and feel overwhelmed with academic and social pressures. This also is the age period (18-24 years of age) in which severe psychiatric disorders, like bipolar and schizophrenia, typically manifests and can disrupt a student. Due to advancements in medicine, those diagnosed with a mental illness can envision themselves attending college. This has led to more people with a mental illness attending college, though they may be more susceptible to the stressors intrinsic in college.

Students may struggle with sleep deprivation, substance abuse and other risky behavior during college life that could impact their risk for suicide.

- Sleep deprivation is often seen as a characteristic for college life, but also is a major trigger for mania.
- Substance abuse can make the difference between suicidal ideation and a lethal attempt.
- Students with a history of suicide ideation have shown an increase in the use of tobacco, alcohol and illegal drugs.

- Students with a history of suicide ideation are more likely to engage in —injury-related risk behavior, like driving intoxicated, riding with someone who is driving intoxicated, swimming or boarding after drinking alcohol, engaging in a physical fight, carrying a weapon and failing to wear seatbelts regularly, if at all.

Some populations to consider when establishing an approach to preventing suicide are commuter students; older students; international students; and gay, lesbian, bisexual and transgender students.

Some warning signs that indicate a student may be considering suicide include:

- Sudden decrease in school performance.
- Fixation with death or violence.
- Unhealthy peer relationships.
- Violent mood swings or sudden change in personality.
- Indications that the student is in an abusive relationship.
- Signs of an eating disorder.
- Difficulty in adjusting to gender identity and/or depression.

### **PROTECTIVE FACTORS**

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The fact a young adult is attending college may be a protective factor against suicide. College students (7.5 /100,000) were less likely to die by suicide than their nonstudent peers (15/100,000) (Silverman et al., 1997; Drum et al., 2009). In addition to campus policies, (e.g., campuses prohibit firearm possession) it is believed the infrastructure of a campus provides a network of support and services to struggling students. However, it is important to remember that suicide remains the second leading cause of death among college-aged students in the United States and strategies, like those listed below, should be implemented to prevent deaths by suicide among college students.

*Campus environmental protective factors include:*

- Effective clinical care for mental, physical and substance use disorders.
- Easy access to a variety of clinical interventions and support for helpseeking.
- Restricted access to highly lethal means of suicide.

*Campus social protective factors include:*

- Strong connections to family and community support.
- Support through ongoing medical and mental health care relationships.
- Skills in problem solving, conflict resolution and nonviolent handling of disputes.
- Cultural and religious beliefs that discourage suicide and support self preservation.

**PREVENTION/INTERVENTION STRATEGIES**

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*STRATEGIES FOR FAMILIES*

Stay actively involved in your student’s live while they are at school. Family involvement serves as a protective factor, whereas, regular contact by phone, e-mail and mail may help remind the student they are loved, cared for and have access to a support network.

Learn the warning signs of suicide and who to refer your student to if they are concerned.

Know the risk factors and be aware of the mental health services available at your student’s school and, if necessary, should help them obtain services.

Find out how your student’s school handles this issue. If you are concerned your student is at risk, contact the school to identify ways to ensure the safety of your student and how to get linked to resources. Keep trying.

Acknowledge up-front the issues of confidentiality for adult students (i.e., over 18) and establish reasonable ways of information transfer.

If the student is living at home during their college years, restrict access to firearms in the

home in the event warning signs of suicide are observed.

*STRATEGIES FOR THE HIGHER EDUCATION COMMUNITY*

*Schools*

- Implement regular screening programs for depression, other serious mental illnesses and suicide-related behaviors.
- Implement campus-wide education efforts.
- Provide educational programs and materials to parents and to families of incoming and continuing students.
- Take a campus-wide approach to address both individual and environmental factors associated with suicide. The entire campus (not just the counseling center) needs to serve an active role, since suicide is a complex problem.
- Reach out to students when their symptoms are just developing so fewer students end up at risk for serious depression, anxiety, fewer consider suicide, fewer attempt and fewer die by suicide.
- Develop a continuum of activities to decrease risk factors and increase protective factors.
  - Identify students at risk
  - Increase help-seeking behavior
  - Provide mental health services
  - Follow crisis management procedures
  - Restrict access to potentially lethal means
  - Develop life skills
  - Promote social networks
- Establish post-vention programs to help the community cope after a suicide death on campus.
- Develop comprehensive medical leave policies, which include mental illness.
- Participate in statewide surveillance system for reporting suicide deaths and serious suicide-related behaviors on campus.

*Faculty and staff*

- Have regular contact with students.

- Attend training on recognizing at-risk students and helping them obtain necessary services.

*Campus-based mental health, counseling centers or psychiatric services*

- Train staff to recognize and manage suicide risk.
- Provide culturally appropriate services.
- Maintain up-to-date lists of off-campus referral options in addition to information on accessing emergency services.
- Be available on-site or with easy access for clinical diagnosis, prescription and monitoring of psychotropic medications.
- Offer general stress-reduction programs on a regular basis along with non-clinical student support networks.

