OFFICE OF SUICIDE & VIOLENCE PREVENTION

NOVA SOUTHEASTERN UNIVERSITY
WINTER 2022 NEWSLETTER

Director: Scott Poland, EdD
Post Doctoral Resident: Juliette Hubbard, PsyD

A Closer Look At Suicide In First Responders

In this issue:

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SVP Events & Highlights

The 10th annual Broward County Out of the Darkness Community Walk was on November 10th, 2021. Many SVP members walked to fight suicide. Together, the event raised $79,421.88 to spread the message that suicide is preventable.

Recent & Upcoming Events

- NASP Presentation: Preparing and Conducting Virtual Suicide Risk Assessment and Intervention – Scott Poland, Ed.D., and Richard A. Lieberman, MA.
- S.T.E.P.S. Training for Hillsborough County Public Schools – Scott Poland, Ed.D. and Emily Powell, B.S.
- Suicide Awareness and Prevention presentation for Nova Southeastern University's Audiology Department – Scott Poland, Ed.D.
- Suicide Assessment, Prevention, and Intervention Team-Based Learning Experience for Nova Southeastern University Medical School – Juliette Hubbard, Psy.D.
- Risk Assessment Presentation for Nova Southeastern University's Counseling Department – Juliette Hubbard, Psy.D.
- Parenting in Challenging Times Presentation for North Broward Preparatory School – Scott Poland, Ed.D.
- Parenting in the Age of Covid-19: The Importance of Self-Care Presentation for the City of Pembroke Pines – Scott Poland, Ed.D.
- Parenting in the Covid-19 Age Presentation for the City of Plantation in Partnership with NSU Presents – Scott Poland, Ed.D., and Elizabeth Hilsman, Psy.D.
- Educators Making the Difference for Student in a Challenging World, Keynote address, Florida Council of Independent Schools Winter Symposium hosted by Pine Crest School – Scott Poland, Ed.D.
- Suicide Contagion and Clusters, Training Module for the Jason Foundation – Scott Poland, Ed.D.
- Suicide Prevention in Challenging Times, Training Module for the Jason Foundation – Scott Poland, Ed.D.

Interview with Dr. Jennifer Davitz: First Responders and the Surfside Condo Collapse

By Stevie Schapiro, B.A. and Sitara Rambarran, B.S.

Jennifer Davidtz, Ph.D., is an Associate Professor in the College of Psychology at Nova Southeastern University, where she is also the Director of Internship Training for the Psychology Services Center (PSC), and Director of Psychological Services for the Emotionally Distressed, a specialty clinic within the PSC that serves people with serious mental illness and personality disorders. She also maintains a part-time private practice specializing in the treatment of complex posttraumatic conditions and personality disorders.

The catastrophic collapse of the Champlain Towers South in Surfside, Florida, left ambiguous loss, trauma, grief, and other psychiatric and psychological sequelae in its wake. Now that a few months have passed since the tragedy, which took the lives of 98 residents, it is helpful to examine the psychiatric and psychological support efforts that emerged from volunteers and first responders (Feldman et al., 2021).

What exactly was your role during this traumatic event? (SS)

I became involved through NSU alumni and adjunct professor Dr. Cassondra Feldman, who grew up in Bel Harbor and is familiar with the community. Cassie connected me to Surfside through Cadena, a Mexican based non-profit organization. I had never been part of a mission like this but once Cassie informed me, I was screened due to my interest in trauma, as Cadena only wanted mental health professionals who had crisis and trauma expertise. I then began doing some sessions there, out of the Family Center, during the first few days following the collapse. This was a reunification site where family members and friends were waiting to be reunited with members in the building. Each role on the job served the practical needs to advocate and connect the survivors to the necessary resources, whether that be providing the space to process or connecting to the police about finding relatives, everyone worked together to best serve everyone.

What was this environment like? Tell us more about the team you worked with. (SS)

The atmosphere was a bit chaotic, but we eventually found a rhythm. We partnered with the Israeli Search and Rescue Delegation for searches at 9:30am and 4:30pm every day. The volunteers organized their shifts around these search times as this was when support was needed the most. We also ensured there was 24-hour coverage to support the victims' families and survivors. We were committed to embracing the chaos and situational demands and divided and conquered our work where needed. It was important to emphasize ongoing self-care, consultation, and debriefing while doing this work.

