

**British Columbia Foster Care Education
Program**

SUICIDE AWARENESS
(5 Hours)

Ministry of Children and Family Development

July 2002

About the Author(s)

ASK z ASSESS z ACT: Suicide Intervention Training for Foster Parents Originally designed for school personnel in BC, ASK z ASSESS z ACT was designed with guidance of an advisory committee, the 1997 Suicide Prevention Training Needs Survey (CUPPL, UBC), and a focus group, as well as an extensive search of the literature. Program developers were Brenda A. Dafoe & Associates and Callum Consulting. See Appendix IV for further information about the Ask z Assess z Act Program.

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INTRODUCTION

Introduction

A. RATIONALE

The Ministry of Children and Family Development has adopted a comprehensive suicide prevention and intervention training strategy for the province of BC as described in *Youth Suicide Prevention: A Framework for British Columbia* (1998). The ASK z ASSESS z ACT program has been revised for use as a basic level of suicide intervention training, appropriate for foster parents. This early intervention *Before-the-Fact* strategy (as described in the *Framework*) has the intent of reducing suicides and suicidal behaviours.

It has been demonstrated that significant numbers of suicide attempts and completed suicides involve youth and it is therefore logical to train foster parents about suicide intervention. Foster parents, as primary caregivers, have the most contact with children in their care and are best situated to recognize suicidal behaviour (Charles and Matheson, 1991). The only way detection can be made is through training and awareness. Similar to first aid training, suicide intervention can be a first response to a potentially life-threatening event, and individuals can be trained to look for warning signs to respond and to find out where to get help.

This special edition of the workshop has been adapted to fit the in-service training needs of foster parents. BC Council for Families agreed that it would be beneficial for all concerned to utilize the program as much as possible. As ASK z ASSESS z ACT was originally developed for school personnel who work with youth, it was seen as appropriate that the workshop be adapted as an in-service training tool for foster parents. LivingWorks two-day suicide intervention training is currently offered to Ministry of Children and Family Development child protection workers, foster parents, and members of multi-disciplinary teams. Components of ASK z ASSESS z ACT are adapted (with permission) from the LivingWorks training. A similar (but shorter) program using common language and a common risk assessment was seen as beneficial to all Ministry divisions and programs.

The intent of this module is to improve the overall competency of foster parents in the recognition and crisis management of potentially suicidal youth.

A key component of the original ASK z ASSESS z ACT training was evaluation. In the original school-based version, evaluation instruments were administered pre and post training. Learning is not being evaluated in this special edition for foster parents. The evaluation instruments, referred to as “quizzes,” are being used but for a different purpose. The pre-quiz encourages participants to focus on suicide and consider what they currently know; the post-quiz reinforces the learning acquired in the workshop.

B. LEARNING OUTCOMES

The caregiver can:

- demonstrate attitudes favourable to suicide intervention, including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation.
- recognize youth stressors and suicide warning signs.
- demonstrate skills in initiating intervention, assessing risk and developing action plans.

C. PREPARATION

The “Suicide Awareness” module is a single five-hour session. The chart following summarizes its components and intended outcomes. Foster parents should be familiar with the material in the module. Read it thoroughly and imagine yourself going through the various exercises and activities. Think of examples you might have from past experiences.

Refer to the “Overview.” This section provides an overview for each particular learning unit with a suggested timeframe. Make notes for yourself to supplement the material provided.

ASK z ASSESS z ACT Program Content, Objectives and Measures			
	Content/Process	Objective	Outcome
Introduction	<ul style="list-style-type: none"> • Administer Quiz (attitudes and knowledge) • Workshop Goal • Pre-assess Participants • BC Statistics on Youth Suicide 		
Attitudes	<ul style="list-style-type: none"> • Explore individual and societal attitudes towards youth suicide and intervention 	<ul style="list-style-type: none"> • To increase the likelihood that participants will adopt attitudes favourable to intervention, including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation 	<ul style="list-style-type: none"> • The proportion of participants who demonstrate attitudes favourable to intervention including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation will increase.
Knowledge	<ul style="list-style-type: none"> • Youth Stressors • Suicide Warning Signs 	<ul style="list-style-type: none"> • To increase participants' knowledge in suicide warning signs. 	<ul style="list-style-type: none"> • The proportion of participants who demonstrate increased knowledge in suicide warning signs will increase.
Skills	<ul style="list-style-type: none"> • Risk Assessment Practice • Standards for Foster Homes 	<ul style="list-style-type: none"> • To improve participants' skills in initiating intervention, assessing risk and developing action plans. 	<ul style="list-style-type: none"> • The proportion of participants who demonstrate skills in initiating intervention, assessing risk and developing action plans.
Closure	<ul style="list-style-type: none"> • Other proactive programs • Administer Attitude Quiz; Knowledge Quiz 		

Instructions

**OVERVIEW OF
CARING FOR CHILDREN:
ASK z ASSESS z ACT
SUICIDE AWARENESS TRAINING FOR FOSTER
PARENTS**

1. Introductions (25 minutes)
2. Attitudes (20 minutes)
3. Knowledge
(2 hours)
4. Skills (1 hour and 40 minutes)
5. Closure (20 minutes)

Instructions

1. INTRODUCTIONS (25 minutes)

Objective: To introduce this module.

Materials:

Handouts

- Handout # 1A Knowledge Quiz
- Handout # 1B Attitudes Quiz
- Handout #2 Canadian and BC Suicide Statistics
- Handout #3 Module Intent and Learning Outcomes

Overheads

- Overhead #1 Canadian and BC Suicide Statistics
- Overhead #2 Module Intent and Learning Outcomes

Instructions: To make sure that the workshop is providing you with the necessary knowledge and skills, we are asking you to complete a “before and after” knowledge and attitudes quiz. Quiz results will assist us in ensuring the workshop is effective. The quiz also helps you focus on issues related to suicide and consider what you

currently know about suicide and youth. Please note: In this workshop we use the term "youth" to refer to all children in care. There are few children under the age of twelve who die by suicide. Of 557 suicides in 1997, two were of children under 12.

Please print off and do the quizzes (1A & 1B).

Please put your quiz aside once you have finished it and remember that you will be asked at the end of the course to repeat the quizzes.

This one-day session has been adapted to address in-service training needs of foster parents. This training is designed to give foster parents the opportunity to increase their awareness of youth stressors and of warning signs of suicide and practice basic intervention skills. The workshop is based on the "Suicide Intervention Handbook," developed in Alberta.

As a foster parent it is important to consider that children in care may be at high risk of suicide because of life circumstances related to coming into care. Many children-in-care have not had the opportunity to develop strong attachments to their family of origin. They also may have unresolved issues arising from abandonment, separation, and multiple loss which may have begun at a young age and which can contribute to suicide risk.

The large body of research on youth suicide points to the crucial importance that youth suicide intervention programs play in reducing youth suicide. We are all aware of the high incidence of youth suicide. We may not all be aware that trained "lay" caregivers are very effective in intervening with youth at risk of suicide. This awareness highlights the importance of providing training to foster parents and others involved with youth. Foster parents, as primary caregivers, have the most contact with children in their care and may be the first to recognize warning signs of suicide risk. Those who foster babies and small children will also benefit from this training. Although the number of children under 12 who commit suicide is very small, there are reported cases (one or two a year in British Columbia). Also, many babies and young children in care have teen-aged mothers or fathers to whom foster parents will be relating and who may be at risk of suicide.

By the end of this session participants should feel more knowledgeable about youth suicide and more confident in their

ability to help a youth at risk of suicide. Active participation in the session is crucial.

A two-day "Suicide Intervention Workshop" may also be available in the region. This workshop is one of several programs developed and offered through LivingWorks Education Inc. This workshop helps participants recognize and assess persons at risk of suicide and continues the development of intervention skills through the use of case studies, videos, and skill practice.

All participants, by virtue of their role as foster parents, are part of the "first responders" group responding to youth at risk of suicide. Consider the following:

- Have you ever attended a workshop on suicide? on youth suicide?
- Have you ever had personal experience with a youth or other person at risk of suicide?
- Have there been any youth suicides in this community?

Refer to Handout #2, "Canadian and BC Suicide Statistics" and Overhead #1, "Canadian and BC Suicide Statistics," emphasizing that:

- after accidents, suicide is the second leading cause of death among youth and young adults age 15 - 24 years in most Canadian provinces.
- approximately 700 youth commit suicide annually.
- the rate for this age group tripled between 1960 and 1980.
- since 1980, this trend seems to have leveled off.
- the risk remains high.

