

# OFFICE OF SUICIDE & VIOLENCE PREVENTION

NOVA SOUTHEASTERN UNIVERSITY

## Quarterly Newsletter

### *The Myriad Ways Available for Assessing and Preventing Suicide*

In this issue:	Page
Education and Training for Parents, Local Series .....	1
Overview of Crisis Action School Toolkit-Suicide (CAST-S) .....	2
Bullying and Suicide Revisited: What schools can do now .....	3
Suicide Prevention Legislation: What School Psychologists Need to Know and DO! .....	5
Technology in Suicide Prevention.....	8
Interview with David Jobes, Ph.D. ....	9

### IMPORTANT DAY FOR PUBLIC POLICY ADVOCACY

Sponsored by the American Foundation for Suicide Prevention (AFSP; [afsp.org](http://afsp.org)), February 21, 2018 is "Florida Day at the Capitol." AFSP Capitol Days are an opportunity for constituents to meet one-on-one with legislators and discuss suicide prevention and personal anecdotes as to the importance. Additional activities are planned for participants. Other states have Capitol Days, including IN, UT, TN, ID, MO, MA, NE, LA, & NY.

## EDUCATION AND TRAINING FOR PARENTS OF SCHOOL-AGED CHILDREN

### Local Series: Pembroke Pines, Florida

Over the past few months, the NSU Office of Suicide and Violence Prevention (SVP) has been working with the City of Pembroke Pines to provide education and training to parents of school-aged children. In November, Principal Mike Cas-tellano invited Dr. Dave Cox to speak to a group of 130 parents at Pembroke Pines Charter West Campus. The two-hour event focused on how parents can recognize stress and early warning signs in their children as well as common symptoms of mood and anxiety disorders that often manifest beginning in middle school. The discussion additionally focused on concrete suggestions and

### UPCOMING LOCAL PRESENTATION:

On March 12, 2018, the City of Pembroke Pines will host an evening event for parents, grand-parents, educators, youth advocates, and any other interested individuals. Dr. Poland will present on the topic of Raising Positive Children: Helping Your Child Cope with Stress in Today's Challenging World.

The event will be held at the Charles F. Dodge City Center. Parking and admission are free.

More information about the event can be found by calling 954-450-1030.

recommendations for parents – how to talk to their children, how to teach and reinforce positive co-ping skills, and how to respond and support when their children face difficulties.

Following the presentation, Dr. Scott Poland and Dr. Cox were invited by Pembroke Pines City Commissioner, Iris Siple, to attend the January Principal's Round-table. Dr. Poland provided information and research

about suicide and violence in schools and what school administration can do to protect their students. The principals, vice principals, and other school administrators in attendance shared their experiences, specific challenges their schools have faced, and the approaches they have used in the past. Over the course of the meeting, it became clear that there is a continued need for, and interest in,

training and education, especially as it relates to identifying and responding to the stresses of school-aged children.



## OVERVIEW OF CRISIS ACTION SCHOOL TOOLKIT-SUICIDE

Dr. Scott Poland and his wife Dr. Donna Poland, a former school principal, have recently completed the Crisis Action School Toolkit-Suicide (CAST-S) for the state of Montana. The CAST-S is designed to help all Montana schools implement the 2017 legislation that requires schools to have a suicide response plan. Unfortunately, Montana has consistently been rated as a top-five state for suicides and they face many challenges due to rural area and isolation, a shortage of mental health facilities, stigma attached to seeking mental health services, many guns that are not safely stored, and the unique needs of 11 Native American tribes.

The CAST-S is based on the Polands' collective 60+ years of working in schools. They interviewed many professionals in Montana and worked closely with the Suicide Prevention Coordinator for the state,

the Montana Office of Public Instruction, the School Administrators Association of Montana, the National Alliance of Mental Illness for Montana and the Big Sky Psychiatry Council. The Toolkit is arranged in four sections: Introduction, Prevention, Intervention and Postvention. The Toolkit provides 32 tools for educators to use and many reusable forms. Scott Poland met with Montana School Psychology leaders at the recent NASP conference (Feb.) and they reported that the CAST-S was a true gift to their state. Scott Poland has been writing about, and working on, suicide prevention in schools since the 1980's and the CAST-S is the culmination of his extensive experience. Although the CAST-S is tailored for Montana, the information is valuable for all schools. The CAST-S can be accessed at the following sites:

NAMI: [www.namimt.org](http://www.namimt.org)  
 Big Sky Regional Counsel of Child & Adolescent Psychiatry:  
[www.bigskyaacap.org/cast-s.html](http://www.bigskyaacap.org/cast-s.html)



## BULLYING AND SUICIDE REVISITED: WHAT SCHOOLS CAN DO NOW

### Scott Poland and Richard Lieberman

The research is clear on youth suicide: Mental illness plays a significant role. Suicide is most often the result of untreated or undertreated mental illness, and when certain disorders coexist in youth, particularly depression and impulse disorders (such as alcohol and substance abuse, non-suicidal self-injury, or conduct disorder), the risk for suicidal ideation and attempts increases dramatically. Adverse childhood experiences can play a role, and these include living of poverty; neglect, physical abuse, sexual abuse, and emotional abuse; and living with a mentally ill or substance abusing family member. Precipitating events can ignite the fuel of mental illness, particularly those involving loss such as a romantic loss, a death by suicide, or a loss of dignity. Situational stressors can play a role, such as an academic or disciplinary crisis at school or an argument with a parent at home. If a perfect storm begins to mount, the presence of a firearm can have traumatic consequences. In short, suicide is complex, and in the aftermath of suicide, no one person, and no one thing, is ever to blame.

#### **Bullying and Suicide**

The research on bullying is also quite clear. Bullying is predatory and antagonistic behavior that contri-

butes to the silent misery of millions of students and puts some at increased risk for suicidal thoughts and behaviors. Bullying is harmful to all children, of all ages and cultures. (Lieberman & Cowan, 2011).