What procedures or debriefing was implemented? (SS)

Cadena provided us with a "Zoom Crisis 101" session for volunteers that was presented by a facilitator in Mexico. This was not mandatory, coordinated, or intentional but very in the moment. The volunteers had a WhatsApp group chat, where the two people who were currently on shift would provide briefings to us about the atmosphere and provide information about the individuals who needed more support like those who just learnt that their family members were not recovered. Our structure naturally came from everyone having basic awareness about what was needed in such a specific circumstance. At this point, the volunteers considered what everyone's basic needs were and how we could attend to these - whether they required emotional support, needed to attend trips to the site with family members or even book hotel rooms for family members who flew in to recover their lost loved ones. Twice-daily briefs held in a centralized location (dubbed the Surfside "family center") and offered structure, order, and predictability. These briefs provided key information on the status of the operation and described the rescue strategy.

What did you notice about the first-responders mentality and behavior when addressing the scene?(SS)

First responders have specific and significant needs; therefore, it requires us to attend to their emotional needs. While we may collude with the cultural tendency to avoid emotion, we need to find a balance between maintaining a healthy distance but encouraging them to connect with their emotions. The role of psychoeducation and activities to express emotions or establishing an outlet for each person is quite salient. There is a need to provide support and a space to communicate for first responders. This experience was incredible because of the profound difference between the American first responders and the Israeli first responders. There is a pronounced disconnect and level of compartmentalization among first responders. I understand there is healthy compartmentalization for daily activities, but it was almost like a dissociative disconnect between emotional aspects of the work that American first responders are doing and the actual mechanics of the work.

There was a culture of "holding it together" and not talking about it. However, there were significant moments where people working the pile (the collapsed rubble of the building) broke down or had scuffles when emotion overcame them. American first responders simply work and don't talk about their experiences, but then there is the possibility that their experiences manifest in symptomatology. The Israeli soldiers had a different approach. When they returned to Israel, they had had 2 weeks of intense psychotherapy to process emotions and the experience of finding bodies at the collapse. They were more connected to their emotions. I would like to see future collaborations and discussions between Israelis and Americans to emphasize what they would learn from each other and what would be helpful to students.

Source:wikimedia commons

How can we prepare clinical psychology students for working with first responders and understanding their specific mental health needs? (SS)

For psychology students, we need to enforce consistency and consider the therapeutic frame regardless of theoretical orientation or therapeutic modality. In this experience, there was a frame even though it wasn't exactly like traditional therapy as we were finding any quiet space possible to provide emotional support for the victims' loved ones. It is important when faced with a situation like this, to understand there will be ambiguity, but attempt to develop a predictable structure where possible (such as time-structured briefings and ensuring volunteers are easily identifiable) and understand people have different reactions to support therefore including cultural and religious considerations.

Naturally, unique complexities came with this tragedy, but having a central location made it possible to offer immediate psychological assistance and support. The team remained flexible and self-regulated when fueled by the desire to help during the response to the crisis that demanded skills to address the suffering, emotional vulnerability, and heightened reactivity of those affected. We all were especially mindful of the word choice used when referring to recovered victims as "souls," rather than "bodies," since it was important for our team to consistently convey sensitivity in our support given to the intensity of anguish, depth of loss, and gravity of the situation.

I collaborated on an article with Dr. Feldman and Col. Elad Edri, Israeli Defense Forces District Commander where we discuss relevant themes and parallels between the psychological intervention/strategies and the first-responder disaster response and the practical utility of implementing an integrated strategy. From this article, it is hoped that a better understanding of these strategies will help future therapists and responders who respond to crises.

What do you think can be done at a wider level to improve the community understanding of the experiences first responders have? (SS)

I think understanding the brevity of a crisis response and all its subcomponents is necessary to comprehend in order to serve the population. Some of these variables include the diverse individuals involved in the crisis as well as unique family dynamics that can affect their personal responses to the crisis. Understanding life before the event and each individual's baseline is crucial to moving forward. This can be done by being cognizant of the greater understanding of the power of "connection". Oftentimes, we can feel like we're floating all alone into this nowhere "land", however, an entire community is present to support those who endured the tragic experiences. After the collapse, civilians did not have secure homes, personal belongings, or even the quiet personal space we all take for granted daily. However, as big of a void as it can be not having physical items; first responders, volunteers, and locals in the area gave and continue to give support to maintain as well as increase personal connections to overcome these several obstacles to find individual purposes in life. Life can be challenging, but at the end of the day our human connections are what carries us through life, united. Understanding the need for identifying remainder connections.

