NEBRASKA SCHOOL SUICIDE PREVENTION AND POSTVENTION TOOLKIT

PROVIDED BY:

Metro Area
Suicide Prevention Coalition

Dear Colleagues,

The Metro Area Suicide Prevention Coalition has worked diligently over the last two years to provide hope in our community, while saving lives from suicide. We know that too many lives are still lost to suicide, but we continue working to implement prevention programs and education throughout the Region 6 Behavioral Healthcare area in hopes that we can reach others.

More than a dozen school districts came together to create the Metro Area Suicide Prevention & Postvention Toolkit. In it you will find information on best practices & evidence based practices regarding the following topics:

- Building Resiliency in Youth
- Coping Mechanisms – Healthy vs Unhealthy
- Creating Safety Plans
- District Crisis Response Teams
- How to Avoid Clusters or Copycats
- How to Have the Conversation
- LGBTQ Youth
- Memorials
- National & Local Resources
- Parent Communications
- Safe Messaging
- Screeners & Assessments
- Social Media Suggestions
- Suicide Warning Signs, Risk Factors & Protective Factors

We know that not all the enclosed information will be useful to your district, but we hope that you are able to find some tools that can better prepare you and your school community to create a comprehensive suicide prevention & postvention plan, or strengthen the one you may already have in place.

If you are interested in more information about the Metro Area Suicide Prevention Coalition, or have questions regarding any of the materials in this resource, please reach out to Julia Hebenstreit at jhebenstreit@thekimfoundation.org or 402.891.6997.

We hope that you have a safe and successful school year!

Metro Area Suicide Prevention Coalition

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Prevention

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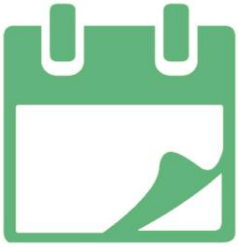
1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year.

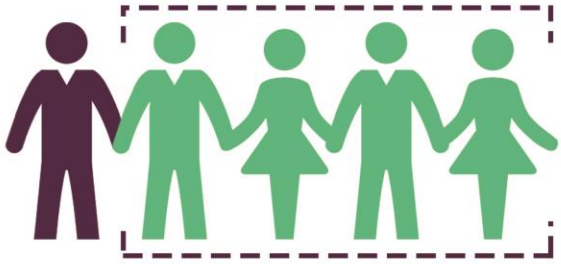
Suicide takes a life **every 13 minutes** in the US.



On average, **one person dies by suicide every 36 hours** in the state.

Suicide is the **10th leading** cause of death overall in Nebraska.

As many people die by suicide as car accidents in NE



Four times as many people die by suicide in Nebraska annually than by homicide. The total deaths to suicide reflect a total of **5,943** years of potential life lost (YPLL) before age 65.

Suicide cost Nebraska a total of **$223,376,000** of combined lifetime medical and work loss cost in 2010, or an average of **$1,157,386 per suicide death**.

Suicide Death Rates			
	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Nebraska	**246**	**13.05**	**37**
Nationally	**44,965**	**13.42**	

In Nebraska, suicide is the...

- **1st leading** cause of death for ages 10-14. 1
- **2nd leading** cause of death for ages 15-34. 2
- **4th leading** cause of death for ages 35-54. 3
- **8th leading** cause of death for ages 55-64. 4
- **20th leading** cause of death for ages 65 and older. 5

Reference: AFSP: https://afsp.org/about-suicide/state-fact-

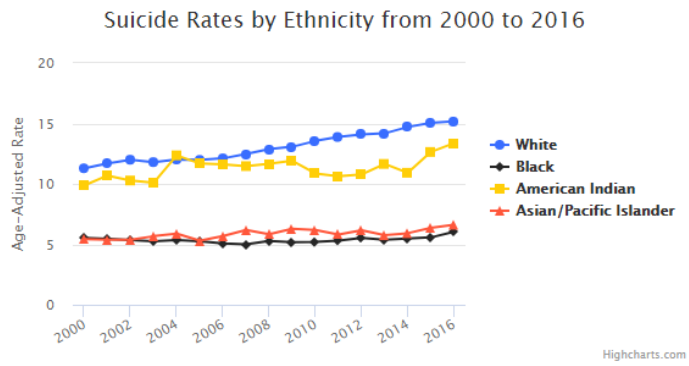
Suicide Epidemiology

All demographic groups have some level of risk. It is important not to dismiss any individual as being free of risk because they belong to a particular demographic group. There are some demographic groups, however, that are at relatively greater risk than others.

Gender

Males are 3.5 times more likely than females to die from suicide. Of the reported suicides in the 10 to 24 age group, 81% of the deaths were males and 19% were females. Females, however, are more likely to report attempting suicide than boys (11.6% vs. 5.5%).

Race/Ethnicity

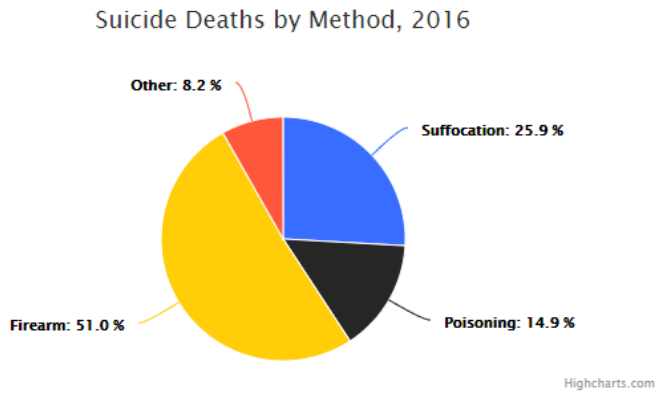


In 2016, the highest U.S. suicide rate (15.17) was among Whites and the second highest rate (13.37) was among American Indians and Alaska Natives (Figure 5). Much lower and roughly similar rates were found among Asians and Pacific Islanders (6.62), and Black or African Americans (6.03).

Note that the CDC records Hispanic origin separately from the primary racial or ethnic groups of White, Black, American Indian or Alaskan Native, and Asian or Pacific Islander, since individuals in all of these groups may also be Hispanic.

Method

In 2016, firearms were the most common method of death by suicide, accounting for a little more than half (51.01%) of all suicide deaths. The next most common methods were suffocation (including hangings) at 25.89% and poisoning at 14.90%.



American Foundation for Suicide Prevention. (2018). Suicide Statistics. Retrieved July 31, 2018, from https://afsp.org/about-suicide/suicide-statistics/

CDC. (2017, September 15). Suicide Among Youth. Retrieved July 31, 2018, from https://www.cdc.gov/healthcommunication/toolstemplates/entertainmented/tips/SuicideYouth.htm

Research Study: Why do Adolescents Attempt Suicide?

BACKGROUND

A suicide attempt is defined as "a self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die" (Silverman, Berman, Sanddal et al., 2007, p. 273). Fortunately, suicide among teenagers is infrequent. However, teens have a relatively higher rate of suicide attempts than adults.

Much of suicide research is concerned with who attempts suicide rather than why they do so. For both researchers and clinicians to gain a better understanding of what contributes to an individual's suicide attempt, Dr. David Klonsky of the University of British Columbia, along with Dr. Alexis May now at Wesleyan University, developed the Inventory of Motivations for Suicide Attempts (IMSA), based on several widely accepted theories of suicide.

QUESTION

Why do adolescents attempt suicide?

STUDY

In the present study, Dr. Klonsky utilized the IMSA to assess suicide attempt motivations of 52 adolescents ages 12-17 years (mean age 14.8 years) who were hospitalized at a psychiatric inpatient unit after a suicide attempt. Eighty-five percent of the sample were female. The average age of the initiation of suicidal ideation was 12 years old. The percentage of participants reporting only one suicide attempt was 67.

The IMSA includes 10 five-item scales plus four additional items. The scales are based around feelings of:

- Hopelessness – the belief that things cannot get better, or one's situation cannot improve
- Psychache – extreme emotional or psychological pain
- Escape – the desire to escape from one's own thoughts, feelings, or actions
- Burdensomeness – the feeling that one is a burden to those around him or her
- Low Belongingness – the feeling that one is not accepted by his or her community
- Fearlessness – the absence of fear which had prevented a suicide attempt at an earlier time

Silverman MM, Berman AL, Sanddal ND, O'Carroll PW, Joiner TE. Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors Part 2: Suicide-Related Ideations, Communications, and Behaviors. Suicide and Life-Threatening Behavior. 2007; 37(3):264–277.

- Problem-solving – the belief that suicide or suicide alone will solve one's problems
- Impulsivity – acting in an unplanned way, often without reasoned thinking
- Interpersonal Influence – direct social pressures promoting suicide
- Help Seeking – the desire for help or care, from others

The first six of these scales reflect internal factors (intrapersonal) while the final two scales reflect factors associated with communication (interpersonal). The middle two scales, Impulsivity and Problem-Solving, aren't strongly associated with either factor and are considered separately. Participants were asked to identify feelings they've experienced, based on a series of statements, each beginning with the phrase, "I attempted suicide because…" For instance, "I attempted suicide because I wanted to die," which highlights the intent behind the attempt; or "I attempted suicide because… I felt overwhelmed and in too much pain from humiliation," which implicates psychache as a driving factor.

The study participants then rated their agreement with four additional general statements about suicide on a scale of zero (not at all important) to four (most important), based on how they felt leading up to their suicide attempt.

To assess if adolescents' reports of suicide attempts were accurate, another suicide scale, the Columbia-Suicide Severity Rating Scale, was also administered.

RESULTS

Describing their motivations at the time of their attempt, 98 percent of participants endorsed the item "I attempted suicide because I wanted to die," though there were varying levels of degree of intent to die. The three strongest motivators for suicide attempts in this teen sample were Psychache, Hopelessness, and Escape. The weakest motivator was Interpersonal Influence. These results were similar to those of Klonsky's previous study of adult suicide attempt survivors, which used the IMSA to assess motivations for attempts.

Burdensomeness was found to be a stronger motivator for adolescents than for adults. Interpersonal Influence, the least important motivator for adults, perhaps surprisingly, appears to be even less important to adolescents.

Internal motivators, for teens, were more strongly associated with suicidal behaviors than external motivators. This means that at the time of the suicide attempt most people perceived that suicide was the only way to end their own emotional or psychological struggles. These results oppose the idea that youth attempt suicide solely for attention or to obtain the help of others. Rather than engaging in suicidal behavior to gain the help of others, the study made evident that teens more often attempt

suicide because they are in emotional pain, feel hopeless, and do not believe there can be any resolution to their problems.

TAKEAWAYS

- The strongest motivations for suicide attempts in both adults and adolescents using the IMSA were emotional pain, hopelessness and wanting to get rid of the pain. (i.e., Psychache, Hopelessness, and Escape)
- Individual's internal feelings of pain were stronger motivators for suicide attempts than interpersonal factors, even for adolescents.
- The Inventory of Motivations for Suicide Attempts (IMSA) has demonstrated reliability and validity across the age span
- Adolescents and adults experience a variety of motivations for suicide, and understanding these motivations can inform clinicians and families about how to intervene to prevent suicide attempts

Silverman MM, Berman AL, Sanddal ND, O'Carroll PW, Joiner TE. Rebuilding the Tower of Babel: A Revised Nomenclature for the Study of Suicide and Suicidal Behaviors Part 2: Suicide-Related Ideations, Communications, and Behaviors. Suicide and Life-Threatening Behavior. 2007; 37(3):264–277.

Recognizing and Responding to Warning Signs for Suicide

Warning signs are indications that someone may be in danger of suicide, either immediately or in the near future.

Warning Signs for Suicide Prevention is a consensus statement developed by an expert working group brought together by the American Association of Suicidology. The group organized the warning signs by degree of risk, and emphasized the importance of including clear and specific direction about what to do if someone exhibits warning signs. This consensus statement describes the general warning signs of suicide. Warning signs differ by age group, culture, and even individual. The recent advent of social media has provided another outlet in which warning signs may be exhibited. The differences in how and where warning signs may be exhibited demonstrate the importance of adapting gatekeeper training for the age group and cultural communities with whom the gatekeepers will be interacting.

Warning Signs for Suicide and Corresponding Actions

Seek immediate help from a mental health provider, 9-1-1 or your local emergency provider, or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) when you hear or see any one of these behaviors:

- Someone threatening to hurt or kill themselves
- Someone looking for ways to kill themselves: seeking access to pills, weapons, or other means
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person

Seek help by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral if you witness, hear, or see anyone exhibiting one or more of these behaviors:

- Hopelessness—expresses no reason for living, no sense of purpose in life
- Rage, anger, seeking revenge
- Recklessness or risky behavior, seemingly without thinking
- Expressions of feeling trapped—like there's no way out
- Increased alcohol or drug use
- Withdrawal from friends, family, or society
- Anxiety, agitation, inability to sleep, or constant sleep
- Dramatic mood changes

- No reason for living, no sense of purpose in life

If you or someone you know is in a suicidal crisis, call 1-800-273-TALK (8255)—National Suicide Prevention Lifeline.

Risk Factors for Youth Suicide

Risk factors for suicide refer to personal or environmental characteristics that are associated with suicide. The environment includes the social and cultural environment as well as the physical environment. People affected by one or more of these risk factors may have a greater probability of suicidal behavior. Some risk factors cannot be changed—such as a previous suicide attempt—but they can be used to help identify someone who may be vulnerable to suicide.

There is no single, agreed-upon list of risk factors. The list below summarizes the risk factors identified by the most recent research.

Behavioral Health Issues/Disorders

- Depressive disorders
- Substance abuse or dependence (alcohol and other drugs)
- Conduct/disruptive behavior disorders
- Other disorders (e.g., anxiety disorders, personality disorders)
- Previous suicide attempts
- Self-injury (without intent to die)
- Genetic/biological vulnerability (mainly abnormalities in serotonin functioning, which can lead to some of the behavioral health problems listed above)

Note: The presence of multiple behavioral health disorders (especially the combination of mood and disruptive behavior problems or substance use) increases suicide risk.

Personal Characteristics

- Hopelessness
- Low self-esteem
- Loneliness
- Social alienation and isolation, lack of belonging
- Low stress and frustration tolerance
- Impulsivity
- Risk taking, recklessness
- Poor problem-solving or coping skills
- Perception of self as very underweight or very overweight

- Capacity to self-injure
- Perception of being a burden (e.g., to family and friends)

Adverse/Stressful Life Circumstances

- Interpersonal difficulties or losses (e.g., breaking up with a girlfriend or boyfriend)
- Disciplinary or legal problems
- Bullying, either as victim or perpetrator
- School or work problems (e.g., actual or perceived difficulties in school or work, not attending school or work, not going to college)
- Physical, sexual, and/or psychological abuse
- Chronic physical illness or disability
- Exposure to suicide of peer

Risky Behaviors

- Alcohol or drug use
- Delinquency
- Aggressive/violent behavior
- Risky sexual behavior

Family Characteristics

- Family history of suicide or suicidal behavior
- Parental mental health problems
- Parental divorce
- Death of parent or other relative
- Problems in parent-child relationship (e.g., feelings of detachment from parents, inability to talk with family members, interpersonal conflicts, family financial problems, family violence or abuse, parenting style either underprotective or overprotective and highly critical)

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students
- Lack of acceptance of differences
- Expression and acts of hostility

- Lack of respect and fair treatment
- Lack of respect for the cultures of all students
- Limitations in school physical environment, including lack of safety and security
- Weapons on campus
- Poorly lit areas conducive to bullying and violence
- Limited access to mental health care
- Access to lethal means, particularly in the home
- Exposure to other suicides, leading to suicide contagion
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as overweight. Stigma and discrimination lead to:

  » Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care

  » Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help-seeking

  » Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection.

Protective Factors for Youth Suicide

Protective factors are personal or environmental characteristics that reduce the probability of suicide. Protective factors can buffer the effects of risk factors. The capacity to cope positively with the effects of risk factors is called "resilience." Actions by school staff to enhance protective factors are an essential element of a suicide prevention effort. Strengthening these factors also protects students from other risks, including violence, substance abuse, and academic failure.

There is no single, agreed-upon list of protective factors. The list below summarizes the protective factors identified by the most recent research.

Individual Characteristics and Behaviors

- Psychological or emotional well-being, positive mood
- Emotional intelligence: the ability to perceive, integrate into thoughts, understand, and manage one's emotions
- Adaptable temperament
- Internal locus of control
- Strong problem-solving skills
- Coping skills, including conflict resolution and nonviolent handling of disputes
- Self-esteem
- Frequent, vigorous physical activity or participation in sports
- Spiritual faith or regular church attendance
- Cultural and religious beliefs that affirm life and discourage suicide
- Resilience: ongoing or continuing sense of hope in the face of adversity
- Frustration tolerance and emotional regulation
- Body image, care, and protection Family and Other Social Support
- Family support and connectedness to family, closeness to or strong relationship with parents, and parental involvement
- Close friends or family members, a caring adult, and social support
- Parental pro-social norms, that is, youth know that parents disapprove of antisocial behavior such as beating someone up or drinking alcohol
- Family support for school

School

- Positive school experiences
- Part of a close school community
- Safe environment at school (especially for lesbian, gay, bisexual, and transgender youth)
- Adequate or better academic achievement
- A sense of connectedness to the school
- A respect for the cultures of all students

Mental Health and Healthcare Providers and Caregivers

- Access to effective care for mental, physical, and substance abuse disorders
- Easy access to care and support through ongoing medical and mental health relationships

Access to Means

- Restricted access to firearms: guns locked or unloaded, ammunition stored or locked
- Safety barriers for bridges, buildings, and other jumping sites
- Restricted access to medications (over-the-counter and prescriptions)
- Restricted access to alcohol (since there is an increased risk of suicide by firearms if the victim is drinking at the time)

LGBTQ Youth

Studies that compare the rate of suicide attempts among LGB youth with those among heterosexual youth show significantly higher rates for LGB youth:

- Suicide is the 2nd leading cause of death among young people ages 10 to 24.1
- LGB youth seriously contemplate suicide at almost three times the rate of heterosexual youth.
- LGB youth are almost five times as likely to have attempted suicide compared to heterosexual youth.
- Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers.
- In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25.3
- LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection.
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average.

LGBTQ-Specific Suicide Prevention Resources

Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth

Author: Suicide Prevention Resource Center, Education Development Center, Inc.

Web link: http://www.sprc.org/training-institute/lgbt-youth-workshop

Description: This toolkit contains all the materials needed to provide a training on suicide prevention among lesbian, gay, bisexual, and transgender youth for staff who work in either youth-serving agencies or suicide prevention programs. The workshop described is 4 hours long, but it can be adapted and/or shortened to fit the needs of the audience. It covers basic information about suicide prevention, including risk and protective factors and warning signs; LGBT cultural competence; and ways to address suicide prevention among LGBT youth. Along with a PowerPoint presentation, the training includes group discussions and participatory activities, and the workshop kit includes a leader's guide and handouts.

LGBTQ Suicide Prevention Training

Author: Washington Youth Suicide Prevention Program

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Suicide Prevention Resource Center. (2008). Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc.

The Trevor Project. "Preventing Suicide – The Trevor Project." The Trevor Project, www.thetrevorproject.org/resources/preventing-suicide/#sm.0001pdv8pb3l5ez5rqk1vd0mqils9.

Web link: http://www.yspp.org/lgbtq/safe_accepted.htm

Description: The OUTLoud program of the Washington Youth Suicide Prevention Program offers a workshop for staff and teachers and a webinar focusing on suicide prevention in gay, lesbian, bisexual, transgender, and questioning (LGBTQ) youth. The workshop Safe and Accepted - LGBTQ Youth Suicide Prevention & Intervention covers warning signs, distinctions between suicide and self-harm, and how to access help. The webinar LGBTQ Youth: An Introduction to Risk & Protective Factors is geared toward all audiences and discusses risk factors, warning signs, protective factors, and resources for LGBTQ youth.

Cost: Webinar free. Workshops free within King County, WA, and negotiated outside. Contact Heather Carter at heather@yspp.org or 206-297-5922, ext.116

The Trevor Project

Web Link: http://www.thetrevorproject.org/

The Trevor Project is a national organization focused on crisis and suicide prevention efforts among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. It provides a nationwide 24-hour, toll-free, crisis intervention telephone lifeline (1-866-488-7386); an online, social networking community for LGBTQ youth ages 13 through 24 and their friends and allies; age-appropriate educational programs for schools; and advocacy initiatives at the local, State and Federal levels. It also is a partner in the It Gets Better Project, which is a place where LGBT adults can share videos they make to help LGBT youth see how "happiness can be a reality in their future" (see http://www.itgetsbetterproject.com). All of the Trevor Project's programs aim to provide a safe, supportive, and positive environment for everyone

Video for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth

To address the issue of suicide among LGBTQ youth, the OUTLoud Project of the Youth Suicide Prevention Program in Washington State produced the video "You Are Not Alone: LGBTQ Youth and Suicide," featuring three LGBTQ youth speaking from their personal experiences with depression, self-harm, and being suicidal. The video also educates youth about the risk and protective factors for suicide that are specific to LGBTQ youth and how to intervene when they think a friend is contemplating suicide. The video was written and produced by LGBTQ youth working with an adult advisor. It can be used as part of a suicide prevention program for all students.

To view the video, go to http://www.youtube.com/watch?v=b3OLfTjOxYs&feature=play er_embedded

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Suicide Prevention Resource Center. (2008). Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth. Newton, MA: Education Development Center, Inc.

The Trevor Project. "Preventing Suicide – The Trevor Project." The Trevor Project, www.thetrevorproject.org/resources/preventing-suicide/#sm.0001pdv8pb3l5ez5rqk1vd0mqils9.

Safe and Effective Messaging for Suicide Prevention

This document offers evidence-based recommendations for creating safe and effective messages to raise public awareness that suicide is a serious and preventable public health problem. The following list of "Do's" and "Don'ts" should be used to assess the appropriateness and safety of message content in suicide awareness campaigns. Recommendations are based upon the best available knowledge about messaging. They apply not only to awareness campaigns, such as those conducted through Public Service Announcements (PSAs), but to most types of educational and training efforts intended for the general public.

These recommendations address message content, but not the equally important aspects of planning, developing, testing, and disseminating messages. While engaged in these processes, one should seek to tailor messages to address the specific needs and help-seeking patterns of the target audience. For example, since youth are likely to seek help for emotional problems from the Internet, a public awareness campaign for youth might include Internet-based resources.

The Do's—Practices that may be helpful in public awareness campaigns:

- **Do emphasize help-seeking and provide information on finding help.** When recommending mental health treatment, provide concrete steps for finding help. Inform people that help is available through the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and through established local service providers and crisis centers.
- **Do emphasize prevention.** Reinforce the fact that there are preventative actions individuals can take if they are having thoughts of suicide or know others who are or might be. Emphasize that suicides are preventable and should be prevented to the extent possible.
- **Do list the warning signs, as well as risk and protective factors of suicide.** Teach people how to tell if they or someone they know may be thinking of harming themselves. Include lists of warning signs, such as those developed through a consensus process led by the American Association of Suicidology (AAS). Messages should also identify protective factors that reduce the likelihood of suicide and risk factors that heighten risk of suicide.
- **Do highlight effective treatments for underlying mental health problems.** Over 90 percent of those who die by suicide suffer from a significant psychiatric illness, substance abuse disorder or both at the time of their death. The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support in an understanding community.

The Don'ts—Practices that may be problematic in public awareness campaigns:

- **Don't glorify or romanticize suicide or people who have died by suicide.** Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide. They should not be held up as role models.
- **Don't normalize suicide by presenting it as a common event.** Although significant numbers of people attempt suicide, it is important not to present the data in a way that makes suicide seem common, normal or acceptable. Most people do not seriously consider suicide an option; therefore, suicidal ideation is not normal. Most individuals, and most youth, who seriously consider suicide do not overtly act on those thoughts, but find more constructive ways to resolve them. Presenting suicide as common may unintentionally remove a protective bias against suicide in a community.

"Safe and Effective Messaging and Reporting." Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) Pocket Card | Suicide Prevention Resource Center, Suicide Prevention Resource Center, www.sprc.org/keys-success/safe-messaging-reporting.

- **Don't present suicide as an inexplicable act or explain it as a result of stress only.** Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim. Additionally, it misses the opportunity to inform audiences of both the complexity and preventability of suicide. The same applies to any explanation of suicide as the understandable response to an individual's stressful situation or to an individual's membership in a group encountering discrimination. Oversimplification of suicide in any of these ways can mislead people to believe that it is a normal response to fairly common life circumstances.
- **Don't focus on personal details of people who have died by suicide.** Vulnerable individuals may identify with the personal details of someone who died by suicide, leading them to consider ending their lives in the same way.
- **Don't present overly detailed descriptions of suicide victims or methods of suicide.** Research shows that pictures or detailed descriptions of how or where a person died by suicide can be a factor in vulnerable individuals imitating the act. Clinicians believe the danger is even greater if there is a detailed description of the method.

"Safe and Effective Messaging and Reporting." Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) Pocket Card | Suicide Prevention Resource Center, Suicide Prevention Resource Center, www.sprc.org/keys-success/safe-messaging-reporting.

Social Media: Suicide Safety

If someone online is posting about wanting to die or kill themselves, feeling hopeless, trapped, like a burden to others, or seeking revenge, you can encourage them to call the National Suicide Prevention Lifeline. You can also contact social media safety teams, who will reach out to connect the user with the help they need. Call 1-800-273-TALK (8255) at any time for help if a friend is struggling. [*Note: Tumblr no longer directly responds to reports of suicide or self-harm. Message the user with the National Suicide Prevention Lifeline number and a message of support.]

Facebook

The National Suicide Prevention Lifeline has worked with Facebook to develop their supportive community tools, which include resources, messages for you to use, and directly contacting Facebook

Reporting Suicidal Content: https://www.facebook.com/help/contact/305410456169423

"From Reporting to Supporting": https://vimeo.com/160565004

Twitter

The link below will report threats of suicide or self-harm to Twitter. Twitter will send the user a direct message with the National Suicide Prevention Lifeline number. https://help.twitter.com/forms/suicide

Instagram

To report threats of suicide or self-harm on Instagram:

Tap "**…**" below the post

Tap **Report Inappropriate**

Select **This Photo Puts People At Risk > Self-Harm**.

Snapchat

To report a safety concern, press and hold on that Snapchatter's name and tap the gear button. Then, tap 'Report' and reach out to Snapchat, and follow the prompts. You can also visit Snapchat's website at *Snapchat Support* to report a safety concern.

Youtube

To report threats of suicide or self-harm, click "More." Highlight and click "Report" in the drop-down menu. Click "Harmful dangerous acts," then "Suicide or self-injury." YouTube will review the video and may send a message to the uploader with the National Suicide Prevention Lifeline number.

Suicide Prevention Lifeline. (2018). *Help Someone Else*. Substance Abuse and Mental Health Services Administration (SAMHSA).

Periscope

If you come across sensitive content on the Periscope app, report the broadcast directly through there. When watching a broadcast on iOS or Android, select the three dot symbol next to the comment field (Say something...) and tap the 'Report Broadcast' button. Once you have selected this, you will be prompted to select a reason for the report. The reasons you can select are ‘Self-Harm,’ ‘Violence,’ ‘Sexual Content,’ and ‘Child Safety.’ Learn how to report content on the site and comments by clicking the link below.

If you need help, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or go to www.suicidepreventionlifeline.org.

If someone indicates they are considering suicide, listen and take their concerns seriously. Let them know you care, and they are not alone. Encourage them to seek help immediately from a knowledgeable professional. Don’t leave them alone.

