



Teen Suicide Prevention Toolkit

*Compiled by
The Suicide Prevention Coalition of
Warren & Clinton Counties*



Suicide Prevention Coalition

c/o Mental Health Recovery Services of Warren & Clinton Counties
212 Cook Rd.
Lebanon, OH 45036
(513) 695-1695



September, 2018

The statistics are alarming – an average of more than 3,000 young people in grades 9 – 12 attempt suicide **each day**, according to the Parent Resource Program of the Jason Foundation. Even more telling, four of five of these teenagers who attempted suicide gave clear warning signs.

Our mission is working to prevent suicide by mobilizing the community through education and awareness. That's why we've put this toolkit together for you. Our goal is to provide some resources and tools that you can keep at your fingertips. It contains ideas and tips for students and school personnel to learn the warning signs of suicide and ways to intervene until trained professionals can be contacted.

In this toolkit you will find:

- Prevention facts, statistics and resources
- Suicide risk factors and warning signs
- Programs that train middle and high school students to see potential signs of suicide
- Information about a phone app, StopBullying, from SAMHSA
- Model School Protocols
- Other helpful links, and
- Screening tools for teen depression, suicide risk, and more

The Suicide Prevention Coalition can provide consultation on creating a school-wide suicide prevention plan. Mental Health Recovery Services can also be a resource of information through its Speakers' Bureau. The Bureau has speakers from the Board office and provider agencies who can tailor a presentation to general or specific needs. For more information, please contact MHRS at (513) 695-1695 or email info@mhrswcc.org.

This toolkit is also available electronically on the MHRS website at mhrsonline.org. Click on "Prevention & Resources" then "Suicide Prevention". The toolkit is listed under "Publications". It will be routinely updated so you can always access timely information.

Thank you for being a partner in our efforts to prevent suicide among our youth. We look forward to continued work together!

Sincerely,
Suicide Prevention Coalition

This toolkit was developed under a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Ohio Department of Mental Health and Addiction Services (ODMHAS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or ODMHAS.



Suicide Risk Factors and Warning Signs

(adapted from American Foundation for Suicide Prevention)

While there's no single cause for suicide, there are some common signs and risk factors that increase the potential for someone to start thinking about it.

Risk Factors

These fall into three categories: health factors, environmental factors, and historical factors:

- | Health | Environmental | Historical |
|--|---|--|
| <ul style="list-style-type: none">• Mental health conditions<ul style="list-style-type: none">◦ Depression◦ Substance use problems◦ Bipolar disorder◦ Schizophrenia◦ Personality traits of aggression, mood changes and poor relationships◦ Conduct disorder◦ Anxiety disorders• Serious physical health conditions including pain• Traumatic brain injury | <ul style="list-style-type: none">• Access to lethal means including firearms and drugs• Prolonged stress, such as harassment, bullying, relationship problems or unemployment• Stressful life events, like rejection, divorce, financial crisis, other life transitions or loss• Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide | <ul style="list-style-type: none">• Previous suicide attempts• Family history of suicide• Childhood abuse, neglect or trauma |

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Warning Signs

There are some things to look for if you're concerned that someone you know is considering suicide. Chief among them: behavioral changes or new behaviors showing up. Watch for things like these:

Talk	Behavior	Mood
If a person talks about: <ul style="list-style-type: none">• Killing themselves• Feeling hopeless• Having no reason to live• Being a burden to others• Feeling trapped• Unbearable pain	Behaviors that may signal risk, especially if related to a painful event, loss or change: <ul style="list-style-type: none">• Increased use of alcohol or drugs• Looking for a way to end their lives, such as searching online for methods• Withdrawing from activities• Isolating from family and friends• Sleeping too much or too little• Visiting or calling people to say goodbye• Giving away prized possessions• Aggression• Fatigue	People who are considering suicide often display one or more of the following moods: <ul style="list-style-type: none">• Depression• Anxiety• Loss of interest• Irritability• Humiliation/Shame• Agitation/Anger• Relief/Sudden Improvement

For more information and resources, visit the MHRS website at mhrsonline.org



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YOUTH SUICIDE FACT SHEET BASED ON 2016 DATA (2018)

Overview

- In 2016, 5,723 youth age 15-24 died by suicide.ⁱ
- Suicide was the 2nd leading cause of death for 15-24-year-olds in 2016. Suicide was also the 2nd leading cause of death for youth aged 10-14 years old.
- The most recent Youth Risk and Behavior Survey found that in the preceding year among high school students: 17.7% seriously considered suicide; 14.6% made a plan for suicide; 8.6% attempted suicide one or more times; 2.8% made a suicide attempt that had to be treated by doctor or nurse.ⁱⁱ
- Girls are more likely to attempt suicide, but boys are 4.34 times more likely to die by suicide than girls.ⁱⁱ
- Among ages 15-24, 4,550 Caucasians, 686 African Americans, 316 Asian/Pacific Islanders and 171 Native Americans died by suicide during 2016.ⁱ
- 51.3% of males age 15-24 used firearms to take their life, and 34.8% used suffocation; however, among females 44.3% died by suffocation compared to 29.2% by firearms.ⁱ

RISK FACTORS

- Mental illness
- Substance abuse ⁱⁱⁱ
- Firearms in the household ⁱⁱⁱ
- Previous suicide attempts ^{iv}
- Non-suicidal self-injury ^v
- Exposure to friends'/family member's suicide ^{vi}
- Low self-esteem ^{vii}

PROTECTIVE FACTORS

- Family and school connectedness ^{viii}
- Safe schools ⁱⁱⁱ
- Reduced access to firearms ^{ix}
- Academic achievement ^{vi}
- Self-esteem ^x

Youth Suicide Can Be Prevented

Youth across America are affected by suicide, be it families, at school, or in their own lives. The cost is immeasurable, but help is available. Friends are often the first to know their friend is suicidal, and we need to help them know where to find help.

ⁱ Centers for Disease Control and Prevention (2017). Fatal injury reports, national and regional, 1999-2016. Retrieved from <https://webappa.cdc.gov/sasweb/ncipc/mortrate.html>.

ⁱⁱ Centers for Disease Control and Prevention. (2017). Youth risk behavior surveillance system (YRBSS). Retrieved from <http://www.cdc.gov/healthyyouth/data/yrbs/index.htm>

ⁱⁱⁱ Brent, D.A., Baugher, M., Bridge, J., Chen, T., & Chiappetta, L. (1999). Age- and sex-related risk factors for adolescent suicide. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38(12), 1497-1505.

^{iv} Beautrais, A.L. (2004). Further suicidal behavior among medically serious suicide attempters. *Suicide and Life-Threatening Behavior*, 34(1), 1-11.

^v Nock, M.K., Joiner Jr., T.E., Gordon, K.H., Lloyd-Richardson, E., & Prinstein, M.J. (2006). Non-suicidal self-injury among adolescents: diagnostic correlates and relation to suicide attempts. *Psychiatry Research*, 144(1), 65-72.

^{vi} Borowsky, I.W. (2001). Adolescent suicide attempts: risk and protectors. *Pediatrics*, 107(3), 485-493.

^{vii} Resnick, M.D. et al. (1997). Protecting adolescents from harm: findings from the National Longitudinal Study on Adolescent Health. *JAMA*, 278(10), 823-832.

^{viii} Kaminski, J.W., Puddy, R.W., Hall, D.M., Cashman, S.Y., Crosby, A.E., & Ortega, L.A.G. (2010). The relative influence of different domains of social connectedness of self-directed violence in adolescence. *Journal of Youth and Adolescence*, 39, 460-473.

^{ix} Grossman et al. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *JAMA*, 293(6), 707-714.

^x Sharaf, A.Y., Thompson, & Walsh, E. (2009). Protective effects of self-esteem and family support on suicide risk behaviors among at-risk adolescents. *Journal of Child and Adolescent Psychiatric Nursing*, 22(3), 160-168.

If you or someone you know is suicidal, please contact a mental health professional or call 1-800-273-TALK (8255).

U.S.A. SUICIDE: 2016 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Suicides)	Rate
Nation	44,965	122.9	13.9	1.6	White Male (31,032)	24.8
Males	34,727	94.9	21.8	2.5	White Female (9,132)	7.2
Females	10,238	28.0	6.2	0.8	Nonwhite Male (3,695)	10.9
Whites	40,164	109.7	15.9	1.7	Nonwhite Female (1,106)	3.0
Nonwhites	4,801	13.1	6.8	1.1	Black/African American Male (2,206) ..	10.2
Blacks/African Americans	2,770	7.6	6.1	0.8	Black/African American Female (564) ..	2.4
Older Adults (65+ yrs.)	8,204	22.4	16.7	0.4	Hispanic/Latino (3,668)	6.4
Young (15-24 yrs.)	5,723	15.6	13.2	17.6	Native Americans/Alaska Natives (629) ..	13.6
Middle Aged (45-64 yrs.)	16,196	44.3	19.2	3.0	Asian/Pacific Islanders (1,402)	6.8

Fatal Outcomes (Suicides): a small rate increase was seen from 2015 to 2016, continuing the recent rate increases after long-term trends of decline

- Average of 1 person every 11.7 minutes killed themselves
- Average of 1 older adult every 1 hour and 4 minutes killed themselves
- Average of 1 young person every 1 hour and 32 minutes killed themselves. (If the 443 suicides below age 15 are included, 1 young person every 1 hour and 25 minutes)

- 10th ranking cause of death in U.S.— 2nd for **young**

- 3.4 male deaths by suicide for each female death by suicide

- Suicide ranks 10th as a cause of death; Homicide ranks 16th

Nonfatal Outcomes (Attempt Survivors) (figures are estimates):

- 1,124,125 annual attempts in U.S. (using 25:1 ratio); 2016 SAMHSA study: 1.3 million adults (18 and up)
- Translates to one attempt every 28 seconds (based on 1,124,125 attempts) [1.3 million = 1 every 24 seconds]
- 25 attempts for every death by suicide for nation (one estimate); 100-200:1 for young; 4:1 for older adults
- 3 female attempts for each male attempt

Leading Causes of Death 15-24 yrs

>> Cause	Number	Rate
All Causes	32,575	74.9
1-Accidents	13,895	31.9
2-Suicide	5,723	13.2
3-Homicide	5,172	11.9
10-14 yrs	436	2.1
15-19 yrs	2,117	10.0
20-24 yrs	3,606	16.1

Suicide Loss Survivors (those bereaved of suicide): † (figures are estimates)

°Recent (Cerel, 2015) research-based estimate suggests that for each death by suicide → 147 people are *exposed* (6.6 million annually); among those, more than 6 experience a major life disruption (*loss survivors*); a low, non-research based estimate see Cerel et al. 2015)

- If each suicide has devastating effects and intimately affects > 6 other people, there are **over 269,000 loss survivors a year**
- Based on the 8651,815 suicides from 1992 through 2016, therefore, the number of *survivors of suicide loss* in the U.S. is more than 5.2 million (1 of every 62 Americans in 2016); number grew by more than 269,790 in 2016
- If there is a suicide every 11.7 minutes, then there are more than 6 new loss survivors every 11.7 minutes as well

Suicide Methods	Number	Rate	Percent of Total	Number	Rate	Percent of Total
Firearm suicides (1st)	22,938	7.1	51.0%	All but Firearms	22,027	6.8
Suffocation/Hanging (2nd)	11,642	3.6	25.9%	Poisoning (3rd)	6,698	2.1
Cut/pierce (5th)	864	0.3	1.9%	Drowning (7th)	497	0.2

U.S.A. Suicide Rates 2006-2016 (Rates per 100,000 population)													15 Leading Causes of Death in the U.S.A., 2016 (total of 2,744,248 deaths; 849.3 rate)			
Group/ Age	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Group/ Age	Rank	Cause of Death	Rate	Deaths
5-14	0.5	0.5	0.6	0.7	0.7	0.7	0.8	1.0	1.0	1.0	1.1	5-14	1	Diseases of heart (heart disease)	196.6	635,260
15-24	9.9	9.7	10.0	10.1	10.5	11.0	11.1	11.1	11.6	12.5	13.2	15-24	2	Malignant neoplasms (cancer)	185.1	598,038
25-34	12.3	13.0	12.9	12.8	14.0	14.6	14.7	14.8	15.1	15.7	16.5	25-34	3	Accidents (unintentional injury)	49.9	161,374
35-44	15.1	15.6	15.9	16.1	16.0	16.2	16.7	16.2	16.6	17.1	17.4	35-44	4	Chronic lower respiratory diseases	47.8	154,596
45-54	17.2	17.7	18.7	19.3	19.6	19.8	20.0	19.7	20.2	20.3	19.7	45-54	5	Cerebrovascular diseases (stroke)	44.0	142,142
55-64	14.5	15.5	16.3	16.7	17.5	17.1	18.0	18.1	18.8	18.9	18.7	55-64	6	Alzheimer's disease	35.9	116,103
65-74	12.6	12.6	13.9	14.0	13.7	14.1	14.0	15.0	15.6	15.3	15.4	65-74	7	Diabetes mellitus (diabetes)	24.8	80,058
75-84	15.9	16.3	16.0	15.7	15.7	16.5	16.8	17.1	17.5	17.9	18.2	75-84	8	Influenza & pneumonia	16.0	51,537
85+	15.9	15.6	15.6	15.6	17.6	16.9	17.8	18.6	19.3	19.4	19.0	85+	9	Nephritis, nephrosis (kidney disease)	15.5	50,046
65+	14.2	14.3	14.8	14.8	14.9	15.3	15.4	16.1	16.7	16.6	16.7	65+	10	Suicide [Intentional Self-Harm]	13.9	44,965
Total	11.1	11.5	11.8	12.0	12.4	12.7	12.9	13.0	13.4	13.8	13.9	Total	11	Septicemia	12.6	40,613
Men	17.8	18.3	19.0	19.2	20.0	20.2	20.6	20.6	21.1	21.5	21.8	Men	12	Chronic liver disease and cirrhosis	12.6	40,545
Women	4.6	4.8	4.9	5.0	5.2	5.4	5.5	5.7	6.0	6.3	6.2	Women	13	Essential hypertension and renal disease	10.3	33,246
White	12.4	12.9	13.3	13.5	14.1	14.5	14.8	14.9	15.5	15.8	15.9	White	14	Parkinson's disease	9.2	29,697
Nonwh	5.5	5.6	5.7	5.8	5.8	5.8	6.1	6.0	6.0	6.3	6.8	NonWh	15	Pneumonitis due to solids and liquids	6.1	19,715
Black	4.9	4.9	5.2	5.1	5.1	5.3	5.5	5.4	5.5	5.6	6.1	Black	-	All other causes (Residual; > 15)	169.1	546,313
45-64	16.0	16.7	17.5	18.0	18.6	19.1	19.0	19.5	19.6	19.2	19.2	45-64	-	Homicide (ranks 16th)	6.0	19,362

- Older adults made up 15.2% of 2016 population but 18.2% of suicides • Young were 13.5% of 2016 population and 12.7% of suicides •
- Middle Aged were 26.1% of the 2016 population but were 36.0% of suicides •

1,290,986* Years of Potential Life Lost Before Age 75 (41,164 of 44,965 suicides are below age 75)

* alternate YPLL figure: 1,289,181 using individual years in calculations rather than 10-year age groups as above.

Many figures appearing here are derived or calculated from data in the following *official data sources*: downloaded 22 and 23 December 2017 from CDC's website: <https://wonder.cdc.gov>. Some figures were derived or calculated from data at the CDC's WONDER site.

