SUICIDE PREVENTION IN SCHOOLS

(***This publication has been adapted from a document prepared for SUPRE, the World Health Organisation's worldwide initiative for the prevention of suicide***)

Introduction

Suicide is among the top five causes of mortality in the 15 to 19 year old age group worldwide, and in many countries it ranks first or second as a cause of death among both boys and girls in this age group.[1] Suicide prevention among children and adolescents is therefore a high priority and given the fact that most people in this age group attend school, this appears to be an excellent place to develop appropriate preventive action.

The document briefly describes the dimension of suicidal behaviour in adolescence, presents the main protective and risk factors behind this behaviour, and indicates how to identify and manage individuals at risk and also how to act when suicide is attempted or committed in the school community.

Having suicidal thoughts now and then is not abnormal. They are part of the normal development process in childhood and adolescence, as are working on existential problems and trying to understand life, death, and the meaning of life. Young people need to discuss these topics with adults.[2] **Suicidal thoughts become abnormal in children and adolescents when the realisation of those thoughts seems to be the only way out of their difficulties.** There is then a serious risk of attempted suicide or suicide.

Facts about Suicide and Young People in Ireland[3]

Dr John Connolly from the Irish Association of Suicidology has shown a twelve-fold increase in suicide in Ireland in 15 to 34 year olds between 1960 and 2000. The Union of Students in Ireland estimate that 25 persons per year between the ages of 20 and 24 complete suicide.

Recent figures from Childline Ireland show that between 1 April 2004 and 31 March 2005, 1,034 children called the helpline primarily about suicidal thoughts. Childline UK reported callers talking about feeling suicidal over problems including abuse, bullying, stress over exams, and low self-esteem.

Suicide attempts are more frequent than completed attempts, with the estimates of 20 to 40 non-fatal attempts per year. The National Suicidal Foundation Registry showed increased attempted suicide between 1998 and 2000 to be 5.7% in the Midland Health Board, 11.9% in the Mid Western Health Board, 8.5% in the South Eastern Health Board, and 12.5% in the Southern Health Board. One in five of these suicide attempts were repeat acts. Attempted suicide was highest amongst young women of 15 to 19 years of age.

PROTECTIVE FACTORS AGAINST SUICIDE

Major factors that afford protection against suicidal behaviour are:

Family patterns
- good relationships with family members;
- support from family.

Cognitive style and personality
- good social skills;
- confidence in oneself and one's own situation and achievements;
- seeking help when difficulties arise, e.g. in school work:
- seeking advice when important choices must be made;
- openness to other people's experiences and solutions;
- openness to new knowledge.

Cultural and sociodemographic factors
- social integration, e.g. through participation in sport, church associations, clubs and other activities;
- good relationships with schoolmates;
- good relationships with teachers and other adults;
- support from relevant people.

RISK FACTORS AND RISK SITUATIONS

Suicidal behaviour under particular circumstances is more common in certain families than in others, owing to environmental and genetic factors. Analysis shows that all the factors and situations described below are frequently associated with attempted and completed suicide among children and adolescents, but it must be remembered that they are not necessarily present in every case.

Cultural and sociodemographic factors

Low socioeconomic status, poor education and unemployment in the family are risk factors. Immigrants may be assigned to this group, since they often experience not only emotional and linguistic difficulties but also the lack of social networks. In many cases, these factors are combined with the psychological impact of torture, war injuries and isolation. These cultural factors are also linked with low participation in society's customary activities, as well as with conflict between various group values. Specifically, this conflict is a powerful factor for girls born or brought up in a new and freer country, but who retain strong roots in their parents' even stronger traditional culture. Each individual young person's growth is intertwined with collective cultural tradition.

Children and adolescents who lack cultural roots have marked identity problems and lack a model for conflict resolution. In some stressful situations, they may resort to self-destructive behaviour such as a suicide attempt or suicide.[4]

The attributes of gender nonconformity and identity issues relating to sexual orientation are also risk factors for suicidal behaviours. Children and adolescents who are not openly accepted in their culture, by their families and peers, or by their schools and other institutions have serious acceptance problems and lack supportive models for optimum development.

