**Agenda**

**The Impact of Suicide on Youth and Families: The Ones We Miss**

**[Date]**

**[Time]**

**[Location]**

**[Trainer]**

**INTRODUCTION TO SUICIDE OF CHILDREN AND ADOLESCENTS IN WISCONSIN**

**THE PHENOMENOLOGY OF SUICIDE**

A. The Burden of Suicide in Wisconsin

B. Risk Factors and Warning Signs

C. Suicidal Behaviors

D. Self-Injurious Behaviors

E. Children and Adolescents

**SUICIDE - “THE ONES WE MISS”**

A. Children and Adolescents

B. Native American Youth

C. African American Youth

 D. Lesbian, Gay, Bi- Sexual, Transgender, and Questioning Youth

E. The Bullies and the Bullied

**PREVENTION AND INTERVENTION MODELS**

A. Familial Pathways to Suicidal Behavior Model

B. The Question Model

C. Additional Approaches

**SURVIVING THE SUICIDAL CLIENT**

A. Introduction

B. The impact of Suicide on Child Welfare Workers

**IT’S ALL IN THE PLANNING**

A. Summary

B. Crisis Planning

**CLOSING**

**Learning Objectives**

1. Gain an understanding of the phenomenology of suicide and its impact on children and adolescents.
2. Understand the warning signs, risk factors, and protective factors of suicide when assessing children and families.
3. Gain an understanding of the scope of the problem facing Wisconsin, and thus Child Protective Services and Juvenile Justice Professionals.
4. Develop awareness and understanding of who are the “ones we miss”, including children in out-of-home care and youth who are bullied.
5. Have an opportunity to discuss several strategies currently utilized in Wisconsin to address the problem of child/adolescent suicide to use in case planning.
6. Understand crisis planning and develop a crisis plan based on a realistic case scenario

**Suicides, Inpatient Hospitalizations, and Emergency Department Visits
by Wisconsin County of Residence 2007-2011 (Aggregate)**

*Table 3. Suicides, inpatient hospitalizations due to self-inflicted injury, and emergency department visits due to self-inflicted injury, by Wisconsin county of residence, 2007-2011.*





\*Rates based on less than 20 deaths are unstable and should be used and interpreted with caution. An X indicates a number less than 5 and is used to protect the privacy of the individuals.

Source: Blackwell, S., Gromoske, A., Guerrieri, M., & Schlotthauer, A., (2014). *The burden of suicide in Wisconsin: 2007-2011.* Wisconsin Department of Health Services, Injury Research Center at the Medical College of Wisconsin, and Mental Health America of Wisconsin. Retrieved from http://www.dhs.wisconsin.gov/publications/P0/p00648-2014.pdf

**Suicides, Inpatient Hospitalizations, and Emergency Department Visits
by Age 2007-20011 (Aggregate)**

*Table 4. Inpatient hospitalizations due to self-inflicted injury, by age, Wisconsin 2007-2011.*



\*Rates based on less than 20 cases are unstable and should be used and interpreted with caution.

*Table 5. Emergency department visits due to self-inflicted injury, by age, Wisconsin 2007-2011.*



\*Rates based on less than 20 deaths are unstable and should be used and interpreted with caution. An X indicates a number less than 5 and is used to protect the privacy of the individuals.

*Table 6. Suicides, by age, Wisconsin 2007-2011.*



An X indicates a number less than 5 and is used to protect the privacy of the individuals.

*Table 9. Suicides, by age and sex, Wisconsin 2007-2011.*



An X indicates a number less than 5 and is used to protect the privacy of the individuals.

Source: Blackwell, S., Gromoske, A., Guerrieri, M., & Schlotthauer, A., (2014). *The burden of suicide in Wisconsin: 2007-2011.* Wisconsin Department of Health Services, Injury Research Center at the Medical College of Wisconsin, and Mental Health America of Wisconsin. Retrieved from http://www.dhs.wisconsin.gov/publications/P0/p00648-2014.pdf

**Circumstances Related to Suicide**

**Behavioral Health/Substance Abuse circumstances:**

59% - current depressed mood

50% - mental health problems

43% - currently in treatment

52% - never had treatment

26% - had an alcohol problem

13% - other substance abuse

**Interpersonal circumstances:**

* 1 out of 3 had relational problems
* Other relational problems include the death of a friend/family member, recent suicide of friend/family member

**Life Stressor Circumstances:**

* Crisis in the past two weeks
* Physical health problem
* Financial problem
* Job problem
* School problem
* Recent criminal or non-criminal legal problem

**Suicide event:**

* 40% left a note or disclosed intent
* 25% had a history of attempts

**Toxicology Testing: (available for 65% of the cases):**

* 37% alcohol
* 32% antidepressants
* 3% amphetamines
* 5% cocaine
* 8% pot
* 19% opiates
* 50% other drugs

Note: Alcohol and drug abuse are second only to depression and other mental health disorders as the most common risk factors for suicide (The Burden of Suicide in Wisconsin, 2007-2011).

