TEXAS SUICIDE SAFER SCHOOLS

2015

Authored by: Dr. Scott Poland and Dr. Donna Poland

Produced in collaboration with

Texas Department of State Health Services and Mental Health America of Texas
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Suicide Safer Schools in Texas

Produced in collaboration with the Texas Department of State Health Services and Mental Health America of Texas

Authored by Dr. Scott Poland and Dr. Donna Poland

Introduction and Incidence

Suicide has been identified (depending on age and data collection date) as the second or third leading cause of death for youths ages 10-24 nationwide. Though it is likely underreported due to social stigma, reported suicides account for approximately 4,600 deaths a year among youth in the U.S. In a 2013 survey, 1 in 13 U.S. 9th-12th graders reported having attempted suicide one or more times in the past year, and more than 1 in 7 reported seriously considering attempting suicide. Youth suicide is a serious public health issue and it has increased in recent years. It is noted that most educators are not familiar with the incidence of suicide and are very surprised to learn how often a high school student has thoughts about suicide, makes a plan and even attempts suicide. There is a great deal of misinformation about suicide and many held myths that have resulted in a lack of awareness and hesitancy to talk directly about a leading cause of death for our youth. This report emphasizes dispelling the many myths that have been perpetuated about suicide with the goal of empowering Texas educators that they can make a difference in creating suicide safer schools!

It is important to know that some groups are at a higher risk for suicide than others. Males are more likely to die by suicide than females, but females are more likely to attempt suicide. Among racial/ethnic groups nationwide, American Indian/Alaska Native youth have the highest suicide rates. In addition, research has shown that lesbian, gay, bisexual, and transgender youth report suicide attempts at significantly higher rates than their heterosexual counterparts. Several other factors put teens at risk for suicide, including a family history of suicide or past suicide attempts, mental or physical illness, substance abuse, stressful life events, easy access to lethal methods, exposure to suicidal behavior of others, and incarceration.
Approximately 157,000 young people ages 10-24 are treated for suicide attempts at U.S. emergency departments every year. According to 2012 data collected by the National Center for Injury Prevention and Control, poisoning is the most common form of intentional, self-inflicted, non-fatal injury resulting in hospitalizations for 10- to 24-year-olds. While our interest in this study is for school aged children, it is important to recognize the data they have collected through the age of 24. Many of our school communities are impacted by suicides of older former students as they have younger siblings or friends still attending school.

This information was compiled from the following sources:


Appendix A provides information about overall suicide rates in the nation and in Texas in relation to our youth.

Purpose of the Report

This report is designed to assist Texas educators to know the incidence of youth suicide and to recognize schools have the ability to increase suicide awareness, increase protective factors, build resiliency in students and very importantly to intervene and get help for a suicidal student. It is essential that educators be able to distinguish the facts about youth suicide from the many myths and misperceptions. Suicide is preventable and a system wide approach is needed that includes the schools and all stakeholders. There is a national focus on suicide prevention and the 2012 Strategy for Suicide Prevention stressed that suicide prevention needs to be a core component of health services and the Zero Suicide Model has the goal of improving outcomes for suicidal individuals. Texas has set goals to improve identification, treatment and support for suicidal youth and to establish Suicide Care Communities within the public mental health system as part of a Zero Suicide statewide emphasis for
healthcare and behavioral health care. Texas has made great progress in increasing suicide prevention efforts in schools and improving partnerships with local and state agencies. This report is designed to clarify the role of the schools and increase not only awareness of youth suicide but to help schools increase their collaborative efforts for prevention and knowledge of available resources. Suicide intervention in schools has three major components that will be addressed in this report: prevention, intervention and postvention. Texas has legislative requirements for schools and suicide prevention. This report will review the legislation and make practical recommendations in the form of a plan for how schools can best implement the legislation. Extensive information about suicide prevention requirements in Texas schools appears in the Legislation section of this report.

Both authors worked in the Texas schools for many years and suicide intervention was the highest priority, but we felt it was essential to survey Texas educators and leaders outside of the schools in state agencies to get an accurate picture of the accomplishments and challenges for suicide safer schools in Texas before writing this report. We are very familiar with one of the most important suicide prevention strategies recommended by the Center for Disease Control (CDC) which is to increase connections as a way to prevent suicide. We believe that every student needs to feel a sense of belonging and connectedness with their school, classmates and school staff. Schools have always impressed upon parents and guardians that we need their partnership in helping their children to be successful. We became professional educators and state leaders in educating our youth because we care about their learning, social growth, mental and physical wellbeing. Children are in school and under direct supervision of teachers and school staff for a minimum of seven hours a day. For students who participate in after-care, sports, or the arts and clubs, the time can extend many more hours. It is not uncommon for parents to comment that their children spend most of their waking hours at school. This makes educators devotion of focused and undistracted time to each student in the classroom, lunchroom, hallways, social play, and organized after-school activities a critical opportunity to observe, report, and intervene when we see a child in emotional distress. It is very important that all Texas educators know the warning signs of suicide and note dramatic changes in a student’s behavior and work as a member of a school team to obtain assistance and support for the student. More data about suicidal thoughts, behavior and actions are gathered on the high school student population that any other school aged group. The most current data for high school students nationally and in Texas appears below.
2013 National and Texas YRBS Results for High School Students:

Data retrieved from: [http://www.cdc.gov/healthyyouth/data/yrbs/data.htm](http://www.cdc.gov/healthyyouth/data/yrbs/data.htm)

<table>
<thead>
<tr>
<th>Nationwide Youth Risk Behavior Surveillance</th>
<th>Texas Youth Risk Behavior Surveillance 2013</th>
</tr>
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<tbody>
<tr>
<td>Surveyed 15,000 H.S students and in the last year</td>
<td>Surveyed 3181 H.S. students and in the last year</td>
</tr>
<tr>
<td>17.0% considered suicide (increase from 2011)</td>
<td>16.7% considered suicide</td>
</tr>
<tr>
<td>13.6% made a suicide plan (increase from 2011)</td>
<td>15.6% made a suicide plan (increase from 2011)</td>
</tr>
<tr>
<td>8.0% made an attempt (increase from 2011)</td>
<td>10.1% made an attempt (unchanged from 2011)</td>
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It is very important to note that the number of Texas high school students who made a suicide plan and attempted suicide in the last year is above the national average. Students with a previous history of suicide are very much considered at risk for future suicidal behavior. YRBS data has been gathered nationally every two years since 1991 by the Center for Disease Control and provides very important information about many at risk behaviors for high school students. All high school personnel are strongly encouraged to review YRBS data for Texas students in all at risk categories.

There has been a national movement to increase suicide prevention in schools and many states currently are requiring annual in-service training for school personnel. Most notably The Jason Flatt Act, and similar legislation which addresses youth suicide awareness and prevention pertaining to annual teacher in-service training has passed in 15 states-Texas is among the thirty percent of our
states who have passed legislation to require teacher suicide prevention training. In all 15 states, this legislation has been supported by the state’s Department of Education and the state’s Teacher’s Association which points to the value seen in such preventative training. The requirements for teachers training differ among the various states. The American Foundation for Suicide Prevention (AFSP) summarizes state legislation and provided a wealth of information for suicide prevention in schools. AFSP noted only a few states are requiring suicide prevention presentations to students.

A survey of Texas educators was conducted by Poland and Poland in 2015 prior to writing this report (a copy of survey can be found in Appendix C) indicated resoundingly, educators at Pre-K through 12th grade campuses and districts in Texas have asked for training and increased resources to aid them in responding to youth suicide thoughts, attempts, and completions.

96% of the respondents have received suicide prevention training. Anecdotal comments written by counselors and other school personnel indicated that they recognized and understood the signs of suicide ideation and had a plan in place for addressing the needs of the distressed student(s). However, a follow-up question regarding their confidence in knowledge and skills for intervening with a suicidal student reflected that 100% in suburban districts expressed they were confident to somewhat confident with their skills but only 50% in rural districts, and 40% in urban districts, expressed they were confident to somewhat confident with their skills.

- 50% of the overall respondents were familiar with the Best Practices resources that are advocated in this document and prescribed by national and state suicide prevention organization.
- 89% of the overall educator respondents indicated they have personally responded to a youth suicide.
- 56% of overall respondents’ schools have provided suicide prevention training to students and parents. Many commenting that training is done when an “at risk” youth is identified and interventions are done only for the specific youth and their parent. Most “yes” responses indicated guidance lessons, or group counseling of a broader nature that does not specifically mention suicide prevention.
• 48% of overall respondents indicated that their school has a procedure for screening depression/suicide with students. The question asked if screening was provided for “all” students, but responses indicated screening is not done for entire student body. Some schools do a “general needs assessment” at the beginning of the school year to determine which students may need attention. Teen Screen was indicated by 2 schools as a tool used for their entire 5th and 6th grade students. (Currently, the Teen Screen Program is no longer available for purchase.)

• 67% of overall respondents did not know or were unsure of any district information or campus improvement plans that included suicide prevention.

A Survey of Texas leaders in Suicide Prevention who work in state agencies was also conducted by Poland and Poland in 2015 prior to writing this report (copy of survey can be found in Appendix D) that indicated that they are very familiar with Best Practices and very dedicated to assisting Texas schools in all aspects of suicide intervention. These Leaders were asked about the top successes for suicide prevention in the Texas schools and cited the following: legislations is in place, school districts have reached out for guidance, free on line training is available for educators and many statewide efforts are in place to promote awareness including electronic resources, apps and websites. In addition, the Department of State Health Services (DSHS) has a suicide prevention coordinator and there are many (30) coalitions for suicide prevention around the state and every local mental health center has a designated suicide prevention coordinator. The state has also provided funding for Mental Health First Aid training that a number of schools have taken advantage of. Mental health and suicide prevention have also been added to local school health advisory council requirements. The fact that ASK suicide prevention trainings have been provided in many locations around the state was also cited as a strength. The Texas Education Agency (TEA) also has facilitated bi-monthly meetings of state agency staff that focus on mental health and suicide prevention for more than a year. Much progress in suicide prevention in Texas has taken place in the last decade!

• 50% of the overall respondents somewhat believed Texas schools were familiar with the Best Practices resources that are advocated in this document and prescribed by national and state suicide prevention organization.
• 75% of the overall respondents somewhat believed Texas schools had a good understanding of how to implement Texas laws regarding suicide prevention in schools

• 75% of the overall respondents were not confident that Texas schools had the knowledge and skills for intervening with a suicidal student

• 75% of the overall respondents somewhat agreed that Texas schools were aware and utilized community and state resources for prevention/intervention

• 50% of the overall respondents somewhat believed Texas schools have the training necessary to work with students and parents in the aftermath of a youth suicide

• 50% of the overall respondents did not believe Texas schools had a comprehensive plan for addressing suicide prevention and postvention

• 100% of the overall respondents believe that youth suicide is a problem in Texas

• 75% of the overall respondents believe that schools play a significant role in educating staff, parents and students on suicide prevention in Texas

• 100% of the overall respondents believe that schools need more information and guidance on suicide prevention/intervention strategies

The Leaders were also asked what they believed to be the biggest challenges for safer suicide prevention schools in Texas and indicated the following: need for more counselor/social workers time to focus on student mental health, mental health is important but state mandates focus on classroom academics, limited time exists for professional development for educators and it is difficult to provide suicide prevention training to everyone who needs it. Additionally it was noted that some schools do not know how to address suicide and it is a difficult subject and many of the best prevention efforts in Texas schools that are in place were implemented only after suicide deaths. Respondents also stressed the need for standardized implementation and monitoring of suicide prevention. It was also noted that there is a lack of developmentally appropriate programs on mental health and prevention for elementary age students. It is also challenging that much of the funding for suicide prevention is dependent on obtaining grants.
Leaders were also asked what would help the Texas schools implement required legislation and improve suicide prevention efforts. Respondents cited the need for more guidance to be provided to districts and increased awareness of legislative requirements and the Best Practices program list that is provided by DSHS. It was also emphasized that key personnel such as counselors need to receive additional training on suicide assessment and intervention. A unified mission for suicide prevention needs to be established that increases collaborative effort between all stakeholders with a recommended focus on how local and state agencies can assist schools with suicide prevention. It was also suggested that suicide prevention be aligned with other major school initiatives such as bullying prevention, dropout prevention and substance abuse prevention. Additional state funding for prevention was described as essential.

Texas Suicide Prevention Overview

An excellent resource that all school personnel need to be familiar with is the Suicide Prevention Resource Center (SPRC) which provides extensive resources for school and community efforts in preventing suicide deaths. Their mission is to assist in suicide prevention efforts. The SPRC believes that suicide is most effectively prevented by a comprehensive approach that employs seven strategies: (1) identify people at risk, (2) increase help-seeking, (3) provide access to mental health services, (4) establish crisis management and postvention procedures, (5) restrict access to lethal means, (6) enhance life skills, and (7) promote social networks and connectedness. Their newsletter, The Weekly Spark, contains announcements and information about suicide, suicide prevention and mental health issues. They provide brief summaries of national, state and tribal and international news; analyses of relevant research findings; descriptions of funding opportunities, and links to additional resources.

The Best Practices Registry (BPR) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and is designed to support program planners in creating effective suicide prevention programs. The BPR has two sections. Section I lists “evidence-based” programs that have undergone a rigorous evaluation and have achieved positive outcomes for effective prevention, and incorporate the best available research. Section II lists statements that summarize the best knowledge in suicide prevention in the form of guidelines, protocols, or consensus statements. These statements
typically result from a collaborative process involving key experts and stakeholders and/or a thorough review of the literature by a preeminent expert in that topic area.

More information very relevant for Texas schools about effective planning and evaluation is available from the SPRC at www.sprc.org and also at TexasSuicidePrevention.org.

- About Suicide Prevention
- A Strategic Planning Approach to Suicide Prevention (free online workshop)
- Locating and Understanding Data for Suicide Prevention (free online workshop)
- American Indian / Alaska Native Suicide Prevention: Basics of Getting Started
- Evaluation Resources in the SPRC Library
- Planning Resources in the SPRC Library

See Appendix E for contact information for Texas State agencies, National/Federal Agencies and organizations dedicated to suicide prevention and Appendix G for a list of training programs that are listed in the Texas Coming Together to Care Toolkit.

General Facts about Suicide

Between 2000 and 2013, the suicide rate for all ages in the United States rose from 10.43 (per 100,000) to 13.02. Over the same time period, the suicide rate for males went from 17.11 to 20.59. Among females, the rate rose from 4.00 to 5.67. Overall, men die by suicide at four times the rate of women. Although suicide rates are lower for younger age groups than for older adults, suicide is the second and third leading cause of death (depending upon age) for young people in the United States.

- 10-14; 3rd leading cause of death after unintentional causes and malignant neoplasms
- 15-24; 2nd leading cause of death after unintentional causes
- Rates of ideation (i.e., considering and planning suicide) among female high school students are nearly double that of male high school students. Thoughts and attempts among high school
students are higher than among adults in general, although deaths among adolescents are lower.

- Young people age 15-19 complete suicide nationally at a rate of 7.53% and at 7.49% in Texas. Children 11-14 years of age complete suicide nationally at a rate of 1.5% and at 1.41% in Texas. [http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html](http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html)

- Suicide is the third leading cause of death among persons aged 15-24 years and accounts for 20% of annual deaths in this age range. [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html)

- Alaska youth suicide ranked highest in the nation with 38.2 annual deaths per 100,000 youth between the ages of 15-19. Texas ranked 33rd with 11 annual deaths per 100,000 youth, and the lowest youth death by suicide was found in the District of Columbia and Rhode Island with .1 per 100,000 youth.

Charts and graphs on overall US and teen suicide rates can be found in Appendix A and at:


**Warning Signs of Suicide**

*Include, but are not limited to the following, (Erbacher, Singer & Poland, 2015, and [www.sprc.org](http://www.sprc.org)*)

- Talking about suicide
- Making statements about feeling hopeless, helpless, or worthless
- A deepening depression
- History of mental illness
- Preoccupation with death
- Taking unnecessary risks or exhibiting self-destructive behavior
- Engaging in non-suicidal self-injury
- Being victimized by bullying
- Out of character behavior, dramatic changes in behavior
- A loss of interest in the things one cares about
- Visiting or calling people one cares about in a way that hints at saying goodbye
- Making arrangements; setting one’s affairs in order
- Giving prized possessions away
- Exposure to suicide

**Leading Methods of Suicide in Youth Between Ages of 10-19**

The most common method of suicide in this age group was by firearm (49%), followed by suffocation- mostly hanging (38%) and poisoning (7%) according to WISQARS data. [http://www.cdc.gov/ncipc/wisqars](http://www.cdc.gov/ncipc/wisqars). It’s important to note that while this mostly reflects the methods used by our male youth, our female youth’s most common method is suffocation followed closely by poisoning. In youth between the ages of 15-24, estimates indicate there are 100-200 suicide attempts for each suicide death.

**Risk Factors That Can Increase Suicidal Ideation**

**Demographic Information and Common Predictors across All Ages:**


**Age**- Suicide rises with age. For white males, the older he is, the more at risk he is. White males over 65 have a suicide rate 4 times that of the national average.

**Gender**- More males complete suicide. More females attempt suicide. Males choose more lethal means.


**Loss**- The more irrevocable the loss, the greater the risk. Suicide is associated with an accumulation of losses throughout life.
Substance Abuse- Alcohol increases the risk of completed suicide. Drug abuse is correlated with more attempts.

