

Florida **School Toolkit** for K-12 **Educators** to **Prevent Suicide**



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Florida School Toolkit for K-12 Educators to Prevent Suicide

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Florida **School Toolkit** for K-12 **Educators** to **Prevent Suicide**

Florida S.T.E.P.S.

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PREFACE

The COVID-19 pandemic is unprecedented and has created much uncertainty in our lives. It follows that there is apprehension about mounting pressures and an escalating potential for suicide. Even under normal circumstances, youth suicide is an acute concern.

The *Florida School Toolkit for K-12 Educators to Prevent Suicide (Florida S.T.E.P.S.)* was developed to assist schools with suicide prevention, intervention, and postvention. School administrators and school mental health professionals (SMHPs), including school counselors, social workers, and school psychologists, are critical leaders in driving suicide prevention efforts. Collaboration between schools and community and state suicide prevention resources is also fundamental. *Florida S.T.E.P.S.* takes a comprehensive approach by including information, tips, and tools that can help you forge coalitions, adjust or enhance existing plans, or create new ones.

Suicide prevention is an ongoing process. Familiarity with legislative changes is key, although they may not all apply to private schools. For example, beginning in the 2019–2020 school year, Senate Bill 7030 requires that Florida schools administer suicide screening before requesting implementation of the Baker Act. The updated Florida legislation also provides schools the

opportunity to become Suicide Prevention School Certified. Considering these changes, Scott Poland, Ed.D., and doctoral student Catherine Ivey, M.S., interviewed key suicide prevention experts and stakeholders from across the state before writing this guide. The author and contributor further recognize there is a statewide Suicide Prevention Coalition, and they reviewed the University of South Florida guide, created in 2003 and updated in 2012, as well as emerging suicide incidence data and youth suicide trends. In addition, some of the challenges as well as potential opportunities presented by social media platforms are explored.

School districts are encouraged to use the tools in the *Florida S.T.E.P.S.* in any way that proves helpful. School professionals who are using or have used *Florida S.T.E.P.S.* are asked to share with us their suicide prevention advancements.

Everyone needs to know that suicide is preventable.

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The following individuals have had significant impact in the field of suicide prevention and were interviewed prior to developing the *Florida S.T.E.P.S.* We deeply appreciate their insight and have included many of their thoughts and recommendations in this document.

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ABOUT THE AUTHOR AND CONTRIBUTOR

Scott Poland, Ed.D.



A professor at the Nova Southeastern University (NSU) College of Psychology in Fort Lauderdale, Florida, Scott Poland is also the director of NSU's Suicide and Violence Prevention Office. He has worked in schools as a psychologist and a director

of psychological services for 26 years. Poland is still very involved in school crisis response and consultation. He has recently provided on-site assistance after suicides in several school districts across the nation. As a survivor of the suicide of his father, he is among those who never believed a suicide could happen in their own family.

After facing the suicides of several students while serving as director of psychological services in Cypress-Fairbanks Independent School District in Houston, Texas, Poland became dedicated to suicide prevention. In 1982, the district superintendent asked him what he was going to do about student suicide. Figuring out how to prevent youth suicide has been his chief professional priority ever since, and he has presented more than 1,000 times on the topics of school crisis and suicide intervention.

A licensed psychologist and an internationally recognized expert on youth suicide and school crisis, Poland has authored and coauthored five books on the subject. His first book, *Suicide in Schools*, was published in 1989 and has been translated into several languages. Additionally,

he and his wife, Donna, a former educator and school principal, wrote the Texas Suicide Safer Schools report for the state of Texas, as well as the *Montana Crisis Action School Toolkit on Suicide (Montana CAST-S)*.

Poland is a past president of the National Association of School Psychologists and a past director of the Prevention Division of the American Association of Suicidology. He has testified about the mental health needs of children before the U.S. Congress on four occasions. He has also assisted school communities after 16 school shootings and after acts of terrorism, natural disasters, and numerous suicide clusters. Most recently, he provided suicide prevention training attended by personnel representing every school district in Florida. Additionally, for providing psychological strategic planning and training for staff members and parents immediately after the Parkland school shootings, he received the Helping Parkland Heal Award from the City of Parkland. Currently, Poland is also helping New Jersey develop a suicide prevention toolkit.

Catherine Ivey, M.S.



Catherine Ivey is a school psychology trainee and doctoral candidate at Nova Southeastern University. She is also a member of NSU's Suicide and Violence Prevention Office. As an undergraduate student leader she contributed to her school's psychology initiatives and researched depression and suicide on her campus at Wofford College. In her graduate education training, Ivey writes articles about suicide prevention and intervention,

which are published in the NSU *Suicide and Violence Prevention* quarterly journal.

As part of her educational experience, Ivey has worked with children in multiple educational settings. After being a member of a community that lost multiple individuals to suicide, she continues her journey in raising awareness and finding prevention information that can be helpful to her and others.



COVID-19 AND TIPS FOR VIRTUAL SUICIDE ASSESSMENT

The COVID-19 pandemic has resulted in significant stress for all Americans and concerns that the suicide rate will increase. Suicide rates have historically increased during pandemics and in times of economic concerns and high unemployment.

Questions have been asked about who might be most at-risk for suicide due to the pandemic. For students, we believe it is likely those with a pre-existing mental illness, those who had a loved one die from the virus, and those living in poverty as a result of the virus. COVID-19 resulted in all Florida schools going virtual in the spring of 2020, and many schools reopened campuses physically in the fall of 2020 with varying percentages of students returning to their campus. Many students and families elected to continue with virtual learning, which has always been an option through Florida Virtual School.

It is difficult to anticipate how many Florida students will continue to learn virtually in the future, and it is acknowledged that suicide assessment is challenging at best and especially challenging when done virtually. Important tips for school personnel are outlined here. They are encouraged to review Section 2 on Intervention in *Florida S.T.E.P.S.* and use Tools 8, 14a, 14b, 14c, 16, 17, 18, and 19.

Virtual Assessment Tips

1. Aim for visual contact.

When possible, request a video conference instead of a telephone conversation so that you can observe the nonverbal behavior of the student.

2. Maintain confidentiality.

Ideally, a parent or guardian should be home, but in another room so they cannot overhear the counseling session.

3. Ask key supervision and safety-related questions.

- Where you are physically located?
- Is a parent present in the home? (If yes, are they in another room?)
- What is the best way to contact you if we lose connection?

Questions like these will help you identify additional ways you can connect with a potentially suicidal student and a parent or guardian.

4. Take appropriate action.

If you determine a student is potentially suicidal, you should immediately contact the parent or guardian and request that they join the conference, develop a safety plan with the student, make a referral for community-based services, and ask the parent to increase supervision and to secure or remove any lethal means in the home. If the parent or guardian is not in the home and cannot be reached, then contact local law enforcement and request a wellness check on the student.

Additional Resources

Comprehensive School Suicide Prevention in a Time of Distance Learning by the National Association of School Psychologists (NASP), available at nasponline.org/resources-and-publications/resources-and-podcasts/covid-19-resource-center/crisis-and-mental-health-resources/comprehensive-school-suicide-prevention-in-a-time-of-distance-learning.

You may also contact Scott Poland at spoland@nova.edu or NSU's Suicide and Violence Prevention Office at svp@nova.edu.

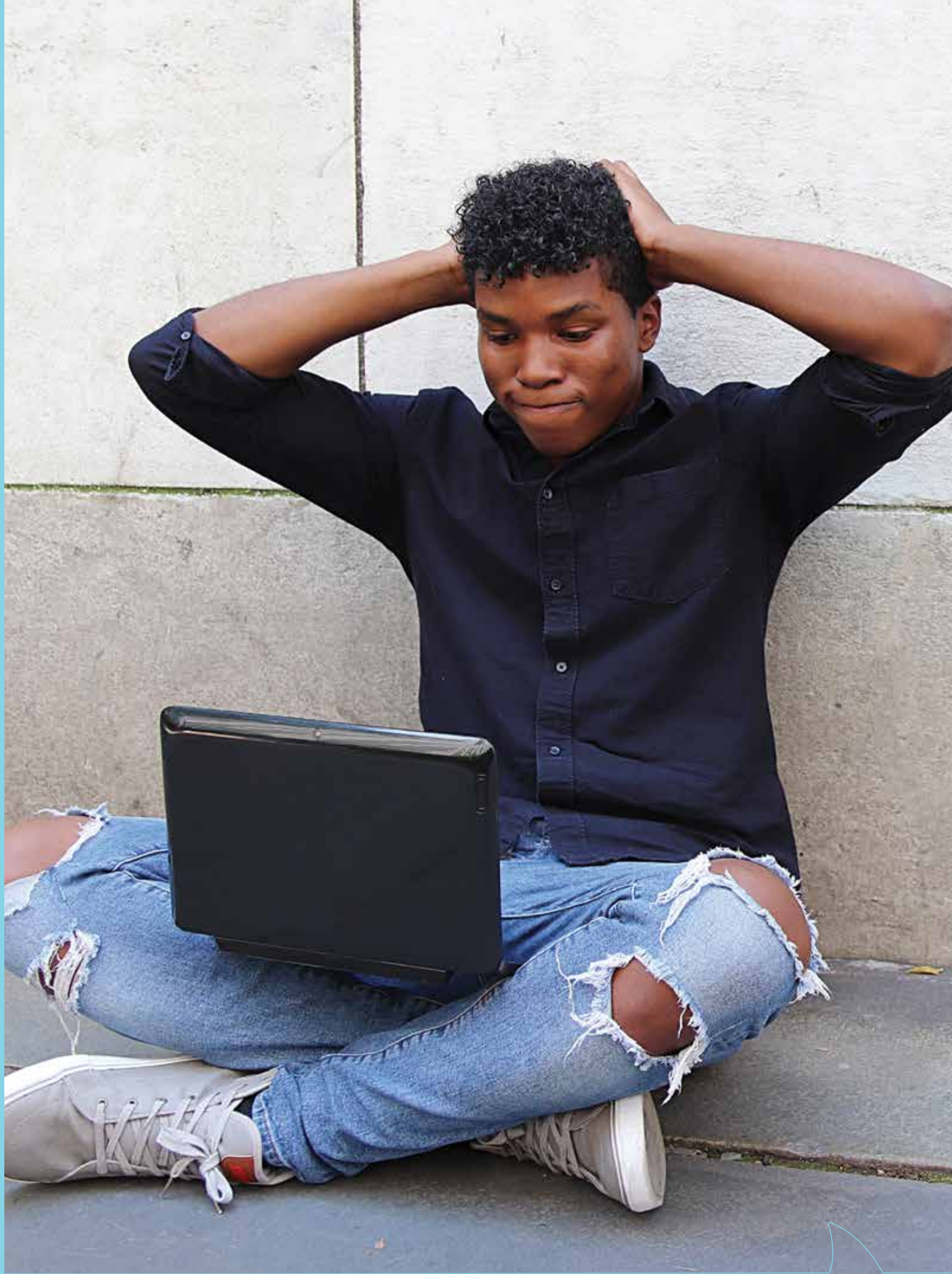


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INTRODUCTION

The *Florida School Toolkit for K-12 Educators to Prevent Suicide (Florida S.T.E.P.S.)* carefully follows the best practices model for suicide prevention released in 2019 by the American Foundation for Suicide Prevention (AFSP), the National Association of School Psychologists (NASP), the American School Counselor Association (ASCA), and the Trevor Foundation. Scott Poland, Ed.D., served as a key advisor in the making of the model, which can be found on the AFSP website and at afsp.org/model-school-policy-on-suicide-prevention. Additionally, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), the best practices model and components of a comprehensive suicide prevention program are prevention, intervention, and postvention. Accordingly, *Florida S.T.E.P.S.* provides guidance on all three components.

Where *Florida S.T.E.P.S.* differs, however, is with its unique focus on Florida schools. With more than 300,000 students (Common Core of Data, 2019), Florida's Miami-Dade County Public Schools ranks as the nation's fourth-largest school district. Other school districts in Florida, such as Union County School District, have fewer than 2,500 students. Combined, Florida boasts 74 public school districts and approximately 2,700 private schools. ***Florida S.T.E.P.S. is designed to assist all Florida K-12 schools, both public and private, in suicide prevention***, and includes both national and Florida-related statistics and related legislation.

The *Florida S.T.E.P.S.* framework establishes the driving principles and guidelines of a comprehensive suicide prevention program addressing prevention, intervention, and postvention.

Section 1

Suicide Prevention includes guidelines for developing suicide prevention programs for elementary schools, middle schools, and high schools. In addition, it provides information on suicide awareness. Staff development, student training, and information for parents are discussed with specific recommendations for creating awareness and coordinating prevention training. Research has identified high-risk groups for youth suicide, which include Native Americans; lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students; homeless students; students living in foster care; students with mental illness; students engaging in self-injury; incarcerated youth; and those bereaved of loved ones by suicide. In addition, we provide an overview of preventative information in Tool 29 to post on the school district's website.

Section 2

Suicide Intervention includes guidelines for developing assessment procedures for suicidal students at each educational level, as well as the development of safety plans, parent emergency notifications, the identification of internal and external resources, and reentry guidelines for students returning from the hospital. *Florida S.T.E.P.S.* uses the term "suicide prevention specialist" or "expert" for school districts. In many cases, that person will be a school counselor, school social worker, or school psychologist, but in smaller districts a school administrator—or even a lead teacher in more isolated schools—may be conducting the initial suicide assessment with a student.

Section 3

Postvention After a Suicide includes guidelines for providing compassionate, honest, and best practice responses in the event of a death. Postvention includes the responses needed to provide support for the family of the suicide victim, your school staff, your students, and the community at large. Additionally, it provides guidelines for facilitating appropriate media coverage. This section recognizes that postvention is a very challenging time for schools while emphasizing that the primary purpose is to help students and staff with their emotions and to prevent further suicides. Adolescents are the most likely to imitate suicidal behavior, and suicide contagion is a process that can lead to suicide clusters. A suicide cluster is when more suicides occur than could be expected in a short time and in a small geographical area. A two-part article about suicide contagion is in Appendix 2. Carefully planned postvention responses are essential to preventing further suicides.

Tools for Schools

This section is what makes this document a true toolkit. It provides sample forms that can be easily adapted and personalized with minor revisions to meet each school's or district's needs. The various tools outline recommendations for training and crisis-action protocols for responding to suicidal students, notifying parents or guardians, documenting all actions, and recommending supervision and services for the suicidal students.

Appendices

This section includes additional information as well as answers to suicide questions Scott Poland is commonly asked by parents, guardians, school personnel, and students.

Previously, it was estimated that a death by suicide profoundly affected six people, but that estimate has been raised to eighteen people. Our experience is that suicide prevention is often driven by survivors. Many years ago, before becoming a trained psychologist, Scott Poland lost his father to suicide and now realizes he missed the warning signs. It is critical for school personnel to keep up with legislative initiatives and best practices. It is our hope that this toolkit results in improved suicide prevention efforts in the Florida schools, both public and private, and empowers everyone to act to prevent suicide.

THE UNIQUE NEEDS OF FLORIDA FOR YOUTH SUICIDE PREVENTION, INTERVENTION, AND POSTVENTION

Incidence of Suicide Nationally Across Ages and for Florida Students

Rates of suicide have steeply and steadily increased in the United States at a rate of 14.2 annually for every 100,000 Americans, which is the highest rate in 50 years (American Foundation for Suicide Prevention, 2020). In 2018, more than 48,000 Americans died by suicide, with more than 1 million attempts. Suicide is the tenth-leading cause of death for all Americans but the second-leading cause of death for those age 10–34. National data has been gleaned regarding youth suicidal behavior through the Youth Risk Behavior Surveillance System (YRBSS), which gathers information about high school students' behaviors and thoughts about suicide. The latest YRBSS national survey is from 2019, which reported that **18.8 percent of high school age youth seriously considered attempting suicide in the past 12 months** (Centers for Disease Control and Prevention, 2020). Florida also participated in the YRBSS survey and has released the 2019 data, which appears below.

The 2019 Florida YRBSS survey of high school students found that nearly 16 percent of Florida high school students reported seriously considering suicide over the past 12 months (see Figure 1). The trends over the past 10 years show that rates of high school suicidal ideation, attempts, and deaths by suicide are on the rise. Specifically, the Florida YRBSS data shows suicidal ideation has increased by 5 percent from 2017 to 2019 (Florida Health, 2019), while the Centers for Disease Control and Prevention (CDC) reports the number of suicides has almost doubled between children and teens in

the last decade (CDC, 2018). After reviewing the CDC data, it appears that, in Florida, on average, two children or teenagers per week die by suicide. More information on suicide statistics for Florida youth is available at [Floridahealth.gov/statistics-and-data/survey-data/Florida-youth-survey/youth-risk-behavior-survey/index.html](https://floridahealth.gov/statistics-and-data/survey-data/Florida-youth-survey/youth-risk-behavior-survey/index.html).

More on the Youth Risk Behavior Surveillance System

The YRBSS offers the best national snapshot of high school students' at-risk behavior. The survey includes bullying, physical fights, school safety, alcohol and drug abuse, carrying a weapon to school, and many other at-risk behaviors. It is critical that the selected Florida schools participate in the YRBSS from the CDC. Florida has participated in the YRBSS, including the cycle for 2017 data and just recently for the 2019 data. To obtain data, at least 60 percent of schools need to participate before the survey will report state-specific data. If enough schools don't participate, Florida will lose out on critical data that can be used to better understand the scope of at-risk behavior and to implement prevention programs.

2019—SUICIDAL BEHAVIOR AND SELF-HARM

PERCENTAGE OF FLORIDA HIGH SCHOOL STUDENTS WHO

| | Total | Male | Female | Black | Hispanic | White |
|---|-------|------|--------|-------|----------|-------|
| felt sad or hopeless for more than two weeks in a row | 33.7 | 24.2 | 43.4 | 30.8 | 33.9 | 34.4 |
| seriously considered attempting suicide | 15.6 | 10.9 | 20.2 | 13.1 | 14.3 | 17.2 |
| made a plan to attempt suicide | 11.8 | 8.2 | 15.5 | 10.9 | 10.9 | 12.1 |
| attempted suicide | 7.9 | 6.0 | 9.6 | 9.5 | 7.6 | 6.9 |

Figure 1: 2019 behavioral health data over the duration of a year period for Florida high school students

Incidence of Youth Suicide: Florida Middle School Students

Like high school students, Florida middle school students also receive a behavioral health survey that captures suicidal behavior. Florida is one of the few states to gather middle school data. The 2019 data shows that middle school students may be just as at risk for suicide as Florida high school students (Florida Health, 2019). Unfortunately, the trend shows steep increases over the past two years, as 21.6 percent of middle school students reported they seriously contemplated suicide over their lifetime in 2019 compared to the 16.8 percent reported in 2017 (see Figure 2). In 2019, 13.9 percent of middle school students reported

making a suicide a plan over their lifetime and 8.4 percent reported a previous suicide attempt. In regard to high school students, the middle school data is difficult to compare because the middle school survey asks for lifetime prevalence versus a 12-month prevalence. For more information about middle school data, visit [Floridahealth.gov/statistics-and-data/survey-data/2019MiddleSchoolSummaryTables.pdf](https://floridahealth.gov/statistics-and-data/survey-data/2019MiddleSchoolSummaryTables.pdf).

BEHAVIORS OVER A 12 MONTH (H.S.) AND A LIFETIME SPAN (M.S.)

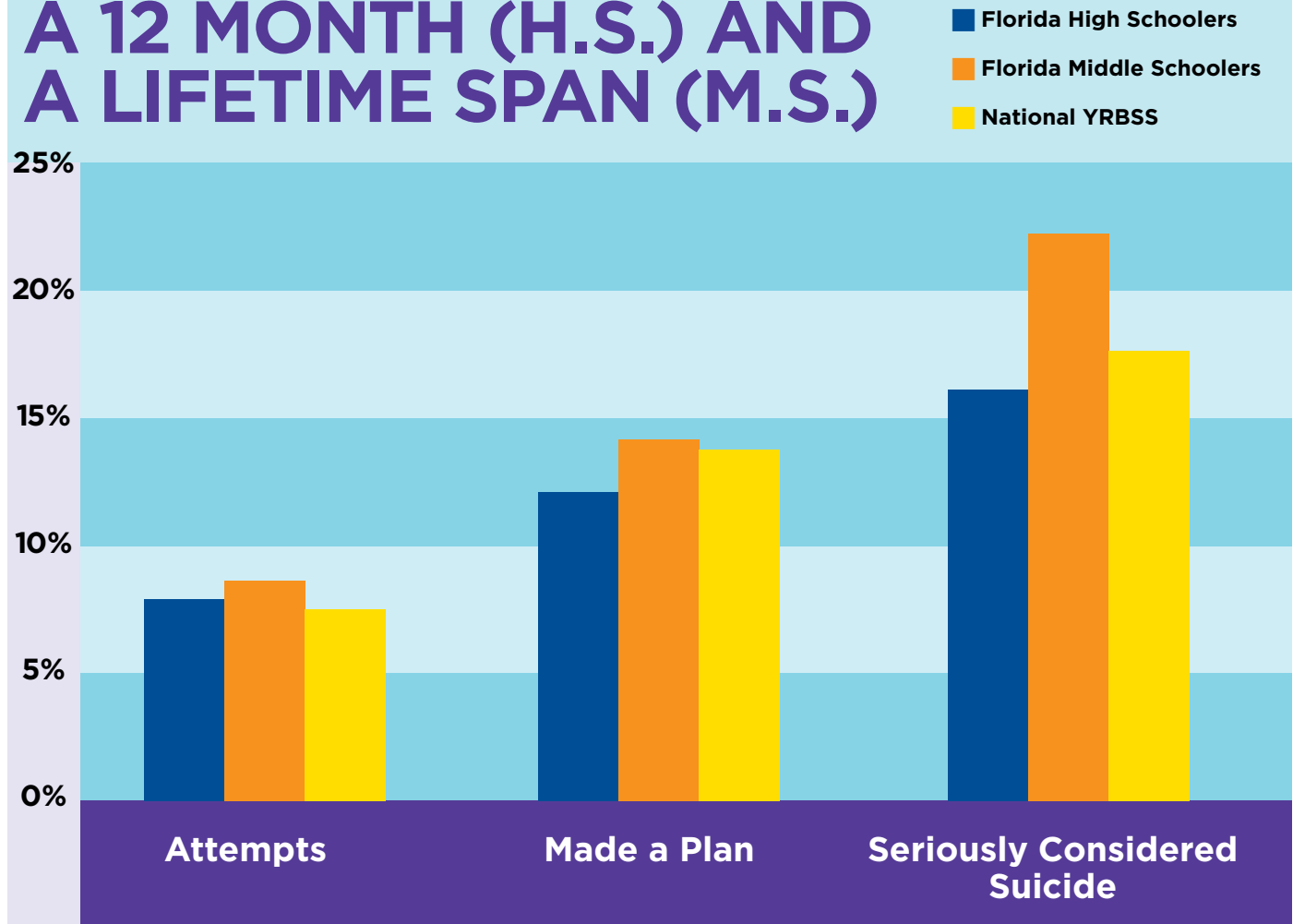


Figure 2: 2019 Behavioral Health Data Comparison—High-school (H.S.) data is for a 12-month period; middle-school (M.S.) and national data are for lifetime behavioral reports.

National statistics also come out every other year.
The national data for 2019 can be found at cdc.gov/healthyyouth/data/yrbs/feature/index.htm.

NSU's Suicide and Violence Prevention Office
compiles the most recent legislative updates and
incidence statistics on its website, which can be found
at nova.edu/suicideprevention/index.html.

LEGISLATION

It is important to emphasize and address these rising rates of suicide for high school students and middle school students. Suicide is preventable. It is important that Florida take action, as approximately 15–20 states have passed legislation for suicide prevention in schools. However, not all legislative action has been mandated, as some states only made recommendations for schools. Florida legislation has not mandated suicide prevention in schools, a very necessary initiative for saving student lives.

Legislative mandates and recommendations are essential in expanding suicide prevention in schools. School personnel need to educate legislators on the scope of youth suicide. Most recently, two 2019 legislative changes in Florida have major implications for suicide prevention. The first one was related to the Baker Act. There are differences in how school districts are using the Baker Act, and we encourage each school to review its procedures and use Tool 30—Understanding the Florida Baker Act.

Change One

The first change was from Senate Bill 7030, the Marjory Stoneman Douglas Act, which states that schools must identify students at risk for suicide and screen them with the state’s approved screening tools before using the Baker Act.

The Florida Department of Education (FDOE) recommended screening instruments for schools to use. The following are department-approved youth suicide risk screening instruments and can be found at fldoe.org/safe-schools/suicide-prevent.shtml.

- **The Columbia-Suicide Severity Rating Scale (C-SSRS)**

This rating scale encompasses the lifetime /recent and risk assessment page and can be found at cssrs.columbia.edu.

- **The Suicide Assessment Five-Step Evaluation and Triage (SAFE-T)**

This incorporates a SAFE-T pocket card that helps clinicians conduct suicide assessments using a five-step evaluation. It is available at store.samhsa.gov/product/SAFE-T-Pocket-Card-Suicide-Assessment-Five-Step-Evaluation-and-Triage-for-Clinicians/sma09-4432. A “suicide safe” mobile app developed by SAMSHA can be found at apps.apple.com/us/app/suicide-safe-by-samhsa/id968468139.

Change Two

The second change in legislation emphasized that any school in Florida may become a suicide prevention certified school. In 2019, the Florida state legislature updated the 2016 Florida Statute 1012.583. The three steps that schools must follow to become certified are listed on the following page. Upon certification, the school name and district will be posted on the FDOE website. Tool 30 addresses suicide screening and understanding the Baker Act. We are excited that some Florida schools have already taken advantage of becoming suicide prevention certified and hope all schools will do so.

Three Steps to Certification

1. Incorporate two hours of an FDOE-approved suicide awareness and prevention training for all instructional personnel.

Recently, the Substance Abuse and Mental Health Services Administration deactivated their National Registry of Evidence-based Programs and Practices. Fortunately, our state has clarified in the new legislation which programs schools should use. The FDOE, in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, developed a list of approved suicide awareness and prevention training materials for grades K-12 instructional personnel, which is posted on the FDOE website, in addition to being listed below.

The following are approved youth awareness and prevention trainings for K-12 instructional personnel.

- **Act on FACTS—2019-2020 National Version**
two-hour, online training (free)
- **At-Risk for High School Educators**
two-hour, online training (with group discussion guide), simulation-based professional development program for Florida educators (*florida.kognito.com*)
- **At-Risk for Middle School Educators**
two-hour, online training (with group discussion guide), simulation-based professional development program (online program must be supplemented with group discussion guide) for Florida educators (*florida.kognito.com*)
- **Professional Development Series—Module 2, Mental Health Issues Surrounding Suicidal Ideation**
two-hour, online or face-to-face, in-service training from the Jason Foundation (free)
- **Professional Development Series—Module 5, Youth Suicide: "A Silent Epidemic"**
two-hour, online or face-to-face, in-service training from the Jason Foundation (free)

- **Making Educators Partners in Youth Suicide Prevention**

two-hour, face-to-face, in-service workshop (\$35 for training materials and completion of Train the Trainer for presenters)

- **More than Sad: Suicide Prevention Education for Teachers and Other School Personnel**

two-hour, face-to-face, in-service program (\$60 for DVD set "More Than Sad: Preventing Teen Suicide" and "More Than Sad: Teen Depression")

- **Response: High School Suicide Awareness Program**

two-hour, in-service training (\$425 per kit, includes student awareness component)

- **Signs Matter: Early Detection**

two-hour, online training (\$35 for individual, group rates available)

- **Youth Mental Health First Aid**

six- or eight-hour, face-to-face, in-service program for Florida educators (must be supplemented with a Kognito simulation training or group discussion guide)

2. Adopt a policy mandating the use of an approved suicide risk assessment instrument prior to an involuntary Baker Act initiation.

3. Have two school-based staff members certified to administer an FDOE-approved risk assessment instrument.

Certification Resources

Scott Poland conducted several in-person trainings on suicide prevention in the spring and summer of 2019, which personnel from every county school district attended. He also conducted two webinars in the fall of 2019. Hopefully, there will be more suicide prevention trainings scheduled regularly. The Florida Office of School Safety and FDOE sponsored these trainings.

Florida S.T.E.P.S. Tools 14a, 14b, and 14c (located in the intervention section), provide more information on screening assessments. *S.T.E.P.S.* provides an example of both the brief and long form of the C-SSRS and the SAFE-T. With the new legislative requirements placed on schools surrounding student and school safety, it is our hope that this toolkit will give school mental health professionals practical guidance about how to assess students at risk of suicide.

Florida is emphasizing prevention, as Casey DeSantis, Florida's first lady, has made youth suicide prevention and student mental health a priority, and we are excited and encouraged by this development.

Clarification on Threat to Self vs. Others

Senate Bill 7030 requires school threat assessment teams to be trained to conduct behavioral threat assessments. Specifically, these assess a student's threat of violence toward others and toward themselves. It is important for school personnel to recognize that most suicidal students are not thinking of harming others, and that a suicidal student not feel that they are in trouble or likely to be disciplined at school.

Here are some things to look for when conducting every suicide assessment:

- Are they blaming others?
- Do they appear angry with others?
- Are they the victim of bullying and want to retaliate?
- Is there a history of violence or violent threats toward others?

The FDOE-recommended suicide instruments do not include questions about thoughts of harming others. Some SMHPs have always included questions of harming others in suicide assessment, while others have not. If a suicidal student talks about harming others, then district procedures for responding to threats of violence toward others must be followed.



TEN THINGS SMHPs CAN DO TO PREVENT YOUTH SUICIDE

It is important to be aware that schools cannot alone provide all the needed treatment for suicidal students, not even SMHPs. Specifically, National Association of School Psychologists (NASP) best practices explain that a school's responsibility is to screen students, notify their parents, recommend community services, and provide follow up at school.

One resource that is very beneficial for SMHPs is from Richard Lieberman and Scott Poland's "Suicide Prevention Legislation: What School Psychologists Need to Know and Do." The authors made 10 recommendations for school psychologists regarding suicide prevention in their schools. This 2017 article was originally created for school psychologists; however, we have recreated it to be applicable to all SMHPs.

1. Be the advocate for suicide prevention in your district and help your district comply with relevant Florida state laws.
2. Review model policies—such as the one developed jointly by the Trevor Foundation, NASP, AFSP, and ASCA in 2019—to reevaluate your district policies and procedures and determine if additional strategies are necessary for suicide prevention, intervention, and postvention.
3. Provide suicide prevention training annually for all school staff members who have direct contact with students even though it is not mandated by the state of Florida.
4. Review all the high-quality suicide and crisis resources from NASP.
5. Make a commitment to staying current in the field of youth suicide prevention by attending NASP, ASCA, FASP, and other professional conferences.
6. Seek input from the suicide prevention advocates in your county and state.
7. Search out local offices or chapters of the Jason Foundation, American Foundation for Suicide Prevention, and American Association of Suicidology, and visit their websites and online resources.
8. Check out the resources of the national Suicide Prevention Resource Center and sign up for their electronic weekly publication, *Spark*.
9. Prepare for suicide postvention by downloading the latest version of AFSP/SPRC *After a Suicide: Toolkit for Schools*.
10. Advocate for suicide prevention efforts in Florida and continue to keep up with legislation.

WORLD HEALTH ORGANIZATION RECOMMENDATIONS

The World Health Organization (WHO) outlined strategies for preventing youth suicide. They recommend to:

1. Remove the lethal means, which very often is a gun. The Harvard T.H. Chan School of Public Health website, Means Matter (*meansmatter.com*), summarized the research from all around the world and found that removing access to lethal means and increasing barriers on bridges reduced suicide rates. School personnel are encouraged to have very direct conversations with parents about gun access when there is any reason to suspect suicidal behavior. One Houston teen left a goodbye for her parents that asked, “Why did you leave this gun so available to me?” Guns are used in only approximately 5 percent of suicide attempts nationally but account for approximately 50 percent of suicide deaths. Rarely does anyone survive when they attempt with a gun.

2. Reduce/eliminate adverse childhood experiences, such as rejection from a parent; living in poverty; living with a mentally ill or a substance abusing family member; being physically, emotionally, or sexually abused; and losses of significant others.

3. Increase education on the warning signs for everyone and promote that suicide can be prevented. Prevention education was especially stressed for physicians, as approximately two-thirds of suicide victims went to see the family doctor shortly before their suicide death. Scott Poland’s father visited his physician just one week before his suicide. It is important for physicians to become more comfortable with asking their patients about suicidal behavior. In 2009, the U.S. Prevention Task Force recommended that all teens seeing the physician for any reason should fill out a short questionnaire that asks questions about energy level, depression, and suicide, and it should be scored before the teen leaves the office. Physicians in Florida have a very important role in preventing youth suicide.

KEY TERMS AND CONSIDERATIONS

Died by Suicide

Many Floridians know someone who died by suicide. The term “died by” is much more acceptable to survivors than the word “committed,” as it takes the emphasis away from the suicide sounding like a criminal act. It is our hope that school personnel in Florida will remember to use the term “died by suicide” and to also encourage others to avoid the term “committed.”

Survivor of Suicide

A person who lost a loved one to suicide. The term does not refer to an individual who survived their suicide attempt.

Suicidal Ideation

A person’s active thoughts of wanting to kill themselves, without accompanied behavior.

Suicide Plan

A person’s plan for how they will kill themselves.

Suicide Attempt

A nonfatal, self-directed, potentially injurious behavior with an intent to die. This means the suicide attempt may or may not have resulted in injury, but the attempt was intentional. The behavior of any person who no longer had intent to die during or after the behavior would still be considered a suicide attempt.

Suicide Postvention

The planned actions made in response to a suicide. The purpose is to process feelings, concerns, and anticipated actions of those affected by the suicide. This is in an effort to prevent further suicides and help all concerned with their emotions, such as shock, grief, confusion, and guilt.

Nonsuicidal Self-Injury (NSSI)

Superficial and harmful behaviors such as cutting, burning, scratching, and not letting wounds heal, performed with no intent to die by suicide.

KEY ROLES

1. Suicide Prevention Task Force

Florida S.T.E.P.S. was built on the considerable momentum in place for suicide prevention in the schools. It provides a comprehensive approach to suicide prevention, intervention, and postvention. We strongly encourage schools to form a suicide prevention task force (American Foundation for Suicide Prevention, 2019). Research shows that about 20 percent of school personnel come in contact with at least one suicidal student within a month span and 39 percent within a year span (Tompkins, Witt, and Ajbraibesh, 2009). The task force needs to link with community prevention partners, meet regularly, and to collect data using Tool 32.

The task force should represent at a minimum the following key school personnel: administrators, counselors, nurses, psychologists, school resource officers (SRO), and social workers.

2. Suicide Prevention Specialist

Each school is also encouraged to identify key personnel to become trained specialists in suicide prevention, intervention, and postvention. These individuals need to be very well trained in suicide assessment. This specialist likely would be a school counselor or school psychologist; however, in the smaller districts this role may need to be filled by an administrator or even a lead teacher. This specialist may not only conduct the risk assessment with a student but also would provide the needed supervision for the student, notify parents, and work toward securing mental health services for the student. Although the tasks above for the specialist may sound daunting, the toolkit outlines all the steps.



KEY PRINCIPLES

A. Suicide Prevention is a Team and Community Effort

Schools are encouraged to partner with state and local prevention initiatives to coordinate youth suicide prevention efforts. School personnel such as SMHPs should try to avoid being the only providers of treatment to suicidal students, as students are only in school seven to eight hours a day. It is important to note that Florida SMHPs are spread very thin, with their numbers not meeting the professional-to-student ratio recommended by all relevant professional associations for counselors, psychologists, and social workers. Suicidal students need to receive community-based mental health services in addition to the support being provided at school by SMHPs. The most isolated schools in Florida will find it the most challenging to obtain mental health treatment outside of the school for a suicidal student, but the Suicide Prevention Task Force should work together to find resources for suicidal students, even if the community based services are a significant distance from the school.