SAMHSA 2016 study (2017): Center for Behavioral Health Statistics and Quality. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Pub. No. SMA 17-5044, NSDUH Series H-52). Substance Abuse and Mental Health Services Administration, Rockville, MD. Retrieved 23 Dec 2017 from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf>

Cerel, J. (2015, April 18). *We are all connected in suicidology: The continuum of "survivorship."* Plenary presentation at the 48th annual conference of the American Association of Suicidology, Atlanta GA. [data from Cerel, Brown, Maple, Bush, van de Venne, Moore, & Flaherty, in progress; personal communication 20 Dec 2015]

† Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The continuum of "survivorship": Definitional issues in the aftermath of suicide. *Suicide & Life-Threatening Behavior*, 44(6), 591-600.

suicide rate = (number of suicides by group / population of group) X 100,000
Prepared for AAS by Christopher W. Drapeau, Ph.D., & John L. McIntosh, Ph.D.

Suicide Data Page: 2016
24 December 2017 • 2014 data revised 9 Jan 2018

Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2016

Rank	State [Division / Region]	Deaths	Rate	Division [Abbreviation]	Rate	Number
1	Alaska [P / West]	193	26.0	Mountain [M]	20.7	4,942
2	Montana [M / West]	267	25.6	East South Central [ESC]	16.0	3,038
3	Wyoming [M / West]	144	24.6	West North Central [WNC]	16.0	3,392
4	New Mexico [M / West]	471	22.6	South Atlantic [SA]	14.1	9,013
5	Nevada [M / West]	650	22.1	West South Central [WSC]	14.1	5,542
5	Colorado [M / West]	1,168	22.1	Nation	13.9	44,965
7	Oklahoma [WSC / South]	822	21.0	East North Central [ENC]	13.7	6,386
8	Idaho [M / West]	351	20.9	Pacific [P]	12.5	6,574
9	Utah [M / West]	620	20.3	New England [NE]	11.8	1,742
10	West Virginia [SA / South]	362	19.8	Middle Atlantic [MA]	10.5	4,336
11	Oregon [P / West]	772	18.9			
11	Vermont [NE / Northeast]	118	18.9	Region [Subdivision Abbreviations]	Rate	Number
13	South Dakota [WNC / Midwest]	163	18.8	West (M, P)	15.0	11,516
14	Missouri [WNC / Midwest]	1,133	18.6	Midwest (WNC, ENC)	14.4	9,778
14	Arkansas [WSC / South]	555	18.6	South (ESC, WSC, SA)	14.4	17,593
16	North Dakota [WNC / Midwest]	140	18.5	Nation	13.9	44,965
17	Arizona [M / West]	1,271	18.3	Northeast (NE, MA)	10.8	6,078
17	New Hampshire [NE / Northeast]	244	18.3			
19	Kansas [WNC / Midwest]	514	17.7			
20	Kentucky [ESC / South]	756	17.0			
20	Maine [NE / Northeast]	226	17.0			
22	Tennessee [ESC / South]	1,111	16.7			
23	South Carolina [SA / South]	815	16.4			
24	Alabama [ESC / South]	788	16.2			
25	Washington [P / West]	1,141	15.7			
26	Indiana [ENC / Midwest]	1,034	15.6			
27	Pennsylvania [MA / Northeast]	1,970	15.4			
28	Florida [SA / South]	3,143	15.2			
29	Wisconsin [ENC / Midwest]	866	15.0			
30	Ohio [ENC / Midwest]	1,707	14.7			
31	Louisiana [WSC / South]	677	14.5			
32	Iowa [WNC / Midwest]	451	14.4			
	Nation	44,965	13.9			
33	Virginia [SA / South]	1,166	13.9			
34	Georgia [SA / South]	1,409	13.7			
34	Michigan [ENC / Midwest]	1,364	13.7			
36	North Carolina [SA / South]	1,373	13.5			
36	Minnesota [WNC / Midwest]	745	13.5			
38	Nebraska [WNC / Midwest]	246	12.9			
39	Mississippi [ESC / South]	383	12.8			
40	Texas [WSC / South]	3,488	12.5			
40	Delaware [SA / South]	119	12.5			
42	Hawaii [P / West]	174	12.2			
43	Rhode Island [NE / Northeast]	126	11.9			
44	Illinois [ENC / Midwest]	1,415	11.1			
44	Connecticut [NE / Northeast]	397	11.1			
46	California [P / West]	4,294	10.9			
47	Maryland [SA / South]	586	9.7			
48	Massachusetts [NE / Northeast]	631	9.3			
49	New York [MA / Northeast]	1,679	8.5			
50	New Jersey [MA / Northeast]	687	7.7			
51	District of Columbia [SA / South]	40	5.9			

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Suggested citation: Drapeau, C. W., & McIntosh, J. L. (for the American Association of Suicidology). (2017). *U.S.A. suicide 2016: Official final data*. Washington, DC: American Association of Suicidology, dated December 24, 2017, downloaded from <http://www.suicidology.org>.

Source: Obtained 23 December 2017 from CDC/NCHS's *WONDER* (to appear in *Deaths: Final Data for 2016*, forthcoming) <http://www.cdc.gov/nchs/products/nvsr.htm>

[data are by place of residence]
[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]

Note: All rates are per 100,000 population.

* Including the District of Columbia.

**Suicide State Data Page: 2016
24 December 2017**

Prepared by Christopher W. Drapeau, Ph.D.
and John L. McIntosh, Ph.D. for



**American Association
of Suicidology**

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***“to understand and prevent suicide
as a means of promoting human well-being”***

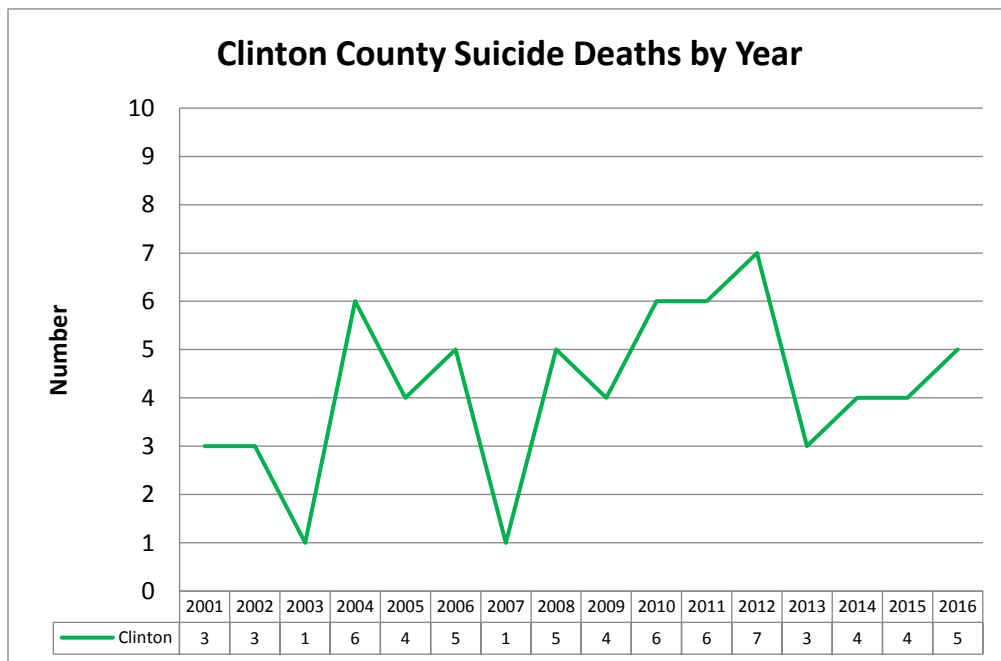
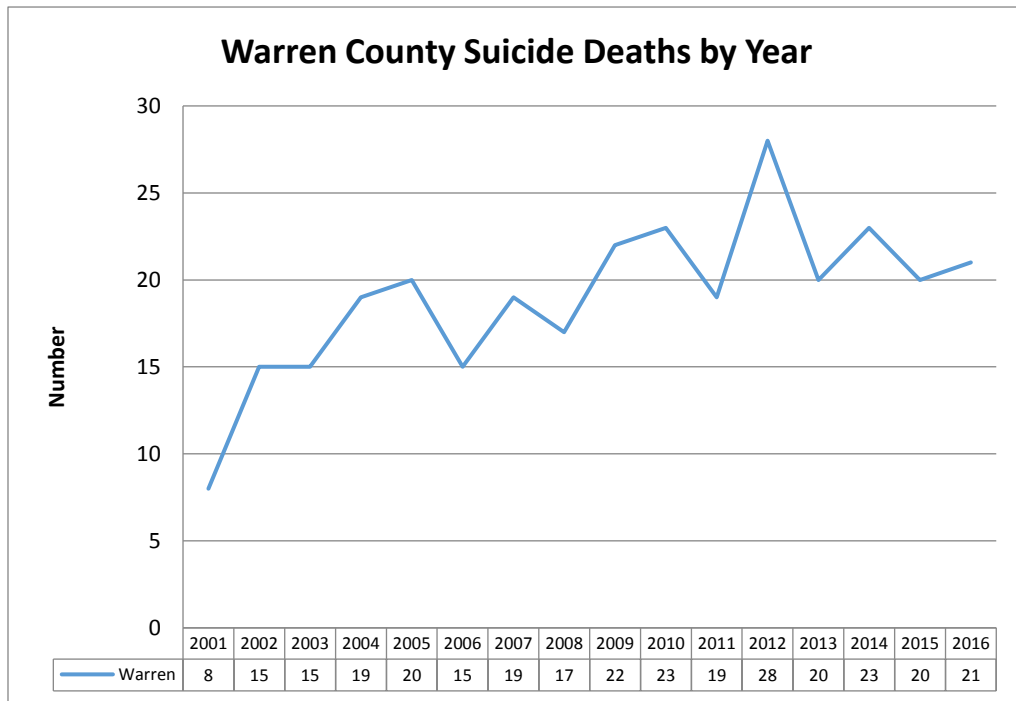
Visit the AAS website at:

<http://www.suicidology.org>

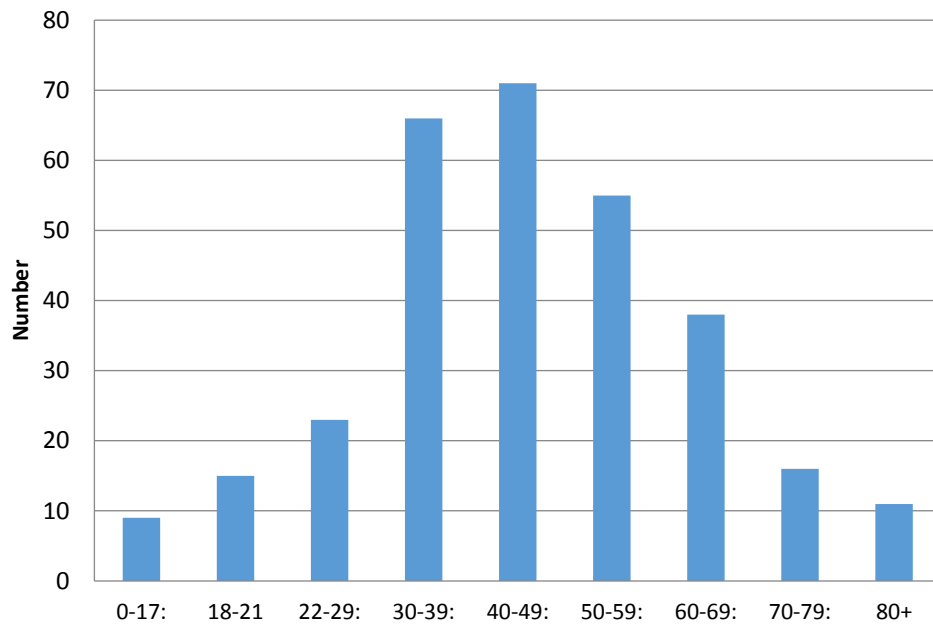
For other suicide data, and an archive of state data, visit the website below and click on the dropdown “Suicide Stats” menu:

<http://pages.iu.edu/~jmcintos/>

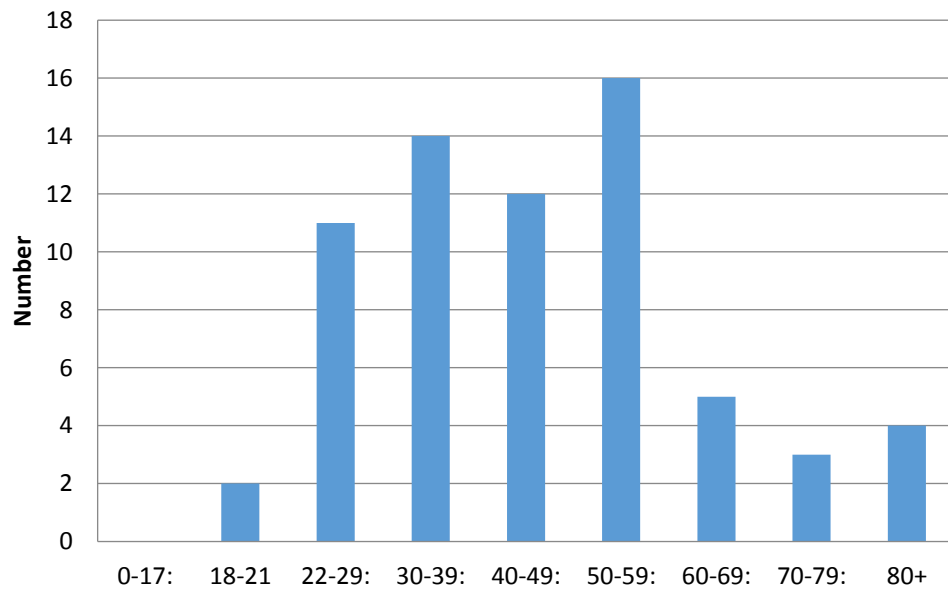
Local Suicide Statistics for Warren & Clinton Counties



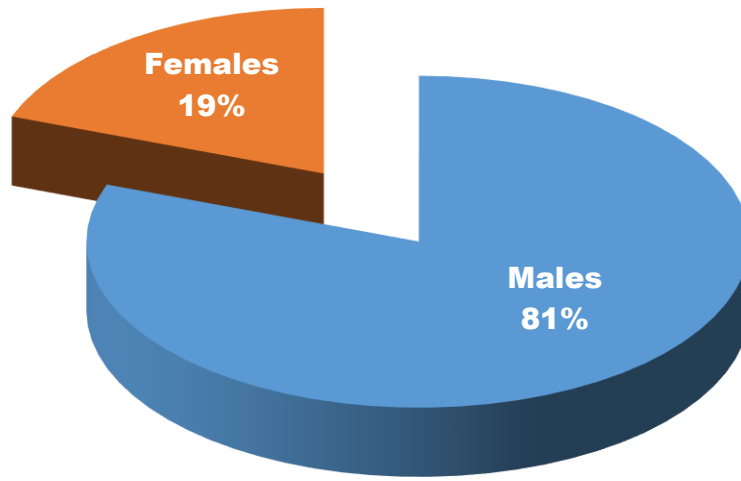
2001-2016 Warren County Suicide Deaths by Age



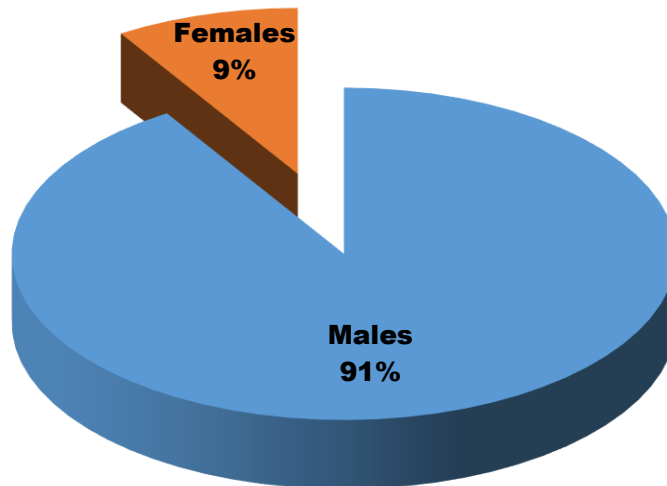
2001-2016 Clinton County Suicide Deaths by Age



**2001-2016 Warren County Suicide Deaths
by Gender**



**2001-2016 Clinton County Suicide Deaths by
Gender**



Section 2



Suicide Risk Factors and Warning Signs

(adapted from American Foundation for Suicide Prevention)

While there's no single cause for suicide, there are some common signs and risk factors that increase the potential for someone to start thinking about it.