Mental illness- Prior psychiatric hospitalization increases level of risk. It is estimated that 1/3 of all completed suicides have a diagnosable depressive illness.

Physical illness- Sudden onset of a serious illness or chronic conditions with poor prognosis and/or intense pain indicates greatly increased risk. Illness generally places a strain on defenses and coping skills, thus increasing risk.

Downward economic mobility- Unemployment, frequent job changes, direction of reduced status or reduced earnings increases risk. Consider how one’s identity is impacted by these setbacks.

Living in the city center- Areas of high crime, alcoholism, mental illness, poverty, or family disorganization.

Urban conditions increase social isolation and alienation.

Relationship disruption- The more final the change, the greater the risk. Marriage is protection for males. Women survive better without a mate than do men.

Previous attempts- Prior attempters are considered high risk. The more lethal the earlier attempts, the greater the rate of subsequent completed suicide.

Family or close friends attempted or completed- Presence of loved ones with attempts or completions increases risk. “Modeling” of behavior plants the seed that suicide is an accepted way of coping.

History of physical or sexual abuse- Themes of vulnerability, posttraumatic stress, etc., complicate coping. History of abuse reduces chances for self-empathy.

Absence of a support system- Lack of resources and social support is correlated with completed suicide. Consider how capable he/she is of developing new resources.

Risk Factors Specific to School Aged Youth

Berman, Jobes and Silverman (2006) identified the following types of youth who would likely be the most at risk for suicidal behavior:

- Depressed: experiences overwhelming hopelessness, irritability and/or sadness even when things are “going well.”
- Substance Abuse: self-medicates with substances, or engages in increasingly risky behavior while under the influence.
• Borderline or schizotypal: has difficulties maintaining healthy interpersonal relationships and expressing emotions in healthy ways.
• Antisocial, acting out, or conduct-disordered adolescent: rejects social sanctioned notions of health, well-being, and pro-social activities.
• Marginal, isolated loner: disconnected from peers, parents, or associates mostly with other marginalized youth (e.g. homeless youth).
• Rigid perfectionist: experiences any type of failure whether it is defined by self or others.
• Psychotic: experiences delusions or hallucinations, or lives in fear of decompensation.
• In-crisis: lives in a state of perpetual stress-related overwhelm; responds in impulsive and irrational ways; unable to engage in creative productive problem solving.

Additional Populations At-Risk and Risk Factors

LGBTQ

• There are higher rates of suicide for these youth due the unique complications rather than their sexual identity. External factors that include conflict, harassment, abuse rejection, and lack of support contribute to their suicidal behavior. Psychological distress is very acute for students who are among the lesbian, gay, bisexual, transgender, or questioning population and studies have found 2 to 3 times more suicide attempts than their heterosexual peers.
• Advocacy for GLBT population in school is often met with resistance and the strongest protective factor is parental acceptance (Lieberman, Poland, Kornfeld, 2014). Bullying, isolation, feelings of being different and unaccepted, in some cases leads to hopelessness, loneliness, depression, and suicidal ideation. Even though these populations have become more acknowledged and accepted nationally, depending on the school’s community, these youth may be at risk.

More information and programs about and support for LGBTQ students can be found at;
• GLBT National Hotline 1-888-THE-GLNH (843-4564)
• Rainbow Youth Hotline 1-877-LGBT-YTH (1-877-542-8984)
• LGBT Suicide Prevention Hotline www.TheTrevorProject.org or 1-800-850-8078
Learning Disabilities

Students with learning disabilities (LD) are well acquainted with academic difficulty and maladaptive academic behavior. In comparison to students without LD, they exhibit high levels of learned helplessness, including diminished persistence, lower academic expectations, and negative affect, (Idan and Margalit, 2014). Social behavioral research has indicated there is an increased risk for suicide among students with LD that is linked to depression, feelings of hopelessness, and isolation/rejection from the mainstream (Bender, Rosenkrans, and Crane, 1999).

Sleep Deprivation in Adolescents

There is a growing body of research that well documents that many adolescents are sleep deprived. Even though adolescents require as much as 8 to 10 hours of sleep at night, according to the National Sleep Foundation they simply are not wired to retire early to bed and have difficulty falling asleep before 11 PM and cell phones calls and messages may awaken them during the night. The majority of secondary schools in American begin as early as 7:30 am. Numerous studies have addressed the harmful effects of sleep deprivation on adolescents and one in particular by Goldstein, Bridge, & Brent (2008) found a significant relationship between sleep deprivation and suicide completion for adolescents. One author of this report responded to suicide clusters in both the Fairfax County and the Palo Alto Schools during the 2014-15 school years and many community concerns were voiced about the lack of sleep for adolescents as a contributing factor for depression, hopelessness and suicide. The Fairfax County Schools beginning with the fall of 2015 will not start the high school day before 8:00 AM.
Non Suicidal Self Injury (NSSI)

The most common forms of NSSI are cutting; burning, scratching the skin and not letting wounds heal. The incidence of NSSI has increased for youth and the primary theories to explain why they engage in this behavior are to release endorphins or to regulate emotions. NSSI is a complex coping behavior that fulfills a multitude of needs for those that engage in it. NSSI is a strong predictor of suicide as students are essentially practicing harming themselves and schools need to develop training and protocols for staff to help them better understand and respond to NSSI and key personnel such as school counselors need to be familiar with the most effective treatments (Erbacher, Singer and Poland, 2015).

Depression

Research has found that approximately 20% of all teenagers suffer from depression at some point during their adolescence and most do not receive treatment. While depression doesn’t mean suicidal ideation is imminent for every student that experiences depression, it is the most common indicator in suicidal youth. Students may appear irritable, tearful, down, or sullen, and not find pleasure in the activities they previously enjoyed. The key to distinguishing depression from normal teenage behavior is whether it is persistent over a several week period and perseverant meaning that it affects all aspects of their life (academic, social and family). Younger children may express depression through somatic complaints; headaches, bad feelings in stomach, etc. School personnel should know the incidence of depression, be alert to students’ shifting moods, and access community mental health resources (Erbacher, Singer, & Poland, 2015). It is particularly important to pay attention to themes of hopelessness and depression in the writing and artwork of students and to alert key personnel such as counselors and administrators when such themes are noted.

Precipitating Event

This has been referred to as the, “straw that broke the camel’s back” meaning that the student was previously suicidal and one more thing they cannot cope with on top of everything else has caused
them to act on their previously thought out suicidal plans. Poland and Lieberman (2002) identified the following stressful events that school personnel should be alert for that might trigger a suicide attempt: romantic breakup, severe argument with family or friends, recent loss of loved one, victim of bullying or severe humiliation, school failure, loss of a dream such as not making a school team or rejection from college of choice, severe school discipline or arrest/incarceration. It is important that school personnel be alert for all of these precipitating events but especially students in serious disciplinary trouble as some parents whose children died by suicide and who received punishment by school administration for serious infractions have claimed the punishment to be a contributing factor to their child’s suicide. Parents claimed that exclusion from school robbed the child of a support system, identity and friends, causing their child to sink into a deep depression and die by suicide and there are many thousand out-of-school suspensions in Texas annually (Fuentes, 2011).

History of Trauma and Abuse

According to a recent study by Fuller-Thomson, E., Rotman, S. (April, 2012) approximately one-third of adults who were physically abused in childhood have seriously considered taking their own life—a rate that is five times higher than adults who were not physically abused in childhood. The research suggests suicide may have developmental origins relating to abuse—that physical or sexual abuse may lead to changes in the stress response in the brain which increase the risk of suicidal thoughts and behavior.

Specific Ethnic Groups and Genders (data taken from 2013 YRBS High School study):

Seriously Considered Attempting Suicide

Nationwide, 17.0% of students had seriously considered attempting suicide during the 12 months before the survey. The prevalence of having seriously considered attempting suicide was higher among female (22.4%) than male (11.6%) students; higher among white female (21.1%), black female (18.6%), and Hispanic female (26.0%) than white male (11.4%), black male (10.2%), and Hispanic male (11.5%) students, respectively.

Made a Suicide Plan
During the 12 months before the 2013 YRBS survey, 13.6% of students nationwide reported they had made a plan about how they would attempt suicide. The prevalence of having made a suicide plan was higher among female (16.9%) than male (10.3%) students; higher among white female (15.6%), black female (13.1%), and Hispanic female (20.1%) than white male (10.1%), black male (7.7%), and Hispanic male (11.2%) students, respectively.

### Attempted Suicide

Nationwide, 8.0% of high school students had attempted suicide one or more times during the 12 months before the survey. The prevalence of having attempted suicide was higher among female (10.6%) than male (5.4%) students; higher among white female (8.5%), black female (10.7%), and Hispanic female (15.6%) than white male (4.2%), black male (6.8%), and Hispanic male (6.9%) students, respectively.

While white males accounted for 80% of all suicides (all age groups) in 2013, the highest U.S. suicide rate (14.2) was among Whites and the second highest rate (11.7) was among American Indians and Alaska Natives. Much lower and roughly similar rates were found among Asians and Pacific Islanders (5.8), Blacks (5.4) and Hispanics (5.7).

More detailed information is available in MMWR / June 13, 2014 / Vol. 63 / No. 4 and at https://www.afsp.org/understanding-suicide/facts-and-figures

### Genetic Predisposition

This category refers to youth who have a family history of mental illness or suicide. Scientific and socio-behavioral research through the years has had mixed findings regarding the genetic predisposition to suicidal ideation and completion among family members. A recent exhaustive review of the literature by Zai, Luca, Strauss, Tong, Sakinowsky and Kennedy (2012), found through family, twin, and adoption studies that, although limited, there is a genetic basis to suicidal behavior. High suicide rates in some families may be influenced by genetics, but can also be closely correlated with environmental factors within the families (Joiner, 2011).
Parental History of Violence, Substance Abuse, or Divorce

The overarching theme for this category is the instability that children experience in the home. Studies have found that family disruption can lead to suicidal ideation. Whether it is divorce, which often creates a change in finances and living arrangements, or the physical aggression children witness or experience, the impact on children is significant. In another study, reported by Thompson, Litrownik, Isbell, Everson, English and Dubowitz, 2012. They studied 340 adult offspring whose parents had depression in the past and found that 7% of the offspring had suicidal ideation in the previous month alone.

Relationship between Bullying and Suicide

The media coined the term “bullycide” as a means to strongly imply that the bullying that the victim received was the causation for his/her suicide. Students involved in bullying, as a victim or bully, are at a significantly higher risk for depression and suicide. Furthermore, the more frequently an adolescent was involved in bullying, the more likely that he or she was depressed, had feelings of hopelessness, had serious suicidal ideation, or had attempted suicide (Gould & Kramer, 2011). Internalizing problems (including withdrawal, anxiety, and depression), low self-esteem, low assertiveness, and aggressiveness early in childhood (possible rejection by peers/social isolation) are personal characteristics that increase a youth’s likelihood of being bullied as well as risk factors for suicidality (Arseneault, Bowes, & Shakoor, 2010). Further, students who are among the lesbian, gay, bisexual, transgender, or questioning (LGBTQ) population are often stigmatized and bullied in school, and are more likely to attempt suicide as well. Knowing the frequency of bullying that occurs in schools and these statistics that illustrate the connection between bullying and suicide, it only makes sense for schools to thoroughly screen for suicidal thoughts/behaviors when addressing bullying incidents and/or through bullying prevention programs (Suicide Prevention Resource Center, Brief on Suicide and Bullying [SPRC], 2011).

The previous schoolyard bullying has now expanded to the potential for 24/7 bullying through the internet. While bullying likely will not lead to a healthy child feeling suicidal, it can exacerbate the instability and hopelessness in vulnerable youth already dealing with stress and mental health issues (Hinduja & Patchin, 2010). Cyberbullying victims report more depressive symptoms, suicidal ideation, self-injury, and suicide attempts than victims of traditional school bullying (Schneider, O’Donnell,
It is very important to note that Texas legislation emphasized that both the bullies and the victims of bullying maybe at risk for suicide.

**Impact of Age on Suicidal Behavior: Elementary, Middle School, High School**

- Elementary school-aged children rarely die by suicide. But, a recent study by Ribeiro, Bodell, Hames, Hagan, and Joiner (2013) found 75% of the social workers in school settings reported working with at least one student who reported serious suicidal ideation, and 40% reported working with at least one who had been hospitalized. Many elementary personnel have commented that they are increasingly working with suicidal students. This report cites two suicides of elementary age students that resulted in a lawsuit filed against schools but there is little guidance in the literature as what a comprehensive suicide program should consist of in elementary schools.

- Middle school-aged youth report the highest rates of suicidal ideation, plan, and attempt of any age group, although the death rate is lower than older adolescents and young adults. Singer & Slovak (2011) research states that this is a time when traditional bullying peaks, cyberbullying continues to escalate, and children have moved away from their parents and school personnel as confidants and sounding boards.

- High school-aged youth have the greatest access to means and report that they have had longer term suicidal ideation and are more likely than younger students to report a prior attempt (Erbacher, Singer & Poland, 2015).

**Cultural Factors**

Culture plays an important dynamic in the thoughts of a suicidal student, the approach used with their family, and any resources that might be recommended. Especially in the aftermath of a death by suicide, school personnel should be sensitive to the cultural beliefs of the family and the student population and great care should be taken to seek out personnel and resources that are a good match for the needs of the family during intervention and/or postvention (Hamilton, 2013). It is especially noted that Native Americans youth have a high suicide rate and Texas educators need to be very familiar with tribal customs and practices.
Impact of Experiences and Personal Resiliency

A young person develops the feeling of self-worth, control, and positivity by a sum total of the events and experiences in his/her life. Covey (2008) emphasized that students have an emotional bank account. When good things happen for students, chips are placed in the emotional bank account; good grades, friendships, engaging activities. When bad things happen: bad grades, breakups with friends, isolation, death of friend or family member, chips are withdrawn. Research reflects that a young person’s ability to bounce back from trauma or stress, to adapt to changing circumstances and respond positively to difficult situations is proportional to their resilience. Research has found that the keys to residency for youth are being surrounded by caring and supportive family and friends, remaining optimistic about the future, utilizing problem solving skills and having the opportunity to vent strong emotions. On the opposite end of the spectrum is the student who has a diminished sense of self-worth, inability to cope, socially withdrawn, and/or unable to handle life stressors and lacks a support network. Family and school environments that are supportive and caring will enhance resilience, while lack of family support or exposure to abuse or trauma may make a student vulnerable. As educators, it’s important to be aware of the events and experiences; multiple events, severity of event, personal association or identification that the student may have with the circumstances of the event (Beautrais, Joyce & Mulder, 1996). Note that Mental Health America of Texas provides short videos of Help and Hope of real students describing their resiliency and how they got help for themselves or someone else. See videos listed in Texas e-Resources in Appendices which can be downloaded to use as part of a more comprehensive suicide prevention awareness or training program.

Protective Factors that Decrease Suicidal Behavior from the World Health Organization


• Family cohesion and stability
• Coping and problem solving skills
• Positive self-worth and impulse control
• Positive connections to school and extracurricular participation
• Successful academically
• Good relationships with other youth
• Seeks adult help when needed
• Lack of access to suicidal means
• Access to mental health care
• Religiosity
• School environment that encourages help seeking and promotes health
• Early detection and intervention

**Most Common Myths about Youth Suicide**

Texas educators must address the many myths of suicide in order to increase prevention efforts. A more detailed list with deeper explanations of the corresponding facts is available in the online eResources for Suicide in Schools: A Practitioner’s Guide to Multi-level Prevention, Assessment, Intervention, and Postvention: [www.routledgementalhealth.com](http://www.routledgementalhealth.com)

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

**Fact:** Asking someone about suicide will not make him or her suicidal. If they are not having suicidal thoughts then the conversation provides an opportunity to talk with them about what to do if they or a friend ever do have suicidal thoughts.

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

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

**Myth:** Students who talks about suicide all of the time is not actually suicidal, therefore you don’t need to take the statements seriously.
**Fact:** Youth who make suicidal statements typically have some risk for suicide. About 80% to 90% of persons who died by suicide expressed their intentions to one and often more than one person. All suicidal statements should be taken seriously.

**Myth:** Suicide usually occurs without warning.

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

**Myth:** A suicidal person fully intends to die.

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

**Myth:** Suicidal individuals do not make future plans.

**Fact:** Many individuals who died by suicide had future plans, for example they had booked and paid in advance for vacations

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

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

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

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

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

**Fact:** Suicidal intentions are often limited to a specific period of time, especially if help is sought and received.

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

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

**Myth:** Suicide occurs most often among the very rich and the very poor.

**Fact:** Suicide occurs in equal proportions among persons of all socioeconomic levels.

**Myth:** Families can pass on a predisposition to suicidal behavior.

**Fact:** Suicide is not an inherited trait, but an individual characteristic resulting from a combination of many variables. One variable may be that another family member has died by suicide creating exposure to suicide and there may be history of depression in the family.

**Myth:** All suicidal persons are mentally ill, and only a psychotic person will commit suicide.
**Fact:** Studies of hundreds of suicide notes indicate that suicidal persons are not necessarily mentally ill.

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

**Fact:** Research has documented that if a specific method is removed and not available that suicidal individuals are very unlikely to seek another method. The Means Matter website at Harvard provides extensive research that removing the lethal means such as a gun and raising the barrier on bridges has decreased suicides. More information is available at [http://www.hsph.harvard.edu/means-matter](http://www.hsph.harvard.edu/means-matter).