Other Ways to Address Suicide-Related Posts by Others

- If someone posts potentially suicidal content online, take action. They may or may not intend to follow through, but don’t take a chance. Reach out to the person online and find out how you can help or provide and encourage them to access resources. Many social networks have a system in place to report suicidal content and get online help to that person. (See suicidepreventionlifeline.org/gethelp/online.aspx.)
- Keep an eye out for trending topics on Twitter and Facebook that may be related to the suicide of a celebrity or other well-known person. Post resources for people who may be experiencing suicidal thoughts as a result of the news. Use the same hashtags or keywords that appear in the trending topics so your posts will be seen by those following the news.
- Do not repost stories or links about suicide attempts or death. Imitative suicides are more likely with more frequent and prominent coverage. In addition, posting links to stories can drive up online traffic, which encourages media organizations to continue posting these stories. Instead, share resources and stories of hope and recovery.
- Avoid perpetuating suicide myths by addressing inaccurate information others post. Myths such as the idea that ‘someone who talks about suicide does not do it,’ or that ‘asking someone if they are suicidal will plant the idea in their head’ may keep people from getting the help they need.
- Be vigilant for suicide hoaxes that may spread quickly online. Do not retweet or repost information that has not been confirmed by a reliable source, and discourage others from doing so as well.
- Work with influencers in online fan communities who can help to quell rumors and spread accurate information to counter suicide hoaxes.

Chart of School Staff Responsibilities

As you work on the steps in the chapters of this toolkit, use the chart on the next page to record the names of the people who will play a role in planning and implementing each component of your program. Check the column representing the activities in which they will be involved. Staff with differing areas of expertise will be required to implement the steps in various chapters. However, this does not mean that you will have to establish separate groups for each component, as you will probably find that many staff will be involved in several of the components. The following people may be helpful in planning and implementing components of your school's suicide prevention program:

- Superintendent
- Principal
- Assistant principal
- Curriculum director
- Health educator
- School nurse
- School health coordinator
- Guidance counselor/school counselor
- School social worker
- Student assistance program staff/pupil services coordinator
- Special education staff
- Members of the Crisis Response Team
- School psychologist
- School-based health center and/or mental health center staff
- Child study team member(s)
- School security officer/school resource officer
- Teachers
- Technology staff
- Athletic staff

STAFF	PROGRAM COMPONENT Check the box for the component(s) that each staff person will plan and implement.					
Name & Title	Getting Started	Protocols for Helping students at risk for suicide	Staff Education & Training	Parent/Guardian Education and Outreach	Student Programs	Screening

REFERENCE: Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Chart of Community Partners

As you go through the steps in each section, use the chart on the next page to fill in the names of individuals or agencies in the community who can help you plan and implement that component of your program. Check the column representing the activities in which they will be involved. Some partners will probably be involved with more than one program component. The following types of community partners may be helpful in implementing components of your school's suicide prevention program:

- Leaders representing the cultural communities of your students
- Mental health providers/community mental health agency staff
- Substance abuse counselors
- Crisis center workers
- Healthcare providers
- Community health department staff, including injury and violence prevention and maternal and child health professionals
- Hospital staff, including emergency department staff
- EMTs, fire and rescue personnel, and first responders
- Police
- Clergy
- County social services staff
- Child welfare providers
- Juvenile justice professionals
- Coroner
- Media representatives
- Immigrant and refugee organization staff
- LGBTQ youth–serving program staff
- Youth development professionals (e.g., YMCA, Boys and Girls Club, community youth center) In tribal communities consider including Indian Health Service hospitals, clinics, and primary care providers, and tribal behavioral health and social service programs.

STAFF	PROGRAM COMPONENT Check the box for the component(s) that each staff person will work on.					
Name & Title	Getting Started	Protocols for Helping students at risk for suicide	Staff Education & Training	Parent/Guardian Education and Outreach	Student Programs	Screening

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Prevention Training & Resources

STAFF EDUCATION AND TRAINING

The following matrix lists all of the Staff Education and Training Programs that are in either the National Registry of Evidence-Based Prevention Practices (NREPP) or the Best Practices Registry (BPR), as of October 2010. The criteria for NREPP and BPR are different. The first section of the matrix lists gatekeeper training programs, and the second section lists programs that train professional staff to assess suicide risk. Several of the gatekeeper trainings center on a student curriculum but contain other components to create a more comprehensive program.

Program	Registry	School Focused	Number and Length of Sessions	Facilitator and Location	Other Components	Notes
Gatekeeper Training Programs						
Be a Link! Suicide Prevention Gatekeeper Training	BPR	No	One 2-hour session	Teachers who take a 2-day facilitator training or Yellow Ribbon representatives. Provided at Yellow Ribbon sites or local locations.		Often used with Yellow Ribbon's student program Ask 4 Help!
Gatekeeper Suicide Prevention Program: A High School Curriculum	BPR	Yes	Different types of training ranging from 1 hour to 2 days	Facilitators must be trained by Gryphon Place Delivered Onsite	Student Programs Parent Education	Mainly available in Michigan
Lifelines	NREPP	Yes	One 45-60 minute presentation, but up to 1.5-2 hours with participant discussion	School Crisis Response Team member (social worker, psychologist, counselor, health teacher). Information on giving the training is in the training	Protocols Student Programs Parent Education	A 2-day onsite training on how to implement all the program components is available through Hazelden Publishing
Making Educators Partners in Youth Suicide Prevention	BPR	Yes	5 modules; total time 2 hours	None; self-directed online training. Fifth module allows users to e-mail questions to a panel of experts.		

Program	Registry	School Focused	Number and Length of Sessions	Facilitator and Location	Other Components	Notes
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	BPR	Yes	2 hours	School staff.		Also suitable for parents and other adults who care for or work with youth.
Question, Persuade, Refer (QPR) Gatekeeper Training	BPR	No	One session of 1-2 hours	None for online version. Certified QPR gatekeeper instructors teach the in-person training onsite and at other local locations. Training of trainers by QPR available onsite or online.		Online and in-person versions are adapted for Native Americans and African Americans. In-person versions available in Spanish and other languages.
Response: A Comprehensive High School-Based Suicide Awareness Program	BPR	Yes	One 2 hour session	School staff. Training for providing staff training is included in the school kit. RESPONSE staff will provide training if	Protocols Student Programs Parent Education	
Suicide Alertness for Everyone (safeTALK)	BPR	No	One 3 hour session	Trainers who are trained and certified by LivingWorks. Training available onsite. 1-day and 2-day train-the-trainer sessions available for local facilitators		

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Program	Registry	School Focused	Number and Length of Sessions	Facilitator and Location	Other Components	Notes
Training Programs to Assess Suicide Risk						
Applied Suicide Intervention Skills Training (ASIST)	BPR	No	2 days	Trainers must be trained and certified by LivingWorks. Training available onsite. 5-day train-the-trainer sessions available for local facilitators.		
Assessing and Managing Suicide Risk (AMSR)	BPR	No	1 day	Training must be given by the program's developer. Onsite and other local locations available		
QPRT Suicide Risk Assessment and Risk Management Training Program	BPR	No	8 hours in classroom or 10 hours online	Training must be given by trainers certified and licensed to teach this program. Onsite and other local locations available		Online and in-person versions are adapted for Native Americans
Recognizing and Responding to Suicide Risk (RRSR)	BPR	NO	2 days	Training must be given by the program's developer. Onsite and other local locations available.		
School Suicide Prevention Accreditation Program	BPR	Yes	Online, self-paced	None; self-directed online training		

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Additional Resources & Extra Information for Training School Staff in Suicide Prevention

*Note: For LGBTQ-specific staff training resources, see LGBTQ section

At-Risk for High School Educators: Identify and Refer Students in Mental Distress

Author: Kognito Interactive

Date: 2010

Web link: http://www.kognito.com/products/highschool/

Description: This online, interactive gatekeeper training program uses virtual role-play to help high school teachers, staff, and administrators learn common signs of psychological distress, including depression, anxiety, and thoughts of suicide, and how to approach an at-risk student for referral to the school counselor. It is a 1-hour simulation in which users take on the role of a teacher, analyze profiles of three at-risk virtual students, and then engage in simulated conversations with them, including to encourage them to see the school counselor. Users practice and learn to use open-ended questions, reflective listening, and other communications techniques. This program is based on At-Risk for University Faculty, which is included in the SPRC Best Practices Registry for suicide prevention programs.

Cost: Available to schools, districts, and states. Price ranges from approximately $5 to $40 per user depending on the number of users. For pricing information, contact Kognito at info@kognito.com.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/AtRiskHSEducators.pdf

Be A Link! Suicide Prevention Gatekeeper Training

Author: Yellow Ribbon Suicide Prevention Program

Date: Revised 2009

Web link: http://www.yellowribbon.org/

Description: This is a 2-hour adult gatekeeper training program developed by Yellow Ribbon. The program may be implemented in a variety of settings, including schools, workplaces, and community groups. The training provides participants with knowledge to help them identify youth at risk for suicide and refer them to appropriate help resources. Training materials include a PowerPoint presentation (provided on a CD) and a trainer's manual. This program is often used in conjunction with the Yellow Ribbon student program Ask 4 Help! Trainers (teachers or representatives of Yellow Ribbon) are required to attend a 2-day training given by Yellow Ribbon that covers both Be A Link! and Ask 4 Help! and is held at either their site or a local location.

Cost: $299.95, which also includes materials for Ask 4 Help! Training of trainers is $295, (which includes training and all materials for both Be a Link! and Ask 4 Help!) plus the individual's travel to a Yellow Ribbon site or a facilitator's travel to a local site.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/BeALinkSuicidePrevGatekeepeeTraining.pdf

School Crisis / School Security: The 6 levels of crisis response training

Author : Dr. John Dudley

Weblink: http://www.schoolcrisis.org/index.htm

Description: This website has information about several materials which give information on how to successfully respond to crisis situations by establishing and training crisis response teams. Examples of actual situations, from Dr. Dudley's work with more than 3,000 school districts, illustrate how to select the team, develop an effective crisis plan, deal with the media, organize effective meetings under pressure, and help students and staff. This new edition features an expanded section on student memorials and a new chapter on school safety and security. The 15 minute video provides a broad overview of school safety issues. It can be shown to all certified and classified staff, parents, and law enforcement. The in-service package contains valuable resources for new staff orientation and ongoing in-service training purposes. A comprehensive assessment tool allows you to evaluate current safety measures and re-evaluate your crisis plan year after year. A free crisis plan review is also offered.

Dealing with Suicide-related Curriculum

Author: Society for the Prevention of Teen Suicide

Date: 2009

Web link: http://www.sptsnj.org/educators/suicide-curriculum.html

Description: This information sheet provides guidance on dealing with suicide themes in traditional coursework, such as the play "Romeo and Juliet," and how to manage the emotions of students who may have been personally affected by suicide. Gatekeeper Suicide Prevention Program: A High School Curriculum.

Making Educators Partners in Suicide Prevention

Author: Society for the Prevention of Teen Suicide

Date: 2007

Web link: http://spts.pldm.com/

Description: Geared toward educators and school staff, this online interactive training program consists of five modules (2 hours total) addressing the critical but limited responsibilities of educators in

identifying and referring potentially suicidal youth. In addition to lecture, question and answer, and role-play formats, experts and survivors provide a rationale for school-based suicide prevention.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/SPTS_NJFactSheet.pdf

More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel

Author: American Foundation for Suicide Prevention

Date: 2010

Web link: http://www.morethansad.org

Description: Geared toward teachers and other school personnel, this 2-hour training program is built around two 25-minute DVDs and can be led by school staff. Also included are a 42-page instructional manual for program participants and slides for teacher trainers. The program is also suitable for parents and other adults who care for or work with youth.

Cost: $99.99

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/MoreThanSad.pdf

Online Staff Development Curriculum

Author: Jason Foundation

Date: 1998

Web link: http://jasonfoundation.com/resources/index_materials.php

Description: This curriculum has three multipart modules with a certificate of completion. The first module gives an overview of suicide and lists warning signs and risk factors. The second module provides further information on suicide prevention and includes excerpts from two professionals. The third module suggests ways to incorporate a protocol in a crisis situation. The modules are available in several formats: staff presented, interactive CD-ROM or DVD (to be used with a local school facilitator), and via Internet access or video conference.

QPR Gatekeeper Training

Author: Paul Quinnett

Date: 1999; Customized versions for different audiences are continually being developed.

Web link: http://www.qprinstitute.com/

Description: This training program uses the mnemonic QPR (Question, Persuade, Refer) to guide lay and professional gatekeeper responses in a mental health emergency, including suicide. It covers recognizing early warning signs, persuading the individual to accept help, and accessing needed services. The

training is delivered in a standardized 1 – to 2-hour, multimedia format by certified QPR gatekeeper instructors. An online version is also available. African American and Native American versions of the 9 1/2-minute video shown at the beginning of the training are available for both in-person and online trainings. Inperson trainings and handouts are available that are tailored for Native Americans and in other languages, including Spanish.

Cost: In-person cost varies. Online training, $29.95; enter QPRO at the prompt for an educational discount. Instructor training, $495. Recertification, $85.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/QPR_FactSheet.pdf Also, Reis, C., & Cornell, D. (2008). An evaluation of suicide gatekeeper training for school counselors and teachers. Professional School Counseling, 11(6), 386–394.

safeTALK

Author: LivingWorks Education, Inc.

Date: 2006

Web link: http://www.livingworks.net/ST.php Description: This 3-hour training program focuses on reducing the social barriers to discussing suicide that may prevent recognition of suicide risk and referral to treatment. Participants are shown video scenarios of a person in crisis and asked to demonstrate learned identification and intervention skills. In schools, it can be used with any staff, students ages 15+, and parents. It is recommended that it be used where there are providers trained in Applied Suicide Intervention Skills Training (ASIST) to whom students can be referred, but it can be used where providers have other equivalent suicide prevention training.

Cost: 3-hour training cost varies. Resource kit, $6.50 each. 2-day training of trainers, $675 per person.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/safeTALK.pdf

SUICIDE AWARENESS/PREVENTION

FOR SCHOOL PERSONNEL | NEBRASKA LB 923 FIVE YEAR PLAN

PER LB 923: At least 1 hour of suicide awareness and prevention training each year.

INTENT OF THE LAW: To equip school personnel with information that could save the life of a student; recognizing signs and symptoms of suicidal behaviors and methods of responding to students in crisis. School personnel are critical components of a suicide prevention plan.

TARGET AUDIENCE: ***Any*** school staff member having contact with students (i.e. In addition to required audience, para-professionals, administrative/secretarial staff, bus drivers, custodians, kitchen staff, etc.)

LB 923 REQUIRED AUDIENCE: ***All*** public school nurses, teachers, counselors, school psychologists, administrators, school social workers, and any other appropriate personnel are legislatively mandated to participate.

School Year	Prevention Program	Cost to District	Method
2015-2016	KOGNITO High School Middle School Elementary	$0 District cost Training cost provided by SAMHSA Grant through DHHS	On-line Available Aug. 1, 2015
2016-2017	Making Educator Partners in Youth Suicide Prevention	$0 District cost	On-line 2016-17 version Available Aug. 1, 2016
2017-2018	Question Persuade Respond (QPR)	Details pending	On-line Available Aug. 1, 2017
2018-2019	Lessons Learned Postvention Prevention Impact	$0 District cost	On-line Available Aug. 1, 2018
2019-2020	KOGNITO High School Middle School Elementary	$0 District cost Training cost provided by SAMHSA Grant through DHHS	On-line Available Aug. 1 – Sept. 30, 2019

Specific suicide prevention training information can be found at www.education.ne.gov. Click on the A to Z List and scroll to "S". Web page available July 1, 2015.

Rationale for System Approach:

- Provide equal access to quality training for all school staff members statewide.
- Create statewide focus of training toward suicide prevention. As teachers move to different schools, new districts can be assured teachers have previously received adequate training in suicide awareness/prevention.
- Afford teachers and staff opportunity to enhance assets for personal resume.
- Construct systems across public and non-public schools, also including education majors in higher education across our state.
- Collect statewide data to support and inform future decisions about youth suicide awareness/ prevention training.
- Select statewide training emphasis based on Nebraska needs and data.
- Create common suicide prevention language.

Selection of Programs:

- Programs with an evidence-base are priority for inclusion. The requirement for inclusion is to be listed on the National Registry for Evidence-based Programs and Practices (NREPP), the National Suicide Prevention Resource Center (SPRC) Best Practice Registry or recommended for use by the Nebraska DHHS Division of Behavioral Health and approved by the National Suicide Prevention Resource Center (content) and NDE (process).
- Data and plan will be evaluated and revised at the end of five years to include additional programs with an approved evidence base and capacity for delivery to all Nebraska schools during the designated 15 day in-service time frame.

For more information contact:
Jolene Palmer, PhD | School Safety/Security Director
402-471-2944 | jolene.palmer@nebraska.gov

Thank you to the following partners who helped to develop this system:

AMERICAN FOUNDATION FOR Suicide Prevention Nebraska Chapter

BHECN BEHAVIORAL HEALTH EDUCATION CENTER OF NEBRASKA

BOYS TOWN Saving Children Healing Families

Department of Health & Human Services DHHS NEBRASKA

the kimmi FOUNDATION

NAMI NEBRASKA Nebraska's Voice on Mental Illness

NASB Nebraska Association of SCHOOL BOARDS

NEBRASKA DEPARTMENT OF EDUCATION

NEBRASKA STATE SUICIDE PREVENTION COALITION

The organizations supporting this training:

NEBRASKA esu Coordinating Council

Nebraska Council of School Administrators

NSEA Nebraska State Education Association

Funded in part under grant number 1U79SM061741-01 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U..S Department of Health and Human Services (DHHS).

SUICIDE AWARENESS/ PREVENTION

FOR SCHOOL PERSONNEL

NEBRASKA LB 923 FIVE YEAR PLAN

APPROVED

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK (8255)

suicidepreventionlifeline.org

NEBRASKA DEPARTMENT OF EDUCATION

Mental Health First Aid

Mental Health First Aid is an 8-hour course that gives people the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps you identify, understand and respond to signs of addictions and mental illnesses. The evidence behind the program demonstrates that it does build mental health literacy, helping the public identify, understand, and respond to signs of mental illness.

Trainees are taught how to apply the 5-step action plan in a variety of situations such as helping someone through a panic attack, engaging with someone who may be suicidal, or assisting an individual who has overdosed. An important component of the Mental Health First Aid course is the opportunity to practice the intervention strategy rather than to just learn about it. This simple experience can make it easier to actually apply the knowledge in a real-life situation.

Instructors may specialize in providing the course to groups such as:

- Public safety
- Higher education
- Military families
- Rural audiences
- Youth

To find a Mental Health First Aid course near you visit https://www.mentalhealthfirstaid.org/

"Mental Health First Aid USA." Mental Health First Aid, 10 Oct. 2013, www.mentalhealthfirstaid.org/.

The Kim Foundation

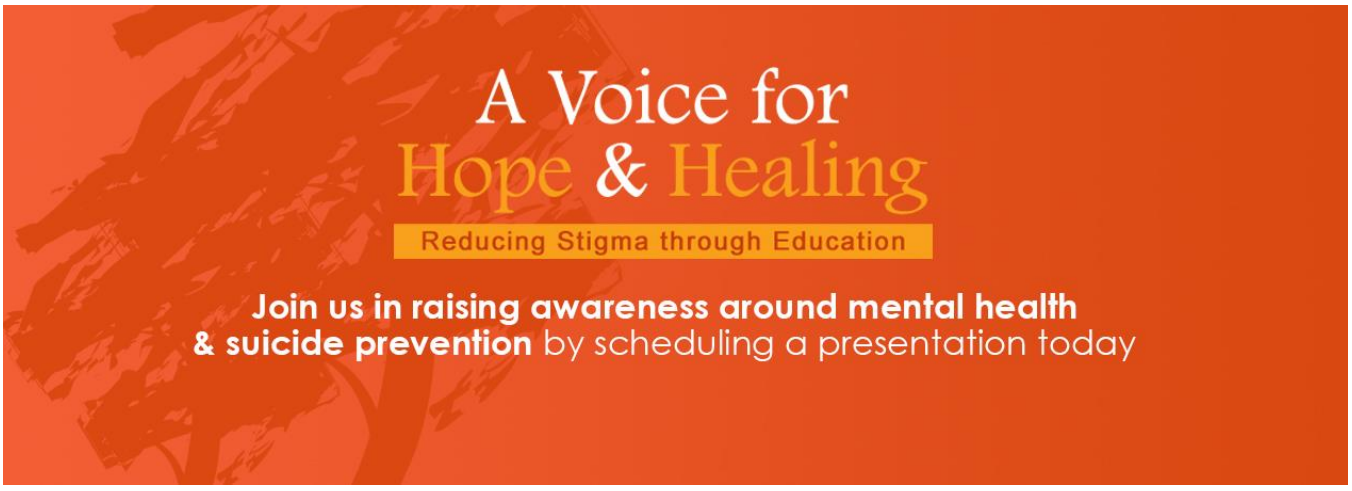
The Kim Foundation is a non-profit based in Omaha, Nebraska working to serve as a supportive resource and compassionate voice for lives touched by mental illness and suicide. They offer a variety of free educational programs in order to increase awareness around mental health and suicide prevention in Nebraska and surrounding areas.

A Voice for Hope & Healing

The Kim Foundation® is working to further inform the community about the stigma associated with mental illness and suicide by giving A Voice for Hope & Healing presentations to raise awareness and share resources. Representatives of The Kim Foundation present to schools, civic or service organizations, churches, or groups that are in need of a speaker. The presentations help build awareness about mental health and suicide prevention, while also focusing on the foundation and its mission. The presentations can be tailored more specifically to the group's size, age, and specific needs.

As The Kim Foundation goes into the community, it is able to provide a general overview of mental health and suicide prevention, as well as available resources in the community. The foundation shares information about its Metro Area LOSS team which provides support to those who have lost a loved one to suicide. The foundation also shares its newest suicide prevention campaign, 13minutes.org. Through the facts vs. fiction demonstration, individuals are able to learn how to better identify the truth about mental health and are often surprised by the staggering statistics. The foundation offers a variety of engaging activities and also a question/ answer session during the presentations.

The Kim Foundation's A Voice for Hope & Healing presentations offer information, support, and hope to the community. If you are interested in having The Kim Foundation speak for your organization or would like more information about A Voice for Hope & Healing presentations, please fill out a request form at www.thekimfoundation.org/a-voice-for-hope-healing.html or contact The Kim Foundation at (402) 891-6911.



"A Voice for Hope and Healing ." The Kim Foundation, 2018, www.thekimfoundation.org/a-voice-for-hope-healing.html.

"13 minutes". The Kim Foundation, 2018, http://www.thekimfoundation.org/13-minutes.html.

13 Minutes

13minutes is a partnership public awareness campaign focused on suicide prevention in the Region 6 Behavioral Healthcare area in Nebraska. The campaign is based on the statistic that every 13 minutes someone dies by suicide. The Kim Foundation is working to change this statistic, decrease the number of suicides experienced in our community, and save lives. Through public education, service announcements, presentations, events, and various communications, the campaign is building awareness around the campaign. People are encouraged to learn the warning signs to watch for in themselves and loved ones, and change the statistics so that more lives can be saved in the community. The 13minutes campaign is led by The Kim Foundation® and was launched in August of 2016.

To get involved with the 13minutes campaign, visit http://www.13minutes.org/ or contact Julia Hebenstreit at (402) 891-6997 or jhebenstreit@thekimfoundation.org.

"A Voice for Hope and Healing ." The Kim Foundation, 2018, www.thekimfoundation.org/a-voice-for-hope-healing.html.

"13 minutes". The Kim Foundation, 2018, http://www.thekimfoundation.org/13-minutes.html.

Screening

Why Is Screening Important?

The purpose of screening is to identify students at risk for suicide, suicidal behaviors, and suicidal ideation. Parents and teachers may not be able to tell that youth are suicidal (Smith et al., 2003; Scott, et al., 2009), and youth may not step forward on their own to get help. The results from a screening indicate which students may need evaluation so that the school and their parents can help them receive evaluation and treatment, if needed. Treatment can prevent suicide as well as improve the student's behavioral health, school performance, social development, and future productivity (Center for Mental Health in Schools at UCLA, 2007). Schools can screen individual students who are thought to be at risk for suicide and/or other behavioral health problems or implement screening programs to screen large numbers of students.

Screening efforts should never be standalone programs. They are more effective when conducted as part of a comprehensive and strategic plan that begins with an assessment of the local context and the resources available to address the suicide problem.

When screening for suicide risk, it is important to have resources and systems in place to connect anyone identified as being at risk to appropriate follow-up care and assistance.

Schools that implement screening programs may experience an increase in the number of students who seek help for behavioral health and suicide-related problems. Schools should put in place these components before implementing screening:

- Protocols to respond to students at risk and in crisis
- Suicide prevention training for all school staff

Basic Information about Screening Programs

Format: Typically, a brief questionnaire is given to each student. If the screening is given in a group setting, pay special attention to ensuring that the questionnaires the students fill out are kept completely confidential. Those who screen positive are given a confidential interview as soon as possible by a mental health provider to assess whether they need a referral for more in-depth evaluation or treatment. Students who need help are referred to appropriate services.

Support of parents: Parents should be informed about the screening program, its purpose, and its value in order to gain their support, since schools often need a parent's consent before screening their child. In addition, parents need to be involved if a referral is indicated. Parent support can make a major difference in whether a child receives treatment. In tribal communities it may also be important to gain the support of tribal leaders and programs.

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Suicide Prevention Resource Center (SPRC). (1970, January 01). Suicide screening and assessment. Retrieved from http://www.sprc.org/resources-programs/suicide-screening-and-assessment

Support of school administrators and staff: School administrators and staff may resist screening programs because of the cost and logistics as well as a concern that the school will not be able to handle the number of students identified as at risk. They need to be made aware that screening programs can have significant benefits for students who are at risk, and for the school environment.

Steps to Plan and Implement a Screening Program

Step 1: Convene a group to plan and conduct a screening program. Determine which individuals will take the lead in planning and conducting a screening program. Use Tool 1.B: Chart of School Staff Responsibilities (see Chapter 1) to help you identify individuals and record the names of the people that should be a part of this group.

Step 2: Secure support from administrators and staff for a screening program. There are a number of ways to secure the support of administrators and staff for a screening program including: • Provide administrators and staff with information that describes the value of screening programs in high schools and strategies for overcoming the challenges • Connect administrators with peers who have implemented screening programs so that they can learn how the challenges were addressed and about the benefits of the program

Step 3: Determine which community mental health providers to use for referrals. Screening is likely to increase the number of students your school identifies as needing to see mental health providers. Look for local providers with whom to partner and

- Decide which ones would be good referrals for students who are at risk for suicide
- Determine whether you need to expand your network of providers to ensure that high-risk students receive a follow-up evaluation and treatment as soon as possible

Step 4: Select a screening program to use for the students at your school. It is important to base your selection of a screening program on information about how well programs may meet the needs of your students and school, including diversity in the students' cultural backgrounds. It can be very helpful to learn about other schools' experiences with implementing screening programs. To locate schools with this type of experience, contact the screening programs directly or ask your professional networks.

Step 5: Engage parents in the screening program.

- It is essential to determine whether there are any State, school district, tribal, Bureau of Indian Education, or program funder requirements about obtaining parental consent in order for your school to conduct a screening program.
- Obtaining parental consent can be challenging. Some parents do not want to consider the possibility that their child could have behavioral health problems or be suicidal. Some students may simply never

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Suicide Prevention Resource Center (SPRC). (1970, January 01). Suicide screening and assessment. Retrieved from http://www.sprc.org/resources-programs/suicide-screening-and-assessment

give the consent form to their parents, and some parents simply may never get around to signing the form.

*Note that all high school programs funded through the Garrett Lee Smith Act are required to obtain active parental consent when using screening programs. In addition, local, State, and Federal laws may require parental consent. For example, the Protection of Pupil Rights amendment (PPRA), which stipulates parental consent requirements for surveys administered in schools, may be applicable to screening programs in schools.

There are a number of methods that can help you gain parental consent, including the following:

- Inform parents about the screening program beforehand and provide them with information about the value of screening and the benefits of getting treatment when it is needed. In tribal communities, establish relationships with tribal leaders and programs to assist in informing families.

- Try strategies used in other schools. Talk with schools that have successfully implemented a screening program

PARENTAL CONSENT

Active Consent

Definition: A student can participate only if the parent gives explicit permission. Usually written permission is required. In some cases, verbal permission is accepted.

Pros*:* Ensures parents are informed and their approval is obtained. This engagement increases the likelihood that parents will help their child obtain treatment, if it is needed.