Risk Factors

These fall into three categories: health factors, environmental factors, and historical factors:

- | Health | Environmental | Historical |
|--|---|--|
| <ul style="list-style-type: none">• Mental health conditions<ul style="list-style-type: none">◦ Depression◦ Substance use problems◦ Bipolar disorder◦ Schizophrenia◦ Personality traits of aggression, mood changes and poor relationships◦ Conduct disorder◦ Anxiety disorders• Serious physical health conditions including pain• Traumatic brain injury | <ul style="list-style-type: none">• Access to lethal means including firearms and drugs• Prolonged stress, such as harassment, bullying, relationship problems or unemployment• Stressful life events, like rejection, divorce, financial crisis, other life transitions or loss• Exposure to another person's suicide, or to graphic or sensationalized accounts of suicide | <ul style="list-style-type: none">• Previous suicide attempts• Family history of suicide• Childhood abuse, neglect or trauma |

(over)

Warning Signs

There are some things to look for if you're concerned that someone you know is considering suicide. Chief among them: behavioral changes or new behaviors showing up. Watch for things like these:

Talk	Behavior	Mood
If a person talks about: <ul style="list-style-type: none">• Killing themselves• Feeling hopeless• Having no reason to live• Being a burden to others• Feeling trapped• Unbearable pain	Behaviors that may signal risk, especially if related to a painful event, loss or change: <ul style="list-style-type: none">• Increased use of alcohol or drugs• Looking for a way to end their lives, such as searching online for methods• Withdrawing from activities• Isolating from family and friends• Sleeping too much or too little• Visiting or calling people to say goodbye• Giving away prized possessions• Aggression• Fatigue	People who are considering suicide often display one or more of the following moods: <ul style="list-style-type: none">• Depression• Anxiety• Loss of interest• Irritability• Humiliation/Shame• Agitation/Anger• Relief/Sudden Improvement

For more information and resources, visit the MHRS website at mhrsonline.org



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The Crisis Hotline: *Help at Your Fingertips*



Life deals some harsh hands sometimes. But when those hands get too hard to bear, or just don't seem to lessen or get better, having someone to talk with can make all the difference. That's why the Crisis Hotline is here. Trained professionals will answer and offer a listening ear, and they can also provide information on places to seek help if needed.

It's your call to make. We'll be here.

(877) 695-NEED (6333)



mhrsonline.org



CRISIS TEXT LINE |

**Text 4hope
to 741 741**

We're there anytime,
day or night, to help
with whatever is
hurting you.



Mental Health
Recovery Services
of Warren & Clinton Counties

More online at
mhrsonline.org

Crisis Hotline:
(877) 695-NEED (6333)

Section 3



QPR- Question, Persuade, Refer - Suicide Prevention Training

Take Action To Make A Difference!

Each year an estimated 775,000 family members are impacted by the suicide attempt or death of a loved one. Countless others are concerned about friends. You can make a difference and possibly save a life.

In a QPR training, individuals can learn to recognize the warning signs of suicide and how to apply three simple steps that may save a life. Presented by a certified instructor, each QPR training includes information on:

- **the problem** of suicide nationally and in Ohio
- **common myths and facts** associated with suicide
- **warning signs** of suicide
- **tips for asking** the suicide question
- **methods for persuading** suicidal individuals to get help
- **ways of referring** at risk people to local resources
- AND time for **Questions and Answers**

Each attendee will receive a QPR booklet and card with information on suicide prevention, as well as resource information for treatment providers and support groups within their community.

To schedule trainings, please contact:

Agency: Solutions Community Counseling and Recovery Centers

Attn: Barbara Adams Marin, LCDCII, OCPS

Phone: 937.383.4441 x116 or 937.302.0009 (c)

e-mail: bmarin@solutionsccrc.org

~~ Available to any Warren or Clinton County organization ~~

SOS – Signs of Suicide Prevention Program For Middle Schools and High Schools

Some secrets should be shared. . . .

WHY IS THIS TRAINING IMPORTANT?

Each year an estimated 775,000 family members are impacted by the suicide attempt or death of a loved one. Countless others are concerned about friends. You can make a difference and possibly save a life.

Suicide is the third leading cause of death for 11-18 year olds in the United States.

According to the National Association of School Psychologists, the reality is that every five hours, a child or adolescent in the United States dies by suicide.



HOW DOES THE TRAINING WORK?

SOS Signs of Suicide® Prevention Program is an award-winning, nationally recognized program designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell). SOS is designed to be implemented in one class period using a DVD and discussion guide with talking points for each topic addressed.

The SOS High School program is the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized control study, the SOS program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

For more information about SOS, go to
<http://mentalhealthscreening.org/programs/youth-prevention-programs/sos/>.

To schedule a training, contact:
Solutions Community Counseling & Recovery Centers

Attn: Barbara Adams Marin
Phone: 937.383.4441
Email: bmartin@solutionsccrc.org

Available *FREE* to
Warren and Clinton County, Ohio Schools

This program is approved by the
Suicide Prevention Coalition of Warren
and Clinton Counties
and
funded by
Mental Health Recovery Services of
Warren and Clinton Counties



Get KnowBullying, the free app from SAMHSA that can prevent bullying.

Research shows that parents and caregivers who spend at least 15 minutes a day talking with their child can build the foundation for a strong relationship and help prevent bullying.

The time you spend will help boost your children's confidence and build effective strategies for facing bullying—whether children are being bullied, engaging in bullying, or witnessing bullying.

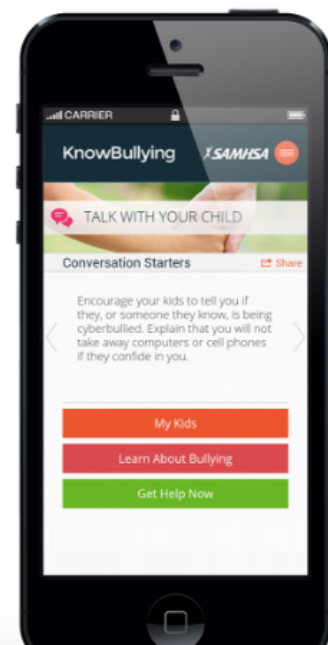
Take a few minutes and “check in,” by asking about school, their friends, and any challenges they face. **KnowBullying** has simple conversation starters to begin a discussion with your child.

App Features

- **Conversation Starters:** Start easy, meaningful conversations with your children.
- **Tips:** Learn strategies to prevent bullying for ages 3–6, 7–13, and teens.
- **Warning Signs:** Recognize if your child is engaging in bullying, being bullied, or witnessing bullying.
- **Reminders:** Talk with your child when the time feels right: a quiet moment on the way to school or a game, during dinner, or relaxing outside.
- **Social Media:** Share successful strategies and useful advice via Facebook, Twitter, email, and text messages.
- **Section for Educators:** Prevent bullying in the classroom and support children who are being bullied.

Help spread the word about
KnowBullying.

Available Now



Put the power to prevent bullying in your hand.

Kognito Program Information and Fliers

Kognito Trainings for Students

The [Ohio Suicide Prevention Foundation](#) offers free online training through Kognito At-Risk for K-12 and/or Kognito Step-In, Speak Up Trainings. These online, on-demand trainings use avatars to equip school personnel or those who interact with youth with lessons on recognizing warning signs of emotional distress in students, initiating and holding helpful conversations, identifying when further help for students is needed, and referring youth to appropriate services. “At Risk” is for personnel who come in contact with Elementary, Middle and High School Students. “Step-in, Speak Up” focuses on equipping school staff with knowledge in how to create welcoming school environments for LGBTQ youth.

Kognito – why this is important:

<https://www.dropbox.com/s/w4wc0c4aou7y1uu/Talking%20Points.pdf?dl=0>

Kognito (At-Risk) elementary school flier:

https://www.dropbox.com/s/ioy13d46r0igb6m/STW_flyers_k-12_ohio_ares.pdf?dl=0

Kognito (At-Risk) middle school flier:

https://www.dropbox.com/s/1kb6venwj0c47na/STW_flyers_k-12_ohio_arms.pdf?dl=0

Kognito (At-Risk) high school flier:

https://www.dropbox.com/s/ygdnc4fguji3uxe/STW_flyers_k-12_ohio_arhs.pdf?dl=0

Kognito (Step-In, Speak Up) flier:

https://www.dropbox.com/s/nqeasw2wh6nq3lh/STW_flyers_k-12_ohio_sisu.pdf?dl=0

Have you ever been worried about a friend? Maybe he or she has been absent a lot recently, or doesn't want to hang out after school. There could be something going on at home, or anxiety about grades or applying to college — but how do you bring up your concern in a constructive way? And if your friend is struggling with anxiety or depression, where can you turn for help? Practice having these tough conversations in an online simulation our school is offering, Friend2Friend.

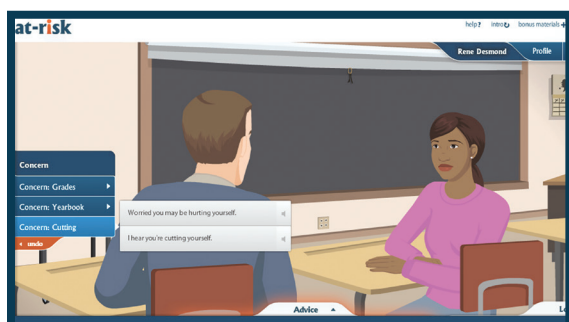
Kognito (Friend to Friend) flier:

https://www.dropbox.com/s/cw2oy5nmvxirjm3/STW_flyers_k-12_ohio_f2f.pdf?dl=0

Enable the conversations that make a difference.

Kognito's conversation simulations featuring virtual humans provide an exciting new opportunity for effectively delivering behavior change outcomes.

AT RISK FOR 6-12



Secondary school educators learn to identify and approach at-risk students and master the conversations to motivate them to seek help.

CONVERSATIONS INCLUDE:
Disruptive Behavior, Anxiety, Cutting, Cyber-bullying, Thoughts of Suicide

STEP IN, SPEAK UP!



Secondary school educators learn to create a safe and supportive learning environment.

CONVERSATIONS INCLUDE:
Hearing Their Stories, Stopping Harassment, Expressing Concern

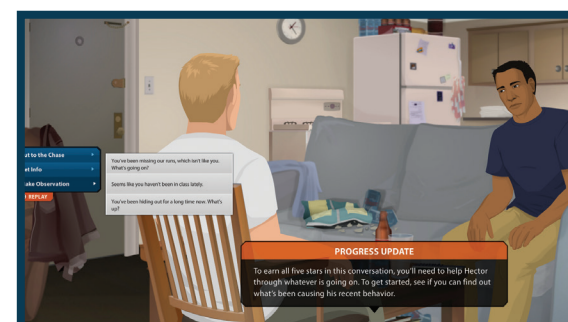
LGBTQ ON CAMPUS



Students and student leaders learn to build a supportive college community for LGBTQ students.

CONVERSATIONS INCLUDE:
Addressing Stigma, Coming Out, Expressing Concern

VETERANS ON CAMPUS



Student veterans learn to build the skills to help other veterans transition to a successful college life.

CONVERSATIONS INCLUDE:
Supporting Peers, Understanding Common Challenges, Learning about Resources

FAMILY OF HEROES



Military family members and friends learn to build the critical skills to adjust to post-deployment life.

CONVERSATIONS INCLUDE:
Identifying Post-deployment Stress, Managing and De-escalating Difficult Conversations, Motivating Loved Ones to Access Help

To access these simulations, please visit ohiospf.org

AVAILABLE NOW AT NO COST TO EVERYONE ACROSS OHIO

Kognito

Conversations that make a difference.

Evidence-based Interventions • 24/7 Online Accessibility • SPRC/AFSP Best Practices Registry • Assessment & Usage Tracking Tools

Section 4

Creating a Comprehensive School-Wide Suicide Prevention Plan

School staff have often been considered the first line of defense to help students who are thinking of or planning to take their own lives. It's important that schools and school staff are prepared with a plan that helps them see the warning signs and how to step in when needed.

But what makes a good, comprehensive plan to prevent suicide among teens? Several papers have been written on the subject, most outlining a common set of components that can help schools build a supportive campus for kids and adults alike. Here are the main components they include:

- Develop protocols that include how to help students and staff who are at risk of suicide; responding to those who attempt suicide; and responding to the suicide of a student or other school community member
- Provide staff education and training that covers risks and protective factors and warning signs, as well as assessing, intervening and referring
- Implementing prevention education programs for students that use evidence-based practices and curriculum at all grade levels
- Offering education and outreach for parents/guardians such as information in orientation packets, e-newsletters, and websites

Here are some good resources for building your own suicide prevention plan:

School-Based Approach to Suicide Prevention (for districts in Lane County, Oregon)
<https://www.preventionlane.org/wp-content/uploads/2013/08/Lane-County-Comprehensive-School-Based-Approach-to-Suicide-rev.-3-17.pdf>

High school suicide prevention programs, *Suicide Prevention Resource Center*
<https://www.sprc.org/settings/high-school>

A Model School Policy on Suicide Prevention, *American Foundation for Suicide Prevention*
<https://afsp.org/our-work/education/model-school-policy-suicide-prevention/>

Model School Protocols & Guidelines

Reducing the risk of youth suicide requires making positive changes. To help make it easier for schools to prevent, assess, intervene in, and respond to suicidal behavior, The Trevor Project has collaborated to create a Model School District Policy for Suicide Prevention. This modular, adaptable document will help educators and school administrators implement comprehensive suicide prevention policies in communities nationwide. Download our fact sheet and full policy today – by adopting or advocating for this model policy in your school district, you can help protect the health and safety of all students.

This model policy was created in collaboration with the American Foundation for Suicide Prevention, the American School Counselor Association, Trevor Project, and the National Association of School Psychologists.