Myths are most often based on static misunderstandings or knowledge from many years ago and can only change when new concepts arise which are research-based. Reflected in the chart below are new insights to guide educators in how we view suicidal students.

<table>
<thead>
<tr>
<th>Old Belief vs.</th>
<th>New Belief</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide- Killing of oneself</td>
<td>Penacide- Killing the pain</td>
</tr>
<tr>
<td>Goal- End life</td>
<td>Goal- End pain/suffering</td>
</tr>
<tr>
<td>Event or behavior</td>
<td>Process of debilitation</td>
</tr>
<tr>
<td>Decision and a personal choice</td>
<td>Disease outcome-no choice involved beyond crisis point</td>
</tr>
<tr>
<td>A means of control and manipulation</td>
<td>The result of severe stress and psychological pain</td>
</tr>
<tr>
<td>Voluntary action</td>
<td>Involuntary response</td>
</tr>
<tr>
<td>Individual is a decision-maker</td>
<td>Individual is a victim</td>
</tr>
<tr>
<td>A psychological phenomenon involving the mind</td>
<td>A physiological or neurobiological phenomenon involving the brain</td>
</tr>
</tbody>
</table>

Understanding Suicide: Interpersonal Theory of Suicide

The most widely accepted theory of suicide was developed by Joiner (2005) which identified two main components to desire for suicide. The first is low belongingness. The theory stressed that lack of connections to others is a major factor in suicide. Texas educators are encouraged to be alert for students who are not connected to school staff, classmates and school activities as they are likely to have few if any friends, be on the fringes of student life, rarely volunteer in the classroom, and seek isolation during social time. Schools should have an environment and academic/social structure that provides avenues for every student to develop a sense of belonging and value within the school community. The second factor perceived burdensomeness is when someone views themselves as a burden to others and believes their family would be better off without them. Joiner (2005) stressed that many people have these two factors present but thankfully most do not attempt or die by suicide.

The additional and critical variable identified in this theory is acquiring the capability for suicide through exposure to pain and suffering. Joiner coined the term learned fearlessness as they no longer fear death as they have habituated or worked up to suicide through a series of provocative behaviors. Texas educators are encouraged to be alert for students who are engaging in reckless behavior, or suffer unexplained injuries and for those engaging in NSSI.

Overview of the Most Current Suicide Prevention/Intervention Requirements in Texas Schools

http://www.dshs.state.tx.us

http://www.TexasSuicidePrevention.org

The following information summarizes the suicide prevention legislation related to K-12 schools from the 84th Legislative session completed in the spring of 2015 which added Senate Bills 674 and HB 2186. The legislation related to suicide and K-12 schools from the 83rd Legislative session in 2013 is also reviewed. A great deal of collaboration between Texas Education Agency (TEA) and the Department of State Health Services (DSHS) and the Mental Health America of Texas (MHAT) keeps school personnel
informed of suicide prevention requirements for K-12 school settings. Clarification and more information and detailed analysis of the legislation are available from the DSHS, TEA and MHAT.

**Senate Bill 674** makes the training for teachers in training (university preparation programs) the same as for existing teachers and the training must use a best practices program recommended by DHSH in coordination with TEA and the agencies will collaborate and provide schools with an updated list of best practices suicide prevention programs each year.

**House Bill 2186** requires all school district staff development orientation for new employees in district and open enrollment charter schools to include suicide prevention. The training schedule (frequency whether annual or every few years) will be determined by TEA for existing teachers. All trainings must use a best practices program recommended by DHSH in coordination with TEA, and the agencies will collaborate and provide schools with an updated list of best practices suicide prevention programs each year.

**House Bill 2684** requires Texas school districts with more than 30,000 students that commissions a school district police officer or at which a school resource officer provides law enforcement to have a policy that requires the officer to complete a training program of 16 hours in a variety of mental health, positive discipline and de-escalation techniques that are spelled out in the law. Suicide prevention advocates are expected to provide input into this training that will be created by the Texas Commission on Law Enforcement (TCOLE). The TCOLE must create this model training program by 12/1/15 and it is to be available to officers by 2/1/16.

These 2015 Bills added to legislation passed previously in the 83rd Legislative Regular Session in 2013 requiring training for public school teachers and teachers in training, counselors, principals, and all other appropriate staff in the detection and education of students at risk for suicide or with other mental or emotional disorders. **Senate Bill 831 of the 83rd Regular Legislative Session**, amended Section 161.325 of the Health and Safety Code to include a list of best practice based programs to be reviewed and posted annually on the websites of DSHS, the Texas Education Agency (TEA), and each Regional Education Service Center (ESC).
**House Bill 1386** from 2013 required independent school districts to have a District Improvement Plan that includes suicide prevention. Advocates of suicide prevention should work with their school district’s local committee and stakeholders to ensure the district’s plan and training includes methods for addressing suicide prevention (Tex. Education Code 11.252). School counselors have been specifically mentioned in Texas legislation as having the role of ensuring that the school’s counseling program and services integrate best practices in suicide prevention (Tex. Education Code 33.006). Texas legislation has also clarified that parental permission is not needed for counseling a child by a licensed or certified physician, psychologist or counselor or social worker having reasonable grounds that a child is contemplating suicide (Tex. Family Code 32.004).

It is recommended that school personnel review the program list provided by DSHS and TEA programs thoughtfully in considering the specific needs of your school district and the personnel needed to provide the training. Programs on the list must at a minimum cover the following: recognition of the warning signs of suicide and how to intervene effectively by providing notice and referral to the parent or guardian so that appropriate action can be taken by a parent or guardian. School personnel who have questions about the implementation of the legislation, how to utilize local and state resources or about any of the programs on the best practices list should contact DSHS or TEA. Programs on the list must help school personnel identify students at risk for suicide including students who are or may be the victims or who engage in bullying, recognize the warning signs of suicide and to know how to intervene effectively by providing notice and referral to the parent or guardian so that appropriate action such as seeking mental health or substance abuse services may be taken by the parent or the guardian (Tex. Health & Safety Code 161.325).

**Blue Print: Implementing Texas Legislation for Suicide Prevention in Schools**

The Texas requires suicide prevention in Texas school district improvement plans:

1. **Goal:** provide all new employees with suicide prevention training and keep a record of who completed the training. Accomplished by conducting suicide prevention training for all new employees that uses a best practices program recommended by DSHS in coordination with TEA and keeping a written record of the name of each employee who attended the training. This goal may also be met through independent review of suicide
prevention material that complies with the guidelines developed by TEA and offered online.

2. Goal: provide all existing employees with suicide prevention training on the schedule required by TEA. Accomplished by contacting TEA to obtain the specific schedule and conducting suicide prevention training for existing employees that uses a best practices program recommended by DHSH in coordination with TEA and keeping a written record of the name of each employee who attended the training. This goal may also be met through independent review of suicide prevention material that complies with the guidelines developed by TEA and offered online.

3. Goal: that all Texas school districts with more than 30,000 students that commissions a school district police officer or at which a school resource officer provides law enforcement to have a policy that requires the officer to complete a training program of 16 hours in a variety of mental health, positive discipline and de-escalation techniques that are spelled out in the law. Accomplished by working with the Texas Commission on Law Enforcement to schedule the training and keeping a written record of the name of each officer who attended the training.

Additional Recommendations: After a Review of Texas Legislation and Education Codes:

1. It is very clear that Texas codes place a great deal of responsibility on school counselors (Tex. Education Code 33.006) for suicide prevention as it is specifically mentioned under their duties in developing a comprehensive guidance program. School counselors have been and continue to be very instrumental in suicide prevention, but it is very important to provide them with training beyond the basic awareness training that will be provided to other employees as the school counselor will most likely be the staff member that suicidal students will be referred to for intervention. The assessment and intervention section of this report outlined specifics steps for counselors to follow. School counselors need training on all aspects of suicide assessment and intervention and it is recommended that training be provided for all school counselors by
DSHS, MHAT, TEA and the Regional Education Service Centers and a written record be kept of the name of the counselor who attended the training.

2. The Texas Health Safety Code (161.326) allows Texas schools to designate at least one person in the district to act as a liaison officer in the district for the purpose of identifying students in need of mental health intervention including suicide prevention. It is strongly recommended that a district designate this liaison and that training be provided to them by DSHS, MHAT, TEA and the Regional Education Service Centers and a written record be kept of the name of the employee who attended the training. It is also recommended that the designation of the liaison be included in the district improvement plan. It would seem highly likely that the designated individual would be a secondary school counselor or the director of counseling services for the district. It is also highly recommended that large school districts would need to designate several liaisons and that the large high school in the state would have an individual campus designee. It is expected that the liaison(s) would be very helpful in developing policies and procedures for the district for suicide prevention and that they would be familiar with local and state resources.

3. There is no mention of postvention in the Texas legislation or in any of the codes that were reviewed, however the aftermath of a suicide is a very challenging time for schools and unfortunately when one youth suicide happens the chances increase dramatically that additional suicides will occur. It is strongly recommended that the district liaison or liaisons for suicide be very familiar with best practices in suicide postvention (see section in this report) and that training be provided by DSHS, MHAT, TEA and the Regional Education Service Centers and a written record be kept of the name of the liaison who attended the training. It is expected that the liaison or liaisons would be very helpful in developing policies and procedures for the district for suicide postvention. The liability section cites the Mares v Shawnee Mission Schools lawsuit that was about failure to implement best practices postvention procedures.

**Screening Programs**

One of the authors has been working on suicide prevention in the school since 1982 and believes strongly that the most promising addition to suicide prevention is depression screening. Before the development of depression screening programs, youth suicide prevention programs only
focused on training the adults to recognize warning signs of suicidal behavior in youth and this was most often referred to as, “gatekeeper training” according to Poland, (1995). The problem with only providing suicide prevention information for school personnel and the other adults in the lives of students is that students are by far the most likely to share thoughts of suicide with their friends instead of the adults in their lives. It is curious that depression screening was referred to in Texas legislation as medical screening as it is simply a questionnaire that students fill out that ask questions about energy level, joy of life and thoughts of suicide. Students score their own questionnaire and can determine if they are likely suffering from depression and need mental health services. Signs of Suicide (SOS) which is evidenced based, BPR I (which is the most rigorous evaluation category) provides a screening and educational package and is used in a large number of schools around the country and extensive information about SOS appears below. SOS is inexpensive and many times the material has been provided by SOS free but the cost for the questionnaires and the ACT video is approximately $200.

- SOS Signs of Suicide is a secondary school-based suicide prevention program that is listed as evidenced based on Best Practices Registry I. The program includes screening and education. Students are screened for depression and suicide risk and referred for professional help as indicated. Students also view a video that teaches them to recognize signs of depression and suicide in themselves and others. They are taught that the appropriate response to these signs is to use the ACT technique: acknowledge that there is a problem, let the person know you care, and tell a trusted adult. Students also participate in guided classroom discussions about suicide and depression. The program attempts to prevent suicide attempts, increase knowledge about suicide and depression and increase help-seeking behavior among middle and high school students. SOS Signs of Suicide has been implemented in more than 7,000 schools in the United States, Canada, and Ireland. In 2012, two gatekeeper tools were made available for use in program implementation: Training Trusted Adults, a 22-minute DVD for use in staff meetings or parent nights, and Plan, Prepare, Prevent: The SOS Online Gatekeeper Training, a 90-minute online course provide A randomized control study found that there was a 40% drop in suicide attempts in schools that implemented the Signs of Suicide Prevention Program (SOS). A concern expressed by many educators is that if they implement the SOS program that many students will be identified as suicidal and
the school will not be able to follow up as needed with each student. The SOS website www.mentalhealthscreening.org provides many practical suggestions for overcoming resistance to screening and for implementation and recommends that only a manageable portion of the student body be screened at a time so that follow up and intervention can be provided. Texas requires that parental permission is obtained prior to students participating in SOS and screening programs were referred to as a medical screening (Tex. Health & Safety Code 161.325). The authors experience has been that often multiple suicides have had to occur in a school before resistance to screening is overcome. Erbacher, Singer and Poland (2015) stressed many benefits of SOS and most notably that student learned the importance of getting adult help for themselves or their friend in a time of suicidal crisis.

- The Columbia University TeenScreen® Program was mentioned by a few Texas districts, in the Educator Survey but it does not appear on the current Best Practices Registry. TeenScreen was designed to ensure that all youth are offered a mental health check-up before graduating from high school. TeenScreen®Program identified and referred for treatment those who were at risk for suicide or who suffered from an untreated mental illness. All students in a school, with parental consent, were given a computer-based questionnaire that screened them for mental illnesses and suicide risk. The Texas survey indicated that it was given mostly to 5th and 6th graders. On 15 November, 2012. TeenScreen announced on its website: “The National Center will be winding down its program at the end of this year.” There have been rumors that TeenScreen has obtained funding and will be restarted.

- The Columbia-Suicide Severity Rating Scale (C-SSRS) is a best practice screening tool that can be used by a variety of agencies. This brief survey has been shown to identify accurately individuals at risk of suicide. It has use in the school system as an early warning tool to screen for suicidality. The C-SSRS has been implemented in countless schools around the country. Implementation of the scale has occurred both when individual schools seek out a tool to help them address suicide in their student population and when departments of education adopt the C-SSRS as the tool of choice.
for a zero suicide approach. At least one school district in Texas (Tarrant) is using the C-SSRS district-wide to screen youth in school for suicide risk.

- More information is available about the C-SSRS and its application in school settings along with a 30 minute training video at http://www.cssrs.columbia.edu/. Materials are offered free. There is more information in the Zero Suicide Texas Toolkit chapter Five about screening for suicide risk located at http://sites.utexas.edu/zest

**Suicide Intervention**

**Assessment and Intervention**

The importance of all school staff receiving training (which is required in Texas) on the warning signs of suicide and the importance of referring at risk students to the administration and counseling staff has already been emphasized as the cornerstone of suicide prevention in schools. A very important component of suicide prevention is depression screening. Students learn the warning signs of suicide, the importance of seeking help from adults when they realize that they or a friend are depressed. Depression screening will result in more suicidal students being identified and referred for a suicide assessment. Poland (1989) stressed that each school needs key personnel trained in suicide assessment and that school counselors are the logical personnel as they are typically based only on one campus. Erbacher, Singer and Poland (2015) clarified that a suicide risk assessment is done to determine if suicidal ideation, intent and plan are present and to identify what steps need to be taken to safeguard the student. A key part of the process is to determine if the student is in imminent risk (for example, in the next 48 hours). Miller (2011) stressed that no problem facing school mental health professionals is more urgent than the need for training in suicide assessment and that a good assessment results in an effective intervention. School personnel understandably experience anxiety when faced with a student who may be suicidal and it is vital that they receive training in assessment. This training can be provided by bringing experts to the school system to provide training in assessment and intervention or by sending key personnel to conferences and trainings conducted by state and national associations that focus on suicide prevention (example the annual Texas symposium on suicide). Key personnel such as school counselors must also know the facts about youth suicide, and it is important that they not believe any of the myths about suicide. Recently a school psychologist
asked the question “Is it true that some students will die by suicide no matter what we do as isn’t their destiny”. This is an example of why the required training in Texas is so important.

School personnel have also frequently asked if all student threats of suicide need to be taken seriously and have commented that many times a student is perhaps just seeking attention or is trying to manipulate a situation. The answer is that all student threats of suicide must be taken seriously and the steps outlined below followed. It is certainly acknowledged that this will take a lot of time for key personnel such as school counselors, but taking all threats seriously will save lives and will also protect school personnel from liability should a suicide occur.

Two key concepts for assessment outlined by Poland (1989) were that inquiry about suicide must be direct and clarified it will not plant the idea in the mind of a student. Students are often ambivalent about suicide and one minute want to die and end what they believe to be unendurable pain but the next minute there is a glimmer of hope and something positive has happened and they want to live. The intervention of any one person can make all the difference. Many students after being questioned about suicidal thoughts and plans have felt relieved that someone is there to help them.

It is essential to respond immediately when a student is believed to be suicidal. A building principal recently shared two examples.

1. A student was rumored to be suicidal and the principal asked the counselor to check into it, assuming the counselor would do so immediately. The principal sought the counselor out two hours later and was dismayed to be told that the counselor had not found time to talk with the student as yet.

2. Another student was reported to be suicidal and the counselor was asked to see the student immediately to make an assessment. The principal asked later what they counselor had found out and the counselor reported that the student seemed to be fine. The principal asked, “What did the student say about suicidal thoughts and actions”? The counselor replied that they did not directly inquire about suicide.
Confidentiality/Confidentiality Exceptions

One issue that school personnel struggle with is when and if they must notify parents in the event they believe a student to be suicidal? It is important to note that while mental health personnel are to always uphold confidentiality, there are exceptions to this rule. Suicidal ideation or behavior is one of those exceptions. All students should be aware of the limits of confidentiality and that the school staff must notify the parents of a suicidal student. While it may upset the student that you are divulging their private information to their parents or other necessary school staff, it will be less difficult to repair rapport with a student who is alive than to deal with the potential outcomes if he/she does attempt and/or die by suicide without parent notification. As previously discussed in this report most of the liability cases against schools following the suicide of a student have been because the parents of a student known to be suicidal were not notified. The only exception to parent notification is when you have reason to believe the suicidal student is being abused by their parents and then the call must be made immediately to Child Protective Services.

