ATTACHMENTS FOR SECTION I: PROMOTION

Promotion of Mental Wellness

1.1 THE IMPERATIVE OF COMPASSIONATE SELF-CARE
1.2 TRANSITIONING – PRIMARY SCHOOL THROUGH LIFE AFTER HIGH SCHOOL
1.3 SOCIAL MEDIA
1.4 CULTURE, MENTAL ILLNESS AND STIGMA
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1.7 TYPES OF STUDENT PROGRAMS INFORMATION SHEET, SAMHSA Toolkit

Suicide Awareness Before a Crisis Arises

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

THE IMPERATIVE OF COMPASSIONATE SELF-CARE

"The more you can develop the internal ability to be a calm, compassionate presence toward yourself, the more you can

bring that presence to everyone you serve."
(Emotional Intelligence, Dr. Daniel Goleman)

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

Eight Dimensions of Wellness

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

What is Self-Compassion?

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

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

Why Self Care is Needed?

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

What is Self Care?

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

Caring for Yourself is a Radical Act: Self-Care Guide for Youth Working in Community

Tools for School Staff Self-Assessment and Care

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

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

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

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

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

(Resource at http://www.compassionfatigue.org)

Tools for Student Self-Care

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

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

Some of these activities include:

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

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

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

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

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

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

Additional Self Care Tools and Information

- Greater Good Science Center: http://greatergood.berkeley.edu/article/item/how_self_compassion_can_help_teens_de_stress

- Psychology Today, Your Ultimate Self-Care Assessment: https://www.psychologytoday.com/blog/living-the-questions/201504/your-ultimate-self-care-assessment- resources

- Wellness Worksheets, SAMHSA http://www.integration.samhsa.gov/health-wellness/wellness-strategies/wellness.pdf

TRANSITIONING: PRIMARY SCHOOL THROUGH LIFE AFTER HIGH SCHOOL

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

The Transition from Elementary School to Middle School

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

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

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

Developmental Changes During Early Adolescence

Adapted from the U.S. Department of Education

Physical:

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

Intellectual:

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

Moral/Ethical:

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

Emotional and Psychological:

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

Social:

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

Expected Changes

Adapted from the Georgia Department of Education

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

How Parents Can Help

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

Before Middle School

Adapted from the Association for Middle Level Education (AMLE)

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

During Middle School

Adapted from the Georgia Department of Education

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

Resources

PDFs / Articles Designed for Children Under Parent Supervision

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

Videos:

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

The Transition from Middle School to High School

Introduction:

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

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

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

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

Interesting Facts

Adapted from the Georgia Department of Education

Did you know…

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

Challenges and Supports

Adapted from Sylvan Learning

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

Academic Challenges

What We know

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

Know the Warning Signs

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

What Parents Can Do

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

The Internet

What We Know

- 8 to 18 year olds spend more than 50 hours a week on social media
- Approximately 7 out of every 10 teenagers do not have rules on how much time they can spend on social media per day.

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

What Parents Can Do

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

Alcohol

What We Know

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

Know the Warning Signs

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

What Parents Can Do

- Establish a strong, open relationship with your teenager so they are comfortable sharing sensitive information
- Talk about alcohol and the reasons to avoid drinking underage
- Talk about ways to avoid succumbing to peer pressure. See link below for more information on this topic
    - https://drinkwise.org.au/parents/combatting-peer-pressure-how-to-help-your-teen/#
- Be aware of your teenager's activities
- Work with other parents to establish solid boundaries regarding alcohol

- Follow through with consequences if rules are broken by teenager
- Be conscious of the example you are setting for your children when consuming alcohol
- If effected by alcoholism, talk to your teenager about its effects on your life

Bullying

What We Know

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

Know the Warning Signs

Your Teenager is Being Bullied:

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

Your Teenager is a Bully:

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

What Parents Can Do

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

Tips for Success

Adapted from Georgia Department of Education

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

Becoming Self-Dependent

- Encourage your teenager to explore extracurricular activities
- Make sure to actively listen as this naturally opens the conversation to ideas and solutions.
- Urge your teenager to express feelings and concerns using words
- Encourage establishing trusted adult mentors for further support

Developing Student Responsibility

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

Academic Performance

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

Preparing for Life After High School

- Regularly refer to your teen's four-year plan as he or she progresses through high school
- Explore opportunities such as job shadowing for your teenager to gain insight into various professional fields
- Discuss post-graduation plans proactively. Be mindful that your student may have ideas to partake in something other than college (gap-year experiences, job opportunities, and more)
    - http://www.pamf.org/teen/life/school/alterpaths.html (link contains information on alternative paths after high school

- Support your student's efforts to explore prospective universities, gap-year experiences, and more
- Attend all college and career events near you ("High School is Happening," 2015).
- For additional details on preparing for the transition from high school to college and adulthood, please visit: https://www.settogo.org/

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

- George Department of Education:
  - High School Is Happening!
    - A guide for students on high school transition
- California Career Center
  - Middle School to High School Transition Tips
- Teens Health
  - Starting High School

PDFs/Articles

- Teens Health
  - Ten Ways to Help Your Child Succeed in High School
- Dr. Paul
  - Starting High School – Helping Your Teenager Adjust
- Portland State University Graduate School of Education
  - Easing the Middle School to High School Transition: A Guide for Schools
- Sylvan Learning
  - Middle and High School Transitions

Videos

- Georgia Department of Education
  - http://www.gadoe.org/School-Improvement/Federal-Programs/Partnerships/Pages/School-Transition.aspx

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

The Transition to Life Beyond High School

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

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

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

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

When applying to college:

1. Think about the "fit" between a college and your personality. Academics are important, but other aspects of a college (e.g., size, location, diversity, extracurricular activities) can impact how well you thrive in all areas of college life.

2. Understand what mental health services, policies, and programs exist at prospective college(s), especially if s/he has an existing emotional disorder: 1,2

3. What services are provided by the counseling center? Are there associated fees? Are there a maximum number of sessions allowed per year? Are there specialists (e.g., in treating eating disorders)? Is there a psychiatrist on staff? Does the counseling center provide off-campus referrals?

4. Is there a counselor on call 24 hours a day? If not, what after-hours emergency services are available?

5. Is there a wait time to see a counselor? If so, how long?

6. Under what circumstances will the college notify a parent regarding their child's mental health? What happens if a parent calls the college with a concern about their child?

7. Does the college train faculty, staff, resident advisors (RAs), etc. to identify and refer students in emotional distress?

8. What kinds of educational programming (e.g.,workshops,talks) are provided to students around mental health and wellness?

