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Suicide Prevention & Response: A Comprehensive Resource Guide for Indiana Schools 2018

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Suicide Prevention & Response:
A Comprehensive Resource Guide for Indiana Schools
2018

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INTRODUCTION

Suicide touches everyone – all ages and incomes; racial, ethnic, and religious groups; across all parts of the country. Suicide is also the 2nd leading cause of death among teenagers (CDC, 2016).

Below are a few facts about suicide:

- Indiana has the **3rd highest** rate (1 in 5) of high school students in the nation who have contemplated suicide.
- Indiana tied for the **10th highest** percentage (1 in 9) of high school students attempting suicide.
- Males are 4 times more likely to die by suicide than females.
- Females are 3 times more likely to attempt suicide than males.
- Suicide is the **3rd** leading cause of death for youth aged 10-14.
- Suicide is the **2nd** leading cause of death for you aged 15-24.

The statistics are alarming, and death by suicide is one of Indiana’s most concerning health issues. However, there is help and hope when parents, schools, and communities join forces to address suicide as a preventable public health problem.

Critical Points: What Schools Need to Know & Share

- School personnel are frequently considered the first line of contact in reaching suicidal students.
- While most school personnel are neither qualified nor expected to provide an in-depth assessment or counseling necessary when working with a suicidal student, they are responsible for taking reasonable and prudent actions to help these students.
- All school personnel need to know that protocols exist to refer at-risk students to trained professionals so that the burden of responsibility does not rest solely with the individual “on the scene”.
- Research has shown that talking about suicide or asking students if they are thinking about suicide will *not* put the idea in their head or cause them to kill themselves. Given the widespread stigma around suicide, most people who are contemplating suicide do not know with whom to speak. By talking openly and being available to students, school personnel may be able to help an individual see there are other options and/or give the student time to rethink his/her decision, thereby preventing suicide.
- School personnel, parents/guardians, and students need to be confident that help is available if/when they raise concerns regarding suicidal behavior. Studies show that students often know, but do not tell adults, about suicidal peers because they do not know how adults will respond or assume they can’t help.
- Advanced planning and practice is critical to providing an effective crisis response. Internal and external resources must be in place to address student issues and to normalize the learning environment for everyone.
- Suicide is preventable, therefore we can take steps toward decreasing the odds of a suicide attempt.
 - Increasing student and community awareness might include posting resources in locations around the school, on social media, in student handbooks, etc. Ease of access and reducing the stigma of reaching out for help are important steps towards preventing suicide. Resources might include the following:
 - National Suicide Prevention Lifeline (1-800-273-8255);
 - text options, such as Families First (text CSIS to 839863) or Mental Health America of Tippecanoe (call or text Safe2Talk to 765-742-0244), and
 - any additional supportive resources within the school and local community.

Cultural Issues in Mental Health Promotion and Suicide Prevention

The students and families that school personnel interact with, comprise an increasingly diverse group with individualized needs. The acceptability of student’s mental health services is highly influenced by attitudes, beliefs, and practices from their families’ cultures of origin.¹ Being culturally responsive assumes that no single “best” way exists to conceptualize human behavior or explain the realities and experiences of diverse cultural groups. Rather, it is best to understand that everyone has a unique culture, and that cultural influences are woven into personality like a tapestry.² From this perspective, three recommendations for education professionals include: (1) developing a broad knowledge and awareness of cross-cultural variations in child development and parenting; (2) integrating this knowledge in a relevant way to offer more informed assessments and interventions; and (3) developing a culturally sensitive attitude and approach in all interactions with students and their families.³

It is important to recognize that lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth are often at higher risk for being the target of bullying, and they have higher rates of suicide than their peers. Generally, LGBTQ youth have more, and more severe risk factors, and fewer protective factors than heterosexual youth.⁴ It is important for schools to increase support for these students, provide a strength-based approach, and implement programs to safeguard and support LGBTQ students. Resources are available from organizations such as the Gay Lesbian Straight Education Network (<https://www.glsen.org/>) and the Trevor Project (<http://www.thetrevorproject.org>).

The table below provides an overview of key facts from the suicide questions among the racial/ethnic youth populations in Indiana from the *2015 Youth Risk Behavior Survey*.⁵

<i>In the past year...</i>	Whites	Blacks	Hispanics	Multiple Races	Heterosexual	Gay, Lesbian, or Bisexual	Total *Indiana
Seriously considered attempting suicide	19.8%	22.2%	23.8%	25.9%	15.2%	46.4%	19.8%
Made a suicide plan	17.0%	19.1%	20.9%	23.5%	13.0%	42.8%	17.0%
Attempted suicide	9.9%	14.5%	15.5%	10.5%	6.8%	34.2%	9.9%
Suicide attempt that had to be treated by a doctor or nurse	3.9%	9.2%	6.7%	5.3%	3.0%	11.1%	3.9%

¹ Pumariega, A.J., Joshi, S.V. (2010). Culture and development in children and youth. *Child and Adolescent Psychiatric Clinics of North America*, 19(4), 661-680.

² McDermott, J.F. (2002). Effects of culture and ethnicity on child & adolescent development. In: Lewis M, editor. *Child and adolescent psychiatry—a comprehensive textbook*. 3rd edition. Philadelphia: Lippincott. p. 494–8.

³ Joshi, S.V., Pumariega, A.J., Reicherter, D., & Roberts, L.W. (2015). Cultural Issues in Ethics and Professionalism, in *Professionalism and Ethics: A Q & A Study Guide for Mental Health Professionals*: Washington, DC: American Psychiatric Press, Inc.

⁴ Suicide Prevention Resource Center. *Culturally Competent Care for LGBTQ Youth* [online]. (August 2015).

⁵ Indiana Youth Risk Behavior System [Survey](#), 2015.

Indiana Requirements for Youth Suicide Awareness and Prevention

Suicide Prevention Policy ([IC 20-26-5-34.4](#))

Per IC 20-26-5-34.4, school corporations shall adopt a policy addressing measures intended to increase child suicide awareness and prevention. The policy must address the following:

- 1) Counseling services for the child and the child's family related to suicide prevention.
- 2) Availability of referral information for crisis intervention to children, parents, and school corporation staff.
- 3) Increasing awareness of the relationship between suicide and drug and alcohol use.
- 4) Training on warning signs and tendencies that may evidence that a child is considering suicide.
- 5) Availability of information concerning suicide prevention services in the community.
- 6) Cooperation among the school corporation and suicide prevention services in the community.
- 7) Development of a plan to assist survivors of attempted suicide and to assist children and school corporation staff in coping with an attempted suicide or death of a student or school employee.
- 8) Development of any other program or activity that is appropriate.

Youth Suicide Awareness and Prevention Training ([IC 20-28-3-6](#))

Per IC 20-28-3-6, superintendents, principals, teachers, librarians, school counselors, school psychologists, school nurses, and school social workers employed at schools that provide instruction to students in grades 5-12, are required to participate in at least 2 hours of youth suicide awareness and prevention training every 3 school years. The training must be during the employee's contracted day or at a time chosen by the employee; shall count toward professional development requirements; must be demonstrated to be an effective or promising program and recommended by the Indiana suicide Prevention Network Advisory Council.

SUICIDE RESPONSE PROTOCOLS

This section provides best practice recommendations, procedures, and protocol.

Policy

Per Indiana statute, all school corporations are required to adopt a policy addressing suicide awareness and prevention. The purpose of a suicide policy is to protect the health and well-being of all students by having procedures in place to prevent, assess the risk of, intervene, and respond to suicide. A policy covers actions that occur in school, on school property, at school-sponsored events, on school buses or school-owned vehicles, and at school sponsored out-of-school events where school staff are present.

See Appendix B for a sample policy for Indiana school corporations.

Suicide Response

The school corporation should establish policies and procedures for intervening when students are observed or suspected to be experiencing emotional or behavioral distress. It is recommended that every school in the corporation use the same suicide screening and risk assessment tool and documentation practices.

It is important to remember that a student who is considering suicide has not done anything wrong and all efforts should be made to listen and empathize with his/her situation and provide appropriate support.

IN-School Suicide Attempts

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

1. First Aid will be rendered until professional medical treatment and/or transportation can be received, following direct emergency medical procedures. Mental health support will be provided as appropriate.
2. The student's parent or guardian will be contacted, unless a delay in notification is warranted.
3. School staff will supervise the student to ensure his/her safety.
4. Staff will move all other students out of the immediate area as quickly as possible.
5. Staff will immediately notify the principal and school suicide prevention coordinator.
6. The school will engage as necessary, the crisis team to assess whether additional steps should be taken to ensure the safety and well-being of other students.
7. Mental health services will be offered, when appropriate, for students and teachers affected by the suicide attempt.
8. If appropriate, staff will immediately request a mental health (risk) assessment of any student suspected to be at-risk of suicide. The family should get their child a full psychiatric assessment prior to his/her return to school. For more information, see the memo [here](#).

Out-of-School Suicide Attempts

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

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

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

Re-Entry

Students who have made a suicide attempt are at an increased risk to attempt to harm themselves again. Having a streamlined and well-planned re-entry process ensures the safety and well-being of students who have previously attempted suicide and reduces the risk of another attempt. An appropriate re-entry process is an important component of suicide prevention and is considered best practice. Educators can help return students by directly involving both the family and the student in planning for his/her return to school. This will provide the student with a sense of control, personal responsibility, and empowerment and sets a tone for collaboration and unified support for the student.

Confidentiality is extremely important in protecting the student and enabling school personnel to provide assistance. Although necessary for continuity of care, it is often difficult to obtain appropriate information in order to assist the student. If possible, secure a signed release from parents/guardians to communicate with the hospital or the student's outside mental health therapist/counselor. Meeting with parents/guardian about their child prior to his/her return to school is integral to making decisions concerning the needed supports, the student's preferences and concerns, and to begin discussing any possible changes to the student's schedule.

For students returning to school after a suicide-related mental health crisis (e.g., suicide attempt or psychiatric hospitalization), the school counselor/school social worker/mental health counselor, principal, and suicide prevention coordinator (or designee), will meet with the student's parent/guardian to ensure the student's readiness to return to school (see Appendix P for Re-entry protocol and documentation template).

1. A school employed mental health professional or suicide prevention coordinator will be identified to help coordinate the re-entry with the student, parent/guardian, and any outside mental health care providers.
2. Prior to the student's return, a meeting between designated school personnel (such as the suicide prevention coordinator or designee), student, and parents/guardian should be scheduled to discuss possible arrangements for support services and to create an individualized re-entry plan.
3. The re-entry coordinator/team will:
 - a. Review or update the student's safety plan.
 - b. Discuss any additional support the student may need.
 - c. Provide an update to the staff that have a *legitimate educational interest* prior to the student returning to the classroom; walk through how to respond to student's questions about where they have been, avoiding triggers, etc.
 - i. Classroom teachers **do** need to know information pertinent to the academic plan and be updated on the student's progress in **general**. They **do not** need clinical information or detailed history.
 - ii. See Appendix L, *Safety Plan: Instructions for Teachers/Support Staff*, which provides guidance on what information is best to share with teachers. It is important to share key details with all educators that the student will have for class throughout the school day to ensure a consistent care plan is provided.

4. A designated staff person will periodically check in with the student to help the student readjust to the school community and address any ongoing concerns. The suicide risk-monitoring tool (Appendix J) may also be utilized during this check-in with the student.
 - a. Given the high risk for suicide following discharge from inpatient hospitalization, it is important to follow-up with students to monitor suicide risk following re-entry into the school setting. The risk-monitoring tool provides school mental health professionals the opportunity to compare the student's current suicide risk with their baseline levels of risk following hospitalization.⁶ Like progress monitoring, this tool can be used to gather suicide risk data over time, which can assist in strengthening the student's safety plan and relevant school-based intervention. See *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention* and *Suicide Risk Monitoring: The Missing Piece in Suicide Risk Assessment* for more information.
5. The designated staff person will periodically check in with the parent/guardian to address any ongoing concerns or provide additional support if possible/needed. Additional supports could include exploring the need for a 504 or special education assessment.

Roles

It is critical that the school corporation ensure that all school employees act only within the authorization and scope of his/her credential and license. The recommendations for actions provided by role shall not be construed as authorizing or encouraging a school employee to assess or counsel a suicidal student unless he/she is specifically licensed, trained, and employed to do so.

School Administrator:

The role of a school administrator includes:

- being informed of a student at risk of suicide;
- informing the school suicide prevention coordinator;
- assisting with care coordination (i.e., referral to psychiatric assessment/treatment, returning to school, parent involvement, school absences); and
- ensuring that all pertinent individuals are aware of plans to address the needs of the student (e.g., suicide prevention coordinator).

When an administrator becomes aware of a student that may be at risk for suicide, the following steps should be taken:

- ensure the student has met with the Suicide Prevention Coordinator to determine the level of risk;
- follow-up with the Suicide Prevention Coordinator regarding communication with the student's parents/guardians;
- communicate with the Suicide Prevention Coordinator regarding the safety plan (see Appendix L for Safety Plan templates) and follow up recommendations for the student;
- assist with notifying necessary teachers/school personnel involved in the student's safety plan and follow up recommendations; and
- assist in the development of a follow-up plan, which may include a check-in with the student within 2 weeks of re-entry and/or assessment.

⁶ Ho, T-P. (2003). The suicide risk of discharged psychiatric patients. *The Journal of Clinical Psychiatry*, 64, 702-707. Retrieved from <http://www.psychiatrist.com/jcp/pages/home.aspx>

Suicide Prevention Coordinator:

District Level

A Suicide Prevention Coordinator at the district level may be designated by the Superintendent and may be an existing district employee. The district level coordinator will be responsible for planning and coordinating the implementation of the corporation policy and procedures.

Building Level

Each building principal may designate a school suicide prevention coordinator to act as a point of contact in each school for issues related to suicide prevention and policy implementation. It is recommended that this position at the building level be a School Counselor, School Social Worker, mental health counselor or someone with appropriate credentials and training to conduct the suicide screening and risk assessments. The Suicide Prevention Coordinator should serve as the point person for assessment and intervention.

**The district and building level coordinators are considered best practice (or recommended) but are not positions required by law. Referrals should be made to a School Counselor, School Social Worker, or mental health professional in the event that the school doesn't have a Suicide Prevention Coordinator.*

Recommended Trainings for District and Building-level Suicide Prevention Coordinators

School personnel who are selected to serve in the Suicide Prevention Coordinator role may need additional training. It is suggested that coordinators be competent in both knowledge and skills on the topics listed below.

- **Suicide Risk Assessment:** Provide appropriate training on the suicide risk assessment tool that is selected by the school corporation.
- **Safety Planning:** Safety training manual and additional training information can be found [here](#).
- **Counseling on Access to Lethal Means (CALM):** Access to lethal means can determine whether a person who is suicidal lives or dies. This course explains why means restriction is an important part of a comprehensive approach to suicide prevention. It will teach how to ask suicidal youth about their access to lethal means, and work with them and their families to reduce access.
- **Community Resources:** Such as grief education for educators, parents and community members. An example is Brooke's Place for Grieving Young People, an organization that provides grief workshops to educators: [Understanding and Supporting Children and Adolescents Living with Grief](#). It is important to have knowledge and skills in grief support and counseling when serving both students and families.
- **Postvention:** Postvention knowledge and skills help put protocols in place in a school community after a suicide to reduce the risk of future suicide deaths. An example would include [NOVA training](#).

School Counselor/School Social Worker/Mental Health Counselor:

The role of the School Counselor/School Social Worker/Mental Health Counselor is to determine the level of suicide risk, communicate with parents about their child's risk, develop collaborative safety plans, and communicate with administrators regarding recommendations and follow-up support as needed. The following action items are recommended:

- Complete a risk assessment (see Appendix J).
 - It is recommended that every school in the district use the same risk assessment and documentation practices.

- Ask questions about risk in a conversational way, encouraging the student to talk as needed. Talking can help reduce the intensity of their distress/suicide thoughts.
- Communicate with the student regarding contacting parents.
- *Contact the parent or guardian when there is any risk for harm to inform of the situation and to request active involvement in support for the student. Include the student in the conversation when possible and appropriate. The following should be addressed with the parent:
 - seriousness of the situation and not to assume the student is seeking attention;
 - a list of community mental health agencies/counselors (recommend developing a workgroup comprised of mental health partners/agencies to create a pipeline of mental health services for students and families);
 - information about when it is necessary to seek outside professional help;
 - the need for ongoing and continuous monitoring at home (see Appendix O for Parent Resources);
 - increasing safety measures in the home, ensuring the home is free of potential safety concerns (see Appendix L, O);
 - the desire and importance of working collaboratively with the student;
 - the need to follow a safety plan and update it as needed;
 - a request for a release of information form so communication between the school and outside health provider may occur to best support the student;
 - a request for the parent/guardian to stay in contact with the school and to be involved at the re-entry meeting for the student (see Appendix P);
 - when appropriate, assist family with urgent referral and/or calling emergency services;
 - support for families who don't speak or understand English, which may require an interpreter, etc. (students should not be translating to their family members).