Together the community unified and a team from all different backgrounds collaborated to provide spaces for families to bond and care for one another. After the immediate response concluded, the team felt like a family where authentic connections with those affected and worked together will forever be cherished and in memoriam of those souls lost.

In loving memory of the 98 lives lost
"There are some who bring a light so great to the world, that
even after they have gone, the light remains"

Surfside Strong

Suicide Risk Among Veterans

By Daniela Aracelis Branson, M.S.

In the United States, the military is an all-volunteer force tasked with defending the interests and security of the nation (United States Department of Defense, n.d.). However, military personnel are more than a fighting force. These individuals are often called on to assist in crisis and disaster-relief situations at home and abroad. Research suggests that individuals join the military for several reasons including family, the call to serve, honor, occupational benefits, and the opportunities afforded by becoming a military professional. (Helmus et al., 2018). While many individuals who join report favorable experiences, the unique circumstances faced in the line of duty expose military personnel to an environment where sacrifice and risk are inherent. These experiences continue to affect military veterans, even after they have left active service.

Suicide among military personnel has become a pressing issue in the United States (Logan et al., 2016). Previous research has found that veterans have higher rates of suicide than non-veterans (McCarthy et al., 2015; Wood et al., 2020). Unfortunately, these rates of suicide have only been increasing, and 22 veterans die by suicide each day (U.S Department of Veteran Affairs, 2018). Historically, many held the assumption that the selection process utilized by the military would exclude individuals that were at risk for suicide (Wood et al., 2020). This is because known risk factors (e.g., poor physical health) disqualified individuals from military service (Bruce, 2010). This thought process, which assumes that individuals in the military are healthier, is known as the "Healthy Solider Effect" (Bruce, 2010). Contrary to this assumption, current research has identified specific suicide risk factors associated with veteran population (Ilgen et al., 2010).

Due to the high rates of suicide, it is important for health care workers to understand the risk factors and warning signs which may help predict increased risk of suicide in veterans. For example, veterans are more likely to live in rural areas, a factor which contributes to suicide risk (McCarthy et al., 2012). Across ages and gender, firearms are the most common means of suicide in veteran populations (Kaplan et al., 2009). Additionally, known risk factors such as psychiatric difficulties (e.g., post-traumatic stress disorder [PTSD], and depression) are disproportionately prevalent in veteran populations (Liu et al., 2019; U.S. Department of Veteran Affairs, 2018). Physical injury and traumatic brain injury (TBI) may further contribute to suicide risk in veteran populations (Wood, 2020; Gutierrez et al., 2008). By improving awareness of these factors, individuals that are detected to be most at risk of suicide can be guided to evidence-based interventions, counseling, and therapies (Wood et al., 2020). in those area (McCarthy et al., 2012).

One of the most popular and highly regarded theories of suicide is the Interpersonal Psychological Theory (IPT) proposed by Thomas Joiner (2009). This theory posits that suicide risk is comprised of three distinct factors: thwarted belongness, perceived burdensomeness, and the acquired capacity to enact lethal self-injury. These factors are clearly applicable to veterans in several distinct ways. Rogers et al., (2017) researched the relationship between negative emotions reported by veterans (e.g., anger, self-directed hostility, shame, guilt) and suicide risk using the IPT framework. The study suggested that anger, self-directed hostility, and shame were significantly related to thwarted belongingness, and that these emotional experiences contributed to suicide proneness. Self-directed hostility, shame, and guilt were also significantly related to perceived burdensomeness, further contributing to suicide proneness. Joiner's theory explains the role that physical health problems play among veterans at risk for suicide. It is important to consider physical health because the culture that service members are exposed to is centered on valuing pristine physicality, even though there is a high risk of physical injuries that may affect one's overall physical functioning (Knapik et al., 2013). This creates a difficult and complicated issue because when veterans are dealing with physical health problems, they are not usually likely to seek out counseling for their mental health, the priority for physical health.