Cons*:* Often difficult to get responses (whether "yes" or "no") from parents. It takes more staff time than passive consent. Fewer students are likely to be screened.

Passive Consent

Definition: Notice about the program must be sent or given to the parent. Communication back to the school is only necessary if the parent does not want the student to participate. Lack of response from the parent means the student has permission to participate.

Pros: Ensures parents are informed and gives them an opportunity to deny their child participation. School staff do not have to spend time trying to get responses. Usually more students are screened than with active consent.

Continued on next page

Substance Abuse and Mental Health Services Administration. Preventing Suicide: A Toolkit for High Schools. HHS Publication No. SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2012

Suicide Prevention Resource Center (SPRC). (1970, January 01). Suicide screening and assessment. Retrieved from http://www.sprc.org/resources-programs/suicide-screening-and-assessment

Cons: Some parents might contact the school after the screening is done and say they never received notification about the screening program and object to it. If parental support is not obtained early, some parents might be less likely to consent to needed treatment for their child.

No Consent

Pros: No time or expense needs to be spent trying to get parent consent.

Cons: If parents are not notified about the screening program or they do not receive information that is sent home about it, some might object to it and be less likely to consent to needed treatment for their child.

Ideas for Maximizing Parental Response Rate

These ideas can help maximize the return rate of parental consent forms, whether the response is "yes" or "no" (Rodgers, 2006, except where otherwise noted) :

• Send the consent form home with students with a registration or "back to school" packet, other important forms, or a report card. Return rates improve if the form is sent with other materials that need to be signed by parents and returned to the school.

• Have parents sign the consent form at parent-teacher meetings or a school-based function, such as Back to School Night. Station school staff at a location where parents have to stop to complete forms.

• Provide incentives for returned forms (regardless of whether the response is "yes" or "no"):

  • Student incentives: Pencils, t-shirts, candy, movie cards, sports memorabilia (Brown & Grumet, 2009 for the last two), or a class party. Extra credit in health class or another class (Gutierrez & Osman, 2008).

  • Parent incentives: Gift cards for local stores or entries for prize drawings.

  • Teacher incentives: Gift cards when a specific number or percent of students return the form.

• Use a simple, easy-to-read, eye-catching, and culturally relevant letter and form printed on colored paper.

• Send a reminder notice with an additional form to parents who do not respond. Or call them.

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Program	Registry	Components	Grades	Number of Questions	Parental Consent
TeenScreen Schools and Communities	NREPP	Screening is the sole component. It may take place during a class period or after school. Teens complete a short screening questionnaire. Those at risk meet with a mental health professional. Those not at risk have a debriefing interview that allows teens to ask questions.	6-12	Columbia Health Screen, a 14-item paper and pen questionnaire, or Diagnostic Predictive Scales, a 52-item computerized questionnaire.	Active Required
SOS (Signs of Suicide)	NREPP	A curriculum of 1–3 lessons is the primary component, and screening is the main secondary component. Screening is done in a class period, usually at the end of a lesson, and is scored by students or staff. Those at risk are given an assessment interview. The screening is not done as a standalone program without the curriculum. The other secondary components are sample presentations for a 1-hour staff in-service and a parent education night	8-12	A 9-item paper and pen questionnaire. One version of screening tool is for parents to complete about their child. Both tools available in Spanish	Choice of active, passive or none (depending on school district policy)

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Suicide Prevention Resource Center (SPRC). (1970, January 01). Suicide screening and assessment. Retrieved from http://www.sprc.org/resources-programs/suicide-screening-and-assessment

Other Screeners and Screening Tools:

Student Risk Screening Scale (SRSS)

The Suicide Behaviors Questionnaire-Revised (SPQ-R): has 4 items, each tapping a different dimension of suicidality:

- Lifetime suicide ideation and/or suicide attempt
- Frequency of suicidal ideation over the past 12 months
- Threat of suicide attempt
- Self-reported likelihood of suicidal behavior in the future

PHQ-9 and **SAFE-T** and other regular screenings in primary care and other healthcare settings enable earlier identification of suicide risk and mental health disorders.

The MacArthur Depression Toolkit helps primary care clinicians recognize and manage depression. This toolkit includes user-friendly instruments to assist with recognizing, diagnosing, treating, and monitoring depression.

How Should I Choose a Suicide Screening or Assessment Instrument or Program?

You should choose an instrument or approach based on the following:

1. The evidence showing it will be effective with the population you are planning to screen or assess

2. The resources you have available to devote to this activity

Questions to ask when choosing an instrument or approach include the following:

» Has the instrument been evaluated and found effective?

» Is there a cost associated with using the instrument?

» For what age group was the instrument developed?

» How long does it take to screen or assess an individual?

» Who will conduct the screening or assessment? Paraprofessionals? Health care professionals? Mental health professionals?

» Does using the instrument require training? If so, how expensive is this training, and how many people will you need to train?

» If you are planning to implement screening, are you planning to screen universally or selectively?

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Suicide Prevention Resource Center (SPRC). (1970, January 01). Suicide screening and assessment. Retrieved from http://www.sprc.org/resources-programs/suicide-screening-and-assessment

It is also essential to remember the advice of the experts: Identifying a screening or assessment instrument—and training people to use it—is only part of the process. It is critical to be prepared to help individuals who are identified as being at risk to stay safe, receive clinical evaluation, and receive treatment. The following resources can help you make decisions about whether engaging in suicide screening or assessment is appropriate for your organization and setting and, if so, how to design and implement this process.

Resources for Choosing a Screening Program:

Assessment of Suicidal Behaviors and Risk among Children and Adolescents D. Goldston, National Institute of Mental Health (2000).
http://www.sprc.org/sites/sprc.org/files/library/GoldstonAssessmentSuicidalBehaviorsRiskChildrenAdolescents.pdf

This report describes instruments used to screen and assess suicidal behaviors and risk among children and adolescents.

Identifying and Assessing Suicide Risk Level National Action Alliance for Suicide Prevention (2014).
http://zerosuicide.actionallianceforsuicideprevention.org

This Web-based resource features information on suicide screening in health care and behavioral health settings as well as links to additional resources.

Finding Programs and Practices, Suicide Prevention Resource Center (2017). http://www.sprc.org/strategic-planning/finding-programs-practices

This page lists resources for finding programs and practices as well as how to use these sources effectively.

Responses to Screening: Protocols for Helping Students at Risk for Suicide

Why is it important to be prepared to help students at risk of suicide?

Many high school students reported that they had seriously considered suicide in the past year, and 1 out of 53 will make an attempt serious enough to require medical attention (CDC, 2010a).

Helping these young people lower their suicide risk is essential if schools are going to:

- Maintain a safe and secure school environment
- Promote the behavioral health of students, which enhances their academic performance
- Avoid liability related to suicides or suicide attempts by students

But before a school implements activities to identify students at risk of suicide, it must be prepared to:

- Help students at risk for suicide preserve their safety and access behavioral health services
- Respond to the infrequent event in which a student tries to take his or her own life in the school or on the campus
- Plan for the return of students after an absence related to suicide risk (including a suicide attempt or a hospitalization for the treatment of a mental health issue related to suicide risk)

Notifying Parents/Guardians

Parents or guardians of a young person identified as being at risk of suicide should be notified by the school and must be involved in consequent actions. Schools should comply with local, State, and Federal policies and laws regarding parental notification. If the school suspects the student's risk status is the result of abuse or neglect, school staff must notify the appropriate authorities.

Steps to Develop Protocols to Help Students at Risk of Suicide

Step 1: Convene a group to create protocols for helping students at risk of suicide. This group should include staff that would normally be involved in the care of at-risk students, including your school's mental health professionals: counselors, social workers, and school psychologists. The group should also include administrators, resource officers, teachers, and a member of the school Crisis Response Team. Tribal communities should include the Tribal Behavioral Health and Tribal Court representatives for children and families. If your school already has a process for identifying students at risk of suicide, you should include staff familiar with that process. Tool 1.B: Chart of School Staff Responsibilities (see Chapter 1) will help you identify and record the names of members of the school staff who should be involved in this effort.

Step 2: Identify the suicide risk response coordinator. Subsequent chapters in this guide will describe programs that schools can implement to increase the likelihood that students, staff members, and parents will be able to identify a student at risk for suicide. Everyone in the school should know that he or she must take suicidal behavior seriously and should know to whom to turn if he or she has a concern. Your planning group should take the following steps:

- Clearly designate at least one individual and one alternate who will serve as the points of contact for anyone in the building who is concerned that a student may be at risk. In this guide, the term "suicide risk response coordinator" refers to this point of contact.
- Make sure all staff know who the suicide risk response coordinator and the alternate are. Keep the list of contacts updated.
- Let all members of the school community know that anyone who has a concern should take immediate action to inform the school administrator, who will locate the suicide risk response coordinator or alternate. Also, let everyone know that a staff person should stay with the student until the suicide risk response coordinator arrives.

Step 3: Identify and involve mental health service providers to whom students can be referred. Many schools cannot directly provide appropriate mental health services for students at risk of suicide. It is important for these schools to identify mental health service providers to whom students can be referred and to involve these service providers while developing these protocols. These service providers may include:

- Hospitals, especially emergency departments and psychiatric units
- Psychiatric hospitals
- Community mental health centers
- Individual mental health service providers, including psychiatrists, psychologists, and social workers in both the public and private sectors
- Primary care providers
- Spiritual leaders or traditional healers to which members of some cultures may turn when confronted with behavioral health issues

In tribal communities, the hospitals, community mental health centers, and primary care providers may be part of the Indian Health Service (IHS). In this toolkit the general terms "hospitals," "community mental health centers," and "primary care providers," should be understood to include IHS services and Tribal Behavioral Health and Social Service programs.

Step 4: Develop a protocol to help students at risk for suicide. It is critical to have a protocol in place for helping students who have been identified as being at potential risk of suicide, as described in Step 2. All

staff should be aware of the protocol and follow it when appropriate. The protocol should include provisions for:

- Assessing suicide risk
- Notifying parents
- Referring to a mental health service provider
- Documenting the process

Assessing suicide risk.

School staff should make sure that all students who are identified potentially at risk for suicide are subsequently assessed for suicide risk. Suicide risk assessment is the process of determining an individual's level of risk, i.e., low, medium, or high. Such an assessment is critical to developing an individualized plan for ensuring the safety of the student and providing support and treatment. It should only be done by mental health professionals who have been trained to assess risk using a scientifically validated process. There are several ways that school staff can ensure that students at risk for suicide are appropriately assessed:

- School mental health staff who have been trained in suicide risk assessment can conduct the assessment.
- The student can be referred to a mental health provider who has been trained in suicide assessment.
- The school can contact a mental health provider or the National Lifeline to identify a local provider who can conduct a suicide risk assessment.

Notifying parents.

Parents or guardians (including guardians appointed by a Tribal Court) must always be notified when there appears to be any risk that a student may harm himself or herself, unless doing so would exacerbate the situation. Keep in mind that you will need to be prepared for a range of responses and emotions.

Referring the student to a community provider.

Students at risk for suicide may need to be referred to community resources. If your school already has a policy addressing referrals to health and mental health service providers, your referral procedure for suicide risk should be consistent with this policy, as well as any district, State, tribal, Bureau of Indian Education, or Federal policies and laws.

Documenting the process.

It is essential to document each step in the process by which a student is identified as possibly being at risk for suicide and assessed for suicide risk. This will help preserve the safety of the student and ensure communication among school staff, parents, and service providers.

Supporting Parents

Parents may experience a complex set of conflicting emotions when they are told their child may be suicidal, such as shock, anxiety, fear, confusion, embarrassment, anger, belligerence, and denial. They may experience some or all of these reactions. Parents usually need support and/or assistance to come to terms with their child's risk and their reaction to this risk, as well as the need to get professional help for their child and possibly for themselves.

Using Referral Data to Understand Your Students' Needs

The data included on referral forms can also be used to guide your suicide prevention efforts. One school district studies and patterns data from its mental health referral forms, including student information related to grade, race, gender, the month/year the referral was generated, and the specific problems or risk factors presented. By analyzing data over a 10-year period, they were able to identify the months with the greatest number of referrals for depressive symptoms and the specific grade levels with the highest referral rates. These data are allowing the school district and its mental health service partners to prepare and plan for this annual increase in referrals.

Maintaining Confidentiality

Student information needs to be kept confidential for both ethical and legal reasons, including a parent's or student's right to privacy under FERPA. This can be challenging. Here are some suggestions for ensuring confidentiality:

- Classroom discussions about particular incidents and students should be avoided entirely because they violate a student's right to confidentiality.
- Gossip about particular incidents and students should also be discouraged.

continued on next page

• If a student who has attempted suicide wishes to talk about his or her experience with other students in class, the teacher and a mental health professional or administrator should meet with the student to discuss what he or she would like to disclose and the possible risks of doing so.

• Staff should be provided with the information necessary to work with the student and preserve the young person's safety. Staff do not need clinical information about the student or a detailed history of his or her suicidal risk or behavior. Discussion among staff should be restricted to the student's treatment and support needs.

Step 5: Develop a protocol for responding to a suicide attempt in the school or on the school campus. Although students infrequently attempt suicide in schools or on a high school campus, such incidents do occur. Schools need to be prepared for such an event. Tool 2.C: Protocol for Responding to a Student Suicide Attempt outlines the actions to be taken and people to be contacted when a student attempts suicide on a school campus.

Step 6: Plan for managing a student's return to school. Schools should be prepared to facilitate the reentry of students who have missed school because of a suicide attempt or related behavioral health issue. Returning to school can be difficult for these young people:

- They may worry about the reactions of their peers and teachers.
- They may have problems catching up on their school work.
- They may be taking medications that can interfere with their academics.

These problems can create additional stress for students who are already under significant emotional strain. They need considerable support and monitoring, especially during the first several months they are back at school, during any school crisis, or near the anniversary of their attempt or mental health crisis. A staff member should be assigned to facilitate the student's return to the school. This might be a teacher or other staff member particularly trusted by the student and his or her family. Or it might be a school psychologist, social worker, or counselor. This staff member will be the primary point of contact for parents, hospital staff, clinicians, and school staff while the student is out of school, and he or she will oversee the student's reentry. Parents should be engaged in every step of this process. A reentry plan should be developed through consensus of the family, school, and providers.

Step 7: Help staff understand the protocols. All staff members need to be familiar with the protocols for helping students at risk of suicide in case they are called upon to participate in implementing the procedures outlined in the protocols. Briefing school staff about these protocols will also educate them about suicide risk and the problems experienced by students returning to school after a suicide attempt or mental health crisis. The protocols should be revisited every year. It is important to determine whether any staff member responsible for a specific activity has left his or her job. If so, his or her protocol responsibility should be assigned to someone else. It is also important to ensure that all new staff become familiar with these procedures.

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Suggestions for Educating Staff about Your School's Protocols

- Educate staff about the protocols during staff meetings or in-service trainings.
- Educate new staff about the protocols as part of their orientation.
- Remind staff about protocols in newsletters or communications on related issues.
- Include copies of the protocols in teacher handbooks and the school crisis plan.

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Intervention

How to Begin the Conversation

Before talking with someone you are concerned about, have suicide crisis resources available, such as the National Suicide Prevention Lifeline number, 1-800-273-8255 (TALK), or numbers and addresses of local crisis lines or treatment centers. Mention what signs prompted you to ask about how they are feeling. Mention the warning signs that prompted you to ask the person about how they are feeling, the words used, or behavior displayed (signs make it more difficult to deny that something is wrong).

Ways to Start a Conversation about Suicide:

"I have been feeling concerned about you lately."

"Recently, I have noticed some differences in you and wondered how you are doing."

"I wanted to check in with you because you haven't seemed yourself lately."

Questions You Can Ask:

"When did you begin feeling like this?"

"Did something happen that made you start feeling this way?"

"How can I best support you right now?"

"Have you thought about getting help?"

How to Ask About Suicide

Ask directly about suicide. Ask the question in such a way that is natural and flows over the course of the conversation. Ask the question in a way that gives you a "yes" or "no" answer. Don't wait to ask the question when the person is halfway out the door. Asking directly and using the word "suicide" establishes that you and the at-risk person are talking about the same thing, and lets them know you are not afraid to talk about it. Ask:

- "Are you thinking about killing yourself?"
- "Are you thinking about ending your life?"
- "Do you ever feel so bad that you think about suicide?"
- "Do you have a plan to kill yourself or take your life?"
- "Have you thought about when you would do it (today, tomorrow, next week)?"
- "Have you thought about what method you would use?"

How NOT to Ask the Question

"You're not thinking about killing yourself, are you?"

Save –Suicide Awareness Voices of Education

IHS –Indian Health Service "How to Talk about Suicide"

Do not ask the question as though you are looking for a "no" answer. Asking the question in this manner tells the person that although you assume they are suicidal, you want and will accept a denial.

Don't try to minimize problems or shame a person into changing their mind. Your opinion of a person's situation is irrelevant. Trying to convince a person suffering with a mental illness that it's not that bad, or that they have everything to live for may only increase their feelings of guilt and hopelessness. Reassure them that help is available, that what they are experiencing is treatable, and that suicidal feelings are temporary. Life *can* get better!

Validate the Person's Experience:

- Talk openly
- Don't panic
- Be willing to listen and allow emotional expression
- Recognize that the situation is serious
- Don't pass judgment
- Reassure that help is available
- Don't promise secrecy
- Don't leave the person alone

Get Help

Even if you feel the person isn't in immediate danger, acknowledge the pain is legitimate and offer to work together to get help. Make sure you follow through. This is one instance where you must be tenacious in your follow-up. Help find a doctor or a mental health professional, participate in making the first phone call, or go along to the first appointment. If you're in a position to help, don't assume that your persistence is unwanted or intrusive. Risking your feelings to help save a life is a risk worth taking.

Share available resources with the person. Be willing to make the call, or take part in the call to the National Suicide Prevention Lifeline at 1-800-273-8255 (TALK). The toll-free confidential Lifeline is available 24 hours a day, seven days a week.

Let the person know that you are willing to go with them to see a professional when they are ready. If you feel the situation is critical, take the person the closest Emergency Room or call 9-1-1. Do not put yourself in danger; if at any time during the process you are concerned about your own safety, or that the person may harm others, call 9-1-1.

Never negotiate with a person who has a gun, call 9-1-1 and leave the area.

If the person has done harm to him or herself in any way, call 9-1-1.

Assessing Suicide Risk

The purpose of suicide assessment is not to predict suicide, but to help you understand the student's situation.

Opening a concerned dialogue about suicide can provide a sense of relief to the student while allowing you to:

- Uncover any associated risk factors or conditions that can be modified
- Identify preventative factors to promote
- Understand the extent and seriousness of the suicidal thoughts
- Develop an informed intervention

SAFE-T is developed from the American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors and is a 5 step evaluation for suicide assessment. For more information on each of these steps, see below.

STEP 1: IDENTIFY RISK FACTORS

Use your conversation with the student, medical records, and any other collateral information to uncover potential risk factors such as:

Psychopathology. Focus on depression, bipolar disorder, schizophrenia, substance abuse, and personality disorders, which are strongly associated with suicide. These disorders are considered modifiable risk factors—diagnosis and appropriate treatment can diminish suicide risk. Suicidality has been associated with early depression or bipolar disorder, often before patients receive a diagnosis or effective treatment. Recovery and immediate post-discharge periods also are thought to be times of heightened suicide risk.

Psychosocial variables. Demographic and psychosocial variables may influence suicide risk estimation. Research on adolescents who have

Muzina, D. J. (2007). Suicide Intervention. Current Psychiatry, 6(9).

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attempted or completed suicide show the following psychosocial risk variables:

- Recent or serious loss (e.g., death, divorce, separation, broken relationship; self-esteem; loss of interest in friends, hobbies, or activities previously enjoyed)
- Family history of suicide
- Witnessing family violence
- Family history of child maltreatment
- Lack of social support
- Sense of isolation
- Victim of bullying or being a bully
- Easy access to lethal methods
- History of alcohol or substance abuse
- Impulsive or aggressive tendencies
- Unwillingness to seek help because of the stigma attached to mental health or to suicidal thoughts

Physical illness may potentiate suicide risk. Medical illnesses that produce great pain, disfigurement, limited function, or fear of dependence may reduce a person's will to live and increase suicide risk. Epilepsy has been associated with a 4- to 5-fold increase in suicide risk and is the only medical diagnosis to carry a documented increase in suicide among children and adolescents. Often these medical disorders coexist with psychiatric disorders, complicating the task of determining independent risk.

Severity of attempts or self-mutilation. When evaluating self-injurious or suicidal behavior in the emergency setting, consider the severity of the attempt as part of overall suicide assessment. Self-injurious behavior (cutting or burning) or impulsive suicide attempts (planned for <3 hours, committed in the presence others, or where discovery is very probable) appear to carry less severity or intent to die than do carefully planned and/or hidden suicide attempts. However, consider at high risk for suicide any student with self-mutilating or suicidal behavior who expresses persistent intent to die; acute stabilization on an inpatient unit may be necessary.

STEP 2: IDENTIFY PROTECTIVE FACTORS

Discover and discuss internal and external factors that might help prevent the individual with suicidal thoughts from converting those thoughts into action (see Table below). When discussing these potentially protective effects, emphasize the student's:

- resilience during past personal crises
- family or friend responsibilities
- religious or spiritual beliefs

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'No-harm contracts.' Suicide (or "no-harm") contracts with patients might help open communication about factors that promote or mitigate suicide risk. Such contacts do not prevent suicide or lessen medicolegal risk in the event of a patient suicide, however.

Potentially protective factors against suicide	
Internal	**External**
Skills in problem-solving, conflict resolution and handling problems in a non-violent way	Access to effective clinical care for mental, physical, and substance abuse disorders
Spirituality	Religious prohibition or beliefs
Successful past responses to stress	Restricted access to highly lethal means of suicide
Frustration tolerance/optimism	Support through ongoing medical and mental health care relationships
Overall individual resiliency	Family and community support (connectedness)

STEP 3: CONDUCT SUICIDE INQUIRY

Ask about suicide thoughts, plans, and behaviors (see Tables below). Probe gently to allow the individual to discuss his or her feelings and to explore the next appropriate avenue of care. According to Dr. David Muzina, patients who reveal passive suicidal ideation (such as, "I sometimes wish I would just die in my sleep") and strong deterrents to acting on thoughts of suicide (such as "It's against my religion") do not need to be placed in an in-patient facility, but should instead receive out-patient treatment. Those without deterrents or who discuss active and imminent thoughts and recent actions—writing suicide notes, buying a weapon, stockpiling pills—require emergent evaluation for psychiatric admission. Ask about thoughts of self-injury or mutilation (such as cutting or burning), as well as homicidal ideation.

Recognizing that patients with suicidal thoughts are almost always ambivalent about suicide to some extent—conflicted by simultaneous desires to live and to die—gives you the opportunity to intervene by allying with the part of the patient that wants to live. Creating a therapeutic connection also will help you determine the level of intervention required.

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Screening: uncovering suicidality

Transition Question: Confirm Suicidal Ideation

Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (Note: the transitional question is not part of scoring.)

1. Thoughts of carrying out a plan. Recently, have you been thinking about how you might kill yourself? If yes, consider the immediate safety needs of the patient.

2. Suicide intent. Do you have any intention of killing yourself?

3. Past suicide attempt. Have you ever tried to kill yourself?

4. Significant mental health condition. Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?

5. Substance use disorder. Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?

6. Irritability/agitation/aggression. Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?

Scoring: Score 1 point for each of the Yes responses on questions 1-6. If the answer to the transition question and any of the other six items is "Yes", further intervention, including assessment by a mental health professional, is needed.

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Assess suicide intent

- What would it accomplish if you were to end your life?
- Do you feel as if you're a burden to others?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g. held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?

Assess suicide plans

• Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?

• Do you have the (drugs, gun, rope) that you would use? Where is it right now?

• Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

STEP 4: DETERMINE RISK LEVEL / INTERVENTION

Understanding why a student feels suicidal—gathered in Steps 1 to 3—can help you choose the appropriate intervention. Among the 5 steps, Step 4 relies most heavily on clinical judgment:

• Is the suicidality acute or chronic?

• How great is the risk for suicide?

• To keep the student safe, how urgent is the required intervention?

At the low end of the spectrum, are students without thoughts of death or wanting to die, and without intent or a plan. Those with highly specific suicide plans, preparatory acts or suicide rehearsals, and clearly articulated intent are at the high end of the risk spectrum. Impaired judgement (being prone to substance abuse, impulsiveness, psychosis, etc.) further exacerbates that heightened risk. There is no screening tool that can predict with complete accuracy which students with suicidal risk will go on to make a suicide attempt, either fatal or nonfatal. However, the decision tree below is a snapshot of the pocket guide developed by the WICHE Mental Health Program and Suicide Prevention Resource Center for assessing suicide risk and determining an appropriate intervention and may provide guidance.

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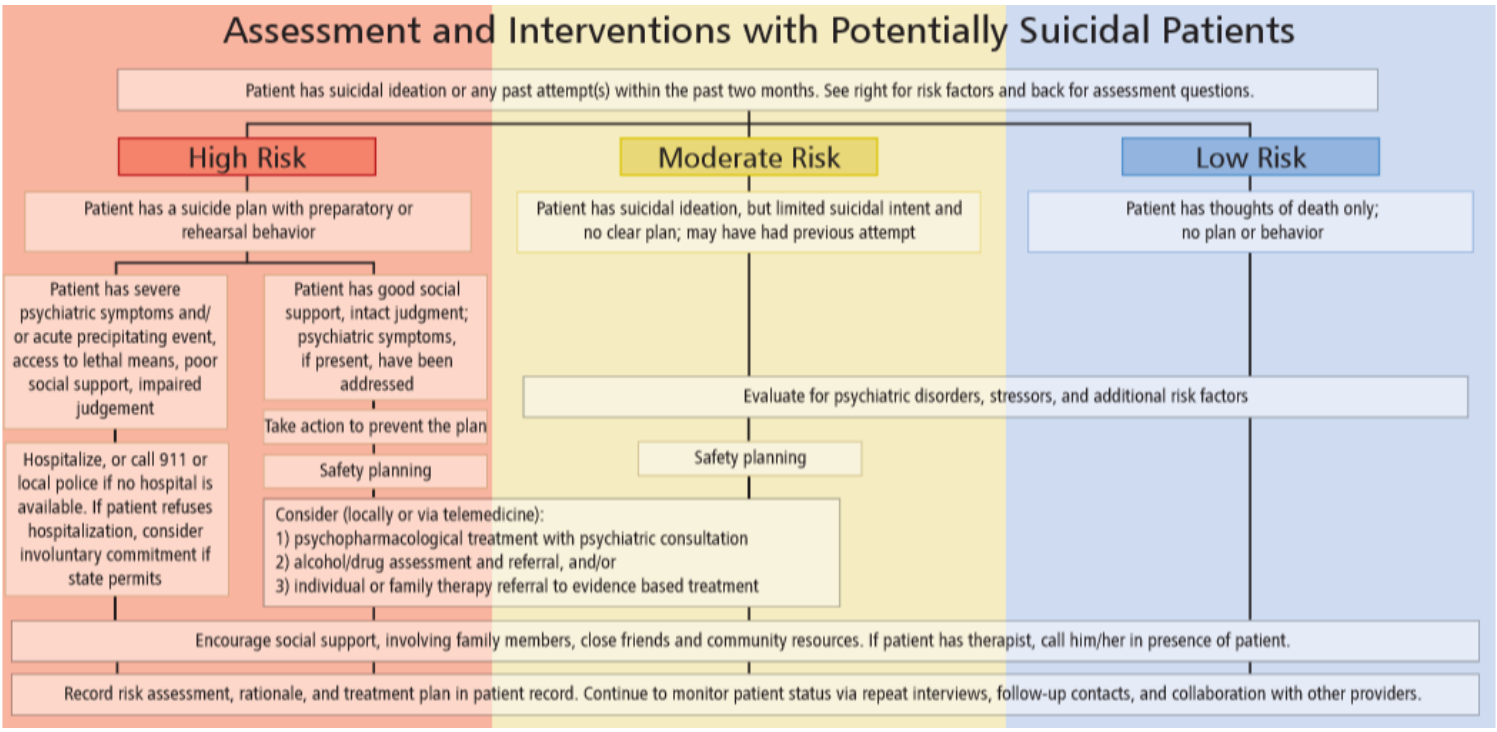

STEP 5: DOCUMENTATION

Document your assessment of the suicidal student and decision making to:

- clarify the intervention plan
- communicate to the caregivers
- manage risk.