*If it is determined that contacting the parent or guardian could endanger the health or well-being of the student, parent contact may be delayed as appropriate, and DCS and/or local law enforcement should be notified immediately. The school in this scenario, should document reasons for which parents were not immediately notified and information that demonstrates the student's health or well-being was assumed to be in danger.

*If reasonable attempts to reach the parent/guardian or adult in whose custody the student may be released are not successful, the case will be treated as a medical emergency and medical services and/or local law enforcement should be contacted. Documentation of all parties attempted to be reached should be made.
- Develop a safety plan for the student. When possible, this should be developed collaboratively with the student, parent, and any other individual(s) determined to be appropriate. The safety plan should be shared with school administration and other personnel who may be involved in the implementation of the plan (see Appendix L for sample safety plans).
- Once imminent risk to harm oneself or others is shared or assumed, confidentiality is not maintained (no longer considered privileged communication). Communicate with the school administrator regarding the imminent risk (danger to self and others), the risk level, recommendations, and collaborative safety plan.
- All actions and assessments must be documented and stored in a secure place.
 - Maintain a complete record of screening and assessment results; behavioral observations; information; and actions taken including dates, times, individuals involved; a copy of the safety plan, phone calls, conversations, and follow-up.
 - Documents should be placed in the Suicide Prevention Coordinator's office in a locked cabinet that is separate from academic student files. Documentation should NOT be placed in the student's permanent file. *It is critical to keep this documentation separate, secure, and confidential.*

- Provide the administrator and suicide prevention coordinator with information regarding follow-up services, re-entry plan and recommendations for the student's return to school.
- Failure on the part of the family to take seriously and provide for the safety of the student in case of potential suicide may be considered emotional neglect and reported to the Indiana Department of Child Services.

School Personnel

The role of school personnel is to inquire about concerns regarding student safety and notify the school suicide prevention coordinator. When school personnel become aware of a student who has thoughts of self-harm/suicide, they should respond in the following ways:

- Do not hesitate to ask the student if he/she has been or is thinking about suicide (see Appendix H, *What Can I Say*).
- Listen to the student with an open and non-judgmental stance.
- Do not dismiss or undervalue what the person is saying; all suicidal talk should be taken seriously.
- Be supportive and offer hope by assuring that everything possible will be done to provide assistance and support.
- Immediately notify the suicide prevention coordinator who will complete a risk screener to ensure safety.
- Notify a school administrator regarding the potential risk.
- Do not leave the student unsupervised and immediately walk him/her to a counselor or administrator.
- Document the date, time, individual(s) involved, summary of conversation, etc. and share with the Suicide Prevention Coordinator (see Appendix I, *Staff Documentation Form*).
- Following the referral, debrief with appropriate staff involved in the student's referral process (avoid sharing details that may be considered privileged communication or unnecessary details that the student may wish to remain private).

Assessments

A corporation-approved suicide assessment may be utilized by trained mental health staff, such as School Counselors, School Social Workers, or School Psychologists. It is recommended that at least three school personnel are trained to screen for the level of risk for imminent harm. It is important to ensure that all School Counselors, School Social Workers, School Nurses, and School Psychologists have the necessary training in suicide risk assessment and screening before assigning this responsibility to their role.

Suicide Screening vs. Suicide Assessment

Suicide prevention experts usually use the term *suicide screening* to refer to a procedure in which a standardized instrument or protocol is used to identify individuals who may be at risk for suicide. Suicide screening can be done independently or as a part of a more comprehensive health or behavioral health screening. Screening may be done orally (with the screener asking questions), with paper and pencil, or using a computer. Suicide assessment usually refers to a more comprehensive evaluation done by a School Counselor/School Social Worker/mental health counselor to confirm suspected suicide risk, estimate the immediate danger to the student, and decide on a course of action. Although assessments can involve structured questionnaires, they also can include a more open-ended conversation with a student, friends, teachers, and/or family to gain insight into the student's thoughts and behaviors, risk factors (e.g.

access to lethal means or a history of suicide attempts), protective factors (e.g., immediate family support), and medical and mental health history.⁷

Support for Students

Schools should be prepared to offer the following support to students:

- School Counselor/Social Worker/Nurse have a current list of community-based mental health resources to provide to parents, if needed.
 - At minimum, a list of mental health providers, their hours, approximate costs/sliding scale fees, location(s), and contact names and numbers should be in an information packet.
- School employees, including the suicide prevention coordinator or designee and teachers(s), will collaborate with the family and community resource(s) involved to prepare for re-entry and to continue to monitor the student's safety plan and additional supports needed.
- Counseling
 - In-School:
 - School Counselors, School Social Workers, School Psychologists, Nurses, and other appropriate school personnel are available to provide support and counseling to students who are victims or alleged victims of abuse.
 - School employees should act only within the authorization and scope of their credential or license. Only those employees with counseling expertise should provide counseling services.
 - Community
 - Community referrals may need to be made as necessary. The school should have a list of community resources available for the student and family.
 - A signed release form may be necessary to communicate with community counselors/therapist.
- Multidisciplinary/Student support/intervention team meetings should occur for the purpose of providing services and supports to students in need. To the extent permitted by confidentiality laws, information may be shared and concerns discussed to coordinate planning services for the student. Appropriate school personnel may also request information outside of the team meeting to coordinate services that may be provided in the community.
- Academic support available, if needed, for a child to continue to be successful in school.
- In the case of a student suicide, postvention plans need to be implemented.

If a suicide occurs, the following support should be available.

- Designate a safe room with counseling support for as long as it's needed. At least two mental health-trained professionals should be present.
 - Students sign in and out of room (important to ensure student safety and so follow-up can occur with students)
 - Students should be escorted to and from the room.
- Make information about grief available in the main and guidance offices and safe room (both general grief and complicated grief as it relates to suicide).

⁷ Suicide Prevention Resource Center, *Suicide Screening and Assessment* [Online]. (September 2014).

POSTVENTION

A death by suicide in the school community (whether by a student or staff member) can have devastating consequences on students and staff. Therefore, it is vital to be prepared in the event of such a tragedy. A school corporation's suicide death response action plan and postvention plan should incorporate both immediate and long-term steps and objectives.

Development and Implementation of an Action Plan: The crisis team, in collaboration with the suicide prevention coordinator, will develop an action plan to guide school response following a death by suicide. All team members should have training in postvention response and practice drills at least yearly.

The following steps are encouraged following a death by suicide:

1. **The crisis team meets.** The team should meet as soon as possible to implement the action plan following the news of the suicide death of a student, staff member, or active volunteer (see [After a Suicide Toolkit](#), pages 10-14).
2. **Identify a staff member to confirm death and cause** (school site administrator or designee). Staff will confirm the death through communication with the coroner's office, local hospital, the student's parent/guardian, or police department. Even when a case is assumed to be an instance of suicide, it should not be labeled as such until after a cause of death ruling has been made. If the cause of death has been confirmed a suicide but the parent or guardian will not permit the cause of death to be disclosed, the school should not share the cause of death but will use the opportunity to discuss suicide prevention with students.
3. **Assess the situation.** The crisis team will meet to prepare the postvention response, consider how severely the death is likely to affect other students, determine which students are most likely to be affected, etc. Be sure that with parent permission, siblings/relatives of the deceased are told separately, before communicating to other students. The crisis team will also consider how recently other traumatic events have occurred within the school community and the time of year of the suicide. If the death occurred during a school vacation, the need for or scale of postvention activities may look differently or be reduced. Also consider the need to notify other schools in the district, particularly schools who may have students related to the student in crisis.
4. **Share information.** Before the death is officially classified a suicide by the coroner's office, the death can and should be reported to staff, students, and parents/guardians with an acknowledgement that the cause is unknown. Inform the faculty that a sudden death has occurred, *preferably in a staff meeting*. Prepare a statement for staff members to share with students. The statement should include the basic facts of the death and known funeral arrangements (without providing details of the suicide method), recognition of the sorrow the news brings, and information about resources available to help students cope with their grief. *Public address system announcements and school-wide assemblies should not be used to deliver this news.* The crisis team may prepare a letter (with the input and permission from the student's parent or guardian) to send home with students that includes facts about the death, information about what the school is doing to support students, the warning signs of suicidal behavior, mental health awareness, and a list of resources available (see [After a Suicide Toolkit](#), pp. 15, 17-19).
 - a. Coordinate an all-staff meeting to include:
 - i. notification (if not already conducted) to staff about suicide death;
 - ii. emotional support and resources available to staff;
 - iii. notification to students about suicide death that is developmentally appropriate and the availability of support;
 - iv. services (if this is protocol determined to be appropriate by administration); &
 - v. information that is relevant and that which the school has permission to disclose.
 - b. Prepare staff to respond to needs of students regarding the following:

- i.* review of protocols for referring students for support/assessment;
 - ii.* talking points for staff to notify students;
 - iii.* mental health resources available to students (in-school and within the community); and
 - iv.* review suicide warning signs.
5. **Avoid suicide contagion.** It should be explained in the staff meeting described above, that one purpose of trying to identify and give services to other high-risk students is to prevent another death by suicide. The crisis team will work with teachers to identify students who are most likely to be significantly affected by the death (both those close to the deceased as well as those who have current mental health or other known life struggles). In the staff meeting, the crisis team will review suicide warning signs and procedures for reporting students who generate concern (see [After a Suicide Toolkit](#), pp 43-45).
6. **Initiate/provide support services.** Qualified school staff will meet with each student suspected to be more affected to determine if suicide risk is present. The crisis team will coordinate support services for students and staff in need of individual and small group counseling as needed. In concert with parents or guardians, crisis team members will refer to community mental health providers to ensure a smooth transition from the crisis intervention phase to meeting underlying or ongoing mental health needs (see [After a Suicide Toolkit](#), pp. 29-30). School personnel may want to consider the following:
- a.* students related to the deceased student;
 - b.* students who are having an unusually strong reaction to the death;
 - c.* the deceased student’s closest friends;
 - d.* the deceased student’s current or former dating partners;
 - e.* teammates, members of the same clubs or classes;
 - f.* students with a history of suicidal thoughts or behaviors;
 - g.* students who have dealt with a recent crisis or loss (or have had loved ones die by suicide); and
 - h.* students experiencing mental health problems or other vulnerabilities.
- When possible, parents may be encouraged to add their children to the list if they have concerns.
7. **Develop memorial plans.** The school should not create physical memorials (e.g. photos, flowers) on school grounds, hold funeral services, or fly the flag at half-mast because it may sensationalize the death and encourage suicide contagion. School should not be cancelled for the funeral. Any school-based memorials (e.g., small gatherings) will include a focus on how to prevent future suicides, increase mental health awareness, reduce stigma, and make prevention resources available (see [After a Suicide Toolkit](#), pp. 35-39).
- a.* It is not a safe practice to hold a candlelight vigil, a memorial service, or erect a permanent memorial (such as a plaque, bench, or tree) at the school in the case of any student death, as these practices could contribute to sensationalizing suicide or students considering suicide as a means to gain admiration or attention.
 - b.* Acceptable “living memorials” that decrease the risk of suicide contagion, reduce stigma associated with suicide, and increase mental health awareness include:
 - i.* A student-led suicide prevention initiative supervised by one or more faculty members. It is also suggested to have mental health providers available at this event.
 - ii.* A donation or fundraiser for a local crisis service or mental health care provider.
 - iii.* Participation as a school in a local suicide awareness event.
 - iv.* Hosting a suicide prevention or postvention training for students, staff, and/or families.

8. **Next Steps.** The school should return to a normal schedule as quickly as possible, with accommodations available for students who have been identified at elevated risk. Accommodations should be discussed on a case-by-case basis and provided in accordance with the school's intervention procedures.
- a. Remove the deceased students name from the school attendance roster, automated call system, any other place that a call home would be initiated.
 - b. If possible, reconvene staff 2-3 days following the death to focus on the following:
 - i. review and make adjustments to crisis plan implementation;
 - ii. any emerging needs among the student body or community;
 - iii. discussion of students identified as at risk and what they need;
 - iv. appreciations to helpful colleagues;
 - v. self-care plan implementation for all staff; and
 - vi. sharing of mental health resources in community-encourage support for staff and students (normalize seeking support).
 - c. Crisis debriefing. Debriefing will help staff, students, and crisis team members reflect on the successes and challenges of the school and district responses. Debriefing is critical to handling the next crisis better and should focus on staff self-care and process improvement. It is advised not only to provide debriefing throughout the immediate days following the crisis, but also after some time has passed allowing for further reflection on the crisis event.

COMMUNICATION

Notification of School Personnel

Death During Out of School Hours

1. Upon verification, the principal will notify the Superintendent, the Suicide Prevention Coordinator, other appropriate administrators, and crisis team.
2. Enact crisis response plan as deemed appropriate.

Death that Occurs during School Hours

1. Follow administrative and staff actions as above.
2. Convene emergency meeting of crisis response team. The team will meet immediately to develop a plan and delegate responsibilities. This should include a communication plan:
 - a. Determine who will contact family
 - b. Prepare a written statement of the facts
 - c. Plan for contact with relatives, friends of student
 - d. Determine who will be available for support
 - e. Identify and plan to support teachers who are uncomfortable or not able to tell students
 - f. Plan how to interface with media
 - g. Determine whether to involve outside consultants/counselors if needed and appropriate
 - h. Determine who else should be notified (parents of friends, colleagues, etc.)
 - i. Determine who will collect student's personal belongings (only immediate need for items in classroom); this should be done when students are not in the building
 - j. Communicate information about upcoming staff meeting (if applicable)
3. Since most staff will be teaching, they should be notified on the basic facts (what, when, who) and advised to follow designated procedures as outlined on the notification. Explain there will be a staff meeting (after school, if possible) with additional information and time to ask questions and gain support.

Staff Meeting

1. If a general staff meeting is held prior to informing students of the death, the meeting should focus on reviewing procedures for faculty meeting (see Appendix R).
2. Staff should be made aware of those students who are "at risk" or "high risk" or other students who may not voluntarily seek help and should be referred. Teachers would most likely know who the student's closest friends were and could provide a short list to the office. See Appendices S, T for guidance on talking to students about suicide.
3. If the general staff meeting is held after students are informed, the meeting should focus on reviewing the day's events, providing time for sharing, and identifying students who may need additional support.
4. In either case, great sensitivity should be taken in responding to staff member needs. Staff will be experiencing all the feelings associated with the death and availability of support for them should also be stressed. They should especially be encouraged to meet with a support staff person or mental health provider if they are experiencing guilt related to unobserved warning signs from the student or related to actions they may have taken with the student (discipline, grades, etc.)

Notification to Students

Death During Out of School Hours

1. Crisis team members should contact close friends as soon as possible as they arrive at school to notify them and stress the availability of support. If possible, parents of the close friends should be notified first – allowing parents to be there when their child finds out or if the parent prefers to tell the child.
2. All other students should be notified from a statement prepared by the crisis response team and suicide prevention coordinator to be shared during the first period of the day.

Death that Occurs during School Hours

1. As the staff is being informed, those students who were closest to the person who has died by suicide should be informed in small groups by a school-based mental health professional. Parents of these students should also be contacted. In addition, the following guidelines should be observed.
 - a. If the student is already in a “risk” category and/or if the student is extremely upset and indicates he/she may be suicidal, a preliminary assessment of suicidal risk should be done.
 - b. Stress the availability of support the student can seek in and out of school.
 - c. Give student the option of returning to class or continuing to meet with support personnel
 - d. Students may be allowed to leave school only if accompanied by a parent or guardian (request parent signature if they leave).
2. The classroom teacher, a crisis team member or other school-based mental health professional will inform students of the basic facts of the death from a prepared statement and stress the availability of immediate and ongoing support as available in the school and community.

Media

1. The school principal or designee should be the sole media spokesperson. Staff will refer all inquiries from the media directly to the spokesperson. The spokesperson will:
 - a. Keep the district and school suicide prevention coordinators and superintendent informed of school actions related to the death.
 - b. Prepare a statement for the media, including the facts of the death, postvention plans, and available resources. The statement will not include confidential information, speculation about victim motivation, means of suicide, or personal family information (see [After a Toolkit](#), pp. 19-21).
 - c. Answer all media inquiries. If a suicide is to be reported by news media, the spokesperson should encourage reporters to avoid the following: making it a front-page story, using pictures of the suicide victim, using the word suicide in the caption of the story, describing the method of suicide, or using the phrase “suicide epidemic” as this may elevate the risk of suicide contagion. They should also be encouraged not to link bullying (or any other issue) to suicide and not to speculate about the reason for suicide. Media should be asked to offer the community information on suicide risk factors, warning signs, and resources available (see [Recommendations for Reporting on Suicide](#)).