We have included selected information from the McCreary Centre Adolescent Health Survey from 1993. The McCreary Centre Society is a non-profit agency located in Vancouver which aims to facilitate clinical and behavioural research on adolescent issues.

Highlight the following:

The McCreary study surveyed 15,549 BC students in 48 school districts.

Findings included the following:

- 16% of those surveyed had considered suicide at least once in the past year (2488 students).
- 14% of those surveyed had planned a suicide (2177 students).
- 7% of those surveyed had attempted suicide (1088 students).
- 2% of those surveyed reported they were injured in a suicide attempt (311 students).

This study is currently being updated; the revised version should be available soon.

Review Overhead #2, “Module Intent and Learning Outcomes” and Overhead #3, “Agenda.”

Please consider the sensitive nature of today’s topic. Talking about suicide can be difficult. For some, suicide is still a taboo topic; for many of us, it is emotionally charged. Most of us have had personal experiences with suicide: family, friends, or perhaps ourselves. If so, you are not alone. Most of us have been touched by suicide, either personally or professionally.

2. ATTITUDES (20 minutes)

Learning Outcome: The caregiver can:

- demonstrate attitudes favourable to suicide intervention, including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation.

Materials:

Handouts

- Handout #5 Exploring Attitudes to Intervention
- Handout #6 Standard B.2 Reportable Incidents

Instructions:

Our attitudes develop over time and are influenced by a combination of personal and societal norms about suicide as well as our own experiences with suicide. Our attitudes influence the way we respond to a youth at risk of suicide.

Exercise:

The following exercise asks you to consider three statements related to your personal attitudes to suicidal youth. Please respond by checking the category that feels most right for you at this moment. Handout #5 "Exploring Attitudes to Intervention."

Statement 1.

I would actively intervene with a youth at risk of suicide.

Consider:

If someone is undecided about or disagrees with statement 1; what possible attitudes may lie behind the response?

Possible attitudes related to an **"undecided"** or **"disagree"** response to this question could include:

Panic: "I'm a foster parent, not a crisis worker"!

Fear: "What if I help, and he does it anyway"?

Frustration: "This is not my job. I'm already too busy."

Resignation: "In her situation, it's probably for the best."

Statement 2.

I would take seriously any indication of thoughts of suicide expressed by a youth.

Consider:

If someone is undecided about or disagrees with statement 2, what possible attitudes may lie behind the response?

Possible attitudes related to an “**undecided**” or “**disagree**” response to this question could include:

Resentment: “This is simply attention-getting behaviour on her part.”

Anger: “You're not serious! Many youth have problems worse than yours”!

A common belief is that the threat of suicide is often used by young people as a form of manipulation or attention-seeking. Those who hold this opinion may be reluctant to intervene because they feel intervention may reinforce what they see as negative behaviour. Any threat of suicide must be taken seriously. Threats and gestures indicate thoughts of suicide and are recognized as behaviour that leads to increasingly serious threats and behaviour.

Conflicted: “If someone really wants to kill himself or herself, no one has the right to stop them.”

Statement 3.
I will keep confidential any information a suicidal youth shares with me.

Consider:
If someone is **undecided** about or **agrees** with statement 3, what possible attitudes may lie behind the response?

Possible attitudes related to an “**undecided**” or “**agree**” response to this question could include issues of trust between the child in care and the foster parent.

Helpful attitudes for foster parents are attitudes favourable to active intervention, breaking confidences and seeking help. The Standards for Foster Homes outline your responsibilities as a foster parent who is concerned about a suicidal youth. Standard B-2 must be followed if a youth is suicidal. Refer to Handout #6, “Standard B.2 Reportable Incidents.”

Also refer to Standard F.2 in the Standards for Foster Homes regarding documentation requirements.

Summary Remarks:

The goal of this session is to reinforce attitudes favourable to intervention including a willingness to:

- intervene with a youth at risk of suicide in a non-judgmental way
- take seriously any thoughts of suicide expressed by a youth
- break confidences and seek consultation if necessary.

3. KNOWLEDGE
(2 hours)**Learning Outcomes:**

The caregiver can:

- recognize youth stressors and suicide warning signs.

Materials:

Handouts

- Handout #7 Suicide Warning Signs
- Handout #8 CPR – The Most Important Risk Factors
- Handout #9 Risk Assessment Exercise
- Handout #10 Risk Assessment Exercise – Answer Key
- Handout # 11 Six Tasks for the Helper

Overheads

- Overhead #4 Stressor
- Overhead #5 Suicide Warning Signs
- Overhead #6 CPR – The Most Important Risk Factors
- Overhead #7 Six Tasks for the Helper

Other

- paper
- pen

- **Instructions:**

What do we need to know about youth and youth suicide in order to be effective helpers? In order to help someone, we need to be able to recognize a person who is in trouble. We need to look for warning signs, specific actions or words that may indicate a youth is considering suicide. In this component of the module we will:

- consider stressors
- look at warning signs of suicide, and
- consider and practice using a risk assessment framework.

Review Overhead #4, "Stressors," to clarify what will be explored in this section.

Like most of us at various times in our lives, youth experience stress. As adults, we may consider some youth stressors relatively unimportant.

However, it is how the youth feels about the stressor that determines the significance of that stressor: Stress is in the eye of the beholder.

Exercise 1:

Draw two outlines on the paper: "Stressed out Samantha" and "Stressed out Sam."

Write stressors, and list them on Sam or Samantha.

- what is the first thing you notice? (Number of stressors)
- are there different stressors for Samantha? for Sam?
- what is the organizing concept behind many of these stressors - the one common factor? (Answer: Loss)

Exercise 2:

Refer to Handout #7, "Suicide Warning Signs" and Overhead #5, "Suicide Warning Signs" to clarify what is going to be explored in this section.

What can you see that could indicate a youth is at risk of suicide. Review the following points:

- Warning signs are symptoms of youth (dis)stress; they indicate things are not going well.
- Warning signs may indicate suicidal thoughts.
- The more that warning signs/symptoms indicate an overall theme of hopelessness and helplessness, the greater the likelihood that these warning signs are indicators that suicide is on the youth's mind.
- Warning signs may be verbal or non-verbal. For example, a youth may comment: "I'd rather die than..." or a youth may give away her Discman for no apparent reason. Both may be warning signs of suicide.
- Signs of depression in pre-school children may appear in the form of anger, restlessness, worry, pains, fears, self-blame, irritability, apathy, tension or fatigue.
- Depression in youth may be masked behind or within "acting out" behaviours.

Now refer back to the paper on "Stressed out Samantha" and "Stressed out Sam."

Identify some common warning signs that may indicate a youth is considering suicide. For example, it has been suggested that Sam feels stressed because he realizes he is gay. What are some of the warning signs Sam might exhibit?

Do this with a number of the identified stressors until most of the common warning signs have been identified. As they are identified, write the warning signs on the paper.

What is the organizing concept is that lies behind many of these warning signs or symptoms - the one common factor. (Answer: Changes).

Review Overhead #5, "Suicide Warning Signs" again.

Exercise 3:

This risk assessment framework was developed in Calgary for the Suicide Intervention Workshop by Ramsay, Tanney, Tierney and Lang (used with permission). It is based on 7 variables developed through research done at the Los Angeles Suicide Prevention Centre. The variables are age, gender, stress, symptoms, current suicide plan, prior suicide behaviour and resources.

Please jot down the 3 factors (variables) you consider to be the most important in identifying and assessing a person at risk. The answer will be evident later in the session.

Now review and discuss Handout #8, "CPR - The Most Important Risk Factors" and Overhead #6, "CPR - The Most Important Risk Factors" with participants.

Risk Assessment Factors

AGE

- Youth are at high risk of suicidal behaviours.

GENDER

- The rate of suicide and suicidal injuries varies with age and gender.
- Males complete suicide more than three times as often as females, but females attempt suicide more than twice as often as males.

Think about what might account for this difference between male and female suicide, and male and female self-injury. One possible reason is that males choose more lethal methods such as guns (although in BC, hanging was the most common method for both males and females in the under 24 age group in the years 1994 – 1995).

TRAINER'S INSTRUCTIONS

STRESS

- Is there stress in the youth's life? Remember the list of possible stressors studied earlier.
- Remember that stress is in the eye of the beholder.
- How does the youth feel about the stress?

SYMPTOMS

- What symptoms or warning signs do you observe in the youth's behaviour (verbal, behavioural, etc.)? Remember the warning signs discussed earlier.

