BISHOPS

SUICIDE PREVENTION POLICY

1. PREAMBLE

We know that males are at particular risk of suicide. The provisional results from the ongoing study by the Violence and Injury Mortality Surveillance Initiative, conducted in a sampling of mortuaries in five South African Provinces, and data from the preliminary National Non-natural Mortality Surveillance System (NMSS) indicates that in 1999, 79.2% of suicides in South Africa were male.

Suicidal behaviour may be related to an immediate crisis or may be an inappropriate form of regulating emotions. As such the effective management of cases of depression, para-suicide, self-harm and suicidal ideation can prevent suicide. To this end this policy has been established.

Access to effective counseling, advice and intervention can reduce the likelihood of young people feeling that situations are “out of control” and that they must face them alone. For this reason, the Bishops Support Unit has been established to provide confidential counselling and psychological and emotional support to pupils at Bishops.

Not all suicides are preventable, but a methodical approach to suicide risk assessment and correct management of depressed and suicidal pupils will significantly reduce the morbidity and mortality as a result of suicide among Bishops’ pupils. In addition the stress, to Psychologists, of identifying and correctly managing a potentially suicidal pupil may be reduced with an organized approach. To these ends this policy has been established.

Although errors of judgment (i.e. failure to *accurately* assess suicide potential) are inevitable, errors of omission (i.e. failure to *adequately* assess suicide potential) are preventable if Psychologists take time to perform a thorough suicide risk assessment. This policy thus provides guidelines and procedures to effectively detect, prevent and manage suicidal and self-harming behaviour by pupils at Bishops.

2. DEFINITIONS

Attempted suicide:	A suicidal act with non-fatal outcome.
Para-suicide:	An act of self-harm with a non-fatal outcome.
Self-harm:	Behaviour that causes physical damage to oneself but which is carried out not necessarily with the intention of causing death.
Suicidal act:	Self-infliction of injury with varying degrees of lethal intent which is carried out with an awareness of the intention.
Suicidal ideation:	Thoughts of wanting to be dead or wanting to end one's life.
Suicidal threat:	A verbal or written expression of an intention or willingness to commit suicide.
Suicide:	An act of self-harm which has a fatal outcome.
Bishops:	The Pre-preparatory School, Preparatory School and the College of the Diocesan College.
Staff members:	All individuals employed by Diocesan College. This includes educators, sanatorium staff, housemothers, administrative staff, support staff and stooges.

3. DEPRESSION AND SUICIDE

There is a growing body of evidence to support the existence of mood disorders in children and adolescents. Furthermore we know that depression and anxiety disorders in children and adolescents exist and can be potentially lethal.

In the United States, millions of people under 18 years of age have depression. Research has shown that major depressive disorder and dysthymic disorder are common recurrent conditions in this age group. These disorders are often accompanied by significant psychosocial problems, comorbid conditions, and a high risk of suicide and substance abuse. As such, Bishops has a responsibility to deal with the issue of depression and to this end a policy on the identification and management of depression in pupils at Bishops should be established to support the content of this policy.

4. IDENTIFYING SELF-HARM AND SUICIDAL BEHAVIOUR

Behaviour which indicates a risk of suicide or self-harm include (but are not limited to):

- marked depression
- restlessness
- anxiety
- unusual quietness
- lack of concentration
- odd and unusual staring
- evidence of tearfulness
- recurrent thoughts of death
- self-harm attempts (for example, superficial cuts, cigarette flesh burns and crosses burnt or scratched into the skin)
- withdrawal, disinterest, lack of motivation
- threats of extreme violence
- drawings and writings (such as poetry) with morbid themes
- drop in the quality of schoolwork
- loss of interest in dress sense
- listening to music characterized by depressive lyrics

5. REPORTING SELF-HARM & SUICIDAL BEHAVIOUR

All acts of self-harm, suicidal behaviour, suicide threats and gestures must be taken seriously.

Staff are responsible for reporting any incident of self-harm they observe or are told about, to the Bishops Support Unit (BSU). Furthermore, staff members should immediately notify the BSU if they become aware of a pupil behaving in a way that indicates risk of suicide or self-harm including:

- any form of self-destructive behaviour resulting in physical injury (including those masqueraded as accidents).
- verbal threats of suicide or threats to kill others (which are known to correlate with suicide risk).

If a pupil is identified as a potential suicide risk by any staff member this must be reported to one of the psychologists personally, as a matter of urgency. Notification by email is not sufficient. If a voicemail message is left for a psychologist, receipt of the message must be acknowledged by the psychologist. If the staff member does not receive confirmation of receipt of the voicemail message within a reasonable time they should contact one of the other psychologists – in such circumstances prep school staff should contact a college psychologist and college staff may contact the prep school psychologist.