Other risk factors may also contribute to thwarted belonginess. The death of a loved one, whether that be friend or family member, has been associated with an increased risk of suicide, especially among veterans (Wood et al., 2020). This may be because the death of a loved one can disrupt of significant relationships (Joiner et al., 2009). Additionally some of the most unique factors associated with military culture include: "…frequent separations and reunions, regular household relocations, living with the missions as a priority, the need for adaptability and conformity, early retirement from career, loss, detachment from mainstream nonmilitary life, advanced security, work that requires travel and adventure, social effects of rank on friends and family, and lack of control on pay, promotion, and other benefits (Soeters et al., 2006).

Physical injury may also contribute to perceived burdensomeness. Physical health problems are more common in veterans than their civilian counterparts (Schult et al.,2019). This Is one of the largest differences identified between veterans and nonveteran who have died by suicide, the presence of physical health problems. The military culture and environment that veterans have served in demands a lot when it comes to physical capability, this same demanding environment involves risk of physical injury and disease (Knapik et al., 2013). The military has its own culture, it requires understanding of rank, grade system, acronyms, the beliefs, fears, goals, complications, as well as the spoken and unspoken assumptions (Hall, 2011). The expectation to be at peak physical performance in a role with a high rate of physical health problems may affect mental health and self-image (Joiner et al., 2009). Additionally, injuries can affect physical performance and functioning. Brenner et al., (2009) found that veterans who had experienced a traumatic brain injury frequently discussed themes related to loss of self, a decreased sense of masculinity, and an increased sense of burdensomeness.

According to Joiner's theory, experiencing or witnessing physical injury may also contribute to the acquired capacity to enact lethal self-injury, which is attained through repeated exposure to painful or provocative experience. According to this theory, experiences in combat situation such as witnessing, experiencing, or engaging in violence is one mechanism through which individuals may habituate to painful experiences. Unfortunately, the connection between the physical and mental/emotional health is often not recognized or acknowledged in military training or active-duty environments. The absence of counseling or therapy when dealing with physical health problems can lead to an increased risk for suicide and/or mental health consequences (Levine et al., 2016).

Source: pxhere.com:

The described risk factors, in conjunction with Joiner's model, provide important considerations for assessment and intervention. Given the risks associated with physical health problems and psychiatric disorders, many VA protocols include a general anxiety and depression survey to screen for any issues that would prompt a recommendation for further mental health services (Seal et al., 2008). In the event that a veteran has lost a loved one, counselors are recommended to examine the events surrounding the death of loved ones, as more recent deaths and those that had a great impact of a veteran are associated with a higher risk of suicide (Bryan & Rudd, 2018, Joiner et al., 2009; Wood et al., 2020).

Suicide notes (i.e., final statements of life, explanations, and/or goodbyes in any written or recorded form) are only left by a small percentage of those that die by suicide (Cerel et al., 2014). However, previous research has suggested that veteran men who die by suicide have a higher likelihood of leaving a suicide note than non-veteran men (Wood et al., 2020). Having a specific plan for suicide, writing a note, and having experience from previous suicide attempts can contribute to an increased capability for suicide (Joiner et al., 2009). Counselors, psychologists, social workers, and mental healthcare professionals are recommended to assess whether a veteran intends to write a suicide note or has one ready. Additionally, researchers have suggested practitioners ask specific questions about someone's plan for suicide, particularly about the method, place, time, and prep (Bryan & Rudd, 2018). Because of the high rates of firearm usage, it may be beneficial for clinicians to screen for gun access, increase firearm in VA facilities, and encourage safe storage outside of the VA (e.g., encourage individuals to store firearms, unloaded, in a locked case or safe) (Kaplan et al., 2009).

In the past decade, risk factors distinctive in veteran populations have been integrated into countless clinical treatments, thus improving the effectiveness in reducing suicide risk in military personnel and veterans (Huh et al., 2018; Bryan & Rudd, 2018). The department of defense and veteran associations have highlighted some informed approaches to suicide intervention such as group therapy. Group therapy is believed to hold the potential to lower thwarted belongingness among at risk veterans by highlighting togetherness (Johnson et al., 2014).

When it comes to veterans, the lens of suicide risk, assessment, and intervention has distinct factors. It requires an understanding of the unique experience and perspective that being in military service provides. Veterans have experienced deployments, rigorous training, family relocations, mission-oriented actions and thought processes, authoritarian leadership, and more (Soeters et al., 2006). By considering the experiences of veterans, screening and referral programs can improve greatly, and individuals which may have gone undetected may be saved (Stanley et al., 2015).

