Guidelines for Making Effective Referrals

School personnel often have to refer students to other community services for a wide variety of problems that commonly surface among their students. In fact, any community consists of a *network* of services and agencies that constantly refer clients to each other. While making referrals is a common activity, it is done with varying degrees of success. That is, it is not easy to make a referral that is equally acceptable to the person making the referral, the person being referred, and the person receiving the referral. Accomplishing this involves not only obtaining the right services for the student but also maintaining open communication and smooth working relationships with other agencies.

Referring an adolescent for counseling or other mental health services, in fact, turns out to be one of the more difficult "handoffs" to accomplish. Research has shown that few of these referrals are followed up on, or, if the adolescent does complete an initial appointment, he or she often fails to return for subsequent appointments.

There are probably many reasons (besides the manner in which the referral was initiated) why this is so. However, there *are* ways of making referrals that increase the likelihood of a successful handoff. These techniques can be roughly divided into three categories:

1. Involving the student in the referral
2. Involving the parents in the referral
3. Considerations involved in the referral process

The first category contains guidelines that have relevance for school administrators or other designated officials to whom troubled students are referred within the school, as well as for classroom teachers or other school personnel who have contact with students. The last two categories contain guidelines for mainly administrators or officials who make contact with parents and other community agencies.

Again, for our purposes here, an effective referral is defined as one that seems acceptable or appropriate to the person making the referral, to the person or agency receiving the referral, and, at least to some degree, to the student and parents who are being referred.

INVOLVING THE STUDENT IN THE REFERRAL

1. Clarify the Problem

This may sound obvious, but it is not uncommon for referrals to be made before the nature of the problem has been clarified. This results in inappropriate referrals that annoy the student,

the referral source, and you. By taking the time to listen and clarify the concerns, you accomplish at least four things:

- Obtaining the information that you need to support your decision to refer and to make a correct referral
- Showing the student that you understand his or her concerns and thus have some basis for your recommendation
- Sending the student to a valuable resource and not just away from you
- Showing acceptance and understanding, thus establishing some rapport without which suggestions or directions are unlikely to be accepted

Even if you know that the student needs additional help before he or she walks into your office, take the time to listen. Referrals work best if they are the end of a process, not the beginning.

2. Address the Reluctance

Give the student a chance to talk about his or her reluctance to accept the referral. A simple way to address this is to ask, "How does this sound to you?" or "How do you feel about my suggesting this?" or "How do you feel about talking to _____?" Pay attention to nonverbal cues such as tone of voice and body language as well as to what the student says.

Some feelings that may interfere with the student's acceptance of the referral include:

- Rejection: "Why can't you help me?"
- Hopelessness: "If you can't help me, nobody can!" "Going for counseling means I'm sicker than I thought."
- Anger: "I thought you were supposed to help me." "I'm tired of telling my story." "You're just trying to get rid of me."
- Concern about parental reaction: "My parents will kill me if they find out I told someone all of this." "They told me if I cause one more problem they will kick me out." "You're crazier than I am if you think my dad would pay for a shrink."

It's very important to address any expressed concern that shows reluctance to follow up on your referral. Ignoring the teen's feelings doesn't make them go away. Addressing them provides the opportunity to clear up misconceptions and speak to the teen's fears about mental health treatment. In addition to acknowledging concerns, you may also offer to accompany the student on the next step in order to smooth the transition.

Sometimes, however, despite your best efforts, the student remains unconvinced about the need for a referral. At this point, it may be best to acknowledge the disagreement, indicate that you would rather be safe than sorry, and invite the student to share his or her concerns

again with the person to whom he or she is being referred. Once rapport has been established and the student at least feels listened to, many educators have developed ways of "framing" the handoff with the student. For example, some may have an agreement with the student that the student is following up not necessarily for himself or herself, but to make the school official feel better.

INVOLVING THE PARENTS IN THE REFERRAL

Once you have determined that a referral is indicated, the student's parents must be contacted. Each school has its own procedure for contacting parents. Some schools require that all such contacts be made by one person such as the principal, vice-principal, or other designated official. It may be a good idea to find out if another faculty member or staff person has had prior contact with the parents and could best make the contact.

Regardless of who makes the contact, a phone call to the parents/guardians to let them know that you are concerned about their child and to ask them to come in for a discussion is an appropriate first step. Make sure you have as much objective evidence as possible to support your concerns. Parents sometimes see their child's problems as a reflection of their parenting and may therefore be defensive about accepting the idea that their child needs professional help. Or, they may hold stereotypic or negative ideas about mental health treatment that affect their response to your suggestions. It is best to briefly state what you have *seen* that causes you concern (rather than make an inference about what the causes for the behavior might be); then ask the parents if this fits with anything they have seen or know that has been going on with the student. This invites the parents to join with you in a discussion about their child, rather than receiving a "report" from you. As with the student, explore the reasons for their reluctance to the referral, then address them directly.

As most school officials know, many parents will accept a referral suggestion. Here, we are considering those parents who may be resistant. You may find that you need to restate your concerns several times before they sink in. With some parents, you may need to appeal to their "good" parenting: "I know you want to do what's best for your child." Unfortunately, with others you may have to resort to pointing out possible consequences of not taking action at this time.

As with the student, your best efforts may leave the parents unconvinced of the need for a referral. This presents a substantial dilemma when you feel that the risk of a suicide attempt is high or where there has been an actual attempt.

The issue almost always arises in consultations with school officials, and there is usually a discussion about involving a child protection agency in such situations. States have different laws regarding the involvement of a child protection agency, and there is even greater variance in their application to suicidal risk as opposed to physical abuse. At this point, it is recommended that superintendents, in consultation with lawyers and/or legislators, develop a policy for this situation.

CONSIDERATIONS INVOLVED IN THE REFERRAL PROCESS

The following are points to keep in mind when initiating the actual referral. Again, they are aimed not only at making better handoffs but also maintaining good working relationships with other community services.

a. Know your local mental health resources. While some communities have only one agency that provides mental health services, many communities have a variety of agencies that meet these needs (e.g., local community mental health center, family services agency, crisis services). Some agencies many even have special services for adolescents. An awareness of community resources will help you make a referral that best meets the student's needs. A personal contact or liaison with a staff member in these agencies can also facilitate the referral process.

b. In cases where you request to have the student evaluated for suicide risk, you need to make sure that the person or agency has the ability to hospitalize the teenager if it seems necessary. Referring to an agency or person without that capacity (e.g., clergy, mental health clinic without psychiatric affiliation) just adds another step to the process at a point when timely action is needed. So when you're checking out your referral source, make sure to inquire about this.

c. Even if a variety of sources could provide the service that the student needs, it is best to select just one for your referral. More than one referral can be confusing at a time when the family's decision-making ability may already be taxed.

d. Try to match the family with the resource available. Anticipate difficulties if the agency is geographically distant and the family lacks transportation. Check other resources that may provide the appropriate counseling service. It will require your spending extra time now, but it could save you time later. If possible, use a referral that is congruent to the family's background and resources (e.g., religious affiliation, cultural background, financial resources). Don't send a low-income family to a private practitioner whom the family can't afford.

e. If you feel that the situation is an emergency, set up the referral yourself before the family leaves your office. Call the referral source and let the staff know you are sending the family immediately for an evaluation. Again, be clear about your reasons for the referral.

f. If you feel comfortable letting the family set up the appointment, make sure to give the complete information about the referral. This includes the name of a person at the agency to contact, phone number, address, directions from school or the family's home, information about cost, and so forth.

g. Do not commit your referral source to a specific course of action by implying or promising to the student or parents that the agency will definitely work with the teen, hospitalize or not hospitalize, and the like. Your previous arrangements with the referral

agency will only ensure that the agency will see the student. After that, the agency must be free to decide the most appropriate course of action.

h. It is best to not make evaluative comments about other agencies or individuals in your community. Your prior arrangements with your referral sources imply your acceptance of their practices and personnel. Any questions about the competence, responsiveness, and so forth of specific agencies or individuals are best deflected with the statement that you are only familiar with those agencies with which you have specific working arrangements. That being said, if a student or parent returns with a complaint or concern about your referral source, it is best to obtain specific details, and follow this up immediately with that agency in order to clarify any misunderstandings about services or procedures.

i. Indicate to the family members your intention to follow up with them and the referral source. Ask them to sign a release of information at the referral agency to allow you to receive limited information about the outcome of the evaluation. Explain that it is imperative that the school coordinate its response with that of the mental health professionals in order to continue to provide a supportive environment for their child. Without the family's specific written consent, this will be impossible. Let the family know that you only need information that relates to the treatment plan, not details about the life of the family.

Your school has the right to obtain such follow-up information in order to ensure the proper responses to the student who is in treatment or has been recently discharged from treatment. Remember that the risk of suicide is very high in adolescents who have made attempts serious enough to be hospitalized (about 1 in 13 for males; 1 in 340 for females). You need information about medication, recommended management, and the number of academic requirements to be placed on the returning student, just as you would require for a student returning to school while recovering from any illness or injury.

Unfortunately, some mental health agencies do not provide such vital information to schools, considering this a breach of their client's confidentiality. Establishing a working relationship between the school and the local mental health provider prior to an actual referral can resolve this issue. It is imperative for schools to have some information that allows them to provide appropriate supports for their students and to avoid conflicts with the students' mental health treatment plans.

Some schools have a policy that they will not accept a student back into the school if such information and joint planning are not in place. Again, having clear prior arrangements and solid working relationships with community agencies will generally satisfy such policies.

Schools must assure mental health providers that they have clear policies about sharing information only with those who have a clear "need to know." Unfortunately, many schools do not do an effective job of maintaining confidentiality in regard to students in these situations. Only faculty who will be interacting with the student should be provided information

about the student, and this information should be specific to their particular interaction with the student. For example, a classroom teacher may need to know what schoolwork was completed while the student was out and whether the student can complete regular assignments. The school nurse should know about medications and when they are to be taken. Such information should be shared in private and "faculty lounge" discussions should be strongly discouraged. If faculty members or other school personnel feel that they need to know something about the student's situation, they should contact the person designated to coordinate transition back to school.

Frequently Asked Questions about Youth Suicide

Q: Will talking about suicide give people the idea to do it? Could we do more harm than good?

A: Talking about suicide does not cause suicide to occur. In fact, it can be an excellent prevention tool. People who are not suicidal reject the idea, while people who may be thinking about suicide usually welcome the chance to talk about it. Often they are relieved because they feel that someone else recognizes their pain. Talking breaks the secrecy that surrounds suicidal behavior, and lets people know that help is available. By not talking about suicide, we increase the isolation and despair of individuals thinking about it.

Q: What causes suicide?

A: Suicidal behavior is one of the most complicated of human behaviors. This question cannot be answered briefly. There is no research that shows that a particular set of risk factors can accurately predict the likelihood of imminent danger of suicide for a specific individual. It is fair to say that suicidal people are experiencing varying degrees of external stressors, internal conflict, and neurobiological dysfunction and that these factors contribute to their state of mind. Depression, anxiety, conduct disorders, and substance abuse all contribute to the possibility of suicide, but they do not cause suicide. A "final straw" for suicide is usually the last thing that a person who kills himself or herself is thinking about, and many left behind want to blame that person or event, but the final straw was NOT the cause of the suicide. Many people who kill themselves had no final straw that others could see. The reasons behind a suicide often remain a mystery.

Q: Doesn't suicide happen mostly in troubled individuals who come from difficult family situations?

A: NO. It is really important to understand that suicidal behavior occurs in all socioeconomic groups. People of all ages, races, faiths, and cultures die by suicide, as do individuals from all walks of life and all income levels. Popular, well-connected people who seem to have everything going for them and those who are less well off both die by suicide. Suicidal youth come from all kinds of families—rich and poor, happy and sad, two-parent and single-parent. To suggest that suicidal youth come only from "bad," "sick," or "neglectful" families is like saying that only these kids get cancer. Historically, our culture has blamed the families of people who die by suicide and this behavior must stop. Suicide can happen in any family. We all must work together to identify and prevent suicidal behavior.

Q: Don't most suicides happen without any warning signs?

A: There are almost always warning signs, but unless we know what they are, they can be very difficult to recognize. That is why suicide prevention education is so important. Research has demonstrated that in over 80 percent of deaths by suicide, a warning sign or signs were given.

Q: Are people who talk about or attempt suicide just trying to get attention?

A: People who talk about or attempt suicide need immediate attention. They are trying to call attention to their extreme emotional pain. Many believe that we should ignore these "cries for help" and "attention-seeking behaviors" because the attention will only encourage the behaviors. Suicidal individuals are trying to get attention the same way people shout if they are drowning or are injured.

Q: Is suicide preventable?

A: Yes, suicide may often be prevented. Many people believe that if someone is suicidal, there is nothing that anyone can do to stop them from killing themselves. Some also believe that those who don't kill themselves on the first attempt will keep trying until they die. The truth is that most young people face a suicidal crisis only once in a lifetime. A suicidal crisis is usually very brief, lasting from a few hours to a few days. With intervention and help, future attempts may be prevented. Experience and wisdom are gained in solving problems in other ways. While suicide is not always prevented, suicide prevention is ALWAYS worth trying.

Q: Why is there so much concern about youth suicide? It's a rare event, after all.

A: Suicide *is* a rare event. However, people of all ages kill themselves and we need to be concerned about all of them. There are traumatic effects for families, friends, and community members when any person dies by suicide. It is particularly tragic when a young person's life is cut short. There are many reasons to focus on preventing youth suicide. Suicide is the third-leading cause of death among youth between the ages of fifteen and twenty-four. The younger the age of the person who dies by suicide, the greater the number of years of potential life lost.

Suicidal behavior among young people is a much larger public health concern than what is represented in death statistics. Compared to suicidal behavior among older people, suicidal behavior among young people is more likely to result in an emergency department or hospital visit. Also, if we appropriately and adequately address children and youth at risk, suicide attempts and completions among adults may be decreased.

Q: What is meant by "suicide contagion" or "copycat suicide"?

A: These words describe a process by which exposure to suicide or suicidal behavior of one or more persons influences others who are already troubled and thinking about it to attempt

and/or die by suicide. Sensationalized and repetitive media coverage of suicide has been associated with a statistically significant excess of suicide, particularly among adolescents. Several well-publicized "suicide clusters" have occurred. While there is no precise definition of a "cluster," it is fair to say that it needs to be considered when more suicides than would be statistically expected happen within a particular geographic area or within a given time frame. The individuals who die may or may not have known each other, but somehow they may identify with each other. Often there are similarities in the manner of death. While one person's death is not the cause of another's, there may be shared vulnerabilities.

Q: What is a suicide pact?

A: A suicide pact describes the suicides of two or more individuals (close friends, lovers, etc.) that are the result of an agreed-on plan to complete a self-destructive act. The plan may be to die together or separately, but closely timed. Suicide pacts are a very real part of suicidology, and historically have been presented in fiction as well as fact. After any suicide attempt or death, it is important to question whether anyone else knew about these plans to try to determine if there is any kind of a pact.

Q: Are gay and lesbian youth at high risk for suicide?

A: Research studies vary greatly in their estimates of gay, lesbian, bisexual, transgender, and questioning (GLBTQ) youth who die by suicide. Recent analyses of research indicate that even though adolescents who report same-sex romantic attractions or relationships are at two to three times the risk for suicide attempts, the overwhelming majority of these youth report no suicidality at all. The risk factors of discrimination, victimization, bullying, and so forth, whether gay or straight, no matter what race or ethnicity, are important to consider in suicide prevention. Further research needs to be done on the risk factors as well as the unique strengths that characterize the lives of sexual minority adolescents and young adults.

Q: Isn't it up to mental health experts to figure out how to manage youth who want to kill themselves?

A: Mental health workers are a key resource in responding to suicidal youth. They are trained to provide therapy and/or manage crises. It is important, however, to realize that anyone can learn how to intervene in suicidal behavior in basic, life-saving ways. It is up to all of us to become educated about suicide, get involved in community prevention efforts, and learn how to access help for someone who is feeling suicidal.

Q: Are some car crashes really suicides?

A: It isn't known how many, but it has been estimated that perhaps 30 percent of single-occupant fatal car crashes are suicides. These cases usually involve a car that hits a fixed object with no evidence of skidding, braking, or other evasive actions. Alcohol and drugs may

or may not be involved. Actual "autocides" are when the driver leaves a note indicating that he or she used a vehicle as a means to die. On rare occasions, more than one person may be in the vehicle.

Q: What is the connection between self-harm and suicide attempts?

A: Self-harm is defined as a deliberate and usually repetitive destruction or alteration of one's own body tissue, without suicidal intent. Other terms used to describe this behavior include cutting, self-injury, self-mutilation, self-inflicted violence, and auto-aggression. It appears that self-harm and suicidal behavior both occur in all gender, racial, education, sexual preference, and socioeconomic groups. Another commonality is that self-harm and suicidal behaviors are being seen in younger and younger individuals.

While difficult to distinguish from a suicide attempt, it is important to understand that the person who engages in self-harming behavior does not intend to die as a result of his or her actions. The behavior is used to gain relief from intense emotions, to calm and soothe. It is possible for self-harm to result in accidental death and it is also possible for suicidal and self-harming behaviors to co-exist in one person.

NOTES FROM THE FIELD

MAINE SCHOOL-COMMUNITY BASED YOUTH SUICIDE PREVENTION INTERVENTION PROJECT of the Maine Youth Suicide Prevention Program (MYSPP)

September 2002 through October 2006
Funded by the Centers for Disease Control and Prevention
Targeted Injury Intervention Project
Grant Number U17/CCU122311

I. Background and Introduction:

In 2002 the Centers for Disease Control and Prevention (CDC) issued a "Request for Proposals for Targeted Injury Prevention Programs" to support implementation and evaluation of promising or best practice injury prevention interventions by state injury prevention programs. The CDC received fifteen proposals/applications, seven of which were suicide prevention proposals. The Maine Injury Prevention Program (MIPP) in the Department of Health and Human Services, Maine Centers for Disease Control and Prevention (Maine CDC), Division of Family Health, coordinates the multi-departmental Maine Youth Suicide Prevention Program (MYSPP). Maine was one of four states awarded funding. Two of the four states, Maine and Virginia, were funded to conduct suicide prevention interventions. Two other states were funded to conduct falls prevention interventions. The MIPP Intentional Injury Prevention Program Manager submitted the application and served as the Project Director throughout the project. Sub-contracts were established for the Project Coordinator, project evaluators and a suicide prevention consultant. The funding was awarded in the fall of 2002. To allow for three full years of data collection and analysis and completion of all project activities, two extensions were permitted, bringing the total grant period to four years ending in October 2006.