Family pattern and negative life events during childhood

Destructive family patterns and traumatic events in early childhood affect young people's lives thereafter, especially when they have been unable to cope with the trauma.[5]

Aspects of family dysfunction and instability and negative life events often found in suicidal children and adolescents are:

- parental psychopathology[6], with the presence of affective and other psychiatric disorders;
- alcohol and substance abuse, or antisocial behaviour in the family;
- a family history of suicide and suicide attempts;
- a violent and abusive family (including physical and sexual abuse of the child);
- poor care provided by parents/guardians, with poor communication within the family;
- frequent quarrels between parents/guardians, with tension and aggression;
- divorce, separation or death of parents/guardians;
- frequent moves to a different residential area;
- very high or very low expectations on the part of parents/guardians;
- parents'/guardians' inadequate or excessive authority;
- parents'/guardians' lack of time to observe and deal with the child's emotional distress, and a negative emotional environment featuring rejection or neglect;
- family rigidity;[7]
- adoptive or foster family.

These family patterns often, **but by no means always**, characterise cases of children and adolescents who attempt or commit suicide. Evidence suggests that young suicidal people often come from families with more than one problem in which risks are cumulative. **Since they are loyal to their parents and sometimes unwilling, or forbidden, to reveal family secrets, they frequently refrain from seeking help outside the family.**

Cognitive style and personality
The following personality traits are frequently observed during adolescence, but are also associated with the risk of attempted or completed suicide (often in conjunction with mental disorder), so that their utility in predicting suicide is limited:

- unstable mood;
- angry or aggressive behaviour;
- antisocial behaviour;
- acting-out behaviour;
- high impulsivity;
- irritability;
- rigid thinking and coping patterns;
- poor problem-solving ability when difficulties arise;
- an inability to grasp realities;
- a tendency to live in an illusory world;
- fantasies of greatness alternating with feelings of worthlessness;
- a ready sense of disappointment;
- anxiety, particularly at signs of mild physical ailment or minor disappointment;
- self-righteousness;
- feelings of inferiority and uncertainty that may be masked by overt manifestations of superiority, rejection or provocative behaviour towards schoolmates and adults, including parents;
- uncertainty concerning gender identity or sexual orientation;[8]
- ambivalent relationships with parents, other adults and friends.

While there is much interest in the relationships between the extensive array of personality and cognitive factors and risk of suicidal behaviour in young people, the available research evidence for any specific trait is generally sparse and often equivocal.

Psychiatric Disorders
Suicidal behaviour is overrepresented in children and adolescents with the following psychiatric disorders:

Depression
The combination of depressive symptoms and antisocial behaviour has been described as the most common antecedent of teenage suicide.[9, 10] Several surveys have established that up to three-quarters of those who eventually take their own lives show one or more symptoms of depression, and many suffer from a full-blown depressive illness.[11]

School students suffering from depression often present physical symptoms when they seek medical advice.[12] Somatic complaints, such as headache and stomach-ache and also shooting pains in the legs or chest are frequent. Depressed girls have strong tendencies to withdraw and become silent, despondent and inactive. Depressed boys tend, instead, towards disruptive and aggressive behaviour and demand a great deal of attention from their teachers and parents.

Aggressiveness can lead to loneliness, which is in itself a risk factor for suicidal behaviour. Although some depressive symptoms or depressive disorders are common among suicidal children, depression is not a necessary concomitant of either suicidal thoughts or suicide attempts.[13] **Adolescents can kill themselves without being depressed, and they can be depressed without killing themselves**.

Anxiety disorders
Studies have shown a consistent correlation between anxiety disorders and suicide attempts in males, while a weaker association has been found in females. Trait anxiety appears to be relatively independent of depression in its effect on the risk of suicidal behaviour, which suggests that the anxiety of adolescents at risk for suicidal behaviour should be assessed and treated. Psychosomatic symptoms are also often present in young persons tormented by suicidal thoughts.