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VETERANS CRISIS LINE

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DIRECTOR- MATTHEW CHENWORTH

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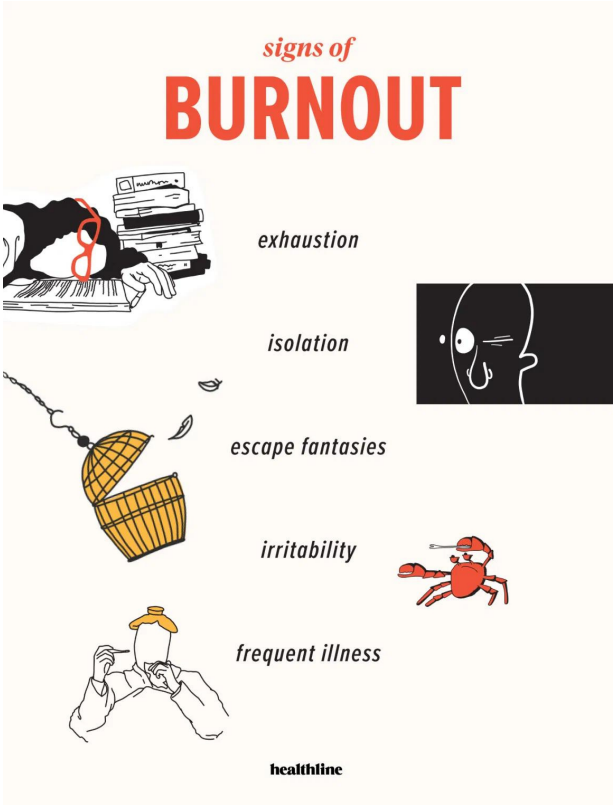
EMAIL- VRC@NOVA.EDU

NOT A CRISIS RESOURCE

Burnout in First Responders

By Christina Castellana, B.S.

Disasters can take many forms, often endangering the health and safety of individuals and communities. These events demand quick responses from individuals with specialized training, known as first responders. First responders include law enforcement officers, firefighters, emergency medical technicians, and 911 dispatchers. Individuals who are part of an emergency response team, may find themselves exposed to traumatic incidents or experiences – this includes any incident that may involve exposure to catastrophic events, severely injured individuals, dead bodies, or even the loss of colleagues (National Institute of Occupational Safety and Health, 2002). These jobs are highly demanding and, as such, first responders are at an increased risk for burnout.

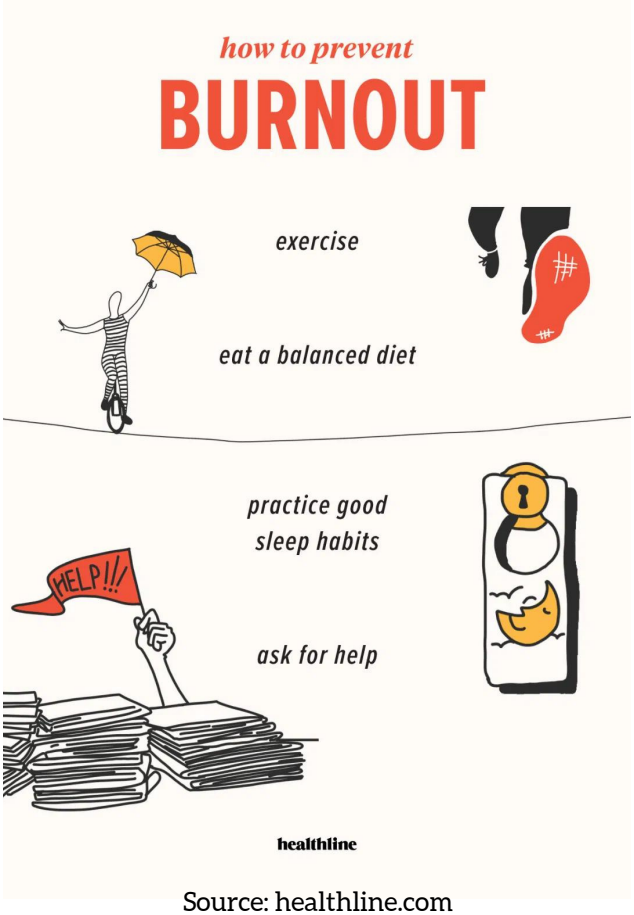


Source: healthline.com.