It is also important to remember that suicide survivors may need to be referred to community resources as well. Suicide survivors have indicated that they received the most significant help when they participated in grief groups attended only by others who had lost loved ones to suicide; they sometimes felt out of place attending grief groups with participants who had lost loved ones due to other causes. Key school personnel, such as SMHPs, are encouraged to refer grieving students and families to the nearest suicide survivor support group. We have provided Tool 28a and Tool 28b to help school personnel identify and work with mental health services in their community or region before and after the suicide crisis.

B. Mobile Crisis Teams Should Be Organized

Through our interview with key personnel around the state, we became aware of differences with regard to mobile crisis teams utilization in Florida counties, and SMHPs are encouraged to carefully assess and identify the services mobile crisis teams provide in their county.

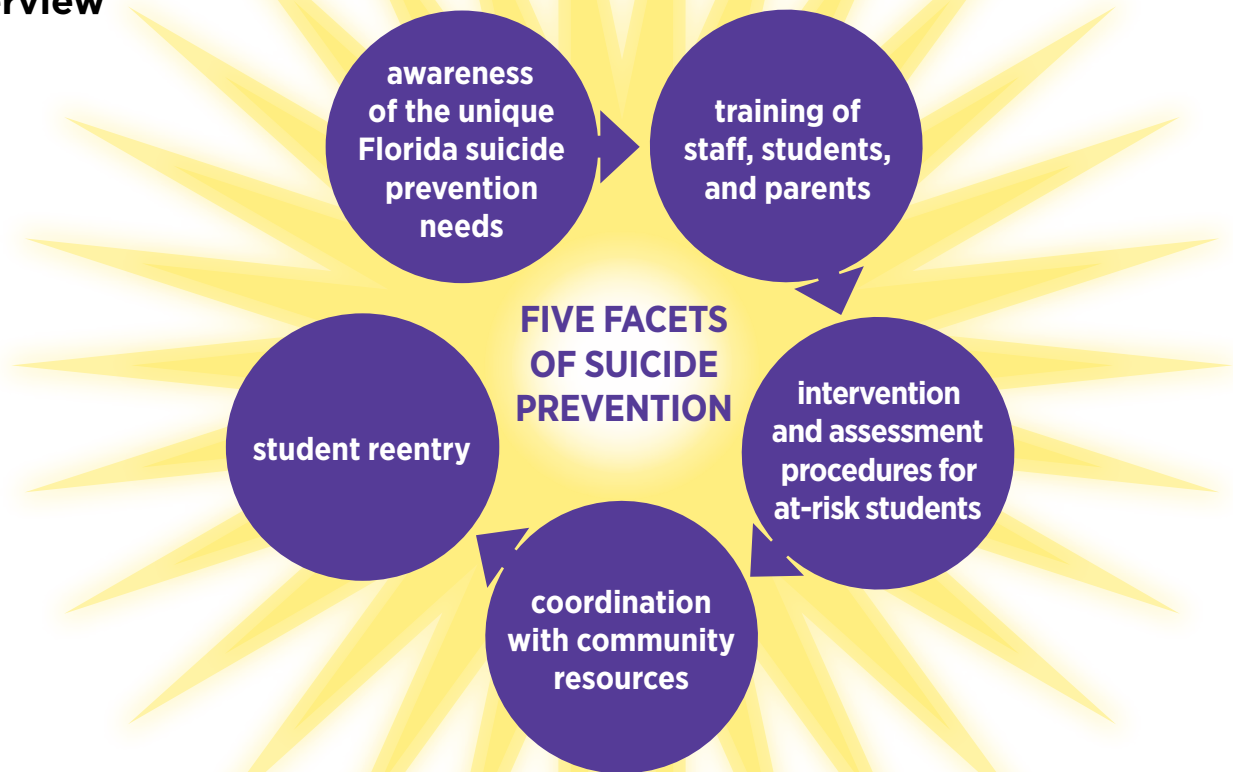
C. The 988 Mental Health Emergency Number Should Be Used

In the future, the 988 mental health emergency number will be an important number for schools to know and share with students and families. The 988 number, which will be implemented nationally but perhaps not until 2022, will work like the 911 number, but will become the go-to number for mental health and suicidal emergencies. SMHPs need to monitor closely when the 988 number becomes available in Florida.

Section 1

SUICIDE AWARENESS AND PREVENTION

Overview



Four Steps to Developing a Program

The Substance Abuse and Mental Health Services Association recommended a four-step process in 2017 for developing suicide prevention programs in schools.

Step 1—Engage administrators, school boards, and other key players who will endorse the programmatic changes in the school and justify the time it takes to train school personnel and students on suicide prevention. Administrators need to understand the scope of the problem, realize that schools are the most logical places for students to be identified, and know that talking about suicide with students will not increase the risk. In short, administrators need to seek training for themselves and provide the leadership necessary to create a culture of suicide awareness and prevention.

Step 2—Bring personnel together to start the planning process and form a Suicide Prevention Task Force. Be sure to include the key players to promote suicide awareness and intervention. In addition to school personnel, key community mental and medical health personnel, Florida suicide prevention coalition members, local clergy, and parent groups should be included.

Step 3—Provide all key players and task force members with basic information about youth suicide and suicide prevention and emphasize that prevention is possible; everyone plays a role.

Step 4—Develop your school's or district's overall strategy for training staff members and students and creating a culture of suicide awareness and prevention.

KEY COMPONENTS OF A MODEL SUICIDE AWARENESS, PREVENTION, AND RESPONSE POLICY

Each Florida school board should adopt a suicide prevention policy that addresses prevention, intervention, and postvention. The policy should outline the training that will be provided to staff and students and the programs that will be implemented. Florida schools have varying levels of policies or suicide prevention plans in place. Each school system is encouraged to review Tool 6 in developing their policy and plan.

Starting Considerations

- A model policy can best be developed by creating a suicide prevention task force that includes community members, reviews local and state models, and is familiar with the evidenced-based best practices for suicide prevention in schools.
- The American Foundation for Suicide Prevention (afsp.org) in the fall of 2019 released a Model School District Policy on Suicide Prevention.
- The Suicide Prevention Resource Center (sprc.org) has a section entitled “Programs with Evidence of Effectiveness” that includes programs previously listed in NREPP.
- Suicide prevention information provided for staff and students should be selected very carefully and use best practices. Schools are strongly encouraged to ensure that any videos about suicide are approved by the administration or curriculum director before being shown to staff or students. It is also strongly recommended that any speakers on the topic of suicide be researched carefully and, ideally, that they have a background in the mental health field. School assemblies on suicide are not recommended due to the dramatic nature of bringing all students together and because students are unlikely to ask questions in a large group setting. It is also difficult to monitor their reactions in a large group setting. Suicide is best discussed in a classroom setting with the session led by a counselor or psychologist with the teacher present and invested in prevention.
- Review incidence of suicidal thoughts, plans, attempts, and deaths by suicide for youth both locally and at the state and national level.
- Consider at-risk populations within the school district, such as LGBTQ students, bullying victims and perpetrators, homeless youth, students in foster care, and students engaging in self-injury (Tool 10).
- Create a district suicide prevention task force that partners with community resources.
- Train and share any information with target groups, including staff members, students, community groups, and parents that provide suicide prevention education and crisis resources (Tools and Appendices include numerous documents for educating each group.)
- Assess and identify processes that adhere to best practices and evidenced-based prevention programs.
- Implement procedures to notify parents when a student is suspected of being suicidal (Tool 18).
- Consider a referral process that includes identified community resource providers that

are well trained in suicide risk assessment and management (Tools 19 and 28a–b).

- Enforce procedures for responding to students at risk of suicide (Tools 14a–c and 16–19).
- Implement reentry procedures for students who have been hospitalized (Tool 20).
- Review and apply the postvention procedures checklist (Tool 21).
- Develop communication guidelines for leadership, staff members, students, and parents that include handbooks, the media, websites, etc. (Tools 22–26)
- Implement documentation procedures for staff training and for actions taken with students referred for being at risk of suicide (Tools 5 and 8).
- Develop a concise overview of the plan for a district’s suicide awareness, prevention, and response policy (Tool 6).
- When selecting suicide prevention programs, Florida schools are encouraged to form a suicide prevention task force and to
 - a. begin with a needs assessment
 - b. review resources listed in the *Florida S.T.E.P.S.* and on the FDOE website and collaborate with other Florida districts and local and state agencies to select programs that fit the school
 - c. address both risk and protective factors for school-age youth

Considerations for Trained Staff Members and Students

Training all school staff members on the warning signs of suicide and referring at-risk students to the administration and counseling staff is the cornerstone of suicide prevention in schools. Students need to learn the warning signs of suicide, as well as the importance of seeking help from adults when they realize that they or a friend

are suicidal. These critical steps will result in more suicidal students being identified and referred for a suicide assessment.

Considerations for Risk Assessment Training

Each Florida school needs key personnel trained in suicide assessment, and school counselors are the logical personnel. Earlier, we mentioned that school mental health professionals should seek out training to increase their expertise. We recommend that schools use the programs identified by the Florida Department of Education. A suicide risk assessment is done to determine if suicidal ideation, intent and plan are present and to identify what steps need to be taken to safeguard the student. **No problem facing school mental health professionals is more urgent than the need for training in suicide assessment.** School personnel understandably experience anxiety when faced with a student who may be suicidal, and it is vital that they receive training in assessment. This can be provided by bringing experts to the school system to provide training in assessment and intervention or by sending key personnel to conferences and trainings conducted by state and national associations. Key personnel, such as school administrators, counselors, and teachers, must also know the facts about youth suicide and not believe myths about suicide. Recently, a school counselor asked “Is it true that some students will die by suicide no matter what we do? Isn’t it their destiny?” This is faulty thinking, and it’s an example of why the recommended training in Florida is so important.

Additionally, it is very important to include positive examples of school personnel actions that resulted in a suicide being averted, for an example, identifying students, notifying parents, making community referrals, and providing follow-up services at school.

Considerations for Staff Member Suicide Prevention Training

School staff members at every grade level need prevention and intervention training. With a growing concern for suicide of elementary age students, we must take all suicidal statements and behavior seriously regardless of the student's age.

Elementary students making statements about suicide are often expressing frustration and anger. We hope that we can help elementary students to be able to more clearly articulate what it is that is bothering them at the moment. If they've made statements about death, dying, and suicide, however, then procedures for suicide prevention must be followed. It is also very important, throughout the entire elementary school curriculum, to reinforce the concept of always getting help from a trusted adult when a student—or a classmate—is talking or thinking about dangerous behavior, including threats of violence toward others or suicide.

School personnel must follow through with the district plans and protocols even if the student is at the elementary level. Most importantly, notify the parents of the student suspected of being suicidal. Ideally, every Florida school annually asks all students to identify the go-to adults in their lives, at home and at school, and emphasizes the need for students to go to that adult if someone is threatening suicide or homicide.

Components of Staff Member Suicide Prevention Training

The recommended training focuses on understanding why suicide is preventable and identifying students who are at risk of suicide and how to utilize best practices for parent notification, community referral, reentry, and postvention.

Training should be designed to achieve several specific goals related to suicide prevention.

- Convey current statistics, beliefs, and attitudes about suicide in youth, and
 - dispel myths
 - review protective factors for youth, including having programming that creates a suicide awareness culture
 - stress never keeping a secret about a student's suicidal behavior, including building a climate with connections between students and trusted adults
- Educate school staff members about suicide myths in order to recognize and respond to warning signs of suicide risk (Tools 9–11).
- Promote the importance of intervention with at-risk youth and connect them with the needed help. For this, it is important to
 - know the school referral procedures (Tool 8)
 - know who the suicide prevention expert for the district or school is
 - know procedures to monitor students at risk of suicide
- Provide information about suicide prevention resources in your school and community.
- Convey that suicide is almost always preventable and, if a student died by suicide, it was probably the result of untreated or undertreated mental illness.
- Document staff member understanding of suicide prevention and intervention with a pre- and post-training survey (Tool 5).

- Document staff member attendance at suicide prevention and intervention training (Tool 4).
- Suicide prevention experts or specialists require additional training and should
 - know how to implement a suicide assessment process (Tools 14a–c, 15a–b)
 - know the Parent Notification of Suicide Emergency Form (Tool 18)
 - know how to implement strategies for reentry to school (Tool 20)
 - know how to monitor suicide (Tool 20)
 - know how to implement postvention strategies (Tools 21–22)
- Principals and administrators serving in leadership roles should also have additional training on communicating with staff members in the aftermath of an attempted or completed suicide, including
 - an agenda for the initial all-staff meeting (Tool 23)
 - working with the local media (Tools 25–26)
 - providing teachers with information and guidance for working with shocked, confused, and grieving students (Tools 23–24)

Considerations for Student Suicide Prevention Training

We strongly recommend that all staff be trained in suicide prevention and intervention before making suicide prevention presentations to students. School procedures and plans for suicide prevention need to be understood by all school staff.

Once all staff members are trained, it is ideal for all students to receive training as well. Training helps students understand the warning signs of suicide and the importance of immediately seeking adult help.

While there are numerous training modules for staff members, only a few are available for students, especially at the elementary level. This is an area that needs more development and can benefit from educators sharing activities and curriculum that they have implemented with positive results.



Section 2

Suicide Intervention

Overview

All school personnel should know that they can be the difference in saving a student's life. Segmented training recommendations are outlined below.

- **Leadership, principals, administrative team**

(recommend minimum 2 hours of training)

- suicide prevention, intervention, and postvention
- identification and assessment of suicidal students
- district/school procedures for providing suicide intervention
- community resources for mental health and suicide intervention
- reentry after hospitalization for suicidal students
- liability issues for schools with regards to suicide

- **Counselors, social workers, psychologists,**

nurses, SMHPs (recommend minimum 4 hours of training, including role play on assessing suicide and notifying parents; sample role plays are provided in Tools 15a–b)

- suicide prevention, intervention, and postvention
- identification and assessment of suicidal students
- district/school procedures for providing suicide intervention
- parent notification procedures
- community resources for mental health and suicide intervention
- reentry after hospitalization for suicidal students
- liability issues for schools with regards to suicide

- **Classroom professionals and support staff**

members (teachers, teachers' aides, secretaries, school resource officers) (recommend minimum 1 hour of training, annually)

- suicide prevention, intervention, and postvention
- identification and assessment of suicidal students
- district/school procedures for providing suicide intervention
- reentry after hospitalization for suicidal students
- liability issues for schools with regards to suicide

- **Secondary student training** after all staff members

are trained in the warning signs and school referral procedures (recommend minimum 1 hour of training) and parents informed about suicide prevention at meetings, district communications, and on school and district websites

- suicide prevention and intervention
- student participation (Signs of Suicide, Sources of Strength, Youth Aware of Mental Health, and other carefully reviewed programs)
- district/school procedures for providing suicide intervention
- National Suicide Prevention Lifeline and Crisis Text Line
- know the new national proposed 988 emergency mental health line (expected in operation in 2022)
- how to use a smartphone to connect with helplines (e.g., tell Siri)

- **Ancillary personnel who come in contact with students** (bus drivers, cafeteria workers, and custodial staff) (highly recommend 1 hour of training, annually)
 - understanding suicidal ideation, prevention, and response
 - dispel the most common myths about suicide
 - know the district referral process and district/school procedures for providing suicide intervention



Confidentiality

What is FERPA?

When intervening with a suicidal student, it is important to know FERPA. The Family Educational Rights and Privacy Act (FERPA) prohibits a school from disclosing personally identifiable information from students' education records without the consent of a parent or eligible student, unless an exception to FERPA's general consent rule applies in an emergency.

How does FERPA apply to a potentially suicidal student's intervention?

One issue that school personnel struggle with is when and if they must notify parents if they believe a student to be suicidal. All parents of students suspected to be suicidal must be notified. **School personnel should know that the only exception to notifying the parents of a suicidal student is if abuse is suspected. At that time, the Florida Department of Children and Families must be called.**

It is important to understand the exception to the FERPA rules when addressing the needs of a suicidal student, as it is an emergency situation. Under this health or safety emergency provision, an educational agency or institution is responsible for determining whether to disclose personally identifiable information on a case-by-case basis, taking into account the totality of the circumstances pertaining to a threat to the health or safety of the student or others. **If the school district or school determines that there is an articulable and significant threat to the health or safety of the student or other individuals and that a party needs personally identifiable information from education records to protect the health or safety of the student or other individuals, it may disclose that information to such appropriate party without consent. 34 CFR § 99.36 (a).** This is a flexible standard under which the U.S. Department of Education defers to school

administrators so that they may bring appropriate resources to bear on the situation, provided that there is a rational basis for the educational agency's or institution's decisions about the nature of the emergency and the appropriate parties to whom information should be disclosed. More information about this exception can be found at ed.gov/policy/gen/guid/fpco/pdf/ferpa-disaster-guidance.pdf.

In summary, all students should be aware of the limits of confidentiality and that the school staff members must notify the parents of a suicidal student. While it may upset the student that you are divulging their private information to their parents or other necessary school staff members, it will be less difficult to repair rapport with a student who is alive than to deal with the potential outcomes if the student attempts and/or dies by suicide without parent notification. Most suicidal students are actually relieved that help or a lifeline is being offered, and many students know their parents will be supportive of them getting the help they need. SMHPs should use all of their training to help the suicidal student understand that it is in their best interest that their parents be notified. If a suicidal student remains adamant that their parents not be contacted, the **SMHPs must notify parents, as it is not a discretionary duty but a required one. Almost all of the cases where schools were found liable following the suicide of a student have been because the parents of a student known to be suicidal were not notified.**

Related Behaviors to Consider

Depression, Bullying, and Non-Suicidal Self-Injury

Depression

A high-risk factor for suicide is a current mental health disorder, such as depression. **A promising addition to suicide prevention is depression screening.** Before the development of depression screening programs, youth suicide prevention programs only focused on training adults to recognize suicidal warning signs. This was most often referred to as “gatekeeper training.” The problem is that students are most likely to share thoughts of suicide with their friends. Signs of Suicide (SOS) uses a questionnaire for students in grades 6–12 that asks about energy level, enjoyment of life, and thoughts of suicide. Students score their own questionnaire and can determine if they are likely suffering from depression and need mental health services. SOS is inexpensive and sometimes the material has been provided by SOS to schools at no charge.

SOS is a secondary school-based suicide prevention program that includes screening and education. Students are referred for professional help when needed. Students also view a video that teaches them to recognize signs of depression and suicide in themselves and others. An appropriate response to these signs is to use the ACT (Acknowledge, Care, Tell) technique: acknowledge that there is a problem, let the person know you care, and tell a trusted adult. Students also participate in guided classroom discussions. Research on the program has shown it to reduce suicide attempts, increase knowledge about suicide and depression, and increase help-seeking behavior among middle and high school students. A concern often expressed by educators is the capacity to follow up as needed, if such a program identifies many students as suicidal. **The SOS website (mindwise.org) provides many practical suggestions and recommends that only a manageable portion of the student body be screened at a time so that follow-up and intervention can be provided promptly.**

Bullying and Suicide Prevention

Research has found a strong association but has not proved that bullying causes suicide, as it is difficult to rule out the many other possible factors that involve family, abuse, mental illness, trauma, and loss. That said, parents have charged in lawsuits following a child’s suicide that bullying at school was a significant factor. To date, we are not aware of any schools that have been found liable in these cases, but a number have settled out of court.

Students who are depressed or anxious, have low self-esteem, and possess few problem-solving skills are likely to be the target of bullying. Children who have been bullied have reported a variety of behavioral, emotional, and social problems.

Suicide is the second-leading cause of mortality for 10- to 19-year-old children. Studies report positive associations between all bullying types and suicidal risks. Consider the following:

- Both victims and perpetrators are at higher risk than peers.
- Personal characteristics, such as internalizing problems, low self-esteem, low assertiveness, increase the risk of being bullied. These factors are also associated with risk for suicide.
- It is difficult to control all the risk factors to determine if being bullied was a proximal cause of a youth suicide.
- LGBTQ youth have higher rates of suicide attempts and deaths than their heterosexual peers, but there is nothing inherently suicidal about same-sex orientation. Suicide may be linked to external factors, such as bullying, harassment, abuse, rejection, and lack of support. **The strongest protective factor for an LGBTQ youth is parental acceptance.**

More information and resources can be found at sprc.org. **Remember, Florida school personnel who know a student is involved in bullying should not hesitate to ask the student about hopelessness, revenge, violent thoughts, and thoughts of suicide.**

Suicide and Non-Suicidal Self-Injury

Non-suicidal self-injury (NSSI) is a behavior that has caught school personnel by surprise with its frequency and complexity. The behavior is most common in adolescents but has also increased with upper-elementary students. This section will answer the following questions:

- What exactly is non-suicidal self-injury?
- How many students engage in it?
- Why do students engage in it?
- What is the school's role with NSSI?
- Do parents need to be notified?
- What is the relationship between NSSI and suicide?
- What is the best treatment for NSSI?

NSSI is defined as the purposeful harming of one's body without suicidal intent. The most common forms are cutting, burning, scratching, or not letting wounds heal. This behavior fulfills a multitude of complex needs for the student engaging in it and often is addictive. The most common theories for NSSI are the following:

- The act has a biological basis as endorphins are released (much like those released in exercise).
- The act provides a psychological regulation of emotions as students concentrate on the injury and are able to shut out the conflict they are having at the moment (an argument or a disappointment).

Estimates are that NSSI is engaged in at least once by 14–18 percent of adolescents. A common denominator found with students who self-injure repeatedly is a trauma history of loss or abuse. Most young people engaging in NSSI cleverly hide the

behavior from adults. The most commonly injured parts of the body are the arms, thighs, and stomach. Students often wear long-sleeved shirts or sweaters even in the summer or wear many bracelets to hide the signs of NSSI. NSSI is also associated with mental illness such as anxiety, depression, and a borderline personality disorder.

School personnel need to know the incidence of NSSI and be alert to the warning signs such as frequent or unexplained bruises, scars, cuts, or burns, and the wearing of inappropriate clothing designed to conceal wounds. Secretive behaviors, such as spending unusual amounts of time in the school bathrooms or isolated areas on campus, may also be warning signs. Students might also show evidence of the behavior in work samples, journals, or art projects. Students might also possess sharp instruments such as razor blades, shards of glass, or thumb tacks.

Schools need to develop a protocol to respond to a student engaging in NSSI, and the school counselor and school nurse should be involved. A staff member who suspects the behavior should approach the student in a confidential manner or go with the student to see a counselor or nurse. A typical adult response to NSSI is to be horrified and demand that the student stop the behavior. It is not that simple. The behavior is complex and is helping the student cope with the issues in their life. Educators need to respond with compassion and empathy and recognize the struggle the student is experiencing. The focus should be on the underlying issues the student is experiencing. Helping the student gain control over NSSI and diminish the behavior is the goal.

Interventions with NSSI need to be done individually, and SMHPs and nurses need to work together to help students learn substitute behaviors that will distract the student when they are having the urge to cut or burn their skin. A few substitute behaviors include scratching clothing, standing on tiptoes, scribbling with a red marker, tearing paper, or playing with clay. Extensive information and school policies for NSSI and treatment procedures are available at the Cornell Self-Injury Center (selfinjury.bctr.cornell.edu).

SMHPs and nurses can also help students keep a trigger log of the situations that caused them to want to self-injure and can explore with them better ways to manage the situation.

Parent notification when a student is known to be engaging in NSSI has been a controversial issue. The counseling/psychology literature has been inconsistent, cautioning that it could result in a loss of rapport with the student.

Parents should be notified by school personnel when a student is engaging in NSSI. Ideally, a conference with key school personnel, parents, and the student will provide an opportunity to discuss the NSSI behaviors with his or her parents. School personnel should follow notification and referral procedures outlined in this toolkit. A referral needs to be made for the student to receive treatment in the community. The most effective treatment is Dialectical Behavior Therapy (DBT), but some communities may not have therapists trained in DBT. *S.T.E.P.S.* has emphasized that when a student is believed to be suicidal and parents are not receptive to obtaining community mental health interventions for their child, Florida's Department of Children and Families (DCF) must be notified. If parents are not receptive to obtaining outside services for their child engaging in NSSI, it is important to clarify whether the student should be reported to DCF. Each school district will have to decide what their protocol is in this situation, but follow-up and support services for the student are essential regardless of whether outside mental health services are obtained.

What is the relationship between suicide and NSSI? School personnel may think that the two behaviors are exclusive. However, NSSI has been added as a risk factor for suicide because students engaging in NSSI are becoming comfortable with the habit of harming their bodies. Additionally, NSSI has diminishing returns as a coping mechanism. Research estimates that approximately 30 percent of adolescents who repetitively self-injure ultimately make a suicide attempt. The NSSI risk factors for suicide are

- utilizing multiple methods
- long standing history of NSSI
- reporting little physical pain from NSSI
- reporting disassociation when engaging in NSSI

School personnel should not hesitate to ask a student known to be engaging in self-injury about thoughts of suicide. Parental notification procedures need to be followed and referrals made to community providers skilled in managing NSSI. If the student admits to suicidal thoughts, then safety planning and pathways to care procedures for suicide outlined in this toolkit must be followed. A video on NSSI created by Scott Poland for the state of Florida provides critical insight into self-injury as he interviewed two young women who received a national award for their willingness to discuss their struggle with self-injury. The free video is available at nova.edu/suicideprevention under training videos.



Responses and Procedures

Responding to a Student Who is at Risk of Suicide

The training outlined earlier will prepare school staff members to be alert and responsive to distressed students. What we haven't mentioned is the part that a student or parent plays in alerting staff members to warning signs and getting assistance for their friend or loved one. Training for students, such as the SOS program, needs to be conducted in the classroom. Parents should be educated as well. Appendix 3 has questions and answers from educators, parents, and students. Tool 29 has key information that can be posted to the school district's website.

- Many times, a friend, parent, or alert staff member will report a concern to the appropriate person such as the school counselor. Sometimes, however, the student who is in distress will self-report. Tool 8 identifies the steps the counselor/suicide prevention expert should take upon notification, while Tool 16 provides a blank report form.
- The designated suicide prevention expert will conduct an initial assessment of the student to determine if he or she is at risk (Tools 14a-14c), a safety plan will be developed with student (Tool 17), parents will be notified (Tool 18), an in-person conference will be held, and a referral to community mental health resources will be made. See Tool 28a for a detailed list of questions to ask community mental health providers. See Tool 28b for a list of questions concerning treatment facilities.
- Community or regional mental health resources ideally should be identified prior to a suicide crisis, preapproved by district administration, and readily available. A guide to their identification includes
 - phone interviews (Tool 28a) to determine if the providers are trained in suicide assessment and management and have experience with school-age youth

- a cooperative relationship between the mental health provider and the district and school and, with parent permission, the ability to share appropriate information with designated school staff members for the purpose of a smooth reentry to school
- a list of prescreened providers that is readily available to the staff members whose role it is to respond to students and to make recommendations to parents
- Administrators, counselors, and the designated suicide prevention expert must understand the importance of a reentry and monitoring procedure (Tool 20). Teachers need to know that suicide is a concern so they can be alert for further warning signs.
- In the event a death by suicide cannot be prevented, postvention procedures are extremely critical for the benefit of the family, grieving students and staff members, and for educating the school and community. Key messages are that no one thing or no one person is to blame. (For guidance, see Section 3: Postvention After a Suicide).

School personnel have also frequently asked if every student threat of suicide needs to be taken seriously and have commented that many times a student is perhaps just seeking attention or is trying to manipulate a situation. The answer is that every student threat of suicide must be taken seriously, even with elementary age students, and the assessment steps outlined below must be followed. Taking suicidal threats seriously and notifying parents will save lives. Secondly, this will also protect school personnel from liability.

Creating a culture that promotes wellness, mental health, and connectedness; respecting students; and honoring their emotional and academic needs will go a long way toward preventing suicide. All students, staff members, and parents need to know how to get help for themselves or others should the suicide warning signs arise.

Assessment Procedures for the Suicidal Student

A brief synopsis of recommended assessment procedures is described herein with additional tools provided in the appendices. Key tools include a Checklist for Reentry After Hospitalization, Sample Safety Plan, Sample Parent Notification Form, Sample Risk Assessment Forms, Student Suicide Risk Report, and Understanding the Florida Baker Act.

Factors and Questions for Schools to Consider When Conducting a Suicide Assessment

Schools cannot treat suicidal students. Treatment must be obtained in the community. The school day is only approximately 7.5 hours and school mental health professionals—such as counselors, psychologists, and social workers—have a ratio of one professional to several hundred or even several thousand students.

The school's role is to make an initial assessment and is not intended to substitute for an extensive clinical suicide assessment by a community- or hospital-based professional. The school assessment of low, medium, or high risk is to determine the level of needed supervision for the student and the urgency for parent notification and, in some cases, notification of law enforcement and or mobile crisis teams. When conducting an assessment, the inquiry

must be direct and rapport established with the student. Direct inquiry will not plant an idea in the mind of a student! Students are often ambivalent about suicide. One minute they may want to die, but the next minute there is a glimmer of hope and they want to live. Many students after being questioned about suicidal thoughts have felt relieved. Peers often are the ones who become aware that a friend is suicidal, so peer reports must be taken seriously.

Assessing students for suicidality results in considerable anxiety for the school personnel conducting the evaluation, and it is ideal to consult with a colleague during the process. Consultation can be obtained by asking another staff member to sit with the student in question while the SMHP makes a call to a colleague or supervisor for support and guidance. **It is very important for the Florida schools to provide training on suicide assessment for key personnel such as school counselors,** and that training should include observing a role play of assessing suicide risk with a student (Tool 15a) and a role play of parent notification (Tool 15b) of their child's suicidal thoughts and/or behavior and referral to community based services. It is suggested that counselors, after observing role-play conduct, do a role-play exercise with another staff member to increase their confidence. It is also very important that counselors know how to take care of themselves emotionally. Tips for caregivers on managing their personal stress are in Tool 27.



Suicide Assessment Questions

- What are the current feelings of the student?
- What warning signs initiated the referral?
- What is the individual's current and past level of depression?
- What is the student's level of hopelessness?
- Has the student currently, or in the past, thought about suicide?
- What is the method of any previous suicide attempt(s)?
- Does the student have a current suicide plan?
- What method does he/she plan to use and does the student have access to the means?
- What are the student's perceptions of burdensomeness and belongingness?
- Have they been exposed to a suicide?
- Do they have history of engaging in NSSI (cutting or burning)?
- Is there any history of alcohol or drug use?
- What are current problems and stressors at home and at school?
- Has the student demonstrated any abrupt changes in behaviors?
- What is the student's current support system and what protective factors are in place?
- What is the student's current mental health status? Is there a history of mental illness?
- Is there a history of bullying, victimization, loss, and/or trauma?
- Has the student experienced other childhood adversities such as poverty; physical, emotional or sexual abuse; neglect; living with a mentally ill relative; or significant losses of loved ones?
- What has kept the student alive thus far?

Standardized Assessment Scales

A thorough interview with a suicidal student with excellent rapport established is essential and standardized assessment scales can be a valuable addition to the interview as they have been published and validated by research. The FDOE has recommended that for suicide screenings, schools use either the Columbia or the SAFE-T (Tools 14a and 14b) or the SAFE-T from SAMHSA (14c). One advantage to using the Columbia is that hospital personnel are very familiar with both versions of it. The brief version of C-SSRS, which consists of six direct questions, is most applicable when a Florida administrator or teacher are making the assessment when a school counselor is not available. The longer version in Tool 14b includes the SAFE-T protocol with the C-SSRS and includes more questions and the identification of protective factors. **The C-SSRS is free, appropriate for all ages and has been translated into more than 100 languages.** The website (cssrs.columbia.edu) provides an overview of the C-SSRS and a link to a video on how to best use the instrument.

In addition, SAMHSA provides a free Suicide Safe app that provides directions for medical and mental health personnel on suicide assessment, including case studies and the identification of risk and protective factors. More information about the Suicide Safe app is available at store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1.

Assessment Response

The standard of care is that parents of students assessed at even a low risk for suicide must also be notified of the suicidal concern. The one exception to notifying parents when their child has had suicidal thoughts is if the parents are believed to be abusing their child. In this case, the Florida Department of Children and Families must be called immediately. It is also highly recommended that the parents of a student who is 18 years or older also be notified. Parents might be difficult to reach, and school personnel should keep the student suspected of being suicidal under close supervision until they

can be transferred to their parents. If the parent simply cannot be reached, then school personnel need to work with local law enforcement and/or psychiatric mobile crisis units to secure the needed supervision for the student.

Low Risk (ideation only)

- Develop a safety plan with the student (Tool 17).
- Notify the parents of their child's suicidal ideation.
- Refer for community mental health treatment for the suicidal student and persuasively request that parents sign the release of information section so that designated school personnel can directly communicate with community mental health professionals.
- Document having parents sign an emergency notification form (Tool 18).
- Fill out the Suicide Risk Report (Tool 16).

Medium Risk (current ideation and previous suicidal behavior)

- Supervise student at all times (including restrooms).
- Develop safety plan with the student (Tool 17).
- Notify and release student ONLY to
 - a parent or guardian who agrees to increase supervision, remove lethal means in the home, and seek an immediate mental health assessment and treatment
 - law enforcement
 - a psychiatric mobile crisis unit
- Persuasively request that parents sign the release of information section (Tool 18) so that designated school personnel can speak directly with community mental health professionals.
- Fill out the Suicide Risk Report (Tool 16).
- Have parents sign an emergency notification form (Tool 18).

- Develop follow-up plan at school that includes a reentry plan if the student is hospitalized. All students returning from mental health hospitalization should have a reentry meeting where parents and school and community mental health personnel make appropriate plans to support the student before he or she returns to class.
- Use Reentry Checklist and Monitoring (Tool 20).

High Risk (current plan and access to method)

- Supervise student at all times (including restrooms).
- Develop safety plan with the student (Tool 17).
- Notify and release student ONLY to
 - a parent or guardian who commits to increase supervision, remove lethal means from home, and seek an immediate mental health assessment and treatment
 - law enforcement
 - a psychiatric mobile crisis unit
- Persuasively request that parent sign the release of information section so that designated school personnel can speak directly with community mental health professionals.
- Document all actions, including having parents sign an emergency notification form (Tool 18).
- Fill out the Suicide Risk Report (Tool 16).
- Develop a follow-up plan at school that includes a reentry plan if the student is hospitalized. All students returning from mental health hospitalization should have a reentry meeting where parents and school and community mental health personnel make appropriate follow-up plans to support the student before he or she returns to class.
- Use Reentry Checklist and Monitoring (Tool 20).

Safety Plans

Many generations of mental health professionals were taught to have suicidal clients/students sign a contract that they would not harm themselves. Criticisms of these contracts were that mental health professionals might rush or even coerce a student into signing one. **Although the use of contracts is still widespread, there is no empirical research to support that contracts were effective in preventing suicide.** Contracts also did not protect the professional from liability.

It is important to know that **safety plans are the gold standard of care.** Unlike “no suicide” contracts, safety plans are not developed ahead of time but are developed jointly with the student in crisis. The safety plan focuses on identifying coping strategies and peer and adult support for the student. It includes local and national suicide prevention resources and hotline numbers and crisis text lines. Students are given a copy of the plan they helped develop and are encouraged to review it when they have suicidal thoughts. A sample safety plan is provided in Tool 17.

A safety plan must include direct language about what to do in a suicidal crisis. It is noted that some safety plans do not mention the word suicide, but we believe it is essential. We recognize that social media and the Internet are important to teens. Some of the sites that teens visit may promote suicide, and they might receive messages on social networks that encourage suicides. This may need to be addressed in safety plans for students, which would encourage them to visit sites that focus on suicide prevention and to use an app like the Virtual Hope Box, available at apps.apple.com/us/app/virtual-hope-box/id825099621. This should include avoiding sites that promote suicide and knowing how to report suicidal concerns on the various social media platforms. It might also address the amount of time the student spends on social media if it is not a positive experience for them. School personnel are encouraged to sit alongside the student to emphasize to the student that the safety plan is being developed jointly. Sample safety plans are also available at [sprc.org](https://www.sprc.org).