**Definitions**

|  |  |
| --- | --- |
| **Suicide:** | A *deliberate act* of self-harm with at least some intent to die that results in death. |
|  |  |
| **Suicide Attempt:** | A *deliberate act* of self-harm with at least some intent to die that does not result in death. Such acts have a wide range of medical seriousness. |
|  |  |
| **Suicidal Ideation:** | Thoughts of attempting suicide. Such thoughts have a wide range of specificity, intensity, and frequency. |
|  |  |
| **Suicide Plans:** | A *severe* form of suicidal ideation that include identifying a method or scenario to attempt suicide. |
|  |  |
| **Death Ideations:** | Thoughts of dying but without ideas for suicidal behavior per se. |
|  |  |
| **Non-Suicidal Self- Injurious Behaviors:**  | Self-directed acts of self-harm without intent to die.Broadly, these acts tend to have intrapersonal (e.g., manage emotion) or interpersonal (e.g. communicate distress) motivations and include a variety of behaviors (cutting, piercing, burning) and a wide range of medical seriousness. |

**Self-Injurious Behavior**

**(SIB)**

**Four Main Types:**

1. **Severe**
* Infrequent
* Significant amount of body tissue destroyed
* Examples: castration, eye enucleation, limb amputation
1. **Stereotype**
* Fixed pattern
* Often rhythmic
* Examples: head banging, finger biting
1. **Socially accepted/emblematic**
* Tattooing
* Piercing
* Scarification
1. **Superficial/moderate**
* Low lethality
* Little tissue damage
* Examples: cutting, burning, scab picking, needle sticking, self-punching, excoriations, or scratching

**Risk and Protective Factors**

**Risk Factors:**

* Previous suicide attempt(s)\*
* History of alcohol and substance abuse\*
* Mood and anxiety disorder\*
* Access to lethal methods\*
* Family history of suicide
* Family history of child maltreatment
* Feelings of hopelessness
* Impulsive or aggressive tendencies
* Barriers to accessing mental health treatment
* Loss (relational, social, work, or financial)
* Physical illness
* Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders, or suicidal thoughts
* Cultural and religious beliefs (i.e. suicide is a noble resolution of a personal dilemma)
* Local epidemics of suicide
* Isolation, a feeling of being cut off from other people

**Protective Factors:**

* Effective mental health care\*
* Connectedness to individuals, family, community and social institutions\*
* Problem solving skills\*
* Contact with caregivers\*
* Easy access to a variety of clinical interventions and support for help seeking
* Support from ongoing medical and mental health care
* Marital status
* Cultural and religious beliefs that discourage suicide and support self-preservation instincts.

Those factors with an asterisk \* are consistently indicated across the most up to date literature (8/2014)

Source: Centers for Disease Control and Prevention National Center for Injury Prevention and Control Suicide: Fact Sheet. (n.d.). Retrieved from <http://www.ct.gov/dmhas/lib/dmhas/prevention/cyspi/suicidefactsheet.pdf>

Source: Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide.* Newton, MA: Education Development Center, Inc.

Warning Signs and Risk Factors in Children

Differences in warning signs from adolescents:

* Don’t often show signs of depression
* Don’t express suicidal intent
* Not as likely to be intoxicated
* Fewer warning signs
* Have conflicts with parents
* Suicide may be precipitated by disciplinary crisis
* Hanging is the most common method

Risk factors include:

* Past suicide attempts or threats
* Past violent or aggressive behavior
* Mental illness (depression, anxiety)
* Cognitive immaturity and impulsivity
* Bringing weapons to school
* Recent experience of humiliation, shame, loss
* Bullying
* Victim of abuse or neglect
* Witnessing violence in the home
* Themes of death or depression in reading, conversation or artwork
* Preoccupation with violence on TV, comics, video games, internet, etc.
* Disciplinary problems
* Vandalism
* Cruelty to animals
* Fire setting
* Poor peer relationships
* Involvement with cults or gangs
* Little or no supervision
* Separation from parents