Include a brief summary that is timely, legible, and communicates the estimated degree of risk, known data, and planned interventions such as consultations, connecting with resources, and follow-up reassessments.

Muzina, D. J. (2007). Suicide Intervention. Current Psychiatry, 6(9).

Western Interstate Commission for Higher Education Mental Health Program (WICHE MHP) & Suicide Prevention Resource Center (SPRC). (2017). Suicide prevention toolkit for primary care practices: A guide for primary care providers and medical practice managers (rev. ed). Boulder, Colorado: WICHE MHP & SPRC.

Implementing a Safety Plan: 6 Step Process

Step 1: Warning Signs

- Ask: “How will you know when the safety plan should be used?”
- Ask: “What do you experience when you start to think about suicide or feel extremely depressed?”
- List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the student’s own words.

Step 2: Internal Coping Strategies

- Ask: “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”
- Assess likelihood of use: Ask: “How likely do you think you would be able to do this step during a time of crisis?”
- If doubt about use is expressed, ask: “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to address potential roadblocks and ID alternative coping strategies.

Step 3: Social Contacts Who May Distract From the Crisis

- Instruct student to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Ask: “Who or what social settings help you take you mind off your problems at least for a little while?” “Who helps you feel better when you socialize with them?”
- Ask for safe places they can go to be around people (i.e. coffee shop).
- Ask patient to list several people and social settings in case the first option is unavailable
- Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- Assess likelihood that patient will engage in this step; ID potential obstacles, and problem solve as appropriate

Step 4: Family Members or friends Who May Offer Help

- Instruct student to use Step 4 if Step 3 does not resolve crisis or lower risk.
- Ask: “Among your family or friends, who do you think you could contact for help during a crisis?” or “Who is supportive of you and who do you feel that you can talk with when you’re under stress?”
- Ask patients to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, student reveals they are in crisis to others.
- Assess likelihood patient will engage in this step ; ID potential obstacles, and problem solve
- Role play and rehearsal can be very useful in this step

Western Interstate Commission for Higher Education Mental Health Program (WICHE MHP) & Suicide Prevention Resource Center (SPRC). (2017). Suicide prevention toolkit for primary care practices: A guide for primary care providers and medical practice managers (rev. ed). Boulder, Colorado: WICHE MHP & SPRC.

Step 5: Professionals and Agencies to Contact for Help

- Instruct the patient to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask “Who are the mental health professionals that we should identify to be on your safety plan?” and “Are there other health care providers?”
- List names, numbers, and/or locations of clinicians, local urgent care services.
- Assess likelihood patient will engage in this step; ID potential obstacles and problem solve.
- Role play and rehearsal can be very useful in this step.

Step 6: Making the Environment Safe

- Ask patients which means they would consider using during a suicidal crisis.
- Ask: “Do you own a firearm, such as a gun or rile?” and “What other means do you have access to and may use to attempt to kill yourself?”
- Collaboratively identify ways to secure or limit access to lethal means: Ask : “How can we go about developing a plan to limit your access to these means?”

Patient Safety Plan Template

Step 1. Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2. Internal coping strategies – things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3. People and social settings that provide distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____ 4. Place _____

Step 4. People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5. Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
2. Clinician Name _____ Phone _____
   Clinician pager or emergency contact # _____
3. Local Urgent Care services _____
   Urgent Care services address _____
   Urgent Care services phone _____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6. Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

Wellness Recovery Action Plan (WRAP)

WRAP is a self-management and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives.

WRAP is designed to

- Decrease and prevent intrusive or troubling feelings and behaviors
- Increase personal empowerment
- Improve quality of life
- Assist people in achieving their own life goals and dreams

WRAP is a structured system to monitor uncomfortable and distressing symptoms that can help you reduce, modify or eliminate those symptoms by using planned responses. This includes plans for how you want others to respond when symptoms have made it impossible for you to continue to make decisions, take care of yourself or keep yourself safe.

Step 1: Wellness Toolbox

This is a list of resources you can use to develop your WRAP. It includes things like contacting friends and supporters, peer counseling, focusing exercises, relaxation and stress reduction exercises, journaling, creative, fun and affirming activity, exercise, diet, light, and getting a good night's sleep.

Step 2: The Daily Maintenance Plan

This includes three parts: 1.) a description of yourself when you are well, 2.) those Wellness Tools you know you must use every day to maintain your wellness, and 3.) a list of things you might need on any day.

Step 3: Identifying Triggers

Start identifying those events or triggers that, if they happened, might make you feel worse--like an argument with a friend or getting a big bill. Then, using Wellness Tools, you develop an action plan you can use to get through this difficult time.

Step 4: Identify Early Warning Signs

Identify those subtle signs that let you know you are beginning to feel worse, like being unable to sleep or feelings of nervousness. Then, again, using your Wellness Toolbox, developing an action plan for responding to these signs you feel better quickly and prevent a possible difficult time.

Step 5: When Things are Breaking Down

In this section, you list those signs that let you know you are feeling much worse, like you are feeling very sad all the time or are hearing voices. And again, using your Wellness Toolbox, develop a powerful action plan that you that will help you feel better as quickly as possible and prevent an even more difficult time.

Copeland, M. (2005). My WRAP Plan. Retrieved August 2, 2018, from https://namiaustin.org/wp-content/uploads/2014/09/Developing-a-WRAP-Plan.pdf

Step 6: Crisis Plan

In the crisis plan, you identify those signs that let others know they need to take over responsibility for your care and decision making, who you want to take over for you and support you through this time, health care information, a plan for staying at home through this time, things others can do that would help and things they might choose to do that would not be helpful. This kind of proactive advanced planning keeps you in control even when it seems like things are out of control.

Step 7: Post Crisis Plan

You may want to think about this part of the plan in advance and even write some things to do in that time. However, you may want to write most of it as you are beginning to recover from the crisis-when you have a clearer picture of what you need to do for yourself to get well.

Review your plans every day, noting how you feel and doing what you need to do to help yourself get better or to keep yourself well. As you become familiar with your plan, you will find that the review process takes less time and that you will know how to respond without even referring to the book. People who are using these plans regularly and updating them as necessary are finding that they have fewer difficult times, and that when they do have a hard time it is not as bad as it used to be and it doesn't last as long.

Copeland, M. (2005). My WRAP Plan. Retrieved August 2, 2018, from https://namiaustin.org/wp-content/uploads/2014/09/Developing-a-WRAP-Plan.pdf

Reducing Access to Lethal Means

"Means reduction" (reducing a suicidal person's access to highly lethal means) is an important part of a comprehensive approach to suicide prevention. It is based on the following understandings:

Many suicide attempts occur with little planning during a short term crisis.

While some suicides are deliberative and involve careful planning, many appear to have been hastily decided-upon and to involve little or no planning. Chronic, underlying risk factors such as substance abuse and depression are also often present, but the acute period of heightened risk for suicidal behavior is often only minutes or hours long.

The Houston study interviewed 153 survivors of nearly-lethal suicide attempts, ages 13-34. Survivors of these attempts were thought to be more like suicide completers due to the medical severity of their injuries or the lethality of the methods used. They were asked: "How much time passed between the time you decided to complete suicide and when you actually attempted suicide?" One in four deliberated for less than 5 minutes.

Duration of Suicidal Deliberation:

- 24% said less than 5 minutes
- 24% said 5-19 minutes
- 23% said 20 minutes to 1 hour
- 16% said 2-8 hours
- 13% said 1 or more days

Intent isn't all that determines whether an attempter lives or dies; means also matter.

It is intuitive to think that those who attempt suicide and live were less intent on dying than those who died by suicide. While seriousness of intent plays a role in severity of attempt and choice of suicide method (means), the relationship is not a straight-forward one. Many studies find little relationship between intent and medical severity or between intent and choice of method. Other studies, however, do find a relationship. One reason for the mixed results is that other factors also play a role, such as the availability and acceptability of methods and attempters' knowledge of the likely lethality of a given method.

90% of attempters who survive do NOT go on to die by suicide later.

Nine out of ten people who attempt suicide and survive will not go on to die by suicide at a later date. This has been well-established in the suicidology literature. A literature review summarized 90 studies that have followed over time people who have made suicide attempts that resulted in medical care. Approximately 7% of attempters eventually died by suicide, approximately 23% reattempted nonfatally, and 70% had no further attempts. This relatively good long-term survival rate is consistent with the

Harvard T. H. Chan School of Public Health. (2018). Means Matter. Retrieved August 2, 2018, from https://www.hsph.harvard.edu/means-matter/

observation that suicidal crises are often short-lived, even if there may be underlying, more chronic risk factors present that give rise to these crises.

Access to firearms is a risk factor for suicide.

Every study that has examined the issue to date has found that within the U.S., access to firearms is associated with increased suicide risk. Guns are more lethal than other suicide means. They're quick. And they're irreversible. About 85% of attempts with a firearm are fatal: that's a much higher case fatality rate than for nearly every other method. Many of the most widely used suicide attempt methods have case fatality rates below 5%.

Firearms used in youth suicide usually belong to a parent.

An NVISS study of firearm suicides among youths ages 17 and under occurring over a two-year period in four states and two counties found that 82% used a firearm belonging to a family member, usually a parent. When storage status was noted, about two-thirds of the firearms had been stored unlocked. Among the remaining cases in which the firearms had been locked, the youth knew the combination or where the key was kept or broke into the cabinet

Reducing access to lethal means saves lives.

A number of studies have indicated that when lethal means are made less available or less deadly, suicide rates by that method decline, and frequently suicide rates overall decline. This has been demonstrated in a number of areas: bridge barriers, detoxification of domestic gas, pesticides, medication packaging, and others.

Harvard T. H. Chan School of Public Health. (2018). Means Matter. Retrieved August 2, 2018, from https://www.hsph.harvard.edu/means-matter/

Suicide Prevention:

Safeguarding Your Home

"Firearms are the most lethal and most common method of suicide in the U.S. More people who die by suicide use a gun than all other method combined. Suicide attempts with a firearm are almost always fatal, while other methods are less likely to kill.

Every U.S. study that has examined the relationship has found that access to firearms is a risk factor for suicides. Firearm owners are not more suicidal than non-firearm owners; rather, their suicide attempts are more likely to be fatal. Many suicide attempts are made impulsively during a short-term crisis period. If highly lethal means are made less available to impulsive attempters and they substitute less lethal means, or temporarily postpone their attempt, the odds are increased that they will survive."

Harvard School of Public Health, Means Matter Campaign *www.hsph.harvard.edu/means-matter/means-matter*

You can help prevent suicide by taking the following actions:

1. Remove or lock all firearms

- Store firearms out of the home especially if you think someone in your home is impulsive or suicidal.
- Some police departments or sheriff's offices will hold firearms temporarily. Call and explain your concern. (Don't take guns to the police department unless they tell you to.)
- Another option is to store them with a trusted friend or relative.
- If storing them elsewhere isn't an option, store all firearms unloaded and locked, and lock the ammunition in a separate location or remove it.
- Make sure the person you are concerned about doesn't have access to the keys/combination until the situation has improved.
- Remember, family members (especially teens) often know each other's hiding places.
- Firearms that must be carried as part of a job should be stored at work if possible.

2. "Suicide-proof" your medicine cabinet

For medicines your family needs

- Keep only non-lethal quantities on hand. (Your doctor or pharmacist can provide guidance.)
- Lock up the rest.

For medicines your family doesn't need or have expired

- See if your town has a drug take-back program.
- If not, empty the medicines into a sealable plastic bag, crush them or dissolve with water, add yucky stuff like coffee grounds or kitty litter, seal the bag and toss into the trash.
- Do not flush or pour down the drain unless the label says to.

- continued on back

Crisis Assistance

If someone you know is in crisis now, seek help immediately.

- Call 1-800-273-TALK (8255) to reach a 24-hour crisis center or dial 911 for immediate assistance or go to the nearest emergency department.
- Call CenterPointe Crisis Response Line at 402-475-6695.

For more information about what you can do to prevent suicide:

www.youthsuicideprevention.nebraska.edu

www.suicideprevention.nebraska.edu

For Additional Resource Information:

Nebraska Network of Care Website:
www.hhs.state.ne.us/networkofcare/

American Association of Suicidology
www.suicidology.org

Suicide Prevention Resource Center (SPRC)
www.sprc.com

Region VI Area Resources
http://www.regionsix.com/services/

Bryan MEDICAL CENTER

Notifying Parents and Guardians

Parents or guardians should be contacted as soon as possible after a student has been identified as being at risk for suicide. The person who contacts the family is typically the principal, school psychologist, or a staff member with a special relationship with the student or family. Staff need to be sensitive toward the family's culture, including attitudes towards suicide, mental health, privacy, and help-seeking.

1. Notify the parents about the situation and ask that they come to the school immediately.

2. When the parents arrive at the school, explain why you think their child is at risk for suicide.

3. Explain the importance of removing from the home (or locking up) firearms and other dangerous items, including over-the-counter and prescription medications and alcohol.

4. If the student is at a low or moderate suicide risk and does not need to be hospitalized, discuss available options for individual and/or family therapy. Provide the parents with the contact information of mental health service providers in the community. If possible, call and make an appointment while the parents are with you.

5. Ask the parents to sign the Parent Contact Acknowledgement Form confirming that they were notified of their child's risk and received referrals to treatment.

6. Tell the parents that you will follow up with them in a few days. If this follow up conversation reveals that the parent has not contacted a mental health provider:

- Stress the importance of getting the child help
- Discuss why they have not contacted a provider and offer to assist with the process

7. If the student does not need to be hospitalized, release the student to the parents.

8. If the parents refuse to seek services for a child under the age of 18 who you believe is in danger of self-harm, you may need to notify child protective services that the child is being neglected.

9. Document all contacts with the parents.

Supporting Parents through Their Child's Suicidal Crisis

Family Support is Critical. When an adolescent experiences a suicidal crisis, the whole family is in crisis. If at all possible, it is important to reach out to the family for two very important reasons:

First, the family may very well be left without professional support or guidance in what is often a state of acute personal shock or distress. Many people do not seek help—they don't know where to turn.

Second, informed parents are probably the most valuable prevention resource available to the suicidal adolescent.

Remember, a prior attempt is the strongest predictor of suicide. The goal of extending support to the parents is to help them to a place where they can intervene appropriately to prevent this young person from attempting suicide again. Education and information are vitally important to family members and close friends who find themselves in a position to observe the at-risk individual.

The following steps can help support and engage parents:

1. Invite the parents' perspective. State what you have noticed in their child's behavior (rather than the results of your assessment) and ask how that fits with what they have observed.

2. Advise parents to remove lethal means from the home while the child is possibly suicidal, just as you would advise taking car keys from a youth who had been drinking.

3. Comment on how scary this behavior is and how it complicates the life of everyone who cares about this young person.

4. Acknowledge the parents' emotional state, including anger, if present.

5. Acknowledge that no one can do this alone—appreciate their presence.

6. Listen for myths of suicide that may be blocking the parent from taking action.

7. Explore reluctance to accept a mental health referral, address those issues, explain what to expect.

8. Align yourself with the parent if possible…explore how and where youth get this idea…without in any way minimizing the behavior

Parent Contact Acknowledgement Form

This form is an example that can be used to verify that the parents have been advised of a student's suicide risk.

Parent Contact Acknowledgement Form

School _____

This is to verify that I have spoken with school staff member _____ ___ on _____ (date), concerning my child's suicidal risk. I have been advised to seek the services of a mental health agency or therapist immediately.

I understand that _____ (name of staff) will follow up with me, my child, and the agency to whom my child has been referred for services within two weeks.

Parent Signature: _____ Date: _____

Faculty Member Signature: _____ Date: _____

Postvention

Policies & Protocol: Best Practices

What is Postvention?

Postvention is an important intervention strategy aimed at attending to the needs of those requiring assistance after someone dies by suicide. It helps people grieve, but it also has the potential to help intervene with those who may be at greatest risk of suicide. As a wider community-level intervention, it's meant to reduce the incidence of suicide contagion through bereavement counselling and education. *Postvention is the first step in continued prevention.*

Why is it Important?

It's estimated that for every suicide victim, there are anywhere between 6 and 28 individuals, including family and friends, who are directly affected by the death. In a school, the reach of a suicide can be even greater. These individuals are at risk of post-traumatic stress disorder (PTSD), depression, suicidal thoughts, substance abuse and a worsening of pre-existing conduct problems. Those left behind by suicide often report receiving less social support than they felt necessary to deal with the death. Your community needs to take measures to provide care to those affected.

Guidelines for Responding to Death by Suicide:

Note: Research examining the effectiveness of postvention programs is limited and results of studies to-date are mixed. There is some evidence that some postvention strategies, including school-wide programs can be harmful. We need to continue to grow the evidence around postvention interventions by evaluating our work and sharing the lessons we've learned.

Interventions following the suicide or death of an individual should be based on four principles: **Support, learn, counsel, educate.**

A whole-community approach is important in postvention strategies – following a suicide, all relevant community partners need to work together.

These postvention guidelines have been adapted from The Riverside Trauma Center Postvention Guidelines.

- **Verify death and cause**
    - No information should be released until circumstances of the death are confirmed by the appropriate authorities.
    - Families may want to keep the cause of death private. They may need support exploring the pros and cons of sharing the cause of death.
- **Coordinate resources**
    - Mobilize a crisis response team comprised of local resource partners and people who are close to and familiar with the youth. The crisis response team should try to gather for an initial meeting within hours of the death.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

- Some organizations (e.g. schools or workplaces) may be inclined to handle the crisis on their own, but outside partners can assist by providing consultation to those unaware of how to support individuals experiencing loss. Outside resources can also ensure that those who are directly responding to the crisis are themselves supported.

- **Disseminate information**
  - The most effective way to provide details is in a written statement that can be distributed.
  - The statement should include factual information about the death (including acknowledgement that it was a suicide), condolences to the family, plans to provide support, information about funeral plans and any changes in work or school schedules over the coming days.

> ***Tips:***
>
> - **Don't read an announcement over a public address system. Rather, have a conversation in smaller groups (e.g. homeroom, team meetings, etc.). This will give you a better chance to gauge reactions.**
> - **Provide everyone with the same information to prevent rumors.**

- **Identify those at risk, support those most impacted by the death, and prevent contagion**
  - There are many people who may be impacted by the death, including family, close friends, fellow team/club members, colleagues, neighbors, a romantic partner, school staff and staff from agencies who may have been in close contact with the individual. Those impacted should be supported.
  - Friends and family of the deceased will experience the most acute loss and will require ongoing support. They should be at the center of your postvention efforts.
  - The emphasis should be on mourning the loss. This extends beyond support provided immediately following the death. Plan to care for vulnerable individuals at potentially sensitive milestones (e.g. birthdays or anniversaries).
  - Individuals deemed at risk need someone who knows them well to check on them and their family.
  - After a death by suicide, it's important to identify whether close friends or others are at risk of suicide or other risky behaviors. Those at risk could include individuals who:
    - have a history of suicidal behavior
    - experience depression
    - have a history of tragic loss or suicide in their family
    - identify with the deceased (regardless of whether they had a close relationship)
    - may have felt responsible for contributing to or who felt they could have prevented the suicide

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

Tips:

- **Many people will struggle to make sense of the why. This is an opportunity to remind people that suicide is never the result of a single factor, but rather is a convergence of many factors.**
- **Those at risk may not need an immediate referral or evaluation, but they should be encouraged to ask for support and should be made aware of those who can be of most help to them.**

- **Commemorate the deceased**
  - Commemoration activities should be the same for any death, regardless of the cause. Focus on the personal attributes that will be remembered, rather than the cause of death. Whole-community events during the school or work day with required participation are not ideal. Voluntary commemoration activities and funerals that are held after school or work hours are preferred.
  - Focus on facilitating healthy grieving as a necessary form of prevention (e.g. memorialize those lost to suicide by encouraging and supporting suicide prevention activities of local or national organizations, raising scholarship money through activities or becoming involved in helping other suicide survivors).
- **Provide psychoeducation on grieving, depression, post-traumatic stress disorder (PTSD) and suicide and link to resources**
  - Help individuals understand the grieving process and educate them about the signs and symptoms of depression, PTSD and suicide.
  - It's important to use an evidence-informed curriculum.
  - Link individuals and groups to resources for continued support as required.
  - Be sure to include contact information for emergency services.

Tips:

- **For younger people who haven't experienced a loss, it may be comforting to understand that their reactions are normal.**
- **Think beyond traditional resources. Consider resources for basic needs, addictions, sexual health and crisis resources.**

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

Crisis Response Teams and District Crisis Teams

When a school receives the news that one of its students has died by suicide, the first step is to make sure this news is true. In this age of social media and smartphones, it is easy for rumors to spread.

- School staff should immediately confirm the death of a student.
- Upon confirmation, the school should immediately implement a coordinated crisis response to achieve the following:
    - Effectively manage the situation
    - Provide opportunities for grief support
    - Maintain an environment focused on normal educational activities
    - Help students cope with their feelings
    - Minimize the risk of suicide contagion

Mobilize a Crisis Response Team

It is most effective for schools to have an identified Crisis Response Team set up and ready to respond to a crisis before one occurs. This team is responsible for implementing the elements of your school's crisis response plan.

Before a crisis occurs, find out whether your school district has a District Crisis Response Team that can provide additional support to your school if needed. Many districts have a Crisis Response Team to handle larger crisis events, with each school having its own Crisis Response Team.

This allows schools to pull from the district-wide team if they require additional support staff to meet the needs of their staff and students in the aftermath of a suicide. A district team is also beneficial if the school's Crisis Response Team is emotionally impacted in a way that makes it difficult for team members to engage in postvention activities effectively, or if they need extra support.

Depending on the size of the school or district, the school CrisisResponse Team should have at least 5 or 6 people (but no more than 15),chosen for their skills, credentials, and ability to work compassionately and effectively under pressure with all members of the school community. Ideally the team will be a combination of administrators, counselors, social workers, psychologists, nurses, and school resource officers. It can also be useful to include a member of the school's information technology staff to help with social media. The team should have the ability to work with all of the cultures represented by the students and their families.

The Crisis Response Team coordinator is usually the principal. The team coordinator:

- Has overall responsibility throughout the crisis
- Is the central point of contact
- Monitors overall postvention activities throughout the school
- Handles communications with the different groups of people within the school (e.g., administration, staff, students, and parents) and the media

A American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Depending on the needs of the school and its Crisis Response Team, the team coordinator may find it helpful to designate a member of the mental health staff to serve as an assistant coordinator for the team. This person assists the coordinator in the following activities:

- Coordinate communication among the staff, students, and community
- Share updates with Crisis Response Team members
- Work with the mental health team to organize safe rooms for students and staff in need of assistance
- Facilitate communication with parents when concerns arise about particular students

If an assistant coordinator is designated, that person can also fill in for the coordinator if he or she is not available. If an assistant coordinator is not designated, a back-up coordinator should be assigned by the coordinator for times when the coordinator is not available.

Team Member Activities When Responding to a Crisis

Crisis Response Team Coordinator's Tasks

- Inform the principal (if not already notified or designated as team coordinator) and school superintendent of the death.
- Contact the deceased's family to:
    - Offer condolences
    - Inquire as to what the school can do to assist
    - Ask them to identify the student's friends who may need assistance
    - Discuss what students should be told
    - Inquire about funeral arrangements

Note: Schools may establish a better rapport with the family if they make this contact in person.

- Call an immediate meeting of the Crisis Response Team to assign responsibilities.
- Establish a plan to immediately notify school staff of the death via the school's crisis alert system. If possible, this should be an in-person notification, especially for those who worked directly with the deceased student.
- Schedule an initial all-staff meeting as soon as possible—ideally before school starts in the morning
- Arrange for students to be notified of the death in small groups, such as in homerooms. Do not notify students by PA (public address) system or in a large assembly.
- Disseminate a death notification statement for students to homeroom teachers (see the tool Sample Death Notification Statement for Students). It is suggested that in the homeroom of the deceased student, it might be helpful to have a mental health professional (e.g., school psychologist, counselor, social worker) present as well as the teacher.
- Identify social media accounts that may need attention or monitoring, and designate a member of the crisis team to monitor them (for more information, see the Social Media section).

- Draft and disseminate a written death notification statement to parents (see the tool Sample Death Notification Statement for Parents.
- Disseminate the handouts Facts about Suicide in Adolescents, Tips for Talking about Suicide, and Youth Warning Signs to teachers and other relevant school staff to give them more information about suicide and how to help their students.
- Speak with the school superintendent and Crisis Response Team assistant coordinator throughout the day.
- Determine whether additional grief counselors, crisis responders, or other resources may be needed from outside the school.

Team Assistant Coordinator's Tasks

The following tasks may be delegated as appropriate to specific staff by the team coordinator if an assistant coordinator is not designated:

- Conduct an initial all-staff meeting.
- Conduct periodic meetings for the Crisis Response Team members.
- Monitor activities throughout the school, making sure teachers, staff, and Crisis Response Team members have adequate support and resources.
- Plan a parents' meeting, if necessary.
- Assign roles and responsibilities to Crisis Response Team members in the areas of safety, support for staff and students, community liaisons, funeral, media relations, and social media.

Other Key Activities

These activities can be implemented by the team coordinator, assistant coordinator, and/or other designated staff, depending on the activity and the specific situation:

Safety

- Keep to regular school hours.
- Ensure that students follow established dismissal procedures.
- Call on school resource officers or facilities managers to assist parents and others who may show up at the school with inquiries and to keep media off school grounds.
- Pay attention to students who are having particular difficulty, including those who are either withdrawing from others or congregating in hallways and bathrooms. Encourage them to talk with counselors or other appropriate school staff.

Support for Staff and Students

- Assign a staff member to follow the deceased student's schedule to monitor peer reactions and answer questions. It is also important to monitor staff reactions to the death.

- If possible, arrange for several substitute teachers or "floaters" from other schools within the district (or outside consultants) to be on hand in the building in case teachers need to take time out of their classrooms.
- If possible, identify an easily accessible mechanism for students to request support (e.g., be able to request a pass to meet with a counselor or others) throughout the day.
- Arrange for crisis counseling rooms for staff and students.
- Provide tissues and water throughout the building and arrange for food for teachers and crisis counselors who may be giving up lunch periods to respond to students.
- Work with the administration, teachers, and school mental health professionals to identify individuals who may be having particular difficulty, such as family members, close friends, and teammates; those who had difficulties with the deceased; those who may have witnessed the death; and students known to have depression or prior suicidality.
- Work with school-based mental health professionals to develop plans to provide counseling and referrals to those who need it.
- Prepare to track and respond to student and/or family requests for memorialization.

Community Liaisons

- Several team members will be needed, each serving as the primary contact for working with community partners of various types, including:
    - Coroner/medical examiner – To ensure accuracy of information disseminated to school community
    - Police – As necessary, particularly if an investigation about the death occurs, and the police wish to speak with school staff
    - Mayor's office and local government – To facilitate a community-wide response to the suicide death
    - Mental health and medical communities and grief support organizations – To plan for student, staff, and community needs
- Arrange for outside trauma responders, if necessary, and brief them as they arrive on scene.

Funeral

- Communicate with the funeral director about logistics for students and staff attending the services, including the need for crisis counselors and/or security to be present at the funeral.
- Encourage the family to hold the funeral off of school grounds and outside of school hours if at all possible.
- Be sensitive to the needs and wishes of different religious, ethnic, and racial groups that may be involved in the funeral.
- When possible, discuss with the family the importance of communicating with clergy/religious leaders, or whoever will be conducting the funeral, to ask if they are comfortable mentioning something about the struggles the student was having. When appropriate, include mental health concerns. While

ultimately this is the family and religious leader's decision, an informed discussion should occur where the family and religious leader are made aware of the benefits of providing this information as a way to promote understanding about suicide as well as to reduce possible contagion.