One-Page Fact Sheet

Fast Facts: Model School District Policy on Suicide Prevention

<https://www.thetrevorproject.org/wp-content/uploads/2017/09/Fast-Facts.pdf>

Full Policy Document

Model School District Policy on Suicide Prevention

<https://www.thetrevorproject.org/wp-content/uploads/2017/09/District-Policy.pdf>

Webinar

Model School District Policy on Suicide Prevention Webinar

https://thetrevorproject.adobeconnect.com/_a1089658254/p4z1v9eyvl9/

Model School District Policy on Suicide Prevention – printed document

<https://www.thetrevorproject.org/wp-content/uploads/2017/09/Model-Suicide-Prevention.pdf>

Responding to a Student Death by Suicide

Guidelines for Schools Responding to a Death by Suicide

<https://www.schoolcrisiscenter.org/wp-content/uploads/2018/02/guidelines-death-by-suicide.pdf>




YOUTH SUICIDE PREVENTION STRATEGIES & RESOURCES

Mental Health Recovery Services of Warren and Clinton Counties
513-695-1695



Develop a districtwide school/organizational policy/protocol concerning youth suicide

- In 2010, our local Coalition developed a **model protocol**. Downloadable in pdf and in Word (so that it can be modified). This also includes warning signs, screening tools and a risk assessment. See: <http://www.mhrsonline.org>
- In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) has created a book entitled **“Preventing Suicide: A Toolkit for High Schools.”** This manual provides essential information about preventing suicide as well as protocols to follow after a death by suicide. This can be downloaded at: <https://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>

Educate school professionals about suicide warning signs and risk factors

- **Youth Mental Health First Aid:** A one day training focusing on various behavioral health issues facing youth - www.mentalhealthfirstaid.org 
- **Question, Persuade, Refer (QPR):** A 90 minute training provided by a mental health professional focusing on risk factors, warning signs, and specific tips on engaging individuals in treatment. www.qprinstitute.com 
- **Kognito:** One hour, on-line professional development with hands-on practice in the form of conversations through virtual role-play, similar to a video game. This evidence-based program is available on-demand, 24 hours/day and provides a certificate upon completion. Free access thanks to the Ohio Suicide Prevention Foundation. Various modules are available: [Elementary School](#), [Middle School](#), [High School](#), [Family of Heroes](#) - for military families & friends and [Step In, Speak Up](#) - Creating a Supportive Classroom for LGBTQ Youth. www.ohiospf.org 

Suicide prevention education for youth - Some options include:

- **Signs of Suicide:** A program with two age-appropriate modules – middle school and high school age youth. This program can be provided to small groups, such as clubs, can be integrated into classroom curriculum, or can be conducted school-wide <https://mentalhealthscreening.org/programs/sos-signs-of-suicide> 
- **Question, Persuade, Refer:** Can be utilized with other teens 
- **Red Flags:** A classroom education program on depression designed for middle school-age youth which can easily be integrated into health class - www.redflags.org

Develop a **“Team Approach”** by encouraging collaboration among staff, teachers, nurses, counselors & school psychologists

Risk Assessments and Screening Tools can be used for identification of students, however, “trusting one’s gut” and communicating with others who may have also seen signs is crucial. This can come in the form of formal or informal information sharing regarding youth who:

- Have been identified as at-risk
- Have specific risk factors such as parental divorce, psychiatric hospitalizations, recent or frequent move(s)
- Have exhibited some change in behavior/academic performance or displayed some behavior/writing which is of concern.

Establish Community Behavioral Health Linkages to aid in quick, efficient referral to services as needed

- School-Based services
- Community-Based services

- Psychiatric inpatient services

Develop supportive partnerships with family by:

- Educating parents – Youth Mental Health First Aid or QPR can be used
- Provide an open line of communication

Develop a peer assistance/peer mentor program matching those who are at a high risk of social isolation/withdrawal with a peer

- Hope Squads – see <http://hopesquad.com/>

Implement activities aimed at increasing school connectedness and increasing coping skills

- Share HOPE and support
 - “Hope is” Challenge: Prompt for completion by individuals describing what Hope means to them. Responses posted on Social Media, on bulletin boards, on school app, etc.
 - #BEthere Campaign: Have students publicize how they can “be there” for their peers
- Educate students on positive coping skills and how to manage anxiety

Provide Opportunities for students to safely and comfortably seek out assistance from school staff

Recruit and train designated staff who are willing to be the “go to” individuals in a school for students who are struggling with issues – Identify these individuals in a simple manner, such as designated picture on their door.

BEST PRACTICE

Develop supportive partnerships with community agencies

Utilize/distribute materials publicizing community resources such as:

- Wallet Cards: Lists warning signs and hotline/treatment resources
- Wristbands/Crisis Text Line Cards: Provides number and info about the Crisis Text line
- Brochures with behavioral health agency contact information

Promote Means Reduction such as:

- Counseling on Access to Lethal Means (CALM) – Free Online training available at <https://training.sprc.org/enrol/index.php?id=3>

BEST PRACTICE

- Medication Disposal sites

- Safe Storage of Firearms

Establish a school or organization crisis intervention team (for after a suicide death)

- **“After A Suicide: A Toolkit for Schools”** by The American Foundation for Suicide Prevention and Suicide Prevention Resource Center
Found at: <http://www.sprc.org/sites/default/files/migrate/library/AfterASuicideToolkitforSchools.pdf>
- **“Guidelines for Schools Responding to a Death by Suicide”** by National Center for School Crisis and Bereavement
Found at: <https://www.schoolcrisiscenter.org/wp-content/uploads/2018/02/guidelines-death-by-suicide.pdf>

EBP

= Evidence Based Practice

MODEL SCHOOL DISTRICT POLICY ON SUICIDE PREVENTION

Model Language,
Commentary, and
Resources

THE **TREVOR** PROJECT



AMERICAN FOUNDATION FOR
Suicide Prevention

MODEL SCHOOL DISTRICT POLICY ON SUICIDE PREVENTION

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KEY:

Model Policy Language

Commentary

The American Foundation for Suicide Prevention (AFSP) is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. To fully achieve its mission, AFSP engages in the following Five Core Strategies: 1) fund scientific research, 2) offer educational programs for professionals, 3) educate the public about mood disorders and suicide prevention, 4) promote policies and legislation that impact suicide and prevention, and 5) provide programs and resources for survivors of suicide loss and people at risk, and involve them in the work of the Foundation. Learn more at www.afsp.org.

The American School Counselor Association (ASCA) promotes student success by expanding the image and influence of professional school counseling through leadership, advocacy, collaboration and systemic change. ASCA helps school counselors guide their students toward academic achievement, personal and social development, and career planning to help today's students become tomorrow's productive, contributing members of society. Founded in 1952, ASCA currently has a network of 50 state associations and a membership of more than 33,000 school counseling professionals. Learn more at www.schoolcounselor.org.

The National Association of School Psychologists (NASP) represents more than 25,000 school psychologists who work with students, educators, and families to support the academic achievement, positive behavior, and mental wellness of all students. NASP promotes best practices and policies that allow school psychologists to work with parents and educators to help shape individual and system wide supports that provide the necessary prevention and intervention services to ensure that students have access to the mental health, social-emotional, behavioral, and academic supports they need to be successful at home, at school, and throughout life. Learn more at www.nasponline.org.

The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24. Every day, The Trevor Project saves young lives through its accredited, free and confidential phone, text and instant message crisis intervention services. A leader and innovator in suicide prevention, The Trevor Project offers the largest safe social networking community for LGBTQ youth, best practice suicide prevention educational trainings, resources for youth and adults, and advocacy initiatives. Learn more at www.thetrevorproject.org.

MODEL SCHOOL DISTRICT POLICY ON SUICIDE PREVENTION

INTRODUCTION

This document outlines model policies and best practices for school districts to follow to protect the health and safety of all students. As suicide is the third leading cause of death among young people ages 10-19, it is critically important that school districts have policies and procedures in place to prevent, assess the risk of, intervene in, and respond to youth suicidal behavior.¹

This document was developed by examining strong local policies, ensuring that they are in line with the latest research in the field of suicide prevention, and identifying best practices for a national framework. The model is comprehensive, yet the policy language is modular and may be used to draft your own district policy based on the unique needs of your district. The language and concepts covered by this policy are most applicable to middle and high schools (largely because suicide is very rare in elementary school age children). Model policy language is indicated by shaded text on white background, and sidebar language – to provide additional context that may be useful when constructing a policy – is indicated by white text on shaded background.

Protecting the health and well-being of students is in line with school mandates and is an ethical imperative for all professionals working with youth. Because it is impossible to predict when a crisis will occur, preparedness is necessary for every school district. In a typical high school, it is estimated that three students will attempt suicide each year. On average, a young person dies by suicide every two hours in the US. For every young person who dies by suicide, an estimated 100-200 youth make suicide attempts.² Youth suicide is preventable, and educators and schools are key to prevention.

As emphasized in the National Strategy on Suicide Prevention, preventing suicide depends not only on suicide prevention policies, but also on a holistic approach that promotes healthy lifestyles, families, and communities. Thus, this model policy is intended to be paired with other policies and efforts that support the emotional and behavioral well-being of youth.

Please refer to the included Resources Section for additional information. If you would like support in writing a policy for your own district or you have questions, please contact the Government Affairs Department at The Trevor Project (202-204-4730 or Advocacy@thetrevorproject.org), or Nicole Gibson, Senior Manager of State Advocacy at the American Foundation for Suicide Prevention (202-449-3600, ngibson@afsp.org).

PURPOSE

The purpose of this policy is to protect the health and well-being of all district students by having procedures in place to prevent, assess the risk of, intervene in, and respond to suicide. The district:

- (a) recognizes that physical, behavioral, and emotional health is an integral component of a student's educational outcomes,
- (b) further recognizes that suicide is a leading cause of death among young people,
- (c) has an ethical responsibility to take a proactive approach in preventing deaths by suicide, and
- (d) acknowledges the school's role in providing an environment which is sensitive to individual and societal factors that place youth at greater risk for suicide and one which helps to foster positive youth development.

Toward this end, the policy is meant to be paired with other policies supporting the emotional and behavioral health of students more broadly. Specifically, this policy is meant to be applied in accordance with the district's Child Find obligations.

PARENTAL INVOLVEMENT

Parents and guardians play a key role in youth suicide prevention, and it is important for the school district to involve them in suicide prevention efforts. Parents/guardians need to be informed and actively involved in decisions regarding their child's welfare. Parents and guardians who learn the warning signs and risk factors for suicide are better equipped to connect their children with professional help when necessary. Parents/guardians should be advised to take every statement regarding suicide and wish to die seriously and avoid assuming that a child is simply seeking attention.

Parents and guardians can also contribute to important protective factors – conditions that reduce vulnerability to suicidal behavior – for vulnerable youth populations such as LGBTQ youth. Research from the Family Acceptance Project found that gay and transgender youth who reported being rejected by their parents or guardians were more than eight times as likely to have attempted suicide. Conversely, feeling accepted by parents or guardians is a critical protective factor for LGBTQ youth and other vulnerable youth populations. Educators can help to protect LGBTQ youth by ensuring that parents and guardians have resources about family acceptance and the essential role it plays in youth health.³

MODEL SCHOOL DISTRICT POLICY ON SUICIDE PREVENTION

DEFINITIONS

1. **At risk** A student who is defined as high risk for suicide is one who has made a suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures.

2. **Crisis team** A multidisciplinary team of primarily administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery. These professionals have been specifically trained in crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.

3. **Mental health** A state of mental and emotional being that can impact choices and actions that affect wellness. Mental health problems include mental and substance use disorders.

4. **Postvention** Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.

5. **Risk assessment** An evaluation of a student who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

6. **Risk factors for suicide** Characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment.

7. **Self-harm** Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Can be categorized as either nonsuicidal or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.

8. **Suicide** Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death.

9. **Suicide attempt** A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.

10. **Suicidal behavior** Suicide attempts, intentional injury to self associated with at least some level of intent, developing a plan or strategy for suicide, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

11. **Suicide contagion** The process by which suicidal behavior or a suicide influences an increase in the suicidal behaviors of others. Guilt, identification, and modeling are each thought to play a role in contagion. Although rare, suicide contagion can result in a cluster of suicides.

12. **Suicidal ideation** Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.

SCOPE

This policy covers actions that take place in the school, on school property, at school-sponsored functions and activities, on school buses or vehicles and at bus stops, and at school sponsored out-of-school events where school staff are present. This policy applies to the entire school community, including educators, school and district staff, students, parents/guardians, and volunteers. This policy will also cover appropriate school responses to suicidal or high risk behaviors that take place outside of the school environment.

IMPORTANCE OF SCHOOL-BASED MENTAL HEALTH SUPPORTS

Access to school-based mental health services and supports directly improves students' physical and psychological safety, academic performance, cognitive performance and learning, and social-emotional development. School employed mental health professionals (school counselors, school psychologists, school social workers, and in some cases, school nurses) ensure that services are high quality, effective, and appropriate to the school context. School employed mental health professionals are specially trained in the interconnectivity among school law, school system functioning, learning, mental health, and family systems. This training ensures that mental health services are properly and effectively infused into the learning environment. These professionals can support both instructional leaders' and teachers' abilities to provide a safe school setting and the optimum conditions for teaching and learning.

Having these professionals as integrated members of the school staff empowers principals to more efficiently and effectively deploy resources, ensure coordination of services, evaluate their effectiveness, and adjust supports to meet the dynamic needs of their student populations. Improving access also allows for enhanced collaboration with community providers to meet the more intense or clinical needs of students.⁴

RISK FACTORS AND PROTECTIVE FACTORS

Risk Factors for Suicide are characteristics or conditions that increase the chance that a person may try to take her or his life. Suicide risk tends to be highest when someone has several risk factors at the same time.

The most frequently cited risk factors for suicide are:

- Major depression (feeling down in a way that impacts your daily life) or bipolar disorder (severe mood swings)
- Problems with alcohol or drugs
- Unusual thoughts and behavior or confusion about reality
- Personality traits that create a pattern of intense, unstable relationships or trouble with the law
- Impulsivity and aggression, especially along with a mental disorder
- Previous suicide attempt or family history of a suicide attempt or mental disorder
- Serious medical condition and/or pain

It is important to bear in mind that the large majority of people with mental disorders or other suicide risk factors do not engage in suicidal behavior.

Protective Factors for Suicide are characteristics or conditions that may help to decrease a person's suicide risk. While these factors do not eliminate the possibility of suicide, especially in someone with risk factors, they may help to reduce that risk. Protective factors for suicide have not been studied as thoroughly as risk factors, so less is known about them.

Protective factors for suicide include:

- Receiving effective mental health care
- Positive connections to family, peers, community, and social institutions such as marriage and religion that foster resilience
- The skills and ability to solve problems

Note that protective factors do not entirely remove risk, especially when there is a personal or family history of depression or other mental disorders.

It is important for school districts to be aware of student populations that are at elevated risk for suicidal behavior based on various factors:

1. Youth living with mental and/or substance use disorders. While the large majority of people with mental disorders do not engage in suicidal behavior, people with mental disorders account for more than 90 percent of deaths by suicide. Mental disorders, in particular depression or bi-polar (manic-depressive) disorder, alcohol or substance abuse, schizophrenia and other psychotic disorders, borderline personality disorder, conduct disorders, and anxiety disorders are

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important risk factors for suicidal behavior among young people.⁵ The majority of people suffering from these mental disorders are not engaged in treatment, therefore school staff may play a pivotal role in recognizing and referring the student to treatment that may reduce risk.

2. Youth who engage in self-harm or have attempted suicide. Suicide risk among those who engage in self-harm is significantly higher than the general population. Whether or not they report suicidal intent, people who engage in self-harm are at elevated risk for dying by suicide within 10 years. Additionally, a previous suicide attempt is a known predictor of suicide death. Many adolescents who have attempted suicide do not receive necessary follow up care.