Five years before this grant application, in 1998, the MYSPP had developed a comprehensive state plan for youth suicide prevention. The Governor and the Maine Children's Cabinet, a group representing the Departments of Education, Health and Human Services, Public Safety, Labor and Corrections, encouraged creation of the plan. Years before applying for the CDC grant, the MYSPP had assessed needs, developed teaching tools and educational resources and gained experience with offering and evaluating several training programs. In addition, the "Lifelines Program" had been piloted in 21 Maine schools, working with John Kalafat, co-creator of the program. The

"Lifelines Program" is a promising practice school-based program designed to assist schools with the preparation steps to safely introduce suicide prevention to an entire school community. Program components include developing administrative protocols, agreements between schools and crisis service providers, suicide prevention education for all school staff and suicide prevention education for students.

The availability of the CDC funding, together with the MYSPP readiness to provide needed training and technical support to Maine schools and our experience with the Lifelines Program, allowed us to develop an exciting proposal. We were clear about what we wanted to accomplish and thrilled to finally have the opportunity to fund local schools to institute a comprehensive approach to youth suicide prevention for their students. Prior to this grant opportunity, MYSPP training programs and other resources were available and a few people in a large number of schools had gained varying capabilities to prevent youth suicide in a piecemeal way. While evaluation of gatekeeper training had demonstrated that those trained maintained increased confidence in their suicide prevention intervention capabilities, we knew that to make a real difference in Maine schools, a few people working in isolation within their schools was not enough. The opportunity to work with a small, manageable number of schools to institute and evaluate comprehensive suicide prevention programs was a dream come true for the MYSPP.

After four years, the Maine School-Community Based Youth Suicide Prevention Intervention Project is now completed. Both a technical and a general evaluation report documenting evaluation findings were developed and will be released in January 2007. Documents detailing specific aspects of evaluating the Maine Gatekeeper training and Maine's implementation evaluation of Lifelines Student Lessons are in development. Throughout the project, we have received questions and requests for information from other states desiring to implement similar efforts. These "*Notes From The Field,*" developed by the project coordinator with the project schools, are presented in response to the most frequently asked questions we have received with the intent of offering a different perspective from the aforementioned technical and evaluative reports.

Copies of all of these reports and other MYSPP resources mentioned in this report are available through the Maine Youth Suicide Prevention Program via our website at http://www.mainesuicideprevention.org, or by contacting the Information Resource Center of the Maine Office of Substance Abuse the Department of Health and Human Services at 207-287-8900, 1-800-499-0027 (Maine only) or online at osaircosa@maine.gov.

II. What was the goal of the project?

The overall goal of the project was to increase the readiness of 12 school systems to reduce suicide crises; intervene effectively in suicide crises; and manage the school environment in a crisis through implementation of the comprehensive Lifelines Program. In other words, to increase the likelihood that school administrators, faculty, other staff, and students who came in contact with students at-risk for suicide would: 1) have enough knowledge to recognize the behavior; 2) have the confidence to provide an appropriate initial response; 3) know where to turn for help; and 4) be inclined to do so.

The likelihood of encountering suicidal behavior in adolescents is very real. Thankfully, most of the behavior does not end in death. The stories at the end of this report will attest to that fact. Conservative estimates suggest that for every young person who dies by suicide, there are at least 100 others who attempt. It is very important to understand that while the goal of this project was ultimately to prevent deaths, it was equally important to focus on early intervention so that death never became an option. Every single one of this project's objectives was related to early intervention for those at-risk of suicide.

III. What was the scope of the project?

The project was designed to work with twelve high school systems to support their efforts to implement a "comprehensive" suicide prevention approach and to evaluate the results. Prior to this funding opportunity, Maine schools were participating in several MYSPP sponsored training and education programs and taking a piecemeal approach to suicide prevention. With the exception of schools that already had established school health coordinator positions in place, it was rare that schools were able to prioritize suicide prevention highly enough to coordinate multiple components in order to create an effective safety net. Simply stated, the comprehensive approach to suicide prevention consists of: a) creating administrative guidelines for how to identify, respond and manage suicidal behavior; b) formalizing working relationships with local crisis providers; c) educating the entire (adult) school community, and then finally, d) educating the students about suicide prevention. Essentially this grant opportunity provided the resources necessary to allow schools to prioritize suicide prevention efforts, gather data and measure the results.

> ***Project Coordinator's Note:*** Throughout the project the word "comprehensive" suicide prevention program was used. In hindsight the word "complete" might have felt less overwhelming! In describing the project's purpose and results to others, the metaphor of a "Safety Net" has been used, with the four corners of the safety net being supported by: 1) administrative protocols; 2) crisis provider connections; 3) education for key gatekeepers and entire staff; and 4) education for students. The net receives extra support from all other resources designed to help at-risk students. Audiences "get it" immediately without question! Instead of feeling overwhelmed, the reaction is "of course" all four elements are needed to create a reasonable and prudent level of safety.

In addition, six of the twelve schools implemented "Reconnecting Youth (RY)," a daily, semester-long course for 9-12th grade high-risk youth. This program takes a peer group approach to building life skills. One critical aspect is that students make an informed choice to participate, rather than be assigned or forced to take the class. Three primary goals are emphasized: to increase school performance; increase "drug use control"; and improve mood management. RY has been shown to be effective for high schools students who are having a poor school experience, are behind in credits, have a drop grades or are skipping school and at risk of dropping out. RY teachers require special training and are important contributors to positive outcome for the students. The teachers serve as student advocates and play a crucial role in providing school support. Further information on implementation and evaluation of RY is presented in the public report and is not addressed within this document.

IV. How were the schools chosen? What criteria were used?

In December 2002, all Maine high school principals and superintendents were mailed an announcement inviting them to submit a proposal to conduct a "School Based Suicide Prevention Project" using an abbreviated "Request for Proposal" process. Project expectations and timelines were described and schools were given six weeks to submit their proposals. Twenty-six schools applied and twelve were selected. The schools represented different sized student populations, from Class A to D, in different geographic areas, and with different degrees of experience in coordinated school health particularly in suicide prevention. This was the first time that Maine schools were given the opportunity to participate in a comprehensive suicide prevention project and it was interesting to note the cross section of schools that applied.

The project application was well organized and concise to encourage participation. The expectations, expected timelines, budget guidelines, benefits and outcomes were clearly spelled out in the application material. Those interested were given a time frame within which to ask questions and the answers were supplied to all potential applicants. Proposals were required to address seven questions to which a point value was assigned and to complete a project budget. The highest possible score was 55. The criteria considered in the application/rating process included:

1. The school's existing framework of Coordinated School Health Programs
2. The description and qualifications of the individual identified to coordinate the grant efforts in the school
3. The readiness and capacity of the comprehensive school health education program and instructor(s) to integrate a unit on youth suicide prevention.
4. Evidence of the need to improve school capacity to manage suicidal behavior
5. Training and assistance needs of administrators, staff and students appropriate to the project
6. Experience with suicide prevention
7. Experience with crisis service providers and status of school crisis plan
8. A complete, accurate and reasonable budget (schools were informed that they would be awarded $8,000-$10,000 each year for three years. The six schools who agreed to implement Reconnecting Youth received $10,000, the others $8,000.)

Two teams, each with four reviewers were formed. All members were experienced in the grant review process and had various backgrounds including education, public health, school health and behavioral health. Each individual independently scored one-half of the proposals, and then met with their team to come to consensus on the scores of their assigned schools. The two review teams then convened to compare their scores and choose the final twelve schools. In the event that two schools were either tied or very close in score, each team was allowed to present more detail on those particular schools. All proposals made a good case for why they needed to address suicide prevention. Discussion led to the selection of 12 schools statewide with varying student population sizes and different levels of internal (school) and external (community) resources.

V. What were the staffing requirements for this project?

The project staff, generally speaking, consisted of 10 individuals all of whom contributed small amounts of time periodically throughout the four-year period. They included four University based evaluators, the MIPP Intentional Injury Prevention Program Manager (who also serves as the MYSPP Program Coordinator), representatives from the Department of Education and Office of Substance Abuse and two health educators. In addition, one 60% FTE project coordinator served as the central link to all the schools. The project coordinator changed 18 months into the project**.** Disruption to the schools was kept to a minimum because the individual who assumed the coordinator's role had served as the training coordinator from the project's beginning and had already developed working relationships with the schools.

Each of the twelve schools developed a team that was directly involved in carrying out project responsibilities. The school teams consisted of the school coordinator (a responsibility shared by co-coordinators in three of the twelve schools), a school administrator, several trained gatekeepers, and the health teacher(s). Participation patterns varied widely from school to school. Some schools had several people each do a small amount of work and some assigned the responsibility for all of the work to a few individuals. In every case the school coordinator assumed the bulk of the responsibility to implement the project and ensure data was provided to the evaluators. Amazingly, all schools finished the project with the same school coordinator at the helm! In three of the twelve schools, co-coordinators shared responsibilities and in each case one of the two changed positions, but the primary contact remained the same. Although administrative support varied tremendously, all of the schools accomplished what was expected.

The project coordinator visited each school multiple times, more often in the first year and second years, and less frequently the third and fourth years. Once expectations were clarified and activities up and running, communication flowed very efficiently via e-mail and phone. Almost always the needs of the schools were addressed immediately via e-mail; occasionally there was a one-day delay. The schools requested and appreciated e-mail contact over face-to-face meetings given the full schedules of the individuals involved. In the one or two schools that didn't have as much access to computers, phone messages, and the U.S. Postal Service worked well.

VI. What expectations were placed upon the schools?

The application packet included details on exactly what would be expected, and the schools were given ample time to question us. All of the schools were asked to implement the following components:

1. Develop Protocols (Guidelines) to address suicide prevention (before the behavior), intervention (if the behavior is present) and postvention (after a suicide).
2. Create Memoranda of Agreement (MOA) with local crisis service providers.
3. Educate their school community: gatekeeper training for key staff, awareness education for all staff members, Lifelines instructor training for health teachers, and outreach education to parents.
4. Provide Lifelines student lessons in suicide prevention (only after the adults in the school community received training and protocols were in place).
5. Participate fully in the required data collection processes as established by the grant's evaluation team.

School teams were also asked to attend two meetings per year, one in the fall and one in the spring to share progress and challenges. An orientation meeting at the start of the project required school coordinators, administrators, health teachers and RY instructors/facilitators to attend. Subsequent meetings were mandatory for the school coordinators, while other staff members were encouraged to come if at all possible. These meetings provided a focus on project expectations, opportunities to clarify and refine methods, time to recognize the constant progress being made and formed vital connections between the schools.

VII. Did the project require any major changes once it was up and running?

There were no major changes, however the expectations needed to be clarified every step of the way. School coordinators, MYSPP project staff, and project evaluators communicated regularly and concerns were addressed quickly. Project staff maintained flexibility and made adjustments in order to accommodate the realities of school processes. For example, it turned out to be too time consuming to collect data with the level of detail initially requested, especially for the Reconnecting Youth Groups. With minor shifts, the process became more manageable and the essential information was gathered.

The MYSPP approach to the project was built upon the expectation that project staff, school staff and project evaluators all had much to learn and that the only way to gain knowledge about how best to implement and evaluate the project was through an open process which welcomed and valued all ideas and concerns. The two questions we worked on together throughout were: 1) What would it take to make this happen? 2) What could be learned?

VIII. Were there "low points" during the project and what kept the schools motivated?

The schools were notified that they had been selected to participate in the grant in the early Spring 2003. They were very anxious to get started before the "end-of-the-school-year" responsibilities. Our project staff, however, could not proceed until IRB approval was obtained from the Maine CDC, a process that was required before school-based efforts could begin. The schools exhibited great patience even though ready to initiate project activities. While waiting the school coordinators concentrated on planning and scheduling the training events for late summer and early fall. The first semester of the 2003-2004 school year was very busy and by December all training activities were completed. It was a bit of a marathon and everyone participated fully. The remainder of that school year all schools concentrated on protocol development, formalizing their Memoranda of Agreement, providing suicide prevention awareness sessions to all staff, reaching out to parents and initiating the student suicide prevention lessons, and complying with all of the evaluation elements. The suicide prevention protocols, once developed and disseminated, served to inform everyone about where to turn for help and what to expect if suicidal behavior is identified.

In the second project year, protocol development remained a challenge and a few schools lagged behind on some of the expectations. The initial excitement of project initiation was over and there was still a long way to go. In spite of site visits to each school to set benchmarks and clarify expectations, the project coordinator sensed a need to provide an extra incentive. In early winter, the project team collaborated on an idea that served to attract the attention of the school coordinator in a productive and fun way! A school "report card" was developed to track progress on thirty three project related items with categories including financial and administrative items, rate of progress with implementation, numbers of staff and students trained, the submission of student logs as well as how the schools felt about the level of support they received from the project team. Some items involved actual ranking (i.e. low, medium, high), some required either yes or no answers and others requested numbers. The schools graded themselves and the project team also completed the same report card on each of the schools. This one page "report" allowed the schools to take note of exactly where they stood, what had been accomplished and what still needed attention. They were encouraged to accomplish tasks that needed doing and could ask for whatever help they needed to receive a "good report card."

It is fair to say that the schools responded very well to the report card. Many of them took immediate steps to accomplish tasks before they turned it in. At the spring meeting, the schools were given an expanded version of their "grades," reflecting not only how they rated themselves, but also how they were rated by the project team and how they measured up to an aggregate score for ALL of the schools. This was NOT a competition between schools. In addition, it was made very clear that project staff would provide whatever support was needed to make certain that every school completed the

project with perfect scores. This approach worked for the project team and the schools in what was truly a win/win experience.

In the summer of 2005, the CDC extended the grant period for an extra ten months to allow a third full year of data collection and analysis of student referrals and to continue support from project staff to sustain suicide prevention efforts in all twelve schools. At this point everyone was very comfortable with expectations and no special steps were necessary to keep the schools motivated. Early evaluation results were shared and the schools could see that the data were providing information that would be very valuable to other Maine schools and agencies and to other states as well. Seeing the results of their efforts transformed into data further motivated the school coordinators to continue collecting data.

IX. In what ways did participating schools involve parents?

The initial focus of the project was on establishing administrative protocols, creating the MOAs and providing several levels of training and education to staff. Outreach to parents and other community members was not emphasized to the schools early in the project as a significant component of the project. When the project team brought up this component to the schools, the coordinators were asked to think about what could be done that would be the most helpful. The goal was to provide parents with suicide prevention information and resources "in a deliberate and consistent manner" as opposed to conducting a one time "event." While this was a challenge for all twelve of the participating schools, each school decided what would work in their community and everyone carried out several "little things" that served to inform/involve parents. It should be noted that, of course, many of the school staff involved in the project were themselves parents of teens. The following is a list of some of the steps undertaken:

1. Parents and community members were invited to participate in gatekeeper training at the very beginning of the project.

2. A community night offering a one-hour suicide prevention awareness presentation with time for questions and discussion was offered twice. Information Booklets were provided and follow-up calls resulted.

3. Description of the Lifelines Student Lessons was provided at parent night-curriculum discussions, and with "Freshmen Awareness for Parents." These events provided opportunities to highlight the suicide prevention efforts of the schools and offer resource information.

4. Suicide Prevention information was mailed to parents of health class participants just before implementation of Lifelines Student Lessons. The purpose was to inform them about the lessons and to obtain passive parental consent for the students to participate in pre/post evaluation questionnaires.

5. One school's website included a brief description of the grant, its services, and a link to the MYSPP website for parents and/or students who wanted more information about preventing suicide.
6. The suicide prevention project was mentioned and information was available at parent conferences, individually with families, or anytime upon request.

7. Ongoing announcements were placed in school newsletters about the grant and suicide awareness and prevention information.

8. Individual parents were provided the MYSPP booklet in conjunction with referral resources and wallet cards whenever a student was identified as "at-risk".

9. Parents received information about a wide variety of services including, but not limited to suicide prevention, during open house and conference times.

10. School suicide prevention protocols were shared any time parents had a concern.

11. Linkage of suicide prevention activities and information to national campaigns for Mental Health weeks was made and publicized in September and May.

X. Were youth involved in helping to reach parents?

12. The Maine Youth Action Network, a statewide organization that partners with the MYSPP, enlisted youth in project schools to help update the MYSPP website.

13. Youth called upon local mental health agencies to sponsor "awareness nights" for their parents.

14. One school used Interactive Theater presentations to involve youth in sharing information.

XI. What did the schools identify as the key challenges to accomplishing the expectations of the grant?

A. **Protocol development:** Every single school struggled with this even though MYSPP provided extensive guidance to support their efforts. MYSPP identified that much of the resistance was based in confusion about the difference between policies versus protocols. Schools were worried about the potential of increasing their liability by putting too much in writing until they realized that developing the protocols provided them with guidelines to help plan for managing a crisis situation in advance of such a situation. Also, through the development process, they found that their protocols could be somewhat flexible to help them prepare for various situations and that the protocols provided invaluable guidance to school personnel in the midst of a crisis. Some schools involved a large number of people in the protocol development process while others assigned the responsibility to a small group. Ultimately, each school found a process that worked for them. Although schools

identified protocol development as the most significant challenge they faced, upon completion of grant activities all schools identified protocol development as the most valuable and rewarding aspect.

B. **TIME to do it all:** It is fair to say that suicide prevention is just one of many, many other concerns faced by schools and the only reason these twelve schools could actually prioritize the time to complete ALL of the steps was because they received financial support for added staff time to conduct their efforts. Once the initial pieces of a comprehensive program were in place, they were relatively easy to keep up and running.

C. **Formalizing a written "Memorandum of Agreement" w/ local crisis agencies:** This was an issue for only one school who preferred to maintain their good working relationship based on a history of working together and a handshake.

D. **Initial influx of referrals:** Most schools were surprised that, once their entire staff and student population were better informed about suicidal behavior and what steps to take to address it, they experienced a marked increase in the numbers of referrals. Crisis services were readily available, and everyone received the attention they needed, but extra time was needed to make sure that each student received the necessary support. Do not panic, but "be prepared" is the message!