Notifying Parents of Student At Risk of Suicide

Parents are the key to helping the suicidal student and obtaining community-based mental health services. Parents who were not notified of their child’s suicidal behavior have successfully sued school districts. The following suggestions are offered for engaging and supporting parents of a suicidal student. **A conference with parents should be held in person rather than by telephone. A suicidal student should not be allowed to leave school on his or her own even if that is what the parents have requested.** Begin with asking parents how their child has been doing and if they have noted any changes in their child’s behavior.

1. State what you have noticed in their child’s behavior and ask how that fits with what they have seen in their child.
2. Advise parents to remove lethal means from the home. You can equate this to how you would advise taking car keys from a person who had been drinking. It is important to note that states with stricter gun laws have fewer suicides. Florida has a child access prevention law which states that a person who knows or reasonably should have known that a child under 16 is likely to gain access to a firearm is criminally liable. Unless the firearm was in a locked box, stored in a location a reasonable person would believe to be secure, or secured with a trigger lock, the owner of the firearm is at risk of prosecution. Our experience is that this law is often not enforced.
3. Key school personnel, such as counselors, are encouraged to ask parents directly about their child’s access to a gun and to recommend strongly that parents keep guns safely stored. A specific discussion with parents regarding removing lethal means is one of the most effective prevention but often underutilized strategies.

4. Acknowledge the emotional state of the parents. Provide empathy for this situation and comment on its scary nature for parents.
5. Emphasize that it is essential that schools, parents, community mental health and medical service personnel collaborate to help a suicidal child.
6. If the parents appear to be uncooperative, find out if beliefs or myths are hindering them from taking certain actions.
7. Acknowledge and explore cultural, religious, or other concerns that might reduce the parents' acceptance of mental health treatment for their child.
8. When possible, align yourself with the parents. It is important for them to understand the stress and likely depression their child is experiencing and to discuss with them ways to obtain mental health assistance.
9. Refer parents to local community mental health treatment that the school has previously identified and explain what parents can expect in seeking treatment.
10. Key questions to ask community service providers to determine their competence in suicide assessment and management are outlined in Tool 28a.
11. Clarify the role of the schools and the follow-up that will be done at school.
12. Persuasively request that parents sign a release of information form so that designated school personnel can speak directly with community mental health professionals. State clearly that you will be checking with the student and their parents to verify that community-based mental health services were obtained.
13. Document all actions on Tool 19 that include having parents sign parent notification of suicidal concern form (Tool 18). If parents refuse to sign the notification form, ask another staff member to witness their refusal.

Getting It Wrong

Many students suspected of being suicidal deny having thoughts and plans when directly asked. **It is critical to understand that the notification process must advance, even when a child denies being suicidal.** Parent notification is not a discretionary duty. It is a ministerial required duty! In 2013, the White Pass School District in Washington settled a case with student denial of suicide to the counselor (Boehme vs. White Pass). The key issue was the counselor did not notify the student's guardian after a peer reported that the student was part of a suicide pact and had written a suicide note. The counselor chose not to develop a safety plan nor notify his guardian, based on the student's response. The student died by suicide later that day. Scott Poland was an expert witness on the side of the plaintiff.

Getting It Right

Suicidal thoughts for students often wax and wane. It is important for school personnel and community providers to monitor suicide risk with students who are known to be previously or currently suicidal. Most suicidal students will not be hospitalized, which is why it is very important for school personnel, such as school counselors, to monitor the student closely. If a student has been hospitalized, utilize Tool 20, which outlines steps for reentry and follow-up. This involves close communication with the student, parents, and the community mental health provider as well as the student's teachers.

Teachers need to know the warning signs of suicide and alert the counselor of any behavioral changes for the student. The counselor should check in with the student at least once a week after hospitalization. At this time, ensure that a safety plan (Tool 17) is still in place and the student has a copy. It is expected that students may continue to have thoughts of suicide. Because of this, the student should be asked if there is anything else he or she wants to add to the plan to keep him or her safe. The counselor should ask direct questions. If a student has suicidal thoughts, all procedures outlined in Tool 16, the Suicide Risk Report, should be followed, and the school administrator should be notified.

Transfer of Responsibilities to Parents: Notification and Making the Call

Failure by a school to notify parents or guardians when there is any reason to suspect that the student may be suicidal is the most common source for lawsuits. School personnel have an obligation to notify parents even if the information received was second hand and the student suspected of being suicidal denied it. Denial is common. The challenge for school personnel is to get a supportive reaction from parents, increase supervision of the student, and obtain needed community-based mental health services for the student.

What Do You Do If Transfer of Responsibilities Is Not Possible?

- **If the parents are believed to be abusive** or if they refuse to obtain recommended mental health treatment in the community, **then the Florida Department of Children and Families should be notified.**
- If parents refuse to come to school to meet with school personnel and/or pick up the child, school staff cannot allow the student to walk home or take transportation home regardless of the parent directive. In 2013, a Maryland school district (*Amory vs. Howard County*) settled out of court with the parents of a student who died by suicide who was allowed to walk home at parent request after the school notified the

parents that the student was suicidal. Parents or guardians must pick up the student and engage in a conference with the designated school staff member who will provide details of school assessment and available community mental health resources. **If parents emphatically refuse to come to school, then law enforcement, the Florida Department of Children and Families, and mobile crisis teams need to be notified and used.** It may be necessary to initiate the Baker Act (Tool 30).

Confidentiality Exceptions

While mental health personnel are expected to uphold confidentiality, there are exceptions. If a school staff member suspects suicidal ideation or behavior of a student, it should be considered an emergency, and information may be shared with staff members for safety reasons according to FERPA. **The parents of students who are 18 years or older must still be notified.** This was a key issue in the *Gallagher vs. Bader* case in 2016 from Loudoun, Virginia, as the student who denied suicidal behavior was 18 years old. The counselor did not notify his parents and the student died by suicide three weeks later. The counselor was personally sued. The key issue was that Virginia law stated parents only have to be notified if the suicide is believed to be imminent. Scott Poland was an expert witness for the plaintiff.



Community Resources and Reentry Notes

School counselors would likely be the appropriate personnel to follow up with the family and student to inquire if outside services are being rendered, but an administrator or even a teacher in the smallest districts of Florida may need to fulfill this role. **It is also strongly recommended that the release of information section (Tool 18) be signed by the parents to allow the school to communicate with outside practitioners such as therapists and medical personnel.** Parents may be reluctant to sign a release of information form, but school counselors are encouraged to explain why sharing information is in the student's best interest.

One of the challenges for school personnel, and especially school counselors, is how to refer suicidal students to private practitioners, agencies, and hospitals where the professionals are well trained in suicide assessment and management. A parent once commented to Scott Poland, "I took my son to a psychologist as the school recommended but was told not to worry as my son was exhibiting typical teenage behavior and two weeks later he died by suicide!"

Florida school counselors should refer to professionals that they know are well trained and competent in suicide assessment and management. **Potential community-based health care providers need to be asked about their training and experience in suicide assessment and management, especially with a school-age client.** Key questions to ask the potential health care providers are in Tool 28a. The school is not responsible for the cost of treatment. The parent notification form reinforces this practice (Tool 18).

Student Reentry After Hospitalization for Suicidal Behavior

The reentry process and follow-up of a student who has been hospitalized for suicidal behavior is extremely important. Key school personnel

such as the counselor or the suicide prevention expert should carefully monitor the student's behavior, as there is a great need for continuing mental health care and assessment of suicide risk. A comprehensive suicide risk-monitoring tool is available in the book *Suicide in Schools* by Erbacher, Singer, and Poland, 2015. A revision of this book is expected in 2021.

The counselor or suicide prevention expert should review the reentry checklist available in Tool 20 as they address the following considerations with the student and his or her parents:

- The student will likely feel very overwhelmed by all of the missed assignments and instruction while they were hospitalized. Empathy and compassion are recommended in this situation. **Educators are encouraged to reduce academic expectations and extend timelines for missed assignments.**
- The suicidal student's teachers need to know that depression and suicide are of concern. **Discussion as to why the student has been suicidal or possible contributing factors such as losses, family issues, mental illness or bullying are to be avoided,** with the emphasis on teachers simply acknowledging depression and suicide as a concern and knowing the importance of being alert to further warning signs of suicide. In the event the teacher becomes concerned about a student's suicidal behavior, the teacher should escort the student to the counseling office for immediate attention.
- **Key school personnel such as counselors should meet weekly for at least a month** with a student returning from a hospitalization due to suicidal behavior. Suicide assessment is not a single event and requires careful follow-up at school and coordination with community mental health providers.

Section 3

Postvention After a Suicide

Overview

Postvention is a series of helpful acts that focus on assisting the survivors of a suicide, and it is a very challenging time for schools. Postvention activities in schools must focus on helping everyone with their shock, grief, confusion, and even guilt. **A primary goal of postvention is to prevent further suicides**, as unfortunately adolescents are the most prone to imitate suicidal behavior, and suicide contagion has led to suicide clusters in a number of school communities.

The U.S. Department of Education (USDOE) has provided grant funding to a number of school districts that experienced suicide clusters. More information about Project SERV (Schools Emergency Response to Violence) grants are available from the USDOE. The Project SERV grant application requires that schools have data on the number of suicides, suicide attempts, suicidal students referred for community mental health services, and the number of students hospitalized. Scott Poland has helped a number of school districts obtain Project SERV funds after a suicide cluster.

If a student suicide has occurred in your student population, those who are in contact with the community, parents, and students must respond in an empathetic and factual way. But it is important to realize that the suicide of a student will likely have an effect far beyond the school he or she attended. **Research has found that school postvention efforts were often too short and focused on too few students.** The information in Tool 21 provides the steps for schools to follow after a suicide. If a student has died by suicide, school administrators should review this tool, which is based on *After a Suicide: Toolkit for Schools*.

After a Suicide: Toolkit for Schools was first published in 2011 and was revised in 2018 (afsp.org and sprc.org). The most recent toolkit is an excellent resource for schools, and educators are strongly encouraged to download and review the toolkit before a student suicide death. Scott Poland was involved in developing both of these resources.



Critical Procedures to Follow in the Aftermath of a Death by Suicide

A postvention checklist, by Scott Poland and Richard Lieberman, is available in Tool 21 and Tool 22 and provides recommendations to support students and staff members after a suicide. It also addresses the challenges that schools face and answers the most commonly asked questions. Additionally, a two-part article in the Appendices section addresses suicide contagion. **Key steps after a suicide are the following:**

1. Verify the death has occurred and determine the cause of death.
2. Mobilize the School Crisis Response Team.
3. Assess the suicide's impact on the school and estimate the level of postvention response that is needed.
4. Notify school staff in person, if possible, and provide support.
5. Encourage everyone to use the term "died by suicide" and avoid the term "committed suicide." The term "died by suicide" is more acceptable to survivors and implies that the suicide victim traveled a long road. Emphasize that no one thing or person is ever to blame for a suicide.
6. Contact the family of the suicide victim.
 - Contact should be made in person and as soon as possible, but certainly within 24 hours of the death.
 - Purposes include
 - expressing sympathy
 - offering support
 - identifying the victim's siblings and friends who need assistance
 - discussing the school's postvention response
7. Determine what information to share about the suicide.
 - Sample letters are available in the toolkit (afsp.org and sprc.org) to use as templates. Message points may include the following:
 - identifying details about the death that can be shared with others
 - discussing funeral arrangements and determining whether the family wants school personnel and students to attend
 - discussing timing of the funeral and encouraging an after-school or weekend service so parents can accompany students who wish to attend

recommendations about disclosure of the cause of death. These recommendations are found in the *After a Suicide: Toolkit for Schools* sample letter addressing the parents wish that the cause of death not be disclosed.

8. Determine how to share information about the death.

- Students should be told the truth about the cause of death in classrooms or smaller groups (not over the public address system). The focus should be on how to help the survivors with their emotions.
- The reason for the suicide died with the victim.
- Avoid details about the suicide method.
- No one person and no one thing was the cause of the suicide.
- Suicide is very complex, and mental illness is almost always involved when a suicide occurs.
- Discussion with students after a suicide should be in a group no larger than a classroom, with a school counselor leading the discussion and the classroom teacher closely monitoring student reactions.
- **No schoolwide assemblies should be held after a suicide** as it will glamorize the death, students will be unlikely to ask questions, and student reactions to the suicide will be difficult to monitor.

9. Identify students significantly affected by the suicide, provide support, and initiate referral for community services, as needed. A single exposure to suicide is unlikely to cause another student to imitate suicidal behavior, unless they were already vulnerable. Recent research has emphasized it is the less close friends with vulnerable issues that may be most at risk.

• Risk factors for imitative behavior include

- destructive facilitation or provision of lethal means
- failure to recognize suicidal intent
- feeling of guilt
- feelings of loss
- identifying with the suicide victim
- history of prior suicidal behavior
- history of psychopathology
- feelings of helplessness and/or hopelessness
- other significant life stressors or losses
- lack of internal and external protective resources

10. Conduct a staff member planning session as soon as possible. If school is not in session, use the staff member calling tree to allow staff members to work through their own issues and turn to others for help.

11. Initiate crisis intervention services.

12. Address memorial services.

- Strive to treat all student deaths the same way by creating districtwide memorialization procedures.
- Encourage and allow students, with parental permission, to attend the funeral.
- Encourage staff member attendance at the funeral to support the family and monitor reactions of students.

- Contribute to a suicide prevention effort in the community.
 - Develop living memorials, such as student assistance programs, that address risk factors in local youth.
 - Prohibiting all memorials is problematic.
 - Recognize the challenge of striking a balance between needs of distraught students and fulfilling the primary purpose of education.
 - Meet with students and be creative and compassionate.
 - Spontaneous memorials at school should be left in place until after the funeral.
 - Avoid holding funeral services on school grounds.
 - Schools may hold supervised gatherings such as candlelight memorials
 - Monitor student gatherings off campus.
 - Student newspaper coverage should follow media reporting guidelines available at *afsp.org*.
 - Yearbook and graduation dedication or tributes should all be treated the same regardless of the cause of death for the student (Tools 25 and 26).
 - Grieving friends and family should be discouraged from dedicating a school event and guided instead towards promoting suicide prevention.
 - Permanent memorials on campus are discouraged because schools need to memorialize all students the same way regardless of the cause of death. If a precedent has been set for planting a tree on campus, then it should be continued. School districts are encouraged to develop a districtwide memorialization policy.
- 13. Address social media.**
- Create a social media manager to assist the Public Information Officer (Tool 12).
 - Use students as “cultural brokers” to help faculty and staff members understand what social media platforms are currently most used by students.
 - Train students in gatekeeper roles, and specifically identify what suicide risk looks like when communicated via social media.
 - Have staff members monitor social networks and provide safe messaging when important (this may require that districts not completely block these networks). Safe messaging (Tools 25 and 26) stresses that suicide is preventable and largely the result of mental illness and that evidence-based treatments exist for mental illness.
 - Encourage parents to monitor their child’s social media.
 - Use social media to post prevention messages, information about crisis support lines, and community mental health resources with the key message that suicide is preventable.
 - Direct parents and students to the suicide prevention information on the district website (Tool 29).
 - Give students specific and helpful preventative language to include on social media.
 - Work with YouTube and Facebook to take down messages with disturbing images or language.
 - Report concerns or issues with content to Facebook.
 - Most adolescents get news from social media. Adolescents play a key role in the dissemination of information after a suicide.
 - We are learning that emotions can be spread by social media.

- Often students receive the news via social media before schools have the opportunity to tell students of the suicide in a classroom or a smaller group.
 - Schools will have more control over the message if they consider using social media to send out a factual message about the suicide. Such a message will stop rumors and promote prevention resources and the importance of adult support (this is an expansion of traditional postvention in schools).
 - Online or offline, everyone needs to know what to do to prevent suicides.
- 14.** Debrief the postvention response with school crisis team members and identify whether additional actions are needed.
- 15.** The suicide of a student over the summer break is especially challenging for schools, but school staff should reach out immediately and follow postvention best practices.
- Key personnel, such as school counselors, should do their best to monitor and support students over school vacation with phone calls and even by opening the school, as they strive for continuing mental health care in the school and the community.
- 16.** Consider what to do on the anniversary of a suicide.
- There is often an anniversary effect to suicide involving the birthday that the suicide victim would have had, the anniversary of their death, or at graduation time. School personnel are encouraged to be alert for these milestone dates, well before the anniversary date of the loss, and to reach out to students that have been identified as having the most difficulty in the aftermath of the suicide.
- 17.** Schools need to be familiar with suicide survivor groups and locate the nearest one in their area, as participation in group sessions with others who lost their loved ones to suicide is very beneficial.



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TOOL 1

Leadership Involvement Checklist

District/School Training Program Participants

- ✓ administrators, counselors, psychologists, school resource officer (SRO), nurses, social workers
- ✓ teachers and teachers' assistants (classroom professionals)
- ✓ office support staff members (secretaries, attendance clerks, etc.)

Strongly Recommended Additional Personnel

- ✓ ancillary staff members (custodians, cafeteria workers, maintenance and security staff members, bus drivers and attendants, part-time staff members)

Training Recommendations

- ✓ Provide suicide prevention training as recommended by Florida legislation (at a minimum) and based on best practices
- ✓ Mental health personnel should train administrators and crisis response designees on the use of mental health services.
- ✓ Every administrator and crisis response designee should receive suicide prevention and intervention training at least once per year.
- ✓ Every classroom professional must receive this training once per year.
- ✓ Staff members entering mid-year or after training has been conducted must be provided training upon employment.
- ✓ Time spent on suicide prevention training and activities must be documented.
- ✓ A pre- and post-training survey (Tool 5) is recommended for identifying degree of understanding and confidence in implementing a suicide awareness culture.

- ✓ All school personnel have completed the recommended annual suicide prevention training for documentation form (Tool 4).
- ✓ All parents have been provided access to the suicide prevention information and the district /school intervention and response information that is posted on the district website (Tool 29).
- ✓ All supervisory personnel in interactive roles with students have completed suicide prevention and intervention training.
- ✓ Student suicide prevention information that promotes prescribed response and suicide prevention lifelines resources has been reviewed and discussed for age appropriateness.

Depression Screening and Identification Procedures

- ✓ All crisis response designees have been educated about the district/school prevention and response procedures and have considered the use of depression screening with secondary students and parent permission procedures. More secondary students will be able to participate in depression screening if passive parental permission procedures are utilized.

Crisis Response Team

- ✓ The district/school has access to a fully trained Crisis Response Team.
- ✓ The district/school has documented and shared with school community the staff roles in the suicide prevention and intervention process.

Communication of Suicide Prevention and Intervention Information

- ✓ information for School Board (Tool 6)
- ✓ information on district or school website (Tool 29)
- ✓ letters to staff members, students, parents, local mental health resources
- ✓ meetings with faculty members, students, parents, local resources

Documentation

- ✓ monitored suicide statistics, tracked suicide prevention training, and confirmed implementation of suicide prevention efforts
- ✓ data kept on the number of students who died by suicide, attempted suicide, or were hospitalized for suicidal behavior; the number of reentry meetings held at school; and the number of suicidal students referred for community based mental health services (Tool 32)



TOOL 2

Leadership Involvement: Recommended District Action Steps

1. Review the suicide prevention information from the Florida Department of Education including how Florida schools can become Suicide Prevention Certified and share them with all building principals.
2. Form a district task force on suicide prevention that includes representatives from the community and ensure that it meets at least twice a year and keeps up with current trends and the incidence of youth suicide.
3. Review previous school responses to suicidal students for lessons learned.
4. Identify mental health resources and treatment facilities in your community and region and identify providers who are competent in suicide risk assessment and management with suicidal youth (Tool 28a and 28b).
5. Develop district procedures and guidelines for intervention with suicidal students, parent notification, and referral and follow-up services at school for suicidal students.
6. Identify local and state resources for suicide prevention and meet with their representatives in person or by conference call to improve collaboration.
7. Designate a suicide prevention expert or experts for the district. This most likely will be a counselor, social worker, or school psychologist.
8. Obtain extensive suicide assessment/intervention training for key personnel such as SMHPs that includes role-play scenarios of suicide assessment and parent notification.
9. Ensure that school counselors, social workers, and school psychologists have the needed training in suicide assessment and intervention, and that their schedule and ratio to students meets national recommendations.
10. Investigate implementing depression screening (SOS) at middle and high schools.
11. Implement programs to safeguard and support LGBTQ students.
12. Utilize best practices and prevention programs and review the recommended programs for Florida.
13. Plan and conduct annual trainings for all staff on suicide prevention and bullying prevention and recognize there is an association between bullying and suicide.
14. Implement programs to increase all students' connections to their school that includes identifying go-to trusted adults.

Review postvention procedures in this report (Tool 21) and download, *After a suicide: Toolkit for Schools* from AFSP and SPRC, and review "Challenging Time for Schools" by Scott Poland and Rich Lieberman (Tool 22).

Additional Steps to Promote a Culture of Suicide Prevention

- Create policy memos regarding staff training and intervention expectations.
- Disseminate messages from administrative leaders across the district/school.
- Ensure administrative leadership addresses suicide prevention at least once per year during in-service opportunities.
- Confirm leadership in district/schools is aware of student suicide risk assessment and procedures in order to encourage early help-seeking behavior.
- Note that leadership in the smallest and most isolated schools where no counselors are available must be comfortable with suicide assessment using the brief version of the Columbia C-SSRS (Tool 14a).



TOOL 3

Checklist for Effective School-Based Suicide Prevention Programs

Specific Training Goals

- ✓ Convey current statistics, beliefs, and attitudes about suicide in youth.
 - dispel myths about suicide
 - identify protective factors
 - stress never keeping a secret about a student's suicidal behavior
- ✓ Educate school staff members to be prepared to recognize and respond to warning signs of suicide risk.
- ✓ Promote the importance of intervention with suicidal youth and connect them with the needed help.
 - know the school response procedures (Tool 8)
 - know who the suicide prevention specialist is
- ✓ Provide information about mental health and prevention resources in your community.
- ✓ Review the information posted on suicide prevention on the district website (Tool 29).
- ✓ Convey that suicide is almost always preventable.
- ✓ Document staff attendance and understanding of key prevention concepts through pre- and post-survey.

Helpful Resources

- American Association of Suicidology—
suicidology.org
- American Foundation for Suicide Prevention—
afsp.org
- Centers for Disease Control and Prevention—
cdc.gov
- National Alliance on Mental Illness—
nami.org
- Suicide Awareness Voices of Education—
save.org
- Jason Foundation—
jasonfoundation.com
- The Trevor Project—
thetrevorproject.org
- Nova Southeastern University Suicide and Prevention Office—
nova.edu/suicideprevention
- Society for the Prevention of Teen Suicide—
sptsusa.org
- Suicide Prevention Resource Center—sprc.org
- Florida Suicide Prevention Resource Center—
sprc.org/states/florida
- Florida Department of Health, Suicide Prevention—
floridahealth.gov/programs-and-services/prevention/suicide-prevention/index.html
- Florida Suicide Prevention Coalition—
floridasuicideprevention.org
- University of South Florida Toolkit—
theguide.fmhi.usf.edu



Tool 4

Training Documentation Form

Actions Taken

| Employee Name | ID# | Suicide Awareness Training for All Staff Date of Completion | Assessment Training for Counselors and Support Staff Date of Completion | Date of Completion | Date of Completion |
|---------------|-----|--|--|-----------------------|-----------------------|
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Staff Member Development Hours Documented by: _____

TOOL 5

Pre- and Post-Training Survey

(additional questions can be added to fit the training)

Name/ID#: _____

The purpose of this survey is to collect information regarding your degree of understanding about youth suicide and confidence levels for identifying and knowing what to do in the event a student expresses or notifies you about another student's suicidal ideation.

Please circle the rating that best reflects your opinion and/or understanding of each statement. A comment space has been provided for additional information should you wish to elaborate on your response.

| Agree=1, Somewhat Agree=2, Disagree=3 | | | Additional Comments |
|---------------------------------------|---|---|--|
| 1 | 2 | 3 | 1. Suicide rates have increased for adolescents. |
| 1 | 2 | 3 | 2. Discussing suicide with a student may increase the chances of him or her attempting suicide. |
| 1 | 2 | 3 | 3. Suicide is largely inherited and is destiny. |
| 1 | 2 | 3 | 4. Suicide often occurs on a whim and without much forethought. |
| 1 | 2 | 3 | 5. Suicidal individuals don't make future plans. |
| 1 | 2 | 3 | 6. A successful student with lots of friends would not take his or her life by suicide. |
| 1 | 2 | 3 | 7. There are often no warning signs before a student takes his or her life by suicide. |
| 1 | 2 | 3 | 8. I'm confident that I can identify suicidal warning signs in my students. |
| 1 | 2 | 3 | 9. I know whom to refer a suicidal student to in my school. |

| Agree=1, Somewhat Agree=2, Disagree=3 | | | Additional Comments | |
|---------------------------------------|---|---|---------------------|--|
| 1 | 2 | 3 | 10. | I have received suicide awareness training. |
| 1 | 2 | 3 | 11. | I am aware of the suicide prevention culture in our schools. |
| 1 | 2 | 3 | 12. | I understand the Suicide Risk Assessment and Safety Chart. |
| 1 | 2 | 3 | 13. | Suicide prevention policies and procedures are clear in my school district. |
| 1 | 2 | 3 | 14. | I feel I have received enough training/information on identification of a student with suicidal ideation to alert. |

Desired answers for each question: 1-Agree, 2-Disagree, 3-Disagree, 4-Disagree, 5-Disagree, 6-Disagree, 7-Disagree, 8-Agree, 9-Agree, 10-Agree, 11-Agree, 12-Agree, 13-Agree, 14-Agree

TOOL 6

Summarized Plan for Suicide Prevention, Intervention, and Postvention

I. Prevention

School staff members will include the following: teachers, administrators, counselors, psychologists, social workers, nurses, secretaries, custodians, bus drivers, and cafeteria workers who are trained annually on suicide prevention. The training will include warning signs and commonly held myths. These key school personnel need to know the district referral procedures when a student is suspected of being suicidal. All educators have a responsibility to work together to prevent youth suicide, and youth suicide is largely the result of untreated or undertreated mental illness. Youth suicide prevention is a shared responsibility between schools and the community, and good training and planning in schools will decrease the stigma surrounding suicide and result in suicidal students being identified.

II. Intervention

The district or school provides training for key personnel such as counselors, psychologists, nurses, and social workers on conducting a suicide assessment for students suspected of being at risk for suicide. In accordance with recommendations provided by suicide prevention experts, risk assessment includes parent notification and referral for community-based mental health services, even if the suicide risk level is rated low. Parent notification will be documented, using forms in the *Florida S.T.E.P.S.* Follow-up services and monitoring at school will be provided for all students suspected of being suicidal regardless of the risk level. A reentry meeting will be conducted for any student returning from hospitalization.

III. Postvention

If the suicide of a student occurs, it is recognized as a challenging and sad time for schools. The best practices postvention procedures outlined in the *Florida S.T.E.P.S.* and the *After a Suicide: Toolkit for Schools* (2018) from the American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org) will be utilized to guide all school and district efforts to support staff, students, and parents with their shock, grief, and confusion. The district recognizes after a suicide there are increasing numbers of students who will have thoughts of suicide and following postvention best practices reduces the likelihood that further suicides will occur.

TOOL 7

Summarized Components for Comprehensive Suicide Prevention in Schools

1. Annual training on suicide prevention awareness for all staff members who interact with students is strongly recommended. This includes staff members who are custodians, bus drivers, and cafeteria workers.
2. Procedures are developed for schools on prevention, intervention, and postvention.
3. Information is posted on the school district website about warning signs of suicide, crisis helpline phone numbers, and resources and whom to contact at school if students or someone they know is suicidal.
4. Lethality assessment training is provided for school counselors, social workers, and school psychologists, often referred to as school mental health professionals. This includes a role play of initial suicide assessment, with a clear understanding that the treatment of a suicidal student needs to be done by competent community mental health providers.
5. Parent notification procedures are formalized with the goal being to secure cooperation from the parents and to have them follow through with treatment recommendations. The only exception to parent notification is when abuse is suspected; then, the proper authorities would be notified.
6. Community-based mental health professionals who are competent in suicide assessment and management are identified and listed for easy referral.
7. Information sharing between community providers, hospital personnel, and key school personnel such as administrators and counselors is facilitated. This is a challenge, as important information about a student's suicidal behavior is often hidden from schools.
8. Before a student returns to classes, a reentry meeting is held at school for any student returning from a hospitalization for suicidal behavior.
9. Data is kept about the number of student suicide deaths, number of suicide attempts, number of students referred for mental health services outside of school and whether services were actually received, the number of students hospitalized for suicidal behavior, and the number of reentry meetings held.
10. The curriculum includes best-practice, age-appropriate information about the vital role of peers in suicide prevention.

It is critical that all school personnel be trained on suicide prevention awareness before information is presented to students so that school staff members will respond appropriately to suicidal students and support suicide prevention in the curriculum. It is our hope that the next generation of Florida adults will know how to prevent suicide because they will have learned how in school.

TOOL 8

Response Procedures for a Student at Risk of Suicide

Referral Comes from a Student, Parent, or School Staff Member

School Suicide Prevention Expert

- meets with student
- assesses risk with direct inquiry and recommends removal of lethal means
- develops safety plan and provides number for crisis hotline
- notifies parents and requests a face-to-face conference immediately
- monitors student closely until parent(s) arrives
- documents all steps
- refers to Community Resources: (Note, if parents are uncooperative and refuse to get help, refer to the Department of Children and Families.)

School Suicide Prevention Expert

- conducts a reentry meeting with student and parent(s)
- conducts a reentry meeting with appropriate staff members if student missed school or was hospitalized
- ensures school staff members and especially teachers are alert to future warning signs of suicide
- follows up daily/weekly face-to-face meetings (depending on severity but weekly minimum)

Community Resources

- pre-identified/approved list of well-trained community providers and available resources
- treatment by community provider
- parent provides release form for community provider to share information with school suicide prevention expert

TOOL 9

Common Myths About Youth Suicide

Florida educators must address the many myths of suicide in order to increase prevention efforts. It is essential that educators know the facts and not hold on to the myths. Questions about suicide and related topics that Scott Poland has been asked by parents, educators, and students are in Appendix 3 along with answers.

Myth: If I ask a student about suicidal ideation, I will put the idea in his or her head.

Fact: Asking someone about suicide will not make him or her suicidal. In fact, if they are suicidal it provides an opportunity for the student to unburden himself or herself and learn sources of assistance. If they are not having suicidal thoughts, then the conversation provides an opportunity to talk with them about what to do if they or a friend ever do have suicidal thoughts.

Myth: There is a single cause or a simple reason for a youth suicide.

Fact: The suicide of a young person is very complex and the result of many factors, and they have often traveled a long road and had significant mental health problems and experienced many traumatic events.

Myth: If a student really wants to die by suicide, there is nothing I can do about it.

Fact: Suicide is preventable. Even students at the highest risk for suicide are still ambivalent about desiring death and desiring life. Most of all they want things to change.

Myth: Students who talk about suicide all the time are not actually suicidal, therefore you don't need to take the statements seriously.

Fact: Youth who make suicidal statements typically have some risk for suicide. About 80 percent to 90 percent of persons who died by suicide expressed their intentions to one and often more than one person. All suicidal statements should be taken seriously.

Myth: Suicide usually occurs without warning.

Fact: A person planning suicide usually gives clues about his or her intentions, although in some cases the clues may have been subtle.

Myth: A suicidal person fully intends to die.

Fact: Most suicidal people feel ambivalent toward death and arrange an attempted suicide at a place and time in the hope that someone will intervene.

Myth: Suicidal individuals do not make future plans.

Fact: Many individuals who died by suicide had future plans; for example, they had planned future activities and trips.

Myth: Those who died by suicide almost always left a note.

Fact: About 75 percent of suicide victims did not leave a note.

Myth: Young people engaging in self-injury such as moderate superficial cutting or burning their body will not attempt suicide.

Fact: Young people engaging in self-injury may acquire the ability for a suicide attempt as they become comfortable with—and used to—harming themselves.

Myth: If a person attempts suicide once, he or she remains at constant risk for suicide throughout life.

Fact: Most individuals who survived a suicide attempt do not make further attempts. Suicidal behavior is often very situational.

Myth: If a person shows improvement after a suicidal crisis, the risk has passed.

Fact: Most suicides occur within three months or so after the onset of improvement, when the person has the energy to act on intentions, say goodbyes, and put their affairs in order.

Myth: Suicide only occurs in certain races and socioeconomic levels.

Fact: Suicide crosses all racial and socioeconomic boundaries.

Myth: Suicide is inherited.

Fact: Suicide can run in families, but it is not an inherited trait. Having a family member who has died by suicide creates only a slightly elevated risk.

Myth: All suicidal individuals are mentally ill, and only a psychotic person will commit suicide.

Fact: Most but not all suicide victims were mentally ill.

Myth: If a suicidal individual is stopped from using one method, they will find another way to die by suicide.

Fact: Research has documented that if a specific method is removed and not available, suicidal individuals are very unlikely to seek another method. The Means Matter website from the Harvard T.H. Chan School of Public Health provides extensive research that removing the lethal means such as a gun and raising the barrier on bridges has decreased suicides. More information is available at hsph.harvard.edu/means-matter.



TOOL 10

Additional Risk Factors Related to Suicidal Ideation

Learning Disabled Youth

Students with learning disabilities (LD) are well-acquainted with academic difficulty and maladaptive academic behavior. Compared to students without LD, they exhibit high levels of learned helplessness, including diminished persistence, lower academic expectations, and negative affect. Social behavioral research has found an increased risk for suicide among students with LD that is linked to depression, feelings of hopelessness, and isolation or rejection from the mainstream.

Sleep Deprivation in Adolescents

A growing body of research shows that many adolescents are sleep-deprived. Even though adolescents require as much as 8 to 10 hours of sleep at night, according to the National Sleep Foundation they simply are not wired to retire early to bed and have difficulty falling asleep before 11:00 p.m. In addition, cell phone calls and messages may awaken them during the night. Most American secondary schools begin as early as 7:30 a.m. Numerous studies have addressed the harmful effects of sleep deprivation on adolescents and found a significant relationship between sleep deprivation and suicide completion for adolescents. Scott Poland responded to suicide clusters in both the Fairfax County and the Palo Alto Schools, and many community concerns were voiced about the lack of sleep for adolescents as a contributing factor for depression, hopelessness, and suicide. The Fairfax County Schools changed the start time of the high school day to 8:00 a.m. or later.

Non-Suicidal Self-Injury (NSSI)

The most common forms of NSSI are cutting, burning, scratching the skin, and not letting wounds heal. The incidence of NSSI has increased for youth, and the primary theories to explain why they engage in this behavior are to release endorphins or to regulate emotions. NSSI is a complex coping behavior that fulfills a multitude of needs for those that engage in it. NSSI is a strong predictor of suicide as students are essentially practicing harming themselves and schools need to develop training and protocols for staff to help them better understand and respond to NSSI. Key personnel such as school counselors need to be familiar with the most effective treatments.

Depressed Youth

Research has found that approximately 20 percent of all teenagers suffer from depression at some point during their adolescence, and most do not receive treatment. While suicidal ideation isn't imminent for every student who experiences depression, it is the most common indicator in suicidal youth. Students may appear irritable, tearful, down, or sullen, and not find pleasure in the activities they previously enjoyed. The key to distinguishing depression from normal teenage behavior is whether it is persistent (more than several weeks) and pervasive, meaning that it affects all aspects of their life (academic, social, and family). Younger children may express depression through somatic complaints such as headaches, bad feelings in stomach, etc. School personnel should know the incidence of depression, be alert to students' shifting moods, and access community mental health resources. It is particularly important to pay attention to themes of hopelessness and

depression in students' writing and artwork and to alert key personnel such as counselors and administrators when such themes are noted.