3. Youth in out-of-home settings. Youth involved in the juvenile justice or child welfare systems have a high prevalence of many risk factors for suicide. Young people involved in the juvenile justice system die by suicide at a rate about four times greater than the rate among youth in the general population. Though comprehensive suicide data on youth in foster care does not exist, one researcher found that youth in foster care were more than twice as likely to have considered suicide and almost four times more likely to have attempted suicide than their peers not in foster care.⁶

4. Youth experiencing homelessness. For youth experiencing homelessness, rates of suicide attempts are higher than those of the adolescent population in general. These young people also have higher rates of mood disorders, conduct disorders, and post-traumatic stress disorder. One study found that more than half of runaway and homeless youth have had some kind of suicidal ideation.⁷

5. American Indian/Alaska Native (AI/AN) youth. In 2009, the rate of suicide among AI/AN youth ages 15-19 was more than twice that of the general youth population.⁸ Risk factors that can affect this group include substance use, discrimination, lack of access to mental health care, and historical trauma. For more information about historical trauma and how it can affect AI/AN youth, see http://www.nctsn.org/nctsn_assets/pdfs/AI_Youth-CurrentandHistoricalTrauma.pdf.

6. LGBTQ (lesbian, gay, bisexual, transgender, or questioning) youth. The CDC finds that LGB youth are four times more likely, and questioning youth are three times more likely, to attempt suicide as their straight peers.⁹ The American Association of Suicidology reports that nearly half of young transgender people have seriously considered taking their lives and one quarter report having made a suicide attempt.¹⁰ Suicidal behavior among LGBTQ youth can be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. For those youth with baseline risk for suicide (especially those with a mental

disorder), these experiences can place them at increased risk. It is these societal factors, in concert with other individual factors such as mental health history, and not the fact of being LGBTQ which elevate the risk of suicidal behavior for LGBTQ youth.

7. Youth bereaved by suicide. Studies show that those who have experienced suicide loss, through the death of a friend or loved one, are at increased risk for suicide themselves.¹¹

8. Youth living with medical conditions and disabilities. A number of physical conditions are associated with an elevated risk for suicidal behavior. Some of these conditions include chronic pain, loss of mobility, disfigurement, cognitive styles that make problem-solving a challenge, and other chronic limitations. Adolescents with asthma are more likely to report suicidal ideation and behavior than those without asthma. Additionally, studies show that suicide rates are significantly higher among people with certain types of disabilities, such as those with multiple sclerosis or spinal cord injuries.¹²

PREVENTION

1. District Policy Implementation A district level suicide prevention coordinator shall be designated by the Superintendent. This may be an existing staff person. The district suicide prevention coordinator will be responsible for planning and coordinating implementation of this policy for the school district.

Each school principal shall designate a school suicide prevention coordinator to act as a point of contact in each school for issues relating to suicide prevention and policy implementation. This may be an existing staff person. All staff members shall report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator.

2. Staff Professional Development All staff will receive annual professional development on risk factors, warning signs, protective factors, response procedures, referrals, postvention, and resources regarding youth suicide prevention.

The professional development will include additional information regarding groups of students at elevated risk for suicide, including those living with mental and/or substance use disorders, those who engage in self-harm or have attempted suicide, those in out-of-home settings, those experiencing homelessness, American Indian/Alaska Native students, LGBTQ (lesbian, gay, bisexual, transgender, and questioning) students, students bereaved by suicide, and those with medical conditions or certain types of disabilities.

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BEST PRACTICE: SUICIDE PREVENTION TASK FORCE

It is recommended that school districts establish a suicide prevention task force in conjunction with adopting a suicide prevention policy. Such a task force should consist of administrators, parents, teachers, school employed mental health professionals, representatives from community suicide prevention services, and other individuals with expertise in youth mental health, and be administered by the district suicide prevention coordinator. The purpose of such a task force is to provide advice to the district administration and school board regarding suicide prevention activities and policy implementation. In addition, the task force can help to compile a list of community resources to assist with suicide prevention activities and referrals to community mental health providers. Some school districts may choose to limit the activities of the task force to one or two years, as needed. Once the task force has expired, the district suicide prevention coordinator can assume the role of maintaining the list of community suicide prevention resources. Other school districts may choose to continuously maintain a core task force to maintain current standards and information and to educate new staff.

REFERRALS AND LGBTQ YOUNG PEOPLE

LGBTQ youth are at heightened risk for suicidal behavior, which may be related to experiences of discrimination, family rejection, harassment, bullying, violence, and victimization. It is therefore especially important that school staff be trained to support at risk LGBTQ youth with sensitivity and cultural competency. School staff should not make assumptions about a student's sexual orientation or gender identity and affirm students who do decide to disclose this information. Information about a student's sexual orientation or gender identity should be treated as confidential and not disclosed to parents, guardians, or third parties without the student's permission. Additionally, when referring students to out-of-school resources, it is important to connect LGBTQ students with LGBTQ-affirming local health and mental health service providers. Affirming service providers are those which adhere to best practices guidelines regarding working with LGBTQ clients as specified by their professional association (e.g., <http://www.apa.org/pi/lgbt/resources/guidelines.aspx>).

Additional professional development in risk assessment and crisis intervention will be provided to school employed mental health professionals and school nurses.

3. Youth Suicide Prevention Programming

Developmentally-appropriate, student-centered education materials will be integrated into the curriculum of all K-12 health classes. The content of these age-appropriate materials will include: 1) the importance of safe and healthy choices and coping strategies, 2) how to recognize risk factors and warning signs of mental disorders and suicide in oneself and others, 3) help-seeking strategies for oneself or others, including how to engage school resources and refer friends for help.

In addition, schools may provide supplemental small-group suicide prevention programming for students.

4. **Publication and Distribution** This policy will be distributed annually and included in all student and teacher handbooks and on the school website.

ASSESSMENT AND REFERRAL

When a student is identified by a staff person as potentially suicidal, i.e., verbalizes about suicide, presents overt risk factors such as agitation or intoxication, the act of self-harm occurs, or a student self-refers, the student will be seen by a school employed mental health professional within the same school day to assess risk and facilitate referral. If there is no mental health professional available, a school nurse or administrator will fill this role until a mental health professional can be brought in.

For youth at risk:

1. School staff will continuously supervise the student to ensure their safety.
2. The principal and school suicide prevention coordinator will be made aware of the situation as soon as reasonably possible.
3. The school employed mental health professional or principal will contact the student's parent or guardian, as described in the Parental Notification and Involvement section, and will assist the family with urgent referral. When appropriate, this may include calling emergency services or bringing the student to the local Emergency Department, but in most cases will involve setting up an outpatient mental health or primary care appointment and communicating the reason for referral to the healthcare provider.
4. Staff will ask the student's parent or guardian for written permission to discuss the student's health with outside care, if appropriate.

IN-SCHOOL SUICIDE ATTEMPTS

In the case of an in-school suicide attempt, the health and safety of the student is paramount. In these situations:

1. First aid will be rendered until professional medical treatment and/or transportation can be received, following district emergency medical procedures.
2. School staff will supervise the student to ensure their safety.
3. Staff will move all other students out of the immediate area as soon as possible.
4. If appropriate, staff will immediately request a mental health assessment for the youth.
5. The school employed mental health professional or principal will contact the student's parent or guardian, as described in the Parental Notification and Involvement section.
6. Staff will immediately notify the principal or school suicide prevention coordinator regarding in-school suicide attempts.
7. The school will engage as necessary the crisis team to assess whether additional steps should be taken to ensure student safety and well-being.

RE-ENTRY PROCEDURE

For students returning to school after a mental health crisis (e.g., suicide attempt or psychiatric hospitalization), a school employed mental health professional, the principal, or designee will meet with the student's parent or guardian, and if appropriate, meet with the student to discuss re-entry and appropriate next steps to ensure the student's readiness for return to school.

1. A school employed mental health professional or other designee will be identified to coordinate with the student, their parent or guardian, and any outside mental health care providers.
2. The parent or guardian will provide documentation from a mental health care provider that the student has undergone examination and that they are no longer a danger to themselves or others.
3. The designated staff person will periodically check in with student to help the student readjust to the school community and address any ongoing concerns.

BULLYING AND SUICIDE

The relationship between bullying and suicide is highly complex, as is the relationship between suicide and other negative life events. Research indicates that persistent bullying can lead to or worsen feelings of isolation, rejection, exclusion and despair, as well as to depression and anxiety, which can contribute to suicidal behavior in those at risk.¹³ Research also suggests that young people who are already at heightened risk for suicide (see page 3, Risk Factors and Protective Factors) are also at increased risk for involvement in bullying.

It is important to remember that most students who are involved in bullying do not become suicidal. While studies have shown that young people who are bullied and those who bully others are at heightened risk for suicidal behavior, youth who exhibit both pre-existing risk for suicide (namely the existence of depression, anxiety, substance use or other mental disorders) and who are concurrently involved in bullying or experiencing other negative life events are at highest risk. Individuals who are bullied in the absence of other risk factors have far fewer negative outcomes than those with pre-existing risk for suicide. Youth who bully are also at risk and their behavior may reflect underlying mental health problems.

It is imperative to convey safe and accurate messages about bullying and suicide to youth, especially to those young people who may be at risk for completing suicide. Suggesting that suicide is a natural response to bullying, or providing repeated opportunities for at-risk students to see their own experiences of bullying, isolation, or exclusion reflected in stories of those who have died by suicide, can increase contagion risk by contributing to thoughts that frame suicide as a viable solution. Idealizing young people who complete suicide after being bullied, or creating an aura of celebrity around them, may contribute to an at-risk youth's illogical thoughts that suicide is the only way to have a voice or to make a difference for others.

Whenever possible, discussions on bullying and suicide should center on prevention (not statistics) and encourage help-seeking behavior.

RELEVANT STATE LAWS

There are numerous types of state laws, both positive and negative, that can affect risk factors for suicidal behavior among youth. A number of states limit the ability for young people to receive access to necessary mental health care. These laws can either limit access based on age, by requiring youth under 18 to receive parental permission before seeking mental health care, or by limiting mental health confidentiality – which can be an especially damaging problem for LGBTQ youth. Conversely, mandated suicide prevention training for school personnel can have a positive effect by ensuring that all school staff members have an understanding of suicide risk and the referral process. While currently less than half of all states require school personnel to receive suicide prevention training, the majority of the laws that are in existence were adopted during the 2012 and 2013 legislative sessions, suggesting a trend toward more state legislatures considering and adopting these laws moving forward.

Anti-bullying and nondiscrimination laws can also affect risk factors for suicidal behavior. While the majority of states have adopted some form of anti-bullying and harassment legislation, not all states specifically prohibit bullying and harassment on the basis of sexual orientation and gender identity. In addition, laws that stigmatize or isolate LGBTQ youth, often called “no promo homo” laws, can affect school climate in damaging ways. These laws prohibit educators from discussing LGBTQ people or issues in school or require these issues to be discussed in negative and stigmatizing ways. Research has shown that in states with these laws, LGBTQ students are more likely to hear homophobic remarks from school staff, less likely to report having supportive educators, and less likely to report that intervention by educators to prevent bullying and harassment is effective.¹⁴

OUT-OF-SCHOOL SUICIDE ATTEMPTS

If a staff member becomes aware of a suicide attempt by a student that is in progress in an out-of-school location, the staff member will:

1. Call the police and/or emergency medical services, such as 911.
2. Inform the student’s parent or guardian.
3. Inform the school suicide prevention coordinator and principal.

If the student contacts the staff member and expresses suicidal ideation, the staff member should maintain contact with the student (either in person, online, or on the phone). The staff member should then enlist the assistance of another person to contact the police while maintaining verbal engagement with the student.

PARENTAL NOTIFICATION AND INVOLVEMENT

In situations where a student is assessed at risk for suicide or has made a suicide attempt, the student’s parent or guardian will be informed as soon as practicable by the principal, designee, or mental health professional. If the student has exhibited any kind of suicidal behavior, the parent or guardian should be counseled on “means restriction,” limiting the child’s access to mechanisms for carrying out a suicide attempt. Staff will also seek parental permission to communicate with outside mental health care providers regarding their child.

Through discussion with the student, the principal or school employed mental health professional will assess whether there is further risk of harm due to parent or guardian notification. If the principal, designee, or mental health professional believes, in their professional capacity, that contacting the parent or guardian would endanger the health or well-being of the student, they may delay such contact as appropriate. If contact is delayed, the reasons for the delay should be documented.

POSTVENTION

1. Development and Implementation of an Action Plan

The crisis team will develop an action plan to guide school response following a death by suicide. A meeting of the crisis team to implement the action plan should take place immediately following news of the suicide death. The action plan may include the following steps:

- a) **Verify the death.** Staff will confirm the death and determine the cause of death through communication with a coroner's office, local hospital, the student's parent or guardian, or police department. Even when a case is perceived as being an obvious instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed as suicide but the parent or guardian will not permit the cause of death to be disclosed, the school will not share the cause of death but will use the opportunity to discuss suicide prevention with students.
- b) **Assess the situation.** The crisis team will meet to prepare the postvention response, to consider how severely the death is likely to affect other students, and to determine which students are most likely to be affected. The crisis team will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the need for or scale of postvention activities may be reduced.
- c) **Share information.** Before the death is officially classified as a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/guardians with an acknowledgement that its cause is unknown. Inform the faculty that a sudden death has occurred, preferably in a staff meeting. Write a statement for staff members to share with students. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news will cause, and information about the resources available to help students cope with their grief. Public address system announcements and school-wide assemblies should be avoided. The crisis team may prepare a letter (with the input and permission from the student's parent or guardian) to send home with students that includes facts about the death, information about what the school is doing to

DISTRICT LIABILITY

Schools have been sued and found liable for failing to take proper action, particularly for failing to notify parents/guardians, when a student was thought to be suicidal. The key issues in court cases have been foreseeability and negligence and have included cases in which schools did not warn parents/guardians about both verbal and written statements about suicide as well as cases in which the school failed to provide supervision and counseling for suicidal students.

Schools have also been sued over more complex issues, such as school climate and failure to reduce bullying, that were claimed to contribute to the suicide of a student. As the U.S. Department of Education Office for Civil Rights has emphasized, schools have legal obligations under anti-discrimination laws. Once a school knows or reasonably should know of possible student harassment, it must take immediate action to investigate, take steps to end the harassment, eliminate a hostile environment, and prevent its recurrence. These duties are a school's responsibility even if the misconduct also is covered by an anti-bullying policy and regardless of whether the student makes a complaint. For more information, including example cases, see: <http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201010.pdf>.

support students, the warning signs of suicidal behavior, and a list of resources available.

- d) **Avoid suicide contagion.** It should be explained in the staff meeting described above that one purpose of trying to identify and give services to other high risk students is to prevent another death. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death. In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern.
- e) **Initiate support services.** Students identified as being more likely to be affected by the death will be assessed by a school employed mental health professional to determine the level of support needed. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer to community mental healthcare providers to ensure a smooth transition from the crisis

MESSAGING AND SUICIDE CONTAGION

Research has shown a link between certain kinds of suicide-related media coverage and increases in suicide deaths. Suicide contagion has been observed when:

- the number of stories about individual suicides increases,
- a particular death is reported in great detail,
- the coverage of a suicide death is prominently featured in a media outlet, or
- when the headlines about specific deaths are framed dramatically (e.g., “Bullied Gay Teen Commits Suicide By Jumping From Bridge”).

Research also shows that suicide contagion can be avoided when the media report on suicide responsibly, such as by following the steps outlined in “Recommendations for Reporting on Suicide” at www.reportingonsuicide.org.

Contagion can also play a role in cases of self-harm behavior. These behaviors may originate with one student and can spread to other students through imitation. Because adolescents are especially vulnerable to the risk of contagion, in the case of a suicide death, it is important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

However, schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student’s family and friends. Refer to the American Foundation for Suicide Prevention’s “After a Suicide” resource listed in the Resources section for sample notification statements for students and parents/guardians, sample media statements, and other model language.