The importance of developing rapport with a suicidal student cannot be overstated. School personnel need to draw on all of their skills for interacting with students and the fact is they might actually be meeting a student for the first time when the student is in the midst of a crisis. School personnel are encouraged to initially concentrate on listening to the student and letting the student know they are not the first student to have suicidal thoughts. It is important that you care and have helped other students in crisis before. The following areas to address in suicide assessment which cover risk factors, warning signs and protective factors for suicidal students were outlined by Lieberman, Poland and Kornfeld (2014)

- What are the current feelings of the student?
- What were the warning signs that initiated the referral?
- What is the individual’s current and past level of depression?
- What is the student’s current and past level of hopelessness?
- Has the student currently, or in the past, thought about suicide (either directly or passively)?)
- What is the method of any previous suicide attempt(s)?
- Does the student have a current suicide plan or plan to harm him/herself (the more specific of a plan, if applicable, the higher the risk)?
- What method does he/she plan to use and does the individual have access to the means (higher risk when either or both of those are affirmed)?
- What are the student’s perceptions on burdensomeness and belongingness?
- Have they been exposed to a suicide?
- Do they have history of engaging in NSSI?
- Is there are history of alcohol or drug use?
- What are his/her current problems and stressors at home and at school?
- Has the student demonstrated any abrupt changes in behaviors?
- What is the student’s current support system and what protective factors are in place (higher isolation might indicate higher risk)?
- What is the student’s current mental health status? Is there a history of mental illness?
- Is there a history of bullying, victimization, loss, and/or trauma (any affirmative response might indicate a higher risk)?
- What are the student’s reasons to live (more, healthy answers to this question might indicate lower risk)?

Much has been written as a guide to determine whether a student is at low, medium or high risk for suicide by Miller (2011), Lieberman, Poland & Kornfeld (2014), Erbacher, Singer and Poland (2015) that is summarized below with recommendations.

**Low Risk** (ideation only)

- Actions: Develop a safety plan collaboratively with the student.
- Notify the parents of their child’s suicidal ideation
- Persuasively request that parents sign a release of information form so that designated school personnel can directly communicate with community mental health professionals
- Document all actions that include having parents sign an emergency notification form
Medium Risk (current ideation and previous suicidal behavior)

- Actions: Supervise student at all times (including rest rooms)
- Develop safety plan with the student

Notify and release student ONLY to:

- Parent or guardian who commits to increase supervision and seek an immediate mental health assessment
- Law enforcement
- Psychiatric mobile responder

- Persuasively request that parents sign a release of information form so that designated school personnel can speak directly with community mental health professionals
- Document all actions that include having parents sign an emergency notification form
- Develop follow up plan at school that includes a re-entry plan if the student is hospitalized. All students returning from mental health hospitalization should have a re-entry meeting where parents, school and community mental health personnel make appropriate follow up plans to support the student.

High Risk (current plan and access to method)

- Actions: Supervise student at all times (including rest rooms).
- Develop safety plan with the student.
- Notify and release student ONLY to:
  - Parent or guardian who commits to increase supervision and seek an immediate mental health assessment
  - Law enforcement
  - Psychiatric mobile responder
- Persuasively request that parent sign a release of information form so that designated school personnel can speak directly with community mental health professionals.
- Document all actions that include having parents sign an emergency notification form.
- Develop follow up plan at school that includes a re-entry plan if the student is hospitalized. All students returning from mental health hospitalization should have a re-entry meeting where parents, school and community mental health personnel make appropriate follow up plans to support the student.
Authors as early as Poland (1989) and as recently as Erbacher, Singer and Poland (2015) emphasized that few thing change in a child’s life without the support of their parents and the challenge for key school personnel such as counselors is to obtain a supportive reaction from the parents of a suicidal student. The following suggestions are offered for engaging and supporting parents of a suicidal student. It is strongly suggested that a conference with parents be held in person rather than via the telephone and that a suicidal student not be allowed to leave school on their own even if that is what his/her parents have requested.

1) Begin with asking parents how their child has been doing and if they have noted any changes in their child’s behavior.

2) State what you have noticed in their child’s behavior and ask how that fits with what they have seen in their child.

3) Advise parents to remove lethal means from the home as their child is possibly suicidal. You can equate this to how you would advise taking car keys from a youth who had been drinking. Please clarify that Texas law requires guns be locked away from minors under the age of 17 (Tex. Penal Code 46.13).

4) Provide empathy for this situation and comment on its scary nature for parents.

5) Acknowledge the emotional state of the parents.

6) Acknowledge that it is essential for schools, parents and community services to collaborate to help a suicidal child, as no one can do this alone. If the parent is angry that you have provided counseling to their child without their consent then advise the parents of Texas legislation that has also clarified that parental permission is not needed for counseling a child by a licensed or certified physician, psychologist, counselor or social worker having reasonable grounds that a child is contemplating suicide (Tex. Family Code 32.004).

7) If the parent appears to be uncooperative or unwilling to take certain actions, find out their beliefs about youth suicide risk/behavior and see if there are myths they believe that are blocking them from taking proper action.

8) Acknowledge and explore any cultural or religious concerns, or any other concerns, that might reduce the parent’s acceptance of mental health treatment.
9) When possible, align yourself with the parent. It is important for them to understand where the youth has gotten this idea without minimizing behaviors.

10) Refer parents to local community mental health treatment that the school has previously worked well with and explain what it is they can expect for treatment of their child.

11) Clarify the role of the schools and the follow up that will be done at school

12) Persuasively request that parents sign a release of information form so that designated school personnel can speak directly with community mental health professionals

13) Document all actions that include having parents sign an emergency notification form

**Suicide Assessment Scales**

There are no standardized scales that can replace a through interview with a student after rapport has been established, (Erbacher, Singer and Poland, 2015) however standardized assessment scales can a be a valuable addition to the interview as they have been published, validated by research, and take about ten minutes to complete and the Beck Scale has a Spanish version. The following scales are listed in the [SAMHSA Toolkit for Schools](http://pathprogram.samhsa.gov/Channel/SAMHSA-Toolkits-494.aspx) which can be found at [http://pathprogram.samhsa.gov/Channel/SAMHSA-Toolkits-494.aspx](http://pathprogram.samhsa.gov/Channel/SAMHSA-Toolkits-494.aspx)

- Beck Scale for Suicide Ideation
- Suicide Ideation Questionnaire
- Suicide Probability Scale
- Inventory of Suicide Questionnaire
- Columbia Suicide Severity Rating Scale

**Safety Plans**

Many generations of mental health professionals were previously taught to have suicidal clients/students sign a contract that they would not harm themselves. These contracts referred to as no suicide or no harm contracts were often preprinted on school stationery. Criticisms of these contracts were that mental health professionals might rush or even coerce a student into signing one.
Miller (2011) emphasized that although the use of contracts is very widespread, there is no empirical research to support that contracts were effective in preventing suicide. Contracts also did not protect the professional from liability and contracts were criticized for focusing on what the student would not do as opposed to what the student would do in a time of suicidal crisis.

Safety plans differ from no suicide contracts in that they are not developed ahead of time but instead are a tool developed jointly with the student in crisis. The safety plan focuses on identifying coping strategies, peer and adult support for the student and includes local and national suicide prevention resources and hotline numbers. Students are given a copy of the plan they helped develop and are encouraged to review it when they have suicidal thoughts. Texas school personnel are strongly encouraged follow best practices and shift from the utilization of no suicide contracts to the creation of safety plans with suicidal students. A sample safety plan is available from the Suicide Prevention Resource Center at the following link:


An example of safety planning intervention can be found at the Texas Zero Toolkit:

http://sites.utexas.edu/zest

The researchers who originally developed safety plans have extensive information on this website:

http://www.suicidesafetyplan.com

Confidentiality/Confidentiality Exceptions

It is important to note that while mental health personnel are to always uphold confidentiality, there are exceptions to this rule. The suspect of suicidal ideation or behavior is one of those exceptions. All students should be aware of the limits of confidentiality. While it may upset the student that you are notifying either their parents or (CPS) Child Protective Services (if parents are believed to be abusive) of their suicidal behavior, it will be less difficult to repair rapport with a student who is alive than to deal with the potential outcomes if he/she does attempt and/or die by suicide.

Notifying Parents

Transfer of Responsibilities to Parents: Notification and Making the Call
The failure of the school to notify parents/guardians when there is reason to suspect that the student is suicidal is the most common source for lawsuits as evidenced by the discussion of Wyke v Polk County (liability section). As noted prior, when there is reason to believe that a student is contemplating suicide, the confidentiality must be broken and the parents should then be notified. School personnel have an obligation to report any child who is suspected to be at-risk for suicide based on foreseeability and the challenge for school personnel is to get a supportive reaction from parents, increase supervision of the student and obtain needed mental health services for the student. Even if a student denies suicidal ideation/intent, as in the Eisel v Montgomery County case discussed in the liability section, it is the duty of the school to notify the parents of suicidal concerns reported by others but denied by their child.

When it comes time to warn parents that their child might be suicidal, some issues may arise. First, if it is believed that the student’s parents are abusive then school staff needs to call Child Protective Services and coordinate supervision of the student and parent notification with CPS. Secondly, a few parents may be uncooperative and may refuse to come to the school to talk and/or personally pick up their child. To avoid a negligence lawsuit, school staff should not allow suicidal students to walk or take the bus home, no matter what the parents have requested. If a parent/guardian refuses to seek out additional mental health services for their child, and/or does not take the suicide risk seriously, it is recommended that the school personnel notify CPS.

When a student’s suicidality is in question, a school counselor/staff member, as clarified above, has the responsibility to notify a parent/guardian and make appropriate recommendations/referrals. Once this is accomplished and it is properly documented, the school staff has fulfilled their legal duty as the responsibility for the student is transferred back to the parents through notification. During this process, school staff is encouraged to utilize emergency notification forms for documentation that parents were notified and to keep a copy of the forms to document that they did, in fact, notify the parents and make appropriate recommendations. These documents will be necessary and advantageous if any legal action is taken against the school regarding that student.

Furthermore, the authors recommend school personnel develop a safety plan with the student as discussed in this document and continue to monitor the student closely and ensure he/she is receiving the support needed. School counselors would likely be the appropriate personnel to follow up with the family and student to inquire if outside services are being rendered. It is also strongly recommended
that a release of information form be signed by the parents to allow the school counselor to communicate with outside practitioners such as therapists and medical personnel. Parents may be reluctant to sign a release of information form and school counselors are encouraged to explain thoroughly and persuasively why it is in the best interest of the student for the release to be signed so that information may be shared and safety ensured.

One of the challenges for school personnel and especially school counselors is to refer suicidal students to private practitioners, agencies and hospitals where the professionals are well trained in suicide assessment. A parent once commented to one of the authors of this report, “I took my son to a psychologist as the school recommended but was told by the psychologist not to worry as my son was exhibiting typical teenage behavior and two weeks later he died by suicide”! A task force of the American Association of Suicidology addressed serious gaps in the training of mental health providers concerning suicide assessment (Schmitz, Allen, Feldman, Gutin, Jahn, Kleespies, Quinett & Simpson, 2012). The task force called for accrediting bodies, training programs and licensing organizations to improve training through coursework, required continuing education and include examination questions for licensure to improve competency in suicide assessment. Few changes are expected in the near future to address the lack of training that most mental health professionals have in suicide assessment although 5 states have now mandated suicide prevention training for mental health professionals.

Schools are urged to work with their local community mental health or behavioral health center. Each of the 37 Local Mental Health Authorities in Texas has designated suicide prevention coordinators who can assist schools with suicide prevention and postvention. They are listed at the Texas Council of Community Center’s website: [http://www.txcouncil.com](http://www.txcouncil.com). Some centers also have Mobile Crisis Outreach Teams who can come to a school when called for assistance. Many of the centers conduct ASIST suicide intervention trainings, safeTALK, Mental Health First Aid and ASK About Suicide To Save A Life gatekeeper trainings with their staff and community, and have implemented zero suicide programs. Texas also has more than 30 local suicide prevention coalitions which may be able to provide some referral information to schools or parents and assist in best practice based suicide prevention training. (See list of community mental health centers and local suicide prevention coalitions at TexasSuicidePrevention.org).
**Suicide Postvention**

The aftermath of a youth suicide is a sad and challenging time for a school. Postvention is a term that was coined by Shniedman (1985) to describe helpful and appropriate acts after a dire event. The term has become synonymous with the challenging aftermath of suicide, and few events are scarier for a school than the suicide of a student. Schools typically underestimate the impact of a suicide and provide assistance to only a few students for too short a period of time (Erbacher, Singer & Poland, 2015). It is essential to support school staff first after a suicide and hopefully they will be better able to assist their students. Many of the Texas school personnel surveyed recently indicated that their school or district had experienced a suicide. Few school personnel have ever received training on best practices in suicide postvention. Many school personnel have the idea that the main postvention recommendation is to do nothing as it might glorify the victim. The postvention literature never said do nothing as recommendations always focused on the living and the key task for schools of dealing with grief, shock and confusion. Previous literature summarized by Poland (1989) did caution against any type of permanent marker at school or any type of a memorial (such as planting a tree) or a ceremony no matter how small as for example lighting candles in memory of the deceased. It is important to note that an excellent guide for schools was developed by the American Foundation for Suicide Prevention [www.asfsp.org](http://www.asfsp.org) and the Suicide Prevention Resource Center [www.sprc.org](http://www.sprc.org) and published in 2011, entitled, After a Suicide: A toolkit for schools, that is available on both of their websites. The guide provides specific guidelines to balance the often felt needs that students have to do something after a suicide without glorifying the suicide victim which might contribute to other teenagers considering suicide. Schools are encouraged to download this guide and have it available if a suicide does occur and follow the excellent recommendations provided that were developed after extensive dialogue with numerous experts in suicide prevention including one of the authors of this report. It is important that Texas school personnel be very familiar with this guide and to recognize they could be criticized and even sued for failing to implement recommendations from the guide (see Mares v Shawnee Mission in liability section).

The major tasks for suicide postvention are to help students and faculty to manage the understandable feelings of shock, grief and confusion. The major focus at this time should be grief resolution and prevention of further suicides. It is essential after a suicide occurs to partner with community resources such as mental, health, law enforcement, clergy, survivor groups and medical personnel. We must acknowledge that not every youth suicide can be prevented but the majority can
be. It is very important for schools to accept assistance from local, state and national resources after a suicide. School personnel are strongly encouraged to avoid the word “committed” and instead to use us the phrase, “died by suicide” as it is much more acceptable to suicide survivors. Exposure to suicide is a risk factor, and suicide is always on the minds of some students and thoughts of suicide and attempts increase after a death by suicide has occurred. It is very important that school counselors in particular reach out to students who are the most affected and provide them an opportunity to talk about what has happened. Counselors have often asked after a student suicide if they need to see all the other students in the school that were known previously to be suicidal and the answer is YES, see those student as soon as possible as they are likely to have increased thoughts of suicide now that it has happened. Postvention is also an optimal time for schools to review the training that is provided to staff and students about suicide prevention and to review protocols and guidelines in place for suicide prevention.

School personnel also need to be familiar with the concept of suicide clusters where suicides are close together in space or time. The term contagion is a possible explanation for a cluster and adolescents are the most susceptible to contagion. Clusters are estimated to account for as many as 200 youth suicides annually (Joiner, 2011). Clusters are of two types as a mass cluster is media related and is in response to national media or social media coverage of an actual or fictional suicide. There was, for example, much concern of a mass cluster recently after the suicide of Robin Williams, the well-known comedian. Point clusters occur in a defined geographical region and may involve numerous deaths (or attempts) in a short period of time. Unfortunately a number of schools have experienced point clusters where an organized response involving school and community and state resources is necessary. Joiner (2011) stressed that there is more empirical support for point clusters than mass ones. If a community is experiencing a point cluster is very important to involve the medical community as many suicidal individuals including teenagers saw the family physician before their death, and physicians are in a unique role to intervene with a suicidal youth. National recommendations have stressed that all teenagers seeing a physician for any reason should be screened for depression and suicide.

The research literature estimates that once a suicide happens the chances of another death by suicide increases dramatically. The following suggestions are intended to guide staff during postvention:
* It is important to be honest with students about the scope of the problem of youth suicide and the key role that everyone (including the students) plays in prevention.

* It is important to balance being truthful and honest without violating the privacy of the suicide victim and his/her family and to take great care not to glorify their actions.

* It is important to have the facts of the incident, be alert to speculation and erroneous information that may be circulating and assertively, yet kindly, redirect students toward productive, healthy conversation.

* School personnel need to reach out to the family of a student who has died by suicide as quickly as possible and offer condolence and support especially to surviving siblings who likely also attend your district schools.

* It is recommended that the funeral for a student who died by suicide be held at a location other than the school as has been previously done in very rural communities. The funeral needs to be scheduled after school so that large numbers of students are not absent from school and most importantly their parents are more likely to be able to attend the funeral with their children. School personnel are also strongly encouraged to attend the funeral and be available to assist grieving children.

* Schools are encouraged to be truthful and factual after verification that the death was by suicide in communication with students and information is best shared either individually, in small groups or in classrooms. Public address announcements are to be avoided.

* Center for Disease Control research cited by Lieberman, Poland and Kornfeld (2014) found that teenagers most susceptible to suicide contagion are the following: students who backed out of a suicide pact, students who had a last very negative interaction with the victim, students who now realize they missed warning signs and students with their own set of adversities/previous suicidal behavior who may not even have known the victim.