Precipitating Event

This has been referred to as the “straw that broke the camel’s back,” meaning that the student was previously suicidal and one more thing he or she could not cope with has caused him or her to act on previous suicidal plans. School personnel should be alert for the following stressful events that might trigger a suicide attempt: romantic breakup, severe argument with family or friends, recent loss of loved one (including a pet), being a victim of bullying or severe humiliation, school failure, loss of a dream such as not making a school team or rejection from college of choice, severe school discipline, or arrest/incarceration. It is important that school personnel be alert for all of these precipitating events but especially for students in serious disciplinary trouble, as some parents whose children died by suicide and had been punished by school administration for serious infractions, have claimed that the punishment contributed to their child’s suicide. If a student is being expelled from school, the school should offer counseling immediately, before the student leaves the campus. One such case from 1995, *Szostek vs. Fowler and Cypress-Fairbanks School District*, was decided in favor of the Texas school district, but lessons from this case include that we should realize that a severe discipline sequence could precipitate a suicidal student’s actions. Administrators must be careful to offer support such as counseling, communicate with the student and parents that they still care about the student, and ask parents to increase the supervision of their child. An administrator in Virginia commented to Scott Poland that she will always be haunted by the thought of the student she expelled. The student went home after the expulsion hearing and died by suicide. This administrator said she now always has a counselor standing by when conducting an expulsion hearing.

Adverse Childhood Experiences

Approximately one-third of adults who were physically abused in childhood have seriously considered taking their own life—a rate that is five times higher than adults who were not physically abused in childhood. The research suggests suicide may have developmental origins relating to abuse—that physical or sexual abuse may lead to changes in the stress response in the brain which increase the risk of suicidal thoughts and behavior. Other key factors for adverse childhood experiences for youth are living in poverty; neglect; parental rejection; living in foster care; emotional, physical, or sexual abuse; loss of a parent; and living with mentally ill or substance-abusing family members. Students who have adverse childhood experiences are in need of a great deal of support and continuing mental health care.

Relationship Between Bullying and Suicide

The media unfortunately coined the term “bullycide” to strongly imply that the bullying that the victim received caused his or her suicide. Students involved in bullying, as a victim or bully, are at a significantly higher risk for depression and suicide. Furthermore, the more frequently an adolescent was involved in bullying, the more likely that he or she was depressed, had feelings of hopelessness, had serious suicidal ideation, or had attempted suicide. Internalizing problems (which includes withdrawal, anxiety, and depression), low self-esteem, low assertiveness, aggressiveness early in childhood, and possible rejection by peers and social isolation are personal characteristics that increase a youth’s likelihood of being bullied as well as risk factors for suicidality. Further, LGBTQ students are often stigmatized and bullied in school and are more likely to attempt suicide as well. Knowing the frequency of bullying that occurs in schools and these statistics that illustrate the connection between bullying and suicide, it only makes sense for schools to thoroughly screen for suicidal thoughts and behaviors when addressing bullying (Suicide Prevention Resource Center, *Brief on Suicide and Bullying*, 2011).

Cultural Factors

Culture plays an important dynamic in the thoughts of a suicidal student, the approach used with his or her family, and resources that might be recommended. Especially in the aftermath of a death by suicide, school personnel should be sensitive to the cultural beliefs of the family and the student population, and great care should be taken to seek out personnel and resources that are a good match for the needs of the family during intervention and/or postvention. It is especially noted that Native American youth have a high suicide rate, and Florida educators need to be very familiar with tribal customs and practices. For example, Native American families may be less willing to talk to mental health professionals and may prefer support from medical personnel or tribal leaders.

Impact of Experiences and Personal Resiliency

A young person develops the feeling of self-worth, control, and positivity by a total of the events and experiences in his or her life. Scott Poland was trained in the Covey model that emphasized students have an emotional bank account. When good things happen for students—good grades, friendships, engaging activities—chips are placed in the emotional bank account. When bad things happen—bad grades, breakups with friends, isolation, death of friend or family member—chips are withdrawn. Research reflects that a young person's ability to bounce back from trauma or stress, to adapt to changing circumstances, and to respond positively to difficult situations is proportional to their resilience. Research has found that the keys for resiliency for youth include being surrounded by caring and supportive family and friends, remaining optimistic about the future, utilizing problem-solving skills, as well as having the opportunity to express strong emotions. On the opposite end of the spectrum is the student

who has a diminished sense of self-worth, is unable to cope, is socially withdrawn and/or is unable to handle life stressors, and lacks a support network. Family and school environments that are supportive and caring will enhance resilience, while lack of family support or exposure to abuse or trauma may make a student vulnerable.

Protective Factors that Decrease Youth Suicidal Behavior from the Suicide Prevention Resource Center

sprc.org/sites/default/files/migrate/library/RiskProtectiveFactorsPrimer.pdf

- family cohesion and stability
- coping and problem-solving skills
- positive self-worth and impulse control
- positive connections to school and extracurricular participation
- academic success
- good relationships with other youth
- ability and willingness to seek adult help when needed
- lack of access to suicidal means
- access to mental health care
- religiosity
- school environment that encourages help seeking and promotes health
- early detection and intervention

TOOL 11

Facts About Suicide and Mental Disorders in Adolescents

After a Suicide: A Toolkit for Schools (2018)

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 80 to 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. Tool 31 provides more information on the most common warning signs of suicide.

Warning Signs of Suicide

- 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

Source: Suicide Awareness Voices in Education (save.org)

Tool 12

Social Media Notes

Social media use among youth is extensive and has a significant impact on their lives. Many parents have shared that social media is consuming the lives of their children, especially adolescents who are on social media almost constantly. Because social media is where our youth are spending many hours daily, we must be attuned to their interactions.

The need for adult involvement is clear. Young people who use social media are more likely to communicate their emotional distress online than to an adult. School personnel are encouraged to keep up with social media platforms and know the best practices to not only educate youth, but to model responsible use of social media. We recommend that someone on the Suicide Prevention Task Force be responsible for keeping up with social media best practices to be prepared to educate students and staff on appropriate media use and the latest most-used platforms. The U.S. Department of Health and Human Services released a statement in 2019 which explains that social media becomes a tool or a risk for teens' health based on how they use it, which is in turn shaped by the guidance they get from caring adults.

The risks and potential effects of social media are very important for school mental health professionals to be aware of, and school IT professionals can be helpful in keeping SMHPs up-to-date on social media. While estimates suggest that 18 people are profoundly affected in the aftermath of a suicide of someone they knew, the estimated number of people who are in some way affected has expanded to 135 people. Social media has increased the number of people exposed to a suicide, as it is the primary method in which teens are exposed to suicidal content. It is important to know the implications that go with the increased use of social media by teens.

Lieberman, Poland, and Niznik have written articles on this topic, published in the National Association of School Psychologists *Communiqué*, and all readers are encouraged to review them. Part 1 can be found through the following citation: Niznik, M., Poland, S., & Lieberman, R (2019). "Adolescent Suicide Prevention in the Context of Social Media," "Part 1: Overview" *Communiqué*, 48 (3), 1, 28-30.

Part 2 can be found through the following citation:

Niznik, M., Poland, S., & Lieberman, R. (2019). "Adolescent Suicide Prevention in the Context of Social Media," "Part 2: Suggestions." *Communiqué*, 48 (4), 1, 17-20.

Social media is always changing, and it is important for school personnel and parents to do their best to keep up with the latest trends, applications, and social networking platforms.

Benefits of Social Media

- Responsible reporting about suicide helps to educate the public, encourages those at risk of suicide to take alternative actions, and inspires a more open and hopeful dialogue about prevention (WHO, 2017).
- Vulnerable youth find each other through social media, which allows teens to connect (Joiner, 2010). This means teens may have the benefit of sharing experiences and emotions, as well as receiving and providing support to each other and understanding the necessity of obtaining adult help if they or a friend are suicidal.
- Social media provides a place to reduce the stigma about seeking mental-health services.
- Social media can play a very important role in prevention, as many platforms provide suicide-prevention resources and screen for suicidal terms posted by content users.

Risks of Social Media

- About 60 percent of individuals ages 14 to 24 are exposed to suicide-related content through Internet sources (Dunlop, More, and Romer, 2011).
- Unfortunately, digital media, such as the news, television, and movies, may encourage suicide when the suicide of the victim is glamorized and details of the suicide are provided.
- Social media gives voice to pro-suicide groups that portray suicide as a solution and an acceptable option, which may normalize and encourage suicide for a troubled individual.
- Social media can encourage a variety of behaviors such as cyberbullying, and 14.9 percent of students reported that they had been electronically bullied through texting or social media sites (CDC, 2018).
- Emotional negativity can be spread much more quickly and to more recipients on social media than through interactions in person.
- Other negative effects may include:
 - Access to suicidal images or methods that may normalize suicidal behavior and increase contagion.
 - The propensity for inaccurate information about suicide to circulate and be viewed (U.S. Department of Health and Human Services, 2019).

Social media platforms commonly used by teens involve the sharing of content that is created by the users (in this case, adolescents) rather than media professionals. This highlights the need to expand safe messaging guidelines to incorporate creators of content (adolescents) on social media. It is important for school personnel to not only model responsible social media usage, but to educate our youth on how to communicate about suicide appropriately on social media. This means emphasizing that suicide is preventable and that the intervention of one young person knowing the importance of seeking adult help can make all the difference to save a life.

Best Practices for Social Media

1. Educate users on creating content.

In the creation of any content, we need to teach our youth how to relay effective and safe messages to their audience. As a natural extension, safe messaging guidelines regarding reporting content relating to suicide via digital media (news, blogs, and networks over the Internet) have also been recommended. They include:

- a . Avoid hyperlinking of suicidal material, such as video or audio footage (e.g., emergency calls) or links to the scene of a suicide, especially if the location or method is clearly presented.
- b . Avoid using pictures of a person who has died by suicide.
- c . Avoid harmful wording in headlines.
- d . Avoid data visualizations or sensationalizing statistics about suicide (WHO, 2017).
- e . Do not use language that normalizes suicide or implies that it solves problems (WHO, 2017).
- f . Do not provide details about the location of the suicide.
- g . Do include information about the warning signs of suicide and where to seek help.

2. Teach teens how to help other teens.

Many of the existing gatekeeper programs provide important information to students about safe messaging through social media and teach teens the suicide warning signs. Research shows that stigmatizing attitudes about suicide can be replaced with empathy, understanding, and the ability to reach out to those in need to let them know they are not alone and there is help available. Moreover, by educating our teens about suicide prevention they will know how to communicate effectively, help one another, and understand the importance of receiving adult help.

3. Proactively provide resources.

Throughout the school year (concurrent with anniversary dates of traumatic events, or before long holiday breaks), schools can send links and gentle reminders to students and staff regarding suicide warning signs, methods to increase resilience and coping, and reminders about safe messaging. Suicide prevention articles and resources should be posted on social media when most needed, in addition to traditional formats such as prevention posters in school hallways and flyers in the counseling office.

In the future, we expect social media to have an even greater impact. We all need to be aware of the influence that social networks have on our youth. We encourage school districts and SMHPs to keep up with the research on the impact of social media and to be aware of harmful information and messages that are posted.

For more information on how to relay safe messages about suicide in the media, please visit the following link from the World Health Organization: apps.who.int/iris/bitstream/handle/10665/258814/WHO-MSD-MER-17.5-eng.pdf?sequence=1.



Tool 13

Increasing Parental Involvement and Awareness of Youth Suicide Prevention

Section 2 of this Toolkit outlines practical steps for schools to follow for a parent notification and referral for community-based services when a student is suspected of being suicidal. Appendix 3 provides answers to the most frequently asked questions by parents, educators, and students about suicide prevention and mental health. Tool 29 also provides an overview of information about suicide prevention that is recommended to be posted on every school district website in Florida. It outlines warning signs, crisis helpline numbers, and most importantly whom to contact at your child's school if you believe your child is suicidal.

Since suicide is the second-leading cause of death for 10- to 34-year-olds nationally, schools are encouraged to include warning signs of depression and suicide in a variety of presentations to parents. For example, during a program for parents about the high-school graduation plan, a few minutes should be set aside to outline key warning signs for depression and suicide.

Epidemiology studies done by the Centers for Disease Control and Prevention (CDC) in the aftermath of youth clusters have found that parents were slow to recognize their child's mental illness and did not obtain the needed treatment. Parents need to know that suicide is almost always the result of untreated or undertreated mental illness and that evidenced-based treatments exist for all mental illnesses. The parents of adolescents in particular may think that their child's moodiness and irritability are typical of being a teen, but three questions need to be considered:

1. Has this behavior gone on for several weeks or more (persistent)?
2. Is the behavior affecting all aspects of their life, school, friends, and family (pervasive)?
3. Have they dropped out of previously enjoyed activities? For example, a student did not want to be on the dance team this year, but she had done it for years and really enjoyed it.

Warning Signs of Suicide: The warning signs of suicide are further outlined in Tool 31.

- 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

Source: Suicide Awareness Voices in Education (save.org)

Presentations and Prompts for Parents

Additionally, schools are encouraged to provide developmentally appropriate presentations regularly for parents of children of all ages that emphasize being involved in their child's life, knowing their child's friends and the friends' parents, recognizing the signs of anxiety and depression, separating their child's misbehavior from their worth as a person, recognizing technology is a privilege and not a right, ensuring technology-free times in their homes and regularly eating meals as a family, avoiding putting children in the middle of divorce, realizing the importance of both parents staying involved in their child's life regardless of the circumstances of separation or divorce, and modeling coping during difficult times.

Parents are encouraged to have deep conversations with their children about what is going on in their lives and to be careful not to question too much but focus instead on listening. **Parents who have any reason to think their child might be suicidal are encouraged to ASK them directly about hopeless and suicidal thoughts.**

Scott Poland has a presentation for parents of children of all ages entitled "Parenting in a Challenging World" that can be emailed to school personnel in Florida upon request. He can be contacted at spoland@nova.edu. He frequently presents on parenting, and more than 2,000 parents in Pembroke Pines, Florida attended his presentation on "Raising Positive Children." It is available at youtube.com/watch?v=gObY3C97JW4.

Specific Suicide Prevention Videos for Parents

Society for the Prevention of Teen Suicide has an 18-minute video for parents entitled *Not My Kid*, which is available free at sptsusa.org/not-my-kid.



Tool 14a

Suicide Assessment: C-SSRS Brief Screening

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

| SUICIDAL IDEATION DEFINITIONS AND PROMPTS | Past Month | |
|--|------------|----|
| Ask questions as grouped and check yes or no for each statement. | YES | NO |
| Ask questions 1 and 2. | | |
| 1) Have you wished you were dead or you could go to sleep and not wake up? Person endorses thoughts about a wish to be dead or not alive anymore or to fall asleep and not wake up. (Ideation: Wish to be dead) | | |
| 2) Have you actually had any thoughts of killing yourself? General non-specific thoughts of wanting to end one's life/die by suicide, "I've thought about killing myself" without general thoughts of ways to kill oneself/associated methods, intent, or plan. (Ideation: Suicidal thoughts) | | |
| If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6. | | |
| 3) Suicidal thoughts with method (without specific plan or intent to act): Person endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place, or method details worked out. "I thought about taking an overdose, but I never made a specific plan as to when, where, or how I would actually do it, and I would never go through with it." (Ideation: Suicidal thoughts with method—without specific plan or intent to act) | | |
| 4) Have you had these thoughts and had some intention of acting on them? Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "I have the thoughts, but I definitely will not do anything about them." (Ideation: Suicidal intent—without specific plan) | | |
| 5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. (Ideation: Suicidal intent with specific plan) | | |

| SUICIDAL IDEATION DEFINITIONS AND PROMPTS | Past Month | |
|--|---------------|----|
| Ask questions 6. | YES | NO |
| 6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? <i>Examples:</i> collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. (Ideation: Suicide behavior) | Lifetime | |
| | | |
| | Past 3 Months | |
| | | |
| If YES, ask: Were any of these in the past 3 months? | | |

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information, contact Kelly Posner, Ph.D.
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Tool 14b

Suicide Assessment: SAFE-T Protocol with C-SSRS Screening

Suicide Assessment Five-step Evaluation and Triage

Use in conjunction with the C-SSRS Brief Screening questions (Tool 14a).

Step 1: Identify Risk Factors (based on reports and observances during the brief screening)

Current and Past Psychiatric Dx

- ☐ Mood disorder
- ☐ Psychotic disorder
- ☐ Alcohol/substance abuse disorders
- ☐ PTSD
- ☐ ADHD
- ☐ TBI
- ☐ Cluster B personality disorders or traits (i.e., borderline, antisocial, histrionic, and narcissistic)
- ☐ Conduct problems (antisocial behavior, aggression, impulsivity)
- ☐ Recent onset

Presenting Symptoms

- ☐ Anhedonia
- ☐ Impulsivity
- ☐ Hopelessness or despair
- ☐ Anxiety and/or panic
- ☐ Insomnia
- ☐ Command hallucinations
- ☐ Psychosis

Family History

- ☐ Suicide
- ☐ Suicidal behavior
- ☐ Axis I psychiatric diagnoses requiring hospitalization

Precipitants/Stressors

- ☐ Triggering events leading to humiliation, shame, and/or despair (e.g., loss of relationship, financial or health status) (real or anticipated)
- ☐ Chronic physical pain or other acute medical problem (e.g., CNS disorders)
- ☐ Sexual/physical abuse
- ☐ Substance intoxication or withdrawal
- ☐ Pending incarceration or homelessness
- ☐ Legal problems
- ☐ Inadequate social supports
- ☐ Social isolation
- ☐ Perceived burden on others

Change in Treatment

- ☐ Recent inpatient discharge
- ☐ Change in provider or treatment (e.g., medications, psychotherapy, milieu)
- ☐ Hopeless or dissatisfied with provider or treatment
- ☐ Noncompliant or not receiving treatment

- ☐ **Access to Lethal Methods:** Ask specifically about presence or absence of a firearm in the home or ease of accessing.

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

Internal

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

External

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

Step 3: Specific Questioning about Thoughts, Plans, and Suicidal Intent (Reference brief screening results from tool 14a.)

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

| C-SSRS Suicidal Ideation Intensity (with respect to the most severe ideation 15 identified above) | Month |
|---|-------|
| Frequency <i>How many times have you had these thoughts?</i> (1) Less than once a week (2) Once a week (3) 2–5 times in week (4) Daily or almost daily (5) Many times each day | |
| Duration <i>When you have the thoughts, how long do they last?</i> (1) Fleeting—few seconds or minutes (2) Less than 1 hour/some of the time (3) 1–4 hours/a lot of time (4) 4–8 hours/most of day (5) More than 8 hours/persistent or continuous | |
| Controllability <i>Could/can you stop thinking about killing yourself or wanting to die if you want to?</i> (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts | |
| Deterrents <i>Are there things—anyone or anything (e.g., family, religion, pain of death)—that stopped you from wanting to die or acting on thoughts of suicide?</i> (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply | |
| Reasons for Ideation <i>What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words, you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge, or a reaction from others? Or both?</i> (1) Completely to get attention, revenge, or a reaction from others (2) Mostly to get attention, revenge, or a reaction from others (3) Equally to get attention, revenge, or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply | |
| Total Score | |

Step 4: Guidelines to Determine Level of Risk and Develop Interventions to LOWER Risk Level

“The estimation of suicide risk, at the culmination of the suicide assessment, is the quintessential **clinical judgment**, since no study has identified one specific risk factor or set of risk factors as specifically predictive of suicide or other suicidal behavior.”

From the American Psychiatric Association’s *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors*, page 24.

| RISK STRATIFICATION | TRIAGE |
|---|---|
| High Suicide Risk Suicidal ideation with intent or intent with plan in past month (C-SSRS Suicidal Ideation #4 or #5) OR Suicidal behavior within the past 3 months (C-SSRS Suicidal Behavior) | <ul style="list-style-type: none">• Initiate local psychiatric admission process.• Stay with patient until transfer to higher level of care is complete.• Follow up and document outcome of emergency psychiatric evaluation. |
| Moderate Suicide Risk Suicidal ideation with method, WITHOUT plan, intent, or behavior in the past month (C-SSRS Suicidal Ideation #3) OR Suicidal behavior more than 3 months ago (C-SSRS Suicidal Behavior Lifetime) OR Multiple risk factors and few protective factors | <ul style="list-style-type: none">• Directly address suicide risk, implementing suicide prevention strategies.• Develop a safety plan. |
| Low Suicide Risk Wish to die or suicidal ideation WITHOUT method, intent, plan, or behavior (C-SSRS Suicidal Ideation #1 or #2) OR Modifiable risk factors and strong protective factors OR No reported history of suicidal ideation or behavior | <ul style="list-style-type: none">• Develop a discretionary outpatient referral process. |

Step 5: Documentation Guidelines

Clinical Notes

- Your risk level assessment
 - Your clinical observation
 - Relevant mental status information
 - Methods of suicide risk evaluation
 - Brief evaluation summary
 - Warning signs
 - Risk indicators
 - Protective factors
 - Access to lethal means
 - Collateral sources used and relevant information obtained
 - Specific assessment data to support risk determination
 - Rationale for actions taken and not taken
 - Provision of crisis line 1-800-273-TALK (8255)
 - Implementation of a safety plan (if applicable)
-

TOOL 14c

SAFE-T PROTOCOL OVERVIEW

Resources

- Five-step Evaluation and Triage SAFE-T Pocket Card (sprc.org)
- The Joint Commission 2007 Patient Safety Goals on Suicide (sprc.org/sites/default/files/migrate/library/jcsafetygoals.pdf)
- SAFE-T drew upon the American Psychiatric Association's *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (psychiatryonline.com/pracGuideTopic_14.aspx)
- *Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior*. Journal of the American Academy of Child and Adolescent Psychiatry, 2001, 40 (7 Supplement 24s-51s)

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

SAFE-T

Suicide Assessment Five-step Evaluation and Triage

1

IDENTIFY RISK FACTORS

Note those that can be modified to reduce risk

2

IDENTIFY PROTECTIVE FACTORS

Note those that can be enhanced

3

CONDUCT SUICIDE INQUIRY

Suicidal thoughts, plans, behavior, and intent

4

DETERMINE RISK LEVEL/INTERVENTION

Suicidal thoughts, plans, behavior, and intent

5

DOCUMENT

Assessment of risk, rationale, intervention, and follow-up

TOOL 15a

Role-Play: Suicide Assessment

The Columbia Suicide Severity Rating Scale (C-SSRS) is recommended for use during this role-play scenario.

Mary Smith Planning Scenario

A 13-year-old middle-school student, Mary, who is new to school has written on her English paper, “Hannah Baker Rocks and she showed them all. I can do it to!” Mary is referred to the counseling office and presents as unkempt, shy, with very little eye contact and a lack of affect. She initially does not want to talk, but when asked about *13 Reasons Why*, she opens up and she is fascinated by the show and how Hannah got even and watched over everyone who mistreated her and escaped a horrid life!

Mary shares serious family issues at home. She has not seen her mother since she was age eight and her father never even answers Mary’s questions about her mother. Mary wonders why her mother does not want to be involved in her life. Her father’s live-in girlfriend, Babs, yells at her frequently, and Mary thinks Babs has a drug problem, as her behavior toward Mary and her brother is so erratic. Her father works all the time in his new position in a Tallahassee law firm and has a significant commute to work each day. The father’s girlfriend does not work and is always home when Mary returns from school and is consistently on Mary about her chores. Mary had been close to her 19-year-old cousin, but she killed herself last year.

Mary did not want to move to the new school and misses her dog Buddy that her father made her leave behind as they moved to a condo that does not allow dogs. Her father says they may get a house and Buddy could come live with them, but Mary doesn’t think that will happen. She misses her old friends in St. Louis and tries to stay in touch by texting and Facebook, but her father and his girlfriend have told her repeatedly to move on and to get new friends. Mary had enjoyed participating in a church youth group in St. Louis but has no plans to attend one in Tallahassee. Mary reports

that all the eighth-grade girls at the new school are already matched up in groups and no one has really welcomed her. Mary played basketball last year on the school B team but does not think she is good enough to make the team in her new school, which is much larger than her previous one.

Her sixth-grade younger brother, John, has already made new friends and Babs is not so hard on him. Mary wonders what is wrong with her, as she is so unhappy here. Mary reports that few things are going well and that she sleeps a lot, spends most of her time at home in her room and has little appetite or energy. She is also behind on school assignments even though it is only the second week of school.

Mary admits that she has thought of cutting herself the way Hannah did and reports she has watched the show three times. Mary admits to researching suicide online and she has also thought that if she couldn’t cut herself, she could pull the trigger on a gun. Her father has one. She is not sure where it is but has thought of looking for it when no one is home.

Discussion Questions

- How many protective factors do you see for Mary?
- How many risk factors?
- Was the C-SSRS used, and if not, then was Mary asked direct questions about previous attempts, current thoughts of suicide, and if she had a specific plan to die by suicide?
- What actions need to be taken to intervene and support Mary?
- How was the need to notify her father introduced and what was Mary's reaction?
- Did the role-play of the assessment ask all the key questions?
- Was rapport established with Mary?
- Was eye contact maintained with Mary and was suicide discussed calmly with no sign of disapproval from the counselor?
- Was Mary assured she was not the first student to feel suicidal?
- Was a safety plan jointly developed?
- Did the counselor sit side by side with Mary while developing the safety plan with her?
- What did the safety plan emphasize?
- What level of suicide risk is Mary?
- What level of intervention support do you feel is warranted at this time?



Role-Play: Parent Notification

Mary Smith Uncooperative Parent Notification Scenario

The father or mother of Mary Smith, a new eighth-grade student in your school, has very reluctantly come to school for a conference with the school counselor who gave Mary's parent very little information on the phone as to why a face-to-face conference had to take place immediately (this morning); it was a long drive from his or her office to the school.

Mr. or Mrs. Smith arrives very frustrated and indicates immediately he or she did not appreciate being called to the school because he or she is an extremely busy attorney and being away from the office is costing client billable hours and, therefore, money.

Throughout the conference, he or she refuses to provide much information about how Mary is actually doing with regard to school, social life, and family. He or she is very defensive about Mary and her family life and repeatedly asks why this any business of yours. "I didn't come here to answer questions. Now who are you and why have you demanded that I come to the school?"

The parent does not take the report of Mary's suicidal plans seriously. "She's a 13-year-old girl what do you expect—teenagers are emotional and say dramatic things! She is new to the school and will make friends soon and be okay. Her younger brother is doing just fine in the new school and community. Now are we done here?"

The parent is particularly defensive when questioned about whether Mary has access to a gun at home. He or she finally admits that yes, there is a gun but there is no way she would ever touch it! The parent dismisses all requests to secure the handgun, which is for protection and kept in the nightstand. When asked about the Netflix show *13 Reasons Why*, the parent is not familiar with it and states that they could not have watched it, as

they do not have a Netflix account. The parent is not supportive of the need for any mental health services outside of school and in fact forbids the school psychologist to ever talk with Mary again.

When the question is raised that you would like the parent to sign an emergency notification form, he or she angrily refuses and further indicates that there are no plans to obtain counseling for her.

Discussion Questions

- How did the role-play go?
- Did the counselor begin by thanking Mary's parent for coming to school for a conference and emphasize that showed how much he or she cares about Mary?
- Did the counselor begin by asking for information from Mary's parent about how he or she thought Mary was adjusting to the new school?
- Did the counselor receive any helpful information?
- How did the parent respond when told that Mary was suicidal?
- Did the counselor emphasize that must be difficult information for the parent to hear?
- Was the counselor clear about what steps needed to be taken to support Mary and to get her counseling services outside of school and to prevent suicide?
- How did the counselor handle the conversation about whether a gun is available to Mary?
- Did the counselor seem judgmental at any time during the parent notification?
- Was Mary's parent asked to sign a suicide notification form?

- Was there a discussion of removing lethal means from Mary's access and the need to increase parental supervision of Mary?
- Did the counselor make a referral to community services and request that information be shared between the school and the community provider?
- Did the parent ultimately agree to obtain counseling services?
- Was follow-up at school outlined?
- If the parent notification did not go well and the parent will not seek outside services for Mary, then what steps should the school counselor take?
- Should they notify the principal and/or DCF?
- Is there a need to contact a mobile crisis team or consider a Baker Act?
- Should the counselor document the actions and seek supervisor and/or collaboration?





TOOL 16

Suicide Risk Report

Assessed Level of Risk: Low: _____ Medium: _____ High: _____ Time: _____

Student: _____ Grade: _____ School: _____

Risk Assessment Completed by: _____

Part 1—Complete in All Cases (Low–High Risk)

| Action | Yes/No | Date Time | Notes |
|--|--------|-----------|-------|
| Initial assessment (Tool 14a or 14b, completed with student) | | | |
| Safety plan (Tool 17, completed with student) | | | |
| Student counselor notified | | | |
| Designated administrator notified | | | |
| Teacher(s) notified | | | |
| Suicide response designee named | | | |
| Parents notified about child's suicidal ideation | | | |
| Parent(s) signed parent notification form (Tool 18; if no, note witness to refusal) | | | |
| Parent(s) signed information release section of same (Tool 18; if no, note witness to refusal) | | | |
| Notification steps and community referrals activated (Tool 19) | | | |

Part 2—Complete if Necessary (Medium–High Risk)

| Action | Yes/No | Date Time | Notes |
|--|--------|-----------|-------|
| Supervisor appointed to remain with student at all times (including restroom) | | | |
| Student released to a) parent or guardian, b) law enforcement, or c) psychiatric mobile crisis unit (note circumstances) | | | |
| Florida Dept. of Children and Families notified (note circumstances) | | | |

_____ Check to confirm copy provided to student's counselor, suicide response designee, and administrator.

TOOL 17

Safety Plan

Student Name: _____ School Caregiver: _____ Date: _____

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

1. _____

2. _____

3. _____

Step 2: How can I keep myself safe? How can I keep my environment safe?

1. _____

2. _____

3. _____

4. The one thing that is most important to me and has kept me alive: _____

Step 3: Trusted adults at school, home, or in my community whom I can ask for help

1. Name: _____ Phone Number: _____
2. Name: _____ Phone Number: _____
3. Name: _____ Phone Number: _____

Step 4: Internal coping strategies—things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)

1. _____

2. _____

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

1. Clinician Name: _____ Phone Number: _____

Clinician Pager or Emergency Contact Phone Number: _____

2. **Local Urgent Care**

Services: _____

Address: _____

Phone Number: _____

Suicide Prevention Lifeline Phone Number: **800-273-TALK (8255)**

CrisisTextLine.org (24 hours nationwide): **text START or HELP to 741741**

Have an iPhone? **Talk to Siri for connection to help.**

Student Signature: _____

Staff Signature: _____

Date: _____

Date: _____

Note: Emphasis is on the safety plan being developed jointly with the student. If the plan is for an older student, have him or her fill it in. School staff members and the student should sit side by side to fill it out. Parents should be given a copy. Students should be continually asked if they still have their copy and do they have anything to add to it to increase their safety? If a student refuses to sign the safety plan, then hospitalization is likely warranted. If the student has lost the safety plan, another one should be developed. It is not uncommon for a suicidal student receiving community-based treatment, or even one who has received hospitalization services, not to have a written safety plan. If that is the case, the SMHP should develop one jointly with the student.

TOOL 18

Parent/Emergency Notification Form for Student at Risk of Suicide

School: _____

Date: _____

Student: _____

As the parent/guardian of the student, whose name is _____, I have authority to make decisions on behalf of my child and have the authority to sign this document. I acknowledge that I have been advised by school staff member _____ on _____ that my child has expressed suicidal ideation and may be at risk of suicide.

I have been advised that a common method of suicide is a gun and I have been asked to secure all guns in my home, and ensure that other common means of suicide, such as pills and ropes, are inaccessible to my child. I understand that removal of all lethal means is an essential suicide prevention strategy.

I understand that I have been advised to take my child immediately to the appropriate medical and/or mental health providers for evaluation and treatment. I agree to release information to _____ (name of school and/or staff member) regarding any evaluations and/or treatment recommendations from the mental health provider that will prepare the school to support my child's reentry into the academic setting.

_____ (name of staff member) will follow up with me and my child within one week from the date of this letter, as well as other times that the staff member determines.

I understand that any referral information provided to me that identifies medical, mental health, or related health providers is meant for my consideration only and not a requirement that I use these providers. I am free to select other providers of my choice.

The school/district is not responsible for evaluation expenses for any service providers.

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Parent/Guardian Address and Phone Number:

Staff Member Signature: _____ Date: _____

Witness Signature (If parent refuses to sign): _____ Date: _____

_____ Check to confirm copies provided to the parent, counselor, and administrator.

Tool 19

Documentation Form for Notification Steps and Community Referral(s)

Assessed Level of Risk: Low:_____ Medium:_____ High:_____

Student: _____ Grade: _____

Counselor/Suicide Response Designee: _____ School: _____

Administrator: _____ Date: _____

Actions Taken

| Date | Action | Members Present | Notes |
|------|---------------------------------------|-----------------|-------|
| | Student conference | | |
| | Principal and key personnel notified | | |
| | Parent notification | | |
| | Parent conference | | |
| | Student safety plan | | |
| | Parent/Emergency notification signed | | |
| | Release of information section signed | | |
| | Mental health provider referral | | |
| | Other community referral | | |

Follow-up Documentation

Student: _____

Risk Assessment Completed by: _____

Student's Counselor Notified: **Yes/No**

Parent: _____

Community Referral(s)/Resources: _____

_____ Check to confirm copies provided to counselor and administrator.

TOOL 20

Reentry Checklist and Monitoring

- ✓ Meet with the student and the student's parent /guardian to discuss reentry and steps needed to ensure the student has a successful return to school.
- ✓ Review student's progress with mental health provider outside of school if a release of information form, or that section of Tool 18, has been signed. If not, then discuss with parents and persuade them of the necessity and benefits for their child if this communication is allowed.
- ✓ Review all information from the mental health provider, especially with regard to safety planning and needed support services at school.
- ✓ Plan the follow-up services within the school community that will be available to the parent(s) and the student.
- ✓ Discuss any foreseeable social and/or academic challenges the child will experience and make a plan for easing those challenges.
- ✓ Counselor or designated staff member, such as suicide prevention risk expert, will meet with the student on first day of return before he or she attends any classes and will regularly check in with the student to assess student's adjustment to academic and social environment.
- ✓ Ensure that a safety plan is in place for the student. If one was not developed while the student was hospitalized, it will be necessary for the school staff members to jointly develop one with the student.
- ✓ Discuss with student the progress he or she feels was made while under mental health care. Does the student feel hopeful for the future? Is the student looking forward to getting back to classes? Is the student looking forward to meeting up with friends? Who are his or her friends?
- ✓ Help the student identify and know how to find you (or another adult the student expresses trust in) if he or she is distressed or has a question.
- ✓ Review the plan for staying in touch with him or her to make sure he or she is adjusting to the academic and social requirements.
- ✓ If the student has been out for an extended time, missed assignments may have to be prioritized by importance, and counselor coordination with teachers is advised in order to set up a manageable schedule for the student. Also, consider postponing interim or final course grades until the student has had time to catch up.
- ✓ Provide appropriate information to the student's teachers and any other staff members on a need-to-know basis so they can be alert to any further warning signs.
- ✓ Follow up with the student weekly for at least two months and, if suicidal thoughts and behaviors are noted, conduct an assessment and follow procedures outlined in Tool 19.