CURRENT SUICIDE PLAN

If you know there is significant stress in the youth's life and have noticed one or more "change in behaviour" warning signs, then you must ask directly about thoughts of suicide. Asking directly will not suggest the idea of suicide to a youth. It is the only way to find out if the youth is thinking about suicide. If asking a very young child (under 12) something like the following can be used: Are you thinking about death/dying? Are you thinking about your death?

It is important to ask directly: "Are you thinking of killing yourself"?

If the answer is "Yes," the following needs to be explored:

- Does the youth have a plan?
- If yes, what is the plan?
- How specific is the plan? How detailed?
- How prepared is she to carry out the plan?
- Does she have access to her chosen method?
- When is she planning to do it?

PRIOR SUICIDAL BEHAVIOUR

Any suicide attempt must be taken seriously. Not only can suicide attempts result in serious injury or death, attempts increase the likelihood of subsequent attempts.

Past behaviour is often the best predictor of future behaviour. Previous attempts increase the risk to 40 times that of the general population. It is also recognized that the risk of suicide can increase for those who have experienced death by suicide of a significant person: relative, friend or hero.

- Is there a history of attempted suicide?

- Ask directly: What happened? When did it happen?
- Does the youth know others who have tried to kill themselves?
- Has a friend, relative or hero committed suicide?

RESOURCES

Supportive resources greatly lower the risk of suicide; inadequate or unavailable resources increase the risk.

- Resources are relative to the individual and may include family, friends, counsellors, religious community, pets, work, etc.
- Resources may offer **Reasons to Live** and include **Responsibilities**, **Relationships**, and **Religion**

The absence, or perceived absence, of supportive resources can greatly increase the risk of suicide.

- Does the youth have a physical and emotional support system that he feels is available?
- Does the youth feel alone?

Consider:

“How did you assess the relevant importance of the risk factors at the beginning of this discussion?”

Summary Remarks:

Review, once again, the relative importance of the risk factors.

- **Age** and **gender** cancel each other: males complete suicide more often; females attempt more; both are at risk
- **Stress** is in the eye of the beholder
- **Symptoms** may not indicate suicidal thoughts: **ASKING** is the only way to find out
- **Resources**, **Prior Suicidal Behaviour** and **Current Plan** are the key **RISK ASSESSMENT** factors.

Review Overhead #6, “CPR: The Most Important Risk Factors.”

Exercise 4:

Begin the risk assessment practice section by summarizing the benefits of risk assessment:

- provides specific risk factors to consider
- provides a useful guideline when gathering information about the youth's situation

- provides a vehicle with which to **ACT** by talking to both the youth and others such as family members, school personnel or the Ministry worker about the reasons for your concern.

Refer to Handout #9, "Risk Assessment Exercise." Come up with a risk assessment for each of the six cases.

Instructions:

- read the information for each case
- decide if the information on each factor suggests an increase (-) or decrease(+) of the risk
- for each case, combine the analysis of each factor to arrive at an overall assessment of risk
- note whether the risk is L = Low, M = Moderate or H = High
- remember that not all risk assessment factors are weighted evenly.

Remind participants that the Current Suicide Plan, Prior Suicidal Behaviour, and Resources (CPR) are more important than the other factors.

Do Person 1 as an example. Go over each category. Would you rate each category as minus (increases risk) or plus (decreases risk)?

Person 1 is a 15 year old female

+	Current Suicide Plan	At present wants to see a worker; not threatening.
-	Prior Suicidal Behaviour	Two or three suicide attempts; overdose of sleeping pills; seen by private doctor.
+	Resources	Supportive foster family.
-	Symptoms	Sad and upset over loss; no other symptoms
-	Stress	Best friend moved away last week; feels sad and lonely.

Then:

- Explain that the risk assessment is shared with the person at risk.
- Ask: What three factors do you weight most heavily?
Answer: Current Suicide Plan, Prior Suicidal Behaviour, Resources.

LOW risk: none of the above three factors are rated as negative

MED risk: one of the above three factors is rated as negative

HIGH risk: two or more of the three above factors are rated as negative

Use Handout #10, "Risk Assessment Exercise – Answer Key" to explain conclusions for Person 1.

Assess the risk for the five remaining cases.

- Do the assessment.
- Go over your assessment of risk for each case.
- Clarify again how these ratings were reached (Handout #10)
- There will be an opportunity for additional practice in using the risk assessment later in the module.

The risk assessment is shared with the person at risk. Demonstrate this by saying something similar to the following:

"Susan, I am very worried about you. Everything you have told me indicates that you are headed towards suicide. You have a very specific and detailed plan and you told me you are thinking of putting that plan into action tomorrow. You have the pills available and have told me that you attempted suicide in the past. You have mentioned that you feel all alone in the world. All this suggests that you are at high risk of suicide."

Next mention the concept of ambivalence which is present in a person at risk of suicide: a wish to live, a wish to die. Illustrate with the Golden Gate Bridge story.

"In San Francisco there is a group of people who have attempted suicide by jumping from the Golden Gate Bridge. Without exception this group of suicide survivors state that as they jumped, a small part of them wanted to live. Their statements demonstrate that most suicidal people are ambivalent. There is almost always, within a person, a small part of them that wants to live even though they are determined to kill themselves."

Summary Remarks:

Refer to Handout #11, "Six Tasks for the Helper" and Overhead #7, "Six Tasks For The Helper."

What does an intervention look like? Review the six tasks for the helper.

An intervention begins with a decision to talk to the youth because of knowledge of severe or multiple stressors, or because of behaviours that indicate possible warning signs of suicide.

Remember the example given earlier about sharing the risk assessment with the person at risk. Remember the concept of ambivalence. It is the ambivalence of the person at risk that you want to tap into and turn to advantage.

4. SKILLS

(1 hour and 40 minutes)

Learning Outcome:

The caregiver can:

- demonstrate skills in initiating intervention, assessing risk and developing action plans.

Materials:

Handout

- Handout #12 Player Roles and Directions for the Simulation Exercise
- Handout #13 (a) and (b) Case Study: Sandra
- Handout #14 (a) and (b) Case Study: Tom
- Handout #15 (a) and (b) Case Study: Jim
- Handout #16 Participant Observation Checklist
- Handout #17 Key to Suicide Risk Assessment

Exercise:

Review Handout #11, "Six Tasks for the Helper"

Refer to Handout #12, "Player Roles And Directions For The Simulation Exercise."

- There are three case studies.
- Now, review Handout #13 (a) and (b), "Case Study: Sandra," Handout #14 (a) and (b) "Case Study: Tom" and Handout #15 (a) and (b), "Case Study: Jim"

- Refer to Handout #16, "Participant Observation Checklist." Read the debriefing instructions on Handout #12, "Player Roles and Directions for the Simulation Exercise" and Handout #16, "Participant Observation Checklist."
- Keep brief notes on each section of the simulation including the decisions reached and the reasoning behind the decisions.

Debriefing:

Please outline:

- the situation as presented by the youth
- the findings of the probing questions.

Review Handout # 16, "Participant Observation Checklist."

Handout #17, “Key to Suicide Risk Assessment”

- the assessment of **low, medium, or high risk**, and the reasons for this assessment
- the action plan chosen and how it relates to the Standards for Foster Homes.

After reviewing the handout, please reflect on the decisions you would make.

5. CLOSURE

(20 minutes)

Objective:

To bring the session to a close

Instructions:

Please retake the following quizzes.

Print off the following:

- Knowledge Quiz
- Attitudes Quiz.

Review Handout #18, “Knowledge Quiz Key”

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APPENDIX I: HANDOUTS

Instructor Notes:

1A and 1B will require 2 copies per participant

The following handouts should NOT BE DISTRIBUTED in advance:

#10 – Risk Assessment Exercise – Answer Key

#13 – (a) and (b) Case Study: Sandra

#14 – (a) and (b) Case Study: Tom

#15 – (a) and (b) Case Study: Jim

#17 – Key To Suicide Risk Assessment

#18 – Knowledge Quiz Key

HANDOUT #1 (A)
ASK Z ASSESS Z ACT

KNOWLEDGE QUIZ

Date:

Thank you for taking the time to complete this questionnaire. The information you provide will be used in the evaluation of this program and in future program planning.

On average, how often are you in a position to respond to a potentially suicidal youth?