- Depending on the family's wishes, help disseminate information about the funeral to students, parents, and staff, including:
    - Location
    - Time of the funeral (keep school open if the funeral is during school hours)
    - What to expect (e.g., whether there will be an open casket)
    - Guidance regarding how to express condolences to the family
    - Policy for releasing students during school hours to attend (i.e., students will be released only with permission of parent, guardian, or designated adult)
    - Procedures for staff who want to attend (i.e., excused time away, getting substitute teachers)
- Work with school mental health professionals and community mental health professionals to arrange for counselors to attend the funeral.
- Encourage parents to accompany their child to the funeral.

Media Relations

- Designate a media spokesperson to field media inquiries.
- Prepare a media statement.
- Advise staff that only the media spokesperson is authorized to speak to the media.
- Advise students to avoid interviews with the media.
- Refer media outlets to recommendations for reporting on suicide.

Social Media

- Oversee the school's use of social media as part of the crisis response.
- See the Social Media section for details on monitoring social media.

Mobilizing a Crisis Response Team

Getting the Facts

A postvention plan should emphasize a single point of contact for information if the school learns of a student death. For example, the school principal would likely be the first person notified when anyone in the school learns of a student death.

Although it may not always be possible to immediately determine all of the details about a death, confirming as much factual information as possible before communicating with students is important. Speculation and rumors can exacerbate the emotional upheaval within the school. Time is also of the essence in confirming factual information since social media and other forms of communication may be occurring simultaneously, and it is possible that others, including students, may already have some information about the death.

It can be challenging for a school to determine how to proceed if the cause of death has not been confirmed to be suicide, if there is an ongoing investigation, or if the family does not want the cause of death disclosed. The school's principal or the superintendent should first check with the family, the coroner, and/or the medical examiner's office (or, if necessary, local law enforcement) to ascertain the official cause of death.

If the Cause of Death is Unconfirmed

If there is an ongoing investigation, schools should state that the cause of death is still being determined and that additional information will be forthcoming once it has been confirmed. Acknowledge that there may be rumors (which are often inaccurate), and remind students that rumors can be deeply hurtful and unfair to the missing/deceased person and his or her family and friends.

Given how quickly news and rumors spread (including through media coverage, e-mail, texting, and social media), schools may not be able to wait for a final determination before they need to begin communicating with the students. In those cases, schools can say, "At this time, this is what we know…" For a more complete example of how to talk with students about this, see Sample Death Notification Statement for Students for Unconfirmed Cause of Death.

The school attorney may wish to first research the applicable state law regarding discussing the cause of death before the school issues a statement. In addition, schools should check with local law enforcement before speaking about the death with students who may need to be interviewed by the authorities.

If the Family Does Not Want the Cause of Death Disclosed

Although the fact that a student has died may be disclosed immediately, official information about the cause of death should not be disclosed to students until the family has been consulted. The need to share information should be carefully balanced with honoring the family's request. Therefore, the school may choose to initially release a more general, factual statement without using the student's name if the family does not give permission (e.g., "We have learned that a ninth-grade student died over the weekend.").

There may be cases where the death has been declared a suicide, but the family does not want this communicated, perhaps due to prejudice, privacy concerns, or fear of risking contagion or because they simply do not (yet) believe or accept that it was suicide. If this situation occurs, someone from the administration or mental health staff who has a good relationship with the family should be designated to contact them to explain that students are already talking about the death among themselves, and that having adults in the school community talk with students about suicide and its causes can help keep students safe.

Schools have a responsibility to balance the need to be truthful with the school community with the need to be sensitive to the family. If the family refuses to permit disclosure, schools can state, "The family has requested that information about the cause of death not be shared at this time." But staff can also use the opportunity to talk with students about the phenomenon of suicide, for example:

> *We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in*

general, ways to prevent it, and how to get help if you or someone you know is feeling depressed or may be suicidal.

Share the News with the School Community

The principal or Crisis Response Team coordinator should use care in sharing the information about the death with staff and parents in the school community. This communication should be done separately from communications with students. Also, what is said publicly may be limited to some degree by the family's wishes, and it is important to distinguish what might be said in a public meeting (e.g., with parents) versus a meeting of necessary school staff (e.g., teachers who taught the deceased student).

In any communication about suicide, it is important to follow guidelines on safe messaging about suicide. It is particularly important to avoid idealizing the person and glorifying suicide. Talk about the person in a balanced manner. Do not be afraid to include the struggles that were known, especially in individual conversations about the death. If the student's struggles are not mentioned, it may cause confusion as well as give the impression that suicide is an effective way of addressing one's distress—especially among the other students.

Address Cultural Diversity

Postvention efforts need to take into consideration the cultural diversity of everyone affected by a suicide, including the family, school, and community. This diversity may include differences in race, ethnicity, language, religion, sexual orientation, and disability. Culture may significantly affect the way people view and respond to suicide and death.

Key points involving cultural differences include the following:

- Be aware that the extent to which people are able to talk about suicide varies greatly, and in some cultures suicide is still seen as a moral failing.
- Be sensitive to the beliefs and customs regarding the family and community, including rituals, funerals, the appropriate person to contact, etc.
- Be sensitive to how the family or community may need to respond to the death before individuals outside of the family or community intervene to provide support.
- Engage a "cultural broker" to act as a liaison between the family, community, and school if key members of school staff are not from the same racial, ethnic, or religious group as the person who died by suicide.
- Bring in interpreters and translators if there are language differences. If possible, have resource materials in different languages available for parents.

Memorials

Students often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. However, it can be challenging for schools to strike a balance between compassionately meeting the needs of grieving students and appropriately memorializing the student who died without risking suicide contagion among other students who may themselves be at risk.

Key Considerations

It is very important that schools develop a policy on memorialization before a suicide death occurs and ensure that the policy is in the school's suicide prevention procedures. 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 prejudice associated with suicide and may be deeply painful to the student's family and friends.

Nevertheless, because adolescents are especially vulnerable to the risk of suicide contagion, it is equally important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Focus on how the student lived, rather than how he or she died. If the student had underlying mental health problems, seek opportunities to emphasize the connection between suicide and those problems, such as depression or anxiety, that may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

Wherever possible, schools should meet with the student's friends and coordinate memorialization with the family in the interest of identifying a meaningful, safe approach to acknowledging the loss. Make sure to be sensitive to the cultural needs of the students and the family.

This section includes several creative suggestions for memorializing students who have died by suicide and a tool to assist with making decisions about school-related memorials.

Funerals and Memorial Services

It is strongly advised not to hold funeral and memorial services on school grounds. The school should instead focus on maintaining its regular schedule, structure, and routine. Using a room or an area of the school for a funeral service can inextricably connect that space to the death, making it difficult for students to return there for regular classes or activities.

It is also strongly advised that the service be held outside of school hours. If the family does hold the service during school hours, it is recommended that the school remain open and that school buses not be used to transport students to and from the service. Students should be permitted to leave school to attend the service only with appropriate parental permission. Regular school protocols should be followed for dismissing students over the age of majority.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

If possible, the school should coordinate with the family and funeral director to arrange for mental health professionals to attend the service. In all cases, the principal or another senior administrator should attend the funeral.

Schools should strongly encourage parents whose children express an interest in attending the funeral to attend with them. This provides not only emotional support but also an opportunity for parents to monitor their children's response, to open a discussion with their children, and to remind them that help is available if they or a friend are in need.

Spontaneous Memorials

It is not unusual for students to create a spontaneous memorial by leaving flowers, cards, poems, pictures, stuffed animals, or other items in a place closely associated with the student, such as his or her locker or classroom seat, or at the site where the student died. Students may even come to school wearing T-shirts or buttons bearing photographs of the deceased student.

The school's goal should be to balance the students' need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. If spontaneous memorials are created on school grounds, school staff should monitor them for messages that may be inappropriate (hostile or inflammatory) or that indicate students who may themselves be at risk.

A combination of time limits and straightforward communication regarding the memorials can help to restore equilibrium. Although it may be necessary in some cases to set limits for students, it is important to do so with compassion and sensitivity, offering creative suggestions whenever possible. For example, schools may wish to make poster boards and markers available so that students can gather and write messages. It is advisable to set up the posters in an area that may be avoided by those who don't wish to participate (i.e., not in the cafeteria or at the front entrance) and have them monitored by school staff.

Memorials may be left in place until after the funeral (or for up to approximately five days), after which the tribute objects may be offered to the family. Find a way to let the school community know that the posters are going to the family so that people do not think they were disrespectfully removed. For example, post a statement near the memorial on the day it will be taken down.

It is recommended that schools discourage requests to create and distribute images of the deceased, such as on T-shirts or buttons. Although these items may be comforting to some students, they may be quite upsetting to others. Repeatedly bringing images of the deceased student into the school can also be disruptive and inadvertently glamorize suicide. The school should prioritize protecting students who might be vulnerable to contagion over what might comfort students who want to remember the deceased student. If students come to school wearing such items, it is recommended that they be allowed to wear the items only for that day, and that staff explain to students the rationale for the school's policy. Some schools have found a middle ground with students, for example, by allowing them to wear wristbands that portray a positive message (i.e., Faith, Hope, Love) as a way to honor and remember the deceased.

Since the emptiness of the deceased student's chair can be unsettling and evocative, after approximately five days (or after the funeral), seat assignments may be re-arranged to create a new environment. Teachers should explain in advance that the intention is to strike a balance between compassionately honoring the student who has died, while at the same time returning the focus back to the classroom curriculum. Students may be involved in planning how to respectfully move or remove the desk; for example, they could read a statement that emphasizes their love for their friend and their commitment to work to eradicate suicide in his or her memory.

When a spontaneous memorial occurs off school grounds, the school's ability to exert influence is limited. It can, nevertheless, encourage a responsible approach among the students by explaining that it is recommended that memorials be time-limited (again, approximately five days, or until after the funeral), at which point the memorial would be disassembled, and the items offered to the family. The school may also suggest that students participate in a (supervised) ceremony to disassemble the memorial, during which music could be played, and students permitted to take part of the memorial home. The rest of the items would then be offered to the family.

Schools should discourage gatherings that are large and unsupervised. When necessary, administrators may consider enlisting the cooperation of local police to monitor off-campus sites for safety. Counselors can also be enlisted to attend these gatherings to offer support, guidance, and supervision.

It is not recommended that flags be flown at half-staff (a decision generally made by local government authorities rather than the school administration, in any event).

Online Memorial Pages

Posting on online memorial pages and messaging sites has become common practice in the aftermath of a death. Some schools (with the permission and support of the deceased student's family) may choose to establish a memorial page on the school website or on a social networking site. It is vital that memorial pages use safe messaging, include resources to obtain information and support, be monitored by an adult, and be time-limited.

It is recommended that online memorial pages remain active only for up to 30 to 60 days after the death of the student. At that time, they should be taken down and replaced with a statement acknowledging the caring and supportive messages that had been posted and encouraging students who wish to further honor their friend to consider other creative suggestions.

Schools should keep a copy of the memorial page after it has been taken down. This could be a print-out of the Facebook page or a series of screenshots, etc. The archive of the memorial page can serve as a reference later if there are concerns about the safety of students who left messages.

If the student's friends create a memorial page of their own, school staff should communicate with the students to ensure the page includes safe messaging and accurate information. School staff should join any student-initiated memorial pages so that they can monitor and respond as appropriate.

School Newspapers

Coverage of the student's death in the school newspaper may be seen as a kind of memorial. Articles may also be used to educate students about suicide warning signs and available resources. Having some focus on healthy coping, resilience, and recovery is also helpful. Any such coverage should be reviewed by an adult to ensure it conforms to the standards set forth in recommendations for reporting on suicide.

Events

The student's classmates may wish to dedicate an event, such as a dance performance, poetry reading, or sporting event, to the memory of their friend. End-of-the-year activities may raise questions of whether to award a posthumous degree or prize or to include a video tribute to the deceased student during graduation. The guiding principle is that all deaths should be treated the same way. Schools may also wish to encourage the student's friends to consider creative suggestions, as noted below, such as organizing a suicide prevention awareness or fundraising event.

Often, the parents of the deceased student express an interest in holding an assembly or other event to address the student body and describe the intense pain the suicide death has caused to their family in hopes that this will dissuade other students from taking their own lives.

While it is understandable that bereaved parents would wish to prevent another suicide death, schools are strongly advised to explain that both presenting this content and holding assemblies or other large events for students is not an effective approach to suicide prevention and may actually be risky. Students suffering from depression or other mental health issues may hear the messaging very differently from the way it is intended, and they may be even more likely to act on their suicidal thoughts. In addition, students are very reluctant to speak in an assembly and may be more trusting in a small group or classroom. A more helpful option is to encourage parents to work with the school to bring an appropriate educational program to the school, such as More Than Sad: Teen Depression, a DVD that educates teens about the signs and symptoms of depression, or others listed on the websites of SPRC and AFSP.

Yearbooks

If there is a history of dedicating the yearbook (or a page of the yearbook) to students who have died by other causes, that policy is equally applicable to a student who has died by suicide. Final editorial decisions should be made by an adult to ensure that it conforms to the standards in Recommendations for Reporting on Suicide. The staff member in charge of the yearbook should work with the principal and school mental health professionals on these decisions.

The focus should be on mental health and/or suicide prevention. Underneath the student's picture it might say, "In your memory, we will work to erase the prejudice surrounding mental health problems and suicide." The page mightalso include pictures of classmates engaging in a suicide prevention event, such as an AFSP Out of the Darkness Walk.

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Graduation

If there is a tradition of including a tribute to deceased students who would have graduated with the class, students who have died by suicide should likewise be included. Schools may wish to include a brief statement acknowledging and naming those students from the graduating class who have died. Final decisions about what to include in such tributes should be made by the principal and appropriate staff.

Permanent Memorials and Scholarships

Some communities wish to establish a permanent memorial: sometimes physical, such as planting a tree or installing a bench or plaque, and sometimes commemorative, such as a scholarship.

While there is no research to suggest that permanent memorials create a risk of contagion, they can be upsetting reminders to bereaved students. Whenever possible, it is recommended they be established off school grounds. The school should bear in mind that once it plants a tree, puts up a plaque, installs a park bench, or establishes a named scholarship for one deceased student, it should be prepared to do so for others, which can become quite difficult to sustain over time.

Creative Suggestions

Simply prohibiting any and all memorialization is problematic in its own right. It is deeply hurtful to the student's family and friends and can generate intense negative reactions.

Schools can play an important role in channeling the energy and passion of the students (and greater community) in a positive direction, balancing the community's need to grieve with the impact that the proposed activity will likely have on students, particularly on those who might be vulnerable to contagion.

Schools may proactively suggest a meeting with the student's close friends to talk about the type and timing of any memorialization. This can provide an important opportunity for the students to be heard and for the school to sensitively explain its rationale for permitting certain kinds of activities and not others. Schools may even wish to establish a standing committee composed of students, school administrators, and family members that can be convened on an as-needed basis.

Schools may also suggest specific types of safe memorialization for students, such as the following:

- Hold a day of community service or create a school-based community service program in honor of the
- deceased.
- Put together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., an AFSP Out of the Darkness Walk) or hold a fundraising event to support a local crisis hotline or other suicide prevention program.
- Sponsor a mental health awareness day.
- Purchase books on mental health for the school or local library.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

- Work with the administration to develop and implement a curriculum focused on enhancing social and emotional development and help-seeking behaviors.
- Volunteer at a community crisis hotline.
- Raise funds to help the family defray their funeral expenses.
- Make a book or notecards available in the school office for several weeks, in which students can write messages to the family, share memories of the deceased, or offer condolences. The book or notecards can then be presented to the family on behalf of the school community.

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Coping and Resiliency

In the aftermath of a suicide, students and others in the school community may feel emotionally overwhelmed. This can make it difficult for the school to return to its primary function of educating students and can also increase the risk of prolonged stress responses and even suicide contagion. A school's approach to supporting students after a suicide loss is most effective when it provides different levels of support depending on the students' needs. It is critical that an opportunity to meet in smaller groups be given to students in need of more in-depth support, augmenting the support given to all students.

Key Considerations

Adolescence is a time of increased risk for difficulties with emotional regulation given the intensification of responses that come with puberty and the structural changes in the brain that occur during this developmental period. Most adolescents have mastered basic skills that allow them to handle strong emotions encountered day to day. But these skills may be challenged in the face of a suicide. Young people may not yet have learned how to recognize complex feelings or physical indicators of distress, such as stomach upset, restlessness, or insomnia.

It is therefore important for schools to provide students with appropriate opportunities to express their emotions and identify strategies for managing them, such as in group and individual counseling sessions. Schools can also help students balance the timing and intensity of their emotional expression. Staff can use the information in the tool When & How to Have a Conversation to help students understand and manage their emotions.

If there are concerns about a student's emotional or mental health, the parent(s) or guardian(s) should be notified, and a referral should be made to a mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available in addition to school-based mental health professionals (e.g., school psychologists, counselors, social workers) include community mental health agencies, emergency psychiatric screening centers, and children's mobile response programs. Pediatricians and primary care providers can also be a source of mental health referrals. In addition, it may be useful for school staff to identify and reach out to families of students who are not coming to school.

When implementing these strategies, leadership will most likely be provided by the school psychologist, counselor, social worker, school nurse, and/or possibly a community mental health partner, all of whom may be members of the school's Crisis Response Team and likely trained in culturally competent counseling strategies. However, all adults in the school community can help by modeling calm, caring, and thoughtful behavior.

Why is Grief following Suicide Different?

Kalischuk and Hayes (2003-2004)[1] outline specific issues for the suicide bereaved:

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Waltham, MA: Education Development Center.

"Guidelines for Schools." Support After Suicide, www.supportaftersuicide.org.au/what-to-do/guidelines-for-schools.

- The grief is more intense and often never fully resolved
- The bereaved are more likely to become socially isolated and withdrawn because of the stigma that still surrounds suicide death
- The bereaved engage in a continuous search for the reason and are likely to assume greater responsibility for the death
- The bereaved experience significant guilt associated with not anticipating or preventing the suicide.

Possible Presentations:

Children - heightened insecurities (e.g. fearful, clingy, tearful) and regressive behaviors (eg. changes in eating, sleeping and toileting patterns).

Young People - increased risk-taking behaviors (use of alcohol / drugs, sexual activity, use of cars / motorbikes in unsafe ways), withdrawal from friends and family, sudden loss of interest / poor performance at school, engaging in 'attention-seeking' behaviors.

Adults - acutely distressed / agitated, in shock, withdrawn, depressed, unable to attend to usual responsibilities, hyperactivity, sensitized to own mortality, any range of bereavement and traumatic responses.

Responding to Suicide Bereavement

Children's Concepts of Death:

Children say things directly, simply and clearly. Their stage of development influences their understanding of death. There are three concepts that are important for children to grasp:

- Death is irreversible and final; it is not 'a trip'
- Death brings about non-functionality - life and body functions stop, the person is not asleep
- Death is inevitable - everyone will die some time

Most children understand these concepts by the age of 7 years. Children who are bereaved before the age of 7 are likely to come to a partial understanding of them earlier.

Ways of supporting a bereaved child or young person:

- Don't put a time limit on the process of grieving. Be available some time down the track
- Sit quietly with the young person and listen while he/she talks, cries or is silent
- Make opportunities to share memories or look at photos of the person who has died

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- Acknowledge and believe the young person's pain and distress whatever the loss - large or small
- Reassure the person that grief is a normal response to loss and there is no wrong or right way to grieve
- Don't panic in the absence or presence of strong emotional responses
- Provide a safe space; have a regular routine
- Be consistent, honest and reassuring
- Give honest, adequate and appropriate information
- Include and involve the child in appropriate decision-making and in what is happening
- Acknowledge feelings and give support when the child is overwhelmed by feelings
- Provide opportunities to remember, create a memory box and make a memory book, draw, paint, make a collage, write stories, poems, collect photos
- Be aware of the effect of special occasions and assist in preparation for them. E.g. Mother's Day, Father's Day, Christmas, Easter, holidays
- Be aware of your own grief and/or feeling of helplessness
- Provide information about grief - books, web sites

Within the school community:
A death can affect a school community at various levels. Those affected directly or indirectly may include an individual student's, teachers, other school staff, a class or student community and families. The experience of the death and associated grief will affect people in different ways.

Death by suicide will affect each individual and community differently. Some people may appear obviously affected while others may not. Regardless of those directly affected, the suicide death of a student, teacher or family member will have an impact on the community as a whole.

A suicide death may lead to shock, confusion, disbelief and anger, to name only some common responses. A suicide death often is often a stigmatized death and can lead to a lack of appropriate support for those affected.

It is also important to be aware that the effect of bereavement can go well beyond the initial crisis period. For those most affected, grief can be a long-term process. It can also have a cumulative effect as the impact ripples through a school community, sometimes unseen. In these circumstances, it can be important to find an appropriate way to commemorate the death.

Students, staff and families within the school community will each have unique responses, which will vary according to such factors as age, level of understanding, the person's character and their relationship to the person who has died, as well as previous experiences of grief and bereavement.

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Sometimes school communities are concerned that talking openly about a suicide death may lead to further suicides. However, the opposite is true. Open and honest accounts of suicide death and the provision of information and support are imperative to a school community.

Supporting a class:

Schedule meetings with students in small groups

Schools will likely need to adjust the regular academic schedule to allow time for helping students address their emotional needs. It is preferable to reach out to students in a deliberate and timely way, rather than allow the emotional environment to escalate, and to do so in homerooms and small group meetings.

All students should be provided with the opportunity to go to a small group meeting where they can express their feelings about the death of their classmate and obtain support. This type of group would be optional for students and should take place outside their classroom in private offices within the school. Ideally, these groups would be facilitated by a school mental health professional or another person experienced in postvention. However, if that is not possible, it is important that the staff who meet with students are comfortable with students' grief and know the school's procedure for addressing a student who is in distress and the importance of referring the student for help. Such small groups also provide a chance for adults to identify youth who appear in need of additional support.

These group meetings can either have a structured agenda and keep to a time limit or be open-ended and focus more on addressing the students' specific needs. It is important to provide each student with an opportunity to speak. The groups should focus on helping students identify and express their feelings and discuss practical coping strategies (including appropriate ways to memorialize the loss) so that they can return their focus to their regular routines and activities.

In addition to the small groups, it might be helpful to have mental health professionals visit classrooms to:

- Give all students accurate information about suicide
- Prepare students for the kinds of reactions that can be expected after hearing about a peer's suicide death
- Provide them with safe coping strategies they can use to help them in the coming days and weeks
- Answer questions students may have and dispel any rumors

If the deceased student participated in sports, clubs, or other school activities, the first practice, game, rehearsal, or meeting after the death may be difficult for the other students. These events can provide further opportunities for the adults in the school community to help the students appropriately acknowledge the loss.

Help Students Identify and Express Their Emotions

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Youth will vary widely in terms of emotional expression. Some may become openly emotional, others may be reluctant to talk at all, and still others may use humor. How they express their emotions may also be influenced by their cultural background. Acknowledge the diversity of experiences and the wide range of feelings and reactions to a crisis that students may have, and emphasize the importance of being respectful of others.

Some students may need help identifying emotions beyond simply sad, angry, or happy, and they may need reassurance that a wide range of feelings and experiences are to be expected. They may also need to be reminded that emotions may be experienced as physical symptoms, including butterflies in the stomach, shortness of breath, insomnia, fatigue, or irritability. To facilitate this discussion, ask students questions, such as:

- What is your biggest concern about the immediate future?
- What would help you feel safer right now?

It may help establish rapport to open a conversation by asking students what their favorite memories are of the student.

Practical Coping Strategies

Encourage students to think about specific things they can do when intense emotions, such as worry or sadness, begin to well up, for example:

- Use simple relaxation and distraction skills, such as taking three deep, slow breaths; counting to 10; or picturing themselves in a favorite calm and relaxing place
- Engage in favorite activities or hobbies, such as music, talking with a friend, reading, or going to a movie
- Exercise
- Think about how they have coped with difficulties in the past and remind themselves that they can use those same coping skills now
- Write a list of people they can turn to for support
- Write a list of things they are looking forward to
- Focus on personal goals, such as returning to a shared class or spending time with mutual friends

Often, youth will express guilt about having fun or thinking about other things. They may feel that they somehow need permission to engage in activities that will help them feel better and take their mind off the stressful situation.

Encourage students to think about how they want to remember their friend. Ideas may include writing a personal note to the family, attending the memorial service, creating a memory book, or doing something kind for another person in honor of their friend. Be sure to educate students about the school's guidelines regarding

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Waltham, MA: Education Development Center.

"Guidelines for Schools." Support After Suicide, www.supportaftersuicide.org.au/what-to-do/guidelines-for-schools.

memorialization. Acknowledging their need to express their feelings while helping them identify appropriate ways to do so can begin the process of returning their focus to their daily lives and responsibilities.

Schools, in partnership with community mental health resources, might also consider creating drop-in centers that provide a safe and comfortable place for youth to be together after school hours. These can be staffed by volunteer counselors and clinicians from the community who can provide grief counseling, as well as identify and refer youth who may need additional mental health or substance abuse services. These centers can also be used during times of particularly heightened emotion, such as graduation or the anniversary of a student's death.

Reach out to parents

Parents may need guidance on how to talk about suicide with their children and how best to support them at this difficult time. They may also need reliable information such as that found in "Warning Signs" and "When and How to Have a Conversation". Encourage parents to contact school mental health staff if they are concerned about their children or other students.

Talk with the class about grief

Provide students with adequate and accurate information about the death in consultation with the bereaved family. Clear and honest information is important to reduce gossip and uncertainty.

Listen and allow time

Listen to each student's particular experience and concern and give them time to talk about what has happened and how they feel.

Provide written information

Students may benefit from reading information about grief in private. Written information can take time to absorb and students may need time alone to deal with their feelings.

Provide flexible support

People grieve in their own time and in their own way, so providing flexible non-judgmental support is important. Allowing the students to have some quiet time and a quiet space is also important.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Waltham, MA: Education Development Center.

"Guidelines for Schools." Support After Suicide, www.supportaftersuicide.org.au/what-to-do/guidelines-for-schools.

Acknowledgement for those directly bereaved

A number of creative expressions of sympathy and memorialization are available to students and may be facilitated and coordinated by school staff. These include making and sending cards, pictures, photos and writing letters. If the students knew the person who died they may create a memory journal to be given to the family.

Anniversary of the Death

The anniversary of the death (and other significant dates, such as the deceased's birthday) may stir up emotions and can be an upsetting time for some students and staff. It is helpful to anticipate this and provide an opportunity to acknowledge the date, particularly with those students who were especially close to the student who died. These students may also need additional support since mourning can be a long-term process, and an anniversary of a loss can trigger the grief and trauma they experienced at the time of the death.

When the bereaved student returns to school

In addition to the above**,** a bereaved student returning to school after a suicide death may have specific needs. The following ideas may assist school staff:

Communicating with the bereaved student

Talk to and or visit the bereaved student before they return to school. This will provide an opportunity for the student to express how they are feeling about returning to school and what support they may specifically need.

Referral to local supports

Referral to counselling and support services may be of benefit to the bereaved student and family.

See the "Resources" section for a list of local and national coping resources.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). *After a suicide: A toolkit for schools* (2nd ed.). Waltham, MA: Education Development Center.

"Guidelines for Schools." Support After Suicide, www.supportaftersuicide.org.au/what-to-do/guidelines-for-schools.