E. **Communicating w/parents-especially when students transitioned back into school quickly (overnight):** Sometimes students referred for an assessment for possibly suicidal behavior were evaluated, deemed "not suicidal," and returned to school the next day. Often there wasn't adequate time for follow-up and this concerned some school personnel. On the other hand, they were pleasantly surprised at the willingness of almost all parents to talk when phone calls were made to check up on the student's well-being (after an assessment referral).

F. **Resistance on the part of important players** was a minor issue, and one that needed to be worked out differently depending upon the player and the school system. For a wide variety of reasons the resistance might have come from an administrator, health teacher, substance abuse or guidance counselor, or other staff members. In no case did the resistance foil the project. The school coordinators took the responsibility to manage the issues as they surfaced and sought assistance from the project team and other schools when needed. The resistance added to the coordinator's job, but it should be noted that all coordinators stayed on the project through completion.

G. **Reconnecting Youth**, the semester long course implemented for high-risk youth in six of the twelve schools, proved to be challenging for most of the six schools that elected to adopt the program. It was more difficult than expected to identify the teacher and prioritize the time to offer such an intensive course for the small numbers of youth who actually chose to attend. Students and teachers who managed

to complete the semester found it worthwhile, and suggested that more flexible versions of the concepts taught in Reconnecting Youth be identified.

XII. What did the schools identify as the major benefits of grant participation?

Upon completion of the entire project, schools were asked to identify the major benefits from having participated. The following list of benefits is shown in the order as prioritized by the schools.

A. **Protocol Development:** As difficult as this process was for schools, they ALL listed protocol development as the top benefit. The process helped them to organize crisis response to various risk behaviors and all types of student deaths. Interestingly, there were 34 deaths in the 12 schools over the three years of data collection, only one of which was a suicide. Protocols served the schools very well.

B. **Education:** The training and education at EVERY level was found to be extremely valuable for adults and students. It increased knowledge, changed attitudes and taught skills that resulted in the benefits below.

C. **Increased Safety Net:** All referrals were recorded and tracked, providing schools with the eye opening experience of just how frequently suicidal behavior surfaces. Along with the experience of helping the students referred came an increased confidence in the ability to make a difference, especially with early intervention efforts.

D. **Systematic Re-entry System After Hospitalizations:** As part of the protocols, a transition planning process was developed for students returning to school after a lengthy absence or hospitalization. This gave parents, students, and school staff an improved readiness to be supportive of returning students.

E. **Strengthened Relationships Between Schools and Crisis Service Providers:** Most schools had established long-standing working relationships with their local crisis service providers. However, two schools discovered that crisis service coverage was provided by two separate agencies and that they needed to strengthen the relationship with the less well-known provider. Another school became aware that with staff changes at the school and the agency, new relationships needed to be formed even if the services remained the same. All schools reported that the personal connections built between the school and crisis agency were advantageous for both.

F. **Stigma Against Seeking Help Reduced:** Stigma reduction was not something that was evaluated, so it came as a nice surprise that a few of the schools felt that their school climate changed as a direct result of the school community having

learned to talk openly and respectfully about suicidal behavior and take concrete steps to help support individuals for whom suicidal behavior was a concern.

G. **Mutual Support:** The twelve schools involved in this project were geographically widespread and very different in many ways. The length of this project provided the opportunity for them to learn from each other, support each other through tragic situations AND reach out and offer assistance to neighboring schools not involved in the project.

H. **Early interventions resulted in fewer emergencies:** It was reported that the extra work involved in accomplishing the project expectations ultimately resulted in fewer crisis situations and better management of those that did occur, whether or not the crisis was related to suicidal behavior.

XIII. Would the project schools recommend that other schools participate in similar programs, if available?

All schools were asked the following question: "If a *new* school was considering undertaking a similar project, and asked you whether or not it was worthwhile, how would you respond?" Their responses follow.

School A: It is well worth the time and effort to plan "in-depth" BEFORE a crisis happens. Mechanisms REALLY need to be in place to guide in times of crisis. It is good to have key contacts identified and updated on an annual basis in preparation for when the need arises. We thought our crisis plan was in reasonably good shape, but in fact this project helped us improve it enormously. Planning for suicidal behavior involves covering a lot of bases not previously thought about.

School B: As difficult as it was to actually prioritize the development of protocols to manage several levels of suicidal behavior, the process resulted in improved communication among school personnel and with crisis workers. School staff members as well as crisis workers change frequently and we found it very beneficial to formalize our relationship and touch base annually. We developed a deeper appreciation of each other's challenges and expectations. We used our protocols more than we imagined we would need to use them and our confidence in our ability to be helpful to a suicidal student improved measurably. The educational components of this project were all very valuable and they served to increase awareness of the issue, resources, and available support of everyone in the school including administrators, teachers, other school staff and even the bus drivers. It was all well worth the effort.

School C: This comprehensive approach gave our school the opportunity to reflect on what we already had in place and what else was required. It allowed us to better meet the needs of our student body.

School D: Our school was going through some difficult times when we took this project on and it was a challenge to prioritize and accomplish the required pieces. The overall

organization of the project and access to comprehensive resources and training made it all worthwhile for us. Initial resistance slowly but surely evaporated as we built a strong system for how to manage suicidal behavior. Our students responded very well to the Lifelines Student Lessons and that was a real plus.

School E: Planning for the possibility of suicide is an essential component of a crisis response plan. It is as important as having staff and students know basic first aid for other kinds of emergencies. This project builds the confidence to handle a situation with which most are not comfortable.

School F: It is much easier to do early intervention in possible suicidal behavior than to respond to crisis situations that in the long run take a lot more time. As a direct result of the program, we recorded fewer emergency situations. We believe that if we made a difference in ONE student's life then it is all worth it, and we know we made a difference for many. We were also surprised at how much the parents appreciated our follow-up calls when a student had been referred for help. They were nowhere near as resistant as we thought they might be.

School G: This project provided the education to markedly raise the awareness of suicide as an issue our school needed to be concerned about. It allowed people to discuss it in a more open manner. As a result our staff was able to recognize and intervene on behalf of our student population in efficient and appropriate ways.

School H: Having a comprehensive protocol and referral system greatly expedited our school's response to potentially suicidal behavior, student/staff deaths, and other crisis situations. Also, the Lifelines Student Lessons are an essential part of a comprehensive health curriculum and need to be supported by the other pieces including identification and referral systems.

School I: The comprehensive approach is very valuable. All staff and all high school students received awareness training. The public is also interested as indicated by the fact that materials disappear when on display. We have seen an increase in referrals resulting in an increase in early interventions. We truly believe that some of the stigma associated with suicidal behavior has lessened in our community.

School J: This project enlarged the safety net for BOTH students and staff. The staff is informed as to what to do and who to contact if they suspect any level of suicidality. The most important message to staff is that they do not have to "fix" anything…they only have to refer to those trained to handle the situation. The staff has grown closer due to mutual concern for the well-being of students. Continued education and awareness is invaluable.

School K: This project provided us with the know-how and opportunity to save lives after the suicide of a very well-known student at our school. It is as simple as that. Worth every bit of the work! The protocols were invaluable.

School L: All of the work was more than worthwhile because it increased awareness about youth suicide significantly and provided numerous opportunities for training on multiple levels. It provided a format for developing intervention and response plans and helped us to re-commit to a relationship between the school and our local crisis service providers. The project also served to break down barriers to issues such as the "we-can't-talk-about-suicide" myth and it gave us a useful common language to move forward in our planning. This was the most useful and productive grant I've ever had the pleasure to work on. The support for this project was extraordinary. We never felt lost in the shuffle of grant life.

XIV. Will the schools sustain suicide prevention efforts once the grant ends?

"Plans for Sustainability" were actually implemented during the third year full year of this grant. All components of the comprehensive plan were up and running in all schools. By the end of the project, the schools expressed some relief about the fact that they would no longer have to comply with the evaluation data collection process, but they felt little doubt that the essential program components were well established and that they would continue. The following comments were shared when sustainability was discussed:

A. Our school has several people trained as gatekeepers, including those who teach the Lifelines Student Lessons and Reconnecting Youth. Those individuals plan to continue to offer those curricula, and if we need additional people trained, we will see to it that they attend the necessary training. The local web site will be used as a tool for updates and informational purposes regarding suicide awareness for the parents and community.

B. We will maintain our protocols (keep them up-to-date) and remind personnel at staff awareness trainings. As needed we will send more people to Gatekeeper Trainings, and we will continue the Lifelines Student Lessons in our health classes. Thanks to MYSPP for keeping these trainings readily available and very affordable.

C. Our new hires will attend an awareness program and our staff will be updated annually with an informational packet on suicide prevention, just to keep it on the horizon!

D. Now that all protocols and the Lifelines student lessons have been incorporated into the comprehensive health curricula and firmly established, they will (have already) set the course for future work in this area. Future training for educators may be a challenge due to time restraints and budget issues.

E. The Lifelines teachers are strong supporters of the Lifelines student lessons, and as such, will continue to incorporate the program into their health classes when the funding ends. It is unclear as to whether RY will continue because the

numbers have not met our expectations for enrollment. I need to meet with the Superintendent about where he sees the project going after funding ends.

F. We receive tobacco settlement money that is currently utilized for some support services. We also receive in-kind contributions from Acadia Hospital. We continually struggle with funding streams. The District has picked up some responsibility for funding. What has helped in this is the fact that we have quantitative data on program success.

G. Our updated Crisis Plan now includes Suicide Prevention Guidelines and that plan in addition to staff trainings will be maintained after the funding has ended. The start-up costs were for stipends, subs, and travel and outside trainings. It was great having these funds as the groundwork took up time that was not available to us during regular work hours. It is motivating to be compensated for time spent outside of school. Professional development money is available to staff for professional training, so that will continue as needed.

H. We will create time for our team to reflect on what's working and how, when and what to continue.

I. We will promote continuance with the school board. There really isn't any financial burden to keep this going at this point.

J. Suicide Prevention is a high priority for our administration, school board, staff and community. We will train staff as necessary in Gatekeeper, Training-of-Trainers, or Lifelines Teacher Training with professional development money or other grant money. New staff will receive an awareness session during orientation and ALL staff will have a review every three years. All of this is stated in our protocols.

XV. What aspects of grant management did the schools appreciate most?

Participating Schools were asked to comment on: 1) what they appreciated about participating in this CDC project; and 2) what additional suggestions they would have for MYSPP if undertaking a similar project again. The responses below surfaced repeatedly.

A. Project Management Items Most Appreciated

1. Clear communication combined with a high level of on-going support (i.e. group interaction, one-on-one, e-mail and telephone support-all outstanding).

2. Ready availability for questions and consultations.

3. Clear expectations and deadlines – this was really helpful.

4. Two annual mandatory meetings – just enough to keep us focused on tasks-at-hand in the fall and appreciate our collective accomplishments in the spring. The meetings allowed us to learn from each other, support each other and share a sense of pride in the data for which WE were responsible!

5. Well-organized meetings that were well worth attending. We felt heard because MYSPP responded to our concerns and suggestions.

6. Inclusion-even in an isolated location, we never felt left out.

7. Ways to measure progress (i.e. rubrics, report cards, check lists); they helped us to move things along and offered standards and guidance.

8. Resource materials…the blue and white (free) "Informational Booklets," the Quick Books, the Gatekeeper Resource Book, the videos for the TOT and Lifelines…having all of the related "products" provided really was a huge help to us.

9. An annual calendar of regularly scheduled trainings because as Maine experiences the "graying" of school faculties, we can anticipate that there will be a lot of new staff needing training.

10. Project staff support is/was key to a project like this; no question went unanswered, no dilemma unresolved, lack of support was never an issue.

11. Flexibility, compassion, knowledge and an understanding of how schools function (or a willingness to learn) was most appreciated.

12. The recognition at the end of the project, the Celebration Summit was really fun and very much appreciated. We truly felt appreciated.

13. Continuation of occasional e-mails, notices on conferences, articles, information about related products and other relevant information is very helpful to our sustainability efforts…even though the project has officially ended. MYSPP should continue to have someone on staff stay in touch with us!

B. Additional Ideas for Project Management

1. Provide regional meetings so that coordinators could have met without the burden of travel, perhaps in between the two required meeting dates.

2. Provide teacher training in suicide prevention and awareness at the college level. Gatekeeper training should be a mandatory part of every college's education department requirements so that every new teacher has this training. Most new teachers, when faced with a student having suicidal thoughts, feel completely unprepared to deal with what is happening. (*Luckily, when this happened to me, I*

had the support of a solid guidance department who helped me identify the necessary resources for the student. However, I received no training in this field at all. Even in my school counseling graduate program there was very little practical training in suicide prevention. My first formal training in this area was a Maine Gatekeeper Workshop (attended in 2000.) Additionally, training at the college level might reduce the number of educators who are resistant, to varying degrees, to anything they perceive as "additional work." Some teachers in my building felt that, by giving them information about suicide intervention, they were being asked to do "just one more thing." I hear this all the time, about all sorts of educational programs. The efforts of the MYSPP seem to be focused at the secondary school and community levels, as they should be. However, I think adding to that an effort at the college level would secure the future of suicide prevention in public education.

3. Encourage use of mentoring system to help any new schools undertaking the implementation of a comprehensive approach to suicide prevention.

4. Insist that protocols be developed as a school community, so that they are based in what *really happens*, rather than on what a few think will happen!

5. Collect even MORE data from schools, especially detailed end of the year reports and interviews. The project was very important to me and I was ready to provide more information than was asked of me!

6. Don't let schools get overwhelmed with the details. Encourage them to complete one step at a time and spread out the work. It is accomplishable!!

7. Be patient with the new schools and at the same time be persistent without nagging about deadlines and other issues.

8. The school is a community unto itself, in many respects we operate in our own little world and it can be difficult to let others into our domain. Find the right person within the school system and you are golden for getting things accomplished.

XVI. What steps has the MYSPP taken to respond to challenges and recommendations of the CDC Schools?

1. After the initial Gatekeeper, Training-Of-Trainers and Lifelines Teacher Trainings were completed, the schools asked what was next! What else would be available for them to gain more in-depth knowledge? As a result, MYSPP now offers an annual "Beyond the Basics of Suicide Prevention" conference in the spring of each year. We feature national level speakers and offer more in-depth opportunities to learn about suicide prevention and related topics. This conference serves to keep the interest and connection between the twelve schools and many, many others statewide. Attendance has significantly grown and the

third “Beyond the Basics of Suicide Prevention” conference will be offered in April 2007.

2. The MYSPP learned much from the experience of protocol development in the twelve CDC schools. It was the #1 challenge. As a result we have developed a “Readiness to Manage Suicidal Behavior” Survey, an assessment tool that asks administrative, staff, parent and student related questions about preparedness to conduct suicide prevention, intervention and postvention activities. Upon completion, the school has a good idea of what they already have in place and what further work needs to be done. In addition we offer a new four-hour “Protocol Development Workshop” in which we discuss why protocols are necessary and how they help schools. The workshop and assessment tool, when combined with the **MYSPP Youth Suicide Prevention, Intervention and Postvention Guidelines-A Resource for School Personnel**, lessen the overwhelming challenge of protocol development. The guidelines were available to the twelve schools, but we found that the assessment tool and the additional workshop substantially increased their value.

3. The MYSPP has created mentoring opportunities between the twelve CDC school and six new schools involved in a new youth suicide prevention project funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2005.

XVII. Stories From The Schools

Participating schools were asked to chronicle events that happened as a direct result of their suicide prevention activities throughout the grant period. These stories, anecdotes, and accounts are not captured in the evaluation data, but provide first person accounts of the impact of the project in the participating schools. Each of the twelve participating schools had “stories” to tell, some of them relating to school experiences and some relating to individual student experiences. Summaries of a few of them follow.

1. The Memory Scrapbook…A Healing Memorial

Early on in this project, MYSPP facilitators came to our district and presented a full day gatekeeper training workshop. One of the agenda items addressed the importance of planning memorial activities to use after any type of death that will not contribute to the possibility of “copycat” suicide if, in fact, the death was by suicide. Less than a month later our school experienced a student death (non-suicide). When our district-wide crisis team met to discuss several aspects of our school’s response plan, we remembered the discussion about establishing guidelines for appropriate memorial activities. We knew that this was the time to set precedents that would serve us in the event that a future death might be a suicide. We remembered the idea of creating a “Memory Scrapbook” and agreed to try it, even though our postvention protocols hadn’t yet been fully developed.

What ensued that following week was very powerful. Students and staff alike shared their condolences, memories, thoughts and feelings in the form of poetry, letters, drawings, photos etc. Contributions to the book were made in the nurse's office, a non-threatening, supervised place. It was organized, tied with a beautiful ribbon and presented to the student's family after the funeral. Months later, the boy's parents shared very positive feedback. They said the scrapbook helped them enormously through the initial stages of their grieving process. It gave them great comfort to know that their son was important to many other people. Our school used the memory scrapbook memorial again later that year when we experienced another student death and again it was a very positive experience; this memorial activity is now standard protocol for our school. It is so important to have a consistent memorial activity for the death of a student, regardless of the cause of the fatality. This levels the playing field, prevents one incident from gaining more attention than another, and is meaningful to the grieving family members.

2. **Neighbors Helping Neighbors**

Last year a neighboring community lost a 9th grade student to suicide. The elementary school in that community sends several students to our high school, thus many of our students knew the boy who died and were very upset by the news of his death. In addition, the elementary school principal in this nearby town was concerned about the 8th graders still at his school who had been friends with the 9th grader and he was looking for guidance as to how to help. Our superintendent called me to ask for my assistance. I was able to share our protocols relating to managing the aftermath of student deaths with the principal. I also was able to recruit some of our gatekeepers to go to the elementary school and spend the day with the students and staff, facilitating quasi-support groups and providing resource information. As a result the neighboring school's principal and one of his staff subsequently attended gatekeeper training to learn more about suicide prevention, intervention and postvention.

Meanwhile in our own school, we immediately identified affected students from the neighboring community and invited these students to participate in a grief support group that met daily for about one week. Follow-up after the funeral was also done, and we kept an eye on those students for many months. I am sure that our training in suicide prevention and participation in the project was THE reason we were able to mobilize quickly and provide good support to the students and staff both in our school and at the neighboring elementary school. Thank you!

