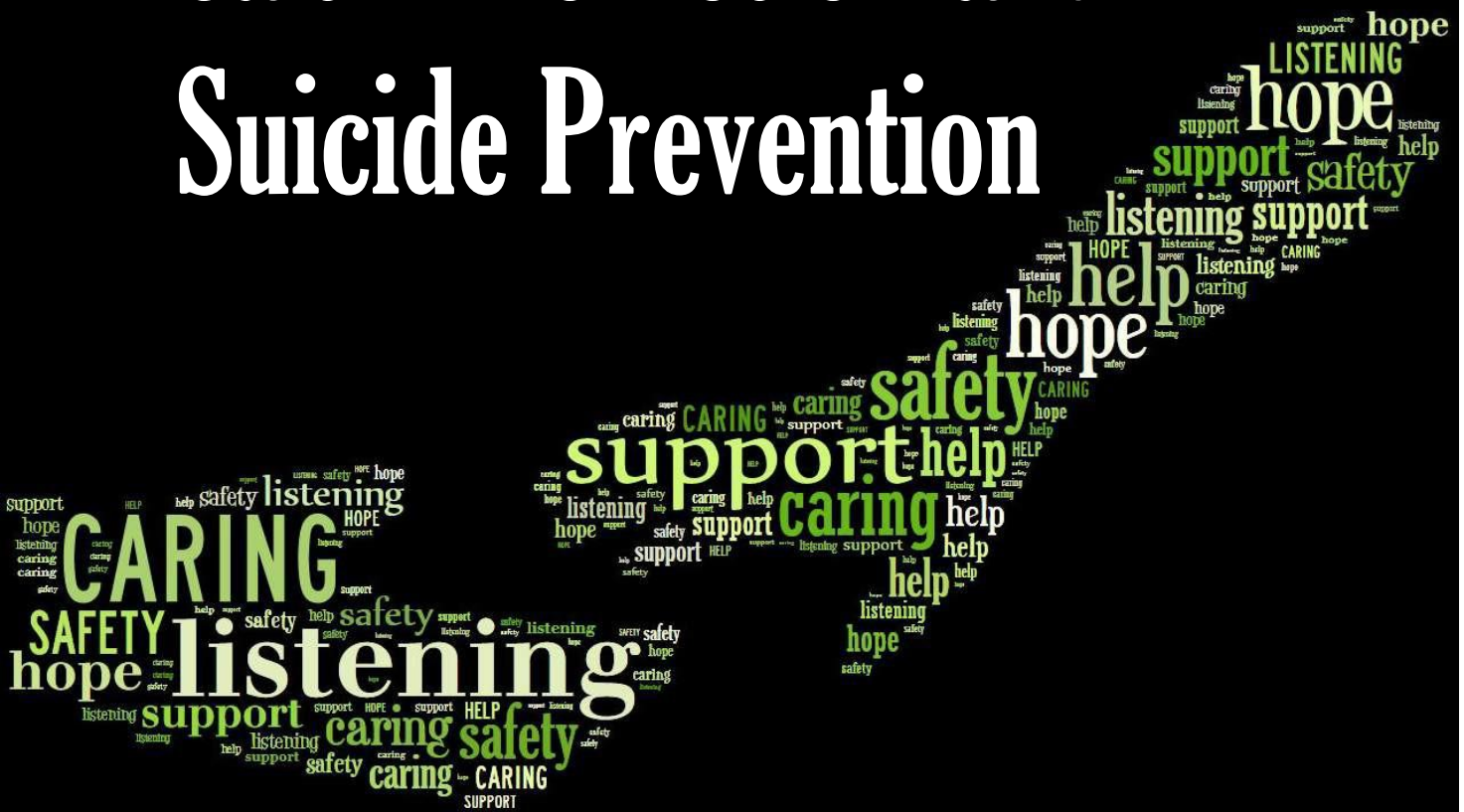


K-12

Toolkit for Mental Health Promotion and Suicide Prevention



Compiled by:

Shashank V. Joshi, MD

Mary Ojakian, RN

Linda Lenoir, RN, MSN, CNS

Jasmine Lopez, MA, NCC



CONSULTANTS FOR VERSION 2017:

Shashank V. Joshi, MD, DFAACAP, FAAP
*Associate Professor of Psychiatry, Pediatrics & Education
Stanford University
Director of School Mental Health
Lucile Packard Children's Hospital at Stanford
Steering Committee: Project Safety Net Palo Alto
Executive Board, HEARD Alliance*

Mary Ojakian, RN
*AFSP: Greater San Francisco Bay Area Chapter Board Member
Santa Clara County Suicide Prevention Oversight Committee
Suicide-Prevention and Mental Health Advocate
Project Safety Net Coordinator - Palo Alto Suicide Prevention Task Force
Tall Tree Award Recipient, 2010*

Linda Lenoir, RN, MSN, CNS
*Retired Certificated School Nurse
Founding Member of Project Safety Net
Executive Board, HEARD Alliance
Suicide-Prevention and Mental Health Advocate
Tall Tree Award Recipient, 2008*

Jasmine Lopez, MA, NCC
*2015-Present
School Mental Health Team Coordinator
Stanford University - Child & Adolescent Psychiatry
Project Coordinator for the HEARD Alliance*

Project Staff 2017:

HIPAA/FERPA
Tara Ford Young Minds Advocacy, San Francisco, Ca, Senior Attorney (Licensed in NM, Registered Legal Services Attorney in CA)

Mindfulness
John P. Rettger PhD; Director of Mindfulness
Early Life Stress and Pediatric Anxiety Program, Lucile Packard Children's Hospital at Stanford University, Department of Psychiatry and Behavioral Science, Stanford University School of Medicine
Renee Burgard LCSW; Mindfulness and Health

Social Emotional Learning
Amy Heneghan MD; Palo Alto Medical Foundation and Sutter Health
Christine Wang Project Director, Education and School Partnerships, Teen Mental Health Initiative Children's Health Council
Eduardo L. Bunge Ph.D; Associate Professor, Palo Alto University
Ramsey Kasho Psy.D; Director of The Center at Children's Health Council,
Clinical Director of The Sand Hill School at CHC
Sarah Klem University of Michigan, Ann Arbor
Sarah Kremer LPCC, ATR-BC; Director of Resilience Consultation Program at Acknowledge Alliance
Taylor N. Stephens Palo Alto University/ Clinical Psychology Ph.D Student

*Research Team from Palo Alto University, Palo Alto, CA:
Narey V. Kelediian, Shweta Ghosh, Caitriona Tilden*

Red Folder Initiative

Becky Beacom Manager, Health Education—Palo Alto Medical Foundation
Karen Li MD; Wellness Coordinator, Sequoia Union High School District

Resources

Lauren Olaiz MPH; Community Liaison Specialist Behavioral Health Services-El Camino Hospital

Self-Care/Grief

Sarah Kremer LPCC, ATR-BC; Director of Resilience Consultation Program at Acknowledge Alliance
Shelly Gillan Director, KARA, Grief Support for Children, Teens, Families and Adults
Jaymie Byron Director of Community Outreach, Crisis Response Coordinator, KARA

Sleep

Darin Conway LCSW, PPSC; Adolescent, Family Counseling Parenting Coach

Social Media

Vicki Harrison MSW; Manager, Center for Youth Mental Health and Wellbeing, Manager of Community Partnerships, Stanford Department of Psychiatry and Behavioral Science
Elizabeth Li UC Berkeley, Class of 2018 Public Health and Media Studies major/Public Policy minor

Transitions

Samantha N. Hartley PhD Student in Clinical-Community Psychology, University of South Carolina

Bharat R. Sampathi 3rd Year Medical Student at UC Irvine School of Medicine, Stanford School Mental Health Research Assistant

PDF and Web Design

Wen Pin Lai, MA

SPECIAL ACKNOWLEDGEMENT

We are deeply grateful for the ongoing financial support from the Lucile Packard Children's Hospital @ Stanford Office of Government and Community Relations. We also thank the founding members of Project Safety Net and the HEARD Alliance (Health Care Alliance for Response to Adolescent Depression and related conditions). Their dedicated efforts provided the basis upon which the 2013 version of the Toolkit was built.

HEARD Alliance 2017

Dr. Shashank Joshi
Dr. Amy Heneghan
Mary Ojakian, RN
Linda Lenoir, RN, BSN, MSN, CNS
Lauren Olaiz, MPH
Becky Beacom, BS
Dr. Ramsey Khasho
Dr. Steven Adelsheim
Michael Fitzgerald, RN, PMHCNS
Dr. Daniel Becker
Ellen Hayenga, MFT
Dr. Meg Durbin
Dr. Jeremy Wilkinson

HEARD Alliance 2013

Dr. Frances Wren
Dr. Meg Durbin
Dr. Shashank Joshi
Dr. Manpreet Singh
Dr. Daniel Becker
Dr. Carol Zepecki
Wes Cedros
Mary Ojakian, RN
Victor Ojakian
Becky Beacom
Susan McKenzie, LCSW
Hinda Weber, Case Manager
Linda Lenoir, MSN

Project Safety Net 2013

Dr. Shashank Joshi
Dr. Carol Zepecki
Wes Cedros
Robert DeGeus
Mary Ojakian, RN
Victor Ojakian
Becky Beacom
Linda Lenoir, MSN

CONSULTANTS FOR VERSION 2013:

Shashank V. Joshi, MD

*Director of School Mental Health
Lucile Packard Children's Hospital at Stanford University
Steering Committee: Project Safety Net Palo Alto
Executive Board, HEARD Alliance*

Mary Ojakian, RN

*AFSP: Greater San Francisco Bay Area Chapter Board Member
Project Safety Net Coordinator - Palo Alto Suicide Prevention Task Force
Suicide-Prevention and Mental Health Advocate
Santa Clara County Suicide Prevention Oversight Committee
Tall Tree Award Recipient, 2010*

Linda Lenoir, RN, MSN

*District Nurse, PAUSD
Founding member of Project Safety Net
Executive Board Member, HEARD Alliance
Project Safety Net Steering Committee
Tall Tree Award Recipient, 2008*

Sami Hartley, Stanford University SSRA

*2012-2015
Project Coordinator and Community Liaison for the HEARD Alliance
Stanford University School Mental Health Team Coordinator*

Erica Weitz, MA

*2009-2012
Project Coordinator and Community Liaison for the HEARD Alliance
Stanford University School Mental Health Team Coordinator
Field Investigator for the American Association of Suicidology*

Jonathan Frecceri, MFT

Director of Community Outreach and Education, KARA Grief Support

PROJECT STAFF 2013:

Brenda Carrillo	<i>Student Services Coordinator, PAUSD</i>
Kathleen Blanchard	<i>Parent Consultant</i>
Mary Sue Budrow	<i>Psychologist: Fairmeadow and Hoover Elementary Schools</i>
Kimberley Cowell	<i>Assistant Principal, Gunn High School</i>
Todd Daly	<i>Psychologist, Jordan Middle School</i>
Roni Gillenson, LMFT	<i>Adolescent Counseling Services On-Campus Counseling Program Director</i>
George Green, PhD	<i>Psychologist, Gunn High School</i>
Tom Jacoubowsky	<i>Assistant Principal, Gunn High School</i>
Bridget Johnson	<i>Health Secretary, PAUSD</i>
Bhavna Narula	<i>Assistant Principal, Terman Middle School</i>
Victor Ojakian	<i>Santa Clara County Mental Health Board</i>
Rita Rodriguez, PhD	<i>Psychologist, Palo Alto High School</i>
Margaret Sachs	<i>Psychologist, Ohlone and Palo Verde Elementary Schools</i>
Selene Singares	<i>Counselor, Palo Alto High School</i>
Stephanie Sheridan, PhD	<i>Psychologist, Jane L. Stanford Middle School</i>
Katya Villalobos	<i>Principal, Gunn High School</i>

DEDICATION

This document is dedicated to the memory of all the youth whom we have lost to suicide. It is our hope that its regular use may help provide better support for those who struggle with thoughts of suicide, and ultimately prevent the loss of life to the causes of suicide.

PREAMBLE

To Be Well...

What does that mean, exactly? What is well-being? Can it be achieved? Can it be taught? Can it be fostered among individuals and within a community?

The [World Health Organization \(WHO\)](#) proposed a definition that linked health to well-being, in terms of "physical, mental, and social well-being, and not merely the absence of disease and infirmity" (World Health Organization (1958). *The first ten years of the World Health Organization*. Geneva: WHO.). This includes wellness in physical, emotional, social, and academic domains. Each of these areas is important; each is intertwined with the others. In essence, well-being is a wholeness, a completeness, a balance. And this is true for individuals as well as for communities.

The goal of this Toolkit, developed with the above definition of well-being, is to support school communities in improving their well-being. It is designed with parents, students, teachers, school personnel, counselors and health providers in mind. The Toolkit provides tools to help promote mental health, intervene in a mental health crisis, and support members of a school community after the loss of someone to suicide. It is divided into three sections: Promotion of Mental Health and Wellness, Intervention in a Suicidal Crisis, and Postvention Response to Suicide. This Toolkit is designed to prevent the most heartbreaking event, youth suicide. Our hope is to promote well-being and prevent suicide through the measures described in this document.

REQUIRED SUICIDE PREVENTION POLICY

Model Youth Suicide Prevention Policy for California
Assembly Bill 2246, Approved September 26, 2016

This Toolkit has been created to help schools comply with and implement AB 2246, the Pupil Suicide Prevention Policy. This California State law requires all local educational agencies (LEA): county offices of education, school districts, state special schools, or charter schools to have a Pupil Suicide Prevention Policy. The policy applies to all students at LEAs in grades 7 to 12. It must be in place by the beginning of the 2017-18 school year. It must be developed in consultation with school and community stakeholders, school-employed mental health professionals, and suicide prevention experts. And it must address procedures relating to suicide prevention, intervention and postvention. Some of the criteria outlined by the law are:

- Address the needs of high risk groups such as youth bereaved by suicide, youth with disabilities, mental illness, or substance use disorders, youth experiencing homelessness or in out-of-home settings, and LGBTQ youth
- Ensure that teachers are trained on suicide awareness and prevention
- Ensure that a school employee acts only within the authorization and scope of their credential or license

Schools without policies can be guided by the California Department of Education model policy. Schools with policies can review and modify as needed to comply with AB 2246.

<http://www.cde.ca.gov/ls/cg/mh/index.asp>

Text of AB 2246; https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB2246

Accurate Language and Concepts About Suicide

By changing the way we talk about suicide, we change the way we think of it. In general the language used for any other illness-based death or sudden loss (such as a heart attack or car accident) is a guiding principle.

- **Died of suicide** (Also 'Died by suicide') - Suicide is death due to brain illnesses. In a suicidal state thought processes become distorted because of biological, psychological, social, cultural and/or situational reasons. Suicidal people are not thinking clearly. They are in fact struggling with a kind of illness in their thinking processes. The term "Committed suicide" does not describe accurately what has occurred. *Committed* implies a crime or immoral act. Suicide is no longer seen as a crime or sin but is recognized to be the result of a mental health condition with a medically treatable cause at least 90% of the time. Often a person with lived experience of suicide will say choice was not involved but instead they were overwhelmingly "compelled" to attempt to kill themselves.
- **Person with lived experience** - A person with the lived experience of suicide has struggled with suicidal thoughts or behaviors and may be an attempt survivor. Resilience is a skill that can be developed - one is not "permanently fragile" when they are an attempt survivor.
- **Bereaved by suicide** - Someone who has been exposed to the suicide of another person and experiences a high level of psychological, physical and/or social distress for a considerable length of time. In the U.S. the term "loss survivor" is often used. This loss can cause PTSD, complicated grief or other deleterious physical and mental consequences. Everyone grieves differently and on their own timeline. Incorporating such a loss into one's life requires work and support.
- **Fatal or Non-fatal Attempt**— Applying the general principle of speaking about suicide using illness based language, fatal and non-fatal is language in line with a fatal or non-fatal heart attack or other illness. It is not advised to add a value statement to suicide such as calling an attempt failed, successful, or botched, etc. Also the term "completed" suicide is not advised. Completing something implies success.

Suicide is a complex phenomenon. It does not have to do with an individual's willpower. There is no simple explanation for any suicide. Though an immediate precipitating event may occur, that is not the "reason" someone has died.

People often ask what to say to a person who has lost someone to suicide. Generally, it is advised to think of what one would say or do if the person had lost their loved one suddenly in a fatal car crash or a heart attack - then do and say that.

KEY TO TOOLKIT ACRONYMS

AACI	Asian Americans for Community Involvement
ACS	Adolescent Counseling Service
AFSP	American Foundation for Suicide Prevention
AR	Administrative Regulation
ASIST	Applied Suicide Intervention Skills Training
CDC	Centers for Disease Control and Prevention
CRT	Crisis Response Team
ERMHS	Educationally-Related Mental Health Services
FERPA	Family Educational Rights and Privacy Act
HEARD	Health Care Alliance for Response to Adolescent Depression
HIPAA	Health Insurance Portability and Accountability Act (Privacy and Security Rules)
IRP	Individualized Re-Entry Plan
LPCH/SMHT	Lucile Packard Children’s Hospital/School Mental Health Team
MYSP	Maine Youth Suicide Prevention Program
NIMH	National Institute of Mental Health
PBIS	Positive Behavioral Interventions and Support
PSN	Project Safety Net
PTSD	Post Traumatic Stress Disorder
QPR	Question, Persuade, Refer – Gatekeeper Training
SAMHSA	Substance Abuse and Mental Health Services Administration
SBP or BP	School Board Policy
SPRC	Suicide Prevention Resource Center
UFS	Uplift Family Services
USF	University of South Florida

TABLE OF CONTENTS

INTRODUCTION	1
SECTION I: PROMOTION OF MENTAL HEALTH AND WELLNESS	4
A. EDUCATION	4
1. STAFF EDUCATION	4
2. STUDENT EDUCATION	4
3. PARENT/COMMUNITY EDUCATION	5
• MEANS RESTRICTION	6
• HEALTHY ADOLESCENT SLEEP	6
B. SAFE AND CARING SCHOOL CLIMATE	10
• CONNECT STUDENTS WITH CARING ADULTS	10
• SOCIAL EMOTIONAL LEARNING	11
• MINDFULNESS	30
ATTACHMENTS FOR SECTION I: PROMOTION	45
• 1.1 THE IMPERATIVE OF COMPASSIONATE SELF-CARE	46
• 1.2 TRANSITIONING – PRIMARY SCHOOL THROUGH LIFE AFTER HIGH SCHOOL	51
• 1.3 SOCIAL MEDIA	66
• 1.4 CULTURE, MENTAL ILLNESS AND STIGMA	72
• 1.5 SAMPLE SEL ACTIVITIES AND STRATEGIES.....	80
• 1.6 MINDFULNESS AND SCHOOL CLIMATE: ONE EXAMPLE	81
• 1.7 TYPES OF STUDENT PROGRAMS INFORMATION SHEET, <i>SAMHSA Toolkit</i>	82
• 1.8 GENERAL GUIDELINES FOR TEACHERS AND STAFF, <i>LA County Youth Suicide Prevention Project</i>	84
• 1.9 RISK FACTORS FOR YOUTH SUICIDE, <i>SAMHSA Toolkit</i>	86
• 1.10 PROTECTIVE FACTORS AGAINST YOUTH SUICIDE, <i>SAMHSA Toolkit</i>	89
• 1.11 RECOGNIZING AND RESPONDING TO WARNING SIGNS OF SUICIDE, <i>SAMHSA Toolkit</i>	91
• 1.12 RED FOLDER INITIATIVE (<i>for administrators and school staff as well</i>)	92
• 1.13a QPR AS A UNIVERSAL INTERVENTION	97
• 1.13b QPR GUIDELINES	100
• 1.14 INCLUDING SUICIDE PREVENTION IN OTHER EFFORTS TO REACH PARENTS, <i>SAMHSA Toolkit</i>	101
• 1.15 IDEAS FOR MAXIMIZING PARENTAL RESPONSE RATE, <i>SAMHSA Toolkit</i>	102
• 1.16 SUICIDE PREVENTION: FACTS FOR PARENTS, <i>SAMHSA Toolkit</i>	103
SECTION II: INTERVENTION IN A SUICIDAL CRISIS	104
A. CRISIS RESPONSE TEAM (CRT) MEMBERS AND ROLES	105
B. IDENTIFY AND MONITOR AT-RISK STUDENTS	110
C. LOW RISK LEVEL OF SUICIDE	111
D. MODERATE TO HIGH RISK LEVEL OF SUICIDE	111
E. EXTREMELY HIGH (IMMINENT) RISK LEVEL OF SUICIDE	112
F. PROCESS FOR RE-ENTRY TO SCHOOL AFTER EXTENDED ABSENCE OR HOSPITALIZATION	114
ATTACHMENTS FOR SECTION II: INTERVENTION	115
• 2.1 SELF-INJURY AND SUICIDE RISK INFORMATION SHEET, <i>SAMHSA Toolkit</i>	116
• 2.2 SUICIDE PREVENTION AWARENESS SESSION APPROPRIATE FOR ALL SCHOOL PERSONNEL	117
• 2.3a SUICIDE RISK ASSESSMENT FORM	123
• 2.3b CONCERN FORM FOR ELEMENTARY LEVEL.....	125

• 2.4 CRISIS INTERVENTION PROTOCOL CHECKLIST AND FLOW CHART	130
• 2.5 GUIDELINES FOR NOTIFYING PARENTS, <i>SAMHSA Toolkit</i>	134
• 2.6 PARENT CONTACT ACKNOWLEDGEMENT FORM, <i>SAMHSA Toolkit</i>	136
• 2.7 GUIDELINES FOR STUDENT REFERRALS, <i>SAMHSA Toolkit</i>	137
• 2.8 REFERRAL PROCESS FOR SPECIAL EDUCATION MENTAL HEALTH ASSESSMENT	138
• 2.9 REFERRAL, CONSENT, AND FOLLOW-UP FORM	139
• 2.10 HEALTH AND EDUCATION PLAN – PHYSICIAN REPORT	140
• 2.11 SAFETY PLANNING GUIDE: A QUICK GUIDE FOR CLINICIANS, <i>WICHE & SPRC</i>	141
• 2.12 SAMPLE PERSONAL SAFETY PLAN (<i>to be used with attachment 2.11</i>)	143
• 2.13 STUDENT SUICIDE RISK DOCUMENTATION FORM, <i>SAMHSA Toolkit</i>	145
• 2.14 GUIDELINES FOR FACILITATING A STUDENT’S RETURN TO SCHOOL, <i>SAMHSA Toolkit</i>	146
• 2.15 GUIDELINES FOR WHEN A STUDENT RETURNS TO SCHOOL FOLLOWING ABSENCE FOR SUICIDAL BEHAVIOR	148
• 2.16 OTHER ISSUES AND OPTIONS SURROUNDING A STUDENT’S RETURN TO SCHOOL, <i>MYSPP</i>	149
• 2.17 CHILD AND ADOLESCENT PSYCHIATRIC HOSPITALS.....	151
• 2.18 MEANS RESTRICTION	152
• 2.19 SUICIDE CONTAGION AND CLUSTERS	156
SECTION III: POSTVENTION RESPONSE TO SUICIDE OF A SCHOOL COMMUNITY MEMBER.....	158
A. STEPS TO TAKE IN THE IMMEDIATE AFTERMATH.....	152
B. STEPS TO TAKE IN THE LONG-TERM AFTERMATH.....	162
ATTACHMENTS FOR SECTION III: POSTVENTION.....	165
• 3.1 POSTVENTION PROTOCOL FLOW CHART.....	166
• 3.2 SAMPLE POSTVENTION TELEPHONE TREE	167
• 3.3 GUIDELINES FOR WORKING WITH THE FAMILY, <i>SAMHSA Toolkit</i>	168
• 3.4 SAMPLE SCRIPT FOR OFFICE STAFF, <i>SAMHSA Toolkit</i>	169
• 3.5 GUIDELINES FOR NOTIFYING STAFF, <i>SAMHSA Toolkit</i>	170
• 3.6 SAMPLE LETTER TO FAMILIES, <i>SAMHSA Toolkit</i>	171
• 3.7 SAMPLE DEATH NOTIFICATION STATEMENT FOR PARENTS, <i>AFSP & SPRC Toolkit</i>	172
• 3.8 SAMPLE AGENDA FOR INITIAL ALL-STAFF MEETING, <i>AFSP & SPRC Toolkit</i>	175
• 3.9 SAMPLE ANNOUNCEMENTS, <i>SAMHSA Toolkit</i>	176
• 3.10 TALKING ABOUT SUICIDE, <i>AFSP & SPRC Toolkit</i>	181
• 3.11 TALKING POINTS FOR STUDENTS AND STAFF AFTER A SUICIDE, <i>SAMHSA Toolkit</i>	183
• 3.12 SAMPLE GRIEF DISCUSSION WITH STUDENTS, <i>KARA</i>	184
• 3.13 FACTS ABOUT SUICIDE AND MENTAL DISORDERS IN ADOLESCENTS, <i>AFSP & SPRC Toolkit</i>	185
• 3.14 MEMORIALIZATION, <i>AFSP & SPRC Toolkit</i>	188
• 3.15 STUDENT SUICIDE RISK DOCUMENTATION FORM, <i>SAMHSA Toolkit</i>	193
• 3.16 WORKING WITH THE COMMUNITY, <i>AFSP & SPRC Toolkit</i>	194
• 3.17 GUIDELINES FOR ANNIVERSARIES OF A DEATH, <i>SAMHSA Toolkit</i>	197
• 3.18i GUIDELINES FOR WORKING WITH THE MEDIA, <i>SAMHSA Toolkit</i>	198
• 3.18ii FRAMEWORK FOR SUCCESSFUL MESSAGING – POSITIVE NARRATIVE	199
• 3.19 MEDIA, <i>AFSP & SPRC Toolkit</i>	200
• 3.20 SAMPLE MEDIA STATEMENT, <i>AFSP & SPRC Toolkit</i>	202
• 3.21 KEY MESSAGES FOR MEDIA SPOKESPERSON, <i>AFSP & SPRC Toolkit</i>	204
• 3.22 RECOMMENDATIONS FOR REPORTING ON SUICIDE, <i>AFSP</i>	205
• 3.23 AT A GLANCE: SAFE REPORTING ON SUICIDE, <i>SPRC</i>	207
• 3.24 CONTAGION AND CLUSTERS	210
• 3.25 GRIEF FOR CHILDREN AND TEENS AFTER SUICIDE	212
APPENDIX A: SCHOOL SUICIDE PREVENTION POLICY, LAW & EDUCATIONAL STANDARDS	215
APPENDIX B: STAFF, PARENT AND STUDENT RESOURCES.....	222
APPENDIX C: KARA GRIEF SUPPORT RESOURCES	257
BIBLIOGRAPHY.....	275

INTRODUCTION

2017

“No matter where we live or what we do every day, each of us has a role in preventing suicide. Our actions can make a difference.”

*Regina M. Benjamin, MD, MBA VADM, U.S. Public Health Service Surgeon General
2012 National Strategy for Suicide Prevention*

<https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report-rev.pdf>

This Toolkit was created in 2013 in response to a need for schools to address student mental and emotional wellness to prevent suicide and, in particular, how to respond after a suicide loss. California law AB 2246, enacted in 2016, requires that all public schools have a “Pupil Suicide Prevention Policy.” This document has been updated to reflect both this need and this policy requirement.

The 2013 Toolkit quoted SAMHSA’s 2012 “Preventing Suicide: A Toolkit for High Schools”. It states, “Schools have an essential role to play in preventing suicide and in promoting behavioral health among America’s young people”. Through the promotion of youth behavioral health, the ability of students to learn and thrive is enhanced. The tools and resources provided in this updated Toolkit are meant to complement what schools may already have in place and to help initiate the implementation of a “Pupil Suicide Prevention Policy”.

Statistics tell us many things.

- In California the rate of youth mental health hospitalizations has risen by 50% between 2007 and 2015.
- In 2011-13 nearly one fifth (19%) of California public school students in grades 9 and 11 seriously considered attempting suicide in the past year.
- In 2013-14 21% of California youth ages 12-17 reported needing help for emotional or mental health problems (“Hospitalizations for Mental Health Issues”, 2016).
- Fifty percent of all lifetime cases of mental illness begin by age 14 and seventy five percent by age 24 (“Mental Health Facts,” 2014).
- Suicide is the second leading cause of death for youth and young adults ages 10 to 24 (“Ten Leading Causes of Death,” 2014).

Though data informs about a great deal it does not paint the entire picture. It cannot quantify the grief, anguish, confusion, guilt and devastation felt by the family, friends and community of an adolescent who dies by suicide. It does not inform about the increased risk youth face for PTSD, other mental health problems or even their own suicide after the loss of a peer to suicide. It does not reveal the uncomfortable reactions evoked by suicide; the fear, blame, isolation, stigmatization, silence and secrecy that surrounds suicide.

Suicide is a major, preventable public health problem. Reducing the number of suicides requires the engagement and commitment of people in many sectors including education. This Toolkit contains information schools need to further the goals of emotional health promotion and suicide prevention for youth. Some actions schools can take include these delineated in Lucile Packard Foundation Kids Data.

- Setting school policies that foster a positive, supportive environment and promote student engagement in school, and supporting comprehensive K-12 education for social-emotional learning, including communication skills, problem-solving skills, and stress management

- Ensuring adequate funding and training for a range of school staff to recognize signs of mental distress and refer students to services; such training also should focus on how to promote a safe and supportive environment for all students, including LGBT youth (“Hospitalizations for Mental Health Issues”, 2016).

Tools to accomplish these actions are found in the sections of this document; Promotion of Mental Health and Wellness, Intervention in a Suicidal Crisis, Postvention Response to Suicide and Appendices. Each section is related to the others. None functions entirely on its own. Though one area may apply in a particular situation all are meant to work together. For instance, when a student is noted to be struggling, actions described in the “Intervention in a Crisis” section may need to be activated and as the student is supported through the crisis mental wellness promotion actions may become more applicable. Or, should a student death due to suicide occur, students may experience a crisis and part of postvention may involve actions described in the intervention section. All parts are necessary and all function together.

The goal of this document is to ensure that schools can participate fully in the broader community effort to promote youth emotional and mental health and prevent youth suicide. It is our intention and hope that the full participation by schools in student behavioral health promotion will lead to more fulfilling and productive lives for all their students.

Cultural Issues in Mental Health Promotion and Suicide Prevention

The students and families that school personnel and child mental health professionals interact with comprise an increasingly diverse group with unique needs. The acceptability of children’s mental health services is highly influenced by attitudes, beliefs, and practices from their families’ cultures of origin. (Pumariega, et al. 2010a)

This Toolkit has been written and compiled under the presumption of multiculturalism, with a broad definition of culture that has been chosen, not limited to ethnic or racial makeup, but rather one that embraces the variable values, attitudes, beliefs, and behaviors shared by a people, and that is often transmitted between generations. Multiculturalism assumes that no single “best” way exists to conceptualize human behavior or explain the realities and experiences of diverse cultural groups. Rather, it is more useful to assume that everyone has a unique culture, and that cultural influences are woven into personality like a tapestry (McDermott, 2002). From this perspective, three of the major tasks for school professionals include (1) developing a broad knowledge base about cross-cultural variations in child development and childrearing; (2) integrating this knowledge in a developmentally relevant way to make more informed assessments and interventions; and (3) developing a culturally sensitive attitude and therapeutic stance in all interactions with students and their families, including those of the same background as the school staff (Pumariega, 2010; Joshi, 2015).

For additional resources that may be helpful for specific cultural populations, please see [Attachment 1.4](#).

SUMMARY

Schools have special reasons for taking action to help prevent the tragedy of suicide:

- A student's mental health can affect their academic performance. Depression and other brain conditions can interfere with the ability to learn.
- Maintaining a safe environment is part of a school's overall mission.
- A student suicide can significantly impact other students and the entire school community. Knowing what to do following a suicide is critical to helping students cope with the loss and preventing additional tragedies that could occur.
- Although this is a school-based toolkit, there is an understanding that children and teens are part of a community and that any comprehensive intervention includes not only members of the school, but also the family and selected members of the child's extended community (such as trusted adults, therapist, primary care, etc.).

Experts recommend that schools use an approach to suicide prevention that includes the following:

1. Provide training and suicide awareness education for key staff, administrators, and site-based partners
2. Educate parents regarding suicide risk and mental health promotion
3. Educate and involve students in mental health promotion and suicide prevention efforts
4. Screen students for suicide risk, as appropriate
5. Identify students at possible risk of suicide and refer them to appropriate services
6. Respond appropriately to a suicide death

Suicide Prevention: A Toolkit for High Schools, SAMHSA

This toolkit addresses suicide prevention and responses to suicidal behaviors in three irrevocably interconnected and interdependent areas:

1. **Promotion** of Mental Health and Wellness
2. **Intervention** in a Suicidal Crisis
3. **Postvention** Response To a Suicidal Death

Each staff member takes responsibility for the part they can play in keeping students safe by becoming familiar with those aspects of this Toolkit that are pertinent to their role in student safety. Parents and the larger school community will be made aware that this toolkit is in place and of their role in youth suicide prevention efforts.

SECTION I: PROMOTION OF MENTAL HEALTH AND WELLNESS

Section one includes a comprehensive approach to wellness. Students need to be taught what mental health is and given the skills to achieve it, including the social-emotional skills needed for mental and physical well-being. These are defined in the Health Education Content Standards for California Public Schools (<http://www.cde.ca.gov/be/st/ss/documents/healthstandmar08.pdf>).

Educational opportunities that specifically relate to depression and suicidal ideation need to be provided for students, staff and parents. Mental health resources need to be compiled, reviewed, and regularly updated and disseminated to students, staff and parents. A safe and caring school climate needs to be maintained. Students of concern need to be identified, monitored and supported. Promotion of well-being is comprised of education, a safe and caring school environment, the identification and monitoring of students of concern, and the provision of mental health resources (see Appendix B2, "Mental Health Resources").

A. EDUCATION

1. STAFF EDUCATION

Key staff and teaching faculty receive training in recognizing depressive symptoms; the warning signs, risk factors, and protective factors for suicide (see Attachment 1.9, "Risk Factors for Youth Suicide", Attachment 1.10, "Protective Factors Against Youth Suicide", and Attachment 1.11, "Recognizing and Responding to Warning Signs of Suicide," see Attachment 1.12, "Red Folder Initiative") and the procedures for referring students to the appropriate school personnel (i.e. principal, assistant principal, guidance counselor, school based mental health counselor, nurse). Training will be scheduled before the school year begins or during staff development days. New staff will receive suicide prevention training, resources, and information as part of their orientation.

Training for key staff members includes:

- a. Gatekeeper training (for example QPR) and a refresher course every 2-3 years (see Attachment 1.13a, "QPR as a Universal Intervention, and Attachment 1.13b, "QPR Guidelines")

Recommended training for Crisis Response Team (CRT) members includes:

- a. A member of each CRT and key representatives at the district office will be trained in ASIST (Applied Suicide Intervention Skills Training) or similar professional training.
- b. Comprehensive CRT trainings occur each year.

2. STUDENT EDUCATION

Most youth who are suicidal communicate with peers about their concerns rather than with adults, yet as few as 25% of peer confidants tell an adult about their suicidal peer (Kalafat, 2003). Student programs that address suicide can play a significant role in reducing risk for suicide when they are used in conjunction with other strategies, such as intervention protocols and staff training. There are three types of student programs, each with different objectives. They are as follows:

a. Curriculum

- Best practice includes a comprehensive health curriculum for students at all elementary, middle and high schools that meets the Health Education Content Standards for California Public Schools.
- Curricula for all students informs them about suicide prevention, promotes positive attitudes about mental health, increases students' ability to recognize if they or their peers are at risk for suicide, and encourages students to seek help for themselves and their peers. Two depression education curricula recommended for use in high school classes are the American Foundation for Suicide Prevention's "More Than Sad" and Children's Hospital Boston's "Break Free from Depression." Parents are informed about the topics of depression and suicide being presented, and are invited to a parent evening to view the video presentation and participate in a discussion.

b. Programs

- Skill building programs such as QPR (Question Persuade Refer) help identify and support at-risk students by building coping, problem-solving and cognitive skills while addressing related problems such as stress, depression and other brain conditions, and substance abuse.
- Peer leader programs such as Sources of Strength teach selected students skills to identify and help peers who may be at risk. Some programs teach peer leaders to build connectedness among students and also between students and staff, which improves the school climate.
- For more information about student-oriented programs see Attachment 1.7, "Types of Student Programs."

c. Resources for Bay Area Students

At the beginning of the school year each middle and high school will list their site resources and hotlines on the back of their student ID cards. These numbers may include such resources as the Santa Clara County Suicide and Crisis Hotline, 1-855-278-4204, the school's mental health support resource, or Reach Out Online Forum at us.reachout.com. Links to these will be provided on the school website. A full list of recommended resources can be found in Appendix B2, "Mental Health Resources".

3. PARENT/COMMUNITY EDUCATION

Although parents may be aware that children and teens die by suicide, they often do not think it could happen to their child or in their community. Parents, primary caregivers and the entire school community need information about:

- The prevalence of suicide and suicide attempts among youth
 - The warning signs of suicide
 - How to respond when they recognize their child or another youth is at risk
 - Where to turn for help in the community when a crisis occurs
- a.** The school sites will work with PTA/ PTSA and PTAC and strongly encourage them to have a parent education program. This program could incorporate information about social-emotional and physical wellness, and suicide prevention.
- i.** To promote attendance this program could be publicized as one of the following examples:
- "Promoting Behavioral Health and Wellness"
 - "Eliminating Barriers to Learning"

- “Supporting Your Child With Transition from 8th grade or 12th grade”
- “Learning How to Keep Your Teenager Safe”

See Attachment 1.14, “Including Suicide Prevention in Other Efforts to Reach Parents”, Attachment 1.15, “Ideas for Maximizing Parental Response Rate”, and Attachment 1.16, “Suicide Prevention: Facts for Parents.”

b. Offer parent education in the middle and high schools about depression and other behavioral health illnesses.

- AFSP More Than Sad Parent Module: <https://afsp.org/our-work/education/more-than-sad/>
See *AFSP More Than Sad* at <https://afsp.org/our-work/education/more-than-sad/>

c. Resources for parents and students can be found on the following websites:

- HEARD Alliance: <http://www.heardalliance.org/>
- Project Safety Net: <http://www.psnpalalto.com/resources/>

Provide these links and a resource guide at the beginning of the school year and at educational events. (See Appendix B2 “Mental Health Resources” and Appendix B3 “Mental Health Information for Students”)

d. Include information about reducing access to lethal means in educational activities.

- One important public health task for suicide prevention, along with other prevention efforts, is restriction of access to the means of suicide. Evidence supports means reduction as an effective preventative strategy (Sarchiapone, Mandelli, Iosue, Andrisano, Roy, 2011). Many suicidal crises are short lived (Sarchiapone et al., 2011 & Barber, Miller, 2014). For about 30% of those who have seriously considered suicide the suicidal period lasted under one hour (Barber, Miller 2014). How a person attempts suicide, the means they use, plays a key role in whether they live or die.

(See Attachment 2.18 for detailed information about ‘Means Restriction’)

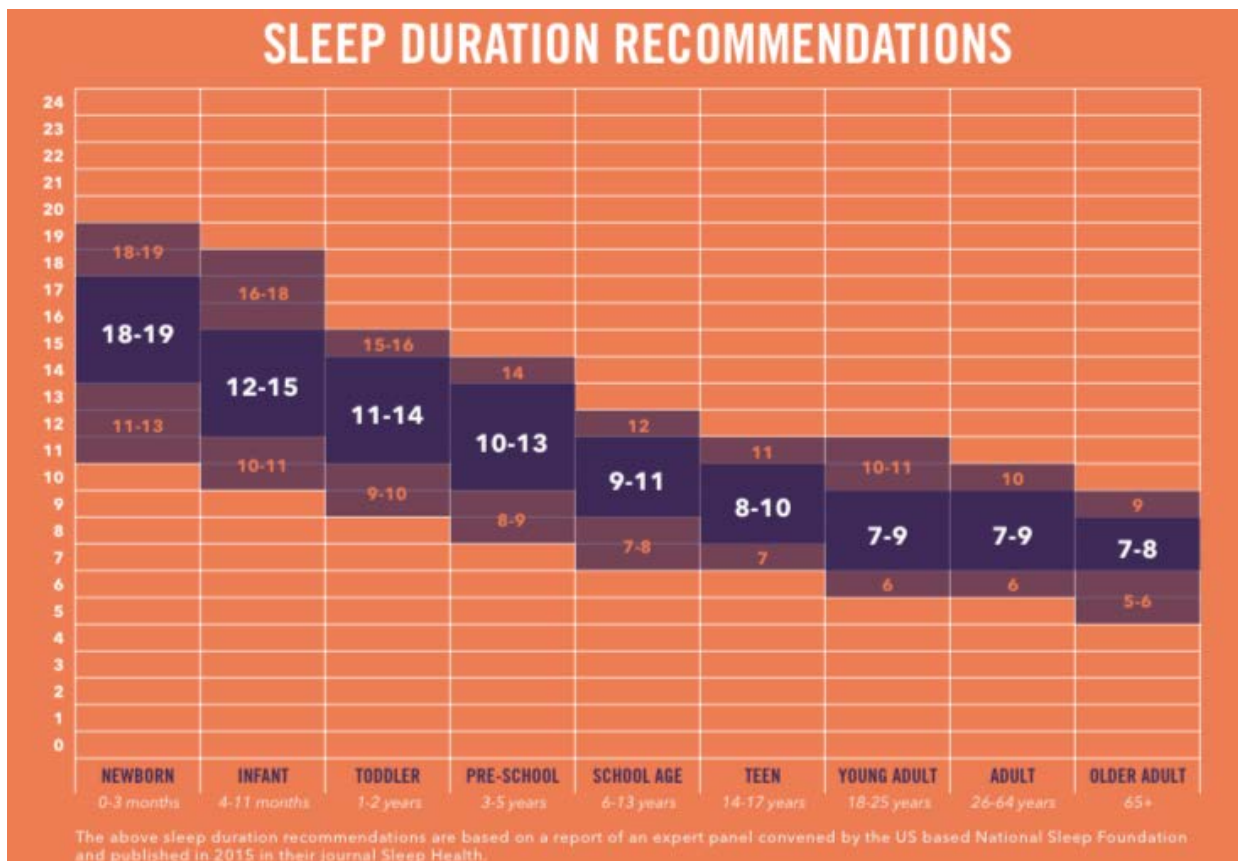
e. HEALTHY ADOLESCENT SLEEP

- **Healthy Sleep Patterns**

Making sleep a priority is essential. Evidence suggests that suicidal ideation and behaviors are closely associated with sleep disturbances, and in some cases, this association appears to exist above and beyond depression (Roberts et al 2001; Bernert et al 2005). Both sleep disorders and general sleep complaints appear to be linked to greater levels of suicidal ideation and depression, as well as both attempted and completed suicide (Krakow et al 2000; Agargun et al 1997a; Fawcett et al 1990).

It likely comes as no surprise that Americans today report feeling chronically exhausted and sleep deprived.

The National Sleep Foundation recommends 8-10 hours of sleep per night for adolescents ages 14-17, yet the average that our students actually get is between 6-8 hours. Teens have a lot of demands on their time and have difficulty balancing those demands with their need for sleep. Most schools start early in the morning, and after a long day they then have to study for hours at night.



http://www.heardalliance.org/wp-content/uploads/toolkit/promotion/Module7_Sleep.pdf

[UCLA's Sleep Disorders Center](#) provides compelling information regarding a shift in sleep for youth during puberty. During this stage of development, girls and boys begin to experience biological changes. Typically, girls begin to enter the stage of puberty earlier than boys. One change in the body during puberty is closely related to how you sleep. There is a shift in the timing of your circadian rhythms. Before puberty, the body is usually in sleep mode around 8:00 or 9:00 pm. As puberty begins, this rhythm shifts to a couple hours later where the body is told to go to sleep at around 10:00 or 11:00 pm.

Teens are also faced with other responsibilities that compete for their time. They frequently participate in after school activities including competitive sports that can take up many hours daily, clubs, and most want to spend time with friends socializing. Once they are old enough, they may begin to look for work after school to help out their families. They may be required to look after younger siblings or need academic tutoring. There is simply not enough time in the day to get it all done, so something has to give. Most frequently, they choose to give up sleep.

Those with mental health issues, particularly anxiety, depression, bi-polar disorder and ADHD are even more likely to suffer from sleep difficulties. Chronic sleep problems affect 50%-80% of patients in a typical psychiatric practice and recent studies are showing that chronic sleep problems increase the risk of developing these mental health problems. Getting a good night's sleep fosters improved mood, ability to cope (resiliency) and mental health, while lack of sleep sets the stage for emotional vulnerability and negative thought patterns. Up to 90% of adolescents being treated for depression report difficulty sleeping. Studies have found that among those who had thought about ending their lives, the risk went up significantly depending on how little

they slept. Additionally, each additional hour of sleep decreased the likelihood of suicidal thoughts. (*University of Pennsylvania: <https://www.pennmedicine.org/news/news-releases/2013/may/more-sleep-reduces-suicide-ris>*)

- **Signs and Solutions**

Some signs that indicate a student might not be getting enough sleep include:

- Having trouble waking up most mornings
- Acting irritable in the early afternoon
- Falling asleep easily during the day
- Having a sudden drop in grades
- Sleeping for very long periods on the weekends (*UCLA Sleep Disorders Center*)

So what can we do about it? Good sleep is essential to a good outlook on life and thus decreased risk of suicidality. The treatment fundamentals for insomnia (the most common sleep disturbance) are the same regardless of whether one is suffering from a mental health issue, or just struggling to get the amount of rest they need. The UCLA Sleep Disorders Center recommends the following list of tips for families who are hoping to help youth get the sleep they need.

- **Tips for Parents**

1. Parents should create a calm atmosphere in the home at bedtime.
2. Teens should have a regular, relaxing routine just before bedtime. They often have busy, hectic schedules. They need a chance to unwind at night.
3. To help them relax, teens should avoid activities that will excite their senses late in the evening. They should find another time for computer games, action movies, intense reading or heavy studying at least half an hour before going to bed.*
4. They should not have anything with caffeine (including soda and chocolate) after 4:00 pm.
5. They should also avoid smoking and drinking (and any other substance use). Along with hurting their health, nicotine and alcohol and other drugs will disturb their sleep.
6. A regular exercise routine and a healthy diet will help them sleep better at night. They should also get outside as much as possible
7. Keep the lights dim in the evening. Open the curtains or blinds to let in bright light in the morning. This helps keep their body clocks set at the right time.
8. If they must take a nap, they should keep it to under an hour.
9. It can be hard for teens to get enough sleep during the week. They may need to wake up later on weekends. But they should not wake up more than two hours later than the time when they normally rise on a weekday. Sleeping in longer than that will severely disrupt a teen's body clock. This will make it even harder to wake up on time when Monday morning arrives.

* **Screen time:** *It has become evident that staring at a screen right before bedtime can interfere with sleep, so the habit of ending the day with social media, video games or Netflix is not helpful to good sleep. Turn everything off at least a half an hour before you plan to try to go to sleep and do something relaxing, such as reading a book, taking a bath or listening to relaxing music.*

For many, further steps must be taken to aid sleep. Meditation, guided imagery, deep breathing exercises, and progressive muscle relaxation (alternately tensing and releasing muscles) can counter anxiety and racing thoughts. Some phone apps that can be downloaded to help include:

- Sleep Genius
- Sleep Cycle
- Nature Sounds Relax And Sleep
- Pzizz Sleep
- Relax Melodies
- Sleep As Android
- Sleep Time
- Sleepmaker Rain
- Awoken (*Android*)
- DigiPill

Some believe that poor sleep habits are learned. Since people with insomnia tend to become preoccupied with not falling asleep, cognitive behavioral techniques help them to change negative expectations and try to build more confidence that they can have a good night's sleep. A therapist can help with teaching these techniques.

- **Key Takeaways**

A couple of key takeaways and points to remember when advocating for the importance of sleep in youth are as follows:

1. Fine-tune your sleep routine
2. Optimize your sleep environment
3. Time your stimulants
4. Use light to your advantage
5. Get enough hours! http://www.heardalliance.org/wp-content/uploads/toolkit/promotion/Module7_Sleep.pdf

Lastly, if all of these changes are not enough, there are medications that can be prescribed by a doctor to help treat insomnia. In some cases, the medications used to help treat a mental health disorder can also treat insomnia at the same time. The studies suggest that treating insomnia could be another tool in the fight against suicide and should always be taken into consideration when helping this population.

B. SAFE AND CARING SCHOOL CLIMATE

A safe and caring school climate includes feeling safe at school, feeling part of decision-making, and having a sense of school connectedness, which “is the belief by students that adults and peers in the school care about their learning as well as about them as individuals” (*CDC, 2009b, SAMHSA Toolkit, p. 12*).

Suicidal behavior can be reduced as a sense of school connectedness is increased. Combining suicide prevention with efforts to increase connectedness furthers both goals.

The Centers for Disease Control and Prevention has cited the promotion and strengthening of connectedness at personal, family, and community levels as a key suicide prevention strategy, explaining that “positive attachments to community organizations like schools and churches can increase an individual’s sense of belonging, foster a sense of personal worth, and provide access to a larger source of support” (*CDC, 2012*).

1. CONNECT STUDENTS WITH CARING ADULTS

Strategies include:

a. For Staff:

- i. Providing professional development and support for teachers and other school staff to enable them to meet the diverse cognitive, emotional and social needs of students such as the “More Than Sad: Preventing Teen Suicide Program for Teachers and Staff.” On-site staff will provide facilitation of the program with the help of community partners.
- ii. Using effective classroom management and teaching methods to foster a positive learning environment (e.g., Positive Behavioral Intervention and Support, PBIS).

b. For Students:

- i. Providing students with the academic, emotional and social skills necessary to be actively engaged in school.

c. For Families:

- i. Providing education and opportunities to enable families to be actively involved in their children’s academic and school life. Most schools are already actively engaged in this process.

d. For All:

- i. Employing decision-making processes that facilitate student, family and community engagement, academic achievement, and staff empowerment.
- ii. Creating trusting and caring relationships that promote open communication among administrators, teachers, staff, students, families, and communities. This is an ongoing effort that requires collaboration and evaluation with our community and school partners. Evaluation will occur on a regular basis through instruments such as the California Healthy Kids survey.

2. SOCIAL EMOTIONAL LEARNING AND MINDFULNESS

Part of mental health promotion and suicide prevention in youth lies in the development of students' social and emotional wellness. (*Note: "wellness" refers to overall emotional well-being for the purposes of this document.*) Two evidence based strategies, Social Emotional Learning (SEL) and Mindfulness, share similar goals and outcomes for the emotional, social, and academic development of youth. Both enhance youth academic achievement and wellness, decrease risky behaviors, and improve relationships with peers and teachers. Each uses a different approach to achieve these outcomes (Lantieri, Zakrzewski, 2015). The SEL framework promotes intra-personal, interpersonal and cognitive competencies. Mindfulness, paying attention in a systematic way, deepens the internal ability to apply the skills learned through SEL. These strategies complement each other. SEL develops skills and Mindfulness enhances the ability to apply those skills such that a student can better understand themselves and others, develop meaningful relationships, and make constructive decisions. This section will first address SEL and then Mindfulness.

a. SOCIAL EMOTIONAL LEARNING (SEL)

• Introduction

Psychological wellness is key to a youth's healthy development. "Psychological well-being refers to how individuals self-evaluate and their ability to fulfill certain aspects of their lives, such as relationships, support, and work" (Cripps & Zyromski, 2009, p. 2). Greater well-being, as well as improved school performance, can be achieved through the mastering of social-emotional competencies (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). Schools have the potential to impact large numbers of children and to reduce suicide rates. SAMHSA states, "Schools have an essential role to play in preventing suicide and in promoting behavioral health among America's young people" (*Preventing Suicide: A Toolkit for High Schools, 2012*. SAMHSA, p. 14). Evidence-based SEL programming can be implemented in the school setting and can be part of the "upstream prevention" of youth suicide. Upstream prevention is defined as "approaches that reduce risk factors or enhance protective processes that influence the likelihood that a young person will become suicidal" (AAS & SPTS, 2012, p. 1). Through promotion of skills needed for mental wellness, schools can provide for "upstream prevention" of youth suicide.

The skills and strategies that children and teens gain through SEL have been shown to increase protective factors and reduce risk factors associated with suicide (AAS & SPTS, 2012). Effective SEL develops skills in problem solving, conflict resolution, nonviolent ways of handling disputes as well as a sense of connectedness all of which serve as protective factors for youth against suicide and other self-destructive behaviors during transitions or crises. Among students aged 13 to 17, shifts in self-control over time tend to influence behavioral issues, social functioning, and the ability to adapt to the demands of secondary school (Ronen, Hamama, Rosenbaum, & Mishlery-Yarlap, 2016). The competencies and skills gained through SEL can provide a foundation for improved adjustment abilities and academic performance, evidenced by less emotional distress and conduct problems, and by improved grades/test scores (Durlak et al., 2011).

As well as increasing protective factors, skills learned in SEL have been shown to reduce risk factors associated with suicide (AAS & SPTS, 2012). High risk behaviors such as drug and alcohol abuse, feelings of helplessness and hopelessness, impulsive and aggressive tendencies, and feelings of being cut off from other people (isolated) have been reduced through SEL (AAS & SPTS, 2012).

Further, by implementing SEL in schools, students, teachers, and administrators are more aware of and skilled in identifying and responding to mental health issues when the behavior first presents itself. Currently, by the age of fourteen 50% of all lifetime mental illness are evident (AAS & SPTS, 2012, p.3). Instead of addressing these issues when these behaviors or reactions have escalated, schools are more prepared to effectively

manage mental health issues with the prevention and intervention strategies they already have in place when they have effective SEL programming as part of their school culture.

For more information on national statistics please visit the following:

National Alliance on Mental Illness: <http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf>

National Adolescent Health Information Center

<http://nahic.ucsf.edu/downloads/MentalHealthBrief.pdf>

- **What is expected development?**

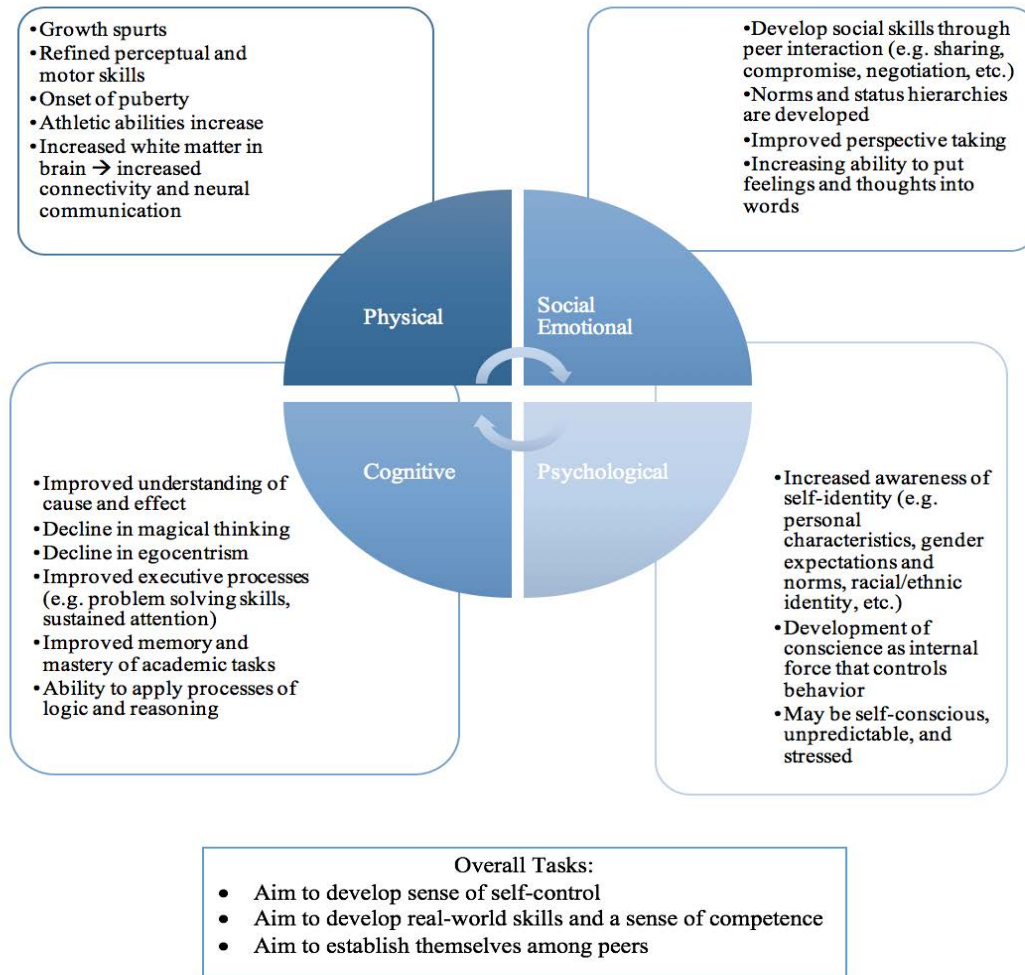
In order to fully understand and appreciate the concept of SEL, one must first understand the typical developmental trajectory of children and teens. Accordingly, let's take a closer look at child and adolescent development and the changes associated with this multi-faceted and rapid growth time of lifespan development. *(For more information on school Transitions see Attachment 1.2)*

Elementary School

During elementary school, children experience growth and development in a variety of domains, including social, cognitive, psychological, and physical. Youth development is driven by the basic psychological needs to achieve a sense of competence, autonomy, and connectedness. Of note, the formative years of elementary school allow children to interact with the outside world where they learn about expectations, norms, and interactions in different contexts (e.g. school, sports, peers, teachers, etc.). SEL in elementary school is designed to address both the individual and group tasks that children are working on during this time. Teachers can lay the foundation for emotional regulation through a variety of activities, as well as support children as they begin navigating peer relationships and develop friendships.

The following schematic depicts the expected growth in each of the developmental domains.

Elementary School Expected Development



Middle School

Early adolescence is a period marked by significant growth – physical, psychological, social-emotional and intellectual. Youth experience social growth and development, such as continued identity development and increased peer socialization during the transitional period of middle childhood. Other social changes include seeking increased independence, yet a strong need to fit in and belong to a peer group, while rebelling against and challenging adults (e.g. parents or teachers). Middle School youth experience many physical changes including shifting their sleep pattern to falling asleep later and waking later. “Research suggests that adolescence brings with it brain-based changes in the regulation of sleep that may contribute to teens’ tendency to stay up late at night. Along with the obvious effects of sleep deprivation, such as fatigue and difficulty maintaining attention, inadequate sleep is a powerful contributor to irritability and depression. Studies of children and adolescents have found that sleep deprivation can increase impulsive behavior; some researchers report finding that it is a factor in delinquency. Adequate sleep is central to physical and emotional health.” (NIMH) *(Note: Please see ‘Healthy Adolescent Sleep’ on page 6 of this Toolkit)*

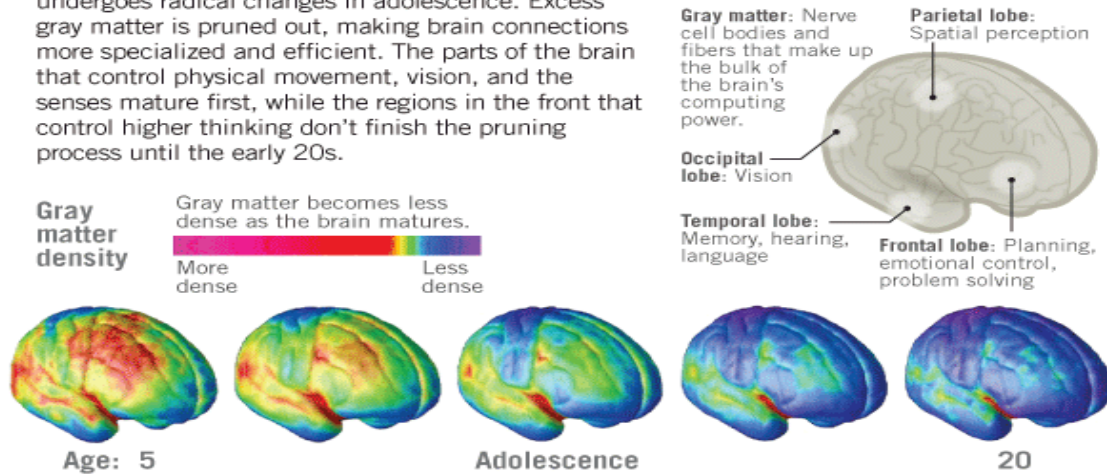
As youth mature, their brains develop and transform. The brain does not begin to resemble the adult brain until the early 20s. The cortex (i.e., grey matter) is where thought and memory are based. Different parts of the cortex mature at different rates. Areas processing information from the senses and those in control of movement mature first. Areas responsible for controlling impulses and planning ahead - hallmarks of adult behavior - mature last. Connections between different parts of the brain increase well into adulthood. Brain circuitry involved in emotional responses is also changing during the teen years. These brain changes have an impact on behavior. In addition, both reproductive and stress hormone systems are changing during the teens. Hormonal changes have complex effects on the brain which in turn affect behaviors.

“In terms of sheer intellectual power, the brain of an adolescent is a match for an adult’s.” (NIMH) However, when reacting to emotionally charged information, adolescents and adults engage different parts of the brain to different extents. “In teens, the parts of the brain involved in emotional responses are fully online, or even more active than in adults, while the parts of the brain involved in keeping emotional, impulsive responses in check are still reaching maturity.” (NIMH) Teens tend to make decisions with the areas of their brains that are more developed - the sensory and emotional areas. They receive strong rewards from decisions made based on impulse and emotion. This decision process has little supervision from the still-developing executive area which weighs the risks and benefits of a decision.

This means that when a risky choice has a strong emotional or sensory incentive, such as winning the acceptance of peers, the emotional system can win over the immature impulse control area, and a risky choice may be made. It is not yet possible to know to what extent a particular behavior or ability is the result of a feature of brain structure. Also “changes in the brain take place in the context of many other factors, among them, inborn traits, personal history, family, friends, community, and culture.” (NIMH) There is now evidence that the decision making process can be influenced by SEL. The following image indicates the many changes that occur in the human brain from early childhood to late adolescence.

Growing a Grown-up Brain

Scientists have long thought that the human brain was formed in early childhood. But by scanning children’s brains with an MRI year after year, they discovered that the brain undergoes radical changes in adolescence. Excess gray matter is pruned out, making brain connections more specialized and efficient. The parts of the brain that control physical movement, vision, and the senses mature first, while the regions in the front that control higher thinking don’t finish the pruning process until the early 20s.



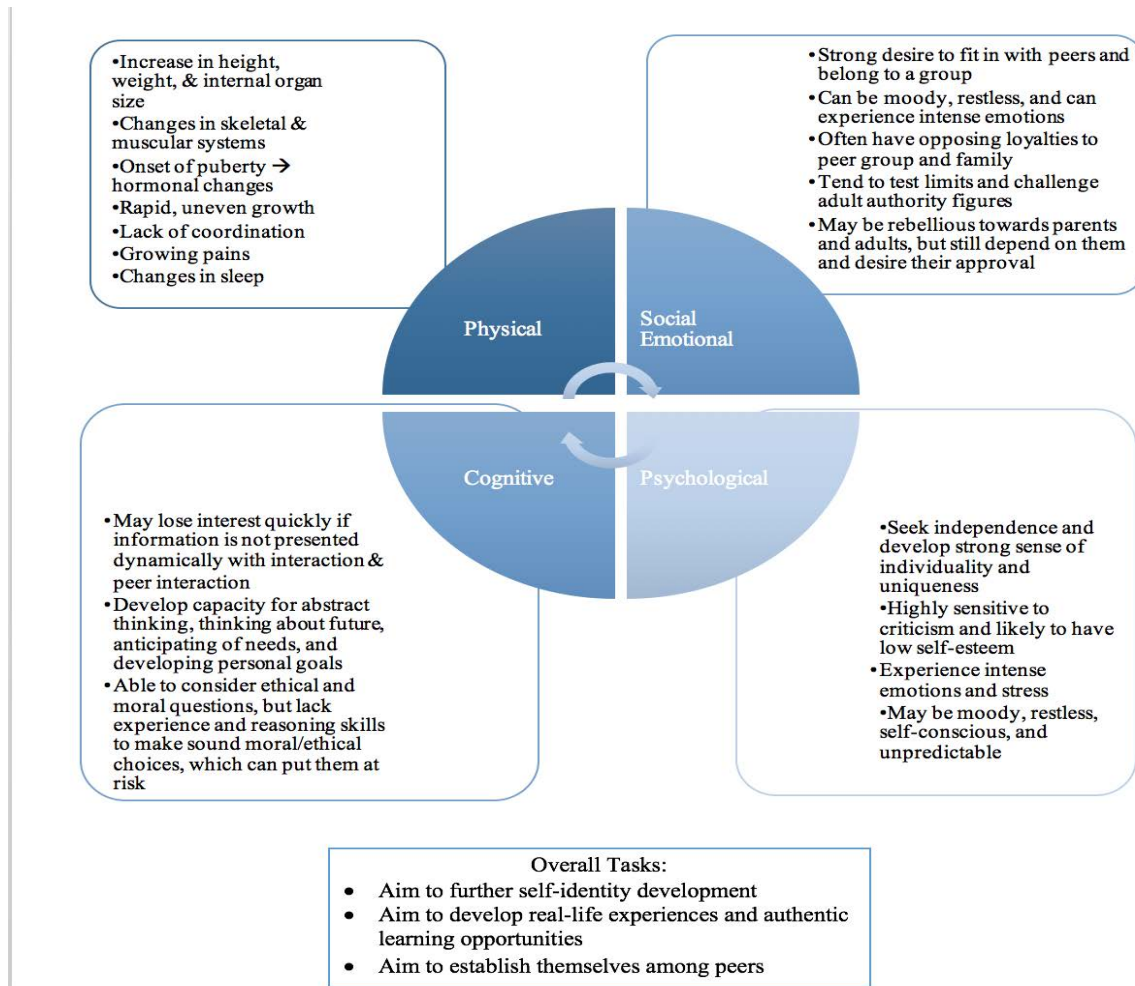
Source: “Dynamic mapping of human cortical development during childhood through early adulthood,” Nitin Gogtay et al., *Proceedings of the National Academy of Sciences*, May 25, 2004; California Institute of Technology

For more information see: LeWinn, K., Timofiyeva, O., Blom E. H. (2015). UCSF, Adolescent Depression: What We All Should Know. Retrieved from <http://www.slideshare.net/UCSFPsychiatry/adolescent-depression-what-we-all-should-know>

It has been shown that adolescence is a period marked by the highest rates of attempted suicides, where each attempt further increases risk of additional attempts or completion (Gould et.al, 2003). This is a serious issue of extreme importance, especially during the middle school period. Social-emotional learning is designed to address this issue early-on through upstream teaching focused on improving self-regulation skills, reducing risk, and increasing protective factors associated with adolescent suicide.

Research shows that SEL programs provide psychological and social benefits, in addition to academic benefits. Students with effective mastery of these social-emotional skills have shown a greater sense of well-being and better academic performance (Durlak et al., 2011). Failure to achieve these social-emotional skills can potentially lead to personal, social, and academic difficulties (Durlak et al., 2011).

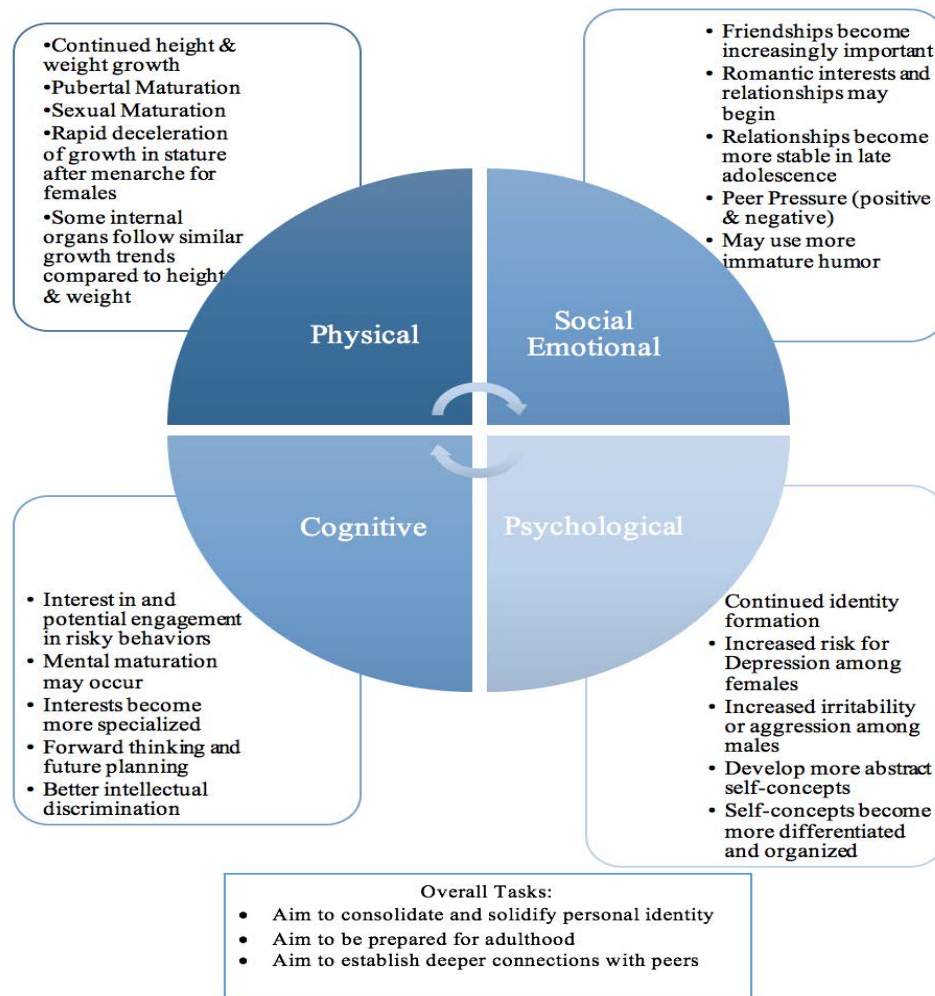
Middle School Expected Development



High School

High school is a time of continued growth and development within all domains. Through the transition to high school, adolescents may experience an increase in responsibilities, usually an increase in independence, as well as a decrease in free time. Adolescence is a period of continued physical development, where pubertal maturation continues to influence bodily growth, changes in hormones, and shifts in behaviors, attitudes, and conduct. Increasing awareness regarding their own development, particularly bodily changes, is accompanied by a change in their behaviors towards adults, members of their own sex, and especially members of the opposite sex. Similar to middle school, adolescence and high school is marked by continued social growth and identity formation, as well. The onset and maturation of puberty may be a potential contributing factor in child-parent conflict. "A pubescent tends to display more or less suddenly acquired but definite attitudes and modes of behavior that are different from habitual childhood reaction patterns. Furthermore, an adolescent's behavior is likely to change from year to year." (Crow & Crow, 1956, p. 69). Adolescence is a stage where youth are beginning the transition to adulthood. SEL during high school addresses the developmental tasks of independence and interdependence, identity formation, and the shift from strong family relationships to more peer and romantic relationships.