9. What accommodations are available through disability services for students with emotional disorders?

10. What is the policy around taking leaves of absence?

11. Is there an office to intercede for students who feel overwhelmed? Will using such resources imperil scholarships?

12. Learn about other available support structures. Ask about tutoring, academic and peer advising education coaching, student activities, and career services. Understand how much support is available in the residence halls, such as the number of resident advisors. Find out how the college helps students to connect with one another.

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

1. Based on the National Mental Health Association/The Jed Foundation. (2002). Safeguarding your students against suicide. Alexandria, VA: National Mental Health Association.

2. Adapted from the Anxiety Disorders Association of America. (2007). Information for parents: helping a college student with an anxiety disorder.

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

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

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

Before starting college:

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

-Will your child's existing insurance cover an out-of-state provider?
-Will s/he be able to fill out-of-state prescriptions?
-What outpatient and inpatient mental health services, emergency care, and prescriptions are covered under each insurance plan?
-What mental health services are covered by student health fees (e.g., number of sessions, psychiatric care, medication)?

4. Identify whether your child is eligible to register with disability services. If your child has a diagnosed mental illness or learning disability, s/he may be eligible to register with the disability services office (may be called the "Office of Accessible Education") to receive reasonable accommodations. This may include education coaching, academic accommodations, or other services.
5. Be familiar with the resources for parents provided by the college and know whom to contact if you are concerned about your child. Many colleges have web pages specifically designed for parents that may link to parent guides or information from a parent advisory council.
6. Read the college's student handbook. This will often include a code of conduct that addresses issues such as alcohol or other drug use and plagiarism. It may also include information regarding confidentiality of records and leaves of absence.

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

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

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

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

For Parents when Your Child is at College

- Keep the lines of communication open. Don't be afraid to talk to him/her if you think that something is wrong. You may be in the best position to notice and address any difficulties that your child is having. If they say that nothing is wrong, it can be helpful to explain what it is you've noticed that concerns you (be specific) and reassure them of why you're mentioning it (e.g., because you love them, don't want them to struggle on their own, know how difficult it can be to reach out for help, etc.). It's ok to be persistent!

- Know the signs and symptoms of emotional disorders as well as the warning signs for suicide. It is common for mental health problems to appear for the first time during the college years, so you may want to familiarize yourself with their signs and symptoms. These signs will take the form of changes or behaviors that are out of character and that are pervasive in their life and persistent for about 2 weeks or more. There may be marked changes such as eating or sleeping more or less, isolation or withdrawal from others, feeling overwhelmed, not going to classes, difficulty concentrating, seeming confused or disoriented, feeling worthless or behaving as if they were worthless, a sudden drop in grades, poor memory or recall, highs or lows in mood, anxiety, and thoughts of suicide. Sleep deprivation on its own increases the risk of suicidal thoughts threefold. If your child is having suicidal thoughts ask about these, listen, and then get professional help immediately ("Half of Us Mental Health Study," 2013).

- Encourage your child to go to the counseling center if one or both of you think it is necessary. Sometimes students can be reluctant to seek help because they are afraid that someone will find out. Reassure your child that counseling services are provided confidentially and that you support them as they reach out for assistance.

- Students who are experiencing emotional distress will tend to turn to friends first for support. Next in line is family followed by online resources. They are least likely to turn to Resident Advisors and Hotlines ("Half of Us Mental Health Study," 2013).

- Find out whom to call at the college if you're concerned about your child's emotional well-being.

- Provide your child with their health information including details of their primary physician and emergency numbers to contact at home. Include a list of current medications and diagnoses if applicable. Keep this up to date. Your young adult should advise a friend where this information is in case an emergency arises.

- Get local contact information including that of a friend of your child. Assure the friend that you will contact them only in an emergency

- Create an emergency plan with your child before a crisis arises.

- Understand the circumstances under which the college will notify you regarding your child's mental health. Review the FERPA and HIPPA resources referenced here (U.S. Department of Education, 2008 & "Family Educational Rights," 2009).

- What Can You Do If You Are Concerned That Your Child May Be Thinking About Suicide

- Remember: Asking someone about suicide does not put the idea into his/her head.

- Be direct. Talk openly and matter-of-factly about suicide.

- Be willing to listen. Allow for the expression of feelings. Accept what they have to say as being reflective of their current experience; don't argue about or dismiss these feelings

- Be non-judgmental. Don't debate whether suicide is right or wrong, or whether feelings are good or bad. Don't lecture on the value of life.

- Get involved. Become available. Show interest and support.

- Don't dare him/her to do it.

- Don't act shocked. This will put distance between you and make them feel less comfortable being entirely honest about how they are.

- Don't be sworn to secrecy. Seek support.

- Offer hope that alternatives are available, but do not offer glib reassurance; it only shows that you don't understand just how distressed they are feeling.

- Take action. Remove means, such as guns or stockpiled pills.

- Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

CONSIDERATIONS AFTER GRADUATION & WARNING SIGNS OF SUICIDE

- *Should you witness, hear, or see your child exhibiting any one or more of the following, get help IMMEDIATELY by contacting a mental health professional, calling the college's emergency number, or calling 1-800-273-8255 (TALK), the National Suicide Prevention Lifeline, for a referral.*

- Threatening to hurt or kill him/herself, or talking of wanting to hurt or kill him/herself
- Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person
- Expressing hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking • Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, inability to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life

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

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

Additional Resources

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

The Jed Foundation, **212-647-7544** or http://www.transitionyear.org

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

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

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

NAMI: http://www.nami.org

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

SOCIAL MEDIA

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

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

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

Benefits

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

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

My3 helps individuals struggling with thoughts of suicide customize coping strategies and sources of support that are readily available in their phone. Reach Out is a website and forum for youth mental health and support. Big White Wall is an online community that encourages anonymous peer support and a safe space for self-expression. 7 Cups of Tea connects users with supportive strangers worldwide for chat conversations, with the option for online therapy. Crisis Text Line is a free and anonymous texting service that puts texters in touch with trained staff to help them work through an immediate crisis and connect them to resources and information. These are a handful of the hundreds of websites and apps that are currently available in a constantly evolving landscape.

