# SOS
# Signs of Suicide®

***An Evidence-based Suicide Prevention Program for High Schools***

# Screening for Mental Health, Inc.

- 1991: Pioneered the concept of large scale mental health screening with National Depression Screening Day.

- SMH Programs include:
  – SOS Signs of Suicide® High School Program
  – National Alcohol Screening Day®
  – College*Response*®
  – Workplace*Response*®
  – Healthcare*Response*®

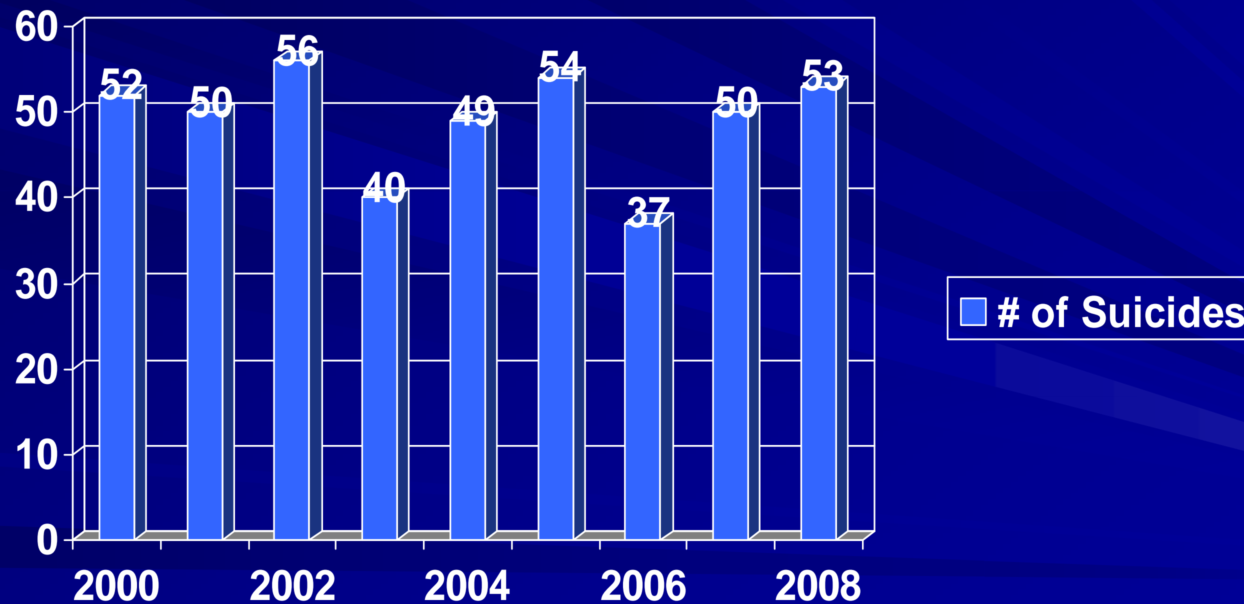
# Youth Suicide:
# Overview of the Problem

# Prevalence of Suicide in Youth

- While child suicide is very uncommon, **mortality from suicide increases steadily through the teens.**
  - *– NIMH, In Harms Way, Suicide in America, 2003*
- Suicide is the **sixth leading cause of death among 5-14 year olds** and the **third leading cause of death among those 15-24**.
  - *– American Foundation for Suicide Prevention*

# Prevalence of Suicide in Youth

- In Mississippi, suicide is the 3rd leading cause of death among youth ages 15-24.



# Prevalence of Suicide in Youth

- Adolescent suicidal behavior is deemed **underreported** because many deaths of this type are classified as unintentional or accidental.

  *– World Health Organization, 2000*

- Over 90% of children and adolescents that die by suicide have a **mental health disorder** at the time of their death, most often depression.

# Risk Factors

# What Are Risk Factors?

- Suicide is a complex behavior that is usually caused by a **combination of risk factors** in the context of negative life events
- A **risk factor is anything that increases the likelihood** that persons will harm themselves.
- Risk factors are **not necessarily causes**.
- **The first step in preventing suicide is to identify and understand the risk factors**.

***-Adapted from the National Youth***

***Violence Prevention Resource Center***

SUICIDE: A MULTI-FACTORIAL EVENT
Psychiatric Illness Co-morbidity
Personality Disorder/Traits
Neurobiology
Impulsiveness
Substance Use/Abuse
Hopelessness
Suicide
Severe Medical Illness
Family History
Access To Weapons
Psychodynamics/ Psychological Vulnerability
Life Stressors
Suicidal Behavior

# Depression and Youth

- In 2004, 9% of adolescents aged 12 to 17 (an estimated 2.2 million adolescents) experienced at least one major depressive episode in the past year

  *-SAMHSA, 2005*

- In children and adolescents, an untreated depressive episode may last between 7 to 9 months (*Birmaher et al., 1996a, 1996b)* —potentially, an entire academic year!

- Depression has been linked to suicide, poor school performance, substance abuse, running away, and feelings of worthlessness and hopelessness

  *-National Institute for Mental Health, 2005*

# Symptoms of Adolescent Depression

- Frequent sadness, tearfulness, crying
- Hopelessness
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self esteem and guilt
- Extreme sensitivity to rejection or failure

# Symptoms of Adolescent Depression (cont.)

- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self destructive behavior

-*AACAP, The Depressed Child*

# Signs of Suicide

- Talking, reading, or writing about suicide or death (including online communication)
- Talking about feeling worthless or hopeless
- Direct verbal cues like "I wish I were dead."
- Indirect verbal cues like "You will be better off without me."
- Visiting or calling people to say goodbye.
- Giving things away.
- A sudden interest in drinking alcohol.
- Purposefully putting oneself in danger.
- Obsessed with death, violence, and guns or knives.
- Previous suicidal thoughts or attempts.