High School Expected Development



For more information on the developmental changes as children grow older, please visit *The University of Chicago Consortium on Chicago School Research*:

*<http://www.wallacefoundation.org/knowledge-center/Documents/Foundations-for-Young-Adult-Success-Infographic.pdf>

*<http://www.wallacefoundation.org/knowledge-center/Documents/Framework-for-Adult-Success-Brief.pdf>

• **What is SEL?**

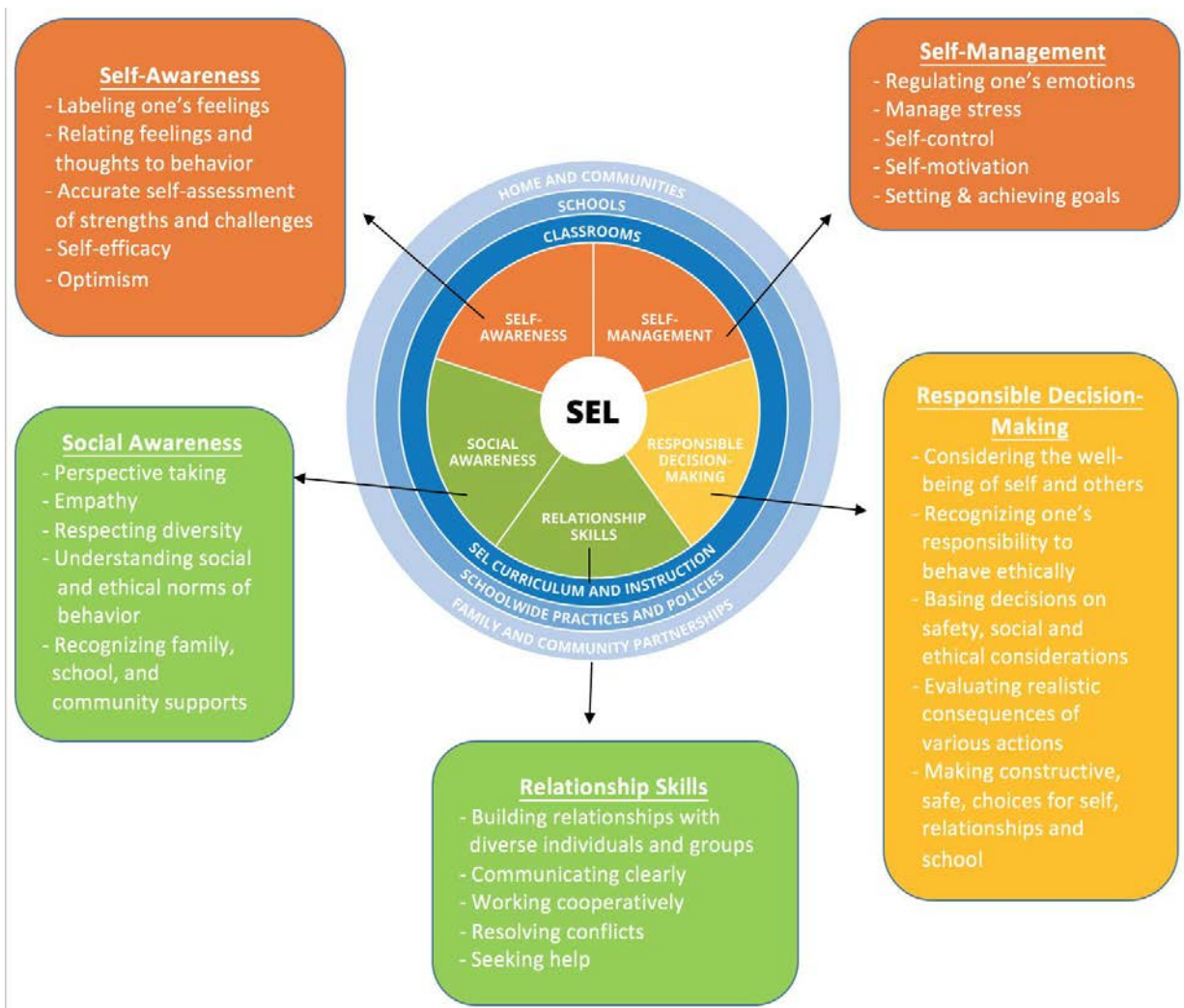
Social and emotional learning (SEL) is the process through which children and adults acquire and effectively apply the knowledge, attitudes, and skills necessary to understand and manage emotions, set and achieve positive goals, feel and show empathy for others, establish and maintain positive relationships, and make responsible decisions. SEL enhances students' capacity to integrate skills, attitudes, and behaviors to deal effectively and ethically with daily tasks and challenges. The use of SEL by schools promotes the positive development of students by improving students' academic achievement and positive social behavior while reducing their conduct problems and emotional distress (CASEL Guide, 2013).

In a study about how to foster SEL skills through technology, the World Economic Forum (2016) defined SEL as a mixture of competencies and character development, as illustrated below.



A variety of general and targeted learning strategies foster social and emotional skills From World Economic Forum. (2016). *New Vision for Education: Fostering Social and Emotional Learning through Technology*. Geneva, Switzerland: Author.

CASEL (Collaborative for Academic, Social, and Emotional Learning), one of the leading centers focused on SEL, has identified five interrelated sets of cognitive, affective, and behavioral competencies: self-awareness, self-management, social awareness, relationship skills, and responsible decision making (CASEL Guide, 2013). The three rings encircling the five competencies represent how SEL is integrated into classrooms (through curriculum and instruction), across the school setting (practices and policies), and in home and communities (through partnerships, like Parent-Teacher Associations and Parent Education programs).



Other equally valid models highlight similar competencies and development from different perspectives. Three examples are listed here.

The Washington State SEL Framework is rooted in CASEL's ideas but also includes elements of other promising frameworks and research on effective implementation. For example, four of the five competencies are listed along with an additional two, Social Management and Social Engagement. All six competencies are framed by family and community partnerships, professional learning (for educators and administrators), and an approach of cultural responsiveness.

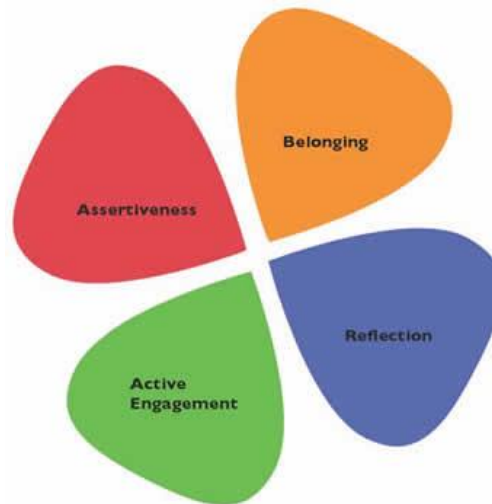
<http://www.k12.wa.us/Workgroups/SELB-Meetings/SELBWorkgroup2016Report.pdf>



The University of Chicago’s Consortium on School Research developed a developmental framework outlining a path to successful young adulthood, starting from preschool. In this model, self-regulation, knowledge and skills, mindsets, and values are foundational components. *Mindsets*, *Knowledge and Skills*, and *Values* are separate components, whereas these components are embedded in the different CASEL competencies. Development includes individual and social growth used to interact with a broader world. Their definition of success includes healthy relationships, a meaningful place in a community, and contributing to a sense of a larger good.

<https://consortium.uchicago.edu/sites/default/files/publications/Foundations%20for%20Young%20Adult-Jun2015-Consortium.pdf>

The Program in Education, Afterschool Harvard Medical School and McLean Model to convey growth, luck, framework assists in understanding and attempts to identify a common communicate with and about children essential elements that, when balanced, learn, and develop: Active Engagement, Reflection. These elements are aligned pathology.



and Resiliency (PEAR) at Hospital created the Clover nurturance and balance. This human developmental needs language with which to and youth. It highlights four provides a climate to thrive, Assertiveness, Belonging, and with resilience as well as

<http://www.pearweb.org/about/Clover.html>

SEL-related approaches also include several innovative perspectives on educational practice that are either aligned with SEL or create opportunities for SEL. SEL can be effectively implemented both in school and after school, and for students with and without behavioral or emotional problems with diverse backgrounds and in diverse settings. Such settings can include after-school programs, sports and other team-based programs, academic and social clubs, formal and informal mentoring programs, college and career readiness programs and with technology-based tools.

Although many SEL programs and approaches are available, school communities are encouraged to create their own framework that address their needs and concerns in order to have more meaningful SEL integration.

- **What skills can be developed through SEL?**

Social-emotional learning is designed for students to gain skills and competencies related to problem-solving, goal setting, recognizing and managing emotions, self-control, perspective taking, developing and maintaining positive relationships, and reducing negative outcomes (Durlak et al., 2011). Current findings suggest that SEL yields significant positive effects on the targeted social-emotional competencies, in addition to the students' attitudes about the self, others, and school (Durlak et al., 2011). Over time, mastery of these skills can produce a developmental progression which begins to shift behaviors from being primarily controlled by external factors to acting according to internalized beliefs (Bear & Watkins, 2006; Durlak, et al., 2011).

Youth benefit from strategies designed to reach all students in three ways: "they display significantly more positive behaviors, significantly fewer negative behaviors and, in some programs, show significantly improved school performance" (Durlak, et al, 2007, p. 276). Four highlighted areas which are positively influenced by the implementation of SEL programs include:

Problem Solving

One of the core competencies that the curricula for SEL programs focus on is developing problem-solving skills. These problem-solving skills include developing and achieving goals, positive decision making, and the ability to handle interpersonal scenarios constructively (Durlak et al., 2011).

Self-Control or Self-Regulation

Self-control or self-regulation is being able to direct attention, thoughts, impulses, and emotional control. Self-control helps individuals engage in actions in order to achieve long-term goals (Tangney, Baumeister, & Boone, 2004). It includes changing or stopping unwanted social behaviors (Palmer, 2010). Self-control helps students develop skills for coping, especially when times are tough (Ronen et al., 2016). Learning self-control also helps with being able to wait for gratifying experiences, specifically related to the student's awareness of the consequences of their actions and being mindful of them (Ng-Night, 2016). Overall, developing self-control skills can be an important part of a student's well-being, evidenced by studies that have shown self-control can play into one's future health and wealth (Israel et al., 2014; Moffitt, 2015).

Trust & Help-Seeking

SEL programming have been associated with positive interpersonal outcomes, including improved attitudes about the self and others.

Additionally, this programming has yielded increased prosocial behaviors among students, such as help-seeking behaviors (Durlak, et al., 2011; Zins, Weissberg, Wang, & Walberg, 2004).

Decreased Self-Destructive Behaviors

The SEL approach integrates development and promotion of competence in order to reduce potential risk factors. (Durlak et al., 2011). Skills gained through SEL programming can lead to decreased self-destructive behaviors. SEL skills can be applied to prevent problem behaviors like bullying, substance use, and interpersonal violence (Durlak, et al., 2011; Zins & Elias, 2006).

- **Why is SEL important in mental health promotion and suicide prevention?**

Two SEL programs have measured the short term or long term effects on suicidal behaviors among their students. Each found profound reduction in suicidal ideation and attempts. A study of the “Skills for Life Programme for Adolescents”, a Dutch program, showed “that the intervention was a significant predictor of decreased suicidality” in the short term (Gravensteijn C. et al., 2011, p. 10). The “Good Behavior Game”, which is implemented in the first and second grades, has been studied for decades. This program reduced by one half rates of suicidal ideation and attempts occurring by age 19-21 (Good Behavior Game (GBG), 2017) & (NREPP, SAMHSA, Good Behavior Game)

Students contend “with significant social, emotional, and mental barriers that prevent them from succeeding in both school and life” (Dymnicki, A. et al., 2013, p. 4). The CDC’s 2013 Youth Risk Behavior Surveillance, SAMHSA’s 2011 National Survey on Drug Use and Health, and the 2012 National College Health Assessment show “that many high school and college students are engaged in health-risk behaviors” which are “major contributors to the leading causes of death among persons aged 10-24 years” (Dymnicki, A. et al., 2013, p. 4). Suicide is the second leading cause of death in the United States for this age group (CDC 2014). SEL addresses some of the barriers to learning and to health.

- **How does SEL influence development?**

One way to approach the best fit for SEL programming is to identify how SEL can positively influence expected developmental tasks according to the age of the students. In the table below, competences are listed in order of introduction by school level. In the preschool years, the competencies listed (e.g., beginning to learn how to self-manage and behave in groups) are foundational for further growth in elementary school. SEL programming needs to continue to address these foundational competencies in elementary school, in addition to others (e.g., showing and sharing emotions, as well as having more complex relationships). This structure continues to build in middle and high schools.

Developmental Tasks of Social and Emotional Competence Pre K - 12

Preschool	<ul style="list-style-type: none"> • Become and be socially and academically engaged • Manage emotions (appropriately for a young child), especially with adult support • Stay connected to adults, while beginning to develop peer relationships • In play and learning, pay attention and follow directions, wait, sit still, and effectively join and leave groups
Elementary	<ul style="list-style-type: none"> • Become increasingly successful at navigating peer relationships and friendships independent of adult support • Show and share emotions appropriately, and with appropriate people
Middle School	<ul style="list-style-type: none"> • Form closer relationships with peers of both genders • Manage increasingly complex academic content and tasks, with increasing independence from adults • Effectively manage transitions to middle and high school • Increase independence from adults
High School	<ul style="list-style-type: none"> • Begin preparing for adult roles (e.g., become more nurturing to younger children, begin preparing and practicing for work roles) • Develop an ethical value system that allows for responsible decision-making and responsible behavior toward self and others

Table #1. Adapted from *Developmental Tasks of Social and Emotional Competence Across the Grade Spans from Denham (2015)*, cited in *Dusenbury et al. (2015)*

- **How can SEL be integrated into schools and districts?**

SEL is itself a widely-defined concept but at its core, it is a process of developing student and adult social and emotional competencies. Therefore, there are multiple ways to develop and nurture social and emotional skills and competencies, ranging from general pedagogical practices, to specific classroom interventions, to a whole school approach. For the most successful implementation, SEL requires the support of everyone at all levels in a school community.

With multiple ways to integrate SEL in schools and school districts, there is not one way or a “right” way. SEL is also not merely a curriculum or program that is delivered to a select group of students by specific teachers or other providers. SEL is an approach that addresses the needs of all students and all staff since everyone has social and emotional needs, concerns, and skills. Because of the nature of SEL, deciding how to implement a curriculum or program can be confusing to teachers, administrators, and even for parents.

For most schools, the best first step is to assess what the school community - teachers, staff, administrators, parents, and students - know about SEL, what the school is already doing well, and where the school wants to grow. It is important to know how SEL aligns with the school goals and core values as the school team determines the core competencies and skills the students and staff already possesses and which they will further develop and refine. Having an understanding that SEL is essential to cognitive processes and positively impacts academic outcomes supports its adoption, especially for educators.

SEL validates what most teachers are already doing in their roles; it is *not* another add-on to the existing endless list of responsibilities for teachers and administrators. Social emotional skills can be implicitly embedded in the practices of teaching and learning. SEL is about reframing the incidental teaching of SEL skills into an intentional practice.

Teacher social and emotional competencies set the tone for effective student social and emotional competencies. The more of these skills and strategies teachers use, both through their own approach and their social and instruction teaching practices, the more skills and strategies students will be exposed to and have opportunities to practice. This is why it is fundamental for teachers to be part of any SEL implementation.



How Do Teachers Support Social and Emotional Learning? from American Institutes of Research’s Center on Great Teachers and Leaders <http://www.gtlcenter.org/sel-school>

The educational process can also dispel common myths about SEL, for example, that it is only for younger students, it is not necessary for academic achievers, and it is for students who don't learn to behave at home. At the same time, it's important to know that SEL is not a panacea that will solve problems of achievement, equity, and behavioral issues at school.

- **Approaches to Promoting SEL**

Schools can help students develop social and emotional competence through several types of approaches. These include:

- Direct and explicit teaching of SEL skills in free-standing lessons
- Integrating SEL in teaching practices to create a learning environment supportive of SEL
- Integrating SEL instruction into an academic curriculum
- Creating policies, organizational structures, and a positive culture and climate that supports students' social and emotional development

These approaches are not mutually exclusive. At the middle and high school level, SEL programming can happen in the context of regular curriculum and instruction activities, but it can also take place through activities such as health promotion and character education, or through prevention efforts such as those that target suicide prevention, violence, substance use, or dropout.

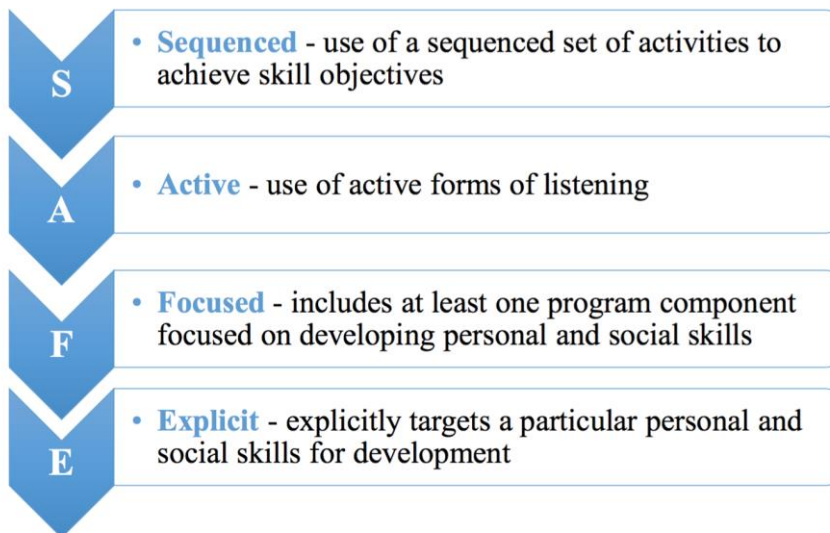
All approaches contribute to the short-term outcomes of skill acquisition, improved attitudes, and an enhanced learning environment, which in turn lead to behavioral and academic outcomes such as positive social behavior, fewer conduct problems, lower emotional distress, and improved academic performance, as listed below.



SEL Approaches from: <http://www.casel.org/what-is-sel/approaches/>

The development of effective SEL programs incorporates four elements referred to as “Sequenced, Active, Focused and Explicit (SAFE) practices” (Dymnicki, A., et al 2013)

CASEL SAFE Practices



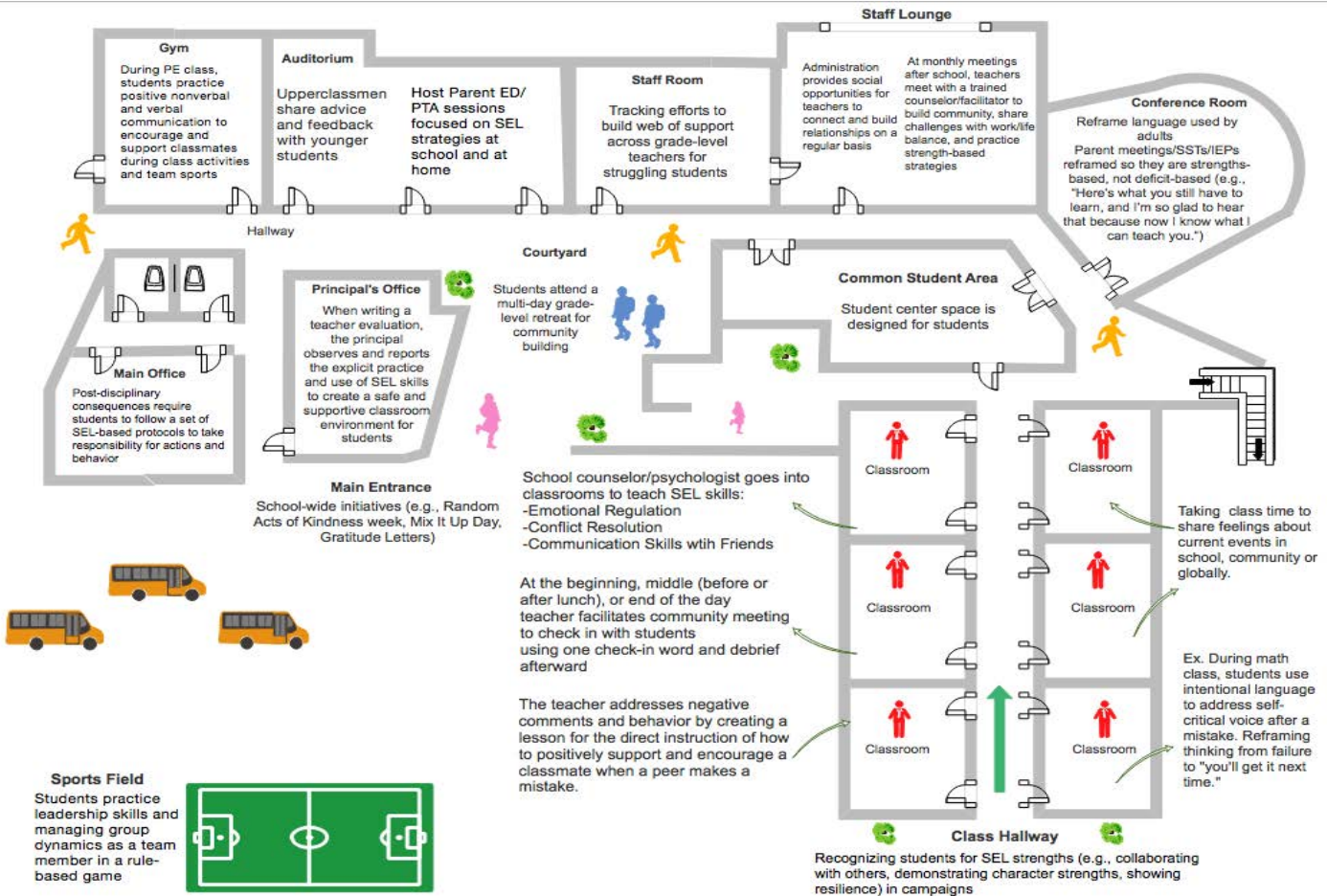
<http://www.casel.org/what-is-sel/approaches>

Students participating in SEL programming which apply the “SAFE” practices demonstrated (on average) “a 12 percentile increase in achievement” (Durlak, J. A., et al., 2010, p. 302). Implementation influences outcomes and requires the support of school leaders (Durlak J.A., et al, 2007). Effective SEL programming can enhance both the promotion of youth wellness and the prevention of suicide.

States and school districts are beginning to identify and define SEL standards for students and educators (found at:<http://www.casel.org/wp-content/uploads/2016/11/WhataretheKeyFeaturesofHigh-QualityStandards11816.pdf>) Illinois, Kansas, and Alaska have all taken steps toward this end. California is currently in this process, collaborating with several other states to develop statewide standards that are comprehensive across the above four approaches.

- **SEL on K-12 School Campus (*Schematic for Integrating programming*)**

Since there is no one way that SEL can take place in school, the map below illustrates some ideas of what SEL can look like in a variety of different places on campus. Adapted from local Bay Area schools, some of these efforts relate to direct-to-student activities, creating an SEL climate, and practices adults (teachers, administrators and parents) can engage in.



Content and visual developed by: Sarah Kremer, Christine Wang and Jasmine Lopez

Additional samples of SEL activities and strategies are available in Attachment 1.5 of the Promotion of Mental Health and Wellness section. These include school-wide efforts for elementary, middle, and high school teachers, administrators and families.

- **Examples of Evidence-Based SEL Programming**

In assessing whether SEL is appropriate for your target community, multiple factors must be considered:

- What is the "goal" of this implementation?
- Who will support the project and the youth?
- Who will support the teachers and other school staff?
- How can you help youth achieve greater self-efficacy in their lives?

For many schools, access and resources for evidence-based programming is limited. For schools that are already working with district or outside school providers, they are encouraged to continue this work in order to support existing partnerships, while researching other programming to fill in the gaps.

Note: While SEL programming has proven academic benefits, only Sources of Strength and The Good Behavior Game have been studied for their effect on the promotion of protective factors and reduction of risk factors for suicide.

Below are a few evidence-based examples that meet these goals. These samples range from Pre-K through secondary school.

Sample Programs

Characteristics	Benefits
<p>Promoting Alternative Thinking Strategies (PATHS)</p> <ul style="list-style-type: none"> - Curriculum for PreK-6th grade -Goal: To build executive function in children while improving classroom atmosphere - 30 min segments that correlate to Common Core State Standards for English Language Arts and American School Counselor Association Standards - At-home activities included for parents and children to do together <p>http://www.channing-bete.com/prevention-programs/paths/paths.html</p>	<ul style="list-style-type: none"> Improves Academic Progress - Students demonstrated higher levels of basic proficiency in reading, writing, and math at some grade levels
<p>Caring School Community (CSC)</p> <ul style="list-style-type: none"> - Curriculum for K-6th grades - Four targeted areas with resources: <ul style="list-style-type: none"> -<i>Class meetings</i>: empathy, set class rules and norms -<i>Cross-age buddies</i>: How to give and receive help, and experience themselves as caring individuals - <i>Homeside activities</i>: understanding perspectives of other families and cultures - <i>Schoolwide community building activities</i>: collaboration, respect, responsibility - Emphasizes promotion of positive development rather than prevention of disorders <p>https://www.collaborativeclassroom.org/caring-school-community</p>	<ul style="list-style-type: none"> - Improvements in Academic performance and positive social behavior - Reduction in conduct problems and emotional distress - Increased trust between administrative adults and students will increase ease of interventions in the future

Good Behavior Game (GBG)	<ul style="list-style-type: none"> - Activity for 1st and 2nd grades - Goal is to reduce off-task behaviors; increase attentiveness and decrease aggressive, disruptive behavior; also decreases shy and withdrawn behavior - Focuses on developing student self-regulation; Improves classroom atmosphere 	<ul style="list-style-type: none"> - Increased graduation rates - Decreased rates of suicide ideation at adolescent follow-up due to positive childhood peer relations
--------------------------	---	--

<http://goodbehaviorgame.org/>

Open Circle/ Circle Solutions	<ul style="list-style-type: none"> -Curriculum for K-5 * Incorporates large and small group discussions, role playing, community-building and mindfulness activities, and children’s literature - Circle Activities provided - Introductory activity - Sentence completion - Mixing Up - Pair/Group Games - Calming, closing activity “I love Circle Time because I learn more and I trust more” 	<ul style="list-style-type: none"> -Includes information on cultural sensitivity and ethnic norms - Role of facilitator is crucial: - Full participant - Encourages Inclusion
-------------------------------	---	---

<http://www.open-circle.org/>

<http://www.circlesolutions.com/>

Mind Up	<ul style="list-style-type: none"> - Mindfulness based intervention <ul style="list-style-type: none"> -Build core social and emotional competencies, such as self-awareness, self-regulation, initiating and maintaining healthy relationships, and treating others with respect and care - Focused on classroom atmosphere -- Implementation recommended during “tween” years (9-12 years old) <ul style="list-style-type: none"> - Includes materials for PreK-12th grades 	<ul style="list-style-type: none"> -Fifteen lessons in four main units -Teachers report more engaged and focused students
---------	---	---

<http://thehawnfoundation.org/mindup/>

- Activities five days/week
- Includes brain builder games (to enhance executive function), weekly theme activities, reinforcing activities, and home links (online)
- Also includes materials for Pre K- Middle School

- Higher dissemination value due to lower cost and ease of implementation
- Targets pre-school self-regulatory behaviors, which predicted greater emotion knowledge and is associated with fewer social problems in first grade

Second Step

www.cfchildren.org/second-step

SOS Signs of Suicide Prevention Program

- Promotes the idea of suicide being directly related to mental illness (rather than a product of stress)
- Uses ACT approach (Acknowledge, Care, Tell)
- Uses video and guided discussion to teach students about signs of suicide and how to respond
- Middle and High School Plans available

- Decrease in suicide attempts
- Among the only programs on the SAMSHA national registry that addresses suicide risk and depression, while reducing suicide attempts

<https://mentalhealthscreening.org/programs/youth>

Positive Action

- Provides intervention focused on school climate change in PreK-12th settings
- Operates on both classroom and school-wide levels
- Programs consists of appx. 140 (15-minute) lessons to be taught in the classroom 24 times a week

- Reaches students in a small group setting while also seeking to positively affect the school's overall environment
- Lessons teach students actions for multiple areas of student functioning: physical, intellectual, social and emotional

<https://www.positiveaction.net/>

Sources of Strength

- Recognized evidence-based suicide prevention program (*SAMSHA*)
- Created for youth to harness the power of peer social networks, with adult mentor guidance
- Program seeks to change unhealthy norms and culture
- Seeks to increase help-seeking behaviors and promoting connections between peers and caring adults
- Moves beyond singular focus on risk factors by utilizing an upstream approach for youth suicide prevention

- Increases youth-adult connectedness
- Increases school engagement
- Increases positive perceptions of adult support for suicidal youth and the acceptability of seeking help

<https://sourcesofstrength.org/>

Find A Program

[Resources & Programs -Suicide Prevention Resource Center \(SPRC\)](#)

[Evidence-Based Programs & Practices: Substance Abuse and Mental Health Services](#)

[Collaborative for Academic, Social and Emotional Learning \(CASEL\)](#)

b. MINDFULNESS IN SCHOOLS

“Mindfulness is: paying attention, on purpose, in a particular way, in the present moment, non-judgmentally, and with openness, curiosity, and kindness.”

Jon Kabat-Zinn

- **Introduction**

Beginning in the late 1970s, mindfulness-based practices were modernized and brought into the health care mainstream by pioneering scientist Jon Kabat-Zinn and his colleagues at the University of Massachusetts. Mindfulness practices are now taught in K-12 classrooms across the country, in the military, in professional schools, and in corporations, startups, and nonprofit organizations. “Mindfulness” is defined by the Greater Good Science Center (<http://greatergood.berkeley.edu>) as a moment-by-moment awareness of our thoughts, feelings, bodily sensations, and surrounding environment. It involves curiosity, acceptance, and openness (Bishop, et.al., 2004), meaning that we pay attention to our thoughts and feelings without judging them—without believing, for instance, that there’s a “right” or “wrong” way to think or feel in a given moment. Mindfulness can cultivate a sense of inner kindness and self-compassion, which in turn can decrease stress and depression, and increase life satisfaction (Morey, J., 2016) When we practice mindfulness, our thoughts tune in to what we’re sensing in the present moment, rather than rehashing the past or imagining the future. Mindfulness practices are designed to develop and strengthen the mind through increasing the ability to focus, recognize and manage emotions, make better decisions, and empathize in relationships.

- **Why is Mindfulness Needed in Education?**

Mindfulness helps youth deal with stressors in their lives. The development of mindfulness - the intentional nurturing of positive mind states such as kindness and compassion, improves the ability to manage a number of significant psychological challenges associated with stress including:

Feeling overwhelmed: the sense that life, and particularly your own thoughts and emotions, is “too much to handle”

Busyness: the sense that “doing things” has become compulsive; that you are constantly avoiding simply being with yourself

Rumination: the sense that the same stressful thought patterns “loop” over and over again in your mind without being questioned

Dissociation: the sense that you maintain unhealthy psychological distance from life and from people, cut off from your own and other people’s emotions

Narcissism: the sense that life is about defending, protecting and enhancing one’s sense of self; a lack of empathy for the needs of others and an inability to take compassionate action.

According to Mindful Schools, healthy stress is a natural part of life, including during childhood. Children and adults alike need to be challenged in order to grow and develop. In the modern education system, healthy stress is frequently replaced by toxic stress. Toxic stress occurs when life’s demands consistently outpace our ability to cope with those demands. Mindful Schools further describes how toxic stress impairs attention, emotion and mood regulation, sleep, and learning readiness daily in American

classrooms. Even more troubling, according to their research, is prolonged exposure to childhood toxic stress, which can have a lifelong impact on both mental and physical health.

Toxic stress starts as decreased productivity and creativity. It can escalate to more serious symptoms like frequent anxiety, frustration, and even dissociation. Children who have not suffered adverse childhood experiences (ACEs) may struggle with frequent “mismatches” between the severity of a stimulus (a pop quiz) and their response (loss of peripheral vision, sweating, nausea, terror and immobility). In children suffering from trauma, these “mismatches” become chronic and habitual. To transform habitual responses, mindfulness skills need to be practiced regularly when not in “flight-fight-freeze” mode. *(For more information on childhood ACEs please visit: <https://www.cdc.gov/violenceprevention/acestudy/> and <https://s-media-cache-ak0.pinimg.com/736x/29/d0/35/29d035b0d30e9fc046a446205f5d1782.jpg>)*

- **Effects of Mindfulness on the Brain**

While we may be able to track many of the external benefits mentioned above to the practice of mindfulness, internally our brains may be positively influenced. Currently, many of the studies on neurobiological changes associated with mindfulness are with adults, with a need for further research involving youth.

Sara Lazar of Harvard Medical School and Massachusetts General Hospital studied how an 8-week mindfulness-based stress reduction program affected the brain of adults who had never meditated before. This study found grey matter thickening in 4 areas important for cognition over the 8 weeks among adults who meditated vs. controls who did not meditate. These results are depicted in Table 1.

Table 1.

<u>Area of Brain</u>	<u>Function</u>	<u>Change</u>
Posterior Cingulate	Mind wandering, self-relevance	Grey matter thickening
Left Hippocampus	Learning, cognition, memory, emotional regulation	Grey matter thickening
Temporo Parietal Junction	Perspective taking, empathy, compassion	Grey matter thickening
Pons	Production of regulatory neurotransmitters	Grey matter thickening
Amygdala	Fight/flight, anxiety, fear, general stress	Decrease in size

Adapted from: https://www.washingtonpost.com/news/inspired-life/wp/2015/05/26/harvard-neuroscientist-meditation-not-only-reduces-stress-it-literally-changes-your-brain/?utm_term=.1a28b13ccc0b

- **Benefits of Mindfulness**

Studies have shown that practicing mindfulness, even for just a few weeks, can bring a variety of physical, psychological, and social benefits.

- Mindfulness is good for our bodies: A seminal study found that, after just eight weeks of training, practicing mindfulness meditation boosts our immune system’s ability to fight off illness.
- Mindfulness is good for our minds: Several studies have found that mindfulness increases positive emotions while reducing negative emotions and stress. Indeed, at least one study suggests it may be as good as antidepressants in fighting depression and preventing relapse.
- Mindfulness changes our brains: Research has found that it increases density of gray matter in brain regions linked to learning, memory, emotion regulation, and empathy.

- Mindfulness helps us focus: Studies suggest that mindfulness helps us tune out distractions and improves our memory and attention skills.
- Mindfulness fosters compassion and altruism: Research suggests mindfulness training makes us more likely to help someone in need and increases activity in neural networks involved in understanding the suffering of others and regulating emotions. Evidence suggests it might boost self-compassion as well. (<http://greatergood.berkeley.edu/topic/mindfulness/definition>)

Mindfulness Develops the Mind's Ability to:

Attend	• This strengthens our "mental muscle" for bringing our focus back to where and when we want it
Emotionally Regulate	• Observing our emotions helps us recognize when they occur, to see their transient nature, and to change how we respond to them.
Calm	• Breathing and other mindfulness practices relax the body and mind, giving access to peace independent of external circumstances.
Adapt	• Becoming aware of our patterns enables us to gradually change habitual behaviors wisely.
Be Compassionate	• Awareness of our own thoughts, emotions, and senses grows our understanding of what other people are experiencing.
Develop Resilience	• Seeing things objectively reduces the amount of narrative we add to the world's natural ups and downs, giving us greater balance.

(from Mindful Schools 2015)

In schools, both teachers and students benefit from mindfulness practices.

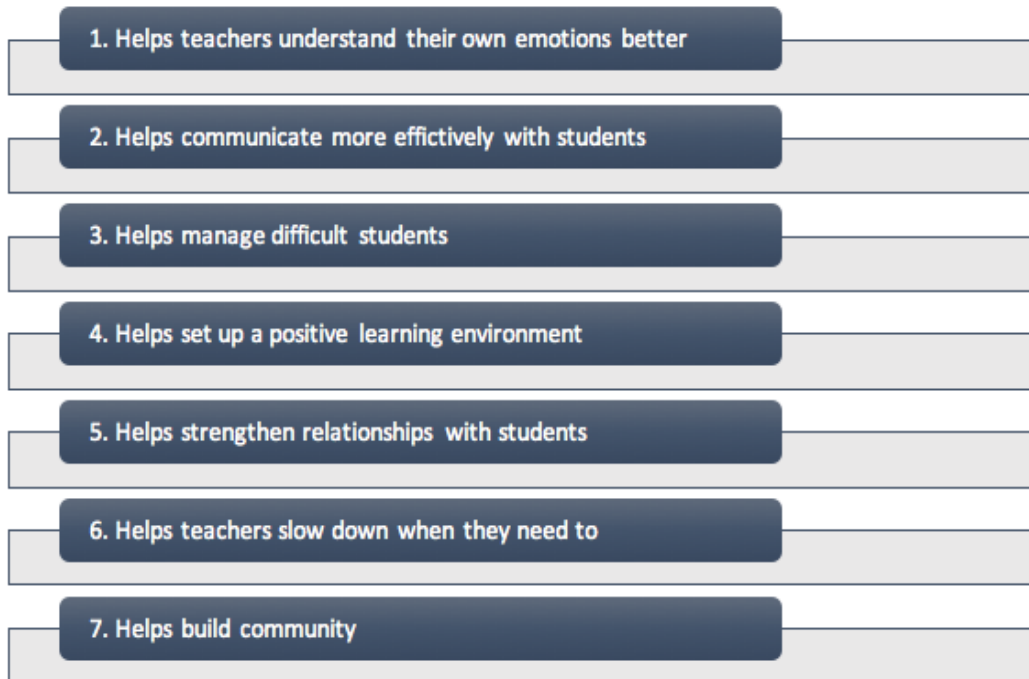
For Teachers:

- Lowers blood pressure
- Less negative emotion and symptoms of depression
- Greater compassion and empathy
- Appears to increase well-being
- Positive emotions including self-compassion
- Teaching skills
- Decreases anxiety

(Flook et al., 2003)

The Greater Good Science Center acknowledges the social and emotional challenges of today's typical classroom. While teachers are often engaging in professional development days focused on content and curriculum, addressing the social, emotional and cognitive demands of the profession are also necessary. Mindfulness seeks to enrich a classroom by helping teachers cultivate the skills to manage their presence in the classroom.

Seven Ways Mindfulness Encourages Teacher Success



(From [The Greater Good Science Center](#))

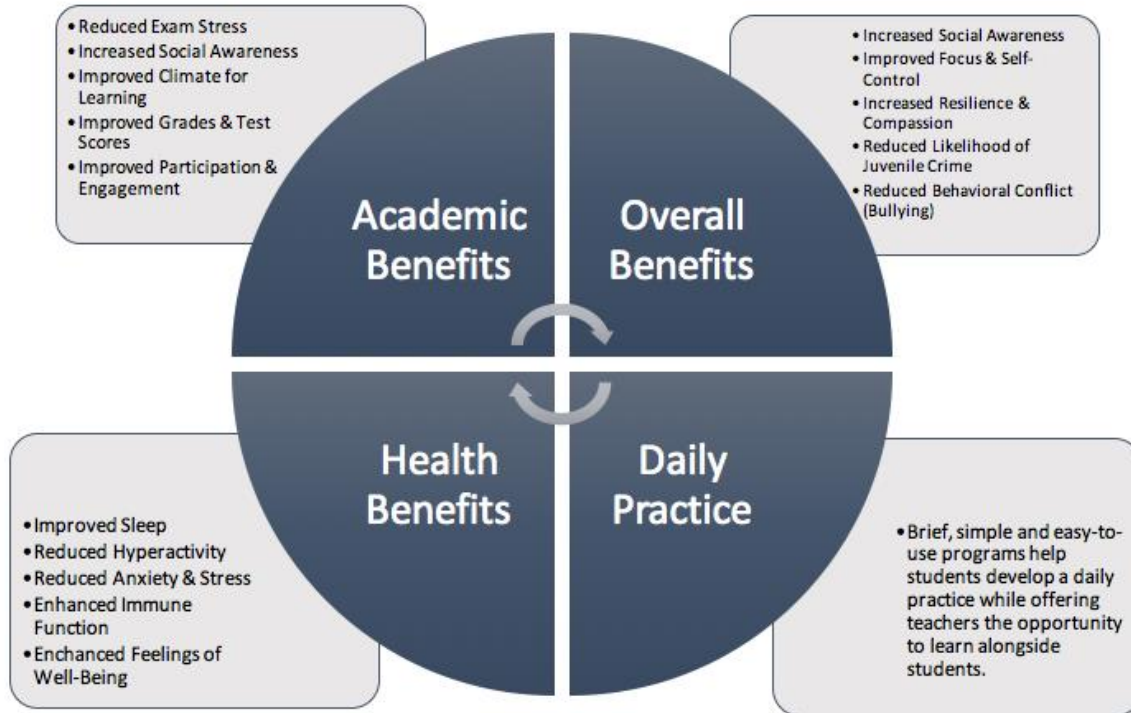
For Students:

- Reduces behavior problems and aggression among students
- Improves their happiness levels
- Improves ability to pay attention
- Improves self-control
- Improves self-care
- Helps develop social-emotional skills
- Decreases anxiety, stress, and fatigue

(*Mindful Schools*)

Students today deal with an array of challenges before they enter the classroom. With the implementation of mindfulness practices in a learning environment, the well-being of students is at the forefront. In their work with mindfulness curriculum, Mindful Schools reported a number of areas where students excelled. The findings highlight that learning mindfulness can also help improve cognitive abilities, social-emotional skills and increase resilience when faced with challenges.

Benefits of Mindfulness



(Adapted from Mindful Schools)

• Integrating and Practicing Mindfulness in Schools

In recent years, researchers have put forward recommendations on implementations based on their experience, research assessments, interview data and other methods (see Khalsa & Butzer, 2016; Dariotis et al., 2017; Childress & Cohen Harper, 2015). Suggestions from this literature are in the sections that follow. These recommendations are not intended to be exhaustive, or an example of a one-size fits all model. Program implementers are advised to determine the specific needs and parameters of each school site and each classroom and collaborating school teachers. Mindfulness interventions can be adapted to work within each unique school environment successfully. It is also beneficial to stay sensitive to what is working and what is not working and to make appropriate adaptations to implementation to create more successful models.

Examples of areas in which adaptations may be necessary include developmental, physical, emotional, intellectual and cultural.

Developmental

Regarding developmental adaptations, researchers proposed that a child can likely engage in formal mindfulness practices for one minute per year of age (Saltzman & Goldin, 2008). However, it is probable implementers will find a range of variance among children's ability levels. This time range will also likely vary depending on the activity selected. As students develop their mindfulness skill set, they will be able to extend their practices out longer.

Physical

It is likely that classrooms will have students with different physical capabilities. Therefore considerations should be made on how to adapt practices for students that may not be able to engage in certain movements. For example, yoga poses are adaptable for those seated in chairs as opposed to standing. Also, some youth may not be able to sit still for extended periods of time, so they can be allowed to alternate between sitting and standing or even lying down.

Emotional

Mindfulness programming should also consider the different emotional needs of students. In particular, approaches that take into consideration the possibility that some students may have body image concerns, low self-esteem, and experienced traumatic events among many other psychological conditions or concerns (for more information see Childress & Cohen Harper, 2015). Mindfulness can bring up different emotional states and therefore instructors should embody compassion, empathy, kindness, patience, and understanding in working with students and know when to refer to counseling services. Instructors may also be prepared to sensitively work with students who may oppose mindfulness and yoga practice. They should not be forced to engage in the practices but be given reasonable alternatives. It is possible that students who first resist but are allowed to watch will see their peers enjoying the experience and then they will engage.

Intellectual

Intellectual adaptations include utilizing language that is understandable to the students. Terms common in mindfulness, such as awareness and attention may be too abstract and complicated for students to grasp. Therefore playful imagery and simple terminology are much more likely to be successful.

Cultural

The topic of cultural sensitivity can be quite complex, and a complete description is beyond the scope of this discussion. However, a few considerations to make are that some families may not understand what mindfulness and yoga are and think they are religious practices that may be in conflict with their beliefs. Implementers should inform caregivers about the practices and explain that they are not religious or spiritual in nature. It is essential that mindfulness instruction in public schools is free from any religious or spiritual terminology or artifacts. Terms such as meditation and yoga can be avoided by using more neutral language. Instead of meditation, controlled attention may be used and mindful moving or stretching can replace yoga. Using culturally relevant examples is also helpful to students for whom mindfulness and yoga are likely to be new topics. For further examples, on this subject, the reader can refer to Fuchs and colleagues in the reference list (Fuchs, Lee, Roemer, & Orsillo, 2013).

- **Mindfulness and School Climate**

In the absence of studies more directly evaluating mindfulness and school climate, a potential proxy may be how mindfulness can be a resource for teacher well-being. An early study by Napoli (2004) reported interview results with teachers in a mindfulness training program. She found that teachers used the mindfulness skills to assist in developing and delivering curriculum, cope with conflicts and feelings of anxiety, enhance their personal lives and generate positive classroom environment changes. A more recent randomized controlled trial of the Cultivating Awareness and Resilience in Education (CARE) model for teachers found that teachers experienced the program as a feasible, acceptable, and effective way to reduce stress and improve performance (Jennings, Frank, Snowberg, Coccia, & Greenberg, 2013). The CARE model for teachers utilizes mindfulness-based professional development training to target teacher stress, improve performance, and promote positive classroom environments. Other studies have found similar findings (see Semple et al., 2017). Researchers speculate that by providing self-care

strategies to teachers, they will be less burned out and more able to teach and create flourishing classroom settings.

See Attachment 1.6 'Mindfulness and School Climate: One Example for the impact of mindfulness on school climate.'

- **Integration with Existing Classroom Culture**

Existing mindfulness instruction occurs in traditional classroom environments or dedicated rooms. Programs can occur during school or in after-school settings. For those integrating into traditional classrooms, this author recommends utilizing existing culture and norms to promote behavior management. Classes that take place in a dedicated classroom environment, such as a yoga room, can develop standards that are unique but also should remain in alignment with the school's larger cultural norms and standards. For instance, in some classrooms, teachers may utilize specific hand signals or gestures that mean "quiet" or other key classroom management behaviors. Mindfulness instructors can learn these symbols and include them in their teaching. Utilizing existing classroom norms will help the students engage more effectively in mindfulness learning. Mindfulness and yoga practice is much different than academics. Therefore children need to be taught the standards of behavior for this type of work. The expectations for the physical and emotional safety of students should also be made clear at the initiation of the program.

A recent study (Dariotis et al., 2017) reported on several implementation areas in which students and teachers gave feedback. In brief, they discussed the importance of certain mindfulness program delivery considerations, strengthening school personnel and student buy-in, facilitator communication with teachers, and instructor qualities.

Examples of program delivery considerations:

- Ensuring mindfulness programming does not prohibit students from participating in other specials classes such as PE, art, or music
- Clean classroom environments that are comfortable and distraction free
- Implementers should consider maximum class sizes
- Consulting with school personnel on determining student subgroups that may not function well together due to interpersonal or safety considerations
- Take into account variables such as age and gender
- Program staff should have clear and consistent communication with other school staff
- Programming could include incentives for students to participate and behave well as well as incentives for teachers to learn how to instruct mindfulness programming
- Essential instructor qualities include kindness, compassion, fun, and maintaining calm.

For more information on the list above, please refer to [Dariotis et al., 2017](#).

- **Sample Mindfulness Programs and Supports**

Below is a list of a few San Francisco Bay Area groups who are leaders in Mindfulness practices and examples of how they implement or support the implementation of Mindfulness in the classroom or school community:

EQ Schools <http://eqschools.com/> provides emotional intelligence training for schools. Their fun and interactive conferences, and custom professional development are designed to inspire and engage educators as they learn how to cultivate more mindful, playful and connected classrooms. Through a focus

on relationships and play, participants are supported to learn practical tools and activities that can help students increase their social and emotional skills.

- Teachers learn mindfulness activities they can use with their students which enhance body awareness, improve non-reactivity to thoughts, cultivate non-judgmental acceptance of emotions increase gratitude and reduce stress, all skills that can improve emotional regulation.
- Teachers learn how to lead improvisational games in their classrooms, which cultivate mindfulness and presence in the moment, and also lead to a lot of laughter and connection which build emotional and social awareness.
- Teachers learn to care for themselves by identifying tools and strategies that help them regulate their own emotions and builds their emotional intelligence, with mindfulness, self compassion and self care techniques.

Mindful Schools www.mindfulschools.org/ This single school program based in Oakland, California highlights the importance of mindfulness in education. Offering training and courses for students and staff, Mindful Schools seeks to reframe the concept of teaching through its emphasis on mindful interventions. These interventions focus on self-awareness and increasing well-being. The six-week online course offered for facilitators includes:

- The basics of mindfulness meditation
- How to work with thinking that arises while practicing mindfulness
- Techniques for meeting and navigating intense emotions
- Practices that cultivate positive states of mind like gratitude, kindness, joy & compassion
- The role mindfulness plays in communication and interaction
- Support for developing a daily sitting practice

Additionally, courses are offered for educators that focus on integrating mindfulness in a K-12 setting. Among providing many valuable tools, the training includes:

- Working with youth at different developmental stages
- Group facilitation and classroom management skills

- **Examples of Mindfulness Practices**

An unclear area in the scientific literature is the training requirements for those wishing to instruct mindfulness in schools and achieve useful results. There are even programs that do not utilize instructors to deliver mindfulness but audio recordings instead (e.g. Inner Explorer, see Bakosh, Snow, Tobias, Houlihan, & Barbosa-Leiker, 2016). However, this author strongly recommends that those wishing to instruct mindfulness practices first develop a practice of their own. Mindfulness and yoga instructors usually agree that self-practice is paramount. A few mindfulness practices are included below to facilitate learning.

The reader can engage in these practices until they achieve mastery of the script and practice sequence. They can then and should be adapted by the teacher to share in their classroom with their students in a way that reflects the teacher's personality and interests. Those wishing to learn more practices can visit the Stanford Early Life Stress & Pediatric Anxiety Program's Mindfulness resource blog at mindful.stanford.edu.

Mindfulness sessions can range in length from a few minutes to a full class period. It depends on students' capabilities and the amount of time available. One way of extending or shortening practices is to adjust

the amount of "silent space" within the practice. Alternatively, yoga practices can be extended by holding the poses longer, moving slower, or repeating the sequence additional times.

Breath Awareness

This meditation can be done sitting in a chair, lying down on the floor, or standing. The script is for sitting in a chair; actual instruction should be modified to accommodate the chosen position of the students. Also, culturally-sensitive images and metaphors can be added to the script to create more resonance with the students. A couple of examples of imagery appear in parenthesis.

Come to a comfortable sitting position in your chair. (Sit like a mountain- grounded down and create a stable base and imagine your head is reaching up through the clouds). Sit forward so that your back is not touching the chair back, see that both of your sitting bones are evenly resting on the seat and ground both your feet to the floor. Breathe in through the nose and sense the air flowing through the nostrils and down through the collar bones, rib cage, and into the lower region of the belly. (Note: Students having a harder time to be still can place one or two hands on these different areas to track the movement of their breath.) Feel your lower belly expand (like a balloon), and the inhale becomes the exhale. The awareness follows the exhale from the bottom of the belly all the way through the rib cage, the collar bones, and up and out through the nostrils.

Let the breath flow naturally one breath to the next. If your mind is hopping around (like a frog), see if you can focus back on the tip of your nose and be still (like a frog resting on a lily pad). Continue in this way for a few minutes (allow an appropriate amount of silent time). Gently bring your awareness back to the breath, again feel your body- feet on the floor, toes, fingers and hands, and slowly let go of this practice as you exhale, and open your eyes reorienting to the room.

Body Scan (adapted from Stahl & Goldstein, 2010)

- Begin with Breath awareness
- Take a seat in in a chair, or lie down on your back in a comfortable position, but remaining awake, you can pad your body with a folded blanket the length of the body across the floor. If it is cold, cover up with a blanket. Gently allow the eyes to close and bring the awareness to the breath. As you breathe in, notice the belly rising and expanding, as you breathe out, the tummy falls and contracts softly. Take a few moments to sense the body in its completeness, from the bottoms of the feet to the top of the head. Feel the earth beneath the body and the points where the body is contacting the earth, inhaling and filling the body with the breath, and exhaling to let the body soften and settle more completely to the ground. Feel the temperature of the air flowing along the surface of the skin. When you are ready, breathe your awareness all the way down to the toes of the left foot. Bring the breath, with the attention/awareness to the left toes, as if you are breathing into and out from the toes. You can support this type of focus, by imagining the breath is traveling from the nostrils down the left side of the body to the toes as you inhale, and all the way back to the top and out with the exhale. Let this method of breathing continue as we journey the awareness through the rest of the body.
- Awareness of the toes, feet, and legs
 - Now you can move the focus up from the left toes to the left foot. Attend to the feeling of the bottom of the foot, the top of the foot, the ankle, the Achilles tendon, the calf, the front of the lower leg, and the knee. Slowly shift the focus now to the back of your thigh, and bring it around to the front of your thigh. Next, take the awareness down to the right toes, slowly moving, feeling the bottom of the foot. Shift your attention to the top of the foot, then the ankle, the Achilles tendon, the calf, the front of the lower leg, the knee, the back of the thigh, the front of the thigh. Compassionately attend to any thoughts, emotions, and sensations as they arise and pass.

- Middle region of the body
 - Move the awareness into the hips, first the right hip, then the left hip and become aware of any sensations that may be present in the pelvic region. (For adults only: sense into the systems of elimination, the genitals, the anus, the organs of reproduction. Note: cueing these body parts for children may not be appropriate due to them likely triggering disruptive behavior and also may not be content-appropriate depending upon the age of the students) Compassionately attend to any thoughts, emotions, and sensations as they arise and pass.
 - Gently move the awareness upward to the abdomen and into the belly, the seat of digestion, assimilation, and feeling into the internal organs with a soft attention and allowing what is to be, to soften.
- Tailbone and Back of the body
 - Shift the awareness from the belly to the tailbone, to the lower, middle, and upper back. Sense and feel the sensations, allow any tension to be soft, and what remains to be.
- Chest, heart, and lungs
 - Softly shift the awareness to the chest, the heart, and the lungs, remain present while sensing into the rib cage, the sternum, and the breasts
- Left Hand / Arm
 - Slowly redirect the attention to the fingertips of the left hand, feel the fingers, the palm, and then the back of the hand and up into the left wrist. Continue upward to the forearm, elbow, and upper left arm, sensing and feeling the sensations.
- Right Hand / Arm
 - Slowly redirect the attention to the fingertips of the right hand, feel the fingers, the palm, and then the back of the hand and up into the right wrist. Continue upward to the forearm, elbow, and upper right arm, sensing and feeling the sensations.
- Shoulder / Armpits / Neck / Throat
 - Scan the awareness up into the shoulders and armpits, the neck and throat while becoming aware and attending to arising sensations, thoughts, and emotions.
- Jaw / Teeth / Tongue / Mouth / Lips
 - Invite the awareness to the jaw, the teeth, tongue, mouth, and lips. Allow the sensations to unfold with the awareness following them and allowing all to be.
- Cheeks / Sinuses / Head / Ears / Eyes
 - Breathe the awareness to the cheeks, sinus passages flowing deep into the head, the muscles around the eyes, the forehead, and temples, staying aware and present.
- Head / Ears / Brain
 - Feel the top of the head, the back of the head, feel into the ears, the inside of the head and the brain. Witness what is alive at the moment.
- Entire Body
 - Feel the body in its completeness, from the bottoms of the feet to the top of the head. Feel the body from the inside out, the current of thought, emotions, sensations, and mental images. Let the inhale move through the body with life and observe the expansiveness. Let the exhalation create a feeling of relaxing the body and settle completely to the earth and let be.
- Gratitude
 - Rest in stillness, upon the support of the ground, and offer yourself appreciation for taking this time and offering yourself this gift of practice.

Mindful Eating Practice (adapted from Kabat-Zinn, 2013)

Materials

To perform this activity, you will need materials including a raisin or another small piece of fruit that you enjoy. Be sure you check-in with the class about any food allergies before you plan to do this practice so you can plan accordingly. The raisin may not be the most popular food choice item for children, so please feel free to use another food choice. However, in support of the students' health, it is best if it is a healthy food choice.

Purpose

The goal of this activity is to explicitly engage each of the five senses in this eating meditation. The underlying assumption is that by focusing on our sensory experience, we can concentrate more deliberately in the present moment.

Time Commitment

approximately 5 minutes

Explore the raisin in the following ways:

1. How does the raisin feel when you touch it?
2. How does the raisin smell if you hold it close to your nose?
3. What colors do you see in the raisin, what is the texture?
4. If you hold it between your fingers and bring it close to your ear, what do you hear as you roll it around between your fingers?
5. Putting the raisin between the lips, how does it feel? Moving the dried grape around in your mouth, notice the sense qualities of the experience. When you are ready, slowly bite into the raisin and observe what you taste. What is the sensory experience of slowly chewing and eating the raisin bite-by-bite?

Foundational Mindful Moving

Instructions: Be sure the students are invited to the training, allowing students who do not wish to participate to engage in another activity that will not disrupt the class. Remind the students to practice safely, and if a posture does not feel safe, to not perform it. You can hold each of the positions for approximately seven breathing cycles.

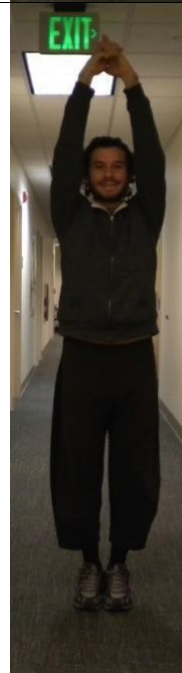
1. Mountain Pose

- Basic Alignment
 - Feet together or hip width distance apart
 - Spine is long
 - Sternum is lifting
 - Chin parallel to the ground
 - Crown of the head is lifting
- Remind students that mountains do not talk, and in general they do not move
- Students may close their eyes and take five calming breaths



2. High Mountain

- Basic Alignment
 - Same as for mountain, inhale and reach the arms up overhead



3. Crescent Moon
- Basic Alignment
 - Press down through the feet
 - With an inhale:
 - Lift up out of the hips
 - Lengthen through the spine
 - Exhale to one side, repeat on the second side, move with the breath – inhale up, exhale to bend
 - Repeat on the second side



4. Tree Pose
- Basic Alignment
 - Put all of the weight on the right foot
 - Inhale and lift the left foot up and place it either below or above the right knee
 - CAUTION: DO NOT PUT ANY PRESSURE ON THE KNEE JOINT WITH THE FOOT
 - Press the foot into the right leg and push the thigh or shin back into the foot
 - Exhale and ground down through the right foot
 - Inhale and reach the arms up overhead creating length through the spine and being sure to lift up out of the hips
 - Repeat on the second side
 - For fun, in the last few seconds of the pose, tell the children that the wind is starting to blow and then begin wavering in the pose



5. Triangle Pose

- Basic Alignment
 - Take a wide stance and turn the right foot out
 - The feet may be aligned heel of the right foot to the arch of the left foot
 - Reach all the way out with both hands, begin to lean to the right with the inhale
 - With the exhalation, you lower the right hand down to the left shin, ankle or foot
 - Reach the left hand to the sky
- Repeat on the other side



6. Elephant (Pyramid) Pose

- Basic Alignment
 - From mountain, turn to the right
 - Feet can be hip width distance apart
 - Place the hands on the hips
 - Inhale lengthen up through the upper body
 - Exhale and fold forward reaching the hands to the floor or keep the hands on the hips
- Repeat on the other side, bringing the left foot forward
- For fun, at the count of five, have the children make their best elephant noises and wave the arms like an elephant trunk



7. Frog Pose



- Basic Alignment
 - Inhale and with the exhale squat down
 - If possible keep the feet flat on the floor, the heels may lift up if needed
 - For fun: count to five and have the students pretend they are frogs- naturally they will jump around and make frog noises!



8. Seated Tree Pose

- Basic Alignment
 - Ground down equally through the sit bones
 - Inhale and bring the left foot to the inside of the right thigh, above the knee
 - Exhale and soften
 - Inhale and reach the arms up overhead
 - Exhale and fold forward with a long spine reaching to the foot or the shin
 - Alternatively, the student may bend the right knee
 - Eventually the neck and head can relax in the pose



<ul style="list-style-type: none"> • Repeat on the second side 	
<p>9. Seated Forward Bend Pose</p> <ul style="list-style-type: none"> • Basic Alignment <ul style="list-style-type: none"> • Ground down equally through both of the sit bones with the legs extended out long across the floor • Inhale and reach the arms up overhead • Exhale and forward fold reaching for the feet • If the student cannot reach the feet, bend the knees as much as needed, so you reach the feet. • Eventually the head and neck can relax in the pose 	
<p>10. Pretzel Pose</p> <ul style="list-style-type: none"> • Basic Alignment <ul style="list-style-type: none"> • Ground down equally through both of the sit bones with the legs crossed in front • Inhale to lengthen the spine, exhale to relax into the posture • Lift the crown of the head with a soft gaze 	
<p>11. Resting Pose (not pictured)</p> <ul style="list-style-type: none"> • Basic Alignment <ul style="list-style-type: none"> ○ Lie down flat on your back ○ If there is low back discomfort, place a rolled blanket underneath the knees ○ Let the arms, hands, legs, and feet relax naturally, arms alongside body, legs, a comfortable distance apart ○ Close the eyes if feeling safe 	

Additional resources and practices can be found at the Stanford University Early Life Stress & Pediatric Program’s Mindfulness blog at mindful.stanford.edu. For more comprehensive school-based health and wellness curriculum, readers are encouraged to visit the websites of non-profit organizations such as Pure Edge Inc. (pureedgeinc.org) and Mindful Schools (mindfulschools.org), which are two of the larger organizations working in schools known to this author. Additional programs and curriculums are reviewed by Semple and colleagues (2017) and may be of interest to readers. Other peer reviewed articles of note that can assist in locating additional programs appear in the reference list below. Specifically, users of this guide can reference Dariotis and colleagues (2017), Felver and colleagues (2016), Khalsa & Butzer (2016), and Burke (2010).

ATTACHMENTS FOR SECTION I: PROMOTION

Promotion of Mental Wellness

- 1.1 THE IMPERATIVE OF COMPASSIONATE SELF-CARE
- 1.2 TRANSITIONING – PRIMARY SCHOOL THROUGH LIFE AFTER HIGH SCHOOL
- 1.3 SOCIAL MEDIA
- 1.4 CULTURE, MENTAL ILLNESS AND STIGMA
- 1.5 SAMPLE SEL ACTIVITIES AND STRATEGIES
- 1.6 MINDFULNESS AND SCHOOL CLIMATE: ONE EXAMPLE
- 1.7 TYPES OF STUDENT PROGRAMS INFORMATION SHEET, SAMHSA Toolkit

Suicide Awareness Before a Crisis Arises

- 1.8 GENERAL GUIDELINES FOR TEACHERS AND STAFF, LA County Youth Suicide Prevention Project
- 1.9 RISK FACTORS FOR YOUTH SUICIDE, SAMHSA Toolkit
- 1.10 PROTECTIVE FACTORS AGAINST YOUTH SUICIDE, SAMHSA Toolkit
- 1.11 RECOGNIZING AND RESPONDING TO WARNING SIGNS OF SUICIDE, SAMHSA Toolkit
- 1.12 RED FOLDER INITIATIVE (for administrators and school staff as well)
- 1.13a QPR AS A UNIVERSAL INTERVENTION
- 1.13b QPR GUIDELINES
- 1.14 INCLUDING SUICIDE PREVENTION IN OTHER EFFORTS TO REACH PARENTS, SAMHSA Toolkit
- 1.15 IDEAS FOR MAXIMIZING PARENTAL RESPONSE RATE, SAMHSA Toolkit
- 1.16 SUICIDE PREVENTION: FACTS FOR PARENTS, SAMHSA Toolkit

THE IMPERATIVE OF COMPASSIONATE SELF-CARE

“The more you can develop the internal ability to be a calm, compassionate presence toward yourself, the more you can bring that presence to everyone you serve.”
(*Emotional Intelligence, Dr. Daniel Goleman*)

Self-care is required for personal wellness. It is not self-indulgence to care for one’s self but rather self-preservation - the means to achieving an effective and fulfilling life. SAMHSA defines wellness not as the absence of disease, illness, or stress but the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness. “Wellness is being in good physical and mental health. Because mental health and physical health are linked, problems in one area can impact the other. At the same time, improving your physical health can also benefit your mental health, and vice versa. It is important to make healthy choices for both your physical and mental well-being.” (SAMHSA)

Eight Dimensions of Wellness



SAMHSA’S Eight Dimensions of Wellness depicted above shows the interplay of multiple areas in one’s life that can positively impact well-being and self care. To make healthy choices it is necessary to first be kind to yourself; be self-compassionate. SAMHSA “What is Wellness, <https://www.samhsa.gov/wellness-initiative/eight-dimensions-wellness>

What is Self-Compassion?

Self-compassion may provide a path to better and more committed self-care. The “tendency to be caring and understanding with oneself rather than being harshly critical or judgmental” (Neff, 2009, p. 212) offers comfort and care rather than a sense of “bucking up” or managing despite suffering. The three main components, self-kindness versus self-judgment, a sense of common humanity versus isolation, and

mindfulness versus over identification (Neff, 2009) encourages the kind of care most educators already show to students. The additional reframing of supporting oneself, in an intentional and practical way, may help to support self-care practices for all adults - and students - in the entire school community. When practitioners fully embrace self-compassion, they may see an increase in psychological wellness: research reports increased feelings of happiness, optimism, curiosity and connectedness, as well as decreased anxiety, depression, rumination and fear of failure (Neff, 2009). Self-compassion “involves the desire for the self’s health and well-being, and is associated with greater personal initiative to make needed changes in one’s life (Neff, 2009, p. 213). Self-compassionate individuals handle failure and making mistakes better, as they perceive these failures as opportunities to learn from their mistakes and make adjustments for future efforts.

Why Self Care is Needed?

Self-care is especially important for those in the helping professions. “The helping professional often expresses the agonizing pull between other-care and self-care: There is a continual pull, constant strain, a tautness” (Skovholt & Trotter-Mathison, 2016, p.4). While most research in this area focuses on those in the counseling and psychology fields, the impact holds true for teachers: more students are coming to school with stress and trauma from their homes and neighborhoods, like poverty, family mental health issues or substance abuse issues, and chronic dysfunction, leaving them underprepared for learning. Teaching sometimes involves working conditions that are under-resourced and they are asked to manage high-stress emotional situations with little support. The school environment can also contribute to stress: high rates of staff turnover and absences, a lack of communication, low morale, and a lack of emotional and/or physical safety can be signs of organizational stress (Volk, Guarino, Grandin, & Clervil, 2008).

What is Self Care?

Practices for self-care generally involve intentionally attending to one’s own care in order to be effective in the care for others (Saakvitne, Pearlman, & Abrahamson, 1996). In the last decade, there has been an increase in the number of tools and strategies practitioners can use in order to identify where they may be neglecting their own self-care and where they need to refocus. These tools are helpful for identifying these areas; however, on their own, they may not result in a long-term change in self-care practices. Simply creating a list of what to engage or re-engage in - like more exercise or spending time with friends - may result in success for a short time, then a decline in the activities. This slowing down or complete abandonment of self-care activities can lead to more negative feelings about the inability to take care of oneself, which in turn can contribute to more feelings of stress and burnout. Therefore maintaining an attitude of self compassion is required for self care.



From *Caring for Yourself is a Radical Act: Self-Care Guide for Youth Working in Community*, (www.ywcacanada.ca/data/research_docs/00000346.pdf)

Tools for School Staff Self-Assessment and Care

The first step toward self-care is an assessment of current levels of burnout and secondary traumatic stress or vicarious traumatization as well as current self-care practices. The following tools assist in such an assessment.

- The Professional Quality of Life: Compassion Satisfaction and Compassion Fatigue version 5 (ProQOL V) (2009) measures burnout and compassion fatigue, along with compassion satisfaction, providing a more balanced understanding of trauma work impacts by including a strengths-based scale of pleasure derived from being able to do the work. http://www.proqol.org/ProQol_Test.html
- The Skovholt Practitioner Professional Resiliency and Self-Care Inventory (2016) provides self-reflection for those in the helping, health, and caring professions (including teaching). The questions focus on Professional Vitality, Personal Vitality, Professional Stress, and Personal Stress. http://www.leadership.umn.edu/news/documents/Gold_ResiliencyInventory.pdf
- The Self-Care Assessment, developed by Saakvitne & Pearlman (1996), can also be used to assist helping professionals in becoming more aware of ways to prevent and manage vicarious traumatization. <http://socialwork.buffalo.edu/content/dam/socialwork/home/self-care-kit/self-care-assessment.pdf>
- The Satisfaction with Life Scale is another tool to find out where you are on the spectrum of happiness, and satisfaction with your life. There is an explanation of the scores, and where you are along the spectrum. You can then determine where you need to go for your own life satisfaction. (Ed Diener, Robert A Emmons, Randy
- J Larsen and Sharon Griffin in the 1985 Journal of Personality Assessment). <http://internal.psychology.illinois.edu/~ediener/SWLS.html>

Remember, approaching these tools with a perspective of self-compassion can help support long-term and ongoing change that can improve engagement in the educational system.

According to the Compassion Fatigue Awareness Project, in order to move forward on a path to wellness one must continually commit to authentic self-care that includes:

- Practice noticing when you are wanting things to be different than the way they are. (*Book: Loving What Is, by Byron Katie; thework.org*)
- Stop your thinking or feelings from controlling your life by changing how you perceive them (*Byron Katie's Work*). Disown them.
- Do just what has to be done right now, for that's all you can do.
- Let go of the belief that you should be able to control the 'stormy situations' in life.
- Health-building activities such as exercise, massage, yoga, meditation.
- Eating healthy foods.
- Drinking plenty of water.
- Practicing the art of self-management. Just say no.
- Developing a healthy support system: people who contribute to your self esteem, people who listen well, people who care.
- Organizing your life so you become proactive as opposed to reactive.
- Reserving your life energy for worthy causes. Choose your battles.
- Living a balanced life: sing, dance, sit with silence.
- Leave time for the quietness of simply being present with yourself. (mindfulness meditation, music, nature...)

(Found at <http://www.compassionfatigue.org>)

Tools for Student Self-Care

The fundamentals of self-compassion and self-care are also relevant when addressing student wellness. Adolescents should be encouraged to learn skills which can help manage stress and other challenges in their daily life. While it can be difficult for school staff to respond to the multitude of needs that students today present, there are a number of resources and websites created to increase awareness around identifying and addressing youth wellness.

The [Break Free from Depression](#) curriculum developed by Boston Children's Hospital has been widely implemented in high schools nationwide. This 4-module classroom curriculum focuses on raising depression awareness and recognizing early signs of mental health struggles in adolescents. Through the progression of the modules, trained facilitators provide an overview of depression, engage students in discussion and conclude with activities that seek to increase coping skills and target students' existing habits. While the activities are not meant to replace treatment for people struggling with mood disorders, they serve as supplementary lessons for all individuals regardless of emotional struggles.