> ***Project Coordinator's Note:*** *Several similar stories to the one above surfaced illustrating how CDC Grant Schools provided outreach to neighboring schools. Some provided extra support in times of crisis, and others offered to provide suicide prevention awareness education and other related information to administrators and staff at neighboring schools. These efforts sparked interest in "new" schools who wanted to do more to prevent suicide.*

3. **The "Ultimate Gatekeeper" Notes Changes in Communication Patterns**

This story is a blend of anecdotal pieces received from our school nurse. Our protocols identify her as a resource and she is our "Ultimate Gatekeeper." As a result of the Lifelines student lessons, students have come to her with concerns they have about their own thoughts and feelings as well as concerns they have about their peers. Teachers also present concerns to the nurse much more so than prior to the gatekeeper training. Whether the concerns may or may not be directly related to suicidal behavior, the flow of communication is much improved. It helps all of us be more aware and watchful. Sometimes these concerns pile up for a particular student and alert us that they may be in more trouble than we might have guessed.

Our educational programming has always promoted the 'total' concern for our students' academic, vocational and emotional needs. The grant allowed us to put more things in place and reflect on our needs to better meet the emotional needs of our students. Without the grant, our opportunity to reflect and make improvements would have been minimal. Once we really started looking at the "needs" of our system, we realized we had to overhaul our crisis policy and develop protocols to assist in all areas of crisis management after a student death. Our plans were well received by the Administrative Team and presented to the School Committee for review and acceptance. Thanks to the CDC/ MYSPP Grant, our efforts were more encompassing than anything we might have attempted on our own. This grant allowed us to prepare a proactive approach with abundant support and a very positive outcome.

4. **Caring, Creative Juices Flow**

Schools who undertake a suicide prevention project may be very surprised by the high interest level of the students. Suicidal behavior is something about which they know a lot and care deeply. For example, one class of Lifelines students decided to create a DVD that would dramatize suicide prevention concepts they learned in their class. The Drama Club, after several months' worth of work, much professional advice and the involvement of a volunteer community-based video producer created a powerful suicide prevention film. It reinforces the concepts taught in the Lifelines student lessons and is a source of great pride among our staff and students.

5. **Postvention Planning Helps with ALL Sudden Traumatic Events**

In the span of thirty months, our school experienced the deaths of four students (car crash, suicide, drowning, mechanical accident) and four staff members (car crash, cancer (2), massive coronary). Although the grant related prevention activities were obviously focused on suicide, the postvention principles applied to any major traumatic death/accident. Our school would not have survived without having protocols in place. I know we saved kids' lives after the death of our student by suicide. I know our expertise

allowed his parents and sister the opportunity to grieve without guilt and with the right support system in place. When our school initiated early suicide prevention efforts back in 2000, we had no idea how important the work would become to the staff and students of the school district. Our suicide prevention protocols saved us from floundering and saved lives. I will go anywhere and tell anyone how worthwhile this program is. Our thanks to the Maine Youth Suicide Prevention Program, the Centers for Disease Control and Prevention, the University of Maine and the Muskie Institute for all they did.

6. **Recollections**

While as school grant coordinator I can't recall any one particular story that came as a direct result of our suicide prevention activities, I can say that there were numerous situations that intertwined with project activities. Each of the six student deaths we endured over the grant became woven into the fabric of our high school's tapestry. As a result of the suicide prevention training and assistance we received and then subsequently delivered to our staff, we were able to continue to maintain a safe environment for students as they grieved and struggled with loss, even though none of the deaths involved suicide. I recall each student who came for help for their own suicidal thinking, students who dragged their reluctant friends in for help, staff who were able to identify hurting kids and knew where to go/what to do. I recall panic-stricken parents calling for help and guidance because their child was identified for being "at-risk." I recall an increased awareness and effort to create more opportunities to deliver information through Lifelines student and community education. I recall being able to talk confidently about suicide and watch people learn to sit with their own fear about it. Uncomfortable? Yes. Essential? Absolutely!

7. **The Tide is Turning…Toward Trusted Adults**

As the person most directly in contact with the majority of students who are identified as possibly being at-risk for suicide, as well as those who have made a suicide attempt, I can honestly say I see a difference in the willingness of students to seek help from trusted adults. This is a direct result of the Lifelines student lessons, in which students learn that the adults in their school system are prepared to respond. During the several years prior to this CDC/MYSPP suicide prevention grant project, I worked as a contracted outpatient mental health provider in this school and personally experienced much less willingness by students to seek help from adults. I am absolutely convinced that, because of grant efforts, we circumvented some very frightening and dangerous behaviors. Every school in the country should have the resources we lucky twelve did! Thank you. ☺

8. **Suicide and Other Forms of Violence May Go Hand-in-Hand**

Last year a senior boy became despondent over the break-up of a relationship and threatened to harm himself. The problem grew with intensity as the parents of the ex-girlfriend believed their daughter was in jeopardy. They suspected that the boy might harm their daughter as well as himself and they did not want to send her to school. The

police were involved and the high school staff (community) was on edge as well. The high school staff and many of the juniors and seniors had received suicide awareness education earlier in the year and were able to talk about this issue openly but with discretion. As coordinator, with assistance from administration, I was able to direct the involved students and parents through the proper channels and minimize the effect on the general student body. Having the protocols in place was beneficial as it served to highlight the many actions needed to be taken to avert a disaster. Having forms that help with the documentation process also proved to be very helpful.

9. Friends Are The First to Know

We experienced a suicide intervention by a student for one of her friends. The friend was having some personal problems and asked her teacher to leave the classroom to go the restroom. The concerned student knew that her friend had a large bottle of aspirin with her and was afraid that she just might overdose. The concerned student requested a pass and went to check on her friend. Her suspicions were confirmed. The friend had begun the process of swallowing the entire bottle of aspirin. The guidance counselor was immediately contacted and crisis services provided. The once troubled student received help, graduated last year, is taking college courses through the outreach center in town and is doing very well.

10. A Tragedy Beyond Imagination

In the final year of this grant, our town experienced a tragic car crash that claimed the lives of four sisters. We immediately turned to our newly updated crisis response plan and it helped us enormously. Even though the deaths were not suicides, the crisis planning served us well. The tragic event happened during a vacation week so we needed a plan to contact staff and students. We also had an immediate need for trained professionals to aid in providing counseling to our students and community members. The protocols and "memorandum of agreement" gave us personal connections and instant responsive contacts. Within hours we had four trained therapists on site, plus three area school counselors. We contacted our local television station and announced that the high school would be open for both students and adults to use for working through immediate grief. MH professionals also helped us the next day, the day of the funeral and the first three days of the following week back at school. Numerous student referrals were made for further counseling during those three days. The gatekeeper training also helped in that several people who attended stepped forward and proved to be very helpful during this time. They were good listeners, understood the importance of having extra support available and had the confidence to recognize those for whom they had concern. Gatekeeper training taught them to be more aware of signs of trouble and where to make referrals within our school staff. The time we spent collaborating and creating our crisis management plans served us extremely well when this terrible tragedy stunned our community. Even in a collective state of shock and grief, we were able to do what needed to be done.

11. Inter-school Intervention

A student athlete from another school e-mailed a couple of our students expressing suicidal thoughts. Our students had completed their Lifelines student (suicide prevention) lessons and recognized the seriousness of the clues in the e-mail. Our students went directly to our school administrator who in turn contacted the other student's administrator who immediately followed up with the student about whom they were worried. Sure enough, he had a plan for suicide and the means to kill himself. An intervention occurred; the young man received immediate help. Several months have now passed and he is doing well…all thanks to an effort initiated by our students who knew that they needed immediate help from trusted adults and had the courage to ask for it. This is an example of the ripple effect and a chain reaction that works when both students and adults know how to intervene in suicidal behavior.

12. A Possible Pact

Two schools within 15 –20 miles of each other were called upon to intervene in suicidal behavior of a different sort. One school was actively involved in the CDC suicide prevention grant and the other school had been a pilot site in which MYSPP had tested some aspects of the Lifelines Program before applying for the CDC grant. On a beautiful May morning, a pilot school student reported that she found a message written on the girls' bathroom wall that divulged a 5-person suicide pact planned for a specific date, just over a week away. The pilot school took the threat very seriously, immediately took digital photos of the writing sample, and matched it perfectly with that of one of the young women they suspected might have written the message. The pilot school knew that this young woman had a cousin and other friends at the nearby school that might also be part of the pact. School #2 was a CDC grant participant, and when called and told of the situation, they took the concerns very seriously and responded by immediately sending key gatekeepers over to the neighboring school for a meeting. Through collaboration, the administrators, counselors, school nurses, key teachers etc. of both schools came up with lists of those about whom they were concerned in VERY short order. Crisis services were enlisted. Within that same school day, those students were interviewed, the pact participants and plans were identified, the "ring-leader" hospitalized, parents notified, referrals made etc.

In addition, one of the students interviewed suggested that there was "someone else," not part of the pact, who should be of concern. That "someone else" was a young man who had very recently planned his suicide in a fit of anger. Although not presently in a suicidal state of mind, his parents were called and he, too, received help appropriate to his circumstances. These two schools moved with remarkable knowledge and speed to intervene in what could have been a terrible tragedy and are to be applauded for taking the behavior seriously, responding immediately and knowing what to do.

13. **Resistance Raised Red Flags**

A female sophomore participating in the Lifelines student lessons was particularly resistant to the idea that anyone should try to prevent anyone else's suicide. She insisted that it was a person's right to choose whether they wanted to live or die. Her unrelenting attitude raised a huge red flag. After one of the classes one of this young woman's friends came to the guidance office and shared that the resistant individual had been doing some serious cutting. The school counselor followed up on this report and discovered that the cutting had done considerable damage and indeed, looked like a case of her practicing for a suicide attempt. An EMT assessed the damage, agreed with the seriousness of the cutting and recommended an assessment.

Her single parent mother was unresponsive to the idea of taking her daughter for an assessment, but two friends borrowed enough money to buy the gas needed to drive this girl some distance for an appointment at the mental health center. With help, this young woman has come full circle, has become emancipated from her parent, is living in a safe place, working part-time, doing EXCEPTIONALLY well in school and planning for her future. Her behavior may have very well gone unreported if not for the classroom lessons that not only opened a discussion about suicide prevention, but alerted several individuals to the seriousness of her actions and attitudes.

14. Self-referral

Immediately upon completion of the Lifelines Student Lessons and the signing of a "Help Seeking Pledge" acknowledging that everyone needs help at some point in their lives, a male student walked into the school counselor's office and self-referred, asking for immediate help. This young man was assessed for suicidality and found to be unmistakably self-destructive. He was hospitalized in an adolescent mental health unit for several weeks and received the help he needed. He is back in school reportedly doing very well.

15. Verbal and Written Clues Lead to Action

A student who had recently completed the Lifelines student lessons returned home from a baseball game one evening to find a troubling phone message from a girlfriend. The phone message was followed by e-mails with verbal statements including one that asked "what things of mine would you like to have?" Having learned that giving away prized possessions is possibly a warning sign of suicide, the student turned to her mother and asked for help because she was worried that her girlfriend might be thinking of killing herself. Together, mother and daughter called the police who decided to make a house call. The girlfriend's parents did not take the policeman's visit or their daughter's behavior seriously, insisting that she was "just trying to get attention." However, the mother did agree to bring her daughter to school the next day and meet with the school counselor who in turn offered to make a counseling appointment. The mother, very reluctant to enter into any kind of counseling, agreed that the school counselor could take her daughter to that first appointment. This troubled young woman

did convince her parents that she needed their support to continue counseling for a few months, and there have been no more episodes of suicidal behavior. Upon graduation, this young woman entered the military, attained an officer's rank and continues to do very well. This just goes to prove that with the right kind of help, suicide can be prevented and individuals can go on to lead full, productive lives.

XVIII. In Conclusion:

A Brief Note From the Project Director

As a person who has been deeply involved in the Maine Youth Suicide Prevention Program (MYSPP) since its inception, it is impossible to offer an unbiased perspective on this project. Long before the CDC grant became available, MYSPP had a vision of how to promote suicide prevention programs in schools. Our experience with the Lifelines Program had been positive and we wanted to build on that. We understood that when tragedy strikes, school protocols serve school crisis teams well. We believed that if the very caring people working with youth knew more about suicide prevention that they would intervene more often and earlier in suicidal behavior and possibly prevent more suicides. We firmly believed that if we could build confidence in health teachers' abilities to discuss suicide prevention within their health curriculum that they would integrate it into their already overloaded schedules. Student surveys indicated that the youth were very concerned about suicidal behavior. We believed that they would help their friends if they knew what to do and could get over the hurdle of feeling like they were betraying the confidence of their troubled friends. We truly believed we were on the right track and we were passionate about wanting to proceed.

What we didn't know was equally important. We didn't know whether or not schools would adopt our beliefs and values with regard to suicide prevention, and we didn't know what it would take for schools to be able to implement a solid suicide prevention program. Prior to funding from the Centers for Disease Control and Prevention, we didn't have the resources to fully support a comprehensive approach to suicide prevention and evaluate the results. This funding allowed us to bring knowledge and resources to the table and work collaboratively with a manageable number of schools to figure out how to do this work. The MYSPP project team and the schools worked hand-in-hand to figure out how to accomplish our goals. Now we know what it takes to make this happen, have learned much from the data collected and have already taken steps to strengthen our ability to support additional efforts. We are more convinced than ever that the implementation of a comprehensive suicide prevention plan is worthwhile and MYSPP will continue to build on this experience by seeking resources to bring this approach to other schools.

MYSPP has been asked what we would do differently if we could do it all again. This is a very difficult question to answer mostly because we know more now! However, given what we knew in 2002, there is very little this project coordinator would do differently. One small but significant change that might make a big difference would be to use the word "complete" instead of "comprehensive" when talking about the

desired suicide prevention program. The shift in language might make the process feel less overwhelming! The schools involved proved to themselves that this is doable, essential work. It makes sense, it is affordable and supportive of work that schools are already doing anyway.

The twelve participating project schools were, and still are, remarkable. Yes, they were initially overwhelmed at the idea of adding this to already full plates, but for a little bit of monetary compensation and a lot of support, they were willing to try. Each step of the way the momentum built, knowledge was gained, confidence bloomed, skills strengthened, young people were helped and lives were saved. All twelve schools maintained their project related efforts until the project's end and continue to sustain the key program elements. As project coordinator I am very proud of this project, its participants and the results. It has been an honor to be a part of it.
Respectfully submitted, Susan O'Halloran, Project Coordinator

A Brief Note From the Project Director

In writing the grant application to CDC, I personally felt tremendous concern about the possibility of one or more student suicides occurring at project schools, as, given the suicide rate among Maine youth, it was more than a remote possibility. I guess I was afraid that the project would be blamed for the death, thus diminishing the potential impact of the approach that we believed would really make a difference to Maine youth. As it turned out, tragically, there were 34 student lives lost in the twelve schools over the three years that data were collected. *That only one of these deaths was a suicide and that the school project staff reports demonstrated that the interventions conducted in the project schools did save numerous lives is something that we proudly share in the hope that others will try this approach and realize the same benefits.*

While mine was not a role that involved lots of direct contact with the school project staff, every time I did get the opportunity to speak with them or hear their presentations, I was extremely impressed by their commitment, their caring and their ability to keep going, even when major obstacles presented themselves. I cannot overemphasize how fortunate Maine is to have had the project team that we had for this work. Not only were we able to recruit talented people who worked well together and were very committed to implementing the project with fidelity, they were open to learning from each other and from the schools what would work best. They were flexible; making adjustments when indicated, and worked very hard to respect the challenges faced by the schools every step of the way. The creativity exhibited by all members of the project team and the schools added innumerable benefits. The school "report card" is one such example, but there were many others. All of this together led to many unexpected benefits, such as reducing stigma for seeking help, improving school climate and improving school preparedness to address many types of crises that might arise. I thank everyone who was involved in realizing the accomplishments that they helped to achieve!
Respectfully submitted, Cheryl DiCara, Project Director

Lifelines

Connecting *Lifelines* to the *Olweus Bullying Prevention Program*

Many youth who complete suicide often leave notes of despair, describing how they have been bullied by their peers. Unfortunately, "bullycide" is now a common term in American society. Research has shown that students who feel victimized by other students or school staff members have an elevated risk of suicidal ideation and behaviors. School boards and administrators are looking for research-based strategies to prevent bullying behaviors and also to find ways to prevent student suicide.

Lifelines is an evidence-based suicide prevention program that can be used effectively in schools using the *Olweus Bullying Prevention Program (OBPP)*.

ABOUT THE *OLWEUS BULLYING PREVENTION PROGRAM*

OBPP is the most-researched and best-known bullying prevention program available today. With more than thirty-five years of research and successful implementation around the world, *OBPP* is a whole-school program that has been proven to prevent or reduce bullying throughout a school setting.

OBPP is used at the school, classroom, and individual levels, and includes methods to reach out to parents, guardians, and the community for involvement and support. School administrators, teachers, and other staff members are primarily responsible for introducing and implementing the program. These efforts are designed to improve peer relations and make the school a safer and more positive place for students to learn and develop.

The goals of *OBPP* are:

- to reduce existing bullying problems among students
- to prevent the development of new bullying problems
- to achieve better peer relations at school

Research and experience suggest that to reduce bullying, it is important to change the climate of the school and the social norms regarding bullying.[1] Doing so requires effort from the entire school community—teachers, administrators, parents and guardians, and students. *OBPP* has been found to significantly reduce bullying by 20 percent to 70 percent.[2] Such schoolwide efforts have been found to be more effective than addressing bullying through classroom components alone.

For additional information about *OBPP*, visit www.olweus.org.

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1. "Best Practices in Bullying Prevention and Intervention." Tip Sheet 23 from Stop Bullying Now! Web site. www.stopbullyingnow.hrsa.gov/adults/tip-sheets/tip-sheet-23.aspx
2. Dan Olweus, Susan Limber, Vicki Crocker Flerx, Nancy Mullin, Jane Riese, and Marlene Snyder, *Olweus Bullying Prevention Program Schoolwide Guide* (Center City, MN: Hazelden, 2007), 4.

OBPP'S RELATIONSHIP TO SUICIDE PREVENTION

The initial research on "mobbing" or "bullying" was conducted by Dr. Dan Olweus and was sponsored by the government in Norway in response to the suicide of three young boys who had been bullied by their peers. Dr. Olweus's objective was to research the dynamics of this aggressive behavior and to determine how to stop the behavior within the school system. The *Olweus Bullying Prevention Program* was replicated in the United States and is now used in thousands of American schools reaching students from kindergarten to twelfth grade.