TOOL 21

Postvention Checklist

- ✓ Contact the police and/or the parents of the student to confirm the death and the facts.
- ✓ Notify district superintendent and the suicide prevention expert.
- ✓ Review Section 3 in *Florida S.T.E.P.S.*, especially with regard to social media (Tool 12).
- ✓ Review Tools 22, 23, 24, 25, and 26.
- ✓ Call neighboring schools for extra counseling support for students and staff; for example, contact the elementary school or middle school the deceased previously attended.
- ✓ Activate the phone calling tree that includes crisis response team, school staff members, transportation administrator (if student rode the bus), coach (if student was an athlete), and notify principals of schools where siblings or friends of the deceased student attend.
- ✓ Contact family of deceased student in person to offer condolences and assistance. Obtain permission from parent to release information about the cause of death. If they refuse to provide information or request the cause of death not be disclosed, this creates a dilemma for schools, especially if the cause of death was a suicide. Schools are encouraged to review the sample letters in the *After a Suicide: Toolkit for Schools* found at afsp.org and sprc.org.
- ✓ Schedule a faculty meeting as soon as possible. Host the meeting before school if the suicide happened the day before, or at the end of the school day if notification of a suicide occurs during the school day.
 - Discuss and complete the following:
 - Dispel rumors by providing only the facts.
 - Allow staff members to ask questions and express feelings.
 - Review the process for students who want to leave the campus due to the suicide.
 - Remind the staff members to not speak to media and provide them with a prepared statement that can be used for any unexpected calls from the community or concerned parents. Staff members should refer any media requests to the principal or the principal's designee.
 - Provide teachers with permission to allow students to express their feelings in class should the need arise. Focus on assisting students with their emotions and refrain from speculating about why the suicide occurred. Avoid sharing details about the suicide method.
 - Compile a list of students close to the deceased student and provide support.
 - Compile a list of staff members who had contact with the deceased student and provide support.
 - Compile a list of students who may be at risk for suicide and provide support.
 - Remind staff members about risk factors and warning signs of youth suicide and clarify school referral procedures.

Source: *After a Suicide: A Toolkit for Schools* (2018), by the American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org)



TOOL 22

ARTICLE: ANSWERING STUDENT SUPPORT QUESTIONS AND PROVIDING SUPPORT

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Overview

The aftermath of a youth suicide is a sad and challenging time for a school. Postvention is a term coined by Edwin Shneidman, American clinical psychologist, to describe helpful and appropriate acts after a dire event. The term has become synonymous with the challenging aftermath of suicide, as few events are scarier for a school and community than the suicide of young person. The major tasks for suicide postvention are to help your students and fellow faculty to manage the understandable feelings of shock, grief, and confusion. The major focus at this time should be grief resolution and prevention of further suicides.

The research literature estimates that, once a suicide happens, the chances of another death by suicide increase dramatically. The following suggestions are intended to guide staff members during this difficult time:

- It is important to be honest with students about the scope of the problem of youth suicide and the key role that everyone (including the students) plays in prevention.
- It is important to balance being truthful and honest without violating the privacy of the suicide victim and his or her family and to take great care not to glorify the student's actions.
- It is important to have the facts of the incident; be alert to speculation and erroneous information that may be circulating; and assertively, yet kindly, redirect students toward productive, healthy conversation.
- Centers for Disease Control and Prevention research has found that the teenagers most susceptible to suicide contagion are those believed to be students who backed out of a suicide pact, students who had a last very negative interaction with the victim, students who now realize they missed warning signs, and students with their own set of childhood adversities or previous suicidal behavior who need not have known the victim.
- Potentially high-risk groups include white, Hispanic, Alaska Native/American Indian, African American, and Asian American youth.
- LGBTQ students can be at additional risk particularly if they have experienced parental rejection or gender-based bullying. Use your campus Gay-Straight Alliance to promote safety and inclusion.
- It is important that students not feel that the suicide victim has been erased and that students be provided an opportunity to talk about the deceased.
- Numerous professional associations caution that memorials not be dramatic or permanent. Instead, encourage activities that focus on living memorials, such as funding suicide prevention.
- Suicide is always on the minds of numerous high school students. The Florida YRBSS high school survey for 2019 found 7.9 percent of students reported making a suicide attempt in the last 12 months.

- School personnel are encouraged to monitor social media after a suicide occurs, as vulnerable youth often connect with each other online, and learn about safe messaging.
- School personnel often consider postponing previously scheduled suicide prevention programs if a suicide has occurred, but prevention information is needed more than ever as suicide postvention focuses on prevention of further suicides.
- Schools are often reluctant to implement depression-screening programs that are available for middle and high school students. Depression screening provides students the opportunity to identify symptoms of depression and encourages them to seek adult help for themselves or a friend. The Signs of Suicide (SOS) program includes empowering videos where students learn how to help themselves—or their friends—through ACT (acknowledge, care, and tell an adult). Detailed information about SOS can be found at mindwise.org.
- **National research has found that talking with youth about suicide does not cause them to think of it** and in fact provides the opportunity for them to relieve anxiety and unburden themselves. The Jason Flatt Act, which focuses on mandated training annually for school staff on suicide prevention, has been passed in approximately 30 percent of all states. More information about the Jason Foundation is available at jasonfoundation.com.
- Major protective factors identified by the World Health Organization are the following: stable families, positive connections at school, good connections with other youth, religious involvement, lack of access to lethal weapons, access to mental health care, and awareness of crisis hotline resources.

Commonly Asked Questions and Appropriate Responses

Why did he or she die by suicide? We are never going to know the answer to that question as the answer has died with him or her. The focus needs to be on helping students with their thoughts and feelings and on everyone in the school community working together to prevent future suicides.

What method did they use to end their life? It is generally best not to state the method, but it is especially important not go into explicit details, such as what was the type of gun or rope used, the condition of the body, etc.

Why didn't God stop him or her? There are varying religious beliefs about suicide and you are all free to have your own beliefs. However, many religious leaders have used the expression "God sounded the alarm but could not stop him or her. God has embraced them, yes, and he or she is in whatever afterlife you believe in, but God is actually saddened that he or she did not stay on this earth and do God's work over his or her natural lifetime."

What should I say about them now that they have made the choice to die by suicide? It is important that we remember the positive things about them and to respect their privacy and that of their family. Please be sensitive to the needs of their close friends and family members.

Didn't they make a poor choice and is it okay to be angry with them? They did make a very poor choice. Research has found that many young people who survived a suicide attempt are very glad to be alive and never attempted suicide again. You have permission for any—and all—feelings in the aftermath of suicide, and it is okay to be angry.

The suicide of a young person has been compared to throwing a rock into a pond with ripple effects in the school, church and the community, and there is often a search for a simple explanation. These ripple effects have never been greater with the existence of social networks. School staff and parents should monitor what is being posted on social networks sites in the aftermath of a suicide. Suicide is a multifaceted event, and sociological, psychological, biological, and physiological elements were all present to some degree. The suicide is no one's fault and yet is everyone's fault, and suicide prevention is everyone's responsibility. Many individuals who died by suicide had untreated mental illnesses—most likely depression—and it is important that everyone is aware of the resources available in their school and community so that the necessary treatment can be obtained. It is always important that everyone knows the warning signs of suicide; they are outlined in great detail on website references in this document.

Isn't someone or something to blame for this suicide? The suicide victim made a very poor choice and there is no one to blame. The decision to die by suicide involved every interaction and experience throughout the young person's entire life, up until the moment her or she died, and yet it did not have to happen. It is no one's fault. No one person, no one thing is ever to blame.

How can I cope with this suicide? It is important to remember what or who has helped you cope when you have had to deal with sad things in your life before. Please turn to the important adults in your life for help and share your feelings with them. It is important to maintain normal routines, proper sleeping and eating habits, and regular exercise. Please avoid drugs and alcohol. Resiliency, which is the ability to bounce back from adversity, is a learned behavior. Everyone does their best when surrounded by friends and family who care about them and when they view the future in a positive way.

What is an appropriate memorial to a suicide victim? The most appropriate memorial is a living one, such as a scholarship fund or contributions to support suicide prevention. The American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org), published an excellent guide for postvention entitled *After a Suicide: A Toolkit for Schools*, that is available on both of their websites. It was first published in 2011 and revised in 2018. The guide provides specific guidelines to balance the often-felt need that students have to do something after a suicide without glorifying the suicide victim, which might contribute to other teenagers considering suicide. Each Florida county school district is encouraged to develop a memorialization policy that treats all student deaths the same regardless of the cause of death, popularity, or the socioeconomic status of the family.

How serious is the problem of youth suicide? In 2018, suicide was the second-leading cause of death for youth over ten years of age and the tenth-leading cause of death for all Americans. More than 48,000 Americans, including over 2,000 school-age youth, die by suicide annually, as suicide rates have increased for Americans but most notably for middle-school-age girls. Many young people think about suicide. The YRBSS for 2019 found that 36.7 percent of high school students reported feeling sad or hopeless for two weeks or more in the last year, an increase from 2017 results; 18.8 percent of high school students reported seriously considering suicide, an increase from 2017; and 8.9 percent of high school students actually made a suicide attempt in the last year, an increase from 2017. Ninth-grade students are the most at risk. National research has found that talking with youth about suicide does not cause them to think of it and in fact provides the opportunity for them to relieve anxiety and unburden themselves. The 2019 national data and Florida results were outlined in the introduction section of *S.T.E.P.S.*

What are the warning signs of suicide? The most common signs are (a) making a suicide attempt; (b) verbal and written statements about death and suicide; (c) fascination and preoccupation with death; (d) giving away prized possessions; (e) saying goodbye to friends and family; (f) making out wills; (g) being overwhelmed and exhibiting dramatic changes in behavior and personality.

What should I do if I believe someone to be suicidal? Listen to them, support them and let them know that they are not the first person to feel this way. There is help available, and mental health professionals, such as counselors and psychologists, have special training to help young people who are suicidal. Do not keep a secret about suicidal behavior. Save a life by getting adult help, as that is what a good friend does; someday your friend will thank you.

How does the crisis helpline work? We are very fortunate to have a nationally-certified Suicide Prevention Lifeline that is available 24 hours a day and can be reached via **800-Suicide** or **800-273-TALK (8255)**. Smartphones can easily connect suicidal individuals with the Lifeline, for example, on an iPhone, if you tell Siri you are suicidal, she immediately offers to connect you with the Lifeline. A national mental health emergency number **988** will be available sometime in 2022. Additionally, many young people today use the 24-hour Crisis Text Line by texting HELP or HOME to **741741** (crisistextline.org).

How can I make a difference in suicide prevention? Know the warnings signs, listen to your friends carefully, do not hesitate to get adult help, remember that most youth suicides can be prevented, and become aware of ways to get involved with suicide prevention. Older high school students can volunteer in some cities and be trained to answer the Teen Line. Contact the local Crisis Lifeline for more information. One person can make the difference and prevent a suicide!

Where can I go for more information about preventing suicide? Contact the American Association of Suicidology (AAS) at suicidology.org, the Jason Foundation at jasonfoundation.com, the Trevor Project at thetrevorproject.org, the Yellow Ribbon Suicide Prevention Program at yellowribbon.org, the American Foundation for Suicide Prevention (AFSP) at afsp.org, the Suicide Prevention Resource Center at sprc.org, or Nova Southeastern University (NSU) at nova.edu/suicideprevention. NSU has three training videos that focus on suicide awareness, suicide assessment, and postvention in schools.

How well do families who lost a child to suicide cope with the loss? The literature documents well the devastating effect of suicide on the family and how family members often feel isolated. Research studies conducted 15 months after the suicide indicate that the families have resumed normal functioning; they are, however, profoundly affected, especially when there is little explanation for the suicide of their loved one. Family members may experience anger toward those they believe are somehow responsible, loss of interest in their employment or schoolwork, increased absences, disrupted sleeping and eating patterns, grief, helplessness, abandonment, isolation, loneliness, shame, and guilt. Suicide survivors have more difficulty with the grieving process than survivors of losses from other causes than suicide. Survivors often reported feeling uncomfortable with the naturally occurring support systems, and school and community members often are unsure of what to say and how to reach out to those who lost a family member to suicide.

If a family member has a preexisting mental health condition it will likely be exacerbated, and substance abuse will increase. Families reported receiving less support than they deemed necessary, and the support they did receive was often poorly timed and especially ineffective for younger siblings. Research studies have also found that approximately 50 percent of the time children were not told that the cause of death was suicide. Children often find out the truth later and are upset that they were not told the truth. Bereavement was complicated when family members had deeply religious beliefs and moral convictions against suicide. Family physicians and school personnel, who are knowledgeable about helping survivors cope and the available community resources, can play a significant role in supporting the grieving family.

Richard Lieberman, M.A., NCSP, is a lecturer in the Graduate School of Education at Loyola Marymount University. From 1986–2011 he coordinated the Suicide Prevention Services for Los Angeles Unified School District, the second-largest school district in the United States. He has coauthored numerous book chapters on suicide intervention in schools, consulted nationally with districts experiencing suicide clusters, served on the Steering Committee for the Suicide Prevention Resource Center, and contributed to both the SAMHSA *Preventing Suicide* and SPRC/AFSP's *After a Suicide* school toolkits.

The authors, who were both reviewers for the 2018 publication *After a Suicide: Toolkit for Schools* from the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, can be contacted at spoland@nova.edu and richard.lieberman@lmu.edu.

More About the Authors

Scott Poland, Ed.D., NCSP, is the director of NSU's Suicide and Violence Prevention Office (nova.edu/suicideprevention) and has nearly 40 years of school experience. He was previously the Prevention Division director for the American Association of Suicidology (AAS), has worked in the aftermath of many youth suicides and led numerous teams following suicide clusters. He is the author/coauthor of five books and numerous chapters and articles about youth suicide and school crisis. He is the coauthor of the *Texas Suicide Safer School Plan and Toolkit* and the *Montana Crisis Action School Toolkit on Suicide*, as well as a 2015 book entitled *Suicide in Schools*, published by Routledge. He has also testified before the U.S. Congress on several occasions, focusing on school violence and youth suicide prevention.



TOOL 23

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 members of the death through the school's predetermined crisis alert system, such as email or calls to classroom phones. Remember that information about the cause of death should be withheld until the family has been contacted by school personnel.

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 members 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 members (e.g., homeroom teachers or advisors) with a scripted death notification statement for students. Arrange coverage for any staff members who are unable to manage reading the statement.
- Prepare for student reactions and questions by providing handouts to staff members 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 members 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 members about identifying and referring at-risk students as well as the need to keep records of those efforts.
- Apprise staff members of any outside crisis responders or others who will be assisting.
- Remind staff members of student dismissal protocol for funeral.
- Identify which crisis-response team member has been designated as the media spokesperson and instruct staff members to refer all media inquiries to him or her.

Source: *After a Suicide: A Toolkit for Schools* (2018), by the American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org)

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 members.
- Review the day's challenges and successes.
- Debrief, share experiences, express concerns, and ask questions.
- Check in with staff members 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 members of the importance of self-care.
- Remind staff members of the importance of documenting crisis response efforts for future planning and understanding.



Tips and Scripts for Talking About Suicide

1. Provide Accurate Information About Suicide

Suicide is a complicated behavior. It is not caused by a single event such as a bad grade, an argument with parents, or the breakup of a relationship. In most cases, suicide is caused by an underlying mental disorder like depression or substance abuse. Mental disorders affect the way people feel and prevent them from thinking clearly and rationally. Having a mental disorder is nothing to be ashamed of, and help is available.

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

2. Address Blaming and Scapegoating

Trying to find the “why?” is common after a suicide, but sometimes this turns into blaming others for the death.

3. 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 go into detail or talk at length about it. The focus should be not on how someone killed himself or herself, but rather on how to cope with feelings of sadness, loss, anger, etc.

Sample Scripts

“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 80–90 percent of people who die by suicide have a mental disorder at the time of their death, it is likely that _____ suffered from a mental disorder that affected [his/her] feelings, thoughts, and ability to think clearly and solve problems in a better way.”

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

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

“It is tragic that he/she died by suicide. 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?”

Source: *After a Suicide: A Toolkit for Schools* (2018), by the American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org)



Tool 25

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 teens 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] at [location], [time]. Experts will be available to answer questions.
- No TV cameras or reporters will be allowed in the school or on school grounds.

School Response to Media

- Media are strongly encouraged to refer to the document *Reporting on Suicide: Recommendations for Journalists*, which is available at afsp.org/for-journalists.
- 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).



TOOL 26

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 the community on [date] at [location], [time]. 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 [email address] for more information.

Trained crisis counselors will be available to meet with students and staff members 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. Suicide warning signs include

- talking about wanting to die or kill oneself
- looking for ways to kill oneself, such as searching online or buying a gun
- talking about feeling hopeless or having no reason to live
- talking about feeling trapped or in unbearable pain
- talking about being a burden to others
- increasing the use of alcohol or drugs
- acting anxious or agitated, or behaving recklessly
- sleeping too little or too much
- withdrawing or feeling isolated
- showing rage or talking about seeking revenge
- displaying extreme mood swings

Local Community Mental Health Resources

[To be inserted by school]

National Suicide Prevention Lifeline

800-273-TALK (8255)

[Local resources and hotline numbers to be inserted by school]

Source: *After a Suicide: A Toolkit for Schools* (2018), by the American Foundation for Suicide Prevention (afsp.org) and the Suicide Prevention Resource Center (sprc.org)

Tool 27

Caring for the Caregiver

School mental health professionals such as counselors, school psychologists, and social workers respond to many tragic situations. One of the most difficult is responding to a suicide.

These professionals have their own issues regarding tragedy and loss and when they respond to yet another school tragedy. It is common to think about our own losses, and it takes a little piece of our heart every time. Caregivers know the importance of staying calm, being collaborative, and focusing on the needs of other people, but crisis response is intense and takes its toll on the caregiver.

It is hoped that the school caregivers are the first ones contacted by an administrator when a school tragedy occurs, and they have time to process the tragedy and get help from their loved ones before being asked to help others.

There may be a time when the individual or family circumstances for an individual caregiver make it difficult—or even impossible—for them to focus on the needs of others. If this is the case, then they need to speak up. Perhaps they can take a supportive role in the background instead of being face-to-face with grieving staff and students.

Caregivers who serve on school crisis teams are sometimes almost constantly relied on if a school district has experienced multiple crises, and burnout can possibly develop. It is a sign of maturity and courage for a school caregiver to speak up when they know that they are being overwhelmed by the stress of crisis intervention. Caregivers are encouraged to be assertive in stating what they need in the way of support from school administration, friends, and family. The wise

school administrator would meet with caregivers at the end of the day and check in with them to see how they are doing in the aftermath of a tragedy. Caregivers need to feel appreciated by the administration and to know they did the best they could in a tragic situation. There is no such thing as a perfect crisis response; it is about showing up and caring. There are no magic words, but it is important to state that we are sorry about the loss and there to listen anytime the affected person wants to talk! Caregivers know that it's important to help those affected by the tragedy to identify previous sources of support, and this is important for the caregiver as well. Caregivers are encouraged to use healthy stress-management behaviors that help them on a normal school day, such as eating well; getting enough sleep; engaging in relaxation, positive imagery and meditation; ensuring that they put some fun and relaxation into their day and get plenty of exercise; reaching out to the significant positive others in their lives; building a professional network; and avoiding isolation. Think of self-care like car maintenance.

- Short term—if HALT (hungry, angry, lonely, and tired) are developing, get a boost and use the strategies outlined above.
- Long term—get professional help, seek formal support, and take an inventory of your health.

Tool 28a

Initial Screening Questions for Mental Health Providers

Professional Qualifications

1. Are you able to provide services to children and adolescents?
2. Are there ages that you work more frequently with or have more expertise and training with?
3. What types of services do you provide?
4. Do you do individual, family, couples, or group therapy?
5. Do you have experience working with LGBTQ students and other groups that are disproportionately at risk for suicide?
6. Do you have experience working with varied cultural, ethnic and religious groups found within our community?
7. Do you have experience assessing suicide risk in youth? If yes, where did you get your training?
8. Do you have experience managing and treating suicide risk in youth? If yes, what treatment approach do you use? Do you have training in any empirically supported treatments for suicidal youth (e.g., cognitive behavioral therapy, dialectical behavior therapy, interpersonal psychotherapy, attachment-based family therapy)?
9. Do you have experience working with people who have lost a loved one to suicide?
10. What process do you follow in the event of a suicide crisis?
11. Under what circumstances would you come to the school or do a home visit in order to see a student or parent?
12. Do you work with a psychiatrist?

Business Issues

1. Where are you located?
2. Are you accessible via public transportation?
3. What is your typical wait time to see a new client?
4. What insurance do you accept?
5. Do you have a sliding fee scale for people who pay out-of-pocket? What is the range of the fee scale?
6. Do you have necessary clearances to work in schools if you were to come here: child abuse, police and FBI clearances?

Source: The questions were drawn from the authors' professional experiences and adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA) Toolkit (2012); and *Preventing suicide: A toolkit for high schools*. HHS Publication No.SMA-12-4669. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

TOOL 28b

Documentation Form for Community-Based Mental Health Facilities and Providers

Completed by: _____ Date: _____

Facility/Provider: _____ Contact Name: _____

Address: _____ Phone: _____

Email: _____ Provides Transportation for Suicidal Individuals (Y/N): _____

Past Experience Summary: _____

Interaction Documentation

Rating: Unsatisfactory=1, Needs Improvement=2, Satisfactory=3

Incident: _____ Start Date: _____ End Date: _____

| Item | Rating (1-3) | Notes |
|-----------------------------|--------------|-------|
| Response time | | |
| Communication effectiveness | | |
| Care coordination | | |
| Follow-up | | |
| Student satisfaction | | |
| Parent satisfaction | | |

Incident: _____ Start Date: _____ End Date: _____

| Item | Rating (1-3) | Notes |
|-----------------------------|--------------|-------|
| Response time | | |
| Communication effectiveness | | |
| Care coordination | | |
| Follow-up | | |
| Student satisfaction | | |
| Parent satisfaction | | |

Incident: _____ Start Date: _____ End Date: _____

| Item | Rating (1-3) | Notes |
|-----------------------------|--------------|-------|
| Response time | | |
| Communication effectiveness | | |
| Care coordination | | |
| Follow-up | | |
| Student satisfaction | | |
| Parent satisfaction | | |

Tool 29

Suicide Prevention Information to Post on School District Website

The _____ School District recognizes that suicide is the second-leading cause of death for school age students 10–19 nationally, and we are dedicated to working with parents, community and state agencies to prevent youth suicide. The suicide of a youth is largely the result of untreated or undertreated mental illness, and we as a district have developed plans for suicide prevention and intervention. If you are a student and concerned about your friend or are a parent concerned about your child, then the key person to contact in our district for assistance is _____, who can be reached at _____. If they cannot be reached immediately, call the National Suicide Prevention Lifeline at 800-SUICIDE or 800-273-TALK. Trained crisis responders are available 24 hours a day. Do not leave a suicidal person alone. If a suicide attempt has been made, immediately contact 911.

If you believe your child or your friend is suicidal, please take every precaution and get immediate help. If you are a student concerned about a friend, it is very important to get a trusted adult involved immediately. If you are a parent concerned about your child, then obtain professional help for your child, increase your supervision, and reduce their access to any lethal objects or substances. Many people are hesitant to ask directly about suicide for fear that they will be planting the idea in the mind of the person. Asking them directly about thoughts of suicide provides them an opportunity to unburden themselves and to receive the support and services they need. Please immediately contact the National Suicide Prevention Lifeline at 800-SUICIDE or 800-273-TALK as trained crisis responders are available 24 hours a day.

It is vital that all school staff members, students' parents, and community members know the warning signs of suicide, which are outlined in Tool 31, and should be posted on each district's website.



Tool 30

Understanding the Florida Baker Act

With the passing of Senate Bill 7030, schools are now required to conduct a suicide screening before the Baker Act for voluntary or involuntary hospitalization can be implemented. SMHPs are encouraged to monitor future legislation, which is considering allowing school psychologists to initiate the Baker Act.

Florida schools have different policies surrounding the Baker Act. Florida schools are strongly encouraged to conduct at least an annual team meeting with key personnel to review practices and issues with previous uses of the Baker Act. The Florida Department of Education is aware of the high number of Baker Act initiations by schools and had a task force that addressed the issue. There are key elements and best practices all school personnel are encouraged to know concerning the Baker Act which are summarized on this tool. Additionally, it is important to note that every Florida school district in the summer of 2019 had school personnel trained by Dewey Cornell and Scott Poland on assessing threats of violence towards self or others. The school personnel in attendance were strongly encouraged to return to their school districts, review important policies and procedures, and provide training. For more information on the Baker Act, visit myflfamilies.com/service-programs/samh/crisis-services/baker-act.shtml.

What is the Baker Act?

The Baker Act is a state law that allows for the involuntary and voluntary placement of an individual in a psychiatric facility or hospital for observation and a psychiatric evaluation.

1. The Baker Act Process is considered to be a last resort for treatment.
2. The Baker Act is applicable only to children who display a “mental illness” as defined in Florida Statutes and who refuse voluntary examination or admission to a mental health facility. F.S. 394.455 (18) states “mentally ill” means an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person’s ability to meet the ordinary demands of living. For the purpose of this part, the term does not include a developmental disability as defined in Chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.
3. The Baker Act procedure must not be considered or implemented as a regular school behavioral intervention such as “time out” or “isolation.” Neither may it be used for removing the child from the school campus for disciplinary reasons. This civil procedure is intended to protect the child from harm to himself or others, and to obtain emergency mental health treatment.

Implementation of the Baker Act is contingent upon the following:

Involuntary Examination

A person may be taken to a receiving facility for involuntary examination if there is reason to believe that he or she is mentally ill (see F.S. 394.463) and because of his or her mental illness:

1. He or she has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or he or she is unable to determine for himself or herself whether an examination is necessary.
2. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services or there is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Transportation Coordination

When schools decide that a student needs to be safeguarded with the Baker Act, it is the school's responsibility to coordinate how a student is transported; however, how the student will be transported is determined by who executes the paperwork. For example, if it is the school resource officer, then law enforcement must transport persons under involuntary status to the nearest receiving facility or hospital. After a school assesses the student for suicide risk, the school could call their local law enforcement officer to initiate the Baker Act. A school may also bring in a third party, such as a mobile crisis team, who could assess the student and arrange for the student to be transported to the facility or hospital.

There is considerable variability concerning Baker Act implementation across Florida county school districts, and SMHPs, school administrators and school resource officers are encouraged to review their district policies.

Completion of Mandated Forms

While schools are not required to have policies for the Baker Act, there are mandated forms for schools if they decide to initiate a Baker Act. These are available on the Florida Department of Education website in English, Creole, and Spanish at myflfamilies.com/service-programs/samh/crisis-services/baker-act-forms.shtml.

The handbook for the Baker Act, the *Baker Act Handbook and User Reference Guide*, is available at myflfamilies.com/service-programs/samh/crisis-services/laws/BakerActManual.pdf.

Free online trainings

Free online trainings are available at myflfamilies.com/service-programs/samh/crisis-services/training/bacourses.shtml.

Courses Offered

- Introduction to the Baker Act
- Emergency Medical Conditions and the Baker Act
- Law Enforcement and the Baker Act
- Long Term Care Facilities and the Baker Act
- Consent for Minors
- Rights of Persons in Mental Health Facilities
- Guardian Advocacy
- Suicide Prevention
- Why People Die by Suicide
- Trauma Series

Best Practice Recommendations

The following recommendations are practices to ensure that schools are protecting the safety of students and using the Baker Act appropriately. It is important to remember that it is a last-resort treatment intervention.

1. Conduct a screening

The state has implemented a new guideline in Senate Bill 7030 requiring schools to screen potentially suicidal students with the following assessment tools recommended by the FDOE before initiating a Baker Act. See **Tools 14a, 14b, and 14c** for the recommended assessment instruments.

2. Never leave the student alone

At every point during this process, it is critical that the student be under the supervision of a designated school personnel or SMHP. The student should not be released to a parent or guardian before assessing the student's risk of suicide.

3. The decision should be made as a team

The legislation puts the responsibility of initiation on one or two professionals in a school. However, the best decisions are always made by a team. When Baker Act initiations do occur, a team approach allows the process to go more smoothly. For example, while one team member is preparing the student for the process, another team member could be communicating with the parents of the student.

4. Use the Mandated Forms

There are separate forms for the law enforcement officer and mental health professional to make clear who initiated the Baker Act at the school. However, it is recommended that both work together to make a collaborative decision, regardless of who fills out the documents.

5. Prepare students for the process

Once the decision has been made to initiate the Baker Act, the student should be educated on the process, so the student knows what to expect. It should be made clear that the Baker Act is being used for their own safety and (if applicable) the safety of others.

6. Contact the Appropriate Individuals

The initiator of the Baker Act should contact the receiving facility to inform them of the concerning behaviors that the student displayed and to ask the staff at the hospital or facility to ask the parent of the student to sign a release of information to allow the sharing of information with the school. Additionally, school staff members are encouraged to request the parent or legal guardian of the student to sign the district release of information form. The purpose of the release is to enhance communication with the hospital or community mental health facility involved in the treatment of a student and to coordinate effective services for the safety and wellbeing of the student upon their return to school. See **Tool 20**.

7. Minimize visibility

All measures should be designed to maximize the student's privacy. The Baker Act initiation should take place in a low-traffic area. For example, the side or back of the building may be a low-traffic area where no one can see the transfer of the student to Baker Act care. Please also consider the school schedule to avoid times when students are in the hallway changing classes. The purpose is to reduce stigmatization and protect the privacy of the student.



8. Err on the side of caution for parents

Always notify parents before the Baker Act process. If this decision is made, this means the student is believed not to be safe even under the care of his or her parents. Parents should constantly be updated on the status of their child when he or she has returned to school after the Baker Act. Collaboration between the parents and school personnel is essential to attend to the mental health and academic needs of the student who was subject to the Baker Act.

9. Always conduct a reentry meeting before the student returns to school

A meeting of the school crisis team or the school safety team should be held after a student was dealt with under the Baker Act and before their return to school. The reentry meeting will be used to identify appropriate interventions that will be necessary to support the student's emotional well-being and academic success upon returning to school. The school reentry meeting should include the student (if possible or available), student's parent(s) or guardian(s), school counselor, school social worker, school psychologist, administrator, and other school personnel, as deemed necessary. Parents likely will have considerable anxiety about their child returning to school, and the team should stress all of the supports that will be provided at school for their child.

Once the student is back at school, the team should designate a mental health professional to meet and check in with the student periodically (at least weekly for the first month). The initial session should consist of reviewing the existing safety plan with the student or creating an initial safety plan. Emphasis should be placed on asking the student what support they need at school. Additionally, the session should discuss with the student what to say to their peers about their absence. Research has found that students are at an increased risk of suicide within the first month of hospital release. See **Tool 20**.

The reentry meeting should address and document

- the nature of the crisis
- a signed release for information sharing between the school and the Baker Act facility
- current diagnosis
- risk behavior and behaviors of concern
- discharge recommendations
- community-based services
- parent/student/teacher concerns
- physical safety concerns
- data review (attendance, academic, behaviors, disciplinary, psychological/medical reports)
- mental health services the school will provide
- academic concerns or supports

Tool 31

Warning Signs

Everyone must know the warning signs of youth suicide. A warning sign is any change in behavior (actions or statements) or mood that indicates a person might be thinking of suicide. People going through life transitions, changes, losses, and painful events are of the most concern, as well as those who show multiple warning signs. The Suicide Awareness Voices of Education explains, “Warning signs are indicators that someone could be in acute danger or may urgently need help.” The following are considered warning signs from SAVE, the World Health Organization, and the American Foundation for Suicide Prevention:

- talking about wanting to die or to kill oneself
- looking for a way to kill oneself
- talking about feeling hopeless or having no purpose
- talking about feeling trapped or being in unbearable pain
- talking about being a burden to others
- increasing the use of alcohol or drugs
- acting anxious, agitated, or reckless
- sleeping too little or too much
- withdrawing or feeling isolated
- showing rage or talking about seeking revenge
- displaying extreme mood swings

One other way to examine these warnings sign is to break them down into the following categories.

Behavioral

- lack of interest in usual activities or withdrawing from activities
- an overall decline in grades
- decrease in effort
- misconduct in the classroom
- unexplained or repeated absence or truancy
- increased use of alcohol or drugs
- recent behavioral incident resulting in school or law enforcement discipline consequences
- looking for a way to end their lives (i.e., searching online)
- isolating from family and friends
- sleeping too much or too little
- visiting or calling people to say goodbye
- giving away prized possessions
- aggression
- fatigue

Talks about

- killing himself or herself
- feeling hopeless
- having no reason to live
- being a burden to others
- being overwhelmed
- feeling trapped
- unbearable pain

Mood indicating

- depression
- anxiety
- loss of interest
- irritability
- humiliation/shame
- agitation/anger
- relief/sudden improvement

Some adolescents are overwhelmed and are not able to manage all of their emotions and feelings. Often, this can be displayed through increased irritability and hostility towards others in their lives.

A number of adolescents are sleep-deprived, and although the solution may seem as simple as their parents getting them to bed early, adolescents

are not wired to go to bed early. Specifically, their levels of melatonin, the sleep hormone, is released later at night and reaches its peak in the early morning, which means teens are more likely to be sleepy in the morning compared to younger students. The National Sleep Foundation recommends that teens get 8-10 hours of sleep per night. Sleep hygiene is important for overall well-being. It is important for SMHPs to know there are associations between sleep disturbances and suicidal thoughts and behaviors. However, many secondary schools start as early as 7:00 a.m. or 7:30 a.m., which results in many adolescents not getting the recommended amount of sleep.



Tool 32

Annual Data Collection Report

School: _____

Data Recorder Name: _____

Phone: _____ Email Address: _____

| Item | School Year and Report Date | | | | |
|---|-----------------------------|--|--|--|--|
| | | | | | |
| Number of students reporting suicidal ideation | | | | | |
| Number of students who made a suicide attempt | | | | | |
| Number of students who were treated under the Baker Act | | | | | |
| Number of students who were referred to community mental health providers | | | | | |
| Number of students whose family allowed record sharing between the school and community mental health providers | | | | | |
| Number of students who were hospitalized for suicidal behavior | | | | | |
| Number of reentry meetings held at school for suicidal students who were hospitalized | | | | | |
| Number of suicide safety plans developed jointly with suicidal students by school personnel | | | | | |
| Number of parents notified of the suicidal behavior of their child | | | | | |
| Number of students who died by suicide | | | | | |

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Appendices

Appendix 1—Resources

Appendix 2—Suicide Contagion

Appendix 3—Scott Poland Answers Questions from Parents, School Personnel, and Students

Appendix 1

Resources

- The **Columbia Suicide Severity Rating Scale (C-SSRS see Tools 14a and 14b)** is the most widely researched and evidence supported screening tool. The Columbia protocol is a screener with a variety of questions related to thoughts and behaviors to assess a person's risk of suicide. Emergency room facilities are very familiar with the screener and it is widely used among them. The benefit of the screener is that anyone from a friend to a researcher is in a qualified position to use this resource. There are multiple versions of the screener appropriate for all ages, it is free to use, and is translated in more than 100 languages. It is very applicable for schools, as there is a version made to guide schools in making next-step decisions for students. For more information, visit cssrs.columbia.edu.
- **Question, Persuade, and Refer** involves gatekeeper training that teaches students and staff members how to identify risks and warning signs of suicide. Just as people trained in CPR and the Heimlich maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. For more information, visit qprinstitute.com.
- **Signs of Suicide (SOS)** educates students about suicide and how to identify suicide warning signs with the motto: Acknowledge, Care, Tell. SOS is designed for grades 6–12 and has two key components: a video and a brief screening instrument that asks students questions. The student scores their own questionnaire and then identifies whether or not they need mental health assistance. Research has found that SOS increases seeking help from adults and reduces suicidal behavior. Scott Poland serves on the advisory board for SOS. For more information, visit mindwise.org.
- The **Suicide Assessment Five-Step Evaluation and Triage (SAFE-T, Tool 14c)** walks the user through a five-step assessment that determines either a low, moderate, or high risk for suicide with recommended interventions depending on the severity level (Substance Abuse and Mental Health Services Administration, 2009). The assessment may be found through the following link. This resource is extremely accessible, as it comes in a pocket card format and is intended to be used by mental health professionals. For more information, visit store.samhsa.gov/sites/default/files/d7/images/sma09-4432.jpg.
- **Youth Aware of Mental Health Program (YAM)** is a role-play curriculum that provides youth with an opportunity to enact real-life situations related to suicide and to focus on changing negative thoughts into positive coping skills. This program has proven to be significant in decreasing bullying and substance abuse and increasing help-seeking behavior. For more information, visit y-a-m.org.
- The **PAX Good Behavior Game** is a program for early elementary school classes to teach children how to self-regulate emotions and behaviors. Follow up studies have found that students who participated in the GBG had fewer suicide attempts in later years than those who did not participate in the program. For more information, visit goodbehaviorgame.air.org.
- **Riding the Wave** is a promising newly developed fifth-grade curriculum from the state of Washington's Youth Suicide Prevention Program. It uses direct language about depression and suicide. For more information, visit crisisconnections.org/riding-the-waves.