Finally, after a death by suicide it is important for schools to encourage parents/guardians to monitor their child’s social networking pages. Students often turn to social networking websites as an outlet for communicating information and for expressing their thoughts and feelings about the death. Parents/guardians should be advised to monitor the websites for warning signs of suicidal behavior.

intervention phase to meeting underlying or ongoing mental health needs.

f) **Develop memorial plans.** The school should not create on-campus physical memorials (e.g. photos, flowers), funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. School should not be canceled for the funeral. Any school-based memorials (e.g., small gatherings) will include a focus on how to prevent future suicides and prevention resources available.

2. **External Communication** The school principal or designee will be the sole media spokesperson. Staff will refer all inquiries from the media directly to the spokesperson. The spokesperson will:

- a) Keep the district suicide prevention coordinator and superintendent informed of school actions relating to the death.
- b) Prepare a statement for the media including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information.
- c) Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters not to make it a front-page story, not to use pictures of the suicide victim, not to use the word suicide in the caption of the story, not to describe the method of suicide, and not to use the phrase “suicide epidemic” – as this may elevate the risk of suicide contagion. They should also be encouraged not to link bullying to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available.

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RESOURCES

GUIDEBOOKS AND TOOLKITS

“Preventing Suicide: A Toolkit for High Schools” – U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services
<http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>

“After a Suicide: A Toolkit for Schools” – American Foundation for Suicide Prevention and Suicide Prevention Resource Center www.afsp.org/schools

“Guidelines for School-Based Suicide Prevention Programs” – American Association of Suicidology
http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf

“Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel” – Maine Youth Suicide Prevention Program
<http://www.maine.gov/suicide/docs/Guideline.pdf>

“Trevor Resource Kit” – The Trevor Project
thetrevorproject.org/resourcekit

“Supportive Families, Healthy Children: Helping Families with Lesbian, Gay, Bisexual & Transgender (LGBT) Children” – Family Acceptance Project
<http://familyproject.sfsu.edu/publications>

National Center for School Crisis and Bereavement
<http://www.stchristophershospital.com/pediatric-specialties-programs/specialties/690>

Adolescent and School Health Resources – Centers for Disease Control and Prevention, contains an assortment of resources and tools relating to coordinated school health, school connectedness, and health and academics
<http://www.cdc.gov/healthyyouth/schoolhealth/index.htm>

SCHOOL PROGRAMS

“Signs of Suicide Prevention Program (SOS) – Screening for Mental Health, Inc.”
<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

“American Indian Life Skills Development/Zuni Life Skills Development” – University of Washington
<http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=81>

“Lifeguard Workshop Program” – The Trevor Project
thetrevorproject.org/adulteducation

“More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel” – American Foundation for Suicide Prevention <http://morethansad.org>

CRISIS SERVICES FOR STUDENTS

National Suicide Prevention Lifeline: The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis or their friends and loved ones. Call 1.800.273.8255 (TALK). Callers are routed to the closest possible crisis center in their area.
<http://www.suicidepreventionlifeline.org>

The Trevor Lifeline: The only nationwide, around-the-clock crisis intervention and suicide prevention lifeline for lesbian, gay, bisexual, transgender, and questioning young people, 13-24, available at 1.866.488.7386.

TrevorChat: A free, confidential, secure instant messaging service that provides live help to lesbian, gay, bisexual, transgender, and questioning young people, 13-24, through <http://www.TheTrevorProject.org>

RELEVANT RESEARCH

“Youth Risk Behavior Surveillance System” – Centers for Disease Control and Prevention. Monitors health-risk behaviors among youth, including a national school-based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments.
<http://www.cdc.gov/healthyyouth/yrbs/index.htm>

2012 National Strategy for Suicide Prevention: A report by the U.S. Surgeon General and the National Alliance for Suicide Prevention outlining a national strategy to guide suicide prevention actions. Includes up-to-date research on suicide prevention.
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

WORKING WITH THE MEDIA

“Talking About Suicide & LGBT Populations” – Gay & Lesbian Alliance Against Defamation, Movement Advancement Project, American Foundation for Suicide Prevention, The Trevor Project, et al.
<http://www.afsp.org/understanding-suicide/for-the-media/reporting-on-suicide/talking-about-lgbt-suicide>

“Recommendations for Reporting on Suicide” – American Foundation for Suicide Prevention, et al.
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SAMPLE LANGUAGE FOR STUDENT HANDBOOK

Protecting the health and well-being of all students is of utmost importance to the school district. The school board has adopted a suicide prevention policy which will help to protect all students through the following steps:

- Students will learn about recognizing and responding to warning signs of suicide in friends, using coping skills, using support systems, and seeking help for themselves and friends. This will occur in all health classes.
- Each school will designate a suicide prevention coordinator to serve as a point of contact for students in crisis and to refer students to appropriate resources.
- When a student is identified as being at risk, they will be assessed by a school employed mental health professional who will work with the student and help connect them to appropriate local resources.
- Students will have access to national resources which they can contact for additional support, such as:
 - The National Suicide Prevention Lifeline – 1.800.273.8255 (TALK), www.suicidepreventionlifeline.org
 - The Trevor Lifeline – 1.866.488.7386, www.thetrevorproject.org
- All students will be expected to help create a school culture of respect and support in which students feel comfortable seeking help for themselves or friends. Students are encouraged to tell any staff member if they, or a friend, are feeling suicidal or in need of help.
- Students should also know that because of the life or death nature of these matters, confidentiality or privacy concerns are secondary to seeking help for students in crisis.
- For a more detailed review of policy changes, please see the district's full suicide prevention policy.



naspweb.org



schoolcounselor.org



AMERICAN FOUNDATION FOR
Suicide Prevention

afsp.org

Guidelines for schools responding to a death by suicide

These guidelines are designed to help school administrators, teachers, and crisis team members respond to the needs of students and staff after a suicide has impacted the school environment, as well as when an individual student's life may be impacted by a suicide within the family. Ideas are offered for addressing the issue of suicide, including how to talk to children about this difficult topic.

Death by suicide is one of the top two causes of death for children 10-24 years of age; for every child that dies by suicide, several hundred have attempted suicide. Approximately 3% of high school students makes a serious attempt that requires medical treatment. More than one of every six high school students has seriously considered suicide and approximately one of every seven has made a plan. Suicide is believed to be widely underreported because many are classified as unintentional or accidental. Death by suicide of school personnel or family members may also touch the lives of children.

ACTIVATE THE SCHOOL CRISIS TEAM

As with any death or other crisis event, the school crisis team should be activated after a suicide has occurred.

1. Accurate information is important. Verify the information (e.g., from family members and/or local authorities).
2. Find out what the family would like shared and what has already been reported by the media and/or authorities.
3. Once the death has been verified, notify school personnel, students, and parents.
4. Determine if additional supports (e.g., grief counselors, community mental health providers) may be needed.

NOTIFICATION

1. Notify the School Crisis Team and develop a plan.

If initial notification occurs outside of school hours, this may require initiating the phone tree, email, or other means to notify the school staff and to have them meet before school to organize a unified plan and to brief school staff.

2. Involve the Public Information Office (PIO) for the school district as early in the process as possible.

It is important that a death by suicide not be sensationalized. If the media is involved, the PIO for the school should discuss coverage of the story with the media. Media coverage should acknowledge the loss, but not sensationalize it (e.g., avoid front page coverage or details about the means of suicide) or risk making suicide appear appealing to depressed or disenfranchised students. The focus of the message should be the importance of talking to someone when upset. Stress prevention and provide information about school- and/or community- sponsored programs for suicide prevention. Note that suicide is usually the result of underlying mental health problems (for which there are sometimes, but not always, observable signs) such that the individual is not thinking clearly and cannot effectively consider other solutions.

3. Notify teachers and staff prior to students when possible.

A meeting before school with teachers and other school personnel to discuss what is known about the death by suicide is one way to ensure everyone hears the same message and to quell rumors. It also allows teachers and other school personnel to ask questions and voice concerns before they face students. Openly discussing the death by suicide sends the message that it is "ok" to talk about the topic. For example, when addressing school personnel, the leader of the crisis team may say, "there has been a death by suicide of one of our students, John Smith." Then insert facts as they are known, but omit graphic details. It is important to directly address the death with students; if a teacher does not feel able to talk to his/her students about the death by suicide, a member of the crisis team should be available to assist with the notification.

(Continued on next page)

4. A staff member who is familiar with the students should share a prepared statement in person.

This should be done in small, naturally occurring groups such as homeroom or first period classes. Avoid the use of public address systems or large assemblies to make such announcements. Every effort should be made to ensure that all students are present at the time this information is shared so all students receive the same information simultaneously. Include information about the availability of mental health and support services and how students may access these services. If some students do not begin the day until second period, consider having these students meet with a familiar staff member in small groups upon their arrival to be informed and offered support.

5. Prepare a statement for parents.

Draft a letter to parents to notify them about the death by suicide and what services are being offered to students and families. Consider posting this on a parent section of the school website. Assure parents that crisis teams have been mobilized and support services are available. Provide information about plans for a meeting for parents to ask questions about what to expect and how to best support their children after a loss.

Template letters that schools can have in advance of a crisis, such as a death by suicide, for staff and parents so that notification statements can be quickly and easily prepared are available at schoolcrisiscenter.org/resources/samples-templates. A sample message for notification of students is also available.

EXPLAINING MENTAL HEALTH PROBLEMS AND SUICIDE

In the aftermath of a death by suicide, helping students understand the connection between mental health problems and suicidal actions is helpful. This is particularly true for young students who may not fully understand the cause of death. For example:

“Everyone feels sad sometimes. However, some people have a mental illness called depression. Most people never feel this sad. When people are depressed, they stop feeling happy about anything at all. They do not make good choices or good decisions. They feel so sad that they think the only way to stop feeling sad is to die; they cannot think of any other way to stop feeling so sad or depressed. They may not even ask for help to come up with another idea to stop feeling sad. When someone we love dies by suicide, we have many different feelings, including feeling very sad. Feeling sad after a death, though, does not mean that you are depressed. It is important to talk to someone about how you are feeling so that you can have some help to feel better and to answer any questions or worries that you may have about what happened.”

With older children and adolescents, talking to them about the connection between depression, substance abuse, and other mental health problems and suicide is important. Stress the fact that when depressed, people are not thinking clearly and cannot make good decisions. They may not identify any alternatives for helping themselves feel better other than death. Death by suicide is an act that is not logical, but one that often comes out of depression, substance abuse, or other mental illness, so others, especially friends and loved ones, may never be able to fully understand why it happened. Again, it is critical to stress the importance of always sharing suicidal thoughts or concerns, whether your own or those shared by others, with a trusted adult.

When informing students, it is important to use the phrase “death by suicide” to underscore that you are willing to discuss this difficult topic. It is preferable to avoid “committed suicide” (which may imply a criminal act). Included in the message should be the importance of sharing any concern for the safety of others with a trusted adult – no secrets about suicidal thoughts or intentions should be kept now or in the future.

TALKING ABOUT THE SUICIDE

When discussing death by suicide, listening is far more important than talking. Emotions can be intense and the listener should be compassionate, validating more than trying to solve the grief. Often children and adults raise the question of “why?” as well as “what could I have done to prevent the death?” There are no easy answers to these questions. In many cases, these questions are rhetorical and intended to voice feelings of helplessness or personal regrets. As these questions are raised, it is important to underscore the relationship between suicide and mental illness and/or substance abuse.

HOW TO ADDRESS SUICIDE WHEN CAUSE IS AN ISSUE

Suicide carries a stigma in society and leaves survivors often with strong feelings of guilt, regret and anger. It is, therefore, not uncommon that family members will ask that the school not disclose suicide as a likely cause of death, especially when the cause of death has not been confirmed by the medical examiner. This may be the case even when the circumstances (e.g., nature of death or presence of a note indicating it was a death by suicide) make it highly likely that the death was a result of suicide.

It is generally best to respect the family’s wishes, while still addressing the topic as it is raised by students. For example: “We are all saddened by John’s death. It is still under investigation [or the family does not agree with the media reports and feels it was an accident]. However, many of you have raised the question of death by suicide and/or death by suicide has been discussed in the news, so let’s talk about suicide in general as it is an important topic.” In this way, the parents’ wishes can be respected, while attending to the students’ comments and addressing the topic.

Suicide, as difficult a topic as it may be, presents a “teachable moment.” It is a time to outline plans for handling suicidal ideations.

Any discussion of suicide should include:

- *Talk to someone.*

If there is suicidal ideation or concern of such for others, it is important that this information be shared with a trusted adult. These thoughts and concerns should **never** be kept secret.

- *Identification of outside suicide resources*

These include websites for information as well as hotline numbers. The hotlines are staffed 24/7 and are available for adults and children. Following a suicide that impacts a school community (or ideally before a death by suicide occurs), resource information about such crisis hotlines and suicide prevention programs should be made available where students and staff gather (e.g., counselors’ office, main office, teachers’ lounge, or library); they can also be listed in school newsletters.

Make sure children appreciate that this advice is intended to help prevent future suicides, not to make people feel guilty if they were aware of depressive or suicidal thoughts or statements of someone who already died by suicide. Encourage students or staff who have guilt feelings to share them with a close family member or other trusted adult and provide access to school mental health providers where they can be shared and explored in private.

CRISIS AND GRIEF COUNSELING AND RELATED SUPPORT SERVICES AT SCHOOL

Availability of crisis, grief, and related support services after a death by suicide is important. They serve to support students and staff who are distressed. They can be an invaluable resource if students, staff, or parents are concerned about others contemplating suicide or if they, themselves, are considering such actions. Provide staff, students, and parents information about when and where the support is available. Outline procedures for students leaving class to access this support.

Remember that suicide is common – staff may have experienced losses due to suicide of family members or friends. Given the high incidence of suicidal attempts and ideation and depression, some staff may have struggled themselves with suicidal ideation or depression. Facilitating discussions with students about suicide after the death of a member of the school community in the context of these personal experiences can be particularly difficult. Let school personnel know how they may access support services, such as through the school's Employee Assistance Program or by talking with school mental health professionals, and provide them information about suicide hotlines and related resources. If a Staff Support Room is being used, address arrangements for teacher coverage such as by hiring one or two substitute teachers to provide rotating coverage so that teachers can access supportive services during the school day.

1. Help students learn coping behaviors to support and maintain their attendance and classroom learning.

Following a death by suicide, addressing the event with students directly may decrease the negative impact on school attendance and learning. This can be done individually and in group settings. The goal is to allow the expression of thoughts and feelings in a safe and non-judgmental environment and to provide ideas for positive coping with the loss. Acknowledging that loss was one of death by suicide gives students a message that you are available to help in the face of an uncomfortable topic of discussion.

2. Help students cope with difficult feelings.

After a death by suicide, students may have a myriad of feelings, including regret, guilt, and shame. These may be exacerbated if they were either close to the deceased or had mistreated the individual in the past. Feelings of guilt and shame may exist even if there is no logical reason. It is important to acknowledge that such feelings are common among survivors after a suicide.

3. Incorporate help from supportive school services.

School counselors, school nurses, school psychologists, and school social workers can help teachers identify risk factors

and signs of distress that may indicate the need for mental health services beyond what is offered at school. Parents may be concerned about the risk of suicide of their children. School-sponsored programs for parents outside of school hours which are led by school support services and/or bereavement specialists should be considered in the immediate aftermath of a death by suicide to allow for education and discussion of the topic, including suicide prevention.