1	2	3	4	5
Never		Occasionally		Frequently

Please indicate any suicide intervention training you have taken:

0	1-2 hours ½ day	1 day	2 days	2 days plus
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Intervention Knowledge Test (IKT) - Modified from Tierney, 1994

Multiple choice: For the following statements, select the best response by circling the appropriate letter. If uncertain, **please provide your best guess.** (Circle one letter only for each question) _____

1. When a youth is exhibiting the warning signs of suicide you should *immediately*:
 - a. refer the person to experienced suicide professionals
 - b. discuss the issue of suicide directly with the person
 - c. call in significant others in the person's life
 - d. encourage the person to talk about the positive aspects of his or her life

2. Active intervention by a helper:
 - a. is ineffective in suicide intervention
 - b. is unethical in suicide intervention
 - c. is the appropriate immediate mode of action
 - d. should be considered only after other approaches have failed

3. Which of the following is not true?
 - a. females attempt suicide more often than males
 - b. males complete suicide more often than females
 - c. suicide is the leading cause of death among adolescents
 - d. a high rate of suicide exists among the elderly

4. People who express suicidal intentions:
 - a. clearly want to die
 - b. are ambivalent about dying
 - c. want to punish others
 - d. are manipulative
5. Of the following, which is the most important in assessing the risk of suicide?
 - a. symptoms
 - b. stress
 - c. resources
 - d. physical health
6. If someone answers “yes” to feeling suicidal, a helper should *first*:
 - a. inquire about what is happening in their life
 - b. find out if they’ve thought of how they would do it
 - c. inform significant others
 - d. arrange for immediate referral

True/False: For the following statements, select the best response by circling either T for true, or F for false. If uncertain, **please provide your best guess.** (Circle **one** letter only for each statement).

- | | True | False |
|---|-------------|--------------|
| 7. The best determinant of suicidal intent of an individual is a “yes” response to the question “Are you thinking of killing yourself”? | T | F |
| 8. The perception of stress is unique to each individual. | T | F |
| 9. The most important stressors are often related to health. | T | F |

Fill in the blanks: For the following questions, fill in the blanks in the space provided. If uncertain, **please provide your best guess.**

11. List **5 warnings signs** of suicide:
 - 1.
 - 2.
 - 3.
 - 4.
 - 5.

11. List the **3 factors** that are **most important** in assessing a person's risk of suicide:

1.

2.

3.

HANDOUT #1 (B)
ASK Z ASSESS Z ACT

ATTITUDES QUIZ

Suicide Intervention Questionnaire (SIQ) Modified from Tierney, 1994

Please circle the response, which most closely represents the extent to which you agree with each of the following statements: **Circle one response only for each line.**

		Strongly Agree	Undecided	Disagree	Strongly
		Agree			Disagree
1.	Caregivers have the right to intervene if someone is at risk of suicide.	SA	A	U	D SD
2.	There is little that I can do to prevent suicide.	SA	A	U	D SD
3.	If someone shows signs and symptoms related to suicide, I would intervene.	SA	A	U	D SD
4.	If someone told me that they were thinking of suicide, I would get more information about their plan.	SA	A	U	D SD
5.	If a youth shared suicidal thoughts with me, I would keep the conversation confidential.	SA	A	U	D SD
6.	Suicide is preventable in the majority of situations.	SA	A	U	D SD
7.	If someone told me they were thinking of suicide, I would intervene.	SA	A	U	D SD
8.	I would reach out to an individual who appears to be at risk of suicide.	SA	A	U	D SD
9.	I don't believe that I can prevent someone from committing suicide.	SA	A	U	D SD
10.	If a person I was helping completed suicide, I would blame myself.	SA	A	U	D SD
11.	It is unlikely that someone who has decided on suicide can be prevented from carrying out the planned action.	SA	A	U	D SD
12.	I am quite comfortable working with someone who is at risk of suicide.	SA	A	U	D SD
13.	If someone I knew was at risk of suicide, I would encourage them to talk about their wish to die.	SA	A	U	D SD
14.	Caregivers have the responsibility to prevent an individual from taking their own life.	SA	A	U	D SD
15.	I am confident in my ability to help suicidal people.	SA	A	U	D SD

HANDOUT #2**CANADIAN AND BC SUICIDE STATISTICS**

- After accidents, suicide is the second leading case of death among youth and young adults age 15 – 24 in most Canadian provinces.
- The rate for this age tripled between 1960 and 1980.
- Since 1980, this trend seems to have leveled off.
- However, the risk remains high.

Results from a 1998 Survey of 25,838 BC Youth (McCreary Centre Society, Vancouver)

- 14% of those surveyed had considered suicide at least once in the past year (3617 students)
- 11% of those surveyed had planned a suicide (2842 students)
- 7% of those surveyed had attempted suicide (1808 students)
- 2% of those surveyed reported they were injured in a suicide attempt (517 students)

. HANDOUT #3

MODULE INTENT AND LEARNING OUTCOMES

Module Intent: To improve the overall competency of foster parents in the recognition and crisis management of potentially suicidal youth

Learning Outcomes:

The caregiver can:

- demonstrate attitudes favourable to suicide intervention, including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation
- recognize youth stressors and suicide warning signs
- demonstrate skills in initiating intervention, assessing risk and developing action plans.

HANDOUT #5 EXPLORING ATTITUDES TO INTERVENTION

Please circle the response that fits best for you:

Statement 1. I would actively intervene with a youth at risk of suicide.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
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Statement 2. I would take seriously any indication of thoughts of suicide expressed by a youth.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
-------------------	-------	-----------	----------	----------------------

Statement 3. I will keep confidential any information a suicidal youth shares with me.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
-------------------	-------	-----------	----------	----------------------

Exploring Attitudes to Intervention

Please circle the response that fits best for you:

Statement 1. I would actively intervene with a youth at risk of suicide.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
-------------------	-------	-----------	----------	----------------------

Statement 2. I would take seriously any indication of thoughts of suicide expressed by a youth.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
-------------------	-------	-----------	----------	----------------------

Statement 3. I will keep confidential any information a suicidal youth shares with me.

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
-------------------	-------	-----------	----------	----------------------

HANDOUT #6**STANDARD B.2 REPORTABLE INCIDENTS**

All information of significance to the safety and well-being of children is promptly reported to a social worker.

Commentary

If the social worker is unavailable, the report is made to another social worker or the supervisor in the same district office. After regular office hours, the report is made to an after hours social worker. After hours social workers are available 24 hours per day, seven days per week.

Results for Children

B.2. 1. Children confirm that they have been informed about reportable incidents and about what will happen if such an incident occurs.

Caregiver Practices

B.2.2. The caregiver notifies the child's social worker immediately after the occurrence of any of the following reportable incidents in order that the child's social worker can plan for the ongoing safety and well-being of the child:

- a) the death of a child or youth;
- b) accident or illness of a child or youth requiring medical treatment or hospitalization;
- c) allegations of abuse, neglect or mistreatment of a child or youth;
- d) any displays of self-injurious or high-risk behaviour by a child or youth;**
- e) gestures, threats, or attempts of suicide by a child or youth;**
- f) situations when a child or youth is missing, lost or runaway, including any subsequent information obtained about the child or youth during the absence (see Appendix 1 for more information);
- g) situations when a child or youth has observed, been involved in, or exposed to a high-risk situation or disaster, such as fire or multiple abuse situation in a school, that may cause emotional trauma or post-traumatic stress;
- h) any intervention by the police or law enforcement authorities with a child or youth;
- i) situations involving the use of physical restraint or any other prohibited behaviour management practices;

- j) the unauthorized removal or attempted removal of a child or youth from the home, facility, school or day program;
- k) marked behavioural changes exhibited by a child or youth;
- l) suspension of a child or youth from their school or day program
- m) plans, not previously authorized, for the child or youth to be cared for by another person overnight, and
- n) any other circumstance affecting the safety or well-being of a child or youth.

B.2.3. The caregiver notifies at least the resource social worker of the following incidents in order that the resource social worker can support the caregiver in planning for the short- and long-term viability of the placement for the child or youth.

- a) limitation in the ability of the caregiver to meet the safety and well-being needs of a child or youth placed, or about to be placed with the caregiver;
- b) limitation in the ability of the caregiver to meet other written caregiver service expectations;
- c) criminal charge or conviction of a caregiver or other member of the household;
- d) court supervised parole or probation of a caregiver or other member of the household;
- e) the onset or recurrence of a physical, emotional or mental condition or substance abuse problem of a caregiver or other member of the household, that could reasonably be expected to impair the caregiver's ability to care for the child;
- f) serious illness or injury of a caregiver or other member of the household;
- g) changes in the household composition (for example, people moving in or out of the household);
- h) significant change in the caregiver's financial circumstances that have potential to affect the care of the child or youth; and
- i) significant increase in the use of alternative care arrangements of the child or youth.