Some of these activities include:

- Journaling
- Deep Breathing Exercises
- Muscle Relaxation
- Guided Imagery and Visualization
- Challenging Negative Thoughts
- Top Ten Approach to Beating Stress
- Group/School-Wide Activities

One of the activities highlighted in the Break Free from Depression curriculum is *Beating Stress Before It Beats You - The Top Ten Approach*. This activity focuses on: teaching students about stress, healthy and unhealthy coping, and creates a space for discussion as students are asked to share everyday stressors, their warning signs/symptoms of stress and the ways in which they are handling stress. *(For a copy of BFFD Module 4 materials, please see the attachment.)*

Another great resource for youth includes the [Making Friends with Yourself](#) website. This site includes tools for promoting self-compassion and encouraging insight. Among the items provided are:

- Audio Meditations
 - Compassionate Body Scan
 - Music Meditation
 - Giving and Receiving Compassion
 - Instructions for Doing a Mindful Daily Activity
 - Instructions for Mindful Eating
- Opportunities for Teen and Teacher Trainings

Similarly, the University of Michigan Depression Center - [Classroom Mental Health](#) page holds a number of student wellness worksheets and printable activities that can easily be adapted for individual or group settings. The following are some examples of tools staff and students can access through the website and its resources:

- Student Self-Care Toolkit (Managing Stress, Exercise, Nutrition, Sleep, Goal Setting)
<https://www.classroommentalhealth.org/self-care/student/>
- Weekly Motivator Tool - Self Care Program
<http://www.campusmindworks.org/downloads/weeklymotivator.pdf>
- Thought Record Worksheet - Challenging Cognitive Distortions
<http://www.campusmindworks.org/downloads/cognitivedistortion.pdf>

(Materials courtesy of University of Michigan - [CampusMindWorks.org](#))

Additional Self Care Tools and Information

- Greater Good Science Center:
http://greatergood.berkeley.edu/article/item/how_self_compassion_can_help_teens_de_stress
- Psychology Today, Your Ultimate Self-Care Assessment:
<https://www.psychologytoday.com/blog/living-the-questions/201504/your-ultimate-self-care-assessment-resources>
- Wellness Worksheets, SAMHSA
<http://www.integration.samhsa.gov/health-wellness/wellness-strategies/wellness.pdf>

TRANSITIONING: PRIMARY SCHOOL THROUGH LIFE AFTER HIGH SCHOOL

Some students may have difficulty during transition experiences. Anxiety symptoms, a drop in academic performance, changes in behavior, and other manifestations of stress may occur as some children enter new environments. Most school transitions occur simultaneously with crucial developmental changes – both physical and psychological. These shifts to “more socially complex and academically demanding contexts” create times when students need a supportive, stable, and caring environment (Madjar et al., 2016). Therefore, you as a parent play a key role in guiding your child through these uncharted waters. You are not in this alone - as transition is a collaborative experience among students, families, and schools. No matter how daunting transition may seem, help is available for you and your child when necessary. The following section has been compiled to provide you with essential information to facilitate a healthy transition experience.

The Transition from Elementary School to Middle School

The transition from elementary school to middle school is a significant step towards independence. While exciting, this transition can also be associated with an array of emotions, behaviors, and concerns for both children and their parents. For example, your children must adapt to a larger student body, multiple teachers, and increased expectations in both performance and responsibility. Stress levels consequently rise and your child’s overall performance in school and extracurricular activities can drop. Puberty also induces rapid physical and mental changes in children, sometimes creating strained relationships at home as families struggle with redefined expectations and roles. Common concerns for budding middle schoolers include:

- Where and who will I sit with for lunch?
- What if I don’t make any friends?
- Will any girls/boys like me? Am I ugly?
- What if I can’t find the bathroom when it’s urgent?
- Will there be as much homework as people say?
- Will I know anyone in my new classes?
- Do I have to change in front of other people before P.E. class?
- Will I be able to open my locker?
- What if I don’t make the basketball team?
- Will bigger kids pick on me?

Essentially, the transition to middle school is an exciting opportunity for children to gain independence and spread their wings, but they need assistance in steering themselves through an unfamiliar environment.

Developmental Changes During Early Adolescence

Adapted from the [U.S. Department of Education](#)

Physical:

Excluding the first two years of life, the early adolescent body experiences more physical development than any other time. Supplemented by puberty, rapid growth occurs in height, weight, internal organ size, skeletal structure, and muscular structure. Furthermore, this physical growth is sporadic, unpredictable, and faster than the body’s ability to adjust to these rapid changes, causing many young adolescents to experience poor hand-eye coordination and pain associated with rapid bone growth.

Intellectual:

Young adolescents tend to lose interest in academic content when it is not presented in a stimulating manner conducive to participation. Consequently, the traditional method of teaching (lecture format) can be both dry and unappealing, and youth can therefore struggle to complete homework and perform up to their potential. Concurrently, early adolescents develop a higher level of reasoning, which allows them to think proactively and engage in deeper conversations (their future, global events, etc.)

Moral/Ethical:

Young adolescents tend to be inflexible when expressing their beliefs, but they possess a strong sense of fairness and begin to consider the feelings of others as they move away from self-centered tendencies. They are also able to contemplate difficult moral and ethical questions, but due to a lack of experience, young adolescents can struggle to make “proper” moral and ethical decisions. As a result, children may exhibit risk-taking behaviors (fights at school, stealing, drugs, etc.)

Emotional and Psychological:

While young adolescents strive for independence and individuality, they also desire to fit in seamlessly with their peers. These contradictory wishes can put children in a vulnerable state as they struggle to find an identity that they are happy with. Concurrently, they can be highly sensitive to criticism, moody, self-conscious, and unpredictable as they experience high stress and intense emotions.

Social:

Young adolescents begin to value peers over family as they become immersed in the social scene and their personal image. They tend to talk to their friends before family when confronting an issue as they struggle to communicate openly with family members. However, while children appear to distance themselves from parents or other adults as they rebel against authoritative figures, they are still dependent and desire guidance (“Making the Transition to Middle School”, 2008)

Expected Changes

Adapted from the [Georgia Department of Education](#)

Socially	Emotionally	Organizationally <i>learning to...</i>	Environmentally	Academically	Organizationally
Loyalty to peers, family is secondary	Freedom from parents	Manage time	Adjust to lockers rather than desks	More homework	Start of puberty
Privacy and secrecy	Fluctuations in mood	Keep up with academic content and homework	Acclimatizing to larger campus and student body	New grading criteria	Growth spurts, fluctuations in weight
Desire to be part of a group	Rebelling against authoritative figures, refusing advice	Make time for relaxing	Adapting to dress code	More class projects	Fatigue from rapid growth
Peer pressure and negative influences	Susceptible to low self-esteem relative to elementary years			Less help from parents, Develop more individuality and responsibility	Body odor
	Stress from competition and comparing to others				Interest in solving real-life issues

How Parents Can Help

The changes that your child and family may experience during the transition to middle school can be overwhelming. Families can best navigate these changes with guidance. Below you will find information that can help make the start of middle school an enjoyable and collaborative experience (“Middle School Matters”, 2015).

Before Middle School

Adapted from the [Association for Middle Level Education \(AMLE\)](#)

1. Provide children with tasks that develop organizational skills and accountability.
2. Encourage children to try new things and interpret failure as a necessary experience for learning and growth.
3. Learn about the needs and worries of children in transition.
4. Aid children in confronting their anxieties by learning school rules, campus layout, bathroom locations, counseling options, etc.
5. Commit to childrens’ schooling by attending school events, extracurricular activities, etc.
6. Support and help navigate children in their work to become independent
7. Sustain a strong family relationship
8. Be on the lookout for any signs of depression or anxiety to help can be sought it a timely manner (“Transitions to/from Middle School,” 2017)

During Middle School

Adapted from the [Georgia Department of Education](#)

1. Keep a calendar that everyone in the family uses on a daily basis. Your child can write in test dates, extracurricular activities, and other important items.
2. Attend school activities that are open to parents. This can include a sporting event, student performance, or career night.
3. Volunteer at your child's school. Examples include advising an extracurricular student group, managing a fundraising campaign, or helping in the library/media center etc.
4. Stay informed by reading information sent home by the school (policies, curriculum, grading, monthly newsletter etc).
5. Monitor your child's academic, social, and developmental progress. If needed, address their concerns in a collaborative manner ("Middle School Matters," 2015).

Resources**PDFs/Articles Designed for Children Under Parent Supervision**

PBS Kids Go: Middle School:

- [Movin' On Up](#)
 - Introduction to middle school
- [What's Different](#)
 - Key changes for first-year middle schoolers
- [The Student Body](#)
 - Your peers
- [Stan and Sarah](#)
 - Concerns and advice from two middle schoolers
- [A Principal's Advice](#)
 - Tips from Linda, a middle school principal
- [From the Mentors](#)
 - Real transition experiences from middle school mentors
- Georgia Department of Education
 - [Middle School Matters!](#)
 - A guide for students on middle school transition

PDFs/Articles:

- Georgia Department of Education
 - [Middle School Matters!](#)
 - A guide for families on middle school transition
- U.S. Department of Education
 - [Making the Transition to Middle School](#)
- National Association of School Psychologists
 - [Transitioning from Elementary to Middle School](#)
- National Education Association
 - [Transition to Middle School](#)
- Association for Middle Level Education
 - [Supporting Students in Their Transition to Middle School](#)
- Sylvan Learning
 - [Middle and High School Transitions](#)

Videos:

- Spokane School District
 - [Getting Ready for Middle School Part 1: Fears and Favorites](#)
 - [Getting Ready for Middle School Part 2: The School Day](#)
 - [Getting Ready for Middle School Part 3: Friends and Activities](#)

The Transition from Middle School to High School

Introduction:

The transition from middle school to high school can be a challenging experience for students and their families. Your children must once again adapt to a new environment just three years after successfully transitioning from elementary school to middle school. During this time of change, your children may also begin to desire more independence as they feel themselves stepping into adulthood. Concurrently, there is a misconception that parents should decrease their involvement in their child's personal, educational, and social lives upon the start of high school. While it is important to refrain from being an overbearing parent, it is very important that you stay engaged in your child's growth as it is proven that family involvement leads to greater academic success and higher graduation rates ("High School is Happening", 2015). Be mindful that strained relationships trickle over from middle school as families continue to struggle with redefined expectations, roles, and relationships. While there are a wide variety of reservations your teenager may have, common concerns for budding high schoolers include:

- Why does my body look so different (height, weight, physical changes from puberty)? Why can't I look like everyone else?
- I am questioning my own sexuality. Who do I talk to?
- Does anyone care about me? Do my teachers know my name?
- Will I get bullied by older students?
- What if high school is too hard for me and I get bad grades?
- Who am I?
- What if I get lost and can't find my classrooms?
- What if my friends from middle school don't go to the same high school as me?
- Will I make new friends?
- What if I don't live up to my parent's expectations?
- Will my new classmates or older kids make fun of my appearance when changing in the lockers before P.E.?

Research shows a decline in grades and attendance for ninth graders ("Middle School and High School Transitions," n.d.). There are a variety of reasons for this including a general low self-esteem (body image concerns etc.), relationship issues, struggles socially, drugs, alcohol, and more. For additional information on the social and behavioral changes your child may experience, please visit:

<http://kidshealth.org/en/parents/emotions/#catfeelings> (browse through the "feelings and emotions" and "behavior" tabs). Concurrently, academic demands rise, standardized tests loom, and getting into college because an overbearing priority. Teenagers may not want your help, but it is important to make high school a collaborative experience as teenagers need someone to care for and accept their identity. Remember, the way you contribute to your teenager's life changes in high school, but your overall role as an involved, supportive parent remains concrete.

Interesting Facts

Adapted from the [Georgia Department of Education](#)

Did you know...

- Family involvement in high school leads to a shorter adjustment period in 9th grade, greater academic success, and higher graduation rates.
- Teenagers perform better in school and are less likely to drop out when they possess a strong connection with an adult that teaches and mentors.
- Students that participate in engaging transition events planned by school officials, teachers, and parents are less likely to drop out of high school.
- A positive correlation exists between a teen's success in high school and family involvement in education. Positive, open communication along with realistic expectations are extremely important in reaching this success.
- The more success a student experiences as a ninth grader, the more likely they are to graduate and enjoy high school ("High School is Happening", 2015).

Challenges and Supports

Adapted from Sylvan Learning

The changes that your child and family will experience during the transition to high school can be overwhelming. It is especially important to keep a watchful eye over your child as they are exposed to academic challenges, drugs, alcohol, peer pressure, bullying, and more. Below you will find important information on how to help your children stay safe and healthy throughout high school.

Academic Challenges**What We know**

- More than half of all freshman in the top 35 cities of America have a reading proficiency recommended for sixth graders.
- Teenagers that watch less than three hours of television a day perform better in reading/writing exams compared to those that watch more than three hours of television a day.
- Those who are comfortable reading and writing tend to score better in mathematics.

Know the Warning Signs

- Spelling the same word differently in the same piece of writing
- Refusing to read or write when asked, and becoming anxious
- Misinterpreting clear directions and information
- Taking longer than normal to learn reading strategies
- Struggling to remember or understand what he/she is reading.

What Parents Can Do

- Be open with your child about their academic challenges and accept them, creating a comfortable environment.
- Referring to your child's challenges as disabilities is detrimental to their self-esteem; Rather, refer to them as differences so your child remains confident in his/her ability to perform.
- Commend and support the effort your child makes to learn
- Stay informed and involved in your child's academic obligations (homework, projects, exams, etc.) If needed, provide help and/or speak with teachers for advice on how to assist your child.
- Children commonly inherit their parent's tendencies, so set a good example – turn off all media devices and spend some time reading or writing every day.
- Monitor your child's progress in adapting to and overcoming their learning differences.

The Internet**What We Know**

- 8 to 18 year olds spend more than 50 hours a week on social media
- Approximately 7 out of every 10 teenagers do not have rules on how much time they can spend on social media per day.
- Teenagers with rules on media use spend approximately 3 hours less per day on internet platforms when compared to those with no rules.
-

- About 70% of children ages 7 to 18 have stumbled across online pornography on accident (usually while using the web search engine for homework).
- Nearly 90% of teenage females claim that they can chat online with anyone without their parents knowing.
- 54% of teenage females believe they can maintain a cyber relationship without their parents knowing (“GuardChild, 2016 & “Daily Media Use Among Children and Teens Up Dramatically From Five Years Ago,” 2010).

What Parents Can Do

- Speak openly and regularly with your child about the use of the internet and other media sources.
- Talk about internet safety and how to act appropriately on social media websites (Facebook, Instagram, etc)
- Be mindful of the popular social media sources such as Facebook, Instagram, YouTube, SnapChat, etc. that your child uses
- Children learn by example. Make sure to filter the sites you visit and moderate the time you spend on the internet.

Alcohol

What We Know

- Underage drinking can hinder memory and development due to damage to the brain’s hippocampus and prefrontal cortex
- Children are at a higher risk of developing alcoholism if the illness is present in parents and close family
- Underage drinking leads to higher chances of alcoholism as an adult
- 4,300 deaths occur per year from underage drinking
- Underage youth drink 11% of alcohol consumed per year, and 90% of this alcohol is binge consumed
- Approximately 190,000 emergency room visits per year are due to injuries related to underage drinking
- On average, approximately 20% of youth between 12-20 years drink alcohol and 13% have binge drank in the last month. Older youth in this age range accounted for more of the alcohol consumption (10% of 8th graders and 35% of 12 graders)
- 8% have operated a vehicle after alcohol consumption, and 20% have been driven by someone who consumed alcohol (“Fact Sheets – Underage Drinking,” 2016).

Know the Warning Signs

- Physical: slowed motor skills, unexplained drop in athletic performance, exhaustion, frequent health complaints, persistent cough, red/glazed eyes
- Emotional: changes in personality, mood swings, irritability, rash behaviors, low self-esteem, poor judgement, depression
- Familial: argumentative, ignores rules, distant from family
- Educational: Lack of motivation, difficulty learning new material, poor academic performance, absences, disobedient
- Social: ignores rules/regulations/laws, new friends with similar struggles

What Parents Can Do

- Establish a strong, open relationship with your teenager so they are comfortable sharing sensitive information
- Talk about alcohol and the reasons to avoid drinking underage
- Talk about ways to avoid succumbing to peer pressure. See links below for more information on this topic
 - <http://pbskids.org/itsmylife/body/alcohol/article7.html>
 - <https://drinkwise.org.au/parents/combating-peer-pressure-how-to-help-your-teen/#>
- Be aware of your teenager’s activities
- Work with other parents to establish solid boundaries regarding alcohol
- Follow through with consequences if rules are broken by teenager
- Be conscious of the example you are setting for your children when consuming alcohol
- If effected by alcoholism, talk to your teenager about its effects on your life

Bullying

What We Know

- Approximately 30% of students are bullied or bully peers
- Approximately 160,000 kids refuse to go to school every day due to bullying
- Students that are bullied are 2-9 times more likely to consider suicide (6)
- Approximately 70% of students and 70% of staff have witnessed bullying at school
- Approximately 55% of LGBT students are cyberbullied.
- Most bullying occurs on campus, but cyber bullying is becoming an increasing concern
- Only 20-30% of students bullied reach out to adult supervisors (7)

Know the Warning Signs

Your Teenager is Being Bullied:

- Cuts, scratches, bruises
- School avoidance
- Lack of friends or social group
- Physical complaints including stomach aches and headaches
- Poor sleep and nightmares
- High anxiety
- Lack of self-esteem

Your Teenager is a Bully:

- Dominant personality
- Lack of control over temper
- Easily irritable even with basic tasks
- Lack of empathy
- Inflated self-esteem
- Refuses to follow rules
- Enjoys violence
- Hangs out with bullies or others than enjoy hurting classmates physically and/or emotionally

What Parents Can Do

- Establish a strong, open relationship with your teenager so they are comfortable sharing sensitive information
- Make sure you have time to help when needed
- Explain that it is not your teenager's fault that they are being bullied
- Never encourage retaliation
- Establish strict rules regarding bullying behaviors that are forbidden
- Follow through with consequences when rules are broken
- Involve school officials to help you alleviate your teenager's situation
- Encourage your teenager to be an up stander if witnessing bullying (intervening is not "tattle tailing")(Middle School and High School Transitions, n.d.).

Tips for Success

Adapted from Georgia Department of Education

The start of high school is like a storm; the initial experience can feel turbulent and difficult, but eventually the storm diminishes and sunny skies return. Students undergo social, emotional, physical, and academic growth in high school as they near adulthood, and they need your help. The most important topics to be aware of are self-dependence, responsibility, academic performance, and preparing life after high school. Below you will find important tips regarding these topics to help you assist your teenager in creating a joyful high school experience with positive memories and lasting friendships.

Becoming Self-Dependent

- Encourage your teenager to explore extracurricular activities
- Make sure to actively listen as this naturally opens the conversation to ideas and solutions. Please see link below for more information regarding this topic
 - <http://www.pbs.org/parents/talkingwithkids/strategies.html> (After visiting link, please read “Spend Time Listening” through “Don’t Discuss Everything”)
- Urge your teenager to express feelings and concerns using words
- Encourage establishing trusted adult mentors for further support

Developing Student Responsibility

- Show your teenager how to remain up-to-date with class material – set small, timely goals to fulfill larger objectives in the future
- Teach time management skills and monitor your teenager’s improvements
- Discuss the important of communicating openly and effectively with peers and staff when working on group activities
- Help your teenager create a calendar that he or she uses daily
- Keep track of your teen’s grades and attendance
- Encourage your teenager to set aside time to relax with friends and family. Stress the importance of self-care and balance.

Academic Performance

- Keep track of your teen’s grades and overall performance in each class throughout the year
- If you are concerned, set up meetings with teachers/counselors to discuss your teen’s growth
- Create a home environment conducive to learning/studying
- Make sure your teen is meeting all school graduation requirements
- Work with your teenager collaboratively to set goals and expectation
- Attend parent discussions and workshops hosted by your teen’s school

Preparing for Life After High School

- Regularly refer to your teen’s four-year plan as he or she progresses through high school
- Explore opportunities such as job shadowing for your teenager to gain insight into various professional fields
- Discuss post-graduation plans proactively. Be mindful that your student may have ideas to partake in something other than college (gap-year experiences, job opportunities, and more)
 - <http://www.pamf.org/teen/life/school/alterpaths.html> (link contains information on alternative paths after high school)
- Support your student’s efforts to explore prospective universities, gap-year experiences, and more
- Attend all college and career events near you (“High School is Happening,” 2015).
- For additional details on preparing for the transition from high school to college and adulthood, please visit: <https://www.settogo.org/>

Below are resources that provide valuable information on the transition from middle school to high school:

Resources

PDFs/Articles Specifically for Adolescents:

- PBS Kids Go: High School:
 - [The Big Kahuna](#)
 - [Introduction to high school](#)
 - [Getting Prepped](#)
 - [Tips to ease the start of high school](#)
 - [Bigger, Faster, More](#)
 - Key changes to expect
 - [Small Fish - Again](#)
 - Tips to a successful high school experience

- It's Academic
 - Changes in academics
- Get Extra-curricular
 - Various extra-curricular opportunities
- The Social Scene
 - Advice on forming healthy social relationships
- Margo's Story
 - Margo's personal story on preparing for high school
- From the Mentors
 - Real transition experiences from high school mentors
- Own Your Own Future:
 - Transitioning to High School
- Georgia Department of Education:
 - High School Is Happening!
 - A guide for students on high school transition
- California Career Center
 - Middle School to High School Transition Tips
- Teens Health
 - Starting High School

PDFs/Articles

- Georgia Department of Education
 - High School Is Happening!
 - A guide for families on high school transition
- Teens Health
 - Ten Ways to Help Your Child Succeed in High School
- Dr. Paul
 - Starting High School – Helping Your Teenager Adjust
- Portland State University Graduate School of Education
 - Easing the Middle School to High School Transition: A Guide for Schools
- Sylvan Learning
 - Middle and High School Transitions

Videos

- Georgia Department of Education
 - <http://www.gadoe.org/School-Improvement/Federal-Programs/Partnerships/Pages/School-Transition.aspx>
- Own Your Own Future
 - Transitioning from Middle School to High School

Below are three sample letters that schools can send to students and families regarding life after high school. The second two are specifically designed for those planning to go to college.

The Transition to Life Beyond High School

1. Choosing Among Possibilities [*sample letter 1 to be sent before Spring Break of Jr. year*]

You have worked hard and are now considering the next phase of your life. The possibilities for this new phase bring new challenges for both you and your parent. As you embark on your search for a college or other adventures in life it is important to consider how to support your emotional and mental wellness in the options you are looking at. The following is meant to aid you in your search for the best fit for you.

If you are looking at colleges, there are a great many things to consider. Not all of them are academic. The college you choose will be your home and your community for a number of years. Your mental and emotional wellness will be greatly affected by your new environment and these, in turn, will greatly affect your ability to thrive in your new setting. Therefore it is important that you check into many aspects of the campuses you are considering that may not seem the usual thing to look for in a college setting.

The JED Foundation, <http://jedfoundation.org/about>, is an excellent resource to help you find out how campuses you are considering support their students mental wellness. The following draws heavily on suggestions offered on their website. As you tour campuses you will find that both administrators and students are knowledgeable about and willing to discuss the mental and emotional support services their campus provides.

When applying to college:

1. Think about the “fit” between a college and your personality. Academics are important, but other aspects of a college (e.g., size, location, diversity, extracurricular activities) can impact how well you thrive in all areas of college life.
2. Understand what mental health services, policies, and programs exist at prospective college(s), especially if s/he has an existing emotional disorder: 1,2
3. What services are provided by the counseling center? Are there associated fees? Are there a maximum number of sessions allowed per year? Are there specialists (e.g., in treating eating disorders)? Is there a psychiatrist on staff? Does the counseling center provide off-campus referrals?
4. Is there a counselor on call 24 hours a day? If not, what after-hours emergency services are available?
5. Is there a wait time to see a counselor? If so, how long?
6. Under what circumstances will the college notify a parent regarding their child’s mental health? What happens if a parent calls the college with a concern about their child?
7. Does the college train faculty, staff, resident advisors (RAs), etc. to identify and refer students in emotional distress?
8. What kinds of educational programming (e.g., workshops, talks) are provided to students around mental health and wellness?
9. What accommodations are available through disability services for students with emotional disorders?
10. What is the policy around taking leaves of absence?

11. Is there an office to intercede for students who feel overwhelmed? Will using such resources imperil scholarships?
12. Learn about other available support structures. Ask about tutoring, academic and peer advising education coaching, student activities, and career services. Understand how much support is available in the residence halls, such as the number of resident advisors. Find out how the college helps students to connect with one another.

Ask the Dean of Students about what support systems are in place. Is there peer counseling on campus? Is there a peer support organization such as “Active Minds on Campus”? Does the college use the Interactive Screening Program (ISP) from the American Foundation for Suicide Prevention.

- 1 Based on the National Mental Health Association/The Jed Foundation. (2002). Safeguarding your students against suicide. Alexandria, VA: National Mental Health Association.
- 2 Adapted from the Anxiety Disorders Association of America. (2007). Information for parents: helping a college student with an anxiety disorder.

2. After Being Accepted to a College [*Sample letter 2 to be sent in January of senior year*]

With high school graduation, students will enter a new phase in life, full of new possibilities, experiences, and responsibilities, for both parents and their young adult children. This document is meant to provide information and guidance about how a young adult’s mental and emotional wellness can be affected during this exciting time, as well as how both parents and their children can work together to support and enhance that wellness. In the same way that physical health concerns and care is discussed, it’s vital that families have an open discussion about mental health before beginning this new part of life.

Discussing mental health proactively, before a student leaves high school, can help ensure that parents are able to play a supportive role, should there ever be a period of crisis or need for care. Once a student reaches the age of 18, the rights accorded to the student’s parents, including authority to permit access to records, are transferred to the students themselves. The Health Insurance Portability and Accountability Act (HIPPA) and the Family Educational Rights Act (FERPA) govern all students’ privacy rules related to sharing information about mental health. These will be discussed in depth separately but given these laws, it is even more important that families consider how they want to manage a mental health crisis before one arises. Such a situation may never occur but knowing how to respond or what is available on your campus or in your community should such a stressful event arise may even save a life.

Before starting college:

1. Be honest on the college’s medical history form about your child’s current or past emotional issues. These forms provide important information to the health/mental health practitioners (no less important than the rest of your child’s medical history), and they are confidential! Knowledge of a pre-existing condition will help in an emergency.
2. If a student is being treated for a mental health problem before going to college, transfer his/her care and records to the college’s counseling center or a local community provider. Your child may never need to visit a mental health professional, but the stresses of college can cause existing (or previous) mental health problems to worsen (or re-emerge). In other words, the start of college may not be the right time to stop treatment.
3. Find out what mental health services are covered when making decisions about your child’s health insurance. You may decide to keep your child’s existing health insurance or you may choose to purchase a health insurance plan offered by the college. When making this decision, consider the questions below:

Will your child’s existing insurance cover an out-of-state provider?

Will s/he be able to fill out-of-state prescriptions?

What outpatient and inpatient mental health services, emergency care, and prescriptions are covered under each insurance plan?

What mental health services are covered by student health fees (e.g., number of sessions, psychiatric care, medication)?

4. Identify whether your child is eligible to register with disability services. If your child has a diagnosed mental illness or learning disability, s/he may be eligible to register with the disability services office (may be called the "Office of Accessible Education") to receive reasonable accommodations. This may include education coaching, academic accommodations, or other services.

5. Be familiar with the resources for parents provided by the college and know whom to contact if you are concerned about your child. Many colleges have web pages specifically designed for parents that may link to parent guides or information from a parent advisory council.

6. Read the college's student handbook. This will often include a code of conduct that addresses issues such as alcohol or other drug use and plagiarism. It may also include information regarding confidentiality of records and leaves of absence.

3. Going to College [*Sample letter 3 to be send at time of graduation from High School*]

As students leave high school they take on not just a new adventure but new responsibility for their own health. With the services available in most college communities students learn to manage their health. This is still challenging given the stresses, poor sleep patterns and rising rates of anxiety and depression emerging or recurring amongst transition aged youth (TAY ages 19-24). It is important to discuss mental health issues even if there is no history of a mental or emotional difficulty before beginning life outside a home setting.

These issues are far from uncommon in college settings or even in the community at large. Mental and emotional health issues are a very serious health concern faced by the TAY age group today. In Spring of 2014 the American College Health Association - National College Health Assessment (ACHA-NCHA) found that within the last 12 months 33.1% of college students "felt so depressed that it was difficult to function". And within the same 12 month period 8.6% of college students had "seriously considered suicide" (American College Health Association, 2014). We provide these health statistics not to scare you but to prepare you. Being aware of possible health concerns in advance of their development brings the possibility of being prepared should a health issue or crisis arise. Mental health conditions can be life threatening. However these conditions are also among the most treatable. Recovery is to be expected with the proper treatment. But if treatment is not sought it cannot be effective.

Sadly, less than 20% of college students who die by suicide have sought help from college counseling centers ("College and Confidentiality," 2009). Though often stigmatized and rarely discussed, mental illnesses are just that: illnesses that can and should be diagnosed and treated. Mental illnesses, like most illnesses, do not get better on their own - without treatment. Many treatment options exist, including talk therapy, medication and/or stress reduction and management. But treatment needs to be accessed before it can be effective. Because it can be difficult for students to realize when they are struggling information on how to recognize mental health issues and what to do when one is suspected is included.

For Parents when Your Child is at College

- Keep the lines of communication open. Don't be afraid to talk to him/her if you think that something is wrong. You may be in the best position to notice and address any difficulties that your child is having. If they say that nothing is wrong, it can be helpful to explain what it is you've noticed that concerns you (be specific) and reassure them of why you're mentioning it (e.g., because you love them, don't want them to struggle on their own, know how difficult it can be to reach out for help, etc.). It's ok to be persistent!
- Know the signs and symptoms of emotional disorders as well as the warning signs for suicide. It is common for mental health problems to appear for the first time during the college years, so you may want to familiarize yourself with their signs and symptoms. These signs will take the form of changes or behaviors that are out of character and that are pervasive in their life and persistent for about 2 weeks or more. There may be marked changes such as eating or sleeping more or less, isolation or withdrawal from others, feeling overwhelmed, not going to classes, difficulty concentrating, seeming confused or disoriented, feeling worthless or behaving as if they were worthless, a sudden drop in grades, poor memory or recall, highs or lows in mood, anxiety, and thoughts of suicide. Sleep deprivation on its own increases the risk of suicidal thoughts threefold. If your child is having suicidal thoughts ask about these, listen, and then get professional help immediately ("Half of Us Mental Health Study," 2013).

ATTACHMENT 1.2

- Encourage your child to go to the counseling center if one or both of you think it is necessary. Sometimes students can be reluctant to seek help because they are afraid that someone will find out. Reassure your child that counseling services are provided confidentially and that you support them as they reach out for assistance.
- Students who are experiencing emotional distress will tend to turn to friends first for support. Next in line is family followed by online resources. They are least likely to turn to Resident Advisors and Hotlines (“Half of Us Mental Health Study,” 2013).
- Find out whom to call at the college if you’re concerned about your child’s emotional well-being.
- Provide your child with their health information including details of their primary physician and emergency numbers to contact at home. Include a list of current medications and diagnoses if applicable. Keep this up to date. Your young adult should advise a friend where this information is in case an emergency arises.
- Get local contact information including that of a friend of your child. Assure the friend that you will contact them only in an emergency
- Create an emergency plan with your child before a crisis arises.
- Understand the circumstances under which the college will notify you regarding your child’s mental health. Review the FERPA and HIPPA resources referenced here (U.S. Department of Education, 2008 & “Family Educational Rights,” 2009).
- What Can You Do If You Are Concerned That Your Child May Be Thinking About Suicide
- Remember: Asking someone about suicide does not put the idea into his/her head.
- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen. Allow for the expression of feelings. Accept what they have to say as being reflective of their current experience; don’t argue about or dismiss these feelings
- Be non-judgmental. Don’t debate whether suicide is right or wrong, or whether feelings are good or bad. Don’t lecture on the value of life.
- Get involved. Become available. Show interest and support.
- Don’t dare him/her to do it.
- Don’t act shocked. This will put distance between you and make them feel less comfortable being entirely honest about how they are.
- Don’t be sworn to secrecy. Seek support.
- Offer hope that alternatives are available, but do not offer glib reassurance; it only shows that you don’t understand just how distressed they are feeling.
- Take action. Remove means, such as guns or stockpiled pills.
- Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

CONSIDERATIONS AFTER GRADUATION & WARNING SIGNS OF SUICIDE

- *Should you witness, hear, or see your child exhibiting any one or more of the following, get help IMMEDIATELY by contacting a mental health professional, calling the college's emergency number, or calling 1-800-273-8255 (TALK), the National Suicide Prevention Lifeline, for a referral.*
- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person
- Expressing hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking • Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

Individuals who are contemplating suicide often give some warning of their intentions to a friend or family member. All suicide threats, gestures, and attempts must be taken seriously.

Adapted from: <https://www.jedfoundation.org/wp-content/uploads/2016/09/jed-nami-guide-starting-conversation-college-mental-health.pdf>

Additional Resources

National Suicide Prevention Hotline, 800-273-TALK (273-8255)

The Jed Foundation, 212-647-7544: <http://www.transitionyear.org>

The Jed Foundation: "Set To Go" <https://www.settogo.org>

Reach Out: <http://us.reachout.com>

Half of Us: <http://www.halfofus.com>

MY3 app: <http://www.my3app.org>

NAMI: <http://www.nami.org>

American Foundation for Suicide Prevention: <http://www.afsp.org>

SOCIAL MEDIA

Social media use has become a cornerstone of adolescence. In 2012, Common Sense Media reported that three-quarters of teens have a social media profile. In 2016, the American Academy of Pediatrics reported that “approximately three-quarters of teenagers own a smartphone, 24% of adolescents describe themselves as ‘constantly connected’ to the Internet and 50% report feeling ‘addicted’ to their phones” (Chassiakos et al., 2016, p. e3). They also reported that more than 70% of adolescents maintain a “social media portfolio” of several selected sites, including Facebook, Twitter, and Instagram, and use these mobile apps for a range of functions, including photo sharing, gaming, and chatting (Council on Communications and Media, 2016, p. 2). Social media is a space in which young people express their feelings, communicate and collaborate with others. It has many benefits. But the role it can play in both minimizing and increasing risk for suicide is complicated and worth giving a closer look.

There are many applications (apps) and websites available specifically for mental health purposes, both clinical and non-clinical. These include mood trackers, symptom management, peer support networks, mindfulness programs and many more. This is a rapidly exploding field in which apps are introduced and removed on a nearly daily basis, with little to no oversight or regulation to monitor quality or whether they are clinically sound. Larsen, Nicholas, and Christensen report in their article titled, “Quantifying App Store Dynamics: Longitudinal Tracking of Mental Health Apps”, that the environment for mental health apps is so volatile that clinically relevant apps for depression are removed from the market every 2.9 days. This volatility makes it difficult to get a true handle on the app landscape for mental health at any given point in time, and demonstrates the need for skill building and parental monitoring to help young people navigate this relatively nascent frontier.

Young people engage in a wide variety of apps and social media platforms – most that do not have a specific mental health focus. However, mental health is inherently a part of all social media regardless of the media’s intended purpose, due to the fact that such a high number of people, especially youth, use it to express themselves, interface with others, and seek interpersonal support. The immediacy and image-based nature of social media opens teens up to far-reaching personal connections and support but also to public judgment, comparison, and potential cruelty on an unprecedented scale. It is crucial for educators, clinicians, parents, and youth to be aware of the benefits and risks of these media as they relate to mental health in order to maximize their potential for support and minimize harm.

Benefits

Participating in social media can help youth feel socially included, in the same way that opting out of participating can lead youth to feel socially *excluded*. According to a 2012 national survey by Common Sense Media, approximately 29% of teens said that using their social network site makes them feel less shy and more outgoing and nearly 20% said that it makes them feel more confident, more popular and more sympathetic to others. Through social media, youth can gain access to new ideas on a global scale, boost their awareness of social issues, find opportunities for civic engagement, find support networks with common interests and/or struggles, and can be exposed to a rich diversity of ideas and perspectives. It offers the sense of belonging and community so critical to adolescent development.

A few examples of some of the media young people use specifically for mental health support are Lantern, Moodkit, Headspace, My3, Reach Out, My Big White Wall, 7 Cups of Tea, and Crisis Text Line. Lantern and Moodkit are apps that encourage mood tracking and other daily exercises based on principles of cognitive behavioral therapy. Headspace is a mindfulness app with over 5 million users. My3 helps individuals struggling with thoughts of suicide customize coping strategies and sources of

support that are readily available in their phone. Reach Out is a website and forum for youth mental health and support. My Big White Wall is an online community that encourages anonymous peer support and a safe space for self-expression. 7 Cups of Tea connects users with supportive strangers worldwide for chat conversations, with the option for online therapy. Crisis Text Line is a free and anonymous texting service that puts texters in touch with trained staff to help them work through an immediate crisis and connect them to resources and information. These are a handful of the hundreds of websites and apps that are currently available in a constantly evolving landscape.

Risks

According to the American Academy of Pediatrics (AAP), excessive media usage can negatively impact many aspects of adolescents' well-being, including sleep, attention, learning, and weight loss or gain. *(For more information please see the Sleep section in this Toolkit)* Poor sleep quality has been associated with greater internet use, number of devices in the bedroom, and later media turn-off time. Media use can also expose adolescents to high risk behaviors such as illegal drug use, sexuality activity, and self-harm with such frequency that evidence suggests young people are being influenced to view such behaviors as "normative" and "desirable." As the 2012 report states so poignantly, "Social media combine the power of interpersonal persuasion with the reach of mass media" (Chassiakos et al., 2016). As a result, the AAP recommends adolescents spend no more than two hours per day with entertainment media, and that it be high-quality content (Council on Communications and Media, 2016).

Body image is a core part of adolescent development, and overt criticism of body image is highly prevalent online. Body dissatisfaction is linked to serious mental health conditions, including depression and eating disorders. Social media can have an impact on teens' attitudes toward body image. As reported by Common Sense Media, "among the teens active on social networks, 35% reported having worried about people tagging them in unattractive photos; 27% reported feeling stressed out about how they look when they post pictures; and 22% reported feeling bad about themselves when nobody comments on or "likes" the photos they post" (Children, Teens, Media, and Body Image, 2015). Due to its visual and one dimensional nature, with the presence of media, adolescents are more likely to compare themselves with others, often focusing on numbers of "likes" and superficial factors, at the cost of their own internal mental wellbeing. What's more, hateful and harassing comments about young people's body images are prevalent online and according to Common Sense Media in 2013, about four in ten teens say that they often or sometimes encounter sexist (44%) or homophobic (43%) comments on social network sites.

For more vulnerable young people, exposure to "extreme communities" that provide support, information and encouragement for behaviors such as disordered eating, self mutilation and suicide, can pose a serious hazard. These interactions may influence a vulnerable individual's decision to engage in these behaviors and promote the idea that suicide will provide relief from their pain. According to a 2012 report, "interactions via chat rooms or discussion forums may foster peer pressure to die by suicide, encourage users to idolize those who have completed suicide, or facilitate suicide pacts" (Luxton et al., 2012)

Benefits and Risks Associated with Apps/Social Media and Mental Health	
Benefits	Risks
Community and connectedness are protective factors	Access to content promoting suicide and self-injurious behavior
Anonymity can foster help-seeking behavior	Decreased self-esteem
Online communities can be sources of support	Cyberbullying
Ability to access far-reaching resources and support systems	Body image focus
Mood/behavior monitoring apps can help manage mental health conditions	Longevity of posts and adverse consequences
Crisis aversion (flagging tools used by many applications)	Contagion risk
Stories of recovery and perseverance	Proliferation of non-evidence-based apps/sites
Can boost civic engagement and awareness of social issues	Access to sexually explicit content & messaging
	Sleep interference

Prevention

Mobile applications focused on supporting mental health can be involved in early prevention of suicide. Apps can be beneficial in that they increase access to information and tools since they are usually affordable or free, involve a low level of commitment, can be discrete and noninvasive, and are convenient to use. On the other hand, apps can be harmful if they are not offering clinically sound information or techniques, including connecting users to higher levels of care should their needs increase. Some of the apps allow users to interface with their medical clinicians, sharing logs of their moods, sleep, activity levels, and other potential indicators of mental health. Other apps are less clinical, and focus on mindfulness techniques or suggestions to increase happiness and overall mental well-being. In evaluating clinical apps, the recently developed ASPECT guidelines recommend that the apps be actionable, secure, professional, evidence-based, customizable, and transparent (Torous, et al., 2016)

(<http://www.psychiatrist.com/JCP/article/Pages/2016/v77n06/v77n0607.aspx>)

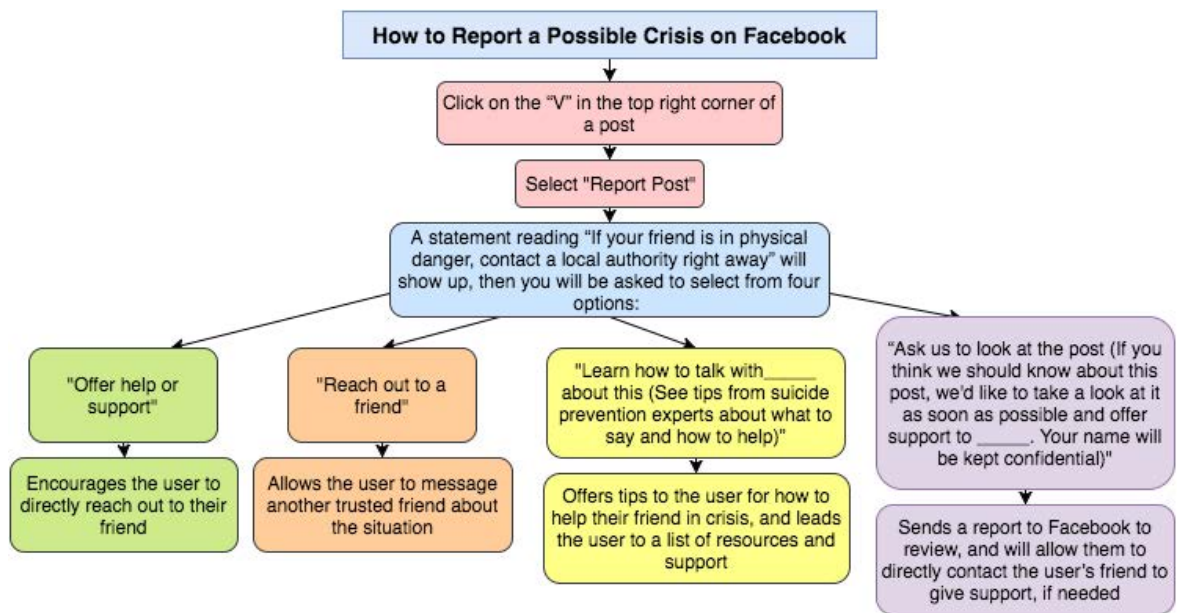
For non-clinical apps, the Anxiety and Depression Association of America recommends that users search for ones that are easy to use, effective, personalized, interactive, and evidence-based (Mental Health Apps, n.d.) (<https://www.adaa.org/finding-help/mobile-apps>).

One common worry with app usage is privacy and anonymity concerns associated with confidential and personal information, which is why seeking apps that are secure and encrypted is vital. Another possible barrier for youth attempting to use a mental health app privately is the inability to purchase apps without having a credit card linked to an online app store account, which may inform a parent or

guardian of the individual's purchase. Common Sense Media provides further information on privacy, which can be found at: <https://www.commonsensemedia.org/privacy-and-internet-safety>.

Intervention

Many social media websites and apps have begun to consider the mental health of their users, and have implemented intervention resources. Facebook has an anti-bullying/harassment protocol, in which moderators can remove content that is making a user feel uncomfortable. Reddit has a suicide watch page, in which users offer peer support to one another. Twitter offers a way to alert their team if someone is indicating self harm or suicidal intent. Facebook and Instagram both have options to intervene if a user feels as if another user is in crisis. Individuals can report others, and trained moderators will assess the situation and can step in if necessary.



Several social media companies have come together to share and rank best practices for online technologies responding to users' cries for help with www.preventtheattempt.com.

The movement by these popular technology companies toward providing some monitoring and support is encouraging. Social media is a place in which people in distress sometimes express their feelings, and peers are in a position where they can see it. Tools and resources are out there, but youth and adults must be made aware of them for them to be helpful. In order to increase usage of the resources that are available, educators can inform and train youth to maintain open communication with administrators, so that they are equipped with the knowledge needed to report any instances through trusted adults or by themselves.

Postvention

After a crisis, preventing suicide contagion is a top priority. How suicide is reported can help save lives. Sensationalizing or romanticizing suicide can contribute to more deaths. Thus, sensitive media reporting is a necessary consideration for postvention. This is critical for preventing contagion and

safely and respectfully ushering a community through the loss. The resource [Social Media Guidelines for Mental Health Promotion and Suicide Prevention](#) provides suggestions for ways to use social media to communicate about suicide and mental health to reduce stigma, increase help seeking behavior and help prevent suicide. Some of the particularly salient guidelines include, using caution not to oversimplify the complex nature of suicide, consider the impact of all communications on grieving family members, promote stories of recovery and avoid dire statistics about suicide, and always offer links to resources for suicide prevention. The guidelines also offer these specific recommendations for how to safely draft and publish communications about suicide:

- Don't overdramatize the event or place "suicide" in the headline/title. (In headlines, "dies" is appropriate.)
- Avoid exact details on locations and methods.
- Avoid photos or videos of the location or method of death, and of grieving family and friends or memorial services.
- Avoid sharing information from suicide notes about motives.

In addition, the American Foundation for Suicide Prevention has thorough guidelines for schools on their [website](#). The website [Reporting on Suicide](#) contains a thorough list of do's and don'ts, reporting recommendations and suggestions for what to do. *(See Attachments 3.22 & 3.23 in this Toolkit)*

What Can Parents and Educators Do?

The most important thing an educator and parent can do is to be tuned in to what youth are using, how they are using it, and the messages that they convey and receive through their use of media. The [American Academy of Pediatrics](#) offers policy statements, toolkits and resources for parents, including encouraging all families to develop a [Family Media Plan](#). Common Sense Media is a reputable resource for both parents and educators, with an extensive inventory of media and an associated rating system. This includes social networking applications, movies, games, websites and much more. My Digital Tat2 stresses the importance of teaching young people critical thinking skills to promote responsible media use and hosts several resource lists for parents and educators:

<http://www.mydigitaltat2.org/resources-1.html>.

[ConnectSafely](#) has several guides for parents and educators, such as A Parent's Guide to Mobile Phones, A Parent's Guide to Instagram, A Parent's Guide to Cyberbullying, An Educator's Guide to Social Media, and more. A range of links to guides for parents, phone contracts and media controls, etc. can also be found through the [HeardAlliance.org](#)

For those interested in using technology to help manage specific mental health conditions and symptoms, [Psyberguide](#) maintains a compendium of technologies categorized by mental disorder and offers a rating system that also references any research that has been done to support the products listed. For coaches, counselors and educators seeking greater skill development, Australia's Orygen National Centre for Youth Mental Health and offers a 28 module, evidence-based online training for a certificate in Youth Mental Health Technology: <https://www.orygen.org.au/Campus/Expert-Network/Training-Modules/Certificate-in-YMHTech>.

Conclusion

The influence of social media on suicide behavior is complicated and not fully understood. All in all, social media has many benefits, as it offers a space for youth to express themselves, communicate with others, and make strong social connections. Teens are more likely to report positive social and emotional impacts from use of social media than negative ones (Common Sense Media, 2012). However, there are also inherent risks, for adolescents in general, and particularly for those who may be more vulnerable and at risk for harmful behavior. Educators and parents must be aware of both the benefits and risks associated with media usage. Moderation is key, and parents and guardians should work to monitor and maintain awareness of their adolescents' media usage, just as they would with relationships and interactions taking place offline.

(For more information on traditional Media see Attachments 3.18-3.23)

Culture, Mental Illness and Stigma

The following excerpt is from the literature review compiled by the Center for Dignity, Recovery & Empowerment.

Mental illness stigma has been identified as one of the most important barriers to the recovery and social reintegration of persons with severe and chronic psychiatric disorders. The supplement to the Surgeon General's Report on Mental Health highlights the need for research on stigma in ethnically diverse populations (1). Understanding culture-specific barriers that stigma poses to treatment and recovery will inform intervention guidelines for underserved populations. However, to date there has not been a comprehensive review or synthesis of how stigma manifests across diverse cultural groups. The present Review document addresses this gap through a comprehensive literature review on existing research of stigma in ethnic/cultural groups in North America and international populations. We also address findings from The California Reducing Disparities Project's (CRDP) population-specific reports to identify new approaches to reducing mental health disparities as reported by California community agencies. This is the first known systematic attempt to review literature across multiple populations and to organize results by ethnic/cultural group with a focus on culturally-specific stigma-change interventions.

We intend this Review to be especially relevant and applicable to the people of California and its counties, in particular its major ethnic groups (African American, Asian American/Pacific Islander, Latino, and Native American). This review is presented as a core report with appendices to supplement the core report with further details. In the Introduction of this core report, we provide an overview of basic concepts and terminologies used in mental illness stigma, followed by an overview of the PPP [Promising Practices Program] project. We then describe our research methodology in the Methods section and present the findings from our literature review. In the Results section, we first describe cultural features of stigma for African Americans, Asian Pacific Islanders, Latinos, and Native Americans. Subsequently, we describe wellness and culturally-specific anti-stigma strategies. Finally, we provide a set of Conclusions, highlighting implications for PPP. Note that each of these sections comprise a core report summarizing findings, with additional details in Appendices A (Glossary of Terms), B (Extended Methods), and C (Extended Results). Appendices contain more comprehensive results and analyses than covered in the core literature review, and are provided as a supplement to the core report for those particularly interested in research findings.

Mental Illness Stigma

We present a brief overview of stigma here; see Appendix A for a glossary of terms with further explanation of stigma vocabulary. Stigma processes are often conceptualized in three ways: public stigma, self-stigma, and structural stigma. Public stigma is the process in which the general public stigmatizes individuals with mental illness. Public stigma consists of three components: Stereotypes, Prejudice, and Discrimination (2). Self-stigma (or internalized stigma) occurs when an individual takes the publically acknowledged or assumed beliefs of stereotypes and applies it him or herself. In addition to public and self-stigma, a third type of stigma is described as structural (institutional) stigma. Structural stigma is the stigma evidenced in societal structures such as laws, health care policy, treatment practices, and mental health funding (3). Structural stigma may occur through subtle forms of institutional practice, as well as systematic discrimination in employment due to preferential hiring practices (4).

Overview

Results from the literature review are broken down into the four major ethnic/cultural group categories determined by the scope of the PPP project, and additional findings are presented on other cultural groups pertinent to California's population (i.e., rural groups). In each section, we provide a summary of stigma findings in each ethnic/cultural group.

African Americans

The literature indicates a general pattern that African Americans endorse more mental illness stigma than do Whites. However, some studies suggest that African immigrants have less stigma, where some African immigrant subgroups (i.e., Afro-Caribbeans) are more likely to believe that recovery is possible. Few studies were conducted in African international contexts, which limits comparisons of public stigma between individuals living in Africa and African immigrants to the U.S. One notable finding concerning public stigma in African Americans was that mental health literacy and beliefs about effectiveness of treatment was associated with lower levels of stigma, suggesting the potential use of mental health literacy to reduce public stigma in this group. Another study indicated that some Christian churches may hold negative attitudes toward mental health treatment, which may require targeted outreach to most effectively reduce stigma. For African Americans with mental illness and their family members, research revealed that they generally experience high levels of self-stigma. Self-stigma in this group has been found to be associated with social isolation, loss of self-esteem, demoralization, and to constitute a significant barrier to mental health treatment. Because of the historical experience of racism and discrimination in African Americans, both structural discrimination and racial discrimination compound the negative effects of mental illness stigma in African Americans.

Native American

No studies comparing mental illness stigma among Native Americans vs. Whites were found in our review. Given the lack of studies examining stigma in Native American groups, we recommend this as an area for future study. In terms of structural discrimination, the historic discrimination and oppression experienced by Native Americans is further manifested in lack of culturally appropriate care and generally limited resources for mental health services, especially in rural areas. Stigma experienced by Native American groups is related to how much traditional belief systems are lost and conversely related to how much Western health beliefs are adopted. That is, the loss of cultural beliefs is associated with more stigma in Native Americans. In terms of public stigma, levels of stigma may be lower in this group because interpretations of symptoms differ greatly in Native American populations. For example, those who hear voices, see visions, or speak to spirits are traditionally revered, even though they are behaviors associated with schizophrenia. In terms of self-stigma, a primary reason for avoiding formal mental health care among Native American adolescents was embarrassment and stigma, particularly because confidentiality was a concern in small isolated communities. In sum, while stigma appears to be a factor that constitutes a barrier to mental health services among Native Americans, much more empirical work is recommended to clarify how stigma operates in this group.

Asian Pacific Islander

Asians and Asian Americans show consistently more mental illness stigma than do Whites across general community, college student, and multiple stakeholder group samples. Many studies take place internationally, which may be used to help understand stigma in recent immigrants. Recent Asian American immigrants may face structural discrimination in relation to language services,

citizenship status, and access to health insurance. Public stigma among Asian and Asian American groups is elevated; however, they are more in favor of allocating resources to help consumers' relatives. Notably, less acculturated Asian Americans endorse higher levels of social distance towards people with mental illness. One potential way to explain the higher levels of stigma among Chinese immigrants is that mental illness represents an increased threat to the lineage among Chinese vs. other groups. Measuring 'what matters most' may provide a conceptual framework to assess the culture-specific aspects of stigma both among Asian American and other cultural groups. Among many Asian international groups, stigma associated with the individual also spreads to family due to concerns of 'face' and the emphasis on family. Among Asian American groups, caregivers of individuals with mental illness who have face concerns tend to internalize mental illness stigma, which in turn is related to more psychological distress, subjective burden, and poorer quality of life. Chinese immigrant caregivers in particular have been found to be more secretive and withdrawn than caregivers in other ethnic groups. The use of indigenous labels such as "excessive thinking" is less stigmatizing. Helping consumers to find face-saving communication strategies—such as avoiding Western labels and framing experiences in terms familiar to consumers—is an approach that may reduce self-stigma in Asian Pacific Islanders.

Latino

Few studies directly examine stigma comparing the level of stigma that Latinos endorse vs. Whites. This may be because there are fewer quantitative studies and a greater number of qualitative studies with in-depth examination of the processes concerning stigma in Latinos. Recent Latino immigrants may face structural discrimination in relation to language barriers, lack of culturally-appropriate care, citizenship status, and access to health insurance. Latinos often experience double stigma of racial discrimination in addition to the stigma of mental illness. Acculturation affects the stigma associated with mental illness in Latinos, with U.S.-born Latino immigrants endorsing less stigma than their internationally-born counterparts. Interestingly, beliefs in biomedical causes of depression are associated with decreased stigma in Latinos. Psychotherapy is less stigmatized since the cultural value of "unburdening oneself" is thought to be important to maintaining emotional health. However, among Latino immigrants, stigma appears to be strongest with respect to medications, both in fear of addiction and being called crazy (*loco*). Stigma emerges in derogatory perceptions of people with mental illness in some Latino immigrant communities, such as illegal drug user or weak (*floja*), useless (*inútil*), or small (*chiquitita*). Self-stigma is an important cause of medication non-compliance and is associated with treatment non-adherence in Latino immigrants. Having a trusting relationship with their provider has a positive effect on treatment participation among some Latinos, likely due to Latino relationship characteristics of trust (*confianza*) and sympathy/friendliness (*simpatía*). Family plays an important role in the recovery of many Latinos, and understanding stigma in family caregivers is important for removing barriers to care. Keeping the illness within the family and turning to church for support constitutes major ways of coping and reducing stigma for Latino immigrants. As there is a significant Latino population in California, consider reading detailed results in Appendix C for a more comprehensive review of stigma in Latinos. Further research in this area would particularly benefit California residents given the larger number of diverse Spanish-speaking populations.

For additional information on the ethnic groups mentioned above, rural groups and culture-specific interventions, please visit the complete PDF document: <http://dignityandrecoverycenter.org/wp-content/uploads/2012/11/Literature-Review.pdf>.

Culture, Mental Health and LGBTQ Youth

The Trevor Project

- Founded in 1998 by the creators of the Academy Award®-winning short film TREVOR, The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender and questioning (LGBTQ) young people ages 13-24. Every day, The Trevor Project saves young lives through its accredited, free and confidential phone, instant message and text messaging crisis intervention services. A leader and innovator in suicide prevention, The Trevor Project offers the largest safe social networking community for LGBTQ youth, best practice suicide prevention educational trainings, resources for youth and adults, and advocacy initiatives.

Note: More information about the LGBTQ community will be added soon.

THE TREVOR PROJECT

FACTS ABOUT SUICIDE

Suicide is the 2nd leading cause of death among young people ages 10 to 24.

- Suicide is the 2nd leading cause of death among young people ages 10 to 24. [1]
- The rate of suicide attempts is 4 times greater for LGB youth and 2 times greater for questioning youth than that of straight youth. [2]
- Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers. [2]
- In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25. [3]
- LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection. [4]
- 1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year. [5]
- Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average. [6]

SOURCES:

[1] CDC, NCIPC. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010) [2013 Aug. 1]. Available from: www.cdc.gov/ncipc/wisqars.

[2] CDC. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance. Atlanta, GA: U.S. Department of Health and Human Services.

[3] James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

[4] Family Acceptance Project™. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics*. 123(1), 346-52.

[5] CDC. (2016). Sexual Identity, Sex of Sexual Contacts, and Health-Risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance. Atlanta, GA: U.S. Department of Health and Human Services.

THE TREVOR PROJECT

ABOUT THE TREVOR PROJECT (/SECTION/ABOUT)

PROGRAMS & SERVICES

The Trevor Project offers accredited life-saving, life-affirming programs and services to LGBTQ youth that create safe, accepting and inclusive environments over the phone, online and through text.

Crisis Interventions

Trevor Lifeline (/pages/get-help-now#lifeline) - The only national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ young people (ages 13-24), available at 1-866-488-7386.

TrevorChat (/pages/get-help-now#tc) - A free, confidential, secure instant messaging service for LGBTQ youth that provides live help from trained volunteer counselors, open daily from 3:00 p.m. - 9:00 p.m. ET / 12:00 p.m. - 6:00 p.m. PT.

TrevorText (/pages/get-help-now#tt) - A free, confidential, secure service in which LGBTQ young people can text a trained Trevor counselor for support and crisis intervention, available Wednesdays, Thursdays, and Fridays from 3:00 p.m. - 9:00 p.m. ET / 12:00 p.m. - 6:00 p.m. PT at 202-304-1200.

Suicide Prevention Trainings and Resources

Trevor Lifeguard Workshop (http://www.thetrevorproject.org/pages/lifeguard) The Lifeguard Workshop is a free online learning module based on The Trevor Project's in-person workshop, which is listed in the SPRC/AFSP Best Practice Registry for Suicide Prevention. The Lifeguard Workshop webpage includes a video, a curriculum guide, lesson plans, and additional resources for educators.

Trevor CARE Training (http://www.thetrevorproject.org/pages/care-trainings) – This training for adults provides an introduction to suicide prevention techniques based on Trevor's CARE model (Connect, Accept, Respond, Empower).

Trevor Ally Training (http://www.thetrevorproject.org/pages/ally-trainings) – This training introduces adults to the unique needs of LGBTQ youth.

LGBTQ on Campus (<http://www.thetrevorproject.org/pages/lgbtq-on-campus-for-faculty-and-staff>) – These online, interactive training simulations for students (<http://www.thetrevorproject.org/pages/lgbtq-on-campus>) and faculty in higher education are AFSP/SPRC Best Practices for Suicide Prevention and were created in partnership with Kognito Interactive and Campus Pride.

Step-In, Speak-Up (<http://www.thetrevorproject.org/pages/step-in-speak-up>) – These online, interactive training simulations for faculty and staff working with youth in Grades 6-12 are AFSP/SPRC Best Practices for Suicide Prevention and were created in partnership with Kognito Interactive.

Model School District Policy for Suicide Prevention (<http://www.thetrevorproject.org/pages/modelschoolpolicy>) - A roadmap to help school leaders easily navigate ways to bring suicide prevention policies and resources to their schools, developed in collaboration with the American Foundation for Suicide Prevention, the American School Counselor Association, and the National Association of School Psychologists.

Coming Out As YOU! (<http://www.thetrevorproject.org/section/YOU>) – A pocket-sized guide to inspire critical thinking in youth who are questioning their sexual orientation or gender identity.

Trevor Support Center (<http://www.thetrevorproject.org/pages/support-center>) - A resource where LGBTQ youth and their allies can find answers to frequently asked questions, and explore resources related to sexual orientation, gender identity and more.

PSAs (<http://www.oktoask.org>) - Our current public service announcements, "Ask for Help," are available free of charge for TV, radio, website, social media, and print use.

Community Resources

TrevorSpace (<https://www.trevorspace.org>) - A social networking community for LGBTQ youth ages 13 through 24 and their friends and allies.

Trevor Ambassadors (<http://www.thetrevorproject.org/pages/regional-cities>) – Local volunteer groups in select U.S. cities (Atlanta, Chicago, Philadelphia, Salt Lake City, San Diego, San Francisco, Seattle, and Washington, D.C.)

Trevor NextGen (<http://www.thetrevorproject.org/pages/regional-cities>) – Groups of young, motivated volunteers in New York and Los Angeles who raise awareness, develop leadership, advocate, and fundraise in support of The Trevor Project's life-saving, life-affirming work.

Trevor Youth Advisory Council (<http://www.thetrevorproject.org/pages/youth-advisory-council>) – This group of 20 young advocates, ages 16-24 from around the country, are trained by

The Trevor Project to raise awareness about LGBTQ youth, mental health, and suicide prevention in their communities.

Trevor Advocacy Network (<http://www.thetrevorproject.org/section/advocacy-landing-page>) – A way for Trevor supporters to take action to improve policies and legislation that protect LGBTQ youth.

If you are thinking about suicide, you deserve immediate support. Please call The Trevor Lifeline at 1-866-488-7386.

© 2017 The Trevor Project. All rights reserved.

[Terms of Service](#) [Privacy Policy](#)

Sample SEL activities and strategies specific for High School

1. With guidance from school counselor/psychologist, teachers collaborate on creating a list of coping strategies for themselves in implementing SEL skills with students
2. Teacher places targeted SEL skills on the grading rubric for a group project and gives constructive feedback to the student on his/her cooperation and self-management skills
3. During flex period, students have a choice time where students can participate in group support, yoga, workout, library, creative corner, crafts, coloring, tea, journal write, reading
4. Students arrive on campus at a later start time
5. At the Student Council meeting, a wellness student representative advocates for ways to reduce academic stress
6. The guidance office hosts a teatime where recent alumni share perspectives and answer questions about life post-high school
7. Before the basketball game, the team sets effort goals, like the team's goal is to get 10 rebounds by the end of the game; shift the focus to how the players can get to a win instead of the win itself
8. All staff work to destigmatize counseling efforts for students and families

Sample SEL activities and strategies specific for Middle School

- Taking time in staff meetings for giving props to or expressing gratitude for each other
- A study skills elective is offered to teach students time management, advocacy, and organization
- During athletic games, team members sit together, shoulder to shoulder with no spaces including the coach
- Administrators and staff have conversations with students about discipline and reinforcing how students can use their own strengths & SEL skills to take care of themselves, especially for 6th & 7th graders
- At the beginning of music class, students practice centering with breathing exercises and using the breath to calm themselves to prepare for performances
- All staff work to destigmatize counseling efforts for students and families

Sample SEL activities and strategies specific for Elementary School

- Having a school counselor/psychologist in classrooms to read SEL-related books, lead mindfulness sessions, or other SEL activity on an occasional/ongoing basis
- Teacher uses characters in stories to identify, analyze, and evaluate emotions and managing emotions
- Dedicated bulletin board in classroom (or office) featuring SEL activities (e.g., writing/drawing about Random Acts of Kindness, Mix It Up Day, gratitude letters)
- Teachers use SEL language with students about discipline to begin building self-awareness and social awareness
- During athletic games, every teammate stands up to recognize and appreciate each player's efforts with a high five as the teammate exits the court
- All staff work to destigmatize counseling efforts for students and families

For additional information on schoolwide SEL implementation, please visit:

<http://www.casel.org/establishing-systemic-social-and-emotional-learning-approaches-in-schools-a-framework-for-schoolwide-implementation/>

Mindfulness and School Climate: One Example

Research examining how mindfulness may directly create changes in the school climate is challenging to conduct due to many potential confounding variables. However, one example of the Tel-Hai Primary School reported in Semple and colleagues (2017) may provide insights into mindfulness and school climate changes. While at the time of Semple's article, there was no formal program evaluation data in peer-reviewed journals on Tel-Hai's mindfulness program (Mindfulness and Mind-Body Skills for Children; MMBS), school faculty and staff have nevertheless credited it with the positive changes they have observed over 13 years of implementation. Examples of these changes are that in 2002, Tel-Hai was performing far below national academic averages and experiencing high incidences of violence. In 2009, Tel-Hai was the third ranking school in academic performance and school climate across Israel. Their Growth and Effectiveness Measures for Schools (GEMS) increased across all metrics (Hebrew Language, math, science, and English). Metrics reported are that in 2008-2009, Tel-Hai 5th grade students average 92% in English (national average, 72%) and 78% in math (national average, 61%; see ref. (1)). Further, the school principal reported the school was nearly free of violence and more community-oriented. For more information on Tel-Hai's Mindfulness program see the web link for [Limone \(2011\)](#) (2) in the reference list.

TYPES OF STUDENT PROGRAMS INFORMATION SHEET**1. CURRICULA FOR ALL STUDENTS**

Purpose: These curricula:

- Provide information about suicide prevention
- Promote positive attitudes
- Increase students' ability to recognize if they or their peers are at risk for suicide
- Encourage students to seek help for themselves and their peers

Content: Typical content includes:

- Basic information about depression and suicide
- Warning signs that indicate a student may be in imminent danger of suicide
- Underlying factors that place a student at higher risk of suicide
- Appropriate responses when someone is depressed or suicidal
- Help-seeking skills and resources

Participants: These curricula are usually offered to all students in a class or a grade. Some programs, schools, districts, and funders require consent from parents for their child to participate. The children of parents who do not give consent are provided with an alternative activity.

Format: These curricula are typically given in one to four class periods of 45-60 minutes each. They are often given as part of a class, such as a health, family life, or life skills class, which addresses related topics (e.g., mental health issues, substance abuse, bullying, and other violence). This enables the connections between the issues to be highlighted. Sometimes they are implemented during other classes, such as English.

Health education standards: Almost all of the curricula address at least some, if not most, of the National Health Education Standards. Some states have their own standards. State standards are typically aligned with the national standards.

2. SKILL-BUILDING PROGRAMS FOR STUDENTS AT RISK OF SUICIDE

Purpose: These programs help protect at-risk students from suicide by:

- Building their coping, problem-solving, and cognitive skills
- Addressing related problems such as depression and other mental health issues, anger, and substance abuse

Content: Typical content includes exercises and activities to:

- Increase problem-solving and coping skills
- Improve resilience and interpersonal relationships
- Prevent or reduce self-destructive behavior

Format: These programs fit into regular class periods and are given as a separate class. They typically last from 12 weeks to a semester.

3. PEER LEADER PROGRAMS

Purpose: Peer leader programs teach selected students skills to identify and help peers who may be at risk. The most effective programs teach peer leaders to build connectedness not only among students but also between students and staff, which improves the school environment.

Format: These programs are usually held outside of class time.

Peer Leader Roles: Roles vary greatly by program and may include:

- Listening to and supporting peers, educating them about mental health problems, and encouraging them to seek help, as well as talking with adults about students possibly at risk for suicide and other mental health problems
- Presenting lessons to their peers in high school classes, to middle school students, and/or to youth in the community
- Developing and promoting messages to change the school environment through public service announcements, posters, videos, Web sites, and text messaging

Peer Leader Training: The training varies according to the roles taken on by the peer leaders.

Basic components of these trainings include:

- Teaching about the risk factors and warning signs of suicide
- Dispelling myths about suicide
- Destigmatizing mental illness and seeking help
- Learning about other physical and mental health problems, as well as other common issues teenagers face

Three examples of programs with evidence to support their use in suicide prevention, stigma reduction or mental health awareness includes:

- [Sources of Strength](#)
- [Youth Aware of Mental Health](#)
- [Let's Bring Change 2 Mind](#)

GENERAL GUIDELINES FOR TEACHERS AND STAFF

- Suicide is the third leading cause of death for youth aged 10-24 in the United States. *
- In recent years more young people have died from suicide than from cancer, heart disease, HIV/AIDS, congenital birth defects and diabetes combined. *
- For every young person who dies by suicide, between 100-200 attempt suicide
- Males are four times as likely to die by suicide as females – although females attempt suicide three times as often as males. *

SUICIDE IS PREVENTABLE Here's what you can do:

- Talk to your student about suicide, don't be afraid, you will not be "putting ideas into their heads". Asking for help is the single skill that will protect your student. Help your student to identify and connect to caring adults to talk to when they need guidance and support
- Know the risk factors and warning signs of suicide.
- Remain calm. Becoming too excited or distressed will communicate that you are not able to talk about suicide.
- Listen without judging. Allow for the discussion of experiences, thoughts, and feelings. Be prepared for expression of intense feelings. Try to understand the reasons for considering suicide without taking a position about whether or not such behavior is justified.
- Supervise constantly. Do not leave the individual alone until a caregiver (often a parent) or school crisis team member has been contacted and agrees to provide appropriate supervision.
- Ask if there is a plan. If so remove means. As long as it does not put the caregiver in danger, attempt to remove the suicide means.
- Respond Immediately. Escort the student to a member of your school's crisis team. If you are unsure of who is on your school crisis team, find the Principal, Assistant Principal or school social worker, psychologist, counselor or school nurse.
- Join the crisis team. You know your students the best. Provide essential background information that will help with assessing the student's risk for suicide. When a teacher says, "this behavior is not like this student", this is critical information indicating a sudden change in behavior.

*M. Heron, D.L. Hoyert, S.L. Murphy, J.Xu, K.D.Kochanek, & B. Tejada-Vera. (2009, April) Deaths: Final Data for 2006. National Vital Statistics Reports 57(14)

**Lieberman, R., Poland, S. & Cassel, R. (2008) Suicide Intervention. In Thomas, A. & Grimes, J., Best practices in school psychology V. Bethesda, MD: National Association of School Psychologists

Source: *Los Angeles County Youth Suicide Prevention Project*

GENERAL GUIDELINES FOR TEACHERS AND STAFF**Youth Suicide Risk Factors**

While the path that leads to suicidal behavior is long and complex and there is no "profile" that predicts suicidal behavior with certainty, there are certain risk factors associated with increased suicide risk. In isolation, these factors are not signs of suicidal thinking. However, when present they signal the need to be vigilant for the warning signs of suicide. In addition, they are also appropriate targets for suicide prevention programs. Specifically, these risk factors include the following:

- History of depression, mental illness or substance/alcohol abuse disorders
- Presence of a firearm or rope
- Isolation or lack of social support
- Situational crises
- Family History of suicide or suicide in the community
- Hopelessness
- Impulsivity
- Incarceration

Suicide Warning Signs

Warning signs are observable behaviors that may signal the presence of suicidal thinking. They might be considered "cries for help" or "invitations to intervene." These warning signs signal the need to inquire directly about whether the individual has thoughts of suicide. If such thinking is acknowledged, then suicide interventions will be required. Warning signs include the following:

- ***Suicide threats.*** It has been estimated that up to 80% of all suicide victims have given some clues regarding their intentions. Both direct ("I want to kill myself") and indirect ("I wish I could fall asleep and never wake up") threats need to be taken seriously.
- ***Suicide notes and plans.*** The presence of a suicide note is a very significant sign of danger. The greater the planning revealed by the youth, the greater the risk of suicidal behavior.
- ***Prior suicidal behavior.*** Prior behavior is a powerful predictor of future behavior. Thus anyone with a history of suicidal behavior should be carefully observed for future suicidal behavior.
- ***Making final arrangements.*** Making funeral arrangements, writing a will, and/or giving away prized possessions may be warning signs of impending suicidal behavior.
- ***Preoccupation with death.*** Excessive talking, drawing, reading, and/or writing about death may suggest suicidal thinking.
- ***Changes in behavior, appearance, thoughts, and/or feelings.*** Depression (especially when combined with hopelessness), sudden happiness (especially when preceded by significant depressions), a move toward social isolation, giving away personal possessions, and reduced interest in previously important activities are among the changes considered to be suicide warning signs.