Alcohol and drug abuse
Abusers of alcohol and illicit drugs are overrepresented among children and adolescents who commit suicide. In this age group, one in four suicidal patients has been found to have consumed alcohol or drugs before the act.[14]

Eating disorders
Owing to dissatisfaction with their bodies, many children and adolescents try to lose weight and are concerned about what they should and should not eat. Between 1% and 2% of teenage girls suffer from either anorexia or bulimia. Anorexic girls very frequently also succumb to depression, and **suicide risk among anorexic girls is 20 times that for young people in general**. Recent findings show that boys, too, can suffer from anorexia and bulimia.[15, 16]

Psychotic disorders
Although few children and adolescents suffer from severe psychiatric disorders such as schizophrenia or manic-depressive disorder, suicide risk is very high in those affected. **Most psychotic young people are, in fact, characterised by several risk factors, such as drinking problems, excessive smoking and drug abuse**.

Previous suicide attempts

A history of single or recurrent suicide attempts, with or without the above-mentioned psychiatric disorders, is an important risk factor for suicidal behaviour.

Current negative life events as triggers of suicidal behaviour

A marked susceptibility to stress, with the cognitive style and personality traits mentioned above (due to inherited genetic factors but also to family patterns and negative life stressors experienced in early life), is usually observed in suicidal children and adolescents.[16] This susceptibility makes it difficult to cope with negative life events adequately, and **suicidal behaviour is therefore often preceded by stressful life events**. They reactivate the sense of helplessness, hopelessness and despair that may bring thoughts of suicide to the surface and lead to attempted suicide or suicide.[17]

Risk situations and events that may trigger suicide attempts or suicide are:

- situations that may be experienced as injurious (without necessarily being so when evaluated objectively): vulnerable children and adolescents may perceive even trivial occurrences as deeply injurious and react with anxiety and chaotic behaviour, while suicidal young people perceive such situations as threats directed against their self image and suffer from a sense of wounded personal dignity;
- family disturbances;
- separation from friends, girl/boyfriends, classmates, etc.;
- death of a loved one or other significant person;
- termination of a love relationship;
- interpersonal conflicts or losses;
- legal or disciplinary problems;
- peer group pressure or self-destructive peer acceptance;
- bullying and victimisation;
- disappointment with school results and failure in studies;
- high demands at school during examination periods;
- unwanted pregnancy, abortion;
- infection with sexually transmitted diseases;
- serious physical illness;

HOW TO IDENTIFY STUDENTS IN DISTRESS AND AT POSSIBLE RISK OF SUICIDE

Identification of distress

Any sudden or dramatic change affecting a child's or adolescent's performance, attendance or behaviour should be taken seriously,[18] such as:

- lack of interest in usual activities;
- an overall decline in grades;
- decrease in effort;
- misconduct in the classroom;
- unexplained or repeated absence or truancy;
- excessive tobacco smoking or drinking, or drug (including cannabis) misuse;
- incidents leading to police involvement and student violence.

These factors help to identify school students at risk of mental and social distress who may have thoughts of suicide that ultimately lead to suicidal behaviour. If any of these signs are identified by a teacher or guidance counsellor, the school team should be alerted and arrangements should be made to carry out a thorough evaluation of the student, since they usually indicate severe distress and the outcome may, in some cases, be suicidal behaviour.[19]

Assessment of suicide risk
When assessing suicide risk, school staff should be aware that problems are always multidimensional.

Previous suicide attempts
A history of previous suicide attempts is one of the most significant risk factors. Young people in distress tend to repeat their acts.

Depression
Another major risk factor is depression. **The diagnosis of depression should be made by a physician or child/adolescent psychiatrist**, but teachers and other school staff should be aware of the variety of symptoms[20] that form part of depressive illness. [21] The difficulty of assessing depression is linked to the fact that the natural transitional stages of adolescence share some features with depression. **Adolescence is a normal state, and during its course such features as low self-esteem, despondency, concentration problems, fatigue and sleep disturbances are common**. These are also common features of depressive illness, but there is no cause for alarm unless they are lasting and increasingly severe. Compared with depressed adults, the young tend to act out, eat and sleep more.