Caring for the caregiver

Make yourself a priority.	•Self-care isn't a luxury - it's a necessity. Make time every day to care for yourself. •Think about the compassion that you extend to others and remind yourself that you also deserve and need that same kind of compassion.
Nurture your body.	•Exercise. Physical and mental fitness often go hand in hand. •Fuel your body in a healthy way. Get plenty of rest and eat well. •Breathe. Don't underestimate the power of deep breathing.
Reach out.	•Remember that you're not alone. Maintain a support network so that you can talk with family, friends, colleagues or someone you trust. •Supportive conversations with those who understand what you're going through may help you reflect on how you feel and how your experiences have affected you.
Practice mindfulness.	•Pay attention to your feelings, thoughts and what you're doing in the present moment. It can help settle the mind and body during periods of stress. •Try mediation, yoga or other simple stress reduction techniques.
Tune in.	•How do you think you're doing? Sometimes it can help to use a self-assessment tool to determine how well you're coping. •There are free tools available online.
Draw the line.	•Remember what your role is. Recognize where you 'stop' and where the young person you're helping 'begins.' •Make every effort to set clear boundaries between your work and home life.
Be kind to yourself.	•You're doing challenging work. Recognize that there are things you cannot control. •Resist the urge to blame or criticize yourself for what you think you should have done in a given situation.
Do what you know.	•What helps you cope when you're stressed? What activities do you enjoy? •Focus on healthy activities that bring you comfort and help you to feel calmer and safer when things are difficult.
Recognize red flags.	•Pay attention to what your mind and body is telling you. •For example, are you dreading work? Unable to sleep? Feeling hopeless? Learn to recognize your warning signs.
Seek help.	•You don't have to manage everything on your own. Connect with your doctor or a mental health professional who is not affected by the situation. •You may find that seeking help gives you a new perspective on the situation.

99 Coping Skills

1. Exercise (running, walking, etc.).
2. Put on fake tattoos.
3. Write (poetry, stories, journal).
4. Scribble/doodle on paper.
5. Be with other people.
6. Watch a favorite TV show.
7. Post on web boards, and answer others' posts.
8. Go see a movie.
9. Do a wordsearch or crossword .
10. Do schoolwork.
11. Play a musical instrument.
12. Paint your nails, do your make-up or hair.
13. Sing.
14. Study the sky.
15. Punch a punching bag.
16. Cover yourself with Band-Aids where you want to cut.
17. Let yourself cry.
18. Take a nap (only if you are tired).
19. Take a hot shower or relaxing bath.
20. Play with a pet.
21. Go shopping.
22. Clean something.
23. Knit or sew.
24. Read a good book.
25. Listen to music.
26. Try some aromatherapy (candle, lotion, room spray).
27. Meditate.
28. Go somewhere very public.
29. Bake cookies.
30. Alphabetize your CDs/DVDs/books.
31. Paint or draw.
32. Rip paper into itty-bitty pieces
33. Shoot hoops, kick a ball.
34. Write a letter or send an email.
35. Plan your dream room (colors/ furniture).
36. Hug a pillow or stuffed animal.
37. Hyperfocus on something like a rock, hand, etc.
38. Dance.
39. Make hot chocolate, milkshake or smoothie.
40. Play with modeling clay or Play-Dough.
41. Build a pillow fort.
42. Go for a nice, long drive.
43. Complete something you've been putting off.
44. Draw on yourself with a marker.
45. Take up a new hobby.
46. Look up recipes, cook a meal.
47. Look at pretty things, like flowers or art.
48. Create or build something.
49. Pray.
50. Make a list of blessings in your life.
51. Read the Bible.
52. Go to a friend's house.
53. Jump on a trampoline.
54. Watch an old, happy movie.
55. Contact a hotline/ your therapist.
56. Talk to someone close to you.
57. Ride a bicycle.
58. Feed the ducks, birds, or squirrels.
59. Color with Crayons.
60. Memorize a poem, play, or song.
61. Stretch.
62. Search for ridiculous things on the internet.
63. "Shop" on-line (without buying anything).
64. Color-coordinate your wardrobe.
65. Watch fish.
66. Make a CD/playlist of your favorite songs.
67. Play the "15 minute game." (Avoid something for 15 minutes, when time is up start again.)
68. Plan your wedding/prom/other event.
69. Plant some seeds.
70. Hunt for your perfect home or car on-line.
71. Try to make as many words out of your full name as possible .
72. Sort through your photographs.
73. Play with a balloon.
74. Give yourself a facial.
75. Find yourself some toys and play.
76. Start collecting something.
77. Play video/computer games.
78. Clean up trash at your local park.
79. Perform a random act of kindness for someone.
80. Text or call an old friend.
81. Write yourself an "I love you because..." letter.
82. Look up new words and use them.
83. Rearrange furniture.
84. Write a letter to someone that you may never send.
85. Smile at least five people.
86. Play with little kids.
87. Go for a walk (with or without a friend).
88. Put a puzzle together.
89. Clean your room /closet.
90. Try to do handstands, cartwheels, or backbends.
91. Yoga.
92. Teach your pet a new trick.
93. Learn a new language.
94. Move EVERYTHING in your room to a new spot.
95. Get together with friends and play Frisbee, soccer or basketball.
96. Hug a friend or family member.
97. Search on-line for new songs/ artists.
98. Make a list of goals for the week/ month/year/5 years.
99. Face paint.

BOYS TOWN National Hotline

www.yourlifeyourvoice.org

Suicide Contagion: Preventing Copycats

Key Considerations

Contagion is the process by which one suicide death may contribute to another. Although contagion is relatively rare (accounting for between 1 and 5 percent of all youth suicide deaths annually), adolescents and teenagers appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. It is also important to recognize the impact of highly publicized suicide deaths, such as those of celebrities, which may contribute to contagion.

If there appears to be contagion, schools should consider taking additional steps beyond the basic crisis response outlined in this toolkit to avoid suicidal behavior and deaths. It is advisable for schools to increase efforts to identify other students who may be at heightened risk of suicide, actively collaborate with community partners in a coordinated suicide prevention effort, and possibly bring in outside experts.

Identifying Other Students at Possible Risk for Suicide

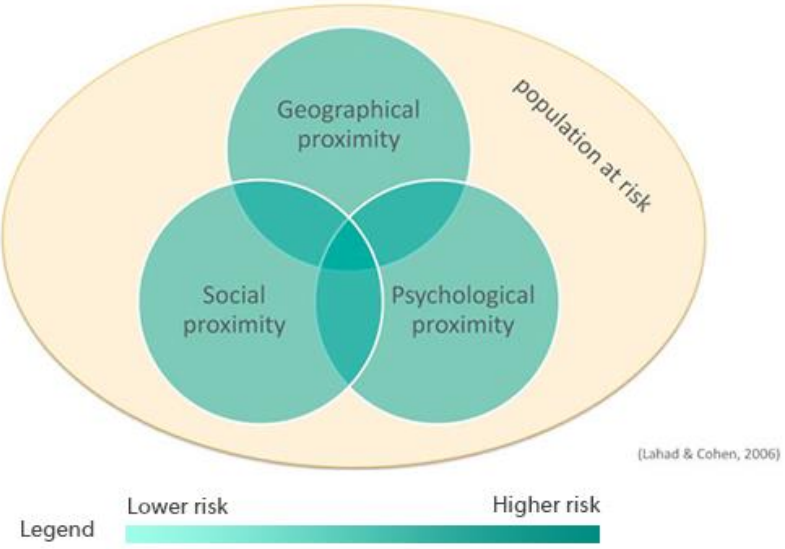
In the face of potential contagion, it is important for schools to use mental health professionals and others who have been trained to identify students who may be at heightened risk for suicide due to underlying mental disorders or behavioral problems (e.g., depression, anxiety, conduct disorder, and/or substance abuse) or who have been exposed to the prior suicide either directly (by witnessing the suicide or by close identification or relationship with the deceased) or indirectly (by extensive media coverage).

The circles of vulnerability model (see Figure on next page) can help determine the degree of emotional impact a death by suicide has on members of a community. Individuals most at risk following a suicide include those in geographical, social and psychological proximity to the individual who died by suicide.

- *Geographical proximity* refers to physical distance from the incident and includes those who were an eye-witness or exposed to the event. In addition, extensive, sensationalized and repetitive media coverage can broaden the impact of the event.
- *Psychological proximity* refers to those who relate to the victim through cultural connections, shared experiences (e.g. fellow victims of bullying, team members, classmates, etc.) or the perception of having similar characteristics.
- *Social proximity* refers to the relationships someone has with the person who displays suicidal behavior. This can include family, friends, social circles, or a romantic interest.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.



Of special concern are those students who:

- Have a history of suicide attempts
- Have a history of depression, trauma, or loss
- Are dealing with stressful life events, such as a death or divorce in the family
- Were eyewitnesses to the death
- Are family members or close friends of the deceased (including siblings at other schools as well as teammates, classmates, significant others, and acquaintances of the deceased)
- Received a phone call, text, or other communication from the deceased foretelling the suicide and possibly feel guilty about having missed the warning signs
- Had a last very negative interaction with the deceased
- May have fought with or bullied the deceased

Schools can also seek to identify those in the general student body who may be at heightened risk by using a mental health screening tool. It is advised that schools consult with mental health professionals on appropriate strategies for screening and assessment.

Connecting with Local Mental Health Resources

Schools should work with local primary care and mental health resources (including pediatricians, community mental health centers, and local private practice mental health clinicians) to develop plans to refer at-risk youth. Once these plans are established, they should be reviewed with all the school-based mental health professionals so that any student who is identified as being at high risk can be referred to a local mental health screening center or private practitioner for further evaluation.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

Suicide Clusters

The possibility of contagion resulting in multiple suicides in a community (also known as a suicide cluster) is rare. But if a potential cluster is suspected, at a minimum, school-based mental health professionals and/or trained outside professionals should be available to meet with distraught students for grief counseling and help them connect with other resources in the community.

Schools need to collaborate with community partners to effectively manage all aspects of reacting to possible contagion and preventing its spread. Many communities may already have a coalition focused on suicide prevention. It is often helpful for school officials and other designated persons to join these coalitions, particularly if contagion occurs. If a coalition does not exist at the local level, it is strongly recommended that the community build a community coalition as described in the section Working with the Community, or at least convene a coordinating committee that meets on a regular basis to work on these efforts.

Bringing in outside help can also be particularly valuable when contagion occurs or is suspected. See the next section for more detailed information.

If multiple suicides do occur, media coverage will likely be more extensive, and journalists may try to interview students, school administrators, and staff. A designated school spokesperson should proactively reach out to media outlets to ensure that media recommendations are followed.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

Social Media: After A Suicide

In the emotionally charged atmosphere that often follows a suicide death, schools may be inclined to try to control or stifle students' use of social tools such as texting, Facebook, Twitter, YouTube, Instagram, and Snapchat—a task that is virtually impossible. However, by working in partnership with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to disseminate information, share prevention-oriented messaging, offer support to students who may be struggling, and identify and respond to students who could be at risk.

Key Considerations

Following a suicide death, students may immediately turn to social media for a variety of purposes, including:

- Getting and sharing news about the death (both accurate and rumored)
- Expressing their feelings about what has happened
- Giving and receiving emotional support
- Calling for impromptu gatherings (both safe and unsafe)
- Creating online memorials (both moving and risky) and posting messages (both appropriate and hostile) about the deceased

The deceased person's social media page often becomes a place where friends and family talk about the suicide and the person who died.

Social media provides schools with a powerful set of tools to do the following:

- Disseminate important and accurate information to the school community
- Identify students who may be in need of additional support or further intervention
- Share resources for grief support and mental health care
- Promote safe messages that emphasize suicide prevention
- Minimize the risk of suicide contagion that could occur through glorifying suicide or describing details of the means used

Schools will be able to use social media most effectively and efficiently if they have set up policies and protocols and developed a presence on social media sites before a crisis takes place. Policies can include guidelines about how social media should be used (e.g., for broadcast, interaction, linkage). Protocols can include platform-specific templates that can be filled in and deployed rapidly in a crisis. Schools should determine which social media tools to use based on the culture and needs of their school community. Schools may also want to have a designated staff person serve as a social media manager to assist the school district's public information officer.

Involve Students

Students themselves are in the best position to assist in the school's efforts. They can:

- Help identify the particular media favored by the student body
- Engage their peers in honoring their friend's life appropriately and safely
- Inform school or other trusted adults about online communications that may be worrisome or inappropriate

It will enhance the credibility and effectiveness of social media efforts to have a designated member of the Crisis Response Team who is familiar with social media work in partnership with student leaders.

Students recruited to help should be reassured that school staff are only interested in supporting a healthy response to their peer's death, not in thwarting communication. They should also be made aware that staff are available to provide support if they see a social media post that indicates someone may be at risk of suicide.

Disseminate Information

Schools may already have a website and/or an online presence on one or more social media sites. These can be used to share information with students, teachers, and parents, for example:

- The funeral or memorial service (schools should check with the student's family before sharing information about the funeral)
- Where students can go for help or to meet with counselors
- Facts related to mental illness and the warning signs of suicide
- Local mental health resources
- The National Suicide Prevention Lifeline: 800-273-TALK (8255) or www.suicidepreventionlifeline.org for live chat
- Other national suicide prevention organizations, such as AFSP and SPRC
- Schools should emphasize help-seeking and suicide prevention. Students can also be enlisted to post this information on their own social media outlets

Monitor and Respond

Social media sites, including the deceased's wall or personal profile pages, should be monitored to whatever extent possible for the following:

- Rumors
- Information about upcoming or impromptu gatherings
- Derogatory messages about the deceased
- Messages that bully or victimize current students
- Comments indicating students who may themselves be at risk

Responses should emphasize safe messaging and dispel rumors, reinforce the connection between mental illness and suicide, and offer resources for mental health care. In some cases, it may be appropriate to go beyond replying online, for example, to notify parents and local law enforcement about the need for security at late-night student gatherings.

It may also be necessary in some cases to take action against so-called "trolls," who seek out memorial pages on social media sites and post deliberately offensive messages and pictures. Most services (e.g., Facebook, Twitter, Instagram) have a report mechanism or comparable feature that enables users to notify the site of the offensive material and request that it be removed. The administrator of the memorial page may also be able to block particular individuals from accessing the site.

On occasion, schools may become aware of posted messages indicating that another student may be at risk of suicide. Messages of greatest concern are those suggesting hopelessness or referring to plans to join the deceased student. In these instances, it may be necessary to alert the student's family, refer the student for immediate mental health services, and/or contact the National Suicide Prevention Lifeline to request that a crisis center follow up with the student.

Sample Information for Students

THIS INFORMATION SHOULD BE GIVEN TO TEACHERS AND OTHER STAFF TO READ TO STUDENTS AT A DESIGNATED TIME TO SHARE WITH THE ENTIRE STUDENT BODY (E.G., HOMEROOM OR FIRST/SECOND PERIOD).

It is with sadness that I tell you about a loss to our school family. On [DATE], [NAME OF DECEASED] [INSERT FACTS ABOUT DEATH].

I understand that many of you may have upsetting feelings and questions about [NAME OF DECEASED]'s death. I will try to answer any questions that I can. If you would like, we will take the remainder of this class period to talk about what has happened. At times like this, it is okay to have many different feelings, including sadness, anger, and disbelief. It is okay to cry. Together, we can talk about whatever you may be feeling or want to talk about. If I can not answer your questions, or you would like to talk to someone privately, there are support rooms now available [LOCATION OF SUPPORT ROOM(S)]. Anyone who would like to go to talk to someone in the support rooms may do so now. I will give you a pass.

[DETERMINE WHICH STUDENTS WOULD LIKE TO LEAVE FOR A SUPPORT ROOM. ASK THE REMAINING STUDENTS IF THEY HAVE ANY QUESTIONS OR COMMENTS THEY WOULD LIKE TO SHARE. TAKE TIME TO ANSWER AND TO TALK AS THE STUDENTS' DESIRE.

IF THERE IS NOT LENGTHY DISCUSSION, CONSIDER QUIET SEAT WORK RATHER THAN LESSON PLANS AS USUAL.]

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Letter to Parents after a Death

[DATE]

Dear Parent,

It is with deep regret that we inform you about a recent loss to our school community. On [DATE], [NAME OF DECEASED][1] [INSERT BRIEF FACTS ABOUT THE DEATH][2]. This loss is sure to raise many emotions, concerns, and questions for our entire school, especially our students.

Our school [AND, IF APPLICABLE, NAME OF SCHOOL DISTRICT] has a Crisis Intervention Team made up of a professionals trained to help with the needs of students, parents, and school personnel at difficult times such as this. At our school [OR INSERT NAME OF ALTERNATIVE SCHOOL], we have counselors available for any student who may need or want help or any type of assistance surrounding this loss. We encourage you, as parents, to also feel free to use our resources.

We have enclosed some information that may be useful to you in helping your child at home. If you would like additional information or need assistance, please do not hesitate to contact [NAME OF COMMUNICATIONS COORDINATOR OR COUNSELING SERVICES COORDINATOR] at [PHONE NUMBER AND/OR EMAIL].

We are saddened by the loss to our school community and will make every effort to help you and your child as you need.

Sincerely,

[NAME OF THE SIGNER AND TITLE. THIS LETTER IS USUALLY SIGNED BY THE PRINCIPAL, SUPERINTENDENT, OR CRISIS TEAM COORDINATOR.]

EXAMPLES OF INFORMATION TO INSERT IN THE OPENING PARAGRAPH:

[1]John Smith, one of our 9th grade students

Mrs. Jones, who taught 7th grade English

[2]was killed in an automobile accident, died after a long-illness, died suddenly, died by suicide (before inserting this information, be sure the immediate family is fine with this information being released)

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Letter to Staff: Confirmed Suicide

Date: [DATE]
To: All Staff
From: [NAME OF SCHOOL] Crisis Team
Re: [NAME OF DECEASED]

The recent death of [NAME OF DECEASED] *(has OR is expected to make)* a significant impact on our entire school community. Our crisis team has been mobilized to respond to this tragic event. On [DATE], [NAME OF DECEASED][1] died by suicide. We expect a variety of reactions to this loss from our students, parents, and you as members of our staff.

To assist all members of our school community, an emergency staff meeting will be held at [TIME] on [DATE] in the [MEETING LOCATION]. At that time, our crisis team will provide further details and answer questions. We will also discuss how to present the information to our students. In the meantime, please refer all inquiries from outside sources to [NAME OF THE MEDIA OR COMMUNICATION COORDINATOR].

If you are asked questions by individual students prior to the time of our meeting, you can acknowledge that this death has occurred. However, please avoid discussion of details; tell them that the school staff will provide information to everyone shortly. Please refer any student who appears to be in crisis or having significant difficulty to [NAME OF COUNSELING SERVICES COORDINATOR].

Suicide is a difficult topic to discuss. Students and staff will have questions and we will talk, in our meeting, about how to address these and how to provide support.

As this tragedy has affected all of us in different ways, we encourage you to also seek assistance, as needed, from [NAME OF COUNSELING SERVICES COORDINATOR].

Emergency Staff Meeting
Time:
Date:
Location:

If you have any questions or concerns before the meeting, please contact [NAME OF CRISIS TEAM COORDINATOR].

[EXAMPLES OF INFORMATION TO INSERT IN THE OPENING PARAGRAPH:

[1]*John Smith, one of our 9th grade students*
Mrs. Jones, who taught 7th grade English

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Letter to Staff: Death Notification

Date: [DATE]
To: All Staff
From: [NAME OF SCHOOL] Crisis Team
Re: [NAME OF DECEASED]

The recent death of [INSERT NAME] (*has OR is expected to make*) a significant impact on our entire school community. Our crisis team has been mobilized to respond to this tragic event.

On [DATE], [NAME OF DECEASED][1] [INSERT BRIEF FACTS ABOUT THE DEATH][2]. We expect a variety of reactions to this loss from our students, parents, and members of our staff. Some of these reactions may be mild, others may be more intense.

To effectively assist all members of our school community, an emergency staff meeting will be held at [TIME] on [DATE] in the [INSERT PLACE (SUCH AS THE CAFETERIA OR OTHER LARGE AREA)]. At that time, our crisis team will provide further details and answer questions. We will also discuss how to present the information to our students. In the meantime, please refer all inquiries from outside sources to [NAME OF THE MEDIA OR COMMUNICATION COORDINATOR].

With students, you can acknowledge that this death has occurred. However, please avoid discussion of any details; simply tell students that the school staff will provide information to everyone shortly. Please refer any student who appears to be in crisis or having significant difficulty to [NAME OF COUNSELING SERVICES COORDINATOR]. As this tragedy has also effected our staff, we encourage you to also seek assistance from [NAME OF COUNSELING SERVICES COORDINATOR], if desired.

Emergency Staff Meeting
Time:
Date:
Location:

If you have any questions or concerns before the meeting, please contact [NAME OF CRISIS TEAM COORDINATOR].

[EXAMPLES OF INFORMATION TO INSERT IN THE OPENING PARAGRAPH:

[1]John Smith, one of our 9th grade students/ Mrs. Jones, who taught 7th grade English

[2]was killed in an automobile accident / died after a long-illness / died suddenly / died by suicide (before inserting this information, be sure the immediate family consents with this information being released)

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Letter to Staff: Unconfirmed Suicide

Date: [DATE]
To: All Staff
From: [NAME OF SCHOOL] Crisis Team
Re: [NAME OF DECEASED]

The recent death of [NAME OF DECEASED] *(has OR is expected to make)* a significant impact on our entire school community. Our crisis team has been mobilized to respond to this tragic event. On [DATE], [NAME OF DECEASED][1] died by [INSERT FACTUAL INFORMATION KNOWN SUCH AS "FROM AN OVERDOSE OF PRESCRIPTION MEDICATION" OR "FROM DROWNING". IF THE FAMILY AGREED, THE FOLLOWING CAN BE INSERTED "WHICH AT THIS POINT IS FELT CONSISTENT WITH SUICIDE"]. We expect a variety of reactions to this loss from our students, parents, and you as members of our staff.

To assist all members of our school community, an emergency staff meeting will be held at [TIME] on [DATE] in the [MEETING LOCATION]. At that time, our crisis team will provide further details and answer questions. We will also discuss how to present the information to our students. In the meantime, please refer all inquiries from outside sources to [NAME OF THE MEDIA OR COMMUNICATION COORDINATOR].

If you are asked questions by individual students prior to the time of our meeting, you can acknowledge that this death has occurred. However, please avoid discussion of details; tell them that the school staff will provide information to everyone shortly. Please refer any student who appears to be in crisis or having significant difficulty to [NAME OF COUNSELING SERVICES COORDINATOR].

As this tragedy has affected all of us in different ways, we encourage you to also seek assistance, as needed, from [NAME OF COUNSELING SERVICES COORDINATOR].

Emergency Staff Meeting
Time:
Date:
Location:

If you have any questions or concerns before the meeting, please contact [NAME OF CRISIS TEAM COORDINATOR].

[EXAMPLES OF INFORMATION TO INSERT IN THE OPENING PARAGRAPH:

[1]John Smith, one of our 9th grade students
Mrs. Jones, who taught 7th grade English

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Message for Students: Confirmed Suicide

This message is designed to be presented by a familiar teacher or staff member to students in small groups such as homeroom or first period class.

With great sadness, I am here to tell you that one of your classmates/teachers/school staff, [NAME], has died by suicide (if suicide is presumed by the authorities and family based on the circumstance of the death, such as death by self-inflicted gunshot with a suicide note found at the scene, then summarize cause of death and say it is presumed to be suicide – "died by a gunshot wound that is presumed to be due to suicide") on (INSERT DATE or time such as "last night"). Whenever people take their own life, it leaves all of us with many questions and feelings. I want you to know that all of our teachers and staff are here to help in any way we can.

Suicide can be difficult to understand. It is usually the result of a mental illness, particularly depression. When people are very depressed, they have a hard time thinking clearly and often cannot make good choices or decisions. They may see death as the only solution to whatever problems they are facing. Sometimes people will show signs that something is wrong like talking about hurting themself or showing major changes in their behavior. But sometimes, there are no obvious signs that anything is wrong before they take their life. No matter what, it is very important to know that there are ways to help and that suicide should never be an option.

I understand that many of you may have upsetting feelings and questions about (INSERT name of deceased)'s death. If you would like, we will take the remainder, or a portion, of this class period to talk and answer your questions. At times like this, it is okay to have many different feelings, including sadness, anger, guilt and disbelief. It is okay to cry. Together, we can discuss whatever you may be feeling or want to talk about. If I cannot answer your questions, or you would like to talk to someone privately, there are support rooms available (INSERT where support rooms are located). Anyone who would like to go to talk to someone in the support rooms may do so now. I will give you a pass.

Determine which students would like to leave to visit a support room. Ask the remaining students if they have any questions or comments they would like to share. Take time to answer their questions and talk with them about what has occurred and how they are doing.

Be sure to remind students of the resources, such as Support Rooms and counseling staff, which are available in the school to help them with their own feelings or if they have concerns about their friends; be sure to include the phone number of a 24-hour suicide support helpline. Emphasize that students should not keep private if their peers share that they are depressed or thinking about harming themselves – they need to share this information with a trusted adult (such as a school counselor) who will keep the information confidential, but make sure that any student who needs help will receive it. If there is not a lengthy discussion, consider quiet seat work instead of regular class time.

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Sample Message for Students: Unconfirmed Suicide

To be delivered if the cause of death has not yet been confirmed as suicide and the family does not wish suicide to be discussed as the cause

This message is designed to be presented by a familiar teacher or staff member to students in small groups such as homeroom or first period class.

With great sadness, I am here to tell you that one of your classmates/teachers/school staff, [NAME], has died by (INSERT CAUSE OF DEATH such as "was struck by a train while crossing the railroad tracks") on (INSERT DATE or time such as "last night").

We understand that there have been rumors that [NAME]'s death was by suicide. The cause of [NAME]'s death has not yet been determined and therefore we do not know whether or not it was due to suicide. We ask that you do not contribute to these rumors as there is the possibility of spreading information that is wrong, making the death all the more difficult to cope with for [NAME]'s family and friends. As information that can be shared becomes available, we will do our best to share this with you.

Since there have been questions raised about suicide and we know this is an important topic, perhaps we can talk very briefly about suicide. Suicide is usually the result of a mental illness, particularly depression. When people are very depressed, they have a hard time thinking clearly and often cannot make good choices or decisions. They may see death as the only solution to whatever problems they are facing. Sometimes people will show signs that something is wrong like talking about hurting themself or showing major changes in their behavior. But sometimes, there are no obvious signs that anything is wrong before they take their life. No matter what, it is very important to know that there are ways to help and that suicide should never be an option. We do not know the cause of [NAMES]'s death, but did not want to ignore questions or concerns that some of you may have about depression or suicide.

I understand that many of you may have upsetting feelings and questions about (INSERT name of deceased)'s death. If you would like, we will take the remainder, or a portion, of this class period to talk and answer your questions. At times like this, it is okay to have many different feelings, including sadness, anger, guilt, and disbelief. It is okay to cry. Together, we can discuss whatever you may be feeling or want to talk about. If I cannot answer your questions, or you would like to talk to someone privately, there are support rooms available (INSERT where support rooms are located). Anyone who would like to go to talk to someone in the support rooms may do so now. I will give you a pass.

Determine which students would like to leave to visit a support room. Ask the remaining students if they have any questions or comments they would like to share. Take time to answer their questions and talk with them about what has occurred and how they are doing.

Be sure to remind students of the resources, such as Support Rooms and counseling staff, that are available in the school to help them with their own feelings or if they have concerns about their friends; be sure to include the phone number of a 24-hour suicide support helpline. Emphasize that students should not keep private if their peers share that they are depressed or thinking about harming themselves – they need to share this information with a trusted adult (such as a school counselor) who will keep the information confidential, but make sure that any student who needs help will receive it. Emphasize that you do not yet know the underlying cause of the death, but will share information as it becomes publicly available.

If there is not lengthy discussion, consider quiet seat work rather than continuing with the lesson plan as usual.

"Notification Templates." National Center for School Crisis and Bereavement, www.schoolcrisiscenter.org/resources/samples-templates/.