*M. Heron, D.L. Hoyert, S.L. Murphy, J.Xu, K.D.Kochanek, & B. Tejada-Vera. (2009, April) Deaths: Final Data for 2006. National Vital Statistics Reports 57(14)

**Lieberman, R., Poland, S. & Cassel, R. (2008) Suicide Intervention. In Thomas, A. & Grimes, J., Best practices in school psychology V. Bethesda, MD: National Association of School Psychologists.

Source: Los Angeles County Youth Suicide Prevention Project

RISK FACTORS FOR YOUTH SUICIDE

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

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

Behavioral Health Issues/Disorders:

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

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

Personal Characteristics

- Hopelessness
- Low self-esteem
- Loneliness
- Social alienation and isolation, lack of belonging
- Low stress and frustration tolerance
- Impulsivity
- Risk taking, recklessness
- Poor problem-solving or coping skills
- Perception of self as very underweight or very overweight
- Capacity to self-injure
- Perception of being a burden (e.g., to family and friends)

Adverse/Stressful Life Circumstances

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

Risky Behaviors

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

Family Characteristics

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

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students
- Lack of acceptance of differences
- Expression and acts of hostility
- Lack of respect and fair treatment
- Lack of respect for the cultures of all students
- Limitations in school physical environment, including lack of safety and security
- Weapons on campus
- Poorly lit areas conducive to bullying and violence
- Limited access to mental health care
- Access to lethal means, particularly in the home
- Exposure to other suicides, leading to suicide contagion
- Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as being overweight.

Stigma and discrimination lead to:

- Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care
- Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help-seeking
- Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection

REFERENCES

- Beautrais, A. L. (2003). Life Course Factors Associated With Suicidal Behaviors in Young People. *American Behavioral Scientist*, 46(9), 1137.
- Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent Suicide: Assessment and Intervention* (2nd ed.). Washington, DC: American Psychological Association.
- Campo, J. V. (2009). Youth Suicide Prevention: Does Access to Care Matter? *Current Opinions in Pediatrics*, 21(5), 628–634.
- Doan, J., Roggenbaum, S., & Lazear, K. (2003). Youth suicide prevention school-based guide—Issue brief2: School climate. Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #218-2)
- Eaton, D. K., Lowry, R., Brener, N. D., Galuska, D. A., & Crosby, A. E. (2005). Associations of body mass index and perceived weight with suicide ideation and suicide attempts among US high school students. *Archives of Pediatrics & Adolescent Medicine*, 159(6), 513-519.
- Epstein, J. A., & Spirito, A. (2009). Risk factors for suicidality among a nationally representative sample of high school students. *Suicide and Life-Threatening Behavior*, 39(3), 241-251.
- Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(4), 386-405.
- Gutierrez, P. M., & Osman, A. (2008). *Adolescent suicide: An integrated approach to the assessment of risk and protective factors*. DeKalb, IL: Northern Illinois University Press.
- Joiner, T. E., (2009). Suicide prevention in schools as viewed through the interpersonal psychological theory of suicidal behavior. *School Psychology Review*, 38(2), 244-248.
- Lofthouse, N., & Yage-Schweller, J. (2009). Nonsuicidal self-injury and suicide risk among adolescents. *Current Opinions in Pediatrics*, 21(5), 641–645.
- Martin, G., Richardson, A. S., Bergen, H. A., Roeger, L., & Allison, S. (2005). Perceived academic performance, self-esteem and locus of control as indicators of need for assessment of adolescent suicide risk: Implications for teachers. *Journal of Adolescence*, 28(1), 75-87.
- Miller, D. N., & Eckert, T. L. (2009). Youth suicidal behavior: An introduction and overview. *School Psychology Review*, 38(2), 153- 167.
- Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth*. Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/SPRC_LGBT_Youth.pdf
- Swahn, M. H., Reynolds, M. R., Tice, M., Miranda-Pierangeli, M. C., Jones, C. R., & Jones, I. R. (2009). Perceived overweight, BMI, and risk for suicide attempts: Findings from the 2007 Youth Risk Behavior Survey. *Journal of Adolescent Health*, 45(3), 292- 295.

PROTECTIVE FACTORS AGAINST YOUTH SUICIDE

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

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

Individual Characteristics and Behaviors

- Psychological or emotional well-being, positive mood
- Emotional intelligence: the ability to perceive, integrate into thoughts, understand, and manage one's emotions
- Adaptable temperament
- Internal locus of control
- Strong problem-solving skills
- Coping skills, including conflict resolution and nonviolent handling of disputes
- Self-esteem
- Frequent, vigorous physical activity or participation in sports
- Spiritual faith or regular church attendance
- Cultural and religious beliefs that affirm life and discourage suicide
- Resilience, ongoing or continuing sense of hope in the face of adversity
- Frustration tolerance and emotional regulation
- Body image, care, and protection

Family and Other Social Support

- Family support and connectedness to family, closeness to or strong relationship with parents, and parental involvement
- Close friends or family members, a caring adult, and social support
- Parental pro-social norms, that is, youth know that parents disapprove of antisocial behavior such as beating someone up or drinking alcohol
- Family support for school

School

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

Mental Health and Healthcare Providers and Caregivers

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

Access to Means

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

REFERENCES

- Bearman, P. S., & Moody, J. (2004). Suicide and friendships among American adolescents. *American Journal of Public Health, 94*(1), 89-95.
- Beautrais, A. L. (2003). Life course factors associated with suicidal behaviors in young people. *American Behavioral Scientist, 46*(9), 1137-1156.
- Beautrais, A., Gibb, S., Fergusson, D., Horwood, L. J., & Larkin, G. L. (2009). Removing bridge barriers stimulates suicides: An unfortunate natural experiment. *Australian and New Zealand Journal of Psychiatry, 43*(6), 495-497.
- Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent suicide: Assessment and intervention* (2nd ed.). Washington, DC: American Psychological Association.
- Birckmayer, J., & Hemenway, D. (1999). Minimum age drinking laws and youth suicide, 1970-1990. *American Journal of Public Health, 89*, 1365-1368.
- Borowsky, I. W., Resnick, M. D., Ireland, M., & Blum, R. W. (1999). Suicide attempts among American Indian and Alaska Native youth: Risk and protective factors. *Archives of Pediatrics & Adolescent Medicine, 153*(6), 573-580.
- Borowsky, I. W., Ireland, M., & Resnick, M.D. (2001). Adolescent suicide attempts: Risks and protectors. *Pediatrics, 108*, 489-493.
- Brent, D. A., Perper, J. A., & Allman, D. J. (1987). Alcohol, firearms, and suicide among youth: Temporal trends in Allegheny County, Pennsylvania, 1960 to 1983. *Journal of the American Medical Association, 257*(24), 3369-3372.
- Cha, C., & Nock, M. (2009). Emotional intelligence is a protective factor for suicidal behavior. *Journal of the American Academy of Child & Adolescent Psychiatry, 48*(4), 422-430.
- Centers for Disease Control and Prevention (CDC). (2009). *School connectedness: Strategies for increasing protective factors among youth*. Atlanta, GA: U.S. Department of Health and Human Services.
- Colucci, E. & Martin, G. (2008). Religion and spirituality along the suicidal path. *Suicide and Life-Threatening Behavior, 38* (2), 229-244.
- Education Development Center, Inc. (Revised 2008). *Assessing and managing suicide risk: Core competencies for mental health professionals*. Newton, MA: Suicide Prevention Resource Center. Education Development Center, Inc. in collaboration with American Association of Suicidology.
- Eisenberg, M. E., & Resnick, M. D. (2006). Suicidality among gay, lesbian and bisexual youth: The role of protective factors. *Journal of Adolescent Health, 39*(5), 662-668.
- Flouri, E., & Buchanan, A. (2002). The protective role of parental involvement in adolescent suicide. *Crisis, 23*, 1-17.
- Goldsmith, S. K. (2001). Risk factors for suicide: Summary of a workshop. Washington DC: National Academy Press. National Academy of Sciences. Retrieved from http://books.nap.edu/openbook.php?record_id=10215&page=18
- Grossman, D. C., Mueller, B. A., Riedy, D., Dowd, D. M., Villaveces, A., Prodzinski, J., & Harruff, R. (2005). Gun storage practices and risk of youth suicide and unintentional firearm injuries. *Journal of the American Medical Association, 293*(6), 707-714.
- Gutierrez, P. M., & Osman, A. (2008). *Adolescent suicide: An integrated approach to the assessment of risk and protective factors*. DeKalb, IL: Northern Illinois University Press.
- Hall-Lande, J. A., Eisenberg, M. E., Christenson, S. L., & Neumark-Sztainer, D. (2007). Social isolation, psychological health, and protective factors in adolescence. *Adolescence, 42*, 265-286.
- Hawton, K., Simkin, S., Deeks, J., Cooper, J., Johnston, A., Waters K., & Simpson, K. (2004). United Kingdom legislation on analgesic packs: Before and after study of long term effect on poisonings. *British Medical Journal, 329*(7474), 1076.
- Kidd, S., Henrich, C. C., Brookmeyer, K. A., Davidson, L., King, R. A., & Shahar, G. (2006). The social context of adolescent suicide attempts: Interactive effects of parent, peer, and school social relations. *Suicide and Life-Threatening Behavior, 36*(4), 386-395.
- King, C., & Merchant, C. R. (2008). Social and interpersonal factors relating to adolescent suicidality: A review of the literature. *Archives of Suicide Research, 12*(3), 181-196.
- Pettingell, S. L., Bearinger, L. H., Skay, C. L., Resnick, M. D., Potthoff, S. J., & Eichhorn, J. (2008). Protecting urban American Indian young people from suicide. *American Journal of Health Behavior, 32*(5), 465-476.
- Randell, B. P., Wang, W., Herting, J. R., & Eggert, L. L. (2006). Family factors predicting categories of suicide risk. *Journal of Child and Family Studies, 15*(3), 255-270.
- Sharaf, A. Y., Thompson, E. A., & Walsh, E. (2009). Protective effects of self-esteem and family support on suicide risk behaviors among at-risk adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 22*(3), 160-168.
- Taliaferro, L.A., Rienzo, B. A., Miller, M.D., Pigg, R. M., & Dodd, V. J. (2008). High school youth and suicide risk: Exploring protection afforded through physical activity and sport participation. *Journal of School Health, 78*(10), 545-553.

RECOGNIZING AND RESPONDING TO WARNING SIGNS OF SUICIDE

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

Warning Signs for Suicide Prevention is a consensus statement developed by an expert working group brought together by the American Association of Suicidology. The group organized the warning signs by degree of risk, and emphasized the importance of including clear and specific direction about what to do if someone exhibits warning signs. This consensus statement describes the general warning signs of suicide. Warning signs differ by age group, culture, and even individual.

The recent advent of social media has provided another outlet in which warning signs may be exhibited. The differences in how and where warning signs may be exhibited demonstrate the importance of adapting gatekeeper training for the age group and cultural communities with whom the gatekeepers will be interacting.

Warning Signs for Suicide and Corresponding Actions

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

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

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

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

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

REFERENCE

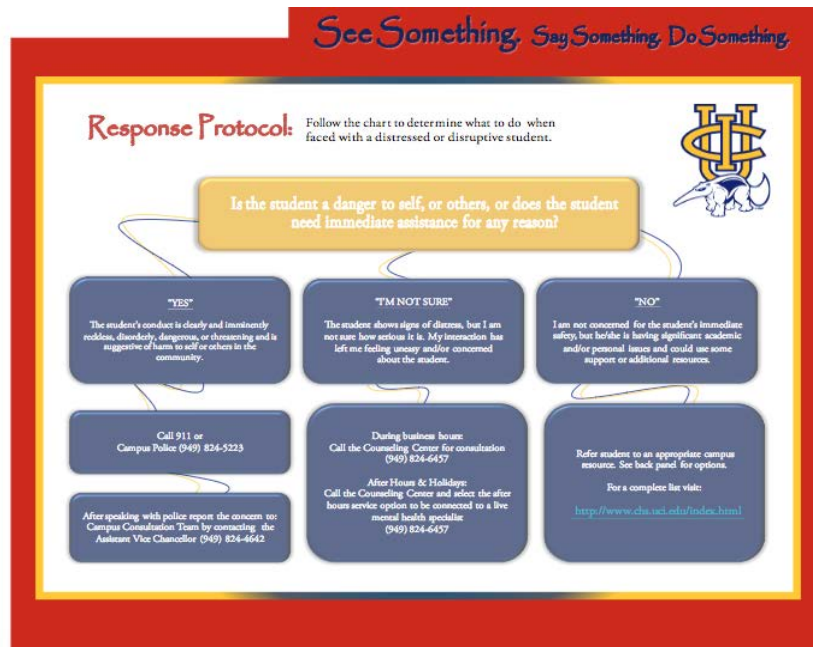
Rudd, M. D., Berman, A. L., Joiner, T. E. Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.

RED FOLDER INITIATIVE

University of California's quick reference guide to help staff assist students in distress

From the *University of California Student Mental Health and Promising Practices* webpage:

"In 2012, UC launched the Red Folder Initiative. Under this initiative, each campus committed to publish a "Red Folder" to serve as a quick reference guide to mental health resources for faculty/staff and graduate teaching/research assistants who may interact with distressing or distressed students.



The customized folders identify common signs of student distress and direct faculty/staff ... through campus protocol to clarify who they should contact in the event of an emergency. The folders also provide tips for how to approach a student who may be in distress and connect that student with the appropriate resource."

The Red Folder Initiative is now in use at California State Universities as well, and a number of secondary schools have adopted this model - creating and distributing their own customized versions of this quick reference guide for teachers and staff.

The Red Folder information can be made available in a variety of formats - to quickly guide school staff toward suggested responses and appropriate protocols when they encounter a student in distress.

1. **Hard-copy folder:** The original format is an actual hard-copy RED file folder – with information graphically designed and printed - utilizing all four available sides; outside front & back cover – and the two internal surfaces as well. Every professor is given this physical folder to keep at their classroom or office desk, or both.
2. **Electronic:** An electronic version – or simple pdf file - can be downloaded to the desktop of a teacher or staff's computer or laptop.
3. **App:** The UCs and Cal State Universities have also designed and created their university's specific Red Folder as a free app – available for all staff to have available on their mobile device.
4. **Wallet cards:** some UCs have made some of the basic information available in wallet card versions as well.

Regardless of format, the purpose is to provide quick "information, safety tips, and contact information for emergency on-campus and community resources in order to help any student in distress."

“Red Folder” at the Middle and High School level:

One California high school district has already taken the solid ideas and concepts of the UC and CSU system’s Red Folder Initiative and created their own “Green Folder” initiative – customizing their folders in a way that allows for consistency in district-wide policies as well as customization for unique requirements and resources at their individual school sites.

School Process to Create “Red Folder”:

The following information is courtesy of [Sequoia Union High School District](#) who, in 2016-2017 adopted this model and launched their own folder initiative.

The school process for creating a ‘Red Folder’ must begin with assembling a team of individuals who are well informed on the needs and resources at their respective district and/or school. This team can include:

- School administrator(s)
- Mental health coordinators
- School psychologist
- School counselor
- Certificated school nurse


It is vital that those involved with the development of the folder should be committed to the maintenance and yearly update of the folder.

For reference, the following examples highlight the district and individual school folders created by Sequoia. The district folder uses the UC and CSU template as a model while the High School folder reflects three of the most common issues on school campuses during school hours and outside of school hours.


The standardized district-wide folder is distributed to all schools.

ASSISTING STUDENTS IN DISTRESS

COMPASSION



Sequoia Union District teachers and staff are in a unique position to demonstrate compassion for students in distress. The purpose of this folder is to help you recognize symptoms of student distress and identify appropriate referrals to campus resources. The Sequoia Union High School District, in collaboration with the Mental Health Task Force, requests that you act with compassion when you are dealing with a student in distress.




SEE SOMETHING	SAY SOMETHING	DO SOMETHING
<p>District teachers and staff interact with students on a daily basis and are therefore able to observe student behavior over a period of time. Educating yourself and learning the symptoms of distress will allow you to recognize them when they surface with your student.</p> <p>Remember, you may be the first person to SEE SOMETHING since you have frequent and prolonged contact with them.</p> <p>✔ Be Proactive: Engage students early on, pay attention to signs of distress, and set limits on disruptive behavior.</p>	<p>High school students may feel alone, isolated, and even hopeless when faced with academic and life challenges. These feelings can easily disrupt academic performance and may lead to other serious consequences. Students exhibiting troubling behaviors in your presence are likely having difficulties coping with life stressors.</p> <p>Trust your instincts and SAY SOMETHING if a student leaves you feeling worried, alarmed, or threatened!</p> <p>✔ Be direct: Show compassion and concern. Don't be afraid to ask directly if students are struggling with some issues. Listen sensitively and carefully: Use a non-confrontational approach and a calm voice.</p>	<p>Sometimes students cannot or will not turn to family or friends. DO SOMETHING! Your expression of concern may be a critical factor in saving a student's academic career or even their life.</p> <p>✔ Follow through: Direct the student to the physical location of the identified on-campus resource or speak to a guidance counselor.</p> <p>✔ Documentation: Always document your interactions with distressed students and consult with your AVP after any incident.</p> <p>✔ Safety first: The welfare of the campus community is the top priority when a student displays threatening or potentially violent behavior. Do not hesitate to call for help.</p>

ASSISTING STUDENTS IN DISTRESS

SEE SOMETHING

SAY SOMETHING

DO SOMETHING



PRIVACY

On-campus mental health counseling services offered to students are confidential. Teachers, counselors and staff are reminded to honor student confidentiality. School employees are mandated reporters and are required by law to report known or suspected child maltreatment, child abuse or neglect to the county child welfare department or local law enforcement agency.

INDICATORS OF DISTRESS

Be aware of the following indicators of distress.

Look for **groupings, changes in behavior, frequency, duration and severity**— not just isolated symptoms.

ACADEMIC INDICATORS	PSYCHOLOGICAL INDICATORS	PHYSICAL INDICATORS	SAFETY RISK INDICATORS
<ul style="list-style-type: none"> ✔ Sudden decline in quality of work and grades ✔ Repeated absences/tardies ✔ Disturbing content in writing or presentations (e.g., violence, death) ✔ A student needs more personal counseling rather than academic counseling ✔ Continuous classroom disruptions 	<ul style="list-style-type: none"> ✔ Self-disclosure of personal distress that could include family problems, financial difficulties, depression, grief, or thoughts of suicide ✔ Excessive tearfulness, panic reactions, irritability or unusual apathy ✔ Verbal abuse (e.g., taunting, badgering, intimidation) ✔ Expressions of concern about the student by his/her peers 	<ul style="list-style-type: none"> ✔ Marked changes in physical appearance including deterioration in grooming, hygiene, or weight loss/gain ✔ Excessive fatigue/sleep disturbance ✔ Intoxication, hangovers, or smelling of alcohol/marijuana ✔ Disoriented or "out of it" ✔ Cuts, bruises, or other injuries 	<ul style="list-style-type: none"> ✔ Unprovoked anger or hostility ✔ Making implied or direct threats to harm self or others ✔ Academic assignments dominated by themes of extreme hopelessness, rage, worthlessness, isolation, despair, acting out, suicidal ideations, or violent behaviors

ASSISTING STUDENTS IN DISTRESS

SEE SOMETHING.

SAY SOMETHING.

DO SOMETHING.

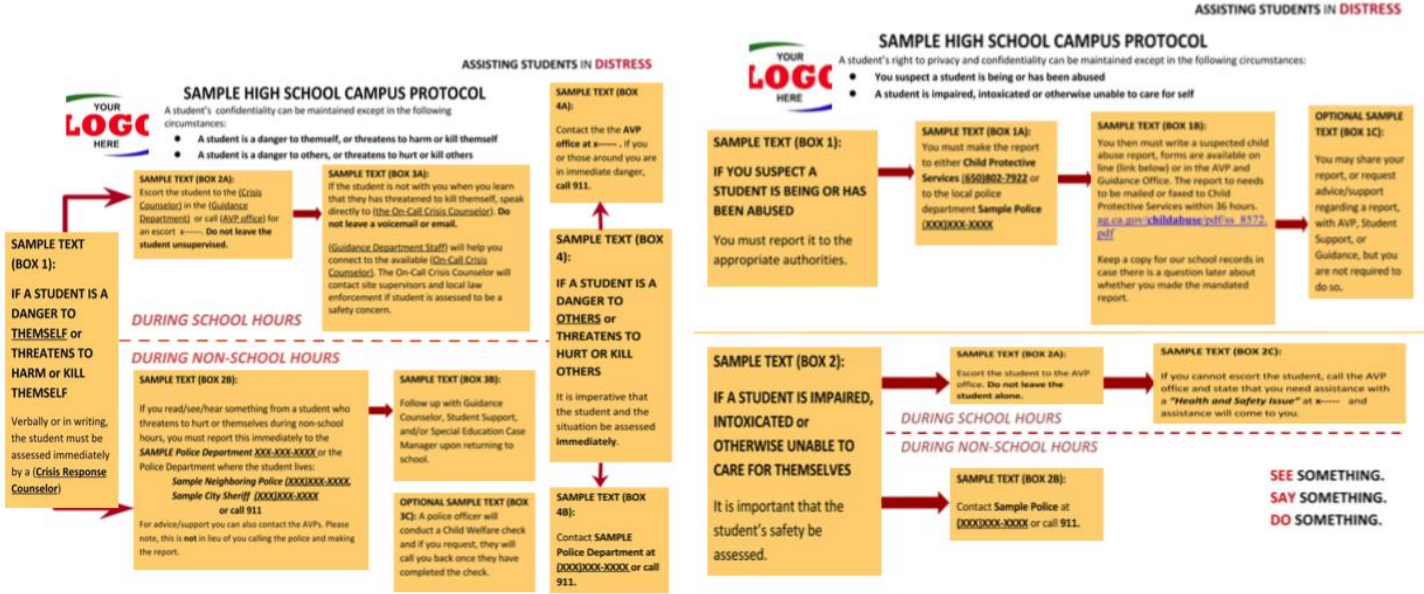


COMMUNITY RESOURCES

The following community organizations provide **critical services** to youth and families. For a complete list of community organizations and their array of services, please visit the County website, sanmateo.networkofcare.org.

COUNTY AGENCIES	HOTLINES	COMMUNITY AGENCIES	TARGETED SUPPORTS
<p>Sequoia Teen Wellness Center (650) 366-2927 www.co.sanmateo.ca.us/Sequoia1416</p> <p>Health services, case management, and school outreach clinic. Conveniently located next to District office.</p> <p>Ravenswood Family Health Center (650) 330-7400 http://www.ravenswoodfhs.org</p> <p>Clinic providing full health services for the Ravenswood community.</p> <p>Fair Oaks Health Clinic (650) 578-7141 http://sanmateomedicalcenter.org/content/FairOaks.htm</p> <p>Clinic providing full health services for the Fair Oaks community.</p> <p>County of San Mateo Behavioral Health and Recovery Services (BHRS) ACCESS Team (800) 686-0101 http://smhealth.org/mh</p> <p>Offers a broad spectrum of mental health and substance use services.</p> <p>Child Protective Services (CPS) (650) 595-7922 http://hsa.smcgov.org/child-protective-services</p> <p>CPS is a 24-hour service provided on the behalf of children who are alleged victims of child abuse/neglect.</p>	<p>National Suicide Prevention Hotline 1-800-273-8255 24-hours, 7 days a week A network of 166 crisis centers in 49 states that connects individuals to crisis services in their local areas.</p> <p>24-HOUR ALCOHOL AND DRUG HELPLINE (650) 573-3950 www.star-vista.org</p> <p>A help line counselor will answer questions about alcohol and other drug prevention and recovery programs.</p> <p>24-HOUR CRISIS LINE (650) 579-0350 www.star-vista.org</p> <p>Provides a free, 24-hour, confidential assessment, counseling referrals, and follow-up for individuals in crisis/risk of suicide.</p> <p>Rape Trauma Services 24-HOUR CRISIS LINE (650) 692-7273 www.rapetraumaservices.org</p> <p>Provides a free, 24-hour, confidential hotline for anyone who has been hurt by sexual violence. Provides support for survivors through hospital medical/legal exams, law enforcement, and the judicial system.</p> <p>Al-Anon/Alateen (650) 592-7935 http://al-anon.alateen.org</p> <p>Info line for anyone affected by someone else's drinking.</p>	<p>healthHigh360 (650) 248-6603 www.healthhigh360.org</p> <p>Offers therapy to youth and adults struggling with mental health issues, substance use.</p> <p>ACS (Adolescent Counseling Services) (650) 424-0853 http://acs-teens.org</p> <p>Provides on-campus counseling services at Woodside HS and Redwood HS as well as a community counseling program at various local Boys and Girls Clubs.</p> <p>El Centro de Libertad (650) 599-9955 recovery@elcentrodellibertad.org</p> <p>Offers therapy to youth and adults struggling with mental health issues, substance use.</p> <p>StarVista (650) 576-KIDS (5437) call or text http://star-vista.org</p> <p>Delivers high impact services through counseling, skill development, and crisis prevention at Menlo-Alherton HS and Serrano HS. Offers a myriad of services including residential programs and outpatient services for youth.</p> <p>PHP (Parents Helping Parents) (408) 850-6125 Parent Crisis Number (408) 727-5775 http://php.com</p> <p>PHP helps families who have children of any age with special needs.</p>	<p>ACS Outlet (650) 424-0692 http://acs.teens.org/ahel.ws.do?outlet</p> <p>Offers free confidential drop-in English-speaking and Spanish-speaking groups for LGBTQ youth, ages 10-25 years old in Redwood City, Mountain View and San Mateo.</p> <p>KARA (650) 321-5272 www.kara-grief.org</p> <p>Provides grief support services for individuals, families and organizations.</p> <p>StarVista Daybreak (650) 364-433 http://star-vista.org</p> <p>Provides transitional housing and independent living skills training for homeless youths ages 16-21.</p> <p>StarVista Your House South (650) 367-9687 http://star-vista.org</p> <p>Provides a "time-out" for both the youth and the family, and an opportunity to work on the family's situation.</p> <p>StarVista Insights (650) 366-8436 http://star-vista.org</p> <p>Offers a structured 22-week drug and alcohol recovery outpatient program for youth.</p>

Individual schools create pages which reflect and identify the needs and resources present on each campus for easy reference and access. These are inserted in the standardized district-wide folder.



ASSISTING STUDENTS IN DISTRESS

SAMPLE HIGH SCHOOL CAMPUS RESOURCES (XXX)XXX-XXXX

Social-emotional services are a vital part of our school community. They provide positive connections to the school and help to remove barriers to learning. **SAMPLE HS** provides both on-site services as well as referrals to outside agencies.

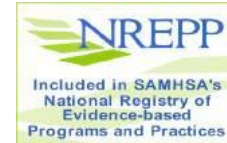
PROGRAM	CONTACT	STAFF	DESCRIPTION
TITLE of program/agencies	email address phone numbers	Supervisor Caseworker Interns	Paragraph descriptors
Example: Student Support and Mental Health Services Coordinator, Partnership for Success Director	superwoman@data clore	Superwoman, LAMT, PPS Program Coordinator/ Director	Provides clinical and programmatic supervision for school based social-emotional counseling and community collaborations. Services are free and confidential, and can include: crisis response, brief intervention, group counseling, family counseling, clinical or academic case management, mentoring, and referral to off-site services. Services are coordinated with school staff, families and community providers as appropriate.
Use as many rows as necessary			Table colors can be changed to reflect school colors

While folders may vary from site to site, the rollout process and all-staff training should be consistently implemented. The individuals taking the lead on the development of the folder should ensure that prior to the beginning of the school year there is time put aside for a school-wide staff training. These Folders should be housed on school websites under teacher portals, but it is also recommended to provide access to the general district folder on the district site. In order to create a comprehensive folder system, adapting the school folder to a parent version would also serve to provide parents the tools and resources for supporting their students.

(From the University of California Student Mental Health and Promising Practices webpage)

Links and Examples from the University of California and Cal State University Systems:

- UC system examples (10) of the Red Folder and how it is unique to each campus:
<http://www.ucop.edu/student-mental-health-resources/training-and-programs/faculty-and-staff-outreach/red-folder-initiative.html>
- Cal State University Red Folder Initiative: <http://calstate.edu/red-folder/>
Read more about the CSU San Bernardino APP -
<https://play.google.com/store/apps/details?id=edu.calstate.redfolder&hl=en>



QPR as a Universal Intervention

A Brief Review

The following document describes the QPR Gatekeeper Training for Suicide Prevention as a universal intervention in the detection of those at risk for suicide, as well as those who may not be at risk for suicidal behaviors, but may need assistance, assessment, and treatment for any number of mental health issues or problems.

The basic QPR Gatekeeper Training for Suicide Prevention program has been taught to more than one million people by more than 5,500 Certified QPR Instructors in the US and other countries. The QPR program meets the requirements for listing in the National Registry of Evidence-based Practices and Policies (NREPP). This version of QPR training also includes a developer-approved, abridged module of the best practice registered CALM training program (Counseling on Access to Lethal Means).

NREPP Listing for QPR: <http://nrepp.samhsa.gov/ViewIntervention.aspx?id=299>

SPRC.ORG listing for CALM: <http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means>

Universal Intervention

While the QPR method was developed specifically to detect and respond to persons emitting suicide warning signs, QPR has also been more widely applied as a universal intervention for anyone who may be experiencing emotional distress. It has been suggested by independent researchers and federal leadership that funded the original assessments of QPR that the QPR intervention could be useful in a much broader application, and not just for the detection of persons at risk for suicide.

Limiting the utility of QPR to the single goal of suicide risk detection accounts for the intervention's origination, but it is not known how many persons emitting distress signals recognized and responded to by individuals trained in QPR methodology were false positives (not suicidal), but still in need of assistance, assessment, and perhaps intervention and treatment. An RO3 research proposal is being submitted to the National Institute of Health at this writing to explore the impact of QPR-trained gatekeepers on not only potentially suicidal persons identified through the intervention, but those experiencing non-suicidal distress.

For example, one can imagine that a youth experiencing a personal crisis may very well send interpersonal distress signals/warning signs and would benefit from help of some kind, but may not be considering suicide as a solution. In fact, the NIMH-funded National

Comorbidity Survey-Adolescent Supplement (NCS-A) found that about 20 percent of youth are affected by a mental health disorder sometime in their lifetime, but the vast majority of these young people never attempt suicide. These disorders - mood, anxiety, ADHD, eating disorder, or substance abuse disorder - resulted in a functional impairment of the child's role in family, school, or community activities, but did not lead to a suicide attempt or completion. (Kessler, et al., 2012). Similar findings for adults have been reported as well.

Moreover, a number known-at-risk populations e.g., police, soldiers, veterans, farmers, athletes and others, may be suffering from treatable disorders that are largely undetected and that go untreated despite public health messaging that attempt to encourage help-seeking behavior. Since those most at risk of suicide are the least likely to ask for help, the application of QPR-based knowledge, compassion and understanding may prove the intervention to be useful for the detection of a wide range of treatable problems, e.g., non-suicidal self-injury (NSSI), perfectionism, eating disturbances, PTSD, TBI, sleep problems, bullying, depression, and other "easily masked" disorders that often lie "upstream" of the onset of suicidal ideation.

The QPR Concept and Theory

The QPR concept is adapted from the CPR "Chain of Survival" literature for how lay and professional citizens can respond to persons experiencing acute cardiac events. A suicide crisis is a life-threatening event which - if not responded to in a helpful fashion - may progress to a self-inflicted injury or death. In a systems approach, multiple levels of recognition and intervention are required to avoid an adverse outcome. These include the following four links in the chain:

1. Awareness and recognition of suicide warning signs/distress signals
2. Early application of QPR
3. Early intervention, initial screening and referral by professionals
4. Early access to mental health professionals fully trained and competent to assess, treat and manage suicidal behaviors

The theory behind the outreach nature of the QPR intervention rests on the following evidence that most suicidal people:

- Tend not to self-refer
- Tend to be treatment resistant
- Often abuse drugs and/or alcohol
- Dissimulate their level of despair
- Go undetected
- Go untreated

Thus, passive systems, e.g., social marketing efforts to "encourage help-seeking behavior" will be largely unsuccessful with those most at risk of suicidal self-directed violence.

QPR differs from other suicide prevention programs in the following ways:

- Recognizes that even socially isolated suicidal individuals have contact with potential rescuers, e.g., friends, family, school officials
- Reaches out to high-risk people *within* their own environments and *does not require suicidal people to ask for help*
- Teaches specific, real-world suicide warning signs
- Has been heavily researched
- Is deliverable in person, online, or in a blended format of online and classroom

Research Highlights

Program adopters must often justify their decision to use one program over another by the application of due diligence in exploring the scientific basis that supports the proposed training. Below is a brief summary of major studies that support the QPR Gatekeeper Training for Suicide Prevention program.

Official QPR training outcomes as determined by independent research reviewers of published studies for National Registry of Evidence-based Practice and Policies found that trained gatekeepers have increased knowledge, confidence and gatekeeper skills per these measures:

- Increased declarative knowledge
- Increased perceived knowledge
- Increased self-efficacy
- Increased diffusion of gatekeeper training information
- Increased gatekeeper skills (ability to engage in active listening, ask clarifying questions, make an appropriate referral)

Source: Cross, W.F., Seaburn, D., Gibbs, D., Schmeelk-Cone, K. et al. (2011); Matthieu, M.M., Cross, W., Batres, A.R., Flora et al. (2008); Wyman, P.A., Brown, C.H. Inman, J., Cross W., et al (2008). (See NREPP web site for full descriptions of support research and citations).

Methods: Three randomized studies conducted in school, outpatient and workplace settings examined the impact of the Question, Persuade, Refer (QPR) training on stratified samples of (1) 340 teachers and parents in a US public school community and (2) 602 community based counseling center staff from the US Department of Veteran Affairs. One study included a 1-year average follow-up assessment and a second study included a 3-month follow-up assessment.

Results: Findings reported an immediate increase in declarative knowledge, perceived knowledge, self-efficacy, diffusion of gatekeeper training information and gatekeeper skills. Results persisted in the 3-month and 1-year follow up with marginal decrements.

Reference:

Kessler R, Avenevoli S, Costello J, Georgiades K, Green JG, Gruber M, He J, Koretz D, McLaughlin K, Petukhova M, Sampson N, Zaslavsky A, Merikangas K. Prevalence, persistence and Sociodemographic correlates of DSM - IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. Archives of General Psychiatry. April 2012; 69(4):372 - 380.

QPR Guidelines

Safe Delivery Of Suicide Prevention Training To Youth

- Training for students should only be undertaken once adults in the school (including teachers and staff) have completed QPR Gatekeeper Training (or QPR Advanced Training for school counselors, nurses, social workers, psychologists or other mental health clinicians).
- Training should, initially, be offered exclusively to students in grades 10 to 12 (entering sophomores through seniors).
- Ideally, any student engaged in training should be screened for risk by a school counselor who has participated in one or more advanced QPR training programs.
- Any student excluded from training based on evidence of risk will be followed up and supported by school health professionals.
- Training will be delivered in facilitated small groups (maximum of 12-15 students) with a supervising school counselor or nurse attending who will be available to students for support and follow-up as needed.
- Several key core messages regarding suicide risk and protection are as follows:
 1. Friends never let friends keep secrets about suicide - Tell An Adult! (Therefore, we want to be very sure that any adult approached by a young person concerned about suicide risk have QPR training such that they know how to respond and what to do)
 2. No student should ever feel that they are totally responsible for the safety of another student.
 3. Ideally the teacher is present at the youth training and receives a QPR certificate or has already been trained in QPR

Adapted from: "QPR for Schools and School Health Professionals: Nurses, Social Workers, School Counselors and Psychologists (Revised July 2013)"

INCLUDING SUICIDE PREVENTION IN OTHER EFFORTS TO REACH PARENTS

Schools have integrated suicide prevention outreach into other activities by:

- Holding a parents' night about student safety that included suicide prevention
- Sponsoring events for the parents of 8th graders or 12th graders that focused on their children's upcoming transition and addressing issues such as anxiety, depression, substance use, and bullying, in addition to suicide prevention
- Sending material-sometimes in the form of a card that fits into a wallet or purse or can be put on the family bulletin board to the parents of every middle and high school student with information about how to help a child in crisis
- Including suicide awareness as part of freshman orientation, safety days, or other health events at the school that involve parents
- Including suicide prevention in parenting classes
- Presenting suicide prevention education at a PTA meeting

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

IDEAS FOR MAXIMIZING PARENTAL RESPONSE RATE

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

- Send the consent form home with students with a registration or "back to school" packet, other important forms, or a report card. Return rates improve if the form is sent with other materials that need to be signed by parents and returned to the school.
- Have parents sign the consent form at parent-teacher meetings or a school-based function, such as Back to School Night. Station school staff at a location where parents have to stop to complete forms.
- Provide incentives for returned forms (regardless of whether the response is "yes" or "no"):
 - Student incentives: Pencils, t-shirts, candy, movie cards, sports memorabilia (Brown & Grumet, 2009), or a class party. Extra credit in health class or another class (Gutierrez & Osman, 2008).
 - Parent incentives: Gift cards for local stores or entries for prize drawings.
 - Teacher incentives: Gift cards when a specific number or percent of students return the form.
- Use a simple, easy-to-read, eye-catching, and culturally relevant letter and form printed on colored paper.
- Send a reminder notice with an additional form to parents who do not respond, or call them.

REFERENCES

- Brown, M., & Grumet, J. (2009). School-based suicide prevention with African American youth in an urban setting. *Professional Psychology: Research and Practice*, 40(2), 111-117.
- Gutierrez, P. M., & Osman, A. (2008). *Adolescent suicide: An integrated approach to the assessment of risk and protective factors*. DeKalb, IL: Northern Illinois University Press.
- Rodgers, P. H. (2006). *Maximizing the return of parent consent forms*. Unpublished manuscript. Newton, MA: Suicide Prevention Resource Center, Education Development Center, Inc.

SUICIDE PREVENTION: FACTS FOR PARENTS

HIGH SCHOOL STUDENTS EXPERIENCE UNIQUE CHALLENGES

High school can be a rewarding time for young people. But for some students, it can also be emotionally difficult, especially in 9th grade during the transition to high school and again in 12th grade during the transition out of high school. The stresses of high school and the mental and emotional stage of adolescence can combine with risk factors for suicide, such as depression, and increase the risk of suicide for some teens. Parents and school staff can help identify students at risk of suicide and help them get treatment before a tragedy occurs.

Many high school students reported that they had seriously considered suicide in the past year.

- In the United States, one out of every 53 high school students (1.9%) reported having made a suicide attempt that was serious enough to be treated by a doctor or a nurse.
- Suicide is now the leading preventable cause of death among teenagers.
- The toll among some groups, such as Native Americans, is even higher.
Source: Centers for Disease Control and Prevention (CDC)

WHY HIGH SCHOOLS ADDRESS SUICIDE

- Administrators and staff care about the well-being of their students.
- Maintaining a safe and secure school environment is part of a school's overall mission.
- Depression and other mental health issues can interfere with students' ability to learn and affect their academic performance.
- Although few suicides take place on high school campuses, students spend much of the day in school. This puts high schools in a position to identify and help students who may be at risk for suicide and related behavioral health issues.

PREVENTING SUICIDE CAN PREVENT OTHER BEHAVIOR PROBLEMS

Students at risk of suicide may also be at risk of other problem behaviors, such as violence and bullying, and substance abuse. Reducing the risk of suicide can help reduce the likelihood of these other behaviors.

HOW PARENTS CAN HELP PROTECT THEIR CHILDREN FROM SUICIDE

- Maintain a supportive and involved relationship with their sons and daughters
- Understand the warning signs and risk factors for suicide
- Know where to turn for help

HOW SCHOOLS CAN HELP PREVENT SUICIDE

Experts recommend that schools use an approach to suicide prevention that includes the following:

- Identifying students at possible risk of suicide and referring them to appropriate services
- Responding appropriately to a suicide death
- Providing training and suicide awareness education for staff
- Educating parents regarding suicide risk and mental health promotion
- Educating and involving students in mental health promotion and suicide prevention efforts
- Screening students for suicide risk

You should encourage your high school to implement some or all of these strategies to prevent suicide and protect the well-being of your children. You can work with the school on these important efforts as well as use the school as a resource for help with your child's needs.

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

SECTION II: INTERVENTION IN A SUICIDAL CRISIS

Intervention protocols to assist students in a crisis involving suicidal thoughts or behaviors are a critical component of both district and school responses. These protocols aid school personnel in intervening effectively with suicidal students. School administrators play a crucial role in establishing a school climate that requires key school personnel to be familiar with and responsive to a suicidal crisis in order to help prevent a youth suicide. Students of concern may be referred to counselors by staff, parents, peers, or self-referral. Intervention protocols vary based on the determined degree of suicide risk.

Key principles to remember in any crisis:

1. **Ensure that the student in crisis is safe:** Remain with the student until a Crisis Response Team (CRT) member arrives.
2. **Send someone for help:** While you remain with the student, send someone to retrieve the nearest available CRT member.
3. **Listen to the student:** Acknowledge their feelings, allow them to express their feelings, avoid giving advice or opinions, and listen for warning signs.
4. **Be direct:** Ask openly about suicide (QPR training) “Suicide is a crisis of non-communication and despair; by asking about it you allow for communication to occur and provide hope” (USF, 2003). Asking about suicide does not put the idea into a student’s mind.
5. **Be honest:** Offer hope but do not condescend or offer unrealistic assurance.
6. **Know your limits:** Involve yourself only to the level you feel comfortable. If you are uncomfortable or feel the situation is beyond your capacity to deal with, refer the student to someone in a better position to help. If you feel the student is in immediate danger, escort the student to the referral. If not, check to see that the referral was followed up on.
7. **Inform student:** At each stage, be sure the student knows what is going on. Provide Appendix B3, “Mental Health Information for Students”.
8. **Inform parents (when appropriate):** Their child is experiencing a crisis. Reassure them that he/she is currently safe. Inform them of community supports that are available to them during and after the crisis. Work with the parents to develop a plan of action for getting their child help. As needed, provide Appendix B2, “Mental Health Resources” and/or Appendices B4i, B4ii, B4iii, B4iv, and B4v “Parent Handouts”.
9. **Keep other students in a safe area:** Allow students to express their fears and concerns or feelings of responsibility or guilt. Let students know that the student in crisis is receiving help, maintain confidentiality and **keep details of the crisis to a minimum**. Let students know where they can get help. Provide Appendix B3, “Mental Health Information for Students”.
10. **Monitor:** Friends of the student and others who are potentially at-risk for suicide.
11. **Debrief:** All faculty and staff involved in the crisis are given opportunities to discuss their reactions and are offered support. Allow expression of feelings, worries, concerns, and suggestions of what was done well and what could have been done better during and following the crisis. Please refer to Attachment 2.18, “Means Restriction” and 2.19, “Suicide Contagion and Clusters”

A. CRISIS RESPONSE TEAM (CRT) MEMBERS AND ROLES

Administrative support is necessary for the successful implementation of this toolkit. In order to respond appropriately, all CRT members must understand their role in suicide prevention. The team is made up of a diverse group of individuals within the school. Possible members are the principal, assistant principals, guidance counselor, school psychologist, school therapist, special education staff, outside agency therapist, a teacher, school nurse, information technology staff, and a member of office staff (secretary). Alternates are designated for key roles, such as CRT leader.

1. Crisis Response Team Leader responsibilities:

- a. Coordinates annual training for the Crisis Response Team and for school faculty and staff
- b. Mobilizes team members as needed
- c. Coordinates Team member assignments
- d. Acts as the liaison between the school principal and district office when district support is deemed necessary

2. Team member responsibilities include:

a. All Members:

- Respond to urgent situations when needed
- Call 911 if needed
- Inform Team Leader about students of concern or at-risk
- Provide first aid when needed (Nurse/Health Technician, Other Trained Staff)
- Clear area and ensure safety of all students

b. Principal/Assistant Principal:

- Assumes responsibility for decisions made and actions taken
- Acts as liaison with police or other authorized outside agency
- Briefs district office administration
- Notifies family members of student crisis
- Modifies school schedule if necessary
- Resumes normal schedule as soon as possible
- Calls on community resources for assistance if needed
- Secures campus (assistant principal)
- Communicates with other sites as needed
- Evaluates school crisis response and revise as needed

c. School Psychologist/Counselors

- Conducts student interviews to assess for level of risk
- Contacts community links and resources
- Contacts and works with parents
- Documents actions

d. School Nurse or Health Technician

- Administers first aid, triage
- Locates emergency card information for injured student

e. School Secretary

- Maintains up-to-date contact information for CRT members
- Maintains communication with principal
- Responds to crisis-related inquiries (see Attachment 3.4, "Sample Script for Office Staff", and modify with principal to fit current situation)

f. Media Spokesman/Associate Superintendent

- Fields and responds to media inquiries - review Attachment 3.18, "Guidelines for Working With the Media"

g. Campus Supervisor

- Coordinates immediate security and protections
- Roams campus to help identify students in need

h. Teachers

- Take every warning sign seriously
- Ensure the safety of students during and after an emergency
- If stay-put situation exists, do not allow students to enter or leave room
- Keep students informed as directed by principal: control rumors
- Assure students the crisis is being handled and they are safe
- Focus discussion on reactions students are having in the moment and how to support each other
- Refer students in need to the Crisis Team Leader

CRISIS RESPONSE TEAM CONTACT INFORMATION FOR SECONDARY SCHOOL :

ROLE	NAME	ROOM	EMAIL	OFFICE PHONE	CELL PHONE
CRT LEADER					
ALTERNATE CRT LEADER					
PRINCIPAL					
ASSISTANT PRINCIPAL					
SCHOOL PSYCHOLOGIST					
COUNSELOR					
COUNSELOR					
COUNSELOR					
COUNSELOR					
CONTRACTED COUNSELING AGENCY					
TEACHER LIASON					
SCHOOL SECRETARY					
NURSE/HEALTH TECH					
CAMPUS SUPERVISOR					
MEDIA SPOKESPERSON: SCHOOL					
MEDIA SPOKESPERSON: DISTRICT					

CRISIS RESPONSE TEAM CONTACT INFORMATION FOR PRIMARY SCHOOL:

ROLE	NAME	ROOM	EMAIL	OFFICE PHONE	CELL PHONE
PRINCIPAL/ACTING PRINCIPAL/CRT LEADER/MEDIA SPOKESMAN					
SCHOOL PSYCHOLOGIST					
CONTRACTED COUNSELING AGENCY					
TEACHER LIASON					
DESIGNATED TEACHER					
DESIGNATED TEACHER					
DESIGNATED TEACHER					
SCHOOL SECRETARY/CLERK					
CUSTODIAN					

B. IDENTIFY AND MONITOR AT-RISK STUDENTS

1. At each site the school psychologist or a selected counselor will maintain a separate file of students who may need added support during the school year; they will follow up with them as needed. These records are only accessible to those staff members who "need to know." These are neither publicly accessible documents nor are they subject to a public records request. All health conditions are protected by FERPA and HIPPA privacy laws (*See Appendix A2*). This will include:
 - Students exhibiting suicidal thoughts, behaviors, or risk factors
 - Students who have been hospitalized for serious mental health issues

For suggested information to be recorded see Attachment 2.13, "Student Suicide Risk Documentation Form". School psychologists and counselors should tailor this form to fit the needs of their school.

2. Alternative approaches to identifying students at risk are offered in the SAMHSA Toolkit, including on the basis of showing difficulty in three or more of the following areas:
 - Academic achievement
 - Effort
 - Conduct
 - Attendance
 - Negative report card comments
 - Code of student violations
 - Involvement with school police
3. Once at-risk students are identified, the counselor will meet with the student and the parent/guardian (when appropriate) to assess specific needs and work with other school staff to help the student succeed in school and cope better with emotional and/or behavioral difficulties, including any suicidal thoughts or behaviors.

INTERVENTION IN A SUICIDAL CRISIS

For use when a peer, parent, teacher, or school staff identifies someone as potentially suicidal because of directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs. *Recognizing and Responding to Warning Signs of Suicide*, attachment 1.11

Low Risk Level of Suicide

Take every warning sign or threat of self-harm seriously.

■ Take immediate action by sending someone to inform the counselor or school psychologist of the situation.

■ Remain with the student until the counselor/school psych talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk with chosen tool.

■ When necessary, counselor or school psychologist will contact an administrator or designee to inform them of the situation.

■ Counselor or school psychologist will notify parent/guardian of situation unless this will exacerbate the situation *Guidelines for Notifying Parents, Supporting Parents Through Their Child's Suicidal Crisis* attachment 2.5, and *Contact Acknowledgement Form*, 2.6

■ Develop a safety plan with the student and parents. *Safety Planning Guide*, 2.11, and *Personal Safety Plan*, 2.12.

■ Refer to primary health care provider or mental health services if necessary *Guidelines for Student Referrals*, 2.7, *Referral Process for Special Education Mental Health Assessment*, 2.8, and *Referral, Consent, and Follow-Up Form*, 2.9

■ Document actions on appropriate forms *Student Suicide Risk Documentation Form*, 2.13

■ Counselor will follow up with the student and family as often as necessary until the student is stable.

Moderate to High Risk Level of Suicide

Students with a moderate to high risk of suicide display suicidal ideation or behavior with an intent or desire to die.

■ Keep student under close supervision.

■ Notify nearest CRT member who will evaluate the situation and then notify a school administrator.

■ CRT member will conduct a suicide risk assessment to determine student's risk level and convey to trained professionals (UFS).

■ Consult with appropriate designated school site staff and/or crisis service agency (e.g. UFS) to assess student's mental state and obtain a recommendation for next steps. If student requires hospitalization or immediate emergency medical treatment proceed to Extremely High (Imminent) Risk.

■ School administrator or designee notifies parents/guardians *Guidelines for Notifying Parents*, and *Supporting Parents Through Their Child's Suicidal Crisis*, 2.5, and *Parent Contact Acknowledgement Form*, 2.6. Arrange to meet with parents.

■ Create a safety plan, or if already in place, review and update.

If the student does not require emergency medical treatment or hospitalization, review the following:

■ Confirm understanding of next steps for student's care.

■ Ensure that student and parents, with the assistance of a CRT member, have discussed importance of lethal means restriction *Means Matter: Recommendations for Families*, 2.18

■ Sign the *Referral, Consent and Follow-Up Form*, 2.9 and *Parent Contact Acknowledgement Form*, 2.6

■ Provide referrals and resources for parent/guardians including *What to Expect; When Your Child Expresses Suicidal Thoughts*, Appendix B4

■ Explain that a designated school professional will follow-up within the next two days.

■ Establish a plan for periodic contact from school personnel

■ Students are eligible for home teaching if a doctor's letter recommends an extended absence of two weeks or more.

■ Document actions taken *Student Suicide Risk Documentation Form* 2.13

■ Debrief with all staff members who assisted with the intervention, providing for the expression of feelings, worries, concerns, and suggestions.

Extremely High (Imminent) Risk Level of Suicide

Students with an extremely high risk level of suicide have voiced the intent to engage in a suicidal act, have access to the lethal means needed to carry out the act, and may have lethal means on their person. Do the following:

■ Ensure that a school staff member remains with the student at all times.

■ Clear the area and ensure that all other students are safe.

■ Alert CRT member.

Mobilize community links (e.g. UFS and/or 911)

■ If a life threatening emergency, call 911. Note: 911-responder will determine if emergency treatment or hospitalization is required and will arrange transport

■ If not life threatening, call UFS Suicide Assessment at 877-412-7474. If student is 18 years or older, call 911

■ Principal or designee notifies parents about the seriousness of the situation, unless this will exacerbate the situation. In certain cases, it may be necessary to wait to notify parents due to clinical circumstances as determined by Psychologist, UFS or other mental health provider.

If the student has lethal means on their person:

- Do not attempt to take a weapon by force
- Talk with the student calmly
- Have someone call 911
- Clear area for student safety
- Once the student gives up the potentially lethal means, stay with the student until the CRT or 911 emergency support arrives.

At this level of risk the student may require hospitalization

■ Case manager (school psychologist or counselor) will work with student's doctor/ therapist. Frequency of check-in with the student, family, doctor and/or therapist will be determined by the individual situation.

■ Before student returns to school, initiate re-entry plan.

C. LOW RISK LEVEL OF SUICIDE

Students with a low risk of suicide display warning signs of suicide and/or express thoughts of killing themselves with no intent to act on these thoughts.

1. When a peer, parent, teacher, or other school employee identifies someone as potentially suicidal because s/he has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs (see Attachment 1.11, “Recognizing and Responding to Warning Signs of Suicide”), consider the following:
 - a. Take every warning sign or threat of self-harm seriously.
 - b. Take immediate action by sending someone to inform the counselor or school psychologist of the situation.
 - c. Remain with the student until the counselor/school psychologist talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk with chosen tool. Create a safety plan (see Attachment 2.12, “Personal Safety Plan”) and provide appropriate support.
 - d. When necessary, counselor or school psychologist will contact an administrator or designee to inform them of the situation.
 - e. Counselor or school psychologist will notify parent/guardian of situation unless this will exacerbate the situation (see Attachment 2.5, “Guidelines for Notifying Parents”, and “Supporting Parents Through Their Child’s Suicidal Crisis” and Attachment 2.6 “ Contact Acknowledgement Form”).
 - f. Develop a safety plan with the student and parents (see Attachment 2.11, “Safety Planning Guide”, and Attachment 2.12, “Personal Safety Plan”).
 - g. Refer to primary health care provider or mental health services if necessary (see Attachment 2.7, “Guidelines for Student Referrals”, Attachment 2.8, “Referral Process for Special Education Mental Health Assessment”, and Attachment 2.9, “Referral, Consent, and Follow-Up Form”)
 - h. Document actions on appropriate forms (Attachment 2.13, “ Student Suicide Risk Documentation Form”).
2. The counselor will follow up with the student and family as often as necessary until the student is stable and no longer of concern.

D. MODERATE TO HIGH RISK LEVEL OF SUICIDE

Students with a moderate to high risk of suicide could display suicidal ideation or behavior with any intent or desire to die. Do the following:

1. Keep the student safe and under close supervision. **Never leave the student alone.** Designate one or more staff members to stay with and support the individual in crisis while help is being sought.
2. Notify the nearest CRT member who will evaluate the situation and then notify a school administrator that a student has expressed the intent to engage in suicidal behavior.
3. Trained Crisis Response Team (CRT) member will conduct a suicide risk assessment with chosen tool, to attempt to determine the student’s risk level and then convey this information to trained professionals, such as UFS.

4. Consult with appropriate designated school site staff and/or crisis service agency (e.g. UFS) to assess the student’s mental state and to obtain a recommendation for next steps. **If the student requires hospitalization or immediate emergency medical treatment based on the assessment, proceed to part C, Extremely High (Imminent) Risk.**
5. School administrator or designee notifies parents/guardians (see Attachment 2.5 “Guidelines for Notifying Parents” and “Supporting Parents Through Their Child’s Suicidal Crisis”, and Attachment 2.6, “Parent Contact Acknowledgement Form”). Arrange to meet with parents whenever appropriate.
6. Create a safety plan or, if a student already has a safety plan, review and update (see Attachment 2.11, “Safety Planning Guide”, and Attachment 2.12, “Personal Safety Plan”).
7. If the student does not require emergency medical treatment or hospitalization based on the assessment, and the immediate crisis is under control; before the student is released to the parent/guardian review the following:
 - a. Confirm an understanding of what next steps for the student’s care will be.
 - b. Ensure that student and parents, with the assistance of a CRT member, have discussed the importance of lethal means restriction (see Harvard School of Public Health “Means Matter: Recommendations for Families: <http://www.hsph.harvard.edu/means-matter/recommendations/families/index.html>).
 - c. Sign both Attachment 2.9, “Referral, Consent and Follow-Up Form”, and Attachment 2.6, “Parent Contact Acknowledgment Form”.
 - d. Provide referrals and resources for students and parent/guardians (See Appendix B3 Mental Health Information for Students and B4 Parent Handouts)
 - e. Explain that a designated school professional will follow-up with parents and student within the next two days.
 - f. Establish a plan for periodic contact from school personnel while the student is away from school to ensure the student is improving and treatment is being maintained.
 - g. If appropriate, make arrangements for classwork assignments to be completed at home.
 - h. Students are eligible for home teaching if a doctor’s letter recommending an extended absence of two weeks or more is provided.
8. Document actions taken (see Attachment 2.13, “ Student Suicide Risk Documentation Form”).
9. Debrief with all staff members who assisted with the intervention, providing for the expression of feelings, worries, concerns, and suggestions.

E. EXTREMELY HIGH (IMMINENT) RISK LEVEL OF SUICIDE

Students with an extremely high risk level of suicide have voiced the intent to engage in a suicidal act, have access to the lethal means needed to carry out the act, and may have lethal means on their person. Do the following:

1. Ensure that a school staff member remains with the student at all times.
2. Clear the area and ensure that all other students are safe.
3. Alert nearest adult to recruit Crisis Response Team (CRT) member.
4. Mobilize community links (e.g. Uplift Family Services and/or 911)
 - If a life threatening emergency, call 911.
 - If not life threatening, call **UFS** Suicide Assessment at 1-877-412-7474

Note: 911 responder will determine if emergency treatment or hospitalization is required and will arrange transport
5. Principal or designee to notify parents about the seriousness of the situation unless this will exacerbate the situation. In certain cases, it may be necessary to wait to notify parents due to clinical circumstances as determined by Psychologist, UFS or other mental health provider.
6. If the student has lethal means on their person:
 - a. Do not attempt to take a weapon by force
 - b. Talk with the student calmly
 - c. Have someone call 911
 - d. Clear area for student safety
 - e. Once the student gives up the potentially lethal means, stay with the student until the CRT or 911 emergency support arrives.
7. At this level of risk the student may require hospitalization.
8. Case manager (school psychologist or counselor) will work with student's doctor and therapist treating the student. Frequency of check-in with the student, family, doctor and/or therapist will be determined by the individual situation.
9. Before student returns to school, initiate re-entry plan.

F. PROCESS FOR RE-ENTRY TO SCHOOL AFTER EXTENDED ABSENCE OR HOSPITALIZATION

Students “need considerable support and monitoring, especially during the first several months they are back at school, during any school crisis, or near the anniversary of their attempt or mental health crisis” (SAMHSA Toolkit). It is critical to create or review the Safety Plan at the first 'return to school meeting' with the student and parents. (See Attachment 2.14, “Guidelines for Facilitating a Student’s Return to School”, and Attachment 2.15, “Guidelines for When a Student Returns to School Following Absence for Suicidal Behavior”) A student is at increased risk of attempting suicide in the days and weeks immediately following discharge from the ER, hospital or care facility.

Important points to remember in facilitating a successful student re-entry:

- 1.** Work with student, family, and relevant staff (counselor and school psychologist) to create an individualized re-entry plan (IRP) before the students return. A meeting with family and student is strongly recommended before the student returns to school.
- 2.** Ensure that the appropriate staff (school psychologist, counselor, administrator) has the pertinent information from the student's doctor, psychiatrist, psychologist or therapist necessary to create the student's IRP.
- 3.** The IRP will be based on Doctor or Mental Health Provider recommendation using Attachment 2.10, "Health and Education Plan - Physician Report" to support the student's psychological and educational needs.
- 4.** Details of the student's mental health history should be shared only as needed to support the student's successful re-entry.
- 5.** A completion of Attachment 2.10, "Health and Education Plan - Physician Report" and Attachment 2.9, "Referral, Consent and Follow-Up Form" is strongly recommended before re-entry.

ATTACHMENTS FOR SECTION II: INTERVENTION

- 2.1 SELF-INJURY AND SUICIDE RISK INFORMATION SHEET, *SAMHSA Toolkit*
- 2.2 SUICIDE PREVENTION AWARENESS SESSION APPROPRIATE FOR ALL SCHOOL PERSONNEL (*MYSPP*)
- 2.3a SUICIDE RISK ASSESSMENT FORM
- 2.3b CONCERN FORM FOR ELEMENTARY LEVEL
- 2.4 CRISIS INTERVENTION PROTOCOL CHECKLIST AND FLOW CHARTS
- 2.5 GUIDELINES FOR NOTIFYING PARENTS, *SAMHSA Toolkit*
- 2.6 PARENT CONTACT ACKNOWLEDGEMENT FORM, *SAMHSA Toolkit*
- 2.7 GUIDELINES FOR STUDENT REFERRALS, *SAMHSA Toolkit*
- 2.8 REFERRAL PROCESS FOR SPECIAL EDUCATION MENTAL HEALTH ASSESSMENT
- 2.9 REFERRAL, CONSENT, AND FOLLOW-UP FORM
- 2.10 HEALTH AND EDUCATION PLAN – PHYSICIAN REPORT
- 2.11 SAFETY PLANNING GUIDE: A QUICK GUIDE FOR CLINICIANS, *WICHE & SPRC*
- 2.12 SAMPLE PERSONAL SAFETY PLAN (*to be used with attachment 2.11*)
- 2.13 STUDENT SUICIDE RISK DOCUMENTATION FORM, *SAMHSA Toolkit*
- 2.14 GUIDELINES FOR FACILITATING A STUDENT’S RETURN TO SCHOOL, *SAMHSA Toolkit*
- 2.15 GUIDELINES FOR WHEN A STUDENT RETURNS TO SCHOOL FOLLOWING ABSENCE FOR SUICIDAL BEHAVIOR
- 2.16 OTHER ISSUES AND OPTIONS SURROUNDING A STUDENT’S RETURN TO SCHOOL, *MYSPP*
- 2.17 CHILD AND ADOLESCENT PSYCHIATRIC HOSPITALS
- 2.18 MEANS RESTRICTION
- 2.19 SUICIDE CONTAGION AND CLUSTERS

SELF-INJURY AND SUICIDE RISK INFORMATION SHEET

Self-injury (also known as self-mutilation or deliberate self-harm) is defined as intentionally and often repetitively inflicting socially unacceptable bodily harm to oneself without the intent to die. Selfinjury includes a wide variety of behaviors, such as cutting, burning, head banging, picking or interfering with healing of wounds, and hair pulling.

The relationship between self-injury and suicide is complicated. Researchers believe self-injury is a behavior separate and distinct from suicide and the result of a very complex interaction among cognitive, affective, behavioral, environmental, biological, and psychological factors. However, in some people the self-destructive nature of self-injury may lead to suicide.

Students who injure themselves intentionally should be taken seriously and treated with compassion. Teachers or other staff who become aware of a student who is intentionally injuring himself or herself should refer the student to the school counselor, psychologist, social worker, or nurse. Staff should offer to accompany the student to the proper office and help broach the issue with the relevant mental health professional.

School mental health staff should:

- Assess the student for both self-injury and risk of suicide
- Notify and involve the parents/guardians
- Design appropriate treatment for the student's current behaviors or refer the student to a mental health provider in the community for treatment

The following resource can be used to understand and prepare to respond to self-injury by students:

- Cornell Research Program on Self-Injurious Behavior in Adolescents and Young Adults. Web site contains numerous informational materials: <http://www.selfinjury.bctr.cornell.edu/>

Developed in consultation with Richard Lieberman MA, NCSP
School Psychologist/Coordinator
Los Angeles Unified School District, Suicide Prevention Unit

From Preventing Suicide: A Toolkit for High Schools, SAMHSA

SUICIDE PREVENTION AWARENESS SESSION APPROPRIATE FOR ALL SCHOOL PERSONNEL

A one and one-half to two-hour workshop provides enough time to share basic information, teach and practice basic suicide intervention skills. All school personnel will benefit from having this basic information.

This section outlines the contents of the basic youth suicide prevention workshop. Training and resource materials to conduct a session are available from the **MYSPP**.

The Problem of Youth Suicide in California

- Suicide is the 2nd leading cause of death for American youth ages 15-25, exceeded only by unintentional injury (mostly car accidents).
- In 2010, there were 150 suicides among youth ages 15-19 in California: 114 males and 36 females.
- In 2010, there were 279 suicides among youth ages 20-24 in California: 227 males and 52 females.
- In 2011, there were 6,341 non-fatal suicide attempt ER visits (treat and release or transfer to another care facility) among youth ages 15-19 in California: 2,249 males and 4,092 females. In Santa Clara County, there were 235 visits: 73 males and 162 females.
- In 2011, there were 2,004 non-fatal suicide attempt hospitalizations for youth ages 15-19 in California: 678 males and 1,326 females. In Santa Clara County, there were 81 hospitalizations: 23 males and 58 females.
- In 2011, there were 4,512 non-fatal suicide attempt ER visits among youth ages 20-24 in California: 2,060 males and 2,452 females. In Santa Clara County, there were 156 visits: 63 males and 93 females.
- In 2011, there were 1,900 non-fatal suicide attempt hospitalizations for youth ages 20-24 in California: 889 males and 1,011 females. In Santa Clara County, there were 73 hospitalizations: 27 males and 46 females.

Source: California Department of Public Health Epicenter, California Injury Data Online

A Few Basic Facts About Suicide

- Contrary to popular belief, talking about suicide or asking someone if they feel suicidal will NOT put the idea in their head or cause them to kill themselves.
- Research has demonstrated that in over 80% of suicides, warning signs were given.
- Suicide crosses all socioeconomic backgrounds.
- It is NOT true that "once a person is suicidal, s/he is always suicidal." People can receive help to make other choices.
- Suicide IS often preventable. Not every death is preventable, but many are.
- Suicidal behavior should not be dismissed as "attention getting" or "manipulative"; it may be a serious cry for help. People who talk about suicide DO kill themselves.
- We must take every threat seriously.
- Most suicidal youth do not really want to die; they want to escape their pain and may see no other alternative course of action.
- Youth who are discriminated against or victimized because of physical differences, sexual orientation, or other reasons are at higher risk for attempting suicide.
- Any trained individual can greatly increase the likelihood of a youth getting the help they need and may very well make the difference between life and death.
- A previous suicide attempt is the single greatest predictor of future suicidal behavior.

A Complicated Human Behavior

Suicide is a rare event. While many think about it, far less than 1% of the population kill themselves. This information is important and reassuring because it provides us with a measure of hope. If we can learn to recognize the warning signs, and gain confidence in our ability to intervene with suicidal youth, we may be able to prevent many youth suicides.

Here Is What We Know:

- There is no typical suicide victim.
- There are no absolute reasons for suicide.
- Suicide is always multi-dimensional.
- Preventing suicide must involve many approaches and requires teamwork.
- Most suicidal people do not want to die; they do want to end their pain.

Suicidal People Share Some Unique Characteristics:

- A suicidal person sees suicide as the "solution" to his or her problems.
 - Efforts to discuss alternative solutions can be lifesaving.
- A suicidal person is in crisis. Suicidal people are experiencing severe psychological distress. They need help in handling the crisis.
- Almost all suicidal people are ambivalent, they wish to live, AND they wish to die. We **MUST** support the side that wants to live and acknowledge the part that wants to die. Talking about these mixed feelings lowers anxiety. Listening and caring may save a life.
- Suicidal thinking is frequently irrational. Depression, anxiety, psychosis, drugs, or alcohol often distorts the thought process of people when they are feeling suicidal.
- Suicidal behavior is an attempt to communicate. It is a desperate reaction to overwhelming circumstances. We need to pay attention!

Warning Signs

Listen and look for these warning signs for suicidal behavior. Warning signs are the earliest detectable signs that indicate heightened risk for suicide **in the near-term** (i.e., within minutes, hours, or days), as opposed to risk factors which suggest longer-term risk (i.e., a year to a lifetime). Note that aside from direct statements or behaviors threatening suicide, it is often a group of signs that raises concern, rather than one or two symptoms alone. These are presented in a hierarchical manner, organized by degree of risk, and were developed by an expert working group convened by the American Association of Suicidology.

Warning signs are things you can see or hear that tell you someone may be suicidal today. If you notice any of these things you need to act quickly. In all cases, do **NOT** leave the person alone.

Take immediate action and call the Santa Clara County Suicide and Crisis Hotline (1-855-278-4204) if:**Someone makes a threat to kill themselves by saying:**

- I wish I were dead
- If such and such doesn't happen, I'll kill myself
- What's the point of living?

Someone is looking for a way to carry out a suicide plan

- They are looking for a gun, pills or other ways to kill themselves
- They have a plan about where they can get these things

Someone is talking or writing about death or suicide

- In text messages
- On social networking sites
- In poems, music

Call 911 if:

- A suicide attempt has been made
- A weapon is present
- The person is out of control

Get professional help if you notice any of the following:**Signs of Depression:**

- Mood: sad, irritable, angry
- Withdrawing from friends, family, activities
- Significant change in sleep, appetite or weight
- Hopelessness: sees no chance of improvement
- Feeling worthless or excessively guilty
- Unable to think or concentrate

Anxiety: Restlessness, agitation, pacing

Feeling like a burden, people would be better off if I were dead

Alcohol or Drug use is increased or excessive

Feeling trapped with no way out of the situation

Neglecting appearance

Drop in grades or increased absences

These are all signs that something is wrong and that help is needed.

Risk Factors

Risk factors are stressful events, situations, or conditions that exist in a person's life that may increase the likelihood of attempting or dying by suicide. There is no predictive list of a particular set of risk factors that spells imminent danger of suicide. It is important to understand that risk factors DO NOT cause suicide. Many things can increase someone's risk for suicide. "Risk Factors" may be things that happened in the past or are happening now that cause stress and make it hard to cope. Suicide is not caused by just one thing and these risk factors affect everyone in different ways.

Risk factors most strongly linked with suicidal behavior are:

- One or more suicide attempts (this is strongly linked to future suicide risk)
- Mental illness
- Exposure to suicide
- Access to firearms or other lethal means
- Loss of any kind
- A history of abuse or trauma

Other common risks factors are:

- Acting on impulse
- Bullying and harassment
- Substance abuse
- Lack of coping or problem solving skills

Protective Factors:

Protective factors are the positive conditions, personal and social resources that promote resiliency and reduce the potential for youth suicide as well as other high-risk behaviors. For youth these can be:

Coping Skills and Personal Traits

- Decision making, anger management, conflict resolution, problem solving and other skills
- A sense of personal control
- A healthy fear of risky behavior and pain
- Hope for the future

Connections

- Religious/spiritual beliefs about the meaning and value of life
- Positive relationships with family, friends, school, or other caring adults
- Responsibilities at home or in the community

Health and Home

- A safe and stable environment
- Not using drugs and alcohol
- Access to health care
- Taking care of self

HELPING SUICIDAL YOUTH**Three Steps to Help a Suicidal Person:****1. Show you care**

- Listen carefully, remain calm, don't judge
- "I'm concerned about you... about how you're feeling."
- "You mean a lot to me and I want to help."