Appendix A

Definitions

At-risk	A student who is defined as high risk for suicide is one who has made a previous suicide attempt, has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition. The student may have thought about suicide including potential means of death and may have a plan. In addition, the student may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain. This situation would necessitate a referral, as documented in the following procedures. *Another important risk factor to note is if a student has had a parent/guardian die by suicide.
Crisis team	A multidisciplinary team comprised primarily of administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery, including for suicide related situations. These professionals have been specifically trained in suicide intervention and crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports.
Mental health	A state of mental and emotional wellbeing that can impact choices, actions, and relationships that affect wellness. Mental health problems include mental and substance use disorders.
Postvention	Suicide postvention is a crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.
Suicide Loss Survivor	A survivor of suicide is a family member or friend of a person who died by suicide.
Risk assessment	An evaluation of a student who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.
Risk factors for suicide	Characteristics or conditions that increase the chance that a person may try to take his or her life. Suicide risk tends to be highest when someone has several risk factors at the same time. Risk factors may encompass biological, psychological, and or social factors in the individual, family, and environment.
Self-harm	Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. It can be categorized as either nonsuicidal self-injury or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.
Suicidal ideation	Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.
Suicidal behavior	These behaviors include suicide attempts, intentional injury to self, associated with at least some level of intent, developing a plan or strategy for suicide, writing a suicide note, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.

Suicide attempt	A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.
Suicide	Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner's or medical examiner's office must first confirm that the death was a suicide before any school official may state this as the cause of death. Parent acknowledgement that the death was a suicide is strongly recommended before discussing the death as a suicide with the students.
School (and District-Level) Suicide Prevention Coordinator	<p>The district-level suicide prevention coordinator may be an existing staff member and is designated by the Superintendent with the responsibility of planning and coordinating implementation of this policy for the school district.</p> <p>The school suicide prevention coordinator is appointed at the building level by the school principal to act as a point of contact in each school for issues relating to suicide prevention and policy implementation (including documentation). All staff members report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator. In the absence of the school suicide prevention coordinator, the school counselor/school social worker/mental health professional or an administrator would be the designee.</p> <p>*Although not required, this position is recommended.</p>

Appendix B

Sample School Policy

I. Policy Statement

It is the responsibility of the _____ School Corporation to provide a safe, supportive, and culturally responsive school environment for all students. The _____ School Board believes that suicide is a preventable public health problem and acknowledges that all students have the right to be protected from those indicators that put students at higher risk for suicide. The board thus acknowledges the necessity of this policy to ensure school personnel are able to recognize and report students at risk of suicide.

II. Purpose

- a. To protect the health and well-being of all _____ (insert school name) students.
- b. To establish procedures to prevent, assess the risk of, intervene, and respond to suicide risk in students, staff, and volunteers and make referrals as needed.
- c. To educate all school personnel on their role in providing an environment that is sensitive to individual and societal factors and one which helps to foster positive youth development.
- d. To ensure that all efforts will be made to maintain the privacy and dignity of students and families.
- e. To identify the Suicide Prevention Coordinator and other lead personnel.
_____ Suicide Prevention Coordinator (District)
_____ School Suicide Prevention Coordinator
_____ Designee(s) when the coordinator is not immediately available

III. Suicide

a. Definitions

- i. Crisis Team (title of the team may be changed to match school's terminology): A multidisciplinary team comprised primarily of administrative, mental health, safety professionals, and support staff whose primary focus is to address crisis preparedness, intervention/response and recovery, including for suicide related situations. These professionals have been specifically trained in suicide intervention and crisis preparedness through recovery and take the leadership role in developing crisis plans, ensuring school staff can effectively execute various crisis protocols, and may provide mental health services for effective crisis interventions and recovery supports. Crisis team members include: _____
- ii. Mental Health: A state of mental and emotional wellbeing that can impact choices, actions, and relationships that affect wellness.
- iii. Suicide Postvention: A crisis intervention strategy designed to reduce the risk of suicide and suicide contagion, provide the support needed to help survivors cope with a suicide death, address the social stigma associated with suicide, and disseminate factual information after the suicide death of a member of the school community.
- iv. Risk Determination/Assessment: An evaluation of a student who may be at risk for suicide, conducted by the appropriate school staff (e.g., school psychologist, school counselor, or school social worker). This assessment is designed to elicit information regarding the student's intent to die by suicide, previous history of suicide attempts, presence of a suicide plan and its level of lethality and availability, presence of support systems, and level of hopelessness and helplessness, mental status, and other relevant risk factors.

- v. Risk Factors for Suicide: Characteristics or conditions that increase the chance that a person may try to take his/her life. Suicide risk tends to be highest when several risk factors are present at one time. Risk factors may include biological, psychological, and /or social factors in the individual, family and environment.
- vi. Self-harm: Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. It can be categorized as either non-suicidal self-injury or suicidal. Although self-harm often lacks suicidal intent, youth who engage in self-harm are more likely to attempt suicide.
- vii. Suicidal Ideation: Thinking about, considering, or planning for self-injurious behavior which may result in death. A desire to be dead without a plan or intent to end one's life is still considered suicidal ideation and should be taken seriously.
- viii. Suicidal Behavior: These behaviors include suicide attempts, intentional injury to self, associated with at least some level of intent, developing a plan or strategy for suicide, writing a suicide note, gathering the means for a suicide plan, or any other overt action or thought indicating intent to end one's life.
- ix. Suicide Attempt: A self-injurious behavior for which there is evidence that the person had at least some intent to kill himself or herself. A suicide attempt may result in death, injuries, or no injuries. A mixture of ambivalent feelings such as wish to die and desire to live is a common experience with most suicide attempts. Therefore, ambivalence is not a sign of a less serious or less dangerous suicide attempt.
- x. Suicide: Death caused by self-directed injurious behavior with any intent to die as a result of the behavior. Note: The coroner's or medical examiner's office must confirm that the death was a suicide before any school official may state this as the cause of death. Parent acknowledgement that the death was a suicide is strongly recommended before discussing the death as a suicide with the students.
- xi. District-Level Suicide Prevention Coordinator: The district-level coordinator may be an existing staff member and is designated by the Superintendent with the responsibility of planning and coordinating implementation of this policy for the school district.
- xii. School Suicide Prevention Coordinator: Appointed at the building level by the school principal to act as a point of contact in each school for issues relating to suicide prevention and policy implementation (including documentation). All staff members report students they believe to be at elevated risk for suicide to the school suicide prevention coordinator. In the absence of the school suicide prevention coordinator, the school counselor/school social worker/mental health professional or an administrator would be the designee.

*The district and school coordinators are considered best practice (or recommended) but are not positions required by law.

See additional definitions in Appendix A.

b. Risk Factors

The student:

- i. has made previous suicide attempt(s);
- ii. has the intent to die by suicide, or has displayed a significant change in behavior suggesting the onset or deterioration of a mental health condition;
- iii. has thought about the potential means of death and may have a plan;
- iv. may exhibit feelings of isolation, hopelessness, helplessness, and the inability to tolerate any more pain;
- v. has had a parent/guardian or other close family member die by suicide.

IV. Response Procedures

First responders/Staff:

- a. School personnel may ask some initial screening questions, if appropriate, or make a referral to the suicide prevention coordinator for initial screening and assessment (see Appendix H, *What Can I Say?*)
 - i. Listen to the student with an open and non-judgmental stance; do not dismiss or undervalue what is being shared; be supportive and offer hope.
 - ii. It is ok to ask the student if he/she has been thinking about suicide.
- b. Always take the threat of harm seriously.
- c. Take immediate action, which may include calling 911 and/or local law enforcement if the student is in imminent danger.
- d. Notify the School Suicide Prevention Coordinator so s/he can meet with the student and conduct a suicide risk assessment.
- e. The student should NOT be left unsupervised.
- f. Notify a school administrator regarding the potential risk.
- g. Document date, time, individuals involved, summary of conversation, etc. and share with the Suicide Prevention Coordinator.
- h. Following the referral, debrief with appropriate staff involved in the student's referral process (avoid sharing details that may be considered privileged communication or unnecessary details that the student may wish to remain private).

The following should be conducted by the School Suicide Prevention Coordinator or designee:

- i. Complete a Suicide Screening (if this hasn't already taken place) and/or a Suicide Assessment to determine or confirm suspected suicide risk. (*Schools should insert the name of the screening and assessment tools used in the district*).
- j. Communicate with the student about contacting parents. Include the student in this conversation with the parent, when possible and appropriate.
- k. Contact the parent/guardian when there is risk of harm to inform of the situation and request active involvement in support of the student. The following should be addressed with the parent:
 - i. seriousness of the situation;
 - ii. do not assume the student is seeking attention;
 - iii. a list of community mental health agencies/counselors;
 - iv. information about when it is necessary to seek outside professional help;
 - v. the need for ongoing and continuous monitoring at home;
 - vi. increasing safety measures in the home, ensuring the home is free of potential safety concerns;
 - vii. the desire and importance of working collaboratively with the student;
 - viii. the need to follow a safety plan and update it as needed;
 - ix. a request for a release of information form so communication between the school and outside health provider can take place to best support the student;
 - x. a request for the parent/guardian to stay in contact with the school and to be involved at the re-entry meeting for the student (see Appendix O for parent information);
 - xi. when appropriate, assist family with urgent referral and/or calling emergency services;
 - xii. support for families who don't speak or understand English, require an interpreter, etc. It's important not to have the student or other family member translate.
- l. If reasonable attempts to reach the parent/guardian or adult in whose custody the student may be released are not successful, the case will be treated as a medical emergency and

- arrangements will be made to contact appropriate medical services or local law enforcement. Documentation of all parties attempted to be reached will be made.
- m. Failure on the part of the family to take seriously and provide for the safety of the student may be considered emotional neglect and reported to the Indiana Department of Child Services.
 - n. Develop a safety plan for the student. When possible, this should be developed collaboratively with the student, parent, and any other individual(s) determined to be appropriate. The plan should be shared with school administration and other personnel who will be involved in the implementation of the plan (see, Appendix L).
 - o. Once imminent risk to harm oneself or others is shared, confidentiality is not maintained (no longer considered privileged communication). Inform the School Administrator (who should contact the District Suicide Prevention Coordinator) regarding the imminent risk (danger to self and others), risk level, recommendations, and safety plan.
 - p. ALL actions and assessments must be documented. This should include screening and assessment results, behavioral observations; actions taken, including dates, times, individuals involved; a copy of the safety plan; phone calls; conversations; and follow-up actions. This documentation must be kept by the Suicide Prevention Coordinator in a secure file cabinet, separate from a student's cumulative folder or academic file. It is critical to keep this documentation separate, secure, and confidential.
 - q. The school administrator and suicide prevention coordinator should be informed regarding follow-up services, re-entry plan, and recommendations for the student to return to school.

V. Reporting to State Authorities

- a. If after informing the parent of the situation, failure by the parent or the family to take seriously and provide safety for the student may be considered emotional neglect and may be reported to the Indiana Department of Child Services.
- b. If it is determined by school staff that contacting the parent or guardian would endanger the health or well-being of the student, parent contact may be delayed as appropriate, and DCS and/or local law enforcement should be notified immediately. The school should document reasons for which parents were not immediately notified and information that demonstrates the student's health or well-being was assumed to be in danger. The school administrator or designee must stay at school with the student until the proper authorities arrive and assume responsibility for the child.

VI. Support for Students

- a. School Counselor/Social Worker/Nurse have a current list of community-based mental health resources.
- b. School employees, including the suicide prevention coordinator or designee and teachers(s), will collaborate with the family and community resource(s) involved to prepare for re-entry and to continue to monitor the student's safety plan and additional supports needed.
- c. Counseling
 - i. In-School:
 - 1. School Counselors, School Social Workers, School Psychologists, Nurses, and other appropriate school personnel are available to provide support and counseling to students who are victims or alleged victims of abuse.
 - 2. School employees should act only within the authorization and scope of their credential or license. Only those employees with counseling expertise should provide counseling services.
 - ii. Community

1. Community referrals may need to be made as necessary. The school should have a list of community resources available for the student and family.
 2. A signed release form may be necessary to communicate with community counselors/therapist.
- d. Multidisciplinary/Student support/intervention team meetings should occur for the purpose of providing services and supports to students in need. To the extent permitted by confidentiality laws, information may be shared and concerns discussed to coordinate planning services for the student. Appropriate school personnel may also request information outside of the team meeting to coordinate services that may be provided in the community.
 - e. Academic support available, if needed, for a child to continue to be successful in school.
 - f. In the case of a student suicide, postvention plans need to be implemented.

VII. School Employee Training

a. Staff Training Required by Indiana Law

- i. Per IC 20-28-3-6, after June 30, 2018, evidence-based youth suicide awareness and prevention training is required for all teachers, including Superintendent licensed under IC 20-28-5; principal; teacher; librarian; school counselor; school psychologist; school nurse; school social worker; and any other appropriate school employees who are employed at schools that provide instruction in any combination of grades 5-12.

Training:

1. must be during the teacher or school employee's contracted day or at a time chosen by the employee;
2. may include an in-person presentation or online;
3. shall count toward professional development requirements; and
4. must be demonstrated to be an effective or promising program and recommended by the Indiana Suicide Prevention Network Advisory Council.

- ii. Suicide Training Required for Indiana Licensure: An initial teaching license (instructional, student services, or administrative) may not be issued at any grade level unless the applicant has completed education and training on the recognition of signs that a student may be considering suicide.

b. Recommended training for Suicide Prevention Coordinators

It is recommended that all Suicide Prevention Coordinators at the district and school levels participate in training on Suicide Risk Assessment; Safety Planning; Counseling on Access to Lethal Means; Community Resource Planning; and Postvention.

VIII. Resources

School webpage

[DOE webpage](#)

IX. History Adopted: January 16, 2018

Appendix C

How To Use This Suicide Prevention Toolkit

Step 1

Develop a coordinated system of how this plan will be communicated to all educators in your school corporation. In doing so, it is recommended to develop an Advisory Group as well as identify a Suicide Prevention Coordinator both at the district level as well as a Suicide Prevention Coordinator per building.

Step 2

Develop school-wide procedures and protocols for suicide prevention, intervention, and postvention. Determine the suicide screening tool and suicide risk assessment tool that the school will adopt as well as who in the buildings will be designated to conduct the screening and assessments.

Step 3

Select an Evidence-based Youth Suicide Awareness and Prevention Training for school staff. Develop a training plan to ensure all school staff has been trained on a regular basis (includes a minimum of a 2-hour training at least every 3 years). Provide resources and ongoing support for all school staff in the area of mental health education and suicide prevention, intervention, and postvention.

Step 4

Develop a referral network of community mental health agencies to coordinate a collaborative partnership between school and community. Provide parent education, outreach, and support for suicide prevention education and mental health education, working to reduce the stigma associated with mental health disorders and suicide.

Appendix D

Risk and Protective Factors for Mental, Emotional, and Behavioral Disorders in Adolescents

Risk Factors	Domain	Protective Factors
<ul style="list-style-type: none"> • Female gender • Early puberty • Difficult temperament: inflexibility, low positive mood, withdrawal, poor concentration • Low self-esteem, perceived incompetence, negative explanatory and inferential style • Anxiety • Low-level depressive symptoms and dysthymia • Insecure attachment • Poor social skills: communication and problem-solving skills • Extreme need for approval and social support • Low self-esteem • Shyness • Emotional problems in childhood • Conduct disorder • Favorable attitudes toward drugs • Rebelliousness • Early substance use • Antisocial behavior • Head injury • Marijuana use • Childhood exposure to lead or mercury (neurotoxins) 	<p>Individual</p>	<ul style="list-style-type: none"> • Positive physical development • Academic achievement/intellectual development • High self-esteem • Emotional self-regulation • Good coping skills and problem-solving skills • Engagement and connections in two or more of the following contexts: school, with peers, in athletics, employment, religion, culture

<ul style="list-style-type: none"> • Parental depression • Parent-child conflict • Poor parenting • Negative family environment (may include substance abuse in parents) • Child abuse/maltreatment • Single-parent family (for girls only) • Divorce • Marital conflict • Family conflict • Parent with anxiety • Parental/marital conflict • Family conflict (interactions between parents and children and among children) • Parental drug/alcohol use • Parental unemployment • Substance use among parents • Lack of adult supervision • Poor attachment with parents • Family dysfunction • Family member with schizophrenia • Poor parental supervision • Parental depression • Sexual abuse 	<p>Family</p>	<ul style="list-style-type: none"> • Family provides structure, limits, rules, monitoring, and predictability • Supportive relationships with family members • Clear expectations for behavior and values
<ul style="list-style-type: none"> • Peer rejection • Stressful events • Poor academic achievement • Poverty • Community-level stressful or traumatic events • School-level stressful or traumatic events 		

<ul style="list-style-type: none"> • Community violence • School violence • Poverty • Traumatic event • School failure • Low commitment to school • Not college bound • Aggression toward peers • Associating with drug-using peers • Societal/community norms favor alcohol and drug use • Urban setting • Poverty • Associating with deviant peers • Loss of close relationship or friends 	<p>School, Neighborhood, and Community</p>	<ul style="list-style-type: none"> • Presence of mentors and support for development of skills and interests • Opportunities for engagement within school and community • Positive norms • Clear expectations for behavior • Physical and psychological safety
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Adapted from O’Connell, M. E., Boat, T., & Warner, K. E. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academies Press; and U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (2009). *Risk and protective factors for mental, emotional, and behavioral disorders across the life cycle*.