HANDOUT #7**SUICIDE WARNING SIGNS**

- Warning signs are symptoms of youth (dis)stress; they indicate things are not going well.
- Warning signs may indicate suicidal thoughts.
- The more that warning signs/symptoms indicate an overall theme of hopelessness and helplessness, the greater the likelihood that these warning signs are indicators that suicide is on the youth's mind.
- Warning signs may be verbal or non-verbal. For example, a youth may comment: "I'd rather die than..." or give away her Discman for no apparent reason. Both may be warning signs of suicide.
- Depression in youth may be masked behind or within "acting out" behaviour.
- Signs of depression in pre-school children may appear in the form of anger, restlessness, worry, pains, fears, self-blame, irritability, apathy, tension or fatigue.

HANDOUT #8**CPR: THE MOST IMPORTANT RISK FACTORS****C**urrent Suicide Plan
Prior Suicidal Behaviour
Resources**AGE**

- Youth are at high risk of suicidal behaviours.

GENDER

- The rate of suicide and suicidal injuries varies with age and gender.
- Males complete suicide more than three times as often as females, but females attempt suicide more than twice as often as males.
- Males tend to choose more lethal methods, such as guns, although in BC hanging was the most common method for both males and females under 24 in the years 1994 - 1995.

STRESS

- Is there stress in the youth's life? Remember the list of possible stressors studied earlier.
- Remember that stress is in the eye of the beholder.
- How does the youth feel about the stress?

SYMPTOMS

- What symptoms or warning signs do you observe in the youth's behaviour? (verbal, behavioural, etc.). Remember the warning signs discussed earlier.

CURRENT SUICIDE PLAN

- **Ask** the youth if he/she is thinking about suicide. If you are asking a young child, under age 12, say something like: "Are you thinking about death/dying? Are you thinking about your death? Ask an older youth: "Are you thinking about killing yourself?"
- If the answer is "Yes," explore the following:
 - Does the youth have a plan?
 - If yes, what is the plan?
 - How specific is the plan? How detailed?
 - How prepared is she to carry out the plan?
 - Does she have access to the chosen method?

- When is she planning to do it?

PRIOR SUICIDAL BEHAVIOUR

- Any suicide attempt must be taken seriously. Not only can suicide attempts result in serious injury or death, attempts increase the likelihood of subsequent attempts.
- Past behaviour is often the best predictor of future behaviour.
- Previous attempts increase the risk to 40 times that of the general population.
- The risk of suicide can also increase for those who have experienced death by suicide of a significant person: relative, friend or hero.
- Consider:
 - Is there a history of attempted suicide?
 - Ask directly: "What happened? When did it happen"?
 - Does the youth know others who have tried to kill themselves?
 - Has a friend, relative or hero of the youth committed suicide?

RESOURCES

- Supportive resources greatly lower the risk of suicide.
- Inadequate resources increase the risk. The absence, or perceived absence, of supportive resources can greatly increase the risk of suicide.
- Resources are relative to the individual and may include family, friends, counsellors, teachers, religious community, pets, work, etc.
- Resources may offer **R**easons to live and include: **R**esponsibilities, **R**elationships, and **R**eligion.
- Consider:
 - Does the youth have a physical and emotional support system that he feels is available?
 - Does the youth feel alone?

HANDOUT #9**RISK ASSESSMENT EXERCISE**

- **Mark with a + to indicate a positive variable that decreases the risk of suicide.**
- **Mark with a - to indicate a negative variable that increases the risk of suicide.**

Person 1 is a 15 year old female

	Current Suicide Plan	At present wants to see a worker; not threatening.
	Prior Suicidal Behaviour	Two or three suicide attempts; overdose of sleeping pills; seen by private doctor.
	Resources	Supportive foster family.
	Symptoms	Sad and upset over loss; no other symptoms.
	Stress	Best friend moved away last week; feels sad and lonely.

RISK ASSESSMENT LOW MEDIUM HIGH

Person 2 is a 14 year old male

Current Suicide Plan No current suicide plan.

Prior Suicidal Behaviour Barbiturate overdose last year; slashed wrists two years ago; may have been other attempts in past.

Resources Has a brother, age 22 that he visits regularly; close to foster brother.

Symptoms Smokes marijuana regularly; hangs out at mall for recreation; feels unconnected.

Stress No stressors

RISK ASSESSMENT LOW MEDIUM HIGH

-
- **Mark with a + to indicate a positive variable that decreases the risk of suicide.**
 - **Mark with a – to indicate a negative variable that increases the risk of suicide.**

Person 3 is a 17 year old male

Current Suicide Plan	Yes and has the gun to do it.		
Prior Suicidal Behaviour	No prior behaviour, but father committed suicide.		
Resources	Good relationship with fosters brothers and sisters.		
Symptoms	None.		
Stress	Father committed suicide (truck exhaust) 6 months ago; girlfriend ended relationship last night.		
RISK ASSESSMENT	LOW	MEDIUM	HIGH

Person 4 is a 15 year old female

Current Suicide Plan	No current suicide plan.		
Prior Suicidal Behaviour	None.		
Resources	Many friends at school; active in sports.		
Symptoms	Feels down but is sleeping and eating well.		
Stress	Dad coming for visit for the first time in 2 years.		
RISK ASSESSMENT	LOW	MEDIUM	HIGH

- **Mark with a + to indicate a positive variable that decreases the risk of suicide.**
- **Mark with a - to indicate a negative variable that increases the risk of suicide.**

Person 5 is a 14 year old female

Current Suicide Plan	Yes, has large number of barbiturates; does not know whether she will live through day.
Prior Suicidal Behaviour	Five weeks ago wrote a suicide note and took a large number and a variety of pills; taken to hospital.
Resources	Loner at school; parents do not keep in touch.
Symptoms	Feels weird; same feeling she had before last attempt.
Stress	Failed last 3 math tests; report cards due in a week.
RISK ASSESSMENT	LOW MEDIUM HIGH

Person 6 is a 17 year old male

Current Suicide Plan	No plan; said he could not kill himself because he does not have the means.
Prior Suicidal Behaviour	None.
Resources	Plays on several school teams; supportive relationship with football coach.
Symptoms	Depressed; not sleeping or eating well.
Stress	Just lost part-time job; mom didn't show up for scheduled visit.
RISK ASSESSMENT	LOW MEDIUM HIGH

HANDOUT #10**RISK ASSESSMENT EXERCISE – ANSWER KEY****Person 1 is a 15 year old female**

<u> + </u> Current Suicide Plan	At present wants to see a worker: not threatening.
<u> - </u> Prior Suicidal Behaviour	Two or three suicide attempts; overdose of sleeping pills; seen by private doctor.
<u> + </u> Resources	Supportive foster family.
<u> - </u> Symptoms	Sad and upset over loss; no other symptoms.
<u> - </u> Stress	Best friend moved away last week; feels sad and lonely.

 M RISK ASSESSMENT MEDIUM

Person 2 is a 14 year old male

<u> + </u> Current Suicide Plan	No current suicide plan
<u> - </u> Prior Suicidal Behaviour	Barbiturate overdose last year; slashed wrists two years ago; may have been other attempts in past.
<u> + </u> Resources	Has a brother, age 22; which he visits regularly; close to foster brother.
<u> - </u> Symptoms	Smokes marijuana regularly; hangs out at mall; feels unconnected.
<u> + </u> Stress	No stressors

 M RISK ASSESSMENT MEDIUM

Person 3 is a 17 year old male

- Current Suicide Plan Yes and has the gun to do it.
 - Prior Suicidal Behaviour No prior behaviour, but father committed suicide.
 + Resources Good relationship with foster brothers and sisters.
 + Symptoms None.
 - Stress Father committed suicide (truck exhaust) 6 months ago; girlfriend ended relationship last night.

 H RISK ASSESSMENT HIGH

Person 4 is a 15 year old female

+ Current Suicide Plan No current suicide plan.
 + Prior Suicidal Behaviour None.
 + Resources Many friends at school; active in sports.
 + Symptoms Feels down but is sleeping and eating well.
 + Stress Dad coming for visit for the first time in 2 years.

 L RISK ASSESSMENT LOW

Person 5 is a 14 year old female

- Current Suicide Plan Yes, has large number of barbiturates; does not know whether she will live through day.
- Prior Suicidal Behaviour Five weeks ago wrote a suicide note and took a large number and a variety of pills; taken to hospital.
- Resources Loner at school; parents busy with handicapped younger brother.
- Symptoms Feels weird; same feeling she had before last attempt.
- Stress Failed last 3 math tests; report cards due in a week.