2. Ask about suicide

- Be direct and caring
- "Are you thinking about killing yourself?"
- "When people are in as much pain as you seem to be, they sometimes think about suicide. Are you thinking about suicide?"

3. Persuade the suicidal person to get help and make sure that they get it

- Never leave a suicidal person alone
- "I know where we can get some help."
- "I can go with you to get help, you're not alone."

If you believe a person might be in danger of suicide, make sure they receive the help they need. Call the Santa Clara County Suicide & Crisis Hotline 1-855-278-4204 for an evaluation or 911 to ensure their immediate safety.

WHAT IS NOT HELPFUL WHEN WORKING WITH SOMEONE WHO MIGHT BE SUICIDAL

- **Ignoring or dismissing the issue.** This sends the message that you don't hear their message, don't believe them, or you don't care about their pain.
- **Acting shocked or embarrassed.**
- **Panicking, preaching, or patronizing.**
- **Challenging, debating, or bargaining.** Never challenge a suicidal person. You can't win in a power struggle with someone who is thinking irrationally.
- **Giving harmful advice,** such as suggesting the use of drugs or alcohol to "feel better." There is a very strong association between alcohol use and suicide.
- **Promising to keep a secret.** The suicidal person is sharing his/her feelings hoping that someone will recognize the pain and help, even though they may verbally contradict this.

Resources for Help

It is necessary to maintain lists of resources available for use by school personnel so that they know exactly who to contact when they are working with a student who might be suicidal. Generate your own list with local and state contact information. Update this list regularly.

It's important to get a suicidal person help so that they:

- Get through the crisis without harm
- Know that hope exists
- See that there are other options
- Identify and obtain available help

School Resources for Help

- School Administrators
- School Nurses
- School Gatekeepers (trained to recognize and respond to suicidal behavior)
- Social Workers & Guidance Counselors
- School Resource Officers

Community Resources

- **Santa Clara County 24/7 Suicide and Crisis Hotline 1-855-278-4204**
- National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- Mental Health Agencies
- Private Clinics/facilities
- Hospital emergency rooms
- Police
- Local Religious Leaders
- Emergency Medical Services

Examples of SF Bay Area Crisis Resources

SELECTED SF Bay Area RESOURCES ON MENTAL HEALTH AND RESILIENCE

HELPFUL NUMBERS

24-hour Suicide and Crisis Line (Santa Clara County) 650-494-8420 or 408-279-3312

Uplift Family Services (UFS) Crisis Team (Santa Clara County) 408-379-9085 or 877-412-7474

Star Vista Crisis Line (San Mateo County): 650-579-0350

NAMI Santa Clara Warm line: 408-435-0400, option 1

NAMI San Mateo Warm line: 650-638-0800

National Suicide Prevention Lifeline: 1-800-273-TALK (8255) Suicide prevention telephone hotline funded by the U.S. government. Provides free, 24-hour assistance.

Rape Crisis Hot Line (24 hour): 650.493.7273

MENTAL HEALTH ORGANIZATIONS AND RESOURCES

HEARD Alliance (heardalliance.org): Collaborative among healthcare agencies, schools and providers in the SF Bay Area; Contains useful resources and websites on mental health

Project Safety Net Palo Alto (psnpaloalto.com)

Jed Foundation (Devoted to college mental health & suicide prevention): <http://www.Jedfoundation.org>

NAMI (Nat'l Alliance on Mental Illness) {nami.org; family support and advocacy}

American Foundation for Suicide Prevention (AFSP): <http://www.afsp.org/>

Suicide Prevention Resource Center (SPRC): <http://www.sprc.org/>

SELECTED RESOURCES ON MENTAL HEALTH AND RESILIENCE

Stanford Center for Youth Mental Health and Wellbeing: <https://med.stanford.edu/psychiatry/special-initiatives/youthwellbeing.html>

NAMI's booklet entitled "What Families Should Know About Adolescent Depression and Treatment Options" http://www.nami.org/Content/ContentGroups/CAAC/Family_Guide_final.pdf

The parent page for The Society for the Prevention of Teen Suicide: <http://www.sptsnj.org/parents/>

National Bullying Information: <https://www.stopbullying.gov/>

Bullying and Cyberbullying Resources for Schools, Youth and Families: <https://www.adl.org/education/resources/tools-and-strategies/bullying-and-cyberbullying-prevention-strategies>

Take Care of Yourself--- Working with Suicidal People is Challenging

- Acknowledge the intensity of your feelings.
- Seek support.
- Avoid over-involvement. It takes a team of people to help a suicidal individual.
- Never do this work on your own. Always inform your supervisor or other designated person as outlined in school protocol.
- Recognize that you are not responsible for another person's choice to end his/her life.

from the Maine Youth Suicide Prevention Program

STUDENT SUICIDE RISK ASSESSMENT FORM

Student's Name: _____ Referred by: _____

Person Conducting Assessment: _____ Date: _____

1. Circumstances preceding referral for suicide risk assessment/summary of reason for concern:

2. Stressors/precipitants from student's perspective (*i.e. What's going on in your life right now?*):

3. Current and Recent Mood

a. *On a scale of 0-10 (0 being the worst and 10 the best), how have you been feeling over the **past week**? Have you been feeling depressed, hopeless, helpless, or overwhelmed?*

b. *How would you describe how you are feeling **right now**?*

4. Current Ideation

a. Assess student's current level of suicidal ideation:

	Yes	No	Unsure
<i>In the past few weeks, have you wished you were dead?</i>			
<i>Have you felt that you or your family would be better off if you were dead?</i>			
<i>Have you felt that your life is not worth living?</i>			
<i>Have you been thinking about ending your life or killing yourself?</i>			

If yes or unsure for any of the above:

b. *How long have you been feeling this way?*

c. *Have you thought about ending your life **today or very soon**?*

5. Plan

a. *Do you have a plan for how you would end your life?*

D Yes/detailed and thought-out

D Considering means/details are vague

D No/thoughts of death without consideration of how they would kill themselves

b. *If yes or considering: What is your plan (including how, when, where)?*

6. Means

a. *Do you have access now to whatever you need to carry out your plan? If yes: Where?*

7. Intent

a. *Do you intend to carry through with your plan to end your life soon?*

D Denies intent

D Endorses intent

D Unclear/Passive

D Evasive in answering question

b. *Do you intend to end your life if something does or doesn't happen? Is there anything that would make you more likely to want to end your life?*

c. *Is there anything that would make you more likely to want to live?*

8. History of Suicidal Ideation/Attempts

a. *Have you ever thought about attempting suicide in the past?*

D No

D Yes. When? _____

b. *Have you ever attempted suicide before?*

D No

D Yes

If **yes**, description of past attempt(s), including trigger for attempt, how student attempted, and what happened:

9. Resources/Support

a. *Do you have someone in your life whom you can turn to for support?*

D No, feels isolated.

D Yes. *Who?* _____

b. If yes: *Have you talked to them about how you are feeling?*

D Yes

D No. *Why not?* _____

Determining Protocol to Follow:

- **Low Risk Protocol:** Student demonstrates suicidal ideation (#4), but does NOT have a detailed plan (#5), access to means (#6), or intent to attempt (#7). History of ideation/attempts, detailed plan, ambiguous intent, or lack of support increases risk to Moderate to High Risk.
- **Moderate to High Risk Protocol:** Student demonstrates suicidal ideation (#4) with some combination of planning (#5), access to means (#6), intent (#7), history of ideation/attempts (#8), and/or lack of support (#9).
- **Extremely High Risk Protocol:** Student reports ready access to or possession of means (#6) and strong intent to carry out plan as soon as possible (#7).

Concern Form for Elementary Level

Student _____ Grade _____ DOB _____
School _____
School Year _____

Reason for Concern _____

REFERRING STAFF:

#1 _____

Print Staff Name

Signature

Phone _____

Fax _____ Email _____

#2 _____

Print Staff Name

Signature

Phone _____

Fax _____ Email _____

Parent/Caregiver 1: _____

Name

Phone

Email

Relationship: Biological parent Relative Other: _____

Address: _____

Parent/Caregiver 2: _____

Name

Phone

Email

Relationship: Biological parent Relative Other: _____

Address: _____

Does the student have a 504 Plan? Yes No

Does the student have an IEP? Yes No

Significant social or family information (including family history of mental health or learning disorders): _____

Other services student is receiving or has received inside or outside school: _____

PARENT: I CONSENT to communication and exchange of information between referring staff and doctors: *(Ed Code 49423.1)*

Dr. _____ Location or

Clinic _____

Phone _____ Fax _____

Email _____

Dr. _____ Location or

Clinic _____

Phone _____ Fax _____

Email _____

Parent/Guardian Signature

Date

Check all behaviors that apply:

Check all risk factors that apply:

<input type="checkbox"/> Appears Distracted	<input type="checkbox"/> Attendance
<input type="checkbox"/> Diminished interest in activities	<input type="checkbox"/> Behavior
<input type="checkbox"/> Low or decreased motivation	<input type="checkbox"/> Trauma
<input type="checkbox"/> Anxious or fearful	<input type="checkbox"/> Recent Loss
<input type="checkbox"/> Irritable mood	<input type="checkbox"/> Family history of mental health
<input type="checkbox"/> Other:	<input type="checkbox"/> Learning Issue
	<input type="checkbox"/> Other:

Has the student experienced and/or been exposed to any of the following:

<input type="checkbox"/> Exposed to domestic violence, abuse, etc.	<input type="checkbox"/> Hallucinations: <input type="checkbox"/> Auditory <input type="checkbox"/> Visual
<input type="checkbox"/> Exposed to community violence, other trauma	<input type="checkbox"/> Irritable Mood
<input type="checkbox"/> Nightmares, intrusive thoughts	<input type="checkbox"/> Feeling overwhelmed
<input type="checkbox"/> Anxious or fearful	<input type="checkbox"/> Family conflict: divorce
<input type="checkbox"/> Jumpy or easily startled	<input type="checkbox"/> Frequent fighting at home, arguments
<input type="checkbox"/> Avoids reminders of trauma	<input type="checkbox"/> Community agency involvement
<input type="checkbox"/> Aggressive or sexualized play/behaviors	<input type="checkbox"/> Physical trauma e.g. head injury
<input type="checkbox"/> Difficulty concentrating/appears distracted	<input type="checkbox"/> Other:
<input type="checkbox"/> Other:	

Check areas of difficulty:

Does it interfere with everyday life:

Emotions	Concentration	Behavior-getting along	Peer Relationships	Classroom Learning
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> Not apparent	<input type="checkbox"/> Not apparent
<input type="checkbox"/> Yes-Minor	<input type="checkbox"/> Yes-Minor	<input type="checkbox"/> Yes -Minor	<input type="checkbox"/> Yes-Minor	<input type="checkbox"/> Yes -Minor
<input type="checkbox"/> Yes-Definite	<input type="checkbox"/> Yes -Definite	<input type="checkbox"/> Yes -Definite	<input type="checkbox"/> Yes -Definite	<input type="checkbox"/> Yes -Definite
<input type="checkbox"/> Yes-Severe	<input type="checkbox"/> Yes -Severe	<input type="checkbox"/> Yes -Severe	<input type="checkbox"/> Yes -Severe	<input type="checkbox"/> Yes -Severe

If you answered yes to any of the above, how long has it been a problem?

<input type="checkbox"/> Less than a month	<input type="checkbox"/> 1-5 months	<input type="checkbox"/> 6-12 months	<input type="checkbox"/> Over a year
--	-------------------------------------	--------------------------------------	--------------------------------------

Student behavior over the last 6 months or this school year

Please mark check boxes →	Not True	Somewhat True	True
Considerate of other's feelings			
Shares readily with other children – example: toys, treats, pencils			
Has at least one good friend			
Generally liked by other children			
Generally well behaved, usually does what adults request			
Kind to younger children			
Often offers to help others			
Thinks things out before acting			
Helpful if someone is hurt, upset, or feeling ill			
Good attention span, sees work through to the end			
Fights or is aggressive with other children or picks on them			
Often unhappy, or sad affect			
Often lies or cheats			
Picked on by other children			
Steals from home, school or elsewhere			
Gets along better with adults than with other children			
Many fears, easily scared			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach aches, or sickness			
Often loses temper, irritable, argumentative or defiant			
Rather solitary, prefers to play alone			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Many worries, or often seems worried			

Angry towards others, blames others			
Disorganized, makes careless mistakes			
Inattentive, distractible, forgetful			
Interrupts and/or blurts out responses			
Talks excessively			
Withdrawn			
Loss of appetite			
Reduced activity during recess			
Self-centered, excessively preoccupied with personal prestige, power, adequacy			
Lack of impulse control			
Other:			

Concern Form - Student Interview

Are you ever worried or afraid?

For how long?

What do you worry about?

How does it make you feel?

Have your eating or sleeping habits changed?

How long has this been going on?

Do you ever feel very sad?

What makes you sad?

How long have you felt this way?

Do you cry a lot?

What makes you cry?

How long have you been feeling this way?

Do you have someone at school to talk to when you feel bad? Who is this person?

Do you have someone at home to talk to when you feel bad? Who is this person?

Does talking to this person make you feel better?

Interventions that have been tried:

<input type="checkbox"/> Classroom modification	<input type="checkbox"/> Communication with parents
<input type="checkbox"/> Classroom accommodations	<input type="checkbox"/> IEP Meeting
<input type="checkbox"/> Behavioral referral	<input type="checkbox"/> 504 Plan
<input type="checkbox"/> On-site school counseling	<input type="checkbox"/> Consultation with private providers
<input type="checkbox"/> School intervention:	
<input type="checkbox"/> Other:	

Comments: _____

Next Steps: _____

Referral: _____

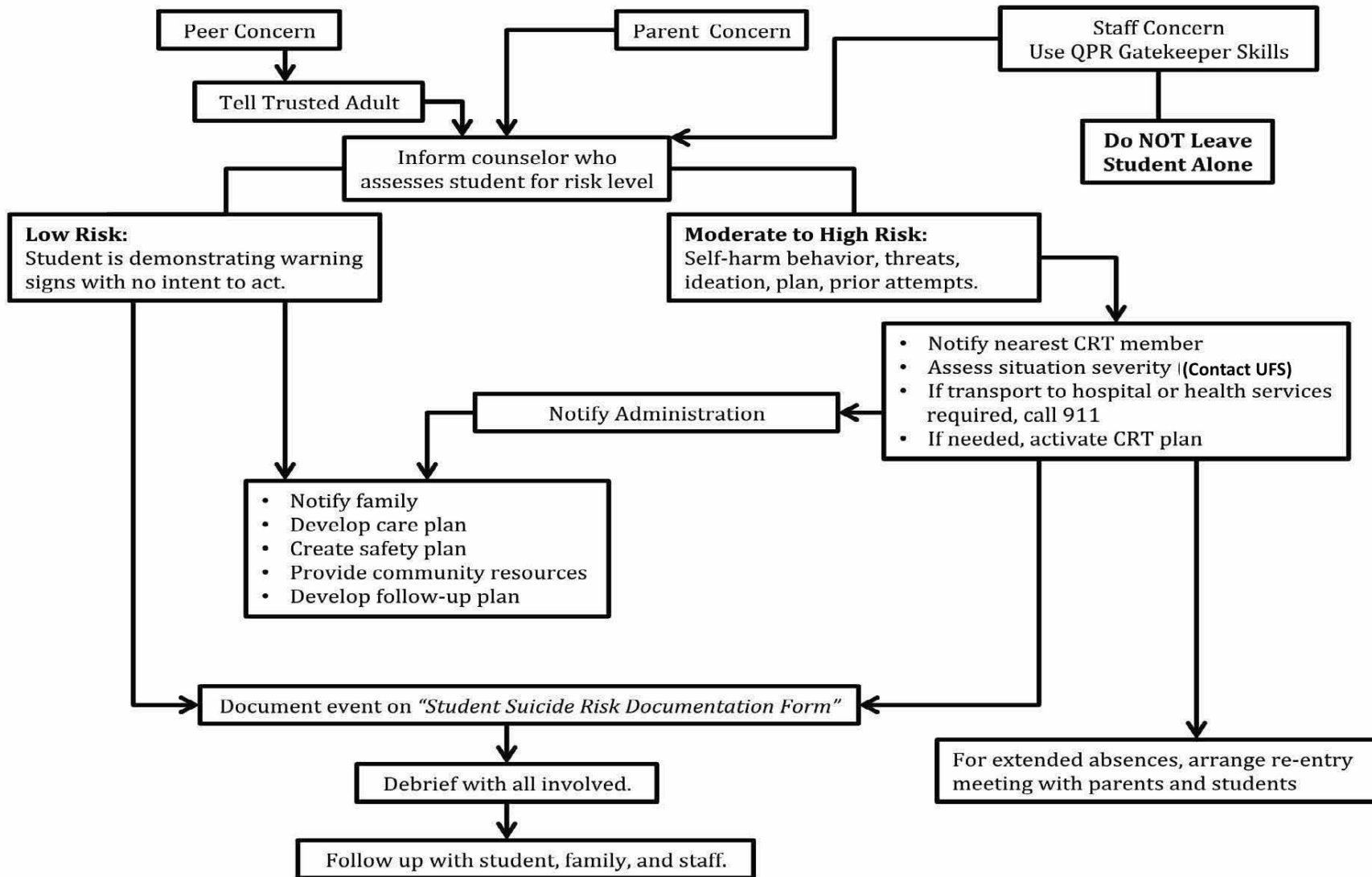
Plans for follow-up: _____

Crisis Response Checklist

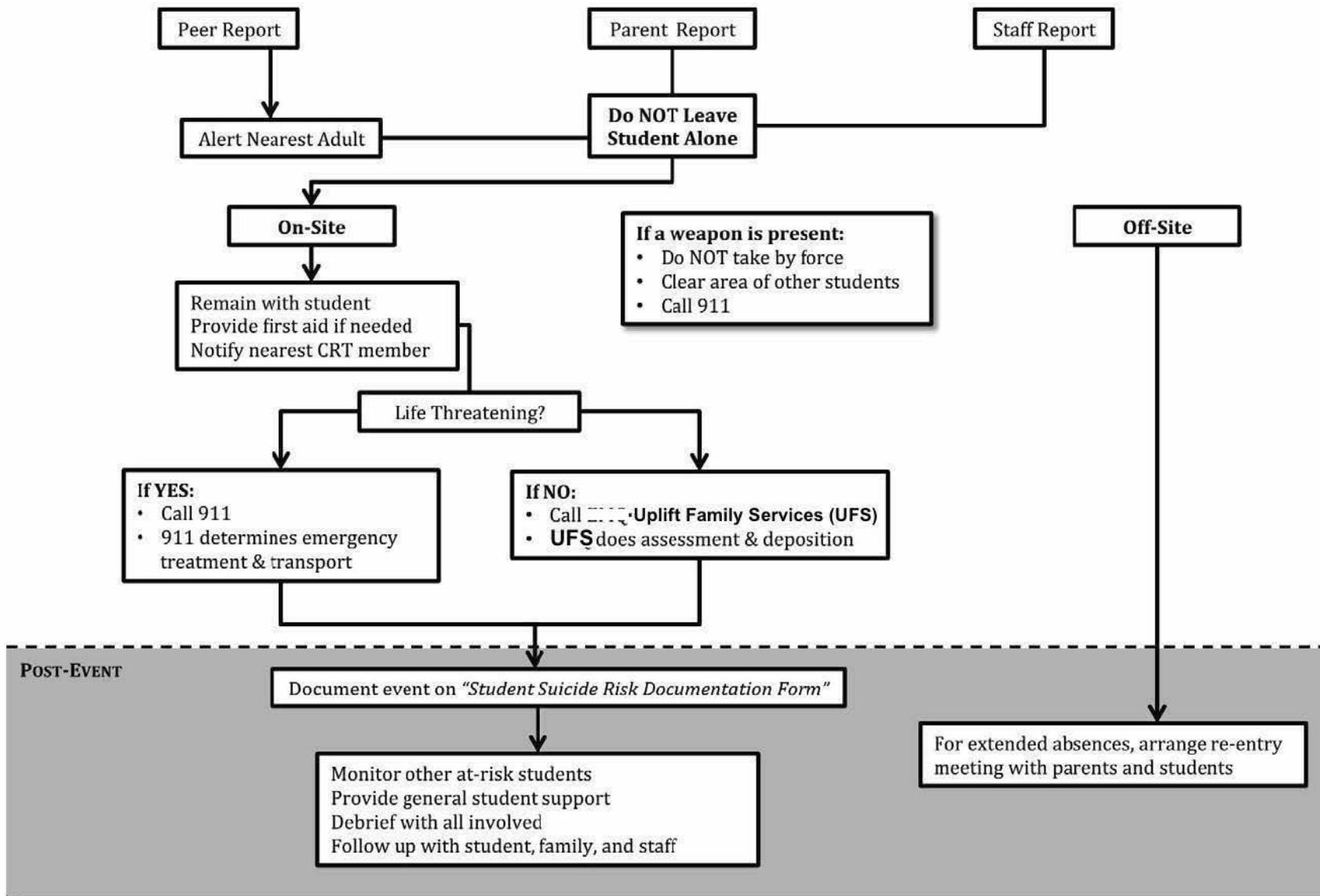
Steps to Take in a Crisis	Staff Responsible and Back-Up	External Contacts	Phone Number
Low Risk Level			
1. Take every warning sign seriously	All		
2. Remain with student	1st Responder		
3. Send someone to inform counselor	1st Responder		
4. Notify parent/guardian	counselor and/or psychologist		
5. Develop safety plan with student and parent	counselor and/or psychologist		
6. Refer to mental health services	counselor and/or psychologist		
7. Document actions	All (counselor)		
8. Follow up with student and family	Counselor		
Moderate to High Risk Level			
1. Remain with student to ensure safety	1st Responder		
2. Send someone to notify nearest CRT member	1st Responder		
3. Move other students to safe area	All		
4. Evaluate situation and notify administration	CRT Member		
5. Conduct suicide risk assessment	Counselor and/or psychologist		
6. Notify parent/guardian of situation	Counselor and/or psychologist		
7. If no hospitalization required, create safety plan with student and parent (see High Risk if hospitalized)	Counselor and/or psychologist		
8. Confirm understanding of next steps	Counselor and/or psychologist		
9. Discuss means restriction	Counselor and/or psychologist		
Get signed "Medical Release, Referral, and Follow Up" Form	Counselor and/or psychologist		
11. Provide referrals and resources	Counselor and/or psychologist		
12. Discuss school personnel follow-up while student is away	Counselor		
13. Arrange for classwork completion at home	Counselor		
14. Document actions	All		
15. Debrief staff involved in intervention	CRT Leader		
Extremely High Risk Level			
1. Do not leave student alone	1st Responder		
2. Do not attempt to remove lethal means by force	All		
3. Clear area and ensure safety of all other students	All		
4. Notify nearest CRT member	All		
5. Mobilize community links	Psychologist and/or counselor or other member	911/UFS	911/UFS
6. Notify parents about seriousness of situation	School Psychologist		
Student Re-entry			

1. Ensure appropriate personnel have pertinent information needed to create a re-entry plan	Counselor and/or psychologist		
2. With student and family create individualized re-entry plan	Counselor and/or psychologist		
3. Ensure staff discussion is limited to student's treatment and educational support needs			

SUICIDE INTERVENTION PROTOCOL FLOWCHART: LOW, MODERATE & HIGH RISK
 STUDENT HAS DEMONSTRATED RISK FOR SUICIDE



SUICIDE INTERVENTION PROTOCOL FLOWCHART: EXTREME RISK
 STUDENT ATTEMPTS SUICIDE OR HAS MEANS ON PERSON



GUIDELINES FOR NOTIFYING PARENTS

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

1. Notify the parents about the situation and ask that they come to the school immediately.
2. When the parents arrive at the school, explain why you think their child is at risk for suicide.
3. Explain the importance of removing from the home (or locking up) firearms and other dangerous items, including over-the-counter and prescription medications and alcohol.
4. If the student is at a low or moderate suicide risk and does not need to be hospitalized, discuss available options for individual and/or family therapy. Provide the parents with the contact information of mental health service providers in the community. If possible, call and make an appointment while the parents are with you.
5. Ask the parents to sign the Parent Contact Acknowledgement Form confirming that they were notified of their child's risk and received referrals to treatment.
6. Tell the parents that you will follow up with them in a few days. If this follow-up conversation reveals that the parent has not contacted a mental health provider:
 - Stress the importance of getting the child help
 - Discuss why they have not contacted a provider and offer to assist with the process
7. If the student does not need to be hospitalized, release the student to the parents.
8. If the parents refuse to seek services for a child under the age of 18 who you believe is in danger of self-harm, you may need to notify child protective services that the child is being neglected.
9. Document *all* contacts with the parents.

Adapted from DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Guidelines'%2010-2009--w%20discl.pdf>

SUPPORTING PARENTS THROUGH THEIR CHILD'S SUICIDAL CRISIS

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

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

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

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

The following steps can help support and engage parents:

1. Invite the parents' perspective. State what you have noticed in their child's behavior (rather than the results of your assessment) and ask how that fits with what they have observed.
2. Advise parents to remove lethal means from the home while the child is possibly suicidal, just as you would advise taking car keys from a youth who had been drinking.
3. Comment on how scary this behavior is and how it complicates the life of everyone who cares about this young person.
4. Acknowledge the parents' emotional state, including anger, if present.
5. Acknowledge that no one can do this alone--appreciate their presence.
6. Listen for myths of suicide that may be blocking the parent from taking action.
7. Explore reluctance to accept a mental health referral, address those issues, explain what to expect.
8. Align yourself with the parent if possible...explore how and where youth get this idea...without in any way minimizing the behavior.

Adapted from DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicide/docs/Guidelines'%2010-2009--w%20discl.pdf>

SAMPLE - PARENT CONTACT ACKNOWLEDGEMENT FORM

Student Name: _____ Date of Birth: _____

School: _____ Grade: _____

This is to verify that I have spoken with a member of the school's mental health staff

_____ (name) on _____ (date) concerning my child's suicidal risk. I have been advised to seek the services of a mental health agency or therapist immediately.

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

Parent Signature: _____

Date: _____

Parent Contact Information:

Phone: _____

Email: _____

School Staff Member Signature: _____

Date: _____

From DiCara, C., O'Halloran, S., Williams, L. & Canly-Brooks, C. (2009). Youth Suicide Prevention, Intervention & Postvention Guidelines (p.45). Augusta, ME: Maine Youth Suicide Prevention Program.

GUIDELINES FOR STUDENT REFERRALS

Schools should be prepared to give the following information to providers.

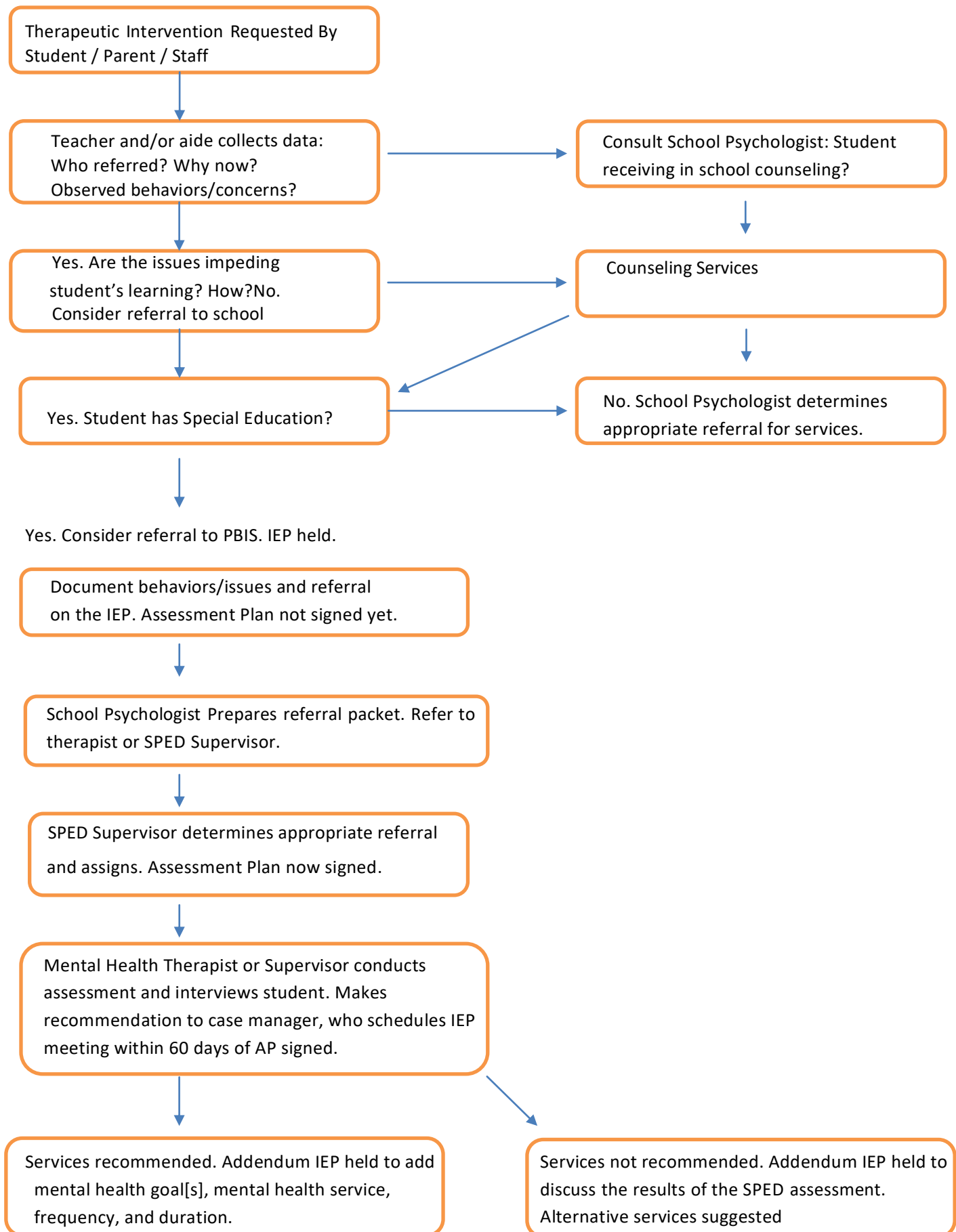
Note: Parent permission may be required to share this information.

1. Basic student information (age, grade, race/ethnicity, and parents' or guardians' names, addresses, and phone numbers).
2. How did the school first become aware of the student's potential risk for suicide? *
3. Why is the school making the referral?
4. What is the student's current mental status?
5. Are the student and parents/guardians willing or reluctant to meet with a mental health service provider?
6. What other agencies are involved (names and information)?
7. Who pays for the referral and possible treatment?
8. Where is the best place to meet with the student (e.g., school, student's home, therapist's office, emergency room)?

** Be sure that parental consent meets the requirements of FERPA as follows:*

1. *Specify the records that may be disclosed.*
2. *State the purpose of the disclosure.*
3. *Identify the party or class of parties to whom the disclosure may be made.*

SAMPLE REFERRAL PROCESS FOR SPECIAL EDUCATION MENTAL HEALTH ASSESSMENT



REFERRAL, CONSENT & FOLLOW-UP FORM

HEALTH SERVICES AND SPECIAL EDUCATION

Referring Staff: _____ EMAIL: _____ Referral Date: _____
 Signature (required): _____ PHONE: _____ Fax Number: _____

I. GENERAL INFORMATION

Student: _____ DOB _____ Age: _____
 Address: _____ Phone: _____ Sex:
 School: : _____ Grade: _____ Primary Language: : _____

II. PLEASE PROVIDE THE FOLLOWING CONFIDENTIAL INFORMATION FOR THE STUDENT NOTED ABOVE:

<input type="checkbox"/> PSYCHOLOGICAL	<input type="checkbox"/> PSYCHIATRIC HISTORY
<input type="checkbox"/> MEDICAL	<input type="checkbox"/> LEGAL STATUS
<input type="checkbox"/> HEALTH AND DEVELOPMENT	<input type="checkbox"/> DIAGNOSIS
<input type="checkbox"/> EDUCATIONAL	
<input type="checkbox"/> OTHER:	

III. TO BE COMPLETED BY PARENT/GUARDIAN: I CONSENT TO COMMUNICATION AND EXCHANGE OF INFORMATION BETWEEN DR. _____ PHONE # _____ AND District STAFF TO DISCUSS AND SHARE RECORDS & CONDITIONS PERTAINING TO THE ABOVE. THIS INFORMATION IS CONFIDENTIAL AND MAY NOT BE GIVEN TO EMPLOYEES OF OTHER SCHOOLS, PUBLIC AGENCIES, OR INDIVIDUAL PROFESSIONALS IN PRIVATE PRACTICE WITHOUT MY CONSENT.

Parent/Guardian (Student Over 18) Name _____ Date _____
 Parent/Guardian (Student Over 18) Signature _____

This authorization shall be valid until _____ (date). You may provide a date after which no information can be released. If no date is provided, authorization is valid for one year from date of signature. This consent is voluntary.

To revoke this consent, send a copy to the referring person above at _____

I revoke this consent for communication and exchange of information.

I understand that the recipient may not lawfully further use or release the information unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law. In accordance HIPPA, FERPA and applicable California laws, all personal and health information is private and must be protected.

Copy provided to Parent / Guardian

IV. TO BE COMPLETED BY HEALTH CARE PROVIDER OR BEHAVIORAL HEALTH PROVIDER

Diagnosis: _____ Treatment: _____
 Medication(s): _____
 Additional referral: _____ Reason: _____

School staff will contact provider if needed for clarification/recommendations. The information being requested is often personal in nature; therefore person-to-person communication may be best in some cases.

Provider Signature: _____ Print Name: _____
 Fax #: _____ Phone #: _____

Sample - Health and Education Plan - Physician Report

Student _____ Grade _____ DOB _____
 School _____ School Year _____

REFERRING STAFF:

#1 _____ Phone _____ Fax _____
 #2 _____ Phone _____ Fax _____
Print Staff Name Signature
 #3 _____ Phone _____ Fax _____
Print Staff Name Signature

PARENT: I CONSENT to communication and exchange of information between referring staff and doctors:

Dr. _____ Phone _____ Fax _____
 Dr. _____ Phone _____ Fax _____

Parent/Guardian Signature Home Phone Cell Phone Date

HEALTH CARE PROVIDER THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Schools can provide the following and thus accommodate the needs of many pupils at school. Any other recommendations need to be specified. The School Team will determine if a 504 OR IEP is necessary. Please check appropriate boxes below.

*Instruction in the home is one of the most restrictive educational placements, must be viewed as a last resort, and used for the shortest time necessary. Careful completion of the following will assist in determining appropriate placement for the student**

DIAGNOSIS (include additional pages if necessary): _____

Student Should:

- Attend School
- Not Attend School Length of time: Weeks(#) _____ Months(#) _____ EXPECTED DATE OF RETURN: ____/____/____

If student is able to attend school, do they need:

- Modified/Reduced Schedule Until: _____/_____/_____
(DATE REQUIRED)
- Modified PE Until: _____/_____/_____
(DATE REQUIRED) No PE Until: _____/_____/_____
(DATE REQUIRED)

Other Recommendations: _____

Current Medications: _____

If medications need to be given during the school day, complete the Medication Required During School Day/Field Trips Form at _____ (school website)

PRIMARY CARE PROVIDER SIGNATURE PHONE FAX DATE

BEHAVIORAL HEALTH PROVIDER SIGNATURE PHONE FAX DATE

PLEASE RETURN TO THE REFERRING STAFF MEMBER, INDICATED AT THE TOP OF THIS PAGE

CLINIC STAMP - OR PRINT DOCTOR'S NAME HERE

Safety Planning Guide

- ▶ For methods with **low lethality**, clinicians may ask patients to remove or limit their access to these methods themselves.
- ▶ Restricting the patient's access to a **highly lethal method**, such as a firearm, should be done by a designated, responsible person – usually a family member or close friend, or the police.

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

ASSESS the likelihood that the overall safety plan will be used and problem solve with the patient to identify barriers or obstacles to using the plan.

DISCUSS where the patient will keep the safety plan and how it will be located during a crisis.

EVALUATE if the format is appropriate for patient's capacity and circumstances.

REVIEW the plan periodically when patient's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE PATIENT AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE PLAN

THE WICHE Center for Rural Mental Health Research is supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration (HRSA), Public Health Services, Grant Award, U1CRH0373



Western Interstate Commission for Higher Education
3035 Center Green Drive, Suite 200 Boulder, CO 80301-2204
303-541-0200 (ph) 303-541-0291 (fax)
www.wiche.edu/mentalhealth/

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

*A Quick Guide for Clinicians
may be used in conjunction with the "Safety Plan Template"*

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is **brief**, is in the **patient's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.



Western Interstate Commission for Higher Education

Implementing the Safety Plan: 6 Step Process

Step 1: Warning Signs

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

Step 2: Internal Coping Strategies

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

Step 3: Social Contacts Who May Distract from the Crisis

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

Step 4: Family Members or Friends Who May Offer Help

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

Step 5: Professionals and Agencies to Contact for Help

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

Step 6: Making the Environment Safe

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

ATTACHMENT 2.12

SANTA CLARA COUNTY SAMPLE PERSONAL SAFETY PLAN

STEP 1: I should use my safety plan when I notice these warning signs (thoughts, images, moods, situations, behaviors):	
1.	
2.	
3.	
STEP 2: Internal coping strategies – Things I can do by myself to help myself not act on how I’m feeling (e.g. favorite activities, hobbies, relaxation techniques, distractions):	
1.	
2.	
3.	
What might make it difficult for me to use these strategies?	
Solution:	
STEP 3: People and places that improve my mood and make me feel safe:	
1. Name:	Phone:
2. Name:	Phone:
3. Place (day):	
4. Place (night):	
What might get in the way of me contacting these people or going to these places?	
Solution:	
STEP 4: People I trust who can help me during a crisis:	
1. Name:	Phone:
2. Name:	Phone:
3. Name:	Phone:
Why might I hesitate to contact these people when I need help?	
Solution:	
How will I let them know that I need their help?	
STEP 5: Professional resources and referrals I should contact during a crisis (available 24/7):	
1. Clinician Name:	Phone
2. Local Urgent Care Services: Address: Phone:	
3. Santa Clara County Suicide & Crisis Center: 855---278---4204 or Text RENEW to 741741	
4. National Suicide Prevention Lifelines: 1---800---784---2433 and 1---800---273---8255	
5. Uplift Child & Adolescent Mobile Crisis Program: 408---379---9085	
6. Call 911 if you need immediate help in order to remain safe.	
STEP 6: Steps I can take to keep myself safe by reducing access to harmful means if faced with a suicidal crisis:	
1.	
2.	
3.	
STEP 7: Complete this sentence- “The one thing that is most important to me and worth living for is...”	

Note: A phone app is available for creating a personal safety plan at **MY3App.org**
In Crisis? Text **RENEW** to 741741 – Free, 24/7, Confidential

SANTA CLARA COUNTY SAMPLE PERSONAL SAFETY PLAN

Where will I keep this plan so that I can easily find and use it during a crisis?

Student Signature

Date

Parent/Legal Guardian Signature

Date

Support Person Signature

Date

Therapist/Counselor Signature

Date

Therapist/Counselor Signature

Date

*Note: A phone app is available for creating a personal safety plan at **MY3App.org**
In Crisis? Text **RENEW** to 741741 – Free, 24/7, Confidential*

Sample-STUDENT SUICIDE RISK
DOCUMENTATION FORM

STUDENT INFORMATION		
Date student was identified as possibly at risk:		
Name:		
Date of Birth:	Gender:	Grade:
Name of Parent/Guardian:		
Parent/Guardian's Phone Number(s):		
IDENTIFICATION OF SUICIDE RISK		
Who identified student as being at risk? Indicate name where appropriate.		
<input type="checkbox"/> Student him/herself <input type="checkbox"/> Parent: <input type="checkbox"/> Teacher: <input type="checkbox"/> Other staff: <input type="checkbox"/> Student/Friend: <input type="checkbox"/> Other:		
Reason for concern:		
RISK ASSESSMENT		
Assessment conducted by:		
Date of assessment:		
Type of assessment conducted:		
Results of assessment:		
NOTIFICATION OF PARENT/GUARDIAN		
Staff who notified parent/guardian:		
Date notified:		
Parent Contact Acknowledgement Form signed:		
<input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide reason:		
MENTAL HEALTH REFERRAL		
Student referred to:	Date of referral:	
Personal Safety Plan developed with student and parent: _____ (date)		
Mental Health Resources List and Student/Parent Handouts given to:		
<input type="checkbox"/> Student _____ (date) <input type="checkbox"/> Parent/Guardian _____ (date)		
Staff member to conduct follow-up:	Date of follow-up:	

GUIDELINES FOR FACILITATING A STUDENT'S RETURN TO SCHOOL

These guidelines will help staff plan for a student's return to school after a suicide attempt or mental health crisis. In addition to meeting regularly with the student, the staff member facilitating the student's return should do the following:

1. Become familiar with the basic information about the case, including:
 - How the student's risk status was identified
 - What precipitated the student's high-risk status or suicide attempt
 - What medication(s) the student is taking

2. With the family's agreement, serve as the school's primary link to the parents and maintain regular contact with the family:
 - Call or meet frequently with the family
 - Facilitate referral of the family for family counseling, if appropriate
 - Meet with the student and his or her family and relevant school staff (e.g., the school psychologist or social worker) about what services the student will need upon returning to school

3. Serve as liaison to other teachers and staff members, with permission of the family, regarding the student, which could involve the following:
 - Ask the student about his or her academic concerns and discuss potential options
 - Educate teachers and other relevant staff members about warning signs of another suicide crisis
 - Meet with appropriate staff to create an individualized reentry plan prior to the student's return and discuss possible arrangements for services the student needs
 - Modify the student's schedule and course load to relieve stress, if necessary.
 - Arrange tutoring from peers or teachers, if necessary.
 - Work with teachers to allow makeup work to be extended without penalty.
 - Monitor the student's progress.
 - Inform teachers and other relevant staff members about the possible side effects of the medication(s) being taken by the student and the procedures for notifying the appropriate staff member (e.g., the school nurse, psychologist, or social worker) if these side effects are observed. When sharing information about medical treatment, you need to comply with FERPA and HIPAA.

4. Follow up behavioral and/or attendance problems of the student by:

- Meet with teachers to help them understand appropriate limits and
- Discuss concerns and options with the student
- Consult with the school's discipline administrator

Consult with the student's mental health service provider to understand whether, for example, these behaviors could be associated with medication being taken by the student

- Monitor daily attendance by placing the student on a sign-in/sign-out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day
- Make home visits or have regularly scheduled parent conferences to review attendance and discipline record
- Facilitate counseling for the student specific to these problems at school

5. If the student is hospitalized, obtain the family's agreement to consult with the hospital staff regarding issues such as:

- Deliver classwork assignments to be completed in the hospital or at home, as appropriate
- Allow a representative from school to visit the student in the hospital or at home with the permission of the parents
- Attend treatment planning meetings and the hospital discharge conference with the permission of the parents

6. Establish a plan for periodic contact with the student while he or she is away from school.

7. If the student is unable to attend school for an extended period of time, determine how to help him or her complete course requirements.

Compiled with information from DiCara, C., O'Halloran, S., Williams, L., & Canty-Brooks, C. (2009). Youth suicide prevention, intervention & postvention guidelines. Augusta, ME: Maine Youth Suicide Prevention Program. Retrieved from <http://www.maine.gov/suicideldocs/Guidefines%2010-2009--w%20discl.pdf>

GUIDELINES FOR WHEN A STUDENT RETURNS TO SCHOOL FOLLOWING ABSENCE FOR SUICIDAL BEHAVIOR

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

Confidentiality is extremely important in protecting the student and enabling school personnel to render 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 therapist/counselor. Meeting with parents about their child prior to his/her return to school is integral to making decisions concerning needed supports and the student's schedule.

Suggestions to ease a student's return to school:

1. Prior to the student's return, a meeting between a designated school staff such as the school nurse, social worker, administrator, or designee who is trusted by the student and parents/guardian should be scheduled to discuss possible arrangements for support services and to create an individualized re-entry plan.
2. The designated school staff should:
 - a. Review and file written documents as part of the student's confidential health record.
 - b. Serve as case manager for the student. Understand what precipitated the suicide attempt and be alert to what might precipitate another attempt. Be familiar with practical aspects of the case, i.e. medications, full vs. partial study load recommendations.
 - c. Help the student through re-admission procedures, monitor the re-entry, and serve as a contact for other staff members who need to be alert to re-occurring warning signs.
 - d. Serve as a link with the parent/guardian, and with the written permission of the parent/guardian, serve as the school liaison with any external medical or mental health service providers supporting the student.
3. Classroom teachers do need to know whether the student is on a full or partial study load and be updated on the student's progress in general. They do not need clinical information or a detailed history.
4. Discussion of the case among personnel directly involved in supporting the student should be specifically related to the student's treatment and support needs. Discussion of the student among other staff should be strictly on a "need to know" basis. That is, information directly related to what staff has to know in order to work with the student.
5. Discussion of any specific case in classroom settings should be avoided entirely since such discussion would constitute a violation of the student's right to confidentiality, and would serve no useful purpose to the student or his/her peers.
6. It is appropriate for school personnel to recommend to students that they discuss their concerns or reactions with an appropriate administrator or other designated school personnel. The focus of these discussions should not be on the suicidal individual, but on building help seeking skills and resources for others who might be depressed or suicidal.

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

OTHER ISSUES AND OPTIONS SURROUNDING A STUDENT'S RETURN TO SCHOOL

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

1. Issue: Transition from the hospital setting**Options:**

- Visit the student in the hospital or home to begin the re-entry process with permission from the parent/guardian.
- Consult with the student to discuss what support he/she feels that he/she needs to make a more successful transition. Seek information about what the student would like communicated to friends and peers about what happened.
- Request permission to attend the treatment planning meetings and the hospital discharge conference.
- Arrange for the student to work on some school assignments while in the hospital.
- Include the therapist/counselor in the school re-entry planning meeting.

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

- Schedule a family conference with designated school personnel or home-school coordinator to address their concerns.
- Include parents in the re-entry planning meeting.
- Refer the family to an outside community agency for family counseling services.
- Include information about those with sliding fee scale.

3. Issue: Social and Peer Relations**Options:**

- Schedule a meeting with friends prior to re-entry to discuss their feelings regarding their friend, how to relate and when to be concerned.
- Place the student in a school-based support group, peer helpers program but not as the helper, or buddy system.
- Arrange for a transfer to another school if indicated.
- Be sensitive to the need for confidentiality and how to restrict gossip.

4. Issue: Academic concerns upon return to school**Options:**

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

5. Issue: Medication**Options:**

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

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

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

7. Issue: Ongoing support***Options:**

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

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

Sample Bay Area- CHILD AND ADOLESCENT PSYCHIATRIC HOSPITALS

St. Mary's, Mills Peninsula & Alta Bates are the places where Stanford's emergency department most commonly hospitalizes patients, but the table below includes information for the full list of hospitals to which students who may be sent.

HOSPITAL NAME	ADDRESS	AGES SERVED	# OF BEDS	INSURANCE COVERAGE	LIMITATIONS
St. Mary's Hospital	450 Stanyan Street San Francisco, CA 94117	11-17	12	Accepts Medi-Cal for Santa Clara & San Mateo counties	
Mills Peninsula Hospital	1783 El Camino Real Burlingame, CA 94101	13-17 (possibly 18)	8	Accepts Medi-Cal for Santa Clara & San Mateo counties	
BCH Fremont Hospital	39001 Sundale Drive Fremont, CA 94538	12-18	20		
Mount Diablo Pavilion	2740 Grant Street Concord, CA 94520	Children's Unit: 4-12 Adolescent Unit: 12-17	Children's: 8 Adolescent: 14		No substance abuse
California Specialty Hospital (St. Helena)	525 Oregon Street Vallejo, CA 94590	Children's Unit: 3-12 Adolescent Unit: 13-17	Children's: 17 Adolescent: 19		
Herrick Campus of Alta Bates Hospital	2001 Dwight Way Berkeley, CA 94703	13-18	16	Accepts Medi-Cal for Alameda, Marin & Contra Costa counties	
Community Hospital of the Monterey Peninsula	23625 Holman Highway Monterey, CA 93490	13-18	13 (mixed with adults)		No violent patients
Sutter Hospital	7700 Folsom Blvd Sacramento, CA 95826	Children's Unit: 5-13 Adolescent Unit: 13-17	Children's: 8 Adolescent: 16		
BCH Heritage Oaks Hospital	4250 Auburn Blvd Sacramento, CA 95841	13-17	18		
Sierra Vista Hospital	8001 Sundale Drive Sacramento, CA 95823	13-18	13		
San Jose Behavioral Health	455 Silicon Valley Blvd, San Jose, CA 95138	14-17	80 (mixed with adults)	Accepts Medi-Cal for Santa Clara County and uninsured patients	

63

MEANS RESTRICTION

Restricting access to the methods used for suicide and reducing the lethality of these means allows for rescue or change of heart (Sarchiapone et al., 2011 & Barber, Miller, 2014). “More people start an attempt and abort it than carry it through” (Barber, Miller 2014, p. S265). Methods that can be interrupted without harm allow for survival (Barber, Miller 2014). If highly lethal means are not available the likelihood of dying is decreased (Sarchiapone et al., 2011 & Barber, Miller, 2014). For these reasons, focusing on the way in which someone may attempt suicide in addition to the reasons why they may do so is vital.

To understand how means restriction is effective it is necessary to understand the nature of a suicidal crisis. The urge to act on a suicidal crisis typically lasts only a few minutes to a few hours (Brady Center). This overwhelming emotional state most often results from a temporary inability to cope with unbearable pain. Seventy studies show that “approximately 90% of attempters who survive a nonfatal attempt will **not** go on to die by suicide” (Brady Center p. 3 & Barber, Miller 2014 p. S265). When in crisis, a person’s perception constricts, narrows, darkens and, essentially, collapses. Suicide is often seen as the only option to end the intense pain they are experiencing.

Most suicides are highly impulsive. In this state of crisis impulsive actions can be fatal. “As many as two-thirds of those who reported suicidal behavior did not plan their attempt” (Brady Center, p. 10). Among those who made a plan minimal time elapsed between the plan and the attempt.

Time elapsed between thought and attempt	Percent of attempt survivors (cumulative)
less than 5 min	25%
less than 20 min	48%
less than 60 min	71% (1,8)

Separating someone from the means of self-harm when they are in this short lived, highly impulsive state of emotion places life saving time between the thought and the act.

Though it seems counter-intuitive, the risk of method substitution when a chosen method is unavailable is highly unlikely (Brady Center & Sarchiapone et al., 2011). “Most people who attempt suicide don’t really want to die, they are just so overwhelmed by their emotions they feel unable to cope” (Brady Center, p. 11). The risk of method substitution is very low. “It has been shown that individuals have a preference for a specific means” (Sarchiapone et al., 2011, p. 3). If a preferred method is unavailable, it is unlikely that a different method will be chosen (Brady Center). Separating someone from the means of self-harm when they are in a short lived highly impulsive and intense state takes away their ability to act on a fleeting thought.

Suicide results from the interplay of multiple factors. Anticipating who will experience a suicidal crisis leading to an impulsive act of self-harm is difficult to predict. This is why means reduction is one component of a comprehensive approach to suicide prevention. Families, professionals, agencies, organizations, media and policy makers can all take action to prevent suicide. Reducing access to methods used for suicide can delay or prevent an attempt until the period of high risk has passed (Sarchiapone et al., 2011). It can save lives.

What To Do: Individual Level**Parent/Guardian:**

“Most parents of adolescents believe their children are old enough to behave responsibly and to exercise good judgement” (Brady Center, p.14). When a child is experiencing a suicidal crisis, as described above, they cannot think rationally. Therefore, educating parents about lethal means restriction is a necessary part of adolescent suicide prevention. *Just as families lock a cabinet to keep curious toddlers safe from harmful chemicals*, they can protect youth from taking impulsive action during a suicidal crisis by removing or limiting availability of means in the home. The simple adjustments a family can make in their home are described on the “Brady’s Suicide-Proof Your Home” website (SPRC, n.d.); <http://www.suicideproof.org>. Additional information is found at Harvard School of Public Health Means Matter site <https://www.hsph.harvard.edu/means-matter/recommendations/families/>. Families can limit both over-the-counter (OTC) and prescription medications, teens’ preferred method. Deaths may be prevented or severity of attempts reduced when medication availability is limited (Barber, Miller, 2014). Firearms are particularly deadly. It is critical to store them safely. For gun safety information see Project Child Safe for more information: <http://www.projectchildsafe.org/blog/afsp-and-nssf-tremendous-potential-save-lives>.

Professionals:

The National Strategy for Suicide Prevention recommends school personnel and health providers counsel their students or patients who are at risk for suicide and their families about reducing access to lethal means. (Objective 6.1, p.44 <https://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>) The majority of people who die by suicide have visited their health care provider or an emergency department before their death.

Seen by Primary Care

Percentage of Suicide Deaths	When Seen
45%	Month Preceding Death
77%	Year Preceding Death

Suicide attempts are a growing portion of emergency department visits by youth (Brady Center). For more information see Kids Data <http://www.kidsdata.org/topic#cat=27,34>. Both points of contact, primary care and ER, offer an opportunity to intervene and provide information. Due to the recurring nature of suicidal crises families need to plan in advance for the safety of youth.

The literature “suggests that families who were counseled to reduce access to firearms and medications at home were more likely to do so than those not receiving such counseling” (Barber, Miller, 2014, p. S267). Lethal means counseling is particularly important with regard to guns. The risk of suicide is two to five times higher for youth in gun-owning homes (Barber, Miller, 2014). It is of note that people living in homes with guns “are not more likely to screen positive for psychopathology or suicidal ideation, or to report having attempted suicide. The heightened risk of suicide associated with the presence of a household firearm applies not only to the gun owner but to all household members” (Barber, Miller, 2014, p. S266).

What To Do: Population Level

Population-level means reduction consists in restriction of means availability of a given lethal means through policy changes or by affecting the popularity of a method (Sarchiapone et al., 2011). Despite evidence of the potential of means restriction to save lives, historically it has not been prioritized. Population level interventions have shown “that method-specific rates of suicide drop when a method becomes less available or less lethal” (Barber, Miller, 2014, p. S265). Conversely a “method of suicide can be established in a population when it is easily available” (Sarchiapone et al., 2011, p. 3). Examples of population level interventions include policy changes that reduce the toxicity of poison substances, limiting medication prescription quantities, placing barriers at high places such as bridges and parking structures, safe rooms in institutional settings, non-legislative approaches engaging the gun-owning community as partners in suicide prevention, providing for safety along train corridors, and safe media reporting.

By following the Media and Social Media Guidelines (<https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf> and <http://chapterland.org/wp-content/uploads/sites/10/2015/02/AFSP-Social-Media-Guidelines-1-22-161.pdf>) media can help prevent additional suicides. *[See Media section in this document for further information]* “Media can increase the cognitive availability of a particular method by distributing technical information and sensationalizing” (Sarchiapone et al., 2011, p. 3). Media can increase the likelihood of additional similar deaths, especially among vulnerable youth when it describes the method of suicide in detail, tells the story repeatedly, describes suicide features dramatically and prominently, and portrays the individual who died as someone the audience may identify with (Sarchiapone et al., 2011). Cognitive access can be reduced by avoiding using this information in publications about suicide (Barber, Miller, 2014).

Policy makers provide for population based means reduction in a variety of ways. They can create policies that require awareness and education for both professionals and the general population about lethal means reduction. Regulations can be put in place that provide protective measures for vulnerable youth. One such proven method has been requiring safety barriers at high places such are bridges, parking structures and roof tops. Death rates go down and deaths at nearby similar sites have not occurred. In some cases, overall deaths by suicide from other methods have decreased when barriers have been put in place. Substitution of site or method is highly unlikely (Brady Center). These and other actions can reduce suicidal deaths.

Conclusion

Suicidal crises are most frequently of short duration and, for some, recurrent. This is a temporary state in which the individual experiencing the crisis is unable to cope with an overwhelming emotional state. They are unable to conceive of any other option than suicide as a way out of their pain. During this temporary state limiting ease of access to potentially lethal methods such as high places, guns, and substances (medications and poisons) can literally make the difference between life and death. Reducing access and lethality of means will help prevent the loss of young lives to suicide.

Resources

AFSP and NSSF (n.d.) Tremendous Potential to Save Lives. Retrieved from <https://afsp.org/afsp-nssf-tremendous-potential-save-lives/>

SAMHSA, Reed J. (n.d.). Primary Care: A Crucial setting for suicide prevention: *Suicide Prevention in Primary Care*. Retrieved from <http://www.integration.samhsa.gov/about-us/esolutions-newsletter/suicide-prevention-in-primary-care>

Harvard School of Public Health (n.d.). Means Matter: Lethal means counseling. Retrieved from <https://www.hsph.harvard.edu/means-matter/lethal-means-counseling/>

Harvard School of Public Health (n.d.). Means Matter: Families, Recommendations for families. Retrieved from <https://www.hsph.harvard.edu/means-matter/recommendations/families/>

American Foundation for Suicide Prevention (n.d.) Firearms and Suicide Prevention: Suicide is a leading cause of death, and it's preventable. Retrieved from <https://afsp.org/about-suicide/firearms-suicide-prevention/>

SUICIDE CONTAGION AND CLUSTERS

*“Data clearly show that exposure to suicidal behavior (ideation and attempts) or a fatality raises the risk of subsequent suicide in people who have been exposed”
(Survivors of Suicide Loss Task Force 2015)*

Adolescents and those in their early 20’s are particularly vulnerable to the adverse effects of exposure to the suicide of a peer. This can lead to phenomena called suicide contagion and suicide clusters among this age group.

The relative risk of suicide among 15-19 year olds is 2 to 4 times greater among those who knew a peer who died by suicide (Survivors of Suicide Loss Task Force, 2015, p.19). The process leading to this increased risk of suicide is called contagion. Through the direct or indirect transmission of suicidal behavior the death of one person by suicide may contribute to another person’s similar death. Although this is comparatively rare among all suicide deaths, adolescents are more susceptible to imitative suicide than adults because they identify more readily with the behavior and qualities of their peers (AFSP & SPRC, 2011, p.43). Using data from the National Longitudinal Study of Adolescent Health (ADD Health) it has been concluded that “among teens, having a friend who died by suicide increased both suicidal ideation and attempts for at least a year following the loss” (Survivors of Suicide Loss Task Force, 2015, p.19).

A suicide cluster is comprised of an excessive number of suicides occurring in close temporal and/or geographical proximity (Lake & Gould, 2014, p. 52). In clusters that occur within localized communities, such as schools, (called space-time or “point” clusters), the teens who die are more likely to have pre-existing vulnerabilities. Research has concluded that “suicide contagion may have triggered suicidal behavior in adolescents who were already vulnerable, but who nonetheless may not have died by suicide without the added impetus of exposure to the suicide of a peer” (Lake & Gould, 2014, p. 55). Clusters account for 1% to 5% of teenage suicides (Zenere, 2009, p.13).

Schools have the opportunity to prevent the contagious behavior contributing to space-time clusters in school communities. After a student’s suicidal death the school can identify students who are particularly vulnerable to the phenomena of contagion. These students are more likely to have the following risk factors:

1. Previous suicidal thoughts or behaviors (attempts),
2. Having been hospitalized for a mental illness or substance abuse problem,
3. A recent or anticipated relationship break-up,
4. Physical self injury or physical violence toward others (Lake & Gould, 2014, p. 56).

Part of a “postvention” effort is identifying and supporting students at risk. Suicidal individuals frequently experience an approach-avoidance conflict regarding suicide: meaning the wish to die coexists in tension with the wish to live (Lake & Gould, 2014, p. 57). Experiencing suicidal behavior modeled by a peer has the effect of disinhibiting suicidal behavior particularly among adolescents. Schools can help support that “wish to live” through all their postvention efforts.

In addition, it has been found that “newspaper coverage of suicide is significantly associated with the initiation of suicide clusters” (Gould, Kleinman, Lake, Forman, Midle, 2014, p. 5). This effect is strongest for news stories about teenage suicides. “Repeated, detailed and explicit reporting on completed suicide might normalize suicide in the eyes of vulnerable young people, reducing their inhibitions against the modeled act” (Gould et al., 2014, p. 7). Research has found “that only stories about suicidal individuals, as opposed to other types of stories about suicide are associated with the occurrence of subsequent suicide” (Gould et

al., 2014 p. 8). This supports the theory that the media effect operates through identification with a model (Gould et al., 2014, p. 8).

Characteristics of print news articles strongly associated with suicide clusters

1. Prominent - front page and pictures displaying sadness
2. Explicit Headlines - contain the word suicide; mention the specific suicide method; sensational (written in tabloid like manner to arouse excitement)
3. Detailed descriptions - name of suicidal individual; name of school; time or place of death; suicide method procedure; number of sentences describing the method; unfavorable characteristics of the suicidal individual; suicide note mentioned
4. Amount and Duration - repetitive reporting on the same suicide
5. Reports about fatal suicide rather than attempted suicide

“Media portrayals of suicide might have a role in the emergence of some teenage suicide clusters” (Gould et al., 2014, p. 9). It is possible to mitigate media effects on suicide by implementing media guidelines for suicide reporting (<http://www.reportingonsuicide.org>) It is also of note that, “Even since the advent of the internet... newspapers remain the predominant source of suicide reporting to which adolescents and young adults are exposed” (Gould et al., 2014, p. 8). Two steps schools can take to prevent the emergence of a suicide cluster and to mitigate the effects of contagion are sharing the research-informed guidelines for print media and heightened vigilance regarding already vulnerable adolescents.

Schools, through a comprehensive and systematic postvention response to a suicide in their community, can prevent potential suicides. Such a response is detailed in the Postvention section of this Toolkit and includes the following:

1. Confirm the facts
2. Mobilize the crisis response team,
3. Identify at-risk students
4. Inform students through personal communications,
5. Support and monitor affected students,
6. Provide appropriate outlets for grieving,
7. Engage the community (Zenere, 2009. p.14-15)
8. Provide all media with the Recommendations for Reporting on Suicide found at <http://reportingonsuicide.org>

If contagion is suspected due to the increase in suicidal thoughts, threats and attempts among students, the support of school mental health professionals should be sought. A community wide approach involving school officials, law enforcement, emergency department directors, clergy, public health, and community mental health agencies may be required to contain an active contagion (Zenere, 2009, p.15).

** We would like to thank and recognize Dr. Madelyn Gould (Columbia University) for her contribution to the development of this section.*

SECTION III: POSTVENTION RESPONSE TO SUICIDE OF A SCHOOL COMMUNITY MEMBER

Postvention (interventions that are conducted after a suicide) assists students in ways that promote the mental health of the entire school community and supports students experiencing a mental or suicidal crisis after the suicidal death of a school community member. These interventions are meant to help manage the various aspects of the crisis and prevent contagion. Support and resources are provided for students, staff, parents and the entire community. All aspects of postvention strive to treat the loss in similar ways to that of other deaths within the school community and to return the school environment to its normal routine as soon as is possible. In this way, postvention is inextricably linked to prevention.

A. STEPS TO TAKE IN THE IMMEDIATE AFTERMATH

1. Day Zero (day of event)

a. Contact key individuals

i. Principal or Designee Verifies Death

- Verify details of death with police or other local authority (see Attachment 3.16, 'Working With the Community')
- See Attachment 3.2 'Sample Postvention Telephone Tree'

ii. Principal or Designee Contacts Family (see "Guidelines for Working With the Family", attachment 3.3, p. 70)

- Express sympathy as you would for any sudden death (see Appendix C5, "Comforting a Grieving Individual")
- Inquire about what the school can share about their loss. If family is unwilling or not ready to share, help the family craft a message that they do want released in order to minimize rumors, misinformation, and speculation. Acknowledge that this is a great tragedy and assist them in understanding that crafting a message about the cause of death will help their child's friends who are suffering.
- Ask what the school can do to support siblings.
- Ask what school can do to support them (e.g., PTA to assist providing meals, inform family about Kara or local grief support and AFSP "Surviving Suicide Loss" support such as the "Survivor Outreach Program" etc.)
 - AFSP's Surviving a Suicide Loss: A Resource and Healing Guide:
http://openhighschoolcourses.org/pluginfile.php/11763/mod_resource/content/1/PRESENTATIONS_MISCELLANEOUS/Resource_Healing_Guide.pdf
 - AFSP Survivor Outreach Program
Call: 212-363-3500, ext. 2035 Email: survivingsuicidloss@afsp.org
 - Kara Grief Support: http://www.kara-grief.org/joomla/index.php?option=com_content&view=article&id=59&Itemid=122
- Let them know the school will be checking in with them in the coming days and weeks to determine what support the school can provide

iii. Principal Notifies Superintendent or Director of Student Services Who Notifies Schools Where Siblings and Close Relatives Attend

- Shut down deceased student and his/her siblings in attendance system so no automated messages regarding absence are sent home
- Shut down face-page on District IT system

iv. CRT leader notified who then activates Crisis Response Team

v. Ensure office staff knows how to respond to inquiries (see Attachment 3.4, “Sample Script for Office Staff”)

vi. Campus Supervisor to prevent unauthorized visitors on campus

vii. Work with district to secure community mental health providers

viii. See Attachment 3.2 ‘Sample Postvention Telephone Tree’

b. Notify School Community

i. CRT Leader to notify all faculty and staff (see Attachment 3.5, “Guidelines for Notifying Staff.)

ii. Principal to notify families of students about the death and the school’s response (see Attachment 3.6 “Sample Letter to Families”, and Attachment 3.7, “Sample Death Notification for Parents”)

- Communicate letter to families in the most expedient way so they will know what their student will be facing at school when the death is announced.
- Letter should include a list of local resources (refer to Appendix B2, “Mental Health Resources”)

2. Day One (first school day after event)

a. Initial All-Staff Meeting (before school)

i. Crisis Response Team Leader conducts the initial all-staff meeting with principal or designated administrator. For a suggested meeting agenda, refer to Attachment 3.8, “Sample Agenda for Initial All-Staff Meeting”

ii. A few goals of this meeting are to:

1. Convey what information can be relayed to students

- For sample announcements, refer to Attachment 3.9, “Sample Announcements” and “Sample Death Notification Statement for Students”
- Prepare staff to inform students in first period classes. In order to deal with student reactions provide them with copies of:
 - Attachment 3.10, “Talking About Suicide”
 - Attachment 3.11, “Talking Points for Students and Staff After a Suicide”
 - Attachment 3.12, “Sample Grief Discussion with Students”
 - Attachment 3.13, “Facts About Suicide and Mental Disorders in Adolescents”
- Identify staff uncomfortable with notifying students of the death. Designate CRT members or counselors to support those staff members in their classrooms throughout the school day.

- Remind staff who the designated media spokesperson is and that they should refer any outside requests for comments or information to this individual.
2. Control rumors
 - Attachment 1.3 for Social Media
 3. Provide staff support
 - Inform teachers that roving substitute teachers are available for those instructors who may need a short break.
 - Advise staff that extra support is available for those who need it.
 - Offer end of day meeting for staff to debrief and to obtain support.
 - Provide staff with resources for themselves and the community (see Appendix B2, “Mental Health Resources” and Attachment 1.1 “The Imperative of Compassionate Self-Care”)
 4. Remind staff of risk factors and warning signs (see Attachment 1.9, “Risk Factors for Youth Suicide”, and Attachment 1.11, “Recognizing and Responding to Warning Signs of Suicide”) and to use gatekeeper training as situation warrants, etc.
 5. Inform staff where to send at-risk students and that they must be sent with another student or escorted by adult -**never alone**
 6. Identify designated locations on campus for students who would like to support one another with a trusted adult nearby. Determine who should monitor these stations (activities director, other mental health providers). Provide snacks if possible along with art and writing supplies for creative expression that may later be preserved for the student’s family.
 7. Share parent location designated for parents who come to campus to ask questions and express concerns.
- Send follow up email after the staff meeting with information discussed in the first meeting and any additional details, such as list of local resources.

b. Support Students During the School Day

- i. Counselors (preferably two) follow deceased student’s schedule to assess students and to assist teachers
- ii. Identify, monitor, and support students who may be at risk
 - Recognize that students who were close to deceased and known vulnerable students may be at-risk for suicide. Assign a CRT member to develop a list of students of concern with input from others.
 - Meet with at-risk students, document, and follow-up as needed.
- iii. Designate someone to circulate on campus to determine who might be in need and to monitor for rumors (e.g. campus supervisor).
- iv. Meet with students in small groups including established groups of the deceased (e.g. sports, clubs, friend groups) to provide emotional support. Meeting should be facilitated by counselor, school psychologist, community counseling and grief support, etc. To guide the meeting refer to Attachment 3.10, “Talking About Suicide”, Attachment 3.11, “Talking Points for Students and Staff After a Suicide”, and Attachment 3.12, “Sample Grief Discussion With Students”.

c. After-School Staff Meeting

- i.** Acknowledge that it's been a difficult day for everyone and that this meeting is an opportunity to share experiences from the day and what their needs for support will be for the next day.
- ii.** Inform staff as to the continued availability of roving substitute teachers and counselors. Determine this based upon expressed need and day one experiences in the classroom.
- iii.** Allow staff to express concerns and ask questions.
- iv.** Emphasize self-care for teachers/staff since they have been primarily focused on taking care of students.
- v.** Reminder to continue to identify, monitor, and support students who may be at risk.

3. Advise on Appropriate Memorialization

In the interest of identifying a meaningful, safe approach to acknowledging the loss, schools should both meet with the student's friends and coordinate with the family. The school's goal should be to balance the students' need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. In all cases, schools should have a consistent policy so that suicide deaths are handled in the same manner as any other deaths. Refer to Attachment 3.14, "Memorialization" for more information from the AFSP & SPRC.

Key Considerations for Memorialization

- Any memorial should have the goals of being life-affirming, raising awareness, and reducing stigma.
- Encourage contributions to suicide prevention or mental health organizations such as AFSP, or to any other local/national organization that supports youth mental health promotion or suicide prevention.
- Because adolescents are especially vulnerable to the risk of suicide contagion, it's important to memorialize the student in a way that doesn't inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying brain conditions such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).
- Determine a date/time to gather materials from spontaneous memorials so that they can be organized and given to the family. Well in advance of this time, let students know when this will occur.
- CRT should be available to students concerned about rumors or social media postings about the death. Social media can be used effectively for the dissemination of accurate information and to promote suicide prevention efforts. See Attachment 3.19, "Media", for recommendations.

4. Key Considerations for Funeral/Memorial Service (see Attachment 3.14, "Memorialization")

- a.** Discuss with the family the importance of informing clergy or whoever will be conducting the funeral about the risk of suicide contagion among adolescents.