**Risk and Protective Factors for Native Youth**

Risk Factors

American Indian/Alaskan Native populations

* Historical trauma – attempts to eliminate culture
* Acculturation
* Lack of access to and use of mental health services
* Alienation
* Alcohol and drug use

AI/AN Youth specific

* Loss of culture
* Loss of language
* Loss of cultural identity
* Family disruption
* Community Violence
* Contagion
* Low perceived social support
* Coming from a home without both biological parents
* Family history of substance abuse
* Discrimination

Protective Factors

* Community control or cultural continuity.
* Cultural identification - following a more traditional way of life
* Spirituality - Commitment to tribal cultural spirituality is significantly associated with a reduction in suicide attempts.
* Family connectedness - Connectedness to family and discussing problems with family and friends
* Emotional health
* Cultural spiritual orientation (cultural spirituality), rather than beliefs (the cognitive aspect of faith)

Sources:

National Indian Child Welfare Association (NICWA). (n.d.). *Ensuring the seventh generation: A youth suicide prevention toolkit for tribal child welfare programs.* NICWA- National Indian Child Welfare Association. Retrieved from <http://www.nicwa.org/resources/documents/YSPToolkit.pdf>

Suicide Prevention Resource Center. (2013). *Suicide among racial/ethnic populations in the U.S.: American Indians/Alaska Natives*. Waltham, MA: Education Development Center, Inc.

American Association of Suicidology, Washington D.C.; www.suicidology.org; 2012 (based on 2010 data)

**Risk and Protective Factors for African American Youth**

Risk Factors

* Family conflict
* Acculturation – increased acculturation can include loss of family cohesion and support
* Hopelessness, racism and discrimination – perceived racism and discrimination along with social and economic disadvantage
* Access to and use of mental health services – African American youth were substantially less likely to have used a mental health service in the year during which they seriously thought about or attempted suicide
* Access to firearms - firearms are the predominant method of suicide among African Americans regardless of gender and age
* Gender and cultural role expectations – this includes the stigma of suicide as the “unforgiveable sin”, African American men as “macho” and not taking their own lives, and African American women as always strong and resilient

Protective Factors

* Religion – Orthodox religious beliefs and personal devotion
* Social and economic support
* Black identity
* Geographic location - There is a diminished risk of suicide for black adolescents who live in the south
* Connection to family, community and social institutions – This includes family support, peer support and community connectedness

Sources:

Suicide Prevention Resource Center. (2013). Suicide among racial/ethnic populations in the U.S.: Blacks. Waltham, MA: Education Development Center, Inc.

American Association of Suicidology, *African American Suicide Fact Sheet*, Washington D.C.; www.suicidology.org; 2012 (based on 2010 data)

**Risk and Protective Factors for LGBTQ Youth**

Risk Factors

* Homophobia
* LGBT Youth’s perception of homophobia
* High rates of bullying and violence in schools
* High rates of alcohol/drug use
* High rates of sexually transmitted infections
* High rates of homelessness/”couch surfing”
* Gender nonconformity
* Internal conflict about sexual orientation
* Time of coming out/early coming out
* Low family connectedness
* Lack of adult caring
* Unsafe school
* Family rejection
* Victimization
* Stigma and discrimination
* Ethnicity

Protective Factors

Regardless of sexual orientation, protective factors for all youth include:

* Family support and acceptance
* Family connectedness
* Caring adults
* Positive role models
* Positive peer groups
* Strong sense of self and self esteem
* Engagement in school and community activities
* Safe schools

Sources:

*LGB Youth: Challenges, Risks and Protective Factors: A Tip Sheet for Grantees of the Office of Adolescent Health and the Family and Youth Services Bureau, May 1, 2014*

Suicide Prevention Resource Center. (2011). *Suicide prevention among LGBT youth: A workshop for professionals who serve youth*. Newton, MA: Education Development Center, Inc.