Here are some key suicide risk factors:

- A recent or serious loss, which might include the death of a family member, friend or pet. The separation or a divorce of parents, or a breakup with a boyfriend or girlfriend, can also be felt as a profound loss, along with a parent losing a job, or the family losing their home.
- A psychiatric disorder, particularly a mood disorder like depression and/or anxiety, or a trauma- and stress-related disorder.
- Prior suicide attempts increase risk for another suicide attempt.
- Alcohol and other substance use disorders, as well as getting into a lot of trouble, having disciplinary problems, engaging in a lot of high-risk behaviors.
- Struggling with sexual orientation in an environment that is not respectful or accepting of that orientation. The issue is not whether a child is gay or lesbian, but whether he or she is struggling to come out in an unsupportive environment.
- A family history of suicide is something that can be really significant and concerning, as is a history of domestic violence, child abuse or neglect.
- Lack of social support. A child who doesn’t feel support from significant adults in his/her life, as well as his/her friends, can become so isolated that suicide seems to present the only way out of problems.

- Bullying. We know that being a victim of bullying is a risk factor, but there's also some evidence that kids who are bullies may be at increased risk for suicidal behavior.
- Access to lethal means, like firearms and pills.
- Stigma associated with asking for help. The more hopeless and helpless people feel, if they feel a lot of guilt or shame or feel worthless or have low self-esteem, the more likely they are to choose to hurt themselves or end their life.
- Barriers to accessing services: Difficulties in getting much-needed services include lack of access to counseling (both in school and out of school), bilingual service providers, unreliable transportation, and the financial cost of services.
- Cultural and religious beliefs that suicide is a noble way to resolve a personal dilemma.

WARNING SIGNS

Warning signs of suicide can be organized around the word "FACTS"

Feelings

- Hopelessness: feeling like things are bad and won't get any better
- Fear of losing control, going crazy, harming himself/herself or others
- Helplessness: a belief that there's nothing that can be done to make life better
- Worthlessness: feeling like an awful person and that people would be better off if he/she were dead
- Hating himself/herself, feeling guilty or ashamed
- Being extremely sad and lonely
- Feeling anxious, worried, or angry all the time

Actions

- Drug or alcohol abuse
- Talking or writing about death or destruction
- Aggression: getting into fights or having arguments with other people
- Recklessness: doing risky or dangerous things

Changes

- Personality: behaving like a different person, becoming withdrawn, tired all the time, not caring about anything, or becoming more talkative or outgoing

- Behavior: can't concentrate on school or regular tasks
- Sleeping pattern: sleeping all the time or not being able to sleep at all, or waking up in the middle of the night or early in the morning and not being able to get back to sleep
- Eating habits: loss of appetite and/or overeating and gaining weight
- Losing interest in friends, hobbies, and appearance or in activities or sports previously enjoyed
- Sudden improvement after a period of being down or withdrawn

Threats

- Statements like "How long does it take to bleed to death?"
- Threats like "I won't be around much longer" or "Don't tell anyone else . . . you won't be my friend if you tell!"
- Plans like giving away favorite things, studying about ways to die, obtaining a weapon or a stash of pills: the risk is very high if a person has a plan and the way to do it.
- Suicide attempts like overdosing, wrist cutting

Situations

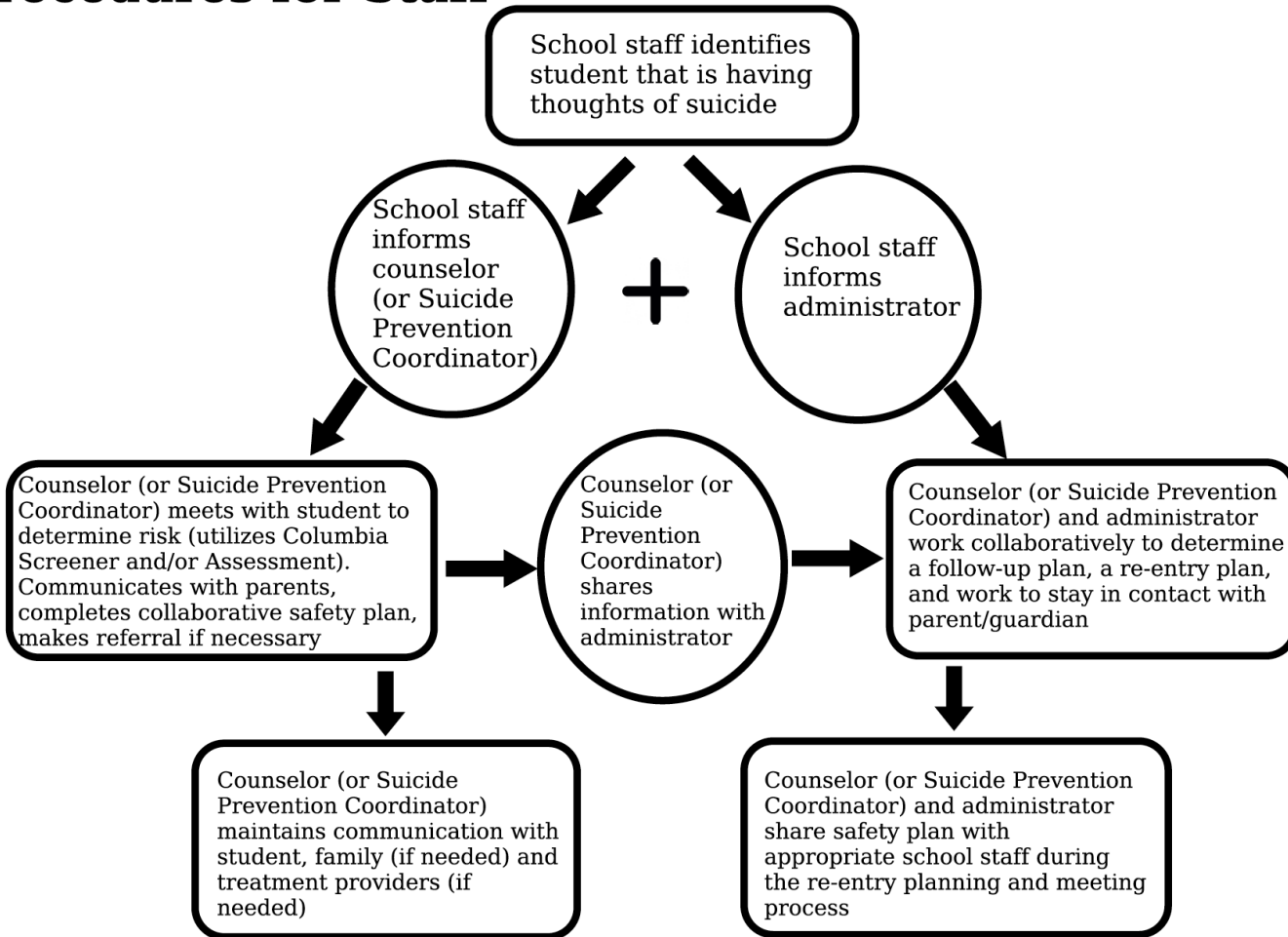
- Getting into trouble at school, at home, or with the law
- Recent loss through death, divorce, or separation; the breakup of a relationship; losing an opportunity or a dream; losing self-esteem
- Changes in life that feel overwhelming
- Being exposed to suicide or the death of a peer under any circumstances

As referenced in the LifeLines Curriculum, (Hazelden, 2011).

** The LifeLines program organizes the warning signs of suicide by use of the acronym FACTS, which stands for feelings, actions, changes, threats, and situations.*

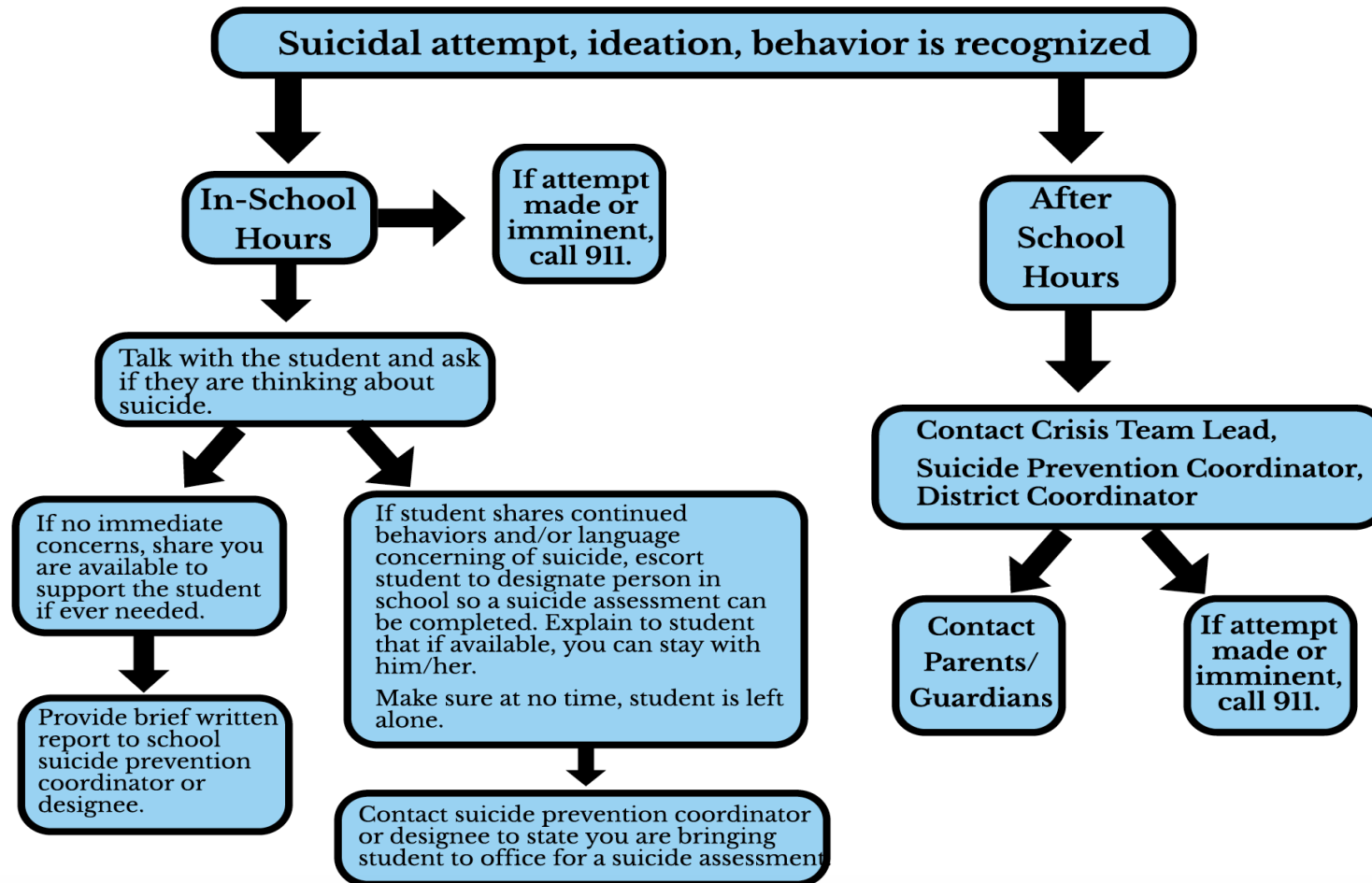
Appendix E

Procedures for Staff



Appendix F

Suicide Intervention Flowchart: Teacher



What do I do when I notice a student might be at risk?

If a school staff member notices changes in the way a student thinks, feels or behaves that cause concern then they should take action. The type of action required depends on the severity and frequency of the observations. The general rule is:

- the longer the worrying behavior persists (duration)
- the more risky or intense the worrying behavior is (intensity)
- the more the behavior interferes with the student's daily functioning, and
- the more distress it causes the individual or others,
- the length of time the behavior has been noticed, then (duration)
- the greater the level of concern.

LEVEL 1

Notice, Talk to Student, & Gather More Information

If you have noticed minor changes that are unusual for the student, talk with the student. It is also wise to ask to see if others (teachers, counselors, parents) have noticed these changes.

LEVEL 2

Provide Assistance & Refer for Additional Support

If several changes have happened over short period of time or behaviors have not improved, then it is time to refer to school-based mental health support. Talk with the student to show your continued support as well and that you will be a part of this process if s/he would like that to happen.

LEVEL 3

Immediate Action

In the event you suspect student is in imminent danger of harm to self or others, seek immediate mental health or emergency support (Suicide Prevention Coordinator or designee).

Appendix H

What Can I Say? Finding The Words

Guide sheet for educators when talking with a student that may be in crisis

Engage in Conversation



- Approach with care and openly discuss the signs/behaviors that are causing you concern. What have you noticed?
- Ask directly about suicide. It is important to be specific and ask the student if s/he is thinking about suicide.

"Sometimes when students are feeling this overwhelmed, they think about suicide. Are you thinking about suicide?"

Actively Listen



- Listen to the reasons the person has for both living and dying.
- Validate that they are considering both options and underscore that living is an option for them.

"I can hear you are feeling a lot of pain and even seem to feel a little uncertain. I am concerned about you and want to help you."

Respectful & Nonjudgmental



- Show the student you are taking this situation seriously.
- Demonstrate care, empathy, and keep a nonjudgmental stance.
- Do not minimize the student's experience or situation.
- Validate the student's story and feelings. It is not the time to challenge the facts.

Show Continued Support



- This student has confided in you. This student chose you to share a deeply personal part of his/her life with. Although it is critical to refer to the appropriately trained school-based mental health staff, do not feel that you cannot be involved in the continued support and care.
- Provide continued support to the student.
- Work collaboratively with the school counselor and family in supporting the student.

Created by, Dr. Brandie Oliver (2017)

Appendix I

Staff Documentation Form

Student:		School:	
Grade:		Date:	
Staff Person Referring:		Time of Day:	

Concern of student suicide was brought to my attention by:

- Student self-report Another student Overheard students talking
 Student's writing Online posting/Social Media Other _____

What other information did this student share that raised a concern about suicide risk?

What steps did you take?

What did the student share when asked about suicide?

****Important to Remember****

- Remain calm.
- Ask the youth directly if he or she is thinking about suicide (e.g., "Are you thinking of suicide?").
- Focus on your concern for their well-being and avoid being accusatory.
- Use your active listening skills—remember, the focus should be all on the student.
- Reassure them that there is help and they will not feel like this forever.
- Take a nonjudgmental and open stance to what the student is sharing, no matter how uncomfortable. The student has chosen you to share his/her painful story.
- Provide constant supervision. **Never leave the youth alone.**
- ***Get help:*** No one should ever agree to keep a youth's suicidal thoughts a secret and instead should tell an appropriate adult, such as a parent, school counselor/school social worker/mental health provider, administrator, teacher, or school psychologist. Parents should seek help from school or community mental health resources as soon as possible. School staff should take the student to the Suicide Prevention Coordinator.

Turn this form into the Suicide Prevention Coordinator, School Counselor, or Administrator (in person) IMMEDIATELY. Your notes will be extremely valuable when completing the student's suicide risk assessment. Do not send this form via email or send it to the office with a student. A teacher may send notification via email or phone call that he/she has a documentation form related to suicide that needs to be delivered to the office but no identifying student information should be sent in the email. If immediate assistance is required, the office should be notified via a phone call, rather than email.