* Students at risk due to their own history of adversities and previous suicide attempts may consider utilizing the same method used by the recent suicide victim

* If the suicide was by gunshot it is recommended that all local families safe guard guns from their children (which is required by law in Texas.)

* It is important that students not feel that the suicide victim has been erased and that students be provided an opportunity to talk about the deceased.
* Numerous professional associations caution that memorials not be dramatic and permanent and suggest instead activities that focus on living memorials such as funding suicide prevention.

* School personnel are encouraged to monitor social media after a suicide occurs as vulnerable youth often connect with each other online.

* School personnel often consider postponing previously scheduled suicide prevention programs if a suicide has occurred but prevention information is needed more than ever as suicide is more on the minds of students than ever before. The presentation should emphasize that not all suicides can be prevented but most can and we all have to work together to prevent further suicides.

* Schools are encouraged to conduct a carefully planned meeting for parents in the aftermath of suicide that focuses on the living and clarifies the warning signs of suicide and how to distinguish typical adolescent behavior from depression and where parents can go for help for their child. This meeting acknowledges the suicide death and follows the guidelines below for talking with students. Local community mental health centers and local suicide prevention coalitions can help with these meetings.

* Suicide prevention information and the warning signs of suicide need to be available on the district website that can be found with a simple search with the terms depression or suicide. The district website information needs to include guidance for parents and how the school district partners with community resources to prevent one of the leading causes of death for children and how they can assist their child if they are exposed to suicide.

* If a suicide cluster does occur the Center for Disease Control recommends convening a planning team that involves all sectors of the community including (medical personnel, law enforcement, mental health personnel, clergy, survivor groups, media, state and community agencies and crisis hotline personnel) identifying and counseling at risk students and delivering a public response that avoids glorification and sensationalism.

* Major protective factors against youth suicide identified by the World Health Organization are the following: stable families, positive connections at school, good connections with other youth, religious involvement, lack of access to lethal weapons, access to mental health care and awareness of crisis hotline resources.
Postvention: Commonly Asked Questions and Responses

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

What method did they use to end their life? Answer specifically with information as to the method such as he/she shot herself or died by hanging but do not go into explicit details such as what was the type of gun or rope used or the condition of the body etc.

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

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

Didn’t he/she make a poor choice and is it okay to be angry with them? They did make a very poor choice and research has found that many young people who survived a suicide attempt are very glad to be alive and never attempted suicide again. You have permission for any and all your feelings in the aftermath of suicide, and it is okay to be angry with them. The suicide of a young person has been compared to throwing a rock into a pond with ripple effects in the school, church and the community and there is often a search for a simple explanation. These ripple effects have never been greater with the existence of social networks (e.g. Facebook). It is recommended that school staff and parents monitor what is being posted on social networks sites in the aftermath of a suicide. Suicide is a multifaceted event and sociological, psychological, biological, and physiological elements were all present to some degree. The suicide is no one’s fault but yet is everyone’s fault and suicide prevention is everyone’s responsibility. Many individuals who died by suicide had untreated mental illnesses, most likely depression, and it is important that everyone is aware of resources that are available in their school and community so that needed treatment can be obtained. It is always important that everyone
knows the warning signs of suicide and they are outlined in great detail on websites references in this handout.

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

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

**What is an appropriate memorial to a suicide victim?** The most appropriate memorial is a living one such as a scholarship fund or contributions to support suicide prevention. The American Foundation for Suicide Prevention [www.asfsp.org](http://www.asfsp.org) and the Suicide Prevention Resource Center [www.sprc.org](http://www.sprc.org) published in 2011, an excellent guide for postvention entitled, After a Suicide: A toolkit for schools, that is available on both of their websites. The guide provides specific guidelines to balance the often felt needs that students have to do something after a suicide without glorifying the suicide victim which might contribute to other teenagers considering suicide. Schools are encouraged to download this guide and have it available if a suicide does occur and follow the excellent recommendations provided that were developed after extensive dialogue with numerous experts in suicide prevention. It is important that Texas school personnel be very familiar with this guide and to recognize they could be criticized and even sued for failing to implement a best practices postvention response. There is also a postvention chapter in the Texas Coming Together to Care toolkit available at TexasSuicidePrevention.org.

**How serious is the problem of youth suicide?** It is the second leading cause of death for teenagers and the eleventh leading cause of death for all Americans, and more than 38,000 Americans die by suicide each year.
What are the warning signs of suicide? The most common signs are the following: making a suicide attempt, verbal and written statements about death and suicide, fascination and preoccupation with death, giving away of prized possessions, saying goodbye to friends and family, making out wills, and dramatic changes in behavior and personality.

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

How does the crisis hotline work? We are very fortunate to have nationally certified crisis hotlines in many cities that are available 24 hours a day and manned by trained volunteers. There is also a 24 hour national suicide hotline and that can be reached via 1-800-Suicide or 1-800-273-8255. All of the Texas local mental health authorities and community mental health centers also are required by law to have a crisis line. It is important to save BOTH the national suicide prevention lifeline number and the local crisis line number in your cell phone so that they are easily available when needed. Note: some Texas school districts have promoted these line with a “Save A Number to Save A Life” campaign announced at sporting events during the annual suicide prevention week.

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

Where can I go for more information about preventing suicide? Contact the American Association of Suicidology (AAS) at www.suicidology.org or Texas Suicide Prevention resources at www.TexasSuicidePrevention.org or the Jason Foundation at www.jasonfoundation.com

Or Yellow Ribbon Suicide Prevention Program at www.yellowribbon.org or the American Foundation for Suicide Prevention www.afsp.org or the Suicide Prevention Resource Center at www.sprc.org or Nova Southeastern University at www.nova.edu/suicideprevention as four training videos focus on suicide awareness, suicide assessment, suicide postvention and self-injury in schools or download the
How well do families who lost a child to suicide cope with the loss? The literature well documents the devastating effect of suicide on the family and that family members often feel isolated. Research studies conducted 15 months after the suicide indicate that the families have resumed normal functioning, however they are profoundly affected especially when there is little explanation for the suicide of their loved one (Erbacher, Singer & Poland 2015). Family members may experience anger towards those they believe are somehow responsible, loss of interest in their employment or school work, increased absences, disrupted sleeping and eating patterns, grief, helplessness, abandonment, isolation, loneliness, shame and guilt. Suicide survivors have more difficulty with the grieving process than survivors of losses from other causes than suicide. Survivors often reported feeling uncomfortable with the naturally occurring support systems and school and community members often are unsure of what to say and how to reach out to those who lost a family member to suicide.

If a family member has a pre-existing mental health condition it will likely be exacerbated and previous substance abuse will likely increase. Families reported receiving less support that they deemed necessary after a suicide and what support they did receive was often poorly timed and especially ineffective for younger siblings. Research studies have also found that approximately 50% of the time that children were not told the truth, that the cause of death was suicide. Children often find out the truth at a later date and are upset that they were not told the truth (Joiner, 2011). Bereavement was especially complicated when family members held deeply religious beliefs and moral convictions against suicide. Family physicians and school personnel who are knowledgeable about helping survivors cope and available community resources can play a significant role in supporting the grieving family. Family members often receive comfort and find meaning in becoming involved in suicide prevention.
Suicide Postvention Checklist

(Key points from Erbacher, Singer & Poland 2015, Lieberman, Poland & Kornfeld 2014 and After a Suicide: Toolkit for schools from www.afsp.org and www.sprc.org.)

1. Verify that a death has occurred and confirm cause.
2. Mobilize the School Crisis Response Team and notify your local community mental health center.
3. Assess the suicide’s impact on the school and estimate the level of needed postvention response.
4. Notify and support school staff.
5. Contact the family of the suicide victim.
   • Contact should be made in person within 24 hours of the death. Purposes include...
     o express sympathy,
     o offer support,
     o identify the victim’s friends who may need assistance,
     o discuss the school’s postvention response,
     o identify details about the death that could be shared with outsiders,
     o discuss funeral arrangements and whether the family wants school personnel and/or students to attend
6. Determine what information to share about the suicide.
   • Sample Letters should be available to use a templates depending on the messaging;
     o Death has been ruled a suicide
     o Cause is unconfirmed (ask that rumors not be spread)
     o Family has requested cause of death not be disclosed (rumors of suicide and since that subject has been raised). (Suicide is a leading cause of death for youth and we must all know the warning signs of suicide and where to get help for ourselves or our friends. Suicide is very complex, but mental illnesses such as depression are usually the cause.)
7. Determine how to share information about the death
8. Identify students significantly affected by the suicide and initiate a referral mechanism
   • Risk Factors for Imitative Behavior
     o Facilitated the suicide
     o Failed to recognize the suicidal intent
     o Believe they may have caused the suicide
o Had a relationship with the suicide victim
o Identify with the suicide victim
o Have a history of prior suicidal behavior
o Have a history of psychopathology
o Show symptoms of helplessness and/or hopelessness
o Have suffered significant life stressors or losses
o Lack internal and external resources

9. Conduct a faculty planning session

10. Initiate crisis intervention services

11. Memorials
   • Strive to treat all student deaths the same way
     o Encourage and allow students, with parental permission, to attend the funeral
     o Reach out to the family of the victim
     o Contribute to a suicide prevention effort in the community
     o Develop living memorials, such as student assistance programs, that address risk factors in local youth
     o Address spontaneous memorials on school grounds
   • Prohibiting all memorials is problematic
     o Recognize the challenge to strike a balance between needs of distraught students and fulfilling the primary purpose of education
     o Meet with students and be creative and compassionate
     o Spontaneous memorials should be left in place until after the funeral
   • Avoid holding funeral services on school grounds
   • With careful planning, schools may participate in gatherings such as candlelight memorials. School counselors should be present to support grieving students.
   • Monitor off campus gatherings
   • Student newspaper coverage should follow media reporting guidelines available at www.afsp.org
   • Yearbook and graduation dedication or tributes should all be treated the same regardless of the cause of death for the student
• Grieving friends and family should be discouraged from dedicating a school event and guided towards promoting suicide prevention
• Permanent memorials on campus are discouraged

12. Social Media
• Create a Social Media Manager to assist the Public Information Officer
• Utilize students as "cultural brokers" to help faculty and staff understand the social media that is currently most used by students
• Train students in gatekeeper role, and specifically identify what suicide risk looks like when communicated via social media.
• Have staff monitor social networks and provide safe messaging when important (this will require that districts not completely block these networks)
• Have parents get involved in their child's social media
• Monitor for high risk students
• Psycho-education: Make use of social media to post prevention messages, hotlines and community mental health resources.
• Give students specific helpful language to include when making use of social media such as banners and info from the National Suicide Prevention Lifeline website (www.suicidepreventionlifeline.org).
• Work with YouTube and Facebook to take down messages, disturbing images or language
• Utilize the Facebook application for concerns or issues with content.

14. Debrief the postvention response with school crisis team members and identify needed additional actions

Suicide and Schools: Liability Issues

Few precedents have been set regarding a school’s liability in cases of the suicide of a student and with only a few exceptions school personnel have been granted sovereign immunity. If one court upheld an action against public school personnel based on a duty to prevent suicide when they were aware of such intent, countless other courts have not taken such action. The courts look at whether or
not the student’s death was a result from inadequate training and/or inadequate responses from school personnel. It is extremely hard to prove that a school’s breach of duty caused the suicide while weighing in all other factor’s in the student’s life. While it is difficult to find school personnel accountable for the suicide of a student, a lawsuit can cost a school district hundreds of thousands of dollars in legal costs, tremendous stress, time, and the placement of a stigma on the district. It is important to note that one of the authors of this report has served as an expert witness in a number of liability cases involving schools and suicide.

Prior to the case of *Eisel v. Montgomery County Board of Education (1991)*, courts consistently concluded that schools did not have a legal obligation to prevent suicide. This case raised the issue that school counselors might have a legal duty to prevent suicide due to the special relationship that counselors have with students. Two school counselors were told by classmates of Nicole Eisel that she planned to die by suicide. Eisel when questioned by the counselors denied suicidal thoughts or plans and the counselors choose not to notify her parents. Eisel later died by suicide. An initial Maryland court found that the counselors did have a duty to warn her parents, but ultimately after many of years of litigation, a higher court found in favor of the counselors and the school district. It is imperative for administrators and key school support personnel such as school counselors to know the status of previous litigation involving schools and suicide and be familiar with key legal terms such as the following:

**Negligence**

Negligence is a breach of duty owed to an individual involving injury or damage (suicide) that finds a causal connection between a lack of or absence of duty to care for the student and his/her subsequent suicide. In a few cases courts have asked schools to produce records of when they trained staff on suicide prevention. It is imperative that schools not only hold annual trainings, but also document when these trainings were held and who was in attendance. One case that raised questions of negligence and training in suicide prevention was *Witsell et al v. The School Board of Hillsborough County (2011)*.

Hope Witsell, a middle school student, was referred to the school social worker after her teacher noticed shallow cuts on her thigh. It was well known by school personnel that she was
experiencing bullying, and harassment following her sending a sexting image via text to another student the previous school year. The social worker had the student sign a no-harm contract but failed to notify her parents of the concerns about suicide. Witsell died by suicide the next day. Her parents found a copy of the no-harm contract signed by Hope and the social worker after her suicide. As mentioned in this report, there is a significant connection between bullying and suicide that must be addressed in schools. Her parents sued the School Board of Hillsborough County, Florida under allegations of negligence. The School Board was not found legally responsible; however one important issue in the case was whether or not the social worker’s failure to follow the district policy of parent notification was due to lack of training on the district policy that required parent notification.

Foreseeability

School personnel can be held liable if it is found that a reasonable person would have been able to recognize that the student was suicidal. Courts have allowed actions against school officials for such a cause, relating to the absence of appropriate supervision or the lack of appropriate policies/procedures used when a student’s suicide is deemed foreseeable (a likely and imminent danger). One case that raised the question of foreseeability was Wyke v. Polk County School Board (1997) as sadly, 13-year-old Shawn Wyke killed himself in his own home after two prior attempts on school property the previous day that the school assistant principal was aware of. The assistant principal talked to Shawn about his suicide attempts but did not notify his parents, increase supervision or obtain any counseling help for him. This case went to a trial and the jury felt his attempts on the school’s campus would cause any sensible person to reasonably assume that he needed help/care or he would be in imminent danger to himself and to attempt suicide again. His suicide was deemed foreseeable. The school district argued that suicide is an intervening force, but the jury found that the defendants had strong reason to anticipate his suicide. The school district was found liable for not offering suicide prevention programs, for not providing adequate supervision of the student, and for failing to notify his parents that he was suicidal.
State-Created Danger

A school can be found to have been in violation of legal responsibility based on the constitution rights of the victims. The argument states that through enacting or failing to enact/follow through with certain policies and procedures, the school is causing danger to the student who has died by suicide. Overall, to have a convincing argument, the plaintiff must establish: there was foreseeable and direct harm, a state actor (school employee) acted with a lack of responsibility that, “shocks the conscience”, and a relationship existed between the state and plaintiff such that the plaintiff was a foreseeable victim of the defendant’s acts. One such case, *Armijo v. Wagon Mound Public Schools (1998)*, involved a special education student that was suspended, driven home by a school employee, and left unattended at the home where he killed himself with a gun. Prior to driving him home and leaving him unattended without parental consent, school employees were aware of the student’s suicidal threats and access to firearms in his home. The school was not ultimately found legally responsible, but the fact that the lower court allowed the case to go to trial allowed for the possibility of finding the school liable for the suicide of a student under state-created danger.

Immunity

Government entities including schools and school personnel are granted immunity if their conduct does not clearly violate constitutional rights of which a reasonable person would have known. There is a constitutional right of a “duty to protect;” however, state laws based on child attendance at schools have failed to convince courts that a child’s attendance at school creates the relationship that would mandate a school's duty to protect students. It is very difficult to successfully sue a school or school district for the actions of its employees, unless the school board or administration failed to enact policies and procedures that violate their duty to protect students from state-created danger or a special relationship existed. Often, courts grant summary judgment in favor of the defendants (schools and school boards) or dismiss cases due to the fact that the actions or lack of actions, taken by the school employee fails to be found to “shock the conscience.”
Special Relationship

A special relationship argument follows the logic that if a state entity holds a “special relationship” with a student, that it is their responsibility to protect the child from harm. It has been argued that public schools (state entities) do hold a special relationship with their students, but it is very difficult to conclude unless the child is in the state’s custody through prison, involuntary commitment into an institution, or placed in foster care. In the case of Doe v. Covington County School District (2012), nine-year-old Jane Doe and her family brought litigation against the girl’s school district for their deliberate indifference to her security. Jane Doe was repeatedly checked out of the school and sexually molested each time by a man who was not authorized to do so. The plaintiff’s argument stated that a special relationship existed due to Jane’s young age (nine years old), and mandated school attendance. This case was ultimately decided by the 5th Circuit Federal Court that found that there was no special relationship between the school and Jane Doe and dismissed the case. This case does not involve a student’s suicide, however it does demonstrate how complicated the “special relationship” argument can become.

In Loco Parentis Doctrine

This doctrine refers to the legal responsibility of a school to function and perform the responsibilities of a parent for a student while at school. In other words, schools may be mandated by this doctrine to look out for the student’s best interest. Schools assume the control and supervision of the children as stand-in parents while they are attending.