Depressive thoughts may be present normally in adolescence and reflect the normal development process, when the young person is preoccupied with existential issues. The intensity of suicidal thoughts, their depth and duration, the context in which they arise and the impossibility of distracting a child or adolescent from these thoughts (i.e. their persistence) are what distinguishes a healthy young person from one in the throes of a suicidal crisis.

Risk situations
Another important task is to identify environmental situations and negative life events, as outlined previously, that activate suicidal thoughts and thus increase suicide risk.

HOW SHOULD SUICIDAL STUDENTS BE MANAGED AT SCHOOL?

Recognising a young person in distress, who needs help, is not usually much of a problem. Knowing how to react and respond to suicidal children and adolescents is much more difficult. **Some school staff have learnt how to treat distressed and suicidal students with sensitivity and respect, while others do not. The latter group's skills should be improved**. The balance that must be struck in the contact with a suicidal student is one between distance and closeness, and between empathy and respect.

The recognition and management of suicidal crises in students may give rise to conflict in teachers and other school staff since they lack the specific skills required, are short of time, or fear facing their own psychological problems.

General Prevention: before any suicidal act takes place

The most important aspect of any suicide prevention is early recognition of children and adolescents in distress and/or at increased risk of suicide. [22] To achieve this goal, particular emphasis should be laid on the situation of the school staff and students concerned, by the means described below. **Many experts share the view that it is unwise to teach young people about suicide explicitly. Rather, they recommend that issues relating to suicide are replaced by a positive mental health approach.**

Strengthening the mental health of schoolteachers and other school staff [23]

First of all, it is essential to secure the well-being and balance of teachers and other school staff. For them, the workplace may be rejecting, aggressive and sometimes even violent. Therefore they need information material that enhances their understanding and proposes adequate reactions to their own, students' and colleagues' mental strain and possible mental illness. They should also have access to support and, if necessary, treatment.

Strengthening students' self-esteem [24]

Positive self-esteem protects children and adolescents against mental distress and despondency, and enables them to cope adequately with difficult and stressful life situations.[25] To foster positive self-esteem in children and adolescents a variety of techniques can be used.

Some recommended approaches follow:

- Positive life experiences that will help to forge a positive identity[26] in the young should be accentuated. Positive past experiences increase young people's chances of greater future self-confidence.
- Children and adolescents should not be constantly pressured to do more and better.
- It is not enough for adults to say they love the child; the child must feel loved. There is a big difference between being loved and feeling loved.
- Children should not only be accepted, but also cherished, as they are. They must feel special just because they exist.

Whereas sympathy impedes self-esteem, empathy fosters it, because judgement is set aside. Autonomy and mastery are building-blocks in the development of positive self-esteem in early childhood. Children's and adolescents' achievement of self-esteem is dependent on their development of physical, social and vocational skills. For high self-esteem, the teenager needs to establish final independence from family and age mates; be able to relate to the opposite sex; prepare for an occupation for self-support; and establish a workable and meaningful philosophy of life. Introducing training in life skills, first by visiting experts and later as part of the regular curriculum, is an effective strategy. The programme should convey knowledge to peers on how to be supportive and, if necessary, seek adult help. Promoting the stability and continuity of students' schooling is another important aim.

Promoting emotional expression
Children and adolescents should be taught to take their own feelings seriously and encouraged to confide in parents and other adults, such as teachers, school doctors or nurses, friends, sport coaches, and religious advisers.

Preventing bullying and violence at school
Specific skills should be available in the education system to prevent bullying and violence in and around the school premises in order to create a safe environment free of intolerance.

Providing information about care services
The availability of specific services should be ensured by widely publicising the telephone numbers of, for example, crisis and emergency helplines and psychiatric emergency numbers, and making them accessible to young people.

Intervention: when a suicide risk is identified
In most cases, children and adolescents in distress and/or at risk of suicidal behaviour also experience communication problems. **Consequently, it is important to establish a dialogue with a distressed and/or suicidal young person.**

Communication
The first step in suicide prevention is invariably a trustful communication. During the development of the suicidal process, mutual communication between suicidal young people and those around them is crucially important. Lack of communication and the broken network that ensues results in:

- Silence and increased tension in the relationship. The adult's fear of provoking the child or adolescent into committing a suicidal act by discussing his or her suicidal thoughts and messages is often the reason for the silence and absence of dialogue.