Appendix J

Suicide Screening & Risk Assessment Tools

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

- Suicide Risk Questionnaire
- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Suicidal Ideation Questionnaire (SIQ)

Assessment Tools

- Columbia-Suicide Severity Rating Scale Lifetime-Recent
- SAMHSA SAFE-T risk assessment tool w/ Columbia-Suicide Severity Rating Scale Recent

Suicide Risk Questionnaire

Part I: Suicide Risk Questionnaire

Have you heard someone say:

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

Have you observed:

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

Part II: Depression Risk Questionnaire

Have you noticed the following signs of depression:

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

If depression seems possible, have you also noticed:

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

SCORING If you checked circles under:

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

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

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

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

Source: http://www.mhrsonline.org/media/spc_schools/Suicide%20Risk%20Questionnaire.pdf

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
	YES	NO
Ask questions that are bolded and <u>underlined</u>.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it." <u>Have you been thinking about how you might kill yourself?</u>		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <u>Have you had these thoughts and had some intention of acting on them?</u>		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) Suicide Behavior Question: <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. <u>If YES, ask: How long ago did you do any of these?</u> · Over a year ago? · Between three months and a year ago? · Within the last three months?		

For inquiries and training information contact: Kelly Posner, Ph.D.
 New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; posnerk@nyspi.columbia.edu
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Source: https://www.integration.samhsa.gov/clinical-practice/Columbia_Suicide_Severity_Rating_Scale.pdf

Suicidal Ideation Questionnaire

The SIQ assesses the frequency of suicidal ideation and serves as a valuable component in a comprehensive assessment of adolescent mental health.



SIQ

Suicidal Ideation Questionnaire

William M. Reynolds, PhD

Purpose:	Screens for suicidal ideation in adolescents
Format:	Paper and pencil, Online administration and scoring via PARiConnect
Age range:	12 years to 18 years
Time:	10 minutes or less
Qualification level:	S

Serves as a starting point for gathering information about your client's suicide potential

- The SIQ consists of 30 items and is appropriate for students in Grades 10-12.
- The SIQ-JR consists of 15 items and is designed for students in Grades 7-9.
- Reliability coefficients are .97 for the SIQ and .93-.94 for the SIQ-JR.

For many adolescents, the SIQ and the SIQ-JR provide a mechanism for informing adults/professionals of their level of distress and suicidal intent, serving as a cry for help that doesn't involve self-injurious behavior. Adolescents who are thinking about suicide may respond to these measures with the expectation that, in telling others of their suicidal thoughts, people will take notice of their distress and act to assist them. It is therefore vital that professionals act quickly once critical SIQ or SIQ-JR scores are obtained.

Source: <https://www.parinc.com/Products/Pkey/413>

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Lifetime/Recent Version

Version 1/14/09

*Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.;
Burke, A.; Oquendo, M.; Mann, J.*

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

*Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)*

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact posnerk@nyspi.columbia.edu

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SUICIDAL IDEATION			
<i>Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.</i>		Lifetime: Time He/She Felt Most Suicidal	Past 1 month
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If yes, describe:			
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., "I've thought about killing myself") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. <i>Have you actually had any thoughts of killing yourself?</i>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If yes, describe:			
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, "I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it." <i>Have you been thinking about how you might do this?</i>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If yes, describe:			
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having <u>some intent to act on such thoughts</u> , as opposed to "I have the thoughts but I definitely will not do anything about them." <i>Have you had these thoughts and had some intention of acting on them?</i>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If yes, describe:			
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>		Yes No <input type="checkbox"/> <input type="checkbox"/>	Yes No <input type="checkbox"/> <input type="checkbox"/>
If yes, describe:			
INTENSITY OF IDEATION			
<i>The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal.</i>			
<u>Lifetime - Most Severe Ideation:</u> Type # (1-5) _____ Description of Ideation _____		Most Severe	Most Severe
<u>Recent - Most Severe Ideation:</u> Type # (1-5) _____ Description of Ideation _____			
Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		_____	_____
Duration <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time		_____	_____
Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts		_____	_____
Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply		_____	_____
Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (0) Does not apply		_____	

SUICIDAL BEHAVIOR (Check all that apply, so long as these are separate events; must ask about all types)		Lifetime		Past 3 months	
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. <i>There does not have to be any injury or harm</i> , just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. <i>Have you made a suicide attempt?</i> <i>Have you done anything to harm yourself?</i> <i>Have you done anything dangerous where you could have died?</i> <i>What did you do?</i> <i>Did you _____ as a way to end your life?</i> <i>Did you want to die (even a little) when you _____?</i> <i>Were you trying to end your life when you _____?</i> <i>Or Did you think it was possible you could have died from _____?</i> <i>Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?</i> (Self-Injurious Behavior without suicidal intent) If yes, describe:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Has subject engaged in Non-Suicidal Self-Injurious Behavior?		Total # of Attempts _____		Total # of Attempts _____	
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act (if not for that, actual attempt would have occurred). Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. <i>Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?</i> If yes, describe:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. <i>Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?</i> If yes, describe:		Total # of interrupted _____		Total # of interrupted _____	
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. <i>Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?</i> If yes, describe:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). <i>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</i> If yes, describe:		Total # of aborted or self-interrupted _____		Total # of aborted or self-interrupted _____	
Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). <i>Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?</i> If yes, describe:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Suicidal Behavior: Suicidal behavior was present during the assessment period?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
		Most Recent Attempt Date:	Most Lethal Attempt Date:	Initial/First Attempt Date:	
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death		Enter Code _____	Enter Code _____	Enter Code _____	
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care		Enter Code _____	Enter Code _____	Enter Code _____	

SAFE-T Protocol with C-SSRS - Recent

Step 1: Identify Risk Factors	
C-SSRS Suicidal Ideation Severity	Month
1) Wish to be dead <i>Have you wished you were dead or wished you could go to sleep and not wake up?</i>	
2) Current suicidal thoughts <i>Have you actually had any thoughts of killing yourself?</i>	
3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) <i>Have you been thinking about how you might do this?</i>	
4) Suicidal Intent without Specific Plan <i>Have you had these thoughts and had some intention of acting on them?</i>	
5) Intent with Plan <i>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</i>	
C-SSRS Suicidal Behavior: <i>"Have you ever done anything, started to do anything, or prepared to do anything to end your life?"</i>	Lifetime
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	
If "YES" Was it within the past 3 months?	Past 3 Months
<p>Current and Past Psychiatric Dx:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mood Disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Alcohol/substance abuse disorders <input type="checkbox"/> PTSD <input type="checkbox"/> ADHD <input type="checkbox"/> TBI <input type="checkbox"/> Cluster B Personality disorders or traits (i.e., Borderline, Antisocial, Histrionic & Narcissistic) <input type="checkbox"/> Conduct problems (antisocial behavior, aggression, impulsivity) <input type="checkbox"/> Recent onset <p>Presenting Symptoms:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anhedonia <input type="checkbox"/> Impulsivity <input type="checkbox"/> Hopelessness or despair <input type="checkbox"/> Anxiety and/or panic <input type="checkbox"/> Insomnia <input type="checkbox"/> Command hallucinations <input type="checkbox"/> Psychosis 	<p>Family History:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Suicide <input type="checkbox"/> Suicidal behavior <input type="checkbox"/> Axis I psychiatric diagnoses requiring hospitalization <p>Precipitants/Stressors:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Triggering events leading to humiliation, shame, and/or despair (e.g. Loss of relationship, financial or health status) (real or anticipated) <input type="checkbox"/> Chronic physical pain or other acute medical problem (e.g. CNS disorders) <input type="checkbox"/> Sexual/physical abuse <input type="checkbox"/> Substance intoxication or withdrawal <input type="checkbox"/> Pending incarceration or homelessness <input type="checkbox"/> Legal problems <input type="checkbox"/> Inadequate social supports <input type="checkbox"/> Social isolation <input type="checkbox"/> Perceived burden on others <p>Change in treatment:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Recent inpatient discharge <input type="checkbox"/> Change in provider or treatment (i.e., medications, psychotherapy, milieu) <input type="checkbox"/> Hopeless or dissatisfied with provider or treatment <input type="checkbox"/> Non-compliant or not receiving treatment
<input type="checkbox"/> Access to lethal methods: Ask <u>specifically</u> about presence or absence of a firearm in the home or ease of accessing	

Step 2: Identify Protective Factors (Protective factors may not counteract significant acute suicide risk factors)

Internal:

- Ability to cope with stress
- Frustration tolerance
- Religious beliefs
- Fear of death or the actual act of killing self
- Identifies reasons for living

External:

- Cultural, spiritual and/or moral attitudes against suicide
- Responsibility to children
- Beloved pets
- Supportive social network of family or friends
- Positive therapeutic relationships
- Engaged in work or school

Step 3: Specific questioning about Thoughts, Plans, and Suicidal Intent – (see Step 1 for Ideation Severity and Behavior)

If semi-structured interview is preferred to complete this section, clinicians may opt to complete C-SSRS [Lifetime/Recent](#) for comprehensive behavior/lethality assessment.

C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 1-5 identified above)	Month
<p>Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day</p>	
<p>Duration <i>When you have the thoughts how long do they last?</i> (1) Fleeting - few seconds or minutes (4) 4-8 hours/most of day (2) Less than 1 hour/some of the time (5) More than 8 hours/persistent or continuous (3) 1-4 hours/a lot of time</p>	
<p>Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (4) Can control thoughts with a lot of difficulty (2) Can control thoughts with little difficulty (5) Unable to control thoughts (3) Can control thoughts with some difficulty (0) Does not attempt to control thoughts</p>	
<p>Deterrents <i>Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (4) Deterrents most likely did not stop you (2) Deterrents probably stopped you (5) Deterrents definitely did not stop you (3) Uncertain that deterrents stopped you (0) Does not apply</p>	
<p>Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?</i> (1) Completely to get attention, revenge or a reaction from others (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (2) Mostly to get attention, revenge or a reaction from others (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (0) Does not apply</p>	
Total Score	

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level
 “The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential clinical judgment, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior.”
 From The American Psychiatric Association Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, page 24.

RISK STRATIFICATION	TRIAGE
<p style="text-align: center;">High Suicide Risk</p> <p>Suicidal ideation with intent or intent with plan <u>in past month</u> (C-SSRS Suicidal Ideation #4 or #5)</p> <p>Or</p> <p>Suicidal behavior <u>within past 3 months</u> (C-SSRS Suicidal Behavior)</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Initiate local psychiatric admission process <input type="checkbox"/> Stay with patient until transfer to higher level of care is complete <input type="checkbox"/> Follow-up and document outcome of emergency psychiatric evaluation
<p style="text-align: center;">Moderate Suicide Risk</p> <p>Suicidal ideation with method, <u>WITHOUT plan, intent or behavior in past month</u> (C-SSRS Suicidal Ideation #3)</p> <p>Or</p> <p>Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime)</p> <p>Or</p> <p>Multiple risk factors and few protective factors</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Directly address suicide risk, implementing suicide prevention strategies <input type="checkbox"/> Develop Safety Plan
<p style="text-align: center;">Low Suicide Risk</p> <p>Wish to die or Suicidal Ideation <u>WITHOUT method, intent, plan or behavior</u> (C-SSRS Suicidal Ideation #1 or #2)</p> <p>Or</p> <p>Modifiable risk factors and strong protective factors</p> <p>Or</p> <p><input type="checkbox"/> No reported history of Suicidal Ideation or Behavior</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Discretionary Outpatient Referral

Step 5: Documentation

Risk Level :

High Suicide Risk
 Moderate Suicide Risk
 Low Suicide Risk

Clinical Note:

- Your Clinical Observation
- Relevant Mental Status Information
- Methods of Suicide Risk Evaluation

- Brief Evaluation Summary
 - Warning Signs
 - Risk Indicators
 - Protective Factors
 - Access to Lethal Means
 - Collateral Sources Used and Relevant Information Obtained
 - Specific Assessment Data to Support Risk Determination
 - Rationale for Actions Taken and Not Taken

- Provision of Crisis Line 1-800-273-TALK(8255)
- Implementation of Safety Plan (If Applicable)

Appendix K

Risk Levels

Risk Level	Observed Behavior/Information Disclosure	Recommendations and Follow Up
LOW	Has thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. General thoughts of suicide WITHOUT a specific method or plan.	Refer to school counselor or other provider (if risk is detected outside of school). Create a collaborative safety plan, notify involved staff and share plan. Parents should be contacted and a plan should be made for follow up contact to determine how often check-ins and meetings will take place. Counselor/suicide prevention coordinator checks in with student daily for first week, once a week for the next three weeks or as student/family deems appropriate.
MODERATE	Endorses thoughts of suicide and has thought of at least one method to kill self but not a specific plan. “I thought about taking an overdose but I never made a specific plan . . .and I would never go through with it.”	Do not leave the student unsupervised. Create a collaborative safety plan, notify involved staff and share plan. Parents should be contacted and plans made for them to come to the school. Recommend parent/guardian make appointment with a mental health counselor. Determine if additional crisis response is necessary.
HIGH	Active suicidal thoughts of killing oneself and reports having some intent to act on such thoughts. Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.	Do not leave the student unsupervised. Make plans to transport student to the emergency room or crisis department. Parents should be contacted and plans made for them to come to the school and assist with getting the student to a safe environment. If parents are unavailable, contact school resource officer or police for transport.

If parent/guardian cannot be reached by the end of the day or parent/guardian refuses to pick up:

- Contact Director of Safety/School Safety Specialist of [INSERT NAME of SCHOOLSAFETY HERE] at _____ *or*
- Contact School Safety Officer, _____ at _____ *or*
- [INSERT LOCAL POLICE DEPARTMENT HERE] for pick up and transport at xxx-xxx-xxxx *or*
- *As a last option: Call CPS at 1-800-800-5556. File a DCS report.

**A report should be filed on a case-by-case basis and only when deemed necessary based on Indiana Code, Chapter 5: Duty to Report Child Abuse or Neglect. All steps should be taken when possible to maintain a collaborative relationship with the student’s guardian in order to promote the well-being of the child.*

Appendix L

Safety Planning Resources

Collaborative Safety Plan Template:

I, _____, developed this plan with my support system, specific to my needs. I am at the greatest risk to harm myself or someone else during the 1st month after a crisis. My safety plan is designed to help ensure my safety and to minimize safety risks. I will review and revise the plan with my support system and provider(s).

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

Step 1: Warning Signs/Risk Factors that I may be headed toward a crisis. (What am I thinking, how am I feeling, what am I doing, what is happening around me?)

Step 2: What coping skills can I use if I start seeing some of my warning signs?

Step 3: Things I can do that bring me joy and help me feel better about life:

Step 4: If I need help, people I can call:

**There should be people listed both at school and outside of school.*

Name	Contact Info	They can help me by:

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

Name	Phone

Step 6: Safety Measures:

(See [Suicide Proof website](#))

My environment will be made safe by my _____ (relationship for example, mom/dad/grandma, etc.), through the completion of the following safety measures. These safety measures will be completed immediately.