- **Youth Mental Health First Aid (YMHFA)** teaches a five-step action plan to offer initial help to young people showing signs of a mental illness or in a crisis and connect them with the appropriate professional, peer, social, or self-help care. YMHFA is an eight-hour interactive training for youth-serving adults without a mental health background. For more information, visit mentalhealthfirstaid.org/population-focused-modules/youth.
- **Safe TALK** is a half-day alertness training that prepares anyone over the age of 15, regardless of prior experience or training, to become a suicide-alert helper. For more information, visit livingworks.net/safetalk.
- **Applied Suicide Intervention Skills Training (ASIST)** is a two-day interactive workshop in suicide first aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. For more information, visit livingworks.net/asist.
- **Kognito At-Risk** is a series of online interactive professional development modules designed for use by individuals, schools, districts, and statewide agencies. It includes tools and templates to ensure that the program is easy to disseminate and measure results at the elementary, middle, and high school levels. Scott Poland and Richard Lieberman recently helped Kognito develop a module on school resiliency after tragedy. For more information, visit kognito.com/products/pk12.
- **After a Suicide: A Toolkit for Schools, Second Edition**, by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center (2018), is an online resource that provides basic information and practical tools for schools to use in developing and implementing a comprehensive response to the suicide death of a student. It includes sections on crisis-response teams and activities, helping students cope, addressing issues related to memorials, social media, contagion, working with the media and the community. Scott Poland was a key contributor to the toolkit. For more information, visit sprc.org/resources-programs/after-suicide-toolkit-schools.
- **Finding Programs and Practices**, by the Suicide Prevention Resource Center (SPRC), is a website that provides information on SPRC's Resources and Programs website and other program registries and lists, as well as suggestions for selecting programs. For more information, visit sprc.org/resources-programs/role-high-schoolteachers-preventing-suicide-sprc-customized-informationpage.
- **Florida Youth Risk Behavior Surveillance Survey (YRBSS)** is a survey from the CDC that is administered—and has the results published—every two years. The 2019 data are the latest results published on the website. It asks a variety of questions to high-school youth related to suicide, such as considering suicide, making a suicide plan, and making a suicide attempt. It also asks questions surrounding risk behaviors including bullying. Florida educators are encouraged to have their county participate, as it is a very valuable snapshot of at-risk behavior. For more information, visit floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/youth-risk-behavior-survey/index.html.
- **Florida Middle School Health Behavior Survey** is similar to the YRBSS, as it asks similar questions to Florida middle schoolers and is also administered and results published every two years. For more information, visit floridahealth.gov/statistics-and-data/survey-data/florida-youth-survey/middle-school-health-behavior-survey/index.html.
- **The Florida Department of Education (FDOE) list of resources** is a list of approved suicide prevention materials (programs and screening tools) recommended by the FDOE. For more information, visit sss.usf.edu/resources/topic/suicide/index.html.

- **The Jason Foundation (JF)** is a foundation created by the Flatt family in efforts to implement suicide prevention legislation for schools through the Jason Flatt Act. Clark Flatt, Jason's father, has dedicated his life to expanding the Jason Flatt Act across our nation. This act requires teachers and certain school personnel to complete two hours of youth suicide awareness and prevention training in order to maintain or renew their licensing credentials. The requirement for this training does not add additional hours of training, but rather falls within the number of hours already required to continue the professional teaching license. Once the act is passed in a state, the training is provided by the foundation at no cost. The training consists of online modules that cover a variety of topics related to suicide. Twenty states have acted to help prevent youth suicide by passing the Jason Flatt Act. States where the act is in place include Tennessee, Louisiana, California, Mississippi, Illinois, Arkansas, Utah, South Carolina, West Virginia, Alaska, Ohio, North Dakota, Wyoming, Georgia, Montana, Texas, South Dakota, Alabama, Idaho, and Kansas. Currently, Florida does not require mandatory suicide prevention training; however, Florida schools can become suicide-prevention certified.

The Jason Foundation has a wealth of suicide prevention information on its website at jasonfoundation.com, including five training modules created by Scott Poland and Richard Lieberman on

- suicide and bullying
- suicide and depression
- suicide and self-injury
- suicide and LGBTQ students
- suicide and postvention

For more information on the Jason foundation and Jason Flatt Act, visit jasonfoundation.com.

- **Preventing Suicide: The Role of High School Teachers**, by the Suicide Prevention Resource Center (revised 2019), is an information sheet that helps high school teachers recognize and respond to the warning signs and risk factors for suicide in their students. For more information, visit sprc.org/resources-programs/role-high-school-teachers-preventing-suicide-sprc-customized-information-page.
- **Society for the Prevention of Teen Suicide (SPTS)** develops educational materials and training programs for teens, parents, and educators, and its website contains separate sections for each group. SPTS is the developer of the online course Making Educators Partners in Youth Suicide Prevention and the Lifelines Trilogy manuals and workshops covering suicide prevention, intervention, and postvention for educators. For more information, visit sptsusa.org.
- **Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth**, by the Suicide Prevention Resource Center (2011), is a kit that provides all the materials for a workshop to reduce suicidal behavior among LGBTQ youth. It is designed for staff members in schools, youth-serving organizations, and suicide prevention programs. It includes a leader's guide, sample agenda, PowerPoint, sample script, handouts, and small group exercises. For more information, visit sprc.org/training-institute/lgbt-youth-workshop.
- **The Trevor Project** is a national organization with a focus on crisis and suicide among LGBTQ youth. It provides counseling by phone, text, and chat; an online social networking community for LGBTQ youth and their friends and allies; educational programs for schools; and advocacy initiatives. For more information, visit thetrevorproject.org.
- **Hope Squad** is a program designed to prevent suicide by creating student hope squads in schools. It focuses on the Circle4Hope model recognizing the role of mental health partnerships, school programs and community connections working together to prevent youth suicide. For more information, visit hopesquad.com.

- **Sources of Strength** is a suicide-prevention program designed to harness the power of peer networks through eight key sources of strength. The program emphasizes the importance of increasing youth-adult connections. For more information, visit sourcesofstrength.org.
- **Florida Suicide Prevention Coalition (FSPC)** is a nonprofit organization composed of survivors, crisis-centers staff, researchers, concerned residents, and regional directors throughout the state who serve as contact points for suicide prevention. FSPC is dedicated to advocacy, collaboration and communication and publishes a quarterly newsletter. For more information, visit floridasuicideprevention.org.
- **Florida Youth Suicide School Based Prevention Guide**, which provides accurate, user-friendly information, is available from the Department of Child and Family Studies for the University of South Florida, at theguide.fmhi.usf.edu.
- **The Florida Department of Children and Families has the Statewide Office of Suicide Prevention and the Coordinating Council**, which focuses on suicide prevention initiatives, such as creating the statewide plan for suicide prevention for Florida. For more information, visit myflfamilies.com.



Appendix 2

Article: Suicide Contagion and Clusters—Part 1: What School Psychologists Should Know

The suicide of a student has a rippling effect in the school environment as well as in the greater community, as a single adolescent death by suicide increases the risk of additional suicides. The process by which a completed suicide (or at times, suicidal behavior) increases the suicidal behavior of others is called contagion. When multiple suicides occur close in time and geographical area, at a rate greater than normally would be expected in a given community, it is considered a cluster (Centers for Disease Control [CDC], 1988).

Adolescents are the most susceptible age group for imitating suicidal behavior; therefore, discussions of contagion often center on prevention efforts in the school environment, necessitating that school psychologists play a central role. Approximately 1–5% of teen suicides occur in a cluster after a youth dies by suicide (Gould & Lake, 2013). Though rare, contagion results in approximately 100–200 seemingly preventable deaths annually.

Clusters

There are two main types of suicide clusters that may impact adolescents in the school environment. Mass clusters are characterized by a temporary increase in suicides during a time period (irrespective of geography) and are often associated with the influence that media reports may have, such as the suicide of a celebrity or a high-profile figure. Point clusters are characterized by an increase in suicides that are close in time or space and occur in communities (such as schools).

Mass clusters

The specific impact of a celebrity suicide on adolescents is not easily discernable, making it

difficult to draw general conclusions; however, several case examples demonstrate the effects of unsafe messaging in news reporting. After Chris Cornell, lead singer of the band Soundgarden died in 2017, vivid details of the police report of the moments leading up to his suicide were published (Pescara-Kovach, 2017). On Cornell's birthday, his close friend, Chester Bennington, lead singer from the band Linkin Park, died by suicide in a very similar manner. Several subsequent suicides by adolescent fans were linked to these deaths, as the methods utilized bore resemblance to the details shared in the celebrity cases. The impact was additionally noted via correlation, as the National Suicide Prevention Lifeline received a 14% increase in calls on the day after Bennington's death (Pescara-Kovach, 2017). Similarly, after the suicide death of comedian Robin Williams, there was an almost 10% increase in deaths by suicide, particularly among males ages 30–44 (Fink, Santaella-Tenorio, & Keyes, 2018). The impact of the recent deaths by suicide of the celebrities Kate Spade (2018) and Anthony Bourdain (2018) on subsequent suicides is not yet known; however, safe messaging was noted across several news outlets. For example, *People* magazine printed the National Suicide Prevention Lifeline phone number (1-800-273-TALK) on the masthead of their issue covering the stories that week and the *Daily News* printed suicide warning signs, as well. In contrast however, there was considerable discussion of the similar details of their methods in many articles.

The impact of entertainment media on suicide contagion has also been noted for fictional characters that die via suicide (Gould & Lake, 2013). This was particularly apparent with the fictional series *13 Reasons Why* (Netflix), as there was a 19% increase (one million additional searches) in Internet searches about suicide immediately after

the series aired (O'Brien, Knight, & Harris, 2017), including searches for the phrases “how to commit suicide” (26%), “how to kill yourself” (9%), and “commit suicide” (18%). Fortunately, some of the increased searches were for seeking help—including “suicide hotlines” (12%) and “suicide prevention” (23%). However, “Past studies have validated that Internet searches mirror real-world suicide rates, so suicide rates have likely gone up as a result of this program” (Ayers, Althouse, Leas, Dredze, & Allem, 2017). In fact, 25% of youth who died by suicide conducted a suicide-related Internet search shortly before their deaths (O'Brien et al., 2017).

Point clusters

More easily identifiable, suicide point clusters have occurred in several school communities such as those Poland and Lieberman worked with in Palo Alto, CA (2002, 2009, and 2014); Fairfax County, Virginia (2014); Colorado Springs, Colorado (2017); and Salt Lake City, Utah (2018). Other clusters have likely gone undetected or were intentionally not reported. In some of these communities, epidemiology studies were conducted in conjunction with the CDC. Results were reviewed by Poland and Lieberman at the most recent National Association of School Psychologists (2018) and American Association of Suicidology (2017) conferences. They identified the following risk factors from these clusters: male gender, mental health issues, history of suicidal ideation or suicide attempt, substance abuse issues, relationship problems, a recent crisis, cutting behavior, parents not recognizing the severity of the mental health needs of their child, sleep deprivation, academic pressure, sexual orientation, and intimate partner violence (Annor, Wilkinson, & Zwald, 2017; Garcia-Williams et al., 2016; Spies et al., 2004).

Exposure to Suicide

Research has found that a death by suicide may touch approximately 135 people, one third of whom experience a severe life disruption as a result (Cerel et al., 2018). Exposure to a peer's suicide has been found

to be associated with suicidal ideation or behavior in adolescents that can persist for up to 2 years. Among at-risk adolescents, a schoolmate's suicide appears to amplify preexisting negative life events and increase serious suicidal ideation or behavior. In other words, a single exposure to the suicidal behavior of another person does not result in imitative behavior in the absence of adolescent vulnerability factors. Such factors include: current or past psychiatric conditions, family history of suicide or past suicide attempts, substance abuse, stressful life events, access to lethal methods, incarceration, social impairments, environmental factors, and lack of protective factors (Gould et al., 2018).

Suicide is complex, particularly with regard to causality; yet, identifying individual students who are at-risk after a suicide is one of the primary tasks of suicide prevention efforts undertaken in the schools to prevent contagion (Lieberman, Poland, & Kornfeld, 2014). Research has supported the fact that though friendship with the student who died by suicide is associated with increased risk for suicidal ideation or behavior, it is not the closest friends, but rather the less close friends that knew the deceased who have the highest rates of suicidal ideation or behavior as a result (Gould et al., 2018). Though previously, a “continuum of survivorship” was assumed, we now know that focusing solely on those students closest to the student who took their life will likely leave many vulnerable students unidentified.

Preventing Suicide Contagion: Guidelines for Media

It has been well established that at-risk individuals with a recent history of suicide attempt or a concurrent severe depression are more likely to attempt suicide in the wake of a media report of suicide (Gould, Kleinman, Lake, Forman, & Midle, 2014). Specifically, media stories that were published after the index suicide (the first) and were associated with clusters employed: front page placement of story, headlines containing description of method, presence of a picture, and detailed description of the suicide (Gould et al. 2014). Therefore, organizations such as the World Health Organization (WHO, 2017) have set

forth recommendations about how to contain a suicide cluster via safe messaging. These guidelines essentially state: refrain from using sensational language or normalizing suicide, avoid unnecessary repetition of the story, use neutral rather than emotionally charged photos, refrain from detailing the method of death, and take particular care when the suicide involves a celebrity (Meindle & Ivy, 2018; WHO 2017).

The CDC put forth a community response plan for the prevention and containment of suicide clusters (in 1988), as well as postvention strategies once a cluster has occurred, though it has not since been updated. In 2017, the CDC produced a Technical Package for Prevention of Suicide, which includes strategies to help at the community and state level, but does not include strategies on the individual level (Stone et al., 2017).

Technology and Suicide Contagion

Estimates reveal that more than 90% of teens have smartphones (Bahrapour, 2018) and 95% have mobile access to the Internet (Pew Research Center, 2018), enabling adolescents to communicate using methods that distribute information almost instantly, to potentially hundreds of people simultaneously without geographical limitations; therefore, the effects of a student death by suicide may have even more far-reaching effects.

Because adolescents use media an average of 9 hours a day (including TV, movies, online videos, playing games, Internet, music, reading, and social media), it is not surprising that more adolescents get their news from online sources rather than traditional media. Among adolescents who use social media, 76% receive news from such sites (Pew Research Center, 2018). Even if traditional media outlets follow established safe reporting guidelines for deaths by suicides, social media messages may not. Adolescents are in the forefront of information dissemination when a suicide of a peer occurs, effectively becoming “citizen journalists,” (public citizens who are actively collecting, reporting, and disseminating information). In fact, one study found that 59% of individuals ages 14 to 24 were exposed

to suicide-related content through Internet sources (Dunlop, More, & Romer, 2011, as cited in Luxton, June, & Fairall, 2012).

Evidence for “massive-scale contagion” via social networks has been found (Kramer, Guillory, & Hancock, 2014) as data revealed that emotions expressed by others on social media can influence our own emotions, even in the absence of in-person interaction and nonverbal cues, which may in turn affect a variety of offline behaviors. Essentially, this research shows that emotions can be spread on social media just like real life, which further supports the concept of contagion via exposure to a suicidal peer via social media (M. S. Gould, personal communication, April 2018).

Social proximity among adolescents is progressively transcending physical geography. As a result, adolescent deaths by suicide are no longer isolated, which enables contagion to occur in a broader and more rapid manner. Consequently, the task of predicting and managing contagion is vastly more difficult for educators.

Currently, there are few accepted guidelines to address safe messaging across social networks (Cox et al., 2012). However, in conjunction with a panel of experts, Suicide Awareness Voices of Education (SAVE) set forth recommendations for blogging on suicide, cautioning users, “It’s important to note that readers’ attitudes and behaviors can be influenced by what and how you write about suicide, mental health, crisis, and suicidal ideation—both negatively and positively” (p. 2), adding, “certain content related to suicide can have harmful or even fatal effects on vulnerable individuals who may be contemplating suicide themselves.... Bloggers can help reduce the risk of suicide and avoid spreading stigmatizing, counterproductive, or harmful messages” (p. 3).

What More Can We Do?

Following suit, perhaps educating the users, in this case adolescents, about safe messaging would be a promising future direction to continue to mitigate the impact of widespread

messages on suicide contagion among youth, particularly since teens most often seek help from their peers. Empowering adolescents to be part of the development of safe messaging for other teens, in conjunction with suicide prevention experts and media representatives, might also be beneficial. The full impact of what some are calling, “social-media contagion” (Luxton et al., 2012) is not yet clear with regard to adolescent suicide prevention and may need to be more clearly defined in order to develop relevant postvention strategies in the schools.

Additionally, efforts to prevent suicide contagion need to consider the research that supports safe messaging, including: publishing stories that educate and shape attitudes while avoiding misinformation; avoiding sharing the initial, unrealistic, and extreme immediate responses of those closest to the deceased; avoiding reports of denial or minimization of warning signs; acknowledging multiple contributing factors to suicide (i.e., not just bullying); and disseminating stories of positive coping, receiving or offering help, and the availability of services (Gould, 2018).

The use of technology to deliver mental health support has grown exponentially (e.g., teleweb services, digital self-help, and mobile apps), increasing the accessibility of online support services to deliver interventions to young people at times of the day when suicidal ideation or thoughts may escalate quickly. Leveraging the communication networks used by adolescents can be an effective way to quickly respond, mobilize resources, and disseminate information to large groups of adolescents following a suicide and to reduce the likelihood of a cluster.

Preventing Contagion: Guidelines for Schools

Successful suicide postvention is dependent upon a timely, efficient, and targeted response to a student suicide and increasingly, the ability of school personnel to recognize the possibility of contagion.

Need for timeliness. Since predicting where a suicide cluster will occur is not possible, it is critical to develop a set of postvention strategies that are ready to implement following the identification of a cluster (Cox et al., 2012). The timely implementation of a response plan following a suicide cluster in a school setting has been associated with fewer students showing negative symptoms (e.g., PTSD; Poijula, Wahlberg, & Dyregrov, 2001). Doing so is complicated, however, by the fact that increasingly, due to the speed of information exchange in our technology-connected world, students are often aware of a peer’s suicide prior to the knowledge reaching educators and parents, narrowing the window during which adults can intervene and prepare affected students. School, parents, and communities need to find ways to intervene and provide information and support to students sooner.

Need to utilize best practice resources. Among the myriad of easily downloadable best practice resources, schools have access to *After a Suicide: Toolkit for Schools* (second edition). This important resource will be discussed more fully in Part 2 of this series (reprinted in this toolkit, starting on page 131).

Need for interventions of longer duration.

Generally, we have observed that postvention assistance in schools after a suicide is often too short in duration. In fact, research has found that 30% of students continue to show signs of PTSD as long as 6 months after a suicide cluster occurs in a school (Poijula et al., 2001). For identified students who are vulnerable prior to a student’s death and are further triggered by a peer suicide, the support needed at school can last even longer. We have

noted that the sibling, best friend, or partner of the deceased often gains “celebrity status” in their school and must navigate changes in the way peers and adults interact with them, all the while dealing with the very real aspects of grief and trauma over time, requiring longer-term intervention.

Need to intervene more broadly. In our experience in the schools, too often postvention efforts focus on an insufficient number of students. As supported by experience and confirmed by research, the impact of a youth suicide on the student population is much wider than the victim’s closest friends (Gould et al., 2018). Though there are varying degrees of impact among those exposed, research has shown that among those exposed, a significant portion report persistent distress (Cerel et al., 2018) and will require substantial support at school.

Clearly, schools cannot do it alone. It takes a village—a collaborative effort among schools, community agencies, mental health practitioners, medical personnel, law enforcement, clergy, parents, survivor groups, and even youth. Community members, medical personnel, clergy, and mental health professionals can assist school personnel in screening exposed teen populations for individuals who are at greatest risk of contagion and imitation. Community personnel with training can make themselves available to school staff to provide resources and support in advance of a student death.

School psychologists need to stay informed of the emerging and relevant factors related to the potential of suicide contagion in the schools to avoid suicide clusters, while simultaneously keeping in mind that it is quite rare. A foundational base to prevent suicide and contagion in the schools can be built on a school climate of positive connections between students and adults, within the community and the school building, while ensuring students consistently and genuinely receive the clear message from all adults that “We are here to help.”

Part 2 in this series, titled “Suicide Contagion and Clusters—Part 2: What Can a School Psychologist Do?” will appear in the next issue of *Communiqué*.

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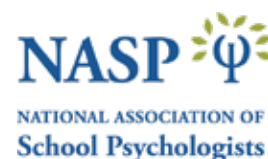
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Article: Suicide Contagion and Clusters—Part 2: What Can a School Psychologist Do?

In Part 1 of this series (Lieberman, Poland, & Niznik, 2019), we discussed the phenomena of contagion and identified adolescents as the most susceptible age group for imitating suicidal behavior. Beyond specifically suicidal behavior, we may be underestimating the full impact of being exposed to a death by suicide—a contention supported by Cerel and colleagues (2018), who found that of approximately 135 people exposed to a death by suicide, as many as 30% found it to be a life-changing event. Ultimately, the primary goal of postvention is to identify those now at risk and prevent the next suicide. Part 2 of this series focuses on limiting contagion and highlights the many potential roles of the school psychologist in suicide postvention. Frequently asked questions (FAQ) are included at the end.

Postvention is defined as an intervention after a suicide. The term was coined by Schneidman (1973), whose basic view was, “the largest public health problem is neither the prevention of suicide nor the management of suicide attempts, but the alleviation of the effects of stress in the survivors whose lives are forever altered.” Research has shown that postvention efforts in the schools are often too short in duration and focus on too few children. While many districts have policies established for intervening with suicidal students, few spell out a process for postvention or how they will intervene in the aftermath of a student death by suicide. School psychologists play a critical role in guiding district policies and procedures, identifying and alleviating the distress of suicidal bereaved individuals, reducing the risk of imitative suicidal behavior, and promoting the healthy recovery of the impacted community (see FAQ 1).

We have assisted many school districts in the aftermath of point clusters (multiple student

deaths by suicide, in geographical proximity, over a short period of time), and in each case the local school psychologist spearheaded the comprehensive district response. Working in collaboration with administrators and other school mental health personnel (such as counselors, social workers, and nurses), school psychologists provided guidance, resources, and ultimately, leadership. They helped their communities see this was not a school problem but a serious community crisis that required commitment and determination to respond (see FAQ 2). The remainder of this article provides suggestions regarding some of the key roles and actions that may be taken by school psychologists in these situations.

Immediate Actions

Respond immediately when a student suicide occurs. Confirm the facts and gather information. Verify that the death was by suicide, preferably by talking directly to the student’s parents, law enforcement, or coroner. Work closely with the school administration and community resources to recognize the possibility of contagion and to identify students most at risk. Students at risk may include: students who were close to the student who died, students who have previously considered or attempted suicide, students who have been exposed to the suicide and have other risk factors, students who have major life events occurring, and students exposed via social media.

Mobilize a crisis response team (assist the principal in establishing this team before the crisis occurs). Collaborate with team members to determine the impact of the crisis and advise the principal on how to proceed. Notify key district and community partners to increase screening and support of affected students.

Reach out to the family. Offer to accompany your principal to the home. Express sympathy and offer support. Identify the victim's siblings and friends who may need assistance. Discuss the school's postvention response. Identify details about the death that could be shared with outsiders. Discuss funeral arrangements and whether the family wants school personnel or students to attend. Communicate directly to parents and students, balancing the family's wishes for privacy and needs of the students (see FAQ 3). Utilize the *After a Suicide: Toolkit for Schools (2nd ed.)* for templates of statements for parents and students and share with your principal.

Next Steps

Triage staff first and notify them in person, if possible. Allow grieving staff to be relieved from the classroom. Conduct a faculty planning session to review the referral process and staff role in postvention. Remind staff that how they respond has great impact on potential traumatization, particularly in young children.

Share resources for students who need additional support. Share crisis hotline information via the school's social media page and send out information about safe messaging via the commonly used social media sites directly to adolescents. Post relevant support information, such as text line or crisis hotline numbers in visible locations for students and staff.

Conduct educational/psychological sessions (see FAQ 4). Avoid large assemblies or large groups (See *Toolkit*, p. 30) where students cannot ask questions or be easily monitored for their reactions (see FAQ 5). Provide support to students in small groups or in classrooms. Share facts, dispel rumors, allow students to share and then normalize a wide range of reactions, and look for students who may be showing signs that they are significantly impacted.

Identify and screen students for suicidal ideation/behavior. Conduct primary screening and triage students utilizing three factors: those physically proximal to the event, those emotionally proximal,

and those with preexisting vulnerabilities. Train or refamiliarize faculty members, parents, and students on how to recognize warning signs and identify support services. Have mental health providers screen for suicidal ideation behavior. Conduct secondary screening with students who may present an elevated risk for suicidal behavior or have been affected by the suicide to determine if interventions are necessary. Some exposed students will have sufficient ability to cope with loss.

Notify parents/guardians of those assessed with suicidal risk and recommend community-based mental health services as needed. Coordinate with community providers with appropriate signed releases to do so.

Assess high-risk students for suicidal ideation or behavior. "All school mental health professionals have the ethical and practical responsibility to conduct suicide risk assessment" (Singer, Erbacher, & Rosen, 2018, p. 8). Suicide risk assessment is an essential role of the school psychologist in suicide intervention and requires specialized training (Lieberman et al., 2014). Risk assessment includes: identifying suicidal ideation, intent, and plan; assessing for risk and protective factors; assessing for access to lethal means and experience with self-injury to address habituation to pain; and creating a risk formulation. Many districts that we have consulted with have utilized the Columbia Suicide Severity Rating Scale for assessment.

Provide individual and group counseling to affected peers. Provide or refer students for individual counseling. This can include school-based counseling, safety planning, or referral to community agencies or mental health practitioners for treatment. Safety planning should include triggers, warning signs, thoughts, moods, coping strategies, agreement to remove access to means, and steps to take for help in a crisis. Parents should be involved in safety planning (Singer et al., 2018). Provide for students reentering from hospitalization (see FAQ 6).

Ensure Safe Messaging

Be aware of policies and procedures on social media sites. Appoint a Social Media Manager to assist the Public Information Manager. Utilize students as “cultural brokers” to help faculty and staff understand their use of social media. Train students in a gatekeeper role, and specifically identify what suicide risk looks like when communicated via social media. Have staff monitor social networks and provide safe messaging when important (this will require that districts not completely block these networks). Have parents get involved in their child’s use of social media.

Support opportunities for memorialization. Assist your school district in developing memorialization policies (see FAQ 7 and consult the memorialization pages of the Toolkit for a host of suggestions). Encourage funeral participation with support from the family. Contribute to a suicide prevention effort in the community. Develop living memorials or primary prevention programs that will help students cope. Monitor all off campus memorial sites (see FAQ 8).

Ensure responsible media reporting and safe messaging (see FAQ 9). Educate everyone about safe messaging by adopting phrase “died by suicide” to replace “committed suicide.” Work with news reporters to inform, limit details, and share the resources listed at the end of this article. Educate students on safe messaging on social media. Encourage parents, staff, community members, and the students themselves to monitor communication that is concerning and to take action to get help for adolescents in need (via a trusted adult, crisis hotlines, crisis text lines, etc.).

Plan for the Long Term

Follow up with all referred students in the days, weeks, and months that follow, particularly with siblings and relatives of the victim. Be mindful of planning for anniversaries, birthdays, and graduation.

Debrief and evaluate the response. Collect data throughout the postvention on students referred, parent notifications, and student hospitalizations. Evaluate these data and update procedures.

Remember that postvention leads back to prevention. Implement evidence-based mental health promotion programs beginning in elementary school so that communication and seeking support for mental health is something that is accepted, encouraged, and supported. Train staff annually on how to respond to students seeking assistance. Have clear procedures in place with identified staff roles for getting students help. Update mental health and suicide prevention resources. Train peers, using gatekeeper programs such as Signs of Suicide (SOS) or Question/Persuade/Refer on how to respond when a peer needs assistance.

Involve parents in all aspects of suicide prevention including policy development and gatekeeper training. Implement evidence-based suicide prevention curriculum such as SOS, Sources of Strength, or Riding the Waves (see FAQ 10).

Engage your community. Implement a comprehensive suicide prevention program that includes the entire community, including school officials, law enforcement officers, emergency room directors, funeral directors, clergy, public health administrators, representatives from mental health agencies, technology experts, and adolescents.

Communicate with other schools in the district or geographic area (including feeder schools) and groups with whom the student was involved (e.g., clubs, sports teams, jobs, and religious organizations) that can help support survivors and identify potential contagion. Ensure that school personnel, parents, and community members are monitoring social media and other forms of preferred communication among adolescents and empowering students to reach out for help and get help for their friends and classmates.

Resources

Utilize the newly released and updated, *After a Suicide: Toolkit for Schools, Second Edition* (2018), which is available at afsp.org and sprc.org.

This resource was created in collaboration with suicide experts, school personnel, clinicians, and crisis responders, and provides guidance and tools to assist with postvention efforts in the schools that aim to provide support to students and staff and prevent additional trauma and deaths. The importance of community collaboration and partnership, well established prior to a crisis, is emphasized to enable good working relationships when necessary.

Be familiar with recommendations from the Centers for Disease Control (CDC) and the World Health Organization. The CDC (1988) recommends the pre-selection of a suicide task force, made up of trained and experienced gatekeepers from various helping professions, to assemble when an adolescent suicide has occurred and to oversee the implementation of the community-based postvention plan. Tasks include organizing local gatekeepers who may not all be familiar with the cluster phenomenon or the postvention plan; helping professionals to review the anticipated reactions from peer survivors so that they can swiftly, uniformly, and effectively respond; creating a statement within 24 hours of the suicide to be shared with gatekeepers, schools, churches, teen organizations, and news sources in order to control what is reported and to advertise public forums and emergent resources; and frequently reconvening while the cluster remains active to discuss any new developments and to review the postvention plans.

Be familiar with safe messaging guidelines and share them with media professionals.

- A useful handout from Reporting on Suicide called Recommendations for Reporting on Suicide can be accessed at reportingonsuicide.org/recommendations

- Media guidelines for safe messaging are available at the Suicide Awareness Voices of Education (SAVE) website (save.org). SAVE also provides recommendations for blogging on suicide (docs.wixstatic.com/ugd/a0415f_0528cf9c81b64da2af583cbc595aabac.pdf)

Be familiar with state and local model programs and toolkits.

- *Montana Crisis Action School Toolkit on Suicide* (Montana CAST-S, dphhs.mt.gov/Portals/85/suicideprevention/CAST-S2017.pdf)
- Heard Alliance: *Toolkit for Health Promotion and Suicide Prevention* (2017; heardalliance.org/wp-content/uploads/HEARDToolkit2017.pdf)
- National Action Alliance for Suicide Prevention: Research Prioritization Task Force. (2014) *A prioritized research agenda for suicide prevention: An action plan to save lives*. Rockville, MD: National Institute of Mental Health and the Research Prioritization Task Force
- The California Model Youth Suicide Prevention Policy (cde.ca.gov/ls/cg/mh/suicideprevres.asp)

Be familiar with grants to help recover from traumatic events. If your district has experienced a cluster, consider applying for Project SERV (School Emergency Response to Violence) short-term grants from the U.S. Department of Education. This program funds short-term and long-term education-related services for local educational agencies and institutions of higher education to help them recover from a violent or traumatic event in which the learning environment has been disrupted (ed.gov/programs/dvppserv/index.html).

Ten Frequent Questions from the Field, Answered

1. ***What is the one essential resource I need if a student in my school dies by suicide?***

If you do one thing after reading this series, we hope it is to download *After a Suicide: Toolkit for Schools*, Second Edition from the Suicide Prevention Resource Center and American Foundation for Suicide Prevention. It is easily accessed, completely electronic, and, at a time when you will find it hardest to think, it will provide you with best practice suggestions on how to proceed. Arrange to review the Toolkit with your principal in “prevention/preparedness” mode, particularly the section on “Crisis Response.” You could also share the “Helping Students Cope” section to highlight mental health services you provide.

2. ***What have you learned from consulting with school districts that have experienced point clusters?***

Each district

- realized they were in it for the long haul (minimum of 2 years)
- received recommendations from the Centers for Disease Control (CDC) to have an intra-district suicide prevention task force establish best practice policies and procedures (1988)
- collaborated with, and assisted in, developing county-level task forces to consolidate CDC suicide-prevention resources and data tracking in the community
- provided specialized training to mental health personnel in suicide risk assessment, parent notification, collaborating with law enforcement and community mental health agencies, and safety and reentry planning for students returning from hospitalization

- created district-level suicide prevention /wellness coordinator positions to implement primary prevention programs such as Signs of Suicide: Depression Screening Program, Sources of Strength, and Riding the Waves
- coped with contagion due to unsafe messaging in television and other news media

3. ***What if the parents do not want the cause of the death of their child to be acknowledged as a suicide?***

We have faced this situation many times and sometimes we have been successful in explaining to parents that no one will be theorizing about the reasons that their child died by suicide. In fact, the reasons for their suicide have died with them, but if we can simply acknowledge that the death was a suicide, this gives us an opportunity to talk truthfully with all staff and students about their important role in preventing further suicides. If the parents do not give permission to disclose the cause of the death, then the school crisis team is encouraged to read in the *Toolkit* the sample templates for student and parent communications that address this situation. It will be up to the crisis team and administration to determine whether or not to adapt the template letter, which essentially states that the parents have asked that the cause of their child’s death not be disclosed but still emphasizes that suicide is a leading cause of death for students and that everyone needs to know what to look for and what to do if someone is suicidal. It is worthwhile to mention there are two other templates for letters, one for when the parent is cooperative with the team in acknowledging the suicide and another for when you do not know if the victim’s death was accidental or intentional.

4. *What are the most common questions that students ask in the aftermath of a suicide?*

- Students always want to know why the suicide occurred, and it is important for the school psychologist to emphasize, “The answers have died with him/her and we will never know why, which is why it is so hard to grieve.”
- Students often asked directly about the method that was used to die by suicide. We have found it best to simply acknowledge the method if it is factually known but not to dwell on any graphic details. Always focus the conversation back to helping students.
- Students also often ask why God did not stop him or her. We do not claim to be religious experts; however, numerous members of the clergy have stated, “Unfortunately, God could not stop him or her but God has embraced them in whatever afterlife you believe in. But God is sad that they did not stay on this earth and do God’s work over their natural lifetime.” We like this approach because it emphasizes that the victim has been embraced but was not chosen at a young age to die.

5. *Why don’t you support an assembly after a suicide?*

We very much believe that suicide prevention must be discussed with students and a death by suicide acknowledged, but in a classroom or an even smaller group setting. An assembly is dramatic and glamorizes the suicide, students will be reluctant to ask questions, and school staff will not be able to ascertain how individual students are coping with the tragedy.

6. *What do you do when the parent just drops the student off at school the day after their hospitalization? Can you tell the first period teacher?*

This question comes up frequently and is known in “prevention phase” as reentry planning. In a perfect world, the parent would accompany the student back and meet with the psychologist to share the records from the hospital and develop a safety plan that includes trusted adults at school. Additional components of reentry planning include:

- Monitor the student to ensure that no bullying takes place as a result of hospitalization.
- Collaborate with members of the team and determine which staff members, including teachers, need to be apprised of the situation to ensure the student’s safety.
- Do not deny entry to any student standing at the front door of the school. They are much better served at school than alone at home.
- Check in frequently the first few weeks, particularly if monitoring medications.