The term "burnout" was created by psychologist Herbert Freudenberger in the 1970s. He used "burnout" to describe the consequences of severe stress and high standards in "helping" professions. Today, burnout can affect anyone, from overworked employees to celebrities (InformedHealth.org, 2020). There are three main symptoms that are signs of burnout: exhaustion, alienation from work-related activities, and reduced performance. Those affected by burnout may feel drained, emotionally exhausted, unable to cope, tired and lacking energy. Physical symptoms include pain and gastrointestinal problems. Those who have burnout find their jobs increasingly stressful and frustrating. They may start to be cynical about their working conditions and their colleagues. Those who have burnout may also distance themselves emotionally and start feeling numb about their work (InformedHealth.org, 2020).

First responders are considered a high-risk occupational group, as their exposure to critical incidents and chronic stressors are linked to high prevalence rates of adverse health outcomes. There are concerns about repeated exposure to stressful stimuli that can overwhelm the body and eventually lead to psychological distress. First responders are at an increased risk for developing acute stress, depression, and suicide (Tal, 2021). Studies show that burnout seems to be associated with increased likelihood of subsequent suicidal ideation, whereas recovery from burnout is associated with less suicidal ideation (Dyrbye et al., 2008).

Several interventions may be effective in preventing burnout in first responders. Social support is related to well-being for those who are under stressful situations. Interventions aimed at increasing the perception of social support, such as providing staff support services, may facilitate psychological well-being in emergency personnel (Setti et al., 2016). Furthermore, psychological resilience may improve positive adaptation to stress. It has been identified as a protective factor against the negative impact of burnout in high-stress populations, like first responders. Resilience-enhancing interventions improve the capacity for adapting to stress and adversity and improving health outcomes, including burnout, in high-stress populations (Kaplan et al., 2017). Mindfulness training (MT) has been shown to increase psychological resilience in high-stress populations.



Source: healthline.com

Mindfulness-Based Resilience Training (MBRT) is a preventative intervention tailored for first responders to reduce negative health outcomes, such as burnout (Kaplan et al. (2017) reported that increased mindfulness was significantly indirectly related to increased resilience and reduced burnout. These findings also lend support to psychological resilience as a mechanism of change in MT with first responders (Kaplan et al., 2017). These findings provide important considerations for practitioners treating first responders.

First responders are asked to take action in high stress situations and may find themselves exposed to traumatic incidents. Consequently, they are at high risk for burnout related to occupational stress. While the primary symptoms of burnout are not life threatening, burnout may represent an additional risk factor for suicidal ideation in first responders. Mental health workers and other health practitioners should be aware of the risk conferred by burnout, and explore interventions aimed at increasing support and resilience. Awareness, prevention, and prompt intervention are critical in ensuring beneficial outcomes for this at-risk population.

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Suicide in Firefighters: Risk Factors, Warning Signs, and Prevention

By: Stephanie Talavera, B.S.

As of 2020, firefighters held about 317,200 jobs in the United States. Firefighters are essential emergency service workers who ensure public health and safety. While they are extensively trained in controlling and putting out fires, firefighters are also responsible for finding and rescuing individuals in dangerous situations, treating sick or injured people, and responding to other emergencies involving life, property, or the environment. (U.S. Bureau of Labor Statistics, n.d.). As part of this work, firefighters are often exposed to dangerous situations such as collapsing buildings and overexposure to smoke and flames.

Source: pixabay.com

Their work schedule is also highly demanding. Firefighters may work 24-hour shifts on duty followed by 48 or 72 hours off duty. When working with more challenging situations, they may work for extended periods (U.S. Bureau of Labor Statistics, n.d.).

Firefighter Suicide

Firefighters are at increased risk for suicide as compared to the general population. One study conducted in 2015 found that 46.8% of firefighters within the sample reported suicidal ideation, 19.2% reported suicide plans, and 15.5% reported a suicide attempt. This is a significant increase when comparing to the general populations' percentages of 5.6-14.3% for suicidal ideation, 3.9% for suicide plans, and 0.4-2.4% for suicide attempts (Stanley, et al., 2015; Martin, et al., 2017). There are also some challenges that currently exist when researching firefighter suicides. There is no formal national tracking database, whichmakes it difficult to get accurate information, and websites such as the Firefighter Behavioral Health Alliance rely solely on family and friend accounts of suicides (Henderson, Van Hasselt, LeDuc, & Couwels, 2016).However, despite these limitations several key factors have been associated with increased risk in firefighters.