**HELP FOR EVERYONE**

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Some behaviors may indicate a person is at immediate risk for suicide. The following three behaviors should prompt you to immediately call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or a mental health professional, as well as stay with the person while they wait for assistance, when you hear or see someone that is:

- Talking about wanting to hurt or kill themselves
- Looking for ways to kill themselves (such as searching online or seeking access to pills, weapons or other means)
- Talking about feeling hopeless or having no reason to live

Other behaviors also may indicate a serious risk, especially if the behavior is new, has increased, and/or seems related to a painful event, loss or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs

- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings.

**RESOURCES**

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- **Suicide Prevention Resource Center**  
[www.sprc.org](http://www.sprc.org)
- **American Foundation for Suicide Prevention**  
[www.afsp.org](http://www.afsp.org)
- **National Suicide Prevention Lifeline**  
<http://www.suicidepreventionlifeline.org>; (800) 273-TALK (8255)
- **National Strategy for Suicide Prevention**  
<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>
- **National Center for Injury Prevention and Control**  
<http://www.cdc.gov/ViolencePrevention/suicide>
- **It Only Takes One** – public awareness campaign for Illinois – [www.itonlytakesone.org](http://www.itonlytakesone.org)
- **The Jed Foundation**  
<http://jedfoundation.org>

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# Suicide Prevention



## *SUICIDE and FIRST RESPONDERS' ROLE*

### ***WHO ARE FIRST RESPONDERS?***

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First responders, also known as first interveners, include a variety of public officials who deal with emergency situations on a day-to-day basis. This group includes, but is not limited to firefighters, police officers, EMTs, paramedics and emergency department personnel. When calls or visits are made for individuals needing emergency assistance, whether by that individual or on their behalf, first responders are the first professionals to come into contact with the situation. First responders uphold a duty to shield those in their community from harm.

### ***WHY THE ROLE OF FIRST RESPONDERS IS SO IMPORTANT***

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Situations that first responders encounter may be of suicidal nature, especially those that are mental health emergencies. The Illinois Violent Death Reporting System indicates 72 percent of Illinois suicides occurred at the victim's residence. First responders are the initial contact in emergency situations occurring in the home. At any time, first responders may be in situations where they need to refer a person to a mental health facility, or even personally recognize and remove lethal means from someone.

The nature of emergency situations that first responders come into contact with is wide in range. Many may assume that first responders deal with common themes, such as fire, theft and automobile accidents.

While this is true, it is important to consider that first responders also are used as a resource by and for people who are suffering emotional, mental health and substance abuse issues.

Unfortunately, most first responders are not specifically trained in the area of mental illness. Many are unaware of the common warning signs of suicide and do not know the appropriate action to take when they encounter someone who is exhibiting suicidal behavior.

Being the first point of contact with individuals in emergency situations, first responders' knowledge and handling of emergency situations greatly influences the end result of these crises. In situations involving suicide, the end result is ultimately fatal if not handled properly. First responders, with the appropriate knowledge and training, can save lives in suicidal situations.

### ***PREVENTION/INTERVENTION STRATEGIES FOR FIRST RESPONDERS***

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#### ***STRATEGIES FOR RESPONDING TO THE SCENE***

It is crucial for first responders to take suicide threats and attempts seriously. Suicide Prevention Resource Center (2013) recommends the following steps for taking precaution at the scene:

- *“Ensure the safety of everyone present”* – this includes eliminating access to lethal means. If available, contact law enforcement who are trained in suicide prevention to intervene. Law enforcement officers should be aware of the dangers of a “suicide by cop” situation,



where a suicidal person threatens harm to others in attempt to provoke officers to fire at him or her

- *“Assess the person for need of medical treatment”* – Address any serious medical needs first, and if not equipped to handle mental health issues, involve somebody who is, such as a mental health clinician or crisis intervention worker. If not aware of the appropriate professional to contact, ask a supervisor for direction.
- *“Establish rapport with the person”* – Listen carefully and speak with the person in a non-confrontational manner.
- *“Assess the person for risk of suicide”* – Determine whether an attempt has already been made while keeping them under constant observation. If the person is suicidal, arrange for them to be transported to a local hospital or mental health center.

#### *STRATEGIES FOR THE COMMUNITY*

There are many ways for first responders to participate in community-wide suicide prevention efforts. First responders can get involved in local prevention efforts, such as community coalitions. If a community has a coalition, then extend an invitation to law enforcement and the fire services. First responders can share written materials with the community and include suicide prevention materials in the department’s lobby.

#### *STRATEGIES FOR THE WORKPLACE*

Local first responders should promote awareness that suicide is a public health problem that is preventable. As often the first people to come into contact with suicidal situations, first responders must recognize how suicide affects their profession.

