Office of Suicide and Violence Prevention

Spring 2023 Newsletter

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Diversity in Suicide Prevention

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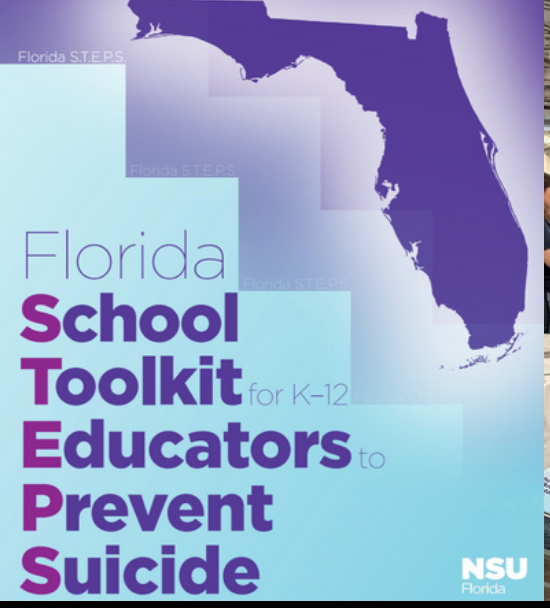
"We cant talk about mental health without talking about diversity" - AFSP



SVP Events and Highlights

2/07/2023: BAGARELLA, K., HUBBARD, J., POLAND, S., & CASTELLANA, C. A LIVING SAFETY NET: SUICIDE PREVENTION WITHIN THE UNIVERSITY COMMUNITY. POSTER PRESENTION. NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS (NASP) 2023 ANNUAL CONVENTION. DENVER, CO.

2/14/2023: DR. POLAND PROVIDED AND INVITED WORKSHOP ON SUICIDE POSTVENTION AT THE NATIONAL ASSOCIATION OF SCHOOL PSYCHOLOGISTS CONVENTION. DENVER, CO.

2/20/2023: CASTELLANA, C., & BAGARELLA, K. FLORIDA TOOLKIT FOR K-12 EDUCATORS TO PREVENT SUICIDE (STEPS). POSTER PRESENTATION. FLORIDA SUICIDE PREVENTION COALITION (FSPC) FLORIDA TAKING ACTION FOR SUICIDE PREVENTION CONFERENCE. LUTZ, FL.

2/22/2023: FLORIDA SCHOOL TOOLKIT FOR K-12 EDUCATORS TO PREVENT SUICIDE (STEPS) TRAINING FOR MIAMI-DADE COUNTY SCHOOL PROFESSIONALS.

3/18/2023: DR. POLAND PROVIDED THE KEYNOTE ADDRESS A THE MIAMI-DADE COUNTY YOUTH MENTAL HEALTH SUMMIT.

4/12/2023: PRESENTATION AT FLORIDA BLUE FOUNDATION COMMUNITY HEALTH SYMPOSIUM AND SAPPHIRE AWARDS.

APRIL 4-6, 2023: DR. POLAND PROVIDED EXTENSION CONSULTATION AND TRAINING TO PARENTS, SCHOOL BOARD, AND SCHOOL STAFF VIA ZOOM FOR THE INTERNATIONAL SCHOOL IN CURITIBA, BRAZIL AFTER THE SUICIDE OF A STUDENT.

4/20/2023: DR. POLAND AND DR. HUBBARD ATTENDED THE INITIAL MEETING OF THE NSU STUDENT MENTAL HEALTH COMMITTEE WHICH IS WORKING WITH THE JED FOUNDATION.

5/10/2023: PRESENTATION AT 8TH ANNUAL BEHAVIORAL HEALTH CONFERENCE HELD BY UNITED WAY OF BROWARD. "SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION: BEST PRACTICES FOR BEHAVIORAL HEALTH AND SOCIAL SERVICES".

Upcoming Events

5/19/2023: PRESENTATION AT NICKLAUS CHILDREN'S HOSPITAL. "SUICIDE AND VIOLENCE PREVENTION FOR SCHOOLS AND COMMUNITIES."

RISE IN SUICIDALITY AMONG BLACK YOUTH

TAYLOR TEJERA, BA

Suicide is a pervasive issue in the United States. In 2020 alone, nearly 46,000 people died by suicide and approximately 1.2 million people attempted suicide (Centers for Disease Control and Prevention [CDC], 2023a). Suicide is also a significant problem affecting our youth as evident by it being the second leading cause of death among individuals aged 10-14 (National Institute of Mental Health, 2022). While no one is exempt from suicide or its impact, some populations have shown less risk for suicidality. For instance, non-Hispanic Black individuals have consistently demonstrated lower rates of suicide in comparison to non-Hispanic White and American Indian/Alaska Native populations (Ramchand et al., 2021). 2018 data showed that the rate of dying by suicide among Black or African American individuals was 60% lower in comparison to non-Hispanic White individuals (Office of Minority Health, 2021). However, our understanding of disparities in suicide risk is changing. Recent literature shows drastic increases in suicide deaths among Black youth over time, highlighting a greater need for suicide prevention and intervention efforts directed to this group. In fact, Black youth appear to have the fastest growing suicide rates in comparison to other groups (American Academy of Child and Adolescent Psychiatry, 2022; Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, 2019). One study concluded that from 2001 to 2017 the rates of suicide among African American male adolescents increased by 60% while rates for African American female adolescents rose by approximately 182% (Price & Khubchandani, 2019).