Risks

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

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

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

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

Prevention

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

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

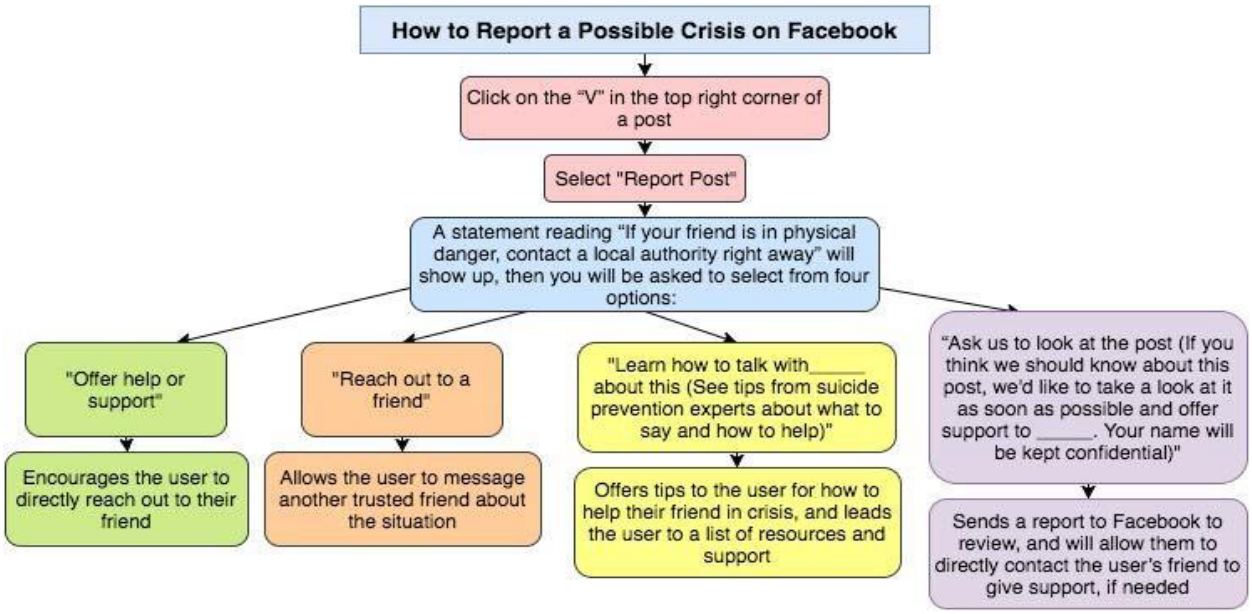
For non-clinical apps, the Anxiety and Depression Association of America recommends that users search for ones that are easy to use, effective, personalized, interactive, and evidence-based (Mental Health Apps, n.d.) (https://www.adaa.org/finding-help/mobile-apps).

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

app store account, which may inform a parent or guardian of the individual's purchase. Common Sense Media provides further information on privacy, which can be found at: https://www.commonsensemedia.org/privacy-and-internet-safety.

Intervention

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



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

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

Postvention

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

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

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

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

What Can Parents and Educators Do?

The most important thing an educator and parent can do is to be tuned in to what youth are using, how they are using it, and the messages that they convey and receive through their use of media. The American Academy of Pediatrics offers policy statements, toolkits and resources for parents, including encouraging all families to develop a Family Media Plan. Common Sense Media is a reputable resource for both parents and educators, with an extensive inventory of media and an associated rating system. This includes social networking applications, movies, games, websites and much more. MyDigitalTat2 stresses the importance of teaching young people critical thinking skills to promote responsible media use and hosts several resource lists for parents and educators: http://www.mydigitaltat2.org

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

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

Conclusion

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

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

Culture, Mental Illness and Stigma

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

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

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

Mental Illness Stigma

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

Overview

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

African Americans

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

Native American

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

Asian Pacific Islander

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

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

Latino

Few studies directly examine stigma comparing the level of stigma that Latinos endorse vs. Whites. This may be because there are fewer quantitative studies and a greater number of qualitative studies with in-depth examination of the processes concerning stigma in Latinos. Recent Latino immigrants may face structural discrimination in relation to language barriers, lack of culturally- appropriate care, citizenship status, and access to health insurance. Latinos often experience double stigma of racial discrimination in addition to the stigma of mental illness. Acculturation affects the stigma associated with mental illness in Latinos, with U.S.-born Latino immigrants endorsing less stigma than their internationally-born counterparts. Interestingly, beliefs in biomedical causes of depression are associated with decreased stigma in Latinos. Psychotherapy is less stigmatized since the cultural value of "unburdening oneself" is thought to be important to maintaining emotional health. However, among Latino immigrants, stigma appears to be strongest with respect to medications, both in fear of addiction and being called crazy (loco).

Stigma emerges in derogatory perceptions of people with mental illness in some Latino immigrant communities, such as illegal drug user or weak (floja), useless (inútil), or small (chiquitita). Self- stigma is an important cause of medication non-compliance and is associated with treatment non-adherence in Latino immigrants. Having a trusting relationship with their provider has a positive effect on treatment participation among some Latinos, likely due to Latino relationship characteristics of trust (confianza) and sympathy/friendliness (simpatia). Family plays an important role in the recovery of many Latinos, and understanding stigma in family caregivers is important for removing barriers to care. Keeping the illness within the family and turning to church for support constitutes major ways of coping and reducing stigma for Latino immigrants. As there is a significant Latino population in California, consider reading detailed results in Appendix C for a more comprehensive review of stigma in Latinos. Further research in this area would particularly benefit California residents given the larger number of diverse Spanish-speaking populations.

Culture, Mental Health and LGBTQ Youth

The Trevor Project

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

NEED HELP? WE ARE HERE FOR YOU 24f7:

1-866-488-7386

THE TREVOR PROJECT

FACTS ABOUT SUICIDE

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

• Suicide is the 2nd leading cause of death among young people ages 10 to 24. [1]

• The rate of suicide attempts is 4 times greater for LGB youth and 2 times greater for questioning youth than that of straight youth. [2]

• Suicide attempts by LGB youth and questioning youth are 4 to 6 times more likely to result in injury, poisoning, or overdose that requires treatment from a doctor or nurse, compared to their straight peers. [2]

• In a national study, 40% of transgender adults reported having made a suicide attempt. 92% of these individuals reported having attempted suicide before the age of 25. [3]

• LGB youth who come from highly rejecting families are 8.4 times as likely to have attempted suicide as LGB peers who reported no or low levels of family rejection. [4]

• 1 out of 6 students nationwide (grades 9-12) seriously considered suicide in the past year. [5]

• Each episode of LGBT victimization, such as physical or verbal harassment or abuse, increases the likelihood of self-harming behavior by 2.5 times on average. [6]

SOURCES:

[1] CDC, NCIPC. Web-based Injury Statistics Query and Reporting System (WISQRS)[online]. (2010) {2013 Aug. 1}. Available from:https://www.cdc.gov/injury/wisqars/index.html

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

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

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

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THE TREVOR PROJECT

ABOUT THE TREVOR PROJECT (SECTION/ABOUT)

Program & Services

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

Crisis Interventions

Trevor Lifeline 1-866-488-7386 A national 24/7 crisis intervention and suicide prevention lifeline for young people (ages 13-24).