ABOUT *LIFELINES*

Lifelines is a suicide prevention program that is made up of four parts: administrative consultation, faculty and staff training, a parent workshop, and student curriculum. This comprehensive, research-based suicide prevention program is a whole-school program. *Lifelines* educates students on the facts about suicide and students' role in suicide prevention. It provides information on where to find suicide prevention resources in the school and community, and practical information on identifying and referring students who might be at risk for suicide. *Lifelines* also includes a presentation for parents and caregivers that answers questions about youth suicide and prevention, and it involves them in the school's suicide prevention activities. *Lifelines* is designed for implementation in middle schools and high schools for students in eighth to tenth grade.

The objectives of *Lifelines* are to increase the likelihood that:

- members of the school community who come into contact with potentially suicidal adolescents can more readily identify them, know how to initially respond to them, know how to rapidly obtain help for them, and are *consistently inclined* to take such action
- troubled adolescents are aware of and have immediate access to helping resources and may be more inclined to seek such help as an alternative to suicidal actions

HOW CAN LINKAGES BE MADE BETWEEN *OBPP* AND *LIFELINES?*

Both *OBPP* and *Lifelines* focus on addressing their respective issues in the community and schoolwide. Both programs include four essential components to educate all involved.

1. Schoolwide Policies and Procedures for Bullying Prevention and Suicide Prevention

The schoolwide component of *OBPP* prepares schools to implement a framework of policies and procedures for working with students that are involved in bullying behavior. *Lifelines* outlines the school's prepared and planned response to suicide prevention. Setting policies and

procedures demonstrates administrative commitment and support for the school's bullying and suicide prevention activities, and provides the guidelines for crisis response to bullying and to students at risk for suicide or in the event of a death by suicide.

2. Faculty and Staff Training

OBPP and *Lifelines* recognize the importance of providing training for teachers and *all* school staff. With *OBPP*, members of a Bullying Prevention Coordinating Committee receive two full days of training from a certified Olweus trainer. The committee, with the guidance of the certified Olweus trainer, then provides a full day of training to faculty and staff members. Ongoing education is encouraged through faculty meetings and staff discussion groups.

A thorough, one-day training session by a certified trainer is available for *Lifelines*. It may be convenient to use the school safety/Bullying Prevention Coordinating Committee to lead efforts in suicide prevention programming as well.

3. Student Education about Destructive Behaviors and How to Seek Help

A key component of *OBPP* involves holding weekly class meetings focused on bullying and related topics. The purposes of class meetings are primarily to (1) teach students about bullying; (2) help students learn more about themselves and their feelings and reactions, and provide a forum during which students can express opinions in a safe and supportive environment; (3) help teachers learn more about the classroom culture and relationships among classmates; and (4) provide a forum for dealing with bullying problems in the classroom.

The *Lifelines* curriculum for eighth- ninth-, and tenth-grade students has four 45-minute sessions that include detailed lesson plans that cover facts about suicide and students' role in suicide prevention. The program also reviews in-school and community resources. Two videos are included with the program. One video shows students acting in role-plays to show appropriate (as well as inappropriate) responses to a suicidal peer, and the other video documents an actual response of three students to a suicidal peer after they had participated in *Lifelines*. The activities and discussions in *Lifelines* feature an emphasis on seeking adult help and identifying the warning signs of suicide.

Teachers could easily incorporate the *Lifelines* lessons as class meeting discussions within *OBPP*, but should do so only if the entire *Lifelines* program is supported by administrative and faculty/staff training. The *Lifelines* curriculum has been identified for middle and high school students and is not intended to be an elementary curriculum.

4. Parent Involvement

Parent and guardian involvement is important to the success of *OBPP* and any comprehensive bullying prevention effort. In *OBPP*, parents and guardians are engaged in multiple ways:

- serving on the Bullying Prevention Coordinating Committee
- attending schoolwide parent/guardian meetings
- helping organize and attend classroom parent/guardian meetings
- talking with their children about bullying

Parents and guardians are important partners in helping children and youth learn about bullying prevention and intervention. They are given information about bullying at the start of *OBPP* and schools hold workshops for parents to educate them as to how to support their children and how to work with the school should a problem develop.

In the *Lifelines* program, parent and caregiver education is also one of the key components. Parents and caregivers attend a workshop designed to review basic information about adolescent suicide and provide an overview of the school's response system, as well as brief guidelines for parental response to suicidal behavior. Resources for additional information on suicide and community support services are also provided.

Lifelines and the *Olweus Bullying Prevention Program* have many opportunities to compliment each other to provide a safe school climate for all students.

Lifelines

Report of Suicide Risk
(Confidential)

Student Name: _____ ◯ Male ◯ Female

Name of School: _____ Grade: _____

Who initiated the referral?

◯ Friend/Student _____ ◯ Administrator _____

◯ Parent _____ ◯ Self-referral

◯ Teacher _____ ◯ Other _____

◯ Other School Personnel _____

Reason for Referral (Check one)

◯ Suicide Attempt (having taken action with the intent to die)

◯ Suicide Threat (saying or doing something that indicates self-destructive desires)

◯ Suicide Ideation (having thoughts about killing self)

Action Taken (Check those that apply)

◯ Student seen by school personnel _____ (Name/Agency)

◯ Student referred to community agency _____ (Name/Agency)

◯ Student referred to private professional _____ (Name/Agency)

◯ Student transported to a hospital/other _____ (Name/Agency)

◯ Student referred to crisis services _____ (Name/Agency)

◯ Parents/Guardians contacted _____

Form completed by: _____ Date: _____

Position: _____

Copies to be filed with: _____

Lifelines

Referral Information for Parents: Student Risk Assessment

(Confidential)

Student Name: _____ Grade: _____

This is to confirm our conversation on _____ regarding your child,
(Date)

_____.
(Name of Student)

As per the district policy, students identified as being at risk for self-harm or suicide must receive medical/psychiatric assessment prior to their return to school.

- An appropriate assessment must be conducted by a licensed mental health practitioner or psychiatric emergency services center.*
- Written documentation must be provided to the school stating that the assessment has been conducted.
- Written documentation must clearly indicate that the student has been medically cleared (is safe) to return to school.
- A re-entry conference must be held prior to attendance in class. Please contact

  _____ to schedule the re-entry conference.
  (Name of designated school personnel)

If you have any questions or concerns, please feel free to contact my office at telephone number _____, extension _____.

Staff Signature _____ Date _____

Parent Signature _____ Date _____

Follow-up assessment needs to be conducted within a reasonable amount of time. Parent/Guardian needs to inform the school of the status of the follow-up assessment within 48 hours of the school-based risk assessment.

***24-Hour Hotline Information:** _____
(fill in local crisis hotline phone number)

(A copy of this form will be kept in a separate file until graduation.)

Lifelines

Issues and Options Surrounding a Student's Return to School Following a Suicide-related Absence

Students who have made a suicide attempt are at increased risk to attempt to harm themselves again. Appropriate handling of the re-entry process following a suicide attempt is an important part of suicide prevention. School personnel can help returning students by directly involving them in planning for their return to school. This involvement helps the student to regain some sense of control.

Confidentiality is extremely important in protecting the student and enabling school personnel to provide assistance. Although necessary for effective assistance, it is often difficult to obtain information on the student's condition. If possible, secure a signed release from parents/guardians to communicate with the student's therapist/counselor. Meeting with parents about their child prior to his or her return to school is vital to making decisions concerning needed supports and the student's schedule.

Any number of issues are likely to surface and will need to be considered on a case-by-case basis and addressed at the re-entry planning session. It is very likely that some school staff, the family, the mental health professional, and the student will express concerns. The more common issues are listed in this document.

1. **Issue:** Social and peer relations

   Options:

   - Place the student in a school-based support group, peer helpers program, or buddy system.
   - Arrange for a transfer to another school if indicated.
   - Be sensitive to the need for confidentiality and how to restrict gossip.

2. **Issue:** Transition from the hospital setting

   Options:

   - Visit the student in the hospital or at home to begin the re-entry process with permission from the parents/guardians.
   - Consult with the student to discuss what support he or she feels is needed to make a more successful transition. Discuss what information faculty may need to facilitate a smooth re-entry.
   - Request permission to attend the treatment planning meetings and the hospital discharge conference.

- Arrange for the student to work on school assignments while in the hospital.
- Include the therapist/counselor in the school re-entry planning meeting.

3. **Issue:** Academic concerns on return to school

   Options:

   - Ask the student about his or her academic concerns and discuss potential options.
   - Arrange tutoring from peers or teachers.
   - Modify the schedule and adjust the course load to relieve stress.
   - Allow makeup work to be adjusted and extended without penalty.
   - Monitor the student's progress.

4. **Issue:** Medication

   Options:

   - Alert the school nurse to obtain information regarding prescribed medication and possible side effects.
   - Notify teachers if significant side effects are anticipated.
   - Follow the policy of having the school nurse monitor and dispense all medication taken by the student at school.

5. **Issue:** Family concerns (denial, guilt, lack of support, social embarrassment, anxiety, etc.)

   Options:

   - Schedule a family conference with designated school personnel or home-school coordinator to address concerns.
   - Include parents in the re-entry planning meeting.
   - Reinforce the fact that the information the school needs to assist the student is limited to facilitating optimal school adjustment and performance, and does not include personal details of emotional distress.
   - Refer the family to an outside community agency or private practitioners for family counseling services.
   - Include information about community agencies with a sliding fee scale.

6. **Issue:** Behavior and attendance problems

   Options:

   - Meet with teachers to help them anticipate appropriate limits and consequences of behavior.
   - Discuss concerns and options with the student.
   - Consult with discipline administrator.
   - Request daily attendance reports from the attendance office.
   - Schedule home visits or regular parent conferences to review attendance and discipline records.
   - Arrange for counseling for the student.
   - Place the student on a sign-in/sign-out attendance sheet to be signed by the classroom teachers and returned to the attendance office at the end of the school day.

7. **Issue:** Ongoing support*

   Options:

   - Assign a school liaison to meet regularly with the student at established times. Try to assign someone who already has a relationship with the student. Talk to the student about his or her adjustment.
   - Maintain contact with the therapist and parents.
   - Ask the student to check in with the school counselor daily/weekly.
   - Utilize established support systems, student assistance teams, support groups, friends, clubs, and organizations.
   - Schedule follow-up sessions with the school psychologist or home-school coordinator.
   - Provide information to families regarding available community resources when school is not in session.

* In the event that a student loses a family member to suicide, school personnel should understand that suicide evokes a special, complicated grief and most of the ongoing support considerations mentioned in #7 would also apply.

Readiness Survey

Administrative Questions

A. Prevention refers to proactive activities designed to prepare a school for effective, timely responses to students who may be at risk for suicide.

1. Does your school have an up-to-date crisis response plan?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

2. Does the crisis response plan have solid administrative support?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3a. Does the crisis response plan have written protocols on how to manage suicidal (student and/or staff) behavior?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3b. Does the crisis response plan have written protocols on how to manage a suicidal (student and/or staff) attempt on campus?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3c. Does the crisis response plan have written protocols on how to manage a suicidal (student and/or staff) attempt off campus?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

4a. Have crisis team members been identified?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

4b. Are individuals from both the school and the community involved in the crisis team?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

5. Are crisis team members provided with training?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

6. Are substitute crisis team members identified in case regular members are not available due to absence, conference attendance, vacation, and so forth?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

7. Would the crisis team be able to support multiple schools in the event of a murder/suicide situation? (For example, a parent murders siblings attending several different schools and then takes his or her own life.)

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

8. Do crisis team members have copies of school floor plans for their use and/or to provide to local law enforcement, if needed?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

9. Does the crisis team meet and practice simulations on a regular basis?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

10. Are copies of the school crisis plan readily accessible to all school personnel?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

11a. Is there an established method for distributing protocols that includes who should receive them?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

11b. Is there a plan for providing new staff with protocols?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

12. Has school administration provided clear direction about legal rights and obligations of administrators, faculty, and staff in assisting with a suicidal student?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

13. Is someone designated to track the number of suicides, suicide attempts, and/or referrals for suicidal behavior?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

14. Has a policy for maintaining confidentiality of sensitive student information been created and disseminated to all school personnel?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

15a. Does the school have a formal memorandum of agreement (MOA) with the local crisis service provider(s) outlining the services to be provided to the school system such as risk assessments, crisis management, and/or debriefing school staff in the aftermath of a crisis?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

15b. Does the MOA include debriefing parents and community members in the event of a suicide?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

16. Does the MOA include guidelines for how the school receives feedback on the outcomes of the referrals that are made?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

17. Have school administrators, faculty, and staff received education and training in suicide prevention?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

18a. Has an effective student suicide prevention education program been incorporated into the comprehensive health education program?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

18b. Does the program focus on building help-seeking skills? (Note: The student component should only be introduced after protocols have been established, MOAs are in place, staff education has occurred, and key staff identified as those who can help with suicidal behavior.)

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

19. Has a discussion with law enforcement occurred so that you know what to expect from the local law enforcement agency in the event of a crisis in school buildings or on school grounds?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

20. Has the traffic pattern to and from the school been reviewed with emergency response personnel?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

B. Intervention refers to an outline of specific actions to be implemented in response to suicidal behavior.

21. Do school procedures/protocols identify key people within each building as contacts to help when suicidal behavior occurs?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

22. Do school procedures designate someone to contact the parents/guardians when suicide risk is suspected?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

23. Does the school have procedures for when the parents/guardians are unreachable?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

24. Does the school have procedures for when parents/guardians refuse to get help for their child?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

25. Does the school provide information to parents/guardians about the importance of removing lethal means?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

26a. Does the school have a system to alert staff of an emergency while school is in session?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

26b. Have volunteers and substitutes been informed about the system?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

27. Are there protocols concerning how to help students re-enter school after an absence or hospitalization for mental illness including suicidal behavior?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

28. Are there systems/teams in place to address the needs of students who are exhibiting high-risk behaviors such as substance abuse, depression, or self-injury?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

C. Postvention refers to a sequence of planned support and interventions carried out in the aftermath of a suicide with the intention of preventing suicide contagion.

29a. Do the protocols include a section about working with the media?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

29b. Has a spokesperson been designated?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

29c. Is there a backup for that person?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

30a. In the event of a suicide, are there established protocols for identifying close friends/ other vulnerable students and plans to support them?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

30b. Does this protocol include students at other buildings?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

30c. Does this protocol include staff that might be affected due to either their relationship with the youth or their own experience with suicide in their families?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

31. Do the protocols consider the fact that, following a suicide, whole-school and/or permanent memorials are *not* recommended?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

Staff-related Questions

1. Have *all* staff members received training about suicide prevention?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

2. Have *all* staff members been provided with the school protocols?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3a. Have trained resource staff members been identified as contacts for when a staff member or student wants to ask about suicidal behavior?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3b. Has everyone in the building been informed of who the resource staff members are?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

4. Do staff members know what to do in the event that they come upon or hear about a suicide incident?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

5. Have the confidentiality guidelines been provided and discussed with *all* staff members?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

6. Do school protocols guide staff members on what to look for and what to do if they find student work/messages (such as artwork, doodling, homework, term papers, journal entries, or notes) that focus on death or suicide?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

7. Will teachers receive feedback on students whom they refer for an evaluation of suicidal risk?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

8. Do staff members understand that it is not their responsibility to assess the seriousness of a situation but that suicidal behavior must be taken seriously and reported using the school protocols?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

9. Do the protocols inform staff members about what to do if there is any reason to suspect a weapon is present/readily available?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

10. Are procedures in place to brief and debrief staff members in the event of a crisis?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

Parent-related Questions

1. Are opportunities provided for parents/guardians to learn about suicide prevention?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

2. Are there efforts to actively communicate with parents/guardians about risk factors, warning signs, and the importance of restricting access to lethal means?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3. Have parents/guardians been told what the school is doing to prevent and address the issue of suicide, what will be done if their son or daughter is thought to be at risk of suicide, and what will be expected of them?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

4. Are parents/guardians provided with a current list of community resources and agencies to contact if they are concerned that their son or daughter is suicidal?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

Student-related Questions

1a. Are students educated about suicide and how to help a troubled friend?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

1b. Does the education include practicing an intervention?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

2. Do students know whom to go to in the school if they are worried about a suicidal friend?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

3. Are behavioral health services readily available to youth?

◯ YES ◯ NO ◯ NEED TO CONSIDER

COMMENTS:

Warning Signs of Suicide

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

Warning Signs for Suicide and Corresponding Actions*

Call 9-1-1 or seek immediate help from a mental health provider when you hear or see any of these behaviors:

- Someone threatening to hurt or kill himself, or talking of wanting to hurt or kill himself
- Someone looking for ways to kill herself by seeking access to firearms, available pills, or other means
- Someone talking or writing about death, dying, or suicide, when these actions are out of the ordinary for the person

Seek help by contacting a mental health professional or calling the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for a referral should you witness, hear, or see someone exhibiting one or more of these behaviors:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped—like there's no way out
- Withdrawing from friends, family, and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

* Adapted by the Maine Youth Suicide Prevention Program from a Suicide Prevention Resource Center document accessed at www.sprc.org.

FACTS

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

FEELINGS
ACTIONS
CHANGES
THREATS
SITUATIONS

FEELINGS

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

ACTIONS

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

CHANGES

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

THREATS

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

SITUATIONS

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

Frequently Asked Questions for Parents

Q: Who considers suicide?

A: In general, people (of all ages) who are depressed or having trouble coping with their feelings may consider suicide if they don't have other coping skills. People of all ages, races, faiths, and cultures die by suicide, as do individuals from all walks of life and all income levels. Both popular, well-connected people who seem to have everything going for them and those who are less well-off die by suicide. Suicidal youth come from all kinds of families, rich and poor, happy and sad, two-parent and single-parent. It is really important to understand that suicidal behavior knows no boundaries.

Q: Can a teen really be suicidal? They haven't lived long enough to know what real problems are!

A: In part, that is exactly the problem. It is widely believed that childhood is free from the stress and problems of adult life and is a time for fun. However, the world is a much different place now than it was when you were a teenager. We live in an information-packed and high-stress society. Competition for college acceptance and jobs is fierce. Teens are expected to go to school full-time, participate in school activities, work twenty to twenty-five hours a week in their "part-time job," and manage to get their chores and homework done on the side. It doesn't leave much time for fun. Many teens don't get enough sleep. This tends to make teens easily frustrated and angry. The expectations placed on teens in our society can be very difficult to handle, as they have not yet developed the skills needed to deal with these stresses. A loss that seems minor to an adult can feel life-threatening to teens if they cannot find a way to cope with the feelings or find a solution. Also, they feel the need to solve the problem as fast as they can in a culture obsessed with "now" (e-mail, voice mail, cell phones, pagers, etc.). For teens, each day is as big as it gets.