To promote an informed staff within their workplace/team, first responders can apply the

following objectives, as outlined by the National Alliance for Suicide Prevention (2012).

- *“Assess the problem and its context within the workplace setting”* - First responders should examine how suicide affects their profession.
- *“Increase workplace buy-in about the consequences of not attending to suicidal behavior”* – First responders can talk with colleagues about the importance of suicide prevention education.
- *“Build the capacity of workplaces to engage in suicide prevention”* – First responders can suggest trainings and print materials for the workplace to review.
- *“Engage employers to take action and to evaluate results”* – Employing the above strategies, first responders may capture the attention of leaders and see workplace changes.

#### *STRATEGIES FOR OCCUPATIONAL TRAINING*

Suicide prevention needs to be a focus of a first responder throughout their professional training and as a part of their continuing education. For example, information can be added to a training block at the academy or school with a brief update or refresher during the time staff received recertification for cardiopulmonary resuscitation (CPR).

The 2012 National Strategy for Suicide Prevention, a report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention includes providing training to community and clinical service providers as a specific goal. Within that goal, the following relevant strategies are presented:

- Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.
- Develop and promote the adoption of core education and training guidelines on the



prevention of suicide and related behaviors by credentialing and accreditation bodies.

- Develop and promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by health professions, including graduate and continuing education.

### **UNIQUE CHALLENGES FOR FIRST RESPONDERS**

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First responders are often exposed to unique situations related to a suicide or a suicide attempt. In addition to directly interacting with suicidal individuals, first responders also must take special care in their interactions with family and friends of a suicidal individual. They need to convey empathy and provide support, but at the same time may be faced with the task of asking sensitive questions in order to obtain more information on the situation.

If an individual completes a suicide, their family and friends become “survivors.” Interacting with survivors of suicide presents the same challenges as mentioned, but also may pose greater risks. Survivors of suicide experience strong emotions following their loss and, in extreme cases, may show concerning behaviors that can be classified as suicidal.

Additionally, first responders may be approached by news media for information. First responders must be aware of the danger of releasing information that may be used to glamorize or criticize a victim. Out of safety to the victim, first responders must learn to react to the media in a minimal way, as detailed media coverage regarding suicide can contribute to other suicide attempts. If first responders must speak with the media, they should take such opportunities to provide sources of assistance for others in danger of suicide.

### **PROTECTING FIRST RESPONDERS**

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Professionals who act as first responders are in high-stress situations for much of their work time. Being involved with these kinds of situations exposes them to overwhelming images, both physical and psychological, of both the victims and surrounding individuals.

If an agency does not have a policy, then they are strongly encouraged to debrief first responders involved with critical incidents, including suicide. Many local organizations will provide the training at no cost.

Co-workers, friends and family members of first responders can recommend Acute Traumatic Stress Management strategies to help them cope with overwhelming work experiences. These include:

- Encourage them to admit their connection to the situation is creating physical and psychological reactions.
- Support them in talking about their personal reactions to their work. Self-disclosure helps them understand experiences and promotes closure.
- Remind them not to forget they are a normal person who has experienced an abnormal event, and remind them not to feel ashamed to seek professional help.

Unfortunately, first responders’ exposure to distress in their work may cause weaker connections in their personal lives, as they may feel like a burden when sharing work-related grief with others. Combined with some first responders’ access to firearms (police officers), the above factors make first responders at risk for attempting and/or completing suicide themselves. If you know a first responder under stress, familiarize yourself with the warning signs of suicide and refer them for assistance.

## HELP FOR FIRST RESPONDERS

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First responders at risk of suicide may display warning signs that differ from that of the public.

The Firefighter Behavioral Health Alliance has identified five common warning signs linked to depression and suicide in firefighters. If you see firefighters who display these signs, step in to help.

- Sleep deprivation
- Anger
- Impulsive behavior – may include sudden changes in ideals
- Isolation - those who suddenly withdraw from others in the workplace more than usual may be at risk
- Loss of confidence in skills – many lose the confidence to perform their jobs

The following warning signs were identified within the International Journal of Emergency Mental Health as warning signs specific to police officers. While not all suicidal officers will show all of these signs, even a few such cues should raise sufficient concern for a supervisor to take action.

- Verbal cues – threatening self; threatening others; surrendering control; throwing it all away; out of control; hostile, blaming, insubordinate; defeated; morbid attraction to suicide or homicide; overwhelmed; or out of options.
- Behavioral cues – gestures; weapon surrender; weapon overkill, excessive risk-taking; boundary violations; procedural violations; final plans; or surrendering control.