 H RISK ASSESSMENT HIGH

Person 6 is a 17 year old male

- + Current Suicide Plan Has no plan; said he could not kill himself because he does not have the means.
- + Prior Suicidal Behaviour None.
- + Resources Plays on several school teams; supportive relationship with football coach.
- Symptoms Depressed; not sleeping or eating well.
- Stress Just lost part-time job; mom didn't show up for scheduled visit.

 L RISK ASSESSMENT LOW

HANDOUT #11

ASK z ASSESS z ACT SIX TASKS FOR THE HELPER

ASK

- 1. Engage:** Ask and listen to gather more information about how the youth is feeling —
helpless? hopeless?
- 3. Identify:** Identify thoughts of suicide by asking **the question**
“Are you thinking of killing yourself?”
If the answer is “yes,” proceed with the risk assessment

ASSESS

- 9. Inquire:**
Ask about **prior behaviour:** *“Have you attempted suicide before?”*
Ask about a **current plan:** *“Have you thought about how you might do it?”*
Ask about **availability:** *“Do you have the (pills, gun, rope, etc.) available?”*
Ask about **timing:** *“When are you planning on doing it?”*
Ask about personal **resources:** *“Are there people/pets etc. in your life that you care about and that care about you?”*
- 5. Assess:** Consider all information: Is there risk of suicide?
Is the risk High? Medium? Low?

ACT

- 11. Contract:** Facilitate appropriate referral: non emergency plan, immediate action plan, or emergency
- 7. Follow Through:** Ensure referral is acted upon in the recommended time frame

HANDOUT #12
ASK z ASSESS z ACT

**PLAYER ROLES AND DIRECTIONS FOR THE SIMULATION
 EXERCISE**

Player 1: Child-in-Care

This player will play the role of a suicidal youth. The participant playing this role will be given a script, which will include information about the suicidal youth they are portraying. The information will vary depending upon the degree of risk of the particular youth portrayed. Information will include the youth's age and sex, stressors, symptoms, current plan, prior behaviour and resources. The youth will answer "**yes**" to the question: "**Are you thinking of killing yourself?**"

Please note: Players 2-4 play the same person, the **Foster Parent**; Player 5 is the **Observer**.

Player 2: Foster Parent

The task of this player is to consider stressors, identify warning signs, and ask directly about suicide. "**Are you thinking of killing yourself?**"

Player 3: Foster Parent

This player picks up where Player 2 left off, building on what has been revealed. Using the risk assessment framework, this player gathers information necessary to assess this youth's risk of suicide. The entire group will discuss and decide whether this youth is at **Low, Medium, or High** risk of suicide.

Player 4: Foster Parent

This player leads the discussion to ensure that the group formulates an action plan based on the degree of risk of suicide for this particular youth. She or he identifies reasons for the chosen action plan **based on degree of risk and the Standards for Foster Homes**. Decisions re contacting worker, parents, etc. should be discussed by the group.

Player 5: Observer

This player observes and records the discussion using the Participant Observation Checklist. This player also debriefs the role-play with the small group as follows.

Ask the youth role-player:

- *What worked for you? What didn't work?*
- *If you were involved in the decision-making process, how did this feel? If not, would you have liked to be? Why?*

Debrief players 2 - 4 individually. Ask: What worked? What didn't work?

- *Share you observations with the group*

HANDOUT #13 (A) ASK
z ASSESS z ACT

CASE STUDY: SANDRA

Information for participant in the child in care role:

Player 1: Child in Care

You are a 15 year-old Aboriginal female, the youngest of three siblings and the only girl. At your mother's request, your middle brother went to live in a group home but he ran from it. You don't know where he is and you miss him. You and your mom don't get along. You were skipping school, missing assignments and gaining weight. Your mom didn't want you living at home so you were placed in a foster home and that's where you're currently living. It's a nice family but it's not an Aboriginal family. You feel like an outsider.

You feel all alone with no one to talk to except your diary. You're seeing a psychiatrist who put you on anti-depressants. But you're not taking them. You're not crazy! Your mom hasn't called or visited for over a month and you really miss your brother. You wonder if you'll ever go home. And if you don't go home, what will happen to you?

And now summer's over and you have to return to school. You're afraid of some of the kids at school. They're bullies. They taunt you about your weight and about being Aboriginal. Lately you've been thinking that it would be easier for everyone if you weren't here at all. You wonder about what it would be like to be dead. Would anyone care?

In your role as the child in care you:

- Give verbal clues related to stress
- Give verbal suicide warning signs
- Give non-verbal suicide warning signs
- Answer "yes" to the question "Are you thinking of killing yourself?"

HANDOUT #13 (B)
ASK z ASSESS z ACT

CASE STUDY: SANDRA

Information for participants in the following roles:

Player 2: Foster Parent

You are Sandra's foster mom. Sandra has been with you and your family since June, over two months now. You're worried about her. She hasn't settled into your home as you had hoped she would. She has told you that she feels like an outsider even though the little kids in the home think that she's great! She spends a lot of time in her room crying and writing in her diary. And she seems so depressed! The pills the psychiatrist gave her don't seem to be helping. And last week her Mom was supposed to come to visit her but didn't show up. You decide to talk to her.

Your task: acknowledge the stressors you know about; probe for unknown stressors; let Sandra know of your concern; mention the warning signs you've observed or are observing now; ask directly about suicide. **"Are you thinking of killing yourself"?**

Player 3: Foster Parent

Pick up where Player 2 left off. Building on what Sandra has revealed, continue the dialogue.

Your task: using questions, paraphrasing and good listening skills find out about Sandra's.

- Current plan? + or -
- Prior suicidal behaviour? + or -
- Resources? + or -

Using the risk assessment framework, assess Sandra's level of risk:

- Low
- Medium
- High

Share this assessment with Sandra.

Player 4: Foster Parent

You now know what level of risk Sandra presents.

Your task: Recommend an action plan based on the degree of risk and the Standards for Foster Homes. Outline the action plan, identifying whom you will contact and what you will do next.

Player 5: Observer:

Your task: using the Participant Observation Checklist, observe and record each player during the intervention. Debrief the role-play and discuss your observations.

HANDOUT #14 (A)
ASK z ASSESS z ACT

CASE STUDY: TOM

Information for participant in the child in care role:

Player 1: Child in Care

You are a 16 year-old boy who has come into care because your mom is just not being a mom to you. She's not very old herself and she treats you more like a friend, sharing her boyfriend problems with you and leaning on you for emotional support.

You're angry with both your mom and the Ministry for getting involved in what you consider to be your private affairs. Just because you wrote that poem in school about suicide, the social worker came over to your apartment and after talking to your mom about your relationship with her, recommended that you go to foster home so that you could "be a teenager." Whatever that means! And your mom agreed! If this is what it's like to be a teenager, you don't want to be one!

You wouldn't mind living with Grandpa Dave. He's cool but too old to care for you and you're not sure how he'd feel about some of your friendships. That way you don't have to worry about "that."

You answer "yes" to the question "Are you thinking of killing yourself"?

In your role as the child-in-care you:

- Give verbal clues related to stress
- Give verbal suicide warning signs
- Give non-verbal suicide warning signs
- Answer "yes" to the question "Are you thinking of killing yourself"?

HANDOUT #14 (B) ASK
 z ASSESS z ACT

CASE STUDY: TOM

Information for participants in the following roles:

Player 2: Foster Parent

You are Tom's foster mom. Tom is an athletic and musically talented teen-ager who seems older than his thirteen years. Your own teenage sons have grown up and moved out so it's particularly nice to have Tom in the house. You have told Tom that he can do anything he wants to his room, paint, posters, stuff on the walls; whatever he wants, but so far the room remains exactly the same as it was when he moved in three months ago. You're worried about him, partly because he seems worried about something. And yesterday when you were cleaning his room you came across a school assignment. Tom had written a poem about suicide. You decide to talk to him.

Your task: Acknowledge the stressors you know about; probe for unknown stressors; let Tom know of your concern; mention the warning signs you've observed or are observing now; ask directly about suicide. **"Are you thinking of killing yourself"?**

Player 3: Foster Parent

Pick up where Player 2 left off. Building on what Tom has revealed, continue the dialogue.

Your task: using questions, paraphrasing and good listening skills, find out about Tom's.

- Current plan? + or -
- Prior suicidal behaviour? + or -
- Resources? + or -

Using the risk assessment framework, assess Tom's level of risk:

- Low
- Medium
- High

Share this assessment with Tom.