Check all applicable:

- Weapons locked up
- Medications secured
- Vehicle keys secured
- Alcohol/drugs removed
- Chemicals/cleaners secured
- Sharp objects secured (knives, razors, scissors, etc.)
- Check room for harmful objects
- Increased supervision
- Ensure safety of pets
- Ropes, belts, neckties removed
- I need to be supervised by an adult at all times, and the adult supervising is aware of the safety risks and is willing to take necessary precautions
- Keep doors unlocked
- Inform school staff of the safety concerns

Promoting Wellness

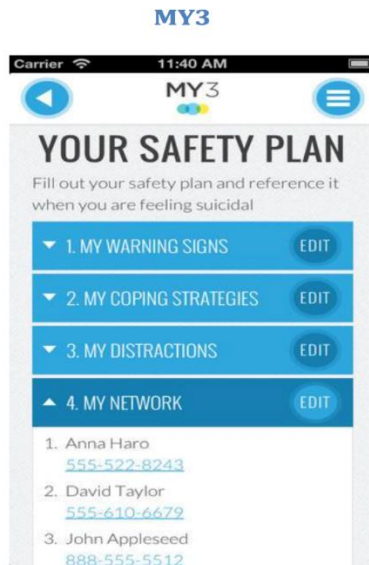
- Encourage me to use my positive coping skills
- I will take my medication as prescribed
- I will attend all outpatient appointments
- Spend quality/fun time with my family and/or supports
- Role model positive behaviors for me
- Emphasize my strengths and praise them often
- Let me know that you are a support and practice good listening skills
- Remind me of other people in my support system I could talk to
- Other:

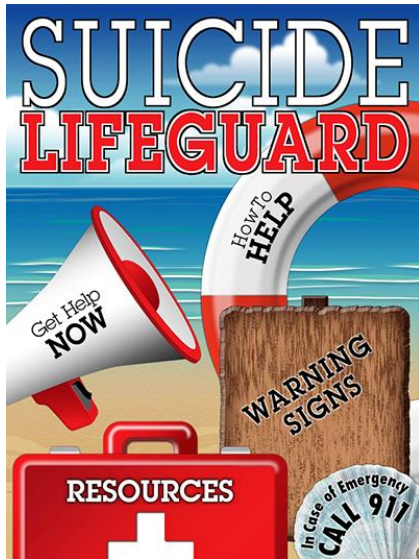
Resources

<p>[List your inpatient facility for youth here as well as your local Community Mental Health Center]</p>	<p style="text-align: center;">Community Behavioral Health Crisis Phone Number: (317) 621-5700 1 - 800 - 662 - 3445</p>
<p>Text Message Help</p>	<p style="text-align: center;">If you'd like to get help for suicidal thoughts by TEXT Messaging, text the keyword “CSIS” to 869863 [Outside of Indianapolis] “HelpNow” to 20121 [if in Indianapolis area]</p>
<p>National Suicide Prevention Lifeline</p>	<p style="text-align: center;">National Suicide Prevention Lifeline 1-800-273-TALK (8255)</p>
<p>Useful Websites</p>	<p style="text-align: center;">SAMHSA’s Preventing Suicide: A Toolkit for High Schools AFSP/SPRC’s After a Suicide Toolkit Mayo Clinic’s Youth Suicide Prevention Video Indiana Dept of Education, Suicide Prevention Training for School Staff [insert link]</p>

Mobile Apps

Two mobile applications have been developed to support SPI. Individuals at risk can utilize one of these applications to keep their safety plan in a convenient location (phone or mobile device), readily available for consultation if suicidal thoughts occur. Providers should ensure that safety plans are documented on paper first and provided to the individual and/or their loved ones. Both applications can be downloaded free from iTunes or Google Play.





Suicide Lifeguard is a FREE app intended for anyone concerned that someone they know may be thinking of suicide. It provides information on:

- How to recognize warning signs of suicide
- How to ask about suicidal thoughts and/or intentions
- How to respond and
- Where to refer

Features include:

- Immediate connection to the National Suicide Prevention Lifeline
- Specific resources for:
 - o Military/Veterans
 - o Those who identify as LGBTQ
 - o Spanish speaking individuals
 - o Persons who are deaf or hard of hearing
- Direct access to national and Missouri resource websites

This suicide prevention information was produced by the Missouri Suicide Prevention Project, a joint effort between the Missouri Institute of Mental Health at the University of Missouri-St. Louis and the Missouri Department of Mental Health.

Safety Plan

If you sometimes struggle with suicidal thoughts, complete the form below.
When you are feeling suicidal, follow the plan one step at a time until you are safe.



Feeling suicidal is the result of experiencing extreme pain, and not having the resources to cope. We therefore need to reduce pain and increase coping resources.

These feelings will pass.

Keep the plan where you can easily find it when you'll need it.



What have I done in the past that helped? What ways of coping do I have?

What I will do to help calm and soothe myself:

What I will tell myself (as alternatives to the dark thoughts):

What would I say to a close friend who was feeling this way?

What could others do that would help?

Who can I call:

- ✓ Friend or relative:
- ✓ Teacher/Adult at School:
- ✓ Health professional:
- ✓ Telephone helpline:
- ✓ Other:

A safe place I can go to:

If I still feel suicidal and out of control:

I will go directly to the Emergency room at the closest hospital.

If I cannot get to the hospital, I will call 911 and seek out emergency support.

I may also call the crisis line.

Teen Suicide Hotline: 1-800-SUICIDE (784-2433)

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Text Line for Suicide Prevention: text HELPNOW to 20121

Modified from: <https://www.getselfhelp.co.uk/docs/SafetyPlan.pdf>

Student 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. _____
<small>Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.</small>

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

Source: https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf

Safety Plan:

Instructions for Teachers/Support Staff (Template)

Today's Date: _____

Staff Member Preparing Safety Plan: _____

_____ (Student's name) has a Safety Plan. While the student is in your classroom/observation, please follow the procedures marked below. **Keep this confidential at all times and follow this plan until further notice.**

If the student has permission to leave your class unsupervised to use the bathroom or visit another classroom, please monitor the time the student is gone. Call the office at extension _____ if you are concerned that the student has been gone too long.

If he/she is visibly upset or expressing thoughts of unsafe behavior, call the office at extension _____. Please escort the student to the office or wait until the office can send an escort for the student. **It is important to never allow the student to be unaccompanied when you are concerned about his/her wellbeing.**

Please remember to include this document with your sub notes when you are absent.

[Insert items from the student's safety plan]

Student's School Counselor: _____

Also see Appendix O, *Making My Home Safer When My Child is Having Thoughts of Suicide.

Appendix M

Suicide Risk Monitoring Tool – Middle/High School Version

Student name _____ Date _____

Completed by (name / title): _____

I. IDEATION

- Are you having thoughts of suicide?** Yes No
- Right now Yes No
- Past 24 hours Yes No
- Past week Yes No
- Past month Yes No

Please circle / check the most accurate response:

How often do you have these thoughts? (Frequency): less than weekly / weekly / daily / hourly / every minute

How long do these thoughts last? (Duration): a few seconds / minutes / hours / days / a week or more

How disruptive are these thoughts to your life (Intensity): not at all= 1 2 3 4 5 =a great deal

II. INTENT

How much do you want to **die**? not at all= 1 2 3 4 5 =a great deal

How much do you want to **live**? not at all= 1 2 3 4 5 =a great deal

III. PLAN

- Do you have a plan?** Yes No
- Have you written a suicide note? Yes No
- Have you identified a method? Yes No
- Do you have access to the method? Yes No N/A
- Have you identified when & where you'd carry out this plan? Yes No N/A
- Have you made a recent attempt?** Yes No

If so, When / How / Where? _____

IV. WARNING SIGNS

How hopeless do you feel that things will get better? not at all= 1 2 3 4 5 =a great deal

How much do you feel like a burden to others? not at all= 1 2 3 4 5 =a great deal

How depressed, sad or down do you currently feel? not at all= 1 2 3 4 5 =a great deal

How disconnected do you feel from others? not at all= 1 2 3 4 5 =a great deal

Is there a particular trigger/stressor for you? If so, what? _____

Has it improved? not at all= 1 2 3 4 5 =a great deal

V. PROTECTIVE FACTORS

REASONS FOR LIVING <i>(things good at / like to do / enjoy / other)</i>	SUPPORTIVE PEOPLE <i>(family / adults / friends / peers)</i>

What could change about your life that would make you no longer want to die?

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**FOR THE CLINICIAN – SUMMARY PAGE
MIDDLE SCHOOL / HIGH SCHOOL STUDENTS**

Purpose: This tool is meant to be a suicide risk management screening. It is not a comprehensive suicide risk assessment measure. At times, we must monitor ongoing suicidality of students who have already been assessed either by you, an outside mental health professional or in a hospital setting. Clinicians working with suicidal students often report being unsure when a student may need re-hospitalization or further intervention and when levels of suicidality are remaining relatively stable for that *individual* student. Monitoring suicidality and managing risk over time is the purpose of this form.

We have created two versions of this tool as older middle school and high school students are better able to identify responses when provided with more choices than elementary and early middle school students. With older middle school and high school students, complete this form with them the first time, explaining each area and ensuring they understand how to complete it. During subsequent sessions, they can complete the form independently, followed by a collaborative discussion of risk and treatment planning.

As you know your student best, we have created within this form a place to document the particular triggers or stressors for this individual. This will allow you to monitor and track their unique stressors over time.

V. LEVEL OF CURRENT RISK:

Recommendations for further treatment and management of suicide risk should be a direct result of the ratings of risk as identified below in collaboration with your school district procedure. In all cases, parents should be notified to inform them you met with their child.

Student meets criteria for low / moderate / high suicide risk based on the following information (If a student falls between levels, err on the side of caution and assume higher risk category):

1. **Low risk:** None or passing ideation that does not interfere with activities of daily living; reports no desire to die (i.e. intent), has no specific plan, exhibits few risk factors and has identifiable protective factors.
2. **Moderate risk:** Reports frequent suicidal ideation with limited intensity and duration; has some specific plans to die by suicide, but no reported intent. Demonstrates some risk factors, but is able to identify reasons for living and other protective factors.
3. **High risk:** Reports frequent, intense, and enduring suicidal ideation. Has written suicide note or reports specific plans, including choice of lethal methods and availability / accessibility of the method. Student presents with multiple risk factors and identifies few if any protective factors.

VI. ACTIONS TAKEN / RECOMMENDATIONS:

Parent/guardian contacted?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Released to parent/guardian?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Referrals provided to parent?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Safety plan developed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending removal of method/means?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If currently in treatment, contact made with therapist/psychiatrist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Outpatient therapy recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending 24-hour supervision?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hospitalization recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Other? Please describe:

Suicide Risk Monitoring Tool – Elementary/Middle School Version

Student name _____ Date _____

Completed by (name / title): _____

I. IDEATION

- Are you having thoughts of suicide? Yes No
- Right now Yes No
- Past 24 hours Yes No
- Past week Yes No
- Past month Yes No

Please circle / check the most accurate response:

How often do you have these thoughts? (Frequency): less than weekly / weekly / daily / hourly / every minute

How long do these thoughts last? (Duration): a few seconds / minutes / hours / days / a week or more

How disruptive are these thoughts to your life (Intensity): not at all somewhat a great deal

II. INTENT

How much do you want to die? not at all somewhat a great deal

How much do you want to live? not at all somewhat a great deal

III. PLAN

- Do you have a plan? Yes No
- Have you written a suicide note? Yes No
- Have you identified a method? Yes No
- Do you have access to the method? Yes No N/A
- Have you identified when & where you'd carry out this plan? Yes No N/A
- Have you made a recent attempt? Yes No

If so, When / How / Where? _____

IV. WARNING SIGNS

How hopeless do you feel that things will get better? not at all somewhat a great deal

How much do you feel like a burden to others? not at all somewhat a great deal

How depressed, sad or down do you currently feel? not at all somewhat a great deal

How disconnected do you feel from others? not at all somewhat a great deal

Is there a particular trigger/stressor for this student? If so, what? _____

Has it improved? not at all somewhat a great deal

V. PROTECTIVE FACTORS

REASONS FOR LIVING <i>(things good at / like to do / enjoy / other)</i>	SUPPORTIVE PEOPLE <i>(family / adults / friends / peers)</i>

What could change about your life that would make you no longer want to die?

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**FOR THE CLINICIAN – SUMMARY PAGE
ELEMENTARY SCHOOL / MIDDLE SCHOOL STUDENTS**

Purpose: This tool is meant to be a suicide risk management screening. It is not a comprehensive suicide risk assessment measure. At times, we must monitor ongoing suicidality of students who have already been assessed either by you, an outside mental health professional or in a hospital setting. Clinicians working with suicidal students often report being unsure when a student may need re-hospitalization or further intervention and when levels of suicidality are remaining relatively stable for that *individual* student. Monitoring suicidality and managing risk over time is the purpose of this form.

We have created two versions of this tool as elementary and early middle school students are better able to identify responses when provided with less choices than older middle school and high school students. With elementary and early middle school students, the clinician should complete this form through collaborative discussion with the child during each session or meeting. Alter the wording as needed to make it developmentally appropriate to ensure the child understands what you are asking.

As you know your student best, we have created within this form a place to document the particular triggers or stressors for this individual. This will allow you to monitor and track their unique stressors over time.

V. LEVEL OF CURRENT RISK:

Recommendations for further treatment and management of suicide risk should be a direct result of the ratings of risk as identified below in collaboration with your school district procedure. In all cases, parents should be notified to inform them you met with their child.

Student meets criteria for low / moderate / high suicide risk based on the following information (If a student falls between levels, err on the side of caution and assume higher risk category):

1. **Low risk:** None or passing ideation that does not interfere with activities of daily living; reports no desire to die (i.e. intent), has no specific plan, exhibits few risk factors and has identifiable protective factors.
2. **Moderate risk:** Reports frequent suicidal ideation with limited intensity and duration; has some specific plans to die by suicide, but no reported intent. Demonstrates some risk factors, but is able to identify reasons for living and other protective factors.
3. **High risk:** Reports frequent, intense, and enduring suicidal ideation. Has written suicide note or reports specific plans, including choice of lethal methods and availability / accessibility of the method. Student presents with multiple risk factors and identifies few if any protective factors.

VI. ACTIONS TAKEN / RECOMMENDATIONS:

Parent/guardian contacted?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Released to parent/guardian?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Referrals provided to parent?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Safety plan developed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending removal of method/means?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If currently in treatment, contact made with therapist/psychiatrist?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Outpatient therapy recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Recommending 24-hour supervision?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hospitalization recommended?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

Other? Please describe:

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Appendix N

Notification of Emergency Conference with Parent/Guardian

I, _____, the parent/guardian of _____
(Student's Name) participated in a conference on _____ (Date) concerning my child's suicide risk. I have been provided this notice so that appropriate action, such as seeking mental health services, may be taken. A list of outside mental health agencies has been provided to me so I can seek the services of a mental health provider or therapist for my child.

I understand a follow-up check by school personnel _____ (School Personnel) will be made with my child and/or me within two weeks.

Parent Signature: _____ Date: _____

School Personnel Signature _____ Date: _____

FOLLOW UP ACTION:

School Personnel will verify and follow up with parent by _____ (date).

Steps Taken by Parent:

Student's Status:

Date: _____

School Personnel's Signature: _____

Appendix O

Parent Information and Resources

Making My Home Safer When My Child Is Having Thoughts of Suicide

When a child or teen has thoughts of suicide (whether these thoughts are active or not) it's important to make your home a safer place:

Remove firearms and weapons

Make sure that there are no firearms, ammunition nor weapons in your home (or make sure they are stored in a securely locked firearms cabinet, and keep the keys with a trusted neighbor, colleague, or your workplace—somewhere your child cannot access them). In a crisis, you can also call your local police station to see if they would store them for you temporarily.

Remove alcohol and any unused prescription drugs

Alcohol and prescription drugs are risk factors for suicide. These substances affect rational thinking and can make children and youth more impulsive. Remove alcohol from your home, or only keep small amounts in a locked cabinet. Additionally, dispose of all unused prescription medication.

Current Medications (Both Over-the-Counter & Prescription)

Lock up all medications, even non-prescription ones (even Tylenol PM or Aspirin™ can be very dangerous overdoses).

People who are depressed often overdose on their depression medications. Fortunately, many newer medications for depression (Fluoxetine/Prozac™ Fluvoxamine/Luvx™, Sertraline/Zoloft™, Paroxetine/Paxil™, Citalopram/Celexa™) are much safer than the older medications, even in overdose. Ask your doctor to prescribe only safe amounts of medications. When you fill prescriptions, ask the pharmacist to dispense safe amounts. This makes it more difficult for your child or teen to overdose.

Supervise children and youth when they take medication.

Other Means

Remove any other means of suicide

Remove or lock up cords, ropes, sharp knives, or other obvious means of self-harm.

Car Keys

Keep car keys hidden so youth can't use your car to hurt themselves.

High Risk Periods

During high risk periods (like holidays, anniversaries, or times when close supports are away), be extra cautious and on high alert:

- Check in often with your child or teen.
- Do not leave your child or teen alone for long periods. If you have to go out, take your youth with you. If you absolutely cannot get your youth to come along, then have someone stay with your child.

If your child is at immediate risk for suicide, or you are afraid for your child's immediate safety:

- Call 911 (or go straight to the emergency room) right away.
 - After you come home from the hospital, do not try to handle things alone. Make sure you have relatives or friends to talk to. Think about contacting a support group, counselor or therapist for yourself as well.

How Can I Help My Child Feel Life Is Worth Living?

Strengthen your relationship with your child. A strong parent-child relationship is the single most important factor that helps any young person with stress.

1. "But my child doesn't want to spend time with me! He'd rather spend time with his friends!" Friends and peers are very important to teens. Although it is healthy for teens to have friends and social activities, this shouldn't completely replace parents and family. Friends can never give the same love and support that parents can. And teens really do need this special love and support that only parents can give. The good news is that there are ways to strengthen your relationship with your child. It may not be easy at first, but it is well worth the effort. Your child really does need you.

2. Spend regular time with your child, ideally one on one. Invite your child to go on 'dates' with you outside of your home. Or find things you can do at home together: cooking, baking, a home project, tossing a ball around outside. Try to find at least one time every day, where you can spend quality time with your child. This gives your child the chance to share feelings or confide in you about what's really going on. Remember that quality time is not asking about homework, chores, or anything that your child might see as criticism. Quality time is about creating a warm atmosphere where your child feels willing to share feelings. It's a chance for you to validate those feelings.