Postvention Training & Resources

Postvention Training

- **Connect: Training Professionals & Communities in Suicide Postvention & Response:** Connect is an interactive 2 day training which facilitates the creation of a comprehensive postvention plan for your community. Connect helps service providers respond in a coordinated and comprehensive way in the aftermath of a suicide or any sudden death. It fosters relationship building and the exchange of resources among participants. Prior to the training, Connect staff work with the host agency to identify and incorporate local cultural issues and begin planning how the training will be applied and sustained. Master trainer/clinicians conduct the six-hour training that includes activities, interactive case scenarios, discussion, PowerPoint, and printed materials. A three-day Train-the-Trainer is also available.
  Link: theconnectprogram.org

- **The Jason Foundation:** This online training module discusses creating an action plan for the aftermath of a suicide. The presenters examine the scope and magnitude of people that are affected by a suicide. The training module and research are presented by Dr. Scott Poland and Richard Lieberman, noted experts in the suicide prevention field.
  Link: jasonfoundation.com

Bringing in Outside Help

School crisis team members should remain mindful of their own limitations and consider bringing in crisis team members from other parts of their school district (if there are any), trained trauma responders from other school districts, and/or staff from local mental health centers to help them as needed. Often, crisis team members are also impacted by a suicide death, and it is important that they respond in a way that protects the school community while not diminishing or ignoring their own reactions to the death.

In especially complicated situations, schools may even consider bringing in local or national experts in school suicide postvention for consultation and assistance (provided that sufficient funding is available). Such steps should generally be taken in consultation with the community committee, and all outside experts must of course be carefully vetted and references and clearances checked.

Following is a list of national organizations that provide crisis response, postvention consultation, and training, and/or that can put schools in touch with appropriate experts:

- The National Association of School Psychologists' School Safety and Crisis Response Committee provides phone, e-mail, and onsite consultation.
- The National Institute for Trauma and Loss in Children (TLC) provides schools, agencies, and parents with names of TLC-certified trauma practitioners in their area who are available for consultation and referrals. TLC also has certified trauma trainers who can come to a school,

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

organization, or community to provide training on suicide crisis response and postvention as well as other trauma-related topics. Call 877-306-5256 or e-mail info@starr.org.

- The Dougy Center: National Center for Grieving Children & Families provides phone and onsite consultation and onsite training.

American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. (2018). After a suicide: A toolkit for schools (2nd ed.). Waltham, MA: Education Development Center.

Together to Live. Postvention: Best practices in postvention. Ottawa, Ontario: Ontario Centre of Excellence for Child and Youth Mental Health, 2016.

Metro Area LOSS Team

Local Outreach to Suicide Survivors

Support for those
impacted by suicide

The Metro Area LOSS Team

The Metro Area LOSS Team is based on a nationally recognized postvention effort to bring immediate support to survivors of suicide. LOSS acts as a first response team when a suicide occurs and works together with law enforcement officers, EMTs, first responders, chaplains, and school districts. Members of the LOSS team, which consists of survivor volunteers (persons who have experienced the suicide of a loved one) and mental health professionals, are activated by first response officials to the scene of the suicide and are present to offer resources, support, and sources of hope to the newly bereaved. Team members additionally provide follow up contact with survivors and help coordinate the utilization of services and support groups within the community.

Through programs such as LOSS, survivors are not only more likely to seek help for their own emotional response to the suicide, but are also at a significantly reduced risk to attempt or complete suicide themselves.

For more information on the Metro Area LOSS Team, contact:

402.891.6911 • LOSS@thekimfoundation.org

Metro Area LOSS Team Partners:

the kim FOUNDATION®

www.thekimfoundation.org

Region 6 Behavioral Healthcare

www.regionsix.com

NEBRASKA LOSS TEAMS Surviving Suicide

www.nelossteam.nebraska.edu

How can you help?

Become a LOSS Team Member

Are you a loss survivor or a mental health clinician? The Metro Area LOSS Team is always growing. Visit www.thekimfoundation.org and click on the Metro Area LOSS Team banner to apply today.

Spread the Word

Do you know a suicide survivor who is looking to share their story of hope or in need of resources? Contact The Kim Foundation® to learn about possible opportunities.

Stay Connected

Visit www.thekimfoundation.org to sign up for The Kim Foundation's monthly newsletter to stay up to date on the Metro Area LOSS Team and suicide prevention efforts in our community.

For more information or to refer a loved one, regardless of the time that has passed since their suicide loss, call The Kim Foundation during regular office hours at 402.891.6911 or email LOSS@thekimfoundation.org.

*"People don't always need advice. Sometimes all they really need is a **hand to hold**, an **ear to listen**, and a **heart to understand** them."*

~ Anonymous

Suicide Resources

Hotlines & Resources

- *National Suicide Prevention Lifeline* 800.273.TALK
- *Boys Town National Hotline*: 800.448.3000
- *Crisis Text Line*: Text HELLO to 741741
- *Nebraska Family Helpline*: 888.866.8660
- *The Trevor Project*: 866.488.7386
- *Your Life Your Voice*: yourlifeyourvoice.org
- *It's OK To Talk*: ok2talk.org

13 MINUTES

Suicide takes a life every 13 minutes.

KNOW THE SIGNS » **CHANGE** THE STATS »

KNOW THE SIGNS »

Learning the warning signs of suicide could save someone's life. While an individual may not be experiencing all of these warning signs, most will experience more than one and for an extended period of time. Some are obvious while some are more subtle, so it's important to know what to look for and what to do next if you do notice these behaviors in someone you care about. With each of these warning signs, watch for a change from the individual's typical behavior.

- » Withdrawal
- » Feeling trapped or in unbearable pain
- » Giving away possessions
- » Excessive drinking or substance use
- » Acting anxious or agitated
- » Talking about being a burden
- » Displaying extreme mood swings
- » Unexplainable physical pain
- » Changes in sleep
- » Risky reckless behavior
- » Saying goodbye
- » Feeling hopeless
- » Talking or writing about wanting to die
- » Increase in anger or rage
- » Looking for a way to kill themselves

GET HELP NOW »

If you are feeling suicidal or if you are concerned about an individual who is suicidal, there is immediate help available. A skilled, trained counselor at a crisis center is able to talk to you now and provide assistance.

Suicide Prevention Lifeline: 800.273.TALK (8255)

Boys Town National Hotline: 800.448.3000
Crisis Text Line: Text START to 741741
The Trevor Project: 866.488.7386
Your Life Your Voice: yourlifeyourvoice.org

RISK FACTORS

Definition: Things that have occurred or exist in someone's life that increase their chances of suicide. Please note, someone who has experienced one or more of these may never think of suicide, but risk increases the more factors that exist.

- History of physical or sexual abuse, trauma, violence, pain
- Death or other trauma in the family
- Persistent serious family conflict
- Personal loss – death, divorce, separation
- Traumatic break-ups of romantic relationships
- Job problems, unemployment, financial loss
- Legal/criminal issues
- School failures & other major disappointments
- Bullying, harassment, or victimization by peers
- Struggling with gender identity or sexual orientation without adequate support
- Family history of alcoholism
- Past suicidal behavior & attempts
- Access to firearms

CHANGE THE STATS

Suicide is the 2nd leading cause of death for 15-34 year olds in the US

1 in 6 students nationwide (grades 9-12) seriously considered suicide in the past year

Each year in Nebraska there are just as many suicide deaths as traffic deaths

Every 13 minutes a person dies by suicide in the US

HOW TO HELP

- Never leave someone who is suicidal alone
- Never keep thoughts or comments about suicide a secret
- Know the warning signs
- Take any and all comments about suicide very seriously
- Be direct, and not afraid to ask the question
- ACT – Acknowledge, Care, Tell

HOW TO HAVE THE CONVERSATION

Have suicide prevention resources in hand when starting the conversation. Be specific. Tell them exactly why you're concerned about them.

For instance:

- "I've noticed you stopped coming to _____ and you've lost interest in things you once enjoyed. I'm concerned about you. What's going on?"
- "You seem down lately. How have things been going at _____?"
- "Tell me more about how you're feeling."

Validate their feelings and provide them with support and resources.

- "You're not alone. We will get through this together."
- It's ok to say, "I want you to live."

See more at 13minutes.org/askthequestion

Metro Area
Suicide Prevention Coalition

The **Metro Area Suicide Prevention Coalition's** mission is to **inspire** our community in **preventing suicide** and promoting resilience through **conversation**, **education**, **support**, and **advocacy**.

For More Information:
Call: 402-891-6911
Email: info@thekimfoundation.org
Visit: www.thekimfoundation.org/Metro-Area-Suicide-Prevention-Coalition

The coalition meets every fourth Tuesday of the month from 8:15 – 9:45 a.m. and is open to the community.

Meeting Location:
C&A Industries
13609 California Street
2nd Floor - Webster Suites

You can make a difference in preventing suicide and providing hope. Get involved!

In crisis?

Text HELLO to 741741 and speak anonymously with a Crisis Counselor.

CRISIS TEXT LINE

Free, 24/7 support for people in crisis.

Lifelines

Issues and Options Surrounding a Student's Return to School Following a Suicide-related Absence

Students who have made a suicide attempt are at increased risk to attempt to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to provide assistance. Although necessary for effective assistance, it is often difficult to obtain information on the student's condition. If possible, secure a signed release from parents/guardians to communicate with the student's therapist/counselor. Meeting with parents about their child prior to his or her return to school is vital to making decisions concerning needed supports and the student's schedule.

Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some school staff, the family, the mental health professional, and the student will express concerns. The more common issues are listed in this document.

1. **Issue:** Social and peer relations

   Options:

   - Place the student in a school-based support group, peer helpers program, or buddy system.
   - Arrange for a transfer to another school if indicated.
   - Be sensitive to the need for confidentiality and how to restrict gossip.

2. **Issue:** Transition from the hospital setting

   Options:

   - Visit the student in the hospital or at home to begin the re-entry process with permission from the parents/guardians.
   - Consult with the student to discuss what support he or she feels is needed to make a more successful transition. Discuss what information faculty may need to facilitate a smooth re-entry.
   - Request permission to attend the treatment planning meetings and the hospital discharge conference.

- Arrange for the student to work on school assignments while in the hospital.
- Include the therapist/counselor in the school re-entry planning meeting.

3. **Issue:** Academic concerns on return to school

   Options:

   - Ask the student about his or her academic concerns and discuss potential options.
   - Arrange tutoring from peers or teachers.
   - Modify the schedule and adjust the course load to relieve stress.
   - Allow makeup work to be adjusted and extended without penalty.
   - Monitor the student's progress.

4. **Issue:** Medication

   Options:

   - Alert the school nurse to obtain information regarding prescribed medication and possible side effects.
   - Notify teachers if significant side effects are anticipated.
   - Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

5. **Issue:** Family concerns (denial, guilt, lack of support, social embarrassment, anxiety, etc.)

   Options:

   - Schedule a family conference with designated school personnel or home-school coordinator to address concerns.
   - Include parents in the re-entry planning meeting.
   - Reinforce the fact that the information the school needs to assist the student is limited to facilitating optimal school adjustment and performance, and does not include personal details of emotional distress.
   - Refer the family to an outside community agency or private practitioners for family counseling services.
   - Include information about community agencies with a sliding fee scale.

6. **Issue:** Behavior and attendance problems

   Options:

   - Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
   - Discuss concerns and options with the student.
   - Consult with discipline administrator.
   - Request daily attendance reports from the attendance office.
   - Schedule home visits or regular parent conferences to review attendance and discipline records.
   - Arrange for counseling for the student.
   - Place the student on a sign-in/sign-out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

7. **Issue:** Ongoing support*

   Options:

   - Assign a school liaison to meet regularly with the student at established times. Try to assign someone who already has a relationship with the student. Talk to the student about his or her adjustment.
   - Maintain contact with the therapist and parents.
   - Ask the student to check in with the school counselor daily/weekly.
   - Utilize established support systems, student assistance teams, support groups, friends, clubs, and organizations.
   - Schedule follow-up sessions with the school psychologist or home-school coordinator.
   - Provide information to families regarding available community resources when school is not in session.

* In the event that a student loses a family member to suicide, school personnel should understand that suicide evokes a special, complicated grief and most of the ongoing support considerations mentioned in #7 would also apply.

For Parents: Talking to your Kids about Suicide

Every parent would like to believe that suicide is not relevant to them or their family or friends.

Unfortunately, it's all too relevant for all of us. It's the 3rd leading cause of death in adolescents and the 2nd for college aged students. Even more disturbing are national surveys that tell us that 16% of high school students admit to thinking about suicide and almost 8% acknowledge actually making an attempt. The unfortunate truth is that suicide can happen to ANY kid in ANY family at ANY time!

So how do you deal with this reality? Once you acknowledge that suicide is as much risk for your child as not wearing a seat belt while driving, or using alcohol or drugs, or engaging in risky sexual behavior, you've taken the first step in prevention. You talk to your children about these other behaviors which can put them at personal risk, and suicide is no different. It's something you CAN and SHOULD talk about with your children!

Contrary to myth, talking about suicide CANNOT plant the idea in someone's head! It actually can open up communication about a topic that is often kept a secret. And secrets that are exposed to the rational light of day often become less powerful and scary. You also give your child permission to bring up the subject again in the future.

If it isn't prompted by something your kid is saying or doing that worries you, approach this topic in the same way as other subjects that are important to you, but may or may not be important to your child:

- Timing is everything! Pick a time when you have the best chance of getting your child's attention. Sometimes a car ride, for example, assures you of a captive, attentive audience. Or a suicide that has received media attention can provide the perfect opportunity to bring up the topic.

- Think about what you want to say ahead of time and rehearse a script if necessary. It always helps to have a reference point: ("I was reading in the paper that youth suicide has been increasing..." or "I saw that your school is having a program for teachers on suicide prevention.")

- Be honest. It this is a hard subject for you to talk about, admit it! ("You know, I never thought this was something I'd be talking with you about, but I think it's really important"). By acknowledging your discomfort, you give your child permission to acknowledge his/her discomfort, too.

- Ask for your child's response. Be direct! ("What do you think about suicide?"; "Is it something that any of your friends talk about?"; "The statistics make it sound pretty common. Have you ever thought about it? What about your friends?")

- Listen to what your child has to say. You've asked the questions, so simply consider your child's answers. If you hear something that worries you, be honest about that too. "What you're telling me has really gotten my attention and I need to think about it some more. Let's talk about this again, okay?"

- Don't overreact or under react. Overreaction will close off any future communication on the subject. Under reacting, especially in relation to suicide, is often just a way to make ourselves feel better. ANY thoughts or talk of suicide ("I felt that way awhile ago but don't any more") should ALWAYS be revisited. Remember that suicide is an attempt to solve a problem that seems impossible to solve in any other way. Ask about the problem that created the suicidal thoughts. This can make it easier to bring up again in the future ("I wanted to ask you again about the situation you were telling me about...")

Here are some possible warning signs that can be organized around the word "FACTS":

- **FEELINGS** that, again, seem different from the past, like hopelessness; fear of losing control; helplessness; worthlessness; feeling anxious, worried or angry often

- **ACTIONS** that are different from the way your child acted in the past, especially things like talking about death or suicide, taking dangerous risks, withdrawing from activities or sports or using alcohol or drugs

- **CHANGES** in personality, behavior, sleeping patterns, eating habits; loss of interest in friends or activities or sudden improvement after a period of being down or withdrawn

- **THREATS** that convey a sense of hopelessness, worthlessness, or preoccupation with death ("Life doesn't seem worth it sometimes"; "I wish I were dead"; "Heaven's got to be better than this"); plans like giving away favorite things, studying ways to die, obtaining a weapon or stash of pills; suicide attempts like overdosing or cutting

- **SITUATIONS** that can serve as "trigger points" for suicidal behaviors. These include things like loss or death; getting in trouble at home, in school or with the law; a break-up; or impending changes for which your child feels scared or unprepared

If you notice any of these things in kids who have always been impulsive, made previous suicide attempts or threats or seem vulnerable in any way, you really should get consultation from a mental health professional.

Resources

Guides

Ensuring the Seventh Generation: A Youth Suicide Prevention Toolkit for Tribal Child Welfare Programs

Author: National Indian Child Welfare Association

Date: 2009

Web link: http://www.nicwa.org/YouthSuicidePreventionToolkit/YSPToolkit.pdf

Description: Although this toolkit is intended for tribal child welfare workers and care providers, it has sections that are relevant for staff working in schools. In addition to discussing general risk and protective factors and warning signs for suicide among youth and for LGBTQ youth as well as child welfare related risk factors, it also includes several articles that address issues particularly relevant to suicide prevention among tribal youth.

Garrett Lee Smith Suicide Prevention Toolkit (Also called Getting Started)

Author: Mental Health America of Wisconsin Date: 2007

Web link: http://www.mhawisconsin.org/gls_toolkit.aspx

Description: This online resource collection contains a wide variety of materials useful for starting a youth suicide prevention program. They are listed under nine different topic sections, including making the case for developing a program, coalition building, youth screening programs and classroom curricula, gatekeeper training, crisis planning and postvention, evaluation tools, and information on obtaining funding.

Guidelines for School-Based Suicide Prevention Programs

Author: American Association of Suicidology, Prevention Division

Date: 1999

Web link: http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf

Description: This set of guidelines describes the conceptual basis for school-based suicide prevention programs; requirements for effective prevention programs, effective implementation, and effective retention of programs over time; and the key components of school-based suicide prevention programs. These guidelines are used as part of the criteria for inclusion of programs in the Best Practices Registry.

Research-Based Guidelines and Practices for School-Based Suicide Prevention

Author: Deborah Kimokeo, National Center on Child Fatality Review

Date: 2006 Web link: http://ican-ncfr.org/documents/SchoolSuicide.pdf

Description: This document summarizes Federal (and California) activity to prevent student suicide and provides research-based guidance for district – local – and site-level suicide prevention programming with comprehensive involvement of school personnel.

School Connectedness: Strategies for Increasing Protective Factors among Youth

Author: Centers for Disease Control and Prevention (CDC)

Date: 2009

Web Link: http://www.cdc.gov/healthyyouth/adolescenthealth/pdf/connectedness.pdf

Description: School connectedness is defined by the CDC in this guide as "the belief by students that adults and peers in the school care about their learning as well as about them as individuals." It is a strong protective factor against suicidal ideation and attempts. At a conference in 2003 sponsored by CDC's Division of Adolescent and School Health and the Johnson Foundation, six evidence-based strategies to increase students' sense of connectedness were identified. This publication outlines the roles and responsibilities of school administrators, teachers, support staff, and parents in implementing the six strategies, along with specific actions that can be taken to implement each strategy.

School Interventions to Prevent Youth Suicide (Technical Assistance Sampler)

Author: Center for Mental Health in Schools at UCLA

Date: Revised 2007

Web link: http://smhp.psych.ucla.edu/pdfdocs/sampler/suicide/suicide.pdf

Description: This packet of author-produced and other collected materials provides the following: an overview of the problem; a suicide risk assessment; information on planning school interventions and training staff; guidance on providing support and preventing contagion in the aftermath of a suicide; and sources for hotlines, consultants, and mental health services.

Schools and Suicide: Latest and Best School-based Strategies

Author: Madelyn S. Gould

Date: 2010

Web link: http://www.wellawaresp.org/pdf/Well%20Aware%20Webinar_Schools%20and%20Suicide.pdf

Description: This 56-slide PowerPoint presentation from a webinar starts by explaining why suicide prevention does belong in schools. It then describes the five types of school-based suicide prevention programs including their rationale, aims, beneficial and detrimental effects, and limitations, and gives examples of each.

Screening/Assessing Students: Indicators and Tools

Author: Center for Mental Health in Schools at UCLA

Date: Revised 2007

Web link: http://smhp.psych.ucla.edu/pdfdocs/assessment/assessment.pdf

Description: This packet of author-produced and other collected materials includes overviews, outlines, checklists, instruments, and recommendations and guidelines from Federal agencies related to early identification through screening. It also examines the controversy related to the many false positives resulting from universal screening, as well as issues related to screening high-risk youth

Suicide Prevention (Quick Training Aids)

Author: Center for Mental Health in Schools at UCLA

Date: Revised 2007

Web link: http://www.smhp.psych.ucla.edu/pdfdocs/quicktraining/suicideprevention.pdf

Description: These quick training aids provide factsheets on suicide rates and methods to assess suicide risk and prevent suicide. Author-produced and other collected materials include several tools and handouts for use with presentations.

To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults

Author: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

Date: 2010

Web link: To download a copy: http://www.sprc.org/library/Suicide_Prevention_Guide.pdf

To order a hard copy: Go to http://store.samhsa.gov/product/Preventing-Suicide-by-American-Indian-andAlaska-Native-Youth-and-Young-Adults/SMA10-4480.

Description: This guide supports American Indian and Alaska Native (AI/AN) communities and those who serve them in developing effective, culturally appropriate suicide prevention plans for youth and young adults. Its intended users include tribal/village leaders, elders, healers, youth activists, suicide prevention program leaders, school administrators, and other community members. Although the guide's focus is on suicide prevention in the community as a whole, many of the programs described in Chapter 7, Promising Suicide Prevention Programs, are school based. The guide also includes information about risk and protective factors that are particularly relevant to AI/AN youth and issues in adapting programs for cultural differences.

Wisconsin Components of a School-Based Suicide Prevention, Intervention, and Postvention Model

Author: Mental Health America of Wisconsin

Date: 2007 Web link: http://www.mhawisconsin.org/schoolbasedmodel.aspx

Description: This guide is for schools to use in developing or improving their prevention programs, crisis plans, and response to suicides. It describes components of a comprehensive, school-based suicide prevention program and provides detailed guidelines and procedures for dealing with suicidal crises and postvention. The

extensive appendices include handouts and tools on suicide prevention, intervention, and postvention geared toward multiple audiences.

Youth Suicide Prevention School-Based Guide

Author: Louis de la Parte Florida Mental Health Institute, University of South Florida

Date: 2003

Web link: http://theguide.fmhi.usf.edu/

Description: This tool provides a series of checklists for schools to assess their existing or proposed suicide prevention efforts and resources and information that school administrators can use to enhance or add to their existing programs. Topics covered include administrative issues, risk and protective factors, prevention guidelines, intervention and postvention strategies, family partnerships, school climate, and diverse populations.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/YouthSuicidePreventionSchoolbasedGuideChecklists.pdf

Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel

Author: Maine Youth Suicide Prevention Program

Date: 2009 (fourth edition)

Web link: http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf

Description: This document provides a description of the components of a comprehensive school-based suicide prevention program; an assessment form for schools to determine if they are ready to manage suicidal behavior; detailed guidelines for implementing suicide intervention and postvention in schools; and appendices with a variety of other related materials, including an outline for an awareness session for all school personnel and sample forms, letters, and handouts.

Review: Best Practices Registry http://www.sprc.org/sites/sprc.org/files/bpr/Maine_BPR_FactSheet.pdf

National Organizations and Federal Agencies with Resources and Information on Adolescent Suicide Prevention

American Association of Suicidology (AAS) http://www.suicidology.org AAS promotes research, public awareness programs, public education, and training for professionals and volunteers, and serves as a national clearinghouse for information on suicide, publishing and disseminating statistics, and suicide prevention resources. AAS hosts national annual conferences for professionals and survivors and serves as an accrediting body for crisis intervention programs. Its School Suicide Accreditation Program prepares school psychologists, social workers, counselors, nurses, and other school professionals to select and implement evidence-based programs in their schools.

American Foundation for Suicide Prevention (AFSP) http://www.afsp.org AFSP funds research to advance understanding of suicide and suicide prevention and pilot programs to prevent suicide. It offers educational

resources and materials such as More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel. With the Suicide Prevention Resource Center (SPRC), AFSP co-produces the Suicide Prevention Best Practices Registry (BPR), which examines the effectiveness of suicide prevention programs, including school-based prevention programs. AFSP's network of local chapters can provide connections to local resources and services address ing suicide prevention as well as organizing awareness events such as "Out-of-the-Darkness" walks. AFSP's Public Policy Division, SPAN USA, keeps track of State legislation related to suicide prevention training for school personnel.

Indian Health Service (IHS) http://www.ihs.gov/NonMedicalPrograms/nspn IHS' Community Suicide Prevention Web site provides American Indian and Alaska Native communities with culturally appropriate information about best and promising practices, training opportunities, ongoing activities, potential partnerships, and other information regarding suicide prevention and intervention. This information can help communities and schools create or adapt suicide prevention programs that are tailored to their needs.

National Association of School Psychologists (NASP) http://www.nasponline.org/index.aspx In addition to serving as the accrediting body for school psychologists and graduate education school psychology programs, NASP offers continuing education and has an extensive library of resources for school psychologists. A resource page for educators and school administrators includes helpful publications and links to organizations and products to promote mental wellness in students. NASP also has a National Emergency Assistance Team that provides consultation to schools and, in some cases, makes site visits.

National Institute of Mental Health (NIMH) http://www.nimh.nih.gov The NIMH Web site has a section on suicide prevention that includes information and resources useful for a variety of audiences, including researchers, healthcare professionals, and consumers (see http://www. nimh.nih.gov/health/topics/suicide-prevention/index.shtml). NIMH also conducts research on youth suicide and youth suicide prevention. Updates on the research can be found through News from the Field: Research Findings of NIMH-funded Investigators, from EurekAlert! at http://search.eurekalert.org/e3/ query.html?qt=youth+suicide+prevention&charset=iso-8859-1&qc=ev3rel&rf=1&col=ev3rel

National Suicide Prevention Lifeline http://www.suicidepreventionlifeline.org/default.aspx The Lifeline is a 24-hour, toll-free suicide prevention service available to anyone in suicidal crisis. Call 1-800-273-TALK (8255). Callers are routed to the closest possible crisis center in their area. With a network of more than 140 crisis centers across the country, the Lifeline's mission is to provide immediate assistance to anyone seeking mental health services. The Lifeline Web site features the Lifeline Gallery where survivors and attempt survivors can tell their personal stories of recovery, emphasizing that suicide is preventable and help is available. Lifeline informational materials, such as brochures, wallet cards, posters, and booklets featuring the Lifeline number, can make help accessible to troubled teens in a moment of crisis and should be a part of any school-based prevention program.

Suicide Prevention Resource Center (SPRC) http://www.sprc.org This SAMHSA-funded center serves primarily State-level agencies and coalitions, as well as State, tribal, and campus grantees, working on suicide prevention. It provides technical assistance, training, and a variety of resource materials. Among the useful resources are State Pages, which can alert schools to current State-sponsored plans, programs, and legislation; the American

Indian/Alaska Native Suicide Prevention pages; the Weekly Spark, a current awareness newsletter that summarizes significant research findings and local, State, national, and international news concerning suicide; and the SPRC Online Library, which includes collections of resources focused on youth (http://www.sprc.org/search/library/ Youth?filters=type%3Alibrary_resource%20tid%3A256) and schools (http://www.sprc.org/search/library/ school?filters=type%3Alibrary_resource%20tid%3A35). Customized information pages outline roles of specific populations in preventing suicide and include teens, teachers, and school health providers. In partnership with the American Foundation for Suicide Prevention, SPRC also co-produces the Best Practices Registry for Suicide Prevention.

The Trevor Project http://www.thetrevorproject.org/ The Trevor Project is a national organization focused on crisis and suicide prevention efforts among lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth. It provides a nationwide 24-hour, toll-free, crisis intervention telephone lifeline (1-866-488-7386); an online, social networking community for LGBTQ youth ages 13 through 24 and their friends and allies; age-appropriate educational programs for schools; and advocacy initiatives at the local, State and Federal levels. It also is a partner in the It Gets Better Project, which is a place where LGBT adults can share videos they make to help LGBT youth see how "happiness can be a reality in their future" (see http://www.itgetsbetterproject.com). All of the Trevor Project's programs aim to provide a safe, supportive, and positive environment for everyone.

U.S. Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/ViolencePrevention/suicide/index.html for suicide prevention http://www.cdc.gov/violenceprevention/pub/youth_suicide.html for youth suicide prevention The CDC Web site has a section on suicide prevention that includes information sheets, resources, and links to a number of statistical databases. Among the CDC databases are WISQARS (Web-based Injury Statistics Query and Reporting System), YRBSS (Youth Risk Behavior Surveillance System), National Violent Death Reporting System, and National Vital Statistics System. There is also a special section on the Web site focused on youth suicide prevention information and resources. The two CDC divisions that address youth suicide prevention are the Division of Adolescent and School Health and the Division of Violence Prevention.