Involvement in bullying creates barriers to learning and is associated with a host of negative outcomes, including increased risk of substance abuse, delinquency, suicide, truancy, mental health problems, physical injury, and decreased academic performance (Rossen & Cowan, 2012). Victims of cyberbullying are also at greater risk for depression. The individual at highest risk for suicidal ideation and behaviors is the youth who has been both the perpetrator and the victim, and risk is increased dramatically if there has been preexisting psycho-pathology. The Suicide Prevention Resource Center (SPRC) published a brief on suicide and bullying that reviewed more than 40 research studies. The brief concludes that there is a strong association between bullying and suicide; however, no causal relationships were found in the research, as it is extremely difficult to rule out the myriad of the factors

with regard to mental illness and adverse childhood experiences (SPRC, 2011).

A more causal relationship between bullying and suicide has been both implied and fostered in the media. This year's *13 Reasons Why*, violating every known tenet of safe messaging, depicted suicide as a likely outcome of bullying and as a way of getting back at others. Suicide is not about revenge because the suicidal youth is not thinking about others but, instead, wants to end un-endurable pain. People magazine ran a cover story about Phoebe Prince under the dramatic banner, "Bullied to Death" (People, April, 2010) giving millions of young readers who identified with Phoebe an option. Sadly, this narrative, crystalized by the term *bullycide*, has led to numerous lawsuits against schools.

#### **Litigation and Schools**

A number of school districts have been sued, as parents claimed that the bullying their child received at school was a proximal cause to the suicide of their child. We have followed all of these cases closely, and have been involved in many, and we offer the following general reflections. Schools must take any report of bullying very seriously, provide consequences for the bully, support for the victim, and above all,

document all actions. Parents in these lawsuits have not produced significant documentation of their notification to schools that their child was being bullied. Issues in these lawsuits have focused on “in loco parentis” and whether or not a special relationship exists between schools and students. Another key term is deliberate in-difference, and one attorney for a plaintiff, when asked the meaning of the term, responded that you have to prove “they just did not give a darn.” No school district to date has been found liable in court for a student suicide related to the school’s failure to intervene to stop bullying. For example, *Myers v Blue Springs, Missouri schools* (2012) was settled out of court; *Lance v Lewisville, Texas I.S.D* (2014). was decided by the U.S. 5th Circuit Court in favor of the school district; and *Patton v Bickford and the Floyd County Schools* (2012) was decided by the Kentucky Supreme Court in favor of the district. It is note-worthy to add that these cases call into question the policies developed, implemented, and documented by district personnel and the training provided to faculty and staff on bullying and suicide prevention.

It is important that schools across the nation take proactive steps to increase their know-ledge and implement bullying and suicide prevention pro-grams. Every school district is encouraged to form a task

force that includes administration, mental health, parent, and student input. The task force will be most effective when it links with community and regional resources. The following are recommendations that educators can implement to enhance their prevention efforts.

### **Bullying Prevention**

- Implement a school-wide program where all staff cooperates toward the common goal of reducing bullying.
- Survey students to determine the extent and nature of the problem and to solicit student recommendations to reduce bullying.
- Recognize that lesbian, gay, bisexual, and transgender youth attempt and die by suicide approximately four times more often than their heterosexual peers, and the greatest protective factor for these student is parental acceptance. Excellent resources are available from the Gay Lesbian Straight Education Network ([www.glsen.org](http://www.glsen.org)).
- Implement a Gay–Straight Alliance program at your school.
- Implement programs designed to reach bystanders and to gain a commitment from them to take action to stop the bullying instead of standing by and allowing bullying to take place. Bystanders need to be trained to provide emotional support for the victim.
- Involve parents and provide training, especially on reducing cyberbullying and taking charge of their child’s technology and social media.
- Teach digital citizenship to all students beginning in primary grades.
- Teach staff to recognize bullying and to take im-mediate action to stop bullying when it occurs.

Ensure that staff members do not try to make the bully and victim work it out. The bully and victim should be separated and the bully given consequences and the victim given support.

- Staff needs to let the bully know that they and other staff will be watching and consequences will increase in severity if the bullying continues.
- The victim needs to know the importance of letting staff know if bullying continues.
- Increase staff supervision in areas where bullying occurs the most.
- For more in-depth information, review evidence-based bullying prevention programs listed on the U.S. Department of Education website (<https://www.stopbullying.gov>)

### **Suicide Prevention**

- Ensure that your school has a comprehensive suicide prevention policy that mandates annual training for all staff on the warning signs of suicide; the referral process and the importance of working as a team; maintaining supervision; and the mandate to report suicidal behavior. The plan should also provide training on suicide assessment and safety planning for key school mental health personnel, including school psychologists, nurses, counselors, and social workers.
- Policies should be developed to ensure that suicidal students are properly supervised and that their parents are notified in a timely fashion. Parents need to sign a form provided by the school that documents notification of their child’s suicidal behavior.
- Schools must be familiar with community resources and any specific interventions available in their state for involuntary hospitalization. Reentry meetings

- must be held at school for students who return to school after mental health hospitalization.
- Review and document that your school has met the suicide prevention requirements for schools in your state.
- Provide mental health presentations for parents that include suicide prevention information.
- Provide information on the district website about the warning signs of depression and suicide that includes information about who to contact if they are concerned about suicidal behavior.
- Provide local, state, and national crisis hotline numbers and text lines that can be accessed by either parents or students on the district website.
- Create a suicide prevention task force that involves both school staff and community resources and agencies.
- Implement the secondary depression screening program Signs of Suicide (SOS) which is listed by SAMHSA on the National Registry of Effective Prevention Programs (NREPP). For more information about SOS, visit [mentalhealthscreening.org](http://mentalhealthscreening.org)
- Designate a suicide prevention expert at your school and have them credentialed in school suicide prevention from the American Association of Suicidology ([www.suicidology.org](http://www.suicidology.org)).
- There is a critical need to develop universal suicide prevention programs for elementary students. One promising program for fifth graders is Riding the Waves (<https://crisisclinic.org/education/community-training-opportunities/school-curriculum>).