*-http://pbskids.org/itsmylife* ** list is not all inclusive*

# Suicidality and Substance Abuse

- Youths aged 12-17 who reported past year alcohol use (19.6%) were more likely than youths who did not use alcohol (8.6%) to be at risk for suicide.
  - *SAMHSA, NHSDA Report, Substance use and the Risk of Suicide Among Youths, 2002*
- 1/3 to ½ of teenagers were under the influence of drugs or alcohol shortly before they killed themselves.
  - *National Strategy for Suicide Prevention, DHHS*

# Self-Injury In Youth

- In the pediatric population, self-injury is defined as deliberate non-lethal harming of oneself
- Self-injury is a maladaptive coping skill employed by youth experiencing painful emotions
- Is generally **NOT** an attempt to die by suicide.
- Between 150,000 and 360,000 adolescents in the U.S. self-injure
  - Walsh, Lieberman, 2004.

# Self-Injury Comes In Several Forms

- Behaviors include:
  - Cutting – the most common form
  - Burning
  - Hitting
  - Poking
  - Picking
  - Hair pulling
  - Putting oneself in harms way
  - Head banging

# Relationship Between Suicide and Self-injury

- Death can occur, even if unintentionally
- Those who self-injure may become suicidal in the future.
- The student is experiencing a mental health disorder that should be treated professionally and stands the best chance of recovery if caught early.
- If handled inappropriately or not at all, there is a potential for contagion.

# Protective Factors

# Protective Factors

- Afford protection against suicidal behavior:
  - Good relationship with family
  - Support from family and friends
  - Good social skills
  - Seeks help and advice
  - Participation in positive social activities

# Overview of the SOS Program For High Schools

# Program Goals

- Decrease suicide & suicide attempts by increasing knowledge & adaptive attitudes about depression among students.
- Encourage individual help-seeking and help-seeking on behalf of a friend.
- Encourage that mental illness, like physical illness, requires treatment.
- Engage school staff in prevention by educating them to identify signs of depression and suicide.
- Reduce stigma associated with mental health problems.

# Program Components

- Implementation binder
- "Friends for Life" video & discussion guide
- Depression screening forms
- Staff training video
- Educational materials for staff, parents, students
- Training lecture for staff and parents
- Postvention guidelines
- Self-injury resources

# Action Message - ACT

**A**cknowledge: Acknowledge that a friend or classmate has a problem, and that the symptoms are serious.

**C**are: Let that friend know they are there for them, and want to help.

**T**ell: Tell a trusted adult about their concerns

# SOS Program Implementation

***at the school level***

# Staff Training Suggestions

- Show the *"Friends for Life"* video and facilitate discussion.
- Review the signs of depression & suicide.
- Answer questions and dispel myths.
- Review school policy.
- Review school and mental health resources.

  * Sample lecture is included in implementation binder.

# Staff Training

- Training faculty and staff is universally advocated and essential to a suicide prevention program.

- Research indicates that training faculty and staff can produce positive effects on an educator's knowledge, attitudes and referral practice.

*Smith, T & Smith V., Lazear, K, Roggenbaum, S., & Doan, J., 2003.*

# Staff Training

- Schools must prepare staff as students may disclose to any adult.
- Train to increase school staff's knowledge about:
  - SOS program:  why, when, where, how
  - Warning signs
  - School and community based mental health resources
  - School protocol for providing help for at-risk youth

# Common Objections & Talking Points

- Suicide is not a problem in our school
  - No school is immune to adolescent suicide
- Schools are not appropriate for suicide prevention programs
  - Student problems with academics, peers, and others are more apt to be evident in school. The majority of parents are unaware of their child's suicidality.
- The program may introduce the idea to students
  - There has been no harm seen in screening teens for suicide risk. *Gould et al, 2005*
- I don't agree with labeling youth
  - The screenings are not diagnostic.

# Common Objections & Talking Points

- I don't have enough staff/time
  - The program can be implemented in one class period using existing resources and partnerships with community providers.
- There are no referral resources in my area
  - Identifying the need can help justify the need for funding and/or additional partnerships.
- We cannot conduct mental health screenings
  - Screenings can be done confidentially or not at all.
- We already have a suicide prevention program
  - SOS is the only evidence-based program shown to reduce suicide attempts.

# Implementation Overview

- School personnel  implement the program with materials provided
- Can be implemented in one or two classroom periods
  - Students view and discuss video in classroom.
  - Students may complete screening form.  Screening may be with identification or not.

# Implementation Overview (cont.)

- Entire student body or a select portion of student body may participate in the program.
- Active or passive parental permission
- Staff Training

# Information You Need to Know Prior to Training

# Info To Know

- School policies and procedures associated with youth who may display suicidal behaviors
- Community resources

# National Suicide Prevention Lifeline

# Talk About It

- ***AnComm's Talk About It*** service allows individuals to communicate anonymously with the MS Department of Mental Health Helpline Staff from this website or from your cell phone via Text Messaging

# For more information, contact:

781-239-0071

sosinfo@MentalHealthScreening.org

www.MentalHealthScreening.org/schools/index.aspx

**Screening for Mental Health, Inc.**
One Washington Street, Suite 304 Wellesley Hills, MA 02481
Phone: 781.239.0071 Fax: 781.431.7447
www.MentalHealthScreening.org