- Obvious ambivalence. Understandably, adults' confrontation with a child or adolescent suicidal communication brings their own psychic conflicts to the fore. The psychological strain of an encounter with a distressed and/or suicidal child or adolescent is usually very heavy, and involves a wide range of emotional reactions. In some cases, the unsolved emotional problems of adults who are in contact with suicidal children and adolescents may come to the surface. Such problems may be accentuated among school staff, whose ambivalence - wanting, but simultaneously being unwilling or unable, to help the suicidal student - may result in avoidance of dialogue.

- Direct or indirect aggression. Adults' discomfort is sometimes so great that their ultimate reaction to the child or adolescent who is in distress or suicidal is one of verbal or nonverbal aggression.

- It is important to understand that the teacher is not alone in this communication process, and learning how to achieve good communication is therefore fundamental. **The dialogue should be created in and adapted to each situation**. Dialogue implies, first and foremost, recognition of children's and adolescents' identity and also their need for help.

Children and adolescents in distress or at risk of suicide are often hypersensitive to other people's style of communication most of the time. This is because they have often lacked trustful relationships with their families and peers during their upbringing, and so have experienced an absence of interest, respect or even love. The suicidal student's hypersensitivity is apparent in verbal and non-verbal communication alike. Here, body language plays as large a role as verbal communication. However, adults should not be discouraged by distressed and/or suicidal children's or adolescents' reluctance to speak to them. Instead, they should remember that this attitude of avoidance is often a sign of distrust of adults.

Suicidal children and adolescents also display marked ambivalence about whether to accept or reject help that is offered, and about whether to live or die. This ambivalence has evident repercussions on the suicidal young person's behaviour, which can show rapid changes from help-seeking to rejection and may easily be misinterpreted by others.

Improving school staff's skills
This may be done by means of special training courses aimed at improving communication between distressed and/or suicidal students and their teachers, and enhancing awareness and understanding of suicide risk. Training all school staff in the capacity to talk among themselves and with the students about life and death issues, improving their skills in identifying distress, depression and suicidal behaviour, and increasing their knowledge about available support are crucial means of suicide prevention.

Clear goals and precise limits as defined in manuals on suicide prevention are important tools in this work.

Referral to professionals
A prompt, authoritative and decisive intervention, i.e. taking the suicidal young person to a general practitioner, a child psychiatrist or an emergency department, can be life-saving. To be effective, youth health services need to be perceived as approachable, attractive and non-stigmatising. Distressed and/or suicidal students should be actively and personally referred by school staff, and received by a team composed of **doctors, nurses, social workers and legal representatives whose task is to protect the child's rights**. This active transfer of the student to the health care system prevents her or him from dropping out during the referral process, which might happen if the referral is conducted only by correspondence.

Removing means of suicide from distressed and suicidal children's and adolescents' proximity

Various forms of supervision and removal or locking-up of dangerous medicines, guns, firearms, pesticides, explosives, knives, and so forth in schools, parental homes and other premises are very important life-saving measures. **Since these measures alone are not enough to prevent suicide in the long run, psychological support should be offered at the same time**.

When suicide has been attempted or committed

Informing school staff and schoolmates

Schools need to have emergency plans on how to inform school staff, especially teachers, and also fellow pupils and parents, when suicide has been attempted or committed at school, the aim being to prevent a cluster of suicides. The contagion effect results from suicidal children's and adolescents' tendency to identify with destructive solutions adopted by people who have attempted or committed suicide. Recommendations on how to manage and prevent suicide clusters, developed and promulgated by the *US Centers for Disease Control* in 1994 are now in wide use.[26] It is important to identify all suicidal students, both in the same class and in others. A suicide cluster, however, may involve not just children or adolescents who know one another: even young people who are far removed from or entirely unknown to suicide victims may identify with their behaviour and resort to suicide as a result. Schoolmates, school staff and parents should be properly informed about a student's suicide or attempted suicide and the distress caused by such an act should be worked through.