**References**

Estate of Montana Lance, et al., vs. Lewisville Independent School District, 743 F.3d 982, 995–96 (US 5th Cir. 2014).  
 Estate of Stephen Patton, et al., vs. Bickford et al., Floyd County School District, No. 2012–CA–000598–MR (Ky. 2013).  
 Lieberman, R., & Cowan, K. (2011). Bullying and youth suicide: Breaking the connection. *Principal Leadership*, 12 (2), 12–17.  
 Myers vs Blue Springs School District et al., No. 10-00081-CV-W-BP (US 8th Cir. 2012)  
 Rossen, E., & Cowan, K. C. (2012). A framework for school-wide bullying prevention and safety [Brief]. Bethesda, MD: National Association of School Psychologists.  
 Suicide Prevention Resource Center. (2011). Suicide and bullying: Issue brief. Retrieved from [http://www.sprc.org/sites/default/files/migrate/library/Suicide\\_Bullying\\_Issue\\_Brief.pdf](http://www.sprc.org/sites/default/files/migrate/library/Suicide_Bullying_Issue_Brief.pdf)

**Resources**

Stop bullying (<https://www.stopbullying.gov>)  
 The Jason Foundation ([www.jasonfoundation.com](http://www.jasonfoundation.com))

## SUICIDE PREVENTION LEGISLATION: WHAT SCHOOL PSYCHOLOGISTS NEED TO KNOW AND DO!

### Richard Lieberman and Scott Poland

Suicide is a leading, preventable cause of death for youth aged 10-24 in our nation and we are saddened to report rates have increased slowly, but steadily since 2007. The rate of increase recorded between 2014 and 2015 for the 15-19-year-olds was the largest jump in the past decade (from 11.6 per 100,000 to 12.5) and the rate for 10-14-year-olds doubled during that 10-year span. While this data highlights a serious public health problem, we know

that suicide is preventable. Since 2007, over 30 states have enacted legislation that either recommend or mandate their school districts to train all personnel and have comprehensive suicide prevention policies and procedures. In a recent national webinar, the authors conducted a brief poll of thousands of participants and less than half were aware of any current legislation in their state.

## History

Suicide prevention legislation, that survives the arduous process to be successfully enacted, has been accomplished through the passionate voices and unrelenting efforts of suicide survivors. Such was the voice of Clark Flatt, a survivor of his son's suicide, who dedicated his life and fortune to establish the Jason Foundation (JF) of Tennessee. JF has been the driving force behind the Jason Flatt Act (JFA), first adopted in Tennessee now the law in 19 states (see Table 1). The JFA requires that every educator in the state receive two hours of training annually in suicide prevention and awareness to gain and maintain certification to teach. When a state passes the JFA, JF agrees to provide and maintain an "On-Line Library" of training modules that will satisfy the requirements for an educator's training. This insures that any teacher or school or district can satisfy the required training without any cost, thus no fiscal note is necessary which is very attractive to state legis-lators. The authors are proud to have contributed to five JF modules on the topics of depression, bullying, non-suicidal self-injury, LGBTQ and suicide postvention in schools. In total, 27 states require staff training in suicide prevention but only 10 require that training be conducted annually. One frustration for advocates has been a state's reluctance to mandate anything and at the last-minute change "required" to "recommended".

Twelve states have taken a more comprehensive approach requiring schools to develop and adopt suicide prevention, intervention and postvention policies where staff training is just one component of prevention strategies. A sample model policy can be found in Table 2. In addition to mandating policies and procedures, California's AB2246 goes further to mandate that policy must address the needs of high-risk groups such as students exposed to suicide, youth with a history of suicide ideation or attempts, youth with mental illness or substance abuse disorders, LGBT, traumatized youth and youth in out of home settings such as foster care. Missouri is currently debating HB 844, which will consolidate earlier

## The Components of a Model Student Suicide Prevention Policy

### Policy statement

- All LEA that serve pupils in grades K-12, inclusive, SHALL adopt a policy on pupil suicide prevention, intervention and postvention. This policy SHALL address the needs of high-risk groups and include annual training for all school staff.

### Prevention

- Safe messaging
- Training to be offered annually under the direction of school employed mental health professional
- Specialized training (suicide risk assessment for school mental health professional)
- Parent involvement/training
- Student education

### Intervention

- Emphasis on collaboration and supervision
- Referral and assessment procedures
- Interventions for Low Moderate and High risk students
- Notifying parents
- Action plans for in/out of school student suicide attempts
- Developing safety and re-entry plans

### Postvention

- Establishing policies to memorialize all student deaths the same way.
- Procedures for crisis response
- Collaborating with district and community resources
- Reaching out to family
- Developing communications for students/parents
- Triage Staff and students
- Memorials
- Social media

ADAPTED FROM: California Education Code Section 215, Assembly Bill 2246 California Department of Education Model Pupil Suicide Prevention Policy

bills mandating every district create policies and plan for annual training of school personnel, two hours in length. The state of Texas for example requires a suicide prevention liaison to be identified for every school district. West Virginia requires secondary schools to provide students information about suicide prevention.

**Moving Forward**

**10 things a School Psychologist can do:**

- Be the advocate for suicide prevention in your district and help bring your district into compliance with your state’s laws
- Use Table 2 to re-evaluate your district policies and procedures and determine if additional strategies are necessary for suicide prevention, intervention and postvention.
- You are the logical choice to train school staff in any state that mandates training of school staff.
- Review NASP best practices chapter and all the high-quality suicide and crisis resources from NASP
- Make a commitment to staying current in the field of youth suicide prevention by attending NASP, NASP affiliate sponsored conferences.
- Seek out local suicide prevention advocates in your county then state.
- Search out local offices/chapters of the Jason Foundation, American Foundation for Suicide Prevention and American Association of Suicidology and visit their websites and online resources.
- Check out the resources of the national Suicide Prevention Resource Center and sign up for their monthly electronic publication, the Weekly Spark.
- Prepare for suicide postvention by downloading the latest version of AFSP/SPRC After a Suicide: Toolkit for Schools.
- Advocate for suicide prevention efforts in your state if your state is one of the 20 yet to enact any school suicide prevention legislation and reach out to the authors if we can be of any assistance.