Trevor Chat (https://www.thetrevorproject.org/get-help-now/) A free, confidential, secure instant messaging service for LGBTQ youth that provides live help from trained volunteer counselors.

Trevor Text (https://www.thetrevorproject.org/get-help-now/) A free, confidential, secure service in which LGBTQ young people can text a trained Trevor counselor for support and crisis intervention.

Suicide Prevention Trainings and Resources

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

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

Trevor Ally Training https://www.thetrevorproject.org/about/programs-services/trevor-ally-training/ This training introduces adults to the unique needs of LGBTQ youth

https://www.thetrevorproject.org/about/programs-services/lgbtq-on-campus/ Training for staff and faculty in higher education are AFSP/SPRC Best Practices for Suicide Prevention and were created in partnership with Kognito Interactive and Campus Pride.

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

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

Coming Out As YOU! https://www.thetrevorproject.org/trvr_support_center/coming-out/?gclid=EAIaIQobChMIsr3gsKHa6wIVx0XVCh15-gyJEAAYASAAEgLrlfD_BwE A pocket-sized guide to inspire critical thinking in youth who are questioning their sexual orientation or gender identity.

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

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

Community Resources

Trevor Space https://www.trevorspace.org A social networking community for LGBTQ youth ages 13 through 24 and their friends and allies .

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

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

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

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

Sample SEL activities and strategies specific for High School

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

Sample SEL activities and strategies specific for Middle School

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

Sample SEL activities and strategies specific for Elementary School

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

For additional information on schoolwide SEL implementation, please visit:
http://www.casel.org/establishing-systemic-social-and-emotional-learning-approaches-in-schools-a-framework-for-schoolwide-implementation/

Mindfulness and School Climate: One Example

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

TYPES OF STUDENT PROGRAMS INFORMATION SHEET

1. CURRICULA FOR ALL STUDENTS

Purpose: These curricula:

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

Content: Typical content includes:

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

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

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

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

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

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

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

Content: Typical content includes exercises and activities to:

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

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

3. Peer Leader Programs

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

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

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

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

Peer Leader Training: The training varies according to the roles taken on by the peer leaders. Basic components of these trainings include:

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

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

- Sources of Strength
- Youth Aware of Mental Health
- Let's Bring Change 2 Mind

Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

GENERAL GUIDELINES FOR TEACHERS AND STAFF

- Suicide is the third leading cause of death for youth aged 10-24 in the United States. *

- In recent years more young people have died from suicide than from cancer, heart disease, HIV/AIDS, congenital birth defects and diabetes combined. *

- For every young person who dies by suicide, between 100-200 attempt suicide

- Males are four times as likely to die by suicide as females – although females attempt suicide three times as often as males. *

SUICIDE IS PREVENTABLE

Here's what you can do:

- Talk to your student about suicide, don't be afraid, you will not be "putting ideas into their heads". Asking for help is the single skill that will protect your student. Help your student to identify and connect to caring adults to talk to when they need guidance and support

- Know the risk factors and warning signs of suicide.

- Remain calm. Becoming too excited or distressed will communicate that you are not able to talk about suicide.

- Listen without judging. Allow for the discussion of experiences, thoughts, and feelings. Be prepared for expression of intense feelings. Try to understand the reasons for considering suicide without taking a position about whether or not such behavior is justified.

- Supervise constantly. Do not leave the individual alone until a caregiver (often a parent) or school crisis team member has been contacted and agrees to provide appropriate supervision.

- Ask if there is a plan. If so remove means. As long as it does not put the caregiver in danger, attempt to remove the suicide means.

- Respond Immediately. Escort the student to a member of your school's crisis team. If you are unsure of who is on your school crisis team, find the Principal, Assistant Principal or school social worker, psychologist, counselor or school nurse.

- Join the crisis team. You know your students the best. Provide essential background information that will help with assessing the student's risk for suicide. When a teacher says, "this behavior is not like this student", this is critical information indicating a sudden change in behavior.

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

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

Source: Los Angeles County Youth Suicide Prevention Project

GENERAL GUIDELINES FOR TEACHERS AND STAFF

Youth Suicide Risk Factors

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

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

Suicide Warning Signs

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

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

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

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

Source: Los Angeles County Youth Suicide Prevention Project

ATTACHMENT 1.9

RISK FACTORS FOR YOUTH SUICIDE

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

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

Behavioral Health Issues/Disorders:

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

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

Personal Characteristics

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

Adverse/Stressful Life Circumstances

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

Risky Behaviors

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

Family Characteristics

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

Environmental Factors

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

Stigma and discrimination lead to:

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

Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

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Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

PROTECTIVE FACTORS AGAINST YOUTH SUICIDE

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

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

Individual Characteristics and Behaviors

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

Family and Other Social Support

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

School

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

Mental Health and Healthcare Providers and Caregivers

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

Access to Means

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

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Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

RECOGNIZING AND RESPONDING TO WARNING SIGNS OF SUICIDE

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

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

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

Warning Signs for Suicide and Corresponding Actions

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

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

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

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

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

REFERENCE

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Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

RED FOLDER INITIATIVE

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

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

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

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

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

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

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

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

"Red Folder" at the Middle and High School level:

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

School Process to Create "Red Folder":

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

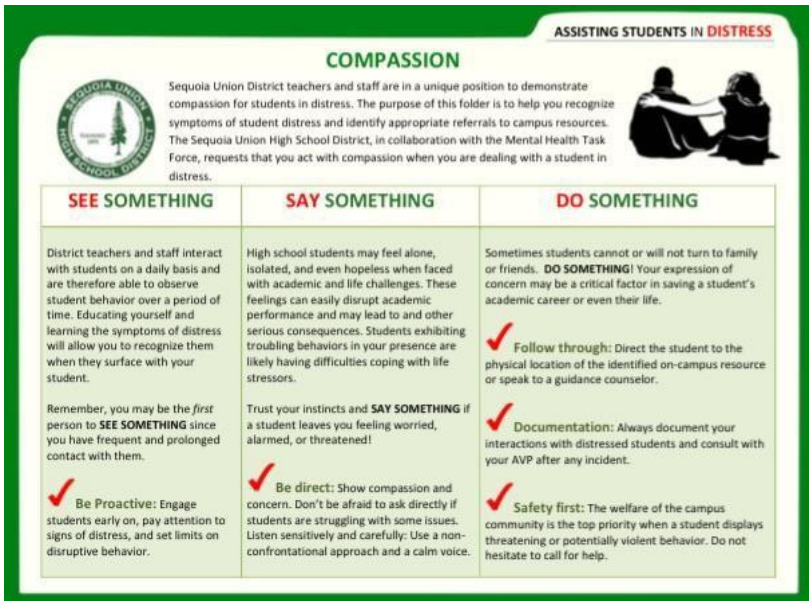
The school process for creating a 'Red Folder' must begin with assembling a team of individuals who are well informed on the needs and resources at their respective district and/or school. This team can include:

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

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

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

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



ASSISTING STUDENTS IN DISTRESS

COMPASSION

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

SEE SOMETHING

District teachers and staff interact with students on a daily basis and are therefore able to observe student behavior over a period of time. Educating yourself and learning the symptoms of distress will allow you to recognize them when they surface with your student.