Intervening Force

Many school district attorneys when defending schools use the “intervening force” argument after the suicide of a student emphasizing that suicide is a superseding and intervening force that breaks any chain of causation between events. This argument states that there would be no way to place cause on a school’s negligence/cause and effect, as suicide is an action that only the individual him/herself can prevent. This argument was used by the Cypress Fairbanks ISD (Fowler v. Szostek, 1995) in the school district’s defense following the suicide of a middle school student named Brandi
Nelson who was removed from school and recommended for expulsion based on statements from other student that she was selling drugs at school. Following her removal her parents took her home and left her alone and she shot herself.

The primary argument from the plaintiff’s attorney was that the school should have realized that because she was in a severe discipline sequence she might be suicidal. This argument was based on the fact that suicide is a leading cause of death for teenagers and that school discipline can be a precipitating event to suicide. The plaintiffs in their wrongful death suit believed that the school had a duty to explore the possibility that Nelson might have suicidal ideation.

The defendants’ motion for summary judgment was ultimately granted after being denied initially, demonstrating that the doctrine of sovereign immunity and the concept of intervening force impede almost all claims made by plaintiffs. Although it is unknown whether or not the discipline situation was a direct cause of her suicide, it likely played a key role in her actions. It is highly recommended that school officials handle disciplinary measures with compassion and care, as it is not uncommon for school discipline such as suspension or expulsion to provoke students to follow through on earlier thought out suicidal plans. It is recommended that the school officials take extra time with any student involved in a serious disciplinary situation. Some examples and recommendations of what to say/do to provide care for the disciplined student are as follows:

1. Ask the student: “Are you going to be okay?” and “Do you need to see the counselor before you leave school?”
2. Tell the student: “We still care about you.”
3. To the parent/guardian: “Do you think you could stay home with your child today as this must be a very difficult time for them?”
4. Discuss with the school counselor if he/she may know about any additional warning signs for that student. Also ask the counselor to question the student about hopelessness and thoughts of suicide.
Professional Ethical Standards for Key School Personnel

No Maleficence/Do No Harm

For a counselor/psychologist in particular to uphold his/her ethical standards, he/she must do no harm. Noting the grave statistics of suicidality in youth, suicide prevention efforts only seem to be common sense to those who wish to do no harm to the student population. Although there is an inconsistency in the outcomes of previous court hearings on the extent of a school administrator, social worker, psychologist or counselor’s legal obligation to prevent a student’s suicide, their ethical obligation is not up for question as they are ethically bound to make every attempt to prevent harm and protect students from potential danger.

Competence

School mental health professionals in particular must be competent and up to date on the risk factors and warning signs of suicide. This can be ensured through mandating trainings on suicide prevention, assessment, and intervention. There is a national movement to mandate training for school personnel on suicide prevention and some states have mandated more than training on the warning signs of suicide. For example, the state of Washington recently passed new legislation entitled “K-12 – Troubled Youth Act” http://apps.leg.wa.gov

This law mandates that school nurses, school social workers, school psychologists, and school counselors attend a training (at least three hours in length) on youth suicide screening and referral as a requirement for both initial and continuing certification. As noted earlier in this report, Texas has recently mandated training for teachers and school personnel.
Suicide Postvention and Liability

The term “postvention” refers to events and activities that are planned for schools to put into action following a suicide as a means to assess the overall impact, identify at-risk individuals, prevent a contagion effect from occurring, and support survivors who are emotionally affected by the death and are likely having increased thoughts of suicide. Schools as discussed in this report are often unprepared to handle the aftermath of a suicide and may not realize that postvention efforts that are carefully planned and implement best practices are essential to prevent further suicides.

The authors are only aware of one legal case that involved how a school’s handling the suicide of a student might have contributed to another suicide, which is the case of Mares v. Shawnee Mission School District (2007). In this suit, Mrs. Mares sued the school for negligence in their duty to protect her second son Justin, who died by suicide (Poland & Chartrand, 2008). The Plaintiff argued that the district failed to implement postvention procedures at the high school following her younger son Jason’s suicide, claiming that such an implementation could have prevented her older son Justin who attended the same high school from dying by suicide just six months after the suicide of his younger brother. The plaintiff, Mrs. Mares, argued that she was naïve as to how she and her family should appropriately cope with the death of her first son Jason and that the school staff also refrained from reaching out to Justin Mares, except to tell him that he could not graduate. The school did not present any sort of postvention response or offer counseling to Justin nor did the school reach out to Mrs. Mares to make suggestions as to how she should handle the aftermath of Jason’s suicide with her other children. One aspect in question was if a sensible person would have had reason to anticipate Justin’s depressive and suicidal thoughts after the death of his younger brother? Further, should school professionals have anticipated his depression and was it negligence not to intervene?

The question of in loco parentis control was also central to the lawsuit however defendants maintained the argument that because Justin’s suicide occurred off campus, they no longer had in loco parentis control. The school district filed for a summary dismissal; however, this motion was denied and the Shawnee Mission School District did settle with Mrs. Mares out of court, but the specifics of the settlement are sealed (Poland & Chartrand, 2008). There is a strong chance that Justin’s suicide could have been prevented most importantly and the amount of time, energy, and money that the Shawnee Mission School District spent on this case (as well as the stigma placed on the district) could have also possibly been prevented by implementing best practices postvention procedures.
Bullying and Suicide Liability

There have been a number of lawsuits filed by parents against school personnel, citing the school’s failure to stop bullying as a proximal cause of their child’s suicide. A number of parents have been very vocal in attributing the suicide of their child to bullying. The district of Blue Springs, Missouri invested considerable time and effort responding to a lawsuit following the suicide of Brandon Myers (Evenson, 2012), a 12-year-old student who reportedly had been a victim of continuous bullying at school. The district settled with the parents out of court for $500,000.00 shortly before a trial was to begin.

In another case linking bullying to suicide, *The Estate of Montana Lance et al v. Kyer et al* (2011) was filed against the Lewisville Independent School District following the suicide of Montana Lance, a fourth grade student who hung himself at school. His parents, Mr. and Mrs. Lance, claimed that the school failed in providing safety for Montana, a suicidal special education student who was known to be suicidal, through their absence of policies, procedures, and trainings for how school staff should have worked with Montana and protected him from the bullying. Mr. and Mrs. Lance further argued that the school had a special relationship with their son, as he was a young student with a disability. Furthermore, the day he died he was in a discipline setting (in school suspension) in which he was being held involuntarily. The plaintiffs also made the claim of state-created danger (knowingly allowing a suicidal Montana to use a restroom that school personnel did not have a key to open the door once it was locked). According to the plaintiffs, Montana was discriminated against as evidenced by the school’s negligence to address Montana and his family’s complaints of the bullying and harassment which they believe led to Montana’s suicide. A judge for the Eastern District Court of Texas dismissed the case, claiming that the plaintiff’s did not provide sufficient evidence to demonstrate that Montana Lance was discriminated against and that no special relationship existed as Montana Lance was not imprisoned, involuntary committed in an institution, or in foster care. The case was appealed to the 5th Circuit Federal Court which also sided with the school district.

While the case was dismissed, the implications from this tragedy are widespread. As numerous youth suicides have been linked to bullying, it is imperative for school districts to implement both bullying and suicide prevention programs and to recognize the strong association between bullying and suicide. Texas legislation identified that student at risk for suicide includes students who are or may be the victims or who engage in bullying (Tex. Health & Safety Code 161.325).
Summative Recommendations for Suicide Safer Schools in Texas

School District Action Steps

Background and Policy

1. Ensure that your school district has a comprehensive suicide prevention policy included in the District Improvement Plan as required by Texas statute that specifies annual training for all staff on the warning signs of suicide and the importance of working as a team and not keeping a secret about suicidal behavior. The plan should also provide training on suicide assessment for key school support personnel including counselors, social workers and school psychologists. Policies should be developed to ensure that suicidal students are properly supervised and that their parents are notified when their child is suicidal. Districts also need to be familiar with local, community and state resources and any specific interventions available in Texas including procedures for involuntary hospitalization.

2. Be very familiar with Texas legislative initiatives for suicide prevention and the excellent resources available at DSHS, TEA and MHAT/TexasSuicidePrevention.org.

3. Recognize that lack of information and misinformation and myths about suicide has resulted in youth suicide prevention not receiving the attention that is needed.

4. Review the suicide prevention requirements from the 84th legislative session and share them with all building principals.

5. Review the best practices list sent out annually by DSHS and TEA and available on their websites.

6. Be familiar with the Best Practices Registry provided by the SPRC.

7. Develop district procedures and guidelines for prevention, intervention and postvention with at risk and suicidal students, parent notification, and referral and follow up services at school for suicidal students (Note: extensive guidelines, forms, letters and procedures available from Preventing Suicide: A Toolkit for High Schools from SPRC and After a suicide: Toolkit for schools from AFSP and SPRC).

8. Develop specific school policies for securing supervision and support for students who are identified as depressed and/or suicidal.
9. Become familiar with the research about sleep deprivation, early school start times and the adverse effect on secondary age students to develop policy regarding optimum start times.

**Infrastructure**

10. Form a district task force on suicide prevention that includes representatives from elementary and secondary schools and ensure that it meets at a minimum twice a year

11. Ensure that your District School Health Advisory Councils (SHAC) includes advisors familiar with mental health and suicide prevention.

12. Identify local and state resources for suicide prevention and meet with their representatives in person or via conference call to improve collaboration (DSHS, local community or behavioral health centers and local suicide prevention coalitions)

13. Designation a suicide prevention liaison or liaisons and consider getting them credentialed in school suicide prevention from the American Association of Suicidology [www.suicidology.org](http://www.suicidology.org)

14. Ensure that school counselor schedules and ratio to students meets national recommendations from the America School Counselor Association (ASCA)

**Training and Tools**

15. Obtain extensive, best practice based suicide assessment/prevention/intervention/postvention training for key personnel such as school counselors and school psychologists

16. Investigate depression screening such as Signs of Suicide, (SOS), C-SSRS or others based on best practices

17. Implement programs to safeguard and support LGBTQ students. Recognize that lesbian, gay, bisexual and transgender youth are often the target of bullying and increase support for those students and that they have higher rates of suicide than their heterosexual peers. Excellent resources to provide support are available from the Gay Lesbian Straight Education Network at [www.glsen.org](http://www.glsen.org)

18. Review and implement training from the best practices list from DSHS and TEA for all school personnel

19. Plan and conduct annual trainings for all staff on bullying prevention and recognize there is an association between bullying and suicide

20. Implement programs to increase student resiliency.
21. Increase efforts to ensure that every Texas student feels connected to their school and provide activities where students are asked to list the significant adults in their life that they could go to for help.

22. Teach students the National Crisis Hotline Numbers (800-273-TALK or 800-273-8255) Students will also be interested to know that on the iPhone if suicide is mentioned to SIRI that they are provided with the National Crisis Hotline Numbers and SIRI offers to connect them.

23. Provide local, state and national crisis hotline numbers that can be accessed by either parents or students on the district website.

24. Provide mental health presentations annually for parents that include suicide prevention information.

25. Provide information on the district website about depression and suicide that includes information about who parents should contact if they are concerned about their child.

26. Review prevention and postvention procedures in this report and from: Preventing Suicide: A Toolkit for High Schools from SPRC and After a suicide: Toolkit for schools from AFSP and SPRC, and postvention chapter in Texas’ Coming Together to Care toolkit.

27. Train staff to “Ask the Question” about suicide and not be afraid to inquire directly about thoughts of suicide since research has shown that direct inquiry is exactly what is needed and is in fact likely to save a life.

State of Texas Action Steps

Education Policy, Outreach and Sustainability

1. In developing statewide policy, it is noted on the Texas Educator Survey that rural and urban district personnel reported the least confidence in responding to suicidal students and all personnel responding supported the need for more familiarity with best practices for prevention.

2. Send a letter at to all Texas superintendents clarifying the suicide prevention requirements from the 84th legislative session from DSHS and/or TEA and post letter on Education Service Center websites.

3. Schedule presentation at state school administrative conferences for principals, superintendents and school board members on the legislative requirements, how to meet them
and to clarify local and state resources for suicide prevention and post on their organizational websites.

4. Conduct biannual, representative statewide survey of Texas educators on suicide prevention that builds on the small survey completed for this report.

5. Send an annual letter at the beginning of each school year to all Texas principals from DSHS and/or TEA, listing or giving links to Texas resources for suicide prevention and including the updated best practices list.

6. The discussion of litigation on suicide and schools should be shared with school administrators in leadership conferences around the state.

7. The Texas Educator Survey also noted even elementary students have suicidal behavior and a need exists for more prevention programs at the elementary level. There is national need for more programs at this level and Texas could take the lead in creating suicide prevention programs for elementary schools.

Training, Tools and Programs

1. Provide state funded regional trainings for school counselors on suicide assessment/intervention (DSHS, MHAT and Regional Education Service Centers (ESC’s)).

2. Increase collaboration of state and local resources offered to schools and youth.

3. Increase usability and visibility of best practices list online for Department of State Health Services, Mental Health America of Texas and it’s TexasSuicidePrevention.org website, regional Education Service Centers and key education and school professional organizations.

4. Adopt a statewide program to enlist schools and school districts in a formal “Suicide Safer School” comprehensive program and recognize outstanding school efforts in implementing suicide prevention programs and utilizing local and state resources.

5. Investigate implementing depression screening (SOS) or other best practice screening statewide.

6. Ensure state funding for youth and school suicide prevention to ensure sustainability of programs.
Appendix

A- Death by Suicide Statistics
B- Texas Suicide Safe Schools Survey for Educators
C- Texas Suicide Safe Schools Survey for Leaders
D- Texas State Agencies, National/Federal Agencies and Organizations
E- SPRC Resources Specific to Youth Suicide Prevention/Intervention/Postvention
F- Suicide Prevention Training Resources Listed in Texas Toolkit
G- Information about SPRC’s National Registry of Evidence-Based Programs and Practices.
H- Texas E-Resources for Suicide Prevention Available from Mental Health America of Texas
I- Additional Suggested Resources
Appendix A

Death by Suicide Statistics

http://www.cdc.gov/violenceprevention/pub/youth_suicide.html
It is important to recognize the suicide prevention challenges in relation to the unique developmental characteristics of pre-K through 12 students within the context of the educational setting and its respective community.

The above map provides an overview of annual deaths by suicide for all ages. As indicated, the western part of the U.S. experiences more suicides than do the eastern states. A few of the correlating factors in specific regions/cities include; isolation and remoteness, dense populations, and senior populations. Factors influencing youth suicide can be found in the section of this document identified as Risk Factors the Increase Suicidal Ideation.
Texas Suicide Death Rates by Age Group 2008-2012  Rate = Deaths per 100,000 population

Age Distribution of Suicide Deaths in Texas

Death by suicide affects all ages, as this chart indicates with males having a higher rate than females for all ages. The rates for suicide begin to rise in the teen and young adult years and the highest rates of suicide in Texas are occurring in the elderly population over age 85 and in the 45-54 age group.
Texas Suicide Death Rates for Last 3 Years For Which We Have Data (2011,2012,2013)

12 leading causes of death in TX, 2013

- Diseases of heart
- Malignant neoplasms
- Chronic lower respiratory diseases
- Cerebrovascular diseases
- Unintentional injuries
- Alzheimer's disease
- Diabetes mellitus
- Septicemia
- Nephritis, nephrotic syndrome and nephrosis
- Influenza and pneumonia
- Chronic liver disease and cirrhosis
- Suicide

*Rates are age adjusted to the 2000 US Standard Population (per 100,000).

Appendix B

Texas Suicide Safe Schools Survey for Educators

Current Position: _________________   Years in Education: ___________

Please circle one of the descriptors. My district/school is RURAL, URBAN, SUBURBAN.

The purpose of this survey is to collect information regarding:

- suicide prevention and intervention information/training previously provided.
- active measures that have been taken by school/district in youth suicide prevention/intervention.
- perceived needs or gaps in training that can ensure you are better prepared to have a suicide safe school.

Please check the descriptor that most reflects your opinion and/or understanding based on your educational experiences in Texas schools. A comment space has been provided for additional information should you wish to elaborate on your response.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Suicide Awareness/Prevention Training</th>
<th>Additional Thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Have you received suicide prevention training?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are you familiar with the Best Practices resource recommended for school administrators in the aftermath of a youth suicide?</td>
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<tr>
<td></td>
<td></td>
<td>Does your school have a plan to prevent youth suicide?</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Do you have a youth suicide prevention plan that is in writing?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have your staff/colleagues rehearsed the actions needed in the aftermath of an attempted or a completed youth suicide?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have any of the schools you’ve worked in experienced a youth suicide?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you personally been involved in prevention or intervention actions for a suicidal youth?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Does Texas legislation require youth suicide prevention efforts in schools?</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Does the district website provide information about youth suicide prevention?</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Does the district/school have youth suicide prevention included in the District or Campus Improvement Plan?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Have you or staff members provided suicide prevention training to students and parents?</td>
<td></td>
</tr>
</tbody>
</table>
Do you have a depression/suicide screening procedure that you use with all students?