SUMMARY OF RECOMMENDATIONS

Suicide is not an incomprehensible bolt from the blue: suicidal students give people around them enough warnings and scope to intervene. In suicide prevention work, teachers and other school staff face a challenge of great strategic importance, in which it is fundamental:

- to identify students with personality disturbances and offer them psychological support;
- to forge closer bonds with young people by talking to them and trying to understand and help;
- to alleviate mental distress;
- to be observant of and trained in the early recognition of suicidal communication whether through verbal statements and/or behavioural changes;
- to help less skilful students with their school work;
- to be observant of truancy;
- to destigmatise mental illness and help to eliminate misuse of alcohol and drugs;
- to refer students for treatment of psychiatric disorders and alcohol and drug abuse;
- to restrict students' access to means of suicide - toxic and lethal drugs, pesticides, firearms and other weapons, etc.;
- to give teachers and other school personnel on-the-spot access to means of alleviating their stress at work.

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RESOURCES FOR SUICIDE PREVENTION IN SCHOOLS ***(courtesy of Irish Association of Suicidology)***

Health Service Executive Resource Officers

HSE, North Eastern
Mr. John Maguire
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Seamus Quirke Rd
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HSE, North Western
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HSE, East Coast
Mr. Martin Kane
Suicide Resource Officer
HSE, East Coast Area
Civic Office
Block B
Main Street
Bray
Co. Wicklow
T: 01 2744366
E: martin.kane@maild.hse.ie

Useful Websites

http://www.mhb.ie/mhb/OurServices/SuicidePrevention/
ASIST - *Applied Suicide Intervention Skills Training* – this training aims to help individuals recognise and intervene to assist people at risk of suicide within their work, social, community or family group

http://www.nsbsn.org/
National Suicide Bereavement Support Network

http://www.suicideinfo.ca/
Canadian site - Suicide Information and Education Centre

http://www.ias.ie
Irish Association of Suicidology

http://www.igc.ie
Institute of Guidance Counsellors – working with the Irish Association of Suicidology to develop seminars and workshops on suicide prevention strategies

http://www.education.ie/home/home.jsp?pcategory=33437&ecategory=33450&language=EN
National Educational Psychological Service Agency (NEPS)

http://www.samaritans.org/
Samaritans

http://www.aware.ie/
Aware

http://www.mentalhealthireland.ie
Mental Health Ireland

http://www.irish-counselling.ie/
Irish Association for Counselling and Therapy

http://www.gayswitchboard.ie
Non-judgemental information and support

http://www.sirl.ie/
Schizophrenia Ireland

http://www.sphe.ie/index.htm
Social Personal & Health Education

http://www.healthpromotion.ie/
Health Promotion Department

http://www.insideouted.com.au/
Bully Busters ® is a three pronged program to deal with bullying quickly, effectively and set long term bully management strategies for teachers, parents and children

http://www.reachout.com.au/
Factsheets on issues relevant to young people

http://www.antibullying.net/
Anti-bullying Network Scotland

www.education.unisa.edu.au/bullying
Link to sites providing advice to schools, students and parents throughout the world

http://www.bodywhys.ie/
The Eating Disorders Association of Ireland

http://www.usi.ie/
Union of Students in Ireland

http://www.nco.ie/
National Children's Office

http://www.youthworkireland.ie/
National Youth Federation

http://www.stammeringireland.ie/
Stammering Association of Ireland

Useful Publications

Second Level Student Councils in Ireland: A study of Enablers, Barriers and Supports
National Children's Office

Educational Disadvantage and Early School-Leaving
Combat Poverty Agency

Student Depression in Higher Education Institutions in Ireland
Union of Students in Ireland

The Health of Irish Students
Health Promotion Unit

Living with Loss and Change
Irish Association of Pastoral Care in Education

Young People's Mental Health - A report of the results from the Lifestyle and Coping Survey
The National Suicide Research Foundation