- b. Communicate the importance of emphasizing the connection between suicide and underlying brain conditions (such as depression), as noted in the key considerations for memorialization listed above.
- c. Encourage the family to consider holding the funeral outside of school hours if at all possible.
- d. If family asks, principal should communicate with the funeral director about logistics, including need for mental health professionals and/or grief counselors to be present at the funeral.
- e. Depending on family wishes, the Principal will disseminate information about the funeral to students, parents, and staff as soon as it becomes available. Include the following information in the announcement:
 - i. Location of the funeral
 - ii. Time of the funeral (keep school open if the funeral is during school hours)
 - iii. What to expect (e.g. whether there will be an open casket)
 - iv. Guidance regarding how to express condolences to the family (e.g. treat like any other sudden death, family wishes for charitable donations vs. flowers, etc.). See Appendix C5, “Comforting a Grieving Individual” for helpful recommendations.
 - v. School policy for releasing students during school hours to attend (i.e., students will be released only with permission of parent, guardian, or designated adult).
 - vi. Consider having a trusted adult or family member accompany students who choose to attend the funeral to provide support.
- f. Support grieving students - See Attachment 3.25 ‘Grief for Children and Teens After Suicide’

5. Minimize Risk of Suicide Contagion by Working with the Media

For more information on Contagion - See Attachment 3.2 ‘Contagion and Clusters’

- a. CRT leader to direct all media inquiries to the district media spokesperson.
- b. Assemble media packet.
 - i. A statement is prepared in advance and a hard copy provided by media spokesperson when contacted by outside organizations for comments or information regarding the death.
 - ii. For guidelines and sample statements refer to:
 - o Attachment 3.18, “Guidelines for Working With the Media”
 - o Attachment 3.20, “Sample Media Statement”
 - o Attachment 3.21, “Key Messages for Media Spokesperson”
 - iii. Include Appendix B2, “Mental Health Resources” for local resources and hotline numbers
 - iv. Provide media with SPRC/AFSP media guidelines (see Attachment 3.22, “Recommendations For Reporting on Suicide”, and Attachment 3.23, “At-a-Glance: Safe Reporting on Suicide”).
 - o <https://suicidepreventioncommunity.files.wordpress.com/2008/10/media-guide-suicide-summary3.pdf>
 - <https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf>
- c. For more on the ‘Imperative of Compassionate Self Care’ refer to Attachment 1.1 in the Promotion of Mental Wellness section.

B. STEPS TO TAKE IN THE LONG-TERM AFTERMATH

1. Coordinate implementation of long-term response protocol

- a. Schedule daily debriefs with Crisis Response Team while in initial assessment period to discuss

at-risk students who need follow-up and to review confidential database. This generally lasts 1-2 weeks, but can vary with the situation.

- b. Discuss with family of deceased student any concerns they may have for siblings, friends or acquaintances and follow up accordingly. Counselor monitors and checks in with at-risk students as long as needed. Documents name of student, date/time of check-in, assessment of areas of concern, follow-up referrals and notifications on standardized forms (see Attachment 3.15, "Student Suicide Risk Documentation Form").
- c. Send e-mail updates to staff to keep them informed about funeral arrangements; resources and supports available for them; physical, emotional, cognitive, and social manifestations of grief in students; referral process for students of concern, etc. This generally lasts 1-2 weeks, but can vary with the situation.
- d. Develop prearranged protocol for removing personal items from locker or desk, respecting family wishes for privacy and/or support
- e. Use QPR/gatekeeper techniques as needed
- f. Convene CRT and facilitate a tactical debriefing of what worked and what could be improved upon during the initial assessment period (1-2 weeks post-intervention). Team leader documents successes, challenges, and recommendations for improvement to be incorporated into the Comprehensive Suicide Prevention Toolkit.

2. Enhance identification and support of vulnerable students

- a. Identify students in need and refer to counselor (note alternative approaches to identifying students at risk in Section I: Promotion of Mental Health Wellness). Attendance office to alert health tech or counselor about increased student absences.
- b. Continue to monitor for rumors.
- c. Campus supervisor to rove on campus throughout the day and monitor the emotional climate (e.g., an increase in fights or school delinquency).
- d. Continue to meet with students in small groups, especially those groups of which the deceased student was a member.
- e. Recommend more individual supports (make sure to offer continued support if needed).
- f. See Section Intervention - 'Identify and Monitor At-Risk Students' on page 103.

3. Prepare for anniversaries and special events

- a. Prior to graduation ceremonies for the deceased student's class, check with family about any requests. Acknowledgment of a student who has died by suicide should be consistent with acknowledgement of a student who has died by any other means.
- b. Be aware of special events (e.g. proms, birthday etc.), holidays, and anniversaries, as these may activate possible stress/grief responses (physical, emotional, social, cognitive) in students or staff. See Attachment 3.17, "Guidelines for Anniversaries of a Death".
- c. The probability of contagion is heightened on the anniversary of the death as well as on other meaningful days.

4. Expect the possibility of long term memorials (see Attachment 3.14, "Memorialization") and continue to work with family, students, and social media.

- 5. Provide support as needed for siblings of the deceased enrolled in the district.** Coordinate with parents. Refer to and choose among the resources located in Appendix B for more information as needed.

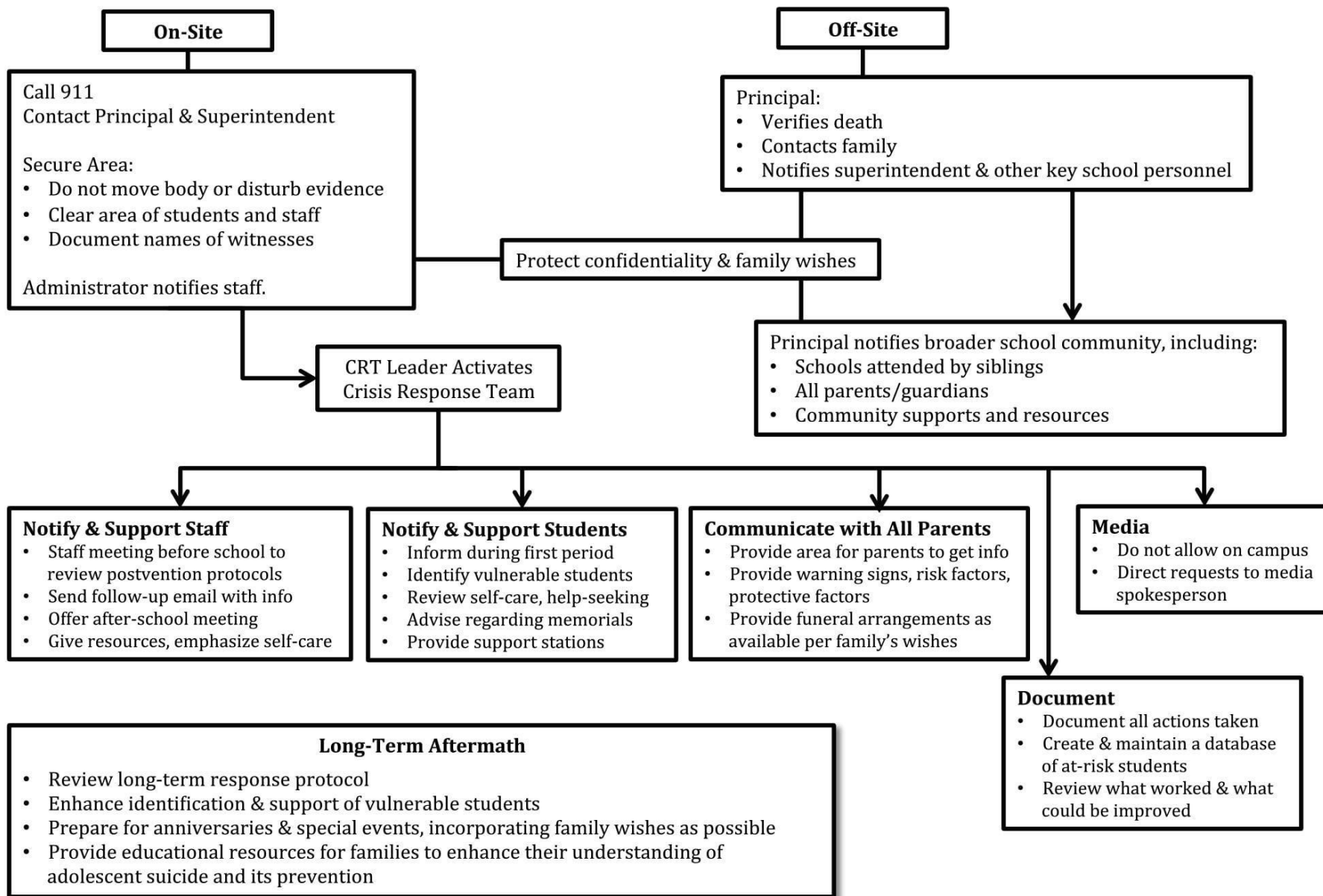
- 6. Principal or designee to remain in contact with family through the funeral and in the weeks following death.**

- 7. Communicate with and support the broader school community.**
 - a. Provide parent/community education about suicide, grief, and self-care within the first month following death.
 - b. Site-based staff, district psychiatrist, district nurse may show AFSP “More than Sad” program providing staff and parents with information about warning signs of suicide, risk-and-protective factors, importance of means restriction, supportive services, community resources, crisis line, and helpful responses to student questions.

ATTACHMENTS FOR SECTION III: POSTVENTION

- 3.1 POSTVENTION PROTOCOL FLOW CHART
- 3.2 SAMPLE POSTVENTION TELEPHONE TREE
- 3.3 GUIDELINES FOR WORKING WITH THE FAMILY, *SAMHSA Toolkit*
- 3.4 SAMPLE SCRIPT FOR OFFICE STAFF, *SAMHSA Toolkit*
- 3.5 GUIDELINES FOR NOTIFYING STAFF, *SAMHSA Toolkit*
- 3.6 SAMPLE LETTER TO FAMILIES, *SAMHSA Toolkit*
- 3.7 SAMPLE DEATH NOTIFICATION STATEMENT FOR PARENTS, *AFSP &SPRC Toolkit*
- 3.8 SAMPLE AGENDA FOR INITIAL ALL-STAFF MEETING, *AFSP &SPRC Toolkit*
- 3.9 SAMPLE ANNOUNCEMENTS, *SAMHSA Toolkit*
- 3.10 TALKING ABOUT SUICIDE, *AFSP &SPRC Toolkit*
- 3.11 TALKING POINTS FOR STUDENTS AND STAFF AFTER A SUICIDE, *SAMHSA Toolkit*
- 3.12 SAMPLE GRIEF DISCUSSION WITH STUDENTS, *KARA*
- 3.13 FACTS ABOUT SUICIDE AND MENTAL DISORDERS IN ADOLESCENTS, *AFSP &SPRC Toolkit*
- 3.14 MEMORIALIZATION, *AFSP & SPRC Toolkit*
- 3.15 STUDENT SUICIDE RISK DOCUMENTATION FORM, *SAMHSA Toolkit*
- 3.16 WORKING WITH THE COMMUNITY, *AFSP &SPRC Toolkit*
- 3.17 GUIDELINES FOR ANNIVERSARIES OF A DEATH, *SAMHSA Toolkit*
- 3.18i GUIDELINES FOR WORKING WITH THE MEDIA, *SAMHSA Toolkit*
- 3.18ii FRAMEWORK FOR SUCCESSFUL MESSAGING – POSITIVE NARRATIVE
- 3.19 MEDIA, *AFSP &SPRC Toolkit*
- 3.20 SAMPLE MEDIA STATEMENT, *AFSP &SPRC Toolkit*
- 3.21 KEY MESSAGES FOR MEDIA SPOKESPERSON, *AFSP & SPRC Toolkit*
- 3.22 RECOMMENDATIONS FOR REPORTING ON SUICIDE, *AFSP*
- 3.23 AT A GLANCE: SAFE REPORTING ON SUICIDE, *SPRC*
- 3.24 CONTAGION AND CLUSTERS
- 3.25 GRIEF FOR CHILDREN AND TEENS AFTER SUICIDE

SUICIDE POSTVENTION PROTOCOL FLOWCHART



SAMPLE POSTVENTION TELEPHONE TREE

SUPERINTENDENT'S SECRETARY WILL CALL:

Phone Number Principal/Secretary..... Secondary Schools
Phone Number Administrators..... District Office

EDUCATIONAL SERVICES SECRETARY WILL CALL:

Phone Number Principal/Secretary..... Elementary Schools

CERTIFICATED SECRETARY WILL CALL:

Phone Number Extension/Contact Person..... Transportation
Phone Number Extension/Contact Person..... Adult Education
Phone Number Extension/Contact Person..... Warehouse
Phone Number Extension/Contact Person..... Maintenance
Phone Number Extension/Contact Person..... Other Depts.

GUIDELINES FOR WORKING WITH THE FAMILY

It is important to work with the family of a student who died by suicide. They will often appreciate the support of the school community, and their cooperation can be valuable for effective postvention. The principal or a representative of the school should request to visit the family in their home. It may be useful for a pair of representatives to visit together so that they can support one another during the visit. It is important to respect the cultural and religious traditions of the family related to suicide, death, grieving, and funeral ceremonies.

The school representative(s) should:

- Offer the condolences of the school.
- Inquire about funeral arrangements. Ask if the funeral will be private or if the family will allow students to attend.
- Ask if the parents know of any of their child's friends who may be especially upset.
- Provide the parents with information about grief counseling.
- Ask the family if they would like their child's personal belongings returned. These could include belongings found in the student's locker and desk as well as papers and projects they may want to keep.
- Briefly explain to the parents what the school is doing to respond to the death.

SAMPLE SCRIPT FOR OFFICE STAFF

This script can help receptionists or other people who answer the telephone to respond appropriately to telephone calls received in the early stages of the crisis.

Hello, _____ School. May I help you?

Take messages on non-crisis-related calls.

For crisis-related calls, use the following general schema:

- **Police or other security professionals:** Immediate transfer to principal.
- **Family members of deceased:** Immediate transfer to principal or anyone else they want to reach at the school. If principal is not available immediately, ask if they would like to speak to a school psychologist or social worker.
- **Other school administrators:** Give out basic information on death and crisis response and offer to transfer call to principal or others.
- **A parent regarding their child's immediate safety:** Reassure parents if you know their child was not involved and outline how children are being served and supported. If their child may have been involved, transfer to a crisis team member who may have more information.
- **Persons who call with information about others at risk:** Take down information and get it to a crisis team member. Take a phone number where a crisis team member can call the person back.
- **Media:** Take messages and refer to principal.
- **Parents generally wanting to know how to respond:** Explain that children and staff are being supported. Take messages to give to Student Services staff from parents needing more detailed information.
- **Where to send parents who arrive unannounced on the scene:** Set aside a space for parents to wait and get information. Any person removing a student from school must be on the annual registration form as the parent or guardian. Records must be kept of who removed the child and when.

From Madison Metropolitan School District. (2005). Sudden death-suicide-critical incident: Crisis response procedures for principals and student services staff. http://www.mhawisconsin.org/Data/Sites/1/media/gls/gls_madisoncrisisplan.pdf

GUIDELINES FOR NOTIFYING STAFF

These preparations should be made by the individual responsible for notifying faculty and staff about a suicide so that a system will be in place in the event of a death.

- Create two telephone trees:
 1. To notify the Suicide Response Team
 2. To notify all staff members of a suicide that occurs during non-school hours
- Hold a staff meeting before school opens to review the postvention process. Provide staff with any information they may need to address the situation when the students arrive.
- Identify which Suicide Response Team members will be responsible for notifying staff if news of a suicide arrives while school is in session. These people should be provided with completed copies of a suicide death announcement (examples can be found in Attachments 3.9 and 3.10).
- Announcements should always be made in classrooms. They should never be made over the school's public address system or in assemblies. In classrooms, school staff familiar to the students can make the announcements and then assess students' reactions, respond to students' concerns, provide support, and identify those who may need additional help. This will help students cope with intense emotions they may experience.

SAMPLE LETTER TO FAMILIES

Dear Parents,

I am writing this letter with great sadness to inform you that one of our sophomore students took his life last evening. Our thoughts and sympathies go out to his family and friends.

All of the students were given the news of the death by their teacher in homeroom this morning. I have included a copy of the announcement that was read to them. Members of our crisis team met with students individually and in groups today and will be available to the students over the next days and weeks to help them cope with the death of their peer.

Information about funeral services will be given to the students once it has been made available to us. Students will be released to attend services only with parental permission and pick up, and we strongly encourage you to accompany your child to any services.

I am including information about suicide and some talking points that can be helpful to you in discussing this issue with your teen. I am also including a list of school and community resources should you feel your child is in need of additional assistance. If you need immediate assistance, call the Santa Clara County Suicide and Crisis Hotline 24/7 at 1-855-278-4204.

Please do not hesitate to call me or one of the counselors if you have questions or concerns. Sincerely,
(Principal)

Adapted from AFSP. After a suicide: A toolkit for schools. Newton, MA: Education Development Center, Inc. Available online at <http://www.sprc.org/sites/sprc.org/files/library/AfteraSuicideToolkitforSchools.pdf>

SAMPLE DEATH NOTIFICATION STATEMENT FOR PARENTS

To be sent by e-mail or regular mail

OPTION 1: WHEN THE DEATH HAS BEEN RULED A SUICIDE

Dear Parents,

I am writing with great sadness to inform you that one of our students, _____ has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The cause of death was suicide. We want to take this opportunity to remind our community that 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; other times, a person with a disorder will show obvious symptoms or signs. I am including some information that may be helpful to you in discussing suicide with your child.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

The school will be hosting a meeting for parents and others in the community at [date/time/location]. Members of our 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.

Please do not hesitate to contact me or one of the school counselors with any questions or concerns. Sincerely,
[Principal]

OPTION 2 - WHEN THE CAUSE OF DEATH IS UNCONFIRMED:

Dear Parents,

I am writing with great sadness to inform you that one of our students, _____ has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The cause of death has not yet been determined by the authorities. 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 have asked the students not to spread rumors since they may turn out to be inaccurate and can be 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.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

Please do not hesitate to contact me or one of the school counselors with any questions or concerns. Sincerely,
[Principal]

OPTION 3 - WHEN THE FAMILY HAS REQUESTED THAT THE CAUSE OF DEATH NOT BE DISCLOSED:

Dear Parents,

I am writing with great sadness to inform you that one of our students, _____ has died. Our thoughts and sympathies are with [his/her] family and friends.

All of the students were given the news of the death by their teacher in [advisory/homeroom] this morning. I have included a copy of the announcement that was read to them.

The family has requested that information about the cause of death not be shared at this time. We are aware that there have been rumors that this was a suicide death. Since the subject has been raised, we want to take this opportunity to remind our community 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 the problems in his or her life and how to solve them. Sometimes these disorders are not identified or noticed; other times, a person with a disorder will show obvious symptoms or signs.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance; we have a list of additional school and community mental health resources.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

Please do not hesitate to contact me or the school counselors with any questions or concerns. Sincerely,
[Principal]

From After a Suicide A Toolkit for Schools 2011, AFSP & SPRC

SAMPLE AGENDA FOR INITIAL ALL-STAFF MEETING

This meeting is typically conducted by the Crisis Response Team Leader and should be held as soon as possible, ideally before school starts in the morning.

Depending on when the death occurs, there may not be enough time to hold the meeting before students have begun to hear the news through word of mouth, text messaging, or other means. If this happens, the Crisis Response Team Leader should first verify the accuracy of the reports and then notify staff of the death through the school's predetermined crisis alert system, such as e-mail or calls to classroom phones. Remember that information about the cause of death should be withheld until the family has been consulted.

Goals of Initial Meeting

Allow at least one hour to address the following goals:

- Introduce the Crisis Response Team members.
- Share accurate information about the death.
- Allow staff an opportunity to express their own reactions and grief. Identify anyone who may need additional support and refer them to appropriate resources.
- Provide appropriate faculty (e.g., homeroom teachers or advisors) with a scripted death notification statement for students. Arrange coverage for any staff who are unable to manage reading the statement.
- Prepare for student reactions and questions by providing handouts to staff on Talking About Suicide and Facts About Suicide and Mental Disorders in Adolescents.
- Explain plans for the day, including locations of crisis counseling rooms.
- Remind all staff of the important role they may play in identifying changes in behavior among the students they know and see every day, and discuss plan for handling students who are having difficulty.
- Brief staff about identifying and referring at-risk students as well as the need to keep records of those efforts.
- Apprise staff of any outside crisis responders or others who will be assisting.
- Remind staff of student dismissal protocol for funeral.
- Identify which Crisis Response Team member has been designated as the media spokesperson and instruct staff to refer all media inquiries to him or her.

End of the First Day

It can also be helpful for the Crisis Response Team Leader and/or the Team Coordinator to have an all-staff meeting at the end of the first day. This meeting provides an opportunity to take the following steps:

- Offer verbal appreciation of the staff.
- Review the day's challenges and successes.
- Debrief, share experiences, express concerns, and ask questions.
- Check in with staff to assess whether any of them need additional support, and refer accordingly.
- Disseminate information regarding the death and/or funeral arrangements.
- Discuss plans for the next day.
- Remind staff of the importance of self-care.
- Remind staff of the importance of documenting crisis response efforts for future planning and understanding.

SAMPLE ANNOUNCEMENTS**Sample Announcements for Use with Students after a (Possible) Suicide**

1. After the school's Suicide Response Team has been mobilized, it is critical for administration and/or crisis team members to prepare a statement about the death for release to faculty and students. The announcement should include the facts as they have been officially communicated to the school. Announcements should not overstate or assume facts not in evidence. If the official cause of death has not as yet been ruled suicide, avoid making that assumption. There are also many instances when family members insist that a death that may appear to be suicide was, in fact, accidental.
2. The Suicide Response Team should either visit all classrooms to give the announcement to staff or present the announcement at a meeting of all staff called by the building administrator as soon as possible following the death. If a meeting is held, the building administrator and a member of the Suicide Response Team could facilitate the meeting. The goals of such a meeting are to inform the faculty, acknowledge their grief and loss, and prepare them to respond to the needs of the students. Faculty will then read the announcement to their students in their homerooms (or other small group) so that students get the same information at the same time from someone they know.
3. The sample announcements in this section are straightforward and are designed for use with faculty, students, and parents, as appropriate. Directing your announcement to the grade level of the students is also important, especially in primary or middle schools. A written announcement should be sent home to parents with additional information about common student reactions to suicide and how to respond, as well as suicide prevention information.

SAMPLE ANNOUNCEMENTS DAY 1**Sample Announcement for When a Suicide has Occurred, Morning, Day 1**

This morning we heard the extremely sad news that _____ took his/her life last night. I know we are all saddened by his/her death and send our condolences to his/her family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available, and students may attend with parental permission.

Sample Announcement for a Suspicious Death Not Declared Suicide: Morning, Day 1

This morning we heard the extremely sad news that _____ died last night from a gunshot wound. This is the only information we have officially received on the circumstances surrounding the event. I know we are all saddened by _____'s death and send our condolences to his/her family and friends. Crisis stations will be located throughout the school today for students who wish to talk to a counselor. Information about the funeral will be provided when it is available; students may attend with parental permission.

Sample Announcement, End of Day 1

At the end of the first day, another announcement to the whole school prior to dismissal can serve to join the whole school in their grieving in a simple, non-sensationalized way. In this case, it is appropriate for the building administrator to make an announcement similar to the following over the loud speaker:

Today has been a sad day for all of us. We encourage you to talk about _____'s death with your friends, your family, and whoever else gives you support. We will have special staff here for you tomorrow to help in dealing with our loss. Let us end the day by having the whole school offer a moment of silence for _____.

SAMPLE ANNOUNCEMENTS DAY 2

On the second day following the death, many schools have found it helpful to start the day with another homeroom announcement. This announcement can include additional verified information, re-emphasize the continuing availability of in-school resources, and provide information to facilitate grief. Here's a sample of how this announcement might be handled:

We know that _____'s death has been declared a suicide. Even though we might try to understand the reasons for his/her doing this, we can never really know what was going on that made him/her take his/her life. One thing that's important to remember is that there is never just one reason for a suicide. There are always many reasons or causes, and we will never be able to figure them all out.

Today we begin the process of returning to a normal schedule in school. This may be hard for some of us to do. Counselors are still available in school to help us deal with our feelings. If you feel the need to speak to a counselor, either alone or with a friend, tell a teacher, the principal, or the school nurse, and they will help make the arrangements.

We also have information about the visitation and funeral. The visitation will be held tomorrow evening at the _____ Funeral Home from ____ to ____ p.m. There will be a funeral Mass _____ at _____ o'clock at _____ Church. In order to be excused from school to attend the funeral, you will need to be accompanied by a parent or relative, or have your parent's permission to attend. We also encourage you to ask your parents to go with you to the funeral home.

SAMPLE DEATH NOTIFICATION STATEMENT FOR STUDENTS

Use in small groups such as homerooms or advisories, not in assemblies or over loudspeakers.

OPTION 1 - 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 taken [his/her] own life. 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.

OPTION 2 - WHEN THE CAUSE OF DEATH IS UNCONFIRMED:

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 cause of death has not yet been determined by the authorities. 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.

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.

OPTION 3 - 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.

From After a Suicide A Toolkit for Schools 2011, AFSP & SPRC

TALKING ABOUT SUICIDE

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, straight-forward manner does not put ideas into kids' minds.

EXAMPLES OF WHAT TO SAY:

- *"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% of people who die by suicide have a mental disorder at the time of their death, it is likely that _____ suffered from a mental health 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.

EXAMPLE OF WHAT TO SAY:

- *"The reasons that someone dies by suicide are not simple, and are often 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 health 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.

EXAMPLES OF WHAT TO SAY:

- *"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?"*

Address anger.

Accept expressions of anger at the deceased and explain that these feelings are normal.

EXAMPLE OF WHAT TO SAY:

- *“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.”*

Address feelings of responsibility.

Reassure those who feel responsible or think they could have done something to save the deceased.

EXAMPLES OF WHAT TO SAY:

- *“This death is not your fault.”*
- *“We can’t always predict someone else’s behavior.”*
- *“We can’t control someone else’s behavior.”*

Encourage help-seeking.

Encourage students to seek help from a trusted adult if they or a friend are feeling depressed or suicidal.

EXAMPLES OF WHAT TO SAY:

- *“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?”*
- *“There are effective treatments to help people who have mental health disorders or substance abuse problems. Suicide is never the answer.”*
- *“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.”*

“After a Suicide: A Toolkit for Schools AFSP& SPRC

TALKING POINTS FOR STUDENTS AND STAFF AFTER A SUICIDE

TALKING POINT	WHAT TO SAY
<p>Give accurate information about suicide. Suicide is a complicated behavior. Help students understand the complexities.</p>	<p><i>Suicide is not caused by a single event, such as fighting with parents, or a bad grade, or the breakup of a relationship.</i></p> <p><i>In most cases, suicide is caused by mental health disorders like depression or substance abuse problems. Mental health disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental health disorder is nothing to be ashamed of.</i></p> <p><i>There are effective treatments to help people</i></p>
<p>Address blaming and scapegoating. It is common to try to answer the question “why” by blaming others for the suicide.</p>	<p><i>Blaming others for the suicide is wrong, and it’s not fair. Doing that can hurt another person deeply.</i></p>
<p>Do not talk about the method. Talking about the method can create images that are upsetting, and it may increase the risk of imitative behavior by vulnerable</p>	<p><i>Let’s focus on talking about the feelings we are left with after _____’s death and figure out the best way to manage them.</i></p>
<p>Address anger. Accept expression of anger at the deceased. Help students know these feelings are normal.</p>	<p><i>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</i></p>
<p>Address feelings of responsibility. Help students understand that the only person responsible for the suicide is the deceased. Reassure those who have exaggerated feelings of responsibility, such as thinking they should have done something to save</p>	<p><i>This death is not your fault. We cannot always see the signs because a suicidal person may hide them well.</i></p> <p><i>We cannot always predict someone’s behavior.</i></p>
<p>Encourage help-seeking. Encourage students to seek help from a trusted adult if they or a friend are feeling depressed or suicidal.</p>	<p><i>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, depressed, or had thoughts of suicide?</i></p>

SAMPLE GRIEF DISCUSSION WITH STUDENTS**Share facts of the death:**

"I have some very sad news to share today. Our teacher, Mrs. _____ died a few weeks ago due to complications from _____. I am feeling pretty sad and would like to take some time to talk to you about how you are and answer any questions you might have..."

Share the information that you have directly and honestly.

- Ask students if they know what happened. Ask them how they found out. At this point allow them to share what they know or think without correcting them.
- Allow students to ask questions. Answer questions as best you can, knowing that it is okay to say "I don't know" when you don't have the answer.
- Talk to your class about how grief affects people and encourage them to share how they feel. One way to do this is to discuss what other types of losses or deaths the students in your class have experienced, and what helped them cope.
- Let students know that if they would like to write a letter and/or draw a picture to support the family that they could do so.
- Let students and families know that there are support counselors that they can speak with today who can help with on-going support as well.
- Discuss how difficult it may be for their classmate(s) to return to school, and how they may help. You can ask your class for ideas about how they would like others to treat them if they were returning to school after a death, pointing out differences in preferences such as:
 - Some grieving students might like to be left alone while others may want the circumstances discussed freely.
 - Some grieving students may want everyone to treat them the same way they treated them before. These students typically don't like people being "extra nice".
 - Other grieving students may say they don't want to be in the spotlight, but they may also feel like they don't want people acting like nothing happened.

Provide a way for your class to reach out to the grieving classmate and his or her family. One of the ways that students can reach out is by sending cards or pictures to the child and family, letting them know the class is thinking of them. If students in your class knew the person who died, they could share memories of that person.

From KARA: Moving through Grief Toward Hope and Meaning. www.karfa-grief.org

FACTS ABOUT SUICIDE AND MENTAL DISORDERS IN ADOLESCENTS

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.

Warning Signs of Suicide

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

What to Do in a Crisis

Take any threat or talk about suicide seriously. Start by telling the person that you are concerned. Don't be afraid to ask whether she or he is considering suicide or has a plan or method in mind. Resist the temptation to argue the person out of suicide by saying, "You have so much to live for" or "Your suicide will hurt your family and friends." Instead, seek professional help.

In an acute crisis:

- Call 911.
- Do not leave the person alone.

- If safe to do so, remove any firearms, alcohol, drugs, or sharp objects that could be used.
- Call the National Suicide Prevention Lifeline: 1-800-273-TALK (8255).
- Take the person to an emergency room or walk-in clinic at a psychiatric hospital.

Symptoms of Mental Disorders Associated with Suicide Risk

Most adults are not trained to recognize signs of serious mental disorders in teens, and symptoms are therefore often misinterpreted or attributed to normal adolescent mood swings, laziness, poor attitude, or immaturity. Diagnosis of a mental disorder should always be made by a qualified mental health professional.

The key symptoms of **major depressive disorder** in teens are sad, depressed, angry, or irritable mood and lack of interest or pleasure in activities the teen used to enjoy, lasting at least two weeks. Symptoms represent a clear change from the person's normal behavior and may include changes in appetite or sleep, feelings of worthlessness/guilt, inability to concentrate, slowed or agitated movement, recurrent thoughts of death or suicide, fatigue/loss of energy, and self-harm behavior.

Sometimes referred to as **manic depression, bipolar disorder** includes alternating episodes of depression and mania. Symptoms of mania last at least one week, cause clear social or academic problems, and include extreme distractibility, lack of need for sleep, unusually rapid speech or motor activity, excessive talking, and involvement in risky activities such as gambling or irresponsible sexual behavior.

The key characteristics of **generalized anxiety** include persistent worry (about tests or speaking in class) occurring on most days for a period of six months. Symptoms may include restlessness or feeling keyed up, irritability, being easily fatigued, muscle tension, difficulty concentrating, and sleep disturbances.

Teens with **substance use disorder** show a problematic pattern of drug or alcohol use over 12 months or more, leading to significant impairment or distress. Symptoms include taking larger amounts, over a longer period, than intended; continued use despite knowing that it is causing problems; increased irritability and anger; sleep disturbances; and family conflict over substance use.

Conduct disorder is a repetitive, persistent pattern in children or adolescents of violating the rights of others, rules, or social norms, occurring over 12 months. Symptoms include bullying or threatening others, physical fights, fire-setting, destroying property, breaking into houses/cars, physical cruelty to people or animals, lying, shoplifting, running away from home, and frequent truancy.

Anorexia nervosa and bulimia are **eating disorders** that are strongly linked to other mental disorders, especially depression and anxiety. Symptoms of anorexia nervosa include refusal to maintain body weight at a minimally normal level for age and height, intense fear of gaining weight, and a denial of low body weight. Symptoms of bulimia include repeated episodes of binge eating (at least twice a week for three months) combined with recurrent inappropriate behaviors to avoid gaining weight such as vomiting, misuse of laxatives, or excessive exercise.

Help Is Available

If there are concerns about a student's emotional or mental health, a referral should be made to an appropriate mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available include school counselors, community mental health agencies, emergency psychiatric screening centers, and children's mobile response programs. Pediatricians and primary care providers can also be a source of mental health referrals.

Some depressed teens show improvement in just four to six weeks with talk therapy alone. Most others experience a significant reduction of depressive symptoms with antidepressant medication. Medication is usually essential in treating severe depression and other serious mental disorders, such as bipolar disorder and schizophrenia. Since 2004, an FDA warning has recommended close monitoring of youth taking antidepressants for worsening of symptoms, suicidal thoughts or behavior, and other changes. Risks of medication must be weighed against the risks of not effectively treating depression or other serious mental disorders.

Adapted with permission from *More Than Sad: Preventing Teen Suicide*, American Foundation for Suicide Prevention, <http://www.morethansad.org>.)

Additional Information

Center for School Mental Health Assistance. Crisis intervention: A guide for school-based clinicians. (2002). http://csmh.umaryland.edu/resources/CSMH/resourcepackets/files/crisis_intervention_2002.pdf

Maine Department of Health and Human Services. Media guidelines for school administrators who may interact with reporters about youth suicide. (2006). <http://www.maine.gov/suicide/professionals/program/mediaschoolhtm>

National Association of School Psychologists. Culturally competent crisis response: Information for school psychologists and crisis teams. (2004). http://www.schoolcounselor.org/files/cc_crisis.pdf

National Suicide Prevention Lifeline. <http://www.suicidepreventionlifeline.org>
800-273-TALK (8255)

Reeves, M. A., Brock, S. E., and Cowan, K. C. Managing school crises: More than just response. (2008). <http://www.nasponline.org/resources/principals/School%20Crisis%20NASSP%20May%20202008.pdf>

Suicide Prevention Resource Center (SPRC). Customized Information for school health and mental health care providers. (2008). http://www.sprc.org/featured_resources/customized/school_mentalhealth.asp

U.S. Department of Education, Office of Safe and Drug-Free Schools. Practical information on crisis planning: A guide for schools and communities (2007). <http://www2.ed.gov/admins/lead/safety/emergencyplan/crisisplanning.pdf>

Weekley, N., and Brock, S. E. Suicide: Postvention strategies for school personnel. (2004). http://www.nasponline.org/resources/intonline/HCHS2_weekley.pdf

AFSO & SPRC: After a Suicide A Toolkit for Schools 2011

MEMORIALIZATION

School communities often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. It can be challenging for schools to strike a balance between compassionately meeting the needs of distraught students while preserving the ability of the school to fulfill its primary purpose of education. In the case of suicide, schools must consider how to appropriately memorialize the student who died without risking suicide contagion among other students who may themselves be at risk.

KEY CONSIDERATIONS

It is very important that schools strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces stigma and may be deeply and unfairly painful to the student's family and friends.

Nevertheless, because adolescents are especially vulnerable to the risk of suicide contagion, it's equally important to memorialize the student in a way that doesn't inadvertently glamorize or romanticize either the student or the death. Schools can do this by seeking opportunities to emphasize the connection between suicide and underlying mental health issues such as depression or anxiety that can cause substantial psychological pain but may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

Wherever possible, schools should both meet with the student's friends and coordinate with the family, in the interest of identifying a meaningful, safe approach to acknowledging the loss. This section includes several creative suggestions for memorializing students who have died by suicide.

Funerals and Memorial Services

All the recommendations made here focus on keeping the regular school schedule intact to the maximum extent possible for the benefit of the entire student body (including those who may not have known the deceased).

While at first glance schools may appear to provide an obvious setting for a funeral or memorial service because of their connection to the community and their ability to accommodate a large crowd, it is strongly advised that such services not be held on school grounds, to enable the school to focus instead on maintaining its regular schedule, structure, and routine. Additionally, using a room in the school for a funeral service can inextricably connect that space to the death, making it difficult for students to return there for regular classes or activities.

In situations where school personnel are able to collaborate with the family regarding the funeral or memorial service arrangements, it is also strongly advised that the service be held outside of school hours.

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

If possible, the school should coordinate with the family and funeral director to arrange for counselors to attend the service. A guide for funeral directors is available at

<http://www.sprc.org/library/funeraldirectors.pdf>. In all cases, the principal or another senior administrator should attend the funeral.

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

Spontaneous Memorials

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

The school's goal should be to balance the students' need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. In all cases, schools should have a consistent policy so that suicide deaths are handled in the same manner as any other deaths. A combination of time limits and straightforward communication can help to restore equilibrium and avoid glamorizing the death in ways that may increase the risk of contagion. Although it may in some cases be necessary to set limits for students, it is important to do so with compassion and sensitivity, offering creative suggestions whenever possible. For example, schools may wish to make poster board and markers available so that students can gather and write messages. It is advisable to set up the posters in an area that may be avoided by those who don't wish to participate (i.e., not in the cafeteria or at the front entrance). After a few days, the posters can be removed and offered to the family.

When a memorial is spontaneously created on school grounds, schools are advised to monitor it for messages that may be inappropriate (hostile or inflammatory) or that indicate students who may themselves be at risk. Schools can leave such memorials in place until after the funeral (or for up to approximately five days), after which the tribute objects may be offered to the family. It is generally not necessary to prohibit access to the site or to cordon it off, which would merely draw excessive attention to it.

It is recommended that schools discourage requests to create and distribute t-shirts and buttons bearing images of the deceased by explaining that, while these items may be comforting to some students, they may be quite upsetting to others. If students come to school wearing such items without first seeking permission, it is recommended that they be allowed to wear the items for that day only, and that it should be explained to them that repeatedly bringing images of the deceased student into the school can be disruptive and can glamorize suicide.

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

When a spontaneous memorial occurs off school grounds, the school's ability to exert influence is limited. It can, nevertheless, encourage responsible approach among the students by explaining

that it is recommended that memorials be time-limited (again, approximately five days, or until after the funeral), at which point the memorial would be disassembled and the items offered to the family. Another approach is to suggest that the students participate in a (supervised) ceremony to disassemble the memorial, during which music could be played and students could be permitted to take part of it home; the rest of the items would then be offered to the family.

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

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

School Newspapers

Coverage of the student's death in the school newspaper may be seen as a kind of memorial; also, articles can be used to educate students about suicide warning signs and available resources. It is strongly recommended that any such coverage be reviewed by an adult to ensure that it conforms to the standards set forth in *Reporting on Suicide: Recommendations for the Media*, which was created by the nation's leading suicide prevention organizations.

Events

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

Often, the parents of the deceased student express an interest in holding an assembly or other event to address the student body and describe the intense pain the suicide death has caused to their family in the hopes that this will dissuade other students from taking their own lives. While it is surely understandable that bereaved parents would wish to prevent another suicide death, schools are strongly advised to explain that this is not an effective approach to suicide prevention and may in fact even be risky, because students who are suffering from depression or other mental health issues may hear the messaging very differently from the way it is intended, and may even become more likely to act on their suicidal thoughts. Instead, parents should be encouraged to work with the school to bring an appropriate educational program to the school, such as *More than Sad: Teen Depression*, a DVD that educates teens about the signs and symptoms of depression {available at <http://www.morethansad.org>} or others that are listed in the Suicide Prevention Resource Center/American Foundation for Suicide Prevention Best Practices Registry (available at <http://www.sprc.org>).

Yearbooks

Again, the guiding principle is that all deaths should be treated the same way. So if there is a history of dedicating the yearbook (or a page of the yearbook) to students who have died, that policy is equally applicable to a student who has died by suicide, provided that an adult makes final editorial decisions.

Whenever possible, the focus should be on mental health and/or suicide prevention. For example, underneath the student's picture it might say, "In your memory we will work to erase the stigma surrounding mental illness and suicide." The page might also include pictures of classmates engaging in a suicide prevention event such as an Out of the Darkness community walk (<http://www.outofthedarkness.org>).

Graduation

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

Permanent Memorials and Scholarships

Some communities wish to establish a permanent memorial (sometimes physical, such as planting a tree or installing a bench or plaque; sometimes commemorative, such as a scholarship). Others are afraid to do so.

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

Creative Suggestions

Some schools may resist allowing any kind of memorialization at all, damping down on any student desire to publicly acknowledge the death for fear of glamorizing suicide and risking suicide contagion. But simply prohibiting any and all memorialization is problematic in its own right—it is deeply stigmatizing to the student's family and friends, and can generate intense negative reactions, which can exacerbate an already difficult situation and undermine the school's efforts to protect the student body's emotional regulation.

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

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

It can also be helpful for schools to come equipped with specific, constructive suggestions for safe memorialization, such as:

- Holding a day of community service or creating a school-based community service program in honor of the deceased
- Putting together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., <http://www.outofthedarkness.org>), or holding a local fundraising event to support a local crisis hotline or other suicide prevention program
- Sponsoring a mental health awareness day
- Purchasing books on mental health for the school or local library
- Working with the administration to develop and implement a curriculum focused on effective problem-solving
- Volunteering at a community crisis hotline
- Raising funds to help the family defray their funeral expenses
- Making a book available in the school office for several weeks in which students can write messages to the family, share memories of the deceased, or offer condolences; the book can then be presented to the family on behalf of the school community

Additional Information

Centre for Suicide Prevention (Calgary). School Memorials After Suicide: Helpful or harmful? (2004). http://www.sprc.org/library_resources/items/school-memorials-after-suicide-helpful-or-harmful

Gould, M. et al. Media Contagion and Suicide Among the Young. *American Behavioral Scientist* 46:9 (May 2003) 1269-1284.

Jellinek, M. et al. When a Student Dies. *Educational Leadership Association for Supervision and Curriculum Development* (November 2007); 78-82.

National Association of School Psychologists. Memorial Activities at School: A List of "Do's" and "Don'ts" (2002). http://www.nasponline.org/resources/crisis_safety/memorialdo_donot.pdf

National School Board Association. Student Suicide Memorial Policy. *School Board News*.18 (March 24, 1998).

Sample-STUDENT SUICIDE RISK DOCUMENTATION FORM

STUDENT INFORMATION		
Date student was identified as possibly at risk:		
Name:		
Date of Birth:	Gender:	Grade:
Name of Parent/Guardian:		
Parent/Guardian's Phone Number(s):		
IDENTIFICATION OF SUICIDE RISK		
Who identified student as being at risk? Indicate name where appropriate.		
<input type="checkbox"/> Student him/herself <input type="checkbox"/> Parent: <input type="checkbox"/> Teacher: <input type="checkbox"/> Other staff: <input type="checkbox"/> Student/Friend: <input type="checkbox"/> Other:		
Reason for concern:		
RISK ASSESSMENT		
Assessment conducted by:		
Date of assessment:		
Type of assessment conducted:		
Results of assessment:		
NOTIFICATION OF PARENT/GUARDIAN		
Staff who notified parent/guardian:		
Date notified:		
Parent Contact Acknowledgement Form signed:		
<input type="checkbox"/> Yes <input type="checkbox"/> No If no, provide reason:		
MENTAL HEALTH REFERRAL		
Student referred to:	Date of referral:	
Personal Safety Plan developed with student and parent: _____(date)		
Mental Health Resources List and Student/Parent Handouts given to:		
<input type="checkbox"/> Student _____(date) <input type="checkbox"/> Parent/Guardian _____(date)		
Staff member to conduct follow-up:	Date of follow-up:	

WORKING WITH THE COMMUNITY

Because schools exist within the context of a larger community, it's very important that in the aftermath of a suicide or other death they establish and maintain open lines of communication with community partners such as the coroner/medical examiner, police department, mayor's office, funeral director, clergy, and mental health professionals.

KEY CONSIDERATIONS

The school is in a unique position to encourage open and constructive dialogue among important community partners, as well as with the family.

Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. For example, a school may be able to offer relevant information (such as the likely turnout at the funeral) and anticipate problems (such as the possibility that students may gather late at night at the place where the deceased died). A coordinated approach can be especially critical when the suicide death receives a great deal of media coverage and the entire community becomes involved.

Coroner/Medical Examiner

The coroner or medical examiner is the best starting point for confirming that the death has in fact been declared a suicide. (In some cases, it may also be necessary to contact the police department to verify the information). It is important that schools Get The Facts First and ascertain that all information is accurate before communicating with students.

However, given how quickly news and rumors spread {including through media coverage, e-mail, texting, and social networking sites), schools may not be able to wait for a final determination before they need to begin communicating with the students. In those cases, schools can say, "At this time, this is what we know..."

There may also be cases in which there is disagreement between the authorities and the family regarding the cause of death. For example, the death may have been declared a probable suicide but the family believes it to have been a homicide or an accident. Or the death may have been declared a suicide, but the family does not want this communicated, perhaps due to stigma, for fear of risking contagion, or because they simply do not (yet) believe or accept that it was suicide.

Schools have a responsibility to balance the need to be truthful with the school community while remaining sensitive to the family. They can take this opportunity to educate the community (including potentially vulnerable students) about the causes and complexity of suicide and to identify available mental health resources. For example, a school might say; "According to the medical examiner, the death has been declared a suicide. It can sometimes be difficult for us to be sure whether a death was intentional or not (for example, in the case of a drug overdose or a motor vehicle accident involving a single vehicle). While we may never know all of the details, we are deeply saddened, and want to take this opportunity to teach you some important information about suicide and where you can find help."

Of course, if a legal gag order is in effect, the school attorney should first research the applicable state law regarding discussing the cause of death before the school issues a statement.

Police Department

The police will likely be an important source of information about the death, particularly if there is an ongoing investigation (for example, if it has not yet been determined whether the death was suicide or homicide). The school will need to be in close communication with the police to determine (a) what they can and cannot say to the school community so as not to interfere with the investigation, and (b) whether there are certain students who must be interviewed by the police before the school can debrief or counsel them in any way.

There may also be situations in which the school has information that's relevant to the ability of the police to keep students safe. For example, the school may become aware that students have established a memorial off-campus and may even be engaging in dangerous behavior (such as gathering in large groups at the site of the death at night or holding vigils at which alcohol is being consumed) and may need to enlist the cooperation of the police to keep the students safe. The school may also be in a unique position to brief the police (and even the family) about what to expect at the funeral or memorial service in terms of turnout and other safety concerns.

Mayor's Office and Local Government

A student suicide death may reveal an underlying community-wide problem such as drug or alcohol use, bullying, gang violence, or a possible community-wide suicide cluster. Because schools function within-not separate from-the surrounding community, local government entities such as the mayor's office can be helpful partners in promoting dialogue and presenting a united front in the interest of protecting the community's young people.

Funeral Director

The school and funeral home are complementary sources of information for the community. Schools are often in an excellent position to give the funeral director a heads-up about what to expect at the funeral in terms of the number and types of students likely to attend, and the possible need to have additional security present. The school can also provide information about local counseling and other resources to the funeral directors, with the request that the information be made available to attendees at the funeral.

Schools can ask the funeral director to provide (or recommend) materials that the school could provide to students to help them prepare for the funeral. Schools can also encourage the funeral director to talk to the family about the importance of scheduling the service outside of school hours, encouraging students' parents to attend, and providing counselors to meet with distraught students after the service (and the need for a quiet area in which to do so).

Clergy

Because the school may be in the best position to understand the risk of contagion, it can play an important role by encouraging a dialogue between the family and the clergy (or whomever will be officiating at the service) to help sensitize them to the issue. This dialogue may provide an opportunity to explain the importance of not inadvertently romanticizing either the student or the death in the eulogy, but instead emphasizing the connection between suicide and underlying mental health issues such as depression or anxiety, which can cause substantial psychological pain but may not be apparent to others (or may manifest as behavioral problems or substance abuse).

Of course, if the school has a religious affiliation, it will be important to include clergy who are on staff in any communications and outreach efforts to support the student body, and encourage them to be familiar with their faith's current understanding of the relationship between mental illness and suicide.

Mental Health and Medical Communities

Most schools have counselors on staff, and it is important that these individuals are linked to other mental health professionals in the community. In particular, it is advisable that the school establish an ongoing relationship with a community mental health center that can see students in the event of a psychiatric emergency. In the aftermath of a suicide death, schools will want to notify the center to ensure seamless referrals if students show signs of distress. Schools will also want to publicize crisis hotline numbers such as Lifeline: 800-273-TALK (8255).

In addition, schools can encourage the local medical community, including primary care doctors and pediatricians, to screen for depression, substance abuse, and other relevant disorders in the youth they see.

Outside Trauma Responders

Working with schools in the aftermath of a suicide death can easily exhaust school crisis team members, which can interfere with their ability to effectively assist the students. Bringing in trained trauma responders from other school districts or local mental health or crisis centers to work alongside the school's crisis team members-and to provide care for the caregivers-can be quite helpful.

Community Organizations

Schools may also wish to network with their local chapter of the American Foundation for Suicide Prevention and with suicide bereavement support groups (see <http://www.afsp.org>).

Additional Information

SPAN USA and Suicide Prevention Resource Center (SPRC). Help at Hand: Supporting Survivors of Suicide loss. A guide for funeral directors. (2008). <http://www.sprc.org/library/funeraldirectors.pdf>

Suicide Prevention Resource Center (SPRC). After a suicide: Recommendations for religious services and other public memorial observances. (2004). <http://www.sprc.org/library/aftersuicide.pdf>

Suicide Prevention Resource Center (SPRC). Consensus Statement on Suicide and Suicide Prevention from an Interfaith Dialogue. (2009). http://www.sprc.org/library/Consensus_Statement.pdf

GUIDELINES FOR ANNIVERSARIES OF A DEATH

A revisiting of grief feelings can resurface on or near the anniversary date of a tragic loss. In some cultures there is a memorial ceremony held about one year after a death. Faculty and staff, if reminded of the anniversary, can be prepared to monitor and support students at that time. Adults are not immune to this, and so staff members may also revisit the loss. The postvention team may consider a follow-up program on the anniversary date. The school should be prepared for grief and emotions associated with the death that may also occur on other occasions, such as:

- The birthday of the person who died
- Holidays
- Athletic or other events in which the deceased would have participated
- The start of a school year
- Proms
- Graduation

The following actions can help a school prepare for such an anniversary:

- Remind staff to be aware that students may experience emotional reactions
- Educate staff about the warning signs of suicide and how to recognize and respond to students who may be at risk or experience severe emotions
- Remind staff that they may also experience an emotional reaction on this date
- Have grief counselors or mental health professionals on call

SAMHSA: Preventing Suicide: A Toolkit for High Schools, 2012

Adapted from Kerr, M , Brent, D., McKain, B., & McCommons, P (2003). Postvention standards manual: A guide for a schools response in the aftermath of sudden death (4th ed.) Pittsburgh: University of Pittsburgh/Western Psychiatric Institute and Clinic

GUIDELINES FOR WORKING WITH THE MEDIA

The staff person responsible for working with the media should prepare a written statement for release to those media representatives who request it. The statement should include the following:

- A very brief statement acknowledging the death of the student that does not include details about the death
- An expression of the school's sympathy to the survivors of the deceased
- Information about the school's postvention policy and program

All other staff (including school board members) should:

- Refrain from making any comments to or responding to requests from the media
- Refer all requests from the media to the person responsible for working with the media

Media representatives should:

- *Not* be permitted to conduct interviews on the school grounds
- *Not* be allowed to attend parent and student group meetings in order to protect information shared by parents who are concerned about their children
- Be provided with a copy of SPRC's information sheet "At-a-Glance: Safe Reporting on Suicide," which can be found at http://www.sprc.org/library/at_a_glance.pdf

SAMHSA: Preventing Suicide: A Toolkit for High Schools, 2012

Adapted from Kerr, M, Brent, D., McKain, B., & McCommons, P. (2003). Postvention standards manual: A guide for a school's response in the aftermath of sudden death (4th ed.) Pittsburgh: University of Pittsburgh/Western Psychiatric Institute and Clinic.

Framework for Successful Messaging - Positive Narrative

The Positive Narrative component of the Framework for Successful Messaging is designed to increase how much public messaging is “promoting the positive” about suicide prevention, including that: there are actions that people can take to help prevent suicide prevention works resilience and recovery are possible effective programs and services exist, and help is available. This idea is at the heart of the Action Alliance priority ” to change the national narratives around suicide and suicide prevention to ones that promote hope, connectedness, social support, resilience, treatment and recovery.”

Why promote a Positive Narrative? Public communications help create stories or “narratives” about suicide and suicide prevention in the public’s mind. Too often, public messaging conveys negative narratives about suicide, for example, that suicide is a common or acceptable response to stressful situations, that suicidal thoughts inevitably lead to death, or that nothing can be done about it. For example, emphasizing data about the extent and severity of suicide without discussing actions or solutions can imply that suicide is unsolvable. Other narratives take the form of a harmful social script for specific groups, for example that attempting suicide is a common or even expected experience for LGBT teens. Or that severe impairment, despair, and suicide is a more typical experience among U.S. military and veterans than resilience and survival. In fact, the opposite is true. This does not mean we should minimize the very real stories of struggle and death. While not concealing the very real problem and the toll it takes, we have to be careful not to portray suicide as inevitable or hopeless.

What about the media’s role in creating narratives?

There’s no question that news and entertainment media often convey negative narratives about suicide, especially given the newsworthiness of sensational deaths, system failures, and the like. Educating media professionals about the media recommendations is a key suicide prevention activity and we should continue these efforts. However, the media’s negative focus makes it even more important that the rest of us emphasize the Positive Narrative.

Given the media’s emphasis on the negative, it is even more critical for prevention practitioners and others messaging about suicide to counterbalance the media’s messages with ones that highlight actions, solutions, successes, and resources.

*For more information and resources on ‘Positive Narrative’ messaging, visit the
National Action Alliance for Suicide Prevention
<http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/narrative>*

MEDIA

The term social media refers to the various Internet and mobile communications tools (such as texting, Facebook, Twitter, YouTube, MySpace and others) that may be used to communicate information extremely rapidly, often to large numbers of people. In the emotionally charged atmosphere that can follow a suicide death, schools may be inclined to try to control or stifle such communications by students—a task that is virtually impossible in any event, since they generally take place outside of school hours and property. Schools can, however, utilize social media effectively to disseminate information and promote suicide prevention efforts.

KEY CONSIDERATIONS

Following a suicide death, students may immediately turn to social media for a variety of purposes, including transmitting news about the death (both accurate and rumored), calling for impromptu gatherings (both safe and unsafe), creating online memorials (both moving and risky), and posting messages (both appropriate and hostile) about the deceased.

Although schools may initially consider social media to be outside of its traditional jurisdiction, they can in fact collaborate with students and utilize these tools to disseminate important and accurate information to the school community, identify students who may be in need of additional support or further intervention, share resources for grief support and mental health care, and promote safe messages that emphasize suicide prevention and minimize the risk of suicide contagion.

Involve Students

It can be very beneficial for a designated member of the Crisis Response Team (ideally someone from the school's information technology department) to reach out to friends of the deceased and other key students to work collaboratively in this area. Working in partnership with student leaders will enhance the credibility and effectiveness of social media efforts, since the students themselves are in the best position to help identify the particular media favored by the student body, engage their peers in honoring their friend's life appropriately and safely, and inform school staff about online communications that may be worrisome.

Students who are recruited to help should be reassured that school staff are only interested in supporting a healthy response to their peer's death, not in thwarting communication. They should also be made aware that staff are available and prepared to intervene if any communications reveal cause for concern.

Disseminate Information

- Schools may already have a website and/or an online presence (or page) on one or more social media sites; students can help identify others that are currently popular. These can be used to proactively communicate with students, teachers, and parents about:
 - The funeral or memorial service (schools should of course check with the student's family before sharing information about the funeral)
 - Where students can go for help or meet with counselors
 - Mental illness and the causes of suicide
 - Local mental health resources
 - The National Suicide Prevention Lifeline number: 800-273-TALK (8255)
 - National suicide prevention organizations such as the National Suicide Prevention Lifeline (www.suicidepreventionlifeline.org), the American Foundation for Suicide Prevention (www.afsp.org)

Schools should emphasize help-seeking and suicide prevention. More specific guidance for safe message content may be found at <http://www.sprc.org/llbrazy/SafeMessagingfinal.pdf>. Students can also be enlisted to post this information on their own online pages.

Online Memorial Pages

Online memorial pages and message boards have become common practice in the aftermath of a death.

Some schools (with the permission and support of the deceased student's family) may choose to establish a memorial page on the school website or on a social networking site. As with all memorialization following a suicide death, such pages should take care not to glamorize the death in ways that may lead other at-risk students to identify with the person who died. It is therefore vital that memorial pages utilize safe messaging, include resources, be monitored by an adult, and be time-limited.

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

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

Monitor and Respond

To the extent possible, social media sites (including the deceased's wall or personal profile pages) should be monitored for:

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

Responses may include posting comments that dispel rumors, reinforce the connection between mental illness and suicide, and offer resources for mental health care. In some cases, the appropriate response may go beyond simply posting a comment, safe message, or resource information. It may extend to notifying parents and local law enforcement about the need for security at a late-night student gathering, for example.

In some cases it may be necessary to take action against so-called trolls who may seek out memorial pages on social media sites and post deliberately offensive messages and pictures. Most sites have a report mechanism or comparable feature, which enables users to notify the site of the offensive material and request that it be removed. The administrator of the memorial page may also be able to block particular individuals from accessing the site. Because the available options vary from site to site and can evolve over time, schools are advised to contact the particular site for instructions.

The National Suicide Prevention Lifeline has developed an in-depth online post-vention manual that details how to find various social media sites and other online groups, post resources, and reach out to parents. It also includes case examples and resource links and is available at

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

Additional Information

National Suicide Prevention Lifeline. Lifeline online postvention manual.

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

Suicide Prevention Resource Center (SPRC). Safe and Effective Messaging for Suicide Prevention. (2006).

<http://www.sprc.org/library/SafeMessagingfinal.pdf>

SANTA CLARA COUNTY - 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

National Suicide Prevention Lifeline

1-800-273-TALK (8255)

Santa Clara County Suicide and Crisis Hotline

1-855-278-4204

Adolescent Counseling Services

650-424-0852

www.acs-teens.org

Local Mental Health Resources:

Refer to Appendix B2, Resource List, Toolkit for Mental Health Promotion and Suicide Prevention

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](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 1V 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).

recommendations for reporting on suicide[®]

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



Important points for covering suicide

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

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

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

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

Instead of this:



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

do this:



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



avoid misinformation and offer hope

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



suggestions for online media, message Boards, Bloggers & citizen Journalists

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

more information and resources at:
www.reportingonsuicide.org or the following local resources:

ATTACHMENT 3.22 helpful side-Bar for stories



Warning signs of suicide

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

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



What to do

If someone you know exhibits warning signs of suicide:

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

the national suicide prevention lifeline
800-273-tALK (8255)

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





At-a-Glance: Safe Reporting on Suicide

Research indicates that the way suicide is reported in the media can contribute to additional suicides and suicide attempts. Conversely, stories about suicide can inform readers and viewers about the likely causes of suicide, its warning signs, trends in suicide rates, and recent treatment advances. The following recommendations have been developed to assist reporters and editors in safe reporting on suicide.

For Reporters

What to Avoid

- *Avoid detailed descriptions of the suicide, including specifics of the method and location.*
Reason: Detailed descriptions increase the risk of a vulnerable individual imitating the act.
- *Avoid romanticizing someone who has died by suicide. Avoid featuring tributes by friends or relatives. Avoid first-person accounts from adolescents about their suicide attempts.*
Reason: Positive attention given to someone who has died (or attempted to die) by suicide can lead vulnerable individuals who desire such attention to take their own lives.
- *Avoid glamorizing the suicide of a celebrity.*
Reason: Research indicates that celebrity suicides can promote copycat suicides among vulnerable people. Do not let the glamour of the celebrity obscure any mental health or substance abuse problems that may have contributed to the celebrity's death.
- *Avoid oversimplifying the causes of suicides, murder-suicides, or suicide pacts, and avoid presenting them as inexplicable or unavoidable.*
Reason: Research shows that from 60–90 percent of suicide victims have a diagnosable mental illness and/or substance use disorder. People whose suicide act appears to be triggered by a particular event often have significant underlying mental health problems that may not be readily evident, even to family and friends. Studies also have found that perpetrators of murder-suicides are often depressed, and that most suicide pacts involve one individual who is coercive and another who is extremely dependent.
- *Avoid overstating the frequency of suicide.*
Reason: Overstating the frequency of suicide (by, for example, referring to a “suicide epidemic”) may cause vulnerable individuals to think of it as an accepted or normal response to problems. Even in populations that

have the highest suicide rates, suicides are rare.

- *Avoid using the words “committed suicide” or “failed” or “successful” suicide attempt.*
Reason: The verb “committed” is usually associated with sins or crimes. Suicide is better understood in a behavioral health context than a criminal context. Consider using the phrase “died by suicide.” The phrases “successful suicide” or “failed suicide attempt” imply favorable or inadequate outcomes. Consider using “death by suicide” or “non-fatal suicide attempt.”

What to Do

- *Always include a referral phone number and information about local crisis intervention services.*
Refer to: The National Suicide Prevention Lifeline toll-free number, 1-800-273-TALK (273-8255), which is available 24/7, can be used anywhere in the United States, and connects the caller to a certified crisis center near where the call is placed. More information can be found on the National Suicide Prevention Lifeline website: www.suicidepreventionlifeline.org
- *Emphasize recent treatment advances for depression and other mental illness. Include stories of people whose treatment was life-saving or who overcame despair without attempting suicide.*
Refer to: Suicide Prevention Resource Center's research and news briefs: www.sprc.org/news/research.asp
- *Interview a mental health professional who is knowledgeable about suicide and the role of treatment or screening for mental disorders as a preventive strategy.*
Refer to: The American Foundation for Suicide Prevention's “Talk to the Experts” page: www.afsp.org, view *About Suicide*, click on *For the Media* to locate the *Talk to the Experts* section.

For Reporters *(Continued)*

Reporters may also contact the Suicide Prevention Resource Center at 1-877-GET-SPRC (438-7772), the American Association of Suicidology at (202) 237-2280, or the Suicide Prevention Action Network USA at (202) 449-3600.

- *Emphasize decreasing trends in national suicide rates over the past decade.*

Refer to: CDC's (Centers for Disease Control and Prevention) WISQARS (Web-based Injury Statistics Query and Reporting System): www.cdc.gov/ncipc/wisqars/ or talk with an expert (see previous recommendation).

- *Emphasize actions that communities can take to prevent suicides.*

Refer to: CDC Recommendations for a Community

Plan for the Prevention and Containment of Suicide Clusters:
wonder.cdc.gov/wonder/PrevGuid/p0000214/p0000214.asp

Best Practices Registry for Suicide Prevention:
www.sprc.org/featured_resources/bpr/index.asp

- *Report on activities coordinated by your local or state suicide prevention coalition.*

Refer to: Your state suicide prevention contact will be able to tell you if there are local groups or organizations providing suicide prevention training in your community. See the Suicide Prevention Resource Center's State Suicide Prevention webpages:
www.sprc.org/stateinformation/index.asp

For Editors

What to Avoid

- *Avoid giving prominent placement to stories about suicide.*

Avoid using the word "suicide" in the headline.

Reason: Research shows that each of the following lead to an increase in suicide among media consumers: the placement of stories about suicide, the number of stories (about a particular suicide, or suicide in general), and dramatic headlines for stories. Using the word "suicide" or referring to the cause of death as "self-inflicted" in headlines increases the likelihood of suicide contagion.

- *Avoid describing the site or showing pictures of the suicide.*

Reason: Research indicates that such detailed coverage encourages vulnerable people to imitate the act.

What to Do

- *Suggest that all reporters and editors review Reporting on Suicide: Recommendations for the Media.*

These guidelines for responsible reporting of suicide were developed by a number of Federal agencies

and private organizations, including the Annenberg Public Policy Center.

Refer to: www.afsp.org, view *About Suicide*, click on *For the Media* section

- *Encourage your reporters to review examples of good and problematic reporting of suicide.*

Refer to: The American Foundation for Suicide Prevention's website: www.afsp.org, view *About Suicide*, click on *For the Media* section

- *Include a sidebar listing warning signs, or risk and protective factors for suicide.*

Refer to: American Association of Suicidology's warning signs:
www.sprc.org/library/helping.pdf

National Strategy for Suicide Prevention's risk and protective factors:
www.sprc.org/library/srisk.pdf

National Institute of Mental Health, Suicide Prevention: www.nimh.nih.gov/topics/suicide-prevention.shtml

ATTACHMENT 3.23

The recommendations in this publication were adapted in 2005, from *Reporting on Suicide: Recommendations for the Media*, a 2001 report by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology, and Annenberg Public Policy Center. www.afsp.org, view *About Suicide*, click on *For the Media* section.

We would like to acknowledge Madelyn Gould of Columbia University for her many contributions to this document. Additionally, we thank Lanny Berman, Lidia Bernik, Ann Haas, Karen Marshall, and Dan Romer for their input.

www.sprc.org

Created 2005 - Updated 2007

SUICIDE CONTAGION AND CLUSTERS

*“Data clearly show that exposure to suicidal behavior (ideation and attempts) or a fatality raises the risk of subsequent suicide in people who have been exposed”
(Survivors of Suicide Loss Task Force 2015)*

Adolescents and those in their early 20’s are particularly vulnerable to the adverse effects of exposure to the suicide of a peer. This can lead to phenomena called suicide contagion and suicide clusters among this age group.

The relative risk of suicide among 15-19 year olds is 2 to 4 times greater among those who knew a peer who died by suicide (Survivors of Suicide Loss Task Force, 2015, p.19). The process leading to this increased risk of suicide is called contagion. Through the direct or indirect transmission of suicidal behavior the death of one person by suicide may contribute to another person’s similar death. Although this is comparatively rare among all suicide deaths, adolescents are more susceptible to imitative suicide than adults because they identify more readily with the behavior and qualities of their peers (AFSP & SPRC, 2011, p.43). Using data from the National Longitudinal Study of Adolescent Health (ADD Health) it has been concluded that “among teens, having a friend who died by suicide increased both suicidal ideation and attempts for at least a year following the loss” (Survivors of Suicide Loss Task Force, 2015, p.19).

A suicide cluster is comprised of an excessive number of suicides occurring in close temporal and/or geographical proximity (Lake & Gould, 2014, p. 52). In clusters that occur within localized communities, such as schools, (called space-time or “point” clusters), the teens who die are more likely to have pre-existing vulnerabilities. Research has concluded that “suicide contagion may have triggered suicidal behavior in adolescents who were already vulnerable, but who nonetheless may not have died by suicide without the added impetus of exposure to the suicide of a peer” (Lake & Gould, 2014, p. 55). Clusters account for 1% to 5% of teenage suicides (Zenere, 2009, p.13).

Schools have the opportunity to prevent the contagious behavior contributing to space-time clusters in school communities. After a student’s suicidal death the school can identify students who are particularly vulnerable to the phenomena of contagion. These students are more likely to have the following risk factors:

1. Previous suicidal thoughts or behaviors (attempts),
2. Having been hospitalized for a mental illness or substance abuse problem,
3. A recent or anticipated relationship break-up,
4. Physical self injury or physical violence toward others (Lake & Gould, 2014, p. 56).

Part of a “postvention” effort is identifying and supporting students at risk. Suicidal individuals frequently experience an approach-avoidance conflict regarding suicide: meaning the wish to die coexists in tension with the wish to live (Lake & Gould, 2014, p. 57). Experiencing suicidal behavior modeled by a peer has the effect of disinhibiting suicidal behavior particularly among adolescents. Schools can help support that “wish to live” through all their postvention efforts.

In addition, it has been found that “newspaper coverage of suicide is significantly associated with the initiation of suicide clusters” (Gould, Kleinman, Lake, Forman, Midle, 2014, p. 5). This effect is strongest for news stories about teenage suicides. “Repeated, detailed and explicit reporting on completed suicide might normalize suicide in the eyes of vulnerable young people, reducing their inhibitions against the modeled

ATTACHMENT 3.24

act” (Gould et al., 2014, p. 7). Research has found “that only stories about suicidal individuals, as opposed to other types of stories about suicide are associated with the occurrence of subsequent suicide” (Gould et al., 2014 p. 8). This supports the theory that the media effect operates through identification with a model (Gould et al., 2014, p. 8).

Characteristics of print news articles strongly associated with suicide clusters

1. Prominent - front page and pictures displaying sadness
2. Explicit Headlines - contain the word suicide; mention the specific suicide method; sensational (written in tabloid like manner to arouse excitement)
3. Detailed descriptions - name of suicidal individual; name of school; time or place of death; suicide method procedure; number of sentences describing the method; unfavorable characteristics of the suicidal individual; suicide note mentioned
4. Amount and Duration - repetitive reporting on the same suicide
5. Reports about fatal suicide rather than attempted suicide

“Media portrayals of suicide might have a role in the emergence of some teenage suicide clusters” (Gould et al., 2014, p. 9). It is possible to mitigate media effects on suicide by implementing media guidelines for suicide reporting (<http://www.reportingonsuicide.org>) It is also of note that, “Even since the advent of the internet... newspapers remain the predominant source of suicide reporting to which adolescents and young adults are exposed” (Gould et al., 2014, p. 8). Two steps schools can take to prevent the emergence of a suicide cluster and to mitigate the effects of contagion are sharing the research-informed guidelines for print media and heightened vigilance regarding already vulnerable adolescents.

Schools, through a comprehensive and systematic postvention response to a suicide in their community, can prevent potential suicides. Such a response is detailed in the Postvention section of this Toolkit and includes the following:

1. Confirm the facts
2. Mobilize the crisis response team,
3. Identify at-risk students
4. Inform students through personal communications,
5. Support and monitor affected students,
6. Provide appropriate outlets for grieving,
7. Engage the community (Zenere, 2009. p.14-15)
8. Provide all media with the Recommendations for Reporting on Suicide found at <http://reportingonsuicide.org>

If contagion is suspected due to the increase in suicidal thoughts, threats and attempts among students, the support of school mental health professionals should be sought. A community wide approach involving school officials, law enforcement, emergency department directors, clergy, public health, and community mental health agencies may be required to contain an active contagion (Zenere, 2009, p.15).

GRIEF FOR CHILDREN AND TEENS AFTER SUICIDE

“Grief is a Form of Love”; the Center for Complicated Grief, <https://complicatedgrief.columbia.edu>

The sudden loss of a student, peer, friend, sibling or relative to suicide can be devastating and traumatic. This is true for children and teens as much as for adults. Grieving after such a loss requires support in order to navigate a profoundly changed world. How profoundly one’s world is changed is a very individual experience, as is grief in general. Children and adolescents are generally more vulnerable to trauma than adults (National Action Alliance, 2015). And children grieve differently than adults. They tend to grieve sporadically reflecting their limited maturity (Requarth, 2006, p. 25). A teen will likely “experience reactions similar to those of adults, but will have fewer ways to cope” (Requarth, 2006, p. 56). The grief following a suicide does not end or go away. Rather, when dealt with successfully, it is transformed and integrated into the background of one’s life (Center for Complicated Grief).