<table>
<thead>
<tr>
<th>Agree=1, Somewhat Agree=2, Disagree=3</th>
<th>Additional Thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 I am confident in my knowledge and skills for intervening with a suicidal student.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I am aware of the significant warning signs for youth suicide.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I have the training necessary to work with parents and students in the aftermath of a youth suicide within my school community.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe my school and/or district has a comprehensive plan for addressing suicide prevention and postvention.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe that youth suicide is a problem in Texas that should be addressed.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe that schools play a significant role in educating staff, students, and parents on suicide prevention.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I feel my staff/colleagues are well trained in responding to youth who attempt and/or complete death by suicide.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I feel I, my staff/colleagues need more information and/or guidance on suicide prevention/intervention strategies.</td>
<td></td>
</tr>
</tbody>
</table>

If you have been trained in suicide prevention, select the training from the following list:

- **ASK** about Suicide to Save a Life
- ASIST Applied Suicide Intervention Skills Training
- QPR Question Persuade Respond
- Mental Health First Aid
- *At-Risk* for Texas Educators, Elementary, Middle School or High School version
- Other:

How frequently does your school/district provide youth suicide prevention information to staff?

Who was required to receive training and what was the focus?

What resources inside and outside the district are available to you for suicide prevention?

Is there anything else you would like to add?
Appendix C

Texas Suicide Safe Schools Survey for Leaders

Current Position: _________________   Organization: __________________Years in Position: ____

The purpose of this survey is to collect information regarding:

- active measures that have been taken toward youth suicide prevention/intervention in Texas schools.
- perceived needs or gaps in training in Texas schools.
- organization/agency collaboration with Texas schools specific to youth suicide prevention/intervention/postvention.

What do you believe are the top 3-5 successes for suicide prevention in Texas Schools?

1. 
2. 
3. 
4. 
5. 

What do you believe are the top 3-5 challenges for suicide prevention in Texas schools?

1. 
2. 
3. 
4. 
5. 

I believe the following would help our Texas schools understand and implement Texas laws regarding suicide prevention:
Please check the descriptor that most reflects your opinion and/or understanding based on your experiences. A comment space has been provided for additional information should you wish to elaborate on your response.

<table>
<thead>
<tr>
<th>Agree=1, Somewhat Agree=2, Disagree=3</th>
<th>Additional Thoughts?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 I believe that Texas schools are aware of suicide prevention and postvention “Best Practices”.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe that Texas schools have a good understanding on how to implement Texas laws regarding suicide prevention in schools.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I am confident Texas schools/districts have the knowledge and skills for intervening with a suicidal student.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe our schools are aware of and utilize community and state resources for youth suicide prevention/intervention.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 Our schools have the training necessary to work with parents and students in the aftermath of a youth suicide in the school community.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe our schools have comprehensive plans for addressing suicide prevention and postvention.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe that youth suicide is a problem in Texas that should be addressed.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I believe that schools play a significant role in educating staff, students, and parents on suicide prevention.</td>
<td></td>
</tr>
<tr>
<td>1 2 3 I feel our schools need more information and/or guidance on suicide prevention/intervention strategies.</td>
<td></td>
</tr>
</tbody>
</table>

If you have been trained in suicide prevention, select the training from the following list:

<table>
<thead>
<tr>
<th>ASK about Suicide to Save a Life</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASIST Applied Suicide Intervention Skills Training</td>
</tr>
<tr>
<td>QPR Question Persuade Respond</td>
</tr>
<tr>
<td>Mental Health First Aid</td>
</tr>
<tr>
<td>At-Risk for Texas Educators, Elementary, Middle School or High School version</td>
</tr>
<tr>
<td>Other:</td>
</tr>
</tbody>
</table>

How frequently does your organization/agency provide suicide prevention information to schools?

Which school personnel should receive training and what should be the focus?

What resources or programs outside the school district do you recommend schools take more advantage of?

Is there anything else you would like to add?
Appendix D

Texas State Agencies and National/Federal Agencies and Organizations

https://www.dshs.state.tx.us

Mental Health and Substance Abuse Services
909 West 45th Street and
1100 W. 49th Street
Austin, TX 78756

**DSHS Health Service Regions** - A listing of the DSHS Public Health Service Regions that includes headquarters locations, Regional Medical Directors and Deputy Directors, and links to their webpages.

http://www.dshs.state.tx.us/mhservices/default.shtm The Texas Department of State Health Services, Mental Health and Substance Abuse division maintains an easy to use listing of local mental health authorities and their 24/7 crisis lines. You are able to search by county, city or zip code to find the one nearest you. You can reach the Suicide Prevention Coordinator for the State, Jenna Heise, at Jenna.Heise@dshs.state.tx.us.

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Texas Suicide Prevention

http://www.texassuicideprevention.org

**Texas Suicide Prevention** offers a number of videos, online and in-person training options related to suicide prevention, including the “ASK” training program. In addition, the website highlights a number of Best Practice designated training options available in Texas and nationally. This website is maintained by Mental Health America of Texas with input from the Texas Suicide Prevention Council and the Texas Department of State Health Services. You can get more resources on suicide prevention and subscribe to a Texas Suicide Prevention e-newsletter by contacting: txsuicideprevention@mhatexas.org. The Coming Together to Care Suicide Prevention and Postvention toolkit available at this website also gives background on the Texas Suicide Prevention Council and letters of agreement for local, college, military/veteran coalitions or official representatives of statewide organizations to join.
Founded in 1935, Mental Health America of Texas is the state’s largest and longest-serving mental health education and advocacy group. Today, their reach extends beyond their original intent by serving to promote mental health, working to prevent mental illness and substance abuse, and ensuring all Texans have access to effective, culturally competent mental health care. In addition, Mental Health America of Texas has served as the facilitator and fiscal agent for the Texas Suicide Prevention Council and has helped the Texas Suicide Prevention Council create and update the Texas State Plan for Suicide Prevention.

Through a wide range of collaborative efforts, Mental Health America of Texas strives to provide consumers, mental health professionals, first responders and public policy leaders with the most comprehensive, evidence-based sources of information related to mental health, substance abuse, mental illness and suicide prevention.

The Texas School Safety Center (TxSSC) is an official university-level research center at Texas State University, a member of the Texas State University System. The TxSSC is tasked in Chapter 37 of the Texas Education Code with key school safety initiatives and mandates that include planning, training, and drilling, and in the Governor’s Homeland Security Strategic Plan. Toward this aim, the TxSSC serves as the central location for the dissemination of safety and security information, including research, training, and technical assistance for K-12 schools and junior colleges throughout the state of Texas. Specifically, the Center provides universal and regional services to students, educators, administrators, campus-based law enforcement, community
organizations, state agencies, and colleges/universities in an effort to increase safety and security in Texas schools. In addition, the TxSSC also builds partnerships among youth, adults, schools, law enforcement officers, and community stakeholders to reduce the impact of tobacco on all Texans through prevention, training and enforcement initiatives.

**National Organizations and Federal Agencies**

Many national organizations and federal agencies are involved in suicide prevention. They are valuable sources of information, and some offer funding opportunities, technical assistance, and trainings as well as resources for professionals and the general public.

**Suicide Prevention Resource Center (SPRC)**

http://www.sprc.org

This SAMHSA-funded, national center helps strengthen the suicide prevention efforts of states, tribes, communities, and college campuses, as well as organizations that serve populations with high suicide rates. It provides technical assistance, training, resource materials, a weekly *newsletter*, the SPRC Online Library, and customized information that outlines the roles of various professionals in preventing suicide. SPRC produces the Best Practices Registry (BPR) for Suicide Prevention. SPRC also helps build partnerships between health and mental health providers and provides organizational support for the National Action Alliance for Suicide Prevention.

**American Association of Suicidology (AAS)**

http://www.suicidology.org
AAS is a non-profit organization that promotes research, public awareness programs, public education, and training for professionals and volunteers. It serves as a national clearinghouse for information on suicide, publishing and disseminating statistics and suicide prevention resources. AAS also hosts national annual conferences for professionals and survivors.

**American Foundation for Suicide Prevention (AFSP)**

http://www.afsp.org

AFSP is a non-profit organization that funds research to advance understanding of suicide and suicide prevention. It also offers educational programs and resources for professionals, survivors of suicide loss, and the public about suicide prevention. AFSP’s Public Policy Division, SPAN USA, promotes and keeps track of policies and legislation related to suicide prevention. AFSP’s chapters organize suicide awareness events and build connections among local resources and services addressing suicide prevention.

**National Suicide Prevention Lifeline**

http://www.suicidepreventionlifeline.org

The Lifeline provides immediate assistance 24 hours a day, 7 days a week to individuals in suicidal crisis by connecting them to the nearest available suicide prevention and mental health service provider through a toll-free telephone number: 1-800-273-TALK (8255). The Lifeline also provides informational materials, such as brochures, wallet cards, posters, and booklets featuring the Lifeline number.
U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

http://www.samhsa.gov

SAMHSA funds and supports the National Lifeline and SPRC, and manages the Garrett Lee Smith grant program, which funds state, territorial, and tribal programs to prevent suicide among youth. It has developed the National Registry of Evidence-based Programs and Practices (NREPP), which reviews evidence of effectiveness for prevention programs on topics related to behavioral health, including suicide. SAMHSA also sponsors several prevention campaigns.

National Institute of Mental Health (NIMH)


The NIMH website has a section on suicide prevention that includes information and resources useful for a variety of audiences, including researchers, health care professionals, and consumers. NIMH also conducts research on suicide and suicide prevention.

National Center for Injury Prevention and Control (NCIPC)

http://www.cdc.gov/ViolencePrevention/suicide/index.html

NCIPC, located at the U.S. Centers for Disease Control and Prevention, is a valuable source of information, resources, and statistics about suicide, suicide risk, and suicide prevention. It includes links to a number of statistical databases, including WISQARS (Web-based Injury Statistics Query and Reporting System), YRBSS (Youth Risk Behavior Surveillance System), National Violent Death Reporting System, and National Vital Statistics System.
Indian Health Service (IHS)
http://www.ihs.gov/suicideprevention/

IHS' Community Suicide Prevention website provides American Indian and Alaska Native communities with culturally appropriate information about best and promising practices, training opportunities, ongoing activities, potential partnerships, and other information regarding suicide prevention and intervention. This information can help communities and schools create or adapt suicide prevention programs that are tailored to their needs.

Suicide Awareness Voices of Education (SAVE)
http://www.save.org

SAVE is a non-profit organization whose mission is to prevent suicide through public awareness and education, reduce stigma, and serve as a resource to people affected by suicide. Its prevention and education programs are designed to increase knowledge about depression, suicide, and accessing community resources, and to increase understanding and use of intervention skills to help prevent suicide.

Children’s Safety Network (CSN)
http://www.childrenssafetynetwork.org

CSN is a national resource center for injury and violence prevention, including suicide prevention. CSN provides technical assistance on injury prevention planning, programs, and best practices; analyzes and interprets injury data; partners with national organizations and federal agencies to promote child and adolescent health and
safety; disseminates injury prevention research; conducts trainings and presentations; and produces publications.

**Injury Control Research Center for Suicide Prevention (ICRC-S)**

http://suicideprevention-icrc-s.org/

This CDC-funded injury control research center promotes a public health approach to suicide prevention through a collaborative process of research, outreach, and education. Its goal is to draw suicide prevention directly into the domain of public health and injury prevention, and link it to complementary approaches in mental health. The center conducts research projects, provides technical assistance, and organizes conference calls, webinars, and an annual Research Training Institute for those working in the suicide prevention field or engaged in suicide-related research.

The Jason Foundation, Inc. (JFI), a non-profit 501c3, is dedicated to the prevention of the “Silent Epidemic” of youth suicide through educational and awareness programs that equip young people, educators/youth workers and parents with the tools and resources to help identify and assist at-risk youth. They provide a curriculum unit for students and informational seminars for teachers and parents.
Appendix E

**SPRC resources specific to youth suicide prevention/intervention/postvention**

SPRC (Suicide Prevention Resource Center) provides customized information sheets on suicide prevention tasks that can help professionals in a variety of roles take action to prevent suicide. Here are some of the resources that specifically address the school community and are available free of charge for you to reproduce and distribute; The Role of High School Teachers in Preventing Suicide

- The Role of **High School Mental Health Providers** in Preventing Suicide
- The Role of **Managers** in Preventing Suicide
- The Role of **Co-Workers** in Preventing Suicide
- The Role of **Faith Community Leaders** in Preventing Suicide
- The Role of **Emergency Medical Services Providers** in Preventing Suicide
- The Role of **Law Enforcement Officers** in Preventing Suicide


Additionally, SPRC has a youth suicide prevention training program that includes the following;

- **Preventing Suicide: A Toolkit for High Schools**
- **After a Suicide: A Toolkit for Schools**
- The Role of **High School Teachers in Preventing Suicide**
- The Role of **High School Mental Health Providers in Preventing Suicide**
- Suicide Prevention among Lesbian, Gay, Bisexual, and Transgender Youth: Expanding the Frame and Broadening Our Approaches: A Research to Practice Webinar
- Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth
- **Other Key Resources from Our Library**

[http://www.sprc.org/for-professionals](http://www.sprc.org/for-professionals)
Appendix F

Information about SPRC’s National Registry of Evidence-Based Programs and Practices.

How does the BPR incorporate the best available research evidence?

1. **By listing evidence-based suicide interventions in Section I.** The source for these interventions is SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP). At minimum, all Section I programs must demonstrate one or more positive outcomes relevant to suicide prevention to qualify for NREPP review. For more information, see Section I.

2. **By basing Section II and III review criteria on current research and expertise.** The design of the BPR recognizes that the suicide prevention field can benefit from dissemination of other information in addition to evaluated programs. These include guidance and recommendations created by experts or consensus processes; and programs, practices, and policies that have undergone review to assess whether the content is accurate, safe, likely to meet specified objectives, and consistent with standards of program design.

While the BPR is a useful resource for identifying programs and materials, selecting programs from the BPR is not a substitute for engaging in effective planning processes and adhering to principles of effective prevention. In other words, planners should not simply "pick from the list," but rather should engage in a systematic planning effort and use the BPR to help identify programs or materials that address local needs and circumstances. The next section provides recommendations for using the BPR within the context of an effective planning process.

How can I use the BPR as a resource for developing effective suicide prevention programs?

(1) **Engage in a systematic planning process.** Program planners are encouraged to use the BPR in the context of a systematic strategic planning process (this example is broadly applicable to community planning, although the surrounding text describes its use in a campus context). In this type of planning process, multiple stakeholders typically work together to assess local needs, assets, and readiness, set goals, choose or create interventions that match local problems and circumstances, and evaluate efforts and use the results for improvement.

BPR listings can be used in several ways during this planning process. For example, planners can search Section I for evidence-based suicide prevention programs that match their identified needs, resources, and audiences. Since the BPR is not a comprehensive list of all evaluated programs, planners are encouraged to conduct a literature search as well. If no evidence-based programs exist that match local needs, planners may consider adapting one of the programs listed in Section I or found in the literature, making revisions based on theory,
local assessment, and an understanding of the audience, while retaining key intervention ingredients. Resources about “program fidelity and adaptation” can be helpful in guiding these types of program revisions. A detailed synthesis of the literature on factors that influence program implementation can also inform decisions about local implementation of evidence-based programs.

Whether creating a new program or using an existing one, planners should consult Section II of the BPR to determine whether there are expert or consensus guidelines relevant to their planning efforts.

Program planners can consult Section III to find examples of resource materials, trainings, protocols and policies for suicide prevention that include accurate information, are likely to meet program objectives, follow safe messaging guidelines, and adhere to recommendations for suicide prevention program design. While the programs and materials in Section III have not been reviewed for effectiveness, they are examples of program content that meet specified standards and may be suitable for addressing identified program needs. Finally, by applying the Section III content standards to programs they create or implement prevention professionals can increase the likelihood that their programs and practices will be effective.

(2) **Follow principles of effective prevention practice.** Suicide prevention practitioners can benefit from the large body of research about what works in the prevention of other health and safety problems such as injury and substance abuse. For example,

- One review of prevention efforts across four areas (substance abuse, risky sexual behavior, school failure, and juvenile delinquency and violence) identified nine characteristics that were consistently associated with effective prevention programs: Programs were comprehensive, included varied teaching methods, provided sufficient dosage, were theory driven, provided opportunities for positive relationships, were appropriately timed, were sociocultural relevant, included outcome evaluation, and involved well-trained staff.

- Recognizing that best practice principles exist for specific kinds of efforts, this summary provides principles of effective substance abuse prevention divided into six domains: Individual, Family, Peer, School, Community, and Society/Environmental.

- The broader public health literature also emphasizes the need to undertake environmental and systems change efforts that complement and work in sync with individually-focused interventions. Injury prevention expresses this concept through the Three Es of Prevention: Education, Enforcement, and Environment.
Once interventions are selected to meet local needs, planners are encouraged to visit Section II of the BPR and to conduct a targeted search of the broader literature to determine whether there are science-based or best practice principles documented for that type of program, policy, or service (e.g., gatekeeper training, media campaigns, professional training programs, policy development.)

(3) **Conduct program evaluation and disseminate the findings.** Planners are encouraged to build evaluation into their efforts to assess the effectiveness of their programs and build the knowledge base in the field.

For more information about effective planning and evaluation, see

- About Suicide Prevention
- A Strategic Planning Approach to Suicide Prevention (free online workshop)
- Locating and Understanding Data for Suicide Prevention (free online workshop)
- Colleges & Universities: Developing a Campus Program
- American Indian / Alaska Native Suicide Prevention: Basics of Getting Started
- Evaluation Resources in the SPRC Library
- Planning Resources in the SPRC Library
## Appendix G

### Suicide Prevention Training Resources Listed in Texas Toolkit

Listed in Coming Together to Care: A Suicide Prevention and Postvention Toolkit for Texas Communities (available online at TexasSuicidePrevention.org)

Schools should check to make sure training program is based on best practices. Note: not all of the programs listed below are in the SPRC Best Practices List although they are based on best practices.