Player 4: Foster Parent

You now know what level of risk Tom presents. **Your task:** Recommend an action plan based on the degree of risk and the Standards for Foster Homes. Outline the action plan, identifying whom you will contact and what you will do next.

Player 5: Observer

Your task: Using the Participant Observation Checklist, observe and record each player during the intervention. Debrief the role-play and discuss your observations.

HANDOUT #15 (A) ASK
z ASSESS z ACT

CASE STUDY: JIM

Information for participant in the child in care role:

Player 1: Child in Care

You are a 14-year-old boy who has been in care for several years. You were removed from your family when you were very young because your dad beat you all the time. And even though he committed suicide two years ago, you can't return home. You feel all alone.

This is the third foster home you have been in and, although this home seems OK, you are feeling pretty unsettled and very depressed. The folks in your last placement were considering adopting you but you became really scared about the adoption. When you were asked whether or not you consented to the adoption you said "no." You didn't really mean "no," you just didn't feel ready to make everything permanent. You were scared. And then it all fell apart and you were placed in this new foster home.

You feel hopeless. You miss the other foster family. When your worker asked you if you'd ever attempted suicide before, you said "yes," because you had tried to kill yourself. More than once. Killing yourself was the only way you could think of to make the pain go away.

And now you're thinking of it again because the pain is back, big-time and the only way you can think of to make the pain go away is to steal a car and crash it.

In your role as the child in care you:

- Give verbal clues related to stress
- Give verbal suicide warning signs
- Give non-verbal suicide warning signs
- Answer "yes" to the question "Are you thinking of killing yourself?"

HANDOUT #15 (B) ASK
 z **ASSESS** z **ACT**

CASE STUDY: JIM

Information for participants in the following roles:

Player 2: Foster Parent

You are Jim's foster dad. Jim has only been in your home a week or two and you are trying to help him settle in but something doesn't seem right. He is very quiet, hasn't much of an appetite and spends most of the time in his room listening to hip-hop. You know that Jim really liked his previous foster family but refused to agree to adoption. You don't know why he refused. You're particularly worried because Jim's worker mentioned that Jim had attempted suicide in the past. You're thinking of talking to him.

Your task: acknowledge the stressors you know about; probe for unknown stressors; let Jim know of your concern: warning signs you've observed or are observing now; ask directly about suicide.

“Are you thinking of killing yourself”?

Player 3: Foster Parent

Pick up where Player 2 leaves off. Building on what Jim has revealed, continue the dialogue.

Your task: using questions, paraphrasing and good listening skills find out about Jim's:

- Current plan
- Prior suicidal behaviour
- Resources Using the risk assessment framework, assess

Jim's level of risk:

- Low
- Medium
- High

Share this assessment with Jim.

Player 4: Foster Parent

You now know what level of risk Jim presents. **Your task:** Recommend an action plan based on the degree of risk and the Standards for Foster Homes. Outline the action plan, identifying any referrals and how you will follow-up with Jim. Decisions about who to contact should be discussed by the group.

Player 5: Observer

Your task: using the Participant Observation Checklist, observe and record each player during the intervention. Debrief the role-play and discuss your observations.

HANDOUT #16
ASK z ASSESS z ACT

PARTICIPANT OBSERVATION CHECKLIST

Method: participant observation – recorder observes each player and checks responses.
Check the appropriate boxes as you observe the tasks.

PLAYER	SUICIDE INTERVENTION OBSERVATIONS - DID EACH PLAYER: (Check each step in the intervention)
Player 1 Child-in-Care	<ul style="list-style-type: none"> ~ give verbal clues about stress ~ give verbal suicide warning signs ~ give non-verbal suicide warning signs ~ respond affirmatively when asked about thoughts of suicide
Player 2 Foster Parent	<ul style="list-style-type: none"> ~ address possible suicide warning signs ~ ask about stressors in the youth's life ~ ask directly about suicide
Player 3 Foster Parent	<p>Using the risk assessment framework:</p> <ul style="list-style-type: none"> ~ ask if the student has a current suicide plan ~ ask about prior suicide behaviour ~ ask about resources such as friends, family, etc. <p>Determine level of risk</p> <ul style="list-style-type: none"> ~ low ~ medium ~ high
Player 4 Foster Parent	<p>Recommends action plan based on degree of risk and the Standards for Foster Homes by:</p> <ul style="list-style-type: none"> ~ notifying the child's social worker ~ calling 911 for emergency services ~ calling parents or caregivers <p>Initiates discussion of a follow-up plan based on degree of risk:</p> <ul style="list-style-type: none"> ~ follows up ~ initiates follow-up plan
Player 5 RECORDER'S COMMENTS	<p>Scenario (check one)</p> <ul style="list-style-type: none"> ~ Sandra ~ Tom ~ Jim

HANDOUT #17
ASK Z ASSESS Z ACT

KEY TO SUICIDE RISK ASSESSMENT

Although you cannot predict exactly how the person playing the teen will portray the situation, the case studies as written represent low, medium and high risk.

Current plan (C), Prior suicidal behaviour (P), and Resources (R) are the only factors used to assess suicide risk. If one is rated as a negative the risk is Medium. If more than one is rated as a negative, the risk is High. If all factors receive a positive rating, the risk is Low.

CASE STUDY: SANDRA

Current plan? None +

Prior suicidal behaviour? None +

Resources? Feels alone -

- Low
- Medium**
- High

CASE STUDY: TOM Current plan? None +

Prior suicidal behaviour? None +

Resources? Grandpa and mom +

- Low**
- Medium
- High

CASE STUDY: JIM

Current plan? Yes, car crash -

Prior suicidal behaviour? Yes -

Resources? No, feels alone -

- Low
- Medium
- High**

HANDOUT #18**ASK Z ASSESS Z ACT:****KNOWLEDGE QUIZ KEY****Intervention Knowledge Test (IKT) - Modified from Tierney, 1994**

Multiple choice: For the following statements, select the best response by circling the appropriate letter. If uncertain, **please provide your best guess.** (Circle one letter only for each question).

Correct response in *italics*

1. When a youth is exhibiting the warning signs of suicide you should *immediately:*
 - a. refer the person to experienced suicide professionals
 - b. *discuss the issue of suicide directly with the person*
 - c. call in significant others in the person's life
 - d. encourage the person to talk about the positive aspects of his or her life

2. Active intervention by a helper:
 - a. is ineffective in suicide intervention
 - b. is unethical in suicide intervention
 - c. *is the appropriate immediate mode of action*
 - d. should be considered only after other approaches have failed

3. Which of the following is not true?
 - a. females attempt suicide more often than males
 - b. males complete suicide more often than females
 - c. *suicide is the leading cause of death among adolescents*
 - d. a high rate of suicide exists among the elderly

4. People who express suicidal intentions:
 - a. clearly want to die
 - b. *are ambivalent about dying*
 - c. want to punish others
 - d. are manipulative

5. Of the following, which is the most important in assessing the risk of suicide?
 - a. symptoms
 - b. stress
 - c. *resources*
 - d. physical health

6. If someone answers “yes” to feeling suicidal, a helper should *first*:
- inquire about what is happening in their life
 - find out if they’ve thought of how they would do it*
 - inform significant others
 - arrange for immediate referral

True/False: For the following statements, select the best response by circling either T for true, or F for false. If uncertain, **please provide your best guess.** (Circle **one** letter only for each statement).

Correct response in *italics*

True False

7. The best determinant of suicidal intent of an individual is a “yes” response to the question “Are you thinking of killing yourself?” *T* F
8. The perception of stress is unique to each individual. T *F*
9. The most important stressors are often related to health. T *F*

Fill in the blanks: For the following questions, fill in the blanks in the space provided. If uncertain, **please provide your best guess.**

11. List **5 warnings signs** of suicide: (many more responses are listed in the brochure *Suicide What You Need to Know: A Guide for School Personnel.*)

- changes in behaviour*
- changes in appearance*
- talking or joking about suicide*
- increased and/or heavy use of substances*
- sudden failure to complete assignments*

11. List the **3 factors** that are **most important** in assessing a person’s risk of suicide:

- Current Plan*
- Prior Behaviour*

3. Resources

Appendix II: Overheads

OVERHEAD #1**Canadian and BC Suicide Statistics**

- After accidents, suicide is the second leading cause of death among youth and young adults age 15 – 24 in most Canadian provinces.
- The suicide rate for this age group tripled between 1960 and 1980.
- Since 1980, this trend seems to have leveled off.
- However, the risk remains high.