**States that have enacted the Jason Flatt Act since 2007:**

Tennessee (2007)*/+	Louisiana (2008)*	California (2008)+
Mississippi (2009) **	Illinois (2010)**+	Arkansas (2011)**
West Virginia (2012)**	Utah (2012)**/+	Alaska (2012)*
South Carolina (2012)**	Ohio (2012)**	North Dakota (2013)*
Wyoming (2014)**	Montana (2015)	Georgia (2015)*/+
Texas (2015)*	South Dakota (2015)**	Alabama (2016)+
Kansas (2016)*+		

**States with legislation other than Flatt Act:**

Connecticut (2011)**/+	Delaware (2015)*/+	DC (2016)**/+
Indiana ((2011)**	Kentucky (2010)*	Maine (2013)**/+
Maryland (2015)**	Massachusetts (2014)**	Missouri (2017)+
Nebraska (2014)*	New Jersey (2006)**	Pennsylvania (2014)**/+
Washington (2013)**		

\*10 states with mandated ANNUAL training

\*\*17 states (plus DC) with mandated training

+12 states (plus DC) with mandated school suicide prevention policies

## TECHNOLOGY IN SUICIDE PREVENTION

### Samantha Guy

Suicide is the second leading cause of death for youth between the ages of 10 and 24. This is even greater than cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined for that age group. For high school students between 9th and 12th grade, over 3,470 attempts occur every day in the United States; and four out of five teenagers who have attempted suicide have given clear warning signs (The Jason Foundation, 2018). While it is possible to spread awareness about the crucial warning signs that suggest a student is at risk for suicide, it can be very challenging to separate the hopeless expressions of pain and suffering that students can experience from the more dangerous and severe indicators.

In an effort to prevent suicide deaths and improve the diagnostic tool-kits of mental health professionals, new technologies in suicide prevention have begun to emerge that may help identify and assist at-risk individuals (Holley, 2017).

“Spreading Activation Mobile” or SAM is a suicide prediction tool that uses a specialized algorithm to analyze speech and determine if an individual is likely to take their own life. While this technology does not replace the clinical judgment of the trained mental health professional, it is another option to help make a determination about a patient’s health. Although still in its initial phase of testing, this technology might be a crucial tool that can eventually be used throughout schools in the country (Holley, 2017).

Other forms of artificial intelligence that have the potential to change the way mental health issues are diagnosed include the use of smart phones and social media. Soon, predictive machine learning algorithms will be able to utilize the data from smart phones to analyze one’s language, emotional state, and social media footprints to predict self-harm. These algorithms have the potential to provide accurate predictive portraits of patients that can provide experienced clinicians with more data to determine risk (Holley, 2017).

Several researchers have developed algorithms that analyze the tone of one’s Instagram feed as well as scan the language, word count, speech patterns, and activity level in their Twitter feed to spot signs of depression and pinpoint the rise and fall of mental illness (Holley, 2017). Facebook has recently announced the creation of a new alert system designed to help those at-risk for suicide. This machine-learning algorithm will identify posts suggesting suicidal thoughts and use two signals to determine if an individual is at-risk. These signals include words or phrases that relate to suicide or self-harm, and comments added by concerned friends (Kwon, 2017). If a post is identified, Facebook will respond by visually encouraging users to click on the

### STUDENTS PRESENT ON PUBLIC POLICY ADVOCACY FOR SCHOOL PSYCHOLOGISTS

At the recent National Association for School Psychology (NASP) annual conference in Chicago, doctoral students Jacklyn Stellway, M.S., and Stephen Beard led a nicely attended presentation on advocacy. The presentation was titled “Developing a Public Policy Advocacy Model for School Psychologists” and the students spoke about definitions of advocacy (i.e., social justice, public policy, and professional advocacy), barriers to psychologists advocating, a training model called Scientist-Practitioner-Advocate Model for professional programs (Mallinckrodt, Miles, & Levy, 2014), and resources for psychologists to easily use (see below).

“report post” button. Furthermore, if algorithmic cues signal a higher risk, Facebook’s community operations teams will be notified and the user will see numerous suicide help resources on their news feed. Friends of users will also have the opportunity to report concerning posts and receive information on hotlines, prompts to reach out, and tips on what to do in a crisis. Facebook is also looking into piloting a program that connects people with mental health counselors using their messenger app and also creating algorithms that recognize troubling photos or videos (Kwon, 2017).

All of these technologies are very new and artificial intelligence is still limited in identifying suicide risk through language alone. However, the possibility of expanding this technology to include the examination of emoji’s, timing and temporal patterns, and frequency of language changes can increase the likelihood of accurately predicting self-harm. In an age where everyone has a smart phone and access to various forms of social media, engaging new technology to enhance our ability to predict suicide, especially for young individuals, is an increasingly important endeavor that will continue to be examined and researched.

The Jason Foundation (2018). Youth suicide statistics. <http://prp.jasonfoundation.com/facts/youth-suicide-statistics/>

Holley, P. (2017). Teen suicide is hard to predict: Some experts are turning to machines for help.