Q: Why do people choose to die by suicide?

A: Suicidal behavior is one of the most complicated human behaviors. This question cannot be answered briefly. There is no research that shows that a certain set of risk factors can accurately predict the likelihood of imminent danger of suicide for any one person. It is fair to say that suicidal people are experiencing varying degrees of outside stresses, internal conflict, and neurobiological dysfunction, and these factors contribute to their state of mind. Depression, anxiety, conduct disorders, and substance abuse all contribute to the possibility of suicide, but they do not cause suicide. A "final straw" for suicide is usually the last thing that a person who kills himself or herself is thinking about, and many left behind want to blame that person or event, but the "final straw" was *not* the cause of the suicide. Many people who

kill themselves had no final straw that others could see. The reasons behind a suicide often remain a mystery.

Q: Won't people think I am a bad parent if my teen is suicidal?

A: Some people may be quick to judge and not understand that given a certain set of circumstances any of us could feel suicidal. It is more likely that people will think you are a loving and caring parent if you are helping to keep your teen alive. Mental health professionals, in particular, deal with suicidal individuals every day. They understand how difficult life can be for a teen and that parents cannot protect their children from all the stress in the world. What you can do is listen to your teen and take action when he or she cannot. Take care of your teen.

Q: Every time I ask, my teen tells me that I won't understand. How can I help her to talk?

A: Acknowledge that you might not understand, but that you care very much and you will try to understand. Also keep in mind that this phrase tends to be used when teens can't explain how they feel. Another option is to tell her you understand she doesn't want to talk to you, but would she agree to talk about it with someone else, like a counselor? If she agrees, make sure to follow up on it; you can even make the initial call yourself if she wants you to.

Q: My teenager listens to horrible music. I'm worried that the violent lyrics will make him kill himself.

A: While you may not like your teen's choice in music, it is unlikely to make him kill himself if that was not already an issue. In fact, for most teens, music, even violent music, may actually allow them to vent some of their anger and frustration and help them to feel better. However, there are situations where a teenager who is already feeling depressed or feeling alienated may choose a certain type of music that can make those feelings stronger. Discuss your concerns with your teen and make a deal that if he feels like hurting or killing himself that he will talk to you.

Q: How can I help my child not to feel suicidal?

A: This begins by talking about suicide before it becomes an issue and the teen is in crisis. We need to acknowledge that suicide is an option that teens consider and open the channels of communication so that teens have somewhere to turn where they know they will be understood. One of the major reasons why teens don't turn to adults is that they feel they will not be understood. The Web site of the Society for the Prevention of Teen Suicide (www.sptsnj.org) can help to educate you about suicide and what you can do.

Q: I think my child may be suicidal. What do I say to him?

A: Suicide can be a difficult topic to discuss, especially with teens. Some possible conversation starters include:

- You haven't seemed like yourself recently. What's been going on?
- I know that some difficult things have happened recently. I'm concerned about how you're feeling.

Once you've opened up conversation, it's important to ask directly about suicidal intent. The following questions may be useful.

- Do you feel like things will never get better?
- Have you been feeling like killing yourself is an answer to your problem?
- Have you ever thought about suicide? Are you suicidal now?

If your child is suicidal, it is important to remove all lethal means from the household and get help. The National Suicide Prevention Lifeline (1-800-273-TALK) can be accessed 24 hours a day, 7 days a week and will help you to determine what type of intervention is necessary. Even if your child does not indicate that he or she is feeling suicidal, seeking out help is always an option—from a school counselor, professional counselor, clergy person, and so forth.

Q: What should I do if my teen is talking about killing herself?

A: *Lifelines* recommends you follow the same three basic suicide intervention steps that have been outlined for school faculty, staff, and students:

1. Show you care: listen carefully.
2. Ask about suicide: ask directly in a caring, nonconfrontational way.
3. Get help: stay with the person; call your local crisis line, the national hotline, or other source of help.

Lifelines

Preguntas hechas frecuentemente por los padres

P: ¿Quién está considerando suicidio?

R: Generalmente, las personas (de todas las edades) deprimidas o con dificultades para lidiar con sus sentimientos pueden considerar el suicidio si no tienen otras habilidades para bregar con ellos. Personas de toda las edades, razas, creencias religiosas y culturas mueren debido al suicidio, así como también individuos de todos los grupos sociales y niveles económicos. Las personas populares, con buena posición social que parecen tener todo a su favor y las menos afortunadas, mueren por suicidio. Los jóvenes suicidas provienen de todo tipo de familias, ricas y pobres, felices y tristes, tanto sea con los dos padres presentes o con uno solo. Es muy importante entender que la conducta suicida no conoce fronteras.

P: ¿Puede un adolescente ser realmente suicida? ¡Ellos no han vivido lo suficiente para saber qué son los problemas reales!

R: En parte, ése es exactamente el problema. Generalmente, se cree que la niñez está libre de la tensión y de los problemas de la vida adulta y que es una etapa para divertirse. Sin embargo, el mundo es hoy muy diferente de cuando usted era un adolescente. Nosotros vivimos en una sociedad saturada de información y con mucho estrés. La competencia para ser aceptado en la universidad y en los empleos es acérrima. Se espera que los adolescentes vayan a la escuela a tiempo completo, participen en actividades escolares, trabajen veinte a veinticinco horas por semana en su "empleo de medio tiempo," y además traten de hacer sus quehaceres y la tarea escolar. No les queda mucho tiempo para divertirse. Muchos adolescentes no duermen lo suficiente. Esto tiende a hacer que se frustren y se enfaden fácilmente. Las expectativas que nuestra sociedad impone en los adolescentes pueden ser muy difíciles de manejar, dado que no han desarrollado todavía las habilidades necesarias para manejar estas tensiones. Una pérdida que parece menor a un adulto puede sentirse como que amenaza la vida de los adolescentes si no pueden encontrar una manera de bregar con los sentimientos o encontrar una solución. También, ellos sienten la necesidad de resolver el problema lo más rápido posible dentro de una cultura obsesionada con el "ahora" (e-mail, correo de voz, teléfonos móviles, buscapersonas, etc.). Para los adolescentes cada nuevo día parece ser una montaña alta difícil de escalar.

P: ¿Por qué mueren las personas a causa del suicidio?

R: La conducta suicida es uno de los comportamientos humanos más complejos. Esta pregunta no se puede contestar brevemente. No hay ningún estudio que demuestre que un cierto juego de factores de riesgo puede predecir con exactitud la probabilidad del peligro inminente de suicidio de una persona. Se podría decir que las personas suicidas están experimentando varios niveles de tensiones, conflictos internos, y trastornos neurobiológicos, y estos factores

contribuyen a su estado mental. La depresión, ansiedad, desórdenes de conducta, y abuso de drogas contribuyen a la posibilidad de cometer suicidio, pero no causan el suicidio. "La gota que colma el vaso" para el suicidio es normalmente la última cosa para una persona que se autoelimina o está pensando hacerlo, y muchas personas allegadas culpan a esa persona o evento, pero "la gota que colma el vaso" no fue la causa del suicidio. Muchas personas que se matan no tenían "la gota que colma el vaso" que la gente pudiera ver. Frecuentemente, las razones detrás de un suicidio siguen siendo un misterio.

P: ¿Pensará la gente que soy un mal padre si mi hijo(a) adolescente tiene la intención de suicidarse?

R: Algunas personas pueden ser rápidas para juzgar y no entienden que si se diera un juego específico de circunstancias cualquiera de nosotros podría pensar en el suicidio. Es más probable que la gente piense que usted es un padre afectuoso y compasivo si está tratando de mantener vivo a su hijo adolescente. El personal profesional, en particular, trata con individuos suicidas todos los días. Ellos entienden lo difícil que puede ser la vida para un adolescente y que los padres no pueden proteger a sus hijos contra toda la tensión en el mundo. Lo que usted puede hacer es escuchar a su hijo(a) adolescente y tomar medidas cuando su él/ella no pueda tomarlas. Cuide muy bien de su hijo adolescente.

P: Cada vez que le pregunto, mi hija adolescente me dice que yo no la entendería. ¿Cómo puedo ayudar a que hable?

R: Admita que usted podría no entender, pero que le importa muchísimo y tratará de entender. También tenga presente que los adolescentes que tienden a usar esta frase no pueden explicar cómo se sienten. Otra opción es decirles que usted entiende que ellos no quieren hablar con usted, pero ¿consentirían de hablar al respecto con otra persona, como un orientador? Si ellos estuvieran de acuerdo, asegúrese de dar seguimiento; usted incluso puede hacer la llamada inicial, si ellos lo desearan.

P: Mi hijo adolescente escucha música abominable. Me preocupa que las letras violentas de las canciones lo inducirán a matarse.

R: Aunque a usted no le agrade la preferencia de música de su hijo adolescente, es improbable que cause que se autoelimine, si eso ya no existiera un problema. De hecho, para la mayoría de los adolescentes, la música, incluso la música violenta, puede permitirles tener una válvula de escape para su enojo y frustración y para ayudarles a sentirse mejor. Sin embargo, existen situaciones, cuando un adolescente que se está sintiendo deprimido o retraido puede escoger un cierto tipo de música que puede intensificar esos sentimientos. Hable de sus preocupaciones con su hijo adolescente y haga un trato que si él/ella siente deseos de lastimarse o de suicidarse, que hable con usted.

P: ¿Cómo puedo ayudar a que mi hijo(a) no piense en el suicidio?

R: Esto empieza hablando sobre el suicidio antes de que se convierta en un problema y el adolescente atraviese una crisis. Nosotros necesitamos reconocer que el suicidio es una opción considerada por los adolescentes y abre los canales de comunicación en los que dependerán si saben que serán entendidos. Una de las razones importantes del porqué los adolescentes no recurren a los adultos es que sienten que no serán entendidos. El sitio Web de *Society for the Prevention of Teen Suicide* (Sociedad para la Prevención de Suicidio en el Adolescente) (www.sptsnj.org) puede ayudar a informarle sobre el suicidio y sobre lo qué usted puede hacer.

P: ¿Cómo pregunto si creo que mi hijo tiene tendencias suicidas?

R: El suicidio puede ser un tema difícil de hablar, sobre todo con los adolescentes. Algunas formas posibles de empezar la conversación incluyen:

- Últimamente, actúas muy diferente de lo normal. ¿Qué te sucede?
- Yo sé que recientemente han ocurrido cosas difíciles. Me preocupa mucho cómo te sientes.

Una vez iniciada la conversación, es importante preguntar directamente por el intento suicida. Las preguntas siguientes pueden ser útiles.

- ¿Piensas que las cosas nunca mejorarán?
- ¿Has estado pensando en autoeliminarte como respuesta a tu problema?
- ¿Has pensado alguna vez sobre el suicidio? ¿Tienes intenciones suicidas?

Si su hijo(a) tiene una intención suicida, es importante quitar todos los objetos letales de la casa y pedir ayuda. Se puede acceder a la Línea Nacional de Prevención del Suicidio (*National Suicide Prevention Lifeline*) (1-800-273-TALK) las 24 horas del día, 7 días a la semana para ayudarle a determinar qué tipo de intervención es necesaria. Aún cuando su hijo(a) no manifieste que está pensando en suicidarse, buscar ayuda es siempre una opción—tanto sea con un orientador escolar, un consejero profesional, un religioso, y otras personas.

P: ¿Qué debo hacer si mi hijo adolescente está hablando de autoeliminarse?

R: *Lifelines* recomienda que usted siga los mismos tres pasos básicos de intervención en casos de suicidio que se han sido reseñados para los docentes, empleados y estudiantes de la escuela.

1. Demuestre su interés: escuche atentamente.
2. Pregunte sobre el suicidio: pregunte directamente en una forma compasiva y no desafiante.
3. Pida ayuda: quédese con la persona; llame a su línea local de crisis, la línea nacional dedicada, u a otra fuente de ayuda.

Starting the Conversation

Talking with your child about suicide is as important as talking about drugs and alcohol and safe driving. However, it can be difficult to bring up this subject with your child. Below are tips for talking with your child about suicide.

1. **Pick a good time.** You want your child's full attention, so choose a time when there are minimal distractions and a reasonable degree of privacy.

2. **Be conversational.** Remember that your goal is to have a conversation with your child, not deliver a lecture. It always helps to have a "reference point"— such as an event or a news story or the school's *Lifelines* classes—to start the conversation.
("I was reading in the newspaper that the rate of suicide for teens has increased . . ." or "I noticed on the school's Web site that the school is having a suicide prevention workshop for the teachers . . .")

3. **Be honest.** If this is a hard subject for you to talk about, acknowledge it. ("You know, I never thought I'd be talking with you about suicide. It's a topic I've never been really comfortable with . . .") By acknowledging your discomfort, you give your child permission to acknowledge his or her discomfort, too.

4. **Be direct.** Ask open-ended questions to clarify your child's responses. ("Tell me how you feel talking about suicide." "What do you think about suicide?" "What have you learned about suicide in school?")

5. **Listen to what your child has to say.** You've brought up the topic. You're interested in his or her responses, so simply listen to your child's answers. Don't interrupt or interject your opinion unless asked.

6. **If you hear something that worries you, ask for more information.** ("You say that one of your friends has talked about suicide. Tell me more.")

7. **Open the door to revisit the conversation.** Suicide isn't a one-time discussion topic. Once you've made it okay to talk about, it should be easier to bring up again. If you've heard something that concerns you, make sure to ask about it again.

Inicio de la conversación

Hablar con su hijo(a) sobre el suicidio es tan importante como hablar sobre las drogas y el alcohol y conducir con cuidado. Sin embargo, puede ser difícil abordar este tema con su hijo. A continuación se ofrecen consejos para hablar con su hijo(a) del suicidio.

1. **Escoja un buen momento.** Usted quiere la completa atención de su hijo(a) así que escoja un momento donde no hayan muchas distracciones y un grado razonable de privacidad.

2. **Converse.** Recuerde que su objetivo es tener una conversación con su hijo(a), no dar una conferencia. Le ayudará siempre tener un "punto de referencia"—como un evento o una noticia o las clases de *Lifelines*—para iniciar la conversación. ("Yo estaba leyendo en el periódico que el porcentaje de suicidios de adolescentes ha aumentado. . ." o "noté en el sitio Web de tu escuela que tu escuela tiene un taller para los maestros de prevención del suicidio. . .")

3. **Sea sincero.** Si éste fuera un tema difícil de hablar para usted, reconózcalo. ("Déjame decirte, yo nunca pensé que estaría hablando contigo sobre el suicidio. Nunca me sentí muy a gusto hablando de este tema. . ."). Al reconocer su incomodidad, usted le da permiso a su hijo(a) para reconocer su propia incomodidad, también.

4. **Sea directo.** Haga preguntas con el objetivo de obtener respuestas de cómo piensa y se siente su hijo(a). ("Dime cómo te sientes hablando sobre el suicidio." "¿Qué piensas tú sobre el suicidio?" "¿Qué has aprendido en la escuela sobre el suicidio?")

5. **Escuche lo que su hijo(a) tiene que decir.** Usted ha tocado el tema y está interesado en sus respuestas, así que simplemente escuche las respuestas de su hijo(a). No interrumpa o inyecte su opinión a menos que se le pida.

6. **Si usted escucha algo que le preocupa, pida más información.** ("Me has dicho que uno de tus amigos ha hablado sobre el suicidio. Cuéntame un poco más.")

7. **Vuelva a tener una conversación.** El suicidio no es un tema para discutir una vez solamente. Una vez que haya decidido que está bien hablar al respecto, será más fácil abordarlo nuevamente. Sobre todo si usted ha escuchado algo que le preocupa, asegúrese de preguntar nuevamente al respecto.

FACTS

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

FEELINGS
ACTIONS
CHANGES
THREATS
SITUATIONS

FEELINGS

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

ACTIONS

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

CHANGES

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

THREATS

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

SITUATIONS

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

HECHOS

Las señales de suicido puede organizarse alrededor de la palabra “HECHOS”:

SENTIMIENTOS

- Desesperación: sentir lo malas que son las cosas, y que no han de mejorar
- Miedo de perder el control, enloquecerse, autolastimarse o lastimar a otras personas
- Impotencia: creer que no hay nada que se pueda hacer para mejorar la vida
- Inutilidad: sentirse como una persona horrible y que sería mejor para todos si se muriera
- Autoodiarse, sentirse culpable o avergonzado
- Estar sumamente triste y solitario
- Sentirse ansioso o angustiado o enfadado todo el tiempo

ACCIONES

- Abuso de drogas o alcohol
- Hablar o escribir sobre la muerte o destrucción
- Agresión: meterse en peleas o discutir acaloradamente con personas
- Imprudencia: hacer cosas arriesgadas o peligrosas

CAMBIOS

- Personalidad: comportarse como una persona diferente, apartarse, estar cansado todo el tiempo, no importarle nada, o ser más hablador, sociable
- Conducta: no puede concentrarse en la escuela o con las tareas regulares
- Patrones de sueño: dormir todo el tiempo o no poder dormir en absoluto, o despertarse en el medio de la noche o temprano por la mañana; no poder seguir durmiendo
- Hábitos de comer: pérdida del apetito y/o comer demasiado y aumentar de peso
- Perder interés en los amigos, pasatiempos, en la apariencia personal o en actividades deportivas que disfrutaba previamente
- Mejora súbita después de un periodo de sentirse deprimido o retraido

AMENAZAS

- Declaraciones como "¿Cuánto tiempo lleva a para sangrar hasta morir?"
- Amenazas como "No viviré por mucho tiempo más" o "No se lo cuentes a nadie. ¡Ya no serás mi amigo si lo cuentas!"
- Planes como regalar cosas preferidas, estudiar formas de morir, obtener un arma o un frasco de píldoras: ¡el riesgo es mayor si la persona tiene un plan y la forma de ejecutarlo!
- Intentos de suicidio como el sobreconsumo de drogas, cortarse las muñecas

SITUACIONES

- Tener problema en la escuela, en el hogar o con la ley
- Pérdida reciente debido a muerte, divorcio, o separación, disolución de una relación, perder una oportunidad o un sueño, pérdida de autoestima
- Cambios en la vida que parecen ser agobiantes
- Estar expuesto al suicidio o a la muerte de un amigo en cualquier circunstancia

Addressing Worrisome Behaviors

As parents, your role in suicide prevention is crucial. You know your child's moods and behaviors better than anyone else. If certain behaviors concern you, it's important to take these worries seriously. Here are guidelines to follow when addressing worrisome behaviors with your child:

- **Don't worry about overreacting.** Sit with your child and let him or her know about your concerns. ("You said something that worries me." or "You don't seem to be yourself lately.")
- **Be specific about your concerns.** ("I've noticed you aren't spending as much time with your friends and you seem annoyed when they call you." or "You spend hours doing your homework, but every time I check on you, you're just staring into space." or "Your teacher called and said you're failing English because you're late to class almost every day.")
- **Expect your child to discount your concerns.** ("All the kids are having trouble getting homework finished." or "My friends are annoying." or "That teacher fails everybody.") Explain that you're not concerned about everybody in the class. You are concerned about your child. Be prepared to offer more than one example; the more evidence you have, the harder it will be for your child to minimize your examples.
- **If your child says anything that even hints at thoughts of suicide, ask about it.** For example, statements like "Sometimes I'm not sure life is worth living." or "I just can't take it much more." *must* be explored further! *You cannot plant the idea of suicide in your child's mind by asking about it!* In asking about thoughts of suicide, you open up the lines of communication as well as introduce the idea of help-seeking behavior by asking to hear more about your child's distressing thoughts.
- **Act immediately if you have concerns about suicide.** Get your child to a mental health professional as soon as possible for an evaluation. There are several ways to do this. Refer to the list of local resources you received from the school.
- **Whatever resource you choose, indicate the urgency of the situation.** Make sure to use the phrase "at risk for suicide." ("I'm concerned that my son may be at risk for suicide and I'd like to schedule an evaluation as soon as possible.") Although the evaluation might determine that your child is not at immediate risk for suicide, this is an assessment you'd like to have made quickly, and it is a decision that is best left to a trained mental health professional.