U.S. Department of Education (ED) http://www.ed.gov ED serves as the grant-making agency for Federal education funding. Project SERV grants have been awarded to some school districts to restore the learning environment after student suicides. ED also collects and interprets data through its National Center for Education Statistics. Data products that include suicide are the annual Indicators of School Crime and Safety and the School-Associated Violent Deaths Surveillance Study (SAVD), an epidemiological study developed by the Centers for Disease Control and Prevention (CDC) in conjunction with ED and the U.S. Department of Justice. ED sponsors the ERIC database, a comprehensive collection of education literature that contains thousands of references to materials related to suicide and suicide prevention.

U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) http://www.samhsa.gov SAMHSA funds and sup ports the National Lifeline and SPRC, and manages the Garrett Lee Smith grant program which funds State, territorial, and tribal programs to prevent suicide among youth. It has developed the National Registry of Evidence-based Programs and Practices (NREPP), which reviews evidence of effectiveness for

prevention programs on topics related to behavioral health, including suicide. There are at least six programs registered that are delivered in the school environment to prevent suicide. SAMHSA also sponsors several prevention campaigns. “The What a Difference a Friend Makes” campaign is geared toward young people and focuses on recovery from mental illness and reducing stigma. It emphasizes the role of friends in providing support and acceptance, a cornerstone of gatekeeper training. Another campaign called We Can Help Us, which was developed with input from teens, stresses that teens can become empowered to develop positive solutions and ways to get through tough times.

Getting Outside Help

School crisis team members should remain mindful of their own limitations and consider bringing in crisis team members from other parts of their school district (if there are any), trained trauma responders from other school districts, and/or staff from local mental health centers to help them as needed. Often, crisis team members are also impacted by a suicide death, and it is important that they respond in a way that protects the school community while not diminishing or ignoring their own reactions to the death.

In especially complicated situations, schools may even consider bringing in local or national experts in school suicide postvention for consultation and assistance (provided that sufficient funding is available). Such steps should generally be taken in consultation with the community committee, and all outside experts must of course be carefully vetted and references and clearances checked.

National organizations that provide crisis response, postvention consultation, and training, and/or that can put schools in touch with appropriate experts:

- **The National Association of School Psychologists’ School Safety and Crisis Response Committee** provides phone, e-mail, and onsite consultation.
- **The National Institute for Trauma and Loss in Children (TLC)** provides schools, agencies, and parents with names of TLC-certified trauma practitioners in their area who are available for consultation and referrals. TLC also has certified trauma trainers who can come to a school, organization, or community to provide training on suicide crisis response and postvention as well as other trauma-related topics. Call 877-306-5256 or e-mail info@starr.org.
- **The Dougy Center: National Center for Grieving Children & Families** provides phone and onsite consultation and onsite training.

Local Resources:

- **Nebraska State Suicide Prevention Coalition** provides information about suicide prevention in Nebraska, recognized as the primary group responsible for coordinating Nebraska’s suicide prevention efforts. NSSPC also has information about regional suicide prevention contacts and coalitions. For access go to http://www.suicideprevention.nebraska.edu/

- **NAMI Nebraska** (877) 463-6264
- **Mental Health Association of Nebraska** (800) 422-6691
- **AFSP Nebraska** (402) 681-9109
- **Suicide Prevention Resource Center (SPRC)** has state-specific information about suicide statistics, prevention plans, grantees, and organizations. Also contains a link to the PDF for the Nebraska Statewide Suicide Prevention Plan. For access go to http://www.sprc.org/states/nebraska
- **The Kim Foundation** has lists of local and national resources, as well as information on crisis hotlines, inpatient facilities, community resources, and support groups organized by the region. For access or more information call (402)-891-6811 or go to http://www.thekimfoundation.org/

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Other Mental Health Conditions

What is Self Injurious Behavior (SIB)?

Nonsuicidal self-injury, often simply called self-injury, is the act of deliberately harming one's own body. Common examples of this behavior include cutting, burning, or scratching. The behavior also commonly co-occurs with eating disorders such as anorexia or bulimia. Self injurious behavior is typically not meant as a suicide attempt, although it is a strong predictor of whether a teen is at risk for suicide.

Studies show that 1 in 12 teens harm themselves through cutting, burning or other life-threatening behavior, and 10 percent will continue to do so into early adulthood. Teens who self-harm often are depressed or overwhelmed by anxiety, stress or pressure.

SIB Stats

A 2008 publication by the US National Library of Medicine reports the following nonsuicidal self injury (NSSI) statistics: (5)

•1/3 to 1/2 of US adolescents have engaged in some type of self injury.

•Cutting and burning are the most common types of non-suicidal self-injury.

•70% of teens engaging in self-injury behavior have made at least one suicide attempt.

•55% had made multiple suicide attempts.

Source: https://www.teenhelp.com/physical-health/cutting-statistics-and-self-injury-treatment/

- The average age of onset for self-injury is between 14 and 15 years old and earlier in adolescents.
- Girls self-injure more than boys, but the rates become more equal through the later adolescence period.

Understanding SIB

Overwhelmingly, teens report they engage in self-injury to escape or reduce painful emotions:

- to cope with feelings of depression: 83%
- to release unbearable tension: 74%
- to cope with nervousness/fear: 71%
- to express frustration: 71%

Other reasons adolescents report for engaging in SIB:

- to feel something, even if it was pain (34%)
- to punish oneself (31%)
- to get other people to act differently or change (15%)

http://www.starcenter.pitt.edu/Files/PDF/Self%20Injury%20STAR%202013%20PGH%20Poling%20Goldstein%20FINAL.pdf

http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx

- to get attention (14%)
- to get help (14%)

The behavior is reinforced (i.e., it works)…

- 60% report emotional relief afterwards

(Kumar et al., 2004; Nock & Prinstein, 2004)

- social reinforcement (e.g., attention, help, removal of expectations/demands)

How To Spot SIB

Typical forms of self-harm include cutting, scratching, burning, picking at wounds, and hitting or punching objects. Red flags include:

• Unexplained wounds or scars from cuts, bruises, or burns, usually on the wrists, arms, thighs, or chest.

• Blood stains on clothing, towels, or bedding; blood-soaked tissues.

• Sharp objects or cutting instruments, such as razors, knives, needles, in the person's belongings.

• Covering up. A person who self-injures may insist on wearing long sleeves or long pants, even in hot weather.

• Wanting to be alone for long periods of time, especially in the bedroom or bathroom.

• Isolation and irritability.

How to Approach SIB

Eight practical guidelines can help adults effectively respond to self-harming students.

1.) Because teachers and school nurses are often the first responders, it is crucial that they be respectful listeners to self-harming students; validate the students; build trust; and serve as a bridge to get the students to a school psychologist, social worker, or counselor for further help. If the self-harming student has a strong relationship with the teacher, it may be useful for the teacher to sit in on counseling sessions. Teachers and school nurses should ask the student these questions:
How can I help you?

How has the cutting helped you?

http://www.starcenter.pitt.edu/Files/PDF/Self%20Injury%20STAR%202013%20PGH%20Poling%20Goldstein%20FINAL.pdf

http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx

How does cutting fit into your life right now?

I'm happy to be there for you, but I also need to connect you with one of our social workers because of our school policy. Would you like to see a male or a female social worker (when the option is available)?

If I can arrange it, would you like me to sit in on your first meeting with your social worker?

2.) At all costs, school personnel need to avoid responding to self-harming students with disgust, anxiety, or fear. They must not lecture the students about the dangers of this behavior, play detective and ask to see their cuts or burn marks, or interrogate and further invalidate them. Instead, they should strive to understand the meaning of this behavior for the student, how the behavior has been helpful, and how they can now be helpful to the student. It is important to remember that each self-harming student's story is unique. Self-harming students need to know that teachers and other school personnel care about them and are available for emotional connection, support, and advice when needed.

3.) Once a referral is made to the school counseling staff member, the counselor needs to determine in conjunction with his or her supervisor and the student whether the school can successfully counsel the student on-site or whether parent involvement is required. For students who have just begun experimenting with self-harming or who have engaged in this behavior only intermittently, a trusting relationship with a school counselor may generate alternative coping strategies. I recommend that the student also participates in an on-site intervention group, such as the Stress-Busters' Leadership Group.

4.) If the student has been self-harming regularly and is engaging in other self-destructive behaviors like bulimia, substance abuse, and risky sexual activity, the school needs to contact the parents immediately for referral to a private practitioner or community-based program for family therapy that specializes in treating these adolescent behavioral difficulties. Concurrent participation in an on-site intervention group is also recommended.

5.) For students who have been self-harming regularly; who are cutting themselves more deeply; or who are cutting or burning themselves around their eyes, necks, and private parts, this is a medical/psychiatric emergency. These students should be taken immediately to the nearest hospital emergency room for evaluation.

6.) Although only a small percentage of self-harming students become suicidal, if these students have not responded well to both on-site and outside counseling, struggle to cope with multiple life stressors, and clearly voice suicidal thoughts, they need to be immediately taken to the nearest hospital emergency room.

http://www.starcenter.pitt.edu/Files/PDF/Self%20Injury%20STAR%202013%20PGH%20Poling%20Goldstein%20FINAL.pdf

http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx

7.) Identified school personnel who have been serving as inspirational adults for other disconnected at-risk students can provide added support to self-harming students who are trying to reduce or stop engaging in this behavior. These adults can closely collaborate with the involved counseling staff members for guidance and back-up if necessary.

8.) Graduates of intervention groups who are interested in schoolwide prevention work help identify at-risk students who are self-harming, get them to counseling staff, and spark their interest in participating in a new group for added support. The school can ask these graduates to cofacilitate new intervention groups and get involved in the school peer counseling program.

Resources for SIB

S.A.F.E Alternatives: has information on state-specific therapists who have interest in treating those who engage in SIB, informative media,

Imalive: IMAlive is a live online network that uses instant messaging to respond to people in crisis.

7 Cups of Tea: free, anonymous and confidential online text chat with trained listeners, online therapists and counselors.

Boys Town Website/Hotline: contains a guide to Self Harm (https://www.boystown.org/parenting/guides/Pages/self-harm.aspx) can also be reached for advice or consultation at 1-800-448-3000.

http://www.starcenter.pitt.edu/Files/PDF/Self%20Injury%20STAR%202013%20PGH%20Poling%20Goldstein%20FINAL.pdf

http://www.ascd.org/publications/educational_leadership/dec09/vol67/num04/Helping_Self-Harming_Students.aspx

Parent's Guide to Teen Depression

Recognizing the Signs and Symptoms and Helping Your Child

Teenagers face a host of pressures, from the changes of puberty to questions about who they are and where they fit in. With all this turmoil and uncertainty, it isn't always easy to differentiate between normal teenage growing pains and depression. But teen depression goes beyond moodiness. It's a serious health problem that impacts every aspect of a teen's life. Fortunately, it's treatable and parents can help. Your love, guidance, and support can go a long way toward helping your teen overcome depression and get their life back on track.

Is my teen depressed?

The teen years can be extremely tough and depression affects teenagers far more often than many of us realize. In fact, it's estimated that one in five adolescents from all walks of life will suffer from depression at some point during their teen years. However, while depression is highly treatable, most depressed teens never receive help.

While occasional bad moods or acting out is to be expected during the teenage years, depression is something different. The negative effects of teenage depression go far beyond a melancholy mood. Depression can destroy the essence of your teen's personality, causing an overwhelming sense of sadness, despair, or anger. Many rebellious and unhealthy behaviors or attitudes in teenagers can be indications of depression. The following are some the ways in which teens "act out" in an attempt to cope with their emotional pain:

- **Problems at school.** Depression can cause low energy and concentration difficulties. At school, this may lead to poor attendance, a drop in grades, or frustration with schoolwork in a formerly good student.
- **Running away.** Many depressed teens run away from home or talk about running away. Such attempts are usually a cry for help.
- **Drug and alcohol abuse.** Teens may use alcohol or drugs in an attempt to "self-medicate" their depression. Unfortunately, substance abuse only makes things worse.
- **Low self-esteem.** Depression can trigger and intensify feelings of ugliness, shame, failure, and unworthiness.
- **Smartphone addiction**. Teens may go online to escape their problems, but excessive smartphone and Internet use only increases their isolation, making them more depressed.
- **Reckless behavior**. Depressed teens may engage in dangerous or high-risk behaviors, such as reckless driving, binge drinking, and unsafe sex.
- **Violence**. Some depressed teens—usually boys who are the victims of bullying—can become aggressive and violent.

Teen depression is also associated with a number of other mental health problems, including eating disorders and self-injury. While depression can cause tremendous pain for your teen—and disrupt

Smith, M., Robinson, L., & Segal, J. (2018, June). Parent's Guide to Teen Depression. Retrieved from https://www.helpguide.org/articles/depression/parents-guide-to-teen-depression.htm

everyday family life—there are plenty of things you can do to help your child start to feel better. The first step is to learn what teen depression looks like and what to do if you spot the warning signs.

What are the signs and symptoms of depression in teens?

Unlike adults, who have the ability to seek assistance on their own, teenagers rely on parents, teachers, or other caregivers to recognize their suffering and get them the help they need. But that isn't always easy. For one, teens with depression don't necessarily appear sad. Instead, irritability, anger, and agitation may be the most prominent symptoms.

Signs and symptoms of teen depression:

- Sadness or hopelessness
- Irritability, anger, or hostility
- Tearfulness or frequent crying
- Withdrawal from friends and family
- Loss of interest in activities
- Poor school performance
- Changes in eating and sleeping habits
- Restlessness and agitation
- Feelings of worthlessness and guilt
- Lack of enthusiasm and motivation
- Fatigue or lack of energy
- Difficulty concentrating
- Unexplained aches and pains
- Thoughts of death or suicide

Depression in teens vs. adults

Depression in teens can look very different from depression in adults. The following symptoms are more common in teenagers than in their adult counterparts:

- **Irritable or angry mood.** As noted, irritability, rather than sadness, is often the predominant mood in depressed teens. A depressed teenager may be grumpy, hostile, easily frustrated, or prone to angry outbursts.
- **Unexplained aches and pains**. Depressed teens frequently complain about physical ailments such as headaches or stomachaches. If a thorough physical exam does not reveal a medical cause, these aches and pains may indicate depression.
- **Extreme sensitivity to criticism**. Depressed teens are plagued by feelings of worthlessness, making them extremely vulnerable to criticism, rejection, and failure. This is a particular problem for "over-achievers."
- **Withdrawing from some, but not all people**. While adults tend to isolate themselves when depressed, teenagers usually keep up at least some friendships. However, teens with depression

may socialize less than before, pull away from their parents, or start hanging out with a different crowd.

Is it depression or teenage "growing pains"?

If you're unsure if your teen is depressed or just "being a teenager," consider how long the symptoms have been going on, how severe they are, and how different your teen is acting from his or her usual self. Hormones and stress can explain the occasional bout of teenage angst—but not continuous and unrelenting unhappiness, lethargy, or irritability.

How to help a depressed teenager

Depression is very damaging when left untreated, so don't wait and hope that worrisome symptoms will go away. If you suspect that your teen is depressed, bring up your concerns in a loving, non-judgmental way. Even if you're unsure that depression is the issue, the troublesome behaviors and emotions you're seeing are signs of a problem that should be addressed.

Open up a dialogue by letting your teen know what specific depression symptoms you've noticed and why they worry you. Then ask your child to share what he or she is going through—and be ready and willing to truly listen. Hold back from asking a lot of questions (most teenagers don't like to feel patronized or crowded), but make it clear that you're ready and willing to provide whatever support they need.

How to communicate with a depressed teen

- **Focus on listening, not lecturing**. Resist any urge to criticize or pass judgment once your teenager begins to talk. The important thing is that your child is communicating. You'll do the most good by simply letting your teen know that you're there for them, fully and unconditionally.
- **Be gentle but persistent**. Don't give up if they shut you out at first. Talking about depression can be very tough for teens. Even if they want to, they may have a hard time expressing what they're feeling. Be respectful of your child's comfort level while still emphasizing your concern and willingness to listen.
- **Acknowledge their feelings**. Don't try to talk your teen out of depression, even if their feelings or concerns appear silly or irrational to you. Well-meaning attempts to explain why "things aren't that bad" will just come across as if you don't take their emotions seriously. Simply acknowledging the pain and sadness they are experiencing can go a long way in making them feel understood and supported.
- **Trust your gut.** If your teen claims nothing is wrong but has no explanation for what is causing the depressed behavior, you should trust your instincts. If your teen won't open up to you,

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consider turning to a trusted third party: a school counselor, favorite teacher, or a mental health professional. The important thing is to get them talking to someone.

Helping a depressed teen

Tip 1: Encourage social connection

Depressed teens tend to withdraw from their friends and the activities they used to enjoy. But isolation only makes depression worse, so do what you can to help your teen reconnect.

Make face time a priority. Set aside time each day to talk—time when you're focused totally on your teen, without distractions or trying to multi-task. The simple act of connecting face to face can play a big role in reducing your teen's depression. And remember: talking about depression or your teen's feelings will not make the situation worse, but your support can make all the difference in their recovery.

Combat social isolation. Do what you can to keep your teen connected to others. Encourage them to go out with friends or invite friends over. Participate in activities that involve other families and give your child an opportunity to meet and connect with other kids.

Get your teen involved. Suggest activities—such as sports, after-school clubs, or an art, dance, or music class—that take advantage of your teen's interests and talents. While your teen may lack motivation and interest at first, as they reengage with the world, they should start to feel better and regain their enthusiasm.

Promote volunteerism. Doing things for others is a powerful antidepressant and self-esteem booster. Help your teen find a cause they're interested in and that gives them a sense of purpose. If you volunteer with them, it can also be a good bonding experience.

Tip 2: Make physical health a priority

Physical and mental health are inextricably connected. Depression is exacerbated by inactivity, inadequate sleep, and poor nutrition. Unfortunately, teens are known for their unhealthy habits: staying up late, eating junk food, and spending hours on their phones and devices. But as a parent, you can combat these behaviors by establishing a healthy, supportive home environment.

Get your teen moving! Exercise is absolutely essential to mental health, so get your teen active—whatever it takes. Ideally, teens should be getting at least an hour of physical activity a day, but it needn't be boring or miserable. Think outside the box: walking the dog, dancing, shooting hoops, going for a hike, riding bikes, skateboarding—as long as they're moving, it's beneficial.

Set limits on screen time. Teens often go online to escape their problems, but when screen time goes up, physical activity and face time with friends goes down. Both are a recipe for worsening symptoms.

Provide nutritious, balanced meals. Make sure your teen is getting the nutrition they need for optimum brain health and mood support: things like healthy fats, quality protein, and fresh produce. Eating a lot

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of sugary, starchy foods—the quick “pick me up” of many depressed teens—will only have a negative effect on their mood and energy.

Encourage plenty of sleep. Teens need more sleep than adults to function optimally—up to 9-10 hours per night. Make sure your teen isn’t staying up until all hours at the expense of much-needed, mood-supporting rest.

Tip 3: Know when to seek professional help

Support and healthy lifestyle changes can make a world of difference for depressed teens, but it’s not always enough. When depression is severe, don’t hesitate to seek professional help from a mental health professional with advanced training and a strong background treating teens.

Involve your child in treatment choices. When choosing a specialist or pursuing treatment options, always get your teen’s input. If you want your teen to be motivated and engaged in their treatment, don’t ignore their preferences or make unilateral decisions. No one therapist is a miracle worker, and no one treatment works for everyone. If your child feels uncomfortable or is just not ’connecting’ with the psychologist or psychiatrist, seek out a better fit.

Explore your options. Expect a discussion with the specialist you’ve chosen about depression treatment options for your teen. Talk therapy is often a good initial treatment for mild to moderate cases of depression. Over the course of therapy, your teen’s depression may resolve. If it doesn’t, medication may be warranted.

Unfortunately, some parents feel pushed into choosing antidepressant medication over other treatments that may be cost-prohibitive or time-intensive. However, unless your child is acting out dangerously or at risk for suicide (in which case medication and/or constant observation may be necessary), you have time to carefully weigh your options. In all cases, antidepressants are most effective when part of a broader treatment plan.

Medication comes with risks

Antidepressants were designed and tested on adults, so their impact on young, developing brains is not yet fully understood. Some researchers are concerned that exposure to drugs such as Prozac may interfere with normal brain development—particularly the way the brain manages stress and regulates emotion.

Antidepressants also come with risks and side effects of their own, including a number of safety concerns specific to children and young adults. They are also known to increase the risk of suicidal thinking and behavior in some teenagers and young adults. Teens with bipolar disorder, a family history of bipolar disorder, or a history of previous suicide attempts are particularly vulnerable.

The risk of suicide is highest during the first two months of antidepressant treatment. Teenagers on antidepressants should be closely monitored for any sign that the depression is getting worse.

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Teens on antidepressants: Red flags to watch out for

Call a doctor if you notice…

- New or more thoughts/talk of suicide
- Suicidal gestures or attempts
- New or worse depression
- New or worse anxiety
- Agitation or restlessness
- Panic attacks
- Difficulty sleeping (insomnia)
- New or worse irritability
- Aggressive, angry, or violent behavior
- Acting on dangerous impulses
- Hyperactive speech or behavior (mania)
- Other unusual changes in behavior

Tip 4: Support your teen through depression treatment

As your depressed teenager goes through treatment, the most important thing you can do is to let them know that you're there to listen and offer support. Now more than ever, your teenager needs to know that they're valued, accepted, and cared for.

Be understanding. Living with a depressed teenager can be difficult and draining. At times, you may experience exhaustion, rejection, despair, aggravation, or any other number of negative emotions. During this trying time, it's important to remember that your child is not being difficult on purpose. Your teen is suffering, so do your best to be patient and understanding.

Stay involved in treatment. Make sure your teenager is following all treatment instructions, whether it's attending therapy or correctly taking any prescribed medication. Track changes in your teen's condition, and call the doctor if depression symptoms seem to be getting worse.

Be patient. The road to your depressed teenager's recovery may be bumpy, so be patient. Rejoice in small victories and prepare for the occasional setback. Most importantly, don't judge yourself or compare your family to others. As long as you're doing your best to get your teen the necessary help, you're doing your job.

Tip 5: Take care of yourself (and the rest of the family)

As a parent, you may find yourself focusing all your energy and attention on your depressed teen and neglecting your own needs and the needs of other family members. However, it's extremely important that you continue to take care of yourself during this difficult time.

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Above all, this means reaching out for much needed support. You can't do everything on your own so enlist the help of family and friends. Having your own support system in place will help you stay healthy and positive as you work to help your teen.

Don't bottle up your emotions. It's okay to feel overwhelmed, frustrated, helpless, or angry. Reach out to friends, join a support group, or see a therapist of your own. Talking about how you're feeling will help defuse the intensity.

Look after your health. The stress of your teen's depression can affect your own moods and emotions, so support your health and well-being by eating right, getting enough sleep, and making time for things you enjoy.

Be open with the family. Don't tiptoe around the issue of teen depression in an attempt to "protect" the other children. Kids know when something is wrong. When left in the dark, their imaginations will often jump to far worse conclusions. Be open about what is going on and invite your children to ask questions and share their feelings.

Remember the siblings. Depression in one child can cause stress or anxiety in other family members, so make sure "healthy" children are not ignored. Siblings may need special individual attention or professional help of their own to handle their feelings about the situation.

Avoid the blame game. It can be easy to blame yourself or another family member for your teen's depression, but it only adds to an already stressful situation. Furthermore, depression is normally caused by a number of factors, so it's unlikely—except in the case of abuse or neglect—that any loved one is "responsible."

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Sample Accommodations for Anxious Kids : Classroom Environment

Anxious children perform best in a calm, supportive, but organized classroom. Because change and uncertainty can be unsettling, a structured classroom, calmly disciplined will let children feel safe and know what to expect. An ideal situation is a teacher who maintains authority positively, using reason and respect rather than fear for punishment.

Seating within classroom

Anxious children often struggle with the unlikely fear that they will get in trouble, seating away from more rambunctious classmates will be less distracting, and may help them focus on their work rather than feeling responsible for the class.

Following directions

Concerns about getting the directions wrong either because of distraction or misunderstanding are common. Signaling the class first when giving directions (flashing lights, clapping hands) and when possible having directions written on the board or elsewhere may assure anxious children that they have understood the directions.

Class participation

Fears of getting the answer wrong, saying something embarrassing, or simply having other kids look at them may be concerns for an anxious child. Determine the child's comfort with either closed ended questions (requiring a yes or no) or with opinion questions, start with whichever is easiest. Use a signal to let the child know that his turn is coming. Provide opportunities for the child to share knowledge on topics in which he or she is most confident.

Class presentations

Children with extreme social anxiety may have difficulty with oral reports. Consider having the child present to the teacher alone, or have the child audiotape or videotape the presentation at home.

Answering questions at the board

For children with social anxiety, the combination of getting the answer wrong, and being visible to the whole class may be so overwhelming that they may opt to avoid school altogether. Consider having the child exempt from going up to the board until they are ready to handle that challenge, or, begin to approach that situation by eliminating the risk of being wrong, by simply asking the child to write the date on the board.

Testing conditions

Extended time on tests will ease the pressure on anxious children, and just knowing that the time is available may obviate the need to use it. Sometimes anxious children become distracted when they see other children working on their tests or turning them in, they may inaccurately assume that they don't

know the material as well. Testing in an alternate, quiet location may be preferable for some children. Consider the use of word banks, equation sheets, to cue children whose anxiety may make them "blank out" on rote material.

Lunchroom/recess/unstructured activities

Free choice times can be a welcomed and necessary break from the pressures of school, but fears of rejection in the cafeteria or on the playground can take the fun out of free time. Bridge the gap socially by creating ties between small groups of children. A lunch bunch with two or three children can create a shared experience which kids can then draw on later. When working in pairs or small groups, don't always have children choose the groupings themselves, alternate this with a "counting off" technique or drawing straws to allow variability in the groupings.

Safe person

Having one person at school who understands the child's worries and anxieties can make the difference between a child attending school and staying home. A guidance counselor, principal, nurse, or teacher can be identified as a point person for the child to check in with briefly (5-10 minutes) to help dispel worry thoughts, take deep breaths and return to class.

Cool down pass

Pressures build for anxious children, being able to leave the situation briefly to get a drink of water or wash their face can allow them to clear their heads and return to class on a less anxious track. Since anxious children may be hesitant to ask for this and risk being the center of attention, use an orange card which the child simply places on his desk, or the teachers desk, which signals they are out on break. In general anxious children are exceedingly honest and responsible and will not take misuse this privilege.

Assemblies/large group activities

Some children become anxious in crowds, until a child has mastered the auditorium, allow them to sit where they feel most comfortable (e.g., at the end of the row in the back of the auditorium), see if they can gradually rejoin their class.

Return after illness

Ever responsible, anxious kids may be very distressed about work they have missed while they were out. Assign a responsible buddy to copy notes and share handouts. If tests are given the day of the child's return, give them the option to take the test at another time and use the test-time to make up any other missing work.

Field trips

Compounding the daily stress of the anxious child, field trips include the factors of being away from home and parents, and a change in routine. Accommodate the child's level of readiness so that he or

she can participate as fully as possible. Consider having the child in the "teachers' group," or having parents accompany the group until the child is ready to handle an excursion without these supports in place.

Change in routine/substitute teachers

Because anxious children try very hard to please and predict what is required in a situation, changes of any sort may be experienced as very stressful. When possible, send a note home the day before to alert the child/family to a change in routine, this will allow the child to process the change in his or her comfort zone and will make the transitions go more smoothly the next day.

Fire/safety drills

While these drills are for a child's safety, anxious children may be very distressed by imagining that these events were actually happening. If there is an opportunity to signal the child in person just before the alarm sounds, this may buffer the surprise of the drill and allow children to mobilize with less distress.

Homework expectations

If children are spending inordinate amounts of time on homework because of OCD redoing, rechecking, rereading, or simply worrying that the assignment wasn't done thoroughly enough, the teacher can set a reasonable amount of time for homework and then reduce the homework load to fit into that time frame. Teachers can also provide time estimates for each assignment (this could be helpful to the entire class), so that the anxious child can attempt to stay within 10% of the estimated time. Eliminate repetition by having the child do every other math question, reduce reading and writing assignments, consider books on tape if a child is unable to read without repetition, for a child with writing difficulties, consider having a parent, teacher, or another student "scribe" for the child while he or she dictates the answers.