There was little research done before 9/11 examining the effects of PTSD on firefighters. After 9/11, there have been increased efforts in examining trauma exposure in first responders and raising awareness. Due to the nature of their career firefighters and other disaster workers are often exposed to traumatic incidents. These include exposure to physical danger, assisting survivors, or working with the dead. Research has shown that disaster workers exposed to these incidents show higher rates of depression, acute stress disorder, and posttraumatic stress disorder (PTSD) (Fullerton, et al., 2004). Severity of depression and PTSD have both been associated with increased risk of suicidality. Furthermore, Vargas de Barros et al., (2013) found that symptoms endorsed by firefighters experiencing PTSD include sleep disturbance, increased a.lcohol use, and rumination.Furthermore, this study found an association between suicidal ideation, unhealthy alcohol use, and sleep disturbance.

Given these findings, it is clear that health practitioners serving firefighters must find way to strengthen protective factors and remediate risk. Engaging and strengthening social support networks may be important in reducing suicide risk in firefighters as research suggests that social support is a protective factor, particularly when occupational stress is high (Carpenter et al., 2015). Furthermore, some research as found that over half of surveyed firefighters prefer to seek assistance from informal support networks such as family and friends (Gulliver et al., 2019). While improving existing support networks is important, encouraging firefighters to use mental health services also represents an important avenue for mitigating risk. Firefighters show relatively high rates of using mental health services. Approximately 63% of those seeking services received help from a psychologist, therapist, or counselor (Hom et al., 2016). However, those who did not seek services reported stigma related barriers to care including concerns about embarrassment and fear of harming their reputation.

Finding effective and acceptable intervention strategies will be key for this population. Mindfulness interventions have shown promise in reducing symptoms of PTSD, depression, alcohol misuse and physical symptoms (Smith et al., 2011), while psychoeducation for friends and family members may help to bolster informal support networks (Johnson et al., 2020),

Overall, existing research emphasizes the high levels of suicide risk experienced by firefighters and highlights the importance of effective support and treatment. The services provided by firefighters are essential in maintaining the health and safety of communities. Reciprocally, friends, family, and health workers play a key role in ensuring the health and safety of firefighters. By increasing knowledge of specific risk factors, barriers to treatment, and effective interventions health care practitioners can help decrease the risk of suicide for this at-risk population.