Remember, you may be the *first* person to **SEE SOMETHING** since you have frequent and prolonged contact with them.

✓ Be Proactive: Engage students early on, pay attention to signs of distress, and set limits on disruptive behavior.

SAY SOMETHING

High school students may feel alone, isolated, and even hopeless when faced with academic and life challenges. These feelings can easily disrupt academic performance and may lead to and other serious consequences. Students exhibiting troubling behaviors in your presence are likely having difficulties coping with life stressors.

Trust your instincts and **SAY SOMETHING** if a student leaves you feeling worried, alarmed, or threatened!

✓ Be direct: Show compassion and concern. Don't be afraid to ask directly if students are struggling with some issues. Listen sensitively and carefully: Use a non-confrontational approach and a calm voice.

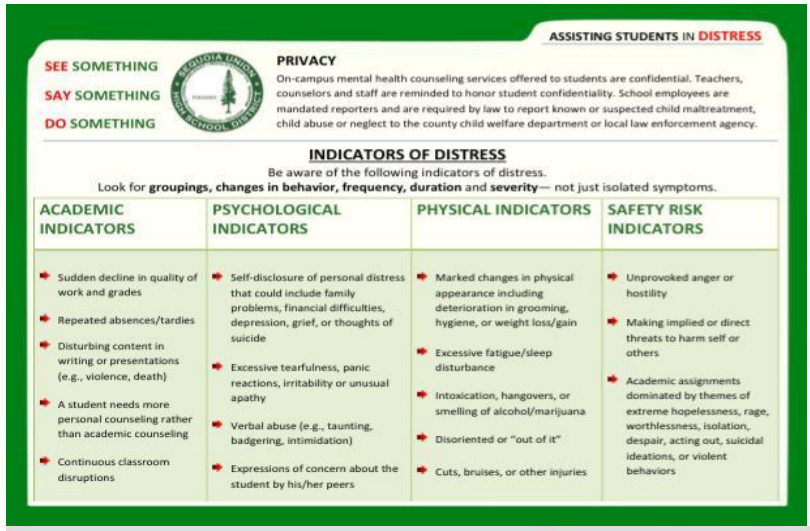
DO SOMETHING

Sometimes students cannot or will not turn to family or friends. **DO SOMETHING!** Your expression of concern may be a critical factor in saving a student's academic career or even their life.

✓ Follow through: Direct the student to the physical location of the identified on-campus resource or speak to a guidance counselor.

✓ Documentation: Always document your interactions with distressed students and consult with your AVP after any incident.

✓ Safety first: The welfare of the campus community is the top priority when a student displays threatening or potentially violent behavior. Do not hesitate to call for help.



ASSISTING STUDENTS IN DISTRESS

SEE SOMETHING
SAY SOMETHING
DO SOMETHING

PRIVACY

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

INDICATORS OF DISTRESS

Be aware of the following indicators of distress.
Look for **groupings, changes in behavior, frequency, duration** and **severity**— not just isolated symptoms.

ACADEMIC INDICATORS	PSYCHOLOGICAL INDICATORS	PHYSICAL INDICATORS	SAFETY RISK INDICATORS
Sudden decline in quality of work and grades	Self-disclosure of personal distress that could include family problems, financial difficulties, depression, grief, or thoughts of suicide	Marked changes in physical appearance including deterioration in grooming, hygiene, or weight loss/gain	Unprovoked anger or hostility
Repeated absences/tardies	Excessive tearfulness, panic reactions, irritability or unusual apathy	Excessive fatigue/sleep disturbance	Making implied or direct threats to harm self or others
Disturbing content in writing or presentations (e.g., violence, death)	Verbal abuse (e.g., taunting, badgering, intimidation)	Intoxication, hangovers, or smelling of alcohol/marijuana	Academic assignments dominated by themes of extreme hopelessness, rage, worthlessness, isolation, despair, acting out, suicidal ideations, or violent behaviors
A student needs more personal counseling rather than academic counseling	Expressions of concern about the student by his/her peers	Disoriented or "out of it"	
Continuous classroom disruptions		Cuts, bruises, or other injuries	

ASSISTING STUDENTS IN DISTRESS

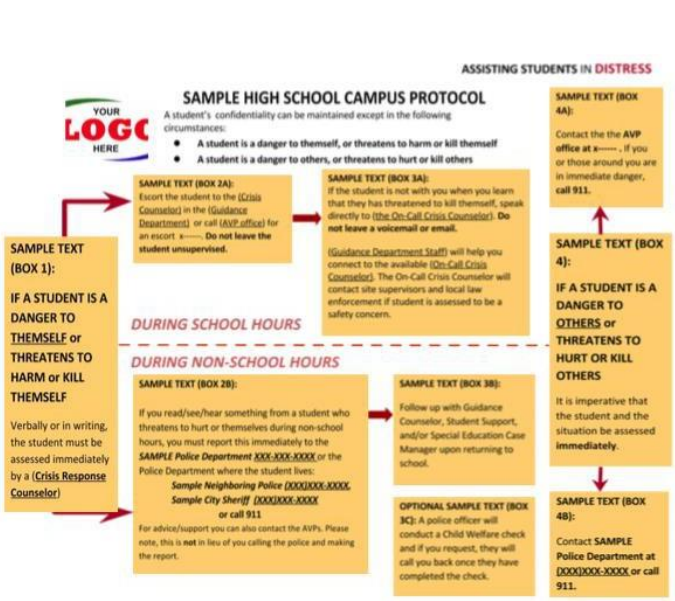
SEE SOMETHING.
SAY SOMETHING.
DO SOMETHING.