The psychologists' contact details are as follows:

Peter Farlam	073 156 1120
Carey Upham	076 896 3900
Anne McDonald	072 421 8007

6. ASSESSMENT & MANAGEMENT BY PSYCHOLOGISTS

The BSU is responsible for:

- Acting on the referral on the day it is reported.
- Making contact with the pupil. Making an assessment of the situation and completing the "Suicide risk assessment form" (Appendix A). Recording any suicide or self-harming behaviour.
- Notifying the Principal
- Notifying the pupil's family (and the pupil's House Director if he is a boarder) as soon as possible.
- Recommending appropriate further action to manage the pupil's behaviour.
- With the pupil's permission, notify the Chaplain.

The BSU must respond to the notification of a pupil who is at risk of suicide on the day in which it is reported.

The response must involve an assessment of the pupil's feelings and needs; suicide risk assessment; an evaluation of the pupil's need for psychiatric or psychological referral; effective counseling; and the outlining of a management plan.

Suicide risk factors:

Predicting suicide is difficult and inexact because suicide is a rare event. However, certain factors have been linked to increased suicide risk. Research has shown that the most important variables in assessing risk of suicide are:

- ***Age.*** Adolescents are particularly at risk (especially those between the ages of 15 and 24).
- ***Alcohol dependence and drug use.*** The suicide rate among persons with alcohol dependence is 50 times that of persons without alcohol dependence. As such pupils with substance use and substance abuse issues should be identified as at risk.
- ***History of suicide attempts.*** Any previous acts of para-suicide, especially those that required lifesaving medical intervention, are an indicator of suicide risk. A history of serious suicide attempts may be the best single predictor of suicide; the greatest risk occurs within 3 months of the first attempt (Kaplan and Sadock , 1998).
- ***History of psychiatric illness:*** Research indicates that most persons who commit suicide have a diagnosed psychiatric disorder.
- ***History of a mood disorder***: Depression combined with social isolation and the recent loss of an intimate relationship dramatically increases risk (Kaplan and Sadock, 1998).
- ***Family History of Suicide:*** Suicide is more common among first-degree relatives of suicide victims. As such it is important to ask the pupil about a family history of suicide.
- ***Suicidal ideation and suicidal planning:*** It is important for psychologists to ask about suicidal ideation when a pupil is suspected of having depression. Expressions of hopelessness are a particularly ominous sign, and pupils who admit to an organized plan of action are at increased risk.

- ***Impulsivity and aggression***: A high percentage of individuals who commit suicide have coexisting personality problems, such as impulsivity and aggression. These traits lead to increased risk of self-harm, especially if substance abuse is also present. Recent violent behaviour, independent of alcohol or drug use, has also been identified as a risk factor for suicide.

- ***Physical illness:*** The relationship between physical illness and suicide is significant: post-mortem studies demonstrate physical illness in up to 75% of individuals who commit suicide.

Guidelines for Psychologists when conducting suicide risk assessments:

- Eliciting a depressed pupil's suicidal thoughts requires the use of an open-ended, non-judgmental interview style.

- The notion that asking about suicidal intention can implant a thought into a pupil's mind and hence precipitate suicide is a fallacy. It is the responsibility of the psychologist to raise the issue of suicide in an appropriate way when this is indicated.

- The topic of suicide should be approached by asking the pupil about feelings of hopelessness and despair, such as *"When you're feeling depressed, have you ever felt that there is no hope or that you will never feel better?"* If the answer is yes, ask more direct questions about suicidal thoughts and intent. Pupils who demonstrate active suicidal ideation or passive thoughts of suicide (For example, by saying *"Life doesn't seem worth living")* require a formal suicide risk assessment and the completion of the form attached as Appendix A.

- Encouraging a pupil to spontaneously elaborate on suicidal thoughts may reveal important clues that are useful in risk management. Begin with an empathic, open-ended request; such as *"Tell me about those thoughts. How did you come to feel this way?"*

- Follow up with more specific, closed-ended questions, such as *"How long have you had these thoughts? Do you have a specific plan? Have you told anyone?"* Also inquire about the pupil's reasons for not having attempted suicide, because this may provide valuable information in formulating the management plan.

- Obtaining a history of suicide attempts is crucial; information should include the circumstances in which attempts occurred, whether the

pupil sought help or treatment before an attempt, and the potential lethality of the method. The more serious the attempts, the higher the risk of a future attempt. Carefully explore the circumstances surrounding attempts, such as loss of a relationship.