Results from a 1998 Survey of 25,838 BC Youth (McCreary Centre Society, Vancouver)

- 14% of those surveyed had considered suicide at least once in the past year (3617 students)
- 11% of those surveyed had planned a suicide (2842 students)
- 7% of those surveyed had attempted suicide (1808 students)
- 2% of those surveyed reported they were injured in a suicide attempt (517 students)

OVERHEAD #2
Module Intent and Learning Outcomes

MODULE INTENT

To improve the overall competency of foster parents in the recognition and crisis management of potentially suicidal youth

LEARNING OUTCOMES

The caregiver can:

- demonstrate attitudes favourable to suicide intervention, including adoption of a non-judgmental approach, demonstration of willingness to make referrals, and the foresight to seek consultation
- recognize youth stressors and suicide warning signs
- demonstrate skills in initiating intervention, assessing risk and developing action plans.

OVERHEAD #4

STRESSORS

Life events that might produce feelings
of intolerable stress and/or overwhelming
loss

OVERHEAD #5

SUICIDE WARNING SIGNS

Changes in behaviour, physical
appearance, thoughts, or feelings

OVERHEAD #6

**CPR:
THE MOST IMPORTANT
RISK FACTORS**

Current Suicide Plan
Prior Suicidal Behaviour
Resources

Variables:

- Age
- Gender
- Stress
- Symptoms
- Current Suicide Plan
- Prior Suicide Behaviour
- Resources

OVERHEAD #7

SIX TASKS FOR THE HELPER

Ask

1. Engage
2. Identify

Assess

3. Inquire about
 - prior behaviour
 - current plan
 - availability
 - timing
 - resources
4. Assess risk

Act

5. Contact
6. Follow through



Appendix IV: the ask • assess • act program

Background to the development of ASK z ASSESS z ACT for school personnel

In 1992 the BC Council for Families introduced Let's Live! A School-Based Suicide Awareness and Intervention Program. Let's Live! was designed to link to the Learning for Living curriculum at the intermediate and graduation levels. Concurrently, in-service training sessions on the implementation of Let's Live! and suicide intervention were delivered to several school districts within the province. In 1994 the Let's Live! program was redesigned to link with the new BC school curriculum, Career and Personal Planning, and in-service training continued. During the fiscal year of 1996-1997 the BC Council for Families focused on revising the in-service training, now known as ASK z ASSESS z ACT. The revised training includes a more comprehensive evaluation component. Pilot testing and field-testing were conducted in January, February and March 1998. Revisions were made to the curriculum and pre/post test questionnaires during the summer of 1998 and are included in this document.

Rationale for the Training Revision and Content Selection

A great deal of attention was given to the most current literature on the topics of suicide prevention and intervention, training, and evaluation for the revision of this training program. The literature search was based on an *Annotated Bibliography on Suicide Prevention and Intervention Training for School Personnel in British Columbia: Program Design and Implementation Issues*, a bibliography compiled by CUPPL, UBC. In addition, BC Council for Families conducted a focus group to determine the suicide intervention needs of school personnel, and CUPPL, UBC conducted an extensive needs assessment survey of all BC school districts (*1997 School Gatekeeper Needs Assessment Survey*). These findings, as well as the experience gained conducting the Let's Live! In-service Training sessions, have been incorporated into the content and format of the revised training.

Program Development Process

Several steps were taken to facilitate this project and many individuals were involved. Under the administration of the BC Council for Families, an advisory committee was formed to look at the issues of school-based training, suicide prevention and intervention, program evaluation and other related issues as outlined in the *Framework for British Columbia*. The committee met and discussed these issues, provided consultation and reviewed drafts. Program developers and BC Council staff worked on the program revision and the evaluation component with the guidance of this advisory committee, and the afore mentioned *Annotated Bibliography on Suicide Prevention and Intervention Training for School Personnel in British Columbia: Program Design and Implementation Issues*. Dr. Lesley Andres at the University of British Columbia provided statistical support and data analysis questionnaire development. In addition, several others agreed to review drafts and provide feedback to the developers. Throughout the process, LivingWorks Education and the Suicide Information and Education Centre provided information and support for the project. The following is the list of those involved in this process including the Project Funders, the Advisory Committee, BC Council for Families Staff, Program Developers, Program Reviewers, Statistical Support and Analysis and Support and Information providers:

Project Funding Province of British Columbia, Ministry of Children and Family Development

Advisory Committee:

Ann O'Connor Coordinator for Special Programs, Delta School District
Arnie Funk School Mental Health Consultant, Child and Youth Mental Health Services

Ann Little School Age Youth Consultant, Ministry of Children and Family Development

Clem Meunier Consultant, Ministry of Children and Family Development
Diane Pollard Coordinator, Special Education Branch, Ministry of Education

Linda Rosenfeld Director, SAFER

Jennifer White Community Development Director, BC Suicide Prevention, Information and Resource Centre

BC Council for Families Staff

Cheryl Haw Program Director

Ann Morrison Administrative Assistant

Program Developers

Brenda Dafoe Brenda A. Dafoe & Associates

Sheila MacCallum Callum Consulting

Program Reviewers: School Personnel

Susan Clayton President, BC School Counsellors Association, Ft. St. John, BC

Linda McDonald Counsellor, Columneetza Secondary, Williams Lake, BC

Mary O'Neill Counsellor, Coquitlam School District

Dick Ramsay LivingWorks Education Inc., Calgary, AB

Program Reviewers: Foster Parent Curriculum

Carolyn Robertson Child Protection Division

Ginny Wilson Federation of Foster Parents Associations

Cheryl Haw BC Council for Families

Statistical Support and Analysis

Lesley Andres Assistant Professor, Department of Educational Studies, UBC

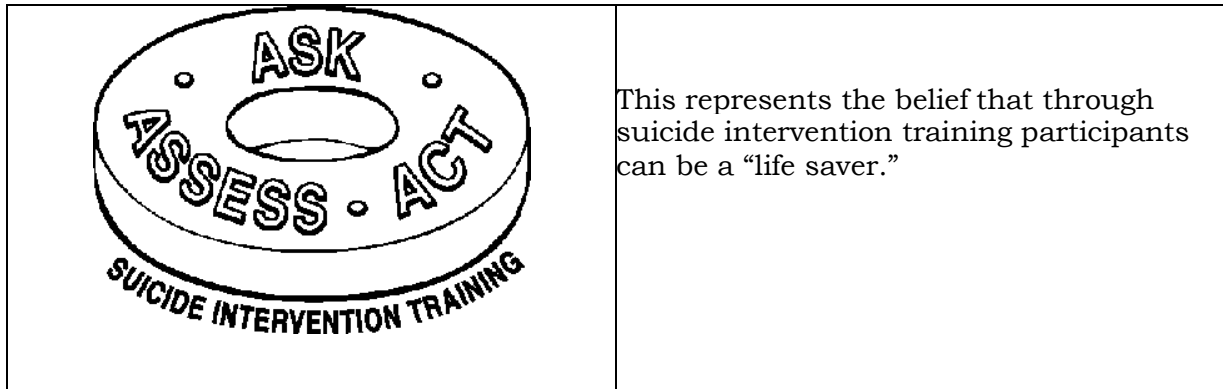
Support and Information

Karen Kiddy Suicide Information and Education Centre, Calgary, AB

Dick Ramsay LivingWorks Education Inc., Calgary, AB

Program Name and Logo - Description

The program title ASK z ASSESS z ACT, was selected to reflect the content of the intervention training and to differentiate it from the Let's Live! A School-Based Suicide Awareness and Intervention Program (BC Council for the Family).



The Intent of Training School Personnel

ASK z ASSESS z ACT is guided by Tierney’s (1994) evaluation research on suicide intervention training, and the Centres for Disease Control’s (1992) research on school-based programs and training. The Centres for Disease Control (1992, p. 11) describes the intent of school personnel training as being to:

Educate staff on how to identify students with emotional or other problems who may also be potentially suicidal. It is not meant to replace professional mental health care or to empower school staff to act as counsellors but is simply meant to enable staff to sound the alarm.

ASK z ASSESS z ACT Workshop Outline and Content

Centres for Disease Control (1992), Tanney (1989) and others report that the key to suicide intervention is to provide gatekeepers, such as foster parents, with knowledge about suicide (facts, myths, and warning signs) and intervention skills so they can assess if there is a risk of suicide, and if necessary, refer the youth for help. This type of training would be expected to influence a change in attitudes and an increase in knowledge so that school personnel would feel more confident to deal with the issue of youth suicide. Based on this rationale, the ASK z ASSESS z ACT program was developed.