### The Suicide Prevention Best Practices Registry can be found at [http://www.sprc.org/bpr](http://www.sprc.org/bpr)

The Texas Suicide Prevention Council urges schools to utilize best practice based programs listed in the SPRC Best Practices Registry which can be found at website above. In addition, recently passed Texas Legislation requires school district staff development for all new district and open enrollment charter school educators must include suicide prevention training annually as part of the district or charter school’s new employee orientation, and must also be provided to existing school district and open-enrollment charter school educators on a schedule adopted in rules by the Texas Education Agency (TEA). The training must use a best practice-based program(s) recommended by the Department of State Health Services in coordination with TEA.

<table>
<thead>
<tr>
<th>Adolescent Wellness</th>
<th>School training manual and toolkit to promote awareness and early recognition of adolescent depression, written by McLean Hospital and Children’s Hospital of Boston. They offer print materials, curriculum, workshops and parent resources.</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="http://www.adolescentwellness.org">www.adolescentwellness.org</a></td>
<td></td>
</tr>
<tr>
<td>ASK (About Suicide to save a Life)</td>
<td>Mental Health America of Texas coordinates a 2-hour suicide prevention gatekeeper workshop in selected communities and schools. Some communities have trainers available.</td>
</tr>
<tr>
<td><a href="http://www.texassuicideprevention.org">http://www.texassuicideprevention.org</a></td>
<td><img src="http://www.texassuicideprevention.org/training/" alt="Image" /> If you would like a presentation for your organization or school, email <a href="mailto:txsuicideprevention@mhatexas.org">txsuicideprevention@mhatexas.org</a> and they can check to see if ASK trainers are available in your area. If you would like to learn how to identify and appropriately respond to someone who is feeling suicidal a 60-minute video is available at <a href="http://www.texassuicideprevention.org/training/">http://www.texassuicideprevention.org/training/</a>.</td>
</tr>
<tr>
<td>At-Risk For Elementary Educators (Texas State Version)</td>
<td>Free one-hour, interactive online suicide-prevention training for elementary educators and teachers-in-training in Texas.</td>
</tr>
<tr>
<td><a href="https://texas.kognito.com">https://texas.kognito.com</a></td>
<td></td>
</tr>
</tbody>
</table>
| **At-Risk For Texas Public Middle School Educators**  
(Texas State Version)  
| **At-Risk For High School Educators**  
(Texas State Version)  
https://texas.kognito.com | Free one-hour, interactive online suicide-prevention training for public high school educators and teachers-in-training in Texas |
| **At-Risk For College Students**  
(Texas State Version)  
https://texas.kognito.com | Free one-hour, interactive online suicide-prevention training for college students in Texas. |
| **At-Risk For College Faculty**  
(Texas State Version)  
https://texas.kognito.com | Free one-hour, interactive online suicide-prevention training for college faculty in Texas. |
| **CALM (Counseling on Access to Lethal Means)**  
http://www.hsph.harvard.edu/means-matter/ | Training to conduct firearm safety counseling and to reduce access to firearms, medications and other lethal means. |
| **Empathos**  
www.empathosresources.com | Empathos’ mission is to enable professionals to be more effective, so that people at risk for suicide have better solutions. New video training – Managing Suicide Risk Collaboratively: The CAMS Framework. |
| **Glendon Associates**  
http://www.glendon.org/ | The Glendon staff conducts educational and training seminars and workshops. These workshops are presented in an interactive style, intermixing lecture, discussion, and video demonstrations. They are designed to give participants the opportunity to discuss the theory and methods presented and their application to clinical practice. Glendon workshops have been conducted at universities, mental health facilities and hospitals throughout the country. |
| **Jason Foundation**  
http://jasonfoundation.com | A resource for students, parents, educators, and community workers. Program created and developed by a parent of child who died by suicide. |
| **Kognito**  
www.kognito.com | Developer of online role-playing simulations, where users build interpersonal skills to manage challenging conversations in the area of health and mental health, including suicide prevention. |
<table>
<thead>
<tr>
<th>Website/Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>LivingWorks</td>
<td>Developed the Applied Suicide Intervention Skills Training (ASIST) workshop (formerly the Suicide Intervention Workshop), a workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Other trainings are also available.</td>
</tr>
<tr>
<td>National Suicide Prevention Resource Center</td>
<td>Provides educational resources to help public officials, service providers, and community-based coalitions develop effective suicide prevention programs and policies. Also provides a resource database composed of suicide prevention articles and information.</td>
</tr>
<tr>
<td>QPR Institute</td>
<td>Over 1,000 trainers of suicide prevention throughout the United States. Offers a variety of training opportunities and materials (including self-study courses) to improve suicide risk detection, assessment and management skills. Also offers suicide risk management inventories and protocols available for those working with adults of all ages, those working with children and adolescents and those treating suicidal people in inpatient and residential settings. Training programs are also available for those who work with survivors of suicide and other trauma.</td>
</tr>
<tr>
<td>Suicide Information and Education Center</td>
<td>Contains suicide information and educational resources as well as suicide prevention training programs. Supports downloadable pamphlets, cards and information kits on a variety of subjects (some resources include a cost).</td>
</tr>
<tr>
<td>Training Institute for Suicide Assessment and Clinical Interviewing</td>
<td>Offers trainings and courses on suicide assessment, suicide prevention, violence assessment, risk assessment, crisis intervention, clinical interviewing, diagnostic interviewing, and methods for engaging clients and transforming resistance.</td>
</tr>
<tr>
<td>Yellow Ribbon Youth Suicide Prevention Program</td>
<td>The Yellow Ribbon Youth Suicide Prevention Program is dedicated to increasing youth awareness, reducing stigma associated with asking for help, and preventing youth suicide through peer group awareness.</td>
</tr>
<tr>
<td>Suicide Information and Education Center</td>
<td>Contains suicide information and educational resources as well as suicide prevention training programs. Supports downloadable pamphlets, cards and information kits on a variety of subjects (some resources include a cost).</td>
</tr>
<tr>
<td>Youth Suicide Prevention Education Program</td>
<td>Washington State’s Program of awareness, education, prevention, intervention, postvention, community building, collaboration, replication &amp; sustainability. Be-A-Link Gatekeeper Presentations and Trainings are available to youth and adults, separately and jointly. Curriculums are designed for professional and lay people, EMS/fire and law enforcement.</td>
</tr>
</tbody>
</table>
## Texas Suicide Safer Home App

The Suicide Safer Home App offers practical tips for parents and caregivers by securing access to lethal means of death by suicide. First responders, health, and mental health professionals can use this app for educational and reference materials. To download app, search “suicide safer home.”

## Virtual Hope Box App

Enjoy puzzles? Then, download this “Hope Box” and find compartments for fun and inspirational mental health messages and activities that promote hope. TheHope Box, available on iPhone and Android phones, is not a substitute for professional help.

## ASK About Suicide App

ASK about Suicide to Save a Life app for mobile devices can help save a life by providing information about suicide warning signs and how to ask about suicide. Crisis hotlines include National Lifeline, 800-273-8255. To download app search “suicide prevention”.

## Mental Health America of Texas

Mhatexas.org
Sign Up For Our Newsletter: TexasSuicidePrevention.org

## Free At-Risk Online Training Public Schools & Colleges

At-Risk interactive training simulations for educators in elementary, middle, high school, colleges, and college students. Texas educators can access training at: http://kognito.com/texas

## True Stories of Hope and Help (Videos)

A series of short and inspirational videos featuring true stories of Texas high school and college students sharing personal messages of hope and help. Videos can be accessed at texas-suicide-prevention.org (Training tab) or https://www.youtube.com/user/mhatexas

### TRAINING VIDEOS & LESSON GUIDES:

- **ASK About Suicide to Save A Life** (1 hour)
- **Suicide Prevention Resources in Texas** (11 mins.)

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Appendix I

Additional Suggested Resources

American Association of Suicidology (AAS)  http://www.suicidology.org

AAS has developed a credentialing program on suicide prevention for school personnel and a Guide for School-Based Suicide Prevention Program are listed on BPR II at SPRC and provide practical recommendations for the safe and effective implementation of school-based suicide prevention programs. Topics in much greater detail that are addressed by the guidelines include the following:

- Requirements for Effective Prevention Programs
- Requirements for Effective Implementation
- Requirements for Institutionalization (Retention Over Time) Of Programs
- Requirements for Comprehensive School Based Suicide Prevention Program(s)

For more details access http://www.sprc.org/bpr/

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

AFSP (American Foundation for Suicide Prevention) has provided several links that share AFSP’s federal legislative and regulatory priorities, which the AFSP Board of Directors updates each year based on recommendations from our Public Policy Council.


The Jed Foundation: https://www.jedfoundation.org

Kid Central TN: https://www.kidcentraltn.com
NAMI (National Alliance on Mental Illness): [https://www.nami.org](https://www.nami.org)

National Association of School Psychologists: [www.nasponline.org](http://www.nasponline.org)

National Council for Suicide Prevention: [www.ncsp.org](http://www.ncsp.org)


Nova Southeastern University Suicide and Violence Prevention Office: [www.nova.edu/suicideprevention](http://www.nova.edu/suicideprevention)

Samaritans USA: [www.samaritansusa.org/contact.php](http://www.samaritansusa.org/contact.php)

Suicide Awareness Voices of Education (SAVE): [https://www.save.org/](https://www.save.org/)

Tennessee Suicide Prevention Network: [www.tspn.org](http://www.tspn.org)

The Trevor Project: [www.thetrevorproject.org](http://www.thetrevorproject.org)

Yellow Ribbon Suicide Prevention Program: [www.yellowribbon.org](http://www.yellowribbon.org)
About the Authors

Scott Poland, Ed.D.

Scott Poland is currently a Professor at CPS and the Co-Director of the Suicide and Violence Prevention Office at Nova Southeastern University in Fort Lauderdale.

I worked in the schools as a psychologist or a director for 26 years and am still very involved in school crisis response and consultation and provided on site assistance in a several Texas school districts recently. I am a survivor of the suicide of my father, and our family is an example of one that never believed a suicide could happen. I became dedicated to suicide prevention after being promoted to the Director of Psychological Services in Cypress-Fairbanks ISD and being faced with the suicides of several students. The Superintendent asked me in 1982 what I was going to do about these suicides. I answered that I did not know but figuring out how to prevent youth suicide has been my highest professional priority ever since, and I have presented more than 1000 times on the topic of school crisis and suicide intervention. I am a licensed psychologist and an internationally recognized expert on youth suicide, and school crisis and have authored or co-authored five books on the subject. I am a past President of the National Association of School Psychologists and a past Prevention Division Director of the American Association of Suicidology. I have testified about the mental health needs of children before the U.S. Congress on four occasions and have personally assisted school communities after 16 school shootings, acts of terrorism, natural disasters and numerous suicide clusters.

Donna Poland, Ph.D.

I have been a professional educator for 37 years of which 27 years were in public schools in the state of Texas where everything is BIG! Imagine my surprise, as a first year teacher, when I discovered that my middle school classes averaged 30+ students and I had six classes each day! I very quickly discovered that I needed to get to know my students and build a respectful and nurturing environment before I could even consider teaching the curriculum. Having that vital connection with each student was the reason I walked joyfully into the building every day. After 17 years in the classroom, I began my administrative journey as a director of instruction, an at-risk coordinator, an associate principal, and finally a principal. Immediately upon taking a leadership role, I was faced with the tragedy of a scholar athlete taking his life by suicide just days before he was due to enter 9th grade. I would like to say it was the only one I experienced. Unfortunately, every year resulted in working with parents, staff,
and children in the aftermath of a death by suicide or an accidental death. The next ten years (at a small private school that is college preparatory in Florida) I have continued to need the skills for developing programs, educating staff, and working with parents regarding the signs of depression and suicide. After experiencing a death by suicide, especially of a young person, one never forgets the details of a life ended too soon and the haunting questions of; what did I not see, what could I have done? I hope the information contained in this report will help you in your work with our young people.
About the Collaborating Organizations

Texas Department of State Health Services

Following the merger of multiple state agencies, the Texas Department of State Health Services (DSHS) was formed in 2003 and took the lead for suicide prevention in Texas by recognizing suicide prevention as a public health problem. Currently, Texas is committed to advancing the mission and work of the National Action Alliance for Suicide Prevention and its strategy to attain a zero suicide outcome for the State. To that end, the Texas Department of State Health Services is working to bring a care system that embraces a goal of zero suicides to Texas. DSHS is building an infrastructure throughout the community mental health system where there is a trained and skilled workforce that has the capacity and confidence to intervene in a suicidal situation.

Furthermore, DSHS is working to ensure that the skills and tools necessary to assess suicide risk and the ability to use best practices and evidence-based strategies for suicide care are in place throughout Texas. By collaborating at the local, state, and national levels, DSHS is working to make sure that the core capabilities are in place to set up treatment plans that support each person for the elimination of suicidality. In a truly suicide safe care site, such agencies will also be supported by quality policies and procedures about suicide care with a system for continuous improvement.

Texas has created a statewide comprehensive suicide safe care system, Texas’ Suicide Safe Care: Zero Suicides in Texas (ZEST). The initiative, funded by a three-year SAMHSA cooperative agreement awarded to the Texas Department of State Health Services (DSHS), is aimed at improving access to mental health services and reducing suicides among youth, ages 10 to 24, at risk of suicide. In partnership with the University of Texas and Mental Health America of Texas, the project will focus on enhancements to the Texas public mental health system to improve service delivery for children, youth, and young adults with serious emotional disturbances or severe or persistent mental illness. This Suicide Safer Schools report is a first step at looking at how some of the Suicide Safe Care concepts can be expanded and implemented in Texas schools. Jenna Heise, Suicide Prevention Coordinator for the state is the primary DSHS contributor to this report.

Additional information and resources can be found at:

http://zerosuicide.sprc.org/
http://www.dshs.state.tx.us/mhsa/suicide/Suicide-Prevention.aspx
Mental Health America of Texas

Mental Health America of Texas has partnered with the Texas Department of State Health Services and its predecessor state agencies on youth suicide prevention statewide programs since 2005 when Texas was first awarded a Garrett Lee Smith Youth Suicide Prevention Grant. It continues as a partner in The Texas Youth Suicide Prevention Project and the Zero Suicide Texas Program which provides public awareness, outreach and training in suicide prevention. Mental Health America of Texas also serves as the facilitator and fiscal agent for the Texas Suicide Prevention Council which is charged with the development and updating of the Texas State Plan for Suicide Prevention. As the state’s largest and longest-serving mental health education and advocacy group, Mental Health America of Texas has also been a leading force for effective advocacy and public policy for mental health and suicide prevention. Merily Keller is the Suicide Prevention and Postvention consultant/contributor to this report with assistance from consultant Mary Ellen Nudd, and Kimberly Williams, Suicide Prevention Program Manager for Mental Health America of Texas.
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Covey, S. (2008). The Leader in Me: How Schools and Parents Around the World are Inspiring Greatness, One Child at a Time. Salt Lake City: Franklin-Covey.

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After a Suicide: A Toolkit for Schools
http://www.sprc.org/library/AfteraSuicideToolkitforSchools.pdf
This handbook provides a broad consensus regarding the best ways to deal with a tragic loss in a school community and to promote a coordinated crisis response in order to effectively manage the situation, provide opportunities for grief support, maintain an environment focused on normal educational activities, help students cope with their feelings, and minimize the risk of suicide contagion. Step by step guidelines are provided and the overall strategy that all deaths needs to be treated the same as much as is possible. Sample letters to send to parents are also provided.

Preventing Suicide: A Toolkit for Schools

http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669
This document from SAMHSA assists high schools and school districts in designing and implementing strategies to prevent suicide and promote mental health. Included are tools to implement a multi-faceted suicide prevention program that responds to the needs and cultures of students.

This book distills the best current knowledge on child and adolescent suicide prevention into comprehensive guidelines for school-based practitioners. The authors based on a wealth of experience provide best-practice recommendations for developing school wide prevention programs, conducting risk assessments, and intervening at different levels of intensity with students at risk. Also presented are postvention procedures for responding effectively if a suicide does occur. Legal and ethical issues are also addressed in detail.

Los Angeles County Youth Suicide Prevention Project
http://preventsuicide.lacoe.edu/index.php
The Los Angeles County Youth Suicide Prevention Project (YSPP) is a joint effort between the Los Angeles County Department of Mental Health (LACDMH), the Los Angeles County Office of Education (LACOE) Center for Distance and Online Learning (CDOL), and the Los Angeles Unified School District (LAUSD). The YSPP website has been expressly developed for the 80 school districts within Los Angeles County, to provide administrators, staff, parents, and students with the most up-to-date information, protocols, materials and resources on the prevention of youth suicide.

**Nova Southeastern University, Suicide and Violence Prevention Office (SVP)**

The Suicide and Violence Prevention office received a GLS grant and developed training videos on the following topics: Suicide Awareness, Suicide Assessment, and Suicide Prevention/Postvention in Schools and Critical Issues in Self-Injury. The videos are available at no charge. SVP also publishes a quarterly newsletter with interviews from experts in the field. All videos and the newsletters are available at [www.nova.edu/suicideprevention](http://www.nova.edu/suicideprevention)

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*This report was developed [in part] under a grant number SM61468 from the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS) and the Texas Department of State Health Services (DSHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA, HHS or DSHS.*