Lifelines

Aborde de conductas problemáticas

Como padre o madre, su papel para prevenir el suicidio es de suma importancia. Usted conoce mejor que nadie las disposiciones de ánimo y conductas de su hijo(a). Si le preocupan ciertos comportamientos, es importante tomarlos muy en serio. Estas son algunas directrices a seguir cuando afronte comportamientos problemáticos con su hijo(a):

- **¡No se alarme por una reacción exagerada!** Siéntese con su hijo(a) y déjele saber sus preocupaciones. ("Has dicho algo que me preocupa" o "Últimamente pareces diferente".)
- **Sea específico sobre sus preocupaciones.** ("He notado que no pasas tanto tiempo con tus amigos y pareces fastidiado cuando te llaman" o "Te pasas horas haciendo tu tarea escolar pero cada vez vengo a ver, tienes la mirada perdida en el espacio" o "Tu maestro me llamó para decirme que estás fallando en inglés porque llegas tarde a clase casi todos los días".)
- **Espere que su hijo(a) desestime sus preocupaciones.** ("Todos los muchachos tienen dificultades para terminar la tarea escolar" o "Mis amigos son sólo dolores de cabeza" o "Ese maestro da malas notas a todos.") Explique que a usted no le preocupa los demás en la clase. Usted se preocupa por su hijo(a). Prepárese a dar más que un ejemplo; cuanta más pruebas tenga, más difícil será para su hijo(a) de minimizar sus ejemplos.
- **Si su hijo(a) dice algo que insinúa pensamientos de suicidio, haga preguntas al respecto.** Por ejemplo, declaraciones como "¡A veces creo que la vida no vale pena vivirla", o "ya no aguanto más," deben explorarse un poco más! ¡Como se dijo previamente, *usted no puede plantar la idea del suicidio en la mente de su hijo(a) con solo preguntar!* Al hacer preguntas sobre los pensamientos de suicidio, usted abre las líneas de comunicación e introduce la idea de buscar ayuda por dicho comportamiento pidiendo escuchar hablar más de los pensamientos inquietantes de su hijo(a).
- **¡Actúe inmediatamente si usted tiene preocupaciones sobre el suicidio!** Lleve a su hijo(a) lo más pronto posible a un profesional de salud mental para que le hagan una valoración. Hay varias formas de hacerlo. Consulte la lista de recursos locales que usted recibió de la escuela.
- **No importa el recurso que escoja, manifieste la urgencia de la situación.** Asegúrese de usar la frase "a riesgo de suicidio." ("Estoy alarmado de que mi hijo puede estar a riesgo de suicidio y me gustaría que le hicieran una valoración lo más pronto posible.") Aunque la valoración podría determinar que su hijo(a) no corre un riesgo inmediato de suicidio, es algo que usted le gustaría que se hiciera rápidamente, y es una decisión que un profesional de salud mental especializado está en mejor posición de tomar.

What Can Parents Do?

Parents can become informed about the warning signs of suicide that they may see in their teens or their teens' friends. These are general signs that a teen may be troubled. There is no list of definite, specific signs that a teen may be thinking about hurting himself or herself. Parents should not hesitate to err in the direction of over- versus underreacting. Warning signs are listed on the FACTS sheet you received.

In addition to these warning signs, parents should monitor teens' computers to see if they are accessing or developing Web sites with themes of death or destruction.

It is important to understand that suicide is a **crisis in communication.** When you sense that your teen is troubled, what will probably help the most is to have already established helpful patterns of communication. Here are ways to establish and maintain communication between you and your teen:

1. Create occasions for communication.
    - No TV during dinner.
    - At times, no radio in the car.
    - Do chores together.
    - Stop by just before bedtime—teens are more relaxed and less guarded at this time.
    - Share information about your day and feelings. (Often parents don't engage in small talk with their kids. Instead most of their communication consists of questions and "tidying up" kids' behavior.)
    - Find common interests/activities.

2. When you talk with your teen:
    - Really listen.
    - Try to understand his or her viewpoint first, before trying to provide an alternate viewpoint.
    - Accept your teen's feelings and concerns rather than evaluate. (Avoid statements such as "You shouldn't get upset over that!" and "If you had made a decision earlier, this wouldn't have happened!")
    - Don't minimize. (Avoid statements such as "Everyone feels that way." and "Don't let little things like that get to you.")
    - Recall that your teen sees his or her experience as unique. Acknowledge this and then let him or her know that others may have also struggled with these concerns.

- Don't compare your teen with siblings, other kids, or your childhood.
- Don't overreact. (Avoid statements such as "How could you think something like that?")
- Pause; take a deep breath and listen.
- Have definite standards and limits, but follow the rule of minimum conformity. That is, decide on the absolute minimum requirements for behavior, talk, dress, and so forth, and let the rest go. You can't enforce these anyway, and the more requirements you have, the less influence you have.

3. Be aware of the pressures and expectations you place on your child. Clearly, kids must learn to stick it out and develop discipline, but each achieves in his or her own way and at different paces. It is difficult to walk the line between preparing kids for life's pressures and adding too much pressure of your own in regard to school, sports, achievement, appearance, manners, and so forth.

4. Be aware of demands kids place on themselves. This may be a very important source of stress for teens.

5. Follow this simple rule from Dr. Hiam Ginott, author of *Between Parent and Child:*

   "Acknowledgment always precedes advice or directives." (For example, "I know that college was very important to you and I can see this is very upsetting, but let's look at some other alternatives." or "I see that Tom meant a lot to you. This is hard, but I'm wondering if you're not being a bit hard on yourself.")

If your child seems troubled or makes a seemingly out-of-the-blue comment about harming himself or herself, don't worry about taking it too seriously. Sit your child down, let him or her know of your concern, and say that you would rather overreact than underreact and that you will always respond to such behavior or statements.

If you are unsure of how to respond to your child, talk to another adult whom you trust: another parent, school personnel, clergy or religious leader, or a mental health provider. Then decide on a specific course of action.

Remember that it is difficult for parents to imagine that their teens could feel so bad that suicide is a possible alternative. But recall that parents of teens who have died by suicide all say that they also felt this way, and they urge parents to listen and take action.

The final point in regard to parents' responsibilities has to do with two facts: (1) much of teen suicide is more impulsive than adult suicide, and (2) the primary method of teen suicide is firearms. Thus, restricting access to means is an important way to prevent suicide. For now, this may mean keeping firearms locked up, but this is not foolproof. Clearly, if a teen is depressed or anxious, or is exhibiting impulsive behavior, guns should be removed from the house.

Lifelines

¿Qué pueden hacer los padres?

Los padres se pueden informar sobre las señales de advertencia del suicidio que noten en sus hijos adolescentes o en sus amigos. Son señales generales que un adolescente puede estar en problemas. No hay una lista de señales definidas y específicas de que un adolescente puede estar pensando en lastimarse a si mismo. Los padres no deben dudar en reaccionar mucho en lugar de hacerlo muy poco. Las lista de señales de advertencia se encuentran en la hoja de HECHOS que recibió.

Además de estas señales de advertencia, los padres deben supervisar las computadoras de los adolescentes para ver si ellos están accediendo o creando sitios Web con temas de muerte o destrucción.

Es importante entender que el suicidio es una *crisis de comunicación*. Cuando usted se da cuenta de que su adolescente tiene problemas, lo que más probablemente le ayude es establecer modelos útiles de comunicación. Estas son maneras para establecer y mantener la comunicación entre usted y su hijo(a) adolescente:

1. Cree ocasiones para comunicarse

- No mirar TELEVISIÓN durante la cena.
- En ciertos momentos, no prender el radio en el automóvil.
- Hacer juntos los quehaceres del hogar.
- Vaya a la habitación de su hijo antes de irse a dormir—los adolescentes están más relajados y menos en guardia en este momento.
- Comparta lo que pasó durante el día y sus sentimientos (A menudo los padres no entablan una conversación trivial con sus hijo(a)s. Por el contrario, la mayor parte de su comunicación consiste en preguntas y cuestiones de comportamiento sobre aseo personal y orden.)
- Encuentre puntos de interés/actividades en común.

2. Cuando hable con su hijo(a) adolescente

- Escuche realmente.
- Trate de entender primero su punto de vista, antes de tratar de ofrecer un punto de vista alternativo.
- Acepte los sentimientos y preocupaciones en lugar de evaluarlos. (“¡Usted no debe incomodarse por esto!” y “Si hubiera tomado una decisión anteriormente, esto no hubiera ocurrido!”)

- No minimice. ("Todos nos sentimos así." "No dejes que cosas pequeñas como esta te molesten.")
- Recuerde a su adolescente que su experiencia no es única. Reconozca esto y luego deje que él/ella sepa que otras personas pueden haber lidiado con esos problemas.
- No compare a su adolescente con sus hermanos, otros hijos, su niñez.
- No reaccione en demasía ("¿Cómo puedes pensar en algo así?")
- Pause; respire profundamente y escuche.
- Tenga normas y límites definidos, pero siga la regla de conformidad mínima. Es decir, decida en los requisitos mínimos absolutos de conducta, hablar, vestir, etc, y deje de lado lo demás. De todas formas, usted no puede hacer cumplir esos requisitos, y cuanto más tenga, menos infuencia tendrá.

3. Sea consciente de las presiones y las expectativas que usted ejerce en su hijo(a). Obviamente, los hijos deben aprender a perseverar y desarrollar disciplina, pero cada uno de ellos lo logra a su manera y a un ritmo diferente.Es difícil llevar un equilibrio entre preparar a los hijos para las presiones de la vida y agregar más presión de su parte con respecto a la escuela, deportes, éxitos, apariencia, modales y demás.

4. Sea consciente de las demandas que los jóvenes se autoimponen. Ésta puede ser una fuente muy importante de tensión para los adolescentes.

5. Siga esta regla simple del Dr. Hiam Ginott, autor de *Between Parent and Child* (Entre el padre y el hijo):

   "El reconocimiento siempre precede al consejo o directrices." (Por ejemplo, "yo sé que la universidad era muy importante para tí y me doy cuenta que esto es muy perturbador, pero consideremos otras alternativas." o "Veo que Tom significa mucho para tí. Es duro, pero me pregunto si no estás siendo un poco severo contigo mismo.")

Si su hijo(a) parece preocupado o hace un comentario aparentemente inesperado de autolastimarse, no se alarme si lo toma muy en serio. Siéntese con su hijo(a) y déjele saber su preocupación, y diga que usted prefiere reaccionar mucho en lugar de muy poco, y que usted siempre responderá a tal conducta o declaraciones.

Si usted no está seguro de cómo responder a su hijo(a), hable con otro adulto de confianza: otro padre, personal escolar, un religioso, o un profesional de salud mental. Luego decida un curso específico de acción.

Recuerde que es difícil para los padres imaginar que sus adolescentes pudieran sentirse tan mal para que el sucidio pudiera ser una alternativa posible (¡no mi hijo!). Pero recuerde que todos los padres de adolescentes que se suicidaron dicen que ellos también se sintieron así, y ellos instan a otros padres a escuchar y tomar medidas.

El punto final con respecto a las responsabilidades de los padres tiene que ver con dos hechos: (1) mucho de los suicidios de adolescentes son más impulsivos que el suicidio en el adulto, y (2) el método primario de suicidio del adolescente es armas de fuego. Por lo tanto, restringir acceso a instrumentos para cometer suicidio es una forma importante de prevenirlo. Por el momento, esto puede guardar las armas de fuego bajo llave, pero esto no es suficiente. Obviamente, si un adolescente está deprimido o ansioso, o demuestra una conducta impulsiva, se deben sacar las armas de la casa.

What Would You Do?

A good friend of yours has seemed troubled lately and has begun to keep more and more to himself. One day you go to see him and he tells you he would like to talk to you about something, but you must promise to keep it a secret. He seems pretty serious and you value your friendship with him so you agree not to tell anyone what he has to say. He tells you that he and everyone else would be better off if he were dead. Then he says, "Sometimes I think I might as well kill myself." He smiles and shrugs his shoulders when he says it. He then reminds you of your promise not to tell anyone. He says that you are the only person he trusts, and if you tell, he will never forgive you.

1. How do you feel when you hear him say this?

2. What do you decide to do or say?

Questionnaire: True or False?

Please answer true or false to the following statements.

	TRUE	FALSE
1. People who talk about suicide do not actually kill themselves.	○	○
2. Suicide happens without warning signs.	○	○
3. Suicide occurs equally as often among rich, middle class, and poor people.	○	○
4. Males die by suicide more often than females.	○	○
5. Once a person is suicidal, he or she is suicidal forever.	○	○
6. If a person feels better after a suicide attempt, it means he or she will probably not try to do it again.	○	○
7. Suicidal people really want to die.	○	○
8. Talking about suicide or asking someone about suicide may put the idea in the person's head and cause suicide.	○	○
9. People who threaten to kill themselves are just seeking attention.	○	○

Warning Signs of Suicide/FACTS

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

FEELINGS

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

ACTIONS

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

CHANGES

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

THREATS

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

SITUATIONS

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

A Teen's Guide to Suicide Prevention
Discussion Guidelines

List the suicide warning signs you observed in each scenario in each category of the word "FACTS":

	FEELINGS	**A**CTIONS	**C**HANGES	**T**HREATS	**S**ITUATIONS
Scene 4					
Scene 3					
Scene 2					
Scene 1					

Observe how friends introduce the idea of involving adults in each situation and whom they choose to involve.

	How?	Who?
Scene 1		
Scene 2		
Scene 3		
Scene 4		

Helpful Steps to Prevent Suicide

1. Show You Care

"I am concerned about you, about how you are acting and the things you are saying . . ."

2. Ask about Suicide

"Are you thinking about suicide?"

3. Get Help

"This is serious. I am going to help you get help. Let's call the crisis line."

One Life Saved
Discussion Questions

What warning signs of suicide did TJ show? Write these in the boxes according to the Warning Signs of Suicide/FACTS handout.

FEELINGS	**A**CTIONS OR EVENTS IN TJ'S LIFE
CHANGES IN TJ	**T**HREATS BY TJ
SITUATIONS	

What steps did TJ's friends take to help prevent his suicide?

1. _____

_____

2. _____

_____

3. _____

_____

The Qualities of Helpful People

Helpful people notice signs of suicidal behavior such as:

- **Feelings:** hopeless, helpless, very sad, agitated, anxious
- **Actions/Events:** drug or alcohol use, talk of death, a major fight or argument, isolation from usual friends and/or activities, aggression
- **Changes:** in personality, behaviors, sleeping and eating patterns, interests and hobbies, appearance; sudden improvement in mood after being down or withdrawn
- **Threats:** statements about death and dying, threat to kill self if something doesn't go right, a plan for suicide, making a will or giving away favorite things, self-injury, or any suicidal gesture or attempt
- **Situations:** recent loss, breakup, or getting into trouble

What to Do:

1. **Show You Care**
   - **a.** Listen without judging or giving advice.
   - **b.** Take all talk of suicide seriously.
   - **c.** Stay calm, stay with your friend.
2. **Ask about Suicide**
   - **a.** Ask about suicide very directly: "Are you thinking about suicide?"
   - **b.** "Are you wishing you were dead?"
   - **c.** "Are you planning how you will kill yourself?"
3. **Get Help**
   - **a.** Take action sooner rather than later.
   - **b.** Have your friend identify a trusted adult and offer to go with him or her to talk to that adult.
   - **c.** Call a crisis line.
   - **d.** Offer help/hope in any way you can.
   - **e.** Know your own limits.
   - **f.** Ask a trusted adult for help, even if your friend resists.

What to Avoid:

- Do not argue with a suicidal person.
- Do not offer simple solutions.
- Do not promise secrecy. Keeping a potential suicide a secret is a form of assuming responsibility.
- Do not treat the situation lightly, even if your friend begins to joke about it.
- Do not challenge your friend or suggest drugs or alcohol as a solution.
- Do not leave your friend alone unless you sense personal danger.
- Do not try to be the only person to rescue your friend. Get help.
- Do not try to forcefully remove a gun from anyone. Call for help.

Relationship Gone Wrong

Role-Play 1

Characters

Moderator
Jorge
Jayden

Instructions: Moderator reads Background and Introduction, and facilitates the discussion questions between scenes with assistance from the classroom teacher as necessary.