7. *What is the key recommendation in the Toolkit about memorials?*

The Toolkit strongly recommends that school districts establish one policy that treats all deaths the same regardless of the cause of death. The school psychologist could advocate for such a policy while in prevention phase before a death by suicide occurs.

8. *What if students arrive at school the day after the suicide with T-shirts with a picture of the deceased and they want to wear them at school?*

This is the scenario that we have encountered quite often and the Toolkit stresses the importance of being compassionate and understanding that students are expressing the

loss of their friends through wearing the T-shirt. We believe it is best to allow the T-shirt for that first school day and then meet with students, remind them of the school's dress regulations, and guide them toward more appropriate prevention and memorialization activities referenced in the Toolkit.

9. What are some examples of the safest messages that I can communicate to my students, staff, and parents?

- Suicide and the grief that follows a death by suicide are complex and no one person, no one thing, is ever to blame.
- While some suicides cannot be prevented, most can.
- Everyone plays a role in suicide prevention.
- There are evidence-based treatments for all the risk factors of youth suicide.
- Kids are resilient and they can get better.

10. What are some available applications to help me with suicide assessment and safety planning?

One application to assist with suicide assessment is SUICIDE SAFE from SAMHSA (store.samhsa.gov/apps/suicide-safe).

The following are three applications to assist with safety planning:

- Virtual Hope Box (play.google.com/store/apps/details?id=com.t2.vhb&hl=en_US)
- A Friend Asks from the Jason Foundation (jasonfoundation.com/get-involved/student/a-friend-asks-app)
- My3, developed with funding from the California Mental Health Services Act (my3app.org)

Source: Poland, S., Lieberman, R., & Niznik, M. (2019). "Suicide Contagion and Clusters—Part 2: What Can a School Psychologist Do?" *Communique*, 47(6), 12–14. nasponline.org/publications/periodicals/communique/issues/volume-47-issue-6/suicide-contagion-and-clusters—part-2-what-can-a-school-psychologist-do



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Appendix 3

Scott Poland Answers Questions from Parents, School Personnel, and Students

Scott Poland, Ed.D., has presented more than 1,000 suicide prevention trainings and has responded to many suicide clusters. He has often been the primary speaker to parents after many tragedies. Here is a compilation of 60+ questions he has fielded over the years.

1. How much does academic pressure affect kids and increase stress and depression?

There are a multitude of problems that contribute to the factors of youth suicide, and epidemiology studies done by the Centers for Disease Control and Prevention have identified a number of factors. Those factors have included family problems, substance abuse, academic pressure, access to lethal means, and issues that have to do with harassment and bullying—especially for LGBTQ students. Academic pressure has been identified as a possible contributing factor. In looking at all these factors together, the most significant one is mental illness and most likely depression.

2. Why do you think the suicide rate is so high in the western United States?

The states with the highest risk for suicide are all in the west, for example Alaska, New Mexico, Wyoming, Washington, Idaho, and Colorado. There have been many theories about why, but these states have a large percentage of Native Americans who have high suicide rates. The rural nature of such areas may exacerbate contributing factors such as the lack of mental health resources, the stigma that is

still associated with getting help for yourself or a member of your family that has a mental illness, and gun access. Another theory relates to elevation. Although there is not definitive research on this, there is some evidence that antidepressants may not be as effective when they are taken at high elevations and that oxygen deprivation affects brain chemistry. I think it is really important to emphasize that other locations in the nation have also been singled out for having high youth suicide rates. I personally have worked in the aftermath of high suicide rates and contagion in the last few years in New Smyrna Beach, Florida; Fairfax County, Virginia; Colorado Springs, Colorado; St. Joseph, Missouri; Palo Alto, California; Jordan, Utah; and Rapid City, South Dakota. The fact is that every state is facing this problem. Local community, state, and school leaders must take many concrete steps to prevent further suicides of youth.

3. Do you know of any specific filtering software or apps that you have found to be effective with teens?

There are a number of applications for both telephones and computers that can help parents be more aware of websites that their teens are visiting and communications they are receiving. I think the most important piece of advice I can give in answering this question is that every school has technology specialists who can respond and provide more specific information to answer this question. The one point I'd like to make is that not all parents are going to need these applications. They should

be used when a parent is excessively concerned about their child's behavior and him or her being consumed by technology. In addition, there may be parents who are concerned about the negative influence other children are having on their own child. When concern increasingly rises, in addition to these applications, I would strongly recommend counseling for your child. The counseling department at your child's school can certainly make referrals to the best providers in the area.

4. *How do I find a good mental health practitioner specifically for tweens and teens?*

There are many mental health practitioners that specialize in working with children and adolescents. My recommendation is to contact the counseling department at your child's school because school counselors are very familiar with practitioners who specialize in working with upper elementary students and adolescents.

5. *Are children who have a stay-at-home parent at a lower risk for suicide?*

Children who have a stay-at-home parent are very fortunate in many respects as there will be more opportunities for parent and child interactions and increased supervision. The research from the World Health Organization has not specifically emphasized having a stay-at-home parent as a protective factor, but instead stressed the following factors that prevent youth suicide: stable families, access to mental health treatment, lack of access to lethal weapons, positive self-esteem, good relations with other youth, and religious involvement.

6. *Which social media sites are dangerous for teens?*

Parents need to visit the websites their children are accessing and make their own determination whether these sites are healthy or not. I believe the other important factor is to examine the overall well-being of your child. For example, I am often asked, "My child likes to visit this particular website as they are fascinated with media violence. Should I be concerned?" I'm going to ask a number of questions, and if I find out that the student in question is involved in at least one organized activity, they go somewhere with mom and dad once in a while, they do a good job taking care of the family pet, they apologize when they hurt someone's feelings, and show empathy for other people, then I am going to relax, because, those are very healthy behaviors for a young person. However, if the young person visits violent and very unhealthy websites; they do not apologize nor show remorse; they are fascinated with violence, guns, and bombs; they tried to harm the family pet; and they are totally isolated from all adults, now I am very concerned. Those behaviors collectively and additively are extremely troubling signs for young people.

The important point is not being overly concerned with a fascination with one subject or the frequent visiting of a social networking site that the parents don't necessarily approve of. The most important thing is the overall adjustment of your child. And, if you are concerned and there are many red flags, please consider obtaining counseling for your child and increasing your supervision. And, yes, I would encourage "snooping" with regards to room, websites visited, journals, and diaries when you have a number of these concerning behaviors.



7. *What causes cluster suicides?*

Clusters of suicides fall into two different categories. Mass clusters have been researched extensively since the 1700s. A mass cluster might occur when a celebrity or a known national figure dies by suicide. There is not a lot of research support for mass suicide clusters; however, the suicide of Robin Williams, for example, a very beloved American actor, resulted in an increased suicide rate in America.

Point clusters refer to more suicides than we would expect in a short space of time in one geographical region. It is well known that teenagers are more susceptible to imitating suicidal behavior than any other age group. Exposure to suicide has been added as a suicide risk factor. Think of it this way, the suicide of a young person is like throwing a rock into a pond causing a ripple effect in the schools, communities, and places of worship. This ripple effect is greater than ever before today because of social networks. Vulnerable youth find each other online. Schools have had a tendency to think that the suicide only affected their one school when, in reality, students in many middle schools and high schools in the area are affected.

There needs to be collaboration between schools, agencies, mental health, law enforcement, medical community, and survivor groups. Essentially, youth suicide prevention must involve the entire village, as no single entity or agency can do enough alone. It is essential that suicide information be shared with all concerned and everyone understand that suicide is not fate, nor is it destiny, and the vast majority of youth suicides can and should be prevented.

8. *Are teens capable of hiding depression?*

There are a number of clear warning signs of teenage depression. Parents have reported that they are often confused as to whether it is really depression or typical teenage moodiness,

irritability, and angst. Here are the key things that parents need to be looking for. First, is this pervasive? That means, is it affecting all aspects of your child's life including school and academic performance, peer and social relationships, and family relationships. Is this behavior persistent? That means, has it gone on for two or three weeks or more? The next thing the parent needs to consider is whether their child has dropped out of activities that were previously pleasurable to them. For example, your son enjoyed playing basketball for years but this year he has decided not to go out for the team. Or, your daughter has enjoyed playing volleyball or has been on the dance team for years and now suddenly, she has lost interest in those activities.

I believe it is vitally important that parents are involved in all aspects of their child's life and, if you pay attention to these factors, I do not think that an adolescent is going to be able to hide their state of depression from you. If they are isolating themselves in their room and they are having problems with their sleep cycle and they don't want to have meals with the family or they are not involved in social activities at the level previously, then I believe you know, as a parent, something is wrong.

Please, do not hesitate to seek professional help for your child. It is estimated that 20 percent of all teenagers suffer from depression at some point during those tumultuous years. It is also concerning that a review of the literature says that 80 percent of depressed teenagers never receive any treatment whatsoever. The treatment needed, very likely, will involve cognitive behavior or talk therapy but also may in addition include antidepressant medications. Many professionals, including myself, believe that the "black box warning" on antidepressants for adolescents has resulted in many adolescents who desperately needed those medications not receiving them. We also believe that not receiving needed medication has contributed to the increase in suicide rates for adolescents, as it is now their second-leading cause of death. This

may be affected by parental reluctance for their child to receive antidepressant medication and a lack of information about their effectiveness.

I believe strongly that a careful diagnosis of depression needs to be made and medication needs to be monitored frequently. I specifically request that medications be monitored weekly for the first month after an adolescent starts taking an antidepressant. If your child is on an antidepressant and you or your child are not pleased with the medication, please go back and talk to the prescribing physician and share your concerns.

9. *How can we engage parents who are in denial or who don't want to talk about youth suicide in our community?*

The topic of suicide is a very difficult one. In my career, I have found many parents, school leaders, and even personal friends and colleagues are reluctant to talk about suicide. Many people believe the myth that if we talk about suicide, people may consider suicide for the first time ever. Nothing could be further from the truth. The U.S. surgeon general commented, "More than 48,000 suicides happen annually in this country. We need to talk about this more in our homes, our schools, our places of worship, and our communities." Unfortunately, many students personally know someone who died by suicide. This reinforces the reality that we need to talk about it more.

Any discussion should always focus on prevention and using crisis helplines, such as the National Suicide Prevention Lifeline at 800-SUICIDE or 800-273-TALK. Young people today are very in tuned with texting and, therefore, it is important that they are all aware of the Crisis Text Line crisistextline.org.

If you are aware of a family in your community that is hesitant to talk about suicide, then the best way to open that conversation is through listening. Begin with a simple statement and

question: I'm really sorry that suicides have affected your family. How can I help? The more you can demonstrate a willingness to actively listen, the better. The greatest problem we have that limits suicide prevention is the misinformation and the myths surrounding this subject and our reluctance to talk about it.

10. *Is there any significance to the location that a student chooses for a suicide attempt?*

The vast majority of youth suicides occur in their own home, after school hours, and when their family members are most likely to be in the home. I've always believed that most suicidal individuals do, in fact, want to be stopped, and they set it up hoping that someone will figure out what they are planning. A suicidal individual is experiencing unendurable pain, is not thinking clearly, and sees no alternatives or a way out. Very rarely does a suicide occur at school, however this has happened in a number of schools in our country. My response to a suicide happening at school would be to not make a dramatic conclusion about the location that was chosen, but instead to focus on the young person, who very likely, wanted to be stopped and hoped that someone would recognize the warning signs they had displayed and get them help.

11. *Are tattoos and/or piercings a safe and culturally acceptable way of cutting?*

Tattoos and piercings, especially for the younger generation, have become socially acceptable, but I am old-fashioned and believe that children need to discuss with parents whether getting a tattoo or piercing is acceptable within the family. I emphasized earlier the importance of parents being involved in their child's life. What I really hope is that there is free and easy communication around the dinner table several nights a week between children and their parents about

many issues. I emphasize in my parenting presentations that we need to bring the family meal back. It's not a McDonald's visit. It's around your kitchen table. Therefore, if you are tuned in and a good listener and really involved in your child's life, hopefully they will share with you any thoughts they are having about getting a tattoo or piercing.

I think it's very important that I distinguish tattoos and piercings from self-injurious behaviors, also referred to as non-suicidal self-injury (NSSI). NSSI is a coping mechanism. It is one that some young people engage in when they are experiencing anxiety or feeling overwhelmed. The most common forms of NSSI are cutting or burning, which results in a moderate or superficial injury to their skin. This behavior has biological and psychological benefits. The psychological benefits are regulation of emotions. They can shut out the humiliation they just experienced, a major disappointment, or perhaps the argument their parents are having in the other room. The biological benefits are that endorphins are released, and these endorphins are the very same ones that are released through exercise. If a young person gets a tattoo or a piercing, this is something they have thought about and planned over days, weeks, or even months. The self-injurious behavior, such as cutting and burning, is usually done impulsively following a precipitating event (e.g., an argument, a humiliating event, etc.). Therefore, these behaviors are very different because to obtain a piercing or a tattoo you are making an appointment, traveling to a location, deciding on the piercing location or deciding on the exact tattoo. To engage in self-injury, all one has to do is go into the bedroom or school bathroom, isolate self from others, and quickly engage in the behavior. It is important that we recognize that a young person engaging in NSSI is getting comfortable with harming their body and estimates are that 30 percent of those who engage repetitively in NSSI ultimately make a suicide attempt.

12. *What input should teens have when it comes to the programs that schools select for suicide prevention?*

I recommend that teenagers who have been affected by suicide be provided opportunities to promote suicide prevention. This could be through promoting crisis helpline resources. In addition, it is also possible for older teenagers to go through training for participation in teen crisis lines in larger cities. Teenagers, in addition to raising money and awareness, can also memorialize their friend with a living memorial. The living memorial doesn't involve permanent shrines or markers or planting trees. It concentrates on promoting awareness, designating key mental health resources in our community, emphasizing depression as being treatable, and the fact that many teenagers suffer from depression in those tumultuous years. Teenagers do need to be involved, and have input in the memorialization decisions/activities, suicide prevention planning, and most importantly being able to debunk the many myths associated with suicide. The actions of any one person may make all the difference in the world in preventing a suicide. One student initiative was based on the motto "Keep on Swimming." After multiple suicides of students who attended a Colorado high school, students decorated and colored fish, and posted them on the walls of their school. The message is really important. No matter what happens, we need to get help for our friends, and ourselves, and face whatever adversity comes along, knowing we're going to get the help we need. I recommend forming a Hope Squad, which was started by a school administrator in Utah. Hope Squad is a peer-to-peer intervention program. More information can be found at hopesquad.com.

13. *Should schools promote social and emotional wellness?*

Absolutely! I practiced as a psychologist full time in the schools for 25 years and have been concerned that too much focus in recent years has been on student academic performance and overall school academic ratings. I strongly support the theory of Abraham Maslow, who emphasized in his pyramid theory that the foundation for all of us is first having physical needs taken care of and feeling safe and secure, with a sense of belonging. National research has found a very significant factor for overall adolescent well-being is whether or not they feel connected to their school. I hope that every student sincerely feels like someone at school cares if they show up today or not. I wrote an article for the National School Board Journal a number of years ago called “The Fourth R—Relationships.” I now teach in a university and I learn my student names immediately and sincerely care about their hopes and dreams and focus on how I can help them be successful. I use many activities in my classes that I learned in my previous school position where, in addition to directing psychological services, I supervised the adventure-based outdoor counseling program that used high elements to build self-esteem and low elements to increase problem solving and connections to others.

14. *How can I differentiate between “normal” stress and anxiety and teen depression?*

This question refers to normal stress, anxiety, and teenage depression. In addition, this question brings up the term anxiety. I think it is important that it be addressed from several avenues, including sleep deprivation. The research is very clear that unfortunately many adolescents are not getting enough sleep. There are a number of factors that contribute to this, including the fact that, unfortunately, teenagers are not wired to go to bed early and the fact that many secondary schools

in this country start too early. The national recommendation is that no secondary school starts before 8:30 a.m. One of the factors that contributes significantly to teenagers’ sleep deprivation is all of their technological devices. I suggest that parents decide the bedtime for their child and simply say, “I need your laptop now, I need your cell phone and iPad, and I will charge them and hand them back to you in the morning.” National research has estimated that as many as one-third of teenagers wake in the middle of the night to check to see what might have posted about them. Taking charge of technology is something parents must do to ensure that their child is getting adequate sleep. Inadequate sleep is connected to anxiety, frustration, hopelessness, and depression for young people.

Anxiety may also be the result of academic demands and pressure on young people. It was only a few years ago that a young person would be accepted to any state university of their choosing when they graduated from high school. Unfortunately, our flagship state universities have increased standards so it might be necessary to be in the top 8 to 10 percent of your class to be accepted into these universities. This has added a lot of pressure to young people, as parents and grandparents were able to go to that flagship university but their own acceptance is in doubt or they may have been rejected for admission. I like to share with young people who are experiencing these difficulties that I did not make the top 25 percent of my own high school class in Kansas. And, in fact, later I was kicked out of the University of Kansas for poor scholarship. It took me a couple of years to find myself, and frankly, military service helped.

Today, I am proud to tell you that I have three degrees, including a doctoral degree, and have authored and coauthored five books. The sentiment that needs to be echoed by staff members and parents is that not everything is going to work out perfectly. It is okay to go to a junior college. I actually attended two of them.

After the student is more successful, he or she will be able to transfer to a college that may have been one of his or her top choices.

The school district in Palo Alto, California, has wrestled with whether they should have zero hour. When I was there, I asked, “What is zero hour?” and I was told it was an opportunity to go to school an hour before everyone else and take an extra AP class. My advice was to do away with zero hour, therefore lessening some of the academic pressure on students. They initially eliminated it. However, zero hour is now back because parents with extremely high academic expectations for their children wanted them to be able to get an extra AP class into their schedule. I believe this was a very unfortunate decision. I am obviously looking at the total well-being of our students and recommend when possible to lessen the academic pressure.

Some thoughts for the school and community are the following: Can we make certain that the various academic departments, especially at the high school level, don’t all give homework on the same night? For example, maybe Tuesday night is the English department; Thursday night is math, and so forth. A second suggestion would be to create a forum to allow students to log in to record the amount of time they are spending on nightly homework. A parent and school committee could examine the number of hours spent on homework and make recommendations that could lessen some of the academic pressure. Perhaps your child is so anxious about a test in his or her class tomorrow and you noted he or she didn’t eat well or sleep well, or they were up all night studying for the exam. Or perhaps he or she is telling you he or she can’t go to school today because he or she is not ready for that important test. As a parent, you know your child the best, and if there is a consistent pattern of these behaviors, please don’t hesitate to get professional help for your child and share concerns about academic expectations with your child’s school administration.

15. *How do you walk the line between your child’s privacy and freedom and keeping them safe?*

It is certainly a challenge in giving your child privacy and balancing your right to know and your concerns about their safety. It has been said that some adolescents are leading secret lives with regards to sex, drugs, and other dangerous behaviors. I have a couple of key thoughts on this.

One: I am a fan of a family desktop computer, although you will notice that when your teenager uses that computer, the websites they will be visiting and the comments they will be posting will be significantly different when you are going in and out of the room where that computer is housed. Unfortunately, many parents “gave away the farm” when they gave their children access to largely unsupervised technology in elementary school. It is then hard to make changes later.

If your child already has a laptop, then the kitchen counter or family room or dining room table needs to become their workspace and not their bedroom. In particular, I am extremely concerned about a laptop that contains a camera. Sexting has become a very severe problem for young people in this country. Most students are not aware that sending a picture of themselves nude to a classmate in some states can be prosecuted, not as a misdemeanor, but as a felony. I also know that sexting, and being severely humiliated, and being taunted and teased by everyone at school for the picture that was sent out, not realizing it would be shared with everyone, was certainly a contributing factor to some tragic suicides of young people. If you have a number of concerns about your child’s behavior choices, then I believe you need to do a little snooping of their online behavior, diaries, and journals. I would also highly recommend finding a shared time that your child will talk to you. I realize parents are extremely busy, but we have to make sure there are at least a few times each week when we are



not distracted and we give our child individual and full attention. Hopefully, our children will share with us the frustration and challenges they are facing.

If you remain concerned about their behavior with school, social life, and family then I suggest it is time to obtain private counseling. I am often asked, “Should it be up to my child whether or not they go to counseling?” My response is, “Absolutely not! Your 14-year-old is not in a good position to determine whether or not he or she needs help.” Simply say, “We are going to get counseling. Would you rather have a male or a female counselor?” Secondly, you could say, “I am happy to go with you and be in the meeting with you and your counselor, if you like. But, going is not up to you given my level of concern about the behaviors you are exhibiting.” I’d like to also take a moment to emphasize I strongly believe that where multiple youth suicides have occurred, that all guns in homes need to be securely locked up. I’m aware of numerous situations where the parents believed that their child didn’t know where they kept the gun, didn’t know the combination to the safe, and didn’t know where the bullets were stored. I am aware of tragedies that did result. Please, take charge and secure firearms because many children have been exposed to suicide and that alone is a risk factor.

Two: The most dangerous activity your child engages in is riding in a car and driving a car. Make sure that you follow the graduated driving laws for your state and be aware that 16-year olds die three times more often than 18-year olds in car accidents and that is usually the result of inexperience. For example, they are less likely to be familiar with driving after dark and can be easily distracted when friends are in the car. Take charge and model wearing your seat belt. Never drive while intoxicated. Never talk or text on your phone while you drive your car. If you do these dangerous things, then your child may do the same. The most

frequent and many crises that I have responded to throughout my career have been tragic car accidents that took the lives of our children. These car accidents could have been prevented.

16. *How can a parent foster a culture of compassion and kindness with their elementary age child?*

Emerson had a great quote: “What we do speaks so loudly to our children that when we talk to them, they cannot hear us.” His quote certainly stressed the importance of modeling. That modeling is especially important for compassion and kindness. As parents, ask yourselves, “How do I treat my partner in my home? How do I treat my neighbors? How do I respond when I interact with law enforcement when I’ve been stopped for speeding or having a taillight out? How do I respond in a teacher conference at school? How do I respond if I’m in the assistant principal’s office because my child has exhibited misbehavior?” These questions set the stage for our children. I believe strongly, when we model compassion, caring for everyone—regardless of his or her sexual orientation or his or her religious affiliation—that we are setting the tone for children to express kindness and compassion for everyone. A suggestion might be that parents ask that a task force be formed that would include school personnel who would look at kindness and compassion at school.

When we address these subjects, we must also bring up the topic of bullying. It is very important that schools support the victim and make it clear that the victim does not deserve this and the school will get it stopped and be there for them every step of the way. The bully needs to be told, “Here are the consequences for today . . . if this behavior continues, then the consequences will escalate. It will not be kept a secret. All the other staff members will be told about your bullying behavior, and they all will be watching.”

It also needs to be a teachable moment for the bystanders. Research has shown that the more bystanders are present, the less likely someone will intervene to stop the bullying. That means one bystander when they are alone and observing the incident is more likely to intervene than when there are several bystanders. It has even been argued that the term bystander is too passive. The term needs to be replaced with witness. When we are a witness to something, we feel responsible to report what took place. Reaching the bystanders/witnesses is the key to reducing bullying in our schools.

Empathy is really important to address. Empathy involves putting ourselves in someone else's shoes. When we can do that, we can envision what it would be like to be treated a certain way. Hopefully, parents discuss empathy with their children as opportunities might arise when watching a movie or television program or discussing something that happened at school. You could ask, "How do you think that person might have felt in that situation?" The parent can help the child envision and empathize with the thoughts that had to be going through the movie character or real child's mind at the time.

17. *There is a high veteran suicide rate in the United States. Are the children of these veterans at a higher risk?*

First and foremost, being a veteran myself, I'd like to thank everyone for their previous or current service. I am very concerned about the number of suicides that have occurred for veterans and even for current active duty personnel. *Time* magazine had an article a number of years ago stating that 22 veterans die of suicide in the United States every single day. Additional articles state that more currently serving military personnel die by suicide every year than those that die in combat. I am aware of many military initiatives to prevent suicide and to destigmatize mental health treatment. But I'm also aware of where high ranking military professionals have talked about what being "Army Strong" really means is that you don't need mental

health treatment. Some military personnel on active duty have shared with me that they felt they couldn't obtain mental health treatment as it would be held against them. Our U.S. Congress passed the Clay Hunt Act in memory of a marine veteran who, unfortunately, didn't receive the mental health services he needed from Veterans Affairs and he died by suicide. Suicide prevention in the military is extremely challenging and I don't propose that I have all the answers. But it is important that I recognize that since the suicide rate is high for veterans and current military personnel, this means that many families of military personnel have been exposed to suicide. A family that has a suicide occur definitely needs to get counseling support for all its members. Suicide is not inherited, it is not destiny, but it can run in families, largely because of the modeling effect. It is critically important in our families that we tell the truth when a suicide has occurred. In my career, many times a student told me, "I finally figured out what happened to my favorite uncle. He was a marine veteran and he killed himself eight years ago. Why didn't they tell me the truth then?"

My strong recommendation, in developmentally appropriate language, is to always tell surviving children the truth about the death by suicide. Then, answer their questions and assure them that help and treatment will be sought for everybody concerned. How do you help a family when they have lost a loved one to suicide? I believe strongly that families greatly benefit from participating in suicide survivor groups. I had a parent say to me, "No one could possibly know how badly I hurt after the suicide of my child." My response is that when you go to a suicide survivor group, you're going to be aware that others have gone through and are coping with the incredibly complicated grief that you are experiencing. Please, go to one of those meetings and give them a chance to help you. I do want to emphasize that it's important to attend a group specifically for suicide survivors, because parents have reported when they go

to a general grief support group and share that their child died by suicide, other group members might say, “Oh, my child died of leukemia,” and the suicide survivor immediately feels out of place. If you don’t know the contacts to obtain information about suicide survivor groups in Florida, then contact the Florida Department of Children and Families or the Florida Suicide Prevention Coalition.

18. *How does bullying in elementary school impact suicide in later years?*

Literature indicates that we have underestimated the impact of being a bullying victim. Bullying victims may be affected for decades, and therefore the things that I said in answering question 16 are vital to be able to reduce and eliminate bullying. In addition, it’s important to clarify that there is a relationship between bullying and suicide. The research, which is produced by the Suicide Prevention Research Center (sprc.org) in a brief entitled, “Suicide and Bullying,” can be summarized with a few statements. There is a strong association between bullying and suicide. The research does not show a causal relationship between bullying and suicide, as it is almost impossible to rule out other factors—for example, things like poverty, loss, trauma, mental illness, and abuse. But a number of parents believe strongly that bullying caused the suicide of their child and they have actually sued schools. One of those cases went all the way to the Supreme Court in Kentucky, which ruled in favor of the Floyd County School District in the case brought by the estate of Stephen Patton in 2013. It is almost impossible to rule out all the other contributing factors to a youth suicide, but it would also be impossible for us to say that being a bullying victim did not contribute to the death by suicide. My strongest hope is that schools have bullying prevention programs and suicide prevention programs and that staff will not hesitate to ask the student known to be a victim of bullying, “Have you thought about giving up? Have you

thought your life might be hopeless? Have you thought about dying by suicide?” There is a strong association between bullying and suicide that schools, families, and communities need to recognize.

19. *Should schools use a universal screening tool to help identify students who are at risk?*

I believe the best thing to come along in decades to prevent youth suicide is depression screening. I am a strong advocate for Signs of Suicide (SOS), which is available at mindwise.org. SOS has two major components. The first is a very well-done video with the motto ACT: acknowledge, care, and tell. The video, which has a middle school and a high school version, shows young people exhibiting suicidal warning signs, which prompts their classmates and teachers to get them help using ACT. The second component is a seven-item questionnaire that contains questions about energy level, joy of life, depression, thoughts of suicide, and suicidal actions. Students in a classroom setting answer the seven questions, turn it over and score it, and know immediately whether they need to see a mental health professional. SOS was listed under the National Registry of Evidence-Based Programs and Practices (NREPP) within the Substance Abuse and Mental Health Services Administration (SAMHSA) before NREPP was deactivated. I am proud to have presented with SOS staff members at numerous national conferences. But, speaking honestly, I have found it difficult to convince schools to use universal depression screening. Given the scope of the problem of youth suicide, I strongly recommend that all middle schools and high schools implement the SOS program. I’ve sometimes been asked, “Well, we’ve done SOS two years in a row with the same students...should we do it again?” And I might say, “This year, bring in a mental health speaker who can talk to students within their classrooms, rather than during an assembly, and highlight the key

components of the ACT motto.” I also want to emphasize the SOS program is not expensive, and I believe it is the best program to come along in decades. Students tell things to each other that they are unlikely to share with adults. The SOS program teaches students how to respond and stresses getting adult help. More information is available at mindwise.org.

20. Are affluent communities at a higher risk for suicide?

Specifically, I have been involved just in the last few years in responding to suicide contagion and clusters in New Smyrna Beach, Florida; Fairfax County, Virginia; Palo Alto, California; Jordan, Utah; and Colorado Springs, Colorado. I believe all of those communities would meet the definition of being affluent. Youth suicide, however, crosses all racial and socioeconomic boundaries in our country. In particular, the suicide rate for black youth has increased. It is difficult to clearly ascertain whether or not affluence contributed to the suicides in those communities. I might argue that clusters in other less affluent communities may have occurred but stayed under the radar by not being a focus of media stories.

As discussed in question one above, the CDC has been studying suicide contagion in adolescents. They have identified a number of factors, including family reluctance to get mental health services for their children, substance abuse, gun availability, harassment of LGBTQ students, and academic pressure. Those epidemiology studies from the CDC need to continue. My hope will be that school communities and the parents who tragically lost their sons and daughters to suicide will contribute to those studies because it can only help us in identifying at-risk youth and preventing future suicides. To summarize, my belief is that affluent communities are at higher risk, but we don’t have substantial research to clearly state that is the case.

21. Is there an increased risk of suicide for students with ADHD or sensory issues?

I am not aware of increased suicide risk for students with sensory issues and hypersensitivity. There is growing research that links attention deficit hyperactivity disorder (ADHD) and suicide. Children with ADHD often have coexisting mental health issues and, if their ADHD is untreated, they are especially at risk for frustration, school failure, and depression. Parents are encouraged to obtain the proper treatment for a child identified with ADHD. Personnel such as physicians, psychologists, and school counselors, in addition to parents, are encouraged to monitor these children for signs of depression. Mental health professionals and parents should not be afraid to inquire directly about suicidal thoughts, and if the child discloses suicidal thoughts or actions, then a safety plan needs to be developed.

22. How can parents best address the “choking game” with their children?

This question has to do with the “choking game,” which goes by many different terms, such as pass out or black out. It’s very unfortunate that it is called a “game” because it can be deadly. Most young people learn about it from another student at school or online. The activity is often engaged in by a pair of students. One young person might ask the second young person to choke them until they pass out. You must be wondering, why they do this and what is the possible benefit? The benefit is that the oxygen to your brain is stopped through the activity and then returns to your brain when the choking has stopped, causing a high. Students do it to get the high. The literature discusses that a number of students have gotten the message that drugs are bad, which is a very important message, but they did not get the message that the choking activity is bad. Some schools have found “good kids,” such as kids who play on sports teams or who are on student council, actually engaging in this behavior, and they do it to experience that sense of a high. The activity is particularly

dangerous when one young person engages in it in isolation because they pass out and therefore cannot release the pressure from the rope that they have put around their neck. I encourage parents to be alert for the following: Are there ropes and straps in your child's bedroom that simply do not need to be there? Have you noticed your child with bloodshot eyes, coming out of their room disoriented, or having marks on their neck? Have you heard a loud thud like someone falling in his or her room? The question of how much to discuss this with young people is actually quite challenging.

Unlike my preference for discussing suicide prevention in a classroom setting, I do not recommend discussing the choking activity in a classroom or assembly setting. The reason for this caution is that someone in the classroom will inevitably speak up and say, "Oh, yeah. I did it, and I felt really cool. I got the feeling of elation afterwards." This is the problem with discussing it in a group. However, given the tremendous danger of the choking activity, I do believe it is important for the parents of middle school adolescents in particular to have a discussion with them. It might be best brokered with a lead in question such as, "Hey, I heard something about this choking game or activity. What is that?" And, then the parent listens and then talks about the dangers of the behavior. For more information I encourage everyone to visit the Games Adolescents Should Not Play Foundation at gaspinfo.com.

23. What are some effective suicide prevention programs?

As previously discussed, I highly recommend Signs of Suicide (SOS). Another program is Sources of Strength, which provides a broad-based approach to teaching young people how to recognize when they or someone they know is suicidal. It also promotes various sources of strength, resiliency factors, and key skills that all promote social and emotional wellness for young people. Other widely used programs are Lifelines and Signs Matter.

24. Should I read my child's texts, Google hangouts, Facebook, Instagram, etc.? How much should I snoop?

This is a great question. I want to again stress that, as a parent, you know your child the best. You should be in a good position to address whether everything is healthy and appropriate in your child's life now. If you do not believe that things are healthy and appropriate and you are concerned about your child's behavior, friendships, and websites, or if you are seeing signs of isolation, depression, or substance abuse then it is really important that you snoop. My experience has been that parents are often extremely high on denial and they are reluctant to acknowledge there is a problem and to get help. The first place to start is with the school counselor, "I am concerned about my child for these reasons ... can you give me some information about how things are going at school? Does this seem out of the norm for you? You're trained as a counselor. Do I need to get some mental health treatment for my child in the community?" Please, share your concerns with the school counselor and determine whether you need to snoop and most importantly, do you need to seek mental health treatment for your child. To be honest, the majority of the time in my 40-year career as a psychologist, when the parent described to me what was going on and asked, "Should I be worried? Should I go get help?" Nearly 100 percent of the time the answer was yes, and the parents knew I was going to say that. They simply needed to hear it. If your child has lost a friend to suicide, then I strongly encourage you to monitor their communication to others through social networks and seek mental health treatment for them.



25. *How can schools and parents help students develop coping skills?*

Resilience is arguably the biggest word in our vocabulary since September 11, 2001. What is resiliency? Resiliency is learned. The modeling that adults do in our families is very important to help our children bounce back from adversity. The keys to resiliency are the following: being comfortable venting and sharing strong emotions, being surrounded by loving and caring family and friends, using problem-solving skills, and always remaining optimistic about the future. These are issues and skills that really need to be emphasized beginning at the elementary school level through activities and learning from Americans that have faced incredible misfortune and yet they persevered. One great example is Abraham Lincoln. He had many misfortunes and lost many elections in a row before he finally won one. Schools should highlight successful people who overcame obstacles in their lives.

Parents often wrestle with how much they should share with their children about their own obstacles, difficulties, mistakes, and misfortunes. As a parent, you will be in the best position to determine when to share some of those obstacles and adversities you've experienced. For example, my own children know that I was kicked out of school. I shared with them in the hope that they would not repeat my poor scholarship in their early days of college, and none did. I think these are important lessons to share in our families. The most important thing about focusing on resiliency and coping skills is the following: the worth of our children—or a student at school—should never be in question, nor should our love for them ever be questioned. This means that we need to be very careful in moments of anger and frustration regarding what exactly we say to them. We should clearly state, "I am disappointed in your misbehavior. However, my love and appreciation for you as

a person is never in question. But there will be a consequence." This means that calling a child stupid and yelling at them should never take place. Only statements such as, "What can you learn from this? Do you need to apologize? How can you do something to make this right?"