- Inquire about previous weapon use and acts of violence, including the circumstances.

- Review the pupil's current depressive symptoms, giving special attention to feelings of hopelessness, helplessness, and excessive and inappropriate guilt.

- Listen for statements such as *"My family would be better off without me."*

- Inquire about the pupil's current attitude toward treatment, including lack of response to medication as it relates to the symptom of hopelessness. In addition, asking about current psychosocial stressors (e.g., relationship loss, onset of serious physical illness) may provide clues to the source of suicidal thoughts. If current stressors are similar to those that occurred before previous suicide attempts, the pupil is at significantly increased risk.

- Pupils with altered perceptions of reality, such as those caused by intoxication or psychosis, are at increased risk of suicide. Given the link between suicide and alcohol dependence, it is important to obtain a complete history of alcohol and drug use. Note whether suicidal thoughts occur during intoxication or sobriety, or both.

- The presence of psychotic symptoms in a depressed pupil with suicidal ideation is an ominous sign. Three types of psychotic symptoms are particularly worrisome and could push a pupil to commit suicide:
  - auditory hallucinations commanding suicidal acts,
  - thoughts of external control (feeling that an outside force controls one's actions), and
  - religious preoccupation.

  Pupils may not readily report these symptoms; collateral interviews with family members can help confirm psychosis.

- Evaluation of the pupil's environment is as important as evaluation of the pupil. Inquire about social supports because they may be necessary in planning a safe clinical intervention. For example, a suicidal pupil who is staying alone (for whatever reason) may require

hospitalization, while a pupil with identical risk factors who lives with supportive family members might be safely treated as an outpatient.

- An assessment of the pupil's access to firearms and other weapons is crucial. Family members can assist by removing weapons from the home until the pupil's suicidal thoughts and depression subside.

Initial management:

After assessing a pupil's risk for suicide, psychologists are faced with the important decision of how to best manage the pupil.

It is useful to categorize depressed pupils who are potentially suicidal into three groups:
(1) Pupils with suicidal ideation, plan, and intent,
(2) Pupils with suicidal ideation and plan but without intent, and
(3) Pupils with ideation but no plan or intent.

The following guidelines should be used by psychologists to manage suicidal pupils:

- **Depressed pupils with suicidal ideation, plan, and intent** should be referred urgently to a Child and Adolescent Psychiatrist, especially if the pupil has current psychosocial stressors and access to lethal means. When a pupil's life is in imminent danger, the psychologist should breach confidentiality and contact a family member. Depressed pupils who refuse a referral may be involuntarily hospitalized by the psychiatrist. In these instances the psychologist should discuss the case with the pupil's family and the consultant psychiatrist.

- **Depressed pupils with suicidal ideation and a plan** should be referred for a psychiatric evaluation. In dealing with these cases, Psychologists should err on the side of caution. The psychologist may need to breach confidentiality and inform the pupil's family. The urgency of the referral will depend on the suicide risk and the pupil's social support.

- **Depressed pupils who express suicidal ideation but deny plan or intent** should be evaluated carefully for psychosocial stressors. In general, pupils in this category may be non-urgently referred to the BSU's Clinical Psychologist for assessment and treatment. Even if they deny suicidal plan or intent, depressed pupils with suicidal ideation and psychotic symptoms (e.g., command hallucinations, delusions of control) should be referred to a Child and Adolescent Psychiatrist.

Strategies to prevent self-harm and attempted suicide:

The psychologist should make use of the following strategies to prevent self-harm and suicide:

- **Assessing the pupil's mood:** A complete assessment should be made of the pupil's mood. When it is suspected that the pupil has a mood disorder an appropriate referral should be arranged.
- **Stress support systems:** The psychologist should stress the support systems that are in place and provide the pupil with contact numbers for Life Line and Childline.
- **Explain the management plan:** The psychologist should clearly outline the management plan to the pupil so that the pupil is in no doubt about what procedure is going to be followed.
- **Maintain personal contact:** The most important safety measure to prevent self-harm is the maintenance of personal contact between staff and the vulnerable pupil. As such the psychologist must contract for the pupil to see him on a daily basis. If the pupil does not check-in with the psychologist as arranged, the psychologist should seek the pupil out and make contact with him as a matter of urgency.
- **Written Agreements:** Written agreements may be used with pupils to build their trust and prevent self-harm. These agreements involve listing goals and responsibilities of all parties, including the pupil. Agreements can be signed by the pupil and should be designed to motivate and mobilize their own capacities Although some psychologists use a written "no suicide" contract with clients, such a contract is not a substitute for a thorough risk assessment. Many individuals who sign such a contract later commit suicide. Therefore, the use of these contracts may give psychologists a false sense of security.