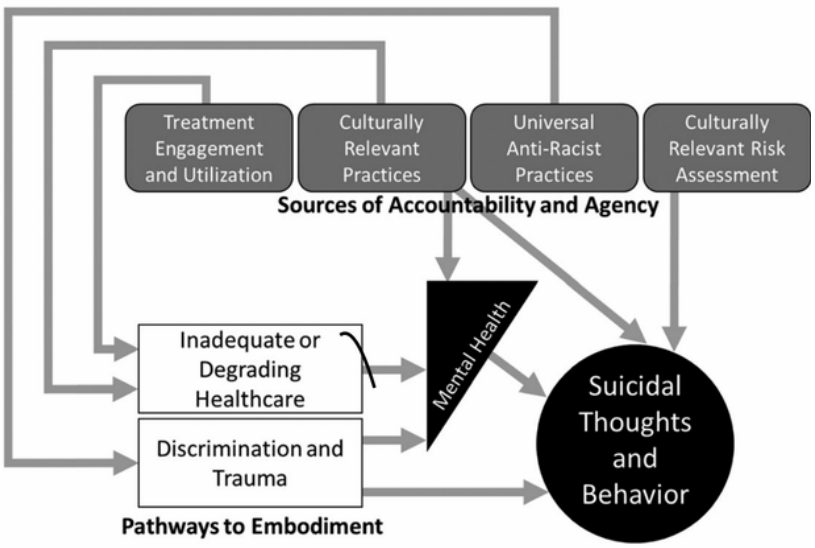
There are also concerning trends within age groups in this population as well. The most prominent increase in suicide rates between 2003 and 2017 was found among those aged 15 to 17 (Sheftall et al., 2022). Greater attention may also need to be directed toward Black children aged 5 to 12 who have demonstrated nearly double the rate of suicide than White children of the same age (Bridge et al., 2018). Moreover, Black adolescents have progressively reported a higher number of suicide attempts from 1991 to 2017 which is opposite to the declining trend depicted among other racial and ethnic groups (Lindsey et al., 2019). In 2019, a comparison of suicide attempts between Black and non-Hispanic White female high schoolers showed that Black females were 60% more likely to attempt suicide in 2019 (Office of Minority Health, 2021). Unfortunately, research has also reported that persistent feelings of sadness and hopelessness have risen in this community, with about 39% of Black high schoolers having these experiences in 2021 (CDC, 2023b). Black youth are evidently at risk for suicide and suicide attempts. As clinicians, it is important to be aware of these trends and work toward understanding how to better serve the needs of this community.

When thinking about why these trends may be present, it is important to first recognize that some Black individuals are exposed to adverse experiences, such as racism and discrimination, that increase their susceptibility to mental health issues. African American males who experience “race-based everyday discrimination” are more likely to have higher reports of depressive symptoms and suicide ideation (Goodwill et al., 2019). Black individuals are also less likely to receive mental health care. Roughly a third of Black individuals with mental illness actually receive treatment (National Alliance on Mental Illness, n.d.).

Additionally, alarming data showed that around 35% of Black youth who made a suicide attempt at some point in their life experienced emotional treatment from a therapist within the past year in comparison to the approximately 51% of White youth (Goodwill & Yasui, 2022). Hence, Black individuals still may not have their mental health needs met despite having access to services, making them more vulnerable to poor outcomes like suicide.

In the face of these alarming trends, clinicians and communities are faced with the question of how to respond. One promising direction is the greater implementation of school suicide prevention and interventions strategies and programs, especially those that are culturally sensitive to Black youth. There are limited studies that have examined culturally appropriate suicide interventions; yet one study found a preliminary decrease in suicide risk among African American adolescents who participated in a culturally adapted Adolescent Coping with Stress Course (Robinson et al., 2016). Specifically, there was an 86% decrease in suicide risk in comparison to adolescents who participated in the standard care for stress reduction (Robinson et al., 2016). Cohen and colleagues (2021) also propose using the ecosocial model derived from Krieger's 2012 theory (shown in figure below) to understand and guide intervention to reduce suicide risk in Black youth.

The model suggests that there are "pathways to embodiment" which worsen mental health and lead to suicidal thoughts and behavior. Specifically, discrimination and trauma are associated with a greater risk for poorer mental health including suicidal thoughts and behavior while inadequate or degrading healthcare affects mental health. This in turn leads to a greater risk of suicidal thoughts and behavior. This model also indicates that suicide prevention and intervention should focus on "sources of accountability and agency" regarding suicide disproportionately affecting Black youth, via encouraging treatment engagement and utilization, including culturally relevant practices, universal antiracist practices, and culturally relevant risk assessment. These methods are linked to reduced risk of pathways to embodiment, better mental health, and a lower likelihood of experiencing suicidal thoughts and behaviors. For example, incorporating culturally relevant practices are specifically associated with improved mental health and reduced suicidal thoughts and behavior while having culturally relevant risk assessment is also associated with less risk for suicidal thoughts and behaviors. Furthermore, including treatment engagement and utilization and culturally relevant practices can prevent inadequate or degrading healthcare while universal anti-racist practices can reduce discrimination and trauma (Cohen et al., 2021).