## HELP FOR EVERYONE

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The following signs may mean someone is at risk for suicide. The risk of suicide is greater if a behavior is new or has increased and if it seems

related to a painful event, loss or change. If you or someone you know exhibits any of these signs, seek help as soon as possible by calling the Lifeline at [1-800-273-TALK](tel:1-800-273-TALK) (8255).

- Talking about wanting to die or to kill themselves.
- Looking for a way to kill themselves, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or isolating themselves.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

## RESOURCES

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- *National Center for Injury Prevention and Control* [www.cdc.gov/ncipc](http://www.cdc.gov/ncipc)
- *National Strategy for Suicide Prevention* <http://mentalhealth.samhsa.gov/suicideprevention/>
- *It Only Takes One* – public awareness campaign for Illinois – [www.itonlytakesone.org](http://www.itonlytakesone.org)
- *Firefighter Behavioral Health Alliance* [www.ffbha.org](http://www.ffbha.org)
- *The Role of Emergency Medical Providers in Preventing Suicide* <http://www.sprc.org/sites/sprc.org/files/ems.pdf>
- *The Role of Law Enforcement Officers in Preventing Suicide* <http://www.sprc.org/sites/sprc.org/files/LawEnforcement.pdf>

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# Suicide Prevention



## SUICIDE AND OLDER ADULTS

The highest rate of suicide in the nation is among persons 65 years of age and older. Of those suicides, 83 percent were males. In fact, the rate of suicides in late life is 6.6 times greater among males than females. Elderly white men are at the highest risk of suicide. The rate for Illinois is comparable to the national rate. In comparison to age groups, the suicide rate for persons 70 years of age or older is nearly 2.0 times the rate for the 15 to 19 year age group.

Older adults are disproportionately impacted by suicide. Nationally, they account for 16.0 percent of suicides; however, they only make up 13.3 percent of the population. In Illinois, older adults make up 13.5 percent of the population, yet account for 21 percent of suicides.

Older adults are less likely to report suicidal thoughts compared to younger adults. They attempt and complete suicide more than other age groups. One of the reasons for a higher completion rate is because they use more lethal methods. More than 70 percent of suicides in this age group are by a firearm, which men use more often than women.

Some older adults purposely engage in indirect life threatening behavior, which will eventually lead to their death. Examples include refusing medication, food, or liquid; refusing or ignoring medical advice; not attending to their hygiene; and living in unsafe/unsanitary conditions. These deaths are not labeled as suicide even when the older adult's intent is to die.

Suicide among older adults is greatly under-reported, which may be due to the unwillingness of doctors and coroners to label a death as suicide because of the impact on family members and the

community. It is documented every hour and 23 minutes an older adult dies by suicide in America.

### RISK FACTORS

The following characteristics are risk factors of older adult suicide:

- access to lethal methods (e.g., firearms)
- debilitating physical health problems
- presence of mental disorder
- depression
- divorced or widowed (rates are highest for those who are divorced or widowed)
- family discord
- major changes in social roles (e.g., retirement)
- perceived poor health
- prior suicide attempts
- recent death of a loved one
- social isolation and loneliness; socially dependent
- substance abuse
- uncontrollable pain or the fear of a prolonged illness

Depression is one of the leading risk factors of older adult suicide. Often times, their depression is undiagnosed and/or untreated.

Approximately 20 percent of older adults experience undiagnosed depression; yet only 12-25 percent of older adults with depression receive treatment for it. It is important to remember depressive disorder is not a normal part of aging. It is normal to experience sadness, grief, response to loss, and temporary "blue" moods; however, persistent depression that significantly impacts a person's ability to function is not normal. The risk of depression increases when an older adult

has other illnesses and has limited ability to function.

- Most older adults who die by suicide had been seen recently by their primary doctor.
- 20 percent had been seen by their doctor within 24 hours of their suicide.
- 40 percent had been seen by their doctor within a week of their suicide.
- 70 percent had been seen by a physician within a month of their suicide.

However, when an older adult visits their doctor, they often describe physical ailments that are the result of depression, such as poor appetite, changes in sleeping patterns and pain not associated with a physical problem, which can lead to a misdiagnosis. Also, older adults receive treatment for diseases, such as heart disease, diabetes, Parkinson's disease, respiratory disease and arthritis, each of which can be accompanied by depression. If depression is untreated, it can delay or prevent full recovery.

Older adults, by nature of growing older, experience many losses, including spouses, family and friends passing away, going to a nursing home, or moving away to live with family. These losses, in addition to a decreased ability to perform daily activities, are factors that increase social isolation in older adults. The loss of physical and/or cognitive functioning (e.g., unable to drive due to poor eyesight, hearing, or reflexes; unable to do what they used to do when they were younger; and in need of help for simple tasks) is one of many reasons older adults experience depression.

Additionally, older adults generally have access to firearms, particularly when an older man is a veteran.

The National Strategy for Suicide Prevention indicated several factors would impact the rate of older adult suicides in the future, including growth in the absolute and proportionate size of this population; health status; availability of services; and attitudes about aging and suicide.