26. *At what age should we begin talking to our students about suicide?*

Upper elementary school counselors all across this country have emphasized that even fourth and fifth graders often have expressed suicidal thoughts. However, most adults have never thought we needed to talk to 9- and 10-year olds about the problem of suicide. In 2012, I was involved as an expert witness for the school in a legal case, *Myers vs. Blue Springs School District*, in Missouri. Sadly, in that case, a 10-year-old child drew a picture of himself hanging and wrote, "If someone doesn't stop me, I will hang myself at 4:35 p.m. today." He handed that note to a fifth-grade classmate. I'm sorry to tell you that the classmate did not alert an adult because no one had ever talked to them about suicide and no one had ever anticipated them being in that position. The child died by suicide that afternoon.

Most suicide prevention programs are aimed at students in middle school and high school. One program at the elementary level is the PAX Good Behavior Game (GBG), which focuses on appropriate behavior and social skills. It does not focus on suicide prevention directly, but it has demonstrated promising results for suicide prevention. I believe strongly that we have to get across to elementary students that if something doesn't feel right, something is giving them a bad headache, or a feeling in the pit of their stomach because something really bad could happen, they need to get adult help.

It is my hope that in the next few years, at least for upper elementary, we come out with programs for students that will emphasize that 800-SUICIDE or 800-273-TALK is the national crisis helpline that can be called every moment of the day. Additionally, crisistextline.org is available 24/7 by inputting 741741 and texting START or HELP. Frankly, most of the calls to the helpline are not about suicide. They are from kids who are experiencing trauma, bullying, or loss; don't know where their parents are; don't have anything to eat in their home; their electricity has been turned off; or they've had a really bad day at school. So, I'd really like to see the crisis help and text lines as something that we share with all elementary students. In addition, for students who have an iPhone, if you say to Siri you are thinking of killing yourself, the immediate response is to offer to connect you the national crisis helpline. There is a new program from the state of Washington's Youth Suicide Prevention Programs for fifth-graders, called Riding the Waves, that focuses on healthy emotional development, depression, and anxiety. More information is available at crisisconnections.org/riding-the-waves.

27. Will talking to students about suicide or dangerous games put the ideas in their head?

I want to reiterate the reason we have so many suicides that occur is because we do not talk about it. Talking about suicide does not plant the idea in someone's head.

28. How do we respond when our child says, "I'm the worst kid in the world!" when they get in trouble or make a bad decision? Is this a warning sign?

What should we say when we have a child who consistently berates themselves, puts themselves down? First, we need to be able to clearly let our children know all of the things we love and appreciate about them, both in our schools and our homes. I like to begin every

conference about a child by asking the adult present, tell me the things you truly love and appreciate about this child. Frankly, I am the most concerned when a person tells me one thing and then goes to the negative or they do not tell me even one positive thing about their child. I believe that all children do far more right than wrong. We all do the best with the 5-to-1 rule, which means we receive 5 positives/compliments about our behavior for every negative comment. Parents need to clearly stress positive qualities for their child. Most importantly, how they love and appreciate the child for who they are. But what if your child continues these derogatory statements and they have been pervasive and persistent? Then you need to get mental health treatment for your child. Get them involved in treatment to help build up their self-esteem.

Additionally, it is really important that all students find their niche. What do I mean by this? Our children need to find an activity where they feel successful. It could be running down the field in football, playing chess, reading books, volunteering in a retirement home, or tutoring a younger child. We simply need to put all children in a position where they are doing something they feel good about. This can go a long way toward alleviating situations in their life that are not going so well. Find an activity that your child can participate in, feels good about it, and has a sense of accomplishment about what he or she is doing.

29. How can I help my child who reached out in a positive way to a child who died by suicide?

This question brings up an important point because many young people have lost someone they knew to suicide. Some of your children may have even reached out and tried to help and yet their friend or classmate still died by suicide. It's important that young people know that while suicide is preventable, we cannot prevent every suicide. The young person who

died by suicide traveled a very long road. It was never one thing, it was never one person, and no one is to blame.

I have often shared with young people devastated by the suicide of their friend that they didn't really know much about suicide. They didn't really think it could happen to someone they knew and cared about. Unfortunately, no one had ever prepared them by providing them with information about suicide prevention and what to do to intervene with their friend. I know, because I lost my own father to suicide, and I missed the obvious warning signs he was exhibiting. I will always second-guess myself for failing to take action to secure mental health treatment and for failing to ask him directly about suicide plans. I have found some comfort in getting involved in suicide prevention and I believe that many survivors of suicide ultimately reach a point where they also get involved in suicide prevention because they just may be able to save the life of someone else's loved one. I would say to these young people who lost a friend to suicide that, in many ways, this will be something you will always feel sad about, but it's very important that you give yourself permission to go on with your life and focus on what is in front of you so you can be successful. There will be times when this will be especially difficult for you. This would logically be the birthday that the deceased would have had, or the anniversary of his or her death. Do not hesitate to reach out to your parents and counselors at that time. As months and years go by it will get a little easier but it may always stay with you. Many people who have lost loved ones to suicide decide ultimately that they would like to get in a helping profession as a counselor, physician, and social worker for example. The adults who are reading this question should always be there for the child who has lost a friend to suicide.

I've been aware that young people have unfortunately been told by well-meaning

adults, "Oh, you should be over that by now. You shouldn't be focusing on that. I'm tired of hearing you talk about the friend(s) you've lost to suicide." Obviously, these are not the correct responses from adults. Instead, the answer should be, "I'm always here to listen to you. Please, know there will be a lot of ups and downs to this and I'm here for you every step of the way. Things will get better and if you feel they are not getting better, we are going to get you professional help. I would strongly recommend that many young people do, in fact, need private mental health counseling as a result of losing friends to suicide. Please, contact the school counseling office and get a referral to recommended providers in your community that are skilled with working with teenagers on trauma and loss issues.

30. *Are there times when well-intentioned peer or teacher support exacerbates normal teenage angst? What are the limits on this support, if any?*

Our schools and families often underestimate the effect of trauma and loss and especially the effect of suicide on our children and students. I don't believe that too much support can be offered. We need support in school, support in our home, support in local mental health, and support in our local places of worship. We need to continue to revisit the losses with our affected young people and not hesitate to ask how they are doing. They will quickly let us know if they are doing okay and will probably thank you for asking. As we look ahead, students are going to be aware of the anniversary of the loss, they will be aware of the birthdays the deceased would have had and the graduation ceremony they will not attend. I'm not recommending the school make a PA announcement about the loss of the student a year ago. No. I'm simply talking about parents being aware of that anniversary. Teachers and counselors being aware of that anniversary, and simply sitting down with students and saying, "I

know that tomorrow is the day a year ago that your friend died by suicide. That might be on your mind. I'm here to listen if you'd like to talk about it."

Studies have clarified that we underestimate the impact of a suicide and focus on too few people being at risk. Studies have also found that losing a friend to suicide might affect classmates and schools for several years. I know that is something that people reading the answer to this question do not want to hear, but it certainly emphasizes the points I've made about schools who have lost students to suicide being in this for the long haul. I have met with high school seniors here in Florida that shared many classmates of theirs had died and even referred to their class as cursed. A large school superintendent shared with me the sadness they felt at graduation time when parents of deceased students attended the graduation ceremony in memory of their child. It's necessary to provide support for students immediately after the suicide of a friend and for many years to come.

31. *I am a school counselor and I know that one of my students has been suicidal. Can I share information with his teachers?*

I believe strongly that suicide prevention in schools is a team effort and that teachers need to know that suicide has been a concern for a student. Teachers then know to be alert for even subtle warning signs and if the student exhibits any warning signs of suicide, the student will be escorted to your office. Teachers do not need to know a lot of details but need to be notified that suicide has been a concern. I'm emphasizing being escorted to the counselor, as on some occasions such as the student typing on the computer, "I just want to kill myself," the student was told immediately to go to the counseling office from the classroom, but instead, the student left campus creating a potentially dangerous situation.

32. *Why is it often late in the school day when, as the administrator, I now know a student is suicidal? Buses are coming in a few minutes. What should I do?*

I know these situations are very challenging but the student in question needs to stay on campus and a suicide assessment conducted, parents notified, and the student handed off to parents, mobile crisis response teams, or law enforcement personnel.

33. *I have called the parents of suicidal students, and they refused to come to the school and, on at least one occasion, said just let the student walk home. What should I do?*

If a parent does not take the suicidal behavior of their child seriously, then I believe we have no choice but to call protective services as it is negligence on the part of the parent. I am aware of one legal case in Maryland where the parents of the student suspected of being suicidal upon notification insisted that the student be allowed to walk home. Unfortunately, the student who was allowed to walk home died by suicide later that night at his home. They settled out of court. I personally chose not to take the case on the side of the plaintiff as I believed that once the student arrived home with parents present, and the parents were notified of the suicidal concerns, that the student became their responsibility. The best advice I can give you in this situation is to insist that parents come to school to pick up their child, and if they refuse, then use law enforcement or mobile crisis response teams to transfer responsibility to adults other than those at school.

34. *As a school psychologist I find it difficult to discuss gun ownership with parents even though I am aware that their child is suicidal. I know means restriction is very important, but what advice do you have for me?*

It is critical that everyone know that perhaps the single greatest suicide prevention strategy is to reduce access to lethal means for a

student. I acknowledge this is a very sensitive issue and would approach it directly by stating to parents, I know that your child and his or her safety is very important to you as a parent. Do you have any ideas about how safety could be improved in your home? Your child has mentioned the availability of a gun in your home and I know that you probably have that gun for safety, but isn't it possible that now that you've been notified that your child is suicidal that having the gun in your home makes it more unsafe? Counseling on access to lethal means training is available free at sprc.org.

35. *Have there been any studies of suicide clusters that are from affected schools and communities?*

There have been a number of studies done by the CDC in recent years in Fairfax County, Virginia, and Palo Alto, California. Those studies have found the common factors in youth suicide clusters to be the following: untreated mental illness, extreme academic pressure, access to lethal weapons, substance abuse history, intimate partner violence, sleep deprivation, and LGBTQ issues, such as harassment.. Additionally, parents often did not recognize the warning signs of depression and see the need for mental health treatment for their child.

36. *What can stop a suicide cluster?*

There is no absolute answer, but a partnership is needed between schools and the community and it must include school and community leaders, law enforcement, parents, mental health and medical personnel, survivor groups, and the clergy. Several school districts that experienced youth suicide clusters implemented the following: suicide prevention information was provided for all school personnel, school mental health professionals received a daylong training

in suicide assessment, the Signs of Suicide (SOS) depression screening program was implemented at the middle and high schools. Additionally, presentations about suicide prevention were provided for parents and suicide prevention information was posted on the district website. The school district also helped form the county youth suicide prevention coalition and suicide prevention became either a high priority for the school suicide prevention liaison or it became their sole duty as a new position was added.

37. *Has the school system ever been sued for failing to provide best practices postvention procedures after a student suicide?*

Yes. I was involved on the side of the plaintiff in the case of Mares vs. the Shawnee Mission School District in Kansas, a case from 2007. Following the suicide death of a sophomore student, the school district provided absolutely no outreach to classmates, friends, or family. The student's older brother was a senior at the same high school and, understandably, had great difficulty after the suicide of his sibling. Sadly, he also died by suicide a few months later. The school district settled the lawsuit brought by the parents, who argued that the failure to enact common sense, widely known suicide postvention procedures contributed significantly to second suicide of their children. The school district settled the case out of court with all details undisclosed.

38. *How much is sleep deprivation connected to the problem of youth suicide?*

There is a national concern that adolescents are not getting enough sleep and all the technology in their room interferes with their sleep. Many U.S. secondary schools start very early. The American Medical Association recommends that no high school should begin before 8:30 a.m. There are no easy answers to



the question of helping adolescents get the required minimum of 8–10 hours of sleep per night. Hopefully, parents will take charge of technology so that it will not keep their child up late at night and encourage their children to go to bed earlier. It is hoped that more secondary schools will recognize that high school students are simply not ready to be in school as early as 7:00 a.m. or even 7:30 a.m.

39. *As an administrator, I struggle with what really is the role of the schools in suicide prevention as I care deeply about my students, but I also want to be realistic?*

The role of the schools is to detect suicidal behavior and to make an initial assessment, which primarily is focused on how immediate the need is for complete adult supervision and a referral for community services. The treatment of a suicidal student is beyond what we can expect of a school counselor, social worker, or a school psychologist. Your administrative duties include implementing any mandated legislation for suicide prevention in your state. If there is no mandated legislation, you are strongly encouraged to do the following: a) provide an annual one hour in-service for all staff members who interact with students, including custodians, cafeteria workers, and bus drivers on the warning signs of suicide and the school referral process; b) ensure that key personnel, such as counselors, social workers, and psychologists are competent in suicide assessment and that procedures have been developed for parent notification and referral of suicidal students to competent practitioners in the community; and c) make every effort to share information between school personnel and mental health professionals in the community. Additionally, it is recommended that a reentry meeting be held at school immediately if a suicidal student is returning from hospitalization and that follow-up services at school are planned.

40. *Do you think it's appropriate for any segments of Netflix's 13 Reasons Why to be shown in school classrooms?*

No, and I was very dismayed to learn of at least a few situations where teachers thought the program was compelling and preventative and shared segments in classrooms. I believe that all information and especially videos provided to students that have suicidal content should be carefully vetted and approved by personnel such as the director of instruction for the school. Early in my career, I had one experience where I received a call from the superintendent's office notifying me about a student suicide the day before. I was told that the suicide victim had watched a made-for-television program about suicide in her classroom and had gone home from school and died by suicide. The superintendent asked that I be the one who would show the program to her parents who were demanding to know the content of the program. I remember asking, "Why me?" I had not even seen the program. The superintendent thought that I would be the ideal person to view the program with the family, but I insisted on the director of instruction being present as well. The student who died had only seen the first half of the television program, which was not very hopeful as it focused on a death by suicide. The second half of the program that the student never viewed was a lot more hopeful as an adolescent was detected as being suicidal and adults were involved, so a tragedy was averted. The parents did not sue the school district and probably that was the result of our willingness to sit down with them and ensure them that we would be taking steps to make sure that teachers did not just tape programs and bring them in to show students on the topic of suicide. I am sure that there were many other factors that were involved in the suicide of that student, but I stand by the statement that all programs that provide content to students about suicide should be carefully planned and utilize best practice programs.

41. Students who engage in repetitive self-injury, i.e. cutting and burning, do they ever become suicidal?

Non-suicidal self-injury (NSSI) is a coping mechanism as a way of regulating emotions and releasing endorphins to feel better. NSSI has diminishing returns and likely is not working as well for an adolescent today as it was three or four months ago. The literature emphasizes that engaging in NSSI is a way of acquiring the capability of suicide as students become comfortable with harming their body. Many of the NSSI cases that I know well, it was a suicide attempt that actually uncovered a long pattern of a student's cutting behavior. A review of the literature says we should keep these things in mind when trying to determine which of the large number of students engaging in NSSI might ultimately make a suicide attempt. Have they engaged in self-injury over an extended period of time? Have they utilized multiple methods to self-injure? Do they experience little pain when they self-injure? Do they disassociate when engaging in self-injury? I believe it's very important when we know the student is engaging in NSSI to ask them directly about suicidal thoughts, plans, and actions.

42. With regards to self-injury, what do you think are the greatest resources for school personnel to review?

I'm a very big fan of the Cornell Self-injury and Recovery Resource website (selfinjury.bctr.cornell.edu/) and, additionally, for the state of Florida I created a video where I interviewed two young women who spoke very eloquently about their struggle with self-injury as they both received a national mental health award. The video entitled, *Critical Insight and Testimony on Self-injury*, is available under training videos at my university website nova.edu/suicideprevention.

43. You have stressed in your presentations the importance that means matter and specifically emphasized removing guns from the ready access of suicidal youth. Why is that so important?

I like to begin by giving you an example as my cousin called me asking for advice as he just arrived at his condo to learn that his neighbor Bob was seen holding a gun to his head in the parking lot only two days ago. My cousin asked what he should do. I responded by asking if anyone rushed Bob to the emergency room? The answer was nothing was done, and then I asked what about Bob's guns, and my cousin responded he asked his wife about that but his wife said those guns are Bob's and she couldn't possibly remove them. My cousin asked what difference would that make anyway, as wouldn't Bob just find another way. I spent considerable time explaining to my cousin about the website at Harvard called Means Matter (meansmatter.com) that summarized research all around the world that found removing the lethal means such as a gun or raising the barrier on the bridge saved lives. My cousin went on to say that Bob was suffering from Parkinson's. I hypothesized that Bob was being treated for that disease but not for the accompanying depression. I'm very pleased to tell you that my cousin took steps to get the guns removed from Bob's home and he accompanied Bob to the doctor where Bob shared his suicidal behavior with his physician. Bob is now receiving treatment for his depression and still alive now months later. Research says that guns are only used in 5 percent of suicide attempts yet result in approximately 50 percent of all suicide deaths in our country. Guns are extremely lethal and those that attempt with a gun rarely get a second chance.

44. What do you think of the Netflix program *13 Reasons Why*? Is it harmful for young people to view it and did it have an impact on youth suicide rates?

Many professional associations and schools sent out warnings to parents about the content in the program and encouraged parents to view the program with their children. Personally, I believe that it's very unlikely that many parents would have the time to view 13 episodes for season 1 of the program nor unfortunately would they be in a good position to counter the many dangerous messages that were contained in the program. I applaud Common Sense Media, which recommended that no one under the age of 16 watch it. They also recommended that those older than the age of 16 and who had a history of anxiety and depression should not watch it. Season one had as the plot the suicide of Hannah Baker, an adolescent girl who blamed others for her death and made 13 revenge tapes and mailed them shortly before her suicide death. Hannah was unfortunately the victim of bullying, sexting, and rape. Hannah's suicide was portrayed in a very dramatic and upsetting scene, which I would have not chosen to watch except I was planning a series of webinars on the dangers of the program. (Two years later, Netflix pulled the suicide scene from the program.) The graphic scene of Hannah's suicide violated the known media guidelines. I happened to be presenting in Tampa, Florida, shortly after the graphic suicide scene aired and was told by local psychiatric hospital personnel that numerous adolescent girls had either attempted exactly the same way as Hannah or were planning their suicides with that method. Netflix waited two years before pulling the graphic scene of Hannah's suicide despite repeated calls from mental health professionals to do so. Shortly after season one of the program, Google searches about how to die by suicide increased dramatically and we now know that adolescent male suicides increased in the month after the airing of season one. Netflix, the director, and the actors stated that they were starting a very

important conversation about suicide. I believe strongly that the biggest problem is that we do not talk about suicide prevention enough in our society; however, they started the conversation with very incorrect messages. First of all, suicide is not about revenge, as suicide is about ending unendurable pain and there's constriction or tunnel vision. Suicide is not about other people. It was unfortunately portrayed in *13 Reasons Why* as a way to get revenge on those that Hannah believed had mistreated her. Suicide is, thankfully, not a common result of being bullied, the victim of sexting, or even being raped. I also found it very upsetting how the program portrayed counselor Porter as he was very apathetic, and when he found out Hannah was the victim of rape, rather than supporting her and responding to her obvious distraught demeanor, he demanded to know who raped her. Hannah told him that it was a senior and he responded with, "Oh good, he'll be gone in a few months." Counselor Porter did not contact her parents, nor did he contact any authorities.

I worked side-by-side with school counselors for nearly 40 years and believe them to be extraordinary individuals who care deeply about the students they work with, and Netflix did them a big disservice. Adolescents who viewed the program will be less likely to approach school counselors in a time of crisis and that's a very unfortunate message to give any of our students. All of the adults in the program were portrayed as either clueless, absent, or even mean. The most likable character in the program was Clay. Clay's mother—in one episode—could see that he was clearly troubled and sat down and was very appropriately in a listening mode with a gentle inquiry and noting that he was troubled and wanted to help him. The program portrayed Clay as saying you can't help, and he stormed out of the room. One of the single greatest prevention methods in this country is to get young people, who are aware of suicidal and homicidal statements, to go to the nearest

trusted adult for help. Hannah Baker's final day portrayed her in front of the post office about to mail her 13 revenge tapes and a community member came up and commented to her that she was really a talented poet and that they had missed her at the poetry meeting on Tuesday. In the real world that's often all it takes for someone to decide life is worth living, as no adolescent is suicidal 24/7 and it would have been much more realistic to have shown Hannah dropping the revenge tapes in the trash and going on with her life. Season one also showed an angry male student with an arsenal of weapons and clearly indicated that season two would likely include a school shooting. Thankfully, season two, three and four were not as popular as season one.

As someone who has responded to 16 different school shootings, I believe strongly that getting young people to go to a trusted adult is a powerful way to prevent a school shooting. It was inexcusable that season two portrayed Clay knowing that a classmate was on the way to the school dance with an assault weapon and rather than notifying law enforcement and adults at school, Clay and his friend Tony chose to try to prevent the shooting on their own. This was a very unfortunate message! The U.S. Secret Service study of school shooters found that 81 percent of them told others of their violent plans. We must end the conspiracy of silence that allows homicidal and suicidal statements to go unreported to adults! Season three and four continued the theme of portraying students as leading secret lives with regards to sex, drugs, violence and mental illness without adult awareness, support, or intervention.

45. *What about the role of medical professionals especially physicians in suicide prevention?*

The literature estimates that approximately 70 percent of the individuals who died by suicide saw the family doctor in the months before their death. Physicians have a tremendous opportunity to be alert for the warning signs of suicide and to intervene. They need

to be comfortable and competent to ask their patients about depression and suicidal thoughts and actions. I know that my father saw his family doctor in the week before he died by suicide.

There is growing awareness that key professionals such as psychologists, family therapists, and physicians should have continuing education on suicide risk assessment and management for renewal of their respective licenses. Currently, there are seven states that require this continuing education for license renewal. My greatest hope is that a future generation of physicians will be much more comfortable with direct inquiry about suicide and will improve their suicide assessment abilities. Specifically, with regards to young people there was a national recommendation that came out in 2009 from the U.S. Prevention Task Force recommending that all teenagers, regardless of the reason they were in the physician's office should fill out a short questionnaire about energy level, joy of life, depression, and thoughts of suicide and that questionnaire should be scored before they walk out of the office. I am hopeful that more physicians will follow that national recommendation. Unfortunately, in responding to suicide clusters I have found the one group least likely in the community to be involved in prevention efforts has been the local physicians, and their involvement is critical. For example, after seven students at a single high school had died by suicide in one school year then it was essential for all high school students from that school to be screened for depression when they saw their family physician for any reason. In another cluster response with more than 100 area professionals at the school planning meeting, the one physician who had promised to attend did not. In another cluster response, the only physician really involved was the county coroner.

46. Consider this scenario: the day after a student suicide, friends arrive at school wearing T-shirts with a picture of the suicide victim on them. Should a principal allow students to wear those T-shirts at school or send them home to change?

This scenario creates a dilemma for the school administrator. *The After a Suicide: Toolkit for Schools* (which I helped develop) from the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center is an excellent guide for postvention, and I do not believe an administrator could be criticized for following the recommendation. They could be criticized for not following the recommendations. The toolkit cannot possibly answer every question, but it does stress striving to treat all the deaths the same. If T-shirts with pictures of other students from your school—who have died—have been worn before, then I would allow the T-shirts today. I recommended meeting with students and letting them know that you acknowledge that this is how they are expressing their emotions and they may wear the T-shirts today, but you expect them to wear normal school attire the following day. This is an opportunity for personnel, such as the school counselor, social worker, or school psychologist to sit down with the affected students help them with their and grief and guide them toward memorials, such as living memorials that raise money and awareness to prevent future suicides.

47. As a counselor in an elementary school, I am experiencing more and more fourth- and fifth-grade students making suicidal statements. Do I need to take it seriously every single time?

The short answer is absolutely yes, take it seriously every single time and ask the student direct questions about suicidal thoughts, actions, and plans and notify their parents each time. I recognize this is time-consuming and frustrating, and I wish younger children could say what it is that is bothering them

and not think it's necessary to say I'm going to kill myself to get the attention of adults. In my previous school district, I responded to the death by suicide of a nine-year-old boy. I'll never forget his father saying to me he tried to hang himself last week and he thought he had hidden all the ropes. I did not want to make the father feel any worse than he already felt but, obviously, I thought to myself I wish he had reached out for help for his suicidal son immediately. There is national research indicating that suicide rates have increased for younger children under 10.

48. I know there have been a number of lawsuits brought by parents against schools after the suicide of their child, with parents believing that bullying at school that was not addressed, was a proximate cause of the suicide. Have you been involved in these lawsuits and what have the courts concluded?

I have followed this very closely and been involved as an expert witness in several of these cases. Several school districts have settled cases of this type out of court. I am not aware of a single court that has found a school liable in this type of case. In 2012, I was involved on the side of the school district in *Myers vs. Blue Springs School District*. I believed the school district did nothing wrong, but the case was settled out of court for \$500,000. A 2013 case in Kentucky, *Patton vs. Bickford*, went all the way to the Kentucky Supreme Court but the school district was not found liable. I was also involved as an expert witness on the side of the plaintiff in a 2011 case, *Lance vs. Lewisville Independent School District*, where a nine-year-old special education student—believed to be the victim of bullying—hung himself at school. The United States Court of Appeals for the Fifth Circuit did not find the school district liable. The court concluded that no special relationship existed as Montana Lance was not incarcerated, involuntarily committed, or in foster care.

The foundation of youth suicide is an untreated or undertreated mental illness often in combination with adverse childhood experiences, which are all the things we do not want a child to experience. The most commonly identified adverse childhood experiences are rejection from a natural parent; physical, emotional, or sexual abuse; living with a mentally ill parent, a substance abusing parent, or in poverty; and experiencing multiple losses. The Suicide Prevention Resource Center Brief on Suicide and Bullying emphasized there is a strong association between bullying and suicide, but it is difficult to rule out the impact of adverse childhood experiences and mental illness. My strongest recommendation is when we know a child is involved in bullying as either the bully or the victim, we should not hesitate to ask them direct questions about hopelessness, thoughts of giving up, and suicide.

49. As a counselor I really struggle with whether I should tell the parents of an 18-year-old student that he or she is suspected of being suicidal. What are your thoughts on this?

I believe strongly that the parents of any high school student, regardless of their age, should be notified of suspected suicidal behavior. This was one of the key questions in the 2016 case Gallagher vs. Bader. I was on the side of plaintiff in this recently settled case that was before the Virginia Supreme Court. The family of Jay Gallagher in Loudoun, Virginia, was stopped from suing the school district due to a Virginia law that does not allow a district to be sued. The plaintiffs instead sued the high school counselor. One of the reasons the counselor chose not to contact Gallagher's parents was the fact that he had recently turned 18. I have never known of an 18-year-old who provided all of their own support, such as filing tax returns and earning the income for their housing and welfare. Additionally, everything we know about brain development is that 18-year old individuals are not adults. I recommend that, if an 18-year-old is suspected of being suicidal,

their parents be notified, as FERPA 99.36(a) says in an emergency situation, everybody who needs to know should be notified for the safety and welfare of all concerned.

50. As a school counselor, how much emphasis should be placed on a peer report that their friend is suicidal?

I believe strongly that friends know much more about what is actually going on in the life of another peer than adults do. If a peer reports that their friend, Sam for example, is suicidal then take it very seriously and immediately bring Sam to the counseling office and ask him directly about thoughts of suicide. If he denies it, and it is common for a student to initially deny being suicidal, then my recommendation would be with Sam in your office to contact his parents to let them know that you were given a reason to believe that Sam was suicidal but when asked directly, he denied it. However, as his parents you need to know and please come to my office immediately so that we can all conference together and figure out the best way to support Sam. Responding to peer reporting and having a student suspected of being suicidal but denying it were all issues in the Gallagher vs. Bader case cited in a previous question.

51. When should children be told the truth that the death was suicide?

It is very important not to lie to children and to tell them the truth in developmentally appropriate language. I have met a number of students in my career that found out years later about the suicide of their favorite aunt for example. I told my son, at age eight, about the suicide of the grandfather that he would never meet. My son said that I lied to him as I had told him that my father had a heart attack. I responded that I did not lie as he had a heart attack a few weeks before his suicide. I was waiting until I thought he was old enough to

understand the word suicide, and I wanted him to hear the complete story from me not from someone else.

52. *What do you think of the fact that, after the third suicide of a student from the same high school, the principal had an assembly and the main speaker was a grieving parent who spoke emotionally about the loss of their child to suicide?*

One of the biggest problems in suicide prevention is that we do not talk enough about how to prevent suicide and that it is everyone's responsibility; however, the ideal way to talk to students about suicide prevention is individually, in a small group, or in a classroom where students will be likely to ask questions and school staff can get a read of how they are experiencing the information. I was instrumental in getting a statement on page 30 of the *After a Suicide: Toolkit for Schools* cautioning against assemblies after a suicide for the reason outlined above, and to avoid glamorization of the suicide victim. Survivors drive suicide prevention in our country, as they do not want anyone else to lose a loved one to suicide. I was asked to speak about prevention, in Idaho, and was told that a mother who lost her child to suicide recently would speak before me. I wondered what tone she might set and whether we would hear a long agonizing story. She did not tell an emotional story but did show a picture of her child and emphasized this is why suicide prevention is so important.

53. *How can schools help survivors of suicide?*

Supporting students who have lost a friend or a loved one to suicide is very challenging. The support that a student needs is beyond what a school counselor can provide. It is important that schools refer to practitioners skilled in supporting families affected by suicide. Survivor groups—where everyone attending lost a loved one to suicide—have provided the

most support to suicide survivors. A number of survivors have told me that when they went to a general loss group they felt out of place when they shared that their loved one died by suicide; not in an accident, not from cancer. A few major cities have suicide survivor groups for teens.

Schools need to know the best support for survivors available in the community, and personnel, such as school counselors, should check frequently on the student affected by a suicide, and their parents. There can be an anniversary date to suicide, and schools need to reach out to survivors in the days before the anniversary of the suicide and offer support.

54. *What was an outstanding postvention activity that you were involved in?*

I commend a district in Colorado Springs, Colorado, for all of their postvention efforts after a suicide cluster, but one specific example comes to mind. The Academy 20 district had gone many months without a suicide of a Discovery Canyon student, but, sadly, one more suicide occurred. The district mobilized quickly and, on the second evening after the most recent suicide, they scheduled a webinar for parents about how to support their children and prevent suicide. More than 700 parents attended either online or at the high school. My partner Rich Lieberman and I provided the webinar. The district partnered with community resources and provided extensive prevention information for school personnel, students, and parents. They also created a full-time suicide prevention position for the district.

55. You have responded to many youth suicides and numerous suicide clusters. What has been frustrating?

There have been a few times when it was challenging to get the principal or superintendent to follow the recommendations in the *After a Suicide: Toolkit for Schools*. Additionally, a few parents, even after suicides of young people with a gun have occurred in their community, did not take steps to secure the guns in their home. It has also been challenging to increase the involvement of physicians in a community experiencing a suicide cluster.

56. Have any schools been found liable in court following the suicide of a student? How do schools protect themselves from a suicide liability lawsuit?

Very few schools have been found liable in civil court after the suicide of a student. The vast majority of the time schools have responded appropriately when a student is suspected of being suicidal. I was involved in one case, *Wyke vs. Polk County Florida School Board*, on the side of the plaintiff. The middle school administrator failed to notify the mother of Shawn Wyke that he was suicidal, and the court found the school one-third liable. There have been a number of cases settled out of court. Schools must notify parents if suicide is suspected, with only one exception: if abuse is suspected, state protective services must be called immediately. School personnel are encouraged to keep good records of parent notification of suicidal concerns.

57. What advice do you have for a principal if a student dies by suicide?

The short answer is follow the recommendations in the *After a Suicide: Toolkit for Schools*. Remember to include school mental health staff members in every step of your planning. Also, be careful not to underestimate the impact of the suicide. One high school principal thought the impact of the suicide of a soccer player would be confined to the high school she attended. I pointed out that she played on an elite travel team with teammates from all across the city and her death did not just impact the high school she attended.

58. What if the parent tells me as the counselor that I cannot speak to their child about suicide?

This scenario has occurred most often when a parent is angry about being notified that their child is suicidal. The school principal needs to be consulted. The school policy should be that school counselors can—and will—talk to any student anytime we suspect them to be suicidal, and that parents will be notified after the initial suicide assessment was done by the counselor. A few states have legislation that clarifies this issue.

59. How much attention should a teachers pay to student writing and poetry about suicide?

The first suicide that I responded to in a school was nearly 40 years ago, and the teacher showed me two suicidal poems written by the suicide victim. I know that, all these years later, the teacher wishes that she had sat down to talk with the student about her thoughts, assure her that she is not the first student to feel this way, and to let her know that help is available and she can count on the teacher to be there every step of the way. Suicidal writing in a student's class journal, and failure to notify his parents, were key issues in the 1997 lawsuit, *Brooks vs. Logan*. I strongly recommend that, if a student is writing about suicide, school referral procedures need to be followed, an initial school suicide assessment conducted, and parents notified.

60. Any memorable statements or questions from students?

Several come to mind. A student said, “What good would it do to stop Jim from killing himself today? It is his fate or destiny.” I stressed the situational nature of suicide and referenced a story about a young man who might have wanted to live if he had merely waited a week!

A student asked “Why weren’t you here last week? If you had been, I would have known what to do to prevent the suicide.” I responded that I wished I had been but we now must focus on the future, help everyone with their emotions, and work to prevent further suicides. This student’s question still haunts me.

A student told me, “I did what you are recommending. I told the school counselor last year that my friend was suicidal, but the counselor made me feel like a snitch.” I emphasized that the student did the right thing and your counselor needs more training on suicide prevention.

Another memorable question came from a high school student who wanted to know what the best suicide prevention apps were. I named a few resources that came to mind immediately:

- *Bethe1to.com*—Although not an app, the site outlines five steps to help someone in a crisis.
- Virtual Hope Box—This coping skills app helps individuals struggling with depression. It has four main sections: distractions, inspirations, relaxation, and coping skills.
- My3—This app provides a support system, safety plan, and mental health resources for an individual to use in a time of need.
- Speak North Alabama—This app helps users recognize suicide warning signs and access prevention resources.
- A Friend Asks—This app stresses that suicide can be prevented and the importance of getting adult help.

61. What do you think of the fact that a Massachusetts teen went to prison for encouraging a friend to die by suicide?

You must be referring to the case of Michele Carter who was convicted of involuntary manslaughter in 2017 for encouraging via text messages the suicide of Conrad Roy. Michele Carter’s appeal was denied, and she served most of the 15-month sentence. Her attorney argued that she had the right to free speech guaranteed by the First Amendment. I was personally surprised by the criminal verdict and think the case involves morality issues more than criminal behavior. The case underscores the need for suicide prevention in schools!

62. What communication should take place within the school when a student is suspected of being suicidal?

School personnel must communicate with each other whenever a student is suspected of being suicidal to increase the circle of care around the student. I have heard from a number of school nurses in particular that they have felt left out. One nurse stated in her deposition that if someone had told her that the student was known to be suicidal, then the nurse would’ve never let him go into the clinic bathroom where the nurse could not unlock the door. The student hung himself there.

63. What do you think about a student not being allowed in school until there has been an evaluation in the community and a mental health provider says the student is safe to return to school?

A suicidal student needs to receive a thorough suicide assessment performed by a community-based mental health professional. All students have a right to a free and appropriate education. I do not believe a school has any legal right to deny a suicidal student access to school unless they are believed to be a threat to others. A suicidal student who is not allowed at school is out of their routine, likely to be unsupervised and to feel that they are being punished. Schools need to convince parents of the need for treatment without denying the student access to their school. I encourage school personnel to coordinate with the student's parents and community-based providers to avoid or minimize the student being out of school.

64. Is there a mental health instruction requirement for Florida school students?

Yes. Starting with the 2019–2020 school year, all grade 6 through 12 students receive five hours of instruction on mental health issues, annually. In addition to warning signs and coping mechanisms, students learn how to use crisis lines and make anonymous reports on cyberbullying, substance abuse, and suicide via the Fortify Florida app. More information can be found at fldoe.org. Numerous Florida school districts are also using the Suite 360 Mental Health and Prevention Program described at navigate360.com.