(Cohen et al., 2021)

There are many strategies recommended in the ecosocial model that we can utilize to reduce the risk of suicide in Black youth. It is important that clinicians and school personnel make an active effort to enhance suicide prevention and intervention and protect the lives of Black children and adolescents. Fortunately, there are already many organizations working toward serving the needs of Black youth and youth of color. Links to some organizations are below and may be helpful to provide to clients within this population.
*References on page 17

THE STEVE FUND

www.stevefund.org

PROUD TO BE LISTED
THERAPY for BLACK GIRLS
EST. 2014

www.therapyforblackgirls.com

SAD GIRLS CLUB

www.sadgirlsclub.org

Black Girls Smile

www.blackgirlssmile.org

SUICIDE PREVENTION FOR INDIVIDUALS ON THE AUTISM SPECTRUM

JULIETTE HUBBARD, PSYD

Suicide prevention efforts have long been underway to address a rise in suicide rates among the general population. However, in addition to the needs of the typically developing population, a greater emphasis has been placed on researching the specific needs of neurodiverse individuals. Individuals with autism spectrum disorder (ASD) are among those considered neurodivergent, making up approximately 1% of the global population (Salari, et al., 2022). Those with ASD present with a wide spectrum of different strengths and difficulties but common to this population are noted difficulties with social communication and self-regulation. Because of these difficulties, individuals with ASD deserve special consideration in the field of suicide prevention as these features may pose additional challenges in identification, assessment, and intervention of suicidal thoughts and behaviors.

Overall, studies which examined suicidal ideation in individuals with ASD showed varying prevalence with one study reporting rates as high as 66% (Cassidy et al., 2014). Rates of suicidal attempts were similarly variable with some studies showing rates as low as 1%(Storch et al., 2013) and as high as 35% (Paquette-Smith et al., 2014). Another study found that individuals with ASD were at a higher risk for death by suicide when examined alongside matched controls from the general population (Hirvikoski et al., 2016). While this variability likely indicates some differences based on methodology and sample selection, the implication remains that suicidal ideation and attempts are a critical issue facing individuals with ASD.

Research has identified several risk factors that might underlie suicidal ideation and behavior in the general population with underlying mental illnesses frequently cited as a major contributing factor (Too et al., 2019). This is important when considering suicide risk for neurodiverse individuals as those with ASD frequently present with additional comorbidities, most commonly anxiety and depression (Hedley & Uljarević, 2018). Additionally, one of the most well researched theories of suicide put forth by Thomas Joiner (2005), proposed that lethal or nearly lethal suicide attempts are heavily affected by thwarted belongingness, perceived burdensomeness, and the acquired capability to enact lethal self-injury. These align with other researched risk factors such as interpersonal conflict, hopelessness, financial difficulties, legal troubles, previous suicide attempts, and exposure to adverse childhood experiences such as abuse or violence (Steele et al., 2018). Although many of these risk factors are salient for individuals with ASD as well as the general population, neurodiverse individuals may present with additional considerations when looking at events or traits that impact risk level.

With regard to thwarted belongingness, the characteristics and traits of ASD may be especially important. Specifically, because of difficulties with social communication and relational interactions, individuals with ASD may have difficulty forming satisfying relationships with romantic partners and peers (Jackson et al., 2018). In turn, Hedley et al., (2018), found that lower levels of social supports and higher levels of loneliness were correlated with depression and suicidal ideation in their sample of 195 individuals with ASD aged 14-80. Unique to this population, in this study greater severity of ASD traits was also associated with loneliness, lower levels of satisfaction with social support, and increased depression severity.

Importantly, higher severity of reported ASD traits might also indicate that the individual has a higher degree of awareness of their condition which may make them more susceptible to depression. Other studies have supported this theory, finding that rates of anxiety and depression in children with ASD are correlated with increases in IQ (Mayes, et al., 2011). This may be especially salient if this results in increased awareness of social limitations (Huang et al., 2017). Although few studies have examined the concept of burdensomeness in individuals with ASD, Hill and Katusic (2020), hypothesized that reliance on others due to challenges with activities of daily living may contribute to this facet of suicidal desire.

Individuals with autism may also be more likely to experience bullying, one of many adverse childhood experiences. These painful or provocative experiences may contribute to the acquired capability to injure oneself. One meta-analysis found that school-aged youth with ASD were three times more at risk of being the target of school bullying than their typically developing peers (Maïano et al., 2016). Verbal bullying was the most commonly identified type, reported by over 50% of youth with ASD. This meta-analysis also found that bullying was more likely in regular education or mixed settings, which might indicate that special attention needs to be paid to students with ASD who are in mainstream placements. High rates of bullying are a critical issue in the question of suicide prevention as bullying has been associated with a significantly higher risk for individuals with ASD (Holden et al., 2020). In this study, the absence of cognitive impairment was also associated with increased likelihood of future suicidality, lending further evidence that individuals with ASD whose intellectual functioning falls in the normal range may need greater care and consideration in suicide prevention efforts. Furthermore, this study also found that females with ASD were at higher risk for suicidality compared to males. Bullying is only one of the ways that individuals can acquire the capacity to enact lethal self-injury. Children with ASD are more likely to experience reported and substantiated maltreatment compared to children in the general population (McDonnell et al., 2019). Childhood maltreatment has been positively associated with suicidal behavior (Liu et al., 2017), and, as theorized by Joiner (2005), this may be due in part because it repeatedly habituates the victim to the experience of physical pain and injury.