<http://www.chicagotribune.com/lifestyles/health/ct-teen-suicide-prediction-machines-20170927-story.html>

Kwon, D. (2017). Can Facebook’s machine-learning algorithms accurately predict suicide? The social media giant aims to save lives by quickly flagging and responding to worrying posts. <https://www.scientificamerican.com/article/can-facebooks-machine-learning-algorithms-accurately-predict-suicide/>

## INTERVIEW WITH DAVID JOBES, PH.D., ABPP

With Scott Poland and Douglas Flemons

**Scott Poland [SP]:** *David, I wanted to ask, you have done so much in the field, when did you first focus on suicide prevention?*

David Jobes: You know, I was a graduate student at American University. I was in the Master’s program and my psychopathology professor was a guy named Lanny Berman. He was then, and clearly became, a major leader in the field and was the Executive Director of the American Association of Suicidology for many years. I was just interested in working with somebody who was doing something interesting, and what was sort of a means to an end to get into a Ph.D. program became my life’s passion. So, it was more of an incidental thing. But as I started getting into it, realizing how unevolved the field was, I

got increasingly passionate about it because there was obviously a critical need. This was back in 1982, so the field was still sort of in its infancy and it was an exciting time to get involved.

**Douglas Flemons [DF]:** *Was your developing the CAMS approach part of your doctoral dissertation?*

Not directly. My research in graduate school, my thesis and

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Dr. David Jobes is a leading expert and researcher on suicide and interventions for suicidal people. He is a professor of psychology and Associate Director of Clinical Training at The Catholic University of America in Washington, D.C.

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dissertation, were focused on medical examiners and the psychological variables in the determination of manner of death. We were looking at the implication of suicide not being accurately certified within the larger data set of the National Center for Health Statistics. It was interesting because it really got me focused on psychological autopsies and I got to interface with Dr. Bob Litman who was one of the founders of the psychological autopsy technique. But as I got into my Ph.D. program and continued to work and got into my academic career, I became more interested in a clinical focus. So, I took a job out of my internship at the VA in the counseling center here at Catholic University and my boss said, “I want you to ensure that our students who are

suicidal get a good assessment and that they don't fall through the cracks." And that was the genesis of developing the Suicide Status Form, which was the precursor to CAMS.

**DF: Where are you now with your assessment work? Have you been developing anything, continuing to be innovative at this point?**

Well, hopefully. This is my 30<sup>th</sup> year at Catholic University; I am a professor here and I direct the Suicide Prevention Lab. I have focused on the field broadly at the public health level. I have done some work with the Centers for Disease Control. I consult a lot with the different organizations here in Washington. But the focus of our work has been on the clinical assessment of suicidal patients, outpatient and inpatient settings, around the world in various locations. And developing the Suicide Status Form, which was originally assessment-focused. But we did these assessment studies for several years and we felt that we were learning a lot about the nature of the suicidal mind. When you do enough assessment work, you back your way into, "Now what are we going to do?" We have understood, or are able to identify, different kinds, or typologies, of suicidal states and that is been a big focus of our system. Knowing intuitively and clinically that there are going to be differences in how suicidal people present and what they are preoccupied with. That led to a pivot toward treatment research and this move from assessment-focused to a full-blown intervention. So, now we are immersed in randomized control trials proving different aspects of the

## QUICK RESOURCES FOR PROFESSIONALS TO EASILY USE FOR ADVOCATING!

NASP Advocacy Tools and Resources:

<https://www.nasponline.org/research-and-policy/advocacy-tools-and-resources>

NASP Policy Platform:

<http://www.nasponline.org/research-and-policy/nasp-policy-platform>

NASP Current Law & Policy Priorities:

<http://www.nasponline.org/research-and-policy/current-law-and-policy-priorities>

NASP Public Policy Institute: [http://www.nasponline.org/research-and-policy/public-policy-institute-\(ppi\)](http://www.nasponline.org/research-and-policy/public-policy-institute-(ppi))

NASP School Psychology Awareness Week\*

Resources year round: <https://www.nasponline.org/research-and-policy/advocacy-tools-and-resources/school-psychology-awareness-week-2017>

Community Tool Box (University of Kansas):

<http://ctb.ku.edu/en/advocating-change>

Daily Kos: <https://www.dailykos.com/>

Resistbot: <https://resistbot.io/>

CAMS intervention: how it works, why it works, what we know about that. We are moving towards dismantling the mechanisms of the intervention and that is been our focus the last 10 years or so. We now have 3 published randomized controlled trials, 2 unpublished RCTs. We review the RCTs periodically so I am eager to submit the next round of data, the data pretty convincingly puts CAMS over the top to being evidence-based or empirically-validated.

**SP: That is great. I wanted to ask you, you were initially skeptical**

**about Zero Suicide and you are now onboard. Could you talk about that for a minute?**

Yeah, I was on the clinical care task force that led to Zero Suicide. It was one of the 11 different task forces under the National Action Alliance for Suicide Prevention. And I felt like it was attention-gathering. Of course, I felt like we should aspire to zero, but I also had this skepticism that no health professional, realistically, could aspire to a zero goal because that is a very extreme thing to aspire to. The thing we were talking about in the early days of

Zero Suicide was best care, and that is not as captivating. But best care is something we can focus on and deliver. Zero Suicide was what everybody was excited about and then, about a year or two after Zero Suicide launched, I really saw the traction it was getting, the attention it was getting, the systems and states and tribes and countries around the world that were embracing the model. And as a suicide prevention pragmatist, I said, "Okay. That's good enough for me." Because, if we now have a policy initiative that we never before had seen, of Zero Suicide having as much impact and getting this much focus and attention, then I'm a convert.

**DF: So, you are a convert pragmatically, that it gets people galvanized to do something.**

I am a pragmatic convert. I also would say that, if you are a medical director of a hospital or you are a suicide prevention coordinator working at a government office, and you want to raise the standard of care across a small or large system, even across a nation, how would you do that? And what Zero Suicide does is make available to you, from A to Z, how you would do

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*"My issue with it is that, in the states where this law is instituted, a lot of training is not evidence-based."*

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that. There is a group in Australia that has done a spectacular Zero Suicide initiative, it is called the Gold Coast Hospital System in eastern Australia. The leader of that group did it all off the existing materials that are online, some of the hard copies and such, and she did

it herself. She did not go through the academy; she was not officially trained. She just did it, mostly online. I love that. I love that they profoundly raised their standard of care across a large healthcare system and embraced the model that way. And that is the beauty of it that you do not have to start from scratch or reinvent the wheel. There are some very thoughtful things that you can integrate into your system that are going to make a difference.