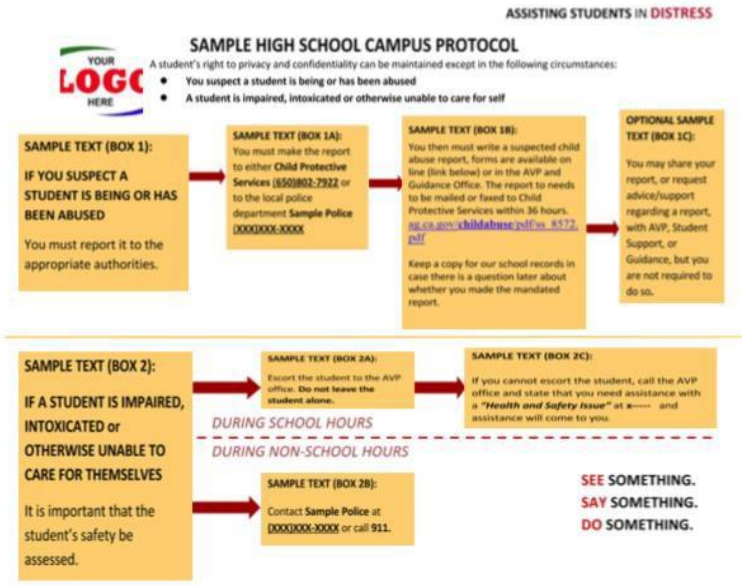
COMMUNITY RESOURCES

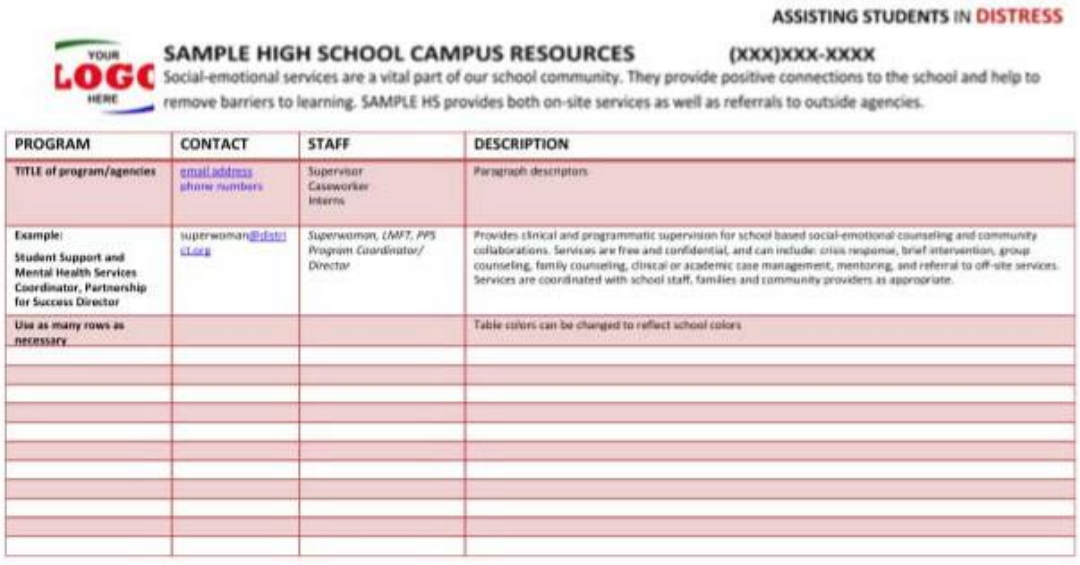
The following community organizations provide **critical services** to youth and families. For a complete list of community organizations and their array of services, please visit the County website, **sanmateo.networkofcare.org**.

COUNTY AGENCIES	HOTLINES	COMMUNITY AGENCIES	TARGETED SUPPORTS
Sequoia Teen Wellness Center **(650) 366-2927** www.co.sanmateo.ca.us/SequoiaTWC Health services, case management, and school outreach clinic. Conveniently located next to District office.	**National Suicide Prevention Hotline** **1-800-273-8255** 24-hours, 7 days a week A network of 166 crisis centers in 49 states that connects individuals to crisis services in their local areas.	**healthRight360** **(650) 248-6603** www.healthright360.org Offers therapy to youth and adults struggling with mental health issues, substance use.	***ACS* Outlet** **(650) 424-0852** http://acs-teens.org/what-we-do/outlet Offers free confidential drop-in English-speaking and Spanish-speaking groups for LGBTQQ youth, ages 10-25 years old in Redwood City, Mountain View and San Mateo.
Ravenswood Family Health Center **(650) 330-7400** http://www.ravenswoodfhc.org Clinic providing full health services for the Ravenswood community.	**24-HOUR ALCOHOL and DRUG HELPLINE** **(650) 573-3950** www.star-vista.org A help line counselor will answer questions about alcohol and other drug prevention and recovery programs.	**ACS (Adolescent Counseling Services)** **(650) 424-0853** http://acs-teens.org Provides on-campus counseling services at Woodside HS and Redwood HS as well as a community counseling program at various local Boys and Girls Clubs.	**KARA** **(650) 321-5272** www.kara-grief.org Provides grief support services for individuals, families and organizations.
Fair Oaks Health Clinic **(650) 578-7141** http://sanmateomedicalcenter.org/content/FOHC.htm Clinic providing full health services for the Fair Oaks community.	**24-HOUR CRISIS LINE** **(650) 579-0350** www.star-vista.org Provides telephone contact, assessment, counseling referrals, and follow-up for individuals in crisis/at risk of suicide.	**El Centro de Libertad** **(650) 599-9955** recovery@elcentrodelibertad.org Offers therapy to youth and adults struggling with mental health issues, substance use.	***StarVista* Daybreak** **(650) 364-433** http://star-vista.org Provides transitional housing and independent living skills training for homeless youths ages 16-21.
County of San Mateo Behavioral Health and Recovery Services (BHRS) ACCESS Team **(800) 686-0101** http://smchealth.org/mh Offers a broad spectrum of mental health and substance use services.	**Rape Trauma Services 24-HOUR CRISIS LINE** **(650) 692-7273** www.rapetraumaservices.org Provides a free, 24-hour, confidential hotline for anyone who has been hurt by sexual violence. Provides support for survivors through hospital medical legal exams, law enforcement, and the judicial system.	**StarVista** **(650) 576-KIDS (5437)** call or text http://star-vista.org Delivers high impact services through counseling, skill development, and crisis prevention at Menlo-Atherton HS and Sequoia HS. Offers a myriad of services including residential programs and outpatient services for youth.	***StarVista* Your House South** **(650) 367-9687** http://star-vista.org Provides a "time-out" for both the youth and the family, and an opportunity to work on the family's situation.
Child Protective Services (CPS) **(650) 595-7922** http://hsa.smcgov.org/child-protective-services CPS is a 24-hour service provided on the behalf of children who are alleged victims of child abuse/neglect.	**Al-Anon/Alateen** **(650) 592-7935** http://al-anon.alateen.org Info line for anyone affected by someone else's drinking.	**PHP (Parents Helping Parents)** **(408) 850-6125** *Parent Crisis Number* **(408) 727-5775** http://php.com PHP helps families who have children of any age with special needs.	***StarVista* Insights** **(650) 366-8436** http://star-vista.org Offers a structured 22 week drug and alcohol recovery outpatient program for youth.