Several obstacles exist for clinicians attempting to identify and to treat suicide risk in individuals with ASD. Specifically, no suicide screening tool has been validated for use in adults with ASD (Cassidy et al., 2018). Similarly, while there are several evidence-based tools commonly used to assess for suicidality in youth within the general population (e.g., the Columbia-Suicide Severity Rating Scale [C-SSRS]), these have not been validated for use with ASD populations (Howe et al., 2020). In their systematic literature review on tools used to assess suicide in children with and without ASD, Howe et al., (2020) also found that studies examining suicidality in youth with ASD utilized only a few items from broader mental health measures or relied on the reported presence of self-injurious behavior. This may complicate accurate identification as individuals with ASD may engage in self-injurious behavior for a number of reasons unrelated to suicide including stereotyped behavior, sensory processing abnormalities, or communication difficulties (Summers et al., 2017). Additionally, research indicates that clinicians may receive less training in screening and managing suicide risk in ASD youth as opposed to identifying and treating core symptoms of ASD (Cervantes et al., 2022). This may result in reduced confidence in treating these high-risk individuals (Jager-Hyman et al., 2020; Cervantes et al., 2022).

Managing and treating suicidal thoughts and behaviors is similarly difficult for clinicians. At present, autism-specific approaches to suicide prevention and intervention are nearly non-existent (Cleary et al., 2022). Furthermore, clinicians may not feel confident in finding referrals for ASD patients at risk for suicide (Cervantes et al., 2022). Commonly used interventions for suicide are also under-researched and, potentially, underused by individuals with autism.

In their systematic literature review, Cleary et al., (2022) found no primary research regarding the usefulness or outcomes of crisis mental health services for people with ASD. Additionally, surveyed clinicians shared that they were less likely to use cognitive-behavioral therapy(CBT), an intervention which has been adapted to effectively reduce suicidal cognitions and behaviors (Mewton & Andrews, 2016), for individuals with ASD (Maddox et al., 2019).

Based on the existing research, it is clear that additional steps need to be taken to understand, to identify, and to treat suicidal thoughts and behaviors in individuals with autism. Clinicians should strive to find and to disseminate research that highlights the unique risk factors and presentation of suicide in neurodiverse populations. Additionally, researchers should take steps to validate, to adapt, or to develop screening tools that can be used to identify suicide risk in children and adults with ASD (Howe et al., 2020). Lastly, both research and practice should extend their focus to interventions that can be utilized or developed to serve individuals with autism. Changing attitudes on the appropriateness of established interventions such as CBT for individuals with autism may be an important avenue for providing successful treatment (Maddox et al., 2019) as autism-specific interventions are still in their infancy. Helping parents and caregivers act as advocates and supporters is another critical aspect of improving mental health care use among those with ASD (Cleary et al., 2022). While much work remains to be done, the dedication of clinicians, individuals with ASD, and their families, has already laid a foundation for greater understanding and more effective service.

*References on page 18

um•nsu•card
University of Miami-Nova Southeastern University
Center for Autism & Related Disabilities

www.nova.edu/card/index.html

AANE
ASPERGER / AUTISM NETWORK

www.aane.org/resources/family-and-friends/teens-support-groups/

SUICIDALITY IN LGBTQ+ YOUTH

KATE FITZPATRICK, BA

In the past two decades alone, the suicide rate in the United States has increased by approximately 30% from 2000 to 2020 (National Institute of Mental Health, 2022). The rates of suicide are increasing nationally in the United States and the population of youth affected by suicide is no exception. For children and adolescents aged 10-14, suicide is the second leading cause of death, and for individuals aged 15-24, suicide is the third leading cause of death (National Institute of Mental Health, 2022). Disparities are evident between individuals affected by suicidal ideation and attempts. Specifically, in the LGBTQ+ community, research has supported that there is an increased risk for suicidality with some studies have indicating that lesbian, gay and bisexual (LBG) youth are four times more likely to attempt suicide than heterosexual youth (Human Rights Campaign, 2021). Adolescents of the U.S. are already at an increased risk for suicide and, coupled with an LGBTQ+ identity, the risk is intensified. The percentage of the U.S. population that identifies as LGBTQ has also shifted, with an increase from about 4 % in the past decade to approximately 8 % reported in 2021(Human Rights Campaign, 2021). Although they make up only 8% of the percent of the nation's population, individuals identifying as LGBTQ+ are disproportionately represented when it comes to suicidality with about 45% of LGBTQ youth reporting that they had seriously considered suicide in the past year (The Trevor Project, 2022). Within the LGBTQ-plus community, the research pertaining to suicide indicates that there is some heterogeneity of risk within this population. Identities may share some similar risk factors in terms of suicidality; however, groups such as non-binary and transgender individuals may also possess unique risk factors pertaining to gender-related differences.

This introduces additional complexity to research and may result in many studies being tailored specifically toward one group among the larger LGBTQ+ umbrella. Even so, the literature identifies bisexual, transgender and non-binary as possessing within-group increased risk of suicide (The Trevor Project, 2019b). Approximately half (48%) of bisexual youth were reported to have seriously considered attempting suicide in the year 2021(Center for Disease Control, 2022). This is only one example of the within-group difference that affects the LGBTQ+ community. While bisexual youth possess an LGBTQ+identity, they show markedly different rates of suicidal ideation than other sexual and gender minorities. Transgender and non-binary individuals also have increased risk of suicide within the LGBTQ+ community, with an approximately 2.5 times higher likelihood of experiencing depressive symptoms, seriously considering suicide, and suicide attempts compared to their LGBTQ peers (The Trevor Project, 2020). There is also significant risk related to intersectionality within this population. . For instance, there are increased suicide rates among LGBTQ youth of color, with black LGBTQ youth reporting higher rates of suicide attempts compared to white peers (Trevor Project, 2022). Notably, one in four black non-binary or transgender children attempted suicide in 2021 (Trevor Project, 2022). Understanding the nuances of and risk factors related to specific and intersectional identities within this community is important for suicide research and clinicians alike.