**SP: I wanted to ask you about, a few years ago AAS had a task force which cited the lack of training for therapists, psychologists, pretty much everybody that we would expect would know how to do suicide risk assessment and management. Have you seen much progress? What do we really need to do to turn out therapists and psychologists that really know how to do it?**

That is a great question. And it is one of the banes of my existence, to be candid. I mean, across health care disciplines, there is a shocking lack of curriculum-based training. Most clinicians, if and when they do learn, learn that it is in the field. And that is certainly

one way to learn. But I think it is easy to argue there should be curriculum-based training as these are the fatalities of our field. 9.8 million Americans suffer with suicidal thoughts every year and it is a leading cause of death. It is a fatality of the field, so why aren't we getting

trained? That said, the states are moving to forcing mental health providers to get training to renew their licenses. There is a new law passed in California for psychologists to get their license to get trained in the assessment and treatment of suicide. I am not a big fan of coercion, but it may have come to believe that we may have to make people get trained. I think there's already a handful of states that are moving in this direction or considering this legislation. My issue with it is that, in the states where this law is instituted, a lot of training is not evidence-based. That is a concern of mine. I am not convinced that some training is better than nothing. I am a big fan of the science and actually doing things that we know work. That has a convoluted answer, but I do think, as a direct result of our recognition that clinicians are not trained, this political movement to make people get trained is a mixed bag that, in the grand scheme of things, especially if it has evidence-based, is probably going to be a good thing.

**SP: What would be your advice to a clinical student who is in a program where there is no required course; what would you advise them to do to get better prepared?**

You know, there is some pretty robust literature out there. I was just this morning reviewing a manuscript where I am (hopefully in a balanced way) critiquing contemporary care and saying that there is an overreliance on medication and inpatient psychiatric hospitalization. Not because medicines or hospitalizations are not helpful, but in my view, they are not sufficiently

suicide-specific and focused. So, I re-looked at this literature over the weekend. The biggest argument you can say for medicine being effective for treating ideation and behavior is that the data are limited or mixed at best. We know from the Joint Commissions, from SAMHSA's research, from the surveys that are done, that hospitalization is not sufficiently suicide-specific and focused. I am involved in a task force with Mike Hogan looking at minimal standards. And minimal standards would be to use stabilization or safety planning and not to use no-harm contracts, to use and know about the national lifeline as a resource, to think in terms of engagement with the suicidal person as being a psycho-educational moment. For example, around lethal means and safety. So, removing firearms or a stash of pills being a very important thing, to be very overt with patients and their families. It does not have to be that they buy into learning biological behavior therapy or my intervention or the other proven interventions. But I think to move to stabilization planning, using the lifeline, and focusing on lethal means safety is low-hanging fruit that every young and old clinician should readily embrace as a minimal expectation of care.

**DF: That is great. Our experience here in Florida is that the involuntary hospitalizations, while they obviously protect the suicidal person from making an attempt, that the time in the hospital is, as you put it, not really focused on suicide prevention. It is more just housing. Have you**

***undertaken any initiatives to train hospitals or hospital staff?***

Well, the premise of your point is not exactly true, because people kill themselves in hospitals. That is one of the reasons the Joint Commissions put out the Sentinel Event Alert that is now getting a lot of push-back in the policy world, was because suicide is the leading sentinel event in the United States, which are suicides that occur in hospitals. So, we would like to believe or hope that people's lives are saved in hospital settings and I would clearly

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*...to move to stabilization planning, using the lifeline, and focusing on lethal means safety is low-hanging fruit that every... clinician should readily embrace as a minimal expectation of care.*

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argue that those are largely protected environments that probably decrease the likelihood a lot. But certainly, people still find ways to take their lives. And yes, we have done several initiatives with my own intervention to move into the inpatient setting. For example, to do CAMS in an inpatient setting. We have done a lot of work with the Menninger Clinic, which is an unusual hospital because people stay for more than five days, it is a lengthier stay. But even a brief version of CAMS or the cognitive therapy intervention developed by Aaron Beck's group that is now being studied by Marjan Holloway for a five or six day stay that is suicide-specific that called post-admission cognitive therapy (PACT). What we know

according to the SAMHSA survey research is that what most people get on average during a 6-8 day stay, get some consultation around the medication. They may get two or three groups that patients do not find especially helpful or valuable. And then they watch a lot of TV, they hang out a lot, and get "stabilized." I am not exactly sure what's stabilizing about those experiences. What they could actually do is talk a lot about lethal means, they can talk about stabilization planning, they could talk about different kinds of

dispositional considerations. Because we know the period after discharge is a very high-risk period for people to take their lives. So, we have done CAMS in inpatient settings where at least they are getting a stabilization plan and they are identifying the problems that are at the heart of their suicidal struggle so that when they get discharged, they can focus treatment on those problems. We like that model, you are getting something for your inpatient stay.

**SP: I wanted to ask you, I was on the CAMS website and there are a lot of great videos there. But I was intrigued by the question of asking the patient, "Does suicide comfort you or disturb you?" Could you elaborate on that?**

In the pursuit of identifying different suicidal states, I think about someone who says, "I think about suicide and it frightens me. I want to get rid of it, but I don't know how to get rid of it." I once had a patient who said that he had like a neon light in his brain flashing suicide and it really upset him; he did not want it there, but he did not know how to get rid of it. It haunted him. But that is a very different kind of person than someone who has thought about suicide for decades or many years and when they think about it, it is actually kind of a comforting thought and it gives them a sense of control over their struggle. It may be ironic, but it is kind of a reassuring way for them to live, to know that I can kill myself. So that has a favorite question of mine to differentiate people who are in a more acute state, where suicide is a bit of a hot potato, versus a more chronic state, where suicide can be more like a warm security blanket that makes people feel more comfortable.