## PREVENTION/INTERVENTION STRATEGIES

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### STRATEGIES FOR THE HOME

Specific steps to prevent suicide can be taken within the home of an older adult, including reducing access to means commonly found in a place of residence.

- *Develop a strong connection to family and community support.*
- *Encourage family members to look out for warning signs of suicide.* Signs include hoarding medication, talking about being with dead loved ones soon, being preoccupied with death, withdrawing from friends and/or activities they once enjoyed and increased use of alcohol or pain medications.
- *Educate older adults on ways to develop skills in problem solving and conflict resolution.*
- *Remove firearms from the home.* If the older adult will not allow this, unload the firearm, store the ammunition in another part of the home and place a trigger lock on the gun.
- *Dispose of out-of-date medications.* If necessary, medications should be monitored by someone who can recognize potentially lethal dosages or combinations of medications and can properly dispose of them if needed.

### STRATEGIES FOR THE COMMUNITY

Responsibilities for older adult suicide prevention lie outside of the home as well. It is crucial for older adults to have simple access to social and clinical support.

- *Reduce social isolation and disconnect.* Form friendly visiting and telephone reassurance programs to increase social interaction. Provide transportation to church, senior centers, senior meal sites, and other social functions to increase social activity. This is especially important in rural areas.
- *Identify avenues to outreach to older adults.* Points of access include:



- health care – primary, specialty, long-term and home
  - mental health services
  - social services – senior centers, nutrition, transportation, peer support and outreach
  - religion – churches and temples
  - community – banks, utility companies, pharmacists, mail carriers and senior living communities
- Offer easy access to a variety of clinical interventions and help-seeking support.
  - Provide effective clinical care for mental, physical, and substance disorders.
  - Prioritize positive family involvement to maintain the emotional well-being of an older adult.

#### *STRATEGIES FOR STATE, CITY, AND LOCAL GOVERNMENT ENTITIES*

Suicide interventions must be aggressive. Older adults are more frail (more likely to die), more isolated (less likely to be rescued), and more planned and determined; therefore, their suicide attempts are more lethal. Thus, it is important to focus prevention efforts on educating both the general public and those populations greatest at risk of suicide.

- Develop broad-based support for older adult suicide prevention.
- Promote awareness that suicide in older adults is a public health problem that is preventable.
- Encourage primary care physicians to become more aware of and look for signs of depression in their older patients.
- Educate doctors, caregivers, in-home care workers, long-term care (nursing home) employees and the community-at-large about the concern of suicide among older adults.
- Develop and implement a training program for employees of local aging programs to assist
  - acting reckless or engaging in risky activities, seemingly without thinking

these workers and volunteers in identifying persons at risk of suicide.

- Develop and implement strategies to reduce the stigma associated with aging and with being a consumer of mental health, substance abuse and suicide prevention services.
- Improve access to and community linkages with mental health, substance abuse and social services designed for the evaluation and treatment of older adults in primary and long-term care settings.
- Encourage health care programs to incorporate screening tools and techniques for depression, substance abuse and suicide risk.
- Focus on treating mood disorders by integrating evidence-based depression treatment into the work of primary care offices, social service agencies and aging services organizations.
- Implement collaborative care models that combine pharmacological and psychosocial treatment for depressive symptoms.

#### *LOOKING FOR HELP*

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Call 9-1-1 or seek immediate help from a mental health provider when you hear or see someone that is:

- threatening to hurt or kill themselves
- looking for ways to kill themselves (e.g., seeking access to pills, weapons, or other means)
- talking or writing about death, dying or suicide

Contact a mental health professional or call the National Suicide Prevention Lifeline at 800-273-TALK (800-273-8255) for a referral should you witness, hear or see anyone with one or more of these behaviors:

- hopelessness
- rage, anger, seeking revenge
- feeling trapped – like there's no way out
- increasing alcohol or drug use



- withdrawing from friends, family or society
- anxiety, agitation, unable to sleep, or sleeping all the time
- dramatic mood changes
- no reason for living; no sense of purpose in life

## RESOURCES

More information about suicide can be obtained from the following organizations:

- **National Center for Injury Prevention and Control:** [www.cdc.gov/ncipc](http://www.cdc.gov/ncipc)
- **National Strategy for Suicide Prevention:** <http://mentalhealth.samhsa.gov/suicideprevention/>
- **Suicide Prevention Resource Center:** [www.sprc.org](http://www.sprc.org)
- **It Only Takes One** (public awareness campaign for Illinois): [www.itonlytakesone.org](http://www.itonlytakesone.org)

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## SUICIDE PREVENTION IN THE JUVENILE JUSTICE SYSTEM

Youth involvement in the juvenile justice system can include court appearances, probationary periods, and sentencing in secure youth facilities. The following information takes a systems-wide approach, addressing each of these entities and their responsibilities to suicide prevention.