*Suicide Risk and Prevention for Lesbian, Gay, Bisexual and Transgender Youth;* Prepared by the Suicide Prevention Resource Center for the Center for Mental Health Services Substance Abuse and Mental Health Services Administration U.S. Department of Health and Human Services 2008

**The Bullied and the Bullies**

**Red Flags that bullying is occurring**

* Acting depressed (not eating, not sleeping, nightmares, anxious, loss of interest)
* Withdrawing socially
* Complaining frequently of illnesses
* Not wanting to go to school or avoiding certain classes
* Bringing home damaged possessions
* Reporting things “lost”
* Stating that he/she feels picked on or persecuted
* Displaying mood swings, including frequent crying
* Talking about running away
* Attempting to take protection to school (stick, rock, knife)
* Taking a different route home after school
* Avoiding taking the bus

**Characteristics of Bullies**

* Thrive on control and dominating others
* Have often been victims of physical abuse or have been bullied themselves
* May be depressed
* Angry or upset about event at home/school
* Often choose children who are passive
* Easily intimidated
* Lack empathy
* Have few friends
* Difficulty following rules
* View violence in a positive way
* Impulsive, hot-headed, dominant

**Family Risk Factors**

* Lack of warmth and involvement on part of parents
* Overly permissive, lack of supervision
* Harsh, physical discipline
* Model for bullying behavior

 **Risk and Protective Factors for Those Involved in Bullying**

Risk Factors

* Bully:

Physical abuse, sexual abuse, mental health problem, running away from home, carrying a weapon and perceiving oneself as overweight

* Victim:

Physical abuse, sexual abuse, mental health problem, running away from home, perceiving oneself as overweight, participation in religious activities, higher levels of distractibility, disabilities or learning differences, LGBTQ

* Bully-victims:

Additional risk factors include witnessing family violence, history of physical abuse, cigarette smoking, marijuana use, skipping school due to safety concerns, perceived school and neighborhood safety concerns.

* All three groups:

History of self-harm, greater emotional distress, involvement in bullying in any way, especially both bullying others and being bullied (highest risk for suicide related behavior of any groups involved with bullying)

Protective Factors

* Bullies:

Stronger connections to non-parental adults was an additional protective factor

* Victims:

Stronger connections to non-parental adults, liking school, feeling safe at school

* All three groups:

Higher levels of parent connectedness, stronger perceived caring by friends

General Protective Factors:

* School connection
* Family Outreach
* Healthy problem coping skills
* Identification of students in need of mental and behavioral health services
* Implementation of effective and inclusive anti-bullying policies, rather than conflict resolution methods

Sources:

*Borowsky, Taliaferro & McMorris; Journal of Adolescent Health 53 (2013) S4-S12; Suicidal Thinking and Behavior Among Youth Involved in Verbal and Social Bullying: Risk and Protective Factors; October 22, 2012*

*Suicide and Bullying: Issue Brief; SPRC Suicide Prevention Resource Center; retrieved from website July 2014*

*Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention, “The Relationship Between Bullying and Suicide: What we Know and What it Means for Schools” 2014;* [*www.cdc.gov/violenceprevention*](http://www.cdc.gov/violenceprevention)

Warning Signs: All Children & Adolescents

* Giving away possessions or making plans for a future when they are gone
* Talk of unbearable feelings or situations
* New or more frequent thoughts of suicide or death
* New or worsened depression
* New or worsened anxiety
* Pronounced agitation or restlessness
* Difficulty sleeping (insomnia)
* New or worsened irritability
* New or increased social isolation
* Suicide attempts
* Aggression, anger or violence
* Acting on dangerous impulses
* Increased use of alcohol or controlled substances
* Extreme hyperactivity in behavior and speech
* Other unusual changes in behavior, including a sudden sense of calm as if a final decision has been made
* Picking fights, arguing
* Refusing help, feeling beyond help
* Sudden improvement in mood after being down or withdrawn
* Neglect of appearance, hygiene
* Dropping out of activities
* A detailed plan for how, when and where
* Obtaining a weapon
* Suicidal gestures (cutting, overdose, etc.)

Less Direct Verbal Cues:

* “You will be better off without me”
* “I’m so tired of it all”
* “What’s the point of living?”
* “Here, take this. I won’t be needing it anymore.”
* “Pretty soon you won’t have to worry about me”
* “Goodbye, we all have to say goodbye.”
* “How do you become an organ donor?”
* “Who cares if I am dead anyway?”