Different factors contribute to the disparities in suicide seen among LGBTQ+ individuals. One of these risk factors is minority stress. Minority stressors within the meta analyses include LGBT bias-based victimization, general victimization, bullying, and negative family treatment (Lange et al., 2022). Each of these factors was significantly associated with suicidal ideation and/or suicide attempts (Lange et al., 2022). Minority stress is something that can be experienced by LGBTQ plus youth in many facets of life, ranging from school settings to social settings and even life at home. The Trevor project elaborates on the impact of minority stress as a risk factor for suicide in the LGBTQ community with research from the organization suggesting that greater experiences of minority stress are associated with increased odds of attempting suicide (Trevor Project, 2022).

Additionally, suicide risk may fluctuate across an individual's lifespan. While literature on gender minority individuals is more limited, some studies indicate that LGB individuals are at the highest risk for suicidal thoughts during adolescence compared to young adulthood (de Lange et al., 2022), further supporting the need for increased awareness and attention to LGB youth suicidality. An additional risk factor highlighted in the literature is rejection and a lack of social support or affirming spaces for LGBTQ+ youth. This extends to support from family and whether or not there is parental rejection. Research suggests that one third of LGBTQ+ youth experience parental rejection, with an additional one-third waiting until adulthood to disclose their LGBTQ plus identity, (Katz-Wise et al., 2015). This leaves a third of LGBTQ + individuals assuming overt parental acceptance, and with this being a key risk factor for suicidal ideation and suicide attempts, it is important to be aware of this risk.

While the predominance of risk factors and stressors experienced by LGBTQ+ youth offer a sobering view of suicide risk, there is hope.

Within the existence of these risks are ways in which protective factors can be magnified and it is important for clinicians to take note of each potential avenue to promote these beneficial strategies. Research consistently finds that lower rates of suicide attempts are reported when access to LGBTQ+ affirming spaces are provided (The Trevor Project, 2020). Increasing access to affirming spaces for LGBTQ+ youth can decrease these risks and also destigmatize the extension of affirming care as a whole. Social support and acceptance is an additional identified protective factor for LGBTQ+ youth in research (The Trevor Project, 2022). Social support can be support from friends at school, an adult in the child's life or even support from the community. Beyond same-aged peers, having at least one accepting adult in the life of an LGBTQ+ child may be able to reduce the risk of a suicide attempt by about 40% (The Trevor Project, 2019a). As in the general population, having a supportive adult to to confide in can offset the risk for suicide in LGBTQ+ youth.

Transgender and non-binary youth share different protective factors in terms of policies and practices than their sexual minority peers. When transgender and nonbinary youth have reported that their pronouns are respected by all or almost all of the people in their lives, the rate of suicide attempts are about half of what is reported by those who do not have their pronouns respected (The Trevor Project, 2022). Importantly, the actions of others are seen as a theme of influence within the risk and protective factors regarding suicide in the LGBTQ+ community, suggesting room for change starting with the community.

As clinicians, being aware of the risk and protective factors that influence suicidality in LGBTQ+ populations is critical. Finding ways to identify support systems, safe spaces and practicing affirming care with LGBTQ+ clients may influence the quality of care in sessions. Also, understanding a client's identity may help clinicians maintain better awareness of the specific risks associated with being a part of a marginalized group in this climate. Using correct pronouns and asking about support at home can be ways in which clinicians can identify risk and support those within the LGBTQ+ community, especially children. The Trevor Project estimates that more than 1.8 million LGBTQ youth (13-24) seriously consider suicide each year in the U.S. — and at least one attempts suicide every 45 seconds (The Trevor Project, 2021). Understanding this increased risk in adolescents identifying as LGBTQ+ may assist in the global effort to prevent youth suicide and identify those at greater risk. As clinicians, these findings are important to be aware of when serving this community of children deeply in need of support and advocacy.

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THE TREVOR PROJECT

For Young LGBTQ Lives

Visit www.thetrevorproject.org for more info

UNDERSTANDING AND ADDRESSING SUICIDE IN THE CARIBBEAN

SITARA RAMBARRAN, MS

Suicide is an alarming public health problem with numerous negative consequences. According to the World Health Organization (WHO, 2021), in developing countries, the stigma attached to mental disorders and particularly suicide, may lead to underreporting. A wide spectrum of risk factors for suicide, specific to the Caribbean, have been recognized. Within the Caribbean, the rate of suicide attempts has been steadily increasing and has become a source of major concern. For example, in the past 15 years, the suicide rate in Suriname alone has doubled (Graafsma et al., 2016). Despite the close proximity of most countries, and some shared cultural aspects, for the Caribbean region, suicide statistics differ drastically. Suicide rates are lowin such territories like Jamaica, Barbados, and Haiti. However, in countries such as Cuba and Trinidad and Tobago, these figures are more closely aligned with the world average. In Latin America and the Caribbean, the age-adjusted rate of suicides is 5.2 (8.4 in men and 2.1 in women), per 100,000 population. Consistent with global reports, mortality from suicide continues to be higher in men than in women (male-female ratio of 3.8); however, women report more suicide attempts (Pan American Health Organization/WHO, n.d.). In the Caribbean, the East Indian community appears most vulnerable. Notably, pesticide intoxication accounts for more than half of these suicidal behaviors (Graafsma et al., 2016).