Though, it is important to understand while all professionals working in the juvenile justice system should take responsibility for promoting suicide prevention in the workplace, those working directly with incarcerated youth are likely to be within close proximity to the location of suicide attempts, should they occur. Therefore, these staff should have a clear understanding of how to prevent suicidality, monitor moods, and respond to suicidality. There should be ongoing and recurring training on this topic.

### JUVENILE JUSTICES' RESPONSIBILITIES TO YOUTH

The National Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force (2013a) recognizes the juvenile justice system has two general suicide prevention-related responsibilities.

The first suicide prevention-related responsibility is for the system to guarantee the safety of youth, which comes under the jurisdiction and authority of the juvenile justice system.

The second suicide prevention-related responsibility involves providing opportunities for

positive youth development. This is achieved through rehabilitation and treatment, with an ultimate goal of preventing future youth delinquency. Suicide prevention should be an integral portion of both of these responsibilities.

### WHY YOUTH IN THE SYSTEM ARE AT RISK

Youth involved with the juvenile justice system have an increased risk of suicide. Though youth seldom die in confinement, historically suicide is the leading cause of youth deaths in confinement. The rate of suicide of youth in residential facilities is nearly three times the rate of their peers in the general population. Studies report that over half of juveniles had current suicidal ideation and one-third had a history of suicidal behavior. This is not to be confused with nonsuicidal self-injury, which is the direct and intentional destruction of one's own body tissue in the absence of any intent to die.

A survey prepared by the National Center on Institutions and Alternatives, *Juvenile Suicide in Confinement: A National Survey*, analyzed 79 youth suicide cases between 1995-1999 (Hayes, 2009). Of those cases, 36.7% occurred in juvenile detention centers:

- 79.3% of victims held in detention centers were on detained status as opposed to commitment status. Those on detained status are those awaiting placement or adjudication, while those on who are on commitment status are being held by order of the court.

- More than 40% of cases in detention facilities occurred within the first 72 hours confinement.
- Nearly 75% of victims were assigned to rooms with no other occupant.
- 85% of youth on room confinement status who died by suicide died during waking hours at their facility.
- Nearly 99% of all suicide deaths were completed by hanging methods. Within those, 72% used their bedding as the instrument, and door knobs/hinges, air vents, bed and window frames were among the anchoring devices used.
- 34.5% of victims were assessed by a qualified mental health professional before their death.
- 37.9% of the detention facilities where the aforementioned suicide deaths occurred provided annual suicide prevention training to staff (Hayes, 2009).

### **RISK FACTORS**

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Characteristics of the juvenile justice system present continuing risk for youth suicide. Experts theorize deaths by suicide within jails may have two primary causes: (1) jail environments are conducive to suicidal behaviors; and (2) the inmate faces a crisis situation.

Risk factors are more prevalent among these youth than those not involved in the juvenile justice system. Risk factors include mental health or substance abuse disorders; suicide or other death of friend or family members; social isolation, relationship problems or separation from family.

The National Strategy for Suicide Prevention included the following expanded list of risk factors:

- History of or existing mental illness and substance abuse
- History of suicidal behaviors
- Lack of mental health care
- History of abuse (e.g., emotional, physical, sexual)

- Family discord/abuse
- Impulsive aggression
- History of interpersonal conflict
- Prior involvement in special education
- Legal/disciplinary problems
- Family history of suicide
- Poor family support
- Prior offenses
- Referral to juvenile court
- Coming from a single-parent home

### **Signs that *immediate* help for suicide risk is needed include:**

- Perceived crisis (e.g., transition within the juvenile justice system)
- Unusual or sudden changes in personality, behavior, or mood
- Talking about wanting to die or kill oneself
- Withdrawal from friends, family, or usual activities
- Expressions of hopelessness or feeling trapped
- Actively securing access to lethal means.

### **PROTECTIVE FACTORS**

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The National Action Alliance for Suicide Prevention: Youth in Contact with the Juvenile Justice System Task Force shared the following protective factors which may *decrease* suicide risk among youth in the justice system include:

- Sense of control over one's own destiny; problem-solving and conflict resolution skills,
- Adaptable temperament
- Support from and connections to family and community
- Positive school or employment experience
- Specific plans for the future
- Religious/spiritual/cultural beliefs that protect against suicide
- Lack of access to lethal means
- Housing that is "suicide-resistant" (i.e., free of protruding objects and means/methods for suicide) and that is proximal to staff and peers
- Easy access to effective mental health and substance abuse treatment services

- Availability of mental health services that are provided consistently by qualified, trained, and supportive staff who provide strong, community linkages and referrals and ensure continuity of care
- Collaborative communication between juvenile justice and mental health systems

### **PREVENTION/INTERVENTION STRATEGIES**

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It is important for individuals who work with youth involved in the juvenile justice system to recognize that these youth may have an increased risk for suicide ideation and suicidal behavior, and that suicide is preventable for this population. It is also important for these individuals to know and pay attention to high risk times and situations.