Information recorded and reported:

The psychologist should ensure that adequate notes are kept of the referral, interview, assessment and management plan. These notes together with the completed form attached as Appendix A, should be sealed in an envelope marked confidential and placed in the pupil's confidential file. In cases when the pupil is assessed to be at risk of suicide it is advisable for the psychologist's notes to be detailed.

7. STAFF RESPONSIBILITIES

The BSU is responsible for:

1. Reviewing the Bishop's Suicide Prevention Policy on an annual basis.
2. Providing in-service training to heighten staff awareness of suicidal or self-harming indicators and the contents of the Bishop's Suicide Prevention Policy.
3. Running staff refresher courses on suicide prevention.
4. Complying with the protocols outlined in this policy.

Staff are responsible for:

1. Attending refresher courses on suicide and self-harm awareness.
2. Familiarising themselves with:
   - The contents of the Bishop's Suicide Prevention Policy.
   - Factors, crises and events that may predispose or place a pupil at risk of suicide or self-harm
   - The various indicators of suicide risk.
   - Procedures for dealing with incidents of self-harm, para-suicide and suicide risk
   - Their responsibility in dealing with incidents involving self-harm, para suicide and suicide risk.
3. Complying with the protocols outlined in this policy.

APPENDIX A

SUICIDE RISK ASSESSMENT AND MANAGEMENT SCHEDULE

For use when conducting suicide risk assessment interviews

Pupil's name: Age:

Date: Time:

Current suicidal thoughts, intent, and plan:

History of suicide attempts (e.g. lethality of method, circumstances, antecedents, date):

Family history of suicide and depression:

History of violence (e.g., weapon use, circumstances):

Intensity of current depressive symptoms and BDI index:

Current treatment regimen and response:

Recent life stressors:

Alcohol and drug use patterns:

Psychotic symptoms:

Social supports and family situation:

Management plan:

References:

Conner KR, Cox C, Duberstein PR, et al. 2001. *Violence, alcohol, and completed suicide: a case-control study*. American Journal of Psychiatry 2001;158(10):1701-5

Frierson RL, Melikian M, Wadman PC. 2002. *Principles of suicide risk assessment: How to interview depressed pupils and tailor treatment.* VOL 112 / NO 3 / SEPTEMBER 2002 / POSTGRADUATE MEDICINE

Jamison KR. 1999. *Suicide and manic-depressive illness*. In: Jacobs DG, ed. *The Harvard Medical School guide to suicide assessment and intervention.* San Francisco: Jossey-Bass, 1999:255-6

Kroll J. 2000. *Use of no-suicide contracts by psychiatrists in Minnesota*. American Journal of Psychiatry 2000;157(10):1684-6

Kaplan HI, Sadock BJ, eds. 1998 *Kaplan and Sadock's synopsis of psychiatry: behavioral sciences/clinical psychiatry.* 8th ed. Baltimore: Williams & Wilkins.

Mann JJ, Waternaux C, Haas GL, et al. 1999 *Toward a clinical model of suicidal behavior in psychiatric pupils.* American Journal of Psychiatry 1999;156(2):181-9

Milton J, Ferguson B, Mills T. 1999. *Risk assessment and suicide prevention in primary care.* Crisis 1999;20(4):171-7

National Center for Injury Prevention and Control. Fact book for the year 2000: suicide and suicidal behavior. Available at: http://www.cdc.gov/ncipc/pub-res/factbook/suicide.htm.

National Institute of Mental Health. *Suicide facts*. Available at: http://www.nimh.nih.gov/research/suifact.htm.

Patterson WM, Dohn HH, Bird J, et al. 1983. *Evaluation of suicidal patients: the SAD PERSONS scale.* Psychosomatics 1983;24(4):343-9

Shea SC. 1999. *The practical art of suicide assessment: a guide for mental health professionals and substance abuse counselors*. New York: John Wiley, 1999:109-23

Shugart, M; Lopez, E. 2002 *Depression in children and adolescents When "moodiness" merits special attention.* Postgraduate Medicine. VOL 112 / NO 3 / SEPTEMBER 2002

US Public Health Service. *The surgeon general's call to action to prevent suicide. Washington, DC: US Public Health Service, 1999*. Available at: http://www.surgeongeneral.gov/library/calltoaction/calltoaction.htm.

Vassilas CA, Morgan HG. 1993. *General practitioners' contact with victims of suicide.* British Medical Journal 1993;307(6899):300-1