From personal experience, when addressing suicide in the Caribbean, cultural considerations such as the stigma of suicide and mental disorders, the relation between homicide and suicide, salient methods of suicide, comorbidities of suicide, the limited access to healthcare and medical resources, and common coping mechanisms must be incorporated. The existing research indicates that extensive levels of mental health stigmatization exist. Moreso, the development and maintenance of a mentally healthy population is not considered a priority in comparison to the emphasis on physical health in the Caribbean (Youssef, 2018). The stigma of mental disorders in the Caribbean can be examined from many perspectives including community members' views of mental illness, emotional responses towards those with mental illness (such as fear or shame), behavioral responses towards those with mental illness (like avoidance or aggression), and perceptions of and beliefs about mental illness, particularly recognition of the difference between "madness" and "mental illness" (Graafsma et al., 2016).

Suicides within the Caribbean, generally elicit anger and contempt as a reaction. However, there is the rare instance in which a suicide attempt receives sympathy when under the circumstance of escaping negative situations like torture, rape, or slavery (Graafsma et al., 2016). Research has also suggested that the low suicide rates in some Caribbean countries are potentially explained by the general tendency among persons in the region to express their anger through externalizing behaviors such as verbal, physical, and emotional violence towards others rather than internalizing behaviors which result in suicide (Hutchinson, 2005). Another form of interpersonal violence, intimate partner abuse or domestic violence is rampant in the Caribbean. Homicides followed by suicides due to conflict with a partner commonly occur (Hutchinson, 2005).

In the Caribbean, the most commonly used methods for suicide are suffocation, firearms, and poisoning through the use of pesticides (PAHO/WHO, n.d). There is a high rate of hospitalization due to the ingestion of poisons in countries with a high East-Indian population. Conversely, in those with a low East Indian population, the predominantly Afro-Caribbean population have been overdosing with analgesics or benzodiazepines. The use of pesticides in suicide and attempted suicide is a well-known phenomenon in developing, agricultural and tropical countries (Gunnel & Eddleston, 2003, as cited in Graafsma et al., 2016). The most widely used method of suicide in the Non-Hispanic Caribbean is poisoning (47.3%) (Mascayano et al., 2015). Based on personal experience, pesticides may be used in impulsive acts of suicide rather than those with a suicide plan and long-term intent. In fact, pesticide as a means of completing suicide is such common knowledge, that it has become a source of humor and discussion when someone is seen to purchase pesticide in a hardware or agricultural/garden center. The individual purchasing the pesticide may be mockingly questioned of their intent by a sales clerk or another consumer.

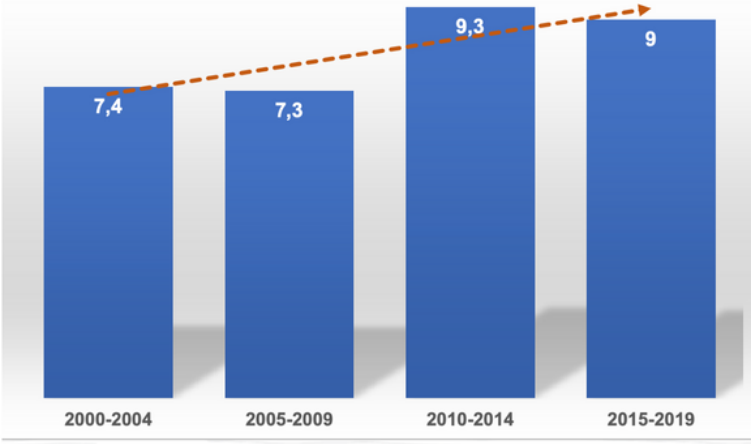
Regarding comorbidities, the Global Burden of Disease study conducted in 2010, has ranked depressive disorders as the largest contributor to years lived with disability (YLD) in the Caribbean since 1990, with these conditions increasing by 948 YLD per 100,000 persons in 2013. Depression frequency and severity, and suicidal behaviour were higher among females (with the exception of completed suicide being more common in males); persons with lower education, income, and occupation levels; those participating in less religious activity; and those with less social capital and support (Brown at al., 2017). The lack of access to healthcare and medical resources as well as the stigma of mental disorders and treatment can be considered a reason for the high rates of comorbidities in the Caribbean. It must be noted that many Caribbean adults who engage in suicidal or self-injurious behaviors have no history of receiving psychoeducation, having contact with a mental health professional or been provided treatment for mental illnessn (Hutchinson, 2012).

Additionally, the health system in the Caribbean is faced with many challenges. They are confronted with limited resources both financially and in terms of the number of trained mental health professionals. From personal understanding, there are numerous obstacles in the implementation of mental health policies which stem from social and political reasons. This, coupled with the strong stigma associated with seeking help for suicide attempts and mental illness results in inadequate and insufficient access to healthcare. Moreover, high levels of inequality, poverty, and illiteracy exacerbate the lack of adequate mental health care (Mascayano et al., 2015). A lack of monitoring systems for tracking and recording suicide attempts also contributes to the under reported suicides.