Needs of bereaved children and adolescents after a suicide (National Action Alliance, 2015)

- Grief support that is appropriate to the child’s age and developmental level,
- Reassurance that someone will take care of their basic physical and emotional needs,
- Support for exploring feelings of responsibility and affirmation that they did not cause the death,
- Opportunities to tell the story of their loss in their own words,
- Help expressing negative thoughts and feelings,
- Ongoing support as their cognitive and linguistic development unfolds and their life experience evolves,
- Recognition that the experience and process of grief will be unique for each child,
- Effective professional assistance for grief complications.

When a student dies of suicide, schools face a particular challenge to identify and support those students who are deeply affected by their loss. Generally, loss to suicide causes shock, confusion or denial and questioning “why”; a roller coaster of emotions - anxiety, panic, numbness, helplessness, anger and guilt to name a few. Though this does not seem to be part of a school’s “mission to educate”, the disruption caused by such a loss and the possibility of the phenomenon of contagion (*see “Suicide Contagion and Clusters” in this Toolkit*) in teens is real and needs to be addressed by schools. Teens are “at increased risk to develop Major Depression, Post-traumatic Stress Disorder, and suicidal ideation following the suicide or suicide attempt of a peer”. Exposure to suicide can also increase the chance of experiencing complicated grief (Abbott & Zakriski, 2014, & Melhem et al., 2004). The “risk of suicide in adolescents following the death of a peer by suicide increases by two to four times higher than other age groups”(Abbott & Zakriski, 2014). Peers who were close to a student who died of suicide endorsed the belief that suicide is not preventable. Peers who were subject to repeated suicides (clusters) were more likely to believe suicide was normal (Abbott & Zakriski, 2014 & Brent et al., 1993). In addition, the stigma of suicide can make the grief process and bereavement harder for suicide loss survivors (Abbott & Zakriski, 2014). For all these reasons it is vital that schools provide support for grieving students after a suicide in their community. When youth are supported, they can eventually come to terms with their loss.

The **Postvention** section of this Toolkit goes into detail about how schools can respond and support students after a suicide death. Three guiding principles for the journey of grief after a suicide loss can be found in “After Suicide Loss; Coping with Your Grief” (Jordan & Baugher, 2016, p. 2):

- You must take care of yourself. (see **Self-Care** section)
- You will learn to cope, but you cannot do this alone
- You will survive this

With these guiding principles in mind, schools can give their students the opportunity to have their grief acknowledged, be encouraged to express their feelings, and given hope that they will get better. “School provides children and teens with a sense of normalcy, reassuring them that life goes on, even in the face of tragedy” (Requarth, 2006, p. 117). It is also important to recognize teachers and staff are impacted by the loss of a student and need support as well. These principles apply to the entire school community.

The Dougy Center offers several tips for helping children and teens after experiencing a loss to suicide. The following are a few:

- Tell the truth. This allows youth to be open with their questions and concerns.
- Expect and allow for different emotions and feelings. This allows youth to feel safe and supported in exploring their feelings.
- Talk openly about suicide. This provides a safe place and/or person with whom youth can talk about their questions, concerns, and fears.
- Talk about and remember the person who died. This helps children share their thoughts and feelings as they work through their grief.
- Share information about depression and mental illness. This helps youth understand that the person who died was struggling with an illness that affected their thought processes and informs them that these illnesses are treatable.
- Be prepared for fears. This is an opportunity to listen to youths’ questions and concerns and to offer reassurance without making unrealistic promises.
- Provide outlets for grieving: play, physical activity, art, ect. This provides the opportunity for adults to reflect back what they see and hear validating a youth’s experience and helping them regain a sense of balance and control.
- Respect differences in grieving styles. Recognizing that each person will grieve in their own way helps clarify and affirm their individual way of grieving.

It is also important to note that grieving sometimes looks like depression. If a child or teen is truly depressed they will exhibit five or more symptoms of clinical depression which will be affecting their daily functioning. “If physical and emotional symptoms seriously impact daily functioning, they should be addressed by a qualified medical professional or counselor” (The Dougy Center).

Resources

1. National Action Alliance (2015)

Bereaved Children

- A Child in Grief — bit.ly/achildgrief — Comprehensive website, from New York Life
- Foundation Dougy Center — bit.ly/dougygrief — Resource page of the Dougy Center website
- When a Brother or Sister Dies — bit.ly/siblingdies — Brochure for those who have experienced the death of a sibling by any means, from The Compassionate Friends
- When Families Grieve — bit.ly/familiesgrief — Lots of resources in various formats for bereaved families and children, from Sesame Street (access downloads at bit.ly/kidsgriefresources)
- Children, Teens and Suicide Loss, Dougy Center, American Foundation for Suicide Prevention
<https://afsp.org/wp-content/flipbooks/childrenteenssuicideloss/?page=1>

Guardians/Caregivers

- After a Suicide Death: Ten Tips for Helping Children & Teens — bit.ly/tipshelping — Brochure, from the Dougy Center

- Child Survivors of Suicide: A Guidebook — bit.ly/childsurvive — Comprehensive guidance on helping children bereaved by suicide, by Rebecca Parkin and Karen Dunne-Maxim (Spanish version: bit.ly/childsurvive-sp)
- Helping Children Cope — bit.ly/helpcope — Concise overview of helping suicide bereaved children, including activities, from a presentation at a VA medical center
- “Talking to Your Child about Suicide” — bit.ly/childabout — Brief article, from the NAMI New Hampshire loss survivor packet
- Understanding Suicide, Supporting Children — bit.ly/kidsupport — In-depth video on the point of view and needs of children bereaved by suicide, from the Dougy Center
- When a Child’s Friend Dies by Suicide — bit.ly/childfrienddies — Tips for parents and caregivers, from Society for the Prevention of Teen Suicide

Trauma and Grief in General

- National Alliance for Grieving Children — bit.ly/childalliance — Resource page of the website
- National Child Traumatic Stress Network — bit.ly/childgrieftrauma — Links and information about children affected by trauma
- NCTSN Caregiver Quick Tips — bit.ly/nctsnstips — Brief, authoritative handouts for helping young children, school-age children, and teens
- NCTSN Advice for Educators — bit.ly/adviceeducators — Handout to help educators in the aftermath of trauma affecting school populations

Books on Grief After Suicide

For Children and Their Caregivers

- After a Parent’s Suicide: Helping Children Heal. Requarth, M. (2008). Healing Hearts Press.
- After a Suicide Death: An Activity Book for Grieving Kids. (2001). The Dougy Center.
- But I Didn’t Say Goodbye: Helping Children and Families after a Suicide. Rubel, B. (2000). Griefwork Center.
- Red Chocolate Elephants: For Children Bereaved by Suicide (includes DVD). Sands, D. (2010). Karridale Pty Ltd.
- Someone I Love Died by Suicide: A Story for Child Survivors and Those Who Care for Them. Cammarata, D.T. (2009). Limitless Press.

2, Dougy Center

Children, Teens and Suicide Loss. (2017) Flip Book, Retrieved from <https://afsp.org/wp-content/flipbooks/childrenteenssuicideloss/?page=1>

For more resources see The Dougy Center website at <http://www.dougy.org>

For a definition of Complicated Grief see <http://www.mayoclinic.org/diseases-conditions/complicated-grief/basics/definition/con-20032765>

APPENDIX A:

School Suicide Prevention Policy, Law & Educational Standards

A1. Youth Suicide Prevention Policy Model for California

A2. FERPA, HIPAA and California Minor Consent Law

A3. Health Education Content Standards for California Public Schools: Mental, Emotional, and Social Health (High School)

Youth Suicide Prevention Policy Model for California

California *Education Code (EC)* Section 215, as added by Assembly Bill 2246, (Chapter 642, Statutes of 2016) mandates that the Governing Board of any local educational agency (LEA) that serves pupils in grades seven to twelve, inclusive, adopt a policy on pupil suicide prevention, intervention, and postvention. The policy shall specifically address the needs of high-risk groups, including suicide awareness and prevention training for teachers, and ensure that a school employee acts within the authorization and scope of the employee's credential or license.

- For more information on AB 2246 Pupil Suicide Prevention Policies, go to the California Legislative Information Web page at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB2246.
- For resources regarding youth suicide prevention, go to the State Superintendent of Public Instruction (SSPI) letter regarding Suicide Prevention Awareness Month on the California Department of Education (CDE) Web page at <http://www.cde.ca.gov/nr/el/le/yr16ltr0901.asp> and the Directing Change For Schools Web page at <http://www.directingchange.org/schools/>.

Additionally, the CDE encourages each LEA to work closely with their county behavioral health department to identify and access resources at the local level.

While the mandate does not apply to private schools or students below grade seven, we do encourage them to consider adopting a suicide prevention policy as a safety net for all students. This is particularly important since suicide is the second leading cause of death for youth ages fifteen to twenty-four. Students in earlier grades are also known to consider, attempt, and die by suicide—which is also a leading cause of death among ten to twelve-year-olds. Research demonstrates that suicidal ideation may start as early as preschool (however, suicide deaths are very rare among children nine years of age and younger). Although elementary and private schools are not legally required to adhere to AB 2246, they may want to consult with their legal staff about the advisability of adopting such a policy.

Please use the following links to view the complete details of the Model Youth Suicide Prevention Policy:

- <http://www.cde.ca.gov/ls/cg/mh/documents/modelpolicy.doc> or
- <http://www.cde.ca.gov/ls/cg/mh/index.asp>

“FERPA, HIPAA and California Minor Consent Law: A Brief Overview”

The federal laws surrounding confidentiality and the sharing of student information and records are traditionally covered by the federal Family Educational Rights and Privacy Act (*FERPA*) and the Health Insurance Portability and Accountability Act (*HIPAA*).

FERPA

FERPA aims to: 1) Protect the privacy of student educational records, defines educational records; and 2) Allow parent access to student educational records.

Educational Record: Definition from U.S. Department of Health and Human Services & U.S. Department of Education, “Joint Guidance on the Application of the Family Education Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records”, November 2008, p.1-2

- “Education Records” is broadly defined to mean those records that are: (1) directly related to a student, and (2) maintained by an educational agency or institution or by a party acting for the agency or institution See 34 CFR; 99.3 At the elementary or secondary level, a student’s health records, including immunization records, maintained by an educational agency or institution subject to FERPA, as well as records maintained by a school nurse, are “education records” subject to FERPA. In addition records that the schools maintain on special education students, including records on services provided to students under the Individuals when Disabilities Education Act (IDEA), are “education records” under FERPA. This is because these records are (1) directly related to a student, (2) maintained by the school or party acting for the school, and (3) not excluded from the definition of “education records”.
- -FAQ:
http://familypolicy.ed.gov/sites/fpco.ed.gov/files/FPCO_Parents%20and%20Eligible%20Students%20FAQ.pdf

While most records held by schools and school employees will be subject to FERPA, not all records created by school employees or held at schools are absolutely covered by FERPA, although these other records may well be subject to other laws governing disclosure. Two examples of records that are not subject to FERPA include:

Records of instructional, supervisory, and administrative personnel in the sole possession of the maker and which are not accessible to any other person except a substitute, also known as “sole possession” records. Sole possession records are generally “memory jogger” notes not intended to be a record of service.

Records on students eighteen years or older made by a physician, psychologist or other recognized professional and used only in connection with the provision of medical treatment.

FERPA applies to any public or private agency or institution which is the recipient of funds administered by the Sec. of Education under any applicable program if the agency provides educational services or instruction to students, or the agency is authorized to direct and control schools. In general, FERPA also applies to agencies who are providing services through contracts with the schools.

Generally, FERPA requires written parental consent for the release of educational records of a student under 18 years of age. Among other exceptions, parental release of educational records is not necessary

APPENDIX A2

to: 1) share information with other school officials with legitimate educational interests in the information; 2) allow parents to inspect and review records; 3) report child abuse; 4) when school staff believe there is a serious and imminent threat to someone (like a possible suicide); and 5) comply with a court order. Parents are entitled to inspect and review all FERPA records, including records created by school nurses, school social workers, teachers and other school personnel.

HIPAA

In contrast, medical and mental health providers outside of the school setting are governed by Health Insurance Portability and Accountability Act (HIPAA) if they use electronic records. Independent school based clinics that do not accept public school funding and do not provide services on behalf of the school are generally covered by HIPAA, even if they are located in a public school. It is important to take into consideration how the source of funding for the services. If public school monies are being used to fund services, providers should make a careful determination of whether FERPA applies to the records. If FERPA applies to a young person's record, HIPAA does not.

The records created by independent medical and mental health providers outside the school setting are covered by HIPAA. These records are also covered by California law. In general, health care providers must protect the confidentiality of personal health information. Providers must have a signed "authorization" to share protected health information unless the disclosure of records is specifically allowed or required under HIPAA. For example, disclosure is allowed or required for child abuse reporting, reporting certain violence, or for treatment purposes.

While in general parents have the right to consent to medical services on behalf of their children, young people can consent to some types of health care and mental health care services under California law, e.g. reproductive health care, mental health care and substance abuse services. When a minor consents to mental health care, some drug treatment and sexual assault treatment, under California law, the provider is required to involve the parent unless the provider determines that involvement by the parents is not appropriate. Involving the parents does not mean providing the parents with access to treatment records.

If the minor has the right to consent to services, the authorization to release records must be signed by the minor. In all other cases, the legal representative (generally a parent or legal guardian) must sign the release. Even when the parent has the right to access the young person's medical or mental health records, a provider can refuse to release records under HIPAA when the provider determines that treating the parent as the child's personal representative is not in the child's best interest or could endanger the child. Psychotherapy notes are provided additional protections regarding release and are not part of the patient's file.

General tips for sharing information:

Medical Providers

Know what system you are working in (do not assume you are covered by HIPAA if you are working with students in schools)

Know what services are confidential

Talk with young people about why sharing information may be in their best interests

Develop protocols for sharing information with families and schools

Schools

Know whether services being offered to students on campus are confidential
Develop protocols to guide “need to know” information sharing within the school setting
Develop protocols to guide sharing information with outside providers
Develop release forms with clear, understandable language
Support parents as partners

Parents

Understand that confidential services increase access to services for young people -- young people might be more willing to get help
Even if you have a “right” to information, allowing the young person to have some control over how information is shared with you might improve outcomes
Help your student understand his/her rights and ask for what s/he needs
Be careful about making decisions about what a young person needs without comprehensive information

Youth

Learn about your own health and mental health needs.
Learn about the services available for young people in your school and in your community
If you are worried about whether your concerns will be kept confidential -- ASK
Remember many young people ask a trusted adult to help them connect to services
Be your own best advocate

Cross system work

Agree on shared goals -- what are you trying to accomplish by working together?
Listen to the interests and concerns each partner brings to the table
Identify what information needs to be shared
Consult with a lawyer to develop policies and procedures, and draft release of information depending on the need for and purpose of sharing information.

For More information

HIPAA or FERPA? A Primer on School Health Information Sharing in California
Available at <https://youthlaw.org/publication/hipaa-or-ferpa-a-primer-on-school-health-information-sharing-in-california/>
Confidential Medical Release FAQ from Schools and Districts <https://www.schoolhealthcenters.org/wp-content/uploads/2016/01/NCYL-FAQ-ConfidentialMedicalRelease-2015.pdf>

Health Education Content Standards for California Public Schools Mental, Emotional, and Social Health Standard – GRADES 9-12

Standard 1: Essential Concepts

- 1.1.M Describe the benefits of having positive relationships with trusted adults.
- 1.2.M Analyze the qualities of healthy peer and family relationships.
- 1.3.M Describe healthy ways to express caring, friendship, affection, and love.
- 1.4.M Describe qualities that contribute to a positive self-image.
- 1.5.M Describe how social environments affect health and well-being.
- 1.6.M Describe the importance of recognizing signs of disordered eating and other common mental health conditions.
- 1.7.M Analyze signs of depression, potential suicide, and other self-destructive behaviors.
- 1.8.M Explain how witnesses and bystanders can help prevent violence by reporting dangerous situations.
- 1.9.M Classify personal stressors at home, in school, and with peers.
- 1.10.M Identify warning signs for suicide.
- 1.11.M Identify loss and grief.

Standard 2: Analyzing Influences

- 2.1.M Analyze the internal and external issues related to seeking mental health assistance.

Standard 3: Accessing Valid Information

- 3.1.M Access school and community resources to help with mental, emotional, and social health concerns.
- 3.2.M Evaluate the benefits of professional services for people with mental, emotional, or social health conditions.

Standard 4: Interpersonal Communication

- 4.1.M Seek help from trusted adults for oneself or a friend with an emotional or social health problem.
- 4.2.M Discuss healthy ways to respond when you or someone you know is grieving.

Standard 5: Decision Making

- 5.1.M Monitor personal stressors and assess techniques for managing them.
- 5.2.M Compare various coping mechanisms for managing stress.
- 5.3.M Analyze situations when it is important to seek help with stress, loss, an unrealistic body image, and depression.

Standard 6: Goal Setting

- 6.1.M Evaluate how preventing and managing stress and getting help for mental and social problems can help a person achieve short- and long-term goals.
- 6.2.M Set a goal to reduce life stressors in a health-enhancing w

Standard 7: Practicing Health-Enhancing Behaviors

- 7.1.M Assess personal patterns of response to stress and use of resources.
- 7.2.M Practice effective coping mechanisms and strategies for managing stress.
- 7.3.M Discuss suicide prevention strategies.
- 7.4.M Practice respect for individual differences and diverse backgrounds.
- 7.5.M Participate in clubs, organizations, and activities in the school and in the community that offer opportunities for student and family involvement.
- 7.6.M Practice setting personal boundaries in a variety of situations.

Standard 8: Health Promotion

- 8.1.M Support the needs and rights of others regarding mental and social health.
- 8.2.M Promote a positive and respectful environment at school and in the community.
- 8.3.M Object appropriately to teasing of peers and community members that is based on perceived personal characteristics and sexual orientation.

For other grade levels refer to: <http://www.cde.ca.gov/be/st/ss/documents/healthstandmar08.pdf>

from California Department of Education

APPENDIX B:

STAFF, PARENT & STUDENT RESOURCES

[B1. Frequently Asked Questions About Youth Mental Health and Suicide](#)

[B2. Mental Health Resources List](#)

[B3. Mental Health Information for Students](#)

[B4. Parent Handouts](#)

[B4i. When Your Child Expresses Suicidal Thoughts or Behaviors:](#)

[What to Do & Available Services/Resources](#)

[B4ii. Self-Care Advice for Parents with a Child in Crisis](#)

[B4iii. Risk Factors for Youth Suicide, SAMHSA Toolkit](#)

[B4iv. Recognizing & Responding to Warning Signs of Suicide, SAMHSA Toolkit](#)

[B4v. Santa Clara County Sample Personal Safety Plan](#)

FREQUENTLY ASKED QUESTIONS ABOUT YOUTH MENTAL HEALTH AND SUICIDE

1) What is expected development during adolescence?

Physical: During early adolescence, the body undergoes more development than at any other time, except the first two years of life. Developmental growth includes significant increases in height, weight, and internal organ size as well as changes in skeletal and muscular systems, and the onset of puberty. Physical growth is often rapid and uneven, causing many adolescents to lack coordination and literally have growing pains.

Intellectual: During early adolescence, youth are most interested in real-life experiences and authentic learning opportunities; they are often less interested in conventional academic subjects. They are deeply curious about the world around them but may lose interest quickly if information is not presented dynamically with plenty of interaction and peer-to-peer involvement. Young adolescents develop the capacity for abstract thinking, and they are able to think about their future, anticipate needs, and develop personal goals.

Moral/ethical: Young adolescents tend to be idealistic and possess a strong sense of fairness. They are moving from being self-centered to considering the rights and feelings of others. They begin to realize that moral issues are not strictly black and white. They are able to consider ethical and moral questions but lack experience and reasoning skills to make sound moral and ethical choices, which can put them at risk.

Social: Young adolescents have a strong need to belong to a group. Peer approval becomes more important and they are likely to turn to friends first when experiencing a problem. As they mature socially, they often have opposing loyalties to peer group and family. Though young adolescents may be rebellious toward parents and adults, they still depend on them and desire their approval. They tend to test limits and challenge adult authority figures (Adapted from Caskey & Anfara, 2007)

Emotional and psychological: Young adolescents begin to seek independence and to develop a strong sense of individuality and uniqueness. At the same time, they are highly sensitive to criticism, want to fit in with their peers, and are likely to have low self-esteem. They may be moody, restless, self-conscious, and unpredictable as they experience intense emotions and stress.

2) What is normal/abnormal teenage behavior?

Normal behavior:

Emotional up and downs—teens experience more intense feelings and become easily irritable
Some withdrawal from family (i.e. spending more time with friends, staying in the room to play video/computer games, etc)
Some risk taking behaviors: drugs, alcohol, sexually active

Abnormal behavior:

Decrease in enjoyment and time spent with friends and family
Big changes in energy levels, eating, sleeping patterns, or other behaviors
Physical symptoms (stomach aches, headaches, backaches)
Intense emotions such as feelings of hopelessness, sadness, anxiety, rage relative to the person's history
Excessive neglect of personal appearance or hygiene
Substance abuse
Dangerous or illegal thrill-seeking behavior
Is overly suspicious of others
Sees or hears things that others do not

Unexplained weight gain or loss
Cutting or self-harm

3) What is depression?

Depression is a medical condition that is treatable with professional help. Although it's normal for everyone to feel sad or depressed once in a while, struggling with clinical depression is not a typical rite of passage for teens. Clinical depression is an illness of the brain that includes imbalanced levels of neurotransmitters and pervasive changes in mood, thoughts, and physical functioning. Depression can be incapacitating and deadly if not treated. It is not a sign of weakness or an inability to "cope". It can happen to anyone at any time, even without an identifiable reason. A depressed person will feel down for at least two weeks and experience some of the other symptoms (described in ques. #7). These feelings will interfere with the ability to function normally. If all of this is present then probably a person has gone from just being sad to being depressed. If this is the case, it's important to reach out to a trusted adult and get the help needed to recover and get back to feeling normal. Depression can be incredibly frustrating and the sense of hopelessness and helplessness that it imbues people with can make it difficult for them to get help without the encouragement and support of the people who care about them.

4) How does grief differ from depression?

It is important to distinguish grief from depression. It is normal for feelings of sadness or grief to develop in response to loss and/or change. The American psychiatric Association states: The "death of a loved one, loss of a job, or the ending of a relationship are difficult experiences for a person to endure". Grief, therefore, is an emotional response to an incident of loss or change whereas depression is a pervasive disorder that stems from a combination of factors listed in the "biopsychosocial model."

5) What is the role of genetics and family history in the development of depression?

Clinical depression is a medical illness that involves abnormal functioning of the brain's chemicals. Clinical depression often runs in families, which suggests that its origins may be genetic as well as learned; it can be accompanied by—and even aggravated by—other illnesses (e.g., substance abuse, learning disabilities, attention-deficit hyperactivity disorder, anxiety, sexual and emotional abuse). Children of parents with a history of depression are twice as likely as other children to develop depression. It is important to note that despite the presence of such a risk, a child may not develop depression. Clinical depression results from a combination of genetic, psychological, and social risk factors. Although people who have experienced a major loss/stressor or have a family history of depression are at a higher risk of developing the disorder than others, sometimes an individual can develop depression for no discernible reason.

6) What are the risk factors/causes of depression?

Depression can result from an interaction of factors that include a biological component, social factors, and psychosocial factors.

- Biological: genetics, brain chemistry, other medical disorders
- Social: thought patterns, coping skills, self-esteem
 - Psychosocial: family, school, neighborhood, peers

Unfortunately, depression does not always have a clear cut cause that can be pointed to, sometimes people develop depression out of nowhere without a specific reason. Clinical depression, at its root, is a medical illness of the brain resulting from abnormal functioning of the brain's chemicals, and, although we're always learning more, we can't always predict or explain the way our brain works. Depression is more common in people whose relatives also have depression but it is not a genetic disorder. A family

history of depression increases the risk of developing depression, but it's no guarantee that you will develop depression.

7) What are symptoms of depression?

Due to the fact that depression can be experienced in so many ways, it's not always easy to identify. In general, there will be changes from a person's normal self that have lasted for at least two weeks. Determining whether someone has depression depends on the number and severity of the symptoms experienced. To be diagnosed as major depression, symptoms need to be present consistently for at least two weeks. On average, episodes of depression in teens tend to last between six and nine months, though they can certainly persist much longer.

Symptoms can include:

- Feelings of sadness
- Loss of interest or pleasure in normal activities
- Irritability, frustration, or feelings of anger, even over small matters
- Insomnia or excessive sleeping
- Changes in appetite (decreased or increased)
- Agitation or restlessness (pacing, hand-wringing, inability to sit still)
- Slowed thinking, speaking, or body movements
- Fatigue, tiredness, loss of energy—even small tasks seem to require a lot of effort
- Feelings of worthlessness or guilt, fixation on past failures/mistakes or self-blame when things are not going right, worrying
- Trouble thinking, concentrating, making decisions, and/or remembering things
- Frequent thoughts of death, dying, or suicide
- Crying spells for no apparent reason
- Unexplained physical problems (especially pain-related), such as stomachaches, back pain or headaches
- Negative and/or abusive self-talk
- Struggling academically, drop in grades
- Isolation/withdrawal from friends and family
- Forgetful or easily distracted
- Substance use or abuse
- Lack of motivation to do anything

If multiple symptoms are present consistently, then there's a good chance that a mental health condition like depression is the cause. Other conditions with similar symptoms include other mood disorders (e.g., dysthymic disorder or bipolar disorder), other mental health diagnoses (e.g., anxiety disorders, substance abuse/dependency, conduct disorder, eating disorders, PTSD), anemia or hypothyroidism. It is important that someone with symptoms see a doctor for a correct diagnosis and treatment.

In addition physical pain frequently occurs with depression. This pain is real. It is not "all in the head". For instance stomachaches commonly occur. One thought about why this happens is that stomachaches result from dysfunction in pain pathways regulated by serotonin and norepinephrine, two of the neurotransmitters that are out of balance in depression. Here's an article from Psychology Today that talks about the symptom of somatic pain in depression:

<http://www.psychologytoday.com/articles/200308/when-depression-hurts>

8) What is the treatment for depression?

Treatment entirely depends upon the individual. The best way to treat depression (in that it gives you the best chance of symptom relief) is a combination of talk therapy, antidepressant medication (if needed),

and a set of healthy self-care practices (adequate sleep, healthy food, exercise, etc). Symptoms will differ from person to person and range along a spectrum of mild, moderate and severe. The following describe the severity of depressive symptoms and the type/length of treatment often recommended for each.

Mild Depression:

Type of Treatment/Length of Treatment:

- Individual outpatient therapy—Brief, 8 weeks, to long term intervention
- Group outpatient therapy—8 to 12 sessions

Moderate Depression:

Type of Treatment/Length of treatment:

- Individual outpatient therapy—6 months to years
- Medication—At least 1 year

Severe Depression:

Type of Treatment/Length of Treatment:

- Inpatient psychiatric hospitalization—5 to 7 days
- Day treatment—1 to 2 weeks
- Residential treatment—Months or years

9) Are all treatments helpful for everyone?

It is important to remember, depression is a medical illness which requires medical help in the form of therapy and/or medication. It is important to get treatment as soon as possible from a medical doctor, psychiatrist or therapist.

The treatment used depends upon the individual. Sometimes a depressed teen can start feeling better just by going to therapy. In other cases, the symptoms of depression don't respond fully to therapy; if teens still aren't feeling better with therapy alone, then a psychiatrist might consider prescribing an antidepressant to help correct the chemical imbalance that underlies depression.

If you feel like you are not improving in spite of therapy, medication and taking care of yourself, then you might want to talk to your psychiatrist about trying different options. It could mean taking a different antidepressant or seeing a different therapist. Treatment does take time and it's important to be patient, but if you feel like things are not working, talk to your care provider about your concerns and your desire to discuss other treatment options. The most important goal of treatment is making sure that you feel better and sometimes that requires more than what's attempted on the first try.

In addition to medical treatment there are a number of things you can do to take care of yourself: get enough sleep, eat healthfully, manage stress, mindfulness, yoga, journaling, use friends and family as a social support system, if you have a faith, religious organizations and formal affiliation can be comforting in times of challenge and distress

10) Is having a relapse possible after receiving treatment?

Whether or not someone experiences a return of depressive symptoms later in life depends on a number of different factors: family history, other mental health diagnoses, stressors, prior number/frequency/severity of depressive episodes and treatment history. Not everyone who experiences a period of depression when they are young will become depressed in adulthood. There is a greater likelihood that depression will NOT become a chronic condition if help is sought early in adolescence, at the first sign that symptoms appear. Research also shows the longer period of time one is depressed the more the brain changes indicating the importance of seeking treatment early.

11) Can clinical depression be completely cured?

Depression isn't necessarily something that can be cured, but almost everyone can experience significant, if not complete, symptom relief with treatment. Treatment does take time and it is important to be patient. If you feel like things are not working, talk to your provider about your concerns and your desire to discuss other treatment options such as a different medication or another therapist. The most important goal of treatment is making sure that you feel better and sometimes that requires more than what is attempted on the first try.

12) How does treatment differ between psychiatrists, psychologists, and social workers?

Psychiatrists are medical doctors (MDs) and can prescribe medications. Some psychiatrists manage the medication aspect of treatment only, while others conduct therapy as well.

Psychologists can have Ph.D., Ed.D. or Psy.D. degree, which means that they attended graduate school and are trained and educated to perform psychological research, testing, and therapy. Psychologists cannot prescribe medication, but they are specifically trained to conduct therapy.

Social Workers attended graduate social work programs, and are trained to conduct therapy as well as work with systems and case management; they have master's degrees in social work and are licensed mental health providers.

13) How do antidepressants work?

Antidepressants work to correct the imbalance of neurotransmitters/chemicals in the brain that influence the kind of symptoms experienced in depression (low energy, loss of pleasure/interest in activities, etc). These chemicals include serotonin, norepinephrine, and dopamine. These medicines need to be taken under the supervision of a doctor or nurse practitioner, and often need 6-8 weeks to be fully effective (many teens report feeling at least a bit better after 2 weeks, though). Studies have shown that the **MOST** effective treatment for teens with moderate-to-severe depression is a combination of therapy and antidepressant medication.

14) Does culture affect how depression is experienced?

Although members of different cultures do sometimes report their experience of depression as being different, it is clear that depression does not discriminate: **EVERYONE**, including people of every culture,

gender, and age, can experience depression and, at its root, biologically, within the brain, depression looks the same. That being said, “how” people describe the symptoms of depression can differ based on culture. In Western cultures, people frequently talk about their moods or feelings, so they may be more likely to describe the malaise they’re experiencing by saying, “Ugh. I don’t know what’s wrong—I’m feeling so hopeless and down, like I can’t even make myself care about stuff I know is important to me. It just does not feel that way anymore.” In many Eastern cultures, it’s not always common practice or socially acceptable to talk about one’s own feelings/moods, so they may be more likely to refer to more somatic symptoms, mentioning aches and pains that persist without cause; being tired, exhausted, bored, or dizzy; and/or experiencing an inner pressure or a general sense of discomfort.

15) What is anxiety?

Experiencing occasional anxiety is a normal part of life. However, people with anxiety disorders frequently have intense, excessive and persistent worry and fear about everyday situations. Often, anxiety disorders involve repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attacks).

These feelings of anxiety and panic interfere with daily activities, are difficult to control, are out of proportion to the actual danger and can last a long time. You may avoid places or situations to prevent these feelings. Symptoms may start during childhood or the teen years and continue into adulthood.

16) What are the symptoms of anxiety?

Symptoms of anxiety include constant, chronic, unsubstantiated worry about things that you don’t necessarily have reason to be worried about. This overwhelming worry can interrupt a person’s ability to function normally in social situations or at school and is also accompanied by symptoms like:

- muscle tension
- feeling restless or tired
- difficulty sleeping
- irritability or edginess
- concentration problems
- stomach problems
- headaches
- racing thoughts
- being completely overwhelmed or afraid of the task at hand
- depressed immune system
- longer time to recover from any injuries or illnesses

Anxiety disorders respond well to treatment and/or medication (or a combination of both) often in a relatively short amount of time.

Panic attacks can occur when anxiety is present. If panic attacks become frequent or severe enough to cause extreme distress or get in the way of things you need to do, it is important to get help, whether from a medical doctor (to rule out somatic causes) or a therapist.

Symptoms of a panic attack are:

“Racing” heart

Feeling weak, faint, or dizzy

Tingling or numbness in the hands and fingers

Sense of terror, or impending doom or death

Feeling sweaty or having chills

Chest pains/Breathing difficulties

Feeling a loss of control

Things you can do to help control anxiety:

- get enough sleep
- exercise regularly
- eat healthfully and regularly
- practice relaxation techniques (progressive muscle relaxation)
- deep breathing
- meditation
- during an anxiety attack divert your thoughts to something that is positive
- focus on something that is not anxiety-inducing

17) What is bipolar disorder?

Bipolar disorder, formerly called manic depression, causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression). When you become depressed, you may feel sad or hopeless and lose interest or pleasure in most activities. When your mood shifts in the other direction, you may feel euphoric and full of energy. Mood shifts may occur only a few times a year or as often as several times a week.

Although bipolar disorder is a disruptive, long-term condition, you can keep your moods in check by following a treatment plan. In most cases, bipolar disorder can be controlled with medications and psychological counseling (psychotherapy).

18) What makes psychotic teens more at risk for suicide than other groups with psychosis?

Suicide is a general risk for people with psychosis. According to research, 20 percent to 40 percent of those diagnosed with psychosis attempt suicide, and up to 10 percent are completed suicides. Teens with psychotic symptoms are nearly 70 times more likely to attempt suicide than adolescents in the general population. Researchers recently reviewed studies of teenagers with psychosis to better understand why they are more at risk for suicide than other groups similarly diagnosed.

Psychoses can cause youth to lose touch with reality, suffer from hysteria and delusions and sound incoherent when talking. Such symptoms in teens between 15 and 18 years old can begin abruptly or be mistaken for substance abuse problems or some diseases - such as brain illnesses - that produce drastic behavioral changes. Parents, teachers, social workers and others need to be vigilant, and to err on the side of concern by seeking help for a teen they believe may be suicidal.

In their Psychiatric Times article, "Psychosis and Suicidality in Adolescents," Timmons-Mitchell and Falcone offer warning signs that parents and professionals should watch for:

- Abrupt shifts to abnormal behavior.
- Talking about things that don't make sense.
- Spikes in anger that go beyond normal teen rebellion and disagreements with family members or teachers.
- Speaking about suicide or death and dying.
- Reports from school about strange behavior changes.

By keeping parents and professionals aware of the warning signs, adolescent suicide attempts have declined significantly in Ohio (11 to 6.2 percent) over the past 10 years, according to the Ohio Department of Mental Health and Alcohol services.

Case Western Reserve University. (2014, April 24). What makes psychotic teens more at risk for suicide than other groups with psychosis?. ScienceDaily.

19) How do I help a friend?

Let your friend know that you care and are concerned about them; mention what you have noticed that's made you concerned and ask them how they *really* are doing. Bring the topic up when you have your friend's full attention or when it comes up in media. Be sure you are in a safe and private environment. Think about what you are going to say ahead of time. Acknowledge that the topic is uncomfortable but you are there to help. Listen to them and let them know when they need to talk you will listen without judgment or criticism. Encourage them to get help, give them the information needed to do so, and/or go with them to talk to a trusted adult or counselor about what they have been experiencing.

If your friend does not want help, you can try to talk to them about why they don't want help (Do they not know what help is like? Do they think it will not make them feel better? Are they afraid of other people knowing? Do they not want to go on their own?). Be supportive and patient. Tell them about the many ways they can get help, such as the school nurse, a trusted coach or teacher, a counselor or their doctor. If your friend refuses to get help, talk to an adult you trust and tell them your concerns about your friend.

If they state they are feeling suicidal don't overreact or under-react. Stay with them and walk with them to help immediately. This may be a trusted adult or counselor, but get them to help immediately.

20) How does one support a family member dealing with depression?

If a family member has been diagnosed with depression, one of the ways you can be supportive is by learning about the signs and symptoms of depression that affect them. Now that they are diagnosed, encourage them to seek and continue with treatment so they can have the best chance of feeling better. Talk with your family member about what depression is like for them, what they are like when their depression is worse vs. better, anything that triggers their depression, and what is most helpful to them when/if their depression gets worse. Make sure they have a list of people they can reach out to during difficult times. Finally, you can provide support by letting them know how much you care about them and their recovery, encouraging them to stick with treatment, listening to how they are feeling without giving advice or being judgmental and taking care of yourself.

21) What should I do when my friend tells me he/she is contemplating suicide?

Start a conversation about suicide by telling him/her that you are worried and feeling concerned about them. Your friend's life may be in jeopardy. If you are concerned about losing their friendship, remember that if they lose their life you will lose your friend. This may be a choice between life and friendship and living trumps friendship. Here are some very important things to remember:

- Take it seriously. All suicide threats and attempts must be taken seriously.
- Show interest and support; listen, be genuine and ask questions in a caring, direct and non-confrontational way.

Here are some samples:

"I'm concerned about you and how you feel. You are not alone I will help you get the help you need."

"Have you ever felt so low that you felt life is not worth living?"

- “Are you thinking about suicide?”
- “Are you thinking of killing yourself?”
- “When did you begin feeling like this?”
- “Do you have a plan?”

Using the word “suicide” will NOT increase the chances that someone will take their own life.

—Do not attempt to “argue” anyone out of suicide. Instead let the person know you care and understand. Avoid saying things like “Why would you even think of such a stupid thing? You have so much to live for.”

—Do not promise to keep a secret about the suicidal thoughts. Your friend might ask you to not say anything, or he/she may threaten to end your friendship if you do not keep the secret. This is definitely a difficult situation to be in, and can be very stressful. However, if your friend is suicidal, you must tell someone about it. Never do this work on your own. You can call your parents and ask for help, you can call 911, you can call your friend’s parents, or talk to an adult in your school. The key is to find someone to help you right away!

—Seek help for yourself. Hearing about your friend’s sadness and pain can be stressful for you, as well. You may experience many feelings related to your friend’s thoughts of suicide. You may feel angry, betrayed, confused, or saddened by your friend’s thoughts. It is important for you to find help for yourself, so that you have the opportunity to process all the feelings you may be experiencing. Recognize that you are not responsible for another person’s choice to end his/her life.

22) What are the risk factors for suicide?

There’s no single cause for suicide. Suicide most often occurs when stressors exceed current coping abilities of someone suffering from a mental health condition. Depression is the most common condition associated with suicide, and it is often undiagnosed or untreated. Conditions like depression, anxiety and substance problems, especially when unaddressed, increase risk for suicide. Yet it’s important to note that most people who actively manage their mental health conditions lead fulfilling lives.

There is no single risk factor for suicide. Suicide may be precipitated due to a combination of factors. Below are some of the risk factors:

Health Factors

- Mental health conditions
 - Depression
 - Bipolar (manic-depressive) disorder
 - Schizophrenia
 - Borderline or antisocial personality disorder
 - Conduct disorder
 - Psychotic disorders, or psychotic symptoms in the context of any disorder
 - Anxiety disorders
- Substance abuse disorders
- Serious or chronic health condition (*including sleep deprivation*) and/or pain

Environmental Factors

- Stressful life events which may include a death, divorce, or job loss
- Prolonged stress factors which may include harassment, bullying, relationship problems, and unemployment
- Access to lethal means including firearms and drugs
- Exposure to another person’s suicide, or to graphic or sensationalized accounts of suicide

Historical Factors

- Previous suicide attempts
- Family history of suicide attempts

23) What are warning signs that someone may be suicidal?

Something to look out for when concerned that a person may be suicidal is a change in behavior or the presence of entirely new behaviors. This is of sharpest concern if the new or changed behavior is related to a painful event, loss, or change. Most people who take their lives exhibit one or more warning signs, either through what they say or what they do.

Talk

If a person talks about:

- Being a burden to others
- Feeling trapped
- Experiencing unbearable pain
- Having no reason to live
- Killing themselves

Behavior

Specific things to look out for include:

- Increased use of alcohol or drugs
- Looking for a way to kill themselves, such as searching online for materials or means
- Acting recklessly
- Withdrawing from activities
- Isolating from family and friends
- Sleeping too much or too little
- Visiting or calling people to say goodbye
- Giving away prized possessions
- Aggression

Mood

People who are considering suicide often display one or more of the following moods:

- Depression
- Loss of interest
- Rage
- Irritability
- Humiliation
- Anxiety

*From AFSP website, <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>

24) What should I expect from an emergency room visit?

When an adolescent is experiencing mental health distress/crisis emergency services (911 or mobile crisis unit 1-877-412-7474) will be contacted to evaluate and possibly transport the youth to an emergency room. It is not recommended that a family member or friend attempt to transport the youth on their own. The law enforcement officer evaluating the situation may initiate a 72 hour hold (a "5150" described below). If an ambulance is called to transport the youth to the nearest ER, a family member may or may not be allowed in the ambulance. If not, determine which hospital emergency room the youth will be taken to and follow the ambulance there. Once there the adolescent, if agitated, may not be given medication to calm them in order not to mask symptoms. For the child's safety a guard may be placed by

their door. You may be able to sit with your child while in the ER; however, at times, you may be asked to leave in order for the physician to speak with your child privately. Once an assessment is complete the adolescent may be admitted, released or transported to an in-patient psychiatric facility.

It is recommended that you take notes about the recommendations for a child's care. This is vital due to the stress family members are experiencing and the quantity of new information. Do not hesitate to ask questions. If the adolescent is released following the emergency be sure to follow up immediately as advised in a discharge plan to ensure continuing care for the youth.

25) Explain the meaning of 5150. What does it entail/what is the process like?

The term "5150" or 72-hour hold, is a means by which someone who is in serious need of mental health treatment can be transported to a designated emergency department or psychiatric inpatient facility for evaluation and treatment for up to 72-hours (even if against their will), because there is an immediate safety threat toward self or toward others. The 5150 status may be placed upon a person by a professional who is certified by the county behavioral health department to do so (and may include a police officer, school counselor, or other trained professional). The 5150 does not automatically mean the student/adult will be admitted to the hospital, but gets them to the emergency department for a formalized evaluation by a psychiatrist. If a parent or teacher is concerned that a student may need a 5150 evaluation, the parent/teacher should call either 911 and ask for a CIT (Crisis Intervention Team) officer or, in Santa Clara County, the Mobile Crisis Unit at 1-877-412-7474.

26) What does "inpatient" treatment and/or services mean? What should I expect from a psychiatric hospitalization?

"Inpatient" treatment usually refers to the therapeutic support, structure, talk therapy, and medication management that occurs on an adolescent psychiatric unit. These units may be part of a larger hospital center (For example: Mills-Peninsula Hospital, St. Mary's Hospital (SF), Fremont Hospital, or Pavilion (Concord)), or can be a short stay evaluation center such as Uplift Family Services (<http://upliftfs.org>): San Jose, Campbell, and other locations.

"Intensive Outpatient", (IOP) programs, such as those offered by BACA (Bay Area Children's Association), Kaiser Permanente, Mills-Peninsula, and El Camino Hospital (the ASPIRE program) are 2-4 month, afterschool (3p-7p) programs designed for teens who may be leaving a hospital setting as a transition back to the community, or may be used to try and prevent hospitalization for teens in sub-acute crises (for example, a teen who is cutting regularly because of multiple and severe stressors, but who is not expressing the wish to die, nor in imminent danger of dying by suicide).

**** Students and parents should understand that 5150 Status, IOP, or outpatient treatment does not appear on a student's transcript****

27) What does it typically look like when a student returns to school post-hospitalization? What occurs, who is involved?

Prior to returning to school, a re-entry meeting is held with the student, parent(s), and designated school staff (usually the counselor, school psychologist, and on-site therapist (if engaged in ongoing treatment at school)). The purpose of this meeting is to create a safety plan and identify specific academic and social-emotional supports that can be put in place to promote student wellness and safety (including naming

specific friends and teachers who can be leaned on during stressful times), initially during the first two weeks back at school, but with an open-ended end-date for accommodations based on how the student is doing. The counselor will coordinate with teachers to make sure that any missed academic work or new assignments, quizzes, tests, etc. is manageable during a time when the student should primarily be focused on feeling better and readjusting to the school environment/schedule.

28) Discuss privacy concerns and parent notification/involvement. (For students who struggle with seeking help or talking to professionals, it may help to touch on HIPAA or FERPA in a way that they can understand confidentiality and when it can and cannot be breached.) *Instead phrase as a question: What are student and parent information and privacy rights under the law with regard to mental health diagnosis and treatment?*

In general, the specific content that is shared by a teen to his/her therapist in psychological treatment and therapeutic support services is confidential, and specific information is available to parents only if a teen agrees to have this information shared. Exceptions occur when a student's safety is at issue--even then, clinicians strive to share "only as needed" information. When a student is undergoing treatment outside the school setting (for instance in the community, privately, via a team member from the LPCH/Stanford School Mental Health Team, or via Uplift Family Services), the medical information is restricted via the HIPAA (Health Insurance Portability and Accountability Act) law, which specifies conditions under which information can be shared. More information on this law is at <http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/sharing-family-friends.pdf>

FERPA (Family Educational Rights and Privacy Act) is a different federal law that protects the privacy of a student's educational record, but allows parents to have access to all portions of the school record (including mental health records) upon request, until the student turns 18. Practically, this means that any mental health record that is recorded by a school mental health professional (ACS or other contracted agency by PAUSD) and is kept onsite at the school may be requested by the parent. By contrast however, the records kept by the LPCH/Stanford team are classified under the HIPAA Law, and not the FERPA Law, and are kept offsite (electronically) as part of hospital records. Thus, a parent may request the mental health record, but the specific content to be released first has to be approved by the treating clinician (thus, sensitive information that the teen and clinician do not want shared may be redacted from any released material). For more information on FERPA, see <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>

MENTAL HEALTH RESOURCES

Note: Resource list 1 and 2 were created for the SF Bay Area and serve as a sample of what you can create for your community.

1- HEALTH/MENTAL HEALTH SERVICES

- Achieve Palo Alto 650-494-1200
<http://www.achievekids.org/aboutus/about.html>
- Adolescent Counseling Services 650-424-0852
www.acs.teens.org
- Alum Rock Counseling Center 408-294-0500
www.alumrockcc.org
- Asian Americans for Community Involvement (AACI) 408-975-2730
www.aaci.org
- Bill Wilson Center 408-243-0222
www.billwilsoncenter.org
- Billy DeFrank Lesbian & Gay Community Center 408-293-2429
<https://www.defrankcenter.org/about-menu/about-summary-menu>
- Catholic Charities of Santa Clara County 408-468-0100
www.catholiccharitiesscc.org
- Children's Health Council 650-326-5530
www.chconline.org
- Chinese Community Center of the Peninsula 650-324-6576
- Community Solutions Hot Line 408-638-4118
www.csi-online.org
- Family and Children Services 650-326-6576
www.fcservices.org
- Lucile Packard Psychiatry Clinic 650-723-7704
<http://med.stanford.edu/childpsychiatry.html>
- Palo Alto Medical Foundation 408-524-4192
www.pamf.org
- Palo Alto University Gronowski Center 650-961-9300
www.gronowski.paloalto.edu
- Uplift Family Services (formerly EMQ) 408-379-3790, for Emergencies 1-877-412-7474
www.upliftfs.org
- Ravenswood Health Clinic 800-704-0900
www.ravenswoodfhc.org
- Safe Space (Menlo Park) <https://www.safespace.org/>
- San Mateo County Mental Health Access Referral Team 800-686-0101
- Stanford Center for Youth Mental Health and Wellbeing
<https://med.stanford.edu/psychiatry/special-initiatives/youthwellbeing.html>

2-MENTAL HEALTH CARE

(A) Hospitals and Centers

- Alta Bates Medical Center 510-204-4569
www.altabatessummit.org
Herrick Campus 2001 Dwight Way, Berkeley, CA (Alameda County)
34 adolescent beds, inpatient services for ages 12-17.

- Fremont Hospital 510-796-1100
www.fremonthospital.com
39001 Sundale Drive, Fremont, CA 94538 (Alameda County)
40 adolescent and 6 child beds. Inpatient services for ages 6-17.
- John Muir Behavioral Health 925-674-4100
www.johnmuirhealth.com/locations/behavioral
2740 Grant St., Concord, CA 94520 (Contra Costa County)
24 adolescent and 10 child beds. Inpatient services for ages 4-18.
- Mills Peninsula Hospital 650-696-5915
www.mills-peninsula.org
www.mills-peninsula.org/centers
Mills-Peninsula Medical Center 1501 Trousdale Drive, Burlingame, CA 94010 (San Mateo County)
17 adolescent beds, inpatient services for ages 12-18.
- San Jose Behavioral Health (669) 900-1731
<http://www.sanjosebh.com/>
455 Silicon Valley Blvd, San Jose, CA 95138 (Santa Clara County)
80 inpatient beds mixed with adults, Services for adolescents 14-17

(B) Regional Adolescent Crisis Centers:

- Santa Clara County Emergency Psychiatric Service 408-885-6100
871 Enborg Ct, San Jose, CA 95128
- Santa Clara County Mental Health Urgent Care 408-885-7855
871 Enborg Ct, San Jose, CA 95128
- Uplift Family Services: Santa Clara 24 HR Mobile Crisis Unit and Crisis Stabilization Unit
Crisis Services 877-41-CRISIS (412-7474)
www.upliftfs.org
251 Llewellyn Ave., Campbell, CA 95008 (Santa Clara County)
 - The Mobile Crisis Program: provides 24-hour intervention to children and adolescents in the community who are experiencing acute psychological crisis. Included is a 5150 assessment along with safety planning and referrals to community based mental health services. Length of the service is two to four hours.
 - The Crisis Stabilization Unit: available for up-to-24-hour hold for assessment and treatment.

3-CRISIS LINES & TEXT LINES

- Alum Rock 24/7 Crisis Line (Phone and Mobile Crisis) 408-294-0579
- California Youth Crisis Line 800-843-5200 <http://calyouth.org/ca-youth-crisis-line/>
- Community Solutions Youth and Family Crisis Line 408-683-4118
- “Crisis Text Line” 741-741 <http://www.crisistextline.org>
- National Suicide Prevention Lifeline 800-273-TALK (also available in Spanish)
- Santa Clara County Parental Stress Hotline 408-279-8228
- Santa Clara County Suicide and Crisis Hotline: Available 24 Hours Day 855-278-4204
- San Mateo County Parental Stress Hotline 650-327-3333
- Suicide Prevention Resources for Teens <http://www.sprc.org/sites/default/files/resource-program/Teens.pdf>
- The Hope Line 1.800.394.HOPE www.hopeline.com.
- The Teen Line 310-855-4673, text “TEEN” to 839863, email @ <https://teenlineonline.org/>
- The Trevor Project 1-866-488-7386

- Uplift Family Services 24-7 Crisis Line (Phone and Mobile Crisis) 877-41-CRISIS (412-7474) - ***Also a Crisis Center for Adolescent Psychiatric Care - both a Mobile Crisis Program and Crisis Stabilization Unit***
- You Matter via National Suicide Prevention Lifeline: 1-800-273-8255 or chat @ <http://www.suicidepreventionlifeline.org/GetHelp/LifelineChat.aspx>
- YWCA: 24-Hour Sexual Assault Crisis Line 408-287-3000

4-MENTAL HEALTH EDUCATION (WEBSITES)

- American Academy of Child and Adolescent Psychiatry www.aacap.org
- American Association of Suicidology (AAS): National Center for the Prevention of Youth Suicide <http://www.suicidology.org/ncypys/about>
- American Foundation for Suicide Prevention www.afsp.org
- American Psychological Association <http://www.apa.org/helpcenter/>, <http://www.apa.org/research/action/suicide.aspx>
- Anxiety and Depression Association of America www.adaa.org
- Building Bridges Initiative www.buidlingbridges4youth.org
- Center for Disease Control (CDC) – Suicide Prevention information <https://search.cdc.gov/search?query=suicide+prevention&utf8=%E2%9C%93&affiliate=cdc-main>
- Center for School Mental Health csmh.umaryland.edu
- Child Adolescent Bipolar Foundation: Balanced Mind Foundation www.thebalancedmind.org
- 3.26HEARD Alliance <http://www.heardalliance.org/>
- Lok-It-Up - - For parents and community members on firearm safety <http://www.kingcounty.gov/depts/health/violence-injury-prevention/violence-prevention/gun-violence/LOK-IT-UP/parents-community.aspx>
- Los Angeles County Youth Suicide Prevention Project <http://preventsuicide.lacoe.edu/resources/organizations.html>
- National Association of School Psychologists (NASP) <https://www.nasponline.org/> and <https://www.nasponline.org/search/search-results?keywords=suicide+prevention>
- ReachOut.com <http://us.reachout.com/> and <http://us.reachout.com/facts/suicide>
- SAVE Suicide Awareness Voices of Education <http://www.save.org/>
- Substance Abuse and Mental Health Services Administration (SAMHSA) – Suicide Prevention <https://www.samhsa.gov/suicide-prevention>
- Society for The Prevention of Teen Suicides (SPTS) <http://www.sptsusa.org/>
- Suicide Prevention Resource Center (SPRC) <http://www.sprc.org/>
- The Jason Foundation <http://jasonfoundation.com/>
- WRAP Wellness Recovery Action Plan www.mentalhealthrecovery.com
- YAM – Youth Aware of Mental Health <http://www.y-a-m.org/>

5-MOBILE APPS

- Anxiety Coach by Mayo Clinic: Anxiety Coach is a self-help app that addresses fears and worries using CBT strategies. <https://itunes.apple.com/us/app/anxietycoach/id565943257?mt=8>
- MY3: Designed for individuals who may experience suicidal crises to help avert crises, practice self-care, and reach out for help. Available in English and Spanish. www.my3app.org
- Stop, Breathe, and Think – For youth, with meditations for mindfulness and compassion; www.stopbreathethink.org

- Calm.com – Guided meditation and relaxation exercises; <https://www.calm.com>
- Calmeleon: Coloring Book for Adults: Coloring for Mindfulness; <https://itunes.apple.com/us/app/calmeleon-coloring-book-for-adults/id1004527643?mt=8>
- Colorfy – Coloring Book Free; www.colorfy.net
- HeadSpace – Meditation and mindfulness made simple; <https://www.headspace.com/headspace-meditation-app>
- Insight Timer – 2,714 free guided meditations; <https://itunes.apple.com/us/app/zen-timer-meditation-timer/id337472899?mt=8>
- MindShift – For teens, with mindfulness and other coping skills for anxiety; <https://www.anxietybc.com/resources/mindshift>
- Smiling Mind – Provides accessible, life-long tools based in mindfulness meditation; <https://smilingmind.com.au>
- Take a Break! – Guided meditations for stress relief; <https://itunes.apple.com/us/app/take-a-break-guided-meditations-for-stress-relief/id453857236?mt=8>

6-COMMUNITY ENGAGEMENT

- CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters <https://www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm> **NOTE: might be useful for clusters/contagion section**
- Collaboration Toolkit: California Community Colleges and California County Behavioral and Mental Health Departments <http://cccstudentmentalhealth.org/docs/CCCSMHP-Collaboration-Toolkit-BMHD.pdf> **NOTE: This might be useful reference for the Transitions section**
- Organizing a Community Response to Suicide – Success Factors and Lessons Learned https://www.sccgov.org/sites/mhd/Providers/SuicidePrevention/Documents/SCCMHD_Organizing-a-Community-Response-to-Suicide.pdf **NOTE: Santa Clara County's report about PSN**
- Recommendations for Reporting on Suicide <https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf>

7-GRIEF SUPPORT

- Children, Teens and suicide Loss; The Dougy Center and The American Foundation for Suicide Prevention <https://afsp.org/wp-content/flipbooks/childrenteenssuicideloss/?page=1>
- Finding Support (American Foundation for Suicide Prevention) <https://afsp.org/find-support/>
- Friends for Survival <http://www.friendsforsurvival.org/>
- National Action Alliance for Suicide Prevention <http://www.sprc.org/sites/default/files/migrate/library/RespondingAfterSuicideNationalGuidelines.pdf>

More Grief resources in Appendix C

8-MEDIA & SOCIAL MEDIA

- Netflix – 13 Reasons Why Resources
 - 13 Reasons Why Talking Points - <http://www.heardalliance.org/wp-content/uploads/2017/05/13RW-Talking-Points-JED-SAVE-Netflix-1.pdf>

- 13 Reasons Why – Spanish Talking Points
<https://www.jedfoundation.org/wp-content/uploads/2017/03/Por-13-Razones.pdf>
- HEADSPACE: How to talk to young people about 13 Reasons Why –
<http://www.heardalliance.org/wp-content/uploads/2017/05/headspace-How-to-talk-to-young-people-about-13-Reasons-Why-V1-1.pdf>
- Tips for Parents – http://www.heardalliance.org/wp-content/uploads/2017/05/TipsForParents_2017-1.pdf
- Letter for School Administrators - <http://www.heardalliance.org/wp-content/uploads/2017/05/3-29-17-13RW-letter-for-school-parents-FINAL-1.pdf>
- 13 Reasons Why Webinar: An Interactive Discussion
<http://go.kognito.com/13reasonswhyondemandfollowup.html?aliId=636693>
- At-a-glance: Safe reporting on suicide. By Suicide Prevention Resource Center. (2005)
http://www.sprc.org/library/at_a_glance.pdf
- For School Administrators and Staff When a School Has Been Impacted by a Death
<http://griefspeaks.com/id97.html>
- Framework for Successful Messaging by National Action Alliance for Suicide Prevention
<http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/framework>
- Making Headlines – Guide to Engaging the Media in Suicide Prevention http://calmhsa.org/wp-content/uploads/2011/11/12-CALM-0500_PurpGuidePDF-09-2012.pdf
- Recommendations for Reporting on Suicide <https://afsp.org/wp-content/uploads/2016/01/recommendations.pdf>
- Safe and effective messaging for suicide prevention
<http://www.sprc.org/sites/default/files/migrate/library/SafeMessagingrevised.pdf>
- Speaking Out About Suicide https://afsp.org/wp-content/uploads/2016/04/13279_AFSP_SpeakingOutAboutSuicide_Flyer_d4.pdf
- Social Media Guidelines for Mental Health Promotion and Suicide Prevention
<http://www.eiconline.org/teamup/wp-content/files/teamup-mental-health-social-media-guidelines.pdf>

9- RESOURCES FOR STUDENTS, STAFF, PARENTS/COMMUNITY MEMBERS

PDF's and Guidebooks

- "Preventing Suicide: A Technical Package of policy, Programs and Practices" <https://www.cdc.gov/violenceprevention/pdf/suicide-technicalpackage.pdf>
- Rocky Mountain MIRECC for Suicide Prevention – Advice on talking to preschool, school aged children and teenagers <http://www.mirecc.va.gov/visn19/talk2kids/e/> **NOTE: for after an attempted suicide**
- "Preventing Suicide: A Technical Package of policy, Programs and Practices" <https://www.cdc.gov/violenceprevention/pdf/suicide-technicalpackage.pdf>
- Suicide and Depression Awareness for Students Guide <http://www.learnpsychology.org/suicide-depression-student-guidebook/>
- Suicide Prevention for Middle School Students
<http://mgms.mesa.k12.co.us/parents/documents/SOS2010PARENTpresentation.pdf>

- Suicide Prevention Resources for Teens <http://www.sprc.org/sites/default/files/resource-program/Teens.pdf>
- To Live To See the Great Day That Dawns: Preventing Suicide by American Indian and Alaska Native Youth and Young Adults Guide
https://education.alaska.gov/tls/suicide/pdf/suicide_prevention_guide.pdf
- The Role of High School Mental Health Providers in Preventing Suicide
<http://www.sprc.org/sites/default/files/resource-program/SchoolMentalHealth.pdf>
- The Role of High School Teachers in Preventing Suicide
<http://www.sprc.org/sites/default/files/resource-program/Teachers.pdf>
- The Role of School Health and Mental Health Providers in Preventing Suicide
<https://www.altru.org/app/files/public/7231/pdf-The-Role-of-School-Health-and-Mental-Health-Providers-in-Prevent.pdf>

Trainings and presentations

- Applied Suicide Intervention Skills Training (ASIST)
<https://www.livingworks.net/programs/asist/>
- Assessing and Managing Suicide Risk (AMSR) Training <http://www.sprc.org/training-events/amsr>
- Break Free From Depression <http://www.childrenshospital.org/centers-and-services/boston-childrens-hospital-neighborhood-partnerships-program/break-free-from-depression-program>
- Connect Project <http://www.theconnectprogram.org/>
- Ending the Silence <http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Ending-the-Silence>
- In Our Own Voice (IOOV) <https://www.nami.org/Find-Support/NAMI-Programs/NAMI-In-Our-Own-Voice>
- Kognito <https://www.kognito.com/>
- More Than Sad <https://afsp.org/our-work/education/more-than-sad/>
- National Alliance For Mental Illness (NAMI):
- Parents and Teachers As Allies <http://www.nami.org/Find-Support/NAMI-Programs/NAMI-Parents-Teachers-as-Allies>
- Question, Persuade, and Refer (QPR) <https://www.qprinstitute.com/>
- Recognizing & Responding to Suicide Risk: Essential Skills for Clinicians
<http://www.suicidology.org/training-accreditation/rrsr>
- SafeTALK <https://www.livingworks.net/programs/safetalk/>
- Suicide Prevention: A Gatekeeper Training for School Personnel <http://www.sprc.org/resources-programs/suicide-prevention-gatekeeper-training-school-personnel>
- Suicide Survivor Speakers Bureau <http://www.namimaine.org/?page=SpeakersBureau>
- Talk Saves Lives <https://afsp.org/our-work/education/talk-saves-lives-introduction-suicide-prevention/>
- Youth - Mental Health First Aid <http://www.mentalhealthfirstaid.org/cs/take-a-course/course-types/youth/>

Transitioning to College

- Collaboration Toolkit: California Community Colleges and California County Behavioral and Mental Health Departments <http://cccstudentmentalhealth.org/docs/CCCSMHP-Collaboration-Toolkit-BMHD.pdf>

- Promoting Student Mental Health: A Guide for UC Faculty and Staff <http://www.ucop.edu/student-mental-health-resources/files/pdf/PSMH-guide.pdf>
- Jed Foundation “Set To Go” <https://www.settogo.org>

Videos and webinars

- Directing Change <http://www.directingchange.org/> and <http://www.directingchange.org/2016-winners/>
- Recommended videos by the American Association of Suicidology <http://www.suicidology.org/resources/recommended-videos>
- Suicide Prevention Resource Center – self paced online courses <http://training.sprc.org/>
- Teen Suicide Prevention by Mayo Clinic <https://www.youtube.com/watch?v=3BByqa7bhto>
- Vignettes for Asian Parents of Teens - Introduction (use slide column to see all 8 vignettes) https://www.youtube.com/watch?v=eNHmRCRf1IQ&list=PLM_IsuL-RjXlqLVlilDOheSFqrLE0UHcA
- We Can Help Us – Suicide section videos (ReachOut.com) <http://us.reachout.com/wecanhelpus/topics/>

Youth Suicide Prevention Programs, Campaign, and Guides:

- CalMHSAs suicide prevention programs: <http://calmhsa.org/programs/pei-statewide-projects/2011-2015-phase-i/suicide-prevention/>
 - Each Mind Matters program <http://www.eachmindmatters.org/>
 - Know the Signs Campaign <http://www.suicideispreventable.org/>
 - Walk In Our Shoes: a mental health education and awareness campaign <http://walkinourshoes.org/>
 - For the media <http://calmhsa.org/wp-content/uploads/2011/11/Media-Analysis-Final-Approved-09-2012.pdf> and http://calmhsa.org/wp-content/uploads/2011/11/12-CALM-0500_PurpGuidePDF-09-2012.pdf and http://calmhsa.org/wp-content/uploads/2011/11/12-CALM-0500_PurpGuidePDF-09-2012.pdf
 - Suicide Prevention Best Practices Data Handbooks by Region: Handbooks exist for all California regions and have a section on best practices, for example the San Francisco Bay Area can be found here <http://calmhsa.org/wp-content/uploads/2014/08/Bay-Area-Region-Data-Handbook.pdf>
- Lifelines: A Comprehensive Suicide Awareness and Responsiveness Program for Teens <http://www.hazelden.org/web/public/lifelines.page>
- National Center for the Prevention of Youth Suicide (NCPYS) <http://www.suicidology.org/NCPYS>
- Source of Strength <https://sourcesofstrength.org/>
- The Trevor Project <http://www.thetrevorproject.org/>

MENTAL HEALTH INFORMATION FOR STUDENTS

School can be an exciting time, filled with new experiences, but at times you might feel as though it's more of a struggle. This handout is meant to help you as you work through a tough time.

Life can be stressful. Between friend drama, packed schedules, classes, clubs, relationships, sports, jobs, parental expectations, figuring out who you are, uncertainty over things, and not enough sleep, life can occasionally get you down and feel overwhelming. And that's normal.

What's not normal is struggling through each day, feeling like things will only get worse. Maybe you feel like you've lost control, that nothing matters, or that you're alone. These feelings may indicate a condition that requires professional help, such as depression, anxiety or other mental health conditions.

Not everyone experiences mental health conditions in the same way, but **everyone struggling with their mental health deserves help**. Depression is among the most common conditions experienced. It is a complex medical illness that significantly interferes with an individual's ability to function, enjoy life, and feel like themselves.

A number of factors may contribute to a person becoming depressed; genetic predisposition and stressful life events can certainly play a role, but sometimes depression can occur without an obvious cause. This means that **anyone can become depressed**, even those who seemingly have every reason to be happy.

Depression commonly affects your thoughts, your emotions, your behaviors, and your overall physical health. Experiencing any one of these symptoms on its own does not constitute depression; a diagnosis of depression requires several of these symptoms to occur for at least two weeks. Here are some of the most common symptoms that point to the presence of depression:

Feelings:

- Sadness
- Hopelessness
- Guilt
- Moodiness
- Angry outbursts
- Loss of interest in friends, family, and favorite activities

Thoughts:

- Trouble concentrating
- Difficulty making decisions
- Trouble remembering
- Thoughts of harming oneself
- Delusions and/or hallucinations can also occur in cases of severe depression

Behaviors:

- Withdrawing from people
- Substance abuse
- Missing work, school, or other commitments
- Attempts to harm oneself (e.g., cutting)

(Symptoms of depression, continued)

Physical problems:

- Tiredness or lack of energy
- Unexplained aches and pains
- Changes in appetite
- Weight loss or gain
- Changes in sleep – sleeping too little or too much

If you are experiencing symptoms of depression, it's important to **talk to a trusted adult** (parent, teacher, counselor, coach, or clergy) or doctor so that you can get the help you need. **Depression does not go away on its own, but with the appropriate help it can be treated!** Studies show that more than 80% of people with depression can feel better with talk therapy (counseling) and/or medication.

Maybe you've noticed that your friend hasn't been acting like themselves lately and you're worried about whether or not they're really "fine" after all. If you think a friend may be depressed, show them you care by reaching out. Give yourself time to talk in a private, comfortable place. Honestly share what you've noticed (changes in behavior, things they've said or done) and ask them how they are feeling. Let them know that you're asking them because you care, because you want them to feel better, and because there is help. Let them know that there is hope and help available, and support them to get the help they need. If you don't feel comfortable asking your friend, share your concerns with a trusted adult who can.

Talking about mental health can be difficult, but reaching out and getting help for depression is one of the most courageous, important things you can do for yourself or for a friend. **It might even save a life.**

Resources

At home or outside school:

- Talk to a parent or older relative
- Call your pediatrician or physician
- Talk to someone at your church

At your school site:

- Talk to a trusted adult, teacher, or guidance counselor
- See a counselor at Adolescent Counseling Services (ACS)

24/7 Confidential Helplines:

- **Santa Clara County Suicide and Crisis Hotline: 855-278-4204**
- **San Mateo Crisis Line: 650-579-0350**
- **San Francisco Crisis Line: 415-781-0500**
- **California Youth Crisis Line: 800-843-5200**
- **Trevor Lifeline for LGBTQ Youth: 866-488-7386**
- **National Suicide Prevention Lifeline: 800-273-8255**
- **Crisis Text Line 741-741 (<http://www.crisistextline.org>)**

If someone is in immediate danger, **call 911.**

Getting help does not mean that you have failed, It means you've allowed others to show they care.

Parent Handouts

When Your Child Expresses Suicidal Thoughts or Behaviors

This paper is designed to support you with the information you need as you and your child work together toward wellness.

You are not alone. It is not uncommon for adolescents to consider suicide as a possible solution to their difficulties. The reasons for this are many and varied. What is most important, for you and your child, is knowing there is help available. With support, recovery is possible.

If you think that your child may be contemplating suicide, you can best help him/her by paying attention, listening, and acknowledging what they are saying or doing. Remain calm and get them to the help they need. It is not uncommon for someone in their emotional state to resist seeking help. There can be many reasons for this: stigmatization, fear of being restrained or locked up, etc. They may plead that you do nothing. They are in crisis and may be incapable of making a rational decision. They may say they are fine and they did not mean what they said or did. Or they may be feeling their situation is hopeless and nothing can help. Whatever may be occurring for them, they will look to you for support. Assure them that help is available.

This is a life and death situation. Accepting any reason for not getting help is too dangerous. Though you and/or your child may fear what will result from acknowledging these suicidal thoughts or actions, the risk of not seeking help is too great.

Attached are Warning Signs and Risk Factors that a suicidal person may be experiencing. This is included to help you identify specific behaviors you may have been noticing. Though someone has expressed suicidal ideation, no one person will show all these behaviors. They may not show any of the specific behaviors listed; even so, it is important for them to seek help.

Seeking Assistance:

There are differing situations where your child's distress may become apparent. Your child may reveal their suicidal thoughts to you, a friend, or a trusted adult. Whoever becomes aware of your child's distress must immediately seek assistance. In seeking assistance, your child's safety is the first consideration. The child should **never** be left alone during this crisis. If your child has a physician or therapist, call to alert them of the situation. Alternatively, the Santa Clara County Suicide and Crisis hotline can be called at 1-855-278-4204 (see Mental Health Resources list provided for additional hotlines and information).

The following two pages are designed to be a tri-fold handout for parents which contains in very brief form information about risk factors and warning signs to help a parent recognize a crisis, what to do in a crisis, what to expect will happen when treatment is sought, and how to care for yourself during the crisis.

What to do in a crisis

- Remain calm
- Pay attention
- Listen
- Acknowledge what they are saying
- Ask if they are thinking of killing themselves
- Get your child to help

Resisting help is common. Assure them there is hope. Support is available. The risk of not seeking help is too great.

Seeking assistance

Never leave a child in crisis alone.

- In immediate danger of self-harm call

911

Ask for a CIT officer

- Call Santa Clara County Suicide and Crisis Hotline

1-855-278-4204

- Call Uplift Family Services:
1-408-379-9085
1-877-41-CRISIS (4127474)
a 24 hour child and adolescent mobile crisis program for assessment and transport

Do not transport your child to the ER. Seek professional support.