Steps juvenile justice personnel can take to prevent suicide include: ensuring access to effective mental health and substance abuse services; understanding the risk and protective factors related to suicide; and knowing the warning signs. In addition, it also is important to implement and evaluate comprehensive suicide prevention policies, programs, and practices that address risk and protective factors on multiple levels. Consequently, it is also important to have effective quality assurance of these policies and procedures.

To establish comprehensive suicide prevention services, the national plan recommends juvenile justice programs include screening, assessment and safe management of individuals at risk for suicidal behaviors as evaluative methods at all points of contact in the juvenile justice system. The critical intervention points within the juvenile justice processing continuum include referral/arrest, courts, probation, detention and secure/non-secure care facilities, and aftercare.

There are eight critical components of a sound juvenile justice program. These policies and programs should include:

- Initial and annual training for all direct care, medical, and mental health personnel

- Initial intake and ongoing assessment of juveniles in detention facilities
- Enhanced communication along the continuum of the justice system
- Levels of supervision for persons at risk of self-harm and suicide
- Appropriate suicide-resistant housing
- Intervention
- Reporting; mortality/morbidity incident review
- Critical incident stress debriefing

### **What COURTS Can Do**

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- Incorporate suicide prevention training into standard training for all judges, clerks, and staff.
- Ensure that a standardized suicide risk screening using a valid and reliable tool is provided to all youth at probation and detention intake, and that suicide risk assessment by qualified mental health professionals occurs as necessary on an ongoing basis.
- Establish a protocol to convene judicially led stakeholder meetings on a regular basis to help improve communication and planning around suicide prevention.
- Establish a protocol for physical safety in all interview rooms and holding cells.
- Create an emergency response protocol that addresses youth suicides, suicide attempts, or other suicide-related crises on court grounds.
- Establish policy requirements for multi-disciplinary participation (including juvenile court staff) in the review and report of incidents involving youth suicides, suicide attempts, or suicide threats.

*For specific resources for court judges and staff see the National Action Alliance for Suicide Prevention link under the **RESOURCES** section.*

### **What PROBATION DEPARTMENTS Can Do**

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Develop, implement, and maintain a comprehensive suicide prevention program that includes the following critical components:



- Routine suicide prevention training for all probation staff
- Standardized intake screening for suicide risk using a valid and reliable tool for all youth, with suicide risk assessment by a qualified mental health professional administered as necessary
- Protocol to share information between probation staff and detention/facility staff about a youth's suicide warning signs and risk/protective factors
- Protocol for physical safety in probation offices and other spaces where youth meet officers and other staff
- Protocol for responding to a suicide, suicide attempt, or suicide-related crises in emergency response plans
- Memoranda of understanding and agreements with mental health providers for emergency referral and treatment
- Reporting requirements for all incidents of suicide, suicide attempts, or suicide-related crises

*For specific resources for and probation staff see the National Action Alliance for Suicide Prevention link under the **RESOURCES** section.*

#### What DETENTION AND SECURE CARE FACILITIES Can Do

Develop, implement, and maintain a comprehensive written suicide prevention program that includes the following eight critical components:

1. Conduct routine suicide prevention training for all staff. Facilities should also become trauma informed, including all staff, executive, administrative, professional, and front line.
2. Standardized intake screening for suicide risk using a valid and reliable tool for all youth, with suicide risk assessment by a qualified mental health professional should be administered as necessary.
3. Develop protocols that provide shared information about suicide risk,
  - a. Among the arresting/transporting officer, family members, and facility staff,
  - b. Between facility staff members, and

- c. Between facility staff and youth
4. Varying levels of supervision should be available.
  - a. Close observation for youth with suicidal ideation or behavior.
  - b. Constant observation for youth who are talking about or displaying suicidal behavior \*\*Closed-circuit television does *not* substitute for observation.
5. Safe physical environment should be provided.
6. Emergency response protocol should be implemented in the case of suicides or suicide attempts.
7. Notification system for suicides or suicide attempts through the chain of command should be used.
8. Critical incident stress debriefing protocol (for all staff and youth) should be used along with a death review.

*For specific resources for detention and secure care staff see the National Action Alliance for Suicide Prevention link under the **RESOURCES** section.*

#### **STRATEGIES FOR STATE, CITY, AND LOCAL GOVERNMENT ENTITIES**

Collaboration across all levels of government and jurisdictions is strongly encouraged, especially between mental health and juvenile justice in order to enhance support and services for youth in the juvenile justice system. The National Action Alliance for Suicide Prevention (2013c) recommends twelve strategies for juvenile justice and mental health agencies to work in partnership on goals for suicide prevention. Please see [Preventing Juvenile Suicide through Improved Collaboration: Strategies for Mental Health and Juvenile Justice Agencies](#) for more information regarding these strategies, which include:

- State mental health and juvenile justice agencies should establish effective data collection and information-sharing for the purposes of 1) law, policy, and program development related to youth at risk for suicidal behavior; 2) individual case-planning and decision-making; and 3) program evaluation and performance measurement addressing suicide prevention.