Background: Jayden has been dating Lindsay for two years and she just dumped him for somebody else. Jayden was really, really upset by it and missed a few days of school. Now he has come back to school. He is partying and pretending like nothing ever happened.

Scene 1

Introduction: Jorge, Jayden's best friend, has pulled Jayden aside at school.

Jorge: Hey, what's going on, dude? I missed you the last couple of days. Where you been?

Jayden: Here and there. Wanna get out of this place and start a party somewhere?

Jorge: What are you talking about? We've got our last driver's ed class after school today.

Jayden: I could care less!

Jorge: I wanna talk to you about that. I've heard you've been blowing off a lot of stuff lately and doing an awful lot of partying ever since Lindsay dumped you. Too bad about that, dude, 'cause she was hot.

Jayden: Whatever. She didn't mean anything to me and it doesn't matter anymore.

Jorge: Are you sure you're okay?

Jayden: *(in a hostile manner)* Yeah. I told you it doesn't matter. *(nonchalant tone)* So are you coming with me or not?

Role-play created by Wiscasset High School (Maine) Suicide Prevention Project Team, 2003.

Jorge: No, I'm not. I want to finish this class so I can get my driver's license. And if you don't get your act together, Jayden, not only will you not get your license but Coach might find out and you're gonna get kicked off the basketball team, too.

Jayden: I don't care; that doesn't matter anymore either. Hey, look dude, you're being a real drag. I gotta go.

Moderator: CUT

Suggested "between-scene" questions for the moderator:

1. What warning signs and clues did you notice in this scene?

   Possible answers:

   - change in behavior: wanting to party
   - being absent from school
   - wanting to cut classes
   - not being upset about breakup
   - not caring about getting license or getting kicked off basketball team
   - being a pain to his best friend

2. Which of the three intervention steps did Jorge use in scene 1?

   Possible answers:

   Jorge showed caring by

   - noticing the changes in his friend
   - asking questions
   - reminding Jayden of consequences of his behavior

Scene 2

Introduction: Jorge goes to Jayden's house after school because he is unhappy about how their conversation ended earlier. He finds Jayden in his unusually immaculate room.

Jorge: Dude, why is your room so clean?

Jayden: I just figured I'd leave everything neat.

Jorge: Where you going?

Jayden: Nowhere. *(in an irritated voice)* Never mind.

Jorge: Not to get on your case or anything, but you've really been acting strange. Dude, you're scaring me; you sound suicidal.

Jayden: *(long awkward pause)* Well, the other day I was walking around the house and I found my dad's gun, and I reached a decision.

Jorge: What's that?

Jayden: That it's the only way I can hurt Lindsay like she hurt me.

Jorge: Whoa. Look Jayden, you're my best friend and I wanna help you. I need to know, are you suicidal? *(PAUSE)* Is there some adult you feel comfortable talking to?

Jayden: I don't know.

Jorge: Well, how 'bout Coach? You've always been close to him.

Jayden: Well, I guess. I just never talked to Coach about that kind of stuff before.

Jorge: Would it help if I came with you?

Jayden: Okay.

Jorge: Why don't we go to my house tonight and we'll talk to Coach in the morning?

Moderator: CUT

Suggested discussion questions for the moderator:

1. Which intervention steps does Jorge use in scene 2?

   Possible answers:

   - Shows caring by going to Jayden's house after school
   - Asks directly about suicide
   - Suggests turning to Coach for help and offers to go with him

2. Why did Jorge suggest spending the night at his house?

   Possible answers:

   - He was so worried about Jayden, he didn't want to leave him alone.
   - He knew there was a gun in Jayden's house.

3. What more could Jorge do?

   Possible answer:

   - Speak to Jayden's parents, or another trusted adult

The Perfect Student

Role-Play 2

Characters

Moderator
Alexa
Owen

Instructions: Moderator reads Background and Introduction, and facilitates the discussion questions between scenes with assistance from the classroom teacher as necessary.

Background: Owen is a straight-A student and a varsity athlete. His parents are very strict and put a lot of pressure on him to be perfect. Owen just got an F on his final research paper in English, bringing his otherwise-perfect grade down to a C. His GPA is in the tank. Because of this, his parents have grounded him and taken away his cell phone.

Scene 1

Introduction: Owen's friend Alexa finds him in the school library staring at his homework rather than doing it.

Alexa: Owen, what's wrong? Were you crying?

Owen: No, no I'm fine. *(wiping his eyes)* Why?

Alexa: You don't seem yourself today. Are you sure you are okay?

Owen: Yeah, actually, I feel a lot better. *(He crumples up a take-home test and throws it in the trash.)* As a matter of fact, now that I've decided not to do this test, I feel great. In fact, I'm not going to do any homework anymore! I'm not going to go to college or get a job, and my parents can just deal with it!

Alexa: Owen, I don't understand, why are you doing this?

Owen: Because I'm tired of being perfect, tired of doing what other people want me to do and just tired of my life! What's the point? I feel like I'm doing all this for everybody else, but nobody really cares. Even my best isn't good enough.

Role-play created by Wiscasset High School (Maine) Suicide Prevention Project Team, 2003.

Alexa: Umm . . . But you're so good at everything you do. You'll see, you'll go to a good school, and get a good job and make a lot of money . . .

Owen: But I don't care! That's what my teachers and my parents and everybody else want, but what about what I want?

Alexa: Well, why don't you talk to your parents and tell them that you don't want to do this anymore?

Owen: They don't care how I feel. They're just trying to live their lives through me. I can't talk to them.

Alexa: I'm here for you. I think all the work you put into school and sports is awesome. You can always talk to me.

Owen: You're just saying that 'cause you feel bad for me. I'm done. The only way I can make my life my own again is to take it from my parents.

Moderator: CUT

Suggested "between-scene" questions for the moderator:

1. What warning signs and clues did you notice in scene 1?

   Possible answers:

   - drastic change in grades, attitude, and behaviors
   - comment "they don't care how I feel"
   - Owen was crying in the library

2. Which intervention steps, if any, did Alexa use in scene 1?

   Possible answers:

   - She showed concern, noticed that he wasn't himself
   - Listened to what he was saying
   - Offered to talk anytime

Scene 2

Introduction: Later that same day at school.

Alexa: Owen, I was thinking about what you said earlier, and the last statement you made really worried me. I just wanted to make sure that you weren't thinking about ending your life.

Owen: What else can I do?

Alexa: Is that a yes?

Owen: I don't know what I'm saying. I just feel so lost. Alexa, PLEASE don't tell anyone. Promise me you won't tell.

Alexa: I can't keep this a secret, Owen. This is VERY serious. I think it would really help you to talk to someone.

Owen: But I don't want to talk to anyone I know. Everyone thinks I'm perfect.

Alexa: How about calling the suicide hotline? They won't know who you are.

Owen: Well . . . I don't know . . .

Alexa: Would you feel better if we called from my house?

Owen: Okay. I can do that, I guess.

Moderator: CUT

Suggested discussion questions for the moderator:

1. Alexa continues her suicide intervention in scene 2. What specifically does she do? How does she handle it when Owen asks her to promise not to tell anyone?

   Possible answers:

   - She asks if he is thinking about ending his life . . . and confirms his response.
   - She immediately refuses to keep his suicidal behavior a secret.
   - She suggests calling the suicide hotline and making the call together from her house.

2. Where could Alexa turn for additional support for herself and Owen? (Name some school or community resources where you could turn for help.)

College Crisis

Role-Play 3

Characters

Moderator
Maria
Olivia

Instructions: Moderator reads Background and Introduction and facilitates the discussion questions between scenes with assistance from the classroom teacher as necessary.

Background: Olivia and Maria are sisters, two years apart in age, and very close. Four years ago, when she was a freshman in high school, Olivia attempted suicide. Olivia has recently gone away to college and she misses home a lot. She feels isolated and has not made many friends yet. She has been struggling academically and she feels like a failure.

Scene 1

Introduction: Maria calls her sister for a phone conversation.

Maria: Hi Olivia, it's Maria. I'm glad I caught you this time. I missed talking to you the other day.

Olivia: I've been busy. College is harder than I thought it would be.

Maria: Why is it so hard? You're so smart.

Olivia: The classes are harder and the professors don't have time to give extra help. Plus, I haven't made many friends. I feel so . . . overwhelmed.

Maria: You mean like how you felt when you were a freshman in high school?

Olivia: I almost feel worse. This is so much harder. Everyone at home expects so much from me.

Maria: Have you talked to Mom or Dad?

Olivia: I don't want to disappoint them. I just feel like giving up.

Maria: Olivia, I love you and I'm worried about you. Are you feeling suicidal again?

Olivia: *(mumbles)* . . . I don't really know how I feel.

Maria: Look, I am really worried about you. Maybe we should talk about it.

Olivia: I'm sorry, I can't right now. I've got to go to class in 10 minutes. I'll call you back after class.

Maria: You promise? What time will you call?

Olivia: I promise. I'll call in an hour and a half . . . look, I PROMISE.

Moderator: CUT

Suggested "between-scene" questions for the moderator:

1. What warning signs did Olivia exhibit?

   Possible answers:

   - Being isolated at school
   - Saying she feels overwhelmed
   - Saying she feels like giving up

2. What steps did Maria take to intervene?

   Possible answers:

   - Asking why Olivia feels the way she does
   - Suggesting Olivia talk to their parents
   - Telling Olivia she loves her
   - Asking if she feels suicidal

3. What could Maria do to get help?

   Possible answers:

   - She could call their parents.
   - She could make sure she's around to take Olivia's next phone call.

Scene 2

Introduction: Olivia calls Maria back after class. During Olivia's class, Maria talked to their mom.

Olivia: Hi.

Maria: I'm glad that you called me back.

Olivia: I just didn't want to worry you.

Maria: Well, I am worried. I talked to Mom about it.

Olivia: You did what? What did she say?

Maria: She's worried too, very worried in fact. We're here for you and we want to help.

Olivia: How can you help me? You're so far away.

Maria: Well, I can stay on the phone with you. What about going to the campus health center?

Olivia: No way! I don't want to talk to a complete stranger. How would that help? Besides, I don't know anyone over there and I don't want anyone to see me go in there.

Maria: Don't you remember when you talked to a counselor last time? That helped.

Olivia: I guess.

Maria: *(pause)* Olivia, Mom has just been on the other phone with the health center. They were really glad she called. They are expecting you and want you to ask for a counselor named Anne. If you don't go in on your own, they will send someone to see you in your room. Why don't you walk to the health center while I stay on the phone, and when you get there we'll hang up and I'll wait for you to call back right after you meet and talk with Anne.

Olivia: Wow. Okay. I can't believe I'm doing this. I'm scared. Keep talking . . .

Maria: Mom said they sounded very nice at the health center . . . and we'll both be waiting to talk to you right after you meet Anne. Just think . . . only three more weeks and you'll be home on break. I can't wait to see you, Olivia.

Moderator: CUT

Suggested discussion questions for the moderator:

1. What were the three steps that Maria took to help Olivia?

   Possible answers:

   - She talked to their mother about her concerns.
   - She stayed on the phone while Olivia walked to the health center.
   - She said she would call back after Olivia saw the counselor.

2. What challenges did Maria have to overcome to help Olivia?

   Possible answers:

   - Being long-distance
   - Having to wait while Olivia went to class
   - Finding an adult—her mom—to make the arrangements to get Olivia help

3. What would you do if Olivia was your friend and she resisted help?

Poor Poetry

Role-Play 4

Characters

Moderator
DeAndre
Seth

Instructions: Moderator reads Background and Introduction and facilitates the discussion questions between scenes with assistance from the classroom teacher as necessary.

Background: Seth and DeAndre are neighbors who have been very close friends since elementary school but now attend different high schools. Seth is a poet who writes lyrics for DeAndre's band. DeAndre just got a text from Seth that contains his latest lyrics.

Scene 1

Introduction: Seth just turned on his cell phone and DeAndre sends him a text message.

(Actors pretend to text, but they read text messages out loud.)

DeAndre: I just got the lyrics you sent me. They're kind of . . . depressing.

Seth: That's just how I've been feeling lately.

DeAndre: Well, why? What's up?

Seth: I have no friends.

DeAndre: Hello? What about me?

Seth: I mean at this school. No one talks to me.

DeAndre: What about the people in drama club?

Seth: I dropped out.

DeAndre: I thought that you liked drama.

Seth: I just don't care about it anymore.

DeAndre: You just had a great part!

Seth: Yeah, but I suck at it. Anyway, I have to go to dinner.

DeAndre: Will you text me later?

Seth: Maybe.

Moderator: CUT

Suggested "between-scene" questions for the moderator:

1. What warning signs has Seth exhibited?

   Possible answers:

   - Writing a depressing song and admitting he feels depressed
   - Dropping out of the drama club
   - Saying he has no friends even though he does
   - Saying he sucks at something he really is good at

2. What intervention steps has DeAndre taken?

   Possible answer:

   - Shows he cares by asking about Seth's life

3. What is the difficulty of not being face to face when you're worried about a friend?

   Possible answer:

   - Can't read nonverbal cues (facial expressions, body language, etc.)

Scene 2

Introduction: Two hours later, DeAndre checks to see if Seth has sent him another text. He hasn't so DeAndre decides to call him.

Seth: Hello?

DeAndre: Oh good, you're home.

Seth: Yeah, but I'm on my way out.

DeAndre: Can I talk to you for a minute?

Seth: Sure, I guess. But make it quick.

DeAndre: I wanted to talk to you about our conversation earlier. Why didn't you get back to me?

Seth: I just didn't feel like it.

DeAndre: I was worried. You don't seem like yourself lately. You seem really unhappy.

Seth: I am. Life sucks. I just want to get it over with.

DeAndre: Are you saying that you want to kill yourself?

Seth: I've thought about it. It might be easier.

DeAndre: Have you told anyone else that you feel like killing yourself?

Seth: No. No one would care.

DeAndre: I care.

Seth: You're the only one. Who else would I tell?

DeAndre: Well, I think you should tell an adult that you trust. You've said that you get along really well with your English teacher. Why don't you tell him?

Seth: I guess, but I've never talked with him about anything really personal. I'd feel really stupid. I should be able to handle this myself.

DeAndre: C'mon Seth, we've been through a lot together. If you want, I could go with you after school tomorrow.

Seth: If you think that will help.

DeAndre: I think it will. If it doesn't, we'll think of something else. Will you promise to meet me after school? Right at the main entrance?

Seth: Yeah, I guess so.

DeAndre: So can you come over here and hang out for a little while now? I want you to hear the music I've written for your latest lyrics. Plus my dad just called and says he's bringing pizza home for supper.

Seth: Sure, I guess.

DeAndre: Okay, I'll be waiting.

Moderator: CUT

Suggested discussion questions for the moderator:

1. How did DeAndre follow up on the intervention he started in scene 1?

   Possible answers:

   - He shows he cares by not waiting for Seth to text him—he called Seth first.
   - He asks Seth if he's thinking about killing himself.
   - He suggests Seth talk to a trusted adult and offers to go with him.

2. How does being on a phone or text messaging affect confronting a friend about suicide?

   Possible answers:

   - It may be easier to discuss when you are not face to face, and your friend may be more honest in texting than in person.
   - More difficult to tell how your friend is responding.

3. Do you think DeAndre's confrontation would have been as effective if he were online or texting?

Role-Play Discussion

Role-Play 1: Jorge and Jayden

What warning signs of suicide did Jayden show? Write these in the boxes according to the Warning Signs of Suicide/FACTS handout.

FEELINGS (JAYDEN'S)	**ACTIONS OR EVENTS IN JAYDEN'S LIFE**
CHANGES IN JAYDEN	**THREATS BY JAYDEN**
SITUATIONS	

What steps did Jorge take to help Jayden?

1. _____

_____

2. _____

_____

3. _____

_____

Role-Play Discussion

Role-Play 2: Owen and Alexa

What warning signs of suicide did Owen show? Write these in the boxes according to the Warning Signs of Suicide/FACTS handout.

FEELINGS (OWEN'S)	**ACTIONS OR EVENTS IN OWEN'S LIFE**
CHANGES IN OWEN	**THREATS BY OWEN**
SITUATIONS	

What steps did Alexa take to help Owen?

1. _____

_____

2. _____

_____

3. _____

_____

Role-Play Discussion

Role-Play 3: Olivia and Maria

What warning signs of suicide did Olivia show? Write these in the boxes according to the Warning Signs of Suicide/FACTS handout.

FEELINGS (OLIVIA'S)	**A**CTIONS OR EVENTS IN OLIVIA'S LIFE
CHANGES IN OLIVIA	**T**HREATS BY OLIVIA
SITUATIONS	

What steps did Maria take to help Olivia?

1. _____

_____

2. _____

_____

3. _____

_____

Role-Play Discussion

Role-Play 4: Seth and DeAndre

What warning signs of suicide did Seth show? Write these in the boxes according to the Warning Signs of Suicide/FACTS handout.

FEELINGS (SETH'S)	**A**CTIONS OR EVENTS IN SETH'S LIFE
CHANGES IN SETH	**T**HREATS BY SETH
SITUATIONS	

What steps did DeAndre take to help Seth?

1. _____

_____

2. _____

_____

3. _____

_____

Help-Seeking Pledge

I know that people sometimes need help with their problems.

I have learned to recognize the signs of suicidal behavior, and I know how to get help.

If I see signs of suicidal behavior in me or someone else, I am willing to get help from a trusted adult.

Those trusted adults include:

Name _____

Phone _____ E-mail _____

Name _____

Phone _____ E-mail _____

Name _____

Phone _____ E-mail _____

Signed _____ _____
(Name) (Date)

Possible warning signs of suicide

- Planning, talking, or thinking about suicide
- Persistent feelings of anger, depression, being overwhelmed
- Drastic change in appearance, mood, attitude, or behavior
- Previous suicide attempts or harming oneself
- Feelings of hopelessness or of being alone

What you can do

- Get help! Find a trusted adult and/or call the National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
- Remember, it's not your fault
- Don't judge, mock, lecture, or put down
- Know your limitations—don't get over-involved

Local resources that can help (school counselor, teacher, trusted adult or relative)

_____

_____

← FOLD IN HALF, THEN CUT ON DASHED LINE

Lifelines

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

Do you know someone who might be thinking about suicide?

Be a LIFELINE!

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Local resources that can help (school counselor, teacher, trusted adult or relative)

_____

_____

← FOLD IN HALF, THEN CUT ON DASHED LINE

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