Self Care

So you can better care for your child

- Reach out to supportive family and friends
- Plan for and allow yourself to rest
- Acknowledge that you will not function as well as you usually do
- Accept help
- Exercise and eat healthy meals
- Participate in stress relievers such as mindfulness meditation, support groups, or NAMI Santa Clara County supports
- Keep a journal
Write in it when/if you cannot sleep

When Your Child Expresses Suicidal Thoughts

A Parent Guide to Prevention and Intervention

HEARD Alliance
www.heardalliance.org

Note: Contact agency numbers are for the SF BAY AREA

Suicide Risk Factors

Dramatic changes from their usual self such as:

Feelings

- Sadness
- Hopelessness
- Moodiness
- Angry outbursts (aggressive/violent)
- Loss of interest in family, friends and activities

Thoughts

- Trouble concentrating
- Difficulty making decisions
- Trouble remembering
- Thoughts of harming oneself
- Delusions and/or hallucinations

Behaviors

- Withdrawing from people
- Substance abuse
- Risky behaviors
- Missing school, work or other commitments
- Attempts to harm oneself (e.g., cutting)

Physical Problems

- Sleeping too much or too little
- Eating too much or too little
- Unexplained aches and pains

What to Expect

Emergency Room

- Possible 72 hour hold initiated
- No medication given so as not to mask symptoms
- Guard maybe present for their safety
- Ask questions
- Use notebook to record information, instructions and observations
- Released if in no immediate danger; follow up immediately with child's doctor or therapist

Hospitalization

- Transferred to a psychiatric care facility after medically stable (no adolescent beds in Santa Clara County)
- Unit locked and possessions restricted for your child's safety
- Provide items of comfort for your child
- Various therapies; some include family
- Work with care team
- Limited visiting hours with phone and e-mail contact
- Your child is safe and your non-invasive support helps as they work to get well

Transition Out of Hospital

- Discharge plan created
- Recommend best setting for recovery
- Increased risk of suicide; use means restriction
- Follow up with therapist immediately
- Fill out Health Plan form before return to school
- Make a "School Re-Entry Plan" with school counselor
- Create a "Safety Plan" with school counselor and child

Suicide Warning Signs

Threatening to kill self

Looking for ways to kill self

Talking or writing about death, dying or suicide

Expressing no reason for living or no sense of purpose in life

Rage, seeking revenge

Recklessness or risky behavior, seemingly without thinking

Expressions of feeling trapped like there is no way out

Increased drug or alcohol use

Withdrawal from friends, family and society

Anxiety, agitation, inability to sleep or increased sleep

Dramatic mood changes

Parent Handouts

What to Do and Available Services/Resources

If your child needs to be transported to an emergency room (ER), there are three ways this can occur:

1. Calling 911

Call 911 when the child is in immediate danger of self-harm. Request a Crisis Intervention Team (CIT) trained officer to assist and possibly transport your child to the ER. CIT officers are well-versed in dealing with individuals in crisis. If there is a specific cultural or language need, mention this during the 911 call. If your child is transported to an ER, the law enforcement officer will often handcuff them for both your child's and the officer's safety. It is important to remind your child that this is being done for their safety, not because they are a criminal.

2. Calling Uplift Family Services (<http://www.upliftfs.org>).

UFS provides Santa Clara County's (SCC) Child and Adolescent Mobile Crisis Program 24-hour crisis line at **408-379-9085** or **1-877-41-CRISIS**. This is a mobile mental health crisis unit in SCC for minors (under 18) only (<http://upliftfs.org/services/crisis/>). The crisis unit will do an assessment and call the local ambulance service if they determine that your child needs to be taken to the ER.

3. Transporting Your Own Child

Transporting your child to the ER yourself is **not** recommended. Driving while helping a child in crisis is not safe. For the safety of you and your child, have a second adult with you. Do not take your child to an Urgent Care facility. Urgent Care does not have the capacity to deal with an emotional/psychological crisis and will transport your child to an ER via ambulance.

Getting Help: What to Expect

When your child's distress is first identified:

If 911 or UFS determines that your child is in immediate danger, they will be transported to Emergency Care. The law enforcement officer may initiate a 72-hour hold for a psychiatric evaluation, called a California Welfare and Institution Code (WIC)5585 for minors or WIC5150 for adults. To place a person on a hold it must be determined that they may harm themselves or others, or that they are gravely disabled (lack the ability to care for themselves).

If an ambulance is called for transport to the ER you may or may not be allowed in the vehicle with your child. If you are not allowed in the ambulance be sure to find out which facility they will be taken to. Youth in crisis are transported to the nearest hospital emergency room. Palo Alto police will send or take your child to the Stanford ER. The ER staff will conduct a full physical and psychological assessment. Be aware that, if your child is agitated, the hospital staff may opt not to calm your child with medication so as not to mask any symptoms. A guard may be placed outside your child's door in the ER; again, this is done for their safety. You may be able to sit with your child while in the ER; however, at times you will be asked to leave in order for the physician to speak in private with your child. Depending on the outcome of this assessment they could either be admitted, released or transported to an in-patient facility.

If it is determined that your child is **not** in immediate danger and is released, the attending physician should review with you discharge plans, including immediate steps to take to ensure continuing care for your child. You should follow up **immediately** with the child's primary care doctor or therapist. It is vital that you seek follow up care for your child (see Mental Health Resources list and the HEARD Alliance's mental health provider/organization search: <http://www.heardalliance.org/business-directory/>)

Other parents who have experienced their child's crisis situation strongly recommend bringing a notebook to record information from healthcare providers, instructions, and observations. This is vital due to the stress you are experiencing and the quantity of new information. Do not hesitate to ask questions.

It is also important that you find support for yourself. (See attached Self Care Advice for Parents with a Child in Crisis.) Expand your compassion circle to include supportive family and friends. Your child will also benefit from knowing there are those who support them just like they would be supported if they had a physical illness.

When your child is hospitalized:

Once the attending doctor determines that your child is medically stable they will be transported to a psychiatric care facility. There are no in-patient beds for the psychiatric care of minors in Santa Clara County. Stanford's Emergency Department most commonly hospitalizes youth in need of psychiatric care at St. Mary's Hospital in San Francisco, Mills Peninsula Hospital in Burlingame, or Alta Bates Hospital in Berkeley. Once hospitalized, parents of minors have access to their child's medical records unless it is determined the child's safety will be compromised if this information is released. Parents can always provide information about their child.

Several things are done in a psychiatric unit for your child's safety:

The unit will be locked. There are restrictions on possessions, including clothing (no belts, straps, shoelaces, etc.), sharp objects, cigarette lighters, and other possibly dangerous objects. You may bring your child some of their favorite possessions (quilts, pillows, pictures, food, etc.). Often the hospital staff provides a list of acceptable items you can provide that will give comfort to your child.

Stabilizing your child requires a variety of services:

An assessment is conducted by the professional team, usually consisting of a psychiatrist, psychologist, nurse, and social worker. Treatment may consist of a combination of talk therapy, mindfulness-based meditation, group support, medication, etc. Family may be included in support or therapy sessions. In order to understand the treatments that are recommended and to begin to process your child's care plan, it is important that you work with the care team. You should keep your child's care team informed of any effects of treatments that you notice. Treatments and medications (dose, frequency, type) may be adjusted depending on their effects.

Supporting your child during their hospital stay:

Your visiting hours will be limited. Often you may visit only in the evenings on weekdays and from midday to the evening on weekends. Telephone and email contact is allowed.

Your child has been through an exhausting experience and is working hard to get well. They may feel frightened and excessively tired. At this point your child is safe and your non-invasive support can be most helpful. It is important that your child knows people do care. You and trusted friends and family can bring some lightness into this serious situation by providing supportive comments and conversations that do not focus on the crisis, in spite of how worried you are. Ask the staff how you can best support your child, understanding that the answer may be to just let your child be. Your child may just need to have down time when they are around you. It is also important that you are open-minded and compassionate towards others who are in the hospital. Remember that they are hurting and in crisis as well.

When your child transitions out of the hospital:

When your child is ready to leave the hospital environment, you will create a Discharge Plan with a discharge planner and your child's care team. It is important that you understand the goals of this plan. For your child's safety, care should not end with their hospital release. Depending on the setting that will most enhance your child's recovery, it may be recommended that your child transition to a residential home or a day program before returning home.

Often, subsequent suicide attempts occur shortly after leaving a treatment facility or ER. Vital to your child's safety is means reduction, which is "reducing a suicidal person's access to highly lethal means" (Harvard School of Public Health Means Matter, <https://www.hsph.harvard.edu/means-matter/>). Reducing access includes removing firearms and alcohol; monitoring medications; and limiting the quantity of potentially poisonous substances present in the home. See "Recommendations for Families" for more information: <https://www.hsph.harvard.edu/means-matter/recommendations/families/>.

When your child returns home they must have an immediate follow up with their psychiatrist/psychologist. Accompany them to the first appointment for support and to guarantee that they attend. Encouraging ongoing attendance at therapy sessions is a must.

In order for your child to return to school the attached Health Plan form must be filled out by your psychiatrist or psychologist. This form will allow the school psychologist or counselor to communicate with your child's care provider. A meeting will then be arranged so that you and your child can make a School Re-Entry Plan with the school psychologist or counselor. This plan ensures that when your child returns to school, they do so in a manner and at a pace that will potentiate their ongoing success and well-being.

It is also important for you and your child to create a Safety Plan with the school psychologist or counselor. This is a personal plan about how to deal with a subsequent crisis, including a list of individuals and resources your child will contact in a crisis. (See the Personal Safety Plan)

Key to the recovery of your child is vigilance. By listening and providing encouragement and understanding your child can feel hopeful. Your continued support adds value to medical services and helps your child continue on the path of recovery.

SELF-CARE ADVICE FOR PARENTS WITH A CHILD IN CRISIS

The importance of caring for yourself:

Caring for a child or teen in crisis is stressful and can be physically and emotionally draining. There can be much uncertainty and fear. You might feel guilty or selfish acknowledging your own fatigue. Taking care of your own health and psyche will allow you to be more fully present for your child and other loved ones. You will also be modeling health-seeking behavior. Remember the lesson from any airplane flight you have taken; put on your oxygen mask first before helping a child put theirs on. Self-care is not optional. Some practical suggestions for self-care include:

- Reach out to supportive family and friends, religious or spiritual sources of support and solace. People care. Talking about your experiences, reactions, and feelings can be very healing.
- Recognize that you may be 'burning the candle at both ends'. Plan for and allow yourself to "crash" at some point and get rest.
- Be patient with yourself; you may be distracted and not able to function as efficiently as usual.
- Let others do their part - accept help when offered.
- Keep up your own good health with exercise and healthy meals; avoid numbing the pain with excess alcohol, caffeine, or drugs.
- Participate in stress-relieving process, whether individually or in a group; for instance, Mindfulness Meditation, caregiver support groups or supports provided by NAMI Santa Clara County
- Keep a journal. Write in it if you can't sleep.
- Go for walks (exercise) - but don't overdo it.

Risk Factors for Youth Suicide

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

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

Behavioral Health Issues/Disorders:

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

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

Personal Characteristics

- Hopelessness
- Low self-esteem
- Loneliness
- Social alienation and isolation, lack of belonging
- Low stress and frustration tolerance
- Impulsivity
- Risk taking, recklessness
- Poor problem-solving or coping skills
- Perception of self as very underweight or very overweight
- Capacity to self-injure
- Perception of being a burden (e.g., to family and friends)

Adverse/Stressful Life Circumstances

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

Risky Behaviors

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

Family Characteristics

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

Environmental Factors

- Negative social and emotional environment at school, including negative attitudes, beliefs, feelings, and interactions of staff and students
 - Lack of acceptance of differences
 - Expression and acts of hostility
 - Lack of respect and fair treatment
 - Lack of respect for the cultures of all students
 - Limitations in school physical environment, including lack of safety and security
 - Weapons on campus
 - Poorly lit areas conducive to bullying and violence
 - Limited access to mental health care
 - Access to lethal means, particularly in the home
 - Exposure to other suicides, leading to suicide contagion
 - Exposure to stigma and discrimination against students based on sexual orientation; gender identity; race and ethnicity; disability; or physical characteristics, such as being overweight.

Stigma and discrimination lead to:

- Victimization and bullying by others, lack of support from and rejection by family and peers, dropping out of school, lack of access to work opportunities and health care
 - Internalized homophobia, stress from being different and not accepted, and stress around disclosure of being gay, which can lead to low self-esteem, social isolation, and decreased help--- seeking
 - Stress due to the need to adapt to a different culture, especially reconciling differences between one's family and the majority culture, which can lead to family conflict and rejection

REFERENCES

- Beautrais, A. L. (2003). Life Course Factors Associated With Suicidal Behaviors in Young People. *American Behavioral Scientist*, 46(9), 1137.
- Berman, A. L., Jobes, D. A., & Silverman, M. M. (2006). *Adolescent Suicide: Assessment and Intervention* (2nd ed.). Washington, DC: American Psychological Association.
- Campo, J. V. (2009). Youth Suicide Prevention: Does Access to Care Matter? *Current Opinions in Pediatrics*, 21(5), 628-634.
- Doan, J., Roggenbaum, S., & Lazear, K. (2003). Youth suicide prevention school-based guide-Issue brief2: School climate. Tampa, FL: Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Series Publication #218-2)
- Eaton, D. K., Lowry, R., Brener, N. D., Galuska, D. A., & Crosby, A. E. (2005). Associations of body mass index and perceived weight with suicide ideation and suicide attempts among US high school students. *Archives of Pediatrics & Adolescent Medicine*, 159(6), 513-519.
- Epstein, J. A., & Spirito, A. (2009). Risk factors for suicidality among a nationally representative sample of high school students. *Suicide and Life-Threatening Behavior*, 39(3), 241-251.
- Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(4), 386-405.
- Gutierrez, P. M., & Osman, A. (2008). *Adolescent suicide: An integrated approach to the assessment of risk and protective factors*. DeKalb, IL: Northern Illinois University Press.
- Joiner, T. E., (2009). Suicide prevention in schools as viewed through the interpersonal psychological theory of suicidal behavior. *School Psychology Review*, 38(2), 244-248.
- Lofthouse, N., & Yage-Schweller, J. (2009). Nonsuicidal self-injury and suicide risk among adolescents. *Current Opinions in Pediatrics*, 21(5), 641-645.
- Martin, G., Richardson, A. S., Bergen, H. A., Roeger, L., & Allison, S. (2005). Perceived academic performance, self-esteem and locus of control as indicators of need for assessment of adolescent suicide risk: Implications for teachers. *Journal of Adolescence*, 28(1), 75-87.
- Miller, D. N., & Eckert, T. L. (2009). Youth suicidal behavior: An introduction and overview. *School Psychology Review*, 38(2), 153-167.
- Suicide Prevention Resource Center. (2008). *Suicide risk and prevention for lesbian, gay, bisexual, and transgender youth*. Newton, MA: Education Development Center, Inc. Retrieved from http://www.sprc.org/library/SPRC_LGBT_Youth.pdf
- Swahn, M. H., Reynolds, M. R., Tice, M., Miranda-Pierangeli, M. C., Jones, C. R., & Jones, I. R. (2009). Perceived overweight, BMI, and risk for suicide attempts: Findings from the 2007 Youth Risk Behavior Survey. *Journal of Adolescent Health*, 45(3), 292-295.

Recognizing and Responding to Warning Signs of Suicide

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

Warning Signs for Suicide Prevention is a consensus statement developed by an expert working group brought together by the American Association of Suicidology. The group organized the warning signs by degree of risk, and emphasized the importance of including clear and specific direction about what to do if someone exhibits warning signs. This consensus statement describes the general warning signs of suicide. Warning signs differ by age group, culture, and even individual.

The recent advent of social media has provided another outlet in which warning signs may be exhibited. The differences in how and where warning signs may be exhibited demonstrate the importance of adapting gatekeeper training for the age group and cultural communities with whom the gatekeepers will be interacting.

Warning Signs for Suicide and Corresponding Actions

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

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

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

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

If you or someone you know is in a suicidal crisis, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or call 911 and ask for a Crisis Intervention Team officer)

REFERENCE

Rudd, M. D., Berman, A. L., Joiner, T. E. Jr., Nock, M. K., Silverman, M. M., Mandrusiak, M., & Witte, T. (2006). Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life-Threatening Behavior*, 36(3), 255-262.

from Preventing Suicide: A Toolkit for High Schools, SAMHSA

SANTA CLARA COUNTY SAMPLE PERSONAL SAFETY PLAN

STEP 1: I should use my safety plan when I notice these warning signs (thoughts, images, moods, situations, behaviors):	
1.	
2.	
3.	
STEP 2: Internal coping strategies – Things I can do by myself to help myself not act on how I’m feeling (e.g. favorite activities, hobbies, relaxation techniques, distractions):	
1.	
2.	
3.	
What might make it difficult for me to use these strategies?	
Solution:	
STEP 3: People and places that improve my mood and make me feel safe:	
1. Name: _____	Phone: _____
2. Name: _____	Phone: _____
3. Place (day): _____	
4. Place (night): _____	
What might get in the way of me contacting these people or going to these places?	
Solution:	
STEP 4: People I trust who can help me during a crisis:	
1. Name: _____	Phone: _____
2. Name: _____	Phone: _____
3. Name: _____	Phone: _____
Why might I hesitate to contact these people when I need help?	
Solution:	
How will I let them know that I need their help?	
STEP 5: Professional resources and referrals I should contact during a crisis (available 24/7):	
1. Clinician Name: _____	Phone: _____
2. Local Urgent Care Services: _____	
Address: _____	
Phone: _____	
3. Santa Clara County Suicide & Crisis Center: 855-278-4204	
4. National Suicide Prevention Lifelines: 1-800-784-2433 and 1-800-273-8255	
5. UFS Child & Adolescent Mobile Crisis Program: 408-379-9085	
6. Call 911 if you need immediate help in order to remain safe.	
STEP 6: Steps I can take to keep myself safe by reducing access to means I would consider using during a suicidal crisis:	
1.	
2.	

SANTA CLARA COUNTY SAMPLE PERSONAL SAFETY PLAN

Where will I keep this plan so that I can easily find and use it during a crisis?

Student Signature Date

Parent/Legal Guardian Signature Date

Support Person Signature Date

Psychologist/Counselor Signature Date

Psychologist/Counselor Signature Date

*Note: A phone app is available for creating a personal safety plan at **MY3App.Org***

APPENDIX C: Kara Resources on Grief

- C1. A Few Thoughts for Teachers and Parents
- C2. Grief and Mourning in Children and Teens
- C3. 10 Basic Principles for Grieving for Children and Teens
- C4. Ways to Support Children in Coping with Trauma or Loss
- C5. Comforting a Grieving Individual
- C6. Grief Discussion with Students after a Suicide
- C7. Useful Grief Insights for Teachers: A Script
- C8. Sample Letter to Parents after a Death
- C9. Realistic Expectations
- C10. How to Help Someone Who Is Suffering From Loss
- C11. Kindness Toward Self



A Few Thoughts for Teachers and Parents

By Lynn Bennett Blackburn

You are faced with the challenge of helping your class and your children cope with the loss of a classmate. The goal of addressing the student's death with them is to give the children some understanding of what they are experiencing, to give them labels for their feelings, and to let them know they are not alone in having these feelings. The goal is to help them grieve, not to make the grief go away. There are several things to consider:

Be honest about your feelings. Share what you are feeling through simple statements coupled with comments about what you do to express and cope with these feelings. Encouraging the children to share and express what they feel is more effective when you model this behavior.

Be honest with the limits of your knowledge. The death of a classmate may raise questions about why it happened, what it feels like to die, and what happens after death. For many of these you will have no answers. It is important to ask what they think, for often such questions represent other worries or concerns that you can address. Sometimes it will be best to encourage the child to share the question with parents. A simple "I don't know, but I wonder about that, too" may be the most helpful and truthful answer you can give.

Be honest with yourself. Recognize that you are grieving, too. Be an advocate regarding the time you need to deal with this loss. You may need someone to fill in for you while you attend the funeral, visit the family, talk with your children. You'll probably need a few minutes alone, too. If you are uncomfortable with certain topics or aspects of approaching this situation, ask others-- the social worker, school psychologist or counselor. You don't have to do it all and you don't have to do it alone.

Provide opportunities for feeling expression. Grieving is often a mixture of anger and sadness. Allow time for tears. Let the children know that crying is a normal reaction to losing someone or something we value; that saying good-bye to a friend can be very sad. Children often view crying as a sign of weakness or immaturity. They may need help to see tears as something positive for adults as well as children.

Finding constructive outlets for anger may be your greatest challenge. It is important to help the children define the source --at whom and about what they are angry. Anger can be released through verbal activities such as role-playing or writing down what you wish you could say or do to the subject of the anger. Physical outlets, such as throwing bean bags at a target, throwing a ball at a wall, or working with clay (pounding, pulling, squeezing) can help release the energy that anger creates.

For older children, anger may be channeled into a class project related to the cause of their friend's death. A sense of meaning can be attached to the tragedy through fund raising to support community action such as fire safety, water safety, groups against drunk driving or informational

campaigns to increase peer and public awareness such as helmet use.

Maintain class and home routine and rules. Children gain security from structure and routine. While brief interruptions may occur to accommodate a funeral or memorial service, returning to routine provides the comforting reassurance that life will go on.

Don't rush. Some classes have come to school to find a dead schoolmate's desk removed and all evidence of the child hidden away. Let your class decide what to do with the empty desk and other things owned by the class. Making things disappear does not make the death easier. Rather, it gives the children a feeling that they don't really matter.

Add feeling-related ideas to your regular curriculum. The need to express feelings will not end with the funeral. It is important, over the months that follow, to continue to provide opportunities for feeling expression. Art and writing projects can be built around feeling themes—things that make you happy, what you do when you feel sad, drawing or writing about a memorable day. Stories about coping with death, plus losses such as divorce or moving can be incorporated into reading activities.

Recognize and affirm your privileged position. This is a time when you can have a very positive influence on your children. How you help them handle this grief will, in some large or small way, help them in the future. Giving them permission to feel and share those feelings, to cry, to love and to care may be the greatest single gift you ever give them.

About the Author: Lynn Bennett Blackburn has a doctorate in child clinical psychology. She is a Pediatric Neuropsychologist in the Division of Pediatric Neurology at the University of Minnesota. Her work involves assessing children with neurological disorders and learning problems, then working with their families and school staff to help staff and parents better understand and respond to each child's special needs.



Grief and Mourning in Children and Teens Compiled by Kara

Developmental Stages and Grief: Children and Teens

Developmental Age: Infancy--birth to 18 months

Primary Developmental Challenge: Ability Being Developed: Basic trust vs. mistrust
Hope

Child's Beliefs About Death: No concept of death, limited concept of time.
Grief Reactions: General distress, shock, despair, protest, sleeplessness. May show increased needs for holding, touching. May show increased reluctance to be separated from nurturer. Needs: Routines maintained, nurturing from a consistently available caregiver, reassurance, love, secure environment. Meet increased attachment needs for eye contact, facial expressions, touching, rocking, singing.

Developmental Age: Toddlerhood: infancy to 3

years Primary Developmental Challenge: Autonomy vs. shame/ doubt

Ability Being Developed: Will and self-control

Child's Beliefs About Death: Death seen as temporary separation; any separation from parent may create anxiety. Repeated explanations do not increase child's understanding, because cognitive ability to understand death is limited. Confuse fantasy/ reality. On an unconscious and non-verbal level, child may assume what happens is under their control & is therefore "their fault."

Grief Reactions: May relieve anxiety through fantasy or distressed behaviors (regression, aggression, clinging.) May feel guilty. May fear being left alone. May regress to earlier stages, needs. May not understand sadness around him or may seem unaffected. Confusion, agitation at night, nightmares. Repeated questions are common.

Toddlerhood: infancy to 3 years (cont'd)

Needs: Reassure child he will be cared for by maintaining routines, nurturing from a consistently available caregiver, reassurance, love, and a secure environment. Simple, honest words, concrete explanations, repetition, & patience help the child distinguish between fantasy & reality. Assure child he did not cause it to happen & it is not his fault. Offer opportunity for inclusion in

family rituals such as funeral, and provide a supportive adult to honor the child's wishes if the child changes his mind or wants to leave. Help child acknowledge own feelings-anger, sadness, etc; Accept regressive behavior.

Developmental Age: Early Childhood:
 Primary Developmental Challenge: Initiative vs. guilt
 Ability Being Developed: Purpose and direction

Child's Beliefs About Death: May still be quite similar to that of a toddler in that death is not understood as permanent. Some 4 and 5 year olds may have the beginnings of an understanding, as experience over time with the concrete reality of the deceased not reappearing begins to have meaning. Cognitive ability to understand death is still limited, however.

Grief Reactions: May regress and "act younger." May cling to adult caregiver, show or even verbalize anxiety that the adult may die or become ill. May tell everyone and anyone about the death. Confusion, agitation at night, nightmares are possible. Repeated questions about the death or the deceased are common. In general, children cycle through their emotions much more rapidly than adults-smiling one minute, crying the next, angry the next, giggling a minute later. Emotions may seem amplified. Frustrations that would have been minor before the loss may result in more frequent major meltdowns that last longer than expected. At other times the child may say "I'm happy," or may seem unaffected.

Needs: Same as above for toddler, plus increased dialog about the deceased and opportunity to participate in the ways to remember the deceased. Helpful to continue to hear stories about the deceased, see pictures of them, and hear about their relationship with them. Give the child age-appropriate, brief information, and then attune to his questions and curiosities, providing frequent opportunities to talk briefly, and answering questions honestly.

Developmental Age: Middle Childhood: 5 years to puberty
 Primary Developmental Challenge: Industry vs. inferiority
 Ability Being Developed: Competency

Child's Beliefs About Death: By 5-7 years old, child begins to see death as final & universal for others; neither believes nor denies that he himself will die; may believe he can escape by being good/ trying hard. Death is often perceived as external: a person, a spirit. By 7-11, children perceive the irreversibility, permanence, inevitability of death, and perceive their own mortality; they have vivid ideas about what occurs after death, and may be concerned with consequences following death.

Grief Reactions: May act like nothing happened or deny that things are different. Tend to show grief through play or behaviors instead of talking about it: numbness, shock, sorrow, confusion, fears, anxiety, anger, embarrassment, happiness & humor, in short cycles. May desire to conform to peers and present a façade of coping. May act younger than his age. Want to understand: may want lots of information, may become an expert in the disease that caused a death, for example. Peer relationships are increasingly important. Some children find support from their friends, others try to hide the fact that they've experienced a death.

Needs: Simple, honest answers & information; ample reassurance. Models for mourning. Acknowledgment of their feelings, allowing a child to express or withhold, as needed. Support the child's unique style of coping. Safe place, people & time to talk, share their experience. Assistance in remembering the person who died. Support in showing grief in his own unique way. Limits & rules, upheld firmly but with kindness. Reassurance about future & clarity that they are not responsible for it, nor for the death. Choices, inclusion. Respect of their "need to know," as information returns some sense of control. Respect child's increasing need for peer relationships. Physical outlets, play, expressive art, reading; memory book can be helpful. Do not require children to be "brave," "grown-up," "in-control," or to comfort others.

Developmental Age: Adolescence
 Primary Developmental Challenge: Identity vs. identity confusion
 Ability Being Developed: Individuation

Three Developmental Stages within

Adolescence: Early Adolescence: 11 to 14 years

Challenge: Reunion vs. abandonment/ separation
Ability Being Developed: Emotional separation from parents

Middle Adolescence: 14 to 17 years
Challenge: Independence vs. dependence
Ability Being Developed: Mastery/ control

Late Adolescence: 17 to 21 years
Challenge: Closeness vs. distance
Ability Being Developed: Intimacy and commitment

Child's Beliefs About Death: Recognize their own mortality but may act as though it could never happen to them. Attitudes towards death becoming similar to adults'.

Grief Reactions

Physical: May feel fatigued, sleep more, gain/lose weight, have headaches, get **ill** more easily, be accident-prone, restless. May be attracted to alcohol, smoking, drugs, excessive risk-taking.

Mental:May experience trouble concentrating in school, forgetfulness, lack of motivation, "negative" attitude, "no one understands". May need to ask "why?" or say "if only," mourning what might have been.

Emotional:Sad, irritable, worried, angry, anxious, fearful, relieved, guilty, lonely, mood swings, crying spells, frustration, revenge. Watch for depression, hopelessness, helplessness. May fill emptiness with intimacy, sex.
Adolescence (cont'd.)

Spirit:May experience loss of direction, future, meaning, faith
Relational:Feeling isolated, less cooperative, withdrawing, or getting very busy, perfectionistic, and social. May lash out or show moods more readily. Friendships may change a lot as the teen wants others to reach out or leave him alone. May have difficulty with others' reactions & what is said about the death, as well as with the everyday content of peer's conversations, which may suddenly seem trivial compared to the death. Can be left feeling isolated in a crowd.

Needs: Balanced, healthy food, water, adequate sleep, exercise, medical check-ups. Professional assistance if alcohol, drug, promiscuity, or eating issues develop. Recognition of the importance of their peer relationships.

Understanding, patience, and assistance of teachers & parents needed if grades suffer, if additional help or time are required for assignments, or if teen needs to step out of classroom during a grief burst.

Respect the teen's need to work through the loss independently. Be available but not intrusive: "I'm here if you want to talk or if you need me." They will be most likely to talk to listeners who make themselves available but don't force talking, who respect the teen's need for privacy, and give the teen a clear sense that they have choices about when & with whom they feel comfortable expressing grief emotions. Teens benefit from opportunities & support for self-expression, and need tolerance of conflicting feelings, and push/pull relationship with adults. Even when they protest, they need adults to look after their safety, as well as set and enforce limits. Even when adults are monolithic in their grief, teens need fun, recreation, and time with peers. They also need inclusion, choices in memorializing the deceased.

The above material was prepared by Liz Powell, adapted from the work of Erik Erikson, J. William Worden, Charles A. Corr, Clyde M. Nabe & Donna M. Corr, the Kara community, and hundreds of children and teens served by Kara since 1993. It includes material adapted by Sue Shaffer from the work of John Bowlby, Earl Grollman, Claudia Jewett, Elizabeth Kubler-Ross, Margaret Nagy, J. W. Worden, Alan Wolfolt, and Valerie Young.

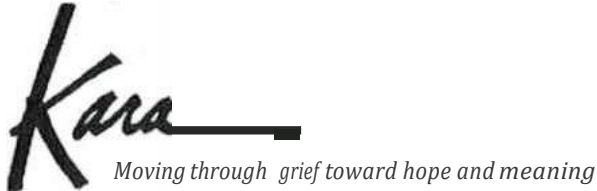


10 Basic Principles of Grieving for Children and Teens:

1. Children are concrete in their thinking: In order to lessen their confusion, use the words "death" and "dying." Describe death concretely. Answer their questions simply and honestly without using euphemisms such as "passed on," "went to sleep," etc. You don't have to add a large number of details. Children will ask if they want to know more. You can see if they are listening because they want to, or if it is for your benefit (they seem agitated, fidgety, and give you little or no eye contact).
2. Children generalize from the specific to the general: If someone died in a hospital, children think that hospitals are for the dying. If someone died in their sleep, children are afraid to go to sleep. If one person died, "someone (or everyone) else will die," or "I will die." They will learn to accommodate new truths on their own if they are allowed to express themselves and try things out (e.g., going to sleep and waking up alive).
3. Children are repetitive in their grief: Children may ask questions repetitively. The answers often do not resolve their searching. The searching itself is a part of their grief work. Their questions are indicative of their confusion and uncertainty. Listen and support their searching by answering repetitively and/or telling the story over and over again.
4. Children are physical in their grief: The older children are, the more capable they are of expressing themselves in words. Younger children simply ARE their feelings. What they do with their bodies speaks their feelings. Grief is a physical experience for all ages, but most especially for younger children. Watch their bodies and understand their play as their language of grief. Reflect their play verbally and physically so that they will feel that they are "being heard." For example, "You are bouncing, bouncing, bouncing on those pillows. Your face is red and you are yelling loudly."
5. Children grieve cyclically: Their grief work goes in cycles throughout their childhood and their lives. Each time they reach a new developmental level, they reintegrate the important events of their lives, using their newly acquired processes and skills. Example: a one year old, upon losing his mother, will become absorbed in the death again when her language skills develop and as she is able to use words for the expressions of her feelings. She may re-experience the grief again as an adolescent, using her newly acquired cognitive skills of abstract thinking.
6. Children need choices: Death is a disruption in children's lives that is quite frightening.
Their lives will probably seem undependable, unstable, confusing, and out of control. These topsy-turvy feelings can be appeased if children have some say in what they do or don't do to memorialize the person who has died, and to express their feelings about the death.

7. **Children grieve as part of a family:** When a family member dies, it will affect the way the family functions as a whole. All the relationships within the family may shift, adjusting to this change in the family structure. Children will grieve for the person who died, as well as the environment in the family that existed before the death. Children may grieve over the changed behavior of family and friends. It is helpful if each family member is encouraged to grieve in his/her own way, with support for individual differences.
8. **Children's feelings are their allies:** Feelings help children pay attention to their loss. Through this attention comes their own understanding about the death that they grieve. It is important not to shield children from their emotions; offering them the option to stay or leave will allow them to feel included, and will give them permission to be with the feelings.
9. **Children's grief is intertwined with normal developmental tasks:** It can be impossible to determine which behaviors are part of developmental phases and which are grief-related (e.g., "Is it adolescence or is it grief?").
10. **Key Tasks of Mourning in Children and Teens:**
 - a. Understand the death, try to make sense of what happened.
 - b. Express emotional and other strong responses to the loss.
 - c. Commemorate the person that's been lost.
 - d. Learn how to go on living and loving.

Let children and teens teach you about their grief



Ways to Support Children in Coping with Trauma or Loss

1. Take time to listen to their concerns; help them to feel safe; encourage expression of their feelings.
2. Acknowledge that trauma and loss are hard to handle for everybody.
3. Smile and hug often; use creative ways to help them express complex feelings.
4. Encourage them through their challenges with "I believe in you" messages.
5. Give age appropriate information about the critical event that is honest and direct.
6. Listen to their experience and respond without judgment.
7. Partner with children; help them decide how they want to deal with difficult "adult" things like funerals and remembrance anniversaries.
8. Let children know about YOUR difficult feelings and vulnerability.
9. Honor their uniqueness and individuality.
10. Affirm that all ways of experiencing grief are "normal".
11. Encourage them to take time for themselves and ask for what they need.
12. Let them know that you are available to talk or just to hang out, as they wish.



Comforting a Grieving Individual

Many people feel inadequate about what to say to a friend or family member who is grieving. This guide to comforting a grieving individual covers both 1) words that offer comfort, and 2) words that, while well intentioned, may harm or stifle the bereaved, making the journey through grief more difficult.

Saying nothing or pretending the death didn't happen also hurts the individual in the long run. It is important for this person to hear words of comfort from you and especially from friends, family members, or colleagues to whom he/she is close.

Words that Do Comfort	Words that May Not Comfort
I'm sorry.	Now she's in a better place.
I'm thinking of you.	Time will heal you.
I care and want to help.	Think of all you have to be thankful for.
You are so important to me.	Just be happy that he's out of his pain.
I'm here for you.	He lived a long life.
If I were in your shoes, I think I'd feel that way too.	Be strong. You are holding up so well.
One of my favorite memories of (use the name of the person or pet) is .. .	Keep busy.
It seems so natural to cry at a time like this.	Try not to think about it.
I don't know what to say but I know this must be very difficult for you.	He wouldn't have wanted you to be sad.
Do you feel like talking for a while?	This is a blessing.
How do you feel today?	Now you have an angel in heaven.
	You shouldn't feel that way.
	Stop acting like a baby.
	You need to be strong.



GRIEF DISCUSSION WITH STUDENTS AFTER A SUICIDE

Before the Meeting with Students

- Review "TALKING ABOUT SUICIDE" (AFSP Toolkit, Pages 15-16)

Meeting Guidelines

Before having the discussion with students, students are asked to respect one another and that not a lot of detailed information will be shared about the person who died.

Share the information that you have directly and honestly.

Read "SAMPLE DEATH NOTIFICATION STATEMENT FOR STUDENTS" (AFSP Toolkit, Pages 17-18)

Allow students to ask questions. Answer questions as best you can, knowing that it is okay to say "I don't know" when you don't have the answer.

Talk to your class about how grief affects people and encourage them to share how they feel. One way to do this is to discuss what other types of losses or deaths the students in your class have experienced, and what helped them cope.

Psycho-educate students on the facts about suicide (i.e., brain illness, warning signs, symptoms) and resources to support themselves and others- "FACTS ABOUT SUICIDE AND MENTAL DISORDERS IN ADOLESCENTS" (AFSP Toolkit, Pages 26-28) is a great resource

Let students know that if they would like to write a letter and/or draw a picture to support the family that they could do so.

Let students and families know that there are support counselors that they can speak with today who can help with on-going support as well.

Recommended: SHARE "HELPING STUDENTS COPE" (AFSP Toolkit, Pages 29-31) with teachers, counselors, and administrators who will be supporting the students and parents



Useful Grief Insights for Teachers: A Script

Scene: You are faced with the challenge of helping your students cope with the loss of a classmate. The goal is to help them grieve, not to make the grief go away.

Action: Tell a story of a death you believe the children will understand (a pet, a tree, a bird, etc.)

or use one of the activities from the enclosed notebook.

Setting the scene:

- *Be honest with yourself.* Recognize that you are grieving too. You don't have to do it all. For example, "I miss Sally too."
- *Be honest about your feelings.* Share what you are feeling with your students, share with them through simple statements and comments about what you do to express and cope. For example, "I sometimes feel better after drawing a picture."
- *Be honest with the limits of your knowledge.* The death may raise questions about what it feels like to die and what happens after death. You won't be able to answer many of their questions. Ask what they think so you can hear what their actual worries or concerns are.
- *Provide opportunities for feeling expression.* When we grieve it is often a mixture of anger and sadness. Allow time for their tears. Let the children know that crying is a normal reaction to the death of a classmate and of a loved one.
- *Maintain class and home routine and rules.* Students need structure and routine. Even with the interruption of a funeral or memorial service, your return to routine will provide reassurance to the students that life does go on.
- *Don't rush.* If a classmate has died let your students decide what to do with the empty desk and the other things owned by the child who died. The idea is not to make the child disappear, it doesn't make it easier for the children. Rather, it gives children a sense that the child didn't really matter.
- *Add feeling-related activities to your regular curriculum.* Many children are kinesthetic learners. The need to express feelings about the loss will continue for all your students. In particular, the kinesthetic student is particularly comforted by art and writing projects built around feeling themes. Stories about coping with death and loss can be incorporated into the classroom reading activities. It is important to continue to provide opportunities for feeling expression.
- *Honor and affirm your privileged position.* This is a time you have a very healing influence on your students. Showing them how to handle grief in even these small ways will help them in the future.

Finale: Giving permission to feel and to share feelings may be the single most important gift you ever give to them.



Sample Letter to parents after a death

Dear Parents,

A very sad thing has happened in our school community. Last night, we lost.... This loss was sudden and unexpected, and we are all profoundly saddened by his death.

We have shared this information with your children today and had discussions with all the students in their homeroom. Bereavement counselors, teachers, and other support staff have been and will continue to be available to students, teachers, and parents. Please contact the school if you have any questions or concerns.

As a parent, you may want to talk to your child about death because it impacts each person in different ways. How children and teens react will depend on the relationship they had with the person who died, their age, and their prior experience with death.

Your child may:

- Appear unaffected
- Ask questions about the death repeatedly
- Be angry or aggressive
- Be withdrawn or moody
- Be sad or depressed
- Become afraid
- Have difficulty sleeping or eating

We suggest that you listen to your children. If they want to talk, answer their questions simply, honestly and be prepared to answer the same questions repeatedly.

Our thoughts are with (family

name). Sincerely,

Principal xxxxxx



Realistic Expectations about Grief

Grief will take longer than most people think.

Grief takes more energy than we ever imagine.

Grief shows itself in all spheres of our life, in the emotional , social, physical, and spiritual.

We feel grief not only for the actual person we lost, but also for our hopes, dreams, unfulfilled expectations, and unmet needs.

New losses bring up unresolved grief from our past, often forcing us to cope with an array of confusing feelings at once.

Grief can temporarily affect our decision-making and problem-solving abilities and cause difficulties in concentrating.

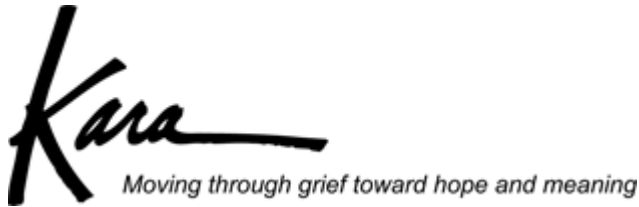
Sometimes grief makes us feel we "are going crazy."

Society has unrealistic expectations about grief and the mourning process and people may respond inappropriately to you.

Grief may cause a variety of physical symptoms, like sleeplessness, tightness in the chest, and decreased energy.

Family members may not always provide the support we expect. And their grief may be very different from ours. Sometimes people have the necessary social support to help them through loss. But more often, they need to reach out for support, let others know what they need, and actively build a network that facilitates personal growth and renewal.

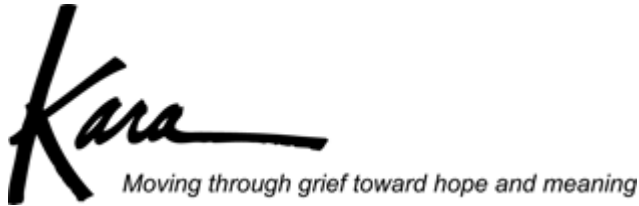
<https://kara-grief.org/article/realistic-expectations/>



How To Help Someone Who Is Grieving

- **DO** let your genuine concern and caring show.
- **DO** be available... to listen or to help with whatever else seems needed at the time.
- **DO** say you are sorry about what happened and about their pain.
- **DO** allow them to express as much unhappiness as they are feeling at the moment and are willing to share.
- **DO** encourage them to be patient with themselves, not to expect too much of themselves and not to impose any “shoulds” on themselves.
- **DO** allow them to talk about their loss as much and as often as they want to.
- **DO** talk about the special, endearing qualities of the person they've lost.
- **DON'T** let your own sense of helplessness keep you from reaching out.
- **DON'T** avoid them because you are uncomfortable (being avoided by friends adds pain to an already painful experience).
- **DON'T** say that you “know how they feel”. (Unless you've experienced their loss yourself you probably don't know how they feel.)
- **DON'T** say “you ought to be feeling better by now” or anything else that implies a judgment about their feelings.
- **DON'T** tell them what they should feel or do. **DON'T** change the subject when they mention their loss or their loved one.
- **DON'T** avoid mentioning their loss out of fear of reminding them of their pain (You can be sure they haven't forgotten it.
- **DON'T** try to find something positive (e.g. a moral lesson, closer family ties, etc.) about the loss.
- **DON'T** point out “at least they have their other ...”
- **DON'T** say they “can always have another ...”
- **DON'T** suggest that they “should be grateful for their so-and-so...”
- **DON'T** make any comments which in any way suggest that their loss was their fault (there will be enough feelings of doubt and guilt without any help from their friends)

<https://kara-grief.org/article/helping-someone-who-is-grieving/>



Kindness Toward Self

Jim Mulvaney, FT

Unkindness Toward Self Happens Through How We:

1. schedule our time
2. push our bodies
3. compare and judge ourselves against others
4. take things personally
5. surrender to too many demands
6. commit to too many projects
7. over-schedule to the point that we rob ourselves of the experience of being alive
8. allocate time in a manner that doesn't reflect our inner priorities
9. want to help everyone in everything
10. go about arranging our lives
11. disregard the signals of imbalance over a long term
12. crave to hold on to what we like
13. crave to get rid of what we find difficult
14. neglect to notice, and to question the truth of, beliefs/expectations that cause us to suffer

Practicing Kindness Toward Self

1. Leave time for the quietness of simply being present with yourself. (mindfulness meditation, music, nature ...)
2. Practice noticing when you are wanting things to be different than the way they are. (Book: Loving What Is, by Byron Katie; thework.org).
3. Stop your thinking or feelings from controlling your life by changing how you perceive them (Byron Katie's Work). Disown them.
4. Do just what has to be done right now, for that's all you can do.
5. Let go of the belief that you should be able to control the 'stormy situations' in your life.

Helpful Thoughts

- Fully accepting what is true in the moment is the only firm ground upon which to make changes in your life and to heal.
- "The internal work and external work of care giving are the same. The more you can develop the internal ability to be a calm, compassionate presence toward yourself, the more you can bring that presence to everyone you serve."
(*Emotional Intelligence*, Dr. Daniel Goleman)
- "The one who can be present with us in our hours of grief, who can tolerate not knowing, and face with us the reality of our vulnerability, that is the one who gives us our best caring." (*Out of Solitude*, Henry Nouwen)
- The more you are able to be with yourself in a kind way, the more kindness/help you will offer to another.
- The true measure of a gift is not in the cost to the giver, but in the need of the receiver.

BIBLIOGRAPHY

- After a Suicide: A Toolkit for Schools.* (2011). Retrieved 2013, from American Foundation for Suicide Prevention Web Site: <http://www.afsp.org/files/Surviving/toolkit.pdf>
- Brent, David A (August, 2011). *Preventing Youth Suicide: Time to Ask How.* Retrieved 2013, from Journal of the American Academy of Child and Adolescent Psychiatry (Vol. 50/No. 8). Web Site: <http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856710007422.pdf>
- California Healthy Kids Survey, Palo Alto Unified Secondary Schools.* (2012). Retrieved 2013, from California Healthy Kids Survey Web Site: http://pausd.org/parents/programs/StudentConnectedness/downloads/palo_alto_se_c1112_main.pdf
- General Guidelines for Teachers and Staff.* (2010). Retrieved 2013, from Los Angeles County Youth Suicide Prevention Project. Los Angeles Unified School District. Web Site: http://preventsuicide.lacoe.edu/admin_staff/staff/documents/guidelines_general.pdf
- Know the Signs.* (2012). Retrieved 2013 from California Mental Health Services Authority, Suicide is Preventable Web Site: <http://www.suicideispreventable.org>
- Preventing Suicide: A Toolkit for High School.* (2012). Retrieved 2013, from Substance Abuse and Mental Health Services Administration Web Site: <http://store.samhsa.gov/shin/content//SMA12-4669/SMA12-4669.pdf>
- Promoting Mental Health and Preventing Suicide in College and University Settings.* (October, 2004). Retrieved 2013, from Suicide Prevention Resource Center Web Site: http://www.sprc.org/sites/sprc.org/files/library/college_sp_whitepaper.pdf
- Resources on Grief and Self Care for Teachers, Parents and Children.* (2012). Kara, Grief Support for Children, Teens, Families and Adults. A cumulative collaboration of evidence. Web Site: <http://www.kara-grief.org/>
- School-Based Youth Suicide Prevention Guide.* (2012). Retrieved 2013, from University of South Florida Web Site: <http://theguide.fmhi.usf.edu/>
- Suicide and Self-Inflicted Injury.* Lucile Packard Foundation. (2011). Retrieved 2013 from Kids Data Web Site: <http://www.kidsdata.org/data/topic/dashboard.aspx?cat=34>

Supporting Survivors of Suicide Loss. (November 2009). Retrieved 2013 from Harvard Health Publications, Harvard medical School Web Site:
http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2009/November/supporting-survivors-of-suicide-loss

The Surgeon General's Call to Action to Prevent Suicide. (1999). Retrieved 2013 from U.S. Public Health Service Profiles in Science National Library of Medicine Washington, DC Web Site:
<http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH>

Youth Risk Behavior Surveillance, Morbidity and Mortality Weekly Report (Vol. 59/No. SS-5). (June, 2010). Retrieved 2013 from Centers for Disease Control and Prevention Web Site:
<http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>

Youth Suicide-Prevention Guidelines for California Schools. Retrieved 2013 from California Department of Education Web Site: <http://www.cde.ca.gov/ls/cg/mh/suicideprevres.asp>

Youth Suicide Prevention, Intervention and Postvention Guidelines - A Resource for School Personnel. (2009). Retrieved 2013 from Maine Center for Disease Control and Prevention, Maine Youth Suicide Prevention Web Site:
<http://www.maine.gov/suicide/docs/Guidelines%2010-2009-w%20discl.pdf>

Suicide Language

American Foundation for Suicide Prevention (n.d.). Speaking out about suicide. Retrieved from https://afsp.org/wp-content/uploads/2016/04/13279_AFSP_SpeakingOutAboutSuicide_Flyer_d4.pdf

The Dougy Center, (n.d.). After a Suicide Death: Ten Tips for Helping Children & Teens, Retrieved from http://www.tdcbookstore.org/store/p24/After_a_Suicide_Death%3A_Ten_Tips_for_Helping_Children_%26_Teens_item_%23552.html

National Action Alliance, Survivors of suicide Task force (2015). Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines. Retrieved from <http://www.sprc.org/sites/default/files/migrate/library/RespondingAfterSuicideNationalGuidelines.pdf>

Introduction

Hospitalizations for Mental Health Issues, by Age Group. (2016, August). Retrieved from <http://www.kidsdata.org/topic/715/hospitaldischarges-mentalhealth/table#fmt=2342&loc=2,127,1658,1659,331,1660,171,1661,357,369,362,360,1662,364,356,217,354,1663,339,365,343,367,344,366,368,265,349,361,4,273,59,370,326,1772,341,338,350,342,359,363,340,335&tf=84&ch=1066,1065,1137>

Joshi SV, Pumariega A, Reicherter D and Roberts LW (2015). Cultural Issues in Ethics and Professionalism, in *Professionalism and Ethics: A Q & A Study Guide for Mental Health Professionals*, L. Roberts and D. Reicherter (eds.); pp. 39-56, American Psychiatric Press, Inc. Washington DC.

Mental Health Facts: Children and Teens. (2014). Retrieved from <https://www.nami.org/getattachment/Learn-More/Mental-Health-by-the-Numbers/childrenmhfacts.pdf>

McDermott JF (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.

Pumariega AJ, Rothe E, Song S, Lu F. Culturally Informed Child Psychiatric Practice Child Adolesc Psychiatric Clin N Am 19 (2010) 739–757

Pumariega AJ and Joshi SV. Child Adolesc Psychiatric Clin N Am 19 (2010) 661–680

Ten Leading Causes of Death and Injury . (2014). Retrieved from <https://www.cdc.gov/injury/wisqars/leadingcauses.html>

PROMOTION

Means Restriction

Sarchiapone, M., Mandelli, L., Iosue, M., Andrisano, C., Roy, A. (2011). Controlling access to suicide means. *International Journal of Environmental Research and Public Health* 8(12): 4550–4562. doi: [10.3390/ijerph8124550](https://doi.org/10.3390/ijerph8124550). Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3290984/>

Barber, C., Miller, M. J. (2014) Reducing a suicidal person's access to lethal means of suicide: A Research agenda. *American Journal of Preventive Medicine* 47(3S2): S264-S272. Retrieved from <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Reducing%20a%20Suicidal%20Persons%20Access%20to%20Lethal.pdf>

Brady Center (n,d). The Truth About Suicide & Guns. Retrieved from <http://www.bradycampaign.org/sites/default/files/Brady-Guns-Suicide-Report-2016.pdf>

SPRC (n.d.). Suicide Proof Your Home. Retrieved from <http://www.suicideproof.org>

Sleep

Bernert, R. A., Joiner, T. E. (2007). ([Krakow et al 2000](#); [Agargun et al 1997a](#); [Fawcett et al 1990](#)). Sleep disturbances and suicide risk: A review of the literature. *Neuropsychiatric Disease and Treatment* 3(6): 735–743. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2656315/>

Dominic, D., (2015). PRYMD Module 7 Sleep. *PYRMD Labs LLC*. Retrieved from http://www.prymd.com/blog/wp-content/uploads/2016/02/Module7_Sleep.pdf

Harvard Mental Health Letter, (2009). Sleep and mental health. *Harvard Health Publications: Harvard Medical School*. Retrieved from http://www.health.harvard.edu/newsletter_article/Sleep-and-mental-health

National Sleep Foundation, (n.d.) Sleep Disorders. Retrieved from <https://sleepfoundation.org/sleep-disorders-problems>

UCLA Health (n.d.). Sleep and Teens. UCLA Sleep Disorders Center. Retrieved from <http://sleepcenter.ucla.edu/body.cfm?id=63>

Social Emotional Learning and Mindfulness Introduction

Lantieri, L. & Zakrzewski, V. (April 7, 2015). How SEL and Mindfulness Can Work Together. Retrieved from http://greatergood.berkeley.edu/article/item/how_social_emotional_learning_and_mindfulness_can_work_together

Social Emotional Learning

American Association of Suicidology (AAS) & Society for the Prevention of Teen Suicide (SPTS) (2012). *Upstream Youth Suicide Prevention Expert Panel Meeting Summary*. pp. 1-12. Retrieved from http://www.sprc.org/sites/default/files/migrate/library/Upstream_Youth_Suicide_Prevention_Expert_Panel_Meeting%20Summary.pdf

CASEL Guide: Effective Social and Emotional Learning Programs, Preschool and Elementary School Edition, (2013). p.4-65 Retrieved from http://blogs.edweek.org/edweek/early_years/CASEL_Guide_FINAL.pdf

CDC, Centers for Disease Control and Prevention, Injury Prevention & Control: Data & Statistics (WISQARS) 2014. Retrieved from <https://www.cdc.gov/injury/wisqars/leadingcauses.html>

Cripps, K. & Zyromski, B. (2009). Adolescents' psychological well-being and perceived parental involvement: Implications for parental involvement in middle schools. *RMLE Research in Middle Level Education*, 33(4), p.1-13 Retrieved from <http://files.eric.ed.gov/fulltext/EJ867143.pdf>

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The Impact of enhancing students' social and emotional learning: A Meta-analysis of school-based universal interventions. *Child Development*, 82(1), p. 405-432 Retrieved from <https://qzprod.files.wordpress.com/2016/04/82ab9-meta-analysis-child-development.pdf>

Durlak, J. A., Weissberg, R. P., Pachan, M., (2010). A Meta-analysis of after school programs that seek to promote personal and social skills in children and adolescents. *American Journal of Community Psychology*, 45: 294-309 Retrieved from http://www.flume.com.br/pdf/Durlak_A_meta-analysisof_after_school.pdf

Durlak, J. A., Taylor, R. D., Kawashima, K., et. al., (2007). Effects of positive youth development programs on school, family, and community systems. *American Journal of Community Psychology*, 39:269-286. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/17401642>

Dymnicki, A., Sambolt, M., & Kidron, Y., (2013). Improving college and career readiness by incorporating social and emotional learning. *College & Career Readiness & Success Center at American Institutes for Research*, p. 1-23. Retrieved from http://www.ccrscenter.org/sites/default/files/1528%20CCRS%20Brief%20d9_lvr.pdf

Good Behavior Game (GBG) (2017). Retrieved from <http://www.sprc.org/resources-programs/good-behavior-game-gbg>

Gould, M. S., Greenberg, T., Velting, D. M., & Shaffer, D. (2003). Youth suicide risk and preventive interventions: a review of the past 10 years. *Journal Of The American Academy Of Child And Adolescent Psychiatry*, 42(4), 386-405.

Gravesteyn C., Diekstra, R., Sklad, M., & deWinter, M. (2011) The Effects of a Dutch school-based social and emotional learning programme (SEL) on suicidality in adolescents. *International Journal of Mental Health Promotion*, 13:4, 4-16. Retrieved from https://www.researchgate.net/publication/233668509_The_Effects_of_a_Dutch_School-Based_Social_and_Emotional_Learning_Programme_SEL_on_Suicidality_in_Adolescents

NIMH, National Institute of Mental Health, (2011). The Teen Brain: Still Under Construction. Retrieved from <https://www.nimh.nih.gov/health/publications/the-teen-brain-still-under-construction/index.shtml>

NREPP SAMHSA's National Registry of Evidenced -based Programs & Practices, (2010), *Intervention Summary, Good Behavior Game (GBG)*. Retrieved from <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=201>).

Ronen, Tammie; Hamama, Liat; Rosenbaum, Michael; Mishely-Yarlap, Ayla (2016). Subjective Well-Being in Adolescence: The Role of Self-Control, Social Support, Age, Gender and Familial Crisis. *Journal of Happiness Studies*, Vol. 17 Issue 1, p.81 <http://connection.ebscohost.com/c/articles/112695600/subjective-well-being-adolescence-role-self-control-social-support-age-gender-familial-crisis>

Mindfulness

Bakosh, L. S., Snow, R. M., Tobias, J. M., Houlihan, J. L., & Barbosa-Leiker, C. (2016). Maximizing Mindful Learning: Mindful Awareness Intervention Improves Elementary School Students' Quarterly Grades. *Mindfulness*, 7(1), 59-67. <https://doi.org/10.1007/s12671-015-0387-6>

Bishop, S. R., et. al., (2004). Mindfulness: A Proposed Operational Definition. *Clinical Psychology: Science and Practice*, V11 N3, 230-241. Retrieved from

http://www.personal.kent.edu/~dfresco/mindfulness/Bishop_et_al.pdf

Burke, C. A. (2010). Mindfulness-Based Approaches with Children and Adolescents: A Preliminary Review of Current Research in an Emergent Field. *Journal of Child and Family Studies*, 19(2), 133–144. <https://doi.org/10.1007/s10826-009-9282-x>

Childress, T., & Cohen Harper, J. (2015). *Best Practices for Yoga in Schools* (Vol. 1). Atlanta, GA: YSC-Omega Publications.

Dariotis, J. K., Mirabal-Beltran, R., Cluxton-Keller, F., Feagans Gould, L., Greenberg, M. T., & Mendelson, T. (2017). A Qualitative Exploration of Implementation Factors in a School-Based Mindfulness and Yoga Program: Lessons Learned from Students and Teachers. *Psychology in the Schools*, 54(1), 53–69. <https://doi.org/10.1002/pits.21979>

Felver, J. C., Hoyos, C. E. C., Tezanos, K., & Singh, N. N. (2016). A Systematic Review of Mindfulness-Based Interventions for Youth in School Settings. *Mindfulness*, 7(1), 34–45. <https://doi.org/10.1007/s12671-015-0389-4>

Flook, L., Goldberg, S. B., Pinger, L., Bonus, K., & Davidson, R. J. (2013). Mindfulness for teachers: A pilot study to assess effects on stress, burnout, and teaching efficacy. *Mind, Brain, and Education*, 7(3), 182–195. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3855679/>

Fuchs, C., Lee, J. K., Roemer, L., & Orsillo, S. M. (2013). Using Mindfulness- and Acceptance-Based Treatments With Clients From Nondominant Cultural and/or Marginalized Backgrounds: Clinical Considerations, Meta-Analysis Findings, and Introduction to the Special Series: Clinical Considerations in using Acceptance- and Mindfulness-based Treatments With Diverse Populations. *Cognitive and Behavioral Practice*, 20(1), 1–12. <https://doi.org/10.1016/j.cbpra.2011.12.004>

Greenberg, M. T., & Harris, A. R. (2012). Nurturing Mindfulness in Children and Youth: Current State of Research. *Child Development Perspectives*, 6(2), 161–166. <https://doi.org/10.1111/j.1750-8606.2011.00215.x>

Jennings, P. A., Frank, J. L., Snowberg, K. E., Coccia, M. A., & Greenberg, M. T. (2013). Improving classroom learning environments by Cultivating Awareness and Resilience in Education (CARE): Results of a randomized controlled trial. *School Psychology Quarterly*, 28(4), 374–390. <https://doi.org/10.1037/spq0000035>

Kabat-Zinn, J. (2013). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York, NY: Bantam.

Khalsa, S. B. S., & Butzer, B. (2016). Yoga in school settings: a research review: Yoga in school settings. *Annals of the New York Academy of Sciences*, 1373(1), 45–55. <https://doi.org/10.1111/nyas.13025>

Limone, N. (2011, August 27). Opening the New School Year - with MINDFULNESS. Retrieved March 5, 2017, from https://www.compassionate.center/pgs/resources/papers/Israel_Mindful_School.pdf

Morey, J. (2016). How Self-Compassion Can Help Teens Distress. Retrieved from http://greatergood.berkeley.edu/article/item/how_self_compassion_can_help_teens_de_stress

Saltzman, A., & Goldin, P. (2008). Mindfulness-Based Stress Reduction for School-Age Children. *Acceptance and Mindfulness Treatments for Children and Adolescents: A Practitioner's Guide*, 139. Retrieved from <http://books.google.com/books?hl=en&lr=&id=cgjm98t9KDUC&oi=fnd&pg=PA139&dq=%22to+peer+pressure+and+risk+y%22+%22Philippe+had+been+documenting+the+benefits+of+teaching+mindfulness%22+%22In+what+settings+are+children+most+likely+to+learn+mindfulness%22+%22After+the+first+practice,+I+asked+the+children+to+describe+how%22+&ots=0WWJtVlZrh&sig=BVUIE5B3A1dofaMEiba4s3rrDJY>

Semple, R. J., Droutman, V., & Reid, B. A. (2017). Mindfulness Goes to School: Things Learned (so Far) from Research and Real-World Experiences. *Psychology in the Schools*, 54(1), 29–52. <https://doi.org/10.1002/pits.21981>

Stahl, B., & Goldstein, E. (2010). *A Mindfulness-Based Stress Reduction Workbook*. New Harbinger Publications.

Mindfulness and School Climate: One Example

- 1) Semple, R. J., Droutman, V., & Reid, B. A. (2017). Mindfulness Goes to School: Things Learned (so Far) from Research and Real-World Experiences. *Psychology in the Schools*, 54(1), 29–52.
<https://doi.org/10.1002/pits.21981>
- 2) Limone, N. (2011, August 27). Opening the New School Year - with MINDFULNESS. Retrieved March 5, 2017, from https://www.compassionate.center/pgs/resources/papers/Israel_Mindful_School.pdf

Red Folder initiative

Student Mental Health Resources & Promising Practices. (2017). Retrieved from <http://www.ucop.edu/student-mental-health-resources/>

Self-Care

Compassion Fatigue Awareness Project: Did you know? (2017). Retrieved March, 2017, from <http://www.compassionfatigue.org/>

Devilley, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian and New Zealand Journal of Psychiatry*, 43(4), 373-385.

Khan, F. (2015) *Caring for Yourself is a Radical Act: Self-Care Guide for Youth Working in Community*. Toronto: ArtReach Toronto. Retrieved from <http://www.farrakhkhan.ca/wp-content/uploads/2015/06/selfcareguide.pdf>

Neff, K. D. (2009). The role of self-compassion in development: A healthier way to relate to oneself. *Human development*, 52(4), 211-214.

Saakvitne, K. W., Pearlman, L. A., & Abrahamson, D. J. (1996). *Transforming the pain: A workbook on vicarious traumatization*. New York: WW Norton.

Skovholt, T. M., & Trotter-Mathison, M. (2016). *The resilient practitioner: Burnout prevention and self-care strategies for counselors, therapists, teachers, and health professionals*. New York: Routledge.

Stamm, B. H. (2009). Professional Quality of Life: Compassion Satisfaction and Fatigue Version 5 (ProQOL). Retrieved from [/www.isu.edu/~bhstamm](http://www.isu.edu/~bhstamm) or www.proqol.org

Volk, K., Guarino, K., Grandin, E., M. and Clervil, R. (2008). *What about You: A Workbook for those who work with others*. Newton Center, MA: The National Center on Family Homelessness.

Transitions Introduction

Madjar, N., & Cohen-Malayev, M. (2016). Perceived school climate across the transition from elementary to middle school. *School Psychology Quarterly*, 31(2), 270-288. doi:10.1037/spq0000129

Transitions: Elementary to Middle School

Making the Transition to Middle School: How Mentoring Can Help. (2008, September). Retrieved from <http://educationnorthwest.org/sites/default/files/making-the-transition-to-middle-school.pdf>

Middle School Matters! A Guide for Families on Middle School Transition . (2017). Retrieved from <http://www.gadoe.org/School-Improvement/Federal-Programs/Documents/Middle%20School%20Matters%20Handout.pdf>

Transitions to/from Middle School. (2017). Retrieved from <http://www.amle.org/BrowsebyTopic/TransitionstofromMiddleSchool/tabid/117/Default.aspx>

Transitions: Middle to High School

Bullying and Suicide." *Bullying Statistics*. Anti-Bullying Help, Facts, and More, 2016. Web. 06 Dec. 2016.

"Daily Media Use Among Children and Teens Up Dramatically From Five Years Ago." *Health Policy Research, Analysis, Polling, Facts, Data and Journalism*. Kaiser Family Foundation, 20 Jan. 2010.

"Facts About Bullying." *StopBullying.gov*. U.S. Department of Health and Human Services, 2016.

"Fact Sheets - Underage Drinking." *Centers for Disease Control and Prevention*. U.S. Department of Health and Human Services, 20 Oct. 2016. Web. 06 Dec. 2016.

High School is Happening! A Guide for Families on High School Transition. (2017). Retrieved from http://www.gadoe.org/School-Improvement/Federal-Programs/Partnerships/Documents/Parent%20Engagement/Publications/03HST/High%20School%20is%20Happening-Family_ENG_8.5x11.pdf

"Internet Statistics, GuardChild." *GuardChild RSS*. N.p., 2016

Middle School and High School Transitions. (2017). Retrieved from <https://www.sylvanlearning.com/docs/default-source/resources/middle-and-high-school-transitions.pdf?sfvrsn=0>

The Transition to Life Beyond High School Sample Letters

American College Health Association - National College Health Assessment; Undergraduate Reference Group Report, Spring 2014 (pdf): http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Spring2014.pdf

College Mental Health and Confidentiality, American Psychiatric Association, June

2009, College mental health and confidentiality (PDF)

FERPA - Family Educational Rights and Privacy Act(4)

a) U.S. Dept. of Education & U.S. Dept. of Health and Human Services "Joint Guidance on the Application of the *Family Educational Rights and Privacy Act (FERPA)* And the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* To Students Health Records: <https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf>

b) Family Educational Rights and Privacy Act Regulations Subpart B 99.31(10) and 99.36(3)(c). <https://www2.ed.gov/policy/gen/guid/fpco/pdf/ferparegs.pdf>

Half of Us Mental-Health-Study-Executive-Summary-Final.pdf: <http://cdn.halfofus.com/wp-content/uploads/2013/10/2006-mtvU-College-Mental-Health-Study-Executive-Summary-Final.pdf>

Social Media

Chassiakos, Yolanda Reid, et al. (2016). Children and Adolescents and Digital Media. *Pediatrics*, 138(5). doi:10.1542/peds.2016-2593.

Children, Teens, Media, and Body Image. (2015). Retrieved from <https://www.common sense media.org/research/children-teens-media-and-body-image>

Council on Communications and Media. (2016). Media Use in School-Aged Children and Adolescents. *Pediatrics*, 138(5). doi:10.1542/peds.2016-2592.

Luxton D, June J, and Fairall J. (2012). Social Media and Suicide: A Public Health Perspective. *American Journal of Public Health*, 102(2). doi:10.2105/AJPH.2011.300608.

INTERVENTION

Clusters and Contagion

American Foundation for Suicide Prevention (AFSP) & Suicide Prevention Resource Center (SPRC). (2011). *After a Suicide: A Toolkit for Schools*, American Foundation for Suicide Prevention. Newton, MA: Education Development Center, Inc. Retrieved from <https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/>

Gould, M. S., Kleinman, M. H., Lake, A. M., Forman, J., Midle, J. B., (2014). *Newspaper coverage of suicide and initiation of suicide clusters in teenagers in the USA, 1988-96: a retrospective, population based, case-control study*, *Lancet*. Retrieved from [http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(14\)70225-1/abstract](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70225-1/abstract)

Lake, A. M., & Gould, M. S. (2014). Chapter 6, Suicide clusters and suicide contagion. In Koslow, S. H., Ruiz, P., Nemeroff, C. B., (Eds). *A Concise Guide to Understanding Suicide: Epidemiology, pathophysiology, and prevention* pp. 52-61. Cambridge University Press.

Survivors of Suicide Loss Task Force. (April 2015) *Responding to Grief, Trauma, and Distress After a Suicide: U.S. National Guidelines*. Retrieved from <http://www.sprc.org/sites/default/files/migrate/library/RespondingAfterSuicideNationalGuidelines.pdf>

Zenere, F. J. (2009). Suicide Clusters and Contagion. *Principal Leadership*, October 2009 pp. 12-16.

POSTVENTION

Grief

Abbott, C. H., & Zakriski, A. L. (2014). Grief and attitudes toward suicide in peers affected by a cluster of suicides as adolescents. *Suicide and Life-threatening Behavior*, 44(6), 668-681. doi: 10.1111/sitb. 12100. <https://www.ncbi.nlm.nih.gov/pubmed/24806293>

Brent, D. A., Perper, J. A., Moritz, G., Allman, C., Liotus, L., Schweers, J., & Canobbio, R. (1993). Bereavement or depression? The impact of the loss of a friend to suicide. *Journal Of The American Academy Of Child & Adolescent Psychiatry*, 32(6), 1189-1197. doi:10.1097/00004583-199311000-00012

Center for Complicated Grief. Retrieved from <https://complicatedgrief.columbia.edu>

The Dougy Center (n.d.). *After a Suicide Death: Ten Tips for Helping Children & Teens*. [Brochure]. Portland, OR. Retrieved from [http://www.tdcbookstore.org/store/p24/After a Suicide Death%3A Ten Tips for Helping Children %26 Teens item %23552.html](http://www.tdcbookstore.org/store/p24/After+a+Suicide+Death%3A+Ten+Tips+for+Helping+Children+%26+Teens+item+%23552.html)

Jordan J., Baugher B., (2016). *After suicide loss: Coping with your grief* (2nd Edition). Newcastle, WA: Caring People Press.

Melhem, N. M., Day, N., Shear, M. K., Day, R., Reynolds, C. F., & Brent, D. (2004). Predictors of complicated grief among adolescents exposed to a peer's suicide. *Journal of Loss and Trauma*, 9(1), 21-34.
<http://dx.doi.org/10.1080/1532502490255287>

National Action Alliance for Suicide Prevention, Survivors of Suicide Loss Task Force (2015). Responding to Grief, Trauma and Distress After a Suicide: U.S. National Guidelines. Retrieved from
<http://www.sprc.org/sites/default/files/migrate/library/RespondingAfterSuicideNationalGuidelines.pdf>

Requarth M., (2006). *After a parent's suicide: Helping children heal*. Sebastopol, CA: Healing Hearts Press.

APPENDIX A

HIPAA/FERPA

Association of State and Territorial Health Officials, (n. d.). Public Health and Schools Toolkit. Comparison of FERPA and HIPAA Privacy Rule for Accessing Student Health Data. Retrieved from
<http://www.astho.org/programs/preparedness/public-health-emergency-law/public-health-and-schools-toolkit/comparison-of-ferpa-and-hipaa-privacy-rule/>

Hustead, J.L., Pritts, J., Choy, A., Goldman, J., (2002) Implementing the Federal health privacy rule in California: Update and supplement to the guide for health care providers. *California Health Care Foundation*. Retrieved from
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20H/PDF%20HIPAProvidersSupp.pdf>

National Center for Youth Law, (2010). HIPAA or FERPA? A Primer on School Health Information Sharing in California. Retrieved from <https://youthlaw.org/publication/hipaa-or-ferpa-a-primer-on-school-health-information-sharing-in-california/>

National Center for Youth Law, Teen Health Law, (n.d.). California Minor Consent and Confidentiality Laws and California Minor Consent Laws - Mental Health Services. Retrieved from
<http://teenhealthlaw.org/consent/>

The National Forum on Education Statistics, (2006). Guide to the privacy of student information: A Resource for schools. Retrieved from
https://nces.ed.gov/forum/pub_2006805.asp

U. S. Department of Health and Human Services & U. S. Department of Education, (2008). Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records, pp. 1-11, Retrieved from
<http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipa-guidance.pdf>