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







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

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

ATTACHMENT 1.12

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

- UC system examples (10) of the Red Folder and how it is unique to each campus: http://www.ucop.edu/student-mental-health-resources/training-and-programs/faculty-and-staff-outreach/red-folder- initiative.html

- Cal State University Red Folder Initiative: http://calstate.edu/red-folder/

Read more about the CSU San Bernardino APP - https://play.google.com/store/apps/details?id=edu.calstate.redfolder&hl=en

QPR as a Universal Intervention
A Brief
Review

ThefollowingdocumentdescribestheQPRGatekeeperTrainingforSuicidePreventionas a universal intervention in the detection of those as risk for suicide, as well as those who may not be at risk for suicidal behaviors, but may need assistance, assessment, and treatment for any number of mental health issues or problems.

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

Listing for QPR: https://qprinstitute.com/

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

Universal Intervention

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

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

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

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

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

The QPR Concept and Theory

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

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

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

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

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

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

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

Research Highlights

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

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

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

Source: Cross, W.F., Seaburn, D., Gibbs, D., Schmeelk-Cone, K. et al. (2011); Matthieu, M.M., Cross, W., Batres. A.R., Flora et al. (2008); Wyman, P.A., Brown, C.H. Inman, J., Cross W., et al (2008). (See NREPP web site for full descriptions of support research and citations).
Methods: Three randomized studies conducted in school, outpatient and workplace settings examined the impact of the Question, Persuade, Refer (QPR) training on stratified samples of (1) 340 teachers and parents in a US public school community and (2) 602 community based counseling center staff from the US Department of Veteran Affairs. One study included a 1-year average follow- up assessment and a second study included a 3-month follow-up assessment.
Results: Findings reported an immediate increase in declarative knowledge, perceived knowledge, self-efficacy, diffusion of gatekeeper training information and gatekeeper skills. Results persisted in the 3-month and 1-year follow up with marginal decrements.
Reference:
Kessler R, Avenevoli S, Costello J, Georgiades K, Green JG, Gruber M, He J, Koretz D, McLaughlin K, Petukhova M, Sampson N, Zaslavsky A, Merikangas K. Pr evalence, persistence and Sociodemographiccorrelates of DSM - IV disorders in the National Comorbidity SurveyReplication Adolescent Supplement. Archives of GeneralPsychiatry. April 2012; 69(4):372-380.

QPR Guidelines

Safe Delivery Of Suicide Prevention Training To Youth

- Training for students should only be undertaken once adults in the school (including teachers and staff) have completed QPR Gatekeeper Training (or QPR Advanced Training for school counselors, nurses, social workers, psychologists or other mental health clinicians).

- Training should, initially, be offered exclusively to students in grades 10 to 12 (entering sophomores through seniors).

- Ideally, any student engaged in training should be screened for risk by a school counselor who has participated in one or more advanced QPR training programs.

- Any student excluded from training based on evidence of risk will be followed up and supported by school health professionals.

- Training will be delivered in facilitated small groups (maximum of 12---15 students) with a supervising school counselor or nurse attending who will be available to students for support and follow---up as needed.

- Several key core messages regarding suicide risk and protection are as follows:

  1. Friends never let friends keep secrets about suicide --- Tell An Adult! (Therefore, we want to be very sure that any adult approached by a young person concerned about suicide risk have QPR training such that they know how to respond and what to do)

  2. No student should ever feel that they are totally responsible for the safety of another student.

  3. Ideally the teacher is present at the youth training and receives a QPR certificate or has already been trained in QPR

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

INCLUDING SUICIDE PREVENTION IN OTHER EFFORTS TO REACH PARENTS

Schools have integrated suicide prevention outreach into other activities by:

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

Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

IDEAS FOR MAXIMIZING PARENTAL RESPONSE RATE

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

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

REFERENCES

Brown, M., & Grumet, J. (2009). School-based suicide prevention with African American youth in an urban setting. Professional Psychology: Research and Practice, 40(2), 111-117.

Gutierrez, P. M., & Osman, A. (2008). Adolescent suicide: An integrated approach to the assessment of risk and protective factors. DeKa1b, IL: Northern Illinois University Press.

Rodgers, P. H. (2006). Maximizing the return of parent consent forms. Unpublished manuscript. Newton, MA: Suicide Prevention Resource Center, Education Development Center, Inc.

Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

SUICIDE PREVENTION: FACTS FOR PARENTS

HIGH SCHOOL STUDENTS EXPERIENCE UNIQUE CHALLENGES

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

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

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

Source: Centers for Disease Control and Prevention (CDC)

WHY HIGH SCHOOLS ADDRESS SUICIDE

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

PREVENTING SUICIDE CAN PREVENT OTHER BEHAVIOR PROBLEMS

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

HOW PARENTS CAN HELP PROTECT THEIR CHILDREN FROM SUICIDE

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

HOW SCHOOLS CAN HELP PREVENT SUICIDE

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

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

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

Source: Preventing Suicide: A Toolkit for High Schools, SAMHSA

SECTION II: INTERVENTION IN A SUICIDAL CRISIS

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

Key principles to remember in any crisis:

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

A. CRISIS RESPONSE TEAM (CRT) MEMBERS AND ROLES

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

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

2. **Team member responsibilities include:**
   a. **All Members:**

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

b. Principal/Assistant Principal:

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

c. School Psychologist/Counselors

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

ci. School Nurse or Health Technician

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

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

f. Media Spokesman/Associate Superintendent
   - Fields and responds to media inquiries --- review Attachment 3.18, "Guidelines for Working With the Media"

g. Campus Supervisor
   - Coordinates immediate security and protections
   - Roams campus to help identify students in need

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

CRISIS RESPONSE TEAM CONTACT INFORMATION FOR SECONDARY SCHOOL:

_____

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

CRISIS RESPONSE TEAM CONTACT INFORMATION FOR PRIMARY SCHOOL:

_____

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

B. IDENTIFY AND MONITOR AT-RISK STUDENTS

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

   - Students exhibiting suicidal thoughts, behaviors, or risk factors
   - Students who have been hospitalized for serious mental health issues

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

2. Alternative approaches to identifying students at risk are offered in the SAMHSA Toolkit, including on the basis of showing difficulty in three or more of the following areas:
   - Academic achievement
   - Effort
   - Conduct
   - Attendance
   - Negative report card comments
   - Code of student violations
   - Involvement with school police

3. Once at-risk students are identified, the counselor will meet with the student and the parent/guardian (when appropriate) to assess specific needs and work with other school staff to help the student succeed in school and cope better with emotional and/or behavioral difficulties, including any suicidal thoughts or behaviors.