Source: National Indian Child Welfare Association (NICWA). (n.d.). *Ensuring the seventh generation: A youth suicide prevention toolkit for tribal child welfare programs.* NICWA- National Indian Child Welfare Association. Retrieved from <http://www.nicwa.org/resources/documents/YSPToolkit.pdf>

**Familial Pathways to Early-Onset Suicidal Behavior**

Parent’s suicide attempt

Parent’s mood disorder

Child’s mood disorder

Suboptimal family environment

Abuse and neglect of child

Child’s suicide attempt

Life stressors

Child’s impulsive aggression or neurocognitive deficits

Parent’s impulsive aggression or neurocognitive deficits

Source: Brent, D.A., and Mann, J.J. (2006). Familial pathways to suicidal behavior – Understanding and preventing suicide among adolescents. The New England Journal of Medicine. DOI: 10.1056/NEJMp068195. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMp068195#t=article>

**Please Listen to Me**

Grant is a 13 year old Native American who has been living with his Aunt since he was 5 years old. He recently told his Aunt that he is gay and she wants him removed immediately because she is afraid he will hurt her other children (ages 4 and 6). Grant does not want you (the social worker) to tell his biological parents or other relatives about his sexual orientation in the meeting where they will be deciding where he should go next. Also, he confided that he has been talking with an elder who suspects he is “two-spirited.” Grant’s Aunt wants his parents to know about his sexual orientation and has probably already told them.

Grant is clearly upset when you talk to him. He shares that he has been drinking alcohol often and just doesn’t see the point in going on, as no one really wants him anyway.

1. Identify the risk factors
2. Identify the protective factors
3. Practice asking the questions

**Kicked Out of Foster Home #7**

Justin is a 14 year old, African American, in 9th grade and currently in his 7th foster home placement. He has been in the system since age 4 when his parents’ rights were terminated due to chronic neglect.

Justin does have a maternal grandmother who has had minimal contact with him throughout his young life. She was not appropriate for placement when he was younger, but did see him several times a year.

Justin’s foster home placement changes have occurred because of his behavioral challenges. He has a history of disruptive behavior in the home and at school, school failure, running away, and socially isolating himself (school and home). He has also been a victim of bullying since his early school years. He is currently placed in a foster home with 3 boys (ages 3, 5, and 7), who are the biological children of his foster parents. He has been there for about one year. Justin has recently been diagnosed with major depression and is currently undergoing psychotherapy/group therapy. During one of his sessions he was able to disclose that he is gay and his group and therapist encouraged him to tell his foster family in an effort to gain support. He did tell them.

Now the foster parents are calling you and saying he needs to be out of their home because of their small children. You also learn that Justin has just told them that the world would be a better place without him. You need to meet with him right away.

1. Identify the risk factors
2. Identify the protective factors
3. Practice asking the questions

Suicide Prevention Strategies

1. Assembly-Type Group Suicide Awareness Programs
2. Screening
3. Gatekeeper Training
4. Crisis Center and Hotlines
5. Restrictions of Lethal Means/Alcohol
6. Skills Training
7. Emergency Room Utilization
8. Antidepressants

Source: Mays, D. (2009). Suicide: Risk assessment and risk management (9th, ed.). Premier Publishing and Media.

**Questions to Ask the Child, Family and Team Members**

 **Prediction, Prevention and Planning for a Crisis**

1. Questions to ask when attempting to get information to **predict** crisis?

* What does a crisis look like for this child/youth?
* What are the child’s strengths?
* What can you tell us about any trauma’s the child might have experienced?
* What incidents, situations etc. might precipitate a crisis with this child?
* What situations may have led to a crisis in the past?
* Are there any behaviors that seem out of place?
* Are there any transitions in the near future?
* Is the child on any medications for mental health issues or behaviors?
* What can we do to reduce child and family stressors?
* Do we need to address caretaker, provider, and/or system “crisis”?

2. Questions to ask when attempting to get information to **prevent** crisis?

* What behaviors/issues might be prevented?
* What strengths does the child have that can help in our team planning to prevent crisis?
* What has worked to help reduce the child’s stress or to avoid a conflict?
* What can be done at home, in school or in the community to prevent the behavior and/or lessen its intensity for the child?
* Who can be involved?
* What steps might we take to keep everyone safe and calm?
* Who can be called for support in a preventing a crisis or to help calm the situation?
* What can we do to reduce child and family stressors?

3. Question to ask when creating a collaborative crisis **plan**?

* Is there a crisis plan in place?
* What are the signs of impending crisis? How will we know?
* What is considered “safe” for this child and his environment?
* What things might escalate the child?
* What works to de-escalate the situation? What strengths can be used?
* Who is most helpful and in what environment are they helpful?
* What is not helpful – or might further escalate the child?
* Is there a place the child can safely go to de-escalate? Is there a safe respite place that the child can go? Who will go with him/her?
* How will we know when we need to involve law enforcement?
* How will we know when placement is needed?
* What is the order of interventions? From least intrusive/restrictive to most intrusive/restrictive?
* Is everyone in agreement with the plan??