**SP: I know you work in a college and Douglas and I co-direct our Suicide and Violence Prevention office here at Nova. We have had some progress, some good things, but we do encounter resistance from certain departments and that attitude of, "We can't talk about suicide." What recommendations do you have? What do you think every colleges should be doing to prevent suicide?**

That is a great question. I think they should know that it is protective to keep highly suicidal or moderately suicidal people in school, if possible. There is a

temptation to get rid of these students or get them off campus and you have now increased their risk. It has the second leading cause of death on campus, but when you compare college students to their age- and gender-matched cohorts who are not in college, the rates are higher for those who are not college students. So, it is a protective environment, it is a good place for a suicidal person to be, especially if they are getting treatment. There are unique things about the university campus environment, like health services or resident life services. When professors and staff can have eyes on these kids that makes it a better place to be. My bias would be that when the counseling centers are providing services, they can actually do treatments that are suicide-specific. We had a NIMH-funded study at the University of Nevada, Reno, where we were studying the use of CAMS and dialectical behavior therapy for suicidal college students in Reno at that university. During of the duration of that study, we hardly ever hospitalized; I think there was one student that hospitalized himself, but we did not hospitalize a single one of those students. Some of them were highly suicidal and we saw very effective treatment. Then there are other campus cultures and environments where a student whispers "suicide" and they are immediately withdrawn and discharged or hospitalized without any effort to even think about treatment. So, we have a wide range of culture on different campuses. People that go to college are going to become employed,

they are going to become leaders, they are going to become the people that make a difference in our lives. So, I think getting rid of such students is a mistake and that there are great things that can be done on campus that are going to save lives and make a difference.

**DF: The knee-jerk hospitalization is often run by the lawyers.**

Yes, and that is unfortunate. That is why I talk about a lot about liability, because what it fosters is a "better safe than sorry" kind of attitude. And I have been an expert witness on malpractice/wrongful death cases. For the record, I am not anti-hospitalization. I am anti-hospitalization where there is no discussion or focus on suicide. I am oftentimes offending people who perceive me as being anti-hospitalization or anti-medication and I am not. But I am for the things that actually work and what works are psychological treatments and a hospitalization that is more focused on the minimal standards. When we look at society, clinicians often wind up practicing defensively, which is often unfortunate for the suicidal person. And it is not always looking out for the patient's best interest, but for what is going to keep me out of trouble. So, the lawyers often get "overly influential", but I look at a place like Reno where we saw highly suicidal students and we were able to not hospitalize any of them. What my challenge would be is, if I am doing an evidence-based intervention and my documentation is thorough, thoughtful, and sound, where is my negligence? I have certainly

seen cases of our own intervention where there has been a fatal outcome. Marsha Linehan has, over the years, had fatal outcomes with DBT. And, knock on wood, we have not been sued because the issue is not that you can never have a fatal outcome. The issue is: did you fall below the standard of care? And if you are assessing suicidal risk and you are treating suicidal risk and you are not dropping the ball in terms of continuity of care, then there really is no negligence and there is basically no lawsuit if that is the case.

**SP: Those are great points. We are really pleased to tell you that Douglas and I are consulted by the vice president's office when we run into students that are engaging in threatening or suicidal behavior and, without going into great detail, our administration seems to want our input and focus on keeping students on campus to get treatment, whatever we need to do to support them.**

I am delighted to hear that and I hope that is a national trend. I think, as Douglas alluded, there tends to be this kind of paranoid, overly-defensive, legalistic approach where it is "better safe than sorry". I can describe countless anecdotes where suicidal people have been invalidated or shamed or coerced or feel like they have been punished for coming forward and saying they are suicidal. Which is why, in the field of suicide prevention, the voice of lived experience of survivors has become so interesting. The people who have been, or are currently, suicidal are now on the

map—they are now a division of the American Association of Suicidology. They are saying, "We're not happy with the status quo. We've been shamed and invalidated and punished for our efforts to seek care and we think the cure needs to change." It is an interesting new perspective that is actually making a big impact on the field.

**SP: Very good. A little bit of a frustration over the years has been physicians, whether it is lack of awareness or lack of competency. I am pleased to tell you that we do get to train medical students here because we believe physicians are in a wonderful place to detect suicidal patients and help them.**

Primary care providers are absolutely the optimal group to save lives. I think, in general, the field feels like they are compelled to get primary care providers to be more sensitive to suicide. I think, in fairness, the challenge has been that we have a model that is venerable, the medical model, which focuses on diagnosing patients and treating them with medications. It is just that, up to this point, medications have not proven to be especially viable from a research standpoint with regard to suicide. And until that research comes through that shows that treating depression or treating schizophrenia is going to change suicidal behavior or completions, I think the argument can be clearly made (and I'm making it) that, when you focus on schizophrenia or anxiety, that may be relevant to the suicidal risk, but it's relegating suicide to symptom status, with the assumption that an SSRI or an antidepressant or a

neuroleptic for anti-psychosis is going to treat the disorder to get to the suicide risk. Really, that literature is, at best, mixed and I think there is plenty of evidence that that does not carry the day. The evidence supports lithium for bipolar disorder suicidal patients, while the evidence for SSRIs is very mixed. I think part of the challenge with physicians and medically-oriented providers is that they have a model that's tried and true and, of course, shapes practice. It is just that that model has not mapped on well, at least up to this point in time, to suicidal risk where the evidence for psychological treatments is robust and replicated in randomized controlled trials but those evidence-based interventions are rarely used in clinical practice.