INTERVENTION IN A SUICIDAL CRISIS

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

Low Risk Level of Suicide

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

- Take immediate action by sending someone to inform the counselor or school psychologist of the situation.
- Remain with the student until the counselor/school psych talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk with chosen tool.
- When necessary, counselor or school psychologist will contact an administrator or designee to inform them of the situation.
- Counselor or school psychologist will notify parent/guardian of situation unless this will exacerbate the situation *Guidelines for Notifying Parents*, *Supporting Parents Through Their Child's Suicidal Crisis* attachment 2.5, and *Contact Acknowledgement Form*, 2.6
- Develop a safety plan with the student and parents. *Safety Planning Guide,* 2.11, and *Personal Safety Plan,* 2.12.
- Refer to primary health care provider or mental health services if necessary *Guidelines for Student Referrals*, 2.7, *Referral Process for Special Education Mental Health Assessment,* 2.8, and *Referral, Consent, and Follow-Up Form*, 2.9
- Document actions on appropriate forms *Student Suicide Risk Documentation Form,* 2.13
- Counselor will follow up with the student and family as often as necessary until the student is stable.

Moderate to High Risk Level of Suicide

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

- Keep student under close supervision. Notify nearest CRT member who will evaluate the situation and then notify a school administrator.
- CRT member will conduct a suicide risk assessment to determine student's risk level and convey to trained professionals (UFS).
- Consult with appropriate designated school site staff and/or crisis service agency (e.g. UFS) to assess student's mental state and obtain a recommendation for next steps. If student requires hospitalization or immediate emergency medical treatment proceed to Extremely High (Imminent) Risk.
- School administrator or designee notifies parents/guardians *Guidelines for Notifying Parents,* and *Supporting Parents Through Their Child's Suicidal Crisis,* 2.5, and *Parent Contact Acknowledgement Form*, 2.6. Arrange to meet with parents.
- Create a safety plan, or if already in place, review and update.

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

- Confirm understanding of next steps for student's care.
- Ensure that student and parents, with the assistance of a CRT member, have discussed importance of lethal means restriction *Means Matter: Recommendations for Families,* 2.18
- Sign the *Referral, Consent and Follow-Up Form,* 2.9 and *Parent Contact Acknowledgment Form*, 2.6
- Provide referrals and resources for parent/guardians including *What to Expect; When Your Child Expresses Suicidal Thoughts*, Appendix B4
- Explain that a designated school professional will follow-up within the next two days.
- Establish a plan for periodic contact from school personnel Students are eligible for home teaching if a doctor's letter recommends an extended absence of two weeks or more.
- Document actions taken *Student Suicide Risk Documentation Form*" 2.13
- Debrief with all staff members who assisted with the intervention, providing for the expression of feelings, worries, concerns, and suggestions.

Extremely High (Imminent) Risk Level of Suicide

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

- Ensure that a school staff member remains with the student at all times.
- Clear the area and ensure that all other students are safe. Alert CRT member.

- **Mobilize community links (e.g. UFS and/or 911)** If a life threatening emergency, call 911. Note: 911-responder will determine if emergency treatment or hospitalization is required and will arrange transport
- If not life threatening, call UFS Suicide Assessment at 877-412-7474. If student is 18 years or older, call 911 Principal or designee notifies parents about the seriousness of the situation, unless this will exacerbate the situation. In certain cases, it may be necessary to wait to notify parents due to clinical circumstances as determined by Psychologist, UFS or other mental health provider.

If the student has lethal means on their person:

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

- **At this level of risk the student may require hospitalization**
- Case manager (school psychologist or counselor) will work with student's doctor/ therapist. Frequency of check-in with the student, family, doctor and/or therapist will be determined by the individual situation.
- Before student returns to school, initiate re-entry plan.

C. LOW RISK LEVEL OF SUICIDE

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

1. When a peer, parent, teacher, or other school employee identifies someone as potentially suicidal because s/he has directly or indirectly expressed suicidal thoughts (ideation) or demonstrated warning signs (see Attachment 1.11, "Recognizing and Responding to Warning Signs of Suicide"), consider the following:

   a. Take every warning sign or threat of self-harm seriously.
   b. Take immediate action by sending someone to inform the counselor or school psychologist of the situation.
   c. Remain with the student until the counselor/school psychologist talks with him/her in a quiet, private setting to clarify the situation, and assess suicide risk with chosen tool. Create a safety plan (see Attachment 2.12, "Personal Safety Plan") and provide appropriate support.
   d. When necessary, counselor or school psychologist will contact an administrator or designee to inform them of the situation.
   e. Counselor or school psychologist will notify parent/guardian of situation unless this will exacerbate the situation (see Attachment 2.5, "Guidelines for Notifying Parents", and "Supporting Parents Through Their Child's Suicidal Crisis" and Attachment 2.6 " Contact Acknowledgement Form").
   f. Develop a safety plan with the student and parents (see Attachment 2.11, "Safety Planning Guide", and Attachment 2.12, "Personal Safety Plan").
   g. Refer to primary health care provider or mental health services if necessary (see Attachment 2.7, "Guidelines for Student Referrals", Attachment 2.8, "Referral Process for Special Education Mental Health Assessment", and Attachment 2.9, "Referral, Consent, and Follow-Up Form")
   h. Document actions on appropriate forms (Attachment 2.13, " Student Suicide Risk Documentation Form").

2. The counselor will follow up with the student and family as often as necessary until the student is stable and no longer of concern.

D. MODERATE TO HIGH RISK LEVEL OF SUICIDE

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

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

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

E. EXTREMELY HIGH (IMMINENT) RISK LEVEL OF SUICIDE

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

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

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

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

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

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

1. Work with student, family, and relevant staff (counselor and school psychologist) to create an individualized re-entry plan (IRP) before the students return. A meeting with family and student is strongly recommended before the student returns to school.

2. Ensure that the appropriate staff (school psychologist, counselor, administrator) has the pertinent information from the student's doctor, psychiatrist, psychologist or therapist necessary to create the student's IRP.

3. The IRP will be based on Doctor or Mental Health Provider recommendation using Attachment 2.10, "Health and Education Plan - Physician Report" to support the student's psychological and educational needs.

4. Details of the student's mental health history should be shared only as needed to support the student's successful re-entry.

5. A completion of Attachment 2.10, "Health and Education Plan - Physician Report and Attachment 2.9, " Referral, Consent and Follow-Up Form" is strongly recommended before re-entry.