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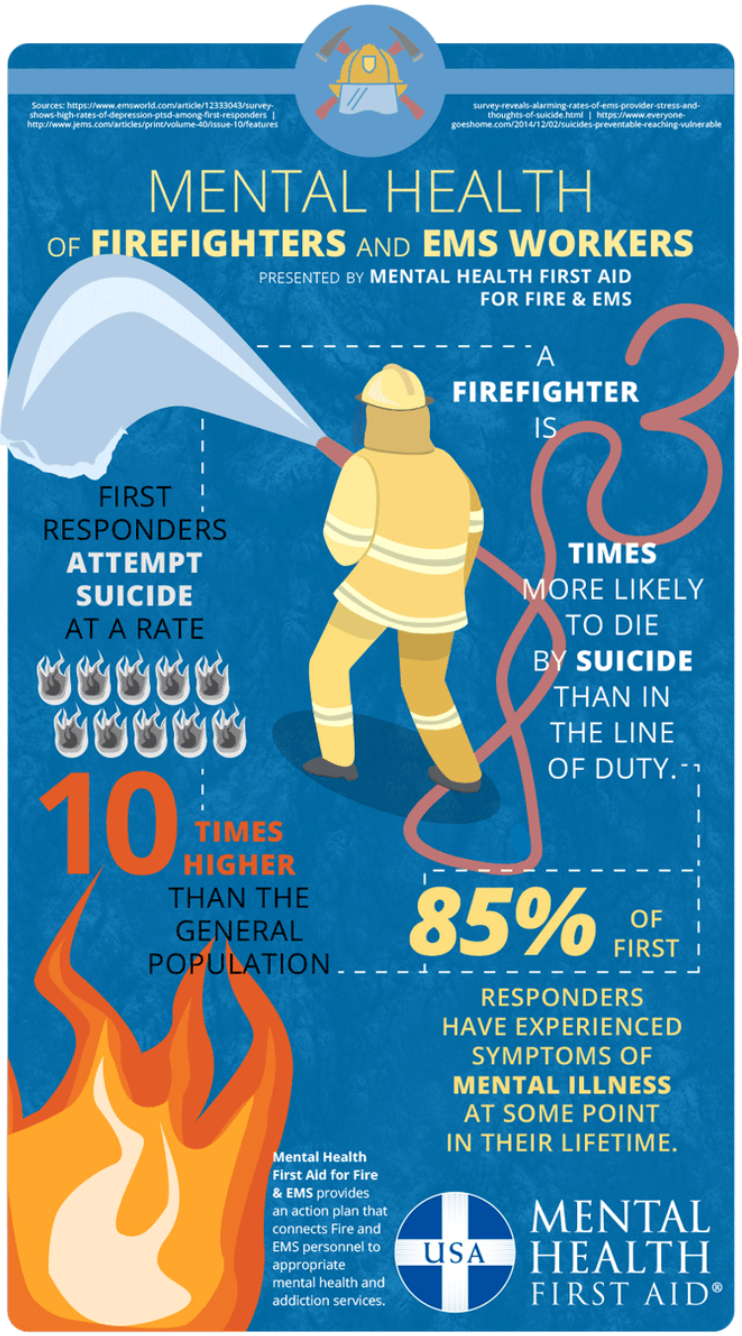

(National Counsel for Mental Wellbeing)

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SVP Newsletter Contributors

Scott Poland, Ed.D., Director
Juliette Hubbard, Psy.D., Editor, Post Doctoral Resident
Christina Castellana, B.S., Graduate Assistant
Katlyn Bagarella, B.A., Graduate Assistant
Stevie Schapiro, B.A., Psychology Trainee
Sitara Rambarran, B.S., Psychology Trainee
Daniela Aracelis Branson, M.S., Psychology Trainee
Stephanie Talavera, B.S., Psychology Trainee

Suicide & Violence Prevention Resources

Center for Student Counseling and Well-Being
954-424-6911 (available 24/7)
www.nova.edu/healthcare/student-services/student-counseling.html

NSU Wellness
(mental health services for NSU employees)
1-877-398-5816; TTY: 800-338-2039
www.nova.edu/hr/index.html

National Suicide Prevention Lifeline
1-800-273-TALK (8255) or 1-800-SUICIDE
www.suicidepreventionlifeline.org
Veterans: Press "1" or Text 838255
Chat:
www.suicidepreventionlifeline.org/chat
TTY: 1-800-799-4889

Crisis Text Line
Text: "Home" to 741741
Mobile Crisis Response Teams
(for on-site crisis assessment)
Broward (Henderson): 954-463-0911
Palm Beach: North: 561-383-5777
South: 561-637-2102
Miami-Dade (Miami Behavioral): 305-774-3627

Broward 2-1-1 Help Line
2-1-1 or 954-537-0211
211-broward.org
Chat:
https://secure5.revation.com/211FirstCallfor He lp/contact.html

Palm Beach 2-1-1 Help Line
2-1-1 or 561-383-1111 or 211Palmbeach.org

Jewish Community Services of South Florida
305-358-HELP (4357); 305-644-9449 (TTY)
www.jcsfl.org/programs/contact-center/

Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locators
www.samhsa.gov/find-help

The Jed Foundation (JED)
www.jedfoundation.org Suicide

Prevention Resource Center
www.sprc.org

Suicide Awareness Voices of Education
www.save.org

The Depression Center
www.depressioncenter.net

Yellow Ribbon International
www.yellowribbon.org

Florida Initiative for Suicide Prevention
www.fisponline.org

Florida Suicide Prevention Coalition
www.floridasuicideprevention.org

National Center for Injury Prevention and Control
www.cdc.gov/ncipc/dvp/suicide

American Association of Suicidology
www.suicidology.org

American Association for Suicide Prevention
www.afsp.org

Florida Department of Children and Families: Suicide Prevention
www.myflfamilies.com/service-programs/mental- health/suicide-prevention