3. Listen and validate. When your child tells you how she is feeling, thank your child or teen for sharing with you. "I didn't know you were feeling so bad... Thanks for telling me."

4. Show empathy. This means accepting how bad your child or teen is feeling. "Yeah, I can see that would be very difficult."

5. What not to say:

- ▶ "You shouldn't be feeling this way"
- ▶ "It's not that bad"
- ▶ "You should count yourself lucky"
- ▶ "How can you be feeling so bad when we've given you so much? What do you expect from us?"

These comments can make children and youth feel guilty and ashamed, and they might not open up to you anymore. Blaming children and youth only makes them feel worse, and may confirm to them that they are a burden for you. This could increase the risk of suicide.

6. Avoid jumping in with advice or criticism. Because as parents we have more life experience than our children, we think we are being helpful when we offer advice or criticism. Even though we mean well, children and youth need to feel 'heard', understood and accepted. Giving advice or criticizing can seem to a child that we are not really hearing them, and really don't understand what she is going through.

7. Give hope. You might say: "This is going to get better." If things were better in the past, you might say, "I will be with you and we'll work on this and get through it as we did before." Help your child remember how he has overcome other challenges and remind him how he used his strengths to get through that difficult time.

8. Assure your child or teen that she is not alone. You might say: "We're in this one together; we're going to help you get over this."

9. Offer support, but ask your child how he wants to be supported. Ask: "How can I support you? How can I help you with this?" Don't give advice if your child doesn't ask for it. Youth will ask for advice if they want it. If you are unsure, ask: "How can I support you? Do you want me to just listen, or do you want my advice?"

10. Whenever you say goodbye, talk about the next reunion. If your child is leaving for school, then you might say, "Have a great day at school! I'll see you after school, and I look forward to our walk together tonight!"

11. Help with problem-solving. Children and youth often think about suicide when they are overwhelmed by stress. Even if those stresses don't directly cause suicidal feelings, stress certainly doesn't help. You can help with problem solving by saying something like: "Sometimes people think of hurting themselves when they're under a lot of stress or trying to deal with some problem. I'm here for you and I want to help you work through this. Is there something that is stressing you out right now?", or "Is there a problem you're trying to work out?"

12. If your child is unsure, about what is bothering him, you might just ask about the usual stresses like school, friendships, peer pressure, bullying, relationships (girlfriends or boyfriends), teachers or schoolwork.

13. Get professional help. You can be a great support, but remember- you are not a therapist/counselor. And even if you are a mental health professional, your role is to be your child's parent or caregiver, not a therapist. For all these reasons and more, if your child is feeling that life isn't worth living, speak to an outside professional. Make sure you have the support you need too; either through your network of friends or family, or by finding your own therapist. It can be extremely stressful caring for a child who is depressed or suicidal. It's important for you to have support at this difficult time, so that you continue to have the energy to care for your child.

References

Practice parameter for the assessment and treatment of children and adolescents with depressive disorders, American Academy of Child and Adolescent Psychiatry, 2007. Retrieved Oct 10, 2007 from http://www.aacap.org/galleries/PracticeParameters/InPress_2007_DepressiveDisorders.pdf .

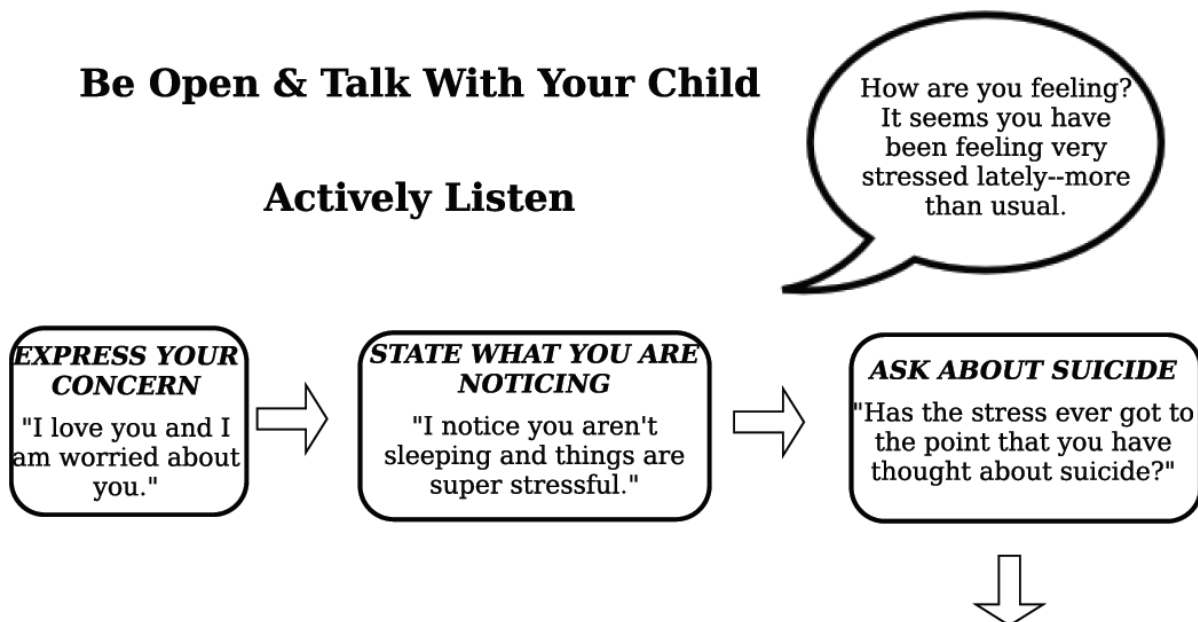
Bridge et al.: Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment. *Journal of the American Medical Association*, 2007; 297:1683-1696. Retrieved Oct 10, 2007 from <http://jama.ama-assn.org/cgi/content/abstract/297/15/1683>.

What Should I Do if I think My Child Is Having Thoughts of Suicide?

Suicide is not easy to talk about. You may have a lot of worries or concerns that may be keeping you from engaging in a conversation about suicide. Some common concerns are fear of giving someone the idea if we talk about suicide. This is a myth--talking about suicide will not give someone the idea--it is actually a relief when someone asks about suicide. Don't be afraid to ask about suicide. Studies show that you cannot 'plant' ideas of suicide in someone's head. If your child is thinking about suicide, you will have opened the door for a conversation and will make it easier for your child to confide in you.

Be Open & Talk With Your Child

Actively Listen



What If My Child Is Suicidal?

If your child is expressing suicide ideation and has imminent plans to hurt self, seek professional help right away:

- DO NOT leave your child alone: make sure that there is someone with your child at all times, whether it is you or a close friend or family member.
- Call for professional help in a crisis: call 911 or call the crisis line. 1-800-273-TALK
- Get support for yourself during this time of crisis. If you have contacted professional help, then consider calling a close family member or friend to support you as you get help for your child.

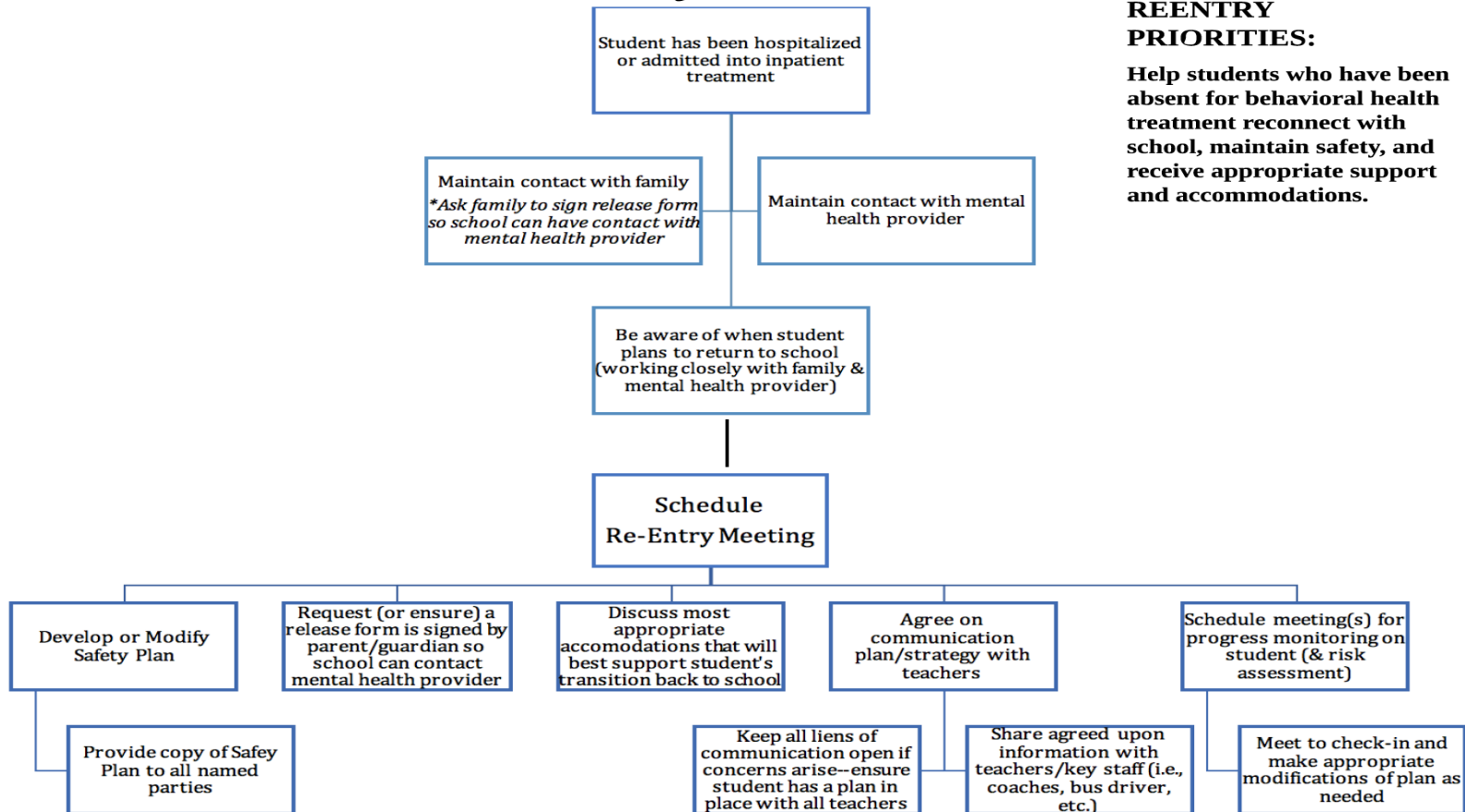


Created by Dr. Brandie Oliver, Butler University, 2017

Appendix P

Re-Entry

Re-Entry Flowchart



REENTRY PRIORITIES:

Help students who have been absent for behavioral health treatment reconnect with school, maintain safety, and receive appropriate support and accommodations.

Re-entry Protocol

The re-entry process works to ensure the safety and wellbeing of students who have previously attempted suicide and reduces the risk of another attempt. Re-entry meetings are for students that have been out of school due to suicide ideation, suicide attempt and/or psychological hospital treatment. This meeting will take place prior to the student's return to discuss systems of care/support and determine the best course of action to meet the needs of the student.

Who should be at the re-entry meeting? (not all of the below school staff need to be at the meeting but do need to be looped into the coordination, planning, and final outcome of the re-entry meeting)

- School administrator
- Suicide Prevention Coordinator; School Counselor/School Social Worker/School Mental Health Provider
- Parent/Guardian
- *Student if parent/guardian deems ready

Who might be other appropriate attendees?

- School nurse; School Psychologist
- Outside family therapist/counselor
- Teacher; Coach (someone that is a key support to the student)

Purpose of re-entry meeting

- Review family's course of action to support student since becoming aware of suicide ideation
- Discuss the existing resources & supports in place for the student and family
- Discuss any additional supports or resources the family/student may need
- Family is encouraged to share any assessments/notes from outside therapy and/or services that the student obtained
- Family is encouraged to bring any recommendations from outside mental health providers and/or treatment facility so school can work to provide continuous care as closely as possible
- Discuss absences & missing homework/tests & begin developing a plan with the family and student to make-up any required assignments/tests
- Review the Safety Plan that was previously developed & make necessary adjustments
- It is important to discuss the below items to gauge if they need to be included in the revised Safety Plan

Safety Plan

- Will the student check-in before and after school?
- Will the student be supervised during passing periods?
- Will the student be supervised in the bathroom?
- Does the student need to be supervised at lunch?
- Does the student need a quiet area at lunch time? Is the cafeteria too loud and busy?
- How does the student access the nurse if s/he needs to see the nurse?
- Who does the student feel most comfortable talking with if s/he is feeling anxious/stressed/depressed?
- Does the student need supervised after-school hours?
- **How often will the Suicide Prevention Coordinator check-in with the student? *During these check-ins, a suicide risk monitoring tool will be used to measure for risk.*
- What is the duration of the safety plan?

Re-entry Meeting Documentation Template

Student's Name: _____ Date: _____

Parent/Guardian Name: _____ Absence From/To: _____

Who was in attendance at the Re-Entry Meeting?

What steps did the family take? What resources are in place? What resources are needed?

Are there recommendations from the student's mental health provider? medical provider?

What is the tentative plan to complete the missing homework/tests/quizzes? What questions still need addressed? What teachers need to be contacted regarding missing work or getting help with homework (or include other resources that will best support the student)?

What revisions need to be made to the safety plan? What are some special considerations? What might the student and/or family be worried about?

[supervision in hallways, locker rooms, bathrooms, lunch room, after school; who are adults at school student can talk/meet with; where does the student go if s/he begins to feel overwhelmed, etc.] In addition, the plan will indicate how often the student will meet the Suicide Prevention Coordinator for a check-in and so s/he can assess using the suicide risk monitoring tool.

Student Signature

Date

Parent/Guardian Signature

Date

Administrator Signature

Date

Suicide Prevention Coordinator Signature

Date

Developed by Dr. Brandie Oliver, Butler University, 2017

School Re-entry for a Student Who Has Attempted Suicide or Made Serious Suicidal Threats

Efforts to respond to suicide attempts and other traumas should be focused on making the student's return to school a comfortable one. Because families exposed to a suicide attempt or serious suicidal threat experience considerable guilt and fear. They are more likely to disclose information if they know the school has a helpful, nonthreatening manner of dealing with suicide.

Because a student who attempted/threatened suicide often is at greater risk for a suicide in the months following the crisis, it is extremely important to closely monitor his or her reentry into school and to maintain close contact with parents and mental health professionals working with that student.

Assuming the student will be absent after a suicide attempt/serious threat and possibly hospitalized in a treatment facility, schools should follow these steps:

- Obtain a written release of information for signed by the parents. This makes it possible for confidential information to be shared between school personnel and treatment providers.
- Ask returning student/family if s/he has special requests about what is said/done by school.
- Inform the student's teachers regarding the number of probable days of absence.
- Instruct teachers to provide the students with assignments, if appropriate.
- Once the student returns to school, designated crisis team member should maintain regular contact with the student. If the student has a previous, positive relationship with a trusted staff member, provide support to that staff member in maintaining ongoing contact with the student.
- Seek recommendations for aftercare from the student's therapist (if release form is in place). If the student has been hospitalized, Suicide Prevention Coordinator (or designee) should attend the discharge meeting at the hospital if available.
- The Suicide Prevention Coordinator (or designee) should convey relevant non-confidential information to appropriate school staff regarding the aftercare plan.
- The school should maintain contact with the parents to provide progress reports and other appropriate information and be kept informed of any changes in the safety plan.

Modified from "Resource Guide for Crisis Management in Virginia Schools" published by the Office of Compensatory Programs, Virginia Department of Education, 2002, accessed at <http://www.indiana-ins.com> on January 18, 2010.