INDIVIDUALS LIKELY TO BENEFIT FROM ADDITIONAL EMOTIONAL SUPPORT

After a death by suicide, there are groups of students who are more likely to benefit from additional emotional support.

These groups include:

- Close friends of the deceased
- Those who had a conflicted or strained relationship with the deceased (e.g., ex-girl/boyfriends or someone who bullied the deceased); the close friends of these individuals may also benefit from support.
- Individuals with a history of depression or similar problems
- Those who may have made a suicide attempt in the past
- Those who have experienced a death by suicide in their lives in the past
- If the deceased was a student:
 - Students who shared a class or extracurricular activity with the deceased
 - Teachers who had taught the student recently or in the past

It is important for school administrators to communicate with other school administrators in the area. Often siblings or close friends attend other schools or the student may have recently relocated to the present school. Furthermore, communication with other area schools can help to identify if there are similar deaths by suicide in the larger community.

PARTICIPATION OF STUDENTS IN FUNERALS AND MEMORIAL SERVICES

Students close to the deceased may wish to attend the funeral or memorial service. Talk to the family of the deceased to determine the plans and their wishes regarding student attendance. Ask if there is an option of visitation hours outside of school hours. A policy should be established for any death to allow students close to the deceased who wish to attend services to do so without consequences. Encourage parents to attend the service with their children. If a large group of students will be attending services, consider having counseling services available after school hours for those who may need additional support.

There is truly nothing anyone can say that will remove the grief, but talking about the death and listening to students as they share their feelings can be an important first step to healing.

MEMORIAL AND COMMEMORIAL EVENTS

After any death, there is a desire to find some meaningful way to remember the deceased. All deaths that impact the school community should be treated consistently. Therefore, it is important to have plans in place to address memorials and commemorative events that can be applied to deaths by suicide.

In the aftermath of a death by suicide, the anxiety about the cause of death may overshadow the loss from the death. No matter how the death occurred, the sense of loss is present. Invite sharing of positive memories of the deceased.

With a death by suicide, avoid sensationalizing the cause of death or taking actions that make suicide seem like an appealing act to others who are depressed or feeling alienated by the school community to gain recognition (e.g., special assemblies). Permanent acts such as planting a tree or placing a plaque are not recommended. However, this does not mean that close friends and family of the deceased cannot acknowledge their loss. They should be actively involved in discussing ways to remember the deceased. After a suicide, they may consider doing something proactive such as participating in a suicide awareness walk or a suicide prevention campaign in the community or at school.

SPONTANEOUS MATERIALS

Spontaneous memorials often “spring up” after any death of a student. Have a timeline and plan for what to do with flowers, notes, and stuffed animals that may be left. For example, items may be picked up every few days for a maximum of 5 days or until after the funeral. Items will be donated to some place of the family’s choosing and/or given to the family. Any notes, cards, and letters should be read by school staff to ensure that these are appropriate to share with family. It is important that there are no unmonitored sites for posting comments (e.g., large pieces of banner paper left unattended for students to write messages) as negative comments about the death by suicide may be written or children who may be contemplating suicide may post a message to this effect. An unsupervised or anonymous expression makes it nearly impossible to follow-up with students who may benefit from timely intervention. Similar issues may arise with the use of websites or postings on social media sites as a means of commemorating the death of a student. Talk with students about postings and other forms of social media communication, encouraging them to talk to a trusted adult about any inappropriate comments or statements of self-harm. Talk to close friends about alternative ways to remember their friend. These may include participation in a suicide awareness fundraiser or walk, volunteering at a local helpline, supporting a local program or charity related to an interest of the deceased (e.g., animal shelter or arts program), or participating in a campaign to reduce the stigma of mental health problems.

HANDLING THE STUDENT’S BELONGINGS

School desks and lockers may serve as uncomfortable reminders of the deceased student. Consider procedures for handling these with input from classmates. Talk to family members to identify a time for returning all personal belongings to the family. Ideally, this can be done after school hours and all belongings can be collected and made available in the front office so that family members are not required to clean out desks, lockers, etc., especially during school hours when other students may be present. Have a member of the

school crisis team available for the family when they arrive as this will likely be an emotional time for them. Newsletters and other school communications can also serve as traumatic reminders of the death; be sure that the name of the deceased is removed from any mailing lists, listservs, or phone trees.

ONGOING MONITORING

It is important to continue to monitor those impacted by the death. Maintain a close eye on students at risk. There will be events that may trigger the return of intense emotions such as special school events (e.g., homecoming, parent day, graduation) or special dates (e.g., birthday, death anniversary). Let students, families, and school personnel know that supportive services will be available as needed, especially at these times.

RISK FACTORS AFTER A SUICIDE

After a death by suicide, there are signs that indicate risk for extreme emotional distress. These can be shared with school personnel, families, and students as part of psycho-education and awareness related to suicide prevention.

These include:

- Presence of a psychiatric disorder, particularly depression
- Thoughts or talk about suicide or dying, especially after an exposure to a death by suicide
- Changes in behavior (e.g., extreme acting out or withdrawal from friends, family, and activities)
- Impulsive and high-risk behaviors (e.g., reckless driving, increased alcohol or substance abuse)
- Talk of a foreshortened future (i.e., cannot see participation in future events or their place in the future)

There are additional factors which increase the risk of a death by suicide.

These include:

- Access to firearms
- Significant family instability
- Recent severe stressor (perceived by the individual) such as:
 - End of a romantic relationship
 - Economic distress
 - Increased bullying or alienation

School counselors, psychologists, social workers, and nurses can help with identifying children who would benefit from additional evaluation or treatment and serve as a resource for staff concerns. Should risk factors be present, a referral for mental health services may be indicated. Similarly, if reactions to the death (e.g., continued decline in school performance, difficulty meeting demands at school, impaired functioning at home and with friends) persist without significant improvement, additional services may be warranted. Response to a death by suicide should not only include the immediate response, but also long-term follow-up and support.

Setting the tone: Be proactive and encourage students to seek out support if they are having troubling thoughts or are concerned about friends or loved ones in the aftermath of a death by suicide.

Section 5

Bereavement Resources

Where to find help:

Solutions Community Counseling & Recovery Centers

- (513) 228-7800 (for all Warren and Clinton County locations)

Talbert House

- Franklin (937) 723-0883
- Lebanon (513) 932-4337
- Wilmington (937) 414-2016

Fernside – a Cincinnati-based non-profit established in 1986 and is the nation's second oldest children's grief center. Fernside provides all services free of charge:

<http://fernside.org/>

Companions on a Journey – Mended Hearts program for youth

<http://companionsonajourney.org/childrens-mending-hearts/>

Oaktree Corner: Center for Grieving Children

<https://www.oaktreecorner.org/>

The Coalition to Support Grieving Students

<https://grievingstudents.org/>

When a Friend Dies: Guidelines for Students

"When I got to school and heard the news, I thought they were kidding. It was too bizarre to believe. Then I realized they couldn't be so sick to make up a joke that Mike was gone. I believed it – sorta. But I got to tell you, even though I saw his body at the funeral and all, sometimes it still seems not real to me."

Zach, High School Junior

Having a friend die suddenly is pretty bad under any circumstances, but when the reason appears to be suicide, it can feel even worse. There is something about having a friend choose to die, especially if the circumstances were violent, that can be really hard to understand. Kids who have gone through this experience tell us that the shock of what happened can take a long time to wear off. They say the reality of what happened doesn't really stick for a long, long time.

What they also tell us is that they can be pretty confused about what happened. They feel a lot of stuff at the same time and it can be hard to sort out. They usually need to talk about what happened with their friends even more than they need to talk to the adults in their lives. Friends seem to understand better- they knew the kid who died, probably better than most of the adults did. But they also tell us that adults can be helpful, especially the ones they trust, the people in their lives who know how to listen to kids.

So how do you help yourselves and your friends at a time like this? We took some of the suggestions we got from kids, added them to what some of the experts in the field tell us, and we made this list that may make it just a little bit easier for you to get through the next few days:

- The first, last, and middle thing to remember is that you are not alone. Sometimes you can feel really lost, alone, and isolated in the tough feelings that often stun you when you learn someone has died. Despite feeling like no one else shares what you're experiencing, other kids- and believe it or not- other adults- often do. Take a minute to look around at the faces you see. Most of them will look as shocked as you. Realizing that you're not alone is the first step in being able to reach out for help
- One of the ways to help yourself is to talk about how you feel. It doesn't have to be one of those heart-to-heart conversations that gets real emotional way too quickly. It can be as simple as saying to another kid, "Wow- I'm blown away by this- what's going on with you?" Psychologists tell us that talking about feelings can be really helpful in making them a bit less intense. Sure, in a situation like this you're going to need to keep talking for a while, but you're got to start somewhere. And the sooner you do, the sooner your healing will begin.
- Reach out to the people who know you. Maybe they knew your friend, too, so they will really understand some of what you're feeling without you even having to say a word. But even if they didn't know your friend, they know you. They know how to listen and support you. Because what you're looking for now is not someone to tell you anything to make this better. The truth is, that would be impossible. Nothing can make it better right now. What you're looking for is someone who simply understands what this death means to you. That's a whole lot easier to come by.
- You will probably spend a lot of time trying to figure out what happened- why your friend did this. You may even think you know, and you'll probably hear a lot of gossip and rumors from other people who think they know, too. Try to remember that the truth behind every suicide is pretty complicated- there's always more than one reason a person chooses to take his life. And even if a lot of what you know and hear turns out to be true, all the facts that drive someone to make this desperate decision are like one of those equations in algebra with a mysterious "X." In the suicide equation, the only person who knows what that "X" really means is the person who died. We won't ever be able to totally figure out the real answer. Tough, but true.
- Kids tell us that when someone they know dies by suicide, they sometimes feel responsible, like there was something they should have done to prevent what happened. And feeling responsible can lead to feeling guilty; this crazy belief that you really are responsible for the death. It may be hard to accept the fact that the only person any of us is responsible for is ourselves. Your friend made a choice- a bad choice- probably not really understanding what the consequences would be. But his life wasn't yours to take away- it belonged to him.
- Let's say that maybe you were mean to the kid who died. Maybe you teased him or bullied him or ignored him. You can't take back what you did, but you can learn from it. It's a pretty intense lesson but it's incredibly important. You never want to do anything to another person that you'll regret. Period. End of sentence.

- You may hear other people saying mean things about your friend. Or maybe they'll joke about the fact that he died by suicide. These kinds of responses might get you really mad. It may help to remember that a lot of people are so uncomfortable when someone dies by suicide that they say stupid, untrue, and unkind things. People can be pretty ignorant about things they don't understand. Getting angry when you hear something like this is a natural reaction, but it isn't necessarily a helpful one. Staying calm and reasonable is a better way to try to get people to listen to the truth.
- Sometimes, when someone we know dies by suicide, we may find ourselves thinking about suicide, too. It's kinda like, "If he could do it, maybe I will too...". Again, normal reaction, but scary reaction. If you find yourself having these kind of thoughts, it is really important to talk with an adult you trust. Not another kid. An adult. You wouldn't go to a friend to fix a broken arm- you'd go to a doctor- someone wiser, with experience in fixing broken arms. Thoughts of suicide benefit from the wisdom and perspective of an adult, who can help you figure out what to do about them.
- You may want to do something to remember your friend, something to show that you cared about him and that he was important in your life. And you can probably come up with lots of cool ideas. The tricky thing with this is that there are going to be some kids in your school- maybe even kids who didn't know your friend very well- who may be pretty misguided by this kind of stuff. They'll see these memorials and think, "Hey, if I die, then at least the school will pay attention to me, remember me in a cool way." It may sound crazy but it is absolutely true and contributes to something called suicide imitation or contagion. Not cool. So this is another time when you want to turn to one of those trusted adults in the school and run your ideas for remembering your friend by them. There are safe things to do that don't feed into the contagion thing.
- Last thing to know- it does get better. Getting back close to normal takes as long as it takes. It's different for everybody, but it does happen. It never goes away, though, the memory of what happened. But it can change your life for the better. You can use your experience with suicide to become more sensitive and compassionate to the people around you who are in that dark place where death seems like a good option. You can learn about the resources that are available to help when life seems hopeless. You can learn where to go if you need help- or where to send a friend. The bottom line? Maybe someday you will save a life.

Section 6

Helpful Links for Educators and School Administrators *from the Suicide Prevention Coalition*

American Suicide Prevention Foundation

<https://afsp.org/our-work/education/>

Suicide Prevention Resources for Youth

Signs of Suicide – A program with two age-appropriate modules – middle school and high school age youth. The “Signs of Suicide” program can be conducted for small groups (like student clubs) or integrated into class curriculum. It can also be conducted school-wide.

https://mentalhealthscreening.org/programs/sos-signs-of-suicide?gclid=EAIaIQobChMI0dnHi4CB3QIVBrbACh398g7xEAAAYASAAEgLJsvD_BwE

Red Flags – A classroom education program on depression that is designed for middle school-age youth which can easily be integrated into health classes.

<https://www.redflags.org/>

Trevor Project – the nation’s leading organization providing crisis intervention and suicide prevention services to LGBTQ young people under 25 years old.

Trevorproject.org

Society for the Prevention of Teen Suicide – an organization with a mission to reduce the number of youth suicides and attempted suicides by encouraging public awareness through education.

sptsusa.org

Trauma and Suicide:

https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf

Peer-Assisted and Peer Mentor Programs

Hope Squads – A peer-to-peer school-based suicide prevention program that empowers students to help one another.

<https://hopesquad.com/>

Grant Us Hope – a local non-profit promoting Hope Squads in Southwest Ohio

<https://www.grantushope.org/>

Helpful Links for Educators and School Administrators *from the Suicide Prevention Coalition*

#chatsafe: A young person's guide for communicating safely online about suicide
<http://www.sprc.org/resources-programs/chatsafe-young-person%E2%80%99s-guide-communicating-safely-online-about-suicide>

Resource for school newspaper advisors:

Recommendations for Reporting on Suicide: <http://reportingonsuicide.org/wp-content/themes/ros2015/assets/images/Recommendations-eng.pdf>

Resources for After a Death by Suicide

Establishing crisis intervention after a suicide death
<http://www.sprc.org/resources-programs/after-suicide-toolkit-schools>

Guidelines for Schools Responding to a Death by Suicide - These guidelines are designed to help school administrators, teachers, and crisis team members respond to the needs of students and staff after a suicide has impacted the school environment as well as when an individual student's life may be impacted by a suicide within the family. PDF format.
<https://www.schoolcrisiscenter.org/resources/guide-responding-suicide/>

Social Media

#BeThere Campaign – from the National Alliance for Suicide Prevention, a Twitter-based campaign that aims to educate about the many ways to take action to support a person who is struggling or in crisis. You can also sign up to get updates:

<https://twitter.com/search?q=%23BeThere&src=typd>

****Compiled by the Suicide Prevention Coalition. Resources will be updated as often as needed. Please visit the MHRS website for updates.***

Section 7

RECOMMENDATIONS FOR REPORTING ON SUICIDE

Developed in collaboration with the American Association of Suicidology; American Foundation for Suicide Prevention; Annenberg Public Policy Center; Associated Press Managing Editors; Canterbury Suicide Project-University of Otago, Christchurch, New Zealand; Columbia University Department of Psychiatry; ConnectSafely.org; Emotion Technology; International Association for Suicide Prevention Task Force on Media and Suicide; Medical University of Vienna; National Alliance on Mental Illness; National Institute of Mental Health; National Press Photographers Association; New York State Psychiatric Institute; Substance Abuse and Mental Health Services Administration; Suicide Awareness Voices of Education; Suicide Prevention Resource Center; Centers for Disease Control and Prevention (CDC); and UCLA School of Public Health, Community Health Sciences.