- All states should establish policies related to collaboration on issues facing youth who are involved with dual jurisdictions, particularly those youth who are at risk for suicidal behaviors.
- Juvenile justice and mental health agencies should work together to ensure that youth who are at risk of suicide always receive evidence-based services in the least restrictive settings possible.
- Juvenile justice and mental health agencies should collaboratively provide mental health services that respond to the gender, ethnicity, and sexual orientation of youth who are at risk of suicide.
- All systems should work collaboratively to provide close follow-up and sufficient support to youth who are re-entering the community from secure care, especially youth with a history of suicidal ideation and behavior.
- Juvenile justice and mental health agencies should work together to establish and provide developmentally appropriate services to youth who are at risk of suicide.
- Youth-serving agencies should establish collaborative agreements and practices to better provide services for youth who are at risk of suicide.
- Collaboratively developed services and strategies for youth who are at risk of suicide should be evaluated regularly.
- Juvenile justice and mental health cooperative agreements should inform courts of existing mental health supports and services in order to avoid placing youth in the juvenile justice system solely to access mental health services.
- State Medicaid and juvenile justice agencies should formally establish a collaborative relationship to better provide services to youth who are at risk of suicide.

### **STRATEGIES FOR THE HOME**

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For youth in the juvenile justice system, family connections and support are specific protective factors for suicide.

Families of youth in the juvenile justice system can also play a role in getting youth who display suicidal ideation the mental health assistance they

need. Families can identify problems that may contribute to violent and delinquent behaviors exhibited by youth and screen for mental health problems.

Families should be encouraged to play an active role in youth who are getting psychiatric treatment to restore the family system which is often times missing with youth involved with the juvenile justice system.

Families should work on decreasing idle time or room time of youth in the juvenile justice system. Various activities such as sports and teaching hobbies can help in decreasing suicidal ideation in youth.

### **LOOKING FOR HELP**

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When a person encounters written, spoken, or other communication of suicide, they should take it seriously. They should be direct to the person in distress and ask questions such as “Are you thinking about killing yourself?” “Are you considering taking your own life?” and “Do you ever feel like things would be better if you were dead?” A person should not judge anyone they believe might be thinking of suicide and should avoid acting shocked if a youth says he or she is considering suicide. In these situations, one should not be sworn to secrecy or make promises that they won’t tell anyone.

Any suspicion that a youth is thinking about suicide should be communicated to a mental health professional or supervisor *immediately*. The person who communicates suspicion to a mental health professional should stay with the youth until assistance arrives. One should *not* leave a suicidal youth alone while they seek assistance for the youth.

Some behaviors may indicate that a person is at immediate risk for suicide. The following three behaviors are a prompt to immediately call the National Suicide Prevention Lifeline at 1-800-273-



TALK (8255) or a mental health professional, as well as stay with the person while they wait for assistance, upon hearing or seeing a person that is:

- Talking about wanting to hurt or kill themselves
- Looking for ways to kill themselves (such as searching online or seeking access to pills, weapons, or other means)
- Talking about feeling hopeless or having no reason to live

Other behaviors may also indicate a serious risk – especially if the behavior is new, has increased, and/or seems related to a painful event, loss or change:

- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or isolating themselves
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

## RESOURCES

Information about suicide can be obtained from the following organizations:

- **National Action Alliance for Suicide Prevention - Youth in Contact with the Juvenile Justice System Task Force**  
<http://actionallianceforsuicideprevention.org/ask-force/juvenilejustice> - this website includes the following resources:

- *Fact sheet series for*
  - *Juvenile court judges and staff*
  - *Juvenile detention and secure care staff*
  - *Juvenile probation staff*

- *Literature review*

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- *Strategies for collaborating between mental health and juvenile justice agencies*

- **Suicide Prevention Resource Center-Suicide Prevention in Juvenile Correctional Facilities**  
<http://www.sprc.org/training-institute/juvenile-correctional-curriculum>
- **National Suicide Prevention Lifeline -**  
<http://www.suicidepreventionlifeline.org>; (800) 273-TALK (8255)
- **National Strategy for Suicide Prevention**  
<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html>
- **National Center for Injury Prevention and Control**  
<http://www.cdc.gov/ViolencePrevention/suicide>
- **It Only Takes One – public awareness campaign for Illinois –** [www.itonlytakesone.org](http://www.itonlytakesone.org)

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