Appendix Q

Procedures for Faculty Meeting following a Suicide

1. Distribute written statement of facts; dispel any rumors or misinformation.
2. Inform faculty of what action steps have been taken up to now; i.e., confirmation of facts, contact with family, notification of key personnel, crisis team meeting, funeral arrangements, etc.
3. Announce administrator, suicide prevention coordinator, and crisis team roles and contact persons for responding to outside requests for information from police, media, parents etc.
4. Allow staff to react, ask questions and express feelings. Staff should be encouraged to discuss feelings; point out that understanding their own feelings will make it easier for them to deal with student feelings.
5. Share support services for staff as well as students'; review who will be available, when and where.
6. Review plan to inform students and guidelines; provide time for staff to ask questions or express concern. Emphasize availability of crisis team members to assist and support staff who are uncomfortable leading class discussion.
7. Discuss need to monitor possible and known "at risk" and "high risk" students more carefully. Review staff responsibilities and steps if they suspect a student is at risk of suicide or would need further assessment.
8. Review plan for school day and for after-school hours.
9. In subsequent faculty meetings:
 1. a. support staff and encourage discussion of their feelings
 - b. identify any problems that have arisen and problem-solve
 - c. identify "at risk" and "high risk" students; develop a plan for monitoring and supporting them
 - d. remind and discuss the importance of continued support of both students and staff and provide mental health resources

Appendix R

Procedures for Talking to Students about Suicide Death

1. Prepare students for the serious and tragic nature of the information you are about to share with them. Say that it is expected this news will upset many of them and that both you and other staff are there to help them get through this.
2. Announce the facts of the situation and what actions are being taken as a result (i.e. all classes are being informed, counseling centers are being set up, etc.).
3. Allow students to react; pay special attention to the following:
 - a. Dispel any rumors or unconfirmed information.
 - b. Stress that we each react differently to tragedies and must respect one another's feelings and ways of reacting.
 - c. Point out that grief, sadness, anger, guilt, fear and disbelief are all normal reactions to such news. Grief is unique to each person and there is no one way to grieve.
4. Convey a sense of acceptance for all the feelings expressed, avoid judgmental or value statements about anyone's feelings.
5. Note that some people's feelings will be stronger than others and that individual help is available.
6. If student's reactions seem particularly intense or you feel unable to respond to them adequately, strongly encourage them to seek assistance from one of the designated counseling centers. Offer to accompany them to the designated counseling area and/or ask a member of the crisis team to accompany them (as they should not be alone).
7. If students have questions you are unable to answer or if you are feeling uncomfortable in the discussion, seek out a member of the crisis team to assist you.
8. Encourage students to be supportive of one another but stress the importance of seeking help or encouraging their friends to seek help from adults if their feelings seem more intense or persistent than "normal".
9. Reassure students that they are not responsible for what happened - discourage guilt and unrealistic "hindsight regrets". Instead, focus discussion on how they might use what they now know to avoid similar tragedies in the future.
10. In cases of suicide, avoid focusing on the details or circumstances that led up to the person's death; stress the reasons that someone dies by suicide are not simple, and are related to mental disorders that get in the way of the person thinking clearly. Blaming others—or blaming the person who died—does not acknowledge the reality that the person was battling a mental disorder.
11. Allow students who do not want to participate in the discussion to study quietly in the room or seek assistance from one of the counseling centers. Don't assume that the lack of a visible reaction means the student has no reaction.
12. Allow as much time as students seem to need for the discussion. Try to move discussion toward how students can help one another and encourage help-seeking behaviors.
13. Students who wish to memorialize the dead person in some way should be referred to a crisis team member.
14. End the class by reminding students of the counseling and support services that are available.

Appendix S

Why is Grief Following Suicide Different?

- 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.

How might students present with grief?

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

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

References

Kalischuk, R. G., and Hayes, V. E. (2004). Grieving, mourning, and healing following youth suicide: A focus on health and wellbeing in families. *Omega*, 48, 45-67.

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
- 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

Appendix T

General Communication Resources

When the death has been ruled a suicide

It is with great sadness that I have to tell you that one of our students, _____, has died by suicide. All of us want you to know that we are here to help you in any way we can.

A suicide death presents us with many questions that we may not be able to answer right away. Rumors may begin to circulate, and we ask that you not spread rumors you may hear. We'll do our best to give you accurate information as it becomes known to us. Suicide is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking clearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; in other cases, a person with a disorder will show obvious symptoms or signs. One thing is certain: there are treatments that can help. Suicide should never, ever be an option.

Each of us will react to _____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known _____ very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction.

We have counselors available to help our school community deal with this sad loss and to enable us to understand more about suicide. If you'd like to talk to a counselor, just let your teachers know. Please remember that we are all here for you.

When the family has requested that the cause of death not be disclosed

It is with great sadness that I have to tell you that one of our students, _____, has died. All of us want you to know that we are here to help you in any way we can.

The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk about the possibility that this was a suicide death. Rumors may begin to circulate, and we ask that you not spread rumors since they may turn out to be inaccurate and can be deeply hurtful and unfair to _____ as well as [his/her] family and friends. We'll do our best to give you accurate information as it becomes known to us.

Since the subject has been raised, we do want to take this opportunity to remind you that suicide, when it does occur, is a very complicated act. It is usually caused by a mental disorder such as depression, which can prevent a person from thinking clearly about his or her problems and how to solve them. Sometimes these disorders are not identified or noticed; in other cases a person with a disorder will show obvious symptoms or signs. One thing is certain: there are treatments that can help. Suicide should never, ever be an option.

Each of us will react to _____'s death in our own way, and we need to be respectful of each other. Feeling sad is a normal response to any loss. Some of you may not have known _____ very well and may not be as affected, while others may experience a great deal of sadness. Some of you may find you're having difficulty concentrating on your schoolwork, and others may find that diving into your work is a good distraction. We have counselors available to help our school community deal with this sad loss. If you'd like to talk to a counselor, just let your teachers know.

Please remember that we are all here for you.

Talking About Suicide from *After a Suicide: A Toolkit for Schools*

Give accurate information about suicide.

Suicide is a complicated behavior. It is *not* caused by a single event such as a bad grade, an argument with parents, or the breakup of a relationship.

In most cases, suicide is caused by an underlying mental disorder like depression or substance abuse. Mental disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental disorder is nothing to be ashamed of, and help is available.

Talking about suicide in a calm, straightforward manner does not put ideas into kids' minds.

by saying . . .

"The cause of _____'s death was suicide. Suicide is most often caused by serious mental disorders like depression, combined with other complications."

"_____ was likely struggling with a mental health issue like depression or anxiety, even though it may not have been obvious to other people."

"There are treatments to help people who are having suicidal thoughts."

"Since 90 percent of people who die by suicide have a mental disorder at the time of their death, it is likely that _____ suffered from a mental disorder that affected [his/her] feelings, thoughts, and ability to think clearly and solve problems in a better way."

"Mental disorders are not something to be ashamed of, and there are very good treatments to help the symptoms go away."

Address blaming and scapegoating.

It is common to try to answer the question "why?" after a suicide death. Sometimes this turns into blaming others for the death.

by saying . . .

"The reasons that someone dies by suicide are not simple, and are related to mental disorders that get in the way of the person thinking clearly. Blaming others—or blaming the person who died—does not acknowledge the reality that the person was battling a mental disorder."

Do not focus on the method or graphic details.

Talking in graphic detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable youth.

If asked, it is okay to give basic facts about the method, but don't give graphic details or talk at length about it. The focus should be not on *how* someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.

by saying . . .

"It is tragic that he died by hanging. Let's talk about how _____'s death has affected you and ways for you to handle it."

"How can we figure out the best ways to deal with our loss and grief?"

<p>Address anger.</p> <p>Accept expressions of anger at the deceased and explain that these feelings are normal.</p>	<p>by saying . . .</p> <p>“It is okay to feel angry. These feelings are normal and it doesn’t mean that you didn’t care about _____. You can be angry at someone’s behavior and still care deeply about that person.”</p>
<p>Address feelings of responsibility.</p> <p>Reassure those who feel responsible or think they could have done something to save the deceased.</p>	<p>by saying . . .</p> <p>“This death is not your fault.”</p> <p>“We can’t always predict someone else’s behavior.”</p> <p>“We can’t control someone else’s behavior.”</p>
<p>Encourage help-seeking.</p> <p>Encourage students to seek help from a trusted adult if they or a friend are feeling depressed or suicidal.</p>	<p>by saying . . .</p> <p>“We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?”</p> <p>“There are effective treatments to help people who have mental disorders or substance abuse problems. Suicide is never an answer.”</p> <p>“This is an important time for all in our [school, team, etc.] community to support and look out for one another. If you are concerned about a friend, you need to be sure to tell a trusted adult.”</p>

Facts about Suicide and Mental Disorders in Adolescents

(After a Suicide: A Toolkit for Schools)

Suicide is not inexplicable and is not simply the result of stress or difficult life circumstances. The key suicide risk factor is an undiagnosed, untreated, or ineffectively treated mental disorder. Research shows that over 90 percent of people who die by suicide have a mental disorder at the time of their death.

In teens, the mental disorders most closely linked to suicide risk are major depressive disorder, bipolar disorder, generalized anxiety disorder, conduct disorder, substance use disorder, and eating disorders. While in some cases these disorders may be precipitated by environmental stressors, they can also occur as a result of changes in brain chemistry, even in the absence of an identifiable or obvious “reason.”

Suicide is almost always complicated. In addition to the underlying disorders listed above, suicide risk can be affected by personality factors such as impulsivity, aggression, and hopelessness. Moreover, suicide risk can also be exacerbated by stressful life circumstances such as a history of childhood physical and/or sexual abuse; death, divorce, or other trauma in the family; persistent serious family conflict; traumatic breakups of romantic relationships; trouble with the law; school failures and other major disappointments; and bullying, harassment, or victimization by peers.

It is important to remember that the vast majority of teens who experience even very stressful life events do *not* become suicidal. In some cases, such experiences can be a catalyst for suicidal behavior in teens who are already struggling with depression or other mental health problems. In others, traumatic experiences (such as prolonged bullying) can precipitate depression, anxiety, abuse of alcohol or drugs, or another mental disorder, which can increase suicide risk. Conversely, existing mental disorders may also lead to stressful life experiences such as family conflict, social isolation, relationship breakups, or school failures, which may exacerbate the underlying illness and in turn increase suicide risk.

Messaging Matters: The Messaging “Don’ts”

The following are practices to avoid in public communications because they can be (1) **Unsafe**, by increasing risk for vulnerable individuals; or (2) **Unhelpful**, by reinforcing problematic norms, conveying negative stereotypes or otherwise undermining prevention.

- **Don’t show or describe suicide methods or locations.** Pictures or detailed descriptions of how or where a person died by suicide can encourage imitation or serve as a “how-to” guide.
- **Don’t include personal details** of people who have died by suicide. Vulnerable individuals may identify with the personal or situational details of someone who died by suicide, encouraging them to end their own lives.
- **Don’t glorify or romanticize suicide.** Portraying suicide as a heroic, romantic, or honorable act may encourage vulnerable people to view it more positively or lead them to desire the positive attention garnered by someone who has died by suicide.
- **Don’t normalize suicidal behavior by presenting it as common or acceptable.** While we don’t want to minimize the magnitude of the suicide problem, we also don’t want to imply that suicidal behavior is acceptable, normal, or *what most people do* in a given circumstance. The vast majority of people who face adversity, mental illness, and other challenges—even those in high risk groups—do *not* die by suicide, but instead find support, treatment, or other ways to cope.
- **Don’t use data or language that suggests suicide is inevitable or unsolvable.**
 - Describing suicide as an “epidemic,” using terms like “bullycide,” or providing extensive statistics about suicide without solutions or action steps are examples of messaging that can make suicide seem too overwhelming to address. These practices also contribute to normalizing suicide (described above) and add to an overall [negative narrative](#) about suicide by implying that nothing can be done about it.
- **Don’t oversimplify causes.** Suicides result from a complex interplay of factors. Therefore:
 - Avoid **attributing suicide to a single cause or circumstance** (e.g., job loss, break-up, bullying, high stress, or being a military veteran, gay youth, or Native American). Presenting suicide as an understandable or inevitable response to a difficult situation or membership in a group can create a harmful “social script” that discourages other ways of coping.
 - Avoid **portraying suicide as having no cause.** Describing suicidal behavior as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the person who died and convey that suicide can’t be prevented. It’s also a missed opportunity to educate the public about warning signs and how to respond to them.
- **Don’t reinforce negative stereotypes, myths, or stigma** related to mental illnesses or suicidal persons, as this may shift beliefs, attitudes, and behaviors in the wrong direction.

Examples:

- Messages linking particular groups with high rates of suicide or mental illness, especially without examples of effective interventions or stories of recovery, may inadvertently increase negative beliefs or discriminatory behaviors towards that group.
- Messaging themes such as “breaking the stigma of mental illness” or other language that reiterates the extent to which stigma is a problem may serve to reinforce stigma, rather than countering it.
- Adjectives like “successful” suicide, “unsuccessful” suicide,” and “failed attempt” inappropriately define a suicide death as a success and a nonfatal attempt as a failure. Terms such as “committed suicide” (associated with crimes), can reinforce stigmatizing attitudes about people who die by suicide.

Reference: <http://suicidepreventionmessaging.org/safety/messaging-donts>

Appendix U

Media Communication

From pages 19-21 in AFSP & SPRC: After a Suicide | A Toolkit for Schools (2011)

<http://www.sprc.org/sites/default/files/migrate/library/AfteraSuicideToolkitforSchools.pdf>

Sample Media Statement

To be provided to local media outlets either upon request or proactively.

School personnel were informed by the coroner's office that a []-year-old student at [] school has died. The cause of death was suicide.

Our thoughts and support go out to [his/her] family and friends at this difficult time.

The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of the school's Crisis Response Team [or mental health professionals] will be present to provide information about common reactions following a suicide and how adults can help youths cope. They will also provide information about suicide and mental illness in adolescents, including risk factors and warning signs of suicide, and will address attendees' questions and concerns. A meeting announcement has been sent to parents, who can contact school administrators or counselors at [number] or [e-mail address] for more information.

Trained crisis counselors will be available to meet with students and staff starting tomorrow and continuing over the next few weeks as needed.

Suicide Warning Signs

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has recently increased in frequency or intensity, and if it seems related to a painful event, loss, or change.

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

Local Community Mental Health Resources

[To be inserted by school]

National Suicide Prevention Lifeline

800-273-TALK (8255)

[Local hotline numbers to be inserted by school]

Recommendations for Reporting on Suicide

Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion (“copycat” suicides), particularly among youth. Media are strongly encouraged to refer to the document “Reporting on Suicide: Recommendations for the Media,” which is available at <http://www.afsp.org/media> and http://www.sprc.org/library/at_a_glance.pdf.

Media Contact

NAME:

TITLE:

SCHOOL:

PHONE:

E-MAIL ADDRESS:

Key Messages for Media Spokesperson

For use when fielding media inquiries.

Suicide/Mental Illness

- Depression is the leading cause of suicide in teenagers.
- About 6 percent of teenagers will develop depression yearly. Sadly, more than 80 percent of these kids will not have their illness properly diagnosed or treated, which can also lead to school absenteeism, failing grades, dropouts, crimes, and drug and alcohol abuse.
- Depression is among the most treatable of all mood disorders. More than three fourths of people with depression respond positively to treatment.
- The best way to prevent suicide is through early detection, diagnosis, and vigorous treatment of depression and other mental disorders, including addictions.

School's Response Messages

- We are heartbroken over the death of one of our students. Our hearts, thoughts, and prayers go out to [his/her] family and friends, and the entire community.
- We will be offering grief counseling for students, faculty and staff starting on [date] through [date].
- We will be hosting an informational meeting for parents and the community regarding suicide prevention on [date/time/location]. Experts will be on hand to answer questions.
- No TV cameras or reporters will be allowed in the school or on school grounds.

School Response to Media

- Media are strongly encouraged to refer to the document “Reporting on Suicide: Recommendations for the Media,” which is available at <http://www.afsp.org/media> and http://www.sprc.org/library/at_a_glance.pdf.
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion (“copycat” suicides), particularly among youth.
- Media coverage that details the location and manner of suicide with photos or video increases risk of contagion.
- Media should also avoid oversimplifying cause of suicide (e.g., “student took his own life after breakup with girlfriend”). This gives the audience a simplistic understanding of a very complicated issue.
- Instead, remind the public that more than 90 percent of people who die by suicide have an underlying mental disorder such as depression.
- Media should include links to or information about helpful resources such as local crisis hotlines or the National Suicide Prevention Lifeline 800-273-TALK (8255).

Appendix V

ADDITIONAL RESOURCES

[Preventing Youth Suicide: Brief Facts and Tips](#)

Site offering suicide facts and tips from the National Association of School Psychologists.

[Talking about suicide and LGBT populations](#)

This guide, co-authored by GLSEN, the American Foundation for Suicide Prevention, GLAAD, the Johnson Family Foundation, the Movement Advancement Project and The Trevor Project, provides ways to talk about suicide more safely, while advancing vital public discussions about preventing suicide, helping increase acceptance of LGBT people, and supporting their well-being.

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

This manual lays the groundwork for community-based suicide prevention and mental health promotion plans for American Indian and Alaska Native teens and young adults. It addresses risks, protective factors and awareness, and describes prevention models for action.

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