Furthermore, poor coping mechanisms for negative emotions and stress include the use of substances such as alcohol or drugs, overeating, and other risky or aggressive behaviors. In the Caribbean, substance use is a common coping mechanism and is considered a major health and social issue (Hutchinson, 2012). The most popular substances used for relief include alcohol, tobacco, cocaine, and cannabis. There is minimal research to establish the degree to which other drugs such as ecstasy, amphetamines and heroin are being used and affecting Caribbean populations. However, there is considerable use which may present a growing threat in the coming years (Hutchinson, 2012). In the Caribbean, persons may experience greater direct exposure to unhealthy practicesby being in a cultural environment that promotes the use of unhealthy food, drugs and alcohol as normative social practice, as well as a means for managing difficulties (Lacey et al., 2015).

Fortunately, effective and evidence-based interventions can be implemented at population, sub-population and individual levels to prevent suicide and suicide attempts. However, more research is necessary to obtain further insight on the stigma of mental disorders in order to develop approaches to reduce such stigma and encourage open discussion about seeking treatment for mental illness. The use of prejudicial language, over-generalizations, and the creation and perpetuation of stereotypes all contribute to the stigma of mental illness and must be combatted and eliminated. Instead, success stories of mental health interventions should be highlighted to encourage people to seek help as a progressive and important step in self-development (Hutchinson, 2012). The accessibility of lethal pesticides provides those who are suffering mentally and wish to end their life with reasonable means of doing so. Considering the prevalence of suicide in the Caribbean, coupled with the alarming rate of pesticide use, this calls for continued research and intervention. Intervention is necessary in multiple forms such as providing psychotherapy to those who have attempted suicide and their relatives, and stricter legislation towards the sale and distribution of pesticides. Programs that offer workshops such as skills training for emotional regulation, coping skills for managing stress and depression, and healthy dietary behaviors should be implemented. Gatekeeper training activities for not only those who are healthcare professionals, but also the social support network of attempt survivors should be promoted. This is key as a strong predictor of suicide, is a history of attempted suicide. Hence, gatekeeper training programs can be an added measure of effective intervention. Another measure is education surrounding healthy coping mechanisms for stress to discourage substance use and dependency. Overall, tailored interventions and further research that incorporate cultural values and norms related to suicide within each Caribbean country are key to reduce the rates of suicide in the Caribbean.

*References on page 19



Regional suicide rates per 100,000 for five-year periods between 2000 and 2019

Retrieved from Pan American Health Organization (PAHO), 2021

SUICIDALITY IN CHILDREN

CHRISTINA CASTELLANA, M.S.

For many years, suicide prevention efforts have focused on adolescents, adults, and older adults, with limited research on children younger than 15 (Soole et al., 2015). While statistics have shown that suicide is relatively uncommon in pre-adolescence (Bridge et al., 2015), hospitalization for suicide risk in this age group has been increasing (Arakelyan et al., 2023). Furthermore, suicide deaths within this age range are often officially reported as accidents or unintentional deaths, likely leading to underreporting (Gray et al., 2014). Because of this, there is increasing pressure to research this population to identify risk factors and develop appropriate screening and prevention practices (Ayer et al., 2020).

Suicide risk in children may be missed due to gaps in our understanding. One misconception is that children do not have the developmental maturity to act on suicidal thoughts as they have an incomplete concept of death. However, research shows that by around age 9, many children thoroughly understand both death and suicide (Tishler, 2007; Whalen et al., 2017; Shirley, 2020). Whether they understand the consequences of their actions or not, children may consider death to end their emotional pain without fully understanding the finality of their actions (Tishler, 2007). While theoretical frameworks to understand suicidal ideation in young children are still developing, it will be important to consider existing theories regarding pain, hopelessness, and lack of connectedness in conjunction with children's still developing ability to control emotions and impulses (Ayer et al., 2020).

As with adults and adolescents, suicide in children is often associated with prior suicidal behavior (Ruch et al., 2021). With this in mind, it is important to identify children thinking about suicide as early as possible so they can receive treatment for mental health concerns (Wyman et al., 2009; Herba et al., 2007). Therefore, it is vital for the adults around them to be able to identify the signs of suicide and take all risks seriously. The following are warning signs that may be seen in children.

Changes in Usual Behavior	• Neglecting personal interests or previously enjoyed activities • Dreaming or worrying about death • Increasing problems at schools or school problems occurring for the first time • Expressing a general dissatisfaction or disinterest in all activities
Risk Taking	• Running into the street • Climbing a tall building • Eating inedible material
Experiencing Multiple Depression Symptoms	• Experiencing long term sadness • Frequent crying • Difficulties concentrating in school • Lacking energy to participate in activities • Losing interest in previously enjoyed activities • Difficulty sleeping • Nightmares • Physical pains not likely linked to verified illness • Experiencing anxiety or phobias

Conversations About Suicidal Thoughts or Plans	• Children may say:
	  • "I'm not very happy most of the time… I think about dying."
	  • "I think my mom left because of me… it would be better if I wasn't here."
	  • "I hate my life. I want to go away."