IMPORTANT POINTS FOR COVERING SUICIDE

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration, and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

Suicide contagion or “copycat suicide” occurs when one or more suicides are reported in a way that contributes to another suicide.

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:



- Big or sensationalistic headlines or prominent placement (e.g., “Kurt Cobain Used Shotgun To Commit Suicide”).
- Including photos/videos of the location or method of death, grieving family, friends, memorials, or funerals.
- Describing recent suicides as an “epidemic,” “skyrocketing,” or in other strong terms.
- Describing a suicide as inexplicable or “without warning.”
- “John Doe left a suicide note saying....”
- Investigating and reporting on suicide similar to reporting on crimes.
- Quoting/interviewing police or first responders about the causes of suicide.
- Referring to suicide as “successful,” “unsuccessful,” or a “failed attempt.”

DO THIS:



- Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
- Use school/work or family photo; include hotline logo or local crisis phone numbers.
- Carefully investigate the most recent CDC data and use nonsensational words like “rise” or “higher.”
- Most, but not all, people who die by suicide exhibit warning signs. Include the “Warning Signs” and “What to Do” sidebar (from p. 2) in your article if possible.
- “A note from the deceased was found and is being reviewed by the medical examiner.”
- Report on suicide as a public health issue.
- Seek advice from suicide prevention experts.
- Describe as “died by suicide” or “completed” or “killed him/herself.”



AVOID MISINFORMATION AND OFFER HOPE

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90 percent of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce, or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates, and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information, and advice that promotes help-seeking.



SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS, AND CITIZEN JOURNALISTS

- Bloggers, citizen journalists, and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs, and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos, and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies, and procedures could support removal of inappropriate and/or insensitive posts.

MORE INFORMATION AND RESOURCES AT:

www.ReportingOnSuicide.org



WARNING SIGNS OF SUICIDE

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated, or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide, but may not be what causes a suicide.



WHAT TO DO

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone.
- Remove any firearms, alcohol, drugs, or sharp objects that could be used in a suicide attempt.
- Call the U.S. National Suicide Prevention Lifeline at 1-800-273-TALK (8255).
- Take the person to an emergency room or seek help from a medical or mental health professional.

THE NATIONAL SUICIDE PREVENTION LIFELINE 1-800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information, and local resources.



SMA-11-4640

Section 8

Suicide and Depression Screening Tools

Some professionals opt to utilize standardized screening tools for determining suicidal risk or level of depression rather than, or in addition to, a psychosocial interview. Some tools which may be utilized by schools for this purpose include:

Suicide Risk Questionnaire

Columbia Impairment Scale (CIS) – Youth Version

Pediatric Symptom Checklist (PSC)

Center for Epidemiologic Studies Depression Scale for Children (CES-DC)

Patient Health Questionnaire -9

Beck Depression Inventory II (available from Pearson Assessments at www.pearsonassessments.com)

Suicidal Ideation Questionnaire (SIQ) (available from PAR at www.parinc.com)

Patient Health Questionnaire -9

Date: _____ Student's Name _____

Comments: Only the student should enter information onto this questionnaire.

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing <u>things</u>	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling <u>or</u> staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or <u>have</u> let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

SCORING FOR USE BY PERSONNEL ONLY

0 ___ + _____ + _____ + _____
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all
☐

Somewhat
difficult
☐

Very
difficult
☐

Extremely
difficult
☐

Instructions – How to Score PHQ-9

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are checked as at least “More than half the days”
- Either #1 or #2 is positive, that is, at least “More than half the days”

Other Depressive Syndrome is suggested if:

- Of the 9 items, 2, 3, or 4 are checked as at least “More than half the days”
- Either item #1 or #2 is positive, that is, at least “More than half the days”

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0; several days=1; more than half the days=2; and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PHQ-9 Scores

Score Action

< 4 The score suggests the patient/student may not need depression treatment.

5 – 14 Clinician/Professional Staff uses clinical judgment about treatment, based on patient's/student's duration of symptoms and functional impairment.

15+ Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

Functional Question: Responses can be one of four -- Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that functionality is impaired. After treatment begins, functional status is again measured to gauge improvement.

(Source: Spitzer RL, Kroenke K, Williams JBW, Patient Health Questionnaire Primary Care Study Group, The. "Validation and utility of a self-report version of prime-md: the PHQ primary care study." JAMA 282:1737-44, 1999. (Class C)

Pediatric Symptom Checklist

Instructions for Use

Instructions for Scoring:

The Pediatric Symptom Checklist is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. Included here are two versions, the parent-completed version (PSC) and the youth self-report (Y-PSC). The Y-PSC can be administered to adolescents ages 11 and up. The PSC consists of 35 items that are rated as "Never," "Sometimes," or "Often" present and scored 0, 1, and 2, respectively. The total score is calculated by adding together the score for each of the 35 items. For children and adolescents ages 6 through 16, a cutoff score of 28 or higher indicates psychological impairment. For children ages 4 and 5, the PSC cutoff score is 24 or higher (Little et al., 1994; Pagano et al., 1996). The cutoff score for the Y-PSC is 30 or higher. Items that are left blank are simply ignored (i.e., score equals 0). If four or more items are left blank, the questionnaire is considered invalid.

How to Interpret the PSC or Y-PSC

A positive score on the PSC or Y-PSC suggests the need for further evaluation by a qualified health (e.g., M.D., R.N.) or mental health (e.g., Ph.D., L.I.C.S.W.) professional. Both false positives and false negatives occur, and only an experienced health professional should interpret a positive PSC or Y-PSC score as anything other than a suggestion that further evaluation may be helpful. Data from past studies using the PSC and Y-PSC indicate that two out of three children and adolescents who screen positive on the PSC or Y-PSC will be correctly identified as having moderate to serious impairment in psychosocial functioning. The one child or adolescent "incorrectly" identified usually has at least mild impairment, although a small percentage of children and adolescents turn out to have very little or no impairment (e.g., an adequately functioning child or adolescent of an overly anxious parent). Data on PSC and Y-PSC negative screens indicate 95 percent accuracy, which, although statistically adequate, still means that 1 out of 20 children and adolescents rated as functioning adequately may actually be impaired. The inevitability of both false-positive and false-negative screens underscores the importance of experienced clinical judgment in interpreting PSC scores. Therefore, it is especially important for parents or other laypeople who administer the form to consult with a licensed professional if their child receives a PSC or Y-PSC positive score.

For more information, visit the Web site:

https://www.massgeneral.org/psychiatry/services/psc_home.aspx .

References:

Jellinek MS, Murphy JM, Little M, et al. 1999. Use of the Pediatric Symptom Checklist (PSC) to screen for psychosocial problems in pediatric primary care: A national feasibility study. *Archives of Pediatric and Adolescent Medicine* 153(3):254-260.

Jellinek MS, Murphy JM, Robinson J, et al. 1988. Pediatric Symptom Checklist: Screening school-age children for psychosocial dysfunction. *Journal of Pediatrics* 112(2):201-209. Web site: https://www.massgeneral.org/psychiatry/services/psc_home.aspx .

Little M, Murphy JM, Jellinek MS, et al. 1994. Screening 4- and 5-year-old children for psychosocial dysfunction: A preliminary study with the Pediatric Symptom Checklist. *Journal of Developmental and Behavioral Pediatrics* 15:191-197.

Pagano M, Murphy JM, Pedersen M, et al. 1996. Screening for psychosocial problems in 4-5 year olds during routine EPSDT examinations: Validity and reliability in a Mexican-American sample. *Clinical Pediatrics* 35(3):139-146.

Pediatric Symptom Checklist (PSC)

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions. Please indicate which statement best describes your child.

Please mark under the heading that best describes your child:

	Never	Sometimes	Often
1. Complains of aches and pains	___	___	___
2. Spends more time alone	___	___	___
3. Tires easily, has little energy	___	___	___
4. Fidgety, unable to sit still	___	___	___
5. Has trouble with teacher	___	___	___
6. Less interested in school	___	___	___
7. Acts as if driven by a motor	___	___	___
8. Daydreams too much	___	___	___
9. Distracted easily	___	___	___
10. Is afraid of new situations	___	___	___
11. Feels sad, unhappy	___	___	___
12. Is irritable, angry	___	___	___
13. Feels hopeless	___	___	___
14. Has trouble concentrating	___	___	___
15. Less interested in friends	___	___	___
16. Fights with other children	___	___	___
17. Absent from school	___	___	___
18. School grades dropping	___	___	___
19. Is down on him or herself	___	___	___
20. Visits the doctor with doctor finding nothing wrong	___	___	___
21. Has trouble sleeping	___	___	___
22. Worries a lot	___	___	___
23. Wants to be with you more than before	___	___	___
24. Feels he or she is bad	___	___	___
25. Takes unnecessary risks	___	___	___
26. Gets hurt frequently	___	___	___
27. Seems to be having less fun	___	___	___
28. Acts younger than children his or her age	___	___	___
29. Does not listen to rules	___	___	___
30. Does not show feelings	___	___	___
31. Does not understand other people's feelings	___	___	___
32. Teases others	___	___	___
33. Blames others for his or her troubles	___	___	___
34. Takes things that do not belong to him or her	___	___	___
35. Refuses to share	___	___	___

Does your child have any emotional or behavioral problems for which she or he needs help? () N () Y
 Are there any services that you would like your child to receive for these problems? () N () Y

If yes, what services? _____

Total Score _____

Pediatric Symptom Checklist – Youth Report (Y-PSC)

Please mark under the heading that best fits you:

	Never	Sometimes	Often
1. Complain of aches and pains	—	—	—
2. Spend more time alone	—	—	—
3. Tire easily, little energy	—	—	—
4. Fidgety, unable to sit still	—	—	—
5. Have trouble with teacher	—	—	—
6. Less interested in school	—	—	—
7. Act as if driven by a motor	—	—	—
8. Daydream too much	—	—	—
9. Distract easily	—	—	—
10. Are afraid of new situations	—	—	—
11. Feel sad, unhappy	—	—	—
12. Are irritable, angry	—	—	—
13. Feel hopeless	—	—	—
14. Have trouble concentrating	—	—	—
15. Less interested in friends	—	—	—
16. Fight with other children	—	—	—
17. Absent from school	—	—	—
18. School grades dropping	—	—	—
19. Down on yourself	—	—	—
20. Visit the doctor with doctor finding nothing wrong	—	—	—
21. Have trouble sleeping	—	—	—
22. Worry a lot	—	—	—
23. Want to be with parent more than before	—	—	—
24. Feel that you are bad	—	—	—
25. Take unnecessary risks	—	—	—
26. Get hurt frequently	—	—	—
27. Seem to be having less fun	—	—	—
28. Act younger than children your age	—	—	—
29. Do not listen to rules	—	—	—
30. Do not show feelings	—	—	—
31. Do not understand other people's feelings	—	—	—
32. Tease others	—	—	—
33. Blame others for your troubles	—	—	—
34. Take things that do not belong to you	—	—	—
35. Refuse to share	—	—	—

Total Score _____

Suicide Risk Questionnaire

Part I: Suicide Risk Questionnaire

Have you heard someone say:

- ☐ Life isn't worth living
- ☐ My family would be better off without me
- ☐ Next time I'll take enough pills to do the job right
- ☐ Take my (prized collection, valuables) – I don't need this stuff anymore
- ☐ I won't be around to deal with that
- ☐ You'll be sorry when I'm gone
- ☐ I won't be in your way much longer
- ☐ I just can't deal with everything – life's too hard
- ☐ Nobody understands me – nobody feels the way I do
- ☐ There's nothing I can do to make it better
- ☐ I'd be better off dead
- ☐ I feel like there is no way out

Have you observed:

- ☐ Getting affairs in order (paying off debts, changing a will)
- ☐ Giving away articles of either personal or monetary value
- ☐ Signs of planning a suicide such as obtaining a weapon or writing a suicide note

Part II: Depression Risk Questionnaire

Have you noticed the following signs of depression:

- ☐ Depressed Mood
- ☐ Change in sleeping patterns (too much/little, disturbances)
- ☐ Change in weight or appetite
- ☐ Speaking and/or moving with unusual speed or slowness
- ☐ Loss of interest or pleasure in usual activities
- ☐ Withdrawal from family and friends
- ☐ Fatigue or loss of energy
- ☐ Diminished ability to think or concentrate, slowed thinking or indecisiveness
- ☐ Feelings of worthlessness, self-reproach, or guilt
- ☐ Thoughts of death, suicide, or wishes to be dead

If depression seems possible, have you also noticed:

- ☐ Extreme anxiety, agitation, irritability or risky behavior
 - ☐ Racing thoughts, excessive energy, reduced need for sleep
 - ☐ Excessive drug and/or alcohol use or abuse
 - ☐ Neglect of physical health
 - ☐ Feelings of hopelessness
-

SCORING If you checked items under:

Part I only, student may be a risk for suicide and professional help should be sought immediately.

Part II only, student may be suffering from depression or bipolar disorder and should seek further evaluation with a mental health professional or his/her primary care physician.

Parts I and II, the suicide risk is even higher. Strongly encourage professional help immediately.

(Suicide Risk Questionnaire was created by Screening for Mental Health, Inc. with educational facts adapted from material provided by National Depression Screening Day sponsors: The American Foundation of Suicide Prevention and the American College Health Association. Consultants: Ross J. Baldessarini, MD and Kay R. Jamison, PhD. Accessed January 18, 2010 at www.stopasuicide.org)

The Columbia Impairment Scale (CIS) Youth Version
INSTRUCTIONS FOR YOUTH

There are thirteen areas of behavior for you to rate from 0 (No problem) for you to 4 (Very bad problem) for you. Rate each item by circling the number that is best describes your behavior at the present time. Since your behavior will change over time, only take into consideration how you feel your recent behavior (within the past week or two) has been. PLEASE RATE ALL THIRTEEN ITEMS. Circle the number 5 if you don't know or the question does not apply to you. If you do not understand an item or items ask the staff person to clarify it for you. S/he will be glad to do so.

Date _____ Student's Name _____

THE COLUMBIA IMPAIRMENT SCALE (C. I. S.)-- (Youth Version)

Please circle the number that you think best describes the child or youth's situation:

0 1 2 3 4 5
 No problem Some problem Very bad problem Not applicable/Don't know

In general, how much of a problem do you think you have with:	
1)...getting into trouble?	0 1 2 3 4 5
2)...getting along with your mother/mother figure.	0 1 2 3 4 5
3)...getting along with your father/father figure.	0 1 2 3 4 5
4)...feeling unhappy or sad?	0 1 2 3 4 5
How much of a problem would you say you have:	
5)...with your behavior at school? (or at your job)	0 1 2 3 4 5
6)...with having fun?	0 1 2 3 4 5
7)...getting along with adults other than (your mother and/or your father)?	0 1 2 3 4 5
How much of a problem do you have:	
8)...with feeling nervous or afraid?	0 1 2 3 4 5
9)...getting along with your sister(s) and/or brother(s)?	0 1 2 3 4 5
10) ...getting along with other kids your age?	0 1 2 3 4 5
How much of a problem would you say you have:	
11)...getting involved in activities like sports or hobbies?	0 1 2 3 4 5
12)...with your school work (doing your job)?	0 1 2 3 4 5
13)...with your behavior at home?	0 1 2 3 4 5

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