**DF: And the physicians must learn how to think like a psycho-therapist in order to refer out or have some sort of intervention on their own that is not just medical or medication-based.**

I suppose. I mean, it is important to know what you can do and what you cannot do. I think that is really important. And I want to be really clear about this: there may be a medicine that is under development right now that is going to decrease suicidal ideation and decrease attempt behaviors as robustly as psychological treatments. I do not want to say that medicine will never do that; it is just that the evidence today, in a randomized controlled trial that has been replicated, is virtually nonexistent for that model. Most of my patients get referred to a psychiatrist for medication because I

know medicine can help some of my patients. But I am under no illusion that it is going to necessarily decrease their suicidal ideation and their suicidal behaviors. So, I think that is the challenge, that many mental health providers assume that psychiatrists must know better, that they are the *real* doctors, and that medicine must help with these problems. I kind of want it both ways; I want to say, "Yeah, medicine can help with some problems, just not problems that are specific to suicidal ideation and behavior, at least not yet in the research." That nuanced truth, I think, is important to appreciate in terms of what a physician can do versus what a psychologist or psychotherapist can do. And it is hard. A lot of people are afraid of these patients. But to embrace that there is a lot we can do to save lives; you do not have to kick the ball over to people who are more qualified because there are plenty of people who could be very competent and qualified to clinically save lives. They must believe that they can and they have to learn what actually works.

***SP: That is a great point. I was pleased to read that you have been working with many branches of the military. Do you have the time to tell us a few things about your efforts with veterans and the military?***

Sure. The military suicide problem over the last decade has really infused tremendous resources into the field of suicide prevention and a number of us have been beneficiaries of getting that level of funding, literally millions of dollars to do clinical trials and to think

about these populations and what is special and unique about them. We know that active duty and veterans are at a higher risk than the general population. So, there is the Brief Cognitive Behavioral Therapy, or BCBT, developed by David Rudd that has been studied at Fort Carson, Colorado, showing a 60% reduction in attempt behaviors. We have done a CAMS trial at Fort Stewart in Georgia with infantry soldiers that were suicidal and we have shown how CAMS eliminates suicidal ideation in 6-8 sessions and can reduce ED admissions and increase overall health and other good outcomes for subsets of soldiers. So, we know that these treatments are feasible and they can be delivered in military treatment environments. And these treatments are also being used with veterans, as well. So, we were very keen on these environments that are remarkably suicide sensitive. You never read it in the New York Times or the Washington Post, but there are no organizations that are doing more for suicide prevention in the entire world than VA and DoD. Whether it is total dollars spent or focus or policy or initiatives, these organizations are doing heroic work to save the lives of high-risk folks. Every time I talk to a reporter, I try to point that out, that they do not get credit for the work that is being done and the fact that we are going to look back on this time as being the watershed of the field in terms of what those research dollars were enabling us to do. Craig Bryan published a paper this year on crisis response planning and has shown in a randomized

controlled trial that crisis response planning is superior to no-suicide contracting and reduced attempt behaviors by 76%. So, behavior change is a big deal and eliminating suicidal ideation in six to eight sessions is a big deal. We hope that that data catches up with practitioners' practices so they start doing things that we believe work, even as simple as moving from a no-harm contract model to some kind of stabilization planning, which we think has now got growing data that it is an effective way to go.

***SP: What would be a few key thoughts about assessment and advice for students or, really, all practicing therapists?***

I would say that you need to appreciate that if someone is talking to a psychotherapist or a mental health professional about suicide, by definition they are an ambivalent person. They are still alive, they're not dead. And that sort of crass appraisal of reality is very important because they have not yet fully embraced suicide as their solution. So, you've got a foot in the door, which is the fact that this person is talking to you about this topic. Then the related challenge is you cannot run. Well, you can, and people do, but my admonition would be not to run, to hang in there and talk to them about this. Not to talk about it in a minimalist way, but talk about it expansively. "What does it mean for you to be suicidal? What makes you think that suicide is the best thing to do?" In CAMS, we call them suicidal drivers. "What are the two problems that compel you to think that suicide is the solution?" And what most

people say is, you know, “My partner broke up with me;” “I’m unemployed;” “I was sexually abused by my father for 10 years.” They are not trivial problems, but they do not have to kill the patient. And that is really the argument that if you can muster the wherewithal to go into that space and be with that person and let them talk about the experience, which can be a therapeutic assessment. That can be a therapeutic engagement, in and of itself. And then the drivers, the

problems that patients articulate, are almost always treatable. We have prolonged exposure, we have insight-oriented psychotherapy, we have supportive psychotherapy, and we have case management. We have things that we can do that address those problems. The CAMS model is not a psychotherapy; it is a framework in which clinicians can focus on this topic, work to stabilize the patient, and then target and treat the patient-defined

drivers which we know how to treat. We know how to treat distressed relationships. We know how to handle dysregulation. We know how to treat hopeless states. So, my final thought is: try not to run away, try to learn about what this is, and always remember that instilling hope is a key ingredient to saving lives.

**SP:** That is great.

**DF:** Beautifully said.

## NOVA SOUTHEASTERN UNIVERSITY’S COUNSELOR IN RESIDENCE



The Counselor-in-Residence is a counselor who lives on campus providing on-call services, such as mediation and response to emergency situations involving mental health issues, crisis situations, and emotional concerns of NSU’s residential population.



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(954) 424-6911 or (954) 262-7050  
\*available 24 hours a day, 7 days a week

### Hours of Operation

Monday-Thursday-Friday  
9:00 am – 5:00 pm

Tuesday-Wednesday  
9:00 am – 8:00 pm

### SVP Newsletter Contributors

David Cox, Psy.D.  
Jacklyn Stellway, M.S.  
Samantha Guy  
Scott Poland, Ed.D.  
Douglas Flemons, Ph.D.

Graduate students looking to write articles on the topics of suicide and violence prevention are encouraged to contact us.

David Cox, Psy.D.  
[dc1502@mynsu.nova.edu](mailto:dc1502@mynsu.nova.edu)

### SVP Presentations

The Office of Suicide and Violence Prevention has provided 300+ presentations to various departments at NSU.

SVP has presented to over 6,000 NSU faculty, staff, and students, on a variety of topics related to suicide and violence training, management, and mental health struggles.

Use this link to request a presentation:

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