(CSP, 2008; Finzi et al., 2001)

In addition to early identification of warning signs, it is important to be able to assess for suicidal ideation appropriately. If a child is showing warning signs, or you are generally worried about them, have a conversation with them. When talking to a child about suicide, be sensitive to the child's mood at the beginning of the conversation and notice any changes during the conversation. Speak slowly and avoid rushing the conversation. Be aware of the child's body language and what they are saying. Maintain an open, non-judgmental tone and use clear, direct language. Start with a lead-in question like, "It seems like something happened that really upset you. Can you tell me what happened?" or "Your (teacher/parent) shared with me that you (said/did/wrote/drew) _____. Do you want to tell me more about this?".

Explore if the child has thoughts about death, or permanent sleep, as an escape or solution and if the child has thought about their own death and thought about actively bringing about their own death. You can then ask about suicide directly, “Did you ever feel so upset you wanted to die?” or “Do you think about hurting or killing yourself?” (CPS, 2008; Conversation Guide for Child Suicidality). If a child does express thoughts of suicide, explore methods (plausible or not plausible), intent, and plan. When assessing for suicide risk, asking the child and family about the mean is especially important. Research suggests that asphyxiation was the most common method, followed by firearms (Bridge et al., 2015; Ruch et al., 2021). Importantly, one study found that in all cases of child suicide where a firearm was used, the firearm was stored unsafely (Ruch et al., 2021).

Certain factors can place people at higher risk for suicide than others. Some risk factors affect children particularly. These include a family history of suicide, depression, or substance use, previous suicide attempts, untreated depression, anxiety, or other mental illness, an incomplete comprehension of death, and self-harm. Risk factors may also include access to means of suicide, learning difficulties or lack of success in school, exposure to physical, emotional, or sexual trauma, unstable home environment, negative school experience, and significant recent losses (CPS, 2008; Tishler, 2007; Whalen et al., 2017; Sheftall et al., 2016). Recent research by Ruch et al. (2021), identified several risk factors that expand on those previously identified. While existing mental illness was still identified as a risk factor, the most common diagnosis in this study's sample was attention-deficit hyperactivity disorder (ADHD).This was also found in research by Sheftall et al. (2016), which underscores the importance of risk assessment even when children are not diagnosed with depression. Family-related problems such as custody issues and parental substance abuse were also found to be associated with child suicide, as were school- or peer-related problems such as expulsion, suspension, and bullying (Ruch et al., 2021). Importantly, this study also identified precipitating events relevant to suicide in children. The most common of these was discipline related to school problems or an argument with a parent/guardian.

Other factors or circumstances can guard a person against thinking about suicide and increase their resiliency. Some protective factors that can build resilience in children include positive relationships; positive self-esteem and self-worth; a hopeful view of the future; effective problem-solving and coping skills; safe and secure home environment; positive school and life experiences; success at school, sports, or arts; involvement in faith or religious communities; and the ability to communicate their needs, feelings, and thoughts to others (CPS, 2008). Positive relationships in a child’s life significantly promote their mental health and build resilience. These relationships foster self-esteem, competence, and the ability to respond to life’s challenges. Anyone who is in a child’s life can help that child build resilience. t home, parents and other family members can take action to build resilience in that child by actively listening, understanding, and validating what they say; teaching a child that mistakes and problems are opportunities to learn new skills; identifying and affirming a child’s strengths; and encouraging children to ask for help when it’s needed (CPS, 2008). At school, teachers, school counselors, coaches, and school administrators can all play a role in fostering resilience in children by providing safe, structured, and predictable schedules and routines; increasing children’s sense of control; increasing children’s confidence and experiencing success by setting achievable goals; teaching positive behaviors; ensuring the appropriate response is taken following the suicide death of a student; and implementing suicide prevention programs (CPS, 2008).

Suicide prevention programming in schools is effective when it includes mental health promotion that emphasizes strength-based activities, resilience, and help-seeking, meaningful student engagement that gives them a sense of belonging and purpose, training teachers and staff to identify thoughts of suicide in children through gatekeeper training, easy and apparent access to mental health support at school, and focused and coordinated care following suicide attempts or behaviors that result in hospitalization (School Mental Health Ontario, 2019).

Increased emphasis on researching, identifying, and preventing suicide in child populations is a positive step toward reducing the devastating consequences of suicidality in children. With increased research and awareness, parents, communities, and health practitioners can increase their ability to identify and respond appropriately to risk.

Early identification and intervention may also improve the high suicide rates in adolescents and young adults, lending further urgency to prevention programs for children (Ruch et al., 2021). Expanding known prevention and protective factors, such as restricting access to lethal means, building resilience, and improving family relationships, will also be important as we work together to address child suicide.

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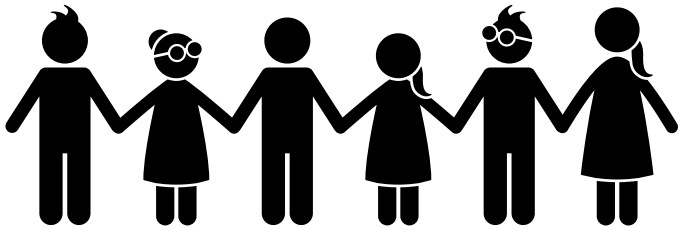

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CENTER FOR STUDENT COUNSELING AND WELL-BEING
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WWW.NOVA.EDU/HEALTHCARE/STUDENT-SERVICES/STUDENT-COUNSELING.HTML

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